Oxford Health NHS Foundation Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC

Wednesday, 25 November 2026, 09:00-12:30

Kassam Stadium, Grenoble Road, Oxford OX4 4XP

AGENDA

No.	Item	Lead	Purpose	Paper	Time
Welcome					
1.	**#Hellomynameis** and apologies for absence[1]	Chair	Welcome	N/A	09:00
Patient and/or Staff Stories (Strategic Aims: Patients, Carers & Families; and People)					
2.	Staff Story – Cost of Living	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 30 September 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	09:30
7.	Chief Executive's report	CEO	Discussion	Enclosed	09:40
	[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; and • Horizon Scanning	ED of Corp Affairs	Information & Assurance	Enclosed	09:55
9.	Board Assurance Framework	ED of Corp Affairs	Information & Assurance	Enclosed	
10.	Planning: a. Annual Plan update; and b. Mid-Year review	Chief Finance Officer / ED of Strategy & Partnerships	Decision, Information & Assurance	Enclosed	10:10
Performance, Sustainability, Quality and People					
11.	Integrated performance and sustainability reporting: a. Integrated Performance Report (**IPR**); b. Quality & Safety Dashboard; c. Finance Report; and d. Workforce Metrics	Exec Team	Information & Assurance	Enclosed	10:30

[1] Apologies: None

	10 minutes' break 11:00 – 11:10				
12.	Patient Safety Incidents (**PSI**) report	Chief Nurse	Assurance	Enclosed	11:10
Communities and Populations – help improve health through research and innovation					
13.	Research & Development (**R&D**) report	Head or Director of R&D/ Chief Medical Officer	Information & Assurance	Enclosed	11:20
Governance & Reports on recommendation of committees					
14.	Committee assurance reports (3As)[2]: a. Mental Health & Law Committee 27 October 2026 b. Quality Committee 12 November 2026 including National Confidential Inquiry into Suicide, Homicide and Safety in Mental Health (**NCISH**) Safety Scorecard c. Finance & Investment Committee 17 November 2026 and recommendation: i. Frontline Digitisation annual update d. People, Leadership & Culture Committee 24 November 2026 (verbal update) and see Reading Room 21: i. Medical Appraisal and Revalidation report	Committee Chairs Chief Medical Officer Chief Finance Officer Chief Medical Officer	Discussion & Assurance	Enclosed, Verbal & Reading Room 21-22	11:35
15.	Corporate Registers: (i) application of Trust seal; and (ii) receipt of gifts and hospitality	ED of Corp Affairs	Information & Assurance	Enclosed	12:10
Closing matters & Resolution to conduct private business					
16.	Any Other Business				12:15
17.	Questions from the public, governors or staff				
18.	Review of the Meeting				
19.	Confidential matters - Resolution by the Board to exclude the public, any observers and press from the remainder of the meeting and conduct its business in private for matters which may be prejudicial to the public interest if conducted in public or for other reasons				
	Close Date of next meeting: 27 January 2027				12:30

READING ROOM/APPENDIX

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

20. 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

[2] None expected from the following, further to 3As reports already delivered to the Board meeting on 30 September 2026: (i) Audit & Risk Committee as not met since 18 September 2026; and (ii) Charity Committee as not met since 22 September 2026.

21. Medical Appraisal and Revalidation report

22. Committee minutes and agendas[3]:
    a) Finance & Investment Committee 15 September 2026 and agenda 17 November 2026
    b) Mental Health & Law Committee 07 July 2026 and agenda 27 October 2026
    c) People, Leadership & Culture Committee agenda 24 November 2026
    d) Quality Committee 09 July 2026,10 September 2026 and agenda 12 November 2026

[3] None expected from the Audit & Risk Committee or the Charity Committee as agendas for their meetings in September 2026 were provided to the Board meeting in public on 30 September 2026.

Oxford Health NHS Foundation Trust

Meeting:	Board of Directors' Meeting
Date of Meeting:	25 November 2026
Agenda item:	2
Report title:	Staff Story – Cost of Living
Executive sponsor(s):	Charmaine De Souza, Chief People Officer
Report author(s):	Steve Bell, Chair of Staffside unions and Unison rep
Action this paper is for:	☐ Decision/approval ☑ Information ☐ Assurance
Reason for submission to the Board:	Staff story
Public or confidential	Public

Executive summary

The Trust has worked closely and productively with union colleagues to review and enhance support mechanisms for the rising cost of living for staff over the last two to three years.

This included a temporary increase to mileage rates when petrol costs first spiked and the introduction of a support scheme from Salary Finance which is aimed at supporting staff to avoid pay day lenders. In September 2026, the Trust with support of Staffside moved mileage rates to those set by NHS Employers as this was more advantageous for the vast majority of staff.

The current employee offer is summarised in **Appendix 1**. To grow this further, the joint Chairs (CPO/Staffside Chair) of the SPNCC (Staff Partnership, Negotiation & Consultation Committee) are hosting an interactive, stakeholder workshop in November to generate further ideas and explore opportunities that may exist.

This staff story brings to life themes shared with union colleagues about the cost of living in recent months. Steve Bell has worked in the NHS since 1992 and has been a Unison rep and Chair of Staffside for much of that time. He will share Staffside views on how wage increases have not kept pace with inflation and what this means to those who work for the NHS.

He will also outline how many of his members are in receipt of work-related benefits and the implications of this. By way of example, in years when the annual pay rise had been distributed as a lump sum late in the year, some individuals did not receive benefits that

month or were removed from benefits altogether due to the apparent rise in salary. This left them needing to reapply.

Members have also fed back that whilst home working has created benefits for some, others report that the cost of Wi-Fi and electricity can be difficult to afford. Other members report continuing struggles in relation to travel costs which is worsened as business travel in excess of home to base mileage is reimbursed in arrears. The high cost of living in Oxford in particular means many staff travel into the county for work and find more affordable accommodation in other locations.

Union colleagues are increasingly seeing the stress and impact of financial pressure on individuals and teams which ultimately impacts interpersonal conflict, resourcing and quality of care. The Trust has shown commitment in offering support across a range of areas and activities and continues to work with union colleagues to remain responsive and innovative wherever possible.

See Appendix 1 below: Summary of current offer to support the rising cost of living

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

Recommendation(s)
n/a

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	

Appendix 1: Current workforce offer to support the rising Cost of Living

Offer	Detail	Link
Cycle to Work	Salary-sacrifice scheme for eligible substantive staff, with a £3,000 allowance. Minimum-wage requirements apply	Cycle to Work
Blue Light Card incl. membership reimbursement	NHS Blue Light Card discount scheme Reimbursement of membership, providing access to external discounts at high street stores including supermarkets	Blue Light Card Membership reimbursement
Financial Times financial literacy hub (FLIC)	Free, independent financial education, with short, self-paced modules covering budgeting, earnings, pensions, managing debt, credit, mortgages and other everyday money topics. Soon to incl. NHS specific advice	FT FLIC Adult Learning Hub
Salary Finance	Access to salary-linked products, saving and financial learning resources, subject to provider terms and eligibility. All optional products, not grants or recommendations to borrow	Salary Finance
Employee Assistance Programme (EAP)	Confidential support available 24/7, including financial and legal information and help with personal or work-related concerns	EAP services
Wellbeing Matters financial -support pages	Financial guidance, benefits and discount information, alongside signposting to wider advice and support	Financial support Staff benefits
Discounted Oxford Bus Company travel	£1 fares and free park and ride for NHS workers. Published information retains pilot wording, so current availability and terms should be checked	Oxford Bus Company Discounts
Staff accommodation	Below-market-rent accommodation options, subject to eligibility and availability	Staff accommodation
Access to Work provided by DWP / Maximus	Support for eligible people whose physical or mental health affects their work, including: • Mental health support: up to 9 months of confidential coaching and practical workplace strategies • Financial support: grants for specialist equipment, assistive technology, support workers and disability-related travel	Access to Work

	This is in addition to the reasonable adjustments employers must provide	
Mileage review	Reviewed mileage rates with Staffside – adjusted to enhanced rate in line with NHS T&Cs	Mileage rates
Band 2 salary review	Reviewed current Band 2 salaries with Staffside and put enhancements in place	Band 2 salaries
Leave	Staff can purchase extra annual leave	Annual leave purchase
	Staff can sell or carry over surplus annual leave	Carry over / Buy back
	Parent, carer, compassionate, special leave options also available to manage caring commitments	Other Leave policies
Wellbeing	£20 per head for team activity	Wellbeing funding
	Extra day of leave	Wellbeing day
Food / refreshments	Free tea, coffee and milk in bases	Tea, coffee, milk
	Bank holiday provision of food for staff on inpatient units	
Flexible working	Flexibility to adjust work hours and attend meetings remotely to reduce some travel costs	Flexible working
Period products	Free emergency period products	Period products
Pensions advice	Pensions workshops and individual advisory calls to support individual planning	Pensions

Oxford Health NHS Foundation Trust

(Agenda item: 3)

REGISTER OF DIRECTORS' INTERESTS

October-November 2026

PART A – CURRENT BOARD MEMBERS
PART B – FORMER BOARD MEMBERS 2026/27

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.
Teresa Beach	Non-Executive Director[2]	**REAch2 Academy Trust** – Member (unremunerated) from January 2027 and formerly Non-Executive Director from 2018-January 2026.
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.

[1] Interim October 2023 – November 2025. Substantive since December 2025.
[2] From 01 September 2026.

		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).
Michael Holland	Chief Executive[3]	**London School of Economics** – Senior Fellow in Department of Health Policy (remunerated). **King's College London** – Executive Fellow – delivers seminars on Leadership and Management (unremunerated).
Britta Klinck	Chief Nurse	No interests to declare.
Emma Leaver	Chief Operating Officer for Community Health Services, Dentistry & Primary Care[4]	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.
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	Chair of National Institute for Health and Care Research (**NIHR**) Steering Committees (unremunerated): (i) **Oxford Health - Biomedical Research Centre;** (ii) **Applied Research Collaboration - Thames Valley;** (iii) **Oxford Health - HealthTech Research Centre;** and (iv) **Oxford Health - Clinical Research Facility** Board Member (unremunerated): **Health Innovation Network Oxford & Thames Valley** Board Member, representing Oxford Health NHS FT shareholding (unremunerated): **AKRIVIA HEALTH**, using data for precision neuroscience. Advisor (unremunerated): **UNTANGLE GRIEF**, digital peer support platform; **TASTING COLOURS**, digital wellbeing service.

[3] From 07 September 2026

[4] Interim 01 March 2025 to December 2025. Substantive since January 2026.

		Honorary member: **Department of Psychiatry, University of Oxford**. Associate Fellow: **Green Templeton College, University of Oxford**. Wife is founder of '**Jump in puddles**' a social purpose 'UK B-Corp' consultancy working with various social purpose companies.
Paul Ringer	Associate Non-Executive Director	Group Chief Executive of the **Age UK Oxfordshire group,** comprising **Age UK Oxfordshire, Action for Carers (Oxfordshire) Ltd, Age UK Oxfordshire Trading Ltd** and **Ethical Legal Services Ltd**, trading as **Beacon CHC** (since August 2023, remunerated). Fitness to Practice Panel Member, Faculty of Health and Life Sciences, **Oxford Brookes University**, covering Psychology, Social Work and Public Health (since August 2025, unremunerated). Listening volunteer/member of the **Samaritans**, Oxford branch (since 2022, unremunerated). Former Appointed Governor representing Age UK Oxfordshire on the Oxford Health NHS FT Council of Governors (September 2023 to October 2026).
Harjit Sandhu	Non-Executive Director	Non-Executive Board Member and Group Audit, Risk and Assurance Chair at the **Department for Transport** (with effect from 01 September 2026). 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.
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[5]	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).

PART B – FORMER BOARD MEMBERS 2026/27

Grant Macdonald	Chief Executive Officer[6] (until 04 September 2026)	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
Mohinder (Mindy) Sawhney	Non-Executive Director (until 31 July 2026)	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.

[5] From 01 April 2026.

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

Meeting of the Oxford Health NHS Foundation Trust Board of Directors

[DRAFT] Minutes of a meeting held on Wednesday, 30 September 2026 at 09:00 Hybrid: Saïd Business School, Park End Street, Oxford OX1 1HP and Microsoft Teams for presenters/observers

Present:[1]

Andrea Young (**AY**)	Trust Chair (the Chair)
Michael Holland (**MH**)	Chief Executive Officer
Amélie Bages (**AB**)	Executive Director of Strategy & Partnerships*[2]
Rob Bale (**RB**)	Chief Operating Officer for Mental Health & Learning Disability
Teresa Beach (**TB**)	Non-Executive Director
Geraldine Cumberbatch (**GC**)	Non-Executive Director – *part meeting*
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
Helen Mackenzie (**HM**)	Non-Executive Director
Kamal Mahtani (**KMa**)	Non-Executive Director appointee of the University of Oxford
Karl Marlowe (**KM**)	Chief Medical Officer
Harjit Sandhu (**HSa**)	Non-Executive Director
Heather Smith (**HS**)	Chief Finance Officer
Rick Trainor (**RT**)	Non-Executive Director
Lucy Weston (**LW**)	Non-Executive Director

In attendance[3]:

Attendees/observers from Oxford Health NHS FT staff	
Laura Carter	Head of Strategy – *part meeting*
Nicky Howells	Deputy People Director – *part meeting*
Vicky Naidoo	Recovery and Lived Experience Involvement Lead – *part meeting*
Donna Mackenzie	Experience & Involvement Team Manager – *part meeting*
Deimante Pelakauskaite - Freimoniene	Senior Contracts and Performance Manager – *part meeting*
Rachel Pirie	Head of Planning – *part meeting*
Lisa Reynolds	Associate Director of Mental Health, Thames Valley Mental Health Provider Collaborative – *part meeting*
Nicole Robinson	Experience and Involvement Lead for Community Services – *part meeting*
Sam Shepherd	Deputy Director of Strategy & Planning – *part meeting*
Roberta Silva	Experience and Involvement Facilitator – *part meeting*
Hannah Smith (**HaS**)	Assistant Trust Secretary (Minutes)
Georgina Thorne	Senior Clinical Lead - Community Children's Nursing – *part meeting*

Other attendees/observers	
Juliet Hunter	Governor representing Public: Oxfordshire
Simon Josephs	Oracle Applications - Healthcare

[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

BOD 78/26	**Welcome and Apologies for Absence**	
a	The Trust Chair welcomed Board members and attendees to the meeting.	
b	Apologies for absence were received from: Charmaine De Souza, Chief People Officer.	
BOD 79/26	**Staff Story – Trauma Risk Management (TRiM) service**	
a	The Deputy People Director introduced the TRiM Practitioner to the meeting and explained that the TRiM service was an internal initiative which involved supporting colleagues following trauma and all TRiM roles were in addition to primary job roles, as set out in more detail in the report.	
b	The TRiM Practitioner took the Board through the story of a colleague's experience following verbal and physical assault from a patient on a ward, and in the context of their additional challenges in dealing with personally difficult circumstances and carer responsibilities, noting the supportive discussions which had taken place with the TRiM Practitioner and the onwards referrals to psychological therapy services.	
c	Further to a question from Helen Mackenzie, the TRiM Practitioner explained how the TRiM service could become involved with supporting staff in the aftermath of incidents through a variety of routes including: TRiM managers and practitioners would review incidents which had happened the day before and offer conversations to staff; managers could also refer staff directly, with their permission; staff could self-refer; and the TRiM service also conducted roadshows and attended team meetings to promote the service.	
d	The Chief Executive led the meeting in: (i) reflection on the powerful story and impact on the colleague involved; and (ii) discussion on how the Trust could learn from the 330 TRiM conversations which took place last year to think about support and helpful interventions for staff. The TRiM Practitioner noted that although a number of initiatives were taking place around preventing violence, addressing discrimination and racism and dealing with the aftermath of incidents, there was still work to do to bring together the relevant knowledge, skills and learning. However, he confirmed that the Director of Psychological Professions was aware and working with the various initiatives to improve staff experiences. The Deputy People Director confirmed that data was collected from those who had received TRiM support, together with data from other processes such as Freedom To Speak Up, but she acknowledged that there was still work to do on triangulating common themes. The Chief Nurse added that TRiM service support also differed from other organisational support because it was not just about supporting staff in their roles but also could cover the personal impact upon them following trauma. She added that the TRiM service was just one element of the wider support available to staff including formal debrief sessions, incident learning huddles, supervision and the employee assistance programme.	
e	The Chief Nurse, in discussion with the TRiM Practitioner, noted that next steps should involve the wider roll-out of the service to provide more coverage in community services and specialist services such as Learning Disabilities. Although currently inpatient services, including Child & Adolescent Mental Health Services (**CAMHS**), were the highest users of TRiM services (over 40% of the incidents received this support), there were also relevant cases from community services (20% with the remainder being spread over other services).	
f	Further to a question from Harjit Sandhu on the support which TRiM staff received themselves in order to process the traumatic experiences shared by colleagues, the	

	TRiM Practitioner explained that TRiM Managers debriefed TRiM Practitioners to help them to process particularly difficult conversations and move forwards. Consideration was also being given to introducing more systematic and ongoing support, including for TRiM Coordinators who reviewed these cases regularly. The Deputy People Director confirmed that she had noted this.	
g	In response to a question from the Executive Director of Corporate Affairs on the uptake rate for the service of 330 conversations following 850 TRiM offers made last year and whether uptake was linked to those who had experienced more traumatic incidents, the TRiM Practitioner noted that the data did not currently support that distinction but anecdotally, uptake may not be related to the severity of the incidents as much as to other factors impacting staff including in their private lives. Experienced staff who had regularly dealt with such incidents might reach out to the TRiM service after other events, which could be at home or in the community, impacted their capacity to cope.	
h	The Trust Chair thanked the TRiM Practitioner for the discussion and the Board thanked them for their support for colleagues.	
i	**The Board thanked the TRiM Practitioner and noted the report and discussion.** *The Deputy People Director and the TRiM Practitioner left the meeting*.	
BOD 80/26	**Register of Directors' Interests**	
a	No interests were declared pertinent to matters on the agenda.	
BOD 81/26	**Minutes and Matters Arising of the meeting held on 22 July 2026**	
a	The Minutes of the meeting were approved as a true and accurate record.	
b	The actions were noted as in progress or scheduled, especially for the Quality Committee (detail in the Summary of Actions document). Helen Mackenzie, in her capacity as Chair of the Quality Committee, confirmed that she was aware.	
BOD 82/26	**Trust Chair's Report**	
a	The Trust Chair took her report as read and highlighted: • ward visits had demonstrated the compassion and skill of staff in managing complex patients and creating calm and therapeutic environments; and • the success of the apprenticeship programmes. Helen Mackenzie congratulated the Learning & Development Team. The Trust Chair agreed and thanked the People Directorate for its leadership in this area. The Chief Nurse added that over the last two years, more qualified nurses had joined the Trust from the apprenticeship programmes than from the university route and the apprenticeships also benefited local staff.	
b	**The Board noted the report.**	
BOD 83/26	**Chief Executive's report**	
a	The Chief Executive took his report as read and noted: • the warm welcome he had received, internally and externally to the Trust, and the commitment to improving care and developing a culture of care across services which he had witnessed from staff. He highlighted the tour of a psychiatric intensive care ward which he had received from a patient who had been positive and enthusiastic about the care which they were receiving, which was a testament to the staff involved;	

	• the opportunity for the Trust to build upon its positive reputation within the local system; • the importance of applicable learning from the Thirlwall Inquiry in relation to culture and governance which should apply to all NHS providers and which was central for the Trust and the implementation of its new Strategy (and also reflected in items later on the agenda such as the Learning from Deaths report at item 94/26(b)(ii) below and the next item at BOD 84/26); and • recent Care Quality Commission (**CQC**) inspections of inpatient mental health services (detail in the report), improvement work which had been implemented and preparation taking place in anticipation of future core services inspections.	
b	**The Board noted the report.**	
BOD 84/26	**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 (including the Thirlwall Inquiry report); and (ii) legal and regulatory updates, together with any specific actions being taken by the Trust in response. He confirmed that the Trust had submitted its Annual Report & Accounts 2025/26 by the NHS England deadline and presented them at its recent Annual Members' Meeting & Annual General Meeting (**AMM & AGM**) on 24 September 2026.	
b	In response to a question from Rick Trainor on the Trust's NHS Oversight Framework (**NOF**) segmentation score of 2.11 (previously the Trust had scored 2.36, as confirmed later in the meeting at item 89/26(a) below), the Executive Director of Strategy & Partnerships explained that the metrics and methodology had changed since scoring was last reported to the Board but a position in segment 2 was as expected in relation to the Trust's underlying performance, although it was recognised that there were also areas for improvement. The Chief Finance Officer added that the Trust had also retained its relative performance in comparison to other trusts in the league table.	
c	The Board considered: i. the Data (Use and Access) Act 2025 which the Chief Medical Officer explained now required the Information Commissioner's Office to temper its regulatory enforcement approach with consideration of the public interest in driving innovation and supporting competitive markets, which could benefit innovation and research within the NHS and fit well with the Trust's strategic approach to research and use of information in its Board Assurance Framework (**BAF**) and with becoming a more agile organisation seeking to innovate and improve. The implications for the Trust were being considered by the Data Protection Officer; ii. the Nursing and Midwifery Educator Framework which the Chief Nurse confirmed was being reviewed through the Oxford School of Nursing and Midwifery (a partnership between the Trust, Oxford Brookes University and Oxford University Hospitals (**OUH**) NHS FT) and no significant changes were anticipated; iii. the renewed Women's Health Strategy for England, which Helen Mackenzie confirmed was on the work plan for the Quality Committee. The Chief Nurse added that this strategy was very focused on women's physical health but would apply to some Trust services. The Chief Medical Officer noted its relevance across quality, safety, research and innovation considerations, in particular in relation to domestic violence and reminded the meeting of the University of Oxford's recent recruitment to relevant posts including a Professorship of Women's Mental Health which would also encompass the role of Founding Director of the newly established Oxford Centre for Women's Mental Health; and	

	iv. the Trust's approach to preventing unauthorised access to patient records, especially in light of recent national incidents involving such data breaches. The Executive Director of Corporate Affairs confirmed that this had been discussed at the Extended Leadership meeting earlier in September 2026 and assurance had been provided on the Trust's systems and processes. Various controls were in place including: through the Clinical Systems team and the Information Governance team; controls related to role-specific access and multi-factor authentication; sign-off through his role as Senior Information Risk Owner; regular audits and reactive audits in response to specified triggers; and oversight through the Information Management Group with reporting up to the Finance & Investment Committee. In response to a question from Helen Mackenzie, he confirmed that in the last two years, there had been two cases related to access and both of which had been investigated and subject to appropriate action. d **The Board noted the report and the actions being taken.**	
BOD 85/26 a b c	**Board Assurance Framework (BAF)** The Executive Director of Corporate Affairs presented the report which provided updates on BAF activity including Committee reviews, risk updates and progress made against Internal Audit recommendations. There had been no changes to current risk scores since the last report to the Board in July 2026. The BAF would be refreshed to align with the new Trust Strategy and the Board meeting in private session later that afternoon would assess alignment of strategic risks to delivery of the new Strategy, with potential to follow-up at a future Board workshop. In response to questions from Harjit Sandhu and Kamal Mahtani, he confirmed that: (i) pending refresh of the BAF, the existing BAF risks would continue to be managed in line with current processes; and (ii) the BAF was subject to annual refresh on a financial year basis but this year this had been held back to align with introduction of the new Strategy. **The Board noted the BAF and that it would be reviewed to align with and support the new Trust Strategy.**	
BOD 86/26 a	**Provider Capability Self-Assessment 2026** The Executive Director of Corporate Affairs presented the report and explained that the 2026 self-assessment built upon the previous 2025 self-assessment in which the Trust had self-rated as 'amber-green' across all six domains of: (i) Strategy, Leadership and Planning; (ii) Quality of Care; (iii) People and Culture; (iv) Access and Delivery of Services; (v) Productivity and Value for Money; and (vi) Financial Performance and Oversight. The 2025 submission had been reviewed and supported by NHS England South East Region. He invited the Board to consider the proposed 2026 self-assessment at Appendix A and the supporting domain narratives at Appendix B. He drew the Board's attention to the progress made since 2025 including: • the Board's consideration of its own effectiveness and that of its Committees which had culminated in a Workshop session on 29 April 2026; • renewal of the Board's skill assessment, as presented to the last meeting on 22 July 2026; • recruitment of a new Trust Chair, Chief Executive Officer and three new Non-Executive Directors; • development of the Strategy Delivery Plan to accompany the new Trust Strategy 2026-31; and • completion of a Well-Led self-assessment and an independent Well-Led review which would be considered by the Board in private session this afternoon.	

b	He reminded the Board that the Trust had received core services inspections and that the Board should consider whether the findings from these should indicate any changes in the proposed ratings. He noted that the test was not whether there were any areas for improvement but whether there were areas with fundamental capability gaps which should be a cause for concern and impact ratings accordingly.	
c	The Chief Finance Officer reminded the meeting that, at item BOD 87/26 below, it would also be considering the Strategy Delivery Plan 2026-2031 and noted the importance of this to delivery of the Trust's new Strategy and the rating against domain (i) on Strategy, Leadership and Planning. She also cautioned against having too many different action plans and noted that the Strategy Delivery Plan should be the most important.	
d	The Trust Chair led the Board through review of the self-assessment narratives and proposed ratings for each of the six capability domains.	
e	Kamal Mahtani noted the benefits of relative continuity during a period of change and recruitment, with an existing Non-Executive having become Trust Chair and Executives in interim roles having been appointed to substantive positions through competitive recruitment processes.	
f	In response to a question from Helen Mackenzie, the Executive Director of Corporate Affairs explained the process of review and challenge by the Corporate Affairs team of the narrative responses provided by Executives for each domain, noting that this ensured consistency and provided an opportunity for further clarifications or additions. He was confident that the exercise had been conducted objectively and fairly and that Executive leads had engaged seriously in the process and used it productively to test and set out their understanding of each domain.	
g	Harjit Sandhu commented upon the importance of appropriate challenge and the value of the independent Well-Led review conducted by the GGI. The Trust Chair noted that the Well-Led review, although high-level and desk-top, had identified useful areas for improvement and next stages.	
h	Teresa Beach reflected upon: (i) other external sources of assurance, such as auditors or regulators like the CQC; and (ii) internal sources of assurance, such as the BAF, and whether these combined sources of data were being triangulated effectively. Based upon the documentation and evidence provided, she concluded that this would appear to be the case. However, she cautioned that some elements in the BAF might suggest that a more cautious position should be taken towards the Trust's risks. The Chief Executive acknowledged the importance of assessing the effectiveness of triangulation and noted that in relation to external sources of assurance in particular, the "so what" test of effectiveness may be answered in the coming year when evidence of progress against improvement plans could be considered, together with actions taken in response to external recommendations and internal improvement activities.	
i	Lucy Weston agreed that triangulation of external and internal sources of assurance was key and challenged the Board on how it could think outside of the framework of the Trust's Strategy about its key risks and areas for improvement. In relation to the self-assessment, she suggested the following areas for challenge and potential qualification or additional detail to be included: i. domain (i) on Strategy, Leadership and Planning – she acknowledged the roll-out of the strategic plan but queried how comfortable the Trust could be that it had been delivered as uniformly as intended and whether digital and data were being used sufficiently to support organisational improvements; and ii. domain (iv) on Access and Delivery of Services – whether there was sufficient clarity around the trajectory to improve performance against the relevant access	

	and waiting times standards and the assurance which the Board received to identify and address inequalities in access/waiting times.	
j	The Executive Director of Strategy & Partnerships replied that the assurance to the Board on identifying and addressing inequalities in access/waiting times was developing; whilst reporting at Board level was not yet finalised, health inequalities were being considered at Directorate and Executive levels, with next steps to include how more formal reporting would be delivered. She added that the Executive would also be discussing this in more depth over October 2026. The Board considered and agreed that the proposed amber-green rating for domain (iv) on Access and Delivery of Services remained appropriate and that the situation was not indicative of a red-rating, given supporting detail in the Integrated Performance Report, trajectories for improvement and confidence of delivery of plans in-year. Helen Mackenzie recommended that it would be even more helpful if information on trajectories could include the position which the Trust aimed to have achieved by the end of March 2027.	**AB**
k	The Trust Chair concluded that the Board had agreed that the proposed amber-green rating for domain (iv) on Access and Delivery of Services remained appropriate and that further detail around identifying and addressing inequalities in access/waiting times would be provided to the Board. The Board supported the 2026 self-assessment and the proposed ratings across all six domains but recognised that some of the narrative statements may be subject to qualification or additional detail, further to discussion above.	**AB**
l	The Trust Chair reflected upon the importance of: • appropriate challenge as part of the self-assessment process; • avoiding having too many action or development plans, noting that the Board should seek to utilise and oversee the Strategy Delivery Plan and hold Executives to account against it accordingly; and • identifying areas to focus on and develop for the Board Development Plan, with discussion and challenge at a future meeting and consideration of which of the domains in the self-assessment which were currently 'amber-green' should be targeted for potential advancement to a 'green' rating, subject to resourcing and capacity. Areas of focus for the Board Development Plan should also support delivery of the overall Trust Strategy and mitigate strategic BAF risks.	**TG**
m	**Subject to the discussion above, and noting that some of the narrative statements may therefore be subject to qualification or additional detail, the Board APPROVED and confirmed the Provider Capability self-assessment ratings for each domain for submission to NHS England South East Region.**	
BOD 87/26 a	**Strategy Delivery Plan 2026-2031** The Executive Director of Strategy & Partnerships presented the Draft Strategy Delivery Plan which set out proposals for how the organisation would deliver against the new Trust Strategy, which had been approved at the last Board meeting in July 2026, and turn its long-term ambitions into action with milestones to meet in order to turn the Strategy into reality. She explained that the Strategy Delivery Plan would remain relatively high level and would provide an outline over the next five years, with more granular plans to be developed for each year. Internally it would act as: (i) a guideline for teams on what to prioritise and how to deliver against the Strategy; and (ii) a tool for the Board to hold the organisation to account for delivering against its priorities. Externally it would help the Trust to communicate with stakeholders, partners and the wider system. She invited the Board to feedback on the draft, with final changes to be made by the Executive ahead of finalisation of the Strategy Delivery Plan.	

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b	She took the Board through: • the outline Strategic Dashboard and the goals under each of the three strategic aims (slide 4), noting that metrics would be set against each and used to monitor, report and inform action over the next five years; • translating the six strategic priorities into action by 2031 (slides 5-11); • ambitions for each of the six strategic foundations (core areas underpinning how the Trust worked) to enable the Trust to deliver on its strategic aims and priorities (slides 23-19); • clinical plans outlining how the Strategy would be delivered across services (slides 20-31); and • prompts and questions (slides 32-34) which would be used throughout the annual planning process each year to ensure that staff at all levels were asking the right questions when developing their local plans. She confirmed that the Annual Planning process for 2027/28 had already commenced.	
c	Non-Executive Directors commended the Draft Strategy Delivery Plan, in particular the consideration given to metrics/future measures to demonstrate delivery, and suggested: i. the next iteration should include more on: ○ digital aspirations, building digital confidence and capability in the workforce. Teresa Beach commented that there was more which the organisation could do or set out more explicitly in its risks and opportunities. The Executive Director of Strategy & Partnerships noted that this was part of the People Plan (slide 16) but could be expanded; and ○ explicit focus on patient experience. Lucy Weston suggested: (i) taking a patient-focused approach to what services could look like and reorienting the culture of the organisation, not just specific pathways, around patient experience as a way of delivering more effective services; and (ii) more explicitly capturing how Quality Improvement (**QI**) was being used from a strategic improvement perspective; and ii. future consideration/discussion on how the Board could oversee the implementation of the Strategy Delivery Plan. Harjit Sandhu noted that the Board should be able to see how the Strategy was being made real and had filtered through to the frontline workforce and how it could act as a golden thread for what the organisation stood for.	**AB**
d	The Chief Executive noted that: (i) metrics and measures to be developed would need to work as, and interact with, system measures and national direction not only as internal measures for the organisation (noting that a new national mental health strategy was anticipated later in the year); and (ii) consideration would need to be given to bringing together QI resources in order to execute the programme for the organisation. Lucy Weston cautioned that system measures and interpretations of what success could look like may be different to those of the organisation and its aspirations. The Chief Medical Officer noted that: (i) delivery and interpretation of the Strategy may always be subject to some fluidity in response to system and national requirements; and (ii) the strategic priority to 'Make things simple' already fit well with a QI approach to reducing inefficiency.	
e	Further to a challenge from the Trust Chair on monitoring the metrics and measures (which were still to be determined, owned and delivered by directorates) and how the Board would know if these were serving the organisation well over the long-term and in order to meet population and place-based outcome measures, the Executive Director of Strategy & Partnerships confirmed that there would be opportunities to challenge directorates, adapt and do things differently if the directorate plans did not provide the assurance which the Board required. Over the five-year period of the Strategy, the metrics would be honed from their high-level starting point. The Chief Operating Officer for Mental Health & Learning Disability agreed and noted that although currently	

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	Oxfordshire and Buckinghamshire had different approaches, in five years' time there should be more joint planning on core measures and outcomes, even if there remained some differences in the local approaches to reach the agreed outcomes. Kamal Mahtani noted the utility of alignment across systems and directorates to support a degree of shared thinking and collaboration. *Geraldine Cumberbatch joined the meeting*.	
f	Further to a challenge from Lucy Weston on whether variation in pathways between geographies was warranted or unwarranted, the Chief Operating Officer for Mental Health & Learning Disability noted that he had also queried this but geographical differences meant that the Trust had a different role with different local partners in Buckinghamshire compared to Oxfordshire.	
g	In response to Harjit Sandhu and how the Board could know that the Strategy had filtered through to the frontline workforce, the Chief Operating Officer for Mental Health & Learning Disability added that yesterday he had attended a celebration event for community mental health in Oxfordshire and staff were already familiar with the slides/content of the Strategy.	
h	The Trust Chair summarised that the Draft Strategy Delivery Plan provided clarity on the Trust's direction of travel, which was supported although it was also acknowledged that metrics and measures were still to be developed. The Executive Director of Strategy & Partnerships noted that these were anticipated by January 2027.	
i	**The Board supported the Draft Strategy Delivery Plan 2026-2031, noting that final changes would be made by the Executive ahead of finalisation of the Strategy Delivery Plan.**	
BOD 88/26	**Winter Plan 2026/27**	
a	The Trust Chair introduced the report and noted her responsibility to ensure that the Board was assured that the Trust was preparing appropriately for winter and to participate in providing system support.	
b	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care took the report as read and highlighted that: • the Winter Plan had been developed with system partners and through robust relationships with both the ambulance trust and the acute trust. The Executive Director of Strategy & Partnerships added that this system plan was also part of Neighbourhood and Place work and had been subject to robust discussion as part of this; • the report focused upon internal preparedness and readiness, building upon work which had been established over the last few years to support patient care and system flow. She confirmed that there was strong focused leadership, the Trust was a regular participant in escalation calls and in supporting patient flow and avoiding Emergency Department attendance and admissions; and • the difference this year had been the summer heatwaves which had led to spikes in demand as well as staff sickness, leading to consideration of workforce resilience particularly in community health services.	
c	The Chief Nurse added that the Trust's Staff Seasonal Vaccination Campaign 2026 was starting this week; all directorates had local plans and vaccination clinics scheduled.	
d	In response to a question from the Trust Chair on the impact of workforce resilience challenges upon agreed trajectories for 2026/27 (for example those related to Out of Area Placements (**OAPs**) or length of stay), the Chief Operating Officer for Mental Health	

	& Learning Disability acknowledged that challenges with OAPs were recognised and he had asked teams to work on their plans to reduce OAPs. Although some smaller services such as Out Of Hours 111 could become overwhelmed, this risk could be mitigated through plans to move staff across to provide cover if required. The Chief Operating Officer for Community Health Services, Dentistry & Primary Care added that services such as District Nursing had winter survival plans in place to address challenging periods but it was still important to pay attention to the wellbeing of staff, especially after periods of working additional hours.	
e	Helen Mackenzie noted that she had already had prior sight of the Winter Plan, and commended the system metrics for community services, but expressed surprise that there were none for mental health services in the plan. Although mental health services may not experience the same seasonal surge as some partner organisations, there would be increased pressure in the system as a whole and the response of mental health services could still be important. The Chief Operating Officer for Mental Health & Learning Disability replied that existing waiting times metrics were the relevant ones, already in place and working reasonably well.	
f	Further to a suggestion from Helen Mackenzie, the Chief Operating Officer for Community Health Services, Dentistry & Primary Care agreed to provide an update to the Board in May 2027 on the Winter Plan and how successful the Trust had been in supporting the local system, with feedback from the acute sector on their experience.	**EL**
g	**The Board noted the report and was assured by the Winter Plan 2026/27 and work being done by services to ensure preparedness.**	
BOD 89/26	**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 reported that at Quarter 1, the Trust had been placed in segment 2 (above average) of the NOF segmentation system for NHS trusts and foundation trusts (with a score of 2.11 having previously scored 2.36, as discussed at item BOD 84/26(b) above). Quality and People metrics were also included in the report together with the Quality & Safety Dashboard (which helped to identify wards/teams which may need support and provided an early warning system).	
b	From the Trust's metrics to monitor clinical performance (derived from nationally reportable metrics and locally agreed metrics) she highlighted pressures in: i. Child and Adolescent Mental Health Services (**CAMHS**) and Eating Disorders waiting times, noting that, as set out in the Summary of Actions document referred to at item BOD 81/26 above, a deep dive was provisionally scheduled for the Quality Committee meeting in November 2026; ii. Length of Stay for mental health inpatient adult acute and Psychiatric Intensive Care unit discharges; and iii. Community services waiting times, especially for Podiatry and the Children's Speech and Language service.	
c	Rick Trainor expressed surprise that the Trust had been assessed as being in quartile 4 for performance against the NOF domain of 'Finance, productivity and innovation', with areas requiring improvement in relation to: (i) Relative Cost Difference (National Cost Collection Index (**NCCI**); (ii) percentage of clinical trials set up within 90 days; and (iii) overall Data Quality Maturity Index. The Chief Finance Officer explained that the NCCI score related to the previous financial year's submission; further to this year's submission, the NOF score was expected to improve. The score had also been impacted by productivity reporting not capturing all activity over time, together with the impact of timeliness in setting up research studies/clinical trials and Data Quality.	

d	Helen Mackenzie asked for an update further to discussions at the last meetings on Data Quality. The Chief Executive replied that the Executive had received a report earlier that week on Data Quality together with an action plan on 32 items to be addressed. He confirmed that the challenges were understood but a considerable amount of work would need to be undertaken to improve Data Quality, especially in reporting in relation to emergency care. The Executive Director of Strategy & Partnerships added that the work was also linked to how Electronic Patient Record systems were configured and whether they had the capability to capture the data required.	
e	The Executive Director of Strategy & Partnerships agreed to respond separately to a query from the Trust Chair about AnDY (Anxiety and Depression in Young People) data not being included in planned activity/the Oxfordshire CAMHS access metric and whether this would be resolved.	**AB**
f	**The Board noted the report.**	
BOD 90/26	**Finance and Sustainability**	
a	The Chief Finance Officer took the Month 4 Finance Report as read. The Income & Expenditure position remained better than plan whilst Capital Expenditure remained below plan.	
b	**The Board noted the report.**	
BOD 91/26	**Patient Story - Family Experience with Jaundice Pathway**	
a	The Experience and Involvement Lead for Community Services presented the report and shared a video on a family's experience following the launch of the Children's Hospital at Home Jaundice Home Phototherapy Pathway. The family reported a positive experience having been discharged with a home phototherapy mat, noting the guidance that they had received in using it and the support which would remain available in the hospital should they have required it.	
b	The Jaundice Pathway had been developed through a QI approach, drawing on national Hospital at Home models, feedback from Experts by Experience, input from the Children's Community Nursing Hospital at Home team and a bilirubin point-of-care testing feasibility study. The Senior Clinical Lead for Community Children's Nursing noted how allowing families to provide care at home enhanced parental experience and early bonding with their baby. She confirmed that: (i) care bundles were created with acute hospital consultants so that parents would have information/guidance to take home about using the equipment; and (ii) parents would have fast access back into the hospital if there were any issues. Initial referral rates into the pathway had been low and the team was considering the reasons for this (some related to timing issues and when the service was available as well as some patient hesitancy to use a new service) and hoping to increase activity over the next 8 weeks as there were potential significant benefits for families.	
c	Further to queries from: (i) Lucy Weston on how the pathway had started and the evidence for service improvement and benefits; and (ii) Geraldine Cumberbatch on the assessments undertaken to establish whether the pathway would be appropriate for families including taking into account any concerns about ability or linguistics, the Senior Clinical Lead for Community Children's Nursing replied that: i. the matron overseeing the service had been linked into the national Hospital at Home working groups where this was already a pre-existing service; ii. the national 'bed days saved' metric for Hospital at Home demonstrated time and money savings for the acute service;	

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	iii. patient involvement work indicated positive feedback from families; and iv. the midwives already involved with the families undertook the assessments and considered any safeguarding concerns, learning disabilities or language barriers.	
d	Kamal Mahtani noted that this Patient Story highlighted the value which the Board should place upon applying research and innovation in practice to improve the lived experience of patients. The Trust should seek to capitalise upon its association with the University and research in considering what more it could provide.	
e	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care thanked the team and highlighted that this was also an example of successful joint working and collaboration with acute sector colleagues at OUH NHS FT.	
f	**The Board noted the report and the video presentation and thanked the Children's Community Nursing Hospital at Home team.**	
BOD 92/26	**Lived Experience Voices at Board – with Experts by Experience (EbEs) from Bucks Voice**	
a	The Chief Nurse welcomed the Experience and Involvement Facilitator together with EbEs from Bucks Voice to the meeting to: provide insight into the contribution of people with lived experience of services; work alongside the Trust to make improvements; and to provide challenge and hold the organisation to account. The Experience and Involvement Facilitator explained that: (i) the EbEs would discuss the impact of involvement work in Buckinghamshire and further afield in the Trust; and (ii) the presentation had been co-produced with all authors having come from different backgrounds and experiences. She emphasised the importance of lived experience work to supporting recovery and strengthening inclusion.	
b	The Experience and Involvement Facilitator and the EbEs took the Board through the presentation highlighting: • the growth of the EbE community in Buckinghamshire, with increasing numbers wanting to contribute their lived experience to services and a greater range of diversity in the group; • the breadth of influence of EbEs across activities (Impact in Action), with their insights, challenges or recommendations helping to shape services or improve experiences for others; • a request/recommendation for funding to support the Buckinghamshire Autism Reasonable Adjustments (**BARA**) service which supported adults with autism or suspected autism to seek reasonable adjustments to help them to feel secure enough to engage with professionals and to address inequalities and diagnostic overshadowing. The service had been reduced to a single person and needed funding and staffing to function; • the ripple effect of an EbE's participation on a recruitment panel for a service manager who, upon appointment, listened to and worked with EbEs to improve the service including through helping to review the language used in documentation, co-producing statements and participating in staff away days; and • the experience of an EbE who had become a published author, sharing their experience of recovering from an eating disorder, and trainer on the Oliver McGowan Training on Learning Disability and Autism, emphasising that change was possible.	
c	The Trust Chair thanked the Experience and Involvement team and the EbEs, commended their impact which reinforced the Trust's commitment to them which was also a key part of the new Trust Strategy and acknowledged the request for the BARA service although it could not be responded to at this meeting.	

d	In response to a question from the Chief Executive on what more the organisation could do to help the EbEs to feel embedded as part of the organisation and its culture and way of working, the EbEs highlighted: • being clear about what added value EbEs could bring to help a process become easier or more impactful; • inviting EbE participation early enough for them to be able to help and participate in discussion rather than too late or as a tick box exercise; • a culture of listening to and accepting EbE views, even if those views or recommendations might not be agreed with or acted upon; • supportive tone from the top in order to change culture or unblock areas which might have been resistant or concerned that the EbEs would be critical rather than recognising that they often agreed with actions taken and wanted to make services better; and • encouraging participation in events with EbEs, including celebrations and workshops, to promote opportunities for co-production.	
e	The Chief Operating Officer for Mental Health & Learning Disability commented that the celebration event for community mental health in Oxfordshire which he had attended yesterday had also involved EbEs and peer workers discussing their experiences, which he hoped would be a powerful message for attendees including partner organisations. He added that feedback from patients was also key in his profession as a psychiatrist.	
f	Lucy Weston asked the Board to consider an action to think further about having a Board member with lived experience of Trust services. The Trust Chair acknowledged the request and noted that it had been discussed a few months ago at a Board Workshop in the context of how best to engage EbEs with the Board and which had led to the inclusion on Board agendas of regular presentations such as this one which had highlighted impact and potential areas for future focus. The Board was also currently trialling EbE/patient voice representatives presenting at these meetings, with only two meetings undertaken so far.	**AY**
g	**The Board noted the report and thanked the Experience and Involvement team and the EbEs.** *The meeting took a break over 11:42-11:52 before resuming.*	
BOD 93/26	**Patient Safety Incidents (PSI) report – July-August 2026**	
a	The Chief Nurse presented the report on learning identified from 9 patient safety reviews over the reporting period and wider learning from the local incident response plan for the national Patient Safety Incident Response Framework (**PSIRF**). A range of learning response approaches were in use and 23 Incident Learning Huddles had taken place over the period. She highlighted that a Thematic Review was considering the increase in unexpected deaths or significant incidents over the June-July heatwave period for patients with severe and enduing mental health illness (across both mental health directorates).	
b	Key areas for learning identified from reviews and Incident Learning Huddles were set out in Table 2 of the report across physical and mental health services and included: physical health deterioration; information sharing with family and engagement with family/carers; self-referral and GP referrals; completion of care plans and risk assessments; self-neglect; and staffing constraints impact on key worker allocation.	
c	The Trust Chair commented upon common themes relating to access to care and waiting times, noting that this endorsed Board focus on waiting times and management of harm and risks.	

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d	Further to a query from Geraldine Cumberbatch on the three cases in which delay in treatment had resulted in pressure ulcers and whether these represented emerging themes or were coincidence, the Chief Nurse confirmed that as they were three similar incidents they were being investigated together and the Quality Committee regularly considered the impact of demand and resourcing challenges upon the District Nursing service. Overall the number of incidents resulting in harm, complaints or litigation for the Districting Nursing team was low for the amount of visits which took place but these incidents were being investigated.	
e	**The Board noted the report and was assured by processes and structure for the identification, review and learning from PSIs.**	
BOD 94/26	**Board Committees' update reports – matters for Alert, Advice & Assurance (3As) and Committee recommendations**	
a	***Quality Committee 3As and reports reviewed and recommended*** Helen Mackenzie presented the 3As report from the Quality Committee meeting on 10 September 2026 and noted that most matters had already been discussed earlier in the Board meeting. She highlighted that the Committee: (i) was seeking further assurance around how CQC requirements were being met further to the inspections; and (ii) had considered waiting lists.	
b	In relation to the reports provided and recommended from the Quality Committee: i. the Joint Children & Adults Safeguarding report was recommended and the Committee in July 2026 had been assured on the safeguarding arrangements in place; and ii. the Learning from Deaths report had been updated since the version provided to the Quality Committee. The Chief Medical Officer presented the report and confirmed that there were no significant differences since the version presented to the Quality Committee. He highlighted that: o four separate and distinct clusters of deaths had been identified in the last few months which were summarised, with the relevant actions taken, in the report and there were no immediate areas of learning; o the Trust had hosted a webinar to mark World Suicide Prevention Day on 10 September 2026 which had been chaired/hosted by an EbE; and o the Trust had not yet received any direct Preventing Future Deaths Notices in 2026/27 but transition of care from the Trust's CAMHS services in Swindon to the Adult Mental Health services of another provider had been mentioned in the response to a notice sent to NHS England in April 2026 (the Trust had been one of four organisations referenced) and the Integrated Care Board (**ICB**) had convened a system working group to review the current commissioned service model for young people to identify areas for improvement (detail in the report). He noted that the Trust would act on learning to make the transition from CAMHS to Adult services more robust.	
c	***Finance & Investment Committee (FIC) 3As*** Lucy Weston, as Chair of the FIC, provided a verbal update of the meeting held on 15 September 2026, noted that there were no alerts to raise and reported that: • the Committee had received assurance that the financial position at Month 4 was £0.4 million better than plan and there was proactive management of overspends by the Executive, as well as initiatives to address underspends. She advised the Board that although the Month 4 financial position was positive, there were risks around cost control, OAPs (especially in Buckinghamshire and Learning Disability services), staffing costs on forensic wards and the need to consider models of care. Capital underspending also remained a risk;	

	• NHS England required run rate trajectories to be provided, these were included at Annex A (Route Map Month 4 to Year-End) of the Month 4 Finance report (in private session) and had been supported by the Committee although they also suggested some future underspends; • £3 million had been reinvested into addressing waiting times as well as QI and digital work; • financial controls were being monitored and Internal Audit had conducted a review of budget monitoring which had achieved an amber-green rating; • the Estates Strategy remained work in progress but there was positive alignment with Neighbourhood Health plans; • the Committee had approved the Treasury Management Policy, the Investment Policy and the Procurement Strategy; • the Committee had received the Inquests & Claims (Legal Services) annual report; • other risks to continue to monitor included: the impact of local government reform and the Estates Strategy in relation to capital spend; the still outstanding Private Finance Initiative exit payment; the BAF risk on financial sustainability as although there had not been full agreement on whether it should remain as high rated as it was, the current rating had been maintained pending discussion at the Board's private session this afternoon; the Warneford redevelopment programme (which would also be discussed at the Board's private session this afternoon); the NOF and Data Quality; funding allocations from the ICB in relation to the Mental Health Investment Standard and Community Investment Standard; and Deconstructing the Block and moving to different payment mechanisms; and • potential opportunities included NHS Property Services' asset disposal.	
d	***Audit & Risk Committee (ARC) 3As*** Harjit Sandhu, as Chair of the ARC, provided a verbal update of the meeting held on 18 September 2026, noted that there were no alerts to raise and highlighted for assurance that, further to a question on Cyber Security which had been raised at the AMM & AGM on 24 September 2026, the Committee had received a Cyber Security report which had also supported a BAF deep dive into the risk on Information & Data. The Committee had considered the various ways in which the Trust's Cyber Security preparedness could be assessed and been assured that the Trust was well protected against common threats and benchmarked well against various companies and organisations. However, no organisation could protect perfectly against every potential malicious attack and it was important for the Trust to also consider its resilience and ability to recover.	
e	***Charity Committee 3As*** Rick Trainor, as Chair of the Charity Committee, presented the 3As report from the Charity Committee meeting on 22 September 2026, noted that there were no alerts to raise and highlighted that the Charity was proceeding to implement its more proactive strategy towards fundraising and to realise the greater potential for the Charity as established by the More Report and previously endorsed. In that context, the Committee had: (i) noted the changes and updates to the Charity's website and the work which had taken place to distinguish the Charity more from other local NHS charities and to raise awareness; and (ii) supported recruitment to a one-year Fundraising and Marketing Manager post, which would also help to reverse the gradual erosion of the Charity's overall financial position. The Committee had also reviewed and commented on an early draft of the Charity's Annual Accounts which would be considered further at its meeting on 08 December 2026 before recommendation for final approval by the Charity Corporate Trustee in December 2026 or January 2027. The Trust Chair added that she had also attended the Charity Committee meeting in September and it had been very positive.	

DRAFT

f	**The Board noted the 3As updates from the Committees, with minutes and agendas in the Reading Room, and received the Joint Children & Adults Safeguarding report and the Learning from Deaths report which had been recommended by the Quality Committee.**	
BOD 95/26 a	**Any Other Business/Questions/Review of the meeting** None.	
BOD 96/26 a	**Board resolution to conduct further business in private** The Board resolved to exclude the public and conduct its business in private for confidential matters which may be prejudicial to the public interest if conducted in public or for other commercial or financial reasons.	
	The meeting was closed at: 12:16.	

DRAFT

Summary of Actions from the Board meeting on 30 September 2026

Relevant Item	Actions	Responsibility:
BOD 86/26 (j)-(k)	**Provider Capability Self-Assessment (domain 4 on Access and Delivery of Services)** To report back on progress to provide formal reporting to the Board on identifying and addressing inequalities in access/waiting times (further to discussion at the Executive over October 2026). Note recommendation from Helen Mackenzie that it would be even more helpful if information on trajectories could include the position which the Trust aimed to have achieved by the end of March 2027. **Status: *in progress -*** *health inequalities reporting will be included in refreshed IPR aligned to new Strategy and Board health inequality reporting in development. Community Health waiting trajectories included in IPR, approach to be rolled out to relevant metrics.*	**AB**
BOD 86/26(l)	**Board Development Plan** To identify areas to focus on and develop for the Board Development Plan, with discussion and challenge at a future meeting and consideration of which of the domains in the Provider Capability self-assessment which were currently 'amber-green' should be targeted for potential advancement to a 'green' rating, subject to resourcing and capacity. Areas of focus for the Board Development Plan should also support delivery of the overall Trust Strategy and mitigate strategic BAF risks. **Status: *in progress*** *- note Board Development Plan was appended to the agenda for the Board Workshop on 21 October 2026.*	**TG**
BOD 87/26(c)	**Strategy Delivery Plan** Next iteration to include more on: (i) digital aspirations, building digital confidence and capability in the workforce; and (ii) explicit focus on patient experience (including: (i) taking a patient-focused approach to what services could look like and reorienting the culture of the organisation, not just specific pathways,	**AB**

	around patient experience as a way of delivering more effective services; and (ii) more explicitly capturing how Quality Improvement (QI) was being used from a strategic improvement perspective). Also consider how the Board could oversee the implementation of the Strategy Delivery Plan, see how the Strategy was being made real and had filtered through to the frontline workforce and how it could act as a golden thread for what the organisation stood for. **Status: *in progress*** - *Strategy Delivery Plan being finalised as part of Executive and Board prioritisation discussions.*	
BOD 88/26(f)	**Winter Plan** To provide an update to the Board in May 2027 on the Winter Plan and how successful the Trust had been in supporting the local system, with feedback from the acute sector on their experience. **Status: *on hold for May 2027***	**EL**
BOD 89/26(e)	**AnDY (Anxiety and Depression in Young People) data** The Executive Director of Strategy & Partnerships agreed to respond separately to a query from the Trust Chair about AnDY (Anxiety and Depression in Young People) data not being included in planned activity/the Oxfordshire CAMHS access metric and whether this would be resolved. **Status:** *narrative update to be provided at the next Board meeting.*	**AB**
BOD 92/26(f)	**Lived experience of Trust services** Lucy Weston asked the Board to consider an action to think further about having a Board member with lived experience of Trust services. **Status: *complete*** *– the Trust Chair acknowledged the request and noted that it had been discussed a few months ago at a Board Workshop in the context of how best to engage Experts by Experience (EbEs) with the Board and which had led to the inclusion on Board agendas of regular presentations such as this one which had highlighted impact and potential areas for future focus. The Board was also currently trialling EbE/patient voice representatives presenting at these meetings, with only two meetings undertaken so far.*	**AY**

Actions from the Board meeting on 22 July 2026		
BOD 66/26(f)(i)	**Quality Improvement zone of control** The Chief Executive suggested that it may be useful for a future Board Development session to consider Quality Improvement (QI) and, in particular, QI zone of control and tolerance within zone of control. **Status: *in progress*** *– being considered for the Board Learning & Development Plan.*	**TG/AY**
BOD 66/26(f)(ii)	**Child and Adolescent Mental Health Services (CAMHS) Eating Disorders** The Quality Committee to undertake a deep dive on Eating Disorder waiting times in CAMHS. **Status: *complete*** *– undertaken at the Quality Committee on 12 November 2026.*	**RB/BK**
Actions from the Board meeting on 20 May 2026		
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: *complete*** *– workforce implications of investments agreed so far were presented at Finance and Investment Committee on 14 July. A full mapping including further investments and offsetting staffing reductions planned has been provided to the Chair for feedback (status update as at 17 November 2026).*	**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.* *Update – November 2026 Private Board receiving the Thematic Review into unexpected deaths of patients on the Adult ADHD Service waiting list.*	**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. *scheduled for the Board/included on Board workplan from November **2027***; ii. *included on Quality Committee workplan;* iii. *included on Quality Committee workplan; and* iv. *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.*	**RB**

Meeting	Board of Directors
Date of Meeting	25 November 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

Peer Support Worker Celebration Day

Over the last couple of months, I've enjoyed meeting more partners and getting to know teams within the Trust. Perhaps one of the most memorable has been the Peer Support Worker (PSW) Celebration Day. The Trust currently employs 67 PSWs, and they provide unique support alongside clinical teams. Stories of how they came to the roles and the impact they have were incredibly moving. They genuinely know what it is like to hit rock bottom, have your life turned upside down and feel desperate and alone. We celebrated all PSWs but also those who have now achieved level 4 and level 5 skills accreditation. I'm hoping that when certificates are awarded next year, we have a much bigger cohort.

Thanks to Vicky Naidoo and her team for sometimes pushing against the odds to get these posts agreed, supported and growing, in the shared knowledge of the enormous difference they make to people's lives.

Psychological Professions Conference

The Psychological Professions Conference last week brought together 200 members of staff, drawn from a workforce of over 1000 staff, making them the second biggest staff group in the Trust. The theme of the day was tackling inequalities in healthcare with some inspiring examples from the Bucks Gateway team in how they set about improving ethnicity data collection, to understand who they were serving now, and how to address inequality gaps by talking to their community. From the questions it is clear there is an appetite for doing this work, along with a wariness of knowing how/where to start.

Oxford University Hospitals NHSFT – appointed governor role

I am pleased to say we had interest from several of our governors in taking on the OHFT appointed governor role for the Oxford University Hospitals' council of governors. Colleen

Jones will take on this role from December, picking up from Stuart Bell who has deployed his knowledge and experience for a number of years most usefully in the last 6 months as we have transitioned to new leadership at both organisations.

Mental Health Voluntary, Community, and Social Enterprise sector

The CEO, Director of Strategy and I met with Mental Health VCSE partners at the beginning of October to continue strengthening our relationships and better understanding the role we each play in supporting patients and communities in Oxfordshire. I attended the Response Annual General Meeting and heard inspiring stories of the work they do in supporting recovery for people discharged from inpatient care and also when they become unwell. We are fortunate in the quality and compassion of everyone working in that sector.

Local government reorganisation

Staying in the local space, it has been announced that the government intends to support the proposal to replace the seven existing councils in Oxfordshire and West Berkshire with three unitary councils; Greater Oxford, North Oxfordshire, Ridgeway Council. The timetable for elections and go live has slipped a year, with elections for shadow authorities planned for May 2028 and go live 2029. There appears to be limited progress on strategic mayoral authorities in our area.

NHS Health Bill & NHS structure

Turning from local to national context, we are still waiting to hear the outcome of debate on the NHS Modernisation Bill. We know that proposals about Healthwatch being replaced have been overturned as have those on the Healthcare Safety investigation body (which was intended to transfer to CQC). We have two great Healthwatch teams in Oxfordshire and Buckinghamshire, in due course it would be helpful for the wider Board to hear about their work and their warm response to working with us more closely in understand community needs and improving services.

In terms of NHS structures, it has been announced that staff working in national roles within NHS England will transfer to the Department of Health & Social Care, in an NHS group to be led by a separate CEO. In relation to the seven new regional teams, they will be established within a new special health authority. On behalf of the Board, I'd like to thank Anne Eden, our outgoing South East Regional Director for her support to our organisation including Warneford Park, and welcome Matthew Winn who has taken up the role on an interim basis. Matthew's substantive role is CEO of East of England Community Health and Care Trust, whilst also having held the role of national director for community health at NHS England.

Andrea Young, Trust Chair

Report history / meetings this item has been considered at and outcome
This report has been produced for November 2026 Board of Directors.

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

Oxford Health NHS Foundation Trust

Meeting	Board of Directors
Date of Meeting	25 November 2026
Agenda item	7
Report title	Chief Executive Officer's report
Executive lead(s)	N/A
Report author(s)	Dr Michael Holland, Chief Executive
Action this paper	☐ Decision/approval ☑ Information ☐ Assurance
Reason for submission to the Board	For information
Public or confidential	Public

Report

Reflections as new Chief Executive

I have been at the Trust for nearly 3 months now and have very much enjoyed meeting new colleagues and learning from the services I've visited. It is clear that one of our strengths is the culture we have built in the organisation and that staff care for each other and for their patients. I have been made to feel very welcome.

In a busy time for the Trust there are too many individual topics to mention here but I'd like to highlight a few. It was wonderful to see some of the improvement work that was highlighted at the Quality Improvement conference and one can see how teams have embedded improvement into their work. It was fantastic that we have now launched the Trust strategy and, of course, now the hard work starts with us putting it into practice and implementing the changes needed to deliver it. It was good to start to see how the directorates are aligning their plans to the strategy and we will support them in further refinement and clarity of the outcomes they are trying to achieve. I would also like to welcome other 'new starters' on the board – Teresa Beach as Non-Executive Director and Paul Ringer as Associate Non-Executive Director.

In the background to all this, like most of the healthcare sector, I have been following the Health Bill 2026-27 as it progresses through Parliament. At the end of October, proposals relating to remove Healthwatch organisations were withdrawn from the Bill. The Bill also proposes the removal of governors from foundation trusts but at the time of writing, this has yet to be confirmed.

New Trust Strategy 2026-31

I am very pleased that one of my first actions as CEO has been to launch a strategy which seeks to make a clear difference to people's quality of life. We have launched our 2026–2031 strategy, setting out how we will improve outcomes and experiences for people who use our services while supporting colleagues to deliver excellent care.

Shaped by patients, carers, families, colleagues and partners, it responds to local needs and the Government's 10-year health plan, prioritising care centred on what matters to people, more joined-up services and reduced inequalities.

I want us to be ambitious about the role we can play in our communities and for people who access our services to improve the experience of the care we provide and outcomes for all. This strategy gives us a clear direction for doing this together.

New first-time psychosis specialist clinic

Last month the Trust launched the Baseline Biomarker Check (BBC) clinic at Warneford Hospital in Oxford to improve assessment for people experiencing first-episode psychosis. Informed by lived experience and supported by NIHR Oxford Health Biomedical Research Centre and Wellcome funding, the clinic offers people in the Early Intervention in Psychosis service a one-off appointment combining clinical interview, brain imaging, thinking and memory assessment, and neurological checks. This is a fantastic development and also offers opportunities to participate in research, with the longer-term aim of developing more personalised assessment and treatment.

Step Care shortlisted for top national HSJ award

I was very pleased to hear that Oxford Health and the HOPE Thames Valley Adult Eating Disorders Provider Collaborative are finalists for Mental Health Innovation of the Year at the HSJ Awards 2026. The service uses digital technology and a multidisciplinary team to provide intensive, personalised treatment for adults with severe eating disorders, offering an alternative to hospital admission where clinically appropriate and supporting recovery after discharge. Shaped by patient and carer feedback, the service has reduced reliance on inpatient care and generated estimated cumulative savings of more than £4 million since 2023. Well done for all involved in being chosen as a finalist for the award.

Occupational therapy week

The first week in November (2nd-6th) was Occupational Therapy Week and focused on the theme of 'Participation Changes Lives'. This celebrated the breadth, value and impact of occupational therapy and how it helps people take part in activities that matter to them, supporting prevention, recovery, rehabilitation and personalised care.

The week-long programme included staff webinars covering occupational therapy across the course of a person's life: prevention and early intervention; participation in mental health and forensic services; urgent care, rehabilitation and discharge pathways; and the profession's future through apprenticeships and research. My thanks to all involved in setting up this week.

Government review of ADHD, Autism and Mental Health conditions

Oxford Health has recently helped shape an independent review commissioned by the Department of Health and Social Care, working alongside leads from the University of Oxford. Contributions spanned psychiatry, public health, youth mental health and research informatics, with the Trust's Adam Pill and Nnenna Omeje contributing expertise alongside Dr William Pettersson-Yeo and Professors Ilina Singh, Cathy Creswell and Mina Fazel. Evidence from the OxWell Student Survey also informed understanding of young people's neurodivergent identities, where they seek support and the role of schools in their care networks.

The review recommends significant changes to support for mental health conditions, ADHD and autism. With services under sustained pressure it calls for support based on people's needs and level of impairment rather than diagnosis alone, while retaining timely diagnosis and specialist care. Its recommendations emphasise earlier intervention, better integrated care and participation in education, employment, family and community life. If implemented, these recommendations could make a real difference to people's lives by helping more people access the right support at the right time.

Buckinghamshire Health & Care Partnership Memorandum of Understanding

I'm pleased to note that the Trust has signed the Memorandum of Understanding (MoU) for the Buckinghamshire Health and Care Partnership. The MoU seeks to formalise the role of the partnership, provide a clear and practical framework for collaboration as well as enabling future delegation from the ICB. Although not legally binding it is a commitment from health and care services partners to commit to continue to work together to meet population need and ensure sustainability of local services.

Dr Michael Holland, Chief Executive

Report history / meetings this item has been considered at and outcome
This report has been produced for 25 November 2026 Board of Directors.

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

Oxford Health NHS Foundation Trust

Meeting:	Board of Directors' Meeting
Date of Meeting:	25 November 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:

- Mental Health Act Statistics: 2025-26 Annual Figures
- Guidance on NHS staff facilities
- Privacy, dignity and safety in hospital accommodation
- Unauthorised, inappropriate and unjustifiable access to confidential patient information
- Implementation of the resident doctors' deal
- Healthwatch England and local Healthwatch organisations will no longer be abolished
- UK Workforce Hopes and Fears Survey 2026

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)

The Board is asked to note the update provided in this report and the actions identified against the horizon scanning report.

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	

Oxford Health NHS Foundation Trust

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

Recent Insights

Item	Description	Lead	Actions	Due Date
Guidance on NHS staff facilities	This guidance advises Trusts on the approach they must take in the provision and use of physical staff facilities including changing, washing and showering areas, toilets and staff accommodation following the supreme court ruling. NHS England » Guidance on NHS staff facilities	CPO	Trust undertaking review and developing an action plan for implementation. Will be reported via People, Leadership & Culture Committee.	Mar 2027
Privacy, dignity and safety in hospital accommodation	The revised guidance sets out clear principles to help staff make decisions about hospital accommodation. It supports the NHS Constitution's pledge on same-sex accommodation and provides practical guidance on how to meet the needs of all patients. All providers of NHS-funded care are expected to deliver services in line with these principles. NHS England » Privacy, dignity and safety in hospital accommodation	CNO CMO	A SOP has been developed to reflect the new guidance. We will monitor and make appropriate changes if required.	Closed
Achieving excellent patient experience	The NHS experience excellence framework defines what excellent experience looks and feels like across NHS-funded care. NHS England » Achieving excellent patient experience	CNO	To review and identify implementation actions. Reported via Quality Committee.	Mar 27
Mental Health Act Statistics: 2025-26 Annual Figures	This publication contains the official statistics about uses of the Mental Health Act ('the Act') in England during 2025-26. Under the Act, people with a mental disorder may be formally detained in hospital (or 'sectioned') in the interests of their own health or safety, or for the protection of other people. Mental Health Act Statistics, Annual Figures, 2025-26 - NHS England Digital	CMO	To be reviewed via Mental Health and Law Committee focusing on lessons learnt.	Jan 26

Unauthorised, inappropriate and unjustifiable access to confidential patient information	A letter from Sir Jim Mackey, Chief Executive Officer of NHS England, about unauthorised, inappropriate and unjustifiable access to confidential patient information. NHS England » Unauthorised, inappropriate and unjustifiable access to confidential patient information	DoCA CMO	The Trust has taken relevant actions in response to the letter. This was in addition to actions already taken prior to the letter.	Closed
Implementation of the resident doctors' deal	Letter to trusts regarding implementation of the resident doctors' deal i.e. latest guidance and next steps. NHS England » Implementation of the resident doctors' deal: latest guidance and next steps	CMO CPO	The Trust will update its action plan which reports regularly to People, Leadership & Culture Committee.	Closed
Healthwatch	Healthwatch England and local Healthwatch organisations will no longer be abolished The King's Fund responds to the the announcement that Healthwatch England and local Healthwatch organisations will no longer be abolished | The King's Fund	CNO	Information only	Closed
UK Workforce Hopes and Fears Survey 2026	PWC Annual UK Workforce Hopes and Fears Survey 2026 has been published. Motivation looking for direction - PwC UK	CPO	Information only	Closed
NHS dentistry	Integrated Care Board given discretion to reduce the required number of urgent treatments NHS England » NHS dentistry – integrated care board discretion to reduce the required number of urgent treatments	COO	Information only	Closed

APPENDIX 1: HORIZON SCANNING REPORT (PART B) - SEPTEMBER 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	Reviewed at Information Management Group.	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
EHRC guidance following UK Supreme Court ruling on the	On 21 May 2026, the Minister for Women and Equalities laid our updated code of practice for services, public functions and associations in Parliament. The Minister has confirmed an	DoCA CNO CPO	This became effective on 5th August 2026. New NHS Guidance is yet to be issued. The Trust has taken action to implement	Nov 2026

meaning of sex in the Equality Act	implementation date for the new guidance of 5th August. UK Supreme Court ruling on the meaning of sex in the Equality Act: our work | EHRC		where possible while still awaiting the new guidance.	
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	Initial review will be presented to the next 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
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	CNO	The Chief Burse and her team are leading on the work for implementing within the Trust.	Mar 2027

	received a letter to implement a sustainable oral health care pathway.			
Thirlwall Inquiry report	Report and recommendations of the public inquiry established to examine the events at the Countess of Chester Hospital from 2015 to 2018. https://www.gov.uk/government/publications/thirlwall-inquiry-report	DoCA	To review the findings and lessons from the report particularly in relation to Board governance and recommend next steps	Dec 2026

Oxford Health NHS Foundation Trust

Meeting:	Board of Directors
Date of Meeting:	25 November 2026
Agenda item:	09
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 late November 2026. Over the coming months, the BAF will be refreshed to align with the new Trust strategy.

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 a lead board committee for oversight for each risk. The Audit & Risk Committee reviews all BAF risks spread over its annual schedule of meetings.

<u>Board committee BAF activity over November 2026 and into December 2026</u>

- The Quality Committee reviewed its four BAF risks at its meeting on the 12 November 2026.
- The Finance & Investment Committee received a paper on its five BAF risks as a reading room item at its 17 November 2026 meeting
- The People, Leadership & Culture Committee will review its two risks at its 24 November 2026 meeting.
- The Audit & Risk Committee meeting on 10 December 2026 will undertake a 'deep dive' into BAF risk A2 *Quality Safety & Experience*. Board is asked to note that the Audit & Risk Committee will receive an updated Risk Management Policy & Strategy document to approve at its 10 December 2026 meeting – amendments to the policy address internal audit recommendations following a planned review of the BAF, specifically on risk appetite (recommendation 2.6). The remaining recommendations from the internal audit BAF review will be completed as part of

the revision of the BAF (aligning with the new Trust strategy), these being – review of terms of reference (2.4), explore use of visual reporting tools in BAF format (2.7) and 'three lines of defence model' for assurances against BAF risks (2.8).

<u>BAF risk updates October/November 2026</u>

- There have been no changes to current risk scores for the BAF since the last report to Board in September 2026.
- A1 *Timely access to services* – updates to actions and status updates. Updated Executive narrative noting ongoing work, engagement with NHS England's oversight process on waits and confidence in Trust plans, and Executive discussion recently to begin to publish waiting list data framed around overall performance of patients being seen.
- A2 *Quality, Safety & Experience* – updates to actions, action timescales and Executive narrative reflecting the publication in July 2026 of the national Quality Strategy by the National Quality Board informed by the findings of the Dash review.
- A3 *Financial sustainability* – updates to controls, actions and Executive narrative.
- A4 *Recruitment & Retention* - updates to assurance on staff survey feedback and monitoring of staff survey scores, and gaps in control around plans for retention initiatives and corresponding actions, and an updated Executive narrative.
- A5 *Staff experience & culture* – updates on controls adding staff standards, TRiM support and culture programme, and updates to actions specific to supporting the people and teams programme, issues identified being addressed through staff survey feedback, and the completion of an action to create an overarching EDI plan. The Executive narrative has also been updated.
- A6 – *Improvement, Research & Innovation* - updates to assurances and gaps in control and actions following review by the Head of Research & Development. Improvement, Research & Innovation - updates to assurances and gaps in control and actions following review by the Head of Research & Development. Action added on development and implementation of internal governance arrangements for intellectual property, and innovation and research contracting.
- A7 *Environmental sustainability* – updates to controls and actions relating to climate adaption and heatwave plans, updates to actions timescales, and updated Executive narrative
- A8 *Information & Data* – added actions on developing the Trust's approach to AI and CCTV and data governance, updated Executive narrative.
- A9 *Partnerships & system-working* – update to controls and actions reflection completion of strategy engagement process and sign-off of new Trust strategy, a new action reflecting developing Trust strategy partnership approach in line with the new strategy and ongoing work in relation to Thames Valley mental health provider collaborative.
- A11 *Infrastructure* – updates to actions and timescales following review by the Director of Estates.

Report history / meetings this item has been considered at and outcome
This report has been prepared for the November 2026 Board of Directors.

Recommendation(s)
The Board is asked to note and provide comment on the Board Assurance Framework.

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	

Oxford Health
NHS Foundation Trust

Board Assurance Framework

Board of Directors
November 2026

Board Assurance Framework – *Introduction*

Oxford Health
NHS Foundation Trust

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 ri*sk (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.

The following three slides summarise the current BAF risks.

Board Assurance Framework – *Summary (1)*

Ref.	Risk Category/ Overview	Risk Description	Strategic Aim	Executive Lead	Lead Committee	Prev. score Sept 26	Current Score Nov 26	Target Score	Risk Appetite
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.*	Quality	Chief Operating Officers	Quality Committee	**16**	**16**	**12**	Cautious
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 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	***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.*	Sustainability	Chief Finance Officer	Finance and Investment Committee	**16**	**16**	**12**	Cautious
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.*	People	Chief People Officer	People, Leadership and Culture Committee	**6**	**6**	**9**	Open

Board Assurance Framework – *Summary (2)*

Ref.	Risk Category/ Overview	Risk Description	Strategic Aim	Executive Lead	Lead Committee	Prev. score Sept 26	Current Score Nov 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

Ref.	Risk Category/ Overview	Risk Description	Strategic Aim[s]	Executive Lead	Lead Committee	Prev. score Sept 26	Current Score Nov 26	Target Score	Risk Appetite
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.*	Quality	Chief Executive & Executive Director of Strategy	Quality Committee	**12**	**9**	**6**	Seek
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.*	Quality	Chief Operating Officers & Chief Finance Officer	Finance and Investment Committee	**12**	**12**	**9**	Open
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.*	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:

Quality

Deliver the best possible care and health outcomes

	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	November 2026
Exec. Dir. Leads	Chief Operating Officers	October 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. Work on waits has been robust and sustained and is, in turn, the increased focus is having a positive impact on the on the culture of leadership across services. Whilst some services continue to struggle to have impact on waiting times some are seeing positive impact as a result of this shift. Ongoing engagement with NHS England's oversight process of waits has highlighted confidence in the Trust's plans to manage waiting times. Waiting list data will begin to be published starting with Buckinghamshire CAMHS data framed around overall performance of patients being seen.

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)	31 December 2026	Range of activities to improve oversight and management of waits have been completed. Regular waiting list review meetings continue, with further work planned to develop a mental health adults SOP aligned with clinical processes and EHR and reporting requirements. An internal audit of waits has recently been completed – the audit found significant assurance with minor improvement opportunities which are being progressed. This work is an ongoing initiative to improve patient experience and learning from practice. A National Oversight Framework (NOF) metric has been created around 104 week waits.
Embed alternative options as part of waiting time approach including digital transformation tool (digital assistant)	COOs	31 March 2027	Clinical systems development work continues across EMIS, Adastra, True Colours, along with cross-system delivery – the Rio Flow pilot will start in January 2027 to accommodate required process-design and configuration work.
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 operational risks

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 – risk of negative outcomes from waiting for care and treatment	20	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:

Quality

Deliver the best possible care and health outcomes

	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	November 2026
Exec. Dir. Lead	Chief Nurse & Chief Medical Officer	October 2026

Controls and Mitigation

(What we are currently doing about the risk)

1. Clinical policies in place – monitored and updated
2. Compliance with regulatory standards
3. Clinical & Quality governance arrangements in place
4. Infection Prevention & Control arrangements in place
5. Clinical Audits – Core Clinical Standards
6. Learning from complaints, incidents, inquests, mortality rates (Patient Safety Incident Response Framework)
7. Weekly Review Meeting
8. Directorate weekly safety reviews
9. Patient Advice & Liaison Service (PALS)
10. Learning from feedback from Patient & Family experience
11. Learning from feedback from staff survey exercises
12. Inpatient Transformation Programme
13. Health & Safety and Violence & Aggression programmes including review of Intensive Case Management approach
14. 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
3. Delivery of care models to work to reduce health inequalities and improve health equity

Executive Lead Narrative: *The Quality Committee will continue to have oversight of quality of care delivery, patient safety and experience in the Trust – this is being informed by the national Quality strategy published by the NHS National Quality Board (NQB). The primary objective of the strategy is placing quality as the core organising principle for all NHS activity over the coming decade. Driven by the Dash Review it aims to streamline and bring together previous quality management arrangements and metrics into a single framework.*

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 as set out in the national Quality strategy.	Chief Nurse & Chief Medical Officer	Ongoing	Oxford Health Improvement (OHI) are 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. Following its publication in July 2026, this work will be undertaken in reference to the national Quality strategy driven by the findings of the Dash Review. The Executive is currently exploring various options for a trustwide governance system.
Explore options to develop a Patient Experience reporting dashboard including for inpatient wards	Chief Nurse	31 December 2026	Options exploration process now completed and implementation of a dashboard is now underway - using/aligning with clinical auditors, core clinical standards and 'I Want Great Care', and in reference to national Quality strategy – with work progressing to the end of 2026.
Delivery of care based on analysis of indices of multiple deprivation, reducing health inequalities and improving health equity.	Chief Medical Officer	Ongoing	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. This work will be further progressed through delivery of the Trust strategy.

Link to operational risks

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

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

Link to Strategic Aims:

Sustainability

Make the best use of our resources and protect the environment

	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 & Investment Committee	November 2026
Exec. Dir. Lead	Chief Finance Officer	November 2026

Controls and Mitigation

(What we are currently doing about the risk)

1. Reputation and relationships with commissioners, supported by strong benchmarking, financial culture governance and credibility
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, processes & quarterly review top 20 suppliers
9. Business Services processes review and manage clinical expenditure and income contracts. Monthly CFO forecast review – reviews in-year forecast position, run-rate, expected position against financial target, and risk and opportunities to achieving target
10. Engagement in regional & national NHSE exercises relating to financial plans and in-year performance, including financial road maps, and temporary staffing controls checklist

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
13. A tiered escalation governance structure for significant or persistent financial pressures, from Senior Management Team level up to board committee and board.

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.
5. Identify mitigation plans for uncontrollable risks – e.g. PFI settlement, and engage with ICB and NHSE where necessary
6. Engage with commissioners & NHSE on new contract forms for mental health and community services. Identify risks and manage accordingly.
7. Review long term sustainability of material contracts and services – work with commissioners to ensure long term financial balance

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. Although anticipated risks did not materialise during the first year of the multi-year planning round, the review of block contracts will have an impact that cannot yet be well understood. Furthermore, there are underlying spending pressures in some Mental Health directorates, and our services remain exposed to demographic and economic changes impacting demand and costs. Work planned on Value & Financial Sustainability as a strategic foundation to the new Trust strategy is designed to support our ability to keep improving our impact and outcomes within the resources available and, along with a strong control environment, is intended to help to mitigate this risk over time.*

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 in line with principles of Value and Financial Sustainability.	Chief Finance Officer	31 March 2027	Process in place and both CIPs and financial plans reported to Finance & Investment Committee. Process for Financial Year FY28 and FY29 in development.
100% of FY25/26 CIPs in line with targets with quality impact assessments completed.	Chief Finance Officer	Complete	Action complete
Introduce costing and activity data to monthly board finance report and make available to teams via TOBI dashboard	Chief Finance Officer	31 March 2027	Costing, Whole Time Equivalent (WTE) and Activity data now available in Board Report. TOBI tools pending availability of key people to finalise them.
Work with ICBs & NHSE over newly proposed contract forms – deconstructing block contracts. Work as part of the wider provider network to identify key flaws or risks, and gain early insight into scale and scope of associated risk	Chief Finance Officer	31 March 2027	

Links to operational risks

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

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

Link to Strategic Aims:

People

Be a great place to work

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

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

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 workforce metrics, includes turnover
4. Quarterly review by Organisational Development team on reasons for leaving, reporting on these to 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 and pay gap reports

Gaps in Control

(Actions to take to achieve target)

1. Focused initiatives to improve retention inc. flexible working, length of service recognition, resident doctors 10 point plan
2. Integration of anti-racism work into culture plan to ensure race critical lens to all recruitment and retention practices
3. Continued delivery of refreshed induction workstreams
4. Work to fully align workforce planning with clinical strategy (and other enablers e.g. digital)
5. Future risk area - relating to entry-point recruitment (particularly HCAs) due to government visa restrictions moving into 2027/28
6. Complete first cycle of Talent programme to underpin evidence-based succession plan for Executive leadership roles

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 building a domestic pipeline of talent particularly at HCA level.

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 and Head of OD	31 December 2026	Consulting on outputs of scoping 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 L&D and Head of Resourcing	*Programme now in place*	Programme is live with events and initiatives planned and will be reviewed in Q1 2026/27. Scoping work experience and work placements now underway.
Complete first cycle of Talent programme to underpin evidence-based succession plan for Executive leadership roles	DPD	31 December 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:



Be a great place to work

	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	November 2026
Exec. Dir. Lead	Chief People Officer	November 2026

Controls and Mitigation

(What we are currently doing about the risk)

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
11. NHS Staff Standards
12. Staff Psychological Service (includes TRiM support)
13. Culture Programme aligned to strategy delivery as an enabler

Assurance / Evidence

(How do we know we are making an impact)

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 and pay gap reports

Gaps in Control

(Actions to take to achieve target)

1. Delivery of Supporting our People and Teams programme
2. Improve staff experience and response to issues identified via staff surveys
3. Score flexible working Staff Standard (NOF metric from April)
4. Address gaps identified in Sexual Safety charter – specific gaps on specialist investigatory training
5. Increasing impact of anti-racism workstreams

Executive Lead Narrative: Work is ongoing to further the Supporting Our People and Teams Programme; we have engaged with a large group of senior leaders regarding the programmme at the most recent Leadership Forum (October 2026) the next stage will be to strengthen the programmme governance and communicate how the various strands of activity come together in relation to building strong and capable teams.

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 (DPD)	*Ongoing*	Previous phase of the programme (including mapping exercise and development of '5 asks') has been completed) and supporting our people and teams programme has been launched. The '5 asks' are being used to deliver leadership training and team development. Action is now in ongoing delivery.
Respond to staff experience issues identified in staff surveys and People Promise elements	DPD & Head of OD	*Ongoing*	Ongoing work to address issues identified in staff survey and People Promise – includes a range of case studies including wellbeing days, mileage reduction, £20 per head team day, annual leave buy-back, anti-racism programme.
Address gaps in Sexual Safety charter	Head of Occupational Health and Wellbeing Progamme Lead	31 December 2026	A lead for sexual safety has been appointed with sexual safety work is reviewed against the charter. The sexual safety lead is reviewing outstanding actions and investigatory training. A Non-Executive Director lead is being appointed.

Link to operational risks

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:

Research

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**

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

Controls and Mitigation

(What we are currently doing about the risk)

1. Internal Research & Development (R&D) Senior Management Team (SMT) in place and reporting to CMO.
2. R&D operational and strategic plans in place/updated
3. Collaborative working with Oxford Joint Research Office partners
4. OH Biomedical Research Centre (BRC) Steering Group
5. Thames Valley Applied Research Collaboration and ARC Board
6. Toronto Collaboration – Oxford Psychiatry
7. Count Me In initiative to increase equitable research participation
8. Quality Improvement hubs and work programme
9. Nurses, Midwives & Allied Health Professionals (NMAHPs) 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-annually)
2. ARC, BRC, CRF, HRC and MHM annual reporting to National Institute for Health & Care Institute (NIHR)
3. ARC 2 bid submitted and awarded – stared in April 2026
4. submitted to NIHR. Will be used as a national exemplar.
5. OH-BRC midterm review recently undertaken in conjunction with external advisory group
6. Annual report research capability submitted to DHSC
7. R&D governance on finance & study set-up time
8. Quality Improvement programme updates and reporting to Executive forums and Quality Committee
9. Assurance on Trust NIHR Regulatory returns / feedback
10. OHFT-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 includes an additional 1.0 WTE post in contracts team to support OHFT studies). Looking to move to in-house contracting model to ensure faster contracting and improve study setup times.
2. Funding sustainability for research – organisational & system
3. Undertake clarification around Intellectual Property (IP) ownership and processes. Trust-wide IP policy written and approved by ELT.
4. Opportunities to increase collaboration in Mental Health research (e.g. Secure Data Environment work)

Executive Lead Narrative: We continue to work on time to set-up NIHR research trials, to balance requirements and risks of financial, information governance and capacity. This drive is linked to the UK Government Office of Life Sciences Strategy and the NHS 10-year healthcare plan for England to boost innovation and effectiveness across the NHS.

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

Action to address gap in assurance/control	Lead	Date of implementation	Status Update
R&D Operational plan development, including review of governance arrangements to support timely decision-making	Chief Medical Officer & Head of R&D	31 December 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 (OHFT controls 90 days)
Sign off Intellectual Property (IP) policy	Executive Director of Corporate Affairs	30 September 2026	IP policy was signed off at September 2026 Extended Leadership Team meeting. Contacting approach to IP is now in development with relevant teams and partners.
R&D strategic development / link to Trust new strategy development (over 2026/27)	Chief Medical Officer & Head of Research	31 December 2026	Development of new R&D strategy underway with scoping to align with development of the Trust's organisational strategy over 2026 – to include focus on governance, sustainability, and collaboration.
Governance arrangements for intellectual property and innovation and research contracting.	Executive Director of Corporate Affairs	31 March 2027	To develop and implement internal governance arrangements for intellectual property, and innovation and research contracting.

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:

Sustainability

Make the best use of our resources and protect environment

	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	November 2026
Exec. Dir. Lead	Chief Finance Officer	November 2026

Controls and Mitigation

(What we are currently doing about the risk)

1. Board commitment to Trust Green Plan 2 (2025-2028)
2. Environmental sustainability prompts included in annual planning templates & business case guidance (for new investments)
3. Full-time sustainability manager & green spaces coordinator
4. Green Task Force chaired by Exec Lead for Environmental Sustainability (CFO).
5. CMO clinical lead for environmental sustainability & green spaces
6. Procurement Policy – sets out supplier sustainability requirements
7. Green Energy Supplier for electricity via CCS
8. Regular review of corporate business mileage
9. OHFT is part of Zero Carbon Oxfordshire Partnership (ZCOP) 'sprint group' with Oxford University to review how to adapt building estates to climate change
10. Active staff communications to promote sustainability and environmental culture (including briefings at induction)
11. QI process prompts staff to consider environmental impacts.
12. Medicines optimisation underway including on inhalers
13. Trustwide Climate Adaptation Risk Assessment underway using the NHS Climate Adaptation Framework

Assurance / Evidence

(How do we know we are making an impact)

1. Oversight of Green Plan action plans by CFO chaired Green Task Force and to Finance and Investment Committee and Board of Directors
2. Performance against strategic dashboard indicators scrutinised by Board of Directors
3. Reporting to national NHS Total Carbon Footprint Plus and in Strategic Dashboard
4. Analysis of Ulysses incident reports and heatwave-related operational impacts used to prioritise adaptation interventions and monitor effectiveness. Regular reporting of climate adaptation progress through Green Task Force
5. EV charging Phase 2: £93,000 PDC award through NHS Chargepoint Accelerator Scheme 2026/27
6. Solar PV Phase 2: FY27 capital funding for Ashurst and Phoenix at Littlemore
7. Heat Decarbonisation Plans (HDPs) FY27 funding approved for Littlemore , Whiteleaf , Witney and Abingdon

Gaps in Control

(Actions to take to achieve target)

1. Neighbourhood Health and Estates Strategies to direct relevant infrastructure investment and minimise carbon impact of care
2. Develop Heat Decarbonisation and Carbon Adaption plans for the estate
3. Climate Adaptation Plan not yet fully developed, approved and embedded across all services and sites
4. Need for more subject matter expertise in energy, travel & transport, and waste management identified.

Executive Lead Narrative: *Heatwaves over the Summer showed the poor thermal qualities of many of our buildings, leading to an uncomfortable environment for patients and staff and necessitating a lot of responsive and environmentally inefficient work by Estates teams. Neighbourhood Health and Estates Strategies are being developed to improve the efficiency of our estate, and to locate care closer to patients, minimising emissions and pollution across clinical and patient journeys. The Trust continues to show leadership in nature-based mental health treatment and recently advertised a post for the UK's first Consultant Eco-psychiatrist.*

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
Neighbourhood Health and Estates Strategies development	Chief Finance Officer	31 March 2027	Consultation phase of Neighbourhood Health and Estates Strategies is in progress.
Confirm Green Plan capital and revenue funding aligned to delivery priorities	Chief Finance Officer	Complete	Action completed
Resource and progress Heat Decarbonisation Plans into investable schemes	Chief Finance Officer	30 January 2027	HDPs to be developed FY26/27 focus on resourcing and prioritisation for delivery of carbon reduction capital projects .
Secure specialist capability for energy management	Director of Estates	31 March 2027	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	Sustainability Manager with Clinical Directors	31 January 2027	Workshop to embed net zero into clinical pathways and service redesign.
Implement targeted fleet, mileage and renewables interventions	Director of Estates	30 December 2026	Targeted actions informed by Green Plan programme and mileage analysis.
Engage workforce leadership to embed sustainability into workforce actions	Sustainability Manager	31 March 2027	Engagement with Deputy CPO and Comms team to align workforce, leadership and culture actions.

***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.*

NHS Oxford Health NHS Foundation Trust

Link to Strategic Aims:

Sustainability

Make the best use of our resources and protect the environment

	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	November 2026
Exec. Dir. Lead	Executive Director for Corporate Affairs (SIRO)	October 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.
7. The Board will provide strategic direction for implementation of Artificial Intelligence alongside a full assessment of associated information risks, risk appetite and mitigations.

Executive Lead Narrative: 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. The risk is being influenced by the increasing sophistication of cyber threats across the UK healthcare sector, greater digital interconnectivity, and expanding use of shared data and emerging technologies. Another core area of focus relates to data quality particularly in the context of the new NOF metrics. Information Management Group and Finance & Investment Committee are receiving detailed assurance on this in November. We are confident about actions we are taking to monitor and prevent unauthorised access to patient records in the context of recent events.

***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 mapping of current Business Critical Information Assets	Senior Information Risk Owner	31 March 2027	An action from the last IMG to review current list and ensure it is up to date and then consider if the right mitigations are in place to ensure these assets do not impact the Trust's day to day operations – this was discussed at the June IMG and will be actioned as part of a refresh of the Information Asset Register. Deadline extended until fully assured.
To assess current records management practice in the Trust's compliance with regulations and best practice guidance.	Data Protection Officer	31 March 2027	We need to agree an approach on how this assessment will be done recognising the resource and technology constraints.
Consider and develop approach to Trust use of Artificial Intelligence	Executive Director of Corporate Affairs & IMG	31 March 2027	Information Management Group and Executive Team to consider Trust approach to use of AI in the context of the October 2026 Board strategic workshop on AI.
CCTV and data governance implications	Director of Estates & Head of Information Governance	31 March 2027	Continued supported of the ongoing work of the Estates & Facilities Team around CCTV including ensuring that appropriate data governance implications are fully considered.

Link to operational risks

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
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:

Quality

Deliver the best possible care outcomes

	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	November 2026
Exec. Dir. Lead	Executive Director for Strategy	October 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 Oxfordshire.

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 delivery progress to be reported 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.
3. Agreed new strategy delivery approach following publication of the 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. Developing a neighbourhood approach will focus on working in Oxfordshire. Following publication of Trust's new strategy, the Trust will develop a new strategy delivery approach.*

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. Following the ICB restructure more clarity on the operating model is expected by the end of Quarter 3. ▪ It has 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, however the developing governance of the ICB may impact allocation of MHIS and planning this year.
Developing initial Trust approach to neighbourhood working, including approach to health inequalities and population.	Transformation Director - Community Health Services, Dentistry and Primary Care	31 March 2027	▪ Neighbourhood Health identified as one of our Trust-wide priority 2026/27 ▪ Internal neighbourhood steering group leading on implementation of our neighbourhood approach and health inequalities/ population health approach ▪ Trust actively participating in neighbourhood work in all its geographies and co-leading place approach in Oxfordshire. Neighbourhood management structures and population health management work now in place and in development.
Trust developing its strategic partnership approach in line with the Trust strategy	Executive Director of Strategy	31 March 2027	▪ Following publication of the Trust strategy, work will take place to develop the Trust's strategic partnership approach in line with the new strategic priority of 'working with partners' to inform priority areas of focus and reporting arrangements.
Strategy delivery approach	Executive Director of Strategy	31 March 2027	▪ Development and begin implementation strategy delivery approach.

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

	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	November 2026
Exec. Dir. Lead	Chief Finance Officer & Chief Operating Officers	October 2026

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 programme)
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. Change Advisory Board reviews whether changes requested to clinical systems align with Making Things Simple principles.
3. Clinical Systems Digital programme reports to Executive and Finance & Investment Committee
4. Information Management Group oversight – chaired by Senior Information Risk Owner (SIRO)
5. Board level Digital Champion (Vacant)
6. Where relevant, reporting to system / ICB digital reporting and assurance, and EPR benchmarking exercises
7. 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. Change management function, and patient and staff user engagement to be strengthened
4. Continuing alignment of digital requirements and priorities with clinical needs assessments and workforce planning
5. Residual risk of cyber attacks on increasingly digitised organisations (*cross-reference with A11 – Infrastructure*)

Executive Lead Narrative: *New Digital Strategy in development, covering digital, data and technology across the Trust's digital estate, and foregrounding skills and culture and opportunities to exploit innovations like AI. Plans for additional digital investments funded by Frontline Productivity being developed, including introduction of ambient voice technology licences. Continued challenges with the EMIS ePR have been escalated to CEO level. Corporate teams are establishing a Systems Working Group to align the refreshes or replacements of systems needed over the next few years.*

***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.
Optimisation of core clinical systems to underpin clinical needs and delivery.	CDIO	31 March 2027	Functionality of core clinical systems is being developed to meet clinical needs. Full programme of work is in place for short-medium team, 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.

Oxford Health NHS Foundation Trust

Link to Strategic Aims:

Sustainability

Make the best use of our resources and protect the environment

	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	November 2026
Exec. Dir. Lead	Chief Finance Officer	October 2026

Controls and Mitigation

(What we are currently doing about the risk)

1. Estates and IT policies in place and reviewed
2. In-house Estates and IT 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. Safety Groups established in line with HTMs
9. Insurance cover & service and maintenance contracts in place
10. Quarterly review by Procurement of critical suppliers
11. IT infrastructure investment in datacentre, back up, devices and connectivity
12. Cyber resilience teams and cyber prevention and assessment
13. Disaster recovery testing and business continuity exercises

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 Patient Led Assessment of Care Environments reviews
4. Estates Return Information Collection (ERIC) & Place Assurance Model (PAM) reports submitted annually
5. Quality Committee (QC) review of physical estate risks, Fire, and Health & Safety reports
6. Internal Audit reviews
7. Reporting of supplier and third-party risks assessments
8. External inspections and reviews of assessments relating to fire, water, electrical safety (inc. Health & Safety Executive, Fire & Rescue Services)
9. Regular interaction with ICB/NHSE region Estates & Facilities and IT teams
10. Data Security & Protection Toolkit - includes cyber assessments and penetration testing

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 need to keep digital infrastructure up to date

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 has been implemented with most key posts now recruited 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	31 December 2026	Estates Strategy will be drafted and ready to go through the governance channels by December.
Complete asset registers for physical estates (to include improvement of known security risks and lone-working device pilot)	Director of Estates	31 March 2027	Physical asset verification and asset register updates of the Estate are progressing alongside the ongoing collection and validation of asset data across the Trust and in preparation for the new CAFM system whilst it is undergoing tendering.
Complete process to assess Authorised Persons (AP) to formally appoint by Designated Person	Director of Estates	31 December 2026	All Authorisation Engineers have been appointed, suitable candidates for the APs have been identified which is linked to recruitment of new roles, formal training is in place.
Complete Estates re-organisation and staff teams and fill staff posts	Director of Estates	31 March 2027	E&F consultation was completed in September. Recruitment is continuing. Additional resources are being identified to meet increasing demands.
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	31 December 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 two main internet breakout circuits having being commissioned. The changeover to local breakout for all OH sites was completed in September 2026.

Link to operational risks

Ref	Risk Description	Score	Review status	Action
1425	Non-uniform estate fire compartmentation diminishes compliance capability to governing fire standards	15	Review in date	Actions in date
1375	Inability to carry out all necessary maintenance in line with legislative and regulatory requirements.	12	Review in date	Action in place

Scoring guidance – Impact x Likelihood

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

Risk appetite definitions

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

Oxford Health NHS Foundation Trust

Meeting:	Board of Directors' Meeting
Date of Meeting:	25 November 2026
Agenda item:	10(a)
Report title:	2027/28 Planning and Strategy Delivery
Executive sponsor(s):	Amélie Bages – Executive Director for Strategy, Heather Smith – Chief Finance Officer
Report author(s):	Rachel Pirie, Head of Planning Charlotte Adamson, Senior Programme Manager – Planning Peter Milliken, Director of Finance Alison Gordon, Deputy Director of Finance – Financial Management
Action this paper is for:	☑ Decision/approval ☑ Information ☑ Assurance
Reason for submission to the Board:	Update on 2027/28 planning and request for conditional delegation of sign-off of an initial national submission, while the national timetable and submission deadlines remain unconfirmed.
Public or confidential	Public

Executive summary

Overview

1. This paper updates the Board on the 2027/28 planning round and how it translates Oxford Health's Strategy 2026–2031 into annual delivery. This year, directorates have built on last year's five-year priorities, considering their 2027/28 priorities in light of the new Strategy and draft Strategy Delivery Plan.

2. An accompanying paper, "Annual Planning November 2026", is presented alongside this report and provides an overview of the current planning position relating to finance, workforce assumptions and performance requirements. The proposal is to submit a breakeven financial plan for 2027/28 and the paper outlines the route to doing this with key risks and opportunities. This includes efficiencies of £24.4m made up of £13.8m directorate CIP targets, a reduction in bank spend of £8.7m to achieve compliance with the bank spend limit set by NHS England and a reduction in out of area placement spend of £1.9m

3. NHS England have not yet released the national planning timetable for 2027/28, and submission timings and Board assurance requirements remain unconfirmed. The Trust is nevertheless preparing for national submissions on the assumption that finance,

activity and workforce requirements will be similar to last year. Our current understanding based on information from the NHS England South East region is that a high level submission covering one year will be required in December.

4. Thames Valley ICB has published its commissioning intentions for 2027/28, including a commitment to allocate 1% of its overall funding to priority pathways and preventative and proactive models of care. The ICB requested initial proposals by 7th November and the Trust has submitted proposals for consideration.

5. The Mental Health Investment Standard (MHIS) is confirmed as outside this 1% funding process and the Trust has worked alongside partners including Thames Valley ICB to agree the areas to be funded from the MHIS with the Thames Valley Provider Collaborative.

6. Clinical directorates presented and discussed emerging 2027/28 priorities at the joint Board and Extended Leadership Team session on 2 November 2026. The session provided an opportunity for discussion with the wider Trust leadership and consideration of potential cross-directorate opportunities and risks. The discussion informed further refinement of priorities and the support required from corporate and central directorates.

7. The Board is asked to provide feedback on the planning approach and, if national guidance requires an initial submission in December 2026, approve a breakeven revenue plan for submission and approve delegated authority to the Chief Executive Officer (CEO) and Chief Finance Officer (CFO), subject to any requirements for assurance or approval by the Board.

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

8. 2 November 2026: Joint Board and Extended Leadership Team planning session — presentation and discussion of emerging 2027/28 clinical directorate priorities in the context of the new Strategy and Strategy Delivery Plan. The discussion informed further refinement of priorities and corporate and central directorate planning.

Report

National Background

9. NHS England's Medium Term Planning Framework (https://www.england.nhs.uk/publication/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/), published in October 2025, sets out national priorities and delivery expectations for 2026/27–2028/29, supporting the move towards longer-term, outcome-focused planning. Our 2027/28 planning round builds on that approach, aligning Oxford Health's existing five-year priorities with the new Strategy and draft Strategy Delivery Plan.

10. The Planning framework for the NHS in England (https://www.england.nhs.uk/long-read/planning-framework-for-the-nhs-in-england/), published in September 2025, set expectations for integrated five-year plans covering 2026/27–2030/31. The Trust has begun preparing for national planning submissions on the assumption that finance, activity and workforce requirements will be similar to

last year. Although guidance for the 2027/28 planning round has not been released by NHS England, information recently received from the South East NHS region indicates that high level information for one year will be required for a December submission, with a final submission for 2027-2029 expected in March 2027.

System planning

11. At a system level, NHS Thames Valley Integrated Care Board (ICB) has published its Thames Valley Commissioning Intentions 2027/28–2030/31 (https://www.thamesvalley.icb.nhs.uk/policies-and-documents/our-plans/813-thames-valley-commissioning-intentions-01-10-25?format=html). Informed by the Integrated Needs Assessment, they focus on improving population health and reducing inequalities through earlier, proactive and preventative care, commissioning whole pathways through local partnerships, and accelerating integrated neighbourhood delivery.

12. The Commissioning Intentions also set out a commitment to use 1% of the ICB allocation (c.£59m) to support priority pathways and preventative, proactive care. The ICB has asked that Health and Care Partnerships lead the development of proposals and therefore the Trust has been working with partners in Buckinghamshire and Oxfordshire. It is understood that community growth funding is included in this envelope and we have therefore submitted proposals relating to key services and for key population groups, including people living with frailty in the community; long term conditions; and to improve access and satisfaction in key services with historically long waits.

13. MHIS funding has been confirmed as outside of this process and we have therefore continued discussions with the Mental Health Provider Collaborative regarding the priorities for MHIS funding. At the time of writing Thames Valley ICB have just confirmed that MHIS amount as £5.2m for the Trust. The main priorities for investment include neighbourhood health models of care; urgent care pathway for adults and children; support for patient flow and inpatient resource; female psychiatric inpatient care; assertive outreach; housing and supported accommodation; and digital and productivity improvements. Additional mental health investment is available via the 1% fund and therefore the Trust has worked with place partners to submit proposals including further opportunities to invest in the neighbourhood model; discharge support in partnership with the voluntary sector; improving physical health outcomes for people with severe mental illness; and support for children and young people.

OHFT Planning

14. Oxford Health Strategy 2026–2031 (https://www.oxfordhealth.nhs.uk/about-us/overview/our-strategy/?highlight=strategy) provides the strategic direction for our annual planning process. The three strategic aims define the people for whom the Trust seeks to make a difference:
    - Patients, carers and families
    - Communities and populations
    - People working at Oxford Health

15. The Strategy sets out six strategic priorities:
    - **Co-produce care:** Work with patients, carers, families and communities to improve their experience of care and achieve outcomes that are meaningful for them.
    - **Make things simple:** Simplify our processes and systems to improve access, experience and outcomes for people 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.

16. The Strategy also includes six Strategic Foundations which support the effective day-to-day running of Oxford Health and enable the changes needed to achieve our strategic aims. They comprise People Plan; Estates and Facilities; Green Plan; Digital and Data; Value and Financial Sustainability; and Quality Management System. Clinical, corporate and central directorate planning will connect annual delivery priorities with the support required from these foundations, identifying dependencies and resource needs.

17. For 2027-28, directorate plans set out how annual actions contribute to the strategic aims and priorities, building on the existing five-year priorities. The 2027/28 Annual Plan will set out in year actions and commitments, informed by refreshed ICB commissioning intentions, and the emerging financial position and national commitments.

Draft directorate priorities for 2027/28

18. Clinical directorates have updated their existing five-year priorities to align with Oxford Health's Strategy 2026–2031 and draft Strategy Delivery Plan. The joint Board and Extended Leadership Team session on 2 November 2026 provided an opportunity to present and discuss these draft priorities and consider how annual delivery contributes to the Trust's aims and priorities. The draft priorities discussed are detailed below and remain subject to further refinement.

    a. Buckinghamshire and Oxon Bath and North East Somerset, Swindon and Wiltshire (BSW) Mental Health Directorates

        i. <u>Patients, carers and families</u>

- *Re-design pathways to improve patient experience and simplify access:* streamline referral, triage and assessment across key mental health pathways.
- *Improve wait times and achieve national performance targets set:* use demand-and-capacity reviews, waiting-list validation, caseload management and pathway redesign, including increasing access to NHS Talking Therapies, improving

treatment completion and reliable recovery and Individual Placement and Support.

- *Improve patient flow:* use digital referrals and timely information to smooth moves between community, crisis and inpatient care.
- *Continue to develop children's services by embedding locality based mental health support through schools:* develop locality-based Child and Adolescent Mental Health Services (CAMHS), wider school support and special educational needs and disabilities (SEND)-ready neurodevelopmental pathways. Expand Mental Health Support Teams (MHSTs) and reduce children and young people's long waits, including over 104 weeks.
- *Provide more care close to home:* complete integration of intensive case management and assertive outreach, and strengthen crisis, home treatment and community support to prevent avoidable admissions and out-of-area placement.
- *Co-production:* strengthen shared decisions and patient choice. Embed lived experience and "You Said, We Did" and improve routine use of patient-reported outcome measures (PROMs). Use feedback and outcomes to improve care and guide resources.

ii. <u>Communities and populations</u>

- *Work through neighbourhoods:* continue neighbourhood integration and co-location with primary care, community health, acute providers, local authority and voluntary, community and social enterprise (VCSE) partners, utilise national capital investment to enable co-location and collaboration.
- *Integrate mental and physical care:* focus on severe mental illness, frailty, dementia, complex needs and frequent urgent-care use.
- *Target inequalities:* use population-health, Patient and Carer Race Equality Framework (PCREF) and lived experience data to target outreach, culturally appropriate care and reasonable adjustments for children and young people, people with severe mental illness, frailty, dementia or complex needs, people experiencing deprivation and ethnic groups facing inequalities.
- *Strengthen partnerships:* redesign contracts and supported-care arrangements, applying learning from Safe Havens and crisis alternatives to reduce emergency-department use.

iii. <u>People working at Oxford Health</u>

- *Build a sustainable workforce:* recruit and retain staff and reduce avoidable agency and locum use within safe staffing and financial plans. Delivery priorities include career development, wellbeing and flexible working.
- *Embed compassionate leadership:* strengthen compassionate leadership, supervision and appraisal.
- *Act on staff voice:* act visibly on staff feedback through listening events, quarterly reviews, teams and the People Board.
- *Simpler working:* simplify processes, reporting and digital information to release capacity safely.
- *Equality and inclusion:* actions include anti-racism tools, equality, diversity and inclusion objectives in leaders' appraisals, fair recruitment and progression, reasonable adjustments, staff network involvement and workforce-data review.

b. Forensic Mental Health Directorate

i. Patients, carers and families

- *Embed co-production and the Patient and Carer Race Equality Framework in* all transformation programmes, using learning from the women's secure pathway and measuring involvement against the co-production ladder.
- *Review male, learning disability and neurodiversity inpatient pathways and provision*.
- *Improve patient-flow reporting and* use of benchmarking by reviewing data systems and flows and strengthening occupancy and referral reporting. Build research and development infrastructure and capacity.

ii. Communities and populations

- *Improve adult mental health interfaces and prison transfers*; align with developing neighbourhoods, agree joint pathway priorities and achieve national prison-to-hospital transfer targets. Deliver and monitor the Littlemore café/shop project with Restore and scope its future service.
- *Improve women's pathways and reasonable adjustments* while maintaining prison in-reach. Implement the women's pathway, centre pilot and outreach service; use evidence and referral-flow reviews to identify inequalities in access, outcomes and experience. Explore adjustment support for teams and work with the Provider Collaborative on regional neurodiversity-model proposals.

iii. People working at Oxford Health

- *Strengthen staff wellbeing* through Task and Finish Group focus groups, the wellbeing strategy and team Wellbeing Champions. Embed trauma-informed approaches to teamworking and implement closed-circuit television. Establish the Workforce Development Forum within the Directorate People Board, supported by better information for decisions.
- *Simplify key performance indicator* suites and processes with the Provider Collaborative to improve consistency and accessibility.

c. Learning Disabilities Directorate

i. Patients, carers and families

- *Co-produce and implement the all-age pathway* to clarify access and transitions for people, families and carers.
- *Develop and test a tiered model for proportionate specialist learning disabilities support*, with clearer thresholds and simpler assessments. Clarify roles and routes for advice, and support delivery through automated reporting and a quality improvement approach.
- *Identify complex needs earlier*, with support following the person across children's and adult services.
- *Strengthen local provision for people with learning disabilities* to reduce reliance on mental health inpatient care and out-of-area placements.

ii. Communities and populations

- *Work across children's, adult and neighbourhood services and partners* to provide more joined-up specialist and physical health support, with clearer service interfaces and smoother transitions.

- *Reduce Health Inequalities:* improve population-health data and data recording to identify variation in access, outcomes and experience. Use the data to target support, improve physical health and experience, and increase the reach of the service.

iii. People working at Oxford Health

- *Equip teams for the tiered model* through a shared training offer, accessible advice and tools, and digital reporting.
- *Develop apprenticeship opportunities* and involve people with learning disabilities on interview panels.

d. Community Health Services, Dentistry and Primary Care Directorate.

i. Patients, carers and families

- *Take forward recommendations from developing the Lived Experience Framework*, focusing on District Nursing, Heart Failure, dentistry under general anaesthetic, Podiatry, out-of-hours workforce, children and young people Experts at Hand and the urgent and emergency care pathway.
- *Explore outcomes for remote monitoring* in Heart Failure, artificial intelligence triage for Single Point of Access and Robotic Process Automation.
- *Strengthen waiting-list management and reduce waiting times*, moving towards delivery of the 18-week referral-to-treatment standard and elimination of 52-week waits over the five-year planning period.

ii. Communities and populations

- *Build research capability and patient outcome measures*, and prioritise those who experience the greatest health inequalities.
- *Develop neighbourhood partnerships* in North & West, City and South to collectively shape investment pathways, with integrated neighbourhood teams and proactive and preventative approaches as initial priorities.

iii. People working at Oxford Health

- *Improve staff experience* through wellbeing and inclusion, with a focus on age, ethnicity and disabilities. Strengthen leadership development through mentoring Band 7s, and support clinical development through a clear advanced clinical practitioner programme.
- *Supporting investment*: estates upgrades for inpatients, wellbeing spaces and neighbourhood hubs.

Next Steps and Board Assurance

19. The Trust is continuing to refine directorate priorities and prepare for national planning submissions on the working assumption that finance, activity and workforce requirements will be similar to last year, subject to review once guidance is released.

20. If national guidance requires an initial submission in December 2026, the Board is asked to approve a breakeven revenue plan for submission and approve delegated authority to the Chief Executive Officer (CEO) and Chief Finance Officer (CFO) to approve the detail of that initial planning submission on behalf of the Board, subject to any requirements for assurance or approval by the Board. Once guidance is

available, the initial return, the timetable for subsequent Board approval and any national assurance requirements will be brought back to the Board ahead of the expected final submission to NHS England in February/March.

Recommendation(s)

The Board is asked to:

- Review the content of this paper and the accompanying paper, “Annual Planning November 2026” and note that preparation for national planning submissions is underway on the working assumption that finance, activity and workforce requirements will be similar to last year, subject to review once guidance is released.
- Provide feedback on the proposed planning approach and, if national guidance requires an initial submission in December 2026, approve a breakeven revenue plan for submission and approve delegated authority to the Chief Executive Officer (CEO) and Chief Finance Officer (CFO) to approve the detail of that initial planning submission on behalf of the Board, subject to any requirements for assurance or approval by the Board. Note that a further submission is expected, and that the initial return, the timetable for subsequent Board approval and any national assurance requirements will be brought back to the Board once guidance is available.

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**	☐ **Trust Risk Register**
Equality, diversity and inclusion	Yes/<u>No</u>	
Legal and regulatory	Yes/<u>No</u>	

Oxford Health NHS Foundation Trust

Annual Planning November 2026

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

Oxford Health NHS Foundation Trust

Introduction

- **Planning framework:** Last year, NHS England required organisations to submit three-year finance and workforce plans. At the time of writing, planning guidance for 2027/28 has not been published. The South-East NHSE region has updated that there will be a high-level submission requirement in December followed by a full submission in February or March.
- **ICB commissioning intentions:** Thames Valley ICB has published its commissioning intentions for 2027/28, including a commitment to allocate 1% of its overall funding as a fund to priority pathways and preventative and proactive models of care. The ICB requested initial proposals by 7 November, and the Trust has submitted proposals for consideration.
- **Growth funding:** Mental Health Investment Standard (MHIS) funding has been confirmed as outside the 1% process, although the position on additional Community growth funding remains unresolved. The Trust has included Community growth proposals within its 1% fund submission to ensure these requirements are visible to the ICB, while continuing to make the case for separate funding for underlying demand growth in existing Community services, in addition to the new 1% fund. Mental Health Investment Standard allocations are being discussed and agreed through the Mental Health Provider Collaborative.

Oxford Health NHS Foundation Trust

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01	Trust Underlying Position
02	Revenue Planning Assumptions
03	Capital Plan
04	Medium Term Planning Framework Requirements
05	Recommendation

Oxford Health NHS Foundation Trust

Section 1

Trust Underlying Position

Trust Underlying Position

- The underlying position based on month 6 directorate forecasts for FY28 is a deficit of £4.0m.
- This includes the full year effect of recruitment to posts funded through FY27 growth, which is the reason for the movement from a balanced position in FY27.
- The Trust is reporting a balanced overall financial position in FY27; however, this reflects a longstanding trend of significant underlying pressures within mental health inpatient services and out-of-area placements, which are currently being offset by reserves and underspends elsewhere. The underlying position includes an adverse variance of £10.5m on mental health wards and £4.5m on out-of-area placements.
- Mental Health directorates have been requested to develop specific, quantified action plans to address the operational drivers of these pressures and reduce the level of overspend.
- Inpatient ward pressures are driven principally by additional staffing requirements, predominantly met through bank staff. This is a key contributor to the Trust exceeding the NHS England bank spend limit. Delivery of the directorate action plans, including reducing additional staffing requirements, is therefore expected to reduce both the underlying ward overspend and bank expenditure.

Oxford Health NHS Foundation Trust

Section 2

Revenue Planning Assumptions

FY28 Planning Bridge

Oxford Health NHS Foundation Trust

£'000s	Underlying position	Inflation & Deflator	CIP & Efficiency Programme	Growth Funding	Other Contract Changes	Forensic Contract Changes	Ward Refurbishment	OPS & R&D Plan	Known Run-rate Pressures	Depreciation & Financing Costs - TBC	FY28 Plan
Clinical Income	591,117	0	0	16,012	4,987	-3,568	0	0	0	0	608,548
Other Income	154,430	1,637	0	0	0	0	0	3,832	0	0	159,899
Pay	-461,693	-9,516	21,068	-12,809	-3,990	1,881	0	-64	-4,363	0	-469,487
Non-Pay	-269,413	-4,230	3,333	-3,202	-997	54	-1,000	-3,568	-1,454	0	-280,478
Depreciation	-18,744	0	0	0	0	0	0	0	0	0	-18,744
Financing Costs	218	0	0	0	0	0	0	0	0	0	218
Adjustments	43	0	0	0	0	0	0	0	0	0	43
Adjusted Surplus/(Deficit)	**-4,042**	**-12,109**	**24,401**	**-0**	**-0**	**-1,633**	**-1,000**	**200**	**-5,817**	**0**	**0**

- The initial plan for FY28 is breakeven, but many details of the plan still need to be finalised. For a December submission it is anticipated that a breakeven position will be submitted.
- Inflation figures are based on last year's medium term planning guidance which included a net inflation increase of 2% offset with an efficiency requirement of 2%. Pay and non-pay inflation has been calculated using these assumptions as no further guidance has been issued on this.
- Temporary Staffing spend is planned to be compliant with the NHSE spend limits for bank and agency. This requires a £7m reduction in bank spend which is included in the Efficiency figures.
- The Forensic Contract changes includes the closure of Lambourn House and repurposing of Evenlode ward.
- CQC have raised with the Trust the need for some of the wards to be decorated and refurbished to improve the environment for patients. Estates & Facilities will start this work this financial year, but it is not likely to be completed until FY28. £1m has been included as an estimate until further work has been done on how much this is going to cost.
- The Known run-rate pressures amount is to acknowledge a risk on delivery of the CIP and efficiency programme and demand pressures on services which are likely to cause financial pressures.
- The next slides outline the planning assumptions made and decisions that still need to be made.

Cost Improvement Plans (CIPs)

Oxford Health NHS Foundation Trust

- The initial plan assumes CIP delivery of £24,401k made up of £13,779k directorate targets and £10,622k of Trust-wide cost reduction plans.
- Trust-wide, the temporary staffing reduction, including a bank reduction programme is £8,667k. Further, there is a target of £1,955k relating to reduced OAP spend.
- The directorate target is made up of £10,967k new CIP targets and £2,812k brought forward CIPs that have not been made recurrently in FY27.
- The table below show the status of directorate plans at the end of October.

Directorate	FY27 B/F £'000	FY28 Target £'000	Total FY28 Target £'000	Recurrent Plans £'000	Non Recurrent Plans £'000	Still to find £'000
Bucks MH	53	1,952	2,005	1,313		693
Community	1,744	2,623	4,367	2,373	1,227	767
OBSW	763	3,861	4,624	3,351		1,273
LD	-	159	159	159		
Forensic	252	994	1,246			1,246
Corporate Affairs	-	48	48	48		-
Nursing & Clinical Governance	-	195	195	195		-
HR	-	263	263	263		-
Pharmacy	-	88	88	88		-
Strategy	-	72	72	72		-
Finance	-	145	145	145		-
Digital	-	176	176	176		-
Estates	-	391	391	132		259
Total	**2,812**	**10,967**	**13,779**	**8,315**	**1,227**	**4,237**
				60%	9%	31%

Growth Funding Assumptions

Oxford Health NHS Foundation Trust

The initial planning assumptions on growth funding are:

- **Community growth £10.3m** – this is based on 7.1% growth on the TV ICB community contract. The 7.1% was within last year's medium term planning guidance as the amount ICB allocations would increase by in FY28 for community growth. Community growth has not yet been agreed with Thames Valley ICB.

- **TV ICB MHIS £5.2m** – this is based on the total ICB MHIS allocation split on a population fair share basis between the Trust and Berkshire Healthcare. This amount has been agreed by Thames Valley ICB and plans will be tagreed through the Mental Health Provider Collaborative.

- **BSW ICB MHIS £0.5m –** this is based on 2% of the contract value. Discussions have started with BSW ICB on ensuring a proportion of their MHIS allocation is allocated to CAMHS services.

- **SDF –** currently no allocations for SDF have been confirmed but it is anticipated that there will be further allocations for Mental Health Support Teams in schools (MHSTs), Talking Therapies (TT) and Individual Placement Support (IPS) to enable these areas to meet the national performance requirements.

Oxford Health NHS Foundation Trust

Temporary Staffing

- NHS England set spend limits for Agency and Bank staff as part of the medium-term planning guidance last year.

- The FY28 spend limit for Agency is £7,007k. The current forecast for agency in FY28 is £7,065k, which is close enough to the spend limit to have confidence in setting the plan as the spend limit. This takes into account that VAT is no longer charged on Medical agency supply. It will require agency controls to continue and further action will be needed to meet the reduced FY29 spend limit of £3,114k.

- The FY28 spend limit for Bank is £29.5m which reduces further to £25.6m in FY29. The current forecast for FY28 (including inflation) is £37.1m which is £7.6m above the spend limit. The Trust's plan will not be compliant if the Bank plan submitted is above the spend limit. The plan assumes that the Trust will reduce bank spend to the spend limit.

- The bank spend is related to the cost pressure on mental health inpatient wards as the majority of additional staffing being used is bank staff.

Risks and Opportunities

Oxford Health NHS Foundation Trust

Risks

- Non-delivery of CIP targets
- Review of Nurse Band 5 job descriptions resulting in re-banding of roles
- Potential transfer of NHS property services properties resulting in increased costs
- Worsening run-rate
- Investment required in Corporate directorates to meet planning priorities

Opportunities

- Slippage on growth funding
- Release of deferred income
- Review of Balance Sheet provisions

Oxford Health NHS Foundation Trust

FY29 and FY30 Plans

Detailed planning work has not yet been completed for FY29 and FY30.

The medium term planning guidance included inflation assumptions for FY29 which was a 2% net inflation uplift offset with a 2% efficiency requirement. These assumptions will be used for planning purposes until further guidance is released.

Assumptions around growth funding will also be made based on the medium term planning guidance.

It is anticipated that the Trust will submit breakeven plans for FY29 and FY30 with CIP targets for directorates staying at the same level as FY27 and FY28 and further efficiencies made on reduction of temporary staffing to reduce spend to the NHSE spend limits.

Oxford Health NHS Foundation Trust

Section 3

Capital Plan

Oxford Health NHS Foundation Trust

Capital Plan

Funding Source:	26/27 £'000	27/28 £'000	28/29 £'000	29/30 £'000	Total £'000
OHFT Opex	*10,083*	10,560	10,779	10,997	42,419
Surplus generated additional Opex	*2,600*	4,750			7,350
Total Opex Funding	***12,683***	**15,310**	**10,779**	**10,997**	**49,769**
ICT	*2,500*	2,500	2,500	2,500	10,000
Lease Costs	*1,012*	7,392	1,822	2,534	12,761
Estates	*9,171*	5,418	6,457	5,963	27,008
Total Opex Spending Plan	***12,683***	**15,310**	**10,779**	**10,997**	**49,769**

- The Trust operational capital allocation has already been set to FY30.
- Estates & ICT are working on priorities with directorates as well as considering any schemes from FY27 with carryover impact.
- A proposed scheme by scheme capital plan will be taken to Finance for approval in due course.

Oxford Health NHS Foundation Trust

Section 4

Medium Term Planning Framework Requirements

Defining medium term priorities to support left shift

- The following slides summarise the requirements for the Trust to meet the trajectories outlined in the Medium-Term Planning Framework.

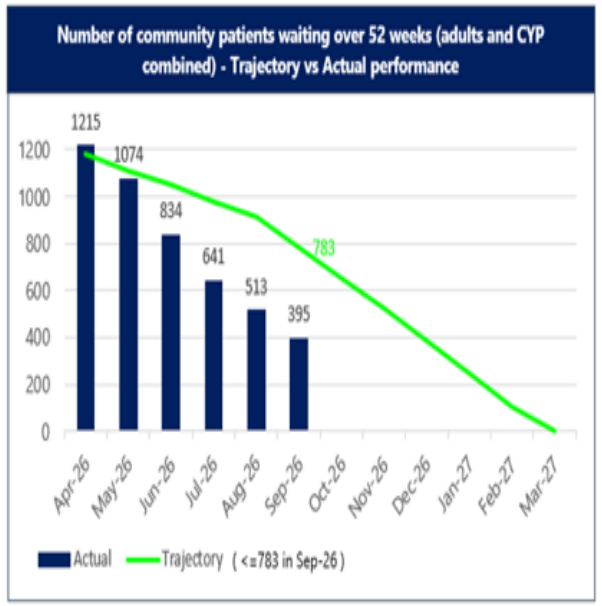
- In addition to this work, clinical directorates have been developing their priorities for the next 5 years, identifying areas of pressures or for potential service expansion in our mental health and community services where further development would support the left shift ambition of the 10 Year Health Plan. These emerging priorities are summarised in the cover paper for this item.

- The Trust is currently working as part of its ICBs' planning processes to develop these priorities with partners and identify sources of funding as part of the left shift growth agenda.

Medium Term Planning Framework – Address long waiting times for community health services

Oxford Health NHS Foundation Trust

- **26/27 Target** – At least 78% of community health service activity occurring within 18 weeks & actively manage long waits for community health services, reducing the proportion of waits over 18 weeks and developing a plan to eliminate all 52-week waits
- **28/29 Target** – At least 80% of community health service activity occurring within 18 weeks





Our current position for the number of people waiting over 52 weeks is 395 which exceeds our trajectory for September, we will achieve 0 for CYP SLT by the end of FY27, Podiatry may be more challenging but currently on plan.

Our current position for % of patients waiting under 18 weeks is 61.92% which exceeds our trajectory for September, we are currently on track to achieve 78% by the end of FY27. The main areas of pressure are within the CYP Speech & Language (SLT) & Podiatry Services.

Medium Term Planning Framework – Expand Coverage of Mental Health Support Teams in schools

- **26/27 target:** 77% coverage of operational mental health support teams and teams in training
  28/29 target: 94% coverage, reaching 100% by 2029.

To reach 100% coverage in Buckinghamshire & Oxfordshire by 2029 investment will be required for the following new teams:

- 26/27: 2 new Oxfordshire teams and 1 Buckinghamshire team **(achieved).**
- 27/28: 1 new Oxfordshire team and 2 Buckinghamshire teams.
- 28/29: 1 new Buckinghamshire team.

It is expected that we will receive SDF to cover these expansions but allocations for 27/28 have not yet been confirmed.

Medium Term Planning Framework – Meet the existing commitments to expand Individual Placement and Support

- **26/27 Target** - 63,500 accessing Individual Placement and Support by the end of 2026/27
- **28/29 Target** - 73,500 accessing Individual Placement and Support by the end of 2028/29

To reach the expected numbers of people accessing Individual Placement and Support in Buckinghamshire & Oxfordshire by 2029 investment and workforce expansion is required as detailed below. It is expected that SDF funding will cover this expansion, but allocations for 27/28 have not yet been confirmed. These figures are as per current guidance.

Oxfordshire & Buckinghamshire	26/27	27/28	28/29
Access Numbers Required to meet National Trajectory			
People Accessing IPS	1230	1358	1425
Workforce Numbers Required			
Number of Employment Specialists Needed	31	34	36
Number of Team Leaders Needed	6	6	6
Number of Service Managers Needed	2	2	2

Our current combined position at the end of September is 941 people accessing the Individual Placement and Support service, With Oxfordshire on plan and Buckinghamshire below plan, it is expected the end of year target will be met once further recruitment has been completed in Buckinghamshire.

Medium Term Planning Framework (MTPF) –
Meet the existing commitments to expand NHS Talking Therapies (SDF Funding)

Oxford Health NHS Foundation Trust

- **26/27 Target** - 805,000 courses of NHS Talking Therapies by the end of 2026/27 with 51% reliable recovery rate and 69% reliable improvement rate-
- **28/29 Target** - 915,000 courses of NHS Talking Therapies by the end of 2028/29 with 53% reliable recovery rate and 71% reliable improvement rate

Both Oxfordshire & Buckinghamshire Talking Therapies are working towards achieving the year end targets for the Medium-Term Planning metrics for Reliable Recovery (51%), Reliable Improvement (69%) & Courses of treatment.

In addition to this the service have an ICB stretched target for the number of courses completed which the trust will be aiming to achieve. Current performance detailed below.

Current Performance for the Number of Completed Courses by area	MTPF Target for September	ICB Stretched target for September	Actual performance September 2026
Buckinghamshire	>=497	>=560	759
Oxfordshire	>=636	>=770	736

Buckinghamshire Talking Therapies-Full Funding will be required to meet national activity expectations	26/27	27/28	28/29
Courses of Treatment	6185	6340	6785
Reliable Recovery-Numerator	2808	2934	3198
Reliable Recovery-Denominator	5556	5700	6096
Reliable Recovery % (Year End position)	51%	52%	53%
Reliable Improvement-Numerator	4086	4404	4776
Reliable Improvement-Denominator	5964	6336	6780
Reliable Improvement % (Year End position)	69%	70%	71%

Oxfordshire Talking Therapies-Full Funding will be required to meet national activity expectations	26/27	27/28	28/29
Courses of Treatment	8246	8453	9046
Reliable Recovery-Numerator	4204	4353	4749
Reliable Recovery-Denominator	8244	8452	9045
Reliable Recovery % (Year End position)	51%	52%	53%
Reliable Improvement-Numerator	5647	5875	6377
Reliable Improvement-Denominator	8244	8453	9045
Reliable Improvement % (Year End position)	69%	70%	71%

Medium Term Planning Framework – Eliminating inappropriate out-of-area placements

Oxford Health NHS Foundation Trust

- **26/27 Target (MTPF)** - Reducing the number of inappropriate out of area placements by end of March 2027.
- Southeast region delivery plan included a stretched target for out of area placements- **To Reduce Adult Acute Out of Area Placements (OAPs) to zero inappropriate placements by March 2027.**
- **28/29 Target** - Reducing or maintaining at zero the number of inappropriate out of area placements.

Current snapshot of performance for September indicates 14 inappropriate out of area placements, For the end of the financial year our Medium-Term Plan target was 4 inappropriate out of area placements.

Metric	Target	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Inappropriate mental health out of area placements – snapshot last day of month - Trust	<=6	0	0	2	7	7	14
Inappropriate mental health out of area placements – bed days in month - Trust	n/a	27	0	35	186	225	297

Oxford Health NHS Foundation Trust

Section 5

Recommendation

Oxford Health NHS Foundation Trust

Recommendation

It is recommended that the Board approve a breakeven revenue plan to be submitted in a December planning submission and approve delegated authority to the CEO and CFO to approve the detail of the planning submission on behalf of the Board.

Oxford Health NHS Foundation Trust

Meeting:	Board of Directors' Meeting
Date of Meeting:	26 November 2026
Agenda item:	11(b)
Report title:	FY26/27 Oxford Health Foundation Trust (OHFT) Annual Plan Mid-Year Review
Executive sponsor(s):	Amélie Bages – Executive Director for Strategy
Report author(s):	Charlotte Adamson, Senior Programme Manager (Planning) Rachel Pirie, Head of Planning
Action this paper is for:	☐ Decision/approval ☐ Information ☑ Assurance
Reason for submission to the Board:	The Board is responsible for reviewing progress made against the OHFT FY26/27Annual Plan.
Public or confidential:	Public

Executive summary

1. This cover note presents the following paper to the Board of Directors for review:

   - FY26/27 Oxford Health Foundation Trust (OHFT) Annual Plan Mid-Year Review

2. FY26/27 is the final Annual Plan aligned to the Trust's previous strategy and the second year of delivery against our two-year focus on six strategic priorities.
3. Colleagues across the Trust developed directorate plans for the 2026/27 financial year, which were approved by the Board of Directors in May 2026. These plans set out our approach to continuous improvement, including developing models of care, improving access and working in partnership across the integrated care systems in Buckinghamshire; Oxfordshire; and Bath, North East Somerset, Swindon and Wiltshire. Clinical directorates identified their top priorities based on the needs of the populations we serve across these areas.
4. Progress against clinical directorate plans is tracked through directorate performance meetings ahead of Executive Performance Meetings, enabling regular monitoring and adjustment where needed.
5. The new Strategy for 2026–2031 has been launched, and teams across the Trust are transitioning to its strategic vision, aims and priorities. A Strategy Delivery Plan for 2026–2031 is being developed as its high-level delivery mechanism. Future Annual Plans will set out the annual actions and commitments required to implement the new Strategy and Strategy Delivery Plan.

6. The mid-year review consolidates updates received through 2026-27 and is structured in two sections:

- Updates on progress against the six strategic priorities and areas of Trust-wide supporting work.
- Clinical directorate and provider collaborative: this section contains updates on directorate progress against priorities for the year.

Report history / meetings this item has been considered at and outcome
Executive Forum 9th November 2026

Recommendation(s)
The Board of Directors is asked to: • Review mid-year progress against the FY26/27 Oxford Health Foundation Trust (OHFT) Annual Plan. • Note that the review reports progress against priorities aligned to the Trust's previous strategy while delivery arrangements transition to the new Strategy for 2026–2031.

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	

Oxford Health
NHS Foundation Trust

Mid-year review of Oxford Health's Financial Year (FY) 2026/27 Annual plan

Board of Directors 25 November 2026

Oxford Health
NHS Foundation Trust

Background and context

Strategy Delivery Plan update:

- 6 strategic priorities
- Trust-wide supporting work update

Clinical directorate updates:

- Buckinghamshire Mental Health directorate
- Oxfordshire and Bath and North East Somerset, Swindon and Wiltshire (BSW) Mental Health Directorate
- Forensic Directorate
- Learning Disabilities directorate
- Community Health Service, Primary Care and Dentistry

Provider Collaborative updates:

- For Me Provider Collaborative
- Child and Adolescent Mental Health Services (CAMHS) Provider Collaborative
- Adult Eating Disorder (AED) Provider Collaborative

Note: the strategic dashboard is included in the Integrated Performance Report.

Background and context

Oxford Health
NHS Foundation Trust

This report presents a mid-year summary of progress against the Trust's Strategic Priorities that were set for 2025-2027. The report relates to actions in the second year of delivery (2026/27) against the six priorities that have guided our work as we developed our next Trust strategy that has now been agreed for 2026-31.

A new Strategy Delivery Plan for 2026-31 is in development alongside our new strategy to act as the high-level delivery mechanism for that strategy. Our future annual plans will set out annual deliverables required to implement both the strategy and the Strategy Delivery Plan. Oxford Health's FY26/27 Annual Plan is therefore the last annual plan delivering against our previous strategic objectives and priorities.

Our FY26/27 Annual Plan was developed by staff across the Trust to set out our approach to continuous improvement, including developing our models of care and improving access, whilst continuing to work in partnership across our geographies. Clinical directorates identified their top priorities based on the needs of the populations we serve across Buckinghamshire, Oxfordshire, Bath, North East Somerset, Swindon and Wiltshire.

This review consolidates regular updates received at the Executive Performance Meetings including:
- Regular updates from the clinical directorates, including tracking performance
- Updates on the strategic priorities

This review provides the Board with information for discussion, including:
- Updates on the previous strategic priorities and Trust-wide supporting work
- Updates from clinical directorates and Provider Collaboratives

Oxford Health's Strategy Delivery Plan for FY25/26 and FY26/27

Oxford Health NHS Foundation Trust

2026/27 is the second year of delivery against our two-year focus on six core priorities, to strengthen our strategic focus and guide our work as we developed our next Trust strategy for 2026-31. Our annual planning cycle sets out how these priorities are being implemented for 2026/27 in line with our clinical planning principles set by our Chief Medical Officer and Chief Nurse.

Aspirations & Measures of Success

Mission: *To be the best Trust of our kind in the country*

Vision: *Outstanding care delivered by an outstanding team*

Values:
Caring, Safe, Excellent

Strategic Objectives: *What we want to achieve*

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

Strategic Priorities

Our focus for the next two years

1. **Developing our neighbourhood health contribution to improve the health of the populations we serve**
2. **Improving access and waiting times**
3. **Listening and responding to the voice of patients, families and carers**
4. **Supporting our people and our teams (Developing our culture in Oxford Health)**
5. **Building an anti-discriminatory organisation**
6. **Prioritising staff safety and minimising violence and aggression**

Supported by Trust-wide work

Our Strategy Delivery Plan on a Page

Oxford Health NHS Foundation Trust

Our Strategy Delivery Plan for 2025/26 and 2026/27 focuses our work on 6 strategic priorities supported by Trust-wide work. Overview documents have been developed for each of the 6 strategic priorities (provided below), enabling executive oversight and ongoing development of these areas of work. The portfolio of Trust-wide supporting work has been reviewed and where available, overview documents are also provided.

This approach has guided our work as we developed our new strategy for 2026-31 and we are working with teams across the Trust to shift our focus to the new strategic vision, aims and priorities which will guide our planning process going forward.

Our 6 Priorities:

- Developing our neighbourhood health contribution to improve the health of the population we serve
- Improving access and waiting times
- Listening and responding to the voice of patients, families and carers
- Supporting our people and our teams (Developing our culture in Oxford Heath)
- Building an anti-discriminatory organisation
- Prioritising staff safety and minimising violence and aggression

Our Trust-wide supporting work:

- Continuing to improve the quality and safety of the care we provide through embedding quality improvement
- Develop and provide innovative clinical services, and support world-class research
- Improving how we use insights and deliver value
- Improving our central support and corporate services
- Measuring and improving outcomes for our patients
- Rolling out our Frontline Digitisation Programme
- Building our workforce planning approach
- Implementing our Operating Framework and building our Well-led Assurance
- Improving our Estates, including delivering the Warneford Park Programme
- Delivering our Green Plan

Oxford Health
NHS Foundation Trust

Strategic priorities

Priority Name: Developing our neighbourhood health contribution to improve the health of the populations we serve

By better understanding the needs and inequalities in access and outcomes of the populations in the neighbourhoods we serve we can tailor our services to improve outcomes

Executive Sponsor: Amelie Bages and Karl Marlowe
Senior responsible owner (SRO): Sue Butt

Oxford Health NHS Foundation Trust

Background and problem statement

Care delivery is fragmented, reactive, and poorly coordinated between acutes, community, mental health, primary care, social care, education, and voluntary, community and social enterprise (VCSE) partners. Results in poorer outcomes— esp. for those with complex or long-term needs— limits the system's ability to prevent ill health and reduce health inequalities, for populations.

Two year programme vision

A neighbourhood approach for integrated, equitable, and person-centred care.

1. **Develop & implement a neighbourhood approach for our services aligned to Place:**
   - Establish local neighbourhood health and care structures focused on seamless care.
   - Shift focus to early intervention and proactive care with improvements in population health.

2. **Reducing health inequalities** :
   - Targeted interventions – Core20+5 approach and Index of Multiple Deprivation (IMD) focus on access and waiting time targets.
   - Enhanced data collection with analytics .
   - Population health approach identifying and supporting those not accessing our services.

Delivery approach

One programme with workstreams:

- **Place based neighbourhood health** plans for Oxfordshire, Buckinghamshire and Bath, North East Somerset, Swindon and Wiltshire..
- **Trust-wide Health Inequalities Group** is in place, with oversight through the Neighbourhood Steering Group and Executive reporting

Governance via Neighbourhood steering group report to Exec

Key existing work across the Trust

Oxford Health NHS Foundation Trust (OHFT), part of the National Health Service (NHS), neighbourhood health approach on prevention, accessibility and population health management. (25/26). Foundations of segmented, locally tailored approaches to improve outcomes and reduce health inequalities.

i) Buckinghamshire: Embedding Integrated Neighbourhood Working

- children and young people (CYP) multidisciplinary teams (MDTs) – plans
- Adult multi-agency groups (MAGs) - proactive care (case finding) of cohorts in each neighbourhood with mental health teams – commence from December
- Bucks New Uni building in Aylesbury – programme board to commence to incorporate a mental health neighbourhood hub for Aylesbury and High Wycombe
- Primary Care Clinical Leads in post

ii) Oxfordshire: Establishing the Foundations for Neighbourhood Delivery

- Multi-neighbourhood Leadership Team structures in North & West; City; South.
- Frailty integrated neighbourhood teams (INTs) delayed – commissioning model being explored
- CYP INTs model agreed
- Innovation funding for cardiovascular disease (CVD) prevention - delivery model to be agreed

iii) BSW: Aligning System Models and Infrastructure

- Vision work started to translate into delivery models. Adults initial focus, with CYP now aligned to Family Hubs and special educational needs and disabilities (SEND) (Experts at Hand) - priority cohorts of focus.
- Geographies still emerging
- ICB leading neighbourhood work but recent changes in structure a delay.

Health Inequalities - Trust-wide analysis of access and waiting times by deprivation and ethnicity is established, with directorates using the findings to identify areas for deeper analysis and action and Connected Care and population segmentation capability is developing.

Key performance indicators (KPIs)

Objectives as described in the national neighbourhood framework (Link) over 3 years.

Milestones

Place based milestones
Q2–Q4 2026/27
Develop local plans for each place.
End of 2026/27
Establish foundations for neighbourhood delivery

Health Inequalities milestones

- Develop focused Connected Care and segmentation use cases, including neighbourhood and pathway-level insight. (Q3–Q4)
- Define the requirements for a patient-level view of inequality, bringing together physical and mental health, deprivation, ethnicity and other relevant information. (Q3–Q4)
- Agree the refreshed workplan, including priorities, actions, governance and reporting arrangements. (Q3–Q4)

Priority Name: Improving access and waiting times
By improving access and waiting time in our services we can make sure that people are adequately supported in the right place at the right time

Executive Sponsors: Rob Bale and Emma Leaver
SROs: Chad Zuriekat, Katrina Anderson and Donna Clarke

Oxford Health NHS Foundation Trust

Background and problem statement

Oxford Health is committed to improving access and waiting times, so people receive support in the right place at the right time. Challenges such as rising demand, staff vacancies, and systemic pressures result in treatment delays and unmet national targets. The services most affected and therefore the focus of this strategic priority are:

- Children's services (mental and physical health)
- Memory Assessment Service
- Adult Community Services

Work will include redesigning the experience of waiting: developing clinical principles to improve patient experience and exploring alternatives such as digital or outsourcing to reduce the impact of delays.

Two year programme vision

Over the next two years, Oxford Health will significantly enhance access to services, focussing on children's services, the Memory Assessment Service, and Adult Community Services.
This priority aims to provide timely and equitable access to these services, reduce waiting times, and improve patient outcomes.

1. **Standardise and reduce variation to improve patient experience and reduce harm** - develop clinical principles to simplify pathways, reduce variation and improve patient experience, whilst waiting with a focus on improving patient experience and harm reduction, including 'waiting well'.
2. **Strengthen internal processes with a systematic approach to waiting list initiatives** - embedding regular data reviews across all services and ensuring services are digital, paperless, performance-managed, and guided by pathway reviews and service mapping. Align processes and build a shared understanding of demand and capacity to enable a more coordinated approach to meeting population needs.
3. **Embed alternative options as part of waiting time approach** - digital transformation to streamline access and improve service delivery – embed digital tools including artificial intelligence (AI), virtual consultations and self-referral platforms, to streamline access and enable a shift towards prevention and alternatives via right to choose.

Delivery approach

Via existing performance governance reporting to Executive meeting on waiting time data.
Alignment with other priorities as required will take place at Strategy Delivery Group, supported by Strategy team.

Key existing work across the Trust

- Continued work to standardise and strengthen internal processes – including service mapping, pathway review and regular analysis of data (e.g. Waits) from the Quality and Safety Dashboard and performance dashboards (including Trust Online Business Intelligence (TOBI) and the Integrated Performance Report).
- Health inequalities and population health work to support more equitable access, including routine review of access and waiting times by deprivation (IMD) and priority cohorts, aligned to Core20PLUS5 and neighbourhood-based approaches (linked to Strategic Priority 1).
- Enhanced collaboration with partners to streamline service delivery – including place-based collaborations and the MH Provider Collaborative.
- Digital and innovation projects – digital tools such as self-referral platforms and virtual consultations.
- Frontline Digitisation programme – builds digital capability and empowers patients to engage with services more easily.
- Joint working board has been developed to ensure consistent working across all Trust mental health areas.

KPIs and outcomes

Community: To achieve 78% waits within 18 weeks and eliminate all 52 week waits and over by end of March 2027
Mental health (MH): To be agreed as pat of Annual Planning prioritisation process

Milestones

Community
Q1-Q2 (2026/27)
- Implement recruitment and quality improvement (QI) plans as defined by service waitlist improvement plans.

Q3 - Q4 (2026/27)
- By Q3 eliminate all 52-week breaches (excluding patient choice)
- Deliver planned reduction in 18 week waits.
- Evaluate year 2 progress and learning

Mental Health:
Q1-Q2 (2026/27)
- Clear understanding of single point of access (SPA) waits and drivers.
- Consistent, high-quality waiting list data and operational grip.
- Targeted focus on highest-pressure MH pathways (adult mental health team (AMHT), Getting More Help (GMH)).
- Data-led productivity and efficiency improvement.

Q3-Q4 (2026/27)
- Consistent digital and data standards for waiting lists.
- Joint system action on priority waits.
- Learning reviewed and future priorities agreed.
- Standardised access and waiting list processes embedded.

Priority name: Listening and responding to the voice of patients, families and carers

By actively listening and valuing the voice of people who use our services we can have a clear picture of how they experience care and improve our services to better respond to their needs

Executive Sponsor: Britta Klinck
SRO: Bill Tiplady

Board Meeting in public

Oxford Health NHS Foundation Trust

Background and problem statement

Oxford Health has established a robust foundation of work on lived experience involvement and roles within the trust, with over 60 peer support workers in place and a dedicated experience and involvement team. There is, however, significant potential to improve the consistency and impact of meaningful involvement of people who have used trust services, and their families and carers to enhance services. This will require an agreed overall approach and framework which can be tailored to allow for the readiness of different services: it is recognised, for example, that community services in the trust will need specific consideration and planning.

Two year programme vision

Vision: Within two years, to make a significant move towards a culture that demonstrates an increased commitment to prioritising lived experience involvement in service improvement and delivery.

1. **Refine and strengthen processes to support co-production** – lived experience roles will be consistently embedded within directorates, with improved career pathways and progression available, and a clear understanding of how these roles are supported by both corporate and directorate structures. We will have improved policies and processes that enable the input of experts by experience which services can use to guide their approach to coproduction.
2. **Hear and respond to user feedback** – the trust has a number of sources of information about service user and carer experience. We will develop an approach to triangulating these and feeding back to patients and carers, services, and leadership teams at all levels from ward to Board to stimulate meaningful discussion and action.
3. **Embed lived experience into care -** we will aim for the voices of patients, families, and carers to be embedded into decision-making at every level. This is a long-term cultural shift which will include equipping staff with the expertise and resources to listen, respond, and integrate lived experience into service delivery and development as well as identifying wider cultural barriers and enablers.

Delivery approach

The delivery approach builds on a leadership structure which brings together experience and involvement work with peer support and recovery. It will be led by the Experience and Involvement team, with experts by experience, and in close partnership with directorates. This will include the facilitation of patient and carer engagement groups, supported by Oxford Health Improvement (OHI), and the integration of lived experience into continuous service improvement and governance. The programme reports quarterly to the Executive, ensuring accountability and continuous alignment with Trust priorities.
Alignment with other priorities as required will take place at Strategy Delivery Group, supported by Strategy team.

Key existing work across the Trust

- Experience and Involvement team in the Trust with embedded lead roles across directorates.
- Peer Support workers embedded across the Trust.
- Experts by experience (EbEs) groups across trust geography and functions and new dialogues with these in terms of interface with trust board.
- Many and growing examples of EbEs involved in quality improvement and Trust governance e.g. involvement in set up of Murray House; part of Mental Health Inpatient Transformation programme governance, development of Trust Strategy.
- Ongoing partnership with third sector partner to foster engagement with CYP voices.
- Multi-year work on implementation of the 'triangle of care' across Mental Health services.
- Council of Governors – active role in representing the voice of patients and carers.
- Multiple mechanisms for gathering service user feedback including 'I Want Great Care' now with new more flexible platform, Patient Advice and Liaison Service (PALS) and surgeries, complaints and compliments, clinical audit, and service user networks and forums.
- Patient Safety Partners well embedded within the Patient Safety Team and have a key role in using their own lived experience of receiving care from OHFT or caring for a loved one, in order to improve patient safety.

KPIs and outcomes

- Improved feedback mechanisms in development.
- The development of Lived Experience governance

Milestones

2026-28

- Development of patient reference groups across directorates
- Lived Experience voice group attendance at Trust Board
- Expert by Experience mentors made available to Executive members
- Development of in-house patient experience survey mechanism

Priority Name: Supporting our people and our teams (developing our culture in Oxford Health)

By developing and empowering our people and teams we will ensure that decisions are made by teams of people working at the closest possible point to our patients and carers and better address their needs

Executive Sponsor: Charmaine DeSouza
SRO: Nicky Howells

Oxford Health NHS Foundation Trust

Background and problem statement

Oxford Health recognises that its culture - how things are done day-to-day - is central to delivering high-quality, safe, and effective care. In 2024, a reference group of around 100 colleagues undertook scoping and discovery work to explore the current state of culture across the Trust. This work has informed the development of a culture statement and a set of guiding "asks" to shape a coherent programme of activities.

There is a need for a more intentional, structured approach to culture development. Variability in team behaviours, leadership inclusivity, and alignment with shared values has created inconsistencies in staff experience. Without a unified cultural framework, opportunities for improvement, innovation, and retention may be missed.

Two year programme vision

By the end of FY 2027/28, Oxford Health will have made significant progress towards embedding the foundations of the culture plan including strategy cascade into team objectives; leader and team development; anti-racism programme; and establishing the wellbeing offer. In addition to the 5 Asks, these will be measured within the NOF as part of the NHS Staff Standards.

The five year vision for the strategy and the programme is to embed a culture based on behaviours that are drawn from the overarching concepts of civility, respect, and kindness; supporting individuals' wellbeing and treating people fairly when things go wrong; building an improvement mindset; and ensuring compassionate and inclusive leadership at all levels.

Our intentional culture development will be guided and measured by a set of "5 Asks" that frame expectations for individuals and teams around:

- Teamwork
- Support and inclusion
- Compassionate leadership
- Quality improvement, learning and innovation
- Professional practice

Delivery approach

A programme of culture development work has been established alongside an associated implementation plan.

The programme will be overseen by the People Steering Group. Alignment with other priorities as required will take place at Strategy Delivery Group, supported by the Strategy team.

Key existing work across the Trust

- Culture programme against the 5 Asks framework, including:
  - strategy cascade
  - leader & team development offers
  - NHS staff standards regarding daily experience
- People Plan
- Equality, Diversity and Inclusion plan
- Health and Wellbeing plan 2026-28
- Education Strategy

KPIs and outcomes

Impact KPIs are drawn from specific staff survey questions aligned to each of the 5 Asks. These will demonstrate impact on employee experience over the life of the programme 2026-31.

Milestones

Q1 2026/27 - DONE

- Design - Executive approval of culture plan and phased implementation plan
- Implement new People directorate structures including OD/Culture team

Q2 2026/27 - DONE

- Develop – resources, materials, communication, engagement.
- Set up governance oversight

Q3 2026/27 - IN PROGRESS

- Deliver - initiate Phase 1
- Refine governance reporting

Q4 2026/27

- Review progress and learning to date
- Refine governance reporting
- Set up for 2027/28

Priority Name: Building an anti-discriminatory organisation

By improving equality, diversity and inclusion we will improve the experience of our staff and teams and the experience and outcomes of our patients, families and carers

Executive Sponsor: Charmaine De Souza
SRO: Nicky Howells

Oxford Health NHS Foundation Trust

Background and problem statement

Prejudice and discrimination, both direct and indirect, exist through behaviour, policies, practices and cultures against certain groups, both within our workforce and our patients. The NHS is built on the values of everyone counts, dignity and respect, compassion, improving lives, working together for patients and a commitment to quality. Ensuring our staff work in an environment where they feel they belong, can safely raise concerns, ask questions and admit mistakes is essential for staff morale - which in, turn, leads to improved patient care and outcomes. This can only be done by treating people equitably and without discrimination.

Delivery approach

Our Anti-racism statement, created in consultation with staff groups and networks, has been published. A Managing Racism toolkit has been consulted upon and is nearing publication. A programme of work is underway to bring the statement to life. This includes participation in a 6 month RHO community pilot aligned to the NHS Staff Standard on Tackling Racism.

The wider EDI work, including workforce PCREF objectives, has been consolidated into one plan aligned to the overarching culture programme and overseen by the EDI steering group.

KPIs and outcomes

Tackling Anti-racism forms part of the NHS Staff Standards and will be monitored via staff survey outcomes via the NOF

- Q14 – Experience of harassment, bullying or abuse from patients/service users, their relatives or members of the public
- Q15 - Organisation acts fairly with regard to career progression
- Q16 – Personal experienced discrimination at work

Two-year programme vision

The overall aim of being an anti-discriminatory organisation is to create an equitable and inclusive workplace and patient care environment. We will aim to identify, track and tackle discrimination systematically for both our staff and patient groups. In particular, we will develop our approach to being an anti-racist organisation.

This will translate into:

- A developed organisational framework for being an anti-discriminatory organisation – starting with anti-racism – covering both our staff and patients and with clear success metrics
- Delivering against our legislative and regulatory duties
- Equitable services in terms of access and outcomes for the populations that we serve

Key existing work across the Trust

The culture programme includes the following key work in this area:

- Anti-racism programme
- EDI plan
- Health and Wellbeing plan 2026-28
- Leadership Development Pathway
- Communications & Engagement plan
- Staff networks and support groups
- PCREF
- Social work strategy – anti-discriminatory practice
- Neurodiversity strategy
- Freedom to Speak Up / PALS
- Adoption of 6 NHS standards including Tackling Racism

Milestones

Q2 – publish anti-racism statement, develop and consult on manager toolkit **- DONE**

Q3 - Establish Anti-racism priorities, milestones, baseline and outcome metrics **- IN PROGRESS**

Q4 – Focused work on:

- Racially motivated abuse in clinical settings
- Representation in disciplinary processes
- Biases in the recruitment pathway

Priority name: Prioritising staff safety and minimising violence and aggression

By prioritising the safety of our staff and minimising violence and aggression we will ensure colleagues feel supported, safe and secure at work and can operate at their best to support patients, families and carers

Executive Sponsor: Britta Klinck and Rob Bale
SRO: Angie Fletcher

Oxford Health NHS Foundation Trust

Background and problem statement

The 2025 NHS Staff survey shows that 22% of our staff have experienced harassment, bullying or abuse at work from patients or other members of the public, and nearly 12% have experienced physical violence. Reports of incidents that include racial abuse within Oxford Health have more than doubled between 2022 and 2024 and in 2025, the number has remained unacceptably high.

The number of reports under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reported due to staff injuries caused by patients has increased over the past 5 years. These unacceptable increases are reflective of a national increase of violence and aggression towards NHS staff over the past 5 years.

Over and above our legal duties, set out in the Health and Safety at Work Act 1974, associated regulations and the Public Sector Equality Duty, Oxford Health is committed to honouring our People's Promise to ensure a safe and healthy workplace for all staff, temporary workers and contractors.

Two year programme vision

Staff will see that Oxford Health has taken concrete steps to reduce incidents of violence and aggression and protect their safety. They will see that when incidents do happen, they are supported through them and that the organisation learns from and takes action in relation to the incidents. This will translate into:

- A closer adherence to trauma-informed, compassion-based approaches to the reduction of violence and aggression in inpatient, outpatient, digital and community settings.
- Reduce harm to employees, with a reduction in reported incidents of violence and aggression, including those targeted due to protected characteristics.
- Continue to improve responsiveness and support offered to colleagues when they are harmed.
- Communicate clearly to the public around the expectations of their conduct and treatment of our staff.
- Strengthen our response to violence and verbal abuse by strengthening interagency working with the police.
- Improved safety and support for lone workers.
- Implement and embed the NHS Sexual Safety Charter for staff.
- Effective implementation of data dashboard providing local and Trust-wide insights in order to inform bespoke interventions.
- Utilisation of National Institute for Health and Care Excellence (NICE) guidelines and evidence available across all workstreams.

Delivery approach

Quality Committee, People Leadership & Culture and Fire, Health & Safety Group. Alignment with other priorities as required will take place at Strategy Delivery Group, supported by Strategy team.

Key existing work across the Trust

- Violence prevention and reduction project (including lone working devices project).
- Mental Health Inpatient Improvement Programme (culture of care)
- Support for staff, e.g. Trauma Risk Management (TRiM), Post incident psychological support service, staff psychology service.
- Each inpatient area has quality improvement projects aimed at reducing restrictive practice and incidents on the wards. These projects and their progress is monitored by local positive and safe groups which report to a Trust-wide group which reports to Quality and Safety Group (QSG) and Quality Committee.
- All clinical-facing staff receive conflict resolution training aimed at verbal de-escalation of conflict and inpatient staff all receive comprehensive British Institute of Learning Disabilities (BILD) accredited training in management of violence and conflict using Positive Engagement and Caring Environments (PEACE).
- All inpatient wards have violence and aggression risk assessments in place and these are now regularly reviewed.

KPIs and outcomes

- Introduction of a new coproduced policy to reduce violence and aggression towards staff.
- Reduction in incidents.
- Increase in staff reporting that they feel that the Trust takes action against violence and aggression.

Milestones

Q1 2026/27

- Governance - Establish data-driven, multi-level governance framework to provide intelligence for the prevention of violence against staff (in development).

Q2 2026/27

- Implementation of Op Cavell – Joint Service Agreement (JSA) for Buckinghamshire and Wiltshire with Police (Bucks and Milton Keynes (MK) updated).
- Comms and Engagement - Separate staff-focused and public-facing comms campaigns (in development).
- Training – In addition to standard conflict resolution training, the Trust will roll out public health focused, trauma informed training that can prevent and reduce violence at individual and community level.
- Policy - Delivery of the Sexual Misconduct policy (delivered).

The programme has moved from policy development into implementation and assurance.
The clearest current risks are sustained exposure in high-acuity inpatient services and persistent discriminatory abuse. Further work is underway to strengthen community lone-working risk mitigation, improve data quality and translate incident and RIDDOR review into demonstrable local action.

Trust wide supporting work update

Oxford Health NHS Foundation Trust

Our Trust-wide supporting work brings together a set of enabling pieces of work that are embedded in day to day delivery and monitored through our Trust's governance arrangements. Key progress in 2026/27 includes:

- Strengthening our quality improvement (QI) approach across the organisation and the training available to colleagues
- Continuing to develop our research infrastructure and widening opportunities for colleagues across all professions to participate in and lead research work
- Developing our analytical work to better understand population health and health inequalities in our services so we can build a comprehensive view and use this to agree where we need to focus, take action and understand whether we are making a difference to inequalities in access, experience and outcomes.
- Continuing our work to improve our central and corporate services with six workstreams identified to support progress: Human Resources (HR) Systems; Procurement involvement plan; Intranet and communication; Corporate performance dashboard; Hiring/onboarding processes; Temporary staffing processes.
- Ongoing work across the Trust to review our governance and work against Well-led requirements and best practice.
- Engaging with Clinical directorates to develop our Estates and Facilities Strategy. Plans to transform the Warneford Hospital site into a major mental health and medical research campus have also been approved in principle by Oxford City Council and we continue to refine plans for the campus, building on our engagement with colleagues and people with lived experience.
- Advancing Green Plan delivery through estate decarbonisation, solar and EV projects, sustainable travel, climate adaptation and nature-based recovery, alongside external partnerships in sustainability research and innovation.
- Forging forwards with the current digital programme underpinning the existing digital strategy to support clinician productivity and enhancing patients experience, improving the Trusts overall digital maturity score and engaging with the wider directorates to develop the new digital strategy

Our new strategy for 2026-31 builds on this supporting work with the inclusion of six strategic foundations, which are recognised as core elements enabling the change necessary to deliver our new strategic vision, aims and priorities.

Oxford Health
NHS Foundation Trust

Clinical Directorate and Provider Collaborative Updates

Clinical Directorate and Provider Collaborative updates

Oxford Health NHS Foundation Trust

- Red, Amber, Green (RAG) Rating Guidance (slide 16)
- Buckinghamshire Mental Health Directorate (slides 17–18)
- Oxfordshire and BSW Mental Health Directorate (slides 19–21)
- Forensic Directorate (slides 22–26)
- Learning Disabilities Directorate (slide 27)
- Community Health Service, Primary Care and Dentistry (slide 28)
- For Me Provider Collaborative (slides 29–30)
- CAMHS Provider Collaborative (slides 31–32)
- Adult Eating Disorder (AED) Provider Collaborative (slides 33–34)

RAG Rating Guidance

Oxford Health NHS Foundation Trust

RAG ratings apply to Directorate and Provider Collaborative updates

RAG Status	Timetable	Scope	Cost	Benefits	Risk / issues
Red	Schedule (plan) slippage of over 3 months	Major constraints to the delivery of agreed outputs in line with the business case	Project is expected to exceed anticipated costs by over 10%.	Project is expected to under deliver against minimum benefit target by more than 10%.	There are live risks / issues relating to the project that are not currently being managed and/or pose a major threat
Amber	Schedule (plan) slippage 1-3 months	Moderate constraints to delivery of agreed outputs in line with the business case	Project is expected to exceed anticipated costs by under 10%.	Project is expected to under deliver against minimum benefit target by up to 10%.	There are live issues relating to the project which are being actively managed and mitigated to an acceptable level
Green	Schedule (plan) expected to deliver on time, or with minor slippage of 2-4 weeks	Insignificant or minor constraints to delivery of agreed outputs in line with business case	Project expected to deliver to budget.	Project expected to deliver against minimum benefit target	All risks related to the project have sufficient mitigations in place
Blue	Priority Complete				

Buckinghamshire Mental Health Directorate

Oxford Health NHS Foundation Trust

Buckinghamshire Mental Health

Good progress made on key priority areas of delivery – neighbourhood mental health centre plans have progressed at pace and have reached external stakeholder engagement phase; work continues to develop on plans to review bed base capacity across the directorate and health inequality work has moved into action planning with good engagement from experts by experience. There are some risks in place that relate to delivery timeframes & impact of change that should be noted.

Priority area	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	RAG Status and what's driving status / change
Service Re-Design and Sustainability	• Key plans continue to develop around mobilisation of intensive case management provision. Model and investment now agreed, recruitment initiated. • In-patient work focused on reviewing bed capacity has progressed. • Work to review other pathway models across secondary care has also initiated.	• Complete recruitment for Intensive Case Management & start to onboard new staff. • Complete options appraisal phase of in-patient work and begin planning for implementation of agreed model.	To note likely large-scale change with impact on staff. Delivery timeframes have slipped due to increase in scope of some of the work in this priority area.	Clear governance in place for development and approval. Careful planning with key senior leadership oversight. Informed decision making through access to data.	Progress against key milestones with some key risks in place.
Neighbourhood and Partnership Integration	• Year 2 (Y2) voluntary, community & social enterprise infrastructure contract in place with Community Impact Bucks – partnership workshops in place to support key areas of delivery. • Continued key attendance and engagement with Integrated Neighbourhood Team development. • Mental health neighbourhood centre (MHNC) model – good progress with stakeholder engagement.	• Agree resource to be committed to support the multi agency group meetings as part of INT. • Complete and submit business case for mental health neighbourhood centre capital to NHS England. • Agree clinical / professional model that will support multidisciplinary team working.	Mental health neighbourhood centre plans contingent on properties not owned by trust.	Clear & open dialogue with partners. Decision making through agreed governance structures to ensure transparency.	Good progress against key milestones with risks in place that are confidently mitigated.
Workforce & Equality, Diversity and Inclusion	• Consistent progress on reducing agency spend within the directorate. • Annual review of people plan being undertaken. • Equality Diversity and Inclusion plan finalised for next 2 years.	None to note this reporting period.	None to note this reporting period.	Not applicable (N/A)	Good progress against key milestones.

Buckinghamshire Mental Health Directorate

Oxford Health NHS Foundation Trust

Priority area	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	RAG Status and what's driving status / change
Health Inequalities	• Directorate action plan developed with priority areas agreed for delivery. • New governance structure in place providing senior leadership oversight of key actions. • Expert by experience reps identified to support the work and now attending Directorate board. • Data flowing into directorate governance structure.	• System workshop delivered to ensure clear alignment of priorities and exploit opportunities for scale working. • Continue delivery of agreed actions. • Work to develop further data insight to inform plans.	None to note for this reporting period.	None to note for this reporting period.	Good mid-year progress seen with confidence to achieve year end targets set.
Prevention and Digital	• Worked undertaken with performance and information team to tailor health inequality data to Buckinghamshire priorities, which now includes breakdown of information by community opportunity Bucks wards. • Directorate performance around ethnicity recording improved, now at 85%, plans in place to target areas that are below 90% (non-diagnostic services). • Mental health support team plans in development for expansion of 1 further team in 2026.27.	• Work to increase ethnicity recording by improving data quality at specific service level. • Continue work with performance and information teams to further tailor health inequality data packs.	None to note in this reporting period.	None to note in this reporting period.	Progress against key milestones and no current risks identified.

Oxfordshire and BSW (Bath and North East Somerset, Swindon and Wiltshire) Mental Health Directorate

Oxford Health NHS Foundation Trust

Priority areas	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	RAG Status
Reviewing Service Delivery	**Whole directorate service review and cost improvement planning:** Focused reviews of Oxfordshire Adult Mental Health and Child and Adolescent Mental Health Services (CAMHS) have progressed. The Adult review is examining demand, capacity, pathway configuration, patient flow, productivity and sustainability. CAMHS has completed service level reviews.	• Complete the Adult Mental Health and CAMHS review activity and translate findings into deliverable service and pathway changes. • Continue developing proposals against the existing savings requirement.	• Current demand, capacity and patient-flow pressures may affect service sustainability. • Fragmented access and pathway arrangements remain a concern within CAMHS. • Services need to identify sufficient proposals to meet the existing savings requirement.	• Use review evidence to identify productivity opportunities and sustainable pathway changes. • Develop a simplified CAMHS model aligned with locality and neighbourhood arrangements, with oversight through directorate cost improvement planning.	
	Oxfordshire Mental Health Outpatients Hub: Evaluation of the eight Keystone Mental Health and Wellbeing Hubs has identified emerging benefits from accessible community-based provision, multidisciplinary working and earlier support. This is helping to shape options for outpatient, community and partner services.	• Estates workshop will be organised to progress this- scope needs to be agreed	• Variation remains across hub delivery, workforce capacity, administration, referral processes, estates and data quality. • The estates workshop has been postponed pending agreement on scope, supporting information and participation.	• Define the workshop scope and decision requirements before considering specific estate options. • Bring together evaluation findings and supporting data with appropriate service and partner participation.	
	National inpatient and community transformation: • Delivery of national mental health transformation requirements is progressing across inpatient, urgent-care and community pathways. • The Mental Health Acute Pathway programme is advancing work on purposeful admission, proactive discharge, care planning, therapeutic observations, Culture of Care and patient flow information.	• Rio Flow pilots are planned for January 2027 with preparation for implementation underway. • Data packs are also being developed to cover length of stay, restrictive practice, violence and aggression and out of area placements.	• Patient flow challenges continue across inpatient, urgent care and community pathways. • Variation in care planning, therapeutic observations and pathway information may affect consistent delivery, with dependencies related to pilot readiness and implementation.	• Use the Rio Flow pilots to test and refine ways to improve patient flow. • Strengthen oversight through a standard data pack and a wider review of inpatient flow, coordinated through the Mental Health Acute Pathway programme.	
	Assertive Outreach Team (AOT): Defined the model and skill mix, established caseload monitoring and launched recruitment. Draft policy, interface guidance and training framework are in place. **Memory Clinic:** Reviewed job plans and prepared pilots for 12 additional initial assessments per week. Doctors completed supervised assessments. Weekend clinics are viable. **Oxfordshire Talking Therapies (OTT) Step 3 Digital:** Procured 350 units of external clinical provision to reduce waiting times.	**AOT:** Secure a base, refine the City caseload and finalise policy and interfaces. Interview nursing, occupational therapy (OT), psychology and medical staff. Training delivery planned for January 2027. **Memory Clinic:** Launch two weekly pilot clinics, add a third team later and pilot a weekend clinic in each team. **OTT Step 3 Digital:** Use the full allocation by the end of 2026/27.	**AOT:** Lack of a confirmed base limits recruitment appeal and multidisciplinary working. Nursing and psychology vacancies may delay case transfers and establishment of a fully functioning team. Key performance indicators (KPIs) are not yet available. **Memory Clinic:** Trust Online Business Intelligence (TOBI) does not provide a reliable view of initial assessment volumes, limiting KPI monitoring. **OTT Step 3 Digital:** No risks reported. KPIs are not yet available and are due next quarter.	**AOT:** Continue work to secure a suitable base for AOT. **Memory Clinic:** Maintain local spreadsheets to track referrals and initial assessments until reporting improves. **OTT Step 3 Digital:** No mitigation required at this stage.	

Oxfordshire and BSW (Bath and North East Somerset, Swindon and Wiltshire) Mental Health Directorate

Oxford Health NHS Foundation Trust

Priority areas	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	RAG Status
Partnership Integration	• Mental health contract review with VCSE partners. • Interim arrangements are protecting service continuity while longer-term models are developed. • The Safe Haven tender has been issued for a broader county-wide non-clinical alternative to emergency departments, with a planned April 2027 start. • Supported accommodation proposals have progressed through the Oxfordshire and Bath and North East Somerset, Swindon and Wiltshire (OBSW) Transformation Board. • Partnership working is increasingly embedded across urgent care, crisis and home treatment, CAMHS locality services, neighbourhood working, psychological therapies and complex needs pathways.	• Progress procurement, redesign and mobilisation of the new service models. • Continue development with voluntary, community and social enterprise (VCSE) and system partners, including primary care, local authorities and acute hospitals. • Strengthen communications and clarify responsibilities across organisational boundaries.	• Risk of service fragmentation or disruption during transition. • Potential lack of clarity around responsibilities across organisations, quality assurance and shared outcomes. • Mobilisation dependencies may affect delivery timescales and continuity.	• Maintain interim arrangements until sustainable long-term models are mobilised. • Use shared governance, quality assurance and outcomes frameworks with system and VCSE partners. • Maintain active oversight of mobilisation, communications and service continuity through established transformation and partnership routes.	
Temporary workforce review	• Temporary workforce management is now embedded within routine finance, workforce and service transformation governance. • Stronger agency controls, vacancy oversight and phased recruitment have improved financial control. • Agency use has decreased significantly. • Monthly finance reporting, weekly forward planning of shifts, roster reviews and combined ward-level KPI monitoring have been introduced. • Services are reviewing medical locum use, bank expenditure, skill mix and opportunities to convert temporary work into sustainable substantive arrangements.	• Continue targeted recruitment into medical, inpatient and other hard-to-fill roles. • Review the increase in bank usage across inpatient wards and improve workforce planning. • Move towards sustainable, permanent staffing for ongoing work currently covered by temporary staff.	• Bank usage increased across several inpatient wards during August. • Medical and inpatient staffing pressures remain. • Hard-to-fill vacancies may prolong reliance on temporary staffing. • Further reductions in temporary staffing require careful management to maintain safe staffing levels, continuity of care and staff wellbeing.	• Maintain strengthened agency and recruitment controls alongside weekly shift planning and roster review. • Use monthly finance and ward-level KPI reporting to identify and address emerging pressures. • Prioritise recruitment and skill mix review in areas with persistent staffing gaps. • Reduce reliance on temporary staff while maintaining safe staffing levels, continuity of care and staff wellbeing.	

Oxfordshire and BSW (Bath and North East Somerset, Swindon and Wiltshire) Mental Health Directorate

Oxford Health NHS Foundation Trust

Priority areas	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	RAG Status
Recruitment & Retention	• The OBSW three-year People Plan has been refreshed around Retain, Reform and Train. • The plan is being developed as a live delivery programme with named leads, measurable outcomes, milestones and defined assurance routes. • Oversight is established through the OBSW People Board and wider workforce, equality, diversity and inclusion (EDI) and directorate governance. • Recruitment has improved in several services, including some roles that had remained vacant for extended periods. • Annual staff listening sessions are now supported by quarterly reviews of themes and actions.	• Finalise the People Plan as a coordinated delivery programme. • Link delivery more clearly to workforce metrics and staff survey findings. • Continue targeted recruitment in Assertive Outreach, inpatient care, community teams and medical and specialist roles. • Strengthen feedback to teams through the revised intranet and directorate communications channel.	• Persistent vacancies remain in several hard-to-fill services and roles. • There is a risk that People Plan activity is not sufficiently linked to measurable workforce outcomes. • Leadership development, wellbeing, career pathways and inclusive workforce practices may not consistently translate into improved retention and staff experience. • Staff confidence may be affected if feedback and visible action following listening activity are inconsistent.	• Assign named leads, milestones, measures and assurance routes across the People Plan. • Use workforce metrics, staff survey findings and quarterly listening reviews to monitor impact. • Maintain targeted recruitment and retention action for priority services and hard-to-fill roles. • Provide regular “you said, we did, we are still working on” updates through directorate communications.	
Health Inequalities	• Health inequalities, EDI and the Patient and Carer Race Equality Framework (PCREF) are now embedded within OBSW governance. • A combined EDI and PCREF structure is in place, requiring each service to identify a local priority, practical action, named lead, measure and support requirement. • EDI and PCREF considerations are being incorporated into workforce redesign and service-development proposals. • The health inequalities dashboard is being used to review referrals and waiting times by ethnicity and deprivation. • PCREF activity has expanded to include community engagement, anti-racism work, culturally responsive care, improved demographic recording and stronger service-user, carer and community involvement.	• Strengthen Bath and North East Somerset, Swindon and Wiltshire (BSW) data coverage and complete further analysis of access and outcomes. • Translate dashboard findings into targeted service level actions. • Continue analysis of physical-health outcomes for people with serious mental illness and potential disproportionality in restrictive practice. • Monitor delivery through the EDI/PCREF Group, People Board, quality governance and senior leadership team (SLT) routes.	• A high proportion of records with unknown ethnicity may limit the reliability of analysis. • Potential variation in access and outcomes requires further investigation. • BSW data coverage is not yet sufficiently developed. • There is a risk that analysis does not consistently translate into demonstrable improvements in access, experience and outcomes.	• Improve demographic data quality and strengthen BSW reporting coverage. • Assign named leads, measures and practical actions at service level. • Use established governance routes to monitor delivery and escalate gaps. • Continue targeted engagement with service users, carers and communities to shape culturally responsive action.	

Forensic Directorate

Oxford Health NHS Foundation Trust

Priority work implemented with overall sustained progress against key milestones. Directorate has an established assurance and reporting framework with ability to track progress and risks to delivery.

Priority area	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	The asks of the Exec/ Board if applicable	RAG Status
People Creating a supportive and psychologically safe working environment that recognises the challenges staff face, prioritises wellbeing and development, and equips teams with the right skills and support systems.	Analysis of **staff survey results** complete and thematic analysis used to create one action across services.	Implementation of the 'one action' across all teams based on analysis of staff survey results.	None	N/A	N/A	
	Established a **Wellbeing Task and Finish Group** which is setting up a series of focus groups across services.	Rolling out focus groups for staff wellbeing across the directorate. Embedding Health and Wellbeing (HWB) Champions in teams with an appointed HWB Champion Coordinator within the directorate to oversee works.	None	N/A	N/A	
	Established a quarterly **workforce development forum** as part of the directorate people board.	The new workforce development forum has been established with ongoing work focused on delivering the programme of workforce development priorities through the forum.	None	N/A	N/A	
	Work schedule developed with estates for installation of **closed-circuit television (CCTV).**	Policy is in draft and will be finalised in the phase of the project. There is a research project to measure the impact of CCTV in patient communal areas. Continue CCTV implementation.	None	N/A	N/A	
	Work schedule developed with estates for installation of closed-circuit television (CCTV).	The safer spaces tool is set to be rolled out across all inpatient wards. The development of materials for trauma-informed leadership and teamship training. These aim to support leaders and teams in understanding trauma's effects. The teamship module will be offered first, targeting clinical staff, with plans for a cohort later in the year. The Trauma Strategy Working Group will transition to a training forum, with monthly presentations and recorded sessions for wider access.	None	N/A	N/A	

Forensic Directorate

Oxford Health NHS Foundation Trust

Priority work implemented with overall sustained progress against key milestones. Directorate has an established assurance and reporting framework with ability to track progress and risks to delivery.

Priority area	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	The asks of the Exec/ Board if applicable	RAG Status
Health Inequalities Continuing to reduce health inequalities experienced by patients with severe mental illness.	Initial work has been started to define a high-level workplan for the Directorate's approach to **health inequalities**. Joint working with the strategy & Performance and Information (P&I) teams to develop data sets to support health inequalities (HI) works.	Continued work with the strategy & P&I teams to further develop data sets on HI for the forensic mental health directorate.	None	N/A	N/A	
	A physical health form for Forensic mental health patients (**Holistic Lifestyle Form**) has been developed, for RIO which enables a comprehensive, editable physical health assessment record to be available on the patient's clinical record. Prioritisation through the Change Advisory Board in April 2026 with Intended development and go-live around July 2026 (delayed).	Physical health form for Forensic mental health patients (Holistic Lifestyle form) to be reviewed and implemented on Rio following further meeting with the Clinical Systems team.	This is on the directorate risk register	N/A	N/A	
	FAST service model and initial multidisciplinary proposal developed, with a focus on reasonable adjustments, neurodivergent needs and reducing restrictive practice. Access to Care and Treatment Tool developed in draft, to support early identification of accessibility needs and personalised reasonable adjustments.	The Provider Collaborative (PC) approved a network-wide neurodiversity service at the PC Partnership Board in July 2026, subject to an evaluation of the current FINDS service and proposed staffing model. Engagement continues with the Provider Collaborative workstream for implementation planning including clarifying interfaces, ensuring neurodiversity expertise is retained within the Oxford Health Forensic Directorate, and that the Directorate has adequate resource to meet the needs of our patients.	None	N/A	N/A	
	Ongoing analysis of **restrictive practice use** in the context of health inequalities.	Incorporate restrictive practice health inequalities data within our governance oversight.	None	N/A	N/A	

Forensic Directorate

Oxford Health NHS Foundation Trust

Priority work implemented with overall sustained progress against key milestones. Directorate has an established assurance and reporting framework with ability to track progress and risks to delivery.

Priority area	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	The asks of the Exec/ Board if applicable	RAG Status
Health Inequalities Continuing to reduce health inequalities experienced by patients with severe mental illness.	The programme for the implementation of **new model for women's secure pathway at Thames House** has progressed significantly. The trauma-informed clinical model has been signed off. There has been extensive engagement with Experts by Experience. The estates proposals are being progressed in stages with the first stage funded and the second reflected in our capital bids FY28. and advancement of the Thames House estates planning. Tender submissions have received from architects. Final model of care signed off at the Forensic Directorate Transformation Board in Oct 2026. New Directorate Transformation Board established and project workstreams set up, covering estates, workforce modelling, patient flow management, and model of care design and delivery plans. Mobilisation plan in draft. The development of proposals for a pilot with funding from the PC to address the unmet needs of women in the community in partnership with a voluntary sector organisation and the criminal justice system.	Appointment of the design team to be confirmed after the evaluation and development of a detailed programme covering Royal Institute of British Architecture (RIBA) design stages with the approved consultancy team. Clinical Team to attend the design meetings for regular engagement with the design team throughout the design development. Design to be sign off by all Estates, Clinical Team and Forensic directorate. Implementation of the workforce, the estates, and clinical models. Embedding across organisations (OH/HIOW) to deliver the new pathway Implementation of the pilot, funded by the PC , in partnership with a voluntary sector women's centre in Oxford and the criminal justice system. We are engaging with the provider collaborative in the development of proposals for a women's out-reach service funded by NHS England.	The overall project delayed due to the significant delay to unresolved workforce affordability model. New bed day rate does not fully finance the proposed workforce model. There are issues with the affordability of the workforce model.	Ongoing discussions with the Provider Collaborative around the approach to EPCs.	N/A	

Forensic Directorate

Oxford Health NHS Foundation Trust

Priority work implemented with overall sustained progress against key milestones. Directorate has an established assurance and reporting framework with ability to track progress and risks to delivery.

Priority area	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	The asks of the Exec/ Board if applicable	RAG Status
Sustainability Collaboration across providers will be strengthened to create a future-proof, population-responsive model connected to community and adult mental health services.	Over recent years, **community-based forensic mental health services** have expanded significantly, proactively contributing to discharge planning, enabling more people to receive specialist support at home and in the community, and replacing the need for inpatient step-down resources. This is the position of NHS England, and commissioning of such provision is no longer supported. A review of Lambourn House, a pre-discharge unit for men and women, considered historical occupancy and referral patterns, evolving national policy favouring SCFTs, alternative discharge pathways and the impact on the wider male forensic inpatient pathway. In partnership with the Provider Collaborative, aligning with commissioning intentions, the decision has been made to close Lambourn House. It is no longer accepting referrals, with a planned closure of 31 March 2027. Significant work has been undertaken with staff, patients, carers and families affected by the closure. Informal staff engagement meetings were held during August and September 2026 and the formal organisational change process started in October 2026. A Directorate Transformation Board has been established to oversee the governance of all Directorate transformation projects.	Lambourn House clinical teams carefully planning transitions into the community for existing patients at Lambourn House, that are tailored to individual need. Ongoing implementation of programme including the formal organisational change process, with consultation closing Nov 2026. Further implementation of communication plan to include family/carer engagement event/s . Lambourn House building be used to accommodate SCFT and Offender Personality Disorder (OPD) clinical activity/services and a simulation training suite. This proposal is reflected in the Directorate FY28 capital bids and an estates workstream will be established to deliver.	N/A		N/A	

Forensic Directorate

Oxford Health NHS Foundation Trust

Priority work implemented with overall sustained progress against key milestones. Directorate has an established assurance and reporting framework with ability to track progress and risks to delivery.

Priority area	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	The asks of the Exec/ Board if applicable	RAG Status
Digital/data development and analytics Establish a Directorate-wide data improvement plan to support care quality, standardisation, clinical decision-making, and productivity.	Initiated the start of a review of current systems and data flows to identify priorities and develop a 2/3-year improvement roadmap, including integration and technical planning. Joint project initiated with P&I team to develop a TOBI dashboard for occupancy and quality data. Introduction of new data dashboards which have been developed on Excel as a means of tracking ward numbers against inpatient occupancy and acuity indicators. Patient flow data recording under review. The Directorate has invested in additional capacity to support this work as it is essential to managing the risk of under-occupancy.	Completion of a full review of the way data systems in place to support how we manage the patient flow both in and out of the Directorate and between the Directorate services, including the approach to bed management. A full review of the processes involved in managing referrals and monitoring occupancy levels is underway to include the function of the weekly Forensic Directorate Clinical Activity Group (CAG). The developments of TOBI dashboard to support the directorate's integrated governance reporting.	N/A		N/A	
Research & Development Continue to advance research and innovation to strengthen evidence-based forensic mental health practice and service improvement, including the development of a cstrategy to ensure research and development activity is aligned to Directorate, Trust, and national priorities.	Developed a clear programme to relaunch and strengthen the Forensic Directorate Research Forum, including refreshed membership and governance arrangements to continue supporting knowledge sharing and engagement across services. The Directorate currently has 18 research projects active, has published/submitted 7 papers for publication (IAFMHS journal & BMJ), presented at 8 conferences and written 3 book chapters.	Development of a clear strategy to ensure research and development activity is aligned to Directorate, Trust, and national priorities.	N/A		N/A	

Learning Disabilities Directorate

Oxford Health NHS Foundation Trust

Priority area	Key achievements to date	Key upcoming activities	Key issues/risks for escalation and awareness	Planned mitigation against risks/ resolution for issues	RAG status
Partnership working to improve health outcomes	• Position paper developed scoping the need for a regional Learning Disability inpatient provision. • Learning Disability Crisis Training delivered to adult mental health teams. • Working with teams to ensure all population health data is recorded on Rio. • Protocol agreed NHS 111 Option 2 for out of hours support for Learning Disability service users.	• Next steps to be reviewed as part of the current planning round, to confirm the immediate next steps and medium term direction of travel. • Ongoing work to track demographic data via performance reporting.	• Lack of Learning Disability Specialist beds in Oxfordshire dependent on out of area placements. • Uptake of Learning Disability Crisis training has been lower than planned.	• Complex Case and Out of Area Manager in post to support. • Recorded sessions are being considered to improve access.	
Digital and data development	• Development of Reasonable Adjustment Flag on Rio. • Spine Synchronisation is ongoing.	• Embed within services. • Awaiting latest synchronisation figures.	• Change fatigue for staff re system changes / new processes in place. • Challenges with some synchronisation. No report received since April.	• Roll out by end of Q4. • Escalation process to liaise with Clinical Application Support Team (CAST) and SPINE Teams Updated report requested.	
Service review & sustainability	• Core Assessment and Screening quality improvement project paused. Service to concentrate on tiered model approach. • FY26/27 Cost Improvement Plan (CIP) achieved and plan submitted. • Continue to work with experts by experience to develop easy read materials, participate in interviews, deliver co-designed research feasibility study sponsored by OHFT.	• Next steps to be reviewed as part of the current planning round, to confirm the immediate next steps and medium term direction of travel. • Co-production will be a key focus in our 27/28 planning cycle.			
Our workforce	• Job plans rolled out in Personal Development Review (PDR) season. • Feedback from staff survey analysed. • Strengthify sessions for senior management team (SMT) complete.	• Job plan evaluation to be arranged.	• Due to staff changes feedback has been delayed.	• This will be progressed to support with future staff survey uptake.	

Community Health Service, Primary Care and Dentistry

Oxford Health NHS Foundation Trust

Workforce: Our People
Prioritising staff wellbeing, enhancing the work experience and strengthening skills and capabilities. Committed to delivering the People plan.

Priority area	Key metrics	Key achievements
Design and implement a targeted Winter Vaccination Programme, using evidence-based engagement and delivery approaches to maximise flu vaccination uptake among frontline healthcare workers and meet or exceed the National Oversight Framework (NOF) target.	Percentage of frontline staff vaccinated	The first report for this metric is due from Quarter 3 onwards, after the start of the flu vaccination campaign.
Enhance staff wellbeing, retention, and continuity of patient care through the analysis of pathway-specific trends and drivers of short- and long-term sickness absence, implementing evidence-based interventions to achieve sickness absence rates at or below the lowest recorded national average (4.1%)	Trust People Plan for Q3/4	The first report for this metric is due from Quarter 3 onwards, when the Trust People Plan is expected.
Finalise and implement the two-year Equality, Diversity and Inclusion (EDI) Work Plan, delivering the key priority actions for 2026 to embed an inclusive culture and improve staff experience and outcomes.		The two-year Equality, Diversity and Inclusion (EDI) Work Plan has been drafted. A workshop is taking place this month to review the plan of work against the Trust EDI Strategy.
Analyse the underlying causes of early staff turnover by pathway and implement evidence-based interventions to improve retention, with the aim of reducing early turnover to or below the local benchmark of 13%.		Monthly key performance indicator (KPI) reports are shared with the Heads of Service in the Directorate People Meeting. Exit interviews are undertaken locally to identify themes or trends for the service. Further analysis will be done with Service Heads where early turnover is above 13%.

Community Health Service, Primary Care and Dentistry

Oxford Health NHS Foundation Trust

Sustainability and Productivity
Driving sustainability through efficiency, productivity, and delivery of our Green Plan, implementing financially sustainable models of care, and progressing towards Net Zero by 2030, aligned with the NHS National Oversight Framework and focused on reducing unwarranted variation and improving outcomes.

Priority area	Key metrics	Key achievements
Ensure delivery of the 18- and 52-week waiting time targets by implementing recovery plans aligned with the 2026/27 NHS National Oversight Framework.	• Percentage of patients waiting over 52 weeks for community services (against Oxford Health NHS Foundation Trust action plan/ trajectory) • Percentage of patients waiting under 18 weeks for community services (against OHFT action plan/ trajectory)	In September, the proportion of patients waiting over 52 weeks was exceeding the trajectory targets. Children at 3.37% (target ≤18.76%); Adults at 7.91% (target ≤10.41%); Overall 6.91% (target of ≤13.02%). In September, the percentage of patients waiting under 18 weeks was achieving trajectory targets overall and for adults. Children at 36.75% (target ≥54%); Adults at 68.79% (target ≥63%); Overall 61.94% (target of ≥60%).
Deliver a 2.5% Cost Improvement Plan (CIP) in 2026/27 to support the Directorate's long-term financial sustainability while maintaining the quality and safety of services.	Percentage of delivery against target	Recurrent savings plans are in place, although a gap remains against the overall target. Vacancy management measures are in place to address the remaining shortfall.
Percentage of intermediate care beds occupied by patients with no criteria to reside	Number – average of quarter	In Q1, this was 18.42% compared with a national average of approximately 24%. OHFT is scoring 2.11 for this metric in the National Oversight Framework.
The Directorate will undertake a comprehensive review of District Nursing procurement, focusing on high-value, high-volume consumables, transport, and storage to identify opportunities for cost savings, standardisation, and service improvement in 2027/28.	Progress against project plan	Scoping work has been undertaken to identify a suitable external consultancy company. This is currently being reviewed and should be in progress Jan 2027.

Community Health Service, Primary Care and Dentistry

Oxford Health NHS Foundation Trust

Digital and Data development
Advancing digital and data capability to enable data-informed service design, improve quality and standardisation, and strengthen clinical decision-making to enhance outcomes and productivity.

Priority area	Key metrics	Key achievements
Demand and Capacity tool deployed /offered to all services and reviewed routinely at senior management team (SMT) meetings, with data triangulated with system partners	Percentage of services offered the demand and capacity support, either as a tailored report or the modelling tool.	As of September 2026, Demand and Capacity final reports have been provided to Podiatry and a further simulation resource is in progress. In progress: children and young people (CYP) speech and language therapy (SALT) and Adult SALT. Next to start is Community Therapy Service (CTS). This is an ongoing process.
To identify Ambient Voice Technology (AVT) solutions which partner with the EMIS clinical record system, pilot 2-3 solutions with 50 staff each and then complete an evaluation by Q4 2026/27	Q1- Secure Investment Q2- Identify solution Q3- Pilot Q4- Evaluate	Investment agreed and business case submitted. 3 pilots are currently being set up across the community directorate: Heidi, Beam notes and Accurx. Beam pilot is now live as of the 2nd November Heidi and Accurx planned to go live in early December, currently working through templates and training. Full Trust rollout planned for February/March 2027 following successful procurement and a contract with the chosen provider(s)
To ensure that the work plan for Performance and Intelligence (P&I) development is agreed and mapped to directorate priorities.	Delivery against P&I workplan	There are 42 active items in total relating to developments specific to Community Services. 11 have been completed this financial year. The plan is reviewed with the Directorate with particular focus on the high-priority developments and resolving any issues.
To review and assess our current clinical systems including implementation of the new clinical system in Dentistry (Sensei)	Delivery against workplan	Investment for Safehands agreed and business case submitted. Technical implementation of Sensei across the Dental services is due to go live on the 12th November with mitigations in place where required by the dental service.

Community Health Service, Primary Care and Dentistry

Oxford Health NHS Foundation Trust

Co-production and Research to improve communities
Embed engagement with patients, carers, and the wider community to shape inclusive, high-value services, drive improvement, and innovation, and deliver the five-year research strategy aligned with population health and system priorities.

Priority area	Key metrics	Key achievements
Develop a strategically focused, 5-year research and development (R&D) Plan which aligns with NHS 10-year health plan. The approach aims to embed research to be delivered at the point of care. The research will focus on 4 priority areas; wound care, podiatry, multi-morbidity and frailty.	Number of research-active staff in the directorate. Number of studies recruited to time and target. Percentage of portfolio studies recruiting patients within 30 days of launch Number of staff with Good Clinical Practice (GCP).	Investment was provided by Trust R & D to support staff on their Good Clinical Practice update/introduction, resulting in growth of Primary Investigators. Strategy board has been launched and all workstreams have their scoping meeting booked or completed – workstreams include information technology (IT) and reporting, human resources (HR), finance, governance, communications and learning and development. Presented a poster at the Community Healthcare Alliance of Research Trusts (CHART) and Department of Primary Care conferences. Risk register developed and continuing engagement is ongoing with teams.
Develop an engagement framework to support embedding a culture of co-production with those with lived experience and our communities who experience the greatest health inequalities to improve patient and carer voice input, experience and outcomes	Develop an engagement framework for the Directorate by Q2. Commence implementation of the framework from Q2 and agree qualitative and quantitative metrics to measure impact.	Framework development delayed (workforce gaps) with revised approach and completion date now anticipated as Q4 – Q1 27/28. Approach and success measures to be agreed in Q3 as a partnership-based piece of work with the Voluntary, Community, Faith and Social Enterprise(VCFSE).

Community Health Service, Primary Care and Dentistry

Oxford Health NHS Foundation Trust

Healthier Communities shaped in Partnership
Working with place-based partners and communities to deliver integrated, person-centred care, embed a neighbourhood health and care approach, and focus on prevention and early intervention to improve access.

Priority area	Key metrics	Key achievements
To deliver the Partnerships, Improvement and Programmes workplan.	% of benefits realisation plans reporting positive progress	Service improvement workstreams Programmes aligned with annual plan, agreed and delegated. District Nursing recovery and Investment plan underway. Community Rehabilitation strategy workshops concluded and draft out for comments. Urgent and emergency care (UEC) workstreams agreed and underway.
		Estates Workstreams Abingdon Emergency Medical Unit (AEMU)and Fiennes complete. Witney Outpatients has outstanding snagging work, and Wantage outpatient refurbishment is now delayed by over 6 months. New projects are now live: Witney ward reconfiguration (Royal Institute of British Architects (RIBA) stage 2), Didcot refurbishment (RIBA stage 1), Witney Neighbourhood Hub (RIBA stage 0)
To design and agree with system partners an Oxfordshire Neighbourhood Health and Care plan by September 2026	Delivery against plan	The 2026/27 focus shifted in Q1 to develop foundations for neighbourhoods with a plan for 2027–29 to be developed in Q3-4. This will then align to national framework requirements too.

For Me Provider Collaborative

Oxford Health NHS Foundation Trust

For Me Provider Collaborative

Priority work implemented with overall sustained progress against key milestones. Directorate has an established assurance and reporting framework with ability to track progress and risks to delivery.

Priority area	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	RAG Status
Women's Service Review - To develop a nationally leading women's secure treatment pathway that delivers a safer future for those in our care, their support networks and carers, and the communities in which they live.	• Completed joint working operational group culminating in monthly joint referral management meeting. • Completed clinical model operational group culminating in shared clinical model. • Wards have begun to utilise direct development funding to improve environments and services. • Started work on implementation of provider plans and workforce model.	• Stand up Meaningful Activity and Physical Health operational groups to improve care/service offer. • Finalise out of hospital improvement work and begin liaison team and women's centre pilots.	• Inequity of provider engagement. • Lack of capital to upgrade estates.	• Continuous engagement with strategic partners. • Options appraisal complete and ready for funding eventuality.	
Workforce Strategy - Implementation of the Provider Collaborative (PC) workforce strategy to deliver sustainable workforce capacity, training and skills sharing across the network, improved focus on staff wellbeing and work experience.	• Hosted our second annual PC Conference, and first Pan PC continuing professional development event in April 2026. • Completed self assessments for our Women's Units focussing on culture, competency and morale as part of the Women's Service Review. • First set of learners began their studies for the Level 4 BTEC Diploma in Reducing Restrictive Practice. • Submitted the Workforce business case for the neurodiverse (ND) Pathway Review.	• Stand up workforce task and finish group to progress the neurodiversity business case. Key tasks will include; development of the new 'core team' job descriptions and finalising the clinical model, procurement of 90 spaces on the Level 5 BTEC Diploma in Practice Leadership & Reducing Restrictive Practice, attention deficit hyperactivity disorder (ADHD) Diagnosis Training for 1-2 members of staff per partner, and development of the Neurodiversity Champions training & support offer. • Review training and/or workforce needs as part of the Healthy Eating Project.	• Geography of the Secure network may create challenges for the new team.	• The PC is experienced in delivering services across a diverse geography, we will ensure transparent recruitment to select the correct people for these posts.	
Improving transitions, access and decision making-	• Project initiation document completed and discussed at partnership board and consultant away day.	• Decide on project infrastructure, meeting schedule and stakeholder group.	• None at this stage.	• None at this stage.	

For Me Provider Collaborative

Oxford Health NHS Foundation Trust

For Me Provider Collaborative

Priority work implemented with overall sustained progress against key milestones. Directorate has an established assurance and reporting framework with ability to track progress and risks to delivery.

Priority area	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	RAG Status
Meeting the needs of our diverse patient groups - aims to address health inequalities faced by patients with learning disabilities and / or autism.	• Health inequalities report delivered, enabling an understanding of inequalities across all sites and patient demographics. • Option 4 of neurodiversity options appraisal approved. • Sensory resource access fund launched and data collection plan finished. • Ward introductory videos filmed and voiceovers being done currently. • Environment audit tender process live. • Neurodiversity implementation group stood up.	• Produce and implement a strategic plan based on the findings in the report and further research across neighbouring organisations. • Workforce model for core team to be finalised. • Environment audit to take place Q3/4.	• Inequity of provider engagement.	• Continuous engagement with strategic partners.	
Physical Health and Frailty - Deliver integrated care that addresses both mental and physical health needs, promotes prevention and lifestyle interventions.	• Healthy weight strategy drafted and brought to partnership board for awareness. • Established expert by experience panel. • Collated feedback from initial Lived Experience interviews.	• Design and complete baseline data monitoring. • Complete staffing gap analysis to identify inequities between providers. • Work with Healthy Eating and Nutrition Group (HE&NG) and lived experience panel to agree potential staffing model to support delivery of the strategy. • Carry out further consultation regarding proposed Key Outcome Measures. • Agree shape of proposed Away Day for staff and patients.	• Variance in provider regulations risks inability to achieve alignment and equality. • Successful implementation of workstream may require funding which will need to be identified.	• Linking in with Care Quality Commission and quality assurance (QA) partners to establish parameters for restrictions. • Early conversations with partnership board to identify possible funding source.	

CAMHS Provider Collaborative

Oxford Health NHS Foundation Trust

CAMHS Provider Collaborative

Priority work implemented with overall sustained progress against key milestones. Directorate has an established assurance and reporting framework with ability to track progress and risks to delivery.

Priority area	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	RAG Status
Specialist Provision in Buckinghamshire - Embed and optimise specialist mental health services in Buckinghamshire in line with the Children and Young People Intensive mental health developmental specification.	• Referral data for initial Intensive Home Treatment Team cases backdated with the provider collaborate and Form 1 referral process implemented by team going forward. • Remaining phase 2 work sessions conducted: Budget Profiling and Organisational structure within Bucks CAMHs/SLT review. • Proposal taken to Bucks Eating Disorders (ED) & Thames Valley (TV) Tier 4 (T4) Parent/Carer Lived Experience Advisory groups. • Initial draft business case shared for feedback.	• Update on accommodation request from the Bucks Operational Space Group. • Next iteration of business case to be shared with wider PC colleagues for feedback. • Take business case to CAMHS Business meeting for final feedback followed by Partnership Board.	• Inequity of provider engagement. • Lack of suitable accommodation identified to enable delivery of phase 2. • Lack of capital funding for accommodation upgrades.	• Continuous engagement with strategic partners. • Early conversations with estates to identify suitable accommodation. • Ongoing conversations around funding sources.	
Specialist Provision in Gloucestershire - Embed and optimise specialist mental health services in Gloucestershire in line with the children and young people Intensive mental health developmental specification.	• Quality Improvement Manager onboarded. • Finance and workforce group started to meeting to assess feasibility of options. • Clinical and Operational Group engagement workshop delivered. • Initial draft business case shared for feedback.	• Continue to explore solutions to the estates' constraint and arrangements for voluntary, community, and social enterprise sector partners including budget and interventions. • Continue the conversation and development of the evaluation metrics including baseline.	• Risk of Gloucestershire Health and Care (GHC) leadership not approving business case inclusive of a building.	• Early phases of the model implementable whilst building conversations ongoing.	
Workforce Strategy - Development of the provider collaborative workforce strategy to build a sustainable workforce capacity, enhance training and skills sharing across the network, and strengthened focus on staff wellbeing and work experience.	• Undertaken stakeholder engagement with staff to understand current and emerging training needs. • Reviewed workforce capacity, supervision, bank and agency usage and appraisal arrangements as part of the Strategic Needs Assessment.	• Establish workforce steering group once the CAMHS Strategy is ratified. • Commence development of the provider collaborative Workforce Strategy.	• There is a risk that delivery of the Workforce Strategy is delayed due to its dependency on the findings and strategic direction of the overarching CAMHS Strategy.	• Progress the elements of the Workforce Strategy that can be developed independently of the CAMHS Strategy.	

CAMHS Provider Collaborative

Oxford Health NHS Foundation Trust

CAMHS Provider Collaborative

Priority work implemented with overall sustained progress against key milestones. Directorate has an established assurance and reporting framework with ability to track progress and risks to delivery.

Priority area	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	RAG Status
Children and Young People (CYP) Intensive Mental Health – Developmental Specification - Align CYP mental health services with the national specification to provide flexible, needs-led care in local settings.	• Completed a gap analysis of current CYP Intensive Mental Health services against the national specification, identifying areas of alignment and opportunities for further development. • Completed the Strategic Needs Assessment, incorporating and aligning the findings with the requirements of the national specification. • Commenced development of an advice and consultation service.	• Mobilise and implement the advice and consultation service. • Review and refresh the gap analysis to reflect progress made and any emerging requirements from the national specification. • Receive the Buckinghamshire and Gloucestershire business cases and assess these against the national specification. • Subject to approval, support implementation of the agreed developments.	• Delivery of some elements of the specification is dependent on the outcome and pace of change within Buckinghamshire and Gloucestershire.	• Maintain close engagement with Buckinghamshire and Gloucestershire. • Progress elements of the specification that can be delivered independently of the business cases in parallel.	
Integration and Partnership Working - Strengthen collaboration between the provider collaborative and other stakeholders including, Integrated Care Board's, Social Care, Community CAMHS, and Primary Care to ensure coordinated, person-centred support for children and young people.	• Engaged with the Integrated Commissioning Board and commenced work with Regional Care Cooperatives to strengthen partnership working and alignment across the system. • Undertaken a review of current CAMHS service provision as part of the Strategic Needs Assessment. • Gathered feedback from patients, families and staff to inform understanding of current experiences and priorities for improvement.	• Facilitate stakeholder workshops to review pathways. • Continue engagement with patients, families, staff and the CAMHS Lived Experience Advisory Group to ensure lived experience continues to inform strategy development. • Consolidate findings from the Strategic Needs Assessment, stakeholder engagement and lived experience feedback to inform the development of the CAMHS Strategy.	• Delivery will depend on consistent participation and commitment from key partners and stakeholders across the system.	• Share emerging findings with stakeholders to encourage continued involvement and build shared ownership of the strategy. • Continue proactive engagement with partners through Partnership Boards.	

Adult Eating Disorder (AED) Provider Collaborative

Oxford Health NHS Foundation Trust

AED Provider Collaborative

Priority work implemented with overall sustained progress against key milestones. Directorate has an established assurance and reporting framework with ability to track progress and risks to delivery.

Priority area	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	RAG Status
Improving Environments of Care – Create safe, comfortable and therapeutic environments that support recovery.	• Completed site visits across AED units, with findings informing the wider AED strategy. • Gathered staff and patient feedback to identify environmental priorities and opportunities for improvement. • Completed a strategic needs assessment which sets out identified needs and recommended improvements. • Garden pods at Cotswold House, Oxford, have been funded to enhance therapeutic environments.	• Undertake strategy development sessions with key stakeholders. • Finalise the AED strategy and associated implementation roadmap. • Establish a steering group to provide oversight, agree priorities and monitor delivery. • Translate agreed priorities into phased and deliverable improvement plans.	• The existing estate presents constraints on the scale and pace of physical environmental improvements that can be delivered.	• Prioritise feasible, improvements within the existing estate. • Phase delivery according to agreed priorities, available resources and identified need.	
Alternative approaches to inpatient pathways - Development of flexible, multidisciplinary service models.	• Completed the evaluation of the Step Care service, with recommendations identified to strengthen and develop the model. • Agreed a transition plan to move Step Care into an Oxford Health Directorate, supporting longer-term operational sustainability. • Mapped existing service arrangements and identified gaps and opportunities across the current pathway. • Completed a Strategic Needs Assessment, providing a clear evidence base for the future AED service model and pathway.	• Undertake strategy development sessions with key stakeholders to socialise outline strategy. • Finalise the AED strategy and implementation roadmap. • Establish a steering group to determine Single Pathway approach with shared clinical leadership across all levels of care. • Develop phased delivery plans for agreed pathway developments and service improvements. • Continue stakeholder engagement to support shared ownership of the future service model.	• Stakeholder engagement across the partnership has been variable, which may affect the pace of strategy development and collective agreement on future pathway arrangements.	• Clearer expectations included within contractual arrangements. • Schedule key meetings and strategy sessions to maximise attendance.	

Adult Eating Disorder (AED) Provider Collaborative

Oxford Health NHS Foundation Trust

AED Provider Collaborative

Priority work implemented with overall sustained progress against key milestones. Directorate has an established assurance and reporting framework with ability to track progress and risks to delivery.

Priority area	Key achievements to date	Key upcoming activities	Key issues / risks for escalation and awareness	Planned mitigation against risks / resolution for issues	RAG Status
Reducing readmissions - Develop joined-up, person-centred care that reduces readmissions by making transitions between services smoother.	• Mapped existing discharge arrangements and identified gaps and opportunities across the current pathway. • Review of exemplar services has been completed. • Feedback gathered from patients, staff, and carers.	• Incorporate the findings from the pathway mapping, exemplar review, feedback and strategic needs assessment into the wider AED strategy. • Agree the priority opportunities for improving discharge and transitions through the strategy development process. • Finalise the AED strategy and associated implementation roadmap.	• Delivery will require engagement across multiple organisations and services, and currently stakeholder engagement is variable.	• Targeted engagement will be undertaken with individual stakeholders.	
Responding to Evolving Complexity - Adapt eating disorder services to meet increasingly complex and diverse needs by providing flexible, inclusive, and equitable care.	• Completed interviews with key stakeholders including patients staff and carers to understand patient presentations. • Review of best practice and international evidence completed. • Identified priority themes in the changing demand profile.	• Obtain clinical input to validate the priority themes and implications for service delivery. • Develop pathway profiles for the priority themes. • Use the pathway profiles to inform the wider AED strategy and implementation roadmap.	• Clinical capacity to engage in the development of patient pathways.	• Targeted engagement will be undertaken with individual stakeholders.	
Workforce Strategy Development of the PC workforce strategy to deliver sustainable workforce capacity, training and skills sharing across the network, improved focus on staff wellbeing and work experience.	• Undertaken stakeholder engagement with staff to understand current and emerging training needs. • Reviewed workforce capacity, supervision, bank and agency usage and appraisal arrangements as part of the Strategic Needs Assessment. • Identified workforce themes. • Study days and AED conference taken place to share skills across the network.	• Establish workforce steering group once the AED Strategy is ratified. • Commence development of the PC Workforce Strategy. • Align the Workforce Strategy with the AED Strategy to ensure workforce requirements support delivery of the future service model and pathway priorities.	• The timing of workforce strategy development is dependent on ratification of the AED Strategy.	• Identify and progress workforce actions that can be delivered ahead of full strategy approval.	

Oxford Health NHS Foundation Trust

Meeting:	Board of Directors' Meeting
Date of Meeting:	25 November 2026
Agenda item:	11
Report title:	Integrated Performance Report – November 2026
Executive sponsor(s):	Amelie Bages, Executive Director of Strategy
Report author(s):	Vicki Bull, Head of Business Services Deimante Pelakauskaite-Freimoniene, Senior Contracts & Performance Manager
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. November's IPR contains September 2026 and quarter 2 (unless stated otherwise in the report) data.

Following the annual review of the IPR in April 2026, the agreed changes have now been implemented, including the refinement of reporting arrangements, alignment of metrics to appropriate governance forums, revisions to performance targets and the integration of Quality metrics within clinical sections. A summary of the changes and their rationale was presented to the Board of Directors and Executive Team in July 2026.

This iteration of the IPR is now mostly aligned with 2026 – 27 reporting requirements. The next review of the IPR will take into account the publication of the new Trust's Strategy to align the reporting requirements to the new strategic framework of the organisation.

(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. NHS England reviewed and

published the National Oversight Framework for 2026/27 with the final technical metric specification yet to be published at the time of finalising this report.

On 11th September 2026, NHS England published Quarter 1 league table, based on the revised set of metrics set out in the updated 2026/27 NHS Oversight Framework. Oxford Health NHS Foundation was placed in segment 2 (above average).

The Trust performed strongly across four (4) of the six (6) NOF domains and placed in Quartile 1 (best performing quartile):

- Experience of Care
- Effectiveness of care and population health
- Patient Safety
- People

Performance in the remaining two (2) domains was assessed as being in Quartile 4 (worst performing quartile):

- Access to services
- Finance, productivity and innovation

Performance within the Access to Services domain remains challenging, particularly in relation to:

1. Patients waiting over 52 weeks for community services (13.75%)
2. Community patients waiting less than 18 weeks for treatment (59.14%)
3. Children and Young People's mental health waits over 104 weeks: (48.33%)

For community waiting times, focused improvement workstreams are maintaining the momentum achieved during the previous financial year, with performance continuing to show steady improvement. However, the Trust remains a significant outlier relative to the national position. National performance for the first two measures is 0.57% and 82.11%, respectively. Consequently, despite continued local improvement, a change in the Trust's NOF scoring for these measures is unlikely until Quarter 4 as per the planned performance improvement trajectories to achieve 0% by end of March 2027. Community waiting times are presented on pages 56 – 57 of the IPR with further supporting narrative in Community Health Services, Dentistry and Primary Care Waits section of this paper.

Children and Young People mental health waits over 104 weeks performance figure should be interpreted with caution, as it is not a direct representation of the underlying number of patients waiting. Performance is partly influenced by data completeness and also includes waits associated with neurodevelopmental condition (NDC) assessments, where commissioned capacity constraints continue to affect reported performance. The metric is being monitored internally and will be incorporated into the IPR once the reporting development has been finalised. Dedicated workstreams are in place to address both data completeness and NDC assessment capacity.

Within the Finance, Productivity and Innovation domain, the following metrics were highlighted as areas requiring improvement:

1. Relative Cost Difference (National Cost Collection Index (NCCI)
2. Percentage of clinical trials set up within 90 days
3. Overall Data Quality Maturity Index

The Board of Directors is asked to note that the NCCI score relates to the previous financial year's submission. This year's submission has been made, and an updated and improved NOF score is expected to be published in the NOF for results in quarter 2 or 3.

Although the People domain is currently within the best-performing quartile, one metric has been identified as requiring improvement:

1. Temporary staffing cost relative band

Workstreams are in place to address all of the underperforming NOF metrics highlighted above where possible. Progress is being monitored through the relevant governance arrangements.

Quarter 2 league table is expected to be published in December 2026.

(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).

<table>
<tr><th>Service area</th><th>Comments</th></tr>
<tr><td>Child and Adolescent Mental Health Services (CAMHS)</td><td>
<table>
<tr><td>Concerning nature and inconsistently passing or failing the target</td><td>• Percentage of referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Buckinghamshire (rolling 3 months position) – 84.21% vs 95% target (national average in August 26 (latest published position) was 81.4%)</td></tr>
<tr><td>No significant change and consistently* failing the target</td><td>• Percentage of referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks – Oxfordshire (rolling 3 months position) – 74.19% vs 95% target (national average in August 26 (latest published position) was 81.4%)</td></tr>
</table>
*Consistency is determined by a certain number of consecutive data points.

- Across the three CAMHS Eating Disorders (ED) services, none achieved the required performance standard for routine access metrics with Oxfordshire's performance noticeably declining in September 2026. There will be an increase in staffing from November and an expected 20 assessments clinic slots per month exceeding the expected demand enabling Oxfordshire's ED to be able to offer some flexibility if patient choice risks appointments being offered out of time frame.
- Buckinghamshire's and Oxfordshire's services have exceeded the target of 95% with 100% of urgent cases seen within 7 days with Bath & North-East Somerset, Swindon and Wiltshire service working towards achieving the target with 83.3% in September 2026.
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- The Board of Directors requested a deep dive to be conducted to understand why these metrics are being flagged by the algorithm and what can be expected in terms of improvement – this was completed and presented to the Quality Committee on 12th November 2026.The deep dive provided assurance on referral waiting times, explained the causes of breaches and set out the service-level actions underway to performance:
1. Recruit and support staff, monitor vacancies and align assessment capacity with demand;
2. Contact families promptly, provide clear appointment information, issue reminders and rearrange appointments as quickly as possible where needed;
3. Strengthen triage and referral recording processes by applying Oxfordshire's two-day triage standard and BSW's referral guidance and pre-submission data quality checks;
4. Review the reasons for breaches and undertake clinical reviews or audits to identify any associated harm, deterioration, incidents, complaints or admissions. Escalate concerns promptly and take appropriate action.

The Board of Directors is asked to note CYP mental health services four (4) week wait (interim metric – one contact based only) performance - all three CAMHS services exceeded September's target of 68% with 84.40% in Buckinghamshire, 73.51% in Oxfordshire and 94.10% in Bath & North-East Somerset, Swindon and Wiltshire. The full CYP mental health four (4) week wait metric, which is based on one (1) contact, Snomed coded intervention or care plan & a baseline outcome measure, is currently reported internally at Directorate & Executive Level with the expectation that it will be reported to Board of Directors once the current data quality/completeness gaps have been addressed.

Buckinghamshire and Bath & North-East Somerset, Swindon and Wiltshire continue exceeding access targets in September 2026. Oxfordshire has missed access rate target by 3 in September 2026.
</td></tr>
<tr><td>Talking Therapies</td><td>
Oxfordshire's and Buckinghamshire's Talking Therapies services are considered to be performing well and/or within expected variation and are not being highlighted by the Making Data Count (MDC) algorithm as requiring attention. However, a few individual targets have not been met in September 2026:
- clinical outcomes were below target with fewer people than expected achieving reliable improvement and recovery.

Services are reviewing performance to understand causes, including whether longer than expected waits for Step 3* therapies have contributed. Treatment options are being reviewed, and progress is being checked at key stages for people who are not improving as expected with the expectation that it will help services to identify sooner when a different approach or additional support may be needed.

To note: while targets have been set to increase the number of adults and older adults completing anxiety and depression treatment, services have an ambition to improve completion rates further and will aim to achieve stretched targets in line with the Talking Therapies Memorandum of Understanding with the Thames Valley Integrated Care Board:

<table>
<tr><td></td><td>Target</td><td>Stretch target</td><td>Actual performance September 2026</td></tr>
<tr><td>Buckinghamshire</td><td>>=497</td><td>>=560</td><td>759</td></tr>
<tr><td>Oxfordshire</td><td>>=636</td><td>>=770</td><td>736</td></tr>
</table>

*Step 3 – high-intensity psychological interventions in the NHS Talking Therapies tiered model designed for people experiencing moderate to severe anxiety, depression or specific mental health conditions like OCD, PTSD or phobias that have not improved with the Step 2 low-intensity support.
</td></tr>
</table>

Adult and Older Adult Community Mental Health Services	- Board of Directors is asked to note Oxfordshire's and Buckinghamshire's services adult four (4) week wait (interim measure – two contacts within pathway) performance against the target of 65% for September 2026 with 82.83% and 57.14% respectively. Reduction in Buckinghamshire's performance is attributed to high sickness within the Service; demand and capacity modelling is underway to identify potential gaps in staffing. - The interim four (4) week wait metric has also been added to the IPR for Bath & North East Somerset, Swindon and Wiltshire (BSW) this month. This applies only to the Adult Community Eating Disorders (AED) service, as it is the only adult community mental health service commissioned in BSW area. The BSW AED service exceeded the 65% target, achieving 91.67% in September 2026. - Similar to CAMHS, the adult full four (4) week wait metric is currently being is reported internally at Directorate & Executive Level with the expectation that it will be reported to Board of Directors once the current data quality/completeness gaps have been addressed. The Buckinghamshire Early Intervention in Psychosis (EIP) service did not achieve the 60% target in September 2026, with 33.33% of patients commencing treatment within two weeks of referral. This reflects two breaches, attributable to a combination of staff sickness and increased patient complexity and acuity. As a mitigating factor, both patients were already receiving care and support from other services at the time of referral, ensuring continuity of care while awaiting EIP treatment. Trajectories for improving 26/27 perinatal access have been rebased in line with national planning expectations to maintain August 2025 performance. The Trust achieved collective perinatal access target of 1053 for September 2026 with 1064 patients accessing the service (Oxfordshire and Buckinghamshire combined). Reducing access rate in Oxfordshire is in line with the decommissioning of the Infant Perinatal Service. As a result, overall perinatal access rate target will reduce from October 2026. Trajectories for improving 2026/27 access to Individual Placement Support (IPS) have been rebased to reflect the funded expansion and support the national ambition to increase access to IPS services. The Trust missed its collective target of 990 in September 2026, achieving 941 across Oxfordshire and Buckinghamshire. All expansion posts in Buckinghamshire have now been filled; however, new starters are still building their caseloads and are not yet operating at full capacity, with staff absence also impacting access performance. Oxfordshire remains relatively stable and only slightly below target, with new staff similarly progressing towards full caseload capacity. Performance is being closely monitored through regular meetings with Team Leaders, with targeted support to address barriers to access and caseload development. Progressive improvement is expected as workforce capacity increases, with new starters anticipated to reach full caseloads within approximately six months, supporting progress towards the combined access target of 1,079 by March 2027.
Mental Health Urgent Care Services	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% Urgent Mental Health Care services across Oxfordshire and Buckinghamshire are performing well overall, with the exception of Buckinghamshire's Crisis Service 24-hour response metric (75.68% in September 2026 versus target of 80%), which is a National Oversight Framework (NOF) metric. Performance is now measured over a rolling three-month period to align with the NOF, providing a clearer picture of sustained performance. Performance is also affected by the data quality issue outlined below.

	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 the reporting definition is confirmed by the national team and reporting mechanism is developed, this metric will be added to the IPR for monitoring. The Trust previously reported on the percentage of acute mental health admissions with no prior contact with Community Mental Health Services in the preceding 12 months. Following a sustained period of regular audit and monitoring, no significant trends or areas requiring action have been identified. The measure continues to be monitored at Directorate level and, while it is no longer routinely reported to the Trust Executive and Extended Leadership Team or Board, it remains relevant to system-level oversight. Notably, this measure is included as a scoring metric for ICBs within the 2026/27 NHS Oversight Framework. S Data Quality (Sign off and review) – Buckinghamshire's Mental Health Crisis service is reviewing clinical coding practices to ensure that urgency classifications are consistently applied in accordance with established clinical criteria and in line with approach in Oxfordshire's Mental Health Crisis service. November data reporting is expected to reflect updated clinical coding approach.
Mental Health Inpatient Services	Quality metrics in relation to restrictive practices are included in this section as part of the continued integration of quality reporting into the IPR. Narrative for these metrics is not provided within the section; however, overall performance of restrictive practices metrics is described within the Quality section of IPR. The Board of Directors is asked to note the continuously elevated and now increasing adult acute and PICU Length of Stay (rolling three months, 43.17 days reported in September 2026 versus the target of no more than 36.28 days; national performance is averaging 48 days). Mean Length of Stay for older adults (rolling three months) increased to 68.15 days in September 2026 (local target 66.98 and national performance is averaging 94 days). 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. Also note: - 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. - Inappropriate out of area placements for September snapshot position was 14 and in month inappropriate bed days for September was 297 bed days (an increase of 72 days compared to August and mainly driven by increase in female acute inappropriate out of area placements from Buckinghamshire). 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. This may be superseded by NHS England's Southeast region Delivery Plan expectations to reduce adult acute Out of Area Placements (OAPs) to zero inappropriate placements by March 2027. S Data Quality (Sign off and review) - the reported reduction in inappropriate out of area placements since April 2026 is primarily attributable to the implementation of revised reporting rules following clarification of the criteria used to define appropriate and

<table>
<tr><td></td><td>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. Automated reporting and trend graphs within the IPR remain delayed due to data completeness issues. A working group has been established to address these gaps and update historical trends and automated reporting should resume for October's data reporting.</td></tr>
<tr><td>Community Health Services, Dentistry and Primary Care</td><td>
<table>
<tr><td>Improving nature, but consistently failing the target*</td><td>• Healthy Child Programme - % of 2-to-2.5-year reviews completed – 84.90% in quarter two (vs target of more than 90%)</td></tr>
<tr><td>No significant change and consistently failing the target</td><td>• Healthy Child Programme - No. and % of families receiving a new birth visit within 14 days of birth – 79.40% in quarter 2 (vs target of more than 90%)
• Healthy Child Programme - % of 6–8-week reviews completed – 84.80% in quarter 2 (vs target of more than 90%)</td></tr>
</table>

The Board of Directors is asked to note underperforming Healthy Child Programme metrics highlighted by the Making Data Count algorithm in the table above. The vast majority of breaches are outside of service' control – please see IPR for details.

The Board of Directors is asked to note the introduction of a new indicator in this iteration of the IPR, measuring the proportion of newly registered patients at Luther Street Medical Centre who receive a holistic health assessment within eight weeks of registration. Luther Street Medical Centre is a specialist GP practice providing primary care services to Oxford's homeless population, many of whom experience complex health and social care needs. While performance against this indicator varies, it is considered generally good in the context of the significant vulnerabilities and challenges faced by the patient population served.

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. Service has commenced regular breach checking and validation to improve data quality.</td></tr>
<tr><td>Community Health Services, Dentistry and Primary Care Waits</td><td>Community services have agreed improvement trajectory targets for 2026/27 (see page 56 of the IPR for performance against trajectory):
- 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. This is a NOF 2026-27 metric.
- 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.</td></tr>
</table>

	In September 2026, community services achieved the target for the percentage of all patients waiting more than 52 weeks. The reported position was 6.94%%, against a target of no more than 13.02%. National performance remains below 1%. Targets for 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 (NOF 2026-27 metric) 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 (see page 57 of the IPR for performance against trajectory): - In September 2026, the Trust exceeded the planned trajectory of more than 60% with 61.92% of adults, children and young people waiting under 18 weeks for community services. The most challenging adult service continues being podiatry – the Trust has allocated resources to address waits of those categorised being at risk. All other adult services continue meeting their planned performance trajectories. - The Children and Young People (CYP) trajectory was below target of more than 54% with only 37.12% waiting under 18 weeks in August 2026. Children's Speech and Language service continues to be a challenging area; however, the recent investments and targeted initiatives are expected to positively impact waiting times. All other children's services are meeting their performance trajectories. The Trust is expecting the overall CYP trajectory to be met as planned by end of March 2027. T P 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:

Reducing the use of restrictive practices remains a key priority for the Trust. In September 2026, the Trust maintained performance below the monthly threshold for prone restraints and remains on track to achieve the annual target of fewer than 105 incidents, with 53 incidents reported year-to-date. The use of seclusion remains a concern, with activity continuing to exceed the monthly threshold of 34.5 incidents. September saw a further increase to 51 incidents. Targeted improvement work remains ongoing, focusing on reducing both the frequency and duration of seclusion episodes. Efforts to reduce the use of physical restraint also continue, with a particular focus on the Child and Adolescent Mental Health Services (CAMHS) inpatient pathway.

Complaints and resolutions increased to 140 in September 2026, compared with 97 in August 2026. Of the 119 complaints managed through rapid resolution, 46 related to a single incident, which contributed significantly to the overall increase. The Board is asked to note that this incident is not associated with patient care or safety and is currently subject to investigation.

The Data Quality Maturity Index (DQMI) has been introduced as a new IPR metric and forms part of the National Oversight Framework (NOF). The Trust's latest performance

was 78.6% in July 2026, significantly below the national average of 93%, placing the Trust among the lowest-performing providers nationally in quarter 1. The Emergency Care Data Set (ECDS) remains the main area of concern, with an improvement action plan in place to address identified data quality issues across all datasets; new AdAstra* configuration is expected to improve eleven (11) data items, which will in turn should improve the DQMI further. Oxford Health's MHSDS score fell from 89.7% in June to 87.3% in July, reflecting the inclusion of two additional discharge-readiness items rather than widespread deterioration, as the average score for the 32 comparable standard items improved from 89.7% to 90.2% The two new items included in MHSDS have been added to the action plan to investigate how we can improve. Whilst the Trust's DQMI of 78.6% remains significantly below average it is an improving position from 77.2% in April.

*AdAstra – clinical patient management and case management software system used across urgent and unscheduled care services.

People:

Agency reduction and adherence to targets has remained on track for all months year to date. The focus is now moving to the use of bank, and a programme of work is being set up to understand what is driving bank usage and to ensure we have the correct level of controls and interventions.

(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.

The full Strategic Dashboard is included in this month's IPR as part of the mid-year review of Oxford Health's 2026–2027 Annual Plan. Please refer to the IPR for further details.

Following the publication of the Trust's new Strategy in Autumn 2026, this section will be reviewed to ensure alignment with the Trust's new strategic priorities.

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.

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.

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): November 2026

September 2026 data unless stated otherwise

Quality

People

Sustainability

Research

Oxford Health NHS Foundation Trust

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Oxford Health NHS Foundation Trust

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- 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

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

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

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

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

- Strategic Dashboard – set of overarching strategic measures supporting the delivery of the Trust strategy to 2026. Grouped into four themes – Quality, People, Sustainability, and Research & Education. Progress against the Dashboard will be assessed on a 6-monthly basis in Section 3 of the IPR. This process will be reviewed after publication of the New Trust's strategy expected in the autumn

- 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, NOF* etc.) or *Local* (set at Trust or ICB level).
Metrics set out in the NHS England's South East Regional Delivery Plan are marked with the following icon: SE
*National Oversight Framework (NOF) – see page 5 for details. Scored NOF metrics are marked with the following icon: NOF
Contextual NOF metrics are marked with the following icon: NOF
Metrics contributing to ICB's NOF performance: NOF

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 90.

Oxford Health
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Section 1
NHS Oversight Framework – overview

NHS Oversight Framework 2026/27 – Overview (1/2)

The NHS Oversight Framework (NOF) 2026/27 sets out NHS England's approach to the oversight of NHS trusts and foundation trusts, as well as integrated care boards (ICBs). It provides a consistent and transparent basis for assessing organisational delivery, capability and risk, and for determining the appropriate level of oversight, support, incentives or intervention. The framework aligns oversight more explicitly with the NHS Medium Term Planning Framework and the 10-Year Health Plan, bringing together measures of access, quality, productivity, workforce and finance alongside an assessment of organisational capability. The 2026/27 framework is described by NHS England as an evolution of the 2025/26 framework, retaining its core architecture while refining the methodology.

For providers, performance is considered across the following domain structure:

1. Effectiveness of care and population health
2. Access to services
3. Experience of care
4. Patient safety
5. Finance, productivity and innovation
6. People

Each applicable scoring metric receives a score between 1.00 and 4.00, where 1 represents higher performance and 4 lower performance. The scores for all applicable scoring metrics are averaged to produce the organisation's average metric score. Importantly, the individual domain scores are used to highlight areas of relative strength or concern but are not themselves aggregated to calculate the overall segment. Contextual metrics are also excluded from the average metric score. The financial override remains a key feature of the framework. Any organisation reporting an underlying financial deficit, planning a deficit, receiving deficit support funding, or meeting the specified criteria for material adverse variance against its financial plan cannot be allocated to Segment 1 or Segment 2.

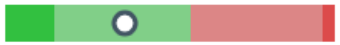
Overall, the 2026/27 framework places greater emphasis on separating what an organisation is delivering from its capability to improve. Delivery segmentation is refreshed quarterly, while provider capability is assessed annually and can be revised in-year. These elements are considered together by NHS England regional teams to determine a proportionate oversight response, ranging from greater autonomy and incentives for high-performing Foundation Trusts to targeted support, mandated improvement activity and regulatory intervention where performance or capability is persistently weak.

NHS Oversight Framework 2026/27 – Overview (2/2)

Organisations are formally segmented on a quarterly basis under the NHS Oversight Framework (NOF), providing a high-level assessment of delivery performance and the breadth of challenges faced by each organisation. Segmentation is based on a range of metrics covering different reporting periods and with varying data lags, using the latest verified official data available for each measure. While formal delivery segmentation is updated quarterly, NHS England's oversight operates continuously throughout the year and action can be escalated or de-escalated in response to emerging performance, financial, quality, governance or leadership concerns. Provider capability is assessed annually but can be reviewed and updated at any point during the year. Delivery segmentation, capability assessments and wider intelligence together inform the level of oversight, support and intervention required. The NOF league tables provide a comparative view of NHS provider performance, ranking trusts relative to their peers across individual metrics and overall performance.

For more information, please see NHS England » NHS Oversight Framework 2026/27 *and* Overview – NHS Oversight Framework - NHS England public data gateway

Oxford Health NHS Foundation Trust's 2026/27 NOF segmentation and ranking on the League table as per latest publication (11th September 2026; Quarter 1):

Headlines	Q1 2026/27	
	NOF score	Placement among peers
Segment	**2 (Above average)**	
Average metric score	**2.11**	
Financial override	**No**	
Ranking among Non-Acute hospital trusts	**20 out of 58**	

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)

2025/26 NOF segmentation page 95 of this Report.

NHS Oversight Framework 2026/27 – dashboard (scored metrics) – quarter 1

Domain	Domain quartile	Domain NOF score	Domain NOF score placement (national distribution)	Metric	Metric NOF score	Metric ranking	Metric reporting period	Metric value	National value
Access to services	4	3.14		Percentage of patients waiting over 52 weeks for community services	3.5	35 out of 41	Jun-26	13.75%	0.57%
				Percentage of cases where a patient is waiting less than 18 weeks for community treatment	3.04	35 out of 41	Jun-26	59.14%	82.11%
				Percentage of total Children and Young People's mental health waits for help that are over 104 weeks	4	46 out of 49	Jun-26	48.33%	27.10%
				Percentage of people discharged from community mental health services with a paired outcome score recorded (all ages)	2	n/a	Rolling 3 months to Jun-26	20.37% CYP 10.74% Adult & OA	21.18% CYP 10.43% Adult & OA
Experience of care	1	1.72		CQC community mental health survey satisfaction rate	2	n/a	2025	n/a	n/a
				NHS Staff survey - advocacy sub-score	1.47	10 out of 58	2025	7.36	6.90
				Mean length of stay for adult acute and psychiatric intensive care unit patients	2	14 out of 47	Rolling 3 months to Jun-26	42.00	46.50
				Mean length of stay for older adult acute mental health patients	1	4 out of 48	Rolling 3 months to Jun-26	58.00	92.00
				Percentage of intermediate care beds occupied by patients without criteria to reside	2.11	17 out of 35	Average of Q1 26/27	18.42%	23.55%
Effectiveness of care and population health	1	1.31		Percentage of inpatients referred to and seen by an in-house tobacco treatment service who make a supported attempt to stop smoking	1.92	12 out of 49	Rolling 12 months to Mar-26	21.05%	17.65%
				Adult acute and rehabilitation mental health, learning disability and autism discharges followed up within 72 hours	1	4 out of 47	Rolling 3 months to Jun-26	91.81%	84.83%
				Mental Health 14-day readmission rate	1	3 out of 41	Rolling 3 months to Jun-26	`3.00%	5.69%
Patient safety	1	1.21		Urgent crisis response within 24 hours	1	12 out of 47	Rolling 3 months to Jun-26	81.98%	75.44%
				NHS Staff survey - raising concerns sub-score	1.42	9 out of 58	2025	6.96	6.66
Finance, productivity and innovation	4	3.01		Planned surplus/deficit	1	9 out of 58	Q1 26/27	0.00%	0.00%
				Variance to plan year-to-date	1	7 out of 58	Q1 26/27	0.19%	0.00
				Relative cost difference (National Cost Collection Index)	3.16	37 out of 58	Dec-25	108.58	100.71
				Percentage of clinical trials set up within 90 days	4	38 out of 45	Q1 26/27	0%	50.00%
				Overall Data Quality Maturity Index	3.88	54 out of 58	Apr-26	77.20	93.00
People	1	1.85		Sickness absence rate score	1.81	9 out 58	To Mar-26	4.93%	5.54%
				NHS Staff survey engagement theme sub-score	1.53	11 out of 58	2025	7.21	7.02
				National Education and Training Survey overall experience sub-score	1.46	17 out of 58	2025	82.33%	78.16%
				NHS staff standards sub-score	1.68	14 out of 58	Jul-05	7.92	7.78
				Percentage of frontline healthcare workers to receive a flu vaccination	1.61	8 out of 58	Q1 25/26	54.60%	49.35%
				Temporary staffing cost relative band score	3	n/a	Q1 26/27	n/a	n/a

NHS Oversight Framework 2026/27 – dashboard (contextual (non-scored) metrics) – quarter 1

Domain	NOF score placement (national distribution)	Metric	Metric reporting period	Metric score	Peer average	National value
Patient safety		Crude rate of restrictive interventions per 1000 bed days	To Jun-26	66.00	13.50	27.00
	n/a	Percentage of hospital spells with at least one new pressure ulcer diagnosis of grade 3 or 4	No data	No data	No data	No data

- peer average (South East region)

Oxford Health
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Section 2.1
Clinical performance (National Mental Health Standards)

Mental Health Services – Matrix (1/2)

Assurance

Variation	P	?	F	No target
H / L	• Improve access to mental health support for children and young people – Buckinghamshire, Oxfordshire, Bath & North East Somerset, Swindon and Wiltshire • CYP - Four (4) week wait (interim metric - one meaningful contact within pathway) – Buckinghamshire • Talking Therapies - % of people receiving first treatment appointment within 6 weeks of referral – Oxfordshire • Talking Therapies - % of people receiving first treatment appointment within 18 weeks of referral – 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 – Oxfordshire and Buckinghamshire (rolling 3 months position) • CYP - Four (4) week wait (interim metric - one meaningful contact within pathway) – Bath & North East Somerset, Swindon and Wiltshire		
	• Talking Therapies - % of people receiving first treatment appointment within 6 weeks of referral – Buckinghamshire • Talking Therapies - % 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) – Buckinghamshire and Oxfordshire	• CYP - Four (4) week wait (interim metric - one meaningful contact within pathway) – Oxfordshire • 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 - Increase the number of adults and older adults completing a course of treatment for anxiety and depression – Buckinghamshire and Oxfordshire • Talking Therapies - Reliable improvement rate for those completed a course of treatment adult and older adults combined – Buckinghamshire and Oxfordshire • Talking Therapies - Reliable recovery rate for those completed a course of treatment adults and older adults combined – Buckinghamshire and Oxfordshire • Talking Therapies - Meet and maintain at least 52% Talking Therapies recovery rate – 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	• **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 and Oxfordshire
H / L		• **CYP - % referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Buckinghamshire (rolling 3 months position)**		

Mental Health Services – Matrix (1/2)

Assurance

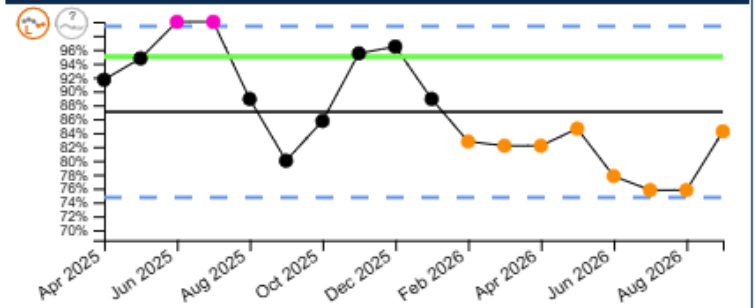
Variation	P	?	F	No target
H / L	• Improve access to perinatal mental health services – Buckinghamshire and Oxfordshire combined	• Response from Mental Health Crisis Service within 24 hours (Urgent) – Oxfordshire • Inpatients - Mental health 14-day readmission rate - Trust level • Number of people accessing Individual Placement Support (IPS) – Buckinghamshire and Oxfordshire combined	• **Response from Mental Health Crisis Service within 24 hours (Urgent) - rolling 3 months - Buckinghamshire**	
	• % 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 (referral source of A&E) – Buckinghamshire and Oxfordshire • Inpatients - Adult acute and rehabilitation mental health, learning disability and autism discharges followed up within 72 hours (rolling 3 months) - Trust level	• Adult and Older Adult community - 4 week wait (28 days) standard (interim metric - two contacts within pathway) – Buckinghamshire and Oxfordshire • 4 week wait (28 days) standard (interim metric - two contacts within episode) - Bath & North East Somerset, Swindon and Wiltshire (BSW) Community Adult Eating Disorders service • % 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 (referral source other than A&E) – Buckinghamshire and Oxfordshire • Response from Mental Health Crisis Service within 4 hours (Very Urgent) – Oxfordshire • Inpatients - Mean LoS for MH adult acute and PICU discharges (rolling 3 months) - Trust level • Inpatients - Mean LoS for older adults (rolling 3 months) - Trust level • % of patients responding that overall care was good or very good - Mental Health • % of patients report being involved in their care - Mental Health		• Inpatients - Average number of clinically ready for discharge patients per day - Trust level • Percentage of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service (12 rolling months) - Trust
H / L				

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

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	Sep-26	8233	H	.	7425
National	Improve access to mental health support for children and young people - Oxfordshire	>=9055	Sep-26	9052	H	.	8828
National	Improve access to mental health support for children and young people - Bath & North-East Somerset, Swindon and Wiltshire	>=7656	Sep-26	7798	H	.	6797
Local Strategic - Quality	Four (4) week wait (interim metric - one meaningful contact within pathway) - Buckinghamshire	>=68%	Sep-26	84.40%	H	P	77.48%
Local Strategic - Quality	Four (4) week wait (interim metric - one meaningful contact within pathway) - Oxfordshire	>=68%	Sep-26	73.51%		?	61.12%
Local Strategic - Quality	Four (4) week wait (interim metric - one meaningful contact within pathway) - Bath & North-East Somerset, Swindon and Wiltshire	>=68%	Sep-26	94.10%	H	?	60.03%
National	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Buckinghamshire (rolling 3 months position)	>=95%	Sep-26	84.21%	L	?	87.05%
National	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Oxfordshire (rolling 3 months position)	>=95%	Sep-26	74.19%		F	81.50%
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%	Sep-26	93.44%	H	?	89.54%
National	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Buckinghamshire (rolling 3 months position)	>=95%	Sep-26	100%	H	?	94.88%
National	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Oxfordshire (rolling 3 months position)	>=95%	Sep-26	100%	H	?	96.80%
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%	Sep-26	83.33%		?	88.78%

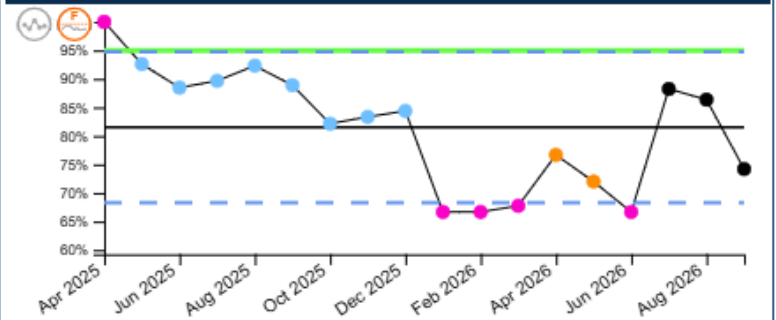
Mental Health Services – Children and Adolescent Mental Health Services

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



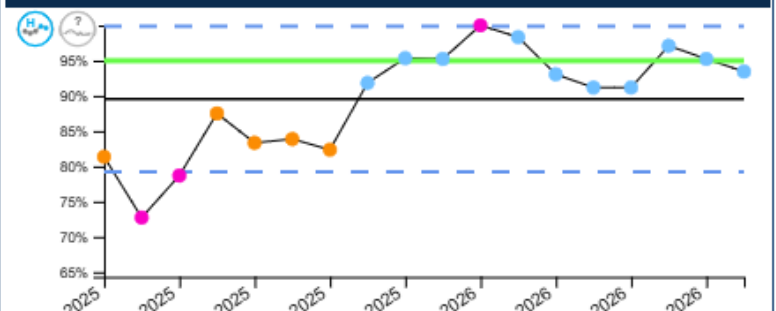
Target:	Month Year	Value	Numerator	Denominator	Median (days)
95%	Sep 2026	84.21 %	32	38	21

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



Target:	Month Year	Value	Numerator	Denominator	Median (days)
95%	Sep 2026	74.19 %	23	31	19

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



Target:	Month Year	Value	Numerator	Denominator	Median (days)
95%	Sep 2026	93.44 %	57	61	15

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 September 2026 performance includes July, August and September 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 cases in 2025/26 averaged 78.7% of referrals being seen within 28 days, based on the three-month rolling metric. The latest available data (August 2026) shows a national average of 81.4%.

- In Buckinghamshire, four (4) breaches occurred in July due to patient choice (patients either not attending appointments or requesting appointments outside of the timeframe), one (1) in August due to patient choice and one (1) in September 2026 due to delay in Single Point of Access contacting the patient (patient seen on day 35).
- In Oxfordshire, no breaches in July 2026. Three (3) breaches occurred in August 2026 – two (2) due to capacity (no available appointments due to planned absences/vacancies; seen on days 32 and 34) and one (1) due to patient choice (assessment offered within timeframe, but declined and another date outside of the timeframe chosen) and five (5) in September – four (4) due to a combination of no capacity due to planned absences and/or vacancies and increase in demand (demand higher than planned assessment slots (patients seen on day 28, 32, 36 and 41), one (1) due to patient choice.
- In Bath and North East Somerset, Swindon and Wiltshire service, there were no breaches in July, two (2) in August attributed to patient choice and two (2) breaches in September 2026 – one (1) due to patient choice and one (1) due to capacity, where demand exceeds the number of planned appointments (patient seen on day 31).

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

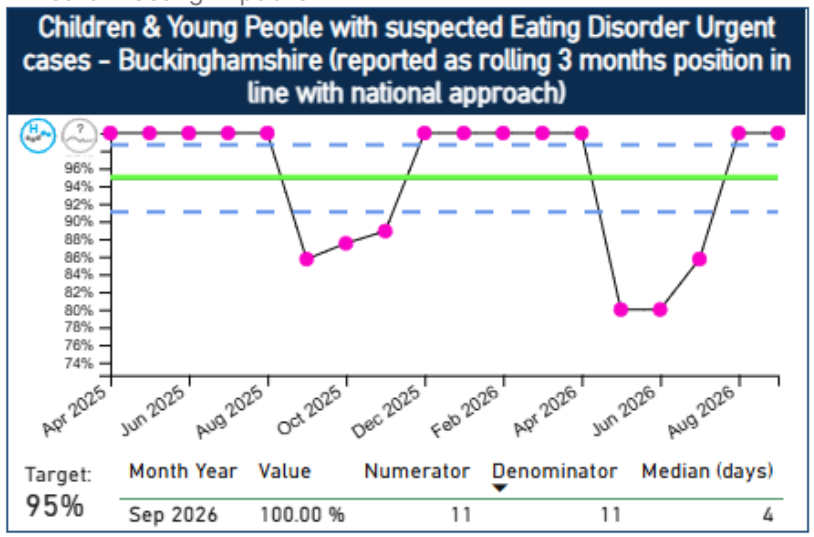
Actions (SMART)

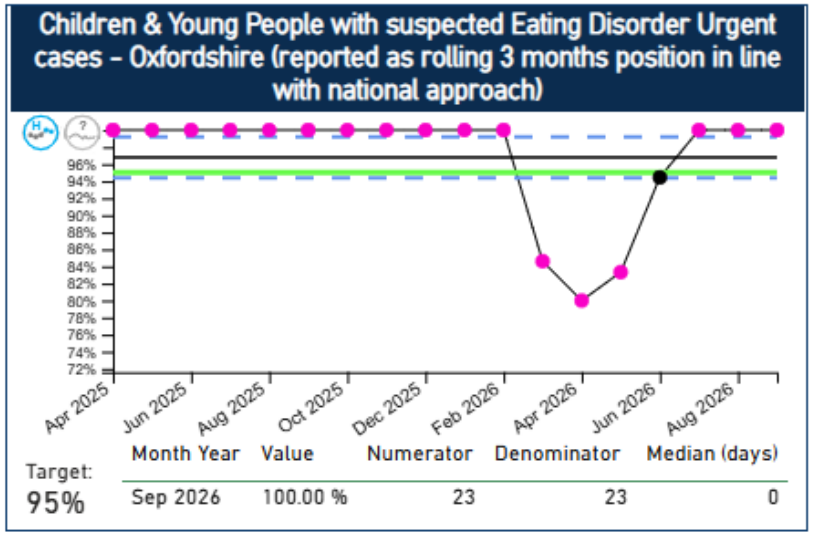
- Continuation of Internal team level performance monitoring and improvement meetings taking place regularly to support teams with data recording, reporting, identifying causes and solutions for improvement.
- Deep dive into performance of all CAMHS ED services
- Triage process change where it must be completed within two days of referral from Single Point of Access. This alongside the recruitment is expected to have a positive impact on performance by November 2026.

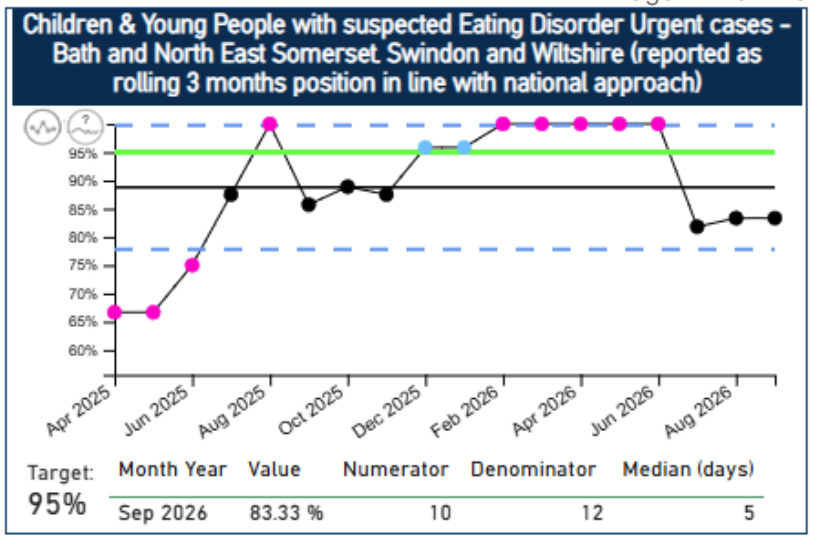
Risks

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 – Children and Adolescent Mental Health Services







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. September 2026 performance includes July, August and September 2026 performance. Patients who choose to be seen outside of the timeframe will still be counted as a breach. Nationally, performance for urgent cases in 2025/26 averaged 73.4 % of referrals being seen within 7 days, based on the three-month rolling metric. The latest available data (August 2026) shows a national average of 78.8%.

- Buckinghamshire exceeded the target in September 2026.
- Oxfordshire exceeded the target in September 2026.
- In Bath and North East Somerset, Swindon and Wiltshire, there were two (2) breaches in July due to capacity where demand is higher than planned assessment slots (both seen on day 8), no breaches in August and September 2026.

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Actions (SMART)

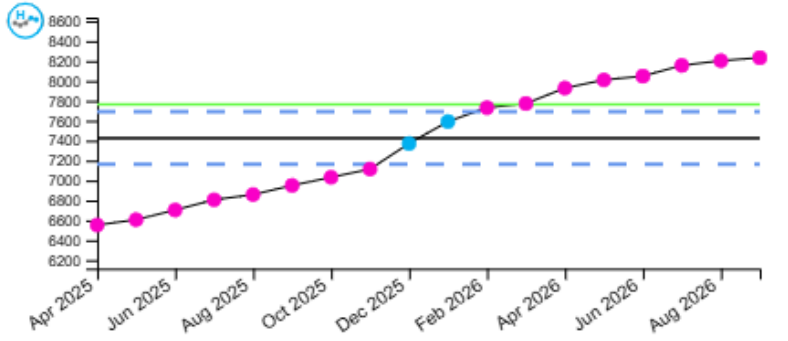
- Continuation of Internal team level performance monitoring and improvement meetings taking place regularly to support teams with data recording, reporting, identifying causes and solutions for improvement.

Risks

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

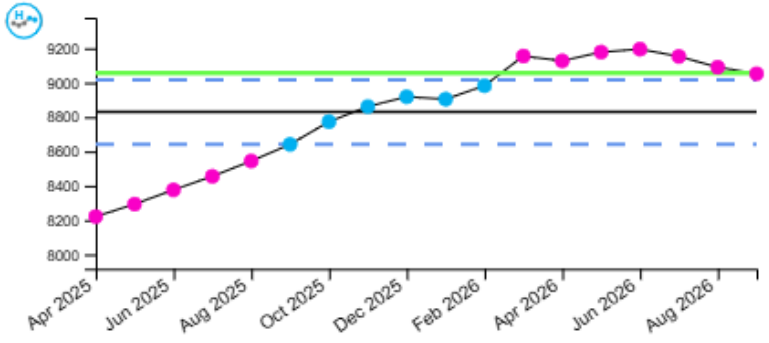
Mental Health Services – Children and Adolescent Mental Health Services - appendices

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



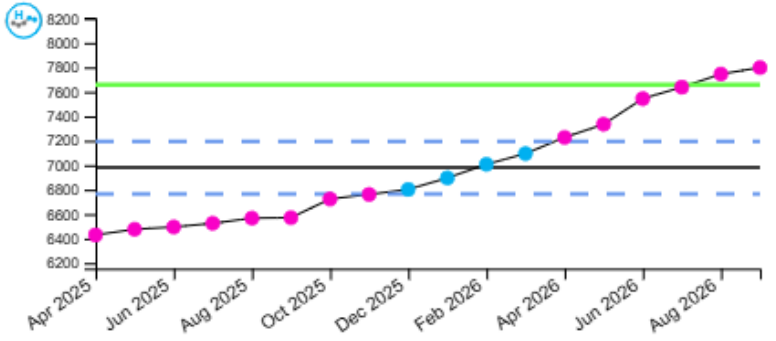
Target (Bucks sub ICB):	Month Year	Value
>=7765	Sep 2026	8,233

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



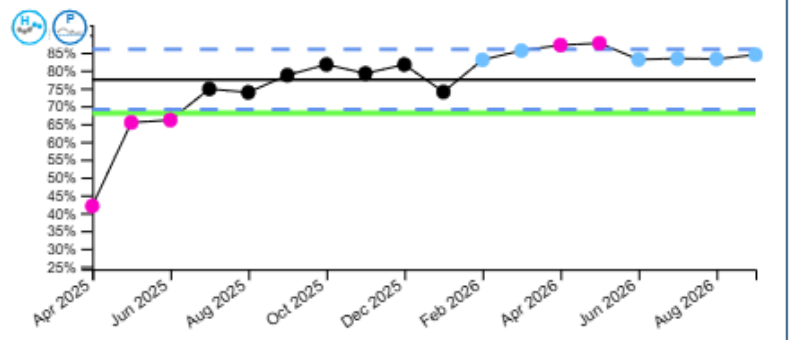
Target (Oxon sub ICB):	Month Year	Value
>=9055	Sep 2026	9,052

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



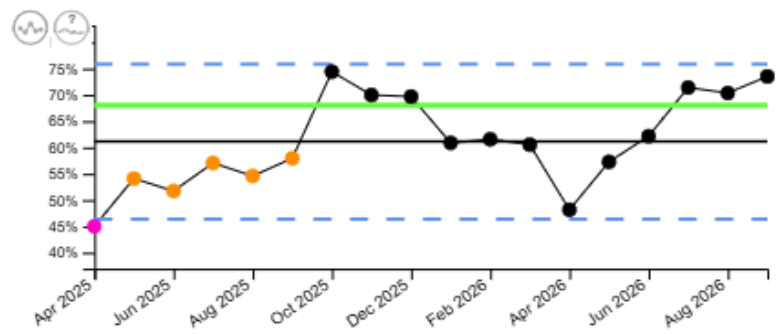
Target (BSW):	Month Year	Value
>=7656	Sep 2026	7,798

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



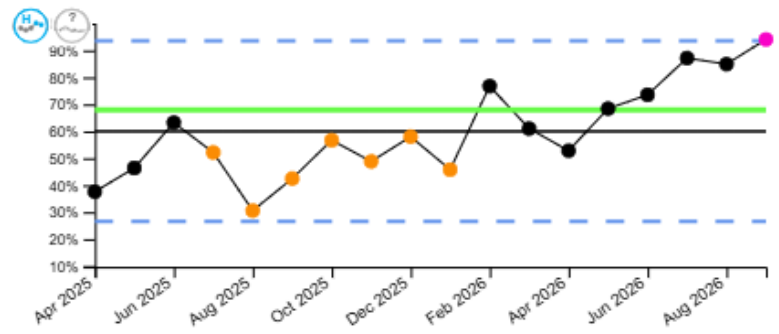
Target	Month Year	Value	Numerator	Denominator	Median (days)
>=68%	Sep 2026	84.40 %	357	423	3

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



Target:	Month Year	Value	Numerator	Denominator	Median (days)
>=68%	Sep 2026	73.51 %	272	370	6

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



Target:	Month Year	Value	Numerator	Denominator	Median (days)
>=68%	Sep 2026	94.10 %	367	390	7

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

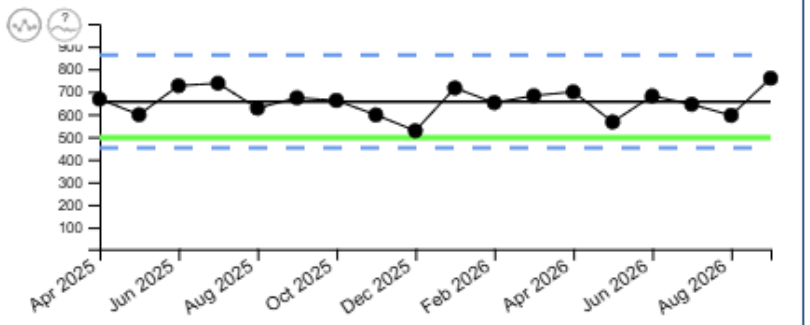
Type of metric	Service Area/Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National	Increase the number of adults and older adults completing a course of treatment for anxiety and depression - Buckinghamshire	>=497	Sep-26	759		?	655
National	Increase the number of adults and older adults completing a course of treatment for anxiety and depression - Oxfordshire	>=636	Sep-26	736		?	733
National	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Buckinghamshire	.	Sep-26	9.35%		n/a	10.21%
National	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Oxfordshire	.	Sep-26	7.88%		n/a	6.72%
National	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Buckinghamshire	>=68%	Sep-26	67.33%		?	68.61%
National	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Oxfordshire	>=68%	Sep-26	66.71%		?	67.93%
National	% of people receiving first treatment appointment within 6 weeks of referral - Buckinghamshire	>=75%	Sep-26	98.16%		P	98.48%
National	% of people receiving first treatment appointment within 6 weeks of referral - Oxfordshire	>=75%	Sep-26	99.32%	H	P	99.08%
National	% of people receiving first treatment appointment within 18 weeks of referral - Buckinghamshire	>=95%	Sep-26	100%	H	P	99.97%
National	% of people receiving first treatment appointment within 18 weeks of referral - Oxfordshire	>=95%	Sep-26	100%		P	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%	Sep-26	0.64%		P	1.68%
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%	Sep-26	4.54%		P	6.39%

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

Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Buckinghamshire	>=50%	Sep-26	47.39%			50.79%
National	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Oxfordshire	>=50%	Sep-26	47.24%			49.50%
National	Meet and maintain at least 52% Talking Therapies recovery rate - Buckinghamshire	>=52%	Sep-26	49.79%			53.37%
National	Meet and maintain at least 52% Talking Therapies recovery rate - Oxfordshire	>=52%	Sep-26	50.28%			53.03%
National	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined - Buckinghamshire	>=52%	Sep-26	44.71%			48.90%
National	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined - Oxfordshire	>=52%	Sep-26	44.53%			47.43%
National	Recovery rate for White British - complete a course of treatment, adult and older adult combined - Buckinghamshire	>=52%	Sep-26	51.36%			55.33%
National	Recovery rate for White British - complete a course of treatment, adult and older adult combined - Oxfordshire	>=52%	Sep-26	51.94%			53.53%

Mental Health Services – Talking Therapies - appendices

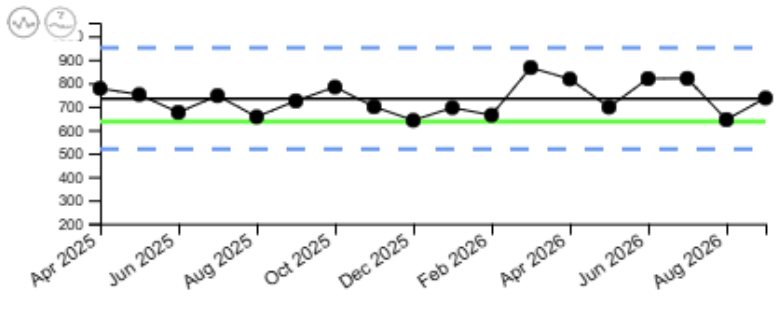
Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies - Buckinghamshire



Target:
>=497

Month Year	Value
Sep 2026	759.0

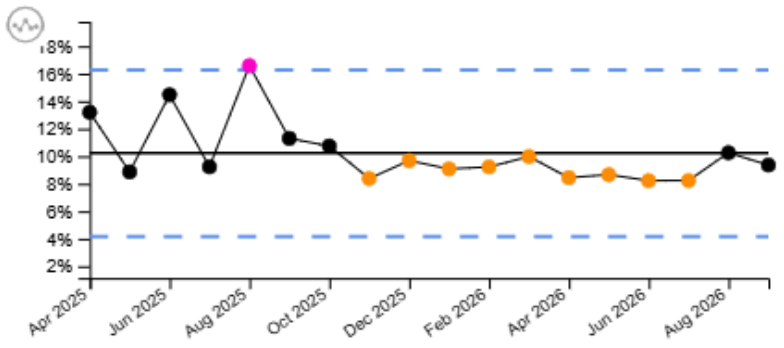
Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies - Oxfordshire



Target:
>=636

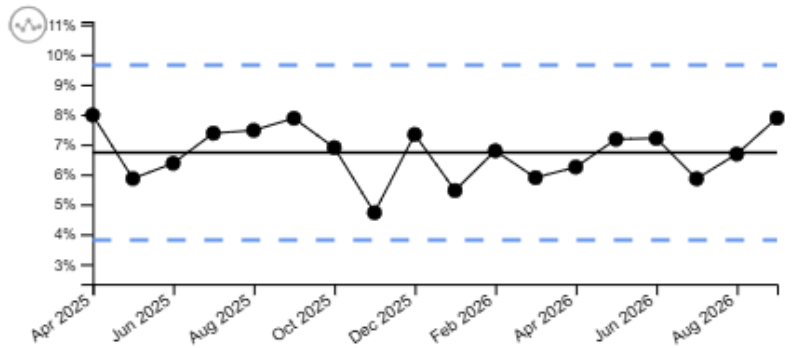
Month Year	Value
Sep 2026	736.0

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



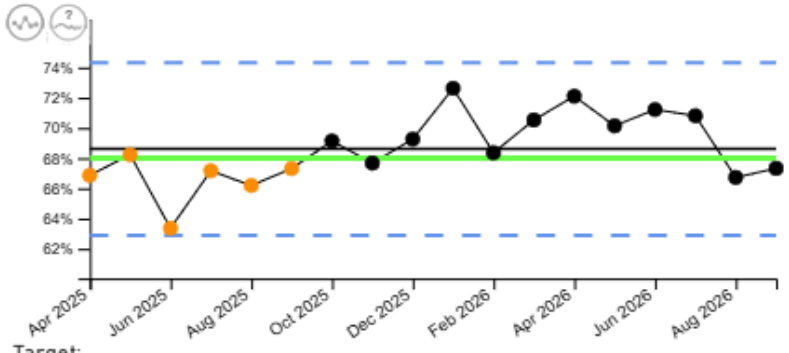
Month Year	Value
Sep 2026	9.35 %

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



Month Year	Value
Sep 2026	7.88 %

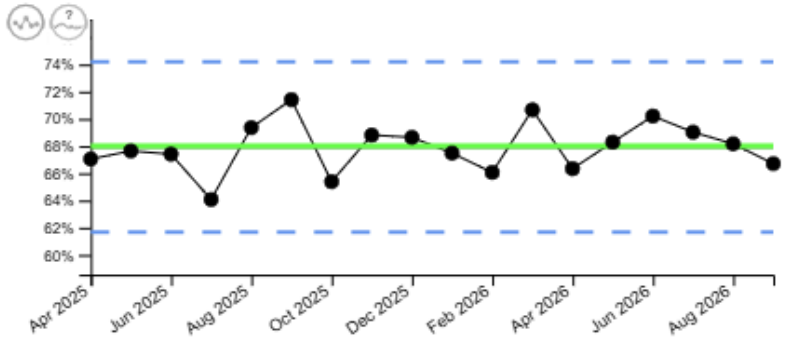
Reliable improvement rate for those completed a course of treatment adults and older adults combined - Buckinghamshire



Target:
Apr-Sep:
>=68%

Month Year	Value	Numerator	Denominator
Sep 2026	67.33 %	511.0	759.0

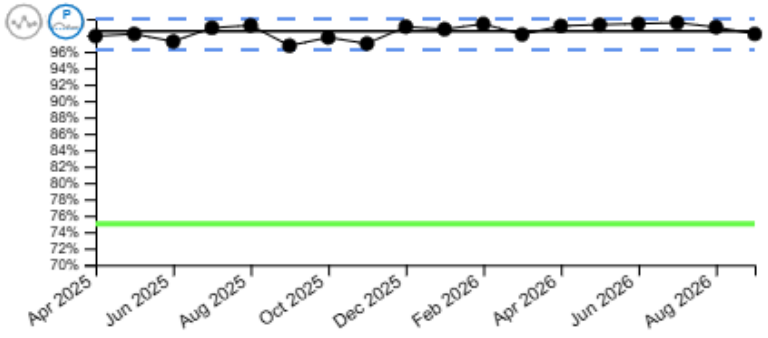
Reliable improvement rate for those completed a course of treatment adults and older adults combined - Oxfordshire



Target:
Apr-Sep:
>=68%

Month Year	Value	Numerator	Denominator
Sep 2026	66.71 %	491.0	736.0

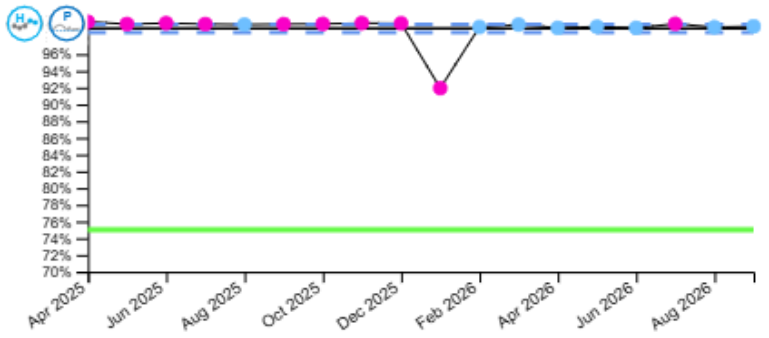
% of people receiving first treatment appointment within 6 weeks of referral – Buckinghamshire



Target: >=75%

Month Year	Value	Numerator	Denominator
Sep 2026	98.16 %	745.0	759.0

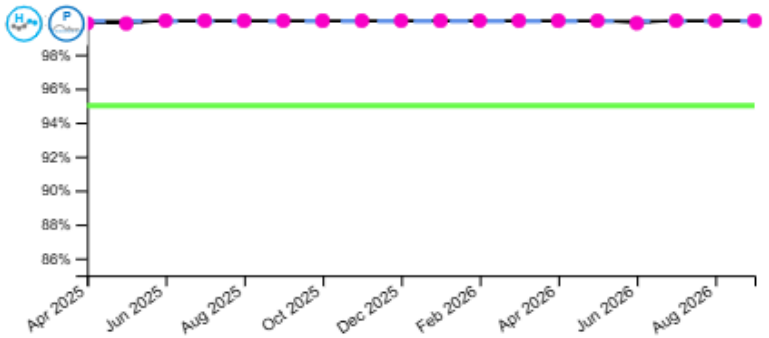
% of people receiving first treatment appointment within 6 weeks of referral – Oxfordshire



Target: >=75%

Month Year	Value	Numerator	Denominator
Sep 2026	99.32 %	732.0	737.0

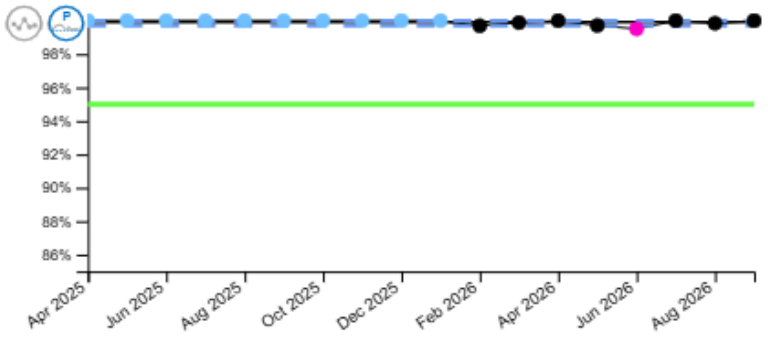
% of people receiving first appointment within 18 weeks of referral – Buckinghamshire



Target: >=95%

Month Year	Value	Numerator	Denominator
Sep 2026	100.00 %	759.0	759.0

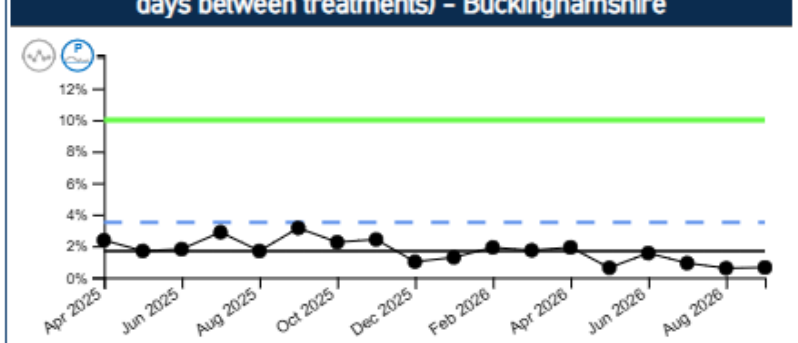
% of people receiving first appointment within 18 weeks of referral – Oxfordshire



Target: >=95%

Month Year	Value	Numerator	Denominator
Sep 2026	100.00 %	737.0	737.0

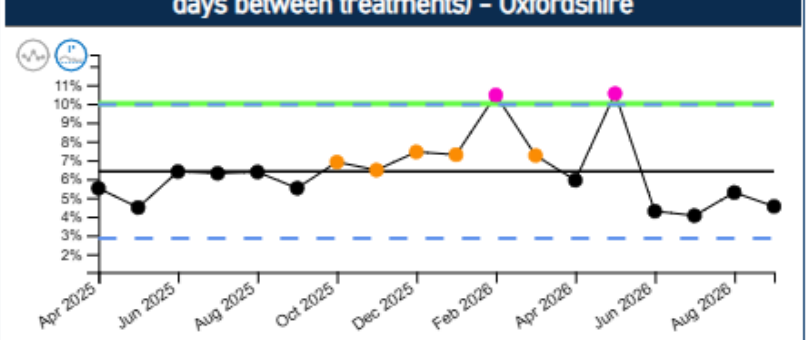
Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting no more than 90 days between treatments) – Buckinghamshire



Target: <=10%

Month Year	Value	Numerator	Denominator
Sep 2026	0.64 %	5.0	787.0

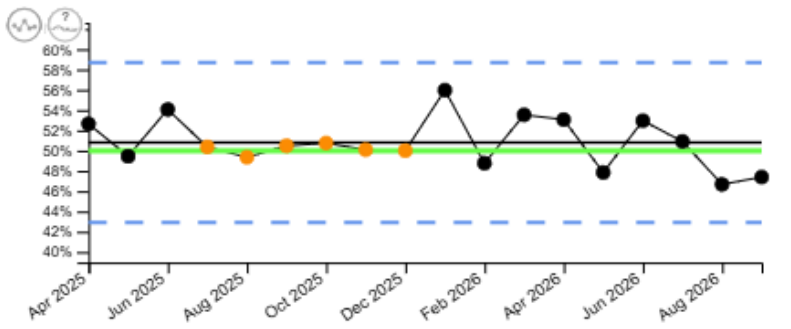
Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting no more than 90 days between treatments) – Oxfordshire



Target: <=10%

Month Year	Value	Numerator	Denominator
Sep 2026	4.54 %	34.0	749.0

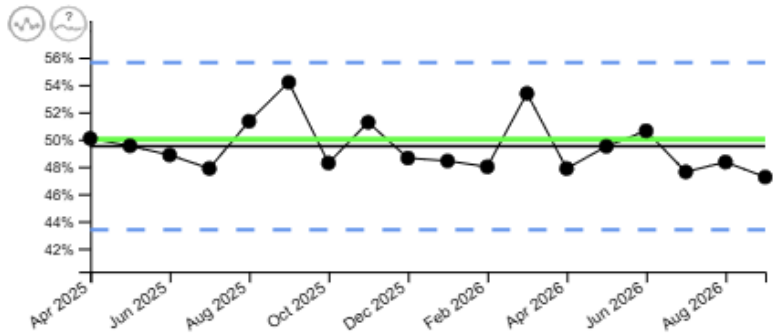
Reliable recovery rate for those completed a course of treatment adults and older adults combined - Buckinghamshire



Target:
Apr-Sep:
>=50%

Month Year	Value	Numerator	Denominator
Sep 2026	47.39 %	336.0	709.0

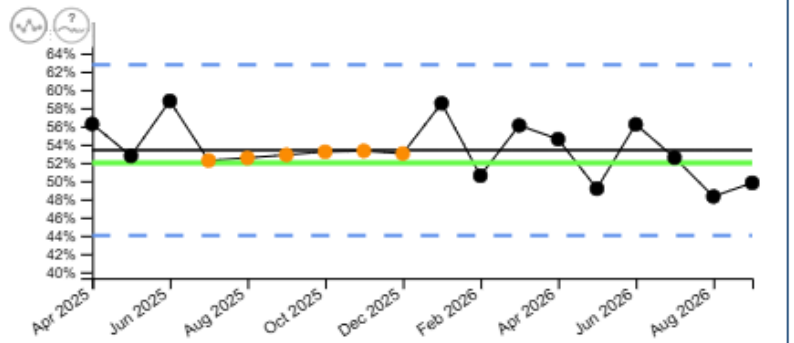
Reliable recovery rate for those completed a course of treatment adults and older adults combined - Oxfordshire



Target:
Apr-Sep
>=50%

Month Year	Value	Numerator	Denominator
Sep 2026	47.24 %	342.0	724.0

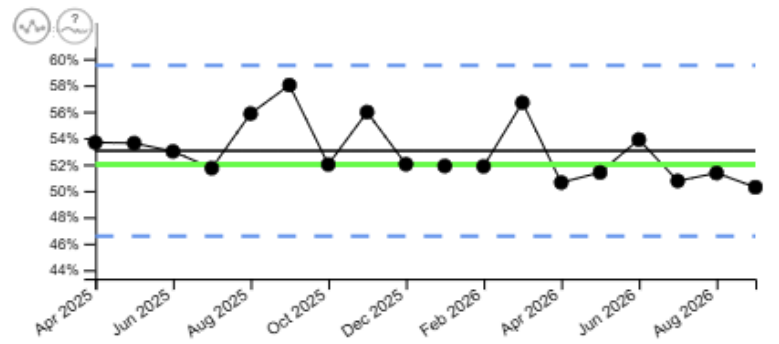
Meet and maintain Talking Therapies standards 52% Talking Therapies recovery rate - Buckinghamshire



Target:
>=52%

Month Year	Value	Numerator	Denominator
Sep 2026	49.79 %	353.0	709.0

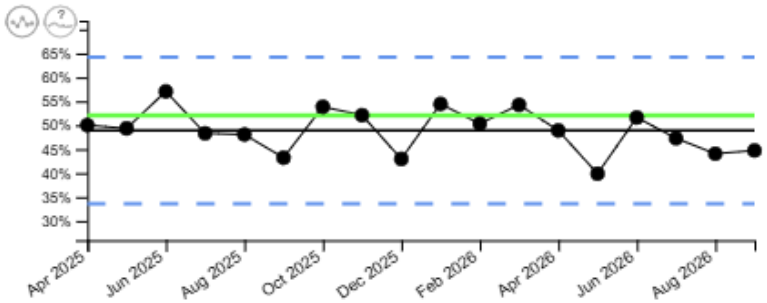
Meet and maintain Talking Therapies standards 52% Talking Therapies recovery rate - Oxfordshire



Target:
>=52%

Month Year	Value	Numerator	Denominator
Sep 2026	50.28 %	364.0	724.0

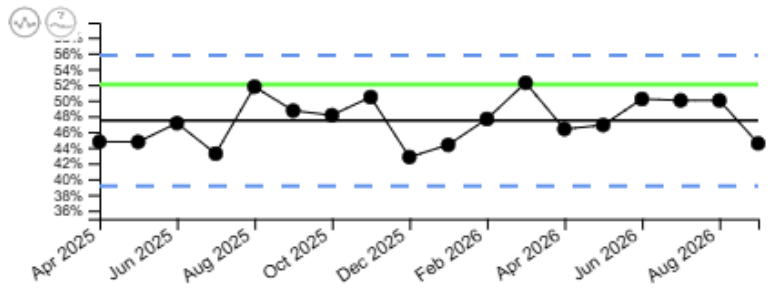
Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) (completed a course of treatment, adult and older adult combined) - Buckinghamshire



Target:
>=52%

Month Year	Value
Sep 2026	44.71 %

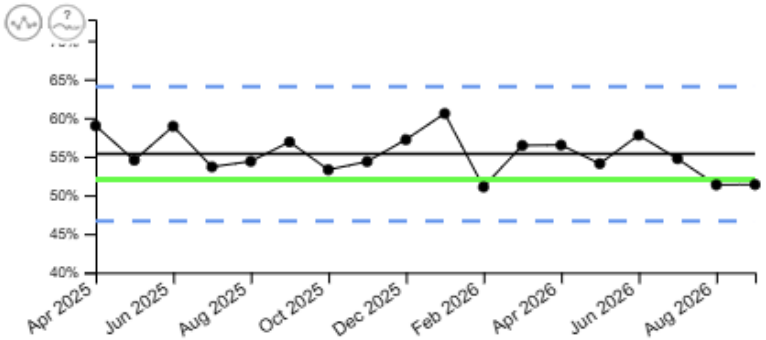
Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) (completed a course of treatment, adult and older adult combined) - Oxfordshire



Target:
>=52%

Month Year	Value
Sep 2026	44.53 %

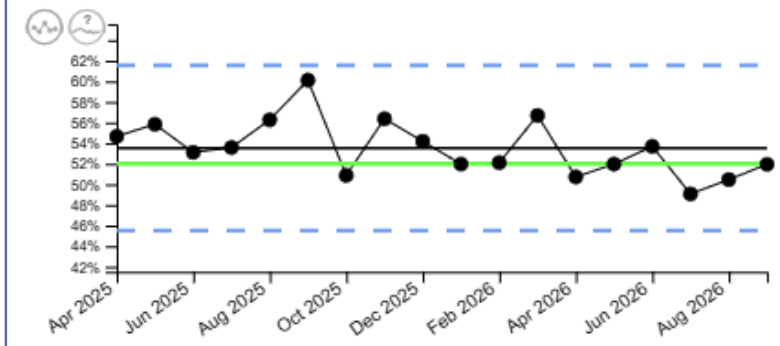
Recovery rate for White British (completed a course of treatment, adult and older adults combined) - Buckinghamshire



Target:
>=52%

Month Year	Value
Sep 2026	51.36 %

Recovery rate for White British (completed a course of treatment, adult and older adults combined) - Oxfordshire



Target:
>=52%

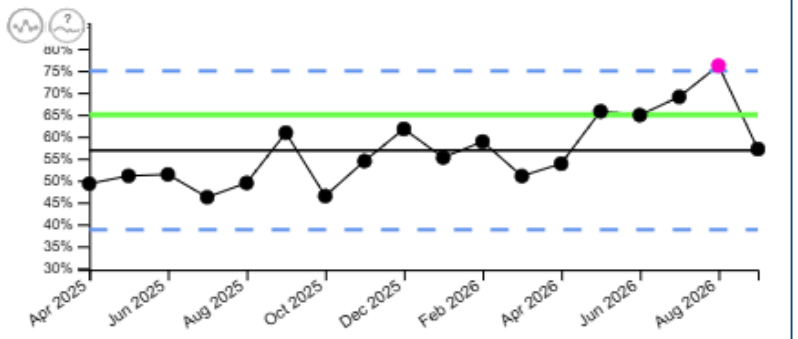
Month Year	Value
Sep 2026	51.94 %

Mental Health Services – Adult and Older Adult Community - summary

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	>=65%	Sep-26	57.14%			56.81%
National	4 week wait (28 days) standard (interim metric - two contacts within pathway)- Oxfordshire	>=65%	Sep-26	82.83%			69.66%
National	4 week wait (28 days) standard (interim metric - two contacts within episode) - Bath & North East Somerset, Swindon and Wiltshire (BSW) Community Adult Eating Disorders service	>=65%	Sep-26	91.67%			54.16%
National	Improve access to perinatal mental health services - Buckinghamshire (rolling 12 months)	>=390	Sep-26	388		.	380
National	Improve access to perinatal mental health services - Oxfordshire (rolling 12 months)	>=663	Sep-26	676		.	628
National	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Buckinghamshire	>=60%	Sep-26	33.33%			75.91%
National	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Oxfordshire	>=60%	Sep-26	85.71%			92.37%
National	Number of people accessing Individual Placement Support (IPS) - Buckinghamshire (rolling 12 months)	>=372	Sep-26	322		.	323
National	Number of people accessing Individual Placement Support (IPS) - Oxfordshire (rolling 12 months)	>=618	Sep-26	619		.	534

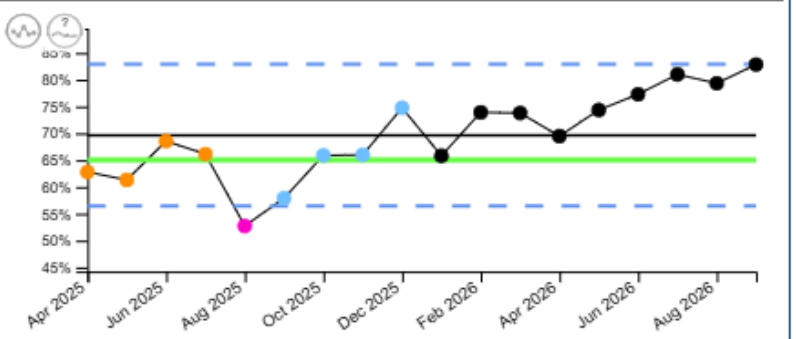
Mental Health Services – Adult and Older Adult Community - appendices

Community Mental Health 4 Week Wait Pathway interim metric – Buckinghamshire



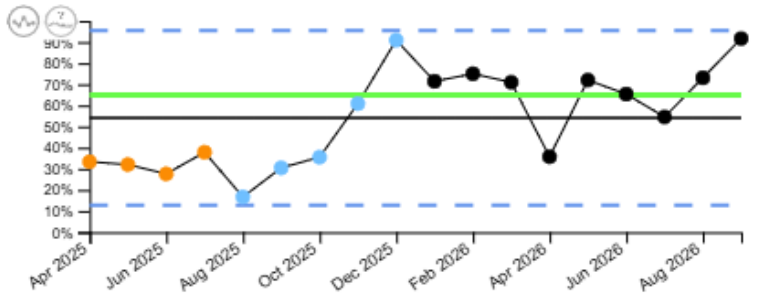
Target:	Month Year	Value	Numerator	Denominator	Median (days)
Jul-Sep: >=65%	Sep 2026	57.14 %	152	266	23

Community Mental Health 4 Week Wait Pathway interim metric – Oxfordshire



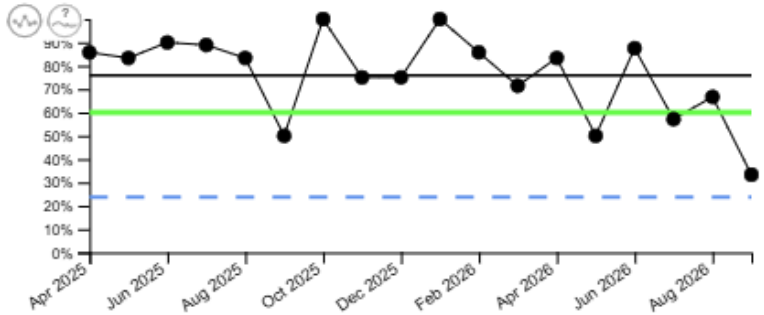
Target:	Month Year	Value	Numerator	Denominator	Median (days)
Jul-Sep: >=65%	Sep 2026	82.83 %	497	600	12

Community Mental Health 4 Week Wait Pathway interim metric – Bath and North East Somerset, Swindon and Wiltshire Adult Eating Disorders service



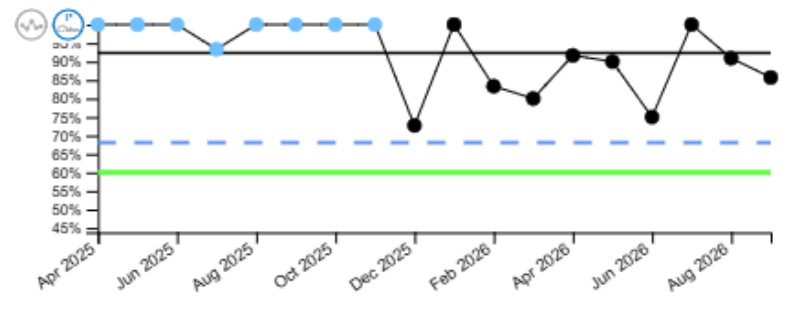
Target:	Month Year	Value	Numerator	Denominator	Median (days)
Jul-Sep: >=65%	Sep 2026	91.67 %	22	24	14

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



Target:	Month Year	Value	Numerator	Denominator
>=60%	Sep 2026	33.33 %	1	3

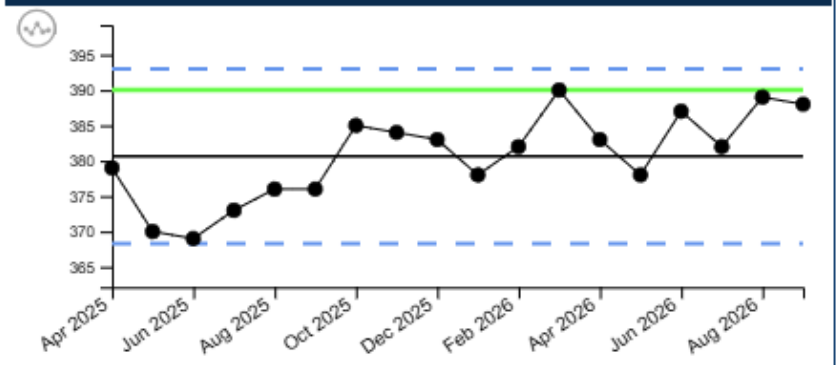
Early Intervention in Psychosis Waits (% of people with first episode of psychosis treated within 2 weeks of referral) – Oxfordshire



Target:	Month Year	Value	Numerator	Denominator
>=60%	Sep 2026	85.71 %	6	7

Mental Health Services – Adult and Older Adult Community - appendices

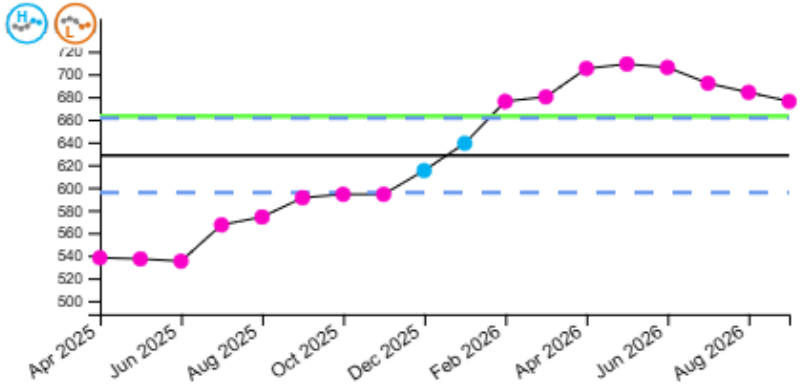
Improve access to Perinatal mental health services – Buckinghamshire



Target (Bucks sub ICB):
>=390

Month Year	Value
Sep 2026	388

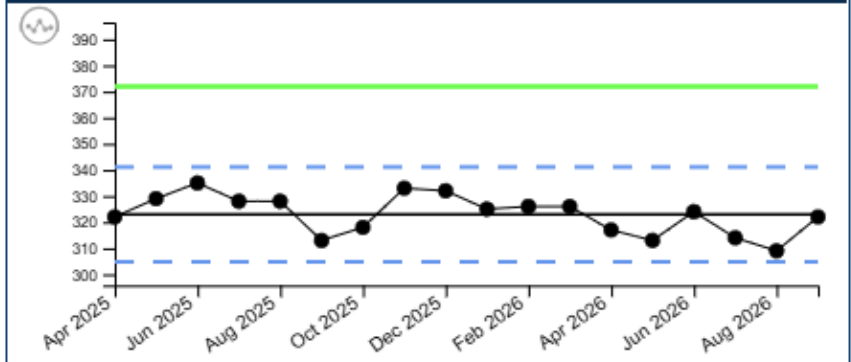
Improve access to Perinatal mental health services – Oxfordshire



Target (Oxon sub ICB):
>=663

Month Year	Value
Sep 2026	676

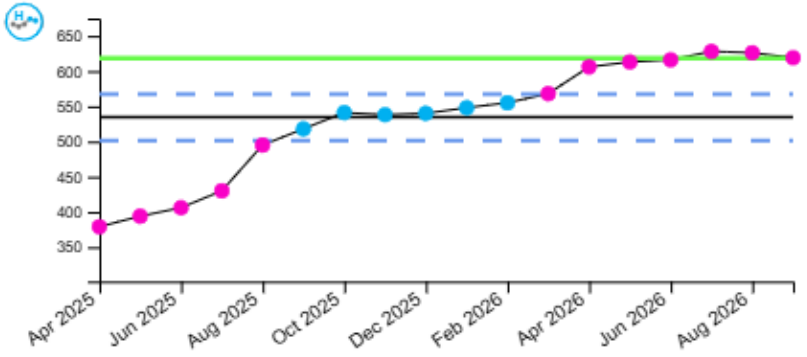
Number of people accessing Individual Placement Support (IPS) – Buckinghamshire



Target (Bucks sub ICB):
>=372

Month Year	Value
Sep 2026	322

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



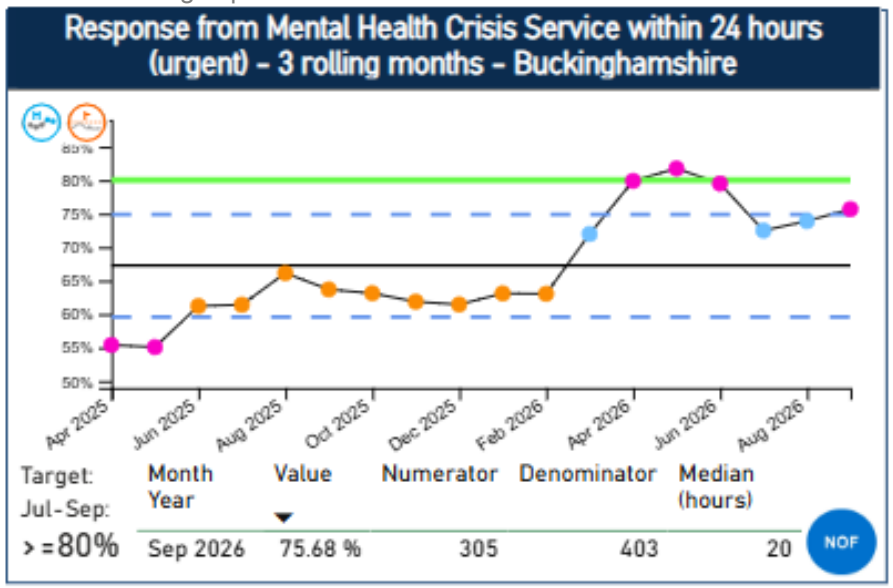
Target (Oxon sub ICB):
>=618

Month Year	Value
Sep 2026	619

Mental Health Services – Urgent Care - summary

Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National	Response from Mental Health Psychiatric Liaison within 1 hour (referral source of A&E) - Buckinghamshire	>=85%	Sep-26	97.92%			93.98%
National	Response from Mental Health Psychiatric Liaison within 1 hour (referral source of A&E) - Oxfordshire	>=85%	Sep-26	97.80%			92.57%
National	Response from Mental Health Psychiatric Liaison within 24 hours (referral source other than A&E) - Buckinghamshire	>=90%	Sep-26	100%			98.43%
National	Response from Mental Health Psychiatric Liaison within 24 hours (referral source other than A&E) - Oxfordshire	>=90%	Sep-26	100%			61.11%
National	Response from Mental Health Crisis Service within 4 hours (Very Urgent) - Buckinghamshire	>=65%	Sep-26	No referrals			
National	Response from Mental Health Crisis Service within 4 hours (Very Urgent) - Oxfordshire	>=65%	Sep-26	100%			60.53%
National NOF 26/27 (scored)	Response from Mental Health Crisis Service within 24 hours (Urgent) – rolling 3 months - Buckinghamshire	>=80%	Sep-26	75.68%	H	F	67.25%
National NOF 26/27 (scored)	Response from Mental Health Crisis Service within 24 hours (Urgent) – rolling 3 months - Oxfordshire	>=80%	Sep-26	89.55%	H		73.43%

Mental Health Services – Urgent Care - appendices



Understanding the performance & Actions

The indicator measures the proportion of new urgent referrals to NHS mental health crisis services that receive their first face-to-face contact within 24 hours of referral, providing an assessment of the timeliness of response for patients requiring urgent assessment or intervention.

The reporting rules and the above visual have been updated to align with the NHS Oversight Framework 2026/27 definition. Performance is now measured on a rolling three-month basis, replacing the previous monthly reporting approach. This means that September 2026 performance takes into account performance in July, August and September 2026.

The Making Data Count algorithm flags this metric as failing based on the latest eight data points. However, these include months when the target was 58%, before it increased in April 2026, during which performance was generally above target. Performance has been below the revised target for the last three consecutive months, with the rolling three-month performance at 75.68% in September 2026. For comparison, the latest published national data (August 26) shows national performance averaging 72.8%

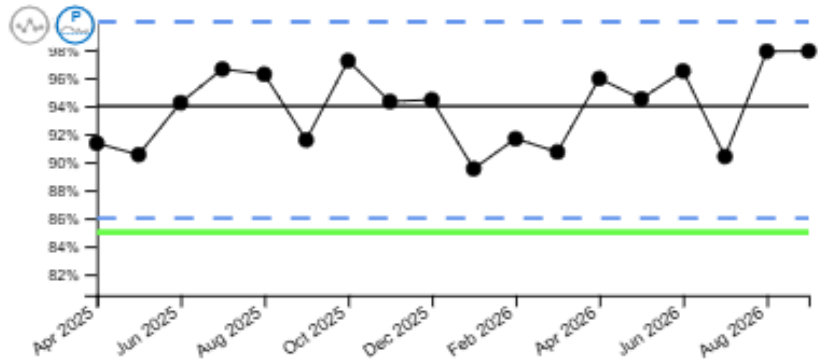
The service is reviewing clinical coding practices to ensure that urgency classifications are consistently applied in accordance with established clinical criteria.

Risks

Failure to achieve the 24-hour crisis response standard presents a risk to patient safety, experience and clinical outcomes, with delays in timely assessment and intervention potentially contributing to deterioration in mental health, increased risk of harm and escalation to emergency or inpatient services. Sustained underperformance may also increase operational pressures across urgent care pathways and result in greater regulatory scrutiny under the NHS Oversight Framework. Continued monitoring and targeted improvement actions are therefore essential to support timely access, mitigate clinical risk and improve patient outcomes.

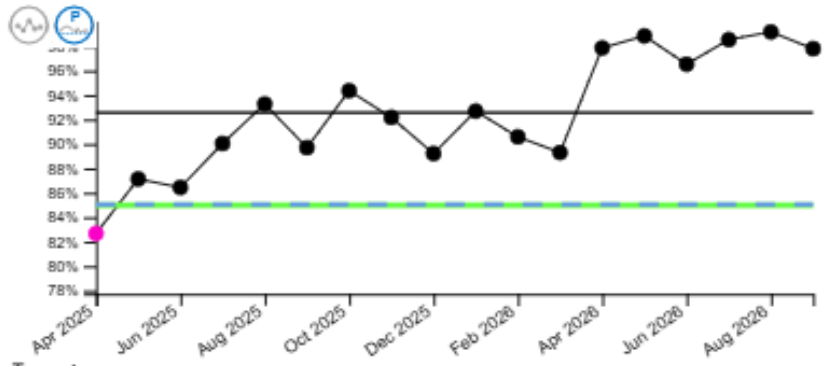
Mental Health Services – Urgent Care - appendices

Response from Mental Health Psychiatric Liaison within 1 hour (referral source of A&E) - Buckinghamshire



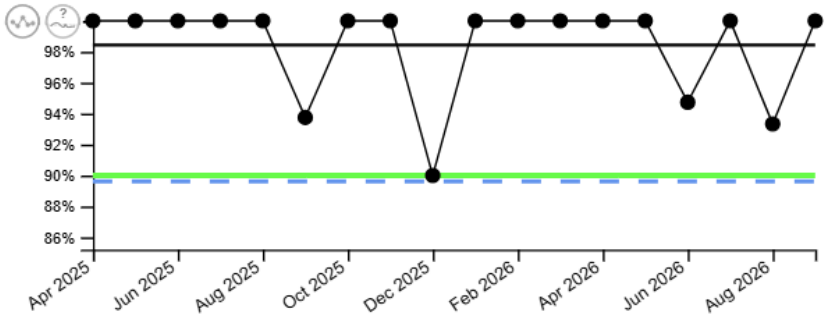
Target: Jul-Sep:	Month Year	Value	Numerator	Denominator	Median (hours)
>=85%	Sep 2026	97.92 %	94	96	0

Response from Mental Health Psychiatric Liaison within 1 hour (referral source of A&E) - Oxfordshire



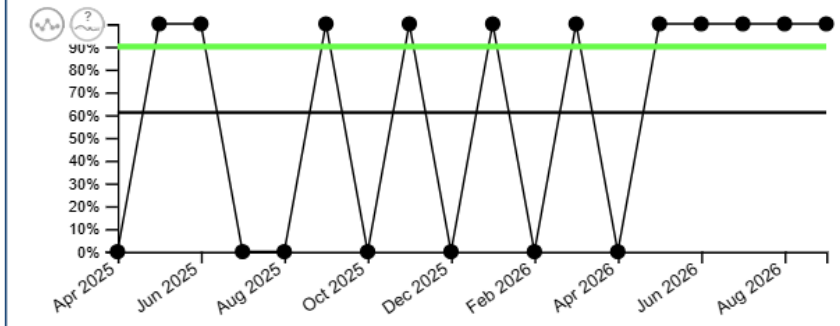
Target: Jul-Sep:	Month Year	Value	Numerator	Denominator	Median (hours)
>=85%	Sep 2026	97.80 %	267	273	0

Response from Mental Health Psychiatric Liaison within 24 hour (referral source other than A&E) - Buckinghamshire



Target: Apr-Sep:	Month Year	Value	Numerator	Denominator	Median (hours)
>=90%	Sep 2026	100.00 %	14	14	16

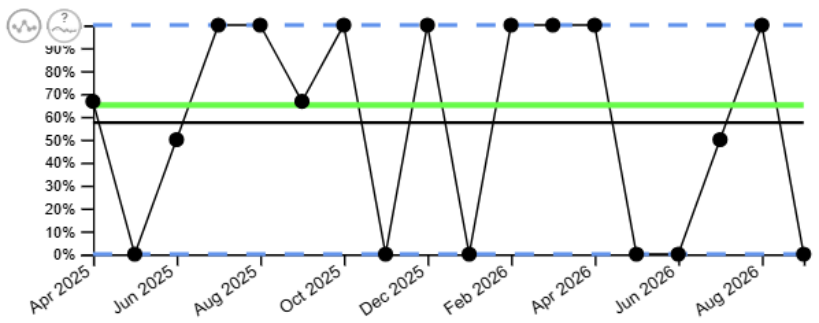
Response from Mental Health Psychiatric Liaison within 24 hour (referral source other than A&E) - Oxfordshire



Target: Apr-Sep:	Month Year	Value	Numerator	Denominator	Median (hours)
>=90%	Sep 2026	100.00 %	4	4	7

Mental Health Services – Urgent Care - appendices

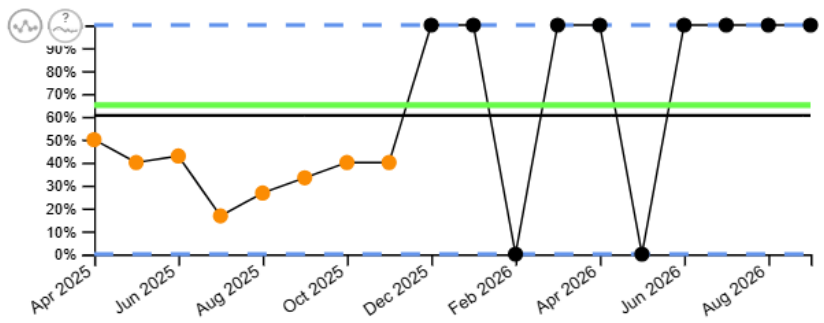
Response from Mental Health Crisis Service within 4 hours (very urgent) – Buckinghamshire



Target:
Jul-Sep:
>=65%

No referrals in Sep 2026

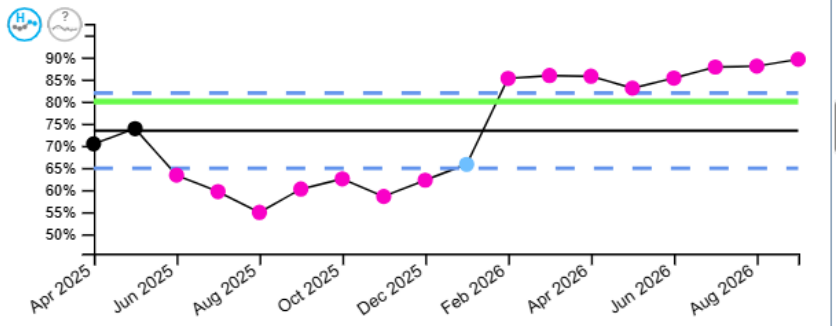
Response from Mental Health Crisis Service within 4 hours (very urgent) – Oxfordshire



Target:
Jul-Sep:
>=65%

Month Year	Value	Numerator	Denominator	Median (hours)
Sep 2026	100.00 %	3	3	3

Response from Mental Health Crisis Service within 24 hours (urgent) – 3 rolling months – Oxfordshire



Target:
Jul-Sep:
>=80%

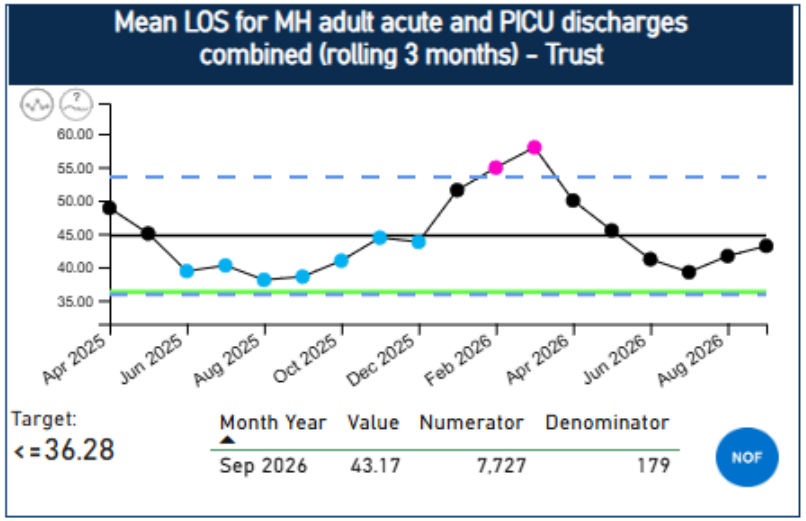
Month Year	Value	Numerator	Denominator	Median (hours)
Sep 2026	89.55 %	60	67	18

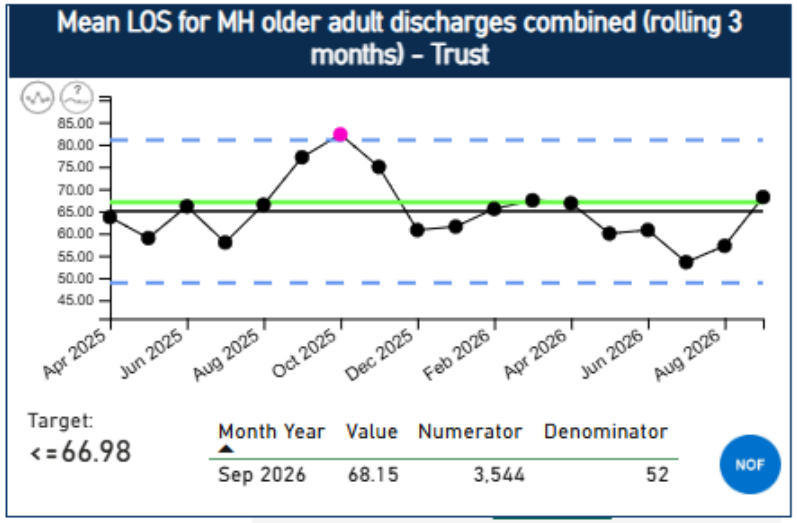
NOF

Mental Health Services – Inpatients – summary

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	Sep-26	43.17			44.69
National	Mean Length of Stay (LoS) for older adults (rolling 3 months) - Trust level	<=66.98	Sep-26	68.15			64.94
National	Adult acute and rehabilitation mental health, learning disability and autism discharges followed up within 72 hours (rolling 3 months) - Trust level	>=80%	Sep-26	92%			93.54%
National NHSE SE Delivery Plan	Trust level mental health inappropriate out of area placements - snapshot last day month	<=6	Sep-26	14	.	.	5
National NHSE SE Delivery Plan *NOF 26/27 for ICB*	Trust level mental health inappropriate out of area - bed days in month	-	Sep-26	297	.	.	128
National *NOF 26/27 (scored)*	Mental health 14-day readmission rate - Trust level	<=5%	Sep-26	2.50%			3.22%
Local	Average number of clinically ready for discharge patients per day - Trust level	-	Sep-26	6.9		n/a	7.28
National *NOF 26/27 (scored)*	Percentage of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service (12 rolling months) - Trust	-	Sep-26	21.92%		n/a	25.46%

Mental Health Services – Inpatients





Understanding the performance

The above metrics are measured on a rolling 3-month position, so September 2026 performance includes July, August and September 2026 performance.

Current performance continues to show an elevated and increasing mean length of stay of adult acute and Psychiatric Intensive Care Unit (PICU) patients in the Trust. In September 2026, the mean length of stay was 43.17 days, compared with the target of no more than 36.28 days. For comparison, nationally the length of stay was averaging approximately 48 days during June - August 2026 (latest published data). This is mainly driven by continuously elevated mean length of stay in Oxfordshire and an increase in Buckinghamshire in September 2026. Mean length of stay of older adult patients increased to 68.15 days in September 2026, slightly above the target of 66.98 days (nationally – 93 days in August 2026).

These trends continue to be 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 are 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.

Mental Health Services – Inpatients

Metric	Target	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Inappropriate mental health out of area placements – snapshot last day of month - Trust	<=6	0	0	2	7	7	14
Inappropriate mental health out of area placements – bed days in month - Trust (SE)	n/a	27	0	35	186	225	297

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 September 2026, adult inappropriate out of area placements for end of month snapshot position was 14 and in month inappropriate bed days were 297. Increase in both bed days and number of placements (snapshot position) is attributable to increase in Buckinghamshire. Contributory factor – short term closure of three beds on one of the Buckinghamshire wards due to a fire.

From April 2026 onwards, the reported position reflects a clarification and consistent application of the 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. The change in reported figures therefore reflects the application of the revised reporting criteria rather than a reduction in inappropriate out-of-area placements.
Performance graphs have been temporarily omitted while the rules within the Trust Online Business Intelligence (TOBI) platform are updated 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)

Short to medium term actions include:

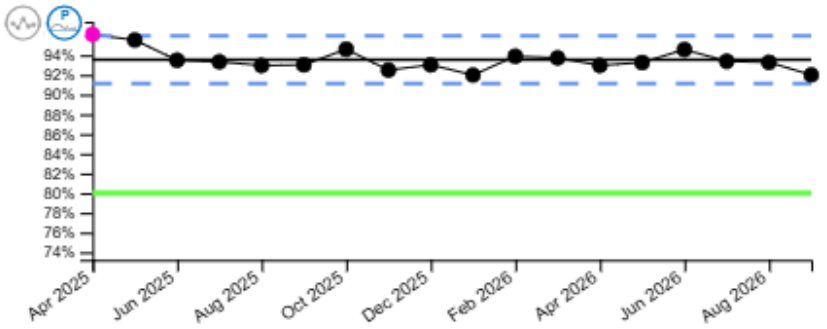
- Demand & Capacity exercise
- Options appraisal with regards to service re-design and improvement
- Further review of OAP governance to test the effectiveness of current controls, confirm escalation thresholds and agree required changes to decision making, reporting and assurance arrangements
- Setting of improvement trajectories and setting up weekly performance reviews

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

Adult acute and rehabilitation mental health, learning disability and autism discharges followed up within 72 hours (rolling 3 months) - Trust

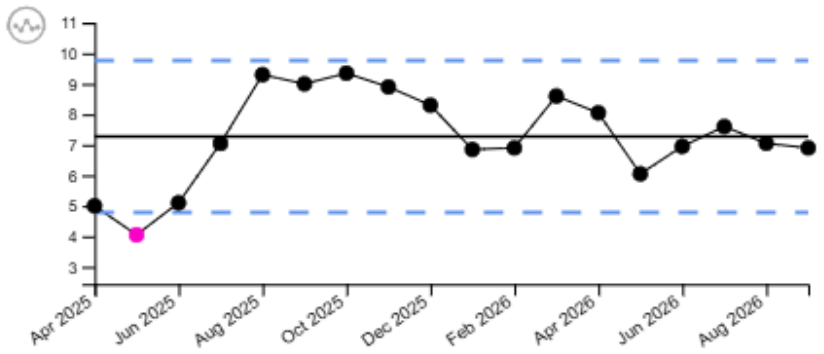


Target:
>=80%

Month Year	Value	Numerator	Denominator
Sep 2026	92.0 %	207	227

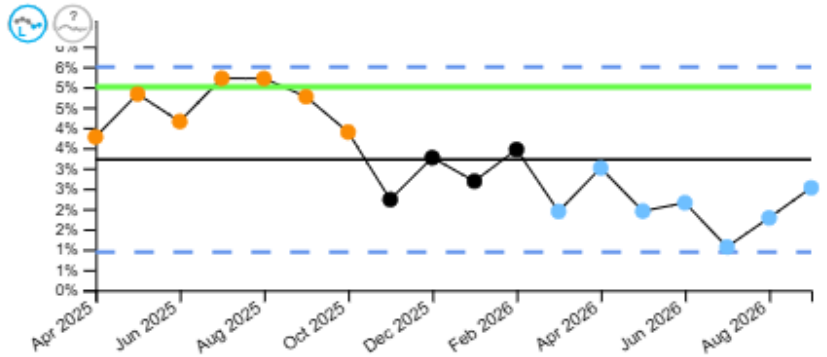
NOF

Average number of clinically ready for discharge patients per day - Trust



Month Year	Value
Sep 2026	6.9

Mental health 14-day readmission rate (rolling 3 months) - Trust

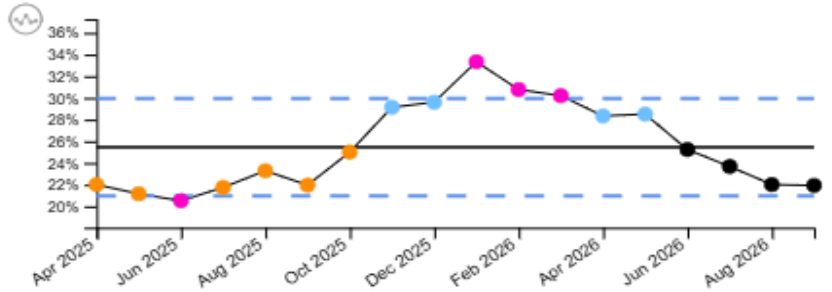


Target:
<=5%

Month Year	Value	Numerator	Denominator
Sep 2026	2.5 %	6	183

NOF

% of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service (reported as rolling 12 months) - Trust

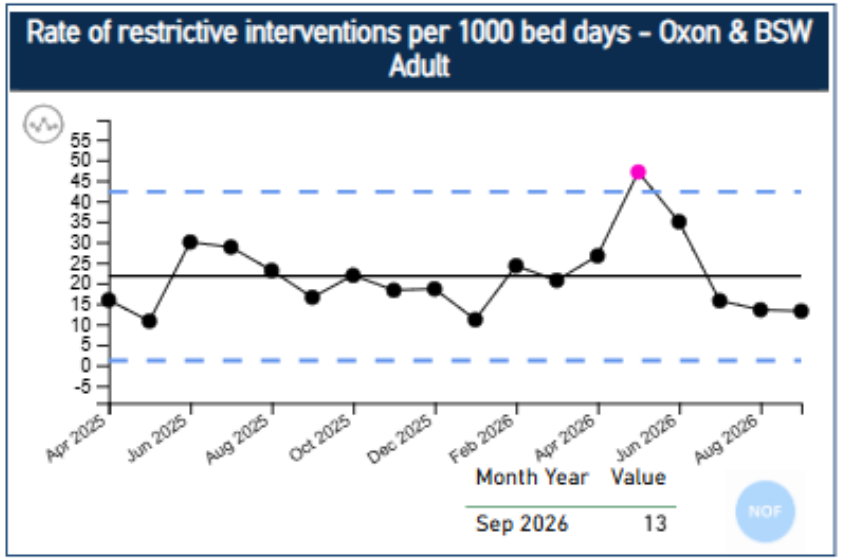


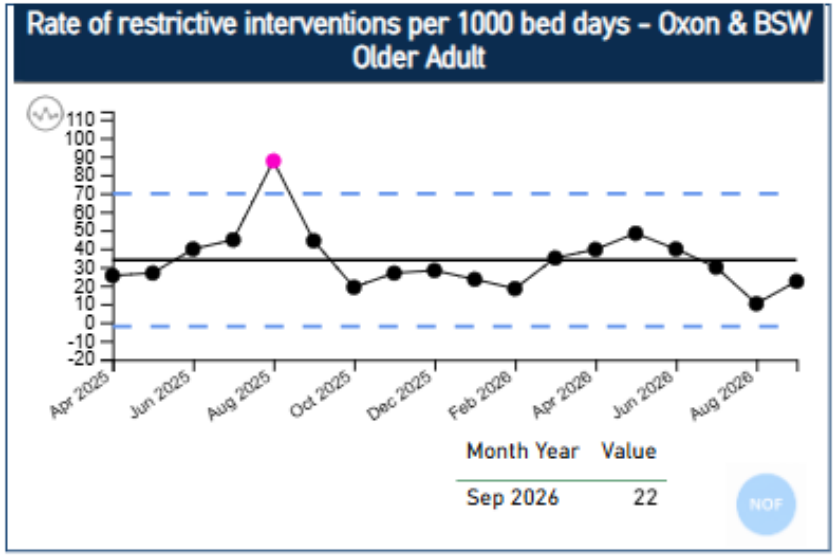
Month Year	Value	Numerator	Denominator
Sep 2026	21.92 %	57.0	260.0

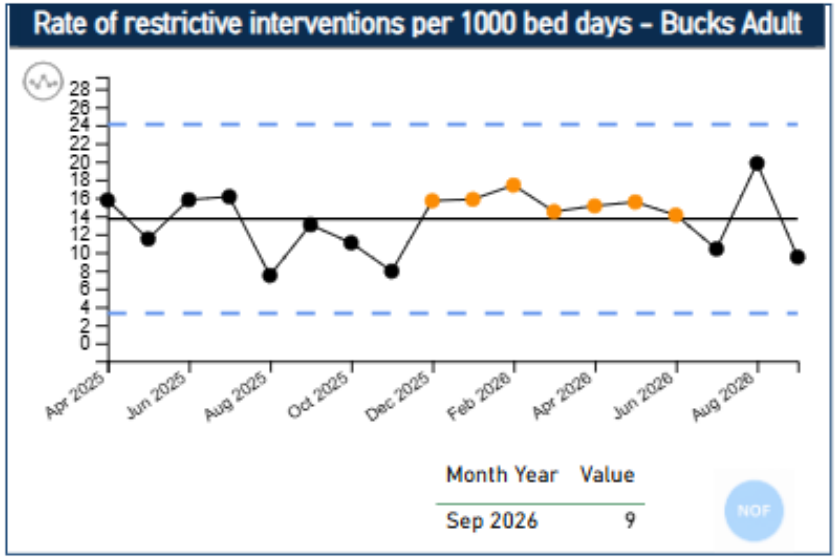
NOF

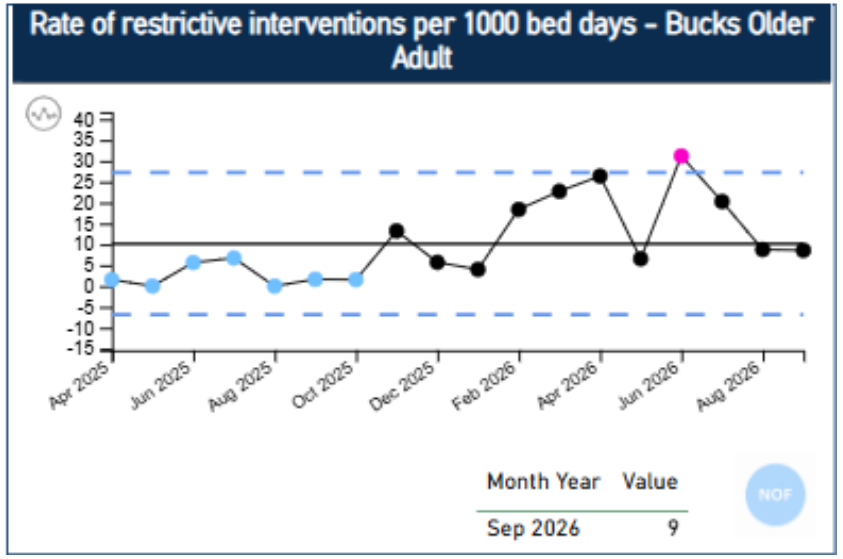
Mental Health Services – Inpatients – Quality - summary

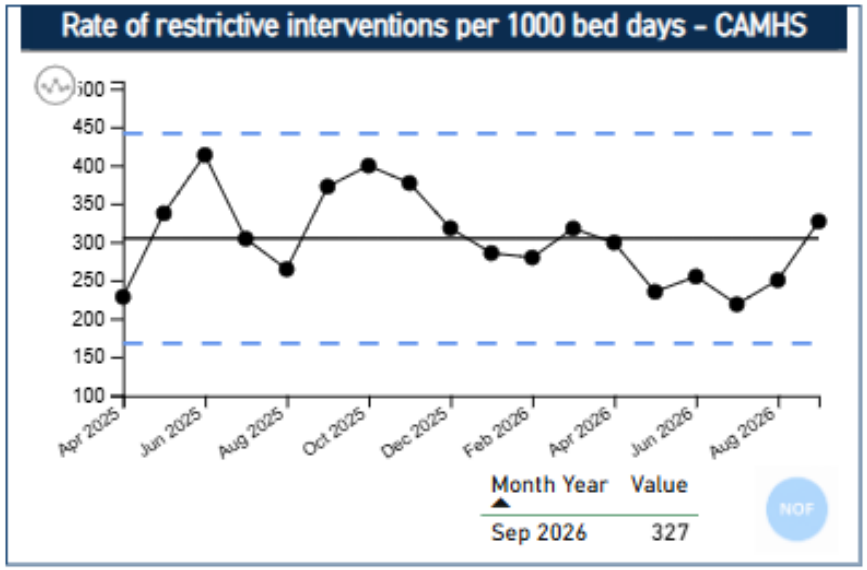
Type of metric	Service Area/Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National NOF 26/27 (contextual)	Rate of restrictive interventions per 1000 bed days – Oxon & BSW Adult	-	Sep-26	13		n/a	23
National NOF 26/27 (contextual)	Rate of restrictive interventions per 1000 bed days – Oxon & BSW Older Adult	-	Sep-26	22		n/a	35
National NOF 26/27 (contextual)	Rate of restrictive interventions per 1000 bed days – Bucks Adult	-	Sep-26	9		n/a	14
National NOF 26/27 (contextual)	Rate of restrictive interventions per 1000 bed days – Bucks Older Adult	-	Sep-26	9		n/a	10
National NOF 26/27 (contextual)	Rate of restrictive interventions per 1000 bed days – Child and Adolescent Mental Health (CAMHS)	-	Sep-26	327		n/a	310
National NOF 26/27 (contextual)	Rate of restrictive interventions per 1000 bed days – Forensic	-	Sep-26	6		n/a	9
National NOF 26/27 (contextual)	Rate of restrictive interventions per 1000 bed days – Eating Disorders (ED)	-	Sep-26	10		n/a	45
Local *Strategic - Quality*	Reduction in the use of prone restraints (number of incidents involving prone restraint) - CAMHS	-	Sep-26	4		n/a	7
Local *Strategic - Quality*	Reduction in the use of prone restraints (number of incidents involving prone restraint) - Forensic	-	Sep-26	0		n/a	1.5
Local *Strategic - Quality*	Reduction in the use of prone restraints (number of incidents involving prone restraint) – Bucks Adult and Older Adult	-	Sep-26	1		n/a	4
Local *Strategic - Quality*	Reduction in the use of prone restraints (number of incidents involving prone restraint) – Oxon & BSW Adult and Older Adult	-	Sep-26	0		n/a	2.5
Local *Strategic - Quality*	Reduction in the use of seclusion (includes seclusions on Ulysses & RiO) – Bucks Adult and Older Adult	Less than 137 in year / 11.4 per month	Sep-26	6			11.4
Local *Strategic - Quality*	Reduction in the use of seclusion (includes seclusions on Ulysses & RiO) – Oxon & BSW Adult and Older Adult	Less than 92 in year / 7.6 per month	Sep-26	3			10
Local *Strategic - Quality*	Reduction in the use of seclusion (includes seclusions on Ulysses & RiO) - Forensic	Less than 83 in year/ 6.9 per month	Sep-26	6			9
Local *Strategic - Quality*	Reduction in the use of seclusion (includes seclusions on Ulysses & RiO) - CAMHS	Less than 136 in year / 11.3 per month	Sep-26	36			15
Local	Total number of incidents involving physical restraint – Oxon & BSW Adult and Older Adult	-	Sep-26	47		n/a	75
Local	Total number of incidents involving physical restraint – Bucks Adult and Older Adult	-	Sep-26	17		n/a	23
Local	Total number of incidents involving physical restraint – CAMHS	-	Sep-26	176		n/a	210
Local	Total number of incidents involving physical restraint – Forensic	-	Sep-26	11		n/a	20
Local	Total number of incidents involving physical restraint – ED	-	Sep-26	5		n/a	25

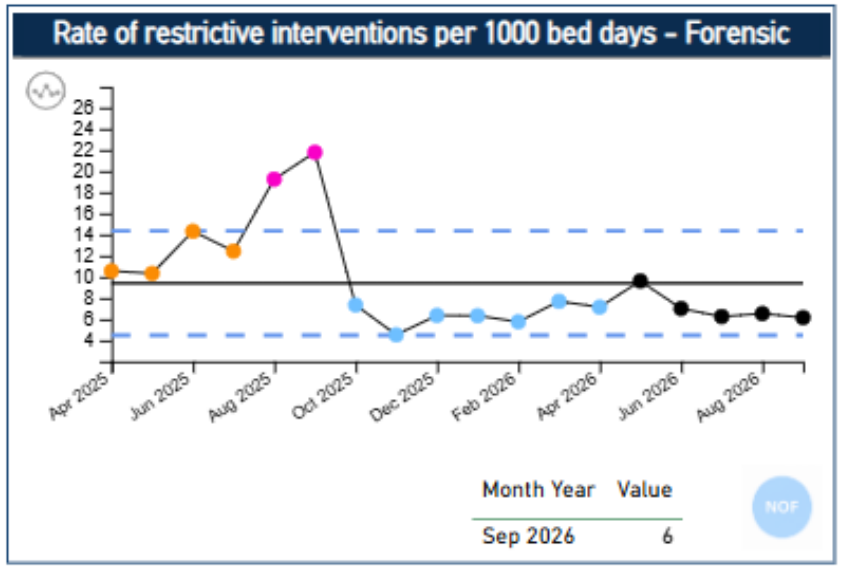

Rate of restrictive interventions per 1000 bed days - Oxon & BSW Adult
55
50
45
40
35
30
25
20
15
10
5
0
-5
Apr 2025
Jun 2025
Aug 2025
Oct 2025
Dec 2025
Feb 2026
Apr 2026
Jun 2026
Aug 2026
Month Year
Value
Sep 2026
13
NOF

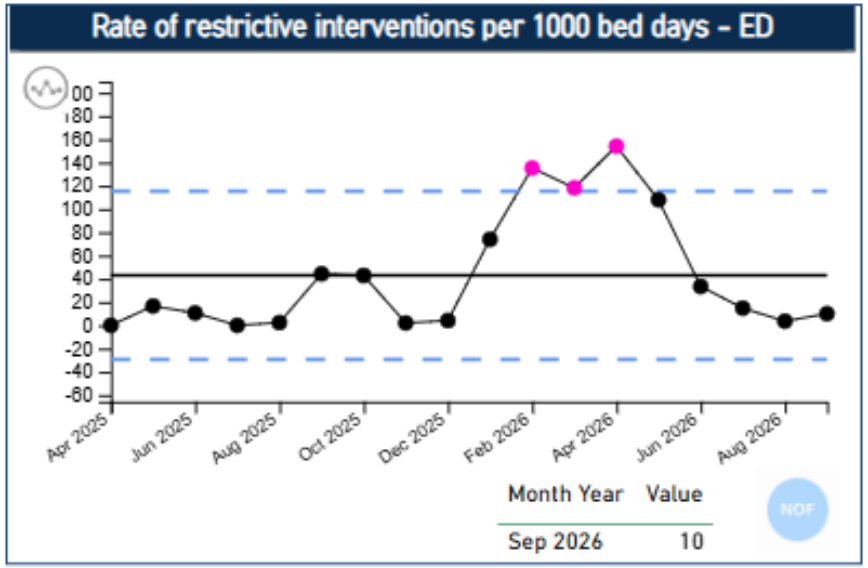

Rate of restrictive interventions per 1000 bed days - Oxon & BSW Older Adult
110
100
90
80
70
60
50
40
30
20
10
0
-10
-20
Apr 2025
Jun 2025
Aug 2025
Oct 2025
Dec 2025
Feb 2026
Apr 2026
Jun 2026
Aug 2026
Month Year
Value
Sep 2026
22
NOF


Rate of restrictive interventions per 1000 bed days - Bucks Adult
28
26
24
22
20
18
16
14
12
10
8
6
4
2
0
Apr 2025
Jun 2025
Aug 2025
Oct 2025
Dec 2025
Feb 2026
Apr 2026
Jun 2026
Aug 2026
Month Year
Value
Sep 2026
9
NOF

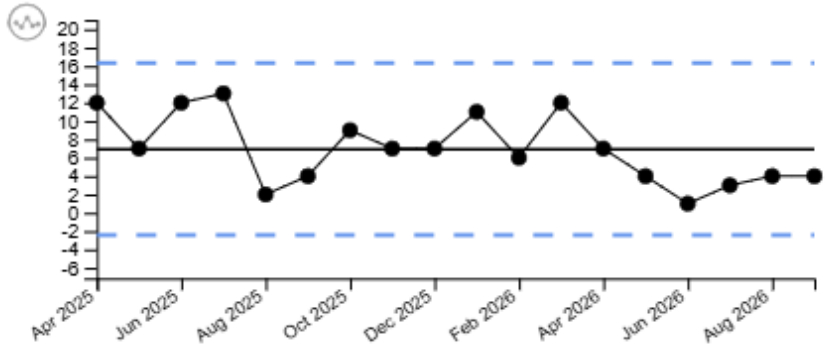

Rate of restrictive interventions per 1000 bed days - Bucks Older Adult
40
35
30
25
20
15
10
5
0
-5
-10
-15
Apr 2025
Jun 2025
Aug 2025
Oct 2025
Dec 2025
Feb 2026
Apr 2026
Jun 2026
Aug 2026
Month Year
Value
Sep 2026
9
NOF


Rate of restrictive interventions per 1000 bed days - CAMHS
500
450
400
350
300
250
200
150
100
Apr 2025
Jun 2025
Aug 2025
Oct 2025
Dec 2025
Feb 2026
Apr 2026
Jun 2026
Aug 2026
Month Year
Value
Sep 2026
327
NOF


Rate of restrictive interventions per 1000 bed days - Forensic
26
24
22
20
18
16
14
12
10
8
6
4
Apr 2025
Jun 2025
Aug 2025
Oct 2025
Dec 2025
Feb 2026
Apr 2026
Jun 2026
Aug 2026
Month Year
Value
Sep 2026
6
NOF

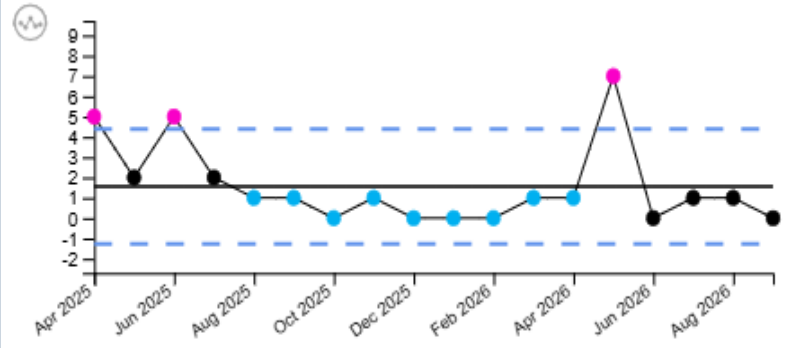

Rate of restrictive interventions per 1000 bed days - ED
200
180
160
140
120
100
80
60
40
20
0
-20
-40
-60
Apr 2025
Jun 2025
Aug 2025
Oct 2025
Dec 2025
Feb 2026
Apr 2026
Jun 2026
Aug 2026
Month Year
Value
Sep 2026
10
NOF

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



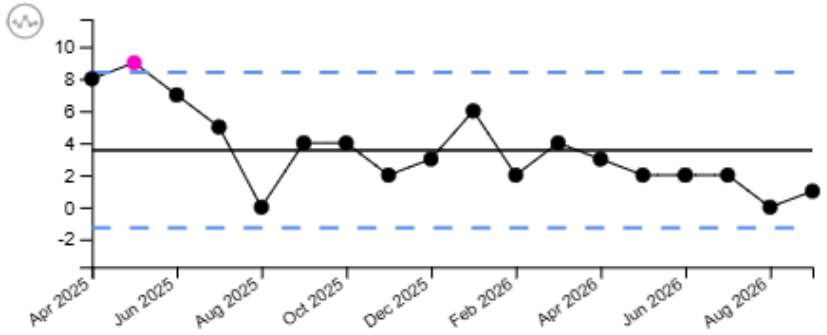
Month Year	Value	FYTD value
Sep 2026	4	23

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



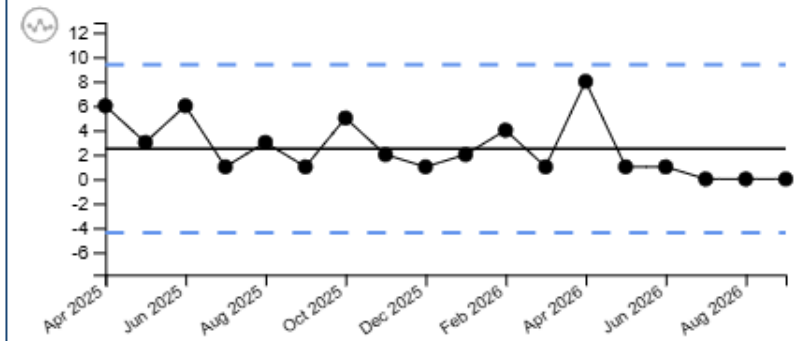
Month Year	Value	FYTD value
Sep 2026	0	10

Reduction in the use of prone restraints (number of incidents involving prone restraint) - Bucks Adult & Older Adult



Month Year	Value	FYTD value
Sep 2026	1	10

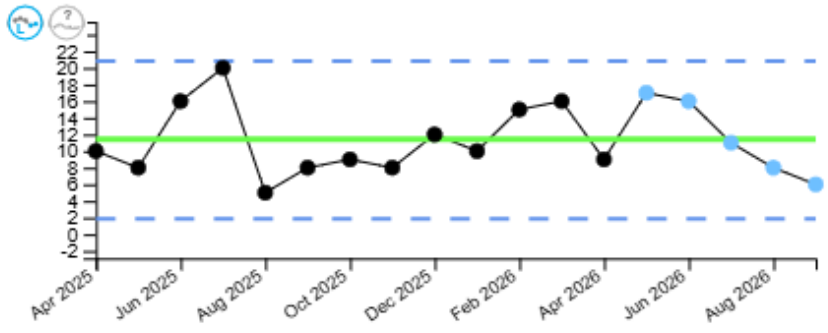
Reduction in the use of prone restraints (number of incidents involving prone restraint) - Oxon & BSW Adult & Older Adult



Month Year	Value	FYTD value
Sep 2026	0	10

Mental Health Services – Inpatients – Quality - appendices

Reduction in use of seclusion (includes seclusions on Ulysses & RiO) - Bucks Adult & Older Adult

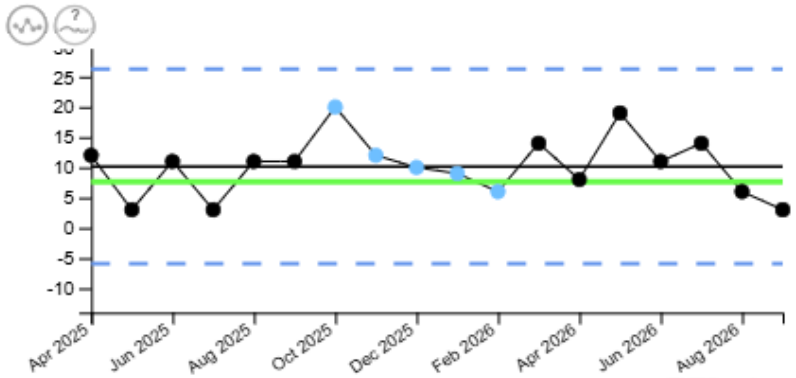


Target:
<=137 in year

Month Year	Value
Sep 2026	6

FYTD value
67

Reduction in use of seclusion (includes seclusions on Ulysses & RiO) - Oxon & BSW Adult & Older Adult

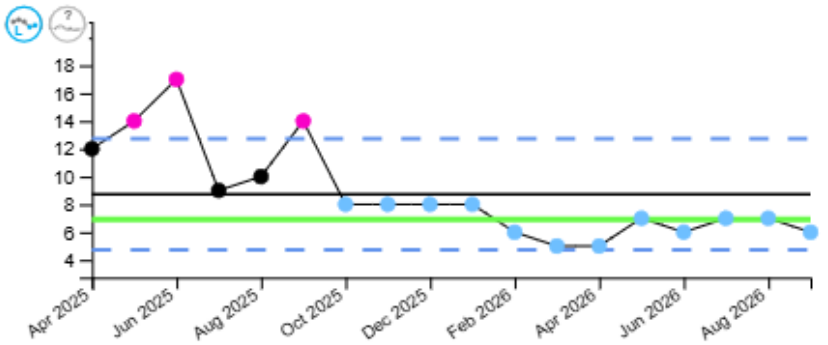


Target:
<=92 in year

Month Year	Value
Sep 2026	3

FYTD value
61

Reduction in use of seclusion (includes seclusions on Ulysses & RiO) - Forensic

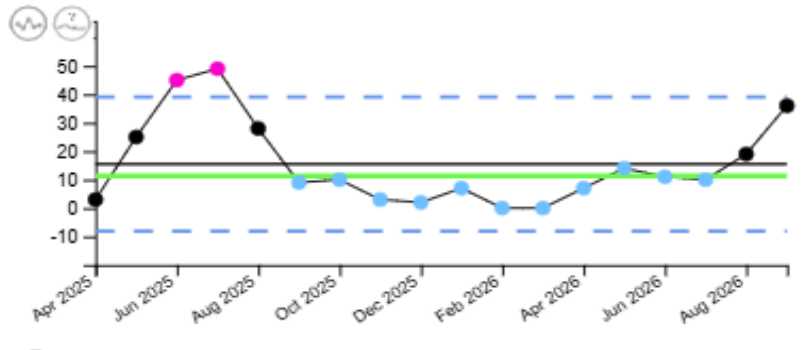


Target:
<= 83 in year

Month Year	Value
Sep 2026	6

FYTD value
38

Reduction in use of seclusion (includes seclusions on Ulysses & RiO) - CAMHS



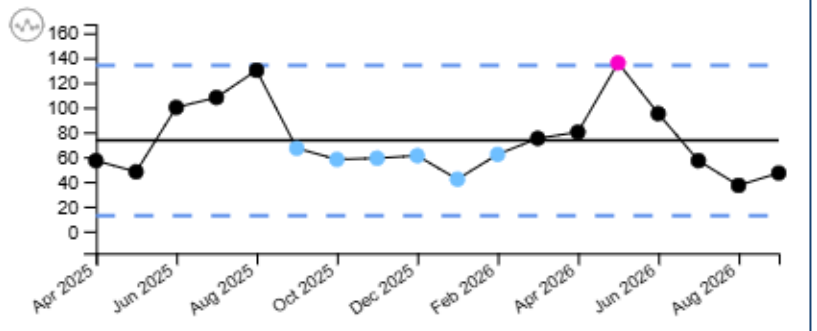
Target:
<=136 in year

Month Year	Value
Sep 2026	36

FYTD value
97

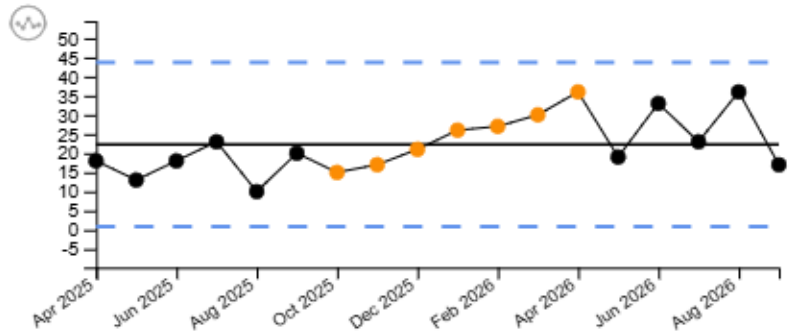
Mental Health Services – Inpatients – Quality - appendices

Total number of incidents involving physical restraint - Oxon & BSW Adult & Older Adult



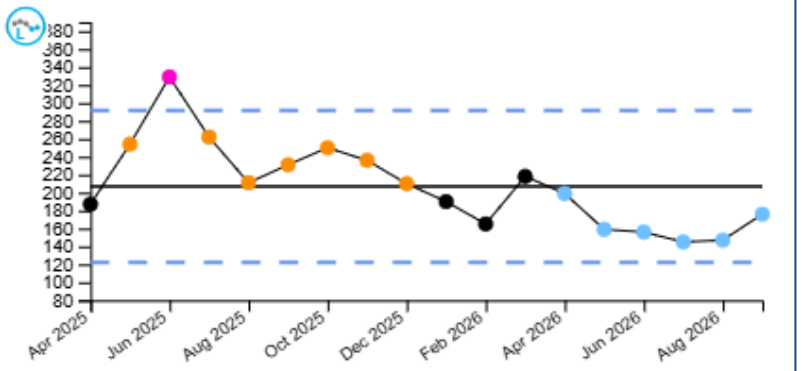
Month Year	Value
Sep 2026	47

Total number of incidents involving physical restraint - Bucks Adult & Older Adult



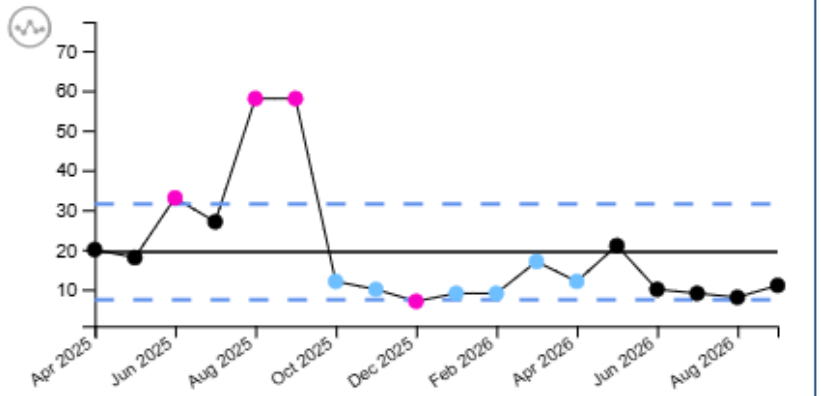
Month Year	Value
Sep 2026	17

Total number of incidents involving physical restraint - CAMHS



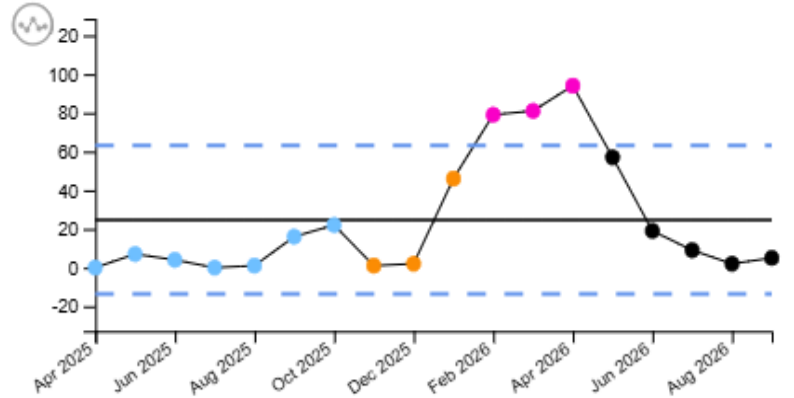
Month Year	Value
Sep 2026	176

Total number of incidents involving physical restraint - Forensic



Month Year	Value
Sep 2026	11

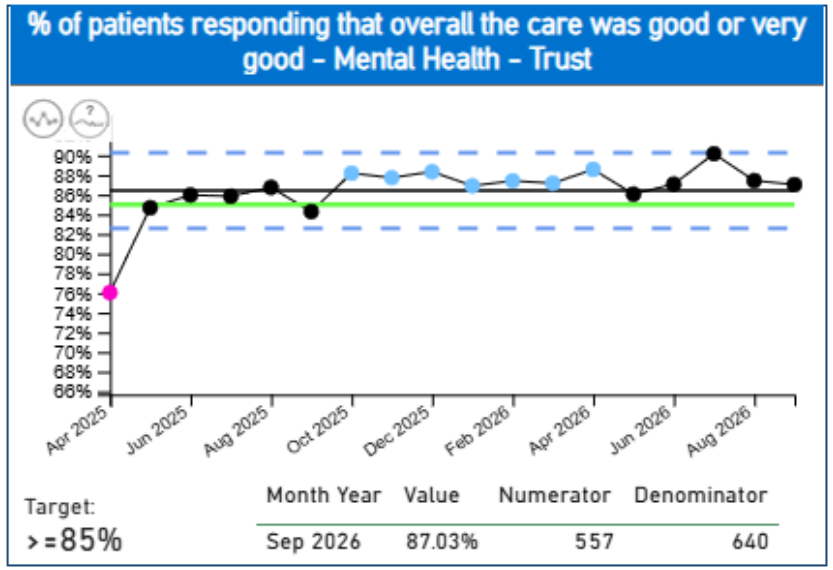
Total number of incidents involving physical restraint - ED

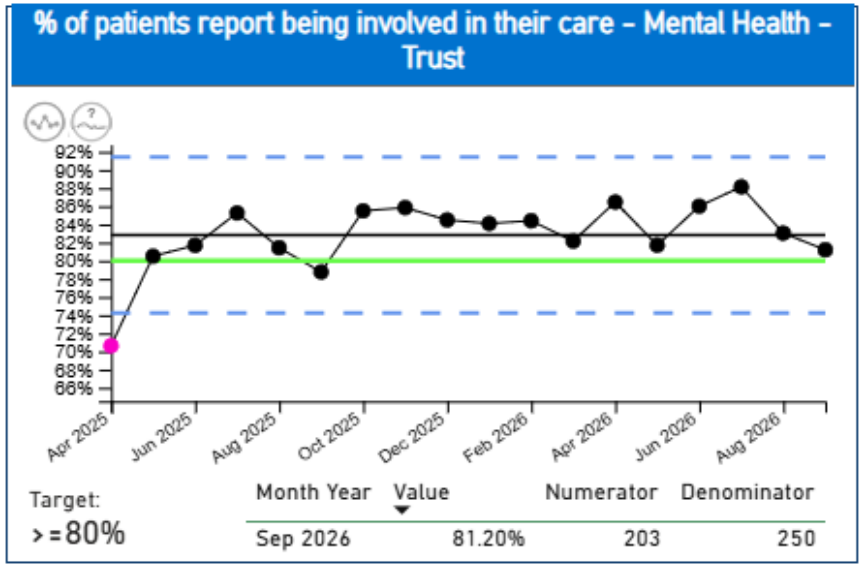


Month Year	Value
Sep 2026	5

Mental Health Services – Other

Type of metric	Service Area/Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
Strategic – Quality Local	% of patients responding that overall, the care was good or very good – Mental Health services	>=85%	Sep-26	87.03%			86.42%
Strategic – Quality Local	% of patients report being involved in their care – Mental Health services	>=80%	Sep-26	81.20%			82.85%





Oxford Health
NHS Foundation Trust

Section 2.2
Clinical performance (Community Health Services, Dentistry and Primary Care)

Community Health Services, Dentistry and Primary Care – grouping services

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 *(none of the metrics selected to be reported on IPR fall into this category)*	
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 *(none of the metrics selected to be reported on IPR fall into this category)*

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.

Community Health Services, Dentistry and Primary Care – Matrix

Assurance

Variation	P	?	F	No target
H / L		• Consistently meet or exceed the 70% 2-hour Urgent Community Response (UCR) standard	• **Healthy Child Programme - % of 2 to 2.5 year reviews completed**	
	• % of patients responding that overall care was good or very good • % of patients report being involved in their care • % of Minor Injury Unit patients seen within 4 hours • Community Dentistry - Proportion of patients accepted for care who are seen for an assessment within 12 weeks (Of those treated in period)	• % of out of hours palliative care referrals responded to within120 minutes: the time from completion of that triage call to the start of the home visit consultation was within 120 minutes • % of out of hours palliative care referrals responded to within 30 minutes: the time from receipt of the call from 111 to the start of the telephone consultation was 30 minutes • Healthy Child Programme - % of breastfeeding prevalence at 6 - 8 weeks old • Healthy Child Programme - % of 12-month development reviews completed by the time the child turned 12 months • Patients newly registered with the practice will have a holistic health assessment within 8 weeks of registering (Luther Street Medical Centre)	• **Healthy Child Programme - No. and % of families receiving a new birth visit within 14 days of birth** • **Healthy Child Programme - % of 6-8 week reviews completed**	• 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 • Percentage of intermediate care beds occupied by patients without criteria to reside
H / L				

Metrics are not included in the above matrix as the Making Data Count algorithm is not designed to account for targets that change on a monthly basis: Percentage and Number of patients waiting over 52 weeks for community services, 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.
Metrics which do not have enough data points to determine Variation & Assurance trends in line with Making Data Count are also not included in the above.

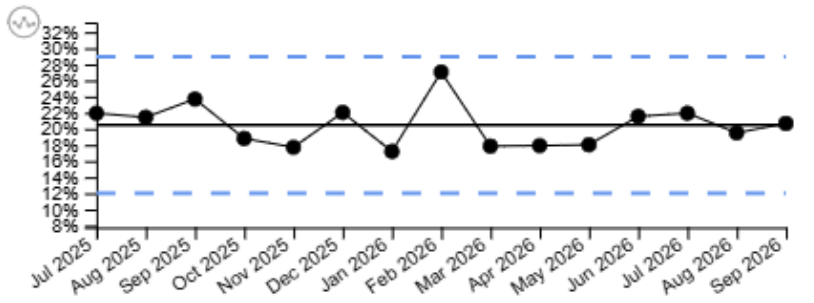
Community Health Services, Dentistry and Primary Care – Adults - summary

Adult Planned Care – community rehabilitation							
Type of metric	**Metric**	**Target**	**Latest reporting period**	**Measure**	**Variation**	**Assurance**	**Mean**
Local	Average number of Medically Optimised For Discharge (MOFD) patients per night	.	Sep-26	22.5		n/a	22
NOF 26/27 (scored)	Percentage of intermediate care beds occupied by patients without criteria to reside	.	Sep-26	20.67%		n/a	20.49%
Local	Average Length of Stay in Community Hospitals by basket of care – Rehab	.	Sep-26	30		n/a	29
Local	Average Length of Stay in Community Hospitals by basket of care - Stroke	.	Sep-26	55		n/a	42
Local	Average Length of Stay in Community Hospitals by basket of care - End of Life	.	Sep-26	0		n/a	12
Local	Average Length of Stay in Community Hospitals by basket of care – EMU (Emergency Multidisciplinary Unit)	.	Sep-26	11		n/a	11

Adult Reactive Care – palliative care and end of life care							
Type of metric	**Metric**	**Target**	**Latest reporting period**	**Measure**	**Variation**	**Assurance**	**Mean**
Local *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%	Sep-26	97.96%			95.01%
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%	Sep-26	93.88%			91.36%

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%	Sep-26	98.46%			86.88%

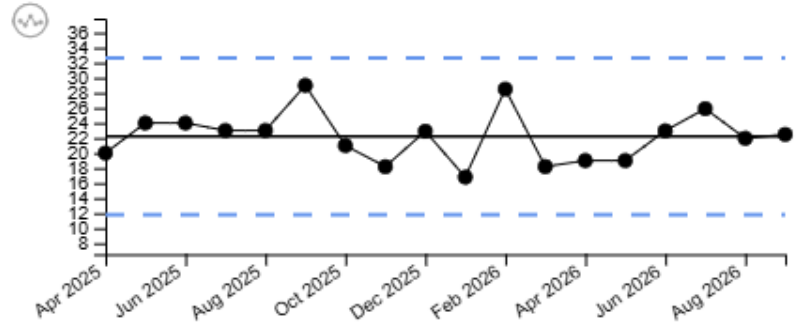
% of intermediate care beds occupied by patients without criteria to reside



Month Year	Value
Sep 2026	20.67 %

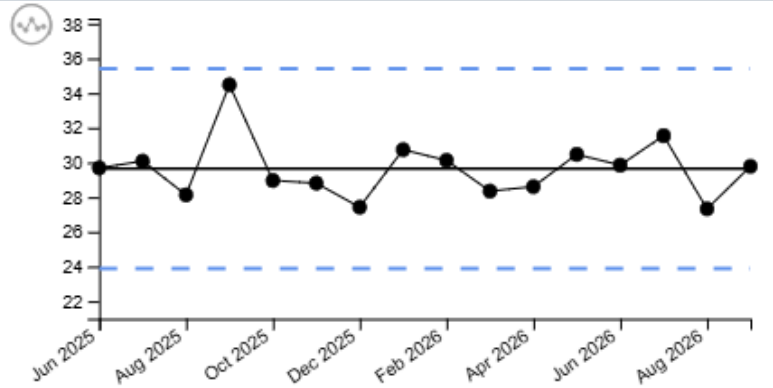
NOF

Average number of Medically Optimised for Discharge patients per night



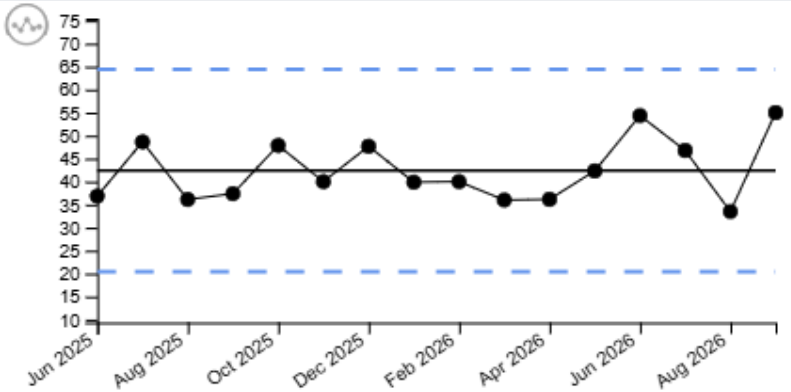
Month Year	Value
Sep 2026	22.5

LOS by basket of care - Rehab



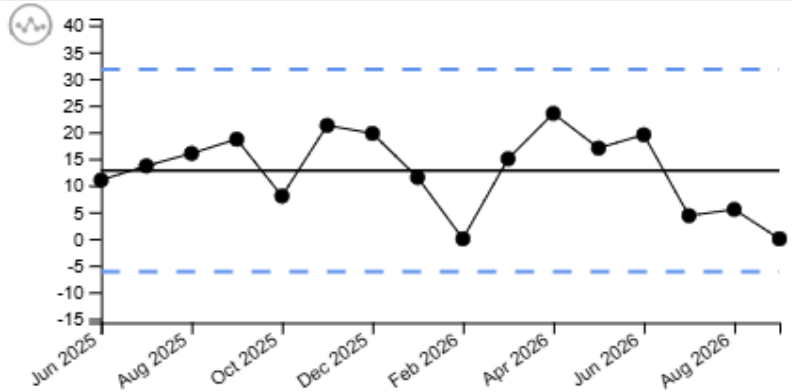
Month Year	Value
Sep 2026	30

LOS by basket of care - Stroke



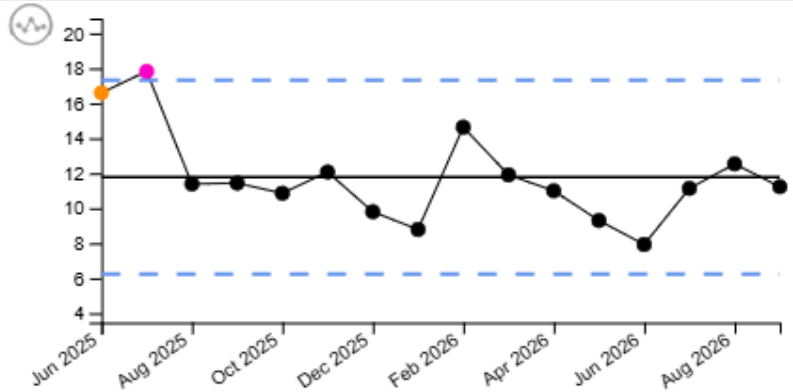
Month Year	Value
Sep 2026	55

LOS by basket of care - End of life



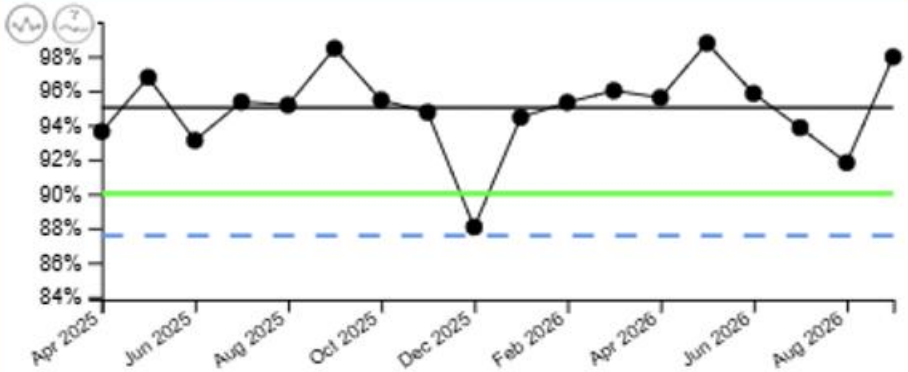
Month Year	Value
Sep 2026	0

LOS by basket of care - EMU



Month Year	Value
Sep 2026	11

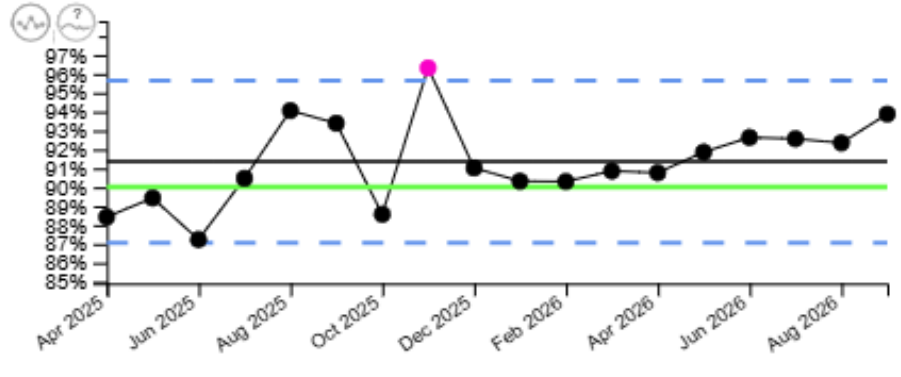
% of out of hours palliative care referrals responded to within 30 mins: the time from receipt of the call from 111 to the start of the telephone consultation was within 30 mins



Target: >=90%

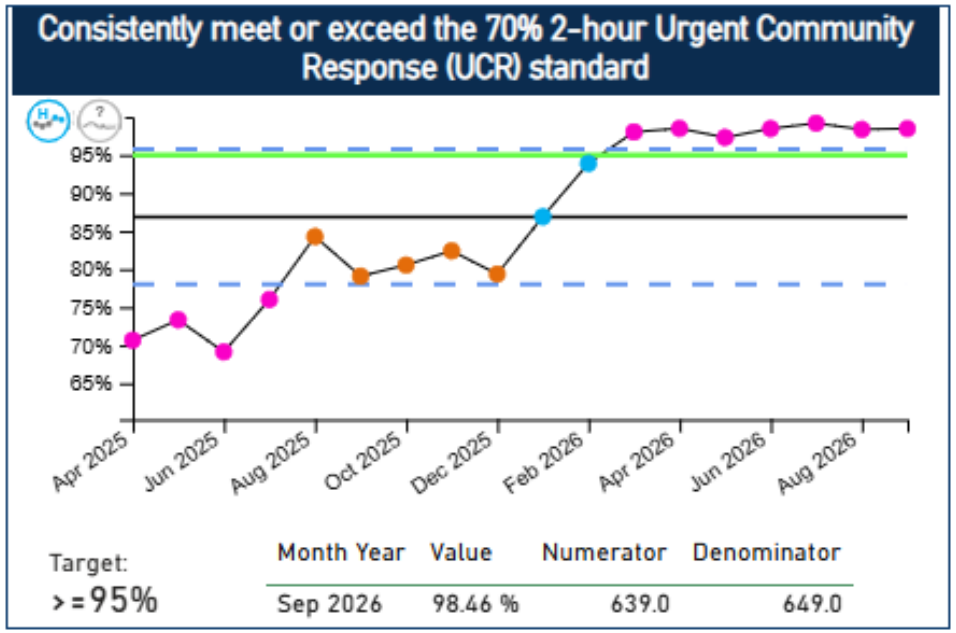
Month Year	Value	Numerator	Denominator
Sep 2026	97.96 %	48.0	49.0

% of out of hours palliative care referrals responded to within 120 mins: the time from completion of that triage call to the start of the home visit consultation was within 120 mins



Target: >=90%

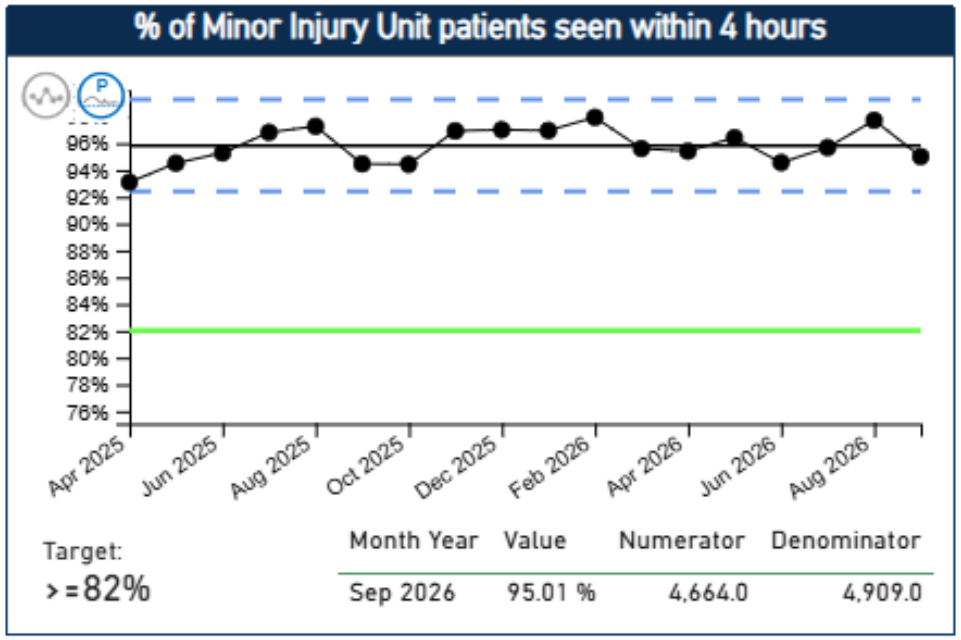
Month Year	Value	Numerator	Denominator
Sep 2026	93.88 %	138.0	147.0

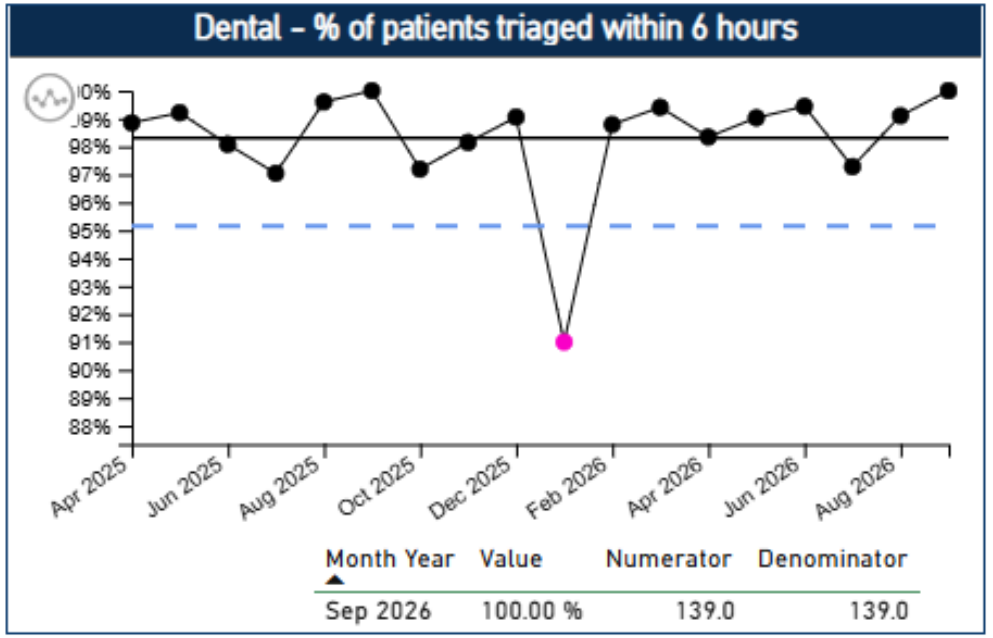


To note: target increased from 70% to 95% in April 2026.

Community Health Services, Dentistry and Primary Care – Adult and Children and Young People reactive care - urgent care summary

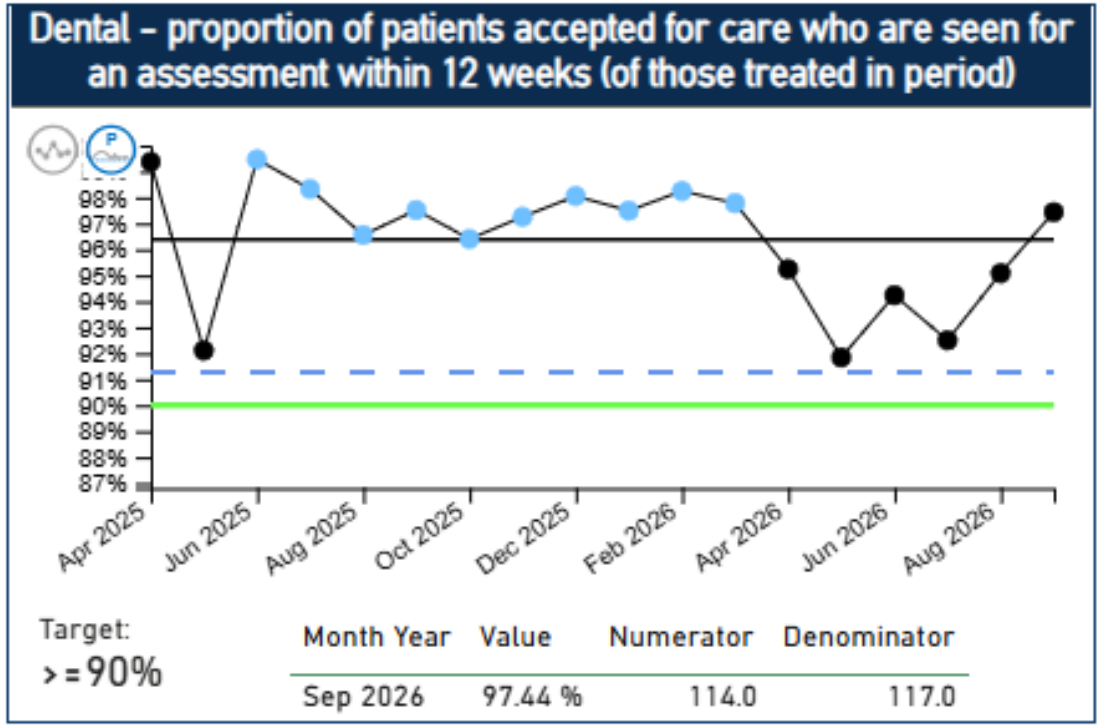
Type of metric	Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National	% of Minor Injury Unit patients seen within 4 hours	>=82%	Sep-26	95.01%		P	95.84%
National	Emergency Dental Service Waiting times to triage - % Patients triaged within 6 hours	.	Sep-26	100%		n/a	98.31%





Community Health Services, Dentistry and Primary Care – Adult and Children and Young People – planned episodic/specialist care - summary

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%	Sep-26	97.44%			96.38%

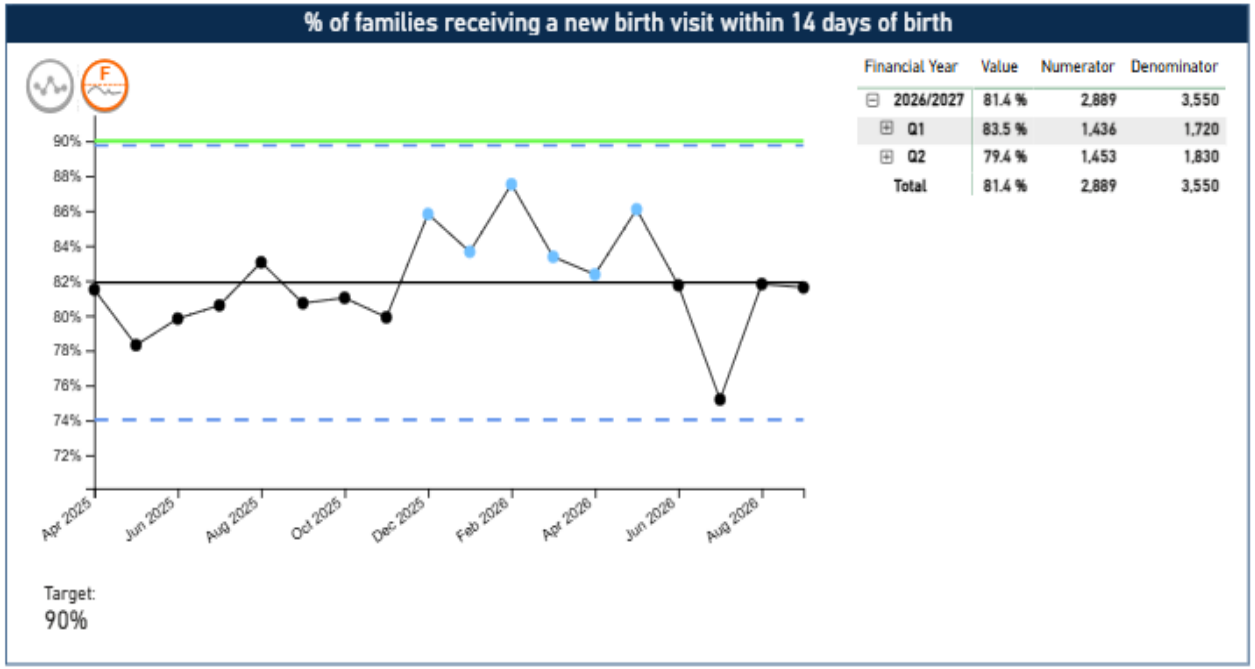


Community Health Services, Dentistry and Primary Care – Children and Young People Planned Care (Specialist, including management of long-term conditions) – summary

S T P

Type of metric	Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
Strategic – Quality National	% of breastfeeding prevalence at 6 - 8 weeks old	>=60%	Sep-26	62.70%			63.42%
National	Healthy Child Programme - No. and % of families receiving a new birth visit within 14 days of birth	>=90%	Q2	79.40%		F	81.89%
National	Healthy Child Programme - % of 6–8-week reviews completed	>=93%	Q2	84.80%		F	84.61%
National	Healthy Child Programme - % of 12-month development reviews completed by the time the child turned 12 months	>=90%	Q2	87.30%			85.82%
National	Healthy Child Programme - % of 2-to-2.5-year reviews completed	>=90%	Q2	84.90%	H	F	82.88%

Community Health Services, Dentistry and Primary Care – Children and Young People Planned Care (Specialist, including management of long-term conditions)



Financial Year	Value	Numerator	Denominator
2026/2027	81.4 %	2,889	3,550
Q1	83.5 %	1,436	1,720
Q2	79.4 %	1,453	1,830
Total	81.4 %	2,889	3,550

Understanding the performance

The metric measures how many newborns receive their first home or in-person contact within 14 days of birth on a quarterly basis – a critical period where feeding issues, postnatal mental health concerns, safeguarding risks and medical deterioration typically emerge.

In quarter two, the Service completed 79.4% of the new birth visits within the statutory timeframe. Typical reasons why the review is not being completed by day 14 include: parental choice, baby or mother still in hospital, parents staying with relatives out of county. On occasion, target dates may be exceeded to preserve continuity of care, where this reflects the best clinical decision. This approach has been agreed in principle with commissioners. Although part-time working can result in short delays, maintaining practitioner continuity supports stronger relationships and improved outcomes for families. The team continues to offer and deliver the reviews even if they are after the 14-day target timeline. As the midwife is the lead healthcare professional until newborns are 28 days old, it means that families continue to be supported even if the new birth visit is not completed within the timeframe by a health visitor.

For information, national annual financial year 2025 - 2026 (latest available data published by Office for Health Improvement and Disparities (OHID)) performance was at 85.5%.

Actions (SMART)

- The team continues to follow-up any declines for this appointment by telephone and confirm genuine reasons for decline, such as the mother or baby still being in hospital or parents staying with relatives out of county.
- Even if there has been a decline for the visit scheduled at 14 days after birth, the team offer includes other contacts shortly after (6-to-8-week visits). In addition, there are other more informal routes to contact the team such as weekly weigh-in and infant feeding clinics or via the text messaging service Chat Health Parent line.
- The service uses a system that automatically reminds families of upcoming appointments, with the aim to reduce the number of missed appointments.
- Meeting with commissioners quarterly to scrutinise performance

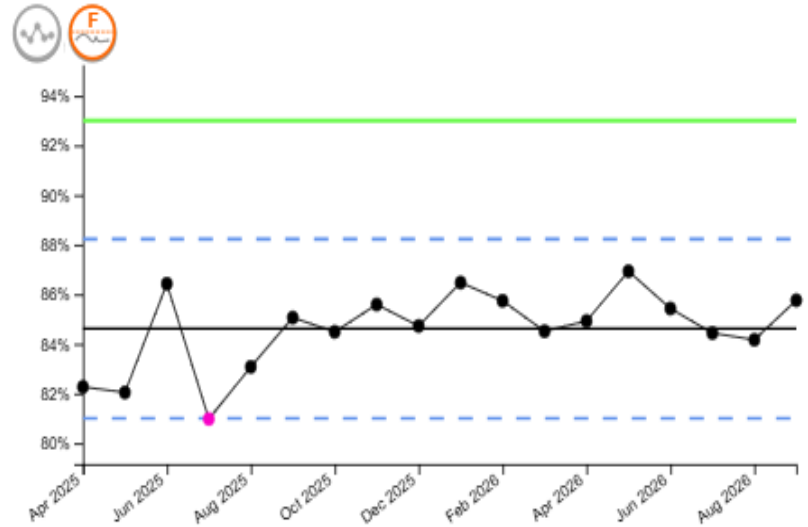
Risks

Physical, mental, emotional or developmental issues may go unnoticed potentially leading to unmet needs, delayed treatment and intervention, and worsening of pre-existing conditions.

Without a timely review, safeguarding concerns may not be identified early and put the child at risk until the next review scheduled at 6 to 8 weeks after birth. This is mitigated in cases when the midwifery team in the acute trust is still visiting the families at day 14. Any vulnerable factors identified by the midwifery team are communicated to the health visiting team.

Community Health Services, Dentistry and Primary Care – Children and Young People Planned Care (Specialist, including management of long-term conditions)

% of 6-8 week reviews completed



Target:
93%

Financial Year	Value	Numerator	Denominator
2026/2027	85.3 %	3,019	3,541
Q1	85.8 %	1,477	1,722
Q2	84.8 %	1,542	1,819
Total	85.3 %	3,019	3,541

Understanding the performance

The 6–8-week review is a universal health check offered to all babies in England, carried out by a health visitor. The metric tracks the percentage of eligible babies who received this review within the designated time window (between 6 and 8 weeks after birth), monitored on a quarterly basis. Performance against this metric is within expected statistical range, however, is consistently under the target.

In quarter two, the team completed 84.8% of the 6-to-8-week reviews within the timeframe. On occasion, target dates may be exceeded to preserve continuity of care, where this reflects the best clinical decision. This approach has been agreed in principle with commissioners. Although part-time working can result in short delays, maintaining practitioner continuity supports stronger relationships and improved outcomes for families. The team continues to offer and deliver the reviews even if they are slightly before or after the target timeline. Declined (patient choice) or missed appointments are not excluded from the count. If the latter are excluded, the performance would then be at 97.2% for quarter two. The service has a follow up policy which ensures any family who Did Not Attend (DNA) or declined the appointment, are offered further appointments and that a review of the records take place to ensure that any safeguarding concerns are addressed.

For information, national annual financial year 2025 - 2026 (latest available data published by Office for Health Improvement and Disparities (OHID)) performance was at 86.5%.

Actions (SMART)

- There are other more informal routes to contact the team such as weekly weigh-in and infant feeding clinics or the text messaging service Chat Health Parent line. Also, all new babies are invited to attend an Early Days health promotional sessions which take place between 12- to 20-weeks after birth.
- The service uses a system that automatically reminds families of upcoming appointments, with the aim to reduce the number of missed appointments.
- On-going work to improve data quality
- Regular deep dives into DNA or declined appointments to identify any themes that could be addressed
- Meeting with commissioners quarterly to scrutinise performance

Risks

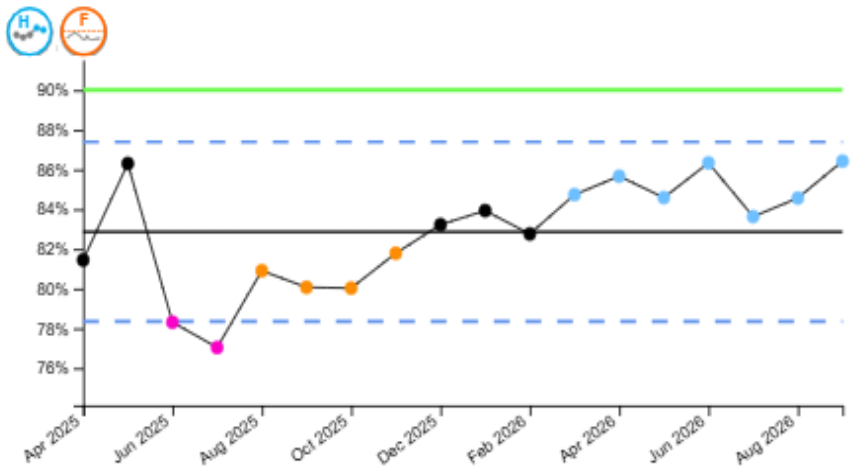
Physical, mental, emotional or developmental issues may go unnoticed potentially leading to unmet needs, delayed treatment and intervention, and worsening of pre-existing conditions.

Without a timely review, safeguarding concerns may not be identified early and put the child at risk until the 12-months review.

Community Health Services, Dentistry and Primary Care – Children and Young People Planned Care (Specialist, including management of long-term conditions)

S T P

% of 2 to 2.5 year reviews completed



Financial Year	Value	Numerator	Denominator
2026/2027	85.2 %	3,080	3,614
Q1	85.6 %	1,575	1,841
Q2	84.9 %	1,505	1,773
Total	85.2 %	3,080	3,614

Target:
90%

Understanding the performance

This metric records the proportion of children aged between 2 and 2½ years who received their developmental review within this timeframe. The review is typically delivered by health visitors or early years public health nurses. Performance is monitored on a quarterly basis and is within expected statistical range, however - consistently under the target.

In quarter two, the team completed 84.9% of the 2- to 2½ -year developmental reviews within the timeframe. Performance is mainly affected by declined or missed appointments. The team continues to offer and deliver the reviews even if they are slightly before or after the target timeline. The team continues to offer and deliver the reviews even if they are slightly before or after the target timeline. Declined (patient choice) or missed appointments are not excluded from the count. If the latter were excluded, the performance would then be at 97.4% for quarter two.

For information, national annual financial year 2025 - 2026 (latest available data published by Office for Health Improvement and Disparities (OHID) performance was at 81.3%.

Actions (SMART)

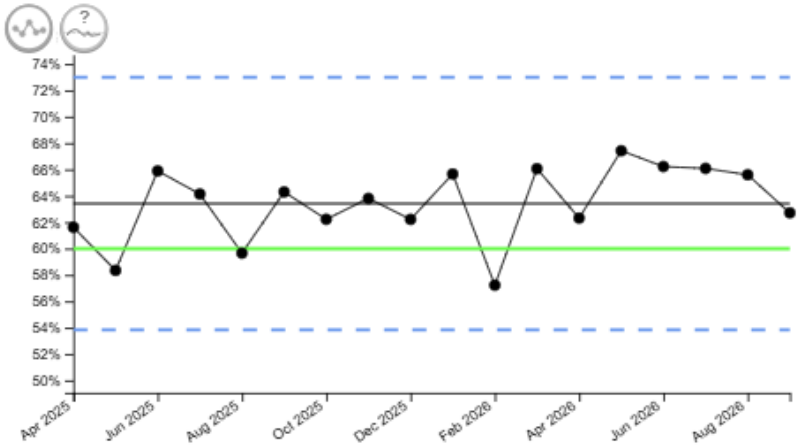
- The service uses a system that automatically reminds families of upcoming appointments, with the aim to reduce the number of missed appointments.
- There are other more informal routes to contact the team such as weekly weigh-in and infant feeding clinics or the text messaging service Chat Health Parent line.
- Meeting with commissioners quarterly to scrutinise performance

Risks

Physical, mental, emotional or developmental issues may go unnoticed potentially leading to unmet needs, delayed treatment and intervention, and worsening of pre-existing conditions.

Without a timely review, safeguarding concerns may not be identified early and put the child at risk until their 4-year review.

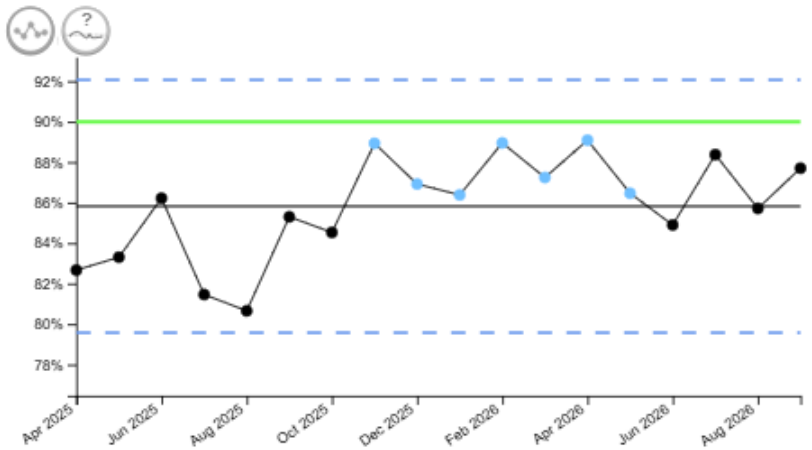
% of breastfeeding prevalence at 6-8 weeks



Target:
60%

Financial Year	Value	Numerator	Denominaor
2026/2027	65.1 %	2,305	3,541
Q1	65.4 %	1,126	1,722
Apr	62.3 %	339	544
May	67.4 %	387	574
Jun	66.2 %	400	604
Q2	64.8 %	1,179	1,819
Jul	66.1 %	378	572
Aug	65.6 %	431	657
Sep	62.7 %	370	590
Total	65.1 %	2,305	3,541

% of 12-month development reviews completed by the time the child turned 12 months



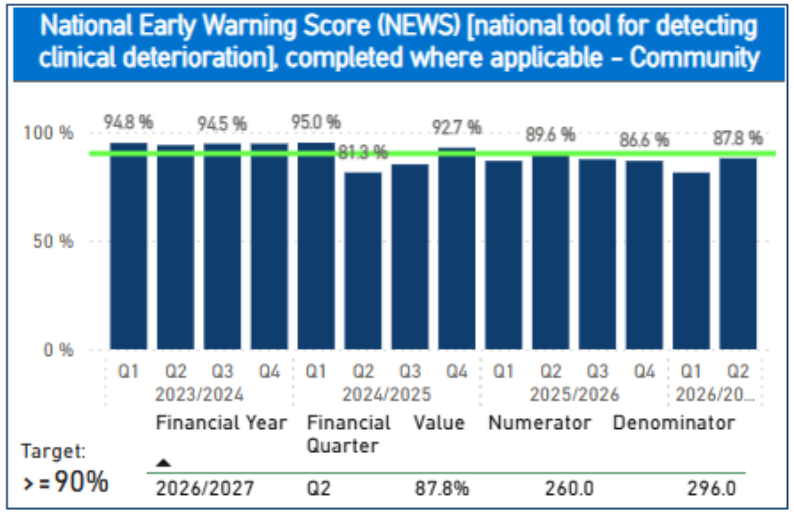
Target:
90%

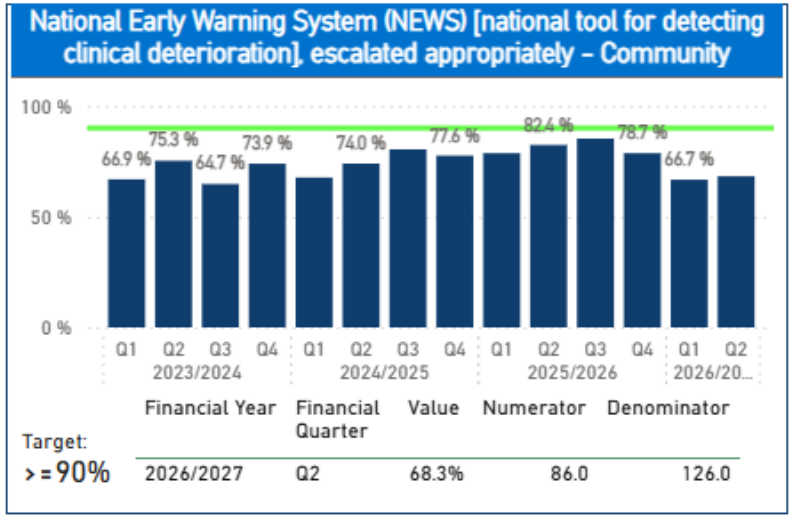
Financial Year	Value	Numerator	Denominator
2026/2027	87.0 %	3,104	3,566
Q1	86.8 %	1,538	1,772
Q2	87.3 %	1,566	1,794
Total	87.0 %	3,104	3,566

Community Health Services, Dentistry and Primary Care – Other

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%	Sep-26	94.11%		P	94.22%
Strategic - Quality	% of patients report being involved in their care	>=85%	Sep-26	92.29%		P	92.49%
National NOF (scored)	Percentage of patients waiting over 52 weeks for community services (CYP and Adults combined)	<=13.02%	Sep-26	6.94%	L	n/a	16.77%
National NOF (scored)	Percentage of patients waiting over 52 weeks for community services (Adults)	<=10.41%	Sep-26	7.94%	L	n/a	9.95%
National NOF (scored)	Percentage of patients waiting over 52 weeks for community services (CYP)	<=18.76%	Sep-26	3.32%	L	n/a	31.67%
Local	Number of people on waiting list for Community services who are waiting over 52 weeks (adults and CYP combined)	<=783	Sep-26	395	n/a	n/a	.
Local	Number of patients waiting over 52 weeks for community services (Adults)	<=430	Sep-26	354	n/a	n/a	.
Local	Number of people on waiting lists for Community Children and Young People services who are waiting over 52 weeks	<=353	Sep-26	41	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)	>=60%	Sep-26	61.92%	H	n/a	54.42%
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)	>=63%	Sep-26	68.78%	H	n/a	64.27%
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)	>=54%	Sep-26	37.12%	H	n/a	31.65%
Local Strategic - Quality	National Early Warning System (NEWS - national tool for detecting clinical deterioration) escalated appropriately	>=90%	Q2	68.30%	n/a	n/a	74.30%
Local Strategic - Quality	National Early Warning System (NEWS - national tool for detecting clinical deterioration) completed where applicable	>=90%	Q2	87.80%	n/a	n/a	89.36%
Local	Patients newly registered with the practice will have a holistic health assessment within 8 weeks of registering (Luther Street Medical Centre)	>=80%	Q2	100%		?	82.73%

Community Health Services, Dentistry and Primary Care – Other





Understanding the performance & Actions

The National Early Warning Score (NEWS2) is a standardised clinical assessment tool used to identify patients at risk of clinical deterioration through monitoring physiological observations, including respiratory rate, oxygen saturation, blood pressure, pulse, temperature and level of consciousness. The two indicators above measure different, but equally important aspects of patient safety:

- NEWS2 completed where applicable measures whether patients receive the appropriate physiological observations and NEWS2 assessments to support the early identification of deterioration.
- NEWS2 escalated appropriately: Measures whether identified signs of deterioration result in timely and appropriate clinical escalation and response

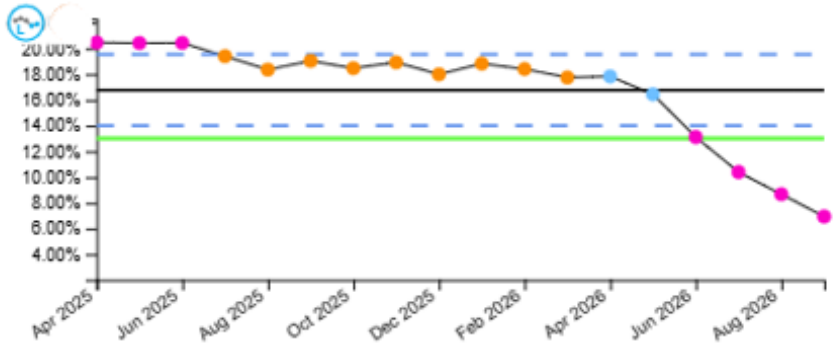
In quarter two, compliance with NEWS2 completion was 87.8%, while appropriate escalation of patients showing signs of deterioration was 68.25%. Although both indicators remained below the 90% target, performance improved compared with Quarter 1. Performance is measured by the Audit Team using data recorded on the Audit Management and Tracking (AMaT) system across three service lines. Ambulatory Care and District Nursing achieved the 90% target for both indicators during Quarter 2. However, challenges remain within Community Rehabilitation, where NEWS2 completion compliance was 83% (187 assessments audited) and appropriate escalation compliance was 55% (87 escalation episodes audited).
An internal audit of Community Rehabilitation records was undertaken to identify the underlying causes of underperformance. Initial findings highlighted variation in NEWS2 scoring accuracy, adherence to escalation processes and clinical documentation. The audit also identified areas of good practice, including established routine monitoring and positive staff engagement.

Improvement actions are being progressed through an ongoing quality improvement programme within Community Hospitals. These include targeted staff training, reinforcement of escalation requirements, ward-level performance feedback and follow-up spot checks scheduled for November 2026 to assess progress and provide assurance of sustained improvement.

Risks

Low compliance with NEWS2 completion and appropriate escalation increases the risk of delayed recognition and management of clinical deterioration, potentially resulting in avoidable patient harm, cardiac arrests and increased mortality. Failure to consistently monitor and escalate deteriorating patients may lead to missed opportunities for timely intervention, poorer clinical outcomes and increased demand for critical care services. Inconsistent adherence to NEWS2 protocols also presents risks to patient safety, clinical governance and regulatory compliance, potentially resulting in serious incidents, reputational damage.

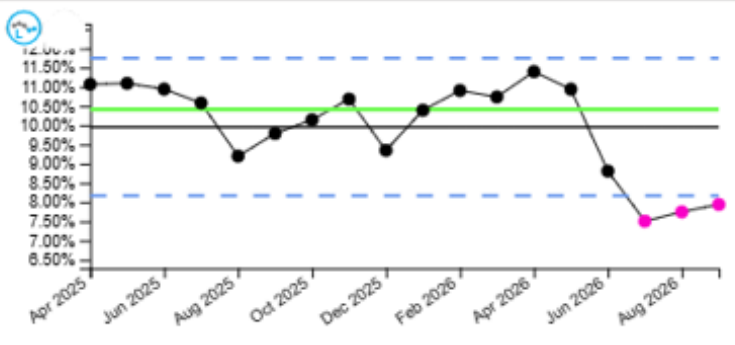
% of patients waiting over 52+ weeks (Adult & CYP)



Target:	Month Year	Value	Numerator	Denominator
<=13.02%	Sep 2026	6.94 %	395	5,693

NOF

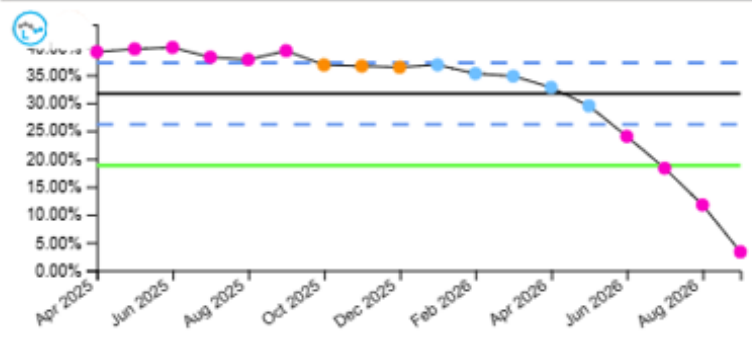
% of patients waiting over 52+ weeks (Adult)



Target:	Month Year	Value	Numerator	Denominator
<=10.41%	Sep 2026	7.94 %	354	4,459

NOF

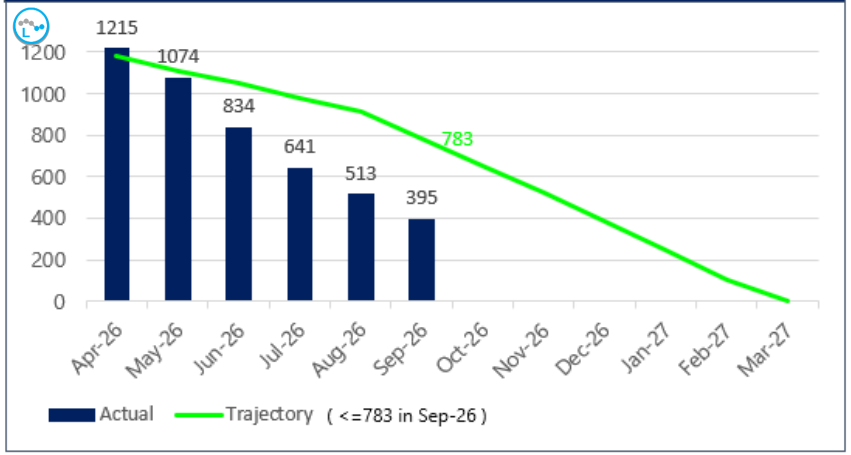
% of patients waiting over 52+ weeks (CYP)



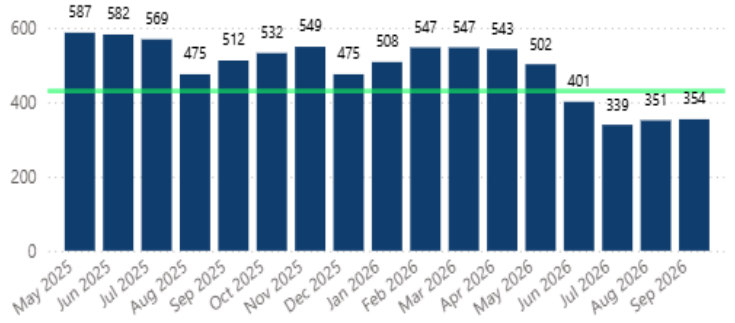
Target:	Month Year	Value	Numerator	Denominator
<=18.76%	Sep 2026	3.32 %	41	1,234

NOF

Number of community patients waiting over 52 weeks (adults and CYP combined) - Trajectory vs Actual performance

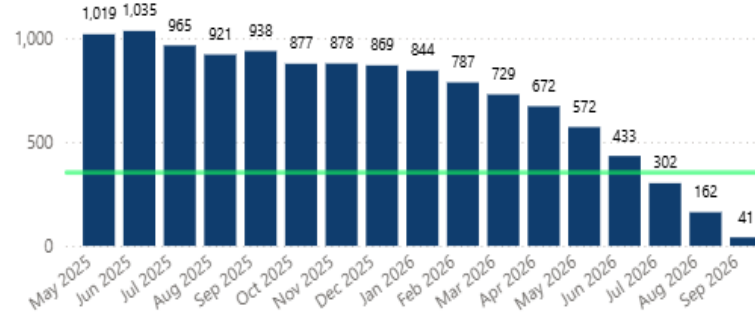


Number of patients waiting over 52+ weeks (Adult)

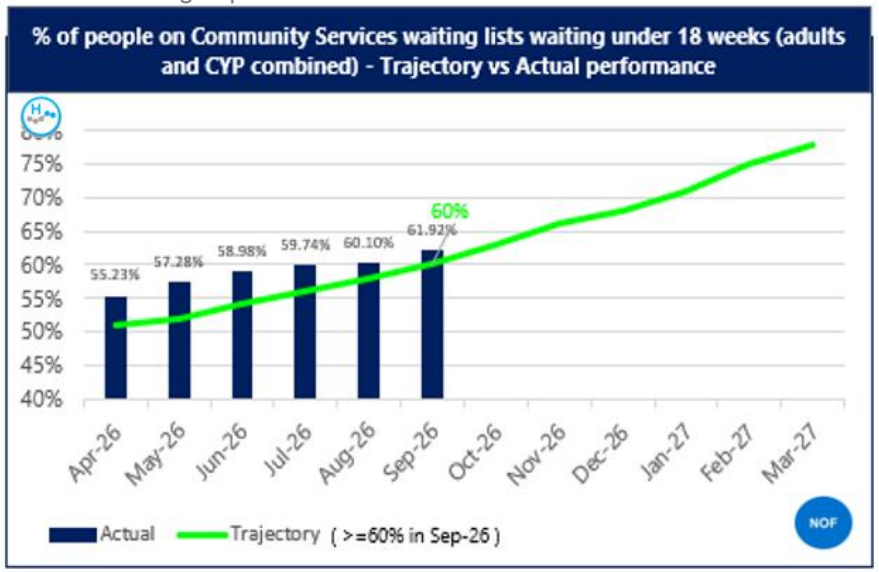


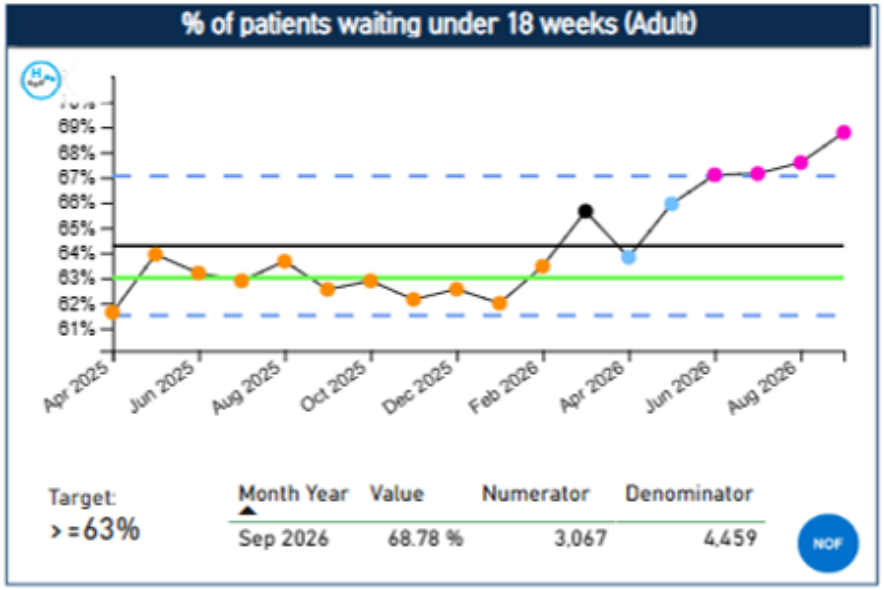
Target:	Month Year	Value
<=430 in Sep	Sep 2026	354

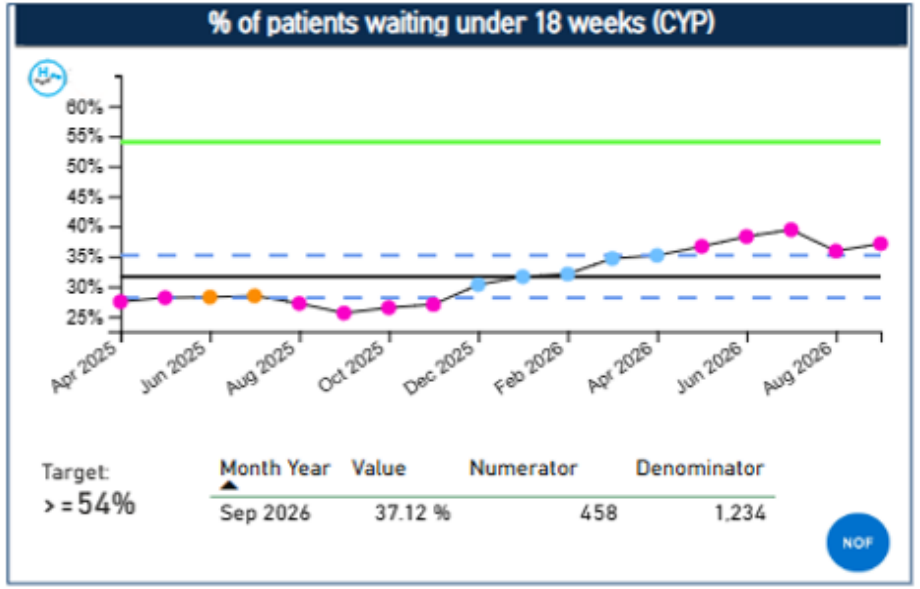
Number of patients waiting over 52+ weeks (CYP)



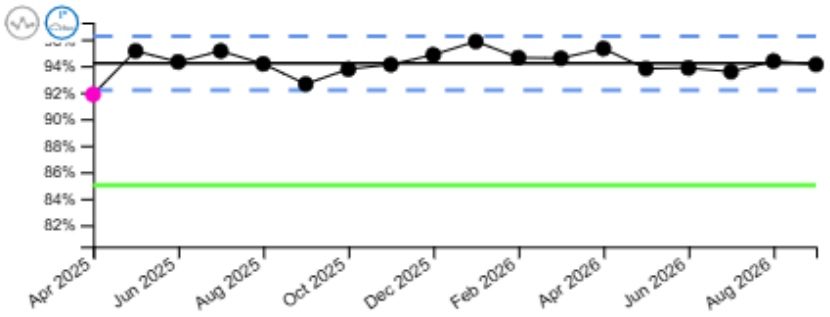
Target:	Month Year	Value
<=353 in Sep	Sep 2026	41


% of people on Community Services waiting lists waiting under 18 weeks (adults and CYP combined) - Trajectory vs Actual performance
75%
70%
65%
60%
55%
50%
45%
40%
55.23%
57.28%
58.98%
59.74%
60.10%
61.92%
60%
Apr-26
May-26
Jun-26
Jul-26
Aug-26
Sep-26
Oct-26
Nov-26
Dec-26
Jan-27
Feb-27
Mar-27
Actual
Trajectory (>=60% in Sep-26)
NOF


% of patients waiting under 18 weeks (Adult)
69%
68%
67%
66%
65%
64%
63%
62%
61%
Apr 2025
Jun 2025
Aug 2025
Oct 2025
Dec 2025
Feb 2026
Apr 2026
Jun 2026
Aug 2026
Target:
>=63%
Month Year
Value
Numerator
Denominator
Sep 2026
68.78 %
3,067
4,459
NOF


% of patients waiting under 18 weeks (CYP)
60%
55%
50%
45%
40%
35%
30%
25%
Apr 2025
Jun 2025
Aug 2025
Oct 2025
Dec 2025
Feb 2026
Apr 2026
Jun 2026
Aug 2026
Target:
>=54%
Month Year
Value
Numerator
Denominator
Sep 2026
37.12 %
458
1,234
NOF

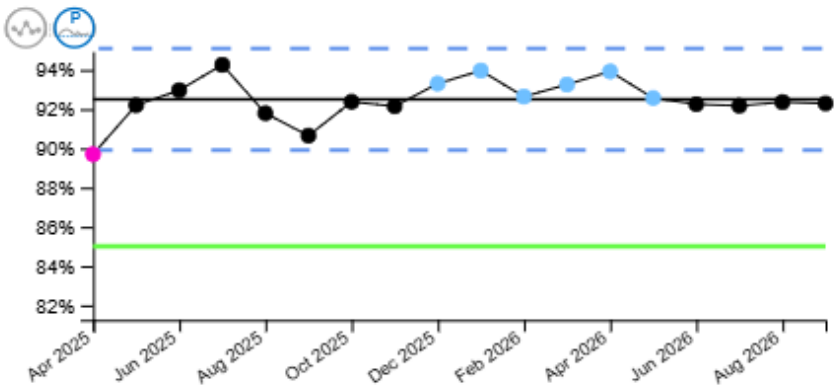
% of patients responding that overall the care was good or very good – Community Health Service, Primary Care & Dentistry



Target:
>=85%

Month Year	Value	Numerator	Denominator
Sep 2026	94.11%	3,803	4,041

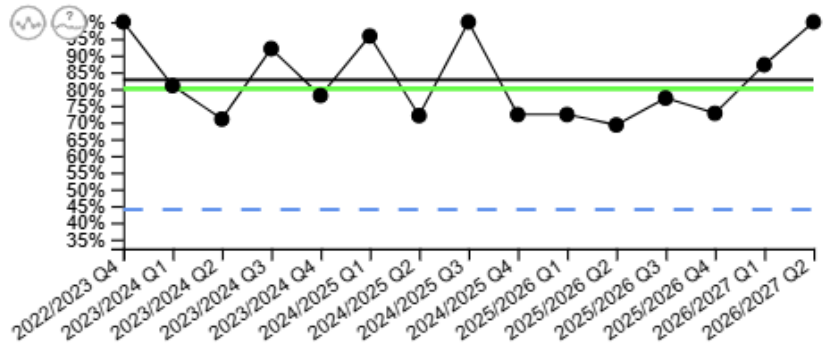
% of patients report being involved in their care – Community Health Service, Primary Care & Dentistry



Target:
>=85%

Month Year	Value	Numerator	Denominator
Sep 2026	92.29%	1,185	1,284

Patients newly registered with the practice who have had a holistic health assessment within 8 weeks of registering (Luther Street Medical Centre)



Target:
>=80%

Financial Year	Financial Quarter	Value
2026/2027	Q2	100.00 %

Oxford Health
NHS Foundation Trust

Section 3

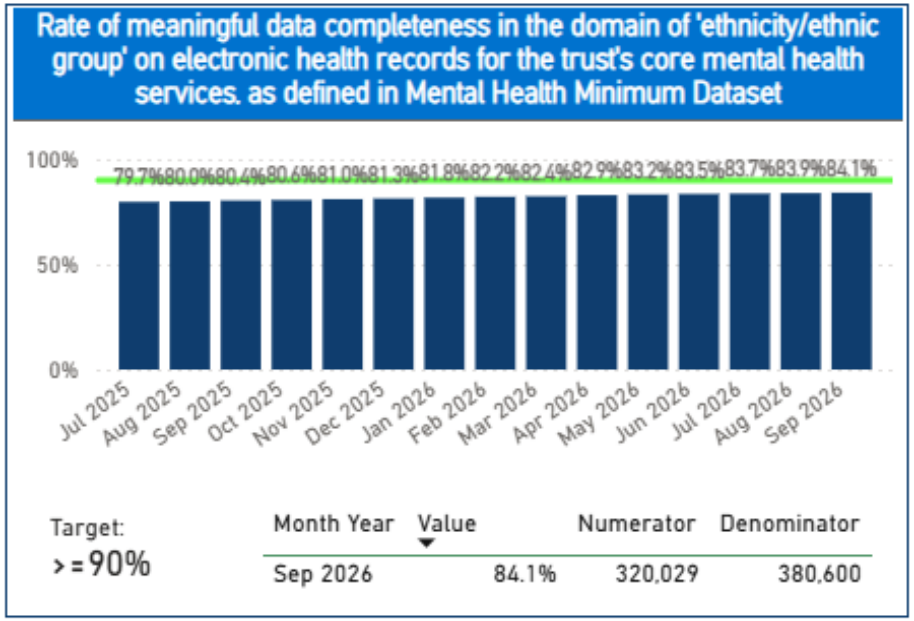
1. Quality
2. People

Oxford Health
NHS Foundation Trust

3.1 Quality - Deliver the best possible care and health outcomes

Quality - summary

Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
Local *Strategic - Quality*	Rate of meaningful data completeness in the domain of 'ethnicity/ethnic group' on electronical health records for the trust's core mental health services, as defined in the Mental Health Minimum Dataset.	>=90%	Sep-26	84.10%	.	.	n/a
Local *Strategic - Quality*	Reduction in the use of prone restraints (number of incidents involving prone restraint) - Trust level	Less than 105 in year / 8.75 per month	Sep-26	5			15
Local *Strategic - Quality*	Reduction in use of seclusion (number of incidents involving seclusion) - Trust level	Less than 414 in year / 34.5 per month	Sep-26	51			46
Local	Total number of patient incidents (all levels of harm excluding inherited skin integrity incidents) – Trust level	.	Sep-26	1299		n/a	1509
Local	Total number of unexpected deaths reported as incidents (by date of death, including natural and unnatural) – Trust level	.	Sep-26	19		n/a	23
Local	Number of suspected suicides – Trust level	.	Sep-26	5		n/a	5
Local	Total number of incidents involving physical restraint - Trust level	.	Sep-26	256		n/a	347
Local	Total number of violence, physical, non-physical and property damage incidents (patients and staff) – Trust level	.	Sep-26	407		n/a	417
Local	Total number of complaints and resolutions – Trust level	.	Sep-26	140		n/a	74
National NOF 26/27 (contextual)	Rate of restrictive interventions per 1,000 bed days – Trust level	.	Sep-26	20		n/a	27
NOF 26/27 (scored)	Overall Data Quality Maturity Index (DQMI) score	.	Jul-26	78.60%		n/a	78.71%



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. PCREF requires meaningful ethnicity data to be complete and reliable so that inequalities in access, experience and outcomes can be identified and addressed.

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.

Performance increased from 79.7% in July 2025 to 84.1% in September 2026. This is an improvement of 4.4 percentage points over 14 months, equivalent to approximately 0.31 percentage points per month. If improvement continued at the same average rate, the Trust would reach 90% in approximately 19 months, around April 2028. This is a straight-line projection, not a forecast: progress may slow as the remaining missing or incomplete records become harder to resolve. Directorates have therefore been asked to focus activity rather than apply a generic response across all services.

Actions (SMART)

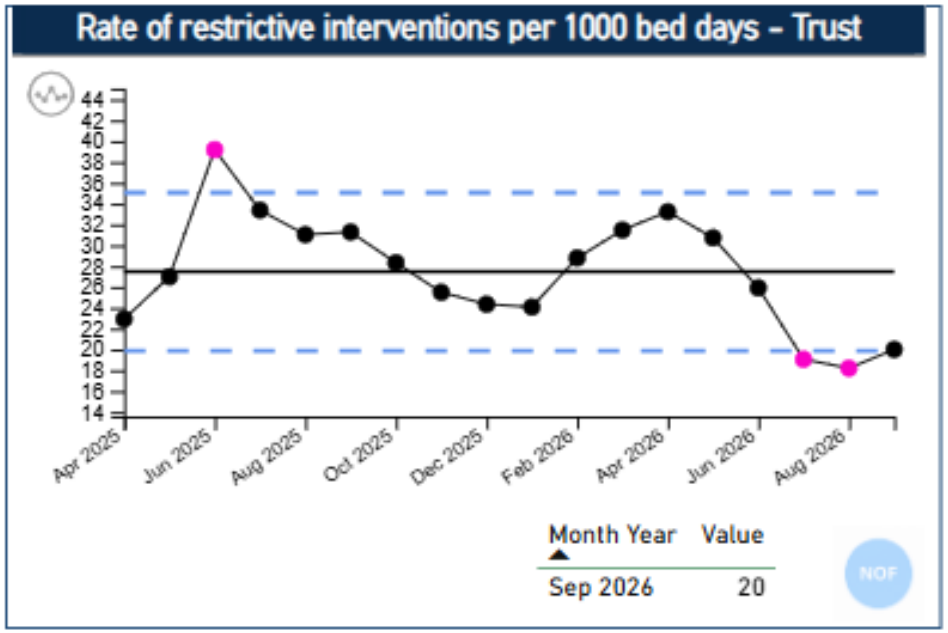
Short-term actions underway to improve position:
As part of PCREF, each Joint Management Group area (BSW, Oxfordshire, Buckinghamshire and Forensic) has been asked to identify three priority services, teams or pathways where ethnicity data completeness requires focused improvement. For each area, the return should set out the current position, action being taken, progress/evidence, accountable lead, next milestone and any risks or support required.

Medium-term actions underway to improve position:
Use directorate returns to target support, share learning and strengthen staff confidence in asking about and recording protected characteristics. The PCREF group will develop practical recording guidance and address barriers including professional confidence, local process and data quality.

Long-term actions underway to improve position:
Deliver a sustained Trust-wide improvement programme to achieve and maintain at least 90% meaningful ethnicity data completeness. This will combine targeted directorate action, routine performance monitoring and accountability, staff guidance and training, service-user communication, and escalation where progress is off track.

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

This metric measures the crude rate of restrictive interventions per 1000 bed days. It support transparency of restrictive interventions in inpatient services, and it also helps to identify variation, target improvement activity and support compliance with the Use of Force Act 2018. In addition, it supports the 10-Year Health Plan commitment to improve quality and reduce avoidable harm and aligns with the Medium-Term Planning Framework focus on improving quality and experience in mental health, learning disability and autism inpatient care (including reducing reliance on restrictive hospital environments where possible).

Numerator: the number of restrictive intervention types recorded for all mental health inpatients in the period (multiplied by 1000)
Denominator: The total number of occupied hospital spell bed days in the period.

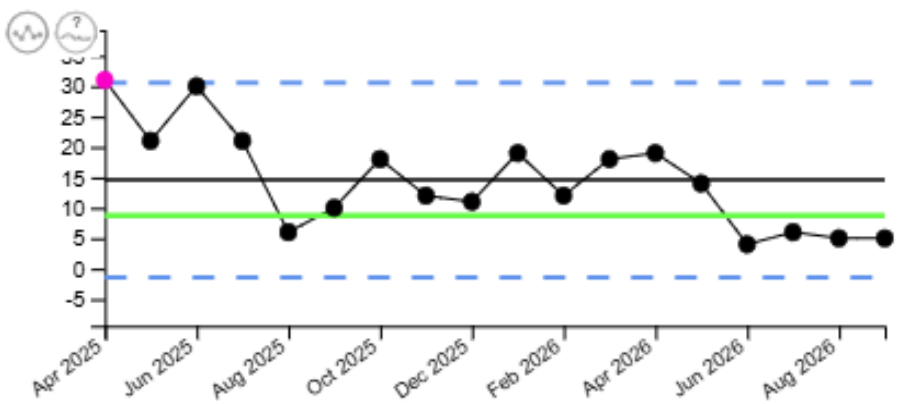
Note: a patient may be subject to multiple types of restraints in a single overall incident of restraint.

The Trust has seen a small increase in the rate of restrictive interventions the first since March 2026 with 20 restrictive interventions taking place per 1000 bed days in September 2026.

Actions (SMART) & Risks

For actions and risks related to Prone restraints – see page 64
For actions and risks related to Seclusions – see page 65
For actions and risks related to Physical restraints – see page 69

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



Target: <= 105 in year

Month Year	Value	FYTD value
Sep 2026	5	53

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. The reduction of the use of prone restraints remains one of the Trusts quality objectives for 2026/27. A revised target was set to reduce overall use of prone by 50% from 2025/2026 to reflect the overall ambition to move to a position of zero preventable prone.

The target for the end of year total at less than 9 per month has been maintained in September 2026 (annual target of less than 105 per year translates into less than 8.75 per month and is represented by the green line in the graph on the left). September 2026 had five (5) prone restraints involving two (2) individuals across two (2) wards:

- Child and Adolescent mental health inpatients had four (4) prone restraints attributed to one individual on one ward (Highfield General Adolescent Unit)
- Ruby Ward Female Adult Acute services reported one (1) prone restraint.

The reasons for prone restraints during September were for administration of Intramuscular Medication (IM) – 2 and Unintentional, led by patient - 2. The 'unintentional led by patient' is difficult to avoid due to it being as a result of the patient moving into the position, however this is still reportable if the person is held in prone for any period of time prior to being repositioned or released. One prone restraint was reported in the 'other' category.

Actions (SMART)

Prone restraint reduction is the primary workstream of the newly established Restrictive Intervention Reduction Programme Board.

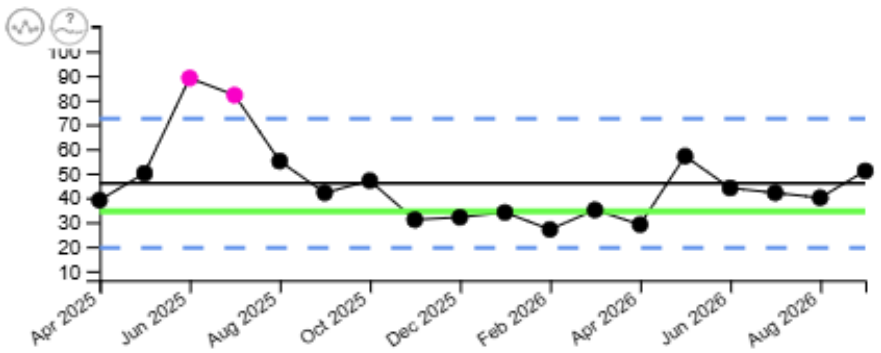
The first Restrictive Intervention Reduction Programme Board commenced in June 2026 to support efforts to move to a Trust position of zero preventable prone restraint. A panel of programme board members sits on a weekly basis to review all prone restraint and ensures learning happens at pace so that reviews have a meaningful impact on unit culture and practice.
All reviews consider learning that could prevent all restrictive interventions (not just prone) for example timing of medication.

Actions arising to date include routine involvement of pharmacy and medical colleagues to ensure risks of prone restraint are included at the point of prescribing and access to Safety Pods in numbers sufficient to support all likely scenarios requiring seclusion exit.
Use of prone in CAMHS has been wholly attributable to one individual for whom on rare occasions provision of emergency medication in the prone position is the safest option to avoid injury to the young person. This person has now been transferred from the service.

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.

Reduction in use of seclusion (includes seclusions on Ulysses & RiO) - Trust



Target:
<= 414 in year

Month Year	Value	FYTD value
Sep 2026	51	263

Actions (SMART)

Seclusion usage data is now generated from both Rio (electronic patient record system) and Ulysses (software solution for risk management and patient safety) achieving improved data quality and is available via Trust Online Business Intelligence (TOBI) platform for viewing and monitoring.

Seclusion duration data will inform the workstream to reduce use of seclusion in the Trust to monitor progress in the reduction of seclusion where there is lower frequency but higher average durations. For example ; Forensic services reported the longest mean and median durations in August (364.8 hrs. mean and 248.5 hrs. median). CAMHS reported the shortest mean and median durations (9.7hrs mean and 4hrs median). Some further work is required to establish standardised analysis of seclusion episodes and duration.

Understanding the performance

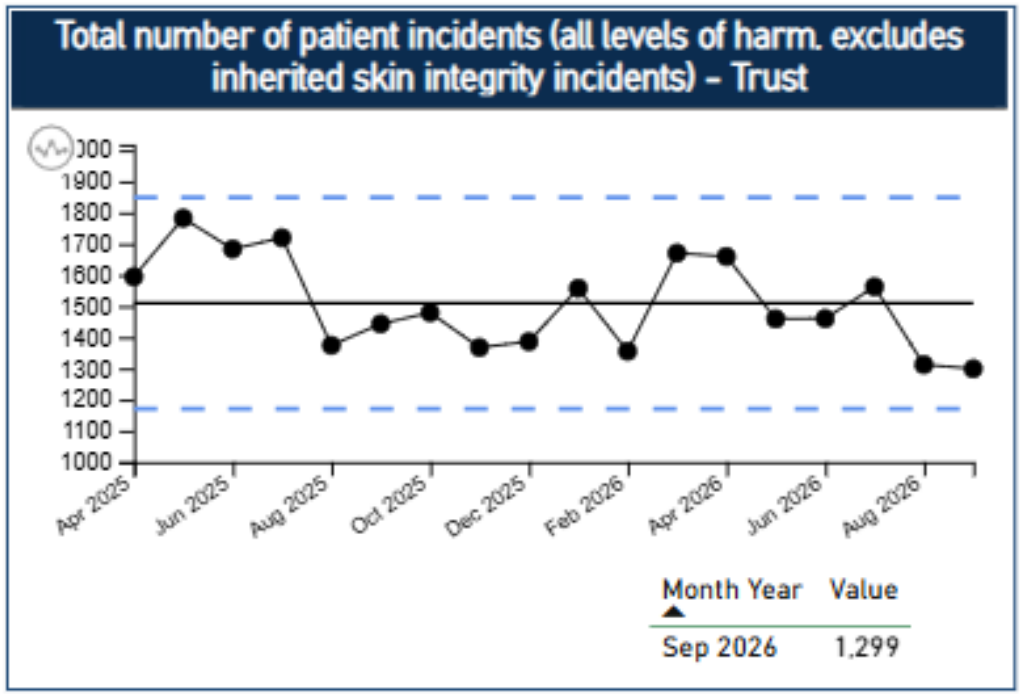
Reduction in the use of restrictive interventions remains a key priority for the Trust in line with the requirements of the Mental Health Units (Use of Force) Act 2018. The revised quality target for 2026/2027 requires all directorates to achieve a 25% reduction in the use of prone from their 2025/2026-year end total. A total Trust Wide target is set for less than 414 in the year. Seclusion must only be utilised when all other options to manage the situation without the use of this restriction have been considered and exhausted

There has been an increase in total seclusion episodes commenced in September 2026 with fifty-one (51) seclusion episodes involving nineteen (19) patients across thirteen (13) wards. The target of less than 35 episodes per month has not been met in September (monthly target is represented by the green line in the graph on the left).

- Child and Adolescent Mental Health inpatient services account for twenty–six (26) seclusion episodes attributable to four (4) individuals - Meadow Unit CAMHS Psychiatric Intensive Care Unit (PICU) (9 episodes) and Highfield General Adolescent Unit 27 episodes).
- Oxfordshire and Bath & North-East Somerset, Swindon and Wiltshire Adult and Older Adult services account for three (3) seclusion episodes attributable to three (3) patients - Ashurst Male PICU (1 episode); Vaughan Thomas Male Adult Acute ward (1 episode) and Wintle Ward Female Adult Acute (1 episode).
- Buckinghamshire Adult and Older Adult services account for six (6) seclusion episodes attributable to six (6) individuals – Opal Ward Place of Safety (1 episode) ; Ruby Ward Female Adult Acute (2 episodes) and Sapphire Ward Male Adult Acute (3 episodes).
- Forensic services account for six (6) seclusion episodes attributable to seven (6) individuals - Kennet Male Medium Secure unit (2 episodes) ; Watling Ward Male Medium Secure Ward (2 episodes) ; Glyme Ward Male Medium Secure Ward (1 episode) and Woodlands House Low Secure (1 episode).

Risks

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



Understanding the performance

Patient incidents include all incidents that could have led or did lead to harm for one or more patients receiving healthcare. Incidents involving harm to staff are not included in this indicator.

Most incidents are recorded with low or no specific physical harm to patients (94.4% in Q2), this is in line with the national position. There is no significant change in moderate or severe harm incidents over time, with most moderate harm incidents relating to category 3 pressure damage and deep tissue injury for patients in the community.

Overall, the most common incident categories reported are;
- Physical condition of a patient
- Self-harm
- Violence by a patient towards property/another patient

There were 2 severe harm incidents under Oxford Health's care in September 2026:
- A patient reported domestic abuse from a partner, whilst under the care of a community mental health team.
- A young person fell from height at home resulting in significant injuries.

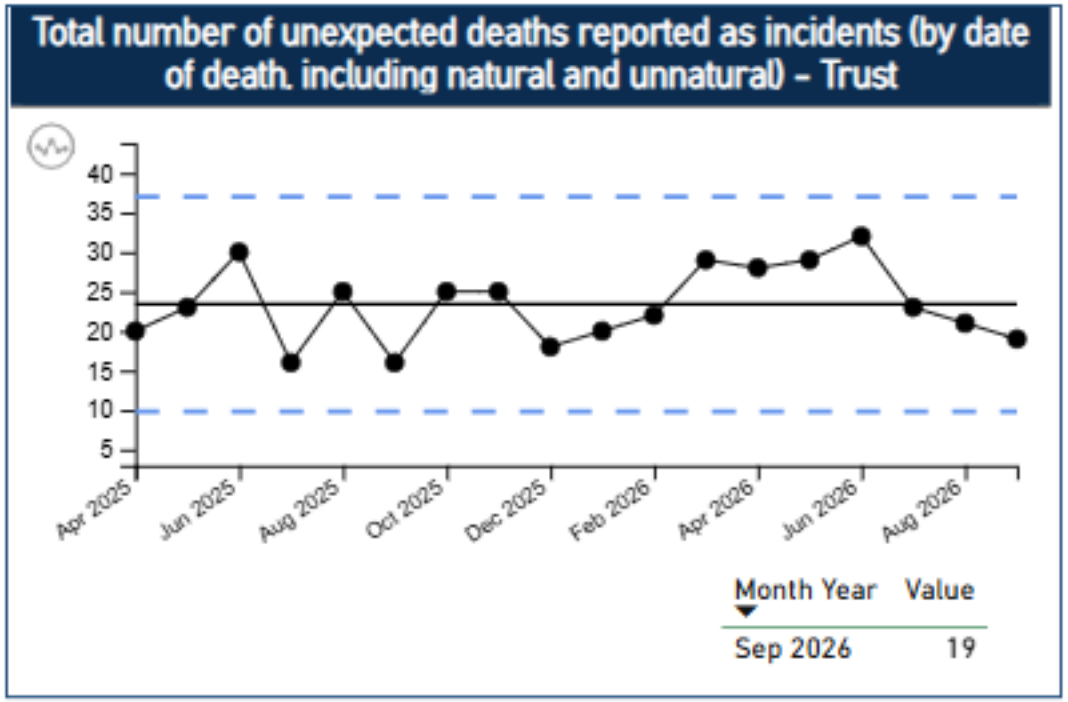
Actions (SMART)

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 and proportion of moderate harm or severe harm incidents is low.

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.



Understanding the performance

The Trust takes its role and responsibilities very seriously around reviewing the care provided to patients after a death to ensure we learn and take appropriate actions. The Trust's learning from deaths process reviews all known patients on our caseload against a national database to ensure we identify all deaths and can take the appropriate steps to review. This includes 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 people aged under 18, 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.

Nothing specifically to note in September 2026.
See next slide on analysis of suspected suicides.

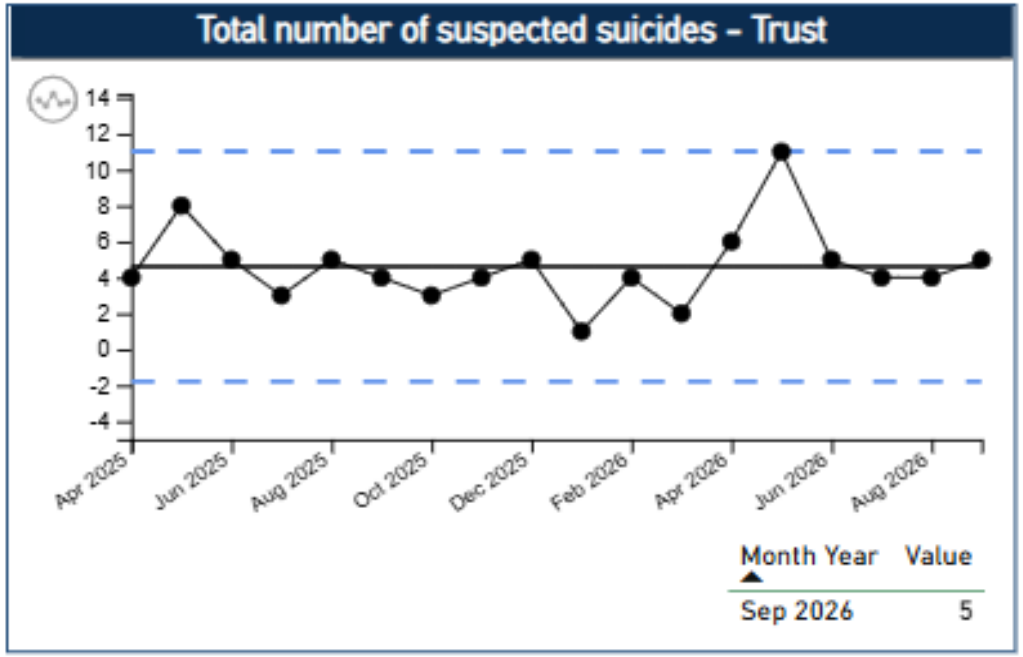
Actions (SMART)

We have robust 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.

Risks

No specific risks identified.



Understanding the performance

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

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 64 confirmed/suspected suicides for open and discharged patients in the last 12 months up to 30th September 2026, which 26 were open at the time to mental health services, 5 to physical health services and 8 to both types of service. We continue to see a higher number of male suspected suicides although the gap between genders is not as pronounced as seen previously (40 males/24 females).

There was an increase in suspected suicides in May 2026 (not all patients were open to services at the time they died) followed by a reduction in subsequent months. The deaths have been reviewed and there was no contagion or themes identified between the people/deaths.

Actions (SMART)

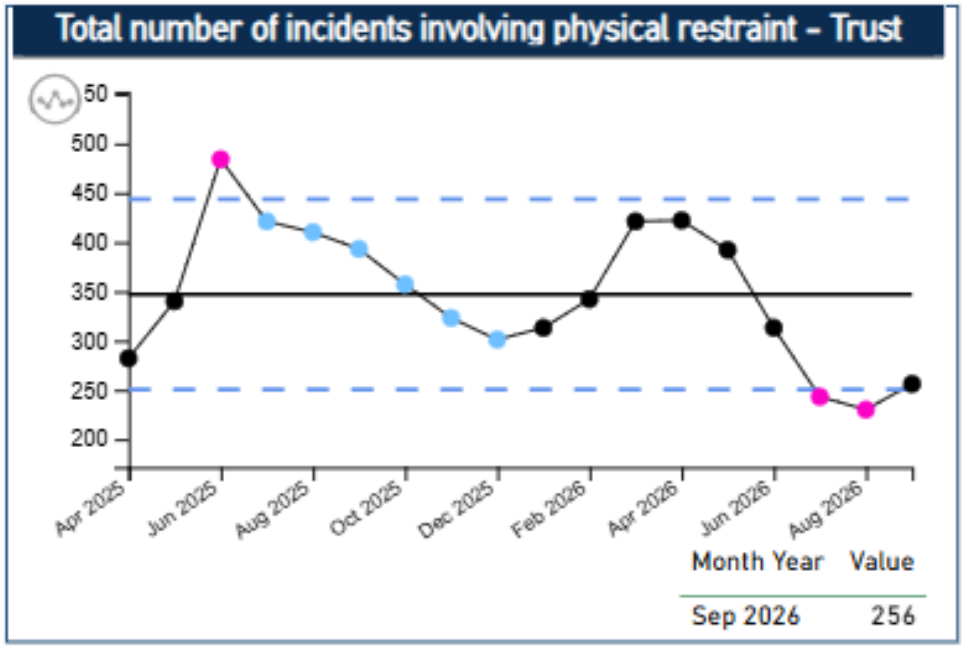
The Trust has strong processes in place to review and learn from all suspected suicides through the national Patient Safety Incident Response Framework, which includes engaging with families affected.

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.

Risks

No specific risks identified to escalate.



Understanding the performance

There has been 256 restraints in September 2026 (an increase of 27 across the month). Child and Adolescent Mental health services (CAMHS) remain the highest user of restraints across all inpatient pathways and account for the increase this month:

- Children and Adolescent Psychiatric Intensive Care Unit (PICU) Meadow accounted for eighty (80) restraints ; - eighty-eight (88) in Highfield General Adolescent Unit and eight (8) in Marlborough House Swindon General Adolescent Unit.
- Wintle Ward Female Acute accounted for fourteen (14) restraints.
- Cherwell Ward Older Adult Female accounted for twelve (12) restraints.
- Ashurst Ward Psychiatric Intensive Care Unit accounted for seven (7) restraints.

The highest cause group for incidents involving restraint changed in September from self harm to prevention and management of violence. In September 2026, 68 of 256 uses of restraint were to prevent or minimise harm to others. The second highest cause of restraint was to prevent self harm with 68 physical restraints. 45 restraints involve prevention of dangerous or destructive behaviour, and 33 health related episodes were for administration of nasogastric (NG feeding) and delivery of essential treatment.

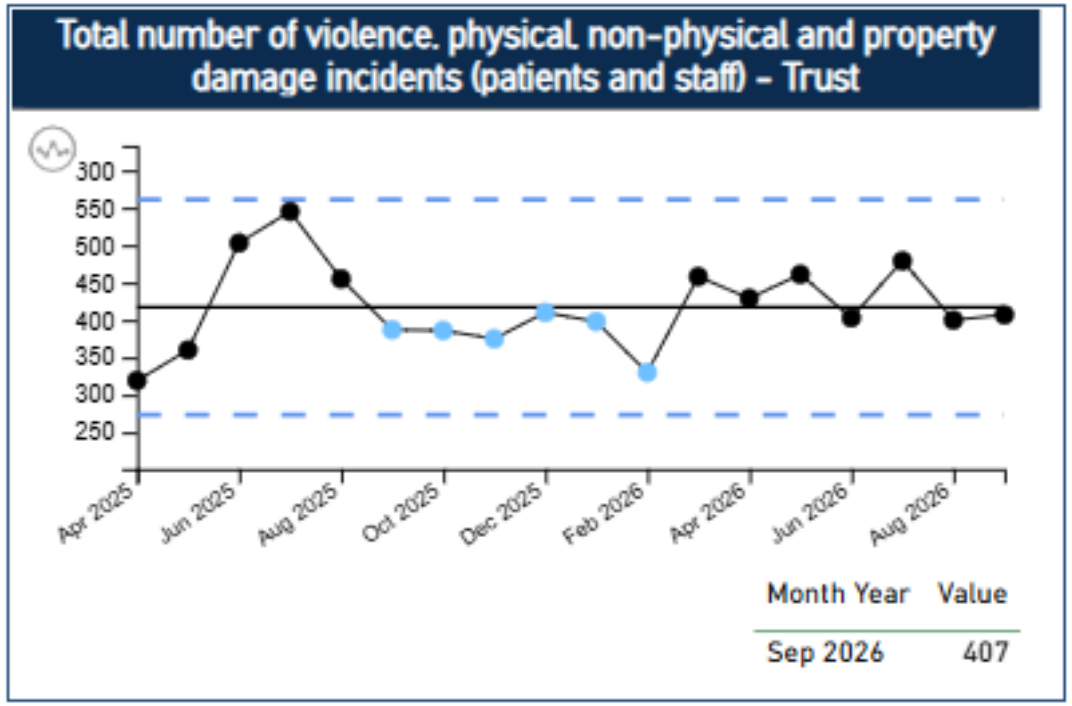
Actions (SMART)

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 and harm to others due to acute behavioral distress.
Work to optimise feeding strategies is undertaken where nasogastric feeding cannot be avoided. This includes prescribing of higher calorie supplement to reduce risks of twice daily feeding regime.

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

In the last twelve (12) months the majority of incidents related to verbal abuse from patients towards staff followed by physical violence with no harm from patients towards staff. 98% of incidents resulted in no specific harm or minor harm.

The highest number of violent incidents occur in inpatient units. In September 2026, the wards with the highest incidents were:

- General adolescent Highfield Unit (n=63)
- Child and Adolescent Psychiatric Intensive Care Unit (n=45)

In September 2026, there were 0 (zero) severe harm incidents. But there were 3 staff RIDDORS (event covered by Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reported to the Health & Safety Executive (HSE) relating to violence from a patient, these occurred across 2 wards.

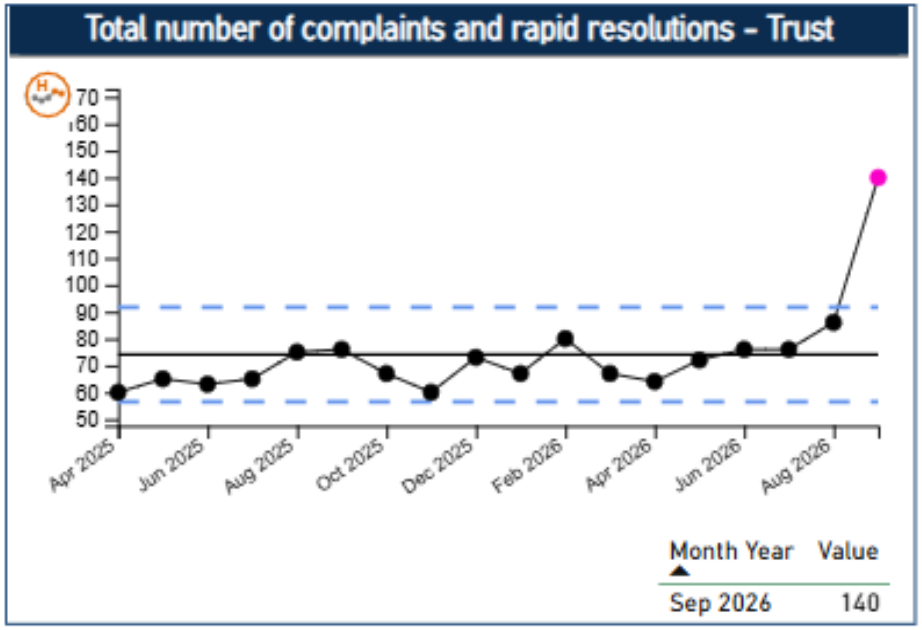
11.5% of violent incidents had a racial element in September 2026, this is fairly consistent month on month. The majority of racial violence comes in the form of verbal abuse from patients towards staff.

Actions (SMART) & Risks

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 actions 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.

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



Understanding the performance

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

In September 2026, there were 18 early resolution cases, 119 rapid resolution complaints, 15 low-level complaints, 17 Member of Parliament (MP) enquiries. Please note that early resolutions are not in scope of the graph on the left. There was a significant increase in the number of rapid resolution complaints (No = 46) related to a single incident. Teams with the most complaints were:

- Adult Mental Health Team (AMHT) Buckinghamshire Aylesbury Team.
- Complex Needs Oxfordshire.

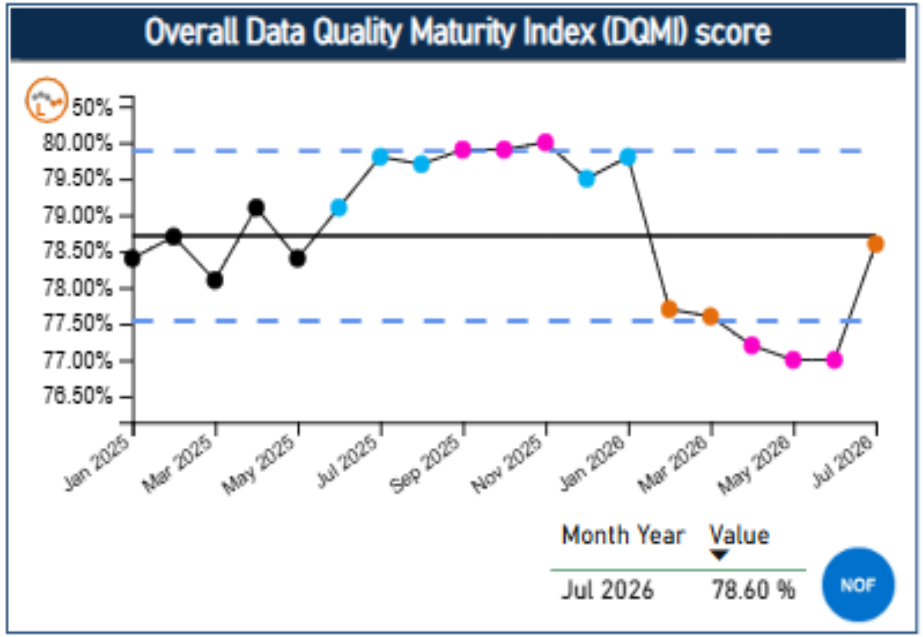
During September 2026, the Trust received 176 compliments across services.

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 Key Performance Indicators (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.



Understanding the performance

Background

- What is DQMI? The Data Quality Maturity Index (DQMI) is a national NHS measure of the completeness and quality of data submitted by providers across key national datasets. It helps compare performance between providers and identify data fields that need improvement. A DQMI item is a specific data field submitted within a national dataset. It is scored mainly on how completely and consistently the field is recorded, with performance benchmarked against other NHS providers.
- Types of issue: Items broadly fall into three categories: operational recording and completeness; clinical-system configuration or functionality; and technical coding, mapping or data-flow issues.

Current performance

- Overall DQMI improved from 77.2% in April to 78.6% in July. This is following actions undertaken as part of the action plan, see actions section for further information..
- ECDS remains is the main gap (54.6%), APC has improved from 72.2% in April to 81.6% in July, while other datasets maintain similar levels of performance MHSDS is at 87.3.%, CSDS 96.9% and IAPT at 98%.

Actions (SMART)

- Performance & Information are leading an action plan with initial recovery actions focusing on 32 data items below 90%. These comprise 7 Admitted Patient Care (APC) items, 1 Community Services Data Set (CSDS) item, 17 Emergency Care Data Set (ECDS) items and 7 Mental Health Services Data Set (MHSDS) items.
- 7 data items are expected to improve by end Quarter 3, forecasting overall DQMI of 82.1%. Examples expected to improve: APC items include Admission Method, Consultant Code, Decided to Admit Date, Discharge Destination, Discharge Method and Source of Admission. MHSDS improvements include Consultation Mechanism and Care Professional Service or Team Type Association.
- Work will continue of the action plan for below 90% to realise improvements
- A further 11 ECDS items are expected to improve through the new Adastra configuration, although the implementation timing remains to be confirmed. It is estimated this will improve DQMI to 87.5% when implemented.
- Further action plan has been developed to extend beyond items below 90%, to those below 100%

Risks

- Adastra delivery timing is unconfirmed; delay would constrain ECDS and overall improvement.
- Even at 87.5%, current benchmarks indicate the Trust would remain in Quartile 4
- Operational capacity may delay improvements that depend on services consistently capturing complete data
- Some data-quality issues may not have an immediately feasible corrective action.

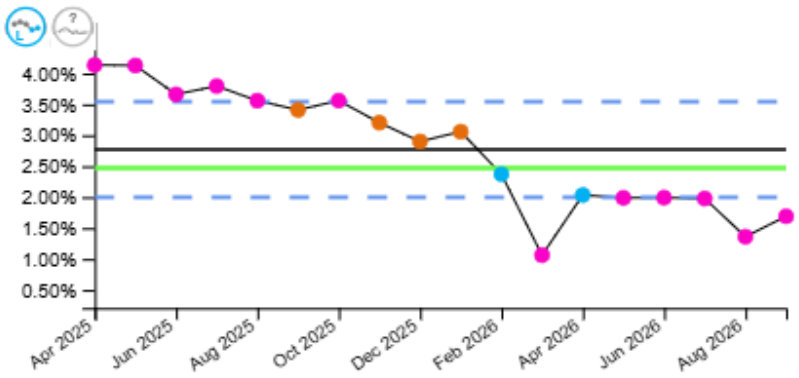
Oxford Health
NHS Foundation Trust

3.2 People - Be a great place to work

People - summary

Type of metric	Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
Strategic - People	Reduce agency usage to meet target (% of agency used)	<=2.47%	Sep-26	1.69%	L	?	2.77%
Strategic - People	Reduction in % labour turnover	<=12%	Sep-26	9.22%	L	P	9.54%
Strategic - People	Number of staff who have completed Quality Improvement Training Level 1	.	Sep-26	1431	H	n/a	1255
Strategic - People	Black, Asian and Minority Ethnic (BAME) representation across all pay bands including Board level.	>=19%	Sep-26	29.21%	H	P	27.55%
Strategic - People	Black, Asian and Minority Ethnic (BAME) representation in senior leadership roles (Bands 8a-8d, Band 9, Very Senior Management).	>=19%	Sep-26	14.42%	H	F	14.18%
Local	Proportion of staff in senior leadership roles (bands 8a - 8d, 9 and Very Senior Manager) who are women - Trust	.	Sep-26	77.55%		n/a	77.78%
National NOF 26/27 (scored)	Reduce staff sickness to 4.5% - Trust	<=4.5%	Sep-26	5.41%		?	4.91%
Local	Personal Development Review (PDR) compliance (PDR season is between April – July) - Trust	>=95%	Sep-26	96.51%	n/a	n/a	.
Local	Reduction in vacancies - Trust	<=9%	Sep-26	6.79%	L	?	8.04%
Local	% of early turnover - Trust	<=13%	Sep-26	11.21%		P	11.70%
Local	Statutory and mandatory training compliance - Trust	>=90%	Sep-26	92.40%		P	92.50%
Local	Overall supervision rate - Trust	>=90%	Sep-26	82.56%	H	F	79.60%
Local	Staff leaver rate - Trust	.	Sep-26	7.34%	H	n/a	6.55%
National	Relative likelihood of white applicant being appointed from shortlisting across all posts compared to Black, Asian and Minority Ethnic (BME) applicants	1	Sep-26	0.9		?	1.78
National	Relative likelihood of non-disabled applicant being appointed from shortlisting compared to disabled applicants	1	Sep-26	6.38	H	?	1.49

Reduce agency usage to meet target (% of agency used) – Trust



Target: <=2.47%

Month Year	Value	Numerator	Denominator
Sep 2026	1.69 %	£ 630,607.39	£ 37,316,402.09

Understanding the Performance

There has been a sustained reduction in the Trust's agency usage, which has been below the 2.47% FY26/27 target since February 2026. This reflects the effective embedding of robust controls and the Bank First approach we have embedded.

Total agency spend in September 2026 increased to 1.69% of total pay bill and remains under target. The Trust is £1,201k better than plan for agency spend Year to Date.

Agency Spend as a % of Temporary Staffing was 18.5% (£631k) and Bank was 81.5% (£2,771k) reflecting the Bank First approach.

Fill rates :
NHS People (NHSP) shifts only (excluding Medical & Dental): In September 26, 91.1% of our temporary staffing shifts (based on hours) were filled by bank workers, above the 85% target. 4.32% were filled by agency workers and 4.53% were unfilled.

Medical & Dental (ID Medical, Allocate and Patchwork agencies): In September 26, 53.4% of our temporary staffing shifts (based on hours) were filled by bank workers; 41.4% were filled by Agency workers and 5.2% were unfilled.

Actions (SMART)

Agenda for Change (AfC) – Care Support Worker (CSW) Development Programme – Temporary Staffing & L&D are working in conjunction with NHSP to plan a roll out for the CSW Development Programme which will aims to increase the supply of Health Care Assistants by training individuals without experience.

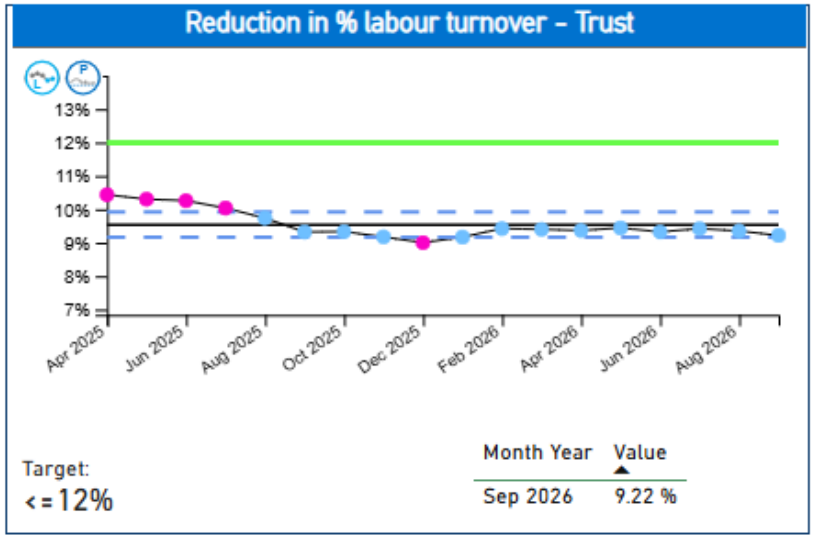
There are 57 bank lines of work, 31 are in Corporate services which includes Estates & facilities and Oxford Pharmacy Store where majority are placed. 3 are in Forensic services within the HMP Estate, and 9 within the Community Health Service Directorate. There are 3 in Buckinghamshire Mental Health and 10 within the Oxfordshire & BSW Directorate. There are 17 Agency lines of work . 4 of these commenced in October and 3 are undertaking pre-employment checks to join the Trust substantively with notice given to their agencies.

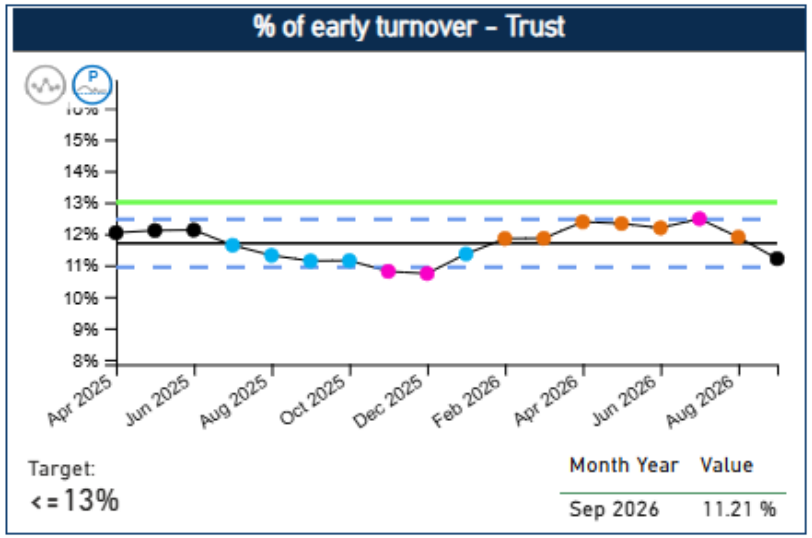
Medics - Focus continues on reducing locum utilisation and rates, supported by improved visibility of medical recruitment pipelines, which are now routinely shared with stakeholders across the Trust. There are 21 lines of work, with 11 working in CAMHS, 2 in OLD age, 1 in LD and 7 in General adult. These numbers will be reduced in the coming months by agency moving to Bank and some successful substantive recruitment

A dedicated project is underway to strengthen the recruitment of GPs to an internal Bank for the Out of Hours Service. There are 155 Active Bank GP's and a further 21 are in the recruitment pipeline with a plan for them to be onboarded before Christmas.

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 September 2026 Turnover decreased from 9.35% to 9.22% and it remains significantly below the new 12% target. Staff turnover of Black, Asian and Minority Ethnic staff is 7.78%. White staff turnover is 10.04%.

Early turnover has decreased from 11.90% to 11.21% and remains below the new 13% target. Early turnover is lower among Black, Asian and Minority Ethnic staff (9.46%) than white staff (13.53%).

Actions (SMART)

We continue to work on workstreams related to turnover as follows:

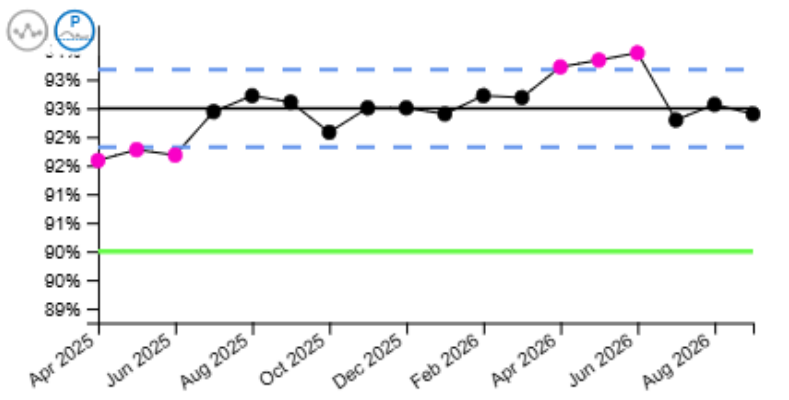
- Recognition of Length of Service, and of Resident Doctors in 10 point plan*
- The Exit Dashboard is available on TOBI and demonstrates most common reasons for leaving. A piece of work is underway with managers to explore why this is most recorded as 'Unknown'
- Flexible Working is now an NHS Staff Standard – NHSE webinar will be held soon to detail the implications of this. Locally we are:
    - Reviewing the Flexible Working policy
    - Supporting managers with flexible working requests
    - Simplifying guidance documentation for those making requests

*10 point plan – NHS England's plan which aims to improve working conditions, wellbeing and operational support for resident doctors across NHS trusts in England

Risks

Turnover is higher in some areas or professions than others which is masked by the mean average. Early turnover is also more variable than the mean % would suggest. This can impact on vacancies and quality of care provided to patients. Continued support is being given to directorates to focus on location and professions where turnover is higher than average.

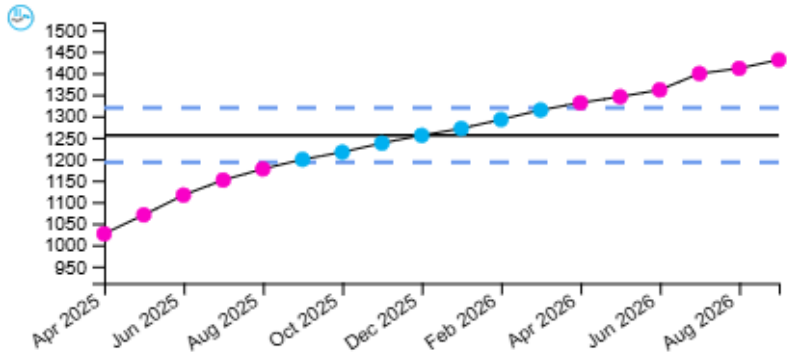
Statutory and mandatory training compliance



Target: >=90%

Month Year	Value	Numerator	Denominator
Sep 2026	92.40 %	100,065.0	108,298.0

Number of staff who have completed Quality Improvement Training level 1



Month Year	Value
Sep 2026	1,431.0

Understanding the performance

The overall Trust compliance rate remains consistently above compliance at 92.5%. Estates & Facilities and Ox Inst Of Clin Psych Training are currently the only areas falling just short of the 90% target, sitting at 88.61% and 87.41% respectively.

Only Resus and Oliver McGowen are reporting as below target but both have improved in compliance over the last month.

Actions (SMART)

- Resus compliance has improved from last month and is now reporting at 85.54% with Primary, Community and Dental Services achieving 90.5%. Inpatient ward compliance has also improved, with most wards reporting Adult Basic Life Support (ABLS) compliance above 85% and several achieving 100% compliance. Level 1 resus awareness training continues to be monitored since its roll out on 15th December 2025 - compliance is now above target at 90.84% but will continue to be monitored as a separate piece of training for a further 6months to ensure this is sustained.

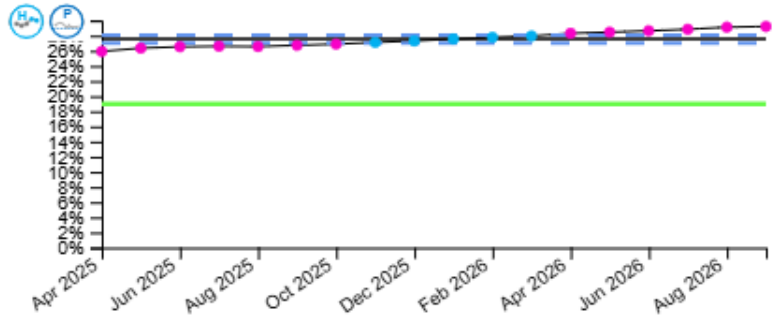
- The resus training team are continuing audits of all resus equipment. Business case completed recommending the implementation of the MyKitCheck digital monitoring system, to provide real-time oversight of emergency equipment checks, expiry dates and audit compliance. This change should result in more structured, efficient remote audit processes resulting in resus team being able to provide more resus training and more timely replacement of any expired equipment.

- Train-the-trainer sessions for Oliver McGowan are underway as part of the trust long-term plan to become local provider of the Oliver McGowan training. This will give better control over delivery of training required as this currently sits within ICB responsibility.

Risks

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

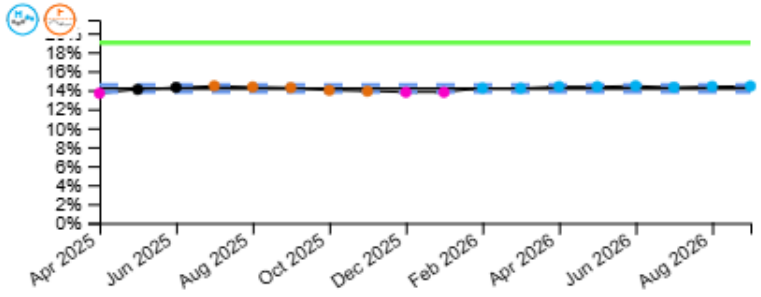
% of BAME (black, Asian and minority ethnic) representation across all pay bands including board level - Trust



Target: >=19%

Month Year	Value	Numerator	Denominator
Sep 2026	29.21 %	2,283	7,816

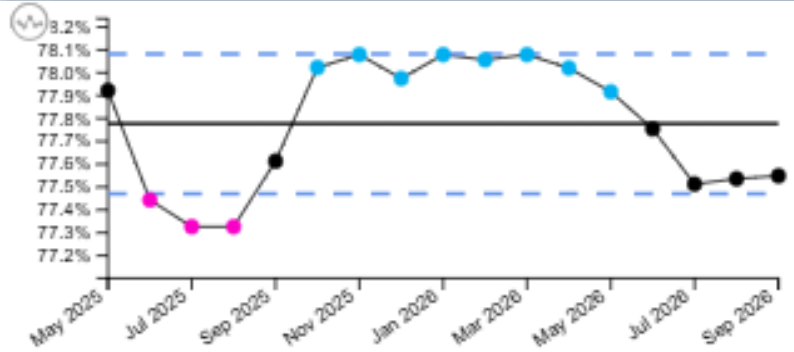
% of BAME (black, Asian and minority ethnic) representation in senior leadership roles (8a -8d, B9 & Very Senior Manager) - Trust



Target: >=19%

Month Year	Value	Numerator	Denominator
Sep 2026	14.42 %	140	971

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



Month Year	Value	Numerator	Denominator
Sep 2026	77.55 %	753	971

Understanding the performance

- There has been a slight increase of 0.09% in the representation of Black, Asian and Minority Ethnic staff across all pay bands during the September 2026 reporting period. Now at 29.21%.
- There has been a slight increase of 0.03% in the representation of Black, Asian and Minority Ethnic staff specifically in senior leadership roles (bands 8A-8D, B9 and Very Senior Manager) in the September 2026 reporting period, now sitting at 14.42%.
- There has been a slight increase of 0.01% in the representation of female staff in senior leadership roles (bands 8A-8D, 9 and Very Senior Manager) in the September 2026 reporting period now sitting at 77.55%.

Actions (SMART)

• The Trust has approved the 2026 – 2028 Equality, Diversity and Inclusion (EDI) Plan bringing together the actions from NHS Workforce Race Equality Standard (WRES), NHS Workforce Disability Equality Standard (WDES), NHS England's EDI Improvement Plan, pay gap reporting, Patient and Carer Race Equality Framework (PCREF) workforce actions and other national equality programmes into one coordinated delivery framework.

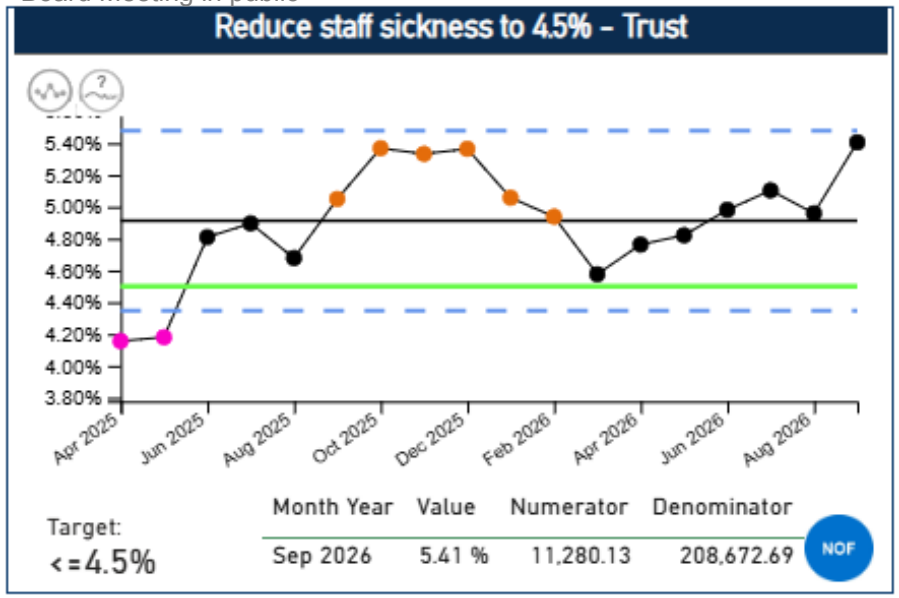
• Delivery of the plan forms part of the overarching culture plan, with progress monitored through the EDI Steering Group and reported to the People, Leadership and Culture Committee.

• Priority actions continue to be improving representation at senior levels, reducing workforce inequalities, strengthening inclusive leadership, supporting disability inclusion, flexible working and reasonable adjustments, and embedding anti-discriminatory practice across the Trust.

Risks

Failure to progress the EDI and anti-racism plan meaningfully could 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.

The EDI function will have reduced capacity for a few months following departure of the Head of EDI. Temporary backfill arrangements are being put in place whilst the service is reviewed.



Understanding the performance

The sickness absence rate has increased from 4.96% to 5.41% in September 2026, 0.91% above target.

Long term absence has increased, from 2.97% in August 2026 to 3.05% in September 2026, and short-term absence has increased from 1.07% to 1.47% in September.

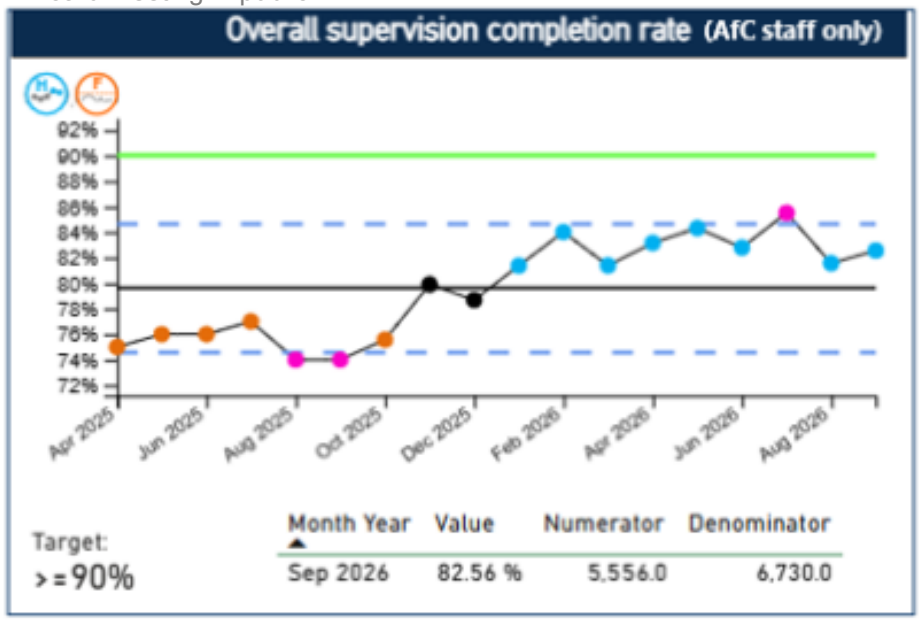
The most common reasons for absence based on number of cases were Cold/Cough/Flu, Gastrointestinal problems, Anxiety/Stress Non-work related, Headache/Migraine, and Not Specified.

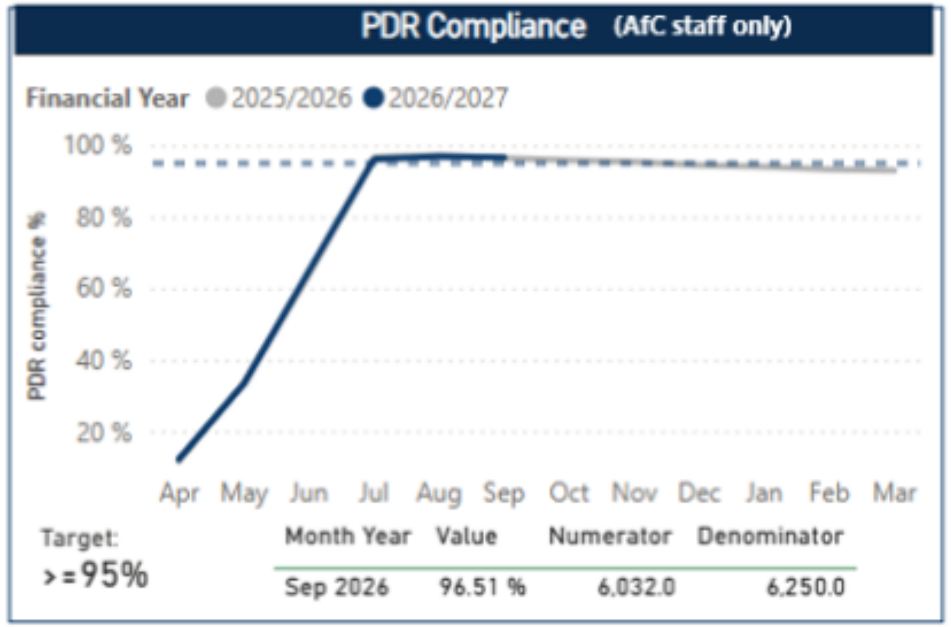
Actions (SMART)

- The NHS Medium Term plan states an ambition for all Trusts to reduce sickness absence levels to 4.1% in this financial year and the Trust is considering what additional support measures we can provide to managers to support sickness management.
- A review by auditors "KPMG" of sickness absences including monitoring, reporting and return to work will be completed in November which will inform a future focused programme of work on absence.
- 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.
- We have recently reviewed the monthly Human Resources (HR) absence workforce reports which are shared with HR leads to monitor sickness absence. This is to ensure the information can be reviewed and analysed effectively.
- 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.

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

The above metrics measure supervision completion and Personal Development Review compliance rate for Agenda for Change (AfC) staff and exclude medics.

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, and it has increased in September to 82.56% from 81.57%

The Personal Development Review (PDR) season is now closed. PDR compliance at the end of September sits at 96.51%, 1.51% above target.

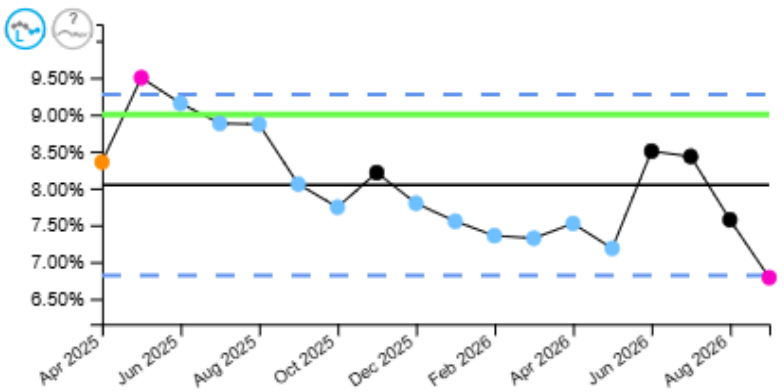
Actions (SMART)

Organisational Development, Learning & Development and Strategy teams are working on the alignment of the new strategy with objective setting in teams and in PDRs

Risks

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

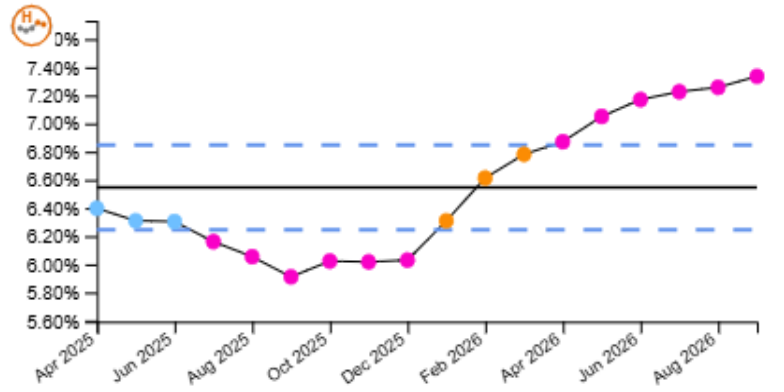
Reduction in vacancies – Trust



Target: <= 9%

Month Year	Value	Numerator	Denominator
Sep 2026	6.79 %	506.95	7,469.17

Staff leaver rate



Month Year	Value	Numerator	Denominator
Sep 2026	7.34 %	502.0	6,843.0

Understanding the performance

Following a sustained reduction in the vacancy rate since September 2024, the rate has further decreased in September 2026 from 7.57% to 6.79%, remaining below the 9% target.

Staff leaver Rate: Staff leaving the Trust has increased from 7.26% in August and now sits at 7.34% at the end of September 26.

Tighter controls on vacancies, particularly newly created vacancies, an improved recruitment process through a Talent Acquisition team and continued development of recruitment marketing mean that vacancies are well-managed, vacancy rates have however recently started to increase, due to the addition of new services and a rise in employee turnover.

Actions (SMART)

Talent Acquisition and Recruitment Marketing:
On 13 October, Oxford Health hosted a Careers Taster Day and Careers Fair at Unipart House, Oxford. The daytime event welcomed 28 students from two local schools, providing an opportunity to explore 14 different healthcare professions and services through interactive activities and conversations with staff. Student and teacher feedback was extremely positive, highlighting increased awareness of NHS career opportunities and the different routes into healthcare. The evening Careers Fair attracted 105 visitors, who had the opportunity to speak with colleagues from across the Trust and attend talks on NHS applications and careers in research. The event also generated 64 new mailing list subscriptions, including 36 sign-ups to Apprenticeship Alerts. Both events received positive feedback, with visitors particularly praising the friendly and informative staff. The next Careers Taster Day is scheduled for 3 March 2027.

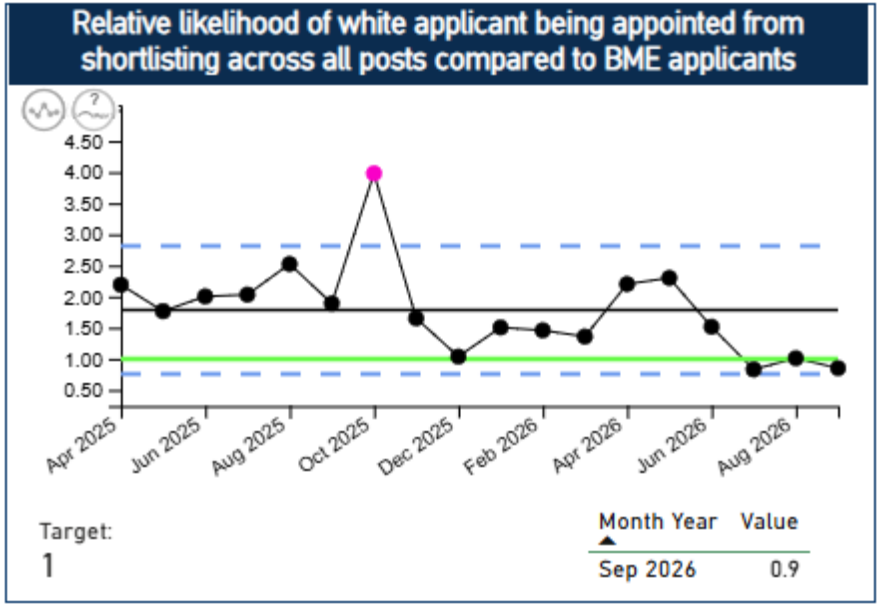
Staff leaver Rate: The leaver % has increased steadily throughout the calendar year. Exploration is underway to improve record accuracy of reasons for leaving. The majority are recorded as 'Unknown'.

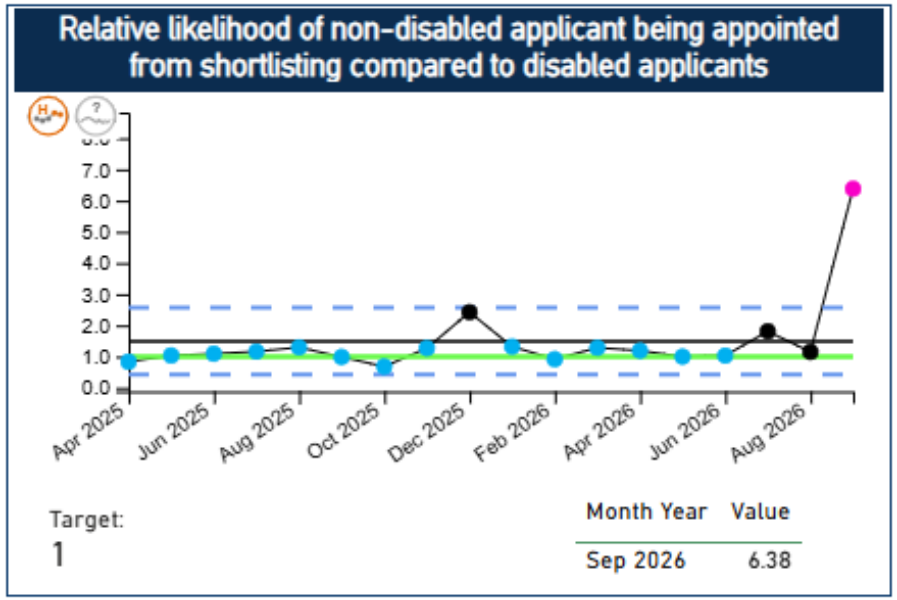
Risks

Vacancies:

- 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. Sponsorship routes for HCAs close on the 31st December 2026.
- 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.

- **Staff leaver rate:** Whilst overall turnover remains manageable, the leaver % has risen steadily throughout the year. This translates into higher recruitment costs and discontinuity in staffing.





Understanding the performance

The relative likelihood of white applicants being appointed from shortlisting compared to Black, Asian and Minority Ethnic applicants has decreased from 1.0 in August 2026 to 0.9 in September 2026. The higher the ratio, the more likely White applicants are to be appointed than Black, Asian and Minority Ethnic applicants. A ratio under 1.0 indicates that Black, Asian and Minority Ethnic applicants are more likely to be appointed than White applicants and vice versa. A ratio of 1.0 indicates equal likelihood for both groups.

The relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants has sharply increased from 1.15 in August 2026 to 6.38 in September 2026. This increase is due to September having a higher than usual number of shortlisted applicants in both the non-disabled and disabled categories but the percentage of disabled candidates being appointed this month was much lower than previous months.
The higher the ratio the more likely non-disabled applicants are to be appointed than disabled applicants. A ratio of 1.0 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 NHS Workforce Race Equality Standard (WRES), NHS Workforce Disability Equality Standard (WDES), NHS England's EDI Improvement Plan, pay gap reporting, Patient and Carer Race Equality Framework (PCREF) workforce actions and other national equality programmes into one coordinated delivery framework.
- Delivery of the plan forms part of the overarching culture plan, with progress monitored through the EDI Steering Group and reported to the People, Leadership and Culture Committee.
- Priority actions continue to be improving representation at senior levels, reducing workforce inequalities, strengthening inclusive leadership, supporting disability inclusion, flexible working and reasonable adjustments, and embedding anti-discriminatory practice across the Trust.

Risks

Failure to progress the EDI and anti-racism plan meaningfully could 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. The EDI function will have reduced capacity for a few months following departure of the Head of EDI. Temporary backfill arrangements are being put in place whilst the service is reviewed.

Oxford Health
NHS Foundation Trust

Section 4
Strategic dashboard

Strategic objectives

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

Strategic Dashboard

Strategic Objective	Strategic ambition	Metric	Target 26-27	Cumulative Apr-Sept 2026 performance (6-month position)
Quality	Care is planned and delivered around the needs of the patient	% of patients responding that overall, the care was good or very good - mental health	>=85%	Cumulative Apr - Sept 26: 87.65% Sept 26: 87.03%
		% of patients responding that overall, the care was good or very good - Primary, Community and Dental	>=85%	Cumulative Apr - Sept 26: 94.13% Sept 26: 94.11%
		% of patients report being involved in their care - mental health	>=80%	Cumulative Apr - Sept 26: 84.18% Sept 26: 81.20%
		% of patients report being involved in their care - Primary, community and dental	>=85%	Cumulative Apr - Sept 26: 92.52% Sept 26: 92.29%
	Patients are receiving effective care	% of adults and older adults accessing select Community Mental Health Services (CMHSs), having their outcomes measure recorded at least twice	Baselining	Metric in development to be reported
		% of children and young people accessing mental health services, having their outcomes measure recorded at least twice	Baselining	Metric in development to be reported
		% of women in the perinatal period accessing mental health services, having their outcomes measure recorded at least twice	Baselining	Metric in development to be reported
		% of Oxfordshire Stroke Rehabilitation Unit (OSRU) patients reporting improved functioning	tbc	Metric in development to be reported
	We provide timely access to care and when waits occur we will effectively monitor patients and minimise harm	% of children and young people, carers/families receiving meaningful contact within 4 weeks from request for mental health service	>=62% April - June >=68% July - Sept >=72% Oct - Dec >=76% Jan-Feb >=80% March 27	Cumulative Apr - Sept 26: 75.70% Sept 26: 85.25%
		Average response time for out of hours palliative care referrals: the waiting time from receipt of the call from 111 to the start of the telephone consultation (<=30mins)	>=90%	Cumulative Apr - Sept 26: 95.70% Sept 26: 97.96%
		Average response time for out of hours palliative care referrals: the time from completion of that triage call to the start of the home visit consultation (<=60mins)	>=90%	Cumulative Apr - Sept 26: 60.62% Sept 26: 56.46%
	We are addressing health inequalities	% of breastfeeding prevalence at 6-8 weeks	>=60%	Cumulative Apr - Sept 26: 64.99% Sept 26: 62.70%
		Rate of meaningful data completeness in the domain of "ethnicity/ethnic group" on electronic health record for the Trust's core mental health services as defined in Mental Health Minimum Dataset	>=90%	Cumulative Apr - Sept 26: 83.46% Sept 26: 84.10%
	We consistently provide safe care, with a reduction in avoidable in-service harm	National Early Warning Score (NEWS) [national tool for detecting clinical deterioration], completed correctly where applicable – Community	>=90%	Cumulative Apr - Sept 26: 84.29% Q2: 87.80%
		Outcome of National Early Warning Score (NEWS) [national tool for detecting clinical deterioration] escalated appropriately – Community	>=90%	Cumulative Apr - Sept 26: 67.45% Q2: 68.30%
		Reduction in use of prone restraint	Less than 105 in year	53 year to date
		Reduction in the use of seclusion	Less than 414 in year	263 year to date
	We have a safe and learning culture	Response to staff survey question-I would feel secure raising concerns about unsafe clinical practice	>79.05% (2025 score)	Annual metric - 2026 results available in March 27

Strategic Dashboard

Strategic Objective	Strategic ambition	Metric	Target 26-27	Cumulative Apr-Sept 2026 performance (6-month position)
People	We have a sustainable workforce	Reduce agency usage to meet target	<=2.47%	Cumulative Apr - Sept 26: 1.84% Sept 26: 1.69%
		Reduction in % labour turnover	<=12%	Average Apr - Sept 26: 9.36% Sept 26: 9.22%
		Develop approach to workforce planning (Process Measure)	Narrative	We are looking to the SE Regional team to support us in relation to an approach for workforce planning within the Trust.
	We have an engaged, well led workforce	Staff survey staff engagement score	>=7.21 (2025 score)	Annual metric - 2026 results available in March 27
		Confirm Trust's approach to leadership development (Process Measure)	Narrative	An organisational culture plan for the Trust has now been approved (ELTM 3/9) as a key enabler of the new organisational strategy. The foundational phase of the programme (2026-28) includes development for multi-disciplinary leadership teams; and for individual leaders and managers aligned to NHSE Leadership and Management Framework. The pilot cohorts for these two offers are respectively underway now and in development for Q4.
	We have a skilled, learning workforce	Number of staff who have completed Quality Improvement Training Level 1		1431 as of Sept 26
	We foster a just work environment	Black, Asian and Minority Ethnic representation across all bands including Board level	>=19%	Cumulative Apr - Sept 26: 28.76% Sept 26: 29.21%
		Black, Asian and Minority Ethnic representation in senior leadership roles (Bands 8a-8d, Band 9, Very Senior Manager)	>=19%	Cumulative Apr - Sept 26: 14.38% Sept 26: 14.42%
		Develop our approach to mitigating the intersectional impacts of disadvantage, discrimination & bias (Process Measure)	Narrative	An overarching Equality, Diversity and Inclusion (EDI) Plan has been developed and is monitored as part of the Trust's culture plan. The EDI plan brings together all inclusion-related work, including the anti-racism programme, workforce elements of PCREF and all action plans relating to regulatory reports such as Pay Gap reports and WRES/WDES. The plan incorporates established initiatives (e.g. Inclusion Representatives) and more recent NHSE requirements, e.g. Trust-wide approach to eliminate antisemitism, Islamophobia and other forms of hate; implement an Equality Analysis framework, etc. Delivery of this plan is monitored through the EDI Steering Group and will support the Trust in responding effectively to the needs of an increasingly diverse and evolving population.

Strategic Dashboard

Strategic Objective	Strategic ambition	Metric	Target 26-27	Cumulative Apr-Sept 2026 performance (6-month position)
Sustainability	We are spending and investing as efficiently as possible and sustaining our financial position over the medium term	Set and meet plans to deliver a balanced or surplus budget each year in revenue	Narrative	The Trust's plan for 2026-27 is for a breakeven financial position. At month 6 the Trust has delivered a surplus of £0.4m YTD which is £0.2m better than the profiled plan of a £0.2m surplus. The forecast is on track for the Trust to deliver a breakeven position for the year. The plans for 2027-28 and 2028-29 are also for a breakeven position. These plans will be refreshed as part of the planning submissions in the next few months but are expected to remain as breakeven.
		Set and meet plans to deliver a balanced or surplus budget each year in capital	Narrative	The Capital Plan for 2026-27 is £14.3m. At month 6 the trust has spent 27% of this funding and plans to spend the full budget by year-end. Capital plans for future years will be updated as part of the planning submissions in the next few months.
		Achieve National Cost Collection of 100 or below	<=100	Annual metric - not due yet
	We are on track for net zero carbon emissions by 2045 as defined with the NHS Carbon Footprint plus	By 2026, achieve 29% reduction in direct carbon emissions compared to 2019 baseline.	>=36% (3920 tCo2)	Annual metric - not due yet
		Confirm the baseline for supply chain carbon emissions and update the Trust Green Plan to show how carbon reductions will be delivered.	Narrative	Supply chain carbon baseline (NHS Carbon Footprint Plus) methodology finalised and FY25/26 data collection completed across key emissions categories. Priority hotspots identified across medicines, medical and non-medical supplies, facilities and IT.
	Our digital systems work for us, providing and asking for the right information to enable clinical care and population health management	Achieve an average score of 4 out of 5 in sections "ensuring smart foundations" within the Digital Maturity Assessment	>=4	Annual metric - not due yet
		Achieve an average score of 4 out of 5 in section "improve care" within the Digital Maturity Assessment	>=4	Annual metric - not due yet
	We will have moved towards a modern, efficient estate that enables access and wellbeing for staff and patients	Develop a strategy for our estates (Process Measure)	Narrative	The production of the Estates strategy has been rescheduled to coincide with the development of the Trust strategy in 2026, to ensure alignment with clinical plans. Directorates are considering clinical priorities in line with the 10-Year Health Plan for England, and the Estates team are undertaking a diagnostic exercise to fully understand the priorities within our estate. This will also support production of the five-year capital plan which is a requirement for all NHS Trusts and will align with the future Estates strategy. The Estates Strategy will be submitted for approval in November 2026.

Strategic Dashboard

Strategic Objective	Strategic ambition	Metric	Target 26-27	Cumulative Apr-Sept 2026 performance (6-month position)
Research	We will sustain our leadership in research, strengthen our academic partnerships and embed research capability in the organisation	Participants recruited to Research Delivery Network (RDN) portfolio studies by directorate	Narrative	Significant progress has been made in delivering high-quality portfolio research and expanding access to research participation. • The ***ENIGMA Phase 3* schizophrenia trial**, OHFT highest recruiter in the UK, recognised y the UK Clinical Research Delivery program as a national success story. • Opened the ***Improving Black Health Outcomes (IBHO)* and *Addressing Bullying, Harassment and Abuse of NHS Staff (BHA)*** studies, supporting research reducing inequalities and improving inclusion amongst both patients and NHS staff. • Recruitment supported through studies such as ***UK REACH – I-CARE WP4*,** nationally significant research focused on workforce wellbeing and retention amongst healthcare staff from ethnic minority backgrounds. • Exceeded recruitment target for ***READ-OUT***, a real-world observational study exploring the use of blood biomarkers in dementia assessment. Have developed an innovative data-led pre-screening that uses READ-OUT biomarker findings to support potential participants for commercial dementia studies. Demonstrate the breadth of research activity across the Research Delivery Teams, portfolio study delivery, innovation in recruitment practices and inclusive research participation.
		Number of active or aspirational principal investigators (PI) by directorate	Narrative	Trust-wide Principal Investigator (PI) development programme continues to progress in collaboration with the ***Mental Health Translational Research Collaboration (MH-TRC), OH-Biomedical Research Centre (BRC) and external partners***. • Forthcoming ***PI development training programme*** by Dr Katy Smith with support from the MH-TRC will provide structured support for aspiring research leaders to develop the next cadre of PIs. • **Several new PIs** have been onboarded across the Trust, strengthening research leadership capacity and increased study delivery. • Identified a **network of champions** to support implementation of the Associate Principal Investigator (API) scheme, creating clearer pathways into research leadership roles. • Research Training and Engagement Team is developing ***Studyline*** to improve reporting and oversight of PI activity, enabling more effective workforce planning and identification of future research leaders across directorates. • Research Informatics Team supporting Professor Benita Oliver, via ***OH-BRC funding to expand a database of Nurses, Midwives and Allied Health Professionals (NMAHPs)*** to baseline and monitor activity in development of NMAHP PIs.
	We will build our capacity to translate our research into services	Number of dual academic/clinical role	Narrative	• Appointed a ***lead for the development of a medical research strategy***, with a particular focus on increasing participation in dual academic and clinical roles and creating clearer pathways for clinicians wishing to combine research and clinical practice. • Strengthen links between ***research infrastructure, clinical services and academic partners*** for growth in clinical academic capacity. • Ensure that research activity is aligned with ***Trust strategic objectives and national research agendas***. This strategic oversight will develop research programmes that address identified organisational and population needs, rather being solely on individual areas of interest. • ***An R&D Steering Committee*** that will provide oversight of research development activity, helping to ensure that investment in research capacity and clinical academic leadership delivers the Trust's strategic objectives, service transformation priorities and meeting the NIHR's 150-day set up target.
		Develop infrastructure to translate research into services and demonstrate impact (Process Measure)	Narrative	• A translational research project developed by the ***Oxford Cognitive Approaches to Psychosis (OCAP) team*** and delivered by the Trust has now progressed into routine clinical care, demonstrating the potential for research to directly influence services and patient outcomes. • Actively identifying funding opportunities to support ***translational focused on improving care for people living with dementi***a. • ***Thames Valley Applied Research Collaboration (ARC)*** has expanded, supporting access to expertise, partnerships and implementation resources. • ***Trust's intellectual property (IP)*** processes and policies are being renewed . A stronger framework for identifying, developing and commercialising innovations arising from Trust-led research and compliance with National Institute for Health and Care Research infrastructure requirements.

Oxford Health
NHS Foundation Trust

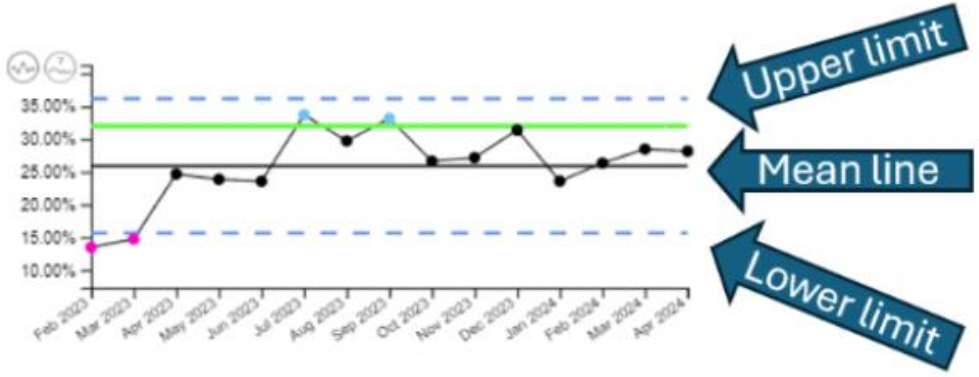
General Appendices

Guide to the Integrated Performance Report – interpreting SPC charts

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.

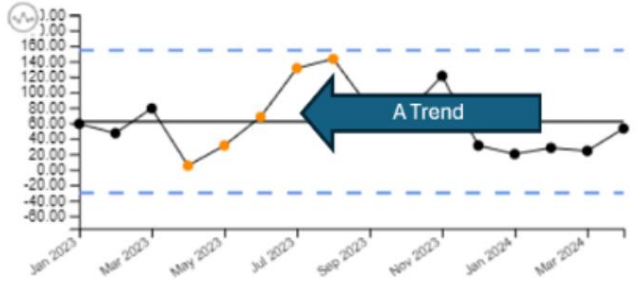
The SPC chart has three lines on it: central line (mean line; black) is the average of data and blue are upper and lower control limits. If data points are within the control limits, it indicates that the activity is within normal range. If the data points are outside of these control units, it indicates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



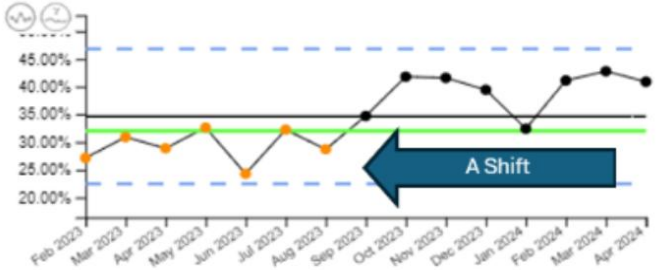
Upper and lower limits on an SPC chart are calculated using statistical formulas based on actual data, typically, by measuring the average and natural variation, to identify the range within which the process should operate if it remains stable.

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

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

	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.

Guide to the Integrated Performance Report – Exception reporting

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”

Latest NHS Thames Valley Integrated Care Board (TV ICB) Performance (source: Mental Health Core Data Pack)

Metric	Latest ICB Target	June-26 / quarter 1					Jul-26					Aug-26				
		TV ICB	Oxon	Bucks	Berks W	Frimley	**TV ICB**	Oxon	Bucks	Berks W	Frimley	**TV ICB**	Oxon	Bucks	Berks W	Frimley
Mean LoS adult acute and PICU discharges	44	**47**	47	33	54	55	**45**	44	39	47	50	**44**	45	41	42	49
Mean LoS older adult acute discharges	76	**71**	57	63	100	80	**67**	56	46	94	80	**69**	60	57	92	77
72hr Follow-up	null	**84%**	84%	76%	90%	84%	**80%**	92%	67%	82%	75%	**82%**	84%	85%	87%	73%
Absolute difference between White and non White per 100,000 of CYP 1+ contact (12 month rolling)	null	**1417**	n/a	n/a	n/a	n/a	**1283**	n/a	n/a	n/a	n/a	**1268**	n/a	n/a	n/a	n/a
Absolute difference between White and non White per 100,000 of detentions (12 month rolling)	null	**42**	n/a	n/a	n/a	n/a	**58**	n/a	n/a	n/a	n/a	**57**	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	**18**	n/a	n/a	n/a	n/a	**21**	n/a	n/a	n/a	n/a	**20**	n/a	n/a	n/a	n/a
Closed referrals from CMH services for people aged 18 and over with at leat 2 contacts and any perspective paired score	null	**13%**	9%	14%	18%	14%	**13%**	9%	16%	19%	14%	**14%**	10%	17%	20%	15%
CYP 1+ contacts (target changing periodically)	33239	**34795**	10020	8860	9110	6845	**34690**	9970	8945	8760	7055	**34755**	9950	8940	8825	7090
CYP Paired scores (%)	null	**18%**	*	*	*	*	**24%**	*	*	*	*	**21%**	*	*	*	*
CYP Self-rated measurable improvement (%)	null	**39%**	*	*	*	*	**50%**	*	*	*	*	**50%**	*	*	*	*
CYP supported through NHS funded MH with a least 1 contact with an education-based MH support team (MHST)	5290	**6870**	1530	1580	1715	2050	**6885**	1550	1605	1645	2085	**7040**	1565	1620	1755	2105
Open CYP referral-spells with a MH related wait of more than 104 weeks for a full clock stop (target changing periodically)	4090	**5985**	2865	985	1240	890	**5965**	2815	945	1270	940	**5635**	2600	855	1215	900
Open CYP referral-spells with a MH related wait of more than 104 weeks for a full clock stop	null	**45%**	54%	45%	40%	33%	**46%**	57%	48%	42%	32%	**49%**	61%	52%	43%	34%
CYP ED Routine (interim)	null	**78%**	56%	78%	94%	*	**85%**	83%	74%	100%	100%	**86%**	86%	75%	100%	100%
CYP ED Urgent (interim)	null	**94%**	95%	*	*	*	**95%**	100%	86%	100%	86%	**95%**	100%	100%	100%	71%
Dementia: 65+ Estimated Diagnosis Rate (quarterly from FY26-27)	null	**63.2%**	65.1%	59.4%	64.9%	63.1%	**n/a**	n/a	n/a	n/a	n/a	**n/a**	n/a	n/a	n/a	n/a
EIP 2 week waits	null	**60%**	65%	46%	*	*	**61%**	67%	47%	*	*	**67%**	78%	48%	*	*
Hospital spells in the RP readmitted within 14 days where bed type is adult acute or older adult acute or PICU	null	**5%**	3%	10%	*	5%	**5%**	3%	7%	*	5%	**5%**	4%	8%	*	*
Inpatient No Contact	null	**10%**	12%	14%	9%	*	**9%**	11%	12%	9%	*	**8%**	10%	13%	7%	*
Individual Placement and Support (IPS, rolling 12 month; target changing periodically)	1895	**2035**	800	375	445	415	**1980**	745	365	435	430	**1995**	740	365	435	450
OAPs active at the end of the period (inappropriate only)	5	**15**	*	*	5	*	**10**	*	*	5	*	**15**	*	*	*	5
Percentage of inappropriate OAPs bed days in Adult acute beds in the period	null	**5.7%**	1.8%	7.7%	7.9%	7.1%	**5%**	1.40%	7.20%	6.80%	5.70%	**3.60%**	1.50%	3.80%	5.60%	4.30%
Percentage of inappropriate OAPs bed days in all other relevant bed types (adult rehab)	null	**10.8%**	50.4%	3.6%	10.9%	16.4%	**12.30%**	44%	3.50%	11.70%	32%	**11%**	55.40%	3.50%	10%	24.70%
Perinatal access (rolling 12 month)	2062	**2140**	705	395	735	305	**2415**	690	385	725	340	**2185**	685	390	735	375
Restrictive Interventions per 1,000 bed days	null	*****	*	*	*	*	*****	*	*	*	*	*****	*	*	*	*
SMI PH (quarterly metric)	null	**53%**	49%	50%	51%	62%	**n/a**	n/a	n/a	n/a	n/a	**n/a**	n/a	n/a	n/a	n/a
Talking Therapies Completing a course of treatment (target changing periodically)	2152	**2270**	820	710	405	334	**2415**	830	685	450	445	**1985**	645	620	390	325
Talking Therapies Completing a course of treatment - Rolling 12 months (target changing periodically)	null	**28100**					**27790**	8940	8250	5310	5290	**27570**	8925	8205	5310	5130
Talking Therapies Reliable Improvement (target changing periodically)	69.0%	**69%**	70%	70%	67%	68%	**68%**	69%	67%	70%	66%	**67%**	67%	65%	71%	67%
Talking Therapies Reliable Recovery (target changing periodically)	51.02%	**50%**	50%	52%	48%	47%	**47%**	47%	49%	47%	44%	**47%**	47%	46%	50%	45%
Urgent referrals to CCS (contacts within 24hrs)	null	**70%**	83%	77%	65%	38%	**67%**	87%	66%	71%	60%	**75%**	77%	82%	75%	66%

* 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

Oxford Health NHS Foundation Trust's NOF segmentation and ranking on the League table during 2025 – 26*:

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	

* See the Addendum below for information on Segment change in Quarter 4:

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 (above average)** based on its true performance.

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)

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	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	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)

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)

Board meeting in public

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

Glossary of metrics (in continuous development)

Area	Metric	Definition	Why is it important?
Quality and People	**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	**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.
	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.

Oxford Health
NHS Foundation Trust

Meeting	Board of Directors
Date of Meeting	25 November 2026
Agenda item	11(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	☐ Decision/approval ☑ Information ☑ Assurance
Reason for submission to the group	Quality surveillance report.
For disclosure or confidential	Public

Executive summary

The Trust produces a monthly Quality and Safety Dashboard as part of our quality surveillance and quality management system.

The data being presented up to 30th September 2026 and waits data is pulled at the time of writing the dashboard. Qualitative and quantitative 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 is detail in the body of the report about the newly published national core quality metrics which will be used to monitor the new national Quality Strategy.

The escalation criteria used for the Dashboard has been recently reviewed and updated, the changes are described in the report with the updated escalation criteria in Appendix B.

The three teams/wards identified in last month's dashboard in enhanced support/warning; CAMHS Meadow PICU, CAMHS Highfield and the City and NE AMHT, have been moved into the new escalation level of Quality concerns but mitigations/improvement plan in place with monitoring.

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.

Link to CQC domain – where applicable

☑**Safe** ☑**Effective** ☑**Caring** ☑**Responsive** ☑**Well-led**

Links to / Implications

Links to Board Assurance Framework (BAF) risk(s) / Trust Risk Register (TRR)	☐ **BAF**	☐ **TRR**

Equality, diversity and inclusion	No
Legal and regulatory	We are 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 up to 30th September 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 dashboard uses a range of quality indicators, both qualitative and quantitative, to identify teams/wards by exception that might be struggling and need support. The full list of indicators are shared in Appendix A these cover workforce and the quality domains of safety, clinical effectiveness and patient experience. Developments continue to be made to the automated quality and safety dashboards available to all staff on TOBI (Trust online Business Intelligence Tool). The underlying data was shared with the members of the Quality and Clinical Governance Group and the Trust's Quality Committee.

For awareness a set of core quality metrics were published by NHSE in August 2026 to accompany and monitor the impact of the new Quality Strategy for the NHS. The metrics use available national data against the quality domains, with the full list of metrics available here https://www.england.nhs.uk/wp-content/uploads/2026/07/prn01848-iii-quality-strategy-technical-annex-aug-2026.pdf. There are a high number of metrics that are based on mortality, then a number based on annual staff and patients survey results, and a number on national data sets related to the NHS Oversight Framework and clinical national standards. Some of the relevant metrics taken from national standards include; access and waiting times, Talking Therapy recovery rates, SMI and learning disability patients annual physical health checks, use of restrictive practice, types of infection rates, inappropriate out of area placements, 72 hour follow up after mental health inpatient discharge, formal complaints, workforce sickness and vacancy rates, patients aged 65+ flu vaccination rates and inpatient falls resulting in a fracture. All of the national standard metrics are reported on in the monthly integrated performance report that goes to the Executive Team and Trust Board. There are no immediate gaps identified in the indicators used in the monthly quality and safety dashboard.

Escalation Criteria

The escalation criteria has been updated, the changes are to amend the term for enhanced support to enhanced warning and to introduce an additional level called 'Quality concerns but mitigations/improvement plan in place with monitoring'. 'Quality concerns but mitigations/improvement plan in place with monitoring' is being introduced to categorise those teams where there are some ongoing concerns (the criterion for Enhanced Warning is met) however the issues are well understood and there are good mitigations and improvement actions in place with close monitoring. The updated escalation criteria is included in Appendix B.

2. Trust-wide 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 changes in the Dashboard this month are as follows;

- Moved out of early warning: Bicester community hospital ward, Adult Speech & Language, Community Respiratory service, Ashurst Adult PICU, and CAMHS Marlborough House.
- New to early warning: Vaughan Thomas ward
- Moved out of enhanced warning into 'Quality concerns but mitigations/improvement plan in place with monitoring': CAMHS PICU Meadow Unit, CAMHS Highfield Unit, and Oxon City and NE AMHT (specifically Aspen team).

	Quality concerns but mitigations/improvement plan in place with monitoring	Enhanced Warning	Early Warning
Inpatient Wards	• CAMHS PICU Meadow Unit • CAMHS Highfield		• Ruby ward • Sapphire ward • Linfoot community hospital ward • Vaughan Thomas ward • Wintle ward

	Quality concerns but mitigations/improvement plan in place with monitoring	Enhanced Warning	Early Warning	
Community Teams	• Oxon City and NE AMHT (Aspen Team)		• Aylesbury CMHT (adult) • 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 • Nutrition and Dietetics • Podiatry • Special Care & Paediatric Dentistry • Oxon South Assessment and Treatment AMHT • 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. Buckinghamshire Mental Health Service

3.1 Performance on inpatients followed up within 48 hours of discharge

The national target is within 72 hours and the internal Trust target is within 48 hours. 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 Sept 2026 is 30 eligible discharges in the 'Bucks Place' commissioning area and 0 breaches to 48-hour follow up. 1 case had DQ elements to resolve to add a contact that had been completed.

3.2 Detail about wards and community teams highlighted

There are no identified wards/teams in Enhanced Warning.

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

Wards at Early Warning

Ward	Reason for highlighting
Sapphire ward	• Sickness 6% in Sept 2026. Vacancies low and safe staffing levels met. • 5 AWOLs in Sept 2026 (same as in Aug 2026) both escorted and unescorted, involving 4 patients. Raised number of AWOLs over the last 3 months. • High number of incidents on the ward relating to violence mostly verbal abuse from patients to staff, on average 13 incidents a month and 15 in Sept 2026. • 0 high/low complaints, 1 rapid resolution complaint and 1 early resolution concern received in Sept 2026. Number of concerns reduced over last few months. • Use of restrictive interventions reduced in Sept 2026 from previous months. In Sept 2026 the following was used; 6 physical restraints, 3 seclusions, 1 use of rapid tranquilisation and 3 uses of LTS.
Ruby ward	• Vacancies low (3.7%) and sickness at 6% in Sept 2026. Safe staffing levels met. • High use of medic agency in the last 3 months and recent locum identified has withdrawn. • Supervision level low at 64% in Sept 2026. • Challenging cohort of patients on the ward with complex discharge plans. • Raised number of incidents since April 2026 and continued in Sept 2026 with 99 incidents of which 1 caused moderate harm. Most incidents relating to physical illness/condition for 1 patient who is experiencing a very high number of psychogenic non-epileptic seizures. • 1 rapid resolution complaint received in Sept 2026 about detention under MHA. Reduction in rapid resolution complaints and early resolutions in Sept compared to previous months. • 2 CQC enquiries raised in last 3 months about care on ward and the inpatient death. • Use of restrictive practice has reduced in Sept 2026 when it had been very high in Aug 2026. In Sept 2026; 4 uses of physical restraint (1 in prone position) and 2 uses of seclusion.

Community Teams at Early Warning

Team	Reason for highlighting
Aylesbury CMHT (adult)	• The team saw an increase in rapid resolution complaints in Sept 2026 (n=6) about changes in care team/care continuity and poor communication. • Core clinical standards audit in Sept 2026 overall score shows need for improvement at 62. • 30 current patients waiting more than 4 weeks to have 2 contacts, as of end of Sept 2026 (28 patients last month). Of which 4 patients waited longer than 12 weeks. • Performance with patients on open caseload having a care plan on RiO or True Colours (Sept 2026); 60%, similar to last month. [Includes only patients with an open referral for more than 90 days and at least 1 attended appointment. However the figures does include patients open to psychiatry/psychology where there is not the same requirement to complete a care plan in the care plan templates on RiO/True Colours.]

Team	Reason for highlighting
	• The team has had some staffing challenges related to long term leave. Vacancies worsened, 15% and sickness 8.3% in Sept 2026.
CAMHS ADHD and Autism service	• As of end of Sept 2026: 3,879 patients waiting for assessment (last month at 3,902). 2,150 patients have been waiting for more than 1 year (reduction from last month). Longest waiter 4.8 years. There are also a significant number of patients waiting post assessment to start medication. • Staff vacancies high in Sept 2026; 41% (similar to last month).
Adult ADHD and Autism	As of end of Sept 2026, • Adult ADHD: 825 patients waiting for assessment (last month at 863). 820 patients have been waiting for more than 1 year (reduction from last month). Longest waiter 6 years. • Adult Autism: 408 patients waiting for assessment (last month at 467). 335 patients have been wating for more than 1 year (reduction from last month). Longest waiter 4.3 years. Improvement plan to support current demand and capacity gap in place. Recent patient safety thematic review completed Sept 2026 identified learning around communication with patients whilst on the waiting list. Data is reported monthly by the Trust into the ICB.
Complex Needs Service	National 4 week wait target, as of end of Sept 2026 (based on current patients waiting that have not yet had 2 contacts, pathway level); 30 patients waiting (30 patients last month). 9 patients have waited more than a year, 2 more than 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 clinic services	As of end of Sept 2026– 701 patients currently waiting for 60 days or longer against wait standard (last month 723 patients). 7 patients have been waiting for more than 1 year, 1 more than last month.
Adult PCMHT	National 4 week wait target, as of end of Sept 2026 (based on current patients waiting that have not yet had 2 contacts, pathway level); 91 patients waiting (112 patients last month). 1 patient has been waiting for more than 1 year.
Adult Psychological therapies	National 4 week wait target, as of end of Sept 2026 (based on current patients waiting that have not yet had 2 contacts, pathway level); 61 patients waiting (58 patients last month). 1 patient has waited more than a year.

4.1 Detail about wards and community teams highlighted

There are no wards/teams identified at Enhanced Warning.

Wards at Early Warning

Ward	Reason for highlighting
Linfoot ward	• Overall incidents have reduced in Sept 2026 (from July and Aug 2026), and there were 0 moderate harm incidents in the month, however 4 of the incidents related to pressure damage developed while on the ward (most being category 2). • Vacancies 14% (worse than last month) and sickness 3.4% in Sept 2026. Staff fill rates lower than expected for registered staff day shifts (66%) and registered staff night shifts (68%). Bed occupancy in Sept 2026 – 93%.

In addition, staffing levels were not fully met as expected on Abbey ward and Wenrisc ward often with fewer registered staff. These were also the wards with the highest staff sickness. However because none of the quality indicators flagged they are not listed in early warning.

Community teams at Early Warning

Team	Reason for highlighting
District Nursing Service	• The Oxfordshire district nursing service is under huge demand meaning the current resource is very challenged. The service sees around 12,000 patients a month. Several external and internal demand/capacity exercises over the years have shown the Oxfordshire commissioned service is not sufficient to meet population needs and is less well-resourced to their counterpart services in Buckinghamshire and Berkshire. The ICB is aware of the capacity challenges and have been leading a BOB and now Thames Valley review of the model of District Nursing Services. The Trust has put additional investment into the service in 2026/27 which will help greatly however this will not increase capacity enough to meet total demand. There are around 500 cancelled/deferred appointment each day whereby capacity cannot meet demand. There is also a waiting list on top of this for routine bloods and continence assessments • The focus at the moment is on centralising the triage service, developing a same day responder model and using ambulatory clinics for urinary catheter care, IV maintenance care and nephrostomy care. There is also work to strengthen the clinical prioritization/escalation framework (agreed with the ICB) and scheduling processes so these are as effective as possible and support frontline staff. The changes are managed through a service improvement plan for the service overseen by the Service Director and Clinical Director monthly. • There is weekly senior clinical oversight of incidents related to delays in treatment to identify learning and changes required. A deep dive on whether harm to patients is increasing as a result of delayed treatment was presented to the QCG Group in the Sept 2026 meeting. • The most commonly reported incidents, all levels of harm, are category 2 pressure damage followed by medicines administration/supply (particularly DTA). Most incidents are reported by the SW team however all teams report incidents. The incidents with moderate harm and above (n=27 in Sept) relate mostly to pressure damage, deep tissue injury and category 3. • Vacancies are low although higher in the City team. Sickness is 7% in Sept 2026, highest in the City, SE and SW teams. There was 0 staff RIDDORs in Sept 2026 however 2 in in the last 3 months relating to a staff fall and manual handling. • Supervision rates in Sept 2026 are variable from 49% to 76%. The NE, SE and City had the lowest levels. • There have been 9 PSIRP cases declared in the last 6 months (April to Sept 2026) involving the DN service, this includes 1 for the Phlebotomy service. Within the cases is a thematic review for the whole service focusing on the processes of prioritisation and

Team	Reason for highlighting
	scheduling visits and escalation routes when the service does not have capacity to see all high-risk patients. • Service received 0 high/low complaints, 3 rapid resolution complaints and 2 early resolution concerns in Sept 2026 about insufficient care, communication and length of wait for an appointment. Over the last 3 months (July-Sept 2026) most concerns have been raised about the City and North teams. There were also 9 compliments received in Sept 2026 and out of 44 IWCG responses in the month the average rating out of 5 was 4.95.
Children's Integrated Therapies – speech and language	• As of end of Sept 2026: 943 patients are waiting to be seen (1,134 patients last month). Of which 616 patients have been waiting for more than 18 weeks (reduction from last month). 27 patients have waited longer than a year (reduction, 86 last month). Median length of time to wait 27 weeks/average 25 weeks. • There are smaller waits for the CIT OT (overall 42 patients waiting, a reduction from last month) and physiotherapy services (overall 36 patients waiting, reduction from last month). Although no patients have waited more than a year to be seen. • Waiting well oversight: clear clinical triage and safety netting processes developed with monthly review trackers.
Nutrition and Dietetics	• As of end of Sept 2026: 354 patients are waiting to be seen. Of which 15 patients have been waiting for more than 18 weeks. 0 patients have waited longer than a year. Median length of time to wait 7 weeks/ average 8 weeks. • Supervision levels significantly dropped, 55%, in Sept 2026.
Podiatry	• The service has a caseload of around 9,200 patients. • As of end of Sept 2026: 2,111 patients are waiting to be seen, less than last month (2,149 patients last month). Of which 337 patients have been waiting longer than a year (slight increase from last month). Median length of time to wait 27 weeks/average 29 weeks. • There are also waits between treatment appointments affecting high risk/urgent patients on weekly follow up appointments that are being deferred due to capacity and pressure on the service. • Waiting well oversight: clear clinical triage and safety netting processes developed with monthly review trackers. • Vacancies in Sept 2026, 32% (improvement from last month) and agency use 6.4%. • Incident numbers have been fairly stable with 17 incidents on average a month. Slight increase in Aug 2026 but no increase in Sept 2026. Most incidents results in no specific harm or minor harm. There were 3 moderate/severe level harms in the last 3 months (July-Sept 2026) but 0 in Sept 2026. The severe harm related to how a referral came into the service which caused a short delay and a patients wound deteriorating. • 1 rapid resolution complaint and 2 early resolution concerns received in Sept 2026 (same number as in Aug 2026) about referral and information.
Special Care & Paediatric Dentistry	Waits for treatment under general anaesthetic (GA) for both children and special care adults. Waiting figures as of end of Sept 2026. ○ 149 children on the waiting list for treatment (132 last month), with waiting times currently up to 6 months. 36 children waiting > 18 weeks (34 children last month). The paediatric lists at the Horton Hospital lists have been suspended for 6 months (from 23/04/2026) and we are waiting for confirmation about if they will be reinstated. ○ 24 weekend sessions (10 all-day lists) – 85 children treated. (FY 26/27) ○ 5 adults have been assessed and are waiting for treatment at the Horton Hospital (9 adults last month), with waiting times of up to 8 weeks, these have reduced. 9 adults assessed and waiting for treatment at JR (10 adults last month), waiting times estimated to be up to 3 years. ○ 16 adults waiting for joint dental/anaesthetic assessment (waiting time from referral to assessment is up to 6 months). (23 adults last month)

Team	Reason for highlighting
	○ Additional paediatric GA weekend sessions are 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 Enhanced Warning. However, there were high medic vacancies in Sept 2026 across some of the wards including Woodlands (43%), Kingfisher (29%), Kennet (21%) and the prison in-reach services into Bullingdon (39%) and Huntercombe (73%). Kestrel and Kingfisher wards did not always meet expected staffing establishment in Sept 2026 however both wards were only occupied 50% by patients hence full staffing establishment was not required.

6. Learning Disability Services

6.1 Detail about community teams highlighted

There are no wards/teams identified at Early Warning or Enhanced Warning. However, there are high vacancies in the **Reasonable Adjustment Service** (66% in Sept 2026, worse than last month), 1 person recruited and waiting to start. 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 target is within 72 hours and the internal Trust target is within 48 hours. 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 Sept 2026 is 45 eligible discharges in the 'Oxon Place' commissioning area with 2 breaches to 48-hour follow up, detailed below;

- 1 patient discharged on a weekend and no communication with keyworker to update of discharge so delay in being seen.
- 1 patient was due to be discharged on the 15/9 with CRHT input, but discharge delayed and CRHT not informed of the discharge on the 17/9 hence no follow up over the weekend so delay in being seen.

There were also DQ issues with 3 discharge records that have now been amended.

7.2 Detail about wards and community teams highlighted

There are three wards/teams identified at 'Quality concerns but mitigations/improvement plan in place with monitoring', listed below.

Quality concerns but mitigations/improvement plan in place with monitoring

All three teams that were previously in Enhanced Warning have moved into 'Quality concerns but mitigations/improvement plan in place with monitoring', as the issues are well understood in relation to the indicators that are triggering and there are effective improvement plans in place with regular oversight and monitoring by the Directorate SLT. There have been recent deep dives into the issues and actions at the QCG Group meetings as well as the Quality Committee and Executive Team Meetings.

- CAMHS PICU Meadow Unit (next update with improvement plan due Nov 2026)
- CAMHS Highfield (next update with improvement plan due Nov 2026)
- City and NE AMHT, predominantly Aspen Team (next update with improvement plan due Dec 2026)

There are no teams identified under Enhanced Warning.

The following wards/teams are identified at an Early Warning;

Wards identified at Early Warning

Team	Reason for highlighting
Vaughan Thomas	• Increase in complaints/concerns received in Sept 2026; 3 rapid resolution complaints and 2 early resolution concerns about physical care needs, staff behaviour and assault by another patient. • 34 incidents in Sept 2026, including 2 AWOLs in Sept 2026 by the same patient (no specific harm identified) and 1 moderate harm incident following violence by a patient towards property.
Wintle	• Incident rate remained raised in Sept 2026. 3 moderate harm incidents in the month relating to a patient fall, patient found having sex with partner (that was visiting) and violence patient on patient. • Increase in use of restrictive practice: 14 physical restraints (involving 3 patients), 1 seclusion and 6 uses of rapid tranquilisation (involving 3 patients). 3 patients accounted for all the uses of restrictive practice. • Vacancies at 13% in Sept 2026, small improvement from last month, although safe staffing levels have been met. • 1 rapid resolution complaint received in Sept 2026 about a MH review tribunal. No significant change in trend over time.

Community Teams at Early Warning

Team	Reason for highlighting
South Assessment and Treatment AMHT	• 0 low/high level complaint and 4 rapid resolution complaints received in Sept 2026 communication and side effects for medication. This is an increase in rapid resolution complaints. • 2 suspected suicides in Sept 2026, both were open to the team at the time they died. This is an increase for the team although the numbers are small. • Vacancies for non-medics in the team are low (11% in Sept 2026), but for medics this is 33% (worsened since last month) • Performance with patients on open caseload having a care plan on RiO or True Colours (Sept 2026); 73% treatment team and 42% assessment team (improvement from last month). [Includes only patients with an open referral for more than 90 days and at least 1 attended appointment. However the figures does include patients open to psychiatry/psychology where there is not the same requirement to complete a care plan in the care plan templates on RiO/True Colours.] • Patients waiting more than 4-week wait (based on current patients waiting that have not yet had 2 contacts, pathway level) as of end of Sept 2026; 13 patients for assessment and treatment teams (12 patients last month). 3 patients have been waiting more than 12 weeks. • 2 PSIRP cases declared in the last 3 months (July-Sept 2026) both reviews are under way.
CAMHS ADHD and Autism service	• As of end Sept 2026 –4,464 patients waiting for assessment (last month at 4,424). 3,360 patients have been waiting for more than 1 year (a reduction of 20 patients from last month). Longest waiter 6.7 years. • There are also a significant number of patients waiting for a long period for medication to be started post assessment. • The service receives a high number of complaints, concerns and MP enquiries about waiting times. There was a reduction in Sept 2026 from previous months.
Oxon CAMHS	The demand for services has increased with around 500-600 referrals each month. National 4 week wait target, as of end of Sept 2026 (based on current waiting patients that have not yet had 1 contact, pathway level); • 32 patients waiting for GH, of which 16 for the supportive steps group. 18 out of the 32 patients have been waiting for more than 12 weeks. Vacancies high and supervision levels low for GH teams in the South and North in Sept 2026. • 27 patients waiting for GMH, of which 21 for the South team. Of which 15 patients have been waiting for more than 12 weeks. • 24 patients waiting for SPA, of which 6 for more than 12 weeks.

Team	Reason for highlighting
	• 5 patients waiting for Learning Disabilities CAMHS team (7 last month). 0 patients waiting for more than a year. There are also high vacancies in Sept 2026 for: CAMHS Eating Disorders 40%, CAMHS Cabhs 77%, CAMHS Crisis/outreach 22%, Perinatal 53% and the FASS team 85%. As well as significant medic vacancies across a number of teams with high agency use.
BSW CAMHS	National 4 week wait target, as of end of Sept 2026 (based on current patients waiting that have not yet had 1 contact, pathway level); • 6 patients waiting for BaNES GMH (6 last month). 4 patients waiting for more than 12 weeks. Supervision rate low at 55% in Sept 2026. Particularly high vacancies in Sept 2026 for medics in BaNES and Marlborough with high use of agency staff. A recent whistleblowing investigation at the Swindon CAMHS identified some work required around team leadership, culture and communication.
Adult ADHD	• The Oxfordshire Adult ADHD Service lacks sufficient operational capacity to meet demand - the service closed to new referrals in 2024. • The service has a waiting list of 1,771 patients awaiting assessment at the end of Sept 2026 (last month at 1,818). 1,771 patients have been waiting for more than 1 year (reduction from last month). Longest waiter is 6.8 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. • Supervision level in Sept 2026 at 50%. Improvement plan to support current demand and capacity gap in place. Recent patient safety thematic review completed Sept 2026 identified learning around communication with patients whilst on the waiting list. Data is reported monthly by the Trust into the ICB.
Complex Needs Service	National 4 week wait target, as of end of Sept 2026 (based on current waiting patients that have not yet had 2 contacts, pathway level); 89 patients waiting (last month 77). 57 patients have been waiting for more than 12 weeks including 4 patients for more than a year. The service saw an increase in suspected suicides in Sept 2026 with 2 current patients that have died. 0 suspected suicides in July and August 2026. There was an unusually high number of rapid resolution complaints made about the conduct of a staff member (n=44) in Sept 2026, the concerns were raised by members of the public. The concerns are being reviewed through appropriate processes.
Memory clinic services	As of end of Sept 2026– 245 current patients waiting for 60 days or longer against wait standard (last month 323 patients). 2 patients have been waiting for more than 1 year a decrease from last month.
Adult PCMHT (Keystone teams)	National 4 week wait target, as of end of Sept 2026 (based on current waiting patients that have not yet had 2 contacts, pathway level); 34 patients waiting (36 last month). 5 patients have been waiting for more than 12 weeks.
Adult Psychological therapies	National 4 week wait target, as of end of Sept 2026 (based on current waiting patients that have not yet had 2 contacts, pathway level); 27 patients waiting (25 last month). 12 patients have waited more than 12 weeks. 0 complaints and concerns received in Sept 2026. There had been an increase in low/high level complaints in July and Aug 2026.

Appendix A. Indicators used for the Dashboard

Below is a list of the indicators used to produce the monthly quality and safety dashboard and highlight teams by exception.

The live Quality and Safety Dashboards are available on TOBI (Trust on-line Business Intelligence tool), the inpatient wards and community teams are on separate dashboards as they have different indicators. Screenshots are shared below to show what staff can see in the Quality and Safety Dashboards alongside the data shown at ward and team level. For some of the indicators the data is outside the quality and safety dashboards these are identified below.

	Data Source	Inpatient Wards	Community Teams
		Indicators	Indicators
Workforce	Quality and Safety Dashboard on TOBI	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, with a focus on any severe harm incidents	Number of patient incidents with moderate or above harm, 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)
	Separate data after verification with directorates	Breaches to the 48 hour follow up after inpatient discharge	
	Separate PSIRP database	Number of Incidents under the PSIRP	Number of Incidents under the PSIRP
	Quality and Safety Dashboard on TOBI	Unexpected deaths (natural and unnatural) incl. within 2 days of inpatient stay	Unexpected/unnatural and suspected suicides
		Number of physical restraint episodes (<10) [for CAMHS wards need to consider number of YP. As usually 1 or 2 patients involved which account for the uses]	

	Data Source	Inpatient Wards	Community Teams
		Indicators	**Indicators**
		Number of prone restraints	
		Number of seclusion episodes	
		Number of uses of LTS	
	Narrative from FTSU Guardians	Intelligence from the Freedom to Speak up Guardians	Intelligence from the Freedom to Speak up Guardians
Clinical Effectiveness Domain	Quality and Safety Dashboard on TOBI. Waits data comes from a separate section in TOBI.	Median Length of Stay (discharged patients)	Number of current patients breached and still waiting; - Mental health services, 4WW pathway level (referral to meaningful contact; based on 1 contact CYP and 2 contacts Adults) and other national wait standards eg for memory services referral to assessment. - Community services waits based on national NHSE sitrep report where waits standards exist. - CAMHS and Adult Autism and ADHD waits referral to assessment, the data is manually verified so the data source used is not TOBI. - Dental service data based on locally held data as data not in TOBI.
		Number of Admissions in Month	
		Bed occupancy in month excluding leave	
	Care plan completeness from a separate section in TOBI		Mental health only. Includes only patients with an open referral for more than 90 days and at least 1 attended appointment. However the figures does include patients open to psychiatry/psychology.
	Separate HR data (waiting for OTR link into data warehouse to bring into TOBI)	Supervision and Mandatory Training	Supervision and Mandatory Training
Patient Experience Domain	Separate data from clinical audit team (waiting for AMAT link into data warehouse to bring into TOBI)	Clinical audit, starting with the mental health Core clinical standards audit	Clinical audit, starting with the mental health Core clinical standards audit
	Quality and Safety Dashboard on TOBI	Number of high/low complaints and rapid resolutions	Number of high/low complaints and rapid resolutions
		Number of early resolutions	Number of early resolutions
		Number of compliments	Number of compliments
		IWCG number of responses/average score across reviews in month	IWCG number of responses/average score across reviews in month
	Separate report from CQC team	Number of concerns raised by the CQC about care	Number of concerns raised by the CQC about care
All Domains	Narrative from Directorates	Key Directorate Risks and Issues	Key Directorate Risks and Issues

Appendix B. Escalation Criteria
Updated in October 2026.

The three-escalation levels and the expected response are detailed below, these are used as a guide.

Escalation level	Brief Description	When is a Team/ward Identified	Response
Early Warning	An emerging quality concern requiring validation and closer monitoring.	• 1 indicator is red rated, and 1 indicator is amber rated across at least 2 of the domains. This is a guide, and a clinical Directorate might identify a team for Early Warning from soft intelligence. • If one patient is causing a number of indicators to trigger this will not necessarily result in the team/ward being highlighted. • If 1 indicator is a significant concern or risk 'rated red' and warrants a need for monitoring such as a very high number of patients waiting over the national target or a number of patients waiting for a significantly long time, the team can be moved into early warning. • A red/amber rating of high vacancies on their own without concerns in fill rates (85% or above) will not cause an indicator to flag for a ward/team. • A red rating of fill rates will be considered in relation to safe staffing levels across registered/unregistered staff and looking at bed occupancy. This will not automatically lead to a ward/ team being identified. • A ward/team can remain at early warning for consecutive months if the concerns are well known/explored, there are mitigations and actions being taken and the risks to quality are being well managed. • A team/ward at Enhanced Warning level can be stepped down to Early Warning if agreed by the Directorate Clinical Director/Associate Director of Nursing. If a team is still triggering on indicators the decision needs to be agreed with the CNO or CMO.	• Monitoring led by the Clinical Directorate level through their quality governance structure.
Enhanced Warning	A stronger or persistent quality signal(s) indicating that a team requires	• 2 indicators are red rated across at least 2 domains. This is a guide, and a clinical Directorate might identify a team for Enhanced Warning from soft intelligence.	• Clinical Directorate to identify actions being taken and report these into the dashboard and

Escalation level	Brief Description	When is a Team/ward Identified	Response
	focused review and intervention/support.	• A team/ward at Enhanced Warning level can be stepped down to Early Warning if agreed by the Directorate Clinical Director/Associate Director of Nursing. If a team is still triggering on indicators the decision needs to be agreed with the CNO or CMO.	reviewed by the QCG group. • Additional support can be requested. • There may be a request for a more detailed presentation/deep dive by the CNO/CMO to come to the QCG group or another forum to look at the impact of the actions being taken.
Quality concerns but mitigations/improvement plan in place with monitoring	An ongoing concern where the issues are well understood and there are good mitigations and improvement actions in place, with effectiveness still being monitored.	• Criteria for Enhanced Warning met and there is an effective improvement plan in place that has been reviewed at the QCG group.	• Monitoring led by the Clinical Directorate level through their quality governance structure. • Progress on improvements reported to the QCG group or another Executive Director led forum at least 3 monthly.

For Information

Finance Report September 2026 (Month 6 FY27)
Report to Board of Directors

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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 6 YTD: £0.4m surplus, £0.2m better than plan
- Forecast: Breakeven, on plan



Capital Expenditure
- Month 6 YTD: £3.8m, £1.1m below plan



Cash
- Actual £107.9m

Key messages:

1. The month 6 YTD position is a surplus of £0.4m, which is £0.2m better than plan. Whilst agency spend remains better than plan, by £1.4m at M6, bank spend is worse than plan by £0.8m. Out of Area Placements are also above YTD budget by £3.1m and a forecasting to be £4.5m above budget by the end of the year.

2. Across the directorate positions the primary pressures relate to inpatient costs – additional staffing and use of Out of Area Placements. This is most prevalent in Buckinghamshire Mental Health which is forecasting a £2.9m overspend. These pressures are being offset in year by delays in new investment areas. Non-recurrent spend of £3m in FY27 and £1.7m in FY28 has been approved by the Executive team to improve waiting times, service quality and performance, which are partly funding by Provider Collaborative funding. This is factored into the Trust forecast.

3. Capital spend for the year to date is £3.8m, against a planned spend of £4.9m. The Estates dept have reprofiled several schemes in year. Fire compartmentation works remain a risk to the capital budget, depending on the timing of the works. Additionally, the capital plan remains oversubscribed on the assumption of some programme slippage. The PFI arbitration remains a risk until an award is made by the arbitrator.

1. Directorate Financial Performance Summary

	Month 6				Year-To-Date				Forecast			
	Plan	Actual	Variance	Variance	Plan	Actual	Variance	Variance	Plan	Forecast	Variance	Variance
Directorate	£m	£m	£m	%	£m	£m	£m	%	£m	£m	£m	%
Oxfordshire & BSW Mental Health	13.6	13.2	0.4	3.1%	80.8	79.9	0.9	1.1%	163.7	163.4	0.3	0%
Buckinghamshire Mental Health	6.5	7.0	-0.5	-7.0%	39.5	40.9	-1.4	-3.5%	79.9	82.8	-2.9	-4%
Forensic Mental Health	3.3	3.1	0.2	5.6%	19.5	19.4	0.1	0.3%	39.1	39.3	-0.1	0%
Learning Disabilities	0.6	0.6	0.0	-8.6%	3.5	4.0	-0.5	-14.6%	7.0	7.4	-0.5	-7%
Provider Collaboratives	-0.1	-0.1	0.0	-0.9%	-0.6	-0.6	0.0	0.2%	-1.2	-1.2	0.0	0%
MH Directorates Total	**23.9**	**23.8**	**0.1**	**0.4%**	**142.7**	**143.6**	**-1.0**	**-0.7%**	**288.5**	**291.7**	**-3.1**	**-1%**
Community Health Services, Dentisty and Primary Care	9.2	9.3	-0.1	-0.7%	56.3	55.4	0.9	1.6%	112.6	112.7	-0.1	0%
Corporate	3.9	4.0	-0.1	-1.3%	23.6	23.4	0.3	1.1%	47.6	47.1	0.5	1%
Estates & Facilities Directorate	2.5	2.6	-0.1	-5.1%	14.9	15.3	-0.4	-2.4%	32.4	32.4	0.0	0%
Oxford Institute Of Clinical Psychology Training	0.0	0.0	0.0	202.4%	-0.1	-0.1	-0.1	60.8%	-0.3	0.0	-0.3	0%
Pharmacy Directorate	0.4	0.3	0.0	7.6%	2.1	2.0	0.0	1.5%	4.2	4.2	0.0	0%
Oxford Pharmacy Store	-0.1	-0.2	0.1	49.3%	-0.7	-0.8	0.2	23.3%	-1.6	-1.6	0.0	0%
Research & Development	0.0	0.0	0.0	8.4%	0.1	0.0	0.1	85.7%	0.2	0.1	0.1	40%
Reserves	0.4	0.9	-0.5	140.6%	-1.1	0.0	-1.1	96.5%	-4.1	-4.0	-0.2	4%
Block Income	-41.7	-42.4	0.6	1.5%	-247.1	-247.5	0.3	0.1%	-497.9	-499.6	1.6	0%
EBITDA	**-1.5**	**-1.5**	**0.0**		**-9.4**	**-8.7**	**-0.7**		**-18.5**	**-17.0**	**-1.5**	
Financing Costs	1.6	1.5	0.1	6.4%	9.2	8.3	0.9	9.9%	18.5	17.1	1.5	8%
Adjustments	0.0	0.0	0.0		0.0	0.0	0.0		0.0	0.0	0.0	
Adjusted (Surplus)/Deficit	**0.1**	**-0.1**	**0.1**		**-0.2**	**-0.5**	**0.2**		**0.0**	**0.0**	**0.0**	

The month 6 position is a **£0.5m** surplus, **£0.2m** favourable to plan. The forecast is breakeven, which is on plan. The Buckinghamshire Mental Health adverse forecast position (**£2.9m**) is due to high out of area placements.

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. Forecast Risks & Opportunities

Risks	£'000	Likelihood
HMRC Ruling Changes	662	High
IT licenses VAT not recovered	279	High
Balance Sheet changes	3,000	Medium
Mental health out of area placements	2,000	Medium
Learning Disabilities OAPs	600	Medium
Bedday penalities	500	Medium
PC investment in CAMHS	200	Medium
Nursing review	150	Medium
Contract reduction	150	Medium
Springfields fire repairs	128	Medium
	7,669	

Opportunities	£'000	Likelihood
Capitalisation of revenue costs	400	High
Balance Sheet changes	3,000	Medium
Review provisions	1,400	Medium
Agree additional clinical income	1,307	Medium
Strategic Estates underspend	1,158	Medium
Agency Doctors VAT reclaim	555	Medium
Slippage on investment spend	323	Medium
Insurance Claim	320	Medium
Profit on sale of asset	110	Medium
Increase in R&D underspend	100	Medium
Agency Doctors VAT reclaim	1,471	Low
IT licenses VAT saving	584	Low
Reduction in spend in Forensics women's	200	Low
	10,929	

The Trust's Forecast Outturn is to be breakeven, which is on plan.

There are **£7.7m** of risks and **£10.9m** of opportunities to the forecast.

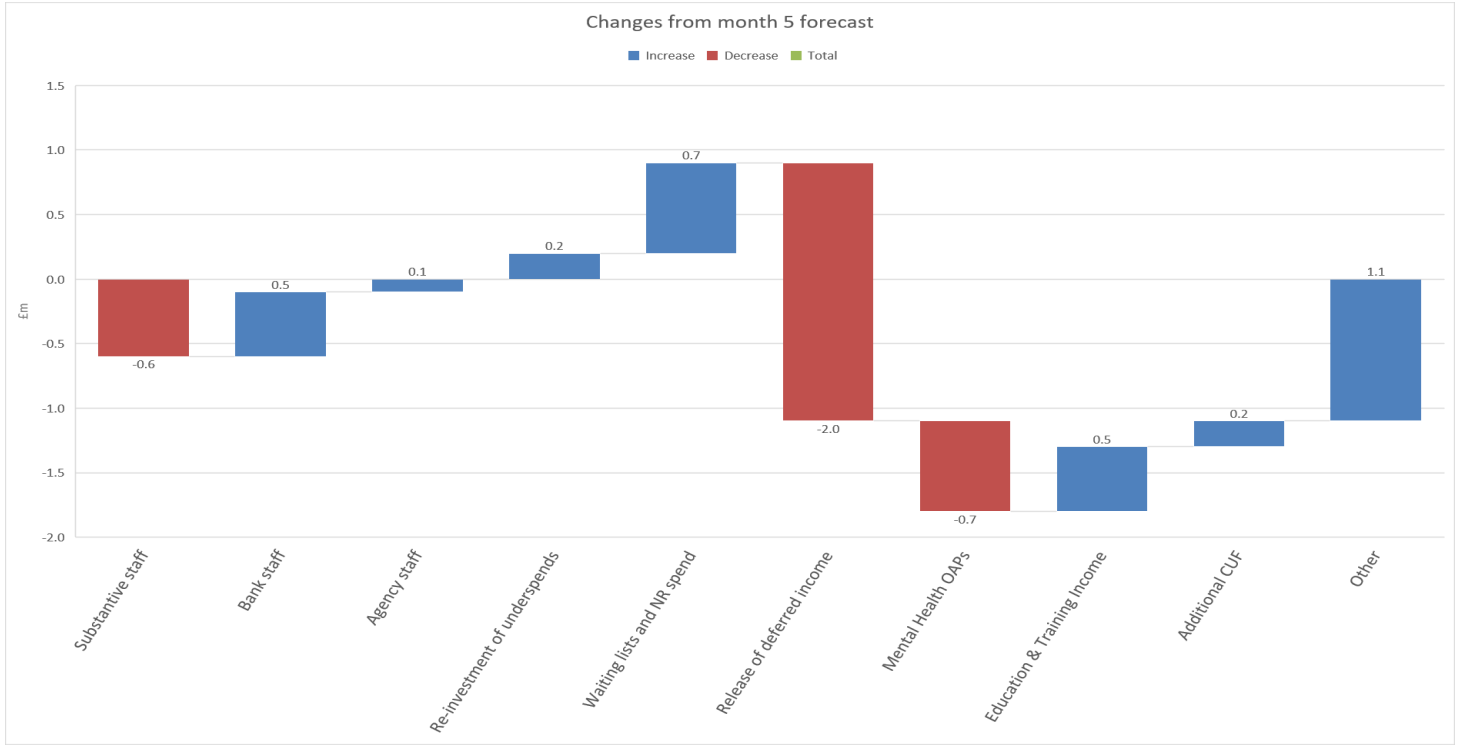
The forecast range for high likelihood risks and opportunities is between **£0.4m** worse than plan and **£0.9m** better than plan.

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

Forecast range - all risks and opportunities			
£'000	Full Year Budget	Full Year Actual	Forecast Variance
Upside Forecast	-0	-10,928	10,928
Downside Forecast	-0	7,669	-7,669

Forecast range - high likelihood risks and opportunities			
£'000	Full Year Budget	Full Year Actual	Forecast Variance
Upside Forecast	-0	400	-400
Downside Forecast	-0	-941	941

3. Changes From Previous Month's Forecast



- Increase = improvement in forecast,
- Decrease = worsening of forecast

- Some of the agreed re-investment of underspends and waiting list and non-recurrent spend will be incurred at the beginning of next financial year. The forecast has been revised to reflect this.
- The release of deferred income relates to Provider Collaborative investment to support addressing performance and quality concerns in CAMHS services, some of which are reflected in the Waiting list and NR spend column. As a result of the revised forecast on non-recurrent items the deferred income forecast has also been changed.
- Additional Cost Uplift Factor (CUF) funding was received in month 6 to fund changes to Resident Doctor payscales.
- Other reflects the net effect of lots of smaller movements in directorate positions and forecasts.

4. Capital Investment Programme – 2026/27

Project Groups	YTD Plan	YTD Actual	YTD Variance	FY Plan	FY Forecast	FY Variance
Agreed Plan FIC						
Operational	943	352	(590)	4,926	5,084	158
Transformational	246	262	16	3,748	2,386	(1,362)
IFRS16 - Leases	927	523	(404)	1,012	1,012	(0)
IT	1,021	1,311	291	1,750	1,750	-
Clinical Systems	472	335	(137)	750	756	6
Sub Total	**3,608**	**2,785**	**(823)**	**12,186**	**10,988**	**(1,199)**
Constitutional Standards Projects						
Constitutional Standards - Community Witney	34	34	-	-	34	34
Estates Safety Fund -Warneford Park **(TBC)**	-	-	-	-	-	-
Sub Total	**34**	**34**	**-**	**-**	**34**	**34**
Total NHSE Funded	**3,642**	**2,819**	**(823)**	**12,186**	**11,022**	**(1,165)**
Externally Funded Projects						-
Wantage	700	700	0	1,050	1,138	88
R&D Medical Equipment	267	138	(129)	533	533	-
Sub Total	**967**	**838**	**(129)**	**1,583**	**1,671**	**88**
Phase 2 Projects Agreed at M2 & M3 CPG						
Operational	245	120	(125)	541	433	(108)
Transformational	33	28	(5)	2,779	2,675	(103)
Medical Equipment	-	85	85	77	85	8
Sub Total	**279**	**233**	**(45)**	**3,397**	**3,194**	**(203)**
Grand Total - Approved	**4,887**	**3,890**	**(997)**	**17,166**	**15,887**	**(1,280)**
Estates Phase 2 Projects Unapproved						
Operational	59	(75)	(134)	-	59	59
Transformational	15	15	0	-	764	764
Sub Total	**73**	**(60)**	**(133)**	**-**	**823**	**823**
Grand Total	**4,960**	**3,830**	**(1,131)**	**17,166**	**16,710**	**(457)**

- The total confirmed funding of the Capital Programme for FY27 is **£14.3m,** made up of: £12.3m core, £0.4m Sale of South Parade and £1.6m Externally funded (£0.5m for R&D medical equipment, funded by NIHR, £1.1m Wantage Hospital funded by CIL & the Charity).
- Any **PFI exit** settlement or **Warneford** project spend capitalisation would increase the Capital forecast.
- Capital expenditure to M6 is £3.8m or 77% YTD plan, net of £0.4m VAT recovered. This represents 23% of FY Forecast and 27% of FY Funding.

Full Year Plan Summary

Dept	FY Funding	FY Forecast	YTD Actual	Var For vs Act	Unfunded For vs Fund
ESTATES	10,303	12,574	1,437	(11,136)	(2,271)
LEASES	1,012	1,012	523	(488)	0
IM&T	2,500	2,591	1,731	(860)	(91)
R&D	533	533	138	(396)	(0)
	14,348	16,710	3,830	(12,880)	(2,362)

The 3As from Capital Programme Group are:

Alert

- Estates & Facilities have reprofiled a number of projects during the year; however, the capital programme continues to forecast an overspend and remains subject to a range of risks and opportunities as set out in the programme risk and opportunity schedule.
- CPG considered the Springfields fire safety works business case and recommended approval of spend to enable progression of the scheme.

Advise

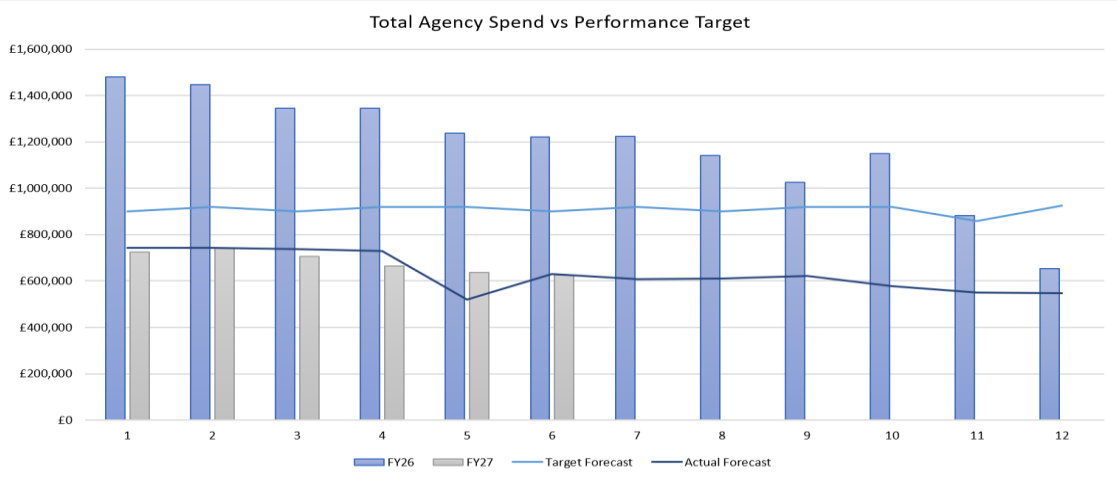
- The Trust is entering a commercial dispute relating to one of its capital schemes, which may impact project delivery, timescales, and financial outcomes, although the majority of work has already been completed.

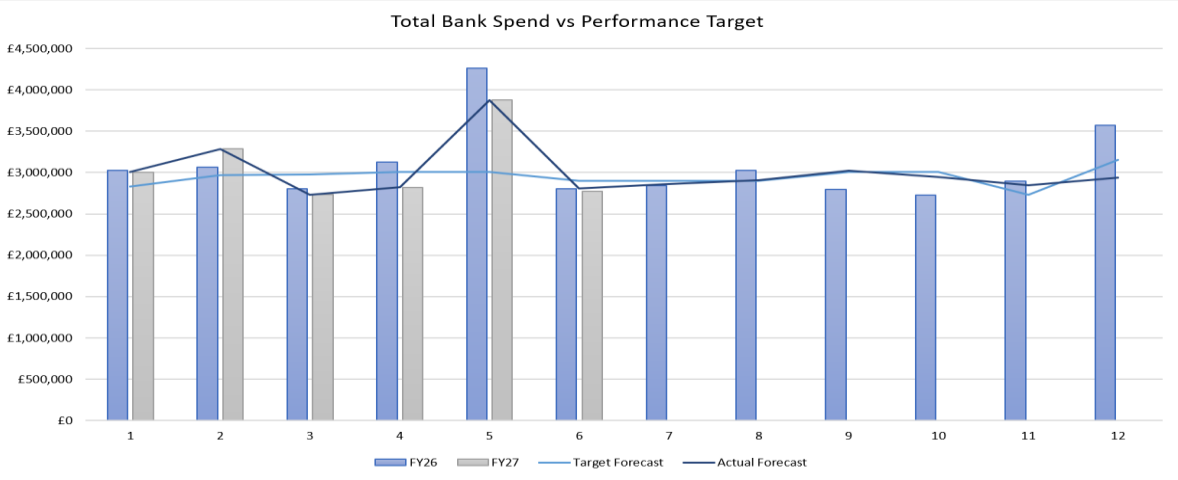
Assurance

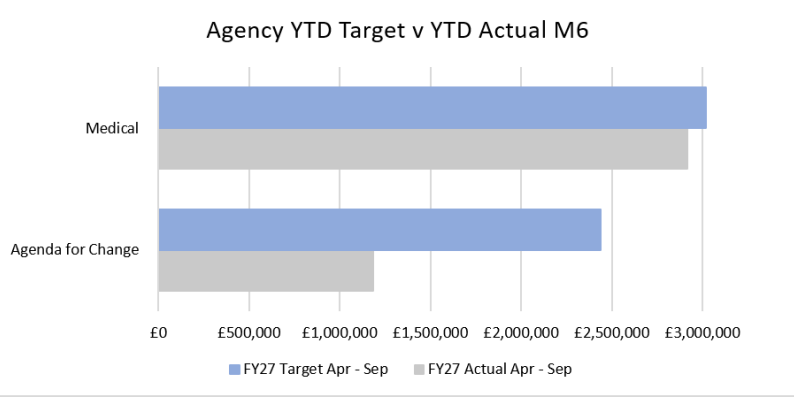
- CPG reviewed the latest capital programme position, including project reprofiling and mitigation actions, and continues to monitor the impact of identified risks and opportunities on the overall programme forecast.
- The Springfields fire safety works proposal received support in principle, subject to finalisation of the remaining financial considerations and completion of the required governance approvals.

5. Temporary Staffing Analysis

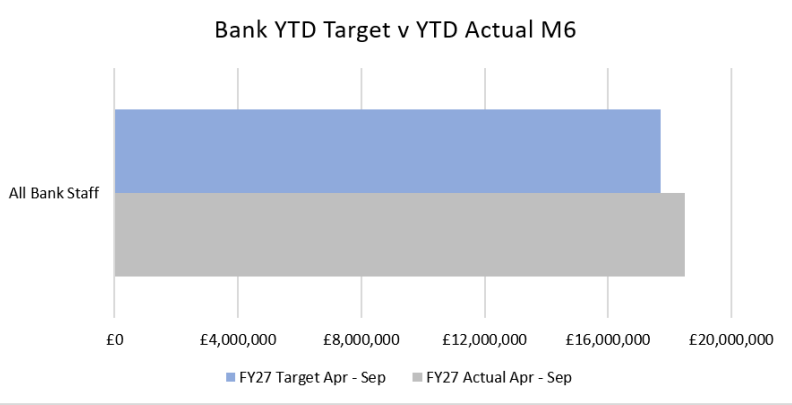
The Trust submitted a plan to NHS England to spend a maximum of **£10.9m** on Agency and **£35m** on Bank in FY27.
In Month 6 YTD temporary staffing was **£22.6m** with **£4.1m** spent on Agency and **£18.5m** on Bank**.**
In Month 6 temporary staffing was **9.1%** of the Trust total pay bill with Agency at **1.7%** and Bank at **7.4%**.
The Month 5 bank expenditure includes **£0.5m** relating to Month 4 activity that was omitted from the Month 4 reporting.





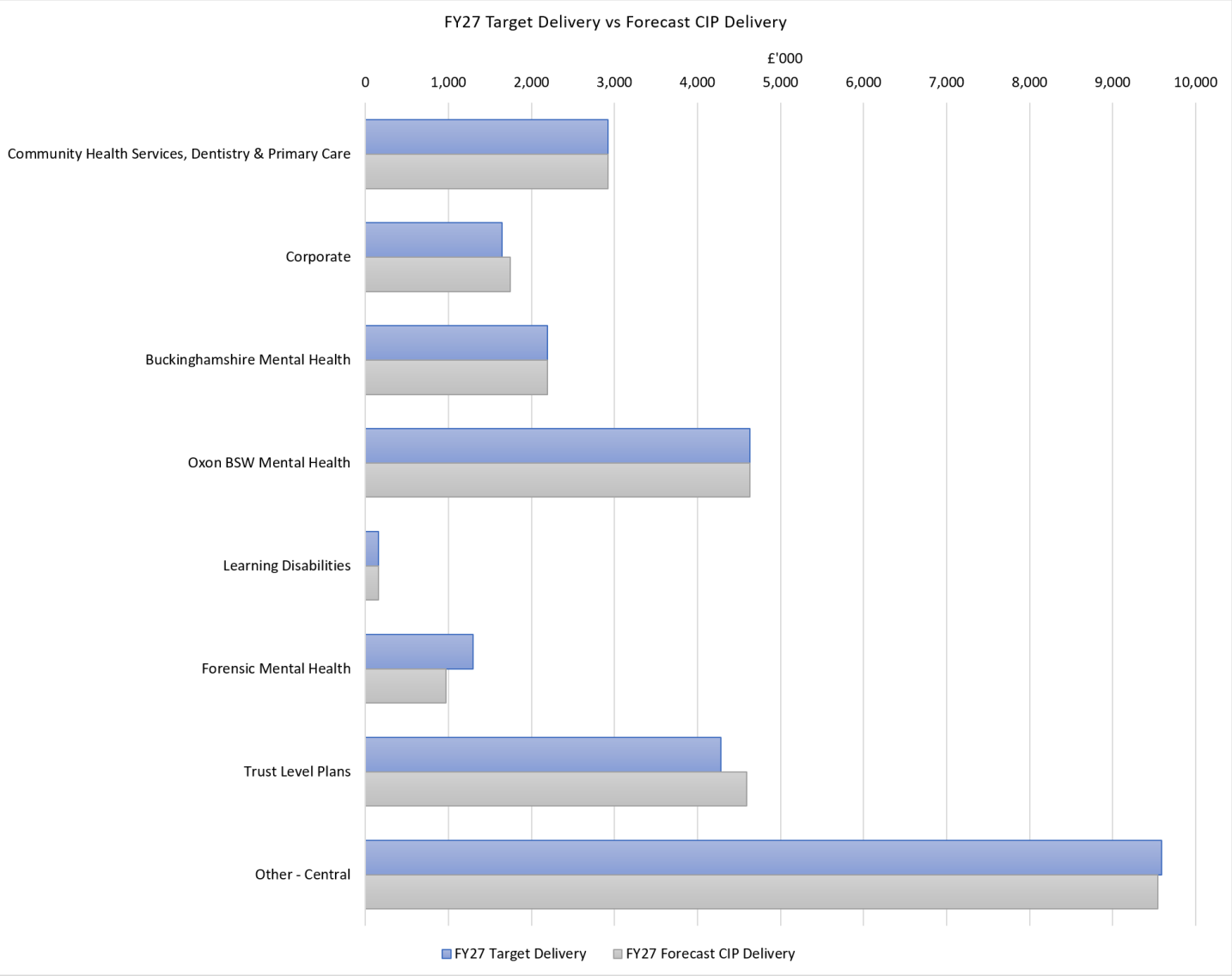


At the end of month 6, agency spend is **£1.4m** better than planned performance year-to-date.



At the end of month 6, bank spend is **£0.8m** worse than planned performance year-to-date.

6. 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.

7. Income & Expenditure Statement

INCOME STATEMENT	Month 6				Year-To-Date				Forecast				Excluding Oxford Pharmacy Store and Provider Collaboratives	
	Plan	Actual	Variance	Variance	Plan	Actual	Variance	Variance	Plan	Forecast	Variance	Variance	Forecast Variance	Variance
	£m	£m	£m	%	£m	£m	£m	%	£m	£m	£m	%	£m	%
Clinical Income	49.7	47.7	-2.0	-4.0%	294.0	284.1	-9.8	-3.3%	592.7	578.2	-14.4	-2%	2.1	0.4%
Other Operating Income	12.8	15.6	2.8	21.8%	76.8	91.6	14.8	19.3%	157.3	176.9	19.6	12%	0.3	0.2%
Operating Income, Total	**62.4**	**63.2**	**0.8**	**1.3%**	**370.8**	**375.7**	**5.0**	**1.3%**	**750.0**	**755.1**	**5.2**	**1%**	**2.3**	**0.3%**
Employee Benefit Expenses (Pay)	38.7	37.3	1.4	3.6%	230.6	223.2	7.4	3.2%	465.8	453.2	12.6	3%	11.3	2.4%
Other Operating Expenses	22.2	24.4	-2.2	-9.8%	130.8	143.9	-13.1	-10.0%	265.7	284.9	-19.2	-7%	-15.1	-6.3%
Operating Expenses, Total	**60.9**	**61.7**	**-0.8**	**-1.3%**	**361.4**	**367.0**	**-5.7**	**1.6%**	**731.5**	**738.1**	**-6.6**	**-1%**	**-3.8**	**-0.5%**
EBITDA	**1.5**	**1.5**	**0.0**	**1.9%**	**9.4**	**8.7**	**-0.7**		**18.5**	**17.0**	**-1.5**		**-1.5**	
Financing costs	1.6	1.5	0.1	6.4%	9.2	8.3	0.9	10.0%	18.5	17.1	1.5	8%	1.5	7.9%
Surplus/ (Deficit)	**0.0**	**0.1**	**0.1**	**-296.1%**	**0.2**	**0.4**	**0.2**		**0.0**	**0.0**	**0.0**		**0.0**	
Adjustments	0.0	0.0	0.0	0.0%	0.0	0.0	0.0	0.0%	0.0	0.0	0.0	0.0	0.0	
Adjusted Surplus/ (Deficit)	**0.0**	**0.1**	**0.1**		**0.2**	**0.5**	**0.2**		**0.0**	**0.0**	**0.0**		**0.0**	

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 the extent that they net to zero and show the forecast variances for the rest of the Trust.

Clinical income is forecasting to be **£2.1m** favourable to plan due to the release of deferred income.

Other Operating Income is forecasting to be **£0.3m** favourable to plan.

Pay is forecasting to be **£11.3m** favourable to plan driven mainly by vacancies arising from delay implementing investment funding in particular in Oxfordshire & BSW Mental Health and Buckinghamshire Mental Health directorates.

Non-Pay is forecasting to be **£15.1m** adverse to plan driven mainly by out of area beds in Oxfordshire & BSW Mental Health and Buckinghamshire Mental Health Directorates, out of area placements in Learning Disabilities and sub-contracts to independent and voluntary sector providers using pay underspends.

8. Provider Collaboratives Financial Performance Summary

	Month 6			Year-to-date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Prior Year b/f	**0.2**	**0.2**	**0.0**	**0.2**	**0.2**	**0.0**	**32.1**	**32.1**	**0.0**
Secure	8.7	8.5	0.0	52.0	50.6	1.4	104.1	102.3	1.7
CAMHS	2.6	2.5	0.1	15.8	14.2	1.6	31.7	29.2	2.5
Adult AED	0.8	0.7	0.1	4.8	4.0	0.8	9.7	8.7	0.9
Provider Collaboratives FY27 Funding	**12.1**	**11.7**	**0.2**	**72.7**	**68.9**	**3.8**	**145.4**	**140.3**	**5.1**
Investments Funded fron Prior Year Balances (Non-Recurrent)	0.0	0.0	0.0	0.2	0.2	0.0	20.5	20.5	0.0
Projected deferred income c/f	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**11.7**	**16.8**	**5.1**

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 **£3.8m** 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.

9. Statement of Financial Position

Statement of Financial Position at 30th September 2026

31 Mar 26 £'000		31 Aug 26 £'000	31 Sep 26 £'000	Movement In-Month £'000	Movement YTD £'000	
	Non-current assets					
4,617	Intangible Assets	4,089	3,958	(131)	(659)	
228,301	Property, plant and equipment	227,571	227,194	(377)	(1,107)	
33,170	Finance Leases	30,080	29,443	(637)	(3,727)	
1,125	Investments	1,125	1,125	0	0	
367	Trade and other receivables	368	368	0	0	
914	Other Assets	914	914	0	0	
268,495	Total non-current assets	264,147	263,002	(1,144)	(5,492)	①
	Current Assets					
7,569	Inventories	6,599	5,732	(867)	(1,837)	②
25,856	Trade and other receivables	29,893	29,632	(261)	3,775	③
985	Non-current assets held for sale	579	579	0	(406)	
98,832	Cash and cash equivalents	106,510	107,859	1,349	9,026	④
133,243	Total current assets	143,580	143,802	222	10,559	
	Current Liabilities					
(72,668)	Trade and other payables	(72,898)	(72,682)	217	(13)	⑤
(1,355)	Borrowings	(1,535)	(1,357)	177	(2)	
(7,779)	Lease Liabilities	(7,130)	(7,137)	(7)	642	
(15,678)	Provisions	(15,330)	(15,280)	49	397	
(38,455)	Deferred income	(47,425)	(48,592)	(1,167)	(10,136)	⑥
(135,936)	Total Current Liabilities	(144,317)	(145,048)	(731)	(9,113)	
	Non-current Liabilities					
(9,373)	Borrowings	(9,374)	(8,705)	669	668	⑦
(19,013)	Lease Liabilities	(16,418)	(15,348)	1,070	3,665	⑧
(8,425)	Provisions	(8,307)	(8,307)	0	118	⑨
(1,500)	Other Liabilities	(1,500)	(1,500)	0	0	
(38,311)	Total non-current liabilities	(35,598)	(33,860)	1,739	4,452	
227,491	Total assets employed	227,811	227,897	85	405	
	Financed by (taxpayers' equity)					
121,321	Public Dividend Capital	121,321	121,321	0	0	
88,166	Revaluation reserve	87,692	87,692	0	(474)	
1,125	Other reserves	1,125	1,125	0	0	
16,879	Income & expenditure reserve	17,673	17,758	85	880	⑩
227,491	Total taxpayers' equity	227,811	227,897	85	406	

1. Non-current assets have decreased by (£1.1) in-month and (£5.5m) YTD which reflects the depreciation charge incurred in month. Capital additions were £0.4m.
2. Inventories have decreased by £1.8m YTD and £0.9m in month.. This is due to normal trading fluctuations and movements.
3. Receivables have increased by £3.8m YTD and decreased by £0.3m in-month. This YTD increase is driven by a decrease in other receivables of (£3.7m). These decreases have been offset by an increase in trade receivables of £3.2m, Prepayments of £2.6m , accrued income of £1.5m and Bad debt provision of £0.1m .
4. The cash balance has increased by £9.0m YTD and £1.3 in-month. The increase in-year is driven by the net inflow of cash used in operations of £18.9m and offset against a net (£2.5m) used in investing activities and (£7.3m) used in financing activities - see cash flow statement.
5. Trade and other payables have had a minimal decrease in year and decreased by £0.2m in-month. The decrease in year is driven by the net reduction in trade payables and accrued expenditure of £1.0m. These decreases have been offset by an increase in the monthly Tax/Pension liabilities of (£0.7m) and other payables of (£0.3m).
6. Deferred income has increased by £10.1m in year and by £1.1m in-month. The increase in month is due to an increase in Provider Collaborative deferrals to match spend. The increase in year is driven by a £8.0m increase in Provider Collaborative deferrals and a £1.3m deferral of growth funding to match the spend profile.
7. Borrowings have decreased by (£0.7m) in-month and YTD due to repayment of DOH loan.
8. Non-current lease liabilities have decreased by £3.7m in year and £1.0m in-month in line with capital repayments against those liabilities.
9. Provisions have decreased by £0.1m YTD and remained the same in month.
10. The £0.9m upward movement in year reflects the Trust's reported surplus YTD.

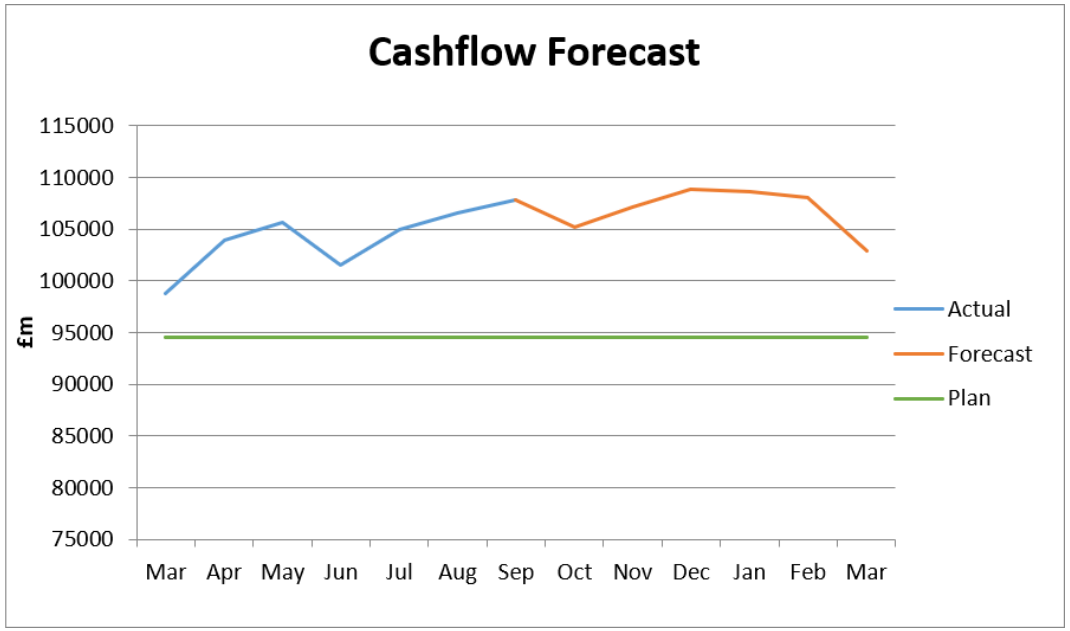
10. Statement of Cashflows

Statement of Cash Flows at 30 September 2026

31 Mar 26		Aug	Apr - Sep	Cash In/(Out) In-Month
£'000	**Cash flows from operating activities**	£'000	£'000	£'000
9,458	Operating surplus/(deficit) from continuing operations	(360)	(327)	33
9,458	**Operating surplus/(deficit)**	**(360)**	**(327)**	**33**
	Non-cash or income and expense:			
17,592	Depreciation and amortisation	7,521	9,026	1,505
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	0	0	0
(6,295)	(Increase)/Decrease in Trade and Other Receivables	(4,036)	(3,775)	261
(3)	(Increase)/decrease in other assets	(1)	(1)	0
(1,106)	(Increase)/Decrease in Inventories	971	1,837	867
(9,146)	Increase/(Decrease) in Trade and Other Payables	799	2,521	1,723
3,354	Increase/(Decrease) in Deferred Income	8,970	10,137	1,167
(713)	Increase/(Decrease) in Provisions	(467)	(516)	(49)
13,220	**NET CASH GENERATED FROM/(USED IN) OPERATIONS**	**13,396**	**18,902**	**5,506**
	Cash flows from investing activities			
4,994	Interest received	2,012	2,411	399
(13,266)	Purchase of Non Current Assets	(4,787)	(5,392)	(605)
507	Sale of PPE	439	439	0
(7,765)	**Net cash generated from/(used in) investing activities**	**(2,336)**	**(2,542)**	**(206)**
	Cash flows from financing activities			
7,357	Public dividend Capital Received	0	0	0
(1,338)	Loans repaid	0	(669)	(669)
0	Movements on other loans	0	0	0
(6,072)	Capital element of lease rental payments	(3,047)	(4,132)	(1,085)
0	Capital element of Private Finance Initiative Obligations	0	0	0
(562)	Interest paid	0	(211)	(211)
(860)	Interest element on leases	(336)	(400)	(64)
0	Interest element of Private Finance Initiative obligations	0	0	0
(2,965)	PDC Dividend paid	0	(1,923)	(1,923)
(4,440)	**Net cash generated from/(used in) financing activities**	**(3,383)**	**(7,334)**	**(3,951)**
1,014	**Increase/(decrease) in cash and cash equivalents**	7,677	9,026	1,349
97,818	**Cash and Cash equivalents at 1st April 2025**	**98,832**	**98,832**	
98,833	**Cash and Cash equivalents at end of period**	**106,510**	**107,859**	**1,349**

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 September was **£107.9m** (£106.5m in July).
- The cash forecast is for £102.9m and the plan is £94.6m at the 31 March 2027.



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

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%	4.8%	
BPPC NHS - Value of Inv's pd within target (ytd)	95.0%	98.9%	
BPPC Non-NHS - Value of Inv's pd within target (ytd)	95.0%	94.0%	
Cash and Cash Equivalents (£m) - per y/e forecast	94.6	107.9	

Working capital ratios

- Debtor days by number of invoices and value are marginally below target.
- Debtors % over 90 days is above target.
- NHS BPPC (Better Payments Practice Code) is above target.
- Non-NHS BPPC (Better Payments Practice Code) is marginally below target. This was primarily driven by a small number of high-value invoices linked to purchase orders that had exhausted their available funding. The necessary amendments could not be completed prior to the cut-off date.
- Cash at M5 is above target with the year end forecast.

12. 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 shows what is expected to be most likely 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 M5
		Provider Collaboratives	Oxford Pharmacy Stores	Other				
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Income	586,341	-3,454		2,268			6,828	591,983
Other Operating Income	159,589	-2	-11,580	5,010			4,263	157,280
Employee Benefit Expenses (Pay)	-450,542	-1,321	-158	-5,463			-8,521	-466,005
Other Operating Expenses	-295,135	4,777	11,392	-1,984	18,744		-2,570	-264,776
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:

Month 6	YTD Plan	YTD Actuals	YTD Variance against Plan	YTD Variance against Budget	Difference
	£'000	£'000	£'000	£'000	£'000
Clinical Income	296,448	284,145	-12,303	-9,831	2,472
Other Operating Income	79,788	91,600	11,812	14,803	2,991
Employee Benefit Expenses (Pay)	-228,520	-223,094	5,426	7,517	2,091
Other Operating Expenses	-147,224	-152,977	-5,753	-12,852	-7,099
Financing Costs	-292	732	1,024	568	-456
Adjustments	24	28	4	4	0
Adjusted Surplus/ (Deficit)	**225**	**434**	**209**	**209**	**0**

Oxford Health
NHS Foundation Trust

Meeting	Board of Directors' Meeting
Date of Meeting	25th November 2026
Agenda item	12
Report title	Learning from Patient Safety Incidents
Executive lead(s)	Britta Klinck, Chief Nurse
Report author(s)	Jane Kershaw, Head of Patient Safety
Action this paper	☐ Decision/approval ☑ Information ☑ Assurance
Reason for submission to the group	• National regulations and requirements. • Oversight of patient safety work. • Regular report to each public Board meeting.
For disclosure or confidential	Disclosure.

Executive summary

This is a regular report to give Board members an overview of the work happening and safety review themes from patient incidents. The report concentrates on the period of September and October 2026.

Key Highlights:

- Three patient safety reviews were identified in September and October 2026 meeting our Patient Safety Incident Response Plan (PSIRP), where we believe there is potential for significant learning. The details 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 13 huddles completed in both September and October 2026.
- The learning identified from reviews completed in the last two months and the safety actions in response are detailed in the report. As well as the overarching areas for improvement.
- A summary of the annual Patient Safety Partner Report is shared.
- The continued developments being made to embed the principles and aims of the Patient Safety Incident Response Framework (PSIRF) are shared in the report including two new initiatives working with the non-profit organisation Making Families Count to support traumatised families, to develop new national training for Family Liaison Officers and a family buddy scheme. As well as working with the Health Innovation Network on one of the national patient safety improvement programmes related to PSIRF with a focus on how to demonstrate meaningful and measurable improvement.

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

Every patient incident is reviewed in 'near real time' 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. The outcome from every review is scrutinized and signed off by senior clinicians and then shared widely for learning. There are several weekly and monthly forums, as well as 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 report is presented quarterly to the Quality Committee.

Recommendation(s)
No action is being requested by the Board, the report is to provide an oversight of patient safety incidents for assurance.

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

1. Types of Patient Safety Incidents

The most common patient safety incident categories reported were:

- Physical illness or condition (increase recently on one ward involving a patient who is experiencing multiple psychogenic non-epileptic seizures)
- Verbal abuse patient on staff (highest on our forensic mental health units)
- Self-harm ligature non-suspended (highest on the CAMHS Psychiatric Intensive Care Unit)
- Violence patient on staff (highest on the CAMHS wards)
- Medicine administration/supply difficulties (highest in the District Nursing service)

Most incidents are recorded with low or no physical harm to patients (94.5%), this compares to the latest national figure of 94.4%. 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.

2. Cases declared under our Incident Response Plan

To support the continual improvement of the safety of care the Trust has embedded the standards and principles of the national Patient Safety Incident Response Framework (PSIRF). A summary of what this means, our approach and local incident response plan is published on the Trust's website and available here Patient Safety Incident Response Framework (PSIRF) - Oxford Health NHS Foundation Trust.

The four key principles of PSIRF are:

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

Following the last report to the Board in September there have been 3 new patient safety reviews identified/started in September and October 2026 aligned to our Patient Safety Incident Response Plan (PSIRP) and where we believe there is potential for significant learning. The cases are listed below in table 1 with the planned safety review we intend to take. From 1st April to 31st October 2026 we have identified 26 cases falling under the Trust's Patient Safety Incident Response Plan (PSIRP), 1 case has been removed since being initially declared as a system review because it was led by another NHS Trust and our input was limited. Out of the 26 reviews, 13 of the cases have been in the local safety area of 'access to care and treatment'.

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.

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.

Table 1.

Incident description	PSIRP safety area	Planned Learning Response
Suspected arson by an inpatient in their bedroom (Forensic ward)	Emergent	Patient Safety Incident Investigation
Serious self-harm by a patient in the community (adult community mental health team)	Ineffective working between teams	Extended Incident Learning Huddle
Pressure damage and appropriateness of wound care	Access to care and	Patient Safety Incident

Incident description	PSIRP safety area	Planned Learning Response
(district nursing service)	treatment	Investigation

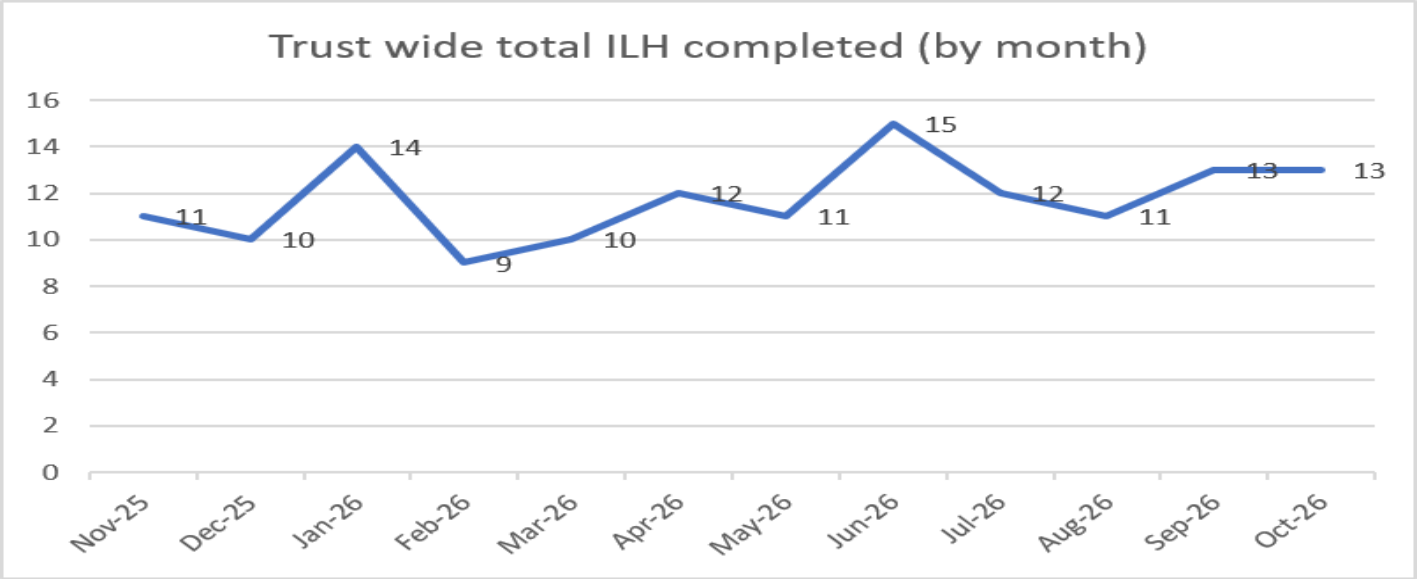
3. Progress with Incident Learning Huddles

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.

We will complete more ILH than incidents that fall under the Trusts Patient Safety Incident Response Plan.

There were 13 ILHs completed in both September and October 2026. Graph 1 shows the number of ILH completed by month over the last year.

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.

Learning from reviews is shared monthly in several ways and through a series of forums. This includes the below but is not an exhaustive list;

- Monthly learning summarises from each review are shared directly and discussed with team/ward managers at monthly governance meetings, as well as posted on the intranet.
- 6-weekly patient safety webinars are held themed around our key areas for learning. The webinar topic in July 2026 was on improving VTE prevention and in Sept 2026 we celebrated World Patient Safety Day with a focus on meaningful patient and family engagement. All recordings are available to staff to watch back.
- Sharing themes with learning advisory leads to bring into regular staff training

The overarching areas for improvement are;

- Working with families
- Communication with others – teams in OHFT and external agencies (multi-professional meetings)
- Completeness of clinical documentation - risk assessment/safety plan, care planning, NEWS2, VTE

The key learning from reviews completed in September and October 2026 and actions being taken in response is 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.

Learning area	Safety action(s)
There were interesting findings from the thematic review however we did not identify waits contributed to the unexpected deaths. Mortality was not limited to suicide. Substance misuse was a common theme among a predominantly young adult male population. The review showed demand significantly exceeded commissioned capacity. We found variability in waiting list support and communication. (Thematic Review: unexpected deaths of patients on the Adult ADHD waiting list over a 3-year period in Oxon and Bucks)	❖ Work is progressing to strengthen waiting-list communication, signposting and patient-facing information. ❖ Review highlighted inequitable access to assessment due to prescribing arrangements at primary care level. This is being actively addressed. ❖ Enhance earlier identification and communication of patient deaths through better use of available data on TOBI. ❖ The finding are being fed into the existing Thames Valley Adult ADHD improvement programme.
How the mental health crisis service engage and consider reasonable adjustments related to culture and possible undiagnosed neurodivergent traits. Working with different organisations to gather information and support patients (in this case with Oxford University). Learning around MDT oversight to share key information/risks and decisions between team members.	❖ A new Student Mental Health Advisory Service is in a pilot phase across 8 colleges at Oxford University. We are working with Oxford University to strengthen processes for joint working when students are referred to secondary mental health services. ❖ Proforma to be implemented to provide a structure to MDT meetings and handovers and associated record keeping to support sharing key information/risks, follow up of actions and MDT oversight of decisions about care. ❖ Implement a standardised process for scheduling and communicating medical appointments. ❖ Reflection on how we explore cultural and communication factors to understand any possible reasons for not engaging with a service.
Two separate incidences identified learning around Clozapine monitoring and support. Education regarding Clozapine and side effects, and the importance of continuous administration. Ensure medication available at points of	Older adult Community Mental Health Team: ❖ Clozapine lead role created in CMHT. ❖ Clozapine training for CMHT staff and offered to supported accommodation providers. ❖ All patients on Clozapine to be assessed using the Glasgow Antipsychotic Side-effect Scale (GASS). ❖ Closer monitoring to ensure cardiometabolic assessments are being completed for SMI patients.

Learning area	Safety action(s)
transition for example inpatient ward to care home. Cardiometabolic assessments to be completed for all patients with a severe and enduring mental illness (SMI). Support and training for nursing team.	❖ Supervision support for staff with patients on Clozapine with a new supervision template introduced Care Home: ❖ Care-home staff received learning on clozapine management and the importance of uninterrupted administration. ❖ The care home's dispensing pharmacy has changed; clozapine is now included on the Medication Administration Record (MAR) chart. ❖ The care home plans to introduce eMAR. ❖ CMHT clinicians are being asked to include medication reconciliation within every care-home mental health review.
A review across three separate pressure damage incidents within the District Nursing Service identified workforce pressures, inconsistent triage processes, gaps in reassessment and care coordination, limitations in equipment provision pathways, and challenges in maintaining oversight of deteriorating patients.	❖ Strengthen process of triaging referrals to improve consistency and accuracy of priorisation – the service is moving to a centralized single triage team. ❖ New processes to improve the oversight of the completion of pressure ulcer risk assessments and care plans, including points of escalation. ❖ Reviewing the process for ordering community equipment across the District Nursing Service
Improved physical health monitoring for mental health, particularly during period of heatwave. Guidance has been developed Trust-wide following the heatwave this year. Access to GP records is possible but highlighted as not all staff aware of this.	❖ The clinical team will circulate video and documents around physical health monitoring requirements and how to access GP records. ❖ Guidance on supporting vulnerable mental health patients was developed and circulated in the extreme temperatures in June. This will be further developed following the outcome of the current thematic review on increased unexpected deaths during June.

5. PSIRF Developments

The Trust has a programme board to oversee the continued developments in embedding PSIRF and our next steps in improving patient safety. The programme board agreed the following objectives for 2026/27;

1. Improve the engagement and involvement of patients/families in ILHs
2. Strengthen actions developed from learning in IRR and ILH
3. Develop how we demonstrate measurable sustained improvements
4. Improve learning from minor harm/near miss medicine incidents
5. Develop and implement a new Trust-wide patient safety educational programme
6. Test new HSSIB competency framework for healthcare safety investigators within patient safety team
7. Build on timeliness and staff confidence to have conversations with patients/ families following incidents
8. Review the Trusts PSIRP and Approach documents

The Trust employs two Patient Safety Partners with lived experiences of healthcare services, they work as part of the patient safety team. This is the second cohort of Patient Safety Partners we have employed, each cohort works with us on a fixed term contract for 18 months. They are integral members of the above programme board. They work alongside clinical staff and patients/families to co-design and implement patient safety initiatives, QI projects and training, co-produce resources, support activities around governance and other opportunities to improve the safety of care. They also lead on gathering feedback from patients/families about their experiences following patient safety reviews. The Partners wrote an annual report up to August 2026 about their activities to raise awareness and

celebrate the great work they are involved in, which has been shared across the organisation. There has also been a recent national review of the implementation of Patient Safety Partner roles across the NHS, NHS England » Patient safety partners: 2025 survey review and recommendations. Overall, the review found Partners brought real value. Key themes from the review were; roles are becoming more established (63% of organisations reporting two or more Partners), effective Partner involvement depends on strong relationships, role clarity and support, however challenges remain around sustainability and retention of Partners.

We are just starting two initiatives with the non-profit organisation Making Families Count, that work to improve how NHS services involve, support and learn from families. The first initiative is developing accredited national training for staff in family liaison roles (that support families affected by serious harm or traumatic bereavement), with an aim to start piloting a course around May 2027 for a small cohort. The second initiative is to pilot the use of a new buddy scheme whereby Making Families Count will provide peer support to families going through NHS investigations processes following a traumatic bereavement or serious harm, this is planned to start in February 2027.

Health Innovation Oxford & Thames Valley Network (HIN) have been commissioned by NHSE to deliver this PSIRF insight to improvement programme across Thames Valley. It is very likely to be a 3-year programme with 2026/27 being a 'diagnostics' year. This programme supports a move beyond implementing the standards and a focus on how to demonstrate meaningful and measurable improvement by building infrastructure, leadership, capability, networks, and governance to support this. The Trust has started working with the HIN on the programme.

Oxford Health NHS Foundation Trust

Meeting:	Board of Directors' Meeting
Date of Meeting:	25 November 2026
Agenda item:	13
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
- Count Me In
- Research Aftercare Resources
- HTA Licence
- Review into Prevalence of ADHD and Autism

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.

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~~ HTA license	

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 updated in March and July 2026's Board reports, 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, reported on a quarterly basis.

For Quarter 1, OHFT failed to meet the national target of 95% of studies being set up within 90 days (0/5 studies). For Quarter 2, set up performance had risen 29% (2/7 studies). Quarter 3 is ongoing, but performance currently stands at 75% (3/4 studies). This upturn in performance is due to the introduction of multiple new processes, as outlined in previous reports, and the cessation of legacy studies coming through from the previous year. For Quarter 4 our intention is to achieve 100% compliance, demonstrating a clear and sustained turn around in performance on a metric that is proving challenging for almost all trusts.

Count Me In
Count Me In (CMI) is an NHS Trust-managed process to facilitate the identification and contact of patients to share information about research opportunities, within a robust and secure governance framework.

Traditionally, information about research at OHFT has been shared with patients by members of the direct care team. However, this approach lacks inclusivity, and many patients are not offered the opportunity to hear about research that may be relevant to them. Time pressures, competing demands, lack of research awareness and research engagement are just some of the significant barriers that affect whether clinicians communicate research opportunities to patients. This can lead to inequality of opportunities for patients to hear about and participate in research, particularly among patients from minority and under-served communities.

Earlier this month an application was submitted for Research Ethics Committee (REC) and Confidentiality Advisory Group (CAG) review and approval for Count Me In. The application sought formal, independent review of the process and Section 251 support for the use of patient information to identify and contact potentially eligible patients about research opportunities. This would mean that approved and researchers who are not part of the patient's care team would be able to contact patients who have not opted out to ask if they would like to receive information about research. These approvals will provide a robust and consistent governance framework for Count Me In and reduce the need for repeated consideration of the process within individual study applications, which can introduce delays to study set-up.

As part of the application process, the team has updated patient-facing information in response to reviewer feedback and with input from the Oxford Health Engage Patient and Public Involvement (PPI) group. This has strengthened the information provided

to patients about the process to include clearer explanations of how their information is used, access by authorised research staff outside the direct care team, and the relationship between Count Me In and the National Data Opt-Out.

The application is now progressing towards final approval, following receipt of a favourable ethical opinion from the REC and provisional support from CAG, subject to confirmation of appropriate contact limits and receipt of the updated patient information materials.

This represents an important step in establishing a more robust governance framework for Count Me In, providing assurance to the Trust, patients and the public, research sponsors and external partners regarding the appropriate use of confidential patient information and supporting more equitable access to research opportunities.

Research Aftercare Resources
In response to the recommendations from the 2024/25 Patient Research Experience Survey (PRES), R&D have developed a toolkit providing links to resources and published articles, supporting innovative methods of communication with research participants to meet diverse information needs. A leaflet, What's Next After Taking Part in Research?, webpage and toolkit for researchers ensure that research participants feel valued after, as well as during research.

HTA Licence
On 05 November 2026, Oxford Health was granted a Human Tissue Authority (HTA) research licence for the Oxford Biostorage Service (BOSS), part of the NIHR Clinical Research Facility: Oxford Health (OH CRF). The OH CRF provides specialist facilities and expertise to support early-phase research studies, while BOSS provides secure storage and management of human biological samples. The HTA licence enables OHFT to store samples (such as blood) donated for research, under nationally regulated standards designed to ensure they are handled, tracked and stored appropriately. This strengthens the Trust's research infrastructure and its ability to support NHS, academic and commercial research.

Review into Prevalence of ADHD and Autism
As part of the Fonagy Independent review into mental health conditions, ADHD and autism contributors from Oxford Health and Oxford University were involved in providing data and insights into the report, cementing the Trust's reputation for national and international research excellence and facilitating research that impacts on people's health and wellbeing.

Oxford Health NHS Foundation Trust

Meeting:	Board of Directors' Meeting
Date of Meeting:	25 November 2026
Agenda item:	14(b)
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
Public or confidential:	Public

Executive summary

The Quality Committee met on 12th November 2026 and has identified the following items:

To Advise:

- A new criterion has been introduced to indicate where services have quality concerns and are requiring additional support with plans are in place to mitigate high risks.
- District nursing deferral rates continue to be very high, on some days there are 500 deferrals, this has potential for patient harm and impact on staff morale. A prioritisation framework is in place, and an ICB system review continues however there is no clear timescale for this to be concluded.
- GP out of hour services continue to see significant demand alongside challenged workforce capacity
- Out of area placements continue with bed pressures in both Oxon and Bucks. Work progresses on bed flow and crisis services. The provider collaborative is sourcing and procuring a single provider for female PICU placements.
- 294 complaints were received in quarter 2, 87% were responded to within timescale. The complaints team have received additional resource to increase capacity. Key learning themes are insufficient mental health care and support, poor communication and lack of information to patients and families and waiting times for neurodiverse services.
- The National Confidential Inquiry into Suicide, Homicide and Safety in Mental Health (NCISH) Safety Scorecard (July 2026) showed the trust's suicide rate is lower than the national average, 3.29 per 10,000 population under mental health care compared to 4.34

- An update from estates noted that progress is being made across all areas. A detailed discussion was held regarding fire safety requirements and how a range of mitigations are in place.
- In quarter 2 there were continued reductions in the use of prone restraint (53). The trust has an ambitious target to reduce the use of prone restraint by 50% compared to 25/26.
- Thames Valley Police Operation Cavell continues across Oxon and Bucks with the committee requesting that a discussion is held with TVP about response to CAMHs inpatient service calls.
- Multi-agency Safeguarding Hub (MASH) referrals have reduced to a manageable level following the introduction ICB review recommendations

For assurance:

1. Good assurance was received regarding the management of Child and Adolescent Mental Health Services (CAMHS) Eating Disorder waiting list management. A small number of breaches will continue to occur as families choose to defer their referral due to work pressures, holidays and school requirements.
2. The committee was assured that systems and processes are in place to manage and monitor learning from deaths.
3. OHFT being the license holder, received assurance that the Oxford Pharmacy store is working within the regulatory framework,.
4. A deep dive was received into the challenges experienced by Aspen CMHT, assurance was received that weekly monitoring and actions are in place to mitigate risks. Reorganisation of teams is planned for the end of November. Discussions covered a breadth of topics including local leadership and corporate support being provided to support changes.
5. Good assurance was received that the Child and Adolescent Mental Health Inpatient services CQC action plan had been progressed. Focus is still required to reduce restrictive practice interventions.

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

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 CQC essential standards	

For Alert (may require discussion)

The Committee wish to alert the Board that: [*provide details of any key matters which you wish to escalate to the Board from your meeting or highlight as an issue for Board discussion or consideration*].

To Advise (to monitor)
The Committee wish to advise the Board that: [*provide details of ideally no more than 3 or 4 matters which you wish the Board to be advised of and which have been discussed in your meeting e.g. to provide a 'heads up' to the Board on live issues under scrutiny by the Committee, or prospective risks not yet on the BAF or a risk register*].

For Assurance (to note)
The Committee wish to assure the Board that: [*provide details of any more regular matters (ideally no more than 3 or 4) which you wish the Board to be assured of and which have been discussed in your meeting e.g. actions having been appropriately taken and not an area of concern but still relevant for the Board to be aware of*].

Sharing of learning
[*If any key points of learning to be shared and highlighted as such for Board awareness then provide here, or delete if this section not required*]

MANCHESTER 1824
The University of Manchester

the centre for
mental health and safety

the national confidential inquiry
into suicide, homicide and safety in mental health

Professor Sir Louis Appleby

Professor Nav Kapur

PO Box 86, Manchester, M20 2EF
Secure email: ncish@nhs.net

Tel: 0161 275 0700/1
www.manchester.ac.uk/ncish

Oxford Health NHS Foundation Trust

27 July 2026

Dear Dr Karl Marlowe,

Re: National Confidential Inquiry into Suicide, Homicide and Safety in Mental Health (NCISH) Safety Scorecard

Please find attached the NCISH Safety Scorecard for your trust, accompanied by an information sheet. **This includes important information about patient suicide rates in your trust.** The NCISH Safety Scorecard was developed in response to the request from our commissioners, the Healthcare Quality Improvement Partnership (HQIP), as a mechanism for sharing and benchmarking data with providers to support quality improvement. In addition, trusts often ask us how their figures compare to other trusts nationally. This Safety Scorecard is to:

1. Share with clinical risk and suicide prevention leads and to be considered for review by your Trust.
2. Compare with your previous Scorecards and assess your services against our "Safer Services" toolkit - key safety measures that trusts can make.
3. Provide information based on data that we hold for you, consisting of certain indicators that relate to the work of NCISH:
    a. **Patient suicide rate**
    b. **Staff turnover**
    c. **NCISH questionnaire response rate**
    d. Additionally, we now provide information **on key characteristics of patients who died by suicide** obtained from the clinical questionnaire completed by clinicians in your Trust.

Thank you for your continued contribution in sending us the data and continued support to our work in patient safety.

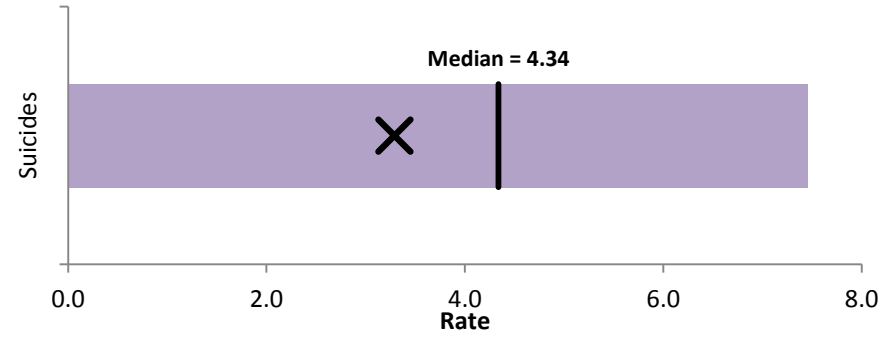
Yours sincerely,

Louis Appleby Navneet Kapur

Professor Sir Louis Appleby and Professor Nav Kapur
Directors of NCISH

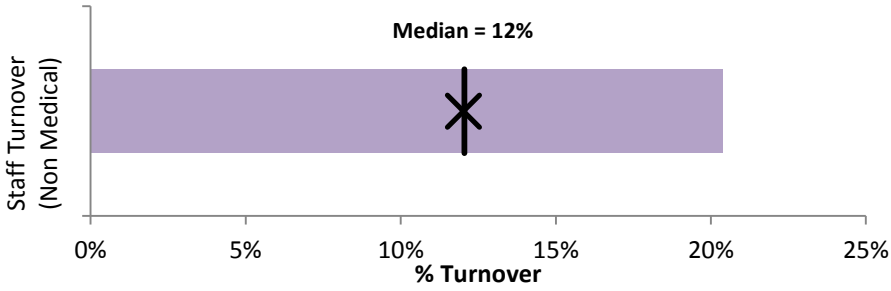
The figures give the range of results for mental health providers across England, based on the most recent available figures published in our 2026 annual report. The suicide rate provided is for a 3-year period 2021-23 and is based on date of death. Non-medical staff turnover is for the period 31 October 2024 – 31 October 2025 and trust questionnaire response rates between 1 January 2023 to 1 31 January 2026. The staff turnover figures presented are obtained from NHS England, which in turn are taken from individual trusts. The figures show the range of results across trusts in England in addition to your own position that is represented by an 'X' in the figures. Rates have been rounded to the nearest 2 decimal places and percentages to whole percentage numbers. The key characteristics table of patients who died by suicide between 2013-2023 are provided alongside regional and national figures for your information.

Your trust is also ranked as one of the trusts with the lowest rate of response for completing suicide questionnaires. For us to share complete data with your trust, we would appreciate questionnaires are completed and returned as timely as possible We thank you for supporting NCISH and recognise the value clinicians provide when sharing important clinical information.



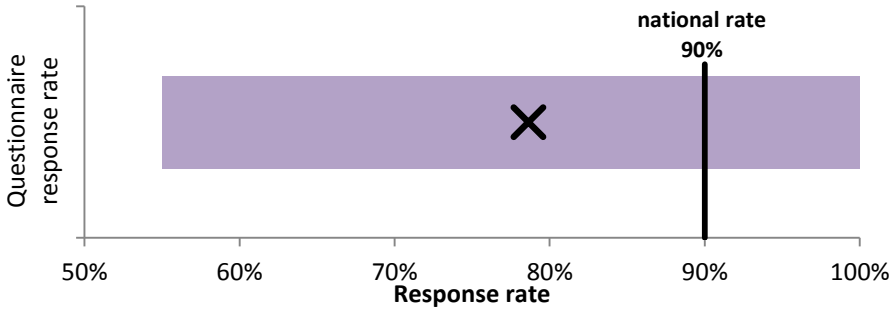
Suicide rate

The suicide rate in your Trust was 3.29 (per 10,000 people under mental health care) from 2021-2023.



Staff Turnover

Non-medical staff turnover was 12% between October 2024 and October 2025.



NCISH questionnaire response rate

You have returned 79% of NCISH questionnaires between January 2023 and January 2026. The graph shows the national response rate and the range across Trusts.

Characteristics of patients who died by suicide in Oxford Health NHS Foundation Trust compared with regional and national data

Year	2013 - 2023			
	Oxford Health NHS Foundation Trust	**South Central**	**ENGLAND**	**UK**
Percentages given are valid percentages	N=288	N=1,010	N=13,936	N=17,944
Sociodemographic:				
Age Median (Min-Max)	45 (14-94)	46 (14-97)	46 (12-100)	46 (11-100)
Male	173 (60.1%)	618 (61.2%)	9,007 (64.6%)	11,658 (65.0%)
Female	115 (39.9%)	392 (38.8%)	4,929 (35.4%)	6,286 (35.0%)
Living alone	107 (39.1%)	419 (43.9%)	6,020 (46.7%)	7,893 (47.7%)
Unemployed	88 (32.5%)	401 (42.9%)	5,680 (45.3%)	7,541 (46.2%)
Clinical:				
In-patient at time of suicide	8 (2.8%)	39 (3.9%)	709 (5.1%)	894 (5.0%)
Died within 3 months of discharge from in-patient care	25 (9.1%)	110 (11.5%)	1,635 (12.5%)	2,172 (12.9%)
Primary diagnosis:				
Schizophrenia & other primary psychotic disorders	41 (14.4%)	149 (14.9%)	2,095 (15.5%)	2,554 (14.6%)
Affective disorders	126 (44.4%)	435 (43.5%)	5,518 (40.7%)	6,765 (38.8%)
Alcohol dependence/misuse	13 (4.6%)	49 (4.9%)	691 (5.1%)	1,138 (6.5%)
Drug dependence/misuse	5 (1.8%)	23 (2.3%)	468 (3.5%)	881 (5.1%)
Personality disorder	34 (12.0%)	131 (13.1%)	1,546 (11.4%)	1,970 (11.3%)
Other diagnosis#	52 (18.3%)	171 (17.1%)	2,741 (20.2%)	3,520 (20.2%)
Any comorbid diagnosis	127 (44.9%)	550 (55.4%)	7,510 (55.9%)	9,689 (55.9%)
History of self-harm	163 (57.6%)	596 (60.3%)	7,921 (59.8%)	10,353 (60.7%)
History of alcohol misuse	92 (33.2%)	374 (38.6%)	5,735 (43.8%)	7,792 (46.1%)
History of drug misuse	77 (27.8%)	321 (33.0%)	4,707 (35.6%)	6,482 (38.0%)
Risk:				
Short-term risk low or none	185 (76.4%)	660 (74.6%)	8,949 (79.0%)	11,880 (80.7%)

These figures are based on actual data. #Other diagnosis includes anxiety disorder, autism, ADHD, eating disorder, drug induced psychosis, dementia, learning disability and other specified.

↑significantly higher compared to national data (England)

Why have you sent us this information?

This information has been collected in response to the request from our commissioners, the Healthcare Quality Improvement Partnership (HQIP), to provide benchmarking data to support quality improvement in mental health trusts. We have also received requests directly from mental health service providers for similar information.

What will this scorecard be used for?

The NCISH Safety Scorecard has been prepared for your information only, to support quality improvement in your trust. We will not share the information directly with any other organisation. The NCISH Safety Scorecard consists of 3 indicators that relate to the work of NCISH: suicide rate, non-medical staff turnover, and NCISH suicide questionnaire response rate, and in addition this year, a table of demographic and clinical characteristics of patients who died by suicide.

Why do you use these indicators?

Suicide cases are the core data collection of NCISH. We send questionnaires to clinicians in trusts for detailed information on these cases, and trust response rates are based on the questionnaire returns. Our previous research found that non-medical staff turnover was associated with increased suicide rates. Our reports can be found on our website.

Where do you get the data from?

Suicide

Suicide data are collected as part of NCISH for individuals aged 10 years and older who died by suicide in England. Suicide data are provided by the Office for National Statistics (ONS). A proportion of these individuals had been in contact with mental health services in the 12 months prior to death (i.e. patient suicides). Based on the information from your trust, we identify the clinicians who had been caring for the patient and for those who died by suicide, we collect detailed clinical information about their care. Therefore, the data given in the NCISH Safety Scorecard represents patients who had been in contact with your services in the 12 months prior to death, notified to us by your trust.

The characteristics table of patients who died by suicide compare figures from your trust to regional and national figures between 2013-2023. Any statistically significant differences where the p-value is <0.05 (significant at the 5% level) between your trust and nationally are highlighted in the document.

Staff turnover

Non-medical staff turnover data provided by your Trust are obtained from NHS Digital. Non-medical staff is defined as all staff excluding doctors. Staff turnover data are made available on request from NHS Digital and this covers the period between 31 October 2024 and 31 October 2025.

Denominator data

Denominator data used to calculate patient suicide are obtained from the MHSDS. These are the number of people in contact with adult and elderly secondary mental health services which are submitted to NHS Digital by the trust. The Mental Health Bulletin from 2018-19 now includes the number of people in contact with NHS funded secondary mental health, learning disabilities and autism services. The annual reports are available on the NHS England website.

NCISH questionnaire response rate

This provides the current rate of response between 1 January 2023 and 31 January 2026 for suicide questionnaires in your trust, in comparison to the national average. We would like to emphasise that these are not response rates for individual consultants but apply to the trust as a whole.

If you feel the data presented in the NCISH Safety Scorecard for your trust are incorrect please contact the person within your trust responsible for returning data. You can inform us that you are looking into data quality issues by emailing us at ncish@manchester.ac.uk

Oxford Health NHS Foundation Trust

Meeting:	Board of Directors' Meeting
Date of Meeting:	25 November 2026
Agenda item:	14(c)
Report title:	Frontline Digitisation annual update (*and recommendation up from the November FIC*)
Executive sponsor(s):	Heather Smith, Chief Finance Officer
Report author(s):	Rachel Hanks, Head of Clinical Systems/ Alison Corfield, Chief Digital Information Officer
Action this paper is for:	☐ Decision/approval ☑ Information ☐ Assurance
Reason for submission to the Board:	Regular Update to the board
Public or confidential	Public

Executive summary

- Digital delivery is moving from technical implementation towards wider adoption, connected workflows and measurable value, with progress across Rio, EMIS, digital medicines, patient access and core infrastructure.
- Most of the FY27 Clinical Systems plan remains on track, with the majority of initiatives delivered or in progress. Delays are concentrated in a small number of areas affected by supplier release dates, contractual changes and delivery priorities. Key items will restart from December 2026, move into the FY28 plan or depend on the Rio EVO update. The LifeYear pilot has been replaced by Luscii to align remote monitoring with funded plans and the Trust's shared care record.
- Several pilots are moving towards wider rollout, including EPS, ICE eRequesting, Virtual Assistant referrals and patient portal capabilities. Rio Flow has moved to January 2027 to allow process design, configuration, forms and readiness activity to complete.
- Ambient Voice Technology pilots are generating comparative evidence to inform formal procurement and Trust-wide rollout planning. Procurement is the next major decision point and requires continued assurance on governance, clinical safety, information governance, implementation capacity and benefits.
- Frontline Productivity funding provides £898.9k external funding, matched by £898.9k Trust funding, creating a total investment of approximately £1.80m across AVT, cyber, change management, digital medicines, remote monitoring and process automation.
- The FY27 position is £455.4k favourable before CIP, £176.4k favourable after the £279.0k CIP requirement, and £54.1k favourable after the expected £122.3k M8 budget change. The early

FY28 planning view indicates an £84.9k pressure after CIP and requires Finance validation before circulation

Report history / meetings this item has been considered at and outcome
This Paper has been to the execs and FIC in November 26

Recommendation(s)

- Note progress across the Clinical Systems and IT delivery portfolios, including the outcomes achieved to date and the small number of initiatives that have been delayed, stopped or reprioritised.
- Receive assurance on the approach to moving proven pilots into wider rollout, supported by strengthened adoption, change management and benefits-realisation capability.
- Note the revised Rio Flow timetable and the key technical and operational dependencies that must be completed before go-live.
- Support the proposed reprioritisation and movement of selected Clinical Systems initiatives into the FY28 work plan, including activity dependent on supplier roadmaps and the Rio EVO upgrade.
- Note the Frontline Productivity funding position and the requirement to finalise investment agreements, ownership, detailed spend profiles and benefits reporting.
- Note the FY27 financial position and emerging FY28 planning pressures, subject to Finance confirmation of CIP treatment, income, adjustments and recurrent/non-recurrent assumptions.

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 Relevant requirements include UK GDPR and Data Protection Act 2018, clinical safety standards DCB0129/DCB0160, cyber-security obligations, procurement rules and CQC expectations for safe, effective and well-led services.	

Board of Directors–IM&T Update November 2026

Digital delivery is moving from technical implementation towards adoption, connected workflows and measurable value.

Oxford Health NHS Foundation Trust

CLINICAL SYSTEMS

- Rio and EMIS pilots are progressing into wider rollout
- Structured assessments, discharge and care-planning templates have been strengthened
- ICE eRequesting is live in Rio with the OUH lab

Outcome: more consistent clinical recording and improved access to information.

PATIENT ACCESS

- True Colours patient portal access
- Virtual Assistant referrals are live across selected adult and CAMHS services
- The Patient Engagement Portal pilot is live and generating early usage evidence

Outcome: more digital routes for patients to access information and services.

MEDICINES & INNOVATION

- EPS and outpatient prescribing are moving beyond pilot
- Community hospital ePMA pilot delivered at Bicester
- AVT pilots are building evidence to inform formal procurement
  - Seca finalising final assurance sign on then will move to implementation
  - Work on Better Meds mobile app for home administrations starting December

Outcome: safer digital medicines workflows and controlled evaluation of new technology.

DIGITAL FOUNDATIONS

- Rio migrated to DC2 in readiness for Rio EVO
- Change Advisory Board established for work outside planned delivery

Outcome: Our digital foundations are reliable, secure and sustainable, enabling safe, connected and effective care.

FOCUS FOR THE NEXT PHASE

- Move pilots into full roll out
- Support with adoption and benefits capabilities
- Digital Champions programme reset

Oxford Health NHS Foundation Trust

Clinical Systems FY27 Plan- 6 Month checkpoint

A broad delivery pipeline, organised around four practical areas of change.

Getting the basics right

- MFA rollout
- Rio Reimagined rollout: diary and referrals
- Waiting lists and validation rollout
- Text messaging full rollout
- eObservations for CAMHS
- Key forms, dashboards, letters and clinics
- EPS full rollout
- eReferrals, Advice & Guidance
- Wound management
- Additional questionnaires for CAMHS and AMHS
- Champions role refreshed
- Compulsory refresher training
- System upgrades
- Interim discharge summary rollout
- CPA recording
- Key Worker recording

The items in red are due to a delay in the release of the functionality by the supplier. This will be part of the Rio evo platform update due in Q3-4 FY28

New functionality

- Flow bed management for mental health inpatients
- Self-referrals
- True Colours across community and inpatient services
- Community hospitals ePMA pilot
- ePMA mobile pilot
- Therapeutic observations
- True Colours patient portal
- Patient Engagement Portal and appointment management
- True Colours: one tenancy for OHFT

The item in red are due to the switchover in support for Better from CGI to Better and the Contract moving to Better. ePMA mobile will be moving to 'in progress' from December 26 to start planning and implementation

Interoperability

- NHS App appointments and documents
- ICE single sign-on from EMIS
- CPIS integration with EMIS
- NHS Notify and True Colours
- Closed-loop medication- supply request
- ICE links with RBH, MK, OUH, Great Western and Bucks
- ICE order tests pilot with OUH
- Point-of-care tests into ICE
- EPR data into TVS
- NHS Login and True Colours
- True Colours and Epicare integration
- True Colours and ePMA integration to track medicines against outcomes
- GP Connect within ePMA
- e-Referrals integration
- RPA: repetitive tasks

GP Connect within ePMA will be progressing from December 26 once we have procured the solution using Frontline productivity funding. The True colours/ ePMA integration will be moving into next years work plan due to other prioritised work

Innovation

- Ambient voice technology pilots
- LifeYear heart failure remote monitoring pilot
- Remote monitoring pilot in community: Luscii
- Clinical decision support for CAMHS NDC
- Copilot use for clinical administration

We have stopped the work with Lifeyear as we are moving forward with Luscii instead as this is funded via the frontline productivity for our remote monitoring solution and is aligned to our TVS shared care record.

Key

Blue - In progress
Red- Delayed/stopped
Green- Delivered

Clinical Systems: delivery and outcomes this quarter

Oxford Health NHS Foundation Trust

RIO

- •SMS reminders, waiting-list and inpatient discharge summary approved for full rollout Core assessments and Section 135/136 recording introduced
- ICE eRequesting live with the OUH lab
- Migration to DC2 completed in readiness for Rio EVO
- Allergies recording policy

OUTCOME More consistent way of recording and quicker access to laboratory requesting, with stronger foundations for future Rio development.

EMIS

- AccuRx, EPS and EMIS Mobile X approved for full rollout
- Discharge, end-of-life, history and diagnosis templates redesigned
- Podiatry, community hospital and heart-failure workflows progressed
- Bicester community hospital ePMA pilot delivered

OUTCOME More standardised community workflows, improved mobile access and safer digital prescribing and discharge processes.

DIGITAL MEDICINES

- EPS and outpatient prescribing approved for wider rollout
- Better Meds and Ascribe supply-request process tested further
- Electronic Section 62 recording introduced for mental health inpatients

OUTCOME Reduced reliance on paper processes and more complete, traceable medicines documentation.

TRUE COLOURS

- Clinical Impairment Assessment questionnaire delivered, with more questionnaires planned
- Read-only access extended to inpatient users
- Patient portal access to True Colours pilot
- An option to add if the care plan was coproduced
- NCAP work for Early Intervention in Psychosis started

OUTCOME Wider access to patient-reported information and greater patient involvement in care planning.

CROSS-SYSTEM DELIVERY

- Several releases delivered across the EPR estate
- Monthly Change Advisory Board established for unplanned work
- Emis data live in TVS; Updated Graphnet Interface live in BSW
- New templates and forms delivered against service priorities

OUTCOME Stronger governance, connected information and a more controlled route from service priorities into delivery.

ADASTRA

- GP Out of Hours workflows improved, including Duty Desk, dispatch and home-visiting caseloads.
- SNOMED illness coding introduced for GP OOH and MIU clinicians, replacing Read Codes.
- Hospital at Home renamed Palliative / Catheter Team, with no change to the underlying workflow.
- MFA implementation and testing progressed, supported by user guidance but not yet live

OUTCOME More consistent urgent-care workflows, standardised clinical coding and stronger access controls.

Board of Directors–IM&T Update November 2026

Oxford Health
NHS Foundation Trust

Pilot Updates

EPS rollout has moved beyond pilot

Eight Mental Health teams are entering three go-live waves, with rollout continuing through March 2027.

93
teams going live

3
Monthly go live tranches (Sept, Oct, Nov)

180+
Clinicians using EPS

What happens next

- Ongoing monitoring of compliance (Exec support needed)
- Embargo on supply of new paper FP10 pads (paper to be BCP only)
- Further benefits realization work re drug costs and cash releasing saving re postage
- Develop BAU processes for new starters and doctor rotations

Go-live waves (by service)

September: South Oxon CAMHS; Oxon EIS & ARMS, Bucks Perinatal; Bucks Older Adults; North & West Oxon AMHT: Salisbury, Melksham and BANES Community CAMHS
October : Older Adult North & West Oxon, Bucks Community CAMHS, Bucks ED Team, Swindon CAMHS, Marlborough CAMHS, Oxon Perinatal, North Oxon CAMHS
November: South Oxon Older Adults, South Oxon AMHT, Chiltern AMHT, Bucks EIS, Bucks Adult ADHD, Central Oxon Older Adults, Oxon ED



Oxford Health NHS Foundation Trust

AVT pilots are generating evidence for Trust-wide procurement

Four products are at different stages, allowing comparison of usage, integration and implementation readiness.

Heidi

Live across 8 Mental Health teams, with 3 Community teams planned. Weekly active usage remains around 20-24 users. Community go live planned for December 2026

38	416	797	293.25
Heidi active users	Heidi sessions	notes and documents	hours transcribed

Beam

DPIA complete
Cyber assessment approved
Champion-user template workshops next
Two templates planned per team
Beam live with Mental Health and Community Pilot users as of the 2nd November 2026

Accurx Scribe

New Project Manager onboarding
DPIA in progress
Six Community teams identified
Go live planned for December 2026
Investigating whether MH can join pilot with Accurx

Smart Notes

Preliminary testing with 20 users across 4 services; integrated with Rio progress notes.- **This is currently suspended**

Oxford Health NHS Foundation Trust

AVT procurement is the next major decision point

Pilot learning is feeding into a formal procurement and Trust rollout plan.

1. **September 2026** — Gather tender documents and review requirements
2. **October 2026** — Finalise Tender documents
3. **November** — Release Tender
4. **December** — Evaluate responses
5. **January 2027** — Award contract and plan for full roll out

Oxford Health NHS Foundation Trust

Rio Flow pilot has moved to January 2027

The pilot remains Green but go-live has been deferred to allow process design and configuration to complete.

Drivers for the delay

Process-design delays
Resource constraints
Configuration backlog
Outstanding forms
Technical blocker, now resolved

Revised roadmap

January-March 2027: Sapphire, Sandford and Wintle pilot wards go live
April-June 2027: pilot evaluation
July 2027-June 2028: wider rollout

Next

Complete dashboard development and engagement workshops; agree future-state processes; complete configuration, forms, training materials and go-live preparation.

Digital Patient Access: Virtual Assistant and PEP

Oxford Health NHS Foundation Trust

Early rollout and pilot evidence, with wider deployment dependent on service readiness and policy decisions.

Virtual Assistant- Self/Professional Referrals

Currently live

- **Adult services:** BPNMT/MMHT and SUN successfully live from **23 June**.
- **CAMHS:** SPA across Bucks, Oxon and BSW live from **10 August**, with CAMHS MHST live from **29 September**.
- **Next phases:** Phases 2 and 3 require **Rio integration** and are awaiting the necessary Rio upgrade.
- **Benefits realisation:** Post-implementation analysis is underway across adult services to assess whether VA Referrals has reduced **clinical and administrative time spent chasing missing referral information**.

Next Steps : Engagement with additional services is progressing to understand requirements, effort and readiness for further onboarding.

Patient Engagement Portal pilot

Live in Buckinghamshire Adult Eating Disorders Service

~160 patient cohort	**512** notifications sent
31% accessed in 7 days	**62.3%** viewed appointment details

NHS App deployment

DPIA and clinical safety report being updated; activation planned following approval currently aimed for go live 1st October 2026

Dependencies for wider rollout

Proxy-access policy and verification • consistent Rio diary use • strong change management • Trust-wide communications and patient engagement • clinical and operational support

ICE eRequesting: pilot progressing to rollout

Oxford Health NHS Foundation Trust

The Fulbrook Centre pilot is live, with positive initial feedback and a defined staged rollout process.

Pilot position

Live since 25 August 2026

2	5	1
Consultants	Resident doctors	Nurse

Initial feedback: no issues encountered

Next steps

- Transition BAU support to CAST
- Finalise Rio training materials
- Agree rollout approach with Clinical Systems teams
- Identify Oxfordshire services and relevant Rio users

Rollout process

1. Engage services
2. Gather user details
3. Configure permissions
4. Complete eLearning
5. Enable access

Dependencies **OUH capacity for account creation • responsive service contacts • timely completion of mandatory eLearning • distribution of request-printing labels**

Oxford Health NHS Foundation Trust

NHS Notify: assessing digital patient communications

The pilot will assess NHS App messaging and other supported channels for Oxford Health patient notifications.

Purpose

To assess the feasibility and benefits of using NHS Notify to deliver patient notifications through NHS App messaging and other supported channels, helping to improve the way Oxford Health communicates with Patients.

Focus: improving how Oxford Health communicates with patients

What the pilot will test

- NHS App Notification- email, SMS, letters
- Other NHS Notify-supported channels
- Feasibility for Oxford Health patient communications
- Benefits identified through pilot activity

Current next step

Progress development and testing in line with the pilot plan.

Key Benefits

Trusted
Patients can recognise NHS App notifications as coming from a trusted NHS source, helping to build confidence and improve engagement.

Cost Efficient
Free unlimited NHS App messages, competitive message rates with no setup or integration fees.

PDS Integrated
Connects with PDS to verify patient details and preferences while filtering out restricted or deceased records.

Secure
Fully GDPR compliant and meets ISO 27001/2 and NCSC Cyber Assessment Framework standards.

Board of Directors–IM&T Update November 2026

Oxford Health NHS Foundation Trust

Benefits: turning digital delivery into measurable value

The specific patient, clinical, workforce and organisational benefits evidenced across the delivery portfolio.

Better patient access and experience

- Reduced DNAs and increased attended appointments
- Patient choice of pharmacy following discharge
- Greater patient involvement and better-quality clinical interactions

Safer, more consistent care

- More accurate and efficient NEWS2 calculations
- Fewer missed or incorrect medication doses
- Faster ordering and review of laboratory tests

More productive and supported staff

- Less time sending, receiving and scoring questionnaires
- Less time prescribing and administering medicines
- Less clinician time writing consultation notes and letters

Greater organisational value

- Reduced medicines expenditure
- Lower printing, postage and letter costs
- Stronger workflows, governance, resilience and connected information

How benefits will be realised

1. **Deploy** — Move proven pilots into wider rollout
2. **Adopt** — Support consistent use in teams
3. **Measure** — Track uptake, experience, safety and productivity
4. **Evidence and sustain** — Use evidence to refine and embed value

ELT focus: strengthen adoption and benefits capability so delivery translates into sustained clinical, staff, patient and financial value.

Frontline Productivity funding: £898.9k to accelerate digital delivery for FY27

Oxford Health NHS Foundation Trust

Six investment areas are progressing through Investment Agreements, with matched Trust funding and benefits reporting requirements.

£898.9k
external funding

£898.9k
Trust match funding

£1.80m
total investment

CURRENT POSITION
Investment Agreements are being completed and spend plans are being aligned to delivery capacity.

AVT	£252,019
Pilot-to-scale delivery, implementation and project support. Cannot be used for licences	

Cyber	£213,038
MFA, zero-trust access, email scanning and password protection	

Change management	£181,088
Additional capacity to support adoption and benefits realisation	

Digital medicines	£138,956
EPS and electronic ordering of medicines (supply request)	

Remote monitoring	£76,009
Initial long-term condition pathway and service-model mobilisation	

Process automation	£37,803
e-referrals and automation of repetitive workflows	

IMMEDIATE FOCUS
Finalise agreements and ownership • confirm detailed spend profiles • mobilise change capacity • track adoption, productivity and patient benefits

Oxford Health NHS Foundation Trust

Clinical Systems Champions: turning digital change into everyday practice

A defined network of local advocates and subject matter experts, connecting frontline services with clinical, operational and digital teams.

1 Adopt and embed change

Act as the local ambassador for clinical systems

Support upgrades, new functionality and agreed ways of working

Identify barriers and bring frontline feedback into delivery

2 Optimise how systems are used

Identify opportunities to improve clinical and operational workflows

Promote standards, consistent recording and best practice

Support testing, user groups and continuous improvement

3 Build confidence and capability

Provide first-line peer support for basic system queries

Reinforce formal training in day-to-day practice

Identify training needs and share system updates locally

4 Strengthen local resilience

Maintain awareness of downtime and contingency procedures

Help teams prepare for planned and unplanned disruption

Contribute to exercises and lessons learned

EXPECTED IMPACT

More consistent system use and data quality • Greater staff confidence • Smoother implementation • Stronger connection between frontline services and digital teams

Next Steps

- Agree a pilot team to work towards this model
- Work with service and HR to add roles and responsibility to JD
- Launch a champions day
- Review current Champions list and identify missing gaps

Oxford Health NHS Foundation Trust

IT FY27 plan: secure foundations and a better staff experience

All projects and BAU activity are grouped into four practical delivery categories.

NETWORK & INFRASTRUCTURE

- Installation of 2 local internet breakout circuits
- Upgrade HSCN circuits to provide better network performance
- Data Centre refresh and back up solution implementation
- Replace Horizon & Citrix with Microsoft VDI solution
- Upgrade server 2016 operating system which is end of life
- Upgrade comms cabinets, switches and hardware as required
- Support Estates Projects

CYBER & RESILIENCE

- DCB1596 secure email standard documentation
- Cyber awareness training platform review
- Phishing exercise across Trust
- Sentinel SIEM Review
- Review Proofpoint & M365 as Mimecast replacements
- Zscaler implementation replacing Forcepoint web filtering to enable mobile devices to be included
- Cyber assessments
- Remove unsupported and unused devices

STAFF TECHNOLOGY

- Additional telephony functionality for switchboards and voice-recording resilience
- Ricoh print project complete rollout
- Copilot adoption support, including Copilot agents
- Accessibility support initiatives
- Review Autopilot to provide devices ready “out of the box”
- Device refresh programme

SERVICE & BAU

- Automation for user accounts, distribution groups and related processes
- Digital Champion forum support
- IT procurements and contracts
- ServiceNow optimisation
- Site audits to reduce incidents
- Supplier relationships

Key

Blue - In progress
Red- Delayed/stopped
Green- Delivered

IT delivery: major works and service performance

Oxford Health NHS Foundation Trust

Major works are shown alongside the full June to August 2026 operational performance position.

FASTER CONNECTIONS

Local Internet Breakouts covering the whole Trust are now operational. This diverts non-clinical traffic away from HSCN, freeing capacity and improving staff experience.

MODERNISED PLATFORMS

Data Centre refresh phase two is under way. New high-performing hardware has been purchased and work has started to replace legacy equipment.

SAFER DIGITAL WORKING

Enhanced cyber-security functionality continues to be introduced, including AI protection for web and email services.

RELIABLE STAFF TECHNOLOGY

All print devices have been replaced, with enhanced reporting now available. The end-user device refresh programme continues through FY27 so no device is older than five years.

VIRTUAL ACCESS

The virtual desktop replacement will allow partners to access Trust systems remotely without needing Trust equipment.

TELEPHONY & DEVICE USE

A new contact-centre solution is planned for Community Services 0–19 SPA. Device rationalisation and recovery of over-provisioned or under-used devices will continue.

IT KPIs | June to August 2026

1,755 / 1,051 inbound calls / Web App	**1,662** calls answered	**2 minutes** average answer time
93 calls abandoned	**64%** first-time fix	**4** agents available

DEVICES REFRESHED / ISSUED

324 laptops	**93** desktop PCs	**4** iPads	**73** mobiles

STARTERS / LEAVERS — **541 new starters** — **291 leavers**

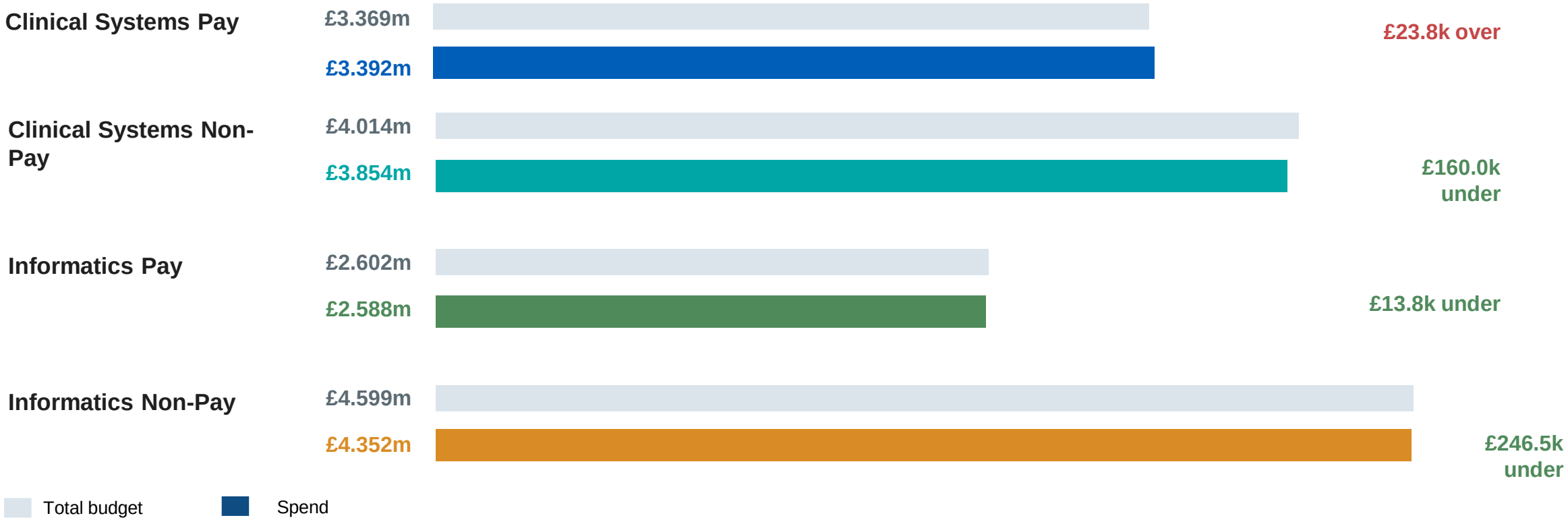
OUTCOME More resilient infrastructure, stronger cyber protection and dependable day-to-day support for staff.

Oxford Health NHS Foundation Trust

FY27 revenue budget: total budget compared with spend

Current FY27 position across Clinical Systems and Informatics, including income and approved funding movements.

Headline: spend is £455.4k below budget before CIP. After the £279.0k CIP requirement, the position is a £176.4k underspend. Allowing for the £122.3k budget change expected in M8, the remaining underspend is £54.1k.



ADDITIONAL FUNDING POTS

Frontline Productivity £672.4k
CS £553.8k + Informatics £118.5k

Q1 allocation £336.2k
Clinical Systems non-pay

Total additional funding £1.009m
FP and Q1 combined

FY28 budget: early total budget compared with spend

Early FY28 position across Clinical Systems and Informatics. This remains a planning view and is not an approved budget.

Oxford Health NHS Foundation Trust

FY28 total budget

£13.527m

including income and Additional funding

BASE BUDGET

£13,343,299

ADDITIONAL FUNDING POTS

Q1 allocation £183.852 k
Clinical Systems non-pay

Frontline Productivity 179.282k
Clinical Systems pay

Clinical Systems Pay

£3.548m Spend £3.533m | £14.6k under

Clinical Systems Non-Pay

£3.308m

Informatics Pay

£2.602m Spend £2.616m | £14.3k over

Informatics Non-Pay

£4.480m

Overall position

- Total spend: £13.157m
- Variance before CIP: £370.0k favourable
- CIP requirement: £454.9k
- Net position after CIP: £84.9k pressure

Still to be considered

1. Confirm the treatment of the £454.9k CIP requirement
2. Validate Clinical Systems income of £411.0k
3. Confirm the Q1 adjustment of £183.9k
4. Separate recurrent and non-recurrent changes
5. Reconcile FY28 assumptions to the approved plan

Planning position only. Finance confirmation is required before circulation.

Oxford Health NHS Foundation Trust

Meeting:	Board of Directors Meeting in Public
Date of Meeting:	25 November 2026
Agenda item:	15(i)
Report title:	Corporate Registers: Application of Trust Seal
Executive sponsor(s):	Taff Gidi, Executive Director of Corporate Affairs
Report author(s):	Leanne Dunkley, Corporate Governance Officer
Action this paper is for:	☐ Decision/approval ☑ Information ☑ Assurance
Reason for submission to the Board:	Regulatory Requirement / Board Standing Orders and Scheme of Reservation & Delegation
Public or confidential:	Public

Executive summary

The Common Seal of the Trust is affixed to documents under the authority of the Board of Directors in accordance with its Standing Orders. A Register of Seals is maintained by the Executive Director of Corporate Affairs.

Standing Orders require, pursuant to section 9, that a report of all seals is made to the Board. The Trust's Board of Directors receives reports of all seals, its last report being presented on 25 March 2026. This report provides information about the application of the Trust's Seal between 23 March 2026 and last entry on 28 September 2026.

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

This report has been prepared for the Board.

Recommendation(s)

The Board is asked to note this report.

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~~	

The Board of Directors is invited to note that the following documents were sealed during this period.

REGISTER OF SEALING

Details	Seal No.	Signatory	Date
Lease transaction as part of East Oxford Health Centre, Manzil Way, Cowley Road, Oxford OX4 1XD Landlord of Community Health Partnerships and Oxford Health NHS Foundation Trust. Rent £1.4m per annum Contract Term is 6 years expiring in 2031	436	Grant Macdonald, Chief Executive Officer and Heather Smith, Chief Finance Officer	23/03/2026
Funding agreement between Vale of White Horse District Council and Oxford Health NHS Foundation Trust relating to funding for refurbishment of ground floor at Wantage Community Hospital, Garston Lane, Wantage, OX12 7AS Total contribution £950,000 inc. VAT	437	Grant Macdonald, Chief Executive Officer and Heather Smith, Chief Finance Officer	27/04/2026
Lease extension of Raglan House, 23 Between Towns Road, Oxford OX4 3LX. Landlord Pashdean Ltd, Tenant Oxford Health NHS Foundation Trust Rent £256,000 per annum, 12-month extension until July 2028	438	Grant Macdonald, Chief Executive Officer and Heather Smith, Chief Finance Officer	04/05/2026
Lease renewal of Psychotherapy Cottage, Warneford Park, Warneford Road. OX3 7JX. Landlord Oxford Health NHS Foundation Trust, Tenant Oxford University. Rent £52,000 per annum Term ten years	439	Grant Macdonald, Chief Executive Officer and Heather Smith, Chief Finance Officer	11/05/2026
Contract for the provision of S75 Services between Buckinghamshire Council and Oxford Health NHS Foundation Trust.	440	Grant Macdonald,	

Term of contract to extend to 31 August 2027. Total income FY25/26 £3,241,660.83		Chief Executive Officer and Heather Smith, Chief Finance Officer	
Supplementary lease for part of first floor of POWIC, Warneford, Warneford Lane, Headington, Oxford. OX3 7JX Rent 26,321 per annum, License approx. 2.5 years	441	Grant Macdonald, Chief Executive Officer and Heather Smith, Chief Finance Officer	13/07/2026
Contract variation for provision of Oral Health Services in Oxfordshire 1 August 2025-31 August 2028 1 August 2025-31 March 2026 £699.78 20206/2027 £1,081.16 2027/2028 £1,113.59	442	Dr Michael Holland, Chief Executive Officer and Heather Smith, Chief Finance Officer	28/09/2026
Contract variation for Healthy Child Programme 1 August 2025-31 August 2028 2024/2025 £255,188.00 2025/2026 £327,457.31 2026/2027 £337,281.03 2027/2028 £347,399.46 2028/2029 £357,821.44	443	Dr Michael Holland, Chief Executive Officer and Heather Smith, Chief Finance Officer	28/09/2026

Oxford Health NHS Foundation Trust

Meeting:	Board of Directors Meeting in Public
Date of Meeting:	25 November 2026
Agenda item:	15(ii)
Report title:	Corporate Registers – Gifts, Hospitality & Sponsorship
Executive sponsor(s)	Taff Gidi, Executive Director of Corporate Affairs
Report author(s):	Leanne Dunkley, Corporate Governance Officer
Action this paper is for:	☐ Decision/approval ☑ Information ☐ Assurance
Reason for submission to the Board:	Regulatory / NHS England guidance
Public or confidential:	Public

Executive summary

The Board is provided with an update on entries in the Register of Gifts, Hospitality & Sponsorship since the last report presented to the Board on 25 March 2026.

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

This report has been prepared for the Board.

Recommendation(s)

The Board is invited to note this report.

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	

GIFTS AND HOSPITALITY (ACCEPTED)

	Details	Individuals	Est. Value	Date Reported
1.	Governance Discussion Dinner hosted and sponsored by the Good Governance Institute (**GGI**) – 19 March 2026	Taff Gidi, Executive Director of Corporate Affairs	£80	20/03/2026
2.	Dinner in Oxford as guest of University of Oxford (Medical Sciences and Dept of Psychiatry) – 18 March 2026	Andrea Young, Trust Chair	£50	05/05/2026
3.	Dinner at Exeter College, University of Oxford as guest of Department of Primary Care – 19 March 2026	Andrea Young, Trust Chair	£50	05/05/2026
4.	21 bottles of wine and 36 bottles of lager from a supplier. Distributed by the Estates team as part of a free staff draw OR might be donated/partly donated into the Charity – Advice being sought regarding how these will be handled in a way that is fair and ethical	Jeremy Philpot, Director of Estates & Facilities and the wider Estates team	£147 + £36	12/05/2026
5.	Hospitality (non-alcoholic drinks and snacks) at a reception hosted by CBRE and Turner & Townsend – 24 June 2026	Heather Smith, Chief Finance Officer	£25	26/06/2026
6.	£50 John Lewis/ Waitrose voucher to staff member in Podiatry service donated by patient's family -advised to direct to charity-awaiting response-Advice being sought regarding how these will be handled in a way that is fair and ethical	Munetsi Masisimani, CDL Podiatrist	£50	29/07/2026

7.	Exercise Bike donated to ward at Witney Community Hospital by a patient	Tendai Mugariri, Clinical Lead Witney Emergency Multi-Disciplinary Assessment Unit	£100	05/08/2026
8.	Five boxes of M&S chocolates donated to the Salsbury CAMHS team from a parent	Karen Newel, Administrator; Terry Pearce, Clinical Team Manager; Sherif Youakim, Psychiatrist; Esme Mackrill, Speciality Doctor; and Nina Heptner, Family & Systemic Therapist Salisbury CAMHS	£50	18/08/2026
9.	Flask mug and 'thank you' ornament from a patient	Louise Tohill, Clinical Lead Nurse CAMHS Community Services	£10	05/11/2026
10.	Evening meeting, including dinner, hosted and sponsored by the GGI – 27 October 2026.	Andrea Young, Trust Chair	£50	10/11/2026

GIFTS AND HOSPITALITY (DONATED INTO THE TRUST CHARITY)

	Details	Individuals	Est. Value	Date Reported
1.	None declared during the reporting period.			

GIFTS AND HOSPITALITY (DECLINED)

	Details	Individuals	Est. Value	Date Reported
1.	Pool table and table tennis table – declined as space and transportation issues.	Wintle Ward team	N/A returned to donor	16/07/2026

GIFTS AND HOSPITALITY (INVESTIGATION/BREACHES)

If vouchers have been accepted from patients/families then there will have been a breach of policy and this will be discussed with staff who will be reminded of the guidance to follow.[1] However, if possible, to decline or redirect the vouchers to the Trust's Charity then this will be done as an alternative.

	Details	Est. Value	Date Reported
	See declaration no. 6 above - Advice being sought regarding how these will be handled in a way that is fair and ethical		

[1] NHS England guidance – gifts of cash and vouchers to individuals from patients/families/service users should always be declined: NHS England » Managing conflicts of interest in the NHS

SPONSORSHIP

	Details	Individuals	Est. Value	Date Reported
	None declared during the reporting period.			

Oxford Health NHS Foundation Trust

Annual Medical Appraisal and Revalidation Report 2025/26

1. Purpose

1.1. This report is presented to the Trust Board to provide assurance that the statutory functions of the Responsible Officer are being appropriately fulfilled; to report on performance in relation to those functions; to update the Trust Board on progress since the 24/25 annual report; to highlight current and future issues and to present action plans to mitigate potential risks.

2. Background

2.1. Medical revalidation was launched in 2012 to assure patients and the public that doctors are up to date and fit to practice. Each doctor must have a Responsible Officer who oversees a range of processes including annual appraisal, and who makes, at five yearly intervals, a recommendation to the General Medical Council (GMC) regarding the doctor's revalidation.

2.2. The Responsible Officer is appointed by the Board of an organisation termed a Designated Body, to which a doctor is linked by a Prescribed Connection (via the GMC). This link is created when a contract of employment, (substantive, locum or honorary), is agreed between the doctor and the Designated Body.

2.3. Designated Bodies have a statutory duty under the Responsible Officer Regulations to support their Responsible Officers in discharging their duties. It is expected that provider Boards will oversee compliance by:

2.3.1. Ensuring that the Responsible Officer is provided with adequate resources to fulfil the role.
2.3.2. Monitoring the frequency and quality of medical appraisals in their organisations.
2.3.3. Checking that there are effective systems in place for monitoring the conduct and performance of their doctors.
2.3.4. Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors and
2.3.5. Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2.4. Designated body/RO for doctors employed by Oxford Health:

Group	DB/RO	Assurance

Consultants, SAS and LED doctors	OHFT – Karl Marlowe	Appraisal, ROAG Regular discussions with GMC-Employment Liaison Advisor and NHS Resolution
GP's	NHSE (performers' list) – if registered in South East, RO is Dr Shahad Ahmad	Annual appraisal, In-house performance review, ROAG GMC-ELA and NHS-R Regular meetings with NHSE-SE professional standards body Liaison with other regions as necessary
Resident doctors	NHSE (Deanery) – Prof Jo Szram	Annual review of competence progression which includes appraisal functions, ROAG, Deanery GMC-ELA and NHS-R Lead employer where appropriate eg Foundation doctors

2.5. Since September 2023, the NHSE 'Professional standards: framework for quality assurance and improvement' (FQAI) requires the Trust to follow the following cycle of assurance:

2.5.1. **Quarter 1 April to June:** The designated body reviews the previous year's metrics and uses the framework of their annual Board report template to assess these against last year's development plan and create their new improvement plan for the coming year.

2.5.2. **Quarter 2 July to September:** The designated body undertakes actions to implement their improvement plan.

2.5.3. **Quarter 3 October to December:** The designated body finalises their annual Board report, which comprises their data compiles in quarter 1 and commentary on the actions identified, with any preliminary data on progress with these and presents this to their Board (or equivalent governing body). The Board approves the Statement of compliance. The final approved Board report and Statement of compliance are then submitted to the level 2 responsible officer by the end of September (we have agreement to submit by end November),

2.6. This report covers the period 1 April 2025 to 31 March 2026.

3. Governance

3.1. The current Responsible Officer (Dr Karl Marlowe, Chief Medical Officer) was appointed by the Trust Board on 10 May 2021 in line with statutory requirements. The Chief Medical Officer is supported by a medical appraisal/revalidation advisor (appointed in January 2023 as part of the medical workforce team) and a medical lead for appraisal/revalidation who was appointed at the end of 2021.

3.2. ROAG is the Responsible Officer Advisory Group, meets monthly, and is attended by CMO, DCMO, CPO, a NED and a senior member of the Medical Workforce team. The

ROAG supports the RO to make revalidation decisions and advises on concerns raised about doctors and dentists.

3.3. Governance for the main areas of compliance are as follows:

Monitoring appraisal system	• All appraisal on Allocate system. • Monthly progress reports to ROAG, quality assurance via audit.
Making revalidation recommendations	• ROAG meetings - discussions of all collated information in appraisal cycle to make revalidation recommendations.
Effective systems for monitoring conduct and performance of doctors	• For each appraisal the medical line manager, PALS and PSI team are requested to provide assurance re concerns. • ROAG discussions of concerns raised about all doctors (including doctors in training and GP's where OHFT is not DB). • Annual summary of ROAG discussions.
Ensuring appropriate pre-employments checks are carried out.	• Audit within medical staffing, and externally.

4. Policy and Guidance

4.1. The HR46 Medical Appraisal and Revalidation Policy was approved in November 2024 at the MAC, had CPO sign-off in June 2025 and is available on the Trust intranet.

4.2. Supporting information of guidance for doctors was updated in February 2025 and circulated to all doctors being appraised for 25/26, with specific reference to gathering evidence across the whole scope of practice.

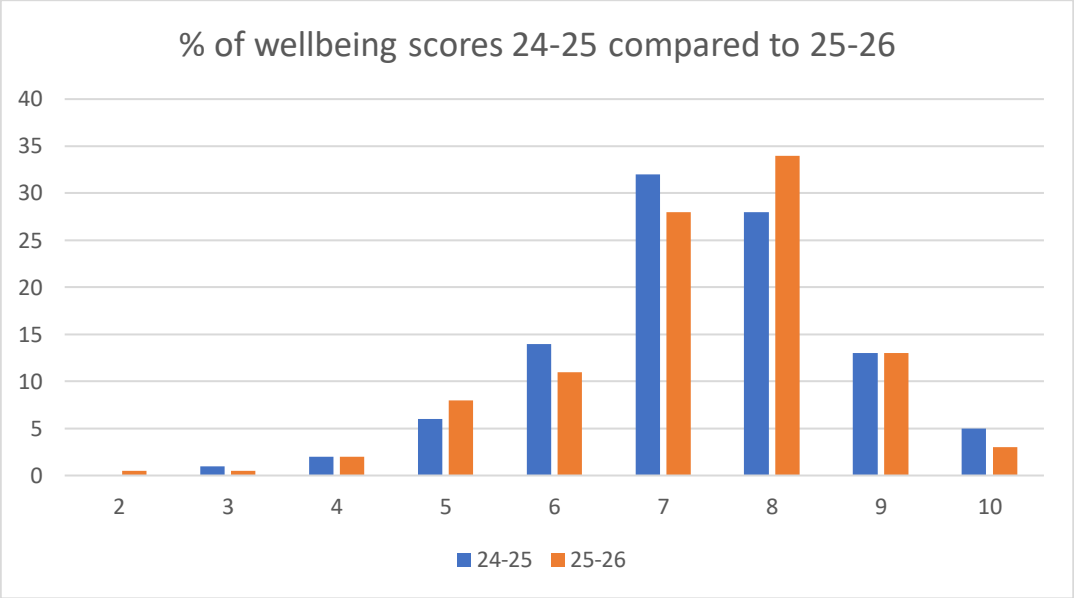
5. Medical Appraisal

5.1. In total, **214** doctors had successfully completed their 25/26 appraisal (up from 173 the year before). **37** were completed after their due date (approved delays) and **37** were exempt due to Maternity Leave/Sick Leave or New Starter Exemptions. There were no letters of non-engagement issued in 25/26.

5.2. A continued challenge in 2025/2026 was meeting the target set by NHS England of returning completed appraisal documentation within 28 days of the appraisal meeting, with 64/214 being signed off late (29%). The biggest reason appears to be delays in obtaining medical manager reports.

5.3. Completed appraisals provide a snapshot of doctors employed by the Trust (apart from agency/resident doctors). When completing their appraisal documentation, doctors are

asked what their overall 'wellbeing score' is (ranked from 1 – most negative to 10 – most positive):



5.4. Appraisers

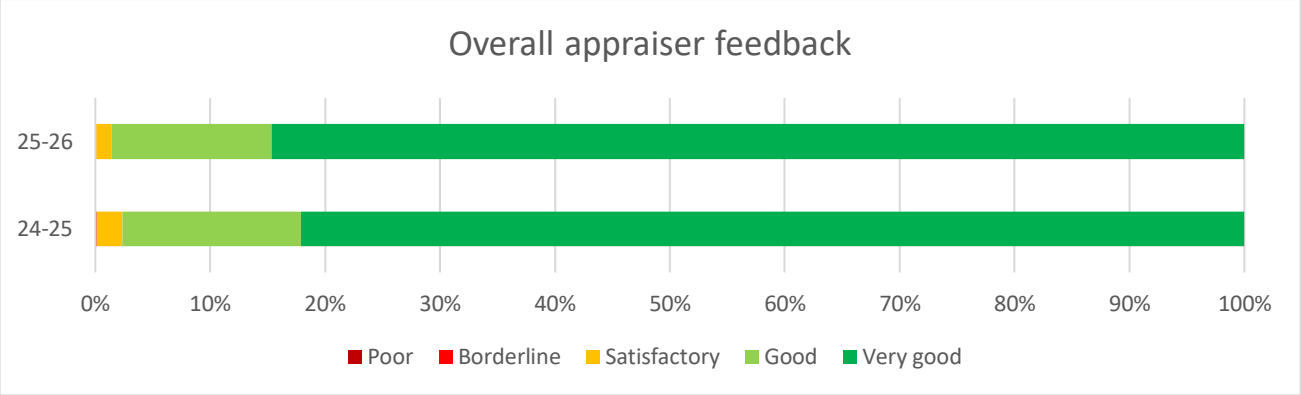
5.4.1. Appraiser capacity has improved since the Trust agreement to pay appraisal work as an additional programmed activity. During 2025/6 we have continued to employ four retired/return consultants to do additional appraisals to ensure appropriate appraiser capacity.

5.4.2. At the end of March 2025 there were 43 NHS appraisers (4 appraisers retired or left during the year) and 9 academic appraisers which allowed for full allocation of all doctors on our DB list for 2025/26.

5.4.3. Another successful appraiser training event was held in September 2025 with a focus on 'tricky appraisal conversations'. The event was well attended with positive feedback received (average rating 4.78/5).

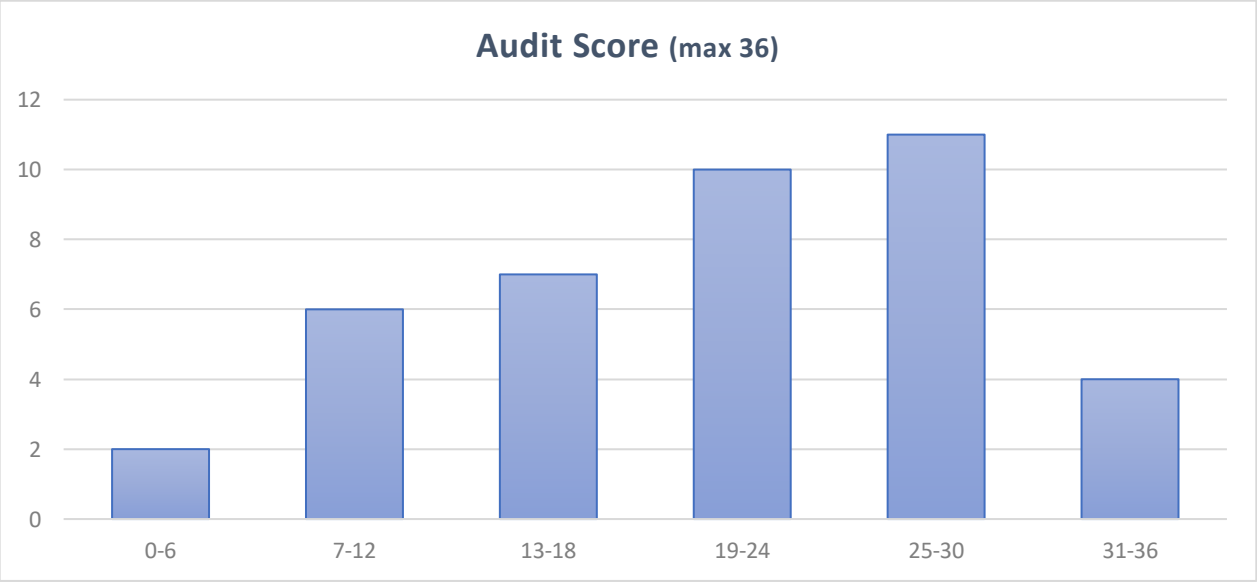
5.5. Quality assurance

5.5.1. Appraisees provide mandatory feedback after their appraisal is complete.



5.5.2. A local audit tool, designed with the learning from the last audit, was created with the aim of improving the quality of audit outputs (summary of the appraisal discussion). All appraisers (apart from the auditor and appraisees who had left) had one of their completed 25-26 appraisals audited against the standards. 38% of appraisals audited scored less than half the total audit score. Appraisers scored best on describing scope of work, positively recording strengths, achievements and aspirations, discussing PSI's/complaints and patient/colleague feedback. Particularly poorly scoring areas included: evidence of challenge, comments on quality of evidence provided for assurance and reflecting on learning from PDP goals.

5.5.3. Each appraiser will receive their result of this audit, their collated appraisee feedback from appraisees and contextual information for the whole cohort of appraisers. The quality of appraisal outputs will be the focus of the next appraiser training event in December 2026.



6. Medical Revalidation

6.1. Monthly ROAG (Responsible Officer Advisory Group) meetings were set up in line with GMC guidance to assure the revalidation recommendation process, and to provide advice to the RO where a significant concern has been raised about a doctor. GMC guidance suggests that a NED be appointed to provide support to the ROAG, and this role was undertaken by David Walker.

6.2. During 25/26, **25** positive revalidation recommendations were made. **2** deferrals were approved (7.4% deferral rate), with reasons including sickness absence and on-going difficulties in collecting 360 patient feedback. In comparison, the GMC states that the average deferral rate for the 'same DB type' for 25-26 was 20%.

7. Recruitment and Engagement Background Checks

7.1. The Medical HR (Human Resources) Team is responsible for ensuring that all necessary pre- and post-recruitment checks are completed in full and for taking any required action, including dealing with start dates, or withdrawing offers of employment, where the responses to these checks are not satisfactory.

7.2. There have been significant changes made in this area over 25/26:

- 7.2.1. A new 'talent acquisition partner' in the medical workforce team has allowed processes to be streamlined and applied consistently
- 7.2.2. New functionalities have been introduced using Trac (recruitment software) - offer letters and contracts are signed electronically and we use electronic stater forms which has improved the overall candidate onboarding experience and reduced their response time in returning documents.
- 7.2.3. The NHS service declaration form has been re-designed to minimise data errors by improving functionality of information boxes and introducing mandatory formats for dates, contracts and pay codes .This has hugely improved the data accuracy when determining CDS dates.
- 7.2.4. Implementation of TrustID software has had a positive impact by making ID checks quicker and easier, and the time taken to obtain DBS checks has improved.
- 7.2.5. A recruitment audit has been built into the system to enable a final review of onboarding records by a senior team member prior to appointment to provide assurance and mitigate risk.

7.3. The medical appraisal/revalidation advisor is responsible for sending MPIT (transfer of information) forms to previous responsible officers to obtain any significant information relating to fitness to practice, and this has been done for all new starters in 2025/26.

8. Monitoring Performance, Responding to Concerns and Remediation

8.1. Concerns about a doctor's performance or conduct are managed under the Trust's Procedure for Handling Concerns related to Conduct, Capability or Health of Medical and

Dental Practitioners. Concerns are also raised under other trust policy frameworks such as grievance, complaints or via the Freedom to Speak Up Guardian. The Trust is committed to a Just and Learning Improvement Culture, and the 'Principles and Framework for Fairness and Proportionality' published in January 2025. During this appraisal year we have contributed a case study and reflection by a doctor to the updated national guidance on Fairness and Proportionality published by NHS-Resolution.

8.2. The Procedure for Handling Concerns related to Conduct, Capability or Health of Medical and Dental Practitioners requires updating and medical managers have been working within a principles framework initially established in 2024 which has formed the basis of the new 'Managing Concerns About Medical and Dental Staff Policy' which is awaiting final feedback from HR colleagues and the BMA.

8.3. There are regular meetings between the RO, DCMO Professional Standards and GMC Employment Liaison Officer and all significant concerns are discussed with NHS Resolution Practitioner Performance Advice.

8.4. **Responsible Officer Advisory Group**: The role of ROAG is to ensure consistency and transparency of approach across the Trust when there are concerns raised about doctors and dentists, and to assist the RO in making decisions regarding process/next steps. ROAG discusses all concerns raised where a medical manager has sought more senior advice.

8.4.1. During 25/26 **25** doctors were discussed in ROAG meetings (up from 16 the year before). The majority of concerns were around conduct/professional behaviour.

8.4.2. **Outcomes**: For 3, there were no concerns identified and 12 had informal resolutions. One doctor had a formal sanction and two doctors were not offered further sessional work. One improvement letter issued and 5 cases remain open. Of the 'other' outcomes – one doctor resigned and one came to the end of their fixed term contract.

8.4.3. **Demographics** of doctors discussed at ROAG: 56% of doctors discussed at ROAG were from a BAME background. In March 2026 the Trust employed in total 322 doctors, and of those who stated their ethnicity, 34% identified as from a BAME background. This indicates a disproportionate number of doctors from a BAME background being discussed although the absolute numbers are small, and in the previous year 24/25, 31% were from a BAME background. Male doctors made up 72% of those discussed.

8.4.4. The Trust has one doctor under GMC supervision with restrictions on practice due to a health condition, whom we have supported since 2023, and there are no concerns.

Breakdown of doctors discussed at ROAG in 2025/26 (n=25)

Issue	Conduct		Capability		Conduct&Capability			
Gender	Male				Female			
Ethnicity	BAME				White			
Health Issue	Yes		No					
Grade	Consultant			GP		SAS	LED	RD
Directorate	Community		Adult MH		OA MH	Forensic/LD	CAMHS	
Contract	Substantive				Bank/sessional/NHS locum		Agency	RD
IMG*	No			Yes				
Outcome	Informal		Open		No issue found	Other	F*	I* SS*

IMG* - International medical graduate – primary medical qualification obtained outside of UK
F* - Formal (formal written warning n record x 6 months)
I* - Improvement letter
SS* - Stopped offering sessions (sessional GP)

Comparison with 2024/5 (16 doctors)

Gender	Male	Female	
Ethnicity	BAME	White	
IMG*	No		Yes

9. Progress against last action plan 2025/26

Objective	Action for 25/26	Progress
Reduce delays in appraisals and sign-offs	1. New process for obtaining medical managers report. 2. Communicate requirement for timely appraisals and early checks to prevent delays.	New processes in place from Sept 25 but these been inconsistently applied and have not made a significant impact. The audit tool included sign-off within time and this personal feedback to appraisers to improve sign-off rates.
Resolve issue of appraiser capacity	1. Recruit further appraisers on APA contract and reduce need for additional paid appraisals from retired consultants, such that by end of 25/26 appraisal year, appraiser capacity is no longer a risk and recruitment is business as usual.	Good appraiser capacity throughout the year and this does not appear to be a significant issue now.

Trust procedures and processes	1. Finalise bank/honorary contracts, roles and responsibilities. 2. Ensure appraisal system(Allocate MedicAppraisal) optimised to align with team-based ESR changes for doctors in Trust 3. Update the current 'procedure' to a 'Policy for managing concerns regarding doctors and dentists' in line with current guidance from GMC	1. Team-based ESR allocations finalised for doctors, and new cost-codes identified for honorary contract holders. On-going discussions with Dept of Primary Care and Dept Psychiatry, University of Oxford, about academic honorary contracts and MoU. 2. Complete 3. Completed but awaiting BMA/HR feedback.
Quality assurance	1. Change audit tool to meet Trust priorities to ensure: - Whole scope of practice covered - Trust and GMC required elements covered - Less time demand on appraisal team 2. Ensure audits of pre-employment checks reinstated	1. Audit tool re-designed and used this year for QA – will be discussed with appraisers at next refresher training Dec 26. 2. Awaiting medical staffing dept capacity.

10. **Proposed action plan for 2026/27**

Objective	**Action for 26/27**
Reduce delays in appraisals and sign-offs	• Introduce new prompts for appraisers • Individual conversations with appraisers whose audit demonstrated significant delays to sign-off.

Trust procedures and processes	• Finalise bank/honorary contracts, roles and responsibilities and Memorandum of Understanding with University of Oxford prior to BRC application. • Get the new Managing Concerns about Medical and Dental Staff Policy signed off. • HR systems to ensure that MedicAppraisal being used to its full capacity and that there are robust processes in place for any member of the medical workforce team to use the system when needed. • Audit changes in recruitment processes to ensure that all pre-employment checks done.
Improve quality of appraisal outputs	• Appraiser refresher training to be based around quality and reflecting on results of assurance audit. • Repeat audit • Introduce system of sign-off of appraisals and return incomplete appraisals to appraiser for further discussion.

11. Recommendation

PLC to receive this report, note the content, and note that it will be shared with the Tier 2 Responsible Officer at NHS England.

The Statement of Compliance (Appendix 1) confirms that Oxford Health NHS Foundation Trust, as a Designated Body, is in compliance with the regulations and that a Board representative will sign this on behalf of OHFT.

Author: Dr Kezia Lange, Deputy Chief Medical Officer, Professional Standards
Lead Executive Director: Dr Karl Marlowe, Chief Medical Officer

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of:

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Y
Action from last year:	No action
Comments:	Dr Karl Marlowe, Chief Medical Officer remains Responsible Officer for the Trust.

Action for next year:	No action

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Y
Action from last year:	Recruit further appraisers on APA contract and reduce need for additional paid appraisals from retired consultants, such that by end of 25/26 appraisal year, appraiser capacity is no longer a risk and recruitment is business as usual.
Comments:	Good appraiser capacity for 25/26
Action for next year:	Continue business as usual

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	No action
Comments:	Regular checks against DB list
Action for next year:	No action

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Y
Action from last year:	No action

Comments:	Trust has regular review schedule in place.
Action for next year	No action

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	N
Action from last year:	No action
Comments:	No peer review
Action for next year:	We are investigating the possibility of peer review with neighbouring Trusts, but this will depend on capacity within our own system too.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	Develop training material for consultants who line-manage fixed-term appointed doctors (eg LED's).
Comments:	Guidance regarding line-management responsibilities in place.
Action for next year	No action

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Y
Action from last year:	Establish and monitor new process for receiving complaints and PSI information for inclusion in the appraisal process. On-going training to appraisers regarding covering whole scope of practice.
Comments:	The new process has been established but with patchy success depending on availability of HR advisor support to the medical appraisal team and IT issues. Appraiser refresher training covered issues about getting feedback across whole scope of practice.
Action for next year:	Continue to review success of assurance around PSI/complaint reporting.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Y
Action from last year:	No action
Comments:	ROAG continues to review those coming up for revalidation across whole scope of practice and seek outstanding information where required, in order to have assurance regarding revalidation requirements.
Action for next year:	No action.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Y

Action from last year:	Continue to review Trust Policy for Medical Appraisal on receipt of updates being issued by NHS England and/or GMC (General Medical Council).
Comments:	No changes currently envisaged.
Action for next year:	No action.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Y
Action from last year:	Recruit further appraisers on APA contract and reduce need for additional paid appraisals from retired consultants, such that by end of 25/26 appraisal year, appraiser capacity is no longer a risk and recruitment is business as usual.
Comments:	Successful recruitment and no issues with appraiser capacity.
Action for next year:	No action.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Y
Action from last year:	Continue annual appraiser training event, and monitor requirement all appraisers attend annual refresher training.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Comments:	Good attendance at refresher training and those unable to attend offered online refresher training via Miad.
Action for next year:	Business as usual.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Y
Action from last year:	Revisit the quality audit tool to ensure an appropriate measure is used instead of the PROGRESS tool.
Comments:	Tailored audit tool introduced and initial audit results will be shared with appraisers and discussed at refresher training. On-going monthy/quarterly reports to ROAG on appraisal assurance.
Action for next year:	Continue to evolve appropriate audit standards.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year:	No action
Comments:	With the oversight from monthly ROAG meetings, staff revalidation recommendations have been made in a timely manner. Deferral rate of 7.4% for 25/26.
Action for next year:	Business as usual.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Y
Action from last year:	No action
Comments:	Portfolios are compiled ahead of ROAG meetings and any concerns discussed with the doctor by the medical appraisal lead ahead of the ROAG meeting. Recommendations updated immediately on GMC connect during the ROAG meeting and communicated to the doctor.
Action for next year:	Business as usual.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	No action
Comments:	The Trust prioritises quality of clinical care and an environment created by a Just and Learning Restorative Culture, which has been embedded in the Trust over the last 3 years. Directorates have clear mechanisms to oversee clinical governance.
Action for next year:	No action.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Y
Action from last year:	No action
Comments:	New systems of reporting complaints and PSI's in a timely manner into appraisals has been adopted, with incidents reported against team rather than individual which ensures doctors are reflective of team clinical governance. All significant concerns about the conduct and performance of doctors are discussed at ROAG and with the GMC ELA/NHS resolution PPA as appropriate.
Action for next year:	No action

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Y
Action from last year:	Monitor new system of feeding information from complaints/PSI into appraisals.
Comments:	Still patchy quality to improve this reporting, partly due to limitations of the IT systems involved, but reporting has improved.
Action for next year:	To continue to work with the complaints/PSI and medical workforce teams to make the system more robust.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Y

Action from last year:	Ratify new policy.
Comments:	The 'Managing Concerns about Medical and Dental Staff Policy' has been written and awaiting final comments from LNC and HR senior advisors.
Action for next year:	Sign-off of new policy.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Y
Action from last year:	No action.
Comments:	Monthly discussions at ROAG and annual report to Board (attached) including review of demographic information.
Action for next year:	Business as usual.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Y
Action from last year:	No action

Comments:	MPiT register kept for recording the information transfer between organisations. Regular discussions with local NHSE office regarding employed GP's and formal transfer of information via MPiT where necessary.
Action for next year:	Business as usual.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	**Y**
Action from last year:	No action
Comments:	EDI, gender and whether IMG included in ROAG annual review, and on-going discussions of most cases with GMC ELA and NHS-R also help to safeguard that our responses are free from bias and discrimination.
Action for next year:	Business as usual.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Y
Action from last year:	No action
Comments:	Clinical effectiveness groups have been set up and wider governance/training issues are regularly disseminated to medical and other staff where relevant. There is a clear HR process about updating policies and procedures to ensure they are in line with national updates. An example is adjusting relevant policies to take into account the Just

	and Restorative Culture learning and medical policies to take into account the Fairness and Proportionality guidance from NHS-R.
Action for next year:	No action.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	No action
Comments:	The Trust has a well-developed PDR process which is actively monitored and quality assured for AfC staff, alongside the appraisal system for doctors. Dentists have a similar arrangements and report into ROAG annually.
Action for next year:	No action

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	**Y**
Action from last year:	Re-start audits of pre-employment checks.
Comments:	Several new processes have been implemented this year: • A new 'talent acquisition partner' in the medical workforce team has allowed processes to be streamlined and applied consistently • New functionalities have been introduced using Trac (recruitment software) - offer letters and contracts are signed electronically and we use electronic stater forms which has

	improved the overall candidate onboarding experience and reduced their response time in returning documents. • The NHS service declaration form has been re-designed to minimise data errors by improving functionality of information boxes and introducing mandatory formats for dates, contracts and pay codes .This has hugely improved the data accuracy when determining CDS dates. • Implementation of TrustID software has had a positive impact by making ID checks quicker and easier, and the time taken to obtain DBS checks has improved. • A recruitment audit has been built into the system to enable a final review of onboarding records by a senior team member prior to appointment to provide assurance and mitigate risk. • The medical appraisal/revalidation advisor is responsible for sending MPIT (transfer of information) forms to previous responsible officers to obtain any significant information relating to fitness to practice, and this has been done for all new starters in 2025/26.
Action for next year:	Audit changes in recruitment processes to ensure that all pre-employment checks done.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Y
Action from last year:	No action
Comments:	Assured at Board Level and via Quality sub-committee.
Action for next year:	No action

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Y
Action from last year:	No action
Comments:	Assured at Board Level and via People, Leadership and Culture board sub-committee.
Action for next year:	No action

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Y
Action from last year:	No action
Comments:	Assured at Board Level and via People, Leadership and Culture board sub-committee.
Action for next year:	No action

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Y
Action from last year:	No action

Comments:	Assured at Board level including robust FTSUG process and review.
Action for next year:	No action

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	**Y**
Action from last year:	No action
Comments:	Primary medical qualification country data added to annual review of cases discussed at ROAG.
Action for next year:	No action.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Y
Action from last year:	No action.
Comments:	RO and medical lead for appraisal regularly attend network meetings, discuss cases and processes with the GMC ELA and NHS-R, and there is regular communication with neighbouring MH and community Trusts.

	We have regular meetings with NHSE Professional Standards/RO's regarding employed GP's, and liaise with the Deanery where appropriate.
Action for next year:	We will review capacity in medical workforce team as to whether participating in peer review would be possible.

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	205
Total number of appraisals completed	214
Total number of appraisals approved missed	37
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	27
Total number of late recommendations	0
Total number of positive recommendations	25
Total number of deferrals made	2
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	14
Total number of trained case managers	2
Total number of concerns received by the Responsible Officer[2]	25
Total number of concerns processes completed	20
Longest duration of concerns process of those open on 31 March (working days)	45 months
Median duration of concerns processes closed (working days)[3]	45 days
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	n/a
Total number of new doctors joining the organisation	53
Total number of new employment checks completed before commencement of employment	53
Total number claims made to employment tribunals by doctors	2
Total number of these claims that were not upheld[4]	Both still open

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

Please see attached board report.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Oxford Health NHS Foundation Trust

Name:	
Role:	

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Signed:	
Date:	

Name of the person completing this form:	Dr Kezia Lange DCMO Professional Standards
Email address:	Kezia.lange@oxfordhealth.nhs.uk

Oxford Health NHS Foundation Trust

PUBLIC

Finance and Investment Committee
Minutes of the meeting held on
Tuesday, 15th of September 2026 at 09:30
Virtual Meeting via Microsoft Teams

Present:
Core members and attending Board members included in quorum[1]

Core members

Lucy Weston (**LW**)	Non-Executive Director (the Chair)
Rob Bale (**RB**)	Chief Operating Officer for Mental Health and Learning Disability
Teresa Beach (**TB**)	Non-Executive Director
Taff Gidi (**TG**)	Executive Director of Corporate Affairs
Emma Leaver (**EL**)	Chief Operating Officer for Community Health Services, Dentistry & Primary Care
Heather Smith (**HeS**)	Chief Finance Officer

Attending Board members

Michael Holland (**MH**)	Chief Executive
Helen Mackenzie (**HM**)	Non-Executive Director – *part meeting*

In attendance:

Jeremy Philpot (**JP**)	Director of Estates & Facilities
Ben Cahill (**BC**)	Deputy Director of Corporate Affairs - *part meeting*
Simon Cook (**SC**)	Warneford Park Programme Director (Cherwell Consulting)
Sam Shepherd (**SS**)	Deputy Director of Strategy and Planning
Alison Gordon (**AG**)	Deputy Director of Finance – Financial Management
Peter Milliken (**PM**)	Director of Finance
Rachel Pirie (**RP**)	Head of Planning
Wayne Heal (**WH**)	Head of Property Services – *part meeting*
Jane Little (**JL**)	Head of Procurement – part meeting
Neil McLaughlin (**NM**)	Trust Solicitor and Risk Manager – *part meeting*
Osa Udoh (**OU**)	Assistant Director of Financial Operations

Observing:

MayFong Low	Speciality Registrar, ST5
Gerald (Gerry) Morrow	Vice Chair and Chair of Quality Committee at Gateshead Health Foundation Trust (attending to observe the Committee Chair)

Post-Meeting Review:

Jack Gilbert	Interim Corporate Governance Officer (Minutes)
Hannah Smith	Assistant Trust Secretary

[1] Quorum is 3 members, including at least 2 Non-Executive Directors and 1 Executive Director (to be the Chief Finance Officer or nominated deputy); deputies and other attending Board members will count towards the quorum. If the Committee is not quorate then the meeting may proceed if those attending agree, but no decisions may be taken, or the meeting may be postponed at the discretion of the Chair.

1.	**Welcome and Apologies for Absence**	
a	Apologies were received from: Amélie Bages, Executive Director of Strategy & Partnerships; and Andrea Young, Trust Chair.	
b	The Chair welcomed all to the meeting and confirmed that the meeting was quorate.	
2.	**Chief Finance Officer's report - Month 4 Financial Report**	**Actions**
a	The Chief Financial Officer presented the report and highlighted: (i) positive financial position with the Trust slightly ahead of plan on revenue at Month 4 and continuing to forecast a break-even position for the year-end. Early year financial headroom had been reinvested into priorities which would support the new Trust Strategy, make a long-term difference for directorates and support performance against NHS National Oversight Framework (**NOF**) metrics including: (i) digital reforms which had been suggested by directorates; and (ii) £3 million primarily to wating list reduction initiatives. Recurrent investments had been approved for: (i) central pharmacy team roles needed to support digital systems; (ii) a Culture of Care pot, held centrally and which inpatient wards could draw on in order to improve environment and culture; (iii) fire prevention resourcing as the Estates team needed three rather than two posts to support fire safety work: and (iv) Mental Health Directorate senior posts; (ii) NHS England has requested all trusts to provide their Month 4 route map to demonstrate how their run rate would change month by month to meet their plan by year end. This has been included at Annex A of the Month 4 Finance report to this Committee (and which would also be provided to the Board for its meeting on 30 September 2026) and the route map demonstrated how early-year slippage would be offset so as to achieve the plan by year-end. The Chief Finance Officer requested the Committee's support for the Month 4 route map at Annex A of the Month 4 Finance report and the narrative included (see item 5(c)&(h) below); (iii) a positive Internal Audit review report of Core Financial Controls – Budget Monitoring in FY28 funding (to be provided to the next meeting in November 2026);	**HeS**
	(iv) the Deconstructing the Block exercise being led by NHS England for implementation in FY28 funding (detail in the report and on the agenda); and (v) (i) significant capital underspends year to date, due to slippage on delivery programmes, although progress was being made and monitored through the Capital Programme Group; and (ii) emerging capital pressures.	
b	In relation to emerging capital pressures, the Chief Finance Officer reported on: • the Private Finance Initiative (**PFI**) exit situation and the risk if the arbitrator identified a settlement at the higher end (detail in the report); • the cost of fire prevention work, noting that the Director of Estates & Facilities had been working on priorities for the Fire Plan and the projects which they could get ahead on; and	

	• the opportunity to lease a building for the Clinical Education Centre, after the expiry of its existing lease. Although capital costs would fall into future years, the lease cost would be this financial year (estimates were being obtained)	
c	The Chief Finance Officer also expanded upon the alert in the report: • local government reforms would impact upon the boundaries used to define the Trust's Estates Strategy; and • NHS Property Services' proposed asset transfers had been reviewed by the Capital Programme Group. If these opportunities were taken on at scale, cross-cutting issues identified would need to be considered further by this Committee and the Board due to the potential impact upon financial position.	
d	Further to discussion at the Quality Committee on Health & Safety-related fire risks, the Chair sought assurance regarding the adequacy of resources (both human and financial) within the budget to be able to mitigate the identified fire risks. The Chief Finance Officer acknowledged challenges if attempting all the work immediately but confirmed that the central team undertaking planning and fire assessments had been boosted and the Director of Estates & Facilities had redeployed some of his team to support this work and was recruiting a project manager to oversee the capital work. The Director of Estates & Facilities set out: (i) the additional investment into fire safety capacity; (ii) the work taking place to prioritise associated risks strategically and divert resources where the opportunity provided in order to progress additional fire projects; and (iii) precautions in place including recent review of fire risk assessments and evacuation risks. As highlighted above under emerging capital pressures, the total cost of fire prevention work would be significant and risk would need to be offset against cost. The Chair noted that the fire prevention work was still work in progress and requested an update to the Board to articulate: (i) the level of tolerable risk; (ii) what sat outside of that; and (iii) how that compared to the currently available resources in the budget. The Chief Finance Officer agreed and noted that as the Health & Safety annual report would be going to the Quality Committee and then to the Board in November 2026, fire prevention work and associated risks could be included in the covering report. She added that original budget allocations would not be used as constraints on necessary works; appropriate consideration would be given to reducing other spend and/or seeking additional funding.	**HeS**
e	**The Committee noted the report and that when the Quality Committee and the Board received the Health & Safety annual report In November 2026, this would also include an update on fire prevention and associated risks to articulate: (i) the level of tolerable risk; (ii) what sat outside of that; and (iii) how that compared to the currently available resources in the budget.**	**HeS**
3.	**Summary of Programmes and Project Approvals**	
a	The Chair introduced the Summary of Programmes and Project Approvals and noted there were no projects requiring approval or detailed review at this meeting. Project proposals are expected to be presented to the Committee at its November meeting.	
b	**The Committee noted the report.**	
4.	**Annual Plan and Financial Planning Update**	
a	The Deputy Director of Strategy and Planning highlighted that this was the first planning cycle aligned to the Trust's newly approved five-year strategy and emerging Strategy Delivery Plan. While the Head of Planning advised that NHS England (**NHSE**) had not	

	yet published planning guidance, planning assumptions has been developed based on previous years' guidance and timelines. Clinical and Corporate directorates have been engaged and given positive feedback to this year's planning approach. The Committee commended the proactive approach to planning in the absence of NHSE planning guidance and alignment with the strategy.	
b	The Chief Finance Officer reported having an initial meeting with the Integrated Care Board (**ICB**) and suggested similar investment levels in FY2027/28 to previous years, also noting there has been no indication of additional savings/Cost Improvement Programmes (**CIP**) requirements beyond current expectations. Significant uncertainties remained around national planning guidance, "Deconstructing the Block" proposals and potential future national policy change, however, it was presumed that the financial envelope would remain broadly consistent to that received within FY2026/27.	
c	Members discussed the importance of embedding a longer-term planning culture across the Trust. The Chair emphasised the need to move beyond viewing CIPs solely as savings initiatives and instead consider them as opportunities to improve value, productivity and patient outcomes, recognising that investment and improvement activity should be viewed as complementary rather than competing priorities. The Committee noted the importance of supporting frontline teams in understanding the relationship between investment, efficiency and service improvement and highlighted the need for clear communication and engagement to ensure improvement programmes are understood as supporting better care and service delivery. The Committee recognised the importance of fostering a culture that supports long-term strategic planning and continuous improvement.	
d	**The Committee noted the report.**	
5.	**Month 4 reporting: Financial Report Including Capital Programme Group 3As; and Productivity Report**	
a	The Director of Finance took the Month 4 Financial Report as read. The Committee noted that the Trust remained ahead of plan at Month 4 and continued to forecast a break-even position at year-end. Capital expenditure remained behind plan, although delivery was improving and expected to accelerate during the second half of the year.	
b	The Committee received an update on national financial matters, including potential financial risks associated with HMRC's position on overseas recruitment sponsorship costs and opportunities relating to the recovery of VAT on agency expenditure which Finance will work with agency providers to reclaim. It was noted that the Trust remains ahead on agency staff savings but behind on bank targets.	
c	Further to the Chief Finance Officer's introduction at item 2(a)(ii) above, the Director of Finance took the Committee through the route map at Annex A and the narrative included. He explained that this was a national exercise to assist in assessment of trajectories. He confirmed that the Trust was performing ahead of plan and that risks and opportunities had been appropriately factored in. The Chair acknowledged that the Trust's positive financial position indicated that this exercise should not be a matter of concern but challenged the extent to which the planned reduction in year-end surplus relied upon the delivery of waiting list initiatives and sought assurance: (i) on the progress to date; (ii) whether it was realistic; and (iii) the likelihood that the Trust would end the financial year with a greater surplus than planned. In response, the Director of Finance advised that, due to the Trust's ability to control opportunities and utilise finances flexibly, a significant surplus was unlikely.	

d	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care and the Chief Operating Officer for Mental Health and Learning Disability both provided updates regarding their progress on waiting list reduction plans highlighting: (i) strengthening of governance arrangements to monitor waiting lists; and (ii) areas of focus such as Podiatry, Child & Adolescent Mental Health Services (**CAMHS**) and neurodevelopmental pathways. They provided assurance to the Chair that expenditure and performance against the waiting list initiatives were being closely monitored and that forecast remained achievable.	
e	Teresa Beach sought assurance regarding the likelihood of risks and opportunities materialising. The Director of Finance explained that likely risks were generally incorporated within the forecast position, whilst opportunities were monitored separately, and noted that opportunities had materialised historically more frequently than financial risks.	
f	The Chair highlighted a recurring pattern of underspends within community services alongside overspends in inpatient wards and noted that areas experiencing the highest waiting lists, including CAMHS and psychological therapies, continued to report staffing vacancies and underspends. She suggested including more narrative in future reporting to explain these variances. The Chief Operating Officer for Mental Health and Learning Disabilities acknowledged the challenge and explained that some community service underspends were linked to recruitment difficulties, whilst inpatient overspends were often driven by fluctuations in patient acuity and associated staffing requirements. He advised that waiting lists in a number of services were reducing and that work was underway to address underlying workforce and process issues. He agreed that future reporting should provide a clearer narrative on these themes. The Chair commented that persistent inpatient overspends and community service underspends might indicate a wider issue with baseline budgeting and noted the potential impact on inpatient services where community vacancies remained unfilled.	
g	The Chair welcomed the separate Productivity Report and highlighted the importance of developing a more sophisticated understanding of productivity metrics. The Chair opened a discussion regarding escalating costs over time of Oxfordshire, Bath & North East Somerset, Swindon & Wiltshire (**OBSW**) occupied bed day costs within inpatient services and requested that the Committee focus on understanding this trend and the drivers for these changes. Committee members acknowledged the need for greater disaggregation of data and noted that work with directorates was taking place to further embed productivity reporting and understanding within services.	
h	**The Committee:** **(i) supported the Month 4 route map at Annex A and the narrative included on the Trust's trajectory to deliver the planned year-end position; and** **(ii) noted the Month 4 Finance report and that future Productivity Reports would include additional narrative and analysis to support understanding of the productivity variations, benchmarking and links to outcomes and value.**	**PM/HeS**
6.	**'Deconstructing the Block' return to NHS England (NHSE)**	
a	The Director of Finance introduced the report outlining the Trust's submission to NHSE as part of the Deconstructing the Block exercise. The Committee noted that the exercise was intended to support understanding of current block contract arrangements and would inform future NHS payment policy from 2027/28 onwards.	

b	The Committee considered: • the comparative efficiency, against national benchmarks, of services commissioned through Thames Valley ICB and through Bath and North East Somerset, Swindon and Wiltshire (**BSW**) ICB. It was noted that the application of a national productivity deflator had a significant impact on the analyses. Concerns regarding the methodology had also been raised by mental health and community providers nationally; and • benchmarking information which may become of further use in the future as part of developing Productivity reporting.	
c	The Chief Executive sought assurance regarding the longer-term implications of the Deconstructing the Block programme. In response, the Chief Finance Officer outlined the uncertainty associated with future funding mechanisms and advised that national decisions regarding payment reform remained under development.	
d	**The Committee noted the report.**	
7.	**Board Assurance Framework (BAF) - risk A3 (Financial Sustainability) deep dive**	
a	The Deputy Director of Corporate Affairs presented the report which provided a deep dive into risk A3 (Financial Sustainability) which had a current score of 16 (high) and a target score of 12. The Chair challenged whether the current risk rating remained proportionate given the Trust's positive financial position and forecast year-end surplus. The Chief Executive noted the importance of distinguishing between the Trust's current risk position and potential future risks, observing that risk scores should reflect the position as it currently stood. The Chief Finance Officer highlighted ongoing uncertainty associated with the Deconstructing the Block programme, future NHS funding arrangements, capital affordability pressures and the Oxford Clinic PFI exit.	
b	Discussion took place regarding whether the current position represented a new strategic risk rating to the management of a surplus position rather than a change to the existing Financial Sustainability risk. The Executive Director of Corporate Affairs noted that this may be better considered as a separate risk rather than an amendment to the existing risk.	
c	Members noted that a wider review of the Board Assurance Framework would be undertaken in quarter three to align it with the new Trust Strategy and there would be further discussion on the new Trust Strategy and associated strategic risks at the Board meeting in private session on 30 September 2026.	
d	The Chair expressed a view that there may be scope to reduce the current risk towards target (12) but agreed that this would be better considered at the Board rather than within this Committee.	
e	**The Committee noted the report and that the current (high) risk score of risk A3 (Financial Sustainability) would remain unchanged pending further discussion at the Board.** *The Head of Property Services and joined the meeting*. *The meeting took a break for 10 minutes and resumed at 11:15.*	

8.	**Neighbourhood health implications for the Estates Strategy 2026-31 and wider Estates Strategy update**	
a	The Chief Finance Officer introduced the report and welcomed comments and challenges from the members. The paper was taken as read.	
b	The Chief Finance Officer advised that the Estates Strategy remained in development and was being drafted to align with the Trust Strategy and Strategic Delivery Plan. The Committee noted that the emerging strategy would be built around the core themes of collaboration, digitalisation and neighbourhood working, including partnership working with the voluntary sector, local authorities and wider system partners. Positive relationships had been established across Oxfordshire and Buckinghamshire, although it was noted that further work was required to strengthen partnerships with Wiltshire partners.	
c	The Head of Property Services introduced the concept of "Core, Flex and Tail" to support the categorisation of estate assets and their long-term strategic role within the Trust. The Committee noted that this framework would be incorporated into the developing Estates Strategy.	
d	Teresa Beach asked about the anticipated risks associated with delivering the neighbourhood vision and any actions being taken to mitigate them. In response, the Head of Property Services highlighted the challenge of aligning the priorities of multiple partner organisations and developing effective partnership working across systems where they have historically had limited experience of working collectively in that way. The Chief Operating Officer for Community Health Services, Dentistry & Primary Care added that neighbourhood working and development was progressing at different rates across localities and highlighted challenges relating to primary care engagement, consistency of approach and the impact of Local Government Reorganisation on Partnership working.	
e	In response to Teresa Beach, the Chief Finance Officer advised that one of the key risks would be ensuring that available capital resources match that of the neighbourhood strategy ambitions. It was also noted that a single neighbourhood model may not be feasible where local circumstances and resources differ.	
f	The Deputy Director of Strategy and Planning asked: (i) how co-production would be embedded within the development of the Estates Strategy; and (ii) whether there was a dedicated communications, engagement and co-production approach, or whether this would sit wholly within the wider neighbourhood programme. The Committee discussed the importance of co-production and engagement activities taking place to ensure stakeholders were involved in shaping future service models and estate requirements. The Head of Property Services and the Deputy Director of Strategy and Planning agreed to work together on identifying appropriate contacts to support the development of a co-production workstream for the Estates Strategy. The Committee was informed that engagement had commenced with voluntary sector leaders, although formal co-production activity had yet to begin.	**SS/WH**
g	The Chief Executive Officer highlighted the opportunity to use Trust estate assets more as community resources and discussed how existing buildings could support voluntary sector or community functions when not in use by the Trust's own services. The Committee noted previous examples of partnership workshops being undertaken with local authorities, Buckinghamshire partners and third sector organisations to explore opportunities for more effective use of estate assets and encourage a more joined up way of working.	

h	The Chief Finance Officer also advised that the review of NHS Property Services asset transfer opportunities remained ongoing and that those assets considered potentially viable for the Trust would be bought back for further consideration in November. The Committee noted progress in relation to work exploring staff and key worker accommodation opportunities and that a national announcement regarding participation in the programme was expected.	
i	**The Committee noted the report and that the NHS Property Services asset transfer would be considered further at the next meeting in November 2026.**	**HeS**
9.	**Warneford Park Programme update and deep dive into total capital cost, risks and opportunities**	
a	The Warneford Park Programme Director joined the meeting and introduced the papers which included: (i) the capital funding position; (ii) programme risks; and (iii) preparations for the forthcoming national and regional NHSE deep dive scheduled for 23 September 2026. The Committee noted the papers and Appendix A.	
b	Teresa Beach asked about alternative options should the Estates Safety Funding (**ESF**) not be approved. In response, the Chief Finance Officer advised that the Trust remained focused on securing the preferred funding solution and noted support received from local stakeholders and NHS regional colleagues. If funding was not approved, further funding options and alternative approaches would be explored.	
c	The Chief Executive queried how the Trust could strengthen its position ahead of the NHSE review and members discussed the importance of articulating the benefits of the scheme, the Trust's ability to deliver the programme successfully and the contribution it would make to improving the quality of the estate.	
d	The Committee discussed how the Trust could utilise findings from the Care Quality Commission (**CQC**) inspections to evidence the challenges associated with the current estate, including in relation to lines of sight and suitability of existing facilities. Members noted the opportunity to utilise evidence relating to the condition and limitations of the current Children and Young People's estate to further strengthen the investment case. It was advised that the relevant CQC report had not yet been finalised.	
e	The Chair challenged references within the presentation to "operational efficiency" benefits, commenting that these may be difficult to evidence. In response, the Chief Finance Officer advised that the benefits of the new hospital extended beyond staff efficiency savings and included opportunities to improve the use of space, patient safety, security and digital solutions to increase operational effectiveness. It was also noted that a modern hospital design would provide greater opportunities to utilise digital solutions and reduce staffing pressures through improved ward design, visibility and observation arrangements.	
f	**The Committee noted the report, progress being made and preparations for the deep dive by NHSE (further to the slide pack at Appendix A).**	
10.	**Treasury Management Annual Report and Treasury Management Policy**	
a	The Committee took the Treasury Management Annual Report and Treasury Management Policy as read. Treasury management activity during 2025/26 had been undertaken in accordance with the policy and the Trust continued to maintain a strong cash position.	

b	**The Committee APPROVED the updated Treasury Management Policy, subject to formatting corrections, and noted the Treasury Management Annual Report.**	
11.	**Investment Policy**	
a	The Committee considered the Investment Policy and noted: (i) alignment with revised NHSE capital approval guidance and delegated authority arrangements; (ii) strengthened governance arrangements for the planning, appraisal, approval and monitoring of capital investments; (iii) clarification of the respective responsibilities of the Capital Programme Group, Finance and Investment Committee and Board of Directors; and (iv) revised approval arrangements for capital business case variations, including application of the £100k threshold.	
b	The Committee discussed the proposed approval arrangements for capital business case variations, including the £100,000 threshold, and received assurance from the Chief Finance Officer that the revised framework would provide proportionate oversight while supporting effective management of the capital programme.	
c	**The Committee APPROVED the Investment Policy.** *The Head of Procurement joined the meeting*.	
12.	**Procurement Strategy 2026-2031**	
a	The Committee took the Procurement Strategy as read. The Head of Procurement explained that the Procurement Strategy had been aligned with the Commercial Continuous Improvement Assessment Framework (**CCIAF**) and supported the delivery of procurement objectives. Further to a suggestion from Teresa Beach on utilising supplier feedback, the Head of Procurement noted that contract management processes could be used more systematically for supplier engagement and to identify opportunities for process improvements.	
b	The Deputy Director of Strategy and Planning emphasised the importance of ensuring clear alignment between the Procurement Strategy and the new Trust Strategy, noting how procurement activity could support the delivery of strategic objectives and broader organisational priorities. Members discussed how the Procurement Strategy could support financial sustainability, improving outcomes for patients, collaboration with partners, the Green Plan and social value, noting that it was an enabler strategy to the new Trust Strategy and the opportunities for closer working between Procurement and Strategy team colleagues (outside of the meeting).	
c	**The Committee APPROVED the Procurement Strategy 2026-2031.**	
13.	**Procurement report including Single Action Tender Waivers (SATWs)**	
a	The Committee received the Procurement report including SATWs update for information. The report noted progress in: (i) procurement activity; (ii) improvements in procurement compliance following implementation of 'No Purchase Order, No Pay'; (iii) ongoing supply chain resilience monitoring; and (iv) the approval of 21 procurement waivers during Quarter 1 of 2026/27.	
b	**No questions were raised and the Committee noted the report.**	

14.	**Inquests & Claims (Legal Services) annual report 2025/26**	
a	The Committee welcomed the Trust Solicitor and Risk Manager to the meeting and received the Inquests & Claims annual report. The Executive Director of Corporate Affairs highlighted the complexity of the work undertaken in supporting the Trust through inquests, claims and associated legal proceedings. Members recognised the positive feedback received regarding the support provided to staff involved in inquest processes and received assurance that learning arising from inquests continued to take place.	
b	The Chief Finance Officer noted that the Trust had seen a reduction in its overall contribution to NHS Resolution indemnity schemes, including to the Clinical Negligence Scheme for Trusts (CNST). Members also noted the completion of the Legal Services tender process and the appointment of the legal services provider from September 2026.	
c	**The Committee noted the report.**	
15.	**Minutes of the Meeting held on 04 July 2026 and Matters Arising**	
a	The minutes of the Committee meeting held on 04 July 2026 were approved as a true and accurate record, with actions in progress or having been completed (and received the CareNotes update which had been appended to the Matters Arising document).	
b	The Executive Director of Corporate Affairs presented the CareNotes update, further to discussion at the previous meeting. Work was progressing to transfer historic data to a new system and funding for the transition had been identified. The Chief Finance Officer confirmed that there would be wider consideration of digital investment at the Committee's next meeting in November 2026.	**HeS**
16.	**Any other business**	
a	None.	
17.	**Brief reflections on today's meeting**	
a	The Chair welcomed the attendance of new Non-Executive Directors, Helen Mackenzie and Teresa Beach, and the new Chief Executive, Michael Holland, to their first Finance & Investment Committee meeting.	
b	Members reflected positively on: (i) the strategic focus of the discussions and the contributions of new Non-Executive Directors in proving constructive challenge; and (ii) operational insight provided through attendance from both Chief Operating Officers.	
c	The Chief Executive highlighted the importance of aligning the agendas of Board committees to the delivery of the Trust Strategy and the principal risks arising from it, ensuring that appropriate assurance and oversight was in place to support delivery of strategic objectives. The Chair endorsed this, with support from the Strategy team as part of the ongoing development of the strategic planning and governance framework.	
Meeting close: 12:35 **Date of next meeting**: 17 November 2026		

Meeting of the Finance and Investment Committee

Tuesday, 17 November 2026, 09:30-13:00

Hybrid: Ascot Room, Trust HQ, Littlemore Mental Health Centre, Oxford, OX4 4XN
and Microsoft Teams

AGENDA

Apologies to: Jack Gilbert, Interim Corporate Governance Officer, Jack.Gilbert1@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: • Internal Audit review on Core Financial Controls – Budget Monitoring; and • Financial Position	HeS	Information & Assurance	Enclosed & AOB	
Financial Management and Culture					
3.	Annual Plan and Financial Planning 2027/28 and 2028/29 update	AB/HeS	Discussion & Information	Enclosed	09:40
4.	Month 6 reporting: a) Financial Report including Capital Programme Group 3As; and b) Productivity Report	PM/AG/HeS	Information & Assurance	Enclosed	10:00
5.	Corporate Services benchmarking	PM/HeS	Information & Assurance	Enclosed	10:15
Strategic – Digital Focus					
6.	Draft Digital, Data and Technology Strategy 26-31 and draft Engagement plan	AC/Rachel Hanks/HeS/TG	Discussion & Assurance	Enclosed	10:30
7.	IM&T Digital Update	AC/Rachel Hanks/HeS	Information & Assurance	Enclosed	10:45

[1] Apologies from Committee members:
Apologies from regular attendees:

Information Management and Data Quality					
8.	Information Management Group – 3As report October 2026	TG	Information & Assurance	Enclosed	10:55
10 minutes' break 11:05-11:15					
Programmes & Projects					
9.	Summary of programmes and project approvals	HeS	Assurance	Enclosed	11:15
10.	Springfields Staff Accommodation Fire Prevention works – Medium Value Business Justification	Ed McG/ WH/JP/ HeS	Approval	Enclosed	11:45
11.	Abingdon Same Day Emergency Care Unit Refurbishment Project: Lessons Learned - First report	Gemma Pugh/ Sarah Lee /Ed McGeehin)/	Information	Enclosed	11:50
12.	NHS Property Services asset transfer and business case paper	WH/JP/ PM/HeS	Approval	Enclosed	12:00
13.	Oxford Pharmacy Store (**OPS**): • draft OPS strategy; and • OPS Banbury warehouse second post-project evaluation/benefits realisation report, 2-year update	MB/HeS	Information & Approval	Enclosed	12:20
14.	Warneford Park Programme update and budget approval request	HeS	Assurance, Decision & Approval.	Enclosed & Reading Room	12:25
Governance					
15.	Acquisition & Disposal Policy v3 for Land & Property	WH/JP/ HeS	Assurance & Approval	Enclosed	12:35
16.	Trust Insurance arrangements	BC/TG	Information	Enclosed	12:40
17.	Minutes of FIC Meeting held on 15 September 2026	LW	Approval	Enclosed	12:45
18.	Actions and Matters Arising including: • True Colours update	LW TG	Assurance	Enclosed	
19.	Any other business: i. Budgetary Control Policy update (arising from Internal Audit recommendation); and ii. Akrivia shareholding	LW HeS TG	 Approval Ratification		12:50
20.	Questions from observing Governor(s)	LW			12:55
21.	Brief reflections on today's meeting	All			

	Close				13:00
	Date of next meeting – 12 January 2027				
READING ROOM/APPENDIX Supporting reports to be taken as read and noted					
22.	Board Assurance Framework (**BAF**)	BC/TG	To note	Enclosed	
23.	Warneford Park Internal Programme Board minutes and agendas: September-October 2026	SC/HeS	To note	Enclosed	
24.	Information Management Group (**IMG**) Agenda from meeting on 22 October 2026	BC/TG	To note	Enclosed	
25.	Springfields Staff Accommodation Fire Prevention works – Annexes	HeS	To note	Enclosed	
26.	Finance & Investment Committee Terms of Reference – updated membership in the Appendix	TG	To note	Enclosed	

MINUTES of the Mental Health & Law Committee meeting held on Tuesday 07 July 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
Kirsty Smith (**KS**)	Clinical Lead-Reducing Restrictive Practice
Andrea Young (**AY**)	Trust Chair
MayFong Low (**ML**)	ST5 Resident Doctor Vaughan Thomas Ward (observing)
Leanne Dunkley **(LCD**)	Corporate Governance Officer

Item	**Discussion**	**Action**
1. a b	**Welcome and Apologies for Absence (GC)** The Chair welcomed members of the Committee and confirmed the meeting was quorate. Apologies were received from: Angie Fletcher, Deputy Chief Nurse.	
2. a b	**Minutes of previous meeting held on 12 May 2026 and Matters Arising** The minutes of the meeting held on 12 May 2026 were approved as a true and accurate record. **Matters Arising from the minutes.** The Chair confirmed there were no outstanding matters arising from the minutes.	
3. a b	**Trends in Mental Health Act and CQC activity/compliance** 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. The Committee discussed the CQC monitoring visits and the Provider action statements, where work is underway to consider how the process works, and	

[1] Please note the updated Committee membership in the Terms of Reference.

	how it could be improved to be more effective and efficient to embed actions, with more centralisation with existing improvement work to get improved consistency. The Mental Health Act/ Liberty Protection Safeguard Lead requested to be involved in these discussions as often the recording of capacity is a theme from these visits, which links with work within the Safeguarding Adults in Oxfordshire that she is involved it. The Associate Director for Social Work and Social Care noted that there are subject matter experts who are owners in terms of most of the domains of the feedback received and there is something about aligning the reports more closely to those people so that there is overarching leadership, rather than individual ward or practitioner practice. It is about having more organisational discipline to manage the regulatory aspect more tightly.	
c	The Committee discussed the lapses in detention. With the new Mental Health Act, Community Treatment Orders (CTO's) will be changing and would have a time limit to it. The Committee agreed to keep monitoring this. The Committee discussed that often there is a reasonable rationale for letting a CTO lapse, however, it is important that the rationale behind it is discussed and noted, as in a court situation it is not so much the decision as how you got there. The Chief Medical Officer highlighted that this is likely to fluctuate especially in the context of the Lampard and Nottingham inquiries which are putting external pressures on clinicians. The more experienced clinicians may well let CTO's lapse as it is not illegal, whereas a less experienced clinical may take the person off the CTO, which then causes a relapse requiring hospital admission and then coming out on a CTO again, which is inefficient.	
d	The Committee discussed the Second Opinion Appointed Doctors (SOADs), noting it is great to see that this has improved. The new Mental Health Act will put increased pressure on the reviews of treatment for shorter periods of time.	
e	The Committee discussed the ethnicity data, noting there Is a three times greater black African detention rate. The national report suggests that black ethnicity have six times greater detention rates so this needs to be monitored. It was noted that ethnicity reporting is overlapping with other agenda's such as PCREF, Use of Force and Mental Health Act along with the broader health inequalities framed around the indices of multiple deprivation and so need to consider how all of this aligns. A deep dive into the use of the Mental Health Act over the past 24 months is due to start, which will allow the data to be looked at per ethnic group and at a service level to break it down into local demographics. The Chair noted that from the data it is clear to see that PCREF is having an impact and the data around who is in need and who the Trust is impacting which is going to critical in terms of future planning and horizon gazing. It was noted that some of the not categorised ethnic group, includes people who have been asked the question and did not want to answer which is their right. The Head of Information Governance noted that he will break this data down for the next report to this Committee.	
f	The Committee discussed the Section 136 issues and noted that it would be helpful to understand the use across the organisation. It	

	would be useful to compare the use of places of safety POS with the rest of Thames Valley, to gain a benchmark and identify any improvements. Approximately 70% of section 136 admissions are discharged within 24 hours, therefore it would be beneficial to understand why this is, potentially through peer review. This would also support the setup of safe havens within the acute care pathway. The Chair supported this deep dive to understand the use of section 136 better to turn it into practical information that can be used to improve care. The Associate Director for Social Work and Social Care noted that the Thames Valley Police data will be stronger as they record where they pick people up from along with where they take them, so would be good a place to do that partnership work and would be happy to do that. The Head of Information noted that that is some national data and locally it is known what the populations of the counties are, so a crude measure could be generated. The section 136 form is about to go live in RIO which will make a big difference to the way in which understanding is gained as to what happened and where they went afterwards, which at present is a manual process to go through the documents to find that information. On average there is one person a day using a place of safety (POS) as an admission bed, which will link with the acute admissions pathway. The Chief Operating Officer for Mental Health and Learning Disability noted that using the POS for 24-48 hours due to the use of a section 140, which is the obligation to provide a bed for someone, makes sense if it is know that there will be a bed locally tomorrow rather than transfer them out of area and therefore may be right to use them in this way, it is about a balance and understanding the impact. He noted that it was discussed yesterday what the escalation and contingency plan would be if all POS were full across the two counties. If they are full, it means that wards and sites are acute and it is about how that is managed safely. The Associate Director for Social Work and Social Care added that in Wiltshire their places of safety are not attached to wards and are not considered hospitals, which means they often have people for several days without a legal framework, which is an uncomfortable legal position and they are in discussion with the ICB as how to make this more acceptable.	
g	The Executive Director of Corporate Affairs asked regarding the cancelled managers hearings, which have increased during quarter one, whether the reasons why are understood and whether this is a concern. The Head of Information Governance responded there is not a concern at present and that the reasons are known, which relate to the availability of professionals or the need to hold a Tribunal which the Trust has no choice in deciding when these happen, as they are set by the tribunal system, and so out of the control of the Trust.	
h	The Chief Medical Officer commented that there is coercive nature of the act that the Trust is always trying to balance that with reporting. This report is one perspective of all the things being done and having it at the top of agenda is helpful as it can be interrogated through the rest of the agenda and reports. He then reflected on the report noting it is stark to see that 300 plus people are being detained and having treatment against their wishes. It was noted	

	that one area the Trust is outlier is the utilisation of section 136 in Oxfordshire, where there are very high rates and the Trust has not made much impact on.	
i	The Chair summarised that this report produces a lot of food for thought and prompts the Committee to probe further. **The Committee noted the update.**	
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 and noted that this is the first time the data that is being developed has been included, which does overlap with other agendas. He noted that the deep dive into the use of the mental health act mentioned above should be ready to bring to the next Committee meeting, which will look at the use of section 2, section 3 and section 136. The data is limited to 2 years due to the previous data outage, which means some peoples stories are incomplete or documented across multiple sections. This will be sliced by service. The Head of Information Governance noted that the Mental Health Act office would have records around detentions and AMP reports, which could provide additional information if required. It was noted that for future deep dives that data would be requested, however for this one it has been agreed to use the information that is available for reporting. It was noted that the Trust is working with the national team who have commissioned the centre for Mental Health to try and develop a toolkit for the ICB's, taking into consideration the competing equalities and agendas to demonstrate where the overlap is and advise on best practice. This relates to the governance and leadership of PCREF.	
b	He noted that he has listed some of the data that has been started to be collected as part of the equalities work, which cuts across the use of force data and the mental health data. The next step will be triangulate this with other safety signals that directorate see, to develop a high level more sophisticated model of thinking about inequalities and what that means.	
c	The Chair commented that the report has been laid out well and provides a good breakdown. She noted that on slide 5, which talks about mixed ethnicity group having the highest level of restraint, that it is good to see this data, the next developments should include what and why answers. She then noted that at the beginning of the report it mentions that the governance arrangements are at an early stage of development and asked whether the Trust should be concerned about this or whether the Trust or Board of Directors should be doing something to push that further. The Associate Director for Social Work and Social Care noted that this is raised in every national call around PCREF, so it feels like this is a concern all over England. It is reassuring to part of the national work to frame what that governance looks like. ICB colleagues who are involved in commissioning and equalities work have expressed an interest in joining this work who will hopefully provide some scrutiny on what is happening now and to help develop something locally that will feed into that national piece. If this work can be done locally then it should not be difficult to get to a better functioning position. Part of the challenge is the competition of the other various health and policies work, and	

	sometimes the PCREF does not feature in the ICB's policy work so it needs more socialising which this will help with. In relation to what to do with the data that is now being captured, from the last equalities meeting, across the indices of multiple deprivation is to map out which forums this information goes to and is discussed it so that it is triangulated with all the relevant information. This will create more insight about what it means and what needs to be done. The challenge will be to align the insights and the reporting so that there is more in-depth narrative. The Chief Operating Officer for Mental Health and Learning Disability commented that regarding the system level challenges which are known. What is important for the Trust is that there is a clear narrative about what we are doing. He noted that the Trust have also linked with Berkshire, who are the other big provider in the local system footprint to align with them. This allows for an understanding of how each other are working, which should then help shape how the system responds to move this forward.	
d	The Chief Medical Officer noted that it is important to keep a focus on the carer's component of the triangle of care as they are important in how this may lead to better care especially for racialised communities. **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.	
b	The Committee discussed the Supreme Court judgement in relation to what amounts to a deprivation of liberty, which is a significant change to practice. The new guidelines were discussed, considering the implications for patients and staff along with the changes needed to be made to clinical practice and training requirements. The Chief Medical Officer noted that previous practice has been defined with the idea that capacity is assumed within the current act and that it must be proved that the person does not have capacity and even if they do lack capacity, they can still consent. However, the CQC during visits have expressed that people should be tested to prove they have capacity which has probably led to practise being out of line with the Mental Capacity Act. He then noted that there are a lot of lobbying groups that feel that this is retrograde and does not allow people in terms of legal definitions to be protected from interventions that they have not had capacity to consent to. He noted that this needs to be included in the report to Board. The Mental Capacity Act has capacity assessment and best interests' framework, which takes in the views of the patient and family. Care should always be proportionate and provided in the less restrictive way. If there is a disagreement about what is in someone's best interest the route is to challenge at the court of protection, which has not changed. The judgment also discussed that there is a safeguarding process within the Care Act along with the Mental Health Act. This judgement will be a big shift for community hospital wards, particularly the older adults' inpatient wards. It was noted that the Trust will continue to have a weekly review meeting. The valid consent issue is tricky to articulate, however what it essentially means is that if a person is accepting, agreeing or appearing content with the arrangements	

	then those wishes and feelings should carry weight and mean the person is now deprived of their liberty requiring authorisation. If a person is objecting or trying to leave should have great weight attached and that should go onto be an authorisation. This means a lot of people who required an authorisation previously will not now, and it will be a best interest decision making process. It was highlighted that following the judgement the training slides have been updated and the Mental Capacity Act/ Liberty Protection Safeguards Lead noted that she has met with inpatient wards at the Whiteleaf as they have been submitting DOLs requests for the older adult wards previously. How this will be documented in patient notes is now being worked through, to ensure that we can offer assurance in the record that the situation is known and recognised but does not meet the threshold. This has been an immediate change which has not allowed for an implementation period. The next steps are to sort out the training, get a code of practice and generate some case examples to work though. For community teams, community DOLs orders were applied for by the local authority. Most of the cases where there is no objection or disagreement will no longer be a DOLs, so will not require authorisation. The Mental Capacity Act/ Liberty Protection Safeguard Lead has met with the Learning Disability team to talk this through and is planning on visiting again to discuss further.	
c	The Mental Capacity Act policy has been updated and all references to the previous test have been removed, and it now discusses the new test and, it is planned to develop a practical toolkit for how this is applied in practice and documented in notes.	
d	The Executive Director of Corporate Affairs noted that it is unusual for something that requires a lot of administrative transition to be imposed with immediate effect and assured the Committee that the Trust has moved quickly with this following the judgment. Immediate guidance has gone out across the Trust, however the changing if the training will take time as will giving staff time to gain confidence in making these decisions. He then noted that it may be worth providing guidance on what should be expected to document in the clinical record in relation to this. The Committee supported this, suggesting that it may be a form or a checklist. The Chair asked whether there was a proposal for a working group around this in terms if implementation and embedding of this to agree the way forward, as it is about changes to practice. The Mental Capacity Act/ Liberty Protection Safeguards Lead responded that there would be an appetite for a working group and that this is planning to be taken forward.	
e	The Chair summarised that the judgement is interesting and thanked the team for their hard work around this assessing the impact of this judgement on the Trust. **The Committee noted the updates and approved the updated Mental Health Act policy subject to further comments in the next 7 to 14 days**	
6.	**Positive and Safe**	
a	The Clinical Lead for Reducing Restrictive Practice took the report as read, noting the key highlights and escalations to the Committee. She noted there is a use of force policy, which the Trust has met the requirements of which commits to reducing force as the intention of the act. At present this is down	

	for a 3 yearly review, in line with other policies, however it is an annual requirement and asked for the support of the Committee to change the policy review to annually. It was noted that there were some gaps identified in terms of attention paid to adjustments that may be needed for people with a learning disability and the debriefing expectations are not fully specified. it is planned to co-produce a debriefing framework for people who have been affected by the use of force. Within the current policy the co-production and consultation with stakeholders is not fully described, and there are improvements to be made as to how patients, carers and people with lived experience are involved.	
b	The Chief Medical Officer thanked the team for the report and noted for this Committee the focus will be on the use of force to demonstrate that Senni's law and that the use of force is being reported to give assurance. From the highlights today, the development of a debrief framework is probably one of the biggest things to work on that will provide assurance to the organisation that the debrief after restriction has been used. This will include working with the individual to understand that if force must be used again, how will it be used, is it proportionate and is there an alternative. The CQC had wanted to see that prior to use of force a care plan which involves the patient is in place and that there is a debrief and review after the use of force, which is law. The Clinical Lead for Reducing Restrictive Practice noted that it is how this is being evidenced and so a use of force audit is underway. She assured the Committee that the use of force is part of the PEACE training and noted that all individuals who have an influence over the use of force are required to undertake training in the use of force, including the responsible person. There is further work to be done around the training and provision as there is a gap and it could perhaps be done in a different way which is being considered. The Chief Medical Officer assured the Committee that he has done the training previously, but not within this organisation. The Executive Director for Corporate Affairs asked what the gap looked like in practice and whether the organisation needed to be worried. The Clinical Lead for Reducing Restrictive Practice noted that in terms of mandatory training for all disciplines has been brought in line with the Statutory requirements, however within the use of force act there is a requirement for all staff to have knowledge on how the use of force act applies to them in their working lives. The Trust is considering how this can be introduced to staff when they first join the organisation as at present there is not an introduction or statement that that covers the principles and the ethos of the use of force act and the impact for people who are subject to restrictive practice to improve knowledge across all disciplines. The Executive Director of Corporate affairs noted that it is a balancing act as to whether training is focused on those individuals who will need to use that skill or build general awareness with people who may never use that skill. The Lead for Reducing Restrictive Practice noted it is not just the skill, but the impact of the use of that skill and so it's about who is making those decisions and how is it reached in a multidisciplinary holistic way involving those who have experience and carers and relatives. It is about understanding where responsibilities sit to adhere to the act. It was noted that this is being discussed in the programme board and at the positive and safe forum, where progress is tracked. The Chief Medical Officer noted that this is part of the CQC readiness in terms of the use of force and process and	

	governance, which has been through the positive and safe forum so far who report to the Quality Committee.	
c	The Associate Director for Social Work and Social Care commented that it is about thinking about the various agendas that are developing and ensuring they complement each other, as PCREF and the use of force both need the golden thread of anti-racism running through them and so they need to link together. He then noted that there is also the shared quality priority of reducing staff harm related to restraint, so although the interventions that are put against the use of force will the same, they will be on different agenda and so should come together which will be work to commit to over the next quarter.	
d	The Chair thanked the Clinical Lead for Reducing Restrictive Practice for the report and discussion, which is the level of detail that this Committee has been asking for. **The Committee noted the update**	
7.	**Complaints and Concerns**	
a	The Chair deferred this item to the next meeting as there was no representative to speal to the report in attendance.	
8.	**True for Us' reports and Legal & Regulatory update:**	
a	The Executive Director of Corporate Affairs noted there were no further updates other than what has been discussed.	
b	The Executive Director for Corporate Affairs drew the Committees attention to the update report around mandatory training as an action from the previous meeting. The report covers the explanation for the changes in the target figures. There is a concern around the uptake of the Oliver McGowen training, which was discussed at the Executive meeting. It was agreed to take a balance approach to recognise the time it takes to complete this training and agree a plan that the Trust is comfortable with, noting it will take longer. It is balanced and informed by operational needs and capacity to deliver the training. The Trust is moving as quickly as possible, however acknowledge that were not moving as quick as the ICB would like. **The Committee noted the update.**	
9.	**Independent Mental Health Advocates (IMHA) service update**	
a	The Associate Director for Social Work and Social Care provided a verbal update on the work on the IMHA service. he noted that the last few monitoring visits have not mentioned access to advocacy which is a positive reflection of the hard work the matrons have been doing and demonstrates an improved position. In Oxfordshire and Buckinghamshire, reports have not been received, due to the timing of the reporting cycle, however they are maintaining their levels. There is an issue in terms of Marlborough House in BSW, who have low figures per year of referral so there probably neds to be some focused work in that area with the commissioners there. It was highlighted there are different issues in Swindon, given that it's a dynamic of	

	providing for children, and the complaints and advocacy contract are being worked on at present to ensure that there is better provision for complaints, forums, check in sessions and regular access to advocacy. From a community perspective there is a focus on, with the local authorities to push advocacy for community patients, those on guardship orders or CTO's, Oxfordshire is leading the way with this and has set new guidance to the CTO process which essentially advocates an opt out process for advocacy. There is likely to be a push back int terms of capacity of the advocacy providers to do that as it is more than difficult than visiting a ward.	
b	The Chair commented that it will be interesting to see the community aspect develop and questioned whether there is the capacity in terms of resource to meet that. The Chief Medical Officer commented that as a Committee this needs to be supported. It is great to see that the independent advocacy is now working, especially going into closed environments which sometimes can become closed in silo behaviour in terms of culture. It is good assurance that independent people are going into these wards, supporting people being advocates and raising issues or concerns with the senor leaders. In relation to the CTO issues, which is why the new Mental health Act is making the argument that it should finish after a year, so that people do not go for a long period of time without advocacy.	
c	The Head of Information Governance commented that thinking about practical arrangements to facilitate IMHA's in the community to have facilities and the patient accessible to them. The Associate Director for Social work and Social Care note that he is meeting with the directorates and AP service to consider the practicalities such as the use of outpatient spaces, neutral venues, or visiting service users' houses. The Chief Operating Officer for Mental Health and Learning Disability added that the Trust has managed to get SOADs to see patients on CTO's so it should not be beyond the Trust to support this in house in the same way with the same investment of thought put in. **The Committee noted the update**	
OTHER BUSINESS		
10. a	**Any other business** The Chief Medical Officer asked all members to review the updated Mental Health Act policy and send through any comments to the Mental Capacity Act/ liberty protection safeguard lead within the next 7-14 days.	
11.	**Meeting Review (ALL)**	
12. a	**Meeting Close** There being no other business the meeting closed at 10:56 hrs.	

The next meeting is scheduled to be held on Tuesday 20 October 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, 27 October 2026

AGENDA

Apologies to: Leanne.dunkley@ocxfordhealth.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 07 July 2026 and actions arising.	Chair		Enclosed	09:05
Ethical and lawful application of Mental Health legislation					
3.	Trends in Mental Health Act & CQC Activity/Compliance Update on new Mental Health delivery	Mark Underwood	Assurance	Enclosed	09:10
4.	Patient Carer Race Equality Framework (PCREF) report -workplans for the next year	Daniel Mercier	Assurance	Enclosed	09:40
5.	Deprivation of Liberties/ Mental Capacity Act Update on Supreme Court Ruling and interim position	Amy Allen	Assurance	Enclosed	09:50
6.	Positive and Safe Highlight report – Use of Force/ Restrictive Practice update	Kirsty Smith/ Angie Fletcher	Assurance	Enclosed	10:10
7.	Independent Mental Health Advocacy & Independent Mental Capacity Act Advocacy	Daniel Mercier	Assurance	Enclosed	10:20
Regulatory, Governance & Risk Management					
8.	Legal & Regulatory update.	Taff Gidi	Assurance	verbal	10:30
9.	Mental Health Managers Story	Mark Underwood	Assurance	verbal	10:50
10.	Any other business	Chair			10:55
	Close				11:00
	Date of next meeting – 02 March 2027				
READING ROOM/APPENDIX Supporting reports to be taken as read for information and/or to prompt discussion 11. Mental Health Act Statistics –Annual Figures 2025-2026 NHS England					

[1] Apologies from Committee members:
Apologies from regular attendees:

Meeting of the People, Leadership and Culture Committee

Tuesday, 24 November 2026, 09:00-12:30

MS Teams virtual meeting

AGENDA

Apologies to: Jack Gilbert, Interim Corporate Governance Officer, Jack.Gilbert1@oxfordhealth.nhs.uk

No.	Item	Lead	Purpose	Paper	Time
Welcome & Introductory Items					
1.	Apologies for absence and quoracy check[1]	TB		N/A	09:00 (10 mins)
2.	Declaration of interests	TB	Assurance	N/A	
3.	Minutes of previous meeting on 08 July 2026	TB	Approval	Enclosed	
4.	Summary of actions & matters arising	CDS	Assurance	Enclosed	
5.	Chief People Officer View/ People related Horizon Scanning	CDS	Information & Assurance	Enclosed	09:10 (10 mins)
Strategic Focus					
6.	Health and Wellbeing Plan 2026-2028	Nicky Howells/ CDS	Assurance	Enclosed	09:20 (20 mins)
7.	Resident Doctors' 10 Point Improvement Plan	Zoe Moorhouse/ CDS	Assurance	Enclosed	09:40 (10 mins)
People Insights					
8.	Draft Nursing Strategy	BK	Information	Enclosed	09:50 (20 mins)
Assurance					
9.	Pay Gaps update and action plans to close gaps – for Gender, Ethnicity and Disability Pay Gaps	Nicky Howells/ CDS	Assurance	Enclosed	10:10 (15 mins)
10.	Employee Relations – equalities focus (further to the annual report provided to the July 2026 meeting)	Jill Castle/ Jo Perkins/ CDS	Assurance	Enclosed	10:25 (15 mins)
11.	Education Quality report - annual assurance against OFSTED statutory requirements	Becky Elsworth/ CDS	Assurance	Enclosed	10:40 (10 mins)

[1] Apologies from Committee members:
Apologies from other Executives: Andrea Young (Non-Executive Director)

12.	Medical Appraisal and Revalidation annual update	Kezia Lange/ KM	Assurance	Enclosed	11:00 (10 mins)
13.	Medical Education annual report	Alastair Reid/ KM	Assurance	Enclosed	11:10 (10 mins)
14.	Supervision reports: (i) Medical and; (ii) Agenda for Change staff groups	Alastair Reid/ Becky Elsworth/ KM/CDS	Information & Assurance	Enclosed	11:20 (10 mins)
15.	Vaccinations update - annual assurance on arrangements	BK	Assurance	Verbal	11:30 (5 mins)
Risk & Governance					
16.	People Plan – annual progress update Q2	Zoe Moorhouse/ CDS	Assurance	Enclosed	11:35 (15 mins)
17.	Board Assurance Framework (**BAF**) - update on PLC BAF risks[2] and Deep Dive into Risk: A5 – Staff Experience & Culture	Ben Cahill/ TG/CDS	Assurance	Enclosed	11:50 (10 mins)
18.	Workforce report: • Integrated Performance Report metrics; • Statutory & Mandatory training and Supervision; and • temporary staffing	Sigrid Barnes/ CDS	Assurance	Enclosed	12:00 (15 mins)
Closing					
19.	Any other business	TB		Verbal	12:15
20.	Questions from observing Governor(s)	TB		Verbal	
21.	Review of the meeting: new risks identified or escalations for other Committees or the Board	TB	Assurance	Verbal	
	Close				12:30
	Date of next meeting – 20 January 2027 (13:30 – 17:00 over Microsoft Teams)				
READING ROOM/APPENDIX Supporting reports to be taken as read and noted					
22.	Highlight/Escalation Report: • People Steering Group	Zoe Moorhouse/ CDS	Information/ Assurance		
23.	Employee Relations Casework review Report Associated Operational Risk: Staff Wellbeing (TRR 1018)	Jill Castle/ Jo Perkins/ CDS	Assurance		

[2] PLC has oversight of 2 BAF risks: A4 – Recruitment & Retention; and A5 – Staff Experience & Culture. Deep Dives to focus on drivers for the risk.

	- To ensure that PLC has sight of numbers of staff currently suspended; and that their wellbeing is being supported				
24.	PLC Workplan	CDS	Information		
25.	PLC Terms of Reference – updated membership in the Appendix	TG	Information		

Minutes of the Quality Committee, 09 July 2026

QC 01

(Agenda item: xx)

Meeting of the Oxford Health NHS Foundation Trust
Quality Committee
Minutes of a meeting held on
Thursday, 09 July 2026 at 10:00
Online

Present[1]:	
Helen Mackenzie	Committee Chair (**HM**)
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**) *part meeting*
Karl Marlowe	Chief Medical Officer (**KM**)
Grant Macdonald	Chief Executive Officer (**GM**)
In attendance[2]:	
Leanne Dunkley	Corporate Governance Officer (**LCD**) (minutes)
Jane Kershaw	Head of Patient Safety (**JK**) *part meeting*
Ben Cahill	Deputy Director of Corporate Affairs (**BC**)-*part meeting*
Angie Fletcher	Deputy Chief Nurse (**AF**)
Pete McGrane	Clinical Director, Community Services (**PM**)
Lola Martos	Consultant Old age Psychiatrist and Clinical Director OBSW (**LM)**
Michael Marven	Chief Pharmacist & Clinical Director for Medicines Management
Jason Jones	Head of Psychology & Psychological Therapies (**JJ**)
Julie Fulea	Associate Director of Nursing Buckinghamshire (**JF**)
Amelie Bages	Executive Director of Strategy (**AB**)
MayFong Low	Resident Doctor Vaughan Thomas Ward (**MF**) *observing*
Daren Baines	Interim Head of Estates (**DB**)-*part meeting*
Lisa Lord	Head of Safeguarding (**LL**)-*part meeting*
Daniel Mercier	Associate Director of Social Work and Social Care (**DM**)-*part meeting*
	Recovery and Lived Experience Involvement Lead (**VN**)-*part meeting*
Vicky Naidoo	Service Director ~Primary Community and Dental Care Services
Chad Zuriekat	(**SD**)-*part meeting*
Minoo Irani	Good Governance Institute -*observer*

1.	**Apologies for Absence**	**Action**
a	Apologies for absence were received from: Emma Leaver, Chief Executive Officer Community Services, Dentistry & Primary Care	
b	Apologies for absence were also received from the following regular attendees: Bill Tiplady, Director of Psychological Professions; Tina Malhotra Clinical Director and Consultant Psychiatrist; and Rami El Shirbiny, Consultant and Clinical Director Forensic Services.	

[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.

	The Chair confirmed the meeting was quorate.	
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 03, Minutes of the Quality Committee (**QC) 07 May 2026** were confirmed as a true and accurate record.	
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: **07 May 2026:** • **5j-Clozapine point of care testing-**this has been stopped and alternatives are being considered; and • **5k-waiting times trajectories-**this is on the agenda today; **12 February 2026:** • **7c-Safe Staffing Report-**This will come to the September meeting; • **9f-Health and Safety Reports-**reports are improving so can be closed • **20e-Annual review of Effectiveness-** this is under review and is ongoing; • **4a-review of model of care in meadow unit-**on the agenda and workplan to come when available; • **8b-Dr Penny Dash Review-** on the workplan to be scheduled when available; • **20d-Development of Board Assurance Framework-**this is underway and should be available for the November meeting; • **21e-Thematic Review "Mind the Gap"-** this is on the workplan to come when available; • **6g-CAMHS restrictive Practice and Self Harm update-** Scheduled for September; and • **73-Mental Health Improvement Plan-**this is now the acute mental health forum, and an update was presented in May showing progress to date.	
Safety		
5.	**Quality and Clinical Governance Sub-Group (QCGSG) escalation report & Quality and Safety Dashboard**	
a	The Chief Nurse took the report at paper 05 as read, noting the key highlights to the Committee, from the May and June meetings. She noted that there have been some serious incidents particularly in Buckinghamshire, including an inpatient death and a fire on Sapphire ward, which are going through the investigation process with immediate actions put in place. The Action plan for the CAMHs inspection has been submitted, and an update is due back to the Committee in September. She noted the positive and safe new task force and thanked clinical directors for excellent engagement which will support traction on improvements in that area. It was noted that there is currently a patient on Kingfisher ward who is a significant challenge for the forensic service.	

b	The Committee discussed the North City Mental Health Teams, particularly Aspen following challenge by non-Executive Director Lucy Weston as to whether a deep dive should be undertaken. The Committee discussed the previous deep dive that had been presented, the current issues, mitigations and actions underway to restructure the team to give them local populations. The additional leadership and additional resources that have been put in place to scaffold the teams whilst the changes and longer-term solutions such as neighbourhood working are worked through were discussed. It was noted that the consultation period for these changes has just completed, starting with the implementation of assertive outreach in the city and a staged plan for further changes to manage this safely. This is monitored weekly to ensure safety and quality at a granular level. Within the Aspen team they are working on safely transferring patients care. There will be two surgeries that will remain north of the city with consultant time and supported by cross cover consultant time from the North team. The Chief Executive Officer noted that it would be worth taking an update on how the changes are going, how the teams are developing and when they anticipate things happening by, however not whilst the teams are in a state of flux and that the situation is not more or less worrying than previously.	
c	The Chair asked regarding the comment in the report around the AMHT Consultants needing to be more fairly distributed. The Chief Operating Officer for Mental Health and Learning Disability said this was around consultant job planning and activity data and around how things are allocated to ensure equality. This work will take some time to map how much consultant time is required for the catchment areas.	
d	The Chief Nurse reminded the Committee that the Quality and Safety Dashboard is a triggering tool across a range of issues. A team remaining in enhanced support is an indication that require continued enhanced support, as these often relate to issues that are not quick fixes. The intention is to pay attention to those teams where quality may be comprised due to a range of issues. There are plans in place for those teams. The Chair noted that it would be good to pull through the actions so that the Committee is clear about them. Lucy Weston added that the role of the Committee is to gain assurance.	
e	The Chair asked regarding the electronic health record and asked where this was discussed. This is discussed extensively elsewhere including digital steering groups in the community and mental health directorates who are working to understand the challenges of the various systems and how they can be improved. Meetings are also planned with system providers. Lucy Weston noted that the digital strategy is being picked up at the finance and investment committee, as the current systems are frustrating for staff and creates risk. The Chief Executive Officer noted that new systems were rushed in following the cyber-attack some years ago, which started a cascade of challenges. The systems do work; however, it is a lot about how they were implemented. Staff are frustrated by the system however they manage it well. If it can be made simpler then it could increase productivity.	
f	The Committee discussed the narrative around MASH, which in the annual safeguarding report indicates a high risk. It was noted that the issues are the increasing referrals without increasing resource. The hub is managed between the	

	Trust and the acute hospital who have had staffing issues, so Oxford Health have ended up putting in extra staff to respond appropriately. The ICB are aware of the issues as are safeguarding boards. The Chief Nurse reassured the Committee that there are mitigations in place.	
g	The Committee discussed the 60-day discharge in the national oversight framework, noting the Trust has two wards that are outliers and impacting the Trust's figures. It was explained the Trust has a low bed base in Buckinghamshire being one of the lowest bed bases per head of population in the country. Bucks does not have a rehab ward to step people down to which results in increased lengths of stay on the acute wards. This is monitored through monthly performance meetings, as flow through the system is crucial, which is scrutinised in numerous places. The Chief Medical Officer added that it is about balancing all components of assurance and the best safe effective patient centred care, and that it is not about being driven by the numbers of the national oversight framework. The Chair supported this, noting that the 60-day target is a positive target because it's about focused treatment and outcomes, however clinicians have to make the right decisions for their patients.	
h	The Committee discussed the complex patient on Kingfisher ward, issues around staff sickness and how to support staff returning to work supporting staff returning to work following abuse and violence. It was noted that a complex case panel took place to see what additional support could be provided. Staff are working hard to support the patient to feel safe and engage in therapy. The Chief Medical Officer assured the Committee that this patient is receiving quality care and has had external review from the CQC and as external consultant psychiatrist which concluded and that the patient has progressed with their care despite the number of incidents.	
i	The Chair summarised that that changes are afoot around the structure of the North and City MH teams, and update will come to the November Committee on the exact position and the what's next. She acknowledged the two serious incidents on Ruby and Sapphire and thanked staff for all their effort.	
j	The Chair noted that the Trust has systems and processes in place to identify issues that might impact on quality and asked the Executives to consider over the coming months how assurance may be provided that the actions are effective through data, with less narrative	
k	The Chief Nurse added the whole approach to quality improvement is about making sure the Trust can measure what is happening and understand the effectiveness of what is being done including stopping something if it is not having the desired impact. Some of these issues are multifactorial, which does make it difficult to pick a single piece of data that would provide the assurance. She agreed that more data was required, however that needs to be seen in the complexity of the work of the Trust. **The Committee noted the update**	
l	***Action: Update on North and City MH teams to November QC***	

m	***Action: The Executive to consider how assurance may be provided that actions are effective through data with less narrative***.	
6.	**Patient Safety Incident Response Framework (PSIF) Quarter 1 report**	
a	The Head of Patient Safety took the report at 06, as read noting any key highlights and escalations to the Committee.	
b	The Committee discussed the eight unexpected deaths of mental health patients during the extreme temperatures in Oxford, mostly from natural causes, mainly male aged 40-50. The current position is 10 deaths, which includes dehydration incidents, involving admission to an acute trust. The Trust is aiming to learn from these incidents, has mitigation elements for patients and is working with Response, the ICB, the safeguarding team and local authorities. The deaths seem to be heat associated, several of the patients were on Clozapine, which is being reviewed by the Chief Pharmacist to gain further understanding. It was noted that this is being looked at through the lens of the core 20+5 around health inequality, noting that this SMI cohort are recognised to die 15-20 years younger than the general population, due to multiple comorbidities associated with cardiometabolic disorders with a degree of autonomous behaviour related to self-neglect. The safety team along with the Chief Nurse and Chief Medical Officer picked up that there is a need to more assertive balanced with autonomy and capacity to make decisions. This is a complex area that one solution does not lead to reduction in dying early.	
c	The Chair noted that this is an interesting piece of work that is going to lead to some interesting outcomes and sounds positive. Non-Executive Director Lucy Weston declared an interest as she is Chair of Response Housing where some of these deaths occurred and thanked all staff for working collaboratively on a really difficult issue to share learning and disseminate best practice. She noted some of it related to building issues, which she suspects will be found across the Trust estate as the environment where excess heat is a significant risk, and will need to consider the responsibility to control excess heat, which will be logistically challenging and expensive. It will not just be about air conditioning; it will involve changes to buildings and providing shade. In Response they recognised that a mitigation would be having air conditioning rules in those high-risk patients.	
d	The Chair noted that the Trust is participating in 19 domestic abuse related deaths and asked whether positive feedback is received from the Trust's involvement in these reviews from system partners. The Head of Patient Safety responded that the Trust does not really receive feedback, although would if there were concerns of issues. She noted the Trust is very much treated as an equal in the panels where everyone's input is heard, shapes the outcome, findings and actions to be taken. Each agency responds on their actions which are monitored by safeguarding boards. The Chief Nurse noted that domestic abuse related death investigations have changed over the past few years in terms of the criteria and often the investigations can last years, so some of these will go back a few years. For some of them the Trust is an active member whereas for others we might have only received a referral. The Trust has a positive experience and feels respected, the information is always provided on time, however it remains to be seen over the longer term the exact output of these lengthy panels.	

e	The Chief Medical Officer noted that domestic violence against women and children has increased. The Committee discussed the Trust approach to domestic violence, given the public narrative that there is a real change in how the Police approach it now. It was noted that the approach to risk assessment is about understanding the risk from others. It is not just about safeguarding but having those difficult conversations as it is an integral part of how care is provided. A holistic assessment is undertaken to understand a patient's needs and life experiences, therefore if abuse is their key factor, then that is where the intervention and support needs to be focused, that could involve engaging with other organisations and how care needs to be trauma informed. The level of confidence of clinicians to deliver care in that trauma informed way is variable, however the principle is embedded. Staff are using the formal safeguarding approach and completing a referral through domestic violence services. It was noted that over the last 10 years domestic abuse crimes have increased 50%, so this is crucial when providing care to consider. On Ruby ward, a female ward in Buckinghamshire the domestic violence service runs a weekly group, so patients can reach out to them. The teams and inpatient services have worked together to help relocate women where domestic services won't take them due to the level of self-harm. Staff are growing in confidence especially around reaching out to the safeguarding team to seek advice about when they should and not refer. There is lots of thoughtful work taking place across the trust in this area, including QI projects around domestic abuse, in adults and children, and it is a routine inquiry within the CAMHs services so consider domestic abuse across the age ranges.	
f	The Chair summarised that the reports and updates show that the process and systems are in place. **The Committee noted the update**	
7.	**Safe Staffing 6 monthly report**	
a	This item was not available for the meeting and has been deferred to September **The Committee noted the update.**	
8.	**Quality Compliance and Regulation update**	
a	The Deputy Chief Nurse took the report at 08 as read, noting any key highlights and escalations to the Committee. It was noted that the new CQC assessment framework has started its pilot cross 40 trusts. She assured the Committee that the Trust has remained compliant with responding to mental health act monitoring visits with the improvement plans and with the CAMH inspection report that was received in April.	
b	Lucy Weston noted that the report provides good bits of assurance and requested that in the future to help close the loop on some of those it would be helpful to see the narrative around some of the feedback and themes to ensure that the learning is shared and embedded across the organisation. She noted that the CQC visits raise important issues around autonomy on wards around access to green space and the ability to make hot drinks and asked whether there was something broader to learn across the Trust and asked for clarity on section 7 as to what inspections are these referring to. The Deputy Chief Nurse responded that the in terms of the	

	CAMHs inspection there is robust oversight monitoring process to ensure the learning is truly embedded to provide assurance and the learning from this is being rolled out across all other inpatient services where appropriate. Some things take longer to change, however there is regular monitoring to ensure that there has been learning, that practises are changing and that the right changes have been made. Section 7 includes the mental health monitoring visits and internal quality review visits which all comes together at the quality regulatory excellence group to monitor and share learning. In relation to autonomy and green spaces, a more robust process to review blanket restrictions has been set up so individual right is primacy. The quality visits provided assurance that the improvements from the CAMHs visit are in place, with notices up regarding blanket restriction and where there was a risk to an individual they have mitigated around that how the blanket restriction did not apply to everyone else.	
c	The Chief Nurse added that everybody does have access to outside space and to drink's etc, however on some wards they may have had to ask permission to access due to the requirement to keep doors locked for the safety of the cohort of patients. The Chief Medical Officer added that the Mental Health and Law Committee are looking at the changes in the deprivation of liberty outcome from the Supreme Court last month, which will change how the CQC looks at inspecting and how people might have their liberty curtailed outside of a framework if they are agreeing to treatments.	
d	The Chair noted the update, which is positive and asked how the Committee and Board will get assurance that those actions have been closed and improvements made. **The Committee noted the update.**	
e	**Action: Assurance on CQC actions have been completed to next meeting**	
9.	**Safety of the Physical Estate Annual report 2025-2026**	
a	The Interim Head of Estates took the report at 09 as read, noting any key highlights and escalations to the Committee. He noted that the reorganisation of structure within the estates team is progressing. All areas are picking up now. The team are now looking at how they collaborate across the Trust so that there is better communication flow.	
b	The Committee discussed the risk of excess heat following the recent heat wave. The heat wave plan is being strictly followed. There are systems in place for ongoing monitoring and responding to seasonal requests including air conditioning. There are also longer-term conversations around changes to buildings to respond to changes in the climate including planning to adapt for the extreme weather.	
c	The Committee discussed damp and mould, following a challenge raised by Lucy Weston would be picked up on ward walks, PLACE audits and other audits.	
d	The Committee discussed the PLACE inspections which showed that two areas below national benchmarks that were around food. It was noted that a new Trust Catering Lead, who has done a thorough review across all inpatient areas in terms	

	of food supply, quality and safety. A new food quality and safety group has been set up which is looking at the regulatory and statutory compliance of safety, training and quality.	
e	The Chair summarised that the cleaning audit results were excellent along with the PLACE results and noted the plans for improvement. She thanked the team for the amount of work taking place in estate and facilities. The Chief Executive Officer reiterated this noting this is a good report **The Committee noted the report and supported the receipt of the PLACE results annually.** *HS and DB left the meeting, LL joined*	
10.	**Safeguarding Annual report 2025-2026**	
a	The Head of Safeguarding took the report at 10 as read, noting the key highlights and escalations to the Committee. She noted progress was being made within the priorities from last year around mental capacity, self-neglect, domestic abuse, safeguarding reviews, exploitation and modern slavery. Mental Capacity Act training has been increased along with safeguarding sessions in response to staff requests. There has been an increase in referrals, which is thought to be the recording of referrals rather than referral activity. There is still work to be done around supporting staff to record and upload referrals in the correct way. An area of risk remains around the Multi Agency Safeguarding Hub (MASH), where the mitigations that had been put in place were not effective, these have been revisited and being closely monitored over the next two quarters to see what the next steps and options are going forward. It has been seen that some of the changes that have been made have made it more effective to provide health information.	
b	The Chair noted that this area is increasing in complexity with new legislation coming though. She then asked whether the children in care receiving the out of area reviews and initial assessments is a significant risk for the Trust. The Head of Safeguarding noted that this is a recognised issue that has been continuously escalated to the ICB who are trying to make improvements with that.	
c	The Chair asked what the level of achievement across the Trust for supervision in safeguarding. The Head of Safeguarding noted that staff within children and young people's services are recommended to undertake three sessions per year. sessions offered are recorded, at present levels within service are not yet reported on, which is an area being developed.	
d	The Chair asked regarding the Trust wide CQC inspection process whether the Trust is meeting the requirements of the supervision policy, which seems to be a helpful and supportive process. The Head of Safeguarding noted that the supervision sessions receive positive feedback from staff which is delivered in different ways including group sessions and the mental capacity act lead joins the safeguarding supervision as they often overlap, which has been positively evaluated.	
e	The Committee discussed the types of safeguarding consultations undertaken by the Trust, with the largest category being other. The committee agreed it would be helpful to know more detail as to the other category.	

f	**ACTION: LL to review the other category for themes in consultations undertaken by the Trust.**	
g	The Chair summarised that this is comprehensive report which provides assurance that the systems and processes are in place and supports the discussion of safeguarding that has taken place throughout the meeting. **The Committee noted the update and approved the report.** *LL left the meeting*	
11.	**Clinical Effectiveness Group report**	
a	The Chief Medical Officer took the report as read noting that it provides an indication of the areas that are being looked at in clinical effectiveness in terms of transformation and changes in practice related to the NICE guidance. He highlighted the issue with GP shared care, NICE guidance and clinical audit. Work is being pushed forward to ensure that all actions and gaps are identified and closed.	
b	The Committee discussed Luther Street GP practice where there are the largest number of NICE guidance actions outstanding and what the risk associated with this is. It was noted that this is the Trust's only GP practice and carries a complex caseload of around 350 patients. It is not comparable with other GP surgeries who are more mainstream, however all NICE guidance related to primary care is applicable to them. Other GP surgeries have arrangements in place through Ardens to screen guidance to see what would be applicable for that surgery, however due to the size of Luther Street it would be disproportionate to have this in place. There is a targeted piece of work underway with Luther Street and risk is minimal.	
c	Non-Executive Director Lucy Weston noted that she struggled with the new format of the report this time to pull out the assurance and risks and asked whether the plan was to move towards a 3A's format. CMO noted that the assurance is that there is a process in place to make sure change is looked at a very senior level in terms of implementation and evaluation. Lucy Weston noted that it may be worth considering the purpose of the information that comes to this Committee as there is some assurance in the report and what is being described is risk management and the strategic intent around improvements. The Chief Medical Officer noted that it would be worth considering the iteration that comes to the Committee, as the group has been in place for around four years now and so it would be worth reviewing how it feeds into the Committee.	
d	The Chair asked whether the outcomes from national audits would be reported, which can provide a good benchmark. The Chief Medical Officer noted that this is reported through the clinical audit group but assured the Committee that the clinical effectiveness groups are looking at clinical audits to ensure that actions are being delivered. The Chief Nurse added that clinical audit also reports to the quality and clinical governance subgroup. **The Committee noted the report.**	

e	**Action: CMO to consider how the clinical effectiveness group feeds into the QC**	
12.	**Provider Collaboratives Annual report 2025-2026**	
a	This report was not available for this meeting and has been deferred to the next meeting.	
13.	**Trust wide Patient Experience and Involvement report**	
a	The Recovery and Lived Experience Lead took the report at 13 as read, noting any key highlights and escalations to the Committee. She noted that the Trust is in the process of developing an in-house patient experience survey system, which will have its own dashboard. Currently the Trust uses I Want Great Care, which has identified that the quality of reporting to assist clinical teams to make better use of the data needs to be improved. An AI system is also being piloted as to how the qualitive free text data from patients can be reviewed. The Chief Nurse added that the Trust is continuing with I Want Great care, which has been the single source of feedback, however the opportunities in this field are really widening as technology becomes more accessible. It is hoped that surveys could be tailored to specific areas and helping patients and their families to engage more readily by different methods that are more accessible to people such as text message.	
b	The Recovery and Lived Experience Lead highlighted the team has been involved in the development of the Trust Strategy, which has been very positive providing new patient experience information previously not known. The Chair noted that the new strategy, which awaiting approval gives significant focus to patient experience and outcomes.	
c	The Executive Director of Strategy noted she welcomed the work taking place to capture patients, carers and their families experience and asked to be included so that it can be fed into the strategy work around how it is going to be tracked and reported on as this is going to be looked at from a strategic perspective across the Trust. She also highlighted that the strategy delivery plan is in development that will sit underneath the strategy and co-production is one of the key delivery initiatives. The learning from this process will be reflected in the delivery plan.	
d	Lucy Weston noted that patient experience and involvement has been an area the Committee has not had sufficient oversight over routinely, noting there is a way to go to change the culture of the organisation. She then asked how the improvements would be captured described. The next steps are to think more creatively about how meaningful co-production is and what impact it is having on improvements in clinical areas, which is still being considered.	
e	The Chief Nurse added that this area of work requires a thoughtful approach as it could become tokenistic if co-production is needed in everything. There are times where the Trust can consult, inform and educate, but not co-produce.	
f	The Chair asked whether the Trust had completed the self-assessment on the national experience of care framework and if so where it scored on the maturity index. The Recovery and Lived Experience Lead confirmed that this has taken	

	place and that the Trust scored low to middle. The Chief Nurse noted that different approaches are required mental health and community services. Lucy Weston noted that it may be helpful to see a summary of the self-assessment at the Committee to raise the profile. The Chief Nurse noted that this has been shared previously, but it could be recirculated.	
g	**Action: CNO to recirculate self-assessment**	
h	The Committee discussed True colours which hosts the patient dialogue care planning tool. The trust is working with True colours to develop a vehicle for sending out surveys.	
i	The Chair summarised that this is an excellent report and noted that peer support makes a real difference to patients' lives.	
	The Committee noted the update	
Governance and Risk		
14.	**Board assurance Framework**	
a	The Deputy Director of Corporate Affairs took the report as read, noting that the BAF is due to be reviewed following the adoption of the new trust strategy. The Committee has oversight of four BAF risks, which have been reviewed. A2 was recently discussed at the Audit and Risk committee. A6 had a risk appetite score change. A9 following end of year review risk score was reduced from 12 to 9.	
b	The Chair asked Committee members whether anything discussed today would raise a new risk in achieving the strategic objectives. Lucy Weston suggested that. patient experience and involvement should be considered when the BAF is reworked to align with the new strategy. The Deputy Director of Corporate Affairs agreed. Lucy Weston noted that the launching of the new strategy is good time to stop and consider what are the top risks and how does the BAF align.	
c	**Action: Patient experience and involvement to be considered as a new BAF risk**	
d	The Chief Medical Officer noted whether the A2 risk needs to consider the environment, estates and climate change, which is starting to affect quality, safety and effectiveness. The Executive Director of Corporate Affairs responded that this does need to be considered as there is a sustainability risk however should it be part of the infrastructure risk which is pulled across into A2. Some of the current risks will remain however the new strategy may mean that there are different strategic risks or current risks that need reframing. The Executive Director for Strategy supported this approach to ensure that this is robust approach to risk management form a Board perspective.	
e	**Action: the impact of climate change, in particular heat, to be considered as part of BAF review**	
	The Committee noted the BAF and changes to scores.	

15	**Update on Scoping Exercise of 7 deaths in ADHD waiting service**	
a	The Chief Nurse provide a verbal update to the Committee, noting that the draft report has gone to the clinical directorate for review. Th review relates to 23 deaths over the past four years of people who were on the ADHD adult wait list. The committee noted that at any given time there is approximately 2000 patients waiting on average around 3 years. The full report will come to the Committee once it has been signed off by the directorate and will include an action plan developed in response. The Chief Operating Officer for Mental health and Learning Disability noted that Adult ADHD wait list was closed was due to a lack of capacity to screen referrals safely due to the volume coming in and any recommendations from the review needs to link with the wider plan that is being created across the Thames Valley to address waits for ADHD services. The Chief Executive Officer noted that there needs to be clear communication to primary care that is there is a risk or worry around mental illness when people are on waiting lists then they need to be referred through the mental health pathway. **The Committee noted the update**	
16	**Access oversight and Risk Management**	
a	The Chair introduced this discussion as concerns were being raised as to how assurance is gained around the management of waiting lists.	
b	The Chief Operating Officer for Mental Health and Learning Disability confirmed that he is working with the Chief Operating Officer for Primary, Dental and Community Services to look at the waits across the two directorates and the different challenges that they have. This is starting with ensuring that the processes are right, teams know who is on the waiting lists and ensuring that the data and information is correct to gain a true picture of who is waiting. In the community directorate one of the key areas of concern has been the podiatry service, particularly nail surgery. There are also issues around children's speech and language in the 0-19 service, which is being addressed through recruitment.	
c	Within mental health the key areas of concern are the NDC waits in children and adults and how they can be addressed effectively. The memory service in both counties is an area of concern, where demand outstrips capacity however there are plans in place to address that along with the waits within the complex needs service.	
d	Each county has a slightly different area to focus on including addressing custom and practice issues that relate to demand for example choice in psychological therapies. Actions include RIO waitlist functionality and help to patients whilst waiting to keep safe and well. around how systems are managing, and a RIO wait list functionality is being introduced. Wait lists are monitored through the different pathway performance and quality meetings and reported at executive level.	
e	Investment into the CAMHS NDC pathway, working with independent providers will support a reduction in the longest waits. He noted that the principles are the same in the community with trajectories being worked through for each pathway. The service Director for Primary Community and Dental Services noted that they have developed trajectories and are monitoring performance against them. There are trackers per service line with a triage process and safety netting letters are sent so	

	every patient on a waiting list has received instructions on what to do if things change or they need support. This is tracked on a central spreadsheet to provide the CQC assurance if requested.	
f	The Executive Officer for Mental Health and Learning Disability in response to a question from the Chair regarding sharing the trajectories at Board level noted that as all the service lines are slightly different it would be difficult to bring them all to Board. The committee requires assurance about the process and achievement of trajectories. She noted that she has heard the Chief Executive Officer talk about triage and small number of patients waiting for mental health triage and that they may wait longer for a particular treatment as they go onto another waiting list. The Chief Executive Officer agreed, noting that for core mental health services, however there are some elements of care the Trust is not funded to provide. However, if you need urgent mental health services you will get them that day.	
g	The Chair asked whether patients were waiting for District Nurse services. The Clinical Director for Primary Care, Dental and Community services noted that there is not a wait list as such, however you may wait for aspects of the service such as a lower leg review or a bladder and bowel assessment. however, if the person needs to be seen that day due to pressure related harm or insulin administration there will not be a wait.	
h	The Chief Nurse noted that waits are part of the quality and safety dashboard which does alert when the waits are increasing. She then asked whether this was an ongoing desire to report around waits. The Chair agreed that this would be a conversation to have outside of the meeting as to what the Board wants to see.	
i	**Action: Chair, CNO and CMO to discuss what the Committee requires to see going forward regarding waiting lists.**	
j	Lucy Weston noted the Board receives various statistics related to waits and it is helpful for a subgroup to unpick those to gain understanding and say how comfortable the Board is with that assurance. The Executive Officer for Strategy noted that from a quality perspective it is important to look at is the harm related to waiting.	
k	Lucy Weston added that often clinicians describe hidden waits where perhaps patients bounce between services therapies and the clock gets restarted each time and questioned whether this was understood. The Chief executive Officer noted that this is looked at Executive level and a version of that will come in due course. He then added that this is a risk to the commissioners as they have not provided enough resources to allow these gaps to be closed. The Trust is doing all it can however it needs to work with the commissioners to get the right resources in place, as the Trust did in community services. Staff are working extremely hard to reduce these waits.	
l	The Service Director for Primary Community and Dental Services added that this has been taking place over the past year and the directorates are at the stage where the SOPS have been validated, process are in place to check and validate everyone on a waiting list weekly along with the safety netting and triage process that have been put in place, which are all key in managing patients safely while	

m	they wait. He noted that he has put together a slide which demonstrates the trajectories and performance against them that can be shared with the Committee. The Chair noted that the discussion had been helpful and summarised that it has been helpful to understand the systems and processes is place, noting the importance of cleaning the lists for accuracy. **The Committee noted the discussion**	
ANY OTHER BUSINESS		
17. a	**AOB** **None declared**	
18.	**Meeting closed at 12:47** **Date of next meeting: Thursday, 10 September 2026**	

Minutes of the Quality Committee, 10 September 2026

QC 01

(Agenda item: xx)

Meeting of the Oxford Health NHS Foundation Trust
Quality Committee
Minutes of a meeting held on
Thursday, 10 September 2026 at 10:00
In Person

Present[1]:	
Helen Mackenzie	Committee Chair (**HM**)
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**) *part meeting*
Michael Holland	Chief Executive Officer (**MH**)
In attendance[2]:	
Leanne Dunkley	Corporate Governance Officer (**LCD**) (minutes)
Andrea Young	Trust Chair (**AY**)
Jane Kershaw	Head of Patient Safety (**JK**) *part meeting*
Ben Cahill	Deputy Director of Corporate Affairs (**BC**)-*part meeting*
Angie Fletcher	Deputy Chief Nurse (**AF**)
Pete McGrane	Clinical Director, Community Services (**PM**)
Lola Martos	Consultant Old Age Psychiatrist and Clinical Director OBSW (**LM)**
Daniel Mercier	Associate Director of Social Work and Social Care (**DM**)-*part meeting*
Rami El Shirbiny	Clinical Director Forensic Services (**RS**)
Jeremy Philpot	Director of Estates and Facilities (**JP**)
Tina Maholtra	Consultant Psychiatrist and Clinical Director for Buckinghamshire (**TM)**
Rachel Pirie	Head of Planning (**PR**) *part meeting*

1.	**Apologies for Absence**	**Action**
a	Apologies for absence were received from: Karl Marlowe, Chief Medical Officer; Emma Leaver, Chief Operating Officer Community Health Services, Dentistry & Primary Care.	
b	Apologies for absence were also received from the following regular attendees: Michael Marven, Chief Pharmacist & Clinical Director for Medicines Management. **The Chair confirmed the meeting was quorate.**	
2.	**Any Other Business** Nothing declared.	
3.	**Minutes of the Quality Committee and Matters Arising**	
a	The Chair welcomed all to the meeting.	

[1] Members of the Committee. The membership of the committee will include executive director members and at least two non-executive directors. The quorum for the committee is five members to include the chair of the committee (or the vice chair of the committee in their absence), one non-executive and one executive director. Deputies will count towards the quorum and attendance rates. Deputies for the chairs of the quality sub-committees (the named vice chair of the sub-committee) will attend in an executive's absence. Non-executive director members may also nominate a non-executive deputy to attend in their absence.
[2] Regular non-member attendees and contributors.

b	The minutes at 03, Minutes of the Quality Committee (**QC) 2026** were confirmed as a true and accurate record. Lucy Weston had an amendment that she will send through	LW
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: **09 July 2026:** • **5(m) The Executive to consider how assurance may be provided that actions are effective through data-**The Committee agreed there is ongoing consideration of this and will continue to be revisited in committee discussions however this action can be closed. • **13 (g) Self-Assessment of National Experience of Care Framework to circulated-**This has been completed.	
Safety		
5.	**Quality and Clinical Governance Sub-Group (QCGSG) escalation report & Quality and Safety Dashboard**	
a	The Chief Nurse took the reports as read, noting the key highlights and escalations, including items to alert, assure and advise the Committee on from the last 2 meetings. The planned changes to the City AMHT were highlighted, noting the risk of destabilisation whilst structural changes are made to the team and recruitment continues however mitigations are in place to support staff and maintain patient safety.	
b	The ongoing demand and capacity issues within the District Nursing service were highlighted, noting that harms associated with delayed or deferred visits are being closely monitored. A thematic review is currently underway of pressure damage along with Quality Improvement projects underway. It was noted that assurance can be taken from the reduction in moderate and severe harms, although harms may not always be immediately visible..	
c	It was noted the Quality Impact Assessment of the closure of Lambourne ward, a forensic rehab ward, has been signed off, with plans in place for the patients and staff due to reduced demand.	
d	It was noted that complaints have steadily increased over the past three to five years. They are also increasing in complexity which means it takes longer to respond to complainants and therefore additional resource is being recruited to the complaints team.	
e	The Committee discussed harms, clinical and non-clinical indicators, noting that indicators that are not clinical could indicate harm is occurring whilst a person is waiting for a service. The Chief Nurse noted that suicide is an example of this as 75% of people who complete suicide have not had any contact with services. Working with public health and other systems partners to develop campaigns to reach communities and people who may not readily engage needs to continue. All patients waiting will have had an initial triage and been prioritised based on clinical judgement of need and risk and provided with additional information for safety netting whilst waiting.	

f	A thematic review of deaths from the adult ADHD waiting list has been completed. This service has a large waiting list, and the thematic review covered the last 3 years. This will be used to inform some resource allocation by the ICB. It was noted that where services have a wait list this is reviewed and reprioritised regularly. Patients are provided with safety netting advice and information on what to do if things deteriorate whilst on the waiting lists and how to access crisis services.	
g	**Action – Thematic review to be shared with QC when finalised**	
h	It was noted that the CAMHS teams are planning to have information about waiting lists on their Internet page. CAMHS NDC wait list is large source of complaints, as parents believe their child needs to have a diagnosis before being able to receive support. As this is not the case, work is required with the wider system to get the correct message out and change attitudes.	
I	The Chief Nurse noted that the Trust works closely with NHS England and Public Health colleague to look at outcomes and evidence-based practice.	
j	The Clinical Director for Community Services noted that within Speech and Language Therapy wait lists, individuals with dysphagia, are prioritised due to the impact on progress in early years.	
k	The Committee discussed True Colours, noting that following feedback from staff it is proposed to separate the safety plan from the care plan as it is not as intuitive as hoped. There is work underway as to how True Colours connects with RIO with several proposed changes to be incorporated. It was noted that all teams now have the link in RIO to access True Colours.	
l	Care Notes accessibility was discussed, noting that this is a priority, and that new solutions are being explored. At present new staff do not have access to Care Notes and work is in progress to mitigate risk.	
m	The recent fire incidents were discussed by the Committee. Each incident was different and immediate action had been taken where required. The incidents were well managed by staff with no related injuries. Each incident is currently undergoing investigation with the fire service. Fire safety is a significant estates risk on the corporate risk register.	
n	The slight increase in pressure damage on Linfoot ward was discussed noting that the learning has been around categorisation of pressure damage, recognising and reporting incidences alongside initial assessment and transfer. The damage related to people using their heels to reposition themselves or where foot protectors were not considered. It was noted that overall, the incidence is low.	
o	The proposed plan to manage Consultant cover in prisons was discussed, through existing consultants doing sessions rather than relying on one consultant.	
p	The Chair summarised the discussion, particularly • noting the good response to the new staff and patient safety policy • the distress of the death of an inpatient was acknowledged, and thoughts are with the staff, thanking them for the care they provided.	

	• Noting that the reports provided a reasonable amount of assurance as to how the Trust manages quality and safety. • Noting the CQC visits to adult wards and the PICU in August and mental health wards in July and August. • The position in Out of Area Placements was noted as due to the additional pressure on acute beds. • The improvements in waits within podiatry and Speech and Language therapy was noted and recognised that the longest waits are CAMHS and adult ADHD and Autism. **The Committee noted the update** *DM and HS joined*	
6.	**Safe Staffing Report 6 monthly**	
a	The Chief Nurse took the report as read, noting that it provides assurance that the Trust has adequate fill rates, with some wards higher than the requirement due to the acuity of patients or low bed occupancy. There are escalations in place for all areas if there is not sufficient staffing. Overall, there is improvement in number of vacancies, although some wards remain a hotspot.	
b	The Committee discussed the shortfalls in staffing during February and March, noting that these are often difficult months to fill due to school holidays, seasonal sickness and staff fitting in their last days of leave. No increase in harms or incidents was observed during this period and quality was not affected.	
c	The Committee discussed the use of national tools for safe staffing levels, such as the one used in the community directorate, which was adopted two years ago which takes into account study leave and skill mix. There is currently a national new tool for the Mental Health wards being finalised that will inform staffing models and reviews going forward,	
d	The Chair noted that overall, it was a positive position and challenged whether this data was used by Executives to increase substantive staffing. The Chief Nurse responded that this was used as a guide and where issues arise then it is reviewed to establish whether the staffing levels are correct or not, or whether the model of care on the ward requires review. **The Committee noted the update, that there is appropriate governance and processes in place with ongoing actions.**	
7.	**Quality Compliance and Regulation update including Well-Led Guidance**	
a	The Deputy Chief Nurse took the report as read noting any key highlights and escalations to the Committee, including the Mental Health Act monitoring visit and preparation for the Well-Led Inspections.	
b	The Committee discussed the CQC inspection on the adult acute wards, noting we are still awaiting the formal feedback from the recent inspections.	
c	The Committee discussed that medicines and recording of patients' rights are being reviewed in detail as staff are very good at ensuring people are aware of their rights,	

	all learning from CQC visits goes through the regulatory action monitoring group to be disseminated to all areas. A lot of positive feedback had been received, which will be celebrated whilst areas for improvement will be considered.	
d	The Chair noted the CQC inspections and that the written reports are awaited and the Trust is preparing for a well-led inspection. It was noted that significant concerns were raised about environments, which the directorates have already started to address.	
	The Committee noted the update.	
8.	**Health and Safety quarterly report**	
a	The Director of Estates and facilities took the report as read noting that the reports are in a transition phase to align with business quarters. Four fire incidents were highlighted • two fires associated with toasters in the Fiennes Centre and Abingdon Minor Injuries Unit • a fire caused by arson on Sapphire ward which caused significant smoke damage • and a fire on Abbey following a cooking incident. The fire service attended all four incidents.	
b	There has also been a further significant fire since the report was written in a bedroom at Oxford Clinic. The team will take this opportunity to undertake exploratory works to understand the extent of the work required to address issues in Oxford Clinic.	
c	The Chair noted that fire safety is a significant risk on the risk register. Gaps in compliance were discussed.	
d	The Director of Estates and Facilities responded that the Sapphire ward fire caused significant smoke and water damage to the room the fire started in, a room opposite and next to it. The extent of the smoke damage was contained to the corridor, as work had been completed on addressing smoke seal and fire doors, which contained the fire so that it did not extend past the fire doors.	
e	The Oxford Clinic fire was contained to the one room and did not reach the celling due to the location of the fire. There is more investigative work required to understand how the fire could have spread, and what work is required to address the issues. Due to the state of the fire doors the smoke was able to spread into further corridors as a result.	
f	The Chair then asked for assurance that where inadequate fire doors have been identified that there is a robust programme of work to be delivered over the next few months to reduce that risk. The Director of Estates and Facilities noted the team are currently working through the risk assessments for fire doors and fire compartmentation to identify the priorities, which includes Lambourne, OSRU, Rowan House and Wallingford, with Oxford Clinic being treated as a separate entity as there are several issues to be addressed there. There is now a dedicated carpenter working solely on fire doors to address those issues.	

g	In terms of water safety, the number of legionella counts was lower than last year, despite the high temperatures over the summer due to a change in the procedures and a change in the Authorising Engineer.	
h	Following a question from Lucy Weston about the RAG rating of outstanding actions, the Director of Estates and Facilities responded that they do all have a RAG rating, however there is additional work taking place to ensure the accuracy of those. This will put the team in a better position to report more accurately on the number of actions which will be broken down to ward and directorate levels and whether it is a low, medium or high risk. This can be included for the next report to the Committee.	
l	The Committee discussed whether additional resource was required to address these overdue high-risk actions and requested that this be taken to the Finance and Investment Committee.	
j	**Action LW to take fire risk resourcing to the Finance and Investment committee**	
k	It was noted that mitigations in place to address these high-risk issues including additional fire drills and staffing to maintain patient and staff safety in the interim.	
l	The Executive Director of Corporate Affairs noted that out of the 51 fire risk assessments overdue, 45 were additional minor tenant sites and asked about the relevance of these. It was noted that the team was working through these small sites to ensure that these were completed, although they were tenant sites Trust staff were working in them and there was duty of care to ensure that the sites are safe and appropriately managed.	
m	The Committee discussed the fire drills noting that the 5 that had not been done for a year had now been completed. Directorates were being informed at the monthly directorate meetings when they are about to fall out of date with fire drills so that they are aware and can get on top of them and ensure they are completed six monthly.	
n	The Committee discussed the recent verbal CQC feedback in relation to issues around cleanliness and maintenance noting that this does not align with the cleaning audits which are undertaken regularly, the PLACE audits or the ward walk arounds. Some areas may be difficult to clean due to the age of the buildings as they are not built to meet current and modern standards. Further careful analysis of the feedback is required alongside the recent audit results and staff feedback to inform the action plan to address the issues.	
o	The Chief Nurse noted the immunisation gap, related to knowledge about immunisation, this will be picked up through the Infection, Prevention and Control Group . She suggested that the risk assessment around harm to staff and staff burnout should be Trust wide. The Executive Director for Estates and Facilities confirmed that will form part of the revision of the Trust risk register.	
p	The Chief Nurse asked for assurance that the issue with the pit alarm had been resolved. The Director for Estates and Facilities noted that there had been a couple of issues with these that are being worked through as some were not working in gardens due to signal issues.	

q	**ACTION**: an update to be provided in the November meeting that the issues with Pit alarms has been investigated and resolved. **The Committee noted the update and the significant fire compliance risks and actions in place.** *HS and JP left*	JP
9.	**Learning from Deaths and Mortality Review Q1 report**	
a	The Head of Patient Safety took the report as read noting the key highlights and any escalations to the Committee and that today is World Suicide Awareness Day.	
b	The Chair asked in relation to the unexpected deaths in people with serious mental illness during the heatwaves whether there is a national review taking place to see if this was across England. It was noted that there was some national work undertaken last year and further work was expected this year. SCAS are undertaking a thematic review around callouts to houses around heat exhaustion, and unexpected deaths which the Trust will link in with. The Chief Nurse added that there were different circumstances around the deaths and assumption should not be drawn until all the causes of death are known. However, people with serious mental illness are vulnerable in extreme weather due to medications and other health conditions. The Deputy Chief Nurse added that these deaths were noted to occur during the heat wave however where postmortem results had been received, influence of heat effects were not noted.	
c	The Chair referred to the young people's report and questioned the effect of media influence, noting it would be important that facts are used for any challenge going forward. It was then asked whether there was a requirement to report deaths in Learning Disabilty specifically and if this can be included for the next report. The Head of Patient Safety noted that each death is reviewed in the mortality group in detail which includes an independent Nurse Consultant multi-agency review and she can include individuals who died whilst under the Trust's care with a learning disability for next time. **The Committee noted the report and systems and processes in place.**	
EFFECTIVE		
10.	**Clinical Effectiveness Group report**	
a	The Chair took the report as read and asked the role of this Committee regarding the closed loop glucose monitoring system. It was noted this is currently being checked that there no inherent disadvantages in a patient with mental health problems, as this has dissuaded colleagues considering this option in this group. I	
b	Lucy Weston noted that a 3A's format of report would be helpful to pull out what is important for the Committee to be aware of, alerted to and provide assurance. She then asked where best practice guidance is picked up from (including NICE guidance and professional guidance). It was noted that there are practice groups in each directorate/discipline along with quality groups, learning and development groups and critical analysis groups to support best practice. There is a structured approach to NICE guidance required by regulation. **The Committee noted the report**	

11.	**Clinical Audit Annual Plan and Update**	
a	The Deputy Chief Nurse took the report as read, noting the key highlights and escalations to the Committee with strong progress to address the overdue actions. Processes have been put in place to disseminate and share NICE guidance. There is a robust plan for clinical audit next year.	
b	The Chair noted the positive report, which should be celebrated. It was then clarified that when the Trust completes national audits, benchmarking with other trusts is undertaken and that these reports will come to the Committee for assurance. The Deputy Chief Nurse noted that at present one has been completed. There are currently nine taking place and four which have yet to commence, and they will be reported here once the reports have been received.	
c	The Chair asked about engagement of the forensics service as it was reported that no actions had been submitted for two episodes. It was highlighted that this had been flagged as an issue with the directorate.	
d	The Chair noted the report and the options for improvement recommended. **The Committee noted the update.** *The Committee stopped for a 10-minute break.*	
ANNUAL PLANS & STRATEGIC PROGRAMMES		
12.	**Provider Collaboratives Annual report 2025-2026**	
a	The Chief Nurse took the report as read noting the key highlights and escalations to the Committee, which shows significant progress in its maturity and a move towards more strategic commissioning in response to changing leads of populations. The benefits of being a provider collaborative were noted, along with some of the challenges they have faced.	
b	The Committee discussed the Chief Nurse overseeing the quality oversight of services we provide and the importance of also having independent scrutiny. In relation to the internal audits, there is scrutiny from the partner providers who will hold the Trust to account.	
c	Lucy Weston commented upon how the provider collaborative had developed over time and looked more holistically at the whole pathway, which was a positive model for longer pathways. She queried how the learning from this could be used to work more broadly with commissioning.	**BK/ RB/ KM**
d	**ACTION:** to consider offline how the learning from the development of the provider collaborative can be used to inform further commissioning work. The Trust Chair noted reasonable assurance is received from reports to this Committee. **The Committee noted the annual report** *BC joined*	
13.	**Patient Carer Race Equality Framework (PCREF)**	

a	The Associate Director of Social Work and Social Care took the report as read noting the key highlights and escalations to the group, including the plan to run a campaign to engage with more staff. NHS England has commissioned a piece of work to clarify the roles of the ICB in overseeing PCREF and aligning of inequalities work.	
b	The Chair thanked the Associate Director for his excellent report and noted that it provides good assurance on data improvement and will make a difference in addressing health inequalities.	
	The Committee noted the report.	
14.	**Quality Account Priorities Q1 report**	
a	The Deputy Chief Nurse took the report as read, noting key highlights and escalations to the Committee. The prone restraint and seclusion priority has seen a reduction in use over the first quarter. Every prone restraint in the Trust was reviewed and comes through to the task force, which hopefully lead to a shift in culture. The Clinical Lead for Reducing Restrictive practice is now visiting wards where prone restraint has been used to consider how it could have been managed differently.	
b	The Chair noted that it was useful to see all the reporting against the priorities, recognising that some are easier to set a clear tangible measure against than others. The BAF indicated that the quality management system will be completed by 2026, which may need aligning. It was good to see work progressing and the areas identified will make a difference to patients.	
C	**ACTION**: the measures of success to be included in the next report. **The Committee noted the report** *RP joined*	**AF/ BK**
15.	**Annual Planning Process 6 monthly update**	
a	The Head of Planning took the report as read, noting any key highlights and escalations to the Committee. The report provided an update for the 2027/2028 planning process. This will be the first year of reporting against the new Trust Strategy. There have been some refinements added to the Quality Impact Assessments (QIAs) to improve robustness.	
b	The Chair asked what was anticipated to be brought to this Committee in February 2027. The Head of Planning noted that this will be a summary of the QIAs undertaken to provide assurance that it has been sufficiently explored and addressed. It was noted that the directorates are supported with the QIAs, with quality and patient experience. The Chief Executive Officer noted that the report should refer to Equality Impact Assessment (EQIA).	
c	Lucy Weston noted that a clear set of principles would be required for directorate plans, including clinical principles to guide development alongside the strategy. the Head of Planning confirmed that quality principles sit within the strategic framework for the quality principles. There is a need to keep the process simple for directorates so that clinical principles are kept central.	
	The Committee noted the planning process and look forward to a further update in February 2027.	

GOVERNANCE AND RISK		
16.	**Board assurance Framework (BAF)**	
a	The Deputy Director of Corporate Affairs took the report as read, noting any key highlights and escalations. He explained that the BAF had not yet been revised to reflect the new strategy, but this was planned to complete over the next few months.	
b	The Chair noted that there have not been any discussions today that would influence or change the BAF. There were points raised last meeting around climate, sustainability and patient experience that are due to be considered as part of the revision. The Deputy Director of Corporate Affairs noted that there had been updates to the risks overseen by FIC around A7 environmental sustainability.	
c	The Chair asked where data on A1 and CAMHS waits would be published. The Chief Nurse responded that this would be on the website. She then noted that patient involvement and experience should be considered a separate BAF risk as part of the revision as it is not always the same as quality and safety. **The Committee noted the BAF.** *BC left*	
FOLLOW UP REPORTS		
17	**Access Oversight and Risk Management-CAMHS**	
a	The Clinical Director and Consultant Psychiatrist for Buckinghamshire provided the Committee with a verbal update on the work underway within the CAMHS service to address waits. She provided a background to the referral process, which is via SPA and it is a national reported measure to have meaningful contact within four weeks. All referrals received are RAG-rated based on priority and there can also be direct referral to the Crisis team if appropriate. The teams offer triage calls to speak with the families and signpost or refer to other services and provide information whilst waiting. There is an active waiting process in place with additional support and resource that can be provide. There is good oversight in place, and it is known whether an individual is awaiting assessment or treatment. This detailed information is reported to the Executives, so there are no hidden waits. There is proposal to develop a joint working board that is considering publishing all waits alongside resources on the CAMHS website in a simple format which is being co-produced.	
b	The teams across Oxfordshire and Buckinghamshire are working together to standardise and align how they are working and share learning. The Chair asked what feedback from patients and families is for those waiting. It was noted that most complaints come from the NDC wait list, which is the largest. The Executive Director for Mental Health and Learning Disability noted that the first steps have included considering the operational processes to get better alignment, and the next steps are now around considering what that initial meaningful contact looks like. In Buckinghamshire the team have worked with families and carers (which is where the request for data on the website arose from) and undertook work around waiting well to change the narrative. The Chair challenged whether he felt assured around the process and systems in place to manage the CAMHS waiting lists, which he confirmed he did note that there will always be room for improvement, however there is better data and understanding than previously.	

c	Lucy Weston noted that it would be helpful to see the waiting lists broken down further to show: what the longest wait is; who is waiting assessment versus treatment; how many people were seen in a month compared to number of referrals received; how the Trust compares with national data; how many people drop off the wait list; and how many referrals are rejected. This would improve understanding of productivity and the impact of long waits and associated risks. The Clinical Director for Buckinghamshire noted that this was an area of focus from the SLT away day last week regarding shared learning around meaningful contact and the use of a single assessment; this was evolving and was and work in progress. The data mentioned above is captured by heads of service and reviewed in the performance meetings. It was noted that the NDC pathway in CAMHS is a national issue.	
d	The Chair noted that there is an action around wating list management outstanding as to what is required by the board.	**TM/ LM/ RB**
e	The Chair summarised that this update provided reassurance around the process to manage the CAMHS wait lists, noting that there will always be room for improvement. **The Committee noted the update**	
18	**CAMHS Restrictive Practice and Self Harm Update and CQC action plan**	
a	This item has been deferred until the November Quality Committee meeting. **The Committee noted the discussion**	
19	**Horizon Scanning report**	
a	The Chief Nurse took the report as read, noting that this report is for information, and will grow as it develops. ACTION: to discuss offline which the Mental Health Framework would report. **The Committee noted the report**	
ANY OTHER BUSINESS		
17. a	**AOB** **None declared**	
18.	**Meeting closed at 13:07** **Date of next meeting: Thursday, 12 November 2026**	

Oxford Health NHS Foundation Trust

Quality Committee

(Conducted electronically via MS Teams)

10:00 on Thursday, 12 November 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	Chair		N/A	10:00
03	Minutes of meeting held on 10 September 2026	All	Approve	Enclosed	10:05
04	Action log and any matters arising	All	Approve	Enclosed	10:10
SAFE					
05	Quality & Clinical Governance Sub-Group Escalation report and Quality & Safety Dashboard	Britta Klinck/ Jane Kershaw	Assurance		10:15
06	Service Deep Dive-CAMHS Eating Disorder Service access and wait times (board action)	Rob Bale	assurance		10:35
07	Patient Safety Incident Response Framework (PSIRF) Q2	Britta Klinck/ Jane Kershaw	Assurance		10:55
08	Learning from Deaths report including mortality and Homicide Reviews Q2	Karl Marlowe/Jane Kershaw	Assurance		11:05
09	Quality Compliance & Regulation update including CQC preparedness	Pamela Mariga/ Angie Fletcher	Assurance		11:15
10	Health & Safety Q2 Report & ~~Annual report 2025/2026~~	Jeremy Philpot/ Heather Smith	Assurance		11:25
EFFECTIVE		**BREAK 11:40-11:50**			
11	Clinical Effectiveness Group Report	Karl Marlowe	Assurance		11:50
12	Medicines Management annual report 2025/2026 and Oxford Pharmacy store (OPS) Q1&Q2 report	Michael Marven/ Karl Marlowe/Heather Smith	Approve/ Assurance		12:00
QUALITY IMPROVEMENT					
ANNUAL PLANS AND STRATEGIC PROGRAMMES					

13	Quality Account/ Quality Priorities Q2 report	Angie Fletcher/ Britta Klinck	Assurance		12:10
GOVERNANCE AND RISK					
14	Board Assurance Framework (BAF)	Taff Gidi/ Ben Cahill	Approve		12:20
15	Trust Policy Register	Taff Gidi/ Ben Cahill	Assurance/ Approve		12:30
FOLLOW UP REPORTS					
16	Update on City AMHT-Aspen	Pip Cuttell/ Catherine Sage/ Lola Martos	Assurance		12:35
17	CAMHS Inpatient CQC inspection update on actions and restrictive Practice	Noki Ndimande/ Lola Martos	Assurance		12:45
18	Horizon Scanning	Britta Klinck	Assurance		12:55
19	Any other business				13:00
20	Date of next meeting – 11 February 2027				13:00
READING ROOM/APPENDIX Supporting reports to be taken as read for information and/or prompt discussion					
21	Health and Safety reports				
22	Clinical Effectiveness Group Minutes and action log				
23	National Quality Strategy				
24	Women's Health Strategy				