

Trust Board Performance Report – M12 FY17

Introduction

This report provides an update to the Oxford Health NHS Foundation Trust Board on National and local contractual performance, specifically;

- National**

The NHS Improvement (NHSI) **Single Oversight Framework (SOF)** which was implemented on 1 October 2016 and replaces Monitor's Risk Assessment Framework. The framework follows five themes which are linked but not identical to those of the Care Quality Commission (CQC). By focussing on these five themes NHSI will support providers to attain and/or maintain a CQC 'good' or 'outstanding' rating.

- Local**

Contractual performance; the Trust is commissioned to provide a range of services across the 3 clinical directorates;

- Children and Young Peoples Directorate (CYP)
- Older Peoples Directorate (OPD)
- Adults of Working Age Directorate (AWA)

This report provides a summary by directorate of operational performance against the key performance and quality indicators, as specified within schedule 4 of the Trust's income contracts.

Performance Scorecard

High level overview

Targets/thresholds are applicable to most indicators. Where there is no target/threshold, the indicator is considered compliant if it is reported.

93% of indicators were achieved in month 12 FY17

Key:	Well Below Target >10%	Below Target </=6-10%	Near Target </=-5%	At Target	Exceeded Target	No data/ Target /not due
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Total	46	18	29	1112	47	7
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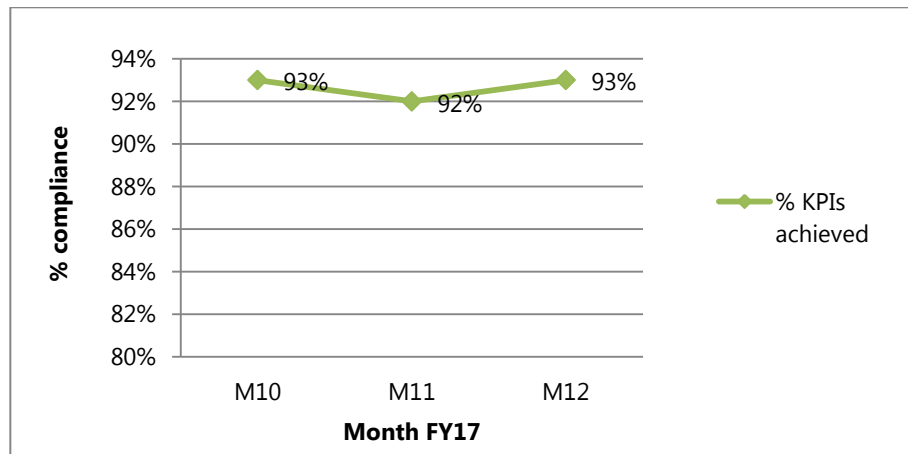
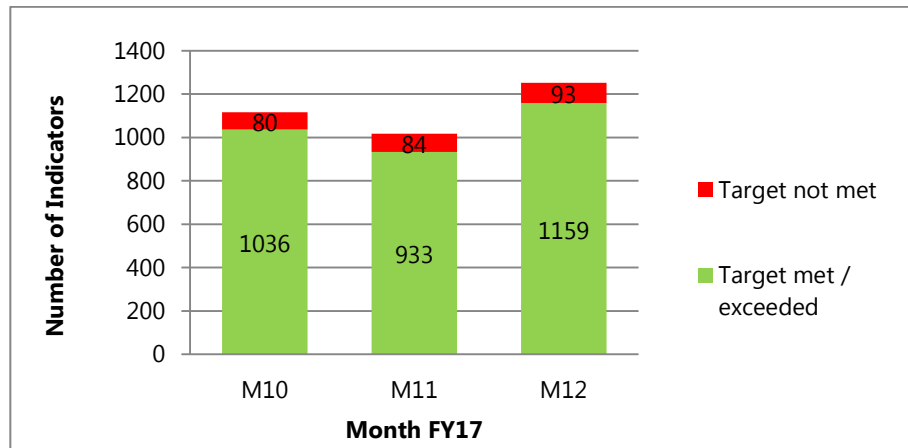
National (SOF)	4	0	1	7	8	7
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Local (Contractual) - see below	42	18	28	1105	39	-
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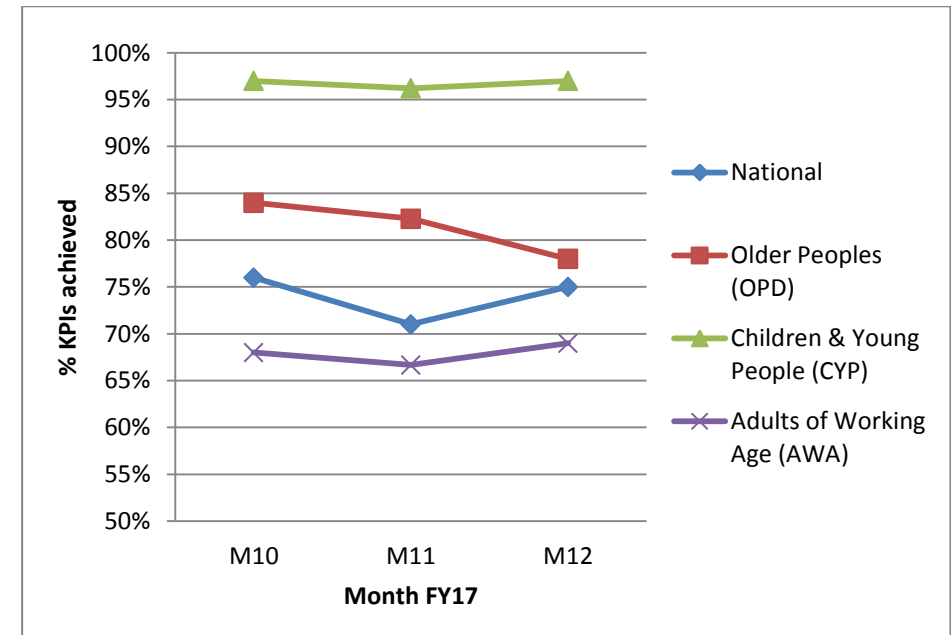
Older Peoples (OPD)	13	0	7	69	1	78%
Oxfordshire	12	0	7	38	1	67%
Buckinghamshire	1	0	0	28	3	97%
Children & Young People (CYP)	11	9	14	974	24	97%
Oxfordshire	4	5	3	534	20	95%
Buckinghamshire	0	0	1	211	0	99%
Swindon, Wilts and Banes	7	4	10	229	4	92%
Adults of Working Age (AWA)	18	9	7	62	14	69%
Oxfordshire	6	5	2	22	7	69%
Buckinghamshire	8	2	5	14	7	58%
Forensic	4	2	0	26	0	81%

Performance Trend

The number of reportable indicators varies each month. In month 12; 1,252 indicators were reportable of which 93% were achieved. Despite the fluctuating numbers of indicators the % level of compliance has remained stable over the past 3 months at 92/93% as illustrated below;



The National (SOF) and Directorate (local contractual) performance trend is illustrated below. Whilst the Older People's Directorate (OPD) trend has declined slightly in month 12, this relates to a small number of indicators (7) that are within 5% of the required target/threshold. Overall directorate compliance over the past 3 months remains high at an average of 81%.



NATIONAL: Single Oversight Framework – M12 FY17

Introduction

NHS Improvement (NHSI) implemented the Single Oversight Framework (SOF) on 1 October 2016 and this replaces Monitor’s Risk Assessment Framework. The framework follows five themes:

- Quality of Care (safe, effective, caring and responsive)
- Finance and use of resources
- Operational Performance
- Strategic change
- Leadership and improvement capability (well led)

The five themes are linked but not identical to those of the Care Quality Commission (CQC). The CQCs questions do not yet incorporate use of resources.

By focussing on these five themes NHSI will support providers to attain and/or maintain a CQC ‘good’ or ‘outstanding’ rating and to identify where providers may benefit from, or require improvement support across a range of areas.

This report focusses on the Quality and Operational Indicators. Although important in the overall framework, NHSI do not consider these to be priority metrics. These metrics will be used by Regional Teams as part of a suite of information to take a broader view of performance. For monitoring purposes they will not have thresholds attached to them (unless indicated) and therefore any small change in performance would not change Trust segmentation.

In the majority of cases NHSI will be sourcing Trust performance data from publicly available sources e.g. CQC, NHS Digital, NHS England, Unify. Oxford Health NHS Foundation Trust (OHFT) will no longer be required to directly submit data nationally for performance management.

March Performance Summary

The majority of the indicators do not have targets/thresholds. To provide a sense of Trust performance, where information is available the published performance has been set against the overall position for England.

Of the 28 indicators, 21 have been reported on. Current performance is 71.4%.

Key:	Well Below Target >10%	Below Target </=6-10%	Near Target </=-5%	At Target	Exceeded Target	No data/Target /not due
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Performance as at latest available published data						
Organisational Indicators	1		1	2	2	4
MH Quality Indicators	3			2	1	1
Community Quality Indicators				1		1
Operational Performance	1			2	5	1
Total	4	0	1	7	8	7

R Red Indicators

Area	Ref	Measure	Target	Actual	Trend	Narrative
Organisational	2	Staff turnover	<12%	14.6%	<p>Staff Turnover Internal</p>	In February, internally OHFT reported turnover as 14.6% (12 month position) which is 22% above the Trusts internal target of 12%. The single biggest reason given for staff leaving the Trust or moving internally is promotion/better prospects. National data has been identified and is currently being worked through to understand the calculations used and identify and understand any differences.
Mental Health	12	Mental Health Friends and Family Test - % positive	England Average 87.7%	79.2%	<p>Mental Health scored from Friends & Family Test - % positive NHS England</p>	Performance in February decreased by 2.1% on the January position and is the fourth month below the national average. This position is being investigated.
Mental Health	15	% of clients in settled accommodation	England Average 58.3%	49.1%	<p>% clients in settled accommodation NHS Digital Note: NHSD only publish pts 18 - 69 on CPA for % in accommodation</p>	There was an increase of 1.1% in performance between November and December. The Information Team continue to work with Advanced Healthcare to ensure the completeness of the Mental Health Services Data Set (MHSDS) submission.

Operational	23 b	Priority Metric % coded (Ethnicity, Employment (Adults only), Accommodation (Adults only),	85%	36.9%	<p style="text-align: center;">Priority metric (Ethnicity, Employment (Adults only), Accommodation (Adult only)) NHS Digital</p> <table border="1"> <caption>Approximate data from the line graph</caption> <thead> <tr> <th>Month</th> <th>OHFT (%)</th> <th>Target (%)</th> <th>England (%)</th> </tr> </thead> <tbody> <tr><td>Apr-15</td><td>48</td><td>85</td><td>55</td></tr> <tr><td>May-15</td><td>48</td><td>85</td><td>55</td></tr> <tr><td>Jun-15</td><td>45</td><td>85</td><td>55</td></tr> <tr><td>Jul-15</td><td>42</td><td>85</td><td>55</td></tr> <tr><td>Aug-15</td><td>40</td><td>85</td><td>55</td></tr> <tr><td>Sep-15</td><td>38</td><td>85</td><td>55</td></tr> <tr><td>Oct-15</td><td>35</td><td>85</td><td>55</td></tr> <tr><td>Nov-15</td><td>35</td><td>85</td><td>55</td></tr> <tr><td>Dec-15</td><td>35</td><td>85</td><td>40</td></tr> <tr><td>Jan-16</td><td>35</td><td>85</td><td>40</td></tr> <tr><td>Feb-16</td><td>35</td><td>85</td><td>40</td></tr> <tr><td>Mar-16</td><td>35</td><td>85</td><td>45</td></tr> <tr><td>Apr-16</td><td>35</td><td>85</td><td>45</td></tr> <tr><td>May-16</td><td>38</td><td>85</td><td>45</td></tr> <tr><td>Jun-16</td><td>38</td><td>85</td><td>45</td></tr> <tr><td>Jul-16</td><td>40</td><td>85</td><td>45</td></tr> <tr><td>Aug-16</td><td>38</td><td>85</td><td>45</td></tr> <tr><td>Sep-16</td><td>38</td><td>85</td><td>45</td></tr> <tr><td>Oct-16</td><td>38</td><td>85</td><td>45</td></tr> <tr><td>Nov-16</td><td>36.9</td><td>85</td><td>50</td></tr> </tbody> </table>	Month	OHFT (%)	Target (%)	England (%)	Apr-15	48	85	55	May-15	48	85	55	Jun-15	45	85	55	Jul-15	42	85	55	Aug-15	40	85	55	Sep-15	38	85	55	Oct-15	35	85	55	Nov-15	35	85	55	Dec-15	35	85	40	Jan-16	35	85	40	Feb-16	35	85	40	Mar-16	35	85	45	Apr-16	35	85	45	May-16	38	85	45	Jun-16	38	85	45	Jul-16	40	85	45	Aug-16	38	85	45	Sep-16	38	85	45	Oct-16	38	85	45	Nov-16	36.9	85	50	<p>This metric is measuring data completeness for the three data items detailed above.</p> <p>Performance increased by 0.6% between November and December. The England average has been included on the graph for an illustration of how the rest of the country is performing. The Information Team continue to work with Advanced Healthcare to ensure the completeness of the MHSDS submission.</p>
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LOCAL: Older People's Directorate – Month 12 FY17

The Community and Mental Health Services **Contracts** with Oxfordshire and Buckinghamshire CCGs stipulate a requirement (within Schedule 4) for the **Older People's Directorate (OPD)** to perform against a set of quality and performance indicators. The 2016/17 indicators were recently agreed and are reportable from month 6.

In total there are **104 indicators** for 2016/17 applicable to OPD (excluding the 4 Trust-wide operational standards; 58 indicators relating to the contract with Oxfordshire CCG and 23 indicators relating to **each** of the contracts with Buckinghamshire (Aylesbury and Chiltern CCGs). The indicators are categorised as follows.

Oxfordshire:

- **National Quality Requirements (NQRs):** 11 indicators
10 are reportable monthly. 1 is reportable quarterly
- **Local Quality Requirements (LQRs):** 17 indicators
All are reportable monthly
- **Community Services:** 20 indicators
15 are reportable monthly, and 5 are reportable quarterly (1 of which is reportable from M8 only)
- **Older People's Mental Health:** 10 indicators
6 are reportable monthly. 4 are reportable quarterly

Buckinghamshire:

- **Aylesbury and Chiltern:** 23 indicators per contract
18 are reportable monthly (1 longstop, 1 not reported) = 16
2 quarterly (both longstop) = 0
2 bi-annually (1 longstop, 1 reported elsewhere) = 0

Contractual Performance Scorecard

The Older People's Directorate was required to report against 90 indicators in month 12. Targets/thresholds are applicable to most indicators. Where there is no target/threshold, the indicator is considered compliant if it is reported.

78% of indicators were achieved;

Key:	Well Below Target >10% (</> activity)	Below Target </=6-10%	Near Target </=-5%	At Target	Exceeded Target
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						% met
Total (90)	13	0	7	69	1	78%
Oxfordshire						
NQRs (11)	4	0	0	7	0	64%
LQRs (17)	4	0	3	9	1	59%
Community Services (20)	2	0	3	15	0	75%
OP Mental Health (10)	2 (1nr)	0	1	7	0	70%
Sub-total (58)	12	0	7	38	1	67%

Buckinghamshire						% met
Aylesbury (16)	0	0	0	16	0	100%
Chiltern (16)	1	0	0	15	0	94%

*nr = not reported

Directorate	Tariff	FY IAP	YE Outturn	YE variance
Older People	Block	428,283	430,206	0%
	C&V	127,870	116,743	-9%

R Red Indicators

Service	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale																										
Out of Hours	NQR 10 B8	OOH urgent triage (walk in) - time to triage; <20 mins of arrival	95%	66%	<table border="1"> <caption>OOH urgent triage performance (NQR 10 B8)</caption> <thead> <tr><th>Month</th><th>Performance (%)</th></tr> </thead> <tbody> <tr><td>Apr</td><td>65</td></tr> <tr><td>May</td><td>85</td></tr> <tr><td>June</td><td>80</td></tr> <tr><td>July</td><td>70</td></tr> <tr><td>Aug</td><td>80</td></tr> <tr><td>Sept</td><td>70</td></tr> <tr><td>Oct</td><td>70</td></tr> <tr><td>Nov</td><td>60</td></tr> <tr><td>Dec</td><td>60</td></tr> <tr><td>Jan</td><td>50</td></tr> <tr><td>Feb</td><td>45</td></tr> <tr><td>Mar</td><td>65</td></tr> </tbody> </table>	Month	Performance (%)	Apr	65	May	85	June	80	July	70	Aug	80	Sept	70	Oct	70	Nov	60	Dec	60	Jan	50	Feb	45	Mar	65	Extended waiting time possibly resulting in delayed care	<p>The Trust Executive Board has commissioned an independent review of the OOH service which is due to start soon and will take 2 – 3 months. Alongside this;</p> <p>NQR10 B8 and B9: The service is in the process of recruiting additional staff to support early triage of these patients as required.</p> <p>NQR 12 B10. The service is working with the 111 service to improve availability of appointments. This will increase the opportunity for patients to be seen within the agreed time.</p> <p>NQR 7 B6: There is continued positive recruitment of GPs and Advanced Nurse Practitioners that will enable us to work towards achieving the target.</p>
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Out of Hours	NQR 10 B9	OOH non-urgent triage (walk in) - time to triage ≥ 95% within 60 minutes	95%	81%	<table border="1"> <caption>OOH non-urgent triage performance (NQR 10 B9)</caption> <thead> <tr><th>Month</th><th>Performance (%)</th></tr> </thead> <tbody> <tr><td>Apr</td><td>84</td></tr> <tr><td>May</td><td>85</td></tr> <tr><td>June</td><td>89</td></tr> <tr><td>July</td><td>86</td></tr> <tr><td>Aug</td><td>89</td></tr> <tr><td>Sept</td><td>86</td></tr> <tr><td>Oct</td><td>88</td></tr> <tr><td>Nov</td><td>87</td></tr> <tr><td>Dec</td><td>82</td></tr> <tr><td>Jan</td><td>80</td></tr> <tr><td>Feb</td><td>86</td></tr> <tr><td>Mar</td><td>81</td></tr> </tbody> </table>	Month	Performance (%)	Apr	84	May	85	June	89	July	86	Aug	89	Sept	86	Oct	88	Nov	87	Dec	82	Jan	80	Feb	86	Mar	81		
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Out of Hours	NQR 7 B6	OOH percentage of unfilled shifts; ability to match capacity with demand	2%	9%	<table border="1"> <caption>OOH percentage of unfilled shifts (NQR 7 B6)</caption> <thead> <tr><th>Month</th><th>Performance (%)</th></tr> </thead> <tbody> <tr><td>Apr</td><td>11</td></tr> <tr><td>May</td><td>6</td></tr> <tr><td>June</td><td>11</td></tr> <tr><td>July</td><td>26</td></tr> <tr><td>Aug</td><td>22</td></tr> <tr><td>Sept</td><td>15</td></tr> <tr><td>Oct</td><td>14</td></tr> <tr><td>Nov</td><td>9</td></tr> <tr><td>Dec</td><td>13</td></tr> <tr><td>Jan</td><td>6</td></tr> <tr><td>Feb</td><td>11</td></tr> <tr><td>Mar</td><td>9</td></tr> </tbody> </table>	Month	Performance (%)	Apr	11	May	6	June	11	July	26	Aug	22	Sept	15	Oct	14	Nov	9	Dec	13	Jan	6	Feb	11	Mar	9		
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Out of Hours	NQR 12 B10	OOH urgent F/F base visit appt within 2 hours of triage	95%	83%		Extended waiting time possibly resulting in delayed care	
All For info only	LQR C2c	% Prevent training compliance; a sub KPI of C2; Compliance with PPST	90%	Prevent training 11%		Shortfall in staff skill, knowledge and competency	Prevent is one of 3 courses that forms KPI C2 which has an overall target of 90%. OPD is targeting non-compliant individuals and supporting staff with time to complete training.
Older People's Mental Health (OPMH)	LQR C8	% of interim inpatient discharge letters that are sent back to GPs within 24 hours of discharge	95%	80%		Delayed communication to primary care	OPMH year to date (YTD) performance against this indicator is good at 96%. In March, however, 2 interim discharge summaries were not sent within 24 hours which were attributable to clinical and administrative capacity.
All	LQR C9	% of cancellations by provider services	< /=4%	7%		Poor patient experience, delayed care and poor Trust reputation	The number of provider cancelled appointments increased at the point that Carenotes was implemented indicating a reporting and/or recording issue. This is being investigated by the Business Intelligence (BI) team and directorates and initial findings have indicated issues with the pick lists, the ability to record conflicting data and front end recording practices. This is included in the 17/18 OCCG contract Data Quality Improvement Plan (DQIP)

Comm Hospitals	LQR C11	Delayed Transfers of Care (DTOC); snapshot number	15	59		Delays adversely impact the whole system pathway and patient flow. This will affect the acute trust's ability to admit, ED and beyond	<p>There has been an unprecedented and unrelenting increase in HART delays since Oct, together with reduced social capacity in parts of the county. Of the 59 reported delayed patients at the last snapshot 49% (29) were awaiting HART intervention and 20% awaiting social care intervention. 9 of the 15 delays attributed to health were patient choice and the remaining 6 are waiting for Elderly Mental Illness (EMI)/Nursing Homes (NH) placement, equipment, housing or continuing healthcare assessment. The average DTOC over the past 8 weeks is 57 against the target of 15.</p> <p>Since 1 October the number of beddays lost to DTOC is 8,115 of which 4,487 are attributable to 'both' which includes HART delays. 1,096 are solely attributable to Social Services. This equates financially to £1,054,950, £583,310 and £142,480 respectively based on a bedday cost of £130.</p>
MSK Physio	CS D8b	% patients will wait no longer than 12 weeks to first appointment offered	95%	72%		Extended waits for assessment and treatment, patient dissatisfaction, condition exacerbation	Performance continues to decline following the withdrawal of additional CCG funding in April 2016. The service is endeavouring to manage over activity by way of a reduced new patient to follow up ratio, however this falls below national benchmarking. Referral patterns for more complex referrals (i.e. trauma) have increased which is further exacerbating the capacity issue. The service is currently out to tender. The Trust has submitted an expression of interest and is in dialogue with OCCG.

OA Mental Health	MH H4	People with mild cognitive impairment will have one follow up appointment 6 - 12 months following first assessment	95%	83%		Not applicable	<p>As of 14th Dec 2016 teams have reviewed practice and patients diagnosed with MCI in Clusters 18 and will remain open on caseload to ensure a follow up review appointment takes place between 6 and 12 months.</p> <p>In March, there were two breaches; 1 patient seen under old operational practice of seen and discharged so no review and 1 due to patient cancellation (was seen on 24/03/16 – offered a follow up on 23/03/17- cancelled this and is due to be seen on 13/04/17).</p>
Chiltern Schedule 4 (Bucks)	Pr04iii	Routine (non-emergency) referral to Mental Health Team will be seen within 28 consecutive days for assessment.	95%	81%		Delay in patient receiving care which could lead to harm re: mental & physical health	There are concerns with the accuracy of the report producing these figures this month which is being investigated. Refreshed figures with accompanying narrative will be provided.

LOCAL: Children and Young People – Month 12 FY17

The Community and Mental Health Services Contracts with Oxfordshire, Buckinghamshire, Swindon, Wiltshire and Bath and North East Somerset CCGs stipulate a requirement (within contract Schedule 4) for the **Children and Young Peoples Directorate (CYP)** to perform against a set of quality and performance indicators.

Oxfordshire-Services

- Oxfordshire CAMHS (Oxon CCG)
- SHN (OCC Public Health)
- College Nursing (OCC Public Health)
- IMMS (NHSE)

Buckinghamshire-Services

- Buckinghamshire CAMHS (Bucks LA/CCG)
- Buckinghamshire PS< (Bucks LA/CCG)

Swindon Wilts & BaNES

- Swindon CAMHS (Swindon CCG)
- Wilts & BaNES CAMHS (Wilts & BaNES CCG)
- Wilts T2 (Wilts CC)
- BaNES T2 (BaNES LA/CCG)
- Wiltshire Adult ED (Wilts CCG)

Contractual Performance Scorecard

The Children and Young People's Directorate was required to report against **1032** indicators in month 12 (this excludes IMMS (NHSE) which is not reportable and Dental). Targets/thresholds are only applicable to a **small proportion** of CYP indicators. Where there are no targets/thresholds, the indicator is considered compliant if it is reported.

97% of indicators were achieved:

Key:	Well Below Target >10%	Below Target </=-6-10%	Near Target </=-5%	At Target	Exceeded Target
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Commissioner	Service	Well Below Target >10%	Below Target </=-6-10%	Near Target </=-5% under	At Target	Exceeded Target	% at Target or Above
Total		11	9	14	974	24	97%
Oxfordshire							% Met
Oxon CCG	LQR	1	2		3	2	63%
	Childrens Community Services	1		1		5	71%
	CAMHS - Schedule 4	2	1		1	4	63%
	CAMHS PAF		1	1	72	8	98%
Oxon LA	SHN		1		210		100%
	College				188		100%
	Health Visiting			1	60	1	98%
Buckinghamshire							% Met
Buck CCG/CC	CAMHS PAF				135		100%
Bucks CCG/LA	Bucks SLT			1	76		99%
Swindon Wilts & BaNES							% Met
Swindon CCG	CAMHS PAF	2	1	2	51		91%
Wilts and BaNES CCG	Wilts and BaNES T3	2	2	4	63		89%
BaNES CCG	BaNES T2	2			38		95%
Wilts CC	Wilts T2	1		1	52	2	96%
Wilts	Adult ED		1	3	25	2	87%

R Red Indicators

Service	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale																										
LQR OCCG	C2b	Mental Capacity	90%	74%	<p>— % of relevant staff up-to-date with training. — Target — Trajectory</p> <table border="1"> <caption>Actual Performance Data for Mental Capacity</caption> <thead> <tr> <th>Month</th> <th>% of relevant staff up-to-date with training</th> </tr> </thead> <tbody> <tr><td>Sep-16</td><td>74%</td></tr> <tr><td>Oct-16</td><td>78%</td></tr> <tr><td>Nov-16</td><td>76%</td></tr> <tr><td>Dec-16</td><td>80%</td></tr> <tr><td>Jan-17</td><td>76%</td></tr> <tr><td>Feb-17</td><td>74%</td></tr> <tr><td>Mar-17</td><td>74%</td></tr> </tbody> </table>	Month	% of relevant staff up-to-date with training	Sep-16	74%	Oct-16	78%	Nov-16	76%	Dec-16	80%	Jan-17	76%	Feb-17	74%	Mar-17	74%	Possible failure of staff awareness of the Mental Capacity Act.	Mental Capacity is one of 4 courses that form KPI C2 which has an overall target of 90%. 67/91 staff are compliant. CYP is targeting non-compliant individuals and supporting staff with time to complete training.										
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Children's Services	E1a	LAC Waits	100%	72%	<p>— % of LAC assessments within 20 days — Target — Trajectory</p> <table border="1"> <caption>Actual Performance Data for LAC Waits</caption> <thead> <tr> <th>Month</th> <th>% of LAC assessments within 20 days</th> </tr> </thead> <tbody> <tr><td>April</td><td>95%</td></tr> <tr><td>May</td><td>90%</td></tr> <tr><td>June</td><td>95%</td></tr> <tr><td>July</td><td>95%</td></tr> <tr><td>August</td><td>85%</td></tr> <tr><td>September</td><td>90%</td></tr> <tr><td>October</td><td>90%</td></tr> <tr><td>November</td><td>95%</td></tr> <tr><td>December</td><td>90%</td></tr> <tr><td>January</td><td>90%</td></tr> <tr><td>February</td><td>90%</td></tr> <tr><td>March</td><td>72%</td></tr> </tbody> </table>	Month	% of LAC assessments within 20 days	April	95%	May	90%	June	95%	July	95%	August	85%	September	90%	October	90%	November	95%	December	90%	January	90%	February	90%	March	72%	Extended waiting time possibly resulting in delayed care	During Month 12 performance reduced with only 18/25 referrals being assessed within 20 days. All assessments were completed within 29 days.
Month	% of LAC assessments within 20 days																																
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CAMHS - OCCG	Sch 4	ED Waits	90%	75%	<p>— % of Routine Referrals starting NICE Compliant Treatment within 4 weeks — Target — Trajectory</p>	Extended waiting time possibly resulting in delayed care	<p>Baseline Data was collected during Months 7-9 which was an average of 80% compliance, Month 10-12 is based on this baseline + 10%</p> <p>During Month 12 performance reduced with only 9/12 referrals being seen within 4 weeks. All patients were assessed within 32 days. Action Plan in place with team to address the underperformance.</p>
CAMHS - OCCG	E6aii	ASD Waits	75%	10%	<p>— % of CYP seen within 12 wks — Target — Trajectory</p>	Extended waiting time possibly resulting in delayed care	<p>This indicator is for Non Co morbid ASD Assessments, Discussions with OCCG Commissioners have taken place and the service is currently sub-contracting via the ADHD Centre to help with the demand around ASD and a further 90 referrals have been outsourced to help with the demand. A new service model has been designed and CYP are currently in a tender process for this to commence in 17/18 which should help address the underperformance.</p>
CAMHS Swindon CCG	PAF	T3 Completed Episodes of Care	669	538	<p>— Target — CAMHS Swindon T3 Completed Episodes of Care — Trajectory</p>	No immediate impact	<p>This indicator is currently being reviewed with Swindon Commissioners and the underperformance is consistent with the last 3 years, therefore target is being reviewed.</p>

CAMHS Swindon CCG	PAF	Waiting 4 Weeks	90%	39%		Extended waiting time possibly resulting in delayed care	<p>This issue has been highlighted to the Team through Performance Meetings</p> <p>A new process which has been agreed by commissioners will commence during February patients will need to contact the service to arrange a suitable time to activate the referral. Swindon CAMHS have seen a 46% increase in referrals during 16-17 compared to 15-16.</p>
CAMHS Wilts CCG	PAF	Wilts T3 Waiting 4 Weeks	90%	70%		Extended waiting time possibly resulting in delayed care	<p>Wiltshire CAMHS are achieving 100% for patients assessed within 12 weeks; this data includes patient cancellations and breaches due to patient choice.</p>
CAMHS BaNES CCG	PAF	BaNES T3 Waiting 4 Weeks	90%	22%		Extended waiting time possibly resulting in delayed care	<p>BaNES CAMHS are achieving 100% for patients assessed within 12 weeks; this week data includes patient cancellations and breaches due to patient choice</p>

CAMHS BaNES CCG	PAF	T2 BaNES Waiting 4 Weeks	90%	22%		Extended waiting time possibly resulting in delayed care	<p>BaNES T2 CAMHS are achieving 100% for patients assessed within 12 weeks; this week data includes patient cancellations and breaches due to patient choice.</p> <p>This service comprises of 3 WTE staff and has seen an increase of 50% of referrals accepted during 16-17 compared to 15-16.</p>
CAMHS BaNES T2	PAF	T2 Waiting 8 Weeks	100%	78%		Extended waiting time possibly resulting in delayed care	<p>BaNES T2 CAMHS are achieving 100% for patients assessed within 12 weeks; this 8 week data includes patient cancellations and breaches due to patient choice.</p> <p>Month 12 14/18 seen within 8 weeks.</p>
CAMHS Wilts CC	PAF	T2 Waiting 4 Weeks	90%	53%		Extended waiting time possibly resulting in delayed care	<p>Wilts T2 CAMHS are achieving 100% for patients assessed within 12 weeks; this 4 week data includes patient cancellations and breaches due to patient choice.</p>

LOCAL: Adult of Working Age Directorate - M12 FY17

Introduction

The contracts with Oxfordshire and Buckinghamshire CCGs and NHS England stipulate a requirement (within Schedule 4) for the **Adult Directorate** to perform against a set of quality and performance indicators.

The Adult's Directorate reports to commissioners as follows:

Oxfordshire CCG

- OBC Incentivised Measures: 5 indicators with targets, reported monthly (7 are baselining)
- OBC Schedule 4: 7 indicators with targets, all reported monthly (9 are baselining)
- CCG Schedule 6 indicators, all reported monthly
- Oxon IAPT: 10 indicators, reported monthly
- Wellbeing: 13 indicators, reported monthly

Buckinghamshire

- Aylesbury & Chiltern CCGs: 30 indicators, 22 reported monthly
- Bucks IAPT services: 8 indicators, all reported monthly.

NHS England: Forensic Service

- MSU & LSU Schedule 4: 16 indicators each with targets, 14 of these reported monthly and 2 reported quarterly.

Performance Scorecard

The Adult Directorate was required to report against 110 indicators in March 2017 (M12)

Targets/thresholds are applicable to most indicators. Where there is no target/threshold, the indicator is considered compliant if it is reported.

Key:	Well Below Target >10%	Below Target 5-10%	Near Target <5% under	At Target	Exceeded Target
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	Well Below Target >10%	Below Target 5-10%	Near Target <5% under	At Target	Exceeded Target	% met
All Measures (106)	18	9	7	62	14	69%

Oxfordshire	Well Below Target >10%	Below Target 5-10%	Near Target <5% under	At Target	Exceeded Target	% met
OBC Incentivised Measures	0	0	0	3	2	100%
OBC Schedule 4	1	0	1	4	1	71.4%
Oxon CCG Schedule 4 Quality Requirements	2	2	1	1	0	16.7%
IAPT	1	1	0	7	1	66.7%
Wellbeing Service	2	2	0	7	3	71.4%

Buckinghamshire	Well Below Target >10%	Below Target 5-10%	Near Target <5% under	At Target	Exceeded Target	% met
Aylesbury	4	0	3	5	2	50%
Chiltern	4	2	2	5	1	42.8%
IAPT	0	0	0	4	4	100%

Forensic Service	Well Below Target >10%	Below Target 5-10%	Near Target <5% under	At Target	Exceeded Target	% met
LSU Schedule 4	2	1	0	13	0	81.3%
MSU Schedule 4	2	1	0	13	0	81.3%

R Red Indicators

Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Oxon OBC Schedule 4	10	Oxon Adult CMHTs - Percentage of referrals categorised as non-urgent that are assessed within 28 calendar days	95%	84%		Delayed delivery of care.	Patient cancellations or non-attendance : 21 Availability of appointments with clinicians: 9 Reasons unclear: 6
Oxon Schedule 4	C2b	Staff up-to-date with Mental Capacity Act safeguarding training	90%	79%		Risk to patient care through insufficiently trained staff	Heads of Service are exploring potential to combine Mental Health Act Training with MCA training because they cover the same areas. Estimated timescale to improvement - June 2017
Oxon Schedule 4	C2c	Staff up-to-date with Prevent safeguarding training	90%	71%		Risk to patient care through insufficiently trained staff.	Train the trainer sessions have taken place during March and Prevent training has increased from 66% in February to 71% in March.

Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale																												
Oxon IAPT Wellbeing	11	Proportion of patients reporting agree or strongly agree with the statement "The service has helped me understand my problems"	90%	77%	<table border="1"> <caption>Line Chart Data: Patient Agreement with Statement</caption> <thead> <tr> <th>Month</th> <th>Actual (%)</th> <th>Target (%)</th> <th>Linear (Actual) (%)</th> </tr> </thead> <tbody> <tr> <td>Oct</td> <td>80</td> <td>90</td> <td>80</td> </tr> <tr> <td>Nov</td> <td>78</td> <td>90</td> <td>78</td> </tr> <tr> <td>Dec</td> <td>80</td> <td>90</td> <td>78</td> </tr> <tr> <td>Jan</td> <td>85</td> <td>90</td> <td>78</td> </tr> <tr> <td>Feb</td> <td>70</td> <td>90</td> <td>78</td> </tr> <tr> <td>Mar</td> <td>77</td> <td>90</td> <td>78</td> </tr> </tbody> </table>	Month	Actual (%)	Target (%)	Linear (Actual) (%)	Oct	80	90	80	Nov	78	90	78	Dec	80	90	78	Jan	85	90	78	Feb	70	90	78	Mar	77	90	78	Risk that patients may not be receiving the care that they need.	The service is working with subcontracted organisation to improve recording and reporting against this measure.
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Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Aylesbury Schedule 4	Local 20	95% people will have their care reviewed within the timescales specified by the cluster package.	95%	57%	<p>100% 80% 60% 40% 20% 0%</p> <p>Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar</p> <p> ■ Total people to be reviewed — % Reviewed within timescales — Target % — Linear (% Reviewed within timescales) </p>	Risk that patient care is not being reviewed frequently enough to manage changing needs.	Clinical teams are being sent fortnightly spreadsheets showing both people with cluster reviews coming up and people who have not been assigned a cluster are being sent to the teams. Service managers are managing progress closely. Estimate 2 months to improvement (April 2017 data)
Chiltern Schedule 4	Local 20	95% people on CPA will have care review within the timescales specified by the cluster package	95%	76%	<p>100% 50% 0%</p> <p>Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar</p> <p> ■ Total people to be reviewed — % Reviewed within timescales — Target % — Linear (% Reviewed within timescales) </p>	Risk that patient care is not being reviewed frequently enough to manage changing needs.	As above.
Aylesbury Schedule 4	Local 20	100% people on CPA will have documented risk assessment	100%	70%	<p>100% 50% 0%</p> <p>Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar</p> <p> ■ No. needing assessment (audit) — Aylesbury % risk assessment — Target % — Linear (Aylesbury % risk assessment) </p>	Patient risks may not be adequately managed.	This piece of work is being taken forward by the team managers and overseen by the service manager. Quality issues are being raised during individual supervision sessions with improvements monitored via the line management process. We have also seen a reduction in scores due to the fidelity of the CPA which we expect to resolve within the next quarter.

Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Aylesbury Schedule 4	Local 16	Carers within cluster group 4-17 will report satisfaction with the level of support to the person they care for	90%	66%		Carer and patient dissatisfaction and lack of support.	The teams have seen a significant increase in responses in Q4 from both carers and patients following a drive by the service to improve the response rate and capture meaningful feedback. A patient and carer experience and involvement lead has also been appointed and will start in post in May. They will be working with teams to ensure a positive level of feedback is received and that areas requiring improvement and development are identified from the feedback and worked on. This will include sharing good practice.
Aylesbury Schedule 4	Local 17	Carers within cluster group 4-17 will report satisfaction with the level of support from the service for themselves	90%	63%		Carer and patient dissatisfaction and lack of support.	
Chiltern Schedule 4	EBS3 / Local 3, 20 & 84	The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	95%	63%		Patient risks may not be adequately managed.	7 breaches, being followed up for better understanding of what went wrong and to mitigate against future breaches. 6 patients have now been followed up (at time of reporting) longest wait being 18 days.

Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale															
Chiltern Schedule 4	Local 16	Carers within cluster group 4-17 will report satisfaction with the level of support to the person they care for	90%	66%	<table border="1"> <caption>Actual % Data for Local 16</caption> <thead> <tr> <th>Quarter</th> <th>Actual %</th> </tr> </thead> <tbody> <tr> <td>Q1</td> <td>~20%</td> </tr> <tr> <td>Q2</td> <td>~75%</td> </tr> <tr> <td>Q3</td> <td>~65%</td> </tr> <tr> <td>Q4</td> <td>66%</td> </tr> </tbody> </table>	Quarter	Actual %	Q1	~20%	Q2	~75%	Q3	~65%	Q4	66%	Carer and patient dissatisfaction and lack of support.	The teams have seen a significant increase in responses in Q4 from both carers and patients following a drive by the service to improve the response rate and capture meaningful feedback. A patient and carer experience and involvement lead has also been appointed and will start in post in May. They will be working with teams to ensure a positive level of feedback is received and that areas requiring improvement and development are identified from the feedback and worked on. This will include sharing good practice.					
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Forensics	LQ 9	% of in-patients who have accessed a routine dental check-up/ examination in the last 12 months	70%	LSU: 51% MSU: 44%	<table border="1"> <caption>Actual % Data for LQ 9</caption> <thead> <tr> <th>Quarter</th> <th>MSU Actual %</th> <th>LSU Actual %</th> </tr> </thead> <tbody> <tr> <td>Q1</td> <td>~45%</td> <td>~65%</td> </tr> <tr> <td>Q2</td> <td>~45%</td> <td>~62%</td> </tr> <tr> <td>Q3</td> <td>~42%</td> <td>~68%</td> </tr> <tr> <td>Q4</td> <td>44%</td> <td>51%</td> </tr> </tbody> </table>	Quarter	MSU Actual %	LSU Actual %	Q1	~45%	~65%	Q2	~45%	~62%	Q3	~42%	~68%	Q4	44%	51%	Risk that patients may not be receiving the care that they need.	Access to routine dental services continue to be problematic in MSU primarily due to patient leave status. Discussions continue around the possibility of providing an in-reach service but funding appears an issue. This continues to be a work in progress. Information has been requested to better understand the drop in LSU, but is likely to be linked to a change in patient population and presentation.
Quarter	MSU Actual %	LSU Actual %																				
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Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Forensics	LQ 8	% Discharge Summaries sent to the Service User's GP and/or Referrer and to any third party provider with 24 hours	100%	MSU: 0%	<p>The chart displays the performance of MSU (Medical Summary Upload) over time. The left Y-axis represents the percentage of MSU (0% to 100%), and the right Y-axis represents the number of discharges (0 to 4). The X-axis shows months from Jun to Mar. The MSU Actual % (blue line) remains at 0% throughout the period. The No. of Discharges (green bars) fluctuates, with peaks in Jul and Sep. A red horizontal line indicates the Target % at 100%. An orange line shows the Linear (MSU Actual %) trend, which is a flat line at 0%.</p>	Delayed communication of pertinent information to primary care/referrer/third party	This is being followed up to better understand why this is not being achieved and to reduce the risk of any future breaches.
Forensics	LQ 4	% HCR20 completed in 3 months	95%	LSU: 67%	<p>The chart displays the performance of LSU (Legal Summary Upload) over time. The left Y-axis represents the percentage of HCR20 completed (0% to 100%), and the right Y-axis represents the number of admissions (0 to 4). The X-axis shows months from Apr to Mar. The LSU % HCR20 completed in 3 months (blue line) fluctuates significantly, reaching 100% in Dec and Jan, and 0% in May, Jun, Sep, and Oct. The Number of admissions in the past 3 months (green bars) fluctuates between 1 and 4. A red horizontal line indicates the Target % at 95%. An orange line shows the Linear (LSU Actual %) trend, which starts at approximately 70% in Apr and gradually declines to about 55% in Mar.</p>		All HCR-20s were completed within 3 months, however, one was not completed on the correct tab in Carenotes, but had, instead, been uploaded. This issue pertains to only one patient, and is being raised with the clinical team.