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Nottinghamshire Healthcare NHS
NHS Foundation Trust

QUALITY & PERFORMANCE REPORT

MONTH 5 August 2016/17

Report to Board of Directors September 2016

Nottinghamshire Healthcare NHS Foundation Trust
Integrated Quality and Performance Report
Month 5 August 2016/17

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Integrated Quality and Performance Report
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EXECUTIVE SUMMARY

Introduction

The purpose of this report is to inform the Board of Directors of current levels of performance as at the end of August 2016. Compliance with Monitor's targets and a range of local indicators provides an overview of performance and quality within the Trust, to provide assurance and escalate actual or potential underperformance. The report has been developed to reflect performance at Trust and Division level, and is structured around Monitor's Risk Assessment Framework and the Care Quality Commission domains of: Safe, Effective, Caring, Responsive and Well-Led. Where there is underperformance, escalation with plans to improve performance is included. Underperformance increases the risk profile for the Trust in terms of financial viability, clinical quality and safety, and reputation. All data relating to this report is also monitored at Divisional level.

Monitor Risk Assessment Framework

From 1st April 2016, 'Monitor', the national body previously responsible for authorising, monitoring and regulating NHS foundation trusts, became part of 'NHS Improvement' the new organisation responsible for overseeing foundation trusts and NHS trusts. At present foundation trusts remain subject to the operational and governance conditions set out by the Monitor Risk Assessment Framework, and this will remain the case until such time as the Monitor Risk Assessment Framework is superseded by new compliance requirements as set out by NHS Improvement.

Currently the NHS foundation trusts are subject to condition 4 (the governance condition). NHS Improvement continues to use the Risk Assessment Framework to assess governance and investigate any governance conditions causing concern.

- **Governance Rating:**
  - The governance rating sets out degree of concern about the governance of a trust and any steps they are taking to investigate concerns or whether they are taking any enforcement action.

  - To calculate the Governance Rating, information is gathered under five categories: CQC information, access and outcome metrics, third party reports, organisational health indicators and financial risk (i.e. the FSRR). If no governance concerns are evident a Green rating is assigned and if regulatory action has been taken a Red rating is assigned. Where there is potential material cause for concern in one or more categories, the Green rating is replaced with a narrative description of the formal or informal action the regulator is taking.

  - For the access and outcome measures component of the rating, a Service Performance Score (SPS) is calculated. The Trust calculates its SPS to be 1 at month 5 2016/17 due to continued underperformance against the new Risk Assessment Framework performance indicator for Early Intervention in Psychosis (see section 3.2 and Exception Report number 7). A governance concern is indicated if there are three consecutive Quarter breaches of a single metric or an SPS of 4 or more.

- **Continuity of Financial Sustainability Rating (FSRR)**

  - The FSSR contains four measures: liquidity, capital servicing capacity, income and expenditure margin, and income and expenditure margin variance from plan. Each of

the four measures is weighted equally and scored from a minimum of 1 to the optimum level of 4.

- At Month 5, the capital servicing capacity measure score is 3 as per plan. The remaining measures all have actual ratings of 4. This leads to an overall FSSR rating of 4.

Summary of Performance

Monitoring quality and performance supports the Trust in meeting its legal and regulatory requirements, in particular, the Care Quality Commission's (CQC) fundamental standards and Monitor's Risk Assessment Framework (RAF).

Of the 13 Trust Performance Summary Dashboard indicators and 14 Monitor Compliance indicators there is 1 indicator significantly below target (red) and 6 indicators below target (amber) in the Trust Performance Summary dashboard, and 1 red in the Monitor Compliance Indicators.

Indicator	August Performance
Early Intervention in Psychosis (EIP); People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	32.3%
Turnover % (rolling 12 month figure)	13.6%
% Complaints closed within agreed timescales in the last month	74.0%
Total Sickness rate	5.2%
Annual Reviews carried out (staff appraisals)	87.3%
Clinical Supervision	74.1%
Safety Thermometer Harm Free Care	93.7%
Patients receiving follow-up contact within seven days of discharge from mental health services (CPA and Care Pathway)	94.4%

Cost Improvement Programme Report

The Trust's divisional reports for Cost Improvement Plans (CIPs) are reviewed on a monthly basis by the Executive Leadership Team, and an escalation/assurance report is provided to the Trust Board each month, allowing the Board to maintain oversight of the key qualitative and financial aspects of delivery of the Trust's annual efficiency programmes.

Patient-Led Assessments of the Care Environment (PLACE)

PLACE assessments assess hospitals across a range of environmental aspects such as food or cleanliness. PLACE assessments were published on the NHS Digital website (the new name for the Health & Social Care Information Centre) on 10th August 2016; the assessments carried out for Nottinghamshire Healthcare NHS Foundation Trust have been summarised in section 8.0 of the Trust Performance Report (page 24), benchmarking Trust sites' performance against the national site average.

There is a new indicator 'Disability' added this year, focussing on the issues of access and mobility provided for disabled patients during their stay, and aspects relating to food and food service. These are not separate questions but detail is taken from specific answers from the aforementioned criteria. The findings from PLACE assessments were reviewed at the Trust Quality Meeting & Infection Control Committee in August 2016; action plans to address any identified issues will be monitored through clinical divisions and the Trustwide Infection Control Committee.

Indicator Glossary and Assurance on Data Quality

The Quality and Performance Report Performance Indicator Glossary is included as Appendix 1.

The RAG-ratings for the indicators assessed to date are included on the Trustwide Performance Summary Dashboard and Monitor Dashboard. The glossary also provides more detailed descriptions, origin, numerator/value and denominator, and performance RAG-rating for each indicator.

Significant Risk

There are risks relating to staffing, in particular sickness and annual reviews; however these are not considered significant enough to affect the achievement of objectives at this stage in the year. Risks have also been identified to achieving quality priorities relating to physical assaults and reduction in the number of pressure ulcers, which are monitored by the Quality Committee who receive Quality Priority Monitoring dashboards.

Recommendations

The Board of Directors is asked to:

- Receive assurance on the overall achievement of quality and performance indicators;
- Note the escalation of areas of underperformance and be assured on the improvement actions defined.

Ruth Hawkins
Chief Executive
September 2016

2.0 Exception Report
Month 5 August 2016/17

INTRODUCTION

Exception reports are provided to give an explanation for identified areas of under-performance. Reports are provided for areas of continued under-performance or downward trends. These reports include:

- Performance against the target and, where possible, projected future performance;
- Where available, benchmarking information with other organisations to provide context to the Trust's performance;
- Narrative explanation and specific actions to address under-performance.

FORENSIC SERVICES DIVISION

Of the 13 Divisional Summary Dashboard indicators, 4 are red and 2 are amber.

Ref. No. 1 - Turnover % (rolling 12 months) - The overall 12 month rolling percentage for the Forensic Division has increased and remains an area of concern. Staffing turnover continues to be addressed via the Forensic Services retention strategy, which is being monitored monthly by the Forensic Senior Management Group. In addition to this, recent successful recruitment campaigns have taken place at Rampton, on-going recruitment campaigns continue at Arnold Lodge and Rampton, and Offender Health are hosting an Open Recruitment Day for the Doncaster cluster in September.

Ref. No. 2 – Total Sickness Rate - Sickness levels have been increasing over the past few months. This was discussed at the September Forensic Senior Management Group meeting due to concerns regarding the recent increases across the Division. Human Resources are taking this forward with clinical directorates via a number of initiatives; these include all clinical directorates having their own individual sickness absence action plans to address. Human Resources are also currently undertaking audits in respect of adherence to the sickness policy and target setting.

Ref. No. 3. Complaints – 14 of the 47 Forensics complaints closed did not receive a timely response. Delays were largely due to competing priorities, particularly within Offender Health Yorkshire and High Secure Mental Health directorates. The issue has been highlighted at recent Offender Health Clinical Governance Group meetings and will once again be addressed within the Governance Report to Forensic Senior Management Group. Individual weekly reports continue to be sent to complaint leads in each service; these highlight all open complaints requiring attention and give investigation report deadlines. This is an on-going issue and the Divisional management team will be receiving more detailed reports to directly request updates and drive improvements.

Ref. No. 4 - Forensic Delayed Admissions – There were 8 patients delayed who were awaiting admission:-

- **High Secure Women's Service** – There are 5 patients delayed**.** The Clinical Director reports that the Directorate is unable to provide any forthcoming admission dates and that the delays continue due to high occupancy levels and demands on beds.

- **High Secure Mental Health** – There are 2 patients delayed due to lack of beds on the admission wards. The high level of occupancy within the mental health service continues, with the service processing high numbers of referrals.;

- **Arnold Lodge Medium Secure Unit** – There is 1 patient delayed who awaits admission to an intensive care bed (ICU); demand for ICU beds remains high.

Ref. No. 5 - Forensic Delayed Discharges – There were two patients delayed who were awaiting discharge:-

- **High Secure Peaks Unit** – 1 patient delayed at the end of the month. It is now reported that a bed is available and a preliminary date has been agreed for the patient to move to their placement the week commencing 10th October. The national shortage of medium secure beds is on-going; the Division continues to work with Commissioners and Case Managers to ensure that delays are managed in a proactive and robust manner.
- **Arnold Lodge Medium Secure Unit** - 1 patient delayed, waiting for a bed it was originally agreed for a period of 6 months trial leave and this was granted by the Ministry of Justice in May 2016; however the Commissioners have since decided they want the patient to go on full transfer. Permission for full transfer was then requested at the beginning of August and the authority came through at the end of August 2016. This patient currently remains on the waiting list and awaits allocation of a ward and consultant.

LOCAL SERVICES DIVISION

Of the 16 Divisional Summary Dashboard indicators, 1 is red and 3 are amber.

Ref. No. 6 – Turnover % (rolling 12 month figure) – Turnover for the Division remains above the Trust target and this reflects the on-going impact of the TUPE of staff from Hotel Services; however two out of the Division's three clinical service directorates are within target, with Adult Mental Health directorate at 10.0% and Mental Health Services for Older People at 9.8%.

Ref. No. 7 – Early Intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral – The Division recognises that performance remains below the target of 50%. Teams are now validating data on a monthly basis, which is improving both the data quality and the overall reported performance. The Division and its commissioners are meeting monthly to identify actions to meet the recommendations of the EIP review. Work is progressing well and improvements continue to be evidenced. The clinical directorates have commenced recruitment and a recovery plan is being developed to ensure compliance is met for Quarter 3 2016/17.

Ref. No. 8 Clinical Supervision - There are two areas contributing to the under-performance within the Division - Adult Mental Health and Specialist Services Directorate. Specialist Services Directorate attributes sub–standard data inputting to some of their performance in part, but also notes that the high level of annual leave in August may also have had an impact. The Directorate is being encouraged to improve planning processes so that leave does not obstruct clinical supervision needs and to reiterate to staff the need for accuracy in data reporting. The Adult Mental Health Directorate cite vacancies, sickness and maternity leave, as well as under-reporting and increased clinical demand, for their dip in performance. Further work is being undertaken to ensure that clinical supervision is undertaken with staff in situations where there are high levels of vacancies and/or sickness, to ensure they feel they are receiving the necessary clinical support.

Ref. No. 9 Mixed Sex Accommodation - There was one MSA breach occurring in August; this was due to no other female bed being available. The decision was taken in best interests of the patient and a side room was utilised with 1:1 observations. The patient was moved to a single sex ward within 24 hours.

HEALTH PARTNERSHIPS DIVISION

Of the 16 Divisional Summary Dashboard indicators, 4 are red and 3 are amber.

Ref. No. 10 - Turnover – The Division has a rolling 12-month turnover rate of 13.9% which is in breach of the 11% ceiling set by the Trust. Turnover is expected to remain above target due to the recent TUPE activity within the Division and the basis on which the rolling turnover rate is calculated. Following analysis of 2015/16 divisional turnover data, a Divisional retention action plan has been devised to address possible ways to increase retention, with delivery of this action plan being monitored by the Division's Workforce, Equality & Diversity Group.

Ref. No. 11 - Clinical Supervision - Health Partnerships have achieved 64.3% against the target of 80% of staff receiving clinical supervision. Staff continue to be monitored and followed up if they have not accessed or recorded their clinical supervision sessions; however, the impact of annual leave on the teams during the summer period has also negatively affected clinical supervision rates. The Division have started trialling a different method for capturing data which will be compared against the current method. The Division continue to update staff on ESR and ensuring that the appropriate clinicians are captured in the clinical supervision numbers.

Ref. No. 12 - Acquired Avoidable Pressure Ulcers – Whilst the level of pressure ulcers is above target, there has been a 20% monthly decrease overall in all stages of acquired avoidable pressure ulcers for August. The Division is pleased to note that there has been a strong downward trend for 2016/17 for reported Stage 3 pressure ulcers when compared to 2015/16. The Trustwide Tissue Viability Steering Group continues to monitor pressure ulcer treatment.

Ref. No. 13 - Venous Lower Leg Wounds Healed within 20 Weeks – Whilst there has been a significant improvement in performance for August when compared to previous months the division remains aware of the need to maintain a strong level of improvement over the coming months in order to comply with the 75% target. The Division recognises that this is a developing area of work and expects to demonstrate significant improvement over the next few months following the implementation of recommendations from a recent audit undertaken to review the pathway. This area of work will have oversight from the Trust Tissue Viability Group which will monitor the improvement plan.

3.1 Monitor/NHS Improvement Governance Rating, Month 5 August 2016/17

Monitor's Risk Assessment Framework defines how the Governance Rating is calculated. Monitor uses information gathered under five categories: CQC information, access and outcome metrics, third party reports, organisational health indicators and financial risk. If no governance concerns are evident a Green rating is assigned and if regulatory action has been taken a Red rating is assigned. Where there is potential material cause for concern in one or more categories, the green rating is replaced with a narrative description of the formal or informal action Monitor is taking.

Indicators of Governance Concerns

Category	Current Governance Rating	Current Position	Metrics	Governance Concern Trigger
CQC Concerns	**Concern**	**A CQC Warning notice in place at Rampton High Secure Hospital. The warning notice in respect of HMP Lowdham Grange has been closed.**	Outcome of CQC inspections and assessments	CQC warning notice Changes to registration conditions Civil and/or criminal action initiated
Access and Outcomes Metrics	**No concerns**	**The Service Performance Score for Month 5 16/17 is 1**	Mental health and community trust metrics included in the Monitor Performance Indicator Dashboard (section 3.2)	3 consecutive quarters breach of a single metric or 4 or more metrics breached in a single period (see Service Performance Score in section 3.2)
3rd Party Reports	**No concerns**	**No 3rd party reports received have triggered a governance concern**	Ad hoc reports from GMC, Ombudsman, commissioners, Healthwatch England, auditor reports, Health and Safety Executive, patient groups, complaints, whistleblowers, medical colleges etc	Judgement based on the severity and frequency of reports
Organisational Health Indicators	**No concerns**	**Outcome of national staff and patient surveys good, Friends and Family Test 95% and Service Quality Rating 94%.** **Staff metrics are monitored and have not identified any significant cause for concern.**	Patient metrics, e.g.: - Patient satisfaction Staff metrics, e.g.: - High executive team turnover - Satisfaction - Sickness/absence rate - Proportion temporary staff - Staff turnover Aggressive cost reduction plans	Material reductions in satisfaction, or increases in sickness or turnover rates Material increases in proportion of temporary staff Cost reduction in excess of 5% in any given year
Financial Risk	**No concerns**	**Score of 4**	Continuity of Financial Sustainability Rating Inadequate planning processes	Breaching Continuity of Service licence condition as a result of governance
Governance Rating Calculated by Trust	**Concern**	**Escalated concern in response to the CQC Warning Notice for Rampton Hospital**		
Governance Rating Calculated by Monitor	**No concerns**	**NHS Improvement's current published rating (subject to review)**		

3.2 MONITOR / NHS IMPROVEMENT PERFORMANCE INDICATOR DASHBOARD, MONTH 5 August 2016/17

Area	Ref	Key Performance Indicator	Target	Qtr 3 15/16	Qtr 4 15/16	Qtr 1 16/17	Jul-16	Aug-16	Sep-16	Qtr 2 16/17	Data Quality	Ref
Access	7-a	Care Programme Approach (CPA) patients - receiving follow-up contact within seven days of discharge	95%	98.7%	98.1%	98.7%	100.0%	98.2%		98.8%		
	7-b	Care Programme Approach (CPA) patients - having formal review within 12 months	95%	97.3%	97.2%	97.2%	96.8%	97.3%		97.0%		
	8	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams	95%	99.5%	98.5%	99.4%	98.4%	96.2%		97.4%		
	9	Meeting commitment to serve new psychosis cases by early intervention teams	95%	131.4%	153.9%	152.6%	154.9%	154.0%		154.0%		
	12	Early Intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	50%			21.4%	30.4%	32.3%		31.5%		See Exception Report No. 7
	13-a	People with common mental health conditions referred to the Improving access to psychological therapies (IAPT) programme will be treated within 6 weeks of referral.	75%	78.2%	83.8%	82.1%	76.3%	83.2%		79.9%		
	13-b	People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	98.2%	98.8%	99.2%	99.5%	99.8%		99.7%		
Outcomes	15	Minimising mental health delayed transfers of care	≤ 7.5%	5.0%	5.9%	6.9%	6.4%	4.0%		5.2%		
	16	Mental health data completeness: identifiers	97%	98.8%	98.9%	98.9%	98.9%	98.9%		98.9%		
	17	Mental health data completeness: outcomes for patients on CPA - new indicator	50%	79.2%	77.6%	77.6%	75.6%	71.8%		71.8%		
	18	Certification against compliance with requirements regarding access to health care for people with a learning disability	n/a	compliant	compliant	compliant	compliant	compliant		compliant		
	19-a	Data completeness: community services - Referral to treatment information	50%	compliant	compliant	compliant	compliant	compliant		compliant		
	19-b	Data completeness: community services - Referral information	50%	compliant	compliant	compliant	compliant	compliant		compliant		
	19-c	Data completeness: community services - Treatment activity information	50%	compliant	compliant	compliant	compliant	compliant		compliant		
		Service Performance Score		0	0	1	1	1		1		

3.3 TRUST QUALITY AND PERFORMANCE DASHBOARD MONTH 5 August 2016/17

Domain	Indicator reference code	Key Performance Indicator	Target / average: on target	Target / average: below target	Target / average: significantly below target	QTR 3 15/16 Oct	QTR 3 15/16 Nov	QTR 3 15/16 Dec	QTR 4 15/16 Jan	QTR 4 15/16 Feb	QTR 4 15/16 Mar	QTR 1 16/17 Apr	QTR 1 16/17 May	QTR 1 16/17 Jun	QTR 2 16/17 Jul	QTR 2 16/17 Aug	QTR 2 16/17 Sep	Trend 16/17 15/16	Data Quality	Reference
CARING	C-1-Tr	Friends and Family Test scores	6 month average 96			97	97	98	97	97	95	95	97	96	97	95				
CARING	C-2-Tr	Service Quality Rating %	6 month average 94			94	94	96	96	96	94	94	94	94	94	94				
CARING	C-3-Tr	Number of new complaints received	6 month average 78			82	73	57	68	81	86	88	74	85	79	58				
CARING	C-4-Tr	% Complaints closed within agreed timescales in the last month	≥80%	≥70%	<70%							78.7	77.0	82.4	77.9	74.0				
CARING	C-5-Tr	% Complaints closed in the last month upheld or partially upheld	To be confirmed									32.2	36.8	32.7	38.8	42.3				
WEL L-LED	WL-2-Tr	Turnover % (rolling 12 month figure)	9% to 11%	8-9% 11-12%	<8%, >12%	12.8	12.4	12.2	12.2	11.8	12.8	12.8	13.4	14.1	13.6	13.6				See Well-Led - Staff in Post detailed report on page 17. Exception Report No. 1,6 & 10
WEL L-LED	WL-3-Tr	Total Sickness rate	≤4%	≤6%	>6%	4.9	4.9	5.4	5.3	5.1	4.9	4.7	4.6	5.0	5.1	5.2				See Well-Led - Sickness detailed report on page 15 . See Exception Report No. 2
WEL L-LED	WL-4-Tr	Vacancy rate %	To be confirmed			8.5	6.8	7.5	6.6	6.8	7.2	7.1	7.6	8.2	8.0	7.9				See Well-Led - Staff in Post detailed report on page 17
WEL L-LED	WL-5-Tr	Annual Reviews carried out % (Staff Appraisals)	≥95%	≥85%	<85%	83.1	87.4	89.7	89.5	88.6	89.5	87.7	88.5	88.1	88.0	87.3				See Well-Led - Learning & Development detailed report on page 16
WEL L-LED	WL-6-Tr	Clinical supervision %	≥80%	≥65%	<65%	78.6	81.0	75.0	76.7	77.2	74.1	77.5	76.5	76.9	75.3	74.1				See Exception Report No. 8 & No. 11
WEL L-LED	WL-7-Tr	Mandatory training %	≥85%	≥75%	<75%	91.0	91.1	91.1	90.9	90.7	90.6	87.8	88.5	89.0	89.1	89.5				See Well-Led - Learning & Development detailed report on page 16
SAFE	S-4-Tr	Safety Thermometer All Harms - % Harm Free Care	≥95%	≥90%	<90%	94.2	92.6	92.7	93.3	93.1	92.3	93.8	94.2	92.9	93.4	93.7				
RESPONSIVE	R-5-Tr	Patients receiving follow-up contact within seven days of discharge from mental health services (CPA and Care Pathway)	≥95%	≥90%	<90%	93.3	96.9	95.8	95.7	95.0	94.4	98.1	95.5	96.1	93.2	94.4				

KEY CODING REFERENCE: DATA QUALITY indicates an indicator that is currently being assessed through the Trust's Information Assessment process to judge the level of data quality and actions needed to improve data quality.

4.1 FORENSIC SERVICES DIVISION QUALITY AND PERFORMANCE DASHBOARD MONTH 5 August 2016/17

Domain	Key Performance Indicator	Target / average: on target	Target / average: below target	Target / average: significantly below target	QTR 3 15/16 Oct	QTR 3 15/16 Nov	QTR 3 15/16 Dec	QTR 4 15/16 Jan	QTR 4 15/16 Feb	QTR 4 15/16 Mar	QTR 1 16/17 Apr	QTR 1 16/17 May	QTR 1 16/17 Jun	QTR 2 16/17 Jul	QTR 2 16/17 Aug	QTR 2 16/17 Sep	Trend (16/17 / 15/16)	Reference
CARING	Friends and Family Test scores	6 month average **69**			x	x	x	x	x	x	67	64	67	81	66			
	Service Quality Rating %	6 month average **78**			90	70	x	x	74	78	78	72	78	82	76			
	Number of new complaints received	6 month average **51**			54	51	38	51	57	59	66	43	60	45	34			
	% Complaints closed within agreed timescales in the last month	≥80%	≥70%	<70%							80.3	70.6	76.0	72.2	70.2			See Exception Report No. 3
	% Complaints closed in the last month upheld or partially upheld	To be confirmed									21.2	33.3	24.0	31.5	34.0			
WELL LED	Turnover % (rolling 12 month figure)	9% to 11%	8- 9% 11-12%	<8%, >12%	13.0	12.2	12.0	11.8	11.6	11.8	11.6	13.2	13.8	13.4	13.9			See Well-Led - Staff in Post detailed report on page 17 See Exception Report No. 1
	Total Sickness rate	≤5%	<7%	≥7%	5.9	5.9	6.7	6.4	5.9	5.9	5.7	5.8	6.1	6.8	7.1			See Well-Led - Sickness detailed report on page 15. See Excepton Report No. 2
	Vacancy rate %	To be confirmed			9.9	8.1	8.4	7.3	7.1	8.6	7.9	8.0	8.9	8.6	9.3			See Well-Led - Staff in Post detailed Report on page 17
	Annual Reviews carried out % (Staff Appraisals)	≥95%	≥85%	<85%	86.3	91.0	92.0	91.6	90.1	91.6	90.0	90.1	90.2	88.7	87.1			See Well-Led- Learning & Development detailed report on page 16
	Clinical supervision %	≥80%	≥65%	<65%	85.5	87.6	85.7	85.6	84.7	84.1	88.0	87.6	86.7	85.7	83.5			
	Mandatory training %	≥85%	≥75%	<75%	91.0	92.0	92.0	92.0	92.0	93.0	92.0	92.0	92.0	92.0	92.0			See Well-Led- Learning & Development detailed report on page 16
RESPONSIVE	Mental Health Delayed Transfers of Care - Admission	=0	n/a	>0	8	7	8	8	7	6	4	4	6	8	8			See Exception Report No. 4
	Mental Health Delayed Transfers of Care - Discharge	=0	n/a	>0	3	3	3	2	2	3	0	1	1	2	2			See Exception Report No. 5

4.2 LOCAL SERVICES DIVISION QUALITY AND PERFORMANCE DASHBOARD MONTH 5 August 2016/17

Domain	Key Performance Indicator	Target / average: on target	Target / average: below target	Target / average: significantly below target	QTR 3 15/16 Oct	QTR 3 15/16 Nov	QTR 3 15/16 Dec	QTR 4 15/16 Jan	QTR 4 15/16 Feb	QTR 4 15/16 Mar	QTR 1 16/17 Apr	QTR 1 16/17 May	QTR 1 16/17 Jun	QTR 2 16/17 Jul	QTR 2 16/17 Aug	QTR 2 16/17 Sep	Trend (16/17 / 15/16)	Reference
CARING	Friends and Family Test scores	6 month average 92			92	94	96	94	95	94	92	94	92	94	92			
CARING	Service Quality Rating %	6 month average 94			92	94	92	94	94	94	92	94	94	92	92			
CARING	Number of new complaints received	6 month average 19			23	19	14	15	22	21	17	27	20	26	22			
CARING	% Complaints closed within agreed timescales in the last month	≥80%	≥70%	<70%							66.7	90.0	85.0	89.0	80.0			
CARING	% Complaints closed in the last month upheld or partially upheld	To be confirmed									61	48	45	53	52			
WELL LED	Turnover % (rolling 12 month figure)	9% to 11%	8- 9% 11-12%	<8%, >12%	11.9	11.5	11.5	11.6	11.3	13.1	13.6	13.7	14.4	14.1	14.0			See Well-Led - Staff in Post detailed report on page 17. See Exception Report No. 6
WELL LED	Total Sickness rate	≤4%	≤6%	>6%	4.6	4.7	5.1	4.9	4.8	4.8	4.9	4.5	4.6	4.5	4.7			See Well-Led - Sickness detailed report on page
WELL LED	Vacancy rate %	To be confirmed			9.5	7.5	7.7	7.9	8.0	7.9	8.6	9.5	9.8	9.2	8.6			See Well-Led - Staff in Post detailed report on page 17.
WELL LED	Annual Reviews carried out % (Staff Appraisals)	≥95%	≥85%	<85%	86.4	88.6	91.0	90.6	90.7	90.6	88.9	90.2	88.6	87.9	88.3			See Well-Led - Learning & Development detailed report on page 16
WELL LED	Clinical supervision %	≥80%	≥65%	<65%	85.0	87.6	82.8	83.2	83.0	79.7	81.2	81.9	78.5	80.0	76.6			See Excepton Report No. 8
WELL LED	Mandatory training %	≥85%	≥75%	<75%	90.5	90.3	90.2	90.7	90.7	90.9	87.1	87.2	87.8	88.6	88.8			See Well-Led - Learning & Development detailed report on page 16
EFFECTIVE	PCPT/IAPT - the Proportion of people who complete treatment who are moving to recovery	≥50%	≥45%	<45%	50.7	51.9	51.6	52.2	53.4	53.6	54.1	50.7	51.3	51.8	54.4			
EFFECTIVE	% patients readmitted within 28 days - Adult	<4%	≥4%	≥10%	1.4	1.5	0.0	4.5	4.0	2.1	1.6	2.3	3.4	3.6	x			
EFFECTIVE	Number of patients readmitted within 28 days - Older People	≤2	2 to 5	>5	1	1	0	1	0	0	0	0	0	0	x			
SAFE	Safety Thermometer All Harms - % Harm Free Care	≥95%	≥90%	<90%	98.8	97.7	97.7	95.3	94.3	97.8	97.8	100.0	96.2	98.7	100.0			
RESPONSIVE	CPA - % patients having a review in last 12 months	≥95%	≥80%	<80%	96.3	96.5	97.1	96.9	95.4	96.3	96.2	96.5	94.9	95.3	96.6			

4.3 HEALTH PARTNERSHIPS DIVISION QUALITY AND PERFORMANCE DASHBOARD MONTH 5 August 2016/17

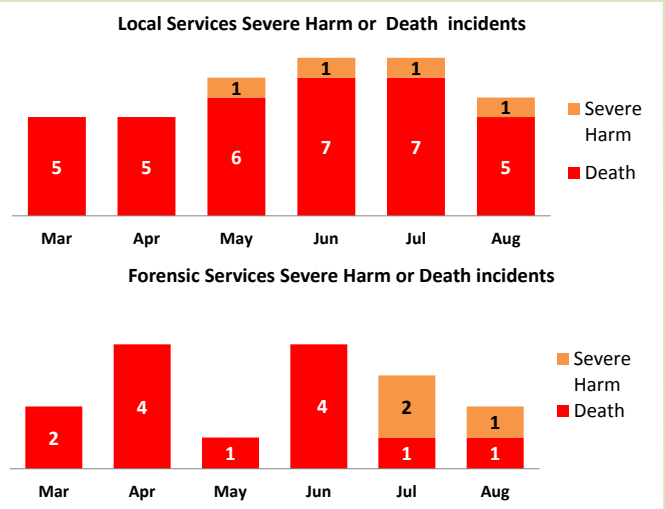
Domain	Key Performance Indicator	Target / average: on target	Target / average: below target	Target / average: significantly below target	QTR 3 15/16: Oct	QTR 3 15/16: Nov	QTR 3 15/16: Dec	QTR 4 15/16: Jan	QTR 4 15/16: Feb	QTR 4 15/16: Mar	QTR 1 16/17: Apr	QTR 1 16/17: May	QTR 1 16/17: Jun	QTR 2 16/17: Jul	QTR 2 16/17: Aug	QTR 2 16/17: Sep	Trend: 16/17 / 15/16	Reference
CARING	Friends and Family Test scores	6 month average **98**			98	97	98	97	98	98	98	98	99	98	98			
CARING	Service Quality Rating %	6 month average **96**			96	94	96	96	96	94	96	96	96	96	96			
CARING	Number of new complaints received	6 month average **5**			8	4	5	2	3	6	5	4	5	8	2			
CARING	% Complaints closed within agreed timescales in the last month	≥80%	≥70%	<70%							100	100	100	100	100			
CARING	% Complaints closed in the last month upheld or partially upheld	To be confirmed									66	0	42	66	67			
WELL-LED	Turnover % (rolling 12 month figure)	9% to 11%	8- 9% 11-12%	<8%, >12%	14.3	14.4	14.2	14.0	13.7	14.7	14.5	14.2	15.1	14.2	13.9			See Well-Led - Staff in Post detailed report on page 17. See Exception Report No. 10
WELL-LED	Total Sickness rate	≤4%	≤6%	>6%	4.6	4.5	4.8	5.2	5.0	4.4	4.0	4.0	4.6	4.3	4.4			See Well-Led - Sickness detailed report on page 15
WELL-LED	Vacancy rate %	To be confirmed			5.8	4.6	4.6	4.5	5.3	5.0	5.2	5.7	5.7	5.8	5.4			See Well-Led Staff in Post detailed report on page 17
WELL-LED	Annual Reviews carried out % (Staff Appraisals)	≥95%	≥85%	<85%	76.9	83.7	87.0	86.8	85.5	86.8	84.7	86.3	87.9	89.0	88.4			See Well-Led Learning & Development detailed report on page 16
WELL-LED	Clinical supervision %	≥80%	≥65%	<65%	67.3	70.0	61.0	64.3	67.0	62.0	66.0	63.0	68.0	63.0	64.3			See Excepton Report No. 11
WELL-LED	Mandatory training %	≥85%	≥75%	<75%	91.0	91.0	90.0	89.0	88.0	87.0	82.0	84.0	86.0	86.0	87.0			See Well-Led Learning & Development detailed report on page 16
SAFE	Total number of acquired avoidable pressure ulcers stages 3 and 4 reported in month	0	n/a	>0									4	5	4			See Safe - Pressure Ulcers detailed report on page 14 See Exception Report No. 12
SAFE	Total number of acquired avoidable pressure ulcers stages 3 and 4 *reviewed post root cause analysis*	0	n/a	>0	9	12	10	12	7	6	19	8	x	x	x			See Safe - Pressure Ulcers detailed report on page 14.
SAFE	Safety Thermometer All Harms - % Harm Free Care	≥95%	≥90%	<90%	93.7	92.1	92.2	93.1	92.9	91.8	93.5	93.7	92.6	92.8	93.1			
SAFE	% Venous Lower Leg Wounds Healed Within 20 Weeks	≥75%	n/a	<75%				48.0	28.0	20.7	22.4	30.0	16.4	8.8	31.4			See Exception Report No. 13
RESPONSIVE	Delayed Transfers of Care (non mental health) - % attributable to the Trust	≤7.5%	n/a	>7.5%	4.2	3.0	3.7	3.2	1.2	2.0	0.6	2.7	5.3	1.2	3.6			

SAFE

5.1 INCIDENT MANAGEMENT, Month 5 August 2016/17

	Trust Year to Date	August month 5 16/17 Trust total	Forensic Services Division	Local Services Division	Health Partnerships Division
Number of Never Events	0	0	0	0	0
Total number of reported incidents (excluding third party)	13996	3029	1670	748	599
Total Patient Safety incidents as reported to the National Reporting and Learning System (NRLS)	5295	1145	567	307	271
% of total incidents resulting in Severe Harm or Death	0.34%	0.26%	0.12%	0.80%	0.00%
Total number of incidents resulting in Severe Harm or Death	48	8	2	6	0
STEIS reportable incidents	153	26	9	11	6
Number of patients 16 to 17 years old admitted to an adult ward	2	0	0	0	n/a
Number of Under 16's admitted to an adult ward	0	0	0	0	n/a
Number of Single Sex accommodation breaches	5	0	0	1	0

Incidents Classified Severe Harm and Death

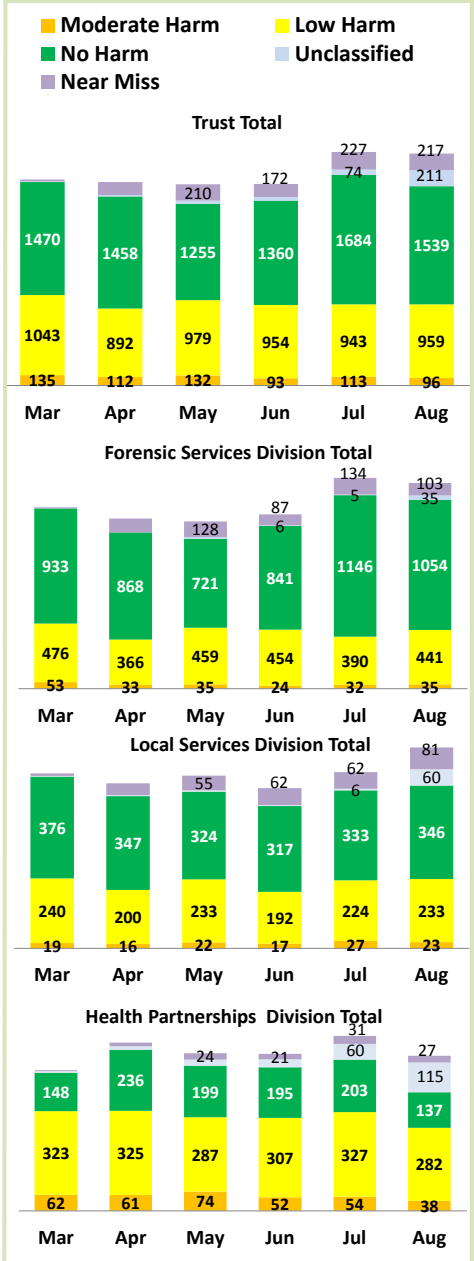


Narrative - Incidents Classified Severe Harm and Death

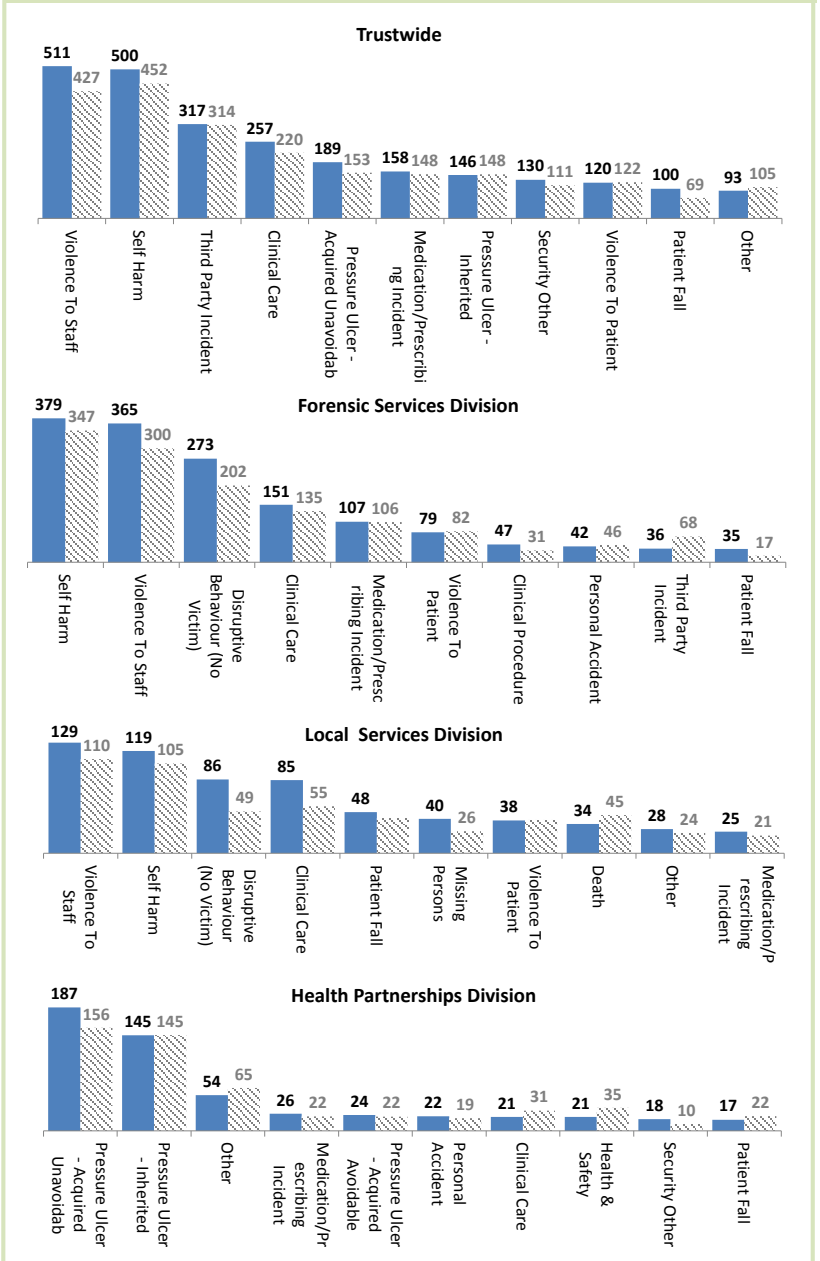
Death/ Catastrophic Local Services Division: 3 x unexpected deaths, 1 x suspected suicide, 1 x homicide. Forensic Services Division: 1 x suspected suicide.

Severe Forensic Services Division: 1 x rapid deterioration. Local Services Division: 1 x suspected self-inflicted harm.

Incident Classifications - Degrees of Harm: No, Low and Moderate Harm



Most Frequently reported types of incident - August 2016 vs average previous 6 months

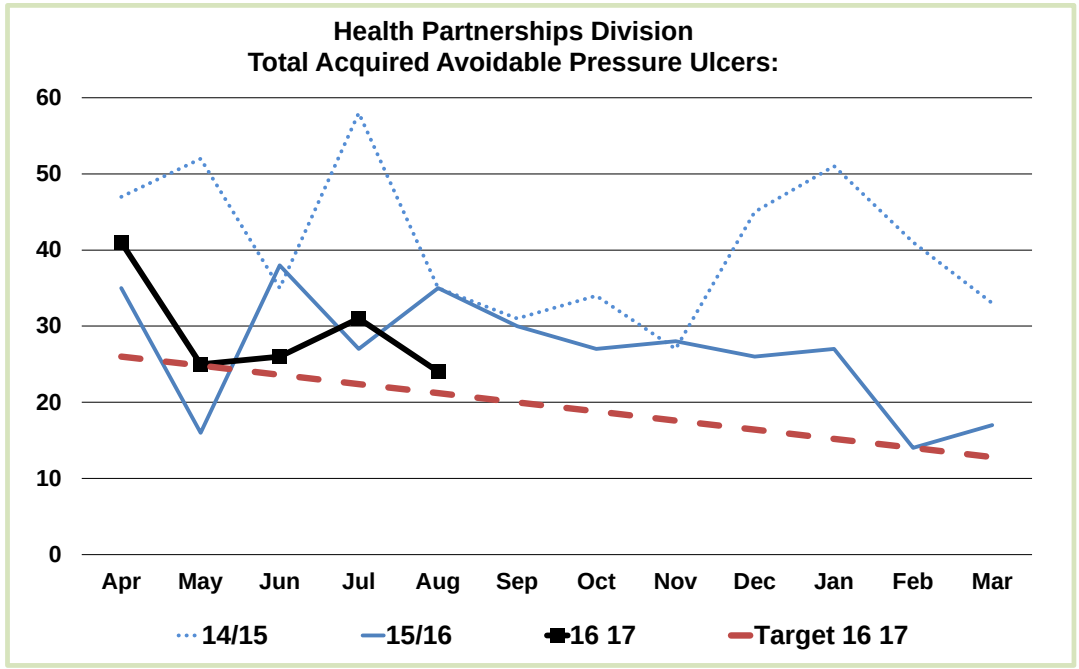


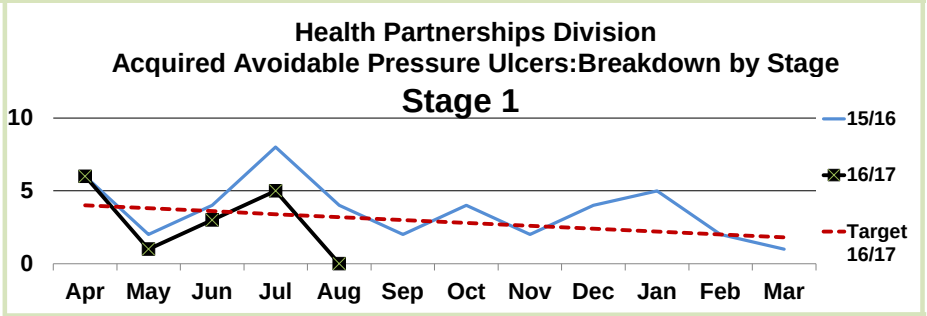
SAFE

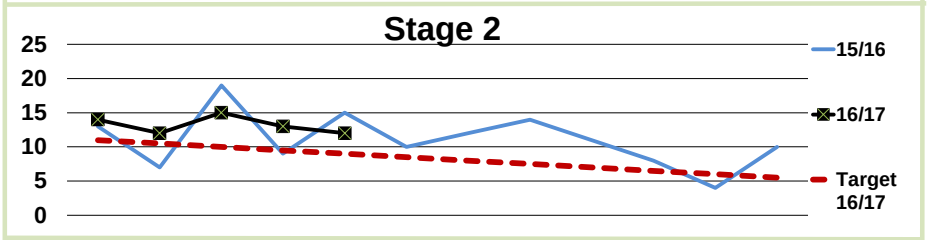
5.2 PRESSURE ULCERS, Month 5 August 2016/17

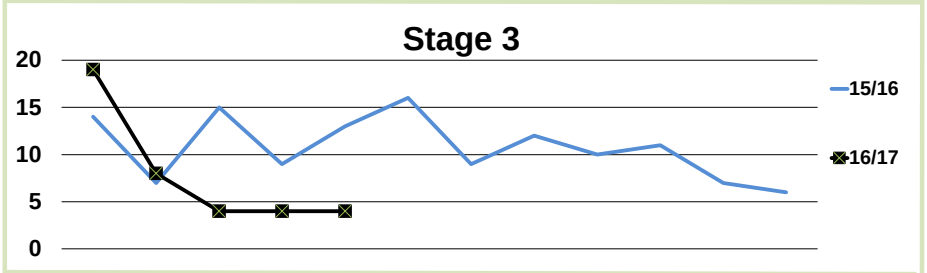
Total avoidable pressure ulcers for the Trust (including mental health divisions)

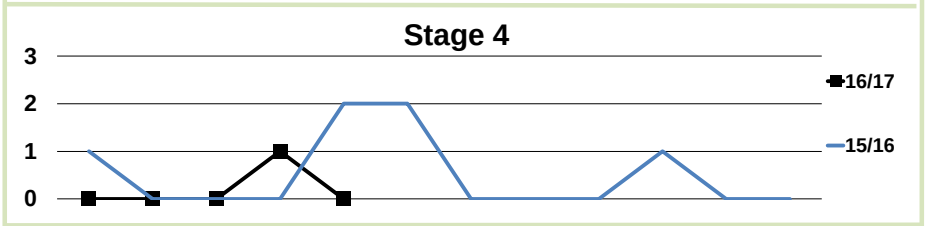
	Trust Target (Year to Date)	Trust Year to Date	Month 5 August 16/17 Trust total	Forensic Services Division	Local Services Division	Health Partnerships Division
Total number of pressure ulcers and SDTIs	n/a	968	217	2	1	214
Acquired avoidable pressure ulcers and SDTIs	n/a	142	25	1	0	24
Acquired avoidable pressure ulcers **STAGE 4**	zero	1	0	0	0	0
Acquired avoidable pressure ulcers **STAGE 3**	zero	38	4	0	0	4
Acquired avoidable pressure ulcers **STAGE 2**	41	65	12	0	0	12
Acquired avoidable pressure ulcers **STAGE 1**	15	14	1	1	0	0
Suspected Deep Tissue **Injury SDTI**	n/a	24	8	0	0	8

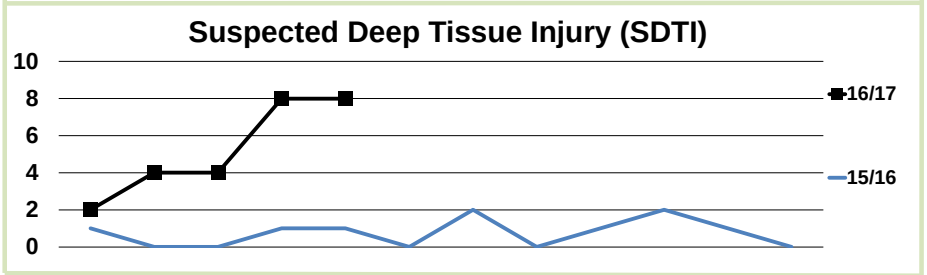












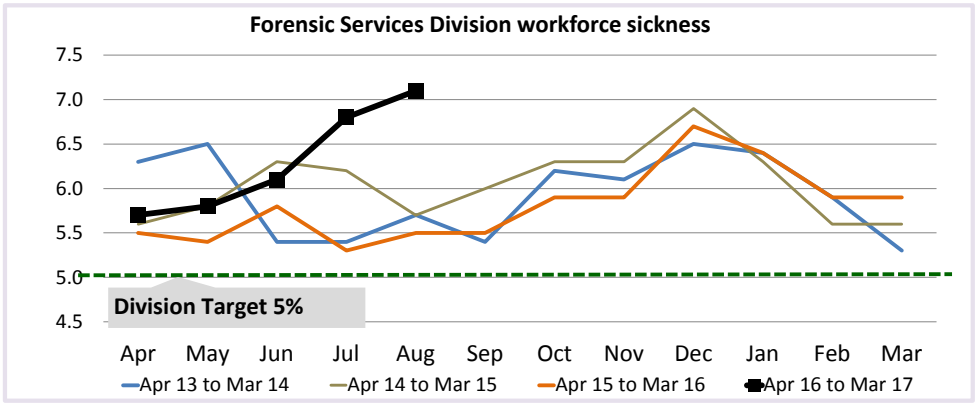
WELL-LED

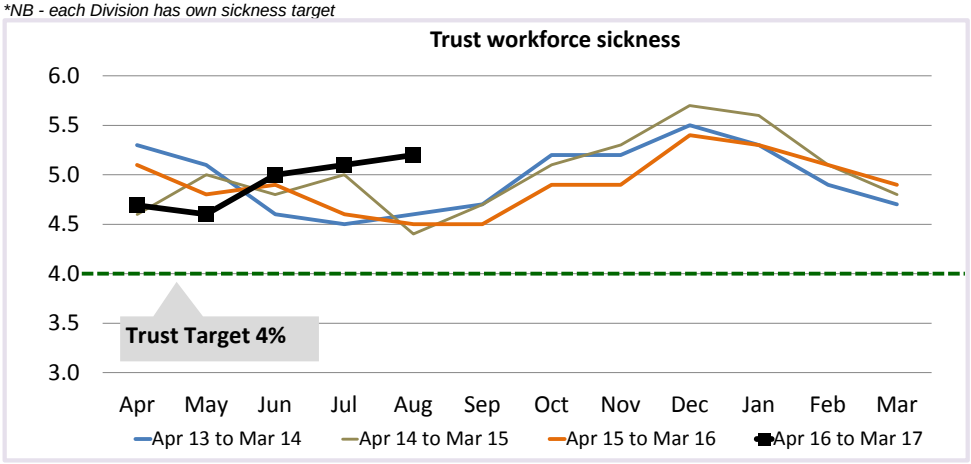
6.1 SICKNESS DETAIL, MONTH 5 August 2016/17

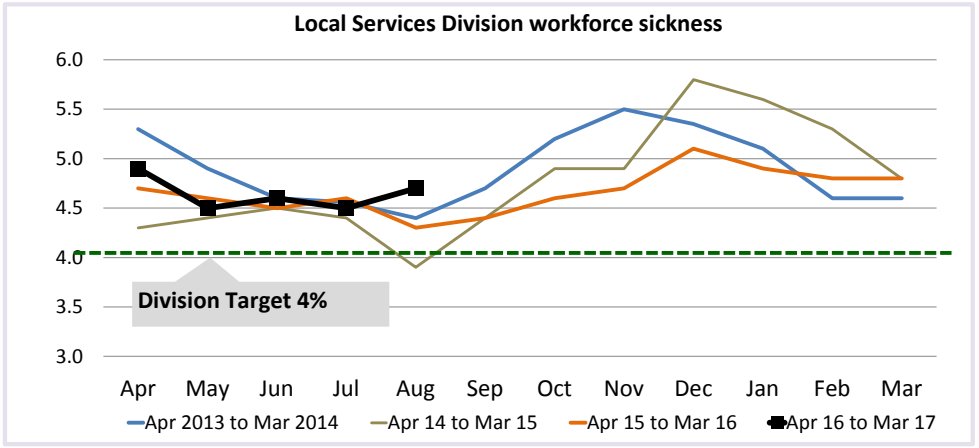
Workforce sickness rates across the Trust

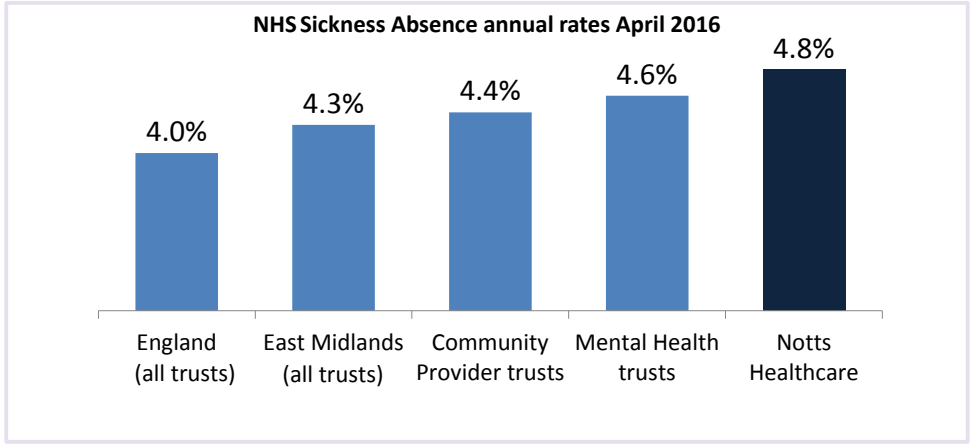
	Trust Target	Trust YTD	Month 5 August 16/17 Trustwide	Forensic Services	Local Services	Health Partnerships	Corporate Services
Total Sickness rate %	≤4%	5.0%	5.2%	7.1%	4.7%	4.4%	2.0%
Short Term Sickness %	n/a	86.6%	85.1%	20.0%	81.0%	80.0%	81.0%
Long Term Sickness %	n/a	13.4%	14.9%	80.0%	19.0%	20.0%	19.0%
Sickness Clinical % registered	n/a	4.5%	4.7%	6.7%	3.4%	4.3%	3.4%
Sickness Clinical % non-registered	n/a	7.0%	7.6%	8.7%	7.6%	5.6%	10.9%
Sickness Non-Clinical %	n/a	3.9%	3.9%	5.5%	5.2%	2.8%	1.4%

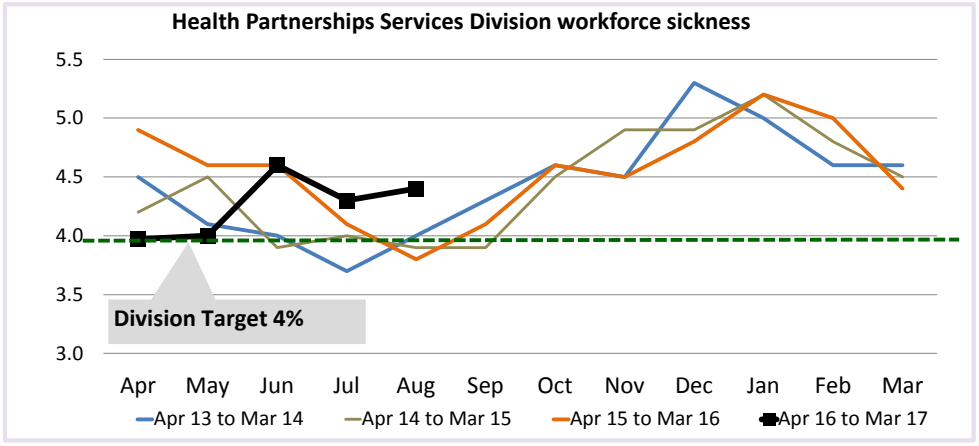
*NB - each Division has own sickness target







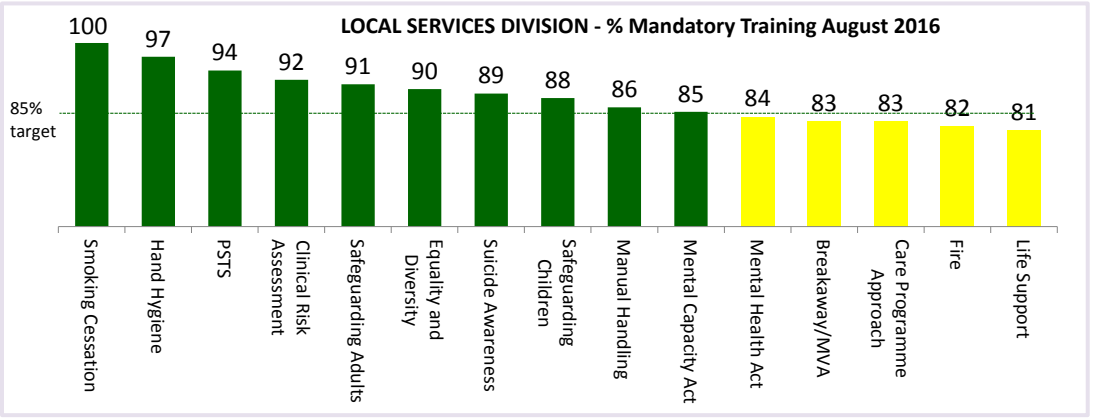


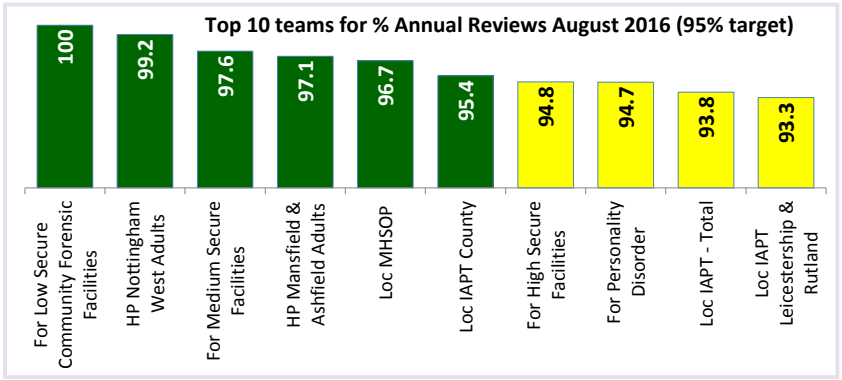


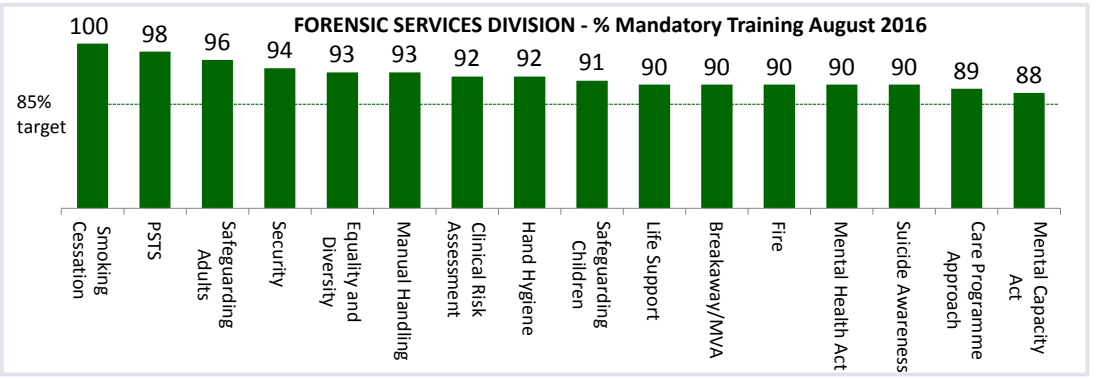
WELL-LED

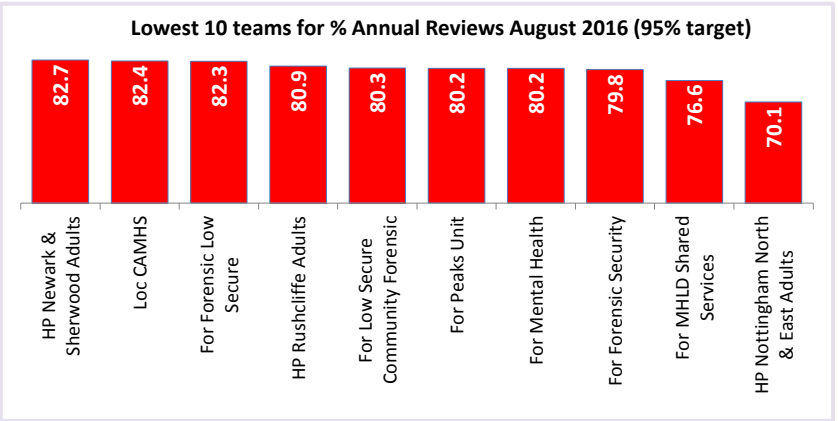
6.2 Learning and Development, MONTH 5 August 2016/17

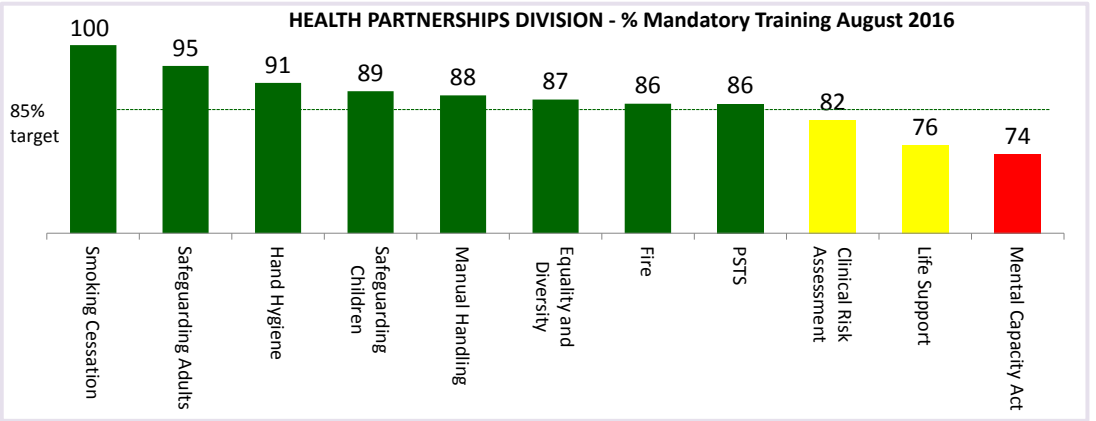
Annual Reviews August 2016 (target 95%)	Trust	Local Services Division	Forensic Services Division	Health Partnerships Division
Clinical Non- Registered Staff	89.6%	89.2%	90.3%	89.3%
Clinical Registered Staff	88.6%	88.9%	87.3%	89.4%
Non-Clinical Staff	85.3%	84.4%	88.7%	87.3%
Information Governance training (target 95% end quarter 2)	89.9%	86.9%	91.7%	90.8%







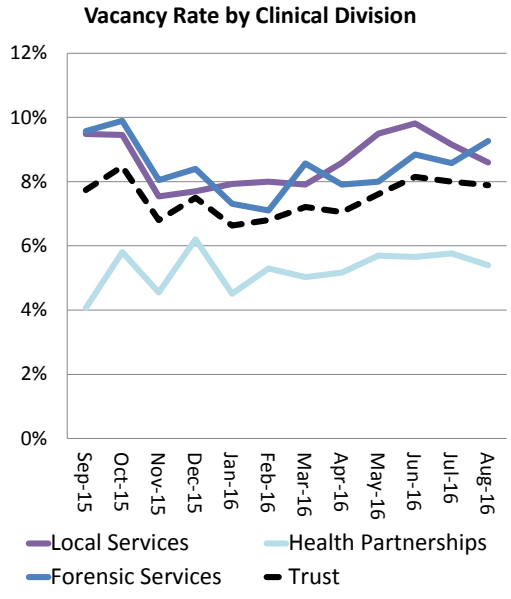


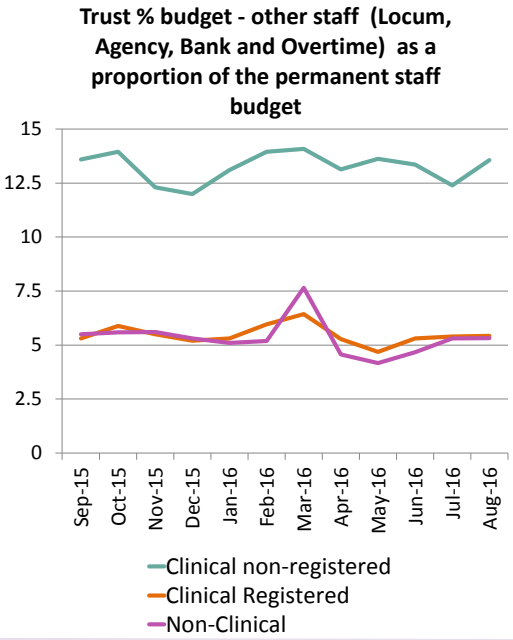


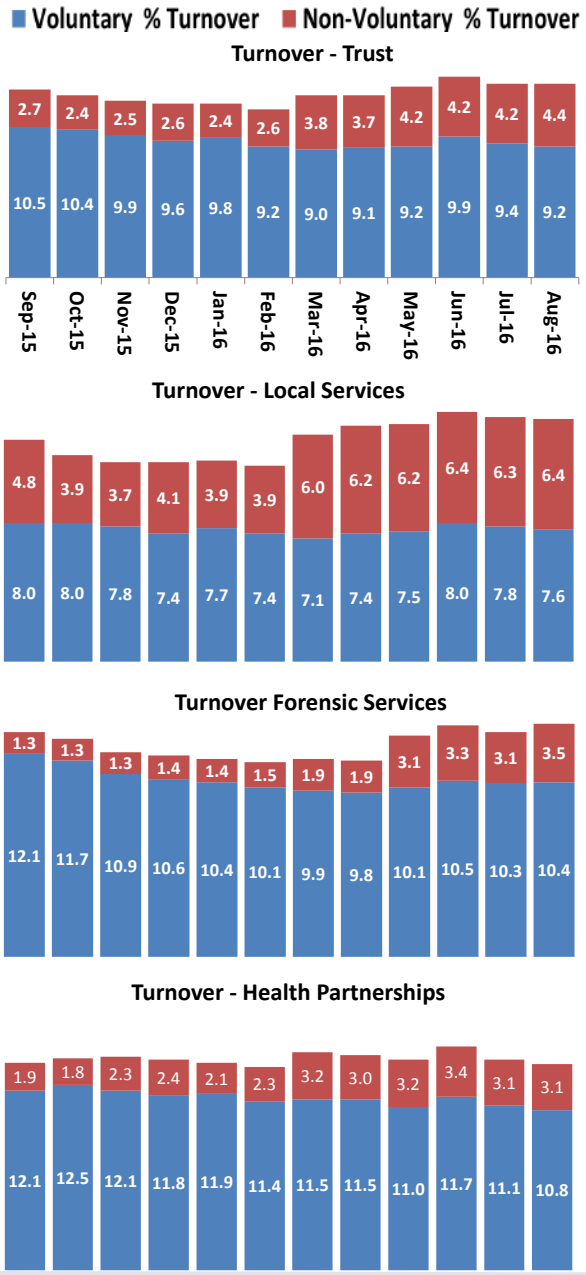
WELL-LED

6.3 Staff in Post, MONTH 5 August 2016/17

	Trust Target	Trust Year to date	Month 5 August 2016/17 Trust	Forensic Services	Local Services	Health Partnerships	Corporate Services
Clinical registered staff							
Vacancy Rate %	tbc	10.0%	9.8%	15.1%	9.9%	4.8%	3.5%
Budget - other staff vs permanent staff (inc bank and agency)	n/a	5.2%	5.4%	9.0%	5.0%	2.8%	0.2%
Budget - Agency vs permanent staff	n/a	2.6%	2.6%	4.7%	1.9%	1.6%	0.0%
Budget - Bank vs permanent staff	n/a	1.6%	1.6%	1.5%	2.5%	0.9%	0.2%
Turnover 12 months rolling %	9 - 11%	n/a	13.4%	17.1%	9.4%	14.4%	11.0%
Clinical non-registered staff							
Vacancy Rate %	tbc	3.2%	3.7%	0.9%	4.8%	6.9%	5.5%
Budget - other staff vs permanent staff (inc bank and agency)	n/a	13.2%	13.6%	15.2%	19.5%	4.2%	3.9%
Budget - Agency vs permanent staff	n/a	0.3%	0.3%	0.2%	0.5%	0.2%	0.0%
Budget - Bank vs permanent staff	n/a	10.6%	11.0%	10.4%	18.5%	3.6%	3.9%
Turnover 12 months rolling %	9 - 11%	n/a	11.3%	9.4%	13.0%	12.6%	12.0%
Non Clinical Staff							
Vacancy Rate %	tbc	7.7%	8.9%	10.3%	10.2%	5.1%	8.9%
Budget - other staff vs permanent staff (inc bank and agency)	n/a	4.8%	5.3%	3.2%	8.4%	2.4%	6.3%
Budget - Agency vs permanent staff	n/a	3.0%	3.4%	1.8%	6.6%	1.2%	3.4%
Budget - Bank vs permanent staff	n/a	1.5%	1.6%	0.7%	1.2%	1.3%	2.8%
Turnover 12 months rolling %	9 - 11%	n/a	16.3%	14.2%	25.2%	13.8%	9.8%







6.4 WELL-LED

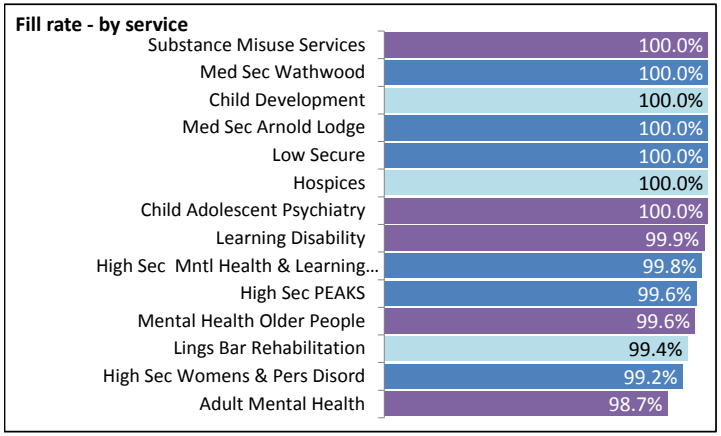
Safe Staffing Levels, MONTH 5 August 2016/17

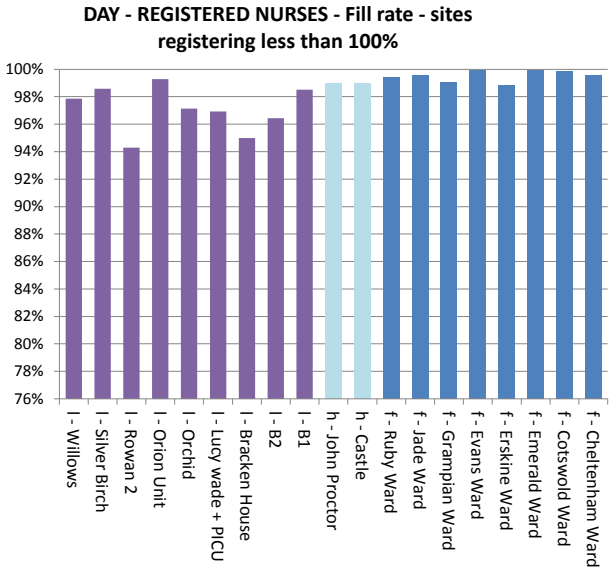
The National Quality Board (NQB) document "How to ensure the right people, with the right skills, are in the right place at the right time" (November 2013) set out expectations for providers of NHS services. The Trust has been reviewing how staffing is reported to enable it to capture areas where additional staffing above the agreed establishment has been required to ensure wards are safe, e.g. due to acuity of patients. This work will continue but will not be reported on until the new guidance has been reviewed. In August 2016 the Trust's 69 clinical teams providing in-patient services, 29 teams reported an occasion of either registered nursing or care staff shortage. The graphs provide the 'fill rate' for those teams reporting less than 100% by staff group and time of day, and also 'fill rate' per clinical speciality as recorded on UNIFY. The table on the left provides a summary of Division and Trust performance.

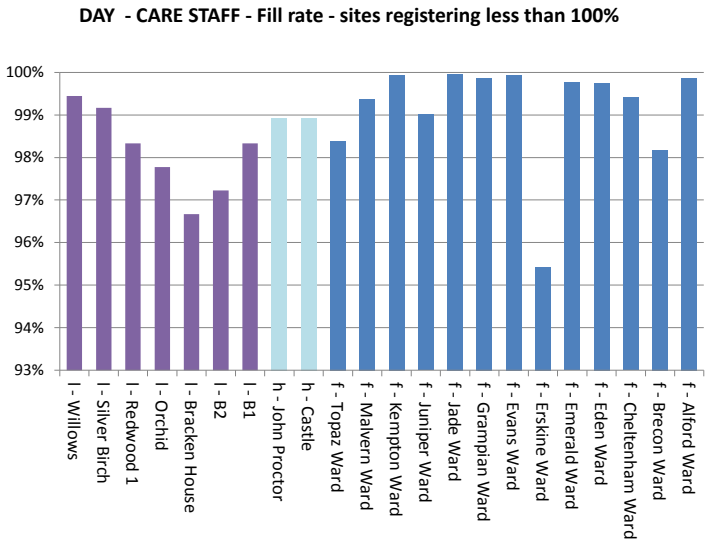
KEY TO CHARTS	
	FORENSIC SERVICES
	LOCAL SERVICES
	HEALTH PARTNERSHIPS

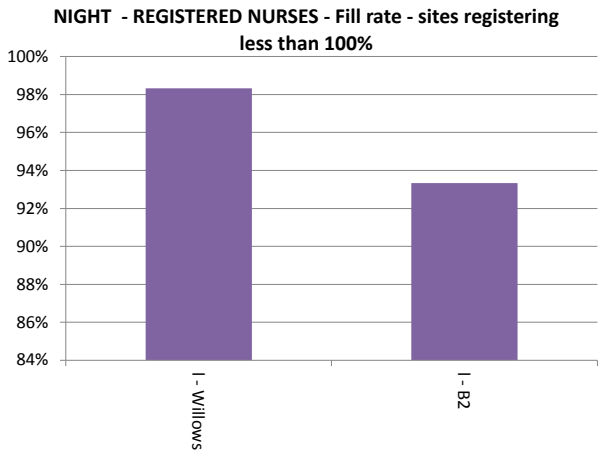
		Month 5 August			
Registered nurses Fill rate - wards reporting an occasion of staffing shortage within the month	Trust Target	Trust Actual	Forensic Services	Local Services	Health Partnerships
total wards		69	43	20	6
DAY wards registering a shortage	tbc	19	8	9	2
DAY % of wards registering a shortage		28%	19%	45%	33%
NIGHT wards registering a shortage	tbc	2	0	2	0
NIGHT % of wards registering a shortage		3%	0%	10%	0%

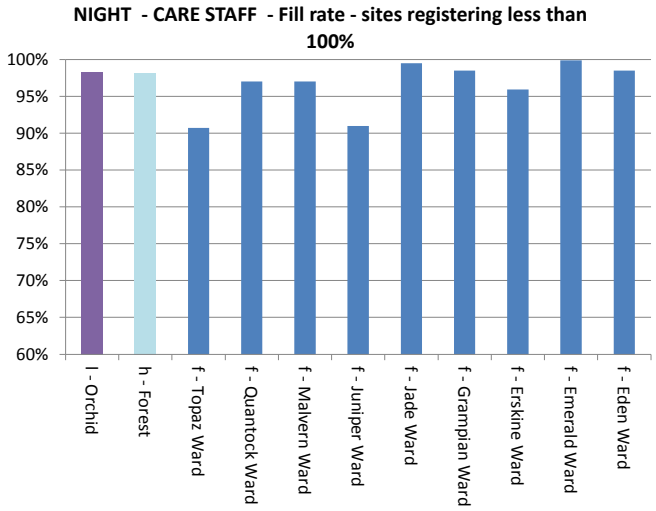
		Month 5 August			
Care staff Fill rate - wards reporting an occasion of staffing shortage within the month	Trust Target	Trust Actual	Forensic Services	Local Services	Health Partnerships
total wards		69	43	20	6
DAY wards registering a shortage	tbc	22	13	7	2
DAY % of wards registering a shortage		32%	30%	35%	33%
NIGHT wards registering a shortage	tbc	11	9	1	1
NIGHT % of wards registering a shortage		16%	21%	5%	17%











WELL-LED

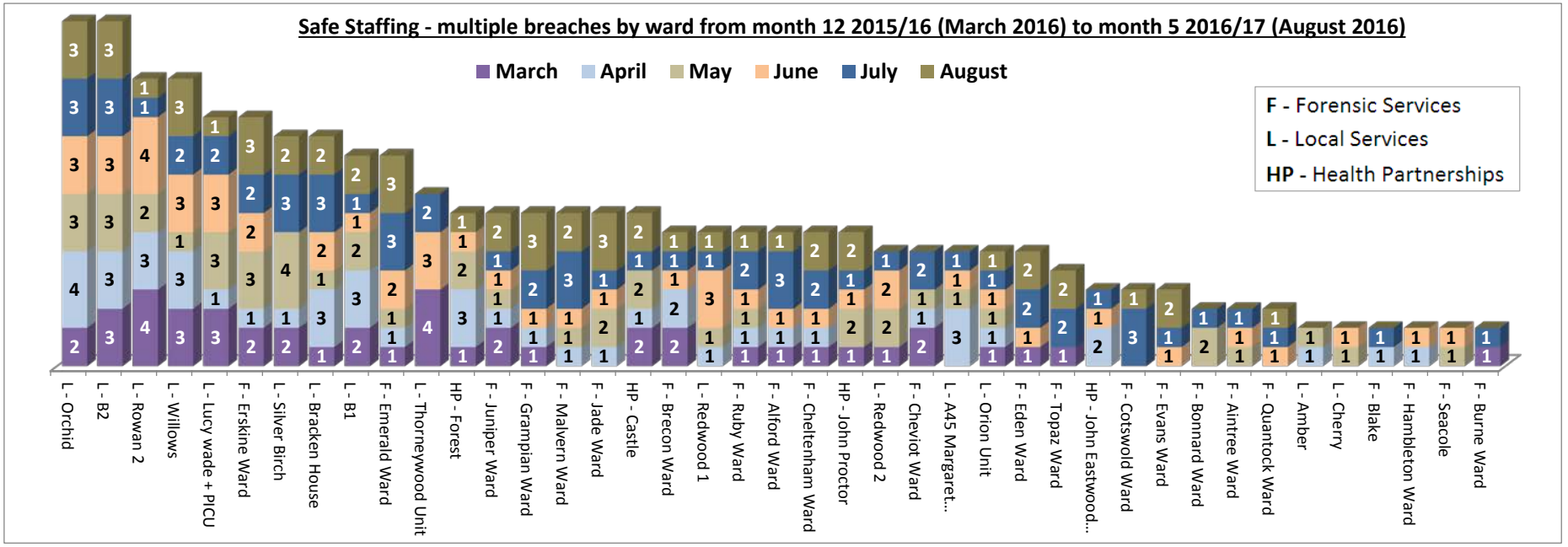
6.5 Safe Staffing Levels - 6 month overview, Month 5 August 2016/17

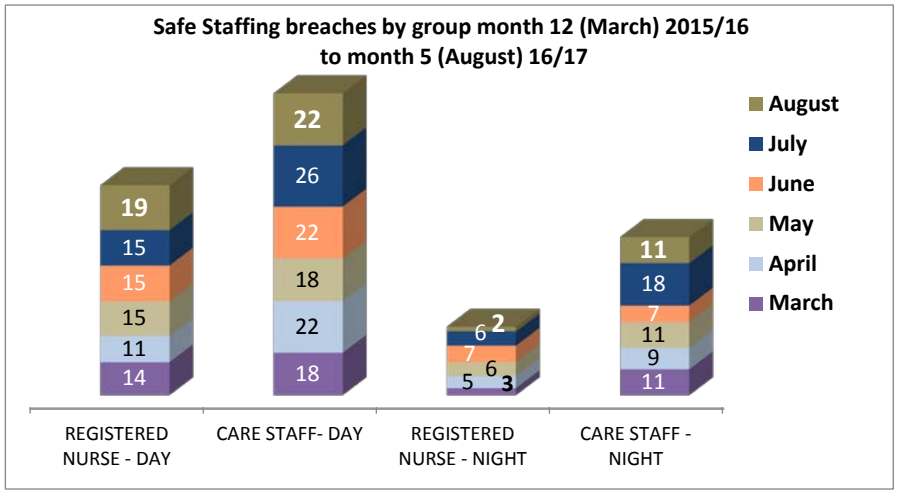
Safe Staffing narrative

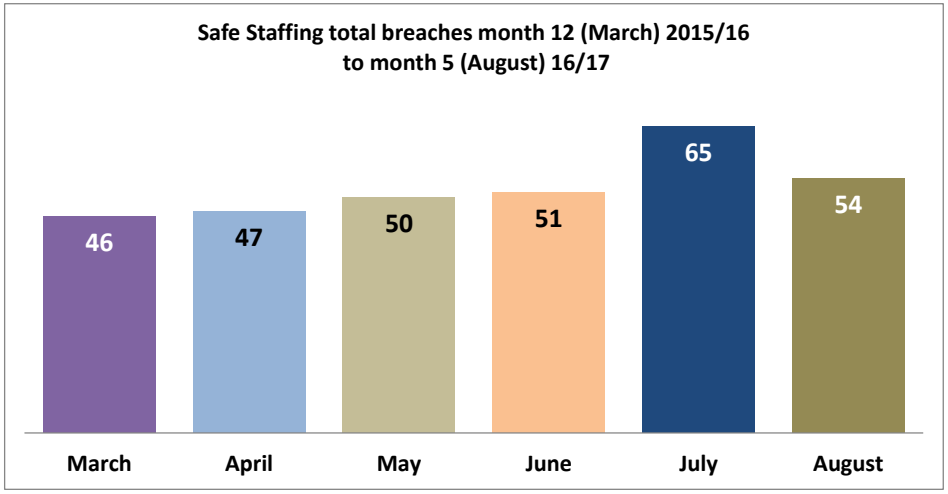
The rate of safe staffing breaches decreased in August 2016; overall the Trust maintains a high level of compliance with the national requirements regarding safe staffing levels, reporting an aggregate for the Trust at over 99% from March to August 2016.

There have been 313 individual team breaches from March to August 2016, with 10 teams reporting 10 or more breaches.

The data indicates that the majority of breaches (69.3%) occur in the day, and that care staffing shortages account for 62.3% of the total number of breaches over the period March to August 2016.







WELL-LED

7.0 Cost Improvement Plan (CIP) Assurance Report

MONTH 5 August (2016/17)

1. INTRODUCTION

In line with Monitor best practice, the Trust has a structured approach to monthly Cost Improvement Plan (CIP) assurance reporting to ensure the Trust Board has strong oversight and ownership of both financial and qualitative aspects of the annual efficiency programmes.

The overall CIP programme oversight remains through the Executive Leadership Team (ELT). Divisional reports are received on a monthly basis with an escalation and assurance report to the Board.

In addition to providing an overall RAG-rating status score for both Deliverability and Quality Impact, the Trust's CIP Assurance Framework allows ELT and the Trust Board to gain specific assurances around those CIP schemes that have a quality impact score of 8 or more. Any areas that require escalation or more intensive challenge may be referred through to the Finance and Performance Committee or the Quality and Risk Committee, or ultimately the Trust Board, as appropriate.

The Divisional overview for month 4 for the period ending 31st August 2016 is as follows:

	Forensic	Local Services	Health Partnership
Overall Status	**Green**	**Green**	**Green**
Quality Impact –	2 schemes with a score of 8 or above	0* schemes with a score of 8 or above **2 schemes above 8 carried over from 15/16*	0 schemes with a score of 8 or above
Deliverability	Target £5,279K	Target £3,891k	Increased Target £3,480k
	Recurrent Savings of 2,032k	Recurrent Savings of 964k	Recurrent Savings of 1150k
	Non-recurrent Savings of 48K	Non-recurrent Savings of 490k	Non-recurrent Savings of 143k
	Total Savings of £2,080k	Total Savings of £1,454k	Total Savings of £1293k
Other Risks to escalate	None	None	None

7.1 Cost Improvement Plan (CIP) Assurance Report - Forensic Services Division - Month 5 2016/17

Report as of 09 September 2016 for Period ending 31 August 2016

REPORT DATE	09-Sep-16
PERIOD ENDING	31-Aug-16
DELIVERABILITY STATUS	
QUALTY IMPACT STATUS	

QUALITY IMPACT	Low/ V Low < 8	Moderate 8-10	High/ Extreme > 10	TOTAL CIP
Number of schemes	41	2	0	43
Value of schemes (£000s)	4,524	851	-	5,375
% of total CIP	84%	16%	0%	100%

ANNUAL FINANCIAL PLAN OVERVIEW (£000)	Plan	Forecast	Variance
Recurrent	5,279	4,883	396
Non Recurrent	96	492	-396
TOTAL	5,375	5,375	0

ANY RISKS TO KEY PRIORITIES?	YES/ NO
Trust Strategies	No
CQC Outcomes	No
Quality Priorities	No
strategic objectives (BAF)	No
other risks	No

STATUS HIGHLIGHTS: Work continues with schemes to ensure 100% delivery.

YEAR TO DATE FINANCIAL PLAN OVERVIEW (£000)	Plan	Actual	Variance
Recurrent	2,034	2,032	2
Non Recurrent	40	48	-8
TOTAL	2,074	2,080	-6

CIP NAME	CIP REF	VALUE (£000)	Quality Impact score August 2016	Quality Impact score July 2016	KPI METRICS	Baseline	Performance as at 31 August 2016	Risk Register Ref	Quality Impact	Overall Delivery (RAG Rating)
Review of Therapy Service Provision & Increased Caseloads	HS11	222	9	9	Average hours of completed therapeutic activity per patient per week	25.8 hours	25.5 hours*	No	Reduction in number of staff may impact on sessions available to patients	On track
					Percentage of patients with less than average of 25 hours programmed activity per week	2.80%	13.6%*			
Review of Pay and Allowances	HS21	629	8	8	Staff Turnover ratio remains above 7%	7%	9.3%	No	Reduction in ability to recruit to key posts, particularly in direct care leading to low staffing levels	On track
					Staff Vacancy level is reduced	4.7%	0.5%			

* data collated on a quarterly basis (data for Quarter 1 2016/17)

* It is reported that 42 patients (13.6%) in total did achieve 25 hours of programmed activity. Reasons for none achievement have been reported to be due to the following:

Mental Health, Deaf Services and Learning Disability - the mental state of patients in long term segregation continues to fluctuate and engagement in activities can be limited during these periods, however, the level of engagement is being actively monitored. Activity information is ow being recorded on the new Activity Monitoring System (AMS) and omissions and inputting errors have occurred during the reporting period, this continues to be monitored by the Ward Managers and Directorate Management Team.

Women's Service and Personality Disorder - patients not achieved 25 hours due to long term segregation and zonal observations. A small number of patients were refusing to engage / unsettled presentation and 2 patients newly admitted. Clinical teams work with patients to increase uptake.

Peaks Unit - 6 Brecon patients did not achieve the target. These patients are reported to have spent periods of time in seclusion and long term segregation and continue to display challenging behaviour.

WELL-LED

7.2 Cost Improvement Plan (CIP) Assurance Report - Local Services Division - Month 5 2016/17

Report as of 12th September 2016 for period ending 31st August 2016

REPORT DATE	12.09.2016
PERIOD ENDING	31.08.16
DELIVERABILITY STATUS	
QUALTY IMPACT STATUS	

QUALITY IMPACT	Low/ V Low < 8	Moderate 8-10	High/ Extreme > 10	TOTAL CIP
Number of schemes	36	(*1 carried over from 15/16)	(*1 carried over from 15/16)	36
Value of schemes (£000s)	3,758	660	613	5,031
% of total CIP	75%	13%	12%	100%

ANNUAL FINANCIAL PLAN OVERVIEW (£000)	Plan	Forecast	Variance
Recurrent	3,891	3,227	-664
Non Recurrent	1,140	1,804	664
TOTAL	**5,031**	**5,031**	**0**

ANY RISKS TO KEY PRIORITIES?	YES/ NO
Trust Strategies	NO
CQC Outcomes	NO
Quality Priorities	NO
Strategic Objectives (BAF)	NO
Other risks	NO

STATUS HIGHLIGHTS:
£1,067m of the 2015/16 target has carried forward into 2016/17, to be added to the 2016/17 target, making the total target for 2016/17 £5,031m.

75% of the CIP target value is deemed to have a low clinical risk. One scheme is assessed as a moderate risk / one as a high risk.

STATUS ISSUES: Schemes have been continually risk assessed on current risk and are reliant on robust community models being in place. Further details on the high clinical risk schemes are provided below, including updated KPI's. These schemes are aligned to the reduction in acute inpatient beds at the QMC (from 13 October 2014) (Scheme AMHS22) and reduction in acute inpatient rehabilitation beds (AMHS39 & 43). Robust project, communication and engagement plans are in place, with engagement being pro-actively managed. KPI monitoring service user feedback following discharge from Rehab Units across AMH. The new Bed Management Team now operates 7 days per week 9-5pm especially supporting the On call managers over weekends. The Bed Managment Team will become 24hour service mid September. Early indication is evidencing the good practice being implemented to ensure the ebb and flow of the inpatient bed usage is effective. Also aligned with the Directorate Clinical Strategy, the development of Beacon Lodge, (delivered by 3rd sector) 12 beds which will provide further support to the appropriate use /discharge of inpatients which will support the directorate to reduce the use of private beds with ultimate zero use. Beacon Lodge opened on Monday 5th September 2016 and 6 clients have been admitted.(09.09.2016)

YEAR TO DATE FINANCIAL PLAN OVERVIEW (£000)	Plan	Actual	Variance
Recurrent	1,081	964	-117
Non Recurrent	373	490	117
TOTAL	**1,454**	**1,454**	**0**

CIP NAME	CIP REF	VALUE (£000)	Quality impact score July 2016	Quality impact score August 2016	KPI METRICS	Baseline	Current Performance	Risk Register Ref.	Quality Impact	Overall Delivery (RAG Rating)
Closure of In-patient Rehabilitation Beds	AMHS39 AMHS43	286 374	**8**	**8**	95% of patients/service users allocated an appropriate Care Pathway (Cluster) on admission to a ward, or with 2 appointments if seen in Community Services throughout 2015/16	98% as at 9 March 2015	94.90%	DIV 0000078	AMBER - Units closed	AMBER
					98% of patients/service users to have an appropriate review within the appropriate Care Pathway Review period throughout 2015/16	93% as at 9 March 2015	87.03%			
Reinvestment in an enhanced community model with a reduction of 42 acute beds	AMHS22	613	**15**	**15**	0% increase in beds used in North of County by City patients.	Figures based on a baseline of 5.2 beds 188% (15/79 admissions) October 2014	400%	360	Red	Red
					Out of Area admissions due to lack of beds target 0 for Nottingham City CCG, Bassetlaw CCG, & Newark & Sherwood CCG and no more than 1 for Mansfield & Ashfield CCG	8 new private admissions in July 2016	9 new private admissions in August 2016	360	Red	Red

WELL-LED

7.3 Cost Improvement Plan (CIP) Assurance Report - Health Partnerships Division - Month 5 2016/17

REPORT DATE	12-Sep-16
PERIOD ENDING	31-Aug-16
DELIVERABILITY STATUS	
QUALITY IMPACT STATUS	

QUALITY IMPACT	Low/ V Low < 8	Moderate 8-10	High/ Extreme > 10	TOTAL CIP
Number of schemes	21	0	0	21
Value of schemes (£000s)	3,762	0	0	3,762
% of total CIP	100%	0%	0	100%
Risk Owner	Team manager	AD/GM	ED/TB	

ANNUAL FINANCIAL PLAN OVERVIEW (£000)

	Original Plan (in year)	Increased target	Actual in year (forecast m5)	End of year Variance (m12) Vs Orig Plan	End of year Variance (m12) Vs revised target
Recurrent	2,613	3,480	3,248	635	-232
Non Recurrent	526	282	514	-12	232
TOTAL	3,139	3,762	3,762	623	0

ANY RISKS TO KEY PRIORITIES?	YES/ NO
Trust Strategies	NO
CQC Outcomes	NO
Quality Priorities	NO
strategic objectives (BAF)	NO
other risks	NO

STATUS HIGHLIGHTS: All schemes continue to be reported at low/very low quality impact rating as at last review Programme Management Group (August). Operational delivery - no current concerns (performance, governance) raised via KPIs re quality. Agency spend continues to be robustly monitored and is £508k YTD spend (£278k below plan). The external productivity scheme at Bassetlaw continues to progress following a detailed review during August. 2017/18 planning rounds: Initial discussions taken place at August to facilitate timely progress for scheme development.

STATUS: Finance - The original CIP plan for the division was £3,139k inclusive of CIP delivered through tender of £1,694k. As a result of the contract outcomes and abnormally high cost pressures for 2016/17 the CIP target was increased to £3,762k. Against the annual target of £3,762k, the Health Partnerships division has delivered £3017k FYE (£2,921k in year value) of recurrent CIP which includes £1,694k of CIP through tenders and £1,323k from in year schemes. YTD CIP of £1,293k has been achieved against the plan of £1,294k. The previously unidentified CIP balance of £41k has now been cleared in full as a result of a post contract pay budget refresh across the South Localities. The variation between recurrent and non-recurrent CIP is due to the Admin review currently being delivered non-recurrently whilst a thorough programme is implemented across the division which is focused consistency and breaking down team boundaries

YEAR TO DATE FINANCIAL PLAN OVERVIEW (£000)

	Original Plan	Increased target	Actual	Variance Vs. original plan	Variance Vs. revised target
Recurrent	953	1,231	1,150	197	-81
Non Recurrent	0	63	143	143	80
TOTAL	953	1,294	1,293	340	-1

8.0 Nottinghamshire Healthcare NHS Foundation Trust Patient-Led Assessments of the Care Environment (PLACE) RESULTS 2016

	Site Type	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
National - site level average		**98.1%**	**88.2%**	**87.0%**	**89.0%**	**84.2%**	**93.4%**	**75.3%**	**78.8%**
Nottinghamshire Healthcare Local Services Division: sites									
Bassetlaw Hospital	Mental Health	93.2%	93.3%	90.4%	95.8%	81.0%	83.8%	84.1%	86.8%
Millbrook Unit (Kings Mill Hospital site)	Mental Health	94.6%	91.5%	90.2%	92.7%	81.1%	91.0%	89.2%	87.0%
Bracken House Rehabilitation Unit	Mental Health	99.7%	95.7%	91.9%	100.0%	95.6%	96.6%		93.2%
106 & 145 Thorneywood Mount	Mental Health	98.4%	96.7%	93.8%	100.0%	79.4%	91.4%		82.1%
Thorneywood Child and Adolescent	Mental Health	96.6%	83.7%	77.4%	94.5%	90.1%	93.8%	100.0%	90.1%
Queens Medical Centre	Mental Health	96.1%	92.7%	92.5%	92.8%	86.6%	98.0%		90.7%
Highbury Hospital	Mental Health and Learning disabilities	92.5%	85.9%	90.8%	84.9%	85.1%	93.6%	76.0%	78.3%
Alexandra House (Mansfield Community Hospital)	Mental Health and Learning disabilities	97.2%	94.5%	92.8%	96.9%	85.5%	97.4%		87.6%
Nottinghamshire Healthcare Forensic Services Division: sites									
Wathwood Medium Secure Hospital	Mental Health	98.3%	92.9%	88.7%	98.8%	88.9%	99.4%		93.8%
Rampton High Secure Hospital	Mental Health and Learning disabilities	97.0%	94.6%	87.8%	96.0%	96.4%	93.4%		85.1%
Arnold Lodge Medium Secure Unit	Mental Health and Learning disabilities	98.4%	92.1%	85.1%	94.9%	96.8%	97.3%		90.6%
Wells Road Centre (Low Secure)	Mental Health and Learning disabilities	99.8%	96.4%	92.0%	100.0%	95.3%	99.0%		91.5%
Nottinghamshire Healthcare Health Partnerships Division: sites									
Children's Development Centre, Nottingham City Hospital	Mixed Service	91.6%	42.2%	30.9%	72.5%	78.6%	94.2%		67.7%
Lings Bar Hospital	Community	98.5%	91.0%	83.9%	93.0%	89.7%	96.2%	91.8%	97.1%
Prospect House	Community	100.0%				88.9%	99.1%		100.0%
Bassetlaw Hospice	Palliative Care	96.6%	93.0%	87.0%	100.0%	91.3%	98.2%	79.7%	75.9%
John Eastwood Hospice	Palliative Care	99.2%	97.4%	95.2%	100.0%	95.3%	99.3%	94.6%	92.1%

5% or more ABOVE NATIONAL AVERAGE

5% or more BELOW NATIONAL AVERAGE

9.0 Change Log
Month 5 August 2016/17

Number	Change/ Issue to be addressed	Location in Trust Quality and Performance Report
1.	No issues to report	

Appendix 1

Quality & Performance Report: Performance Indicator Glossary

INTRODUCTION

This document describes key information about the Performance Indicators contained within Nottinghamshire Healthcare NHS Trust Board's Quality & Performance Report. It is intended to help you understand where the indicators come from, how we have constructed them, how we have rated their data quality and where relevant, to provide comments about the data quality of each indicator.

INDICATOR REFERENCE NUMBERS

The report is structured using the Care Quality Commission's domains. Each indicator on the dashboards has a unique reference number. This consists of a CQC Domain Reference, an Indicator Origin Reference and a number.

CQC Domain	CQC Indicator Reference
Caring	C
Well-led	WL
Effective	E
Safe	S
Responsive	R

Indicator Origin	Indicator Origin Reference
Trust Internal	Tr
Monitor	Number on Monitor Dashboard

DATA QUALITY

Each indicator on the Dashboards is assessed against five dimensions of data quality and an overall RAG rating applied.

Data Quality Dimension	Definition	Abbreviation re comments
Completeness	Valid data – measures how much of the collected data can be used	C
Timeliness	Data entry – is all the data readily available at the time of calculation for the period being measured	T
Accuracy	Accurate recording of data, consistent interpretation of business rules when selecting values from lists and accurate calculation method for indicator construction	Ac
Audit	Has an audit, either local, internal or external, been carried out in the last 2 years and on either the system used to collect the data or on the specific indicator itself, and if so, what was the result	Au
Validation	Divisions or other departments are monitoring the indicators locally and flagging up if there's an issue	V

Indicator Data Quality RAG Rating	Definition
Blue	Highly Significant Assurance (very robust)
Green	Significant Assurance (Sufficient for basing decisions on)
Amber	Limited Assurance (significant issues)
Red	Very Limited Assurance (systemic issues, minimal confidence)

Where an indicators data quality RAG rating is amber or red, the action required to increase the rating to green is defined in the 'Data Quality Rating Comments' in the glossary below.

PERFORMANCE TARGETS

Where appropriate each indicator has a performance target which is RAG rated. Where a national target exists, this is the target applied. Where it is not appropriate to set a target, a six-month average performance is included to enable readers to understand whether the current month performance is above or below what is expected.

Indicator Performance RAG Rating	Definition
Green	Target achieved
Amber	Target under-achieved to a minor degree
Red	Target under-achieved to a major degree

There are sometimes occasions when the performance RAG rating masks some significant underperformance in either a division or directorate. Therefore, when a green or amber RAG rating is masking red performance, this symbol is applied and an exception report provided.

MISSING DATA

For some indicators, accurate data is not available in the time-scale required to produce the report, e.g. complaints resolution timescales and emergency readmissions. Where an indicator is new and previous data is not available this is also classed as missing.These are indicated by:

INCIDENT DATA

All incidents are recorded on the Trusts internal Risk Management System, *Ulysses* and all 'Patient Safety Incidents' are uploaded from Ulysses monthly to NHS Englands *National Reporting and Learning System* (NRLS). As part of this internal and external reporting process, each incident is assigned a 'degree of harm':

1 - No harm
2 - Low harm
3 - Moderate harm
4 - Severe harm
5 - Death/catastrophic (this does not include natural cause deaths)

In addition, any incident which meets the requirements of NHS England's *Serious Incident Framwork* is also reported on the *Strategic Executive Information System* (STEIS). NB: not all incidents with a degree of harm of 4 or 5 meet the requirement for reporting on STEIS, e.g. under 18 admitted to an adult ward.

GLOSSARY OF INDICATORS

Each indicator is contained in a table below. The first table explains what each of the fields contain.

Indicator Reference: Quality & Performance Report Reference Number – each indicator has a unique identifier.	
Indicator Title (Board Report): Title as it appears in the Quality & Performance Report.	
Indicator Title (External): Title as it appears on external source documents, such as Monitor documentation.	
Indicator Description: A description of the indicator. Uses external description where appropriate.	
CQC Domain: Name of the CQC Domain the indicator is grouped in.	**Indicator Origin:** Regulator, Other External source e.g. commissioner, or Internal Trust indicator.: The name of the indicator origin such as Monitor.
Numerator/Value: If a single number value, definition here. If a %, numerator definition/description. Use standard external definitions if possible.	
Denominator: If a %, denominator definition/description, otherwise blank. Use standard external definitions if possible.	
RAG Rating: Red: Threshold for Red Amber: Threshold for Amber Green: Threshold for Green	
Data Quality Rating: Overall rating given to the indicator. Consists of an aggregation of 5 different dimensions.	
Data Quality Rating Comments: Comments on any of the rating elements or overall rating and actions to mitigate any issues.	

Indicator Reference: C-1-Tr	
Indicator Title (Board Report): Friends and Family Test scores.	
Indicator Title (External): Friends and Family Test scores.	
Indicator Description: The Friends and Family Test Score is calculated as the percentage of patients returning a completed Friends and Family Test who are 'extremely likely' or 'likely' to recommend a service.	
CQC Domain: Caring	**Indicator Origin:** Department of Health: NHS England
Numerator/Value: The number of patients who are 'extremely likely' or 'likely' to recommend a service.	
Denominator: Total number of patients completing the Friends and Family Test.	
RAG Rating: 6 month average	
Data Quality Rating: Significant Assurance (to be re-confirmed following change in calculation methodology)	
Data Quality Rating Comments: T: Results reflect rating for the period when recorded on the system and reflect a general impression of care rather than care delivered at a particular moment in time. Au: This metric has not been subject to audit. Will be considered for a future audit.	

Indicator Reference: C-2-Tr	
Indicator Title (Board Report): Service Quality Rating %.	
Indicator Title (External): Service Quality Rating %.	
Indicator Description: The service quality rating is the result of a rating between 1 and 5 (1 being very poor, 5 being excellent) which is translated into a percentage (1 = 20%, 2 = 40% etc.).	
CQC Domain: Caring	**Indicator Origin:** Internal
Numerator/Value: Responses are summed using the following coding:- The worst response ("Very poor") is assigned a value of 1, "Poor" – 2, and so on up to 5 – "Excellent". Aggregated data is multipled by 20 to generate a percentage.	
Denominator: Total number of responses.	
RAG Rating: 6 month average	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: T: Results reflect rating for the period when recorded on the system and reflect a general impression of care rather than care delivered at a particular moment in time.	

Indicator Reference: C-3-Tr	
Indicator Title (Board Report): Number of new complaints received.	
Indicator Title (External): Complaints.	
Indicator Description: Total number of new complaints received in the period managed in accordance with the Health and Social Care Act complaint regulations (2009).	
CQC Domain: Caring	**Indicator Origin:** Internal
Numerator/Value: Total number of new complaints received in the period managed in accordance with the Health and Social Care Act complaint regulations (2009).	
Denominator:	
RAG Rating: 6 month average	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: Ac: There is potentially under-reporting of formal complaints within Forensic Division in Offender Health related to the feedback mechanism used. This is in the process of being rectified to ensure issues raised by prisoners which should be managed in accordance with the Trust's formal complaints policy are identified.	

Indicator Reference: C-4-Tr	
Indicator Title (Board Report): % complaints closed in the last month which were within agreed timescales.	
Indicator Title (External): % complaints closed in the last month which were within agreed timescales.	
Indicator Description: % of complaints closed in the last month which were closed within agreed timescales.	
CQC Domain: Caring	**Indicator Origin:** Internal
Numerator/Value: Total complaints closed in the last month which were closed within agreed timescales.	
Denominator: Total complaints closed in the last month.	
RAG Rating: Red: <70% Amber: ≥70% Green: ≥80%	
Data Quality Rating: TBC	
Data Quality Rating Comments:	

Indicator Reference: C-5-Tr	
Indicator Title (Board Report): % complaints closed in the last month upheld or partially upheld.	
Indicator Title (External): % complaints closed in the last month upheld or partially upheld.	
Indicator Description: % of complaints closed in the last month upheld or partially upheld.	
CQC Domain: Caring	**Indicator Origin:** Internal
Numerator/Value: Total complaints closed in the last month which were upheld, or upheld in part.	
Denominator: Total complaints closed in the last month.	
RAG Rating: Red: Amber: Green:	
Data Quality Rating: TBC	
Data Quality Rating Comments:	

Indicator Reference: WL-2-Tr	
Indicator Title (Board Report): Turnover % (rolling 12 month figure).	
Indicator Title (External): Trust Turnover Rate.	
Indicator Description: The percentage of leavers to the average monthly Staff in Post from previous rolling 12 months.	
CQC Domain: Well-led	**Indicator Origin:** Internal
Numerator/Value: Number of leavers in the reporting period (in FTEs).	
Denominator: Average number of staff in post (in FTEs) within the reporting period.	
RAG Rating: Red: <8% and>12% Amber: 8-9% and 11-12% Green: 9% to 11%	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: T: ESR External reporting is 1 month behind internal reporting. This does cause minor variation in results between internally and externally reported performance due to data changes. Au: This metric has not been subject to audit. Will be considered for a future audit.	

Indicator Reference: WL-3-Tr	
Indicator Title (Board Report): Total Sickness Rate.	
Indicator Title (External): Total Sickness Rate.	
Indicator Description: The percentage of sickness days against the numbers of FTE days available.	
CQC Domain: Well-led	**Indicator Origin:** Internal
Numerator/Value: Number of sickness days recorded (in FTEs) within the reporting period.	
Denominator: Total number of FTE days available within the reporting period.	
RAG Rating: Red: >6% Amber: ≤6% Green: ≤4%	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: C: Possibly small pockets of underreporting still exist. T: ESR External reporting is 1 month behind internal reporting. This does cause minor variation in results between internally and externally reported performance due to data changes.	

Indicator Reference: WL-4-Tr	
Indicator Title (Board Report): Vacancy rate %.	
Indicator Title (External): N/A	
Indicator Description: The percentage of vacant budgeted posts against the budgeted establishment.	
CQC Domain: Well-led	**Indicator Origin:** Internal
Numerator/Value: The variance between budgeted and contracted establishment (including seconded staff), expressed as a WTE.	
Denominator: Budgeted Establishment (WTEs).	
RAG Rating: Not Applicable	
Data Quality Rating: Highly Significant Assurance	
Data Quality Rating Comments: None.	

Indicator Reference: WL-5-Tr	
Indicator Title (Board Report): % Annual Reviews carried out (Staff Appraisals).	
Indicator Title (External): N/A	
Indicator Description: The percentage of completed appraisals to the number of staff in post (excluding Medical Staffs, Maternity Leave, Students, bank and honorary staff).	
CQC Domain: Well-led	**Indicator Origin:** Internal
Numerator/Value: Number of employees with completed appraisal reviews in the last 12 months from the reporting date (excluding Medical Staffs, Maternity Leave, Students, bank and honorary staff).	
Denominator: Number of employees in post within the reporting period (excluding Medical Staffs, Maternity Leave, Students, bank and honorary staff).	
RAG Rating: Red: <85% Amber: ≥85% Green: ≥95%	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: C: Now all sourced from ESR across all Divisions. T: Data entered on average in 4 days after event. Ac: Some potential data accuracy issues due to possible data entry errors or not completing the process properly etc. Action: All teams are actively working to ensure Annual Reviews are recorded correctly on ESR.	

Indicator Reference: WL-6-Tr	
Indicator Title (Board Report): Clinical supervision %.	
Indicator Title (External): N/A	
Indicator Description: Percentage of relevant staff who have had a supervision session in the last reporting period.	
CQC Domain: Well-led	**Indicator Origin:** Internal
Numerator/Value: Number of staff with a completed supervision session within the reporting period.	
Denominator: Number of staff who should have had a supervision session in the reporting period.	
RAG Rating: Red: <65% Amber: ≥65% Green: ≥80%	
Data Quality Rating: Very Limited Assurance	
Data Quality Rating Comments: C: Significant areas of underreporting. Also recorded on 2 different systems. T: We are not aware of systems in place to measure timeliness of data entry. Ac: Lack of consistency of business rules over who should have a supervision session across the Trust. Data is adjusted manually between systems extraction and publishing results. Lack of precision in expected frequency of supervision, has led to inconsistent frequency. Au: Results of recent audit was Limited Assurance. V: Lack of evidence of robust scrutiny of published figures. Action: Internal Audit report received in August 2014. An ESR Steering Group workstream will include evaluation of how we capture Supervision data consistently across the Trust.	

Indicator Reference: WL-7-Tr	
Indicator Title (Board Report): Mandatory training %.	
Indicator Title (External): N/A	
Indicator Description: % of completed mandatory training courses in date.	
CQC Domain: Well-led	**Indicator Origin:** Internal
Numerator/Value: Total number of mandatory training courses completed in date.	
Denominator: Total number of mandatory training courses required to be undertaken by staff (including locally agreed staff who are not in ESR, and excluding staff on long term sick, maternity, secondments and career breaks).	
RAG Rating: Red: <75% Amber: ≥75% Green: ≥85%	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments:	

Indicator Reference: S-4-Tr	
Indicator Title (Board Report): Safety Thermometer All Harms - % Harm Free Care.	
Indicator Title (External): Harm free care (pressure sores, falls, C-UTI and VTE).	
Indicator Description: Safety Thermometer provides a 'temperature check' on harm. It is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care and relevant patients are surveyed on one day each month using clearly defined criteria. The population for Safety Thermometer is all inpatients in Mental Health Services for Older People, all inpatients at Lings Bar Hospital and patients who are seen by a district nurse from the Health Partnerships Division on the day of the survey. Safety Thermometer enables the calculation of the proportion of patients who received harm-free care. This is calculated using the number of patients receiving harm-free care and the total number of patients surveyed. Harm-free means absence of:- 1 - A pressure ulcer stage 2, 3 or 4 (both avoidable and unavoidable). 2 - A fall which resulted in any degree of harm within the previous 72 hours. 3 - A new Venous Thromboembolism (VTE) of any type [Examples of a VTE include Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE)]. 4 - Treatment of a Urinary Tract Infection (UTI) in patients with an indwelling urethral urinary catheter.	
CQC Domain: Safe	**Indicator Origin:** Department of Health
Numerator/Value: The number of harms reported on the day of the survey (NB: one patient can have more than one harm).	
Denominator: The total number of patients included in the survey.	
RAG Rating: Red: <90% Amber: ≥90% Green: ≥95%	
Data Quality Rating: Limited Assurance	
Data Quality Rating Comments: Ac: The recent internal audit has found consistent differences between the falls recorded in the Safety Thermometer for the reporting periods compared to Ulysses for the same periods. A further study will determine whether these differences are isolated to small areas of the Trust or are more widespread. Au: Limited Assurance due to issues of accuracy detailed above.	

Indicator Reference: R-5-Tr	
Indicator Title (Board Report): Patients receiving follow-up contact within seven days of discharge from mental health services (CPA and Care Pathway).	
Indicator Title (External): Patients receiving follow-up contact within seven days of discharge from mental health services (CPA and Care Pathway).	
Indicator Description: Patients receiving follow-up contact within seven days of discharge from mental health services (CPA and Care Pathway).	
CQC Domain: Responsive	**Indicator Origin:** Internal
Numerator/Value: The number of people under adult mental illness specialties on CPA or Care Pathway who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care.	
Denominator: The total number of people under adult mental illness specialties on CPA or Care Pathway who were discharged from psychiatric inpatient care.	
RAG Rating: Red: <90% Amber: ≥90% Green: ≥95%	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: Identical to 7-a except covers patients not on CPA as well. Although not rated independently yet, it is likely to be similar to 7-a.	

Indicator Reference: 7-a	
Indicator Title (Board Report): Care Programme Approach (CPA) patients - receiving follow-up contact within seven days of discharge.	
Indicator Title (External): Care Programme Approach (CPA) patients - receiving follow-up contact within seven days of discharge.	
Indicator Description: Care Programme Approach (CPA) patients - receiving follow-up contact within seven days of discharge.	
CQC Domain: Access	**Indicator Origin:** Regulator: Monitor
Numerator/Value: The number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care.	
Denominator: The total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care.	
RAG Rating: Target: ≥95%	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: C&T: For a small number of records, the final CPA Level is not determined within the 7 days after discharge. Although operationally any patients with a potential change are followed up as if they were on CPA, if the CPA Level is not finalised before a) data flows into the monthly Q&P Report and b) quarterly externally, it is possible that our final actual numbers of included patients are slightly higher than reported. Ac: As above. For data in the last 2 years, although numerator and denominator numbers have increased slightly, this issue has not changed the overall percentage figure in any significant way therefore still significant assurance provided.	

Indicator Reference: 7-b	
Indicator Title (Board Report): Care Programme Approach (CPA) patients - having formal review within 12 months.	
Indicator Title (External): Care Programme Approach (CPA) patients - having formal review within 12 months.	
Indicator Description: People with an open CPA Episode at the end of the reporting period that started at least 12 months earlier, who have had a CPA Review within the previous 12 months. Although Monitor's definition wording is slightly different to TDA (doesn't say for people who have been on CPA for the whole of the last 12 months) we cannot see how they can calculate it differently from the TDA so are assuming that it is the same in reality.	
CQC Domain: Access	**Indicator Origin:** Regulator: Monitor
Numerator/Value: People with an open CPA Episode at the end of the reporting period that started at least 12 months earlier, who have had a CPA Review within the previous 12 months.	
Denominator: People with an open CPA Episode at the end of the reporting period that started at least 12 months earlier.	
RAG Rating: Target: ≥95%	
Data Quality Rating: Limited Assurance	
Data Quality Rating Comments: T: Still a few issues around late data entry which causes the external performance to be lower than internal. Ac: National definition not transparent, we are inferring it. Au: Internal Audit underway. V: scrutiny has improved significantly at local levels.	

Indicator Reference: 8	
Indicator Title (Board Report): Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams.	
Indicator Title (External): Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams.	
Indicator Description: Percentage of emergency admissions to inpatients services where Crisis Resolution/Home Treatment have gate-kept the admission and been part of the decision to admit process.	
CQC Domain: Access	**Indicator Origin:** Regulator: Monitor
Numerator/Value: Number of relevant admissions from the denominator that have been gate-kept by a crisis resolution team. i.e. if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission.	
Denominator: Total number of admissions of working age (16-65) patients to the trust's mental health psychiatric inpatient wards excluding:- - planned admissions for psychiatric care from specialist units; - internal transfers of service users between wards in a trust and transfers from other trusts; - patients recalled on Community Treatment Orders; or - patients on leave under Section 17 of the Mental Health Act 1983.	
RAG Rating: Target: ≥95%	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: T: Most RiO data is being validated quickly enough to change if needed, would still be helpful to eliminate using a separate spreadsheet record. Ac: Further pre-submission validation process has reduced incorrectly categorised admissions substantially. Au: Result was Significant Assurance.	

Indicator Reference: 9	
Indicator Title (Board Report): Meeting commitment to serve new psychosis cases by early intervention teams.	
Indicator Title (External): Meeting commitment to serve new psychosis cases by early intervention teams.	
Indicator Description: Percentage of cases of First Episode Psychosis which have been taken on by Early Intervention teams for treatment and support in the current financial year against the number of cases expected for commissioner LDP target.	
CQC Domain: Access	**Indicator Origin:** Regulator: Monitor
Numerator/Value: Number of cases of First Episode Psychosis which have been taken on by Early Intervention teams for treatment and support in the current financial year. Include all new cases taken on the caseload of an EI team from 1 April to the end of the latest Quarter.	
Denominator: Number of cases of First Episode Psychosis planned to have been taken on at this point in the financial year.	
RAG Rating: Target: ≥95%	
Data Quality Rating: Highly Significant Assurance	
Data Quality Rating Comments: None.	

Indicator Reference: 12	
Indicator Title (Board Report): Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	
Indicator Title (External): Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.	
Indicator Description: Percentage of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.	
CQC Domain: Access	**Indicator Origin:** Regulator: Monitor
Numerator/Value: Number of people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral.	
Denominator: Number of people with suspected First Episode Psychosis referred.	
RAG Rating: Target: ≥50%	
Data Quality Rating: Very Limited Assurance	
Data Quality Rating Comments: Although there is now external guidance on the process by which this indicator will be measured, until HSCIC release their calculated results we are unable to be assured that our internal calculations are as aligned as we can make them. Further, we are currently using a proxy measure of EIP team waiting times while we implement the requirements and are able to fully capture all of the elements required.	

Indicator Reference: 13-a	
Indicator Title (Board Report): People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	
Indicator Title (External): People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral.	
Indicator Description: The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	
CQC Domain: Access	**Indicator Origin:** Regulator: Monitor
Numerator/Value: The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 6 weeks of referral.	
Denominator: The number of ended referrals who finish a course of treatment in the reporting period. Note: In IAPT, a course of treatment is defined as having attended at least two treatment contacts.	
RAG Rating: Target: ≥75%	
Data Quality Rating: TBC	
Data Quality Rating Comments:	

Indicator Reference: 13-b	
Indicator Title (Board Report): People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	
Indicator Title (External): People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral.	
Indicator Description: The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	
CQC Domain: Access	**Indicator Origin:** Regulator: Monitor
Numerator/Value: The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 18 weeks of referral.	
Denominator: The number of ended referrals who finish a course of treatment in the reporting period. Note: In IAPT, a course of treatment is defined as having attended at least two treatment contacts.	
RAG Rating: Target: ≥95%	
Data Quality Rating: TBC	
Data Quality Rating Comments:	

Indicator Reference: 15	
Indicator Title (Board Report): Minimising mental health delayed transfers of care.	
Indicator Title (External): Minimising mental health delayed transfers of care.	
Indicator Description: Percentage of secondary mental health patients' occupied bed days where transfer of care was delayed during the period.	
CQC Domain: Outcomes	**Indicator Origin:** Regulator: Monitor
Numerator/Value: The number of secondary mental health patients (aged 18 and over on admission) per day whose transfer of care was delayed during the period. For example, one patient delayed for five days counts as five.	
Denominator: The total number of occupied bed days during the period. Delayed transfers of care attributable to social care services are included.	
RAG Rating: Target: ≤7.5%	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: An accuracy issues has been identified and immediately rectified. Performance has reduced as a result. However, because interpretation of business rules has been corrected, current and future reported results are accurate but previous data was underreported.	

Indicator Reference: 16	
Indicator Title (Board Report): Mental health data completeness: identifiers.	
Indicator Title (External): Mental health data completeness: identifiers.	
Indicator Description: Patient identity data completeness metrics from MHSDS (was MHLDDS) to consist of: - NHS number; - Date of birth; - Postcode (normal residence); - Current gender; - Registered General Medical Practice organisation code; and - Commissioner organisation code.	
CQC Domain: Outcomes	**Indicator Origin:** Regulator: Monitor
Numerator/Value: Count of valid entries for each of the data items	
Denominator: Total number of entries	
RAG Rating: Target: ≥97%	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: C & Ac: Currently we cannot add the numerical data from high and medium secure to that of Local RiO based services (approx. 500 out of 12-13000 patients). Minimal impact due to slow turnover of patients whose identifiers are almost all 100%. Au: Internal Audit due to be carried out Mar-Apr 16.	

Indicator Reference: 17	
Indicator Title (Board Report): Mental health data completeness: outcomes for patients on CPA.	
Indicator Title (External): Mental health data completeness: outcomes for patients on CPA.	
Indicator Description: Patient data completeness metrics from MHSDS (was MHLDDS) to consist of: - Employment Status recorded in last 12m - Accommodation Status recorded in last 12m - HoNOS recorded in last 12m.	
CQC Domain: Outcomes	**Indicator Origin:** Regulator: Monitor
Numerator/Value: - Employment status: Numerator: the number of adults in the denominator whose employment status is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported quarter. - Accommodation status: Numerator: the number of adults in the denominator whose accommodation status (ie, settled or non-settled accommodation) is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported quarter. - Having a HoNOS in the last 12 months: Numerator: The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months.	
Denominator: - Employment status: Denominator: The total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported quarter. - Accommodation status: Denominator: The total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported quarter. - Having a HoNOS in the last 12 months: Denominator: The total number of adults who have received secondary mental health services and who were on the CPA at the end of the reference period.	
RAG Rating: Target: ≥50%	
Data Quality Rating: Limited Assurance	
Data Quality Rating Comments: C: Internal reporting doesn't currently reflect invalid HoNOS records (any nulls or 3 or more 9s). T: Accommodation and Employment Status now being rerecorded annually in RiO. Au: Internal Audit due to be carried out Mar-Apr 16.	

Indicator Reference: 18	
Indicator Title (Board Report): Certification against compliance with requirements regarding access to health care for people with a learning disability.	
Indicator Title (External): Certification against compliance with requirements regarding access to health care for people with a learning disability.	
Indicator Description: Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (DH, 2008): - Does the NHS foundation trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? - Does the NHS foundation trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: o treatment options; o complaints procedures; and o appointments? - Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? - Does the NHS foundation trust have protocols in place to routinely include training on providing health care to patients with learning disabilities for all staff? - Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers? - Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: NHS foundation trust boards are required to certify that their trusts meet requirements a) to f) above at the annual plan stage and in each quarter. Failure to do so will result in the application of the service performance score for this indicator.	
CQC Domain: Outcomes	**Indicator Origin:** Regulator: Monitor
Numerator/Value: Self certification declaration of compliance or not.	
Denominator:	
RAG Rating: Target: Not Applicable	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: Would merit a reaudit.	

Indicator Reference: 19-a	
Indicator Title (Board Report): Data completeness: community services - Referral to treatment information.	
Indicator Title (External): Data completeness: community services - Referral to treatment information.	
Indicator Description: Data completeness levels for community services, using Community Information Data Set (CIDS) definitions, to consist of referral to treatment times – consultant-led treatment in hospitals and allied health care professional-led treatments in the community.	
CQC Domain: Outcomes	**Indicator Origin:** Regulator: Monitor (RAF Outcomes 20a)
Numerator/Value: All data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems).	
Denominator: All activity data required by CIDS.	
RAG Rating: Red: Amber: Green: ≥50%	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: The data fields we think are used are almost all mandatory and as such, our level of completeness is very high within in-scope services.	

Indicator Reference: 19-b	
Indicator Title (Board Report): Data completeness: community services - Referral information.	
Indicator Title (External): Data completeness: community services - Referral information.	
Indicator Description: Data completeness levels for community services, using Community Information Data Set (CIDS) definitions, to consist of community treatment activity – referrals	
CQC Domain: Outcomes	**Indicator Origin:** Regulator: Monitor (RAF Outcomes 20b)
Numerator/Value: All data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems).	
Denominator: All activity data required by CIDS.	
RAG Rating: Red: Amber: Green: ≥50%	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: The data fields we think are used are almost all mandatory and as such, our level of completeness is very high within in-scope services.	

Indicator Reference: 19-c	
Indicator Title (Board Report): Data completeness: community services - Treatment activity information.	
Indicator Title (External): Data completeness: community services - Treatment activity information.	
Indicator Description: Data completeness levels for community services, using Community Information Data Set (CIDS) definitions, to consist of community treatment activity – care contact activity.	
CQC Domain: Outcomes	**Indicator Origin:** Regulator: Monitor (RAF Outcomes 20c)
Numerator/Value: All data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems).	
Denominator: All activity data required by CIDS.	
RAG Rating: Red: Amber: Green: ≥50%	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: The data fields we think are used are almost all mandatory and as such, our level of completeness is very high within in-scope services.	