PAPER
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Report to the Meeting of the Oxfordshire & Buckinghamshire Mental Health NHS Foundation Board of Directors

For Information

16th February 2010

Annual Plan Quarter 3 report

Executive Summary

The attached reports on progress against the Trust's objectives as contained in the 2009/10 Annual Plan agreed by the Board of Directors in May 2009.

The report consists of two sections:

- Summary report
- Q3 position against the 2009/10 objective milestones

Recommendation

The Members' Council is asked to note the Q3 position.

Author and Title: Helen Millar, Director of Corporate Management
Lead Executive Director: Julie Waldron, Chief Executive

Annual Plan Quarter 3 report

The Q3 Annual Plan report is attached. The report consists of two sections

- Summary report
- Q3 position against the 2009/10 milestones

Summary Report

Trust Objectives RAG Status 2009/10

Key
(1) Overall RAG (2) PI Status (3) Overall Risk

Accountability		(1) -2 -3
09.I.1 Services will be of demonstrably high quality and value		A R !L
Current Concerns:	Capital schemes and forensic strategic development; embedding benchmarking; delay in review of carers strategy	
PI negative variance	Data completeness; Early intervention caseload; waiting time udner 4 weeks	
Accountability		(1) (4) (5)
09.I.2 Services will be provided to the highest standards of safety		A R !L
Current Concerns:	Learning from all incidents and from participation in SHA Patient Safety Federation; preparation for NHSLA assessment; mixed	
PI negative variance	Patient experience	
Accountability		(1) (4) (5)
09.I.3 Work will take place to promote wellbeing, working with local partners wherever possible		A R !L
Current Concerns:	Equality and diversity agenda; Public health agenda; membership recruitment and engagement	
PI negative variance	HONoS coding	
Accountability		(1) (4) (5)
09.II.1 The wellbeing of OBMH staff will be promoted through active programmes of support and the impact of staff ill-health on teams reduced		A R !L
Current Concerns:	Wellbeing strategy	
PI negative variance	Sickness rate	
Accountability		(1) (4) (5)
09.II.2 Staff will be well managed and will regard working for OBMH as a positive experience		G G !L
Current Concerns:	None	
PI negative variance	None	
Accountability		(1) (4) (5)
09.II.3 OBMH employees will have individual plans and support to maintain and develop their skills.		A R !L
Current Concerns:	Personal Development Reviews	
PI negative variance	Personal Development Reviews	

Quarter 3 progress against objective milestones

Appendix A shows the Q3 position against the objectives and milestones agreed as part of the Annual Plan in May 2009. Each milestone is given a RAG status (column headed **RAG**) indicator showing the level of confidence that the objective will be achieved to plan.

One milestone still remains rated as RED - **09.I.1.03 – Approval of revised Warneford SOC and Highfield replacement business case by June 2009, with work commenced on site for the Highfield by March 2010**. The impact of the economic climate remains a real risk to all the major capital schemes (see also 09.I.1.01) and remains under close scrutiny.

There are 14 milestones currently showing a RAG rating of AMBER. In the main this is due to delay against original timescales and staff changes. In the case of two milestones the amber rating relates to the disappointing results of

the Patients' Surveys. Two milestones previous rated as AMBER have now been re-rated as GREEN (09.I.1.02 – Re-provision of Manor House, 09.I.1.14 – workforce planning).

The reasons for variance, and any action being taken, are detailed in Appendix A.

Key performance indicators (KPIs)

Key performance indicators can give assurance on how the Trust is progressing against the milestones and in improving the Trust's overall performance. KPIs contained in the Trust's performance framework have been aligned to the Trust's objectives. KPIs showing a negative variance against target are indicated in the summary table above.

Helen Millar
Director of Corporate Management

Board Quarter 3 Progress report against Annual Plan 2009/10

Accountability Title	Accountability Owner	Key Achievements Since Last Report	Current Concerns	Reasons for variance and Actions Taken	(1)
09.I.1 Services will be of demonstrably high quality and value					
09.I.1.01 Delivery of a clear strategy for the future development of Forensic Mental Health Services by April 09 with business case to support investment by Sept 09	Chief Operating Officer	Forensic SOC and business case developed. To be reviewed by Capital Investment Programme Board in light of the current economic position in Jan 2010. The Warneford Estates SOC heavily impacts on the Forensic Strategy, and options are currently being reviewed. Discussion also held previously at Trust Board Seminar in Oct 09.	Delay in confirming strategy for forensic services, however this is due to constraints outside the Trust's control from the Specialist Commissioning Group, change in economic position and review of the Warneford Estates SOC.	The Forensic Directorate continues to review and consult on the Forensic strategy, including working with the Specialist Commissioning Group to understand commissioning intensions in the future.	A
09.I.1.02 Approval of the Manor House business case (including Maximum Guaranteed Price) by April 2010	Chief Operating Officer	Manor House SOC approved, demolition started 1st June 09 to be completed by Feb 2010, retraction plan complete. Kier Health appointed at 21 Principle Supply Chain Partner. Planning consent applied for in Nov 09 as planned. Business Case planned to be completed by April 2010, in draft form in Jan 2010. Consultation has included the mailing of leaflets to residents local to Manor site with invitation to regular local open evening. User group established which incorporates service users, carers and staff; now meeting monthly to steer design and quality. To ensure optimum staff involvement there is a clear communication and involvement plan to which the Acute Pathway manager meets with staff on a weekly basis. Work is being considered alongside Master Estates Plan for Buckinghamshire NHS services. Ongoing engagement with Buckinghamshire PCT and Ridgeway Learning Disability Trust.			G
09.I.1.03 Approval of revised Warneford SOC and Highfield replacement business case by June 2009, with work commenced on site for the Highfield by March 2010	Chief Operating Officer	Warneford SOC options currently being revamped following health economy wide review of finance and resources at SHA. Meetings being held during Jan 2010 with formal date of 20th Jan to make decision by. Highfield Business Case approved. Planning consent for Highfield Unit applied for in Nov 09.	Delay in approval of Warneford SOC and risk to DH funding stream in respect of Highfield Business Case.	Change in economic situation has lead to a review of the options in the Warneford SOC. The review of the Warneford SOC led to a delayed in the approval of the Highfield business case.	R
09.I.1.04 Development of Carbon Management Strategy by March 2010, working with Carbon Trust from May 09	Chief Executive	15% Carbon baseline reduction by 2015 agreed by the Board. Detailed Implementation Plan is being developed to be proposed to the Board in February. Pilot Sites identified and a programme to work with them to identify opportunities is underway.	Changes and uncertainties in estate plans limiting opportunities for Carbon reduction		G
09.I.1.05 Implementation of new service models, in line with contracts, for new business won for Oxfordshire IAPT and Buckinghamshire CAMHS Tier 2 and 3, and further development opportunities including Wiltshire CAMHS, Swindon CAMHS, Buckinghamshire IAPT, OPS, OCTC online explored	Chief Operating Officer	The service development plans and new provider contracts for Highfield, Oxfordshire IAPT, and Buckinghamshire CAMHS T2 are all on track and being delivered. The Trust has also recently won the tender to deliver CAMHS in Swindon, Wiltshire and BaNES and is in discussions to take over the provision of Buckinghamshire IAPT. A business plan for OCTC online has been completed for approval.	None	None	G
09.I.1.06 Effective use of Resources across the 24 hour day with Increase availability of community based services outside normal office hours (evenings and weekends)	Chief Operating Officer	Both Oxfordshire and Buckinghamshire have Crisis Services operating 24 hours a day, 7 days a week, over 365 days a year. Oxfordshire operates an awake night shift and Buckinghamshire operates an on call system between the hours of 11pm-8am. April-Dec 09 96% of admissions were seen by the Crisis Service prior to admission (98% in Buckinghamshire and 94% in Oxfordshire), to see if an alternative to admission was appropriate. The Crisis Day Hospitals deliver services 7 days a week. Crisis Service response times to new referrals are monitored monthly and an audit as part of the CQUIN has been completed in Dec 2009. Oxfordshire has set up a new Mental Health Intermediate Care Service to deliver intensive support to older adults in their homes or community, 7 days a week. At the weekends the team are co-located with the Oxfordshire Crisis Service. The AOT Services operates 7 days a week including an evening service. The Addictions Services in Oxfordshire and Buckinghamshire offer clinics in the evenings and at weekends. CAMHS in Buckinghamshire and Oxfordshire offer an Assertive Outreach Service and Buckinghamshire have a Crisis Service with evening and weekend access. The Directorates continue to monitor the demand for providing CMHT services outside normal working hours. AMHP and EDT services provided by the County Councils are also another access route to services out of normal office hours. Full compliance is declared against the Core Standard on choice of access to services and treatment (C18).	None	None	G

09.I.1.07 Integrated pathways of anticpated care across all the Trust's services are in place which are able to meet individual needs and expectations, and avoid unreasonable delays resulting from referrals between teams.	Chief Operating Officer	Each of the Directorates has clear service models and care pathways in place which identify interfaces with other services from primary to tertiary services and referral routes. The Forensic Directorate has, for the first time, been commissioned to provide whole service pathways from medium security to community services, in addition to linking prison in-reach and the criminal justice system with forensic psychiatric care. Patients are able to self refer to the Oxfordshire Crisis Services, Complex Needs Service and the Early Intervention Services. Trust wide protocols are in place with regard to the transfer of children and adolescents to adult services and from adult services to older adult services. Patient waits for new referrals into the Trust are monitored weekly at directorate level and reported to Trust Board monthly, with a focus on patient waits within the care pathway for Psychological Therapy Services. The Delayed Transfers of Care across the trust have been reduced (80% compared with position last year) and maintained at a minimal level, April-Dec 09 2.3%, due to the integration and joint working between health and social care staff and services. The County Council leads met with Trust Board members in Oct 09 to discussion the achievements, challenges and future steps for S75 and partnership working. The use of electronic notes in PCIS has been implemented across the inpatient and community services in the Trust to improve the sharing and access to patient notes and the integration of care and treatment. The service pathways continue to be reviewed by service directorates to ensure quality of service, patient experience, efficiency and innovation. For example reform/ lean work and patient typing is being used across Buckinghamshire inpatient and community services, lean work in Oxfordshire Psychological Therapies, and Oxfordshire Crisis Service has been implementing lean principles. CPA is embedded across the trust services to ensure joint planning, working and care. However, the policy is being reviewed following the refocus in Nov 09. The adult and older adult Directorates in Oxfordshire and Buckinghamshire, CAMHS and Forensic complete regular CPA audits to improve and promote the quality and use of CPA within services. CPA audit reports are reported to the S&E QIC, JMGs and Trust Board.	None	None	G

Board Quarter 3 Progress report against Annual Plan 2009/10

09.I.1.08 The Carers Strategy reviewed and relaunched by September 2009 and implementation started	Chief Operating Officer	The Carers Strategy first launched in June 2006. Completed and current actions against the Carers Strategy were reported to the Trust Board in Nov 2009. The report also reviewed the current monitoring and reporting arrangements for the Carers Strategy and made a number of recommendations to refresh the work around improving how carers experience, access and receive services to support them. The below recommendations were approved by Trust Board: 1. Review 2006 Carers Strategy, to widen the scope to include input from CAMHS, Complex Needs, Eating Disorders, Forensic and Older Adults. Ensure implementation around Dementia Strategy is incorporated. 2. Review how the Trust wide Service User and Carer Steering Group feeds into the Carers Strategy. Suggestion chair of Service User and Carer Steering Group who currently sits on Project Team continues to be a member and is the formal reporting link. 3. Develop stronger links with established carer groups within both counties for example with the Carers Reference Groups and the Carer Governors. 4. Carers Strategy Project Team to be reviewed. Following a brief consultation with some of the current members there is a preference to move to a county model to encourage team level ownership and involvement and also to reflect the different development stages in each county. Proposal for two new Carer Steering Groups one in each county to be established in place of the existing Project Team. Once established the Carer Steering Groups will need to review action plan and set up terms of reference. 5. The reporting arrangements for the Project Team/ new Carer Steering Groups will be strengthened so that they are accountable and report progress quarterly to the relevant county JMG. The Chief Operating Officer is a key member of both JMGs so would be the overall link between the two Carer Steering Groups. In addition the two Carer Steering Groups would meet 6 monthly to share best practice and actions achieved.	Delay in review of Carers Strategy and therefore re-launch of Carers Strategy.	Review completed and recommendations approved by Trust Board. Recommendations to be implemented	A
09.I.1.09 Comprehensive benchmarking framework in place and embedded at all levels of operation across the organisation to drive performance improvement by March 2010	Director of Finance	Initial meeting with key stakeholders to agree a set of indicators that could be used in inpatient and outpatient settings. Next stage to take forward with Directorates.	Delays in implementing the KPI sets within services leads to the risk that benchmarking will not be embedded by end of financial year.		A
09.I.1.10 Clear quality indicators / metrics support the audit structure thereby demonstrating improvement in clinical care and areas for development/improvement	Director of Nursing & Clinical Governance	Trust-wide audit action plan approved. CEAC (Internal Audit) ratings now in use against clinical audits for Trust assurance - 8 clinical audits presented through IGC. Process in place for approving the assurance against clinical audit findings. Infection control audit findings have shown the need to improve in some areas of infection control and an action plan is now in place, which has been signed up to through the infection control committee. POMH-UK audit shows that the Trust is the second best performing Trust in the country with regard to the prescribing of anti-psychotic medication. There has been an incremental change since 2006 and demonstrates the effectiveness of the audit cycle.	Urgent audits as a result of SUIs reduce the likelihood of all audits being completed according to the audit time plan. An example of this is the recent risk assessment audit requested by the Execs as a result of an SUI.	Clinical Effectiveness committee will be informed of any slippage of audits due to urgent audit activity that does not fall within the agreed plan, last reported to meeting in January 2010.	G
09.I.1.11 Trust systems for managing NICE guidelines reviewed and implemented by October 2009	Director of Nursing & Clinical Governance	Process for implementing NICE guidance approved at CEC Sept 09, subject to minor adjustments. Meeting has taken place (July 09)with an adviser from NICE to facilitate review of the process. Improved engagement from all directorates with NICE guidance	Still have outstanding NICE guidance to review despite general improvements.	Quality and audit team working with all directorates to improve engagement. Teaching sessions for all Bucks CMHTs. Forensic identifying charge nurses who will lead on NICE guidelines. CAMHS have identified medical leads for NICE and Oxford have also now identifed leads for NICE guidance.	G

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09.I.1.12 Service user and carer satisfaction with the Trust's services is shown to have improved, the evidence being provided through the use of research and focus group techniques, local surveys and the Dr Foster Patient Experience Tracker system.	Chief Operating Officer	The Directorates continue to engage actively with service users and carers in a variety of ways to ensure a wide diversity of people are able to feedback about their experiences of services, to influence and to share ideas about service changes and developments. Examples of this include; the development of young people's involvement within CAMHS with the establishment of Article 12 Council in Buckinghamshire and the Young People's Advisory Panel in Oxfordshire; Patient Councils in the Forensic Services; use of focus groups across services; patients and carers involvement in PEAT inspections on wards, Satisfaction questionnaires are being used throughout services as well as being an important part of the Productive Ward Initiative, Essence of Care audits and the reform work in Buckinghamshire. Between Dec 08 to Dec 09 the Trust introduced 26 Patient Experience Tracker (PET) devices across inpatient and community services to gather rapid feedback from service users/ patients, the results of feedback are used to implement actions. 6452 responses have been received through the PET devices with 71.2% of responses positive for inpatient services (including Forensic) and 82.1% of responses positive for community services (including CAMHS) . The benefits to collecting and using rapid patient feedback are being realised, however the feedback from the directorates highlights a number of limitations with using the PET devices for service and practice developments. A review of PET devices and real time feedback was completed between Oct-Nov 09. A decision around the possible options for a new method to collect real time feedback in 2010 is still being considered. The Trust internally commissioned for the Community Patient Survey to be re-ran in 2009 alongside the National Inpatient Survey, results from both have been disseminated to directorates who have developed action plans. The 2010 national Patient Survey will focus on Community Services.	Levels of satisfaction indicated by the National Patients' Survey results in some areas	Build improvement in patient satisfaction into business plans. Continue to assess "real time" patient satisfaction through a variety of methods including surveys and rapid feedback techniques, addressing deficiencies through action plans	A
09.I.1.13 Concerns and complaints are dealt with in a way that satisfies the individual involved - processes and systems reviewed in light of new national regulations by September 2009	Director of Corporate Management	A draft protocol was agreed by the Integrated Governance Committee in March 2009 in light of new national regulations for handling complaints. The protocol was shared and consulted on with the Trust's governors, services users and carers, and front line staff. A pilot for the new protocol was run between September and December and the draft policy refined. The new policy is to be considered for approval at the meeting of the Integrated Governance Committee on the 21st January 2010. A Non-Executive has been appointed to have an interest in complaints.			G
09.I.1.14 Workforce planning is embedded in service planning and redesign ensuring recruitment of the right number of staff with the right skills to deliver services and elimination of the use of agency and bank.	Acting Director of Human Resources	Workforce plans are curently being updated and meetings are now held in conjunction with Learning & Development to consider training & development needs. Involving Learning & Development will support the drive to develop longer term workforce plans. Due to the forthcoming financial constraints, directorates are required to focus on workforce planning to ensure that savings plans are realised.	Next steps will require amendments to the current workforce template, more engagement with HR business partners to support Directorates and further information on current workforce.		G
09.I.1.15 Structured learning and development opportunities through PDRs are available to support staff to operate at the highest level of quality.	Acting Director of Human Resources	Development priorities have been established as part of the new SHA funded contract effective from 1/4/10, through the collation of inputs from service directorates and submission of funding requests to the SHA.	Development requests exceed capacity to deliver.	Lack of funding.	G

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09.I.1.16 Improve the quality of services provided on the inpatient wards	Chief Operating Officer	Link with point 09.1.2.9. The Productive Ward Initiative continues to be implemented across three wards to empower front line staff to find solutions to improve the direct care time provided to patients on inpatient wards. Buckinghamshire have introduced the reform/ lean work onto the adult wards to create capacity on the wards resulting in: 1) improved processes; for example having a clear purpose for admission engages staff early; facilitates prompt treatment and discharge planning; 2) reduced bank & agency use, which in turn increases stability on the ward 3) time for quality initiatives such as role clarification i.e. clarity on who is doing what; in-house professional development programmes and completion of mandatory training - all of which improve quality on the wards. Oxfordshire adult and older adult wards are assessing themselves against the standards within the Accreditation for Inpatient Mental Health Services (AIMS) set out by The Royal College of Psychiatrists, to identify areas for action. Buckinghamshire and Oxfordshire hold regular Acute Care Forums with representation from patients. Both the adult and older adult wards in Oxfordshire and Buckinghamshire are included within the Warneford and Manor House SOC to rebuild, update and improve the physical environments. In Buckinghamshire the Upward 3 Business Justification is about to be submitted which will improve the physical environment in the interim whilst the Manor House work is completed. The annual external PEAT ratings between Jan-April 09 showed 6 out of 9 sites excellent for environment, 7 out of 9 sites excellent for food provision and 6 out of 9 sites good for privacy and dignity (the other 3 sites received an excellent rating). Internally PEAT assessments are completed quarterly on each ward and overall performance is above 90%. The Trust completed an assessment against the DoH's checklist for privacy and dignity and single sex accommodation, the majority of inpatient accommodation meets the guidelines on single sex accommodation and where this is not the case an action plan is in place to achieve this, see further information in point 09.1.2.9. Between May-Dec 09 there were 64 reported breaches out of 1071 admissions, 94% of admissions were to single sex accommodation. The National Inpatient Survey results for 2009 have been disseminated to directorates and action plans are in place, including funding for 2 additional B3 posts to improve activity provision on Buckinghamshire wards. one of these areas is to strengthen leadership on the wards. The Directorate of Nursing & Clinical Governance hold regular Trust wide "lunch and learn" sessions for ward staff to explore issues of leadership and safety. 11 of the 26 Patient Experience Tracker (PET) devices are being used across inpatient services to gather rapid patient feedback to drive practice development, as stated in point 09.1.1.12, the future method for collecting rapid feedback is under review.	Levels of satisfaction indicated by the National Patients' Survey results in some areas	Focus activity improvements on areas identified by the Patients' Survey including safety on the wards , access to activities, privacy and dignity thorugh the Productive ward initiative, implementation of single sex wards and the capital programme). Develop the ward Leadership capabilities through re-establishment of the Modern Matron role.	A

Board Quarter 3 Progress report against Annual Plan 2009/10

09.I.2 Services will be provided to the highest standards of safety					
09.I.2.1 The Trust can demonstrate improvements in patients safety by the application of learning to local services including through its participation in the SHA Patient Safety Federation	Director of Nursing & Clinical Governance	OBMH, Hampshire Partnership Trust and Berkshire Healthcare have agreed to participate in mental health workstream allied with the SHA Patient Safety Federation. Terms of reference are in draft form and funding contributions (£10k/trust) have been agreed. However, Hampshire is requesting additional funding and negotiations over final funding contributions, therefore, remain outstanding. However, this will not delay the work. The PID for mental health work stream is in final draft			A
09.I.2.2 Continuous improvement in performance against mandatory training targets is demonstrated ensuring high levels of staff competence to operate safely.	Acting Director of Human Resources	Learning Advisory Committee endorsed the raising of the overall target to 80% following continued achievement of current target.	Increasing demand for PMVA training and a reduction in the availability of part-time instructors has led to a gap in provision which is being addressed through an action plan agreed with Clinical Governance.	Appointment of an additional PMVA Trainer expected from March will require extra L & D pay budget.	G
09.I.2.3 Learning from SUIs and incidents to improve the quality of services and avoid further adverse incidents can be demonstrated	Director of Nursing & Clinical Governance	The revised 72 hour report template and action plan are being completed on all red and orange incidents. The implementation of RCA actions is monitored by the Risk Team, using Safeguard. 73% of actions from RCAs were implemented within an agreed timeframe in Q3. Posters are being developed to advertise changes in practice that have resulted from incidents and should be in place in the next few weeks. The CQC completed its preliminary enquiries and an action plan has been developed and submitted. The CQC will be visiting the Trust to review the plan on February 25th and 26th. The action plan is being implemented and preperations, including unannounced visits, are being made with wards, teams and service managers.	Placing diectorate risk registers on Performance Accelerator still has not been completed - this is partially due to staff sickness.	Completing the directorate risk registers on PA is part of the preperation for NHSLA level 2	A
09.I.2.4 Safe recruitment practices reflecting changes in legislation and good practice are in place by October 2009	Acting Director of Human Resources	The safe recruitment training has progressed well with in excess of 110 members of staff trained to date. Monthly sessions are planned to continue through to the summer . Feedback from attendees continues to be good. Recruitment process has been amended to reflect the needs of safeguarding which includes advertising, job descriptions, person specifications and additional information sent to candidates.Safeguarding questions are now part of all recruitment acrivity for posts in children's services.		Monitor attendance of all staff required to undertake training.	G
09.I.2.5 The Trust achieves Level 2 National Health Service Litigation Authority (NHSLA) Risk Management Standards for learning disability and mental health trusts by Q1 2010/11	Director of Nursing & Clinical Governance	Project to achieve NHSLA is in 2 parts - Part 1 is to implement the assessor's recommendations following Level 1 assessment; Part 2 is to collect evidence required to confirm the implementation of the standards. Part 1 of the project was due for completion September 2009 - there remain some outstanding issues that are being pursued with the responsible people and their managers. Part 2 of the project is underway with evidence being collected to show the implementation of the standards. A informal review will be held with our assessor on 25th January 2010. The formal assessment date is 18th and 19th May 2010.	Completion of part 1 of project has continued to be delayed.	Majority of actions have been completed but the delay is mainly around policy ratification following changes. Regular progress reports against actions are requested and failures to progress have been raised with the project director and the relevant senior managers.	A
09.I.2.6 Incentives introduced to drive an improvement in the quality of services and raising standards.	Acting Director of Human Resources	There will be an annual awards ceremony to recognise winners and share best practice. Award winners are promoted through the Trust magazine and articles are contributed by staff from across the organisation to promote the work they are doing locally to improve quality and raise standards. The Quality & Productivity website has been launched http://www.obmh.nhs.uk/qp/and promotes the sharing of good practice and innovations. Anyone can email in their ideas to the Trust, including staff service users and carers. There is a blog for people to share their thoughts on innovation, quality & productivity. The Living the Values programme will tie together all aspects of the work around quality, productivity and LEAN to ensure that they are linked to our values.			G

Board Quarter 3 Progress report against Annual Plan 2009/10

09.I.2.7 Continuous improvement in clinical data and information management is evidenced through performance management and targeted interventions to improve the quality of decision making	Chief Operating Officer	A standardised quality performance framework has been implemented across all directorate areas from 1st April 09, with the focus of indicators more towards the quality domains of safety, user experience, effectiveness and innovation. The completeness and timeliness of data quality continues to be monitored at directorate and Trust Board level. At Q3 trust wide the data quality against 15 key demographic and CPA fields is 87.2% an improvement from Q2 by 2%. A new Trust wide Quality Report has been implemented from Nov 09, which reviews data quality/ governance. Patient information is available and accessible through the Trust's person centered information system (PCIS) 24 hours a day, 7 days a week and 365 days a year. The project to roll out electronic notes on PCIS has been completed across Oxfordshire and Buckinghamshire adult and older adult teams. The Trust is deploying a new patient information system called RiO in 2010 as part of the national programme for IT, the plan is for teams to start to go live from Nov 2010. As part of the project a data warehouse is being implemented, phase 1 will be in place from April 2010 to ease transition between the information systems PCIS and RiO and to improve real time data reporting. Phase 2 of the data warehouse will include a wider range of data sources e.g. incidents, complaints, training reports, audit etc..			G
09.I.2.8 Compliance with all elements of the standard for single sex accommodation is fully achieved by June 2009	Chief Operating Officer	The Trust has taken the DoH recommendations around elimination of same sex accommodation seriously. The majority of inpatient accommodation within the Trust is single sex. Following an assessment against the DoHs checklist on privacy and dignity and same sex accommodation, an action plan has been developed with support from commissioners, to work towards achieving full compliance in all areas. The action plan is regularly updated and progress reported. Some of the actions are dependent on physical estate changes within the Warneford SOC and Manor House SOC. Single sex accommodation breaches have been reported monthly from July 09 and are included within the new Trust Board Quality Report. Between May-Dec 09 there were 64 reported breaches out of 1071 admissions, 94% of admissions were to single sex accommodation. EDS - Cotswold House Oxon identified as female unit and Cotswold House Marlborough identified as mixed sex as all bedrooms are ensuite. Forensic - majority of wards same sex, except Woodlands which has designated same sex wings and Lambourne which has all single bedrooms and designated same sex washing facilities. CAMHS - offers same sex wings within ward. Oxon AWA and OA - AWA moved to single sex wards from end of Nov 09 and OA waiting for estate changes. Bucks AWA and OA - AWA and OA waiting on estates changes and longer term Manor House SOC.	Moving to same sex accommodation is not possible on all wards until estate work has been completed. There are plans and actions in place and significant improvement and commitment can be shown..	Action plan in place to achieve full compliance.	A

Board Quarter 3 Progress report against Annual Plan 2009/10

09.I.2.9 Improvements in safety and quality on the inpatient wards can be demonstrated through the patients experience.	Chief Operating Officer	The Trust entered into a 1 year contract with Dr Foster to use 26 of their Patient Experience Tracker (PET) devices across inpatient and community services to gather feedback from service users/ patients showing areas the trust are doing well in and areas for improvement to drive practice development. To embed the importance and ensure results lead to improvements a leadership framework has been developed within the trust, at the top two PET champions have been identified at Executive Director level which work down to a PET lead identified for each team/ ward with a device. The results from the PET devices are reported on a monthly basis to senior managers and PET Leads, reporting is being developed further to reach frontline staff and service users and carers. In Q1 the trust received 828 responses from inpatients, of which 61% of patients said they felt safe on the ward all of the time today, 89% of patients said they felt they had been treated with dignity and respect and 53% said a member of staff had spent time with them today discussing their feelings. Actions around areas for improvement are being lead at device and directorate level, and collated centrally to demonstrate improvements. Service users and carers are also involved in Patient Environmental Assessment Team (PEAT) visits, Oxfordshire adult and older adult wards use inpatient discharge questionnaires, all wards hold regular community meetings or patient councils, service user and carer groups have been established linked to specific wards for example Friends of Cherwell, plus other inpatient and carer engagement methods are used.			G
09.I.3 Work will take place to promote wellbeing, working with local partners wherever possible					
09.I.3.1 The Trust demonstrates, throughout the year, better promotion and sharing of information about mental health and wellbeing including an improved presence of information in GP practices and further development of all forms of social networking media, including website and Facebook content	Chief Executive	Facebook, Twitter and You Tube have continue to grow in popularity and are used to stimulate discussion and promote events and the work of the Trust. Consultation with staff, Governors and the Trust Service User and Carer Involvement group has taken place around the Privacy & Dignity Promises. The Chief Executive's blog is now live on the website and the public have been posting comments about topics including the values of the Trust. The Communications and Involvement Team have moved to a model of directorate links in order to ensure each directorate is better supported to promote and communicate information about services and developments to key stakeholders.			G
09.I.3.2 The Trust demonstrates its commitment to promoting equality and diversity through the approval of a Single Equality Scheme by April 2009 and the action plan for 2009/10 implemented to target	Director of Corporate Management	The Equality & Diversity Support Officer has been appointed and has been in post since December. The Single Equality Scheme Action plan is being reviewed for update to February Board. The Diversity Forum has been started again as a virtual group. The Equality & Diversity induction training has been reviewed and a new workshop will take place for new starters from April 2010.	Potential slippage with actions on Single Equality Action Plan due to vacancy (now filled). This is being reviewed currently and will form part of the Board report.	With equality post vacancy there has been little pressure on services to meet the designated actions. The Equality & Diversity Support Officer is now reviewing the action plan and is following this up.	A
09.I.3.3 Quality Accounts developed and made available to the public and service users and carers across the range of services provided by the Trust by March 2010 and expectation of the Commissioning for Quality and Innovation (CQUIN) payment delivered	Director of Nursing & Clinical Governance	The Trust completed a Quality Accounts report as required by Monitor for the 2008/09 Annual Report which served as a trial run for the the March 2010 deadline when this is expected to be a statutory requirement. The CQUIN has been agreed with the Oxon and Bucks PCTs, which will also serve as the CQUIN for minor contracts. Forensic have agreed CQUIN with Specialist commissioning. CQUIN targets met for Q2 although one of the 5 (HONoS) is at risk. The Q3 discussion with commissioners is outstanding. Monthly quality report for the board has been developed and has been in place since Oct 09.			G
09.I.3.4 Systematic and managed disease prevention and health promotion programmes in place, working with primary care, to meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted diseases.	Medical Director	Two consultant psychiatrists, one each from Oxon & Bucks, recruited to provide medical leadership to public health programme. Protocols agreed in both counties for GPs to provide physical health information (including pathology results) at time of referral and key points subsequently. Audit of physical health assessment & monitoring at advanced stage in forensic directorate, and physical health checks undertaken routinely now in Bucks adult CMHTs.	No Trust lead in place yet for public health. Attendance of former lead at key inter-agency meetings not replaced. Will compromise shortly our meeting basic public health targets.	Loss of focus and direction resulting from recent staff changes.	A

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09.I.3.5 A strategic approach to the development of the Trust's membership is agreed by July 2009 that will assist the Trust meet its aims and objectives but particularly target stigma in mental health services, drive the quality of services for users and carers and enhance the reputation of the organisation	Director of Corporate Management	The existing strategy, developed as part of the application to become an NHS foundation trust, remains in place and is actively being implemented. A revised strategy, developed in partnership with a working group of governors, remains in draft format but will be presented to the Members' Council for adoption in the coming months. Nevertheless, key parts of the draft strategy are being implemented, including the publication of the Members Update (2 editions now published) distribution of membership leaflets and posters to Trust sites, development of business case to support a new option to manage membership data, and supporting Members and Governors to communicate with each other. The number of members continues to slowly grow month-on-month.	The development of the revised strategy has been a difficult process due to a general lack of engagement across the Trust in what is an important part of the terms of the Trust's Foundation Trust status - to grow a representative membership. Additionally, despite efforts and attending numerous community events, the growth of Membership, in terms of numbers, has been minimal.	As part of the adoption of the new strategy it is planned to propose that a formal membership committee be established with both governors and non-executive membership to drive forward the strategy. The Members' Council will also be reminded that it needs to hold the Trust to account for this as part of the terms of authorisation.	A
09.II.1 The wellbeing of OBMH staff will be promoted through active programmes of support and the impact of staff ill-health on teams reduced					
09.II.1.1 Working in partnership with the Staffside and Staff Governors deliver a meaningful improvement in the annual national staff survey result for the organisation, demonstrating the learning from the staff surveys, direct business and well-being strategies.	Acting Director of Human Resources	Staff survey responses have increased for the 2009 survey to 62%. This has been achieved by engaging staff, staffside and staff governors in the importance of completing the staff survey. The action plan for 2008 responses has been implemented in directorates and the staff survey working group will continue to meet in 2010 to analyse the responses from 2009 and produce an action plan accordingly.			G
09.II.1.2 The Wellbeing Strategy is implemented producing, over time, a significant improvement in the physical and mental wellbeing of our staff, resulting in improved service delivery, recruitment and general community wellbeing	Acting Director of Human Resources	The Wellbeing strategy is still being reviewed and will be signed off in 2010. In the meantime a county group in Oxfordshire is being set up by the PCT to review wellbeing and workplace health in the Oxfordshire NHS. The Occupational Health consultation has been completed and a new structure is now in place.			A
09.II.2 Staff will be well managed and will regard working for OBMH as a positive experience					
09.II.2.1 Corporate services are aligned with the goals and business objectives of operational directorates and leading corporate strategies.	Chief Executive	The Nursing and CG Directorate restructuring has been agreed and new structure will be fully populated by February 2010. The aim of the new structure is to improve the interface between corporate and operational services, the key focus of this interface will be on enhancing and monitoring the quality of practice. HR and finance team members are designated to specific directorates and work closely to ensure their work is aligned with the goals and business objectives of directorates. The Executive Team is pursuing a Transformation programme across the whole Trust emcompassing the corporate services.			G
09.II.2.2 Leadership capacity across the Trust can be demonstrated to improve the effectiveness in people management and delivering improved patient care.	Acting Director of Human Resources	Place secured on SHA Potential Leadership programme. Successful completion of further cohort of in house first line management programme. Funding for some deliverables contained with the SHA fundinng bid.	Capacity and continued funding provision to sustain Trust wide leadership programmes.	No formal funding provision for leadership programmes.	G
09.II.2.3 The Trust can demonstrate that it has a values based culture which supports localised decision making, based on a set of values agreed by June 2009 and recognised by all staff.	Acting Director of Human Resources	The Living the Values programme will bring together all of the initiatives and work around quality, productivity, LEAN etc and ensure that it is tied into the Trust values and communicated in a meaningful way to staff, service users and carers. The Values themselves are promoted on the website, email auto signatures , trust materials, including letterheads, business cards etc. The values are discussed with new starters as part of their induction and this is led by the Chief Executive. The Chief Executive has also talked about the values in the blog on the Trust website and asked staff for comments and examples of values in action. The Trust has consulted with staff and agreed a set of Privacy & Dignity Promises to support the caring value.			G
09.II.3 OBMH employees will have individual plans and support to maintain and develop their skills.					
09.II.3.1 85% of staff have received a management review by 31st March 2010 (snapshot)	Acting Director of Human Resources	End Q3 result of 77%, compared with target of 85%.	Target of 85% may not be achievable given continued pressure on operational staffing and recent adverse weather.	The trend from 2008 shows declining performance in Q3 before increasing throughout the last quarter.	A