**Trust Board Performance Report – M7 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**

Targets/thresholds are applicable to most indicators. Where there is no target/threshold, the indicator is considered compliant if it is reported. SOF data is not fully published therefore the M7 FY18 Trust performance % position relates to local contractual performance only.

**91% (939/1037) of local indicators were achieved in M7 FY17/18**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Key:** | Below Target >10% | Below Target <10% | At/above target | Data not published | % met |

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| --- | --- | --- | --- | --- | --- |
| **Total (local contractual)** | 37 | 61 | 939 | 7 | **91%** |
| **National (SOF) – M7** | | | | | |
| **National (SOF)** | 4 | 4 | 12 | 7 |  |
| **Local contractual – M7** | | | | | |
| **Older Peoples** |  |  |  |  | **75%** |
| Oxfordshire (69) | 12 | 12 | 45 |  | 65% |
| Buckinghamshire (40) | 1 | 2 | 37 |  | 93% |
| **Children & Young People** |  |  |  |  | **95%** |
| Oxfordshire (450) | 2 | 12 | 436 |  | 97% |
| Buckinghamshire (135) |  |  | 135 |  | 100% |
| Swindon, Wilts and Banes (215) | 8 | 17 | 190 |  | 88% |
| **Adults of Working Age** |  |  |  |  | **75%** |
| Oxfordshire (62) | 8 | 10 | 44 |  | 74% |
| Buckinghamshire (54) | 5 | 7 | 42 |  | 76% |
| Forensic (32) | 1 | 1 | 10 |  | 75% |

**PERFORMANCE TREND**

The number of reportable indicators varies each month. In month 7 1037 indicators were reportable of which 939 were achieved – 91%. Despite the fluctuating numbers of indicators, the level of compliance has remained fairly stable over the past 6 months, averaging 90%.



The Directorate (local contractual) performance trend is illustrated below.

- **Children and Young People (CYP) Directorate** performance has averaged 95% since M1  
- **Adults of Working Age (AWA) Directorate** performance had been steadily improving over recent months, but has dipped from 82% in M5 **-- Older People’s Directorate (OPD)** performance has averaged 73% since M1

Further information in relation to areas of underperformance is detailed within the attached performance dashboard.





**NATIONAL: Single Oversight Framework (SOF) – FY17 & FY18**

**NATIONAL: Single Oversight Framework (SOF) – FY17 & FY18**

In Sept 2016 NHS Improvement (NHSI) published the first SOF which replaced Monitor’s Risk Assessment Framework, to help NHSI identify where NHS trusts/foundation trusts may benefit from, or require, improvement support. It sets out how NHSI will identify providers’ potential support needs under the following five themes (linked to, but not identical to CQC themes); **quality of care** (safe, effective, caring and responsive), **finance and use of resources**, **operational performance**, **strategic change** and **leadership and improvement capability** (well led).

NHSI have reviewed the current SOF and propose the following changes, reflecting changes in national policy and standards, data quality and other regulatory frameworks as well as learning from the last year;

* The metrics were previously grouped under two headings; Organisational Health and Operational Performance.  This changed to four headings in October: Quality of Care, Finance Score, Operational Performance and Organisational Health.
* 4 metrics applicable to OHFT have been removed (Executive Team Turnover, Aggressive Cost Reduction Plans, CQC Community Survey and ‘patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team’).  Some new indicators are being developed to provide a more sensitive measure of performance against these standards
* 1 metric has been added (inappropriate out of area placements. Total number of bed days patients have spent out of area in last quarter)
* 1 data metric applicable to OHFT has been amended (Data Quality Maturity Index (DQMI) – MHSDS dataset score’

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

The majority of the indicators do not have targets/thresholds, so 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. At end of October, 3/4 Organisational Health metrics had been published, 2 of which were below target/England average; 11/13 Quality of Care metrics had been published, four of which was below target, and 7/10 Operational Performance metrics had been published, two of which were below target.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Key | Well below target >10% | Below Target <10% | At Target | No Data/ Target/ Not Due |
| Performance as at latest available published data | | | | |
| Organisational Health | 1 | 1 | 0 | 2 |
| Quality of Care | 2 | 2 | 7 | 2 |
| Operational Performance | 1 | 1 | 5 | 3 |
| **Total** | 4 | 4 | 12 | 7 |

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| --- | --- |
| **R** | **Red Indicators** |

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| --- | --- | --- | --- | --- | --- | --- |
| **Area** | **Ref** | **Measure** | **Target** | **Actual** | **Trend** | **Narrative** |
| Organisational Health |  | Staff turnover (rolling 12 months) | 12% (Trust) | 14.88%  (Sept) |  | Staff turnover in October 17 was 14.88%, a slight decrease compared to September’s figure of 14.94%. |
| Organisational Health |  | Admissions to adult facilities of patients who are under 16 years old | 0 | 1 | One under-16 admission to the Calm Suite on Opal Ward in October 2017. Patient was discharged to secure social care placement on 06/10/17. | |

Whilst data has not been published for October, the following metrics were showing below target at the most recent available data:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Quality of Care (Mental Health) | 15 | % of clients in settled accommodation | 59.6%  (Eng Ave) | 43.1%  Aug 17 |  | Performance decreased by 1.3% in August to 43.1%. Following liaison with NHS Digital the P&I team are developing a data quality improvement plan to address the issues which are contributing to the low performance. |
| Operational Performance | 23b | Priority Metric % coded (Ethnicity, Employment (Adults only), Accommodation (Adults only) | 85%  50.3% (Eng Ave) | 37.0%  Aug 17 |  | Performance decreased slightly from 37.2% in July to 37.0% in August. The England average decreased by 0.7% and 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 7 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.

The indicators in 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 contract Schedule 6.

There are **117 indicators** for 2017/18 applicable to OPD (excluding the 8 trust-wide Operational Standards and National Quality Requirements); 77 indicators relating to the Oxon CCG contract and 40 indicators relating to the Buckinghamshire CCG contract. The indicators are categorised as follows.

**Older People**: 80 indicators

* Community Services: 70 indicators
* 69 are reportable monthly (2 from M6 only), 9 are reportable quarterly and 2 are reportable bi-annually.
* Older People's Mental Health**:** 10 indicators

7 are reportable monthly, 3 are reportable quarterly

Buckinghamshire: 40 indicators

* **Aylesbury and Chiltern**: 19 indicators per CCG and 2 indicators county-wide

**Contractual Performance Scorecard**

The Older People’s Directorate was required to report against 109 indicators in month 7. 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 due to a fault of the Trust are classed as non-compliant (red). **75% of indicators were achieved in month 7:**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Key:** | Well Below Target >10% | | Below Target </=6-10% | | At/above Target | |  |
|  | | | | | | | **% met** |
| **Total (109)** | | **13** | | **14** | | **82** | **75%** |
| **Oxfordshire** | | | | | | |  |
| Community Services (62) | | 11 + 1nr\* | | 11 | | 39 | 63% |
| OP Mental Health (7) | |  | | 1 | | 6 | 86% |
| Sub-total (69) | | **12** | | **12** | | **45** | **65%** |
| \*nr = not reported | | | | | | |  |
| **Buckinghamshire** | | | | | | | **% met** |
| Aylesbury (19) | |  | | 1 | | 18 | 95% |
| Chiltern (19) | | 1 | | 1 | | 17 | 89% |
| Countywide (2) | |  | |  | | 2 | 100% |
| Sub-total (40) | | **1** | | **2** | | **37** | **93%** |

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| --- | --- |
| **R** | **Red Indicators** |

| **Service** | **Ref** | **Measure** | **Target** | **Actual** | **Trend** | **Impact** | **Action and Resolution Timescale** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Bucks Older Adult Mental Health – Chiltern CCG | TBC | 90% of patients will have a documented risk assessment | 90% | 80% |  | Absent risk assessments may have a direct impact upon patient safety. | 8/10 risk assessments in place. YTD performance for this team is 91%.  The first patient has a care plan from July 2017 which was updated in Sept 17 and then a new care plan in Oct 17. In regards to risk assessment this was completed in Feb 2017 and therefore within the 12 months.  The second patient has a care plan that was created in June 2017 and then updated three times over the month. In regards to risk assessment this was completed in May 2017 and then again in June 2017 on the ward.  This KPI is being reported by an existing audit until we have developed and tested new report based on total caseload on CPA. |
| Out of Hours | LNQR 7 | OOHs % of unfilled clinical shifts | </= 2% | 7%  61/904 |  | Extended waiting time for patients to be seen. Could also lead to increase in the number of complaints received. | Slight dip in rota fill this month mainly due to school half-term holidays having a negative effect on GP availability.  An additional 6 shifts filled would have mirrored last month’s figure.  There has been a renewed effort to recruit additional GPs and a more streamlined HR process has been agreed whereby GPs should be through the necessary checks onto the rota quicker than previously.  This should hopefully have a positive effect on future figures.  Winter rota fill over the 2-week period, 22 Dec – 2 Jan currently stands at 68% and focus for the next few weeks will be on improving this figure.  Improvement trajectory to reach this QR target is Apr 18. |
| Out of Hours | B9 NQR10 | OOH non-urgent triage (walk in) - time to triage | ≥ 95% within 60 minutes | 84%  319/379 |  | Extended waiting time possibly resulting in delayed care | This NQR has unfortunately suffered this month as focus was concentrated on urgent base visits in an attempt to improve performance in this area where there is the most clinical risk to patients.  On reviewing some of the cases that did not meet the one-hour target, the majority had been triaged by a clinician within minutes of entering the base but were subsequently not seen within the time frame.  Patients that remained in the base were in a safe environment and are informed that should they feel their condition worsens they are to inform a member of staff immediately.  An arrivals process is being tested at the moment for walk in patients to prevent paper forms being raised for each case.  This will assure of accurate record keeping and also reduce the risk of incorrect information transfer from paper to clinical system.  Improvement trajectory to reach the QR target is Jan 18. |
| Community Hospitals | C3 | All patients have a discharge plan with an expected discharge date within 24 hours of admission to a community hospital as an inpatient (all pathways inc. EMU, Stroke, generic) | 90% | - | Data unavailable |  | The system to report this KPI is being developed and community hospitals are now using a new discharge planning form on CareNotes. The functionality is now live on the clinical information system and clinical records being updated in a phased approach.  Reports are being developed and data validated with a view to report M8 data at the beginning of December. |
| Community Hospitals | C10 | Average length of stay, excluding DTOC, for patients in community hospitals (excluding patients on the stroke pathway and EMU beds i.e. includes stroke patients without structured stroke specific rehabilitation in generic beds) | 21 | 26 |  | Delayed discharge or transfers of care | DTOC is starting to improve, partly because of increased HART pick up, but also escalation of choice delays. The service will focus especially on these with additional support from the Older People’s Directorate SMT and ongoing from Perfect Week (w/c 6th Nov). Some reduction in HART delays, and a successful push on choice patients over the last few weeks with DTOC w/c 13 Nov standing at 30 in total.  One OHFT Patient Flow Lead is to be released for 3 months from Nov for a dedicated project collaborating with a Social Care colleague to drill down on each choice code delay and support the discharge process.  The service is formally reviewing length of stay across all wards with Matrons at the Community Hospitals Performance Board, which is working to understand and reduce the ongoing difference between sites.  We also require OCCG to support across the whole system, for example legal support to financially charge or evict choice delayed patients at the end of the TOC process.  The Community Rehab Pathway, with virtual beds held on each ward to support some early supported discharges is fully up and running with 2 virtual beds each at Wallingford and Witney as from mid-November. This will be rolled out to the other CH sites in coming weeks. This aims to impact on both length of stay and DTOC. |
| Community Hospitals | D2 | % of rehabilitation patients will have an improved FIM score of 11 points or more by their MDT fit date | 75% | 60% (35/58) |  | Failure of patients to reach their full rehab potential leading to greater reliance on services to maintain independence | As with stroke patients, there are patients whose rehab needs are more complex and need to be delivered in an inpatient environment and therefore there is always a risk that the rehab element can’t be fully achieved - it is difficult to always estimate correctly which patients will achieve the 11 points improvement (who will respond maximally to rehab) and who will not. We are reviewing our data to see whether we are overestimating the initial FIM for some patients.  The service is continuing to work on starting the patient’s assessment in EMU so we capture the patient’s score from the very start of the admission, and also ongoing training of staff to be even more accurate in their measurements, particularly of the initial FIM. |
| Physical Disability Physiotherapy Service | LQR D8 | Percentage of Patients will wait no longer than 12 weeks to first appointment offered | 95% | 44%  46/105 |  | Extended waits for assessment and treatment, patient dissatisfaction, condition exacerbation | A 5% improvement on M6. Comments submitted in the M6 report continue to be applicable. The service has met with OCCG to discuss capacity issues within the service. The CCG agrees that the service has done everything to manage this situation. Unless increased staffing capacity is put in place the service will not be able to meet the KPI.  The service is pulling together a business case outlining these issues, and are in discussions with OUH around whether to work together on a business case for a Parkinson’s Disease specific service for physiotherapy, SALT and OT, as the most significant increase in referrals to the PDPS is the PD population. |
| Stroke | D31ii | Median % of days as an inpatient on which physiotherapy is received | 60% rising to 65% Q4 | 50% |  | Failure of patients to reach their full rehab potential leading to greater reliance on services to maintain independence | In an attempt to maintain length of treatment at 45 minutes (or as close to as possible) patients are being seen less often. Workforce issues are affecting the service’s ability to achieve this KPI. |
| Stroke | D31aii | Median % of days as an inpatient on which occupational therapy is received | 60% rising to 65% Q4 | 41% |  | Failure of patients to reach their full rehab potential leading to greater reliance on services to maintain independence | Workforce issues are affecting the service’s ability to achieve this KPI. In an attempt to maintain length of treatment at 45 minutes (or as close to as possible) patients are being seen less often. Cross-cover over the two sites is difficult however workforce changes required as a result of the relocation are being planned accordingly. |
| Falls | D38 | % of Routine referrals had an appointment (offered) within 8 weeks | 95% | 70%  106/152 |  | Extended waits for assessment and treatment, patient dissatisfaction, condition exacerbation | There was a significant increase in the number of referrals received during October thereby increasing demand on the service. Falls clinical staff are currently triaging referrals instead of Single Point of Access. There continues to be a reduced number of assessment slots which is impacting on waiting times. This is due to the service ensuring that all the patients offered a multifactorial assessment are appropriate, clinicians have to spend time triaging these referrals resulting in fewer appointment slots offered.  The falls pathway is going to be reviewed by the falls project board at the next meeting. |
| Continuing Health Care | 1 | Eligibility decisions are made within 28 days of accepting a referral. All assessments required for eligibility decisions are to be completed within this timeframe | 95% | 59%  48/82 |  | Extended waits for assessment and treatment, patient dissatisfaction, condition exacerbation | It is noted that there is a decline in the percentage of assessments undertaken within the 28 days from receipt however this includes the backlog of referrals which is now complete. It is anticipated that for subsequent months the percentage will improve. |
| Continuing Health Care | 5 | If eligible the package of care for Fast Track individuals will be in place within 2 working days | 95% | 50%  8/16 |  | Extended waits for care, blockage in the patient pathway affecting wider DTOC, patient dissatisfaction | The provision of care remains a challenge and currently outside the control of the service.  However, of the 8 Fast Track clients who did not receive care within the 48-hour period, 2 took 3 days, 2 took 6 days, 1 took 7 days, 2 took 12 days and 1 took 14 days. |
| Continuing Health Care | 9 | All appeals will be processed and closed within 6 months of receipt | 95% | 50%  1/2 |  | Extended wait for appeal decision | The one case that breached the 6 month KPI relates to a family who moved house and did not receive our outcome letter in a timely manner due to an administration slip-up. As a good will gesture we extended the period of appeal to reflect the delay. |

**CYP Performance Overview – Month 7 FY17-18**

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 and Children’s Services (Oxon CCG)
* SHN (OCC Public Health)
* College Nursing (OCC Public Health)
* Health Visiting Q2 (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 800 indicators in month 7. (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:**



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| --- | --- |
| **R** | **Red Indicators** |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Service** | **Ref** | **Measure** | **Target** | **Actual** | **Trend** | **Impact** | **Action and Resolution Timescale** |
| CAMHS - OCCG | E6ai | CAMHS - 12 Week - Waits | 75% | 43%  104/290 |  | Extended waiting time possibly resulting in delayed care | Waiting times continue to be affected by a combination of workforce pressures and increased demand. A report has been produced within the Directorate detailing staffing and performance to date and issues and actions are being tracked by the Directorate Leadership Team. Further information and resolution timescales will be included in this report once confirmed. |
| CAMHS - OCCG | E6aii | ASD Waits | 75% | 13%  2/15 |  | Extended waiting time possibly resulting in delayed care | This indicator will not be measured until December 2017 as part of the new CAMHS contract. This is to allow the new Neuro developmental pathway to be embedded within the service. |
| CAMHS BaNES /Wilts CCG | PAF | Wilts T3  Waiting 4 Weeks | 90% | 61%  23/38 |  | Extended waiting time possibly resulting in delayed care | Wilts T3 CAMHS are achieving 95% for patients assessed within 12 weeks; data includes patient cancellations and breaches due to patient choice.  An Action plan has been put in place to address performance. |
| CAMHS BaNES /Wilts CCG | PAF | Wilts & BaNES T3  Completed Episodes of Care | 132 | 80 |  | 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 Wilts CC | PAF | Wilts Direct Contacts T2 | 299 | 250 |  | No immediate Impact | We are currently investigating the reported underperformance in activity in particular with direct and indirect contacts. Further information will be provided once analysis has been completed |
| CAMHS Wilts CC | PAF | Wilts Indirect Contacts T2 | 158 | 120 |  | No immediate Impact | We are currently investigating the reported underperformance in activity in particular with direct and indirect contacts. Further information will be provided once analysis has been completed |
| CAMHS Wilts CC | PAF | T2 Wilts  Waiting 4 Weeks | 90% | 36%  19/53 |  | Extended waiting time possibly resulting in delayed care | Wilts T2 CAMHS are achieving 98% for patients assessed within 12 weeks; this 4 week data includes patient cancellations and breaches due to patient choice. |
| CAMHS Wilts CC | PAF | T2 Wilts  Waiting 8 Weeks | 95% | 51%  27/53 |  | Extended waiting time possibly resulting in delayed care | Wilts T2 CAMHS are achieving 98% for patients assessed within 12 weeks; this 8 week data includes patient cancellations and breaches due to patient choice. |
| CAMHS Wilts CC | PAF | Wilts CAMHS ED- 1-week urgent assessment | 95% | 67%  2/3 |  | Extended waiting time possibly resulting in delayed care | Month 7-2 out of 3 patients seen within 1 week, 1 patient seen within 8 days |
| Wilts CC | PAF | Adult ED  Waits 4 weeks | 95% | 50%  3/6 |  | Extended waiting time possibly resulting in delayed care | 3 Breaches reported. 1 was due to patient choice. The remaining 2 were seen within 5 weeks. |

**LOCAL: Adult of Working Age Directorate – M7 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 Directorate reports to commissioners as follows:

**Oxfordshire CCG**

* OBC Incentivised Measures: 13 indicators reported monthly (of which 6 baselining, under review or no target)
* OBC Schedule 4: 16 indicators reported monthly (of which 4 baselining, under review or no target)
* CCG Schedule 4: 3 indicators, reported monthly
* Oxon IAPT: 12 indicators, 11 reported monthly and 1 annually
* Wellbeing: 13 indicators, reported monthly
* Learning Disabilities: 6 indicators, reported monthly.

**Buckinghamshire**

* Aylesbury & Chiltern CCGs: 15 indicators each, reported monthly (of which 5 without target)
* Bucks IAPT services: 8 indicators reported monthly
* PIRLS: 6 indicators reported monthly
* Perinatal: 10 indicators reported 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 128 indicators in October 2017 (M7). Targets/thresholds are applicable to most indicators. Where there is no target/threshold, the indicator is considered compliant if it is reported.

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

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| --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | % met |
| **All Measures (128)** | 14 | 18 |  | 96 |  | 73% |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Oxfordshire** | | | | | | 74% met |
| OBC Incentivised Measures | 1 | 2 |  | 10 |  | 77% |
| OBC Schedule 4 | 2 | 6 |  | 8 |  | 50% |
| Oxon CCG Schedule 4 Quality Requirements |  | 1 |  | 2 |  | 67% |
| IAPT | 1 |  |  | 10 |  | 91% |
| Wellbeing Service | 1 | 1 |  | 11 |  | 85% |
| Learning Disabilities | 3 |  |  | 3 |  | 50% |

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| --- | --- | --- | --- | --- | --- | --- |
| **Buckinghamshire** | | | | | | 76% met |
| Aylesbury | 1 | 2 |  | 12 |  | 80% |
| Chiltern | 2 | 2 |  | 11 |  | 73% |
| IAPT |  | 1 |  | 7 |  | 88% |
| PIRLS |  |  |  | 6 |  | 100% |
| Perinatal | 2 | 2 |  | 6 |  | 60% |

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| --- | --- | --- | --- | --- | --- | --- |
| **Forensic Service** | | | | | | 75% met |
| LSU Schedule 4 |  | 1 |  | 5 |  | 94% |
| MSU Schedule 4 | 1 |  |  | 5 |  | 94% |

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| **R** | **Red Indicators** |

| **Contract** | **Ref** | **Measure** | **Target** | **Actual** | **Trend** | **Impact** | **Action and Resolution Timescale** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Oxon OBC |  | % of people that have had their cluster reviewed within the agreed timescale | 85% | 66% (59/90) |  | Right cluster of package care may not be delivered. | All staff receive a monthly patient level report for patient’s where the cluster review date has expired or is about to expire in that month. Staff have also been reminded of the ‘front page’ function in Carenotes where a variety of summarised data can be reviewed for that patient, including the cluster review date. Managers have escalated with the Trust’s Clinical Applications support Team the urgent need for Carenotes functionality to be improved to include a dashboard which clinicians can refer to at a glance for their caseload in order to easily understand which patients require a cluster review. This functionality has been agreed, but is still in development. In addition to monthly reporting for Care Coordinators, staff will continue to be supported through team meetings and supervision to ensure clusters are reviewed within the correct timescale. |
| Oxon OBC |  | Percentage of outpatient letters that are sent back to GPs (uploaded to CareNotes) within 10 calendar days | 95% | 74% (64/88) |  | Risk to continuity of care. | We have looked at the data more closely to identify areas of good practice and areas where performance is below expected. Variation has been identified both inter team and intra team which is currently being investigated so that a common solution can be identified. Resolution date to be confirmed. |
| OBC Incentivised |  | % of identified carers who are, as a carer, are satisfied with the care and support s/he receives as a carer | 75% | 53%  (9/17) |  | Risk to unsupported carers. | There has been an impact on this indicator following staff changes. Also, the plans to change to using I want great care (IWGC) for carers in the near future may have impacted on people using the current Survey Monkey questionnaire.  The IWGC questionnaires are being amended to contain specific carers questions, this will be completed in December and there will be a drive to encourage teams to start using this, as it is a much simpler system we will hopefully see numbers start to increase over the next few months. |
| Oxon IAPT |  | The length of wait for the 75th centile at Step/Cluster 3 for CBT (weeks) | 8 weeks | 20 weeks |  | Risk that patients may be waiting too long to receive care. | Talking Space Plus continues to see the impact of the 3 staff that left the service during July. We have successfully recruited to these vacancies and people are now in post. We have also recruited a locum to address the longest waiters using the short term funding from the CCG. We aim to achieve our target of 8 weeks by the end of the FY. |
| Oxon Wellbeing |  | Patient experience Question 1: "The service I received has helped me to better understand my problems" | 90% | 71% |  | Risk that patients may not be receiving the care that they need. | The service is piloting a revised questionnaire from Oct-Dec, asking ‘did you need help…’ and screening out those who said ‘no’ |
| Learning Disabilities |  | % of urgent referrals to Specialist Learning Disability Health Services 48 hour wait | 95% | 0% (0/1) |  | Delayed access to services. | Service are adapting to their new contract schedule which defines ‘urgent’ differently. This one case was regarded and deemed routine. Performance team were alerted. |
| Learning Disabilities |  | Discharges: % of GP discharge templates issued within 10 days of patient discharge | 95% | 70% (26/37) |  | Risk to continuity of care. | This is an operational issue and is being addressed by managers. |
| Learning Disabilities |  | % of Service Users receiving accessible discharge summary within 10 days of discharge | 95% | 76% (28/37) |  | Risk to continuity of care. | This is a process issue that has been highlighted at a recent awayday considering business process and standardising operating procedure - some users are literally referred and signposted, so do not receive an assessment and intervention. Need to work with Carenotes team to enable this cohort to be screened out of the KPI. |
| Bucks |  | Aylesbury Vale: % people will have care review within the timeframe specified by the cluster package | 95% | 55% (21/38) |  | Right cluster of package care may not be delivered. | The team have been working on improving this measure which was recorded at 50% last month. Data reports are discussed weekly and clinicians are supported through supervision to improve this target. |
| Bucks |  | Chiltern: % people will have care review within the timeframe specified by the cluster package. | 95% | 58% (36/62) |  | Right cluster of package care may not be delivered. | The team have been working on improving this measure which was recorded at 48% last month. Data reports are discussed weekly and clinicians are supported through supervision to improve this target. |
| Bucks |  | Chiltern: Routine (non-emergency) referral to Mental Health Team will be seen within 28 consecutive days for assessment. | 90% | 79% (84/107) |  | Delayed access to services. | 14 referral breaches were due to patient choice.  9 referral breaches were due to appointments needing to be rearranged due to staff sickness, one clinic was overbooked and 6 breaches had unclear documented reasons. Plan going forward is that the Team Manager is working with the team to ensure clear reasons for breaches are monitored and recorded. |
| Perinatal |  | Bucks: % women requiring treatment will be offered a treatment within 1 month of referral (1st appointment). | 90% | 75%  (3/4) |  | Risk to access to care | 1 patient did not respond to contact from the team until the 5th attempt. Following assessment at that time an intervention was not deemed appropriate. |
| Forensics |  | MSU: *Number of discharge summaries to the services users GP within 24 hrs* | 100% | 67%  (2/3) |  | Risk to continuity of care. | The one discharge summary not sent within 24 hours related to a prisoner who was returned to prison. He is not registered with a GP and a pre-discharge meeting was held with the prison in-reach mental health team prior to his discharge as recorded in Carenotes |