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Nottinghamshire Healthcare NHS
NHS Foundation Trust

QUALITY & PERFORMANCE REPORT

MONTH 8 NOVEMBER 2016/17

Report to Board of Directors December 2016

Nottinghamshire Healthcare NHS Foundation Trust
Integrated Quality and Performance Report
Month 8 November 2016/17

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1.0 Nottinghamshire Healthcare NHS Foundation Trust
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 November 2016. Compliance with the new Single Oversight Framework standards 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 the Single Oversight 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.

Single Oversight Framework

On 30th September 2016 NHS Improvement published the Single Oversight Framework (SOF) which replaces Monitor's Risk Assessment Framework. The Single Oversight Framework, effective from 1st October 2016, applies to all NHS trusts. The purpose of the framework is to identify where providers may benefit from, or require, improvement support across a range of areas.

There are five themes in the Single Oversight Framework:

- Quality of care (safe, effective, caring, responsive)
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

While the five themes are linked to CQC's key questions, they are not identical. By focusing on these five themes NHS Improvement will support providers to improve, to attain and/or maintain a CQC 'good' or 'outstanding' rating.

Quality of care

The CQC's most recent assessments of quality regarding whether a provider's care is safe, effective, caring and responsive, in combination with in-year information such as warning notices, any civil or criminal actions, or changes to registration conditions, will be used to assess this theme.

Finance and use of resources

NHS Improvement will oversee a provider's financial efficiency, sustainability and progress in meeting its financial control total and compliance with sector controls, such as agency staffing and capital expenditure. NHS Improvement is co-developing this approach with the CQC.

Operational performance

NHS Improvement will monitor a series of performance standards which may relate to one or more facets of quality (i.e. safe, effective, caring and/or responsive). They will track providers' performance against, and support improvements in, a number of NHS standards, wherever possible using nationally collected and evaluated datasets.

Strategic change

Working with system partners, NHS Improvement will consider how well providers are delivering the strategic changes set out in the 5 Year Forward View (5YFV), with a particular focus on their contribution to sustainability and transformation plans (STPs), new care models, and, where relevant, implementation of devolution. They will consider the extent to which providers are working with local partners to address local challenges and improve services for patients.

Leadership and improvement capability

Building on the joint well-led framework, CQC and NHS Improvement will develop a shared system view of what good governance and leadership look like, including organisations' ability to learn and improve. As a provider, we will be expected to demonstrate three main characteristics – effective boards and governance, continuous improvement capability and effective use of data − as part of this theme.

Segmentation of organisations

NHS Improvement segments trusts according to the level of support each trust needs across the five themes of quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability.

The segment a provider is in determines the level of support NHS Improvement provides, described as universal offers, targeted offers and mandated. The segments are as follows:

- **1: Providers with maximum autonomy**: no potential support needs identified. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance
- **2: Providers offered targeted support:** there are concerns in relation to one or more of the themes. NHS Improvement identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in segment 2, more evidence may need to be gathered to identify appropriate support.
- **3: Providers receiving mandated support for significant concerns**: there is actual or suspected breach of licence and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements.
- **4: Providers in special measures**: there is actual or suspected breach of licence with very serious and/or complex issues. The Provider Regulation Committee has agreed it meets the criteria to go into special measures.

The first official national segmentation of trusts has been publicly released by NHS Improvement in November 2016. NHS Improvement has acknowledged that the timings of the data used in relation to one of the Operational Performance metrics has resulted in our Trust being placed in segment 2; this issue is common to many Mental Health trusts and we are consulting with NHS Improvement to determine how best to manage this going forward.

Performance Indicators and Standards

For Single Oversight Framework (SOF) standards (section 3.2) that have yet to be scored by the Trust, a detailed exception report is supplied in section 2.0; there is one SOF indicator under target for November 2016.

For the 15 Trust Performance Summary Dashboard indicators (section 3.3), there are 2 red indicators (significantly below target) and 5 amber indicators (below target):

Source	Indicator	November Performance
Single Oversight Framework indicator	Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards (UNIFY2 and MHSDS)	92.0%
Trust indicator	Turnover % (rolling 12 month figure)	13.9%
Trust Indicator	Annual Review	84.5%
Trust Indicator	% Complaints closed within agreed timescales in the last month	79.5%
Trust indicator	Total Sickness rate	5.6%
Trust indicator	Clinical Supervision	78.4%
Trust indicator	Safety Thermometer Harm Free Care	93.6%
Trust indicator	Patients receiving follow-up contact within seven days of discharge from mental health services (CPA and Care Pathway)	92.7%

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.

Indicator Glossary and Assurance on Data Quality

Each of the Operational Performance and Trust-wide performance indicators is subject to an assessment of its data quality. The Quality and Performance Report Performance Indicator Glossary is included as Appendix 1. 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
December 2016

2.0 Exception Report
Month 8 November 2016/17

INTRODUCTION

Exception reports are provided to give an explanation for identified areas of under-performance. Exception Reports are provided for areas of continued under-performance or downward trends - significantly underperforming indicators (red), or underperforming indicators (amber) that have deteriorated from the previous month's performance.

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.

Please note:-

Single Oversight Framework Operational metrics: Cardio-metabolic assessment and treatment for people with psychosis

Cardio-metabolic assessment and treatment for people with psychosis is one of the new national operational performance metric indicators as set out in the NHS Improvement Single Oversight Framework, published on the 30 September 2016 (thus replacing the Monitor Compliance Framework).

Standard	Frequency	Standard target
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:		
a) inpatient wards	Quarterly	90%
b) early intervention in psychosis services		90%
c) community mental health services (people on Care Programme Approach)		65%

Currently there is a lack of definition around how individual trusts can accurately collect and measure performance against this indicator. Clarity is being sought from NHS Improvement but the Trust has yet to receive clear guidance in this regard; consequently the Trust is not in a position to give an accurate report of its level of compliance against this indicator at this point in time.

It should be stressed that this indicator is aligned to an existing National Commissioning for Quality and Innovation (CQUIN) (**please note Local Division only*) scheme for 2016/17. This scheme seeks to incentivise trusts to put into place the necessary pathways and staff training that would enable reporting against cardio-metabolic targets by the end of quarter 4 2016/17. This CQUIN indicates that trusts are expected to be implementing systems of reporting (as opposed to reporting compliance percentages) for quarter 3 2016/17.

Clarity is thus being sought to determine timescales for reporting metrics for the Single Oversight Framework from the implementation date of 1st October 2016, to determine whether trusts are expected to be reporting compliance figures against this target for quarter 3 or solely implementing reporting frameworks to enable reporting against target by end of quarter 4.

Single Oversight Framework Operational metrics: Priority metrics (Ethnicity, accommodation and employment status, CYP school attendance, ICD10)
The standard for complete and valid submission of data for priority metrics is a new indicator, valid from 1st October 2016. It comprises 5 elements and the target of 85% is for achievement by 2016/17 year-end. The source is stated as the Mental Health Services Data Set. We provide a data submission to this data set on a monthly basis. It is likely that NHS Digital, who receive and process the data for all Trusts, will calculate the indicator on behalf of NHS Improvement.

No further technical details have yet been provided, and therefore we are at present unable to replicate a calculation methodology for this indicator and provide even an estimate of what our current performance might be. There are a number of fundamental uncertainties and questions which must be made clear, including the scope of which patients should be included and which data elements will be used, and what constitutes valid and invalid values.

The following table shows the individual elements and what we currently record:

Element	Status
Ethnicity	Recorded in RiO, included on current data quality reports for all patients who have had an appointment with the Trust in the last 6 months.
Accommodation Status	Recorded in RiO and re-recorded annually. We have recorded and monitored this only for patients who have been on CPA, not for all patients. We have not been informed yet whether this will apply to CPA or all patients.
Employment Status	Recorded in RiO and re-recorded annually. We have recorded and monitored this only for patients who have been on CPA, not for all patients. We have not been informed yet whether this will apply to CPA or all patients.
School Attendance	We do not currently routinely capture this data in RiO, although it may be accessible via other information systems. NHS Improvement has indicated that further details will be issued in the provider bulletin.
ICD10 Coding	We routinely record diagnosis for finished consultant episodes for inpatients, but we do not routinely record diagnosis for non-inpatients.

At the time of writing, no further details have been released and therefore we are unable to interpret and calculate this indicator internally. Once details emerge, our intention will be to copy the methodology to be able to apply it to our data in order to report on a monthly basis, and we will compare our results to the external results when they start to be published, normally 3 months in arrears.

FORENSIC SERVICES DIVISION
Of the 13 Divisional Summary Dashboard indicators, 4 are reported as being of significant under-performance (red) and 1 is reported as under-performance (amber).

Ref. No. 1 - Complaints Closed within Agreed Timescales (%) - The Division has seen complaints closed within agreed timescales improve to 65.0% for November from 58.8% for October, but is aware that it is still under target. A concerted effort is being made across the Division to ensure complaints are responded to within timescales; the need to improve performance in managing complaints in a timely fashion has been highlighted as a matter of urgency, with all senior managers signed up to the concept of supporting staff to ensure complaint investigations are prioritised. Issues contributing to delays have been investigated and shared with the senior managers across the Division and discussed in detail at the Forensic Services Management Group. In order to support the drive for improvement, a new system has recently been implemented in relation to requests for extensions. Weekly update reports are sent to general managers and the Deputy Director of Forensic Services, in order to challenge progress and request updates in a timely fashion.

Ref. No. 2 - Turnover % (rolling 12 months) - Turnover stands at 14.0% at the end of November, a slight increase from 13.7% reported last month. The overall 12-month rolling percentage for the Forensic Division remains an area of concern. Staffing turnover continues to be addressed via the Forensic Services retention strategy, which is being actively monitored each month by the Forensic Senior Management Group and which is exploring new ways of working. In addition to this, recent successful recruitment campaigns have taken place at Rampton and ongoing recruitment campaigns continue at Arnold Lodge and Rampton. The Offender Health Directorate has experienced turnover at a higher rate than the Trust target for a variety of reasons. The commercial nature of this service has resulted in changes to the contract portfolio, with some teams transferring to other providers through TUPE. The Directorate has developed a Recruitment & Retention Plan that aligns to the Forensic Services Plan.

Ref. No. 3 - Workforce Sickness & Absence – The sickness rate is 7.1% for November, an improvement from 7.7% reported for October but still significantly outside the 5% target. Human Resources continue to take this forward with directorates via a number of initiatives which includes the requirement that all clinical directorates have their own individual sickness absence action plans, as well as Human Resources supported meetings with staff who have high levels of non-attendance to ensure they are offered adequate support. The HR department is currently undertaking sickness audits to understand levels of adherence to the sickness policy and target setting.

Ref. No. 4 - Annual Reviews - 86.4% for November, a slight fall off in performance from 87.3% reported for October. Key areas of concern have been identified: sickness and annual leave, an increase in clinical activity and missing data or late data entry on the Electronic Staff Record (ESR). Senior managers continue to monitor and discuss performance with line managers. This is an ongoing issue and the Divisional management team will be receiving more detailed reports to directly request updates and drive improvements.

Ref. No. 5 - Forensic delayed admissions - 11 patients delayed for November 2016. For those patients experiencing delays in admission, the directorates concerned send regular correspondence to the Referring bodies to ensure they are kept up to date as to bed availability. Regular communication also ensures that the directorate is kept updated as to the patient's clinical presentation. The following exceptions have been provided:

- **High Secure Women's Service** - 4 patients delayed. Delays continue due to high occupancy levels (currently 100%) and demand on beds. One patient was returned early from trial leave during November and this has further impacted on the current pressure on beds.
- **High Secure Mental Health** - 5 patients are 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. Arrangements are now in place to admit one patient on 15th December 2016.
- **High Secure Personality Disorder** - 1 patient was recorded as delayed as at the end of the month; however admission has been facilitated for 14th December 2016.
- **Arnold Lodge Medium Secure Unit** - 1 patient became a delayed admission during June 2016. Following discussions with commissioners in August it was agreed that this patient should remain at their current place of care and be admitted to Arnold Lodge as and when a bed becomes available.

LOCAL PARTNERSHIPS - MENTAL HEALTH (FORMERLY LOCAL SERVICES)

Of the 16 Divisional Summary Dashboard indicators, 1 is significantly under-performing (red) and 3 are under-performing (amber). There is 1 underperforming indicator relating to the Single Oversight Framework

Ref. No. 6 - Information Governance training: Target 95% by end of September – Reporting 93% for November against a target of 95%. This is a marginal improvement from the October reported position. Each directorate continues to review staffing records and support staff to attend their training. The majority of staff that have yet to complete their training are either on long-term sick or maternity leave. Other members of staff who are at work and have not completed it are either new in post or just returned from sick/maternity leave. They have been asked to complete the training as a matter of urgency.

Ref. No. 7 – Workforce Sickness & Absence - Seasonal illnesses are believed to be a factor for the increase in sickness for November that has been seen across all areas. Furthermore there is an increasing number of absences related to staff injuries obtained whilst at work and subsequent impact of work-related stress due to increased workloads to cover staff absences. Close monitoring and sickness absence management is in place, although the Division is aware that there tends to be increase in sickness over the winter period.

Ref. No. 8 – % Turnover (rolling 12 month figure) - Mental Health remains above the Trust target and this reflects the ongoing impact of the TUPE of staff from Hotel Services; it is therefore expected that the turnover will remain above target levels, given the 12 month rolling figure used for turnover calculation.

Ref. No. 9 - Mixed Sex Accommodation – 6 instances of mixed sex accommodation were reported in November 2016. 1 breach occurred due to management of patient safety, using a side room which was in a male area - all dignity protocols were followed. 5 instances occurred on MHSOP ward with male patients in side rooms that were not en-suite and therefore patients needed to walk through female areas to use bathroom facilities. Dignity protocols were followed in all instances.

Ref.10 Crisis Gatekeeping - The Directorate have reported four instances where admissions were not gate kept which as a result has dropped performance to 92% for November. The Directorate have been asked to re-review these admissions as the Crisis Resolution and Home Treatment Team were involved and therefore this may be amended for December reporting.

LOCAL PARTNERSHIPS – Community (FORMERLY HEALTH PARTNERSHIPS)

Of the 16 Divisional Summary Dashboard indicators, 3 are significantly underperforming (red) and 3 are underperforming (amber).

Ref. No. 11 - Information Governance – There was a slight increase in uptake during November to 94.2% from 92.6% for October. A total of 2606 staff in post 2765 have completed the training, with 159 non-compliant staff, some of whom are on long-term leave. A request has been made that general managers target these staff directly. The IG Training Tool via the Health and Social Care Information Centre (HSCIC) will be decommissioned on 31st December 2016. The Trust is therefore encouraging all remaining non-compliant staff to complete the IG training before 31st December 2016. This was discussed at Strategic Information Governance Group on 12th December in order to determine the best way forward regarding IG training for the future.

Ref. No. 12 – Turnover – The Division has a rolling 12 month turnover rate of 13.8% which is in breach of the Trust's 11% target, but is lower than the rolling percentage turnover as at the end of October 2016 (14.1%). The number of in-month leavers in November is 22, as compared with 30 in October 2016. We continue to have a number of organisational change programmes underway within services, and managers are working to redeploy affected staff across the Trust to minimise future turnover as a result of these required workforce reductions, thus retaining skills and experience staff within our services. Voluntary turnover continues to be monitored, including reasons why people are choosing to leave, informing any appropriate action(s) to be undertaken to seek to reduce this.

Ref. No. 13 – Annual Reviews carried out % - The target remains a challenge and performance has seen a further slight decline by 1%. As outlined in the October narrative, the target date of the end of December has been set to achieve the appraisal target and a further reminder has been sent to general managers regarding the importance of meeting this timeline.

Ref. No. 14 - Acquired avoidable pressure ulcers – Target zero; Actual: stage 3 x 0; stage 4 x 0). For November the Division is 1 below the agreed acquired avoidable trajectory for 2016/2017. There have been no reported acquired avoidable stage 3 or 4 pressure ulcers reported this month. The Division is currently piloting a new Root Cause Analysis process within Mansfield and Ashfield with the results of this to be available in January 2017.

Ref. No. 15 - Venous Lower Leg Wounds Healed within 20 Weeks – Service improvement methodologies are being applied to leg ulcer clinics to ensure they operate as productively as possible and to also assist with the healing rates. A review of the clinical leadership model for this pathway is underway.

3.1 NHS Improvement Single Oversight Framework Overview - Month 8 November 2016/17

NHS Improvement use information from data monitoring processes and insights gathered though work with providers, to identify where providers have a potential support need under one or more of the five themes . NHS Improvement also use judgement, based on consistent principles, to determine whether or not providers are in breach of licence – or the equivalent for NHS trusts – and to determine, as part of that judgement, if providers should go into special measures

Summary of information required for monitoring (green: no concerns, yellow: emerging concerns, red: evident concerns)

Themes	Monitoring period	Triggers	Current position (internal monitoring)	Issues/ concerns
Quality of Care	**In-Year** quality information to identify any areas for improvement **Annual / less frequently** Annual quality information **Ad-hoc** Results of CQC inspections CQC warning notices, fines, civil or criminal actions and information on other relevant matters	CQC 'inadequate' or 'requires improvement' assessment in 'safe' - 'effective' - 'caring' - 'responsive' CQC warning notices Any other concerns identified through CQC's monitoring process, eg civil or criminal cases raised, whistleblower information, etc trends in our quality indicators	No concerns	
Finance and Use of Resources	**In year** Monthly returns **Annual / less frequently** Annual Plans **Ad-hoc** One-off financial events (e.g. sudden drops in income/increases in costs) Transactions/mergers	Poor levels of overall financial performance (average score of 3 or 4) Very poor performance (score of 4) in any individual metric Potential value for money concerns	No concerns	
Operational Performance	**In Year** Monthly/quarterly (in some cases weekly[2]), operational performance information **Ad-hoc** Any sudden and unforeseen factors driving a significant failure to deliver	Failure to meet target for at least two consecutive months (quarterly for quarterly metrics)	No concerns	
Strategic Change	**In Year** Delivery of sustainability and transformation plans (STPs). Progress of any new care models, devolution plans **Annual / less frequently** STPs **Ad-hoc** Any sudden and unforeseen factors driving a significant failure to deliver	Material concerns with a provider's delivery against the transformation agenda, including new care models and devolution	No concerns	
Leadership and Improvement Capability	**In Year** Third-party information with governance implications[1] Organisational health indicators: staff absenteeism/ staff churn / board vacancies **Annual / less frequently** Staff and patient surveys Third-party information with governance implications1 **Ad hoc** Findings of well-led reviews Third-party information with governance implications1	Material concerns CQC 'inadequate' or 'requires improvement' rating against 'well-led'.	No concerns	

[1]e.g. reports from quality surveillance (QSGs), GMC, ombudsman, CCGs, Healthwatch England, auditors, Health and Safety Executive, patient groups, complaints, whistleblowers, medical Royal Colleges
[2]Where necessary

3.2 NHS Improvement Single Oversight Framework: Appendix 3: Operational performance - Month 8 November 2016

Ref	Standard	Frequency	Minimum Standard *(from Oct 16)*	Qtr 1 16/17	Qtr 2 16/17	Oct-16	Nov-16	Dec-16	Qtr 3 16/17	Data Quality	Ref
20	Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards (UNIFY2 and MHSDS)	Quarterly	95%	99.4%	97.7%	95.5%	92.0%		93.6%		See exception report No 10
21	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral (UNIFY2 and MHSDS)	Quarterly	50%	21.4%	43.0%	67.3%	70.4%		68.4%		
	Ensuring that cardio - metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:										
22	- Inpatient wards	Quarterly	90%				See exception report				
23	- Early intervention in psychosis services	Quarterly	90%				See exception report				
24	- Community mental health services (people on Care Programme Approach)	Quarterly	65%				See exception report				
	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital:										
25	- Identifier metrics (NHS Number, date of birth, postcode, gender, registered GP, commissioner)	Monthly	95%	98.9%	98.9%	98.9%	98.9%		98.9%		
26	- Priority metrics (Ethnicity, accommodation and employment status, CYP school attendence, ICD10)	Monthly	85% *				See exception report				
	Improving Access to Psychological Therapies (IAPT)/talking therapies:										
27	- Proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	Quarterly	50%	51.9%	50.3%	50.0%	52.3%		51.3%		
28	- Waiting time to begin treatment (from IAPT minimum dataset) within 6 weeks	Quarterly	75%	82.1%	80.6%	78.6%	82.8%		80.9%		
29	- Waiting time to begin treatment (from IAPT minimum dataset) within 18 weeks	Quarterly	95%	99.2%	99.7%	98.7%	99.3%		99.0%		

*** = Min. Std. is for end of FY 16/17**

3.3 TRUST QUALITY AND PERFORMANCE DASHBOARD Month 8 November 2016/17

Domain	Indicator reference code	Key Performance Indicator	Target / average: on target	below target	significantly below target	QTR 4 15/16 Jan	Feb	Mar	QTR 1 16/17 Apr	May	Jun	QTR 2 16/17 Jul	Aug	Sep	QTR 3 16/17 Oct	Nov	Dec	Trend (16/17, 15/16)	Data Quality	Reference
CARING	C-1-Tr	Friends and Family Test scores	6 month average 96			97	97	95	95	97	96	97	95	94	96	97				
CARING	C-2-Tr	Service Quality Rating %	6 month average 95			96	96	94	94	94	94	94	94	94	95	95				
CARING	C-3-Tr	Number of new complaints received	6 month average 71			68	81	86	88	74	85	79	58	65	64	72				
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	71.3	66.2	79.5				See Exception Report No. 1
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	31.8	45.6	41.1				
WELL-LED	WL-2-Tr	Turnover % (rolling 12 month figure)	9% to 11%	8-9% 11-12%	<8%, >12%	12.2	11.8	12.8	12.8	13.4	14.1	13.6	13.6	13.7	14.0	13.9				See 6.3 Well-Led - Staff in Post detailed report on page 18. See Exception Report No. 2 ,8 & 12
WELL-LED	WL-3-Tr	Total Sickness rate	≤4%	≤6%	>6%	5.3	5.1	4.9	4.7	4.6	5.0	5.1	5.2	5.1	5.3	5.6				See 6.1 Well-Led - Sickness detailed report on 16. See Exception Report No.3 & 7
WELL-LED	WL-4-Tr	Vacancy rate %	To be confirmed			6.6	6.8	7.2	7.1	7.6	8.2	8.0	7.9	7.8	7.7	7.4				See 6.3 Well-Led - Staff in Post detailed report on page 18
WELL-LED	WL-5-Tr	Annual Reviews carried out % (Staff Appraisals)	≥95%	≥85%	<85%	89.5	88.6	89.5	87.7	88.5	88.1	88.0	87.3	85.9	84.6	84.5				See 6.2 Well-Led - Learning & Development detailed report on page 17. See Exception Report No. 4 & 13
WELL-LED	WL-6-Tr	Clinical supervision %	≥80%	≥65%	<65%	76.7	77.2	74.1	77.5	76.5	76.9	75.3	74.1	78.0	74.4	78.4				
WELL-LED	WL-7-Tr	Mandatory training %	≥85%	≥75%	<75%	90.9	90.7	90.6	87.8	88.5	89.0	89.1	89.5	89.3	89.7	90.1				See 6.2 Well-Led - Learning & Development detailed report on page 17
SAFE	S-4-Tr	Safety Thermometer All Harms - % Harm Free Care	≥95%	≥90%	<90%	93.3	93.1	92.3	93.8	94.2	92.9	93.4	93.7	93.7	94.9	93.6				
SAFE	S-5-Tr	Minimising mental health delayed transfers of care %	<7.5%	n/a	>7.5%				6.7	6.9	7.3	6.4	4.0	2.8	2.5	2.8				
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%	95.7	95.0	94.4	98.1	95.5	96.1	93.2	94.4	93.5	90.4	92.7				
RESPONSIVE	R-6-Tr	CPA - % patients having a review in last 12 months	≥95%	≥80%	<80%				97.4	97.6	96.6	96.8	97.3	96.6	97.1	97.6				

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 8 November 2016/17

Domain	Key Performance Indicator	Target / average: on target	below target	significantly below target	QTR 4 15/16: Jan	Feb	Mar	QTR 1 16/17: Apr	May	Jun	QTR 2 16/17: Jul	Aug	Sep	QTR 3 16/17: Oct	Nov	Dec	Trend (16/17, 15/16)	Reference
CARING	Friends and Family Test scores	6 month average **69**			x	x	x	67	64	67	81	66	68	62	77			
CARING	Service Quality Rating %	6 month average **78**			x	74	78	78	72	78	82	76	78	75	84			
CARING	Number of new complaints received	6 month average **42**			51	57	59	66	43	60	45	34	37	35	40			
CARING	% Complaints closed within agreed timescales in the last month	≥80%	≥70%	<70%				80.3	70.6	76.0	72.2	70.2	71.7	58.8	65.0			See Exception Report No No. 1
CARING	% Complaints closed in the last month upheld or partially upheld	To be confirmed						21.2	33.3	24.0	31.5	34.0	24.5	29.4	37.5			
WELL LED	Turnover % (rolling 12 month figure)	9% to 11%	8- 9% 11-12%	<8%, >12%	11.8	11.6	11.8	11.6	13.2	13.8	13.4	13.9	13.5	13.7	14.0			See 6.3 Well-Led - Staff in Post detailed report on page 18. See Exception Report No.2
WELL LED	Total Sickness rate	≤5%	<7%	≥7%	6.4	5.9	5.9	5.7	5.8	6.1	6.8	7.1	6.8	7.7	7.1			See 6.1 Well-Led - Sickness detailed report on page 16. See Exception Report No. 3
WELL LED	Vacancy rate %	To be confirmed			7.3	7.1	8.6	7.9	8.0	8.9	8.6	9.3	9.6	9.2	8.9			See 6.3 Well-Led - Staff in Post detailed Report on page 18.
WELL LED	Annual Reviews carried out % (Staff Appraisals)	≥95%	≥85%	<85%	91.6	90.1	91.6	90.0	90.1	90.2	88.7	87.1	88.5	87.3	86.4			See 6.2 Well-Led- Learning & Development detailed report on page 17. See Exception Report No. 4
WELL LED	Clinical supervision %	≥80%	≥65%	<65%	85.6	84.7	84.1	88.0	87.6	86.7	85.7	83.5	84.4	83.5	85.6			
WELL LED	Mandatory training %	≥85%	≥75%	<75%	92.0	92.0	93.0	92.0	92.0	92.0	92.0	92.0	91.0	92.0	92.0			See 6.2 Well-Led- Learning & Development detailed report on page 17.
RESPONSIVE	Mental Health Delayed Transfers of Care - Admission	=0	n/a	>0	8	7	6	4	4	6	8	8	10	10	11			See Exception Report. No. 5
RESPONSIVE	Mental Health Delayed Transfers of Care - Discharge	=0	n/a	>0	2	2	3	0	1	1	2	2	1	0	0			
RESPONSIVE	CPA - % patients having a review in last 12 months	≥95%	≥80%	<80%				99.8	99.8	99.8	99.6	98.4	98.0	98.4	98.0			

4.2 LOCAL PARTNERSHIPS - MENTAL HEALTH (FORMERLY LOCAL SERVICES) QUALITY AND PERFORMANCE DASHBOARD Month 8 November 2016/17

Domain	Key Performance Indicator	Target / average			QTR 4 15/16			QTR 1 16/17			QTR 2 16/17			QTR 3 16/17			Trend	Reference
		on target	below target	significantly below target	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	16/17 15/16	
CARING	Friends and Family Test scores	6 month average 92			94	95	94	92	94	92	94	92	88	89	92			
CARING	Service Quality Rating %	6 month average 93			94	94	94	92	94	94	92	92	92	92	94			
CARING	Number of new complaints received	6 month average 24			15	22	21	17	27	20	26	22	23	27	29			
CARING	% Complaints closed within agreed timescales in the last month	≥80%	≥70%	<70%				66.7	90.0	85.0	89.0	80.0	69.2	65.4	96.7			
CARING	% Complaints closed in the last month upheld or partially upheld	To be confirmed						61	48	45	53	52	54	65	50			
WELL LED	Turnover % (rolling 12 month figure)	9% to 11%	8- 9% 11-12%	<8%, >12%	11.6	11.3	13.1	13.6	13.7	14.4	14.1	14.0	14.2	14.7	14.3			See 6.3 Well-Led - Staff in Post detailed report on page 18. See Exception Report No.8
WELL LED	Total Sickness rate	≤4%	≤6%	>6%	4.9	4.8	4.8	4.9	4.5	4.6	4.5	4.7	5.0	4.5	5.2			See 6.1 Well-Led - Sickness detailed report on page 16. See Exception Report No. 7
WELL LED	Vacancy rate %	To be confirmed			7.9	8.0	7.9	8.6	9.5	9.8	9.2	8.6	8.9	8.0	7.5			See 6.3 Well-Led - Staff in Post detailed report on page 18.
WELL LED	Annual Reviews carried out % (Staff Appraisals)	≥95%	≥85%	<85%	90.6	90.7	90.6	88.9	90.2	88.6	87.9	88.3	86.0	85.8	86.6			See 6.2 Well-Led - Learning & Development on page 17.
WELL LED	Clinical supervision %	≥80%	≥65%	<65%	83.2	83.0	79.7	81.2	81.9	78.5	80.0	76.6	82.4	81.9	84.0			
WELL LED	Mandatory training %	≥85%	≥75%	<75%	90.7	90.7	90.9	87.1	87.2	87.8	88.6	88.8	85.1	87.3	86.6			See 6.2 Well-Led - Learning & Development on page 17.
EFFECTIVE	% patients readmitted within 28 days - Adult	<4%	≥4%	≥10%	4.5	4.0	2.1	1.6	2.3	3.4	3.6	2.3	4.1	1.5	x			
EFFECTIVE	Number of patients readmitted within 28 days - Older People	≤2	2 to 5	>5	1	0	0	0	0	0	0	0	0	2	x			
SAFE	Safety Thermometer All Harms - % Harm Free Care	≥95%	≥90%	<90%	95.3	94.3	97.8	97.8	100.0	96.2	98.7	100.0	95.4	97.5	96.6			
SAFE	Minimising mental health delayed transfers of care %	<7.5%	n/a	>7.5%				8.5	8.8	9.3	8.1	5.2	3.6	3.0	3.5			
SAFE	Minimising mental health delayed transfers of care % - delayed transfers attributable to the Trust	<7.5%	n/a	>7.5%				0.5	0.7	0.5	0.0	0.0	0.0	0.4	1.2			
RESPONSIVE	CPA - % patients having a review in last 12 months	≥95%	≥80%	<80%	96.9	95.4	96.3	96.2	96.5	94.9	95.3	96.6	96.0	96.4	97.2			
RESPONSIVE	Patients receiving follow-up contact within seven days of discharge from mental health services (CPA and Care Pathway)	≥95%	≥90%	<90%				98.0	95.5	96.8	93.2	94.3	93.4	90.2	92.7			

4.3 LOCAL PARTNERSHIPS - COMMUNITY (FORMERLY HEALTH PARTNERSHIPS) QUALITY AND PERFORMANCE DASHBOARD Month 8 November 2016/17

Domain	Key Performance Indicator	Target / average: on target	below target	significantly below target	QTR 4 15/16: Jan	Feb	Mar	QTR 1 16/17: Apr	May	Jun	QTR 2 16/17: Jul	Aug	Sep	QTR 3 16/17: Oct	Nov	Dec	Trend (16/17, 15/16)	Reference
CARING	Friends and Family Test scores	6 month average **98**			97	98	98	98	98	99	98	98	98	98	98			
CARING	Service Quality Rating %	6 month average **96**			96	96	94	96	96	96	96	96	96	95	96			
CARING	Number of new complaints received	6 month average **4**			2	3	6	5	4	5	8	2	5	2	3			
CARING	% Complaints closed within agreed timescales in the last month	≥80%	≥70%	<70%				100	100	100	100	100	100	100	100			
CARING	% Complaints closed in the last month upheld or partially upheld	To be confirmed						66	0	42	66	67	0	42	0			
WELL-LED	Turnover % (rolling 12 month figure)	9% to 11%	8- 9% 11- 12%	<8%, >12%	14.0	13.7	14.7	14.5	14.2	15.1	14.2	13.9	13.9	14.1	13.8			See 6.3 Well-Led - Staff in Post detailed report on page 18. See Exception Report No. 12.
WELL-LED	Total Sickness rate	≤4%	≤6%	>6%	5.2	5.0	4.4	4.0	4.0	4.6	4.3	4.4	4.2	4.3	5.2			See 6.1 Well-Led - Sickness detailed report.on page 16.
WELL-LED	Vacancy rate %	To be confirmed			4.5	5.3	5.0	5.2	5.7	5.7	5.8	5.4	5.7	5.3	5.4			See 6.3 Well-Led Staff in Post detailed report on page 18
WELL-LED	Annual Reviews carried out % (Staff Appraisals)	≥95%	≥85%	<85%	86.8	85.5	86.8	84.7	86.3	87.9	89.0	88.4	85.7	82.8	81.8			See 6.2 Well-Led Learning & Development detailed report on page 17.
WELL-LED	Clinical supervision %	≥80%	≥65%	<65%	64.3	67.0	62.0	66.0	63.0	68.0	63.0	64.3	69.6	61.0	68.0			
WELL-LED	Mandatory training %	≥85%	≥75%	<75%	89.0	88.0	87.0	82.0	84.0	86.0	86.0	87.0	88.0	89.0	90.0			See 6.2 Well-Led Learning & Development detailed report on page 17
SAFE	Total number of acquired avoidable pressure ulcers stages 3 and 4 reported in month	0	n/a	>0									10	3	0			See 5.2 Safe - Pressure Ulcers detailed report on page 15. Exception Report No. 4
SAFE	Total number of acquired avoidable pressure ulcers stages 3 and 4 *reviewed post root cause analysis*	0	n/a	>0	12	7	6	18	8	4	8	6	x	x	x			See 5.2 Safe - Pressure Ulcers detailed report on page 15.
SAFE	Safety Thermometer All Harms - % Harm Free Care	≥95%	≥90%	<90%	93.1	92.9	91.8	93.5	93.7	92.6	92.8	93.1	93.5	94.7	93.2			
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	25.9	26.0	24.4			See Exception Report No. 15.
RESPONSIVE	Delayed Transfers of Care (non mental health) - % attributable to the Trust	≤7.5%	n/a	>7.5%	3.2	1.2	2.0	0.6	2.7	5.3	1.2	3.6	3.6	4.1	1.7			

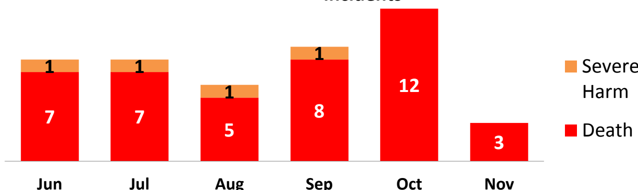
SAFE

5.1 INCIDENT MANAGEMENT, Month 8 November 2016/17

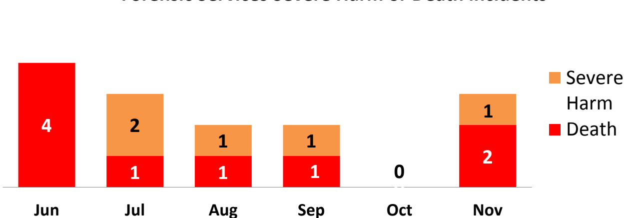
	Trust Year to Date	Trust total	Forensic Services Division	Local Partnerships - Mental Health	Local Partnerships - Community
		November month 8 2016/17			
Number of Never Events	0	0	0	0	0
Total number of reported incidents (excluding third party)	22321	2661	1236	732	684
Total Patient Safety incidents as reported to the National Reporting and Learning System (NRLS)	8473	1114	466	378	270
% of total incidents resulting in Severe Harm or Death	0.35%	0.26%	0.24%	0.41%	0.15%
STEIS reportable incidents	222	16	3	4	9
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	17	6	0	6	0

Incidents Classified Severe Harm and Death

Local Partnerships - Mental Health Severe Harm or Death incidents

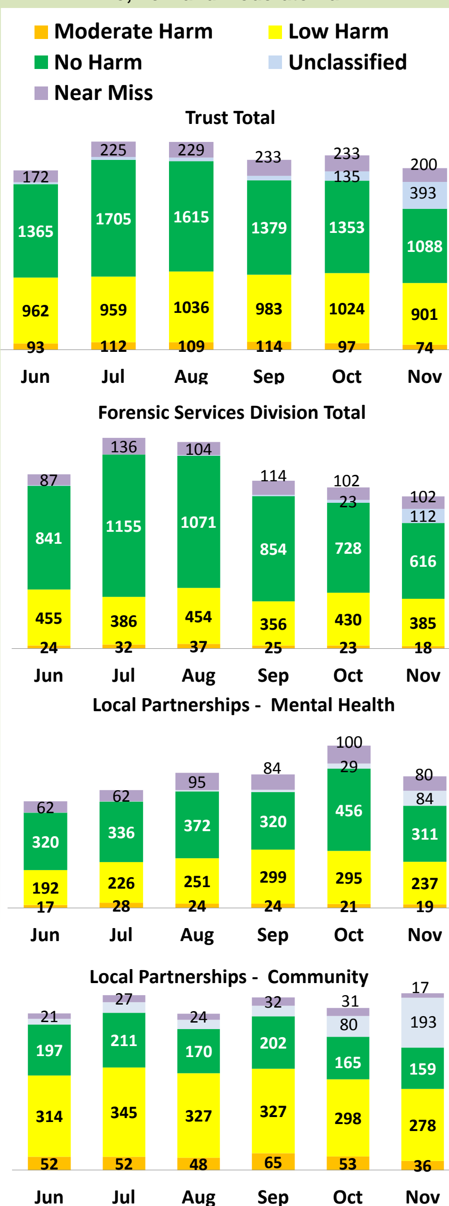


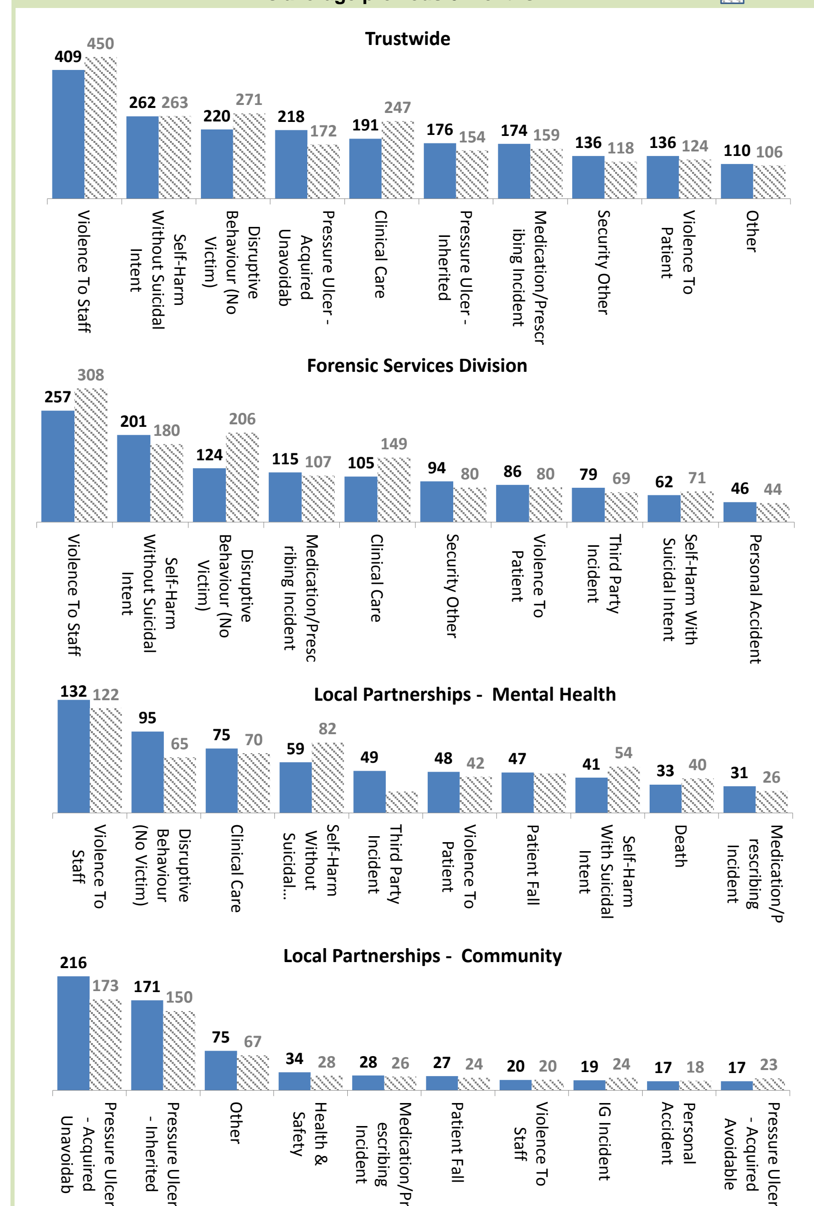
Forensic Services Severe Harm or Death incidents



Narrative - Incidents Classified Severe Harm and Death

Death/ Catastrophic Local Partnerships - Mental Health: 1 suspected suicide, 2 unexpected deaths. Forensic Services Division -1 unexpected death, 1 suspected suicide.
Severe Local Partnerships - Community: 1 failure in clinical care. Forensic Services Division - 1 injury during restraint

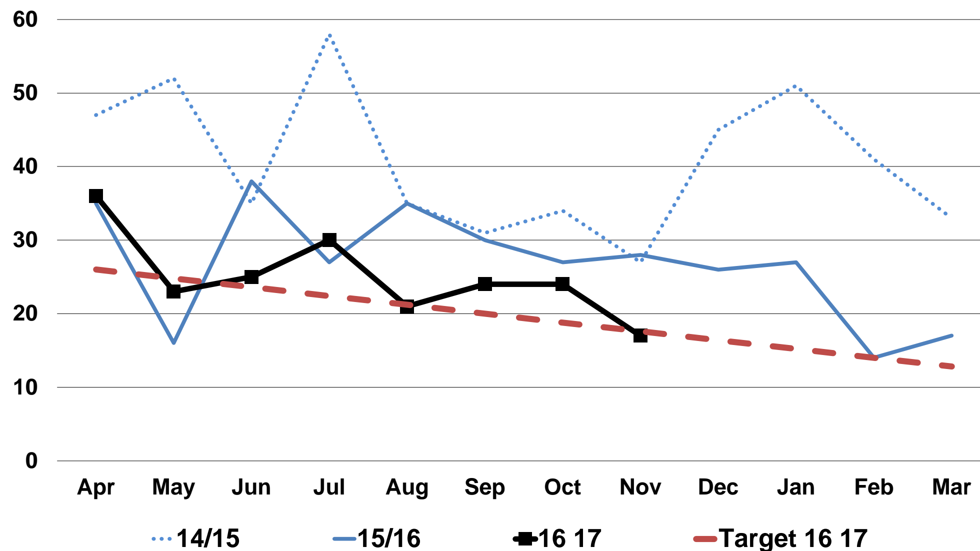


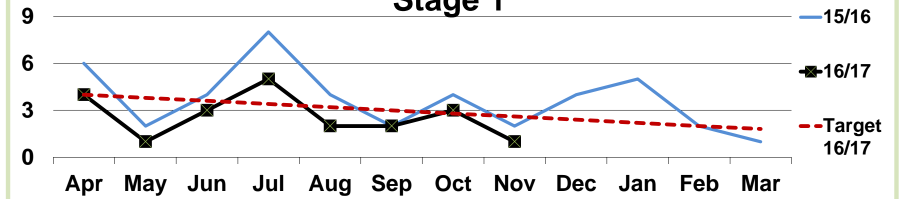


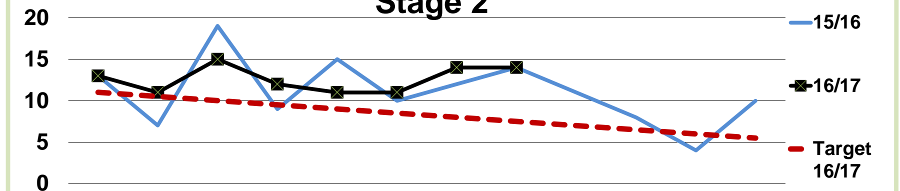
SAFE

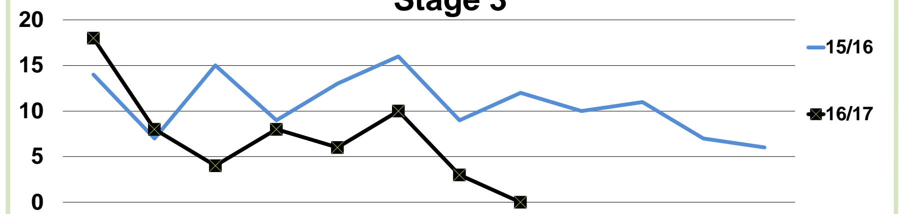
5.2 PRESSURE ULCERS, Month 8 November 2016/17

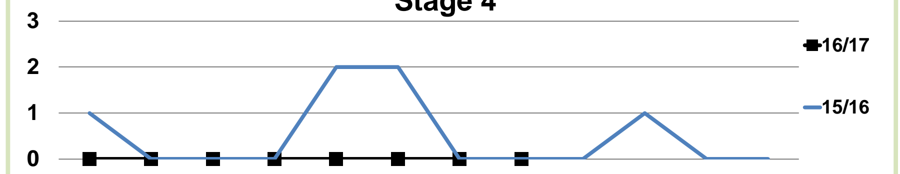
Total avoidable pressure ulcers for the Trust (including mental health divisions)	Trust - LP Community Target year to date	Trust year to date	Month 8 November 16/17: Trust total	Forensic Services Division	Local Partnerships: Mental Health	Local Partnerships: Community
Total number of pressure ulcers and SDTIs	n/a	1608	240	1	5	234
Acquired avoidable pressure ulcers and SDTIs	n/a	212	18	0	1	17
Acquired avoidable pressure ulcers **STAGE 4**	zero	0	0	0	0	0
Acquired avoidable pressure ulcers **STAGE 3**	zero	57	0	0	0	0
Acquired avoidable pressure ulcers **STAGE 2**	67	110	15	0	1	14
Acquired avoidable pressure ulcers **STAGE 1**	24	23	1	0	0	1
Acquired avoidable Suspected Deep Tissue Injury **SDTI**	n/a	22	2	0	0	2

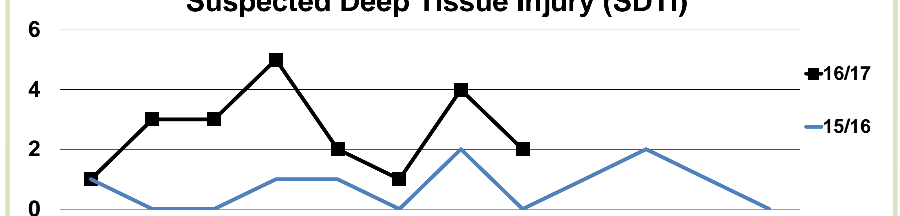










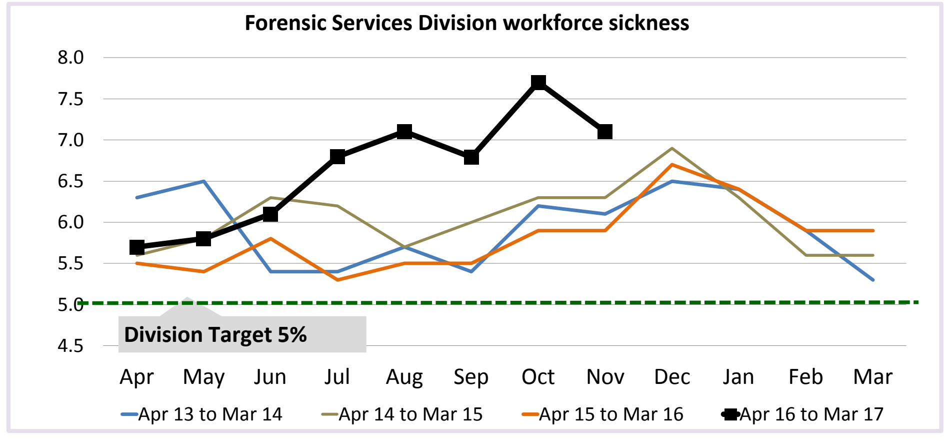


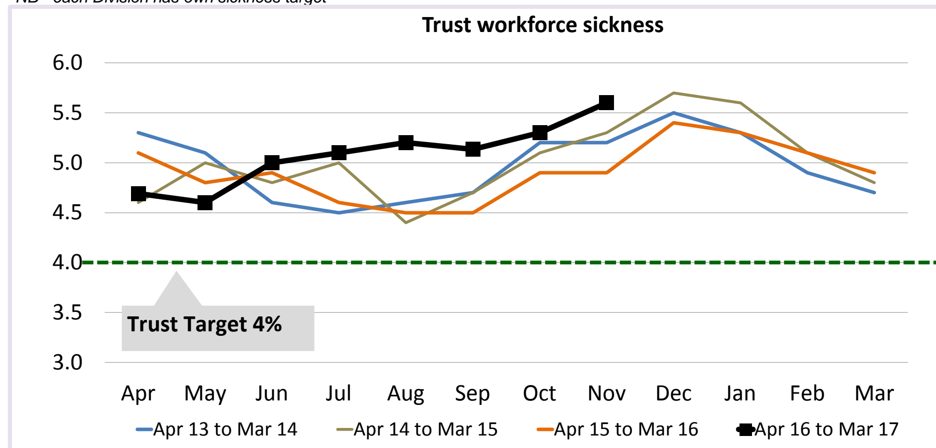
6.1 SICKNESS DETAIL, MONTH 8 November 2016/17

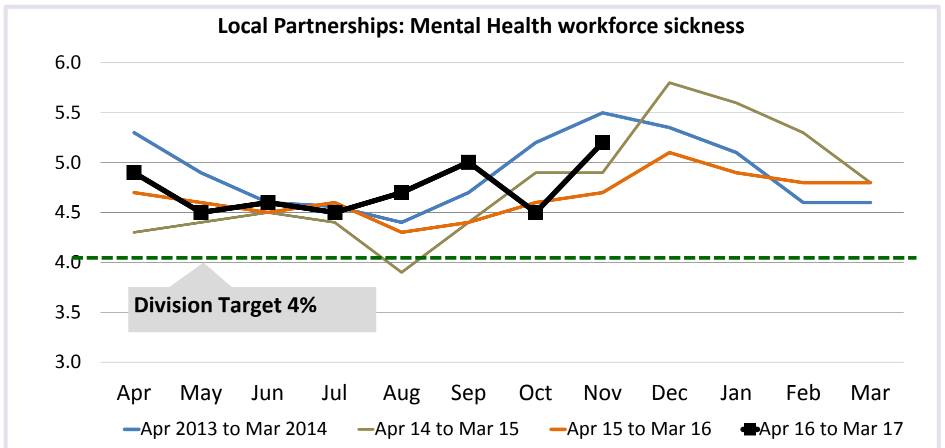
Workforce sickness rates across the Trust

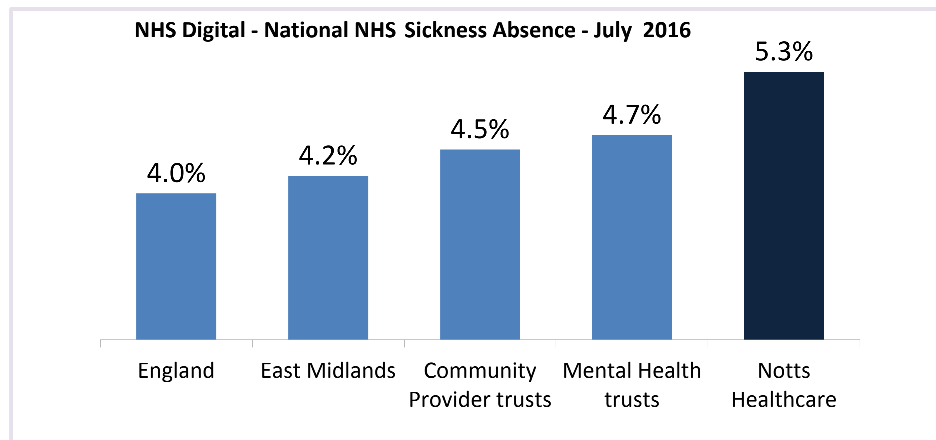
	Trust Target	Trust YTD	Month 8 November 16/17				
			Trustwide	Forensic Services	Local Partnerships: Mental Health	Local Partnerships: Community	Corporate Services
Total Sickness rate %	≤4%	5.2%	5.6%	7.1%	5.2%	5.2%	2.5%
Short Term Sickness %	n/a	86.3%	90.6%	22.0%	80.9%	78.0%	80.9%
Long Term Sickness %	n/a	13.7%	9.4%	78.0%	19.1%	22.0%	19.1%
Sickness Clinical % registered	n/a	4.6%	5.4%	6.7%	4.3%	5.5%	3.5%
Sickness Clinical % non-registered	n/a	7.4%	8.1%	9.3%	8.8%	5.8%	8.9%
Sickness Non-Clinical %	n/a	4.0%	4.3%	6.1%	4.6%	3.9%	2.2%

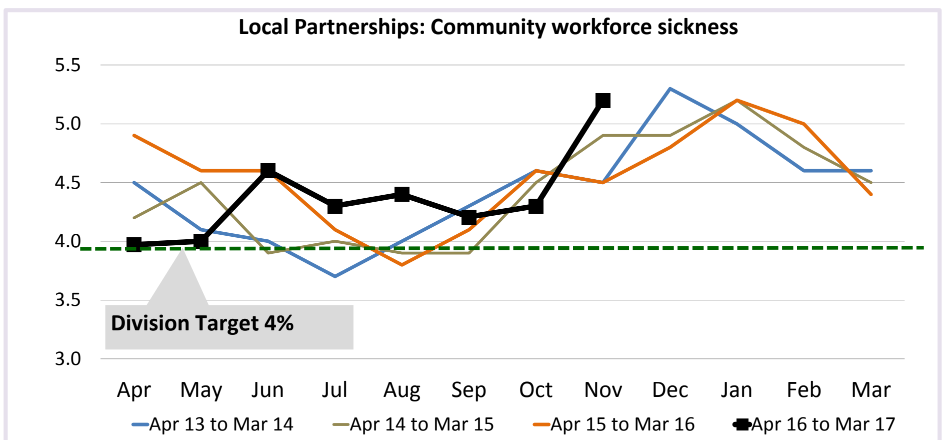
NB - each Division has own sickness target







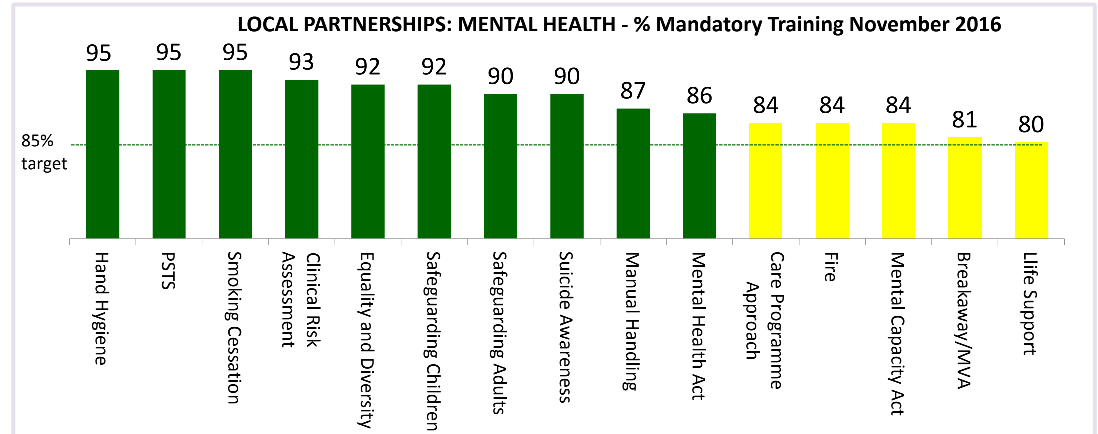


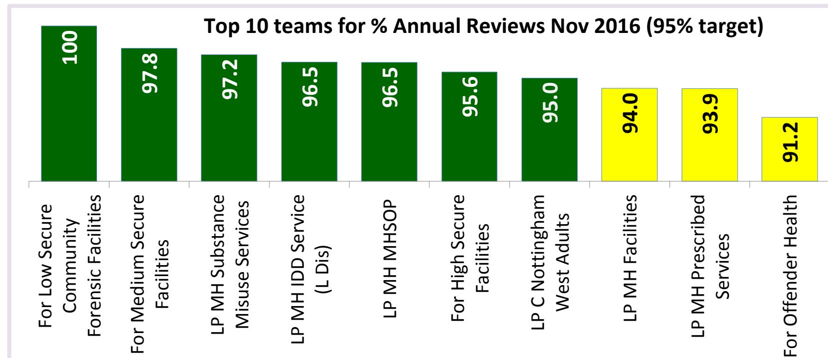


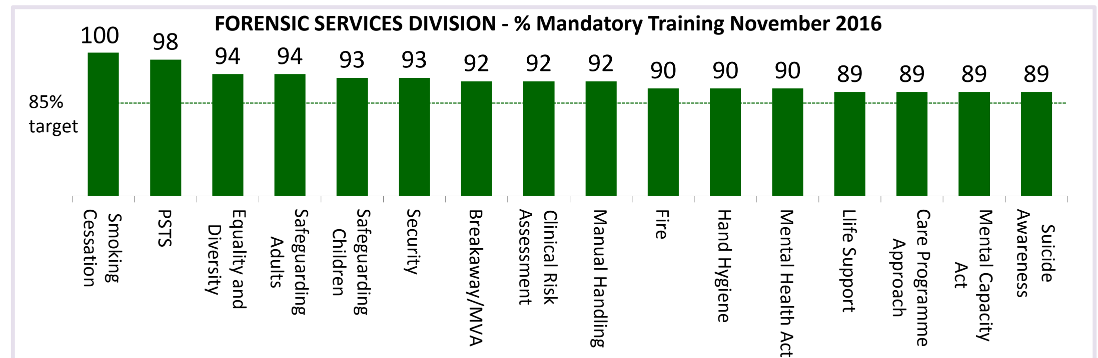
WELL-LED

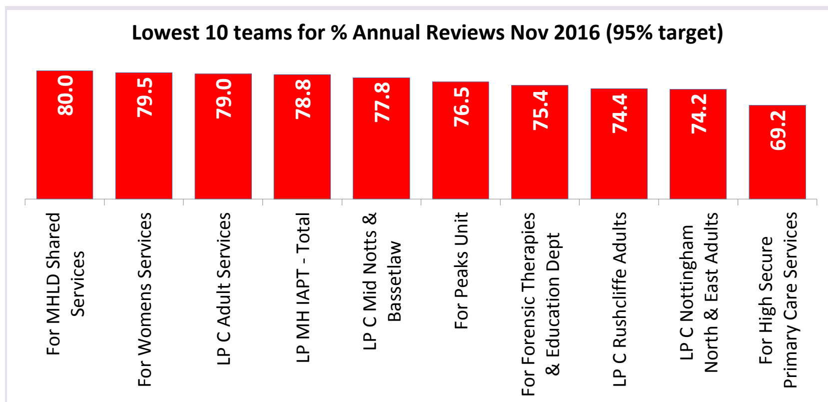
6.2 Learning and Development, Month 8 November 2016/17

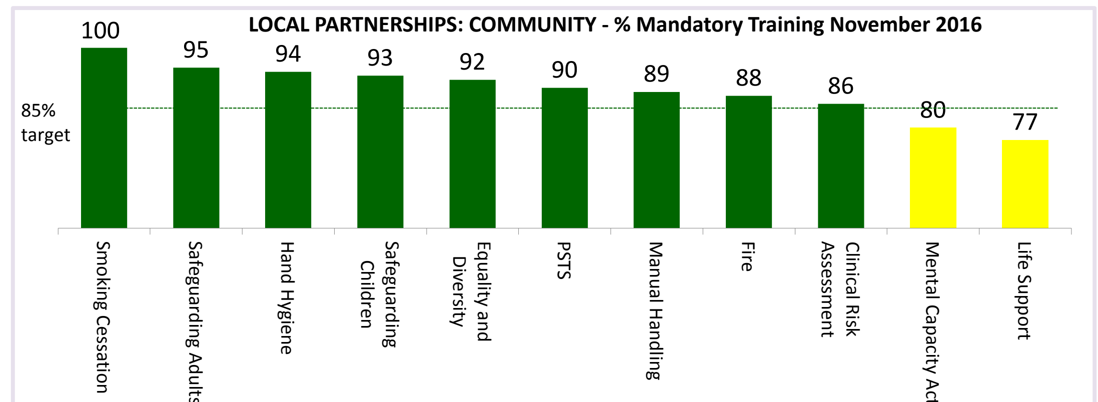
Annual Reviews November 2016 (target 95%)	Trust	Local Partnerships: Mental Health	Forensic Services Division	Local Partnerships: Community
Clinical Non- Registered Staff	85.8%	88.0%	86.6%	82.8%
Clinical Registered Staff	83.7%	85.6%	85.4%	81.2%
Non-Clinical Staff	84.0%	85.7%	90.5%	84.2%
Information Governance training (target 95% end quarter 2 - Trust target)	93.8%	93.0%	94.8%	93.7%











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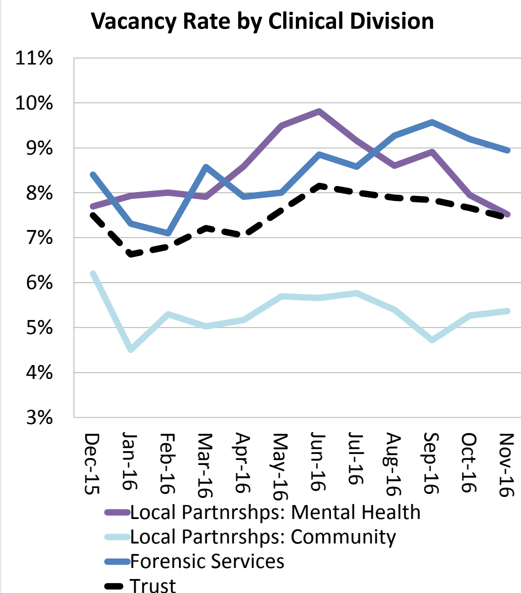
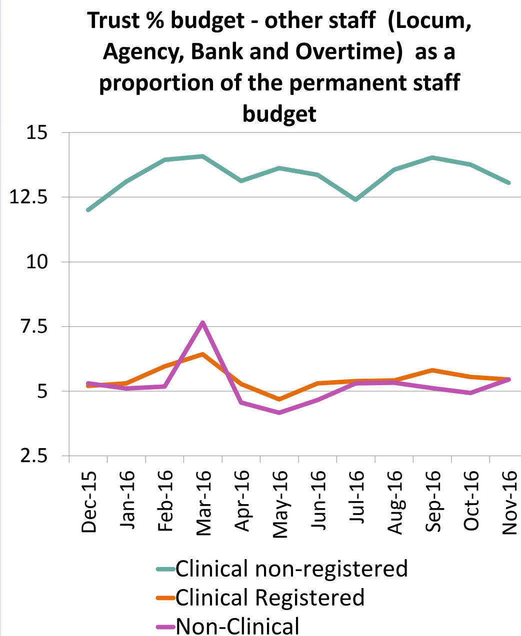
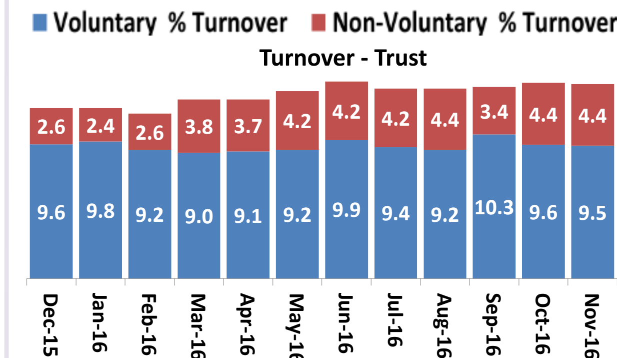
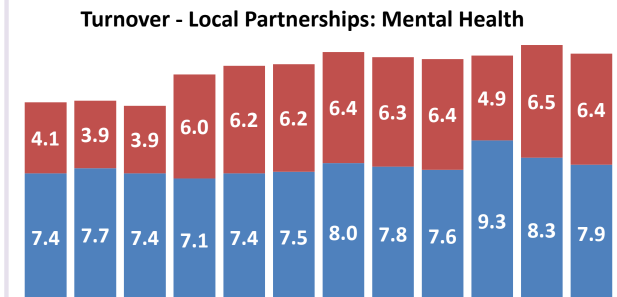
6.3 Staff in Post, Month 8 November 2016/17

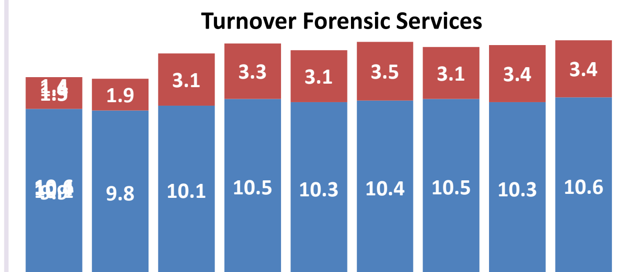
	Trust Target	Trust Year to date	Trust	Forensic Services	Local Partnerships: Mental Health	Local Partnerships: Community	Corporate Services
			Month 8 November 2016/17				
Clinical registered staff							
Vacancy Rate %	tbc	9.8%	9.0%	14.6%	10.5%	4.8%	4.1%
Budget - other staff vs permanent staff (inc bank and agency)	n/a	5.4%	5.5%	9.1%	5.0%	2.9%	1.2%
Budget - Agency vs permanent staff	n/a	2.7%	2.7%	4.7%	1.8%	1.8%	0.0%
Budget - Bank vs permanent staff	n/a	1.5%	1.5%	1.6%	1.9%	0.9%	0.3%
Turnover 12 months rolling %	9 - 11%	n/a	13.8%	17.4%	10.0%	14.6%	10.1%
Clinical non-registered staff							
Vacancy Rate %	tbc	3.1%	3.1%	0.9%	1.1%	5.4%	9.7%
Budget - other staff vs permanent staff (inc bank and agency)	n/a	13.4%	13.1%	16.1%	19.5%	4.1%	3.8%
Budget - Agency vs permanent staff	n/a	0.4%	0.4%	0.2%	0.8%	0.2%	0.0%
Budget - Bank vs permanent staff	n/a	10.6%	10.2%	9.1%	17.8%	3.5%	2.7%
Turnover 12 months rolling %	9 - 11%	n/a	11.2%	9.8%	13.0%	11.3%	15.6%
Non Clinical Staff							
Vacancy Rate %	tbc	8.4%	9.5%	11.5%	10.2%	6.9%	9.4%
Budget - other staff vs permanent staff (inc bank and agency)	n/a	4.9%	5.4%	3.2%	8.5%	3.2%	4.5%
Budget - Agency vs permanent staff	n/a	3.0%	2.8%	2.1%	5.7%	1.2%	2.0%
Budget - Bank vs permanent staff	n/a	1.6%	2.3%	3.8%	1.3%	0.9%	2.7%
Turnover 12 months rolling %	9 - 11%	n/a	16.8%	13.7%	25.5%	14.6%	11.4%

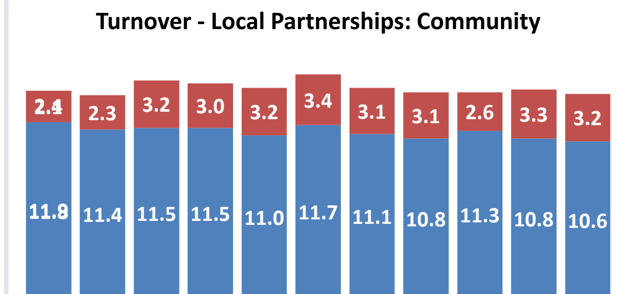












WELL-LED

6.4 Safe Staffing Levels, MONTH 8 November 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 November 2016 the Trust's 69 clinical teams providing in-patient services, 35 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

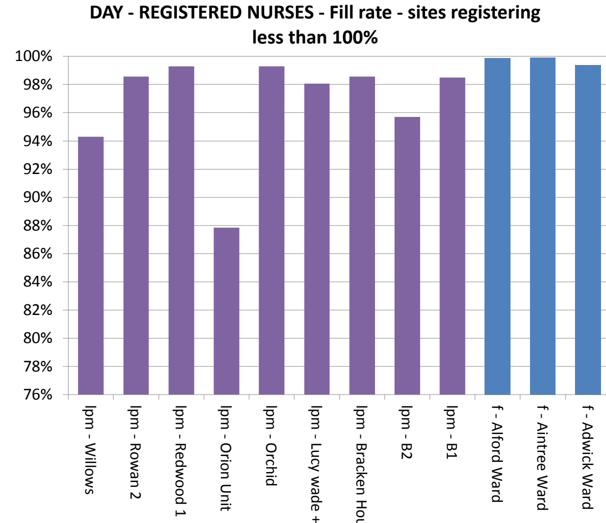
- FORENSIC SERVICES
- LOCAL PARTNERSHIPS: MENTAL HEALTH
- LOCAL PARTNERSHIPS: COMMUNITY

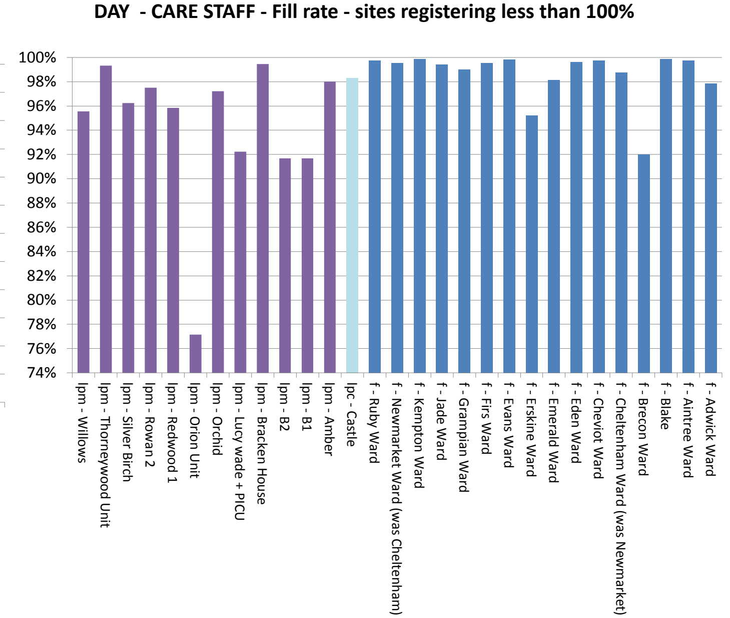
Registered nurses Fill rate - wards reporting an occasion of staffing shortage within the month	Trust Target	Month 8 November Trust Actual	Forensic Services	Local Partnerships: Mental	Local Partnerships: Community
total wards		69	43	20	6
DAY wards registering a shortage	tbc	12	3	9	0
DAY % of wards registering a shortage		17%	7%	45%	0%
NIGHT wards registering a shortage	tbc	5	0	5	0
NIGHT % of wards registering a shortage		7%	0%	25%	0%

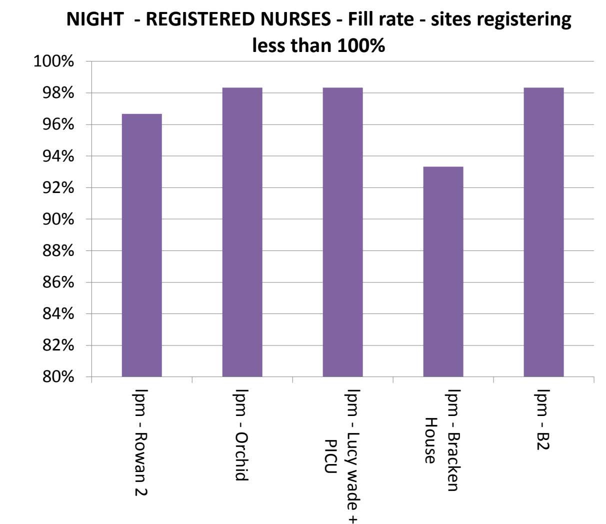
Care staff Fill rate - wards reporting an occasion of staffing shortage within the month	Trust Target	Month 8 November Trust Actual	Forensic Services	Local Partnerships: Mental Health	Local Partnerships: Community
total wards		69	43	20	6
DAY wards registering a shortage	tbc	29	16	12	1
DAY % of wards registering a shortage		42%	37%	60%	17%
NIGHT wards registering a shortage	tbc	13	10	3	0
NIGHT % of wards registering a shortage		19%	23%	15%	0%

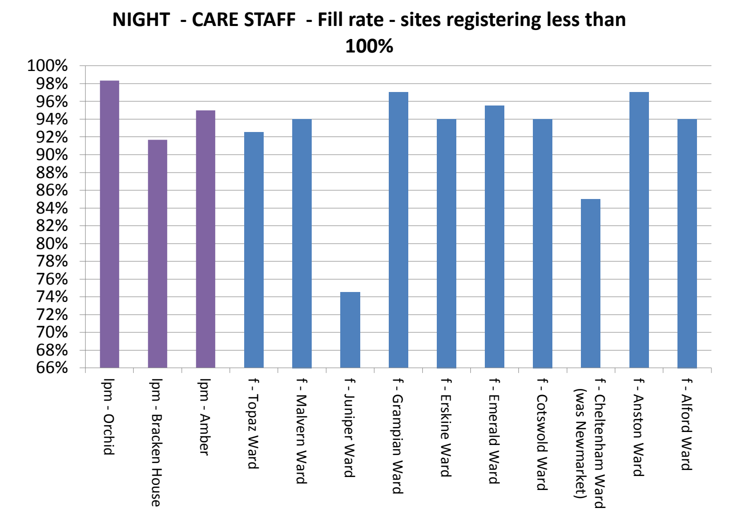
Fill rate - by service

Service	Fill rate
Substance Misuse Services	100.0%
Med Sec Wathwood	100.0%
Child Development	100.0%
Low Secure	100.0%
Med Sec Arnold Lodge	100.0%
Hospices	100.0%
Lings Bar Rehabilitation	99.8%
Child Adolescent Psychiatry	99.8%
High Sec Mntl Health & Learning...	99.2%
High Sec Womens & Pers Disord	99.1%
High Sec PEAKS	99.1%
Mental Health Older People	98.7%
Adult Mental Health	98.1%
Learning Disability	93.9%









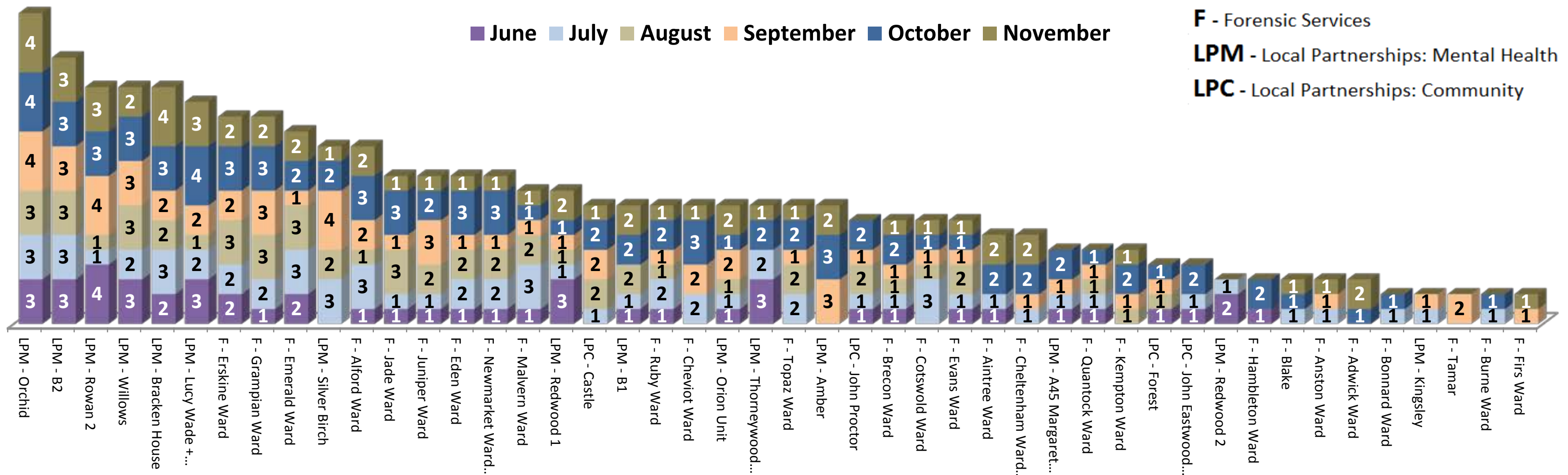
6.5 Safe Staffing Levels - 6 month overview, Month 8 November 2016/17

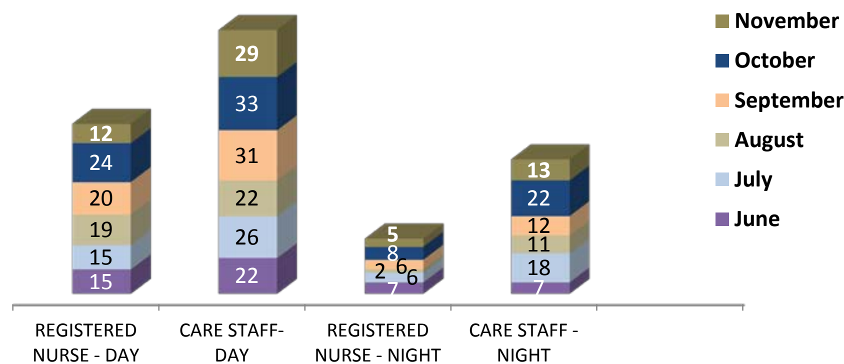
Safe Staffing narrative

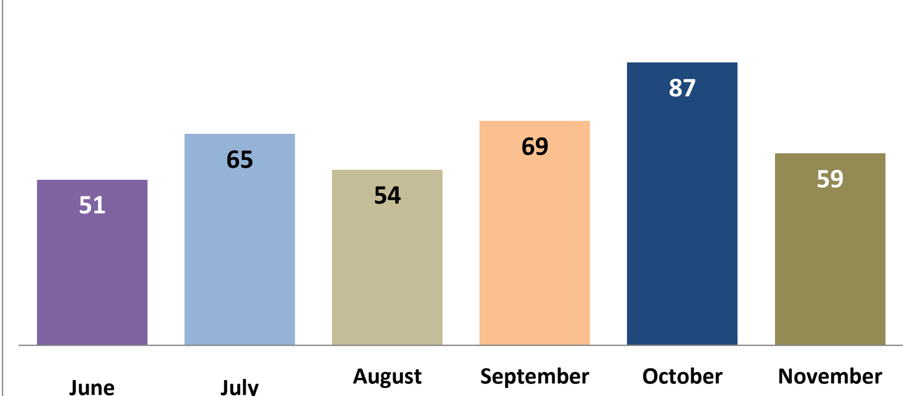
The rate of safe staffing breaches decreased in November 2016; overall the Trust maintains a high level of compliance with the national requirements regarding safe staffing levels, reporting an aggregate for the Trust at over 99% from June to November 2016.

There have been 385 individual team breaches from June to November 2016, with 14 teams reporting 10 or more breaches (i.e. instances of non-achievement of 100% fill rate) within this 6-month period.

The data indicates that the majority of breaches (69.6%) occur in the day, and that care staffing shortages account for 63.9% of the total number of breaches over the period June to November 2016.







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7.0 Cost Improvement Plan (CIP) Assurance Report

MONTH 8 November 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 8 for the period ending 30th November 2016 is as follows:

	Forensic Services	Local Partnerships: Mental Health	Local Partnerships: Community
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 3,145k	Recurrent Savings of 1,565k	Recurrent Savings of 1,975k
	Non-recurrent Savings of 204K	Non-recurrent Savings of 1,282k	Non-recurrent Savings of 312k
	Total Savings of £3,349k	Total Savings of £2,847k	Total Savings of £2,287k
Other Risks to escalate	None	None	None

7.1 Cost Improvement Plan (CIP) Assurance Report - Forensic Services Division - Month 8 2016/17

Report as of 5 December 2016 for Period ending 30 November 2016

REPORT DATE	12-Dec-16
PERIOD ENDING	30-Nov-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	5,143	136
Non Recurrent	96	232	-136
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: There has been no change in CIP delivery in the month. The variance of £136k remains and is down to slippage in the opening of C/D Block and moving to new wards, and also from procurement savings. We are currently covering the slippage non-recurrently from reserves.

YEAR TO DATE FINANCIAL PLAN OVERVIEW (£000)	Plan	Actual	Variance
Recurrent	3,370	3,145	225
Non Recurrent	64	204	-140
TOTAL	3,434	3,349	85

CIP NAME	CIP REF	VALUE (£000)	Quality Impact score November 2016	Quality Impact score October 2016	KPI METRICS	Baseline	Performance as at 30 November 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	19.8 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%	11.1%*			
Review of Pay and Allowances	HS21	629	8	8	Staff Turnover ratio remains above 7%	7%	9.5%	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%	3.7%			

* data collated on a quarterly basis (data for Quarter 2 2016/17)

* It is reported that 34 patients (11.1%) in total did achieve 25 hours of programmed activity. Reasons for non-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 now 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.
The dip in performance for patients with an average of less than 25 hours of completed activity per week is attributed to patients refusing to engage, patients in seclusion/long term segregation and staff shortages on the ward.

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7.2 Cost Improvement Plan (CIP) Assurance Report - Mental Health - Month 8 2016/17

Report as of 9th December 2016 for period ending 30th November 2016

REPORT DATE	09.12.2016
PERIOD ENDING	30.11.16
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	2,524	-1,367
Non Recurrent	1,140	2,507	1,367
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. Aligned with the Directorate Clinical Strategy, Beacon Lodge, (delivered by 3rd sector) 12 beds provides further support to the appropriate use /discharge of inpatients. This is being supported by the role of a Band 4 (non-recurrent monies) embeded into the Bed Managment Team who is proactivley working with the wards to facilitate discharges in a timely manner. This role is enabling service users to overcome issues for example: debt, housing issues etc which are often a reason for delayed discharge. Currently there are 9 guests in Beacon Lodge. AMH's trajectory for the reduction of private bed use is fluctuating due to meeting the demand of acute presentations.

YEAR TO DATE FINANCIAL PLAN OVERVIEW (£000)

	Plan	Actual	Variance
Recurrent	2,173	1,565	-608
Non Recurrent	674	1,282	608
TOTAL	**2,847**	**2,847**	**0**

CIP NAME	CIP REF	VALUE (£000)	Quality impact score Oct 2016	Quality impact score Nov 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 15/16	98% as at 9 March 2015	94.96%	DIV 0000078	AMBER - Units closed	AMBER
					98% of patients/service users to have an appropriate review within the appropriate Care Pathway Review period throughout 15/16	93% as at 9 March 2015	87.27%			
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	380.8%	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	11 new private admissions in October 2016	18 new private admissions in November 2016	360	Red	Red

WELL-LED

7.3 Cost Improvement Plan (CIP) Assurance Report - Community - Month 8 2016/17

REPORT DATE	12-Dec-16
PERIOD ENDING	30-Nov-16
DELIVERABILITY STATUS	
QUALITY IMPACT STATUS	

QUALITY IMPACT	Low/ V Low < 8	Moderate 8-10	High/ Extreme > 10	TOTAL CIP
Number of schemes	22	0	0	22
Value of schemes (£000s)	3,762.0	0	0	3,762.0
% 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 m8)	End of year Variance (m12) Vs Orig Plan	End of year Variance (m12) Vs revised target
Recurrent	2,613	3,480	3,186	573	-294
Non Recurrent	526	282	576	50	294
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 within former Health Partnerships division continue to be reported at low/very low quality impact rating as at last review Programme Management Group (Nov). Eleven schemes have been delivered at end of month 8. Operational delivery - no current concerns (performance, governance) raised via KPIs re quality; actions in progress to support delivery against appraisal target. Agency spend continues to be robustly monitored and is £801k YTD spend, which is £291k below the plan of £1,092k YTD. The external productivity scheme at Bassetlaw continues to progress; initiative being extended within Mid Notts and learning from Bassetlaw shared. 2017/19 planning: schemes submitted for 2017/18 & 2018/19; shortfall to date £1.1m for the former HP element, ongoing development.

STATUS: Finance - Against the annual target of £3,762k, the Health Partnerships division has delivered £3,259k FYE (£3,103k in year value) of recurrent CIP which includes £1,694k of CIP through tenders and £1,565k from in year schemes. YTD CIP of £2,287k has been achieved against the plan of £2,325k. The variation between recurrent and non-recurrent CIP is largely 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. Two schemes have been uplifted in October in Mid Notts and Bassetlaw and both relate to Meridian productivity outputs. These cover the balance against two schemes that will carry forward into 2017/18, one in relation to management structure (deferred whilst Meridian work is completed) and the other regarding the transfer of Newark Hospital wards management to the Trust which has been deferred until next year.

YEAR TO DATE FINANCIAL PLAN OVERVIEW (£000)

	Original Plan	Increased target	Actual	Variance Vs. original plan	Variance Vs. revised target
Recurrent	1,530	2,083	1,975	445	-108
Non Recurrent	0	242	312	312	70
TOTAL	1,530	2,325	2,287	757	-38

8.0 Change Log
Month 8 November 2016/17

Number	Change/ Issue to be addressed	Location in Trust Quality and Performance Report
1.	For all sections of the Board of Directors Quality and Performance Report, all references to the 'Local Services Division' have been amended to 'Local Partnerships Division - Mental Health', and all references to the Health Partnerships Division have been amended to Local Partnerships Division – Community, to reflect the new organisational structure.	Multiple locations

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. NHS Improvement standards are indicated by 'Operational Performance'.

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

Indicator Origin	Indicator Origin Reference
Trust Internal	Tr
NHS Improvement	Number on SOF 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 described in the 'Data Quality Rating Comments' in the glossary below.

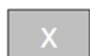
PERFORMANCE TARGETS

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.

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 Framework* 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.

<table>
<tr><td colspan="2">Indicator Reference: Quality & Performance Report Reference Number – each indicator has a unique identifier.</td></tr>
<tr><td colspan="2">Indicator Title (Board Report): Title as it appears in the Quality & Performance Report.</td></tr>
<tr><td colspan="2">Indicator Title (External): Title as it appears on external source documents, such as Single Oversight Framework (SOF) documentation.</td></tr>
<tr><td colspan="2">Indicator Description: A description of the indicator. Uses external description where appropriate.</td></tr>
<tr><td>CQC Domain: Name of the CQC/SOF Domain the indicator is grouped in.</td><td>Indicator Origin: Regulator, Other External source e.g. commissioner, or Internal Trust indicator.: The name of the indicator origin such as NHS Improvement.</td></tr>
<tr><td colspan="2">Numerator/Value: If a single number value, definition here.
If a %, numerator definition/description. Use standard external definitions if possible.</td></tr>
<tr><td colspan="2">Denominator: If a %, denominator definition/description, otherwise blank. Use standard external definitions if possible.</td></tr>
<tr><td colspan="2">RAG Rating: Red: Threshold for Red Amber: Threshold for Amber Green: Threshold for Green</td></tr>
<tr><td colspan="2">Data Quality Rating: Overall rating given to the indicator. Consists of an aggregation of 5 different dimensions.</td></tr>
<tr><td colspan="2">Data Quality Rating Comments: Comments on any of the rating elements or overall rating and actions to mitigate any issues.</td></tr>
</table>

<table>
<tr><td colspan="2">Indicator Reference: C-1-Tr</td></tr>
<tr><td colspan="2">Indicator Title (Board Report): Friends and Family Test scores.</td></tr>
<tr><td colspan="2">Indicator Title (External): Friends and Family Test scores.</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>CQC Domain: Caring</td><td>Indicator Origin: Department of Health: NHS England</td></tr>
<tr><td colspan="2">Numerator/Value: The number of patients who are ‘extremely likely’ or ‘likely’ to recommend a service.</td></tr>
<tr><td colspan="2">Denominator: Total number of patients completing the Friends and Family Test.</td></tr>
<tr><td colspan="2">RAG Rating: 6 month average</td></tr>
<tr><td colspan="2">Data Quality Rating: Significant Assurance (to be re-confirmed following change in calculation methodology)</td></tr>
<tr><td colspan="2">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.</td></tr>
</table>

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%;>12% Amber: 8-9%;11-12% Green: 9-11%	
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: S-5-Tr	
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:** Internal
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: None.	

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: 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: R-6-Tr	
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.	
CQC Domain: Access	**Indicator Origin:** Internal
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 V: scrutiny has improved significantly at local levels.	

Indicator Reference: 20	
Indicator Title (Board Report): Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams.	
Indicator Title (External): Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards (UNIFY2 and MHSDS)	
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: Operational Performance	**Indicator Origin:** Regulator: NHS Improvement
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: Red: <95% Amber: N/A Green: ≥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: 21	
Indicator Title (Board Report): People with a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral.	
Indicator Title (External): People with a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral (UNIFY2 and MHSDS)	
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: Operational Performance	**Indicator Origin:** Regulator: NHS Improvement
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: Red: <50% Amber: N/A Green: ≥50%	
Data Quality Rating: Limited Assurance	
Data Quality Rating Comments: C & Ac: We have significant assurance in the data flowing from our systems. We have limited assurance on meeting the full requirements of the standard as we currently only capture for ages 18-35 (traditional EIP teams). We are working with Commissioners on investment and service reconfiguration that will therefore allow us to capture the full dataset for the standard.	

Indicator Reference: 25	
Indicator Title (Board Report): Complete and valid Identifiers data in the monthly Mental Health Services Data Set submissions.	
Indicator Title (External): Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: - Identifier metrics (NHS Number, date of birth, postcode, gender, registered GP, commissioner)	
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: Operational Performance	**Indicator Origin:** Regulator: NHS Improvement
Numerator/Value: Count of valid entries for each of the data items	
Denominator: Total number of entries	
RAG Rating: Red: <95% Amber: N/A Green: ≥95%	
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 in Mar-Apr 16 - result was Significant Assurance.	

Indicator Reference: 27	
Indicator Title (Board Report): Improving Access to Psychological Therapies (IAPT)/talking therapies: - Proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	
Indicator Title (External): IAPT – The proportion of people who complete treatment who are moving to recovery.	
Indicator Description: Percentage of patients who have completed their treatment whose outcome score undertaken at the point of discharge demonstrates they are moving towards recovery.	
CQC Domain: Operational Performance	**Indicator Origin:** Regulator: NHS Improvement
Numerator/Value: The number of patients in the reporting period whose outcome score at point of discharge demonstrates they are moving towards recovery.	
Denominator: The number of patients who have been discharged from the service in the reporting period.	
RAG Rating: Red: <50% Amber: N/A Green: ≥50%	
Data Quality Rating: Significant Assurance	
Data Quality Rating Comments: T: On occasions small number of late date entries.	

Indicator Reference: 28	
Indicator Title (Board Report): IAPT/talking therapies - Waiting time to begin treatment within 6 weeks	
Indicator Title (External): Improving Access to Psychological Therapies (IAPT)/talking therapies: - Waiting time to begin treatment (from IAPT minimum dataset) within 6 weeks	
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: Operational Performance	**Indicator Origin:** Regulator: NHS Improvement
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: Red: <75% Amber: N/A Green: ≥75%	
Data Quality Rating: Limited Assurance	
Data Quality Rating Comments: Ac & Au: Audit in Apr 16 raised issues around data accuracy with some follow up actions to be carried out.	

Indicator Reference: 29	
Indicator Title (Board Report): IAPT/talking therapies - Waiting time to begin treatment within 18 weeks	
Indicator Title (External): Improving Access to Psychological Therapies (IAPT)/talking therapies: - Waiting time to begin treatment (from IAPT minimum dataset) within 18 weeks	
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: Operational Performance	**Indicator Origin:** Regulator: NHS Improvement
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: Red: <95% Amber: N/A Green: ≥95%	
Data Quality Rating: Limited Assurance	
Data Quality Rating Comments: Ac & Au: Audit in Apr 16 raised issues around data accuracy with some follow up actions to be carried out.	