[***PUBLIC***]

Oxford Health NHS
NHS Foundation Trust

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

27 July 2011

Quality and Performance Report

For: Information

This is the integrated Quality and Performance report for Oxford Health NHS FT reporting on Month 3 of FY12. The attached report format continues to be developed through discussion with the Executive Directors and from comments from the Board as a whole.

Report

The Board report format captures all the current performance indicator requirements of Monitor, the Care Quality Commission and contractual requirements which are a high priority or risk. These will be expanded when confirmation is received as to the indicators which will be relevant for Monitor to community services.

The month 3 (quarter 1) report contains three quarterly reports:

- Commissioning for Quality and Innovation (CQUIN) reporting on progress against goals and quarterly milestone agreed with the commissioners. This is contained within the quality and performance detail. The key risk is the Community CQUIN agreement which is still to be finalised.
- Audit reporting on progress against the Trust wide clinical audit plan. This is contained within the quality and performance detail
- CQC Benchmark Indicators reporting on progress against national priorities to facilitate benchmarking between similar Trusts. The CQC also use this information to assess the validity of Trusts' registration status. The benchmarking is undertaken on an annual basis, the last exercise related to 09/10 and was published in October 2010. It is anticipated that the next publication will be October 2011. The key areas of focus for improvement are patient experience (national survey results), minimum data sets and the indicators about healthcare for people with learning disabilities.

The Trust currently has a green Monitor governance rating which takes account of the (then) 0.5 penalty point attributed at Q4 for non compliance against the CPA review within 12 months target which the Trust had reported non compliance against throughout 2010/11. The Board should note that the Trust has achieved the CPA review within 12 months target this quarter following a performance improvement plan, in advance of the target date given to Monitor of Q2. The performance improvement plan is continuing to ensure ongoing compliance.

Recommendation
The Board is asked to note the report and comment on specific areas of performance. The Board is also asked specifically to comment on the reporting format of the quarterly reports.

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Helen Millar, Head of Performance and Information

Lead Executive Director: Stephen Cass, Director of Strategy and Commercial Development

1. *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.*
2. *This paper provides assurance and evidence against the Care Quality Commission Outcomes*

Oxford Health NHS
NHS Foundation Trust

Quality and Performance Report: Executive Summary

Introduction & Summary

This report provides an overview of Oxford Health NHS FT performance for **June 2011.**

Page 1: Performance Highlights and Exceptions
Page 2: Quality and Performance Detail
Page 3: Performance Exception Recovery Plan
Page 4: CQC Benchmark indicators

Performance against Monitor targets is positive with the exception of CDiff (SHA) target. CQC Benchmarking is included within this report: Q1 performance area of concern is data quality . Board is asked to note the performance exceptions reported below.

Performance Highlights

(1) CPA reviews within 12 months (18-65) - Threshold 95%
Following implementation of the recovery plan, the Q1 Monitor target was achieved with performance reported at 95.41%.

(2) Community Services Contract KPI Performance
In Q1, KPI compliance against this contract averaged 92% which is within the incentive payment range (>90%).

Performance Exceptions

A summary of key exceptions and risks is provided below. Further detail on supporting pages

		Ref	
Quality & Patient Satisfaction	**Monitor**	M2	**CPA reviews within 12 months (18-65) - Threshold 95%** Following implementation of the recovery plan, the Q1 target was achieved with performance reported at 95.41%. The recovery plan will remain in place and will focus on sustainability against the Monitor targets as well as compliance against contractual and CQC indicators which underpin best clinical practice.
		M8	**Clostridium *difficile* - Threshold 20** 1 case reported in Community Hospitals in June which is a decrease on last month (3). A total of 6 cases have been reported YTD. An RCA is underway. No connections have been found between *Cdiff* and incidents to date. Risks: patient safety and *Cdiff* has been agreed as CQUIN gateway (threshold of 20 cases).
	Trust	T30	**MH DTOCs NHS and Social Care**- reduction in the number of DTOCs. Work continues in to improve flow of processes. Training arranged for Bucks staff.
		T31	**Community Hospitals DTOCs - Threshold 12%** There was an average of 43 delays in Community Hospitals in June which equates to 21% of the bed stock. The YTD DTOC position is also 21%. in June, 53% of delays were attributable to S&CS, 31% to NHS and 16% to both. A whole system meeting took place on 13 July to discuss potential resolutions to the sytem wide DTOC issue.

Quality & Patient Satisfaction	**Trust**	T34	**Single Sex Breaches** - 4 breaches in month, 2 CAMHS commissioner confirmed permitted. 2 awaiting if commissioner will apply penalty.
		T35 a + b	**Emergency readmissions** - no emergency readmissions for Older Adults MH. Adult MH services by over target by 0.2%**.** Monitoring continues to identify trends.
		T36	**SIRIs**- Only three months data for the integrated organisation so no trends identified to date. Monitoring for trends will continue.
Human Resource	L&D	H64a	**Mandatory training** - The mandatory training information for community services is in the process of being migrated into the Learning & Development database.
	Appraisals	H65	**Organisational wide achievement** - Information on Community PDRs is being input to the L&D database. Data collection to continue through July.
Finance	Community Services Division	K54	**Hospital at Home** Performance notice remains. The service is progressing the jointly agreed action plan and is working closely with the commissioner. **Activity** (number of avoided NEL admissions) is 118 YTD (Q1). Whilst there is currently no agreed contractual activity plan the annual QIPP target is 1210 avoided NEL admissions (303 per quarter). Activity is therefore under the QIPP plan at Q1, but trajectory has improved. Plans are in place to extend the service within the county which will increase activity. 4 step up beds are being designated which will support the whole system and delivery of the Hospital at home service.
			Oxon Activity: Overall -1% variance against block contract plan This variance reflects the exclusion of activity relating to Podiatry and Case Management. Once available and included, the overall position will be over plan. **Risks:** (1) Community Hospitals continue to be under plan at the end of Q1 by -3% (17 episodes of care). This represents a year end financial risk of c£260K if this trend continues. (2) Diabetes Specialist Nurse activity (education sessions) is under plan by -28%. If the service continues on this trend, this presents a £10-20K financial risk. (3) Out of Hours (OoH): 14% over activity YTD. Negotiation with NHS Oxon initiated.
	Finance	Q45-51	**Capital Expenditure** **CQUIN** for Community Services negotiations to be completed. Risk-Cdiff is agreed as gateway. The CQUIN proposals include Admission Avoidance (Non elective care), reduction in excess beds days at ORH and reduction in A&E admissions. These proposals are stretch targets- some of which may be unattainable. **Benefits Realisation** slippage against project plans and finance achievement. YTD variance:**-£374,260**

Report produced by:	**Lead Director Responsible**
Charlotte Hunt, Nic McDonald, Helen Millar & Marie Pritchard	**Stephen Cass** Director of Strategy and Commercial Development

Date of report: 15th July 2011 updated 20th July 2011

QUALITY AND PERFORMANCE DETAIL

Oxford Health NHS
NHS Foundation Trust

RAG & Trend key				
⬆		meeting target & trend improving	⬆	failing target & trend improving
⬇		meeting target & trend deteriorating	⬇	failing target & trend deteriorating
⟷		meeting target & no change	⟷	failing target & no change

Monitor and CQC Targets

Lead Divisional Director	Ref	Indicator description	Threshold	April	May	June	RAG	YTD Target	YTD Actual	YTD RAG & 12 month Trend	Comments/Actions
										NOTE: 12 month rolling trend not YTD trend	
Specialised Ox Bucks Mental Health	M1	Admissions with prior access to CRHT	90% (M) 95% (PCT)	**97.7%**	**98.8%**	**98.9%**	●	90% (M) 95% (PCT)	**98.5%**	⬆	April: 97.7%, May 98.84%
Specialised Children & Families Ox Bucks Mental Health	M2	% of adults (18-65) on CPA having a formal review in last 12 months (Monitor are using "date last seen by care coordinator" as a proxy for this indicator)	95.0%			95.4%	●	95.0%	**95.0%**	⬆	
Specialised Ox Bucks Mental Health	M3	Early intervention caseload	Oxon 135 Bucks 13	**Oxon 148 Bucks 2**	**Oxon 145 Bucks 8**	**Oxon 141 Bucks 13**	●	Oxon 135 Bucks 13	**Oxon 141 Bucks 13**	⬆	
Specialised Ox Bucks Mental Health	M4	Follow up in community within 7 days from inpatient discharge	95.0%	**98.2%**	**97.7%**	**96.5%**	●	95.0%	**97.6%**	⬆	
Specialised Children & Families Ox Bucks Mental Health	M5	Data completeness: Outcomes	50.0%	**64.3%**	**74.3%**	**76.8%**	●	50.0%	**76.8%**	⬇	There has been a further 6.5% improvement in HoNOS coding in the last 12 months. The declining trend is due to low performance in February, March and April 2011.
Specialised Children & Families Ox Bucks Mental Health	M6	Data completeness: Identifiers	99.0%	**99.3%**	**99.1%**	**99.0%**	●	99.0%	**99.0%**	⬇	Although a declining trajectory performance has moved between 99.3% and 99.0% over the last 3 months. There is an issue with purchaser code for Forensic inpatients that is due to the National Spine over writing trust data. Will be liaising with Connecting for Health and the Information Centre for advice.
Specialised Ox Bucks Mental Health	M7	NHS Delayed Transfers of Care (MH NHS attributable only)	<=7.5%	**4.6%**	**6.0%**	**8.6%**	●	<=7.5%	**6.5%**	⬇	Buckinghamshire NHS DTOCs have decreased from 8 (May) to 7 (June) and Oxfordshire NHS DTOCs have decreased from 7 (May) to 6 (June) . Action being undertaken as part of Recovery plan for All DTOCs (ref: T30)
All Divisional Directors	M8	Incidence of Clostridium *difficile*	7	**3**	**2**	**1**	●	3	**6**	⬆	1 reported case in Abingdon in June bringing the YTD total to 6 cases. An RCA is underway. There has been no connection between any cases reported so far this year.
All Divisional Directors	M9	CNST >=1	0-3	**0**	**0**	**0**	●	1	**0**	⟷	The former OBMH and CHO were both previously CNST Level 1. Trusts are assessed every 2 years by the NHS Litigation Authority(NHSLA) to confirm their CNST levels. CHOs last assessment(2010) was not undertaken due confusion about assessment dates leading to new CNST Level 0. CNST scores are amalgamated therefore the score of Oxford Health is now 0. The trust will be formally assessed by the NHSLA 11th and 12th January 2012. This indicator is currently being consulted on by Monitor in the Consultation on community service governance indicators and quality governance assessments in transactions (20 April 2010). Failure to achieve a CNST level of 1 would normally attract a penalty of 2 but the consultation document suggests *where an NHS FT has a CNST level of 0 but where its board can certify that:* *1. the level of 0 is solely due to a delay in the NHSLA assessment process - e.g. in circumstances where the level is a result of acquiring an organisation without a CNST level; and* *2. an NHSLA assessment has been scheduled* Monitor will not apply the score of 2.0 as set out in the compliance framework.
All Divisional Directors	M10	Formal CQC concerns or other activity									1 section 57 (follow up on previous investigations) patient complaint raised by the CQC. No returns to Monitor.
All Divisional Directors	M11	Self certification against requirements relating to healthcare for people with learning disabilities								⟷	Annual Assessment for newly integrated organisation still to be completed.
All Divisional Directors	M12	Never Events	0	**0**	**0**	**0**	●	0	**0**	⬇	Downward 12 month trend reflects 1 Never Event in November 2010.

CQC Compliance

This section has been replaced with a new separate tab of CQC Benchmarking indicators

Contractual Targets

Trust wide indicators

Lead Divisional Director	Ref	Indicator description	Threshold	April	May	June	RAG	YTD Target	YTD Actual	YTD RAG & 12 month Trend	Comments/Actions
										NOTE: 12 month rolling trend not YTD trend	
All Divisional Directors	T23	Incidence of MRSA Bacteraemia	0	**0**	**0**	**0**	●	0	**0**	⟷	
Community Services	T24	% complaints responded to within agreed timescales	95.0%	**100.0%**	**100.0%**	n/a					June data not available. Will receive on Friday 22nd July. Target will be measured as part of whole organisational target in T25 from July 2011
Specialised Children & Families Ox Bucks Mental Health	T25	Complaints per 1,000 appointments and bed days (3 month rolling average)	0.3	**0.3**	**0.3**	**0.4**	●	0.3	**0.3**	⟷	
All Divisional Directors	T26	Number of patients transferred between wards for non clinical reasons	10	**6**	**10**	**16**	●	0	**32**	↑	see recovery plan
All Divisional Directors	T27	Trust cancelled appointments	n/a	**n/a**	**6.4%**	**7.4%**		**n/a**	**6.9%**		
Specialised Children & Families Ox Bucks Mental Health	T28	Patient Feedback- overall how would you rate the care you are receiving from the MH service?	80.0%	**77.0%**	**82.0%**	**78.0%**	●	80.0%	**78.0%**	↑	Each team develop a action following collection of real time feedback. The action plans are monitored by regular patient experience leads meeting. Quarterly Patient Experience report goes to the Information Governance Committee. Target under review.
Community Services	T29	Patient Feedback- overall how would you rate the care you are receiving from the Community service?	Service specific			**79**	●	Service specific	**79**		Targets are service specific with the expectation being that all services achieve an improvement on the overall satisfaction score they achieved last year. This score reflects results received to the surveys for Children's Therapies and School Health Nursing both of which achieved an improvement on last year, thereby exceeded their overall satisfaction score target.
Specialised Ox Bucks Mental Health	T30	MH Delayed transfers of care (NHS and Social Care)	<=7.5%	**12.5%**	**13.3%**	**16.0%**	●	<=7.5%	**14.1%**	↓	see recovery plan
Community Services	T31	Community Health Delayed transfers of care (NHS and Social Care)	12.0%	**19.0%**	**22.0%**	**21.0%**	●	12.0%	**21.0%**	↓	see recovery plan
Specialised Children & Families Ox Bucks Mental Health	T32	Compliance with CPA metric	100.0%	**71.0%**	**84.0%**	**79.0%**	●	100.0%	**77.4%**	↑	see recovery plan. This % is a result of a sample audit.
Ox Bucks Mental Health	T33	HoNOS Paired scores									This indicator is reported under CQUIN Q41
All Divisional Directors	T34	Single sex breach	0	**6**	**1**	**4**	●	0	**11**	↓	Commissioners have agreed that 2 of these breaches were permissible and will not incur financial penalties. See recovery plan
Ox Bucks Mental Health	T35a	Adult Emergency readmissions within 28 days of discharge	10.3%	**9.3%**	**15.6%**	**10.5%**	●	10.3%	**10.7%**	↓	see recovery plan
Ox Bucks Mental Health	T35b	Older Adult Emergency readmissions within 28 days of discharge	5.3%	**3.0%**	**3.4%**	**0.0%**	●	5.3%	**2.3%**	↓	
All Divisional Directors	T36	SIRI (Serious Incidents Requiring Investigation)	n/a	**12**	**14**	**6**		n/a	**32**	⟷	There were 2 additional SIRIs last month bringing the total to 14. In June, 2 in community services and 4 in Mental Health . Comparison to previous year will be provided in next report.
Specialised Ox Bucks Mental Health	T38	Ward closures due to infection	0	**4**	**0**	**0**	●	0	**4**	↑	There were no ward closures due to control of infection but there was a suspected outbreak of noroviris on Watling ward that affected 4 patients and 1 member of staff.

Trust wide indicators

Lead Divisional Director	Ref	Indicator description	Threshold	April	May	June	RAG	YTD Target	YTD Actual	YTD RAG & 12 month Trend	Comments/Actions
										NOTE: 12 month rolling trend not YTD trend	
Specialised Children & Families Ox Bucks Mental Health	T39	Bed Occupancy	86.0%	**89.3%**	**89.1%**	**90.3%**	●	86.0%	**90.9%**	↑	Trust wide MH bed occupancy was 89.3% in April and 89.1% in May.
Specialised Children & Families Ox Bucks Mental Health	T40	Mental Health PEAT - Reported quarterly	95.0%			**97.0%**	●	95.0%	**97.0%**		Across Mental Health wards 23 of the 26 wards achieved 95% or over with three ward achieving 100%. Three wards failed to meet the target of 95% - Harding 94%, Glyme 91% and Phoenix 77%. Housekeeping teams have already started programmes of work including deep cleaning and this will be kept under review by the Modern Matrons. All community hospital achieved 95% or over.
Community Services		Community PEAT - Reported quarterly	95.0%			**97.0%**	●	95.0%	**97.0%**		All community hospital achieved 95% or over. Wantage ward achieved the highest score at 99%.

Commissioning for Quality and Innovation (CQUIN)

Division	Ref	Indicative Value	Description of Scheme	RAG	Comments
Children & Families Ox Bucks Mental Health	Q40	£1.1m	Oxfordshire and Buckinghamshire Adult and Older Adult Mental Health	●	All Q1 milestones have been achieved with the exception of: ● 1 milestone relating to the CQUIN goal to Leading improvements in patient safety - prevention of deaths of patients in receipt of care. The Q1 target for the fourth goal is to Need confirmation to be implemented to reduce community deaths. The delay is not deemed a risk to the overall achievement of the CQUIN goal. ● Milestones relating to the outcomes CQUIN goal. The Trust has achieved 38.3% at 5th July (against a target of 46% by 31st July 2011)of patients with 2 HoNOS scores within the last 12 months as part of mental health clustering tool and 29% at 5th July (against a target of 53% by 31st July 2011) of patients open to Trust for longer than 2 months with an identified mental health cluster. Action plans are in place.
Specialised	Q41	£353k	Forensic Specialist Commissioning Group	●	All Q1 Milestones met
Children & Families	Q42	£98k	Wiltshire & BaNES CAMHS	●	All Q1 Milestones met
Children & Families	Q43	£59k	Swindon CAMHS	●	All Q1 Milestones met
Children & Families	Q44	£82.5k	Buckinghamshire County Council CAMHS	n/a	Not agreed
Community Services	Q45	£1.2m	Oxfordshire Community	n/a	Negotiation of CQUIN due to complete 29 July 2011. Targets to note/exceptions against targets under negotiation: ● Q1 action plan to reduce severe medical errors in community hospitals submitted to OPCT for agreement and review; awaiting final sign off. The YTD number of severe medication errors is 6. This equates to a 25% reduction YTD against the 10/11 baseline.
Children & Families	Q46	£15k	Other small contracts including East of England Commissioning Group and Wiltshire Eating Disorders	n/a	East of England CQUIN not yet agreed

Clinical Audit

Division	Ref	Description of Scheme	YTD Target	YTD Actual	RAG	Comments
All Divisions	A52	Trust wide Audit Plan	14	**14**	●	14 out of 14 clinical audits have started/finished as planned. No audits have been delayed. The audits last reported to the Information Governance Committee in March April with rating were: ● POMH-UK Topic 7b monitoring of patients prescribed lithium - good results regarding lithium monitoring although poor results surrounding monitoring weight, renal and thyroid function. ● Audit against schizophrenia NICE Guidelines within Buckinghamshire Early Intervention Service - good ● CPA Q3 - satisfactory ● POMH-UK Medicines Reconciliation re-audit Topic 8b - satisfactory ● Carers Survey - satisfactory ● Infection Control - Decontamination of Commodes (OA) Jan 2011 - poor ● Infection Control - Hand Hygiene Jan 2011 - good

Key Performance Indicators and Activity

Proposed dashboard providing detail for each division is being developed

Division	Ref		Indicator description	Threshold	April	May	June	RAG	YTD Target	YTD Actual	YTD Variance	Comments/Actions
Oxfordshire Community Services	K53	KPIs	% of all divisional KPIs achieved	90.0%	**88.0%**	**94.0%**	**92.0%**	●	90.0%	**92.0%**	2.0%	48 of the 52 KPIs that were reportable in June were achieved or exceeded. The 4 areas of under performance related to pressure ulcer management (Community Nursing and Community Hospitals), Care Home Support Service and Physiotherapy. Please refer to the recovery plan for actions.
	K54	Activity	Actual activity against plan	<10% var	**55,526**	**51,037**	50268	●	179,455	**177,314**	-1.0%	Overall -1% variance against block contract plan This variance reflects the exclusion of activity relating to Podiatry and Case Management. Once available and included, the overall position will be over plan. Under activity: Services with noteworthy under activity against YTD plan are Community Hospitals, Falls and Diabetes Specialist Nurse. Whilst there is no agreed activity plan for Hospital at Home, the validated activity figures for this service are under the PCT QIPP plan by -61%. Over activity: Services with noteworthy over activity against YTD plan are Out of Hours, Home Oxygen Assessment Service (HOAS), Nutrition and Dietetics, CASH and Physiotherapy.
Specialised	K55	KPIs	% of all divisional KPIs achieved	90.0%		**96.0%**	**98.8%**	●	90.0%	**98.8%**	**6.0%**	
	K56	Activity	Actual activity against plan- INPATIENT	<10% var				●	12,411	**12,672**	**2.1%**	
		Activity	Actual activity against plan- COMMUNITY	<10% var				●	407	**1022**	**151.1%**	Baseline is being queried . No risk to contract as is block.
Children & Families	K57	KPIs	% of all divisional KPIs achieved	90.0%								Data reporting from July 2011
	K58	Activity	Actual activity against plan	<10% var								Data reporting from July 2011
Oxon and Bucks MH	K59	KPIs	% of all divisional KPIs achieved	90.0%								Data reporting from July 2011
	K60	Activity	Actual activity against plan	<10% var								Data reporting from July 2011

Human Resources

Indicator	Ref	Indicator description	Threshold	April	May	June	RAG	YTD Target	YTD Actual	YTD RAG & 12 month Trend	Comments/Actions
Sickness	H61		3.5%	**3.8%**	**3.5%**	**3.4%**	●	3.5%	**3.5%**	↑	
Vacancy Rate	H62		9.0%	**8.0%**	**7.9%**	**7.6%**	●	9.0%	**7.6%**	↑	
Mandatory Training - MH Services	H63										Reported trust wide below
Mandatory Training - Community Services	H64										Reported trust wide below
Mandatory Training - Trust wide	H 64a		85.0%	**85.0%**	**71.0%**	**72.0%**	●	85.0%	**72.0%**	↓	See Recovery plan
Appraisals	H65		85.0%	**67.6%**	**69.0%**	**59.0%**	●	85.0%	**59.0%**	↓	See Recovery plan
Leadership Training	H67										target and reporting under development
Turnover (12 month rolling)	H68		12.0%	**10.9%**	**10.7%**	**10.5%**	●	12.0%	**10.7%**	↑	
Workforce planning	H69										Reporting from July 2011
Use of bank and agency across organisation	H70	Actual spend against plan	5.0%	**2.2%**	**2.7%**	**3.1%**	●	5.0%	**2.7%**	↓	
Use of sessional contracts across organisation	H71		n/a	**1.6%**	**1.7%**	**1.7%**		n/a	**1.7%**		

Finance

Area	Ref	Indicator description	Threshold	YTD% achievement against plan	RAG	YTD Target	YTD Actual	Comments/Actions
Income and Expenditure (EBITDA)	F70	Actual EBITDA achieved against plan	95.0%	112.1%	●	£3.3m	£3.7m	Positive Variance is driven by lower than planned commitments against inflation and CQUIN reserves offsetting overspends on Service Lines
Income and Expenditure (YTD Retained surplus/deficit)	F71	YTD actual surplus/deficit achieved against plan	95.0%	130.8%	●	£1.3m	£1.7m	Positive Variance is driven by lower than planned commitments against inflation and CQUIN reserves offsetting overspends on Service Lines
Income and Expenditure (Forecast Retained surplus/deficit)	F72	Forecast year-end surplus/deficit against plan	100.0%	100.0%	●	(£0.6m)	(£0.6m)	Service risks being managed by agreed action plans and mitigated by contingency reserves
Financial risk rating	F73	Actual FRR achieved against plan	At least 3		●	4	4	In line with plan
Capital Expenditure	F75	Actual spend against plan	+/-25%	50.5%	●	£1.1m	£0.6m	Due to slippage on spend some strategic schemes including the Manor House
Liquidity	F76	Actual cash balance against plan	95.0%	95.0%	●	£20.1m	£19.1m	The small adverse variance due to the delay in capital receipt in respect of the Park and lower than planned trade payables.

Benefits Realisation (BR) & CIP

Area	Ref	Indicator description	YTD actual £	YTD variance £	YTD project RAG	Mitigating Actions and comment
Corporate projects	F77	Estates, Finance & Performance, HR, ICT, Organisation Design, Legal, Governance & Comms	430,374	-20,600	**4.6%**	Working with Project Leads and Executive Board to identify new mitigating projects and downside plans to replace non-delivering projects. Focus on identifying mitigations for ICT, nursing and clinical standards and HQ wide shortfalls
Divisional projects	F78	Children & Families, Community Services, Specialised Services, Oxfordshire Mental Health: Adults & Older Adults, Pharmacy & Medicine Management	940,816	-57,828	**5.8%**	Working with Project Leads and Executive Board to identify new mitigating projects and downside plans to replace non-delivering projects. Focus on identifying mitigations in the areas of Adult and Older Adult Mental Health and in Community Services for the Podiatry and MSK redesign project.
Trust wide projects	F79	Finance & Performance, Estates & HR Trust-wide benefits e.g. Reduction in Procurement Costs, Leave in year, Facilities Efficiency Savings	590,047	-295,832	**33.4%**	Working with Project Leads and Executive Board to identify new mitigating projects and downside plans to replace non-delivering projects. Focus is on supporting business cases for facilities and lease car projects and replacement schemes for HR.
			1,961,237	**-374,260**	**16.0%**	

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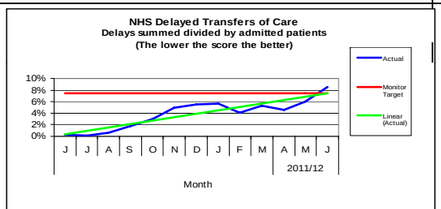
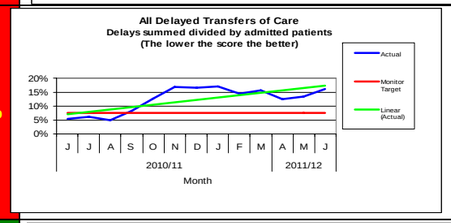
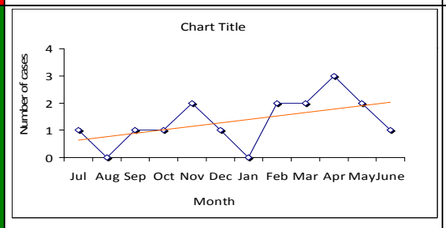
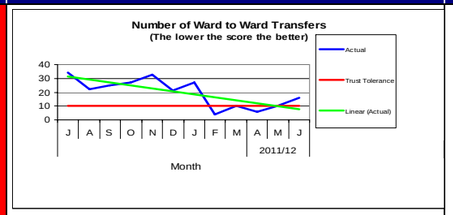
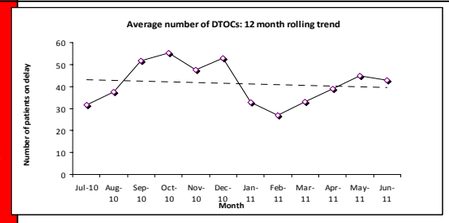
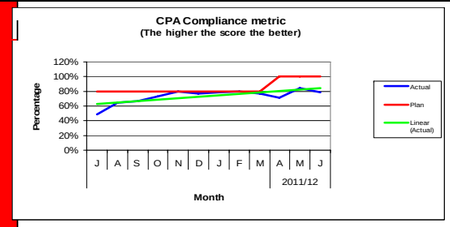
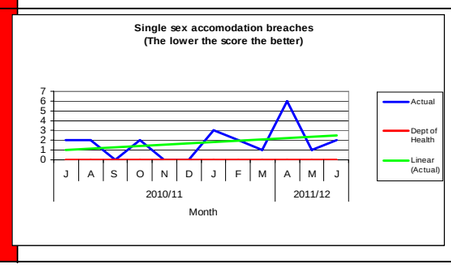
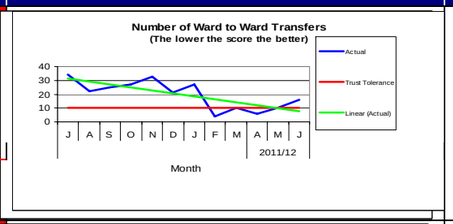
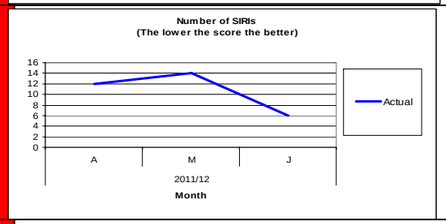
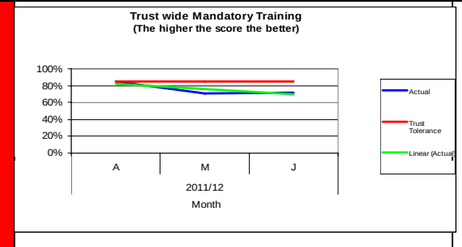
Performance Exception Recovery Plans re Corporate Performance Detail

Division and Service Area	Ref	Performance Indicator description	Threshold	April	May	June	Trajectory (graph)	Potential Penalty	Recovery Plan	Performance Forecast	Recovery complete by	Recovery Lead
Oxon and Bucks MH, Children & Families, Specialised Services	M2	% of adults (18-65) on CPA having a formal review in last 12 months (Monitor are using "date last seen by care coordinator" as a proxy for this indicator)	95.0%			95.4%	Not applicable - first data set	Monitor weighting 1.0	The stage 1 recovery plan focussed on; ● Clarification of the indicator definition to ensure accurate reporting ● Improved reporting/data analysis to ensure that the correct cohorts of patients from the legacy system (PCIS) and current information system (RiO) were being included and the reporting tools were equipped to extract the required data ● Data quality and cleansing exercise to eradicate inconsistencies Stage 1 of the plan will complete at month end. Stage 2 actions are in the process of being agreed but are focussed on clinical best practice indicators including achievement of completion of reviews within 12 months per a pure definition and implementation of reporting against the CPA metric to negate the need for manual reporting/auditing.		Q2	Divisional Directors
Specialised Ox Bucks MH	M7	NHS Delayed Transfers of Care (MH NHS attributable only)	<7.5%	4.6%	6.0%	8.6%		Monitor weighting 1.0	Improvement achieved: DTOCs reduced to 13 as at the first week of July from 20 in the first week of. Reduction in NHS DTOCs same period, 12 down to 8. Work continues in accordance with action plan to improve flow, and improve quality of paperwork. (Timescales end Jul-end Sept). Decision Support Tool training arranged for Bucks staff. No change to Bucks PCT criteria. For quarter 1 there is no penalty from Monitor.			Divisional Director Mental Health
Oxon and Bucks MH, Children & Families, Specialised Services	T30	Delayed transfers of care (NHS and Social Care)	<7.5%	12.5%	13.3%	16.0%		n/a				Divisional Director Mental Health
Community Services	M8 & Q45	Incidence of Clostridium *difficile*	13 cases throughout 2010/11	3	2	1		TBC	The contractual threshold is under negotiation. The CQUIN gateway target is a threshold of 20 cases. YTD there have been 6 reported. An RCA is in progress for the June case. There were no connections between any of the 5 cases reported in April and May. An action plan was drafted last month and submitted to the Director of Nursing and Clinical Quality (and DIPC). This is still awaiting comments and sign off. Headline actions relate to; ● Review of affected patients history ● Hand hygiene promotion and audits ● Patient management ● Environmental cleanliness monitoring ● Antimicrobial prescribing ● Eliminating inappropriate sampling ● Surveillance (internally and externally)	Actions ongoing	TBC	Divisional Director Oxford Community Health Services

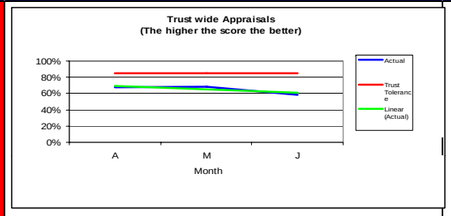
Performance Exception Recovery Plans re Corporate Performance Detail

Division and Service Area	Ref	Performance Indicator description	Threshold	April	May	June	Trajectory (graph)	Potential Penalty	Recovery Plan	Performance Forecast	Recovery complete by	Recovery Lead
Oxon and Bucks MH	T26	Number of patients transferred between wards for non clinical reasons	10	6	10	16		n/a	Plan in place to monitor reasons for transfers (ie whether clinically necessary, due to Male/Female bed pressures) and ascertain whether rise in transfers is cause for concern. (Timescale end Aug)	Actions ongoing	TBC	Divisional Director Mental Health
Community Services	T31	Delayed transfers of care (Community NHS and Social Care)	<=12.0%	19.0%	22.0%	21.0%		TBC	The CSC contract outlines a tolerance of </=12% DTOCs which equates to 30 patients on delay at any one time. In June there was an average of 43 reportable delayed discharges in Community Hospitals which represents 21% of the contracted bed stock. 31% were attributable to health, 53% to S&CS and 16% to both. This is a slight reduction on May during which an average of 45 delays were reported.A whole system meeting took place on 8 July to discuss a resolution to the system wide DTOC issue. Defining what a 'community bed' is and a clear admission criteria were being worked up.	TBC	TBC	Divisional Director Oxford Community Health Services
Oxon and Bucks MH, Children & Families, Specialised Services	T32	Compliance with CPA metric	100.0%	71.0%	84.0%	79.0%	 The CPA complinace metric consists of elements: ● Is there a care co-ordinator identified? ● Is there a current care plan? ● Has the care plan been reviewed in the last 6 months? ● Is there a current Safety/Risk Assessment and Management plan?	n/a	Actions: ● Trust wide CPA metric being developed to include 12 month review date (currently 6 months) and other NPSA suicide toolkit indicators as part of the LIPs programme. ● Each Division is following up with individual teams areas of underperformance. ● Trust wide CPA Lead part of group to review/ develop recording and reporting of CPA elements on RiO ● Trust wide CPA lead undertaking additional team level training sessions on the clinical use and recording on RiO ● CAMHS teams are implementing a specific action plan lead by the Divisions CPA lead to improve low performance. Results are reported to the Oxon and Bucks CAMHS and Swindon, Wiltshire and BaNES CAMHS clinical governance groups monthly. ● Full more detailed quarterly CPA audit continues to support the improvement of the CPA metric. ● Target to be reviewed	TBC	TBC	Director of Nursing and Clinical Standards
Children & Families	T34	Single sex breach	0	6	1	2		Negotiated on individual breach basis	4 single sex breaches identified, 1 for one night to free up a bed for a new admission, 1 for two nights. There were 2 further breaches confirmed as permissible by CAMHS commisioner			Director of Nursing and Clinical Standards

Performance Exception Recovery Plans re Corporate Performance Detail

Division and Service Area	Ref	Performance Indicator description	Threshold	April	May	June	Trajectory (graph)	Potential Penalty	Recovery Plan	Performance Forecast	Recovery complete by	Recovery Lead
Oxon and Bucks MH	T35	Adult Emergency readmissions within 28 days of discharge	10.3%	9.3%	15.6%	10.5%		n/a	Work continues in accordance with action plan to monitor reasons for readmissions and ascertain whether this is cause for concern. Oxford Adult and Older Adult and Buckinghamshire Older Adult are all under target in June. Percentage compliance affected by relatively low number of patients discharged. (Timescale end July)	Data analysis complete by end of July	determined by data analysis	Divisional Director Mental Health
Oxon and Bucks MH and Community Services	T36	SIRI	n/a	12	14	6		n/a	Clinical Governance trend review			Director of Nursing and Clinical Standards
Oxon and Bucks MH Specialised Services	Q40	Outcomes :The percentage of people who have 2 paired scores from HoNOS as part of MH clustering tool following being open for 9 months or more. This is recorded in notes.	46.0%			38.3%	Not applicable - first data set	0.15% of contract income	Data quality reports to be developed to identify underperforming areas. Recovery plan will be applied as required.			Divisional Director's Mental Health and Specialised Servicers
Oxon and Bucks MH Children & Families	Q40	Outcomes: The percentage of patients open to the Trust for longer than 2 months identified to a mental health cluster.	53.0%			29.0%	Not applicable - first data set	0.15% of contract income	Meeting on 19 July to look at reporting difficulties and performance improvement. Further clustering training arranged for staff. Validation of reports ongoing. All team progress monitored weekly. (Timescale end Aug)			Divisional Director's Mental Health and Children & Families
All Divisional Directors	H64a	Mandatory Training	85.0%	85.0%	71.0%	72.0%		n/a	The mandatory training information for community services is in the process of being migrated into the Learning & Development (L&D) database. During July and August the L&D team will be releasing to community services reports detailing the mandatory training gaps against individuals for the services to validate and update. Individual records can then be updated in the L&D database as queries are returned. This will eventually provide community services with an accurate status of their mandatory training performance by individual and enabling central Trust wide reporting. As the response rate is anticipated to be high the L&D team have prepared to be in a position to respond to the volume of queries.	TBC	TBC	Director of Human Resources

Performance Exception Recovery Plans re Corporate Performance Detail

Division and Service Area	Ref	Performance Indicator description	Threshold	April	May	June	Trajectory (graph)	Potential Penalty	Recovery Plan	Performance Forecast	Recovery complete by	Recovery Lead
All Divisional Directors	H65	Appraisals	85.0%	67.6%	69.0%	59.0%		n/a	Previously PDR details for former Community services had not been recorded centrally on individual staff records. During June requests were sent out to services to provide PDR date by individual staff member. 35% of requests have been returned and updated on the L&D database. During July the data collection process will continue and thereafter, ongoing maintenance of dates will be required by line managers and administrators using the on-line tool.	TBC	TBC	Director of Human Resources

Performance Exception Recovery Plan re Benefits Realisation

Division and Service Area	Ref	Performance Indicator description	Threshold	April YTD	May YTD	June YTD	Trajectory (graph)	Penalty	Recovery Plan	Performance Forecast	Recovery complete by	Recovery Lead
Benefits Realisation	F74 - 76				-428,508	-374,260			Please see month 3 Benefits Report for recovery plan	TBC	TBC	TBC

Performance Exception Recovery Plans re Divisional Dashboards

Division and Service Area	Div Ref	Performance Indicator description	Threshold	April	May	June	Trajectory (graph)	Penalty	Recovery Plan	Performance Forecast	Recovery complete by	Recovery Lead
Community Nursing-community	CSD 8	Community Nursing - Completion of adapted Walsall assessment on first contact for all patients identified at risk of pressure ulcers	75.0%			73.0%	Not applicable - first data set	None	Q1 performance reflects poor levels of compliance in the City locality. An action plan has been drafted and is awaiting review and sign off by the Head of Service.		Q2	Divisional Director Oxford Community Health Services
Community Nursing- - commuity hospitals	CSD 9	Community Hospitals - City Completion of adapted Walsall assessment on first contact for all patients identified at risk of pressure ulcers	75.0%			33.0%	Not applicable - first data set	None	Q1 performance reflects poor levels of compliance on the City and Bicester wards. An action plan has been drafted and is awaiting review and sign off by the Head of Service.		Q2	Divisional Director Oxford Community Health Services
Care Home Support	CSD 13	Percentage of people with an personalised care plan	95% of caseload			81.0%	Not applicable - first data set	3 failure points	The KPI for personalised care plans is low due to some care homes having no documentation for transfer. Until such time as the Medicines Management Team and CHSS team meet to agree what should be in the document with regards to personal patient information the service cannot advise – commissioners are aware of this issue. Also some of the care homes are unable to put these documents in place because they do not have up to date information about their residents (we are working with these homes to support them on improving this). In light of the issues, the Business and Performance Team are in discussion with commissioners with regards to exclusions to this KPI.			Divisional Director Oxford Community Health Services
Physiotherapy	CSD 43	Lower Limb - Percentage of patients with a lower limb disability who show a clinically significant improvement with LEFS	75.0%			73.0%	Not applicable - first data set	3 failure points	The service has started negotiations with the commissioner to review the threshold for this KPI in light of evidence that supports the fact that this threshold is potentially an unrealistic expectation.			Divisional Director Oxford Community Health Services

CQC Benchmark Indicators

RAG key

🟡	Expected level of performance (average performance of all organisations	🟢	"+2.0 standard deviations (better than the average performance of all organisations)
🟢	"+1.6 standard deviations (better than the average performance of all organisations)	🟡	"-1.6 standard deviations (worse than the average performance of all organisations)
🔴	-2.0 standard deviations(worse than the average performance of all organisations)	↑	meeting target & trend improving
↓	meeting target &trend deteriorating	↑	failing target & trend improving
↓	meeting target &trend deteriorating	↔	meeting target/meeting target & no change
↔	not meeting target & no change	↓	no target & trend deteriorating

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Division	Ref	Indicator description	CQC latest published benchmarking (Oct 2010) - highest and lowest scores relate to all organisations within the benchmarking exercise					Threshold	Current position		Comments/Actions
			Best score	Worst score	Oxford Health	Relative position	CQC RAG		Q1	RAG	
Child and Families Oxon/Bucks Mental Health Specialised	**B13**	Care programme approach 7 day follow up (Also Monitor key indicator)	100.0%	82.7%	96.0%	**54/68**	🟡	**95.0%**	**97.6%**	↑	
Oxon/Bucks Mental Health Specialised	**B14**	Delayed transfers of Care (NHS attributable) (Also Monitor key indicator)	0.1%	14.9%	1.6%	**11/57**	🟡	**<=7.5%**	**6.5%**	↓	
Oxon/Bucks Mental Health Specialised	**B15**	Access to crisis resolution/home treatment services (Also Monitor key indicator)	100.0%	9.4%	96.2%	**36/68**	🟡	**90% (M) 95%(PCT)**	**98.5%**	↑	
Child and Families Oxon/Bucks Mental Health Specialised	**B16**	Mental Health Minimum Data Set (MHMDS) data completeness (indicator 1 - equates to Monitor indicator Data completeness identifiers with the addition of marital status)	100.0%	92.4%	99.9%	**7/67**	🟡	**99.0%**	**97.2%**	↓	There was an issue with Marital status during the migration of data from PCIS to RiO and is now only 85.3% coded. Teams are working to complete coding where this has not transferred from PCIS. Performance against the Monitor target which excludes Marital status is reported in the Quality & Performance Detail is currently 99.0%.
		Mental Health Minimum Data Set (MHMDS) data completeness (indicator 2 - equates to Monitor indicator Data completeness outcomes)	90.7%	11.3%	32.0%	**51/66**	🟢	**50.0%**	**75.5%**	↑	
Child and Families Oxon/Bucks Mental Health Specialised	**B17**	Mental Health Minimum Data Set (MHMDS) data completeness (indicator 2 - percentage of discharged patients on CPA that have a care coordinator in place)	n/a	n/a	89.2%	**n/a**	**n/a**	**n/a**	**100.0%**	↑	
Oxon/Bucks Mental Health	**B18**	Best practice in mental health services for people with a learning disability (Green Toolkit) - compliance against 12 key requirements	48	12	41	**54/68**	🟡	**42**			Being reassessed will report in in Q2.
Oxon/Bucks Mental Health	**B19**	Access to healthcare for people with a learning disability	24	12	16	**58/68**	**n/a**	**24**			Being reassessed will report in in Q2.
Child and Families Oxon/Bucks Mental Health Specialised	**B20**	Data quality of ethnic groups (HES)	100.0%	67.6%	96.8%	**41/67**	🟡	**99.0%**	**89.0%**	↓	The current performance is based on the data quality on the Trust's patient information system
Child and Families Oxon/Bucks Mental Health Specialised	**B21**	Data quality of ethnic groups (MHMDS)	100.0%	80.5%	97.6%	**39/65**	🟡				
Oxon/Bucks Mental Health Specialised	**B22**	Patient Experience	325.75	273.51	289.25	**58/67**	🟡	**n/a**	**n/a**		Annual reporting of CQC overall assessment of patient satisfaction is based on the 2010 annual patient survey - community. The 2011 patient survey is due to be published in August 2011.
Child and Families Oxon/Bucks Mental Health Specialised	**B23**	NHS Staff satisfaction	3.98	3.37	3.56	**29/58**	🟡	**n/a**	**n/a**		Annual reporting of CQC overall assessment of staff engagement based on the annual staff survey. Threshold is based on the average for Scores based on other mental health/learning disability trusts on an overall indicator of staff engagement. Methodology not available to replicate to determine current score based on latest survey.
Child and Families (Addictions service)	**B24**	Number of drug users in effective treatment- assessment of the 12 week retention rate	n/a	n/a	n/a	**86.0%**	**n/a**	**n/a**	**83.0%**	↓	Quarterly reporting in August, November, February, May (Data provided by the National Treatment Agency 1.5 months after end of quarter). Q4 FY11 position was 83%.
Child and Families	**B25**	Child and Adolescent MH Service - 6 questions based on the National Service Framework for Children, Young People and Maternity Services standards and milestones for improvement in child and adolescent mental health services, including year on year improvement	24	18	23	**n/a**	**n/a**	**24**	**24**	↔	Score based on annual assessment (11/12). To be confirmed by Exec Team in Q2.