Oxford Health NHS
NHS Foundation Trust

Trust Board Performance Report – M1 FY17/18

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 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. M1 SOF data has not been published therefore the M1 FY18 Trust performance % position relates to local contractual performance only.

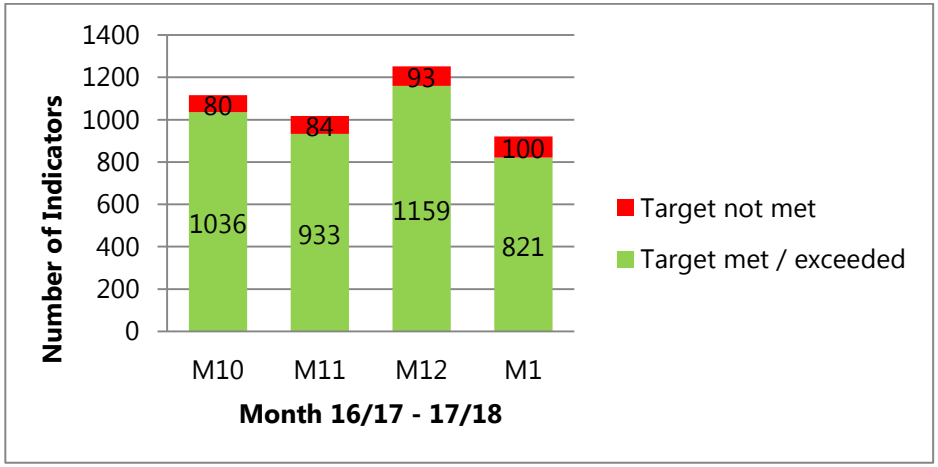
89% (821/921) of indicators were achieved in month 1 FY18

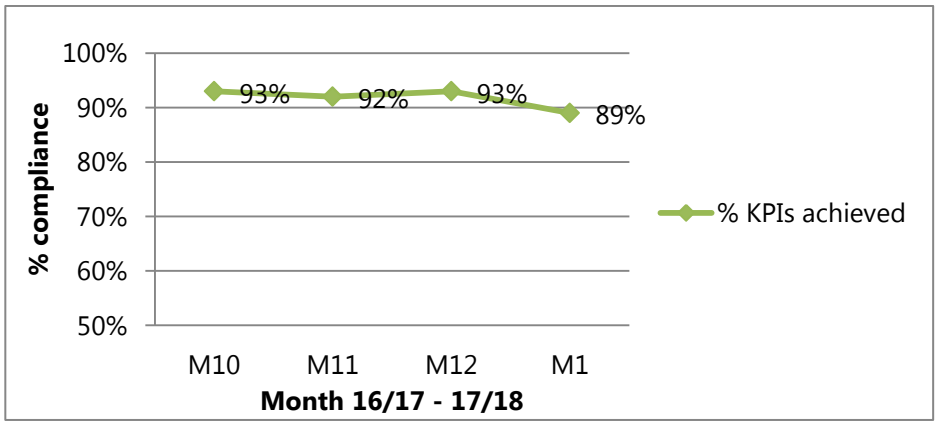
Key:	Well Below Target >10%	Below Target </=6-10%	Near Target </=-5%	At Target	Exceeded Target	No data/ Target /not due

Total (local only)	**58**	**14**	**28**	**757**	**64**	**-**	**89%**
National (SOF) – FY17	5	0	2	5	9	7	
Local (Contractual) –M1	58	14	28	757	64	-	89%
Older Peoples	**26**	**5**	**4**	**43**	**19**	**97**	**64%**
Oxfordshire	23	5	4	27	0	58	46%
Buckinghamshire	3			16	19	38	92%
Children & Young People	**20**	**2**	**13**	**656**	**39**	**730**	**95%**
Oxfordshire	3	0	5	324	9	341	98%
Buckinghamshire	0	0	0	135	0	135	100%
Swindon, Wilts and Banes	17	2	8	197	30	254	93%
Adults of Working Age	**12**	**7**	**11**	**58**	**6**	**94**	**68%**
Oxfordshire	6	4	8	18	4	40	55%
Buckinghamshire	5	3	3	29	2	42	74%
Forensic	1	0	0	11	0	12	92%

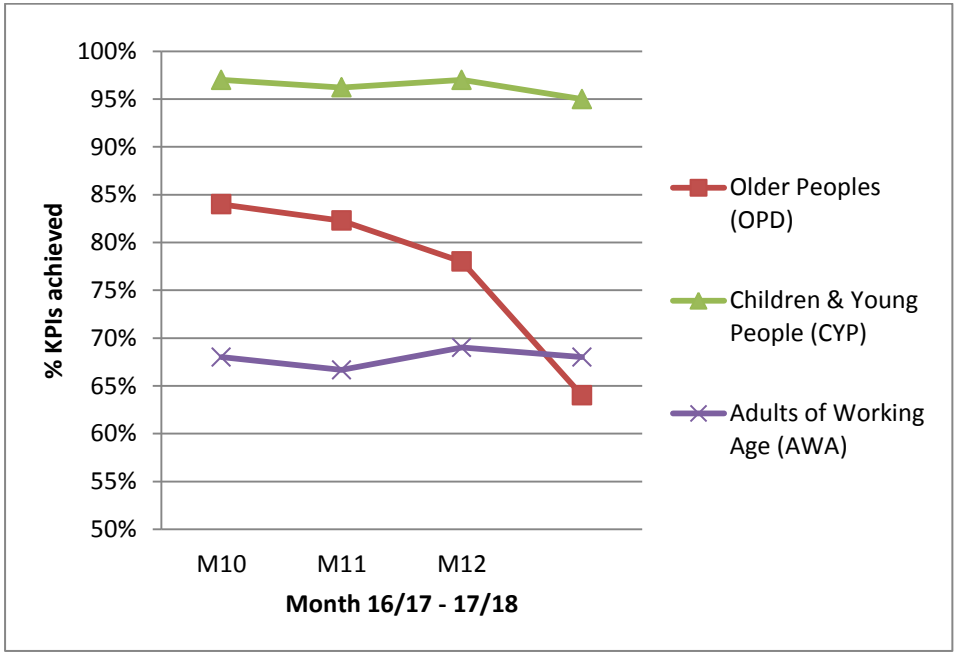
Performance Trend

The number of reportable indicators varies each month. In month 1; 921 indicators were reportable of which 821 were achieved – 89%. Despite the fluctuating numbers of indicators the % level of compliance has remained stable over the past 4 months at circa 90%.





The Directorate (local contractual) performance trend is illustrated below. The Older People's Directorate (OPD) performance has declined in month 1 which is due in part to 10 non –reported KPIs (and all non-reported KPIs are classed as non-compliant). This is the first time these non-reported KPIs have been included in the contract and have been reported in this way. The service is therefore validating the data before it is published.



NATIONAL: Single Oversight Framework – FY17

Introduction
NHS Improvement (NHSI) implemented the Single Oversight Framework (SOF) on 1 October 2016 and this replaced the 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.

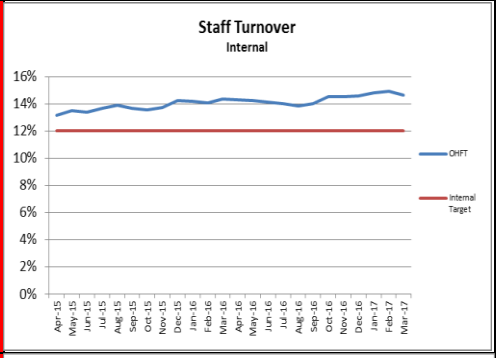
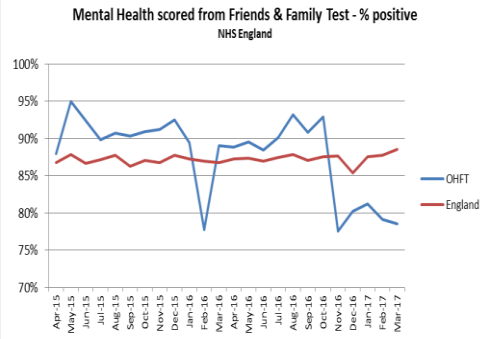
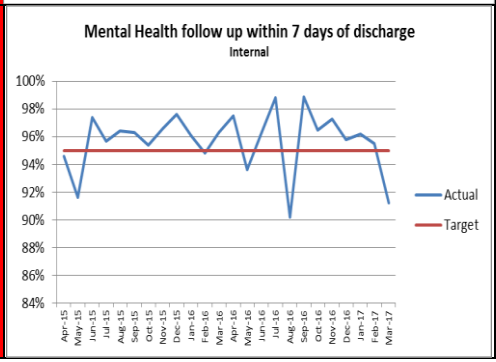
In the majority of cases NHSI will be sourcing Trust performance data from publicly available sources e.g. CQC, NHS Digital, NHS England, Unify. Oxford Health NHS Foundation Trust (OHFT) will no longer be required to directly submit data nationally for performance management.

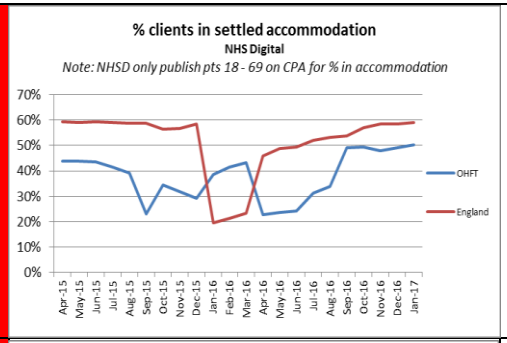
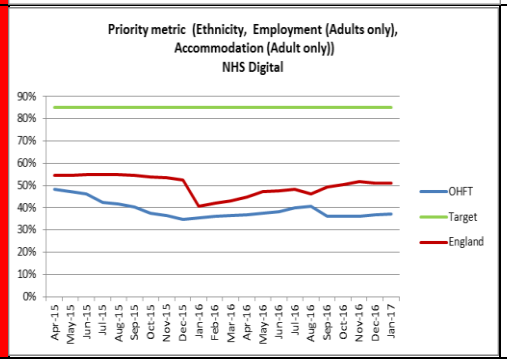
The majority of the indicators do not have targets/thresholds. To provide a sense of Trust performance, where information is available the published performance has been set against the overall position for England.

There is a time lag of when data is published nationally and therefore the final position for 2016/17 is not yet available. At the time of writing 21 of the 28 indicators have been reported on and current performance is 66.7%. Performance against the SOF is therefore excluded from the overall M1 FY18 Trust performance % position.

Key	R Well below target >10%	A Below Target <10%	Y Near Target <5% under	DG At Target	LG Exceeding Target	No Data/ Target/ Not Due
Performance as at latest available published data 2016/17						
Organisational Indicators	1		1	2	2	4
MH Quality Indicators	3			2	1	1
Community Quality Indicators			1			1
Operational Performance	1			1	6	1
Total	**5**	**0**	**2**	**5**	**9**	**7**

R Red Indicators

Area	Ref	Measure	Target	Actual	Trend	Narrative
Organisational	2	Staff turnover	Internal Target <12%	14.6% (Mar)		In March, 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 88.6%	78.6% (Mar)		Performance in March decreased by 0.6% on the February position and is the fifth month below the national average. This position is being investigated.
Mental Health	14	Mental Health Discharges from hospital followed up within 7 days	95%	91.2% (Mar)		Performance for Mental Health Discharges from hospital followed up within 7 days is below target this month and is at its lowest point since August 2016. In March there were 102 valid discharges of which 93 were followed up within 7 days of discharge. A number of the breaches were due to patient DNAs.

Mental Health	15	% of clients in settled accommodation	England Average 59.1%	50.2% (Jan)		Performance increased by 1.1% in **January** to 50.2%. The Performance and Information Team continue to work with Advanced Healthcare to ensure the completeness of the Mental Health Services Data Set (MHSDS) submission and with services to improve data completeness.
Operational	23 b	Priority Metric % coded (Ethnicity, Employment (Adults only), Accommodation (Adults only)	85%	37.3% (Jan)		Performance increased by 0.4% between December and **January**. The England average has been included on the graph for an illustration of how the rest of the country is performing. The Performance and Information Team continue to work with Advanced Healthcare to ensure the completeness of the MHSDS submission and with services to improve data completeness.

LOCAL: Older People's Directorate – Month 1 FY18

The Community and Mental Health Services **Contracts** with Oxfordshire and Buckinghamshire CCGs stipulate a requirement (within Schedule 4 for Oxon and via the Performance Dashboard for Bucks) for the **Older People's Directorate (OPD)** to perform against a set of quality and performance indicators.

It should be noted that the indicators within the Bucks Performance Dashboard have yet to be specified within the contract, however, there is an informal agreement between the Trust and Bucks CCG to report the indicators from month 1. The aim is for these to be formalised within Schedule 6 of the contract.

In total there are **114 indicators** for 2017/18 applicable to OPD (excluding the 8 trust-wide Operational Standards and National Quality Requirements); 76 indicators relating to the contract with Oxfordshire CCG, and 39 indicators relating to the contract with Buckinghamshire CCGs (19 for each CCG and 1 countywide). The indicators are categorised as follows.

Oxfordshire: 76 indicators

- **Community Services:** 66 indicators
  54 are reportable monthly (2 not agreed), 9 are reportable quarterly, 2 are reportable bi-annually and 1 is reportable at month 6
- **Older People's Mental Health:** 10 indicators
  7 are reportable monthly. 3 are reportable quarterly

Buckinghamshire: 38 indicators

- **Aylesbury and Chiltern**: 18 indicators per CCG and 2 indicators county-wide

Contractual Performance Scorecard

The Older People's Directorate was required to report against **97 indicators** in month 1. Targets/thresholds are applicable to most indicators. Where there is no target/threshold, the indicator is considered compliant if it is reported. Indicators that are not reported are classed as non-compliant (red).

64% of indicators were achieved;

Key:	Well Below Target >10% (</> activity)	Below Target </=6-10%	Near Target </=-5%	At Target	Exceeded Target >/= 10%

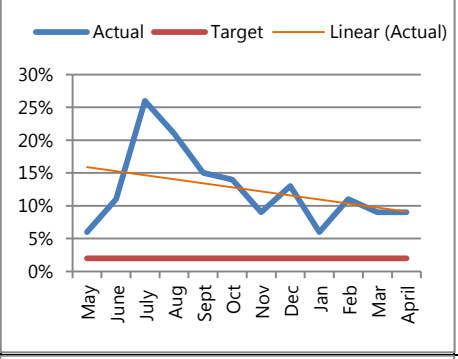
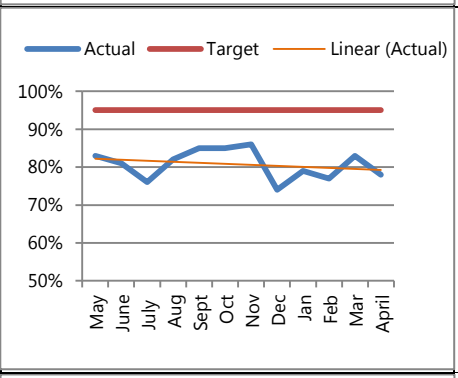
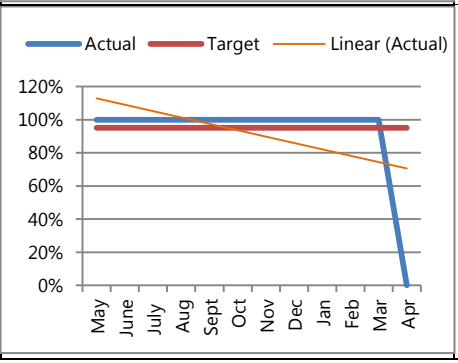
						% met
Total (96)	**26**	**5**	**4**	**43**	**19**	64%
Oxfordshire						
Community Services (52)	12+ 10 nr	5	4	21	0	40%
OP Mental Health (7)	1			6	0	86%
Sub-total (59)	**23**	**5**	**4**	**27**	**0**	46%

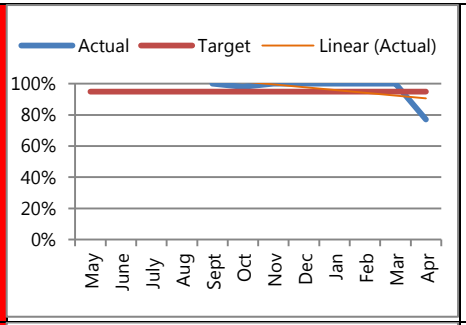
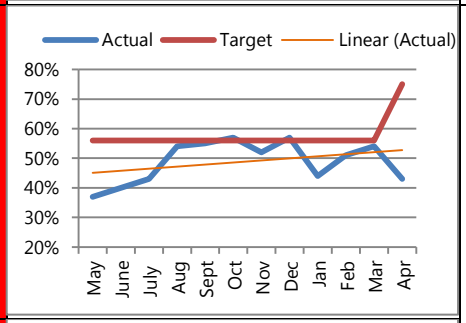
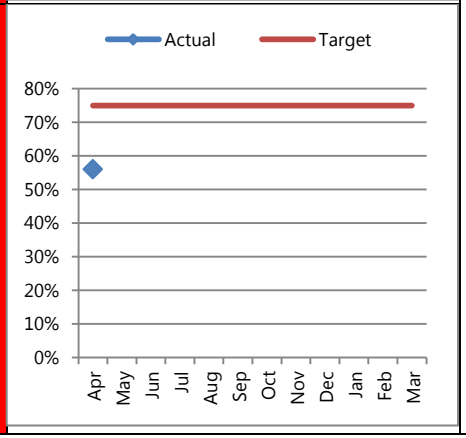
Buckinghamshire						**% met**
Aylesbury (18)	1			8	9	94%
Chiltern (18)	2			8	8	89%
Countywide (2)					2	100%
Sub-total (38)	**3**			**16**	**19**	92%

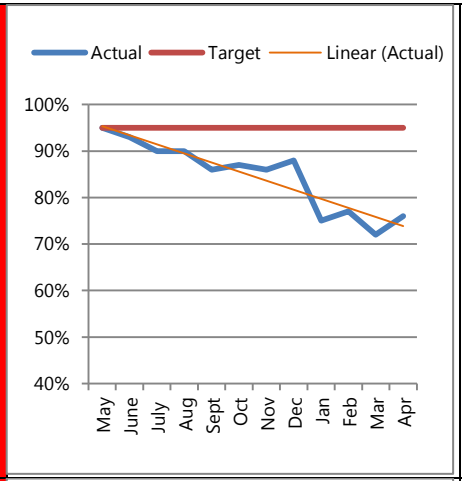
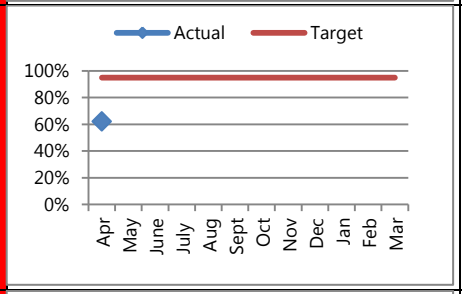
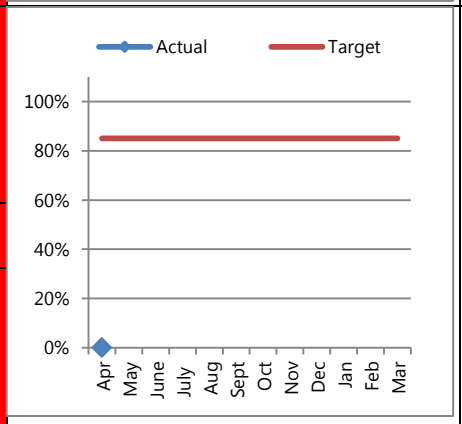
*nr = not reported

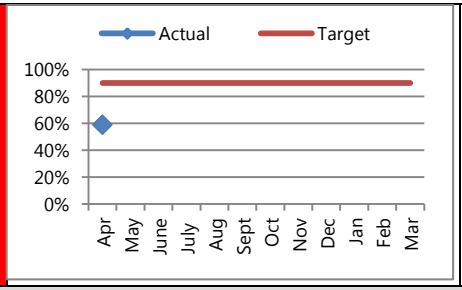
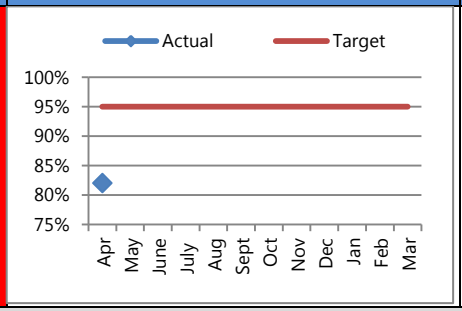
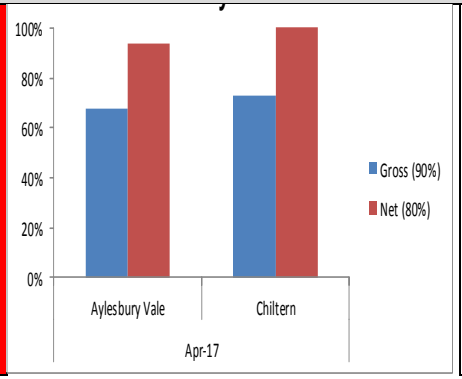
Directorate	Tariff	FY IAP	YTD Outturn	YTD variance
Older People	Block	32,471	35,174	-2,703
	C&V	11,909	11,367	542

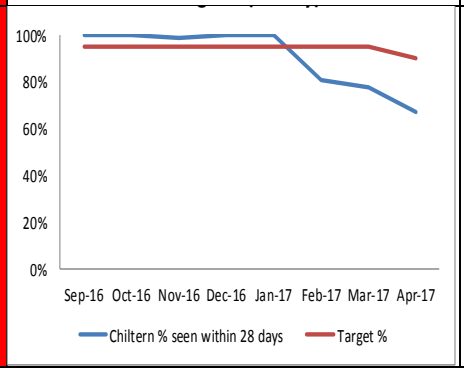
R Red Indicators

Service	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Out of Hours	LNQR 7 B6	OOH percentage of unfilled shifts; ability to match capacity with demand	</=2%	9%		Extended waiting time possibly resulting in delayed care	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. In relation to unfilled shifts, there is continued positive recruitment of GPs and Advanced Nurse Practitioners that will enable the services to work towards achieving the target.
Out of Hours	LNQR 12 B10	OOH urgent F/F base visit appt within 2 hours of triage	95%	78%		Extended waiting time possibly resulting in delayed care	The service continues to work with the 111 service to improve availability of appointments. This will increase the opportunity for patients to be seen within the agreed time, but is dependent on appropriate allocation of appointments by 111
Out of Hours	LNQR 13 B14	Patients unable to communicate in English will be provided with interpreter <15 minutes of initial contact	95%	0%		Failure to communicate effectively combined with extended waiting time possibly resulting in delayed care	This equated to 1 patient. The service is in the process of investigating the reasons for the breach

Pulmonary rehab	LQR C7	Percentage of clinic letters that are sent back to GPs within 10 days	95%	77%		Delayed communications with primary care which could result in delayed follow up treatment	7 letters were sent beyond the 10 day target. The service has never previously breached this KPI and is therefore investigating further. Any data anomalies will be corrected for M2.
Community Hospitals	LQR D2	% of rehabilitation patients will have an improved FIM score of 11+ points by their MDT fit date.	75%	43%		Failure of patients to reach their full rehabilitation potential, leading to greater reliance on tertiary services in order to maintain activities of daily living and independence	The FY18 target has increased this year. Currently there is an elevated level of data quality and completeness issues for this KPI which will have impacted on the ability of the service to achieve the target in M1. Work is commencing to ensure complete and accurate data is being supplied to the PJD.
Community Hospitals	LQR D2b	% of stroke patients will have an improved FIM score of 11 +points by their MDT fit date	75%	56%			This is a new KPI for FY18. Currently there is an elevated level of data quality and completeness issues for this KPI which will have impacted on the ability of the service to achieve the target in M1. Work is commencing to ensure complete and accurate data is being supplied to the PJD. The trust is in ongoing discussion with the CCG regarding a whole systems review of the stroke delivery pathway.

MSK Service	LQR D8	Percentage of Patients will wait no longer than 12 weeks to first appointment offered	95%	76%		Extended waits for assessment and treatment, patient dissatisfaction, condition exacerbation	Demand continues to exceed capacity following the cessation of non-recurrent CCG funding in March 2016 and patients continue to encounter increased waiting times. The service is endeavouring to manage over activity by way of a reduced first to follow up ratio, however this is below national benchmarking. Referral patterns for more complex referrals (i.e. trauma) have increased which is further exacerbating the capacity issue.
Physical Disability Service	LQR D8	Percentage of Patients will wait no longer than 12 weeks to first appointment offered	95%	62%		Extended waits for assessment and treatment, patient dissatisfaction, condition exacerbation	This is a new KPI for FY18 for the Physical Disability Service. The service is in the process of analysing the performance data to understand where the delays are and to confirm accurate data reporting
Community Hospitals – Stroke patients Physio	LQR D31	85% of patients receive at least 45 minutes of Physiotherapy as required that they can tolerate, at least 5 days per week	85%	0%		Failure of patients to reach their full rehab potential leading to greater reliance on services to maintain independence	This is a revised measure for FY18 with 3 KPIs associated with stroke therapy input. Whilst patients received therapy provision this was not achieved 'at least 5 days per week'. The service continues to review the staff to patient ratio which will allow the targets to be met, against current job vacancies. The trust is in ongoing discussion with the CCG regarding a whole systems review of the stroke pathway.
OT			85%	0%			
Speech and Language Therapy			85%	0%			

Falls Service	LQR D38	% of Routine referrals had an appointment within 8 weeks	90%	59%		Extended waits for assessment and treatment, patient dissatisfaction, condition exacerbation	This is a new KPI for FY18. The service is currently mapping the process to understand if there are any delays in the system and/or poor data recording so that they can address any issues and improve patient waiting times.
Older Peoples Mental Health							
Service	**Ref**	**Measure**	**Target**	**Actual**	**Trend**	**Impact**	**Action and Resolution Timescale**
Older Peoples Mental Health	F1	Service users will have their cluster reviewed within the agreed timescale	95%	82%			This is a revised KPI for FY18. The service is currently mapping the process to understand where the delays are in the system in order to address them, and ultimately achieve this KPI'
Mental Health – Bucks (Aylesbury Vale/Chiltern)							
OA Mental Health (Bucks – Aylesbury Vale)	-	Memory Service (users in clusters 18-19) will receive an assessment within 40 days of receipt of referral (gross figure)	90%	68%		Delay in patient receiving care which could lead to harm re: mental & physical health	7/22 patients were not seen in time. 6 were due to patient choice and 1 breach (first available slot in clinic) seen day 42. The net target for this KPI in Aylesbury Vale is 80% (achievement excluding factors beyond the service's control e.g. patient choice and further medical investigation) – the service achieved 94%

OA Mental Health (Bucks – Chiltern)		Memory Service (users in clusters 18-19) will receive an assessment within 40 days of receipt of referral (gross)	90%	73%	As above	Delay in patient receiving care which could lead to harm re: mental & physical health	9/33 patients were not seen in time: 7 were due to patient choice and 2 required further scans. The net target in M1 for this KPI in Chiltern is also 80% and the service achieved 100%
OA Mental Health (Bucks – Chiltern)		Routine (non-emergency) referral to Mental Health Team will be seen within 28 consecutive days for assessment	90%	67%		Delay in patient receiving care which could lead to harm re: mental & physical health	13 breaches; 6 related to patient choice, 4 breaches were due to further information required from GP and the remaining three were administrative delays. The CCG is in discussion with the trust to review how they can assist in facilitating earlier scanning by the OUH.

LOCAL: Children & Young Peoples Directorate – Month 1 FY18

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.

These are categorised below;

Oxfordshire-Services

- Oxfordshire CAMHS and Children's Services (Oxon CCG)
- SHN (OCC Public Health)
- College Nursing (OCC Public Health)
- Imms (Public Health)

Buckinghamshire-Services

- Buckinghamshire CAMHS (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)

Performance Scorecard

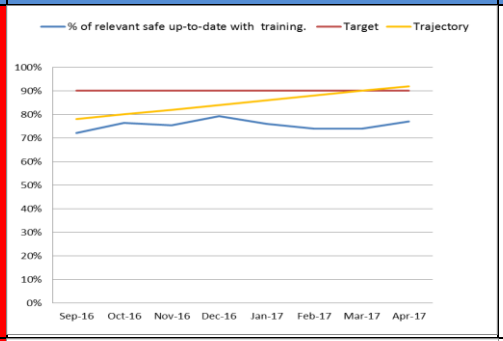
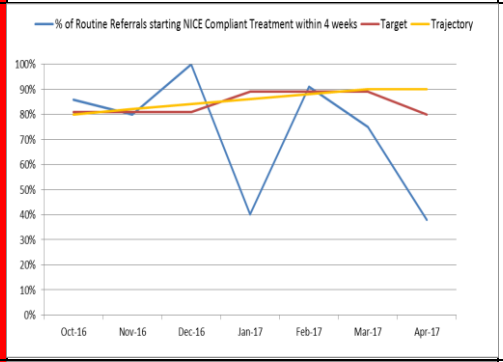
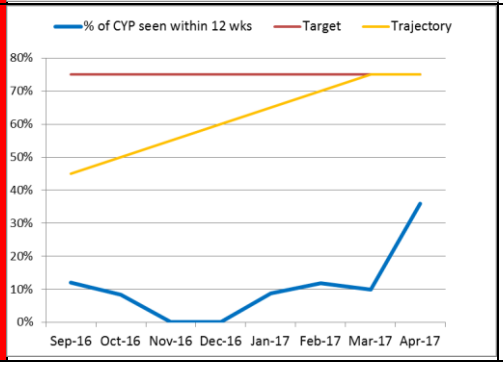
The Children and Young People's Directorate was required to report against **730** indicators in month 1 (this excludes Dental).

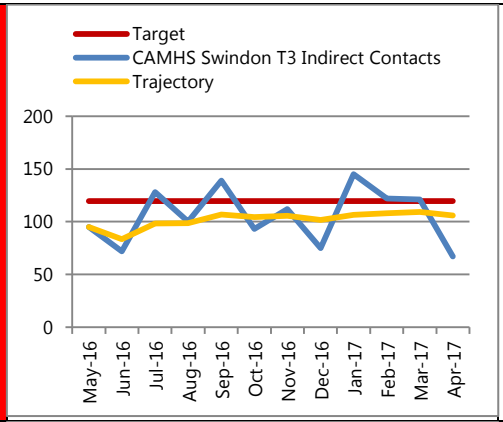
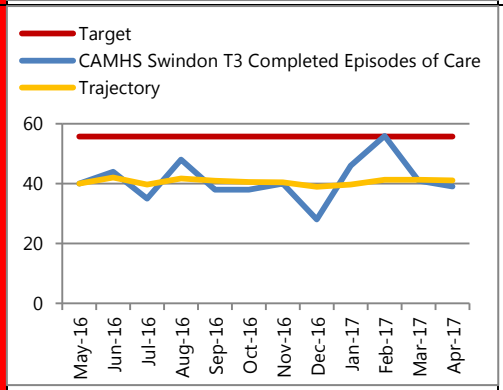
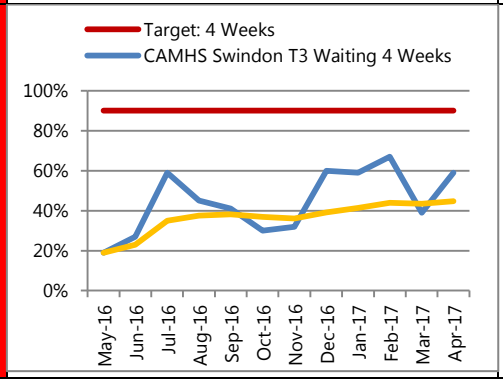
Targets/thresholds are only applicable to a **small proportion** of CYP indicators. Where there are no targets/thresholds, the indicator is considered compliant if it is reported.

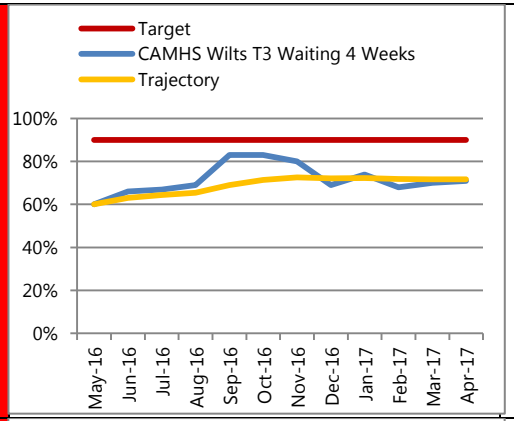
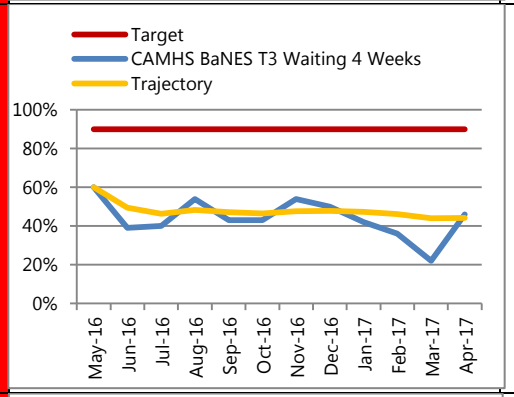
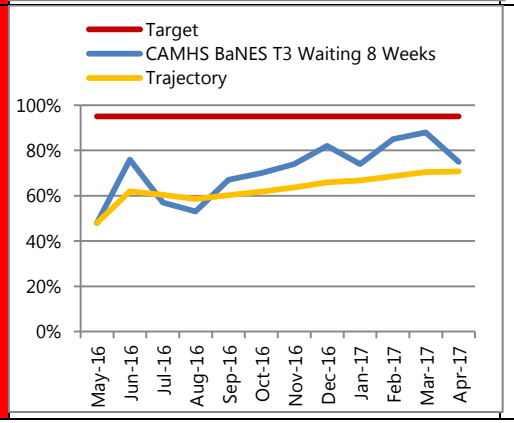
95% of indicators were achieved:

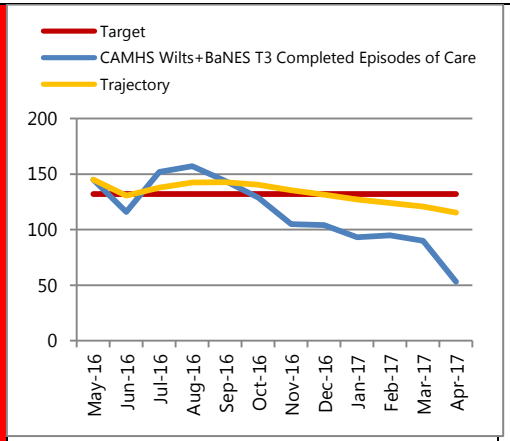
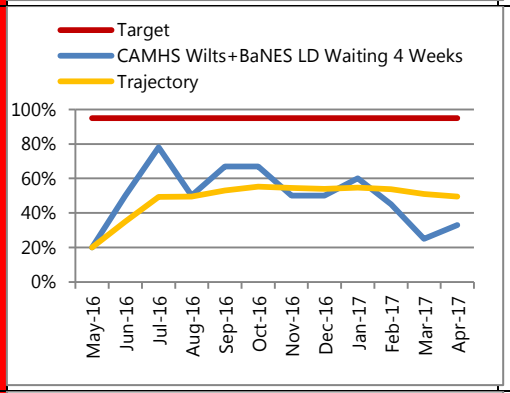
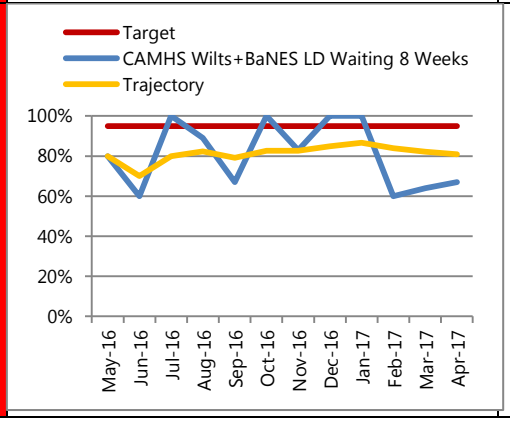
Commissioner	Service	Well Below Target >10%	Below Target </=6-10%	Near Target </=5% under	At Target	Exceeded Target	% at Target or Above
Total		20	2	13	656	39	95%
Oxfordshire							**% Met**
Oxon CCG	LQR	1		2		3	50%
	Childrens Community Services				2		100%
	CAMHS - Schedule 4	2		1	3		50%
	CAMHS PAF			2	74	6	98%
Oxon LA	SHN				170		100%
	College				70		100%
Public Health	Imms				5		100%
Buckinghamshire							**% Met**
Buck CCG/CC	CAMHS PAF				135		100%
Swindon Wilts & BaNES							**% Met**
Swindon CCG	CAMHS PAF	3		5	35	13	86%
Wilts and BaNES CCG	Wilts and BaNES T3	6	1	2	50	12	87%
BaNES CCG	BaNES T2	4			34	2	90%
Wilts CC	Wilts T2	3	1		51	1	93%
Wilts	Adult ED	1		1	27	2	94%

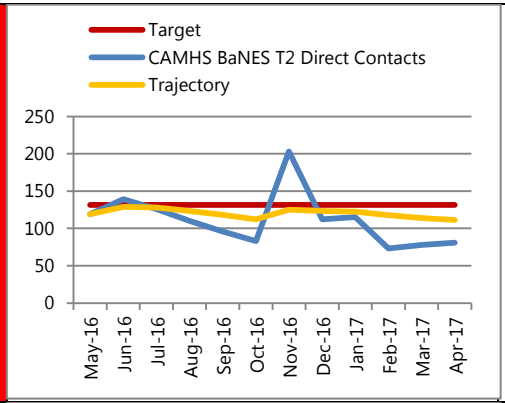
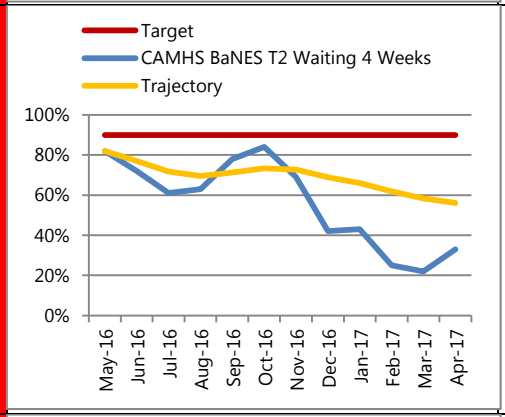
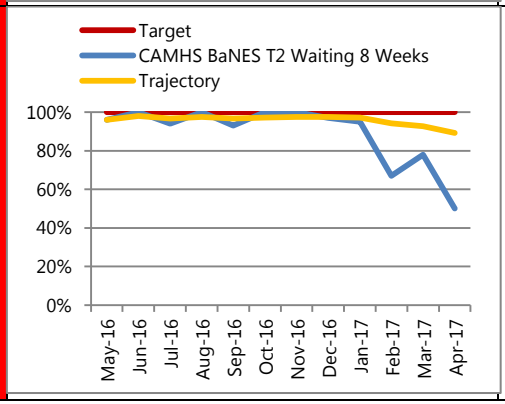
R Red Indicators

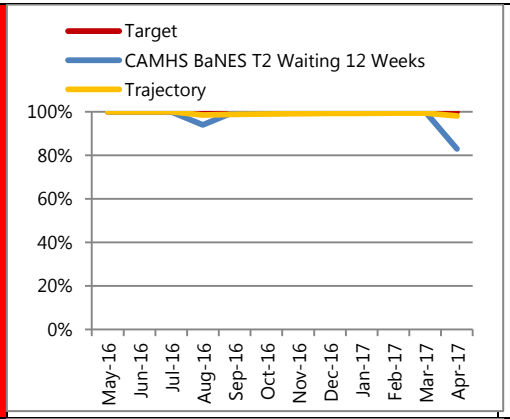
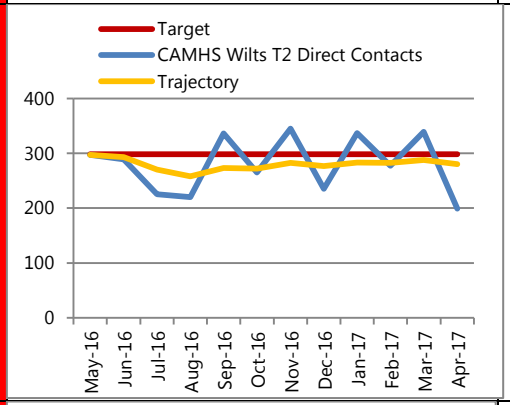
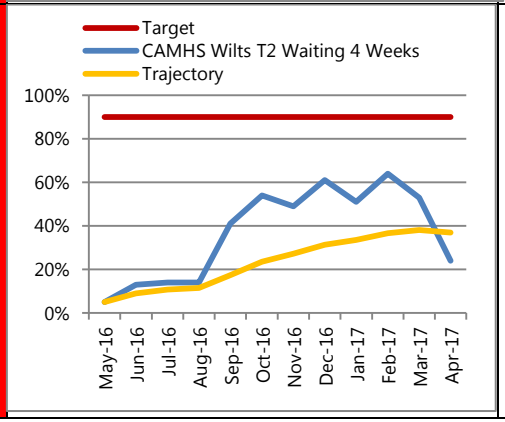
Service	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
LQR OCCG	C2b	Mental Capacity	90%	77%		Possible failure of staff awareness of the Mental Capacity Act.	Mental Capacity training is one of 4 courses that form KPI C2 which has an overall target of 90%. 72/93 staff are compliant. CYP is targeting non-compliant individuals and supporting staff with time to complete training.
CAMHS - OCCG	Sch 4	ED Waits	80%	38%		Extended waiting time possibly resulting in delayed care	During Month 1 performance reduced with only 3/8 referrals being seen within 4 weeks. All patients were assessed within 32 days. An action plan is in place with team to address the underperformance.
CAMHS - OCCG	E6aii	ASD Waits	75%	36%		Extended waiting time possibly resulting in delayed care	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 demand and a total of 120 referrals have been outsourced. A new service model has been designed and CYP are currently in a tender process for this to commence in June 2017 which should help address the underperformance.

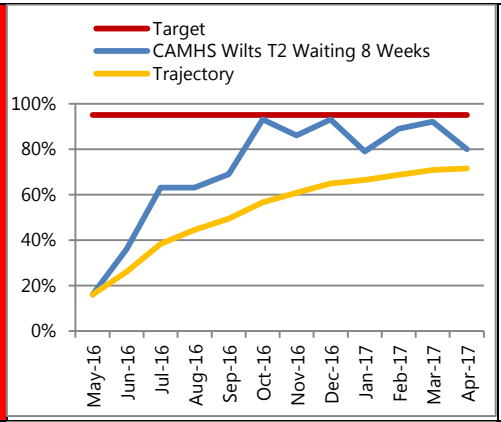
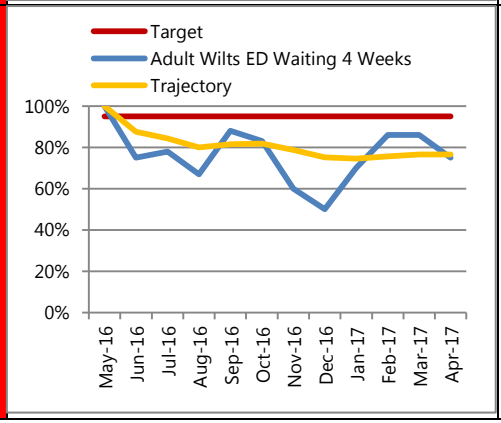
CAMHS Swindon CCG	PAF	T3 Indirect Contacts	120	67		No immediate impact	Indirect contacts is below target for month 1, this can be contributed to a seasonal trend due to the Easter Holidays. Performance is expected to even out over the next couple of months.
CAMHS Swindon CCG	PAF	T3 Completed Episodes of Care	56	40		No immediate impact	This indicator is currently being reviewed with Swindon Commissioners and the underperformance is consistent with the last 3 years, therefore the target is being reviewed. Underperforming by 16 completed episodes of care.
CAMHS Swindon CCG	PAF	Waiting 4 Weeks	90%	59%		Extended waiting time possibly resulting in delayed care	This issue has been highlighted to the Team through Performance & contract meetings. Swindon CAMHS have seen a 46% increase in referrals during 16-17 compared to 15-16, demand continues to outweigh capacity, this has been highlighted to Swindon Commissioners.

CAMHS Wilts CCG	PAF	Wilts T3 Waiting 4 Weeks	90%	71%		Extended waiting time possibly resulting in delayed care	Wiltshire CAMHS are achieving 100% for patients assessed within 8 and 12 weeks; this data includes patient cancellations and breaches due to patient choice.
CAMHS BaNES CCG	PAF	BaNES T3 Waiting 4 Weeks	90%	44%		Extended waiting time possibly resulting in delayed care	BaNES CAMHS are achieving 100% for patients assessed within 12 weeks; this week data includes patient cancellations and breaches due to patient choice
CAMHS BaNES CCG	PAF	BaNES T3 Waiting 8 Weeks	95%	75%		Extended waiting time possibly resulting in delayed care	BaNES CAMHS are achieving 100% for patients assessed within 12 weeks; this week data includes patient cancellations and breaches due to patient choice

CAMHS BaNES /Wilts CCG	PAF	Wilts & BaNES T3 Completed Episodes of Care	132	53		No immediate impact	The number of discharges will fluctuate from month to month; we would expect this underperformance to even out over the next couple of months.
CAMHS BaNES CCG	PAF	BaNES LD Waiting 4 Weeks	95%	33%		Extended waiting time possibly resulting in delayed care	This is based on 3 patients, with only 1 being seen within 4 weeks, this data does not account for patient choice.
CAMHS BaNES CCG	PAF	BaNES LD Waiting 8 Weeks	95%	66%		Extended waiting time possibly resulting in delayed care	This is based on 3 patients, with only 2 being seen within 8 weeks, this data does not account for patient choice.

CAMHS BaNES CCG	PAF	T2 BaNES Direct Contacts	131	81		No immediate impact	Direct contacts are below target for month 1, this can be attributed to a seasonal trend due to the Easter Holidays, performance expected to even out over the next couple of months.
CAMHS BaNES CCG	PAF	T2 BaNES Waiting 4 Weeks	90%	33%		Extended waiting time possibly resulting in delayed care	This 4 week data includes patient cancellations and breaches due to patient choice. This service comprises 3 WTE staff and has seen an increase of 50% of referrals accepted during 16-17 compared to 15-16. This data represents 12 patients, with 8 breaches.
CAMHS BaNES T2	PAF	T2 Waiting 8 Weeks	100%	50%		Extended waiting time possibly resulting in delayed care	This 8 week data includes patient cancellations and breaches due to patient choice. This data represents 12 patients, with 6 breaches

CAMHS BaNES T2	PAF	T2 Waiting 12 Weeks	100%	83%		Extended waiting time possibly resulting in delayed care	This 12 week data includes patient cancellations and breaches due to patient choice This data represents 12 patients, with 2 breaches.
CAMHS Wilts CC	PAF	T2 Direct Contacts	299	199		No immediate impact	Direct contacts is below target for month 1, this can be attributed to a seasonal trend due to the Easter Holidays, performance expected to even out over the next couple of months.
CAMHS Wilts CC	PAF	T2 Waiting 4 Weeks	90%	24%		Extended waiting time possibly resulting in delayed care	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.

CAMHS Wilts CC	PAF	T2 Waiting 8 Weeks	95%	80%		Extended waiting time possibly resulting in delayed care	Wilts T2 CAMHS are achieving 100% for patients assessed within 12 weeks; this 8 week data includes patient cancellations and breaches due to patient choice.
CAMHS Wilts CC	PAF	Adult ED Waiting 4 Weeks	95%	75%		Extended waiting time possibly resulting in delayed care	This 4 week data includes patient cancellations and breaches due to patient choice. This data represents 4 patients, with 1 breach.

LOCAL: Adult of Working Age Directorate - M1 FY18

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, 9 reported monthly and 1 annually
- Wellbeing: 13 indicators, reported monthly

Buckinghamshire

- Aylesbury & Chiltern CCGs: 13 indicators each, reported monthly.
- Bucks IAPT services: 8 indicators all reported monthly
- PIRLS: 3 indicators reported monthly
- Perinatal: 5 indicators measured monthly

NHS England: Forensic Service

- MSU & LSU Schedule 4: 16 indicators for each service with targets, 6 of these reported monthly and 10 reported quarterly.

Performance Scorecard

The Adult Directorate was required to report against **94 indicators** in April 2017 (M1) Targets/thresholds are applicable to most indicators. Where there is no target/threshold, the indicator is considered compliant if it is reported. **68% were achieved**.

Key:	Well Below Target >10%	Below Target 5-10%	Near Target <5% under	At Target	Exceeded Target

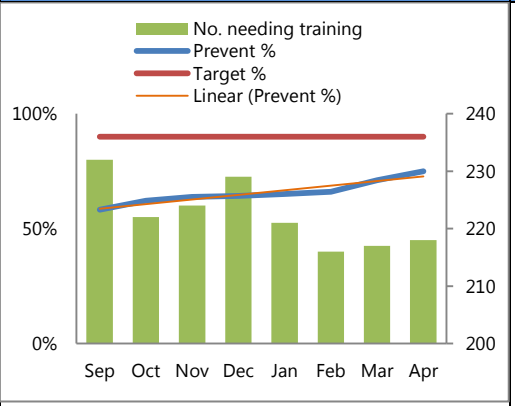
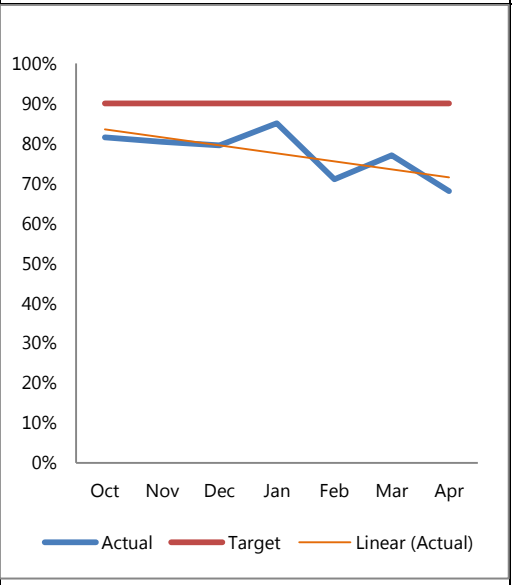
						% met
All Measures (94)	12	7	11	58	6	68%

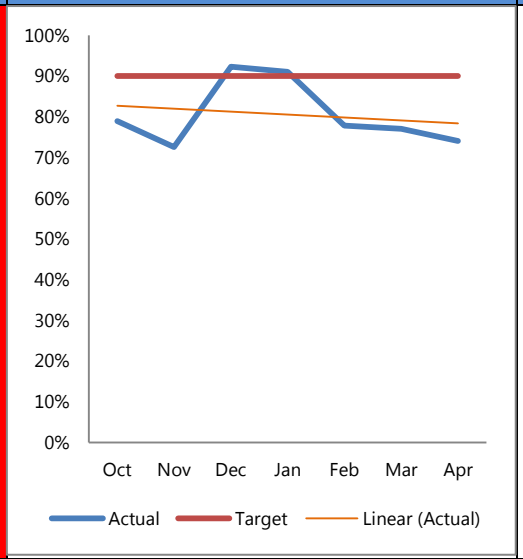
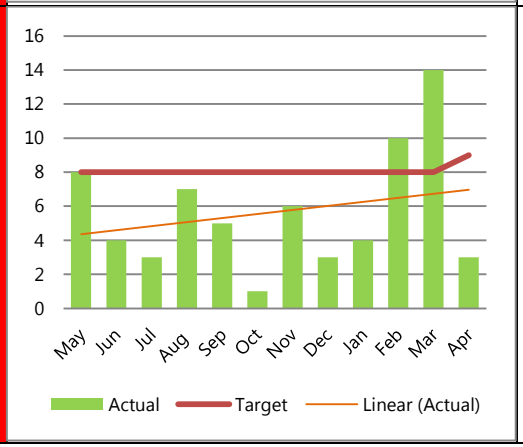
Oxfordshire						% met
OBC Incentivised Measures		1	1	1	2	60%
OBC Schedule 4		1	2	4		57%
Oxon CCG Schedule 4 Quality Requirements	1	2	1	2		33%
IAPT	2		1	5	1	67%
Wellbeing Service	3		3	6	1	54%

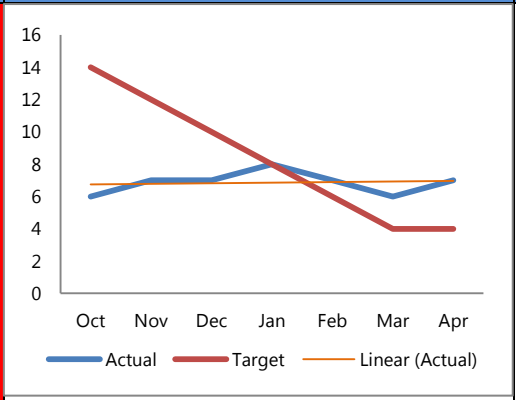
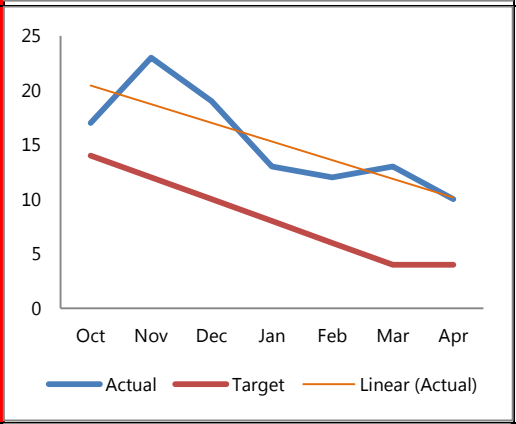
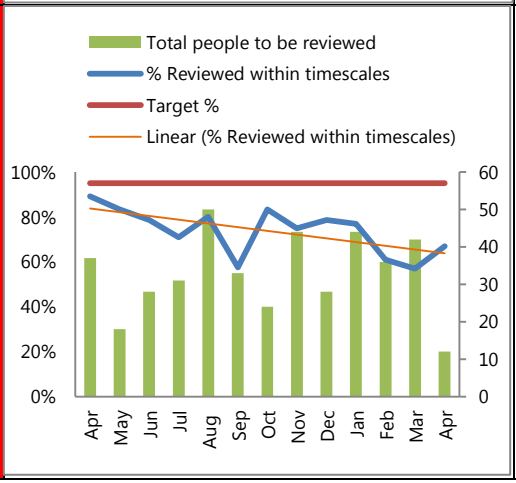
Buckinghamshire						% met
Aylesbury	1	1	2	8	1	69%
Chiltern	1	1		10	1	85%
IAPT			1	7		88%
PIRLS				3		100%
Perinatal	3	1		1		20%

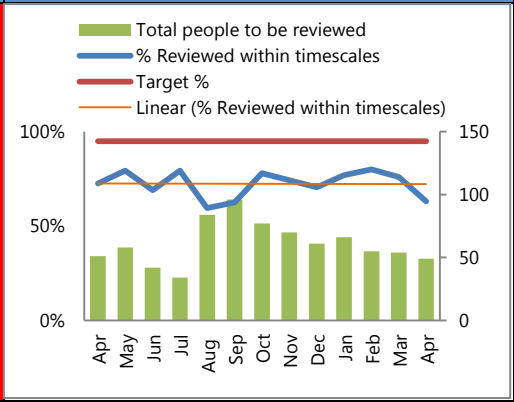
Forensic Service						% met
LSU Schedule 4	1			5		83%
MSU Schedule 4				6		100%

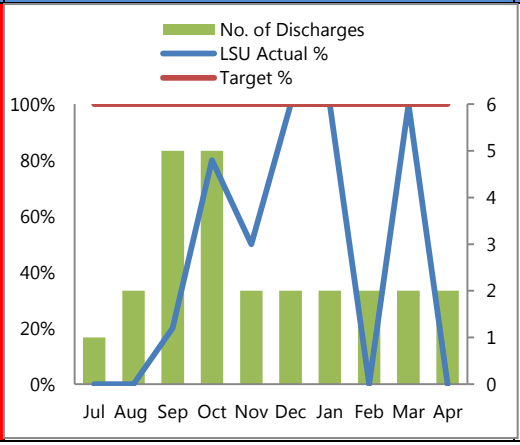
R Red Indicators

Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Oxon Schedule 4	C2c	Staff up-to-date with Prevent safeguarding training	90%	75%		Risk to patient care through insufficiently trained staff.	Prevent training has increased from 71% in March to 75 in April. Trend is improvement.
Oxon IAPT Wellbeing	11	% of patients reporting agree or strongly agree with the statement "The service has helped me understand my problems"	90%	68%		Risk that patients may not be receiving the care that they need.	Some survey respondents do not find the questions relevant to them due to either not having received treatment at the time of follow up call (some people do not say 'agree' or 'strongly agree' as their intervention is still underway), or due to the ambiguity in the questions. In response, we are reviewing the time at which we ask the question. Our current follow-up call is done after 4 weeks while intervention is still under way – doing the follow-up call at the end of the intervention should therefore be more representative of the service user experience.

Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Oxon IAPT Wellbeing	11	% of patients reporting agree or strongly agree with the statement "I got the help that mattered to me"	90%	74%		Risk that patients may not be receiving the care that they need.	As above regarding timing. In addition, we will be able to deliver the support that matters to a greater proportion of people through expanding the range of interventions and support we can offer. We are developing our offer for people in clusters 0-3, using a needs-led, person-centred model. A series of workshops has been designed. This work will be completed (in conjunction with clinical staff and people accessing services) by the end of June, with improvements/expansions to our offer following afterwards.
Oxon IAPT Wellbeing	13	The number of older people 65 and over who have received support from the wellbeing service	9 per month	3			We are addressing this KPI through targeted work with agencies/organisations working with Older People. This work is taking place though visiting services, clubs, care homes etc. No visits were scheduled in April. However, we have 3 dates scheduled in May and June which will make up the difference.

Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Oxon IAPT		Oxon IAPT: length of wait (weeks) Step 3 for Counselling	4 weeks	7 weeks		Risk that patients may be waiting too long to receive care.	We continue to work closely with PML to reduce the numbers and length of waits on counselling lists. In addition to increasing capacity, PML have merged all individual practice lists in the West Locality with the main aim to reduce waiting lists. This will be achieved by counsellors seeing patients who have waited the longest irrespective of which practice they are registered with.
Oxon IAPT		Oxon IAPT: length of wait (weeks) Step 3 for CBT	4 weeks	10 weeks		Risk that patients may be waiting too long to receive care.	Step 3 continue to be addressed and we have seen a further reduction in the CBT waiting list with a current wait of 10 weeks using the 75th percentile to exclude outliers. All patients currently being assessed (where clinically appropriate) are offered a Step 3 CBT group.
Aylesbury Schedule 4	Local 20	95% people will have their care reviewed within the timescales specified by the cluster package.	95%	67%		Risk that patient care is not being reviewed frequently enough to manage changing needs.	As reported in March we estimated 2 months to improvement (April 2017 data). Improvements are being made, albeit slowly and work continues with every care coordinator to address all performance areas. Service managers continue to review weekly with team managers. We will be reviewing the perfect week data alongside our performance data to understand the capacity issues and impact on performance across the AMHTs

Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Chiltern Schedule 4	Local 20	95% people on CPA will have care review within the timescales specified by the cluster package	95%	63%		Risk that patient care is not being reviewed frequently enough to manage changing needs.	As above.
Bucks Perinatal		Perinatal: % women requiring non-emergency assessments completed within 2 weeks of referral	95%	44% (8/18)	New service in 2017/18 contract.		Aylesbury and Chiltern Assessment Functions have been supporting Perinatal Services with triage and completing assessments. Perinatal Non-emergency targets for completing assessment is 14 days whereas Assessment function is 28 days. These are new measures. A member of staff is being tasked with simplifying our data collection and reporting processes to match clinical practice.
Bucks Perinatal		Perinatal: % of women will have an up to date care plan	95%	80% 28/35			
Bucks Perinatal		Perinatal: % of women will have an up to date risk assessment	95%	80% 28/35			

Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Forensics Schedule 4	LQ8	LSU: Number of the discharge summaries sent to the Service User's GP and/or Referrer and to any third party provider within 24 hours.	100%	0%			The discharge summaries were sent, but they missed the within 24 hours target. The circumstances around the delay are being explored.