Oxford Health NHS
NHS Foundation Trust

Trust Board Performance Report – M6 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

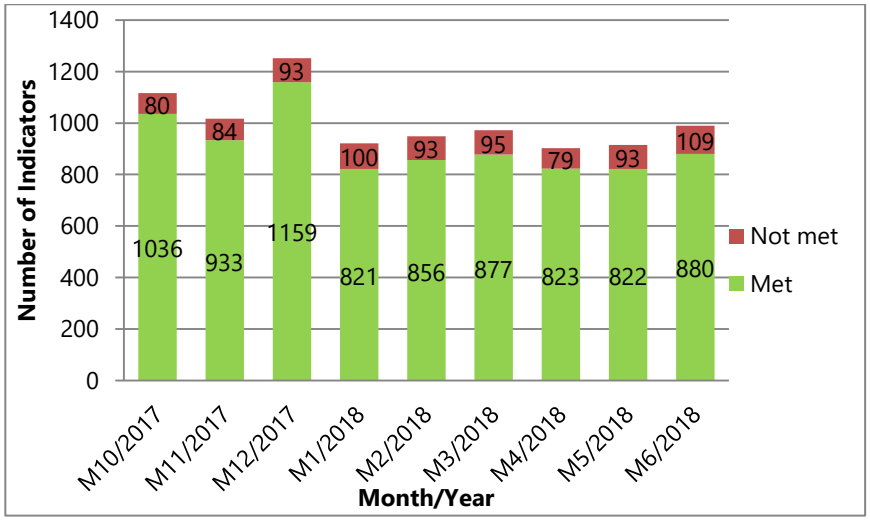
Targets/thresholds are applicable to most indicators. Where there is no target/threshold, the indicator is considered compliant if it is reported. SOF data is not fully published therefore the M6 FY18 Trust performance % position relates to local contractual performance only.

89% (880/989) of local indicators were achieved in month 6 FY17/18

Key:	Below Target >10%	Below Target <10%	At/above target	Data not published	% met
Total (local contractual)					**89%**
National (SOF) – M6					
National (SOF)	2	0	6	22	
Local contractual – M6					
Older Peoples					**73%**
Oxfordshire (77)	12 + 8nr*	10	45		60%
Buckinghamshire (40)		1	39		97.5%
Children & Young People					**94.6%**
Oxfordshire (346)	4	4	338		98%
Buckinghamshire (135)			135		100%
Swindon, Wilts and Banes (243)	11	20	212		87%
Adults of Working Age					**75%**
Oxfordshire (62)	7	9	46		74%
Buckinghamshire (54)	3	10	41		76%
Forensic (32)	5	3	24		75%

PERFORMANCE TREND

The number of reportable indicators varies each month. In month 6; 989 indicators were reportable of which 880 were achieved – 89%. Despite the fluctuating numbers of indicators the level of compliance has remained fairly stable over the past 6 months, averaging 91%.

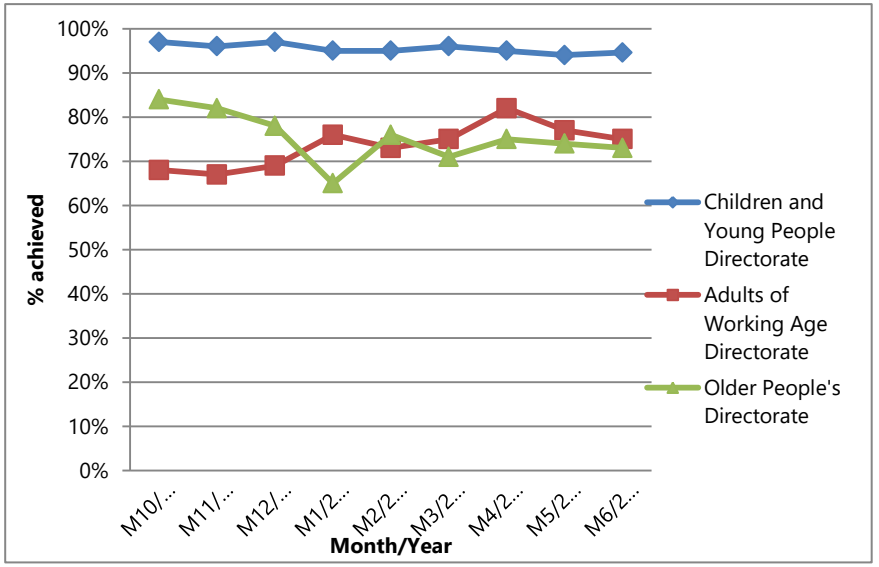


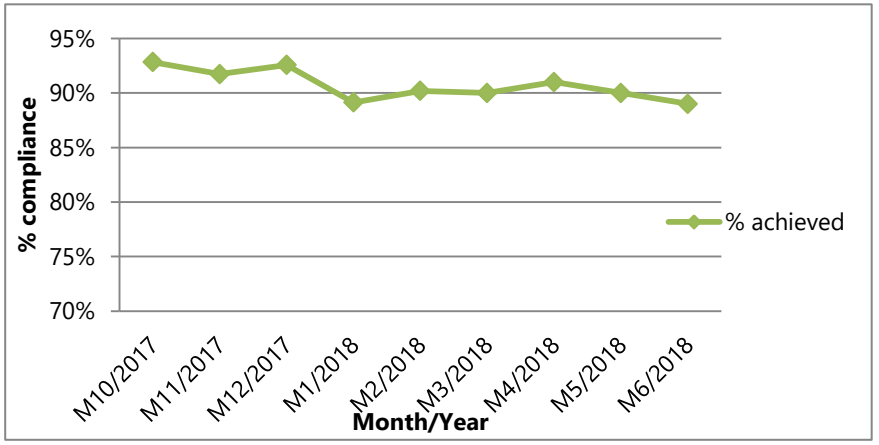
The Directorate (local contractual) performance trend is illustrated below.

- **Children and Young People (CYP) Directorate** performance has averaged 96% since M1
- **Adults of Working Age (AWA) Directorate** performance had been steadily improving over recent months, but has dipped from 82% in M5

The Older People's Directorate (OPD) performance has averaged 72% since M1

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





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 will change 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'

NHSI intend to publish the updated SOF in early Oct 2017, and introduce the changes during Q3 (Oct-Dec 2017). This report will reflect the changes.

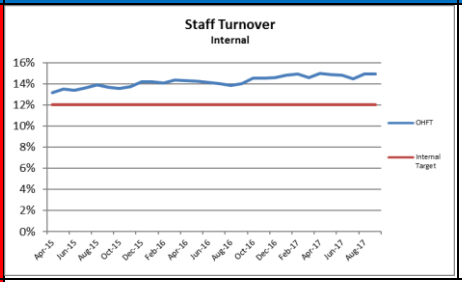
In the majority of cases NHSI will be sourcing Trust performance data from publicly available sources e.g. CQC, NHS Digital, NHS England, and Unify. OHFT will no longer be required to directly submit data nationally for performance management.

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.

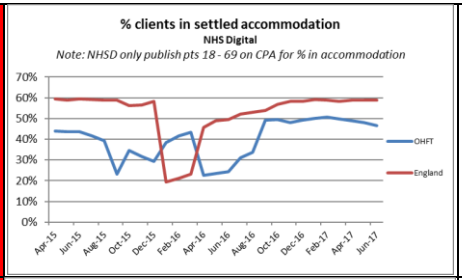
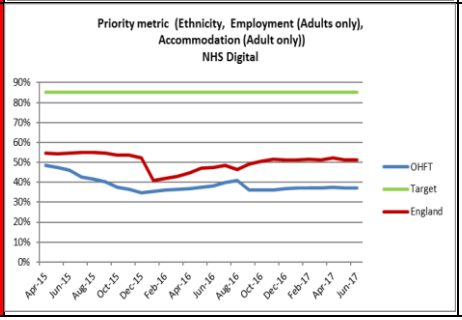
There is a time lag of when data is published nationally and therefore the final position for 2016/17 is not yet available. At end of September, 5/19 Organisational Health metrics had been published, 2 of which were below target and 3/11 Operational Performance metrics had been published, all of which had achieved target.

Key	Well below target >10%	Below Target <10%	At Target	No Data/ Target/ Not Due
Performance as at latest available published data				
Organisational Indicators	2	0	3	14
Operational Performance	0	0	3	8
Total	2	0	6	22

R Red Indicators

Area	Ref	Measure	Target	Actual	Trend	Narrative
Organisational Health		Staff turnover (rolling 12 months)	12% (Trust)	14.94% (Sept)		Staff turnover has averaged 14.85% YTD; a slight increase against the 2016/17 average of 14.4% and 2015/16 average of 13.8%
Organisational Health		Admissions to adult facilities of patients who are under 16 years old	0	1	There was one admission of a 15-year-old to Opal ward – the patient was admitted from Stoke Mandeville Hospital on 05/09/17 at 17h50 due to no beds available, and transferred the same evening at 23h20 to Brookside Child and Adolescent Unit in Essex.	

Whilst data has not been published for September, the following metrics were showing below target at the most recent available data*;

Mental Health	15	% of clients in settled accommodation	59% (Eng Ave)	46.7% *Jun 17		Performance decreased by 1.3% in June to 46.7%. 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.
Mental Health	23 b	Priority Metric % coded (Ethnicity, Employment (Adults only), Accommodation (Adults only)	85% 51.2% (Eng Ave)	37.3% *Jun 17		Performance remained the same in June at 37.3%. The England average decreased by 1% 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 6 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.

Oxfordshire: 77 indicators

- **Community Services:** 67 indicators
- 57 are reportable monthly (2 from M6 only), 8 are reportable quarterly and 2 are reportable bi-annually. The performance of 2 of the quarterly indicators (SSNAP) has yet to be published and will therefore be included in future months' report.
- **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 104 indicators in month 6. 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). **73% of indicators were achieved in month 6:**

Key:	Well Below Target >10%	Below Target </=6-10%	At/above Target	
				% met
Total (115)				**73%**
Oxfordshire				
Community Services (65)	11 + 6 nr	9	39	60%
OP Mental Health (10)	1 + 2 nr	1	6	60%
Sub-total (75)	**12 + 8 nr**	**10**	**45**	**60%**

*nr = not reported

Buckinghamshire				**% met**
Aylesbury (19)			19	100%
Chiltern (19)		1	18	95%
Countywide (2)			2	100%
Sub-total (40)		**1**	**39**	**97.5%**

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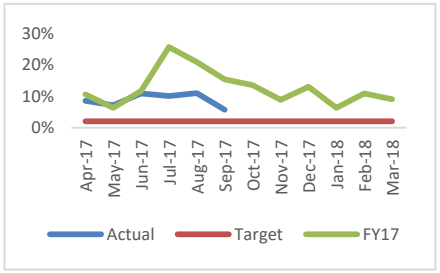
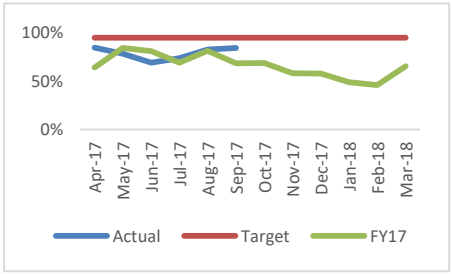
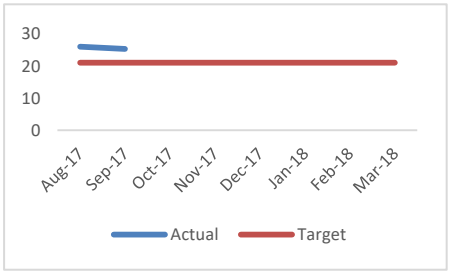
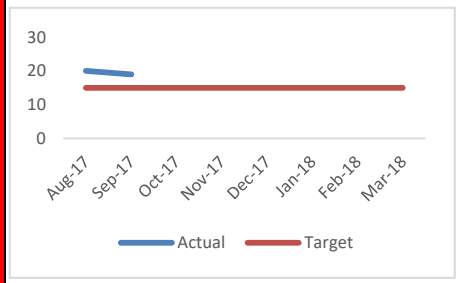
R Red Indicators

Service	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Out of Hours	LNQR 7	OOHs % of unfilled clinical shifts	</= 2%	6% (53/ 938)		Extended waiting time for patients to be seen. Could also lead to increase in the number of complaints received.	Rota fill this month improved to reach within target threshold and its highest achievement year to date. This was achieved through an increased focus on rota fill by the dedicated rota team and the continuation of targeted incentives to fill the hard to fill shifts: so there will be a financial impact. If the service had managed to successfully fill another 34 shifts it would have returned a performance indicator of 2% and would have been Green. GP sessional recruitment is a continuous activity and this shows a steady improvement since Feb 2016 - 99 applications, 24 withdrawals, 32 still in recruitment pipeline and 43 new GPs working.
Out of Hours	LNQR 10 B8	OOH urgent triage (walk in) - time to triage	95%	84% (32/38)		Extended waiting time that could result in delayed care. Patients remain in a safe environment whilst waiting to be seen and so reducing patients risk	Performance continues to improve for the fourth successive month. The manual patient arrival assessment process still continues as the solution on ADASTRA has still to be delivered by Advanced Healthcare. It is expected that this will deliver further improvement once implemented.

Service	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
						and ensuring patient safety	
Community Hospitals	C3	All patients have a discharge plan with an expected discharge date <24 hours of admission (all pathways)	90%	Waiting data	Waiting data	Delayed discharge or transfers of care	The system to report this KPI is being developed and community hospitals are now using a new discharge planning form on CareNotes. Data will be available in Q3.
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	25		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). We are formally reviewing length of stay across all wards with Matrons at the new Community Hospitals Performance Board which started in May, 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.

Service	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
							The Community Rehab Pathway, with virtual beds held on each ward to support some early supported discharges, will be started at Wallingford and Witney at the end of November. If successful this will be rolled out to the other CH sites. This aims to impact in both length of stay and DTOC.
Community Hospitals	C11	The snapshot number of DTOCs that are within the service's control (i.e. excluding delays coded to Social Services and E2 Both)	15	19		Delayed discharge or transfers of care	Please see comment above.
MSK Service	LQR D8	Percentage of Patients will wait no longer than 12 weeks to first appointment offered	95%	65% 231/353)		Extended waits for assessment and treatment, patient dissatisfaction, condition exacerbation	As agreed, due to the transition arrangements to Healthshare there are no supplementary comments and the breach breakdown has been excluded.

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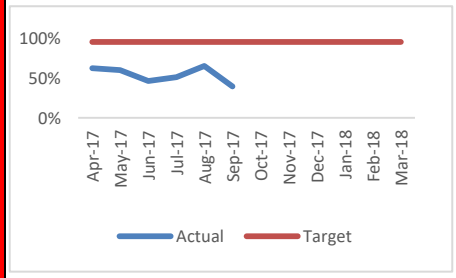
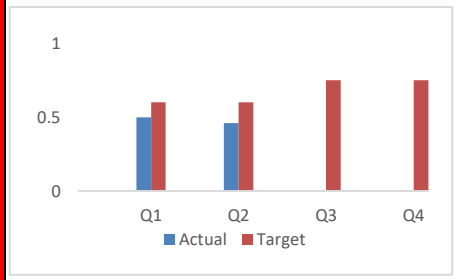
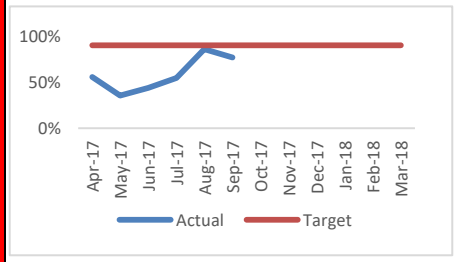
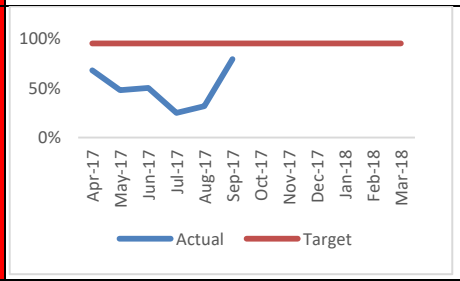
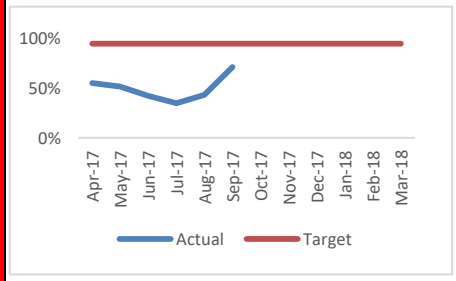
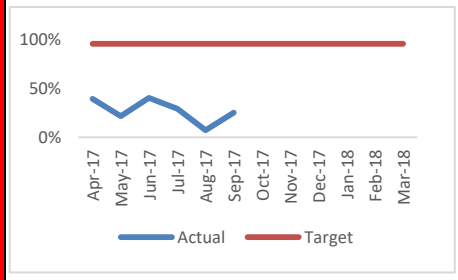
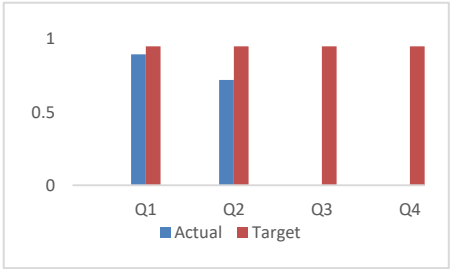
Service	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Physical Disability Service	LQR D8	Percentage of Patients will wait no longer than 12 weeks to first appointment offered	95%	39% (41/104)		Extended waits for assessment and treatment, patient dissatisfaction, condition exacerbation	The service has met with OCCG on 3 occasions to discuss the capacity issues within the service as the demand for the service is exceeding resources. The CCG agrees that the service has done everything to manage this: defined pathways, triage, and goal-based treatment in place along with a range of service efficiencies. Unless increased staffing capacity is put in place the service will not be able to meet the KPI.
Community Nursing	D24	Each patient on the District Nursing caseload risk stratified as high or medium risk has a named nurse who has seen that patient (face to face) at least once in the previous 3 months	75%	465 (892/1937)		Extended waits for treatment, patient dissatisfaction, condition exacerbation	Not all patients on the caseload risk stratified as medium risk are currently given a named nurse and so this will affect the report. All high risk patients have a named nurse. This is partly due to staffing (although we are making very good progress with recruitment) and the way named nurses are recorded on CareNotes. Teams have changed on the system as we move to neighbourhood teams and so named nurses are not always picked up properly – this is being rectified with the CareNotes team. Secondly, if a patient deteriorates then they may need to be seen by a higher banded nurse/nurse with different skills to their named nurse. This decision is made as part of the patient's care review.

Service	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
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%	Waiting data	Waiting data	Failure of patients to reach their full rehab potential leading to greater reliance on services to maintain independence	A new KPI has been agreed with OCCG and this will be reported from next month as final detail of the targets and thresholds are finalised. This new KPI will be more sensitive to demonstrate the actual therapy delivered alongside the clinical outcomes.
OT	LQR 31a		85%	Waiting data			
Speech and Language Therapy	LQR 31b		85%	Waiting data			
Falls	D38	% of Routine referrals had an appointment (offered) within 8 weeks	95%	77% (110/143)		Extended waits for assessment and treatment, patient dissatisfaction, condition exacerbation	A reduction in slots for assessment resulted in increased waiting times across the county due to several factors: • To ensure all the patients offered a multifactorial assessment are appropriate, clinicians have to spend time triaging these referrals resulting in fewer appointment slots offered. Although the number referred reduced slightly in September the service is still trying to catch up from previous months. • In addition in order to keep specialists' mileage to a minimum (thus maximising patient face-to-face time) the service clusters together home visits which on occasion means that some patients may not be seen

Service	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
							in time. • Staff sickness within the team.
Continuing Health Care	2	Individuals eligible for CHC will receive a case review 3 months after eligibility decision	95%	79% (15/19)		Extended waits for assessment and treatment, patient dissatisfaction, condition exacerbation	A significant improvement although there is still a small backlog of reviews which are being addressed this month.
Continuing Health Care	3	Individuals eligible for CHC will receive a case review every 12 months	95%	71% (15/21)		Extended waits for assessment and treatment, patient dissatisfaction, condition exacerbation	The service has used the agency staff that they have contracted to focus on this work. You will see from KPI 2 and KPI 3 that this has been a significant focus of the service's work.
Continuing Health Care	5	If eligible the package of care for Fast Track individuals will be in place within 2 working days	95%	25% (3/12)		Extended waits for care, blockage in the patient pathway affecting wider DTOC, patient dissatisfaction	This area of work does demonstrate some challenges beyond the control of the service. The service is able to clearly evidence their efforts on attempting to source care packages and nursing home placements - evidence not held in this document. The delay was due to the provider's staff holidays. No patients were left without care.

Service	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Older Adult Mental Health (Oxon)	F5a	Service users will have their s117 status reviewed in time	95%	72%		Impact on quality of care if status not reviewed in a timely manner	The reporting of this KPI is currently being discussed by the three CMHTs and the Performance and Information team; therefore narrative was not able to be provided in time for submission of the Board report, but will be resolved for the CRM reports at the end of the month.

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LOCAL: Children and Young Peoples Directorate – Month 6 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.

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

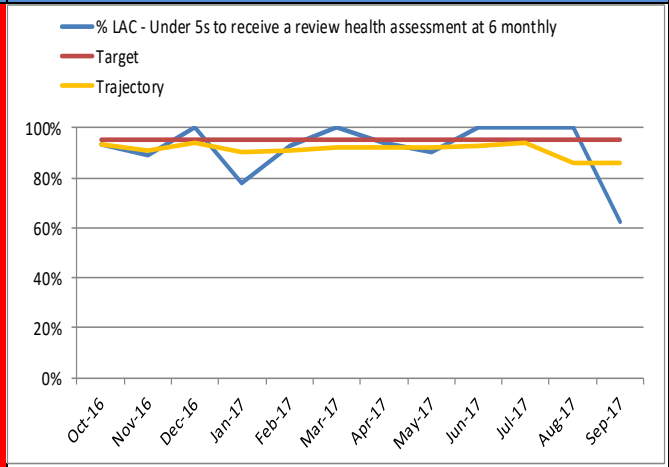
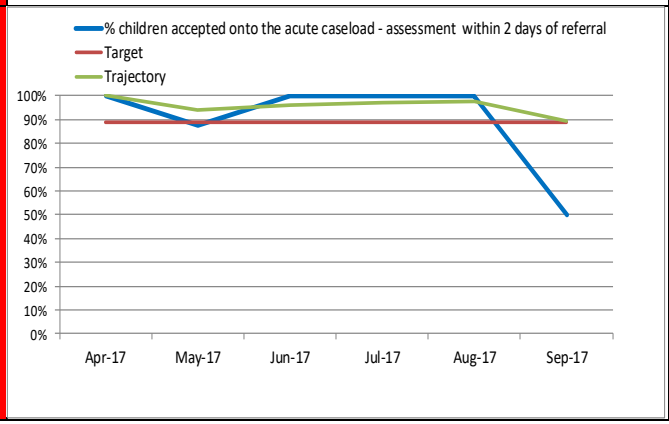
The Children and Young People's Directorate was required to report against 719 indicators in month 6. (This excludes Dental)

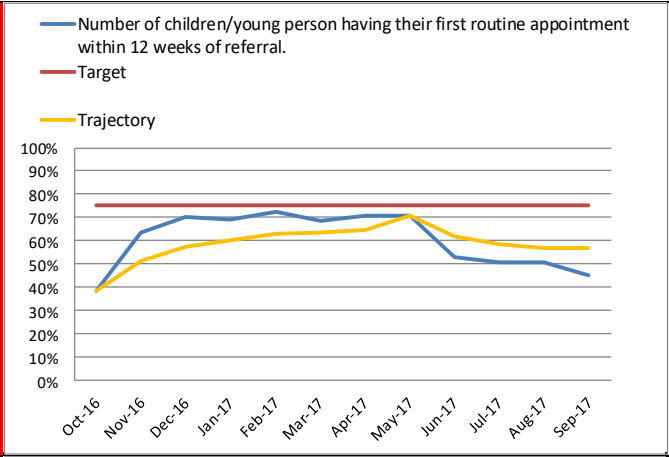
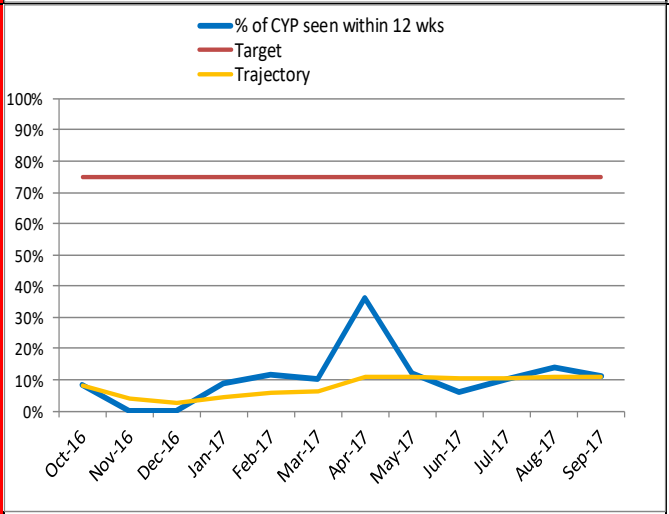
Targets/thresholds are only applicable to a **small proportion** of CYP indicators. Where there are no targets/thresholds, the indicator is considered compliant if it is reported.

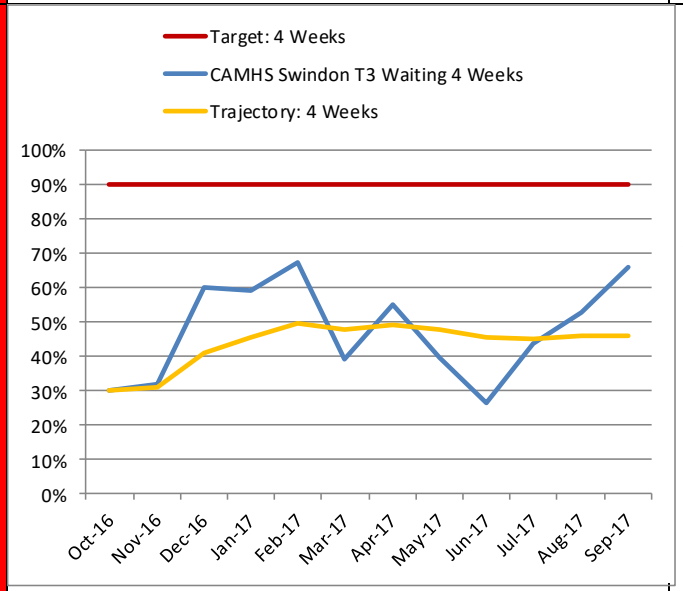
95% of indicators were achieved:

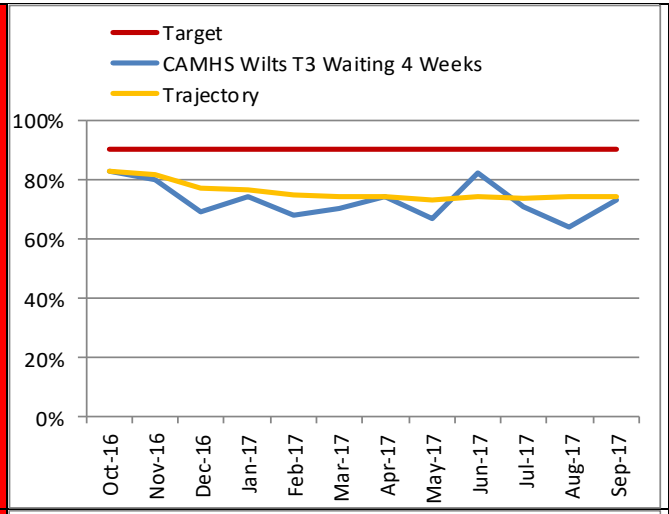
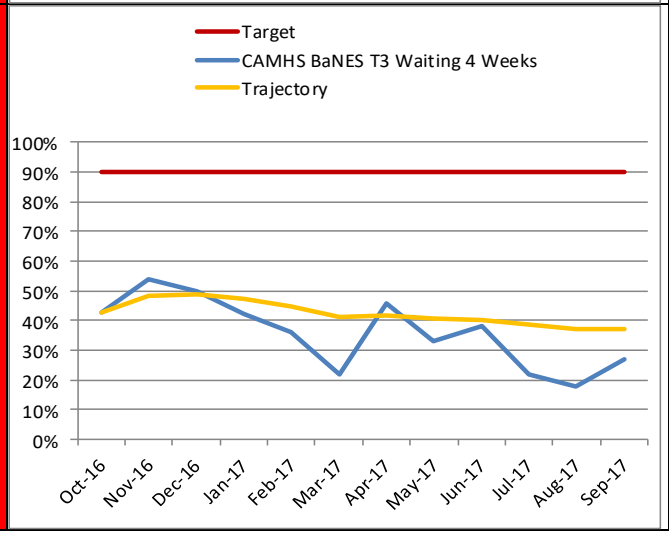
Commissioner		Well Below Target >10%	Below Target </=6-10%	Near Target </=5% under	At Target	Exceeded Target	% at Target or Above
Total		15	13	11	596	84	95%
Oxfordshire							**% Met**
Oxon CCG	LQR				1	2	100%
	Childrens Community Services	2		3	1		17%
	CAMHS - Schedule 4	2			1	4	71%
	CAMHS PAF			1	70	11	99%
Oxon LA	SHN				173		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	1	3	4	31	17	86%
Wilts and BaNES CCG	Wilts and BaNES T3	6	5	1	50	19	85%
BaNES CCG	BaNES T2	1	2	1	18	4	85%
Wilts CC	Wilts T2	3	1	1	15	1	76%
Wilts CCG	Adult ED		2		31	26	97%

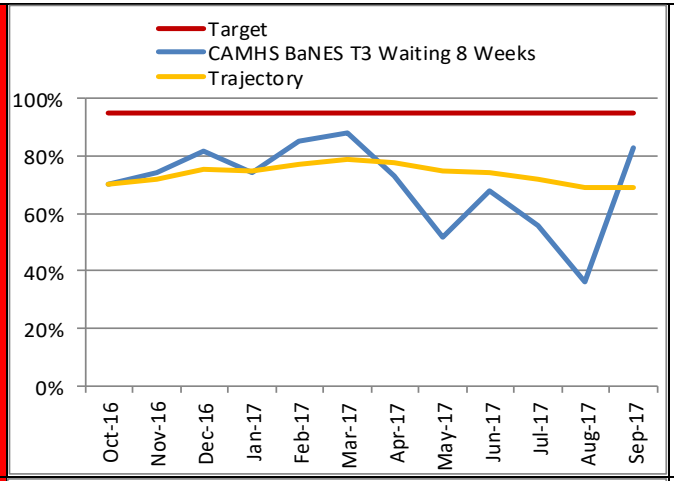
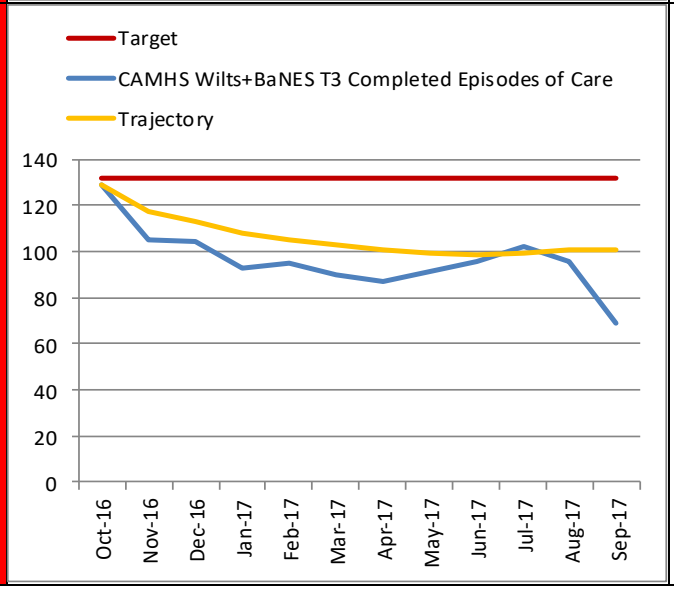
R Red Indicators

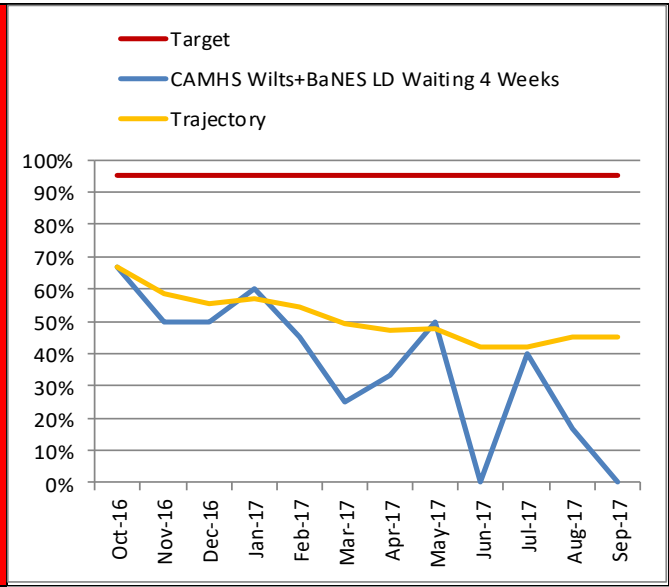
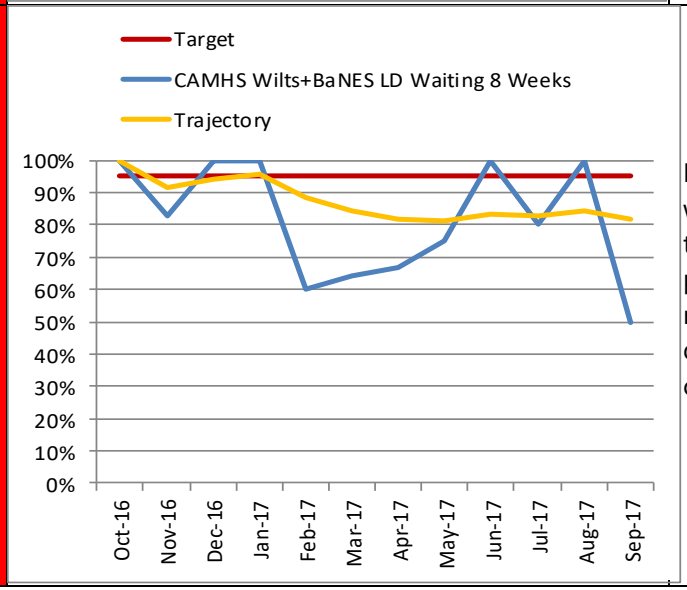
Service	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Children's Community Services- OCCG	E1b	LAC - Under 5s health assessment at 6 monthly intervals	100%	95% 5/8		Delay in Review could possibly result in delayed care	All Exceptions are reported directly to the Safeguarding Lead for Oxfordshire CCG.
Children's Community Services- OCCG	E4	CCN Acute – Assessment within 2 days	89%	50% 3/6		Extended waiting time possibly resulting in delayed care	The first two were due to issues with staffing capacity and intense clinical intervention required in another part of the caseload. The third breach was due to child being readmitted to hospital at short notice.

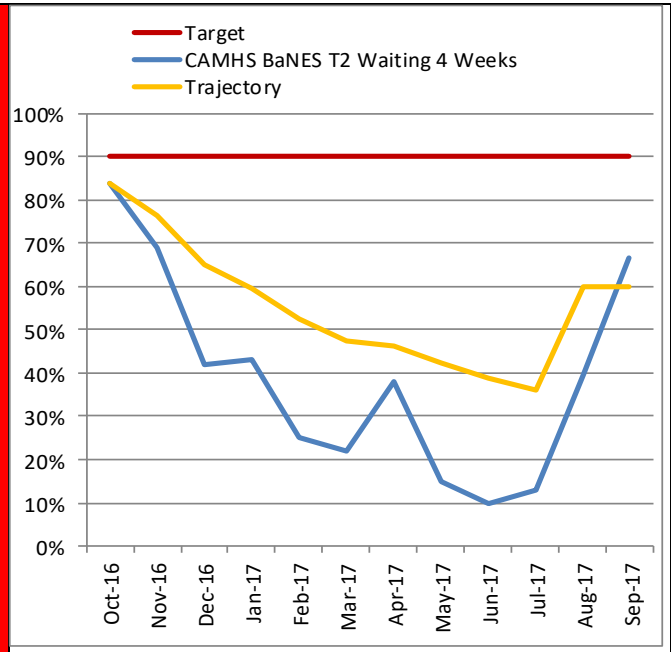
CAMHS - OCCG	E6ai	CAMHS - 12 Week - Waits	75%	45% 106/234		Extended waiting time possibly resulting in delayed care	Separate waits paper provided for Oxfordshire CAMHS detailing staffing and performance to date for September 2017 and actions in place. Risk mitigation report within the paper.
CAMHS - OCCG	E6aii	ASD Waits	75%	11% 2/18		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. ASD waits continue to breach the 12 week target due to the large number waiting to be seen and we have sub contracted approx. 150 referrals to help reduce this backlog. We have also developed an ASD pathway which is now seeing young people within 4-6 weeks of receiving all required information, however some of these cases were referred into the T3 teams for an ASD assessment longer than 12 weeks ago. As such, these referrals will continue

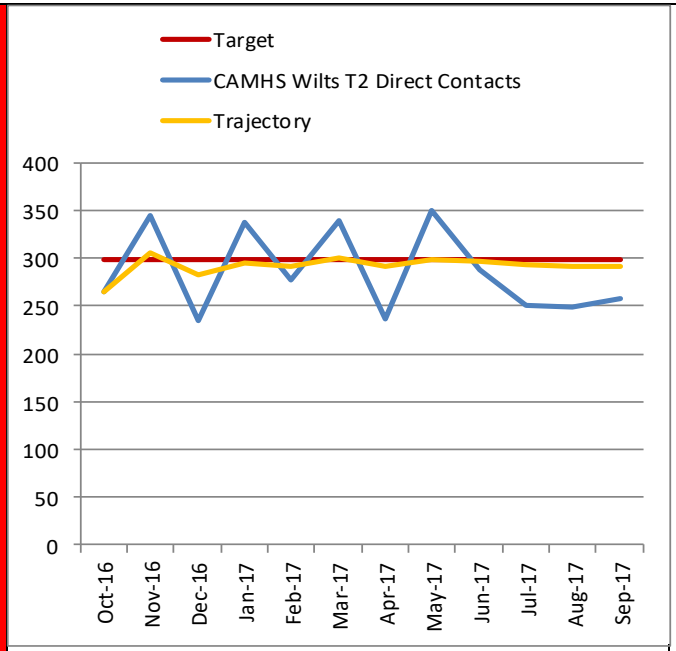
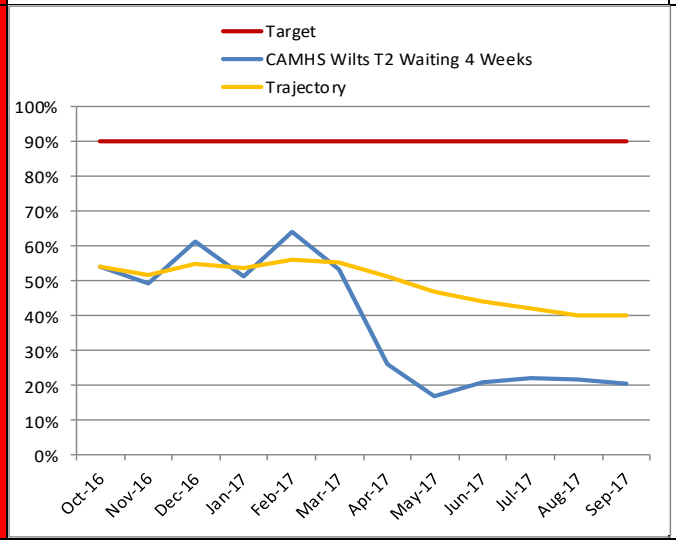
							to breach the 12 week wait whilst the back log is being worked through. In the last five months we have reduced the number of young people waiting over 12 weeks from 64 to 36. This is a reduction of 44%.
CAMHS Swindon CCG	PAF	Waiting 4 Weeks	90%	66% 23/35		Extended waiting time possibly resulting in delayed care	This issue has been highlighted to the team through Performance and contract meetings. Swindon CAMHS have seen a 46% increase in referrals during 16-17 compared to 15-16, demand continues to outweigh capacity, and this has been highlighted to Swindon Commissioners, referrals are being prioritised by clinical need. 100% have been assessed within 8 weeks and 12 weeks. Targets are being reviewed with commissioners for 18-19.

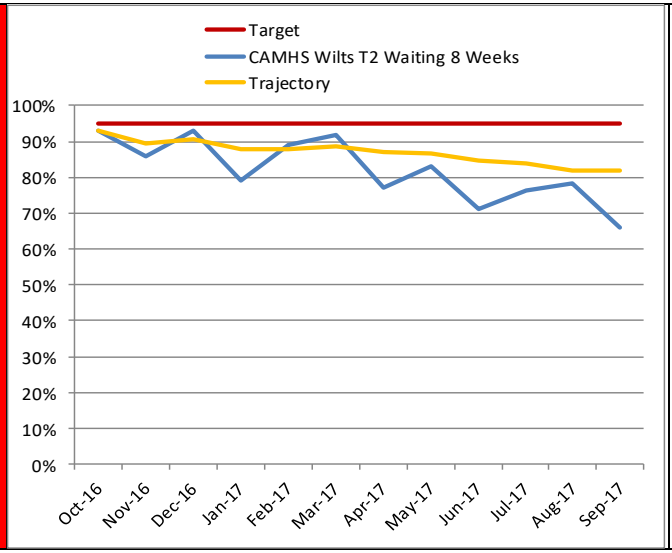
CAMHS BaNES CCG	PAF	Wilts T3 Waiting 4 Weeks	90%	73% 22/30		Extended waiting time possibly resulting in delayed care	Wilts T3 CAMHS are achieving 100% for patients assessed within 12 weeks; data includes patient cancellations and breaches due to patient choice. An Action plan has been put in place to address performance.
CAMHS BaNES CCG	PAF	BaNES T3 Waiting 4 Weeks	90%	27% 8/30		Extended waiting time possibly resulting in delayed care	BaNES CAMHS are achieving 100% 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 CCG	PAF	BaNES T3 Waiting 8 Weeks	95%	83% 25/30		Extended waiting time possibly resulting in delayed care	BaNES CAMHS are achieving 100% 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	69		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 /Wilts CCG	PAF	Wilts & BaNES LD Waits 4 weeks	95%	0% 0/2		Extended waiting time possibly resulting in delayed care	This is based on 2 patients First breach - meeting with family within 4 weeks and cancellation by patient Second Breach – at 8 weeks 3 days
CAMHS BaNES /Wilts CCG	PAF	Wilts & BaNES LD Waits 8 weeks	95%	50% 1/2		Extended waiting time possibly resulting in delayed care	This is based on 1 patient who was seen 3 days late

CAMHS BaNES CCG	PAF	T2 BaNES Waiting 4 Weeks	90%	67% 20/30		Extended waiting time possibly resulting in delayed care	This 4 week data includes patient cancellations and breaches due to patient choice. The service has seen an increase of 50% accepted referrals during 16-17 compared to 15-16. BaNES T2 comprises 3 WTE staff and was carrying vacancies through April and May. The team has now implemented further assessment slots each week and are currently fully established; this should have an impact on the % assessed within 4 weeks in the next few months. 97% assessed within 12 weeks.

CAMHS BaNES CCG	PAF	Wilts Direct Contacts T2	299	256		No immediate Impact	Wilts T2 are underperforming on direct contacts, this fluctuates from month to month and July/August is usually low due to the holiday period. The service is over performing on their indirect contacts by 26 contacts.
CAMHS Wilts CC	PAF	T2 Wilts Waiting 4 Weeks	90%	20% 9/40		Extended waiting time possibly resulting in delayed care	Wilts T2 CAMHS are achieving 93% 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%	78% 29/44		Extended waiting time possibly resulting in delayed care	Wilts T2 CAMHS are achieving 93% for patients assessed within 12 weeks; this 8 week data includes patient cancellations and breaches due to patient choice.

LOCAL: Adult of Working Age Directorate – M6 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.

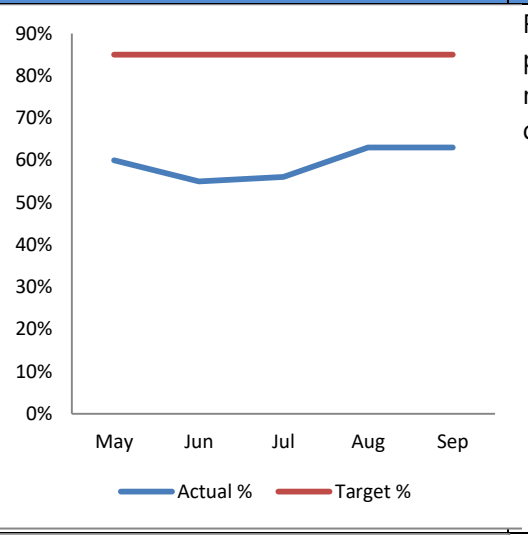
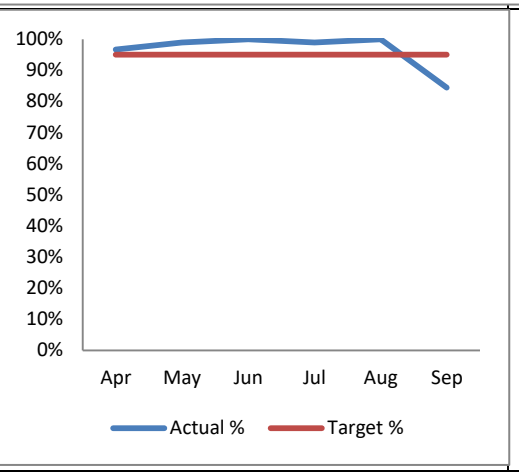
Performance Scorecard

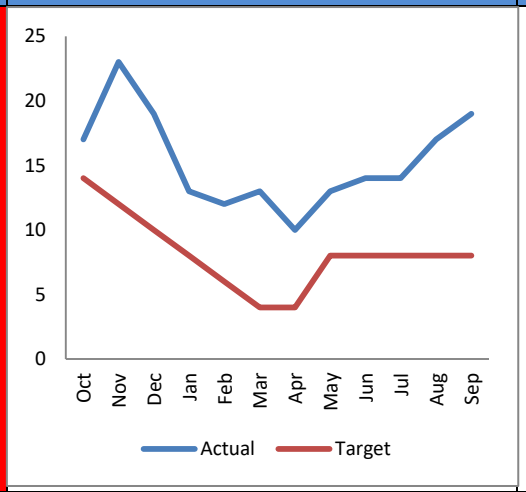
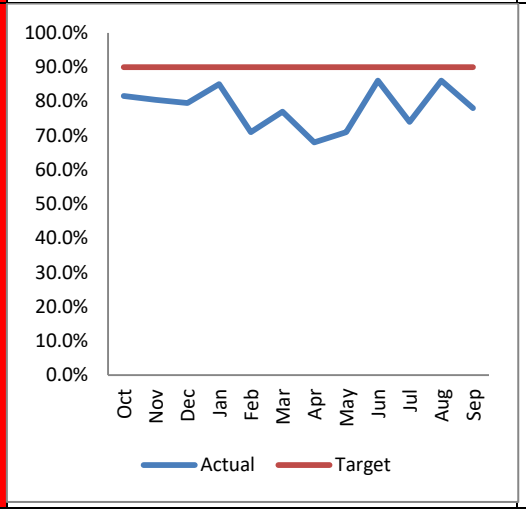
The Adult Directorate was required to report against 148 indicators in September 2017 (M6). Targets/thresholds are applicable to most indicators. Where there is no target/threshold, the indicator is considered compliant if it is reported.

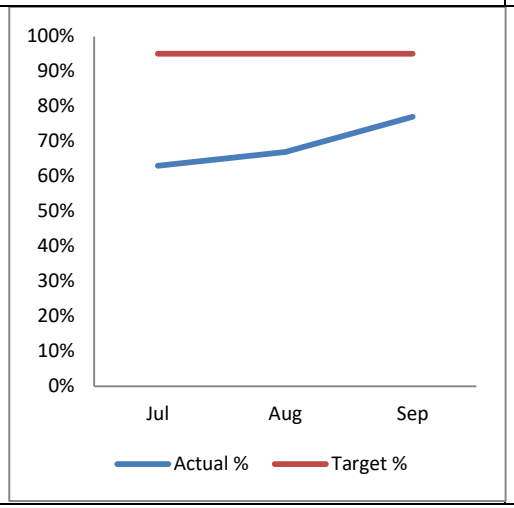
Key:	Well Below Target >10%	Below Target 5-10%	Near Target <5% under	At Target	Exceeded Target

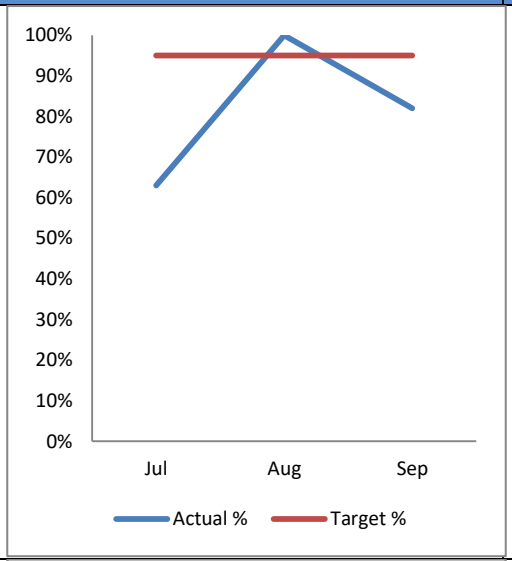
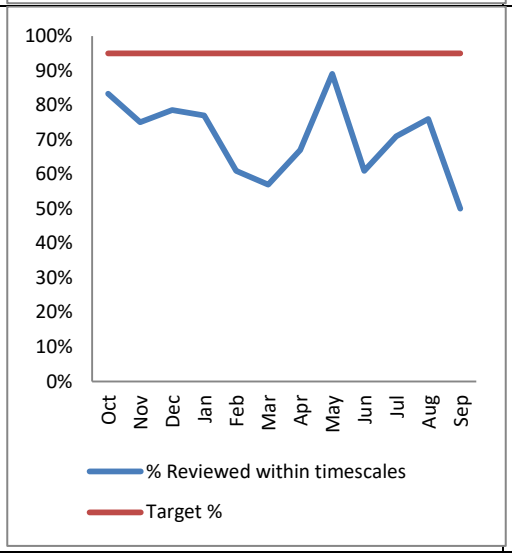
						% met
All Measures (148)	15	6	16	94	17	75%
Oxfordshire						74% met
OBC Incentivised Measures		1		10	2	92%
OBC Schedule 4	2	1	2	10	1	69%
Oxon CCG Schedule 4 Quality Requirements		1		2		67%
IAPT	1		1	8	1	82%
Wellbeing Service	1		1	4	7	85%
Learning Disabilities	3	1	1	1		17%
Buckinghamshire						76% met
Aylesbury	1	1	2	10	1	73%
Chiltern	2		4	8	1	60%
IAPT			1	5	2	88%
PIRLS				6		100%
Perinatal			2	6	2	80%
Forensic Service						75% met
LSU Schedule 4	1	1	1	13		81%
MSU Schedule 4	4		1	11		69%

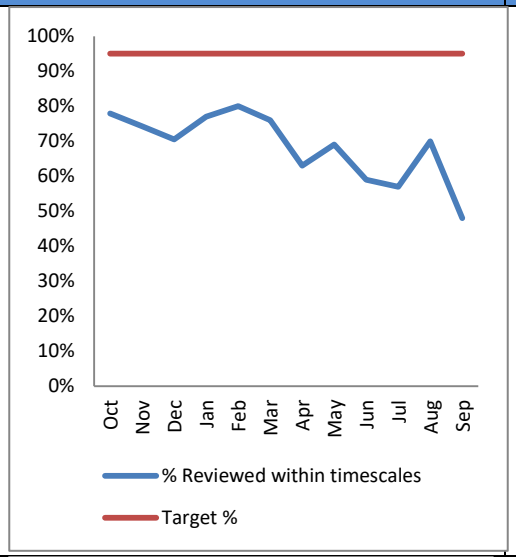
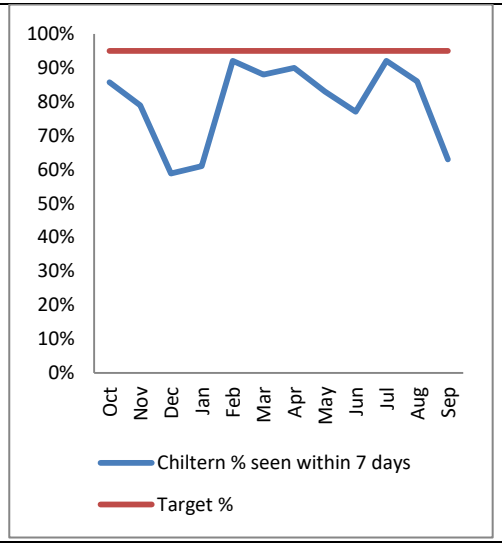
R Red Indicators

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%	63% (50/79)		Right cluster of package care may not be delivered.	We continuously remind staff to check the cluster review dates which can be seen in the summary page in the patient's Carenotes record; the utility of the summary page is not widely understood. Performance reports for individual teams and clinicians are used to prompt cluster reviews.
Oxon OBC		Percentage of outpatient letters that are sent back to GPs (uploaded to CareNotes) within 10 calendar days	95%	84% (76/90)		Risk to continuity of care.	We are implementing a new auditing process which is anticipated to be more effective in highlighting areas for improvement which we can action against. The new style audit is starting this month.

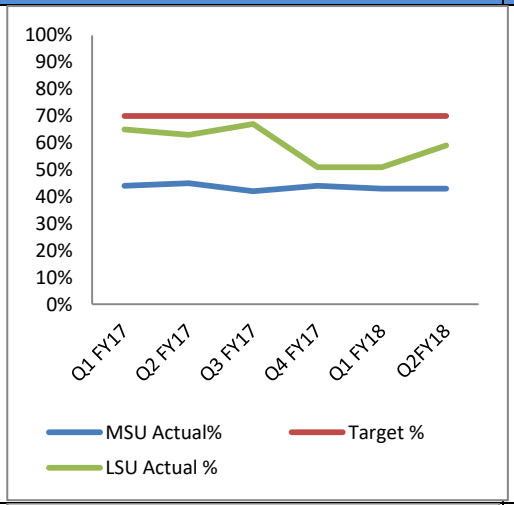
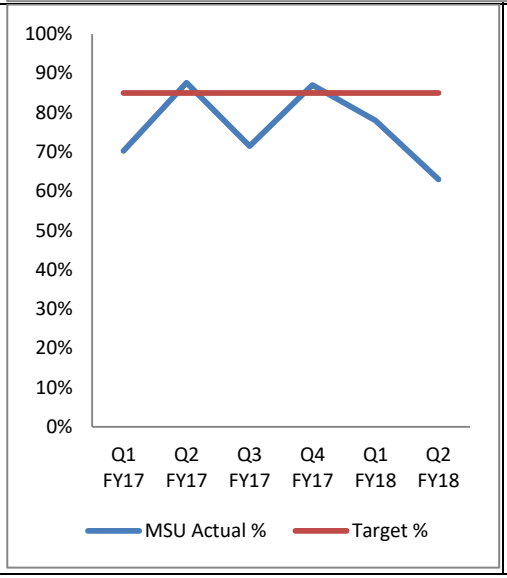
Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Oxon IAPT		The length of wait for the 75th centile at Step/Cluster 3 for CBT (weeks)	8 weeks	19 weeks		Risk that patients may be waiting too long to receive care.	TSP continues to see the impact of the 3 staff that left the service during July. We have successfully recruited to these vacancies and people will be in post during late September to mid-October. We are also in the process of recruiting 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 financial year.
Oxon Wellbeing		Patient experience Question 1: "The service I received has helped me to better understand my problems"	90%	78%		Risk that patients may not be receiving the care that they need.	The service is piloting a revised question from Oct-Dec, asking 'did you need help…' and screening out those who said 'no'.

Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Learning Disabilities		% of urgent referrals to Specialist Learning Disability Health Services 48 hour wait	95%	0% (0/1)	Jul: 100% (3/3) Aug: 75% (3/4) Sep: 0% (0/1)	Delayed access to services.	This is the first time OHFT has reported on LD services. As part of the collection of this data, manual audits were undertaken, whilst systems are adapted to support future reporting. We are working closely with our managers, and measures are being put in place to address these issues.
Learning Disabilities		Discharges: % of GP discharge templates issued within 10 days of patient discharge	95%	77% (17/22)		Risk to continuity of care.	As above.

Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Learning Disabilities		% of Service Users receiving accessible discharge summary within 10 days of discharge	95%	82% (18/22)		Risk to continuity of care.	As above.
Bucks		Aylesbury Vale: % people will have care review within the timeframe specified by the cluster package	95%	50% (12/24)		Right cluster of package care may not be delivered.	Team Managers are aware that the performance for clustering needs to be a priority. The target is more difficult to achieve than anticipated. Team Managers are checking that the data is correct and working individually with clinicians to rectify this target. This target does not indicate that there is a clinical impact on patient care.

Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Bucks		Chiltern: % people will have care review within the timeframe specified by the cluster package.	95%	48% (21/44)		Right cluster of package care may not be delivered.	As above.
Bucks		Chiltern: Urgent referrals to Mental Health Team will be seen within 7 consecutive days for assessment.	95%	63% (10/16)		Delayed access to services.	All referrals have been now been assessed. 5 – Patient choice (availability or cancelled appointments). 1 – Appointment cancelled by Doctor due to an emergency.

Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Forensics		MSU: Number of patients with a HCR 20 completed in 3 months of admission.	95%	End Q2 67% (2/3)	Reported quarterly from 1 April 2017. Q1: 100% Q2: 67%	Right package of care may not be delivered.	An audit of all HCR20 to be completed by the service in order to ensure compliance.
Forensics		MSU: Number who have had an HCR 20 and HONOS Secure Assessment within previous 6 months.	95%	End Q2 61% (22/36)	Reported quarterly from 1 April 2017. Q1: 85% Q2: 61%	Right package of care may not be delivered.	It has been agreed that HCR20 and Honos secure assessment be reviewed at each CPA which is held 6 monthly. At times CPA meetings are cancelled or the date needs to be to be changed and this may account for 61% compliance. An audit of all HCR20 to be completed by the service in order to ensure compliance.

Contract	Ref	Measure	Target	Actual	Trend	Impact	Action and Resolution Timescale
Forensics		MSU: Total number of in-patients > 12 months in who have accessed a routine dental check-up/ examination in the last 12 months.	70%	MSU: 43% (17/40) LSU: 59% (35/59)		Risk to physical health.	Emergency dental treatment is available to all patients. However, access to routine dental services for patients who are out of area or not registered with a local dentist continues to be problematic. The Trust's dentistry team could fulfil this requirement if funding could be secured. We raised the funding issue at the April 2017 contract review meeting, but have yet to receive a response.
Forensics		MSU: Number of eligible staff who have received clinical supervision.	85%	63% (83 / 132)		Risk to patient care through insufficiently trained staff.	Clinical supervision has been adversely affected by the acuity across the service, staff sickness and difficulty in recruiting nursing staff. There is an on-going project to review and ensure all staff have an identified clinical supervisor and recording of supervision sessions is done.