West London Mental Health NHS Trust

INTEGRATED PERFORMANCE REPORT - KEY RISKS

Performance Report Month : 5 (August 2011)
To be presented by: Executive Director of Finance & Information
Executive Summary: See over page for current risk ratings against KPIs

Key Issues for Discussion

Quality Indicators:

Positive improvement (i.e.reduction) in number of inpatients with No CPA and patients discharged without CPA.

Rag Status have now been applied to Grade 1 & 2 incidents commissioned.

Finance:

The Trust continues to have a positive run rate and is performing ahead with £567k surplus, compared to planned position of £313k at M5.
The Cassel income remains well below target.
Local services position worsening (£220k overspend in month; £564k overspend year-to-date).
Capital under spend of £3,395k reflects delays in projects commencing. Capital Plan is being re profiled by Director of Estates.

Workforce:

Mandatory Training - there seems to be a decrease in staff attending courses and with a slightly increased DNA on some courses non-compliance overall needs to be addressed.
PDR - completion of end of year reviews 2010-2011and agreed objectives for 2011-2012 is particularly low in Local and Corporate Services (including Estates).

Specialist and Forensic Service:

Note the inclusion of Specialist and Forensic service KPIs on page 7

High Secure:

To note the inclusion of KPIs from High Secure Services. Only red rated risk is patients with BMI over 30. This is addressed in care plans.

DH Performance Targets: Delayed discharge continues to under perform for Adult/OPS acute services

Links to Trust Corporate Objectives: 1, 2 and 3

Assurance or management of risks associated with meeting Corporate Objectives
This report provides an integrated high level position on key indicators of Trust performance.

Action Required by the Trust Board

1. The Board should review the IPR red rated risks highlighted in key issues for discussion and satisfy itself appropriate action is being taken.

Quality Indicators — Data Month 5 (August 2011)

Trust Never Events	Apr-11	May-11	Jun-11	Jul-11	Aug-11
Self inflicted death in an Inpatient Unit	0	0	0	0	0
Escapes from Secure Environment (High Secure and London Forensic Secure)	0	0	0	0	0
Mixed Sex Accommodation Breach	0	0	0	0	0
Number of Inpatient admissions to Adult facilities who are <18 yrs age	0	2	0	0	0

Patient Safety	Apr-11	May-11	Jun-11	Jul-11	Aug-11
Number of new Grade 2 (Level 1) incident reviews commissioned	0	2	0	0	0
Number of new Grade 1(Level 2) incident reviews commissioned	0	1	1	3	4
Number of Grade 2 (Level 1) incident reports overdue	0	0	0	0	0
Number of Grade 1 (Level 2) incident reports overdue	3	1	1	0	0
Number of Incidents involving violence reported to police (Inpatient Unit)	6	18	28	17	23
Number of medication errors causing serious harm	0	0	0	0	0
No of episodes of absence without leave (AWOL) for patients detained under the MH Act	24	21	32	29	27
% CPA patients receiving a follow up contact within 7 days of discharge (target to exceed 95%)	95%	95%	97%	98%	96%
Inpatients with no CPA (number not to exceed is 5)	3	2	5	3	1
Inpatients discharged no CPA recorded on RiO (target not to exceed is 0)	1	2	7	4	1
Community patients no CPA (target not to exceed is 5%)	6%	4%	6%	6%	5.1%
% of clients with no Risk assessment within 72hrs of admission (Target not to exceed 5%)**	12%	10%	9%	15%	13%
% of all CPA clients without Careplan (target not to exceed 5%)**	2%	3%	3%	3%	3%
Number of referrals to Children's Services	n/a	n/a	n/a	n/a	n/a

Commentary:

Trust Never Events:

•There were no new never events in August 2011.

Patient Safety:

• **Incident Review**: In August 2011, there were no new Grade 2 Incident Reviews commissioned. There were four new Grade 1 Incident Reviews commissioned, two in Broadmoor Hospital, first one being physical assault patient-to-patient, second one being damage to property/security threat, involving four patients, one in Local CSU (Ealing), being unexpected death of a community patient and one in Forensics being a death apparently self-inflicted of a community patient.
Ongoing at the end of August 2011, there were seven Grade 1 Incident Reviews and no Grade 2 Incident Reviews, all of which are anticipated to be completed within the required timescale.

•**Incidents involving Violence Reported to Police:** There has been an increase in reported numbers from 17 in July to 23 in August. Indicator being reviewed

•**Inpatients with no CPA:** There has been improvement from last month with a decrease from 3 clients in July to 1client in August.

•**Inpatients Discharged, with no CPA on RiO:** There has been improvement this month with a decrease from 4 clients to 1 client discharged without CPA.

•**% of clients with no Risk Assessment within 72 hours:** Is showing a decrease for the month of August 2011. Likely recording issue being addressed by clinical leads

•**Number of Referrals to Children Services:** Indicator in development. Current systems to be developed to capture data electronically.

Clinical Effectiveness	Apr-11	May-11	Jun-11	Jul-11	Aug-11
Readmissions within 28 days (aim not to exceed 10%)	9.8%	11%	6%	10%	12%
% Inpatients with a physical health care check within 72 hr admission (aim to exceed 95%)	93%	94%	93%	91%	91%
% Enhanced pts with no 6 mth CPA review (not to exceed 10%)	9%	6%	7%	7%	8%
Adult Acute: Median Length of stay (aim reduce)	25	28	28	24	25
*Adult Acute: Number of inpatients discharged in month where length of stay > 50 days (aim reduce)	36	36	39	38	44
Adult Acute: Number of ACTIVE inpatients at mth end where length of stay >50 days (aim reduce)	124 ↓	122 ↓	112 ↓	123 ↑	123 ⇔
% Admissions via CRT (Target :90% gatekept)	96%	97%	94%	98%	94%
% DNA rate for Medical Outpatient appointments (1st Assessment Appointments)	21%	17%	19%	20%	20%
% Delayed transfer of care attributed to all reasons for Adult Acute & OPS (Target: Not to exceed 7.5% - Target used to be 10%)	11%	13%	12%	10%	10%
% Delayed transfer of care attributed to health reasons only for Adult Acute & OPS (Target: Not to exceed 7.5% - Snap shot position in mth)	8%	11%	7%	7%	7%

•**Readmissions:** An increase in readmissions for the month of August with Ealing CSU having the highest increase from 3 patients in July to 11 patients in August. Readmission rates are based on all readmissions including emergency, within the month based on 28 days - this will be adjusted to 30 days as per CQC Quality and Risk guidelines and the Operating Framework.

•**% Inpatients with a physical health care check within 72 hr of admission:** Has stayed the same as last month for the month of August. Underperformance is mainly due by H&F Adult Acute and OPS services and Hounslow Adult acute services which are performing under the 95% target.

•**Number of inpts LOS >50 days:** *Data historically presented for Number of inpatients where LOS was over 50 days was based on discharged patients. This indicator wording has been updated to reflect the data and a new indicator has been introduced to reflect the number of clients who are still active at month end where LOS is greater than 50 days. An increase in August for clients discharged clients over than 50 days (20pts Ealing, 9pts H&F and 15pts Hounslow). The number of current inpatients with LOS greater than 50 days remains the same this month

•**% DNA rate for Medical Outpatient appointments (1st Assessment Appointments):** Overall the Trust continues to perform above the 15% target with a slight increase in August 2011. Hounslow Adult and OPS services are performing well against the target at 15%. Both CAMHS services across the Trust, H&F Adult Acute and Ealing Adult and OPS have increased DNA rate to over 20%.

•**% Delayed transfer of care attributed to health reasons only for Adult Acute & OPS:** There has been a slight reduction in the % of Delayed transfers attributed by all reasons from May to August. Note: The delayed transfer attributed to Health reasons only is based on a snapshot position (last Thur of month). Delay transfer attributed by all reasons is based on % of beds.

Medical Director

Patient Experience

Complaints and Compliments	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11
No of compliments received within month	1	0	0	4	0	2	1	1	3	5
Complaints received within month	17	16	14	21	19	16	20	17	19	11
Complaints received by end of month (cumulative)	154	170	184	205	224	16	36	53	72	83
Cumulative performance of % Completed within agreed timeframe by end of month	98%	98%	98%	98%	98%	*	100%	96%	97%	96%
Number of complaints still open within agreed timeframe	3	0	3	6	15	15	24%	20	31	14
Number of complaints closed outside agreed timeframe	0	1	1	0	0	0	0	2	0	0
Cases opened by Parliamentary Health Services Ombudsman (PHSO) in month	1	1	0	1	0	1	0	2	1	0
Total current cases open with the PHSO (this does not infer investigation)	2	3	1	2	2	2	0	3	3	2

* Indicates data not currently available due to average 6 week interval between complaint receipt and closure

Complaint Themes	Q3 10/11	Trend	Q4 10/11	Trend	Q1 11/12	Trend	Q2 11/12	Trend
All aspects of care and treatment	14	↓	16	↑	15	↓		
Other category	10	↓	14	↑	9	↓		
Failure to follow agreed procedures	4	↓	3	↓	2	↓		
Staff attitude	6	↑	8	↑	10	↑		
Property and expenses	5	↑	3	↓	7	↑		
Appointments				new	1			
Communication written and oral				new	3			
Privacy and dignity				new	1			
Complaints handling				new	1			
admission discharge and transfer arrangements				new	3			
Hotel Services				new	1			
Total number of complaints	39	↑	44	↑	53	↑		

Commentary:

Patient Experience:
Five compliments were received, 2 from Ealing Police thanking staff support during riots, 1 from Ealing OPS (Windermere Ward) thanking the team for mother's treatment, 1 from Ealing Adult inpatient thanking Conway & Beverley wards regarding visits and 1 from HSS thanking PALS for assisting in joint query with SLAM.

Complaints:
The number of complaints received in August was the lowest recorded this year. The complaints were spread across all CSUs (4 Specialist and Forensic, 5 Local Services and 2 Broadmoor). The number of complaints concerning staff attitude remains a concern and this will be a subject for discussion at a future service user and carer experience group.

Themes from Specialist & Forensic Services Patient User Forum:

Feedback: Ongoing feedback regarding staff attitudes and feelings of being alienated from decision-making.
Actions: Continuing to drive forward with the Recovery Approach and developments include;
• Staff, service user and carer conference on 29.09.11 (120 delegates signed up)
• Appointment of joint senior lecturer / recovery facilitator
• Development of Recovery and involvement team and current advert out to recruit 3 service users to work in the team for one day per week each
• All wards have recovery champions who attend regular support/development sessions, and 15 of these are attending Recovery and Social Inclusion Module at Bucks New University (BNU)
• Bespoke Band 5 development programme commenced and provided in collaboration with University of West London (UWL) and Rethink – focusing on recovery, service user and carer experience and relational security with complex service user populations

Feedback: Service users in the men's directorates continue to be unhappy about not being able to smoke in the secure gardens. This ties into a ban of electrical equipment in bedrooms of service users in Three Bridges Unit due to multiple security incidents, including fires that were caused by attempts to light cigarettes from plug sockets.
Action: A working group was established to review the current policy (involving both staff and service users) and an initial proposal to facilitate smoking in the secure gardens is being explored by the Senior Management Team (SMT).

Feedback: Lack of privacy when making phone calls has been a cause for concern in the men's directorates.
Action: Possibility of using cordless phones currently being explored by the Directorate Management Team (DMT).

Feedback: Service users and carers waiting in Tony Hillis Wing (THW) reception were unhappy about the lack of drinking facilities.
Action: Water filter has been repaired and is now functioning.

CQC Registration Compliance

Fully Compliant ●

Commentary:
Final reports for CQC Compliance visits carried out at the Limes & Cassel have been returned and all outcomes confirmed as being met.

Director of Nursing & Patient Experience

Finance - Income & Expenditure — Data Month 5 (August 2011)

Operational Income and Expenditure Budget Variances (£ 000s) — Green

Table - 1

INCOME Annual Budget £'000s	INCOME Budget to date £'000s	INCOME Actual to date £'000s	INCOME Variance to date £'000s		EXPENDITURE Annual Budget £'000s	EXPENDITURE Budget to date £'000s	EXPENDITURE Actual to date £'000s	EXPENDITURE Variance to date £'000s	OVERALL Net Variance £'000s
(82,610)	(34,453)	(33,938)	515	Broadmoor CSU	49,602	21,012	20,324	(688)	(173)
(86,886)	(36,313)	(36,482)	(169)	Local Services CSU	68,828	29,054	29,787	733	564
(65,669)	(27,366)	(26,032)	1,334	Specialist & Forensic CSU	49,442	20,513	20,082	(431)	903
(12,052)	(5,170)	(5,031)	139	Estates and Corporate	39,104	16,586	16,686	100	239
(247,217)	(103,302)	(101,483)	1,819	**Sub total**	**206,976**	**87,165**	**86,879**	**(286)**	**1,533**
				Central reserves	16,842	1,940	-	(1,940)	(1,940)
				Net income and expenditure position	(23,399)	(14,197)	(14,604)	(407)	(407)
				ITDA (Interest & capital charges)	23,399	9,750	9,590	(160)	(160)
				Total	**-**	**(4,447)**	**(5,014)**	**(567)**	**(567)**

Table 1- Operational Income and Expenditure Budget Variances (£ 000s)

Broadmoor CSU - under spent in the month by £53k (YTD under spend £173k). This was partly due to under spends relating to the recognition of CQUIN income (£42k). The Mental Illness directorate over spent in August by £46k which is an improvement on over spends seen in previous months.

Local Services CSU - over spent by £220k in the month (YTD £564k). This was due mainly to ward over spends of £158k in August relating to use of bank staff to cover sickness, annual leave, training, maternity cover and 1:1 observation. Medical staff over spends of £99k in August relate to use of locum and agency staff to cover sickness and ongoing recruitment issues.

Specialist & Forensic Services CSU - over spent by £205k in the month (YTD £903k). This includes the Cassel which over spent by £210k in August (YTD £756k) due to zero family inpatients and consequent under performance against income targets. Gender Identity Services under spent by £12k in the month (YTD £57k overspend) due to increased cost per case income.

Income & Expenditure — Green

In month net income and expenditure position against FIMS plan

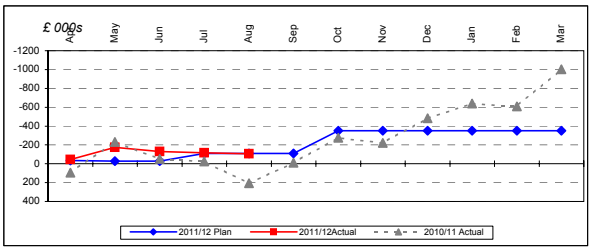


Table 2

There was an I&E surplus of £105k in August (£567k YTD). This is slightly behind the planned "in month" surplus of £110k for August (YTD planned surplus £313k). The grey line in the graph shows last year's monthly actual performance - above zero indicates a positive run rate. The blue line indicates the FIMS plan monthly figure for 2011/12 - if the 2011/12 actual line (in red) is above the blue line then performance is better than plan.

Income & Expenditure — Green

Net Operational Income and Expenditure Budget Variances (£ 000s)

	In Month	Cumulative
Broadmoor CSU	(53)	(173)
Local Services CSU	220	564
Specialist & Forensic CSU	205	903
Clinical Service Units	372	1,294
Estates & Facilities	(41)	48
CEO	29	71
Planning & Corporate Affairs	7	(40)
Finance & Information	13	52
Organisational Dev & Workforce	35	86
Medical	(23)	(13)
Nursing Directorate	(2)	44
R & D	(12)	(9)
Corporate & Estates	6	239
Central Reserves	(450)	(1,940)
Operational (under)/o'spend	(72)	(407)
ITDA	(33)	(160)
Budget (under)/o'spend	(105)	(567)
Run Rate	0.5%	0.6%

Table - 3

The Trust has a positive run rate in month of 0.5% which means it is performing better than planned and expenditure incurred for the month was less than income generated for the same period.

Cost improvement progress to date

Table - 4

M5 (£)	Annual CIPs allocated	CIPs allocated to date	Achieved to date	Variance to date	Annual target Unallocated
LS CSU	**4,012,640**	**1,436,740**	**1,433,407**	**3,333**	**367,680**
Broadmoor CSU	**3,926,884**	**1,636,202**	**1,636,202**	**0**	**0**
Specialist & Forensic CS	**2,459,222**	**1,024,676**	**1,024,676**	**0**	**399,778**
Estates & Facilities	1,214,206	516,026	436,532	79,494	0
Chief Executive	168,700	70,292	70,292	0	0
Director of Strategy	52,000	21,667	21,667	0	0
Finance	228,918	95,383	95,383	0	0
IMT	441,383	183,910	183,910	0	0
Org.Dev & Workforce	430,072	146,719	146,719	0	57,928
Medical Directorate	91,000	37,917	37,917	0	0
Nursing	327,118	136,299	136,299	0	127,882
Estates & Corporate	**2,953,397**	**1,208,210**	**1,128,716**	**79,494**	**185,810**
Total	**13,352,142**	**5,305,828**	**5,223,001**	**82,827**	**953,269**

Finance - Balance Sheet and Cash

Data Month 5 (August 2011)

Outstanding Debtors

Month	Total Debtors	Total Value £'s
Apr-11	305	6,839,826
May-11	341	5,147,903
Jun-11	337	4,640,078
Jul-11	349	6,975,641
Aug-11	326	4,749,582
Sep-11	0	-
Oct-11	0	-
Nov-11	0	-
Dec-11	0	-
Jan-12	0	-
Feb-12	0	-
Mar-12	0	-

Table - 5

Debtors & Cash

The Trust continues to monitor its cash position carefully and its forecast year end cash balance is broadly in line with expectations.

Total debtors as at 31st Aug 2011 were £4,750k representing a reduction of 30% both from Aug 2010 and the prior month (July 2011).

Outstanding Creditors

Month	Total Creditors	Total Value £'s
Apr-11	153	542,096
May-11	181	286,809
Jun-11	149	391,447
Jul-11	405	432,276
Aug-11	947	1,208,314
Sep-11	0	-
Oct-11	0	-
Nov-11	0	-
Dec-11	0	-
Jan-12	0	-
Feb-12	0	-
Mar-12	0	-

Table - 6

Creditors

The Trust ended M5 with a strong set of ytd PSPP results with 99% each for both the value and number of NHS invoices paid and 96% each for both value and number of Non NHS invoices paid. Creditor balances increased from July to Augut because the August payment run at month-end was delayed as a result of the Bank holiday. This payment run was actioned in the first week of September.

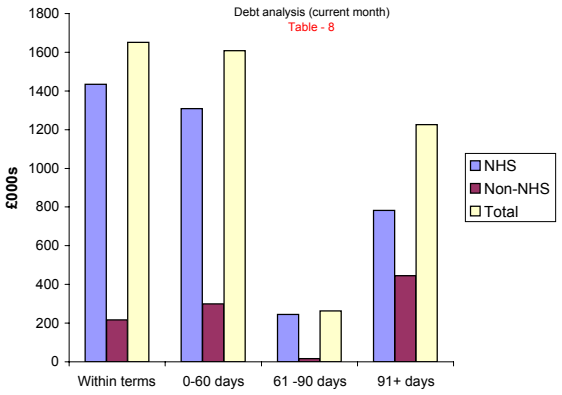
Balance Sheet as at 31 August 2011

(£ '000)	31/07/2011	31/08/2011	Mvmt in month
Fixed Assets	341,959	341,218	**(741)**
Current Assets	26,982	28,257	**1,275**
Current Liabilities	(24,768)	(25,801)	**(1,033)**
Total Assets Less Current Liabilities	**344,173**	**343,674**	**(499)**
Long term creditors	(151)	(151)	
Provisions for Liabilities & Charges	(3,528)	(2,924)	**604**
Total Assets Employed	**340,494**	**340,599**	**105**
Financed by			
Public Dividend Capital	257,362	257,362	
Revaluation Reserve	96,519	96,519	
Donated Asset Reserve	2,343	2,343	
I&E Reserve	(15,726)	(15,621)	**105**
Other reserves	(4)	(4)	
Total Capital & Reserves	**340,494**	**340,599**	**105**

Table - 7

Movement in Assets & Libilities

Fixed Asset movements relate to depeciation charges for the first 5 months offset by capital works across the whole Trust.
Current Liabilities increase is mainly due to higher PDC accruals. Current Assets are higher than M4 due to higher cash.



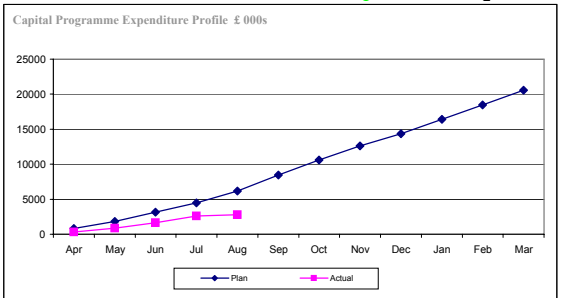


Table - 9

The year to date capital spend is £2.79m compared to a planned spend of £6.19m. The Trust is still awaiting DoH approval for the OBC, and Public Dividend Capital for Broadmoor has been requested but not yet agreed at £9.03m for 2011/12. Year to date spend on the Broadmoor Redev is £1.89m (total spend is £11.4m). Year to date spend for the St Bernards redev (MSU) is £0.69m (VAT refund received in month) (total spend is £2.69m).

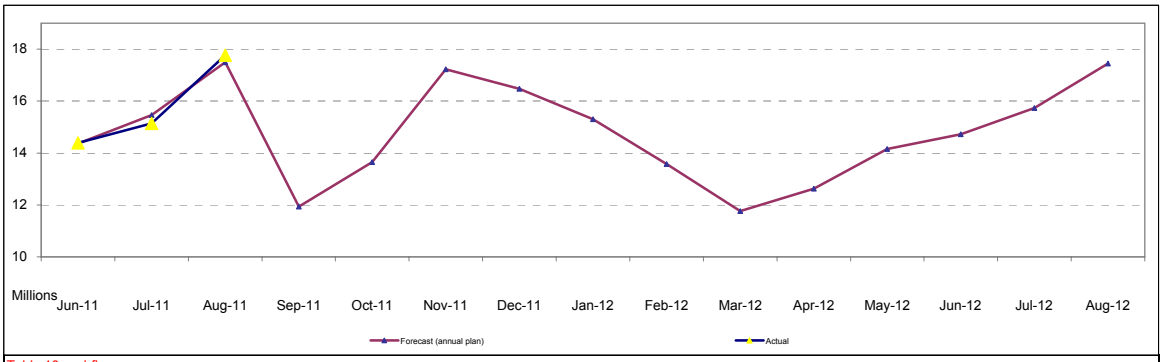


Table 10 cashflow

The cashflow shows income and expenditure is broadly in line with the forecast position for this month. At the end of Aug 2011 the balance was £17.7m. The drop is September 2011 and March 2012 are as a result of anticipated PDC payments. The increase in November 2011 is as a result of a PDC receipt expected.

Table - 11

Trust Financial Risk Self-Assessment

		%	Score
Achievement of Plan	EBITDA achieved (%)	104.2	5
Underlying Performance	EBITDA margin (%)	10.0	4
Financial Efficiency	ROA (%)	3.9	3
Financial Efficiency	IE surplus margin (%)	0.6	2
Liquidity	Liquidity ratio (days)	2.3	1

1	2	3	4	5

At 31 Aug 2011, the Trust's score is still 2 using the SHA risk rating calculation tools. However EBITDA was achieved at 104%, which within the FT (Monitor), calculations gives us a score of 5. Liquidity ratio has increased to 2.30 days. Once we become an FT we will have access to working capital facility and this will improve our liquidity rating to at least a 4.

Director of Finance & Information

Trust-wide (Level 1) Risks - Current Risk Rating — Data Month 5 (August 2011)

Risk Number	Risk owner	Board Assurance Framework Number	Risk Description	Jun-11	Jul-11	Aug-11		Date of last review*
4190	DoFS	CO4.3	Failure to redevelop St Bernards Medium Secure Service to meet DoH Medium Secure Standards by April 2015	16	16	16	↓	23/08/11
4241	DoN&PE	CO1.5	Failure to manage suicide risk on inpatient wards, resulting in avoidable inpatient deaths	16	12	12		18/08/11
4104	DoHSS	CO1.6	Uncontrolled evident ligature risks in in-patient settings, resulting in reasonably avoidable patient suicides	15	12	12		25/08/11
4182	DLS	CO1.7	Risk of major fire in an inpatient unit	12	12	12		13/07/11
4192	CEO	CO4.1	Poor quality of care and loss of reputation as a result of OBC for Broadmoor not being approved	12	12	12		04/08/11
4207	DoOD&W	CO3.1	Risk of adverse effect on the Trust's reputation as a result of adverse publicity	12	12	9	↓	16/08/11
4103	MD	CO1.2	Inconsistent clinical practice and skill in risk assessment, management and case formulation	12	12	12		24/08/11
4127	DoOD&W	CO1.4	Not all existing staff are equipped with the skills and abilities that enable them to deliver safe and effective service	12	12	12		19/08/11
4211	DoOD&W	CO1.8	Risk of poor quality leadership, resulting in a significant adverse effect on high quality safe levels of care	12	12	12		28/07/11
4237	DLS	CO1.10	Failure to redesign and implement effective 'local services' changes to achieve Trust objectives regarding care quality and patient recovery	12	12	12		03/08/11
4186	DoOD&W	CO5.1	Staff not feeling sufficiently engaged or valued by the organisation, resulting in less than ideal performance	12	12	12		29/07/11
4101	DoN&PE	CO1.14	Systematic failure leading to homicide (Failure to manage third party risk of serious injury presented by patient)	15	10	10		31/08/11
5259	DoN&PE	CO1.11	Failure to attain level 2 NHSLA risk management standard by October 2012	10	10	10		18/08/11
5170	CEO	CO3.5	Failure to achieve Foundation Trust Status by December 2012	10	10	10		20/07/11
4239	DoHSS	CO2.2	Poor quality physical environment	9	9	9		18/08/11
4238	DoN&PE	CO2.1	Failure to implement recovery-focused practice, leading to poor service user and carer experience	9	9	9		22/08/11
4198	DLS	CO3.4	Failure to maintain business continuity	9	9	9		13/07/11
4205	DoF&I	CO3.3	Missing business opportunities for business growth/diversification	9	9	9		30/08/11
4113	DoN&PE	CO1.1	Failure to change clinical practice in response to investigations	12	8	8		22/08/11
4132	DoN&PE	CO1.15	Serious Incidents of violence towards patients, staff and the public	8	8	8		23/08/11
4133	DoN&PE	CO2.4	Poor implementation of Engagement and Observation Policy	12	6	6		30/08/11
4217	DoN&PE	CO1.9	Failure to respond to service user feedback, hampering service delivery improvement	8	6	6		30/08/11
4196	MD	CO3.6	Inability to demonstrate quality	4	4	4		05/08/11

Commentary

The Board Assurance Framework and its associated risks should be reviewed at least monthly by the Executive Directors

*'Date of last review' - this is the most recent date the risk was recorded by the Exchange risk register as having been reviewed. In accordance with the Trust's Risk Management Policy, the risk should be reviewed at least once every 31 days (month)

New risks

None

Retired risks

None

Changes in the ratings of existing risks

4190 - between 14 July and 16 August, the risk rating was reduced to 12 and then increased back to 16

4207 - rating reduced following completion of all the actions. Good communication channels now exist between Trust and media, plus strong membership involvement, plus the directors have now received media training.

Additional comments

None

Specialist & Forensic Services Performance Indicators — Data Month 5 (August 2011)

Specialist & Forensic Services KPIs - Clinical Effectiveness	Apr-11	May-11	Jun-11	Jul-11	Aug-11
Physical healthchecks in the last 12 months	100%	100%	100%	100%	100%
Physical healthchecks offered within 72 hours of admission	89%	100%	100%	100%	100%
% of inpatient using the recovery tool	70%	n/a	n/a	n/a	n/a
% of inpatient with a completed HoNOS in the last 12 months	98%	98%	98%	99%	99%
% of inpatient with a completed 6 monthly CPA review	99%	99%	99%	99%	98%

Specialist & Forensic Services KPIs - Safety & Security	Apr-11	May-11	Jun-11	Jul-11	Aug-11
Number of staff assaults	22	29	21	18	41
Number of patient assaults	3	15	12	15	9
Escape	0	0	0	0	0
Abscond from escorted leave	2	0	0	1	1
% of positive drug screen **for the Forensic service**	2%	1%	2%	2%	1%
Number of complaints received in the month	6	4	1	5	4

Specialist & Forensic Services KPIs - Commissioning	Apr-11	May-11	Jun-11	Jul-11	Aug-11
% Occupancy **for forensic services**	96%	97%	97%	95%	95%
% occupancy **for cassel services ESPD**	79%	92%	81%	78%	67%
Referrals **for Forensic services**	9	10	18	11	11
Referrals **for Gender Identity Clinic**	93	96	135	101	55
Average Length of Stay **for Forensic Services (days)**	1134	1176	1198	1188	1186
Number of prisoners waiting > 12 weeks for admission	0	0	0	0	0
Waiting time for assessment **for the Gender Identity Clinic (mths)**	n/a	n/a	n/a	n/a	6 mths
Number of delayed/planned discharges/transfers	22	31	38	40	38

Commentary:

% of inpatient using the recovery tool, Currently there is not system in place to capture this information readily, however an audit will be commissioned at regular intervals to monitor this.

Number of Staff assaulted, the number of reported staff assaults significantly increased in the CSU, particularly in the WEMSS service, where 24 incidents of staff assaults were reported in the month of August.

% of positive Drug screen - the majority of positive drug screens in the first 5 months of this financial year came from the low secure & specialist rehab directorate.

% Occupancy for Forensic services, this includes all services within the forensic service, including the Wells unit (forensic adolescent inpatient unit) which has consistently under-performed, on average the Wells unit has been 56% occupied in the first 5 months of this financial year.

% Occupancy for ESPD, for the service to breakeven it is required to sell 12 out of the 15 beds. The service is currently not meeting this target.

Average Length of Stay for inpatients in the medium secure service, this is a CQUIN target with over £350k attached to achieving a 1% reduction in the length of stay. It was agreed with commissioners that the 2010-11 figures would be used as the baseline target which equates to 1396 days. We are currently on target to achieving this. Although we have been experiencing significant problems in relation to discharging patients back to the community/hostel placements, which the commissioners (London SCG) are aware of.

Waiting time for assessment in the Gender Identity Clinic, the current waiting time for an assessment is 6 months, the reason why this has increased is because the service has experienced a significant rise in the number of new referrals, this financial year, although referrals did drop in the month of August. We have invested in additional resource to help reduce the waiting time for assessments.

Number of delayed discharge/transfers, the primary reason why the number of reported delayed discharge/transfers has increased is because of placement panels not agreeing to funding or delay in agreeing to funding. In addition to this there are a number of service users waiting to be assessed and waiting for beds to become available.

Director of Specialist & Forensic Service CSU

High Secure Key Performance Indicators — Data Month 5 (August 2011)

High Secure KPIs - Clinical Effectiveness	May-11	Jun-11	Jul-11	Aug-11
% CPAs with unmet needs	3%	3%	0%	0%
% patients with less than 25 hrs / week programmed activity (target = 0)	n/a	n/a	n/a	49%
% patients with a BMI of over 35	25%	24%	22%	24%
% patients with a BMI of 30 - 34.9	22%	28%	23%	23%
% patients with a BMI of under 18.5	0%	0%	0%	0%

High Secure KPIs - Safety & Security	May-11	Jun-11	Jul-11	Aug-11
Number of staff assaults	14	6	16	13
Number of patient assaults	13	11	6	8

High Secure KPIs - Commissioning	May-11	Jun-11	Jul-11	Aug-11
% Occupancy (target = 93%)	84%	82%	82%	85%
Referrals	5	10	6	8
Admissions	3	4	4	4
Delayed admissions (target = 0)	0	0	0	2
Discharges	6	8	6	4
Delayed discharges (target = 0)	4	3	2	3

Commentary:

CPAs: Of the 23 patients whose CPAs were held in August, none were identified as having unmet needs.

Programmed Activity: Following the relaunch of the new activity data collection system on 1st August 2011, the initial data returns have flagged up some anomalies with data entry, which are being fed back to departments / managers. However, the reports for August indicate that 49% of patients had less than 25 hours of programmed activity per week. We have discussed this with the various managers and it has become apparent that there have been a number of activities that had been offered but had not been recorded on the system. They are now aware of these issues and will work with their teams to ensure all activities offered are recorded.

BMI: The number of patients with high BMIs, 47% overall, remains a concern and is being regularly monitored. Patients are seen for individual dietetic therapy and initial appointments include a nutritional assessment, education and goal setting, with follow up appointments continuing assessments, education, review and setting new goals as appropriate.

The dietician's ongoing work in relation to healthy eating and weight management involves:

- Working with the catering department on new menus and menu/recipe analysis
- Development of a "Point's" diet: linked to menus and working with the patients' shop and Café
- Exploring the feasibility for Bariatric surgery as an obesity intervention

As part of CQUIN 2011/12 we are developing a system to collect BMI trend data.

Assaults: The majority of assaults on staff occurred on the intensive care ward (7/13) and the remainder occurred across both high dependency and assertive rehab wards. The number of patient assaults slightly rose this month. The majority of these were punching and occurred across both high dependency and assertive rehab wards. One of these incidents, which involved two patients assaulting a fellow patient, is subject to a Grade 1 review.

Occupancy: The occupancy reported is against commissioned bed numbers. There were 2 admissions that fell outside the 14 day timescale from referral to admission. Of the two that were admitted within the timescale, one was from an out of catchment area and the other was an emergency admission. The two delayed admissions were as a result of limited bed availability on the admissions ward.

Discharges: The number of delayed discharges has risen slightly this month. Two of these are waiting for beds to become available and one has been delayed due to concerns raised by the RSU as to the patient's suitability for transfer to their service. The Performance Improvement Manager holds monthly meetings with the Assistant Director, Mental Health from the London SCG and all cases are monitored closely.

Risk Register:

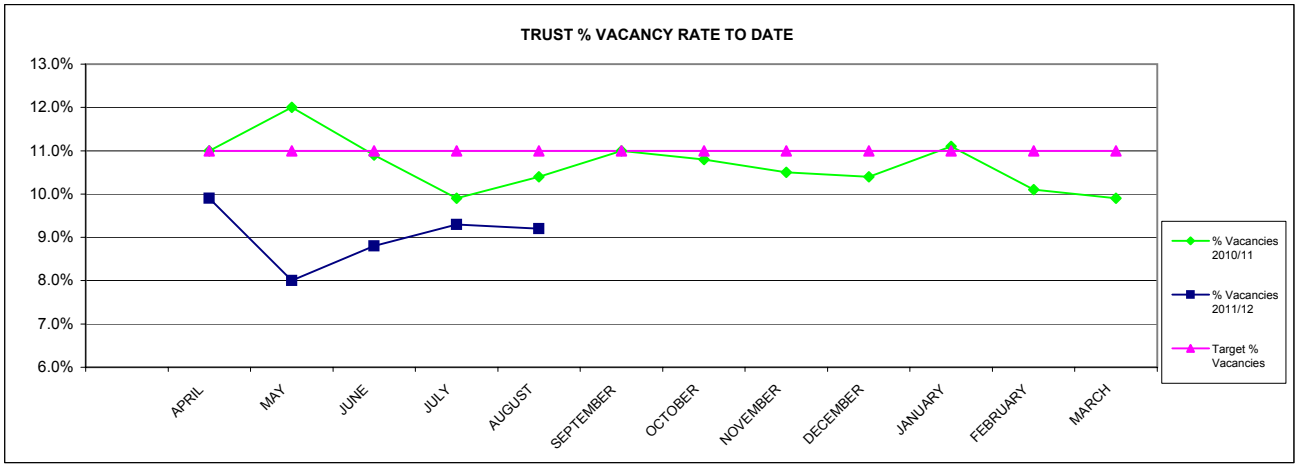
There are currently four risks rated as red on the high secure services risk register:

Two are in relation to a risk of copycat behaviour (one for each Directorate) from patients following an incident on Milton ward, one is regarding the risk of in patient suicide possibly increasing, given numbers of patient transfers and associated ward moves and one risk in relation to the lack of clarity regarding long term functionality and income of the DSPD Unit that will impact on longer term financial viability of the hospital. Consequent over establishment of staff at all levels and disciplines resulting in over spend in some areas, and poor productivity.

Director of High Secure

WORKFORCE - HR KPIs — Data for month 5 - AUGUST 2011

RAG ● ⬆

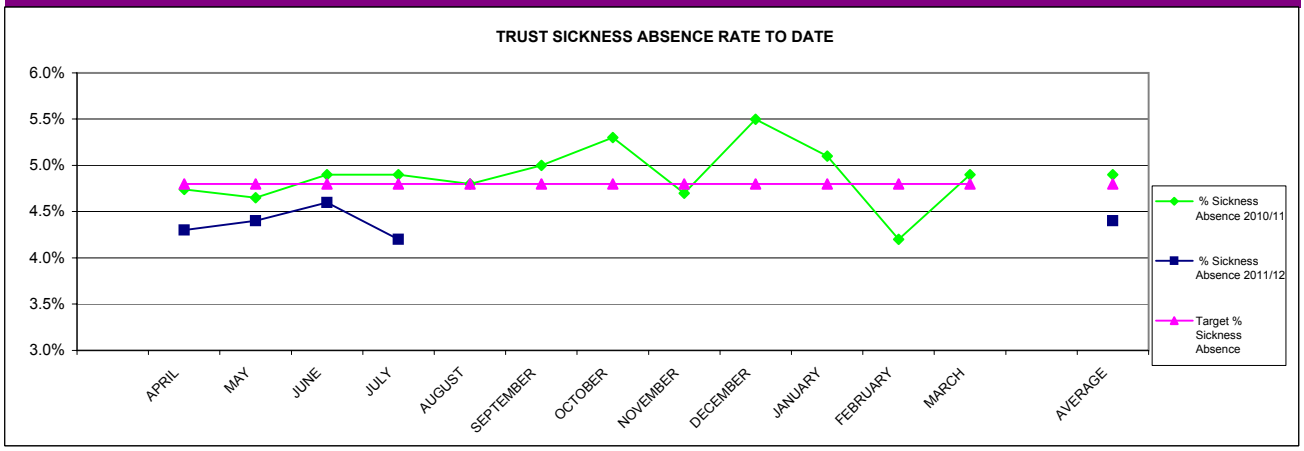


Vacancy rate

There has been a slight reduction in the vacancy rate for month 5 to 9.2 %. The rate remains low within the High Secure Services and Specialist and Forensic Services CSUs, while Local Services CSU and Estates & Corporate services are both higher at 12%.

There were 13 new starters during August with an additional 47 rotational doctors. The vacancy rate has continued to remain below both the target for 2011/12 and also when compared with August 2010 when the rate was 10.5%.

RAG ● ⬆



Sickness Absence

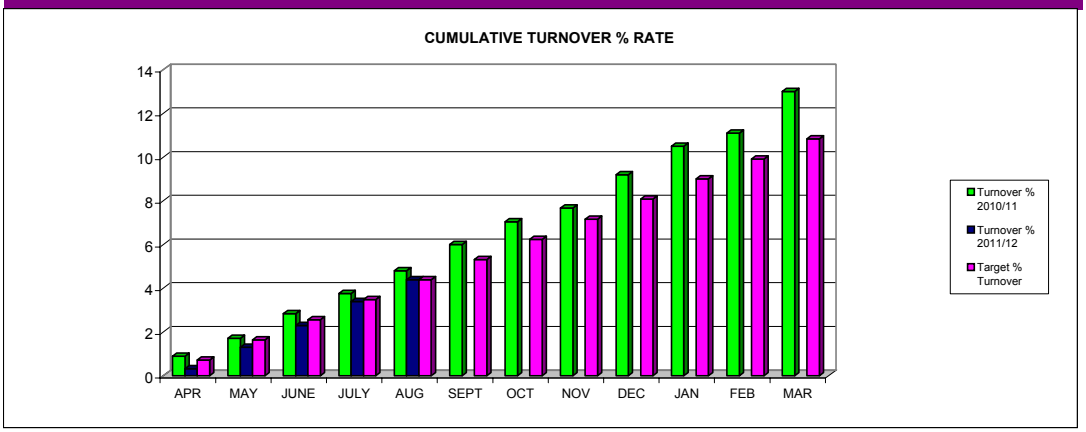
The sickness absence rate for month 3 shows a slight reduction to 4.2%. This results in a cumulative rate so far this year of 4.4% and remains below the target rate of 4.8% and also when compared with the cumulative rate for the same period last year when the rate was 4.8%. The highest rates are within High Secure Services CSU with a rate of 6.2%, while Estates & Corporate services have a rate of 3.1%, Local Services CSU 3.6% and Specialist and Forensic Services CSU 3.9%.

Managing absence within the Trust remains a priority in order to reduce the number of days lost to sickness absence across the Trust. The accuracy of the chart above is dependent on the timely recording by managers of sickness absence via the Exchange.

Director of Organisation Development & Workforce

WORKFORCE - HR KPIs — Data for month 5 - AUGUST 2011

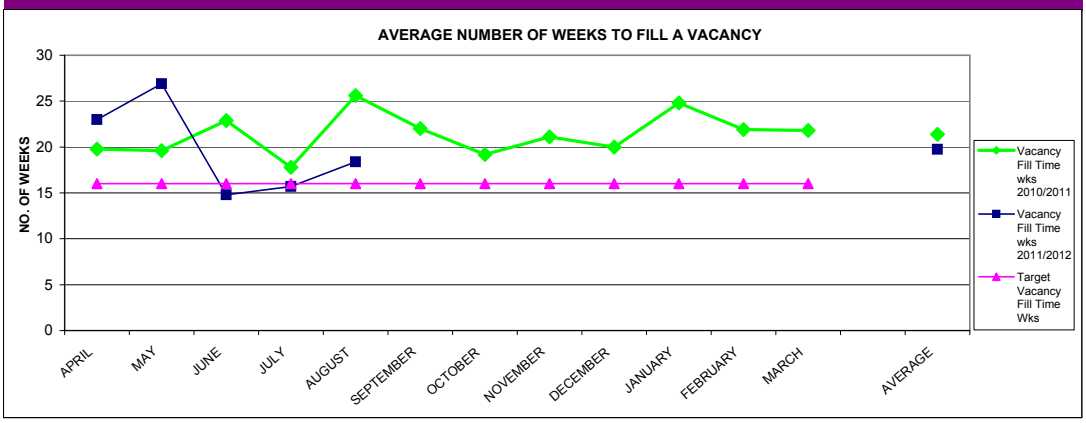
RAG



Turnover

The turnover rate for month 5 has continued to remain slightly lower than the target for 2011 but is the same rate as month 5 in 2010 showing a projected annual rate of 11%. The number of leavers during August was 38, this excludes any Junior Doctors and those staff on short fixed term contracts which were an additional 32. The number of leavers on permanent contracts so far this year is 182 compared with 200 for the same period last year. The main reasons given for departure include: 38 retirements, 42 due to personal reasons including work life balance and 31 due to promotion or further training.

RAG



Time to Hire

The number of vacancies currently advertised remains low, with 13 new starters for August.

The average time to hire has increased from 15.7 weeks in July to 18.4 weeks in August. This can be attributed to one campaign which took 51 weeks. This is due to significant delays in CRB and reference checks and a resulting CRB trace that required review and investigation. If this campaign is discounted the overall Time to Hire would be 15.6 weeks, below the target of 16 weeks.

The recruitment tracker system continues to provide robust monitoring of activity during the recruitment process in identifying any blocks or delays, while the recruitment scorecard monitors compliance against the overall time to hire at each stage of the process across the Trust.

Director of Organisation Development & Workforce

WORKFORCE - HR KPIs					Data for month 5 - AUGUST 2011
Statutory and Mandatory Training -Compliance Trust Summary	Trust	Local Services	Specialist & Forensic Services	High Secure Services - Broadmoor	Estates & Corporate Services
As at July 2011	%	%	%	%	%
Breakaway	86%	81%	100%	79%	88%
Basic Fire Awareness	75%	77%	83%	69%	67%
PSTS Theory	82%	77%	98%	81%	76%
Mental Health Law Update	93%	84%	91%	100%	100%
Basic Life Support/AED	77%	66%	78%	91%	100%
Equality and Diversity	83%	89%	85%	84%	67%
Health & Safety	80%	83%	83%	80%	71%
Information Security and Confidentiality	81%	81%	83%	80%	79%
Moving and Handling	86%	86%	86%	91%	77%
Safeguarding Children Level 1	90%	95%	89%	91%	82%
Safeguarding Children Level 2	95%	94%	93%	96%	100%
Safeguarding Children Level 3	95%	89%	100%	n/a	n/a
Safeguarding Adults	67%	66%	74%	62%	92%
PMVA Teamwork	91%	78%	100%	100%	n/a
Clinical Risk Day	75%	70%	62%	94%	58%
Infection Control	84%	87%	85%	95%	60%
Security Update	79%	n/a	n/a	79%	n/a
PDR Final Reviews 2010/11 Completed on-line	58%	12%	81%	81%	56%
PDR 2011/12 Objectives Agreed	78%	41%	89%	96%	59%

Mandatory Training scorecard

The August scorecard is the first month where we see a number of courses decreasing in compliance. Whilst 5 courses have improved, 6 courses have decreased in compliance and 6 courses remain the same. Courses with improved compliance are Breakaway, PSTS Theory, Equality and Diversity, Information Governance and Safeguarding Adults. Courses remaining the same are Health & Safety, Safeguarding Children Level 1, Safeguarding Children Level 2, PMVA Teamwork, Clinical Risk Day and Security Update. Courses with decreased compliance are Basic Fire Awareness, Mental Health Law Update, BLS/AED, Moving and Handling, Safeguarding Children Level 3 and Infection Control.

However, on a positive note, August is the first month where the scorecard shows no Red RAG rated courses Trust wide or at CSU level. There are however some variations in directorates and departments below CSU level.

The decrease in compliance for Breakaway at Broadmoor has meant a change in the RAG rating from Green in July to Amber this month. The main reason for this is that a course due to run on 31st August, which had 70 people booked to attend was cancelled due to a major incident within the hospital. This also impacted on Security Update performance as it is a combined course. On a positive note at Broadmoor there has been a change in the RAG rating from Red in July to Amber this month for Safeguarding Adults.

DNA rates have worsened this month from 214 in July to 223 in August. The L&D team continue to work with managers to address the problem. A prompt is sent to managers via an automated e-mail reminder of forthcoming training 48 hours-prior to the booked training. This is in addition to the reminder already sent a week before the planned training. Again this month we have circulated a more in-depth DNA report which shows the number of DNA's per staff member. This report has been be sent to HR business partners to enable them to work with the managers of these staff to address individual staff members who are persistent DNAs on courses.

This is the fourth month we are reporting on the % PDR reviews completed for 2010-2011 and the number of staff with Objectives agreed for 2011-2012 these can be found at the bottom of the scorecard. Although this currently shows an improving position the Trust is still someway off achieving the required targets both in relation to end of year reviews for 201/2011 and having agreed objectives for staff for this current PDR year. Both Broadmoor and Specialist and Forensic Services have made significant improvements both are RAG rated green.

Director of Organisation Development & Workforce

Staffing costs for WLMHT (M5)

Resource Type (Revenue)	Budgets WTE	Actuals WTE	Variance WTE	*Actuals % Mix*	Budget Full year £000	Budgets Month £000	Actuals Month £000	Variance Month £000	*Actuals Month % Mix*	Budgets YTD £000	Actuals YTD £000	Variance YTD £000	*Actuals YTD % Mix*
Broadmoor													
Agency		0.0	0.0	*0%*			1	1	*0%*		-2	-2	*0%*
Bank		29.1	29.1	*3%*			99	99	*3%*		806	806	*4%*
Permanent	998.4	958.4	-39.9	*97%*	46,966	3,910	3,599	-311	*97%*	19,806	18,626	-1,181	*96%*
Total	998.4	987.6	-10.8	*100%*	46,966	3,910	3,698	-212	*100%*	19,806	19,430	-376	*100%*
Local Services													
Agency		87.3	87.3	*6%*			481	481	*8%*		1,977	1,977	*7%*
Bank		134.5	134.5	*10%*			433	433	*8%*		1,993	1,993	*7%*
Permanent	1,340.0	1,138.5	-201.5	*84%*	63,439	5,454	4,760	-694	*84%*	26,790	23,433	-3,357	*86%*
Total	1,340.0	1,360.2	20.2	*100%*	63,439	5,454	5,674	220	*100%*	26,790	27,404	614	*100%*
Specialist & Forensic													
Agency		16.8	16.8	*2%*			79	79	*2%*		445	445	*2%*
Bank		104.6	104.6	*11%*			399	399	*11%*		1,707	1,707	*10%*
Permanent	942.1	836.4	-105.7	*87%*	43,840	3,644	3,106	-538	*87%*	18,210	15,772	-2,438	*88%*
Total	942.1	957.8	15.7	*100%*	43,840	3,644	3,585	-60	*100%*	18,210	17,924	-286	*100%*
Corporate Services													
Agency		80.6	80.6	*11%*			199	199	*10%*		991	991	*9%*
Bank		11.4	11.4	*2%*			26	26	*1%*		105	105	*1%*
Permanent	736.0	614.2	-121.8	*87%*	25,477	2,082	1,799	-283	*89%*	10,807	9,851	-956	*90%*
Total	736.0	706.2	-29.8	*100%*	25,477	2,082	2,024	-58	*100%*	10,807	10,947	139	*100%*
Total Trust													
Agency		184.7	184.7	*5%*			760	760	*5%*		3,411	3,411	*5%*
Bank		279.6	279.6	*7%*			957	957	*6%*		4,611	4,611	*6%*
Permanent	4,016.5	3,547.5	-469.0	*88%*	179,722	15,090	13,265	-1,826	*89%*	75,613	67,682	-7,931	*89%*
Total	4,016.5	4,011.8	-4.7	*100%*	179,722	15,090	14,981	-109	*100%*	75,613	75,704	91	*100%*

Month 5 Analysis

Broadmoor: Cumulative pay costs at Broadmoor have underspent by £376k, due primarily to underspends in the DSPD service. Some wards in the Mental Illness directorate are still overspending albeit at a reduced rate: the total ward overspend in August was £39k compared to £50k in July, £103k in June, £114k in May and £174k in April.

Local Services: Cumulatively pay costs in Local Services are £614k over spent. There was a worsening of the position across all three boroughs in August with an "in month" over spend of £220k. This is due to in particular to overspends in inpatients and in medical costs.

Specialist & Forensic Services: In August the CSU pay budgets were under spent by £60k (under spent on a year-to-date basis by £286k). This is due mainly to the impact of skills mix including savings made where bank staff are used to cover permanent vacancies.

Director of Organisation Development & Workforce

DOH NHS Performance Framework 2011/12 - Mental Health

Performance Indicator	Target/ Threshold: Performing	Target/ Threshold: Under - performing	Monitoring Period	Data Assessed Source	Qtr1 10/11*	Qtr2 10/11*	Qtr3 10/11*	Qtr4 10/11*	Qtr1 11/12**	11/12 - Internal**: Jul 11	11/12 - Internal**: Aug 11
% of adults on Care Programme Approach receiving secondary mental health services in settled accommodation (1)	11/12: >60%	11/12: >40%	Qtrly	MHMDS*	73.6%	71.8%	72.5%	73.5%	73%	73%	73%
% of adults on Care Programme Approach receiving secondary mental health services in employment (2)	11/12: >10%	11/12: >5%	Qtrly	MHMDS*	6.6%	6.1%	6.0%	6.1%	6%	6%	6%
Proportion of people on CPA receiving 7day follow up	95%	90%	Qtrly	MH Community Teams Activity Return	98%	98%	96%	94%	96%	98%	96%
Proportion of users on New CPA who have a HoNOS assessment in last 12 mths (3)	Qtr1-3: >25% to >75% Qtr4:>90% 11/12: >90%	Qtr1-3: <25% to <50% Qtr4:<75% 11/12:<75%	Qtrly	MHMDS*	51.3%	84.4%	85.2%	87.3%	88%	87%	87%
Proportion of users on New CPA reviewed in last 12 mths (4)	95%	90%	Qtrly	MHMDS*	95.6%	94.9%	93.8%	98.0%	98%	99%	98%
Proportion of patients who had recorded incidents of physical assault to them	No threshold		Annual	Count me in Census		-	-	tbc			
No of episodes of absence without leave (AWOL) for detained under MH Act	No threshold		Qtrly	Board		3.4%	2.8%	3.0%	4.4%	1.4%	n/a
No of new cases of psychosis served by EIS per year against contract plan (5)	95%	90%	Qtrly	Omnibus	103%	116%	113%	109%	120%	118%	124%
% of admissions to trusts acute ward gate kept by CRT	95%	85%	Qtrly	Omnibus	95.9%	94.6%	96.6%	94.7%	96%	98%	95%
Number of Minor (U16) admissions to acute wards (Occupied bed days)	0	1+	Qtrly	VSMR	0	0	0	0	0	0	0
***% Delayed transfers of care attributed to ALL Reasons only (6) (snapshot position)	<7.5%	>10%	Qtrly	DD SitREP	7%	5%	7%	7%	11.2%	11.0%	10.3%
% Data quality - ethnic group (7)	85%	75%	Qtrly	MHMDS*	98%	96%	98%	97%	94%	93%	93%
% Data completeness of MHMDS (Part 1) (8)	10/11:99% 11/12:97%	95%	Qtrly	MHMDS*	96.9%	96.8%	97.3%	97.8%	98%	98%	98.0%

Achieving Near achieving Under achieving

Definitions Notes:

* Uses published external MHMDS results from the DOH Information Centre Data Quality Reports for indicators based on MHMDS Data source where applicable. Qtr 4 still provisional

** Avg. data completeness taken from internal Data Quality Reports where data source would have been from MHMDS. Published actuals to be confirmed. Analysis is based on the interpretation of how the MHMDS Assembler calculates the data.

(1) & (2) For 11/12 Accommodation & Employment status is based on active New CPA clients within most recent assessment/review within last 12 months. This is a change from 10/11 where indicator was assessed on data coverage.

(3) HoNOS assessment within last 12 months for active New CPA clients inclusive for all age and specialities and linked to Review or assessment date.

(4) CPA review within 12 months. Date last seen by the CPA care-coordinator will be used as proxy

(5) Awol episodes is reported cumulatively per Qtr and Monthly

(5) New cases of psychosis served by EIS per year against contract plan (147 cases per year target)

(6) % delayed transfer of care attributed all reasons only. During 10/11 this was for Health reasons only. Note data excludes Forensic and this is being confirmed for inclusion

(7) Ethnicity - Historically reported on Inpatients - Qtr1 11/12 reported by Inpatient and Community - Definition to be confirmed by DOH (Status Update as July 2011)

(8) Data Completeness MHMDS metrics to consist of: *Date of birth, Postcode, Current gender, Marital status, Registered GP code and Commissioner code. Change in 11/12 with target at 97% and exclusion of NHS Number coverage*

Commentary:

The DOH Performance Framework applies to all NHS providers that are not yet FTs and is largely underpinned by existing national indicators and mandatory data collections for 2011/12.The above framework is one element of the quarterly DH Performance Assessment (other elements are financial management, registration and patient experience which are already reflected within the Integrated performance Report). FTs will not be assessed under this Framework, and will continue to be regulated by Monitor as set out in their Terms of Authorisation.

% of adults in Accommodation and employment. This indicator is now based on compliance and not coverage as historically reported. The Trust is compliant with % in settled accommodation but target for 11/12 is to have 10% as employed for clients on CPA. Data for previous qtrs have been updated to reflect trend.

New cases of psychosis served by EIS team is over performing well against target plan due to an increase in accepted new cases against average monthly target of 12 cases. Cumulatively the target is 147 or more new cases by year end and performance is reported cumulatively.

Ethnicity : Qtr1 2011/12 shows a drop in ethnicity, however this is based on inclusion of community and inpatient data (historically based on in inpatients). This change is new based on DOH specification.

% of admissions to trusts acute ward gate kept by CRT shows a decrease from 98% in July to 95% in August based on 120/126 cases being gatekept by CRT.

***Delayed transfer of care attributed to all reasons (Adult and OPS services)** The target for this indicator has changed from 10% to 7.5% for all reasons. Previous 10/11 data presented was reflective of attributes to health only reasons (Note data shown for 10/11 is health reasons only, 11/12 is now based on all reasons). Forensic data is not included as this is being confirmed with the DOH for inclusion.

There are no published results for QTR1 2011/12 MHMDS data sourced items due to the complete overhaul of MHMDS to V4 from V3.5 to improve technical issues identified by the IC regarding interpretation of key data values for producing data quality. The benefits of this will be the data quality published by the IC should be in par with our own internal DQ

Director of Finance and Information

FT Compliance — Data month 5 (August 2011)

FT Compliance Indicators[1]

CO1 To provide a safe and effective service

	Weighting[1]	Target/ Threshold	Qtr2 10/11*	Qtr3 10/11*	Qtr4 10/11*	Qtr1 11/12**	Jul 11	Aug-11
Care Programme Approach (CPA) patients:							Internal Monitoring**	
- receiving follow-up contact within 7 days of discharge	0.5	>=95%	98%	96%	94%	96%	98%	96%
- having formal review within 12 months	0.5	>=95%	94.9%	93.8%	98.0%	98%**	99%	98%
Minimising delayed transfers of care[2]	1	<=7.5%	5.2%	6.8%	7.2%	8.6%	7%	7%
Admissions to inpatients services had access to crisis resolution home treatment teams	1	>=90%	94.6%	96.6%	94.7%	96%	98%	95%
Meeting commitment to serve new psychosis cases by early intervention teams[3]	0.5	>=95%	116%	113%	109%	120%	118%	124%
Data completeness: identifiers[4]	0.5	>=99%	97%	97%	98%	99%	99%	99%
Data completeness: outcomes[5]	0.5	>=50%	79.0%	85.0%	85%**	55%**	not avail	not avail
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	0.5 (Annual)	Not applicable	-	-	-	-	-	-
NHSLA Level 1 *compliance? - the process for managing risks has been described and documented*	Pass/Fail (Bi-Annual)	40/50 criteria	-	-	Pass[6]			
Achievement of the Key Info Gov v8 criteria	Pass/Fail (Annual)	all 22 key criteria	-	-	Pass - Level 2		-	-

Achieving Near achieving Under achieving

Definitions notes:

* Uses published external MHMDS results from the DOH Information Centre Data Quality Reports for indicators based on MHMDS Data source where applicable.
** Avg. data completeness taken from internal Data Quality Reports. To be confirmed once the DOH Information Centre publish the Data Quality Reports.
(1)Financial Compliance Indicators and Quality are already reflected throughout the Integrated Performance Report
(2) Delayed discharges are based on a quarterly snapshot attributed to health reasons only. Social care excluded - This is based on internal Adult and OPS services. Lower compliance when including all other wards.
(3) New psychosis cases based on cumulative position as need to achieve 100% for cases year end for local PCT targets.
(4) Patient identity data completeness metrics to consist of:
NHS number, Date of birth, Postcode, Current gender, Registered GP code and Commissioner code- ***Note change from 10/11 excluding marital status***
(5)Completeness of outcomes for patients on enhanced CPA (18-69) to consist of:
In paid Employment status, In settled accommodation, Having an HoNOS assessment in the last 12 months - note change from 10/11 not based on discharged clients and excludes diagnosis
(6)Evaluation last conducted - 24&25 February 2011
Where a NHS Foundation trust fails to meet the same national or the same target weighted 1 for three or more consecutive quarters, the governance score for that breach will increase to 4.0.

Commentary:

See explanations linked to DOH Framework.
Delayed discharges - The above compliance is reflecting OPS and Adult Acute services only and based on a snap shot last Thursday of month for attributes to health reasons only. This is different to the DOH performance Framework.

Data Completeness: identifiers : Change in 2011/12 data definitions excluding marital status bringing WLMHT compliance to 99%

Data completeness: Outcomes : Change from 2010/11 as not based on discharged clients and excludes diagnosis completeness for 2011/12. There is a significant change in the way this indicator is now calculated as it is basing the outcomes on those actually in paid employment, in settled accommodation and with a valid HoNOS assessment within last 12 months. Definition is being clarified.

Progress on Recruiting Members

Number of members:	Jan	Feb	Mar	Apr	May	June	July	August*
Staff	0	3649	3649	3794	3795	3794	3794	3794
Public	65	374	410	1240	1416	2276	2927	3161
TOTAL	**65**	**4023**	**4059**	**5034**	**5211**	**6070**	**6721**	**6955**

* as at 09/9/2011

Commentary:
The aim is to have recruited a total of 10,000 members over the next 6 months
There are also planned actions next month and further actions developing to increase membership to 10,000 members. In addition there is also to date
Open Minds facebook page = 231 likes
Website blog: 6 blogs

Director of Planning and Corporate Affairs

Glossary - Performance

Standard *"National Standards, Local Action" DH July 2004*

Standards are a means of describing the level of quality that healthcare organisations are expected to meet or to aspire to. The performance of organisations can be assessed against this level of quality.

Quality Requirement *"National Standards, Local Action" DH July 2004*

Quality requirements will be established through the National Service Frameworks. They describe the care which clinicians and others will use to guide their practice.

Criteria *"National Standards, Local Action" DH July 2004*

Criteria are ways of demonstrating compliance with, and performance relevant to, a standard. They establish specific, objective expectations, drawing on such evidence and indicators as the Healthcare Commission may establish.

Target *"National Standards, Local Action" DH July 2004*

Targets refer to a defined level of performance that is being aimed for, often with a numerical and time dimension. The purpose of a target is to incentivise improvement in the specific area covered by the target over a particular timeframe.

Benchmark *"National Standards, Local Action" DH July 2004*

Benchmarks are used as comparators to compare performance between similar organisations or systems.

Glossary - Finance

CCA *Capital Cost Absorption Duty*

This is an annual measure that NHS trusts are required to achieve. A trust has a duty to absorb the cost of capital at the rate of 3.5% of its average relevant net assets. There is an allowable tolerance of 0.5% either side of this target.

CIP *Cost Improvement Programme*

These are cost savings arising from improvements in Trust efficiencies which are readily convertible into real cash savings. Such savings arising under a scheme may also be known as CIPs.

CRL *Capital Resource Limit*

This is a fundamental target of the NHS trust financial regime. It controls the amount of capital expenditure that a trust may incur in the financial year. It is an accruals based control. Overspends against CRL are not permitted.

EBITDA **Earnings Before Interest, Taxes, Depreciation and Amortization**

This measure is one of the main financial criteria that Monitor look at in assessing underlying Trust performance. It also gives a feel for cash flow before debt financing, taxes and depreciation charges. It is a significant factor in Monitor's assessmen

EFL **External Financing Limit**

This is a fundamental target of the NHS Trust financial regime. It is a cash based control which trusts are not permitted to overshoot. A positive EFL arises where Trusts draw on Government funding or spend cash resources.

I&E Margin **Income & Expenditure Margin**

I&E margin is the retained surplus or deficit ("bottom line") i.e. income less all costs for the accounting period. It has a rating of 12.5% in Monitor's assessment of the Trust's financial risk rating.

ROA **Return On Assets**

This is calculated as net margin before dividend as a percentage of average net assets employed by the Trust over the financial period. As a measure of efficiency it is an important factor (weighting 12.5%) contributing to the risk rating of an NHS founda

Aged Debtors

All debtors outside of payment terms are considered to be aged and are included in Table 11 in the finance report. The current payment terms of the Trust are 30 days.

Glossary - Workforce

Turnover

Number of leavers during the reported period as a percentage of the average staff in post for the same period.

Stability

Number of staff in post at the end of the reporting period who have been employed with the Trust for 1 year or more.

WTE **Whole Time Equivalent**

Glossary - Information

Accommodation and Employment

This measure is derived from the Vital Sign Indicator and in Year 1 of application of the Framework trusts will only be assessed on % in employment and accomodation for clients on CPA. The indicator was set out as a key priority of tackling social inclusion amongst vulnerable adults

CPA 7 day follow up

Measures patients on CPA discharged from inpatient care who are followed up within 7 days. The indicator support reduction of death by suicide as research has shown that patients are most vulnerable in this period directly after discharge. Exemptions appl

CPA Reviewed within 12 months

This is a indicator measuring active clients on CPA reviewed with the last 12 months

HoNOS assessment within last 12 months

Health of Nation Outcome Scales is an established outcome measure that is collected within the MHMDS and is the proposed basis for developing currencies for mental health. Measurement measures clients with a HONOS assessment within last 12 months

AWOL

Absent without leave for patients detained under the Mental Health Act and used as a gauge of wider organisational performance

New cases of Psychosis

Indicator is an existing commitment currently monitored via the PCT commissioners measuring new cases of psychosis serviced by the Early intervention Team per year against the contracted plan

Admissions gate kept

Indicator is an existing commitment measuring number of admissions gatekpet prior admission via the crisis resolution team

<16 years minor admissions

Indicator is count of admissions for patients aged <16 years to adult facilities and is legal requirements set out in the MHA 1983.

Delayed transfers

Delayed transfer is count of actual bed days where 'fit for discharge' clients delayed transfer of care blocking a bed

MHMDS

Mental Health Minimum Data Set contains record level data about the care of adults and older people using secondary mental health services. The dataset comprises of daily clinical and legal interventions for every patient.

CQC **Care Quality Commission**

The Care Quality Commission is the independent regulator of health and social care in England that regulate care provided by the NHS, local authorities, private companies and voluntary organisations.CQC will publish benchmarking data for 2009/10.