Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 28 June 2017

Title and Author of Paper: Integrated Commissioning & Quality Assurance Report **(Month 2 May 2017)** – Anna Foster, Deputy Director of Commissioning & Quality Assurance

Executive Lead: Lisa Quinn, Executive Director of Commissioning & Quality Assurance

Paper for Debate, Decision or Information: Information & Debate

Key Points to Note:

- Following assessment against the Single Oversight Framework (SOF) by NHS Improvement, the Trust has improved from segment 2 (targeted support) to segment 1 (maximum autonomy). This change in segment is based on the Trust not triggering any of the metrics in the Single Oversight Framework and the general confidence of NHS Improvement in the goverance of the organisation. (page 4).
- At Month 2, the Trust has a year to date surplus of £0.5m which is £0.2m less than plan and equates to a finance and use of resources score of 2 (this is a sub theme of the Single Oversight Framework). The Trust needs to continue to improve its underlying financial position to achieve this years control totals. The main financial pressures during the month were staffing pressures in CYPS Inpatient and LD transformation and income being less than plan in Specialist Care. See pages 20-21
- There are a number of contract requirements largely relating to CPA metrics which were not achieved across local CCGs during month 2 with only South Tyneside and NHS England achieving fully. (page 16)
- All CQUINs are internally assessed as forecast to be achieved at the end of Quarter 1 (page 17)
- Four of the five quality priorities are forecast to be achieved in quarter 1, whilst waiting times remains RAG rated as amber. (page 23)
- The Accountability Framework for each group is currently forecast as 4 due to the continuing underperformance in each group against a number of quality metrics. (p24)
- Reported appraisal rates have remained static in the month at 78.9% (p22)
- The in month sickness absence rate has increased to 4.71% in the month. The 12 month rolling average sickness rate has decreased to 5.34%. (p22)
- Training rates have continued to see most courses above the required standard. The only course more than 5% below the required standard is PMVA Basic Training (77.9% was 76.2% last month). (p22)
- The service user and carer FFT recommended score was 84% in May which was lower than the 88% achieved in April. (page 27)

Risks Highlighted: NHS Improvement Single Oversight Framework

Does this affect any Board Assurance Framework/Corporate Risks: No

Equal Opportunities, Legal and Other Implications: none

Outcome Required / Recommendations: for information only

Link to Policies and Strategies: NHS Improvement – Single Oversight Framework, 2017/18 NHS Standard Contract, 2017-19 Planning Guidance and standard contract, 2017-18 Accountability Framework

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

NTW Integrated Commissioning & Quality Assurance Report

2017-18 Month 2 (May 2017)

Contents:

NHS Improvement Risk Assessment Framework:		1	The Trust's assigned shadow segment under the Single Oversight Framework has improved from "2" (targeted support) to segment "1" (maximum autonomy)

Quality Priorities:	Quarter 1 achieved:	Quarter 1 part achieved:	Quarter 1 not achieved	In total there are five quality priorities identified for 2017-18 and at month 2 four are forecast to be achieved whilst the waiting times quality priority is currently rated as amber.
	4	1	0	

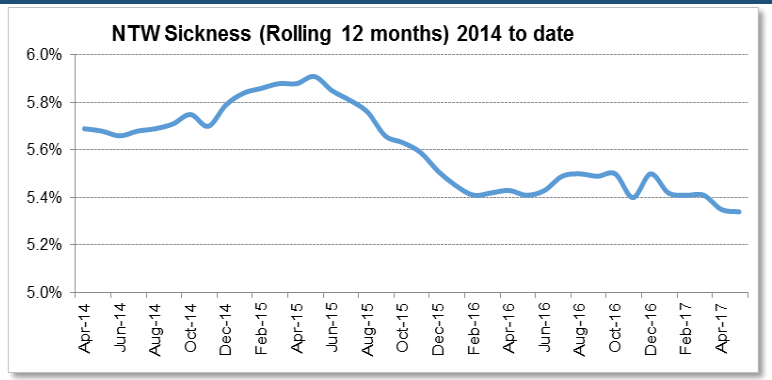
CQUIN:	Quarter 1 forecast achieved:	Quarter 1 forecast part achieved:	There are a total of ten CQUIN schemes in 2017-18 across local CCGs and NHS England commissioned services. All have been internally assessed as forecast to be achieved in the quarter.
	10	0	

Workforce:

Statutory & Essential Training:

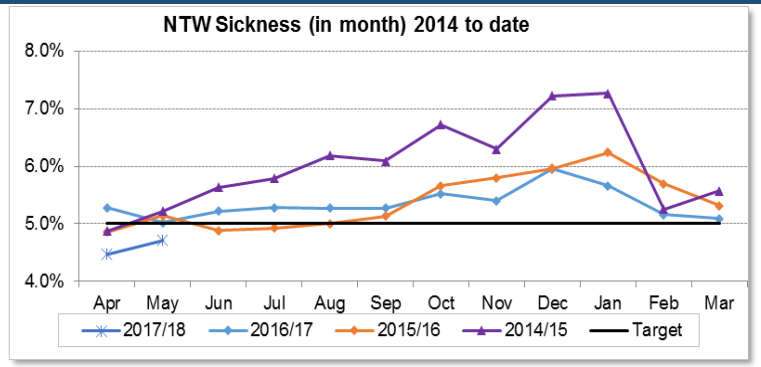
Standard Achieved Trustwide:	Performance <5% below standard Trustwide:	Standard not achieved (>5% below standard):	Clinical Supervision training (82.0%), Mental Capacity Act/ Mental Health Act/ DOLS Combined training (84.9%) and Information Governance training (91.5%) are within 5% of the required standard, PMVA Basic training is more than 5% below the standard at 77.9% Trustwide.	**Appraisals:** Appraisal rates have remained the same at 78.9% in May 17 (was 78.9% last month).
14	4	1		

Sickness Absence:



The "in month" sickness absence rate is below the 5% target at 4.71% in May 2017

The rolling 12 month sickness average has decreased to 5.34% in the month



Finance:

At Month 2, the Trust has a year to date surplus of £0.5m which is £0.2m less than plan. Pay spend at Month 2 was £41.6m which is £0.3m higher than plan and includes £1.5m agency spend which is £0.1m under the planned trajectory to hit our agency ceiling of £8.6m.

The Trust is forecasting to meet its control total of £7.1m by delivering a surplus before Sustainability and Transformation Fund (STF) funding of £5.2m and receiving its STF funding of £1.9m. The Trust's finance and use of resources score is currently a 2 (this is a sub theme of the Single Oversight Framework) and the forecast year-end risk rating is also a 2.

The main financial pressures at Month 2 are staffing pressures in CYPS inpatients & Learning Disabilities transformation and income being less than plan in Specialist Care. The Trust needs to reduce pay spend down to planned levels to improve the underlying financial position and to achieve this year's control total.

To achieve this, spending on temporary staffing (agency, bank and overtime) needs to continue to reduce to reduce staffing levels to budgeted establishments. Work is ongoing to reduce overspends across the main pressure areas and savings schemes continue to be developed/implemented.

Contract Summaries:

NHS England	Northumberland & North Tyneside CCGs	Newcastle / Gateshead CCG	South Tyneside CCG	Sunderland CCG	Durham, Darlington & Tees CCGs	Cumbria CCG
100% of metrics achieved in the month	90% of metrics achieved in the month	90% of metrics achieved in the month	100% of metrics achieved in the month	86% of metrics achieved in the month	71% of metrics achieved in the month	63% of metrics achieved in the month
The areas of under performance relate mainly to CPA metrics						

2. Compliance

a) NHS Improvement Single Oversight Framework

Self assessment as at month 2 against the "operational performance" metrics included within the Single Oversight Framework:

Metric Id	Metrics: (nb concerns will be triggered by failure to achieve standard in more than 2 consecutive months)	Frequency	Source	Standard	Quarter 1 to date self assessment	NTW % as per most recently published MHSDS/RTT/EIP/IAPT data	National % from most recently published MHSDS data	Comments. NB those classed as "NEW" were not included in the previous framework	Data Quality Kite Mark Assessment
80	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	Monthly	UNIFY2 and MHSDS	92%	100%	99%	90.30%	National data includes all NHS providers and is at March 2017	
31	Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards	Quarterly	UNIFY2 and MHSDS	95%	100.0%	100%	98.80%	National data includes all NHS providers and is at March 2017	
1400	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	Quarterly	UNIFY2 and MHSDS	50%	83.9%	74%	63.00%	Published data is as at March 2017	
	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:								
1426	a) inpatient wards	Quarterly	Provider return / CQUIN audit	90%	88%	no data	no data	from weekly sheet 07.06.17	
1427	b) early intervention in psychosis services	Quarterly	Provider return / CQUIN audit	90%	91%	no data	no data	from weekly sheet 07.06.17	
1425	c) community mental health services (people on Care Programme Approach)	Quarterly	Provider return / CQUIN audit	65%	84%	no data	no data	from weekly sheet 07.06.17	
	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital:								
	· identifier metrics:								
238	NHS Number	Monthly	MHSDS	95%	99.9%	99.0%	99.0%	National data includes all NHS providers and is at February 2017	
240	Date of Birth	Monthly	MHSDS	95%	100.0%	100.0%	100.0%	National data includes all NHS providers and is at February 2017	
239	Postcode	Monthly	MHSDS	95%	99.7%	99.0%	99.0%	National data includes all NHS providers and is at February 2017	
241	Current Gender	Monthly	MHSDS	95%	99.9%	100.0%	100.0%	National data includes all NHS providers and is at February 2017	
242	GP code	Monthly	MHSDS	95%	99.7%	99.0%	98.0%	National data includes all NHS providers and is at February 2017	
243	CCG code	Monthly	MHSDS	95%	99.4%	99.0%	99.0%	National data includes all NHS providers and is at February 2017	
	· priority metrics:								
17	ethnicity	Monthly	MHSDS	85% by 16/17 year end	92.7%	94.00%	83.0%	NEW. Data from metric 17 in dashboard.	
27	Employment status recorded	Monthly	MHSDS	85% by 16/17 year end	93.8%	28.9%	32.8%	The 93.8% reported internally is based on patients on CPA for 12 months with status recorded in the last 12 months. MHSDS uses different methodology to calculate recording of employment status. NTW is above the national average, both of which are significantly below the 85% standard required by NHSI	
3	Proportion of patients in employment	Monthly	MHSDS		7.0%	6.7%	8.1%	MHSDS methodology TBC	
28	Accommodation status recorded	Monthly	MHSDS	85% by 16/17 year end- unclear if standard applies to recording status or proportion	93.6%	28.2%	37.9%	The 93.6% reported internally is based on patients on CPA for 12 months with status recorded in the last 12 months. MHSDS uses different methodology to calculate recording of employment status. NTW is below the national average, both of which are significantly below the 85% standard required by NHSI	
29	Proportion of patients in settled accommodation	Monthly	MHSDS		77.1%	50.3%	58.8%		
	Improving Access to Psychological Therapies (IAPT)/talking therapies							(Sunderland service only)	
1079	· proportion of people completing treatment who move to recovery	Quarterly	IAPT minimum dataset	50%	50.0%	57.0%	51.1%	NEW metric 1079 published data February 2017	
	· waiting time to begin treatment :								
1349	- within 6 weeks	Quarterly	IAPT minimum dataset	75%	100.0%	100.0%	89.3%	published data February 2017	
1348	- within 18 weeks	Quarterly	IAPT minimum dataset	95%	100.0%	100.0%	98.7%	published data February 2017	

NHS Improvement Single Oversight Framework & Model Hospital Portal

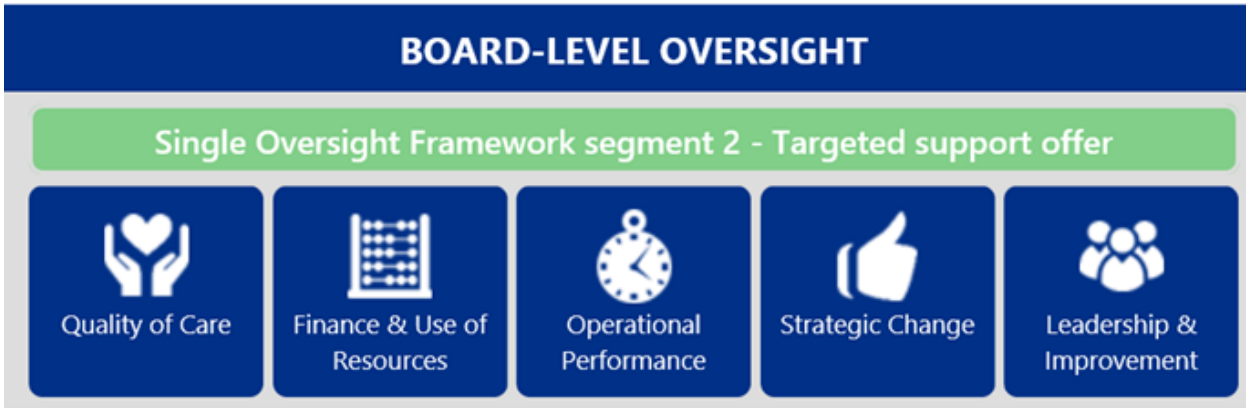
As at the end of May 2017, the Trust has improved from segment 2 to segment 1 within the Single Oversight Framework as assessed by NHS Improvement. This change in segment is based on the Trust not triggering any of the metrics in the Single Oversight Framework and the general confidence in the goverance of the organisation.

NHS Improvement have published the data that has led to this assessment. This data is available via the Model Hospital portal.

The Model Hospital portal aims to provide a nationally available performance information system relating to metrics of productivity, efficiency and quality of care.

The portal uses a combination of nationally available data and data collected from Trusts to support Trusts in developing a greater understanding of their performance and how they compare nationally. It allows Trusts to easily access their data compared to others and offers a dynamic and interactive platform to benchmark performance, with the ability to choose a bespoke peer group.

Data held within the portal currently relates to metrics included within the Single Oversight Framework, broken down as follows:



Due to the volume of data included within the portal a summary of each of the above themes is being considered in turn over a three month period, as follows:

May 2017	Quality of Care
June 2017	Operational Performance
July 2017	Finance & Use of Resources plus Leadership & Improvement

(nb there is currently no data reported in relation to strategic change)

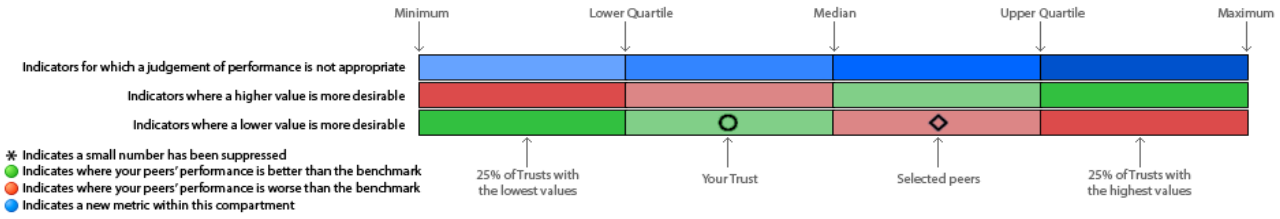
Single Oversight Framework comparative data – Operational Performance:

The chart below shows NTW performance against key performance metrics and with the exception of EIP waits, NTW are consistently above the national average:

Mental Health Services Data Set	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
MHSDS - Accommodation status (adults)	Dec 2016	40%	0%	35%			
MHSDS - Commissioner org code	Oct 2016	100%	0%	98%			
MHSDS - Date of Birth	Oct 2016	100%	0%	100%			
MHSDS - Employment status (adults)	Dec 2016	41%	0%	34%			
MHSDS - Ethnicity	Oct 2016	94%	0%	81%			
MHSDS - Current gender	Oct 2016	100%	0%	100%			
MHSDS - Registered GP org code	Oct 2016	99%	0%	98%			
MHSDS - NHS number	Oct 2016	100%	0%	98%			
MHSDS - Postcode	Oct 2016	99%	0%	97%			

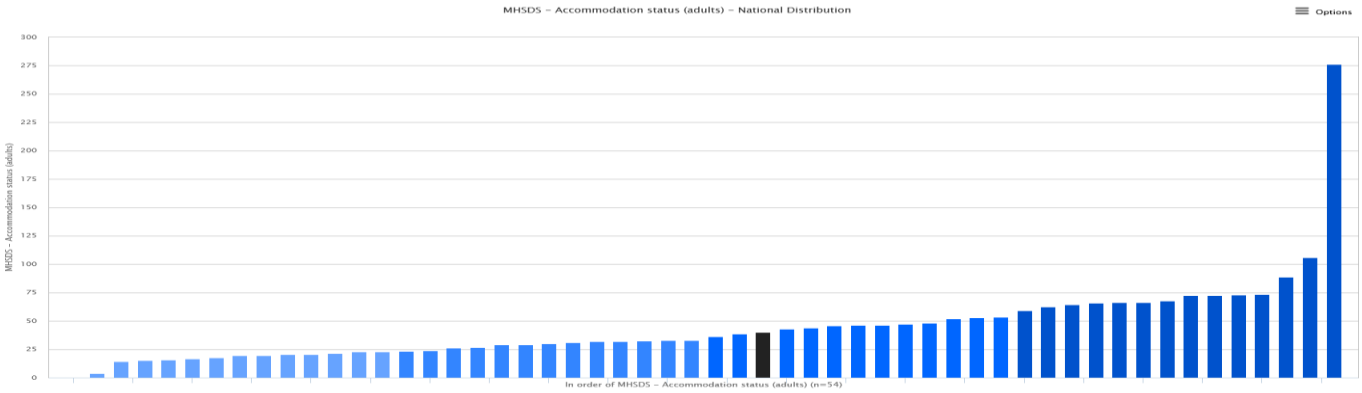
Community Mental Health Team	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Patients requiring acute care who received best practice gatekeeping assessment	Q3 2016/17	100%	0%	99%			

Early Intervention psychosis waits	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
EIP - first episode treatment within 2 weeks of referral	Jan 2017	74%	0%	78%			

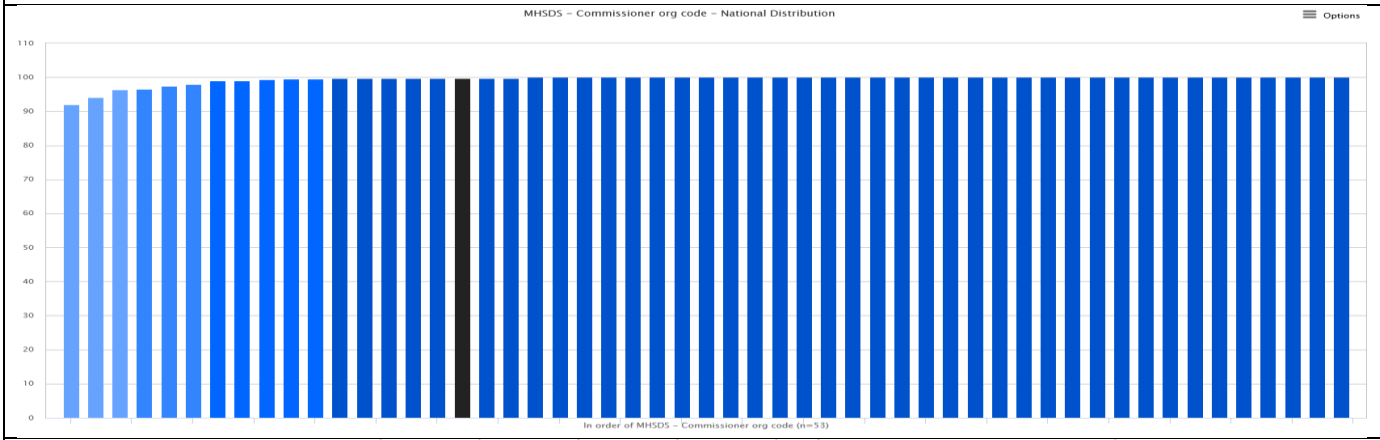


National Metrics (MH providers only)	NTW performance

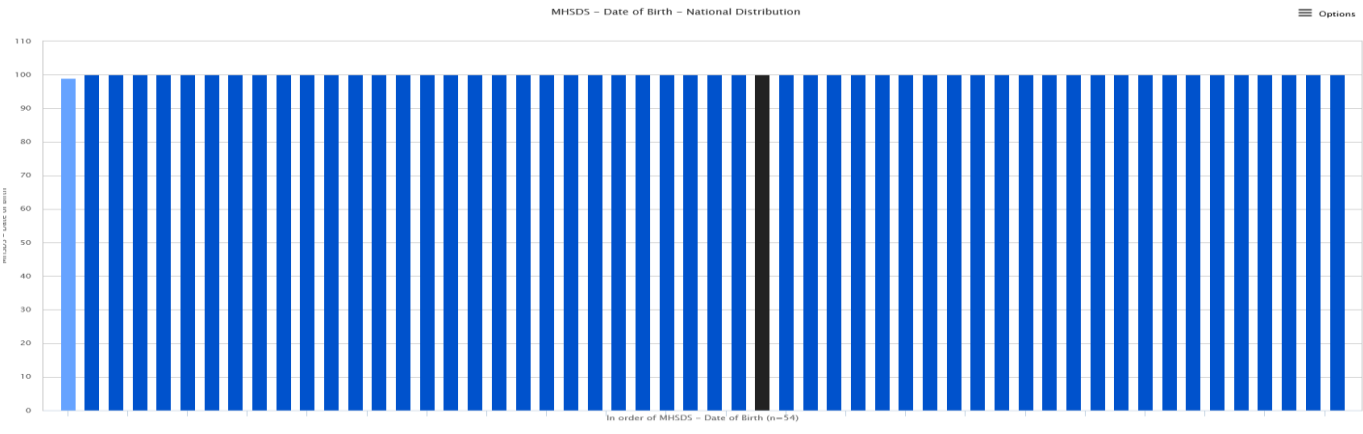
Mental Health Services Data Set	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
MHSDS - Accommodation status (adults)	Dec 2016	40%	0%	35%			



Mental Health Services Data Set	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
MHSDS - Commissioner org code	Oct 2016	100%	0%	98%			

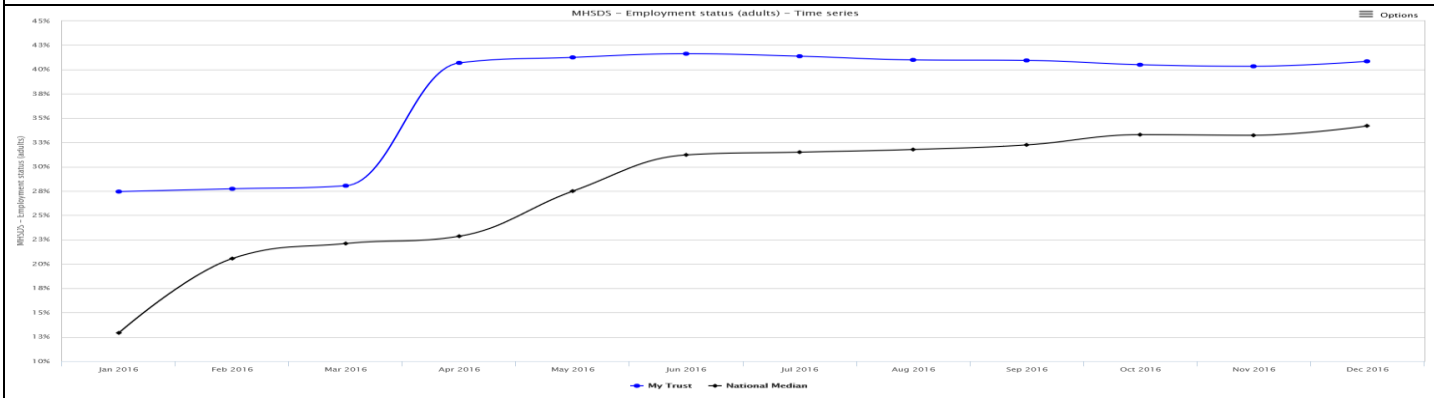


Mental Health Services Data Set	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
MHSDS - Date of Birth	Oct 2016	100%	0%	100%			

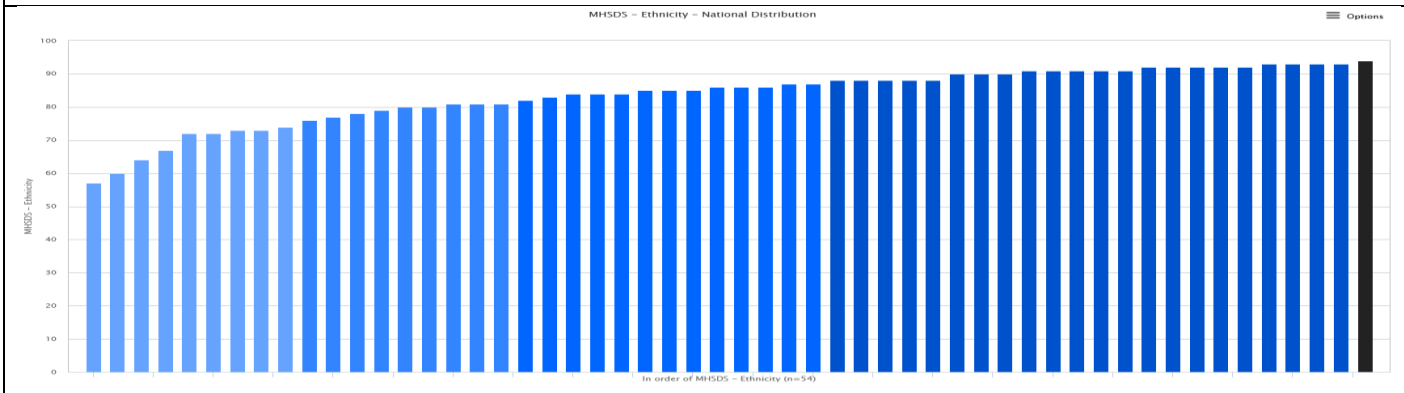


National Metrics (MH providers only)	NTW performance

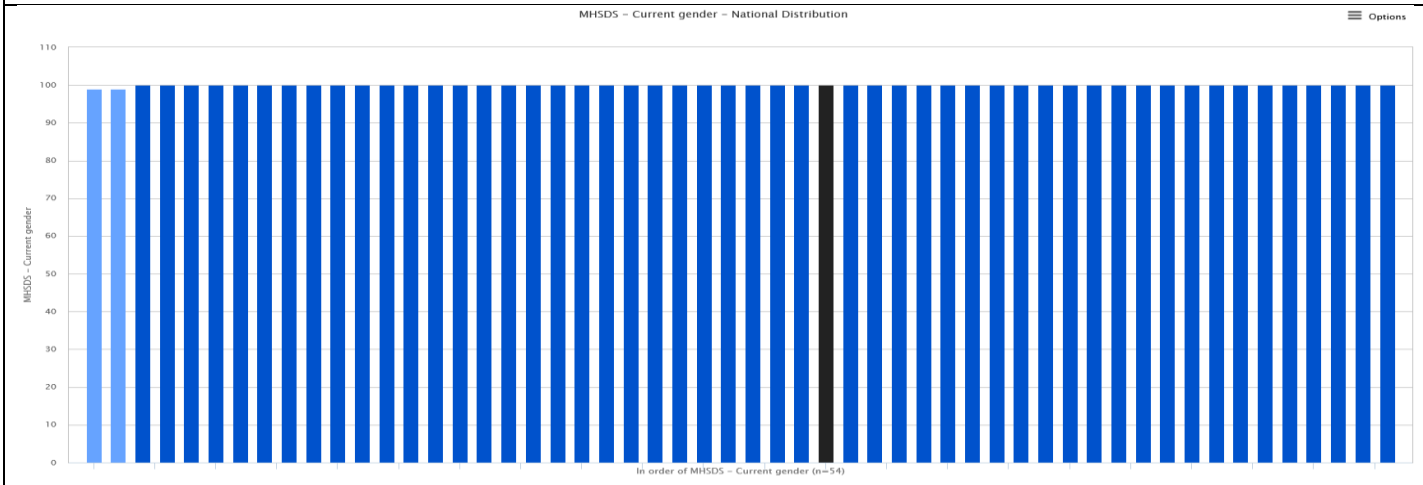
Mental Health Services Data Set	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
MHSDS - Employment status (adults)	Dec 2016	41%	0%	34%			



Mental Health Services Data Set	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
MHSDS - Ethnicity	Oct 2016	94%	0%	81%			

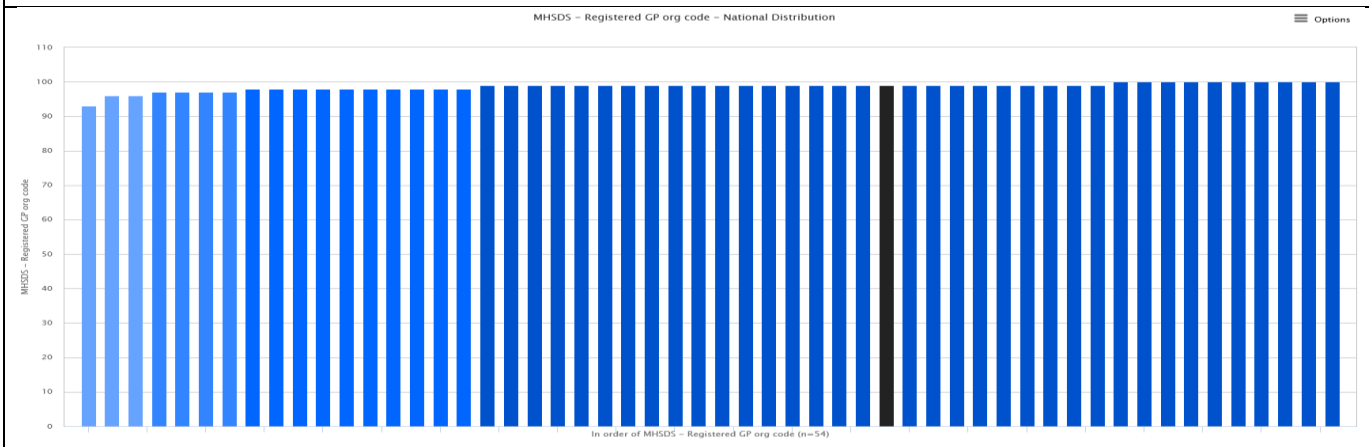


Mental Health Services Data Set	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
MHSDS - Current gender	Oct 2016	100%	0%	100%			



National Metrics (MH providers only)	NTW performance

Mental Health Services Data Set	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
MHSDS - Registered GP org code	Oct 2016	99%	0%	98%			



Mental Health Services Data Set	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
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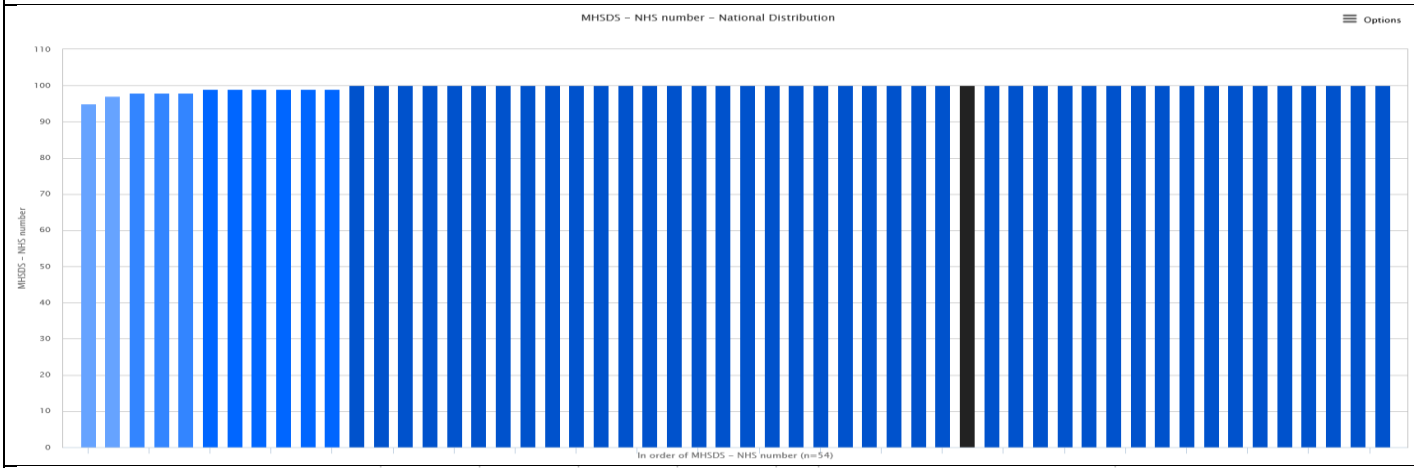
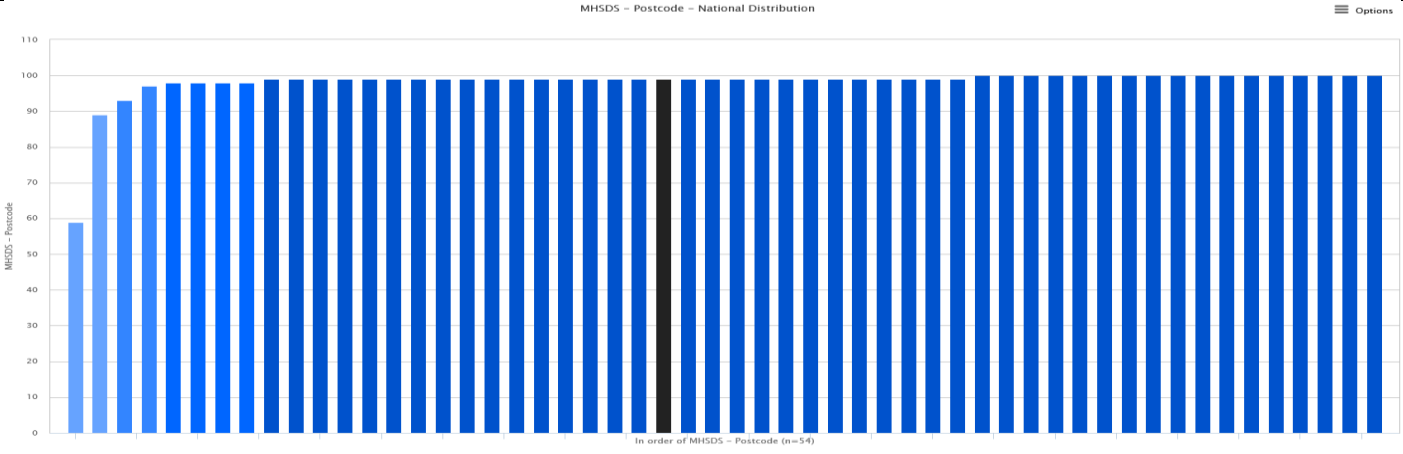


Mental Health Services Data Set	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
MHSDS - Postcode	Oct 2016	99%	0%	97%			



National Metrics (MH providers only)	NTW performance

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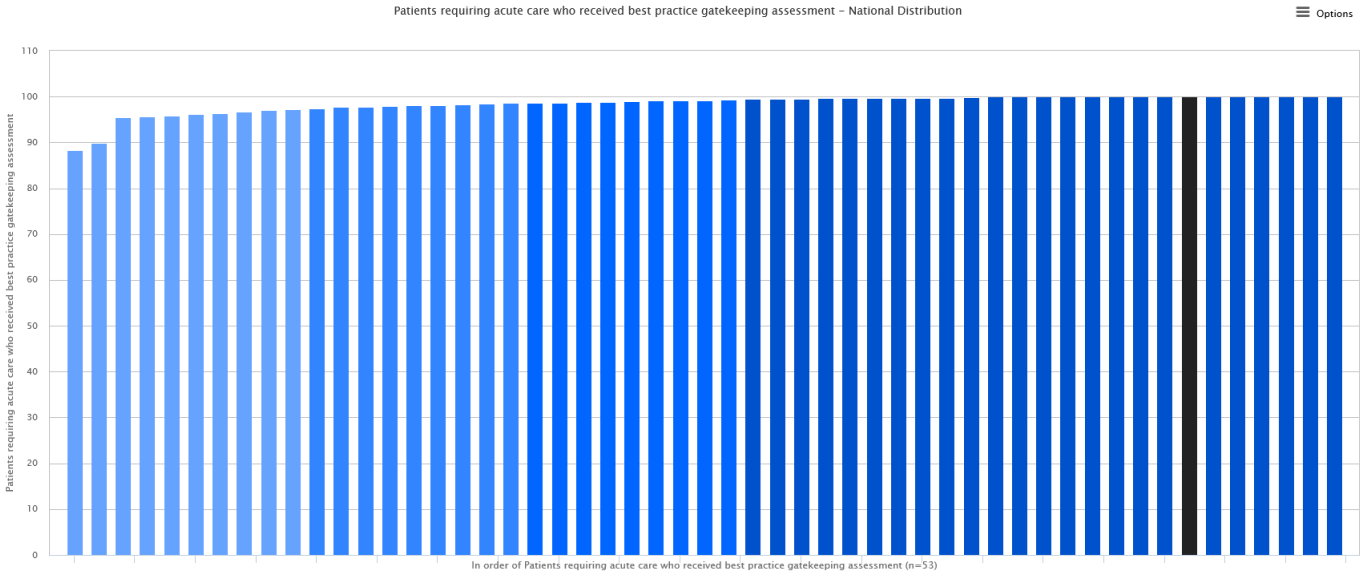
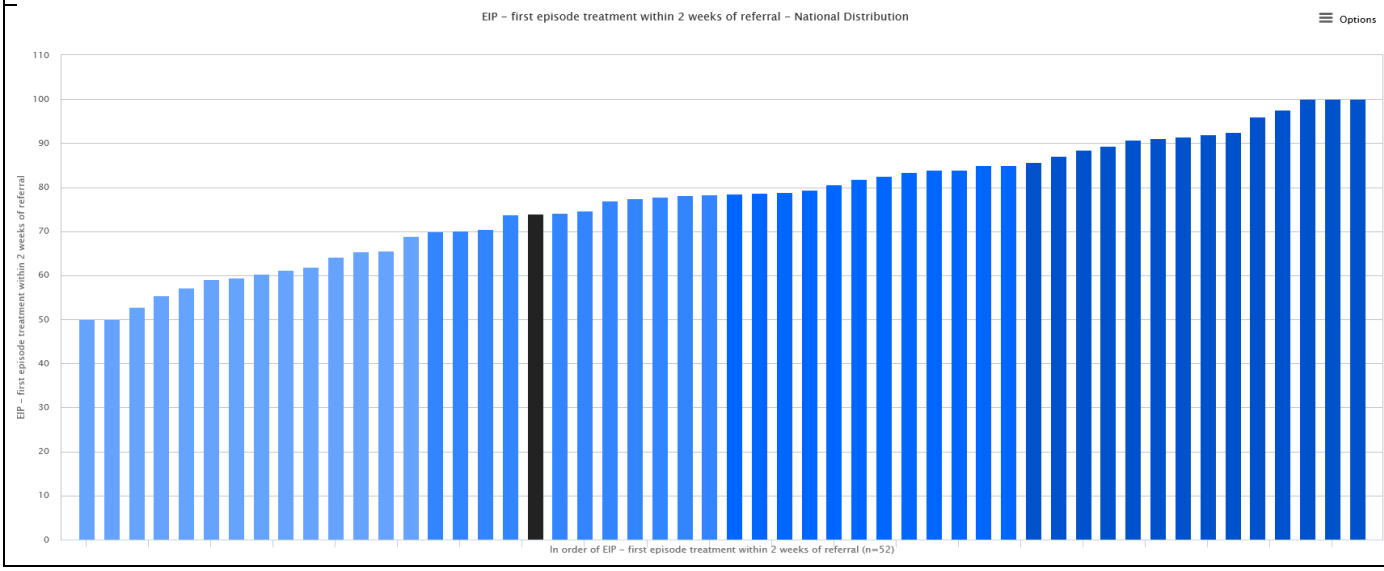


Early Intervention psychosis waits	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
EIP - first episode treatment within 2 weeks of referral	Jan 2017	74%	0%	78%			



Compliance

2. Compliance

b) CQC Update May 2017

CQC Comprehensive Inspection update

An update of progress towards the two formal actiona plans has been provided separately to CDT/Trust Board, highlighted completed an ongoing actions as follows:

1. The CQC “must do” action plan relating to the use of Mechanical Restraint Equipment (MRE) within inpatient services for Children and Young People:
    - The Positive and Safe strategy has been implemented within inpatient wards for children and young people, encompassing the implementation of “Talk First” approaches, the provision of training for staff and the development of a dashboard to provide patient level data relating to safer care.
    - A review of this data as at May 2017, comparing data from 2015-16 with 2016-17, highlights decreases in restraint, prone restraint, the use of mechanical restraint, seclusion, violence and aggression and staff assaults. There has been an increase in instances of self harming behaviour with no or minor harm impact, potentially linked to a planned increase in the use of a psychology informed approach, broadly providing the young person a greater level of individual control of how they manage how they feel.
    - Separate papers have been provided to the Trust Board with regards to potential reprovision options for the adolescent medium secure inpatient service.
2. The CQC “must do” action plan in relation to the personalisation of care plan in wards for older people with mental health problems:
    - A detailed action plan was developed in response to the CQC findings and all identified actions have been completed.
    - A re-audit of care plans, conducted in April 2017, found improvements in the majority of areas and also identified some areas for continuing improvements (in particular in relation to the evaluation of care plans and documentation relating to the sharing of copies of care plans with patients and carers).
    - These identified issues have been raised with ward managers and included within ward action plans. Clinical Managers will monitor these ward action plans and conduct a re-audit of these areas in September 2017.

- CQC have recently revisited Alnwood and a further discussion on this matter is due to take place with the Chief Executive and Executive Director of Commissioning & Quality Assurance.

- The CQC monthly monitoring submissions continue to be submitted to the CQC.

Registration notifications made in the month:

None this month

Mental Health Act Reviewer visits in the month:

Lamesley Ward on 3rd May 2017

This was an unannounced scheduled visit by a Mental Health Act reviewer. During the visit the reviewer spoke to seven detained patients. One patient chose not to meet or complete a patient engagement form and two patients were off the ward on leave.

Findings:

- Inconsistency giving patients their rights
- Patients don't have access to a bedroom door key
- Medication levels
- SOAD visits

All actions identified on last visit (11/8/15) have now been fully resolved.

Rosewood on 11th May 2017

This was an unannounced scheduled visit by a Mental Health Act Reviewer. During the visit the reviewer spoke to three detained patients in private and two patients with staff present. The reviewer also spoke to three carers in private and they requested that CQC did not speak to their relative (patient) as this would not benefit them or provide any information for this visit. Other patients were off the ward during the visit.

Findings:

- Missing AMHP report
- Problems with the admission process and the use of the MHA
- Lack of exercise based activity
- SOAD visits
- Seclusion room environment
- Patient segregation

Recently published CQC inspection reports to note:

Trust	Date of Inspection	Date of Report	Overall rating	Comments	Link to Report
Somerset Partnership NHS Foundation Trust	March 2017	01/06/17	Good	Following re-inspection the trust's overall rating has been upgraded to 'good'. The Trust had made significant progress in addressing the concerns raised following the inspection in September 2015 and this has changed the overall ratings in the key questions of effective, responsive and well-led from requires improvement to good	here
South West London and St George's Mental Health NHS Trust	March 2017	05/06/17	Good	Following re-inspection the trust's overall rating has remained 'good'. This re-inspection involved the re-inspection of the specialist eating disorder service	here
Sussex Partnership NHS Foundation Trust	April 2017	02/06/17	Requires improvement	Following re-inspection the trust's overall rating has remained as 'requires improvement'. Four of the core services were rated as 'requires improvement' across adults of working age and psychiatric intensive care units, and wards for older people. There were long waiting times from assessment to treatment within specialist community mental health services for children and young people.	here
Tees, Esk and Wear Valley NHS Foundation Trust	January 2017	11/05/17	Good	Following re-inspection the trust's overall rating has remained as 'good'. There have been improvements in a number of areas however, their overall well-led rating has reduced from outstanding to good	here

Future announced inspections:

June 2017

- Pennine Care NHS Foundation Trust
- Coventry and Warwickshire Partnership NHS Foundation Trust

CQC Recent News Stories:

Outcome of CQC Consultation Update

Between December 2016 and February 2017, the CQC consulted on how to develop and evolve their inspection approach. The outcome of that consultation has now been published.

Key points:

- There will now only be two CQC assessment frameworks - one for healthcare and one for adult social care.
- New content to strength specific areas and reflect current practice but the five key questions remain the same (with some revisions and additions)
- Assessment framework to be introduced from second half of June 2017
- Next phase of inspections to take place between September and November 2017
- All trusts can expect to have an assessment of the well-led key question and at least one core service inspection approximately once each year
- New ‘CQC Insight’ system, a monitoring tool to help decide which core services to inspect and when
- Quarterly Trust/CQC meetings

A second consultation on the proposed changes was launched on 12 June, 2017, seeking views on specific proposals.

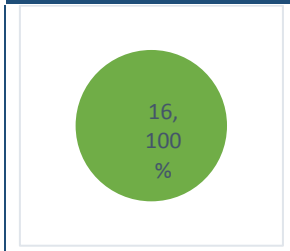
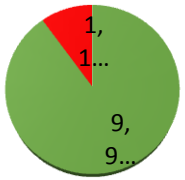
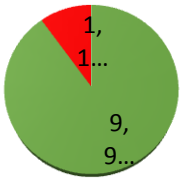
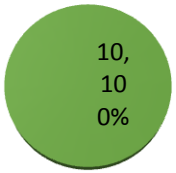
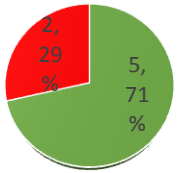
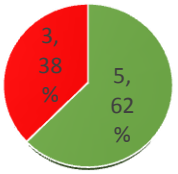
2. Compliance

c) Five Year Forward View – *In development*

Please note that performance against RTT, EIP and IAPT waiting times is covered in the NHS Improvement - Single Oversight Framework section of the report. Performance against MDT waits and other local access requirements (eg Gender Dysphoria, ADHD) are included within the quarterly quality priority update to CDT-Q.

3. Contract Update May 2017

a) Quality Assurance – achievement of quality standards May 2017

NHS England	Northumberland & North Tyneside CCGs	Newcastle / Gateshead CCG	South Tyneside CCG	Sunderland CCG	Durham, Darlington & Tees CCGs	Cumbria CCG
						
All achieved in Month 2	The contract under performed for month 2 on Crisis and Contingency (47 patients, 94.5%)	The contract under performed for month 2 for 7 day follow up (3 patients, 94.1%)	All achieved in Month 2	The contract under performed against the contract in month 2 against the the numbers entering IAPT Treatment (530) and CPA Reviews in last 12 months (15 patients, 94.4%)	The contract under performed for month 2 on CPA reviews in last 12 months (2 patients, 92.9%) and Crisis & Contingency (2 patients, 94.6%)	The contract under performed for month 2 on Completion of Risk assessment (3 patients, 62.5%), Crisis & Contingency (1 patient, 80.0%) and CPA Reviews in last 12 months (1 patient, 80%)
						

3. Contract update May 2017

b) CQUIN update May 2017

CQUIN Scheme:	Annual Financial Value	Requirements	Quarterly Forecast:				
			Q1	Q2	Q3	Q4	Comments
1.Improving Staff Health and Wellbeing	£625k	To improve the support available to NHS Staff to help promote their health and wellbeing in order for them to remain healthy and well.					
2. Improving physical healthcare to reduce premature mortality in people with serious mental illness(PSMI)	£625k	Assessment and early interventions offered on lifestyle factors for people admitted with serious mental illness (SMI).					
3. Improving services for people with mental health needs who present to A&E	£625k	Ensuring that people presenting at A&E with mental health needs have these met more effectively through an improved, integrated service, reducing their future attendances at A&E.					
4. Transitions out of Children and Young People's Mental Health Services	£625k	To improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services.					
5. Preventing ill health by risky behaviours – alcohol and tobacco	£625k	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.					
6. Health and Justice patient Experience	£5k	NHS England has a national priority and focus on patient experience in order to improve the quality of services.					
7. Recovery Colleges for Medium and Low Secure Patients	£1.2m	The establishment of co-developed and co-delivered programmes of education and training to complement other treatment approaches in adult secure services.					
8. Discharge and Resettlement		To find initiatives to remove hold-ups in discharge when patients are clinically ready to be resettled into the community. To include implementation of CUR for MH at pilot sites					
9. CAMHS Inpatient Transitions		To improve transition or discharge for young people reaching adulthood to achieve continuity of care through systematic client-centred robust and timely multi-agency planning and co-ordination.					
10. Reducing Restrictive Practices within Adult Low & Medium Secure Services		The development, implementation and evaluation of a framework for the reduction of restrictive practices within adult secure services, to improve patient experience whilst maintaining safe services.					
Grand Total	**£3.7m**						

3. Contract update May 2017

c) Service Development and Improvement Plan – No update this month

3. Contract update May 2017

d) Mental Health Currency Development Update

Mental Health Currency Development Update														
Key Metrics	Contract Standard	Internal Standard	Q1 2017-18			Q2 2017-18			Q3 2017-18			Q4 2017-18		
			Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Current Service Users, in scope for CPP, who are in settled accommodation			58.0%	58.5%										
Current Service Users on CPA			10.1%	10.0%										
Current in scope patients assigned to a cluster			86.7%	86.6%										
Number of initial MHCT assessments that met the mandatory rules			85.3%	85.5%										
Number of Current Service Users within their cluster review threshold		100%	77.4%	78.2%										
Current Service Users with valid Ethnicity completed MHMDS only	90%	90%	92.3%	92.7%										
Current Service Users on CPA, in scope for CPP who have a crisis plan in place	95%	95%	93.0%	92.2%										
Number of CPA Reviews where review cluster performed +3/-3 days either side of CPA review within CPP spell		100%	68.9%	70.7%										
Number of Lead HCP Reviews where review cluster performed +3/-3 days either side of CPA review within CPP spell		100%	54.7%	55.2%										
Current Service Users on CPA reviewed in the last 12 months	95%	95%	95.2%	95.7%										

N.B The outcomes steering group will be proposing revised standards for the three metrics highlighted above

4. Finance Update May 2017

Financial Performance Dashboard

NTW Income & Expenditure

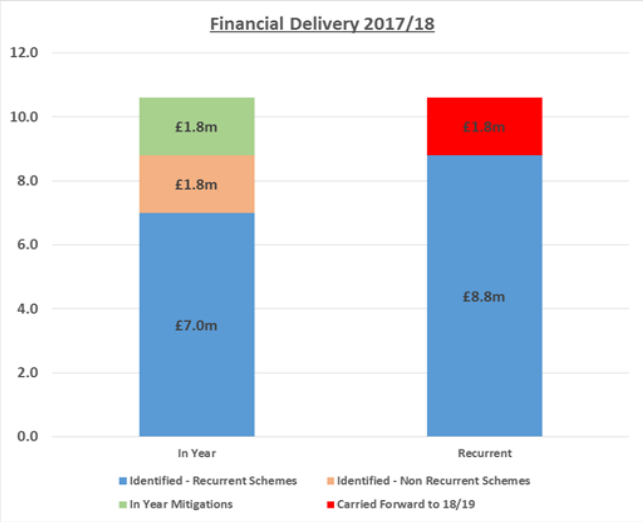
	Plan £m	YTD £m	Variance £m
Income	52.1	51.5	0.6
Pay	(41.3)	(41.6)	0.3
Non Pay	(8.4)	(7.6)	(0.8)
EBITDA	**2.4**	**2.3**	**0.1**
Cost of Capital	(1.7)	(1.8)	0.1
Surplus/(Deficit)	**0.7**	**0.5**	**0.2**

Control Totals

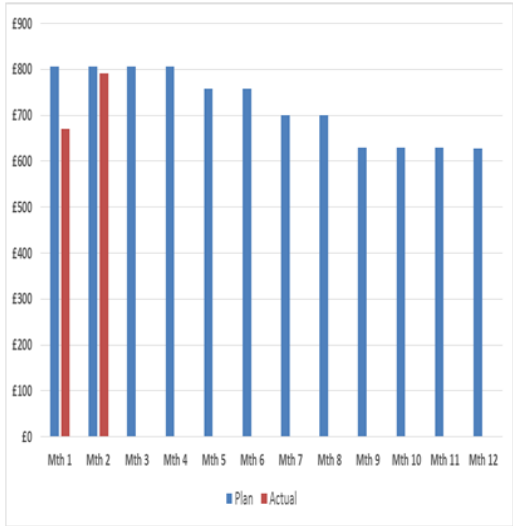
	Plan £m	YTD £m	Variance £m
Specialist	4.5	3.7	0.8
Community	3.8	3.8	0.0
Inpatient Care	4.7	4.4	0.3
Central	(12.3)	(11.4)	(0.9)
Surplus/(Deficit)	**0.7**	**0.5**	**0.2**

Key Indicators	Current
Risk Rating	2
Agency Spend	£1.5m
FDP Delivery	£1.5m
Cash	£16.3m
Capital Spend	£0.4m

Financial Delivery Plan



Agency Spend



Key Issues/Risks

- Surplus - £0.5m at Mth2 which is £0.2m less than plan.
- Control Total – The Trust is forecasting delivery of its £7.1m Control Total.
- Risk Rating – The Use of Resources rating is a 2 at Mth2 & the forecast year-end rating is also a 2.
- Pay costs and staff numbers are above plan at Mth2. Monthly pay spend needs to continue to reduce if the Trust is to meet its control total this year.
- Main pressures - CYPS In-patients, LD transformation & below plan income in Specialist Care which have resulted in the Group being £0.8m above their control total at Mth2.
- Agency Spend – Target spend in 17/18 is £8.6m. Spend at Mth2 is £1.5m which is £0.1m below target trajectory.
- Financial Delivery Plan - £1.5m of the planned £1.7m savings achieved at Mth2.
- Cash – £16.3m at Mth2 which is £5.2m below plan.
- Capital Spend - £0.4m at Mth2 which is £1.1m below plan.

Agency Dashboard – Month 2 2017/18

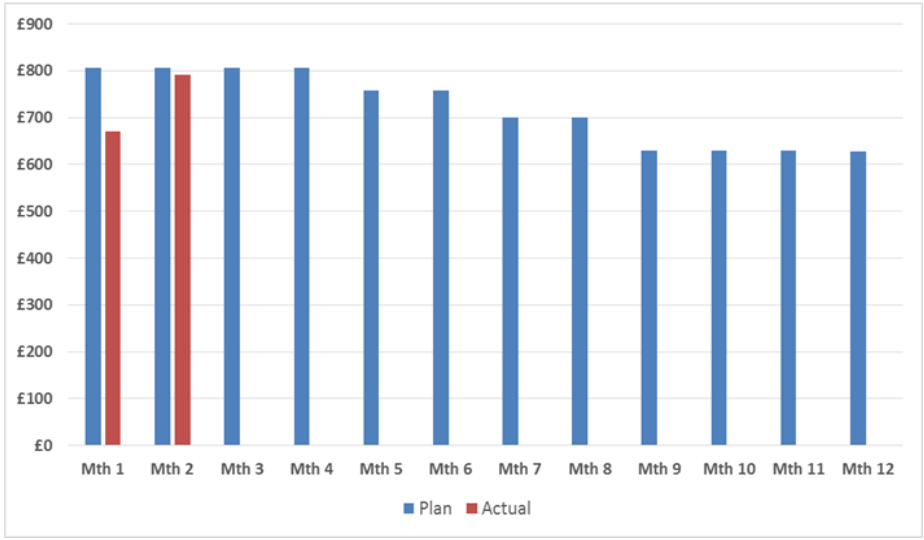
Key issues

1. Monitor introduced capped rates for Agency staff in November 2015 as well as a requirement to use approved suppliers for agency nursing and a ceiling on qualified nursing agency spend of 3%. Trust spend was below this at 2.2% in March 2016.
2. Cap rates reduced on 1st Feb and reduced further on 1st April 2016 when the need to use suppliers on approved frameworks for all staff groups and agency spend ceilings were also introduced.
3. The Trust's ceiling in 16/17 was £8.6m, which was a £5m reduction on 15/16 spend. Agency spend in 16/17 was £11.3m.
4. The Trust's ceiling for 17/18 remains at £8.6m but a medical agency spend target of £3.1m has also been introduced.
5. Agency spend at Mth2 is £1.5m which is £0.1m below trajectory.
6. Medical agency spend at Mth2 is £0.6m which is in line with trajectory.
7. The number of price cap breaches has reduced significantly since price caps were introduced. In May, the Trust reported an average of 15 above price cap shifts (breaches) per week (10 medical & 5 nursing). At the end of May, 2 medics were being paid above the capped rate. Agency medics are brought in at or below capped rates except in exceptional circumstances.

NTW - Temporary Staffing Spend 2017/18

	Year to date - Mth 2			
	Agency	Bank	Overtime	TOTAL
Group	£m	£m	£m	£m
Specialist	0.4	0.8	0.3	1.5
Community	0.5	0.2	0.0	0.7
Inpatients	0.4	0.5	0.0	0.9
Support Services	0.2	0.0	0.1	0.3
	1.5	**1.5**	**0.4**	**3.4**

Agency Spend v Agency Ceiling



Monitor Agency Price Cap Breaches (Number of shifts)

Staff Group	Wk 1 3/4 - 9/4	Wk 2 10/4 - 16/4	Wk 3 17/4 - 23/4	Wk 4 24/4 - 30/4	Wk 5 1/5 - 7/5	Wk 6 8/5 - 14/5	Wk 7 15/5 - 21/5	Wk 8 22/5 - 28/5
Medical	10	20	20	20	20	5	5	10
Nursing	5	5	0	5	5	5	5	5
Total	15	25	20	25	25	10	10	15

5. Monthly Workforce Update May 2017

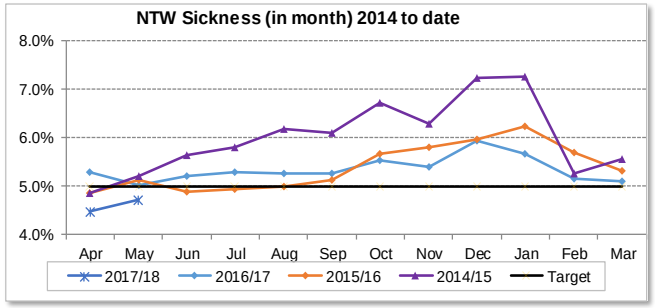
Workforce Dashboard

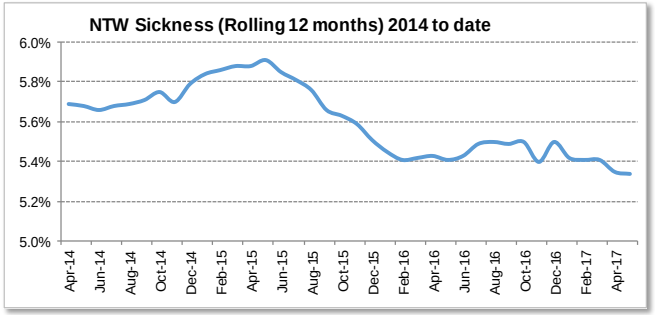
Training and Appraisals	Standard	M2 position	Overall Trend	Inpatient Group	Community Group	Specialist Group	Support & Corporate	Doctors in Training *	Staffing Solutions - Nursing	Staffing Solutions - Psychology	NTW Solutions
Fire Training	85%	86.9%	▼	87.8%	87.8%	87.5%	79.1%	60.0%	91.4%	95.0%	92.6%
Health and Safety Training	85%	91.5%	▼	93.6%	90.5%	93.4%	86.7%	64.0%	90.9%	100.0%	95.4%
Moving and Handling Training	85%	93.2%	▼	98.1%	90.9%	95.8%	86.8%	61.6%	95.8%	100.0%	95.6%
Clinical Risk Training	85%	90.7%	▼	93.1%	90.2%	92.0%			66.7%		
Clinical Supervision Training	85%	82.0%	▼	85.7%	82.0%	80.9%			72.8%		
Safeguarding Children Training	85%	95.2%	▼	97.6%	94.8%	97.0%	90.9%	64.0%	96.7%	100.0%	97.0%
Safeguarding Adults Training	85%	92.9%	▬	95.8%	92.3%	93.4%	88.9%	64.8%	96.1%	95.0%	96.5%
Equality and Diversity Introduction	85%	93.9%	▼	96.5%	93.6%	95.0%	91.9%	64.8%	90.6%	100.0%	97.0%
Hand Hygiene Training	85%	92.5%	▬	95.4%	91.4%	95.2%	87.3%	63.2%	87.3%	100.0%	96.2%
Medicines Management Training	85%	89.2%	▲	92.5%	88.1%	89.6%	84.8%		82.7%		
Rapid Tranquilisation Training	85%	84.4%	▼	91.5%		85.0%			49.4%		
MHCT Clustering Training	85%	87.3%	▼	85.4%	87.5%	74.6%					
Mental Capacity Act/ Mental Health Act/ DOLS Combined Training	85%	84.9%	▲	91.0%	86.1%	85.7%			63.7%		
Seclusion Training (Priority Areas)	85%	95.4%	▲	96.9%		94.4%					
Dual Diagnosis Training (80% target)	80%	89.6%	▲	93.9%	91.6%	90.1%			68.1%		
PMVA Basic Training	85%	77.9%	▲	79.5%		79.9%			68.7%		
PMVA Breakaway Training	85%	91.7%	▼	100.0%	88.0%	95.8%					
Information Governance Training	95%	91.5%	▼	92.2%	92.2%	92.6%	87.2%	63.2%	92.0%	85.0%	
Records and Record Keeping Training	85%	98.2%	▼	99.5%	98.6%	98.8%	95.7%	80.0%	98.9%	100.0%	100.0%

* NB Prior learning may not be reflected in these figures

Appraisals	85%	78.9%	▬	82.8%	77.5%	85.0%	64.0%				81.3%

Managing Attendance	Target	M2 position	Trend
In Month sickness	<5%	4.71%	▼
Short Term sickness (rolling)		0.17%	
Long Term sickness (rolling)		5.17%	
Average sickness (rolling)	<5%	5.34%	▲





Best Use of Resources	Target	M2 position	Trend
Agency Spend		£791,638	▼
Admin & Clerical Agency (included in above)		£145,769	▼
Overtime Spend		£155,868	▲
Bank Spend		£772,358	▼

Recruitment, Retention & Reward	Target	M2 position	Trend
Corporate Induction	100%	100.0%	▬
Local Induction	100%	91.5%	▲
Staff Turnover	<10%	16.6%*	▬
Current Headcount		6355	

*under investigation

Behaviours and Attitudes	M2 position
Disciplinaries (new cases since 1/4/17)	51
Grievances (new cases since 1/4/17)	5

6. Quality Goals/Quality Priorities/Quality Account Update May 2017

Following an engagement process and internal development work within clinical groups, the Quality Priorities for 17-18 have been established as follows:

Quality Goal:	2016-17 Quality Priority:		Quarterly Forecast Achievement:					
			Lead	Q1	Q2	Q3	Q4	Comments
Keeping you safe	1	Embedding the Positive & Safe Strategy (includes Risk of Harm Training which continues from 2016/17)						
Working with you, your carers and your family to support your journey	2	Improve waiting times for referrals to multidisciplinary teams.						
	3	Implement principles of the Triangle of Care						
	4	Co-production and personalisation of care plans						
Ensure the right services are in the right place at the right time to meet all your health and wellbeing needs	5	Use of the Mental Health Act – Reading of Rights						

The **2016/17 Quality Account** was approved by the Board in May 2017 and can be found here

7. Accountability Framework

N.B Reflects the revised Accountability Framework for 2017-18 which took effect from 1st April 2017

		Inpatient Group				Community Group				Specialist Group				Comments:
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
	Overall Rating	4				4				4				
Quality Governance	Performance against National Standards:	1				1				1				
	CQC Information:	2				1				2				
	Performance against Contract Quality Standards:	1				2				2				The Community Group was below target on 4 contract metrics in May. Discussions are on-going within the Group to bring these in line by the end of Q1.
	Clinical Quality Metrics:	4				4				4				Inpatient Group - Due to the failure to meet the current CPP requirements with targets of 100% for the 3 previous quarters and we do not consider them achievable by the end of the quarter. Underperformance on IG & PMVA training in Month 2 but consider these achievable. Community Group - The Group was below target on 8 internal metrics in May . Although discussions are on-going within the Group to address it is unlikely these will be met by the end of Q1. As such the Group will have failed these areas in 3 consecutive quarters. Whilst CPP metrics remain at 100% it is likely the Group will remain at a level 4.
Use of Resources	YTD Contribution	4				1				4				
	Forecast Contribution	2				2				2				
	Agency Spend	2				1				1				
	Use of resources metrics													

		1	2	3	4
Quality Governance	**Performance against national standards**	All Achieved or failure to meet any standard in no more than one month	Failure to meet any standard in 2 consecutive months triggered during the quarter	Failure to meet any standard in 3 or more consecutive months triggered during the quarter	Trust is assigned a segment of 3 (mandated support) or 4 (special measures)
	CQC Information	No Concerns -all core services are rated as Good or Outstanding and there are no "Must Do's" with outstanding actions.	No Concerns - all core services are rated as Good or Outstanding however there are "Must Do's" with outstanding actions.	Concerns raised – one or more core services are rated as "Requires Improvement"	Concerns raised – one or more core services are rated as "Inadequate"
	Performance against contract quality standards *(measured at individual contract level)*	All Achieved	All but a small number of contract metrics are achieved for the quarter and there is a realistic plan in place to recover the underperformance within the following quarter.	Quarterly standard breached in 2nd consecutive quarter, or there is a contract metric not achieved which is not recoverable within the following quarter.	Quarterly standard breached and contract penalties applied or are at risk of being applied.
	Clinical Quality Metrics	All Achieved	All but a small number of contract metrics are achieved for the quarter and there is a realistic plan in place to recover the underperformance within the following quarter.	Quarterly standard breached in 2nd consecutive quarter, or there is a contract metric not achieved which is not recoverable within the following quarter.	Quarterly standard breached in 3rd consecutive quarter.
Use of resources	**YTD contribution**	Exceeding or meeting plan.	Just below plan (within 1%).	Between 1% and 2% below plan	More than 2% below plan
	Forecast contribution				
	Agency Spend	Below or meeting ceiling.	Up to 25% above ceiling.	Between 25% and 50% above ceiling.	More than 50% above ceiling.
	Use of resources metrics	TBC	TBC	TBC	TBC

8. Monthly activity update (Currently in development)

9. Service User & Carer Experience Monthly Update May 2017

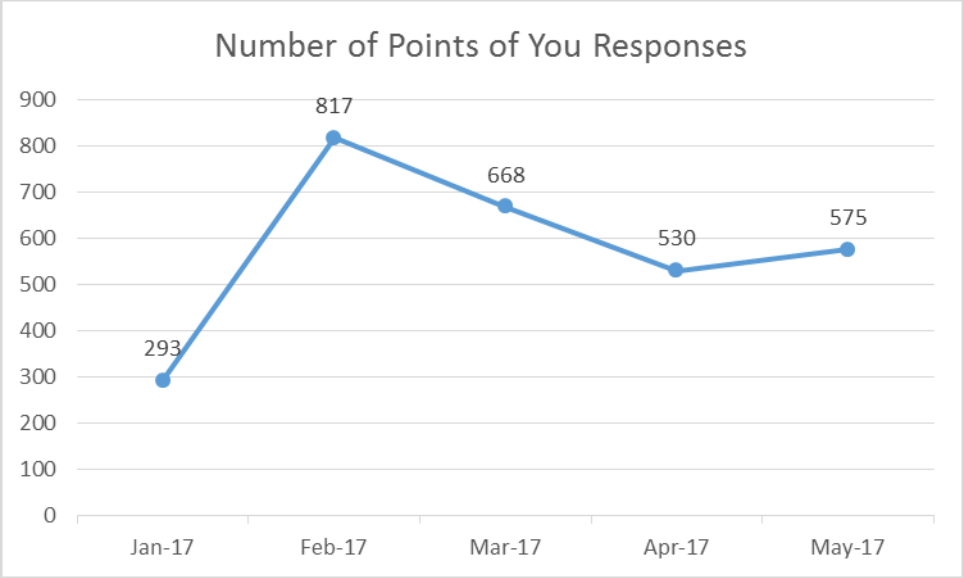
Experience Feedback:

Feedback received in the month – May 2017:

	Responses received May 2017	Results May 2017
Points of You Feedback from Service Users ('Both' option included here)	436	Overall, did we help? Scored: 8.3 out of 10* (8.7 in April)
Points of You Feedback from Carers	139	
Friends and Family Test (FFT) (now a subset of the Points of You responses)	562	Recommend Score**: 84% (88% in April)

* score of 10 being the best, 0 being the worst
** national average recommend score resides around 87-88%

Graph showing Points of You responses received by month:



In May the number of Points of You responses increased compared to the previous month of April. The results however have deteriorated, with 84% of respondents identifying they would recommend our services to family or friends, this figure is below April's recommend score and below the national average.

The latest phase of the Points of You dashboard went live in early June. This second phase displays an analysis of the responses received each month and over time. The dashboard is being trialled for a month from its launch and we are seeking the comments and views of staff during this time.

We are currently collating data to submit to Quality Health for service users who fall under the criteria set by CQC to participate in the 2017 inpatient survey. This survey is not mandated for Mental Health Trusts.

10. Mental Health Act Dashboard

Mental Health Act Dashboard												
Key Metrics	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
Record of Rights (Detained) Assessed within 7 days of detention start date	92.0%	92.4%										
Record of Rights (Detained) Revisited in past 3 months (inpatients)	94.8%	93.5%										
Record of Rights (Detained)Assessed at Section Change within the Period	87.0%	73.9%										
Record of Capacity/CTT for Detained clients Part A completion within 7 days of 3 month rule Starting	50.8%	42.4%										
Community CTO Compliance Rights Reviewed in Past 3 months	45.7%	48.9%										
Community CTO Compliance Rights Assessed at start of CTO	42.9%	33.3%										

The dashboard metrics for rights will be updated as part of the launch of the revised rights form which went 'live' on 5 June 2017.

The dashboards show that the provision of rights to patients detained in hospital is fairly well embedded within the Trust. In May 2017 compliance with the metric was 92.4% which is 4.3% lower than for the same period in 2016.

Compliance with rights having been revisited within the past 3 month period for May 2017 has also dipped slightly to 93.5%. For the period April 2016 to March 2017 the compliance rate was consistently above 95%.

Compliance is lower in relation to the provision of rights where the section the patient was detained under had changed - for May 2017 this was 73.9%. This represents a significant dip since December 2016 when compliance was 95.8%. This metric is to be included within the Rights Quality Priority for 2017/2018.

It is relevant to note, that providing detained patients with explanations of their rights is not only a requirement of the Code of Practice but a **legal requirement** under the Mental Health Act.

The CQC, in their annual report "Monitoring the Mental Health Act in 2015/16" provide details of their national level findings in relation to the provision of rights. While the majority of records the CQC reviewed during their MHA visits showed evidence that patients had been given information there was no evidence that staff discussed rights with patients at the point of detention in 10% of cases and no evidence that patients had been reminded of their rights from time to time in 18% of cases. Compliance within NTW Trust is currently higher than that reported in the CQC national level findings.

The CQC, following 14 of their last 32 MHA reviewer visits (1st April 2016 to 30/04/17) reported issues in relation to the provision and recording of rights. The number of occasions the CQC are identifying rights issues is decreasing (the last report showed 13 of 26).The issues reported included - rights not given at the review date that was set or when the section had changed. The CQC also reported instances where rights were not given on transfer to a different ward.

The reduction in compliance in April/May 2017 is disappointing however the local 'rights' recording form has been reviewed by the local forms group. The revised form was made 'live' on 5 June 2017. Awareness sessions to support the introduction of the new form and the changes in practice required are underway and will continue throughout June. Registered Nurses will be required to attend. An e Learning package is also being developed by the Mental Health Legislation Team. It is anticipated that these and other measures will help drive up compliance and in particular for community patients where compliance is lower.

In relation to CTO patients the dashboards show that the improvement in compliance seen in August 2016 (91.7%) with the provision of rights at the point the CTO is made was not sustained throughout the reporting period for 2016/2017 (1st April 2016 – 31st February 2017). The high in August 2016 of 91.7% dropped to 69.2% in September 2016 however the average since October 2016 was 80%. In April 2017 compliance dropped significantly to 42.9% and in May 2017 still further to 33.3%. A specific piece of work will be carried out to try and identify the root cause of this and any other factors that might have a bearing.

Compliance with the provision of further explanations within a three month period remains low in comparison with the related metric for detained patients, the average compliance as a percentage over the period April 2016 to March 2017 was 45.7% with a range of 30.7% to 56.1%. The compliance rate for April 2017 is the same as last year's average of 45.7%. A slight increase has been in noted in May 2017, compliance being 48.9%.

How these shortfalls can be addressed is being considered as part of the remit of the CTO Task and Finish Group. Some further recommendations to try and improve compliance had been made by the CTO Task and Finish Group and will be included on the agenda for discussion/agreement at the Mental Health Legislation Steering Group. A memo highlighting issues with compliance in the community has been sent to all Group directors.

Two 'local forms' awareness sessions (which covered both the requirements of the 'rights' and consent to treatment forms), have been delivered to Sunderland community staff. These sessions were well received and feedback was good.

As noted above the 'new' rights form has now been made 'live and the planned awareness sessions continue.

The provision of 'rights' to detained and CTO patients has been agreed as a Quality Priority for this year. A lead has been appointed (Dr R Nadkarni) however trajectories still need to be agreed. The CTO task and finish group, at a recent meeting made some recommendations to be taken to the MHL Steering Group for agreement. This included transferring responsibility for the reporting on compliance to representatives from Clinical Services who would be in a position to report on progress against the action plans that have been put in place to improve compliance.

……

Compliance in relation to recording capacity assessments/discussions about consent to treatment (at the point of detention) - in relation to section 58 treatment (medication for mental disorder) has been consistently under 68.3%. The average for the year 1st April 2016 to 31st March 2017 was 61%. For April 2017 the compliance rate was 50.8% and for May 2017 42.45.This is despite a prompt to undertake this, from the MHA office when the section papers are received.

The review of the recording form and associated practice issues is part of the remit of the local forms group and any changes recommended by the group (including practice changes which may improve compliance) will be submitted to the MHL Steering Group. The Local Forms Group has agreed that the review of these particular forms will start in June 2017)

Improvement in compliance for CTO patients is also part of the remit of the CTO Task and Finish Group.

13. Outcomes/Benchmarking/National datasets Update and Other Useful Information

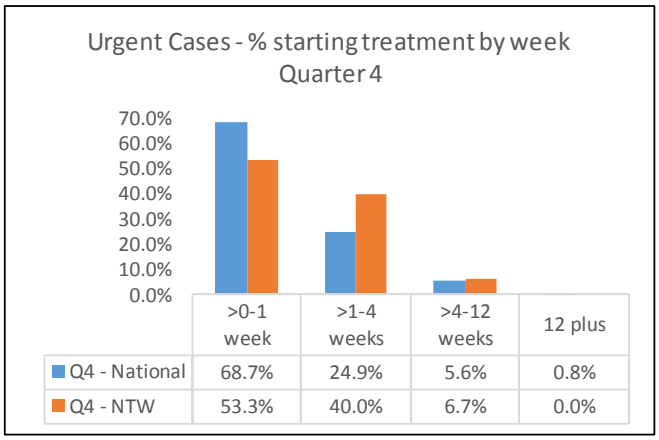
Children and Young People Eating Disorder Submission

NHS England have recently published the main findings from the Quarter 4 2016/17 data collection relating to waiting times for Children and Young people with an Eating Disorder and detailed reports can be accessed here

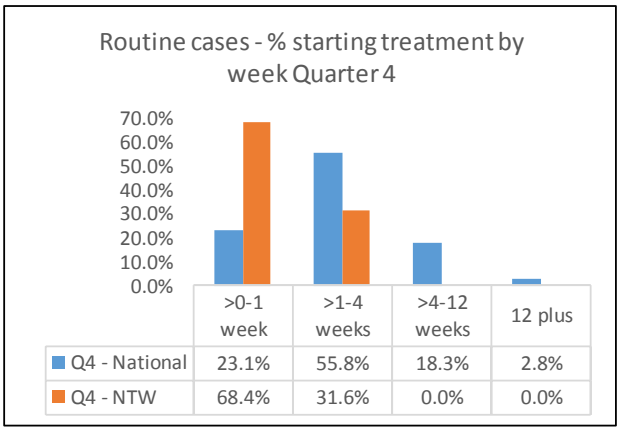
The main findings for Q4 2016-17 nationally were:

- 68.7% of patients started urgent treatment within one week in Q4 2016-17 (NTW was 53.3%)
- 78.9% of patients started routine treatment within four weeks in Q4 2016-17 (NTW was 100%)

NTW's reported data against national comparison is reported below



	>0-1 week	>1-4 weeks	>4-12 weeks	12 plus
Q4 - National	68.7%	24.9%	5.6%	0.8%
Q4 - NTW	53.3%	40.0%	6.7%	0.0%



	>0-1 week	>1-4 weeks	>4-12 weeks	12 plus
Q4 - National	23.1%	55.8%	18.3%	2.8%
Q4 - NTW	68.4%	31.6%	0.0%	0.0%

Benchmarking

The data collection continues to be collated for the CAMHS and Mental Health benchmarking. This will be circulated to the groups prior to submission for comment.

Improving Access to Psychological Therapies (IAPT)

Listed below are the Sunderland IAPT Outcome Measures for May 2017.

SUNDERLAND CCG PATIENTS - IAPT Only Patients - Quality Metrics in 2017-2018

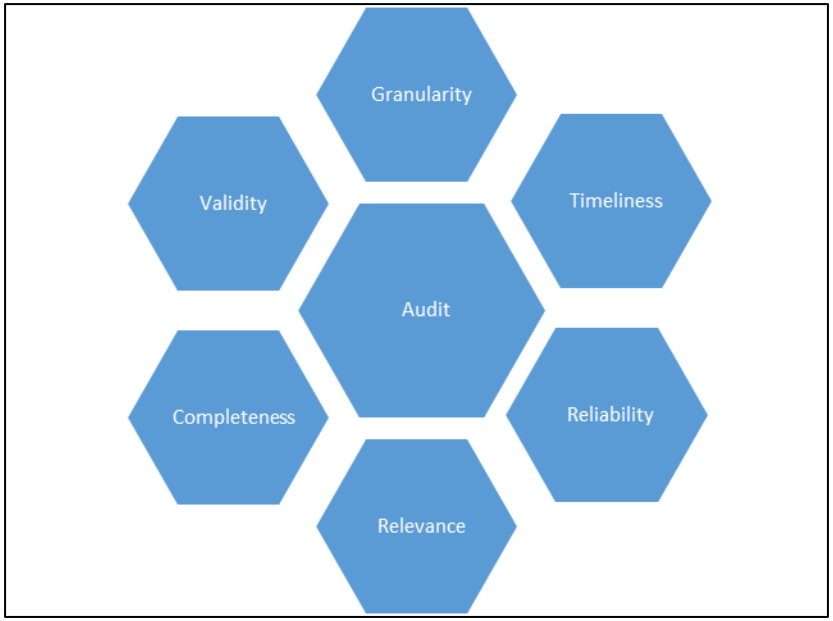
Outcome Measure	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Access - BAME (% of total service users entering treatment)	TBA	4.44%	2.53%										
Access - Over 65 (% of total service users entering treatment)	TBA	7.71%	6.94%										
Access - Specific Anxieties (% of total service users entering treatment)*	TBA	14.09.%	10.68%										
Choice - % answering no	TBA	0%	0%										
Choice - % answering partial	TBA	1.94%	5.26%										
Choice - % answering yes	TBA	98.06%	94.74%										
Employment Outcomes - Moved from Unemployment into Employment or Education	TBA	2	2										
Patient Satisfaction (Average Score)	TBA	19.31	19.34										
Recovery	50% of patients completing treatment	53.57%	50.00%										
Reduced Disabilty Improved Wellbeing	TBA	36.31%	32.00%										
Reliable Improvement	TBA	73.53%	68.73%										
Self Referrals (% of discharges who had self referred)	TBA	73.81%	75.60%										
Waiting Times	95% entering treatment within 18 weeks	100%	100%										
Waiting Times	75% entering treatment within 6 weeks	99.61%	100%										

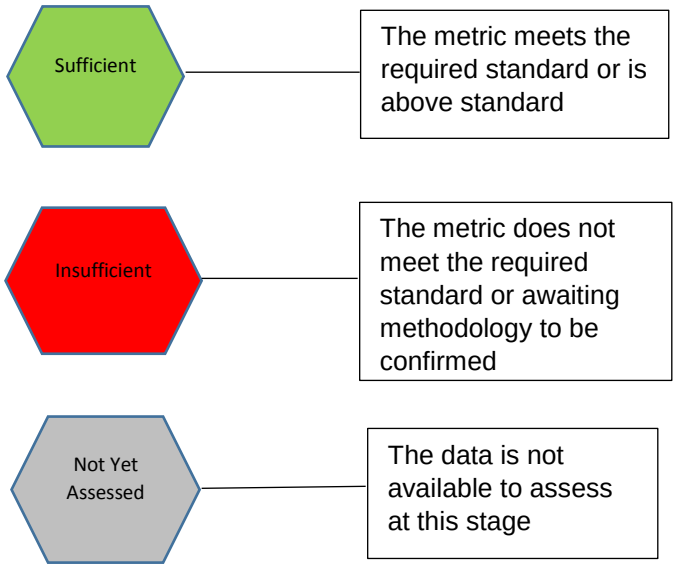
- Note These figures are marginally different from the Trust wide figure reported in the Single oversight framework (page 4). The reasons for this are being investigated

  It is anticipated that an element of the IAPT contract payment may be linked to these outcomes in future financial years

Appendix 1 Data Quality Kite Marks

Data Quality Kite Mark Assessment





Each metric has been assessed using the seven elements listed in blue to provide assurance that the data quality meets the standard of sufficient, insufficient or Not Yet Assessed

Data Quality Kite Mark – This page provides guidance relating to how the metrics have been assessed within NHS Improvements, Single Oversight Framework and Contract Standards

Data Quality Indicator	Definition	Sufficient	Insufficient	What does it mean if the indicator is insufficient	Action if metric is insufficient
Timeliness	Is the data the most up to date and validated available within the system?	The data is the most up to date available	Data is not available for the current period due to problems with the system or process	The data is not the most up to date and decisions may be made on inaccurate data	Understand why the data was not completed within given timeframes. Report this to relevant parties as required
Granularity	Can the data be broken down to different levels e.g. Available at Trust level down to client level?	Where relevant the Trust has the ability to drill down into the data to the correct level	The Trust is unable to drill down into the data to the correct level	It is not possible to drill down to the relevant level of data to understand any issues	Work with relevant teams to ensure the data can be broken down to varying levels
Completeness	Does the data demonstrate the expected number of records for that period?	There is assurance that effective controls are in place to ensure 100% of records are included within the metrics as required and no individual records are excluded without justification	There is inadequate assurance or no assurance that effective controls are in place to ensure 100% of records are included within the metrics	Performance cannot be assured due to the level of missing data	Understand why the data was not complete and request when the data will be updated. Report this to relevant parties as required

Data Quality Indicator	Definition	Sufficient	Insufficient	What does it mean if the indicator is insufficient	Action if metric is insufficient
Validity	Is the data validated by the Trust to ensure the data is accurate and compliant with relevant rules and definitions?	The Trust have agreed procedures in place for the validation and creation of new metrics and amendments to existing metrics	A metric is added or amended to the dashboard without the correct procedures being followed	The data has not been validated therefore performance cannot be assured	The metrics are regularly reviewed and updated as appropriate
Audit	Has the data quality of the metric been audited within the last three years?	The data quality of the metric has been audited within the last three years	The metric has not been audited within the last 3 years	The system and processed have not been audited within the last three years therefore assurance cannot be guaranteed	Ensure metrics that are outside the three year audit cycle are highlighted and completed within the next year. Review the rolling programme of audit
Reliability	The process is fully documented with controls and data flows mapped	Mostly a computerised system with automated controls	Mostly a manual system with no automated controls	Process is not documented and/or for manual data production controls and validation procedures are not adequately detailed	Ensure processes are reviewed and updated accordingly and changes are communicated to appropriate parties
Relevance	The indicator is relevant to the measurement of performance against the Performance question, strategic objective, internal, contractual and regularity standards	This indictor is relevant to the measurement of performance	This indicator is no longer relevant to the measurement of performance	The metric may no longer be relevant to the measurement of standards	Ensure dashboards are reviewed regularly and metrics displayed are relevant and updated or retired if no longer relevant