Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group

Governing Body

Date of Meeting: 29 January 2015	**Paper No: 15/06**

Title of Presentation: Quality and Performance Report

Is this paper for	**Discussion**		**Decision**		**Information**	✓

Purpose of Paper:

To update the Committee on quality and performance issues to date.

The Quality and Performance Report is designed to give Governing Body assurance of the processes and controls around quality and performance. It contains analysis of how OCCG and associated organisations are performing. The report is comprehensive but seeks to direct members to instances of exception.

Action Required: The Governing Body is asked to note the report.

NHS Outcomes Framework Domains Supported (please tick ✓)	
✓	Preventing People from Dying Prematurely
✓	Enhancing Quality of Life for People with Long Term Conditions
✓	Helping People to Recover from Episodes of Ill Health or Following Injury
✓	Ensuring that People have a Positive Experience of Care
✓	Treating and Caring for People in a Safe Environment and Protecting them from Avoidable harm

Equality Analysis completed	Yes	No	Not applicable ✓
Outcome of Equality Analysis			

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NHS
Oxfordshire
Clinical Commissioning Group

Quality and Performance Report – Governing Body level Exception report – January 2015

Introduction

This is the new streamlined Quality and Performance Report. After a brief overview section, the report focuses on key NHS Constitution indicators (**in blue**). A handful of other indicators identified as key supporting measures for specific programmes are examined.

Measures are presented as per:

1. Performance for Oxfordshire patients (irrespective of provider) (Column headed: Com)
2. Performance for Oxfordshire patients for specific providers (Where the row header is the provider name and the column header is "Com")
3. Provider performance irrespective of commissioner, i.e. Including more than Oxfordshire patients. This tends to be presented for those providers where OCCG is the lead commissioner only. (Where the row header is the provider name and the column header is "Prov")

Measures are associated with "Direction of travel" information: a down pointing arrow indicates a reduction in count/% . The colour refers to the position in relation to performance target, e.g. a down pointing red arrow indicates performance below target and worsening.
A black arrow indicates direction of travel where no performance target has been set.

Indicates an area where measure is not available this month: commentary is not necessary.
Indicates that target is met: commentary is not necessary

Commentary is provided by exception, i.e. Only those targets not met include a commentary. It is focused on answering the following questions:

1. Context column:
    a. What is the brief context (length of time this has been an issue, demand, trends, service redesign impact)? What are the causes of the performance issue?
    b. What has been inferred from the data? What is worthy of note?
2. Action column:
    a. Confirmation of current action (including current level of application of contract levers) and any new action being taken? What leverage is being applied or sought?
    b. What are the prospects for improvement?
3. Expected resolution date column: Within what time frame?

a. Overview	
Overall activity in the system	**Acute Sector** The urgent care system is under pressure with steep growth compared to last year for the volume of activity associated with patients over the age of 60 and patients under 18. The volume of Non elective admissions is 4.6% higher than last year to date but 6.9% up for those two age groups. The majority

	of these admissions will have been preceded by an A&E attendance and for Older people, over 50% of those A&E attendances will have involved the ambulance service. The latter is 7% higher than last year or the same period with a 4% increase in the "See, Treat and Convey" part of the system. Delayed Transfers of Care are also increasing, further increasing the level of pressure within the acute system. There is less clarity about trends affecting the planned care system. There are known performance difficulties with RTT as a drop was expected in the backlog clearance period. The Cancer waits are still a challenge with an agreed action plan to recovery. The extent to which planned care performace is associated with direct growth in demand for planned care or a by-product of the urgent care system is uncertain at this stage. **Community and Social Services** Information obtained as part of the Delayed Transfers of Care system point to increased pressures achieving flow through Community Hospitals and the system's ability to secure sufficient levels of support and care packages to facilitate all patients' discharges.		
PMO – delivering QIPP changes	QIPP Savings Programme - Update (January 2015) • £2.5m QIPP savings have been achieved to date. The year-end savings are forecast to be £4.4m, against the target of £15.69m. Explanation of these variances is explored in the Finance report. • 2015/16 programme is in development: Project Briefs and Business Cases being written; Portfolio being prioritised using criteria to be signed off by PMB; Stakeholder engagement under way. System transformation programme in development following CEOs discussion		
Contractual levers usage	**Current open contractual actions in place**	Start date	Expected resolution date
	Currently, OCCG has one exception report open. An exception report is issued when a provider breach in the remedial action plan which remains un-remedied and can lead to withholding of funding.		
	• A first exception report was issued in relation to OUHT failing to roll out Directly Bookable Services as previously agreed. The CCG believe this will significantly reduce the difficulties that patients and GPs are having in accessing appointments.	December 2014	March 2015
	Currently, OCCG has one performance notice open. A performance notice is issued to a provider where there are concerns about the services. • A performance notice remains in place in relation to two issues: outpatient communication and administrative problems (including answering of phones) in high-volume outpatient services (for example ENT). On outpatient letters OUHT continues to audit compliance and the CCG and OUHT have begun to roll out electronic transfer of letters from September 2014.		
	OCCG has two open contract queries. A contract query is issued where there is evidence that a service is not performing. Providers are required to provide an action plan addressing the concerns. Failure to do so may lead to escalation to a performance notice. The current open contract queries are:		
	• In response to not meeting the 62 day cancer waiting time target (urgent GP referral to treatment) wait for first treatment, OUHT and the CCG have agreed a remedial action plan and are meeting shortly with the Trust. Performance was failed in the latest month. The Trust expects to achieve the target by January. This contract query will be closed when OUHT can demonstrate two consecutive months of achievement.		OUHT expect to meet the standard in January 2015

	• In response to a number of incidents reported by Oxfordshire GPs via Datix, where clinicians have failed to follow up results or inform the patient's registered GP of the result where clinically appropriate. Actions in the Plan to be monitored through the Quality Review Group. Since the last report to Governing Body, the following performance notice was closed: • There was a performance notice that related to SCAS not meeting the required national performance standard against the call handling standard (95% within 60 seconds) (111 service). SCAS has produced a remedial action plan to deliver contracted performance by October 2014. October performance showed a consistent improvement and OCCG stated at the contract meeting on 24 November 2014 that this performance notice will be closed. Following closure of the performance notice, where there had been consistent achievement over the previous four months, performance has dipped below the national standard.	December 2014	Remedial Action Plan due 22 January 2015. Complete

		Latest month		Direction of travel		Context	Action	Expected resolution date
		Prov	Com	Prov	Com			
b. Patient Journey								
a. Urgent Care								
111 call answering time	SCAS		**96.8%**					
OOH Patient satisfaction	OHT							
Category A Ambulance calls	Red 1	**71.9%**	**67.8%**	→	↘	Seasonally significant increase in demand with the number of patients. This has been seen nationally.	Actions taken include: - Implementation of SOS Bus, use of HALO staff within OUHT and primary care capacity measures via ORCP- Impact to be reported from December; - Engagement with HOSC to identify service improvements in rural areas; - Virtualisation of Emergency Operations Centre to improve call response times. On-going recruitment of Community First Responders and placement of defibrillators in rural areas.	Completed Completed Mar 2015
	Red 2	**73.0%**	**68.7%**	→	↘			
	19	**94.7%**	**92.2%**	↘	→			

		Latest month		Direction of travel		Context	Action	Expected resolution date
		Prov	Com	Prov	Com			
b. Patient Journey								
A&E 4 Hour wait QTD	OUHT	**87.5%**		➘		Seasonally significant increase in demand with the number of patients. Nationally Oct-December has seen as increase of 446,049 and England's performance against the 4 hour target is at 86.7%	All ORCP schemes are now live and additional funding for tranche 2 monies has been spent on 'beds and heads' to further increase available capacity within the system. System wide escalation plan is to be reviewed and approved at the SRG as well as a review of the ORCP schemes to ensure that value for money is being achieved and re-invested where appropriate. Expansion work within EAU is still on-going and due to complete third week of January. The Trust do not expect to reach 95% in Quarter 4 See annex for further actions.	April 2015
	RBFT	**94.5%**		➘			Recovery process from activity surges expected.	February 2015
	GWHT					Awaiting data		
Attendances to Patient ratio for patient with multiple attendances	OUHT		2.58		➡		Work on-going jointly with CSU to identify measures to support high intensity users of services. Business Case under preparation to support SCAS in developing care plans.	March 2015
Emergency re-admission	OUHT		12.7%		➚	Rise in readmission.	See above for high users of service. Business Case in preparation.	

		Latest month		Direction of travel		Context	Action	Expected resolution date
		Prov	Com	Prov	Com			
b. Patient Journey								
DTOC 18 week Rolling AVG	DTOC per 100,000 (AVG/ month)		5026 (Monthly Target 2,873)		→	SRG signed off the DTOC plan 11th Dec 2014.	DTOC plan identifies 7 workstreams with associated leads across health and social care with corresponding actions plans to support. Steering group to meet on 16th Jan to review Progress. ORCP schemes are in place within OCC to try to reduce delays with care homes/ domiciliary care agency through the provision of subsidies for weekend discharges. See annex for further information.	Project plan for DTOC to be reviewed at Jan meeting and approved.
	Overall		200		→			
	OUHT		158		→			
	OHT		36		→			
Length of Delay	Overall							
Permanent admissions of older people (age 65 and over) to residential and nursing care homes, per 100,000 population			567.0 Data is 2014-15 (YTD) Nov 2014.					
Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into re-enablement / rehabilitation services			86.2% Data is 2013-14					
b. Planned Care								
RTTs								
Complete – Admitted	Overall		**84.3%**		→		Please see annex Planned Care Assurance Report	Dec 14 Reported Jan 15
	OUHT		**83.7%**		→		Please see annex Planned Care Assurance Report	Dec 14 Reported Jan 15

		Latest month		Direction of travel		Context	Action	Expected resolution date
		Prov	Com	Prov	Com			
b. Patient Journey								
	RBFT	**No data**						
	Bucks	**77.5%**			↘	Performance dropped Oct 2014.	Under investigation	
Completed – non Admitted *(target 95%)*	Overall	**93.9%**			↘	Performance dropped Nov 2014.	Please see annex Planned Care Assurance Report	Dec 14 Reported Jan 15
	OUHT	**93.7%**			↘	Performance dropped Nov 2014.	Please see annex Planned Care Assurance Report	Dec 14 Reported Jan 15
	RBFT	**No Data**						
	Bucks	**100%**			→			
Incomplete *(target 92%)*	Overall	**93.3%**			→			
	OUHT	**93.2%**			→			
	Bucks	**87.1%**			↘	Performance dropped Jul 2014.	Under investigation	
52 week waiters *(target 0)*	OUHT	**15**			↘	Performance has dropped Nov 2014.	Please see annex Planned Care Assurance Report	March 2015 reporting April 2015
Diagnostic test waiting time	Overall	**0.66%**			→			
	(National standard 1% tolerance to breach) OUHT	**0.73%**			→			
	RBFT	**0%**			→			
2 week wait GP referral – Suspected cancer *(target 93%)*	All Providers		**92.0%**		↘	Performance dropped Nov 2014.	Dependent on OUHT as below	
	OUHT	**92.4%**		↘		Performance dropped Nov 2014.	Please see annex Planned Care Assurance Report	Jan 2015 Reporting Mar 2015
	RBFT	93.0%		→				
2 week wait GP referral	All Providers		**98.6%**		→			
	OUHT	95.5%		→				

		Latest month		Direction of travel		Context	Action	Expected resolution date
		Prov	Com	Prov	Com			
b. Patient Journey								
Breast Symptoms	RBFT	96.0%		→				
31 day wait to first treatment *(target 98%)*	All Providers		**95.9%**		↘	Performance dropped Nov 2014.	Investigating why a fail as no known local provider fail	TBC
	OUHT	96.4%						
	RBFT	97.8%						
31 day wait to subsequent treatment (surgery)	All Providers		**95.2%**					
	OUHT	94.4%						
	RBFT	96.5%		→				
31 day wait to subsequent treatment (Anti-cancer drug)	All Providers		**100%**					
	OUHT	100%						
	RBFT	100%						
31 day wait to subsequent treatment (radiotherapy)	All Providers		**100%**					
	OUHT	100%						
	RBFT	99.1%						
62 day from urgent GP referral to first treatment *(target 85%)*	All Providers		**80.3%**		↘	Improvement trend since April, dipped in November (2 % approx)	Dependent on OUHT as below	
	OUHT	**79.5%**		↘			Please see annex Planned Care Assurance Report	Jan 15 Reported Mar 15
	RBFT	87.9%		→				
62 day from screening to treatment	All Providers		**93.3%**		→			
	OUHT	100%		→				
	RBFT	92.3%						
Other Indicators								

	Latest month		Direction of travel		Context	Action	Expected resolution date
	Prov	Com	Prov	Com			
b. Patient Journey							
Mixed sex accommodation	OUHT	**10**			The mixed sex accommodation breach that occurred in November happened at the Emergency Assessment Unit (EAU). It involved 10 patients; eight men and two women. The two female patients were acutely unwell so they needed to be transferred to the Intensive Care Unit (ICU) from the Resuscitation Area. ICU was full, and therefore the patients were transferred to EAU. It was justified for the two female patients to be placed in mixed sex accommodation as they were in need of a very high level of care.	The matron for Clinical Support Services (CSS) is reviewing the length of stay for patients that require the lowest level of care in Churchill ICU and Adult ICU. By doing this, they should be able to ensure that ICU always has the patients that require the highest level of need. The CCG will require the Trust to be reporting mixed sex accommodation breaches in the Trust's ICU and Critical Care Unit (CCU) from April 2015.	This breach is now resolved.
	OHFT	**0**					
Cancelled Operations	OUHT	5.83% (7/120)		→	Increase in urgent care admissions. Winter pressures.	Daily review on Sitrep of cancellations.	
	RBFT	8.00%			Increase in urgent care admissions. Winter pressures.	Daily review on Sitrep of cancellations.	
c. System wide aspects/Other Measures							
Incidence of Healthcare associated infections	MRSA	**1 (7 YTD)**		→	1 pre-48 hour MRSA bacteraemia taken in Abingdon Emergency Medical Unit (EMU). Please note that since the last Governing Body there has also been one avoidable post 48 hour MRSA bacteraemia where the blood culture was taken in Cardiology Ward, OUH. This was not attributable to Oxfordshire as the patient is not from the county.	Post Infection Review (PIR) investigation commenced by OCCG 13/01/15. Unable to state if the bacteraemia was unavoidable or avoidable as full review still to be completed. Review meeting planned for 22/01/15. PIR review form and meeting completed with OUH, who were identified as the attributable organisation. Action plans relating to antimicrobial prescribing, pre-operative skin cleansing and cannula documentation have been put in place. OUH reporting back to OCCG on progress against action plans.	January 29 2015 January 31 2015
	C Diff.	106 vs. 130 allowance YTD (172 Annual limit)					
Care Programme approach (CPA)		97.3%					

		Latest month		Direction of travel		Context	Action	Expected resolution date
		Prov	Com	Prov	Com			
b. Patient Journey								
IAPT	Access to services		**3.4%**			The target in Q4 increases to 3.7% of proportion of people with depression and anxiety entering treatment, this in line with national expectations. OCCG is aware of issues around staff turnover and DNAs which will make meeting the year end trajectory a challenge; alongside working to meet an increased target within existing resources. Staff turnover issues are thought to be due to the current IAPT services being re tendered. The procurement advert will be published by early February for a wellbeing and psychological service that is expected to meet national IAPT standards.	TalkingSpace action plan presented in December 2014; includes work to identify those patients who might prefer and might benefit by from group therapy and through an increased use of telephone support rather than face to face, and also operating a more stringent management of DNAs. In addition locum staff have been appointed to backfill vacant posts, whilst recruitment is undertaken. These developments will both extend the reach of the psychological therapy service in terms of numbers of people able to enter treatment and also offer an alternative form of intervention that may help more people recover more effectively.	31 March 2015
	Proportion of people accessing IAPT services and recovery rate		**48.9%**					
Medication-related Incidents								

			Context	Action	Expected resolution date
d. Quality					
Monitor Enforcement Action (RBFT)			RBFT has until 31 March 2015 to carry out "high priority actions" to improve the way it is run, under enforcement action initiated by the healthcare regulator, Monitor. Following an inspection in November, Monitor has reasonable grounds to suspect RBFT was in breach of its licence. Problems with record-keeping meant the hospital was unable to accurately report whether people were being treated within the 18 weeks of being referred for treatment by GPs. Monitor also said there were weaknesses in the way senior staff monitored care that patients received and the hospital's financial position was also worsening.	The Trust must produce an action plan by 31 January 2015 and carry out key actions by the end of March. If the Trust failed to improve, Monitor has legal powers to order the Trust to take further steps, pay a fine, or remove its operating licence. Monitor's remit is to check whether Foundation Trusts are well-led and financially sound for the good of patients, while the other regulator, the Care Quality Commission, rates quality of care.	March 31 2015
SCAS CQC Inspection			South Central Ambulance Service (SCAS) have been inspected by CQC as part of a new wave of ambulance inspections. The methodology used is to be applied to develop further understanding of this area of healthcare by CQC. As a result ratings have not been provided for the Trust. In most areas the report was positive, notably: - care and compassion are delivered to high standards often where staff are working in difficult and pressurised environments; - innovative learning resource for frontline staff; - Addition of a midwife to the clinical support desk; - Clinical lead in mental health and learning disability.	The CQC report highlighted the following areas that the Trust must improve: - Staff uptake of Statutory and Mandatory Training meets trust targets; - Staff in Emergency Operations Centre (EOC) and Patient Transport Services (PTS) understand the Mental Capacity Act 2005; - All EOC and PTS staff receive Safeguarding training to the required level so that they are able to recognise signs of abuse and ensure there are robust arrangement in place for staff to report concerns within the agreed timescale; - Emergency call takers answer calls, and the emergency medical dispatchers dispatch an ambulance within target times.	

			Context	Action	Expected resolution date
Clinical communication			One of the areas with which OCCG has a performance notice open with the OUHT is around outpatient communication. GPs have regularly reported back on the poor response times of outpatient communication which could lead to a patient not getting optimal care.	The OUHT are rolling out electronic communication within specialities and has drawn up a plan for the order in which specialties will have electronic communication. Eventually, it is expected that all specialties will have electronic communication. The benefit of this will be that communication will be auditable and can be measured on a regular basis as well as being a more efficient process.	Regular updates provided via contract review meeting
Management of test results			The OUHT undertake over 110,000 investigations each week with the vast majority been managed efficiently and effectively; however the CCG have concerns about the administration of this process in a small number of cases due to a small number of SIRIs and GP feedback. These incidents highlighted that clinicians have failed to follow up results or inform the patient's registered GP of the result where clinically appropriate. The OUHT have acknowledged that this represented a patient safety risk and a paper was presented to the Trust's Clinical Governance Committee in June setting out the issues.	Following discussions with the provider, an action plan was requested as to how test results will be managed appropriately. Following further discussion with the Trust, it was agreed the action plan would be submitted to the CCG in December, however the action plan remains outstanding and it is on this basis the CCG is issuing a Contract Query Notice.	
Serious Incidents			Since the last report to the Governing Body, there have been four Never Events reported by the OUHT. Two of the Never Events relate to retained foreign objects post operation. In both instances a guide wire was retained; one was following a line insertion and one following a cardiac procedure. One of the Never Events related to a wrong site surgery and the other Never Event related to a misplaced nasogastric tube.	Each Never Event is being investigated individually and a report is expected by the CCG by the beginning of March 2015. The CCG and NHS England Area Team will both need to be assured that there will not be any further occurrences before these incident investigations can be closed. OCCG have escalated their concern to the Medical Director at the OUHT via the Quality Review Group.	March 2015

			Context	Action	Expected resolution date
National Audit of Schizophrenia (NAS) 2014			Participating in NAS enables clinicians who treat people with schizophrenia in the community to assess the quality of their prescribing of antipsychotic drugs and of their monitoring of patient's physical health. It also supports them to monitor patient experience of treatment and its outcome plus carers satisfaction with information and support. The survey results from the patient experience has shown some positive results with 88% of respondents satisfied with the care received and a high proportion having physical health checks (weight, blood pressure and blood tests). There were areas for improvement including 45% not having Cognitive Behavioural Therapy treatment and only 70% knew the name of their key worker.	The areas for improvement reflect similar feedback received from the more recent annual national mental health service user survey covering a sample of all adult and older people being seen in the trust. Similar areas include: involving patients in agreeing care to be delivered, who to contact outside 9am – 5pm if you have a crisis, involved in decisions about medicines, support with finding help to get work and involvement of family members. Over the next year the Trust is undertaking work to improve information on their website for patients and carers, physical healthcare and family (as well as patients) involvement in care.	Jan 2016
Sentinel Stroke National Audit Programme (SSNAP)			The SSNAP aims to improve the quality of stroke care by auditing stroke services against evidence based standards, and national and local benchmarks. The most recent results for July – September 2014 has been published. There has been an improvement in the results for the JR. Examples include the proportion of patients that had a swallow assessment within 72 hours of admission going from 78% to 94%. The proportion of patients assessed by a speech and language therapist also increased from 26% to 58%.	OCCG will alter the key performance indicators within the contract with the OUHT so that the standards are tighter and in line with the stroke audit and NICE quality standards. This will allow the CCG to receive information in a timelier manner rather than having to wait for this information. The CCG will continue to work with the OUHT and NHS England to enhance existing care pathways where possible.	April 2015

			Context	Action	Expected resolution date
Pedometer Accelerometer Consultation Evaluation-Lift			The Pedometer Accelerometer Consultation Evaluation (PACE)-Lift trial was carried out in one Oxfordshire and two Berkshire practices. 148 60-75 year old patients were split into two groups. Both groups wore devices to measure their physical activity. One group received exercise advice from trained practice nurses. After a year, the group who received the advice was still taking 8% more steps a day and were active for 40 minutes a week more than the group who did not.	The PACE-lift trial showed that a combination of practice nurse time, pedometers and accelerometers can get older people to walk more and to walk a bit faster. The increase in moderate intensity physical activity is important for long-term health benefits.	Trial completed
Friends and Family Test	OUHT Inpatient = 95% A&E = 76%				
	RBFT Inpatient = 98% A&E = 90%				

Blue Font – Indicates an indicators included in the NHS England Assurance Framework.

Direction of travel: a down pointing arrow indicates a reduction in count/% . The colour refers to the position in relation to performance target, e.g. a down pointing red arrow indicates performance below target and worsening.
A black arrow indicates direction of travel where no performance target has been set.

Indicates an area where no measure exists this month and/or performance meets target: commentary is not necessary.

Annex A: Planned Care Assurance Briefing – January 2015

The overall RTT (referral to treatment) target is being met for incomplete pathways. The Trust is still managing the admitted and non-admitted pathway failure in accordance with its agreement with the Trust Development Agency.

Underlying Causes of Performance Failure

Performance against the admitted standard deteriorated in October 2013 and the non-admitted standard in January 2014.

The key reasons underlying the performance failures at specialty level which resulted in the Trust missing the admitted and non-admitted standards were:

- Across all services there was a significant increase in activity with elective episodes out turning at 108,132 compared to 97,701 in 2012/13 an 11% increase.
- Admitted performance in Orthopaedics was averaging 96% against the 90% standard until December 2013. The validation process on incomplete pathways then identified significant 'real' patients who would need surgery and had already exceeded the 18 week standard. Performance dropped to 80% in January 2014 and for the subsequent three months reduced to 75%, 65% and 60% respectively. Data validation has identified that there are 1,615 patients on the waiting list of which 701 patients are undated and 607 have waited over 18 weeks.
- High levels of emergency activity caused a loss of elective Neurosurgery capacity resulting in performance dropping below the 90% standard.
- Increase in spinal referrals and insufficient capacity to cope with high complexity surgery. Inpatient waiting list is 236 patients with 203 patients undated and 142 waiting over 18 weeks.
- Closure of JR 2 theatres 9 and 10 and inability to reinstate total lost capacity of 20 sessions per week despite reconfiguration in the Churchill and West Wing theatres.

Actions implemented from December 2013

- Weekly waiting list review meeting with Director of Clinical Services monitoring movement in the inpatient/day case, outpatient and incomplete PTL and agreeing actions to reduce the backlog.
- Contracts in place with the Nuffield (Manor, Oxford), Medinet (in Oxford) and Circle (Reading) to treat patients in key specialties.
- Additional in house lists operational during weekends across all sites.
- 'C' Ward at the NOC opened (2nd June) to provide additional bed capacity (10 beds) resulting in increased weekend operating.
- Spinal referrals from outside Thames Valley suspended.
- NHS contracts in place with Swindon and the National Orthopaedic Hospital (Stanmore).
- Stage 1 of Outpatient Capacity Project complete in June 2014.
- Prioritisation of over 18 week patients to clear 'backlog'.

National 'Backlog Clearance' Initiative June 2014

- An indicative activity plan to support backlog clearance was agreed taking account of patient need and choice. All activity will be managed within a fixed sum of £3.1m for OCCG registered patients and waiting 12 weeks or more. The plan is based on consolidation of December 2013 actions.
- The number of clock stops during August 2014 was below the anticipated level due to patient choice and staff capacity. Further national guidance was released in September which gave Trusts the opportunity to continue with backlog clearance plans until end November 2014 acknowledging that targets would not be met.

The Trust and OCCG agreed that October & November 2014 backlog plans would focus on patients waiting the longest. There was therefore a planned and expected fail in October and November agreed between TDA and OCCG.

- The Trust is confident that they will meet the RTT 18 week targets in December 2014.

January 2015

- December figures will be reported week beginning 26th January 2015 at which it is hoped the target will have been met, however the unprecedented demand in Urgent Care has had unintended consequences for planned care capacity.

52 Week waiters

November data shows 28 patients as having waited longer than 52 weeks for treatment, 15 of them are Oxfordshire CCG patients. As described in the above initiative for October and November 2014, patients who have waited the longest will be treated first. The Trust have an internal ambition to clear these patients as soon as possible and believe this will be January 2015, OUHT have formally committed to having zero people waiting 52+ weeks by the end of March 2015.

Specialty Name	TCI Date	Comments	CCG	Report As
Plastic Surgery	20/11/2014	Clock stopped November	NHS CHILTERN CCG	Admitted
Physiotherapy		POAC 11.12.14, awaiting TCI at JR	NHS MILTON KEYNES CCG	Incomplete
Spinal Surgery Service	04/11/2014	Clock stopped November	NHS NENE CCG	Admitted
Ophthalmology	13/11/2014	Clock stopped November	NHS NENE CCG	Admitted
Spinal Surgery Service	29/01/2015	POAC 02.12.14, has a TCI January at JR	NHS NENE CCG	Incomplete
Spinal Surgery Service	N/A	Clock stopped November	NHS OXFORDSHIRE CCG	Non-Admitted
Ophthalmology	N/A	Clock stopped November	NHS OXFORDSHIRE CCG	Non-Admitted
Spinal Surgery Service	N/A	Clock stopped November	NHS OXFORDSHIRE CCG	Non-Admitted
Physiotherapy	N/A	Clock stopped November	NHS OXFORDSHIRE CCG	Non-Admitted
Plastic Surgery	07/11/2014	Clock stopped November	NHS OXFORDSHIRE CCG	Admitted
Ophthalmology	29/11/2014	Clock stopped November	NHS OXFORDSHIRE CCG	Admitted
Plastic Surgery	18/11/2014	Clock stopped November	NHS OXFORDSHIRE CCG	Admitted
Spinal Surgery Service	17/11/2014	Clock stopped November	NHS OXFORDSHIRE CCG	Admitted
Spinal Surgery Service	19/12/2014	POAC 20.11.14, has a TCI December at NOC	NHS OXFORDSHIRE CCG	Incomplete
Spinal Surgery Service	08/12/2014	Admitted December	NHS OXFORDSHIRE CCG	Incomplete
Spinal Surgery Service	18/12/2014	POAC 20.10.14, TCI cancelled 21.11.14, has a TCI December at JR	NHS OXFORDSHIRE CCG	Incomplete
Maxillofacial Surgery	05/12/2014	Admitted December	NHS OXFORDSHIRE CCG	Incomplete
Spinal Surgery Service	N/A	Clock stopped 03.12.14 at FU appt, discharged	NHS OXFORDSHIRE CCG	Incomplete
Spinal Surgery Service		Last seen July 14, sent for diagnostic nerve root block. Follow-up appt booked 30.01.15	NHS OXFORDSHIRE CCG	Incomplete

Specialty Name	TCI Date	Comments	CCG	Report As
Spinal Surgery Service	N/A	Clock stopped 16.12.14 at FU appt, discharged	NHS OXFORDSHIRE CCG	Incomplete
Spinal Surgery Service	19/01/2015	POAC 25.11.14, has a TCI January at NOC	NHS SLOUGH CCG	Incomplete
Plastic Surgery	15/11/2014	Clock stopped November	NHS SWINDON CCG	Admitted
Plastic Surgery	15/11/2014	Clock stopped November	NHS WOKINGHAM CCG	Admitted
Plastic Surgery	17/11/2014	Clock stopped November	NHS WOKINGHAM CCG	Admitted
Plastic Surgery	07/11/2014	Clock stopped November	NHS WOKINGHAM CCG	Admitted
Paediatric Plastic	20/11/2014	Clock stopped November	WESSEX AREA TEAM	Admitted
Neurosurgery	11/11/2014	Clock stopped November	WESSEX AREA TEAM	Admitted
Paediatric Plastic Surgery	21/11/2014	Clock stopped November	WESSEX AREA TEAM	Admitted

Cancer Targets

Monthly performance trends are under review and show inconsistent results. The CCG is supporting progress on the 2 week standard (and benefits to all cancer pathways) by mandating the use of the proformas in primary care which prompts the discussion with patients they are on the two week pathways and ensure that all relevant diagnostics results are included.

Cancer performance is discussed bi-weekly at the OCCG Internal Contract Oversight (ICO) Meeting. This is a multidisciplinary meeting of OCCG and CSU contract leads and senior management from quality, information's, provider performance and finance to review and agree actions of receipt of performance, activity and finance data.

OUHT has assured the OCCG that cancer breaches have the attention of the highest level within the trust. Each tumour site has met with the Cancer Management Team to ensure focus to improving performance over the coming months. The Lung, Lower GI and Urology Teams are meeting with Paul Brennan and the Cancer Management Team within the next two weeks. The OUHT continue to work with the action plans submitted, the current pressures remain the underlying causes previously cited.

The main reasons for breaches have typically been due to:

- Patient choice,
- Diagnostic delay/ multiple tests being required,
- Administrative delays.

The failure of the 62 day target relates to 3 main areas - Urology, Lung and Lower GI of which there are 3 x action plans in place. These have been scrutinised by the CCG at the request of the Governing Body. For 2 week waits the focus is on the outcomes of the GP referral audit and implementation of the recommendations. Expect to meet targets by January 2015, reported March 2015.

Philippa Mardon
Interim Programme Manager Planned Care
January 2015

Annex B: Oxfordshire Urgent Care Assurance Briefing – Jan 2015

Introduction:

Oxfordshire Clinical Commissioning Group (OCCG) has made steady progress over the last 3 months, to address system-wide challenges with achieving the 95% A&E target and reducing delayed transfers of care (DToC). Since September 2015, the Oxfordshire constituent health and social care partners have collaborated on:

- improving system leadership and governance through the development of the System Leadership Group (SLG) and reinvigorating the Systems Resilience Group (SRG), including agreement to address as a priority 3 primary system risks:
    - System leadership,
    - DToC,
    - Escalation.
- developing and implementing a plan to respond to the ECIST recommendations to improve the system,
- the development of a whole-system DToC plan and establishment of the DToC steering group,
- implementation of the 'Choice and Equity' policy to support patients and their relatives when care moves on from a hospital setting,
- a whole-system approach to escalation which has included the establishment of COBRA – an escalation teleconference involving operational leads and executive directors from all Oxfordshire statutory organisations, and
- Implementation of the operational resilience capacity plan (ORCP) recognising the need for a 'mid-season' evaluation and potential reassignment of resources in the plan to ensure optimum benefits.

Despite the above measures being enacted, quarter 3 performance has dipped. Whole system consensus suggests that this is in part due to unprecedented demand from older, frail individuals suffering with respiratory illnesses, and/or sepsis-type exacerbations. In addition planned building works in the emergency assessment unit (EAU) at the John Radcliffe Hospital, has reduced capacity by 6-8 patient clinical spaces which would usually serve 18 patients per day. These works will increase capacity and the new AEU will resume full function by the 26th January. The DToC levels peaked in the first week in January. The top 3 reasons for this were attributable to (in ascending order):

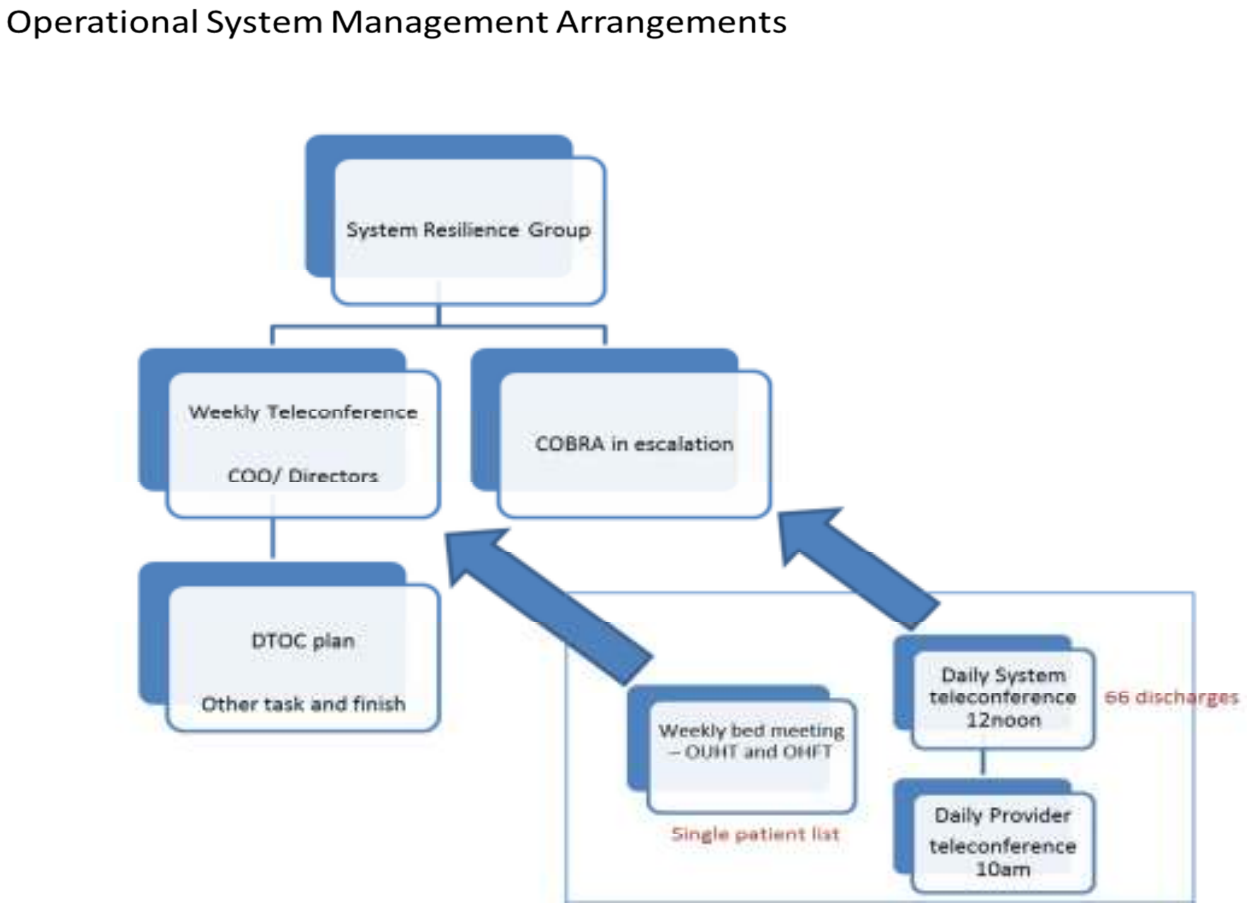
1. Under capacity in bed-based NHS care, not intermediate care,
2. Under capacity in care packages in patient own home – predominantly reablement,
3. Under capacity in health related assessments.

This narrative offers a further analysis of performance across Oxfordshire and will cover:

1. Governance.
2. Diagnosis of the Drivers for Current Performance.
3. Implementing Key Metrics.
4. Escalation arrangements.
5. Whole-system vision and strategy for urgent and emergency care.

1. Governance

The Chief Executives, under the leadership of David Smith have reinforced system leadership through the development of the System Leaders Group. This group involves the CEOs for all the statutory health and social agencies in Oxfordshire and PML (Principle Medical Limited) representing primary care. This initiative together with experiential learning from COBRA has generated the need to revise the meetings structure, to ensure that all whole-system functions including governance, operational decisions linked to escalation, and transformational workstreams are effectively conducted with the right membership and powers of delegation.



The development of revised governance arrangements are underway, with the emphasis on changing the "Daily System Resilience Teleconference" which happens at 12:00, to have a more focused, proactive action led discussion using real-time data as evidence to make improvements with flow in the system. In addition the system is seeking to combine the 'medically-fit for discharge' meetings into one weekly meeting, accompanied by a single DToC patient register. The new governance arrangements are likely to

transfer the transformational functions of the weekly Urgent Care Summit (UCS) meeting to workstream task and finish groups, while operational issues will be addressed via the teleconference and the 'medically-fit for discharge' meetings. This is likely to make the current format of the UCS redundant.

2. Current Performance.

Anecdotally all partners agree that the system has coped well with the unprecedented demands for urgent care in recent weeks. Despite this, achievement of the 95% A&E target has proved challenging, also reflecting as an issue across many other providers nationally. DToC also peaked at 200 in the first week of January.

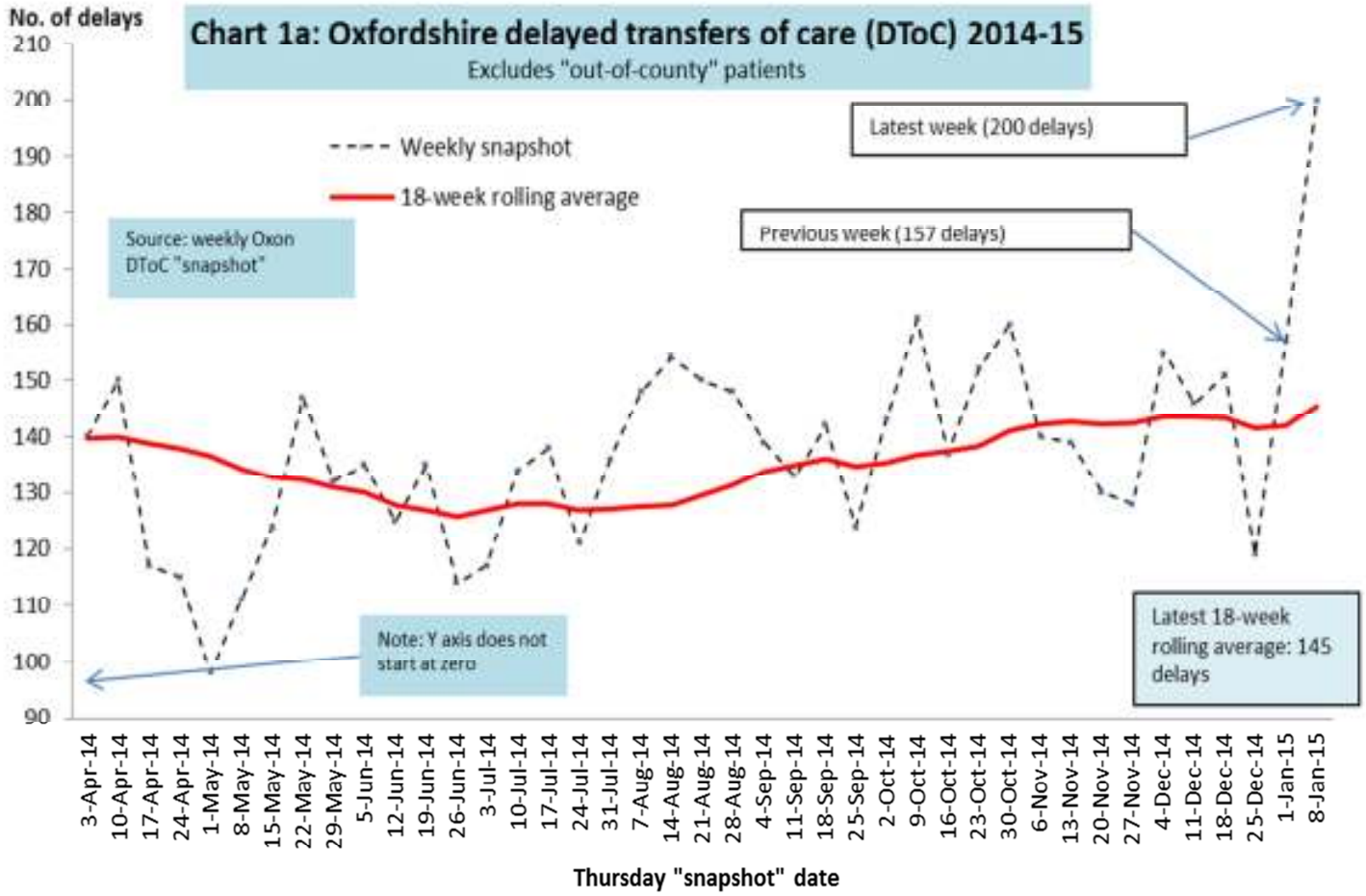
Table 1 sets out comparative performance improvement between November and December 2014.

Table 1:

Measure	Performance Improvement
Ambulance Response Time – Category A8 Red1	3% increase
Ambulance Handover – JR	2.5% increase
DTOC: from hospital per 100,000 population	1% reduction
DTOC: Reduction in days lost to delayed transfers that are the responsibility of Social Care	1% reduction
NELs: Avoidable emergency admissions	13% reduction

As noted previously there are 3 main issues facing system escalation over the last two weeks. A snapshot assessment conducted the week ending 8th January 2015, concluded that out of 158 delays: 51 were attributable to under capacity in non-acute NHS bed based care; 38 were attributable to lack of reablement provision; and 27 were attributable to NHS related assessment processes. These issues will be at the forefront of the DToC plan and associated KPIs.

DToC



The Oxfordshire Delayed Transfer of Care (DToC) Plan 2015/16 sets out the priority goals, objectives and actions that will be delivered to improve the system over the coming year. The plan has been developed as a whole-system entity based on the main reported reasons for delay. Compilation of the plan follows 3 multi-agency workshops and a feedback session with the Urgent Care Summit during November 2014. The plan has incorporated the outcomes of the review conducted by the Emergency Care Intensive Support Team (ECIST) undertaken in September 2014 and will become a significant element of the emerging whole-system vision and strategy for urgent and emergency care.

The workshops have explored the underlying reasons for the delays and considered how constraints in the system could be mitigated. There were 4 overwhelming messages which if overcome, could have the potential to dramatically improve the DToC position in Oxfordshire:

- Earlier engagement of patients and their families in transfer of care options,

- Improve the timeliness and efficiency of the assessment pathway particularly for frail, older people (including continuing health care assessments).
- Become less 'risk averse' as a health/social care system thereby increasing the proportion of patients considered suitable for reablement.
- Develop a broader perspective of what constitutes the whole-system thus bringing the independent care and residential provider sector alongside statutory agencies.

The plan pulls together a comprehensive set of actions against each of the main reasons for delay in transfer of care. Within these, there are six priority objectives for improving patient care during 2015/16 correlating with the 4 primary outcomes from the workshops. These include:

- Full implementation of the joint Choice Policy.
- To bring about an increase the proportion of people who access reablement by default including a rise in uptake direct from the community.
- The development of an acute/community single assessment process for frail older people, with single documentation and consistent clinical assessment standards which are accepted by the onward step of the pathway.
- Taking steps to improve market management of independent care and residential agencies, and ensuring the risks and pressures that face this industry are understood as part of the whole system in Oxfordshire.
- The development of a homeless discharge pathway working with key homeless charities in Oxfordshire.
- The development of a housing assessment pathway to ensure that an individual's housing needs are considered as early as possible, preferable before deterioration and an emergency admission are inevitable.

The DToC steering group will report progress against the plan to the SRG quarterly and by exception should any extraordinary issue arise. A number of new key performance indicators (KPIs) are indicated in the plan and these will be incorporated into the SRG dashboard.

ORCP

Table 2 sets out the current mobilisation status for the all ORCP schemes. The progress and performance of the schemes has been mixed, with the result that a 'mid-season' evaluation is to be conducted to ensure optimal use of resources. Additional bed capacity has been secured for care and nursing homes as part of the second tranche of monies.

Table 2:

Scheme	Description	Status
SCAS4	HALO	LIVE
SCAS8	SOS BUS	LIVE
SCAS9	SCAS Primary care capacity	LIVE
SCAS11	PTS for EMU's	LIVE
OH3	GP support for 999	LIVE
OH8	Extended MIU opening	LIVE
OH11	Urgent response; locality teams to ED	LIVE
OUH1	Additional beds	Partially live
OUH2	HCAs in ED	LIVE
OUH3	ED consultant rota	LIVE
OUH4	Extended consultant and therapy support to Peads	LIVE
OUH5	Extended GP hours in ED	Partially live
OUH6	Dedicated Portering	LIVE
OUH7	Surgical Specialities inpatient unit extended opening	LIVE
OUH8	Pharmacy technicians on medical wards	LIVE
OUH9	Discharge Lounge	LIVE
OUH10	Additional PTS	LIVE
OUH11	SHDS expansion	LIVE
OUH12	Extended Pharmacy working	LIVE
OUH13	Endoscopy capacity	LIVE
OUH14	Increased medical surgery	LIVE
OUH15	Echo Cardiology extended	LIVE
OCC1	7 day working A&E and EMU	Partially live
OCC2	Discharge to assess	LIVE
OCC3	Dom care subsidies	LIVE
OCC4	Care Home subsidies	LIVE
OCC5	Reduction in choice delays	LIVE
OCC6	Additional dom care capacity	LIVE
OCC7	Increased crisis support	Partially live

3. Implementing Key Metrics

The SRG is developing a suite of KPIs which are reported through the SRG dashboard. Currently this focuses on national metrics and KPIs developed to support performance monitoring of the ORCP. The DToC steering group is in the process of compiling additional KPIs which will become part of the SRG dashboard. Similarly the Better Care Fund schemes will also be monitored via metrics within the dashboard. The dashboard will become the means of focus for all transformational programmes across the health/social care economy.

In addition daily operational metrics are required to support operational teams understand the pressures in the system and manage flow every day. These are an important feature of the 12 noon teleconference and will include performance against the '66/day discharges'. The breakdown of these discharges is as follows:

- 38 OUH home without support
- 10 OH community bed (TBC)
- 10 OCC nursing home, social care at home, restart packages
- 8 OUH/OH reablement and Supported Hospital Discharge Service.

4. Escalation Arrangements

Over the last 6 weeks the system has collaborated on the development of escalation arrangements. This follows recommendations from ECIST and an inter-agency workshop held in November 2014. COBRA has been established as a result of this work, and gaps in 'business as usual' capacity identified by all partners. Next steps are the formation of a joint 'policy' which will be submitted to the SRG for approval in February, together with an implementation plan which will be monitored through SRG.

In addition a workstream to develop the care pathway for out of hours and primary care escalation has been established. This work will be incorporated into the Prime Ministers Challenge Fund bid as well as appearing in the escalation plan.

5. Whole-system vision and strategy for urgent and emergency care.

The vision and strategy for urgent and emergency care approach is built around 6 key design principles:

1. Integration of services overcoming organisational and sector boundaries.
2. Enhancing self-care management.
3. Rapid access to community/primary care based urgent care 24/7.
4. Care closer to home.
5. Ambulatory Emergency Care.
6. Reducing delayed transfers of care

The strategy will provide a transformational approach to improvement, pulling together the Better care Fund (BCF) initiatives, with the DToC plan and escalation improvement. The plan is due to be received by the SRG in February 2015.

The Oxfordshire health and social care community are awaiting the outcome of the BCF submission, which is integral to Oxfordshire's strategy for transforming the system. In essence the 11 schemes designed in the plan are as follows:

New schemes:
DToC Plan.
Ambulatory Emergency Care.
Integrated Neighbourhood Teams.
Care closer to home – Advanced care plans EoLC and proactive medical support to care homes.

Expansion of existing:
Expansion of EMUs.
Expansion of reablement services.
Expansion of Hospital at Home.

Existing schemes:
Oxfordshire care summary.
Protecting adult social care.
Care Act implementation.
Carers breaks.

It is anticipated that the 11 schemes will be complemented by further work to develop primary care. The BCF fund will be managed via the pooled budget arrangement, with transformational progress monitored via the SRG, and financial management monitored via the Older People's Joint Management Committee.

Shereen Bayat, Commissioning Manager.

Alison Edgington, Interim Deputy Director of Delivery and Localities.

19.01.15