

BOARD OF DIRECTORS' MEETING IN PUBLIC

Wednesday, 22 July 2026, 09:00-12:30

Microsoft Teams for presenters/observers

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 – GP Out of Hours (OOH) service	Chief People Officer	Discussion	Enclosed	09:05
Opening Items					
3.	Register of Directors' Interests and declarations on items on the agenda	Chair	Assurance	Enclosed	09:20
4.	Minutes of the meeting held on 20 May 2026		Approval	Enclosed	
5.	Action log and Matters Arising from the Minutes		Assurance	Enclosed	
Strategic, Regulatory & System					
6.	Trust Chair's report	Chair	Discussion	Enclosed	09:25
7.	Chief Executive's report	CEO	Discussion	Enclosed	09:35
[Link to the NHS Thames Valley Integrated Care Board (ICB) Board papers: https://www.thamesvalley.icb.nhs.uk/about-us/board-meetings-in-public]					
8.	Corporate Affairs report: • Legal, Regulatory and Policy; • Horizon Scanning; • Board site visits quarterly update; • Fit & Proper Person annual submission	ED of Corp Affairs	Information & Assurance	Enclosed	09:50
9.	Board Assurance Framework	ED of Corp Affairs	Information & Assurance	Enclosed	
10.	Trust Strategy 2026-2031 including: a. Trust Strategy b. Draft Strategy Delivery Plan c. Strategy Engagement report	ED of Strategy & Partnerships	Approval & Information	Enclosed	10:00

¹ Apologies: Rob Bale, Chief Operating Officer for Mental Health & Learning Disability
Attending virtually: Mohinder Sawhney and Lucy Weston, Non-Executive Directors

11.	Integrated performance and sustainability reporting: a. Integrated Performance Report (IPR) b. Quality & Safety Dashboard c. Finance report	Exec Team	Information & Assurance	Enclosed & Reading Room (25)	10:15
12.	Patient Safety Incidents (PSI) report	Chief Nurse	Assurance	Enclosed	10:35
13.	Guardian of Safe Working Hours report	Chief Medical Officer	Assurance	Enclosed	10:45

10 minutes' break 10:55 – 11:05

14.	Thames Valley Mental Health Provider Collaborative update	ED of Strategy & Partnerships ²	Information & Assurance	Enclosed	11:05

Research & Education

15.	Research & Development (R&D) report	Director of R&D/ Chief Medical Officer	Information	Enclosed	11:20

Governance & Reports on recommendation of committees

16.	Committee assurance reports (3As) ³ : a. Audit & Risk Committee 15 June 2026 b. Mental Health & Law Committee 07 July 2026 c. People, Leadership & Culture Committee 08 July 2026 d. Quality Committee 09 July 2026 e. Finance & Investment Committee 14 July 2026	Committee Chairs	Discussion & Assurance	Enclosed, Verbal & Reading Room (28)	11:35
17.	Recommendations from the People, Leadership & Culture Committee: a) Workforce Race Equality Standard (WRES) report; b) Workforce Disability Equality Standard (WDES) report; and c) Freedom to Speak Up report	Chief People Officer FTSU Guardians	Assurance	Enclosed & Reading Room (26-27)	11:55
18.	Board Skills Assessment	ED of Corp Affairs	Information	Enclosed	12:05
19.	Modern Slavery Act Transparency Statement	ED of Corp Affairs	Approval	Enclosed	

Closing matters & Resolution to conduct private business

20.	Any Other Business				12:20
21.	Questions from the public, governors or staff				
22.	Review of the Meeting				

² Rob Bale, Chief Operating Officer for Mental Health & Learning Disability, has given apologies for this meeting.

³ None expected from the Charity Committee as not met since 13 May 2026.

Close

12:30

Dates of next meetings:

- 30 September 2026
- 25 November 2026

READING ROOM/APPENDIX

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

24. Appendix to the Chief Executive's report:
 - Link to the NHS Thames Valley Integrated Care Board (**ICB**) Board papers:
<https://www.thamesvalley.icb.nhs.uk/about-us/board-meetings-in-public>
25. IPR appendices:
 - A. Changes to IPR metrics monitored during Financial Year 2026-27
 - B. National Oversight Framework (**NOF**) 2026/27
26. WRES and WDES reports
27. Freedom to Speak Up annual report
28. Committee minutes and agendas:
 - a) Audit & Risk Committee 23 April and agenda 15 June 2026
 - b) Finance & Investment Committee 05 May and agenda 14 July 2026
 - c) Mental Health & Law Committee 12 May and agenda 07 July 2026
 - d) People, Leadership & Culture Committee 21 April and agenda 08 July 2026
 - e) Quality Committee 07 May and agenda 09 July 2026

Meeting:	Board of Directors' Meeting
Date of Meeting:	22 July 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 (interim)
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 story is presented by V who is an Advanced Clinical Practitioner in our Oxfordshire GP Out of Hours (OOH) service. V joined Oxford Health as an agency Advanced Clinical Practitioner after a long nursing career that began in 1999, bringing experience from both care homes and acute settings.

After a year in post, in June 2025 V secured a substantive role with Oxford Health and became the first ACP in the GP Out of Hours team, playing a pivotal role in shaping and improving the service. Today, the team includes two ACPs, with three more nurses working towards Master's-level ACP qualifications, supported by V through training, induction and development—including non-medical prescribing. As part of the role, ACPs provide face-to-face and telephone care, lead home visits and triage, and support many patients with complex and palliative needs.

V's leadership has helped build a trusted, highly collaborative team working closely with GPs and community services such as Hospital at Home and the Urgent Community Response team. Together, they focus on delivering high-quality, continuous care while reducing unnecessary hospital admissions. When admission is needed, the team carefully plans each step to improve patient experience and reduce anxiety for families. Alongside clinical leadership,

V is also leading research at one of 100 national sites (our Banbury site) in the Afloat study, sponsored by Southampton University, exploring the use of antibiotics in older adults with lower respiratory infections—helping to strengthen the evidence base for care in this important area.

The GP Out of Hours service operates across Oxfordshire's large and diverse population (≈800,000), delivering urgent primary care outside normal hours (evenings, overnight, weekends and bank holidays) when the rest of the system is largely closed.

This extended operating model presents some unique challenges making workforce stability difficult to achieve, continuity and team cohesion difficult. However, the team remain dedicated to continuous improvement and engaged with research alongside four Quality Improvement projects.

A review of the GP Out of Hours service identified the need for a more sustainable, multidisciplinary workforce model to address demand, recruitment challenges and the need for timely, community-based care—particularly for palliative patients. In response, budgets were realigned to support a broader skill mix, including dedicated non-medical clinicians, supported through buddying models and targeted recruitment.

The development of dedicated advanced and specialist practice was also a key part of the model. Competency development and learning opportunities was identified as essential to ensure staff were supported to work safely and confidently within the OOH environment. This provided assurance that the evolving workforce was underpinned by appropriate training, supervision and clinical governance.

To support ongoing development and governance, quarterly meetings have been introduced alongside eight-weekly group clinical supervision, with the option for additional one-to-one support where required aside from normal line manager supervision. Away days have also been commenced to strengthen team engagement, shared learning and service development.

The revised OOH model has strengthened service resilience by creating a more structured and sustainable workforce to meet demand outside normal working hours. The introduction of dedicated non-medical clinicians, specialist practitioner and healthcare assistant buddying, and additional palliative care support has improved the service's ability to provide timely community-based care and support admission avoidance.

For staff, the model has provided clearer role development, improved access to clinical supervision and created opportunities for shared learning through quarterly meetings and away days. From a governance perspective, the focus on competency development, supervision and structured review has helped provide assurance that the service is developing safely, with a workforce model aligned to patient need and the operational demands of urgent care.

We will hear more from V about his journey with the OOH team and how he has been supported in his own development and with supporting others in the team.

Background information

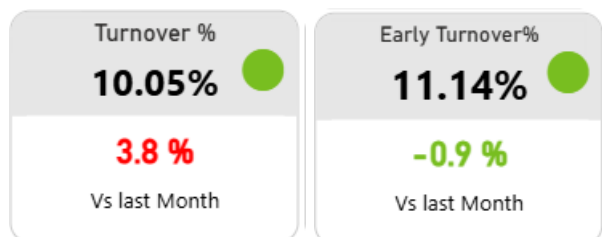
GP Out of Hours Services;

Oxfordshire has over 60 GP practices and a registered population of just under 800,000. The GP Out of Hours (OOH) service provides care when surgeries are closed. The service also supports an estimated 50,000 transient population (visitors and seasonal students) and operates for longer hours than any single practice, providing consistent access across evenings, overnight, weekends and bank holidays. Nationally and locally, demand has shifted: patients increasingly

seek same day support through OOH, including for needs that are not clinically urgent. NHS 111 is not yet sufficiently refined to consistently filter this demand, which continues to shape workload and flow.

The GP Out of Hours (OOH) is a distinct, demand-led service and is not directly comparable with other community services. It provides urgent access to primary care outside normal hours and acts as a safety net for the wider system; as such, activity cannot be “switched off” or deferred when demand increases.

Workforce Indicators for GP Out of Hours:



PDR rate 88% (as of 23 June 2026)

Supervision rate 75%

This story brings to life **We are a team** through the strong partnerships between ACPs, GPs and community services, working together to deliver seamless, patient-centred care and reduce unnecessary admissions. It also reflects **We are learning**, with V leading the development of a new ACP workforce, supporting training and contributing to national research that is shaping future clinical practice.

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 V 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	



(Agenda item: 3)

REGISTER OF DIRECTORS’ INTERESTS

July 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.

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
Helen Mackenzie	Non-Executive Director	Non-Executive Director with Royal Berkshire Hospital NHS Foundation Trust (provides acute services to the population of Berkshire and is part of the NHS Thames Valley Integrated Care Board (ICB), formerly the Buckinghamshire, Oxfordshire and Berkshire West (BOB) ICB) until August 2026.
Kamal Mahtani	Non-Executive Director – Nominee of the University of Oxford	Professor Kamal Mahtani (KM) is Professor of Evidence-Based Healthcare in the Nuffield Department of Primary Care Health Sciences at the University of Oxford . His academic responsibilities include leadership roles across postgraduate education and research, including serving as Director of the MSc in Global Healthcare Leadership and Director of the Oxford International Primary Care Research Leadership Programme. He is also a Fellow of Kellogg College, University of Oxford, and a Fellow of the Royal College of General Practitioners . He continues to provide clinical services to the NHS as a General Practitioner . KM is also a Director of KAM Healthcare Consultants Ltd , a family-owned private limited company operated jointly with his wife.
Karl Marlowe	Chief Medical Officer	Honorary member of Oxford University's Department of Psychiatry . Associate Fellow, Green Templeton College, University of Oxford . Chair: Oxford Health Biomedical Research Centre; Applied Research Collaboration Oxford & Thames Valley; Oxford HealthTech Research Centre; Oxford Health Clinical Research Facility Board Member: Health Innovation Network Oxford & Thames Valley Chairman of Trustees: 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).

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

		Wife is founder of ' Jump in puddles ' a social purpose 'UK B-Corp' consultancy working with various social purpose companies.
Harjit Sandhu	Non-Executive Director	Non-Executive Director and Chair of Audit and Risk Assurance Committee at Building Safety Regulator, an executive non-departmental public body sponsored by the Ministry of Housing, Communities and Local Government. Shareholder in Soha Housing Ltd, a social housing company. The shareholding carries no financial benefit, but was linked to having previously been a Non-Executive Director at Soha, and opted to keep the shareholding after the Non-Executive Director role ended.
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); Provost of Rhodes House for a 2-year period from July 2026-28.

		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 Content Editorial Board, London Museum, 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)
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. Patient and Public Involvement (PPI) Lead for a grant application from the University of Oxford – Department of Psychiatry, working with Child & Adolescent Mental Health Services in Oxford, including through Oxford Health NHS FT, and Liverpool to the Wellcome global charitable foundation.
Andrea Young	Trust Chair (from 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, 20 May 2026 at 09:00 Microsoft Teams virtual meeting

Present:¹

Andrea Young (AY)	Trust Chair (the Chair)
Grant Macdonald (GM)	Chief Executive Officer
Amélie Bages (AB)	Executive Director of Strategy & Partnerships* ²
Rob Bale (RB)	Chief Operating Officer for Mental Health & Learning Disability
Geraldine Cumberbatch (GC)	Non-Executive Director – <i>part meeting</i>
Charmaine De Souza (CDS)	Chief People Officer
Taff Gidi (TG)	Executive Director of Corporate Affairs*
Emma Leaver (EL)	Chief Operating Officer for Community Health Services, Dentistry & Primary Care
Kamal Mahtani (KMa)	Non-Executive Director appointee of the University of Oxford
Helen Mackenzie (HM)	Non-Executive Director
Karl Marlowe (KM)	Chief Medical Officer
Harjit Sandhu (HSa)	Non-Executive Director
Heather Smith (HS)	Chief Finance Officer
Rick Trainor (RT)	Non-Executive Director

In attendance³:

Attendees/observers from Oxford Health NHS FT staff

Charlotte Adamson	Senior Programme Manager, Planning – <i>part meeting</i>
Julie Cooper	Experience & Involvement Facilitator – <i>part meeting</i>
Charlotte Evans	Executive Office Manager
Etelvina Ferreira	Head of Infection Prevention & Control – <i>part meeting</i>
Tina Malhotra	Clinical Director for Buckinghamshire Mental Health Services – <i>part meeting</i>
Lola Martos	Clinical Director for Oxfordshire, Bath & North East Somerset, Swindon and Wiltshire (OBSW) Mental Health Services – <i>part meeting</i>
Petronella Moyo	Healthcare Assistant
Tendai Mugariri	Clinical Lead – Witney Emergency Multidisciplinary Assessment Unit – <i>part meeting</i>
Isalet Mutua	Assistant Project Manager - IM&T – <i>part meeting</i>
Vicky Naidoo	Recovery and Lived Experience Involvement Lead – <i>part meeting</i>
Maria Nikolaou	Interim Corporate Governance Officer – <i>part meeting</i>
Rachel Pirie	Head of Planning
Roberta Silva	Experience & Involvement Facilitator – <i>part meeting</i>
Hannah Smith (HaS)	Assistant Trust Secretary (Minutes)
Amber Sparrowhawk	Experience & Involvement Lead – <i>part meeting</i>
Bill Tiplady	Director of Psychological Professions – <i>in attendance for the Chief Nurse</i>
Helen Wain	Experience & Involvement Lead (Buckinghamshire) – <i>part meeting</i>

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

Haiyong Wang

Project Manager – Performance Team

Other attendees/observers

Anna Barnes

Good Governance Institute

Michael Holland

Chief Executive Designate

BOD 40/26	Welcome and Apologies for Absence	
a	The Trust Chair welcomed Board members and attendees to the meeting, especially: (i) newly appointed Non-Executive Directors, Harjit Sandhu and Helen Mackenzie; and (ii) Chief Executive Designate, Michael Holland, who would be observing.	
b	Apologies for absence were received from: Britta Klinck, Chief Nurse; and Mohinder Sawhney and Lucy Weston, Non-Executive Directors.	
BOD 41/26	Lived Experience Voices Groups – with Experts by Experience	
a	The Director of Psychological Professions introduced to the meeting: members of the Experience & Involvement team; the Chair and Co-Chair of 'Our Voice' in Oxfordshire; and members of 'Bucks Voice' in Buckinghamshire.	
b	The Experience & Involvement team presented the slides and the Chair of 'Our Voice' in Oxfordshire: (i) introduced themselves and their work as an Expert by Experience over a number of years, including most recently with the Oxfordshire Mental Health Partnership; (ii) explained the opportunity for Adults and Older Adults with experience in Oxfordshire Mental Health services, including both patients and carers, to participate through the 'Our Voice' forum in shaping models of care, co-designing and delivering training; and (iii) highlighted that participation could be a powerful part of recovery and help to provide better person-centred care for patients. They commented that their experiences of services had been mixed but they were pleased that they could share positive experiences as well as more challenging ones.	
c	The members of 'Bucks Voice' described their experiences as carers and service users and highlighted that their roles as Experts by Experience provided opportunities to: (i) act as critical friends for the Trust in providing support and challenge; and (ii) become involved in projects with departments, directorates and individuals to improve services. They highlighted their work: participating in interview panels (for example for the incoming Chief Executive); providing feedback on patient information leaflets; contributing to peer review processes; updating core clinical standards; delivering staff training sessions; and working on the Trust's first Neurodivergent Strategy 2026-29.	
d	The 'Bucks Voice' and 'Our Voice' members emphasised the potential resource which lived experience could provide for the Trust in supporting patient care and improvements. They looked forward to presenting more regularly at Board meetings in public in this agenda slot, alternating with Patient Stories, and: (i) bringing the voices of lived experience more directly to the attention of the Board; (ii) sharing the depth of Expert by Experience work taking place across the Trust; (iii) offering insights on matters relevant to Board business and decision-making; (iv) engaging in dialogue with the Board, noting their aim to be pragmatic and respect the systemic and financial limitations which also impacted the Trust; and (v) operating as partners with the Trust.	
e	The Chief Executive acknowledged the constructive challenge and learning he had received from Experts by Experience, including those presenting to this meeting, over the years and thanked them. He welcomed the Voices Groups presenting more regularly at Board meetings in public and the potential for this to close the gap in understanding between imagined, as opposed to real, experiences and to help the Board to make better informed decisions.	

f	Further to questions from Non-Executive Directors, the 'Bucks Voice' and 'Our Voice' members: - explained that the work and focus of Experts by Experience was informed by a two-way communication process between the Experts by Experience and Trust staff. They commended the support they had received from senior staff and the Experience & Involvement team; and - highlighted their input into: (i) Patient-Reported Outcome Measures (PROMs) collaborative care planning; (ii) training and webinars developed for staff to accompany the Neurodivergent Strategy; (iii) the 'Right Care, Right Person' national operational model used by the police when responding to calls, including when considering application of Section 136 of the Mental Health Act; and suicide awareness and prevention training, including Q&A discussion with staff.	
g	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care noted that she looked forward to working more closely with Experts by Experience and developing these roles in the Community Health Services directorate. The Director of Psychological Professions added that the Voices Groups had been most developed in the mental health directorates but the Experience & Involvement team hoped to expand these into the Community Health Services directorate as well as Forensic and Learning Disability services.	
h	The Trust Chair thanked the Experts by Experience and the Experience & Involvement team for the discussion and their contribution to the ongoing development of the Trust, noting that this could be the beginning of a series of conversations which should also encompass difficult and challenging topics.	
i	The Board thanked the Chair and Co-Chair of 'Our Voice' in Oxfordshire, the members of 'Bucks Voice' in Buckinghamshire and the Experience & Involvement team and noted the presentation and discussion. <i>The Chair and Co-Chair of 'Our Voice' in Oxfordshire, the members of 'Bucks Voice' in Buckinghamshire and the members of the Experience & Involvement team left the meeting.</i>	
BOD 42/26	Register of Directors' Interests	
a	No interests were declared pertinent to matters on the agenda.	
BOD 43/26	Minutes and Matters Arising of the meeting held on 25 March 2026	HaS
a	The Minutes of the meeting were approved as a true and accurate record, subject to including more detail of the feedback from Rick Trainor on his visit to Abingdon Community Hospital.	
b	Item BOD 36/26(a) – the Trust Chair referred to the recommendation from the Audit & Risk Committee (ARC) for a further Non-Executive Director to be added to the ARC to strengthen resilience and confirmed that this had been actioned now that newly appointed Non-Executive Directors, Harjit Sandhu and Helen Mackenzie, had joined.	
c	The remaining action (BOD 05/26(b) & 24/26(b)) was noted as open until the next Research & Development report to July 2026 (detail in the Summary of Actions document).	
BOD 44/26	Trust Chair's Report	
a	The Trust Chair took her report as read and added that, since the report had been written, the NHS Modernisation Bill (formerly known as the Health Bill) had been included in the 2026 King's Speech. Further to proposed reforms including national streamlining, governance changes at Integrated Care Board (ICB) and Foundation Trust (FT) level and changes to statutory data functions and the single patient record, the Trust	

	would consider the areas relevant for the organisation, including the implications for NHS governance, alongside its Well Led governance review.	
b	The Board noted the report.	
BOD 45/26	Chief Executive's report	
a	The Chief Executive took his report as read and highlighted: - recent Trust conferences which continued to develop services and activities and build on Strategy and Engagement work, including: (i) the Trust's Annual Nursing Summit; (ii) the Oxfordshire, Bath & North East Somerset, Swindon & Wiltshire (OBSW) Mental Health nursing conference (in particular the range of initiatives underway from both a bottom-up and top-down perspective, as well as the mutual support amongst staff); (iii) the Trust's fourth Senior Doctors' and Dentists' leadership conference; and (iv) the Dental Service development event which took place yesterday; and - the medical and dental Staff Survey results, showing that 75% would recommend the Trust as a place to work, noting the improvement from 55% in 2023. He commended the leadership and engagement activity of the Chief Medical Officer, the Deputy Chief Medical Officer (Professional Standards) and clinical leaders.	
b	The Chief Medical Officer referred to the Dental Service development event and emphasised the importance of the Dental Service in delivering equity for the population which the Trust served, in particular marginalised groups in the local system.	
c	In response to a question from Helen Mackenzie on whether the Trust could achieve equal attendance and access at its professional conferences from across the wide breadth of its geography, the Chief Executive replied that there had been good attendance recently and this was monitored (including attendance from inpatient or other staff groups and from different ethnicities). The OBSW Mental Health nursing conference had also been an example of the Trust providing a regional conference further to the Trust-wide Annual Nursing Summit and in order to provide an additional opportunity for staff who may not have been able to attend the Annual Nursing Summit.	
d	The Trust Chair commended the work taking place on Strategy and Engagement.	
e	The Board noted the report.	
BOD 46/26	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 Trust would assess: (i) the new national clinical standards to reduce maternal deaths; and (ii) the nursing and midwifery educator framework and implement where relevant to Trust services in the Community Health Services directorate; and - the Board and its committees had completed their annual effectiveness self-assessment, as set out in more detail in the report.	
c	Further to a comment from Rick Trainor on the Trust's achievement in improving its digital maturity score and becoming ranked 2 nd out of 50 mental health trusts, the Chief Finance Officer noted that the Trust had only ranked behind a neighbouring trust which it also worked closely with but there was still room for further development and more consistent rollout of digital innovations.	

d	The Board noted the report and that whilst the improvement in the Trust's digital maturity score was positive, it still aspired to further development.	
BOD 47/26	Board Assurance Framework (BAF)	
a	The Executive Director of Corporate Affairs presented the report which provided updates on the BAF and the outcome of a more in-depth year-end review of its risk scores, risk appetite and whether to close any strategic risks.	
b	Further to the detail in the report, he took the Board through proposals to: - review the risk appetite for BAF risk A6 (Improvement, Innovation & Research) which was currently set to 'Open' but the Trust may wish to be less conservative in its approach; - change the risk appetite for BAF risk A8 (Information & Data) to 'Open' from 'Minimal' as although it was important to maintain a strong position on data security, the Trust also needed to be able to use information safely and effectively in order to deliver high quality care; and - change the current risk score for BAF risk A9 (Partnerships & system-working) to 9 from 12, with reduction of the impact score from 4 to 3 given controls and assurances in place.	
c	Further to a question from Kamal Mahtani, the Executive Director of Corporate Affairs explained that: (i) changing the risk appetite for BAF risk A6 (Improvement, Innovation & Research) from 'Open' to 'Seek' would put the Trust in the risk appetite category of being able to more actively pursue innovative options that may offer potentially greater benefits, even if they involved greater inherent risk; (ii) would signal to staff that this was an area in which to think more about solutions to advance delivery of care than risk aversion; and (iii) the BAF risk was set at a strategic, not operational, level and if any operational risks arose in this area then they would be escalated to the Executive, as appropriate, including the Chief Medical Officer as Caldicott Guardian, but the change to risk appetite was a cultural and behavioural change rather than an operational one.	
d	The Chief Medical Officer added that by maintaining a more risk averse approach, the Trust could lag behind other comparative organisations in trialling technology, being innovative or pushing for transformation. The Chief Finance Officer referred to the recent Internal Audit review of the Cyber Assessment Framework-Aligned Data Security & Protection Toolkit (DSPT) which had achieved a green rating of 'significant assurance' and noted that whilst this had been very positive, the Trust was not complacent as cyber security threats evolved rapidly; she confirmed that she supported changing the risk appetite from 'Open' to 'Seek' as appropriate cyber security practices would continue but the organisation needed to be proactive in seeking improvement. Harjit Sandhu, as Chair of the ARC which had received and reviewed the DSPT Internal Audit review added that whilst no Internal Audit review could provide a 100% guarantee, it was highly unusual to receive a review with no recommendations and this provided a high level of confidence that the Trust was operating well within the frameworks set for the NHS and had appropriate controls in place.	
e	The Trust Chair summarised that the Board supported the proposals in the report and acknowledged that the BAF was still developing and would be further reviewed once the new Trust Strategy had been approved. She emphasised the importance of ensuring that the right information was available in order to review BAF controls and risk ratings.	
f	The Board noted the BAF and APPROVED changing: (i) the risk appetite for BAF risk A6 (Improvement, Innovation & Research) to 'Seek' from 'Open'; (ii) the risk appetite for BAF risk A8 (Information & Data) to 'Open' from 'Minimal'; and (iii) the current risk score for BAF risk A9 (Partnerships & system-working) to 9 from 12.	

BOD 48/26	Annual Plan including Financial Plan	
a	The Executive Director of Strategy & Partnerships introduced: (i) the final 2026/27 Annual Plan for approval prior to publication; (ii) the Financial Planning update for information; and (iii) (in the Reading Room) the 2025/26 Annual Plan full year review for information. She explained that the 2026/27 Annual Plan was aligned to the current Trust Strategy, which runs until 2026, and had been updated since previous review to reflect the Trust's contribution to ICB Mental Health & Community Operational Planning Activity and Performance Trajectories. From next year the Annual Plan would be aligned to the new Trust Strategy.	
b	She drew the Board's attention to the Strategic Objectives and Strategic Priorities set out in the presentation at slides 9-11 and highlighted that: reducing use of restrictive practice remained a challenge; there was continued focus on improving working environments for staff and on Equality, Diversity and Inclusion and becoming an anti-discriminatory organisation; and maintaining a balanced financial plan remained a sustainability objective. The 6 Strategic Priorities would help to bridge the current Trust Strategy to the new Trust Strategy which would be finalised over the summer. In terms of the system position, she confirmed that compliant plans, with some caveats, had been submitted to, and approved by, NHS England and the Trust planned to meet all applicable performance targets which the ICB had submitted on behalf of the mental health and physical health sector. Slide 23 set out key Quality Priorities for 2026/27 which had been included in the Annual Plan, including continuing to reduce use of restrictive practice, and the following slides set out priorities for clinical directorates.	
c	The Chief Finance Officer presented the Financial Planning update for information and confirmed that this had not changed significantly from the previous version presented. Income growth was anticipated at £11.7 million and the remaining misalignment between provider expectations and ICB provision was £5.9 million but some of that was anticipated to be resolved once allocations had been finalised. Cost Improvement Programmes had been almost all fully developed for the Trust and the risks and opportunities were set out in the report. The Trust had not been requested to fund system pressures elsewhere.	
d	Further to a question from the Trust Chair on risks to delivery with less overall budget and reduced funding for both Buckinghamshire and OBSW directorates, the Chief Finance Officer noted that she would separately provide the Trust Chair with an update on workforce mapping. The Chief Executive added that there would be more focus this coming year on Whole Time Equivalent growth and increasing capacity to focus upon patients with more serious mental illness, as would be considered by the Chief Operating Officer for Mental Health & Learning Disability and relevant for investment in the Assertive/Intensive Outreach Development Programme (see item BOD 53/26 below).	HS/RB
e	Further to queries from the Trust Chair and Helen Mackenzie on data quality assurance and confidence in achieving performance trajectories: - the Executive Director of Strategy & Partnerships reported that good progress had been made with data quality which was now reviewed through performance boards in each directorate, albeit more progress was needed on recording around ethnicity and protected characteristics; and - the Chief People Officer reported that she was reasonably confident that further agency spend reduction targets could be met, noting better than plan results for 2025/26 temporary staffing and significant medical recruitment. The Chief Finance Officer emphasised that there had been a good trajectory achieved on agency reduction and this had been monitored by NHS England.	

f	The Board APPROVED the 2026/27 Annual Plan and noted the Financial Planning update, the trajectories which the Trust had committed to and (in the Reading Room) the full year report of the 2025/26 Annual Plan.	
BOD 49/26	Integrated Performance, Quality and Sustainability reporting	
a	The Executive Director of Strategy & Partnerships presented the Integrated Performance Report (IPR) which included the NHS National Oversight Framework (NOF) reporting overview. She highlighted that, at Quarter 3, the Trust had moved from segment 1 to 2 of the NOF segmentation system for NHS trusts and foundation trusts. She reminded the Board that movement between segments was relative to the performance of other providers and if other providers improved more then, on relative benchmarking, the Trust would drop in its league table position. Further to the update at the last meeting, she explained that the position had been driven by performance against the metrics on: (i) percentage of discharged patients with a stay over 60 days for Adult Acute Mental Health, which reflected pressures on inpatient services; (ii) 24 hour Crisis Mental Health response times, where improvement had not matched the rate of improvement in other comparable organisations; and (iii) 52-week waits for community services.	
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: - Child and Adolescent Mental Health Services (CAMHS) and challenges with Eating Disorders waiting times. Measures to address this included recruiting to vacancies and reviewing triage processes. A revised CAMHS access target had also been agreed with commissioners and this was anticipated to be met; - overall good Mental Health Urgent Care Services which were performing above national averages but which still had not kept pace with peers on Crisis Mental Health response times. Additional investment would be put into these services through the Mental Health Investment Standard; - performance in Adult and Older Adult acute/inpatient services although there was good understanding of the reasons for long length of stay and Out of Area Placements and some of the new investment for 2026/27 would be used to bolster inpatient provision and community support so as to relieve pressure on inpatient services; - ongoing challenges meeting targets in Community physical health services and work with commissioners to improve performance, although 2-hour emergency care performance remained strong; and - in relation to 52-week waits for community services, focus work required to improve waits for the Children's Speech and Language Therapy service and the Podiatry service. Further to a question from the Helen Mackenzie on whether these services had been impacted by capacity and/or demand issues, the Chief Operating Officer for Community Health Services, Dentistry & Primary Care replied that the Children's service had been impacted by capacity issues and investment had been focused in response; further to recruitment, she anticipated that waits would reduce. She explained that the Podiatry service was subject to national workforce issues although the Trust had deployed apprentices and nurses into the service, to support tissue viability work, the service was impacted by demand and capacity challenges.	
c	'Quality' and 'People' Strategic Objectives She highlighted that in relation to delivery of the: 'Quality' Strategic Objective and Quality metrics, yearly targets for restrictive practice had been exceeded and work continued to reduce usage. Focus	

	remained to reduce verbal racial abuse directed towards staff and was supported by the formal launch of the Violence Prevention and Reduction policy; and • 'People' Strategic Objective, the year-end agency reduction position was £3.45m better than plan and equated to a reduction of £9.7m less spend than last year. The Staff Survey results were for discussion at item BOD 52/26 below.	
d	Further to a query from the Trust Chair on improvement in GP Out Of Hours and palliative care response times, which had been reported to the Quality Committee, and whether this had been sustained, the Chief Operating Officer for Community Health Services, Dentistry & Primary Care reported that this remained an area of focus for the team and although the national target was 2 hours, the team had set itself a stretch target of 1 hour; good performance had been sustained and a palliative care line had been set up which patients could call. <i>Geraldine Cumberbatch joined the meeting.</i>	
e	In response to a question from the Trust Chair on documenting ADHD waits, although this was not currently part of the NOF, the Executive Director of Strategy & Partnerships replied that ADHD waits were monitored at team and service level and considered by the Executive; this was a key area of challenge and the Trust was working with the ICB to review models of care and try to address the backlog. Additional investment had also been secured for this year from the ICB to clear the longest waits, which could be over 4 years in Oxfordshire and 3 years in Buckinghamshire. The Chief Operating Officer for Mental Health & Learning Disability confirmed that ADHD waits were reviewed regularly at directorate and service level for both Children and Adults; investment would be focused on reducing longer waits; and work was taking place through the Provider Collaborative on a plan to address Adult ADHD across the footprint, together with Primary Care.	
f	In response to a question from Helen Mackenzie on whether there were system issues associated with the percentage of discharged patients with a stay over 60 days for Adult Acute Mental Health, the Chief Operating Officer for Mental Health & Learning Disability explained that there were not significant system issues beyond ensuring that appropriate step-down accommodation could be provided. There were also different challenges between the two geographies and work was taking place through the Provider Collaborative to understand rehabilitation needs across the whole Thames Valley geography. In addition, the nature of some illnesses required detention for longer periods in order to receive treatment. However, enhancement of Crisis treatment services should improve Assertive Outreach and length of stay. In Oxfordshire a decision had been taken not to have an inpatient rehabilitation ward (to which patients with long length of stay might have been transferred and then would not be included in the metric) but to work to a High Intensity Support model, which he supported.	
g	The Chief Executive reminded the meeting of: (i) the wider context and that Buckinghamshire had the lowest level of beds per head for the population in England, whilst Oxfordshire had a lower level of beds per head than average; and (ii) the disproportionate impact of 1-2 wards upon the overall reported position.	
h	The Trust Chair noted that as better outcome measures became available, this would support understanding of whether the model of care worked well for people with enduring mental illness.	
i	The Trust Chair confirmed that the Quality & Safety Dashboard (which helped to identify wards/teams which may need support and provide an early warning system) continued to highlight three teams in enhanced support and had been reviewed by the Quality Committee and referred to in the 3As report, for receipt at item BOD 54/26 below. She	

j	referred to the Patient Safety Thematic Review across Buckinghamshire and Oxfordshire into the 7 deaths identified for patients on the ADHD waiting list since early 2022 (at section 2.2 in the Quality & Safety Dashboard) and noted that once the Quality Committee had reviewed the detail then the outcome of the review should also be brought to the Board. The Board noted the report.	BK
BOD 50/26 a b	Finance and Sustainability The Chief Finance Officer presented the Month 12 Finance Report and highlighted that: - revenue surplus had doubled further to allocation of a national redistribution of unutilised Deficit Support Funding; and - the Trust had underspent on capital The Board noted the report and the surplus Month 12 position.	
BOD 51/26 a b c d	Patient Safety Incidents (PSI) report – March-April 2026 The Director of Psychological Professions presented the report on learning identified from 1 patient safety review over the reporting period (related to the Crisis team) 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 22 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 3 of the report across physical and mental health services and included: escalation processes following physical health deterioration; and multi-disciplinary working and holding joint responsibility. Further to a question from the Chief People Officer on how Experts by Experience could be appropriately involved in issues identified from PSIs, the Director of Psychological Professions explained the key lived-experience role of the Patient Safety Partner; this role was closely involved in the process of looking at how investigations were conducted and in holding the Trust to account and considering the actions taken. The Chief Medical Officer added that over the last 3 years, Patient Safety Partners had been valuable in PSIs in challenging perceptions of these investigations and being part of the process. Geraldine Cumberbatch commented upon the increase in use of Incident Learning Huddles and asked whether that reflected an increase in incidents or improved identification of incidents from which learning could be gleaned (cultural improvement). The Director of Psychological Professions reported that there had been a reduction in the number of incidents going to formal investigation but an increase in the number of Incident Learning Huddles, thereby indicating an appropriately calibrated approach. The Board noted the report and was assured by processes and structure for the identification, review and learning from PSIs.	
BOD 52/26 a	Staff Survey results The Chief People Officer presented the report (with supporting detail in the Private Reading Room) and confirmed that the Staff Survey results had been considered by the Extended Leadership Team and the People, Leadership & Culture Committee. She highlighted: the positive increase in engagement demonstrated by the 10% increase in response rates. There remained room for improvement and to build upon this in the future;	

	- the Trust scored above the national average for all 9 of the People Promise elements and themes; - the Trust was now ranked 6th in the country, amongst mental health trusts, as being recommended by staff as a place to work; - continued progress to build an inclusive culture and work taking place with directorates using protected characteristics data. However, staff with a disability continued to report fewer positive experiences across the People Promise themes than non-disabled staff, especially around reasonable adjustments; and - agreed actions were set out in the report and included actions in relation to race equality, reducing violence and aggression, team development, flexible working and directorate action plans and team actions.	
b	Further to a query from Kamal Mahtani on what had been done to improve response rates this year and what else might be done to improve response rates still further, the Chief People Officer referred to a combination of actions including: clinical directorates providing protected time for completion of the survey; the Trust providing additional laptops in clinical areas, especially inpatient unit; reassuring staff that responses remained anonymous; and the Trust providing the opportunity to win small prizes. She added that the new Head of Communications and Engagement would also have a role to maintain and improve response rates. The Chief Operating Officer for Community Health Services, Dentistry & Primary Care added that the Trust had also publicised the ways in which actions had been taken and followed through in response to previous Staff Survey feedback, in order to evidence to staff that their participation made a difference.	
c	In response to a question from Helen Mackenzie on whether Trust staff experienced similar levels of verbal racist abuse as staff nationally, the Chief Executive replied that although there was some in community services, especially in the District Nursing service, the majority was in inpatient settings. The Equality, Diversity & Inclusion Steering Group was considering the results in more granular detail along with potential actions. The Director of Psychological Professions commented upon the challenge in identifying effective actions and noted that inpatient wards were being supported to set up Quality Improvement projects to help to identify actions. The Chief People Officer reflected upon the increasingly challenging national picture and the risks for lone workers conducting visits in the community.	
d	The Trust Chair referred to concerns regarding levels of autonomy and workload in the report and noted the potential correlation with the Royal College of Nursing survey of community mental health nurses (linked to in the Corporate Affairs report discussed at item BOD 46/26 above) which had highlighted staffing issues and caseloads. She asked where workload pressures were most experienced or whether concentrated in particular services and whether the reasons were understood. The Chief People Officer noted that there may be a number of factors including how workforce planning was undertaken. The Chief Operating Officer for Community Health Services, Dentistry & Primary Care noted the challenge for the District Nursing service and the opportunity to do more consistently with administrative staffing roles in order to provide support, as there were some variations across services.	
e	The Trust Chair summarised that even with the positive increased response rate, the Trust aspired to further improvement and would use the available learning and resources to develop meaningful actions. Monitoring and oversight continued through the People, Leadership & Culture Committee whilst the Board would continue to track actions in relation to achieving anti-racism and improving workloads.	
f	The Board noted the report and was assured that the Trust was meeting its mandated requirement to survey its staff and had taken adequate and necessary action based upon the results.	

	<i>The meeting took a break for 10 minutes and resumed at 11:30.</i>	
BOD 53/26	Assertive/Intensive Outreach Development Programme	
a	The Chief Operating Officer for Mental Health & Learning Disability welcomed Tina Malhotra and Lola Martos, respectively the Clinical Directors for Buckinghamshire and OBSW Mental Health Services, to the meeting. He introduced the report and explained that 'Assertive Outreach' (AO) and 'Intensive Case Management' (ICM) were two arms of the same outreach offer and model to deliver care to a client group who could be poorly served, with whom there could be engagement difficulties and who could have enduring mental illness combined with a range of other factors such as homelessness. The Trust's role was to work alongside this client group to help them to utilise the services which were available and to ensure that services reached them. He confirmed that the Trust had reviewed its systems and processes in light of the Care Quality Commission rapid review of Nottinghamshire Healthcare NHS FT, considered how to identify this client group and support staff to work effectively with them. He reported that an application for Mental Health Investment Standard (MHIS) funding had been successful and MHIS funding was now being used to establish a targeted specialist outreach offer: (i) Buckinghamshire would develop an ICM embedded function within existing Community Mental Health Teams; and (ii) Oxfordshire would implement AO hub-and-spoke provision, with the hub operating across the city and spoke components across the north and south of the county (as set out in more detail in the report). Although plans were being progressed through a phased implementation, there was more work to be done and a key feature would involve changing to a new way of working and rolling the changes out carefully in a way that would support service users and their families without disrupting existing services.	
b	The Clinical Director for OBSW explained the choice of the AO hub-and-spoke model and noted that the patient cohort was already known more in the city area and city teams were already delivering more functions in this way, therefore this was a more logical transition to make. The Clinical Director for Buckinghamshire commented on the differences in Buckinghamshire and the need to match local need and geography, for which a county-wide ICM embedded function had been more appropriate. The Chief Operating Officer for Mental Health & Learning Disability added that there would be a network of community practice across both counties to ensure that effective psychosocial interventions (not just medication) were delivered to support people to engage with their families and manage their risks in community settings, as well as to support different groups and partners operating in this environment (including housing services and the voluntary sector).	
c	The Chief Executive acknowledged national attention further to the tragic incidents in Nottingham and commented upon the Assertive/Intensive Outreach model as a population health management approach which could support people with psychosis and other limiting factors. He emphasised the importance of continuity of care for this client group and invited the Chief Operating Officer for Mental Health & Learning Disability to comment upon the variation between the AO and ICM service models. The Chief Operating Officer for Mental Health & Learning Disability explained the variation by reference to the different demographics and areas of deprivation in the two counties, noting the concentration of the client group in Oxford city compared to more even distribution across Buckinghamshire where it had been determined that staff could be more effective if embedded within existing teams. He also noted the importance of additional interventions which needed to work alongside the Trust's interventions, for example: supporting people with accommodation, relationships and meaningful daytime activity; and physical health needs.	

d	Further to questions from Geraldine Cumberbatch on the effectiveness of the new models, cost of implementation and how the models would allow space for family members and carers, the Chief Operating Officer for Mental Health & Learning Disability confirmed that: he was familiar with both AO and ICM models as he had used both before; their effectiveness had been evidenced through research; and the AO and ICM models were not very different to previous models but focused more on supporting people in the community in a more assertive way. He acknowledged the challenge with families feeling disenfranchised and emphasised the importance of working in partnership with families. The Chief Medical Officer added that appropriately involving carers and sharing information was emphasised throughout the Trust. The Clinical Director for Buckinghamshire added that MHIS funding had been provided and services were keen to utilise this. The Chief Medical Officer noted that investment was also being provided for mental health urgent response and developing early intervention teams.	RB
e	The Chief Medical Officer commented that the autonomy of individuals in the client group to make decisions for themselves needed to be balanced with the appropriate application of assertive interventions. He commented upon the challenge of doing two things at the same time in giving individuals autonomy whilst being appropriately assertive.	
f	Further to discussion with the Board, the Chief Operating Officer for Mental Health & Learning Disability agreed: i. to provide an update in 18 months' time on implementation and impact of Assertive/Intensive Outreach for the Board in public; ii. in relation to continuity of care for the patients in the Assertive/Intensive Outreach group, and prior to any patients moving consultant, to bring a report to the Quality Committee setting out how risks would be mitigated for patients in that group and for the Quality Committee to take assurance on this (and then be able to report back to the Board via 3As reporting); iii. when the outcome of the Nottingham Inquiry was published, to provide an update to the Board against recommendations arising (although more detailed oversight of the implementation should sit with the Quality Committee); and iv. to consider whether patients from this client group could come and discuss their care and experiences with the Board and reflect upon what may have changed from their perspective and whether they felt a difference through working with the new model 6-9 months in.	
g	The Board noted the report and that whilst more detailed oversight would sit with the Quality Committee, updates would be provided to the Board, including on: implementation and impact of Assertive/Intensive Outreach; and recommendations arising from the Nottingham Inquiry.	
BOD 54/26	Board Committees' update reports – matters for Alert, Advice & Assurance (3As)	
a	The Board took as read the 3As report from the Quality Committee.	
b	Verbal updates were provided by: i. Harjit Sandhu, as Chair of the ARC, who confirmed he had the draft minutes to refer to, and there were no matters to escalate for alert or advice. He confirmed that he had undertaken preliminary meetings with the external providers of the Trust's External Audit, Internal Audit and Counter Fraud services, which had been positive and reassuring. The ARC meeting had: received and welcomed the DSPT Internal Audit review referred to at item BOD 47/26(d) above; considered progress with the production of the year-end Annual Report & Accounts; and recommended the outcome of the competitive tender process for the next External Audit contract for final approval by the Council of Governors;	

c	ii. Geraldine Cumberbatch, as Chair of the Mental Health & Law Committee, who: (i) reported increased compliance with training (albeit with potential passporting challenges for some medical staff which may have impacted previously reported figures); and (ii) highlighted that representation from a clinical staff member would be required to support the Committee and replace the previous provider but in the interim, cover was being provided through the Chief Medical Officer and the Chief Operating Officer for Mental Health & Learning Disability; and iii. Rick Trainor, as Chair of the Charity Committee, who reported that the meeting last week had considered the Charity's finances including the outturn for 2025/26, which had demonstrated further depletion of resources in the context of increases in expenditure. However, the Committee had been able to conclude that the Charity was clearly still a Going Concern and it had endorsed a more proactive and strategic fundraising approach which it was hoped would have net positive results for the year ahead. A future meeting would consider refining reporting on the distinction between restricted and unrestricted funds. The Committee also supported bringing the reporting of the Charity's risks into a format more consistent with that in use in the wider Trust. The Board noted the 3As updates from the Committees, with minutes and agendas in the Reading Room.	
BOD 55/26 a b c	Recommendations from the Quality Committee: Director of Infection Prevention & Control (IPC) report; and Complaints annual report The Trust Chair introduced the: Director of Infection Prevention & Control report; and the Complaints annual report. She confirmed that both had been reviewed and recommended by the Quality Committee to the Board. She highlighted from the Director of IPC report the improved compliance and rigour on IPC and strengthened antimicrobial stewardship (AMS) which she invited the Head of IPC to discuss with the Board. The Head of IPC outline plans to further enhance AMS governance through setting up an AMS Steering Group and a new AMS Strategy which would be reviewed through the Quality Committee. The Board received and approved the: Director of Infection Prevention & Control report; and the Complaints annual report.	
BOD 56/26 a b	Any Other Business/Questions/Review of the meeting None. There was no formal Board meeting in private after the conclusion of this meeting.	
	The meeting was closed at: 12:17	

Summary of Actions from the Board meeting on 20 May 2026

Relevant Item	Actions	Responsibility:
BOD 43/26(a)	Minutes of the meeting held on 25 March 2026 To include more detail of the feedback from Rick Trainor on his visit to Abingdon Community Hospital. Status: complete – updated at BOD 27/26(c) to read: “The Board discussed recent visits to services which they had undertaken. The Chief Executive and the Trust Chair noted the importance of appropriately resourcing Estates; and the potential for formal and informal visits to support staff to raise their aspirations for their environments. Rick Trainor reported that he had visited Abingdon Community Hospital and been struck by the commitment and morale of staff and their rapport with the Chief Operating Officer for Community Health Services, Dentistry & Primary Care.”	HaS
BOD 48/26(d)	Annual Plan and Financial Planning Further to a question from the Trust Chair on risks to delivery with less overall budget and reduced funding for both Buckinghamshire and OBSW directorates, the Chief Finance Officer noted that she would separately provide the Trust Chair with an update on workforce mapping. Status: in progress – workforce implications of investments agreed so far were presented at Finance and Investment Committee on 14 July. A full mapping including any further investments and any offsetting staffing reductions planned will be provided after the Phase 2 allocations have been completed.	HS/RB
BOD 49/26(i)	Patient Safety Thematic Review across Buckinghamshire and Oxfordshire into the 7 deaths identified for patients on the ADHD waiting list since early 2022 Once the Quality Committee had reviewed the detail then the outcome of the review should also be brought to the Board. Status: in progress – the Quality Committee meeting on 09 July 2026 received a verbal update on the scoping exercise for the Patient Safety Thematic Review into the 7 deaths on the ADHD waiting list (also referred to in the 3As report on the agenda for the July 2026 Board meeting at item 16(d) and noted that due to report later in the year). Once reviewed by the Quality Committee later in 2026 then the outcome to be reported to the Board.	BK

BOD 53/26(f)	Assertive/Intensive Outreach Further to discussion with the Board, the Chief Operating Officer for Mental Health & Learning Disability agreed: i. to provide an update in 18 months' time on implementation and impact of Assertive/Intensive Outreach for the Board in public; ii. in relation to continuity of care for the patients in the Assertive/Intensive Outreach group, and prior to any patients moving consultant, to bring a report to the Quality Committee setting out how risks would be mitigated for patients in that group and for the Quality Committee to take assurance on this (and then be able to report back to the Board via 3As reporting); iii. when the outcome of the Nottingham Inquiry was published, to provide an update to the Board against recommendations arising (although more detailed oversight of the implementation should sit with the Quality Committee); and iv. to consider whether patients from this client group could come and discuss their care and experiences with the Board and reflect upon what may have changed from their perspective and whether they felt a difference through working with the new model 6-9 months in. Status: in progress: i. <i>scheduled for the Board/included on Board workplan from November 2027;</i> ii. <i>included on Quality Committee workplan;</i> iii. <i>included on Quality Committee workplan; and</i> iv. <i>in progress - Experience & Involvement Leads discussing with the Oxon Adult/Older Adult MH E&I team to develop a patient story for later in the year.</i>	RB
	Action from the Board meeting on 28 January 2026	
BOD 05/26(b) & 24/26(b)	Research & Development (R&D) report R&D report to set out how the Trust translated research into clinical practice. Lucy Weston noted that potentially a heading in the next report may satisfy this. Status: complete - <i>R&D reporting on the agenda for July 2026 and action may be more for directorate service transformation than R&D.</i>	KM

Meeting	Board of Directors
Date of Meeting	22 July 2026
Agenda item	6
Report title	Trust Chair's report
Executive lead(s)	N/A
Report author(s)	Andrea Young, Trust Chair
Action this paper	☐ Decision/approval ☒ Information ☐ Assurance
Reason for submission to the Board	For information
Public or confidential	Public

Report

It's been an uplifting month in terms of showcasing and listening to some of the great work going on with our partners and in our communities.

First up, several of us participated in the **Oxford Academic Health Partners** awayday to discuss how best to improve our collaboration in research activity, innovation and translation into practice across the two Universities, the Health Innovation Network and the two large Trusts in Oxford. The Thames Valley ICB is also an informal partner. The aim being to maximise investment potential and research success, and in a way that benefits can be extended beyond our immediate region. Key priorities include developing the Nursing, Midwifery, AHP research workforce and making it as easy as possible for industry to get a single Oxford voice. A new chair for the Partnership is being sought, further updates will come later in the year. Meantime both Trusts with the Universities and collaborating partners, are in the process of renewing BRCs, where the financial envelope is likely to be capped for some.

University of Oxford Academic Department of Psychiatry hosted an uplifting day on the **Future of Psychiatry** at which many of our clinicians, with joint research roles spoke of their ground breaking work into mental health conditions, speeding up diagnosis through prediction tools (Philip McGuire), personalising medication for better outcomes (Andrea Cipriani), reaching people beyond clinic rooms (young people and schools, Mina Fazal), the correlation of co-morbidities and dementia (Sana Suri) and highlighting the impact of gender and hormonal differences on treatment regimes (Bodyl Brand). The event also provided a highly relevant opportunity to showcase the new Warneford Park Development as embodying an optimistic view of the future of

mental health care. This presentation was perfectly pitched by Heidi Johansen Berg, PCV of Strategic initiatives at the University of Oxford, demonstrating the strength of our partnership in this programme.

Last week the **Oxfordshire Director of Public Health launched his Annual Report** at Unipart House and took the opportunity to review progress made in the last 5 years (2019-2025). Remarkably of our 10 most deprived wards, several have made progress on closing the mortality gap. Those remaining in the most deprived include Littlemore/Rose Hill, Greater Leys and West Witney. The report can be read here.

[Homepage | Public Health Report Oxfordshire](#)

The event also included presentations from all the different Community Development groups working in Oxfordshire, many in the mental health space. There is a very robust infrastructure in place in each District, with Community Health development officers acting as a resource and connector for all work in their area. As we move into population health and neighbourhood working activities there are clearly well-established links, rooted in the communities they serve, well connected and with support from Healthwatch, evaluating their impact. Community insight profiles have been successfully deployed to match support with community identified needs in 3 places. These are now being rolled out across the County. Useful information to tap into.

Staying with Community Health, I attended the launch of the recently refurbished **Emergency Medical Unit at Abingdon**. Given all we know about the constraints of this site, the facility is a tribute to great planning, teamwork, and a patient focus. Despite 30c plus heat it was a very successful event, and we could see the attention to detail that has gone into making this a facility, which cares for acutely unwell and sometimes vulnerable, frail patients a fantastic space. The staff are a credit to us.

Finally, this is the last Board meeting for our Chief Executive, Grant Macdonald and I want to put on record my and the Board's thanks for everything he has done for our organisation. I know Grant will be much missed by staff, he has struck the tricky balance of leading an organisation with clarity and an improvement focus, whilst staying firmly rooted in the 'real work' that goes on in wards, clinics and community. He has done this with a deep appreciation of, and respect for our staff, and the patients we serve. We wish him all the best in his retirement and whatever comes next.

I also want to say thank you to Mindy Sawhney, Non-Executive director who has served the Board for five years. Mindy has steered the People, Leadership and Culture work of the board to a place where most of our people metrics are in a good place. Mindy is continuing with her NHS NED career, and we wish her every success.

Andrea Young, Trust Chair

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
Date of Meeting	22 July 2026
Agenda item	7
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

Staff awards 2026

June's Oxford Health Staff Awards were a powerful opportunity to recognise the talent, dedication and compassion of colleagues across the organisation, and to celebrate those whose achievements demonstrate our values in action and the difference they make every day for patients, carers and one another. My thanks to all those who won and who were nominated (I've included the award categories and winners and runners-up at the end of my report), and to those who helped make the event such a success.

Recognition of staff

Our staff's contribution has also been recognised nationally. Specialist Perinatal Mental Health Nurse Leanne Howlett was awarded a Medal of the Order of the British Empire (BEM) in the King's Birthday Honours for her work supporting families affected by perinatal mental illness. Meanwhile, Jamie Terone, Jess Higgs and Adrian Krajewski were featured in NHS England's campaign *The Faces That Make Up Our NHS*, recognising their contribution towards a workforce to be proud of nationwide.

Furthermore, I was delighted to receive a letter from colleagues in public health at NHS England expressing their sincere gratitude to our colleagues in community health services and the school immunisation team lead by Mark Chambers and Fiona Singleton for their exceptional commitment and unwavering support during the recent response to the meningococcal Group B cluster in Reading. They noted that;

The speed, professionalism and flexibility demonstrated by your teams were instrumental in delivering a timely and effective public health response. We are particularly grateful for

your leadership in organising and delivering chemoprophylaxis through your community clinics, ensuring that those identified as close contacts were able to access treatment promptly and efficiently.

In addition, your willingness to mobilise resources at short notice to provide on-site vaccination clinics at the college was invaluable. This rapid deployment helped protect those at increased risk, reassured students, staff and families, and played a vital role in the wider management of the incident.

Staff support hub

Alongside recognition, we continue to strengthen the support available to colleagues. The launch of our new Staff Support Hub brings together guidance and resources in one place, including support on wellbeing, inclusion and anti-racism, and provides a single source of information during periods of operational pressure. This focus on support and development is reflected in the annual Personal Development Review (PDR) process, now well underway, with expectations of improved completion rates and constructive conversations building on good work in recent years to improve retention and engagement.

Quality Account 2025/26

In recent weeks, the Trust's Quality Account 2025/26 has been published. Quality Accounts are annual report published by NHS providers providing information on the quality services. It evaluates patient safety, treatment effectiveness, and patient feedback, outlining areas of success, ongoing areas of focus, and specific improvement priorities. OHFT's report, which is available on our website, demonstrates strong performance on quality, health inequalities and organisational culture.

Clinical Audit week

Late June was Clinical Audit Awareness week – a week focusing on how clinical audit and data-driven improvement can help improve the quality, patient outcomes and safety. To mark the week, the OHFT put on a programme of sessions including clinical audit as a strategic enabler, patient involvement and care equity, and data informed improvement. My thanks to all involved for the work put into the week.

Learning Disability week

The 15-21 June was Learning Disabilities Awareness week – the theme of the week was 'Do you see me?' and set out to highlight the voices, achievements and experiences of people with learning disabilities. The Trust's Learning Disability team showcased its important work in this areas highlighting work by experts by experience in improvement recruitment of staff, and the design and delivery of care for example dental care and minor injury services. The week also helped promote the 'Have a go' festival on 9th July at the Horspath Sports Ground. This is the 12th annual festival and is a popular event for people with a learning disability across Oxfordshire and surrounding areas promoting socialising, having fun, being active and promoting accessible sports and leisure opportunities locally.

Commemorating 200 years of the Warneford Hospital

Friday 10 July marked 200 years to the day of the first patient admitted to the Warneford Hospital back in 1826. This year has seen a range of activities and events arranged to commemorate the bicentenary of the hospital and the history of mental health in Oxfordshire including a therapy garden, historical play, and exhibitions on the history of

the site. The 10 July date was marked with a few words from our Chief Medical Officer, Dr Karl Marlowe, the opening of the Warneford guided history walk, and prayers from local faith leaders.

Final Board meeting as Chief Executive

As this is my final report to the Board as Chief Executive, I would like to take this opportunity to thank colleagues across the Trust for their commitment, support and candour during my years as Chief Executive.

My successor, Michael Holland, starts in early September and I have no doubt he will continue to build the culture required to ensure that we serve – patients and public – and our colleagues, in line with the principles and values inherent in the NHS Constitution.

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.

Staff award categories, award winners and runners-up

Award	Winner	Runners-up
Inclusion Award	Jennifer Cox	Babung Ceesay; Lama Halime
Living the Values Award	Gemma Footman	Carol Beaumont; Claire Rae
Delivering Care Award	Marie Steele de Lozada	Clarrie Kannan; Rebecca Wimble
Safe Award	Clarrie Kannan	Kirsty Gee; Sasha Robinson Keiller
Health & Wellbeing Award	Joanne Mildenhall	Poonkuzhali Chandramohan; Thomas Smith
Recognising Excellence & Innovation Award	Adrian Krajewski	Heather McManus; Lilly Grantham-Hughes
Preceptorship Award	Diana Baah	Eleojo Omede
Volunteer of the Year Award	Johan Schoeman	Godwin Adejo; Shayan Gul
Clinical Teamwork Award	Buckinghamshire CAMHS Single Point of Access	Evenlode; Swindon CAMHS Team
Central Services Teamwork Award	Mental Health Outcomes Improvement Programme Team	E&F Compliance; Mental Health Act Legislation Team (MHA Office)
Inspiring Team Award: Mental Health and Learning Disabilities Directorate	Allen Ward	Aylesbury CMHT; Wiltshire Mental Health Support Teams
Inspiring Team Award: Community Health Services, Dentistry and Primary Care Directorate	District Nurse Locality Leads	Abbey Ward, Didcot Community Hospital Teams & Abingdon EMU; Witney MIU
Flexible Clinical Team Award	Community Therapy Service West	Care Home Support Service (CHSS); School Aged Immunisation Team
Flexible Central Services Team Award	GP Out of Hours: Operational Rota Team	CHSDPC Transformation Team; IPS Employment Services
Co-Production Award	PROMS, Collaborative Care planning and Keyworker roles (PCK Project)	Co-ordination of services as part of the Trust wide End-of-Life Steering Group; Optimising ROSY respite within the CCN service
Improving Patient Experience Award	John Stewart	Oxford Crisis Resolution & Home Treatment Team; Simolen Muchechetere

Meeting:	Board of Directors' Meeting
Date of Meeting:	22 July 2026
Agenda item:	8
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:

- Best practice guide for NHS frailty pathways
- EHRC guidance following UK Supreme Court ruling on the meaning of sex in the Equality Act
- UK Supreme Court judgment on deprivation of liberty
- Trust pleads guilty to charges under fire safety legislation
- Renewed Women's Health Strategy for England
- NHS England - Records Management Code of Practice
- Cyber security guide for executive and non-executive directors
- Ockenden Maternity Review
- Guidance to Procurement Policy Note 024: Insourcing and the Public Interest Test
- Improving mouthcare standards for hospital inpatients
- Advanced Foundation Trust

Board 'Listen & Learn' Visits

In November 2025, the Trust introduced a refreshed approach to Board 'Listen & Learn Visits' to provide different opportunities for Board members to visit clinical and corporate support services throughout the year for Board members to jointly or individually visit services. The visits allow Board members to triangulate information received through Board reports with insights from observations and hearing directly from staff and service users. Included in [Appendix 2](#) below is a summary of the recent visits completed between February and June 2026, and Part B includes the upcoming visits that are planned from July 2026 onwards.

Annual Report and Accounts

The Trust successfully submitted its Annual Report and Accounts for 2025-26 to NHS England by the deadline of 30 June 2026. This will be presented to the Trust's Annual General Meeting on 24th September 2026.

Non-Executive Board Changes

Mindy Sawhney will be leaving the Trust on 31 July 2026. Mindy has been a Non-Executive Director with the Trust since January 2021 and most recently was Chair of the People, Leadership and Culture Committee. We thank her for her lasting contributions and wish her well in her new role. Mindy will be replaced by Teresa Beach who will join the Board from 1 September 2026 as Chair of the People, Leadership and Culture Committee. Teresa brings extensive experience as a Non-Executive Director including having previously been a Vice Chair and Chair of Risk, Audit and Nominations Committee at Reach2 Academy Trust. She brings commercial executive experience in HR and technology including previously a Group HR Chief Operating Officer for a global professional services firm.

Annual Fit & Proper Person Test Submission

The Trust successfully submitted its annual Fit & Proper Persons compliance report to NHS England by the end of June deadline. Annually NHS England require Trust's to submit a return on completion of Fit & Proper Person Tests (FPPT) for the outgoing year to comply with the FPPT framework for board members. Following completion of individual declarations by directors over May and June 2026, OHFT's return was submitted to NHS England on the 30th June 2026 deadline noting that directors had completed their individual declaration with no issues to raised. There was one outstanding self-assessment which was not completed by the time of the submission and will be returned to NHSE over July.

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 in this report and the actions identified against the horizon scanning report.

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) – JULY 2026

Recent Insights

Item	Description	Lead	Actions	Due Date
EHRC guidance following UK Supreme Court ruling on the meaning of sex in the Equality Act	On 21 May 2026, the Minister for Women and Equalities laid our updated code of practice for services, public functions and associations in Parliament. Parliament had 40 days from the laying date to review the code. If Parliament does not disapprove the code, the UK government will set a date for it to come into force and we will publish it on our website. UK Supreme Court ruling on the meaning of sex in the Equality Act: our work EHRC	DoCA CNO CPO	An initial briefing was presented by DoCA to the Executive Team Meeting on 8 th June. Actions have been agreed for CNO and CPO to progress. NHS specific Guidance not yet issued.	Sep 2026
Supreme Court redefines Deprivation of Liberty	The UK Supreme Court judgment on deprivation of liberty has overturned its 2014 Cheshire West ruling and changed the definition of deprivation of liberty. The Supreme Court's reversal of Cheshire West explained - Community Care	DoCA CMO COOs	An initial briefing was presented to the Executive Team Meeting on 8th June. Update was presented to Mental Health & Law Committee. Summary is attached in Appendix 3.	Closed
Trust pleads guilty to charges under fire safety legislation	Lancashire and South Cumbria NHS Foundation Trust recently pleaded guilty to six charges under fire safety legislation. Charges were brought against the Trust and a Facilities Management company by Lancashire Fire and Rescue Service. Charges were brought following a fire in December 2023 where a patient reportedly set fire to a mattress in his room and died from injuries sustained from the fire. The charges against the trust include breaches of the Fire Safety Order relating to general fire safety precautions, maintenance and staff training. Whilst the Trust pleaded guilty to six charges,	CFO	This will be reported via Fire, Health, Safety & Security (FHSS) Meeting and Quality Committee with a focus on learning where applicable.	Sep 2026

	the facilities management company have reportedly pleaded not guilty to four charges related to fire safety. Trust pleads guilty after patient fire death - News - Patient Safety Learning - the hub			
Renewed Women's Health Strategy for England	The renewed Women's Health Strategy sets out how the government will improve women's health and healthcare over the next 10 years. Renewed Women's Health Strategy for England - GOV.UK	COOs CMO CNO	To review the strategy and identify actions the Trust needs to take. This will need to be reported via Quality Committee.	Dec 2026
NHS England - Records Management Code of Practice	NHS England published a revised Records Management Code of Practice in June 2026. The Records Management Code of Practice provides guidance on how to keep records, including how long to keep different types of records. Records Management Code of Practice - NHS England Digital	DoCA	Trust to undertake review and identify any changes required. This will be overseen via the Information Management Group and then reported to Finance and Investment Committee.	Dec 2026
Cyber security guide for executive and non-executive directors	A letter has been received from the head of Cybersecurity for NHSE asking boards to assure themselves that cyber security risks are being managed effectively, with clear, sustained programmes for improvement. Cyber security guide for executive and non-executive directors - NHS England Digital	CFO DoCA	Work is now underway with updates to IMG and then Finance and Investment Committee.	Dec 2026
Ockenden Maternity Review	The final report on the independent review of maternity services at the Nottingham University Hospitals NHS Trust has been published which considered the quality of care relating to newborn, infant and maternal harm at the Trust. Final Report of the Independent Review - Ockenden Review	CEO CNO	Covered in the Chief Executive's Report in July 2026.	Closed

NHS overhauls clinical standards to reduce maternal deaths	Every maternity service in England will need to meet new clinical standards, set out by the NHS, to significantly reduce the number of women who die each year during or after pregnancy. NHS England » NHS overhauls clinical standards to reduce maternal deaths	COO CHDPC	The Trust does not deliver maternity services. We now have access to Badgernet which is the Maternity IT system used by the OUH meaning we get notification of every Oxfordshire mother at booking. This means we can monitor pregnancy outcomes as they progress. Maternity services risk assess mothers and rate them 1-4 on a vulnerability matrix. The 0-19 service would offer a home visit antenatally to those mothers flagging vulnerability. The 0-19 service do also take referrals from GPs or social care of antenatal mothers.	Closed
Guidance to Procurement Policy Note 024: Insourcing and the Public Interest Test	The guidance introduces a formal framework to help public bodies consider whether services currently outsourced would deliver better public value if brought back in-house. It is intended to support more strategic sourcing decisions that consider long-term value, service quality, resilience and wider social and economic benefits, rather than focusing primarily on short-term cost. It is mandatory for central government	CFO	Trust to develop an implementation plan. Update will be provided to Finance & Investment Committee in the next Procurement Report.	Dec 2026

	departments. All other contracting authorities (including NHS trusts) should consider this guidance as best practice. PPN 024: The Public Interest Test and Insourcing Strategy - GOV.UK			
Improving mouthcare standards for hospital inpatients	The Mouth Care Matters (MCM) programme, demonstrates how simple interventions including training staff, providing appropriate oral health care products and embedding mouth care into daily practice, can deliver significant improvements. Analysis shows how every £1 invested in MCM, £2.66 was returned in inpatient healthcare benefits and £17 in wider social benefits. The Trust has received a letter to implement a sustainable oral health care pathway.	CMO CNO	Trust's dentistry services to lead on the work for implementing within the Trust.	Mar 2027
Advanced Foundation Trust	The second wave of the Advanced Foundation Trust Programme is planned to include 16 trusts who will begin assessment in 2026/27. NHS England » Advanced foundation trusts	CEO DoCA	Broadly speaking, 16 Trusts selected were all in NOF 1 over the last 4 quarters.	Mar 2027

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

Previous Insights: Updates & Actions

Item	Description	Lead	Actions	Due Date
Data (Use and Access) Act 2025	The DUAA updates UK digital information laws to promote innovation and economic growth, easing 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	CMO DoCA	The Trust's Data Protection Officer to review the new law 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.	Dec 2026
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	The Thames Valley ICB will be developing a strategic commission strategy.	Jul 2026
Best practice guide for NHS frailty pathways	This best practice guide sets out the priorities and related key actions to help ensure people living with frailty and those who support them. NHS England » Best practice guide for NHS frailty pathways	COO CHDPC	We have a range of services who focus on managing frailty proactively. Further	Closed

			developments as part of the neighbourhood work.	
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	AI Policy up to date and operational teams are working to new guidance. There is a future Board development session planned focusing on this.	Closed
Nursing and midwifery educator framework	The Nursing and midwifery educator framework supports the development of a sustainable educator workforce by encouraging nurses, nursing associates and midwives into educator roles and helping employers and education bodies build future capacity. NHS England » Nursing and midwifery educator framework	CPO CNO	To review and consider relevant areas for implementation in the Trust.	Sep 2026

APPENDIX 2: BOARD 'LISTEN & LEARN' VISITS (PART A)**Update on Recent Visits by Board Members**

Name	Job Title	Date	Directorate	Location	Service
Emma Leaver	COO - Community Health Services, Dentistry & Primary Care	Jan-26	CHDPC	Witney	Emergency Multidisciplinary Unit and Minor Injuries Unit
Rick Trainor	Non-Executive Director	Feb-26	CHDPC	Abingdon Community Hospital	Minor Injuries Unit
Britta Klinck	Chief Nurse	Feb-26	CAMHS	Warneford	Highfield / Meadow
Britta Klinck	Chief Nurse	Feb-26	CAMHS	Swindon	Marlborough House, Swindon
Britta Klinck	Chief Nurse	Feb-26	CAMHS	Whiteleaf	Ruby, Sapphire & Amber Wards & Crisis Team
Rob Bale	COO Mental Health	Mar-26	OBSW	Littlemore	Phoenix Inpatient Ward
Britta Klinck	Chief Nurse	Apr-26	CHDPC	Witney Hospital	Wenrisc Ward
Andrea Young	Trust Chair	Apr-26	Bucks	Aylesbury	Regents House Open Day
Britta Klinck	Chief Nurse	Apr-26	OBSW	Swindon	OBSW Annual Nursing Event
Heather Smith	Chief Finance Officer	Apr-26	Oxon MH / Eastes refurb	Witney	Adult Mental Health Team (AMT) with FSUG
Britta Klinck	Chief Nurse	May-26	CHDPC	Abingdon Community Hospital	Daisy Award presentation and site visit
Taff Gidi	Executive Director of Corporate Affairs	May-26	OBSW	Littlemore	Phoenix Inpatient Ward
Rob Bale	COO Mental Health	May-26	OBSW	Nuffield Health Centre, Witney	North & West Oxon Adult MH Team
Rob Bale Heather Smith	COO Chief Finance Officer	May-26	BSW	Marlborough House, Swindon	CAMHS teams
Britta Klinck	Chief Nurse	May-26	BSW	Marlborough House, Swindon	CAMHS teams

Rob Bale	COO Mental Health	Jun-26	Bucks IAPT	Aylesbury	Regents House
Amelie Bages Taff Gidi	Executive Director of Strategy Executive Director of Corporate Affairs	Jun-26	Corporate	Banbury	OPS
Rob Bale	COO Mental Health	Jun-26	Learning Disability	Banbury	North LD Team
Karl Marlowe	Chief Medical Officer	Jun-26	Learning Disability	Slade site	Learning Disability
Andrea Young	Trust Chair	Jun-26	R&D	Warneford	Clinical Research Facility
Heather Smith	Chief Finance Officer	Jun-26	BSW	Savernake - Marlborough	MH CAMHS Service
Lucy Weston Andrea Young Amelie Bages	Non-Executive Director Trust Chair Executive Director of Strategy	Jun-26	Mental Health	Manzil Way Resource Centre	CAMHS CRHT

APPENDIX 2: BOARD 'LISTEN & LEARN' VISITS (PART B)**Upcoming Visits by Board Members**

Name	Job Title	Date	Directorate	Location	Proposed Service
Heather Smith	Chief Finance Officer	Jul-26	Oxon MH / Eastes refurb	Thames House Littlemore	MH Forensics
Heather Smith	Chief Finance Officer	Aug-26	BSW	Melksham CAMHS	
Heather Smith	Chief Finance Officer	Aug-26	BSW	Temple House, Keynsham	
Andrea Young Gerladine Cumberbatch Rick Trainor	Trust Chair Non-Executive Director Non-Executive Director	Oct-26	Learning Disability Service	The Slade	To be confirmed
Heather Smith Taff Gidi	Chief Finance Officer Executive Director of Corporate Affairs	Oct-26		Salisbury District Hospital	BSW

APPENDIX 3: MENTAL CAPACITY ACT & DEPRIVATION OF LIBERTY RULING

1. Supreme Court judgment

On 2 June 2026 the Supreme Court handed down its judgment on deprivation of liberty, mental capacity, and Article 5 of the European Convention on Human Rights.

In summary, the Supreme Court overturned its earlier decision from 2014 in 'Cheshire West' and rejected the 'acid test' set out in that case resulting in a fundamental change to the definition of deprivation of liberty. When deciding if a patient in our care is deprived of their liberty, and therefore in need of authorisation to provide a legal framework for that care, we must no longer follow the acid test of not free to leave, under continuous supervision and continuous control. In practical terms, what we must now consider is set out below.

1.1. The objective situation – is the patient 'confined'?

This is a 'multifactorial' test and requires us to focus on the concrete situation of the individual patient. We should consider a range of factors including:

- Type of accommodation
- Duration of the restrictions
- Effect of the arrangements on the patient
- Manner of implementation of the measures

Factors pointing to a DoL authorisation required:

- Objection by the patient
- Coercion
- Physical restraint
- Medication which suppresses an ability to express wishes and feelings

Conversely, factors pointing away from a deprivation of liberty:

- Normality or ordinary nature of the arrangements
- Limitations by reason of their own physical or mental condition

If there is no objective deprivation of liberty, then no further authorisation will be required through DOLS or the Court of Protection.

1.2. Is the patient agreeing, accepting or 'not objecting' to the arrangements?

The judgment referred to this as the patient giving 'valid consent' even though they lack the legal capacity to make decisions about their care, support, treatment and accommodation arrangements.

NB: It is important to note that the concept of 'valid consent' is applicable only in the context of deprivation of liberty arrangements and does not extend to other decisions which require patient consent.

- If the individual has a basic level of awareness and consciousness of their living arrangements that is sufficient to enable them to communicate whether they are happy or unhappy with them, they may be treated as able to give or withhold valid consent to the confinement through an expression of their wishes and feelings.
- Mere compliance or acquiescence is not enough; there must be positive expression.
- Administration of medication is relevant if it has the effect of suppressing the individual's ability and freedom to express wishes and feelings.
- Where there is serious doubt about their views, no inference should be drawn that they are giving 'valid consent'.

If the patient can give 'valid consent' to the arrangements, there is no deprivation of liberty and therefore no requirement for any authorisation from DOLS or the Court of Protection.

2. Implications of this judgment.

This significantly changes the legal test for deciding whether a person's care arrangements, and the restrictions within those arrangements, amount to a deprivation of their liberty for Article 5 purposes. It does not change what care the person needs nor remove the need for mental capacity assessments, best interests decision-making, consultation, advocacy, person centred care planning, or safeguarding.

- Decisions must still be taken in accordance with the Mental Capacity Act 2005, Mental Health Act and Care Act. We must still act lawfully, proportionately, and in a person-centred way.
- Practically, many care arrangements which would previously have required authorisation under DoLS, or by the Court of Protection, will no longer require that authorisation.
- Careful consideration should be given to patients on mental health inpatient wards who are not detained on a section of the MHA but lack capacity to consent to informal admission.
- We will need to consider the individual circumstances more closely, including establishing the patient's wishes and feelings, whether they appear happy or content with the arrangements, and whether they are objecting. This must all be robustly and clearly documented in the patient record and kept under close review.

Meeting:	Board of Directors
Date of Meeting:	22 July 2026
Agenda item:	9
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 update 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* as at mid-July 2026.

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 five meetings per year.

BAF overview June/July 2026 for board information

- The current score and risk appetite changes approved at the 20 May 2026 Board meeting have been made in the reported BAF following review of the BAF at year end 2025/26, these being:
 - Risk appetite change from 'Open' to 'Seek' for A6 *Innovation & Research*
 - Risk appetite change from 'Cautious' to 'Open' for A8 *Information & Data*
 - Reduction in current score from 12 to 9 for A9 *Partnerships & System working*
- 15 June 2026 Audit & Risk Committee received updates on three BAF risks as part of the committee schedule of reviewing each BAF risk over a year, these being: A2 *Quality, Safety & Experience*; A4 *Recruitment & Retention*; and A10 *Digital transformation*. A2 *Quality Safety & Experience* will be deferred to the December ARC to allow for attendance by relevant leads;
- 8 July People, Leadership & Culture Committee reviewed A4 *Recruitment & Retention* as a 'deep dive' – this was originally planned for the April PLC but was

deferred to July where a discussion was held on this, with assurance given to maintain the risk scores and controls as currently captured for this BAF risk;

- 9 July Quality Committee reviewed the four BAF risks for which the committee has oversight with assurance given for these risks as currently set-out. The committee will determine a pattern of reviewing risks as a 'deep dive' approach over 2026/27;
- 13 July Executive meeting received an update on the BAF;
- 14 July Finance & Investment Committee reviewed at A11 *Infrastructure* as a 'deep dive'. The committee reviewed the current controls and scores for this risk, discussing articulation of controls, asking whether IT infrastructure risk is appropriately reflected, and suggested the impact of and response to seasonality (e.g. recent heat waves) on Trust services be reflected in relevant BAF risks.

Internal audit review of BAF

Progress is being made against the internal audit of the Board Assurance Framework completed in March 2026. Three of the eight recommendations due for either the end of April or June 2026 have been completed, these being: clear assignment of owners and deadlines (2.3); risk identification dates added to the BAF template (2.5); operational risks mapped to BAF (2.1) – this has been done where appropriate and the operational risk scores 12+; and putting in place a process to periodically review and validate BAF-to-operational risk alignment (2.2).

Work is planned for the remaining recommendations and will be undertaken as part of the review of the BAF in the context of the new Trust strategy over Q3 2026/27, these being:

- 2.4 Terms of Reference to be reviewed and updated where required to make consistent approach to BAF oversight and clarify committee/group responsibilities where required;
- 2.6 Risk Management Strategy & Policy will be updated to capture BAF updates and processes;
- 2.7 Visual reporting tools will be assessed and if feasible and supported will be added to BAF reporting process;
- 2.8 'Three lines of defence' model will be applied as part of revision of BAF in context of new Trust strategy.

New Trust strategy and BAF revision

Over the coming months, the BAF will be reviewed with regard to the forthcoming new Trust strategy. The Board will have dedicated discussions on BAF revisions in light of the new Trust strategy.

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

This report has been prepared for the July 2026 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

Board of Directors
22 July 2026

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 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 final slides 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). Where relevant to the strategic risk, higher scoring operational risks from the Trust's risk register will be included for information.

Each BAF risk notes controls and mitigations, how assurance on 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 final slides 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, and a lead Executive director(s). The Audit & Risk Committee will work through reviewing 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 (May 26)	Current Score (July 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 to patients, staff or the public, regulatory intervention, and a failure to continuously learn and improve.	 Quality	Chief Nurse & Chief Medical Officer	Quality Committee	12	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)

Board meeting in public

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Ref.	Risk Category/ Overview	Risk Description	Strategic Aim	Executive Lead	Lead Committee	Prev. score (May 26)	Current Score (July 26)	Target Score	Risk Appetite
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.	 People	Chief People Officer	People, Leadership and Culture Committee	12	12	8	Open
A6	Improvement, Research & Innovation	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.	 Research	Chief Medical Officer & Chief Nurse	Quality Committee	12	12	6	Seek
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.	 Sustainability	Chief Finance Officer	Finance and Investment Committee	12	12	8	Open
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.	 Sustainability	Executive Director of Corporate Affairs (SIRO)	Finance and Investment Committee	12	12	9	Open

Board Assurance Framework – Summary (3)

Board meeting in public

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Ref.	Risk Category/ Overview	Risk Description	Strategic Aim[s]	Executive Lead	Lead Committee	Prev. score (May 26)	Current Score (July 26)	Target Score (July 26)	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	9	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	12	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 (May 2026)	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 identified: July 2025			Risk Appetite	Cautious

Last Reviewed By		
Lead Committee	Quality Committee	9 July 2026
Exec. Dir. Leads	Chief Operating Officers	June 2026

Controls and Mitigation

(What we are currently doing about the risk)

1. Clinical policies in place on 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. Two-year programme on improving access and waiting times - COOs sponsored - with focus on specific service areas
4. Performance management framework tracking access, referral and treatment data
5. Workforce planning and skill mix work to review and seek to align capacity with demand and projected demand
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)
10. Oversight of trajectories on waiting times reviewed at performance board

Assurance / Evidence

(How do we know we are making an impact)

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

Gaps in Control

(Actions to take to achieve target)

1. Implementation of consistent processes for referral triage and safety netting across services lines, reducing variations
2. Standardise and reduce variations to improve patient experience e.g. simplifying pathway variation
3. Embed regular data reviews with a health inequality lens e.g. breaking down waits by deprivation area in the Mental Health & Community Waits Report
4. Embed alternative options as part of waiting time approach including digital transformation and tool
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. Ongoing engagement with NHS England’s oversight process of waits has highlighted confidence in the Trust’s plans to manage 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. Working with EHR and Performance & information teams to address issues impacting wait list reporting including patients seen but remaining on waiting list	Chief Operating Officers (COOs)	30 September 2026	Across community and mental health services, a range of actions are being implemented to strengthen the oversight and management of waits, including: review of communications to patients waiting; development of standard operating procedures for validating waits and managing DNAs and cancellations; use of TOBI waiting list reports; and introduction of clinical triage and ‘safety-netting’ trackers. Regular waiting list review meetings are in place, with further work planned to develop a mental health adults SOP aligned with clinical processes and EHR and reporting requirements. This work is an ongoing initiative to improve patient experience and learning from practice.
Embed alternative options as part of waiting time approach including digital transformation tool (digital assistant)	COOs	30 September 2026	Pilot with Rio has commenced with evaluation on learning from digital assistant tool
Development of standard operating procedures for data validation and completeness	COOs	31 March 2027	Standard operating procedure in development to guide required recording of outcomes including ethnicity data capture with EMIS, P&I and Business Services teams

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 date
1068	Waiting times (mental health services)	16	Review in date	Action in date
1206	Increased waiting times for dental surgery requiring general anaesthetic for Special Care & Paediatric Dental patients	16	Review in date	Action in date

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 to patients, staff and the public, regulatory intervention, and a failure to continuously learn and improve.

Link to Strategic Aims:



Deliver the best possible care and health outcomes

Previous scoring (May 2026)	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 identified: July 2025			Risk Appetite	Minimal

Last Reviewed By		
Lead Committee	Quality Committee	9 July 2026
Exec. Dir. Lead	Chief Nurse & Chief Medical Officer	17 June 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. CQC report on CAMHS inpatient wards with actions
4. Clinical & Quality governance arrangements in place
5. Infection Prevention & Control arrangements in place
6. Clinical Audits – Core Clinical Standards
7. Learning from complaints, incidents, inquests, mortality rates (Patient Safety Incident Response Framework)
8. Weekly Review Meeting
9. Directorate weekly safety reviews
10. Patient Advice & Liaison Service (PALS)
11. Learning from feedback from Patient & Family experience
12. Learning from feedback from staff survey exercises
13. Inpatient Transformation Programme
14. Health & Safety and Violence & Aggression programmes including review of Intensive Case Management approach
15. Police collaboration e.g. Project Cavell

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 reports key metrics to Quality Committee
5. Weekly patient safety meeting – learning & reporting
6. Safer Staffing Report
7. Inspections, regulator visits and Peer Reviews (Royal Colleges)
8. Self-assessments against CQC standards & Self-Assessment against Provider capability (Insightful Board)
9. Annual OHFT Quality Account developed, reported & published
10. Staff survey 2025 results show good and improving scores for staff engagement in patient safety culture inc confidence to report near misses and a supportive learning culture

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

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 to patients, staff and the public, 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	30 September 2026	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	30 September 2026	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 based on analysis of IMD reducing health inequalities and improves health equity.	Chief Medical Officer	30 September 2026	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. Segmentation of IMG demography / geographies to understand areas of greatest need and prioritisation.
Responding to the recommendations of the Dash review	Chief Medical Officer & Chief Nurse	30 September 2026	Continued development of plan in response to the Dash review recommendations following update to Quality Committee in late 2025.

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 date
1334	Lack of appropriate room space in Bullingdon Prison impacting patient and staff safety and patient outcomes	15	Review in date	Action in date

Link to Strategic Aims:



Sustainability

Make the best use of our resources and protect the environment

Previous scoring (May 2026)	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

Controls and Mitigation

(What we are currently doing about the risk)

1. Reputation and relationships with commissioners, supported by strong Benchmarking, financial culture of ownership and transparency, governance and credibility in meeting financial expectations

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 and associated cashflows produced annually and reviewed by FIC and the Board

6. Contract and financial risk monitoring and horizon scanning.

7. Business case approval process and controls

8. Procurement systems and processes & quarterly review top 20 suppliers

9. 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. Show system leadership in respect of Mental Health Provider Collaborative and Neighbourhood Health planning

2. Allocate resources strategically through commissioner negotiations and planning rounds, aiming to continuously improve value, designing and delivering optimal services for resources available & planning future efficiency improvements

3. Develop use of costing, activity and (in due course) outcome data, benchmarking and challenging the underlying cost base and tackling unwarranted variation.

4. Address existing value weaknesses e.g. Estates non-pay, Medical agency and Out of Area Treatments.

	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 identified: July 2025			Risk Appetite	Cautious

Last Reviewed By

Lead Committee

Finance and Investment Committee

20 January 2026

Exec. Dir. Lead

Chief Finance Officer

April 2026

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	1 April 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	31 July 2026	Costing, Whole Time Equivalent (WTE) and Activity data now available in Board Report. TOBI tools pending availability of key people to finalise them.

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 date
1230	Inability to deliver required capital investments due to level of current capital commitments / constraints	12	Review in date	Action in date

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:



Be a great place to work

Previous scoring (May 2026)	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

Controls and Mitigation

(What we are currently doing about the risk)

1. Training, supervision and PDR 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 over-represented in disciplinary processes
5. Freedom to Speak Up guardians report themes 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. Monitoring of staff survey question 'recommend as a place to work' year on year and national benchmark
2. Monitoring of staff survey 'thinking of leaving' scores year on year and against national benchmark
3. Reporting against Retention Plan to People Steering Group (PSG) & Executive
4. Quarterly review by OD team on reasons for leaving and reporting on reasons for leaving to PSG and Executive
5. Reporting of key recruitment,–retention and development initiatives to People Leadership & Culture committee
6. Reporting on recruitment & retention indicators to Board of Directors
7. 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. Focused initiatives to improve retention inc. flexible working, length of service recognition, resident doctors 10 point plan
3. Integration of anti-racism work into culture plan to ensure race critical lens to all recruitment and retention practices
4. Continued delivery of local induction project workstreams
5. Work to fully align workforce planning with clinical strategy (and other enablers e.g. digital)
6. Future risk area - relating to entry-point recruitment (particularly HCAs) due to government visa restrictions moving into 2027/28
7. Launch Talent programme to underpin evidence-based succession plan for Executive leadership roles

	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 identified: July 2025			Risk Appetite	Open

Last Reviewed By		
Lead Committee	People, Leadership & Culture Committee	8 July 2026
Exec. Dir. Lead	Chief People Officer	June 2026

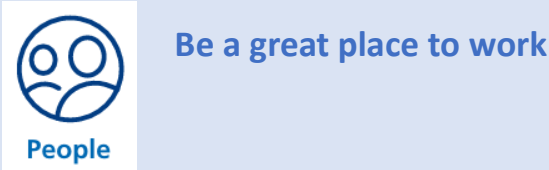
Executive Lead Narrative: Both retention and recruitment have improved considerably over the last 18 months and informed a reduction of the current risk scoring in November 2025 to below the target risk. The current risk score sits at 6. Further work is now being planned to ensure that we are continuing 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
Focused initiatives to improve and maintain retention inc. flexible working, length of service recognition, resident doctors 10 point plan	Deputy People Director (DPD) with Head of OD & Head of Medical Staffing	31 December 2026	- The Personal Development Review (PDR) window is now business as usual - 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 - Single EDI plan agreed including anti-racism and PCREF work – to be overseen as part of culture programme delivery plan - Flexible working plan being developed covering policy, information, manager skills, directorate oversight
Explore improvements to the current staff recognition process, specifically around length of service	DPD & Interim Head of OD	30 September 2026	Scoping has begun on reviewing length of service recognition beginning with a discovery phase of what other organisations do. Increase focus on recognition within 10 point plan for resident doctors.
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
Launch Talent programme to underpin evidence-based succession plan for Executive leadership roles	DPD	30 June 2026	Executive briefings completed; cohort briefings in June/July; first cycle to be completed by end of Q3 2026/27.

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:



Previous scoring (May 2026)	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 identified: July 2025			Risk Appetite	Open

Last Reviewed By		
Lead Committee	People, Leadership & Culture Committee	21 April 2026
Exec. Dir. Lead	Chief People Officer	June 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 – informs action
5. Equality, Diversity & Inclusion – address identified gaps in WRES, WDES and pay gap reports – informs actions

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.

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 & Inclusion, Compassion Leadership; Quality Improvement, Learning & Innovation; and Professional practice). A multi-disciplinary working group is now working on a proposal for developing individuals and teams.
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 and will include manager skills in having these conversations
Address gaps in Sexual Safety charter	CPO & Interim Head of OD	30 September 2026	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. A lead for sexual safety has been appointed.
Creation of an overarching EDI plan capturing actions from workforce data on race and disability equality, EDI high impact areas and patient & carer race equality framework (PCREF)	CPO & Interim Head of OD	30 June 2026	Single overarching EDI plan has been shared with PSG and EDI steering group and is being distilled into a smaller number of priority actions. It will then be shared with PLC. Following sign of the EDI Plan at the EDI Steering Group in late June this action has been completed.

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 identified: July 2025			Risk Appetite	Open

Previous scoring (May 2026)	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	9 July 2026
Exec. Dir. Lead	Chief Medical Officer & Chief Nurse	17 June 2026

Controls and Mitigation

(What we are currently doing about the risk)

1. Internal Research & Development (R&D) Senior Management Team in place and reporting to CMO
2. R&D operational and strategic plans in place/updated
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* initiative seeking to open up research participation
8. Quality Improvement hubs and work programme
9. Nurses, Midwives & Allied Health Professionals research engagement programme (inc. Chief Nurse Research Fellowship)
10. Work programme developed and embedded with government's 150-day study set up target
11. Developing internal contracting and IP structures
12. Collaborations with Oxford University Department of Primary Care / ARC / Community Services to increase community-based research
13. Strengthening digital platforms to maximise use of patient data

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. Improved R&D governance and intellectual property (IP) 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)
2. Funding sustainability for research – organisational & system
3. Undertake clarification around intellectual property ownership and processes – to develop IP governance arrangements
4. Opportunities to increase collaboration in Mental Health research (e.g. Secure Data Environment work)

Executive Lead Narrative: We continue to work 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. Following May 2026 discussion and board approval the risk appetite assessment for this risk has been changed from 'Open' to 'Seek'.

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	30 June 2026	Operational plan development, seeking to translate research into practice, and governance arrangements review underway. Responding to NIHR requirement for 150 days study set-up for clinical trials.
Develop a Trust approach to Intellectual Property (IP) governance including development of an IP Policy	Executive Director of Corporate Affairs	30 June 2026	Intellectual Property Policy has now been drafted and is being finalised for approval. Contracting approach to IP is now in development with relevant teams / partners.
R&D strategic development / link to Trust new strategy development (over 2026)	Chief Medical Officer & Head of Research	30 September 2026	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 not mapped to the five R&D matrices	12	Review in date	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 (May 2026)	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 identified: July 2025			Risk Appetite	Open

Last Reviewed By		
Lead Committee	Finance & Investment Committee	5 May 2026
Exec. Dir. Lead	Chief Finance Officer	April 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. 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.

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

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
Resource and progress Heat Decarbonisation Plans into investable schemes	Chief Finance Officer	30 September 2026	HDPs to be developed FY26/27 focus on resourcing and prioritisation for delivery of carbon reduction capital projects .
Confirm Green Plan capital and revenue funding aligned to delivery priorities	Chief Finance Officer	30 June 2026	To be confirmed through FY26/27 planning round, aligned to risk reduction.
Secure specialist capability for energy management	Director of Estates	30 June 2026	Transport and Waste capability in place; further capacity to be reviewed regarding Energy Management given the wider challenges around energy security .
Deliver Net Zero Clinical Transformation workshop with clinical leads	Medical Director / Sustainability Manager	30 June 2026	Workshop to embed net zero into clinical pathways and service redesign.
Engage workforce leadership to embed sustainability into workforce actions	Director of Workforce / Sustainability Manager	30 September 2026	Engagement with Nicky Howells to align workforce, leadership and culture actions.
Implement targeted fleet, mileage and renewables interventions	Director of Estates	30 December 2026	Targeted actions informed by Green Plan programme and mileage analysis.

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 (May 2026)	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 identified: July 2025			Risk Appetite	Open

Last Reviewed By		
Lead Committee	Finance & Investment Committee	17 March 2026
Exec. Dir. Lead	Executive Director for Corporate Affairs (SIRO)	26 June 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. Annual SIRO Report
8. Regular penetration testing in line with national guidance
9. Monitoring of timeliness of implementation of patches
10. Annual report outlining recovery plans for critical systems, including evidence that these plans have been tested

Gaps in Control

(Actions to take to achieve target)

1. Continued data quality reviews/work
2. Strengthening where possible supplier diligence pre and post-implementation
3. Continued awareness of good cyber security practice recognising ongoing risks of user error
4. Clarity that records management practice in the Trust is compliant with regulations and best practice guidance.
5. To implement standard processes for assessing and approving adoption of novel technologies.
6. Application of Board defined risk appetite consistently by operational teams.

Executive Lead Narrative: My assessment based on assurance received via the Information Management Group continues to be 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 are proposing a change in risk appetite from minimal to open for 2026/27. This is reflected in the Annual SIRO Report which went to IMG and will be presented to FIC in July. Following discussion and approval by the May 2026 Board, the risk appetite assessment for this risk has changed from 'Minimal' to 'Open'.

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
Review and refresh of Information Asset Register and delivery of IA owner guidance and training	Head of Information Governance	31 March 2026 - Complete	Review by Information Governance leads and Deputy Director of Corporate Affairs of register of Information Asset Owners is complete and will report revised IAO to April Information Management Group (IMG). Over Q4 2025/26, training and guidance on Information Asset Owner role and good practice were delivered. Action complete.
Annual SIRO Report to be presented to FIC	Senior Information Risk Owner	30 June 2026	New format of the report to be designed and will be presented annually to the committee. Report presented to the 18 June 2026 Information Management Group (IMG).
Review and mapping of current Business Critical Information Assets	Senior Information Risk Owner	30 September 2026	An action from the June IMG was to review current list and ensure it is up to date and consider if the right mitigations are in place to ensure these assets do not impact the Trust's day to day operations – this was discussed at the June IMG and will be actioned as part of a refresh of the Information Asset Register.

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

Previous scoring (May 2026)	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

	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	4	4	16	Extreme
Current Risk (with controls in place)	3	3	9	High
Target Risk (with improved controls)	3	2	6	Medium
Risk identified: July 2025			Risk Appetite	Seek

Last Reviewed By		
Lead Committee	Quality Committee	9 July 2026
Exec. Dir. Lead	Executive Director for Strategy	25 June 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. Thames Valley Mental Health Provider Collaborative - joint leadership with Berkshire Healthcare and ICB of the system MH agenda inc. transformation, delivery of ICB MH 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 developing neighbourhood health approach with focus on Oxon
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 Thames Valley Mental Health Provider Collaborative
2. Trust developing its strategic partnership approach in line with draft trust strategy.

Executive Lead Narrative: OHFT will work closely with the ICB to support the development of its new operating model and strategic commissioning approach. In particular to develop the role of the Thames Valley Mental Health Provider Collaborative within this new model. Following discussion by the May 2026 Board, the current risk score from 12 to 9 was approved.

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 Thames Valley Mental Health Provider Collaborative	Associate Director of Mental Health	31 December 2026	- ICB operating model being reviewed in 2025/26, which in turn will help clarify current role that the Thames Valley MH PC should play in the operating model. Ongoing Executive level oversight group meetings are taking place to oversee this work with one meeting planned for the end of June. Following the ICB restructure more clarity on the operating model is expected by the end of Quarter 3. - It has now been agreed with Integrated Care Board that the Thames Valley Mental Health Provider Collaborative will oversee the allocation of the Mental Health Investment Standard going forward
Developing initial Trust approach to neighbourhood working, including approach to health inequalities and population.	Transformation Director - Community Health Services, Dentistry and Primary Care	30 September 2026	- Neighbourhood Health identified as one of our Trust-wide priority for 2025/26 and 2026/27 - Internal neighbourhood steering group leading on implementation of our neighbourhood approach and health inequalities/ population health approach - Health inequality and population health work plan approved by Executive and now being implemented within the Trust - Trust actively participating in neighbourhood work in all its geographies and co-leading place approach in Oxfordshire. - An internal engagement approach on this work is currently being developed to support finalisation of the Trust's strategy.
Trust developing its strategic partnership approach with VCSE sector	Executive Director Strategy	Completed	As part of the development of the new strategy, the Trust is exploring the scope of an emerging priority around Partnerships more broadly rather than a specific approach around partnership with the VCSE sector. Going forward, this action will thus be reframed around the Trust developing its strategic partnership priority in line with the new Trust draft strategy. Action completed with paper to Board.

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 (May 2026)	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 the Digital Steering Boards (chaired by Chief Operating Officers)
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
6. Recurring capital investment in core IT infrastructure and devices allocated and governed by Capital Programme Group.

Gaps in Control

(Actions to take to achieve target)

1. Sustainability of available investment for digital transformation
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. Residual risk of cyber attacks on increasingly digitised organisations (cross-reference with A11 – Infrastructure)

	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 identified: July 2025			Risk Appetite	Open

Last Reviewed By		
Lead Committee	Finance & Investment Committee	17 March 2026
Exec. Dir. Lead	Chief Finance Officer & Chief Operating Officers	June 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
Development of new Digital Strategy for the Trust	Chief Digital Information Officer (CDIO)	31 March 2027	Scoping and development of a new digital strategy for the Trust – initial work to include
Optimisation of core clinical systems to underpin clinical needs and delivery.	CDIO	31 March 2027	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	31 March 2027	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	31 March 2027	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).

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 (May 2026)	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 identified: July 2025			Risk Appetite	Minimal

Last Reviewed By		
Lead Committee	Finance & Investment Committee	14 July 2026
Exec. Dir. Lead	Chief Finance Officer	July 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 in development 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 and drawings 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

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. The Warneford programme planning application has been secured and funding is being sought to replace the 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	30 September 2026	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	31 March 2027	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	31 March 2026	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. Action completed.
Complete process to assess Authorised Persons (AP) to formally appoint by Designated Person	Director of Estates	30 September 2026	Authorisation Engineers have been appointed, suitable candidates for the APs are being identified which is linked to recruitment of new roles, now awaiting formal training.
Complete Estates re-organisation and staff teams and fill staff posts	Director of Estates	30 September 2026	Consultation completed in September 2025 - first tranche of recruitment has started with the second tranche underway and ongoing.
Progression of Warneford Park business case and planning permission	Warneford Programme Director	Ongoing programme	Underway – joint investment committee completed, and planning application secured over June 2026.
Take account of future digital infrastructure and cyber needs and address in digital planning	Head of IT	30 September 2026	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
1425	Non-uniform estate fire compartmentation diminishes compliance capability to governing fire standards	15	Review in date	Action in place
1375	Inability to carry out all necessary maintenance in line with legislative and regulatory requirements.	12	Review in date	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:	22 July 2026
Agenda item:	10
Report title:	Oxford Health Strategy 2026-2031
Executive sponsor(s):	Amélie Bages – Executive Director for Strategy
Report author(s):	Rachel Pirie, Head of Planning Laura Carter, Head of Strategy Sam Shepherd, Deputy Director of Strategy & Planning
Action this paper is for:	☒ Decision/approval ☐ Information ☐ Assurance
Reason for submission to the Board:	The Board of Directors is asked to review and sign off the new Trust strategy, and to review accompanying documentation.
Public or confidential	Public

Executive summary

This cover note presents the Board of Directors with three papers:

Annex 1: The draft of the Trust's new Strategy which, if agreed by the Board, will run from 2026 – 2031 and set the new strategic direction for the Trust.

Annex 2: An outline draft of the Strategy Delivery Plan which, when finalised in the autumn, will accompany the strategy in setting out how we will deliver against the new strategic aims and priorities.

Annex 3: A Strategy Engagement Report which summarises the process, activity and feedback for engaging stakeholders in the development of the draft strategy in Annex 1.

Recommendation(s)

The Board of Directors is recommended to:

- a) Agree the draft strategy in Annex 1 to guide the Trust from 2026-2031.
- b) Agree that any final and minor changes to the Strategy text, and progressing the design and presentation of the final Strategy document, is delegated to the Strategy Steering Group for oversight.

- c) Review the initial Strategy Delivery Plan in Annex 2 and provide feedback, with a focus on the proposed structure and outline content, to inform a further draft for agreement at a Board meeting in the autumn 2026.
- d) Note the Strategy Engagement Report in Annex 3.

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

Strategy development has taken place over recent years involving the Board of Directors, the Executive Team and in discussion with colleagues at Oxford Health. This includes the following meetings:

8th June 2026 – Executive forum
 29th April 2026 – Board workshop in private
 25th February 2026 – Board workshop in private
 9th February 2026 – Executive Team meeting
 10th December 2025 – Board workshop in private
 22nd October 2025 – Board workshop in private
 24th September 2025 – Board meeting in public
 27th June 2025 – Board workshop in private
 30th April 2025 – Board workshop in private
 26th February 2025 – Board workshop in private

Overview

Strategy development

1. Oxford Health's existing strategy is coming to an end. We began development of our new strategy in summer 2025, taking into account national and local factors in order to set our new strategic direction. This development work has included:
 - Reviewing national and local policies and strategies related to our work. This includes the 10 Year Health Plan, our system-level commissioning intentions and local health and wellbeing strategies.
 - Understanding the health and care needs of the people, communities and populations we serve.
 - Understanding performance information about our services and the drivers behind this.
 - Scenario planning around the future of healthcare, undertaken in collaboration with Oxford University, Said Business School.
2. The Government's 10 Year Health Plan for England sets out a new level of ambition for the NHS to deliver three shifts: from sickness to prevention; from analogue to digital; from hospital to community. Our new strategy sets out how we will respond to

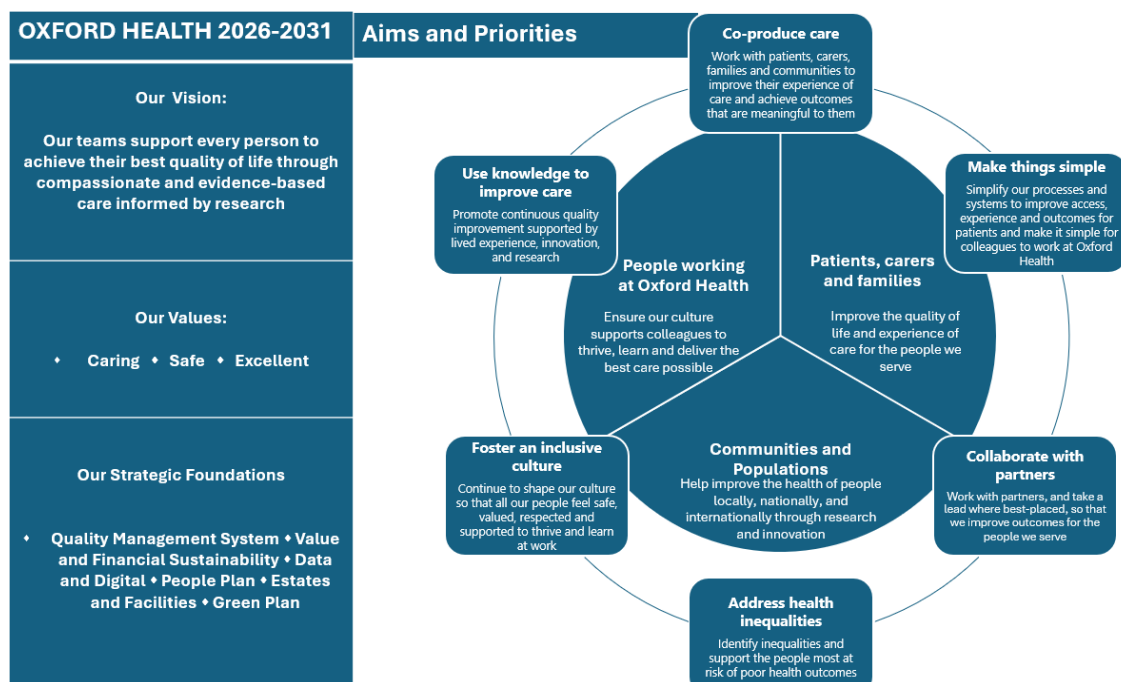
these new ambitions and reflects that we are well placed to deliver these. We remain determined that the care we provide is high quality and meets the changing needs of our populations.

3. We recognise that our approach and care models need to adapt to support demographic changes. More people are living longer with multiple and complex conditions across both physical and mental health. People experience variation in access, experience of care and outcomes; linked with deprivation, ethnicity, societal and other factors. We must adapt to these changing needs and provide care tailored to the needs of communities that focuses on prevention and early intervention, whilst still delivering care and treatment when people need it.
4. It is important that alongside the national policy landscape and our understanding of local demographics, we hear from the people we serve, our colleagues and the partners we work with in developing our new strategy. We have conducted two phases of engagement, hearing from over 1000 people who have provided feedback that has helped us identify what matters most to our communities and to design the new strategic focus for the Trust. A copy of the Strategy Engagement Report is provided for information in **Annex 3**.
5. During this process we heard that our existing values of 'Caring, Safe and Excellent' continue to resonate strongly with our colleagues. We heard that colleagues strive to embody these values in their roles and that people recognise these values as part of the Oxford Health identity. It is therefore proposed that our values continue to be 'Caring, Safe and Excellent'.
6. An important part of our new strategy is the new vision for the organisation, which sets out what we want to achieve in a single statement. Our proposed new vision is ***"Our teams support every person to achieve their best quality of life through compassionate and evidence-based care informed by research."***
7. This vision is proposed following the feedback we received during the engagement process as it puts front and centre the importance of teamwork and the compassionate strength of our colleagues. It also reflects the holistic focus of our work on quality of life, and the broader role of the Trust beyond local healthcare delivery through our research and innovation assets which contribute to the broader research agenda.

Our new strategy for 2026-2031

8. Our new strategy is illustrated below, setting out:
 - Our three strategic aims: what we want to achieve by 2031 to deliver our long term vision, supported by our values
 - Our six strategic priorities: the areas we will focus on to deliver the change

- Our strategic foundations: the core elements that must be in place to ensure we are an effective organisation.



9. Our three strategic aims are:

- Patient, Carers and Families:** Improve the quality of life and experience of care for the people we serve. This means that:
 - Patients, carers and families remain at the centre of what we do, with our core focus on improving quality and experience of their care.
 - We recognise explicitly the importance encompassing families and carers in our work.
 - Over the next five years our focus will be on improving outcomes, experience and reducing waiting times.
- Communities and Populations:** Help improve the health of people locally, nationally, and internationally through research and innovation. This means that:
 - We will focus on population health in order address increasing need and ensure resources are used in a sustainable way that drives better outcomes for all
 - We recognise that our focus does not stop at people currently waiting to access or accessing our services but extends to the local communities that we serve, as well as to address key population health challenges in our geographies.
 - Through our research, we recognise our ability to improve the health of people on an international level.
 - Over the next five years we will focus on reducing health inequalities, impacting the health of our local populations by working towards key priorities set with

partners and improving the translation of the research we generate so it improves care

- c. **People working at Oxford Health:** Ensure our culture supports colleagues to thrive, learn and deliver the best care possible. This means that:
 - i. We will continue to strive to be a great place to work for our colleagues. Our latest staff survey results show the highest response rate since 2009 at 61.3% (above the national average response rate of 52% for our sector) and show that we are above the national average for all nine of the elements covered. We will retain this commitment to our people being at the heart of everything we do as we go forward with the new strategy.
 - ii. Over the next 5 years we want to keep improving engagement for our colleagues and developing ourselves as an inclusive organisation.

10. To deliver these aims, our proposed strategy sets out six strategic priorities which represent our areas of focus that are important as we build on our existing strengths to meet needs and deliver high-quality care across all our service areas.

11. The strategic priorities are:

Co-produce care: Work with patients, carers, families and communities to improve their experience of care and achieve outcomes that are meaningful to them.

Make things simple: Simplify our processes and systems to improve access, experience and outcomes for patients and make it simple for colleagues to work at Oxford Health.

Collaborate with partners: Work with partners, and take a lead where best-placed, so that we improve outcomes for the people we serve.

Address health inequalities: Identify inequalities and support the people most at risk of poor health outcomes.

Foster an inclusive culture: Continue to shape our culture so that all our people feel safe, valued, respected and supported to thrive and learn at work.

Use knowledge to improve care: Promote continuous quality improvement supported by lived experience, innovation, and research.

12. To support the delivery of these new priorities there are important core elements that must be in place to ensure we are an effective organisation. These are described in the draft strategy document as strategic foundations and are essential functions, not

only for the effective day-to-day running of Oxford Health but also to enable the change needed to achieve our strategic priorities. These are:

Quality Management System: we will ensure our Quality Management System is embedded across all services, guiding how they are designed and delivered to provide safe and effective care, as well as a positive patient experience.

Value and Financial Sustainability: we will make the best use of our resources in an equitable, sustainable and transparent way to achieve better outcomes for those we serve.

Data and Digital: we will build our analytical capabilities and routinely use evidence to improve care. We will embed digital technologies in how services are designed and delivered, supporting colleagues with the right tools and training. This will be supported by a Digital Strategy.

People Plan: we will develop our people plans so that our workforce is equipped with the skills and capabilities required for future care. This will be supported by our work to foster an inclusive culture.

Estates and Facilities: we will develop our estate so that it is modern, flexible and supports high-quality care closer to the communities we serve through a neighbourhood health and care approach. This will be supported by an Estates and Facilities Strategy.

Green Plan: We will deliver high-quality care in ways that reduce environmental impact and are sustainable for the future.

Strategy Delivery Plan

13. These new aims, strategic priorities and the strategic foundations set out how we will prioritise our work over the coming five years. Whilst we recognise the hard work and importance of developing and agreeing the strategy, this work must continue as we turn the strategy into delivery.
14. Throughout the strategy development process, we have been working with our colleagues and teams to understand how our strategy will be delivered. An outline of this Strategy Delivery Plan is shared as **Annex 2**, this currently includes draft content to illustrate what the final version of the plan may look like. The key points to note are:
 - a. For each of the strategic priorities we have set out where we want to be in 2031 and the key milestones to get there. These will be delivered across the organisation to ensure that delivery of the strategy happens in all our teams to deliver real change across the Trust.
 - b. For each of the strategic foundations we have set out where we want to be by 2031, how we will know when we have got there.

- c. For each of our clinical areas we will set out where we are currently and what we will focus on to deliver the strategy. Examples are included in the attached draft document relating to our mental health services and community health services, dentistry and primary care services. This content is draft and will be further refined and developed to include learning disabilities and forensic services for future versions.
 - d. We will also include a section setting out how the ambitions, actions and milestones described in the Strategy Delivery Plan will relate to the work of our directorates, as they set their annual plans each year.
15. The Strategy Delivery Plan will inform our Annual Planning processes going forward by providing the high-level overview of our delivery plans. Annual planning will set out more detail of how these plans will be delivered year on year. As we begin annual planning for 2027-2028, this work with directorates will coincide with a programme of engagement to launch the strategy and mobilise it throughout the Trust as we translate what it means for clinical areas, directorates, services, teams and individuals.
16. The Board is asked to comment on the proposed structure and outline content of the Strategy Delivery Plan. Pending comments and discussion from the Board of Directors today, we will continue to work with colleagues across the Trust to develop these sections.

Next steps

17. Following Board agreement of the strategy, design work will be undertaken to ensure the document is produced to a high quality, is consistent with Trust branding and considers accessibility guidelines. This will be primarily a document to view online and will be designed accordingly; printed versions will be made available.
18. Given the support we provide for people with a learning disability, neurological conditions (like autism), those who find it hard to read and write, have dementia or other memory issues or who speak English as a second language, it is important our strategy can be accessible to all. We have therefore started work on an 'easy read' version of the strategy which will be progressed and finalised pending the Board of Directors' comments and sign off of the final strategy. The easy read version will be progressed with oversight from the Strategy Steering Group.
19. Following agreement, the strategy will inform the way we work until 2031. This means it will inform the work of the Board, the planning of services and how we work in services, teams and as individual colleagues. Implementation of the strategy - including launch events, reflecting the new strategic aims and priorities in procedures

and ways of working, and embedding the strategy in team working - will take place in the coming months.

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	

Oxford Health Foundation Trust Strategy vfinal

Oxford Health exists to support people to live as well as possible. Every day our teams work with patients, carers and families to provide compassionate and effective care rooted in the communities we serve. Our people are our greatest strength. We are proud of our colleagues at Oxford Health - their commitment, skills and professionalism are at the heart of everything we do. Through their research, learning and education, we use knowledge to improve care and outcomes for people locally and contribute to better health on a wider scale.

People's needs are changing; many are living longer, often with a mix of physical and mental health needs. Too many people still have very different experiences of health and care, depending on who they are or where they live. Care can feel difficult to access and not always well coordinated between different teams and organisations.

This strategy has been shaped by what we have heard from patients, carers, families, colleagues, local communities and partners. It sets out how we will respond to the changing needs of our patients and communities. For the next five years we will focus on making support simpler, more joined-up and centred around what matters to each person. We will use research, innovation and learning to improve outcomes in ways that are visible in everyday care. We will work closely with and support NHS organisations, primary care, local authorities, voluntary and community organisations, universities and other partners to improve outcomes for our communities. We will take a lead for bringing partners together where we add the most value.

To enable this change, we will equip colleagues with the skills required for new ways of working, continuing to support them to thrive, learn and deliver the best care possible.

This is a shared commitment to work differently, make clear choices about where we focus, and deliver real improvements in outcomes and experience.

Signed by Trust Chair

Signed by Trust Chief Executive Officer

People's need for care and treatment is growing, and those who require our support most often have the most complex needs. At the same time, **our resources are limited**.

This strategy is about being **more focused** on how we improve outcomes for the people we serve over the next five years. This means we need to make clear choices about where we focus our effort to deliver the greatest possible impact on people's lives.

We will **build on what works**, continue to learn and develop new ways of working, and make sure improvements are felt by all the people we serve.

Board meeting in public

Our Vision:

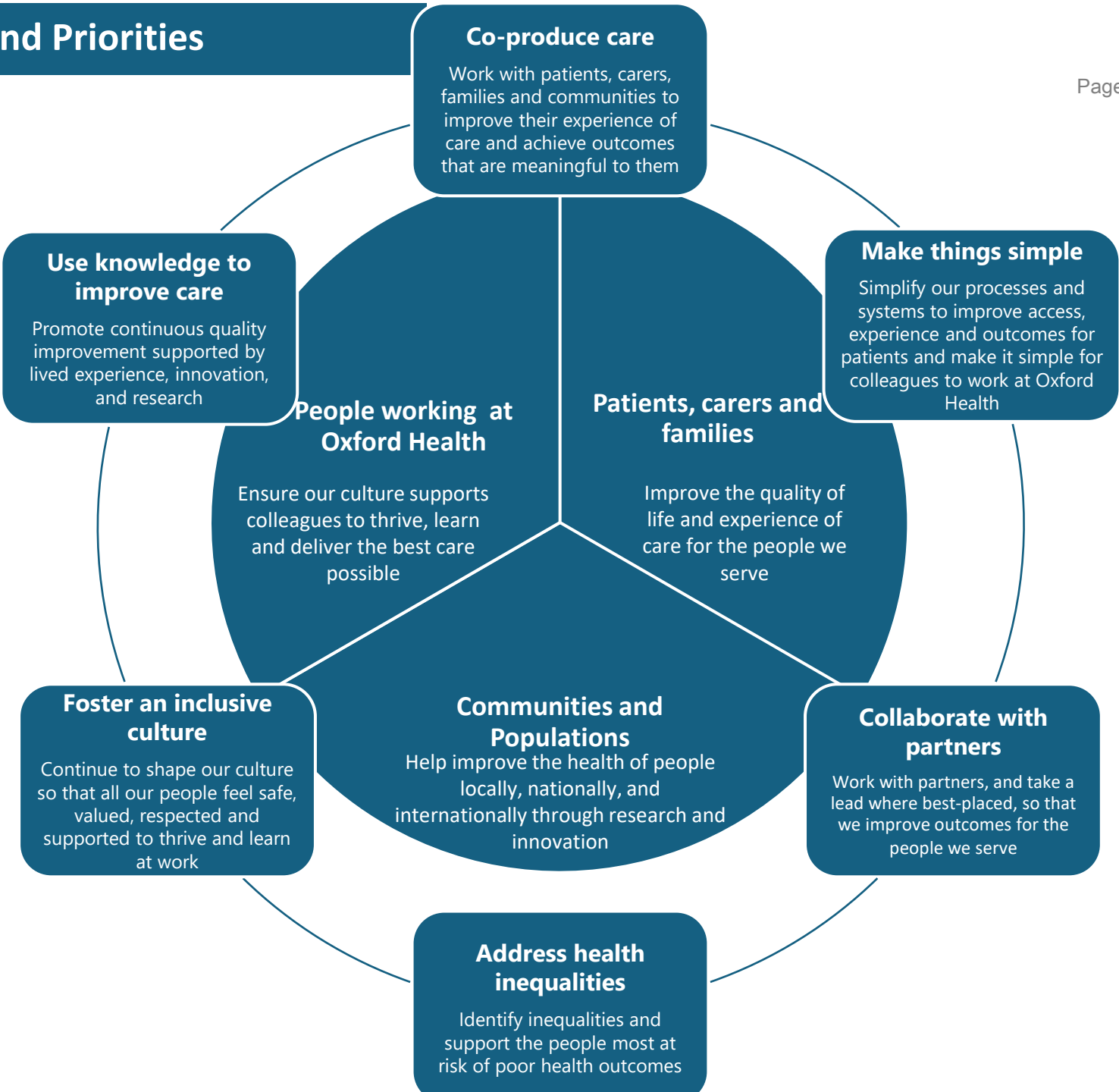
Our teams support every person to achieve their best quality of life through compassionate and evidence-based care informed by research

Our Values:

- ♦ Caring ♦ Safe ♦ Excellent

Our Strategic Foundations

- ♦ Quality Management System ♦ Value and Financial Sustainability ♦ Data and Digital ♦ People Plan ♦ Estates and Facilities ♦ Green Plan



Patients, carers and families

Improve quality of life and experience of care for the people we serve

1- We will improve outcomes for patients across our services

2- We will reduce waiting times across our services

3- We will improve the experience of carers and families

Communities and Populations

Help improve the health of people locally, nationally, and internationally through research and innovation

4- We will reduce inequalities in access, experience and outcomes

5- We will work to improve the outcomes for our communities, agreeing the priority area of focus with our partners

6- We will increase the reach of our research and its application within our services

People working at Oxford Health

Ensure our culture supports colleagues to thrive, learn and deliver the best care possible

7- We will improve the engagement of our colleagues

8- We will ensure our leadership represents the diversity of our colleagues

For each aim we have identified goals that will guide the successful delivery of our strategy.

We will set specific measures against these and use them to monitor, report on and inform action over the next five years.

Co-produce care

Work with patients, carers, families and communities to improve their experience of care and achieve outcomes that are meaningful to them

Where we are today

- Co-production happens in an increasing number of services, but not consistently
- Patients, carers and families want more involvement in decisions about their care and care that reflects their unique needs
- More can be done to ensure that patients, carers, families and communities are involved in the design of care and services
- We are starting to capture patient outcome data; but are not yet using it consistently
- Some colleagues are confident and experienced in co-production; we can build on this and share understanding as we go

Where we want to be in 2031

Patients, carers and families share decisions about care that is personalised and focused on the outcomes that matter most to them and are involved in the design of care and services

Communities and Populations are systematically engaged to help shape services and how they are delivered

People working at Oxford Health have the skills and are supported by a culture that enables them to work with patients and communities to co-design and improve care

How we will get there

- ✓ **Focus on ensuring we capture and deliver the outcomes that patients define** so that our resources are used to make the biggest difference to quality of life for those we serve
- ✓ **Use co-production** to involve patients, carers, families and our communities in the care and services we provide so that we improve experience and outcomes
- ✓ **Coordinate and personalise care around patients** through joined-up working and rolling out a **neighbourhood health and care approach**

Make things simple

Simplify our processes and systems to improve access, experience and outcomes for patients and make it simple for colleagues to work at Oxford Health

Where we are today

- People can find services hard to access and interact with, with long waits and the need to repeat their story
- Systems and processes can be complex and not easy to use for our colleagues
- Digital tools are not yet used across all services to support care delivery, access or experience

Where we want to be in 2031

Patients, carers and families can easily find and access services, and move seamlessly between health and care services

Communities and Populations have easier access to services that are organised around their specific local needs

People working at Oxford Health are supported by simple, reliable systems and processes that make it easier to deliver care

How we will get there

- ✓ **Simplify our services, systems and processes** so that services are consistent and easy to find, access and interact with for patients
- ✓ **Simplify our services, systems and processes** so that it is as easy as possible for colleagues to do their job

Collaborate with partners

Work with partners, and take a lead where best-placed, so that we improve outcomes for the people we serve

Where we are today

- Care can still feel fragmented across services and organisations
- Outcomes and services vary depending on where people live
- Support is not always well coordinated for people with complex needs
- We have opportunities to do more prevention and early intervention through a neighbourhood health and care approach

Where we want to be in 2031

Patients, carers and families experience care that is joined-up across different organisations

Communities and Population have access to care that is well co-ordinated across different organisations, with a stronger focus on prevention

People working at Oxford Health design and deliver services across organisations and share skills and resources to get the best outcomes for people

How we will get there

- ✓ **Lead Provider Collaboratives and develop commissioning approaches** in our areas of expertise, to join up services, deliver consistent care, and improve population outcomes
- ✓ **Collaborate with health and care partners**, including NHS acute hospitals, primary care, the voluntary and community sector and local authorities, to join up services and make the best use of skills and resources to improve outcomes through a **neighbourhood health and care approach**

Address Health Inequalities

Identify inequalities and support the people most at risk of poor health outcomes

Where we are today

- There are significant differences for people in access, experience and outcomes depending on who they are or where they live
- In particular, people in more deprived communities experience poorer health earlier
- Demand and complexity is increasing, including for children and young people and people with severe mental illness
- We are not yet consistently using data to identify and address inequalities in our services and populations

Where we want to be in 2031

Patients, carers and families have consistently good health outcomes and experiences, regardless of who they are or where they live

Communities and Populations have their health needs clearly understood, with care targeted to reduce differences in access, experience and outcomes

People working at Oxford Health use data and evidence to identify inequalities and support people most at risk of poorer outcomes

How we will get there

- ✓ **Develop population health management capabilities** to better focus on prevention and early intervention for people at risk of poorer outcomes; starting with early years, children and young people, patients with severe mental illness and those who are frail and/or with complex needs
- ✓ **Build an anti-discriminatory organisation** that actively addresses inequalities in access, experience and outcomes
- ✓ Target care through a **neighbourhood health and care approach** focused on reducing inequalities in the communities we serve

Foster an inclusive culture

Continue to shape our culture so that all our people feel safe, valued, respected and supported to thrive and learn at work

Where we are today

- Colleagues deliver high-quality, compassionate care, often under pressure
- We have good engagement and satisfaction amongst our colleagues and need to keep supporting people with managing workloads and wellbeing
- Experience is not consistent for everyone, and colleagues still experience unacceptable discrimination
- We can strengthen the support we have in place for colleagues to learn, grow and thrive at work

Where we want to be in 2031

Patients, carers and families experience high-quality and compassionate care from well-functioning teams

Communities and Populations have access to high-quality services delivered by a workforce that reflects and understands the communities they serve

People working at Oxford Health feel safe, valued and treated fairly, and have equitable opportunities to develop, progress and have meaningful careers

How we will get there

- ✓ Build an **inclusive, anti-discriminatory culture** across Oxford Health
- ✓ Embed **compassionate and inclusive leadership** across Oxford Health
- ✓ Support colleagues to develop their **skills and capability** to have a greater impact

Use knowledge to improve care

Promote continuous quality improvement supported by lived experience, innovation, and research

Where we are today

- We have strong research, innovation and improvement expertise and strong partnerships with universities
- However, research findings and innovation are not consistently translated into practice
- There are good examples of Quality Improvement work but outcomes and learning are not always shared effectively across services
- We could make better use of data and innovation to improve care

Where we want to be in 2031

Patients, carers and families receive high-quality care and effective treatment, that is continuously improving supported by the latest evidence and innovation

Communities and Populations benefit from high-quality, evidence-based care, with innovation and research improving services locally and internationally

People working at Oxford Health provide high quality and evidence-based care through continuous improvement, harnessing the potential of innovation and research translation

How we will get there

- **Use Quality Improvement approaches consistently across Oxford Health** to help all our services make improvements in patient care and colleague experience
- **Deliver the masterplan for the Warneford hospital** to advance applied research in mental health
- **Lead on world-class research and innovation and deepen partnerships with universities** to inform evidence-based care and translation into practice

The strategic foundations are core elements that support the effective day-to-day running of Oxford Health and enable the changes needed to achieve our strategic aims. Over the next 5 years we will focus on the following improvements:

Quality Management System

We will ensure our Quality Management System is embedded across all services, guiding how they are designed and delivered to provide safe and effective care, as well as a positive patient experience

Value and Financial Sustainability

We will make the best use of our resources in an equitable, sustainable and transparent way to achieve better outcomes for those we serve

Data and Digital

We will build our analytical capabilities and routinely use evidence to improve care. We will embed digital technologies in how services are designed and delivered, supporting colleagues with the right tools and training. This will be supported by a Digital Strategy

People Plan

We will develop our people plans so that our workforce is equipped with the skills and capabilities required for future care. This will be supported by our work to foster an inclusive culture

Estates and Facilities

We will develop our estate so that it is modern, flexible and supports high-quality care closer to the communities we serve through a neighbourhood health and care approach. This will be supported by an Estates and Facilities Strategy

Green Plan

We will deliver high-quality care in ways that reduce environmental impact and are sustainable for the future

What we do	➤ Around 7,700 colleagues provide mental health, learning disability, community health, primary care and dentistry services in the community and in hospital settings, working from around 150 sites ➤ We support people across their lives in their homes, communities but also in inpatient settings. The majority of our care is delivered outside hospitals ➤ We work across organisations to join-up services and improve outcomes for patients and the wider population. We do this by playing a key role in local systems and leading specialist mental health collaboratives. They cover adult low and medium secure care, adult eating disorder services, and children and young people’s mental health services. ➤ Research is fundamental to what we do, we collaborate closely with universities on research and education and host one of the two Biomedical Research Centres in the UK focused on brain health as well as the Department of Psychiatry of the University of Oxford
Who we serve	➤ Around 2 million people across Oxfordshire, Buckinghamshire, Bath and North East Somerset, Swindon, Wiltshire ➤ Diverse communities with significant differences in access, experience and outcomes and with growing needs among: • children and young people mental health • people with severe mental illness • people with frailty and complex needs

The difference we make across people’s lives
(figures 2025/26):

- **Supporting families early:** Our Health Visitors in Oxfordshire supported over 37,000 families with children aged 0-5 and worked with over 7,000 families who needed additional, focused or specialist support.
- **Keeping people well:** Our Talking Therapies services gave employment advice to nearly 3,000 people with significant depression and/or anxiety disorders to remain in or return to work.
- **Supporting mental health:** Our Mental Health teams supported over 57,000 people to manage a serious mental illness.
- **Care at the end of life:** Our Community Nursing teams supported around 250 adults each month to have palliative or end of life care in their own homes. Our Children’s Nursing Teams supported over 15 children, young people and their families in their home at the end of their life and support each month around 30 children and young people and their families with palliative care.

Across the areas we serve, people are living longer, often with more complex health and care needs. Experiences and outcomes still vary between communities, and demand is growing. In addition, a small number of people with higher needs require much more support and account for a large share of care.

Oxfordshire

- People in Oxfordshire live longer than average, but this hides clear inequalities, particularly in Oxford City, parts of Banbury and Abingdon.
- The population is growing and ageing, with more people living with conditions such as dementia, cancer and heart disease.
- Some children and families face deprivation, along with challenges such as housing, fuel poverty and access to services.
- As the most rural county in the South East of England, there are specific challenges faced by people in rural areas notably around access.

What this means for us - We need to better coordinate our mental health, learning disability and community health services to focus on communities with poorer outcomes, using a neighbourhood health and care approach to improve access and help people stay well as they live longer.

Buckinghamshire

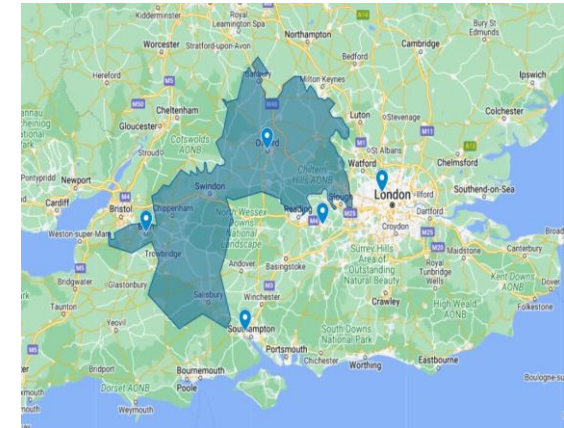
- Buckinghamshire is one of the least deprived areas nationally, but this hides clear inequalities, particularly in High Wycombe, Aylesbury and Chesham.
- The population is growing and ageing, with people living longer but spending more years in poorer health.
- Mental health and musculoskeletal conditions are leading causes of ill health in working-age adults, with 10 priority areas identified for targeted intervention to address poorer health outcomes.

What this means for us - We need to focus our mental health services on targeted support in specific communities, strengthening early intervention and prevention.

Bath and North East Somerset, Swindon and Wiltshire

- The population is growing and ageing overall, with significant variation across the area, including older populations in Wiltshire and Bath and North East Somerset and a younger, more diverse population in Swindon.
- Health outcomes vary, with clear inequalities linked to deprivation, rurality and access, including transport and housing challenges.
- Demand is increasing across services, notably for mental health services and in particular children and young people's mental health services.

What this means for us - We need our mental health services to address the growing needs in local communities, with a focus on children and young people.



Sources: Thames Valley ICB Population Segmentation Analysis (2026), BSW Integrated Needs Assessment (2025/26), Oxfordshire Joint Strategic Needs Assessment (2025), Buckinghamshire Joint Health and Wellbeing Strategy (2025)

Across the areas we serve, there is a shared focus on prevention, early intervention and providing more joined-up care. This is particularly important for Oxford Health, given the range of services we provide. This also reflects the national direction for the NHS, including the three key shifts set out in the 10 Year Health Plan. These local and national priorities helped shape our strategy and its focus.

From hospital to community

Care is delivered closer to home, in neighbourhoods and communities.

What we do now

- Providing care close to home and avoiding the need for hospital admission is at the heart of what we do across our wide range of services in the community.
- Our specialised provider collaboratives in mental health also focus on reducing the need for inpatient care and bringing care closer to home.

What this shift means for Oxford Health

- This strategy focuses on working with people and communities to improve their experience of care and delivering outcomes that are meaningful to them.
- Collaborating with others to deliver a neighbourhood health and care approach will be a central focus of our work.

From analogue to digital

Greater use of digital tools, data and technology to improve care.

What we do now

- We increasingly use data and digital tools in our services to support care, reduce waiting times and improve quality.

What this shift means for Oxford Health

- We will use digital technologies more consistently across services to improve access, experience and outcomes.
- We will also use digital technologies more effectively to make it easier for colleagues at work and will spread key innovations.
- We will build our population health management capabilities to better respond to the needs of our communities and address health inequalities.
- This work will be further developed in our upcoming Digital Strategy.

From sickness to prevention

More proactive care, focusing on prevention and early support.

What we do now:

- Our services already do critical prevention work working with partners. Our focus includes:
 - working with children and families in early years
 - preventing escalation of long-term conditions for example through our district nursing services
 - helping close the gap of life expectancy for those with serious mental illness.

What this shift means for Oxford Health

- This strategy recognises our role in improving health for wider communities, working with partners to support people who may not be accessing our services.
- Through the delivery of a neighbourhood health and care approach, we will take a more proactive, system-wide approach to prevention and focusing on reducing health inequalities.

Engagement: shaping our strategy

Board meeting in public

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We developed this strategy through two phases of engagement with colleagues, patients, carers, families, young people, local communities and partners, alongside discussion and challenge with our Board. What we heard has helped us make the strategy clearer and focused on what will change in practice for the people we serve.

Engagement at a glance:

- ❖ 1,000+ people engaged
- ❖ 2 phases of engagement
- ❖ Board workshops and Steering Groups
- ❖ Input from colleagues, patients, carers and partners

Colleagues

Patients,
families and
carers

Partner
organisations

60 x strategy conversations, 1000 participants (over 50% clinical staff)

Online survey to all colleagues, c. 110 responses

2 x all colleague webinars c. 200 participants

Strategy discussions as part the 5 year planning process

7 x Expert by Experience group conversations, c. 50 participants

Piloted lived experience strategy reference group

Online survey to public, c. 50 responses

Focus group with young people, link workers, parents and carers

Public webinar with Healthwatch Oxfordshire & Healthwatch Buckinghamshire

Online survey – c. 20 Responses from 11 organisations

Invitation to input to content and feedback on draft strategy sent to c. 50 organisations

Engaged with Oxfordshire and Buckinghamshire local authority health committees

Leadership discussions with partners

Throughout engagement we heard feedback about where we can improve and examples of how it feels for some people when we don't get it right. We are using this feedback to ensure we focus on what matters to people in our strategy:

What we heard

Our strategy response



Care should be easier to access and better joined-up

People described challenges getting into services, navigating care and having to repeat their stories.



Prioritising reducing waits and health inequalities as well as joining-up care.



Consistency of experience needs to improve

Many spoke positively about care and support, but this is not yet the experience for everyone, in every service.



Stronger focus on improving experience, with co-production as a strategic priority.



Services are also complex to work within for colleagues

Colleagues highlighted fragmented services, inconsistent digital tools and barriers to working across teams and partners.



Simplification of the processes and systems that colleagues interact with every day.



There is strong support for meaningful realistic change

People want a strategy that is ambitious but honest, with a clear focus on improving care and experience.



Sharpened action-oriented strategic priorities, with clarity on the change we want to see delivered.

Examples of how people can feel when we don't get it right*

"Because I'm being treated for multiple conditions, from lots of services, I can feel like I'm 'too complicated' to deal with"

"I gave feedback on how my care could be improved – but three years later, I see the same mistakes still happening"

"It look a long time for my care to be focused on me"

Examples of what people might say if we get things right by 2031*

"I trust that my stories and questions will be passed onto the next person involved in my care so that I don't have to repeat things"

"When I share my feedback, I can see how it has helped improve care for me and others."

"I was involved in planning my care and it feels personalised"

* Example quotes are based on feedback shared during engagement*

This strategy sets the direction — delivery across all teams will make the difference.

1. Turning strategy into action: the Strategy Delivery Plan

We will develop a Strategy Delivery Plan to drive the execution of the strategy. It will set out how we will measure and track our impact for each of our strategic aims and the key changes we will make across our six strategic priorities. It will also show how these link to our services, teams and ways of working.

2. Aligning strategy, planning and resources

We will use the Strategy Delivery Plan to guide our annual planning each year, so priorities shape how we make decisions and use our resources. Directorates will set out what this means for their services and the communities they serve, and how they will deliver these priorities.

3. Embedding the strategy across the organisation

We will make the strategy part of everything we do. Our culture programme will support this, helping teams work in ways that reflect our strategic aims and priorities. Colleagues will see clear links between strategic priorities, team objectives and their roles.

4. Monitoring progress and staying focussed

We will track delivery through our existing governance and reporting, including the Integrated Performance Report. This will help us stay focused on priorities, monitor progress and adapt where needed.

Thank you.

The development of this strategy was guided by input from our colleagues; people who use our services and their families; our local communities; and from our partners. We are grateful for the time that people contributed and the perspectives that were shared.

For more information about the Trust, to get in touch or join the conversation:



oxfordhealth.nhs.uk

Proof of concept Strategy Delivery Plan 2026-2031

Board
July 2026
V1

This document presents a ‘proof of concept’ Strategy Delivery Plan.

The Strategy Delivery Plan is a key document which follows from the Strategy and will guide annual planning from 2027/28 onwards. Together, these documents set Oxford Health’s strategic direction and how it will be delivered.

Our Strategy Delivery Plan plays an important role in translating the ambitions of our Strategy into meaningful change we expect to see for our patients, communities and colleagues. It integrates the delivery of our Strategy with the operational requirement of the Medium-Term Planning Framework, which the Trust submitted the final return on in February 2026 in line with the NHS England deadline.

The Strategy Delivery Plan provides more granular information about the key milestones underpinning the Strategy. It however remains higher level than annual plans, giving an overview of delivery plans across multiple years, whilst annual plans will provide an annual detailed view of the in-year plan, refreshed annually.

This proof of concept provides an overview of the proposed structure and content of the Strategy Delivery Plan. We have worked with the Executive Team and wider Trust leadership to begin developing this plan. Further development will continue through the annual planning process. This proof of concept gives an overview of the proposed structure and content of the Strategy Delivery Plan.

The Board is asked to:

- Review and comment on this the proposed structure and content of the Strategy Delivery Plan
- Give a steer for the refinement of the plan before it is finalised by autumn so it can be used to inform 2027/28 Annual Planning.

The Strategy Delivery Plan will build on the Strategy and set out how each of the strategic priorities will be put into practice, and the milestones that we will measure. It is proposed that Strategy Delivery Plan contains the following sections:

1. **The aims, priorities and difference we want to see over 5 years.** This will repeat the content from the strategy and is important to set the scene regarding our new strategic direction.
2. **Delivering the strategic priorities.** For each of our 6 strategic priorities, we will set out the ambitions that will be delivered by 2031 – for patients, for communities and populations, for families and carers, and for people working at Oxford Health. This section will include the key milestones required to deliver these ambitions which will be delivered across the Trust and will inform the annual planning process at directorate level. Our annual plans will set out more detail about delivering these milestones on an annual basis. In this draft of the Strategy Delivery Plan we have not included detailed measures to assess milestone progress. This thinking is still being developed for a future version of this plan.
3. **Strategic foundations.** For each of these core elements that support Oxford Health's effective day to day running, we will set out where we want to be by 2031, and the areas of focus to enable these ambitions.
4. **Our clinical plans.** For mental health; learning disabilities; forensics; and community health services, primary care and dentistry we will set out the current national performance requirements and the key areas of focus for teams to deliver these and our strategic priorities over 2026-31. It is proposed that the Strategy Delivery Plan includes high level content reflecting delivery over the medium term with more detail included in our annual plans.
5. **What does this mean for directorate planning?** The final section is aimed at providing a clear guide to support directorate-level planning and will set out key principles to be taken forward through the planning process as directorates develop their more detailed annual plans. We will continue to work closely across the trust to meet national planning requirements and ensure that annual plans set out strategy delivery.

Board meeting in public

Our Vision:

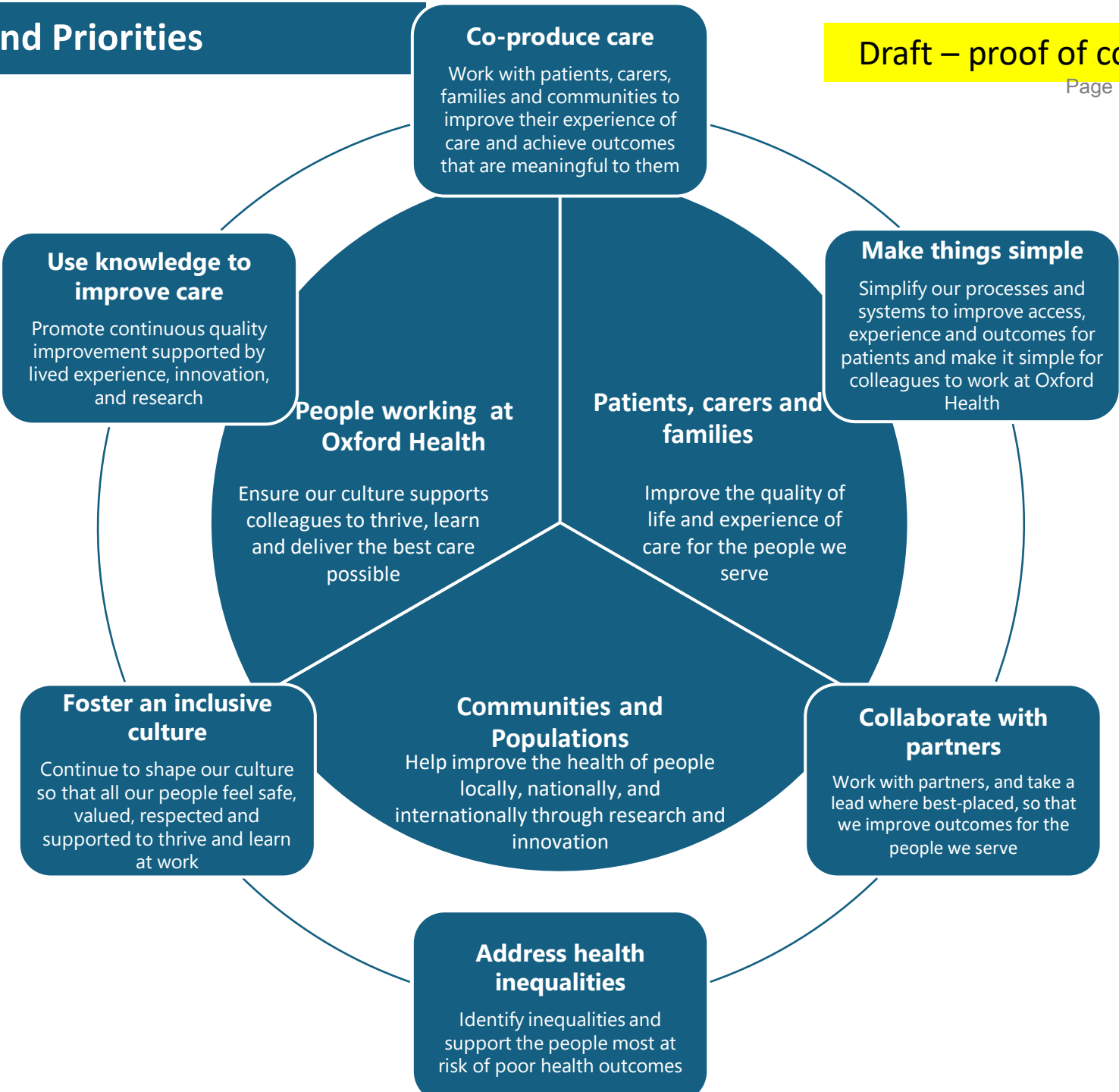
Our teams support every person to achieve their best quality of life through compassionate and evidence-based care informed by research

Our Values:

- ♦ Caring ♦ Safe ♦ Excellent

Our Strategic Foundations

- ♦ Quality Management System ♦ Value and Financial Sustainability ♦ Data and Digital ♦ People Plan ♦ Estates and Facilities ♦ Green Plan



Patients, carers and families

Improve quality of life and experience of care for the people we serve

1- We will improve outcomes for patients across our services

2- We will reduce waiting times across our services

3- We will improve the experience of carers and families

Communities and Populations

Help improve the health of people locally, nationally, and internationally through research and innovation

4- We will reduce inequalities in access, experience and outcomes

5- We will work to improve the outcomes for our communities, agreeing the priority area of focus with our partners

6- We will increase the reach of our research and its application within our services

People working at Oxford Health

Ensure our culture supports colleagues to thrive, learn and deliver the best care possible

7- We will improve the engagement of our colleagues

8- We will ensure our leadership represents the diversity of our colleagues

Draft – proof of concept

For each aim we have identified goals that will guide the successful delivery of our strategy.

We will set specific measures against these and use them to monitor, report on and inform action over the next five years.

This section will include a focus on each of the 6 strategic priorities, building upon the content included in the Strategy.

For each priority we will set out:

- Where we want to be in 2031 for patients, carers and families; communities and populations; and people working at Oxford Health.
- The steps we will take to get there. The content included in this draft of the Strategy Delivery Plan has been developed in conjunction with colleagues from our directorates and services but is still in development.
- In the final version of the Strategy Delivery Plan we will aim to go further to set out the specific metrics or deliverables that each point can be measured against.

Board are asked to:

- Consider and comment on the proposed structure of this section
- Note any gaps that could be further developed for the final version.

Delivering our strategic priority: Co-produce care

Board meeting in public

Priority summary

Co-produce care

Work with patients, carers, families and communities to improve their experience of care and achieve outcomes that are meaningful to them

Where we want to be in 2031

Patients, carers and families share decisions about care that is personalised and focused on the outcomes that matter most to them and are involved in the design of care and services	Communities and Populations are systematically engaged to help shape services and how they are delivered.	People working at Oxford Health have the skills and are supported by a culture that enables them to work with patients and communities to co-design and improve care

Delivery summary

How we will get there	Where we want to be in 2031	Key milestones
Focus on ensuring we capture and deliver on the outcomes that patients define so that our resources are used to make the biggest difference to quality of life for those we serve	✓ Outcomes that matter most to patients are routinely measured and used to improve care and quality of life across mental health and community services.	✓ Embed and mature our approach to capturing patient identified outcomes in our mental health services ✓ Design a process to capture patient identified outcomes in our community health services ✓ Fully integrate patient identified outcomes in the way we manage services and monitor performance ✓ Develop and implement a patient experience dashboard
Use co-production to involve patients, carers, families and our communities in the care and services we provide so that we improve experience and outcomes	✓ A co-production approach is fully developed and embedded across all mental health and community services, with experts by experience engagement embedded as a way of working. ✓ Communities are actively involved in shaping local services through neighbourhood-based engagement and partnership approaches.	✓ Model of co-production fully developed and embedded in mental health and community services, in line with neighbourhood health and care development work ✓ Set of key performance indicators / outcomes measures agreed and reported ✓ Define and implement the role of experts by experience in service design and improvement ✓ Agree and implement co-produced care planning across mental health and community services ✓ Agree and implement an approach to measuring care plan quality across mental health and community services ✓ Establish a Patient Council (or equivalent)

Understanding progress: we will work with the Executive team and directorate colleagues to develop measures

Delivering our strategic priority: Make things simple

Board meeting in public

Priority summary		
Make things simple		
Simplify our processes and systems to improve access, experience and outcomes for patients and make it simple for colleagues to work at Oxford Health		
Where we want to be in 2031		
Patients, carers and families can easily find and access services, and move seamlessly between health and care services.	Communities and Populations have easier access to services that are organised around their specific local needs.	People working at Oxford Health are supported by simple, reliable systems and processes that make it easier to deliver care.

Delivery Summary		
How we will get there	Where we want to be in 2031	Key milestones
Simplify our services, systems and processes so that services are consistent and easy to find, access and interact with for patients	✓ Patients can easily find and access services, understand how to get help when they need it, and move seamlessly between health and care services.	✓ Agree and review priority pathways, simplified and embedded using a consistent co-design approach and clear target operating models. In particular: ✓ Urgent and same-day access pathways streamlined, and a consistent access model implemented across partner organisations ✓ Develop clearer and simpler access routes for patients, including digital routes where appropriate. ✓ Test and roll out improved access models, including neighbourhood access points and single routes into services.
Simplify our services, systems and processes so that it is as easy as possible for colleagues to do their job	✓ Colleagues are supported by simple, reliable and integrated systems and processes that reduce duplication, minimise administrative burden and maximise time available for patient care.	✓ Establish a staff reference group to identify and prioritise simplification opportunities ✓ Review and redesign priority staff facing processes that create duplication or administrative burden ✓ Implement digital tools that reduce administrative burden and support new ways of working. ✓ Improve integration between digital and clinical systems to support joined-up working ✓ Implement Oracle / national workforce system as part of staff-facing simplification

Understanding progress: we will work with the Executive team and directorate colleagues to develop measures

Delivering our strategic priority: Collaborate with partners

Board meeting in public

Priority summary

Collaborate with partners

Work with partners and take a lead where best-placed, so that we improve outcomes for the people we serve

Where we want to be in 2031

Patients, carers and families experience care that is joined-up across different organisations.	Communities and Populations have access to care that is well co-ordinated across different organisations, with a stronger focus on prevention	People working at Oxford Health design and deliver services across organisations and share skills and resources to get the best outcomes for people.

Delivery summary

How we will get there	Where we want to be in 2031	✓ Key milestones
Lead Provider Collaboratives and develop commissioning approaches in our areas of expertise, to join up services, deliver consistent care, and improve population outcomes	✓ Through the work of the Thames Valley Mental Health Provider Collaborative we will ensure that mental health resources in the ICBs in which we work are best used to improve people’s health outcomes and experience of care, and address inequalities. We will work jointly with acute, local authority, VCSE and primary care partners to enable the left shift. ✓ Through the work of the specialised mental health provider collaboratives we will ensure that resource are best used to improve people’s health outcomes and experience of care, and address inequalities.	✓ Formalise the role of the Thames Valley Mental Health Provider Collaborative in the operating model of the Thames Valley ICB to tackle unwarranted variation and improve mental health outcomes for the Thames Valley population. ✓ Identify opportunities for transformation at scale across the geographies in which the specialised mental health provider collaboratives work, to develop more integrated and resilient models of care and improved outcomes, value and experience of care for patients, families, carers and communities.
Collaborate with health and care partners , including NHS acute hospitals, primary care, the voluntary and community sector and local authorities, to join up services, make the best use of skills and resources to improve outcomes through a neighbourhood health and care approach	✓ Support is designed around neighbourhoods, not hospitals, so people can access help locally and only go to hospital when necessary. There is recognition that health and care is shaped by more than care and treatment. Social, economic and environmental factors are given equal importance.	✓ Establish the neighbourhood health and care governance approach, including roles, responsibilities, decision making arrangements and VCSE partnership arrangements to ensure neighbourhood delivery. ✓ Establish and embed Integrated Neighbourhood Teams with system partners, aligned to national policy and best practice guidance. ✓ Strengthen engagement with underserved communities and those who experience the greatest health inequalities, using population health insights to embed data driven models of care focused on improving equitable outcomes. ✓ Develop and implement community-based alternatives to hospital admission, to support people closer to their homes and deliver measurable impact.

Understanding progress: we will work with the Executive team and directorate colleagues to develop measures

Delivering our strategic priority: Address Health Inequalities

Board meeting in public

Priority summary		
Address Health Inequalities		
Identify inequalities and support the people most at risk of poor health outcomes		
Where we want to be in 2031		
Patients, carers and families have consistently good health outcomes and experiences, regardless of who they are or where they live.	Communities and Populations have their health needs clearly understood, with care targeted to reduce differences in access, experience and outcomes.	People working at Oxford Health use data and evidence to identify inequalities and support people most at risk of poorer outcomes.

Delivery summary		
How we will get there	Where we want to be in 2031	Key milestones
Develop population health management capabilities to better focus on prevention and early intervention for people at risk of poorer outcomes; starting with early years, children and young people, patients with severe mental illness and those who are frail and/or with complex needs	✓ Teams routinely use data to identify and reduce inequalities in access, experience and outcome for patients. ✓ Teams routinely use data to identify and reduce inequalities in access, experience and outcomes. ✓ Teams understand and target support towards people most at risk of poorer outcomes, including those not currently accessing services. ✓ Population health insight routinely informs planning, service design and resource allocation.	✓ Develop and implement a Trust-wide approach to health inequalities and population health management reporting and oversight. ✓ Embed the use of health inequalities data within service planning, quality reviews and decision-making. ✓ Develop and implement a patient-lens approach to inform service design. ✓ Develop and implement a comprehensive Population Health Management and Health Inequalities Plan, including priority cohorts for targeted prevention and intervention activity.

Understanding progress: we will work with the Executive team and directorate colleagues to develop measures

Delivering our strategic priority: Foster an inclusive culture

Board meeting in public		Priority summary		Page 120 of 530	
Foster an inclusive culture					
Continue to shape our culture so that all our people feel safe, valued, respected and supported to thrive and learn at work					
Where we want to be in 2031					
Patients, carers and families experience high-quality and compassionate care from well-functioning teams.		Communities and Populations have access to high-quality services delivered by a workforce that reflects and understands the communities they serve.		People working at Oxford Health feel safe, valued and treated fairly, and have equitable opportunities to develop, progress and have meaningful careers.	
Delivery summary					
How we will get there	Where we want to be in 2031		Key milestones		
Build an inclusive, anti-discriminatory culture across Oxford Health	✓ Our teams ensure that all interactions are civil, respectful and kind, and we are careful to ensure that everyone is able to contribute and feel part of our teams.		✓ Implement the equality, diversity and inclusion plan and the anti-racism plan. ✓ Embed the Equality Impact Assessment process. ✓ Improve recruitment, selection and career progression processes to reduce inequalities and increase equitable access.		
Embed compassionate and inclusive leadership across Oxford Health	✓ Our teams are effective and work together both within Oxford Health and across partner organisations. ✓ Our teams have a culture of listening, creating a shared understanding of challenges, in order to empathise and help in an inclusive way. ✓ People who work at Oxford Health report positive experiences of compassionate, visible and responsive leadership.		✓ Compassionate and inclusive leadership behaviours are embedded, with leaders routinely assessed against the NHS management and leadership framework, to ensure a culture where colleagues feel safe, valued, respected and treated fairly at work.. ✓ Organisational development approaches are strengthened to embed equity and inclusion, talent development and career progression pathways that ensure equitable opportunities for all. ✓ Our leadership development offer is embedded across the Trust.		
Support colleagues to develop their skills and capability to have a greater impact	✓ Teams take responsibility for improving quality, embedding learning and continuously developing better ways of doing things. ✓ Teams have clear priorities and objectives, informed by relevant data and evidence to delivery quality, performance and outcomes. ✓ Colleagues consistently experience meaningful appraisal and development conversations that enable them to build their skills, maximise their contribution and achieve their career aspirations.		✓ Talent and succession planning processes are implemented across mental health and community services. ✓ Implement an enhanced appraisal and performance development review approach that supports career development and progression. ✓ Continue to develop and implement a Trust-wide training, education and development offer that supports continuous learning and the skills needed to deliver high-quality care, leadership and organisational performance.		

Understanding progress: we will work with the Executive team and directorate colleagues to develop measures

Delivering our strategic priority: Use knowledge to improve care

Board meeting in public

Page 121 of 530

Priority summary

Use knowledge to improve care

Promote continuous quality improvement supported by lived experience, innovation, and research

Where we want to be in 2031

Patients, carers and families receive high quality care and effective treatment, that is continuously improving supported by the latest evidence and innovation.

Communities and Populations benefit from high-quality, evidence-based care, with innovation and research improving services locally and internationally.

People working at Oxford Health provide high quality, evidence-based care through continuous improvement, harnessing the potential of innovation and research translation.

Delivery summary

How we will get there	Where we want to be in 2031	Key milestones
Use Quality Improvement approaches consistently across Oxford Health to help all our services make improvements in patient care and colleague experience	✓ Quality Improvement is used consistently across the mental health and community services and is fully integrated within the Quality Management System to ensure systematic spreading of learnings. ✓ Quality Improvement hubs are delivering high impact by focusing on key strategic themes across directorates. ✓ By 2031, all Quality Improvement projects that have a patient focus will be co-produced with patient involvement.	✓ Establish and embed the Quality improvement maturity dashboard to establish a mature learning system for tracking capability, governance, measurement and sustainability of improvement activity. ✓ Quality improvement capability is embedded across Oxford Health, with increasing numbers of colleagues trained and actively applying Quality Improvement methods to enhance patient outcomes, staff experience and service performance. ✓ Development of an approach to understand the impact of Quality Improvement projects on patient outcomes.
Deliver the masterplan for the Warneford hospital to advance applied research in mental health	✓ Modern research, clinical and education facilities at the Warneford support research, innovation and the translation of evidence into improved patient care.	✓ Complete detailed design and approvals for the Warneford programme. ✓ Complete land transfers and enabling delivery of POWIC 2 and research building ✓ Secure Outline and Full Business Case approval for the Warneford redevelopment programme ✓ Commence redevelopment of the Warneford site. ✓ Complete delivery of priority Warneford programme buildings and facilities by 2032.
Lead on world-class research and innovation and deepen partnerships with universities to inform evidence-based care and translation into practice	✓ Research is embedded and integrated across all our teams, so that all staff have access to research resources to support the delivery of cutting edge care for our patients. We will be able to evidence the impact of research in outcomes for patients, and the impact of our research in best practice.	✓ Placeholder <i>Develop a Research and Innovation Plan</i> ✓ Broaden research participation and inclusivity, ensuring that research populations are representative of the communities we serve. ✓ Embed research as a driver of service improvement, with evidence that research activity informs and improves care pathways with a focus on areas of inequality and delivering clinical impact.

Understanding progress: we will work with Execs and leads to develop measures

This section will include a focus on each of the 6 strategic foundations, recognising that these are essential areas to ensure that Oxford Health runs effectively and is equipped to deliver the strategic priorities. It is a key element of the plan to communicate clearly across the Trust the expected priority area of work for our corporate & central services.

This section will set out:

- Where we want to be in 2031 for each of the strategic foundations
- The steps that we will take to develop and further embed these areas by 2031

Board are asked to:

- Consider and comment on the proposed structure of this section
- Note any gaps that could be further developed for the final version.

The Strategic Foundations are core elements that support the effective day-to-day running of Oxford Health and enable the changes needed to achieve our Strategic Aims. Over the next 5 years we will focus on the following improvements:

Quality Management System

We will ensure our Quality Management System is embedded across all services, guiding how they are designed and delivered to provide safe and effective care, as well as a positive patient experience

Value and Financial Sustainability

We will make the best use of our resources in an equitable, sustainable and transparent way to achieve better outcomes for those we serve

Data and Digital

We will build our analytical capabilities and routinely use evidence to improve care. We will embed digital technologies in how services are designed and delivered, supporting colleagues with the right tools and training. This will be supported by a Digital Strategy

People Plan

We will develop our people plans so that our workforce is equipped with the skills and capabilities required for future care. This will be supported by our work to foster an inclusive culture

Estates and Facilities

We will develop our estate so that it is modern, flexible and supports high-quality care closer to the communities we serve through a neighbourhood health and care approach. This will be supported by an Estates and Facilities Strategy

Green Plan

We will deliver high-quality care in ways that reduce environmental impact and are sustainable for the future

Where do we want to be by 2031	How will we know we have got there?
We will ensure our Quality Management System is embedded across all services, guiding how they are designed and delivered to provide safe and effective care, as well as a positive patient experience	A consistent Quality Management System is fully embedded across all services. This means that: • All teams use a shared approach to quality planning, control, assurance and improvement • There is a common language of quality from ward to Board, enabling consistent understanding and practice
	Quality is built into how services are designed and delivered. This means that • Services are planned around population need, co-produced with patients, carers and families, with clear pathways, and defined outcomes. • Teams routinely use data over time to manage performance and take action • Clear processes exist for monitoring, escalation and maintaining quality
	Quality assurance drives learning and improvement. This means that: • Quality is regularly reviewed through audits, visits and structured assessments • Assurance processes identify gaps and lead to clear actions and improvement • Learning is at the centre of how we improve services, with insights from incidents, feedback and reviews routinely used to drive change across the organisation
	Quality improvement is a core way of working. This means that: • Teams consistently use improvement methods to test, implement and scale change • Quality Improvement is applied to our most important strategic priorities and complex challenges • Staff across the organisation are confident and capable in improving quality

Where do we want to be by 2031	How will we know we have got there?
We will make the best use of our resources in an equitable, sustainable and transparent way to achieve better outcomes for those we serve	We are financially sustainable and maintain financial balance. This means that: • The Trust consistently delivers balanced financial plans • Plans are affordable and delivered within available funding
	We make clear, strategic decisions about how we use our resources. This means that: • Investment decisions are aligned to strategic priorities and population needs. • Resources are focused on areas that deliver the greatest value for patients and populations
	We improve value and efficiency across our services. This means that: • Services are delivered in ways that make the best use of available resources • Productivity has improved and resources are used more effectively over time
	We use our resources to improve patient outcomes, patient experience and reduce inequality. This means that: • Decisions will consider impact on outcomes, patient experience and resources together • Outcomes are more consistent across services and for different groups of patients.
	We have a culture of value and accountability across the organisation. This means that: • Teams understand how resources are used and the outcomes they are delivering • Decisions about resources are clear and transparent

Where do we want to be by 2031	How will we know we have got there?
We will build our analytical capabilities and routinely use evidence to improve care. We will embed digital technologies in how services are designed and delivered, supporting colleagues with the right tools and training. This will be supported by a Digital Strategy	Digital is embedded in how services are designed and delivered. This means that: - Digitally enabled, integrated care pathways are in place, including virtual services - Patients can easily access and manage their care digitally
	Data is shared and routinely used to improve care and decision-making. This means that: - High-quality data supports clinical care, service design and population health management - Data is available and used to inform operational and clinical decision-making
	Our workforce is digitally enabled and supported. This means that: - Staff have reliable access to systems, tools and data, and are confident in using them - Digital tools reduce manual processes and support more time for care
	Core digital systems enable integrated care across organisations. This means that: - Systems are connected ,with information shared safely across care settings. - A joined-up view of patient information supports coordinated care
	Core digital systems enable integrated care across organisations. This means that: - Systems are connected ,with information shared safely across care settings. - A joined-up view of patient information supports coordinated care
	Innovative digital tools and a secure digital environment are enabling service transformation. This means that: - AI and other innovative digital products are effectively integrated into care pathways - Digital infrastructure is resilient and cyber-secure, protecting and maintaining access to critical patient data.

Where do we want to be by 2031	How will we know we have got there?
We will develop our people plans so that our workforce is equipped with the skills and capabilities required for future care. This will be supported by our work to foster an inclusive culture	Our workforce has the skills and capability to deliver future care. This means that: • Clear and accessible career pathways are in place and widely used • Leadership capability is strengthened across the organisation
	Our people feel supported, valued and able to thrive. This means that: • There are high levels of staff wellbeing, engagement and retention • Staff experience across all roles and groups is positive and consistent
	We are an inclusive and anti-discriminatory organisation. This means that: • There are equitable opportunities and outcomes for all staff • Inclusion is embedded in everyday practice and leadership
	Our workforce is sustainable, flexible and well planned. This means that: • Workforce plans are aligned to service need and future demand • There is reduced reliance on temporary staffing
	Our culture supports learning, improvement and compassionate leadership. This means that: • Leadership behaviours are consistent with our values • Staff feel able to contribute, learn and improve

Where do we want to be by 2031	How will we know we have got there?
We will develop our estate so that it is modern, flexible and supports high-quality care closer to the communities we serve through a neighbourhood health and care approach. This will be supported by an Estates and Facilities Strategy	Our estate is aligned to a neighbourhood-based model of care. This means that: • Services are delivered from locations that are closer to communities and better aligned to population need • Greater use of shared, flexible spaces and co-location with partners
	Our estate provides safe, high-quality environments for staff and patients. This means that: • Facilities are safe, clean and fit for purpose and that supports therapeutic care • Environments promote staff wellbeing, inclusion and a positive experience
	We have an efficient and well-used estate footprint. This means that: • The estate is better aligned to how services are delivered rather than historical use • Space is used flexibly, with reduced silo working across teams and sites
	Estates planning supports long-term sustainability and service delivery. This means that: • The estate is aligned to clinical models, sustainability and wider organisational planning • Investment decisions are prioritised to support future service needs
	We have made targeted improvements to modernise our estate. This means that: • Priority sites have been improved to address key estate challenges • Development opportunities have supported innovation and partnership working
	Our services are aligned and support the level of care for patients. This means that: • Develop services that support and aid the recovery of patients and improve the patient experience • Services are delivered efficiently that frees clinicians to focus on providing care

Where do we want to be by 2031	How will we know we have got there?
We will deliver high-quality care in ways that reduce environmental impact and are sustainable for the future	Our environmental impact is considered in how services are designed, planned and delivered. This means that: - Reducing environmental impact is built into how service are designed and planned - Clinical, operational and investment decisions reflect both quality and environmental impact
	We have reduced our carbon impact across key areas. This means that: - Emissions from estates, travel and our supply chain have reduced, focusing on the biggest sources of carbon. - The way we procure , prescribe and use medicines now reduces our environmental impact, with lower-carbon alternatives and less waste
	Our staff understand how their work affects the environment and take action to reduce it. This means that: - Awareness of environmental impact has increased across clinical and corporate teams - Staff take practical steps to reduce environmental impact in their day-to-day work
	Green spaces are integrated across our sites, supporting recovery, wellbeing and the natural environment. This means that: - Green spaces are part of our sites and support patient recovery and staff health and wellbeing - Our sites support and improve the natural environment, with more green space and improved biodiversity
	We design and deliver services that are efficient, reliable and able to meet future challenges. This means that: - Services reduce unnecessary travel while maintaining access and quality of care - Services continue to operate safely during extreme weather, with plans in place to manage risks such as heat, flooding and disruption

In addition to setting out how the strategic priorities will be delivered across Oxford Health, the Strategy Delivery Plan will set how these will be specifically delivered within our clinical areas. The Strategy Delivery Plan will include sections for mental health; forensics; learning disabilities; and community health services, dentistry and primary care. This draft document includes example content for mental health, and for community health services, dentistry and primary care. Content for forensics and learning disabilities will be developed for subsequent drafts in the autumn.

The draft content proposed in this version is subject to further review and refinement so should be considered as illustrative. It has been drafted based on the five year planning priorities developed by our clinical areas as part of the last planning round, and sets out the areas of delivery at a high level for 2026-31. Further detail regarding in year delivery against these areas will be set out through the annual planning process, with the Strategy Delivery Plan guiding this process. Detail regarding national metrics and trajectories will also be set out through the annual planning process, allowing for more detail and the opportunity to reflect any changes to the required national metrics.

Board are asked to:

- Consider and comment on the proposed structure of this section
- Note any gaps that could be further developed for the final version.

Oxford Health NHS Foundation Trust is responsible for the following key performance indicators, to be delivered over 5 years:

- Number of active inappropriate adult acute out of areas placements
- Number of children and young people with mental health waits over 104 weeks
- Sum of total bed days across all adult acute and psychiatric intensive care unit mental health beds
- Total number of discharges from adult acute and psychiatric intensive care unit mental health beds
- Sum of total bed days across all older adult acute mental health beds
- Total number of discharges from older adults acute mental health beds
- Average length of stay for patients in older adult acute mental health beds

We also contribute to metrics delivered with partners across the Integrated Care Board which are nationally reported by the Integrated Care Board. These metrics which are monitored are listed below and reflect the national and local focus on improving access to services.

- Number of patients that achieved reliable recovery
- Number of patients discharged having received at least two treatment appointments in the reporting period, that met clinical threshold at the start of treatment
- Access to mental health support teams in schools and colleges
- Number of women accessing specialist community perinatal mental health services
- Number of children and young people accessing mental health services
- Number of patients accessing individual placement support services

Our five year plan will build on our plans for 2026-27:

- We continue to aim to meet the Operational Planning Activity and Performance metrics we are nationally required to report on for our mental health services.
- For the Length of Stay metric, we are aiming to maintain rather than reduce as our baseline use to set the target is already stretching
- For CYP Mental Health waits over 104 weeks, we do not have any waits above 104 weeks excluding neurodevelopment waits, in line with the intended focus of the measure. However, due to the technical definition of the measure and data quality issue, some waits for neurodevelopmental services may continue to show in our data.
- We continue to work in partnership with the Thames Valley Integrated Care Board (ICB), for our mental services' contribution to the system-wide Operational Planning Activity and Performance metrics that the ICB lead on.

We are currently delivering robust performance against these metrics, whilst recognising the demand growth for our services. In particular neurodevelopmental waits and inpatient pressures.

Where we are now

- Progress has been made in embedding lived experience roles in the way services are designed and delivered.
- Feedback from communities is incorporated into some of our service design and delivery.
- Patient and carer feedback is incorporated into how services are assessed.
- Expanding opportunities for patients, families and carers to shape services, including through forums and carer engagement activities.
- Starting to capture and report outcomes

What we will focus on to deliver our strategy

- Further embed co-production and use of feedback capturing experts by experience, patient, carer and families' experience to develop a consistent approach.
- Build a systematic approach to incorporate feedback from communities into service design and delivery.
- Use the neighbourhood health and care approach to continuously gather patient and community insights and improve integrated, personalised care
- Embed co-production through care planning, to ensure that people who use services and their families and carers are equal partners in decisions about care, support and recovery.
- Further develop use of patient based outcomes. *This point to be developed further with services, to set the approach and focus for this work.*

Where we are now

- Good progress to change services in order to deliver care closer to home and improve experience, outcomes, and sustainability.
- Focus on value to drive outcomes and focus on removing unwarranted variation
- Increasing focus on addressing waiting lists, including a focus on long waits.

What we will focus on to deliver our strategy

- Systematically understand variation in outcomes and experience between services and consistently implement best practice to address this.
- Address variation and complex pathways in CAMHS; Urgent and Emergency care; Community and step-down provision.
- Focus on partnership with the ICB to address the need for children, young people and adults with neurodivergence.
- Simplify access to mental health services as part of the development of the neighbourhood health approach, exploring the development of Single Points of Access.
- Continued focus on management of waiting lists. *This point to be further developed with services, to set out how the approach will be developed over 5 years.*

Where we are now

- Experience working with partners to improve mental health outcomes. Including as co-lead of the Thames Valley Mental Health Provider Collaborate and lead provider for three specialist collaboratives.
- Collaborating with VCSE partners, including through the Oxford Mental Health partnership & Buckinghamshire mental health coalition
- Working with local authority, primary care partners, acute providers and wider partners to drive better integration of care.

What we will focus on to deliver our strategy

- Continue to jointly lead the Thames Valley ICB MH Provider Collaborative to improve the mental health outcomes for the population.
- Work with partners as part of the neighbourhood health approach to make the best use of collective resources and capabilities to improve the health of local communities.
- *Placeholder – [continue to strengthen our partnership with the VCSE sector]*

Where we are now

- Our approach to addressing health inequalities has developed with targeted effort to address communities with the highest need.
- We have developed our data enabling us to understand patterns of inequalities in our services.
- The implementation of the patient carer race quality framework has also brought about a much-needed focus on known areas of challenge.

What we will focus on to deliver our strategy

- Systematically use data to identify and address differences in outcomes and experience for people and unmet need in the communities that we serve, in line with ICB population segmentation approach.
- Focus our efforts on areas that we know can have the greatest impact to address population health:
 - People with Severe mental illness, notably through the provision of assisted outpatient treatment / intensive case management and working with partners to improve the physical health of those with severe mental illness
 - Children and Young People, with the focus on integrating provision with partner organisations.

Where we are now

- Building our understanding of staff safety risks and solutions, particularly in inpatient services.
- Continued focus on developing multidisciplinary ways of working and culture.
- Continued focus on effective leadership.
- Implementation of PCREF to bring focus on areas of challenge.

What we will focus on to deliver our strategy

- Strengthen workforce experience and capability through improved recruitment, staff wellbeing initiatives, career development pathways, and targeted leadership programmes.
- Embed a listening and responsive culture by using regular staff engagement and feedback mechanisms to inform decision making
- Deliver a strategic, inclusive workforce agenda through robust workforce planning and implementation of equalities, diversity and inclusion priorities.
- Enhance workforce capability and progression through a structured training plan that supports continuous skills development and career growth
- Across our mental health teams, we will implement the People, Culture and Race Equality Framework

Where we are now

- We are recognised for our research facilities and assets enabling innovation in this field.
- Progress towards the Warnford development.
- A strong approach to Quality Improvement, with multiple QI projects delivering innovations for patients and colleagues.

What we will focus on to deliver our strategy

- Maintain focus and delivery of QI methodology, working with teams to develop new areas for improvement and innovation.
- Embed research and data-driven improvement across all services, using evaluation, demand and capacity modelling, and digital innovation to inform service redesign and improve outcomes.
- Expand research capability and partnerships, including clinical-academic roles and a coordinated research strategy to drive innovation and evidence-based practice.
- Strengthen cross-system collaboration and learning, ensuring insights are shared and scaled to deliver integrated, high-quality, and sustainable care models.

Oxford Health NHS Foundation Trust (OHFT) monitors a range of nationally required performance standards to ensure we continue to provide high-quality, timely care across our mental health and community services. These standards help us understand demand, track improvement, and ensure services remain safe, effective, and responsive.

For our Community Health Services, Dentistry and Primary Care teams, the metrics are delivered with partners across the Integrated Care Board and are nationally reported by the Integrated Care Board. These metrics which are monitored are listed below and reflect the national and local focus on improving access to services and reducing wait times.

- Community waiting list over 52 weeks, including number of people on waiting lists for children and young people's services and for adult services who are waiting over 52 weeks
- Number of people on waiting lists per Integrated Care Board who are waiting 18 weeks or less, and as proportion of the entire waiting list
- Number of people on entire waiting list
- Number of people on waiting list for adults services and for children and young people's services per system who are waiting 18 weeks or less, and as a proportion of the whole list.

Our five year plan will build on our plans for 2026-27 :

- We will track progress monthly, ensuring our teams remain focused on delivering improvements.
- Detailed performance metrics and trajectories will continue to be reviewed monthly by our Executive Team and reported to our Board.
- Continue our focus on reducing 52 week waits. Good progress has been made against this target with no waits over 52 weeks in most services, however we will continue to monitor this in conjunction with partners.
- Deliver robust performance against most of these metrics, with specific focus on the areas of challenge. These will be reported as part of the annual planning process.

Co-produce care

Where we are now

- Progress has been made in embedding lived experience roles in the way services are designed and delivered.
- Feedback from communities is incorporated into some of our service design and delivery.
- Patient and carer feedback is incorporated into how services are assessed.
- Expanding opportunities for patients, families and carers to shape services, including through forums and carer engagement activities.

What we will focus on to deliver our strategy

- Further embed co-production and use of feedback capturing patient, carer and families' experience to develop a consistent approach.
- Build a systematic approach to incorporate feedback from communities into service design and delivery.
- Use the neighbourhood health and care approach to continuously gather patient and community insights and improve integrated, personalised care
- Design a process to capture patient identified outcomes.

Make things simple

Where we are now

- Improved oversight of waiting times, including demand and capacity modelling across key pathways.
- Targeted improvements and partnership working where waits have been highest, including increasing use of an ethnicity and deprivation lens to identify potential health inequalities
- No 52 week waits by March 2026 in most adult community services.

What we will focus on to deliver our strategy

- Simplify and strengthen access to care by optimising the Single Point of Access across community health services and through improved efficiencies in district nursing services.
- Improving urgent and emergency care pathways, improving entry to same-day and community-based services.
- Reduce waiting times and improve performance by delivering the 18-week referral to treatment standard, eliminating all 52-week waits, and strengthening waiting list management with a focus on tackling health inequalities.
- Drive consistency, digital innovation, and quality improvement by standardising care pathways, expanding remote monitoring, and aligning with the NHS Oversight Framework to reduce variation and improve outcomes.
- Improving digital access for patients and staff, including exploring use of digital innovation to improve flow.

Where we are now

- We have established the foundations for neighbourhood delivery including developing the neighbourhood geographies.
- Good experience of working with partners to support people at home and avoiding admission to hospital.
- Growing focus on prevention within our services

What we will focus on to deliver our strategy

- Strengthen system-wide partnerships and planning through alignment with Thames Valley Integrated Care Board, public health, and academic partners (including ARC and universities), supporting initiatives such as urgent care and dental access.
- Embed a population health and neighbourhood-based approach, ensuring care is co-designed across urgent and planned services and delivered closer to communities, including support the delivery of the national Neighbourhood Health Framework and – in Oxfordshire – support the delivery of the 5 year neighbourhood health plan.
- Co-location of services where possible in hubs across health, care and community support services
- Deliver integrated, cross-provider models of care, including collaboration with partner trusts to improve access and outcomes and deliver the left shift

Where we are now

- Emerging use of population health data to identify health inequalities and use this to target support for underserved groups.
- Increasing co-ordination across partners to support people with complex needs

What we will focus on to deliver our strategy

- Use data and Population Health Management (PHM) to drive decision-making, triangulating insights with system partners to identify priorities, target health inequalities, and improve population outcomes.
- Improve access and experience for children and young people, particularly across integrated physical and mental health pathways, supported by timely mobilisation of specialist and urgent dental care contracts.
- Embed neighbourhood-based models of care, developing neighbourhood plans with partners to shift towards prevention and early intervention, reduce variation, and deliver more integrated care closer to home.

Where we are now

- A continued focus on developing multidisciplinary ways of working and culture.
- Continued focus on effective leadership
- Delivering Oxford Health's team work principles

What we will focus on to deliver our strategy

- Strengthen workforce experience and capability through improved recruitment, staff wellbeing initiatives, career development pathways, and targeted leadership programmes.
- Embed a listening and responsive culture by using regular staff engagement and feedback mechanisms to inform decision making
- Deliver a strategic, inclusive workforce agenda through robust workforce planning and implementation of equalities, diversity and inclusion priorities.
- Enhance workforce capability and progression through a structured training plan that supports continuous skills development and career growth

Where we are now

- Research and innovation work has been strengthened across teams
- A strong approach to Quality Improvement, with multiple QI projects delivering innovations for patients and colleagues.
- A five year research strategy has been developed.

What we will focus on to deliver our strategy

- Maintain focus and delivery of quality improvement methodology, working with teams to develop new areas for improvement and innovation
- Embed research and data-driven improvement across all services, using evaluation, demand and capacity modelling, and digital innovation to inform service redesign and improve outcomes.
- Expand research capability and partnerships, including clinical-academic roles and a coordinated research strategy to drive innovation and evidence-based practice.
- Strengthen cross-system collaboration and learning, ensuring insights are shared and scaled to deliver integrated, high-quality, and sustainable care models.
- Delivery of the five year research strategy

Oxford Health has a well-established planning process. The next planning cycle will be guided by the new Strategy and Strategy Delivery Plan, with directorates setting out how they will contribute to delivering our strategic aims and priorities. We will continue to work with teams to develop and support the planning process, taking account of national guidance when it is issued and focusing on the following areas:

- How do plans contribute to delivering the three strategic aims and the improvements we want to see over the next five years for patients, carers and families; people who work at Oxford Health; and our communities and populations?
- How do plans deliver against the national planning requirements?
- How do directorate planning priorities support delivery of the 6 strategic priorities:
 - Co-produce care:
 - What steps are necessary to develop and report on patient outcome measures?
 - How are you supporting embedding co-producing care planning and how will you monitor quality?
 - How will you be using co-production to shape the design of services with patients, families and carers and local communities?
 - Make things simple:
 - If applicable- What work will be undertaken in year to review pathways, identifying any unwarranted variation across the Trust, seeking to improve access, waiting times, experience and outcomes? What are the priority areas of focus? What support is required to enable this work?
 - If applicable- What work will be undertaken in year to simplify and streamline central and support services system processes to improve efficiency and user experience for people who work at Oxford Health?
 - Collaborate with partners:
 - If applicable- How will provider collaboratives aim to reduce unwarranted variation and improve outcomes?
 - How will planning priorities support, enable and deliver the neighbourhood health approach?
 - What will work with partners and on which priorities to make the best use of skills and resources available?
 - Address health inequalities:
 - What actions will be taken in year to improve use of data to understand health inequalities across services, derive hypotheses about what is causing the health inequalities, identify options to address and take action to address the identified inequalities?
 - How are population health insights used to design services in a way that supports people identified as most at risk of ill health? What actions will be taken to address this? The Trust-wide area of focus identified in the strategy are early years and children, people with frailty and people with SMI.
 - Fostering an inclusive culture:
 - What actions will you take to reduce discriminations faced by colleagues in line with our anti-discriminatory trust approach?
 - What actions will you take to embed a compassionate and inclusive leadership?
 - What action will you take to support colleagues to develop their skills and capability?
 - Using knowledge to improve care:
 - What actions will be taken in teams to embed the use of quality improvement?
 - How will you support the translation of research and embedding use of research in your services?

To reflect the importance of the strategic foundations in delivering our new strategy, we will work with directorates to ensure their plans reflect the strategic foundation ambitions. Plans will be produced to reflect the following:

- Quality Management System:
 - How quality review, management and planning is embedded into directorate ways of working and used to support the planning process.
- Value and financial sustainability:
 - Plans are developed to deliver financial balance, with clear delivery plans for cost improvement programmes and investment areas, including any impact on outcomes.
 - Productivity is understood across services, including steps to be taken to improve this in line with local and national benchmarking.
 - There is a growing understanding and use of the notion of 'value' to support the transformation of services.
- Data and digital:
 - Data is understood and used to inform planning priorities to improve value and the outcomes for people.
 - Digital opportunities are explored to support patients, families and communities when accessing services, and to improve efficiency and reduce the administrative burden for staff.
 - We can describe how teams deliver the analogue to digital shift.
 - Directorate planning reflects Oxford Health's Digital Strategy.
- People plan:
 - Opportunities to upskill people who work at Oxford Health are explored, and the skills required are considered when planning priorities are developed.
 - Planning priorities are developed in conjunction with teams, allowing people who work at Oxford Health to feel properly engaged in planning the work of their teams.
- Estates and facilities:
 - Opportunities to increase the efficiency and productivity of our estate are explored.
 - Planning priorities reflect the opportunities to improve the quality and where necessary maintain the safety of our estate for patients and people who work at Oxford Health.
 - Directorate planning reflects Oxford Health's Estates and Facilities Strategy.
- Green plan:
 - Planning priorities take account of the environmental impact of how services are designed and delivered.
 - Directorate planning reflects Oxford Health's Green Plan.

Oxford Health NHS Foundation Trust:

Strategy Engagement Report

July 2026

1. Introduction

In 2025, Oxford Health began the development of our new strategy in preparation for our previous strategy reaching its end in 2026. This aligned with the publication of Government's Ten-Year Plan for Health in England which set new expectations and ambitions for the NHS to meet the challenges ahead. Development of the new strategy was therefore an opportunity to think about how we will deliver against these national ambitions and set our focus and priorities to deliver these changes over the coming five years.

The development of Oxford Health's new strategy has drawn on a wide range of insight and evidence, ensuring it is grounded in our services, the wider operating and policy context, and the needs of the people we serve and the partners we work with. In particular, we were keen to hear from our patients, carers and families; wider communities and our colleagues to understand their ambitions for the coming five years.

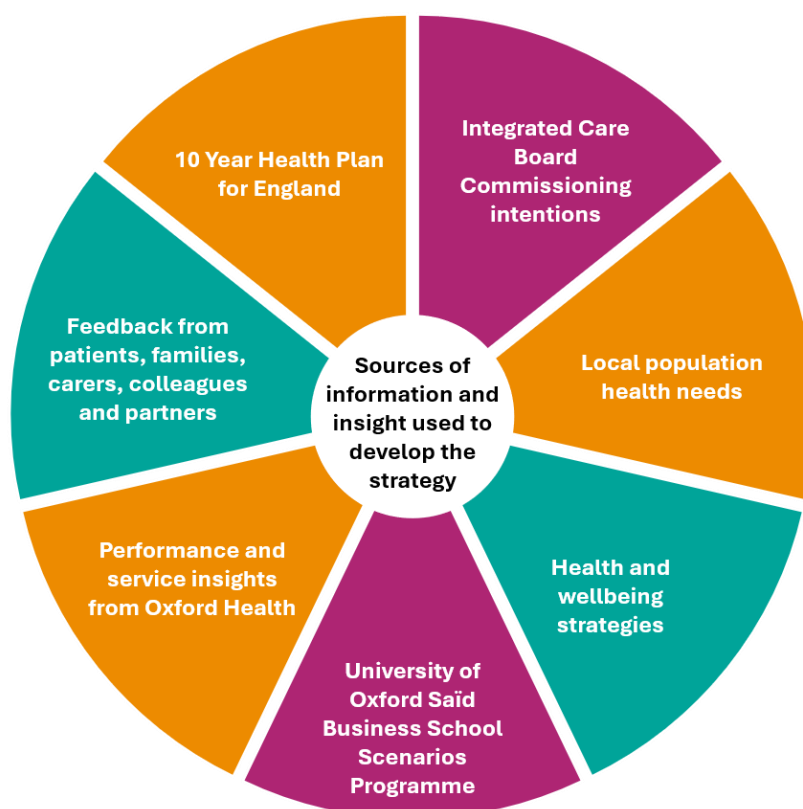


Figure 1: Sources of information used to develop Oxford Health's new strategy

Gathering feedback for the strategy centred on being inclusive and reflective of the needs and priorities of those who will be impacted. Stakeholder engagement and communication plans were drawn up to build on the existing channels that our Experience and Involvement and Communications Teams have established. We wanted to align with ongoing engagement of our patients, carers and colleagues in the running of our organisation and strengthen our engagement structures for both internal and external engagement.

This report provides an overview of the engagement activity that Oxford Health undertook with key groups of people impacted by the strategy. This included our patients, their families and carers; our communities; our colleagues who work at Oxford Health, and our partner organisations with whom we deliver care. This report demonstrates how the feedback from this engagement informed our new strategy.

2. Summary of engagement activity

Engagement was carried out over two phases: firstly a broad conversation with people about what matters to them which was used to inform the development of a draft set of aims and priorities; these were tested with people during the second engagement phase. Alongside this, regular workshops were held with Oxford Health's Board, to consider the information and insight developed through the engagement and inform the development of the strategy.

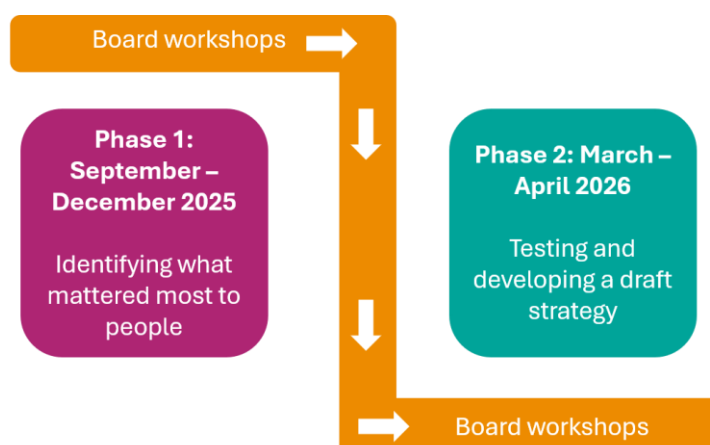


Figure 2: Phases of engagement activity

It was important that engagement reached the wide ranging and varied groups of people that Oxford Health interacts with, including:

- Patients, carers and families including patients and carers that work with us as Experts by Experience (EbEs)
- The wider community and local residents; including groups whose voices are seldom heard
- Colleagues that work for Oxford Health; including our Peer Support Workers and volunteers

- Colleagues that work for partner organisations that we work with in delivering services
- Partner organisations across the NHS, Local Authorities and Voluntary and Community Sector Enterprises (VCSE).

Reaching these varied groups required a tailored approach using the following methods:



Figure 3: Engagement methods

3. Phase 1 engagement

Purpose of engagement

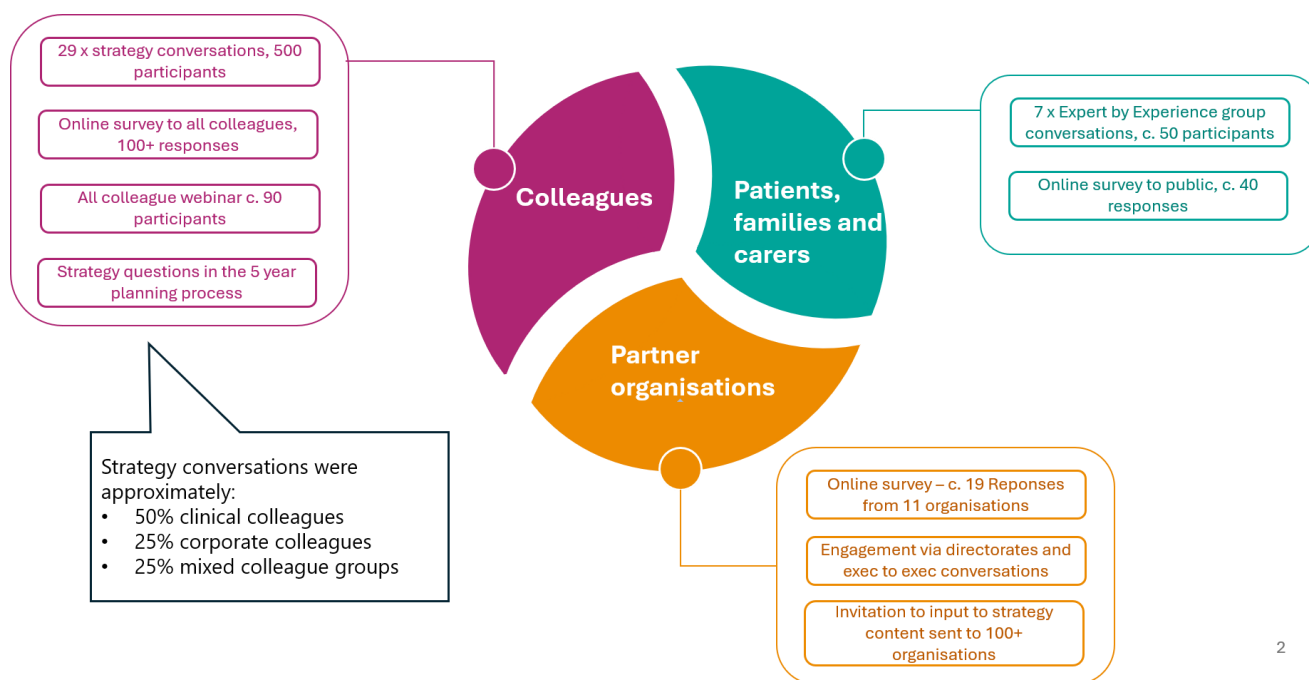
The first phase of engagement, carried out between September and December 2025 focused on a set of deliberately broad and general questions, with the aim that the second phase of engagement would focus on specific areas of improvement for Oxford Health. The core questions asked were:

- What does Oxford Health do well?

- Where could Oxford Health improve?
- What are the biggest opportunities for Oxford Health?

Overview of engagement activity

We heard feedback from all channels of engagement; the following summarises the engagement activity for phase 1:



2

Figure 4: summary of phase 1 engagement activity

Feedback from Phase 1 Engagement

We heard the following key messages during phase 1.

What does Oxford Health do well?

- **Colleague pride and patient care:** Our colleagues expressed strong pride in their work and the quality of care delivered. Patient safety, clinical governance, and incident response were highlighted as strengths. Patients described colleagues as professional, responsive, dedicated, and supportive.
- **Inclusion and wellbeing:** The Trust was praised for its inclusive policies, colleague support networks, and genuine focus on colleague wellbeing. Flexible working and the improvements that have been made to the speak-up culture are valued.

- **Training and development:** Access to training and continuing professional development opportunities were frequently cited as benefits.
- **Patient involvement:** Patients and EbEs are actively involved in service improvement, with forums and coproduction efforts widely praised by both colleague and patients.

What could Oxford Health do better?

- **Consistency of experience for colleagues:** Colleagues reported that the positive aspects of culture and inclusion are not felt equally across all teams and levels.
- **HR and clinical systems:** Colleagues reported finding HR systems complex and hard to navigate, with insufficient support. Clinical systems were described as not user-friendly or reliable, impacting care and data quality.
- **Inclusion:** Colleagues cited a need for stronger action on tackling racism and better support for neurodivergent colleagues.
- **Tackle challenges to providing good care:** Patients and colleagues both reported that transitions between services (especially 0-18 to adult) are challenging, with delays impacting patient-centred care. Colleagues noted that low staffing and increased workload affect colleagues' wellbeing and patient safety.
- **Communication:** Both patients and partner organisations highlighted issues with communication, including lack of clear information, medicalised language, and difficulty navigating services. Internally, colleagues also requested improvements to communication.
- **Estates:** Colleague reported experience of poor Wi-Fi in Trust buildings, unreliable technology, and a lack of suitable working environments . Requests for improved parking and communal spaces were common.
- **Joined-up working:** Colleagues and partner organisations noted the need for better collaboration across teams and organisations to avoid duplication of efforts and improvements in patient care, in particular in relation to how improvements are introduced.

What are Oxford Health's biggest opportunities?

- **Leveraging position and reputation:** Oxford Health could lead important conversations and developments for the NHS, such as anti-racism initiatives and education offering for NHS colleagues.
- **Research and innovation:** There are opportunities to expand research activity, focus on translational research, and match research capabilities to clinical priorities.
- **Prevention and community support:** Emphasising prevention, especially through community support and rehabilitation, can reduce the need for more acute forms care.
- **Patient and EbE involvement:** Initiatives like 'reverse mentoring' and involving EbEs at every level of governance can strengthen patient voice and coproduction.
- **Digital transformation:** Investing in digital innovation (e.g., AI for admin tasks, wearable tech for patient monitoring) can improve efficiency and outcomes, provided infrastructure issues are addressed.

- **Partnerships:** Closer working with partners, including VCSE sector, public health, and primary care, can improve patient outcomes and system efficiency.
- **Joined up care:** Reviewing and integrating care pathways across directorates and between mental and physical health services can address disparities and improve productivity.

From our patients, carers and families, we specifically heard:

- Strong appreciation for the professionalism, compassion and commitment of Oxford Health colleagues.
- Concerns about access, in particular waiting times, speed of referrals, and the consistency of appointments and service availability.
- Barriers linked to location of services, travel, and navigating complex pathways, particularly for those in rural areas or with additional needs.
- Themes around communication; patients and carers wanting clearer information, better updates, and smoother transitions between teams and services.
- A call for deeper involvement of lived experience in shaping services, influencing decisions and improving accountability, including support for carers and better recognition of their role.
- Interest in prevention and early intervention, and a desire for more joined-up working across mental and physical health.

4. Learning from phase 1 engagement.

The feedback from phase 1 provided some valuable learning both for the development of the strategy itself and for how we engaged in phase 2.

The views of our stakeholders informed the drafting of our strategy in the following ways;

- Colleagues told us that the existing vision and mission of Oxford Health did not strongly resonate, which informed a decision to draft a new vision and a purpose to test in phase 2.
- Colleagues gave overwhelmingly positive feedback about the existing values ‘caring, safe and excellent’, so it was agreed that no changes would be proposed to the organisational values.
- A priority to ‘Make Things Simple’ was identified, responding to messages from patients relating to the challenges of accessing and navigating care, and from colleagues relating to complex systems and processes that can get in the way of providing care to patients.
- A priority to ‘Deliver high quality care through QI, innovation and research’ was included in the draft strategy, after we heard that we could maximise opportunities around research and innovation. The aim relating to communities and population health referenced improving the health of people locally, nationally and beyond to recognise the potential reach of research undertaken by Oxford Health.

Taking the learning from phase 1 of engagement, we amended our plans for phase 2 to carry out some additional and targeted engagement. This included:

- Piloting the 'Lived Experience Strategy Reference Group', which was made up of EbEs, who used their experience to feed views in on the development of the strategy and its implementation.
- Holding an engagement session with young people, their link workers, parents and carers.
- Holding a public-facing webinar jointly hosted by Healthwatch Oxfordshire and Healthwatch Buckinghamshire to seek views of the wider community.

5. Phase 2 engagement

Overview of engagement

Along with the feedback gathered in phase 1, the implications of the national 10 Year Plan, our local system priorities and local population health needs informed the initial draft of the strategy, as shown below:

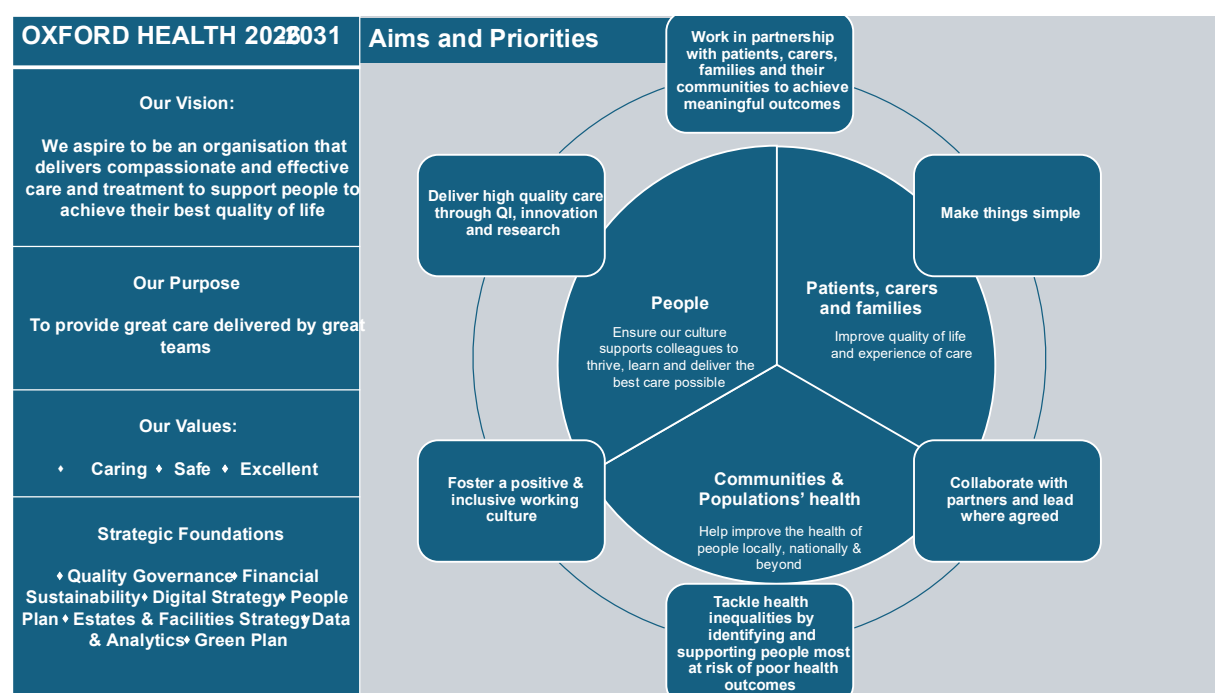


Figure 5: Draft strategy shared during phase 2 engagement

Phase 2 of the engagement was designed to test the draft strategy with stakeholders and gather feedback on proposals, both in terms of the main messages within the content but also on the language that had been used.

Engagement activity

The following summarises the engagement activities that took place in phase 2:



Figure 6: summary of phase 2 engagement activity

Feedback from phase 2 engagement

We heard through phase 2 engagement that there was broad support for the direction of the strategy, and its aims and priorities were broadly right. Stakeholders welcomed the opportunity to engage with the draft content. The following summarises the messages we heard:

- Feedback consistently highlighted areas that needed further strengthening if the strategy was to feel credible, distinctive and deliverable. A key perception was that, while the aims and priorities listed in the strategy were broadly supported, they read as familiar and generic. It was mentioned that the content could be revised to better articulate what will change because of the strategy and what will set Oxford Health apart in its approach.
- A recurring tension between ambition and realism was raised, with stakeholders keen to understand how the strategy would balance available resources, workforce capacity and the need to avoid unintended pressure on colleague with delivery of change.
- There was a strong desire for clearer, more accessible wording. In particular, feedback suggested the vision could be shorter and more memorable. The distinction between the vision and purpose was questioned.
- Respondents asked for clearer articulation of the meaning, scope and intended outcomes of the aims and how these would take into account the specific context in which Oxford Health operates. Feedback suggested that the themes of prevention; access to care; productivity; and use of digital systems could be strengthened and made more prominent.
- Queries were raised by respondents that showed a need to clarify the scope and level of ambition within each priority.
- Feedback also suggested there could be a clearer and more visible link to the Ten Year Plan for Health.

6. Learning from phase 2 feedback.

The feedback we heard in phase 2 of engagement informed the drafting of our strategy in the following ways;

- The vision was further revised to be more unique to Oxford Health and inspiring. The vision and purpose were combined, to describe what we are aiming for in the long term.
- The titles of the priorities were made shorter and clearer, but with subtitles to explain the meaning of each priority.
- Each priority has been expanded in the final document to highlight where we are now, describe where we want to get to and how we will get there.
- The feedback has informed drafting of the strategy document to use plain English and avoid jargon where possible.
- We are developing a Strategy Delivery Plan that will set out greater clarity on how we will deliver the strategy.

The feedback from phase 2 built on the messages we heard during phase 1 to comprise a robust and thoughtful range of comments. Engagement participants provided challenge, suggestions and debate that informed the drafting process; supported the Board to have rich conversations about the content and ambitions; and supported the other insights gathered including from the national direction. Bringing together this range of insights has supported the final draft of the strategy presented to Board for approval.

7. Overview of engagement activities across Phase 1 and Phase 2

The figure below provides an overview of the engagement activities undertaken across the two phases of engagement.

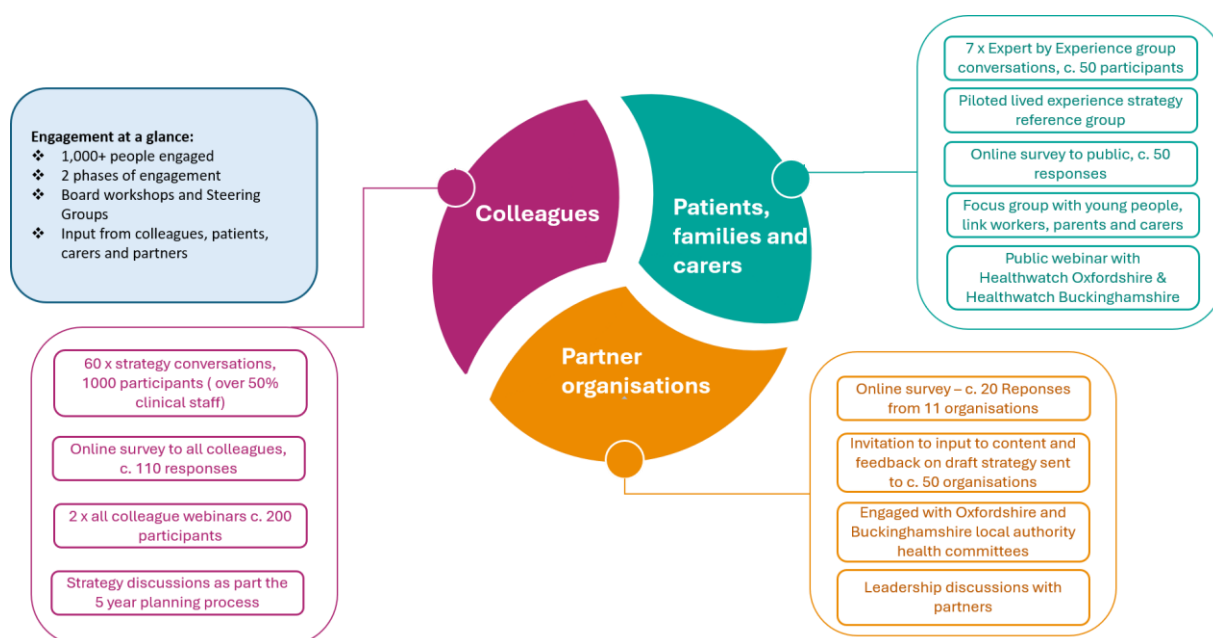


Figure 7: summary of phase 1 and 2 engagement activity

8. Conclusion

The engagement outlined in this report has been a vital component in shaping the next Oxford Health Strategy 2026-2031. Engagement has built a shared understanding of how we can respond to the needs of our patients, carers, families, communities, colleagues and partners so we can deliver on what matters most to people.

Taken together, the two phases of engagement demonstrate strong alignment on strategic direction of Oxford Health, but also clear expectations on how it must be delivered. As the strategy is implemented, we will continue to engage stakeholders to gather feedback, support learning, and inform ongoing adaptation and decision-making, ensuring the strategy evolves in response to the needs of the people and partners we work with.

We would like to thank all the engagement participants, each of whom provided insights and reflections which have shaped our strategy and will in turn shape the direction of the Trust over the next five years.

Meeting:	Board of Directors' Meeting
Date of Meeting:	22 July 2026
Agenda item:	11(a)
Report title:	Integrated Performance Report – July 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. July's IPR contains May 2026 (unless stated otherwise in the report) data.

The IPR underwent an annual review in April 2026, with agreed changes to be implemented over the next few reporting cycles. These changes include, but are not limited to, the escalation or de-escalation of selected metrics to the most appropriate governance forum, with some measures moving from Trust Board reporting to Directorate Performance Boards; the presentation of certain metrics at Trust level rather than by Place; and the introduction or revision of performance targets where appropriate as well as integration of Quality metrics within clinical sections (initially Inpatient services). A summary of these changes and the rationale for them is presented in **Appendix A**.

Following completion of the planning returns, a set of additional stretch ambition metrics were communicated at national and local levels, as follows:

On 8th of June 2026, the NHS England's National Priority Programme Director for Mental Health, Learning Disability and Neurodevelopment Conditions informed Mental Health provider Chief Executive Officers of a set of priority delivery actions stretching delivery beyond the expectations in the Multi - Year Planning Framework. The actions are:

- Reducing inappropriate adult acute Out of Area Placements by 95% (based on March 2026 position) by end of March 2027 with the expectation that this will virtually eliminate inappropriate out of area placements by end of March 2028.

The focus on adult acute only beds is deliberate as these placements are more often readily addressed and can be impacted more rapidly compared to other bed types.

- Reduce the number of people known to Mental Health Services who attend Emergency Departments in Mental Health crisis. The proposed new metric to monitor is the proportion of Referrals from Emergency Departments to Liaison Psychiatry Service for people who are already known to Mental Health Services. Further work will be undertaken by the national team to define a precise target for delivery by March 2027.
- To double the number of children who start treatment within four weeks by ensuring at least 50% of children and young people mental health referral-spells meet all criteria to stop the patient waiting (Appointment with a snomed coded intervention or care plan & a baseline outcome measure being completed) in less than four weeks by end of March 2027. A stretch target of at least 5 percentage points is proposed for Trusts already above 50%.
- To undertake a full and detailed analysis of all free text comments generated through Staff Survey and identifying a minimum of three areas where the data shows greatest staff dissatisfaction, develop a detailed action plan and to resolve those issues within a year.
- To complete at least one full survey cycle to capture the experience of people waiting for care in quarter two and implement improvements through quarters three and four.

In addition, the Talking Therapies Memorandum of Understanding with the Thames Valley Integrated Care Board sets out agreed targets to increase the number of adults and older adults completing anxiety and depression treatment, contributing to the ICB's share of the national ambition. Services are also working towards a further local stretch ambition to improve completion rates – see Talking Therapies section below for details. Work is ongoing to build these stretch targets in the directorate's plan and report against them.

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

In summer 2025, NHS England updated the NHS National Oversight Framework, assessing providers against defined metrics to determine segment scores and identify where targeted improvement support is needed. Interventions are also informed by each organisation's leadership, governance and capability.

On 9 September 2025, NHS England published its first NOF league table, scoring providers against 2025/26 priorities and placing them in segments from 1, requiring no support, to 5, requiring intensive support. Oxford Health NHS Foundation Trust was placed in segment 1, indicating high performance, for quarter 1. Quarter 2 position was confirmed in December 2025, and the Trust remained in segment 1. Quarter 3 position was published on 18th March – the Trust was placed in segment 2 (above average), in line with the Trust's internal forecast.

Underlying performance for quarter 4 segmentation places the Trust in segment two. Areas for improvement are the Community Waits over 52 weeks & the % of patients discharged with a length of stay over 60 days (noting this is no longer a NOF metric for 2026/27).

It is important to note, however, that due to an error in the Trust's submitted Urgent Community response 2-hour performance data, the quarter 4 segmentation published on 11th June 2026 saw the Trust placed in segment 3 (below average). This is due to the error in the Trust's submitted data, and the dashboard using provisional March 2026 data rather than the expected final March 2026 data which the Trust has partly been able to correct, resulting in the performance showing at 33.19% rather than the expected 85.9% performance in the final March 2026 data.

The Trust has engaged with the regional team, and the national team has been alerted, but it was not possible to correct Oxford Health's position within the League table as it would have impacted the position communicated to all other providers. This is in line with the approach taken in previous quarters when incorrect data submissions have similarly impacted other Trusts. Internally, the Trust has reviewed learning from this error, and an action plan has been drafted for review by the Board.

The Regional team and ICB team are keen to recognise the true performance of Oxford Health. The IPR therefore includes the corrected position using the expected final data published in the Community Services Data Set, alongside an **addendum** showing the data that was published as part of the quarter 4 segmentation which included the error.

NHS England reviewed and published the National Oversight Framework for 2026/27 with the final technical guidance yet to be released, these measures will be incorporated into the IPR within the next few months. See **Appendix B** for details.

(2) Clinical performance

The Trust has a set of metrics to monitor clinical performance derived from nationally reportable metrics and locally agreed metrics. 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 and the Executive Team. For a comprehensive narrative, please refer to the full Integrated Performance Report (IPR).

Service area	Comments	
Child and Adolescent Mental Health Services (CAMHS)	Concerning nature and consistently* failing the target	Percentage of referred (routine cases) with suspected eating disorder (ED) that start treatment within 4 weeks – Oxfordshire (rolling 3 months position)
	Concerning nature, but consistently passing the target	Percentage of referred (urgent) cases with suspected eating disorder (ED) that start treatment within 7 days – Oxfordshire and Buckinghamshire (rolling 3 months position)
	Concerning nature and inconsistently passing or failing the target	Percentage of referred (routine cases) with suspected eating disorder (ED) that start treatment within 4 weeks – Buckinghamshire (rolling 3 months position)
*Consistency is determined by a certain number of consecutive data points.		
The Board of Directors is asked to note that none of the services achieved the 95% target for routine cases to be seen within 4 weeks (rolling 3-month position) in May 2026 as well as Oxfordshire's and Buckinghamshire's service not achieving the 95% target for urgent		

	referrals be seen within 7 days (rolling 3-month position) in May 2026. Oxfordshire's performance has been particularly affected by both vacancies and unplanned absences – recruitment is underway and is expected to have a positive impact on performance against targets within the next three to six months. While services may not be meeting the targets, they continue to perform better or broadly in line with national annual FY25/26 (latest published data) averages. See IPR for details on Children and Young People Eating Disorders services performance. The Board of Directors is asked to note new CYP mental health services four (4) week wait (interim metric – one contact based only) targets for 2026/27 – they have been set as a stepped improvement trajectory starting with a target of at least 62% April to June and increasing towards 80% by end of March 2027. National averages were applied to this metric last financial year. The full 4 week wait metric which is based on (1) one contact, snomed coded intervention or care plan & a baseline outcome measure has started to be reported internally at Directorate & Executive Level, this will be reported to Board when the current data quality/completeness gaps have been addressed. CAMHS access targets for FY26/27 have been rebased in line with national planning expectations to maintain August 2025 performance levels and the Trust is exceeding May's trajectories across all three CAMHS services (Oxfordshire, Buckinghamshire and Bath & North-East Somerset, Swindon and Wiltshire). P Data Quality (Process and System) – Activity from AnDY* Research Clinic has not been included in Oxfordshire's CAMHS access metric as it is recorded on a separate system and reported through a different dataset. As of April 2026, AnDY activity accounted for 200 patients accessing (May 2026 data not yet available due to reporting lag). *AnDY – Anxiety and Depression in Young People				
Talking Therapies	<table border="1"> <tr> <td>Concerning nature, but consistently passing the target</td><td> % of people receiving first treatment appointment within 18 weeks of referral – Oxfordshire - Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) - Oxfordshire </td></tr> <tr> <td>Concerning nature, and inconsistent passing or failing the target</td><td></td></tr> </table> The Making Data Count (MDC) algorithm has flagged the above metrics as requiring attention due to its concerning variation status. The Board of Directors is asked to note that no systemic risks have been identified at this stage – see IPR for further details. Otherwise, Oxfordshire's and Buckinghamshire's Talking Therapies services are performing well. Targets for 26/27 have been collaboratively reviewed and updated. The Board of Directors is asked to note that, while targets have been set to increase the number of adults and older adults completing anxiety and depression treatment (≥ 497 Buckinghamshire and ≥ 636 Oxfordshire), services have a further stretched ambition to improve completion rates (≥ 560 Buckinghamshire and ≥ 770 Oxfordshire) in line with the Talking Therapies Memorandum of Understanding with the Thames Valley Integrated Care Board. The trust will aim to meet these stretched targets.	Concerning nature, but consistently passing the target	% of people receiving first treatment appointment within 18 weeks of referral – Oxfordshire - Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) - Oxfordshire	Concerning nature, and inconsistent passing or failing the target	
Concerning nature, but consistently passing the target	% of people receiving first treatment appointment within 18 weeks of referral – Oxfordshire - Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) - Oxfordshire				
Concerning nature, and inconsistent passing or failing the target					
Adult and Older Adult Community Mental	The Board of Directors is asked to note 4 week wait targets (interim metric – two contacts based only) for 2026/27 have been set as a stepped improvement trajectory starting with a target of at least 60% for April to June and increasing towards 80% by the end of March 2027.				

Health Services	Trajectories for improving 26/27 perinatal access have been rebased in line with national planning expectations to maintain August 2025 performance levels, due to the decommissioning of the Infant Perinatal service in Oxfordshire CAMHS the target will reduce from October 2026. Trajectories for improving 26/27 access to Individual Placement Support (IPS) have been rebased to reflect the funded expansion and to support the national ambition with increasing access to IPS services.		
Mental Health Urgent Care Services	Urgent Mental Health Care services across Oxfordshire and Buckinghamshire are generally performing well and are exceeding the agreed targets. The 2026/27 targets have been set as improvement trajectories, with the following levels to be achieved by the end of March 2027: • Mental Health Psychiatric Liaison response within 1 hour and 24 hours: 95% • Mental Health Crisis Service response within 4 hours: 75% • Mental Health Crisis Liaison response within 24 hours: 95% Due to significance, the Board of Directors is asked to note narrative within the IPR for the following Mental Health Crisis service National Oversight Framework (NOF) metrics: • Urgent response (24 hours) from Mental Health Crisis in Buckinghamshire at 75% and in Oxfordshire at 88.89% in May 2026 (against NOF Q4 2025/6 mean position of 71.97%%). Mental Health Sector Priority Actions briefing sets out the expectation for Trust to monitor referrals to Liaison Psychiatry for People Known to Services as a proxy measure to understand how effective community mental health services are at preventing unplanned emergency care utilisation. Once reporting mechanism is developed, this metric will be added to the IPR for monitoring.		
Mental Health Inpatient Services	This section has undergone the most changes, with most directorate-level metrics transferred to monitoring through directorate-level governance arrangements. The Board of Directors will continue to monitor performance at Trust level. As noted above, relevant quality metrics have also been introduced within this section as part of the continued integration of Quality reporting into the IPR. <table border="1" data-bbox="411 1435 1433 1563"> <tr> <td data-bbox="411 1435 879 1563">No significant change and consistently failing the target</td><td data-bbox="879 1435 1433 1563"> • Mean Length of Stay (LoS) for MH adult acute and PICU discharges (rolling 3 months) - Trust level </td></tr> </table> The Board of Directors is asked to note the above metric flagged by the MDC algorithm. However, as new targets were set and applied from April 2026, any assessment indicating inconsistent achievement or non-achievement of target should be interpreted with caution during this transitional period. Mean Length of Stay targets have been set using the August 2025 baseline, in line with national planning guidance. As August 2025 represented the Trust's best-performing month, the targets are considered ambitious and may be challenging to sustain consistently throughout the year. The Board of Directors is asked to note that the increase in the Trust's Mean Length of Stay for adult acute and PICU discharges (45.42 days in May 2026 vs. target of 36.28 days) is primarily driven by an increase in the mean length of stay in Oxfordshire's adult acute and PICU inpatient wards. The Board of Directors is also asked to note:	No significant change and consistently failing the target	• Mean Length of Stay (LoS) for MH adult acute and PICU discharges (rolling 3 months) - Trust level
No significant change and consistently failing the target	• Mean Length of Stay (LoS) for MH adult acute and PICU discharges (rolling 3 months) - Trust level		

	- Pressures in inpatient services continue to be driven by both acuity of patients and delays in discharging clinically ready-for-discharge patients. Investments secured through the planning round will enable to strengthen inpatient provision and further grow the crisis offering, reducing the need for admission and improving flow - see IPR for details. - Inappropriate out of area placements for May snapshot position was 0 and in month inappropriate bed days for May was 20 bed days. In addition to operational oversight and management improvements, the Trust is commissioning additional out of area placements beds from April 2026 for Oxfordshire's patients to ensure continuity of care principles are met whilst addressing pressures on inpatient services - see IPR for further details. The Mental Health Sector Priority Actions briefing sets out a national expectation of virtually eliminating inappropriate out of area placements by the end of this financial year by aiming for a 95% reduction in adult acute Out of Area Placements based on March 2026 levels. S Data Quality (Sign off and review) - the reported reduction is primarily attributable to the implementation of revised reporting rules following clarification of the criteria used to define appropriate and inappropriate bed placements (out of area placements that do not meet the continuity of care principles set out in NHS England guidance are deemed to be inappropriate). This has resulted in a change to the classification methodology for inappropriate out-of-area placements. Performance trend graphs are currently being updated to reflect this change.		
Community Health Services, Dentistry and Primary Care	<table border="1" data-bbox="411 999 1437 1093"> <tr> <td data-bbox="411 999 879 1093">Improving nature, but consistently failing the target*</td><td data-bbox="879 999 1437 1093"> Consistently meet or exceed the 70% 2-hour Urgent Community Response (UCR) standard </td></tr> </table> *A local target of 95% has been applied from April 2026 to the UCR metric. Therefore, any assessment indicating consistent non-achievement of target should be interpreted with caution during this transitional period (Trust achieved 97.29% in May 2026). The Making Data Count algorithm uses the most recent eight data points to assess performance assurance. Whist this metric was a scored NHS Oversight Framework metric during 2025/26 it will be removed from the framework for 26/27; The national target will remain at 70% and will continue to be reported to Board. T Data Quality (Timely and Complete) - 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. Before the code can be developed, scoping and mapping exercises with services are taking place to ensure consistency in approach and Standard Operating Procedures (SOPs) across services are followed. The workplan initially anticipated completion by end of quarter two of 2025-26. However, due to technical complexities, in total of three distinct workstreams, each requiring different solution approaches, have been identified. As a result, implementation for those elements will extend into the financial year 2026-27. Service has commenced regular breach checking and validation to improve data quality. The Board of Directors is also asked to note that January – March 2026 data reported nationally does not match the internally reported position due to a coding error that prevented referrals from flowing into the national dataset. The final	Improving nature, but consistently failing the target*	Consistently meet or exceed the 70% 2-hour Urgent Community Response (UCR) standard
Improving nature, but consistently failing the target*	Consistently meet or exceed the 70% 2-hour Urgent Community Response (UCR) standard		

	nationally published Quarter 4 (January – March 2026) position is 85.9%, whereas internal data indicates a position of 94%.
Community Health Services, Dentistry and Primary Care Waits	Reporting of Community Health Services monthly waits sitrep data within the IPR commenced with May 2025 data. This included reporting against the percentage of patients waiting over 52 weeks for community services, combining adults and children and young people. The percentage of patients waiting over 52 weeks for community services will be a scored NHS Oversight Framework metric for 2026/27. Community services now have agreed improvement trajectory targets for 2026/27: - Percentage of patients waiting over 52 weeks for community services (CYP and Adults combined) starting with a target of no more than 19.59% in April and gradually reducing to 0% by end of March 2027. - Number of people on waiting list for Community services who are waiting over 52 weeks (CYP and Adults combined) starting with a target of less than 530 in April and gradually reducing to 0 by end of March 2027. In May 2026, community services achieved the target for the percentage of all patients waiting more than 52 weeks. The reported position was 17.09%, against a target of no more than 18.45%. Podiatry and Children's Speech and Language Therapy, previously identified as the two outlier services, also met their individual service-level trajectories. As the new trajectories have been applied from April 2026, MDC analysis should be interpreted with caution at this stage. The algorithm may indicate that targets are not being consistently achieved or consistently breached. Any assessment of sustained achievement or non-achievement should therefore be treated as provisional during this transitional period. This month's IPR also introduces a new metric: the percentage of patients waiting under 18 weeks for community services. Targets have been set as a stepped improvement trajectory starting with more than 51% in April and gradually increasing towards the national target of no less than 78% by end of March 2027. In May 2026, the Trust exceeded the local month target of more than 52% for this metric with 56.14% of adults, children and young people waiting under 18 weeks for community services. This metric will be a scored NHS Oversight Framework metric for 2026/27.  Data Quality – on-going data validation by Services, specifically for those 52+ weeks is on-going.

(3) Quality and People

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

Quality:

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 2026/27. May has seen a small reduction in the use of prone restraint. There is a target reduction of 20% in the use of prone restraint the monthly rate for reduction has not been met since August 2025. See detailed actions in the IPR.

There has been an increase in seclusion episodes in May 2026 with 56 seclusion episodes involving 30 patients. Duration data is now available via a manual report and will inform the Trust Quality target of a 20% reduction in durations of seclusion, a programme board is being put in place to oversee this work. See IPR for details.

There has been an increase in suspected suicides in May 2026 which has been reviewed as part of looking at all unexpected/unnatural deaths. No clusters by team or links between patients have been identified. The deaths have been initially reviewed for immediate learning and further reviews are underway. There was one inpatient suspected suicide in May 2026, a full in-depth PSI investigation has started. Prior to this death the last inpatient suicide was in September 2024 and occurred while a patient was on leave.

The number of violent incidents increased between June-August 2025 and has reduced since then but remains above the average level in May 2026. 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

Work across the CAMHS pathway continues to focus on alternatives to physical restraint to maintain the young person's safety through self-harm reduction with personalised plans and alternatives to restraint in the event of self-harm. May 2026 has seen a small reduction in physical restraints across all services, the first decrease since December 2025.

People:

A revised set of targets have been included in this IPR in relation to People metrics. Given our performance in relation to turnover and vacancies we have lowered our targets for both. We have adopted the national recommendation for Statutory and Mandatory training which is 90% and are focusing on the one module (Resus) which remains below 90%. Further work has been done to expand the resus training places available together with better directorate reporting so that local managers can monitor compliance more easily. We have brought Supervision in line with Statutory and Mandatory training, and we have seen a steady increase in our supervision compliance which is 83% against the target of 90%. We are currently at the start of the appraisal period and are aiming for above 95% as in previous years.

(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 and the Executive Team in May 2026. With the publication of the new Trust's Strategy expected in the Autumn 2026, this section will be reviewed.

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

The IPR continues to be reviewed and refined to strengthen performance insight across the Trust. Recent developments include improved coverage for Community Health Services, Dentistry and Primary Care, with further phased expansion planned, including Forensic and Learning Disabilities metrics during 2026/27. As the next phase of Quality reporting integration within the IPR, a small number of quality Directorate level metrics have also been introduced within relevant clinical sections. This includes the addition of restraint information within the inpatient clinical section, with further narrative and additional quality metrics by Place to be introduced over the next few reporting cycles. The report will also continue to evolve in response to the NHS Performance Assessment Framework/National Oversight Framework, including any changes arising from NHS England's review for 2026/27.

Data Quality Indicators have been introduced for clinical metrics, aligned to Insightful Board guidance. These provide a RAG-rated view across key domains including sign-off and review, timeliness and completeness, and process and system, supporting clearer assessment of data quality and reporting processes.

The Trust continues to implement its locally adapted Making Data Count approach, using Statistical Process Control charts to support better interpretation of performance over time and reduce reliance on traditional RAG ratings or two-point comparisons. This remains aligned with Insightful Board principles and supports more informed decision-making.

Directorate-specific IPRs and tailored service review reports continue to support discussion with senior teams and services.

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): July 2026

May 2026 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

Guide to the Integrated Performance Report

Board meeting in public

Page 164 of 530

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 5 for details. Scored NOF metrics are marked with the following icon:  Contextual NOF metrics are marked with the following icon: 

Guides to interpreting Statistical Process Control (SPC) charts and Data Quality indicators, and rules of exception reporting can be found in General Appendices section starting on page 77.

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 for Quarter 4 based on correct UCR data*:

* See the Addendum on page 9 of this Report for information on Segment change

Headlines	Q1 2025/26		Q2 2025/26		Q3 2025/26		Q4 2025/26	
	NOF score	Placement among peers	NOF score	Placement among peers	NOF score	Placement among peers	NOF score	Placement among peers
Segment	1 (High performing)		1 (High performing)		2 (Above average)		2 (Above average)	n/a
Average metric score	2.03		2.06		2.21		2.36	
Financial override	No		No		No		No	
Is the organisation in the Recovery Support Programme?	No		No		No		No	
Ranking among Non-Acute hospital trusts	13 out of 61		15 out of 61		21 out of 61		n/a	

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 2025/26 – dashboard (scored metrics) – quarter 4

Board meeting in public

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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	3.6	38 out of 42	Mar-26	18.15%	↓	0.19	2.67	
	Annual change in number of children and young people accessing NHS-funded Mental Health services	1.74	15 out of 50	Apr-25 - Mar-26 vs Apr-24 - Mar-25	13.78%	↑	8.76%		
Effectiveness and experience of care	CQC community mental health survey satisfaction rate	2	n/a	2025	.	n/a	.	2.52	
	Percentage of patients with >60-day length of stay (adult acute mental health; quarter)	3.49	39 out of 47	Q4 2025/26	31.34%	↓	24.52%		
	Urgent Community Response 2-hour performance (quarter) (corrected for final March 2026 data)*	2.08	24 out of 38	Q4 2025/26	85.9%	↓	87.18%		
Patient Safety	NHS Staff Survey - raising concerns sub-score	1.45	10 out of 61	2025	6.96	↑	6.66	1.81	
	Percentage of patient in mental health crisis to receive face-to-face contact within 24 hours	2.17	19 out of 45	Q4 2025/26	74.95%	↑	71.97%		
People and workforce	Sickness absence rate	2.03	12 out of 61	Q3 2025/26	5.44%	↓	6.22%	1.79	
	NHS Staff Survey engagement theme sub-score	1.55	12 out of 61	2025	7.21	↓	7.02		
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	19 out of 61	Mar-26	0.65%	↑	0.49%		
	Relative difference in costs score	2.93	38 out of 61	2024-25	108.58	→	104.85		

- see dashboard on page 83 of this report for quarter 3 performance

↑ - improvement ↓ - regression → - no change

* See the Addendum on page 9 of this Report for information on Segment change

Domain	Metric	Metric reporting period	Metric value	Metric value change (compared to previous quarter)	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 Dec-25	17.72%	↓	12.04%	5.09%	
	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	Dec-25	98%	→	99%	98%	
Patient safety	Rate of restrictive interventions use per 1,000 bed days	To Mar-26	71	↓	27	27.5	
People and workforce	National Education and Training Survey "Overall experience" score	2025	82.33%	↑	77.18%	78.21%	
Improving health and reducing inequality	Percentage of inpatients aged 65 years and over with a length of stay at discharge exceeding 90 days	Dec-25	24.64%	↑	41.35%	39.01%	

* - see dashboard on page 83 of this report for quarter 3 performance

↑ - improvement ↓ - regression → - no change

Domain	Metric	Metric score	Metric ranking	Metric reporting period	Metric value	Metric value change*	Corrected position using expected final data is the CSDS system	Note
Effectiveness and experience of care	Urgent Community Response 2-hour performance (quarter)	4	38 out of 38	Q4 2025/26	33.19%	↓	85.9%	Final data for March 2026 in Community Services Data Set (CSDS) system had a fix applied to it that corrected part of the data error and positions the Trust in segment 2 based on its true performance.

Oxford Health NHS Foundation Trust’s NOF segmentation and ranking on the latest public League table (11th June 2026; Quarter 4):

Headlines	Q1 2025/26		Q2 2025/26		Q3 2025/26		Q4 2025/26	
	NOF score	Placement among peers	NOF score	Placement among peers	NOF score	Placement among peers	NOF score	Placement among peers
Segment	1 (High performing)		1 (High performing)		2 (Above average)		3 (Below average)	
Average metric score	2.03		2.06		2.21		2.36	
Financial override	No		No		No		No	
Is the organisation in the Recovery Support Programme?	No		No		No		Information not available on Model Hospital	
Ranking among Non-Acute hospital trusts	13 out of 61		15 out of 61		21 out of 61		35 out of 61	

Section 2.1

Clinical performance

(National Mental Health Standards)

Assurance

				No target
Variation	  - Improve access to mental health support for children and young people (CYP) – Buckinghamshire, Oxfordshire and Bath & North East Somerset, Swindon and Wiltshire - Talking Therapies - % of people receiving first treatment appointment within 18 weeks of referral – Buckinghamshire - 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	- CYP - Four (4) week wait (interim metric - one meaningful contact within pathway) – Buckinghamshire - CYP - % referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Bath & North East Somerset, Swindon and Wiltshire (rolling 3 months position) - CYP - % referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Bath & North East Somerset, Swindon and Wiltshire (rolling 3 months position) - Talking Therapies - Reliable improvement rate for those completed a course of treatment adult and older adults combined - Buckinghamshire		
	 Talking Therapies - % of people receiving first treatment appointment within 6 weeks of referral – Buckinghamshire and Oxfordshire	- CYP - Four (4) week wait (interim metric - one meaningful contact within pathway) – Oxfordshire and Bath & North East Somerset, Swindon and Wiltshire - 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 – 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 – Buckinghamshire and 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 - % of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Oxfordshire
	  - CYP - % referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Oxfordshire and Buckinghamshire (rolling 3 months position) - Talking Therapies - % of people receiving first treatment appointment within 18 weeks of referral – Oxfordshire	- CYP - % referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Buckinghamshire (rolling 3 months position) - Talking Therapies - Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) – Oxfordshire	CYP - % referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Oxfordshire (rolling 3 months position)	Talking Therapies - % of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Buckinghamshire

Mental Health Services – Matrix (1/2)

Board meeting in public

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Assurance

				No target
 	- Improve access to perinatal mental health services - Oxfordshire (rolling 12 months) - Number of people accessing Individual Placement Support (IPS) – Buckinghamshire and Oxfordshire combined (rolling 12 months) - Response from Mental Health Psychiatric Liaison within 1 hour – Oxfordshire	Trust level mental health services - % of patients responding that overall care was good or very good		
	- Improve access to perinatal mental health services - Buckinghamshire (rolling 12 months) % of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral – Oxfordshire - Response from Mental Health Psychiatric Liaison within 1 hour – Buckinghamshire - Response from Mental Health Psychiatric Liaison within 24 hours – Buckinghamshire 72 hour follow up for those discharged from mental health wards - Older Adults – Trust	- Adults - 4 week wait (28 days) standard (interim metric - two contacts within pathway) – Buckinghamshire and Oxfordshire % of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral – Buckinghamshire - Response from Mental Health Psychiatric Liaison within 24 hours – Oxfordshire - Response from Mental Health Crisis Service within 24 hours (Urgent) – Oxfordshire and Buckinghamshire - Mean LoS for older adults (rolling 3 months) - Trust level 72 hour follow up for those discharged from mental health wards - Adults – Trust - Trust level mental health inappropriate out of area placements - snapshot last day month - Trust level mental health services - % of patients report being involved in their care	Mean LoS for MH adult acute and PICU discharges (rolling 3 months) - Trust level	- Trust level mental health inappropriate out of area - bed days in month - Trust level % adult acute readmission within 30 days for mental health - Trust level % older adult readmission within 30 days for mental health - Average number of clinically ready for discharge patients per day - Trust level
 				

Variation

Mental Health Services – Children and Adolescent Mental Health Services - summary

Board meeting in public

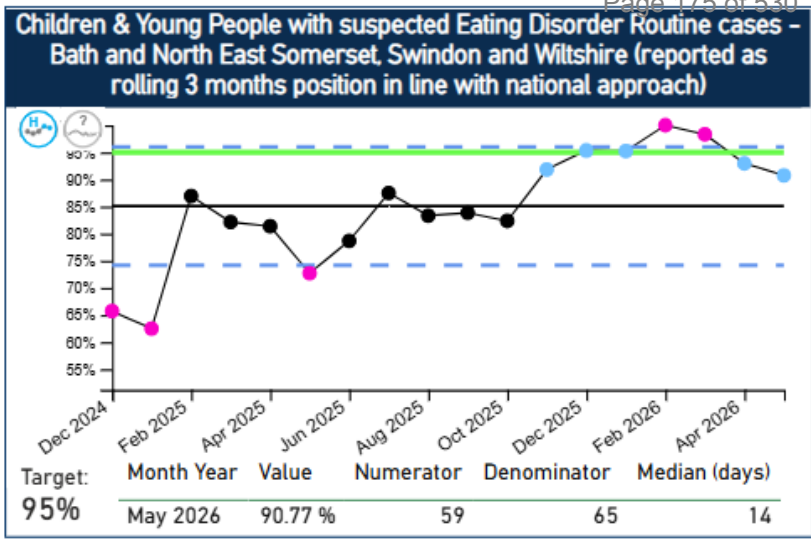
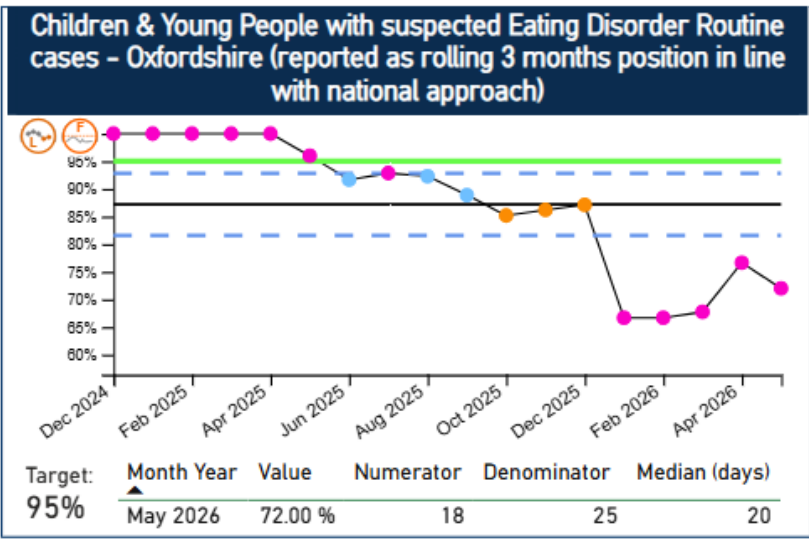
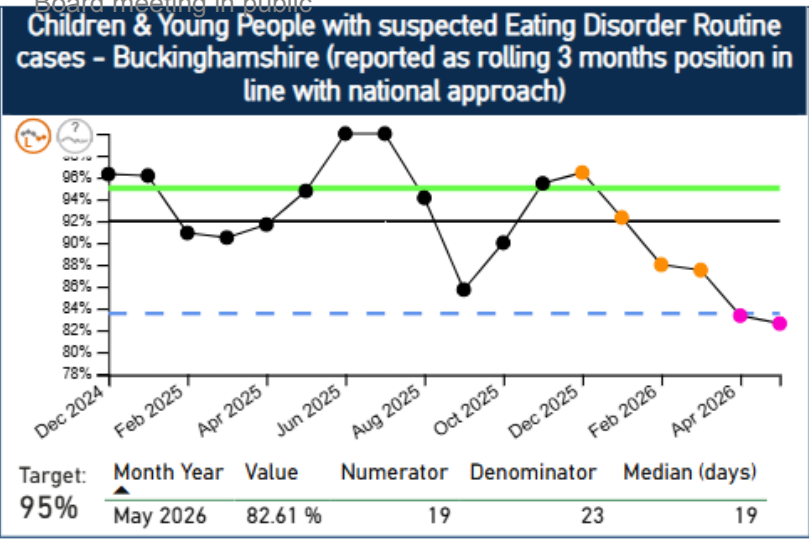
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Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National	Improve access to mental health support for children and young people - Buckinghamshire	>=7765	May-26	8007		.	7014
National	Improve access to mental health support for children and young people - Oxfordshire	>=9055	May-26	9135		.	8587
National	Improve access to mental health support for children and young people - Bath & North-East Somerset, Swindon and Wiltshire	>=7260	May-26	7334		.	6681
National Strategic - Quality	Four (4) week wait (interim metric - one meaningful contact within pathway) - Buckinghamshire	>=62%	May-26	88.03%			71.46%
National Strategic - Quality	Four (4) week wait (interim metric - one meaningful contact within pathway) - Oxfordshire	>=62%	May-26	60.09%			56.55%
National Strategic - Quality	Four (4) week wait (interim metric - one meaningful contact within pathway) - Bath & North-East Somerset, Swindon and Wiltshire	>=62%	May-26	68.63%			
National	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Buckinghamshire (rolling 3 months position)	>=95%	May-26	82.61%			91.98%
National	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Oxfordshire (rolling 3 months position)	>=95%	May-26	72.00%			87.22%
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%	May-26	90.77%			85.09%
National	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Buckinghamshire (rolling 3 months position)	>=95%	May-26	80.00%			96.78%
National	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Oxfordshire (rolling 3 months position)	>=95%	May-26	83.33%			97.11%
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%	May-26	100%			90.33%

Mental Health Services – Children and Adolescent Mental Health Services

Board meeting in public

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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 May 2026 performance includes March, April and May 2026 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. Nationally, performance for routine eating disorder cases in 2025/26 shows that, on average, 78.75% of referrals were seen within 28 days, based on the 3-month rolling metric.

- In Buckinghamshire, one (1) breached occurred in March 2026 due to transitioning to adult services, two (2) in April 2026 (one (1) due to patient choice and one (1) due to issues with Single Point of Access (SPA) triage process (patient seen on day 47)) and one (1) in May due to patient choice.
- In Oxfordshire, two (2) breaches occurred in March 2026 (one (1) due to patient choice and one (1) due to capacity (seen on day 35)), three (3) in April due to capacity (demand exceeding the number of planned appointment slots; patients seen on days 28, 29 and 34) and 2 (two) in May due to capacity (demand exceeding the number of planned appointment slots; patients seen on days 42 and 56).
- In Bath & North East Somerset, Swindon and Wiltshire services, one (1) breach occurred in March 2026 due to patient choice, four (4) in April (two (2) due to patient choice and two (2) due to higher demand than planned appointment slots (patients seen on days 30 and 32)) and one (1) in May due to patient choice.

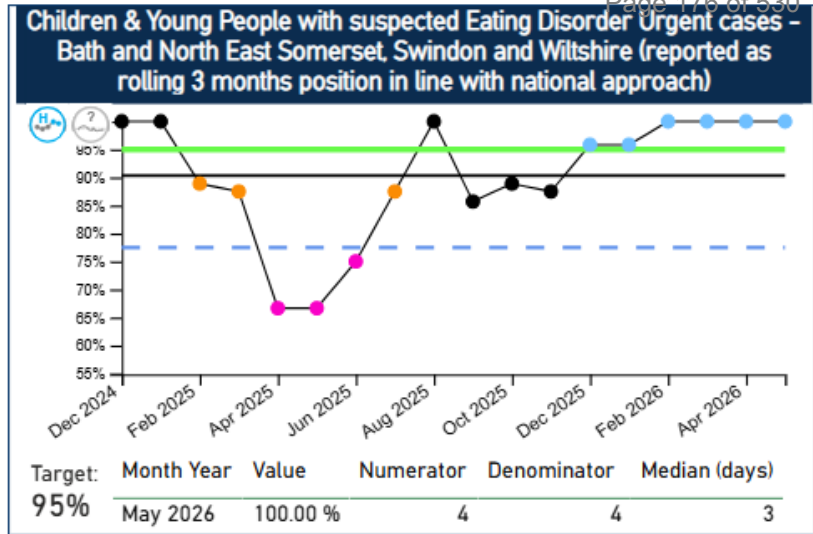
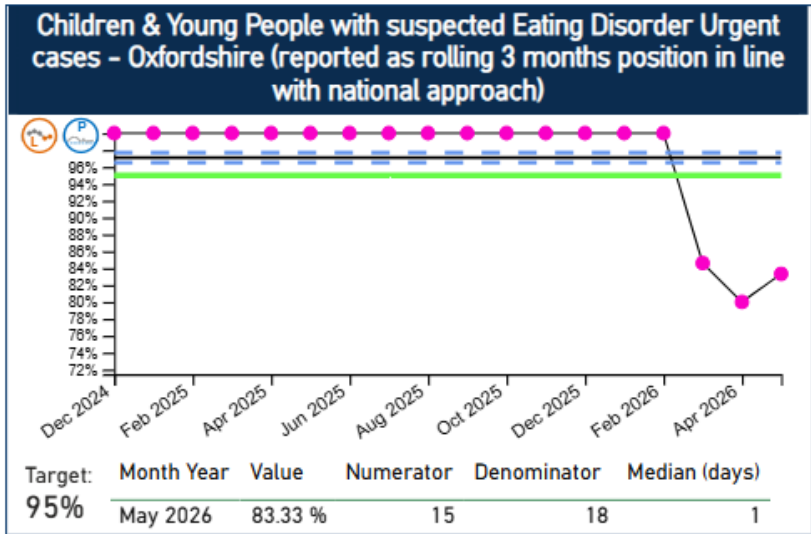
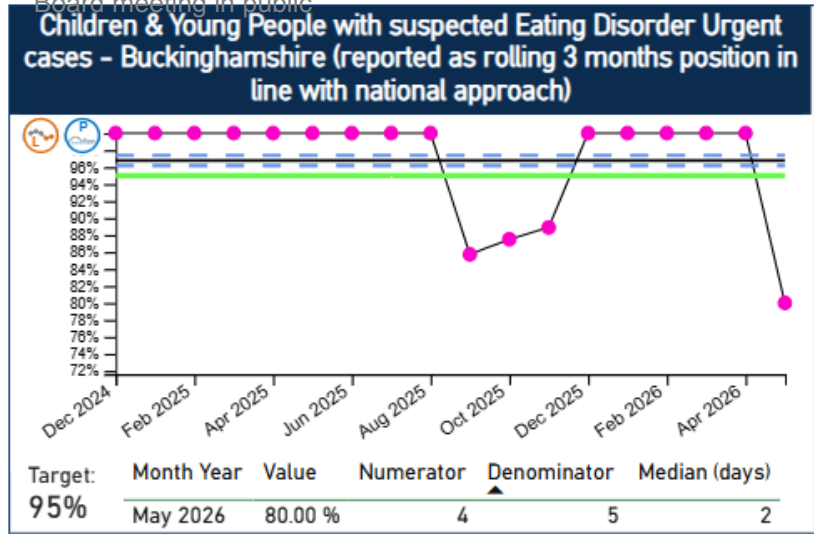
*SNOMED is a comprehensive, multilingual clinical terminology system used in healthcare.

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.
- Recruitment to vacancies in Oxfordshire’s team
- Triage process change where it must be completed within two days of referral from Single Point of Access. This alongside the recruitment is expected to have a positive impact on performance in the next 3-6 months.

Risks

Delays in treatment can increase the likelihood of deterioration of mental and physical health as well as 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. May 2026 performance includes March, April and May 2026 performance. Patients who choose to be seen outside of the timeframe will still be counted as a breach. Nationally, performance for urgent eating disorder cases in 2025/26 shows that, on average, 73.44% of referrals were seen within 7 days, based on the 3-month rolling metric.

Bath and North East Somerset, Swindon and Wiltshire service met the target in May 2026.

- In Buckinghamshire, one (1) breach occurred in May due to patient choice.
- In Oxfordshire, two (2) breaches occurred in March 2026 – one (1) due to patient choice and one (1) due to a mix of reasons (challenges with timely communication with patient and subsequently limited capacity - patient seen on day 22) and one (1) breach in April 2026 due to patient being in an inpatient setting and too unwell physically to be assessed during the timeframe in which the urgent appointment should have taken place. (seen on day 8). No breaches in May 2026.

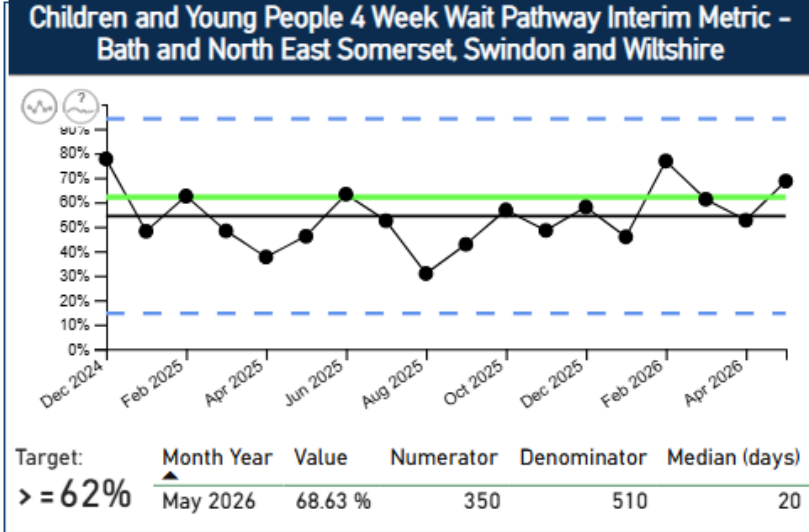
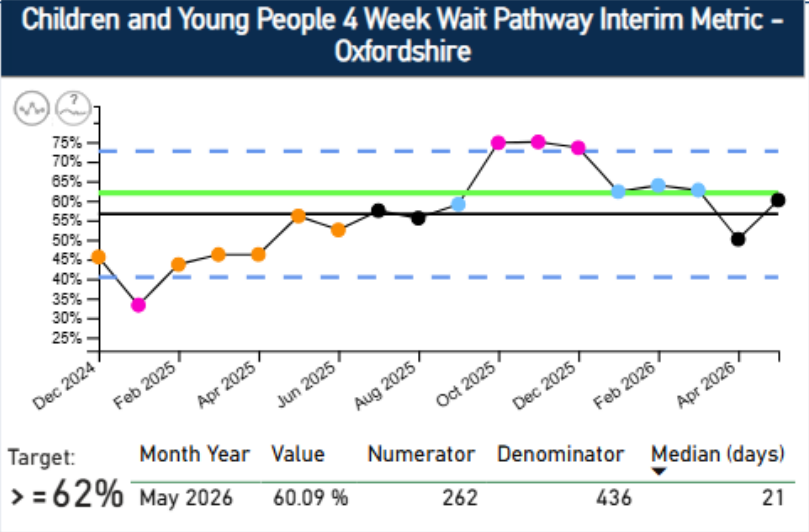
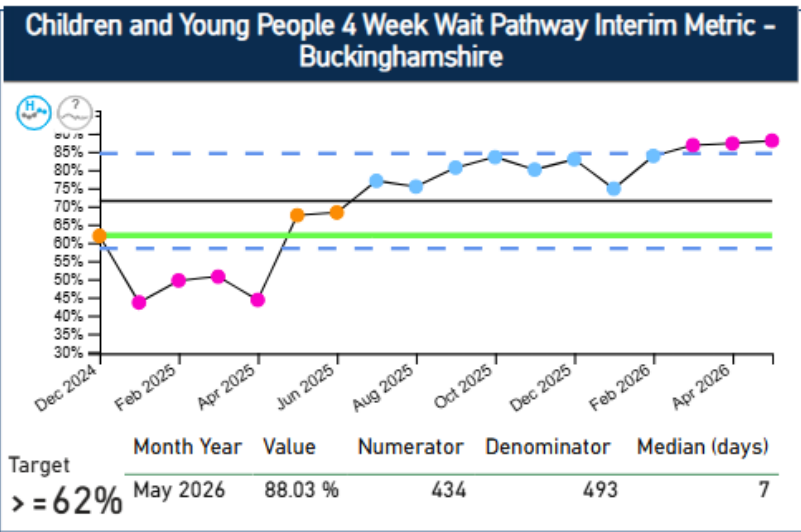
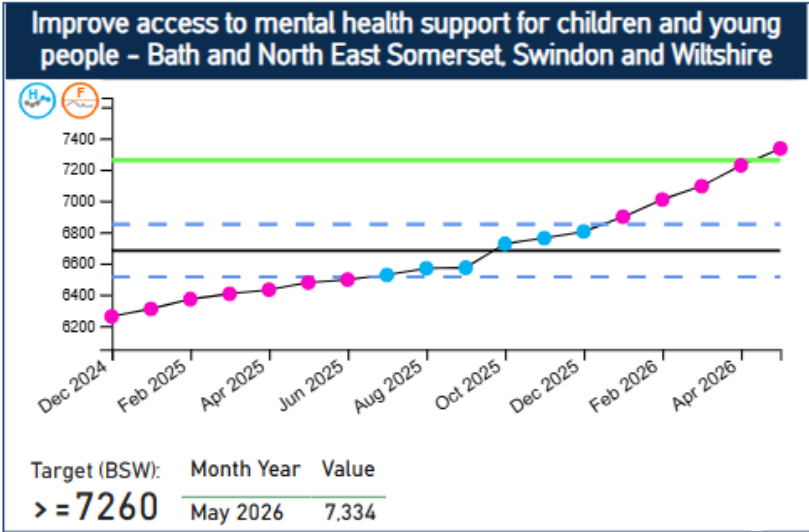
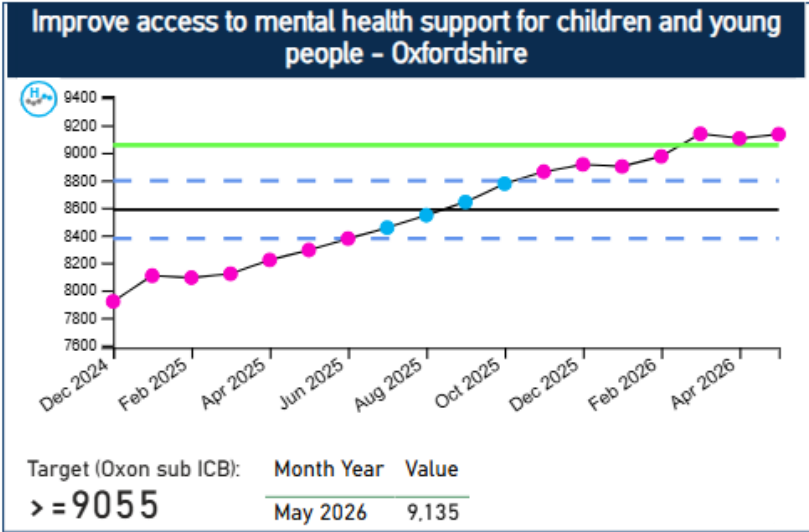
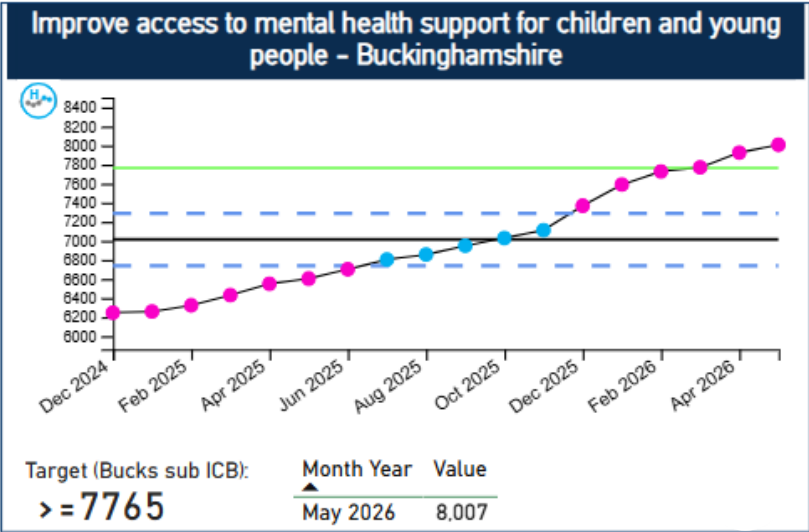
*SNOMED is a comprehensive, multilingual clinical terminology system used in healthcare.

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.
- Recruitment to vacancies in Oxfordshire’s team
- Triage process change where it must be completed within two days of referral from Single Point of Access. This alongside the recruitment is expected to have a positive impact on performance within the next few months.

Risks

Delays in treatment can increase the likelihood of deterioration of mental and physical health as well as 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.



Mental Health Services – Talking Therapies- summary (1/2)

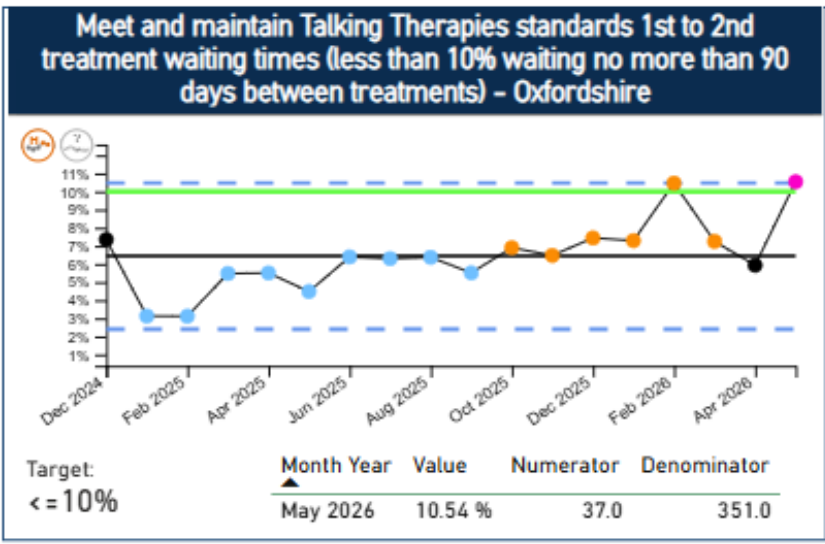
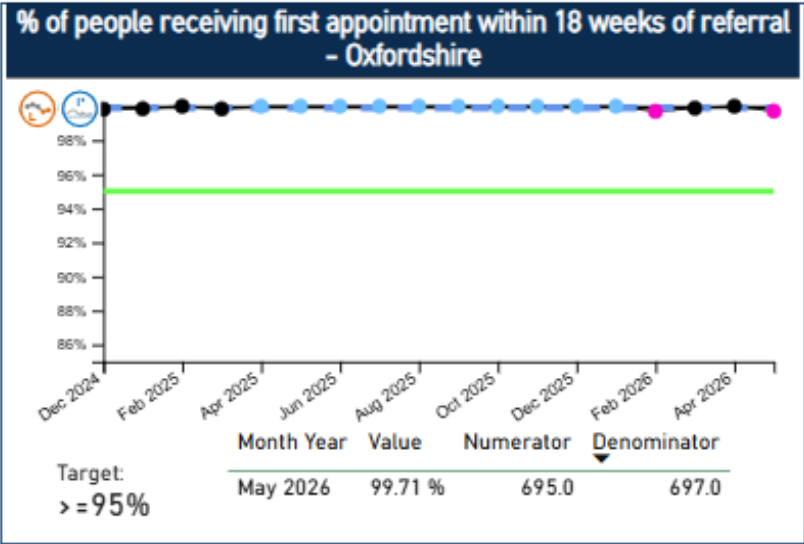
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Type of metric	Service Area/Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National	Increase the number of adults and older adults completing a course of treatment for anxiety and depression - Buckinghamshire	> =497	May-26	566			640
National	Increase the number of adults and older adults completing a course of treatment for anxiety and depression - Oxfordshire	> =636	May-26	697			706
National	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Buckinghamshire	.	May-26	8.66%		n/a	10.75%
National	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Oxfordshire	.	May-26	7.17%		n/a	6.86%
National	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Buckinghamshire	> =68%	May-26	70.14%			67.72%
National	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Oxfordshire	> =68%	May-26	68.29%			67.86%
National	% of people receiving first treatment appointment within 6 weeks of referral - Buckinghamshire	> =75%	May-26	99.29%			98.11%
National	% of people receiving first treatment appointment within 6 weeks of referral - Oxfordshire	> =75%	May-26	99.20%			99.14%
National	% of people receiving first treatment appointment within 18 weeks of referral - Buckinghamshire	> =95%	May-26	100%			99.98%
National	% of people receiving first treatment appointment within 18 weeks of referral - Oxfordshire	> =95%	May-26	99.71%			99.93%
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%	May-26	0.62%			1.96%
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%	May-26	10.54%			6.44%

Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National NOF (scored)	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Buckinghamshire	>=50%	May-26	47.84%			50.62%
National NOF(scored)	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Oxfordshire	>=50%	May-26	49.49%			50.92%
National	Meet and maintain at least 52% Talking Therapies recovery rate - Buckinghamshire	>=52%	May-26	49.16%			53.43%
National	Meet and maintain at least 52% Talking Therapies recovery rate - Oxfordshire	>=52%	May-26	51.40%			54.26%
National	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined - Buckinghamshire	>=52%	May-26	39.87%			49.33%
National	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined - Oxfordshire	>=52%	May-26	46.86%			48.32%
National	Recovery rate for White British - complete a course of treatment, adult and older adult combined - Buckinghamshire	>=52%	May-26	54.08%			55.19%
National	Recovery rate for White British - complete a course of treatment, adult and older adult combined - Oxfordshire	>=52%	May-26	51.97%			55.04%



Understanding the performance

- The national expectation is that more than 95% of patients should be offered a first appointment within 18 weeks of referral. Oxfordshire’s Talking Therapies service is currently performing well above the target. Due to consistent performance at near 100%, the upper and lower control limits of the statistical range are at very close proximity resulting in Making Data Count algorithm highlighting even the slightest variation. There is no true concern about the performance.
- The national expectation is that fewer than 10% of patients should experience a wait longer than 90 days between these contacts. In May 2026, Oxfordshire’s Talking Therapies have reached the upper control limit triggering a review of contributory factors. No systemic risk has been identified at this stage; the majority of patients are being seen within three to four weeks between appointments.

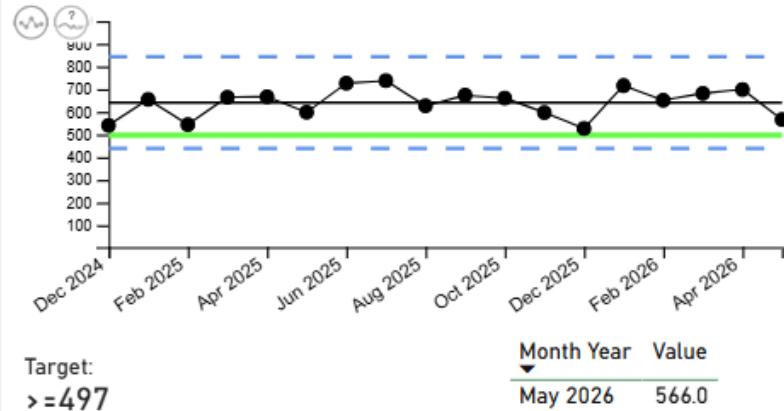
Actions (SMART)

- Continuous monitoring at Service level

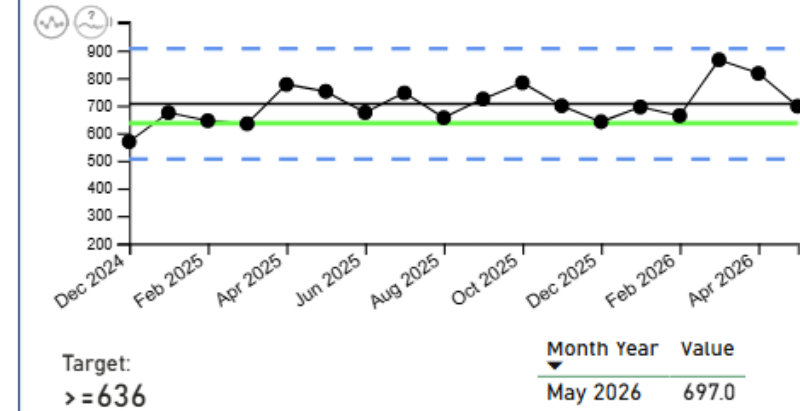
Risks

- Delays in receiving first appointment can worsen conditions like anxiety and depression, increasing severity and complexity.
- Longer gaps between appointments may be associated with disengagement, deterioration of symptoms and poorer recovery outcomes.

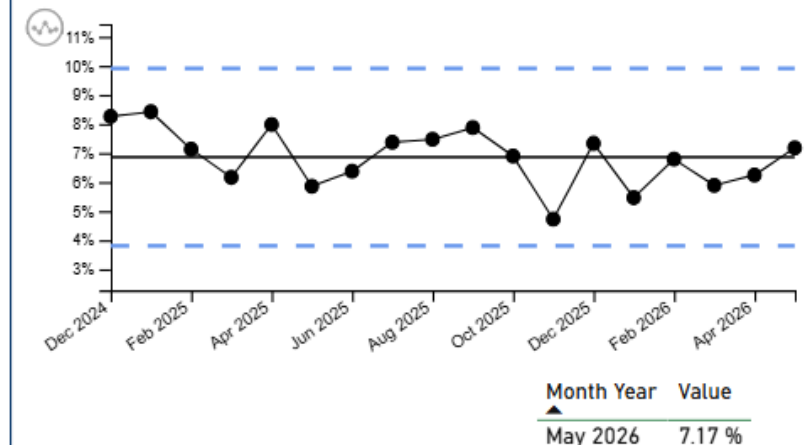
Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies - Buckinghamshire



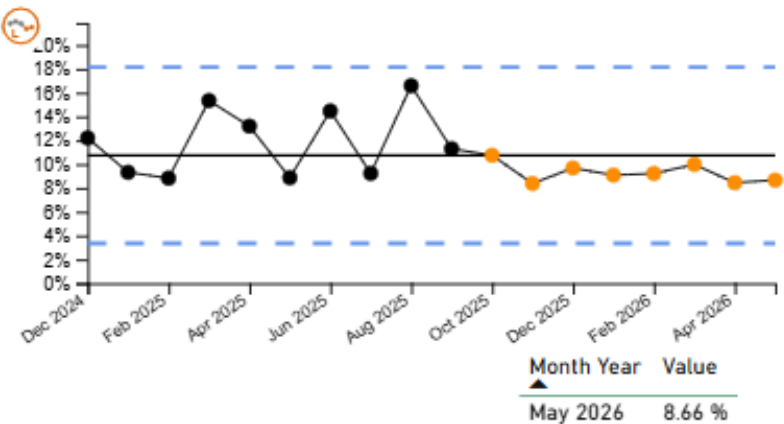
Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies - Oxfordshire



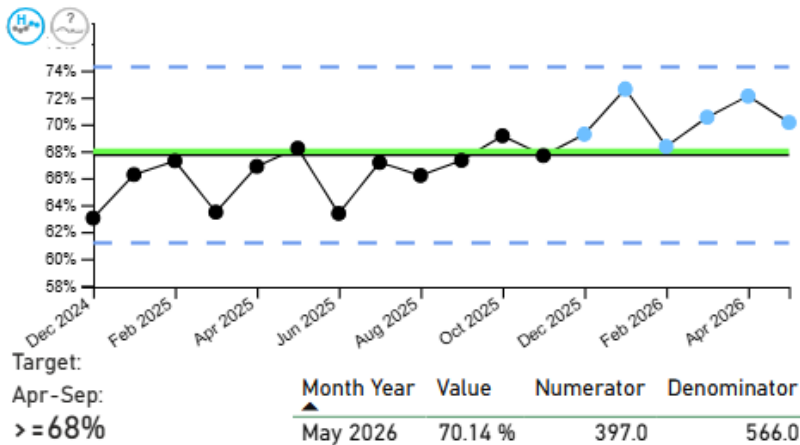
% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Oxfordshire



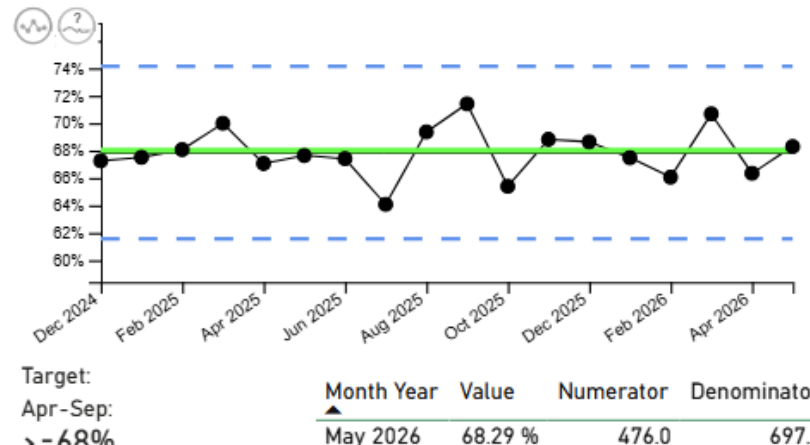
% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Buckinghamshire

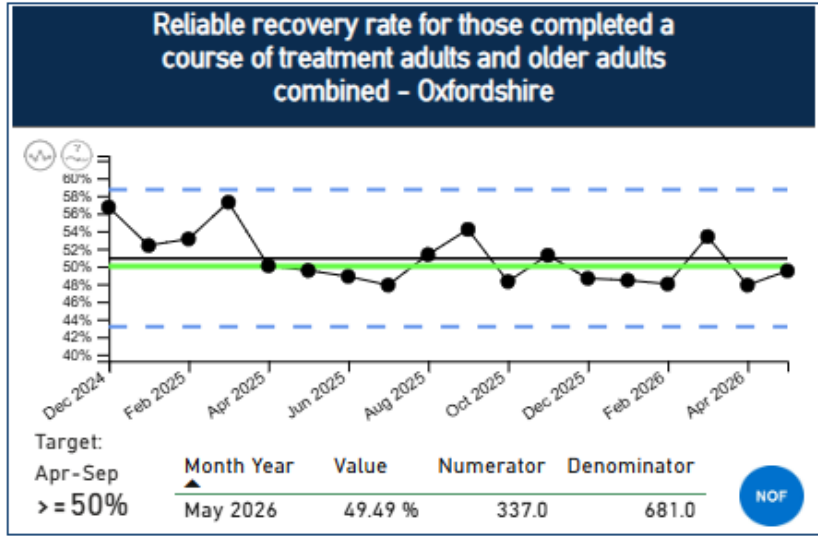
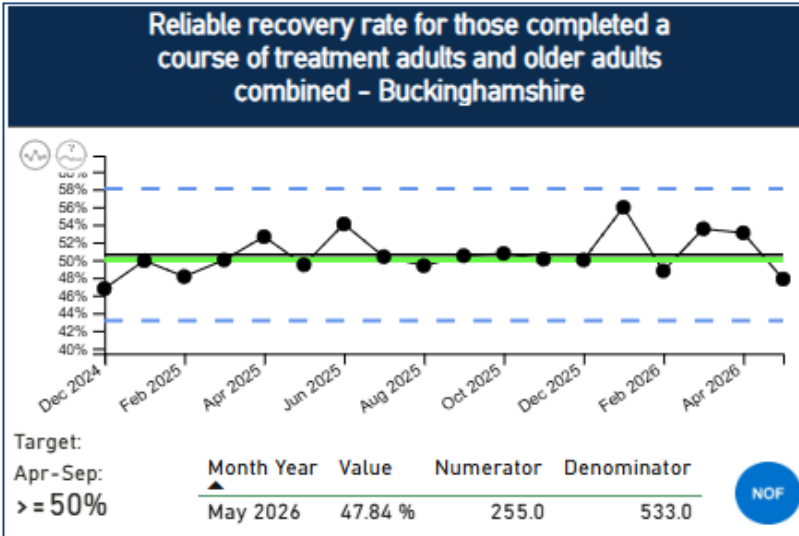
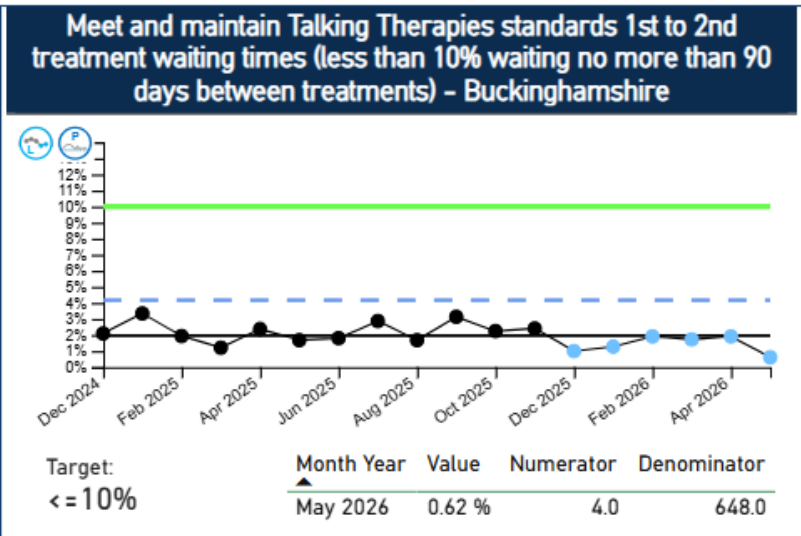
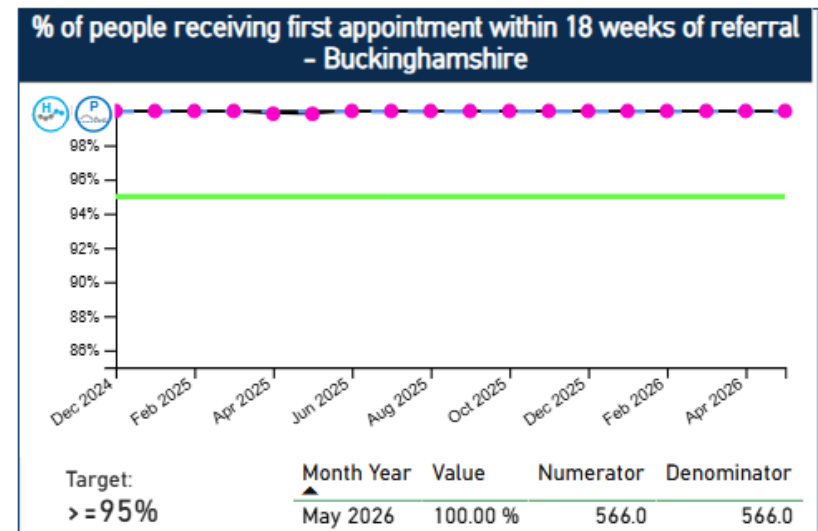
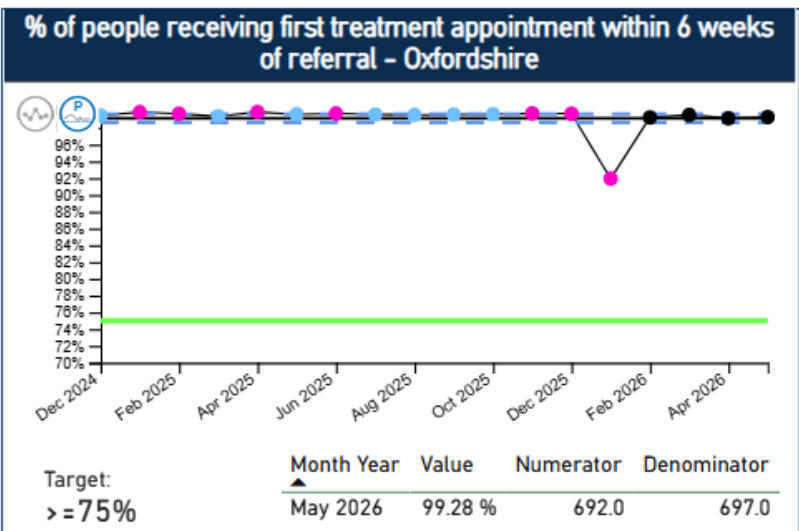
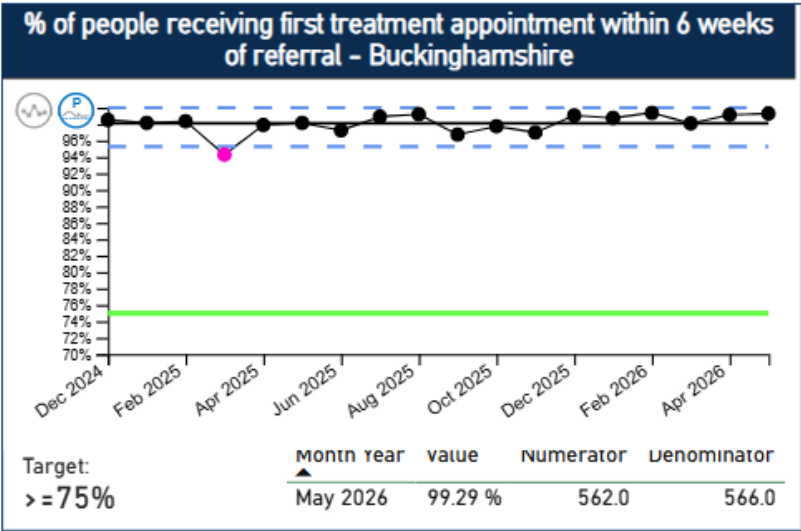


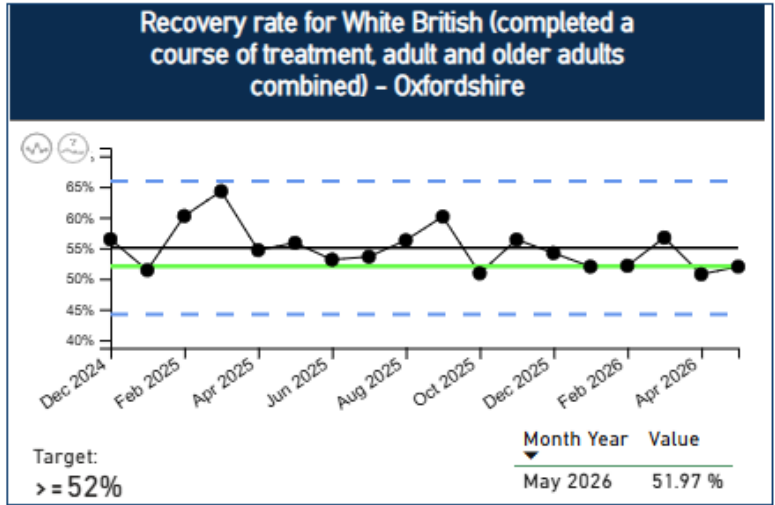
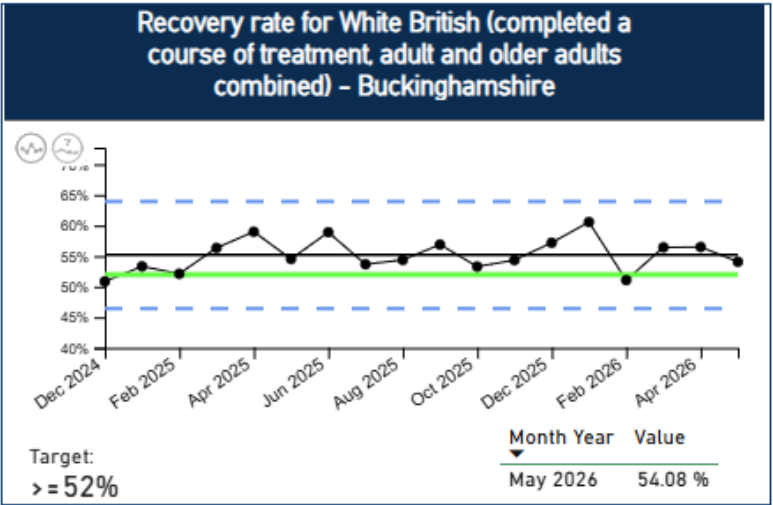
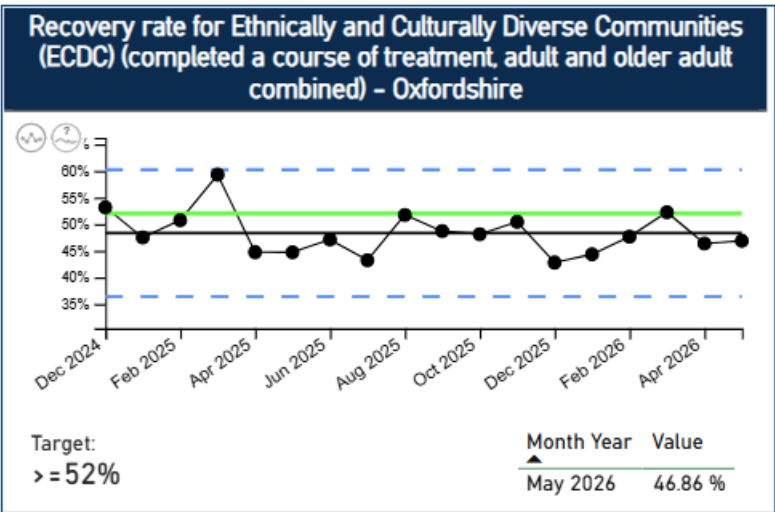
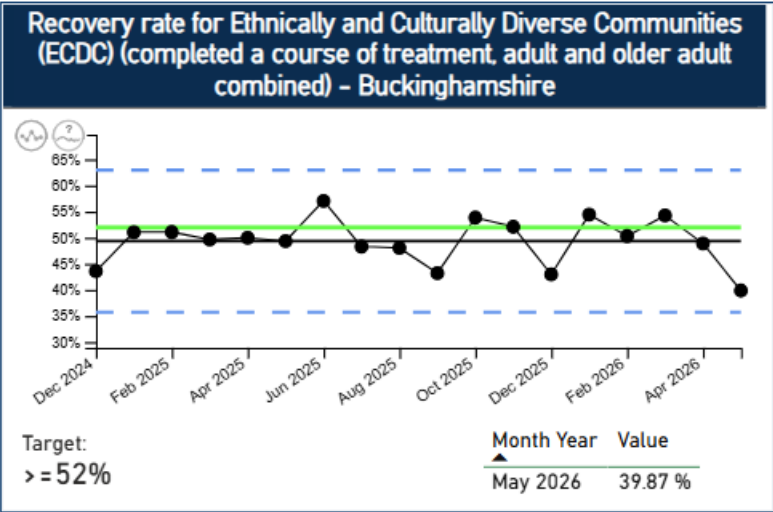
Reliable improvement rate for those completed a course of treatment adults and older adults combined - Buckinghamshire



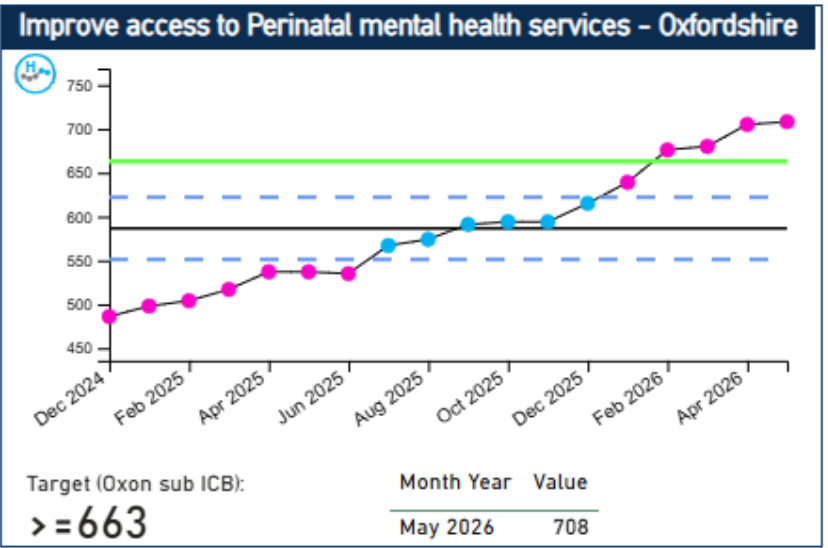
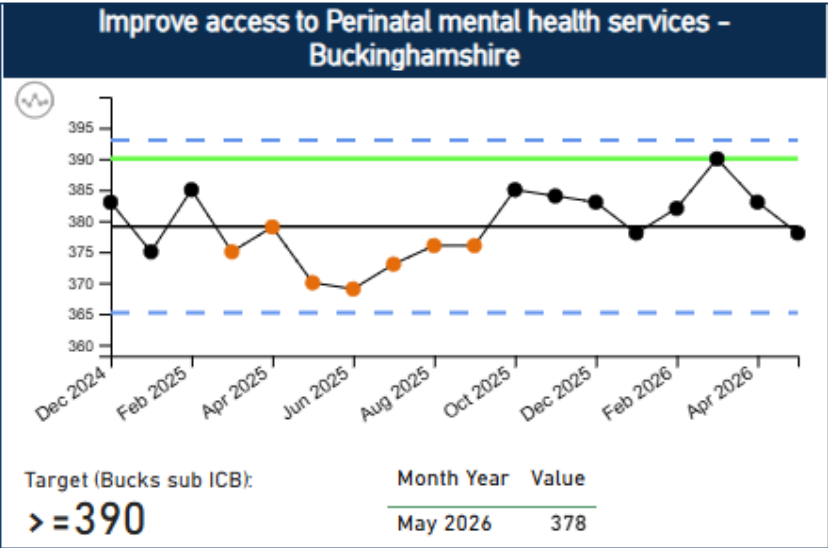
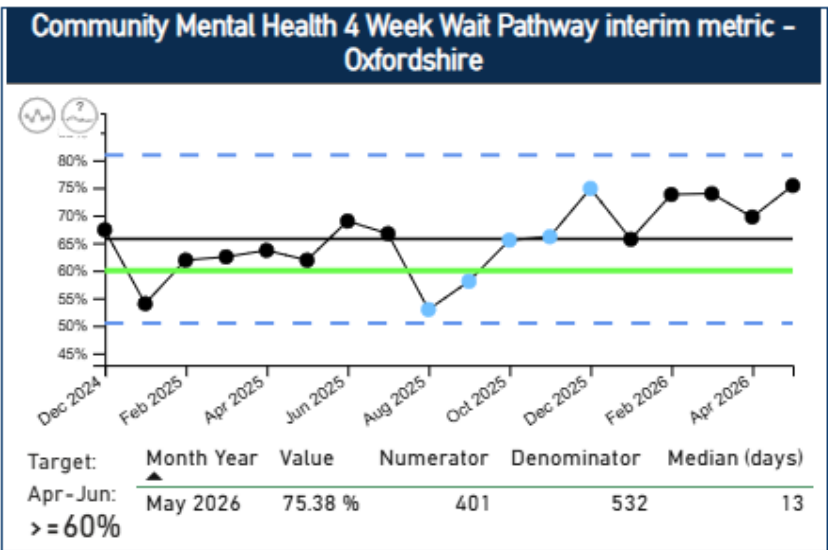
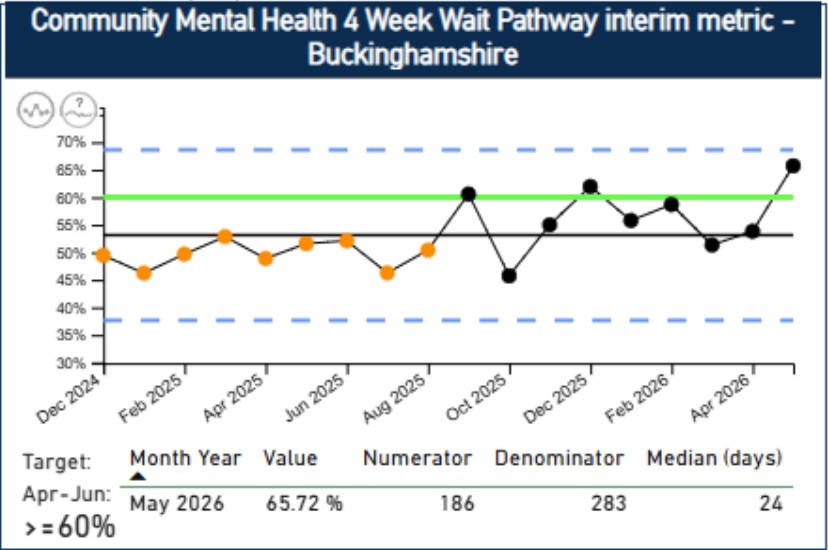
Reliable improvement rate for those completed a course of treatment adults and older adults combined - Oxfordshire

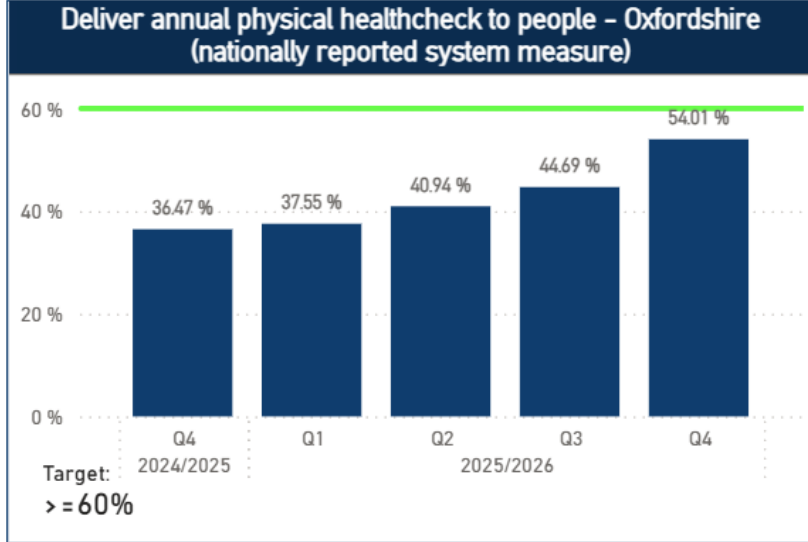
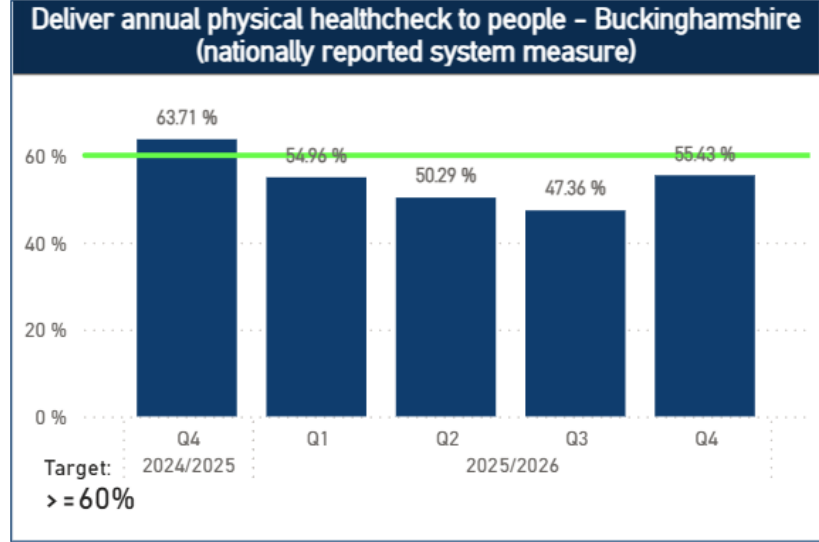
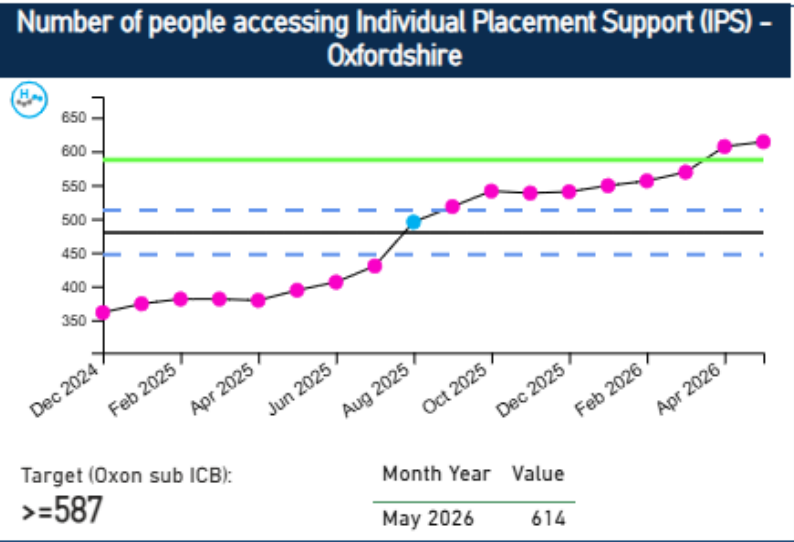
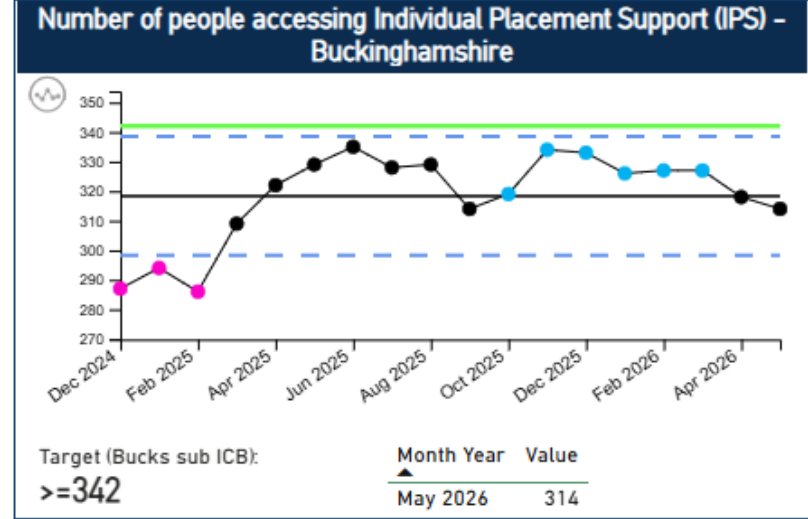
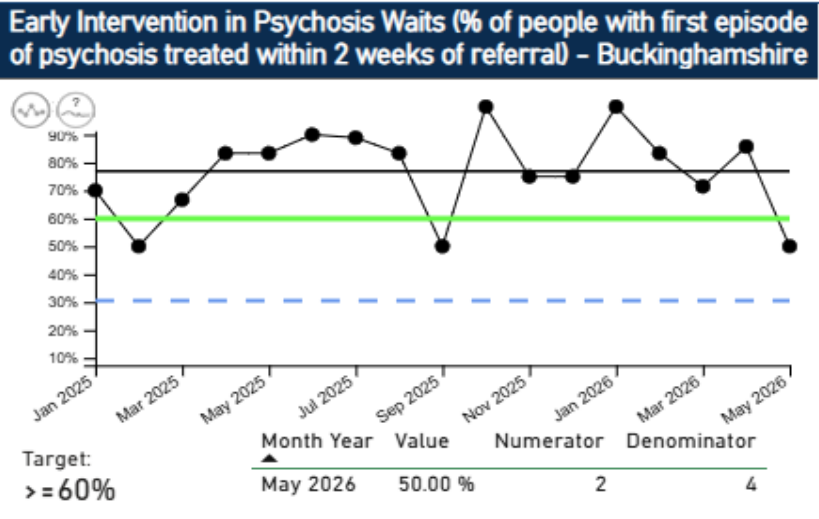
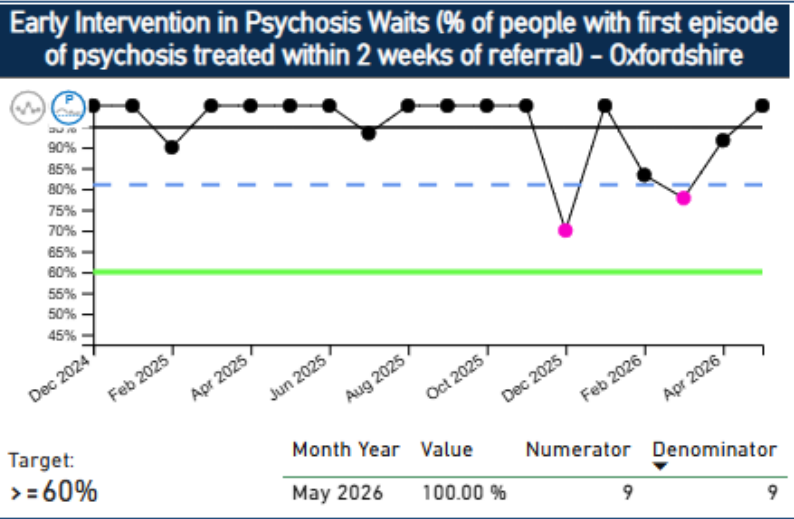






Type of metric	Service Area/Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National	4 week wait (28 days) standard (interim metric - two contacts within pathway) - Buckinghamshire	> =60%	May-26	65.72%			53.11%
National	4 week wait (28 days) standard (interim metric - two contacts within pathway)- Oxfordshire	> =60%	May-26	75.38%			65.70%
National	Improve access to perinatal mental health services - Buckinghamshire (rolling 12 months)	> =390	May-26	378		.	379
National	Improve access to perinatal mental health services - Oxfordshire (rolling 12 months)	> =663	May-26	708		.	586
National	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Buckinghamshire	> =60%	May-26	50.00%			76.72%
National	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Oxfordshire	> =60%	May-26	100%			94.78%
National	Number of people accessing Individual Placement Support (IPS) - Buckinghamshire (rolling 12 months)	> =334	May-26	314		.	318
National	Number of people accessing Individual Placement Support (IPS) - Oxfordshire (rolling 12 months)	> =587	May-26	614		.	480
National	Recover dementia diagnosis rate (nationally reported system measure - Buckinghamshire)	> =63%	April and May data not published nationally yet				
National	Recover dementia diagnosis rate (nationally reported system measure - Oxfordshire)	> =63%	April and May data not published nationally yet				
National	Deliver annual physical health checks to people with Severe Mental Illness (System Measure - Buckinghamshire)	> =60%	Q4	55.43%	n/a	n/a	54.35%
National	Deliver annual physical health checks to people with Severe Mental Illness (System Measure - Oxfordshire)	> =60%	Q4	54.01%	n/a	n/a	42.72%





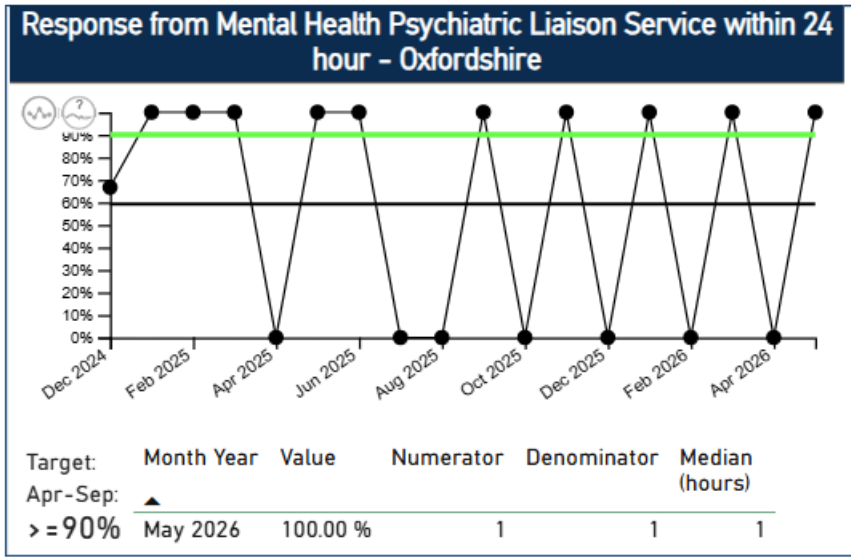
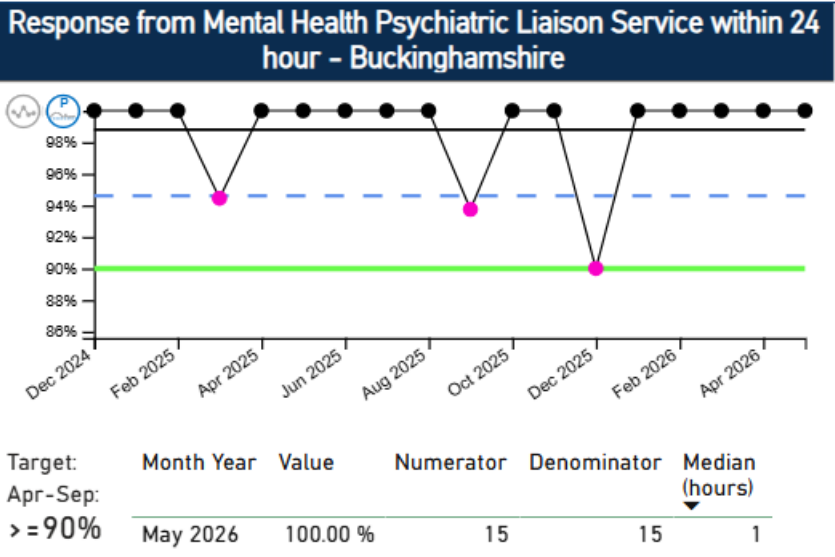
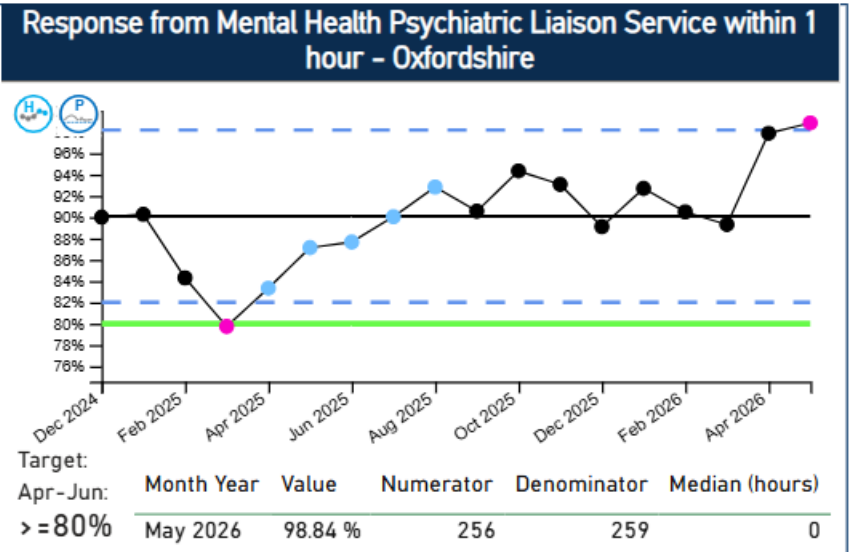
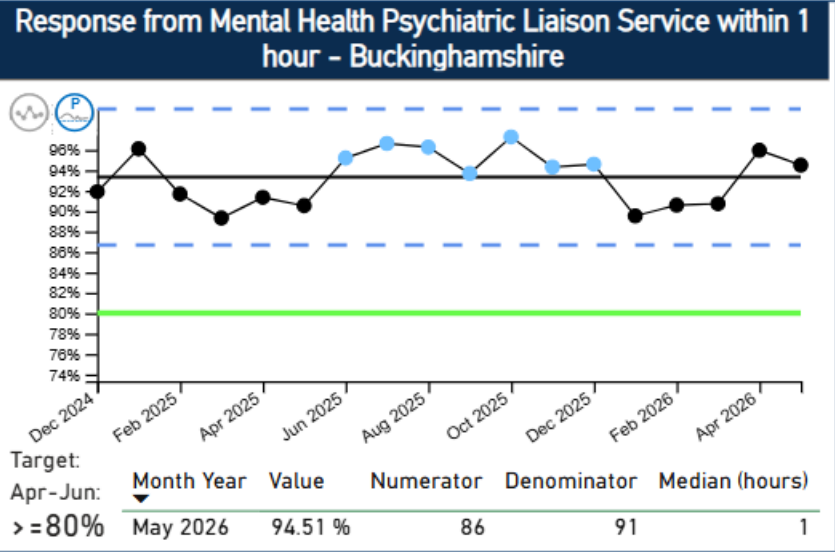
Mental Health Services – Urgent Care - summary

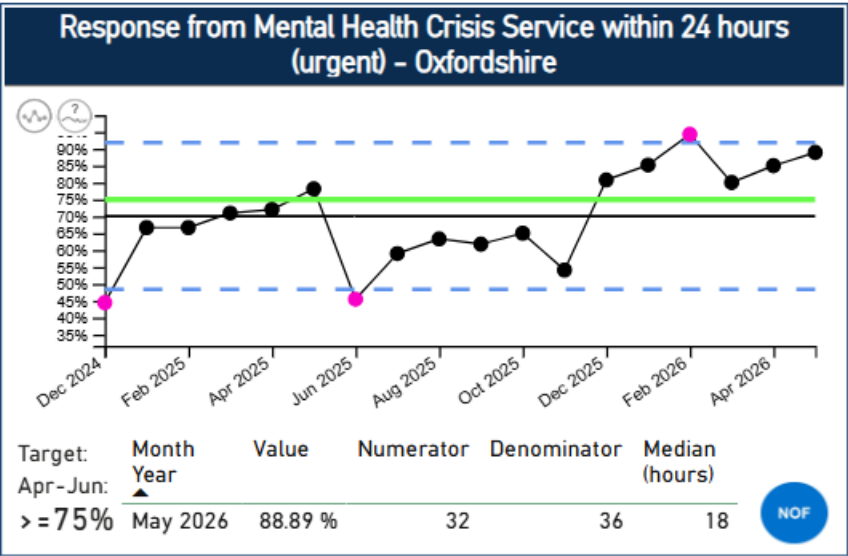
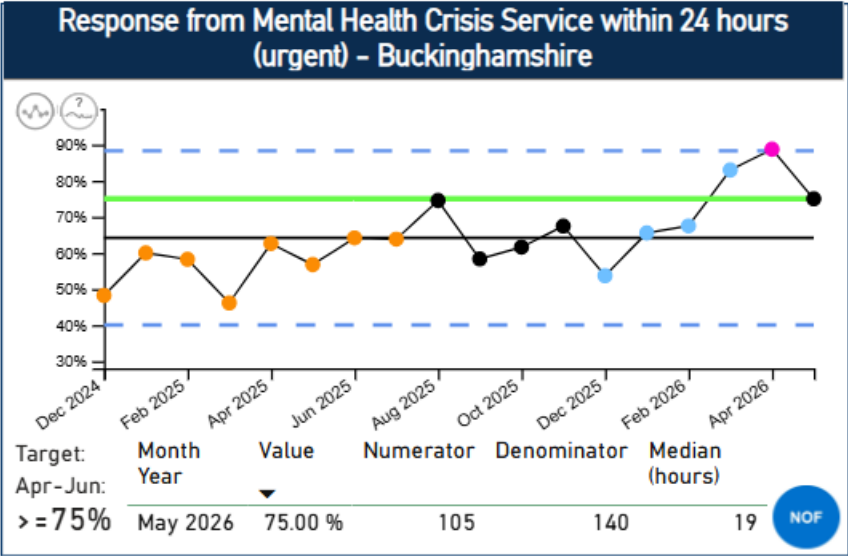
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Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National	Response from Mental Health Psychiatric Liaison within 1 hour - Buckinghamshire	>=80%	May-26	94.51%			93.34%
National	Response from Mental Health Psychiatric Liaison within 1 hour - Oxfordshire	>=80%	May-26	98.84%			90.89%
National	Response from Mental Health Psychiatric Liaison within 24 hours - Buckinghamshire	>=90%	May-26	100%			98.79%
National	Response from Mental Health Psychiatric Liaison within 24 hours - Oxfordshire	>=90%	May-26	100%			96.97%*
National	Response from Mental Health Crisis Service within 4 hours (Very Urgent) - Buckinghamshire	>=61%	May-26	No referrals in scope of 4-hour target received in May 2026			
National	Response from Mental Health Crisis Service within 4 hours (Very Urgent) – Oxfordshire	>=61%	May-26	No referrals in scope of 4-hour target received in May 2026			
National NOF (scored)	Response from Mental Health Crisis Service within 24 hours (Urgent) - Buckinghamshire	>=75%	May-26	75.00%			64.18%
National NOF (scored)	Response from Mental Health Crisis Service within 24 hours (Urgent) – Oxfordshire	>=75%	May-26	88.89%			70.09%





Mental Health Services – Inpatients – summary (1/2)

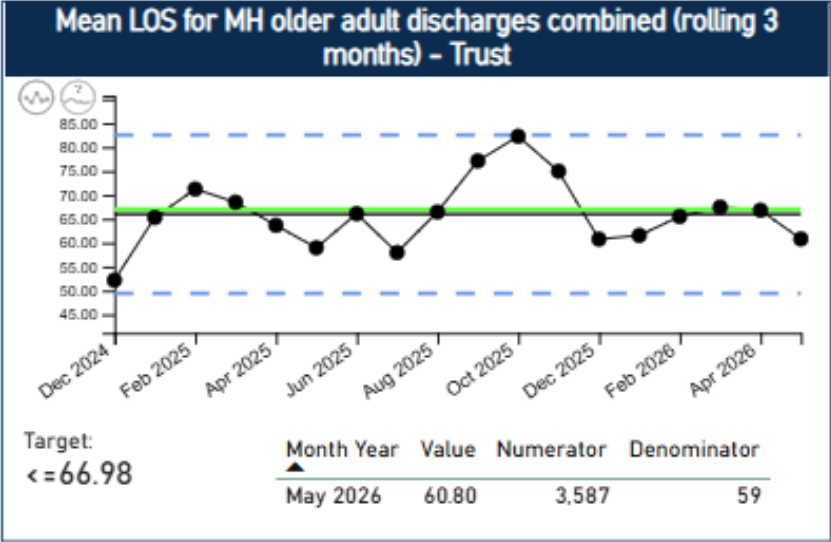
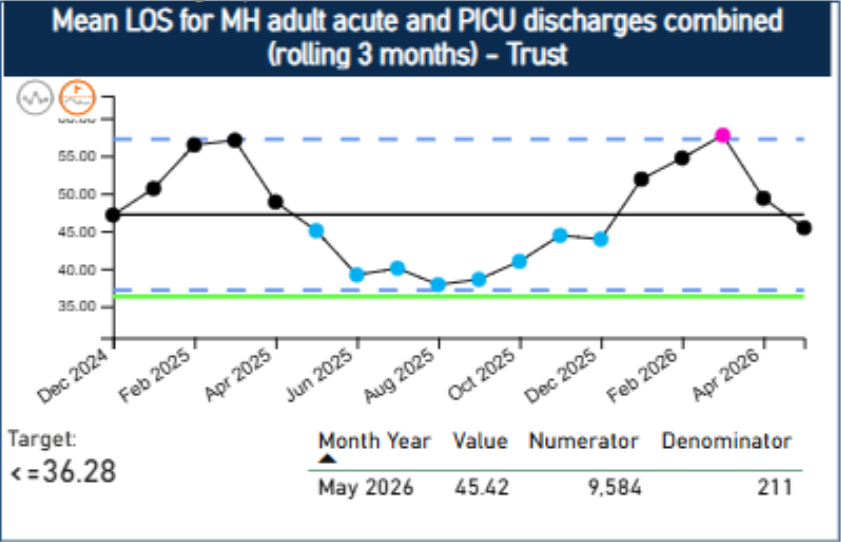
Type of metric	Service Area/Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National	Mean Length of Stay (LoS) for MH adult acute and PICU discharges (rolling 3 months) - Trust level	<=36.28	May-26	45.42			47.14
National	Mean Length of Stay (LoS) for older adults (rolling 3 months) - Trust level	<=66.98	May-26	60.80			65.96
National	72 hour follow up for those discharged from mental health wards - Adults – Trust level	>=80%	May-26	93.40%			92.10%
National	72 hour follow up for those discharged from mental health wards - Older Adults – Trust level	>=80%	May-26	100%			97.63%
National	Trust level mental health inappropriate out of area placements - snapshot last day month	<=6	May-26	0	N/A	N/A	N/A
National	Trust level mental health inappropriate out of area - bed days in month	.	May-26	20	N/A	N/A	N/A
Local	Trust level % adult acute readmission within 30 days for mental health	.	May-26	1.40%		n/a	6.24%
Local	Trust level % older adult readmission within 30 days for mental health	.	May-26	0%		n/a	2.75%
Local	Average number of clinically ready for discharge patients per day - Trust level	.	May-26	6.1		n/a	7.22

Mental Health Services – Inpatients – summary (2/2)

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Type of metric	Service Area/Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
Local	Total number of incidents involving physical restraint - Children and Young People	.	May-26	158		n/a	203
Local	Total number of incidents involving physical restraint - Adults	.	May-26	123		n/a	59
Local	Total number of incidents involving physical restraint - Older Adults	.	May-26	32		n/a	31
Local	Total number of incidents involving physical restraint - Forensic	.	May-26	21		n/a	21
Local	Total number of incidents involving physical restraint - Eating Disorders	.	May-26	57		n/a	24
Local Strategic - Quality	Reduction in the use of prone restraints (number of incidents involving prone restraint) - Children and Young People	.	May-26	4		.	7
Local Strategic - Quality	Reduction in the use of prone restraints (number of incidents involving prone restraint) - Adults	.	May-26	3		.	6
Local Strategic - Quality	Reduction in the use of prone restraints (number of incidents involving prone restraint) - Older Adults	.	May-26	0		.	1
Local Strategic - Quality	Reduction in the use of prone restraints (number of incidents involving prone restraint) - Forensic	.	May-26	7		.	2
Local Strategic - Quality	Reduction in the use of prone restraints (number of incidents involving prone restraint) - Eating Disorders	.	May-26	0		.	0
Local Strategic - Quality	Reduction in use of seclusion (number of incidents involving seclusion) - Children and Young People	.	May-26	14		.	10
Local Strategic - Quality	Reduction in use of seclusion (number of incidents involving seclusion) - Adults	.	May-26	31		.	17
Local Strategic - Quality	Reduction in use of seclusion (number of incidents involving seclusion) - Older Adults	.	May-26	0		.	0
Local Strategic - Quality	Reduction in use of seclusion (number of incidents involving seclusion) - Forensic	.	May-26	7		.	9
Local Strategic - Quality	Reduction in use of seclusion (number of incidents involving seclusion) - Eating Disorders	.	May-26	0		.	0
National	Rate of restrictive interventions per 1k bed days	.	In development				



Understanding the performance

The above metrics are measured on a rolling 3-month position, so May 2026 performance includes March, April and May 2026 performance.

Current performance continues to show an elevated mean length of stay of adult acute and Psychiatric Intensive Care Unit (PICU) patients in the Trust. In May 2026, the mean length of stay was 45.34 days, compared with the target of 36.28 days (a reduction of 4 days compared to April 2026). Mean length of stay of older adult patients has decreased and is below the target of 66.98 days with 60.80 days in May 2026.

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 continued joint working between inpatient services and the Electronic Healthcare Records (EHR) team. The CRFD form has now been developed and is live within Rio, replacing manual recording and supporting more accurate capture of actual bed days and the number of patients affected. Work is now progressing to develop reporting through Trust Online Business Intelligence (TOBI) platform and establish the data flow to Mental Health Services Data Set (MHSDS), with completion expected in quarter 3. This will strengthen operational oversight and enable more targeted interventions to reduce avoidable delays. Further investment in crisis and inpatients settings for 26-27 is expected to improve patient flow and reduce pressure on inpatient services.

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.

Metric	Target	April 2026	May 2026
Inappropriate mental health out of area placements – snapshot last day of month - Trust	<=6	1	0
Inappropriate mental health out of area placements – bed days in month - Trust	n/a	35	20

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) and where the continuity of care principals are not being met. 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 May 2026, adult inappropriate out of area placements for May snapshot position was 0 and in month inappropriate bed days for May was 20 bed days.

**The reduction since March 2026 is primarily attributable to the clarification and consistent application of criteria defining appropriate bed placements, resulting in more accurate classification of inappropriate out-of-area placements (out of area placements that do not meet the continuity of care principles set out in NHS England guidance are deemed to be inappropriate). Performance graphs have been temporarily omitted while the rules are updated in the Trust Online Business Intelligence (TOBI) platform to reflect the revised definitions for inappropriate out-of-area placements. This will ensure that future trend reporting is accurate, consistent and aligned with the agreed reporting criteria.*

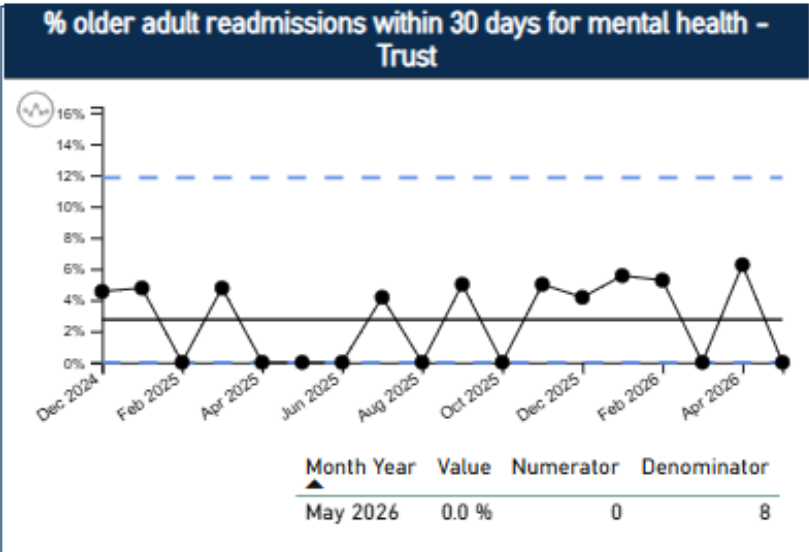
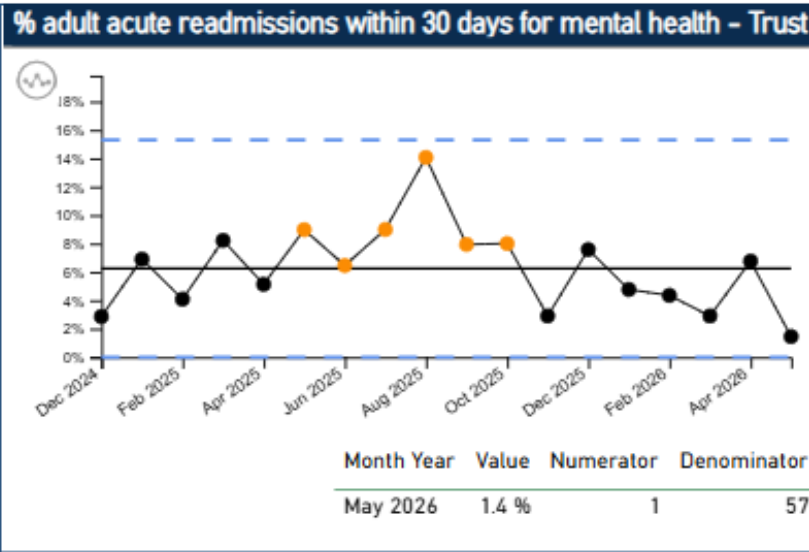
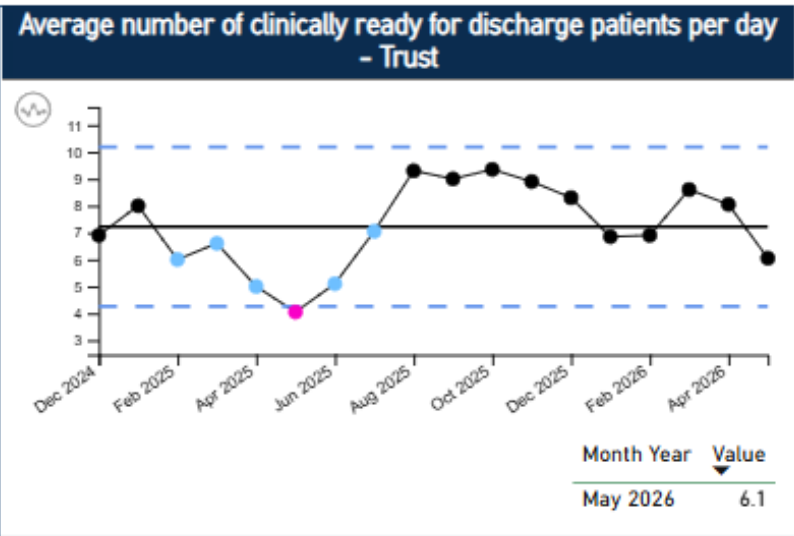
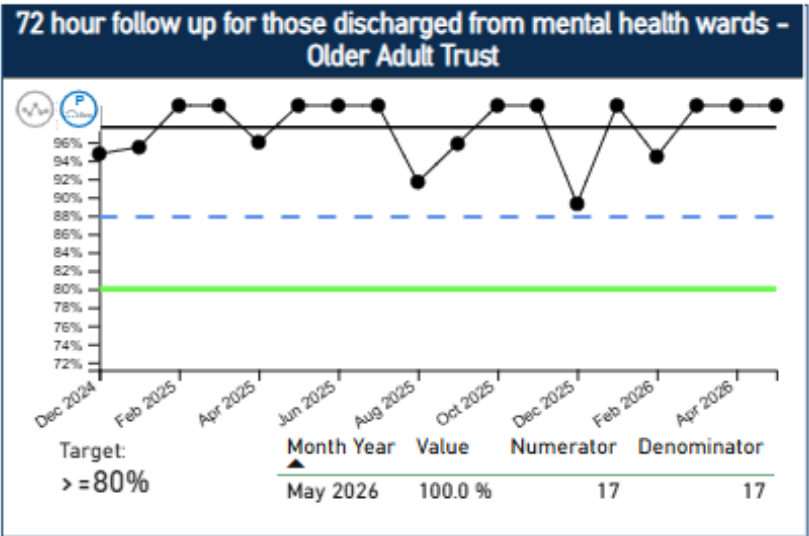
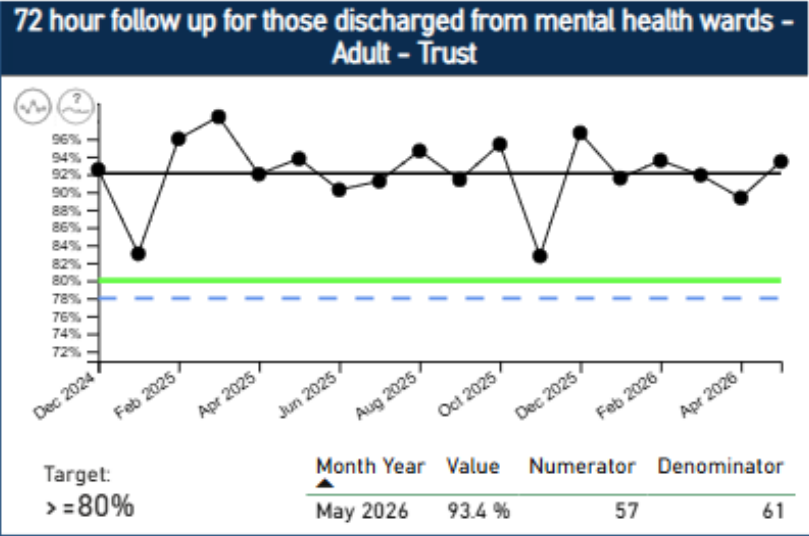
Actions (SMART)

- 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.
- Enhanced admission purpose and patient journey documentation and tracking task and finish project was concluded in January 2025. Achievements include the implementation and first stage evaluation of a purpose of admission form, a Patient Flow data dashboard on internal Trust Online Business Intelligence (TOBI) app, and greater oversight on the causes of Length of Stay and the use of Out of Area Placements.
- The Trust is commissioning additional out of area placement beds from April 2026 for Oxfordshire’s patients to ensure continuity of care principles are met.

Risks

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

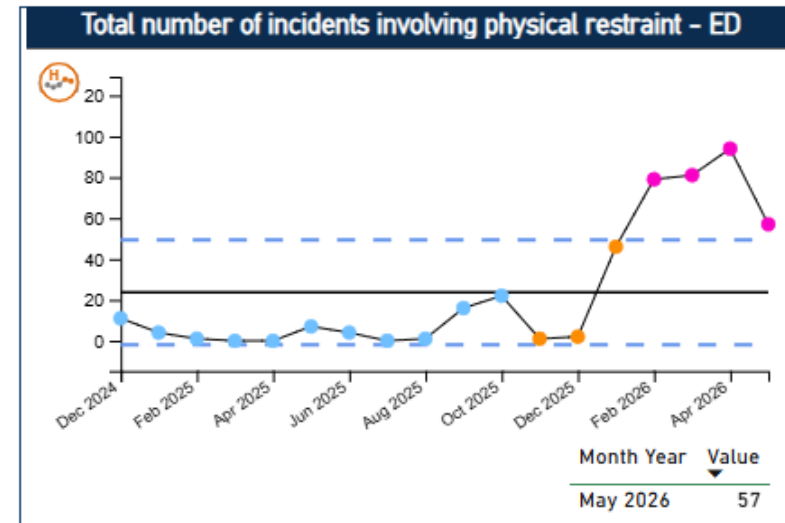
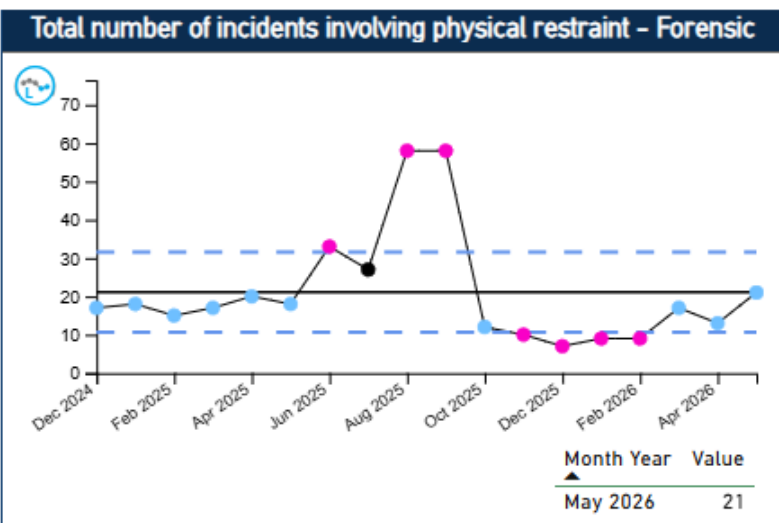
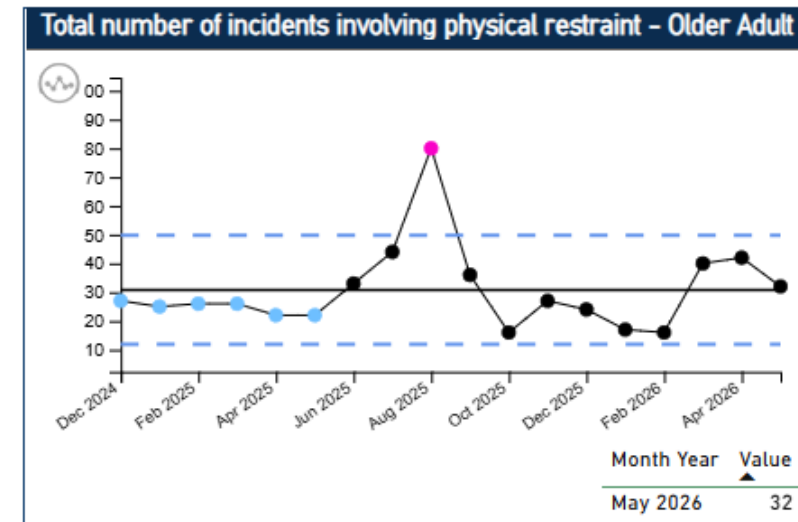
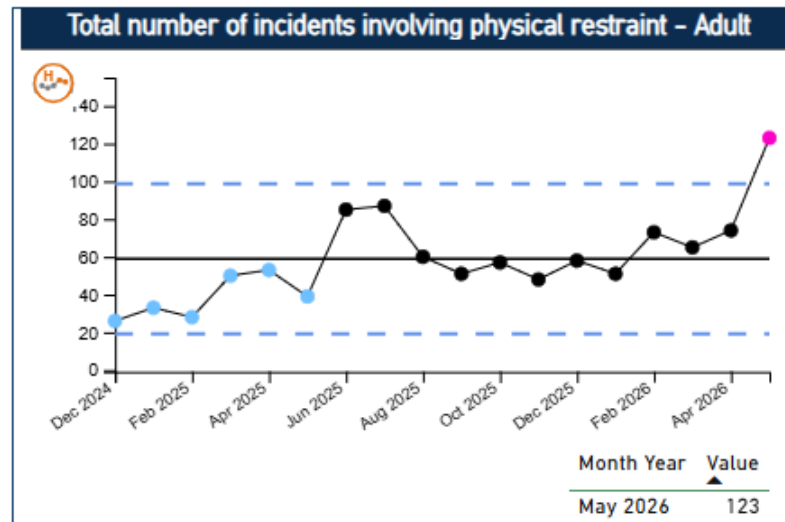
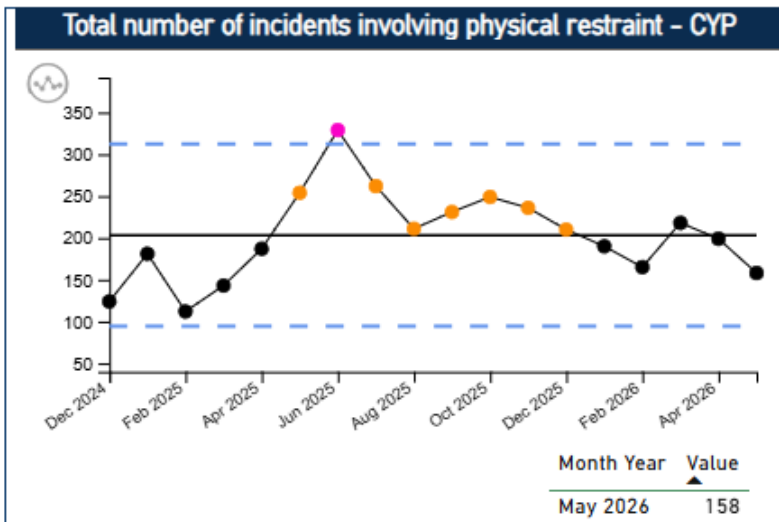
- Potential disruption of support networks where the patient is separated from family, carers and friends
- Possibly poorer continuity of care as it may be harder for local clinicians to stay involved in care planning and reviews
- Increased likelihood of delayed discharge and longer stays as discharge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

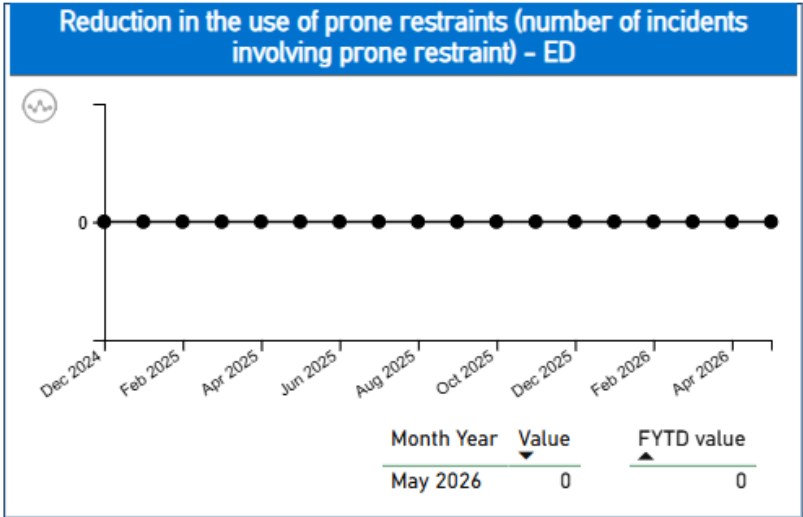
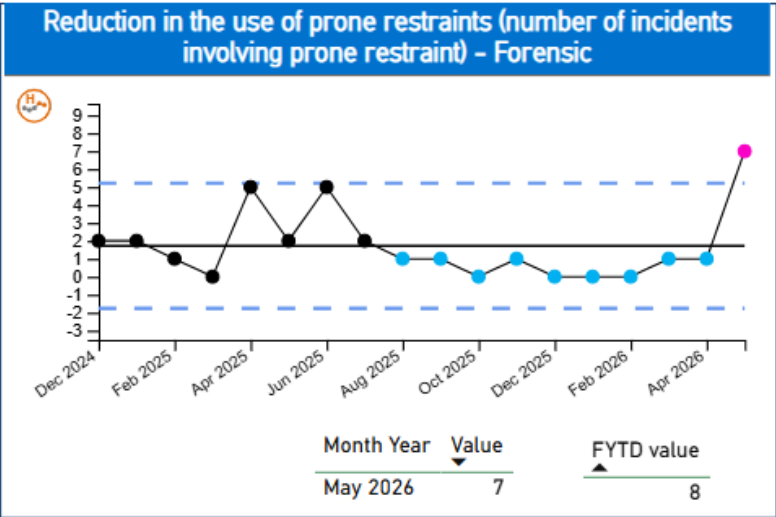
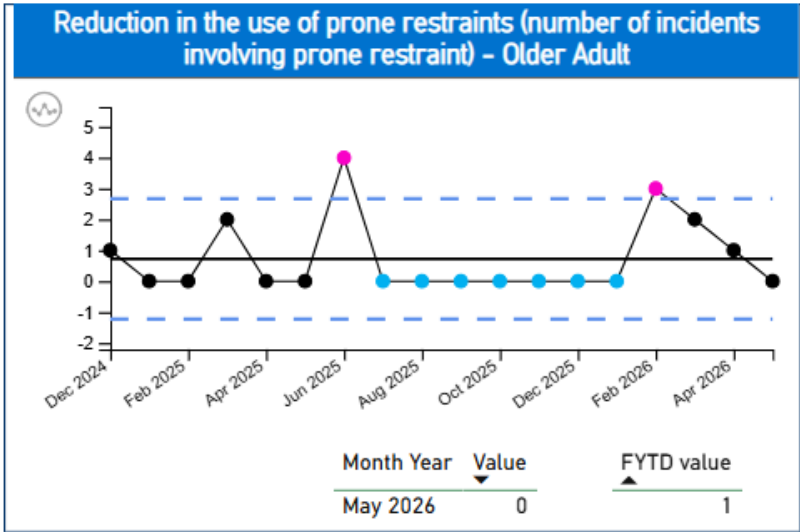
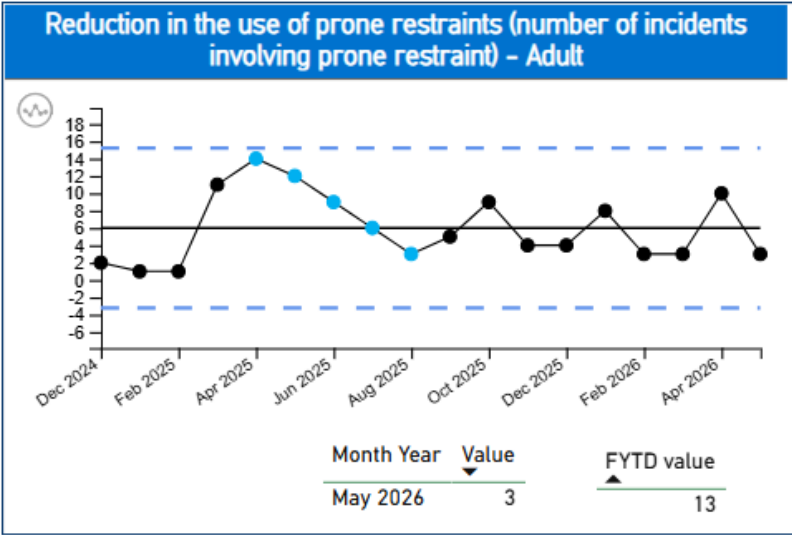
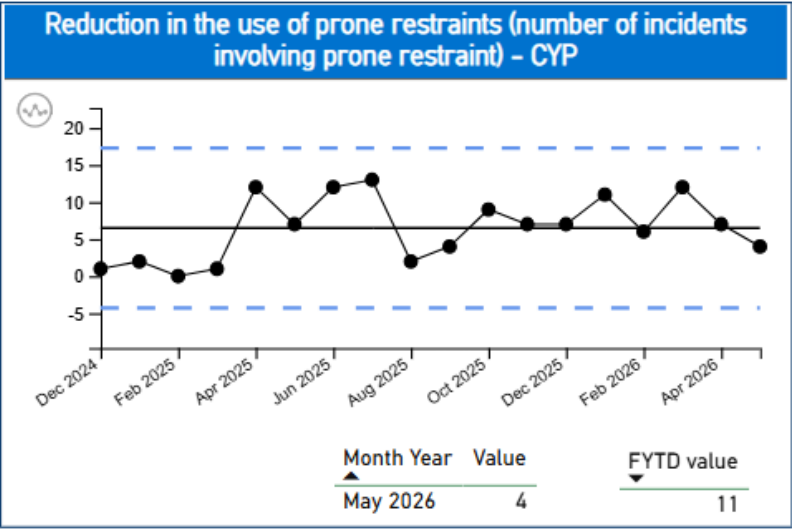


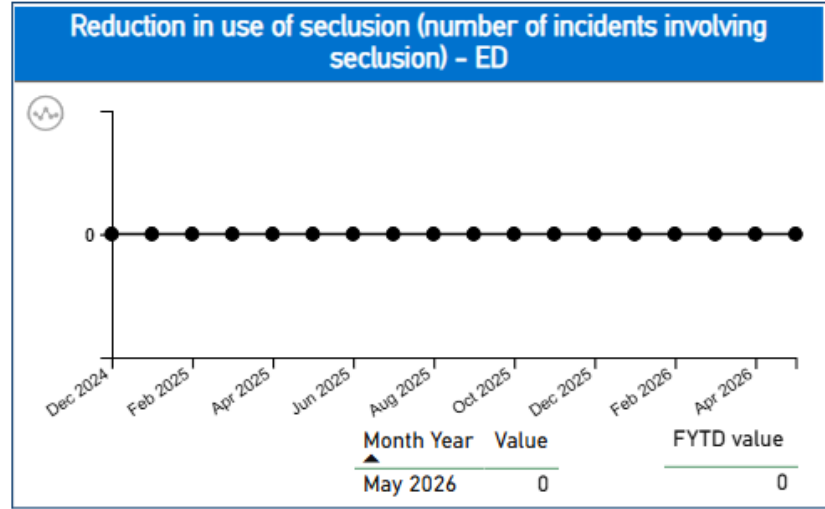
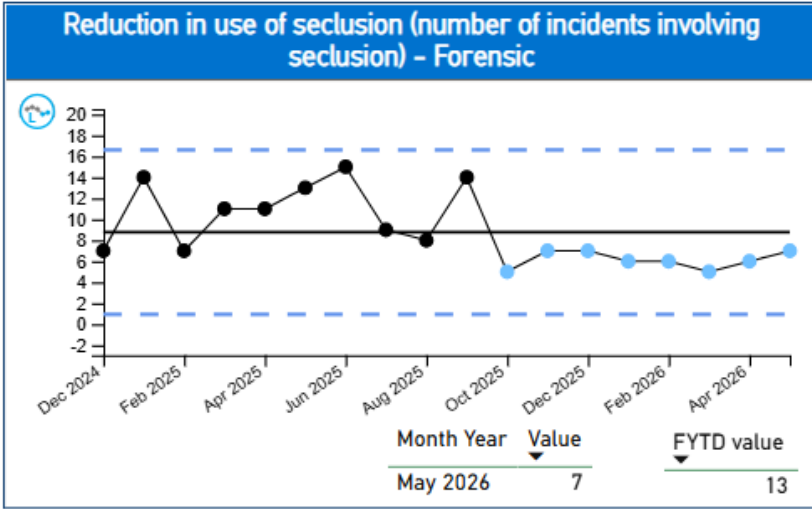
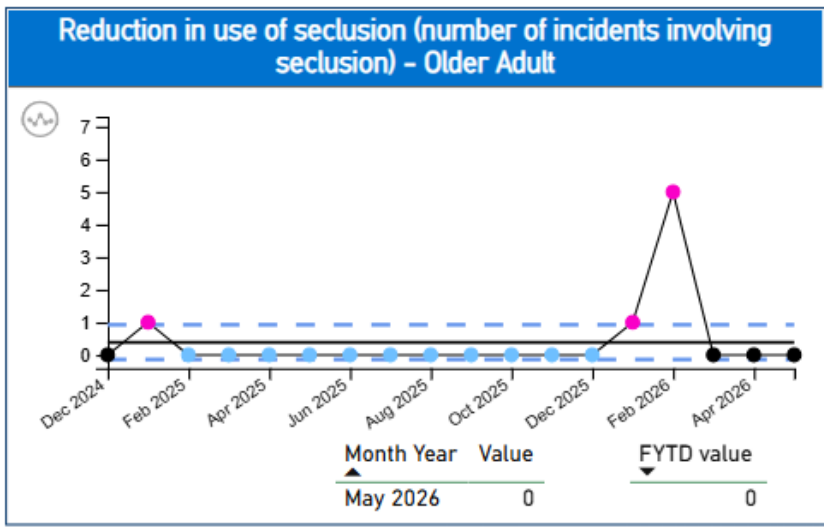
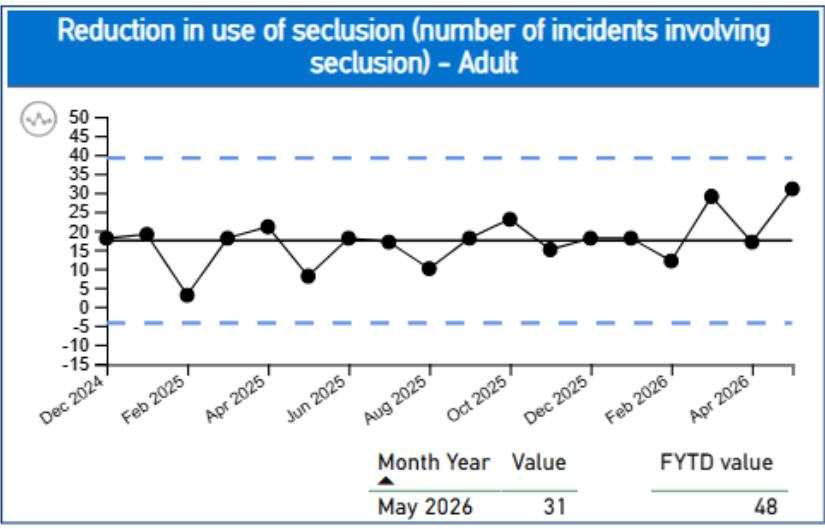
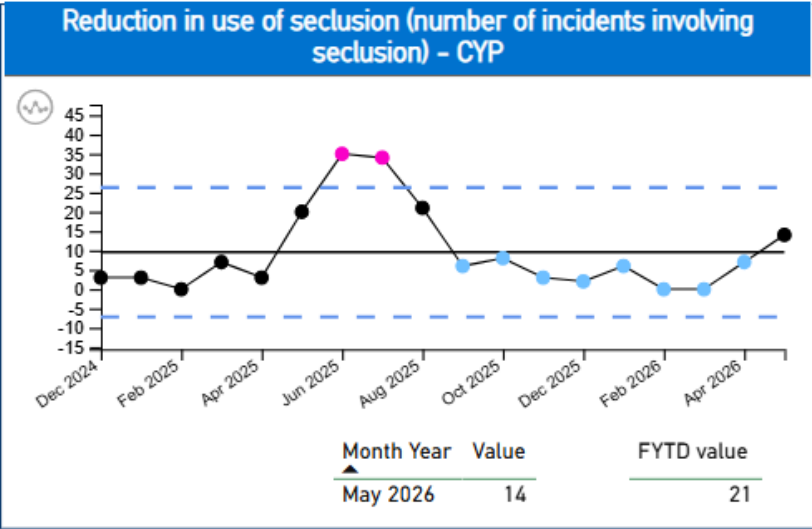
Mental Health Services – Inpatients - appendices

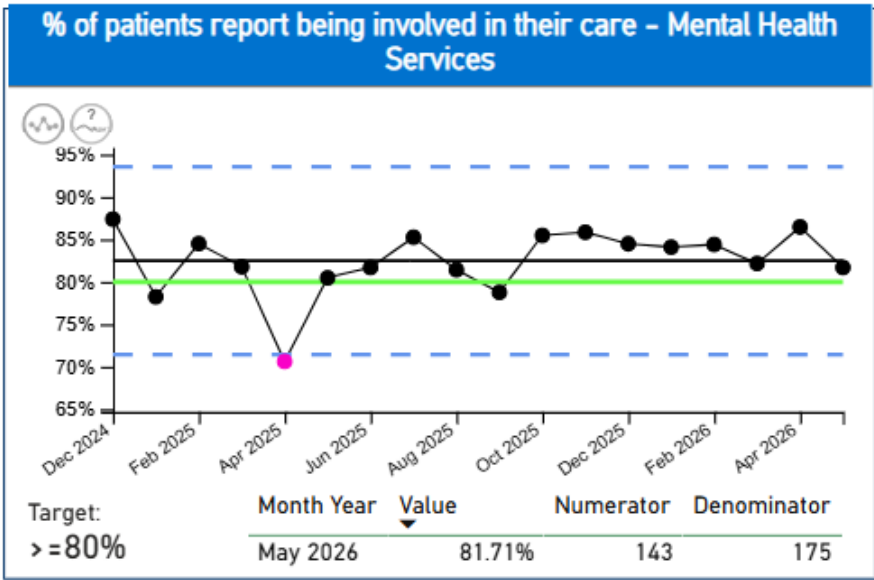
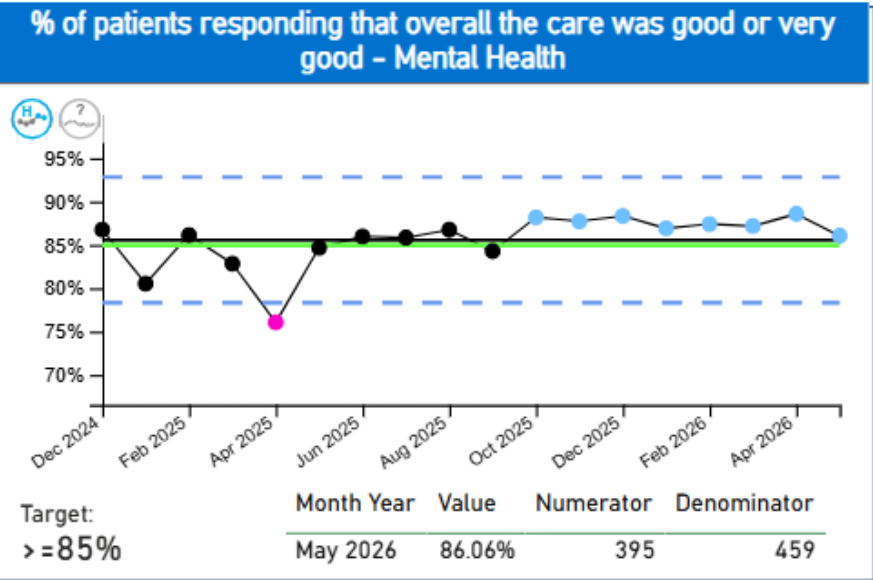
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Section 2.2

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
 	Community services - % of patients report 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 - Percentage of patients waiting over 52 weeks for community services (CYP and Adults combined) - 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 (Adults and CYP combined; month end snapshot)	Consistently meet or exceed the 70% 2-hour Urgent Community Response (UCR) standard Percentage of patients waiting over 52 weeks for community services (CYP) Percentage of people on waiting list for CYP Community Services per system who are waiting 18 weeks or less as a proportion of the entire waiting list (month end snapshot)	
	- Community services - % of patients responding that overall care was good or very good % 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) - Percentage of patients waiting over 52 weeks for community services (Adults) - Percentage of people on waiting list for Adult Community Services per system who are waiting 18 weeks or less as a proportion of the entire waiting list (month end snapshot)	% 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 - Healthy Child Programme - % of breastfeeding prevalence at 6 - 8 weeks old		- Average Length of Stay in Community Hospitals by basket of care – Rehab, Stroke, End of Life, EMU - Average number of Medically Optimised For Discharge (MOFD) patients per night - Emergency Dental Service Waiting times to triage - % Patients triaged within 6 hours
 				

Adult Planned Care – community rehabilitation

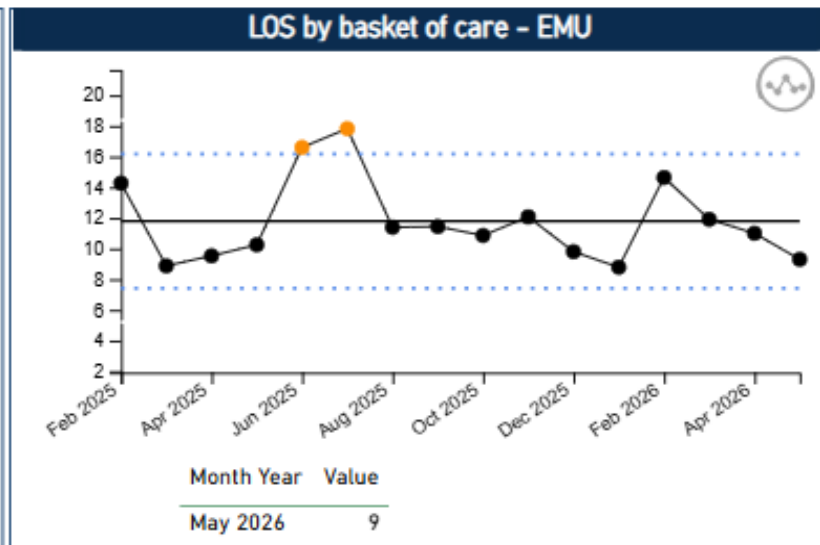
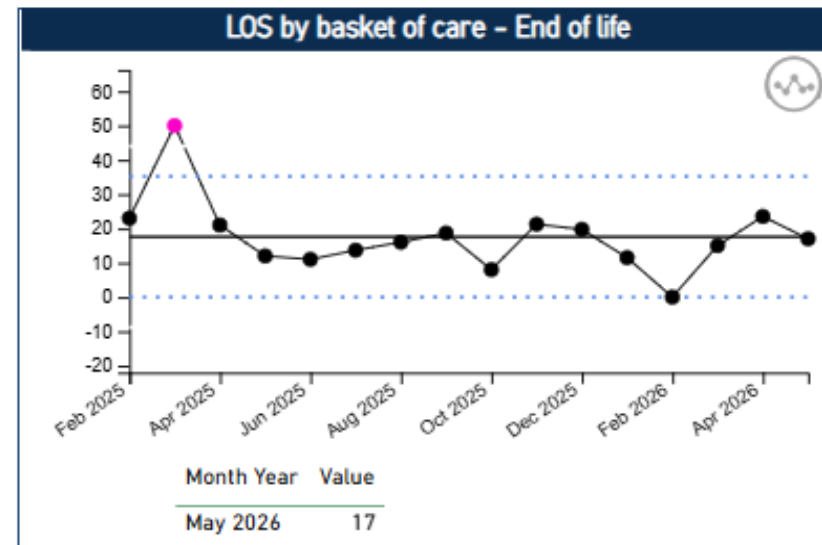
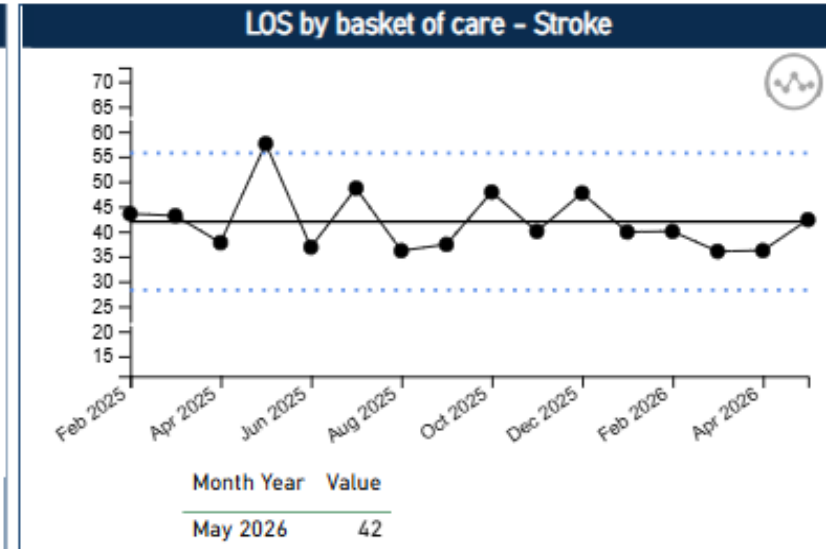
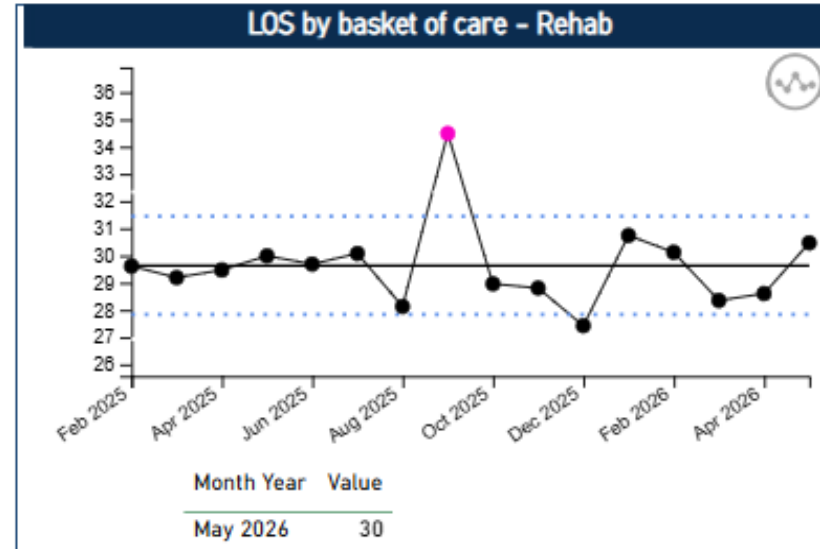
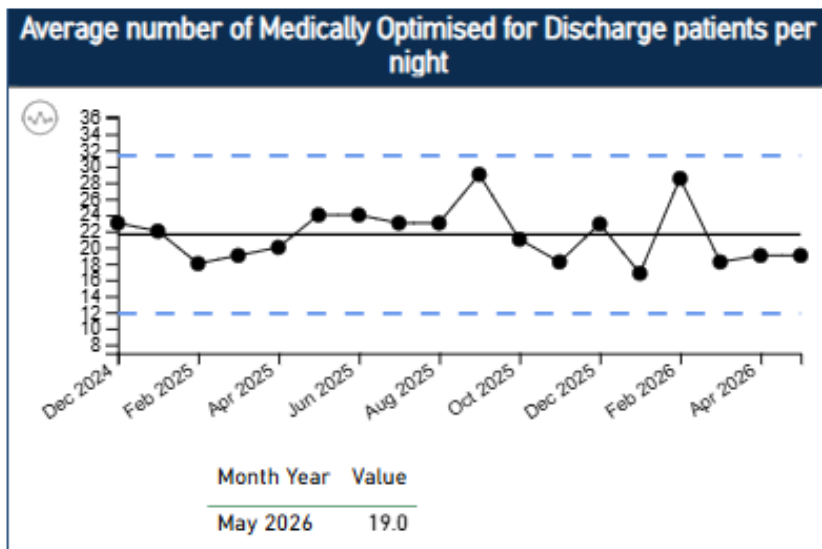
Type of metric	Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National	Average number of Medically Optimised For Discharge (MOFD) patients per night	.	May-26	19		n/a	21.59
Local	Average Length of Stay in Community Hospitals by basket of care - Rehab	.	May-26	30		n/a	29.63
Local	Average Length of Stay in Community Hospitals by basket of care - Stroke	.	May-26	42		n/a	41.93
Local	Average Length of Stay in Community Hospitals by basket of care - End of Life	.	May-26	17		n/a	17.58
Local	Average Length of Stay in Community Hospitals by basket of care – EMU (Emergency Multidisciplinary Unit)	.	May-26	9		n/a	11.78

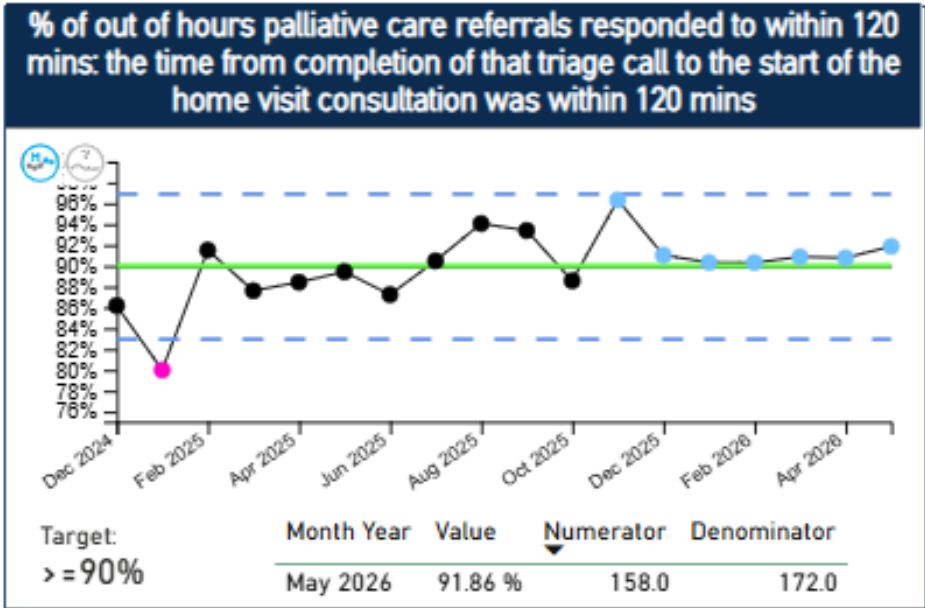
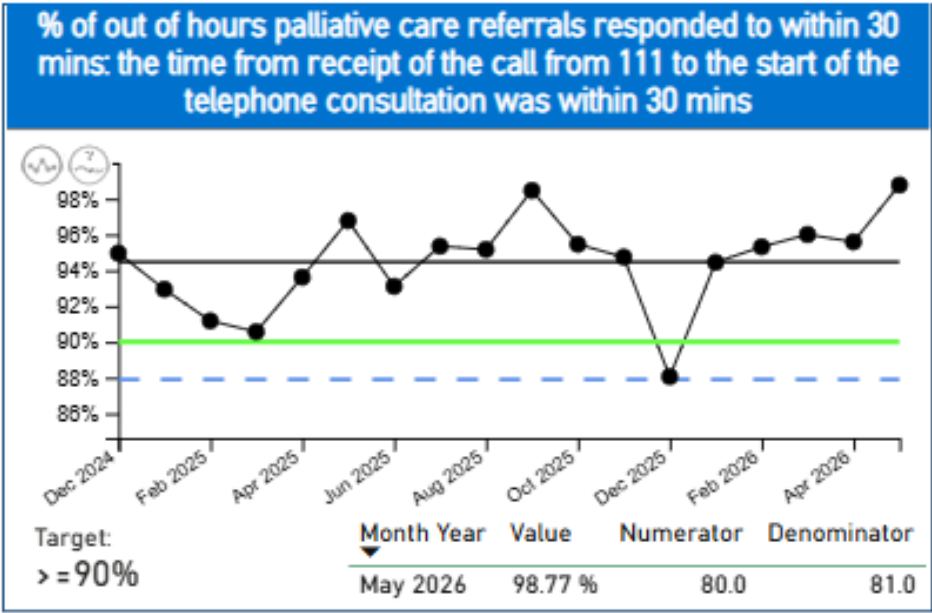
Adult Reactive Care – palliative care and end of life care

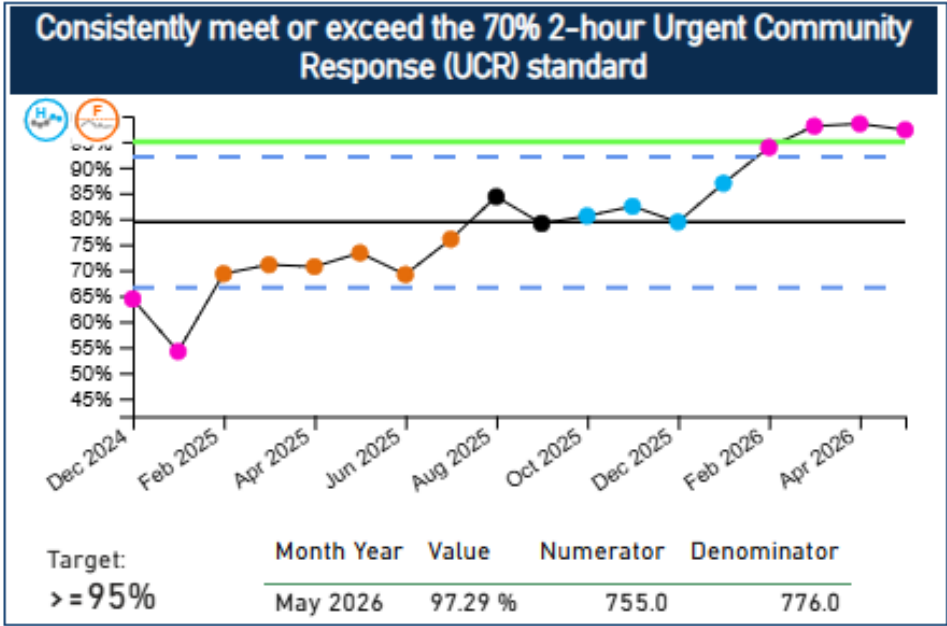
Type of metric	Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
Strategic - Quality	% of out of hours palliative care referrals responded to within 30 minutes: the time from receipt of the call from 111 to the start of the telephone consultation was 30 minutes	>=90%	May-26	98.77%			94.47%
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%	May-26	91.86%			89.91%

Adult Reactive Care – urgent care

Type of metric	Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National	Consistently meet or exceed the 70% 2-hour Urgent Community Response (UCR) standard	>=95%	May-26	97.29%			79.34%



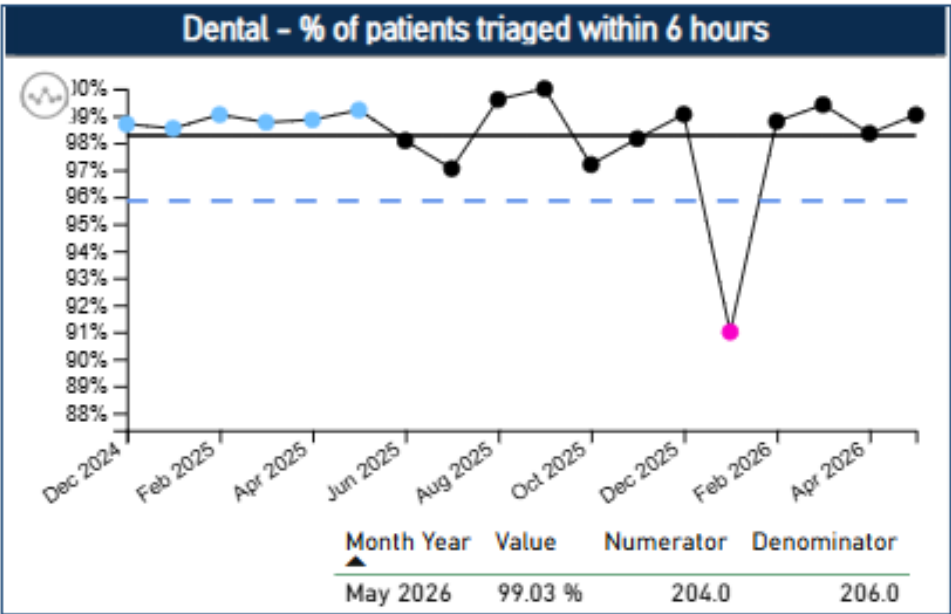
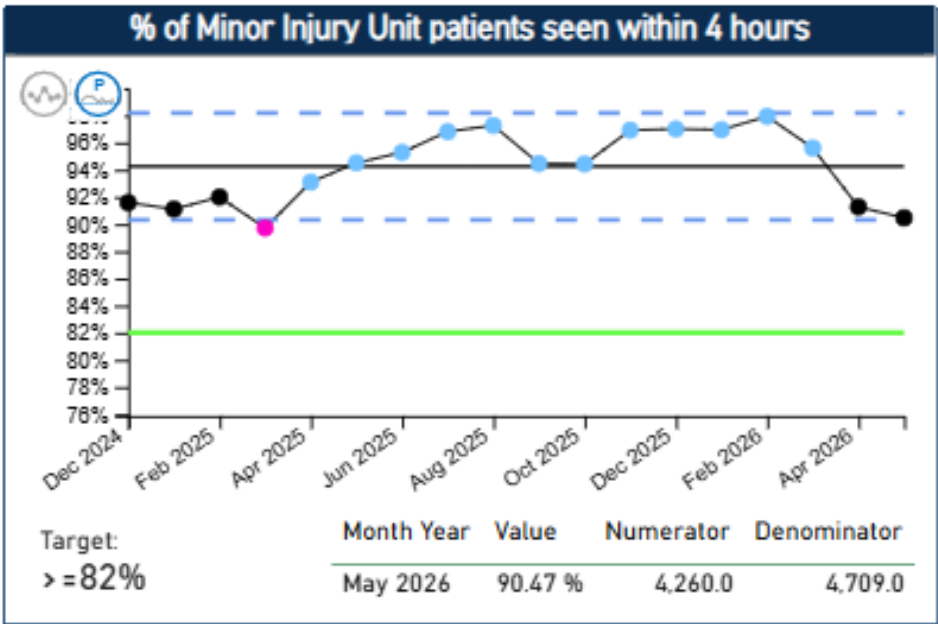




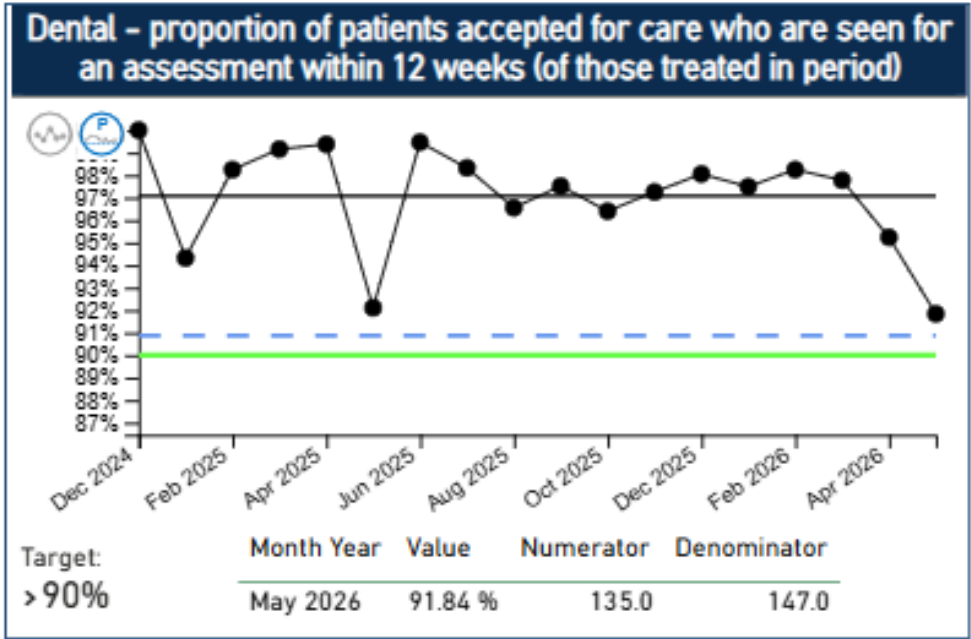
To note: January – March 2026 data reported nationally does not match the internally reported position (above) due to a coding error that prevented referrals from flowing into the national dataset. The final nationally published Quarter 4 (January–March 2026) position is at 86%, whereas internal data indicates a position of 94%.

Local target for FY26/27 has been set at $\geq 95\%$ meaning that any Assurance assessment against Making Data Count rules (currently indicating consistent failure of target) should be interpreted with caution during the transition period as Assurance assessment is based on last eight data points.

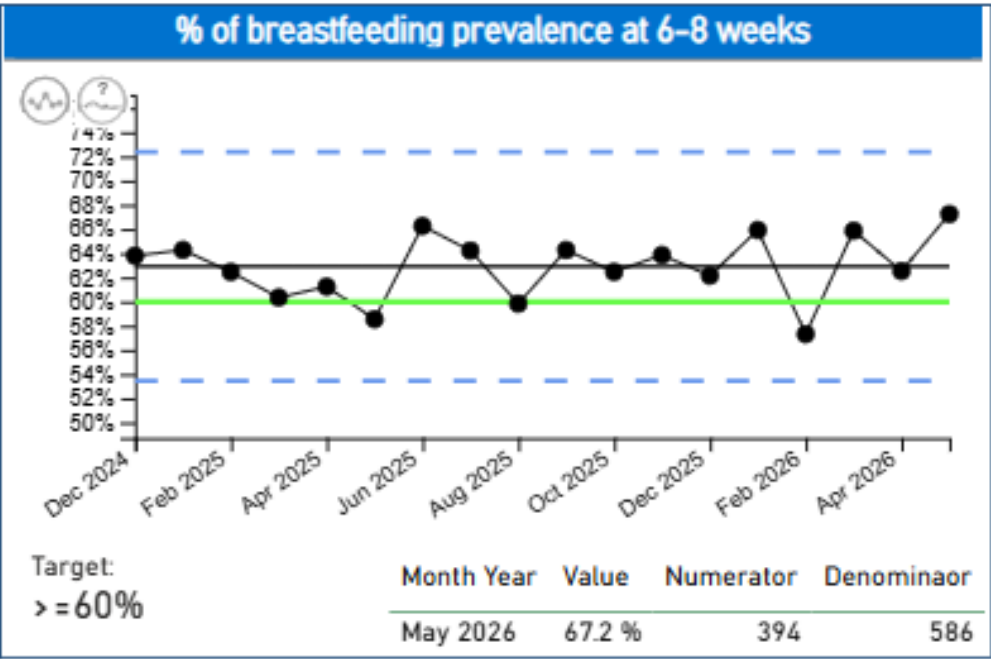
Type of metric	Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National	% of Minor Injury Unit patients seen within 4 hours	>=82%	May-26	90.47%			94.25%
National	Emergency Dental Service Waiting times to triage - % Patients triaged within 6 hours	.	May-26	99.03%		n/a	98.26%



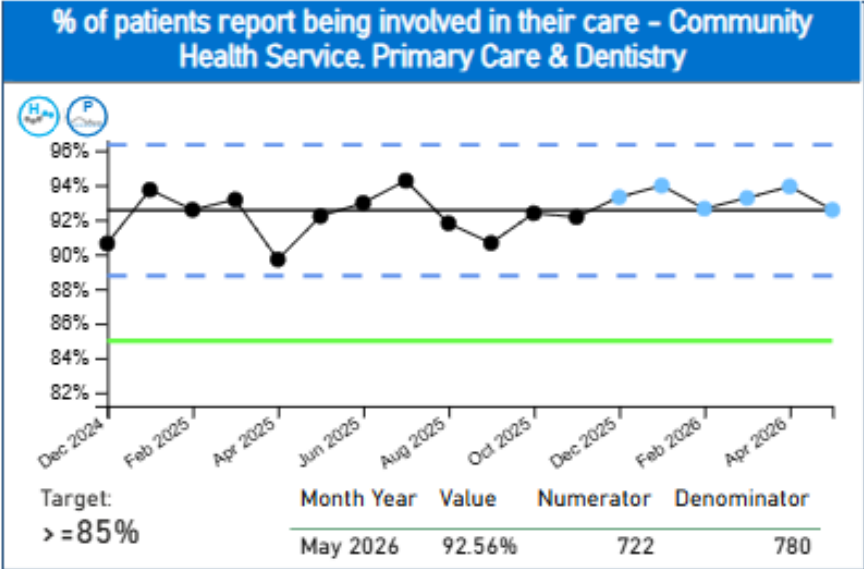
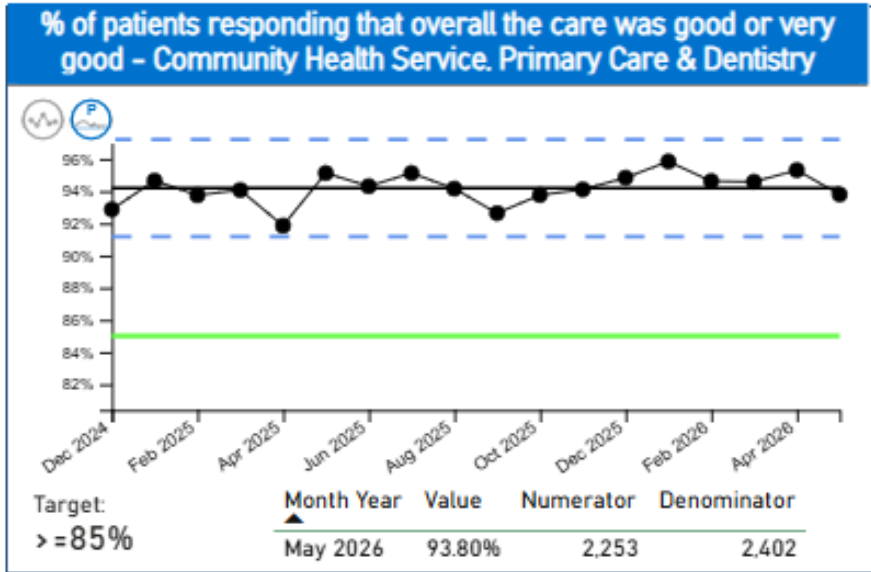
Type of metric	Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National	Community Dentistry - Proportion of patients accepted for care who are seen for an assessment within 12 weeks (Of those treated in period)	>=90%	May-26	91.84%			97.07%

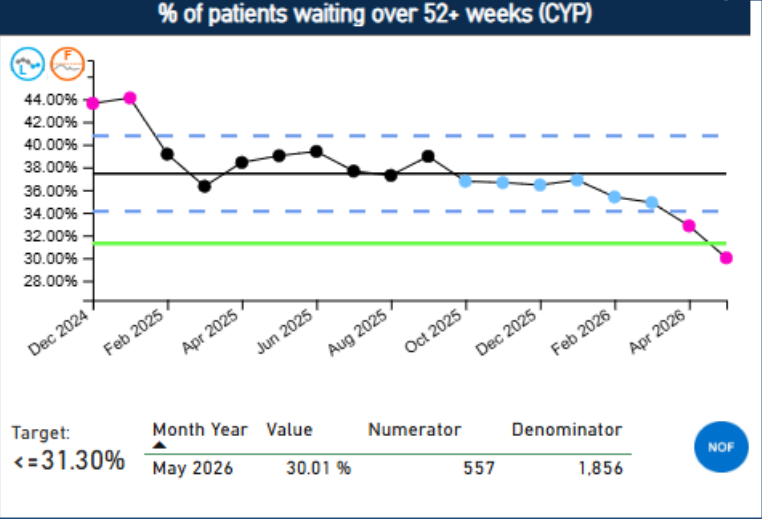
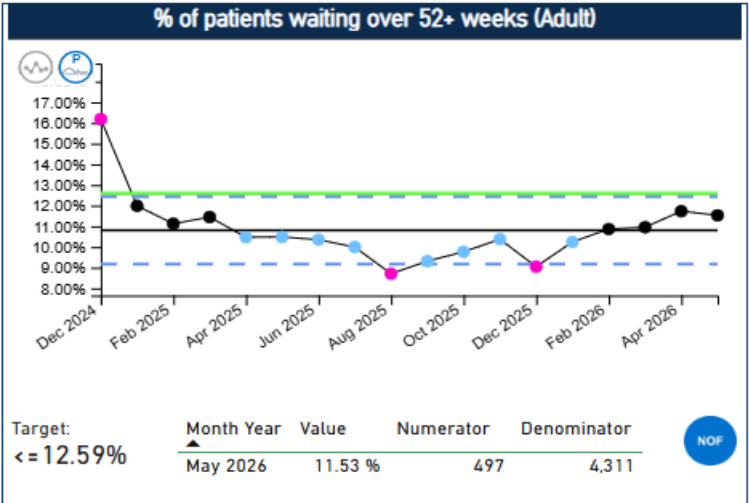
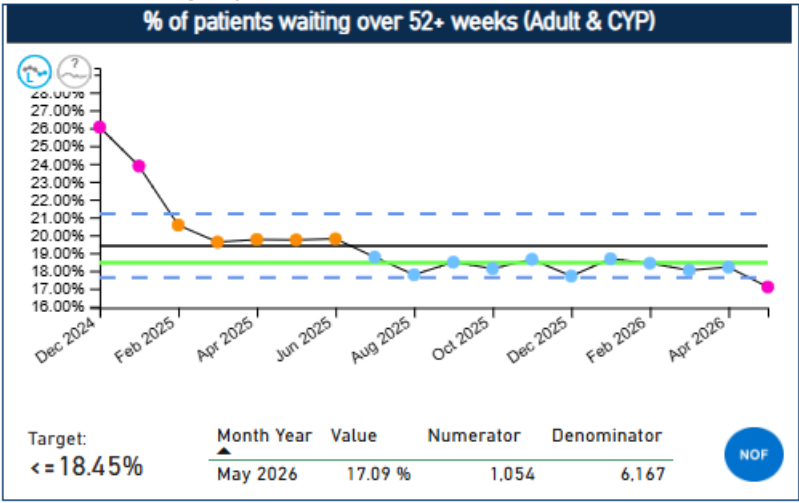


Type of metric	Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
Strategic – Quality National	% of breastfeeding prevalence at 6 - 8 weeks old	>=60%	May-26	67.20%			62.91%



Type of metric	Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
Strategic - Quality	% of patients responding that overall care was good or very good	>=85%	May-26	93.80%			94.19%
Strategic - Quality	% of patients report being involved in their care	>=85%	May-26	92.56%			92.54%
National NOF (scored)	Percentage of patients waiting over 52 weeks for community services (CYP and Adults combined)	<=18.45%	May-26	17.09%			19.39%
National NOF (scored)	Percentage of patients waiting over 52 weeks for community services (Adults)	<=12.59%	May-26	11.53%			10.79%
National NOF (scored)	Percentage of patients waiting over 52 weeks for community services (CYP)	<=31.30%	May-26	30.01%			31.30%
Local	Number of people on waiting list for Community services who are waiting over 52 weeks (adults and CYP combined)	<=1109	May-26	1054	n/a*	n/a*	n/a*
Local	Number of patients waiting over 52 weeks for community services (Adults)	<=520	May-26	497	n/a*	n/a*	n/a*
Local	Number of people on waiting lists for Community Children and Young People services who are waiting over 52 weeks	<=589	May-26	557	n/a*	n/a*	n/a*
National	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 (Adults and CYP combined; month end snapshot)	>=52%	May-26	56.14%			51.94%
National	Percentage of people on waiting list for Adult Community Services per system who are waiting 18 weeks or less as a proportion of the entire waiting list (month end snapshot)	>=59%	May-26	64.95%			62.74%
National	Percentage of people on waiting list for CYP Community Services per system who are waiting 18 weeks or less as a proportion of the entire waiting list (month end snapshot)	>=37%	May-26	35.67%			29.25%





Understanding the performance & Actions

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.

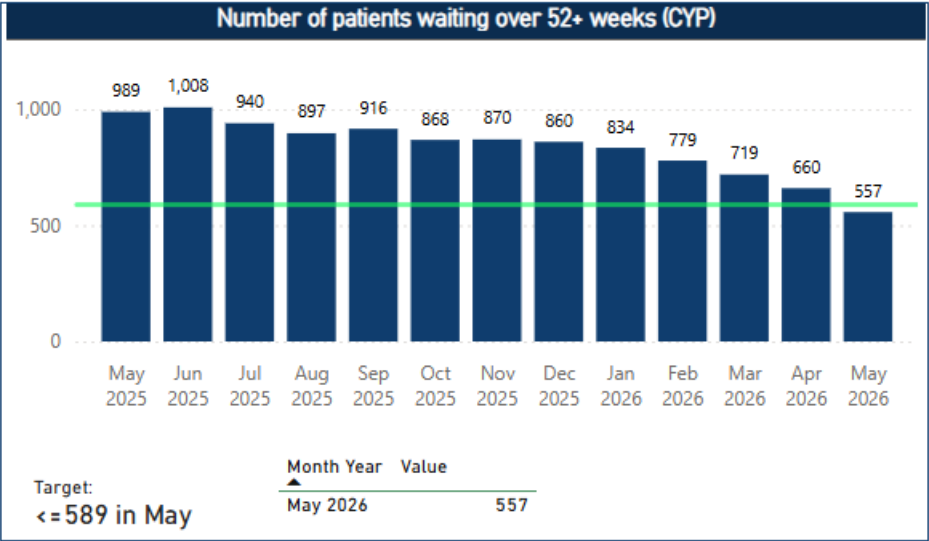
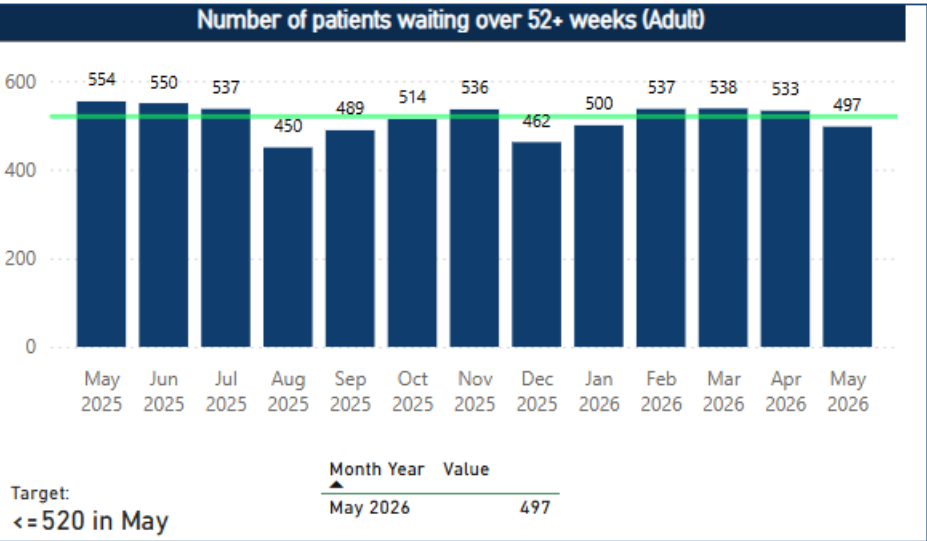
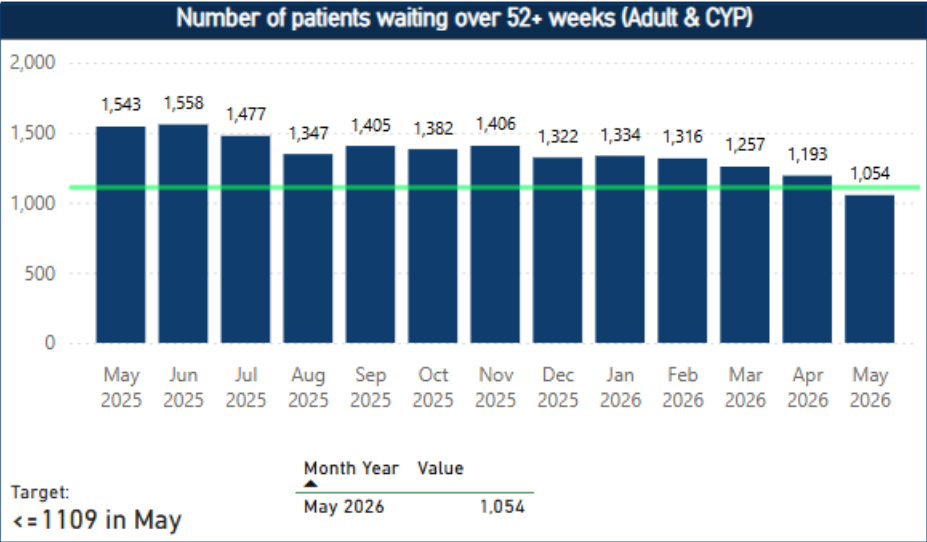
Performance continues to be influenced by a range of complex factors, including national workforce shortages in specific service areas and inconsistencies in the use of electronic health record system.

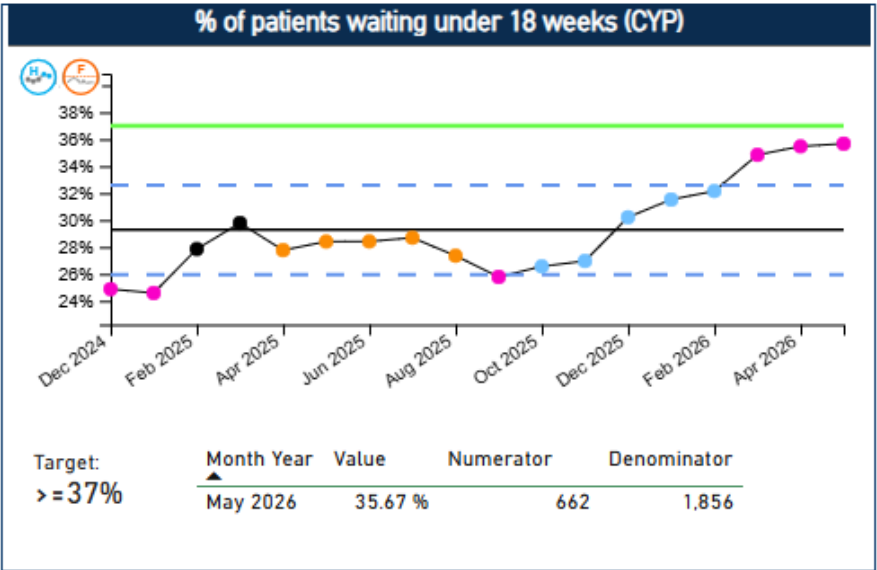
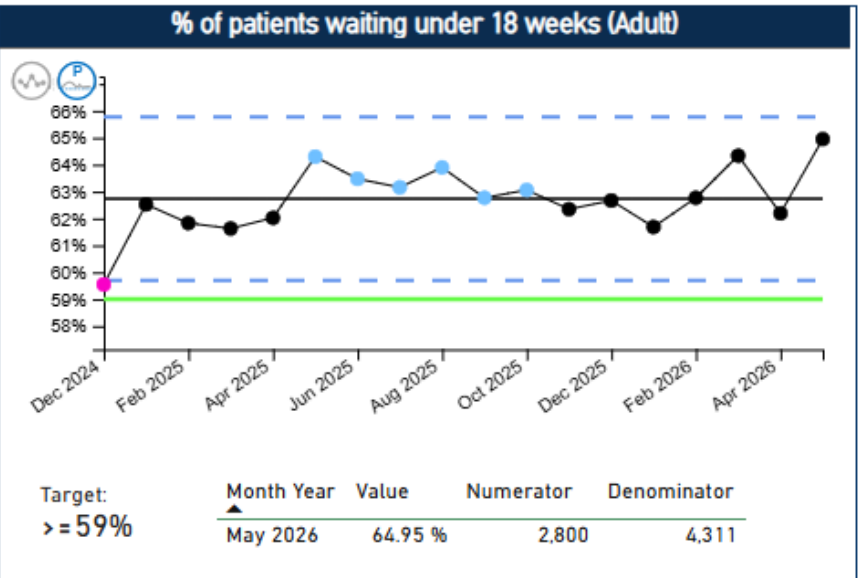
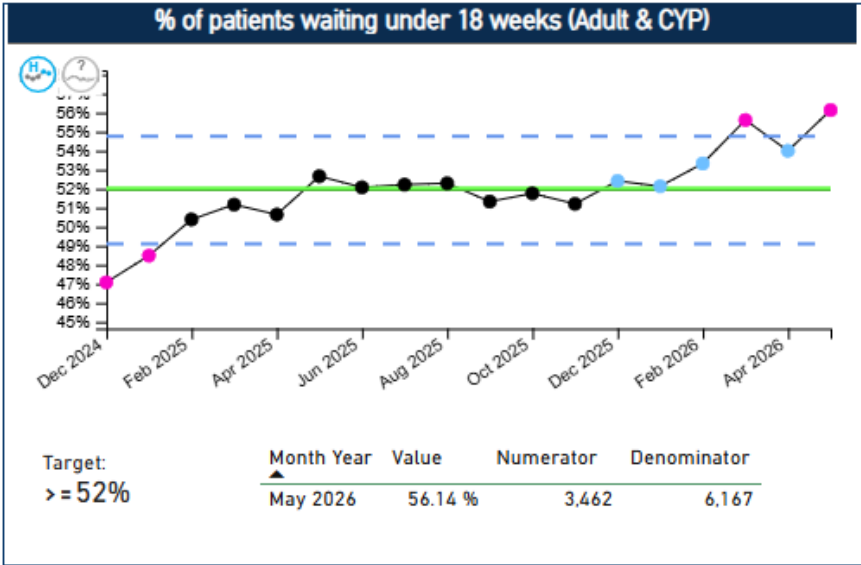
Since May 2025, the vast majority of community services have reduced their waiting lists to under 52 weeks with two service areas remaining with continued focused work required – Children’s Speech and Language Therapy service and Podiatry service.

- Comprehensive data cleanse is underway including manual validation of waiting lists, prioritising long waiters, review of appointment outcomes.
- Services are monitoring performance against set improvement trajectories (eliminating 52 week wait and seeing 78% of patients within 18 weeks by March 27) at bi-weekly meetings.
- Developed Directorate Access Policy - including approach to managing DNA’s (Did Not Attend)
- Children’s Integrated Therapy service continues looking to secure additional resource to support addressing of the waiting list. Service continues working with NHS Elect to conduct demand and capacity analysis.
- Podiatry continues with a pilot outsourcing some of the tasks to manage those waiting the longest. In addition, a Quality Improvement project for nail surgery using patient-initiated follow ups (instead of an automatically offered follow-up) has started.

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

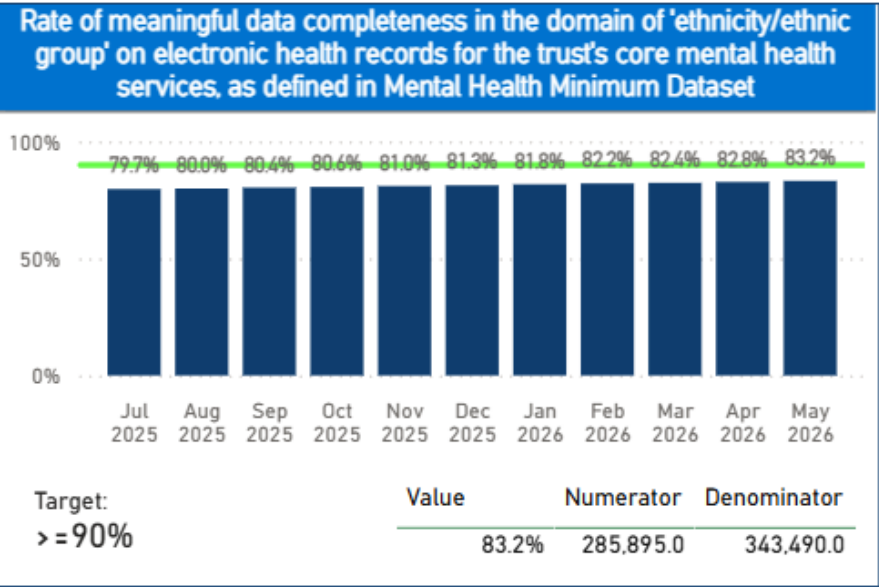
3.1 Quality - Deliver the best possible care and health outcomes

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%	May-26	83.20%	.	.	81.40%
<i>Local Strategic - Quality</i>	Reduction in the use of prone restraints (number of incidents involving prone restraint) - Trust level	Less than 8 per month / less than 97 in year	May-26	14			15
<i>Local Strategic - Quality</i>	Reduction in use of seclusion (number of incidents involving seclusion) - Trust level	Less than 25.25 per month / less than 303 in year	May-26	52			36
<i>Local</i>	Total number of patient incidents (all levels of harm excluding inherited pressure damage)	.	May-26	1472		n/a	1504
<i>Local</i>	Total number of unexpected deaths reported as incidents (by date of death, including natural and unnatural)	.	May-26	31		n/a	1504
<i>Local</i>	Number of suspected suicides	.	May-26	11		n/a	5
<i>Local</i>	Total number of incidents involving physical restraint - Trust level	.	May-26	391		n/a	338
<i>Local</i>	Total number of violence, physical, non-physical and property damage incidents (patients and staff)	.	May-26	460		n/a	397
<i>Local</i>	Total number of complaints and resolutions	.	May-26	101		n/a	82



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 left 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 May 2026 performance was at 83.2% demonstrating a further steady increase.

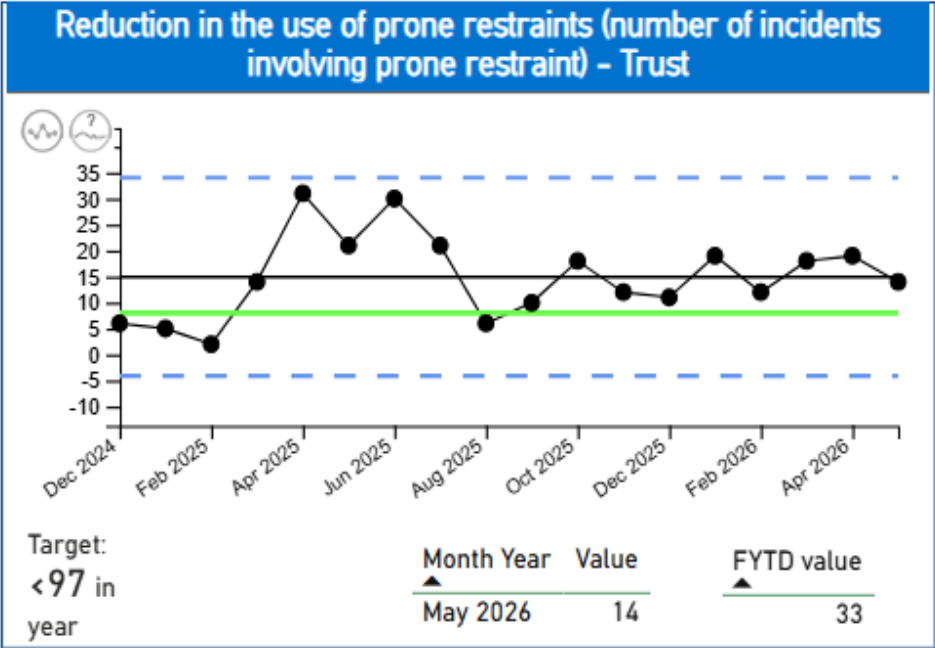
- High data completeness allows Trusts to:
- Monitor Disparities: Identify differences in access, experience, and outcomes among ethnic groups.
 - Inform Interventions: Develop targeted strategies to address identified inequalities.
 - Enhance Accountability: Provide transparent data for regulatory bodies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

Actions (SMART)

- Short-term actions underway to improve position:
Via the BRIDGE programme, in Buckinghamshire we are continuing to promote data completeness with services in scope. BSW, Oxon and Forensic services have Joint Management Groups which will facilitate local conversations about the need for data completeness.
- Medium-term actions underway to improve position:
Quality Improvement (QI) Project - There is a need for the Gateway team QI project on data completeness to be replicated in other areas of low data completeness/quality over the next quarter. For reference, as a result of the QI project, the rate of meaningful recording of ethnicity improved from 25.4% to 82.9% over a period of 12 months in the Gateway team.
- 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 conversations 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 2026/27. May has seen a small reduction in the use of prone restraint. There is a target reduction of 20% in the use of prone restraint the monthly rate for reduction has not been met since August 2025.

May 2026 had fourteen (14) prone restraints involving 10 individuals across 8 wards:

- Six (6) prone restraints were in one Forensic Low Secure Ward – Wenric House and attributed to one individual (6)
- Four (4) prone restraints within Oxon CAMHS GAU – Highfield (4) and attributed to one individual ; Buckinghamshire’s Mixed Rehab and Place of Safety (POS) Opal ward (2) attributed to one individual ; Forensic medium secure Kennet ward (1) Oxfordshire’s Adult Psychiatric Intensive Care – Ashurst Ward (1)
- The reasons for prone restraints during May were for administration of IM medication (8) ; Seclusion Procedure (3) and Unintentional led by patient (3) and (1) The 'unintentional led by patient' is difficult to avoid due to it being as a result of the patient moving into the position .

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.

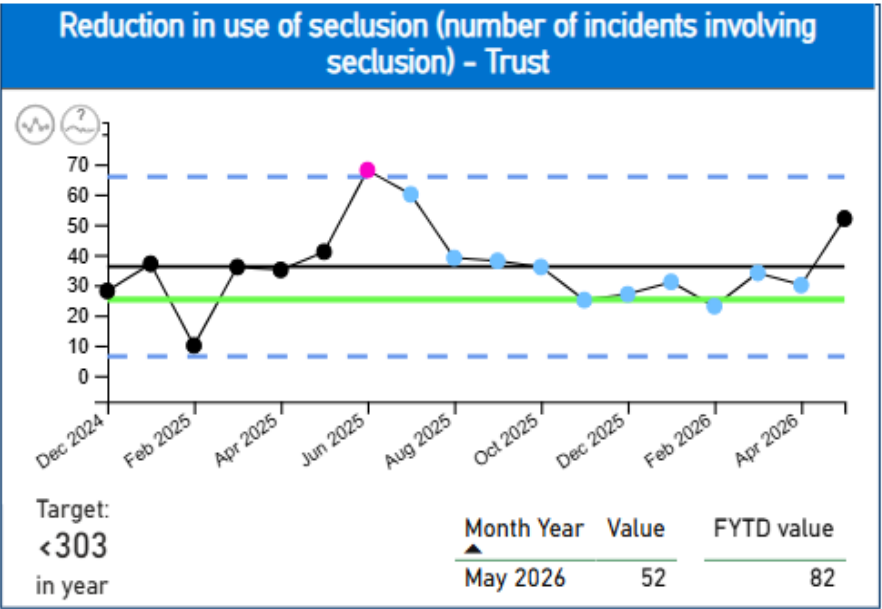
Weekly review mechanisms were introduced when the use of prone restraints increased. To address the lack of progress in this domain a taskforce commenced on the May 1st 2026 to target barriers to progression with a weekly IIR review specific to prone in place to quickly identify and action learning. The first IIR Panel commenced on the 9th June 2026 and is predicted to support reductions in line with or exceeding the target.

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. 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.

A review of PEACE techniques is due to be undertaken for approval at the August Positive and Safe Committee which will further strengthen the adoption of interventions that do not use the prone position in an intentional manner.

Risks

In general, prone restraints can have risks associated with physical well-being, psychological trauma to patients and lead to harm, can raise safeguarding concerns. 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 unintentional led by patient and then seclusion exit procedure.



Understanding the performance

Reduction in the use of restrictive practices remains 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 behaviours.

There has been an increase in seclusion episodes in May 2026 with 56 seclusion episodes involving 30 patients (4 episodes were not reported via Ulysses but were picked up in Rio and added to the TOBI dashboard) across 11 wards. There was an increase in the use of seclusion in CAMHS PICU (Meadow Unit) attributable to the management of one individual. Usage at Ashurst Adult PICU also increased to 10 episodes and Ruby Ward (Female Adult Acute Bucks) saw the third biggest increase in usage to 9 episodes in May.

The annual reduction target of less than 303 seclusions during 2025/26 was exceeded in October 2025 and not met. The annual target has been rolled over to 2026/27 and the monthly target of 25.25 has not been met in May 2026.

Actions (SMART)

Seclusion usage data is now generated from both RiO and Ulysses achieving improved data quality. Duration data is available via a manual report and in the final stages of data quality checking of historical duration and episode data. Weekly data quality monitoring is in place to ensure the data is reliable going forward. Update to the seclusion form have been made to improve data quality.

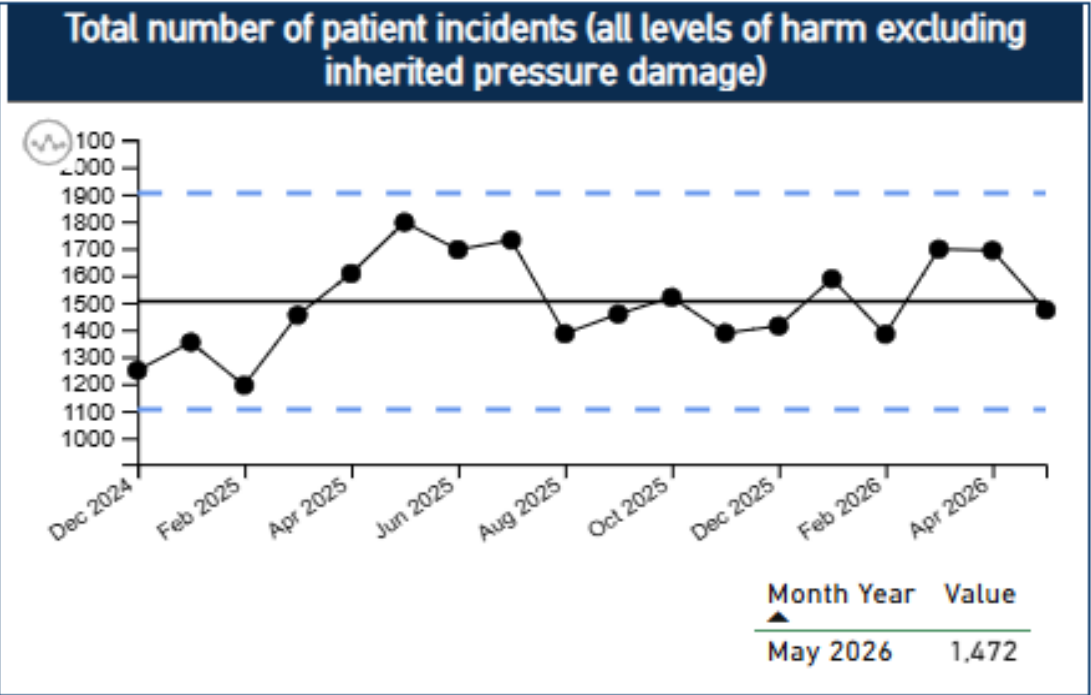
Duration data will inform the Trust Quality target for a 20% reduction in durations of seclusion. .

A programme board is being developed to focus on interrogation of the data to inform targeted reduction strategies where there are high users of seclusion either in episodes or duration.

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.



Actions (SMART)

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.

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

Understanding the performance

Most incidents are recorded with low or no physical harm to patients (94.1%), this compares to the national figure of 94.2%. There is no significant change in moderate or severe harm incidents over time, with the incidents with most harm relating to category 3 pressure damage and deep tissue injury for patients in the community under the District Nursing service.

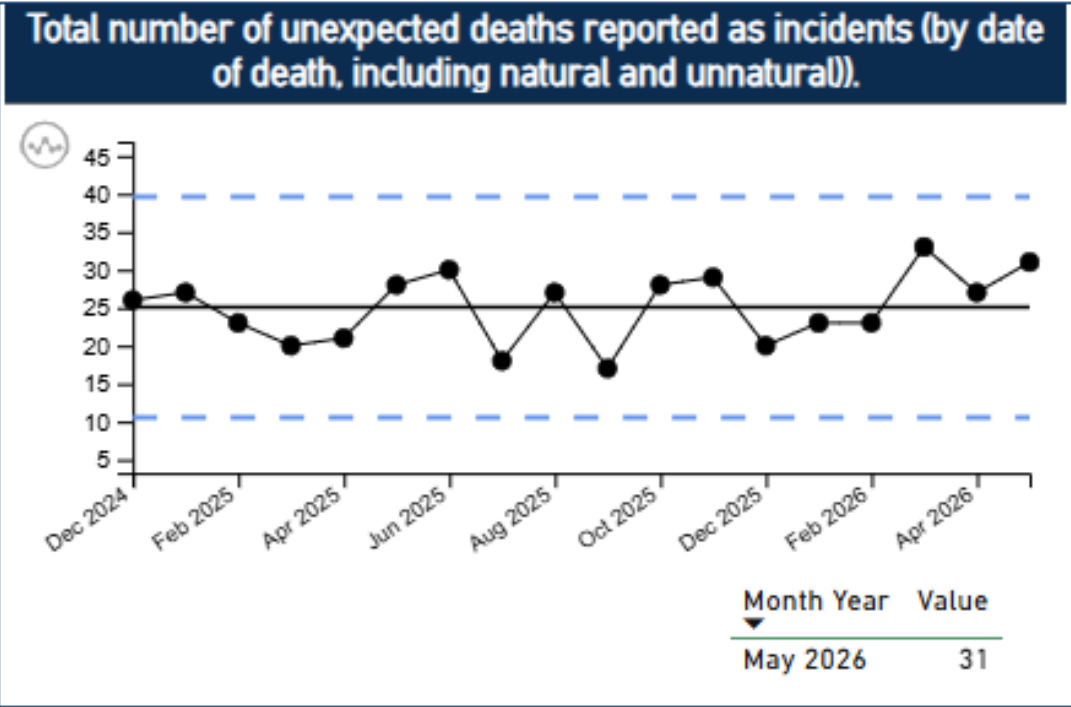
- The most common types of incidents in May 2026 were:
- Physical illness (with an increase on Ruby ward predominantly involving one patient who is experiencing multiple psychogenic non-epileptic seizures)
 - Violence with no physical injury or verbal abuse - patient on staff (highest on Kingfisher ward, Wenric ward and Cherwell ward)
 - Medicine administration/supply (highest in the District Nursing service)
 - Self-harm incidents (highest on CAMHS PICU and CAMHS Highfield Unit)

- In May 2026 overall most of the incidents were on;
- Ruby ward, female adult acute mental health (relating to a patient having seizures)
 - Child and Adolescent (CAMHS) Psychiatric Intensive Care Unit (PICU) Meadow (relating to self-harm)
 - CAMHS Highfield general acute (relating to self-harm)

- There were 3 severe harm incidents under Oxford Health’s care in May 2026:
- A patient self-harmed by taking an overdose in the community. She was admitted to an acute hospital and had subsequent surgery. Known to the Trust’s memory assessment service.
 - A patient self-harmed by swallowing a battery and jumping from a building in the community, resulting in fractures and surgery to remove the battery. Open to an adult community mental health team.
 - A patient on an adult acute mental health ward fall to the floor during a seizure. Ambulance called and transferred to A&E.

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 significant harm or concerns about care 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.

No further actions are 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 appropriate 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 which meets quarterly.

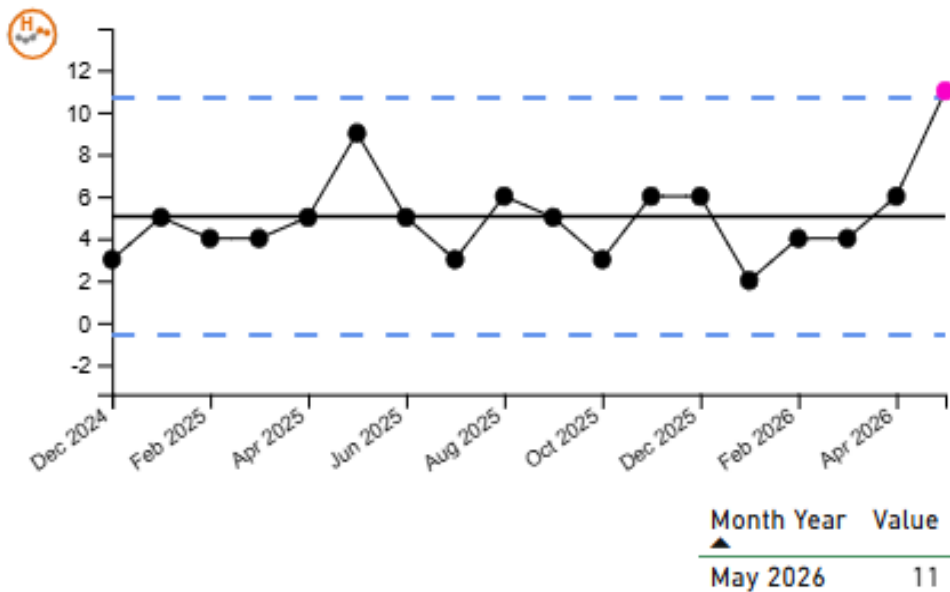
Our internal process involves two senior clinicians screening every known patient death and then depending on the outcome of this initial screening and/or the circumstances of the death, this is then reported onto the Ulysses system. The unexpected deaths reported onto the Ulysses system are represented in the graph shared. All unexpected deaths are then scrutinised by the Directorate senior management team through their weekly patient safety forums, which identify any actions and if a 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 increased in May 2026 relating to 15 unexpected/unnatural deaths, of which 11 of the people were open to services at the time they died. Out of the 15 deaths 11 are suspected suicides. One of the deaths was an inpatient on a female acute ward. The deaths are across all age groups children to older adults, spread across a number of teams and across Buckinghamshire, Oxfordshire and Swindon. The deaths have been initially reviewed and no link between the patients has been identified. Further reviews for each of the deaths are underway.

Risks

No specific risks identified.

Total number of suspected suicides



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 are 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.

The Trust is part of two Real Time Surveillance Systems to enable the sharing of information across agencies so that we can learn and make changes as quickly 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.

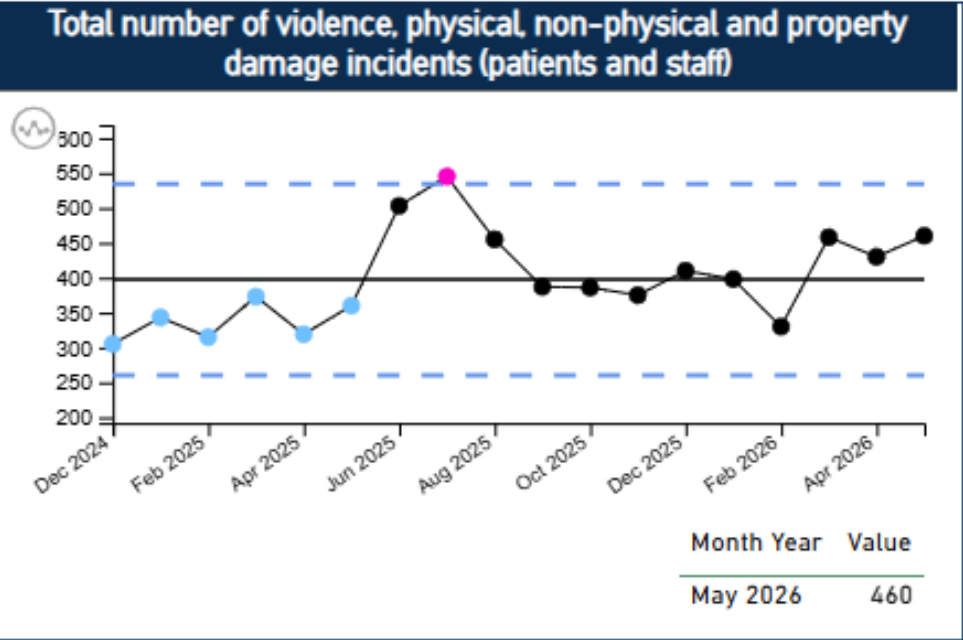
There were 61 confirmed/suspected suicides for open and discharged patients in the last 12 months up to 31st May 2026, of which 34 were open at the time to an OHFT service. We continue to see a higher number of male suspected suicides although not as big a gap as seen previously (35 males/26 females).

There has been an increase in suspected suicides in May 2026 which has been reviewed as part of looking at all unexpected/unnatural deaths. No clusters by team or links between patients have been identified. The deaths have been initially reviewed for immediate learning and further reviews are underway.

We had one inpatient suspected suicide in May 2026, a full in-depth PSI investigation has started. Prior to this death the last inpatient suicide was in September 2024 and occurred while a patient was on leave.

Risks

No specific risks identified to escalate.



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.

Understanding the performance

The number of violent incidents increased between June-August 2025 and has reduced since then but remains above the average level in May 2026. In the last 12 months the majority of incidents relate to verbal abuse from patients towards staff followed by physical violence with no harm from patients towards staff. The majority of incidents resulted in no specific harm or minor harm (98%). However, 4 of the violent incidents in May 2026 were RIDDORs* reportable, all for mental health wards.

It is the inpatient units with the highest number of violent incidents, in May 2026 the wards with the highest were;

- Ashurst Psychiatric Intensive Care Unit (PICU)
- Evenlode, forensic learning disabilities ward
- Kingfisher, forensic secure ward
- Phoenix, adult acute mental health ward
- Cherwell, older adult mental health ward

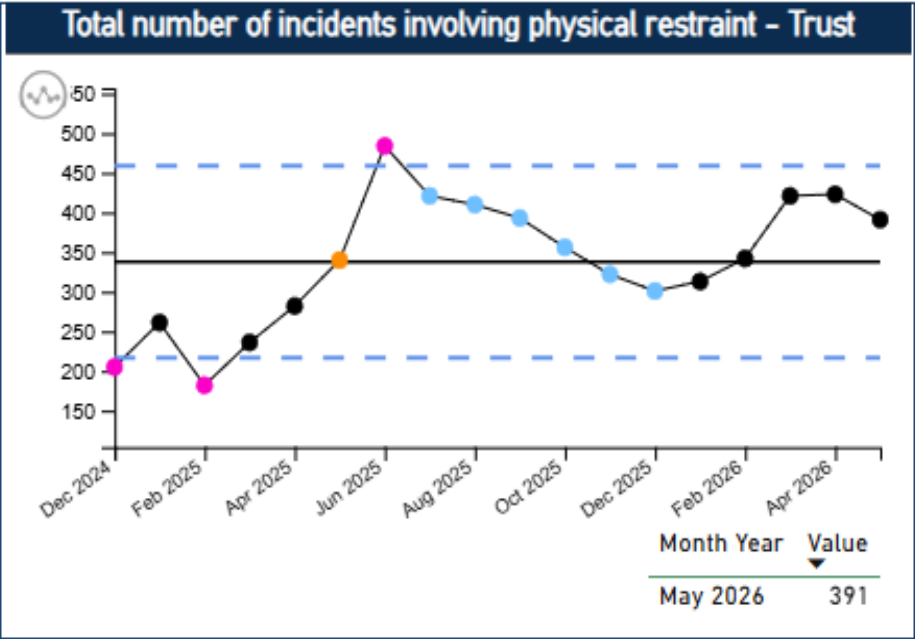
In May 2026, there was 0 severe harm violent incidents.

12% of violent incidents had a racial element in May 2026, this is fairly consistent month on month. On average there are 57 racially violent incidents each month. The majority of racial violence comes in the form of verbal abuse from patients towards staff and occurred mostly on Kingfisher ward, Ashurst PICU, Kennet ward and Evenlode ward.

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

Risks

Staff being injured by patients during their work, impacting on morale, sickness and retention.



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.

May 2026 has seen a small reduction in physical restraints (391) , the first decrease since December 2025 . There was a sharp increase in March which sustained in April 2026.

CAMHS PICU – Meadow Unit accounted for 78 restraints and 73 for CAMHS GAU – Highfield Unit.
Oxford Female Adult Acute Pathway accounted for 30 restraints.
Cotswold Eating Disorder Unit (Marlborough) and Cotswold Eating Disorder Unit (Oxford) accounted for 30 and 27 restraints respectively.

The highest cause group for incidents involving restraint is self-harm. This has changed in the last two years from violence and aggression. In May 2026, 157 of 391 uses of restraint was to prevent or minimise self-harm for the individuals’ safety. The second highest reason was violence & aggression with 116 physical restraints. 86 incidents were to deliver healthcare, 64 of which were for administration of nasogastric (NG) feeding.

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.

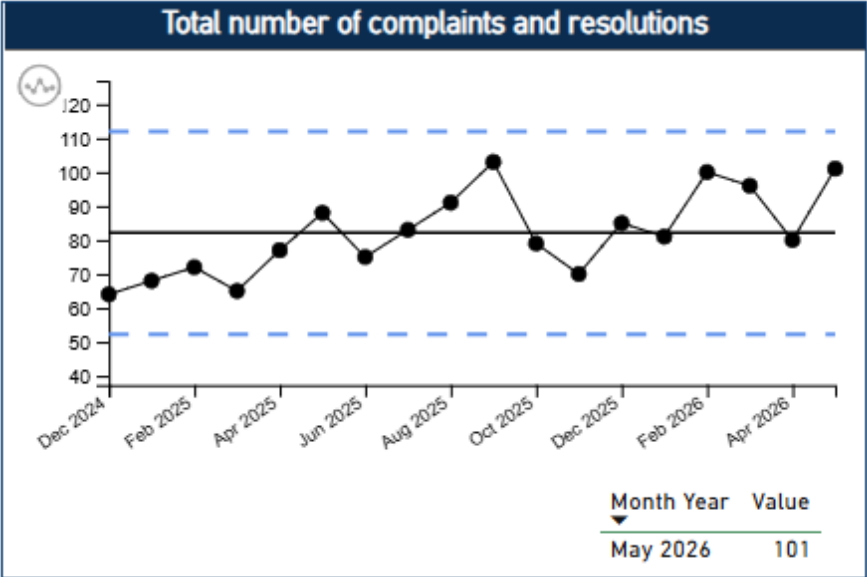
Work to optimise feeding strategies is undertaken where nasogastric feeding cannot be avoided.

A programme of restrictive practice reduction is underway to establish targeted interventions based on data analysis.

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.

Restraint when employed with a physically frail cohort means that all attendant risks are increased e.g. nasogastric feeding under restraint , preventing harm to others and facilitating personal care in the older adult population.



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 May 2026, there were 21 early resolution cases, 51 rapid resolution complaints, 27 low level complaints, 4 Care Quality Commission (CQC) cases, and Member of Parliament (MP) enquiries. The top teams were AMHO Primary Care Oxford City & NE, AMHT Bucks Aylesbury Team, Ashurst Ward, Oxfordshire’s Child and Adolescent Neurodevelopmental Pathway, and Ruby Female Acute Ward.

During May 2026, the Trust received 209 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.

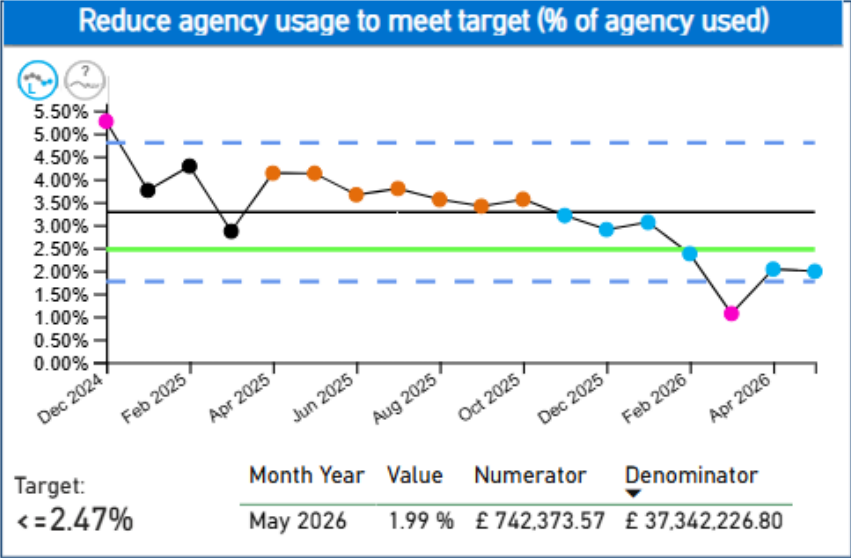
3.2 People - Be a great place to work

People - summary

Board meeting in public

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Type of metric	Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
<i>Strategic - People</i>	Reduce agency usage to meet target (% of agency used)	<=2.47%	May-26	1.99%			3.28%
<i>Strategic - People</i>	Reduction in % labour turnover	<=12%	May-26	9.41%			9.95%
<i>Strategic - People</i>	% of staff completing Quality Improvement Training Level 1	.	May-26	1348		n/a	1144
<i>Strategic - People Local</i>	Black, Asian and Minority Ethnic (BAME) representation across all pay bands including Board level.	>=19%	May-26	28.39%			26.78%
<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%	May-26	14.38%			13.97%
<i>Local</i>	Proportion of staff in senior leadership roles (bands 8a - 8d, 9 and Very Senior Manager) who are women	.	May-26	77.92%		n/a	77.84%
<i>National NOF (scored)</i>	Reduce staff sickness to 4.5%	<=4.5%	May-26	4.95%			4.85%
<i>Local</i>	Personal Development Review (PDR) compliance (PDR season is between April – July)	>=95%	May-26	33.40%	n/a	n/a	.
<i>Local</i>	Reduction in vacancies	<=9%	May-26	7.93%			8.67%
<i>Local</i>	% of early turnover	<=13%	May-26	12.30%			11.96%
<i>Local</i>	Statutory and mandatory training compliance	>=90%	May-26	93.34%			92.18%
<i>Local</i>	Overall supervision rate	>=90%	May-26	84.32%			77.74%
<i>Local</i>	Staff leaver rate	.	May-26	7.10%		n/a	6.46%
<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	May-26	2.0			1.73
<i>Local</i>	Relative likelihood of non-disabled applicant being appointed from shortlisting compared to disabled applicants	1	May-26	1.05			1.09



Understanding the performance

We have seen a sustained reduction in the Trust's agency usage, which has consistently remained below the 4.23% target for FY25/26 since June 2025, and below the 2.47% target for FY26/27 since February 2026. This demonstrates that robust controls and a bank-first approach are now firmly embedded.

Total agency spend in May 2026 decreased to 1.99% of total pay bill and remains under target. The Trust is £334k better than plan for agency spend Year to Date.

Agency Spend as a % of Temporary Staffing was 18.4% (£742k) and Bank was 81.6% (£3,286k) reflecting the Bank First approach.

Fill rates :
NHS People (NHSP) shifts only (excluding Medical & Dental): In May 26, 88.8% of our temporary staffing shifts (based on hours) were filled by bank workers, above the 85% target. 6.89% were filled by agency workers and 4.29% were unfilled.

Medical & Dental (ID Medical, Allocate and Patchwork agencies): In May 26, 57.6% of our temporary staffing shifts (based on hours) were filled by bank workers; 35% were filled by Agency workers and 6.8% were unfilled.

Actions (SMART)

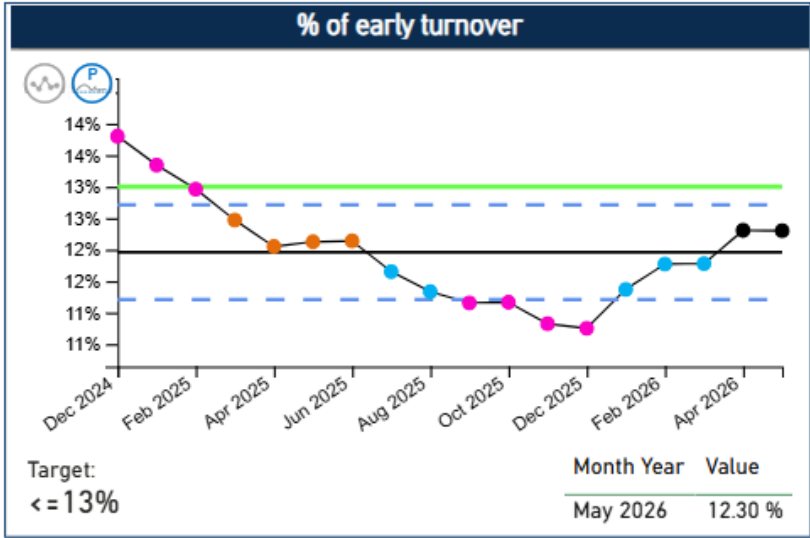
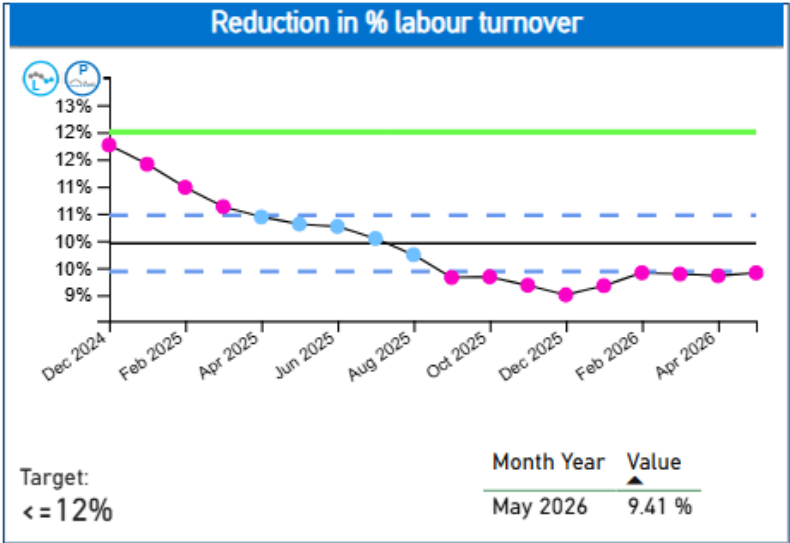
There continues to be successful fulfilment of all vacant shifts, although bank fill slightly decreased from 88.9% to 88.8% in May 2026, whilst agency fill decreased to 6.89%.

AfC – The rate reduction for Band 5 & 6 Agency nurses introduced at the beginning of April, to bring these workers under cap, has not had any significant impact on fill rates, and no staffing concerns have been raised by employees. This measure will contribute towards achieving our savings target for 26/27. Similarly, since the reduction on Emergency Practitioner rates for the Out of Hours Service, we have seen no negative impact on fill rate. From 4th May 2026 we have reduced the cascade of Agency Band 5 & 6 roles to 7 days across all in-patient services this has had no impact on Agency fill rate so far. Once embedded, the Temporary Staffing Team will look to implement an authorisation process for any qualified nursing agency request. Discussions have commenced between OHFT and NHSP on working together on the training of Band 3 HCA's to support the Trust requirement for Bank workers in this category. We continue to closely monitor long lines of work (there are 29 in total with 8 being migrated across to NHSP currently) and will be focusing on reducing all those that are above 12 months.

Medics – Focus continues reducing locum use and their rates. We have better quality data in relation to the recruitment pipelines for medics and have started to share this with stakeholders across the Trust.-Support is being given to the Out of Hours service to ensure they have adequate supply of GPs given changes to the pool we have been drawing from.

Risks

Lack of supply from agency could negatively impact patient safety. Equally lack of controls in relation to agency could drive up costs unnecessarily.



Understanding the performance

Staff turnover has shown a sustained reduction since October 2024. In May 2026 there was an increase from 9.35% to 9.41% although it remains significantly below the new 12% target. Staff turnover of Black, Asian and Minority Black, Asian and Minority Ethnic staff is 8.01%. White staff turnover is 10.28%.

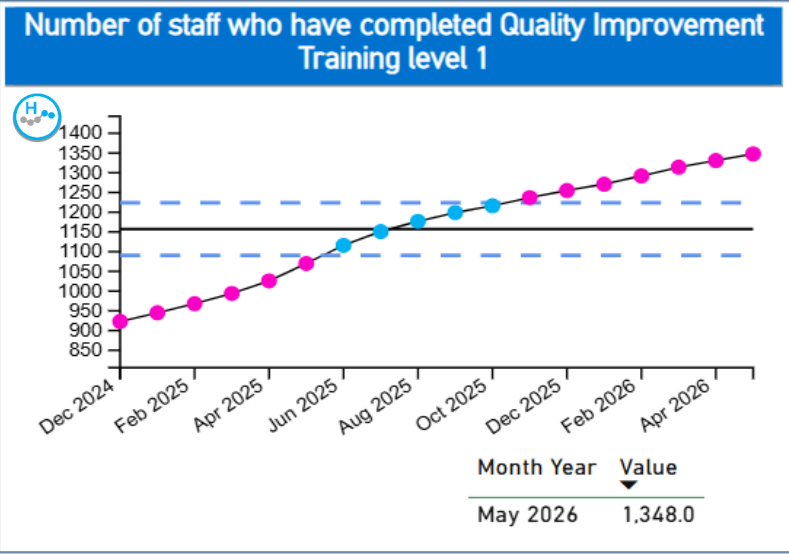
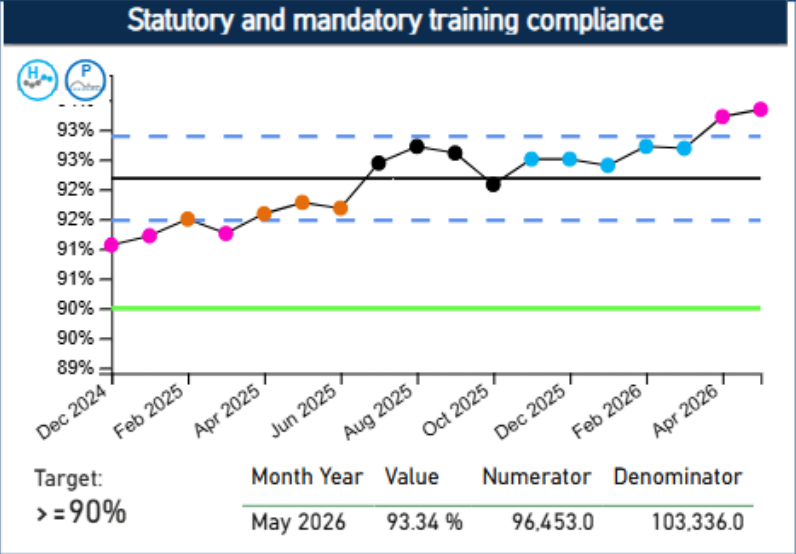
Early turnover has slightly decreased from 12.31% to 12.30% and remains below the new 13% target. Early turnover is lower among Black, Asian and Minority Ethnic staff (10.57%) than the white staff (12.3%).

Actions (SMART)

- The retention programme has been reviewed, several workstreams have been closed and will now focus on:
- Staff recognition work which has now been brought together with the Staff Awards. The 2026 Staff Awards attracted 632 nominations under 14 categories. The awards event took place on 17 June 2026.
 - The Exit Dashboard has been launched and used to report reasons for leaving. The Flexible Working programme is focusing on
 - reviewing policy
 - guiding managers with flexible working requests
 - simplifying guidance documentation for those making requests
 - Reviewing recognition of service to include various lengths of service

Risks

Turnover is higher in some areas or professions than others which is masked by the average. This can impact on vacancies and quality of care provided to patients. Continued support will be given to directorates to focus on location and professions where turnover is higher than average.



Understanding the performance

The trust compliance rate has increased from 93.22% to 93.34%. Only R&D has an overall compliance below the 90% target but there are plans in place to address this.

11 out of 12 modules of Mandatory training have a compliance rate above 90%. 3 have compliance rates of over 95%. Resus remains the only module under 90% at 82.19%

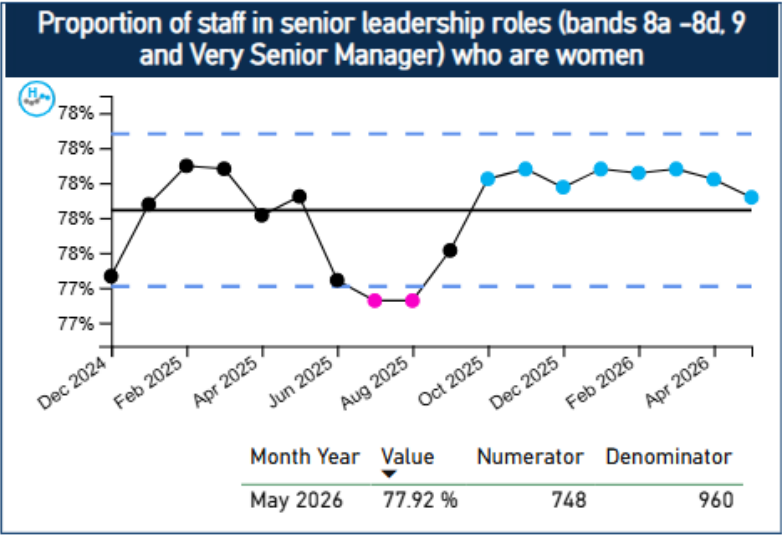
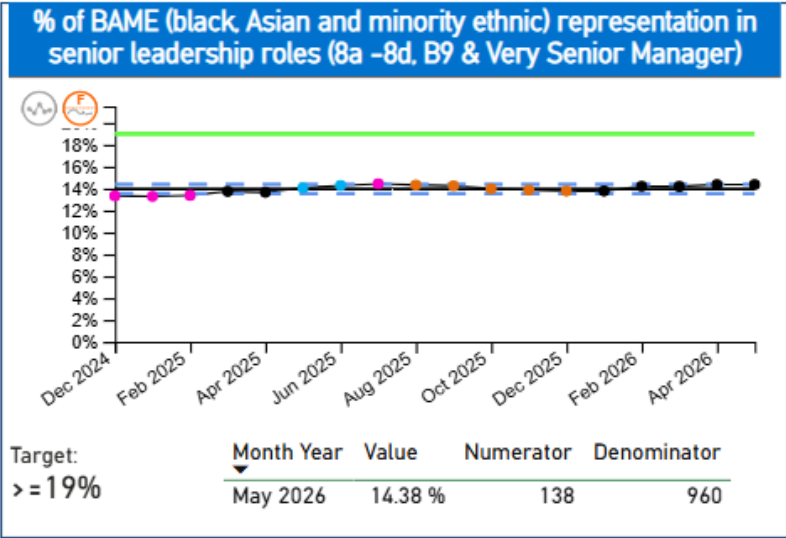
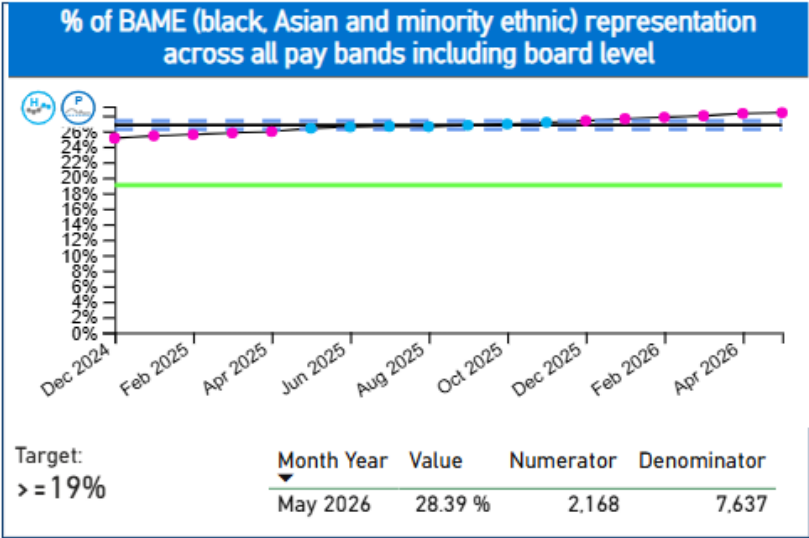
The National NHSE Core Skills Training Framework (CSTF) alignment programme remains due for publication.

Actions (SMART)

- Resus compliance is stable at 82.19% compared to 81.25% last month with continued efforts resulting in reduced DNA rates and improved access to training. In line with expectation from NHSE National S&M training programme, some clinical teams that are largely telephone/online services are being considered for a reduction in requirements from face-to-face ABLS to Level 1 ABLS e-learning only. This will have positive impact on both the compliance for those services and access to training for other services. Level 1 resus awareness training has been monitored since its roll out on 15th December 2025 and is continuing to rise. Compliance is 78.97%, compared to 73.04% last month. This will be included in the overall Statutory & Mandatory training compliance figures from 1 July 2026, and a communication campaign is planned for June 2026 to drive up compliance for this module. The Trust is considering reduction of resus training in line with a risk-based approach
- We are still awaiting the release of the national review of the Core Skills Training Framework by NHSE and planned roll out of changes.

Risks

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



Understanding the performance

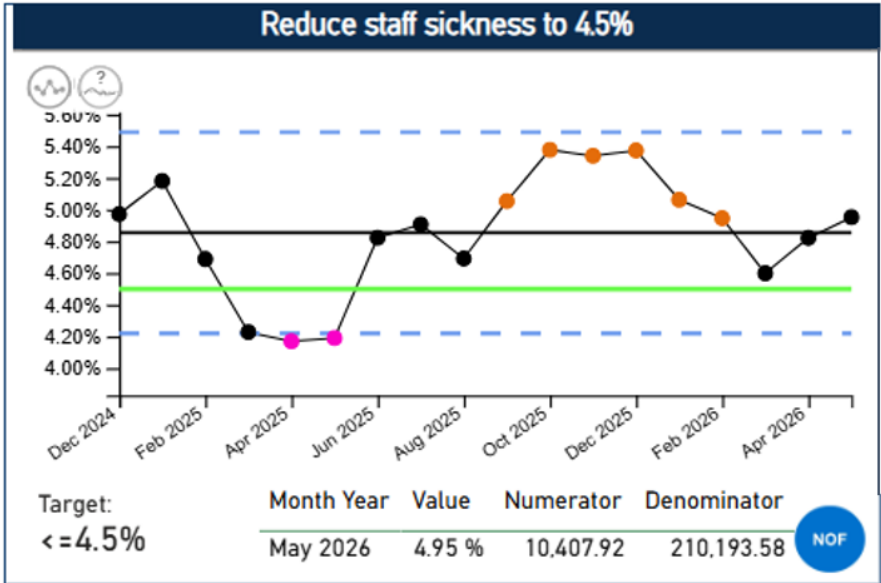
- There has been a slight increase of 0.11% in the representation of Black, Asian and Minority Ethnic staff across all pay bands during the May 2026 reporting period.
- There has been no change in the representation of Black, Asian and Minority Ethnic staff in senior leadership roles (bands 8A-8D, B9 and Very Senior Manager) in the May 2026 reporting period.
- There has been no change in the representation of female staff in senior leadership roles (bands 8A-8D, 9 and Very Senior Manager) in the May 2026 reporting period.

Actions (SMART)

- The Trust has approved the 2026 – 2028 Equality, Diversity and Inclusion (EDI) Plan bringing together the actions from WRES, WDES, NHS England's EDI Improvement Plan, pay gap reporting, PCREF workforce actions and other national equality programmes into one coordinated delivery framework.
- Delivery of the plan is now underway, with progress monitored through the EDI Steering Group and reported to the People, Leadership and Culture Committee to strengthen organisational oversight and accountability.
- Priority actions include improving workforce representation at senior levels, reducing workforce inequalities, strengthening inclusive leadership, improving staff experience, supporting disability inclusion and reasonable adjustments, addressing bullying, harassment and discrimination, and embedding anti-discriminatory practice across the Trust.

Risks

Failure to deliver the EDI Plan may result in continued workforce inequalities, reduced staff engagement, difficulty attracting and retaining diverse talent, increased regulatory risk, and a negative impact on organisational culture, patient care and service quality.



Understanding the performance

The sickness absence rate has increased from 4.82% to 4.95% in May 2026, 0.45% above target.

Long term absence has increased, from 2.71% in April 2026 to 2.90% in May 2026, and short-term absence has increased slightly from 1.21% to 1.22%.

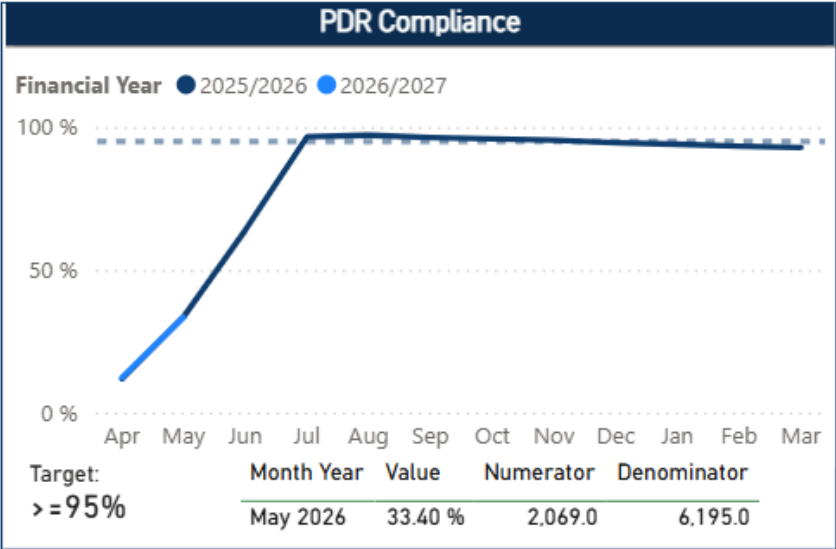
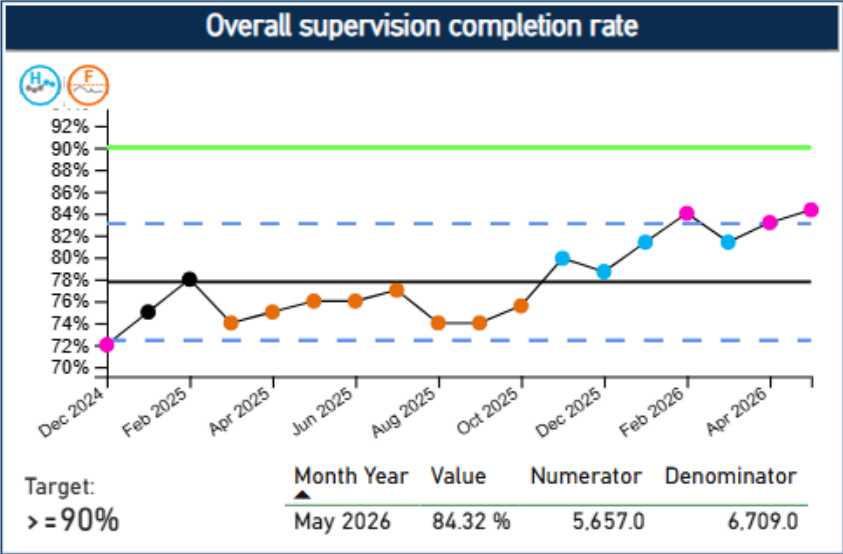
The most common reasons for absence based on number of cases were Cold/Cough/Flu, Gastrointestinal, Anxiety/Stress Non-work related, Headache/Migraine and Not Specified.

Actions (SMART)

- Absence levels are reviewed monthly in Operational Meetings/Service Reviews and in Directorate People Meetings/Senior Management Team meetings and the service areas with higher absences are highlighted.
- Human Resources (HR) Advisors are proactively working with managers to review sickness casework and to support to 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.
- Line managers are prompted to complete return to work interviews and information is disseminated within the directorates on any outstanding Return to Work Interviews.
- The NHS Medium Term plan states an ambition for all Trusts to reduce sickness absence levels to 4.1% in the new financial year and the Trust is considering what additional support measures we can provide to managers to support sickness management. A focused piece of work on absence management is planned for the second half of this financial year.

Risks

- If periods of long-term sickness absence are not regularly reviewed by the line manager, then this can potentially delay any return to work and result in longer periods of staff absence. This can also result in delays in progressing formal cases, where appropriate.
- 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.

Since the change to a single reporting mechanism for supervision in Autumn 2025 there has been a steady upward trend in compliance with Supervision at 84.32% in May 2026

The PDR season started on 1st April 2026 with Trust-wide communications highlighting resources available. PDR data will be reported in the IPR alongside August data.

Actions (SMART)

L&D are trialling detailed reports with service leads from psychological therapies who need to report on whether staff have completed weekly clinical supervision.

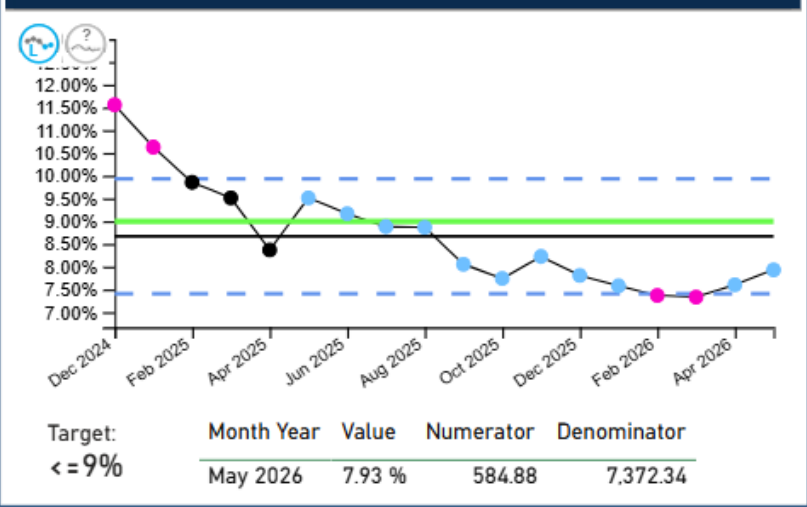
Managers are trialling changes in reporting including push emails reminding them that staff are going out of date for supervision. A Feedback questionnaire has been sent to review the usefulness as well as frequency before widening this roll out to all managers.

OD and L&D teams are planning work to address PDR quality/feedback and considering additional question in the Staff survey to inform actions taken.

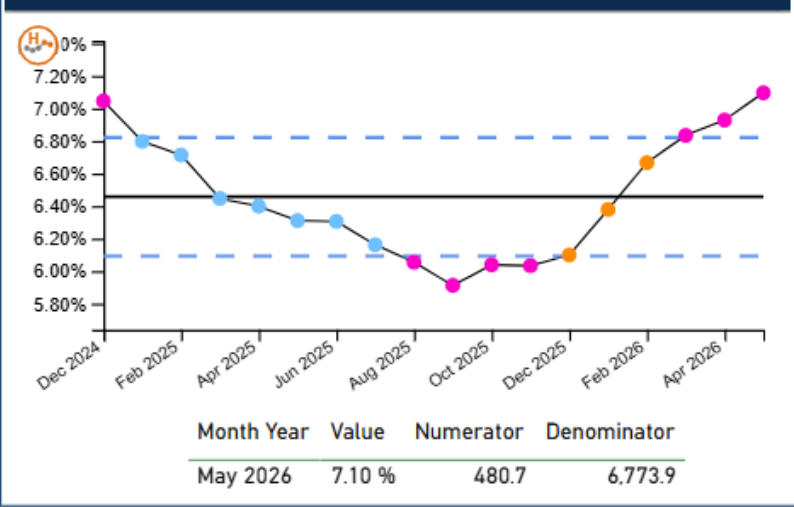
Risks

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, the rate has increased in May 2026 from 7.60% to 7.93% and remains below the 9% target.

Staff leavers - people leaving Oxford Health NHS Foundation Trust and not moving to another NHS employer has showed an increasing trend from December 2025 which will be monitored for any themes

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

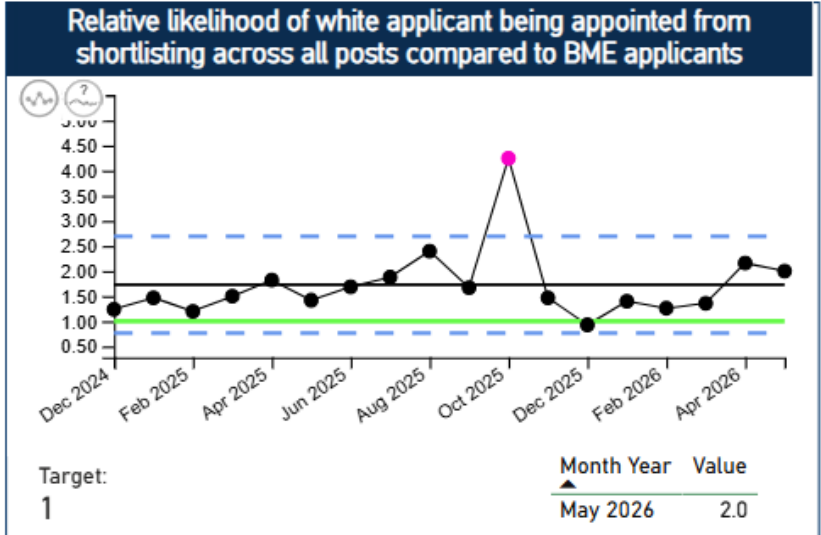
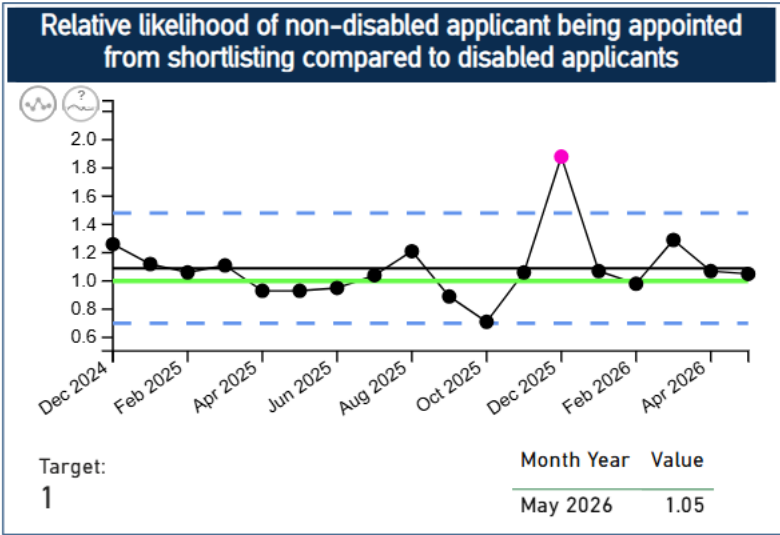
- The most recent centralised assessment centre delivered excellent outcomes across both nursing and HCA recruitment, with 100% of vacancies filled on the day. The event was structured in two phases: community hospitals recruited seven HCAs in the morning session, followed by forensic services appointing five nurses in the afternoon. Both directorates also established reserve lists, strengthening their ability to respond quickly to upcoming vacancies.
- The B5 & B6 generic nursing job descriptions have been created by recruitment and shared with the nursing leadership team for their input and work on creating standardised roles to reflect our nursing workforce. They are expected to complete this work at the end of June and report back to recruitment.

Recruitment Marketing and Communications:

- Weekly internal recruitment bulletin – Sent to all colleagues, consistently achieving 40%+ readership.
- Monthly external recruitment bulletin – 500+ subscribers with an average 70%+ readership.
- Apprenticeship Alert – 500+ subscribers receiving notifications as soon as apprenticeship opportunities are advertised.

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.
- Building sustainable talent pipelines, including early-careers, local and underrepresented communities 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 2.16 in April 2026 to 1.05 in May 2026. 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 1.07 in April 2026 to 2.0 in May 2026. 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)

- The Trust has approved the 2026 – 2028 Equality, Diversity and Inclusion (EDI) Plan, bringing together the actions from WRES, WDES, NHS England's EDI Improvement Plan, pay gap reporting, PCREF workforce actions and other national equality programmes into one coordinated delivery framework.
- Delivery of the plan is now underway, with progress monitored through the EDI Steering Group and reported to the People, Leadership and Culture Committee to strengthen organisational oversight and accountability
- Priority actions include improving workforce representation at senior levels, reducing workforce inequalities, strengthening inclusive leadership, improving staff experience, supporting disability inclusion and reasonable adjustments, addressing bullying, harassment and discrimination, and embedding anti-discriminatory practice across the Trust.

Risks

Failure to deliver the EDI Plan may result in continued workforce inequalities, reduced staff engagement, difficulty attracting and retaining diverse talent, increased regulatory risk, and a negative impact on organisational culture, patient care and service quality.

Section 4

Strategic dashboard

Strategic objectives

Board meeting in public



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Oxford Health
NHS Foundation Trust

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

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.

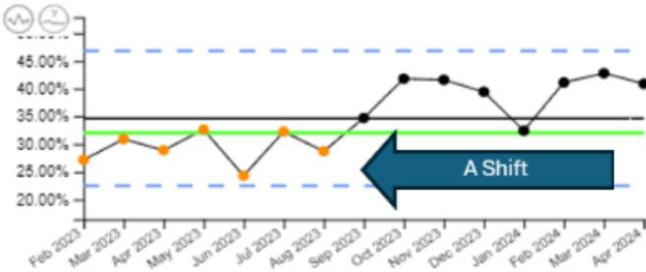
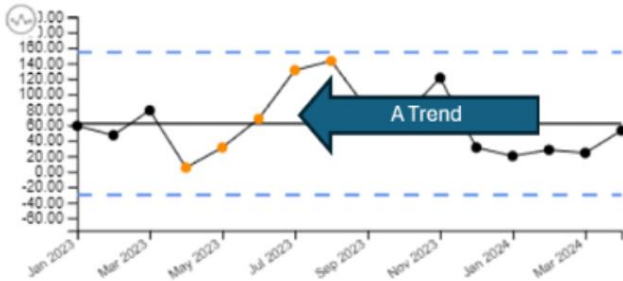
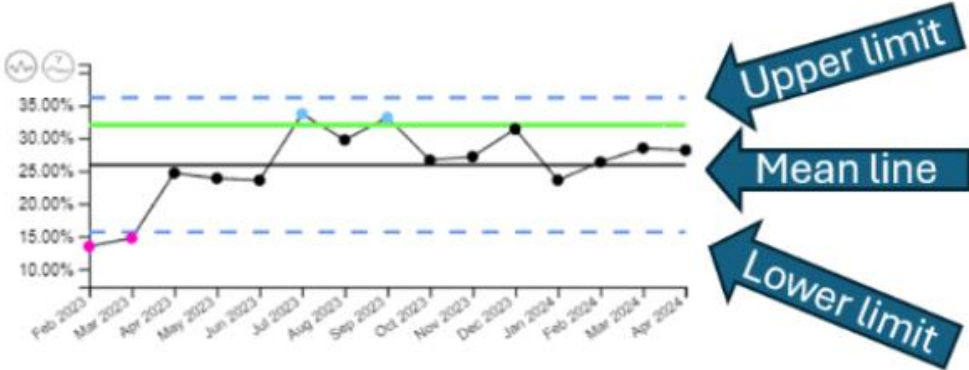
The SPC chart has three lines on it: central line (mean line; black) is the average of data and blue are upper and lower control limits. If data points are within the control limits, it indicates that the activity is within normal range. If the data points are outside of these control units, it indicates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

Board meeting in public

The below legends explain Variation and Assurance icons and Statistical Process Control (SPC) charts 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.

Guide to the Integrated Performance Report – Interpreting the Data Quality Indicator

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"

Board meeting in public Metric	Latest ICB Target	Page 243 of 530 Apr-26				
		TV ICB	Oxon	Bucks	Berks W	Frimley
Mean LoS adult acute and PICU discharges	44	55	61	32	61	62
Mean LoS older adult acute discharges	76	82	61	87	102	110
72hr Follow-up	null	90%	88%	84%	96%	94%
Absolute difference between White and non-White per 100,000 of CYP 1+ contact (12-month rolling)	null	1384	n/a	n/a	n/a	n/a
Absolute difference between White and non-White per 100,000 of detentions (12-month rolling)	null	35	n/a	n/a	n/a	n/a
Absolute difference between White British and non-White British per 100,000 CTOs (12-month rolling)	null	16	n/a	n/a	n/a	n/a
CYP 1+ contacts (target changing periodically)	33239	35030	9975	8850	9205	7045
CYP Paired scores (%)	null	19%	*	*	*	*
CYP Self-rated measurable improvement (%)	null	44%	*	*	*	*
CYP supported through NHS funded MH with a least 1 contact with an education-based MH support team (MHST)	5290	6565	1485	1480	1700	1905
Open CYP referral-spells with a MH related wait of more than 104 weeks for a full clock stop	6427	6035	3025	1005	1200	805
CYP ED Routine (interim)	null	85%	74%	91%	92%	100%
CYP ED Urgent (interim)	null	88%	81%	100%	*	*
Dementia: 65+ Estimated Diagnosis Rate	null	*	*	*	*	*
EIP 2 week waits	null	67%	57%	71%		71%
Inpatient No Contact	null	10%	12%	12%	9%	7%
Individual Placement and Support (IPS, rolling 12 month; target changing periodically)	1895	2020	805	350	450	410
OAPs active at the end of the period (inappropriate only)	5	10	*	*	5	*
Percentage of inappropriate OAPs bed days in Adult acute beds in the period	null	3.10%	0.30%	3.50%	5.50%	4.70%
Perinatal access (rolling 12 month)	2062	2055	710	390	705	250
Restrictive Interventions per 1,000 bed days	null	*	*	*	*	*
SMI PH (quarterly metric)	null	n/a	n/a	n/a	n/a	*
Talking Therapies Completing a course of treatment	2448	2275	815	760	370	335
Talking Therapies Reliable Improvement (target changing periodically)	69%	68%	66%	67%	70%	69%
Talking Therapies Reliable Recovery (target changing periodically)	51%	48%	47%	50%	47%	47%
Urgent referrals to CCS (contacts within 24hrs)	null	74%	79%	90%	68%	63%

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

- Data prior to April 26 not included due to BOB ICB becoming Thames Valley ICB on 1st April 2026

NHS Oversight Framework – dashboard (scored metrics) – quarter 3

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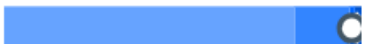
Domain	Metric	Metric score	Metric ranking	Metric reporting period	Metric value	Metric value change*	Average value (other providers)	NOF score	NOF score placement (national distribution)
Access to services	Percentage of patients waiting over 52 weeks for community services	3.62	37 out of 41	Dec-25	17.89%	↑	0.25%	2.73	
	Annual change in number of children and young people accessing NHS-funded Mental Health services	1.84	14 out of 49	Jan-25 - Dec-25 vs Jan-24 - Dec-24	13.61%	↑	7.09%		
Effectiveness and experience of care	CQC community mental health survey satisfaction rate	2	n/a	2024	.	n/a	.	2.31	
	Percentage of patients with >60-day length of stay (adult acute mental health; quarter)	3.23	35 out of 47	Q3 2025/26	28.34%	↓	23.24%		
	Urgent Community Response 2-hour performance (quarter)	1.68	11 out of 38	Q3 2025/26	88.57%	↑	86.40%		
Patient Safety	NHS Staff Survey - raising concerns sub-score	1.65	14 out of 61	2024	6.99	→	6.81	2.14	
	Percentage of patient in mental health crisis to receive face-to-face contact within 24 hours	2.63	27 out of 48	Q3 2025/26	64.21%	↑	65.99%		
People and workforce	Sickness absence rate	2.06	12 out of 61	Q2 2025/26	4.96%	↓	5.62%	1.88	
	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	28 out of 61	Dec-25	0.01%	→	0.01%		
	Relative difference in costs score	2.93	38 out of 61	2024-25	108.58	→	104.85		

↑ - improvement ↓ - regression → - no change

NHS Oversight Framework – dashboard (contextual (non-scored) metrics) – quarter 3

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Domain	Metric	Metric reporting period	Metric value	Metric value change (compared to previous quarter)	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 Sep-25	26.40%	↑	6.11%	4.26%	
	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	Sep-25	98%	↓	99%	98%	
Patient safety	Rate of restrictive interventions use per 1,000 bed days	To Sep-25	26	↑	15.5	21	
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	Sep-25	29.79%	↓	41.34%	40.88%	

↑ - improvement ↓ - regression → - no change

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		

↑ - improvement ↓ - regression → - no change

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

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*Contextual (non-scored) metrics were introduced in quarter hence no information for quarter 1

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%	

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

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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)

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 251 of 530	
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)

Area		Page 252 of 530	
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 253 of 530	
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	Waiting in public		Page 254 of 530
	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.
Quality and People	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.
	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 256 of 530
	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
Date of Meeting	22nd July 2026
Agenda item	12(b)
Report title	Quality and Safety Dashboard
Executive lead(s)	Britta Klinck, Chief Nurse
Report author(s)	Jane Kershaw, Head of Patient Safety
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board	Quality surveillance report.
For disclosure or confidential	Disclosure

Executive summary

This is a monthly Quality and Safety Dashboard reporting by exception that is used as part of The Trust's quality surveillance and reported into a number of forums across the Trust. The data being presented is for 31st May 2026 and waits data is pulled at the time of writing the dashboard. Indicators are reviewed across the quality domains which are listed in Appendix A these cover workforce and the quality domains of safety, clinical effectiveness and patient experience.

There are three teams/wards identified in enhanced support; CAMHS Meadow PICU, CAMHS Highfield and the City and NE AMHT. These teams have been in enhanced status for more than 6 months. The mitigations and actions being taken and oversight is detailed in the report.

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

The Dashboard is a regular paper, developed with input from the Clinical Directorates. It is presented monthly to the Quality and Clinical Governance Group chaired by the Chief Nurse and Chief Medical Officer, and quarterly to the Trust's Quality Committee.

Recommendation(s)

The Trust 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

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	We are nationally required to report on the inpatient staff fill rates to Trust Board members, this role has been delegated to the Quality Committee. Inpatient staff fill rates is an indicator considered in the monthly dashboard.	

1. Introduction

The information in the Quality and Safety Dashboard is based on data for 31st May 2026. However as waiting list data is point prevalent this is pulled at the time of writing the dashboard in early June 2026. 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.

Development of Indicators

The list of indicators reviewed are provided in Appendix A these cover workforce and the quality domains of safety, clinical effectiveness and patient experience. We continue to make developments on the automated quality dashboards available on TOBI.

Escalation Criteria

The escalation criteria used in the Dashboard was reviewed and update by the Quality and Clinical Governance Group in May 2026 and shared with the Quality Committee.

2. 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 based on the escalation criteria.

The three teams/wards in enhanced support have been the same for more than 6 months. Mitigations and actions detailed from page 19.

The changes this month are as follows;

- ❖ Moved out of early warning: Phoenix ward
- ❖ New to early warning: Sapphire ward, Ashurst Adult PICU, Oxon South Adult Assessment and Treatment Team, Oxon Adult Psychological therapies
- ❖ Moved from enhanced to early warning: no teams.
- ❖ New to enhanced support: no teams.

	Enhanced Support	Early Warning	
Inpatient Wards	• CAMHS PICU Meadow Unit • CAMHS Highfield	• Ruby ward • Sapphire ward • Ashurst Adult PICU	
Community Teams	• Oxon City and NE AMHT (Aspen Team)	• Aylesbury CMHT • 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 • District Nursing service	• Children's Speech & Language • Adult Speech & Language • Nutrition and Dietetics • Community Respiratory service • Podiatry • Special Care & Paediatric Dentistry • Oxon South Assessment and Treatment Team (Adult) • Oxon CAMHS • BSW CAMHS • Oxon Complex Needs Service • Oxon OA Memory Clinic • Oxon Adult PCMHT (Keystone Hubs) • Oxon Adult Psychological therapies

The rest of the report is organised by clinical Directorate.

3.1 Performance on inpatients followed up within 48 hours of discharge

The national rules have changed from January 2026 with the timescale now measured in days rather than hours and a contact on the day of discharge can now be included.

The performance for May 2026 is 33 eligible discharges in the 'Bucks Place' commissioning area and 3 breaches to 48-hour follow, detailed below;

- 1 patient there were several unsuccessful attempts to see them at home for a review. Outside the 48-hour period the Crisis team made contact on day 4 after discharge.
- 1 patient with no fixed abode and would not engage with follow up, however has now been readmitted.
- 1 patient on discharge returned to Hungary.

3.2 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
Ruby ward	• Vacancies in May 2026 at 6.4% (reduced from previous months). Sickness 12.4% most likely related to a very challenging time on the ward. Safe staffing fill rates have been exceeded to offer the staff team and patients more support. There is a high use of medic agency staff, 59% in May 2026. There have been 18 admissions/transfers in May 2026 and high bed occupancy. • High number of patients incidents in May 2026 related to a small number of patients. The acuity on the ward has been high. The number of incidents in May was much higher than other months. 1 incident had moderate harm (violence patient on patient) and 1 was fatal, an inpatient unexpectedly died on the Whiteleaf Centre site, a post mortem is being completed. A PSI investigation has been declared to identify learning. • Patient violence towards staff remained higher in May 2026, although no RIDDOR incidents reported. • There were 6 uses of seclusion in the month involving 3 patients. • 5 rapid resolution complaints were received in the month in relation to a number of concerns, this is much higher than usual. No IWGC surveys were received in May 2026. There was 1 enquiry from the CQC in May 2026 about the treatment for a patient.
Sapphire ward	• The number of incidents increased in May 2026, mostly related to violence both patient on patient and patient to staff. Although all resulted in no harm or minor harm. There was a fire incident on the ward in May, no patients or staff were injured. Initially 10 patients were moved to alternative beds and currently 2 bedrooms remain out of order. There was a disruption to service provision and an increased use of out of area placement beds followed for new admissions. Immediate actions were identified in relation to patients access to contraband items (lighters) and review of mattress specifications. A PSI investigation has been declared to identify learning with multiagency involvement. • 3 AWOLs in May 2026 involving 2 patients. The ward on average has 2 AWOLs a month. • There was 1 enquiry from the CQC in May 2026 about the treatment for a patient.

- Overall supervision at 50% in May 2026.

Community Teams at Early Warning

Team	Reason for highlighting
Aylesbury CMHT (adult)	• In May 2026 – 2 early resolution concerns and 3 rapid resolution complaints received about discharge, medication and change in care team. • 27 patients waiting more than 4 weeks to be seen, as of end of May 2026 (28 patients last month). 2 patients have waited 12-26 weeks but 0 patients have waited longer, this is a reduction from 9 last month. • Performance with patients on open caseload having a care plan on RiO or True Colours (May 2026); 44.9%, same as last month. [There is a caveat with the performance reporting on care plans as the denominator includes some patients not yet seen and patients open to psychiatry/psychology where there is not the same requirement for these professionals to complete a care plan in the care plan templates on RiO/True Colours.] • The team has had some staffing challenges related to long term leave. Vacancies improved in May 2026, agency use 9% and sickness at 11.3%. • Supervision rate in May 2026 at 82%, improvement from last month.
CAMHS ADHD and Autism service	• As of 1st June 2026: 3,861 patients waiting for assessment (last month at 3,835). Mean wait time 83 weeks. 149 new referrals received this month. Nearly half of the patients waiting have waited more than 2 years. Longest waiter 5.6 years. There are also a significant number of patients waiting for on average 52 weeks post assessment to start medication. • Staff vacancies including for medics high in May 2026; around 32.7% (same as last month).
Adult ADHD and Autism	As of 1st June 2026, • Adult ADHD: 882 patients waiting for assessment (last month at 924). Mean wait time 151 weeks. 1 new referral received this month. Longest waiter 4.2 years. • Adult Autism: 446 patients waiting for assessment (last month at 449). Mean wait time 109 weeks. 7 new referrals received this month. Longest waiter 6.8 years. A patient safety thematic review has been started across Buckinghamshire and Oxfordshire services as there have been a number of deaths identified for patients on the ADHD waiting list since early 2022. Buckinghamshire, Oxfordshire and Berkshire ADHD working group tasked with developing ADHD offer across region, within context of current demand and the capacity gap.
Complex Needs Service	National 4 week wait target, as of end of May 2026 (based on patients that have not yet had an initial contact, pathway level); 27 patients waiting (33 last month). 3 patients have waited more than a year a reduction from 6 reported last month. Large number of clients waiting for MBT and Therapeutic community groups. Prioritising changes to expand capacity and access to the service. Considerable work implemented in ensuring therapeutic community group is at capacity. Inviting larger numbers to preparatory group to reduce drop out numbers.
Memory services	As of end of May 2026– 755 patients waiting for 60 days or longer against wait standards (last month 785 patients). 13 patients have been waiting for more than 1 year a slight increase from 11 reported last month.

Team	Reason for highlighting
	Vacancies much improved in May 2026 to 9.3% from 18.4% last month.
Adult PCMHT	National 4 week wait target, as of end of May 2026 (based on patients that have not yet had an initial contact, pathway level); 142 patients waiting (144 last month). 3 patients waiting for more than a year a reduction from 5 patients last month. Deep dive on position to the QCG Group in May 2026.
	Both vacancies and supervision rate (87%) improved from last month.
Adult Psychological therapies	National 4 week wait target, as of end of May 2026 (based on patients that have not yet had an initial contact, pathway level); 36 patients waiting (30 last month). 1 patient has waited more than a year a reduction from 4 last month.

4. Community Health Services, Dentistry and Primary Care

4.1 Detail about wards and community teams highlighted

There are no wards/teams identified at Enhanced Support.

Wards at Early Warning

None of the quality indicators are flagging however the following wards are reported as not meeting the internal Trust target of minimal safe staffing levels in May 2026;

- Abbey ward: Day and night registered staff levels are lower than expected at 75% and 70%. Sickness was 8.3% in May 2026. Bed occupancy 100%.
- Didcot ward: Day registered staff 79% with staffing met through an increase of above 100% of unregistered staff. Sickness was 11.7% in May 2026. Bed occupancy is at 100%.
- Linfoot ward: Night registered staff 71%. Vacancies at 11.2%. Bed occupancy 84%.
- Wenrisc ward: Day shifts for registered (67%) and unregistered staff (73%) and nights shifts for registered staff (71%) are below the expected levels. Bed occupancy at 77%.

Community teams at Early Warning

Team	Reason for highlighting
District Nursing Service	• The service sees around 12,000 patients a month. There has been recent investment into the service which will help greatly however demand is still higher than capacity. There are around 500 cancelled/deferred appointment each day whereby capacity cannot meet demand. On average 13 incidents are reported a month related to a delay in treatment, in May 2026 there were 19 delay related incidents of which 2 resulted in moderate harm. • The number of incidents with moderate and severe harm have very slightly increased in 2026, with more months being above the average rate but there is not a consistent upward trend. Most of the incidents with moderate/severe harm relate to category 3 pressure damage followed by deep tissue injuries and this is where we have seen a small increase with 5 of the last 6 months slightly above the average number. Most of the incidents are reported by the SW locality, then City and West localities. • There were 3 PSIRP cases declared in May 2026 (2 involving the North locality) in relation to pressure ulcer care and delay in accessing care. Early learning around cancellation of appointments, capacity issues and escalation. • There was 2 RIDDORs in May 2026 related to manual handling both involving staff in the South East locality. The South East locality has had no other RIDDORs in the last 12 months and this is a sharp increase for the whole service. • Supervision rates in May 2026 range from 66% (North locality) to 90% (City locality). • In May 2026 the service received 1 early resolution, 2 rapid resolution complaints

Team	Reason for highlighting
	and 1 low level complaint. No increase in concerns received in May. The concerns have been raised about all localities and mostly concern insufficient care and communication.
Children's Integrated Therapies – speech and language	- As of end of May 2026: 1,556 patients are waiting to be seen, less than last month (when there were 1,709 patients). Of which 1,306 patients have been waiting for more than 12 weeks (reduction from last month). 492 patients have waited longer than a year, this is a reduction from 585 last month. Median length of time to wait 34 weeks/average 37 weeks. - There are also smaller waits for the CIT OT (overall 52 patients waiting, reduction from last month) and physiotherapy services (overall 751 patients waiting, reduction from last month).
Adult Speech and Language	- As of end of May 2026: 485 patients are waiting to be seen, more than last month (when there were 441 patients). 82 patients have been waiting for more than 12 weeks (increase from last month), but 0 patients have waited longer than a year. Median length of time to wait 5 weeks/average 7 weeks. - In May 2026 vacancies at 16.1% (same as last month).
Nutrition and Dietetics	As of end of May 2026: 307 patients are waiting to be seen, less than last month (when there were 385 patients). Of which 129 patients have been waiting for more than 12 weeks (less than last month). 0 patients have waited longer than a year. Median length of time to wait 10 weeks/ average 11 weeks.
Community Respiratory service (respiratory, COPD and home oxygen assessment)	As of end of May 2026: 155 patients are waiting to be seen, less than last month (when there were 172 patients). 92 patients have been waiting for more than 12 weeks (less than last month), and 0 patients have waited longer than a year. Median length of time to wait 18 weeks/average 17 weeks.
Podiatry	- The service has a caseload of around 9,200 patients. - As of end of May 2026: 1,879 patients are waiting to be seen, less than last month (when there were 1,961 patients). Of which 400 patients have been waiting longer than a year (reduction from last month when there were 493). Median length of time to wait 31 weeks/average 33 weeks. - There are also waits between treatment, including high risk/urgent patients on weekly follow up appointments that are being deferred due to capacity and pressure on the service. - Vacancies in May 2026, 35.6% (slightly improved from last month) and agency use 6%. - In May 2026 there were 21 incidents mostly relating to patient ambulance transport. Only 1 related to a delay in treatment. All of the incidents resulted in no harm or minor harm. - There were no concerns or complaints raised in May 2026 and only 1 rapid resolution complaint in April 2026.
Special Care & Paediatric Dentistry	Waits for treatment under general anaesthetic (GA) for both children and special care adults, as of 18th June 2026 (snapshot in time): 115 children on the waiting list (145 last month), with waiting times currently up to 6 months. 37 children waiting > 18 weeks (51 last month). These waiting times are likely to increase due to the suspended Horton Hospital theatre use from 23/04/2026 for 6 months. 12 weekend sessions held year to date - 44 children treated. (FY 26/27) 13 adults who have been assessed and are waiting for treatment at the Horton

Reason for highlighting

Hospital (8 last month), with waiting times of up to 8 weeks. 6 adults assessed and waiting for treatment at JR, waiting times up to 2 years (same as last month).

- 15 adults waiting for joint dental/anaesthetic assessment (waiting time from referral to assessment is up to 3 months). (9 adults waiting last month)
- Additional paediatric GA weekend sessions continuing when available—commissioners confirmed the carry-over of remaining reset and restoration funding to FY27.

5. Forensic Services

5.1 Detail about wards and community teams highlighted

There are no wards/teams identified at Early Warning or Enhanced Support. However the below two wards are noted because of one indicator flagging.

Kingfisher ward continues to manage two very acutely unwell patients that have a high amount of self-harm incidents and are verbally abusive and physically violent towards staff impacting on morale and sickness. 2 RIDDOR cases related to violence were reported in May 2026. High sickness at 25%. The 2 patients are managed in long term segregation, with 1 patient having been in segregation since Sept 2025. There are zero vacancies and safe staffing levels exceeded as staff from Kestrel have moved to work on Kingfisher ward since the temporary ward closure from October 2025.

Wenric ward used the restraint position of prone was used 6 times in May 2026 involving 1 patient, 3 for IM and 3 for a seclusion procedure. The ward has experienced a high number of violent incidents toward staff in May 2026, mostly verbal abuse involving a couple of patients. Vacancies are 10.6% and sickness 7.2% in May 2026 although safe staffing levels have been exceeded.

6. Learning Disability Services

6.1 Detail about community teams highlighted

There are no wards/teams identified at Early Warning or Enhanced Support. However, there are high vacancies in the **Intensive Support Team** for behavioural assistants unregistered staff (24.5% in May 2026, same as last month) and **Reasonable Adjustment Service** (57% in May 2026, worse than last month). The capacity shortages are being met currently by SLT members and cross working between teams.

7. Oxfordshire and BSW Mental Health Services

7.1 Performance on inpatients followed up within 48 hours of discharge

The national rules have changed from January 2026 with the timescale now measured in days rather than hours and a contact on the day of discharge can now be included.

The performance for May 2026 is 47 eligible discharges in the 'Oxon Place' commissioning area with 2 breaches to 48-hour follow up, detailed below;

- 1 patient was contacted within 72 hours but not 48 hours.
- 1 patient was discharged out of area with another NHS Trust completing the follow up of care.

In addition, there was 1 further breach for a patient commissioned by Berkshire that was discharged out of area from Ashurst PICU with another NHS Trust completing the follow up of care.

7.2 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 Highfield
- City and NE AMHT, predominantly Aspen Team

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

Wards identified at early warning

Team	Reason for highlighting
Ashurst Adult PICU	• 17% vacancies in May 2026. Safe staff fill rates were met in month however there was a skill mix change with more unregistered staff than registered staff on night shifts. Registered staff fill rate at night 83%. Activity: 6 admissions/transfers in month and bed occupancy 89%. • The unit has had a high number of violent incidents from patients to staff in April and May 2026. Although no staff RIDDORs reported. • The unit received 1 early resolution concern and 2 rapid resolution complaints in May 2026. These were about consent to treatment, medication and staff behaviour. The unit had no feedback via IWCG surveys. • There were 2 enquiries from the CQC in May 2026 about the treatment for 2 different patients. • Restrictive interventions; 25 physical restraints (involving 6 patients) including 1 use of prone, 1- seclusions episodes, 9 uses of rapid tranquilisation and 1 use of LTS. Use of physical restraint, rapid tranquilisation and seclusion increased in May 2026.

Community Teams at Early Warning

Team	Reason for highlighting
South Assessment and Treatment Team (Adult)	• Increase in low level complaints in April and May 2026, 3 received across 2 months mostly about insufficient care and communication. • Number of suspected suicides has increased slightly, although the number of deaths are small. There was 1 suspected suicide in April and 2 in May 2026. 2 out of the 3 patients were open to the team at the time they died. The number of self-harming incidents on average is 4 a month (all degrees of harm) but there has been no change over time and there have been 0 with moderate harm in April and May 2026. • Vacancies are low, 11.6% in May 2026, sickness 6.3% in May 2026, no agency use and fill rates good. • Performance with patients on open caseload having a care plan on RiO or True Colours (May 2026); assessment team 31.7% and treatment team 70%. [There is a caveat with the performance reporting on care plans as the denominator includes some patients not yet seen and patients open to psychiatry/psychology where there is not the same requirement for these professionals to complete a care plan in the care plan templates on RiO/True Colours.] • Patients waiting more than 4-week wait (based on patients that have not yet had an initial contact, pathway level) as of end of May 2026; 10 patients for assessment team and 3 patients for treatment team all within 12 weeks.
CAMHS and service	ADHD Autism
	As of 1 st June 2026 –4,737 patients waiting for assessment (last month at 4,783), about half have waited for more than 2 years. Average wait for assessment 111 weeks. 46 new referrals received this month. Longest waiter 7.4 years.

	There are also a significant number of patients waiting for a long period for medication to be started post assessment. Vacancies at 19.6% in May 2026, same as last month. The service receives a number of complaints, concerns and MP enquiries about waiting times. In the last 3 months up to end of May 2026 the service received 6 rapid resolution complaints and 3 low level complaints mostly about waiting times. There was an increase in complaints in April 2026.
Oxon CAMHS	The demand for services has increased with around 500-600 referrals each month. National 4 week wait target, as of end of May 2026 (based on patients that have not yet had an initial contact, pathway level); • 158 patients waiting for Getting Advice (SPA) (last month at 134). 6 patients reported as having waited for more than a year. • 32 patients waiting for Getting Help (48 last month). 1 patient is waiting for more than a year. • 27 patients waiting for Getting More Help (26 last month). 2 patients are waiting for more than a year. • 6 patients waiting for Learning Disabilities CAMHS team (3 last month). 1 patient waiting for more than a year. • 18 patients waiting for MHST (21 last month), of which 4 patients are waiting for more than a year. Vacancies in May 2026 high for; FASS team 22.6% (improved from last month), CABHS 26.8% (same as last month), CAMHS LD 25.2% (same as last month), CAMHS Eating Disorders 32.8% (worse than last month), and CAMHS Crisis/outreach 40.6% (worse from last month). There are also significant medic vacancies across a number of teams.
BSW CAMHS	National 4 week wait target, as of end of May 2026 (based on patients that have not yet had an initial contact, pathway level); • 53 patients waiting for Getting Advice (SPA) (39 last month) • 2 patients waiting for Getting Help (5 last month) • 9 patients waiting for Getting More Help (11 last month) • 1 patient waiting for Learning Disabilities CAMHS team (1 last month). • 39 patients waiting for MHST (58 last month) High use of medic agency staff across all BSW teams.
Adult ADHD	The Oxfordshire Adult ADHD Service lacks sufficient operational capacity to meet demand - the service closed to new referrals in 2024 and has a waiting list of 1,842 patients awaiting assessment as of 1st June 2026 (last month at 1,887), while the average waiting time for assessment is 169 weeks. Longest waiter is 6.5 years. Waiting time from diagnosis until first titration appointment for appropriate medication is approximately 19 months. The number of patients waiting 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. Each new titration will require a minimum of 3 appointments across a three-month period. A patient safety thematic review has been started across Buckinghamshire and

		Oxfordshire services as there have been a number of deaths identified for patients on the ADHD waiting list since early 2022. Buckinghamshire, Oxfordshire and Berkshire ADHD working group tasked with developing ADHD offer across region, within context of current demand and the capacity gap. Vacancies at 19% in May 2026.
Complex Needs Service		National 4 week wait target, as of end of May 2026 (based on patients that have not yet had an initial contact, pathway level); 88 patients waiting (last month 114). 18 patients have been waiting for more than a year, a reduction of 1 patient from last month.
Memory clinic services		As of end of May 2026– 450 patients waiting for 60 days or longer against wait standards (last month 566 patients). 17 patients have been waiting for more than 1 year an increase from 13 reported last month.
Adult PCMHT (Keystone teams)		National 4 week wait target, as of end of May 2026 (based on patients that have not yet had an initial contact, pathway level); 57 patients waiting (80 last month). 0 patients have been waiting for more than a year.
Adult Psychological therapies		National 4 week wait target, as of end of May 2026 (based on patients that have not yet had an initial contact, pathway level); 43 patients waiting (increase from last month). 1 patient has waited more than a year.

Teams/Service	In last Dashboard under Enhanced Support?	Reason for Highlighting	Mitigations & Actions
CAMHS PICU Meadow Unit	Yes	- In May 2026 vacancies at 19.31% (improvement from last month) and agency use 8.6%. Safe staff fill rates were met in month however there was a skill mix change with more unregistered staff than registered staff on night shifts. Registered staff fill rate at night 83%. Activity: 0 admissions/transfers in month and bed occupancy 38%. - High use of restrictive interventions to mostly prevent patients from self-harming, in May 2026: 78 physical restraints involving 3 patients, 0 uses of prone position. 14 uses of seclusion involving 2 patients and 10 uses of rapid tranquilisation involving 1 patient. Overall, 1 patient accounted for 68 interventions. The use of physical restraint is reducing as is the use of rapid tranquilisation. - The number of patients incidents has reduced in May 2026, although remains high. In May 2026 there were 99 patient incidents involving 4 patients. The majority relate to self-harm and either resulted in no harm or minor harm. - Violence towards staff and staff injuries with harm was high in May 2026, although there were 0 RIDDORs. - The ward has received 0 high/low complaints or concerns in May 2026. But also no feedback via IWCG surveys.	Improvement plan in place with fortnightly oversight by the SLT. Recruitment is ongoing. % vacancies improved from last month. Safe staffing levels are being met and bed occupancy is low. List of key work happening to reduce restrictive practice. There has been a reduction seen; - Meadow PICU and Highfield are engaging in the HOPE programme, an evidence-based approach to reduce long term segregation and restrictive interventions. - All CAMHS inpatient wards have allocated staff to attend RAID (Reinforce Appropriate, Implode Disruptive) Training , a positive psychological approach for managing challenging behaviours. - Weekly working group with the aim of reducing violence and aggression which is often a precipitating factor for restrictive practices. - Engagement in the Positive and Safe Forum with current focus on debriefs for staff and patients. - Seclusion audits are being completed for all episodes of seclusion. - Evidence of therapeutic interventions/de-escalation included in all incident reports and progress notes - Implementation of shared learning from incidents meetings with a focus on reducing restrictive practices - All wards have positive engagement/ activity workers to promote engagement in therapeutic activities - Introduction of prone review panel process from May with fortnightly Trust-wide review of all uses of prone.
CAMHS Highfield	Yes	In May 2026 vacancies at 12.5% (improved from last month) and sickness 6.8%. Safe staff fill rates were met, with the exception of a skill mix change for night shifts with more unregistered and less registered staff than	Improvement plan in place with fortnightly oversight by the SLT. Recruitment is ongoing. % vacancies improved from last month. Safe staffing levels are being met and bed occupancy is low.

Teams/Service	In last Dashboard under Enhanced Support?	Reason for Highlighting	Mitigations & Actions
		planned. Registered staff fill rate at night 67%. Activity: 3 admissions/transfers in month and 63% bed occupancy. • Overall supervision rate for May 2026 77%. • High use of restrictive interventions in May 2026 mostly to prevent patients self-harming; 73 physical restraints involving 6 patients, 4 uses of prone restraints involving 1 patient (3 for IM and 1 unintentional led by patient), 28 uses of rapid tranquilisation (involving 2 patients). 1 patient has been in LTS for 214 days in the past 6 months. Overall, 1 patient accounted for 39 interventions. The use of physical restraint and rapid tranquilisation has reduced in May 2026 from a spike in April 2026 but is still at a higher level. • The number of patients incidents has reduced in May 2026, although remains high. In May 2026 there were 2 moderate harm incidents for the same patient relating to self-harm by ingesting a harmful item. • The ward has received 1 low level complaint, 1 early resolution concern and 1 rapid resolution complaint in May 2026 around the theme of staff behaviour and communication. The number of complaints/concerns is a bit higher than usual. There was one IWCG survey feedback in the month which had some very positive feedback for named staff members and also a suggestion about how to improve the use of restraint. The ward also has parent forums, weekly patient 'have your say' meetings and monthly patient forums.	List of key work happening to reduce restrictive practice. There has been a reduction seen; • Meadow PICU and Highfield are engaging in the HOPE programme, an evidence-based approach to reduce long term segregation and restrictive interventions. • All CAMHS inpatient wards have allocated staff to attend RAID (Reinforce Appropriate, Implode Disruptive) Training , a positive psychological approach for managing challenging behaviours. • Weekly working group with the aim of reducing violence and aggression which is often a precipitating factor for restrictive practices. • Engagement in the Positive and Safe Forum with current focus on debriefs for staff and patients. • Seclusion audits are being completed for all episodes of seclusion. • Evidence of therapeutic interventions/de-escalation included in all incident reports and progress notes • Implementation of shared learning from incidents meetings with a focus on reducing restrictive practices • All wards have positive engagement/ activity workers to promote engagement in therapeutic activities • Introduction of prone review panel process from May with fortnightly Trust-wide review of all uses of prone.
City and NE AMHT, predominantly Aspen Team	Yes	• Vacancies as of May 2026; Aspen 10.6% (similar to last month), Oak 12% (similar to last month) and Willow no vacancies. Sickness has been high in Aspen team (11.8%) and Oak (15.3%). • In May 2026 the AMHT has received 3 rapid resolution complaints and 1 low level complaint. In both April and May the team has received 1 low level complaint. The	There is an improvement plan in place overseen by the Directorate SLT. Below are the key actions in progress; Staff consultation to create a separate North East AMHT based primarily in Bicester and merge the remaining City GP's into Willow and Oak has ended and a decision made to go ahead with the proposal. Work has now started on implementing the change

Teams/Service	In last Dashboard under Enhanced Support?	Reason for Highlighting	Mitigations & Actions
		common themes are insufficient care and staff behaviour. 11 incidents in May 2026, 5 of which related to medicine management. 2 of the 11 incidents were self-harm and resulted in moderate/severe harm. The number of self-harm incidents is below average in May 2026. There have been raised levels Jan-April 2026 but these have reduced this month. - There have been historic PSIRP cases with significant learning for the AMHT. There has only been 1 PSIRF case started in 2026. - Supervision rates in May 2026 were 58% in Aspen, 95% Oak and 96% in Willow. - Performance with patients on open caseload having a care plan on RiO or True Colours (May 2026); Aspen 53.8% (55% last month), Oak 56.4% (57% last month) and Willow 50.1% (49% last month. [There is a caveat with the performance reporting on care plans as the denominator includes some patients not yet seen and patients open to psychiatry/psychology where there is not the same requirement for these professionals to complete a care plan in the care plan templates on RiO/True Colours.] - Patients waiting more than 4-week wait (based on patients that have not yet had an initial contact, pathway level) as of end of May 2026; 9 Aspen (same number as last month), 15 Oak (10 patients last month) and 16 Willow team (12 patients last month). This does not show patients with no allocated Key Worker which is an issue in Aspen team currently being mitigated through use of duty team.	which will require staff changes, communication with GPs and patients and recruitment to new posts. Caseload management. Aspen in particular has been using a “team working” caseload due to vacancies and limited options for Key worker allocation – agency staff have been recruited to assist with this. Ongoing Caseload cleansing required to ensure that the patient caseload is accurate. A caseload weighting tool is being used but challenging to fully adopt whilst there are significant staffing pressures. RiO “waiting list” – some delays due to adjustment of lists and ensuring staff are adequately trained. Aspen has significant staffing pressures due to sickness and recruitment needs. The CRHT Team have been supporting alongside use of NHSP bank staff and agency staff. All three teams are facing recruitment pressures currently with significant movement of staff to other services. Aspen and Oak are recruiting Band 6 agency staff due to vacancies. Consultant allocation –there is a need to agree a consistent approach to consultant allocation across all AMHTs.

Appendix A. Indicators used for the Dashboard

Board meeting in public

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	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%)	
	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
	Number of violent incidents towards staff (all levels of harm)	Number of violent incidents towards staff (all levels of harm)
	Number of AWOLs for detained patients (mental health) and number of Fall incidents with harm 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
	Supervision	Supervision
	Overall Mandatory Training performance	Overall Mandatory Training performance
	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 (manually added)	Clinical audit starting with the mental health Core clinical standards audit (manually added)
	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
	IWCG number of responses/average score across reviews in month	IWCG number of responses/average score across reviews in month

For Information

Finance Report May 2026 (Month 2 FY27)

Report to Board of Directors

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9. Working Capital Indicators
10. Variances report to NHS England

Annexes (private report only)

- A. Directorate Financial Performance
- B. Block Income Variances
- C. Provider Collaborative Financial Performance
- D. 26/27 Contracts & Contract Variations not signed
- E. Pay Spend Analysis
- F. Non-Pay Expenditure analysis
- G. Out of Area Placements

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



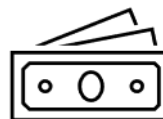
Income & Expenditure position

- Month 2 YTD: £0.5m surplus, £0.2m better than plan



Capital Expenditure

- Month 2 YTD: £1.3m below plan



Cash

- Actual £105.6m

Key messages:

1. The month 2 I&E position was a deficit of £0.3m following the accounting correction from the sale of South Parade, which had created a surplus to plan in M1 (as notified in the M1 report). YTD however the Trust remains in surplus and better than plan, £0.5m and £0.2m respectively. Agency spend remains lower than our NHSE target, £0.3m under as at M2.
2. Gross capital spend for the year to date is £0.8m, though reduced down to £0.4m due to a £0.4m VAT reclaim. Work remains ongoing, though moving forward positively, for additional constitutional standards capital funding from NHSE. This would be allocated across this and the following 3 financial years (total 4 year capital funding period).
3. Contract finance discussions have now concluded with our main ICB and NHSE contracts, with agreement reached on both. Some residual discussions remain ongoing for low value contracts which will not impact on the Trust's ability to deliver its financial plan.

1. Directorate Financial Performance Summary

Directorate	Month 2				Year-To-Date			
	Plan	Actual	Variance	Variance	Plan	Actual	Variance	Variance
	£m	£m	£m	%	£m	£m	£m	%
Oxfordshire & BSW Mental Health	13.2	13.0	0.2	0.0%	26.2	26.1	0.1	0.3%
Buckinghamshire Mental Health	6.3	6.7	-0.4	-5.6%	12.9	13.3	-0.4	-3.4%
Forensic Mental Health	3.2	3.1	0.1	3.3%	6.5	6.4	0.1	0.9%
Learning Disabilities	0.6	0.7	-0.1	-19.8%	1.2	1.5	-0.4	-32.8%
Provider Collaboratives	-0.1	-0.1	0.0	0.0%	-0.2	-0.2	0.0	0.0%
MH Directorates Total	23.2	23.4	-0.2	-0.8%	46.5	47.2	-0.7	-1.5%
Community Health Services, Dentistry and Primary Care	9.3	9.2	0.1	0.7%	18.4	18.2	0.2	1.1%
Corporate	4.0	3.9	0.1	1.4%	7.9	7.4	0.5	6.5%
Estates & Facilities Directorate	2.6	2.4	0.1	4.7%	5.1	5.0	0.1	2.9%
Oxford Institute Of Clinical Psychology Training	0.0	0.0	-0.1	437.4%	0.0	0.1	-0.1	549.1%
Pharmacy Directorate	0.3	0.3	0.0	-5.1%	0.5	0.5	0.0	-5.7%
Oxford Pharmacy Store	-0.1	-0.1	0.0	-2.5%	-0.3	-0.3	0.0	-0.9%
Research & Development	0.1	0.1	0.0	-0.3%	0.1	0.1	0.0	22.1%
Reserves	0.2	-0.1	0.2	-132.4%	0.0	-0.1	0.1	281.4%
Block Income	-40.8	-40.7	-0.1	-0.3%	-81.5	-81.4	-0.2	-0.2%
EBITDA	-1.5	-1.6	0.1		-3.3	-3.3	0.0	
Financing Costs	1.6	1.9	-0.4	-25.0%	3.1	2.9	0.2	7.7%
Adjustments	0.0	0.0	0.0		0.0	0.0	0.0	
Adjusted (Surplus)/Deficit	0.0	0.3	-0.3		-0.2	-0.5	0.2	

The month 2 position is a £0.5m surplus, £0.2m favourable to plan.

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

2. Capital Investment Programme – 2026/27

Actual Spend vs Profile to M2

Project Groups	Full Year Plan	M2 Actual	Profiled Spend	Variance
Agreed Plan FIC				
Operational	4,497	34	285	(251)
Transformational	2,866	(115)	385	(500)
Estates TBC	1,401	-	-	-
IFRS 16 - Leases	1,012	81	81	(0)
IT	1,750	387	399	(12)
Clinical Systems	750	49	253	(204)
Sub Total	12,276	436	1,403	(967)
Phase 2 Projects Agreed at M2 CPG				
Operational	400	(63)	50	(113)
Transformational	3,164	(1)	-	(1)
Sub Total	3,564	(64)	50	(114)
Externally Funded Projects				
Wantage	1,050	129	250	(121)
R&D Medical Equipment	533	-	-	-
Constitutional Standards - MHLDA (TBC)	2,140	-	-	-
Constitutional Standards - Community (TBC)	2,600	-	-	-
Estates Safety Fund - Warneford Park (TBC)	6,000	-	15	(15)
Sub Total	12,323	129	265	(136)
Estates Phase 2 Projects TBC				
Operational	65	(72)	-	(72)
Transformational	3,767	8	30	(22)
Sub Total	3,832	(64)	30	(94)
Grand Total	31,995	437	1,748	(1,311)

- The Trust's Capital plan was approved by Execs on 30th April and FIC on 5th May.
- The Capital Programme for FY27 has been agreed at £12.3m and comprises of £8.8m – Operational & Transformational Estates, £2.5m - IM&T and £1m – Leases.
- Additionally, the plan includes £0.5m for R&D medical equipment, funded by NIHR, £1.1m Wantage Hospital funded by CIL & the Charity and £3.6m Four projects agreed at May's CPG (Marlborough House, Kennet Ward HDU, Littlemore Solar PV & Warneford Perimeter Wall)
- Capital expenditure to M2 is £0.4m, of which £0.4m relates to the core capital programme and £0.1m relates to capitalised leases (IFRS16), as shown in the table below. Please note these figures include VAT recovered of £0.4m.

The 3As from Capital Programme Group are:

Alert

- none

Advise

- CPG has approved half a million pounds towards Oxford Clinic fire prevention design and development: £100k for investigations and a contingency budget of £400k for works identified as needed during this phase.
- Contractor performance concerns are being escalated in respect of the Wantage site developments.

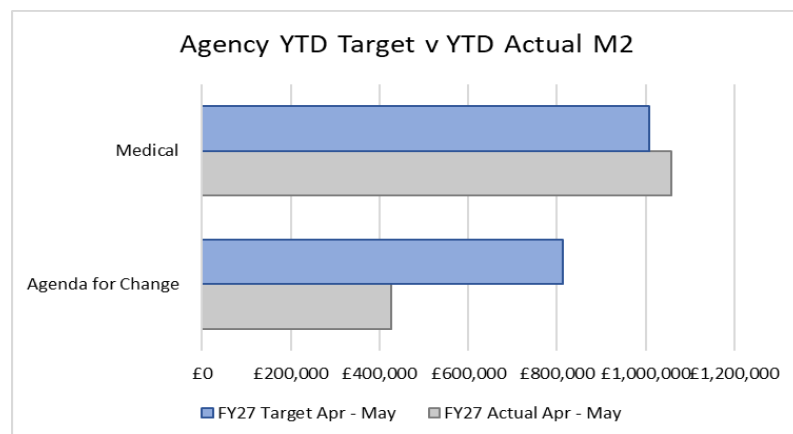
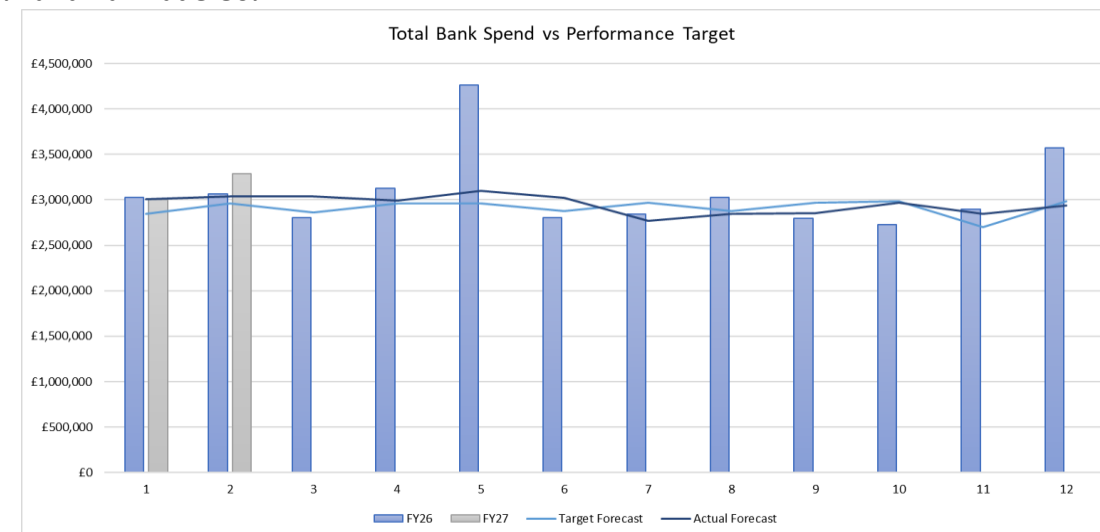
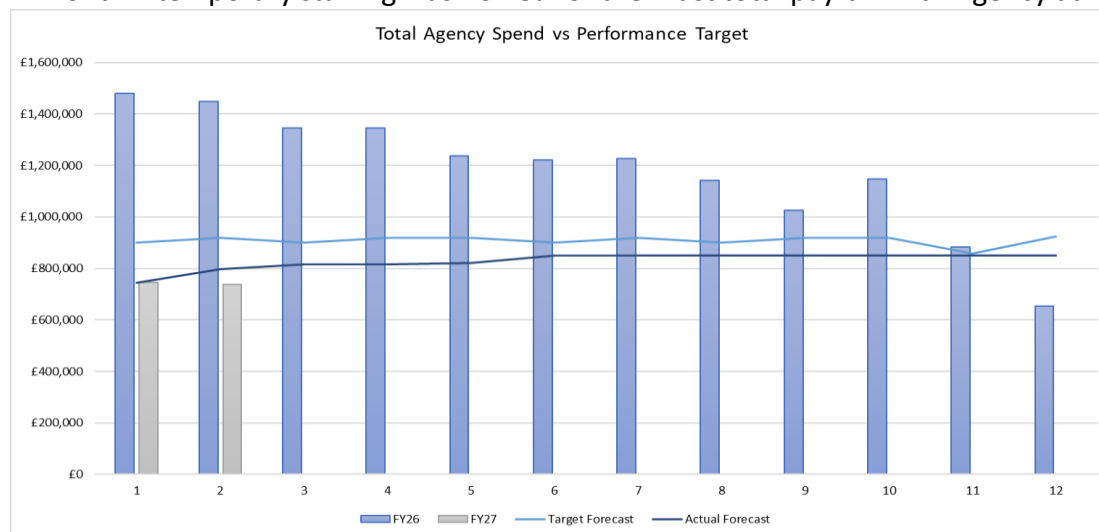
Assurance

- CPG is continuing to review the phase two capital plan allocations and negotiating with NHS England about how much return to constitutional standards money will be available for this year and future years.
- There are four main projects that CPG are looking to take forward under return to constitutional standards, which are
 - Witney across physical and mental health, which community health services will provide an SRO for,
 - Two neighbourhood MH centres in Buckinghamshire in Aylesbury and in Wickham, which Bucks are going to provide an SRO for,
 - And the Slade CYP project where funding isn't yet clear, but design works are underway and an Oxon SRO is to be provided.
- Three external project managers have been appointed by a project management services contract to help get the capacity needed to deliver some of this scope of programmes and
- CPG have approved the extension of the lease at Psychotherapy Cottage in the Warneford.

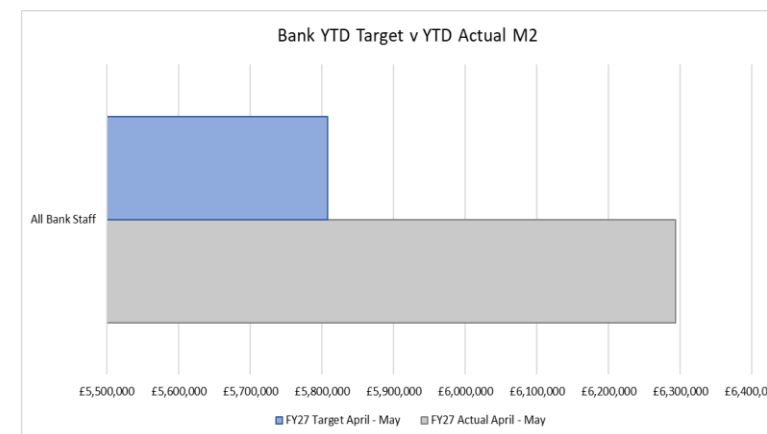
3. Temporary Staffing Analysis

The Trust submitted a plan to NHS England to spend a maximum of **£10.9m** on Agency and **£35m** on Bank in FY27.

In Month 2 temporary staffing was **10.79%** of the Trust total pay bill with Agency at **1.99%** and Bank at **8.80%**.

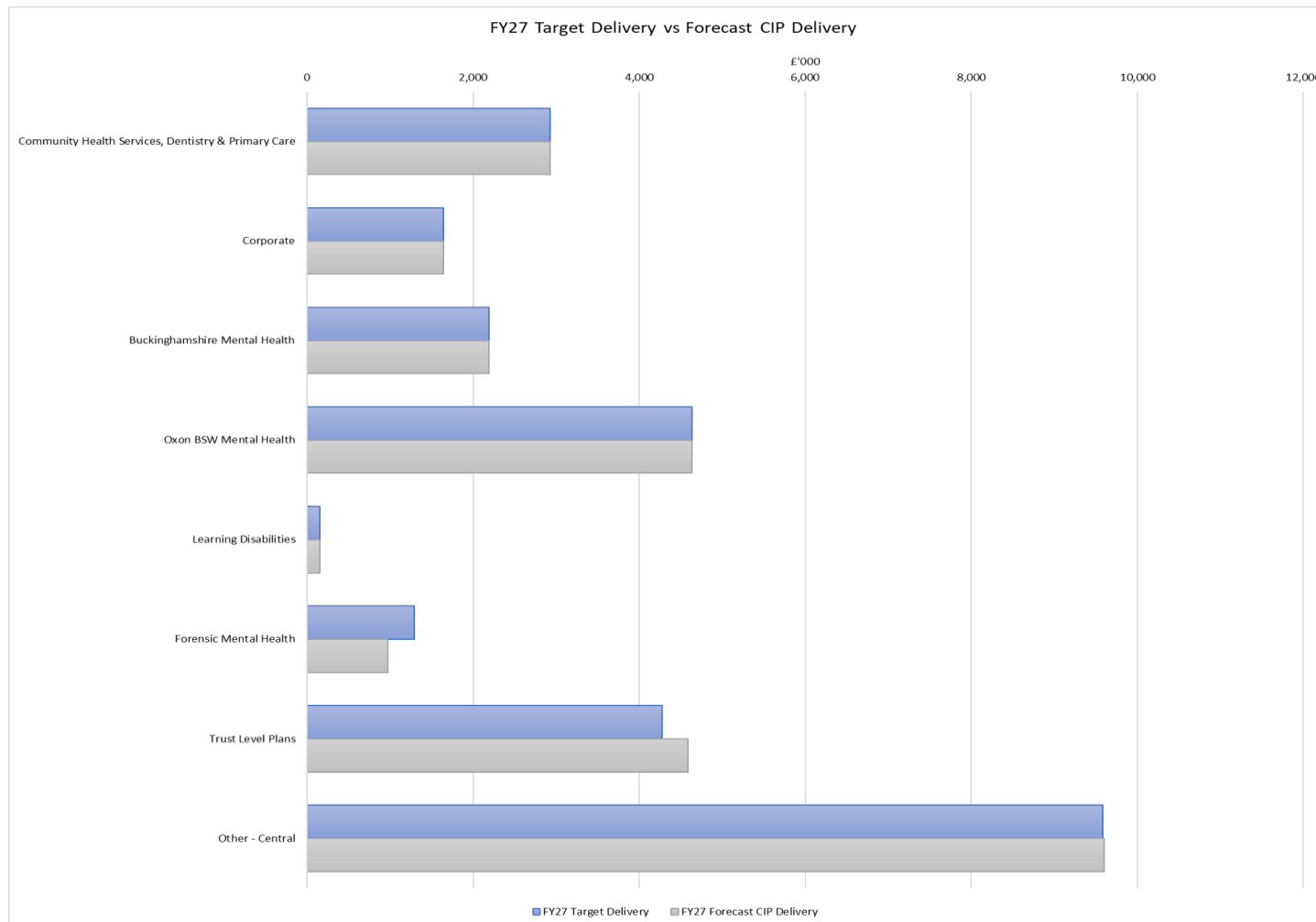


At the end of month 2, agency spend is **£0.3m** better than planned performance year-to-date.



At the end of month 2, bank spend is **£0.4m** worse than planned performance year-to-date.

4. Cost Improvement Programme (CIP)



The Trust has submitted a plan to NHSE to deliver CIPs of **£26.7m** made up of a **£11m** efficiency from FY27 contract requirements (CIP) and **£16.7m** additional CIPs which include **£1.8m** which was delivered non recurrently in FY26 and **£13.9m** of central trust wide schemes.

The Trust is forecasting full delivery of the **£26.7m** to NHS England on the assumption that any shortfall in these programmes is mitigated by other non-recurrent benefits in the Trust's position.

All directorates are forecasting to meet their targets except for Forensic Mental Health which is being mitigated by over delivery on non recurrent central schemes.

5. Income & Expenditure Statement

INCOME STATEMENT									Excluding Oxford Pharmacy Store and Provider Collaboratives		
Month 2					Year-To-Date						
Plan	Actual	Variance	Variance	Plan	Actual	Variance	Variance	Variance			Variance
£m	£m	£m	%	£m	£m	£m	%	£m			%
Clinical Income	48.9	48.9	0.1	0.1%	96.9	93.5	-3.4	-3.6%	-0.9	-1.0%	
Other Operating Income	13.0	14.2	1.2	9.3%	25.9	29.4	3.5	13.4%	0.6	6.1%	
Operating Income, Total	61.9	63.1	1.3	2.0%	122.9	122.9	0.0	0.0%	-0.2	-0.2%	
Employee Benefit Expenses (Pay)	38.5	37.3	1.1	2.9%	75.6	73.9	1.7	2.2%	1.4	1.8%	
Other Operating Expenses	21.9	24.2	-2.3	-10.5%	44.0	45.7	-1.7	-3.8%	-1.2	-6.5%	
Operating Expenses, Total	60.3	61.5	-1.2	-1.9%	119.6	119.6	0.0	0.0%	0.2	0.2%	
EBITDA	1.5	1.6	0.1	5.1%	3.3	3.3	0.0		0.0		
Financing costs	1.6	1.9	-0.4	-25.0%	3.1	2.9	0.2	7.7%	0.2	7.7%	
Surplus/ (Deficit)	0.0	-0.3	-0.3	905.0%	0.2	0.4	0.2		0.2		
Adjustments	0.0	0.0	0.0	0.0%	0.0	0.0	0.0	0.0%	0.0		
Adjusted Surplus/ (Deficit)	0.0	-0.3	-0.3		0.2	0.5	0.2		0.2		

Provider Collaboratives and Oxford Pharmacy Store report large variances on income and other operating expenses which offset with each other. The additional columns on the table exclude these variances to show the variances for the rest of the Trust.

6. Provider Collaboratives Financial Performance Summary

	Month 2				Year-to-date		
	Plan £m	Actual £m	Variance £m		Plan £m	Actual £m	Variance £m
Secure	8.7	8.7	0.0		17.3	17.1	0.2
CAMHS	2.6	2.4	0.3		5.3	4.8	0.4
Adult AED	0.8	1.1	(0.3)		1.6	1.3	0.3
Provider Collaboratives FY27 Funding	12.2	12.1	0.0		24.1	23.2	0.9
Prior Year Funding	0.1	0.1	0.0		0.1	0.1	0.0
Provider Collaboratives I/E FY27	12.2	12.2	0.0		24.2	23.3	0.9

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 **£0.9m** 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.

7. Statement of Financial Position

Statement of Financial Position at 31st May 2026					
31 Mar 26 £'000		30 Apr 26 £'000	31 May 26 £'000	Movement In-Month £'000	YTD £'000
Non-current assets					
4,617	Intangible Assets	4,488	4,364	(124)	(254)
228,301	Property, plant and equipment	227,810	227,305	(505)	(997)
33,170	Finance Leases	32,571	31,891	(679)	(1,279)
1,125	Investments	1,125	1,125	0	0
367	Trade and other receivables	367	368	0	0
914	Other Assets	914	914	(0)	0
268,495	Total non-current assets	267,275	265,966	(1,309)	(2,528)
Current Assets					
7,569	Inventories	6,905	6,146	(759)	(1,424)
25,856	Trade and other receivables	24,521	24,665	143	(1,192)
985	Non-current assets held for sale	985	579	(406)	(406)
98,832	Cash and cash equivalents	103,986	105,645	1,658	6,812
133,243	Total current assets	136,398	137,034	636	3,791
Current Liabilities					
(72,668)	Trade and other payables	(68,397)	(69,956)	(1,560)	2,712
(1,355)	Borrowings	(1,390)	(1,426)	(36)	(71)
(7,779)	Lease Liabilities	(7,805)	(7,805)	0	(26)
(15,678)	Provisions	(15,601)	(15,310)	291	368
(38,455)	Deferred income	(45,004)	(43,677)	1,327	(5,221)
(135,936)	Total Current Liabilities	(138,197)	(138,175)	22	(2,239)
Non-current Liabilities					
(9,373)	Borrowings	(9,374)	(9,374)	0	(1)
(19,013)	Lease Liabilities	(17,982)	(17,677)	305	1,336
(8,425)	Provisions	(8,368)	(8,368)	0	56
(1,500)	Other Liabilities	(1,500)	(1,500)	0	0
(38,311)	Total non-current liabilities	(37,225)	(36,919)	305	1,392
227,491	Total assets employed	228,251	227,906	(345)	415
Financed by (taxpayers' equity)					
121,321	Public Dividend Capital	121,321	121,321	0	0
88,166	Revaluation reserve	88,166	87,692	(474)	(474)
1,125	Other reserves	1,125	1,125	0	0
16,879	Income & expenditure reserve	17,639	17,768	128	889
227,491	Total taxpayers' equity	228,252	227,906	(345)	415

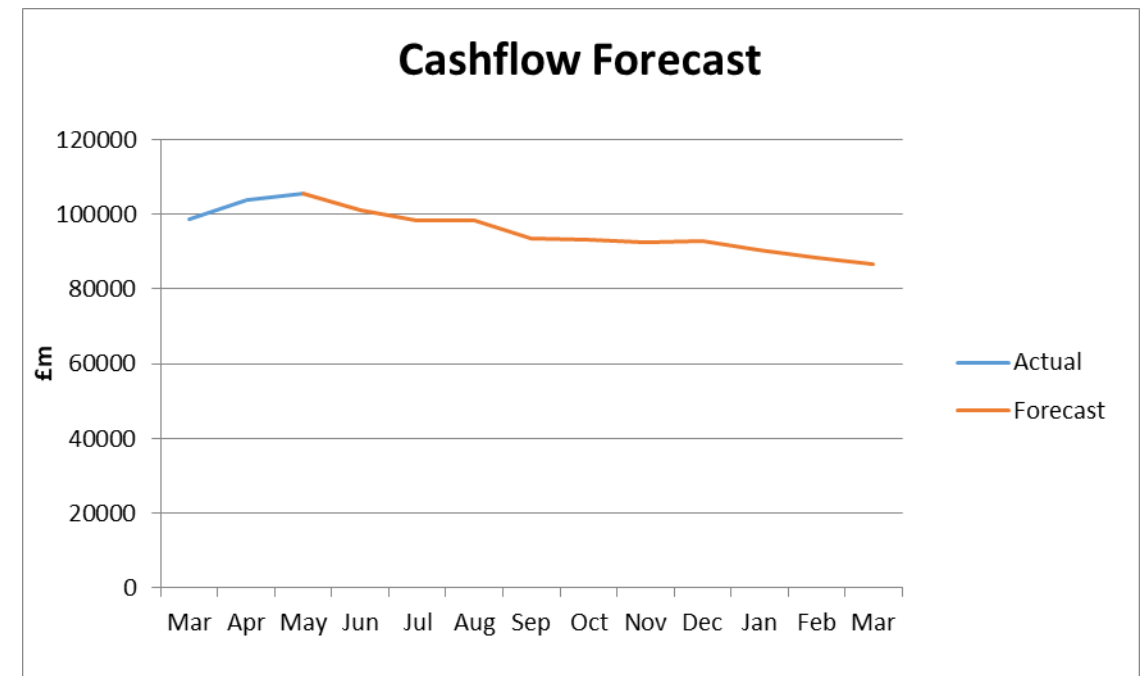
- Non-current assets have decreased by (£2.5m) in May which reflects the depreciation charge incurred in month. Capital additions were negligible.
- Inventories have decreased by £1.4m YTD and £0.8m in month.. This is due to normal trading fluctuations and movements.
- Receivables have decreased by (£1.2m) YTD and increased by £0.1m in-month. This decrease is driven by a decrease in VAT receivables of (£1.1m) and other receivables of (£3.8m). These decreases have been offset by an increase in trade receivables of £2.1m, Prepayments of £0.7m, accrued income of £0.7m and Bad debt provision of £0.1m.
- The cash balance has increased by £6.8m. The increase in-year is driven by the net inflow of cash used in operations of £9.8m and offset against a net (£1.5m) used in investing activities and (£1.5m) used in financing activities - see cash flow statement.
- Trade and other payables have decreased by £2.7m in year and increased by £1.6m in-month. The decrease in year is driven by the net reduction in trade payables and accrued expenditure of £3.1m and other payables of £0.1m. These decreases have been offset by an increase in the monthly Tax/Pension liabilities of (£0.4m).
- Deferred income has increased by £5.2m in year and decreased by £1.3m in-month. The change in year is driven by £2.2m Provider Collaborative gain share income that will be spread over 12 months of the year, £1.2m deferral of the Education & Training income which is paid quarterly in advance and a £0.9m deferral of growth funding to match spend.
- Borrowings have stayed the same in-month.
- Non-current lease liabilities have decreased by £1.3m in year and £0.3m in-month in line with capital repayments against those liabilities.
- Provisions have decreased in month by £0.1m due to release in provision paid in month.
- The £0.9m upward movement in year reflects the Trust's reported surplus in month.

8. Statement of Cashflows

Statement of Cash Flows at 31 May 2026				
31 Mar 26		Apr 26	Apr - May	Cash In/(Out) In-Month
£'000		£'000	£'000	£'000
9,458	Cash flows from operating activities	209	323	114
9,458	Operating surplus/(deficit) from continuing operations	209	323	114
	Operating surplus/(deficit)	209	323	114
	Non-cash or income and expense:			
17,592	Depreciation and amortisation	1,483	2,965	1,482
292	Impairments and profit on disposal of assets	0	0	0
(180)	Income recognised in respect of capital donations (cash and	0	0	0
(35)	On SoFP pension liability	1,335	0	(1,335)
(6,295)	(Increase)/Decrease in Trade and Other Receivables	665	1,192	527
(3)	(Increase)/decrease in other assets	(2,393)	0	2,393
(1,106)	(Increase)/Decrease in Inventories	6,549	1,424	(5,125)
(9,146)	Increase/(Decrease) in Trade and Other Payables	(134)	(810)	(676)
3,354	Increase/(Decrease) in Deferred Income	0	5,221	5,221
(713)	Increase/(Decrease) in Provisions	0	(425)	(425)
13,220	NET CASH GENERATED FROM/(USED IN) OPERATIONS	7,714	9,890	2,176
	Cash flows from investing activities			
4,994	Interest received	403	773	370
(13,266)	Purchase of Non Current Assets	(2,312)	(2,758)	(446)
507	Sale of PPE	505	438	(67)
(7,765)	Net cash generated from/(used in) investing activities	(1,404)	(1,547)	(143)
	Cash flows from financing activities			
7,357	Public dividend Capital Received	0	0	0
(1,338)	Loans repaid	0	0	0
0	Movements on other loans	0	0	0
(6,072)	Capital element of lease rental payments	(1,085)	(1,390)	(305)
0	Capital element of Private Finance Initiative Obligations	0	0	0
(562)	Interest paid	(71)	0	71
(860)	Interest element on leases	0	(141)	(141)
0	Interest element of Private Finance Initiative obligations	(0)	0	0
(2,965)	PDC Dividend paid	0	0	0
(4,440)	Net cash generated from/(used in) financing activities	(1,156)	(1,531)	(375)
1,014	Increase/(decrease) in cash and cash equivalents	5,154	6,812	1,658
97,818	Cash and Cash equivalents at 1st April 2025	98,832	98,832	
98,833	Cash and Cash equivalents at end of period	103,986	105,645	1,658

Summary Notes

- The actual cash flow movements are consistent with the comments made on the Statement of Financial Position.
- The closing cash position at the end of May was **£105.6m** (£104.0m in April).
- The cash forecast is for £95m at the 31 March 2027.



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

Month 2

Statement of Financial Position - Headlines

Net assets have decreased by £0.3m YTD to **£227.9m**. This is represented by:

	£m
Decreases in net capital assets	(£1.3m)
Increases in current assets	£0.6m
Decreases in net liabilities	£0.3m
Net increase	£0.3m

Cash Flow - Headlines

Cash balance of **£105.6m** at the end of May

Forecast year-end cash balance of **£95m**

Net cash has increased by **£6.8m** YTD. This is represented by:

Net Cash generated from operations	£9.8m
Net Cash used in investing activities	(£1.5m)
Net Cash used in financing activities	(£1.5m)
Net increase	(£6.8m)

Working Capital Ratios	Target	Actual	Risk Status
Debtor Days by value	30	33	●
Debtor Days by number of inv's	30	32	●
Debtors % > 90 days	5.0%	7.0%	●
BPPC NHS - Value of Inv's pd within target (ytd)	95.0%	49.4%	●
BPPC Non-NHS - Value of Inv's pd within target (ytd)	95.0%	92.6%	●
Cash and Cash Equivalents (£m) - per y/e forecast	94.6	105.6	●

Working capital ratios

- Debtor days by number of invoices and value are marginally below target.
- Debtors % over 90 days is marginally below target, due to unpaid invoices. These are mainly various ICB's £86k (£94k in M1), OUH £228k (£228k in M1), NHS BOB £206k (£252k in M1), NW London £77k (£78k in M1), Salary overpayments £231k (£236k in M1), and other £77k (£113k in M1).
- NHS BPPC (Better Payments Practice Code) is below target due to a backlog of staff car lease invoices. The Estates team requested a move from over 400 individual invoices per month to a single consolidated invoice to improve processing efficiency. However, a delay in implementing the new arrangement during April - May resulted in a backlog of approximately 900 invoices (around two months' worth), which adversely impacted payment performance. When confirmed, the consolidated invoicing process is expected to improve processing times and support a return to BPPC compliance.
- Non-NHS BPPC (Better Payments Practice Code) is marginally below target.
- Cash at M2 marginally below target with the year end forecast. Forecast cash is still to be finalised.

10. Variances reported to NHS England

The starting point for budget setting is recurrent service budgets whereas the starting point for the plan submitted to NHS England is forecast outturn. Although the surplus or deficit is the same in the plan and budget, the expenditure and income figures vary – the Plan is what is expected to happen in reality whereas the Budget reflects agreed establishments and expenditure based on historic funding agreements. In addition, the budgets will be updated in year, whereas plan values stay the same. This creates difference between the plan and budget figures as show in this reconciliation:

	Full Year Plan	Plan starting point is forecast outturn not recurrent budgets			Categorisation of Depreciation	Revised Assumption for Financing Costs	In Year Budget adjustments	Full Year Budget M2
		Provider Collaboratives	Oxford Pharmacy Stores	Other				
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Income	586,341	-3,454		2,268			3,095	588,250
Other Operating Income	159,589	-2	-11,580	5,010			100	153,117
Employee Benefit Expenses (Pay)	-450,542	-1,321	-158	-5,463			-3,057	-460,541
Other Operating Expenses	-295,135	4,777	11,392	-1,984	18,744		-138	-262,344
Financing Costs	-296				-18,744	515	0	-18,525
Adjustments	43						0	43
Adjusted Surplus/ (Deficit)	0	0	-346	-169	0	515	0	0

The variances against plan reported to NHS England are shown in the table below:

	YTD Plan	YTD Actuals	YTD Variance against Plan	YTD Variance against Budget	Difference
	£'000	£'000	£'000	£'000	£'000
Clinical Income	97,722	93,499	-4,223	-3,449	774
Other Operating Income	26,596	29,377	2,781	3,470	689
Employee Benefit Expenses (Pay)	-74,960	-73,867	1,093	1,665	572
Other Operating Expenses	-49,050	-48,685	365	-1,678	-2,043
Financing Costs	-134	92	226	234	8
Adjustments	8	10	2	2	0
Adjusted Surplus/ (Deficit)	182	426	244	244	0



Oxford Health
NHS Foundation Trust

Meeting	Board of Directors' Meeting
Date of Meeting	22 nd July 2026
Agenda item	12
Report title	Patient Safety Reviews in May and June 2026
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 is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board	This paper follows the last report to the meeting in May 2026. The report is provided to give Board members an overview of the work happening and themes from patient safety incidents.
For disclosure or confidential	Disclosure.

Executive summary

This is a regular report on the oversight of patient safety incidents and the areas we are focusing on for change. The report concentrates on the period of May and June 2026.

Key Highlights:

- ❖ 12 patient safety review were identified in May and June 2026 meeting our Patient Safety Incident Response Plan (PSIRP), where we believe there is potential for significant learning. The detail of the cases are included in the report.
- ❖ We use a range of learning response approaches which all use a human factors methodology. Incident learning huddles are one type of response which continues to be used well to identify learning quickly, with 11 huddles completed in May 2026 and 15 in June 2026. A Quality Improvement project has started to look at how to improve the patient/family voice and representation at ILH.
- ❖ The learning identified from reviews completed in the last two months and the safety actions in response are detailed in the report. The overarching areas for improvement are;
 - Working with families - within this managing the therapeutic relation with the patient, a

- Communication with others – between teams in OHFT and external agencies (multi-professional meetings). This theme reflects the changing patient needs and the number of different services having contact with an individual patient.
- Clinical documentation - risk assessment/safety plan, care planning, NEWS2, VTE assessment
- ❖ The outcome of a recent safety action review visit is shared following a revisit to one of the community hospital wards. The visit found significant progress and sustained improvement from the original actions put in place. The next steps include expanding the QI project from this ward to the other community hospital wards and rolling out Better Meds ePMA (Electronic Prescribing & Medicines Administration) system following the current pilot on Bicester community hospital ward.
- ❖ It is World Patient Safety Day on Thursday 17th September 2026 with the theme of "Safe care for noncommunicable diseases" for example heart disease, stroke, cancer, diabetes and chronic lung disease. The Trust will be hosting a number of events throughout the week to help staff to reflect and talk about how they are improving the safety of care.

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

Every patient incident is reviewed and those with significant harm to a patient or where we believe there is a great potential for learning we carry out a safety review. All those affected by an incident (patient, family and staff) we make every attempt to involve in any review. Patients and families can also trigger a review through the complaints process. The outcome from every review is scrutinized and signed off by senior clinicians and then shared widely for learning. There are a number of weekly and monthly forums and different methods used to share learning across the Trust and to address areas for improvement, this includes the Trust's Weekly Review Meeting which focuses on patient and staff safety.

A monthly patient safety incident report is presented to the Quality and Clinical Governance Group and a quarterly report to the Trusts Quality Committee.

Recommendation(s)

No action is being requested from the Board, the report is to provide an oversight and assurance of 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

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	• Learning from Deaths Guidance • Patient Safety Incident Response Framework • Duty of Candour Legal Framework	

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 latest 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.

There has been a measurable improvement in safety culture and staff engagement across the Trust. This is demonstrated in a number of ways, one being the recent annual staff survey results for 2025. All four patient safety measure questions in the survey have improved from 2024 and all are above the national average levels compared to other NHS Trusts. The survey results mirror the formal and informal internal feedback we receive from staff as part of their engagement in safety reviews. Full national survey results available here [National results across the NHS in England | NHS Staff Survey](#).

A brief analysis on all patient incidents, unexpected deaths and suspected suicides is included in the quality metrics in the integrated performance report also presented to Board members.

2. Cases declared under our Incident Response Plan

Following the report to the last Board of Directors meeting there have been 12 patient safety reviews identified in May and June 2026 that fall under our local Patient Safety Incident Response Plan (PSIRP), where we believe there is potential for significant learning. These are listed below in table 1 with the planned learning review we intend to take.

For each safety review we use a human factors 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.

Table 1.

Incident description	Type of service	PSIRP safety area	Planned Response	Learning
Category 4 pressure ulcer (District Nursing)	Physical Health Service	Delay in accessing care/treatment	Incident Learning Huddle	
Category 4 pressure ulcer (District Nursing)	Physical Health Service	Physical Deterioration	Patient Safety Incident Investigation	
Sepsis death (Phlebotomy)	Physical Health Service	Physical Deterioration	Patient Safety Incident Investigation	
Suspected suicide (adult community mental health)	Mental Health Service	Delay in accessing care/treatment	Patient Safety Incident Investigation	

Incident description	Type of service	PSIRP safety area	Planned Learning Response
team)			
Unexpected deaths of 2 people discovered at the same time, 1 person was a patient (older adult community mental health team)	Mental Health Service	Delay in accessing care/treatment	Incident Learning Huddle
Suspected suicide (Crisis Team)	Mental Health Service	Delay in accessing care/treatment	Patient Safety Incident Investigation
Fire incident (Inpatient ward)	Mental Health Service	Emergent	Patient Safety Incident Investigation
Suspected suicide (Inpatient ward)	Mental Health Service	Mental health inpatient death	Patient Safety Incident Investigation
Road Traffic Accident and arrest for manslaughter (adult community mental health team)	Mental Health Service	Manslaughter	Patient Safety Incident Investigation
Sepsis death (Urgent Care, Therapy Team and District Nursing)	Physical Health Service	Physical Deterioration	Initial Review Report
Suspected Suicide (adult community mental health team)	Mental Health Service	Delay in accessing care/treatment	System Patient Safety Incident Investigation – Lead other trust
Suspected suicide (child and adolescent mental health service)	Mental Health Service	Delay in accessing care/treatment	Patient Safety Incident Investigation

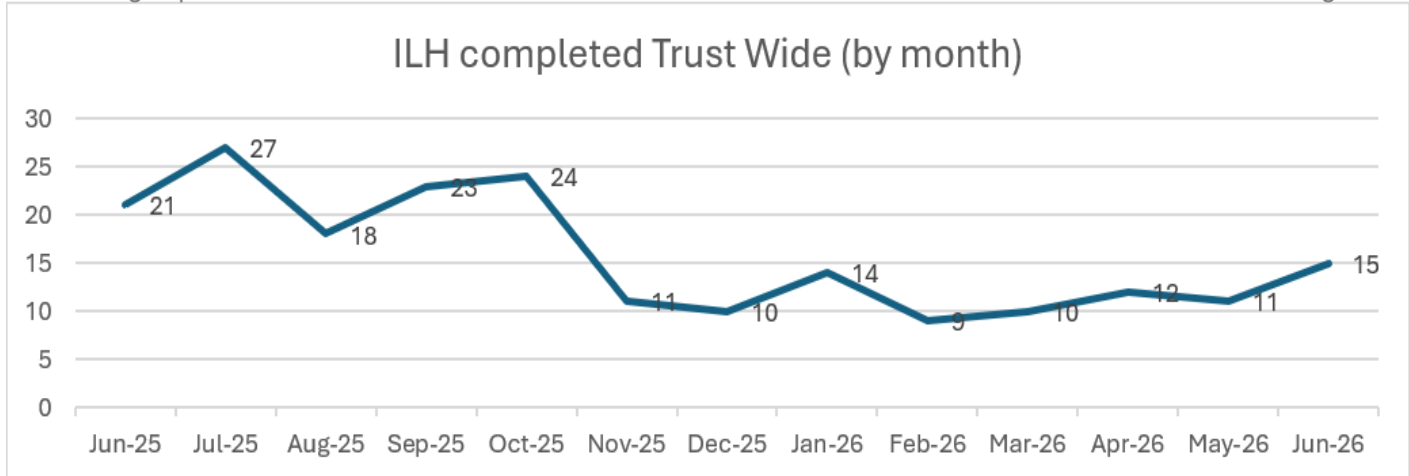
3. Progress with Incident Learning Huddles

We use incident learning huddles (ILH) (sometimes known as After Action Reviews in other NHS Trusts) 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 involved in the care provided to a patient to help us to understand more about what's happened and why. The huddles will check support is in place for those affected and focus on what can be learnt. The approach has proven to be an effective way to improve engagement in identifying and acting on learning.

There were 11 ILHs completed in May 2026 and 15 in June 2026. Graph 1 shows the number of ILH completed by month over the last year.

The patient safety team have recently started a Quality Improvement project 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.

Graph 1.



4. Key Learning and Changes

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.

Over the last year the overarching areas for improvement are;

- Working with families - within this managing the therapeutic relation with the patient, a patients consent and sometimes fluctuating capacity.
- Communication with others – between teams in OHFT and external agencies (multi-professional meetings). This theme reflects the changing patient needs and the number of different services having contact with an individual patient.
- Clinical documentation - risk assessment/safety plan, care planning, NEWS2, VTE assessment

The learning from reviews completed in May and June 2026 and actions being taken in response are provided in table 2. Each safety action has an action lead and timescale although this level of detail is not provided in the report.

Table 2.

Type of service	Learning area	Safety action(s)
Physical Health Service	Review of medicine reconciliation policies	Review of Pharmacy Med Rec SOP (CP08) v2 and Trust Medicines Reconciliation Policy (MM02).
Mental Health Service	Recognition and escalation of physical deterioration ; NEWS2 and food/fluid intake monitoring	• All staff required to complete NEWS2 and eObs training with competency sign-off. • Registered staff oversight introduced for physical health observations. • NEWS2 prompts added to handover documentation to improve escalation reliability. • Regular audit and MDT review of NEWS2 compliance implemented. • Food and fluid charts reviewed at every handover. Added to shift coordinator sign-off processes to

Type of service	Learning area	Safety action(s)
		ensure completion. • Expectation set for daily MDT oversight of intake monitoring. • Introduction of Wellbeing Clinics and supervised practice sessions. • Strengthening of the Physical Health Champion role to support the team. Introduction of monthly supernumerary shifts to support clinical responsibilities.
Physical Health Service	Dental - Inconsistencies in the implementation of LocSSIP (Local Safety Standards for Invasive Procedures) intended to support correct tooth identification, shared access to treatment plans, effective use of the pause step, and verbal cross checking between clinicians. Documentation was often completed retrospectively, reducing its effectiveness as a real time safety barrier. Limited access to the treatment plan during procedures constrained the dental nurse's ability to actively participate in safety checks. Affecting a robust, team-based safety system, increasing the risk of error in the context of workload pressures, complex dentition, and evolving treatment plans. The absence of regular auditing and formalised training has contributed to a gradual erosion of standardised safety practices.	• For the dynamic treatment plan to be accessible to both clinicians at the pre-operation sign in step on LocSSIP. • To implement a service wide training programme to include the LocSSIP and the rationale for completing, included within the Induction programme for new starters. • To review the LocSSIP against national guidelines and feedback from clinicians prior to implementing a regular audit schedule. • To introduce best practice in documentation and treatment plans held on the electronic patient record.
Physical Health Service	Patient information on stockings, doppler and Lower Limb Assessment in District Nurse Teams	• Identify patient leaflets available to support this discussion, linking with Tissue Viability. • Team to raise awareness when seeing patients to check if doppler/LLA have been completed, or any change in presentation to book assessment.
Physical Health Service	Patient experience in End-of-Life care	• To enhance patient experience, it was agreed that providing a single contact number for patients/families and a list of contacts for professionals with brief descriptions of each team and their operating hours.
Mental Health Service	Neuro-Inclusive Passport and recording	The team are raising awareness - Sharing of neuro-inclusive passport format and recording in RIO, including an alert and discussion in business meeting.

Type of service	Learning area	Safety action(s)
Mental Health Service	Transfer of Care from acute hospital – information sharing between agencies	Discussions and liaison with acute hospital – strengthen transfer of care meetings when patients have complex care needs.
Mental Health Service	Improve quality of working relationship and ease of communication between AMHTs and Oxfordshire Mind.	• Ensuring that both services have up-to-date details of staff members in respective teams, including knowing how to escalate concerns. • AMHT will seek to routinely invite Mind staff to join AMHT reviews (with consent of the patient). Managers of respective services will meet quarterly. • AMHT to ensure that when creating care plans with patients in supported accommodation clearly identify that they are living in supported accommodation, include contact details for relevant staff, a breakdown of the support being offered, and a clear conversation about consent to share information. Ideally the Mind staff would be directly part of the care planning process.
Mental Health Service	Absence of role clarity for key worker and a fully integrated MDT approach : The integrated MDT model was not fully realised, largely due to ongoing professional silos separating mental health, physical health, and social care rather than delivering comprehensive care.	The Directorate are implementing an Assertive Outreach Team and associated clinical model of care delivery for patients who present with more challenging and complex needs and risks.
Mental Health Service and Physical Health Service	A number of reviews this month identified engagement with family/carers	Actions have been around reviewing Triangle of care self assessments and actions in teams, using the reviews completed as examples in away days to raise awareness.

Safety Action Review Visits

As part of the PSIRF development to test if safety actions developed as part of PSIRF reviews are making the intended impact. We have developed a process of returning to clinical teams to see how these have been implemented in practice, if the action(s) had the intended impact and also any further improvements the clinical team would like to take forward. This is a supportive visit to allow the team to reflect on the improvement work undertaken, as well as to celebrate what has worked well.

A visit was undertaken to evaluate the impact of safety actions implemented on Abbey Community Hospital Ward following a 2024 thematic review addressing increased medication incidents. The review visit in May 2026 found the ward demonstrated significant progress against all 9 recommendations made, embedding safer practices and a reduction in the number of medicine incidents. The next steps include expanding the QI project from this ward to the other community hospital wards and rolling out Better Meds ePMA (Electronic Prescribing & Medicines Administration) system following the current pilot on Bicester community hospital ward.

World Patient Safety Day

The theme for World Patient Safety Day in 2026 (Thursday 17th September) is "Safe care for noncommunicable diseases", supported by the slogan "Safe care for life!".

Noncommunicable diseases (NCDs), including heart disease, stroke, cancer, diabetes and chronic lung disease, are collectively responsible for 74% of all deaths worldwide. More than three-quarters of all NCD deaths, and 86% of the 17 million people who died prematurely, or before reaching 70 years of age, occur in patients from low- and middle-incomes.

NCDs share five major risk factors: tobacco use, physical inactivity, the harmful use of alcohol, unhealthy diets and air pollution.

The key objectives of World Patient Safety Day are to:

- Raise awareness of patient safety challenges associated with NCDs and determinants of health that may increase the risk of harm.
- Strengthen patient safety practices such as safer diagnosis, medication safety and meaningful patient engagement.

The Trust will be hosting a number of events throughout the week to help staff to reflect and talk about how they are improving the safety of care.

Meeting:	Board of Directors' Meeting
Date of Meeting:	22 July 2026
Agenda item:	13
Report title:	Quarterly Report on Exception Reporting for Resident Doctors
Executive sponsor(s):	Dr Karl Marlowe, Chief Medical Officer
Report author(s):	Dr Matthew Gee, Guardian of Safe Working Hours
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board:	Contractual requirement for quarterly and annual report to Trust Board
Public or confidential	Public

Executive summary

- Exception Reporting is the means by which Resident Doctors and Dentists report occasions on which there is an exception to their work schedule, such as an unscheduled late finish, and can result in the Resident Doctor or Dentist being paid for additional hours worked, receiving time off in lieu (TOIL) and/or the Trust being fined.
- Quarterly reporting to the Trust Board in the format used is required in the Terms and Conditions of Service for Resident Doctors
- There were 60 Exception Reports received that related to instances of variation in pattern and hours of work over the quarter (mainly finishing shifts late), in the context of a workforce of 128 Resident Doctors and Dentists across the Trust.
- Over the quarter, across all Resident Doctor rotas across the Trust, 216 shifts were initially unfilled, but all except 9 were covered by internal cover, bank shift or locum.
- Some doctors are reporting detriment or discouragement from Exception Reporting on the anonymous quarterly survey: this is a new reporting requirement, and the survey was open for a short period resulting in low response rate, and more work is needed to make sense of the results.

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

Recommendation(s)

The Board is asked to note the contents of 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 Terms & Conditions of Service for Resident Doctors & Dentists require quarterly report to the Board in this format.	

'Exception reporting' is the mechanism by which Resident Doctors and Dental Trainees employed under the Terms & Conditions of Service report when there has been a difference in their work or education compared to the Work Schedule. This might include working additional hours due to exceptional clinical need, not being able to take contractual breaks, or not getting required rest during non-resident on-call.

There was a substantial change in exception reporting brought in nationally from February 2026 following nationally negotiated changes to Resident Doctors and Dentists' Terms and Conditions of Service. Changes include exception reports being kept confidentially from the doctors' supervisors, meaning that exception reports are now processed and administered by Medical HR without the involvement of the doctors' supervisors; and the process is overseen by the Guardian of Safe Working Hours (GoSWH).

This report follows the standard template for reporting requirements for Trust Board reports on Exception Reporting as provided by NHS Employers.

All data relates to 2026 Q1 (1 April 2026 to 30 June 2026).

a) Number of exception reports submitted

The GoSWH will have access to all exception reports and will review and scrutinise exception reporting patterns to ensure reports are accurate, valid and adhere with the purpose of exception reporting.

Number of exception reports submitted over the last quarter:	107

Note this includes 32 Access and Completion Test reports; 7 withdrawn reports; and 2 reports submitted outside of the 28 day window.

b) Categories of exception reports submitted

Supporting information

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours: an unscheduled early start	1	1	0		2
Additional hours: an unscheduled late finish	35	20	13		55 ¹
Breaches of non-resident on-call patterns	0	3	3		3
The inability to take contractual breaks			0	5	5
Inadequacy of clinical support				0	0

Inadequacy of rostered skills mix				0	0
Raising concerns of a suspected non-compliant rota pattern				0	0
Detriment or threat of detriment related to exception reporting				1 ²	1 ²
Information breach			0		0
Access and completion resolved in time				0	0
Access and completion breaches			0		0
Access and completion test				32	32
Total					98

¹ Additional 7 ERs withdrawn/entered in error, and 2 ERs submitted outside of the 28 day limit in the category *Additional hours: an unscheduled late finish*

² Submitted in this category by error – ER related to additional hours worked/TOIL.

c) Experiences of actual or threatened detriment

One of the guiding principles of the exception reporting reforms is to prevent doctors experiencing, either threatened or actual, detriment as a result of exception reporting or indicating intent to exception report. Detriment in an employment context is when an employer, or colleagues, treats an individual unfairly or subjects them to a disadvantage for the sole or main reason that they asserted an employment right.

Quarterly survey response rate	11.7% (15 respondents)
Doctors experiencing actual detriment as a result of exception reporting	2
Doctors feeling that they are <u>not</u> discouraged from exception reporting	12

Note the survey was sent out very late, so was open for a very short period, which may explain the very low response rate, which means results may not be representative. Next quarter, the survey will be sent out earlier.

d) Withdrawals

A doctor can choose to withdraw an exception report that they have submitted at any point in the process following submission. All exception reporting data, including those which have been withdrawn, will be retained for the GoSWH to allow them to perform their role in checking for potential safety implications.

Number of exception reports withdrawn over the last quarter	7

e) Access to individual doctors' exception reporting data

Personally identifiable data related to exception reporting must not be shared without the doctors' specific consent, except where a senior manager or member of the board of directors is presented with an overriding public interest or has a legal obligation.

The affected doctor should be notified of this action as soon as practically possible, and the number of such disclosures must be presented in a manner that preserves a doctors' anonymity.

Number of exception reports disclosures over the last quarter	0

f) Work schedule reviews related to exception reporting pattern/instances

The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose. A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer.

Number work schedules reviews related to exception reporting patterns or instances	1

g) Rota gaps on all shifts

Total number of rota gaps on all shifts over the last quarter	9 unfilled shifts

Note there were additionally **207** shifts which were initially rota gaps, but were covered by internal cover, bank shift or locum, leaving only 9 shifts that were unfilled.

h) Additional information on an ad hoc basis

The GoSWH is required to report any escalated issues in relation to working hours, raised in exception reports, to the relevant executive director, or equivalent, for decision and action, where these have not been addressed at departmental level.

Details
I am satisfied that there are not issues in relation to working hours that need to be escalated. There are, on average, approximately 0.5 exception reports per Resident Doctor per quarter, which would suggest that Resident Doctors are, on the whole, working within their Work Schedules. The majority of exception reports relate to an unscheduled late finish, and of these, a significant proportion relate to emergency/acute out-of-hours work, which would be expected given the nature of this work. The anonymous quarterly survey on detriment shows that some doctors are reporting detriment or discouragement from Exception Reporting, which is of some concern: it is difficult to know how to interpret the results, as the survey was open for a very short period resulting in low response rate; and this is the first time it has been done, as it is a new requirement. More work is needed to understand the results, and I will ensure the next quarterly survey has a much longer window for responses to try to get a more representative result.

The GoSWH is required to report issues, with certain posts, that cannot be remedied locally and require a system-wide solution. The board is required to raise the system-wide issue with partner organisations (for example, NHS England) to find a solution.

Details
I am satisfied that patterns of exception reporting data is not indicating concerns with regard to specific issues or posts. Of the exception reports received, they relate to a range of posts and situations. Overall, I do not feel there are issues which need to be escalated for a system-wide solution.

Meeting:	Board of Directors' Meeting
Date of Meeting:	22 July 2026
Agenda item:	14
Report title:	Thames Valley Mental Health Provider Collaborative update
Executive sponsor(s):	Amelie Bages, Executive Director of Strategy Rob Bale, Consultant Psychiatrist and Chief Operating Officer for Mental Health and Learning Disability
Report author(s):	Lisa Reynolds, Associate Director of Mental Health for the Thames Valley Mental Health Provider Collaborative
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board:	Board update
Public or confidential	Public

Executive summary

Background

The Thames Valley Mental Health Provider collaborative (TV MHPC) was initially developed as the Buckinghamshire, Oxfordshire and Berkshire West Mental Health Provider Collaborative (BOB MHPC), and later aligned with the Thames Valley ICB footprint in 2025. The Provider collaborative was established in 2023 through the NHS England Provider Collaborative Innovator Programme and in response to NHS England's requirement that all mental health and acute trusts become part of a provider collaborative. The TV MHPC has brought together Berkshire Healthcare NHS Foundation Trust, Oxford Health NHS Foundation Trust, the BOB Integrated Care Board, and wider system partners to drive transformation and improvement across non-specialised mental health services for all age groups across the BOB Integrated Care System.

The collaborative's overarching aim is to improve population mental health outcomes through large-scale service transformation, improved partnership working, and more effective use of collective resources. It seeks to reduce unwarranted variation in access, experience and outcomes, address health inequalities, improve system resilience, and deliver greater value through coordinated service design and delivery. Since 2023, the collaborative has enabled partners to work collectively to identify priorities, share best practice, and implement sustainable improvements supported by continuous quality improvement approaches.

A portfolio of transformation programmes has been developed through extensive engagement with system partners, including the NHS, local authorities, primary care and the voluntary, community and social enterprise (VCSE) sector. These programmes have been refreshed over time to align

with evolving system priorities, with leadership and delivery responsibilities shared across partner organisations.

Progress across these programmes is monitored through established collaborative governance arrangements, that supports delivery at both place and system levels.

Key achievements through collaboration include the successful joint delivery of the NHS England funded national three-year adult in patient transformation programme with cross-trust learning forums and a Community of Practice model to strengthen partnership working; shared work to develop trauma-informed care approaches. Reducing restrictive practices through quality improvement methodologies and strengthening support following incidents of violence and aggression. Both BHFT and OHFT worked collaboratively to address racial violence and discrimination, including engagement with Operation Cavell and Thames Valley Police. More than seven wards participated in the two-year Culture of Care programme, over fourteen wards engaged in staff development initiatives, and more than ten ward managers completed leadership development programmes, resulting in wider adoption of Culture of Care principles, improved staff engagement, enhanced patient experience and stronger, more recovery-focused inpatient services.

Key messages

- The TV MHPC has become a recognised collective voice for mental health across Thames Valley through shared commissioning priorities, robust governance and strong partnership working.
- The Thames Valley Mental Health Provider Collaborative's workplan for 2026-7 sets out a programme of transformation aimed at delivering a consistent, high-quality and financially sustainable mental health system across the region. Key priorities include developing a sustainable Female PICU model, implementing a collaborative secure transport framework, redesigning adult ADHD pathways to improve access and reduce waiting times, establishing shared Mental Health Investment Standard governance arrangements, and co-designing a system-wide mental health rehabilitation pathway focused on recovery and reducing inpatient dependence.
- Expected benefits include reductions in unwarranted variation, enhanced patient outcomes and experience, stronger shared decision-making, increased provision of care closer to home, and greater value achieved through collaborative commissioning and procurement
- The collaborative provides a strong foundation for integrated mental health leadership and commissioning, effectively linking system with Place based arrangements so that delivery is tailored to the needs of the population of Thames Valley with equity of access and outcomes and efficiencies through working together at scale are realised.
- Through connecting Place with system the TV MHPC ensures that delivery is tailored to local need, with opportunity to extend collaboration to include education, housing and employment as the collaborative matures.

- Alignment with the Thames Valley ICB operating model presents an opportunity to strengthen commissioning, partnership working and integrate mental health leadership across the region.

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

Executive Performance Review meeting 20 July 2026

Recommendation(s)

The board is asked to note the update on the Thames Valley Mental Health Provider collaborative

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

Board of Directors

Thames Valley Mental Health Provider Collaborative

Update to the Board of Directors | 22 July 2026

Lisa Reynolds; Associate Director Mental Health
Amelie Bages; Executive Director Strategy
Rob Bale; Consultant Psychiatrist and Chief Operating Officer for Mental Health
and Learning Disability

2026

SECTION 01

Background

An overview of the development and purpose of the Thames Valley Mental Health Provider Collaborative

01

Background

Origin, partners, footprint and delivery purpose

Developed in 2023 as part of the 2022 NHS England Provider Collaborative Innovator Scheme, the Thames Valley Mental Health Provider Collaborative brings partners together to improve mental health outcomes across the TV Integrated Care System.

PARTNERSHIP

Berkshire Healthcare NHS Foundation Trust and Oxford Health NHS Foundation Trust work with the BOB Integrated Care Board and system-wide partners.

SCOPE (expanded April 2026)

The collaborative covers all non-specialised, all-age mental health and neurodiversity (Autism and ADHD) services across Berkshire, Buckinghamshire and Oxfordshire.

PURPOSE

Its aim is to improve population mental health by coordinating transformation at scale and strengthening alignment with place-based partnerships.

DELIVERY FOCUS

- Lead comprehensive transformation at scale
 - Use resources efficiently and reduce unwarranted variation
 - Redesign pathways to reduce inequalities and improve outcomes
-

SECTION 02

Governance

Oversight, alignment and decision-making

02

Governance

System alignment, accountability and delivery links at a glance

SYSTEM VOICE AND OVERSIGHT

The TV MHPC aligns Place with the wider system, using the Partnership Programme Board to bring Thames Valley partners together as a single mental health voice, agree shared commissioning intentions and oversee system transformation programmes.

ACCOUNTABILITY MODEL

The TVMHPC governance structure aligns Place with the wider system so partners can work effectively at scale, while formal decision-making remains with each organisation.

ICB ALIGNMENT

- Further connect the TV MHPC with strategic commissioning for mental health.
- Use MHIS planning arrangements to support effective joint working while assurance meetings are paused.
- Governance to be further developed following ICB's operating model development: e.g., performance and quality approaches.

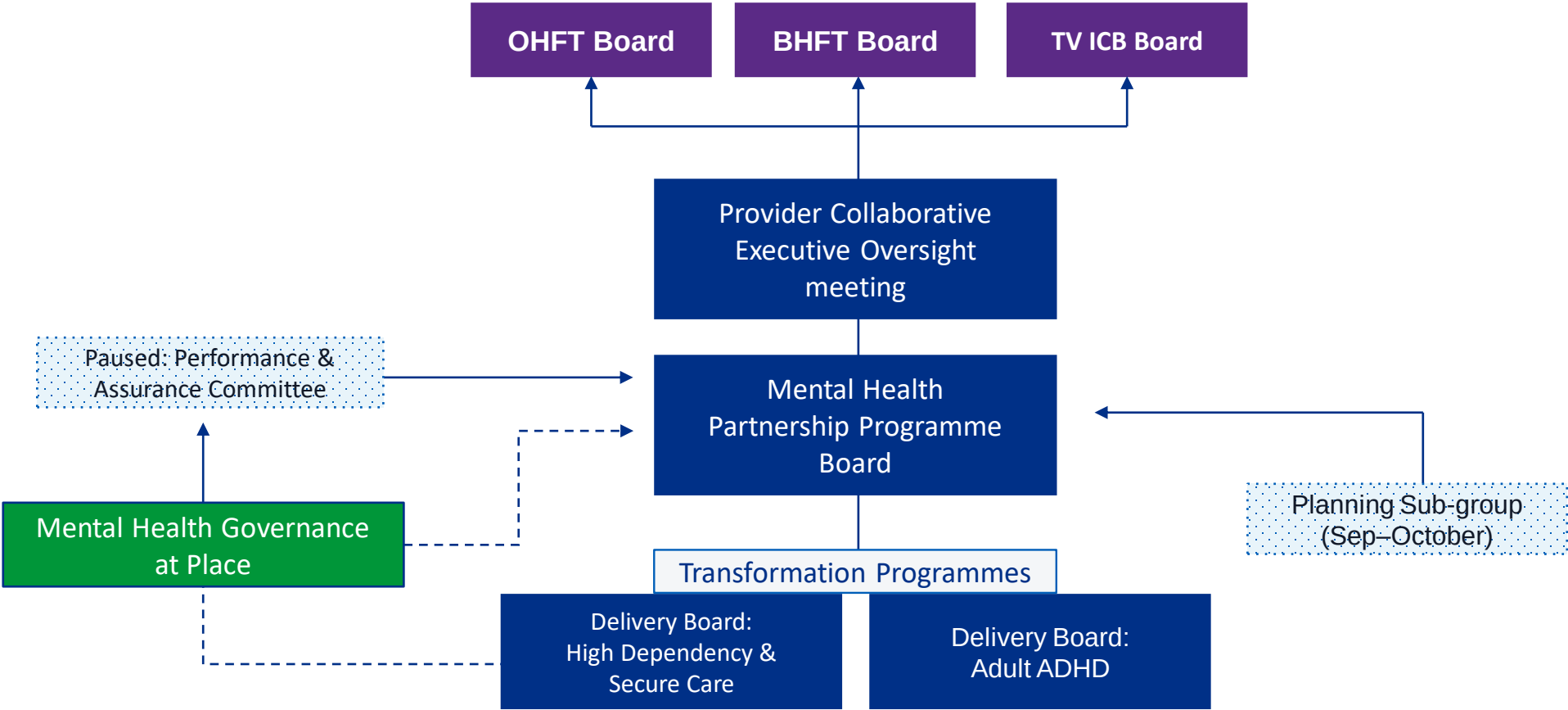
PLACE AND NEIGHBOURHOOD LINKS

- Place boards provide reporting and escalation; variability in structures needs resolution.
- Transformation programmes, VCSE input and workshops support Place alignment.
- Neighbourhood Health links are maintained through OHFT/BHFT governance and VCSE partners.

In practice, governance provides a single system voice while keeping accountability with each partner organisation.

TV Mental Health Partnership Governance July 2026

Board meeting in public



Key:

Organisational governance	Provider collaborative	Place governance	Paused / planned

SECTION 03

TV MHPC progress 2025-6

03

MHPC development and key achievements 2025-6

- **Sustainable improvement in adult inpatient services** embedded through shared learning, quality improvement and emerging communities of practice across both Trusts through successful delivery of the 3-year Adult Inpatient Quality transformation programme.
- **Commenced Joint Procurement of Secure Transport and Female PICU**, improving quality, consistency and reducing reliance on out-of-area placements.
- **Delivered system learning and efficiencies** through completion of the MHLDA Resource Review, with learning informing future rehabilitation pathways, Section 117 arrangements and ongoing work to further reduce use of out-of-area placements.
- **Initiation of the revised Adult ADHD pathway**, moving from strategic design into operational delivery, supported by dedicated programme leadership, strengthened governance, GP training and implementation of shared care arrangements.
- **Strengthened partnerships with the VCSE sector**, increasing strategic collaboration, improving visibility of VCSE organisations and supporting more integrated prevention, early intervention and place-based mental health services.
- **The MHPC provides the single voice for mental health across Thames Valley**, reflected in shared medium term mental health commissioning priorities for the system.
- **Enhanced strategic oversight of mental health investment**, providing transparent, collaborative governance for Innovation Funding and MHIS investment decisions, supporting equitable prioritisation and system-wide decision-making.

1

Programme 1: High Dependency and Urgent Care

Shared transformation and procurement of specialist and secure patient services.

Key Activities and workstreams:

Learning disability inpatient scoping — provision and demand review complete; outputs will inform potential 2027-28 workplan inclusion.

Female PICU — review complete; BHFT/OHFT joint procurement by Q4 2026-27 to create local Thames Valley capacity and reduce out-of-area placements.

Secure transport — joint procurement by Q3 2026-27 to improve quality, patient safety and equity while gaining scale efficiencies.

2

Programme 2: Three-year Adult Inpatient Transformation

Joint delivery of the NHS England three year Adult in Patient quality Transformation Programme to ensure therapeutic and purposeful admissions with timely and effective discharge.

Key Activities and workstreams:

Staff support after incidents & Operational Cavell — shared resources support a consistent response to violence and aggression; multiagency approach adopted to protect NHS staff from violence and abuse. Learning shared nationally through presentation at MHNAUK Mental Health Nursing Research Conference and Royal College of Psychiatry Quality Improvement Conference in October 2026

Enhanced therapeutic observation and care — MDT collaboration continues with sharing of best practice to enable continuous service improvement.

Closure and legacy — from April 2026, improvements are embedded in business as usual with BHFT, ICB, VCSE and Experts by Experience.

3

Programme 3: MHLDA Resource Review and Improvement Group

Collaborative approach to addressing system risk share for mental health through effective management of contracts and reduction in use of out of area and private beds

Key Activities and workstreams:

Risk share and s117 aftercare — joint TV ICB work strengthened contract management and aftercare provision.

Delivery constraints — data limitations and ICB financial reporting structures affected the ability to evidence outcomes.

System workshop — VCSE and Local Authority input supported a more consistent Thames Valley approach.

Learning for new programmes — system structures and interoperability issues now inform future MHPC design.

SECTION 06

Progress and planning 2026-7

06

Progress against MHPC commissioning intentions

Board meeting in public



Thames Valley Mental Health
Provider Collaborative

2026-7 / 2027-2028 outlook: medium-term intentions will evolve with the development of the ICB strategic commissioning role and mental health strategy.

Commissioning intention	Progress 2026 and next steps
Develop a coherent system wide, all age offer for people with neurodiversity needs	Adult ADHD programme to reopen local Adult ADHD wait lists, moved into the MHPC in June 2026. The programme is being refreshed for joint delivery with TV ICB and to reflect ICB operating model changes.
Treatment and support for people with Serious Mental Illness (SMI) support	A system-wide rehabilitation pathway review commenced in June 2026 to identify areas of focus for a system wide approach to service improvement to enable equity of access and outcomes. A September workshop planned with VCSE partners and Experts by Experience.
Crisis and acute services	Work is happening at Place to respond to the Ten-Year Health Plan ambition for mental health Emergency Departments (EDs) and 24/7 crisis support. To enable system oversight this work will report into the MHPC governance from July 2026.
Access to Children and Adolescent Mental Health services (CAMHS)	Through the MHPC MHIS funding has been allocated across Berkshire, Buckinghamshire and Oxfordshire to reduce waits, including recruitment of additional CBT-focused psychological therapists. Delivery will report through the MHPC governance.
Dementia diagnosis and management	A review of current provision to commence once national guidance on new dementia treatments is published and local implications are clearer.

MHPC transformation programme priorities for 2026-7

Board meeting in public

Programme priorities: developed from commissioning intentions, system pressures, regional and national drivers.

Priority	Delivery 2026/27	Timeline	Impact
Female PICU	Refine specification; benchmark providers; test costs; shape procurement model.	Summer: specification agreed. Autumn 2026: procurement launched. Winter: award and mobilisation.	More consistent care standards, clearer cost visibility, stronger value for money, safer inpatient environments.
Secure Transport	Procure a single system-wide framework with fixed standards for quality, pricing and oversight, including future provision for conveyance to a place of safety under Section 136 of the Mental Health Act.	Jul 2026: tender issued. Aug–Sep: evaluation. Autumn/Winter: award and mobilisation.	One system approach, stronger control and assurance, clearer conveyance responsibility, scalable for future Section 136 use if funded.
Adult ADHD	Transform the Adult ADHD pathway across the Thames Valley by reducing waiting times, enabling the safe re-opening of paused waiting lists, and improving the quality and consistency of care through the patient pathway.	2026/27: programme transformation plan in progress with process measures agreed and monitored through robust governance.	Reduced waiting times, restored local access to assessment and treatment, more consistent provision across the Thames Valley, improved patient experience.
Mental Health Rehabilitation Pathways	System review of rehabilitation pathways; co-design with Experts by Experience, VCSE partners and providers; develop future model of care with partners and ICB.	Autumn 2026: System workshop with ICB and VCSE partners. 2026/27: Model development and pathway design.	More care delivered closer to home, reduced reliance on inpatient rehabilitation, stronger recovery focus, improved experience and outcomes for patients.

Programme focus: Adult ADHD

Thames Valley Mental Health Provider Collaborative (TV MHPC) for implementation and provide a co-ordinated and deliverable response to longstanding pressures in access, capacity and pathway consistency. Its purpose is to stabilise current services whilst mobilising a more sustainable Thames Valley model for adult ADHD support.

Work is currently in progress, with 4 workstreams currently established for joint delivery with the ICB:

1

Waiting List Integration:

Reduces Adult ADHD waits, improves patient flow and supports reopening local waiting lists through short-term action while longer-term transformation develops.

2

Community & Digital Support:

Expands voluntary and community support beyond diagnosis and treatment, including a website and offer co-designed with lived experience and local VCSEs.

3

Shared Care, Advice and Guidance:

Builds consistent primary-secondary care pathways, including support for complex needs, advice and guidance, and GP education.

4

Single Point of Access Vision and Future Operating Model:

The workstream will consider different delivery options, where this function should sit, and how it can support a more coherent and sustainable model in the future. It is intended as a strategic transformation workstream rather than an immediate solution, helping to create consistency, reduce variation, and clarify how people enter and move through the ADHD pathway.

Next steps

Alignment with ICB structure and strategic commissioning

Joint planning meetings with BHFT, OHFT and ICB in September with MHIS allocation for 2027-8 to be agreed at the 14 October Partnership Programme Board

System engagement with rehabilitation scoping work; system workshop planned for September 2026

Annual refresh of system MH priorities in Spring 2027

TV MHPC potential commissioning function to be considered; to support development of neighbourhood and partnership working with VCSE

Meeting:	Board of Directors' Meeting
Date of Meeting:	22 July 2026
Agenda item:	15
Report title:	Research and Development (R&D) report to the Board Meeting of Oxford Health NHS Foundation Trust
Executive sponsor(s):	Dr Karl Marlowe, Chief Medical Officer
Report author(s):	Dr Martin Batty, Head of R&D Professor Vanessa Raymont, Director of R&D
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board:	Board Request
Public or confidential	Public

Executive summary

To draw board attention for information and assurance on R&D Teams' areas of work:

- Performance against the Government's 150-day set up target
- Update on BRC Application
- Host overarching PPIE Strategy
- ARC Update
- Automated virtual reality psychological therapy for needle phobia
- Future of Psychiatry Conference

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

This report has not been submitted elsewhere and has been written specifically to update the board of developments within R&D and its related NIHR infrastructure.

Recommendation(s)

Not applicable. This report is intended solely for information.

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	

This report covers recent activity related to Oxford Health NHS Foundation Trust (OHFT) Research and Development (R&D) under the direction of Professor Vanessa Raymont, R&D Director.

National 150-day set up target

As detailed in March 2026's Board report, NHS providers are required to meet site-specific timeframes of the government's 150-day clinical trial set-up target, which aims to reduce study set up times from an average of 250 days to fewer than 150 days. For 2026/27 the [NHS Oversight Framework](#) (NOF) includes a new metric of the percentage of clinical trials set up within 90 days (see below), reported on a quarterly basis.

Two separate reports were submitted to the Extended Leadership Team (ELT; 02 February 2026) and the Quality Committee (QC; 12 February 2026), detailing the 3 distinct sub-components that make up the target, comprising 60/60/30 days. As the first 60 days (submission for REC/HRA approval) is out of study teams' hands, Trusts will only be measured on the second and third components totalling 90 days: 60 days from joint approval to study opening; and 30 days for first recruit.

For Quarter 1, Oxford Health NHS Foundation Trust (OHFT) failed to meet the national target of 95% of studies being set up within 90 days. Based on [data from the UK Clinical Research Delivery](#) (UKCRD), currently the only source available to enable pan Trust comparisons, 0/5 OHFT-led studies met the 90-day metric, with a median of 153 days from site approval/site selected to first participant. It should be noted that these data cover a wider period (January-June 2026) than that used for the NOF (April-June 2026). To put this in context, the national median for the same period was 6 studies, with 40% meeting target. Our Joint Research Office (JRO) partner, Oxford University Hospitals (OUH) evidenced a similar pattern of performance, with 0/7 studies meeting target and a median of 150-days. While the figures are stark, it is important to note that for OHFT (and probably many other Trusts), the data include legacy studies in which although the set up began during 2025/26, the first patient visit did not occur until 2026/27. Consequently, these data are included in the 90-day dashboards.

In response to the Government's mandate, during 2025/26 OHFT R&D evaluated its study set up processes and began implementing a swathe of new and/or redesigned procedures designed to reduce delay. These included the introduction of a revised study prioritisation framework and feasibility and pipeline process, parallel review pathways, enhanced contracting and governance processes, digital system developments, improved data quality and reporting, strengthened recruitment planning, and capacity management and escalation mechanisms. Taken together, these changes have moved study set-up from a largely sequential and reactive model to a more strategic and parallel-based process. Data from studies currently progressing through this redesigned pathway suggest that these changes are paying dividends. Of the 5 studies that entered OHFT's new prioritisation process (from 01 March 2026) 4/5 have met the 60-day target (median 57 days). While this substantial improvement in study set-up performance is promising, it is crucial that participants are recruited to these studies once 'green light' has been issued by the sponsor or these improvements will count for nothing. This is further complicated by the fact that other legacy studies may yet show in later quarters this financial year depending on

whether they are included or excluded from the metric. However, the trajectory appears to be much improved, and we will continue to update on performance to the Board in addition to the NOF.

Somewhat related, OHFT led an analysis of an NIHR dataset to assess the relationship between time to recruiting the first patient to a clinical trial and ability to recruit to time and target at both a site and study level (global, European and UK 'firsts'). Sites that recruit their first patient early are more likely to complete accrual in a timely manner. A secondary analysis showed this effect was particularly strong across all 'firsts', particularly global firsts, highlighting the importance of rapid study set up ([Batty, MJ., Wason, JMS, Ward, DJ et al. The predictive power of first recruits to commercial trial performance. BMC Med Res Methodol \(2026\)](#)). OHFT also continues to work with the Health Research Authority (HRA) to streamline processes for cyber checks that can delay study set up. Together, this ongoing work ensures that OHFT is at vanguard of developing evidence and is leading national processes to streamline trial delivery.

BRC Renewal

The National Institute for Health and Care Research (NIHR) Biomedical Research Centre (BRC) Oxford Health will complete work for its current NIHR contract on 31 March 2028. The NIHR has launched a new BRC competition (guidance available [here](#)), inviting current and new NHS Trusts in England to apply for up to £50 million of funding per BRC over a five-year period from 1 April 2028.

Oxford Health will be submitting a stage one proposal by 17 September 2026, continuing to focus on **brain health** (with primarily mental health) and retaining the current model of partnership and collaboration with other Universities and NHS Trusts in England. The NIHR is clear that current BRCs will not be prioritised and this is a new scheme with different rules and the expectation of extensive partnership and collaboration. Six hundred million pounds is available nationally, so there will be significant competition for funding. To put this in context, if each of the BRCs were awarded the maximum £50 million, this would only support 12 BRCs and there are currently 20. We are aware of new BRCs with a mental health focus being proposed in addition to the Maudsley and Oxford Health BRCs, which will increase competition even further.

An Expression of Interest (EoI) process was held, widely advertised within the Trust, which elicited 41 EoIs. Twelve groups, including partners outside Oxford, have been invited to put together research Themes. There is significant current activity around the partners and collaborators, plus work being done to refine the Theme objectives. Once the stage one application has been submitted a further update will be provided to the Board. If we are invited to submit a stage two proposal this will be due on 24 March 2027, with interviews scheduled for June 2027 and a final outcome available by September 2027. The new funding contract would start on 1 April 2028.

Host overarching PPIE Strategy

In 2025 the NIHR announced that holders of its infrastructure awards must develop a single Institutional level Public and Patient Involvement, Engagement and Participation (PPIEP) strategy. As a host of multiple NIHR infrastructure awards (ARC, BRC, CRF, HRC), OHFT convened a Steering Group to oversee this work,

comprising representatives from each of OHFT's NIHR infrastructures and PPIE members. The Steering Group met 6 times over the course of a 9-month period, from October 2025-June 2026 and the strategy was submitted to the NIHR on 06 July for feedback and approval. Once approved, each infrastructure will be required to devise their own implementation plan, with progress reported through OHFT's NIHR Managers' group and other established Trust processes, including updates to the Board.

ARC Update

OHFT hosts the NIHR Applied Research Collaboration Thames Valley (ARC-TV), a five-year research infrastructure commissioned from April 2026 with funding of just under £18 million.

With a geographic footprint covering the Thames Valley and North-West London, the ARC brings together NHS, academic, local authority, industry and community partners to undertake applied research that addresses shared health and care priorities. The ARC complements the Trust's wider NIHR research infrastructure by supporting collaboration across the health and care system to generate, implement and evaluate research that improves services and patient outcomes.

During the mobilisation phase, governance arrangements have been established through the Strategic Board and ARC Executive, recruitment to the core team is progressing, and work is underway with Trust and Integrated Care Board leaders to develop a research portfolio aligned with regional priorities. Inclusive patient and public involvement and equitable access to research participation are being embedded from the outset to support delivery of equitable impact over the lifetime of the award to serve the needs of the regions' diverse population segments.

The ARC team is currently preparing for its NIHR site visit, supported by the wider Trust Research and Development infrastructure to demonstrate the governance, operational, and organisational arrangements expected of an NIHR-hosted infrastructure.

Automated virtual reality psychological therapy for needle phobia

A new study led by Professor Daniel Freeman and researchers from the University of Oxford and NIHR Biomedical Research Centre: Oxford Health and conducted with the Oxford Health Oxfordshire School Aged Immunisation Service (SAIS) suggests that needle phobia can be successfully treated using an automated virtual reality (VR) psychological therapy.

Although needle fears are common, especially among children and adolescents, very few people can currently access therapy to treat them. With the user guided by a 'virtual coach', the new VR treatment can reach many more patients. In the first ever clinical trial of a VR treatment for needle fears in adolescents, published in *The Lancet: eClinical Medicine*, the automated therapy was shown to substantially reduce needle fears in young people aged 12-15 years.

Needle fears affect around 20-50% of adolescents. However, several key vaccinations are given during the teenage years to protect against tetanus, diphtheria, polio, meningitis, and the human papillomavirus (HPV). The NHS aims to

vaccinate 90-95% of adolescents, but currently only 70-75% are vaccinated, with around 10-20% of the shortfall being attributable to fear about needles.

The new treatment, which takes around 2.5 hours to complete, involves participants working through five levels of exposure: looking at needles, picking up needles, using needles, observing needle procedures, and receiving needle procedures. The tasks build up from seeing virtual needles in display cases to piercing balloons with needles to injecting a penguin and a giant to watching a person being vaccinated to a final gym-set school scene, in which a nurse gives a vaccination into the user's virtual arm.

Future of Psychiatry Conference

As part of the Warneford 200 events, Oxford University's Department of Psychiatry held a day-long event, "The Future of Psychiatry" on 08 July. The day included keynote addresses by Dr Lade Smith, President of the Royal College of Psychiatrists; and Professor Steven Hyman. A range of presentations from distinguished Oxford and international experts on topics ranging from Biomarkers and Mathematical models in Psychiatry, The Warneford Park Project, Mental Health Prevention and Equity, and Personalised, Repurposed and Scalable Care made for a thought provoking and engaging event that was well-received and attended.

Meeting:	Board of Directors' Meeting
Date of Meeting:	22 July 2026
Agenda item:	16(a)
Report title:	Report from Audit and Risk Committee on matters to Alert, Advise or Assure
Executive sponsor(s):	N/A
Report author(s):	Harjit Sandhu Non-Executive Director and Chair of Audit and Risk Committee
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board:	To provide assurance to the Board on the Financial Statements and Accounts for 2025-26, and to recommend their approval to the Board
Public or confidential:	Public

Executive summary

The Audit and Risk Committee met on 15 June 2026 and, amongst other matters, reviewed the Financial Statements and Accounts ("the Accounts") for the year ended 31 March 2026. The Committee received the draft report from the Trust's External Auditors, Ernst and Young, who confirmed that they would be issuing an unqualified opinion on the Accounts.

The Committee also received and reviewed other reports to support the Committee's recommendations; these included:

- Internal Audit annual report for 2025-26, including the final Head of Internal Audit Opinion
- Counter Fraud annual report for 2025-26
- Going Concern Statement
- Annual Report for 2025-26, including the Remuneration Report and Annual Governance Statement
- Annual report on whistleblowing arrangements
- Oxford Health in Numbers 2025-26.

This report is to provide assurance to the Board on the Accounts for 2025-26, and to recommend their approval to the Board, as well as recommending approval of the Annual Report (including the Remuneration Report and Annual Governance Statement), and the External Audit Letter of Representations due from Management.

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

N/A

Recommendation(s)

The Board is asked to:

- note the recommendations of the Audit and Risk Committee
- approve the Financial Statements and Accounts for 2025-26 on a going concern basis, and
- approve the Annual Report (including the Remuneration Report and Annual Governance Statement), and
- agree and sign the External Audit Letter of Representations due from Management.

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 To meet legal and regulatory annual reporting requirements	

For Assurance (to note)

The Audit and Risk Committee wishes to assure the Board:

- That the Trust received a positive Internal Audit annual report with no items of concern to highlight (three amber-green ratings and one green rating on data captured and used by the organisation)
- That the Trust received a positive Counter Fraud annual report with an overall green rating and two amber ratings; the latter amber ratings are expected to change to green in-year once the NHS Counter Fraud Authority has updated its national guidance
- Of a positive External Audit process, which is currently ahead of the position last year. In particular:
 - External Audit anticipate issuing an unqualified opinion on the Accounts;
 - External Audit anticipate providing their final External Audit report for this Board meeting, to include management responses;
 - External Audit have confirmed that the Letter of Representations due from Management is based on their standard template for NHS foundation trusts, and they are not requesting any additional representations from the Trust this year;
 - whilst work is still ongoing on the Remuneration Report as a result of some errors identified, none of these are anticipated to prevent sign-off of the Accounts by the Board on 24 June;
 - some work on risk areas is still in progress (deferred income, receivables and the Remuneration Report) and one ongoing difference of opinion in relation to Modern Equivalent Asset valuations (anticipated to be resolved next year when the Estate will be subject to a full valuation) (currently a potential understatement in the asset valuation rather than an overstatement);
 - no post-balance-sheet adjusting event anticipated on PFI settlement; this is expected in the next financial year 2026-27 instead;
 - some low value errors/recommendations identified in relation to lease disclosures and de minimis threshold for accruals but low value impact on the Accounts – *if* those errors were replicated through all transactions in the Trust's entire financial records, then the knock-on effect would be a £3.6 million reduction in income;
 - there were no specific actions/recommendations proposed in relation to the control environment, just internal governance procedures (especially in relation to the Remuneration Report (see below) and exit packages);
 - the Committee has asked for improvements in the accounting and reporting of any staff exit packages, particularly when confirmed close to the year-end, as Remuneration Report issues have been picked up by External Audit over the last few years e.g. agreeing up front whether exit packages should be reported when they are agreed or when they are actioned, as this may affect which financial year the cost is posted to;

- changing methodology on preparation of fair pay multiples, firstly, these now need to include agency staff and secondly, the use of total remuneration (including pension and other benefits) versus salary alone, which can be more of an issue for senior clinical staff, who can skew the data set. The previous approach was to use basic salary for all staff but in the case of senior clinical staff this can be misleading as their basic salary could be half of their total remuneration when all benefits are taken into account
- That, after having reviewed the Going Concern Statement as presented to the Committee in April and June 2026, Going Concern is the appropriate basis for preparation of the Accounts
- That, after having reviewed the Annual Report (including the Remuneration Report and Annual Governance Statement), that it is recommended for approval
- That, having reviewed the annual whistleblowing report to the Committee, there continues to be sufficient evidence and ongoing oversight/improvement activity to provide reasonable assurance that appropriate arrangements are in place with regard to the Trust's whistleblowing and "Speak Up" procedures
- That "Oxford Health in Numbers" remains a useful snapshot and user-friendly presentation of work carried out by the Trust over the last 12 months.

In addition to the above work on year-end/annual reporting cycles, the Committee also received reports on:

- Losses & Special Payments
- Estates/Health & Safety
- Deep dives on risks A4 Recruitment & Retention and A10 Digital transformation
- 3As report from the Emergency Preparedness, Resilience and Response (EPRR) Committee.

Meeting:	Board of Directors' Meeting
Date of Meeting:	22 July 2026
Agenda item:	16(c)
Report title:	Report from the People, Leadership & Culture (PLC) Committee on matters to Alert, Advise or Assure
Executive sponsor(s):	N/A
Report author(s):	Mindy Sawhney Non-Executive Director and Chair of the PLC Committee
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board:	For Board advice and assurance, or discussion as appropriate.
Public or confidential:	Public

Executive summary

The Committee continues to meet every quarter and last met 8 July 2026 and considered the agenda (available in the Reading Room). There were no new matters for Alert and no outstanding Alerts from the April meeting on which to update.

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

N/A

Recommendation(s)

- FTSU Guardian Annual Report** The Committee approved the annual FTSU report and commends this to the Board. The number of concerns raised remains broadly stable with the vast majority relating to staff safety and wellbeing.

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	No	

Recommendations

1. **FTSU Guardian Annual Report** The Committee approved the annual FTSU report and commends this to the Board. The number of concerns raised remains broadly stable with the vast majority relating to staff safety and wellbeing. Work is continuing to strengthen consistency across the Trust in terms of leader visibility, responsiveness and follow up. Two complaints have been raised regrading perceived detriment, both have been escalated and investigated by the CPO and CEO. Perceived futility continues to be a barrier to speaking up. While significant efforts are being made to identify and pursue opportunities to improve, the Trust continues to perform strongly in this area evidenced by consistently higher than national average scores from the staff survey.

For Alert

No new matters for Alert.

To Advise

Colleagues advised the Committee that there is some disaffection among staff groups when single groups of staff are highlighted in terms of wellbeing, recognition and reward. A current challenge is communicating Trust delivery of the national 10 Point Plan for Resident Doctors. The Committee agreed there was an opportunity to frame such improvements as improvements in experience for the specific staff group and for all Trust colleagues, noting the gains made in fostering a 'One Trust' culture.

To Assure

Workforce

1. **Metrics** The Committee noted the sustained improved performance across all people metrics. We also noted the improved reporting of metrics, including both aggregated and disaggregated data on key risk areas such as vacancy. While all people metrics are broadly within target there remain challenges in key areas including vacancy rate in Forensics. The Committee asked for strengthened commentary, particularly including the 'so what' including when there is variance between the aggregated and disaggregated figures
2. **WRES WDES & EDI Integrated Plan 2026-28** The Committee received the WRES and WDES reports which show a mixed but improving picture. Ethnic minority colleagues continue to be more likely to be appointed following shortlisting. The Committee asked colleagues to consider a) extending analysis to all stages of the recruitment process to understand where opportunity for improvement is greatest and b) to consider whether our goal is to redress historic imbalance in the workforce and how this might be perceived by white colleagues. While harassment, bullying and discrimination is reported as improved, there remains a difference between the experience of ethnic minority and white colleagues. Ethnic minority colleagues continue to be three times as likely to face disciplinary procedures. Disability declaration rates have increased and, as for race, the WDES shows a mixed but improving picture particularly in recruitment, capability processes, reasonable adjustments and behaviour of colleagues. Areas for focus include bullying / harassment from patients/ public, and perceptions of career progression. The Committee welcomed production of an integrated plan for EDI work, bringing all the various Trust programmes and national requirements into a single plan of work

3. **Employee Relations annual report** The Committee received the report with thanks and noted the availability of AI, and forthcoming changes to Employment Rights are contributing to an increase in both employee relations casework and Employment Tribunal Cases and that this is likely to continue. The Trust should consider whether it needs to reassess its approach and resourcing for such cases. We noted that while the number of Disciplinary cases has increased (from 80 to 129 cases), the number of Grievances, Whistleblowing and Capability procedures has reduced. More cases are being resolved informally even with increased numbers (72% vs 65% in the preceding year). Further work has been undertaken to assess Trust performance compared to our sister Trusts and we have established that we are broadly in line. The new HR structure allows for ER Casework Specialists which will increase our capacity to analyse our data to understand better what is driving the over representation of ethnic minority and male colleagues in disciplinary cases. The Committee note the importance of including 'where' incidents are taking place (eg Forensics sees a high number of cases) and, where possible, to develop both an intersectional view (including socio-economic background) and a segmented view of ethnic background to better formulate interventions going forward.
4. **National Job Evaluation** The Committee was assured that the Trust is compliant with the national approach with Band 6 colleagues and is on track to deliver to NHSE its plan for implementation by 31 July.
5. **Alteration of Workforce KPIs** The Committee received assurance regarding the resetting of key workforce targets noting all targets setting more demanding performance except for Supervision and Statutory and Mandatory Training compliance which moves from 95% to 90% in line with common practice across the NHS and is also in line with the national Core Skills Training Framework.

Leadership & Culture

6. **Staff Survey** The Committee received the segmented analysis of the staff survey and was assured that the data are being appropriately analysed by protected characteristics, staff professional group, directorate and team and that a programme of targeted work has been developed and is underway. The Trust remains limited in its ability to develop an intersectional view of the data due to limitations on data manipulation by NHSE. We are again flagging this nationally
7. **Our People, Our Culture** The Committee was pleased to receive this update and noted inclusion of the link to Trust strategy, Purpose, and the focus on Teams. The Committee flagged an opportunity to reference Patients more directly and to connect this Culture work to other OD levers including structures, systems and processes. The executive confirmed there is a conversation with Strategy colleagues about performance indicators and embedding these within the indicators used to monitor overall implementation of Trust strategy. We noted the difference in view about how to formulate the implementation programme (individual vs cross cutting work streams) and the Committee asked to consider the efficacy of implementation at its Jan 27 meeting
8. **Medical Engagement & Wellbeing** As part of its twice-yearly deeper look at the wellbeing and engagement of Medic colleagues, the Committee received an update from the DCMO (Professional Standards) who noted continuing improvements particularly in recruitment and in colleagues who would recommend the Trust as a place to work. We also noted improving relationships with the LNC and the importance of hearing also from colleagues who are not represented by the BMA. Areas of focus going forward include retention,

addressing lower ratings for Freedom to Speak Up (65% for Medics vs 72% for the Trust as a whole) and for the People Promise *We are always learning*

9. **Forensics: Thames House deepdive** The Committee was delighted to welcome Forensics colleagues to the meeting. We had a candid conversation about the interlocking challenges of acuity, patient flow and vacancy, noting the combined impact of a single patient requiring intensive intervention, some experienced senior staff leaving, and removing our reliance on long lines of agency. The Committee was assured that the team is leading an improvement (including filling vacancies) but recognised that significant work remains to stabilise and improve the service. We were encouraged by the openness to feedback, candour regarding the challenges faced, and recognition of opportunities to strengthen approaches to QI and race equality, and whether senior management can do more of the assurance to external stakeholders to free up service managers to support and develop staff confidence and capability
10. **Social Work Strategy** The Committee was pleased to have the opportunity to learn more about the Trust's first social work strategy. Appropriately for a first iteration, the strategy is focused on strengthening professional identity, culture and values, workforce development, leadership, and research and evidence-based practice. The Committee noted future strategies might link more directly to the overall Trust strategy and to addressing the challenges of the Trust in terms of patient care and outcomes
11. **AHP Strategy Update** The Committee was pleased to receive an update on implementation of the AHP strategy which shows impact through improving metrics and contributions to service delivery, notably CYP SALT pathway. The Committee noted and encouraged efforts to link with system partners to expand Apprenticeship capacity and noted the impact of this initiative in improving workforce diversity

Risk

12. **BAF Deepdive: A4 Recruitment and Retention** The Committee received the deepdive on this risk and agreed that the risk continued to be appropriately identified. We noted that the BAF would be revisited once the Trust's new strategy is in place. The Committee noted the opportunity to think more deeply about risk drivers – for example in terms of workforce supply and to consider how these drivers might be modifiable at Trust level (eg the global shortage of RMNs)
13. **Risk mitigations** The Committee considered the wording of the risk 'sustainable and skilled workforce now and in the future' (emphasis added) and noted controls and mitigations are strong in managing present and near-term risk but were silent about articulating medium- and longer-term risk
14. **Risk ratings** We considered the proposed retention of the current risk ratings and agreed these should be left unchanged although did acknowledge that considerable progress had been made in Staff Experience and Culture, and this may be reflected when ratings are next considered.

Meeting:	Board of Directors' Meeting
Date of Meeting:	22 July 2026
Agenda item:	16(d)
Report title:	Report from Quality Committee on matters to Alert, Advise or Assure
Executive sponsor(s):	N/A
Report author(s):	Helen Mackenzie Non-Executive Director and Chair of Quality Committee
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board:	For Board Alert/ to Advise/Assurance items from the committee and recommend for approval the Safeguarding Annual Report
Public or confidential:	Public

Executive summary

The Quality Committee met on 9th July 2026 and has identified the following items:

To Advise:

- The systems and processes are in place to identify issues that might affect quality of care and the executive have been asked to consider how assurance might be provided that agreed actions are effective. Reducing the use of prone restraint continues to be an area for focus along with the challenges of accessing the full electronic health record on RIO.
- The systems and processes are in place to meet the requirement of the Patient Safety Incident Response Framework (PSIRF). In quarter one 14 patient safety reviews were commissioned as potential for significant learning was identified. These reviews cover both community and mental health services. 38 incident learning huddles were held. Overarching areas for improvement found were working with families, communication between teams and external agencies and clinical documentation. Detailed discussions were had regarding the impact of domestic abuse related death reviews.
- The annual Patient Led Assessments of the Care Environment (PLACE) results showed improvement on last year's achievement with 6 areas showing above the national average. Plans are being developed to improve 2 areas, relating to food provision, which are reporting below the national average.
- There are two thematic reviews in progress:
Adult Attention Deficit Disorder Deaths over the last 4 years, this is due to report later this year

And patient self neglect in mental health teams - The receipt of a comprehensive report on patient experience and involvement covering peer support, experience and involvement (supporting the development of the new trust strategy gave new insights), individual placement and support and recovery colleges. Work is in progress to increase patient experience and involvement activities with community services. For assurance: - Evidence was received regarding the management of safe and positive practice - Data was received regarding the achievement of defined national waiting time targets - Systems and processes for managing heatwave conditions are constantly under review - The Safeguarding Annual report confirmed that systems and processes for safeguarding are in place and effective. Discussions were held about the increasing complexity of safeguarding. The annual report is recommended for approval There are no items to alert.

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

Recommendation(s)
The Board is asked to - Note the report - Approve the Safeguarding Annual 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			
<table border="1"> <tr> <td>Links to Board Assurance Framework (BAF) risk(s) / Trust Risk Register (TRR)</td> <td>☒ BAF</td> <td>☒ TRR</td> </tr> </table>	Links to Board Assurance Framework (BAF) risk(s) / Trust Risk Register (TRR)	☒ BAF	☒ TRR
Links to Board Assurance Framework (BAF) risk(s) / Trust Risk Register (TRR)	☒ BAF	☒ TRR	

Equality, diversity and inclusion	Yes
Legal and regulatory	Yes CQC essential standards

Meeting:	Board of Directors' Meeting
Date of Meeting:	22 July 2026
Agenda item:	17(a)
Report title:	Workforce Race Equality Standard (WRES) Report 2026
Executive lead(s):	Charmaine De Souza, Chief People Officer
Report author(s):	Mohamed Patel, Head of Equality, Diversity & Inclusion
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Committee:	Annual regulatory Workforce Race Equality Standard (WRES) report and assurance on race equality performance.
Public or confidential	Public

Executive summary

- The 2026 WRES report shows a mixed but improving position, with progress in recruitment, access to training and staff experience.
- BAME candidates continue to be more likely than white candidates to be appointed from shortlisting (0.69 to 0.60).
- The disparity in formal disciplinary processes reduced (4.59 to 3.31), although inequalities remain.
- Harassment, bullying and discrimination indicators improved, but gaps in experience between BAME and white staff persist.
- Board-level BAME representation fell from 25.0% to 23.5%, highlighting the need for continued focus on inclusive leadership.
- The PLC Committee is asked to endorse the proposed WRES Improvement Plan 2026/27, including actions to improve workforce representation, increase senior leadership and Board diversity, maintain equitable recruitment and development opportunities, reduce disciplinary disparities, improve career progression, reduce bullying, harassment and discrimination, and ensure continued organisational oversight of race equality outcomes, alongside delivery of the wider Equality, Diversity and Inclusion (EDI) Plan 2026–2028.

It should be noted that in the preparation of the 2025/26 data, it became apparent that the 2024/25 data contained an error related to the likelihood of white/BAME staff being appointed from shortlist. The impact of this error was that we reported a less favourable position than was in fact the case. The current report presented here (2025/26) contains the corrected data for 2024/25 and 2025/26. There is further investigative work being undertaken to explore how this may have impacted workforce metrics within the IPR.

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

Annual WRES Report was partially presented to the EDI Steering Group at the meeting held on 30th April 2026.

The report will be re-presented to the EDI Steering Group on 25th June 2026.

The report was presented to PLC on 8 July 2026 – see comments above.

Recommendation(s)

The Committee is asked to:

- Note the contents of the WRES Report 2026
- Consider the findings and the feedback from the People Leadership and Culture Committee.
- Endorse the proposed actions to improve the experience, opportunities and outcomes of Black, Asian and Minority Ethnic staff

Strategic objective this report supports	Select
Quality - Deliver the best possible care and health outcomes	☐
People (Workforce) - Be a great place to work	X
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 – supports Trust EDI and anti-racism objectives	
Legal and regulatory	Yes – regulatory NHS Workforce Race Equality Standard (WRES) reporting requirement.	

Meeting:	Trust Board
Date of Meeting:	22 July 2026
Agenda item:	17(b)
Report title:	Workforce Disability Equality Standard (WDES) Report 2026
Executive lead(s):	Charmaine De Souza, Chief People Officer
Report author(s):	Mohamed Patel, Head of Equality, Diversity & Inclusion
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Committee:	Annual regulatory NHS Workforce Disability Equality Standard (WDES) report providing assurance on disability equality performance and progress.
Public or confidential	Public

Executive summary

- The 2026 WDES report shows a mixed but broadly improving picture of disability equality across the Trust.
- Improvements are evident in recruitment, capability processes, bullying/harassment from managers and colleagues, reasonable adjustments and board representation.
- Areas requiring further action include harassment from patients/public, lower reporting rates, presenteeism, feeling valued and career progression perceptions.
- Disability declaration rates on ESR increased from 8.8% to 9.6%, with a reduction in unknown disability status.
- The findings have informed both the WDES Improvement Plan 2026/27 and the Trust's wider Equality, Diversity and Inclusion (EDI) Plan 2026–2028, ensuring disability inclusion actions are embedded within the organisation's broader approach to addressing workforce inequalities.
- The PLC Committee is asked to endorse the proposed WDES Improvement Plan 2026/27, including actions to improve workforce data and disability disclosure, increase representation and career progression, strengthen reporting culture, reduce bullying and harassment, improve wellbeing and staff engagement, maintain effective reasonable adjustment support, and ensure continued Board-level oversight of disability inclusion, alongside delivery of the wider EDI Plan 2026–2028.

It should be noted that in the preparation of the 2025/26 data, it became apparent that the 2024/25 data contained an error related to the likelihood of disabled/non-disabled staff being appointed from shortlist. The impact of this error was that we reported a less favourable position than was in fact the case. The current report presented here (2025/26) contains the corrected data for 2024/25 and 2025/26. There is further

investigative work being undertaken to explore how this may have impacted workforce metrics within the IPR.

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

Annual WDES Report was first presented to the EDI Steering Group at the meeting held on 30th April 2026.

The report will be re-presented to the EDI Steering Group on 25th June 2026.

Recommendation(s)

The PLC Committee is asked to:

- Note the contents of the WDES Report 2026
- Consider the findings
- Endorse the proposed actions to improve the experience and outcomes of disabled staff

Strategic objective this report supports	Select
Quality - Deliver the best possible care and health outcomes	☐
People (Workforce) - Be a great place to work	X
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 – regulatory NHS Workforce Disability Equality Standard reporting requirement.	

Meeting:	Board of Directors' Meeting
Date of Meeting:	22 July 2026
Agenda item:	17(c)
Report title:	Board Report: Freedom to Speak Up Annual Report
Executive sponsor(s):	Charmaine De Souza, Chief People Officer
Report author(s):	Rita Bundhoo-Swift & Lianne Bowes, Freedom to Speak Up Guardians
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board:	For assurance following PLC recommendation
Public or confidential:	Public

Executive summary

This report provides assurance to the Board on the effectiveness of Freedom to Speak Up (FTSU) arrangements across the Trust. Overall, the Trust continues to demonstrate a strong speaking up culture, with staff survey results consistently above national averages.

However, a slight downward trend in staff confidence that concerns will be addressed, alongside increasing demand on the service, highlights the need to strengthen feedback mechanisms, leadership responsiveness, and organisational learning.

The transition of the National Guardian's Office (NGO) into NHS England (NHSE) oversight from June 2026 following the Dash report, represents a significant national change, this will require ongoing monitoring and the necessary changes at Trust level.

Background and Context

The FTSU service is delivered by 1.6 WTE Guardians in alignment with NGO guidance. The service supports the Trust's strategic objectives, particularly the People Promise commitment that *"we each have a voice that counts."*

During the year, Guardians have worked closely with Directorates and key stakeholders to triangulate intelligence, identify emerging risks, and support learning. Regular quarterly reports have been submitted to the Executive Team/ extended leadership team

and NGO. Progress has been made against the 2023–2025 plan, and a new 2025–2027 plan has been approved by the Board.

Speak Up Culture and Staff Survey Findings

The Trust continues to perform strongly in the National Staff Survey in relation to speaking up. Staff report that they feel able to speak up, and scores remain above national and system averages. However, there has been a slight decline in confidence that concerns will be addressed, which mirrors national trends.

Oxford Health remains a strong performer; however, the slight decline from 2024 highlights the importance of sustaining momentum. Strengthening feedback loops and ensuring staff see tangible outcomes from speaking up will be critical to maintaining engagement.

FTSU Activity and Demand

During 2025–2026, 301 cases were raised, representing 3.9% of the workforce. While this is a slight decrease from the previous year, demand remains high and closely linked to increased visibility and engagement activity.

A significant proportion (79%) of Guardian time has been spent on reactive casework. This limits the ability to deliver proactive interventions such as training, engagement, and preventative culture work. Without review of capacity, there is a risk that proactive culture development will be, impacting long-term improvement.

Key Themes and Trends

The predominant theme across FTSU cases continues to be staff safety and wellbeing, with 235 cases. Concerns frequently relate to poor team culture, incivility, lack of compassionate leadership, workload pressures, and inequitable treatment.

Although patient safety cases reduced to 23, concerns raised indicate that workforce issues—including communication breakdown, leadership gaps, and capability concerns—continue to have indirect impacts on care quality.

There has been a slight increase in bullying and harassment cases (20), including some relating to racial inequality and unfair treatment. Anonymous cases have also increased, indicating ongoing hesitancy among some staff to speak up openly.

Directorate-Level Insights

Variation exists across directorates. Oxon and BSW reported the highest number of cases and continues to experience challenges with leadership visibility, delays in response, and perceptions of futility.

The Community Directorate has seen a reduction in cases and generally positive engagement with senior leaders, although consistency in communication remains an area for improvement.

Bucks and Corporate services show ongoing challenges in leadership responsiveness, team culture, and timely action. Lower engagement continues to be noted in Estates, Facilities, Pharmacy, Research and Development, and among students, aligning with staff survey findings.

Variation in leadership behaviours, particularly in visibility, responsiveness, and follow-up, presents a risk to maintaining a consistent speaking up culture across the organisation.

Priorities for 2026–2027

In the coming year, the Trust will deliver the FTSU 2025–2027 plan, with a focus on high-impact actions. Efforts will target directorates and staff groups with lower engagement, while strengthening collaboration with key stakeholders to improve organisational learning.

A review of FTSU capacity will be required if demand continues to increase. The service will also support the transition from NGO to NHS England oversight.

In addition, there will be a renewed focus on sharing positive outcomes from speaking up to address futility and reinforce trust in the process.

Conclusion

Oxford Health NHS FT continues to demonstrate a strong and positive speaking up culture. To sustain and build on this position, the Trust must focus on leadership responsiveness, compassionate engagement, and visible action following concerns.

Ensuring that every member of staff feels heard, supported, and confident that speaking up leads to meaningful change remains critical to delivering high-quality, safe care.

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

Report presented at PLC on 8 July 26 with following suggestions:

- FTSUGs and NED to work together to consider a plan of work to address areas of low engagement
- Collaboration work with senior managers/leaders to address poor team culture
- Clarification of detriment cases as perceived or actual in FTSU Annual Report

Recommendation(s)
The Trust should prioritise strengthening compassionate and inclusive leadership, with a focus on communication skills, cultural competence, and handling difficult conversations for early resolution. Timely follow-up and clear communication of actions taken in response to concerns must be improved to build trust and reduce perceptions of inaction. Targeted work is required to engage underrepresented groups and low-engagement areas, alongside continued focus on psychological safety and team culture.

Strategic objective this report supports	Select
Quality - Deliver the best possible care and health outcomes	☒ x
People (Workforce) - Be a great place to work	☒ x
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 – ongoing monitoring of referrals by protected characteristics.	
Legal and regulatory	Yes – FTSU is nationally mandated and monitored	

Meeting:	Board of Directors' Meeting
Date of Meeting:	22 July 2026
Agenda item:	18
Report title:	Board Skills Assessment 2026/27
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:	Well Led best practice
Public or confidential	Public

Executive summary

A Well Led board comprises individuals bringing a balance of different capabilities, perspectives, and experiences to enhance decision-making and the overall performance of the Trust. In line with best practice, all Board members are required to complete an annual Board skills self-assessment. This information will be used to produce an up-to-date Board Skills Matrix which helps inform the Board's learning and development plan, Board recruitment as well as succession planning. The Chair and Chief Executive will consider implications of this report for succession planning.

Important to note that this assessment does not include Mindy Sawhney who leaves her role on 31 July 2026. Teresa Beach who joins the Trust as Chair of People, Leadership and Culture committee from 1st September 2026 is included.

While there has been a shift in skills due to recent changes in Board membership, the results show that the Board continues to have a good balance of skills overall with some gaps to be addressed through recruitment and learning and development.

See attached results of the self-assessment process.

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

N/A

Recommendation(s)

The Board is asked to discuss the report and agree:

1. any areas that should be added to the Board's annual development plan; and
2. areas of focus for the next round of Non-Executive recruitments.

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 – Well Led	

BOARD SKILLS ASSESSMENT 2026/27

Purpose	A Well Led board comprises individuals bringing a balance of different capabilities, perspectives, and experiences to enhance decision-making and the overall performance of the Trust. In line with best practice, all Board members are required to complete an annual Board skills self-assessment. Information will be used to produce an up-to-date Board Skills Matrix which helps inform the Board's learning and development plan, Board recruitment as well as succession planning.
Author	Taff Gidi, Executive Director of Corporate Affairs
Who Completed?	Andrea Young, Chair Prof. Sir Rick Trainor, Senior Independent Director Lucy Weston, Non-Executive Director Helen Mack, Non-Executive Director (Start date 1st May 2026) Geraldine Cumberbatch Sanya, Non-Executive Director Prof Kamal Mahtani, Non-Executive Director Teresa Beach, Non-Executive Director (Start date 1st September 2026) Grant Macdonald, Chief Executive Officer Amélie Bages, Executive Director of Strategy Charmaine De Souza, Chief People Officer Britta Klinck, Chief Nurse Rob Bale, Chief Operating Officer for Mental Health & Learning Disability Emma Leaver, Chief Operating Officer for Community Health Services, Dentistry & Primary Care Karl Marlowe, Chief Medical Officer Taff Gidi, Executive Director of Corporate Affairs Heather Smith, Chief Finance Officer
Last Updated	July 2026

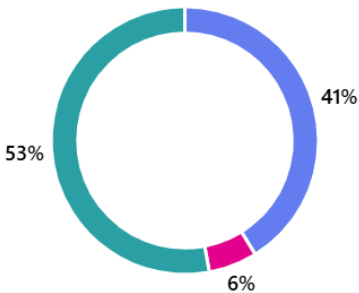
What is your role?

Executive Director	9
Non-Executive Director	8



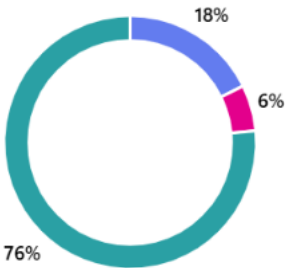
Are you currently or were you previously a registered clinician (i.e. Nurse, Midwife, Doctor or AHP)?

Yes - Currently Registered	7
Yes - Previously Registered	1
No	9



Are you currently or were you previously a qualified accountant?

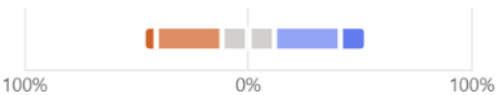
Yes - Currently Registered	3
Yes - Previously Registered	1
No	13



Patient Safety

None Basic Proficient Advanced Expert

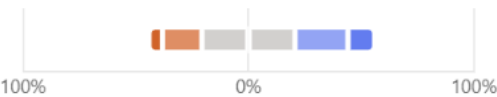
Level of Expertise



Patient/Service User Involvement

None Basic Proficient Advanced Expert

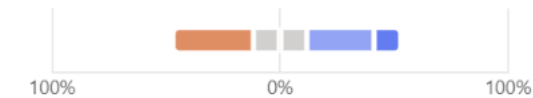
Level of Expertise



Safeguarding

None Basic Proficient Advanced Expert

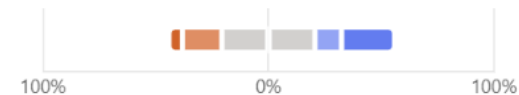
Level of Expertise



Mental Health

None Basic Proficient Advanced Expert

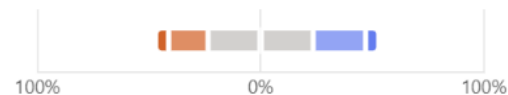
Level of Expertise



Community Healthcare Services

None Basic Proficient Advanced Expert

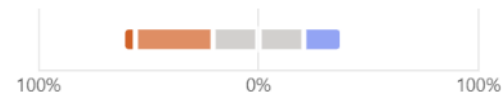
Level of Expertise



Public Health

None Basic Proficient Advanced Expert

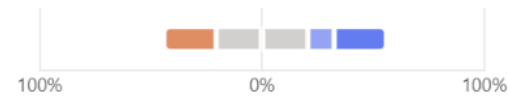
Level of Expertise



Financial management and other finance expertise

None Basic Proficient Advanced Expert

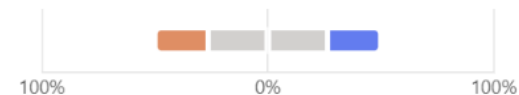
Level of Expertise



Audit (Internal/External)

None Basic Proficient Advanced Expert

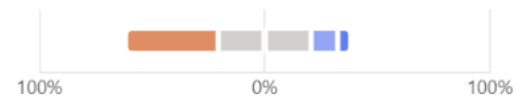
Level of Expertise



Counter Fraud

None Basic Proficient Advanced Expert

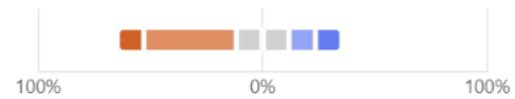
Level of Expertise



Clinical Audit

None Basic Proficient Advanced Expert

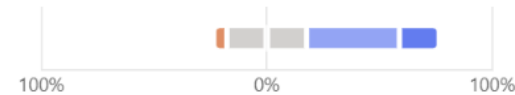
Level of Expertise



Strategy & Planning

None Basic Proficient Advanced Expert

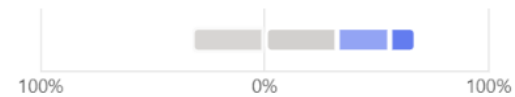
Level of Expertise



Learning & Development

None Basic Proficient Advanced Expert

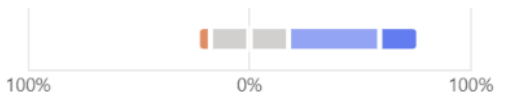
Level of Expertise



Organisational Development & Culture

None Basic Proficient Advanced Expert

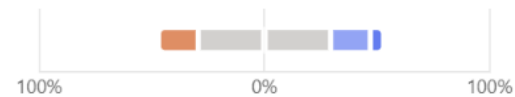
Level of Expertise



HR

None Basic Proficient Advanced Expert

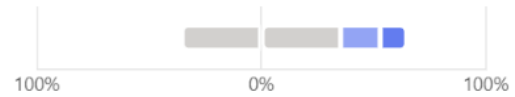
Level of Expertise



Equality, Diversity & Inclusion

None Basic Proficient Advanced Expert

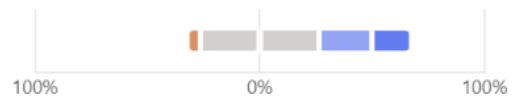
Level of Expertise



Freedom to Speak Up/Whistleblowing

None Basic Proficient Advanced Expert

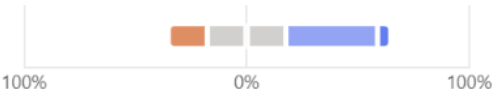
Level of Expertise



Staff Engagement including Employee Health & Wellbeing

None Basic Proficient Advanced Expert

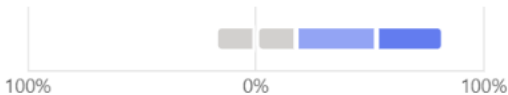
Level of Expertise



Risk Management

None Basic Proficient Advanced Expert

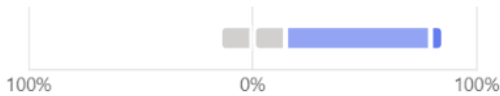
Level of Expertise



Performance Management

None Basic Proficient Advanced Expert

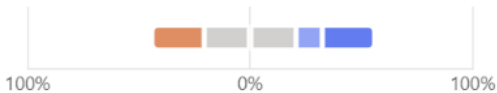
Level of Expertise



Operational Management / Service Delivery

None Basic Proficient Advanced Expert

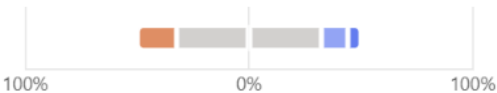
Level of Expertise



Health & Safety

None Basic Proficient Advanced Expert

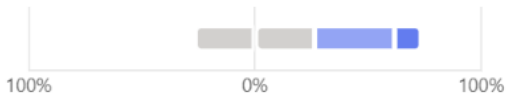
Level of Expertise



Corporate Governance

None Basic Proficient Advanced Expert

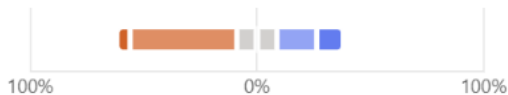
Level of Expertise



Legal - Mental Health Act

None Basic Proficient Advanced Expert

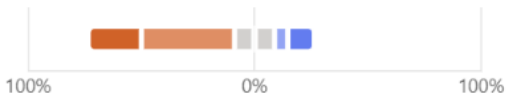
Level of Expertise



Legal - Inquests & Claims

None Basic Proficient Advanced Expert

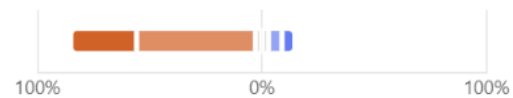
Level of Expertise



Legal - Other including commercial legal expertise

None Basic Proficient Advanced Expert

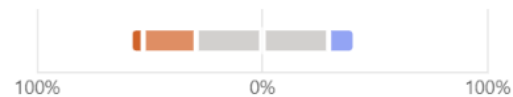
Level of Expertise



Information Technology

None Basic Proficient Advanced Expert

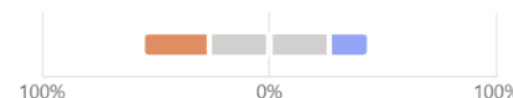
Level of Expertise



Business Intelligence & Informatics

None Basic Proficient Advanced Expert

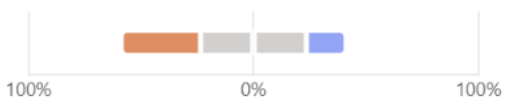
Level of Expertise



Digital Transformation

None Basic Proficient Advanced Expert

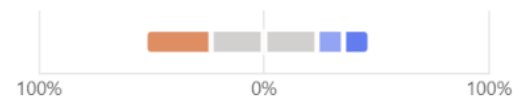
Level of Expertise



Information Risk Management including Cybersecurity and IG

None Basic Proficient Advanced Expert

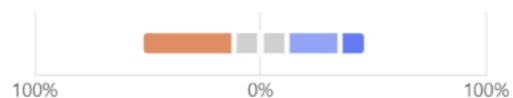
Level of Expertise



Research & Innovation

None Basic Proficient Advanced Expert

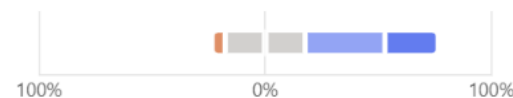
Level of Expertise



Major change and Transformation

None Basic Proficient Advanced Expert

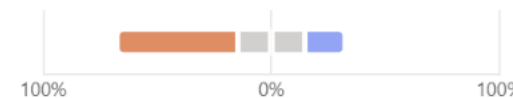
Level of Expertise



Large Project Financing

None Basic Proficient Advanced Expert

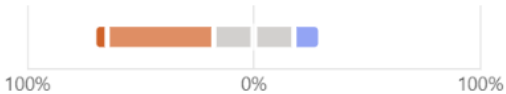
Level of Expertise



Estates & Facilities Management (Including PFI)

None Basic Proficient Advanced Expert

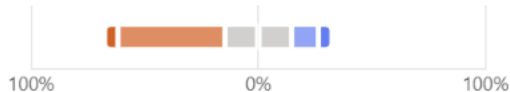
Level of Expertise



Environmental, Social and Governance (ESG)

None Basic Proficient Advanced Expert

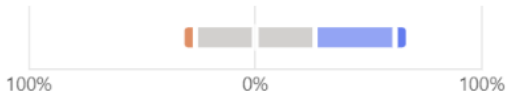
Level of Expertise



Communications & Engagement

None Basic Proficient Advanced Expert

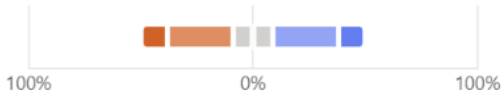
Level of Expertise



Influencing Policy (including Political & Parliamentary)

None Basic Proficient Advanced Expert

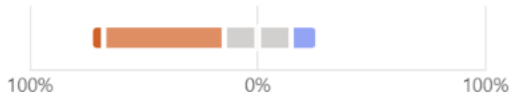
Level of Expertise



Procurement & Contract Management

None Basic Proficient Advanced Expert

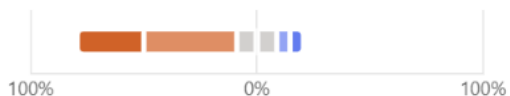
Level of Expertise



Commercial Sector Experience

None Basic Proficient Advanced Expert

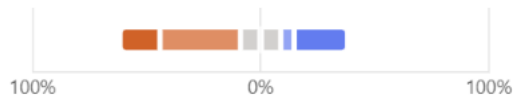
Level of Expertise



Charity Management

None Basic Proficient Advanced Expert

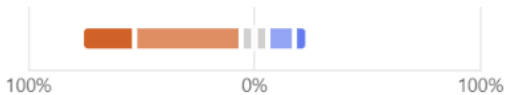
Level of Expertise



Charity Fundraising

None Basic Proficient Advanced Expert

Level of Expertise



Any other skills and expertise you bring to your role?



- Board Dynamics
- Member of the local community. Voluntary sector, working with the public. experience of leading public facing organisations when things go wrong.
- Local community member.
- Quality Improvement Expertise
- Experienced NED
- extensive clinical experience and clinical leadership in-depth knowledge of OH system knowledge and relationships
- management consultancy
- Using evidence in healthcare decision-making
- Some knowledge of housing sector and supported housing given NED role
- Patient/carer lived experience. I think this omission from the list is telling and perhaps worth reflecting on.
- This is a comprehensive list of likely skills reqd
- Twenty-five plus years of experience as a chief executive in higher education, extensive chairing/board experience, significant activity (especially as President of Universities UK) in influencing government, wide-ranging international involvements.
- Clinical governance and regulatory activity
- Advanced experience in the interpretation of legal contracts and dispute resolution

Looking at the Board overall, are there any skills or expertise that you feel the Board lacks at this time?



- commercial probably
- New members cover most previous gaps. Important to also maintain continuity of experience.
- Innovation
- Medical Non-Executive Director
- Having only recently joined the Board, this is difficult to answer, but one area to strengthen might be digital transformation?

- real digital expertise
- digital transformation
- Digital transformation - crucial given it's one of the left shifts. Public health
- Legal?
- Digital expertise, public relations
- A more concentrated focus on digital transformation and how AI can be used to improve the delivery of healthcare services by the trust

Meeting	Board of Directors
Date of Meeting	22 July 2026
Agenda item	19
Report title	Modern Slavery statement 2025/26
Executive lead(s)	Taff Gidi – Executive Director of Corporate Affairs
Report author(s)	Lisa Lord – Head of Safeguarding (coordinated statement drafting) Ben Cahill – Deputy Director of Corporate Affairs
Action this paper	☒ Decision/approval ☐ Information ☐ Assurance
Reason for submission to the Board	Board are required to approve the Modern Slavery statement 2025/26 in order to comply with the Modern Slavery Act 2015.
Public or confidential	Public

Executive Summary

To comply with the Modern Slavery Act 2015, NHS trusts are required to have their organisational Modern Slavery statements approved annually by their board of directors. Once approved and dated, the statement must then be published on the Trust's website. The drafting of the OHFT 2025/26 Modern Slavery statement (Appendix 1) has been coordinated by Head of Safeguarding with contributions from other relevant Trust teams for example HR and procurement teams.

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

This report has been prepared for the 22 July 2026 meeting of the Board of Directors.

Recommendation(s)

The Board is asked to approve the draft Modern Slavery statement 2025/26 ahead of its publication on the Trust's relevant webpages.

Strategic objective this report supports

Quality - Deliver the best possible care and health outcomes

Select

☐

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	

MODERN SLAVERY ACT TRANSPARENCY STATEMENT 2025/26

Slavery and Human Trafficking Policy Statement

1. Introduction

Modern Slavery remains a hidden blight on society. In the UK, modern slavery is defined under the Modern Slavery Act 2015. It encompasses several forms of exploitation, including slavery, servitude, forced or compulsory labour and human trafficking.

We all have a responsibility to be alert to the risks of modern slavery, however small, in our organisation and in the wider supply chain. Trust colleagues are expected to report concerns, and our management teams are expected to act upon them. At Oxford Health NHS Foundation Trust (OHFT) we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain upholding the provisions of the Modern Slavery Act 2015.

This statement sets out actions taken by OHFT to understand all potential modern slavery and human trafficking risks and to implement effective systems, controls and best practice in order take all reasonable steps to prevent slavery and human trafficking. We expect our staff and suppliers to comply with the legislation and report any concerns where they may have them.

OHFT wishes its service users, staff, and all stakeholders to be confident in the knowledge that we operate a zero tolerance approach to modern slavery and human trafficking, and we are working as best we can to ensure that such practise does not exist anywhere in our Trust or in our supply chain.

2. Our commitment

We are fully aware of the responsibilities we have towards our service users, staff and local communities. We aim to follow good practice and to take all reasonable steps to prevent slavery and human trafficking.

We are committed to promoting a proactive and inclusive approach to equality in both employment and service provision which supports and encourages an inclusive culture which values diversity. This includes a commitment to building a workforce which is valued and whose diversity reflects the communities it serves, enabling the Trust to deliver the best possible healthcare services.

OHFT is guided by a strict set of ethical values in all of its business dealings and expects its suppliers to adhere to these same principles. The Trust is committed to ensuring there is no modern slavery in any part of the business and, in so far as possible, requires suppliers to hold the same ethos.

OHFT is also committed to ensuring that all staff are aware of the Modern Slavery Act 2015 and their safeguarding duty to protect and prevent any further harm and abuse when it is identified or suspected that an individual may be or is at risk of modern slavery and human trafficking.

3. About Oxford Health

OHFT provides physical, mental health, learning disability and social care for people of all ages across Oxfordshire, Buckinghamshire, Bath and North East Somerset, Swindon and Wiltshire. The Trust's services are delivered at community bases, hospitals, clinics and in people's homes. The Trust focuses on delivering care as close to home as possible. Further information can be found on the 'About us' pages of the Trust's website. Our supply chains enable the procurement of a wide range of goods and services on behalf of our clients and service users

4. Our Policy on Slavery and Human Trafficking

We are fully aware of the responsibilities we bear towards our service users, employees and local communities. We are guided by a strict set of ethical values in all our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking. OHFT Safeguarding Adult and Children policies include information on modern slavery and human trafficking, and staff are expected to report concerns about slavery and human trafficking, and management are expected to act upon them in accordance with our policies and procedures.

5. Due Diligence, Risk Assessment and Management

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain we:

- Undertake appropriate pre-employment checks on directly employed staff and agencies on approved frameworks. Agency compliance is audited to provide assurance that pre-employment clearance has been obtained for agency staff;
- Adhere to National NHS Employment Checks/Standards. This includes right to work in the UK, employees' UK address and factual references;
- Implement a range of controls to protect staff from poor treatment and/or exploitation, which comply with all respective laws and regulations. These include provision of fair pay rates, fair Terms and Conditions of employment and equitable access to training and development opportunities. We are

working towards embedding an overarching just and restorative learning culture throughout the organisation which will underpin our ongoing provision of fair employment terms and conditions;

- Consult and negotiate with Trade Unions on proposed changes to contractual terms and conditions and proposals relating to organisational change, in the context of ongoing dialogue to provide a supportive work environment;
- Have systems to encourage the reporting of concerns, including a Raising Concerns Policy so that all staff know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our Trust or supply chain, without fear of reprisals. We also make every effort to promote the role of our Freedom to Speak up Guardians.
- Purchase a significant number of products through NHS Supply Chain, whose 'Supplier Code of Conduct' includes a provision around forced labour;
- Our purchase orders and tender specifications comply with the NHS Standard Terms and Conditions, thereby complying with the UK Modern Slavery Act (2015), all of which set out our commitment to ensuring no modern slavery or human trafficking related to our business;
- Ensuring that our suppliers are carefully selected through our robust supplier selection criteria and processes. All NHS Contracts for the Supply of Goods and Provision of Non-Clinical Services have contractual clauses requiring compliance with the Modern Slavery Act (2015);
- Include a minimum of 10% Social Value criteria evaluation in our tender documents and ensure appropriate weight is given to modern slavery and human trafficking elements;
- Ensure adherence to the Cabinet Office Procurement Police Notice for Tackling Modern Slavery in Government Supply Chains by identifying and managing risks in new and existing procurement activities.
- Uphold professional codes of conduct and practice relating to procurement and supply, including through adherence to Sustainable and Ethical Values as advocated through the Chartered Institute of Procurement and Supply and/or other appropriate professional bodies; and
- Ensure ongoing due diligence through effective contract management and by building strong working relationships with suppliers;
- Monitoring of actions put in place to review and provide assurance on their effectiveness.

6. Training and awareness

Advice and training about modern slavery and human trafficking is available to staff through our Safeguarding Children and Adults training, our Safeguarding policies and procedures and our Safeguarding leads.

As part of our recruitment process we consider the extent to which applicants have knowledge of and skills to comply with their obligations to safeguard service users which includes Modern Slavery and Human Trafficking. It is extremely important to Oxford Health that all employed staff are supported to recognise signs and indicators of abuse which includes concerns relating to modern slavery and human trafficking. We have a responsibility as an organisation delivering care and treatment to vulnerable children and adults and we take this duty very seriously.

The organisation monitors any modern slavery issues through our Safeguarding Service and together with partner agencies.

7. Board of Directors' Approval

This statement has been approved by the Trust's Board of Directors on DATE [22 July 2026] who will continue to support the requirements of this legislation. The Board will aim to review and update it on an annual basis.

The statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes Oxford Health NHS Foundation Trust's slavery and human trafficking statement for the financial year ended 31 March 2026.

Appendix A to Integrated Performance Report – July 2026

Changes to Integrated Performance Report metrics monitored during Financial Year 2026-27

Mental Health services			
Children and Adolescent Mental Health Services (CAMHS)			
	Metric	Comments for 26/27	Comments for 25/26
1	Improve access to mental health support for children and young people (12 rolling months) - Buckinghamshire, Oxfordshire and Bath & North-East Somerset, Swindon and Wiltshire	Updated targets for FY26/27: Fixed target for Buckinghamshire at ≥ 7765 for FY26/27 in line with planning requirements to maintain existing performance Fixed target for Oxfordshire at ≥ 9055 for FY26/27 in line with planning requirements to maintain existing performance Confirmed local trajectory for Bath & North-East Somerset, Swindon and Wiltshire for FY26/27: ≥ 7161 (Apr26), 7260, 7359, 7458, 7557, 7656, 7755, 7854, 7953, 8052, 8151, 8250 (Mar27)	Buckinghamshire had an increasing trajectory in FY25/26: ≥ 6274 (Apr-25), 6318, 6362, 6406, 6450, 6494, 6553, 6612, 6671, 6730, 6789, 6848 (Mar-26) Oxfordshire had an increasing trajectory in FY25/26: ≥ 8000 (Apr-25), 8170, 8340, 8510, 8680, 8850, 9147, 9444, 9741, 10038, 10335, 10612 (Mar-26) Bath & North-East Somerset, Swindon and Wiltshire did not have any targets or trajectory in FY25/26
2	Four (4) week wait (interim metric - one meaningful contact within episode) – Buckinghamshire, Oxfordshire and Bath & North-East Somerset, Swindon and Wiltshire	As no national target, local incremental improvement trajectory has been applied for FY26/27: $\geq 62\%$ April- June $\geq 68\%$ July - Sept $\geq 72\%$ Oct - Dec $\geq 76\%$ Jan - Feb $\geq 80\%$ March 27	Monitored against national average of $\geq 62\%$ during FY25/26.
3	Four (4) week wait (full metric - waiting time standard for a meaningful contact & outcome	New metric for FY26/27. Monitored at Executive IPR and Directorate level to improve data quality	

	measure - Buckinghamshire, Oxfordshire and Bath & North-East Somerset, Swindon and Wiltshire	before adding to public IPR. No confirmed target for time-being, however, national ambition is to have at least 50% of children and young people meeting all criteria to be no longer waiting by end of the financial 2026-27 year.	
4	Improve access to mental health support teams (MHSTs) in schools and colleges for children and young people - Buckinghamshire, Oxfordshire and Bath & North-East Somerset, Swindon and Wiltshire	New metric for FY26/27. Monitored at Executive IPR and Directorate level to improve data quality before adding to public IPR. No target for time-being	
5	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks (rolling 3 months position) - Buckinghamshire, Oxfordshire and Bath & North-East Somerset, Swindon and Wiltshire	No change, national target remains at $\geq 95\%$ for FY26/27	
6	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days (rolling 3 months position) - Buckinghamshire, Oxfordshire and Bath & North-East Somerset, Swindon and Wiltshire	No change, national target remains at $\geq 95\%$ for FY26/27	
7	Self-rated measurable improvement %	New metric for FY26/27 – currently in development to be reported to Executive IPR and Directorates	
8	% of children and young people accessing mental health services, having their outcomes measure recorded at least twice (also known as Paired scores)	New metric for FY26/27 – currently in development to be reported to Executive IPR and Directorates	
9	Children and young people referral-spells waiting for a full clock stop - (still waiters over 104 weeks)	New metric for FY26/27 – currently in development to be reported to Executive IPR and Directorates	

Talking Therapies			
	Metric	Comments for 26/27	Comments for 25/26
10	Increase the number of adults and older adults completing a course of treatment for anxiety and depression – Oxfordshire and Buckinghamshire	Updated targets for FY26/27: Oxfordshire >=636 Buckinghamshire >=497 Services have a further stretched ambition to improve completion rates (>=560 Buckinghamshire and >=770 Oxfordshire) in line with the Talking Therapies Memorandum of Understanding with the Thames Valley Integrated Care Board.	Oxfordshire was >=687 in FY25/26 Buckinghamshire was >=515 in FY25/26
11	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Oxfordshire and Buckinghamshire	No change, no target	
12	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Oxfordshire and Buckinghamshire	Updated targets for FY26/27: >=68% April to September >=69% October to March 27	FY25/26 targets were: >=67% April to September >=68% October to March
13	% of people receiving first treatment appointment within 6 weeks of referral - Oxfordshire and Buckinghamshire	No change, target remains at >=75% for FY26/27	
14	% of people receiving first treatment appointment within 18 weeks of referral - Oxfordshire and Buckinghamshire	No change, target remains at >=95% for FY26/27	
15	Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) – Oxfordshire and Buckinghamshire	No change, target remains at <10%	

16	Reliable recovery rate for those completed a course of treatment adults and older adults combined – Oxfordshire and Buckinghamshire	Updated targets for FY26/27: >=50% April to September >=51% October to March 27 Same targets applicable to both Oxfordshire and Buckinghamshire	FY25/26 targets were: Buckinghamshire: >=49% April to September >=50% October to March Oxfordshire: >=48% April to September >=49% October to December >=50% January to March
17	Meet and maintain at least 52% Talking Therapies recovery rate - Oxfordshire and Buckinghamshire	No change, target remains at >=52% for FY26/27	
18	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined - Oxfordshire and Buckinghamshire	Target updated for FY26/27 to >=52%	FY25/26 target was >=50%
19	Recovery rate for White British - complete a course of treatment, adult and older adult combined - Oxfordshire and Buckinghamshire	Target updated for FY26/27 to >=52%	FY25/26 target was >=50%
Adult and Older Adult Community services			
	Metric	Comments for 26/27	Comments for 25/26
20	Improve access for Adults and Older Adults to support by community mental health services – Buckinghamshire and Oxfordshire	Targets removed for FY26/27 as no longer a national priority. Local target setting to be revisited if metric confirmed as National Oversight Framework metric or metric requires focused intervention and monitoring.	In FY25/26 Buckinghamshire had a fixed target of >=4568 In FY25/26 Oxfordshire had a fixed target of >=6737
21	Improve access to perinatal mental health services - Buckinghamshire and Oxfordshire	Targets updated for FY26/27:	In FY25/26 targets were:

		Buckinghamshire: ≥ 390 (reduction due to incorrect team being included previously) Oxfordshire: ≥ 663 April to September ≥ 482 October to March 27 (reduction due to service change)	Buckinghamshire ≥ 422 Oxfordshire ≥ 501
22	4 week wait (28 days) standard (interim metric - two contacts within episode - Buckinghamshire and Oxfordshire	As no national target, local incremental improvement trajectory has been applied for FY26/27: $\geq 60\%$ April - June $\geq 65\%$ July - Sept $\geq 70\%$ Oct - Dec $\geq 75\%$ Jan-Feb $\geq 80\%$ March 27	Monitored against national average of $\geq 36\%$ during FY25/26.
23	4 week wait (28 days) standard (Full metric) - Buckinghamshire and Oxfordshire	New metric for FY26/27. Monitored at Executive IPR and Directorate level to improve data quality before adding to public IPR. No target for time-being	
24	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Buckinghamshire and Oxfordshire	No change, target remains at $\geq 60\%$ for FY26/27	
25	Number of people accessing Individual Placement Support (IPS) (rolling 12 months) - Buckinghamshire and Oxfordshire	FY26/27 year-end target agreed with Integrated Care Board is ≥ 663 for Oxfordshire and ≥ 416 for Buckinghamshire. Locally this has been modified into an increasing trajectory throughout this FY26/27 as follows: Buckinghamshire ≥ 334 (Apr-26), 342, 349, 357, 364, 372, 379, 386, 394, 401, 409, 416 (Mar-27)	In FY25/26 targets were: Buckinghamshire fixed target of ≥ 286

		Oxfordshire >=580 (Apr-26), 587, 595, 602, 610, 618, 625, 633, 640, 648, 655, 663 (Mar-27)	Oxfordshire had an increasing trajectory: >=385,390,395,400,405,410,415,420,425,430,435,440
26	Recover dementia diagnosis rate (nationally reported system measure) - Buckinghamshire and Oxfordshire	No change, target remains at >=63% for FY26/27	
27	Deliver annual physical health checks to people with Severe Mental Illness (nationally reported system measure) - Buckinghamshire and Oxfordshire	No change, target remains at >=60% for FY26/27	
28	% of adults and older adults accessing Community Mental Health Services having their outcome measures recorded at least twice	New metric for FY26/27 – currently in development to be reported to Executive IPR and Directorates	
29	% of women accessing perinatal services having their outcome measures recorded at least twice	New metric for FY26/27 – currently in development to be reported to Executive IPR and Directorates	
Urgent Care			
	Metric	Comments for 26/27	Comments for 25/26
30	Response from MH Psychiatric Liaison within 1 hour – Buckinghamshire and Oxfordshire	As no national target, local incremental improvement trajectory has been applied for FY26/27: >=80% Apr - Jun >=85% Jul - Sept >=90% Oct - Dec >=93% Jan- Feb >=95% March 27	Monitored against national average of >=66% during FY25/26.
31	Response from MH Psychiatric Liaison within 24 hour – Buckinghamshire and Oxfordshire	As no national target, local incremental improvement trajectory has been applied for FY26/27:	Monitored against national average of >=81% during FY25/26.

		>=90% Apr - Sept >=93% Oct - Feb >=95% March 27	
32	Response from MH Crisis Service within 4 hours (very urgent) - Buckinghamshire and Oxfordshire	As no national target, local incremental improvement trajectory has been applied for FY26/27: >=61% Apr - Jun >=65% Jul - Sept >=70% Oct - Dec >=73% Jan - Feb >=75% March 27	Monitored against national average of >=61% during FY25/26.
33	Response from MH Crisis Service within 24 hours (urgent) - Buckinghamshire and Oxfordshire	As no national target, local incremental improvement trajectory has been applied for FY26/27: >=75% Apr - Jun >=80% Jul - Sept >=85% Oct - Dec >=90% Jan - Feb >=95% March 27	Monitored against national average of >=61% during FY25/26.
34	Proportion of referrals from Emergency Departments to Liaison Psychiatry Service for people who are already known to Mental Health Services	New metric for 2026/27 - not reported on IPR yet as reporting in development. National team yet to define a precise target for delivery by end of March 2027.	
Inpatients			
	Metric	Comments for 26/27	Comments for 25/26
35	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	Metric removed from FY26/27 IPR to be monitored at Directorate level only. To be escalated to IPR if Executive awareness becomes required.	Monitored against national average of <=12% during FY25/26.

	Care Units – Buckinghamshire and Oxfordshire		
36	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 and Oxfordshire	Metric removed from FY26/27 IPR to be monitored at Directorate level only. To be escalated to IPR if Executive awareness becomes required.	Monitored against national average of <=12% during FY25/26.
37	Mean Length of Stay (Los) for MH adult acute, older adult acute and PICU discharges combined (rolling 3 months) - Buckinghamshire and Oxfordshire	Changes: - Metric split into two separate components: 1. adult acute & PICU 2. Older adults - Reporting by Place removed from IPR and replaced by Trust level (below, see metrics ref. 38 and 39)	Reduction trajectories applied in FY25/26: Apr - June <=53, Jul-Sept <=52, Oct-Nov <=51, Dec-Jan <=50, Feb-Mar <=49
38	Mean LoS for MH adult acute and PICU discharges (rolling 3 months) – Trust level	New metric – see comment against ref. 37 above Fixed target of <=36.28 days set for FY26/27 as per baseline position from August 2025 as per planning requirements. Performance by Place monitored at Directorate level.	
39	Mean LoS for older adults (rolling 3 months) – Trust level	New metric – see comment against ref.37 above Fixed target of <=66.98 days set for FY26/27 as per baseline position from August 2025 as per planning requirements Performance by monitored at Directorate level.	

40	Percentage of adult inpatients discharged with a length of stay over 60 days at discharge – Buckinghamshire and Oxfordshire	Target of $\geq 15\%$ applied for FY26/27 If this metric is not a NOF measure for 2026/27, it will be removed from monitoring in the IPR and will be monitored at Directorate level only.	No target in FY25/26
41	Percentage of adults over the age of 65 with a length of stay beyond 90 days at discharge	Target of $\geq 21\%$ applied for FY26/27 If this metric is not a NOF measure for 2026/27, it will be removed from monitoring in the IPR and will be monitored at Directorate level only.	No target in FY25/26
42	72 hour follow up for those discharged from mental health wards - Adults	Target remains at $\geq 80\%$. Monitored at Trust level for FY26/27 with Place performance monitored at Executive IPR and Directorate level.	
43	72 hour follow up for those discharged from mental health wards - Older Adults	Target remains at $\geq 80\%$. Monitored at Trust level for FY26/27 with Place performance monitored at Executive IPR and Directorate level.	
44	Inappropriate adult acute mental health out of area placements - snapshot last day month Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month Inappropriate older adult acute mental health out of area placements - snapshot last day month	26/27 IPR monitors Trust level performance only and combines all three bed types (adult acute, PICU and older adult) Performance by Place and by bed type monitored at Directorate level. Trust level targets for 26/27 (all bed types combined): Apr-Dec ≤ 6 Jan-Feb ≤ 5 March 27 ≤ 4 National ambition is to reduce inappropriate adult acute Out of Area Placements by 95%	Reduction trajectories in FY25/26 were: Buckinghamshire (all bed types combined): ≤ 1 (Apr-25), 2, 5, 3, 1, 2, 4, 2, 0, 1, 3, 1 (Mar-26) Oxfordshire (all bed types combined): ≤ 3 (Apr-25), 1, 2, 1, 2, 1, 2, 1, 2, 1, 1 (Mar-26)

		(based on March 2026) by end of March 2027. Monitoring of this reduction trajectory to be introduced in the IPR imminently.	
45	Inappropriate adult acute mental health out of area placements - beds days in month Inappropriate older adult acute mental health out of area placements - beds days in month Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements	26/27 IPR monitors Trust level performance only and combines all three bed types (adult acute, PICU and older adult) Performance by Place and by bed type monitored at Directorate level. No target (same as FY25/26)	
46	Trust level % adult acute readmission within 30 days for mental health – Buckinghamshire and Oxfordshire	26/27 IPR monitors Trust level performance and performance by Place is monitored at Directorate level. No target (same as FY25/26)	
47	Trust level % older adult readmission within 30 days for mental health - Buckinghamshire and Oxfordshire	26/27 IPR monitors Trust level performance and performance by Place is monitored at Directorate level. No target (same as FY25/26)	
48	Average number of clinically ready for discharge patients per day	26/27 IPR monitors Trust level performance and performance by Place is monitored at Directorate level. No target (same as FY25/26)	
Other			
	Metric	Comments for 26/27	Comments for 25/26
49	Percentage of people with suspected autism awaiting contact for over 13 weeks – Buckinghamshire and Oxfordshire	New metric for FY26/27. Monitored at Executive IPR and Directorate level to improve data quality before adding to public IPR. No target for time-being	

		If this metric is not a NOF measure for 2026/27, it will be removed from monitoring in the IPR and will be monitored at Directorate level only.	
50	% of patients responding that overall, the care was good or very good – Mental Health services	No change, target remains at $\geq 85\%$	
51	% of patients report being involved in their care – Mental Health services	No change, target remains at $\geq 80\%$	

Community Health Services, Dentistry and Primary Care			
	Metric	Comments for 26/27	Comments for 25/26
52	Number of people on waiting list for Community services who are waiting over 52 weeks (adults and CYP combined) Number of people on waiting lists for Community CYP services who are waiting over 52 weeks Number of people on waiting lists for Community adult services who are waiting over 52 weeks	Incremental improvements trajectories set for FY26/27: Adults and CYP combined: ≤ 1178 (Apr26), 1109, 1050, 981, 912, 783, 654, 520, 386, 247, 103, 0 (Mar27) CYP: ≤ 648 (Apr26), 589, 530, 471, 412, 353, 294, 235, 176, 117, 59, 0 (Mar27) Adults: ≤ 530 (Apr26), 520, 520, 510, 500, 430, 360, 285, 210, 130, 44, 0 (Mar27)	No targets or trajectories in FY25/26
53	Percentage of patients waiting over 52 weeks for community services - Adults and CYP Percentage of patients waiting over 52 weeks for community services – Adults Percentage of patients waiting over 52 weeks for community services - CYP	Incremental improvements trajectories set for FY26/27: Adults and CYP combined: $\leq 19.59\%$ (Apr26), 18.45%, 17.47%, 16.32%, 15.17%, 13.02%, 10.88%, 8.65%, 6.42%, 4.11%, 1.71%, 0% (Mar27) Adults: $\leq 12.83\%$ (Apr26), 12.59%, 12.59%, 12.35%, 12.11%, 10.41%, 8.72%, 6.90%, 5.08%, 3.15%, 1.07%, 0% (Mar27)	No targets or trajectories in FY25/26

		CYP: <=34.43% (Apr26), 31.30%, 28.16%, 25.03%, 21.89%, 18.76%, 15.62%, 12.49%, 9.35%, 6.22%, 3.13%, 0% (Mar27)	
54	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 (Adults and CYP combined; month end snapshot)	New metric for 26/27 IPR. Incremental improvement trajectory set at: >=51% (Apr26), 52%, 54%, 56%, 58%, 60%, 63%, 66%, 68%, 71%, 75%, 78% (Mar-27) National target >=78%	
55	Percentage of people on waiting list for CYP Community Services per system who are waiting 18 weeks or less as a proportion of the entire waiting list (month end snapshot)	New metric for 26/27 IPR. Incremental improvement trajectory set at: >=34% (Apr26), 37%, 41%, 45%, 49%, 54%, 58%, 62%, 66%, 71%, 75%, 79% (Mar-27) National target >=78%	
56	Percentage of people on waiting list for Adult Community Services per system who are waiting 18 weeks or less as a proportion of the entire waiting list (month end snapshot)	New metric for 26/27 IPR. Incremental improvement trajectory set at: >=59%(Apr26), 59%, 60%, 61%, 62%, 63%, 65%, 67%, 69%, 71%, 74%, 78% (Mar-27) National target >=78%	
57	Average number of Medically Optimised for Discharge (MOFD) patients per night	No change	
58	Average Length of Stay in Community Hospitals by Basket of Care (rehab, stroke, end of life, EMU)	No change	
59	% of Minor Injury Unit patients seen within 4 hours	Target increased to >=82% for FY26/27 in line with national directive	FY25/26 target >=78%

60	Consistently meet or exceed the 70% 2-hour Urgent Community Response (UCR) standard	Local target increased to $\geq 95\%$ for FY26/27 (national target remains at $\geq 70\%$)	FY25/26 target $\geq 70\%$
61	% 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	No change, target remains at $\geq 90\%$	
62	% of out of hours palliative care referrals responded to within 60 minutes: the time from completion of that triage call to the start of the home visit consultation was within 60 minutes	No change, target remains at $\geq 90\%$, reported 6-monthly	
63	% 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	No change, target remains at $\geq 90\%$.	
64	National Early Warning System (NEWS - national tool for detecting clinical deterioration) escalated appropriately (quarterly metric)	No change, target remains at $\geq 90\%$	
65	National Early Warning System (NEWS - national tool for detecting clinical deterioration) completed where applicable (quarterly metric)	No change, target remains at $\geq 90\%$	
66	% of breastfeeding prevalence at 6 - 8 weeks old	No change, target remains at $\geq 60\%$	

67	Percentage of Children notified by LA to the LAC team as new to care to be offered a health assessment within 20 working days (measured from notification to offered)	Temporarily suspended monitoring in 26/27 IPR pending metric review. Monitoring at Directorate level continues.	FY25/26 target 100%
68	No. and % of families receiving a new birth visit within 14 days of birth (quarterly metric)	No change, target remains at $\geq 85\%$	
69	% of 6–8-week reviews completed	No change, target remains at $\geq 90\%$	
70	% of 12-month development reviews completed by the time the child turned 12 months	No change, target remains at $\geq 85\%$	
71	% of 2-to-2.5-year reviews completed	No change, target remains at $\geq 85\%$	
72	Special Care - Core (community dentistry) and Urgent Care - Out of Hours (community dentistry) activity	Metric removed from FY26/27 IPR to be monitored at Directorate level only. To be escalated to IPR if Executive awareness becomes required.	
73	Out of Hours Emergency Dental Service Waiting times to triage - % of patients triaged within 6 hours	No change, no target (same as FY25/26)	
74	Proportion of patients accepted for care who are seen for an assessment within 12 weeks (Of those treated in period) (Community dentistry)	No change, target remains at $\geq 90\%$	
75	% of patients responding that overall, the care was good or very good – Community Health Services, Primary Care and Dentistry	No change, target remains at $\geq 85\%$	

76	% of patients report being involved in their care – Community Health Services, Primary Care and Dentistry	No change, target remains at >=85%	

Quality			
	Metric	Comments for 26/27	Comments for 25/26
77	CQC Community Mental Health survey satisfaction rate score	No change.	
78	Total number of incidents involving physical restraint	Continue reporting Trust level within the Quality section in 26/27. New for 26/27 – split by Care Group (CYP, adult, older adult, forensic, eating disorders) within the Mental Health section in IPR. Further split by Place monitored at Directorate level.	
79	Rate of restrictive interventions per 1k bed days	New for 26/27 – currently in development for reporting on IPR.	
80	Reduction in the use of prone restraints (number of incidents involving prone restraint)	Continue reporting Trust level within the Quality section in 26/27. New for 26/27 – split by Care Group (CYP, adult, older adult, forensic, eating disorders) within the Mental Health section in IPR. Further split by Place monitored at Directorate level.	
81	Reduction in use of seclusion (number of incidents involving seclusion)	Continue reporting Trust level within the Quality section in 26/27. New for 26/27 – split by Care Group (CYP, adult, older adult, forensic, eating disorders) within the Mental Health section in IPR. Further split by Place monitored at Directorate level.	

82	Response to staff survey question "I would feel secure raising concerns about unsafe clinical practice" – annual metric	No change	
83	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 Data Set	No change, target remains at $\geq 90\%$	
84	Total number of patient incidents (all levels of harm excluding inherited pressure damage)	No change	
85	Total number of unexpected deaths reported as incidents (by date of death, including natural and unnatural)	No change	
86	Total number of suspected suicides	No change	
87	Total number of violence, physical, non-physical and property damage incidents (patients and staff)	No change	
88	Total number of complaints and resolutions	No change	

	People		
	Metric	Comments for 26/27	Comments for 25/26
89	% of BAME representation in senior leadership roles (Bands 8a-8d, 9, Very Senior Manager)	No change, target remains at $\geq 19\%$	
90	% of BAME representation across all pay bands including board level	No change, target remains at $\geq 19\%$	

91	Proportion of staff who agree that their organisation acts fairly with regards to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age – annual metric	No change	
92	Staff survey - compassionate and inclusive theme score – annual metric	No change	
93	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES) Relative likelihood of non-disabled applicant being appointed from shortlisting compared to disabled applicants	No change, targets remain at =1	
94	Staff survey (annual metrics) - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from another colleague Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	No change	
95	Staff leaver rate	No change, no target (same as FY25/26)	
96	% of early turnover	Target for 26/27 updated to <=13%	Target in FY25/26 was <=14%
97	Reduce staff sickness to 4.5%	No change, target remains at <=4.5%	
98	Staff survey engagement theme score – annual metric	No change	

99	Staff survey raising concerns people promise element sub-score	No change	
100	National Education and Training Survey satisfaction rate – annual	No change	
101	Reduce agency usage to meet target (% of agency used)	Target for 26/27 updated to <=2.47%	Target in FY25/26 was <=4.23%
102	Reduction in % labour turnover	Target for 26/27 updated to <=12%	Target in FY25/26 was <=14%
103	Number of staff who have completed Quality Improvement Training level 1	No change	
104	PDR compliance	No change, target remains at >=95%	
105	Reduction in vacancies	No change, target remains at <=9%	
106	Statutory and mandatory training compliance	Target for 26/27 updated to >=90%	Target in FY25/26 was >=95%
107	Overall supervision rate	Target for 26/27 updated to >=90%	Target in FY25/26 was >=95%

Appendix B to Integrated Performance Report – July 2026

National Oversight Framework (NOF) 2026/27

NHS England published reviewed National Oversight Framework (NOF) for 2026/27 on 11th June 2026. It has been updated to reflect the maturing operating model, introduces delivery segmentation for ICBs and clarifies the role of NHS England's regional teams in overseeing performance. The Framework can be viewed here: <https://www.england.nhs.uk/long-read/nhs-oversight-framework-2026-27/>

The metrics underpinning the NHS Oversight Framework are reviewed annually to ensure they continue to reflect NHS operating priorities. They are designed to cover a broad range of areas, supporting a balanced judgement of the challenges facing each organisation and highlighting specific areas of concern.

There are 85 metrics underpinning the framework, although no organisation is assessed against all of them. Any organisation that submits data for a given activity will be scored against the corresponding metric unless an explicit exemption applies. The relevant exemptions will be confirmed through the technical guidance, which is expected to be published by the end of quarter one (the technical metric specification document has been published but still has draft & subject to change included within document). Until this guidance has been finalised, the exact metrics applicable to Oxford Health NHS Foundation Trust cannot be confirmed with certainty.

The list of metrics is currently being reviewed to identify any potential issues and priority work that could be undertaken. It is important to note that the ability to impact Q1 NOF data will be limited. September's Integrated Performance report will reflect the new NOF metrics.

Based on the draft NHS Oversight Framework 2026/27 technical metric specification document, the metrics set out below are considered likely to apply to OHFT in 2026/27:

Domain	Metric	Status	Comments
Population health, prevention and reducing inequality	% of mental health inpatients making a supported quit attempt with an in-house tobacco dependence treatment service (rolling 12 months)	Scoring	New NOF metric for 2026/27
Access to Services	% of patients waiting less than 18 weeks for community care	Scoring	New NOF metric for 2026/27
	% of patients waiting over 52 weeks for care	Scoring	Rolled over from 2025/26 NOF
	% of total open children's and young people mental health related waits that are over 104 weeks	Scoring	New NOF metric for 2026/27
	% of people accessing mental health services with at least 2 contacts and a paired patient reported outcome score (all ages)	Scoring	New NOF metric for 2026/27
Experience of care	CQC community mental health survey satisfaction rate	Scoring	Rolled over from 2025/26 NOF

	NHS staff survey advocacy rate	Scoring	New NOF metric for 2026/27
	Mean length of stay for adult acute and psychiatric intensive care unit patients	Scoring	New NOF metric for 2026/27
	Mean length of stay for older adult acute discharges	Scoring	New NOF metric for 2026/27
	% of intermediate care (Community Hospitals) beds occupied by patients without criteria to reside	Scoring	New NOF metric for 2026/27
Effectiveness of care	% of NHS Talking Therapies patients completed a course of treatment and achieving reliable recovery	Scoring	Rolled over from 2025/26 NOF, status changing from Contextual to Scoring
	% of adult acute and rehabilitation mental health, learning disability and autism discharges followed up within 72 hours (rolling 3 months)	Scoring	New NOF metric for 2026/27
	14-day readmission rate	Scoring	New NOF metric for 2026/27
Patient Safety	% of urgent mental health crisis response patients to receive face-to-face care within 24 hours (rolling 3 months)	Scoring	Rolled over from 2025/26 NOF
	Crude rate of restrictive interventions per 100,000 bed days	Contextual	Rolled over from 2025/26 NOF
	% of inpatients who suffer a new hip fracture while an inpatient (annual)	Contextual	New NOF metric for 2026/27
	% of inpatients to acquire a new grade 3 or 4 pressure ulcer	Contextual	New NOF metric for 2026/27
	% of all safety incidents defined as resulting in harm	Contextual	New NOF metric for 2026/27
	NHS staff survey raising concerns sub-score	Scoring	Rolled over from 2025/26 NOF
	Planned surplus or deficit	Scoring	Rolled over from 2025/26 NOF
Finance, productivity and innovation	Variance to plan year-to-date	Scoring	Rolled over from 2025/26 NOF
	Relative cost difference (National Cost Collection Index)	Scoring	Rolled over from 2025/26 NOF
	Rate of implied productivity growth	Contextual	New NOF metric for 2026/27
	% of clinical trials set up within 90 days	Scoring	New NOF metric for 2026/27
	Overall Data Quality Maturity Index score	Scoring	New NOF metric for 2026/27
	Sickness absence rate	Scoring	Rolled over from 2025/26 NOF
People	NHS staff survey engagement theme score	Scoring	Rolled over from 2025/26 NOF
	National education and training survey satisfaction rate (annual)	Scoring	Rolled over from 2025/26 NOF, status changing from Contextual to Scoring

	NHS staff standards score (annual)	Scoring	New NOF metric for 2026/27
	Percentage of frontline healthcare workers to receive a flu vaccination	Scoring	New NOF metric for 2026/27
	Temporary staffing cost relative band	Scoring	New NOF metric for 2026/27

2025/26 NOF metrics that are expected to no longer be reported as NOF metrics in 2026/27, subject to change once the final 2026/27 NOF technical guidance is published:

Domain	Metric	Status
Effectiveness and experience of care	Percentage of Urgent Community Response patients seen within two hours	Scoring
	Percentage of adult inpatients discharged with a length of stay over 60 days at discharge	Scoring
Access to services	Improve access to mental health support for children and young people	Scoring
	Improve access for Adults and Older Adults to support by community mental health services	Contextual
	Percentage of people with suspected autism awaiting contact for over 13 weeks	Contextual
Improving health and reducing inequality	Percentage of adults over the age of 65 with a length of stay beyond 90 days at discharge	Contextual

Out of the above, “percentage of Urgent Community Response patients seen within two hours” and “improve access to mental health support for children and young people” will continue being reported in the Integrated Performance report as clinical operational metrics. The remaining metrics will be monitored at Directorate level only

Workforce Race Equality Standard (WRES)

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Workforce Race Equality Standard (WRES) Report 2026

Executive Summary

This report presents the Workforce Race Equality Standard (WRES) data for 2026, drawing on information from the Electronic Staff Record (ESR) and the NHS National Staff Survey. The WRES continues to provide a critical mechanism through which the Trust can assess race equality across the workforce, offering both a diagnostic view of current performance and a strategic framework for targeted improvement.

As in previous years, the WRES highlights both areas of progress and areas where inequalities persist. Overall, the 2026 position reflects a mixed but improving picture, with notable progress across several indicators relating to recruitment, staff experience, and access to development, alongside ongoing structural challenges in representation, disciplinary processes, and senior leadership diversity.

Encouragingly, the Trust has continued to strengthen its position in relation to inclusive recruitment, with the likelihood of BME staff being appointed from shortlisting now consistently more favourable than for white staff. There have also been meaningful reductions in reported experiences of harassment, bullying and discrimination, suggesting that organisational efforts to improve culture and inclusion are beginning to have a positive impact.

However, these improvements must be considered alongside continued disparities. The data indicates that BME staff remain disproportionately likely to enter formal disciplinary processes and are less likely to perceive the organisation as providing equal opportunities for career progression. Furthermore, the decline in BME representation at Board level represents a concerning reversal, particularly in the context of the Trust's wider commitment to inclusive leadership.

The findings reinforce that while progress is being made, systemic inequalities have not yet been fully addressed, and sustained, focused action will be required to achieve equitable outcomes across all indicators.

This coversheet accompanies the power point WRES 2026 Report and the analysis from page 11 below, and provides a useful summary that analyses which indicators have:

- Worsened: Indicators 1 (decreases in BME staff in some clinical and non-clinical AfC Bands), 9.
- Remained the same: Indicator 1 (Some AfC Bands have remained the same in the representation of non-clinical and clinical BME staff)
- Improved: Indicators 1 (increases in BME staff in some clinical and non-clinical AfC Bands), 2, 3, 4, 5, 6 and 8.

N.B.

- Indicator 1 appears multiple times in the analysis to fully draw out the changes in the representation of BME staff by AfC banding.

Situation

The Workforce Race Equality Standard is a regulatory requirement for NHS organisations and forms a central component of the national Equality, Diversity and Inclusion (EDI) framework. It requires organisations to report annually against nine indicators that measure disparities between BME and white staff across key aspects of workforce experience and workplace culture.

For Oxford Health, the WRES serves not only as a compliance requirement but as an essential tool for organisational learning. It provides a structured way of identifying inequities, understanding their root causes and tracking progress over time. The insights generated through WRES reporting are complemented by internal staff engagement work, including targeted staff surveys and staff network feedback, which provide additional context to the quantitative data.

This report should therefore be read as part of a broader evidence base that informs the Trust's Equality, Diversity and Inclusion (EDI) Plan.

Background

Since its introduction in 2015/16, the WRES has enabled NHS organisations to take a more systematic and transparent approach to addressing race inequality in the workforce. For Oxford Health, this has supported a gradual improvement in workforce diversity over time, alongside increasing organisational maturity in how equality data is analysed and acted upon.

Nationally, the WRES continues to highlight persistent inequalities across the NHS, particularly in relation to recruitment outcomes, disciplinary processes, and staff experience. While many organisations have made progress in increasing workforce diversity, translating this into equitable experiences and outcomes remains a significant challenge.

Within this context, Oxford Health's 2026 data reflects both alignment with national trends and areas where the Trust is demonstrating stronger performance, particularly in recruitment outcomes and access to development opportunities.

Assessment

Indicator 1: Representation of Black, Asian and Minority Ethnic Staff in the Workforce

The comparison between 2024/25 and 2025/26 shows a mixed, but generally positive picture of Black, Asian and Minority Ethnic (BME) representation across the workforce, with increases across a number of Agenda for Change (AfC) bands in both the clinical and non-clinical workforce, alongside some areas of decline and continued under-representation in the most senior bands.

In the non-clinical workforce, headcount data shows increases in BME representation in Band 7 (24 to 25) and Band 8A (21 to 23), while Bands 5, 8B and VSM remained unchanged. There were decreases in Band 2 (71 to 66), Band 3 (44 to 41), Band 4 (91 to 86) and Band 6 (37 to 36). Band 8C increased from 3 to 5, although this remains a relatively small staff group in overall terms. There continues to be no BME representation in Bands 1, 8D and 9.

When viewed proportionally, the non-clinical data shows that representation has increased in a number of bands despite some reductions in headcount. Most notably, Band 2 increased by 4.9% from 32.6% to 37.5%, Band 3 by 0.4% from 13.5% to 13.9%, Band 6 by 0.8% from 18.5% to 19.3%, Band 7 by 0.5% from 14.5% to 15.0%, and Band 8A by 2.3% from 14.9% to 17.2%. Band 8C also increased by 3.5% from 7.9% to 11.4%. By 2025/26, the highest proportional representation in the non-clinical workforce is seen in Band 2 (37.5%) and VSM (42.9%), although the latter reflects a very small headcount. The lowest levels remain in Bands 8B and 8C, and there remains no representation in Bands 1, 8D and 9.

These findings indicate that, in the non-clinical workforce, changes in representation are not uniform across all bands. Some bands show decreases in headcount while still showing proportional increases, reflecting changes in the composition of the total workforce at those bands. The data also shows a reduction in the 'Unknown' category in several bands, including Band 2, Band 3 and Band 6, which improves the reliability of the representation profile.

Within the clinical workforce, the year-on-year picture is more clearly positive. Headcount data shows increases in BME representation across most bands, with particularly notable growth in Band 3 (380 to 432), Band 5 (366 to 449), Band 6 (335 to 395) and Band 7 (142 to 177). There were also increases in Band 8A (58 to 60), Band 8C (10 to 13) and Band 8D (2 to 3), while Bands 8B and VSM remained unchanged. Reductions were seen in Band 2 (4 to 1) and Band 4 (146 to 134). There continues to be no BME representation in Bands 1 and 9.

Percentage data for the clinical workforce reinforces this overall pattern of improvement. Representation increased in Band 2 by 6% from 19.0% to 25.0%, Band 3 by 3.3% from 43.9% to 47.2%, Band 4 by 0.5% from 25.2% to 25.7%, Band 5 by 1.5% from 41.2% to 42.7%, Band 6 by 3.7% from 23.5% to 27.2%, Band 7 by 2.2% from 17.6% to 19.8%, Band 8C by 4.1% from 11.9% to 16.0% and Band 8D by 0.9% from 16.7% to 17.6%. The only proportional decreases were in Band 8A by 0.6% from 14.6% to 14.0% and Band 8B by 0.4% from 14.2% to 13.8%, while VSM remained unchanged at 33.3%. By 2025/26, the highest proportional representation in the clinical workforce is seen in Bands 3 and 5, at 47.2% and 42.7% respectively.

The clinical data therefore shows stronger upward movement than the non-clinical data between 2024/25 and 2025/26, particularly across the mid-band workforce where staff numbers are highest. This is evident in both headcount and percentage terms, especially in Bands 3, 5, 6 and 7. At the same time, representation remains absent in Bands 1 and 9, and the very small numbers in some senior bands mean that percentage changes should be interpreted with caution.

Across both workforce groups, the overall picture between 2024/25 and 2025/26 is one of continued progress in a number of key bands, particularly within the clinical workforce and across mid-level grades. However, this progress is not consistent across all bands. In the non-clinical workforce, there are a number of bands where headcount has reduced, even where proportional representation has improved. In both workforce groups, representation at the most senior levels remains limited, with no BME representation in Band 9, no non-clinical representation in Band 8D, and very small numbers in the most senior clinical bands.

Overall, the 2025/26 data shows that BME representation has strengthened across several parts of the workforce, particularly in clinical Bands 3, 5, 6 and 7, and in selected non-clinical bands including 7, 8A and 8C. However, the distribution of representation remains uneven across bands, and the pattern of improvement is stronger in some areas than others. This indicates continued progress in workforce diversity, but not yet consistent representation across all levels of the organisation.

Indicator 2: Recruitment

The Trust's performance in relation to recruitment represents one of the most significant areas of progress in the 2025/26 data. The relative likelihood of white staff being appointed from shortlisting compared to BME staff has reduced further by 0.09 from 0.69 in 2024/25 to 0.60 in 2025/26.

A figure below 1.00 indicates that BME candidates are more likely to be appointed than white candidates. At 0.60, this means that white candidates were less likely to be appointed from shortlisting compared to BME candidates in 2025/26, representing a further strengthening of this position compared to the previous year.

This continues a sustained downward trend over recent years, with the indicator having remained below 1.00 since 2020/21. The 2025/26 figure is the lowest recorded across the time series, indicating continued improvement in relative appointment outcomes for BME candidates.

Importantly, this marks the sixth consecutive year in which the Trust has achieved a figure below 1.00, demonstrating sustained progress and consistency in recruitment outcomes. The year-on-year reduction in 2025/26 further reinforces this positive trajectory.

This improvement is likely to reflect the impact of targeted interventions to support inclusive recruitment, including the use of diverse panels and a continued organisational focus on reducing bias in selection decisions.

Indicator 3: Disciplinary Process

The data for Indicator 3 shows a significant improvement, with the relative likelihood of BME staff entering formal disciplinary processes decreasing from 4.59 to 3.31.

While this reduction is positive and suggests that recent interventions may be having an impact, it is important to recognise that the disparity remains substantial. A BME staff member is still more than three times as likely as white staff to enter formal disciplinary processes, indicating that systemic inequalities persist within this area.

This finding is consistent with national trends, where disparities in disciplinary processes have proven particularly resistant to change. It reinforces the need for continued focus on reviewing processes, strengthening oversight, and ensuring that disciplinary process is applied fairly and consistently.

Indicator 4: Access to Training and Development

The Trust continues to demonstrate strong performance in relation to access to non-mandatory training and continuing professional development (CPD). The relative likelihood of white staff accessing training compared to BME staff has decreased further from 0.99 to 0.86.

This indicates that BME staff are now more likely than white staff to access training opportunities, representing a positive shift towards equity. It also suggests that organisational efforts to improve access to development opportunities are having a tangible impact.

Ensuring equitable access to training is a critical component of supporting career progression social mobility, and this improvement provides a strong foundation on which to build further work in this area.

Indicators 5, 6 and 8: Harassment, Bullying and Abuse

The data for Indicators 5, 6 and 8 shows encouraging improvements in staff experience, with reductions in reported harassment, bullying and discrimination across most measures.

For Indicator 5 (harassment, bullying or abuse from patients, relatives or the public), the proportion of BME staff reporting experience decreased slightly by 0.4% from 31.8% to 31.4%, while the proportion for white staff decreased by 0.6% from 19.8% to 19.2%. Despite these reductions, the gap between BME and white staff remains substantial at 12.2%.

For Indicator 6 (harassment, bullying or abuse from staff), there were further reductions for both groups. The proportion of BME staff decreased by 2.2% from 20.1% to 17.9%, while the proportion for white staff decreased by 0.6% from 15.2% to 14.6%. The 2025/26 figures represent the lowest reported levels for both groups across the available time series. The gap between BME and white staff stands at 3.3%

For Indicator 8 (discrimination at work), the proportion of BME staff reporting discrimination decreased by 0.7% from 12.5% to 11.8%, while the proportion for white staff increased slightly by 0.1% from 6.0% to 6.1%. This results in a gap of 5.7% between BME and white staff.

Across all three indicators, BME staff continue to report higher levels of negative experience than white staff. While there have been reductions in reported experiences for most measures, the differences between groups remain evident.

Indicator 7: Career Progression

Due to changes in the wording of the NHS Staff Survey question, 2025 represents a new baseline for this indicator. In 2026, 57.2% of BME staff reported that they believe the organisation provides equal opportunities for career progression, compared to 60.8% of white staff.

While the gap between the two groups is relatively small (3.62%), it remains indicative of a perceived inequality in opportunity, which is consistent with findings from previous years and wider staff feedback.

Perceptions of career progression are a critical measure of inclusion, as they reflect staff confidence in the fairness and transparency of organisational opportunities. Addressing this gap will require continued focus on talent management, leadership development and removing barriers to progression.

Indicator 9: Board Representation

The data for Board representation shows a decrease by 1.5% in the proportion of BME Board members from 25.0% to 23.5%. Over the same period, the proportion of BME staff in the overall workforce increased by 2.2% from 25.8% to 28.0%.

As a result, the difference between Board representation and overall workforce representation has widened by 3.6% from 0.8% in 2024/25 to 4.4% in 2025/26, indicating a larger gap between senior leadership and the wider workforce.

While Board representation has improved over the longer term (from 0% in 2015/16 to 23.5% in 2025/26), the 2025/26 data shows a reversal of the more recent trend. In 2022/23 and 2024/25, the gap between Board and workforce representation had narrowed to -0.7% and -0.8% respectively, indicating near parity. The increase to -4.4% in 2025/26 represents a shift away from this position.

Across the time series, the difference between Board and workforce representation remains negative in all years, indicating that BME staff are consistently underrepresented at Board level relative to the overall workforce.

Conclusion

The 2026 Workforce Race Equality Standard (WRES) data demonstrates that the Trust continues to make meaningful progress in advancing race equality, particularly in relation to inclusive recruitment, access to development opportunities and improvements in staff experience.

Encouragingly, the Trust has sustained positive outcomes in recruitment, with BME staff now more likely to be appointed from shortlisting, and has seen reductions in reported experiences of harassment, bullying and discrimination across several indicators. These improvements reflect the impact of continued organisational focus on anti-racism and a growing maturity in how data is used to inform action.

However, the data also highlights that significant inequalities persist. BME staff remain disproportionately likely to enter formal disciplinary processes, are less likely to perceive equal opportunities for career progression and continue to report higher levels of negative workplace experiences compared to their white counterparts. In addition, the decline in Board-level representation represents a concerning step backwards in achieving inclusive leadership.

The Trust's continued commitment to anti-racism, inclusive leadership and a whole-system approach to equality, diversity and inclusion will be critical in driving forward this agenda. By building on the progress made to date and maintaining a clear focus on areas of inequality, the Trust can continue to move towards its ambition of becoming a truly inclusive organisation where all staff can thrive.

Workforce Race Equality Standard (WRES) Analysis 2026

WRES Indicators: **Worsened**

WRES Indicator	Analysis
Indicator 1: BME Staff	By headcount, there have been decreases in the representation of BME staff from the previous year in the following bands: Non-Clinical: ○ Band 2 = -5 BME staff ○ Band 3 = -3 BME staff ○ Band 4 = -5 BME staff ○ Band 6 = -1 BME staff Clinical: ○ Band 2 = -3 BME staff ○ Band 4 = -12 BME staff
Indicator 9: Percentage difference between the organisation's Board membership and its overall workforce disaggregated by voting membership of the Board & by executive membership of the Board	• There has been a decrease of 1.5% from 25% to 23.5% in the representation of BME members on the Board. • There is now 4.4% difference between the BME Board membership and the Trust's overall BME workforce representation.

WRES Indicators: Remained the same

WRES Indicator	Analysis
Indicator 1: BME Staff	There have not been changes in the representation of BME staff from the previous year in the following bands: Non-Clinical: ○ Band 8D = 0 BME staff (0%) ○ Band 9 = 0 BME staff (0%) Clinical: ○ Band 9 = 0 BME staff (0%)
Indicator 7: Percentage of staff believing the organisation provides equal opportunities for career progression or promotion	• Due to a change in the wording of this question in the 2025 NHS Staff Survey, results are not comparable with previous years. Therefore, 2025 will act as the baseline year for future analysis. • 60.8% of White staff reported believing that the organisation provides equal opportunities for career progression or promotion. • 57.2% of BME staff reported believing that the organisation provides equal opportunities for career progression or promotion. • BME staff were less likely to report that the organisation provides equal opportunities for career progression or promotion than White staff (57.17% vs 60.79%). • The difference between the two groups is 3.62%.

WRES Indicators: Improved

WRES Indicator	Analysis
Indicator 1: BME Staff	By headcount, there have been increases in the representation of BME staff from the previous year in the following bands: Non-Clinical: ○ Band 7 = +1 BME staff (+0.5%) ○ Band 8A = +2 BME staff (+2.3%) ○ Band 8C = +2 BME staff (+3.5%) Clinical: ○ Band 3 = +52 BME staff (+3.3%) ○ Band 5 = +83 BME staff (+1.5%) ○ Band 6 = +60 BME staff (+3.7%) ○ Band 7 = +35 BME staff (+2.2%) ○ Band 8A = +2 BME staff (-0.6%) ○ Band 8C = +3 BME staff (+4.1%) ○ Band 8D = +1 BME staff (+0.9%)
Indicator 2: Relative likelihood of white staff being appointed from shortlisting compared to BME staff	• The relative likelihood of white staff being appointed from shortlisting compared to BME staff has decreased by 0.09 from 0.69 to 0.60, indicating that BME staff are more likely than white staff to be appointed from shortlisting for the Trust as a whole. • This is the sixth consecutive year of being below 1.00, meaning it is in favour of BME staff being appointed from shortlisting.
Indicator 3: Relative likelihood of BME staff entering formal disciplinary process compared to white staff	• There has been a decrease of 1.28 from 4.59 to 3.31 in the relative likelihood of BME staff entering formal disciplinary process compared to white staff.
Indicator 4: Relative likelihood of white staff accessing non-mandatory training & CPD compared to BME staff	• There has been a decrease of 0.13 from 0.99 to 0.86 in the relative likelihood of white staff accessing non-mandatory training & CPD compared to BME staff. • This indicator continues to show parity between white staff and BME staff accessing non-mandatory training & CPD.
Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	• There has been a decrease of 0.4% from 31.8% to 31.4% in the percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public. • There has also been a decrease of 0.6% from 19.8% to 19.2% in the percentage of white staff experiencing harassment, bullying or abuse from patients, relatives or the public. • This is the lowest % this indicator has achieved for white staff since the introduction of the WRES in 2015.
Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	• There has been a decrease of 2.2% from 20.1% to 17.9% in the percentage of BME staff experiencing harassment, bullying or abuse from staff. • There has been a decrease of 0.6% from 15.2% to 14.6% in the percentage of white staff experiencing harassment, bullying or abuse from staff. • This is the lowest % this indicator has achieved for both BME and white staff since the introduction of the WRES in 2015.

Indicator 8: Percentage of staff experiencing discrimination at work from manager/ team leader or other colleagues in last 12 months	• There has been a decrease of 0.7% from 12.5% to 11.8% in the percentage of BME staff experiencing discrimination at work from manager/team leader or other colleagues. • There has been a small increase of 0.1% from 6.0% to 6.1% in the percentage of white staff experiencing discrimination at work from manager/team leader or other colleagues.

WRES Theme	WRES Indicator(s)	Improvement Objective	Key Actions	Success Measures / KPI	Responsible Owner	Target Date	RAG
Workforce Representation	Indicator 1	Increase BME representation across underrepresented bands and senior leadership roles.	- Complete workforce representation analysis - Identify barriers to progression - Develop targeted interventions for Bands 8D, 9 and VSM roles	Increase BME representation in Bands 8D-VSM	Head of EDI	Ongoing	
Senior Leadership Diversity	Indicators 1 & 9	Improve representation of BME staff in senior leadership and Board-level positions.	Implement targeted succession planning, talent management and leadership development programmes	Board representation moves closer to workforce representation, reducing gap from 4.4% to below 2%	Head of EDI		
Inclusive Recruitment	Indicator 2	Maintain equitable and inclusive recruitment outcomes.	- Continue use of diverse recruitment panels - Review recruitment data quarterly - Deliver inclusive recruitment training	Recruitment likelihood ratio remains below 1.0 and demonstrates equity	Head of EDI Head of Resourcing	Quarterly	
Disciplinary Processes	Indicator 3	Reduce disproportionality in formal disciplinary processes.	- Comprehensive review of disciplinary processes - Strengthen oversight of cases - Monitor outcomes by ethnicity	Reduce likelihood ratio from 3.31 to below 2.0	HR Opps		
Access to Training & Development	Indicator 4	Maintain equitable access to non-mandatory training and CPD opportunities.	- Monitor participation rates by ethnicity - Promote development opportunities - Review access barriers	Maintain likelihood ratio within equitable range (0.80–1.20)	Head of L&D	Quarterly	

Psychological and Physical Safety	Indicator 5 Indicator 6 Indicator 8	Reduce harassment, bullying, abuse and discrimination from patients, relatives, public and staff, experienced by BME staff.	• Develop and deliver the 'Anti-Racism Toolkit' and training • Introduce the 'Micro-aggression and Allyship' training into leadership development • Strengthen incident reporting and support mechanisms	Reduce BME staff experience rate of harassment from patients and public from 31.4% to below 28% Reduce BME staff experience rate of harassment from staff from 17.9% to below 15% Reduce BME discrimination rate from 11.8% to below 9%	Directorate Leads Anti-Racism Programme Lead	Page 394 of 530	
Career Progression	Indicator 7	Improve perceptions of fair career progression opportunities.	• Increase access to mentoring, sponsorship, coaching and leadership development programmes for BME staff	Improve positive response rate from 57.2% to at least 62%	Head L&D Head of OD		
Leadership Accountability	Indicators 1–9	Strengthen accountability for race equality outcomes across the Trust.	• Require Directorates to review WRES data and develop local action plans	Performance reports received by EDI Steering Group	Directorate Leads		

Oxford Health NHS FT

Equality, Diversity & Inclusion

Workforce Race Equality Standard (WRES) 2026

To find out more about what Oxford Health NHS FT is doing to be a fair and equal employer and care provider, please contact: EqualityandInclusion@oxfordhealth.nhs.uk

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the [NHS standard contract](#).

The [NHS Equality and Diversity Council](#) announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

This is important because studies show that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety.

In April 2015, after engaging and consulting with key stakeholders including other NHS organisations across England, the WRES was mandated through the NHS standard contract, starting in [2015/16](#). From 2017, independent healthcare providers are required to publish their WRES data.

The [first WRES report](#), was published in June 2016, followed by the [2016 WRES report](#) on 19 April 2017.

NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.

[NHS England » NHS Workforce Race Equality Standard](#)

Black, Asian and minority ethnic (BME);

Throughout this report, we use the term Black, Asian and minority ethnic (BME), to refer to those members of the NHS workforce who are not white. As set out in the workforce race equality standard (WRES) technical guidance, the definitions of “Black, Asian and minority ethnic” and “white” used in the WRES have followed the national reporting requirements of ethnic category in the NHS data model and dictionary and NHS digital data. **We are aware that terminology is being reviewed and we will follow NHS guidance as it is produced.

Data Source;

Indicators 1,2,3,4 & 9 Anonymous data is derived from our secure and confidential electronic staff record system (known as ESR).

Indicators 5,6,7, & 8 are derived from the annual [NHS National Staff Survey](#).

Distance from equity;

For likelihood questions (indicators 2,3 & 4), this refers to how far the number is from 1.

For other indicators (indicators 1,5,6,7,8 & 9), it refers to the percentage difference between BME and White experiences.

For example, if 45% of White staff believe the organisation provides equal opportunity for career progression, then it would be equitable if 45% of BME staff felt the same way. here, the greater the percentage difference, the greater the inequity.

1 = Indicator 1

Indicator 1

Percentage of staff in each of the AfC bands 1 to 9 or medical and dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: non-clinical staff & clinical staff (non-medical staff, medical and dental staff).

2 = Indicator 2

Indicator 2

Relative likelihood of staff being appointed from shortlisting across all posts.

3 = Indicator 3

Indicator 3

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

4 = Indicator 4

Indicator 4

Relative likelihood of staff accessing non-mandatory training and CPD.

5 = Indicator 5

Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

6 = Indicator 6

Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

7 = Indicator 7

Indicator 7

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.

8 = Indicator 8

Indicator 8

Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months

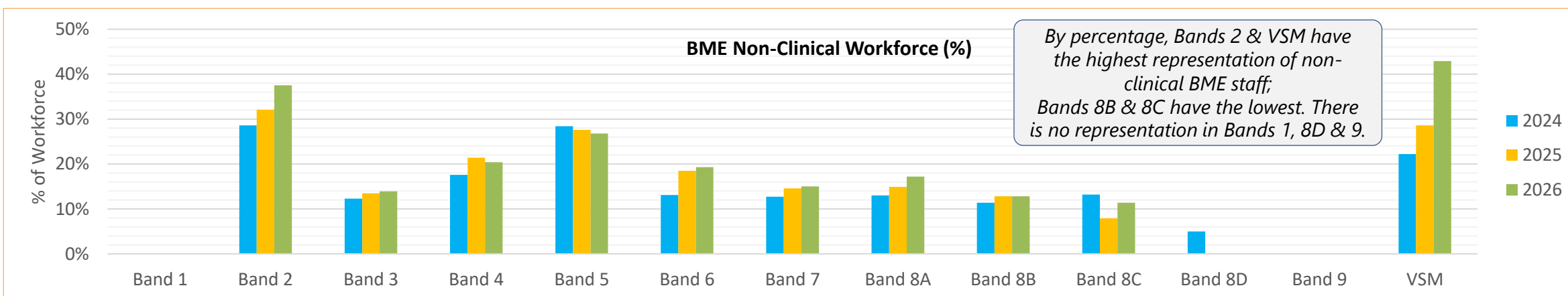
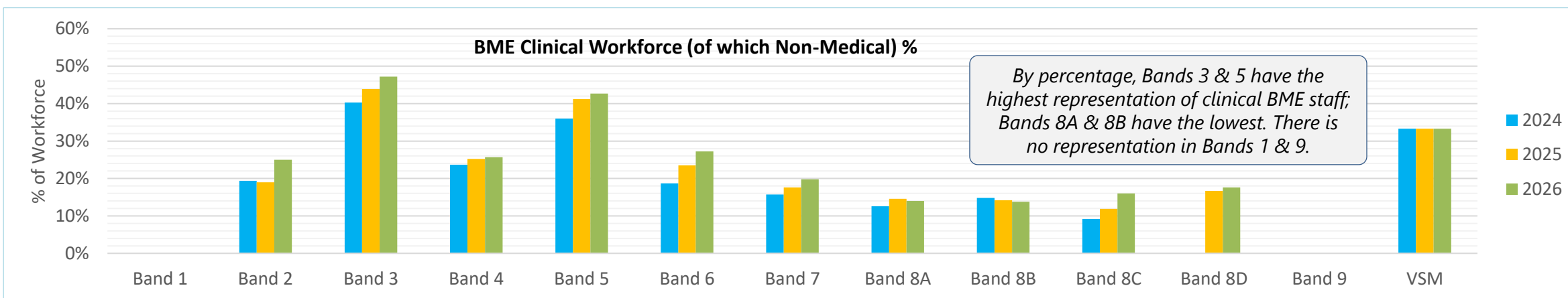
9 = Indicator 9

Indicator 9

Percentage difference between the organisations' Board membership and its overall workforce disaggregated:

- By voting membership of the Board
- By executive membership of the Board

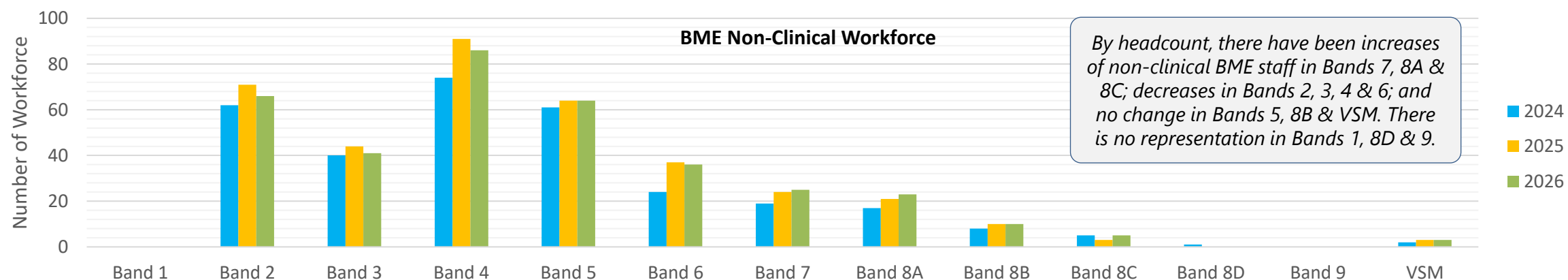
As of 31st March 2026, the proportion of BME staff increased by 2.20%, from 25.77% to 27.97%.



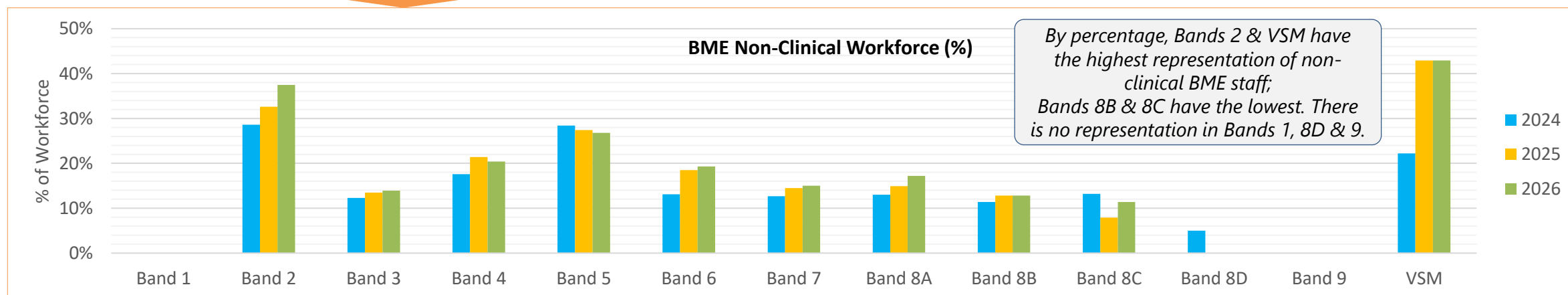
Indicator number and description	Results 2025/26	Results 2024/25	Change	Distance from equity
Indicator 1: BME representation in the workforce by pay band				
Non-clinical	20.19%	19.80%	+0.39%	–
Clinical	30.58%	28.04%	+2.54%	–
Medical & Dental	26.63%	24.06%	+2.57%	–
Indicator 2: Likelihood of appointment from shortlisting				
Likelihood ratio (White : BME)	0.60	0.69	-0.09	0.40
Indicator 3: Likelihood of BME entering formal disciplinary proceedings				
Likelihood ratio (BME : White)	3.31	4.59	-1.28	2.31
Indicator 4: Likelihood of BME taking non-mandatory training				
Likelihood ratio (White : BME)	0.86	0.99	-0.13	0.14
Indicator 9: Difference between BME representation on the Board and the overall workforce				
Overall workforce	27.97%	25.77%	+2.20%	–
Board	23.53%	25.00%	-1.47%	–

Indicator number and description	Results 2025/26	Results 2024/25	Change	Distance from equity	National Average
Indicator 5: Harassment, bullying or abuse from patients, relatives or the public in last 12 months					
BME	31.4%	31.8%	-0.4%	12.2%	29.2%
White	19.2%	19.8%	-0.6%		23.5%
Indicator 6: Harassment, bullying or abuse from staff in last 12 months					
BME	17.9%	20.1%	-2.2%	3.3%	23.4%
White	14.6%	15.2%	-0.6%		19.6%
Indicator 7: Career progression					
BME	57.2%	Note: Due to changes in the question wording, previous years' results for WRES indicator 7 (Q15) are not reported.		3.6%	49.7%
White	60.8%				55.8%
Indicator 8: Discrimination from manager / team leader or other colleagues in last 12 months					
BME	11.8%	12.5%	-0.7%	5.7%	13.9%
White	6.1%	6.0%	-0.1%		6.5%

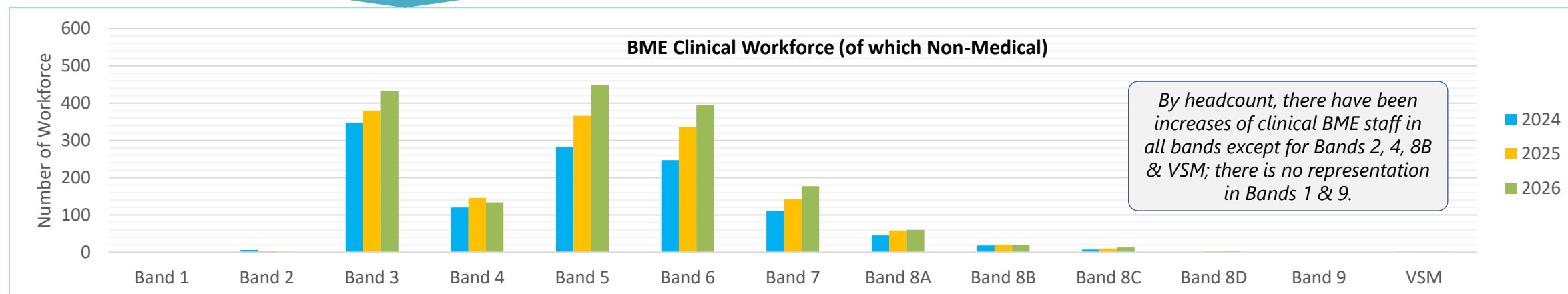
Non-Clinical Workforce	BME 2024	BME 2025	BME 2026	White 2024	White 2025	White 2026	Unknown 2024	Unknown 2025	Unknown 2026
Band 1	0	0	0	1	1	1	0	0	0
Band 2	62	71	66	138	131	97	17	16	13
Band 3	40	44	41	279	275	250	7	6	5
Band 4	74	91	86	337	327	328	9	8	8
Band 5	61	64	64	151	165	171	3	5	4
Band 6	24	37	36	144	153	143	15	10	8
Band 7	19	24	25	122	130	132	9	11	10
Band 8A	17	21	23	110	120	111	4	0	0
Band 8B	8	10	10	61	67	67	1	1	1
Band 8C	5	3	5	33	35	39	0	0	0
Band 8D	1	0	0	19	17	18	0	0	0
Band 9	0	0	0	7	8	7	1	1	2
VSM	2	3	3	7	4	4	0	0	0



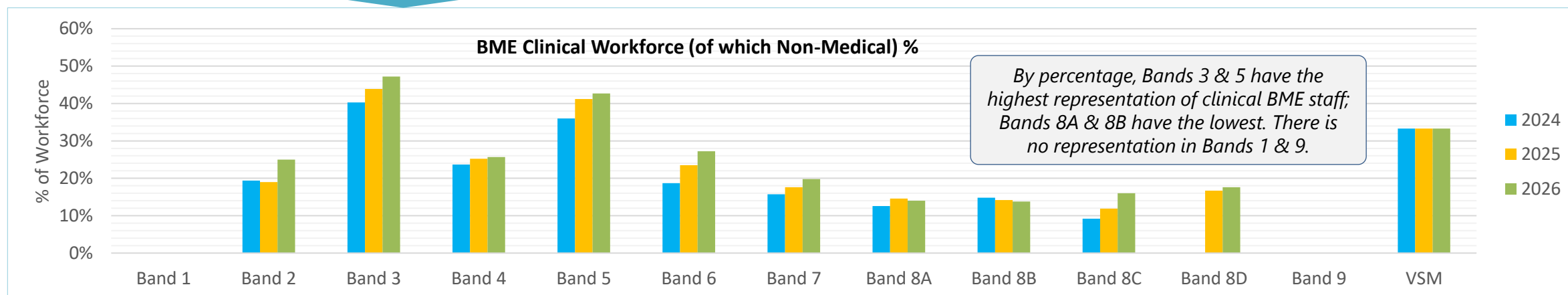
Non-Clinical Workforce	BME 2024	BME 2025	BME 2026	White 2024	White 2025	White 2026	Unknown 2024	Unknown 2025	Unknown 2026
Band 1	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%
Band 2	28.6%	32.6%	37.5%	63.6%	60.1%	55.1%	7.8%	7.3%	7.4%
Band 3	12.3%	13.5%	13.9%	85.6%	84.6%	84.5%	2.1%	1.8%	1.7%
Band 4	17.6%	21.4%	20.4%	80.2%	76.8%	77.7%	2.1%	1.9%	1.9%
Band 5	28.4%	27.4%	26.8%	70.2%	70.5%	71.5%	1.4%	2.1%	1.7%
Band 6	13.1%	18.5%	19.3%	78.7%	76.5%	76.5%	8.2%	5.0%	4.3%
Band 7	12.7%	14.5%	15.0%	81.3%	78.8%	79.0%	6.0%	6.7%	6.0%
Band 8A	13.0%	14.9%	17.2%	84.0%	85.1%	82.8%	3.1%	0.0%	0.0%
Band 8B	11.4%	12.8%	12.8%	87.1%	85.9%	85.9%	1.4%	1.3%	1.3%
Band 8C	13.2%	7.9%	11.4%	86.8%	92.1%	88.6%	0.0%	0.0%	0.0%
Band 8D	5.0%	0.0%	0.0%	95.0%	100.0%	100.0%	0.0%	0.0%	0.0%
Band 9	0.0%	0.0%	0.0%	87.5%	88.9%	77.8%	12.5%	11.1%	22.2%
VSM	22.2%	42.9%	42.9%	77.8%	57.1%	57.1%	0.0%	0.0%	0.0%



Clinical Workforce	BME 2024	BME 2025	BME 2026	White 2024	White 2025	White 2026	Unknown 2024	Unknown 2025	Unknown 2026
Band 1	0	0	0	0	0	0	0	0	0
Band 2	6	4	1	24	16	3	1	1	0
Band 3	348	380	432	484	461	453	32	25	30
Band 4	120	146	134	370	417	373	17	17	14
Band 5	282	366	449	449	486	555	52	36	47
Band 6	247	335	395	995	1031	1017	79	57	40
Band 7	111	142	177	582	646	696	16	20	21
Band 8A	45	58	60	297	321	350	16	18	18
Band 8B	18	19	19	98	111	115	6	4	4
Band 8C	7	10	13	69	74	68	0	0	0
Band 8D	0	2	3	10	8	12	2	2	2
Band 9	0	0	0	2	2	2	0	0	0
VSM	1	1	1	2	2	2	0	0	0



Clinical Workforce	BME 2024	BME 2025	BME 2026	White 2024	White 2025	White 2026	Unknown 2024	Unknown 2025	Unknown 2026
Band 1	-	-	-	-	-	-	-	-	-
Band 2	19.4%	19.0%	25.0%	77.4%	76.2%	75.0%	3.2%	4.8%	0.0%
Band 3	40.3%	43.9%	47.2%	56.0%	53.2%	49.5%	3.7%	2.9%	3.3%
Band 4	23.7%	25.2%	25.7%	73.0%	71.9%	71.6%	3.4%	2.9%	2.7%
Band 5	36.0%	41.2%	42.7%	57.3%	54.7%	52.8%	6.6%	4.1%	4.5%
Band 6	18.7%	23.5%	27.2%	75.3%	72.5%	70.0%	6.0%	4.0%	2.8%
Band 7	15.7%	17.6%	19.8%	82.1%	80.0%	77.9%	2.3%	2.5%	2.3%
Band 8A	12.6%	14.6%	14.0%	83.0%	80.9%	81.8%	4.5%	4.5%	4.2%
Band 8B	14.8%	14.2%	13.8%	80.3%	82.8%	83.3%	4.9%	3.0%	2.9%
Band 8C	9.2%	11.9%	16.0%	90.8%	88.1%	84.0%	0.0%	0.0%	0.0%
Band 8D	0.0%	16.7%	17.6%	83.3%	66.7%	70.6%	16.7%	16.7%	11.8%
Band 9	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%
VSM	33.3%	33.3%	33.3%	66.7%	66.7%	66.7%	0.0%	0.0%	0.0%



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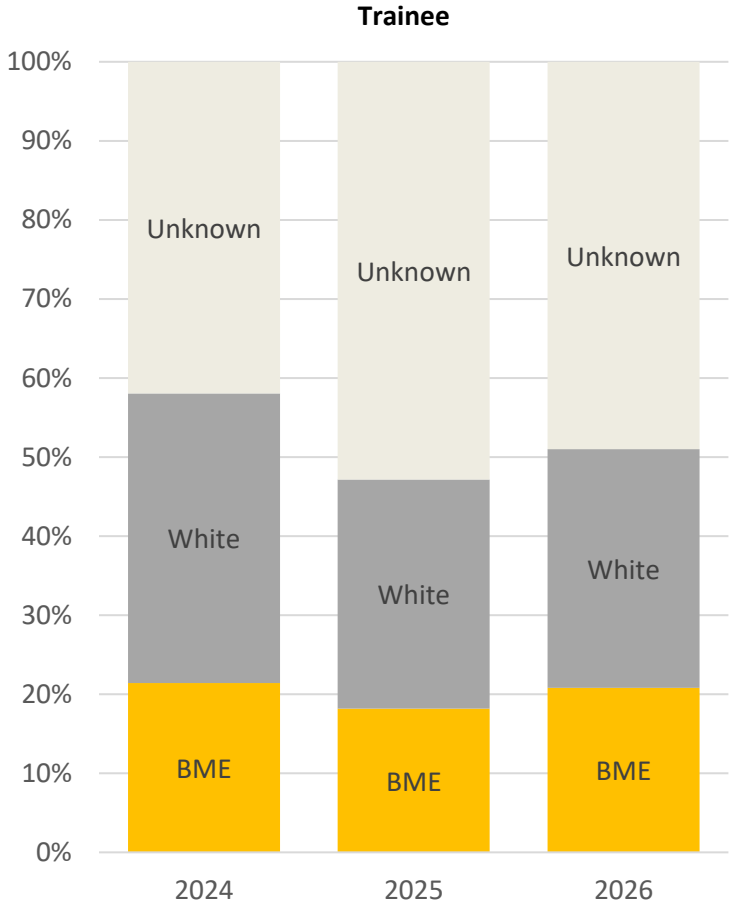
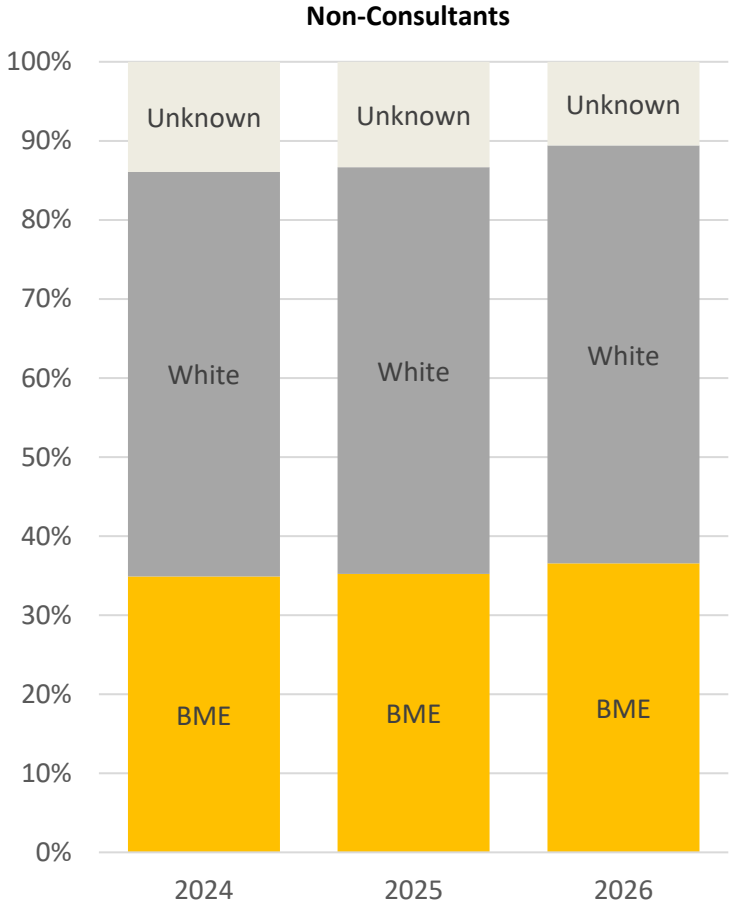
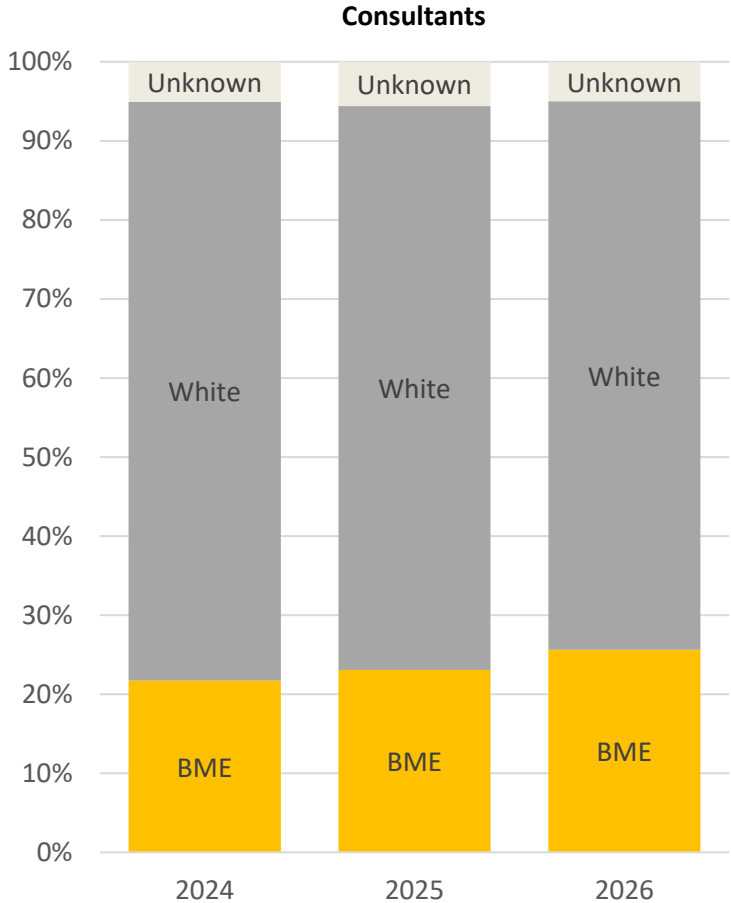
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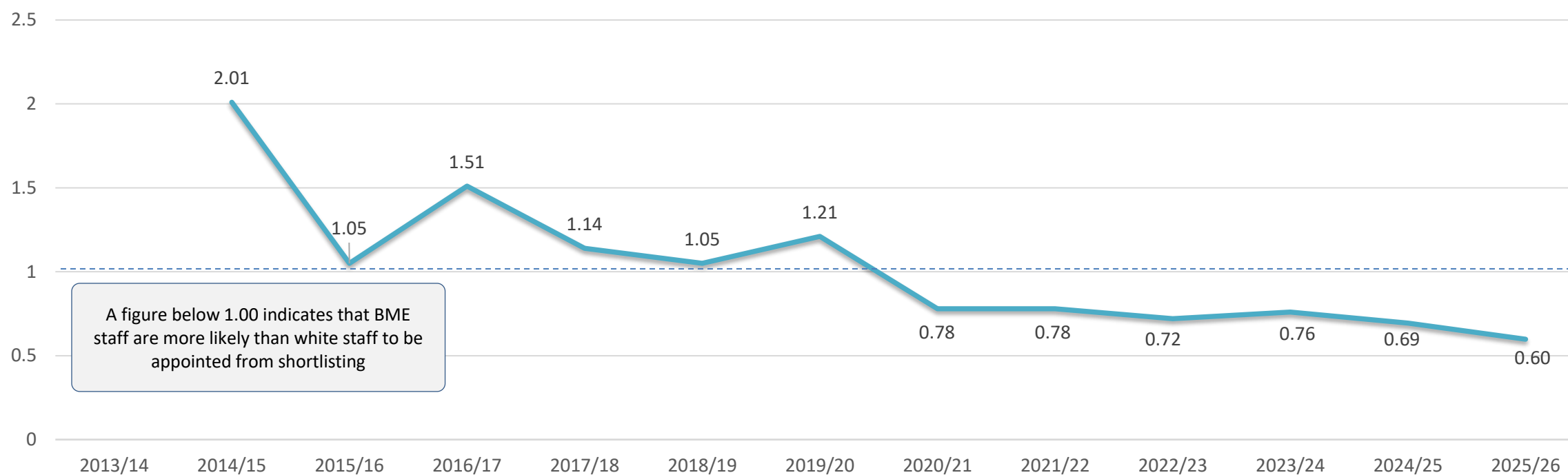
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Medical & Dental	BME 2024	BME 2025	BME 2026	White 2024	White 2025	White 2026	Unknown 2024	Unknown 2025	Unknown 2026
Consultant	30	33	41	101	102	111	7	8	8
Non-consultant	30	37	38	44	54	55	12	14	11
Trainee	24	32	31	41	51	45	47	93	73
Other	0	0	0	0	0	0	0	0	0



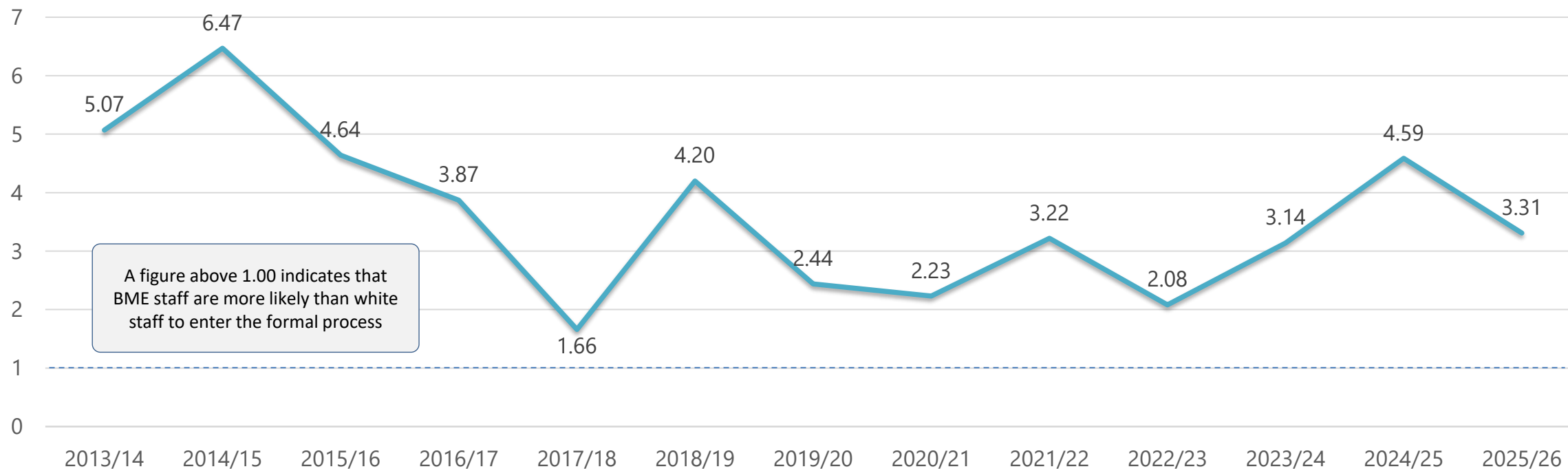
Relative likelihood of white staff being **appointed from shortlisting** compared to BME staff

2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
No data	2.01 times more likely	1.05 times more likely	1.51 times more likely	1.14 times more likely	1.05 times more likely	1.21 times more likely	0.78 times more likely	0.78 times more likely	0.72 times more likely	0.76 times more likely	0.69 times more likely	0.60 times more likely
-	-	-0.96	+0.46	-0.37	-0.09	+0.16	-0.43	0.00	-0.06	+0.04	-0.07	-0.09



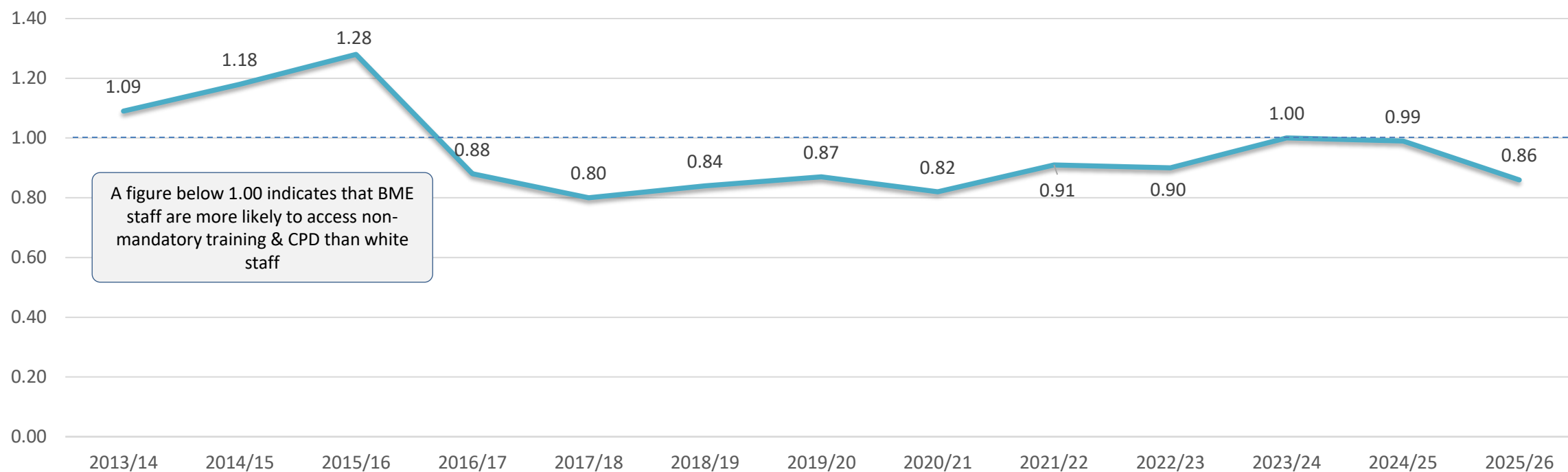
Relative likelihood of BME staff entering into **formal disciplinary process** compared to white staff

2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
5.07 times more likely	6.47 times more likely	4.64 times more likely	3.87 times more likely	1.66 times more likely	4.20 times more likely	2.44 times more likely	2.23 times more likely	3.22 times more likely	2.08 times more likely	3.14 times more likely	4.59 times more likely	3.31 times more likely
-	+1.4	-1.83	-0.77	-2.21	+2.54	-1.76	-0.21	+0.99	-1.14	+1.06	+1.45	-1.28



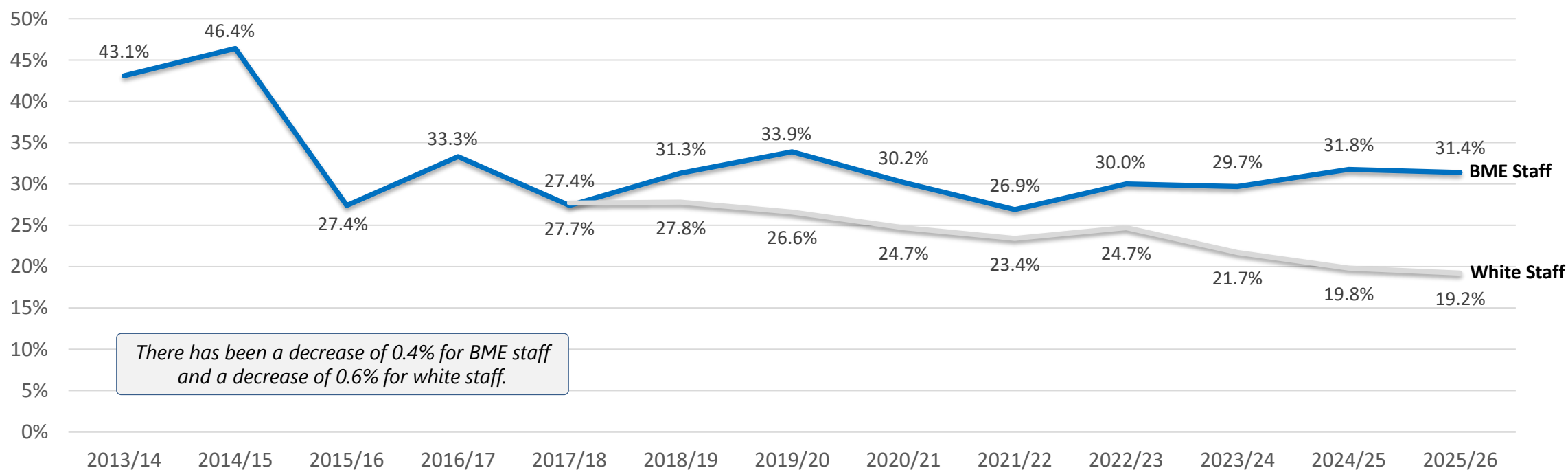
Relative likelihood of white staff accessing **non-mandatory training & CPD** compared to BME staff

2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
1.09 times more likely	1.18 times more likely	1.28 times more likely	0.88 times more likely	0.80 times more likely	0.84 times more likely	0.87 times more likely	0.82 times more likely	0.91 times more likely	0.90 times more likely	1.00 times more likely	0.99 times more likely	0.86 times more likely
-	+0.09	+0.10	-0.40	-0.08	+0.04	+0.03	-0.05	+0.09	-0.01	+0.10	-0.01	-0.13



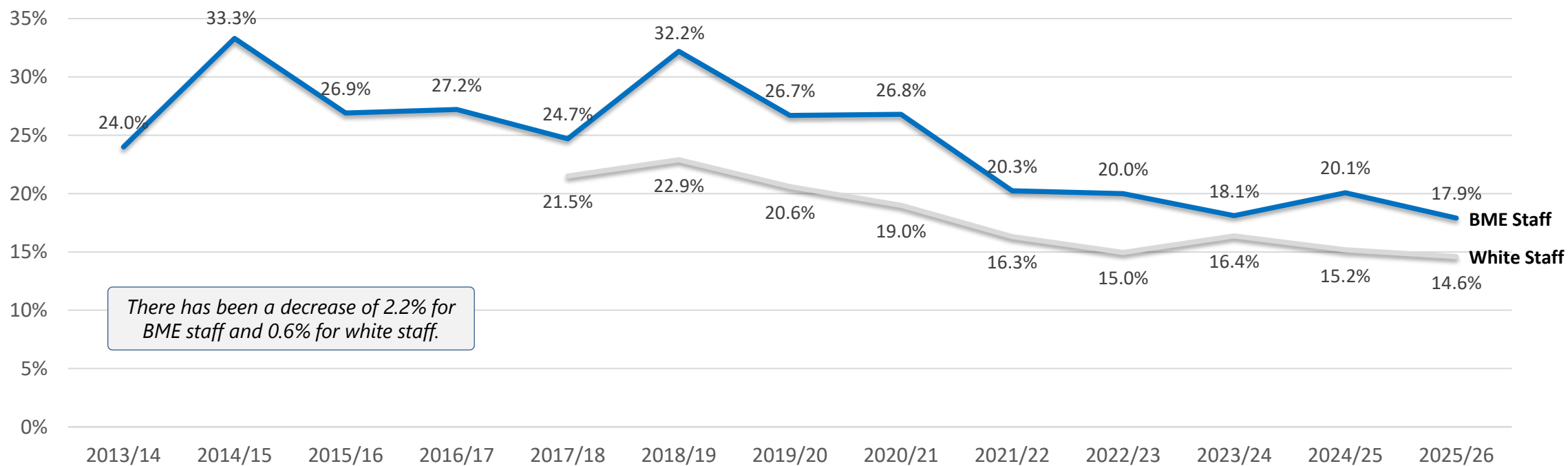
Percentage of staff experiencing harassment, bullying or abuse
from patients, relatives or the public in last 12 months

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
BME Staff	43.1% -	46.4% +3.3%	27.4% -19.0%	33.3% +5.9%	27.4% -5.9%	31.3% +3.9%	33.9% +2.6%	30.2% -3.7%	26.9% -3.3%	30.0% +3.1%	29.7% -0.3%	31.8% +2.1%	31.4% -0.4%
White Staff					27.7% -	27.8% +0.1%	26.6% -1.2%	24.7% -1.9%	23.4% -1.3%	24.7% +1.3%	21.7% -3.0%	19.8% -1.9%	19.2% -0.6%



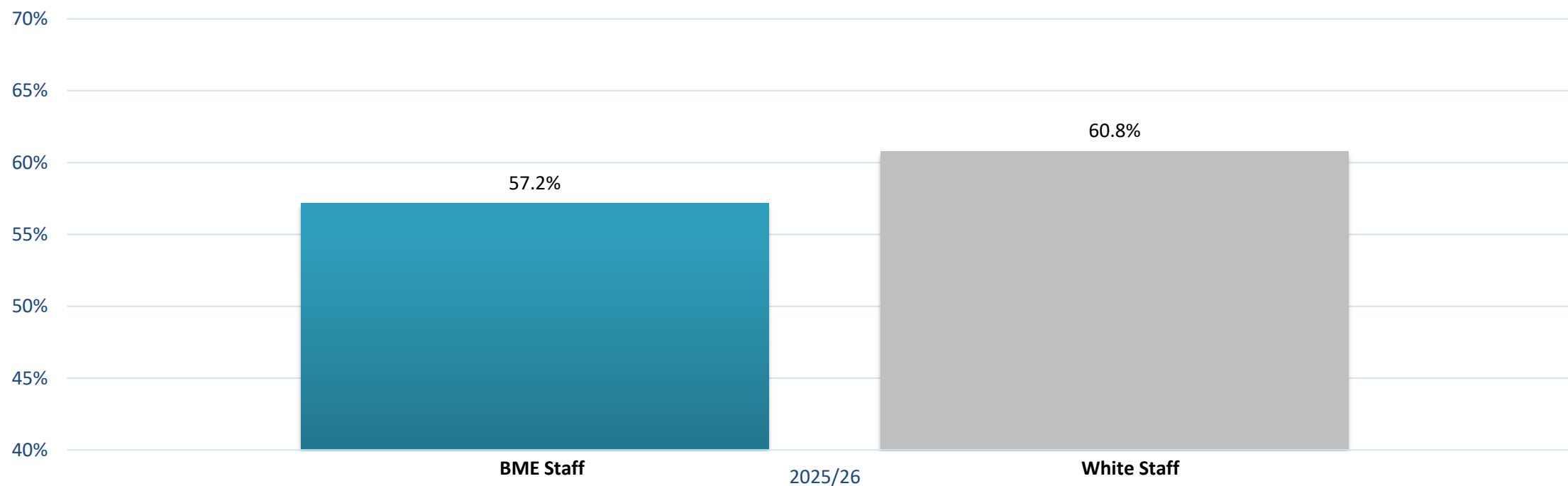
Percentage of staff experiencing harassment, bullying or abuse
from staff in last 12 months

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
BME Staff	24.0%	33.3% +9.3%	26.9% -6.4%	27.2% +0.3%	24.7% -2.5%	32.2% +7.5%	26.7% -5.5%	26.8% +0.1%	20.3% -6.5%	20.0% -0.3%	18.1% -1.9%	20.1% +2.0%	17.9% -2.2%
White Staff	-	-	-	-	21.5% -	22.9% +1.4%	20.6% -2.3%	19.0% -1.6%	16.3% -2.7%	15.0% -1.3%	16.4% +1.4%	15.2% -1.2%	14.6% -0.6%



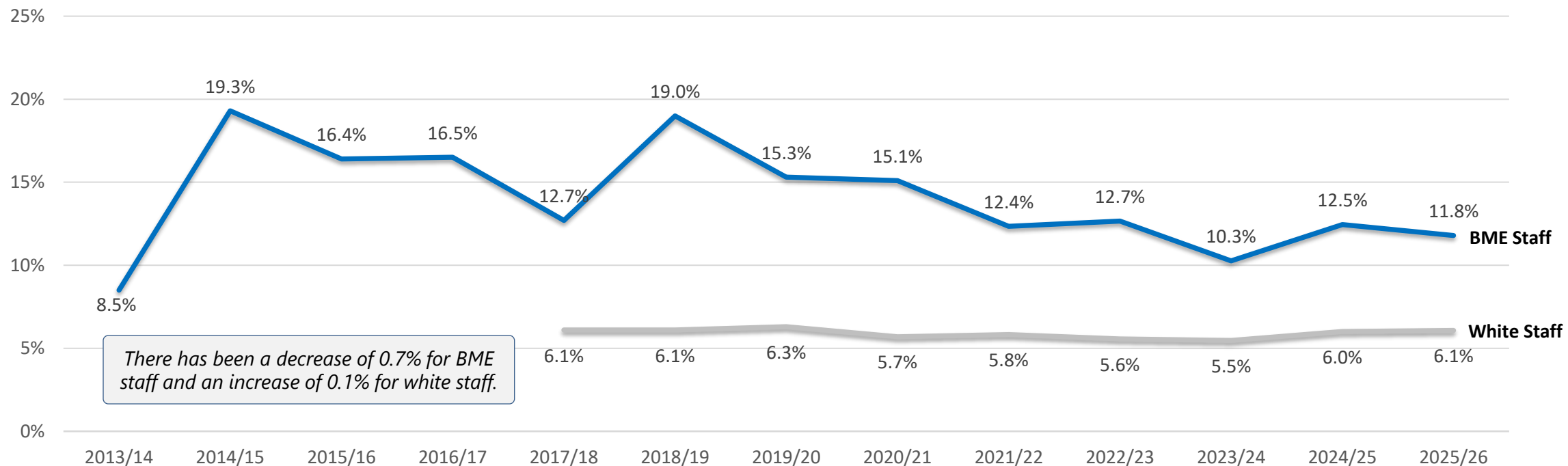
Percentage of staff believing the organisation provides **equal opportunities** for career progression or promotion

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
BME Staff													57.2%
	Note: Due to changes in the question wording in 2025, previous years' results for WRES indicator 7 (Q15) are not reported.												
White Staff													60.8%



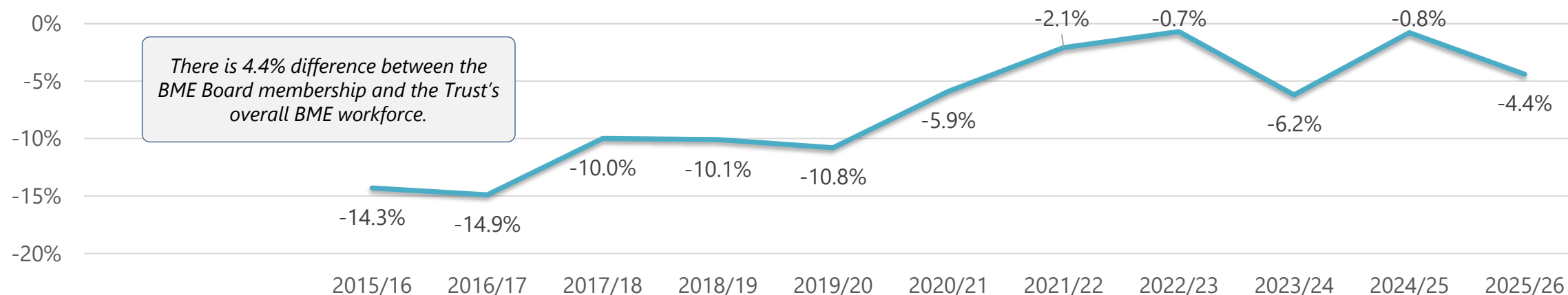
Percentage of staff experiencing discrimination
at work from **manager/team leader** or **other colleagues** in last 12 months

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
BME Staff	8.5% -	19.3% +10.8%	16.4% -2.9%	16.5% +0.1%	12.7% -3.8%	19.0% +6.3%	15.3% -3.7%	15.1% -0.2%	12.4% -2.7%	12.7% +0.3%	10.3% -2.4%	12.5% +2.2%	11.8% -0.7%
White Staff					6.1% -	6.1% 0%	6.3% +0.2%	5.7% -0.6%	5.8% +0.1%	5.6% -0.2%	5.5% -0.1%	6.0% +0.5%	6.1% +0.1%



Percentage difference between the organisations' Board membership and its overall workforce disaggregated by voting membership of the Board & by executive membership of the Board

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Percentage of BME members on the Board	0%	0%	5.9%	6.3%	6.3%	12.5%	17.6%	20.0%	16.7%	25.0%	23.5%
Percentage of BME Staff in Overall Workforce	14.3%	14.9%	15.9%	16.4%	17.1%	18.4%	19.7%	20.7%	22.9%	25.8%	28.0%
Percentage difference between the organisations' Board membership and its overall workforce (BME representation)	-14.3%	-14.9%	-10.0%	-10.1%	-10.8%	-5.9%	-2.1%	-0.7%	-6.2%	-0.8%	-4.4%



Workforce Disability Equality Standard (WDES)

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Workforce Disability Equality Standard (WDES) Report 2026

Executive Summary

This report presents the Workforce Disability Equality Standard (WDES) data for 2026, drawing on data from the Electronic Staff Record (ESR) and the NHS National Staff Survey. It builds on previous years' reporting and should be read alongside the detailed WDES data reports.

Overall, the 2026 data presents a mixed but broadly improving picture, with notable progress across several key metrics, alongside areas of regression that require targeted action.

Encouragingly, improvements are evident in recruitment and progression, with near parity in appointment rates between disabled and non-disabled candidates, and a significant reduction in the likelihood of disabled staff entering formal capability processes. Experiences of harassment, bullying and abuse from managers and colleagues have also improved, alongside a continued increase in the proportion of disabled staff receiving reasonable adjustments. Board representation of disabled staff also remains favourable compared to the wider workforce.

However, challenges remain. There has been a deterioration in some aspects of staff experience, including increased reports of harassment from patients and the public, reduced reporting of incidents among disabled staff, and a rise in presenteeism. In addition, satisfaction with feeling valued has slightly declined, and disparities in staff engagement persist between disabled and non-disabled colleagues.

Representation of disabled staff across Agenda for Change (AfC) bands shows a mixed position, with increases across several bands but reductions in others, particularly in some clinical roles.

Overall, while the Trust continues to compare favourably in several areas and demonstrates sustained progress, inequalities in experience and outcomes for disabled staff remain, requiring continued organisational focus and targeted interventions.

This coversheet accompanies the power point WDES 2026 Report and the analysis from page 10 below, and provides a useful summary that analyses which indicators have:

- Worsened: Metrics 1 (decreases in disabled staff in some clinical and non-clinical AfC Bands), 4a, 4d, 6 and 7.
- Remained the same: Metrics 1 (representation of disabled staff in some clinical and non-clinical AfC Bands), 5 and 9.
- Improved: Metrics 1 (increases in disabled staff in some clinical and non-clinical AfC Bands), 2, 3, 4b, 4c, 8 and 10.

*Metric 1 appears multiple times in the analysis to fully draw out the changes in the representation of disabled staff by AfC banding.

**Metric 4 appears multiple times in the analysis because it is made up of Part A's three sub-metrics + Part B, for disabled and non-disabled staff.

Situation

Introduced in 2019, the Workforce Disability Equality Standard (WDES) builds on the principles of the Workforce Race Equality Standard (WRES) and is specifically designed to improve the workplace experience and career opportunities of disabled people working in, or seeking employment within, the NHS.

The WDES comprises ten metrics which provide a comprehensive overview of the experiences of disabled staff across key areas including recruitment, career progression, workplace culture, and staff wellbeing. By comparing outcomes for disabled and non-

disabled staff, the WDES enables organisations to identify inequalities, understand where disparities exist, and take targeted, evidence-based action to address them.

The WDES is a regulatory annual requirement for NHS organisations and forms part of the NHS Standard Contract. It is a key component of the wider Equality, Diversity and Inclusion (EDI) framework and supports organisations to demonstrate progress against national priorities to create fair, inclusive and supportive workplaces.

Background

Since its introduction in 2019, the WDES has supported NHS organisations to better understand and address inequalities experienced by disabled staff. Oxford Health has published WDES data annually and will continue to embed this work within its broader Equality, Diversity and Inclusion (EDI) Plan.

The report presents the Trust's 2026 WDES data, drawing on information from the Electronic Staff Record (ESR) and the NHS National Staff Survey. It provides a narrative analysis of performance across all ten metrics, identifying areas of improvement, stability and deterioration. The report also highlights key themes and sets out priority actions to support continued progress and reduce inequalities experienced by disabled staff.

As with previous years, the data reflects both ESR and NHS Staff Survey returns. Variations between these datasets remain, particularly in relation to disability declaration, although improving confidence in disclosure continues to be evidenced through reductions in the 'Unknown' status.

Assessment

Metric 1: Representation of Disabled Staff in the Workforce

Representation of disabled staff across Agenda for Change (AfC) bands between 2024/25 and 2025/26 shows overall increases across a number of bands, particularly within Bands 5–8 in both clinical and non-clinical workforces.

In the non-clinical workforce, headcount data indicates increases in several bands. Notable growth is seen in Band 5 (18 to 26), Band 6 (16 to 18), Band 7 (13 to 17) and Band 8B (6 to 8). Band 4 remains the same at 41, maintaining its position as one of the largest groups. Percentage data reflects these increases, with Bands 5, 7 and 8B reaching approximately 10% or above representation in 2025/26.

There are some areas of reduction, including Band 3 (26 to 23) and Band 8A (11 to 10). Other bands, including 8C and 8D, show minimal change. There continues to be no representation in Bands 1, 9 and VSM.

Within the clinical workforce, there are consistent increases in disabled staff across key bands. Growth is evident in Band 5 (75 to 109), Band 6 (143 to 155) and Band 7 (84 to 101). Increases are also observed across Bands 8A–8C and 8D, indicating upward movement across both mid-level and more senior clinical roles.

These changes are reflected proportionally, with Bands 4 and 8D showing the highest levels of representation (both above 11%), alongside continued increases across Bands 5, 6, 7 and 8B.

Some reductions are evident, including Band 4 (80 to 71) and Band 2 (2 to 0), while Band 3 remains broadly unchanged. As with the non-clinical workforce, there is no representation in Bands 1, 9 and VSM.

Across both workforce groups, there has been a reduction in the 'Unknown' category across most bands, indicating improved data completeness.

Overall, the 2025/26 data shows continued upward movement in representation across a number of bands, particularly at mid-level grades, with fewer areas of decline than in the previous year. However, representation remains absent at the most senior levels, and variation between bands persists.

Metrics 2 and 3: Recruitment and Progression

There are positive indicators in recruitment and progression:

- The relative likelihood of appointment from shortlisting has moved closer to parity (0.76), indicating near-equitable recruitment outcomes.

- The likelihood of disabled staff entering formal capability processes has significantly reduced (from 2.32 to 0.66), representing a substantial improvement.

These findings suggest that organisational interventions are having a positive impact on fair recruitment and performance management practices.

However, staff perceptions of career progression remain unequal, with disabled staff less likely to believe opportunities are fair compared to non-disabled colleagues. Due to changes in survey wording, 2025 data establishes a new baseline for future comparison.

Metric 4: Bullying, Harassment and Abuse

The 2025/26 data shows changes across all four measures when compared to 2024/25, with variation between disabled staff and non-disabled staff.

For Metric 4a (harassment, bullying or abuse from patients, relatives and the public), the proportion of disabled staff reporting experience increased by 0.3%, from 25.8% in 2024/25 to 26.1% in 2025/26. In contrast, the proportion for non-disabled staff decreased slightly by 0.1%, from 20.6% to 20.5%. This results in a marginal widening of the gap between disabled and non-disabled staff in 2025/26.

For Metric 4b (harassment, bullying or abuse from managers), reported experience decreased for both groups. For disabled staff, the proportion reduced by 1.9%, from 11.8% to 9.9%. For non-disabled staff, the proportion decreased by 0.3%, from 5.6% to 5.3%. The reduction is greater for disabled staff, leading to a slight narrowing of the gap between the two groups.

For Metric 4c (harassment, bullying or abuse from colleagues), there was also a decrease for both groups. For disabled staff, the proportion reduced by 2.1%, from 17.8% to 15.7%. For non-disabled staff, the proportion decreased by 0.3%, from 11.3% to 11.0%. As with Metric 4b, the larger reduction among disabled staff results in a small reduction in the disparity between groups.

For Metric 4d (reporting of incidents), the proportion of disabled staff reporting that they or a colleague reported the most recent incident decreased by 2.4%, from 64.0% in 2024/25 to 61.6% in 2025/26. In contrast, reporting among non-disabled staff increased by 1.7%, from 66.0% to 67.7%. This has led to a widening gap in reporting rates between disabled and non-disabled staff.

Across all measures, disabled staff reported higher levels of bullying, harassment and abuse than non-disabled staff. While gaps have narrowed slightly for experiences involving managers and colleagues, they have widened for experiences involving patients and the public, as well as for reporting rates.

Metric 6 and 7: Morale and Wellbeing

Indicators of morale show some deterioration between 2024/25 and 2025/26, with changes observed across both presenteeism and perceptions of feeling valued.

For Metric 6 (Presenteeism) has increased for both disabled and non-disabled staff. For disabled staff, the proportion reporting pressure from their manager to attend work despite not feeling well increased by 0.7% from 15.9% in 2024/25 to 16.6% in 2025/26.

For non-disabled staff, the proportion increased by 0.4% from 10.5% to 10.9%. As a result, the gap between disabled and non-disabled staff remains at 5.7%, with disabled staff consistently reporting higher levels of presenteeism.

For Metric 7 (feeling valued), there has been a slight decrease for both groups. The proportion of disabled staff who feel that the organisation values their work reduced by 0.5% from 49.6% in 2024/25 to 49.1% in 2025/26. For non-disabled staff, the proportion decreased by 0.9% from 58.5% to 57.6%. Despite the decrease for both groups, the gap between disabled and non-disabled staff remains unchanged at 8.5%.

Across these indicators, disabled staff continue to report fewer positive experiences than non-disabled staff. While changes between the two years are relatively small, the differences between groups remain consistent across measures of presenteeism and feeling valued.

Metric 8: Reasonable Adjustments

The proportion of disabled staff reporting that their employer has made adequate reasonable adjustments has increased by 1% from 83.1% to 84.1% in 2025/26.

This continues a broadly upward trend over recent years, with levels remaining consistently above 80% since 2020/21. The 2025/26 figure is also the highest recorded across the reporting period, indicating sustained improvement in this area.

Despite a slight dip in 2024/25, the increase in the most recent year suggests a recovery and continued strengthening of provision. The consistently high proportion indicates that the majority of disabled staff report receiving the adjustments required to carry out their roles.

Overall, reasonable adjustments remain a key area of strength for the organisation, with stable and improving performance over time.

Metric 9: Staff Engagement

The staff engagement score for disabled staff remains stable at 6.9, with no change between 2024/25 and 2025/26. The gap between disabled and non-disabled staff remains at 0.4, with non-disabled staff reporting a higher score of 7.3.

Metric 10: Board Representation

Board-level representation of disabled staff remains positive, with a higher proportion of disabled members on the Board (11.8%) compared to the overall workforce (9.6%) in 2025/26. This represents a positive difference of 2.2% in favour of Board representation.

While there has been a slight decrease of 0.7% in Board representation from 12.5% in 2024/25 to 11.8% in 2025/26, the overall workforce proportion has continued to increase by 0.8% from 8.8% to 9.6%. As a result, the gap between Board and workforce representation has narrowed slightly from 3.7% to 2.2%.

Despite this narrowing, Board representation remains higher than the overall workforce, maintaining a positive differential for the third consecutive year. This reflects a position in which disabled staff are proportionally more represented at Board level than across the wider organisation.

Overall, Board representation continues to demonstrate a positive position relative to workforce representation, with the differential remaining above zero since 2021/22.

Conclusion

The 2026 WDES report demonstrates continued progress across several key areas, particularly in recruitment, capability processes, and reasonable adjustments. However, persistent inequalities in staff experience and representation remain, particularly in relation to morale, reporting culture, and career progression.

Oxford Health is well positioned to build on its progress, but achieving equity for disabled staff will require sustained, targeted action and continued organisational commitment.

Workforce Disability Equality Standard (WDES) Analysis 2026

WDES Metrics: **Worsened**

WDES Metric	Analysis
Metric 1: Representation of Disabled Staff in the Workforce	There have been decreases in the representation of disabled staff from the previous year in the following bands: Non-Clinical: - Band 3 = -3 - Band 8A = -1 Clinical: - Band 2 = -2 - Band 4 = -9
Metric 4a: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: Patients, their relatives or other members of the public	- There has been an increase of 0.3% from 25.8% to 26.1% in the percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public. - There has been a decrease of 0.1% from 20.6% to 20.5% in the percentage of non-disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public. This is the lowest % this indicator has achieved for non-disabled staff since the introduction of the WDES in 2019.
Metric 4d: Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague, reported it.	- There has been a decrease of 2.4% from 64.0% to 61.6% in the percentage of disabled staff saying that the last time they experienced harassment, bullying and abuse at work, they or a colleague reported it. - There has been an increase of 1.7% from 66.0% to 67.7% in the percentage of non-disabled staff saying that the last time they experienced harassment, bullying and abuse at work, they or a colleague reported it. - This is the highest % this indicator has achieved for non-disabled staff since the introduction of the WDES in 2019.
Metric 6: Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	- There has been an increase of 0.7% % from 15.9% to 16.6% in the percentage of disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. - There has been an increase of 0.4% from 10.5% to 10.9% in the percentage of non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
Metric 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	- There has been small decrease of 0.5% from 49.6% to 49.1% in the percentage of disabled staff saying that they are satisfied with the extent to which their organisation values their work. - There has been a decrease of 0.9% from 58.5% to 57.6% in the percentage of non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

WDES Metrics: Remained the same

WDES Metric	Analysis
Metric 1: Representation of Disabled Staff in the Workforce	There have not been changes from the previous year in the representation of disabled staff in the following bands: Non-Clinical: ○ Band 9 = 0 ○ VSM = 0 Clinical: ○ Band 9 = 0 ○ VSM = 0
Metric 5: Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	• Due to a change in the wording of this question in the 2025 NHS Staff Survey, results are not comparable with previous years. Therefore, 2025 will act as the baseline year for future analysis. • In 2025, 55.7% of staff with a long-term condition (LTC) or illness reported that they believe the organisation provides equal opportunities for career progression or promotion. • This is 5.58% lower than staff without a long-term condition (61.3%).
Metric 9: The staff engagement score for Disabled staff, compared to non-disabled staff.	• On a scale of 1–10, the staff engagement score for disabled staff is the same as last year at 6.9. • On a scale of 1–10, the staff engagement score for non-disabled staff is similar as last year at 7.3. • Disabled staff reported lower engagement than non-disabled staff (6.92 vs 7.32). • The difference between the two groups is 0.40 points on the 0–10 engagement scale.

WDES Metrics: Improved

WDES Metric	Analysis
Metric 1: Representation of Disabled Staff in the Workforce	By headcount, there have been increases from the previous year in the representation of disabled staff in the following bands: Non-Clinical: ○ Band 2 = +3 (+2.5%) ○ Band 5 = +8 (+3.2%) ○ Band 6 = +2 (+1.6%) ○ Band 7 = +4 (+2.3%) ○ Band 8B = +2 (+2.6%) Clinical: ○ Band 5 = +34 (+2.0%) ○ Band 6 = +12 (+0.7%) ○ Band 7 = +17 (+0.9%) ○ Band 8A = +7 (+1.2%) ○ Band 8B = +1 (+0.4%) ○ Band 8C = +1 (+1.3%) ○ Band 8D = +1 (3.5%)
Metric 2: Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	• The relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff has increased by 0.09 from 0.67 to 0.76. • This is still close to the equitable figure of 1.00, indicating that there is almost parity between disabled and non-disabled being appointed from shortlisting for the Trust as a whole.
Metric 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	• There has been a decrease of 1.66 from 2.32 to 0.66 in the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.
Metric 4b: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: ○ Managers	• There has been a decrease of 1.9% from 11.8% to 9.9% in the percentage of disabled staff experiencing harassment, bullying or abuse from managers. • There has been a decrease of 0.3% from 5.6% to 5.3% in the percentage of non-disabled staff experiencing harassment, bullying or abuse from managers.
Metric 4c: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: • Other colleagues	• There has been a decrease of 2.1% from 17.8% to 15.7% in the percentage of disabled staff experiencing harassment, bullying or abuse from other colleagues. • There has been a decrease of 0.3% from 11.3% to 11.0% in the percentage of non-disabled staff experiencing harassment, bullying or abuse from other colleagues.

Metric 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	There has been an increase of 1% from 83.1% to 84.1% in the percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.
Metric 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.	There has been a decrease of 0.7% from 12.5% to 11.8% in the percentage of disabled members on the Board, resulting in a 2.2% positive difference in favour of disability representation between the Board (11.8%) and the overall workforce (9.6%).

Workforce Disability Equality Standard (WDES) Draft Improvement Plan 2026/27

WDES Theme	WDES Metric(s)	Improvement Objective	Key Actions	Success Measures / KPI	Responsible Owner	Target Date	RAG
Disability Declaration & Workforce Data	Metric 1	Improve the accuracy and completeness of disability workforce data.	• Deliver annual disability declaration campaign • Provide assurance on confidentiality • Encourage ESR updates through manager conversations and staff network engagement	Disability declaration rate increases from 9.6% to ≥11% Unknown category reduced from 8.2% to <6%	Head of EDI	Ongoing	
Workforce Representation & Recruitment	Metric 1 Metric 2	Maintain equitable recruitment outcomes for disabled applicants and increase representation of disabled staff across underrepresented bands and professions.	• Undertake workforce analysis • Identify barriers to progression • Develop targeted interventions for Bands 8C–VSM • Monitor recruitment data quarterly • Review reasonable adjustments in recruitment • Deliver training to recruiting managers	Increase disabled staff representation in Bands 8C–VSM by at least 1% Recruitment likelihood ratio remains between 0.90–1.10 (equitable range)	Head of EDI Head of Resourcing	Quarterly	
Capability Processes	Metric 3	Sustain improvements in formal capability outcomes.	• Monitor capability cases by disability status	Likelihood ratio remains below 1.0	HR Ops	Quarterly	

Reporting Culture & Psychological Safety	Metric 4a Metric 4b Metric 4c Metric 4d	Reduce harassment, bullying, abuse and discrimination from patients, relatives, public and staff, experienced by Disabled staff. Increase confidence in reporting bullying and harassment incidents.	• Develop targeted interventions in high-risk services • Introduce the 'Micro-aggression and Allyship' training into leadership development • Promote Raising of Concerns Policy • Promote Freedom to Speak Up • Strengthen incident reporting and support mechanisms • Review barriers to reporting	Reduce disabled staff experience rate from 26.1% to below 24% Reporting rate increases from 61.6% to ≥66%	Directorate Leads Freedom to Speak Up Guardian	Ongoing	
Career Progression	Metric 5	Improve perceptions of fair career progression opportunities.	• Introduce mentoring, coaching and leadership development opportunities for disabled staff	Improve positive response rate from 55.7% to ≥60%	Head of L&D Head of EDI	Q3 26/27	
Wellbeing & Presenteeism	Metric 6	Reduce levels of presenteeism experienced by disabled staff.	• Deliver Disability Inclusion training to managers • Strengthen wellbeing conversations	Reduce presenteeism from 16.6% to below 14%	Head of EDI	Q3 26/27	
Feeling Valued	Metric 7	Improve disabled staff experience of feeling valued by the organisation.	• Recognise and promote contributions of disabled staff	Increase positive response from 49.1% to ≥55%	Head of EDI	Q4 26/27	
Reasonable Adjustments	Metric 8	Maintain and strengthen high-quality reasonable adjustment support.	• Review adjustment processes • Promote Reasonable Adjustment Passports • Monitor implementation timescales	Maintain ≥85% positive response rate	HR Opps	Q3 26/27	
Staff Voice & Engagement	Metric 9	Strengthen the voice of disabled staff in decision-making.	• Continue supporting the Disability Equality Staff Network and associated Support Groups • Involve network in strategy/ policy development and EDI governance	Engagement score improves to ≥7.1	Network Chairs	Q3 26/27	

Board Representation & Leadership	Metric 10	Maintain positive disability representation at Board level and strengthen leadership accountability.	• Quarterly Board review of WDES progress • Integrate disability inclusion objectives into People Plan reporting	Board representation remains above workforce representation	Head of EDI	Quarterly	

Oxford Health NHS FT

Equality, Diversity & Inclusion

Workforce Disability Equality Standard (WDES) 2026

To find out more about what Oxford Health NHS FT is doing to be a fair and equal employer and care provider, please contact:
EqualityandInclusion@oxfordhealth.nhs.uk

The NHS **Workforce Disability Equality Standard** was introduced in 2019 and is designed to improve the workplace experience and career opportunities for Disabled people working or seeking employment in the NHS.

The WDES is a series of evidence-based metrics that provide us with a snapshot of the experiences of our Disabled colleagues.

By providing comparative data between Disabled and Non-Disabled staff, this information can be used to understand where key differences lie and will provide the basis for the development of action plans, enabling us to track progress year on year.

Data Source;

The WDES takes data from the Electronic Staff Record (ESR) and the [annual NHS National staff survey](#). Staff can update their personal data via employee self-service at any time on ESR and are asked to self declare anonymously in the staff survey.

On ESR disability declaration rates are 737 out of 7697 staff on ESR (9.6%) compared with 1267 out of 4541 staff who completed the National Staff Survey (27.9%). This context is important when considering the data source for each of the indicators, which is as follows:

Indicators 1,2,3,4 & 9 data is derived from our secure and confidential electronic staff record system (known as ESR).

Indicators 5,6,7, & 8 are derived from the annual [NHS National Staff Survey](#).

Distance from equity;

Throughout this report, we will also mention 'Distance from Equity'. For likelihood questions, this refers to how far the number is from 1.

For other metrics, it refers to the percentage difference between disabled and non-disabled experiences.

For example, if 40% of Disabled staff say they feel valued at work, then it would be equitable if 40% of Non-Disabled staff also felt the same way. Here, the greater the percentage difference, the greater the inequity.

For likelihood questions (indicators 2 & 3), this refers to how far the number is from 1.

For other indicators (indicators 1,4,5,6,7,8 &10), it refers to the percentage difference between Disabled and Non-Disabled staff.

1 = Metric 1

2 = Metric 2

3 = Metric 3

4 = Metric 4

5 = Metric 5

6 = Metric 6

7 = Metric 7

8 = Metric 8

9 = Metric 9

10 = Metric 10

Metric 1

Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

Metric 2

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Metric 3

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Metric 4

- a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:
 - i) Patients, their relatives or other members of the public
 - ii) Managers
 - iii) Other colleagues
- b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

Metric 5

Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

Metric 6

Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Metric 7

Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Metric 8

Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

Metric 9

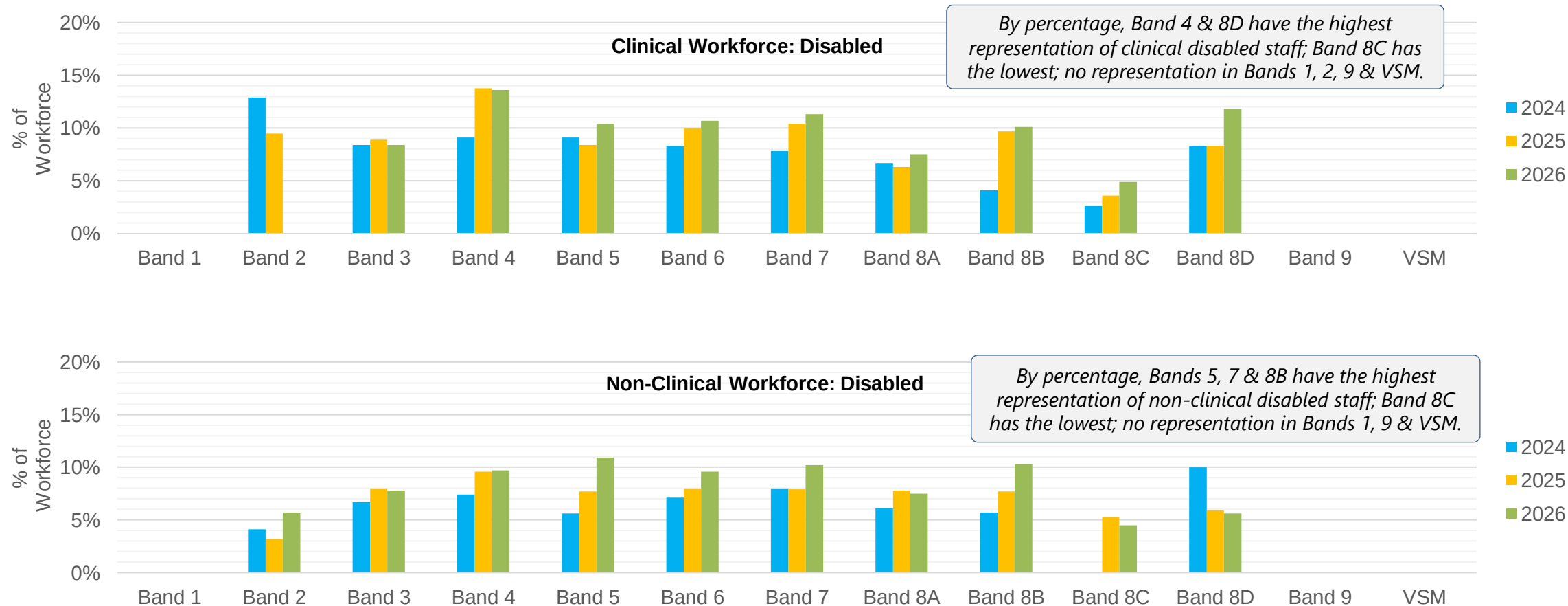
- a) The staff engagement score for Disabled staff, compared to non-disabled staff.
- b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

Metric 10

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- By voting membership of the Board.
- By Executive membership of the Board.

As of 31st March 2026, 9.6% of the Trust's workforce reported a disability on ESR (see slide 6 for further detail).



Indicator number and description	Results 2025/26	Results 2024/25	Change	Distance from equity
Metric 1: Disabled representation in the workforce by pay band				
Non-clinical	8.77%	7.58%	+1.19%	—
Clinical	10.26%	9.64%	+0.62%	—
Medical & Dental	3.87%	3.30%	+0.57%	—
Metric 2: Likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff				
Likelihood ratio (Non-disabled / Disabled)	0.76	0.67	+0.09	0.24
Metric 3: Likelihood of entering formal capability process due to performance management				
Likelihood ratio (Disabled / Non-disabled)	0.66	2.32	-1.66	0.34
Metric 10: Disabled representation on the Board				
Overall workforce	9.58%	8.77%	+0.81%	—
Board	11.76%	12.50%	-0.74%	—

Indicator number and description	Results 2025/26	Results 2024/25	Change	Distance from equity	National average
Metric 1 (equivalent): Proportion with a long-term condition or illness					
Disabled	27.9%	27.6%	+0.3%		
Metric 4a: Harassment, bullying or abuse from patients, relatives or the public in last 12 months					
Disabled	26.1%	25.8%	+0.3%	5.6%	29.7%
Non-disabled	20.5%	20.6%	-0.1%		23.4%
Metric 4b: Harassment, bullying or abuse from line managers in last 12 months					
Disabled	9.9%	11.8%	-1.9%	4.6%	13.6%
Non-disabled	5.3%	5.6%	-0.3%		7.4%
Metric 4c: Harassment, bullying or abuse from other colleagues in last 12 months					
Disabled	15.7%	17.8%	-2.1%	4.7%	22.9%
Non-disabled	11.0%	11.3%	-0.3%		14.8%
Metric 4d: Reporting last incident of harassment, bullying or abuse					
Disabled	61.6%	64.0%	-2.4%	6.1%	54.9%
Non-disabled	67.7%	66.0%	+1.7%		54.9%
Metric 5: Career progression					
Disabled	55.7%	Note: Due to changes in the question wording, previous years' results for WDES metric 5 (Q15) are not reported.		5.6%	48.6%
Non-disabled	61.3%				55.7%
Metric 6: Presenteeism					
Disabled	16.6%	15.9%	+0.7%	5.7%	25.6%
Non-disabled	10.9%	10.5%	+0.4%		17.5%
Metric 7: Feeling valued					
Disabled	49.1%	49.6%	-0.5%	8.5%	34.4%
Non-disabled	57.6%	58.5%	-0.9%		46.1%
Metric 8: Reasonable adjustments					
Disabled	84.1%	83.0%	+1.1%	-	74.9%
Metric 9a: Staff engagement					
Disabled	6.9	6.9	0	0.4	6.3
Non-disabled	7.3	7.4	-0.1		6.9

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Electronic Staff Record

Disclosure rates for disability have increased by 0.8%, from 8.8% to 9.6% of staff declaring a disability. The disability status of 8.2% of the workforce is unknown, down by 1.5% from the previous year.

Staff are requested to review their data every 6 months on the ESR (Electronic Staff Record), so is dependable on the individual logging in to update their details.

Also, the disability status may change in the course of employment, therefore, fully accurate data even for those declaring (as disabled or non-disabled) is unlikely.

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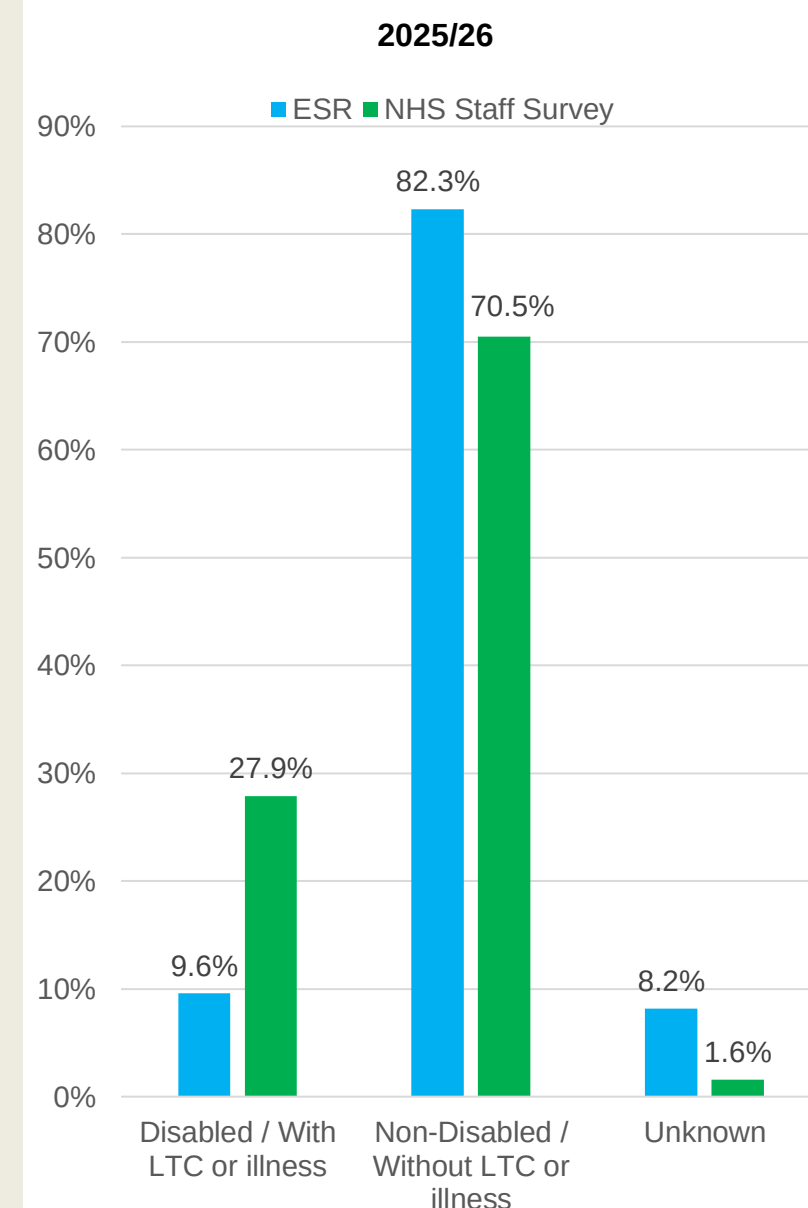
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NHS Staff Survey

Disclosure rates for disability are higher in the staff survey with 27.9% of staff declaring a disability. The disability status of 1.6% of staff who completed the NHS Staff Survey is unknown.

	Electronic Staff Record (ESR)		NHS National Staff Survey	
	2024/25	2025/26	2024/25	2025/26
Disabled / Staff with LTC or illness	658 (8.8%)	737 (9.6%)	1013 (27.6%)	1267 (27.9%)
Non-Disabled / Staff without LTC or illness	6115 (81.5%)	6331 (82.3%)	2587 (70.5%)	3200 (70.5%)
Unknown	728 (9.7%) ↓	629 (8.2%) ↓	67 (1.8%) ↓	74 (1.6%) ↓
TOTAL	7501	7697	3667	4541



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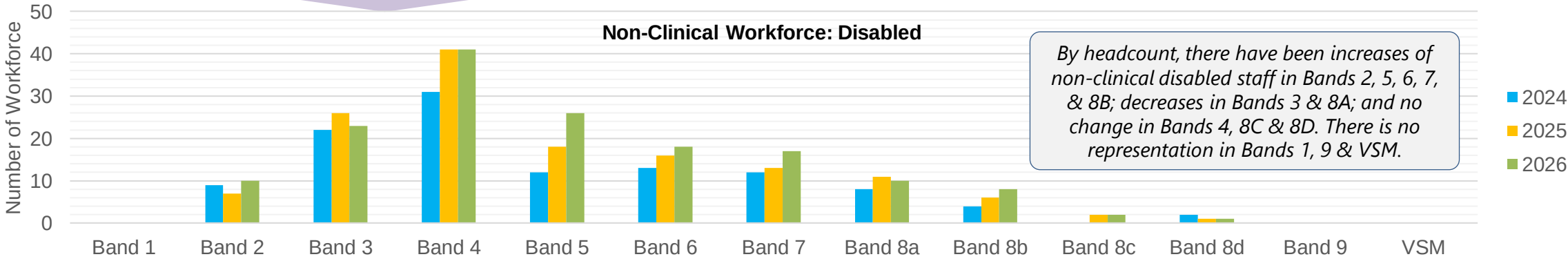
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Non-Clinical Workforce	Disabled 2024	Disabled 2025	Disabled 2026	Non-Disabled 2024	Non-Disabled 2025	Non-Disabled 2026	Unknown 2024	Unknown 2025	Unknown 2026
Band 1	0	0	0	1	1	1	0	0	0
Band 2	9	7	10	165	173	138	43	38	28
Band 3	22	26	23	268	272	249	36	27	24
Band 4	31	41	41	353	356	358	36	29	23
Band 5	12	18	26	191	206	202	12	10	11
Band 6	13	16	18	157	174	160	13	10	9
Band 7	12	13	17	126	141	141	12	11	9
Band 8a	8	11	10	104	115	109	19	15	15
Band 8b	4	6	8	61	66	63	5	6	7
Band 8c	0	2	2	34	32	40	4	4	2
Band 8d	2	1	1	17	15	17	1	1	0
Band 9	0	0	0	6	8	8	2	1	1
VSM	0	0	0	9	6	6	0	1	1



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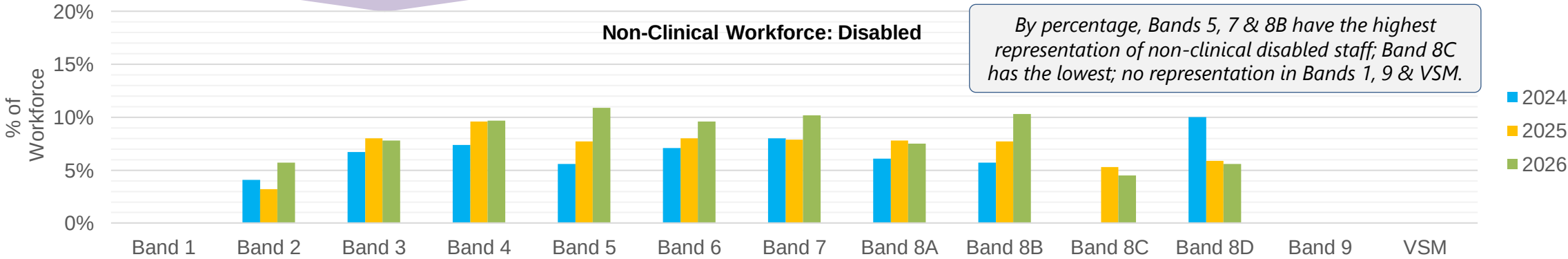
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Non-Clinical Workforce	Disabled 2024	Disabled 2025	Disabled 2026	Non-Disabled 2024	Non-Disabled 2025	Non-Disabled 2026	Unknown 2024	Unknown 2025	Unknown 2026
Band 1	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%
Band 2	4.1%	3.2%	5.7%	76.0%	79.4%	78.4%	19.8%	17.4%	15.9%
Band 3	6.7%	8.0%	7.8%	82.2%	83.7%	84.1%	11.0%	8.3%	8.1%
Band 4	7.4%	9.6%	9.7%	84.0%	83.6%	84.8%	8.6%	6.8%	5.5%
Band 5	5.6%	7.7%	10.9%	88.8%	88.0%	84.5%	5.6%	4.3%	4.6%
Band 6	7.1%	8.0%	9.6%	85.8%	87.0%	85.6%	7.1%	5.0%	4.8%
Band 7	8.0%	7.9%	10.2%	84.0%	85.5%	84.4%	8.0%	6.7%	5.4%
Band 8a	6.1%	7.8%	7.5%	79.4%	81.6%	81.3%	14.5%	10.6%	11.2%
Band 8b	5.7%	7.7%	10.3%	87.1%	84.6%	80.8%	7.1%	7.7%	9.0%
Band 8c	0.0%	5.3%	4.5%	89.5%	84.2%	90.9%	10.5%	10.5%	4.5%
Band 8d	10.0%	5.9%	5.6%	85.0%	88.2%	94.4%	5.0%	5.9%	0.0%
Band 9	0.0%	0.0%	0.0%	75.0%	88.9%	88.9%	25.0%	11.1%	11.1%
VSM	0.0%	0.0%	0.0%	100.0%	85.7%	85.7%	0.0%	14.3%	14.3%



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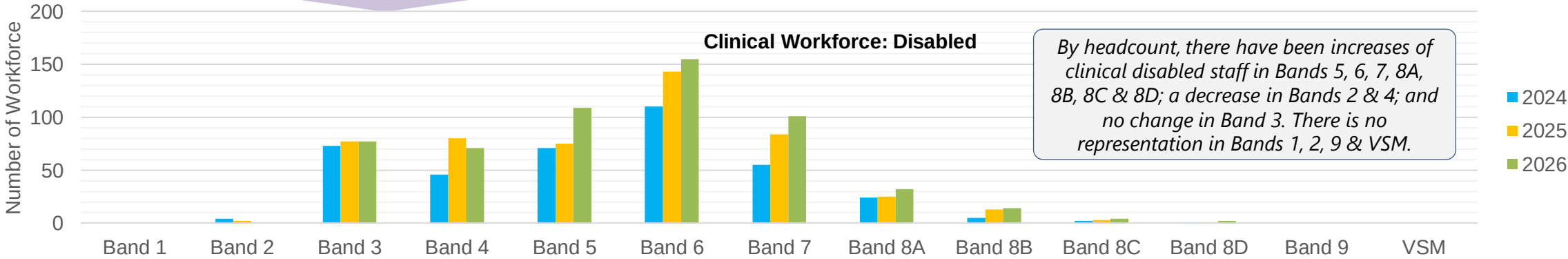
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Clinical Workforce	Disabled 2024	Disabled 2025	Disabled 2026	Non-Disabled 2024	Non-Disabled 2025	Non-Disabled 2026	Unknown 2024	Unknown 2025	Unknown 2026
Band 1	0	0	0	0	0	0	0	0	0
Band 2	4	2	0	24	17	4	3	2	0
Band 3	73	77	77	735	736	787	56	53	51
Band 4	46	80	71	428	467	415	33	33	35
Band 5	71	75	109	617	749	881	95	64	61
Band 6	110	143	155	1035	1124	1181	176	156	116
Band 7	55	84	101	601	680	754	53	44	39
Band 8a	24	25	32	305	344	372	29	28	24
Band 8b	5	13	14	105	112	116	12	9	8
Band 8c	2	3	4	64	71	67	10	10	10
Band 8d	1	1	2	9	10	13	2	1	2
Band 9	0	0	0	2	2	2	0	0	0
VSM	0	0	0	3	3	3	0	0	0



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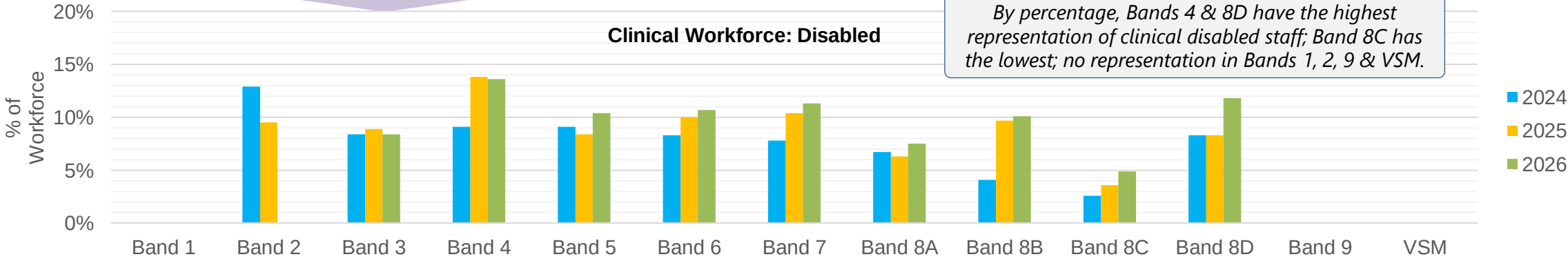
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Clinical Workforce	Disabled 2024	Disabled 2025	Disabled 2026	Non-Disabled 2024	Non-Disabled 2025	Non-Disabled 2026	Unknown 2024	Unknown 2025	Unknown 2026
Band 1	-	-	-	-	-	-	-	-	-
Band 2	12.9%	9.5%	0.0%	77.4%	81.0%	100.0%	9.7%	0.0%	0.0%
Band 3	8.4%	8.9%	8.4%	85.1%	85.0%	86.0%	6.5%	9.5%	5.6%
Band 4	9.1%	13.8%	13.6%	84.4%	80.5%	79.7%	6.5%	6.1%	6.7%
Band 5	9.1%	8.4%	10.4%	78.8%	84.3%	83.8%	12.1%	5.7%	5.8%
Band 6	8.3%	10.0%	10.7%	78.3%	79.0%	81.3%	13.3%	7.2%	8.0%
Band 7	7.8%	10.4%	11.3%	84.8%	84.2%	84.3%	7.5%	11.0%	4.4%
Band 8a	6.7%	6.3%	7.5%	85.2%	86.6%	86.9%	8.1%	5.4%	5.6%
Band 8b	4.1%	9.7%	10.1%	86.1%	83.6%	84.1%	9.8%	7.1%	5.8%
Band 8c	2.6%	3.6%	4.9%	84.2%	84.5%	82.7%	13.2%	6.7%	12.3%
Band 8d	8.3%	8.3%	11.8%	75.0%	83.3%	76.5%	16.7%	11.9%	11.8%
Band 9	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	0.0%	8.3%	0.0%
VSM	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%



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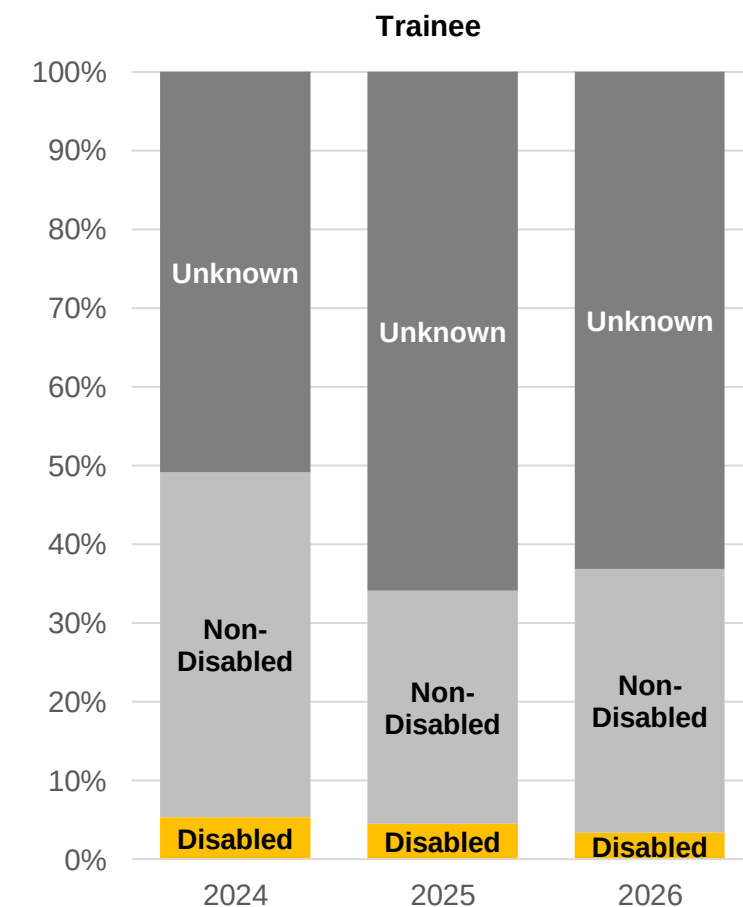
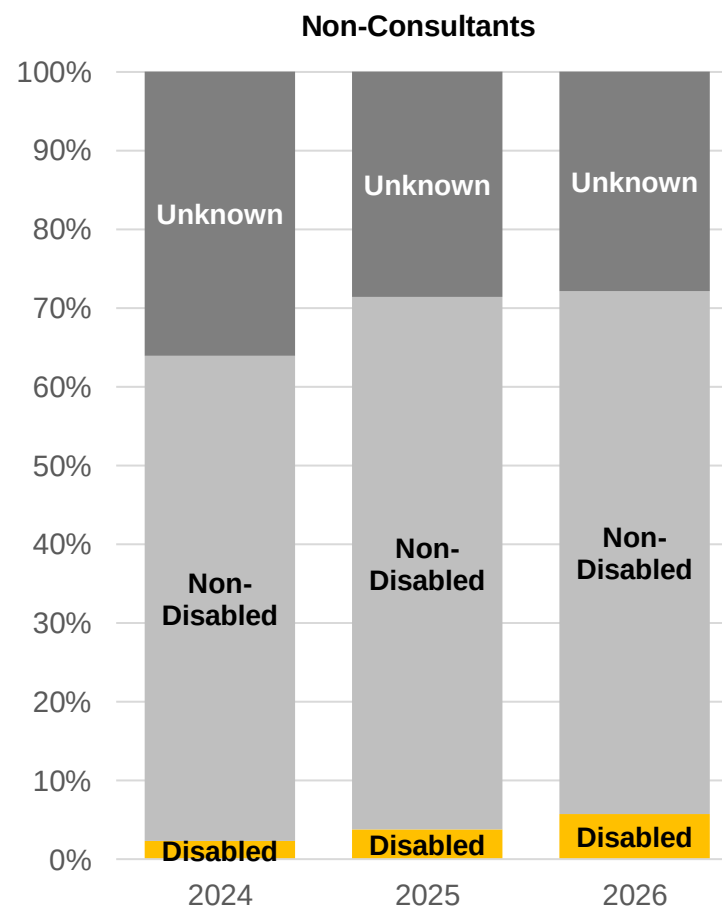
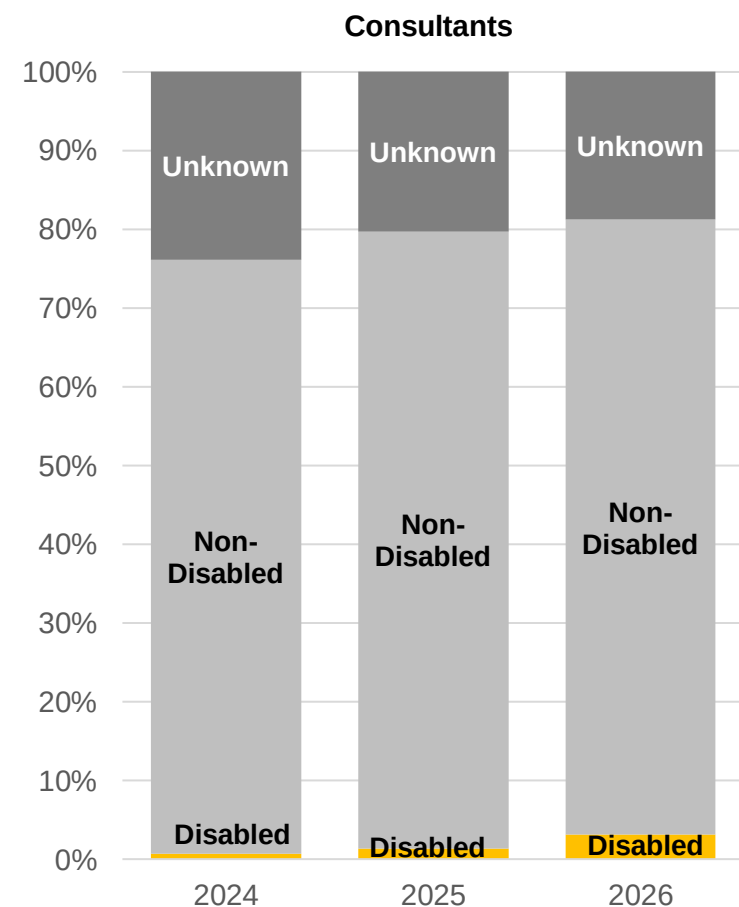
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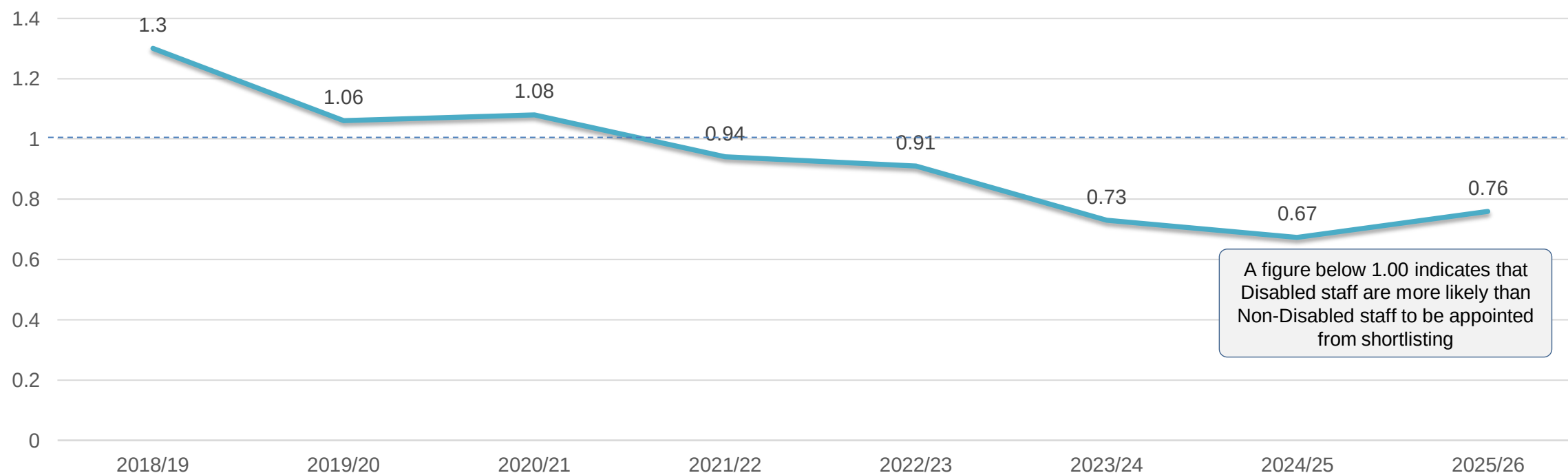
	Disabled			Non-Disabled			Disability Unknown or Null		
	2024	2025	2026	2024	2025	2026	2024	2025	2026
Consultant	1	2	5	101	112	125	32	29	30
Non-consultant	2	4	6	53	71	69	31	30	29
Trainee	6	8	5	49	52	50	57	116	94



Relative likelihood of non-disabled staff being **appointed from shortlisting** compared to disabled staff

A figure below 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to be appointed from shortlisting

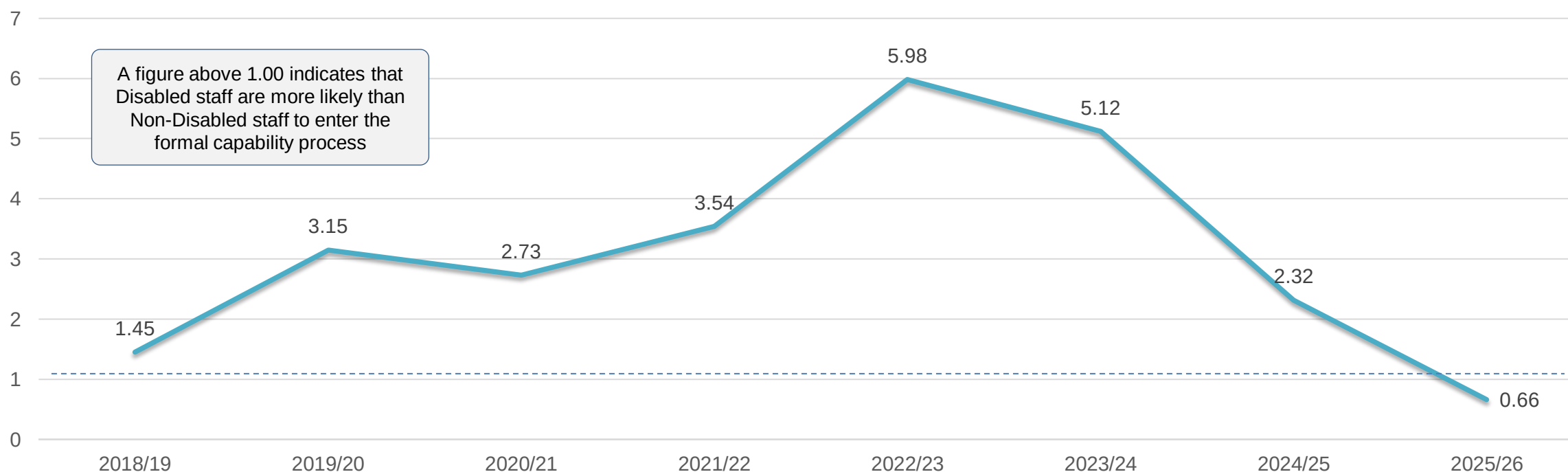
2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
1.30 times more likely	1.06 times more likely	1.08 times more likely	0.94 times more likely	0.91 times more likely	0.73 times more likely	0.67 times more likely	0.76 times more likely
-	-0.24	+0.02	-0.14	-0.03	-0.18	-0.06	+0.09



Relative likelihood of disabled staff entering into **formal capability process** compared to non-disabled staff

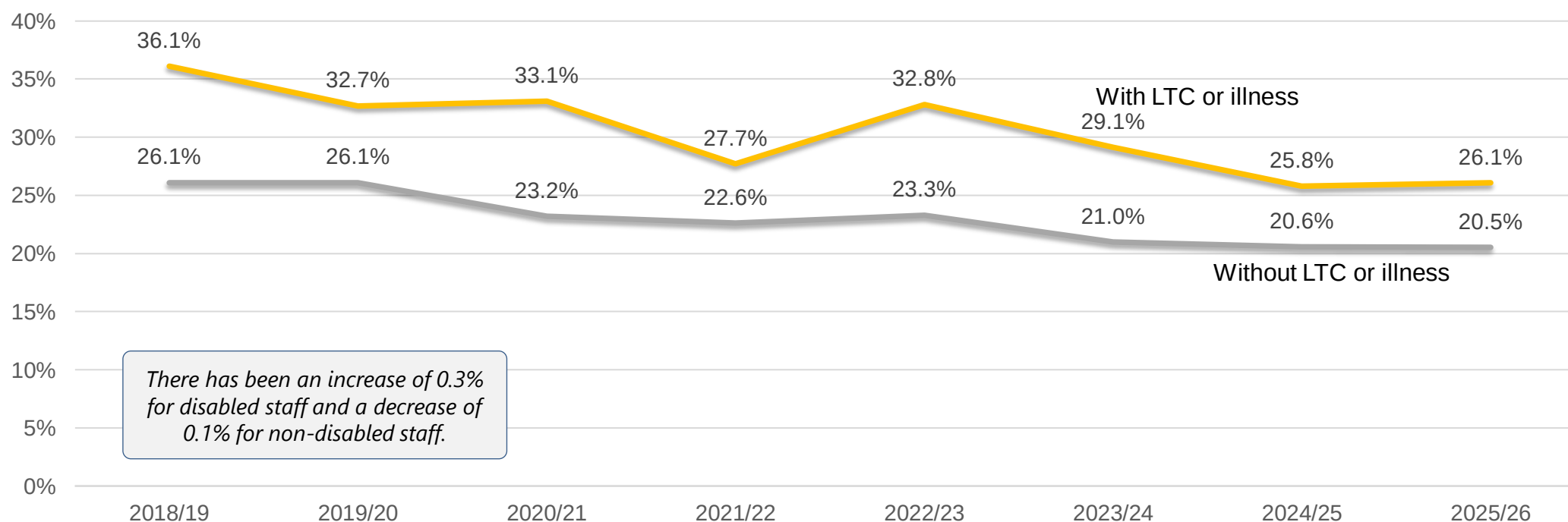
A figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process

2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
1.45 times more likely	3.15 times more likely	2.73 times more likely	3.54 times more likely	5.98 times more likely	5.12 times more likely	2.32 times more likely	0.66 times more likely
-	+1.70	-0.42	+0.81	+2.44	-0.86	-2.80	-1.66



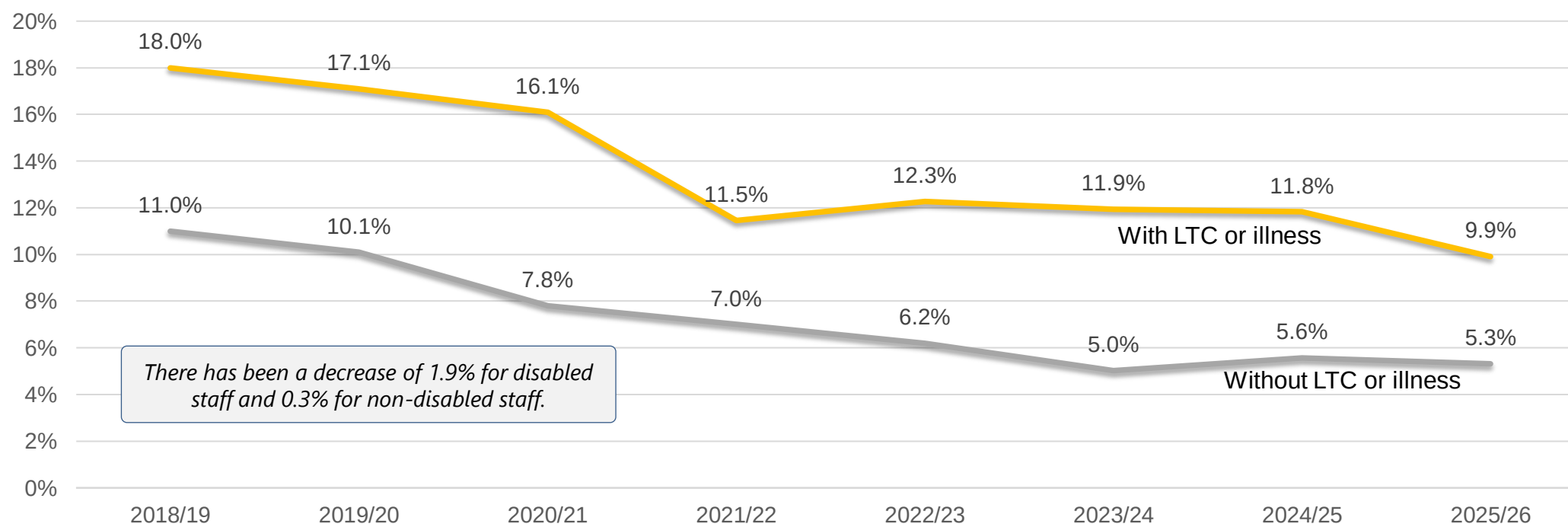
Percentage of staff experiencing harassment, bullying or abuse in the last 12 months
from Patients/service users, their relatives or other members of the public

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Staff with LTC or illness	36.1% -	32.7% (-3.4%)	33.1% (+0.4%)	27.7% (-5.4%)	32.8% (+5.1%)	29.1% (-3.7%)	25.8% (-3.3%)	26.1% (+0.3%)
Staff without LTC or illness	26.1% -	26.1% (0%)	23.2% (-2.9%)	22.6% (-0.6%)	23.3% (+0.7%)	21.0% (-2.3%)	20.6% (-0.4%)	20.5% (-0.1%)



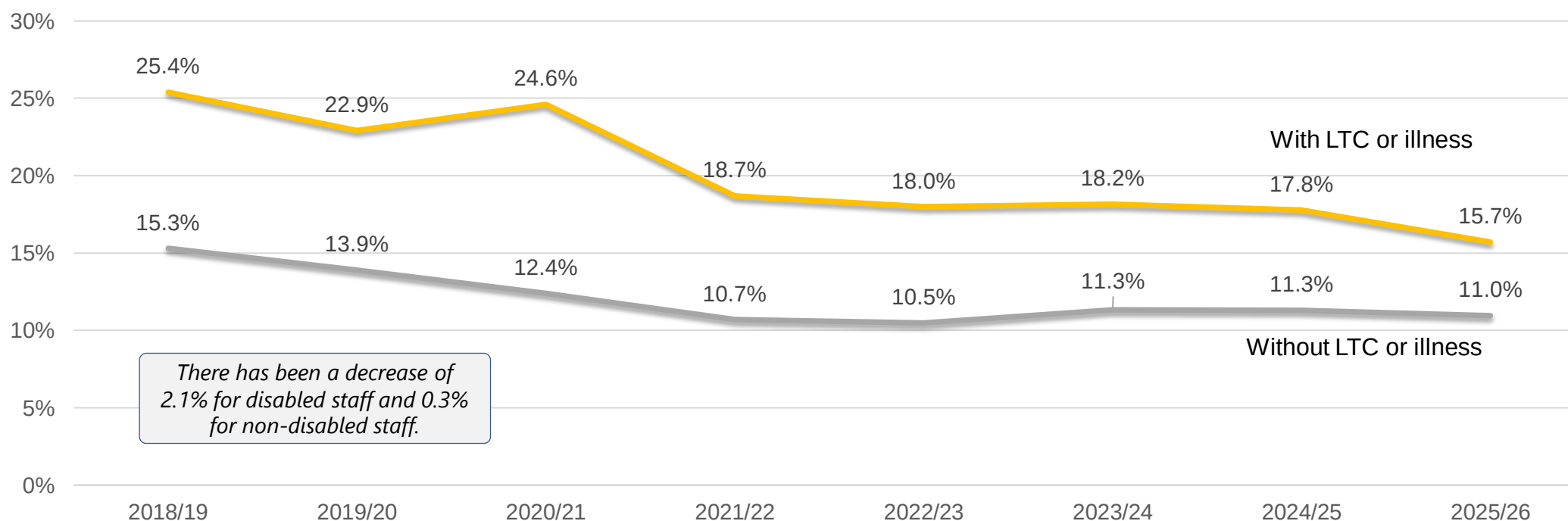
Percentage of staff experiencing harassment, bullying or abuse in the last 12 months
from Managers

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Staff with LTC or illness	18.0% -	17.1% (-0.9%)	16.1% (-1.0%)	11.5% (-4.6%)	12.3% (+0.8%)	11.9% (-0.4%)	11.8% (-0.1%)	9.9% (-1.9%)
Staff without LTC or illness	11.0% -	10.1% (-0.9%)	7.8% (-2.3%)	7.0% (-0.8%)	6.2% (-0.8%)	5.0% (-1.2%)	5.6% (+0.6%)	5.3% (-0.3%)



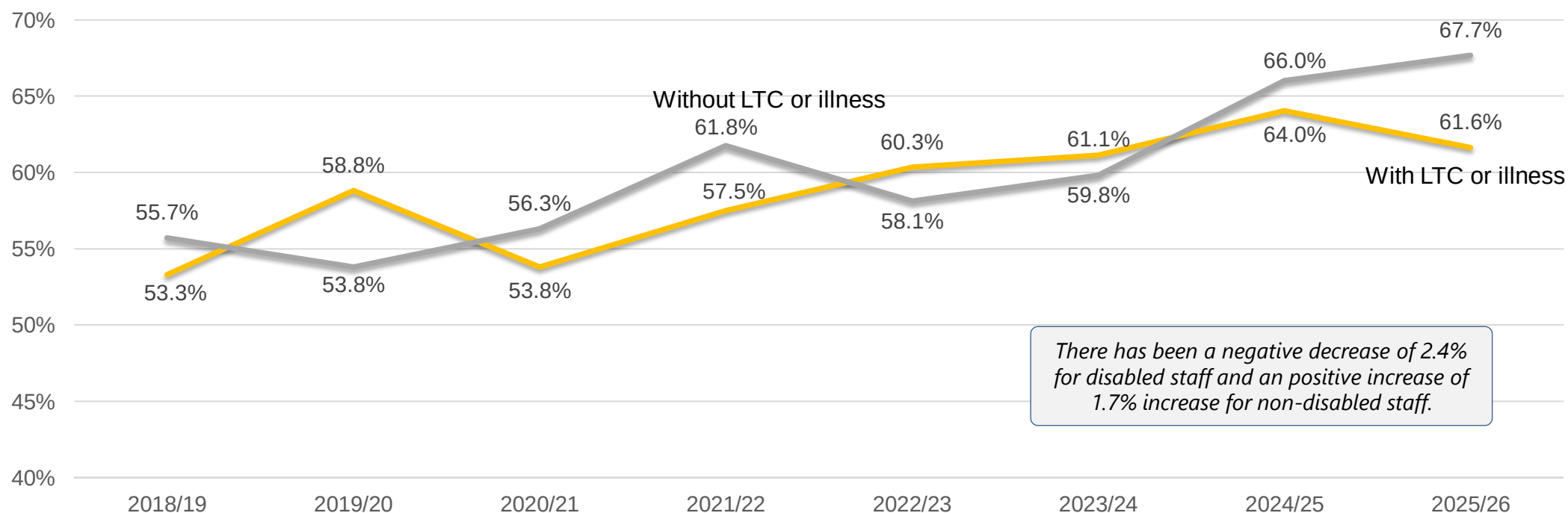
Percentage of staff experiencing harassment, bullying or abuse in the last 12 months
from other Colleagues

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Staff with LTC or illness	25.4%	22.9%	24.6%	18.7%	18.0%	18.2%	17.8%	15.7%
	-	(-2.5%)	(+1.7%)	(-5.9%)	(-0.7%)	(+0.2%)	(-0.4%)	(-2.1%)
Staff without LTC or illness	15.3%	13.9%	12.4%	10.7%	10.5%	11.3%	11.3%	11.0%
	-	(-1.4%)	(-1.5%)	(-1.7%)	(-0.2%)	(+0.8%)	(0.0%)	(-0.3%)



Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

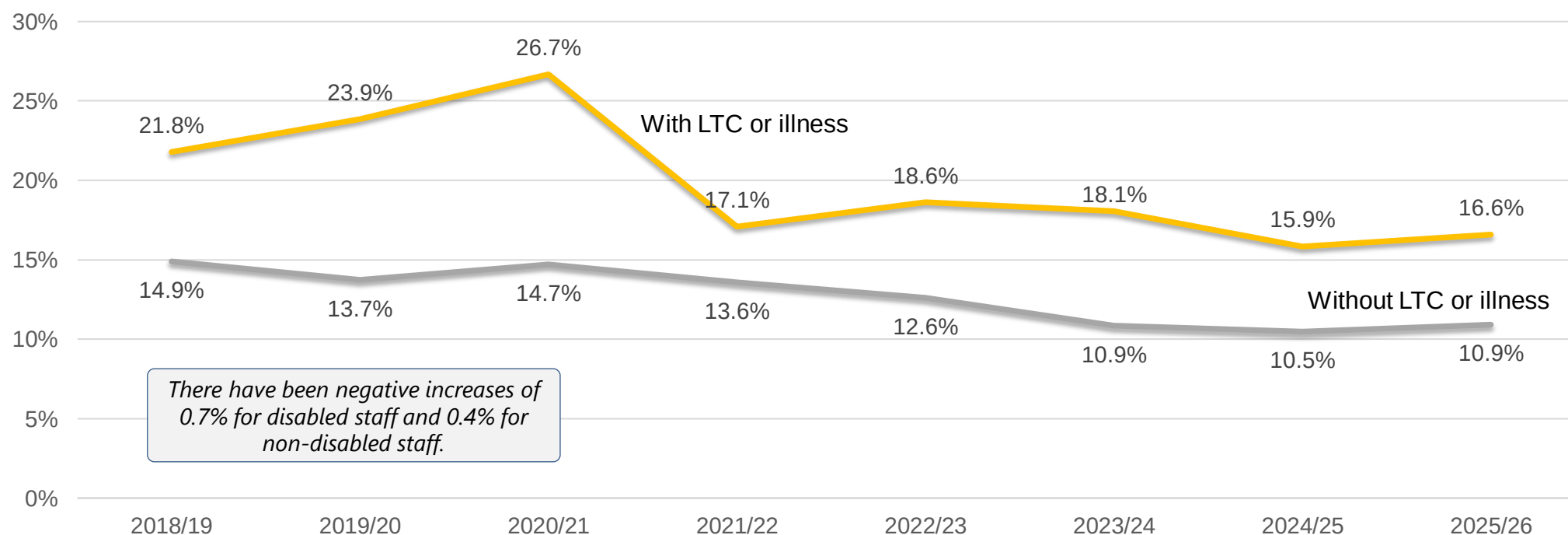
	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Staff with LTC or illness	53.3%	58.8% (+5.5%)	53.8% (-5.0%)	57.5% (+3.7%)	60.3% (+2.8%)	61.1% (+0.8%)	64.0% (+2.9%)	61.6% (-2.4%)
Staff without LTC or illness	55.7%	53.8% (-1.9%)	56.3% (+2.5%)	61.8% (+5.5%)	58.1% (-3.7%)	59.8% (+1.7%)	66.0% (+6.2%)	67.7% (+1.7%)



There has been a negative decrease of 2.4% for disabled staff and an positive increase of 1.7% increase for non-disabled staff.

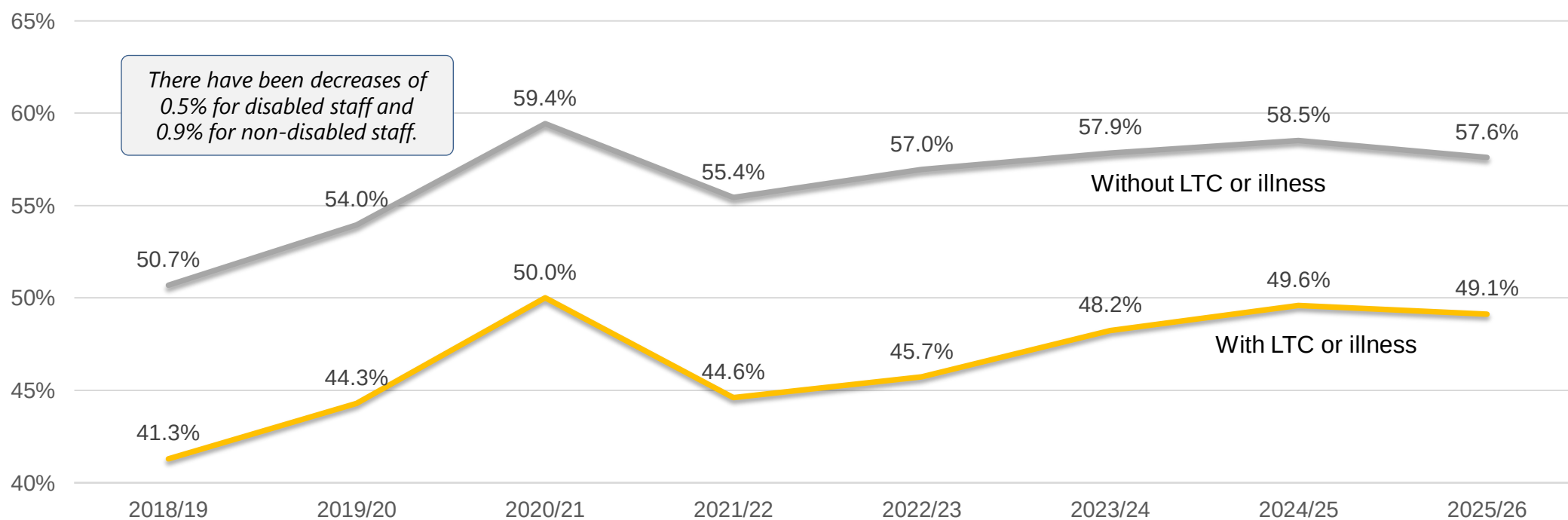
Percentage of staff who have **felt pressure from their manager to come to work**, despite not feeling well enough to perform their duties

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Staff with LTC or illness	21.8%	23.9% (+2.1%)	26.7% (+2.8%)	17.1% (-9.6%)	18.6% (+1.5%)	18.1% (-0.5%)	15.9% (-2.2%)	16.6% (+0.7%)
Staff without LTC or illness	14.9%	13.7% (-1.2%)	14.7% (+1.0%)	13.6% (-1.1%)	12.6% (-1.0%)	10.9% (-1.7%)	10.5% (-0.4%)	10.9% (+0.4%)



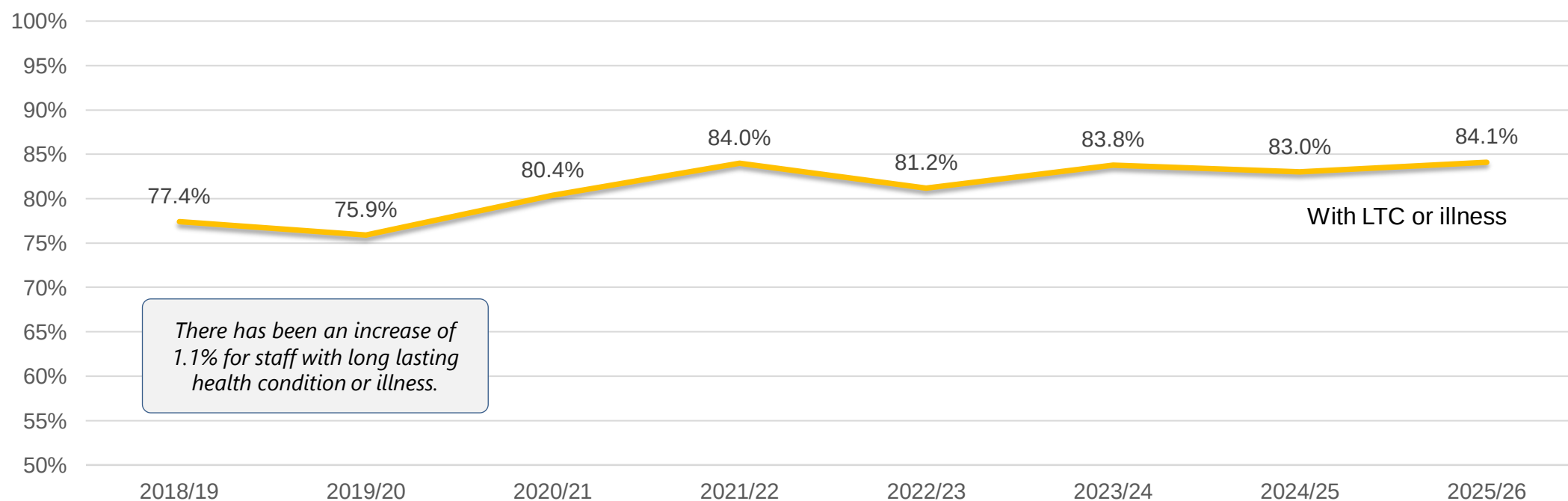
Percentage of staff satisfied with the extent to which the **organisation values** their work

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Staff with LTC or illness	41.3%	44.3% (+3.0%)	50.0% (+5.7%)	44.6% (-5.4%)	45.7% (+1.1%)	48.2% (+2.5%)	49.6% (+1.4%)	49.1% (-0.5%)
Staff without LTC or illness	50.7%	54.0% (+3.3%)	59.4% (+5.4%)	55.4% (-4.0%)	57.0% (+1.5%)	57.9% (+0.9%)	58.5% (+0.7%)	57.6% (-0.9%)



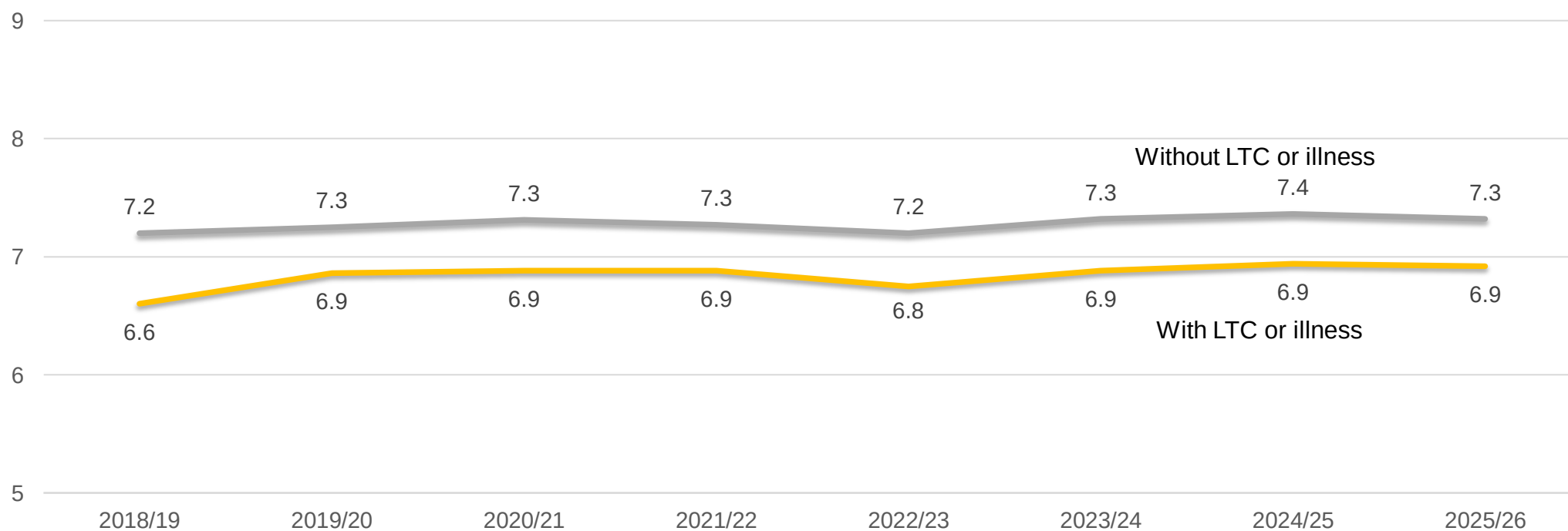
Percentage of staff with a long lasting health condition or illness saying that their employer has made **adequate adjustment(s)** to enable them to carry out their work

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Staff with LTC or illness	77.4%	75.9% (-1.5%)	80.4% (+4.5%)	84.0% (+3.6%)	81.2% (-2.8%)	83.8% (+2.6%)	83.0% (-0.8%)	84.1% (+1.1%)



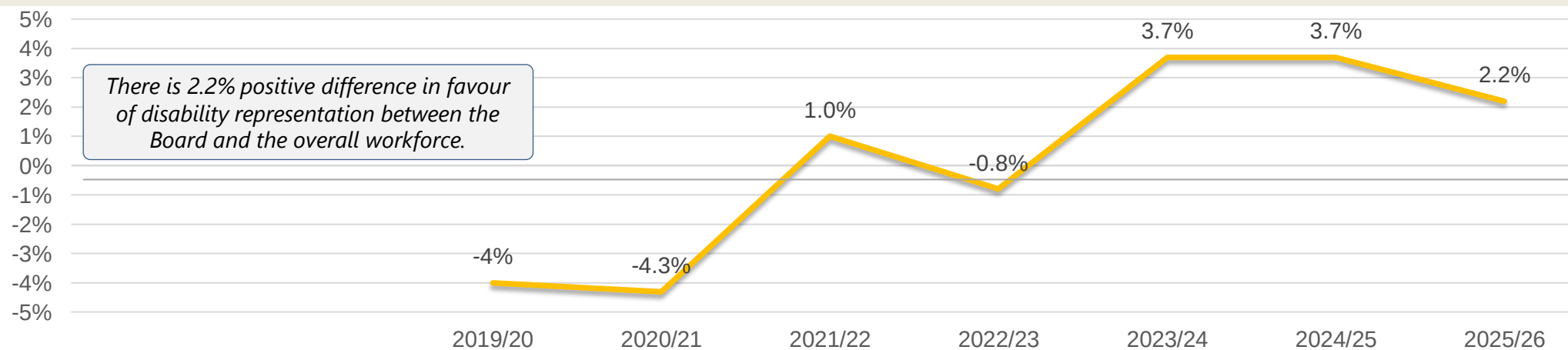
Staff engagement score (0-10)

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Staff with LTC or illness	6.6 -	6.9 (+0.3)	6.9 (0%)	6.9 (0%)	6.8 (-0.1%)	6.9 (+0.1)	6.9 (0%)	6.9 (0%)
Staff without LTC or illness	7.2 -	7.3 (+0.1)	7.3 (0%)	7.3 (0%)	7.2 (-0.1%)	7.3 (+0.1)	7.4 (+0.1)	7.3 (-0.1%)



Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by voting membership of the Board & by Executive membership of the Board

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Percentage of disabled members on the Board	0%	0.0%	5.9%	5.0%	11.1%	12.5%	11.8%
Percentage of disabled staff in Overall Workforce	4%	4.3%	4.9%	5.8%	7.4%	8.8%	9.6%
Percentage difference between the organisation's Board membership and its overall workforce (Disability representation)	-4%	-4.3%	1.0%	-0.8%	3.7%	3.7%	2.2%



Freedom to Speak Up Annual Report April 2025 – March 2026

Introduction

This is an annual report related to the activities of the Freedom to Speak Up (FTSU) for the period between April 2025 and March 2026. Two FTSU Guardians (1.6 WTE) work within the remit of the National Guardian's Office (NGO) guidance; support the delivery of "Quality and People" Trust Strategic Objectives and the key element "we each have a voice that counts" set out by People Promise.

We have worked collaboratively with each directorate and met regularly with directors and other key stakeholders to triangulate emerging themes/gaps for learning and improvement. We have submitted regular quarterly FTSU reports to NGO and Executive Team to discuss emerging themes, activities and key learnings. We have achieved various priorities set within the 23/25 reflection tool two-year plan. We also completed a second two-year plan for 25/27 which has been approved by the Board.

NGO highlights

Dash report

Following the Dash report, the National Guardian's Office (NGO) will close at the end of June 2026. Going forward FTSU will be supported by NHSE. There have been several engagement events discussing how the changes will impact Guardians and Trusts. The Trust has prepared for this transition and awaits more information from NHSE on the areas that are changing. More information can be found in Appendix 1.

Speak Up Week 2025 Highlights

The theme was "Following up". We joined the national campaign and hosted various activities for staff to engage during the FTSU month. This included:

- Site visits with several of our Executive team
- Trust wide webinar and communication of key messages (poems and shared stories)

As always, this promotional work increases interest in our service, and we saw a rise in cases during this period.

National Staff Survey Comparison

Overall, the National Staff Survey results show a consistent score in speaking up at Oxford Health (OH). Staff feel able to speak up. There is a slight decrease in the

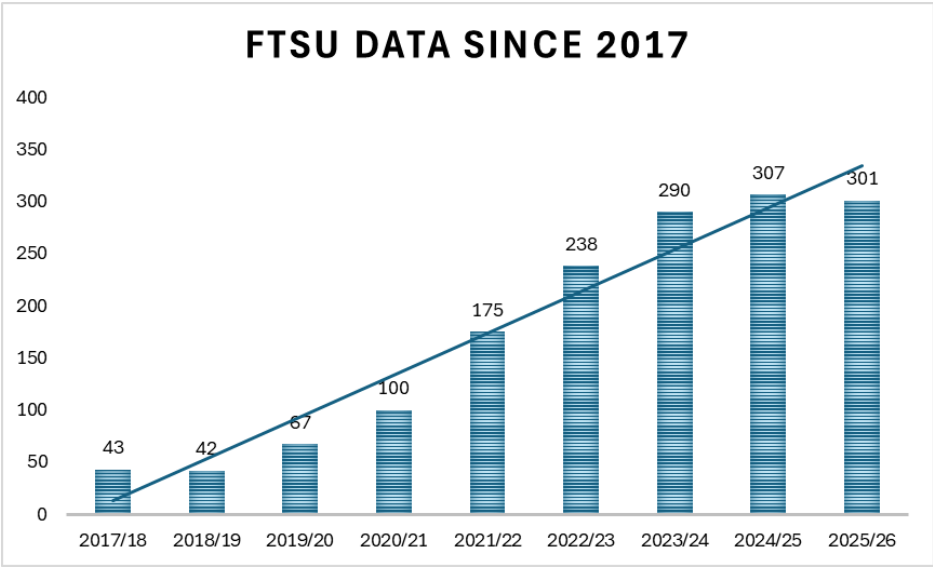
category that "OH would address concerns raised", 60.7% (from previous year, 61.7%) however this remains above the national average of 51.6%.

The table below compares the National Staff Survey 2023, 2024 and 2025 scores for "we have a voice that counts". Oxford Health NHS FT continues to perform above national and system averages on staff voice, maintaining a strong and stable position (7.05 in 2025). While this reflects a positive culture of speaking up, there has been a slight decline since 2024, mirroring national trends (Source: NGO annual report 25/26). The Trust remains one of the stronger performers locally, though behind Berkshire Healthcare. This suggests a need to sustain momentum by strengthening feedback loops and ensuring staff see tangible outcomes from speaking up, to prevent further drift and maintain engagement.

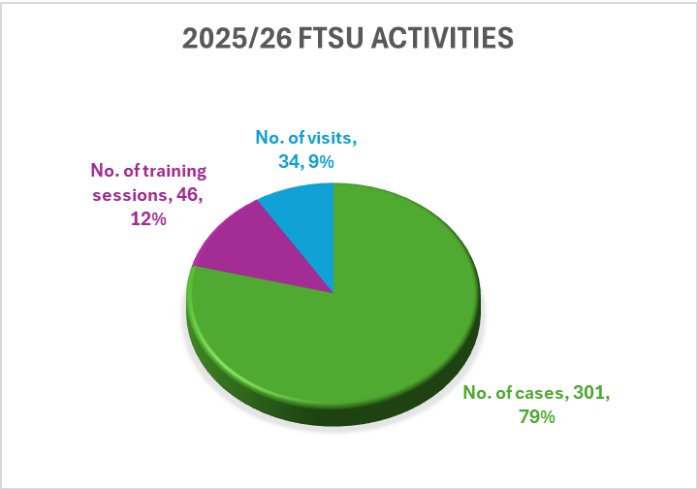
	2023 scores (out of 10)	2024 scores (out of 10)	2025 scores (out of 10)
National staff survey average "we have a voice"	6.72	6.69	6.63
Similar (benchmarked) organisations)	6.98	6.94	6.89
BOB average	6.39	6.91	6.86
Oxford Health NHS Foundation Trust	7.08	7.09	7.05
Buckinghamshire NHS Trust	6.85	6.85	6.85
Berkshire Healthcare NHS Trust	7.27	7.31	7.31
Oxford University Hospitals	6.84	6.76	6.65

FTSU Cases

Since 2017, FTSU numbers have increased as FTSUGs' capacity has increased, with a slight decrease to 301 cases (3.9% of workforce) recorded for 2025/26. This is broadly in line with the increases in headcount at Trust level over this period. There is a clear correlation between our proactive work and increased visibility. Positive role modelling and engagement from our leaders are also having a positive impact on trust speak up culture as indicated by staff survey.



This reporting year, 79% of our work has been mainly reactive (dealing with cases) in comparison to proactive work (site visits and training). The increasing number of FTSU cases remain a challenge for the future sustainability within our current capacity (1.6 WTE). Proactive work is significant within our role as it helps us to tackle speaking up barriers and continue to embed a positive speak-up culture. Staff value the FTSU service and staff feedback details are included in Appendix 2.



Examples of FTSU successful outcomes and their impact:

Case story 1

A new member of staff joined an existing specialist team. This change caused some strained dynamics between colleagues and a blurring of role clarity and responsibilities. This was evident in communication and affected the team culture. I was approached to support the senior leadership team and to help them with how they could approach the situation . It was decided that to ensure staff voices were

heard, the Guardians would support listening events for staff to feel safe to highlight the issues that maybe impacting on them.

Following these sessions, the FTSU Guardians were able to pull themes for senior leaders to take away and consider next steps.

Work is ongoing but it was clear that our input was valued and importantly staff had a safe space to raise their concerns and be assured that action would be taken.

Case story 2

A staff member began to feel intimidated and unfairly treated by their line manager and reported that the manager spoke to them abruptly and criticised them in front of colleagues. The staff member felt singled out, with heavier workloads and less flexibility than others, which impacted their confidence and wellbeing.

Feeling unable to raise concerns directly, the staff sought support from the Freedom to Speak Up Guardian (FTSUG), who provided a confidential space to explore their concerns and options. With this support, they agreed to a reflective conversation facilitated by the Senior Matron.

The conversation created a safe and constructive space for them and their manager to share perspectives, clarify expectations, and reflect on behaviours. The manager acknowledged how their communication style had been perceived and committed to a more respectful and supportive approach.

As a result, the working relationship improved, with clearer communication, fairer workload allocation, and regular check-ins. The staff reported feeling more valued and confident, and the overall team environment became more positive.

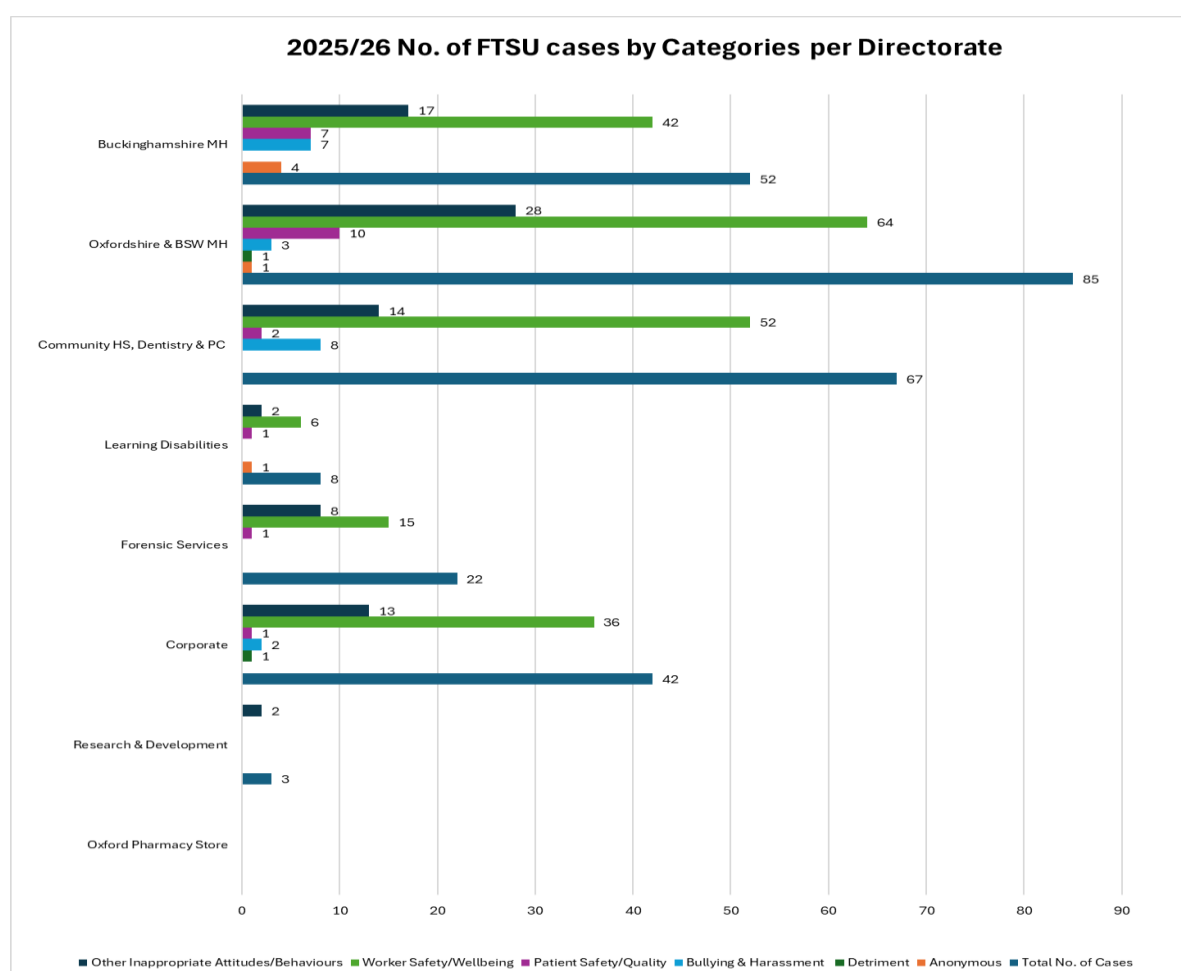
This case highlights the importance of creating space for compassionate listening, ensuring staff feel heard, respected, and supported when raising concerns. It also demonstrates the value of timely follow-up and senior-led reflective conversations in rebuilding trust, resolving issues early, and strengthening a positive team culture.

FTSU Cases by Category per Directorate

We have triangulated data from various sources including PALS, wellbeing, TRiM, HR, EDI, patient safety and staff survey where appropriate. We are working collaboratively with these teams to enable us to identify gaps and focus on teams that require our support. Senior managers / directors have been made aware of concerns raised relevant to their areas for action taking and learning.

The chart below shows the key themes and trends emerging from FTSU data per directorate.

- Total of 301 cases raised during this reporting year, 91% of cases are now closed with a few complex cases still ongoing.
- Highest number of cases from Oxon & BSW (85) followed by Community directorate (67) and Bucks (42)
- There is a low or lack of engagement from Estates & Facilities, Pharmacy, Research and Development. These areas also show below Trust average score for "we have a voice" in Staff survey. These will continue to be areas of focus for proactive work.



- **Staff safety / well-being** (235 cases) remained the highest reporting category across all the directorates, with 60 cases citing inappropriate and uncivil behaviour. These include poor / toxic culture; lack of compassion leadership support; issues with communication; rudeness & disrespectfulness; work related stress and sickness; lack of cultural intelligence and inclusivity; HR issues relate to delays in processes impacting on staff wellbeing.

- **Patient safety** 23 cases - down from 53 cases last year. Whilst cases brought to the Guardians are not directly impacting on patient safety, we do know that this has a direct impact on the quality of care given to patients. We know that staff are reporting incident issues. Concerns include unsafe practice; impact of poor teamwork (toxic culture); poor communication; lack of competence/capability of staff; poor or lack of leadership support.
- **Bullying and Harassment** 20 cases - a slight increase from the previous year (18). Examples of these are relating to unfair/unfavourable treatment from manager and colleagues; and poor team cultures (some cases of a racial nature).
- **Anonymous** 7 cases raised via FTSU compared to 2 last year. 4 were relating to the same issue and resulted in an investigation, 1 case advice was given and the other 2 were passed to Whistleblowing lead for investigation.
- **Detriment** 2 cases were reported during this period. Both cases were escalated and managed in line with the detriment guidance. The Trust remains committed to learning from these cases and is keen to identify opportunities to further strengthen the support provided to staff.

Insights by Directorates

Oxon and BSW (85 cases, 3.9% of HC)

85 cases, an increase from last year (70), over 50% of cases are from Community Mental Health teams (CMHT) and CAMHs services. Most issues are relating to toxic team culture; uncivil behaviours; staff shortage and lack of support from managers. Potentially indicating increased pressures within these clinical areas was also supported by the highest number of complaints received via PALS 383 (an increase from 298 in 24/25). 10 patient safety cases related to unsafe practice, inconsistent approach to patients boundaries, impact of poor team dynamic on standard of care.

Staff survey shows that there an increase in staff engagement in feeling safe to speak up from this area, however, our data shows that 67% (57 cases) of staff who sought our support had already raised their concerns with managers/senior managers, mostly citing that they don't feel heard, lack of confidence in action taking or supported when speaking up. Futility remains a common theme.

From our team /site visits, we regularly hear from staff of the lack of visibility from senior leaders.

Engagement and collaboration with senior leadership team remains challenging.

Community Directorate (67 cases, 3.2% of HC)

67 cases, a reduction from 85 last year this includes only 2 cases relating to patient safety despite an increase in complaints from 136 to 175 (PALS data). Common themes cited are poor behaviour; poor leadership and poor team culture particularly in children & young people care and planned & preventative care where service demands and staff shortage are high.

Staff survey shows that there is an increase in staff engagement in feeling safe to speak up from this area, however, similar to Oxon and BSW, 64% (43 cases) of staff had already raised their concerns with managers/senior managers before seeking our support. The themes were similar "not feeling heard", "lack of confidence in action taking" or "supported when speaking up". Futility remains a common theme.

There appears to be improvement with regards to communication about transformational changes from last year as we saw a decline in reporting this year.

There continues to be positive engagement and collaboration with the senior leadership team.

Bucks (52 cases, 4.3% of HC)

52 cases, an increase from previous year (36). Common themes are similarly to other directorates: poor behaviour; poor leadership and poor team culture. 7 cases were directly relating to Bullying & Harassment. 7 patient safety cases were raised via FTSU, however, complaints via PALS have increased from 164 to 217.

Staff survey shows that there was a decrease in staff engagement in feeling safe to speak up from this area with 65% (34 cases) of staff having already raised their concerns with managers/senior managers before seeking our support. The themes were similar "not feeling heard", "lack of confidence in action taking" or "supported when speaking up". Futility remains a common theme.

We saw some good engagement from senior leaders and we will continue to build on these relationships, however, futility remains an issue.

Forensic services (22 cases, 3.9% of HC)

22 cases, a reduction from previous year (38) includes Patient safety (1); 54% (12) of cases were raised to manager and senior managers.

Staff survey "a voice that counts" is same as trust average.

We continue to see concerns raised relating to abuse of staff from patients from most inpatients services and a feeling that despite reporting there is no change. When action is taken this can often take a long time thus reducing staff confidence

Poor behaviour, poor leadership and poor team culture reported at Thames House due to staff shortage and team restructuring.

We continue to build good relationships with leaders and staff and carried out various site visits.

Learning Disability (8 cases, 8% of HC)

7 out of 8 cases related to one particular team where team dynamics were poor and there was a lack of strong leadership. Staff survey shows that staff feel able to speak up about anything that concerns them, however this is slightly below the Trust average.

Low numbers of complaints raised via PALS (3) may indicate **under-reporting**.

We have built good relationships with leaders and carried out focussed proactive work providing a good foundation for improvement.

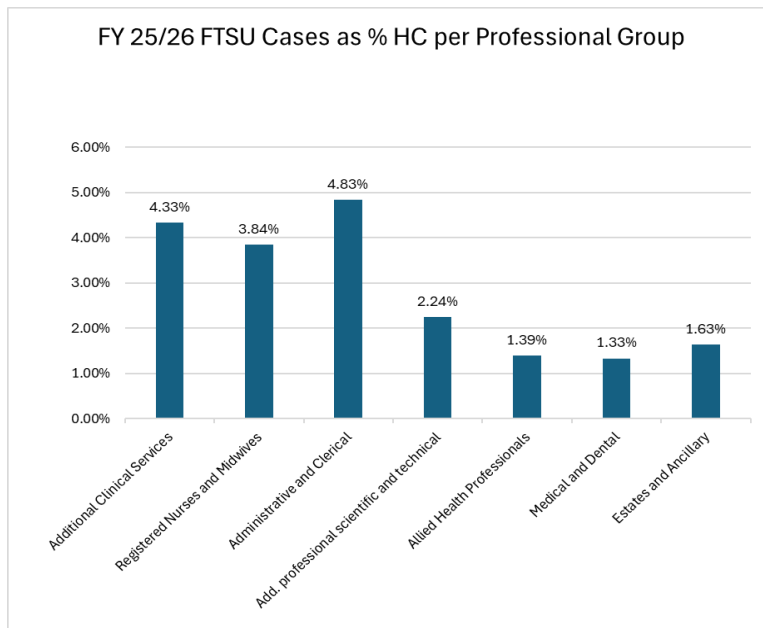
Corporate (42 cases, 3.1% of HC)

42 cases, a reduction from previous year (55). 52% (22) of cases were raised to manager and senior managers initially. We have seen various cases from different teams; the main themes are around poor leadership, breakdown of relationships and poor behaviour/attitudes. The staff survey shows a slight reduction in confidence in speaking up against the Trust average. We will continue to tackle barriers for speaking up across all areas.

FTSU Cases by Professional Groups

Admin and clerical were our highest reporting staff group (81) followed by nurses (76) and additional clinical staff (74). In the cases raised, we are seeing a consistent spread across professional groups in relation to headcount. National Staff survey shows Estates staff are less likely to speak up, our data also supports this. We started some proactive work; however, leadership engagement has been limited, an area that requires further input.

Low engagement from AHP and Medics staff may indicate they are utilising other routes for speak up or may not feel safe to speak up. We are currently working with leaders to promote speak up culture and tackle barriers.

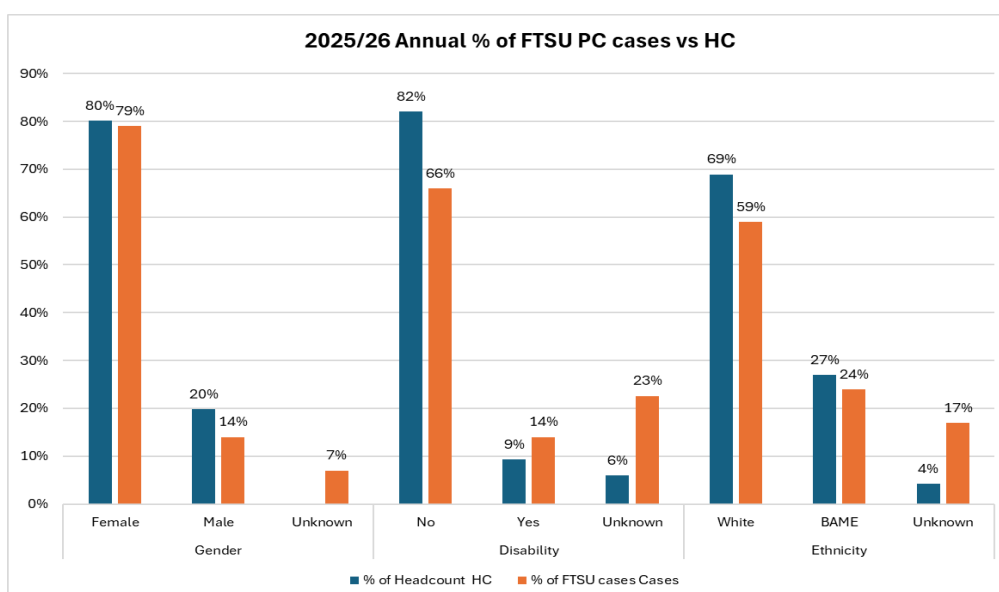


FTSU cases by protected characteristic (PC) against workforce headcount analysis

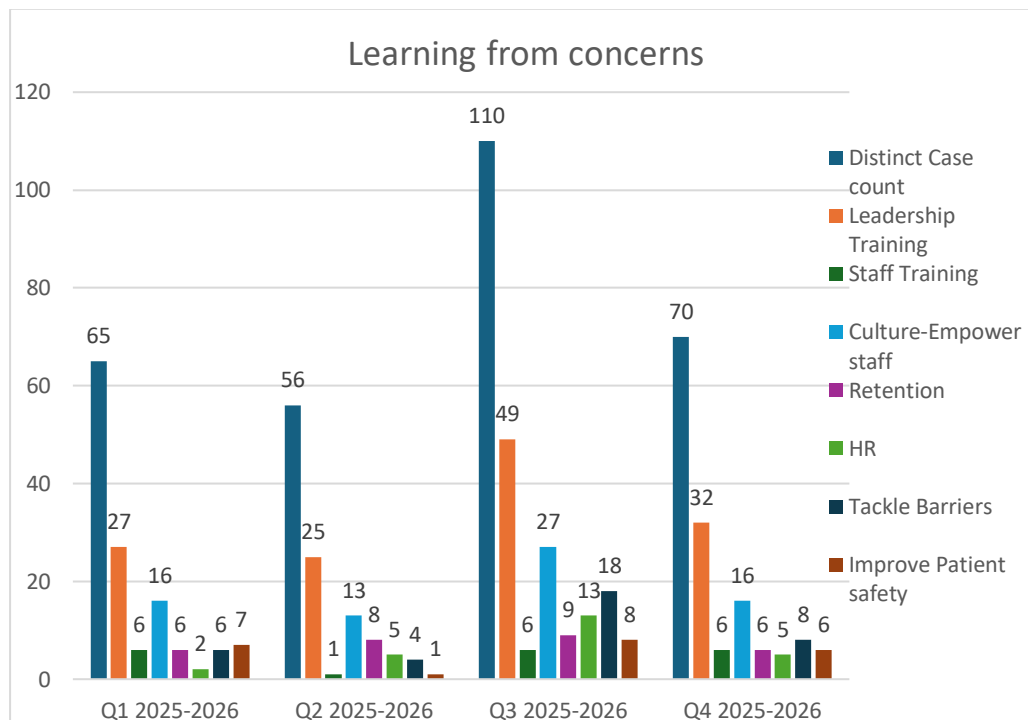
We will focus on key areas in relation to protected characteristics

The data below shows that:

- **Disability Disparity:** Staff with a disability raise a disproportionately higher percentage of cases (14%) compared to their overall representation in the workforce headcount (9%).
- **Underrepresentation in Reporting:** Both male staff (14% of cases vs. 20% of headcount) and BAME staff (24% of cases vs. 27% of headcount) are underrepresented in reporting relative to their workforce size, which could indicate potential barriers to speaking up within these groups



Recommendations for improvement and learning.



The Trust should prioritise strengthening compassionate and inclusive leadership, with a focus on communication skills, cultural competence, and handling difficult conversations for early resolution.

Timely follow-up and clear communication of actions taken in response to concerns must be improved to build trust and reduce perceptions of inaction.

Targeted work is required to engage underrepresented groups and low-engagement areas, alongside continued focus on psychological safety and team culture.

Priorities for 2026–2027

In the coming year, we will deliver the FTSU 2025–2027 plan, with a focus on high-impact actions; efforts will target directorates and staff groups with lower engagement, while strengthening collaboration with key stakeholders to improve organisational learning.

We will also continue to build our speak up culture by:

- Working with OD colleagues to analyse staff survey results and look at trends/ areas for focus
- Auditing local induction packs to ensure staff know routes for speaking up
- Work with staff awards team to consider how we can amplify the importance of speaking up for staff

A focus on sharing positive outcomes from speaking up to address futility and reinforce trust in the speak up process.

To ensure a smooth transition from NGO to NHS England, leadership support and oversight is needed.

Appendix 1 – National Guardians Office (NGO) closure NHSE/Trust Roles and Responsibilities

Section	Objective	NHS England Commitments	Oxford Health Responsibilities
1.1 Guardian Registry	Ensure worker access to guardians and local accountability.	Support existing guardian networks and individual guardians.	Trusts responsibility to ensure guardian contact info is accurate, accessible, and publicly available.
1.2 Policy & Guidance	Maintain clear, consistent standards across all sectors.	Review national FTSU policy and guidance across all sectors, starting with primary care.	No updates required as already existing policy already adheres to national standard
1.3 Data Collection	Improve national learning via consistent, anonymized data.	Collect FTSU data nationally	Routinely submit FTSU data through the national system. (Note: Trusts and ICBs only for 2026/27). Guidance to follow
1.4 System Learning	Strengthen system-wide learning and best practice.	Routinely share thematic insights and best practices with guardian networks.	Use shared national insights to inform and improve local speaking-up cultures.
2.1 Guardian Training	High-quality, consistent training for all guardians.	Provide and maintain the platform for free online foundation training (for newly appointed guardians).	Ensure any appointed guardian completes mandatory foundation training before starting their role.
2.2 Guardian Support	Provide a supportive infrastructure and psychological help.	Manage general enquiries through the national contact centre and escalate specialist queries.	Ensure appropriate psychological support is available locally, noting the national EAP ends 31 December 2026.
2.3 Guardian Networks	Strengthen peer support and shared learning.	Support regional and national guardian networks to facilitate peer support.	Support guardians' continuing professional development and participation in these networks.
2.4 Guardian Enquiries	Accessible routing for general and specialist queries.	Manage enquiries via the national contact centre (0300 311 2233) and specialist teams.	Ensure guardians are aware of these central routes for complex or specialist support.

Appendix 2: Feedback from staff who have used the FTSU service.

Below are direct quotes received on the FTSU feedback questionnaire from staff after accessing the service:

"Very helpful. Lianne has been very compassionate and understanding whilst helping me navigate difficult team dynamics. She has helped me feel heard but also supported me with talking through options and offering support."

"Very supportive, and proactive with following up, thank you"

"A really wonderful and needed service, while working in such a complex team and services. I can't thank Rita and Lianne enough for the support they have given me and know that others have felt the same. They are an asset to the Trust. Only suggestion is that the service could expand so that wait times to speak to you are shorter!"

"Rita was brilliant. She listened, asked questions which helped me to reflect, think and make changes to my situation."

"Lianne was very positive and very knowledgeable. She explained the process clearly and I felt very comfortable speaking to her and she has given me the confidence to approach my managers. The follow up email was very clear and concise. I am very grateful that we have this service available. Massive thanks"

"Rita was fantastic - I felt listened to and understood, she provided me with really helpful suggestions. I was great to talk to someone who understands the environment that I work in."

"According to the process and outcome, the actions and effect of speak up are limited (only speaking to manager or manager's manager doesn't work out, which I have done but didn't see any meaningful effect)."

"I have found this service invaluable, I have felt listened to, validated and supported when I was not being heard or supported by my manager and higher management team. The service is transparent, non-judgemental and offers "Freedom" to express concerns. I am concerned that myself and 2 other team members have been told by 3 managers that Freedom to speak up is being used inappropriately and that we should go through the proper channels to report concerns- the reason we went to Freedom to speak up was because we felt unheard and bullied by management. We felt there was no other alternative but to go to freedom to speak up. It is an excellent service."

Audit & Risk Committee
Minutes of the meeting held on
23 April 2026 at 14:00
via Microsoft Teams

Present¹:

Harjit Sandhu (HSa)	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 – <i>part meeting</i>
Michael Mason (MM)	External Audit, Ernst & Young – <i>part meeting</i>

Internal Audit and Counter Fraud – KPMG

Gareth Hall (GH)	Internal Audit, KPMG – <i>part meeting</i>
Sarah Knight (SK)	Internal Audit, KPMG – <i>part meeting</i>
Isabel Turner (IT)	Counter Fraud, KPMG – <i>part meeting</i>

Oxford Health NHS FT**Attending Board members**

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) – <i>part meeting</i>
Heather Smith (HeS)	Chief Finance Officer (the CFO) – <i>part meeting</i>

Other Trust staff in attendance

Ben Cahill (BC)	Deputy Director of Corporate Affairs – <i>part meeting</i>
Ashley Harvey (AH)	Head of Improvement & Effectiveness – <i>part meeting</i>
Alison Gordon (AG)	Deputy Director of Finance (Financial Management) – <i>part meeting</i>
Peter Milliken (PM)	Director of Finance
Jewel Mollah (JM)	Senior Accountant – <i>part meeting</i>
Hannah Smith (HaS)	Assistant Trust Secretary (Minutes)
Osa Udoh	Assistant Director of Financial Operations – <i>part meeting</i>

Observing Governors

Colleen Jones	Governor representing Public 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	There were no apologies for absence from Committee members. Apologies from attendees were received from: Rob Bale, Chief Operating Officer for Mental Health & Learning Disability; 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 11 February 2026 and Matters Arising	
a	The minutes of the Committee meeting on 11 February 2026 were approved as a true and accurate record.	
	Matters Arising	
b	The action at item 8(c) (recommendations from Committee annual effectiveness review) was discussed. The Executive Director of Corporate Affairs noted that the feedback from all committees' annual effectiveness reviews would be discussed at the Board Workshop on 29 April 2026. The Chair requested that the action be held open until further discussion had taken place but it could be considered again for potential closure at the next meeting.	
c	The following actions were noted as on the agenda for the meeting: - item 10(a) – Internal Audit and Counter Fraud Plans FY27; and - item 12(b) – risk scoring guidance.	
d	The following actions were noted as scheduled for the June or September 2026 meetings: - item 6(d) – further update on Health & Safety/Estates (June or September); and - item 9(e) – further update on operation of revised payroll controls and processes, to obtain assurance that changes implemented were operating effectively (June).	
	<i>Jewel Mollah, Senior Accountant, joined the meeting.</i>	
INTERNAL AUDIT & COUNTER FRAUD		
4.	Internal Audit updates	
	Internal Audit progress report and FY27 Plan	
a	Sarah Knight, Internal Audit, presented: - the progress report and highlighted that the FY26 planned work had been completed, with the final 4 reports being presented to this meeting, all of which had achieved green or amber/green ratings. The overdue actions on the tracker were progressing and had revised due-dates for the end of April 2026. The Internal Audit annual report was not yet available and would be provided to the meeting in June 2026; and - the Internal Audit Plan for FY27 which proposed to deliver 7 reviews of which: (i) 4 were core reviews and required in order to deliver a year-end conclusion (including Core Financial Controls, Data Quality, Risk Management and Data Security & Protection Toolkit); and (ii) 3 were risk-based reviews (Consultant Job Planning, Absence Management (Sickness) and Incident Reporting which she clarified referred to Patient Safety).	

b	In response to a question from the Chair, she explained that the Internal Audit Plan FY27 had been generated further to: review of Board papers and the Board Assurance Framework; meetings with Executives (as listed on page 3 of the Plan); and discussion of the longlist at an Executive meeting in March in order to select the priority areas. The Chair invited the Executives present to comment and the Chief Finance Officer confirmed that she was satisfied that the Internal Audit Plan FY27 focused appropriately on strategic risks and that the Executive team had been able to direct Internal Audit to get the balance right between review of areas where: (i) controls were expected but required assurance; and (ii) where it could be useful to deploy Internal Audit resource to identify opportunities for improvement.	
c	<i>Oxford Pharmacy Store (OPS) review</i> Gareth Hall presented the review into the design and operation of controls across the OPS medicines management lifecycle and consideration of counter-fraud across all areas. He noted that there had been changes since the draft report and the final report had achieved a rating of significant assurance with minor improvement opportunities (amber-green), with the overall conclusion being that there was a strong control environment with targeted actions to strengthen stock control against potential fraud and error. The Chief Finance Officer commented upon the highly regulated nature of the OPS business and its responsibilities in relation to management of controlled drugs. She invited Jewel Mollah, Senior Accountant, to comment upon implementation of the findings from the Internal Audit review. Jewel Mollah explained that the recommendations had been discussed at the OPS weekly review and work was progressing on implementing a more system-based approach to stock rotations and stock counts; he confirmed that training and record-keeping recommendations had already been implemented through the Electronic Quality Management System. <i>Jewel Mollah, Senior Accountant, left the meeting. Claire Mellons and Michael Mason, External Audit, and the Chief People Officer joined the meeting.</i>	
d	<i>Risk Management – Board Assurance Framework (BAF)</i> Gareth Hall presented the review on the refreshed BAF which had achieved a rating of significant assurance with minor improvement opportunities (amber-green), with the overall conclusion being that: there was a strong foundation; the BAF was regularly reviewed through committees; and recommendations were low priority and focused upon targeted enhancements to strengthen standardisation, consistency and reporting clarity. The Executive Director of Corporate Affairs confirmed that achievable implementation timescales had been applied to the recommendations, noting that these had needed to provide for sign-off of the Trust's new 5-year Strategy as this would impact implementation. In relation to recommendations around clarity and style of reporting, he noted that consideration would be given to the amount of resource required for implementation, compared to the potential benefit, but mapping of assurances would be explored further.	
e	<i>Cyber Assessment Framework – Aligned Data Security & Protection Toolkit review</i> Gareth Hall presented the review on the 12 outcomes across the 5 objectives of the Cyber Assessment Framework and confirmed that the review had achieved a rating of significant assurance (green), all outcomes having met NHS England requirements and no issues identified but some minor opportunities for continued improvement which had no impact on compliance or assurance. He concluded that Information Governance controls were effective, well governed and operating as intended.	

f	Rick Trainor commended the Information Governance team on this achievement, especially in light of cyber attacks which had been experienced a few years previously by suppliers and which had resulted in a clinical systems outage.	
g	Staff Retention review Gareth Hall presented the review on processes for supporting staff retention, including recruitment and onboarding, use of feedback and monitoring of turnover data. He confirmed that it had achieved a rating of significant assurance with minor improvement opportunities (amber-green), with a solid framework in place and opportunities to strengthen systematic analysis of staff feedback and consistency of exit questionnaires. The Chief People Officer reported that recommendations were already being progressed, some had been completed, timescales were achievable and Recruitment and Retention continued to perform strongly and were green-rated indicators on the Trust's Integrated Performance Report to the Board.	
h	The Committee noted the progress report and the review reports and APPROVED the Internal Audit Plan FY27. <i>The Chief People Officer left the meeting and the Deputy Director of Finance (Financial Management) joined the meeting.</i>	
5.	Counter Fraud progress report and Plan FY27	
a	Isabel Turner, Counter Fraud, presented: - the progress report and highlighted that there had been 16 referrals over FY26 and some new referrals had also come in at the start of FY27. A case remained ongoing in relation to timesheet fraud, as referred to at Appendix B. Appendix C included guidance in relation to management of Mutually Agreed Resignation Schemes; and - the Counter Fraud Plan FY27 which included two proposed areas of review (Estates, having been held over from FY26, and patient property) and which she confirmed had been subject to the same process of review by the Executive as the Internal Audit Plan. The Chief Finance Officer added that it was also aligned to the government functional standard on Counter Fraud.	
b	The Chair noted that it had been helpful that the Counter Fraud Plan document also included a strategic overview of reviews for 2023-28 and had set out past coverage.	
c	The Committee noted the progress report and APPROVED the Counter Fraud Plan FY27.	
EXTERNAL AUDIT		
6.	External Audit Plan FY26 and progress report	
a	Claire Mellons and Michael Mason presented the External Audit planning report, on the proposed audit approach and scope for FY26, and took the meeting through the risks, areas of focus and materiality thresholds highlighting: change in the focus of the regular risk presumed around potential fraud in revenue and expenditure recognition (further to International Standards on Auditing (ISA) 20) to focus this year on potential understatement of Research & Development (R&D) income and deferral of income in light of a forecasted surplus financial position;	

	• valuation of land and buildings and risk of material misstatement – continued to be included as this was an inherently complex area impacted by judgements and estimation techniques; • Private Finance Initiative (PFI) exit provision – included since FY24 and in anticipation of a potential adjusting event after the reporting period; • risk of material misstatement around the Remuneration report and any exit packages; and • increase in the performance materiality threshold from 50% to 75% (as set out in more detail in the report) which reflected improvements in the accounts preparation process and reduction in errors. b The Chief Finance Officer welcomed the increase in the performance materiality threshold and noted that this reflected good control processes. She added that the External Audit Plan had been informed by debriefing and learning from prior years. c The Committee noted the report	
DRAFT ANNUAL REPORT & ACCOUNTS AND SUPPORTING DOCUMENTS		
7.	Draft Financial Statements and Accounts a The Chief Finance Officer and the Director of Finance presented: (i) the Draft Annual Statutory Accounts – Year Ending 31 March 2026; (ii) a high-level Analytical Review of the Primary Financial Statements from the draft 2025/26 Annual Accounts illustrating variance compared to the 2024/25 Annual Accounts; and (iii) a PFI exit update paper on the Trust's accounting treatment and impact of its PFI exit plan and how this may still impact the 2025/26 financial statements. No new accounting standards or revisions to existing standards had been early adopted. b The Director of Finance highlighted: • the increase in operating expenses further to the increase in staff pay costs and reduction in agency spend. He explained that this was positive and also linked to the reduction in vacancy rates as the Trust had been able to recruit into permanent posts which historically had been a challenge; • an additional £4.9 million under contract receivables from non-recurrent accrued support funding from NHS England via the Integrated Care Board (a cash benefit available to providers who were on plan at year-end); • strong cash balances had been maintained which was a positive sign of financial sustainability over several years; and • the PFI exit update paper set out the impact if there was an adjusting event after the reporting period. Further to a query from the Chair, he noted that it may be more likely to be a FY27 accounting entry, with a capital rather than a revenue impact and he confirmed that NHS regional and national teams were aware. c Analytical Review The Deputy Director of Finance (Financial Management) took the meeting through the Analytical Review and highlighted in relation to Income activity: • increased income from patient care activities including £7 million for the Mental Health Investment Standard and £1.2 million additional Service Development Funding. The £4.9 million support funding referred to at item 7(b) above had been split between Mental Health and Community services;	

	• income from Mental Health Collaboratives (Provider Collaboratives), distinguishing between income received from services which the Trust provided and income from commissioning services from other providers; • income from commissioners and local authorities for Community services, in particular £3.3 million of Community growth and non-recurrent inflation funding on the 0-19 contract; • additional employer pension contribution income, as notified by NHS England; • increase in Education & Training income especially from the Oxford Institute of Clinical Psychology Training; and • increased OPS sales.	
d	In relation to Expenditure activity she highlighted: • increase in Out of Area Placements, mainly in Buckinghamshire; • the most significant increase was staff pay costs further to an increase in substantive staffing (including at the Oxford Institute of Clinical Psychology Training) and a decrease in agency staffing; • increase in OPS cost of sales which was associated with the overall increase in OPS sales; • overall reduction in R&D non-pay spend; and • increased variable lease payments as FY25 had included a credit for settlement with NHS Property Services for prior year invoices, which was not available in FY26.	
e	The Assistant Director of Financial Operations took the meeting through the Statement of Financial Position and highlighted: • additions of £1 million to intangible assets less depreciation of £1.8 million; • new capitalised leases of £0.8 million and lease renewals of £0.3 million, but increased dilapidations of £0.7 million less depreciation of £7.8 million; • inventories (current assets) had increased by 17% in line with OPS in-year inventory movement; • cash increase due to net inflows from operating activities and interest receivable exceeding outflows from investment activities such as capital expenditure and financing activities; • increase in lease liabilities (borrowings); • public dividend capital as a payable in FY26 rather than a receivable; and • reduction in trade payables largely due to paying approved invoices due within 2 weeks of year-end in FY26 (compared with those due within only 1 week of year-end in FY25).	
f	The Chair commented that before the meeting he had already had the opportunity to work through the detail of the Draft Financial Statements and Accounts, which had been helpful. He referred to the £4.9 million bonus from non-recurrent accrued support funding and asked whether cash had yet been received for that. The Deputy Director of Finance (Financial Management) replied that it had not. Therefore, this would further increase the cash position.	
g	Further to a query from the Chair, the Assistant Director of Financial Operations confirmed that a decision had been taken to pay trade payables more quickly and there was flexibility available to do this.	

h	The Chief Finance Officer noted that changes identified through the External Audit process could lead to movement in the Draft Annual Statutory Accounts and the Analytical Review and would be highlighted before presentation of the near-final Accounts to the next meeting. There were some additional notes still to add, as some final information was awaited, but they did not affect the core statements as presented at the meeting today.	
i	The Committee RECEIVED the Draft Annual Statutory Accounts and the high-level Analytical Review of the 2025/26 Annual Accounts Primary Financial Statements and, subject to final refinements to be made, noted that these should be submitted to NHS England.	
8.	Preparation of Statutory Accounts on a Going Concern basis	
a	The Director of Finance presented the draft Going Concern Statement which included, at Appendix 1, references to the sources and documentation to support the going concern basis for preparation of the 2025/26 Statutory Accounts. In due course, in approving the final Statutory Accounts, the Committee would be asked whether it agreed with the decision made by management to prepare the accounts on a going concern basis and based on the anticipated continuation of future provision of services in the public sector.	
b	Since FY22, the focus of the Going Concern Statement had shifted from organisational future financial sustainability to anticipated continuity of the provision of services in the public sector. The HM Treasury Financial Reporting Manual and the NHS FT Annual Reporting Manual (NHS FT ARM) set out that inclusion of financial provision for such services in published financial accounts was normally sufficient evidence of anticipated continuity of services and going concern status. As healthcare services continued to be provided, it was therefore highly unlikely that an NHS body would prepare its accounts on anything other than a going concern basis. The key consideration was whether the services it was providing would continue to be provided in the public sector. The Trust could evidence this by reference to the sources and documentation listed in Appendix 1 which referenced contracts in place for FY27 and set out NHS commitments to mental health and community services and to Provider Collaboratives, including NHS England FY27 priorities, planning guidance and neighbourhood health guidelines.	
c	The Chair supported the statement that the Trust was clearly a going concern and it was appropriate for the (draft) accounts to be presented on a going concern basis, in light of ongoing commissioning of mental health and community services and the likelihood that the Trust would need, and be able, to provide these services at least 12 months on from finalising the accounts.	
d	The Committee noted the report and supported the preparation of the draft 2025/26 Annual Accounts on a going concern basis, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual. <i>The Chief Executive, the Chief Finance Officer, the Deputy Director of Finance (Financial Management) and the Assistant Director of Financial Operations left the meeting.</i>	
9.	Draft Annual Governance Statement	
a	The Deputy Director of Corporate Affairs introduced the draft Annual Governance Statement (AGS) on the stewardship of the Trust and system of internal control. He reminded the Committee of the prescribed nature of much of the drafting, in accordance with the NHS FT ARM. The draft AGS was at Appendix 1, whilst Appendix 2 set out the	

	Trust's disclosures required either as statements or 'comply or explain' provisions, all of which were anticipated to be complied with.	
b	Further to queries from the Chair, the Deputy Director of Corporate Affairs confirmed that the FY26 AGS was in the same format as FY25 and the Executive Director of Corporate Affairs added that there were no significant control weaknesses or associated remedial actions to highlight. Although some changes may emerge following the External Audit process, no significant updates were anticipated and assurance from Internal Audit and other governance work indicated that systems remained strong and with opportunities to further improve.	
c	The Committee noted the draft AGS and supported the direction of the narrative in setting out the work of the Trust in assuring the effectiveness of controls and management of risk and that it reflected the existence, or otherwise, of any significant control weaknesses and any associated remedial actions.	
10.	Approach to 'Oxford Health in numbers'	
a	The Committee took as read a written update from the Chief Finance Officer that work had begun on the latest edition of 'Oxford Health in numbers' and noted last year's version for reference and an example of the insights which the publication could provide into the work of the Trust, further to the detail available in the full Annual Report & Accounts.	
b	The Committee noted the update. <i>The meeting took a break for 10 minutes and resumed at 15:50. The Head of Improvement & Effectiveness joined the meeting. The Chief Executive rejoined the meeting.</i>	
RISK, GOVERNANCE & ASSURANCE		
11.	Clinical Audit & NICE² Guidance interim update report (October 2025 to March 2026)	
a	The Head of Improvement & Effectiveness presented the report (which provided a six-month overview of performance, risks and improvement actions relating to Clinical Audit and NICE guidance management) and explained that this was also relevant for assurance to support the AGS. He noted that the Quality Committee also separately received reporting on the detail of clinical audits, which was available upon request and had already been provided separately to the Chair for information. He summarised that there had been improvements in governance and controls. Risks remained around capacity and some system limitations, with mitigating actions taking place with directorates and good engagement with senior clinical and leadership teams. The Trust had moved from a reactive position to a risk-based, planned and proportionate approach to assurance, with consistent progress in reducing overdue NICE guidance reviews (from 84 in October 2025 to currently approximately 12) and clinical audit actions. Although the number of overdue clinical audit actions had reduced, there was still room for improvement.	
b	In relation to system limitations, and further to a query from the Chair, he noted that work needed to take place to train users of the Audit Monitoring and Tracking system (AMaT) so as to avoid unduly triggering overdue actions and to also improve AMaT's functionality when used on tablet devices. In response to the Chief Executive, he confirmed that AMaT was still the most appropriate system to use.	

² National Institute for Health & Care Excellence (**NICE**)

c	The Committee noted the report and was assured that appropriate systems were in place around Clinical Audit and NICE guidance management. <i>The Head of Improvement & Effectiveness left the meeting.</i>	
12.	Board Assurance Framework (BAF) report	
a	The Deputy Director of Corporate Affairs presented the BAF report which focused on three clustered risks for a deep dive across risks with a conceptual link: A1 (Timely Access to Services); A5 (Staff Experience and Culture); and A6 (Improvement, Research and Innovation). Further to discussion at previous meetings, he confirmed that the Committee would cycle through deep dives of all eleven BAF risks over the course of a year. He summarised that there had been good progress against most actions and that risks A1 and A6, which were monitored by the Quality Committee, were currently being revised for the Quality Committee meeting in May 2026. Further to a query from the Chair, he noted that once risks had been reviewed by their relevant committee, an overview of discussion from the meeting could be included in the next overarching report to the Board.	
b	In response to a question from the Chair on confidence with the implementation of proposed actions and timescales, the Deputy Director of Corporate Affairs replied that there was generally a high degree of confidence as BAF actions were designed to be practical rather than abstract. He noted that in relation to A1 (Timely Access to Services), the action did relate to programmes which would be delivered over the long-term but were achievable. The Executive Director of Corporate Affairs emphasised the importance of getting the right actions in place to address risks and achieve their mitigations; he noted that he had confidence in the actions and the engagement with Executives and senior leaders through the various forums at which the risks were discussed, which also provided triangulation to other assurance activity. The next stage was to progress the recommendations from the Internal Audit review and link more actions to the Trust's Strategy. The Chief Executive commented that at strategic BAF-level, although the actions were important they may not quickly change risk ratings but over time they would mitigate against deterioration in the risk and guard against the risk moving in a negative, rather than a positive, direction. The Chair acknowledged that it would be valid to have actions in place to prevent deterioration rather than allowing the risk score to increase and the position worsen.	
c	Further to the comments and reflections above, the Committee supported the revised BAF and the work taking place across risks A1 (Timely Access to Services); A5 (Staff Experience and Culture); and A6 (Improvement, Research and Innovation).	
13.	Any Other Business	
a	The Chair confirmed with the Internal and External Auditors that they had no further comments or matters to raise. <i>The representatives from KPMG and EY and the Deputy Director of Corporate Affairs left the meeting.</i>	
PRIVATE SESSION - PROCUREMENT		
14.	External Audit procurement – update	
a	The Director of Finance presented the report on the competitive process to provide External Audit services, highlighted the outcome from the scoring and the preferred provider. He also noted that observing Governor Colleen Jones had been part of the procurement process.	

b	The Committee RECOMMENDED to the Council of Governors that the preferred provider be appointed, further to the procurement process.	
ANY OTHER BUSINESS		
15.	Any Other Business (AOB) and Questions	
a	The Chair invited comments/questions from observing Governor Colleen Jones who asked about the link/relationship between the BAF and Committee 3As reports to the Board, noting the potential for misalignment if there were red-rated risks on the BAF but positive Committee 3As reports to the Board and acknowledging that the Executive Director of Corporate Affairs had separately commented upon the difference between short-term and long-term risks and the differences in approach to these. The Executive Director of Corporate Affairs clarified that: (i) Committee 3As reports focused specifically upon discussion from a particular meeting and may not always reflect the longer-term trajectory for improvement; and (ii) the BAF was a Board-owned strategic level document whereas the Trust Risk Register focused on more immediate operational risks. The Executive Director of Corporate Affairs and the Deputy Director of Corporate Affairs would consider a separate session with Governors on the BAF.	BC/TG
16.	Review of the meeting	
a	For 3As escalation purposes for the Board in May 2026: • matters of concern or alert to escalate: none; and • to note for assurance: completion of the Internal Audit planned work for FY26 and a particularly positive outcome for the Cyber Assessment Framework – Aligned Data Security & Protection Toolkit review.	
	Meeting Close: 16:46	
	Date of next meeting: 15 June 2026	

Meeting of the Audit & Risk Committee

Monday, 15 June 2026, 09:30-12:30¹

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	HSa, Chair		N/A	09:30 (10 mins)
2.	Confirmation of items for Any Other Business			N/A	
3.	Minutes of the Audit & Risk Committee meeting held on 23 April 2026		For approval	Enclosed	
4.	Summary of Actions and matters arising			Enclosed	

Supporting Documents to the Annual Report & Accounts

5.	Internal Audit: a) annual report 2025/26 including final Head of Internal Audit Opinion; ³ and b) progress report with update on Internal Audit Plan 2026/27	KPMG/ HeS	For assurance	Enclosed	09:40 (20 mins)
6.	Counter Fraud: a) annual report 2025/26; and b) progress report with update on Counter Fraud Plan 2026/27	KPMG/ HeS	For assurance	Enclosed	
7.	External Audit provisional results report (including Value For Money commentary and draft letter of representation (Appendix C))	EY	For assurance	Enclosed	10:00 (20 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 Apologies from Committee members: none.

Apologies from regular attendees: Grant Macdonald, Chief Executive; Britta Klinck, Chief Nurse; and Karl Marlowe, Chief Medical Officer.

³ The Head of Internal Audit Opinion should be considered before the Annual Report (and the Annual Governance Statement). The Head of Internal Audit Opinion contributes to the assurances available to the Accounting Officer and the Board to underpin assessment of the effectiveness of the Trust's system of internal control and to assist in the completion of the Annual Governance Statement.

Annual Accounts and Annual Report

8.	Financial Statements and Accounts (audited) 2025/26	OU/PM/HeS	For approval	Enclosed	10:20 (35 mins)
9.	Going Concern Statement 2025/26	OU/PM/HeS	For assurance	Enclosed	10:55 (5 mins)
<i>10 minutes' break if required</i>					11:00
10.	Annual Report 2025/26 including: Annual Governance Statement ⁴ and timetable for laying of the Annual Report & Accounts	BC/TG	For approval	Enclosed	11:10 (20 mins)
11.	Oxford Health in Numbers 2026/27	MC/HeS	For information	Enclosed	11:20 (5 mins)

Risk, Governance & Assurance

12.	Losses & Special Payments – Payroll Overpayments controls update report	CDS (and JP)	For information & assurance	Enclosed	11:25 (15 mins)
13.	Estates/Health & Safety update report	JP/HeS	For assurance	Enclosed	11:40 (15 mins)
14.	Whistleblowing arrangements annual report	Jill Castle /CDS/HeS	For assurance	Enclosed	11:55 (10 mins)
15.	Board Assurance Framework report with deep dives ⁵ into risks on: - Quality, Safety & Experience; - Recruitment & Retention; and - Digital transformation	BC/TG CDS/WH/HeS	For assurance		12:05 (15 mins)
16.	Emergency Preparedness, Resilience and Response (EPRR) Committee 3As (Alert, Advice, Assurance) report	TG	For assurance	Enclosed	12:20 (5 mins)

Any Other Business

17.	Any other business	HSa, Chair		N/A	12:25 (5 mins)
18.	Questions from observing Governors			N/A	

⁴ Although the Quality Report and Quality Account used to feature at this meeting as part of the Annual Report, since FY20 and the response to the coronavirus/COVID-19 situation, the annual audited Quality Report is no longer a regulatory requirement. The Quality Account is separately considered by the Quality Committee before presentation to the Board.

⁵ 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.

Review and Close

19. Review of the Meeting HSA, Chair
- a) any escalations to the Board or Board Assurance Framework;
 - b) any points to raise from the private pre-meetings; and
 - c) content and behaviours.

Meeting Close

12:30

Date of next meeting – 18 September 2025

Finance and Investment Committee

Minutes of the meeting held on

Tuesday, 05 May 2026 at 09:30

Microsoft Teams virtual meeting

Present:

Core members and attending Board members included in quorum

Core members

Lucy Weston (**LW**)

Amélie Bages (**AB**)

Dr Rob Bale (**RB**)

Taff Gidi (**TG**)

Emma Leaver (**EL**)

Mohinder Sawhney (**MS**)

Heather Smith (**HeS**)

Attending Board members

Grant Macdonald (**GM**)

Harjit Sandhu (**HSa**)

Non-Executive Director (the Chair)

Executive Director of Strategy and Partnerships

Interim Chief Operating Officer for Mental Health and Learning Disability

Executive Director of Corporate Affairs

Interim Chief Operating Officer for Community Health Services, Dentistry and Primary Care

Non-Executive Director and People, Leadership & Culture Committee Chair

Chief Finance Officer

Chief Executive Officer

Non-Executive Director and Audit & Risk Committee Chair

In Attendance:

Jo Faulkner (**JF**)

Katrina Anderson (**KA**)

John Upham (**JU**)

Benjamin Cahill (**BC**)

Simon Cook (**SC**)

Jane Little (**JL**)

Peter Milliken (**PM**)

Osa Udoh (**OU**)

Jeremy Philpot (**JP**)

Alison Gordon (**AG**)

Head of Forensic Services

Service Director Oxon & BSW Mental Health

Sustainability Manager

Deputy Director of Corporate Affairs

Warneford Park Programme Director (Cherwell Consulting)

Head of Procurement

Director of Finance

Assistant Director of Financial Operations

Director of Estates and Facilities

Deputy Director of Finance

Governor Observers:

Juliet Hunter

Public: Oxfordshire

Post-meeting review:

Maria Nikolaou

Interim Corporate Governance Officer (Minutes)

Apologies:

Andrea Young

Non-Executive Director

1.	Welcome and Apologies for Absence	Actions
a	LW welcomed everybody to the meeting and introduced the new Audit & Risk Committee Chair, Harjit Sandhu.	
2.	Chief Finance Officer's report including: Internal Audit Review – OPS Counter Fraud	
a	HeS went through the report and highlighted that: the anticipated revenue forecast had been achieved, along with a larger surplus due to additional national deficit support funding. However, there had been challenges with forecasting of capital spend. Further to a request from LW, HeS agreed to bring an update to the next meeting in July 2026 on Estates capital spend/review of lessons learned and Capital Programme Sub-Group assurance.	HES
b	The Committee noted the report.	
3.	Annual Plan and Financial Planning including: Revenue and Capital financial planning update including FY26/27; and Cost Improvement Programme (CIP)	
a	AB set out that in terms of our annual plan for this year, the financial position will not change drastically, and we are planning to bring the plan before publication to the Board in May. There is still some work ongoing with the ICB to allocate some money that was left as part of the innovation fund. We are looking to start the allocation for next year early on because we have the amount of funding. We do not have confirmation of the timetable for next year from NHS England yet. We will start planning to work towards the September timeframe, which would enable us to align with our new strategy and our new strategy delivery plan.	
b	PM went through the presentation and pointed out that the Capital plan was presented for the Committee to approve. The revenue part had already been submitted, and it went through Board. A lot of the schemes had moved into the fully developed and signed off stage. The plans were in place to deliver and budget moves and the Quality Impact Assessments (QIA) will have been signed off. With regards to CIP development, we are at the top end in comparison to the other providers in our Integrated Care System and region.	
c	On temporary staffing, we should not have any significant issues in achieving our agency plans for this year. We need to go back to NHS England with a plan by the 30th of June 2026.	
d	With regards to the Equality Impact Assessment, the criteria are included in the QIA policy.	
e	Misalignment gap technically exists but can be resolved through the Innovation Fund. It does not create an issue in terms of delivering the plan because we have an agreed finance schedule with our Integrated Care Board.	
f	LW expressed concern that, with regards to digital spend, adjustments may need to be made to increase investment as £2.5 million capital was 0.3% of our revenue spend and very low especially if we are seeking to transform our digital offer.	

g	HeS explained that most of our IT spend needs to be in revenue. In phase two, we should check whether we have secured enough through the capital and revenue bidding processes to achieve the right level of digital investment. It is an area where we can be flexible and aligns with our discussion at the previous meeting about the digital strategy.	
h	PM drew the meeting's attention back to the operational capital plan which needed to be agreed. Constitutional standards for mental health and community were still going through sign off with NHS England. We should get one of the two community schemes we have bid for. Our operational capital is a baseline of between £10-11 million each year; including the surplus it is £12 million. PM pointed out that it was less risky to over programme as some capital could be pulled forward if needed.	
i	The Committee APPROVED the £11 million in phase 1 and approved the approach to phase 1 and phase 2.	
j	With regards to the Mental Health Investment Standard (MHIS) proposals, RB confirmed that there were three areas of spend for improvements, in particular Community Waiting Times, Assertive Outreach/Intensive Case Management (ICM) and Urgent Care pathways improvement. LW asked for clarification on how success would be measured against these investments. HeS and AB informed the committee that investment justifications were being developed that would give an overview on performance and workforce expectations. AB added that as an organisation we need to build a culture of tracking the impact of investments in a more systematic way.	
k	LW acknowledged the positive culture change that had happened around CIPs and noted that the next stage was how to frame CIPs and set the principles for making them sustainable in the future within the organisation.	
4.	M12 Financial Report (including Capital Programme Group 3As)	
a	PM commented that the surplus had increased in Month 12 up to £9.7 million, further to £4.9 million of national deficit support funding from NHS England which was made available to providers who had met their target plan.	
b	The Committee noted the report.	
5.	National Cost Collection pre-submission assurance report	
a	HeS commented that national cost collections were becoming an important part of the NHS management framework, particularly as they would drive productivity analysis. Productivity was a key part of making sure that the funding regime had the right incentives going forward. It was also one of our strategic dashboard indicators around our national cost collection comparator and the aim was to get back to a score of 100 which would mean that our costs were in the average or below 100. The paper set out the process to complete and provide the national cost collection data to the right timetable.	

b	HeS pointed out that we can deliver the data to the quality standard required but it was important to understand how we use that data and how we embed that in our management of the organisation day-to-day.	
c	The Committee agreed that it was important to identify the learning outcomes of this process and the value for our organisation. HeS mentioned the report was very well scrutinised to ensure that it included all the costs of the organisation. Financially it aligned directly with our total expenditure. With regards to the query on how to embed what this data was telling us into the culture of the organisation and how we use it in decision making, HeS suggested to have the data more available to senior leadership teams to get more familiar with it and understand the differences between fully costed and budgeted data and indirect and overhead costs and how they are related to activity levels.	
d	The Committee APPROVED the report and noted that a more detailed report regarding the submission would be available once the submission was finalised and the national results published.	
6.	Longer term trends/impact on resource allocation from overspends in Inpatient services and underspends in Community services (in particular Children & Young People)	
a	EL introduced the report and emphasised that it provided focus on management of budgets and performance across the directorate, and that there was now real clarity around the budget for children's services. She commented upon the positive trajectory and positive recruitment into services.	
b	LW commented that she had found the paper very helpful, with the kind of analysis that would be helpful to receive in financial reporting and also demonstrated that issues had already been addressed and the directorate was using the information provided in order to drive improvement programmes.	
c	RB commented upon offsetting inpatient overspend (often driven by patient acuity) with community underspend and explained that work was taking place across both mental health directorates to address inpatient overspends but, due to patient acuity, it may reoccur.	
d	The Committee noted the report.	
7.	Annual Accounts update	
a	PM commented that the accounts and the analytical review had been reviewed in detail at the Audit & Risk Committee meeting on 23 April 2026.	
b	Harjit Sandhu confirmed that the Audit & Risk Committee had reviewed the accounts and supporting documentation in detail. External Audit providers had identified some of the same risks as last year but there were no concerns from the Audit & Risk Committee about either the process or where we might end up. There remained uncertainty about the timing of the Private Finance Initiative (PFI) exit payment (the same paper which the Audit & Risk Committee had received was also on the agenda for this meeting).	
c	He added that the confidential External Audit tender was nearing completion, subject to approval by the Council of Governors.	
d	The Committee noted the report	

8. a b	Private Finance Initiative (PFI) Exit payment and impact on FY26 and FY27 PM explained that the recommendation for the paper was that it was for assurance only not for approval and that it had already been reviewed by the Audit & Risk Committee and the accounting treatment considered. The paper set out the two valuations and the difference between them. Discussions were also taking place with NHS England about covering any capital impact so it will not impact directly onto our capital plan. The Committee noted the report.	
9. a b c d e f g h	Board Assurance Framework (BAF) - deep dive into risk A7 on Environmental Sustainability, Green Plan update and Internal Audit review into Risk Management <i>BAF risk A7 (Environmental Sustainability) and Green Plan/Sustainability programme update</i> HeS welcomed JU who was supporting the deep dive into risk A7 on Environmental Sustainability and the separate paper on the Green Plan/Sustainability programme update, noting that the Green Plan paper provided assurance as to activity taking place against the Green Plan and steps being taken to reduce carbon emissions. AB informed the committee that the new Trust Strategy identified the Green Plan as one of our key strategic foundations and it would be included in the Strategy Delivery Plan, with consideration to be given to the level of ambition and commitment to apply to it. JU added that it was essential to reduce our energy demands across the estate in order to reduce not only the carbon footprint but also costs across the estate. Further to discussion, HeS noted that there would be more work to do to develop the wording of the BAF risk and explain in more detail some of the actions which needed to be put in place in order to manage the risk as a whole, including reducing business mileage, heat decarbonisation and other environmental improvements covered through the Estates Strategy and which could also be set out through an annual report against the Green Plan. JU informed the committee that a presentation would be taken to the Executive meeting next week on a five-year programme setting out where we are at the moment and where we want to get to by 2031 in terms of carbon reduction and how we get there across four pillars: travel and transport; estates and facilities; supply chain; and clinical transformation. HeS added that the direct admissions trajectory was in the strategic dashboard and scorecard and there will be the six-monthly update on that soon. With regards to clinical engagement, a lead for clinical environmental sustainability had been named and there was good clinical engagement but each directorate tended to send different clinical leads at different times, rather than providing a sustained approach. <i>Internal Audit review into Risk Management</i> With regards to the Internal Audit review into Risk Management (BAF), TG confirmed that it had been reviewed by the Audit & Risk Committee and noted that it had highlighted potential lack of consistency across committees in how BAF risks were reviewed and the amount of time committees were allotting to doing so. TG and BC were leading on the recommendations from the Internal Audit review. The Committee noted the reports and the progress being made against the Green Plan.	

10.	Summary of programmes and project approvals	
a	The Committee took the report as read.	
11.	Warneford Park Programme: programme budget and deep dive (procurement and commercial)	
a	SC took the committee through the deep dive on procurement and tax, which would increasingly become the next focus of activity (after planning and funding considerations). He commented upon the potential benefits of using the same contractor across the hospital, research building and the link building for economies of scale and timeliness. Next stages would involve the joint venture parties jointly procuring a development advisor, developing a procurement strategy and obtaining agreement to it from NHS England as part of the outline business case. The involvement of other parties would mean that this would not be a standard NHS procurement exercise and the team would require some additional resources in order to prepare for procurement. If approval to proceed to procurement was obtained then procurement itself could commence at the start of 2028.	
b	The next step was to prepare a paper with the joint venture (currently being developed), which would be shared with NHS England this month to seek approval before appointing a development advisor jointly between the parties.	
c	Further to support from the meeting around joint procurement, HeS invited thoughts for inclusion in the development of the procurement strategy. The meeting discussed: • appreciating that a joint approach may reduce flexibility in some areas and it would be important to understand the trade-offs in taking such an approach; and • taking third party advice to understand risks, options, mitigations and potential dispute resolution.	
d	SC took the meeting through the VAT implications of: (i) a managed health facility but noted that these were not currently supported by NHS England further to concerns about the implications of transferring staff; and (ii) Relevant Residential Purpose (RRP) buildings.	
e	LW summarised that the committee was broadly supportive and understood that there would be negotiations with NHS England so as to be clear on the range of appropriate options to consider.	
f	Further to discussion on the terms of the Conditional Options Agreement (COA) LW commented that the Trust had a duty to demonstrate that it was dealing with public assets appropriately and obtaining maximum value for healthcare purposes.	
g	SC took the meeting through the clinical space utilisation review in the report. RB confirmed that there was a process to work out clinical space utilisation, including how the Warneford could also serve the local neighbourhood population and taking into account transport challenges. LW noted that this could be discussed further during one of the scheduled deep dives into the Warneford project.	
h	With regards to the committee giving approval for delegating the budget HeS advised that the committee had previously approved this but Board approval was awaited.	
i	The Committee noted the report and progress being made. A further update was anticipated as part of regular reporting to the next meeting in July 2026.	

13.	Business cases for High Dependency Units (HDUs) (annexes in Reading Room)	
a	JP introduced the business cases and attending teams for: (i) the Swindon HDU (Katrina Anderson); and (ii) Kennet Ward HDU (Jo Faulkner for Jude Deacon).	
b	JP explained that these projects were supposed to start last year on site but had been delayed further to factors including additional planning requirements. Approval was now sought for both projects so that contractors could be appointed and delivery commenced.	
c	Further to queries from the Committee, JF and KA provided detail on the improvements recommended to the environments and the patient benefits.	
d	The Committee APPROVED the business cases for the Swindon HDU and the Kennet Ward HDU.	
14.	Procurement and Supply Chain Resilience report including Single Action Tender Waivers (SATWs)	
a	JL confirmed that the 'no Purchase Order (PO)/no pay' policy had been implemented across the Trust. The initial impact had been an increase in manual requisitions via the Operations team but this was being managed with no significant issues.	
b	The Committee noted the report.	
15.	Information Management Group (IMG) 3As update	
a	TG highlighted: (i) retention process; and (ii) governance (noting the need for clarity on robustness of systems and compliance with records retention and destruction requirements). He confirmed that there was confidence around the controls in place to ensure appropriate access to patient records and to investigate and act on any breaches.	
b	LW referred to the Reading Room and commented positively upon: (i) the outcome of the Internal Audit review into the Data Security & Protection Toolkit; and (ii) the Cyber Risk Report.	
c	The Committee noted the report and the supporting information in the Reading Room (IMG agenda, Internal Audit review into the Data Security & Protection Toolkit and the Cyber Risk report).	
16.	Minutes of FIC Meeting held on 17 March 2026	
a	Accepted as accurate but with a comment that the Digital Strategy areas for action were too narrow and too functionally specific. There was a mismatch between having a Digital Strategy which was Trust-wide but which described activity which sat within a relatively small team within the Trust. A similar mismatch should also be prevented in the Estates Strategy.	
17.	Actions and Matters Arising They were accepted as clearly described and in progress.	
18.	AOB None	

19.	Brief reflections on today's meeting None	
	Meeting Close: 12:38 Date of next meeting: 14th July 2026, 09:30 – 12:00, MS Teams	

Meeting of the Finance and Investment Committee

Tuesday, 14 July 2026, 09:30-12:30

Hybrid: Ascot Room, Trust HQ, Littlemore Mental Health Centre, Oxford, OX4 4XN
and Microsoft Teams

AGENDA

Apologies to: Maria Nikolaou, Interim Corporate Governance Officer: Maria.Nikolaou@oxfordhealth.nhs.uk

No.	Item	Lead	Purpose	Paper	Time
Welcome and opening items					
1.	Apologies for Absence and quoracy check ¹	LW		N/A	09:30
2.	Chief Finance Officer's report including: Private Finance Initiative (PFI) exit payment and impact on FY27	HeS	Information & Assurance	Enclosed	
Programmes, Projects and Governance					
3.	Summary of programmes and project approvals	HeS	Assurance	Enclosed	
4.	'Our Central Support and Corporate Services' (OCSCS) project (Enabler 2)	HeS/ Lindsay Fenn/ Rachel Garnett	Information	Enclosed	09:45
5.	Information Management Group (IMG) 3As update	TG	Information & Assurance	Enclosed	10:00
6.	Senior Information Risk Owner (SIRO) annual report	TG	Information & Assurance	Enclosed	
Strategic and Operational Risks					
7.	Board Assurance Framework (BAF): a) deep dive into risk A11 - Infrastructure²; and b) Estates & Facilities update to the Audit & Risk Committee	HeS/DB/ (JP)/ BC/TG	Information & Assurance	Enclosed	10:15

¹ Apologies from Committee members: Rob Bale, Chief Operating Officer for Mental Health & Learning Disability; and Mohinder Sawhney, Non-Executive Director. Joining from 10:15 – Andrea Young, Trust Chair.

Apologies from regular attendees: Jeremy Philpot, Director of Estates & Facilities (Daren Baines, Interim Head of Estates, and Wayne Heal, Head of Property Services, attending for Jeremy Philpot)

² FIC has oversight of 5 BAF risks: A3 – Financial sustainability; A7 – Environmental sustainability; A8 – Information & Data; A10 – Digital transformation; and A11 – Infrastructure

8.	Annual Plan and Financial Planning update including: - Revenue and Capital financial planning update including FY26/27; - Cost Improvement Programme; and - Q1/Phase 2 funding allocations	AB/HeS HeS/ PM	Discussion, Information & Assurance	Enclosed	10:30
9.	Month 2 reporting: a) Financial Report including Capital Programme Group 3As; and b) Productivity Report	HeS/PM/ AG	Assurance	Enclosed	10:50
10.	Costing analysis: - National Cost Collection FY25/26 final submission report; and - Service Line FY25/26 report	HeS/PM	Approval & Information	Enclosed	11:05

10 minutes' break 11:20-11:30

Strategic

11.	Value & Financial Sustainability Strategy (Draft)	HeS/PM/ AG	Discussion & Information	Enclosed	11:30
12.	Warneford Park Programme: - update; and - deep dive into Design, Space Utilisation, Location of Functions and Clinical Vision	HeS/SC	Decision & Information	Enclosed	11:55

Governance

13.	Minutes of FIC Meeting held on 05 May 2026	LW	Approval	Enclosed	12:20
14.	Actions and Matters Arising	LW	Assurance	Enclosed	
15.	Any other business	LW			12:25
16.	Brief reflections on today's meeting	All			
	Close				12:30
	Date of next meeting – 15 September 2026				

READING ROOM/APPENDIX

Supporting reports to be taken as read and noted

17.	Warneford Park Internal Programme Board minutes and agendas: May-July 2026	HeS/SC	To note	Enclosed	

**MINUTES of the Mental Health & Law Committee meeting held on
Tuesday 03 May 2026 at 09:00 hrs via Microsoft Teams**

Present:¹	
Geraldine Cumberbatch (GC)	The Chair
Karl Marlowe (KM)	Chief Medical Officer
Taff Gidi (TG)	Executive Director of Corporate Affairs
Rob Bale (RB)	Chief Operating Officer for Mental Health and Learning Disabilities

In attendance:	
Mark Underwood (MU)	Head of Information Governance
Amy Allen (AA)	Mental Capacity Act/Liberty Protection Safeguards Lead
Daniel Mercier (DM)	Associate Director of Social Work and Social Care
Brian Averyard (BA)	Risk Assurance & Compliance Manager
Onyeka Ogundiran (OO)	Lead Infection Prevention & Control Nurse
Leanne Dunkley (LCD)	Corporate Governance Officer

Item	Discussion	Action
1.	Welcome and Apologies for Absence (GC)	
a	The Chair welcomed members of the Committee and confirmed the meeting was quorate.	
b	Apologies were received from: Angie Fletcher, Deputy Chief Nurse.	
2.	Minutes of previous meeting held on 03 March 2026 and Matters Arising	
a	The minutes of the meeting held on 03 March 2026 were approved as a true and accurate record.	
b	Matters Arising from the minutes The Chair confirmed there were no outstanding matters arising from the minutes.	
3.	Trends in Mental Health Act and CQC activity/compliance	
a	The Head of Information Governance took the committee through the presentation at paper 03, which included updates on: (i) risks; (ii) Hospital Managers; (iii) number of detained patients; (iv) Hospital Managers hearings and Tribunals; (v) The Mental Health Act (MHA), Mental Capacity Act (MCA) group; (vi) training and education; (vii) Section 17 leave and Consent to Treatment; (viii) Section 135 & 136, Place of Safety; (ix) Statutory compliance; and (x) Equality impact.	

¹ Please note the updated Committee membership in the Terms of Reference.

b	The Committee discussed the 51 lapses in section 2 detentions, which are not unlawful. There is a reminder system in place from the Mental Health Office and there is now a dashboard in RIO, which allows staff with access to keep tabs on the dates of detention. This has been brought into greater focus following the CQC visit to the adolescent wards last year, as it is not respectful of the least restriction principle. When a decision is made not to detain an individual then it requires a form to be completed to that discharges them from the detention. Possible solutions were then discussed, including the use of incident reporting, increased awareness, training and reviewing and addressing each one as it arises. It would be good to see this improve as it is a quality metric, so it would be meaningful to have an increased focus on this area. The Committee discussed whether there were any patterns or trends to this or whether there was an area that required greater focus. It was agreed to take this discussion offline and compare to similar trusts across the country through the Forums the Trust participates in. The Committee debated the likely reasons that these lapses occur, including ignoring reminders, cultural behaviour that this is acceptable, and delays in decisions about detention being made. It was agreed that the next report would include further analysis about why these lapses are occurring, rather than just the number of lapses, to provide greater context as this appears to be a continual issue to help identify what can be done and what is outside of the Trusts control.	
c	The Head of Information Governance noted that as of yesterday there were 143 CTO's, which after reducing over the past year or so has increased again, which is likely due to the clients and changes in staff and attitudes. The highest concentration of detained individual's is in the areas of greatest urban deprivation.	
d	The Committee discussed the managers hearings, where there continues to be cancellations or delays in these going ahead including the reasons for this and how this can be reduced, as this affects the patient experience and quality of care. It was agreed that further insight into the reasons for cancellations/delays would be included for the next round of reporting, whether these relate to capacity/ diary clashes or whether a tribunal happens on the same day as the managers hearing was going to be.	
e	In terms of training the Committee discussed that the reduction in the target from 95% to 90%, which could result in 10% of the staff may not have done their training, the rationale for the reduction is not clear and it was agreed that a response would be provided at the next meeting. It was noted that Research and Development are the outlier for training, behind all other areas and it is not clear why, with 34 people requiring training, and agreed to review this for the next update as staff have asked whether they need to do this as not all are patient facing.	
f	The Head of Information Governance escalated that there continues to be an issue with the availability of Second Opinion Appointed Doctors (SOAD), with 36 outstanding, one dating back to November. The Trust	

	continues to challenge this and has mitigations in place including the use of section 62 and section 64 to provide urgent treatment. In terms of overdue CQC actions, there are currently 2 which are in hand. This will increase once the Trust responds to the review of adolescent services last year.	
g	The Committee discussed the numbers of ethnic categories detained and noted a steady increase in those detained from Pakistani origin, which is greater than in seen in the other ethnic groups. The recording of ethnic group continues to improve as part of the work of PCREF.	
h	The duration of detention was highlighted, noting that there is difference between duration for Men and Women, with some long periods of detention forensic services, with men being detained twice as long. There is an X group listed, which are those individuals who do not identify as male or female.	
i	The Committee discussed the recent changes in the legislation to do with deprivation and that it will potentially be next year before the rest of the significant changes in legislation to be implemented. A draft proposal of what these legislation changes will look like is awaited, which has not been changed since 2007. It is hoped that these changes will reduce the number of people detained. Whilst the proposals are awaited, it was suggested the Trust consider undertaking a maturity exercise to consider what changes are impacted by the transformation work that is underway and what may want to be brought forward. It was highlighted that in Buckinghamshire the IMHA service has had changes to its commissioning arrangements to expand provision to informal patients, which all local authorities are now looking to do in preparation for some of the proposed changes, along with an open access opt out model. This has had a positive impact in terms of quality and patient voice. The proposed legislation changes in the act could have a significant impact on the way in which the Trust operates, however there are still questions as to how all this will be funded and commissioned.	
j	The Chief Medical Officer highlighted that he was not aware of the old section 5 CPI, which is called the insanity and unfitness to Plead act, which is no longer being used, following changes to the law removing insanity laws. There are a few patients detained under this legacy part of the court system. He then noted the significant number of people who are detained as a place of safety, with 4 out of 6 not being detained. This needs to be fed back to the system, as this is an outlier. He then discussed that under section 136 there is no appeal system like the rest of the mental health act, which is significant when four out of six people being picked up are not detained. In terms of the legislative changes, it is likely that there will be a need to work to a higher threshold for detention, which is likely to cause much debate. It is likely that serious harm will be a threshold, which is worthwhile considering now in terms of current investigations and inquiries, which suggest the threshold is too high.	

k	The Committee discussed the Section 136 and the Police and Crime Act 2017, which introduced a clause that required the police to consult with a mental health professional that the section 136 exercise of the power was appropriate. In Thames Valley approximately 40% do consult with a mental health professional, however there is massive variation across the different patches. This is important from a civil liberties point of view, and there needs to be a focus on the system to increase this towards the 80-90%, which would provide assurance that the power is being used appropriately. The Trust has the clinicians available to consult, so there needs to be further understanding of why this is not being used and what are the barriers the Police are facing. It was noted that the police get very little training around mental health act and mental capacity act about how to use and deploy this power. It requires a whole system challenge to get to the bottom of it. It was noted that it would be useful to compare this with different areas. It would be worth considering how the Trust compares with the rest of Thames Valley in terms of conversion rates. There needs to be a meaningful space to consider this from both an operation and patients' rights perspective. This would link with the mental health A&E considerations, as if these were available would half of these people go there instead? The Executive Director of Corporate Affairs asked the Head of Information Governance to take this forward. He then notes that this needs to stay in the thinking so that it does not come as a surprise and needs to be built into the planning for 2027/2028/2029 where the Trust may need to consider changes in resources for the future.	
l	ACTIONS: 1. A discussion offline regarding the trends in lapses in detention and comparison with other trusts; 2. Further analysis of why lapses in detention are occurring to be included for the next report; 3. Further insights into cancellations/ delays in managers hearings to be included for the next report; 4. Summary report detailing the rationale for the reduction in training targets for Mental Health Act/ Mental Capacity Act; and 5. Review of the Research and Development services training figures as they are an outlier. The Chair summarised that the report highlights so much that needs to be kept in mind, not just for the present but for the months and years to come.	RB/MU MU MU TG/CD AA/MU
4.	Patient Carer Race Equality Framework (PCREF) and workplans for the year.	
a	The Associate Director for Social Work and Social Care took the Committee through the report, noting the key highlights and escalations to the group. He highlighted that the four joint management groups have now been set up, which are meeting monthly. These are local manifestations of PCREF, which has supported embedding PCREF into teams and services. They have good plans to engage with local organisations both existing partnerships and new partnerships, which feels very productive. As mentioned in the previous report the recording	

	of ethnicity data continues to increase by 0.3% each month and teams are now discussing the need to capture this data and what it means in terms of personalised and culturally appropriate care for people. He then went on to discuss the next steps including the anti-racism statement, which is now awaiting Board sign off before being published, which will be PCREF aligned. The challenge of PRCEF has been aligning it with the various equality agendas making sure that they are not competing for space. The ICB have a significant role in their equalities remit for overseeing this and in terms of their emerging role in strategic commissioning, they are going to need to be PCREF aligned when it comes to commissioning culturally appropriate services. A national framework has been developed, and the Trust are leading in terms of contributions to that process, which should be delivered in quarter 3. This will impact how the Trust plans and strategies and consider how we will be held to account over PCREF.	
b	In relation to ethnicity data, this is linking with the around inequalities to ensure that there is alignment in directorates for the data. It is planned that a deep dive looking at section 136 through an ethnicity lens. This will be a retrospective look over the past financial year of the use of the Mental health act of a section 2 section 3 and section 136. This will be considered at service level, which will be contextualised against local data. It is planned that this will be completed by quarter 2.	
c	The Chief Medical Officer noted that this has really gained momentum, and staff are really engaging with it. He then asked how the Trust gets a patient's voice and lived experience of people who have been detained and suggested the Recovery College for co-production. The associate Director of Social Work and Social Care noted that this was the plan to invite them to the PCREF board. There has been input from some expert by experience who have helped co-chair and co-govern the arrangement, however the next step is to really hear the voices of diverse people with lived experience, which will be the focus over the next quarter.	
e	The Chair noted that this is very comprehensive report and demonstrates the work taking place to embed this across the organisation.	
	The Committee noted the update	
5.	Deprivation of Liberties (DoLs)/ Mental Capacity Act/ Supreme Court Ruling Update report	
a	The Mental Capacity Act/ Liberty Protection Safeguarding Lead took the report as read noting the key highlights to the Committee. She noted that in terms of training, she has linked with the patient safety team about training. A webinar for the Trust on the MCA and when patient safety incidents pick up recommendations about mental capacity act. There is a session arranged to do a recording of how to use the Mental Capacity Act form on RIO. In relation to medical staff training, there has been lots of work taking place with the medical education team to ensure their records are accurate, which they are now achieving 73% which compared with a few quarters ago is a huge jump. The safeguarding training is being	

	promoted as well for these doctors, which means the Trust is on the right trajectory in terms of medical staff training which has been a concern previously.	
b	Currently there is one section 49 report, which is working well and there are a couple of open court protection proceeding taking place, which staff are really engaged with.	
c	The number of days delay between making the application for DoLs request and the patient being discharged has reduced significantly. There has been an increase in DoL's requests from inpatient wards. This is patients on older adult wards who are still there but do not need to be detained from the section 3 any longer. The Chair asked in relation to the local authority delays in processing DoL requests, whether this was a national issue or a local resource issue and whether there is anything the Trust can do to improve and challenge this? It was confirmed that this is the national picture and the local picture reflects this and is a national resource issue. The Trust are meeting with the local authority weekly to escalate cases to push them through. In Oxfordshire the Safe Young Adults Board are looking at DoLs data. The Performance, Information, Quality and Assurance (PICA) are looking to add DoLs data to some of the local authority work in the DoL's arena. There are number of Social Workers in Oxfordshire who are best interest assessor trained and are planning to get these social workers completing assessments in community hospitals. Which would help reduce numbers and ensure assessments get completed. The Chief Medical Officer highlighted that DoL's and the Mental Health Act legislation, there are areas that are not fit for purpose and there is change needed here. The Chair agreed with this and noted it will likely require something drastically bad to happen until changes are made. There is a reactive hold at present, and these things are not currently receiving the resource and attention required. It was highlighted that the number of DoLs is higher in the acute sector compared to Oxford Health where the majority come from care homes, which is risk for them to hold as they are restricting patient s liberties in greater way. The Chair noted that the annual statistics show that 50% of applications are closed without any assessments as the majority were adults aged 85 and above, which could mean they pass away before the application is dealt with.	
d	There is no update on the LPS consultation or from the Supreme Court at present. The code of practice is currently being refreshed. Within the report a couple of key case law developments have been included. The Townsend case was discussed which suggests that any clinical decision regarding incapacitated adults need to make to a best interest lens which is shift, as previously only clinically appropriate options would be put forward, however the court is saying that every available option must go through best interest lens. This is currently being appealed through the Supreme Court.	
e	Further information regarding the supervised discharges and deprivation of liberty, which is the only change that has happened with the Mental	

	Capacity Act is detailed in the report. In terms of the terminally ill adults bill, it has stalled, which is quite significant in terms of capacity legislation. The Executive Director of Corporate Affairs noted that it is useful to see case law, and the legal principles underneath it and how it may affect how care is delivered. The Chair noted that case law is important in terms of the lens through which practitioners take their approach and noted that she is not surprised it is being appealed as it could have massive implications. She then asked in terms of the impact of decisions like this what is the cascading method to ensure that medics are appraised of the current situation and position. It was noted that the training slides are updated to reflect any significant case law, to ensure training is up to date and noted that a briefing note would be a good idea to provide those real time updates. The Chief Medical Officer added that the majority of doctors involved in this will be doing it under private practice, instructed by solicitors for a view or expert opinion, rather than routine day to day work. This is done through the medial legal group, however supported that updates would be beneficial but not to all consultants.	
f	The Chair summarised that this is comprehensive report and it is good to see the training figures increasing following the work that has been put in and it is a good example of identifying a concern and having a focus on it to improve the situation and close the circle.	
6.	Independent Mental Health Advocacy & Independent Mental Capacity Advocacy updates	
a	The Associate Director for Social Work and Social Care took the report as read, noting the key highlights to the Committee. It was noted that Buckinghamshire has strong performance in terms of referrals and number of them in cases taken on at 136 cases taken on for the last quarter. This is based on the continuation of the open access opt out model, with a significant number of informal cases which is positive to see. There will be a focus on the what the advocates are providing for this group of patients, so that some standards of what might be helpful can be provided. The Matrons and Commissioners have been pivotal in seeing this increase over the past year. The rate of uptake for IMHA for CTO remains low, which the Trust will continue to push. In Oxfordshire there have been 8 children and young people referrals which is a small increase which is significant as the opt out process for children and young people in Oxfordshire is being embedded, with partial success, due to some process issues that the ward and provider need to pin down. At present the data from Oxfordshire is fairly crude and a better breakdown of who is using the service has been requested. There is an underusage of IMHA in people who are subject to LTS or other restrictions so there is a push via the Trust Wide IMHA group to Matrons to ensure that they are considering involving IMHA's and have them as part of MDT reviews and care plan development.	
b	The Chief Operating Officer for Mental Health and Learning Disability confirmed that the Buckinghamshire service covers Milton Keynes and noted that considering the CMAHs reference there is a Children's ward in Swindon which would be an important service to engage with, along with	

c	the eating disorder ward in Wiltshire. The Associate Director of Social Work and Social Care noted that he had recently met with the Commissioners in Swindon and Wiltshire to discuss the need to develop an opt out system. Swindon are slightly nervous regarding capacity but have committed to thinking with Marlborough House as to how to do this. There are small numbers of people detained in Wiltshire, so it is still early in its consideration there. The Trust will ensure that this stays on their agenda. The Chief Medical Officer noted that this is brilliant work, as a year ago patients were not getting advocacy. The Committee noted the update	
7.	'True for Us' reports and Legal & Regulatory update: a The Executive Director of Corporate Affairs noted there were no updates for the Committee to be aware of currently. b The Chief Medical Officer noted that the CQC have recently published the report on the Trusts Children's services, where there were concerns about advocacy and process of care planning, which actions are already being addressed. This was also reported in the BBC last week. The Committee noted the update.	
8.	Trust Risk Register a The Risk, Assurance and Compliance Manager took the Committee through the register, noting that the Committee has one risk which is the Mental Health Act Code, which is waiting for a final review by government. It is low level risk for monitoring at present. There are two associated risks relating to other risk registers, which is 1026; the inability to report on nationally and locally mandated patient information following the adoption of the new clinical system. This is scored at 12 currently and there are no live migrations in pace for this. The second one is reporting on waiting list times, which is in progress at present as the systems have been changed. Although this sits with the IT department, it does have an impact as it could be something that we have to report on. The breach of section 15 of the Mental Health Act was also noted, which is the Trusts inability to correct mistakes on applications within a limited timeframe and has been brought here for consideration for inclusion to the Committee's risk register. it would be worth keeping on the register from a risk perspective, because it relates to something if does not get resolved, it could lead to the Trust losing out as on average there are 80 cases that are outside the scrutiny timeframe. The Head of Information Governance noted that there are mitigations in place, however at present this is reliant on people volunteering to do it currently and requires a longer-term successor plan. The Chair asked what are the steps to get a successor? As if a decision is challenged, there is going to be a question about what scrutiny there is, which the Trust is exposed in this regard at present and this needs to be resolved as soon as possible. It was noted that pleas have been made through the medical advisory committee and clinical directors along with	

	escalation to Executives. There is someone willing to do it, however due to the workload, they are not prepared to do this alone. There is a need to find someone else. The Chief Medical Officer has also volunteered to and is happy to start working on this as soon as possible. It would be helpful if the advice that comes from the Mental Capacity Act Office as a headline to each of those scrutiny papers would be helpful. He is happy to go through this on a weekly basis to review the numbers and develop a solution. The Executive Director for Mental Health and Learning Disability also agreed to work with the Chief Medical Officer to catch up on these and work with directorates to take this on board and get into a routine.	
b	The Committee noted the update and agreed to add this to the risk register until there is a clear direction, with the holding actions to ensure that it is recorded and provides assurance that this is being addressed.	
9.	Annual Committee Effectiveness Review	
a	The Executive Director of Corporate affairs took the report as read, noting that this is an opportunity for the Committee to reflect on how is doing any areas where things could be done differently and improve. The Committee has been on a maturity journey, with improvements in reporting and conversations. There have been good improvements over the past twelve months. The Chair commented that over the past 18 months the Committee has developed well and considering the Risk register, things are being picked up and are considering practical issues to tie of risks. The Committee probably provides one of the most accurate windows into the day-to-day work of the Trust and agreed that the standard of reports has improved. Moving forward she noted that she would want the report to the Board to take on a slightly different format to feedback more holistically about the discussions and work taking place. The members not feeling their skills are used to the maximum was highlighted and the Committee members were asked if they had suggestions as to how to utilize skills better, noting that reviews like this are useful to consider how to stretch the boundaries of the Committee to make it more fruitful and purposeful. The Executive Director of Corporate Affairs noted that Committee's like this rely on the experts directing the energy and focus is right and ensuring the right things are on the agenda. He noted that the Board has had a conversations of the overall effectiveness of all the committees in April, which has highlighted additional work to do around the role of all the committees together to ensure that there is cross alignment and that the right things are being looked at in the right committee. This will be a cycle of continuous improvement and learning.	
b	The Chief Operating Officer for Mental Health and Learning disability agreed that the Committee has improved, however noted that it is a small Committee in terms of members who are having those conversations and questioned whether the profile of the Committee needs raising, especially in light of changing legislation, PCREF and use of force act, the role of this Committee is to protect people's rights and ensuring that the protection is being administered in the right way. The conversations today	

c	have demonstrated there are differences between how different areas operate, using the IMHA requests as an example. The Chair supported this noting that it links with her earlier point about how to report to Board what is actually happening. The Executive Director for Corporate Affairs added that there is a need to increase the Non-Executive Director membership, which was supported by the Chair, as although a smaller Committee it is no less important than the others. The Head of Information Governance noted that on a daily basis 1% of the Trusts caseload is in a mental health unit with some degree of restrictions and this Committee provides an organisational focus on that. ACTION: the Chair and Executive Director of Corporate affairs to discuss offline inviting other Non-Executive Directors to attend the Committee and flag it through the 3A's report to the Board. The Chair summarised that reviews like this are good as it provides the opportunity to stop and reflect on how to do things better.	TG/GG
OTHER BUSINESS		
10. a	Any other business The Chair thanked everyone for their hard work and noted that this Committee will only get better over time.	
11. a	Meeting Review (ALL)	
12. a	Meeting Close There being no other business the meeting closed at 10:52 hrs.	

The next meeting is scheduled to be held on Tuesday 03 March 2026 at 09:00 hrs via Microsoft Teams

Oxford Health NHS Foundation Trust

Mental Health and Law Committee

(Conducted electronically via MS Teams)

09:00 on Tuesday, 07 July 2026

AGENDA

Apologies to: Leanne.dunkley@oxfordhealth.nhs.uk

No.	Item	Lead	Task	Paper	Time
Opening items					
1.	Chair's welcome, apologies and quoracy check ¹	Chair		N/A	09:00
2.	Minutes of meeting held on 12 May 2026 and actions arising. -update on MHA/MCA training	Chair		Enclosed	
Ethical and lawful application of Mental Health legislation					
3.	Trends in Mental Health Act & CQC Activity/Compliance	Mark Underwood	Assurance	Enclosed	09:10
4.	Patient Carer Race Equality Framework (PCREF) report -workplans for the next year	Daniel Mercier	Assurance	Enclosed	09:45
5.	Deprivation of Liberties/ Mental Capacity Act/ update on Supreme Court Ruling	Amy Allen	Assurance	Enclosed	09:55
6.	Positive and Safe Highlight report – Use of Force/ Restrictive Practice update	Kirsty Smith/ Angie Fletcher	Assurance	Enclosed	10:15
7.	Complaints, Compliments and PALS in Mental Health	Claire Price/ Angie Fletcher	Assurance	Enclosed	10:25
Regulatory, Governance & Risk Management					
8.	Legal & Regulatory update.	Taff Gidi / Karl Marlowe	Assurance	verbal	10:35
9.	Independent Mental Health Advocates (IMHA) Service-Human Rights/MCA/MHA issues	Daniel Mercier/ Karl Marlowe	Assurance	verbal	10:45
10.	Any other business	Chair			10:55
	Close				11:00
	Date of next meeting – 20 October 2026				

¹ Apologies from Committee members: [•].
Apologies from regular attendees:

Supporting reports to be taken as read for information and/or to prompt discussion

11.



Oxford Health
NHS Foundation Trust

People Leadership and Culture Committee
Minutes of the meeting held on
Tuesday, 21 April 2026 at 13:30
Whiteleaf Centre (Ground Floor Meeting Room 1), Bierton Road,
Aylesbury, HP20 1EG

Present¹:

Mohinder Sawhney (MS)	Non-Executive Director (Chair)
Geraldine Cumberbatch (GC)	Non-Executive Director (<i>part meeting</i>)
Taff Gidi (TG)	Executive Director of Corporate Affairs
Britta Klinck (BK)	Chief Nurse
Emma Leaver (EL)	Chief Operating Officer for Community Health Services, Dentistry & Primary Care

Deputising for the Chief People Officer:

Nicky Howells (NH)	Deputy People Director

In attendance:

Attending Board members

Grant Macdonald (GM)	Chief Executive Officer

Other Trust staff in attendance

Sigrid Barnes (SB)	Head of HR Systems & Reporting (<i>part meeting</i>)
Jane Blacklock (JB)	Head of Temporary Staffing and Medical Workforce (<i>part meeting</i>)
Jill Castle (JC)	Head of HR - Community & Corporate (<i>part meeting</i>)
Heather Daw (HD)	Head of Medical Workforce and Education (<i>part meeting</i>)
Zoe Moorhouse (ZM)	Interim Head of Organisational Development (OD)
Angela O'Neill (AN)	Senior Clinical Lead for GP Out-Of-Hours and the Minor Injuries Unit (MIU) (<i>part meeting</i>)
Hannah Smith	Assistant Trust Secretary (Minutes)
Jodie Summers (JS)	Head of Service for GP Out-Of-Hours and the MIU (<i>part meeting</i>)

Apologies (Committee members):

Amélie Bages	Executive Director of Strategy & Partnerships
Rob Bale	Chief Operating Officer for Mental Health and Learning Disability
Charmaine De Souza	Chief People Officer
Andrea Young	Trust Chair

¹ Quorum for the Committee is 5 members to include the Committee Chair or Vice Chair, one Non-Executive Director and **at least one Executive Director to be the Chief People Officer or nominated Deputy**. Deputies and other attending Board members will count towards the quorum and attendance rates.

1.	Introductions and apologies	Action
a	The Chair welcomed attendees to the meeting.	
b	Apologies received from Committee members: Amélie Bages (Executive Director of Strategy); Rob Bale, Chief Operating Officer for Mental Health and Learning Disability; Charmaine De Souza (Chief People Officer); and Andrea Young, Trust Chair.	
2.	Declarations of Interest	
a	No interests were declared.	
3.	Minutes of the meeting 21 January 2026	
a	The minutes of the previous meeting were received subject to any comments from the Deputy People Director (who had attended the last meeting for the Chief People Officer who had given apologies for the meeting in January 2026).	
4.	Action tracker and matters arising from the minutes	Corp Gov
a	The Chair took the meeting through the open actions on the log: i. 7(e) Disability to be split into two actions to: (i) consider a deep dive later in the year on disability and reflect upon what may make it hard for staff to talk about and disclose having a disability; and (ii) develop a unified Equality, Diversity & Inclusion (EDI) Plan (the EDI Plan was already anticipated for the July 2026 meeting); ii. 4.i Usefulness of (Personal Development Reviews) PDRs – the Chair commented that although PDR completion rates continued to look good, Staff Survey results suggested that staff were not necessarily finding PDRs to be any more useful than had been reported 3 years ago. Staff Survey results were on the agenda for consideration at this meeting (item 11 below) and she emphasised that PDRs should be useful for staff; iii. 6.j Administrative processes to align leadership development interventions – the Chair noted that this action may be overtaken by the development of the Culture Plan which would include a workstream on leadership development (an item on ‘Developing Our Culture – supporting our people and teams’ was already anticipated for the July 2026 meeting); iv. 11.o Medics’ regime/supervision review/overview (and AC 53/2022 on mandatory training – action to remain open until compliance of 95% reached) – the Chair noted that an update on the national 10 Point Plan for improving resident doctors’ working conditions/resident doctor improvement plan was on the agenda for this meeting (item 10 below). However, the action should remain open as its focus was upon getting a complete picture of statutory and mandatory training across the Trust, including providing the data for medics but without necessarily merging together two different data sets which may not sit together; and v. AC 53/2022 (8a) Mandatory Training – action to remain open until compliance of 95% reached – the Chair acknowledged that resuscitation training had achieved 92% completion but was still not at the target compliance level of 95%.	
5.	Chief People Officer View/Horizon Scanning	
a	The Deputy People Director presented the report and highlighted: • once the NHS England (NHSE) 10 Year Workforce Plan had been published, the Trust’s 2026/27 People Plan would be reviewed and updated accordingly;	

	• HR policies would be updated in line with the first wave of rights coming into force under the Employment Rights Act 2025; • the Chief People Officer was preparing with regional and system colleagues for the first phase go-live of NHSE's Transforming People Services: Target Operating Model; • a number of system improvements had already been delivered in readiness for implementation of NHSE's Future Workforce Solution which would replace the existing Electronic Staff Record system and provide the functionality needed for NHSE's Target Operating Model; • the Medical Training (Prioritisation) Act 2026 was not anticipated to impact Trust-level recruitment. The Chair commented upon the importance of maintaining a watching brief should tensions arise within staff groups. The Head of Medical Workforce & Education noted that the picture around additional training places was evolving but it was for NHSE to implement; and • national guidance was anticipated on the introduction of new Staff Standards under the 10 Year Health Plan.	
b	The Committee noted the report.	
6.	Service deep dive – First Contact and Primary Care GP Out Of Hours (OOH) Service	
a	The Chair welcomed to the meeting the Head of Service for GP OOH and the Minor Injuries Unit (MIU) and the Senior Clinical Lead for GP OOH and the MIU. The Chair introduced the Service deep dive item and invited discussion on thoughts about the GP OOH service, what was going well, opportunities, risks and any gaps in assurance.	
b	The Head of Service highlighted: • workforce actions taken or planned in order to support a sustainable workforce, improve staff experience and engagement and reduce usage of temporary staffing; • response to the Staff Survey results, noting work underway through supervisions and appraisals to understand the results and the response rate; and • workforce engagement underway to understand where increasing leadership visibility could have the most impact and support staff to be able to escalate concerns to a named person at periods of peak demand. The Senior Clinical Lead added that overnight patient flow coordinators had been introduced and consideration was being given to overnight operational manager roles. <i>Geraldine Cumberbatch joined the meeting.</i>	
c	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care commented positively upon the progress made by the GP OOH Service especially further to: (i) work done by the Medical Director for the Community Health Directorate to understand demand and capacity, which had significantly improved ability to predict workforce requirements in order to deliver shifts; and (ii) enhanced scrutiny of patient experience. She, together with the Chief Nurse and the Head of Service, noted the unique challenges faced by this Service in order to support staff who operated outside of normal working hours and may be working additional hours on top of day jobs and conducting urgent home visits to patients they did not know (which also led to staff safety considerations); they explained how this could impact upon, and limit availability for, engaging in the Staff Survey.	
d	The Chair recognised the additional investment put into improving the experiences of patients as well as staff and supported the approach to look in more detail at the Staff Survey results and test the rationale for the low response rate. The Senior Clinical Lead added that a follow-up survey was being prepared which would also include temporary staff. The Head of Service reflected upon the link to actions underway to increase leadership visibility, noting that these may help to improve engagement with surveys.	
e	Further to a query from the Chair, the Chief Executive and the Chief Operating Officer for Community Health Services, Dentistry & Primary Care explained that although other staff in the	

	Trust may also sometimes work outside of normal working hours, in other services they may still be rotating through shifts and part of a regular team for whom time could be set aside to complete the Staff Survey. In the GP OOH Service however, the work and the shifts may be more unpredictable and this may be additional work rather than the primary role for staff.	
f	The Interim Head of OD noted that there were some positive trends in the report and the HR scorecard and that the Service was acting appropriately to understand the Staff Survey results and the response rate. Geraldine Cumberbatch added that the picture was not necessarily a negative one and that this was an unusual service, for which the Staff Survey results represented a snapshot in time. Geraldine Cumberbatch and the Chair acknowledged the positive indicators of: low turnover rate; decreased temporary staffing usage; and high supervision rates (especially given the peripatetic nature of the service), noting that supervision could also become a means to build upon a sense of belonging to a team. The Executive Director of Corporate Affairs added that it was also important to benchmark appropriately when comparing Staff Survey results and understand the context and profile of a particular service and the hours within which it operated.	
g	Further to a query from the Executive Director of Corporate Affairs, the Senior Clinical Lead explained that staff fatigue had been more focused within the back-office operational team in response to periods of increased demand or at peak times for this particular service, such as at the start of the evening shift when there could be an influx from in-hours services which could impact patient flow overnight and result in pressure on the core team to manage urgent overnight needs.	
h	The Chief Executive reflected upon the good progress which the GP OOH Service had made over a number of years, strengthened leadership and development of the service from operating MIUs into delivery of urgent treatment, which also involved dependencies between service lines. The Senior Clinical Lead and the Head of Service commented upon: (i) the integration into the service of the Hospital at Home team, together with some district nurses from daytime teams; and (ii) the alignment of practices required in order to support 24-hour flow work and the avoidance of admission where appropriate.	
i	Further to a query from the Chair on target vacancy rates, the Head of Service confirmed that 18 Whole Time Equivalent GPs would be required to manage patient flow, supported by 6 non-medical clinicians at advanced practice/specialist level. Achieving substantive recruitment remained a challenge.	
j	The Chair summarised that the Committee was assured that the senior leadership team understood the nature of the challenges faced by the GP OOH Service, acknowledged the positive progress which had been made and supported the approach to further understand the Staff Survey results and the response rate. She noted that more work may be required on pathway transformation and workforce skill mix.	
k	The Committee noted the deep dive into the GP OOH Service. <i>The Head of Service and the Senior Clinical Lead for GP OOH and the MIU left the meeting.</i>	
7.	Staff Health & Wellbeing ambitions	
a	The Chair introduced the item and reminded the meeting that it was to set out the organisation's ambitions for Staff Health & Wellbeing; although a lot of activity already took place around wellbeing it would be useful to try and identify areas to target activity towards.	
b	The Deputy People Director presented the report and explained that the wider team was going through a period of transition and the Head of Wellbeing role was currently vacant; the organisational change process should be complete by September 2026. The proposed Key Performance Indicators (KPIs) at Appendix 1 were therefore indicative, rather than final and quantified, for Health & Wellbeing ambitions against the seven elements of the NHS Health and Wellbeing Framework; several of the proposed KPIs at Appendix 1 were also focused on improving Staff Survey metrics. She emphasised the importance of: (i) a more outcomes-	

	focused approach to Health & Wellbeing which would support a culture of improvement and high quality patient care; and (ii) including understanding of EDI and the Culture Plan as there was a strong link between wellbeing, EDI and organisational culture and performance.	
c	The Chief Nurse, the Executive Director of Corporate Affairs and Geraldine Cumberbatch welcomed the report and proposed plan, noting the importance to staff wellbeing of: • basic working conditions and environments (including staff rooms), as these signalled to staff that they were valued and appreciated; • Occupational Health which impacted how quickly staff could return to work, amongst other supportive services which aided teams to deliver; and • building a culture of ownership so that leaders could take appropriate responsibility for core areas rather than a sense of wider collective responsibility leading to no one taking responsibility. The Deputy People Director agreed and noted that consideration of these areas was already taking place.	
d	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care added that leaders in Agenda For Change Band 6-7 roles should also be supported to manage implementation of the plan in due course as they would be crucial to its successful delivery.	
e	The Chair reflected on the link to the new Trust Strategy, noting that as management attention could only ever be finite and management therefore had to be selective in its areas of focus, the new Trust Strategy and strategic priorities would be key in order to direct the focus of organisational attention. She commended the commitment to making the Health & Wellbeing plan and proposed KPIs performance-orientated and emphasised the importance of alignment with the new Trust Strategy. She summarised that the Committee was assured that the Health & Wellbeing plan was on the right track and at the beginning of helpful conversations to inform its development and delivery.	
f	The Committee noted the report and was assured by the outline Health & Wellbeing plan, pending implementation of the organisational change process and subsequent refinement of the proposed KPIs at Appendix 1.	
8.	Reflections from previous Deep Dives into: 0-19 Contract; and Finance	
a	The Chair led the meeting in discussion of, and reflection upon, the Deep Dives at the previous meeting into: (i) the 0-19 Contract; and (ii) Finance.	
b	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care reflected upon the significant service change which the Oxfordshire 0–19 Healthy Child and Young Person Public Health Service had undergone, following a competitive tender process and ambitious implementation plan. She commended the team for how they had embraced working together more closely but noted that changes were still being worked through in some areas and there remained some variations across localities; she emphasised the importance of developing leadership capacity and skills. The benefit of bringing staff together at Murray House was again highlighted.	
c	Further to a query from the Chair on potential wider benefits of bringing together more organisational activity in one space and regardless of directorate boundaries, the Chief Executive commented upon the difference in approaches between specialist and generalist services, noting that there could be unintended consequences of bringing these together as well as risks around inefficiencies, potentially focusing upon the wrong areas or unnecessarily pathologizing certain conditions. The Chief Operating Officer for Community Health Services, Dentistry & Primary Care added that although initially taking administrative staff out of local teams and centralising them had had efficiency benefits, there had been some loss in the nurturing element of their role and therefore some peripatetic administrative staff had been put back into teams.	

d	The Chair noted that: - as the new Trust Strategy was being developed, it would be helpful to consider a workforce plan which took into account the need for both specialist and generalist skills and how staff could meet those requirements and support patients to access appropriate services without over-pathologizing conditions; and - variation across localities and differences between teams, especially within one overarching service, might require attention and consideration of whether Learning & Development interventions and oversight through supervision and PDRs were sufficiently moving the relevant metrics.	
e	The Chair led the meeting in reflection upon the Deep Dive into the Finance team. The Committee was reminded of the Finance team's achievement in being in the top 5 nationally in finance department NHS Staff Survey results (highest locally). The Chief Operating Officer for Community Health Services, Dentistry & Primary Care commended the support and team-working demonstrated by members of the Finance team when supporting directorates, noting the positive shift in directorate financial performance. The Deputy People Director noted that directorates received support from Finance and HR business partners and that it was important to strike an appropriate balance between support and consistency with central expectations.	
f	The Committee noted the discussion.	
9.	Temporary Staffing update	
a	The Head of Temporary Staffing and Medical Workforce joined the meeting and presented the report on the progress of the Agency Reduction Programme for both Agenda for Change (AfC) and Medic workforces. She highlighted that at the end of FY25/26, the Trust's overall Agency spend was £14.2 million against a target of £17.6 million, which was £3.4 million better than target; she commended the Oxfordshire and Bath & North East Somerset, Swindon & Wiltshire (Oxon & BSW) directorate for particular progress against medical spend, noting that the directorate was now anticipated to be under-forecast for the year ahead. For the year ahead, attention would be given to: Bank spend; reducing usage of Agency AfC Bands 5-6; introduction of a robust authorisation process when requesting agency support; and developing a Bank-first approach for Medics.	
b	In response to a question from the Chair, she and the Chief Nurse confirmed that clinical colleagues were engaged and that there was appropriate challenge around maintaining safer staffing and respecting the judgement of duty nurses in order to continue to provide good quality safe care. The Chair acknowledged that appropriate consideration was given to safer staffing and managing clinical risk as well as constructive challenge to avoid overstaffing.	
c	Further to a query from the Chair, the Chief Nurse and the Chief Executive confirmed that the 'break glass' authorisation process which had been implemented to support the move to non-utilisation of agency Health Care Assistants had been effective and not negatively impacted patient safety. The Trust had already been moving in this direction prior to the announcement from NHSE.	
d	The Chair led the meeting in more detailed review of the performance of the providers of Agency support. The Head of Temporary Staffing and Medical Workforce provided an update on respective contracts.	
e	The Chair noted the pending departure of the Head of Temporary Staffing and Medical Workforce and thanked her for her leadership, noting the significant achievement in reducing the Trust's Agency spend.	
f	The Committee was assured that appropriate consideration had been given to safer staffing in achieving the reduction in Agency spend and noted the report. <i>The Head of Temporary Staffing and Medical Workforce left the meeting. The Head of Medical Workforce and Education and the Head of HR Systems & Reporting joined the meeting.</i>	

Break 15:36 (10 mins)		
10.	Resident Doctor Improvement Plan – 10 Point Plan and exception reporting	
a	The Head of Medical Workforce and Education presented the report which set out: (i) the Trust's progress against the national programme of work to improve the working lives of resident doctors; (ii) confirmation that the Trust had fully implemented the exception reporting reforms; and (iii) priority areas for focus over the coming period, as set out in more detail in the report. She noted that the Trust was a large employer of resident doctors in the region and had an engaged group to work closely with on the particular challenges of these roles, including: shift work involving on-call rotas and overnight work; the need for rest space; rota and work schedule transparency; and course-related expenses. The Chief Executive added that he also met with resident doctor representatives every six weeks to discuss concerns, solutions and options.	
b	The Chair reflected back on the discussion at item 7 above on Staff Health & Wellbeing ambitions and noted that access to hot food had been a previous theme and although wellbeing activity had progressed, there was still not a food strategy and it would be useful to know more about trajectories to determine whether the Trust was on track against the 10 Point Plan. The Chief Executive replied that staff could still access food through vending machines across sites.	
c	The Committee noted the report including the progress update against the 10 Point Plan and the priority areas for the coming period.	
11.	Staff Survey results	
a	The Interim Head of OD presented the report and highlighted that: the Trust had achieved the largest response rate in a decade; the Trust was scoring above average for all 9 elements of the People Promise and had improved from 4 years ago when there had been 2 elements which had been above average. Further to reflection and previous discussion upon the usefulness of PDRs (at item 4(a)(ii) above), she added that PDR season had started and the Trust was currently doing well on numbers; she had reviewed the questions related to PDRs over the last 5 years' Staff Survey results and generally positive answers had been provided, despite the decrease in recent results against the question on 'Appraisal helped me agree clear objectives for my work'. The EDI Steering Group would consider the Staff Survey results in more detail and would also receive reporting on the Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES).	
b	She explained that NHSE required all NHS trusts to: (i) undertake a full and detailed analysis of all free-text Staff Survey comments in accordance with the Medium-Term Planning Framework; (ii) identify a minimum of 3 areas where the data indicated greatest staff dissatisfaction and which impacted most within the organisation; and (iii) develop action plans to resolve those issues within a year wherever possible. The lowest scoring free-text comments had been grouped within themes around: Reward & Recognition; Voice that Counts; and Staff Engagement. The Chief Executive confirmed that these three areas from the free-text comments would be considered in more detail because even though the overall scores relating to them were above national average, there was still room for improvement and an opportunity to look beneath the positive headlines.	
c	In response to a question from Geraldine Cumberbatch on the decreased score against the question on 'last experience of physical violence reported', the Deputy People Director replied that this would also be considered as part of the reporting to the EDI Steering Group, especially as different ethnicities did not have an equal experience of violence.	
d	The Chair noted that the more detailed review of the Staff Survey results should inform the development of OD and EDI Plans to ensure that the Trust remained focused on key areas.	
e	The Committee noted the report and that a further update on the Staff Survey (thematic action updates) would be provided to the next meeting in July 2026.	ZM/ CDS

Public Meeting in public		Page 516 of 520
12.	National Job Evaluation Profiles update	
a	The Chief Nurse provided a verbal update and confirmed that there was a plan to reduce the approximately 200 job descriptions at AfC Bands 5-6 down to 10-15, with appropriate consultations, staff side support and discussions through supervisions and PDRs. The next phase would involve a similar exercise for AfC Band 7 roles.	BK
b	The Chair requested an update to the next meeting in July 2026 on progress and trajectories to completion against the National Job Evaluation Programme.	
c	The Committee noted the report and that an update would be provided to the next meeting in July 2026 on progress and trajectories to completion against the National Job Evaluation Programme.	
13.	Workforce report (Integrated Performance Report (IPR) metrics)	
a	The Chair introduced the item and noted that she continued to discuss with the Chief People Officer what level of detail it was useful for the Committee to have in order to interrogate the IPR metrics; different approaches to the Workforce report had therefore been tried over time. She commented positively upon improved: (i) uptake of Oliver McGown Tier 1 and 2 training on Learning Disability and Autism; and (ii) supervision rates.	BK/RB
b	The Chair asked whether the next stage of work around supervision would involve considering the different frequency of supervision which different types of staff may need and more nuanced thinking around the kind of supervision required. The Chief Nurse replied that the policy already set out a 6-weeks' minimum standard and the Head of HR Systems & Reporting confirmed that compliance against this minimum standard was monitored.	
c	The Head of HR Systems & Reporting highlighted: • an error in reporting of sickness reasons by hours lost (the data should have referred to Musculoskeletal (MSK)) although the reporting against periods/numbers of absence was correct; and • the Executive had recently reviewed targets (using benchmarking against NHS Model Hospital data and Integrated Care System data) and amended targets would be deployed from the next data set.	
d	In response to questions from the Chair on: i. differences in reporting of forensic nursing vacancy rates, the Chief Executive explained that the data on one slide referred to the inpatient forensic team whilst the other referred to the community forensic team; ii. the efficacy of the exit dashboard for leavers, the Interim Head of OD confirmed that leavers received an exit questionnaire automatically through the system but there was room for improvement on the response rate to it. A programme was in place to increase awareness and explain why capturing exit questionnaire data and engaging in leavers' interviews was important; and iii. managing risks around take-up of resuscitation training, the Chief Nurse confirmed that this was overseen through the Quality Clinical Governance Sub-Group, reporting up to the Quality Committee. Directorates were required to set out how this was being tracked and checks were undertaken at the start of each shift to ensure that sufficient staff who had completed their resuscitation training were available.	
e	In response to a question from Geraldine Cumberbatch on relatively low representation of ethnic diversity at senior leadership level in the Forensic service, the Chief Executive noted that the Forensic senior leadership team was a small group of staff where there had not been turnover in the last 5 years. The Chief Nurse added that she had also reached out to actively encourage applications from the Forensic service for the next cohort of the Chief Nurse Fellowship programme. The Chair asked for the Forensic service to present to the next available meeting of the Committee.	

f	The Committee noted the report and that the Forensic service would be invited to present to the Committee.	
14.	Raising Concerns Policy (HR07)	
a	The Head of HR for Community & Corporate joined the meeting and presented the new Raising Concerns Policy which, further to the recommendation of the National Guardian's Office (Freedom to Speak Up), combined the Trust's previous Freedom to Speak up Policy and the Management of Concerns (Whistleblowing) Policy. The Chief Nurse confirmed that this had been subject to discussion and review already through the Quality & Clinical Governance Sub-Group.	
b	The Committee welcomed the new policy including the useful one-page overview which accompanied the policy and the Raising Concerns Flowchart within the main body of the policy. Further to questions, it was confirmed that references to when acknowledgement of a concern would be received were consistently referred to as within 3-7 days within the one-page overview and the policy. The overall timescale for completion of the process provided for some flexibility and should be no longer than 3-4 months in total.	
c	The Committee received the new Raising Concerns Policy, for assurance, noting: (i) the input of the Freedom to Speak Up Guardians to its development and to ensure that the new policy reflected the direction from the National Guardian's Office; and (ii) prior review through the Executive, the Quality & Clinical Governance Sub-Group, staffside colleagues and the People Steering Group. <i>The Chief Nurse left the meeting.</i>	
15.	Strategic Risks – Board Assurance Framework (BAF)	
a	The Chair deferred discussion of the BAF to the next meeting and noted that the 2 risks owned by the Committee were within their tolerance levels.	TG
16.	People Plan annual update	
a	The Chair deferred discussion of the People Plan to the next meeting.	CDS
17.	Committee annual effectiveness review	
a	The Chair deferred discussion of the Committee's annual effectiveness review to the next meeting but invited any comments on observance of Trust values.	TG
18.	Any other business	
a	None	
19.	New risks identified and actions for other Committees and the Board	
a	None.	
20.	Transforming People Services (NHS England CPO Board Briefing Pack)	
a	This report was noted as read.	
21.	Staff Survey Results appendices	
a	This report was noted as read.	
22.	Highlight/Escalation Report – People Steering Group	
a	This report was noted as read.	
23.	ER Casework review report	
a	This report was noted as read.	

24. a	Workplan Noted as read.	
	Meeting Close: 17:04 Date of next meeting: 08 July 2026	

Meeting of the People, Leadership and Culture Committee

Wednesday, 08 July 2026, 09:30-13:10

virtual via MS Teams

AGENDA

Apologies to: Maria Nikolaou, Interim Corporate Governance Officer

No.	Item	Lead	Purpose	Paper	Time
Welcome & Introductory Items					
1.	Apologies for absence and quoracy check ¹	MS		N/A	09:30 (10 mins)
2.	Declaration of interests	MS	Assurance	N/A	
3.	Minutes of previous meeting on 21 April 2026	MS	Approval	Enclosed	
4.	Action tracker and matters arising	CDS	Assurance	Enclosed	
5.	Chief People Officer View/Horizon Scanning including Leadership Development and update on NHS England competency framework	CDS	Information & Assurance	Enclosed	
Matters Arising – actions/updates from previous meeting					
6.	Resident Doctors Improvement Plan	ZM/CDS	Assurance	Verbal	09:40 (5 mins)
7.	Staff Survey – thematic action updates	NH/CDS	Information	Enclosed	09:45 (5 mins)
8.	National Job Evaluation Profiles update - Nursing Band 5 role review	TOB/CDS	Information	Enclosed	09:50 (5 mins)
9.	Reflections from previous Deep Dive into: First Contact and Primary Care GP Out Of Hours Service	BK/EL	Assurance	Verbal	09:55 (5 mins)
Strategic Focus					
10.	Developing Our Culture – ‘Our People, Our Culture’ programme of work	NH/CDS	Information	Enclosed	10:00 (20 mins)
People Insights					
11.	Service deep dive – Forensic Mental Health: Thames House, Women’s Secure Pathway	JD/RB	Information	Enclosed	10:20 (30 mins)

¹ Apologies for July 2026: none from Committee members.

Apologies from other Executives: Karl Marlowe, Chief Medical Officer; and Heather Smith, Chief Finance Officer

12.	Equality, Diversity & Inclusion Plan	NH/CDS	Assurance	Enclosed	10:50 (20 mins incl. WRES item below)
13.	WRES & WDES ² analysis	NH/CDS	Assurance	Enclosed & Reading Room	

10 minutes' break 11:10-11:20

14.	Employee Relations annual report	JC/JP/ CDS	Assurance	Enclosed	11:20 (10 mins)
15.	Medical Engagement and Wellbeing report	KL/KM	Assurance	Enclosed	11:30 (15 mins)
16.	Freedom To Speak Up annual report	RBS/LB/ CDS	Assurance	Enclosed	11:45 (15 mins)
17.	Workforce report: - Integrated Performance Report metrics; - Statutory & Mandatory training and Supervision; - temporary staffing including rankings/benchmarking; and - targets for FY27 – new vs old and rationale for setting new targets	RB/EL/ CDS	Assurance	Enclosed	12:00 (10 mins)

Risk & Governance

18.	HR policies annual report	JC/CDS	Assurance	Enclosed	12:10 (5 mins)
19.	Social Work Strategy	AD/DM/BK	Information	Enclosed	12:15 (15 mins)
20.	Allied Health Professionals Strategy	EC/BK	Assurance	Enclosed	12:30 (15 mins)
21.	Board Assurance Framework (BAF) - update on PLC BAF risks ³ and Deep Dive into Risk: A4 Recruitment & Retention	CDS/TG/BC	Assurance	Enclosed	12:45 (10 mins)
22.	Annual Effectiveness Review: - Feedback from Self-Assessment Questionnaire - Review of Terms of Reference	TG	Discussion & Approval	Enclosed	12:55 (10 mins)

Closing

23.	Any other business	MS		Verbal	13:05
24.	Review of the meeting: new risks identified or escalations for other Committees or the Board	MS	Assurance	Verbal	

² Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES)

³ PLC has oversight of 2 BAF risks: A4 – Recruitment & Retention; and A5 – Staff Experience & Culture. Deep Dives to focus on drivers for the risk.

Date of next meeting – (11) November 2026 (13:30-17:00 Whiteleaf Centre, Conference Room) –
November date anticipated to be rescheduled at request of the Chief People Officer

READING ROOM/APPENDIX
Supporting reports to be taken as read and noted

25.	People Plan Annual Update (item held over from April 2026 meeting)	ZM/CDS	Information
26.	Highlight/Escalation Report • People Steering Group	ZM	Information/ Assurance
27.	ER Casework Review Report Associated Operational 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
28.	WRES & WDES supporting documents	NH/CDS	Assurance
29.	PLC Workplan	CDS	Information

**Meeting of the Oxford Health NHS Foundation Trust
Quality Committee
Minutes of a meeting held on
Thursday, 07 May 2026 at 10:00
In Person**

Present¹:		
Andrea Young	Trust Chair (Committee Chair) (AY)	
Britta Klinck	Chief Nurse (BK)	
Rob Bale	Chief Operating Officer for Mental Health and Learning Disability (RB)	
Taff Gidi	Executive Director of Corporate Affairs (TG)	
Lucy Weston	Non-Executive Director (LW)	
Heather Smith	Chief Finance Officer (HS) <i>part meeting</i>	
Emma Leaver	Chief Executive Officer for Primary	
Grant Macdonald	Chief Executive Officer (GM)	
In attendance²:		
Helen Mackenzie	Non-Executive Director (HM)	
Leanne Dunkley	Corporate Governance Officer (LCD) (minutes)	
Jane Kershaw	Head of Patient Safety (JK) <i>part meeting</i>	
Tina Malhotra	Clinical Director, Buckinghamshire Mental Health Services (TM)	
Ben Cahill	Deputy Director of Corporate Affairs (BC) <i>part meeting</i>	
Angie Fletcher	Deputy Chief Nurse (AF)	
Pete McGrane	Clinical Director, Community Services (PM)	
Lola Martos	Consultant Old age Psychiatrist and Clinical Director OBSW (LM)	
Rami El-Shirbiny	Consultant and Clinical Director Forensic Services	
Kirsten Prance	Clinical Service Director Learning Disabilities	
Julian Laverty	Specialist Registrar ST6	
Michael Marven	Chief Pharmacist & Clinical Director for Medicines Management	
Angie O'Neil	Senior clinical Lead, Minor Injuries units	
Jodie Summers	Head of Service Minor Injuries Units and GP Out of Hours	
Jeremy Philpot	Director of Estates and Facilities	
Etelvina Ferriera	Head of Infection, Prevention and Control	
Iga Ciesielska	Lead Pharmacist-Antimicrobial Stewardship and Ambulatory Care	
Colleen Jones	Public Governor Buckinghamshire (CJ)	
1.	Apologies for Absence	Action
a	Apologies for absence were received from: Karl Marlowe, Chief Medical Officer; and Lynda Dix, Associate Director of Nursing, Forensic Services.	
b	Apologies for absence were also received from the following regular attendees: Bill Tiplady, Director of Psychological Professions. The Chair confirmed the meeting was quorate.	

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.

2.	Any Other Business Nothing declared.	
3.	Minutes of the Quality Committee on and Matters Arising a The Chair welcomed all to the meeting. b The minutes at QC 03, Minutes of the Quality Committee (QC) were confirmed as a true and accurate record, with an amendment to be made after the meeting which Lucy Weston will email through to the administrator regarding the data quality in waiting lists triangulated with complaints and the effect on quality related to the BAF.	LW/LD
4.	Matters Arising a 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: • 5f-discussion of the quality management system at Board-this has been scheduled for a board meeting; • 9(b)-Completion of evacuation- this has now been completed; • 11(e)- Update on the Changes to Oxford Pharmacy store Oversight Board regarding Responsible Person-this was provided at today's meeting; • 16(b)-renewed focus in the community on ethnicity data capture-this is improving as part of a targeted piece of work;	
Safety		
5.	Quality and Clinical Governance Sub-Group (QCGSG) escalation report & Quality and Safety Dashboard a The Chair introduced this item, noting that this report is received to raise awareness of the current issues and themes that are concerning in terms of current quality issues. The Chief Nurse took the reports at paper 05 as read, noting the key highlights to the Committee, from the last three QCGSG meetings, which included: • Concerns around Ruby Ward due to the cohort of patients, which makes it a risky environment at times. The situation is settling and the team managed this very proactively, limiting bed base to 11 out of 17 and staggering admissions; • Demand and capacity issues within the District Nursing service, where there is the potential for harm, there has been an increase in pressure damage and harm, however this is small in comparison to the size of caseload. • CAMHS wards are a focus on the Dashboard, particularly Highfield and Meadow unit, due to the high levels of incidents. Meadow Unit is one of only five PICU's in the county for young people, the incidents approximately 85%, relate to the prevention of self-harm. The CQC report following the inspection of CAMHS has been received and rated as requires improvement. The services received a good rating in terms of caring and effective and were one point off good for responsive and well	

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	led. There is a robust action plan in place. The Trust will be submitting the response to the CQC next week; • A suspected cluster of seven young people dying by suicide has been seen, the research team have undertaken a detailed investigation, however there was no clear connection between these individuals. This has been passed to Public Health England to review. • The medicines management report noted that Clozapine point of care testing has been stopped due to a discrepancy between the point of care testing results and the assay. • The Trust received a prevention of future deaths notice in February, which raised two issues: (i) the availability of beds in the community; and (ii) the investigation process, as further information came to light that the Trust was not informed about, the family have been engaged with the investigation with learning being taken forward. • The group took the TRiM annual report and noted the work and referral onwards for staff.	
b	The Committee discussed the suspected cluster of deaths referred to public health. It was noted that the use of the term cluster can lead to creating a lot of systems moving, therefore it should be made clear that this is not a thought to be a cluster. Each of these cases will be reviewed in detail and it is thought that an emerging theme to these tragic deaths is neurodiversity. The investigation showed that these people had no direct contact with each other and had varying levels of contact in the previous three years. Non-Executive Director Lucy Weston challenged that as this is a second incident of high number of people where neurodiversity has been a theme is there something to learn about the care they receive. The Chief Nurse noted that these are being reviewed from all angles to see if there is something for the Trust to learn in terms of our care or services and whether there is a need to consider a different approach. It was discussed that staff are trained in terms of risk and neurodiversity including the use of safety plans adaptation to meet their needs, these along with the care plans are being reviewed as part of the investigations. All the learning from these reviews will be pulled out and shared. The Chair summarised that there are 2 pieces of assurance in place from this, which are that the individual deaths are being reviewed and the information has been passed to Public Health England to consider other factors. The Chief Executive Officer added that this is an interesting discussion as all 7 had mental health problems and likely some anxiety and that it would be worth doing a triangulation on each of the different things as there are commonalities amongst this group, that could be pulled out.	
c	The Committee discussed the excellent and prompt intervention on Ruby Ward to manage the high acuity of patient and the potential lead indicators that were identified ahead of time and how assurance would be provided over the intervention measures to ensure that the actions were effective in reducing the overall risk. It was noted that there are consistent staffing levels on the ward, a good working relationship with the locum consultant, along with daily reviews of patient flow and escalations. The team are being regularly supported, which allowed for some beds to be re-opened, demonstrating the intervention was effective. The team worked hard to proactively discharge patients where possible and learning from the processes in place. It was noted that due to the rising acuity	

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	of complex patients similar incidents might occur. Assurance can be taken that the team took prompt action, kept some beds open and have been able to start re-opening beds and there was no impact on staff sickness.	
d	The Highfield unit and Meadow unit were discussed as both have been flagging on the dashboard for some time. It was noted that the units provide service to patients with the highest acuity. The Committee discussed that these units might always flag on the dashboard due to this complexity. The Chief Nurse noted that whether they should be taken off the dashboard has been discussed in the QCGSG, however it was felt that they should remain so that assurance can be provided that plans are in place.	
e	The Chief Nurse noted that there is assurance that the correct systems and processes in place to flag issues across the trust. Incidents in high acuity wards often relate to 1-2 patients. The Chair summarised that in the environment the Trust operates in, it is not possible to close every risk and mitigate every control and suggested that this discussion was held at Board as to how the Board understands and assures itself.	
f	The Chief Operating Officer for Mental Health and Learning Disability noted learning from incidents is paramount. Ruby ward identified that working with dysregulating was a challenge for the team, they undertook a QI project to develop ways of working to reduce incidents as much as possible. If you consider the cohort of patients that they are working with, they would have previously been on Meadow or Highfield units years ago. The Chief Executive Officer added that maybe this is an opportunity to stabilise the bed base in Ruby ward down to 16, as managing the new group of people was a lot of the challenge.	
g	The Chair summarised that the Committee has heard in relation to Ruby ward, there were triggers and alarms, which the team took the appropriate actions to address the risks and manage the situation. There is a discussion to be had as to how this is managed in the future.	
h	The Chair sought assurance that in relation the Safeguarding resource. The Chief Nurse noted that this is a long-standing problem and has been pushed back to the ICB to resolve. Changes have been made recently and the Trust frequently put extra staff on to ensure there is cover and priority cases are not missed.	
i	The Chair asked in relation to the suspension of Clozapine point of care testing, whether that means that everyone now must go in for blood tests. It was confirmed that is the case at present. It was noted that this is reported into the medical devices committee. The Committee discussed that this was not a local calibration issue, but a nationally registered issue that the company were aware of.	
j	ACTION: The Clinical Director for Community Services to check that the issue with the Clozapine point of care testing has been reported properly.	
k	Non-Executive Director Helen Mackenzie noted that moving forward it would be helpful to understand when actions might be expected to be completed by, such as the General Anaesthetic waiting list.	

	<i>The committee moved to agenda item 07 next.</i>	
6.	Service Deep Dive-GP Out of Hours	
a	The Head of Service for Minor Injuries Unit and GP Out of Hours and The Senior Clinical Lead Minor Injury Units shared the slides which provided a background to the service; the service model; the challenges faced and how they are being mitigated and managed. The Chief Operating Officer for Community Health Services, Dentistry and Primary Care added that the Medical Director has completed work around demand and capacity to identify the optimum workforce across the year.	
b	The Chair asked in relation to the rise in end-of-life care provision, is the hypothesis that this is not being managed well during the day and asked what the feedback mechanism with primary care. The Clinical Director for Community services responded that yes, volume of activity is not being managed during the daytime. The volume of patients dying in the community has increased and the access to primary care has become more constrained. There has also been changes in the focus to the way in which hospice provision has been delivered. The Trust taking a system wide approach to try and improve communication and efficiency of services and some gains have been seen there. It is often that it is easier to get hold of out of hours care. He then went on to discuss the internal target of a visit within one hour to manage symptoms, which is ambitious, regardless of the day or time. It was noted that there were challenges with this initially especially around the data, which has now resolved and the teams are doing well at achieving that target.	
c	The Chair noted that this is a large service, however feedback from staff is that they enjoy working there and demonstrates a massive amount of improvement to deliver responsive care and if it continues should consider a HSJ award.	
	<i>The committee took item 15 next JS and AO left the meeting</i>	
7.	Patient Safety Incident Response Framework (PSIRF)	
a	The Head of Patient Safety took the report as read, noting the key highlights and escalation to the Committee, which includes the results of the most recent staff survey, which shows the Trusts improvement across all four measures, demonstrating the Trust is above national average. There has been no disproportionate representation by ethnicity, age or gender when the demographics of the incidents was reviewed. The report also included the key areas of learning from the 37 patient safety reviews completed over the last year. There is a risk around interface and transition, so coordination between the Trusts teams and also external agencies will be a key focus moving forward.	
b	The Committee discussed that the Trust is now its second year of using this process and there has been a reduction in all the different learning responses along with Patient Safety Incident investigations which is positive. The actions from these are fed into an action plan that is stored on the central system, which sends weekly reminders to staff. Before an action is closed, all the evidence supplied is reviewed to ensure that it allows the action to be closed by the patient safety team. Overdue actions are discussed weekly at the directorate weekly safety meetings. Safety	

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	review visits have also been introduced, whereby the patient safety team visit the team or service one year later to review whether the actions resolved the issues and sustained. Six of these were completed last year and it hoped that more of these can be completed over the next 12 months. All teams have been proactive in this process and have been sharing learning across teams and services. This demonstrates the positive learning culture being embedded.	
c	The Committee discussed the changes to the pressure ulcer work, including innovative wound mapping and updated risk assessment tool. Often issues identified in the District Nursing service relate to communication, assessment, prediction of risk and capacity to intervene in a timely way. There are also issues that are outside of control including patient and family choice and concordance, a specialist group has been set up to consider all this and the Deputy Chief Nurse offered to review the systems to consider how it all fits together. The Committee noted the update.	
8.	Learning from Deaths Mortality & Homicide Review	
a	The Head of Patient Safety took the report as read, noting the key highlights and escalations to the Committee.	
b	The Committee discussed the recent seven teenage deaths within the ADHD service, which is not thought to be a cluster as there was no know interactions. This has been passed to public health for review.	
c	The Committee discussed that there has been an increase in medical examiner feedback, this is not due to concerns but due to the service maturing. All other trend data is in line with national picture. These are all reviewed in the mortality group to look for any learning.	
d	The Committee discussed that deaths are not graded, using a social judgement framework, however the Trust does use the MAZAR to record whether deaths were expected or not. Deaths are reviewed as mortality reviews and incidents are triangulated on weekly basis. The Committee noted the update. <i>The Committee moved to agenda item 11 next</i> <i>JK left the meeting</i>	
9.	Health and Safety Quarter 4 update	
a	The Chief Finance Officer introduced the item, noting that this is the second time the report has come to this Committee and is part of the journey to improve governance around health and safety. Previously it was a top-down health and safety team led approach to reporting, which is changing to a bottom-up approach with clear accountability to the experts in each area who provide the information which is then presented to the fire, health and safety scrutiny groups, Executives then via this Committee to Board. The Appointment of Claire Rock, Health and Safety Lead has helped to pull all of this together so far and will continue to improve the reporting over time. Staff are now producing more comprehensive reports and understand their roles better. The plan is to re-introduce trend reporting to show how things are progressing.	

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b	The Appointment of the subject matter experts (SME) are making a difference; however, they are identifying problems that were not previously known, which will increase issues before reducing. There are two BAF risks that touch on this area, one being around infrastructure, which demonstrates how things are changing and how the Board are being kept up to date regarding this risk and its management. The other is around safety.	
c	The Director of Estates and Facilities took the Committee through the Compliance report, noting the key highlights and escalations to the group. He noted that there is now a full set of Authorising Engineers (AE) in post for all the relevant Health Technical Memoranda (HTM) and are now looking to recruit Authorised persons (AP) who may require training. The SME will cover these roles in the interim to address issues identified by the authorising engineers and monitor compliance. He talked through an example of issues with water testing last year, whereby legionella was detected, which was focused on weekly, reviewing the results ensuring the system was regularly flushed, chlorinating and then testing and monitoring the progress of the results which demonstrated a slow reduction in the detection of legionella. It is hoped that the Trust will be better prepared if this happens again this year in the high temperatures.	
d	The AE's have been undertaking a lot of audits, which have generated a number of tasks that need to be worked through, the highest area is in fire safety. A dedicated person to focus on fire door repair has now been employed. As part of the HTMs safety groups for all have them have been set up and are being held with the authorising engineer and clinicians. The risks from the safety groups are now being managed in a different way, which will put the Trust in a better place moving forward. The statutory maintenance is improving and going forward the focus will be the more granular detail in terms of the planned preventative maintenance, of what and is not being completed. This will be supported by a new Computer Aided FM (CAFM) system, once available.	
e	The Chief Nurse noted that there was an error in the report around violence and aggression which she has asked the Associate Director for Social Work and Social Care to update and recirculate. The work around violence and aggression is a separate group, which is intensively linked to the work around estates, positive and safe. The vast majority of violence and aggression will occur on inpatient wards.	
f	Non-Executive Lucy Weston congratulated on team on the progress so far, noting that there is lots of work taking place, however she noted that from the reports it is not clear what the Trust's position is in relation to compliance and oversight. Gas; Electrical safety; fire; water; lifts; asbestos and hazards are the seven domains around buildings and estates that are British standards that it would be good to see consistent reports around the Trusts compliance. The Director for Estates and Facilities noted that a lot of these are covered under the HTMs and a HTM for asbestos is now being written. He agreed to confirm whether Gas was covered by a HTM but noted that there is work underway looking at gas and responsibilities and demarcations of gas maintenance with the supplier, so it is clear who is responsible for what. The greatest risks are with fire compartmentalisation. The Trust is mostly in date with electrical safety in terms of the 5-year electrical testing. Water is being monitored closely in terms of legionella detection and treatment and	

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g h	management. Ventilation is being looked at closely as it was identified that the Trust did not have the right air changes following poor maintenance due to not being on asset lists. There is programme of refurbishment and repair work for lifts. The team are on a journey to improve compliance, with all SMEs in post who need to be in. The Chief Nurse noted that there strong oversight from the Infection, Prevention and Control team in terms of water safety and ventilation and where cases of legionella have been found the IPC are involved in decision making such as closing of unused units and toilets. The Chair summarised that it was helpful to hear the top risks and noted that the quality of reporting is improving and moving towards a dashboard would be helpful. The Chief Finance Officer has agreed that the Committee will continue to receive all the reports, which could be put into the reading room, with a clear summary report. The Committee noted the update. <i>JP left the meeting</i>	
10. a b c	Oxford Pharmacy Store The Chief Pharmacist took the report as read, noting the key highlights and escalations to the Committee. including the internal audit report provided in the reading room. It was noted that the volume of business that goes through OPS is around 90 million. He reminded members that there is an open offer of training around the GDP and regulatory requirements of OPS if anyone would like some. The Committee discussed the delay in governance changes in terms of the responsible person, which should be resolved by the end of the month, with new arrangements starting in June. The Chair noted that compliance is good, and this is helpful report which demonstrates the volume of work over the year and got excellent staff survey results. The Committee noted the update <i>The Committee moved to item 6 next.</i>	
11. a b c	Infection, Prevention and Control annual report 2025/2026 The Head of Infection, Prevention and Control took the report at 11 as read, noting the key highlights and escalations to the Committee, including the increased surveillance to manage the winter and summer pressures. Another focus for the year ahead will be antimicrobial stewardship. The Committee discussed that there are more infections thought out the year rather than being associated with winter pressures. The Trust needs to remain vigilant and have the right monitoring, protection and practices around infection control. The Chief Executive Officer asked regarding the water safety group, how it is going and whether it has the right people attending. It was noted that the group meets 4 times a year, at present the Head of Infection, Prevention and Control is the only clinician in attendance. The new authorising engineer has now started in post,	

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	which has made a huge difference, implementing changes including reviewing the sampling protocol and the developed the new water safety plan. There will also be new training that will come into place later this year.	
d	The Committee discussed that the improvements in water safety and ventilation are as a result of the Health and Social Care Act. The Trust knew that there were issues and had difficulty recruiting into some of the authorising engineering roles, however the testing and mapping has always been taking place, there is now better oversight.	
e	The Chair noted that this shows the Trust has clear systems and processes in place, which is seen through consistent improvements, despite the reduced capacity the service has experienced over the past year and recommend the annual report to Board.	
f	Trust's Position on the actioned points of the NHSE letter to take action around Antimicrobial Stewardship (AMS)	
g	The Lead Pharmacist for Antimicrobial Stewardship and Ambulatory Care took the Committee through the Trust's Position in response to the NHS England call to action letter. Antimicrobial resistance (AMR) is a current and escalating risk, with The World Health Organisation identifying it as a one of the top 10 global public health threats and is on the UK government risk register. AMR was linked to nearly 5 million deaths in 2019, and it is predicted that by 2050 will cause around 40 million deaths. This letter shows benchmarking against other organisations, with targets and identifies three priorities that the Trust will be working on to improve AMS. The Trust has high antibiotic use, which directly impacts resistance, patient safety and future treatment options. There are some gaps in consistency, diagnostic capability, digital oversight and MDT coordination, which are areas to strengthen. An MDT antimicrobial stewardship group will improve governance, data use and increased visibility to improve practice. The Trust is not an outlier in terms of antimicrobial stewardship and is improving to achieve the targets. The digital capability to monitor prescribing is not quite there. The Clinical Director for Community services noted that the EPMA pilot has been launched which will help with the monitoring. He commented that all of this work is seen in the context of the real drive to address preventable sepsis as well, which at the clinical point of care is tricky. There is increased governance in terms of the decision making relative to issuing an antimicrobial under a PGD, compared to more subjectivity seen among some prescribers. There needs to be caution about how this work is approached in the context of preventing sepsis.	
h	The Committee discussed the AMS, which is requirement of Board to have visibility and will be reported as part of the regular IPC reporting to the Committee.	
i	The Chair summarised that the report will be recommended to Board and acknowledged the strong systems and processes in place.	
	The Committee endorsed the Trusts response.	
12.	Complaints Concerns and PAL's annual report 2025/2026	
a		

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	The Deputy Chief Nurse took the report as read, noting the key highlights and escalations to the Committee. It was noted that an increase in demand and activity along with complex presentation and challenges in the team, have resulted in response not being as timely as the Trust would like. Changes in the team have been made to work more efficiently. The focus for the year is to learn from complaints and triangulate with other data and safety review visits. There are pockets of waits across the organisation, however this is known and the coding relates to areas of highest concerns. Coding does require some further work in the future as not quite correct yet.	
b	The Committee discussed that emergent this year has been complaints generated using AI technology, which increases the complexity and analysis. This is causing concerns with the complaints team, and it is likely that they will require further resourcing over the upcoming year to manage. It was noted that often rapid resolution cases, which should be the simpler cases are often not once you progress them and they take a lot of time within the directorates to unpick, review and respond. The Chief Executive commented that it is likely the Trust will need to take more risk to the management of complaints to ensure the right things get the attention. The Deputy Chief Nurse noted that there is further work around how complaints are reviewed and responded. The Chair asked how the Trust intelligently discriminates between those things that need to be paid attention to and those that can be closed down and suggested the team consider how to handle this moving forward and before the next annual report.	
c	The Committee discussed that the themes from incidents are triangulated by the complaints team. The New strategy should make it easier for directorates but expectation management is important as currently 50% require an extension due to multifactorial issues. This will continue to develop over time.	
d	The Chair summarised that there are big questions as to how the Trust manages complaints that fits with the national guidance and framework. The Chief Executive Officer noted that directorates require a team to do this with business interface. The Committee noted the updates and improvement in the reporting <i>The committee stopped for a 10-minute break.</i>	
ANNUAL PLANS & STRATEGIC PROGRAMMES		
13.	Intensive Case Management Adult Mental Health Community Provision Transformation Programme The Chair informed the Committee that this item has been removed from the agenda as will be presented directly to the Board of Directors.	
14.	Provider Collaboratives (PC) Specialist Services a The Chief Nurse took the report as read, noting the key highlights and escalations to the Committee. There are a few units that have required some enhanced monitoring for quality issues, Dorset healthcare being one of them where there have been issues with the level of engagement in response to the concerns, however this has greatly improved with new people in post.	

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b	The Committee discussed that the Trust is not consistently meeting the 28-day prison transfer challenge, due to a variety of reasons, that the Trust often has no control over, including accessing the prison, and arranging transport. There is increased scrutiny and the Trust is trying to improve the systems and escalating delays.	
c	In relation to St Andrews, where the Trust has three patients, two of whom have a discharge plan in place, and one will move to a different unit. The Committee noted that some wards will remain open and be re-branded as specialist services. The contract is being extended, which is a good endorsement of the Trust's capability and quality governance. The Chief Executive Officer noted that the organisation is the only provider in the ICB with contract commissioning ability, which is good model and a good place to be to bring key leaders together. The Chief nurse noted that this provides the opportunity to do things differently as the Trust manages the commissioning model.	
d	The Chair summarised that this has been managed well and has stopped units closing that would have been closed previously, and the fact contracts are being extended is good endorsement of the Trusts capabilities in managing theses collaboratives. The Committee noted the comprehensive report. <i>The Committee took agenda item 9&10 next</i>	
15.	Quality Account Annual report 2025/2026	
a	The Deputy Chief Nurse took the report as read, noting any key highlights and escalations to the Committee. It was noted that the document will go to stakeholders for feedback before being published on the website and sent to the Health Overview and Scrutiny Committee for scrutiny. The priorities have been based on the strategic ambitions this year. The Trust did not achieve all it set out to achieve over the year in certain areas such as restrictive practice, due to multifactorial reasons, which will be continued to work on over the coming year.	
b	The Chair commended that the priorities not achieved this year are being carried on.	
c	The Committee noted that this is brilliant report. How these priorities would be communicated to teams and services was discussed which would be via the quality programme board which breaks them all down for teams so that they know what to focus on. There are team-based objectives, such as reviewing feedback from patients and carers which will help to achieve the frameworks set out in the priorities. They all have actions attached to that which will be more meaningful and pragmatic for staff to engage, understand and implement in terms of the quality management system. the aim with these priorities is that directorates and services have mechanisms in lace to understand where concerns are. Directorates are being asked to adopt the quality board approach used in community services to understand the areas for improvements. There are indicators and metrics in pale to measure success which can be shared with the Committee. The Committee approved the Annual report to go to stakeholders for feedback subject to the spelling mistakes being corrected.	

Strategies and Policies		
16.	Policies for Approval:	
a	Environmental Cleaning Policy The Committee took the policy as read and endorsed its publication. <i>The committee moved to item 18 next</i>	
GOVERNANCE & RISK MANAGEMENT		
17	Board Assurance Framework (BAF)	
a	The Deputy Director of Corporate Affairs took the report as read, noting the key highlights and escalations to the Committee regarding the four risks the Committee oversees, with the focus on A1 for this meeting.	
b	The Chief Operating Officer for Mental Health and Learning Disabilities noted that the Directorates have work plans to address the waits within services, focusing on the longest waiters first. The aim is to get the core waits back down to 4-12 week standard. This will not be achievable for all services such as Community and NBC service, however there are steps in place to reduce those waits over time. There are also waiting list initiatives with one off investments over the next year. At present triangulation with complaints, compliance, safety and outcome is undertaken using the quality dashboard to co-ordinate a range of different metrics. Within each directorate service review meetings, they are reviewing the changing waits and incidents and other quality metrics to build outcome measure. Work is also underway to restructure the integrated performance report so that all information around a service is in one place, which can then be developed further to consider effectiveness. This will be a journey over the next year. The Committee discussed whether teams and services are clear about what are their risks and mitigations and whether they are clear as to the processes to escalate if things are not heading in the right direction. It was noted that these waits are being constantly reviewed along with the pathways to see if there is something that could be done differently	
c	It was discussed as to whether the risk score reflects confidence in the systems. There is shared learning between services who are undertaking QI projects. The Chief Executive noted that it is the narrative that needs to be developed and shared to allow challenge and development. The BAF is used to influence decision making and plan more strategically. Discussions noted that services are proactively thinking about how to move things forward with early interventions and prevention within the budget available.	
d	The Chair summarised that this has been a good conversation about: a-how do you risk assess your waiting list, where does the risk really sit and b-the trajectories, which if you can see month on month improvements it provides increased assurance that the things are making a difference. Seeing trajectories being achieved would provide assurance. The Committee noted the report and the updates on the scores and actions.	
18.	Trust Policy Register	

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a	The Deputy Director of Corporate Affairs took the report as read, noting the key highlights to the Committee. The number of overdue policies is now reduced to 6.	
b	The Chair summarised that this is a good improvement and the report provides assurance there is good oversight and management of this.	
	The Committee noted the update.	
ANY OTHER BUSINESS		
19.	AOB	
a	None declared	
20.	Meeting closed at 13:15 Date of next meeting: 09 July 2026	

Oxford Health NHS Foundation Trust

Quality Committee

(Conducted electronically via MS Teams)

10:00 on Thursday, 09 July 2026

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			N/A	10:05
03	Minutes of meeting held on 07 May 2026			Enclosed	10:05
04	Action log and any matters arising			Enclosed	10:10
SAFE					
05	Quality and Clinical Governance Sub-Group (QCGSG) Escalation Report and Quality and Safety Dashboard	Britta Klinck/ Jane Kershaw	assurance	Enclosed	10:10
06	Patient Safety Incident Response Framework (PSIRF) Q1	Britta Klinck/ Jane Kershaw	assurance	Enclosed	10:40
07	~~Safe Staffing report 6 monthly~~	~~Britta Klinck/ Pamela Mariga~~	~~assurance~~	Defer to September	11:00
08	Quality Compliance & Regulation update	Britta Klinck/ Pamela Mariga	assurance	Enclosed	11:10
09	Safety of the Physical Estate annual report 2025-2026	Heather Smith/ Jeremy Philpot/ Daren Baines	approve	Enclosed	11:20
10	Safeguarding annual report 2025-2026	Lisa Lord/ Daniel Mercier	approve		11:30
EFFECTIVE			BREAK 11:40-11:50		
11	Clinical Effectiveness Group report	Karl Marlowe	assurance	Enclosed	11:50
ANNUAL PLANS & STRATEGIC PROGRAMMES					
12	~~Provider Collaboratives annual report 2025/2026~~	~~Britta Klinck/ Karen Drabble~~	~~assurance~~	Defer to September	12:00
13	Trust wide Patient Experience and Involvement report (learning from patients, families and carers and working with families group)	Vicky Naidoo/ Bill Tiplady	assurance	Enclosed	12:10
GOVERNANCE AND RISK					

14	Board Assurance Framework	Taff Gidi/ Ben Cahill	assurance	Enclosed	12:20
FOLLOW UP REPORTS					
15	Update on Scoping exercise of 7 deaths in ADHD waiting service (if available)	Britta Klinck	assurance	verbal	12:40
16	Access oversight and risk management	Chad/ Britta Klinck	Assurance	Verbal	12:50
AOB					
17	Any other business				12:55
18	Date of next meeting – 10 September 2026				
READING ROOM/APPENDIX					
Supporting reports to be taken as read for information and/or to prompt discussion.					
19	Clinical Effectiveness Group minutes and action log			Enclosed	