Item 19/0619

Report to: Trust Board, 6th June 2019
Author: Chris Woon, Head of Information Management and Clinical Systems
Presented by: John Campbell, Director of Service Delivery

SUBJECT: **Performance Dashboard Report for the contract year 2018-19**

This Report is provided for:			
Decision	Endorsement	**Assurance**	**To Note**

EXECUTIVE SUMMARY:

Overview

This outturn report sets out the performance of the Trust's Clinical Services for the full 2018/19 contract period against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 151 reportable measures, 125 are compliant and 26 are non-compliant. Of the remaining 43 indicators, 16 are for baseline information to inform future reporting, 5 have had either no activity or insufficient activity recorded against them during the year to support reliable performance reporting and 22 are not yet available, of which all are Gloucestershire CCG Contractual measures. We are working with services to ensure data capture and reporting processes which will enable performance to be reported against those indicators which have been carried forward in the 2019/20 contract.

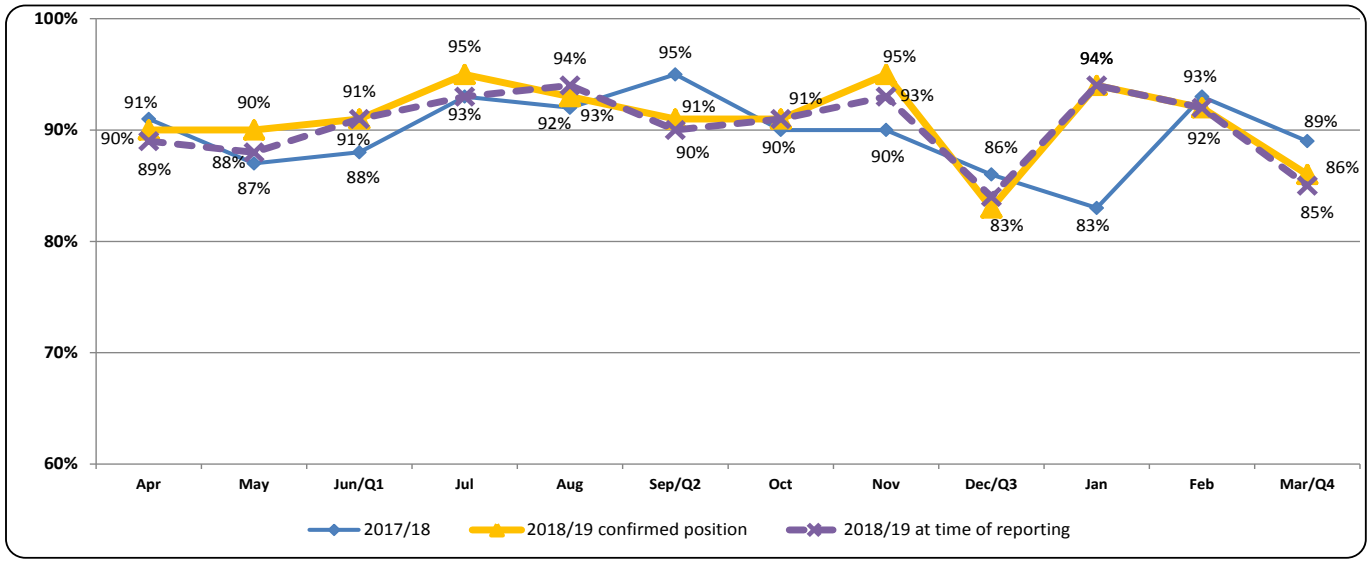
The key performance indicators that were compliant at the end of 2017/18 but non-compliant at the end of 2018/19 are:

- 3.25: CYPS: Referral to assessment within 4 weeks
- 3.40: LD: To deliver specialist support in accordance with specifically developed pathways
- 4.10: Percentage of eligible Service Users with Personal Budget receiving Direct Payments
- 5.15 CYP Eating Disorders; Routine referral to NICE treatment within 4 weeks
- 7.01a: Improvement of health and wellbeing of NHS Staff (Gloucestershire CQUIN)
- 9.01a: Improvement of health and wellbeing of NHS Staff (Herefordshire CQUIN)

The following table summarises our performance position as at the end of March 2019 for each of the KPIs within each of the reporting categories.

Indicators Reported in 2018/19 and Levels of Compliance							
Indicator Type	Total Measures	Reported in Month	Compliant	Non Compliant	% non-compliance	Not Yet Required or N/A	NYA
NHSi Requirements	14	13	13	0	0	1	0
Never Events	17	17	17	0	0	0	0
Department of Health	10	9	8	1	11	1	0
Gloucestershire CCG Contract	89	56	37	19	34	11	22
Social Care	15	13	12	1	8	2	0
Herefordshire CCG Contract	24	18	15	3	17	6	0
CQUINS	25	25	23	2	8	0	0
Overall	194	151	125	26	17	21	22

The following graph shows our percentage compliance by month and the previous year's compliance for comparison.



The confirmed position for February has fallen from 93% to 92% due to the following indicator previously reported as N/A (no data to report) now being reported as non-compliant:

- 3.66: Adolescent Eating Disorders–Urgent referral to Non-NICE treatment within 1 week,

The reported position for March has risen from 85% to 86% due to:

- Quarter 4 CQUIN indicators previously reported as not yet available, of which 23 can now be reported as compliant and 2 non-compliant

Although performance isn't necessarily of current concern, the following key performance areas remain a priority for the Trust as they have the potential to carry contractual, financial, reputational or quality risk:

- Under 18 admissions to Adult Inpatient Wards (2.21)
- Improving Access to Psychological Therapies (IAPT)
  - Recovery (3.17, 5.08), Access (3.18, 5.09a)
- CYPS/ CAMHS Level 2 and 3 Referral to Treatment waiting times (3.26 & 3.27)
- Eating Disorders (ED) Waiting times (3.63, 3.64, 3.65, 3.67 & 3.68)

Summary Exception Reporting

The following 26 key performance thresholds were not met cumulatively for the Trust for 2018/19:

Department of Health Requirements:

- 2.21 – No children under 18 admitted to adult in-patient wards

Gloucestershire CCG Contract Measures

- 3.21 – Inpatient discharge summaries to be sent electronically within 24 hours to GP
- 3.25 – CYPS: Referral to assessment within 4 weeks
- 3.26 – CYPS: Referral to treatment within 8 weeks
- 3.27 – CYPS: Referral to treatment within 10 weeks
- 3.35 – Care plan audit to show all dependent children and under 18s living with adults
- 3.36 – CYPS Transition to Adult (Recovery) Service
- 3.40 – LD: to deliver specialist support in accordance with specifically developed pathways
- 3.53 – Patients with Dementia have weight assessments on admission
- 3.54 – Patients with Dementia have weight assessments at weekly intervals
- 3.55 – Patients with Dementia have weight assessments near discharge
- 3.63 – Adolescent Eating Disorders – Routine referral to NICE treatment within 4 weeks
- 3.64 – Adolescent Eating Disorders – Routine referral to non-NICE treatment within 4 weeks
- 3.65 – Adolescent Eating Disorders – Urgent referral to NICE treatment within 1 week
- 3.66 – Adolescent Eating Disorders – Urgent referral to non-NICE treatment within 1 week
- 3.67 – Adult Eating Disorders: Wait time for assessments will be 4 weeks
- 3.68 – Adult Eating Disorders; Wait time for psychological interventions will be 16 weeks
- 3.71 – LD Active involvement in Care, Treatment Reviews and Blue Light protocol meetings
- 3.78 – Perinatal: Urgent referrals with High Risk Indicators seen within 48 working hours
- 3.80 – Perinatal preconception advice: Referral to assessment within 8 weeks

Gloucestershire Social Care Measures

- 4.10 – Percentage of eligible service users with Personal Budget receiving Direct Payments

Herefordshire CCG Contract Measures

- 5.09a –IAPT Access rate; percentage accessing service
- 5.15 – CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks
- 5.19 – CYP Access: Percentage of CYP in treatment against prevalence

Gloucestershire CQUIN Measures

- 7.01a –Improvement of health and wellbeing of NHS Staff

Herefordshire CQUIN Measures

- 9.01a –Improvement of health and wellbeing of NHS Staff

Where non-compliance has highlighted issues within a service, Service Directors have taken the lead to address issues and indicators have been “red flagged” to show where further analysis and work has been undertaken to fully scope data quality and performance issues.

Section 2 of this report provides a detailed commentary on indicators which did not meet the required performance threshold level during the final month of the year and also cumulatively for the 2018-19 reporting period.

RECOMMENDATIONS

The Delivery Committee is asked to:

- Note the Performance Dashboard Report for the full 2018-19 contract period
- Accept the report as a significant level of assurance that our contract and regulatory performance measures are being met or that appropriate action plans are in place to address areas requiring improvement.
- Be assured that there is ongoing work to review all of the indicators not meeting the required performance threshold. This includes a review of the measurement and data quality processes as well as clinical delivery and clinical practice issues.

Corporate Considerations	
Quality implications:	The information provided in this report is an indicator into the quality of care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service / care we provide.
Resource implications:	The Information Team provides the support to operational services to ensure the robust review of performance data and co-ordination of the Dashboard
Equalities implications:	Equality information is included as part of performance reporting
Risk implications:	There is an assessment of risk on areas where performance is not at the required level.

WHICH TRUST STRATEGIC OBJECTIVE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	P
Increasing Engagement	P
Ensuring Sustainability	P

WHICH TRUST VALUES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Seeing from a service user perspective			P
Excelling and improving	P	Inclusive open and honest	P
Responsive	P	Can do	P
Valuing and respectful	P	Efficient	P

Reviewed by:		
John Campbell	Date	May 2019

Where in the Trust has this been discussed before?		
Not applicable.	Date	

What consultation has there been?		
Not applicable.	Date	

Explanation of acronyms used:	AKI	Acute kidney injury
	ARFID	Avoidant restrictive food intake disorder

	ASCOF Adult Social Care Outcomes Framework CAMHS Child and Adolescent Mental health Services CBT Cognitive Behavioural Therapy C-Diff Clostridium difficile CLDT Community Learning Disability Teams CPA Care Programme Approach CQUIN Commissioning for Quality and Innovation CRHT Crisis Home Treatment CSM Community Services Manager CYPS Children and Young People's Services DNA Did not Attend ED Emergency Department EI Early Intervention EWS Early warning score GARAS Gloucestershire Action for Refugees and Asylum Seekers HoNoS Health of the Nation Outcome Scale IAPT Improving Access to Psychological Therapies IST Intensive Support Team (National IAPT Team) KPI Key Performance Indicator LD Learning Disabilities MHARS Mental Health Acute Response Service MHL Mental Health Liaison MRSA Methicillin-resistant Staphylococcus aureus MUST Malnutrition Universal Screening Tool NHSI NHS Improvement NICE National Institute for Health and Care Excellence PBS Personal Behaviour Support plan PICU Psychiatric Intensive Care Unit SI Serious Incident SUS Secondary Uses Service VTE Venous thromboembolism YOS Youth Offender's Service

1. CONTEXT

This report sets out the performance Dashboard for the Trust for the complete 2018/19 contract period.

1.1 The following sections of the report include:

- An aggregated overview of all indicators in each section with exception reports for non-compliant indicators supported by the relevant Scorecard containing detailed information on all performance measures. These appear in the following sequence.

    - NHSI Requirements
    - Never Events
    - Department of Health requirements
    - NHS Gloucestershire Contract – Schedule 4 Specific Performance Measures
    - Social Care Indicators
    - NHS Herefordshire Contract – Schedule 4 Specific Performance Measures
    - NHS Gloucestershire CQUINS
    - Low Secure CQUINS
    - NHS Herefordshire CQUINS

2. AGGREGATED OVERVIEW OF ALL INDICATORS WITH EXCEPTION REPORTS ON NON-COMPLIANT INDICATORS

2.1 The following tables outline the performance in each of the performance categories within the Dashboard as at the completion of the 2018-19 period. Where indicators have not been met during the reporting period, an explanation is provided relating to the non-achievement of the Performance Threshold and the action being taken to rectify the position.

2.2 Performance indicators include all relevant Trust activity allocated between Gloucestershire and Herefordshire based on locality of the service.

2.3 Where stated, 'Cumulative Compliance' refers to compliance recorded from the start of this contractual year April 2018 to the current reporting month, as a whole.

	=	**Target not met**
	=	**Target met**
NYA	=	**Not yet available**
NYR	=	**Not yet required**
N/A	=	**Not applicable: No data to report or baseline data to inform 2018/19**

DASHBOARD CATEGORY - NHSI REQUIREMENTS

NHS Improvement Requirements				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	14	14	14	14
🔴	0	0	0	0
🟢	13	13	13	13
NYA	0	0	0	0
NYR	0	0	0	0
N/A	1	1	1	1

Performance Thresholds not being achieved in Month

1.08: New psychosis (EI) cases treated within 2 weeks of referral (Herefordshire)

There was 1 case in Herefordshire where the client was recorded as starting treatment outside of 2 weeks. The patient was initially referred whilst an inpatient, however, due to the complex mental health history and physical health care needs it was not clinically appropriate to assess the patient within the required time period. The client was seen as soon as it was clinically appropriate which was within 3 weeks.

(Note: Treatment is recorded as having started, when a client has attended an assessment and been allocated a care coordinator)

Cumulative Performance Thresholds Not being Met

None

Changes to Previously Reported Figures (M12)

None

Early Warnings / Notes

None

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
1							
1.01	Number of MRSA Bacteraemias	PM	0	0	0	0	0
		Gloucestershire	0	0	0	0	0
		Herefordshire	0	0	0	0	0
		Combined Actual	0	0	0	0	0
1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3
		Gloucestershire	0	0	0	0	0
		Herefordshire	0	0	0	0	0
		Combined Actual	0	0	0	0	0
1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	98%	98%	98%	98%
		Herefordshire	99%	100%	100%	100%	99%
		Combined Actual	99%	99%	98%	99%	98%
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%
		Gloucestershire	98%	99%	98%	98%	98%
		Herefordshire	98%	98%	98%	99%	98%
		Combined Actual	98%	99%	98%	98%	98%
1.05	Nationally reported - Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	3.2%	1.1%	0.7%	1.3%	2.4%
		Herefordshire	2.4%	5.4%	2.9%	2.2%	2.3%
		Combined Actual	3.0%	2.1%	1.3%	1.5%	2.4%
1.05b	- Delayed Discharges - Outliers	PM					
		Gloucestershire	10.1%	6.9%	4.9%	6.2%	7.4%
		Herefordshire	12.5%	0.7%	3.2%	10.3%	3.6%
		Combined Actual	10.7%	5.4%	4.5%	7.2%	6.5%
1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	100%	100%	97%	99%
		Herefordshire	100%	100%	100%	100%	100%
		Combined Actual	99%	100%	100%	98%	99%
1.07	New psychosis (EI) cases as per contract	PM	72	60	66	72	72
		Gloucestershire	80	84	92	98	98
		PM	24	20	22	24	24
		Herefordshire	31	22	24	26	26
		PM	96	80	88	96	96
		Combined Actual	111	106	116	124	124
1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%
		Gloucestershire	71%	79%	50%	67%	68%
		Herefordshire	68%	100%	100%	50%	85%
		Combined Actual	70%	81%	60%	63%	72%

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Gloucestershire	69%	99%	99%	99%	97%
		Herefordshire	59%	98%	99%	98%	94%
		Combined Actual	67%	99%	99%	99%	97%
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Gloucestershire	88%	99%	100%	99%	99%
		Herefordshire	75%	100%	100%	99%	95%
		Combined Actual	85%	99%	100%	99%	98%
1.11	**MENTAL HEALTH SERVICES DATA SET PART 1 DATA COMPLETENESS: OVERALL**	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%
1.11a	Mental Health Services Data Set Part 1 Data completeness: DOB	PM	97%	97%	97%	97%	97%
		Gloucestershire	100.0%	100.0%	100.0%	100.0%	100.0%
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%
		Combined Actual	100.0%	100.0%	100.0%	100.0%	100.0%
1.11b	Mental Health Services Data Set Part 1 Data completeness: Gender	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%
1.11c	Mental Health Services Data Set Part 1 Data completeness: NHS Number	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	100.0%	100.0%	100.0%	99.9%
		Herefordshire	99.9%	100.0%	100.0%	100.0%	100.0%
		Combined Actual	99.9%	100.0%	100.0%	100.0%	99.9%
1.11d	Mental Health Services Data Set Part 1 Data completeness: Organisation code of commissioner	PM	97%	97%	97%	97%	97%
		Gloucestershire	100.0%	100.0%	100.0%	100.0%	100.0%
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%
		Combined Actual	100.0%	100.0%	100.0%	100.0%	100.0%
1.11e	Mental Health Services Data Set Part 1 Data completeness: Postcode	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.8%	99.7%	99.7%	99.6%	99.7%
		Herefordshire	99.9%	99.9%	99.8%	99.8%	99.8%
		Combined Actual	99.8%	99.7%	99.7%	99.7%	99.8%
1.11f	Mental Health Services Data Set Part 1 Data completeness: GP Practice	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.6%	99.6%	99.7%	99.6%	99.6%
		Herefordshire	99.7%	99.9%	99.9%	99.9%	99.9%
		Combined Actual	99.7%	99.7%	99.7%	99.7%	99.7%

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
1.12	MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL	PM	50%	50%	50%	50%	50%
		Gloucestershire	94.7%	97.0%	97.0%	96.8%	97.0%
		Herefordshire	90.9%	91.9%	92.2%	92.0%	91.9%
		Combined Actual	94.1%	96.2%	96.3%	96.1%	96.2%
1.12a	Mental Health Services Data Set Part 2 Data completeness: CPA Employment status last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	89.4%	95.7%	95.7%	95.4%	95.7%
		Herefordshire	86.4%	88.0%	88.5%	88.4%	87.8%
		Combined Actual	88.9%	94.5%	94.6%	94.4%	94.5%
1.12b	Mental Health Services Data Set Part 2 Data completeness: CPA Accommodation Status in last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	96.6%	97.1%	97.0%	96.7%	97.1%
		Herefordshire	87.1%	88.5%	88.9%	88.9%	88.7%
		Combined Actual	94.9%	95.8%	95.8%	95.6%	95.8%
1.12c	Mental Health Services Data Set Part 2 Data completeness: CPA HoNOS assessment in last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	98.2%	98.2%	98.2%	98.2%	98.2%
		Herefordshire	99.2%	99.1%	99.1%	98.6%	99.2%
		Combined Actual	98.4%	98.3%	98.4%	98.2%	98.4%
1.13	Learning Disability Services: 6 indicators: identification of people with a LD, provision of information, support to family carers, training for staff, representation of people with LD; audit of practice and publication of findings	PM	6	6	6	6	6
		Gloucestershire	6	6	6	6	6
		Herefordshire	6	6	6	6	6
		Combined Actual	6	6	6	6	6

DASHBOARD CATEGORY – DEPARTMENT OF HEALTH PERFORMANCE

DoH Performance				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	27	27	27	27
🔴	0	0	0	1
🟢	25	25	25	25
NYA	0	0	0	0
NYR	1	1	1	0
N/A	1	1	1	1

Performance Thresholds not being achieved in Month

None

Cumulative Performance Thresholds Not being Met

2.21: No children under 18 admitted to adult inpatient wards

There have been 5 admissions of under 18s to adult wards during 2018/19; 2 in Gloucestershire and 3 in Herefordshire. There were 11 admissions of under 18s in 2017/18.

Changes to Previously Reported Figures (M12)

None

Early Warnings

None

DOH Never Events

ID	Performance Measure (PM)		2017/18 Outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
2							
2.01	Wrongly prepared high risk injectable medications	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.02	Maladministration of potassium containing solutions	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.03	Wrong route administration of oral/enteral treatment	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.04	Intravenous administration of epidural medication	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.05	Maladministration of insulin	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.06	Overdose of midazolam during conscious sedation	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.07	Opioid overdose in opioid naive patient	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.08	Inappropriate administration of daily oral methotrexate	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.09	Suicide using non collapsible rails	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.10	Falls from unrestricted windows	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.11	Entrapment in bedrails	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.12	Misplaced naso - or oro-gastric tubes	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.13	Wrong gas administered	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.14	Failure to monitor and respond to oxygen saturation - conscious sedation	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.15	Air embolism	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.16	Severe scalding from water for washing/bathing	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.17	Mis-identification of patients	PM	0	0	0	0	0
		Actual	0	0	0	0	0

DOH Requirements

ID	Performance Measure (PM)		2017/18 Outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
2.18	Mixed Sex Accommodation - Sleeping Accommodation Breaches	PM	0	0	0	0	0
		Gloucestershire	0	0	0	0	0
		Herefordshire	0	0	0	0	0
		Combined	0	0	0	0	0
2.19	Mixed Sex Accommodation - Bathrooms	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes
		Combined	Yes	Yes	Yes	Yes	Yes
2.20	Mixed Sex Accommodation - Women Only Day areas	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes
		Combined	Yes	Yes	Yes	Yes	Yes
2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0
		Gloucestershire	6	0	0	0	2
		Herefordshire	5	0	0	0	3
		Combined	11	0	0	0	5
2.22	Failure to publish Declaration of Compliance or Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes
		Combined	Yes	Yes	Yes	Yes	Yes
2.23	Publishing a Declaration of Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes

DOH Requirements

ID	Performance Measure (PM)		2017/18 Outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
2.24	Serious Incident Reporting (SI)	Glos	33	1	1	4	26
		Hereford	18	2	0	2	12
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	100%	100%
		Herefordshire	100%	100%	100%	100%	100%
2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	100%	100%
		Herefordshire	100%	100%	N/A	100%	100%
2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	100%	100%	100%	100%	100%
		Gloucestershire	100%	NYR	NYR	NYR	100%
		Herefordshire	100%	NYR	NYR	NYR	100%
2.28	SI Report Level 3 - Independent investigations - 6 months from investigation commissioned date	PM	100%	100%	100%	100%	100%
		Gloucestershire	N/A	N/A	N/A	N/A	N/A
		Herefordshire	N/A	N/A	N/A	N/A	N/A
2.29	SI Final Reports outstanding but not due	Gloucestershire	5	1	1	4	14
		Herefordshire	2	2	2	2	9

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	89	89	89	89
	4	6	14	19
	22	19	36	37
NYA	1	1	24	22
NYR	0	0	0	0
N/A	14	15	15	11

Definition Note

3.64: Adolescent Eating Disorders: Routine referral to Non-NICE treatment within 4 weeks
3.66: Adolescent Eating Disorders: Urgent referral to Non-NICE treatment within 1 week

"*Non-NICE treatment*" is a locally defined term used to transparently present all intervention activity within our Eating Disorder (ED) services such as Avoidant/ Restrictive Food Intake Disorder (ARFID). Due to the lack of NICE treatment codes for certain interventions this activity would otherwise be lost or incorrectly impact our NICE performance indicators. There are low incidences of non-NICE treatments (hence the common recording of Not Applicable).

Performance Thresholds not being achieved in Month

3:15 People within the memory assessment service to have a care plan within 4 weeks of diagnosis
There were 5 cases where the care plan was not recorded on RiO within 4 weeks of the confirmed Dementia diagnosis.

The care plan is uploaded following an appointment at which the details of the careplan are discussed with the patient. In 3 of these cases the appointment was more than 4 weeks after the confirmed diagnosis due to the client's choice of appointment date.

In 1 case the care plan appointment was delayed as the patient was in hospital.

For the remaining case the diagnosis date was entered incorrectly on RiO. Once the data has been corrected in the clinical system the indicator will become compliant.

3.21: Inpatient discharge summaries to be sent electronically within 24 hours to GP
To enable us to report on this indicator, electronic discharge summaries need to be copied to a specific audit email address. Unfortunately this step continues to be overlooked in some instances. We are reporting 80% for Quarter 4, however for assurance a manual audit has been undertaken and shows that compliance is at 94%. The longer term electronic correspondence resolution is underway which will automate this and remove manual user error. A whole system agreement has just been signed to use Docman.

3.25: Referral to assessment within 4 weeks and
3.26 & 3.27: CYPS: Referral to treatment within 8 & 10 weeks
Work is ongoing within our service delivery team to resolve this.

3.35: Care plan audit to show all dependent children and under 18s living with adults
For Quarter 4 we are reporting 68% against a performance threshold of 75%. This is one of four targeted areas for improvement which the Trust is taking forward. Service Directors continue to be given trajectories for improvement. Audit results are shared to help inform this improvement work.

3.40: LD: to deliver specialist support in accordance with specifically developed pathways
An audit of 40 records found that 25 (62.5%) of these indicated which clinical care pathway the client was on.

It is believed that the improved automated functionality on RiO will great improve the recording of this information as the current, essentially paper based system, is somewhat cumbersome.

3.53 - 3.55: Patients with Dementia have weight assessments on admission, at weekly intervals and near discharge.
Weight recording is embedded into clinical practice and further methodology improvements have been introduced to better represent clinical service delivery. The clinical systems team have added recording options to RIO to capture the instances within the clinical system when it has not been clinically appropriate to weigh a patient. Taking into account these reasons for Quarter 4, however, would not make these indicators compliant.

Further investigation has shown that Staff are still recording the date and time they enter the information on RiO not the actual date and time the weighing takes place. This pushes many of the cases to day 8 and therefore non-compliance.

3.63: Adolescent Eating Disorders–Routine referral to NICE treatment within 4 weeks

We previously reported 11 cases at the end of March where treatment did not start within 4 weeks, since then the number of non-compliant records has reduced to 10.

Of these, 8 began treatment at the first available appointment which was within 5 to 6 weeks of referral.

1 case was non-compliant due to patient choice, the first appointment booked within 8 days was cancelled, 2 further appointments were declined and the first attendance was therefore 5 to 6 weeks after referral.

We reported at the end of March that 2 clients were waiting to start CBT, however, it has been recognised that for one client February CBT sessions were not recorded. RiO has been updated to reflect this and the case is no longer non-compliant in March.

3.65: Adolescent Eating Disorders–Urgent referral to NICE treatment within 1 week

We previously reported 3 non-compliant cases in March; this has now reduced to 2.

In one of these cases, the client was given an appointment on day 7, but due to staff sickness this was re-arranged to day 9.

In the 2nd case, the client was offered the next available appointment which was 11 days after referral.

The 3rd case was reported as non-compliant as the initial assessment on a paediatric ward indicated that there was no eating disorder. The patient deteriorated and the service was involved again due to concerns around rapid weight loss. The team remained involved to address symptoms and treatment commenced as soon as clinically appropriate.

This record has been amended on RiO to show that the patient commenced treatment for ARFID earlier in their pathway and therefore, this case is now reported as non-compliant against indicator 3.66 (Non-NICE treatments) in February.

3.67: Adult Eating Disorders: Wait time for assessments will be 4 weeks

We previously reported 8 non-compliant cases where assessment did not take place within 4 weeks; this has now reduced to 7.

Previously reported as 6 clients being seen at the first available appointment (5-6 weeks after referral), this has now reduced to 5 as 1 client has since been found to have attended an assessment in January. RiO has been updated and this case is no longer reported as non-compliant in March.

1 client was in Bristol Priory under the care of the Bristol Eating Disorders team; however, due to a break-down in the relationship, clinical and commissioning agreement was that the patient would be offered treatment by our Trust. Involvement with us was not required until prior to the patient's discharge.

The remaining client was offered an appointment within the required 7 days but did not attend. They were given another appointment the following week but again did not attend. Treatment began on the 1st attended appointment which was 15 days after referral.

3.71: LD Active involvement in Care and Treatment Reviews and Blue Light protocol.
There were 6 cases, of which 5 were compliant.

For the non-compliant case, the Skills Assessment was not completed by the Occupational Therapist prior to the CTR meeting as the patient was not willing to engage.

Cumulative Performance Thresholds Not being Met

3.21: To send Inpatient discharge summaries electronically within 24 hours to GPs
As above

3.25: Referral to assessment within 4 weeks and
3.26 & 3.27: CYPS: Referral to treatment within 8 & 10 weeks
As above

3.35: Care plan audit to show all dependent children and under 18s living with adults
As above

3.36: CYPS Transition to Adult (Recovery) Service
There were 5 non-compliant cases during the year due to incorrect recording. For all cases there is assurance from the service that there was no risk to the clients.

3.40: LD: to deliver specialist support in accordance with specifically developed pathways
As above

3.53 - 3.55: Patients with Dementia have weight assessments on admission, at weekly intervals and near discharge.
As above

3.63: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
3.64: Adolescent Eating Disorders: Routine referral to Non-NICE treatment within 4 weeks
3.65: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
3.66: Adolescent Eating Disorders: Urgent referral to Non-NICE treatment within 1 week
Although previously reporting that we expected to meet the performance thresholds by the end of the financial year, this is not the case due to an unexpected major increase in referrals over the last few months. The current trajectory is based on a 10% increase in referrals on the previous year and the increase over December, January and February has been significantly above this assumption.

The service also has 3 full-time vacant posts and is currently booking assessment appointments 5 to 6 weeks after the referral is received.

3.67: Adult Eating Disorders: Wait time for assessments will be 4 weeks
3.68: Adult Eating Disorders: Wait time for psychological interventions will be 16 weeks
Along with the Adolescent Eating Disorders, the service is in the process of staff recruitment and also process changes to meet these performance thresholds.

3.71: LD Active involvement in Care and Treatment Reviews and Blue Light protocol.
As above

3.78 Perinatal: Urgent referrals with High Risk Indicators seen within 48 working hours
There was 1 non-compliant case in Quarter 2. The client was seen 28 minutes outside of the required time. The service has confirmed that there was no risk to the client.

3.80: Perinatal preconception advice: Referral to assessment within 8 weeks
There have been 3 cases where assessment did not take place within 8 weeks.

During Quarter 2, one client was seen within 9 weeks due to a shortage of staff. The client was under the care of the Recovery service and therefore was not at risk.

During Quarter 3, there were 2 cases. Both clients were offered an appointment within the required time-frame but chose not to take these appointments and were seen outside of the required time. There was no clinical risk to either of these clients.

Changes to Previously Reported Figure (M12)

3.66: Adolescent Eating Disorders–Urgent referral to Non-NICE treatment within 1 week
One case reported against indicator 3.65 (Urgent referral to NICE treatment)in March has been amended on RIO to show as an ARFID case in February, however it was still outside of the required 7 days and so is now reported as a non-compliant case against indicator 3.66 (Urgent referral to Non-NICE treatment) in February.

Early Warnings/Notes
None

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
	B. NATIONAL QUALITY REQUIREMENTS						
3.01	Zero tolerance MRSA	PM	0	0	0	0	0
		Unavoidable	0	0	0	0	0
3.02	Minimise rates of Clostridium difficile	PM	0	0	0	0	<3
		Unavoidable	0	0	0	0	1
3.03	Duty of candour	PM	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant
3.04	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS,	PM	99%	99%	99%	99%	99%
		Actual	100%	100%	100%	100%	99%
3.05	Completion of Mental Health Services Data Set ethnicity coding for all detained and informal Service Users	PM	90%	90%	90%	90%	90%
		Actual	99%	100%	95%	97%	99%
3.06	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	PM	90%	90%	90%	90%	90%
		Actual	99%	99%	99%	99%	99%
	C. Local Quality Requirements						
	Domain 1: Preventing People dying prematurely						
3.07	Increased focus on suicide prevention and reduction in the number of reported suicides in the community and inpatient units	PM	Report			Annual	Annual
		Actual	28			25	25
3.08	To reduce the numbers of detained patients absconding from inpatient units where leave has not been granted	PM	< 144			< 36	<144
		Actual	122			34	130
3.09	Compliance with NICE Technology appraisals within 90 days of their publication and ability to demonstrate compliance through completion of implementation plans and costing templates.	PM	Report			Report	Annual
		Actual	N/A			N/A	N/A
	Domain 2: Enhancing the quality of life of people with long-term conditions						
3.10	2G bed occupancy for Gloucestershire CCG patients	PM	> 91%	> 91%	> 91%	> 91%	> 91%
		Actual	93%	96%	95%	95%	95%
3.11	Care Programme Approach: 95% of CPAs should have a record of the mental health worker who is responsible for their care	PM	95%	95%	95%	95%	95%
		Actual	100%	100%	100%	100%	100%
3.12	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	PM	95%	95%	95%	95%	95%
		Actual	99%	99%	99%	99%	99%
3.13	Assessment of risk: % of those 2g service users on CPA to have a documented risk assessment	PM	95%			95%	95%
		Actual	99%			99%	99%
3.14	Assessment of risk: All 2g service users (excluding those on CPA) to have a documented risk assessment	PM	85%			85%	85%
		Actual	97%			96%	97%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
3.15	People within the memory assessment service with a working diagnosis of dementia to have a care plan within 4 weeks of diagnosis	PM	85%	85%	85%	85%	85%
		Actual	93%	97%	98%	84%	94%
3.16	AKI (previous CQUIN 1516) 95% of pts to have EWS score within 12 hours	PM	95%			95%	95%
		Actual	98%			100%	99%
	Domain 3: Helping people to recover from episodes of ill-health or following injury						
3.17	IAPT recovery rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%
		Actual	51%	51%	53%	56%	52%
3.18	IAPT access rate: Access to psychological therapies for adults should be improved	PM	15.00%	1.42%	1.42%	1.42%	17.00%
		Actual	13.32%	1.53%	1.35%	1.52%	18.24%
3.19	IAPT reliable improvement rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%
		Actual	70%	69%	70%	71%	68%
3.20	Care Programme Approach (CPA): The percentage of people with learning disabilities in inpatient care on CPA who were followed up within 7 days of discharge (Berkeley House)	PM	95%	95%	95%	95%	95%
		Actual	100%	NA	NA	NA	NA
3.21	To send :Inpatient and day case discharge summaries electronically, within 24 hours to GP	PM	Report			100%	100%
		Actual	93%			80%	76%
	Domain 4: Ensuring that people have a positive experience of care						
3.22	To demonstrate improvements in staff experience following any national and local surveys	PM	Report			Report	Annual
		Actual	Compliant			Compliant	Compliant
3.23	Number of children in crisis urgently referred that receive support within 24 hours of referral by CYPS	PM	95%			95%	95%
		Actual	100%			NA	100%
3.24	Children and young people who enter a treatment programme to have a care coordinator - (Level 3 Services) (CYPS)	PM	98%	98%	98%	98%	98%
		Actual	99%	98%	98%	97%	98%
3.25	95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS)	PM	95%			95%	95%
		Actual	98%			49%	84%
3.26	Level 2 and 3 – Referral to treatment within 8 weeks , excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	80%			80%	80%
		Actual	78%			44%	41%
3.27	Level 2 and 3 – Referral to treatment within 10 weeks (excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	95%			95%	95%
		Actual	86%			42%	45%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
3.28	Adults of working age - 100% of MDT assessments to have been completed within 4 weeks (or in the case of a comprehensive assessment commenced within 4 weeks)	PM	85%	85%	85%	85%	85%
		Actual	90%	93%	95%	91%	93%
	Vocational Services (Individual Placement and Support)						
3.29	100% of Service Users in vocational services will be supported to formulate their vocational goals through individual plans (IPS)	PM	98%			98%	Qtr 2
		Actual	100%			NYA	100%
3.30	The number of people on the caseload during the year finding paid employment or self-employment (measured as a percentage against accepted referrals into the (IPS) Excluding those in employment at time of referral - Annual	PM	50%			50%	50%
		Actual	NYA			NYA	NYA
3.31	The number of people retaining employment at 3/6/9/12+ months (measured as a percentage of individuals placed into employment retaining employment) (IPS)	PM	50%			50%	50%
		Actual	NYA			NYA	NYA
3.32	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%			50%	50%
		Actual	NYA			NYA	NYA
3.33	Fidelity to the IPS model	PM	90%			90%	90%
		Actual	100%			NYA	NYA
	General Quality Requirements						
3.34	GP practices will have an individual annual (MH) ICT service meeting to review delivery and identify priorities for future.	PM	Annual			Report	Annual
		Actual	NYA			NYA	NYA
3.35	Care plan audit to show : All dependent Children and YP <18 living with adults know to Recovery, MAHRS, Eating Disorder and Assertive Outreach Services. Recorded evidence in care plans of impact of the mental health disorder on those under 18s plus steps put in place to support.(Think family)	PM	Qtr 4			75%	75%
		Actual	82%			68%	68%
3.36	Transition- Joint discharge/CPA review meeting within 4 weeks of adult MH services accepting :working diagnosis to be agreed, adult MH care coordinator allocated and care cluster and risk levels agreed as well as CYPS discharge date.	PM	100%			100%	100%
		Actual	0%			NA	17%
3.37	Number and % of crisis assessments undertaken by the MHARS team on CYP age 16-25 within agreed timescales of 4 hours	PM	90%	90%	90%	90%	90%
		Actual	NYR	100%	100%	100%	100%
3.38	MHARS Wait time to Assessment: Triage wait time 1 hour (Emergency assessments within 1 hour of triage)	PM		TBC	TBC	TBC	TBC
		Actual		100%	100%	100%	92%
3.39	MHARS Wait time to Assessment: Full Assessment 4 hours (Urgent assessments within 4 hours of triage)	PM	90%	TBC	TBC	TBC	TBC
		Actual	NYR	100%	100%	92%	81%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
	New KPIs for 2017/18						
3.40	LD: To deliver specialist support to people with learning disabilities in accordance with specifically developed pathways	PM	95%			95%	95%
		Actual	100%			63%	63%
3.41	LD: To demonstrate a reduction in an individual's health inequalities thanks to the clinical intervention provided by 2gether learning disability services.	PM	Report			TBC	TBC
		Actual	Compliant			67%	67%
3.42	LD: People with learning disabilities and their families report high levels of satisfaction with specialist learning disability services	PM	75%			75%	Qtr 2
		Actual	Compliant			NYA	100%
3.43	LD: To ensure all published clinical pathways accessed by people with learning disabilities are available in easy read versions	PM	95%			95%	95%
		Actual	100%			100%	100%
3.44	LD: The CLDT, IHOT & LDISS will take a proactive and supportive role in ensuring the % uptake of Annual Health Checks for people with learning disabilities on their caseload is high	PM	75%			75%	75%
		Actual	80%			80%	80%
3.45	Of those supported by 2g to access AHC 100% are then further supported with their Health Action Plans & screening	PM				100%	100%
		Actual				NYA	NYA
3.46	IAPT DNA rate	PM	<16%	<16%	<16%	<16%	<16%
		Actual	13%	13%	15.5%	14%	14%
3.47	IAPT Equity of Access for Service Users: aged 65 and over on the caseload					TBC	TBC
		Actual				6%	7%
3.48	IAPT Equity of Access for Service Users: Numbers of BAME on the caseload					TBC	TBC
		Actual				107	524
3.49	IAPT Clinical productivity by Groups and 1:1 sessions for: Hi Intensity					> 18 per week	> 18 per week
		Actual				N/A	N/A
3.50	IAPT Clinical productivity by Groups and 1:1 sessions for: Lo Intensity					> 18 per week	> 18 per week
		Actual				N/A	N/A
3.51	IAPT treatment outcomes: Women in the Perinatal period showing reliable improvement in outcomes between pre and post treatment	PM	50%	50%	50%	50%	50%
		Actual	75%	69%	75%	75%	73%
3.52	% of CYP entering partnership in CYPS have pre and post treatment outcomes and measures recorded					TBC	TBC
		Actual				NYA	NYA

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
3.53	Patients with Dementia have weight assessments on admission	PM				85%	85%
		Actual				77%	80%
3.54	Patients with Dementia have weight assessments at weekly intervals	PM				85%	85%
		Actual				72%	74%
3.55	Patients with Dementia have weight assessments near discharge	PM				85%	85%
		Actual				71%	84%
3.56	Patients with Dementia have delirium screening on admission	PM				85%	85%
		Actual				NYA	NYA
3.57	Patients with Dementia have delirium screening at weekly intervals	PM				85%	85%
		Actual				NYA	NYA
3.58	Patients with Dementia have delirium screening near discharge	PM				85%	85%
		Actual				NYA	NYA
3.59	CPI: Referral to Assessment within 4 weeks	PM	85%	85%	85%	85%	85%
		Actual	91%	93%	100%	98%	96%
3.60	CPI: Assessment to Treatment within 16 weeks	PM	85%	85%	85%	85%	85%
		Actual	99%	97%	91%	96%	97%
3.61	Comprehensive audit in relation to timeliness and quality of discharge communication (non-medical)					Report	Report
		Actual				70%	68%
3.62	Daily submission of information to inform the daily escalation level	PM		Report	Report	Report	Report
		Actual		NYA	NYA	NYA	NYA
3.63	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	PM	95%	95%	95%	95%	95%
		Actual	29%	50%	67%	17%	46%
3.64	Adolescent Eating Disorders - Routine referral to non-NICE treatment start within 4 weeks	PM	95%	95%	95%	95%	95%
		Actual	9%	0%	N/A	N/A	10%
3.65	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	PM	95%	95%	95%	95%	95%
		Actual	64%	100%	80%	33%	73%
3.66	Adolescent Eating Disorders - Urgent referral to non-NICE treatment start within 1 week	PM	95%	95%	95%	95%	95%
		Actual	N/A	100%	0%	NA	75%
3.67	Eating Disorders - Wait time for adult assessments will be 4 weeks	PM	95%	95%	95%	95%	95%
		Actual	36%	47%	72%	53%	68%
3.68	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	PM		95%	95%	95%	95%
		Actual		76%	71%	100%	62%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
3.69	LD Health facilitation - awareness and support for all stakeholders including reasonable adjustments support to reduce health inequalities					Annual	Annual
		Actual				NYA	NYA
3.70	LD: Patients on the LD challenging behaviour pathway have a single positive behaviour support plan (containing primary, secondary and reactive interventions) completed within 30 days of allocation to clinician (CLDTs: 60 days)	PM				95%	95%
		Actual				100%	100%
3.71	LD: Active involvement in Care and Treatment Reviews & Blue Light protocol meetings to prevent admission and actively support and plan for integration/discharge in the community: 100% completion of the CTR Provider Checklist prior to CTR meetings	PM				100%	100%
		Actual				98%	98%
3.72	LD: Active involvement in Care and Treatment Reviews & Blue Light protocol meetings to prevent admission and actively support and plan for integration/discharge in the community: 75% CTRs being completed within 10 days of admission to Berkeley House	PM				75%	75%
		Actual				N/A	N/A
3.73	CYP report being satisfied or more than satisfied with service experience	PM				Report	Report
		Actual				NYA	NYA
3.74	CYP report being satisfied or more than satisfied following Transition to Adult services	PM				Report	Report
		Actual				NYA	NYA
3.75	CYP report being satisfied or more than satisfied with Transition to Adult Services: 95% of CYP asked to complete Service Questionnaire	PM				95%	95%
		Actual				NYA	NYA
3.76	Perinatal: Urgent Referral to Assessment within 4 - 6 hours - During working hours (unless otherwise negotiated with referrer or patient) in conjunction with Crisis Team	PM				95%	95%
		Actual				NYA	NYA
3.77	Perinatal: Out of hours emergencies assessed by MHARS to be discussed with the Specialist Perinatal Service the next working day	PM				95%	95%
		Actual				NYA	NYA
3.78	Perinatal: Urgent referrals with High risk indicators (following telephone screening) will be seen with 48 working hours	PM				95%	95%
		Actual				100%	83%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
3.79	Perinatal: Preconception advice - Referral to assessment within 6 weeks	PM				50%	50%
		Actual				100%	71%
3.80	Perinatal: Preconception advice - Referral to assessment within 8 weeks	PM				90%	90%
		Actual				100%	82%
3.81	Perinatal: Routine referral to assessment within 2 weeks	PM				50%	50%
		Actual				83%	74%
3.82	Perinatal: Routine referral to assessment within 6 weeks	PM				95%	95%
		Actual				100%	99%
3.83	Perinatal: Number of women asked if they have a carer	PM	80%			80%	80%
		Actual	82%			90%	90%
3.84	Perinatal: Number of women with a carer offered carer's assessment	PM	90%			90%	90%
		Actual	90%			93%	93%
3.85	Perinatal: Women and families views inform the development of the service via a service user forum	PM				Report	Report
		Actual				NYA	NYA
3.86	Perinatal: all perinatal care plans to be reviewed within 3 months	PM				95%	95%
		Actual				NYA	NYA
3.87	Perinatal: Reduction in number of episodes of Crisis	PM				Report	Report
		Actual				NYA	NYA
3.88	GARAS: Accepted referrals receive an initial assessment appointment within 6 weeks	PM				95%	95%
		Actual				NYA	NYA
3.89	GARAS: percentage of referrals completing the course of therapy	PM				90%	90%
		Actual				NYA	NYA

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month

None

Changes to Previously Reported Figures (M12)

None

Early Warnings / Notes

None

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures - National Indicators

ID	Performance Measure (PM)		2017/18 Outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0
		Actual	0	0	0	0	0
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3
		Actual	0	0	0	0	0
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Actual	99%	98%	98%	98%	98%
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	3.2%	1.1%	0.7%	1.3%	2.4%
NHSI 1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%
		Actual	99%	100%	100%	97%	99%
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%
		Actual	71%	79%	50%	67%	68%
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Actual	69%	99%	99%	99%	97%
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Actual	88%	99%	100%	99%	99%
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0
		Actual	0	0	0	0	0
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0
		Actual	6	0	0	0	2
DoH 2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%
		Actual	100%	100%	100%	100%	100%
DoH 2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM	100%	100%	100%	100%	100%
		Actual	100%	100%	100%	100%	100%
DoH 2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	100%	100%	100%	100%	100%
		Actual	100%	NYR	NYR	NYR	100%

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	15	15	15	15
	1	1	2	1
	12	12	11	12
NYA	0	0	0	0
NYR	0	0	0	0
N/A	2	2	2	2

Performance Thresholds not being achieved in Month

4.05: Current placements aged 65+ in residential and nursing care per 100,000 population
For March this indicator is recorded at 22.56 against a threshold of 22. Initial, thoughts were that this is due to the increasing age of the population supported by the community care budget. The data has been looked at and does not confirm this and the service is continuing to investigate.

4.10: Percentage of eligible service users with Personal Budget receiving Direct Payments
The service has been reviewing their processes to check that they are interpreting the direct payment methodology appropriately – and have identified that the arrangements for some service users do not meet the threshold. Our new personalisation project will aim to increase both direct payments and personal health budgets. 170 people hold a personal budget in March, with 23 receiving direct payments. 26 is the threshold.

Cumulative Performance Thresholds Not being Met
4.10: Percentage of eligible service users with Personal Budget receiving Direct Payments
As above

Changes to Previously Reported Figures (M12)
None

Early Warnings/Notes
None

Gloucestershire Social Care

ID	Performance Measure		2017/18 outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
4.01	The percentage of people who have a Cluster recorded on their record	PM	95%	95%	95%	95%	95%
		Actual	98%	100%	100%	100%	100%
4.02	Percentage of people getting long term services, in a residential or community care reviewed/re-assessed in last year	PM	95%	95%	95%	95%	95%
		Actual	97%	97%	95%	97%	97%
4.03	Ensure that reviews of new packages take place within 12 weeks of commencement	PM	80%	80%	80%	80%	80%
		Actual	74%	92%	100%	100%	85%
4.04	Current placements aged 18-64 to residential and nursing care homes per 100,000 population	PM	13	13	13	13	13
		Actual	9.44	9.10	9.61	9.86	9.10
4.05	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	22	22	22	22	22
		Actual	16.54	21.79	22.56	22.56	19.45
4.06	% of WA & OP service users on caseload asked if they have a carer	PM	80%	80%	80%	80%	80%
			88%	85%	85%	86%	86%
4.07	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	PM	90%	90%	90%	90%	90%
		Actual	91%	94%	94%	93%	93%
4.08a	% of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC
		Actual	43%	37%	36%	34%	34%
4.08b	Number of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC
		Actual	521	581	573	549	549
4.09	% of eligible service users with Personal budgets	PM	80%	80%	80%	80%	80%
		Actual	95%	100%	99%	92%	93%

Gloucestershire Social Care

ID	Performance Measure		2017/18 outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
4.10	% of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2)	PM	15%	15%	15%	15%	15%
		Actual	19%	13%	15%	14%	14.9%
4.11	Adults subject to CPA in contact with secondary mental health services in settled accommodation (ASCOF 1H)	PM	80%	80%	80%	80%	80%
		Actual	87%	87%	87%	87%	87%
4.12	Adults not subject to CPA in contact with secondary mental health service in settled accommodation	PM	90%	90%	90%	90%	90%
		Actual	96%	97%	97%	96%	96%
4.13	Adults subject to CPA receiving secondary mental health service in employment (ASCOF 1F)	PM	13%	13%	13%	13%	13%
		Actual	18%	16%	16%	16%	16%
4.14	Adults not subject to CPA receiving secondary mental health service in employment	PM	20%	20%	20%	20%	20%
		Actual	21%	23%	24%	23%	23%

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	24	24	24	24
🔴	1	0	2	3
🟢	16	16	15	15
NYA	0	0	0	0
NYR	0	0	0	0
N/A	7	8	7	6

Performance Thresholds not being achieved in Month

5.09a: IAPT Access rate; percentage accessing service
For March, the access rate is at 1.23% against an expected locally agreed threshold of 1.25%, however, we overachieved in January and February and therefore the Quarter 4 outturn was 15.3% which is compliant.

5.12 – Admitted patients 65+ to have a completed MUST assessment
There was 1 patient where a MUST assessment was not completed. The patient was admitted but refused to stay and discharged themselves 8 hours later.

Cumulative Performance Thresholds Not being

5.09a: IAPT Access rate; percentage accessing service
As above

5.15: CYP Eating Disorders: Routine referral to NICE treatment within 4 weeks
There were 2 cases in April 2018 and both started treatment outside of the required 4 weeks.

One case was due to the initial appointment, which was within 4 weeks, being cancelled by the family. The second case was as a result of unprecedented caseload activity and the need to manage deteriorating presentations in existing cases.

5.19: CYP Access: percentage of CYP in treatment against prevalence
The performance threshold for 2018/19 is 30% of prevalence, which equates to 973 young people having accessed treatment during 2018/19. We are 92 below the anticipated number required to achieve this at the end of March.

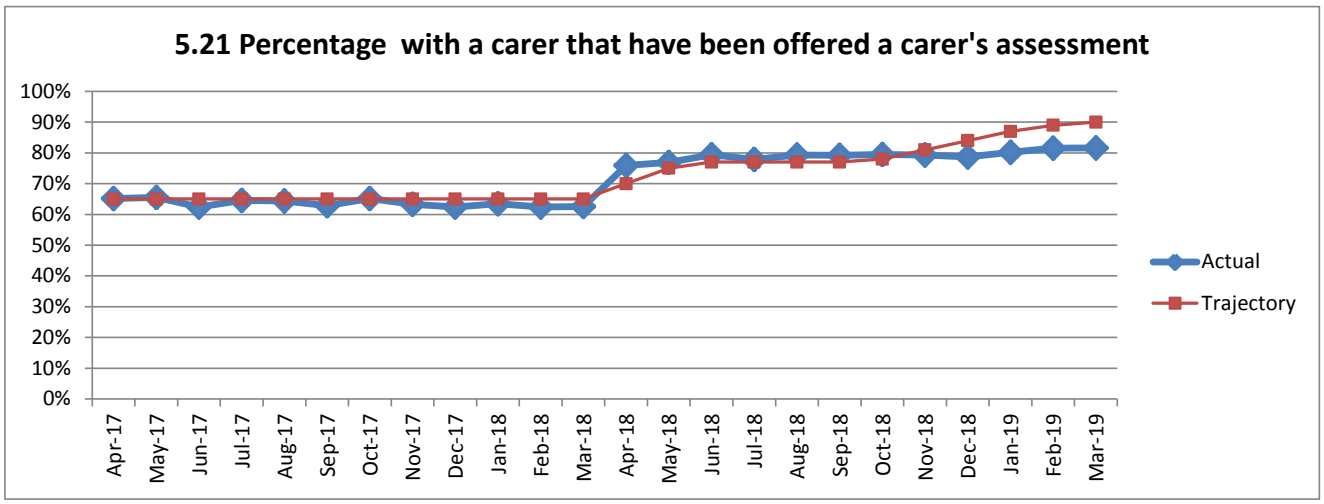
Referral, treatment and DNA rates are relatively stable and it is believed that improvements in the quality and consistency of CHOICE assessment and strict adherence to thresholds, along with more awareness and consistency in signposting, has limited treatment numbers. This feels positive as we feel that the right people are accessing our specialist service. We believe that we are treating all CYP who are referred to us for Tier 3 concerns within our commissioned specification.

Additionally, more efficient practices in our team mean that many CYP do not require a second appointment. Much of core CAMHS work is indirect, via consultation and advice, and we are working to capture this activity within our clinical system more accurately. We have been linking with Commissioners to scope options to increase access but this may require resourcing and/ or revision to the service specification. This is being discussed with Commissioners.

Changes to Previously Reported Figures (M12)
None

Early Warnings / Notes

5.21: Percentage with a carer that have been offered a carer's assessment
The following chart monitors progress against a trajectory to reach 90% by March 2019.



Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 Outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
5.01	Duty of Candour	Plan	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant
5.02	Completion of a valid NHS number field in metal health and acute commissioning data sets submitted via SUS.	Plan	99%	99%	99%	99%	99%
		Actual	100%	100%	100%	100%	100%
5.03	Completion of Mental Health Services Data Set ethnicity coding for all service users	Plan	90%	90%	90%	90%	90%
		Actual	100%	100%	100%	100%	99%
5.04	Completion of IAPT Minimum Data Set outcome data for all appropriate service users	Plan	90%	90%	90%	90%	90%
		Actual	100%	100%	100%	99%	99%
5.05	Zero tolerance MRSA	Plan	0	0	0	0	0
		Unavoidable	0	0	0	0	0
5.06	Minimise rates of Clostridium difficile	Plan	0	0	0	0	0
		Unavoidable	0	0	0	0	0
5.07	VTE risk assessment: all inpatient service users to undergo risk assessment for VTE	Plan	95%	95%	95%	95%	95%
		Actual	98%	94%	97%	97%	99%
5.08	IAPT Recovery Rate: The number of people who are below the caseness threshold at treatment end	Plan	50%	50%	50%	50%	50%
		Actual	49%	58%	51%	57%	53%
5.09a	IAPT Roll-out (Access Rate) - IAPT maintain 15% of patient entering the service against prevalence	Plan		1.25%	1.25%	1.25%	15.00%
		Actual		1.29%	1.30%	1.23%	14.76%
5.09b	IAPT Roll-out (Access Rate) - Number accessing service	Plan	2,178				
		Actual	1,977	1,824	2,013	2,191	2,191
5.10a	Dementia Service - number of new patients aged 65 years and over receiving an assessment	Plan	540	45	45	45	540
		Actual	667	76	62	70	770
5.10b	Dementia Service - total number of new patients receiving an assessment	Plan					
		Actual	711	81	63	74	818

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 Outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
5.11	Patients are to be discharged from local rehab within 2 years of admission (Oak House). Based on patients on w ard at end of month.	Plan	80%	80%	80%	80%	80%
		Actual	100%	90%	89%	89%	89%
5.12	All admitted patients aged 65 years of age and over must have a completed MUST assessment	Plan	95%	95%	95%	95%	95%
		Actual	100%	100%	100%	83%	98%
5.13	Any attendances at ED with mental health needs should have rapid access to mental health assessment within 2 hours of the MHL team being notified.	Plan	80%	80%	80%	80%	80%
		Actual	89%	100%	100%	95%	93%
5.14	Attendances at ED, wards and clinics for self-harm receive a mental health assessment (Mental Health Liaison Service)	Plan	85%	85%	85%	85%	85%
		Actual	96%	97%	100%	100%	97%
5.15	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - NICE treatments	Plan	95%	95%	95%	95%	95%
		Actual	96%	100%	100%	100%	91%
5.16	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - non-NICE treatments	Plan	95%	95%	95%	95%	95%
		Actual	N/A	N/A	N/A	N/A	N/A
5.17	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - NICE treatments	Plan	95%	95%	95%	95%	95%
		Actual	80%	100%	N/A	100%	100%
5.18	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - non-NICE treatments	Plan	95%	95%	95%	95%	95%
		Actual	N/A	N/A	N/A	N/A	100%
5.19	CYP Access: Number and percentage of CYP entering treatment (30% of prevalence)	Plan - %		5.5%	4.0%	4.0%	100.0%
		Actual %		6.4%	4.8%	4.8%	90.5%
		Plan - numbers		53	39	39	973
		Actual - numbers		62	47	47	881

Herefordshire Carers Information

ID	Performance Measure		2017/18 Outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
5.20	Working Age and Older People service users on the caseload asked if they have a carer. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan					
		Actual	67%	87%	87%	87%	87%
5.21	Working Age and Older People service users on the caseload who have a carer who have been offered a carer's assessment. (Includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan					
		Actual	63%	82%	83%	83%	83%
5.22	Working Age and Older People service users/carers who have accepted a carers assessment. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan					
		Actual	28%	23%	22%	22%	22%

Performance Thresholds not being achieved in Month

1.08: New psychosis (EI) cases treated within 2 weeks of referral (Herefordshire)

There was 1 case in Herefordshire where the client was recorded as starting treatment outside of 2 weeks. The patient was initially referred whilst an inpatient, however, due to the complex mental health history and physical health care needs it was not clinically appropriate to assess the patient within the required time period. The client was seen as soon as it was clinically appropriate which was within 3 weeks.

(Note: Treatment is recorded as having started, when a client has attended an assessment and been allocated a care coordinator)

Changes to Previously Reported Figures (M12)

None

Early Warnings / Notes

None

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures - National Indicators

ID	Performance Measure (PM)		2017/18 Outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0
		Actual	0	0	0	0	0
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3
		Actual	0	0	0	0	0
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Actual	99%	100%	100%	100%	99%
NHSI 1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%
		Actual	98%	98%	98%	99%	98%
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	2.4%	5.4%	2.9%	2.2%	2.3%
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%
		Actual	68%	100%	100%	50%	85%
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Actual	59%	98%	99%	98%	94%
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Actual	75%	100%	100%	99%	95%
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0
		Actual	0	0	0	0	0
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0
		Actual	5	0	0	0	3

DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

Gloucestershire CQUINS				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	12	12	12	12
🔴	0	0	1	1
🟢	0	0	11	11
NYA	0	0	0	0
NYR	12	12	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month

7.01a: Improvement of health and wellbeing of NHS Staff
Despite great efforts being made to improve the results supplied by staff to the staff survey we did not achieve the required percentage point increases. However this was reflected nationally and the Trust did show an overall increased score. It is hoped that the Commissioners will look favourably upon our endeavours and Gloucestershire have confirmed that we will not be financially penalised.

Cumulative Performance Thresholds Not being Met

None

Changes to Previously Reported Figures (M12)

Previously reported as Not Yet available, Quarter 4 can now be reported with 11 of the indicators being compliant and 1 non-compliant – see above.

Early Warnings

None

Gloucestershire CQUINS

ID	Performance Measure (PM)		2017/18 Outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
	CQUIN 1						
7.01a	Improvement of health and wellbeing of NHS Staff	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Non-compliant	Non-compliant
7.01b	Healthy food for NHS staff, visitors and patients	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
7.01c	Improving the update of flu vaccinations for frontline clinical staff	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
	CQUIN 2						
7.02a	Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with psychoses	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
7.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
	CQUIN 3						
7.03	Improving services for people with mental health needs who present to A&E	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
	CQUIN 4						
7.04	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
	CQUIN 5						
7.05a	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
7.05b	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
7.05c	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
7.05d	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
7.05e	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant

DASHBOARD CATEGORY – LOW SECURE CQUINS

Low Secure CQUINS				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	1	1	1	1
🔴	0	0	0	0
🟢	0	0	1	1
NYA	0	0	0	0
NYR	1	1	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures (M12)
Previously reported as Not Yet available, Quarter 4 can now be reported as compliant

Early Warnings
None

Low Secure CQUINS

ID	Performance Measure (PM)		2017/18 Outturn	January-2019	February-2019	March-2019		(Apr-Mar) Cumulative Compliance
	CQUIN 1							
8.01	Reducing the length of stay in specialised MH services	PM	Qtr 4			Report		Qtr 4
		Actual	Awarded			Compliant		Compliant

DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

Herefordshire CQUINS				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	12	12	12	12
	0	0	1	1
	0	0	11	11
NYA	0	0	0	0
NYR	12	12	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month

9.01a: Improvement of health and wellbeing of NHS Staff

Despite great efforts being made to improve the results supplied by staff to the staff survey we did not achieve the required percentage point increases. However this was reflected nationally and the Trust did show an overall increased score. It is hoped that the Commissioners will look favourably upon our endeavours.

Cumulative Performance Thresholds Not being Met

None

Changes to Previously Reported Figures (M12)

Previously reported as Not Yet available, Quarter 4 can now be reported with 11 of the indicators being compliant and 1 non-compliant – see above.

Early Warnings

None

Herefordshire CQUINS

ID	Performance Measure (PM)		2017/18 Outturn	January-2019	February-2019	March-2019	(Apr-Mar) Cumulative Compliance
7							
	CQUIN 1						
9.01a	Improvement of health and wellbeing of NHS Staff	PM	Qtr 4			Report	Report
		Actual	Awarded			Non-compliant	Non-compliant
9.01b	Healthy food for NHS Staff, Visitors and Patients	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
9.01c	Improving the uptake of Flu vaccinations for Front Line Clinical Staff	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
	CQUIN 2						
9.02a	Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with psychoses	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
9.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaborating with primary care clinicians	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
	CQUIN 3						
9.03	Improving services for people with mental health needs who present to A&E	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
	CQUIN 4						
9.04	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
	CQUIN 5						
9.05a	Tobacco screening	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
9.05b	Tobacco brief advice	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
9.05c	Tobacco referral and medication offer	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
9.05d	Alcohol screening	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant
9.05e	Alcohol brief advice or referral	PM	Qtr 4			Report	Qtr 4
		Actual	Awarded			Compliant	Compliant