Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 27 September 2017

Title and Author of Paper: Integrated Commissioning & Quality Assurance Report (Month 5 August 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:

- The Trust remains assigned to segment 1 by NHS Improvement as assessed against the Single Oversight Framework (SOF). (page 4).
- At Month 5, the Trust has a year to date surplus of £2.1m which is slightly above plan and equates to a finance and use of resources score of 1 (this is a sub theme of the Single Oversight Framework), the forecast year-end risk rating is a 1. The Trust needs to continue to improve its underlying financial position to maintain this year's control totals. The main financial pressures during the month were staffing pressures in CYPS inpatient, Older People's in-patients, LD transformation and income being less than plan in Specialist Care. See pages 16-17
- There are a number of contract requirements largely relating to CPA metrics which were not achieved across local CCGs during month 5 with only Newcastle Gateshead and North CCG's achieving fully in the month. (page 11)
- There are continuing pressures on waiting times across the organisation, particularly within community services for children and young people. An action plan is in place to address the underlying issues (page 15)
- All CQUINs are internally forecast to be achieved at the end of Quarter 2 (page 12)
- Two of the five quality priorities are forecast to be achieved at the end of Quarter 2, whilst three remain RAG rated as amber. (page 19)
- 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. (p20)
- Reported appraisal rates have increased in the month to 82.6% (was 81.5% last month). (p18)
- The in month sickness absence rate has increased to 5.57% in the month. The 12 month rolling average sickness rate has increased to 5.48%. (p18)
- 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 (78.9% was 77.7% last month). (p18)
- The service user and carer FFT recommended score was 87% in August which is an increase from 86% in July and is below the national average. (page 23)

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 5 (August 2017)

Contents:

Northumberland, Tyne and Wear NHS
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SOF:	1			The Trust's assigned shadow segment under the Single Oversight Framework remains assigned as segment "1" (maximum autonomy). NHSI are consulting on proposed amendments to the SOF which are likely to significantly impact on the Trust. A consultation response is currently being prepared.
Waiting Times				
Quality Priorities:	Quarter 2 achieved:	Quarter 2 part achieved:	Quarter 2 not achieved	In total there are five quality priorities identified for 2017-18 and at month 5 two are forecast to be achieved whilst the waiting times, embedding the positive and safe strategy and mental health act – reading of rights quality priorities are currently forecast as amber.
	2	3	0	
CQUIN:	Quarter 2 forecast achieved:	Quarter 2 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 achieved during the month.
	10	0		

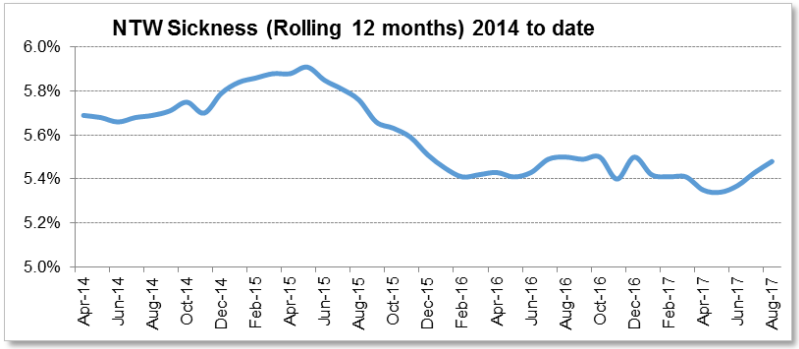
Workforce:

Statutory & Essential Training:

Standard Achieved Trustwide:	Performance <5% below standard Trustwide:	Standard not achieved (>5% below standard):	
14	4	1	Clinical Supervision training (84.9%), Information Governance training (91.4%), Rapid Tranquilisation training (84.2%) and MHA combined training (83.2%) are within 5% of the required standard, PMVA Basic training is more than 5% below the standard at 78.9% Trustwide.

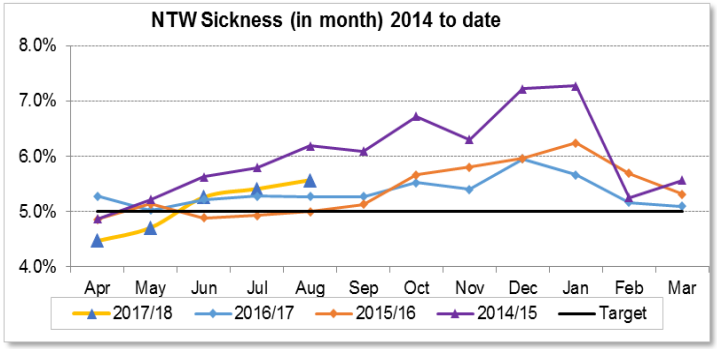
Appraisals: Appraisal rates have increased to 82.6% in August 17 (was 81.5% last month).

Sickness Absence:



The "in month" sickness absence rate is above the 5% target at 5.57% in August 2017

The rolling 12 month sickness average has increased to 5.48% in the month



NB An investigation into the recent increase in sickness absence is being undertaken

Finance:

At Month 5, the Trust has a year to date surplus of £2.1m which is slightly above plan. Pay spend at Month 5 was £103.6m which is in line with plan and includes £3.1m agency spend which is £0.9m under the planned trajectory to hit our agency ceiling of £8.6m. Income was £0.9m less than plan which is offset by non-pay spend being less than plan.

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 1 (this is a sub theme of the Single Oversight Framework) and the forecast year-end risk rating is also a 1.

The main financial pressures at Month 5 are staffing pressures in CYPS inpatients, Learning Disabilities transformation and income being less than plan in Specialist Care and Older People's in-patients. The Trust needs to reduce pay spend down to the planned levels over the remainder of the year 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 align staffing levels with 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
94% of metrics achieved in month 5	100% of metrics achieved in month 5	100% of metrics achieved in month 5	90% of metrics achieved in month 5	93% of metrics achieved in month 5	57% of metrics achieved in month 5	75% of metrics achieved in month 5

The areas of under performance relate mainly to CPA metrics

2. Compliance

a) NHS Improvement Single Oversight Framework

Self assessment as at August 2017 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 2 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%	100%	89.90%	National data includes all NHS providers and is at June 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%	98.70%	National data includes all NHS providers and is at June 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%	81.5%	84%	77.50%	Published data is as at June 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%	95%	no data	no data	from weekly sheet 07.09.17	
1427	b) early intervention in psychosis services	Quarterly	Provider return / CQUIN audit	90%	92%	no data	no data	from weekly sheet 07.09.17	
1425	c) community mental health services (people on Care Programme Approach)	Quarterly	Provider return / CQUIN audit	65%	87%	no data	no data	from weekly sheet 07.09.17	
	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 May 2017	
240	Date of Birth	Monthly	MHSDS	95%	100.0%	100.0%	99.0%	National data includes all NHS providers and is at May 2017	
239	Postcode	Monthly	MHSDS	95%	99.9%	99.0%	98.0%	National data includes all NHS providers and is at May 2017	
241	Current Gender	Monthly	MHSDS	95%	99.8%	100.0%	100.0%	National data includes all NHS providers and is at May 2017	
242	GP code	Monthly	MHSDS	95%	99.6%	99.0%	98.0%	National data includes all NHS providers and is at May 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%	92.5%	94.00%	83.0%	NEW. Data from metric 17 in dashboard.	
27	Employment status recorded	Monthly	MHSDS	85%	95.9%	28.8%	33.1%	The 95.9% 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	
28	Accommodation status recorded	Monthly	MHSDS	85%	96.0%	28.2%	39.7%	The 96.0% 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	
	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%	51.8%	50.0%	50.0%	NEW metric 1079 published data May 2017	
	· waiting time to begin treatment :								
1349	- within 6 weeks	Quarterly	IAPT minimum dataset	75%	99.8%	100.0%	89.3%	published data May 2017	
1348	- within 18 weeks	Quarterly	IAPT minimum dataset	95%	99.2%	100.0%	99.0%	published data May 2017	

NHS Improvement Single Oversight Framework & Model Hospital Portal

As at the end of August 2017, the Trust remains segment 1 within the Single Oversight Framework as assessed by NHS Improvement. The organisation is one of the 13 mental health providers nationally achieving this rating. Recently providers (South London and Maudsley NHS Foundation Trust and Essex Partnership University NHS Foundation Trust) have deteriorated from segment 1 to segment 2, and one provider (Lancashire Care NHS Foundation Trust) has improved from segment 2 to segment 1. There are currently no MH providers in the lowest segment (segment 4) and four providers remain in segment 3.

NHS Improvement have issued a draft single oversight framework 2017/18 which is out for consultation. The paper will help providers to understand how NHS Improvement monitor performance and how they identify support needed to improve standards and outcomes. The document summarises the data and metrics which are collected and reviewed for all providers and specific factors that may require further detailed investigation for organisations.

The current SOF has been reviewed and a set of proposed changes have been identified to be introduced from 2017-18 quarter 3. The changes reflect national policy and standards, data quality and other regulatory frameworks and learning over the past year. There will be no changes to the underlying framework. The small identified changes relate to information and metrics used to assess provider's performance under each theme and indicators that may trigger the requirement for potential support.

A summary of the main changes impacting on NTW is listed below

- The presentation of the document has been reviewed making it explicit that providers are expected to notify NHS Improvement of significant actual or prospective changes in performance or risk outside of routine monitoring.
- It has been noted under all themes that in addition to specific triggers, other material concerns arising from intelligence gathered by or provided to NHS Improvement could trigger consideration of a support need.
- The finance and use of resources score has been replaced with 'finance score' to make a clear distinction between this and the new use of resources ratings.
- Once a provider has undergone a use of resources (UoR) assessment and received a proposed rating, this will be used alongside the finance score to inform the support needs of the provider. The use of resources score has not yet been developed for Mental Health Trusts.
- There have been changes to the operational performance metrics
    - Inappropriate adult mental health out of area placements have been added. Measured as a year on year reduction and eliminated by 2021. During the period 17th October 2016 – 31st May 2017 NTW has reported 15 out of area placements within the period against 4824 for England (0.3%).
    - Patients requiring acute care who received a gatekeeping assessment by the crisis resolution and home treatment team is to be removed and a new indicator is to be developed.
    - Data Quality Maturity Index (DQMI) – Mental Health Services data Set (MHSDS) Score is to be amended and this will replace the MHSDS identifier metrics and priority metrics indicator. This should improve transparency in the data to

promote choice, efficiency, access and quality in mental healthcare to drive improvements in services. We are currently at 99% against a standard of 95%. This removes the employment and accommodation status metrics.

- The operational performance triggers have been amended and have been linked to the quarterly Sustainability and Transformation fund, they will now take effect if any standard for at least two consecutive months is failed.
- Performance against metrics will be measured on a three month rolling basis

The engagement process will run from 8th August to 18th September 2017.

The draft single oversight framework can be found here

2. Compliance

b) CQC Update August 2017

CQC are undertaking a thematic review of mental health services for children and young people nationally, to address the following question: ***"How can we ensure that all partners make their unique contribution and work together so that children and young people, and their families/carers have timely access to high-quality mental health care?".*** The South Tyneside Health & Wellbeing Board has been identified as an area for inspection to support the review, and CQC will visit the area in September/October 2017.

A focussed inspection took place in May 2017 of Beckfield, Alnmouth, Bridgewell and Kinnersley wards following a serious incident which had led to the death of a patient. These wards span two core services therefore two reports have been drafted and are currently undergoing a factual accuracy check prior to publication.

Registration notifications made in the month:

None this month

Mental Health Act Reviewer visits in the month:

Ashby on 1 August 2017

During the visit CQC toured the ward facilities and outdoor space. They spoke to two patients in private. They spoke to one patient with staff present due to risk issues. Two patients declined to meet with them. They had the opportunity to speak to ward based staff and interview the clinical team lead.

Findings:

- All en suite doors were in the locked open position unless a risk assessment indicated a young person could not access the en suite.
- All communal lounges and areas, including toilets were accessed by requesting staff open the room, regardless of individual patient need.
- Limited information displayed for patients.
- Not all staff aware of the availability of a screen to use when undertaking personal searches of young people which could impact on privacy and dignity.
- Nowhere to place clean clothes or towels in one of the bathrooms except the floor or balanced on the wash basin.
- No record that following the SOAD visit, the patient had been informed of the outcome of the visit.

Previous visit – 2/12/15. Not all issues resolved. Any unresolved actions have been referred to this report.

Collingwood Court on 17 August 2017

They interviewed six patients in private and one with a member of staff. Two of the patients they saw could not engage in a discussion due to their current mental illness. They spoke to three patients informally who declined to meet with them or complete a patient engagement form. Other patients were either off the ward or

unavailable during the visit. They spoke to ward staff and interviewed the ward manager. They toured the ward to view patient areas. They spoke to an independent mental health advocate (IMHA) who was visiting the ward. This IMHA regularly worked into this ward. They reviewed three patient records.

Findings:

- The notice to inform informal patients of how to leave the ward was displayed inside this foyer. Patients could not see this from the ward exit door.
- There were concerns regarding the explanation of section 132 rights to patients. The patient was not informed of their detention status and section 132 rights until six days after detention in one record which was reviewed.
- Difficulty seeing patient's thoughts and views about the admission and their care within all care plans reviewed. They could not evidence that patients were involved in the care plan document.
- No evidence that the RC was speaking to patients following the SOAD visit. There was no evidence as to why the RC felt it was not appropriate to do this.
- Patients complained of boredom. On the day of our visit, no activities were available on the ward.
- Two patients reported they regularly received racist abuse though staff did act if they saw this. Homophobic language witnessed on visit.
- The seclusion room had no blind or dimmable light. This could impact on patient's trying to rest or sleep.
- First tier tribunal – patients not receiving relevant reports (e.g. nursing, RC's) in good time before the hearing or not receiving reports at all.

Previous visit – 15/10/15. Not all issues resolved. Any unresolved actions have been referred to this report.

Warkworth on 30 August 2017

They interviewed four patients in private. Three patients declined to meet with them, one took a patient engagement form but did not complete this. One detained patient was taken to the local acute hospital by ambulance during our visit due to their physical health needs. Two detained patients had been admitted late in the evening or early hours of the morning before the visit and were sleeping during the visit.

They spoke to other patients informally in communal areas. They spoke to the nurse in charge and toured the ward. They reviewed three patient records.

Findings:

- There were some concerns about the environment which could impact on patient's privacy and dignity:
  - There was nowhere to place clothes/ towel in the bathroom.
  - Patients did not have bedroom door keys.
  - Patients told them the ward was too busy when the swing beds were open.
  - There were not enough seats in the dining room for all patients when the ward had 23 patients.

- Lounge areas could not accommodate all of the patients when the ward was full.
- There was no bin in the garden area.
- Patients told them food portions were reduced or food ran out when the ward had 23 patients. They found this had been reported to a community meeting.

- Staff were unable to say if there was any delay in accessing an IMHA. On the visit day, staff were unclear about whether patients who lacked capacity to understand their section 132 rights or the role of the IMHA were automatically referred to the service.
- Community meetings – only two meetings recorded during 2017. No clear actions recorded in minutes; it was difficult to see if issues raised had been addressed. Patients unaware of patient or community meetings.
- Patient's views and thoughts not included in care plans and some patients said they had not seen their care plan.
- Patients reported treatment involved medication and little else.
- Patients said they did not see their doctor very often and there was no evidence of patients regularly seeing their RC.
- Patients complained of being bored. Patient engagement session cancelled due to ward activity and staffing.
- Capacity to consent form not fully completed, thereby making it difficult to see if the patient had capacity not to consent to medication.
- No evidence the patient's capacity to consent had been recorded following transfer to ward.

Previous visit – 13/08/15. Not all issues resolved. Any unresolved actions have been referred to this report.

Recently published CQC inspection reports to note:

Trust	Date of Inspection	Date of Report	Overall rating	Comments	Link to Report
Central and North West London NHS Foundation Trust	October 2016 – May 2017	18/08/17	Good	Following re-inspection the trust's overall rating has been reported as 'good'.	here

Future announced inspections:

CQC Recent News Stories:

None to report this month

2. Compliance

c) Five Year Forward View for Mental Health – *In development*

Children and Young People Eating Disorders	Quarter 1 UNIFY Submission	Quarter 3 2016/17 England
Number of Urgent cases seen within one week	63.6%	67.2%
Number of Routine cases seen within four weeks	79.6%	79.0%

Children and Young People		
Under 18 admitted to Adult wards	NTW August 2017	Quarter 3 2016/17 England
Number of patients	0	83
Number of Bed Days	0	2700

IAPT - Sunderland	NTW August 2017	Quarter 3 2016/17 England
% seen within 6 weeks	100%	88.6%
% moving to recovery	51.6%	48.8%

EIP	NTW August 2017	Quarter 3 2016/17 England
% starting treatment within 2 weeks of referral	88.5%	76.3%
% incomplete waiting more than 2 weeks * July data	14.8%	36.0%

	NTW August 2017	Quarter 3 2016/17 England
% of people aged 18-69 in employment	6.6%	6.2%
% of people aged 18-69 in stable accommodation	78.3%*	29.2%

*Currently under investigation

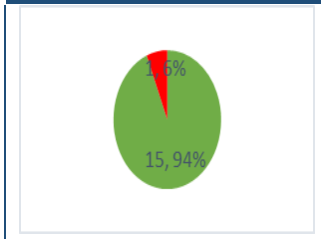
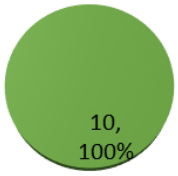
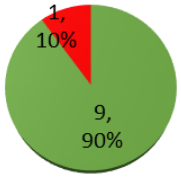
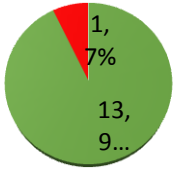
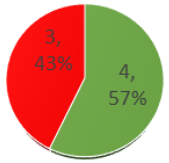
	NTW August 2017	Quarter 3 2016/17 England
7 day follow up	97.9%	96.7%

	NTW July 2017	July 2016/17 England
Delayed Transfers of Care (bed days)	429 (0.7%)	63,561

Latest NHS England Five Year Forward View dashboards are available here

3. Contract Update August 2017

a) Quality Assurance – achievement of quality standards August 2017

NHS England	Northumberland & North Tyneside CCGs	Newcastle / Gateshead CCG	South Tyneside CCG	Sunderland CCG	Durham, Darlington & Tees CCGs	Cumbria CCG
						
The contract under performed in month 5 on Current Service Users with a valid Ethnicity completed MHSDS only (88.3%)	All achieved in month 5	All achieved in month 5	The contract under performed in month 5 for 7 day follow up (1 patient, 90.0%)	The contract under performed in month 5 on IAPT - numbers entering IAPT treatment (477)	The contract under performed in month 5 on CPA reviews in last 12 months (2 patients, 93.8%) and Crisis & Contingency (5 patients, 86.1%), CPA risk assessments (5 patients, 91.1%)	The contract under performed in month 5 on Completion of Risk assessment (3 patients, 66.7%), Crisis & Contingency (1 patient, 66.7%)
						

3. Contract update August 2017

b) CQUIN update August 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**						

*NB Sunderland CCG have requested additional information prior to agreement relating to quarter 1 CQUINS

3. Contract update August 2017

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

3. Contract update August 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%	58.9%	59.1%	59.3%							
Current Service Users on CPA			10.1%	10.0%	9.8%	9.7%	9.6%							
Current in scope patients assigned to a cluster			86.7%	86.6%	86.9%	87.6%	87.5%							
Number of initial MHCT assessments that met the mandatory rules			85.3%	85.5%	85.2%	84.8%	85.6%							
Number of Current Service Users within their cluster review threshold		85%	77.4%	78.2%	79.0%	79.4%	78.8%							
Current Service Users with valid Ethnicity completed MHMDS only	90%	90%	92.3%	92.7%	93.0%	92.8%	92.5%							
Current Service Users on CPA, in scope for CPP who have a crisis plan in place	95%	95%	93.0%	92.2%	92.8%	93.5%	93.2%							
Number of CPA Reviews where review cluster performed +3/-3 days either side of CPA review within CPP spell		85%	68.9%	70.7%	67.7%	71.4%	68.1%							
Number of Lead HCP Reviews where review cluster performed +3/-3 days either side of CPA review within CPP spell		85%	54.7%	55.2%	53.6%	53.5%	55.1%							
Current Service Users on CPA reviewed in the last 12 months	95%	95%	95.2%	95.7%	97.3%	96.4%	96.6%							

4. Waiting Times

The number of people waiting to access adult community services has increased to 3,815 in the month, and nearly 2% of these had been waiting more than 30 weeks as at 31.8.2017. The number of people waiting to access specialised community services who have been waiting more than 18 weeks has deteriorated in the month, with 35% waiting more than 18 weeks, of which two thirds had been waiting more than 30 weeks. There has been further challenges to waiting times in children and young peoples services south of tyne, with 37% of people on the waiting list for Sunderland now waiting more than 18 weeks (32% in South Tyneside). Waiting times are monitored via the Accountability Framework and each clinical group has developed an action plan to address waiting times.

As at 31.8.2017, there were 3,244 service users waiting to be allocated a healthcare professional and start their treatment programme.

Waiting Times Summary August 2017	As at 31st August 2017:		*As at 31st July 2017:*	
1. Number of service users waiting to access **adult community services provided by the community group**:	3815		*3712*	
Proportion waiting more than 18 weeks at that date:	198	5.2%	*201*	*5.4%*
Proportion waiting more than 30 weeks at that date:	71	1.9%	*65*	*1.8%*
2. Number of service users waiting to access **adult community services provided by the specialist care group***:	2483		*2359*	
Proportion waiting more than 18 weeks at that date:	876	35.3%	*823*	*34.9%*
Proportion waiting more than 30 weeks at that date:	529	21.3%	*464*	*19.7%*
** neuro rehabilitation, gender dyshporia, adult autism diagnosis, adult ADHD etc*				
3. Total number of children and young people waiting for **treatment** by **community CYPS** services:				
Northumberland	468		*502*	
Proportion waiting more than 18 weeks at that date:	80	17.1%	*82*	*16.3%*
Proportion waiting more than 30 weeks at that date:	0	0.0%	*0*	*0.0%*
Newcastle	310		*284*	
Proportion waiting more than 18 weeks at that date:	18	5.8%	*25*	*8.8%*
Proportion waiting more than 30 weeks at that date:	0	0.0%	*0*	*0.0%*
Gateshead	272		*247*	
Proportion waiting more than 18 weeks at that date:	25	9.2%	*5*	*2.0%*
Proportion waiting more than 30 weeks at that date:	0	0.0%	*0*	*0.0%*
South Tyneside	205		*202*	
Proportion waiting more than 18 weeks at that date:	65	31.7%	*51*	*25.2%*
Proportion waiting more than 30 weeks at that date:	11	5.4%	*0*	*0.0%*
Sunderland	617		*610*	
Proportion waiting more than 18 weeks at that date:	226	36.6%	*172*	*28.2%*
Proportion waiting more than 30 weeks at that date:	21	3.4%	*5*	*0.8%*
4. Services in scope for RTT (**referral to treatment**) measurement:				
Incomplete waiters less than 18 weeks	100% achieved		*100% achieved*	
Incomplete waiters more than 52 weeks	nil		nil	
5. Number of service users with **no recorded HCP/care co-ordinator** or **record of CPA status**	3244		*3267*	

5. Finance Update August 2017

Financial Performance Dashboard

NTW Income & Expenditure

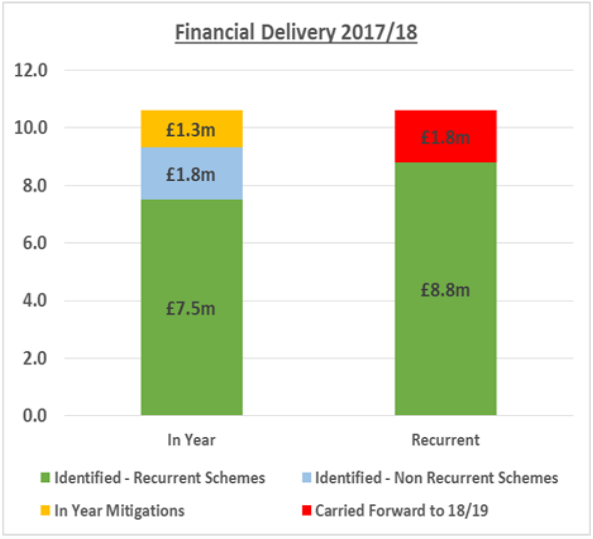
	Plan £m	YTD £m	Variance £m
Income	130.7	129.8	0.9
Pay	(103.7)	(103.7)	(0.0)
Non Pay	(20.6)	(19.6)	(1.0)
EBITDA	**6.4**	**6.5**	**(0.1)**
Cost of Capital	(4.5)	(4.4)	(0.1)
Surplus/(Deficit)	**1.9**	**2.1**	**(0.2)**

Control Totals

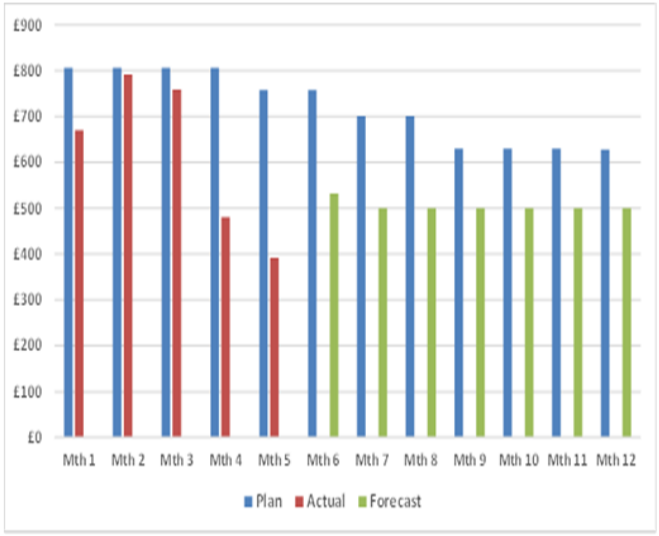
	Plan £m	YTD £m	Variance £m
Specialist	11.1	10.4	0.7
Community	9.5	9.3	0.2
Inpatient Care	11.4	10.9	0.5
Central	(30.1)	(28.5)	(1.6)
Surplus/(Deficit)	**1.9**	**2.1**	**(0.2)**

Key Indicators	Current	Fore-cast
Risk Rating	1	1
Agency Spend	£3.1m	£6.6m
FDP Delivery	£4.4m	£10.6m
Cash	£20.9m	£19.8m
Capital Spend	£1.5m	£8.5m

Financial Delivery Plan



Agency Spend



Key Issues/Risks

- Surplus - £2.1m at Mth5 which is on plan.
- Control Total – The Trust is forecasting delivery of its £7.1m Control Total.
- Risk Rating – The Use of Resources rating is a 1 at Mth 5 & the forecast year-end rating is a 1.
- Pay costs in line with plan at Mth5. Monthly pay spend needs to reduce in the 2nd half of the year 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 £0.7m above their control total at Mth5. Also Older Peoples In-Patients.
- Agency Spend – Target spend in 17/18 is £8.6m. Spend at Mth5 is £3.1m which is £0.9m below target trajectory. Forecast spend is £6.6m.
- Financial Delivery Plan - Planned savings of £4.4m have been achieved at Mth5.
- Cash – £20.9m at Mth5 which is £0.6m above plan.
- Capital Spend - £1.5m at Mth5 which is £3.1m below plan.

Agency Dashboard – Month 5 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 Mth5 is £3.1m which is £0.9m below trajectory.
6. Medical agency spend at Mth5 is £1.3m which is in line with trajectory.
7. Forecast agency spend is £6.6m which is £2.0m below ceiling.
8. The number of price cap breaches has reduced significantly since price caps were introduced. In August, the Trust reported an average of 19 above price cap shifts (breaches) per week (14 medical & 5 nursing). At the end of August, 3 medics were being paid above the capped rate. Agency medics are brought in at or below capped rates except in exceptional circumstances.

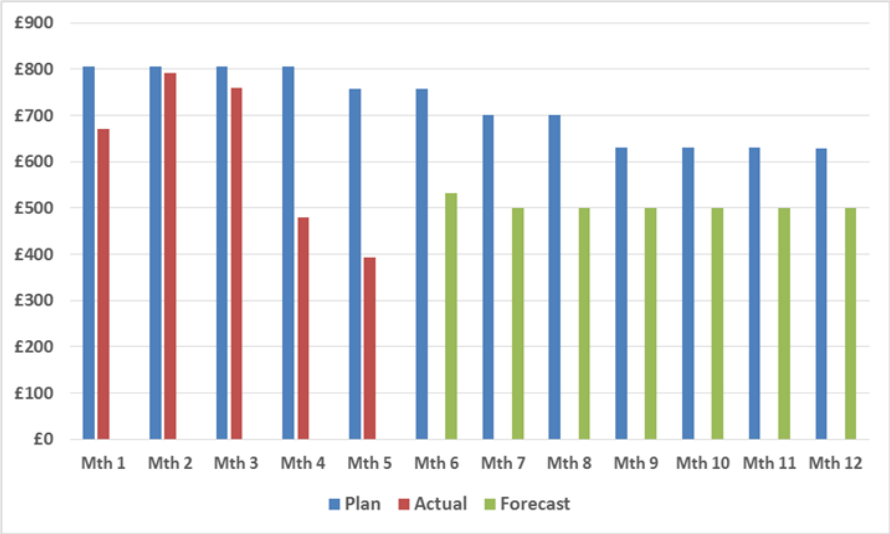
NTW - Temporary Staffing Spend 2017/18

	Year to date - Mth 5			
	Agency	Bank	Overtime	TOTAL
Group	£m	£m	£m	£m
Specialist	0.8	1.9	0.7	3.3
Community	1.3	0.5	0.0	1.7
Inpatients	0.8	1.3	0.1	2.2
Support Services	0.3	0.0	0.2	0.4
	3.1	**3.7**	**0.9**	**7.7**

Monitor Agency Price Cap Breaches (Number of shifts)

	April	May	June	July	August
Staff Group	3/4 - 30/4	1/5 - 28/5	29/5 - 25/6	26/6 - 30/7	31/7 - 3/9
Medical	70	40	45	70	72
Nursing	15	20	20	20	25
Total	85	60	65	90	97

Agency Spend v Agency Ceiling



6. Monthly Workforce Update August 2017

* Note that sickness absence has been increasing recently and the underlying issues are being explored further

Workforce Dashboard

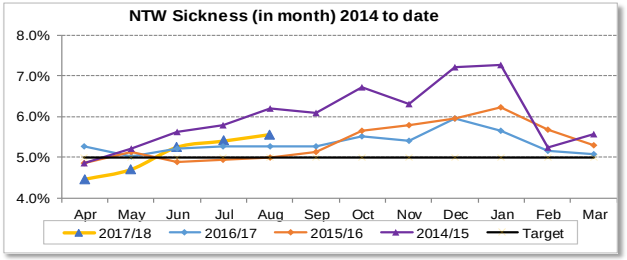
Training and Appraisals	Standard	M5 position	Overall Trend	Inpatient Group	Community Group	Specialist Group	Support & Corporate	Doctors in Training *	Staffing Solutions - Nursing	Staffing Solutions - Psychology	NTW Solutions
Fire Training	85%	88.9%	▲	91.6%	88.7%	90.3%	85.3%	36.4%	91.1%	92.6%	94.3%
Health and Safety Training	85%	91.0%	▲	94.2%	90.4%	92.8%	91.0%	51.9%	90.9%	96.3%	89.5%
Moving and Handling Training	85%	92.9%	▲	97.4%	90.7%	96.0%	91.9%	48.8%	95.4%	96.3%	89.9%
Clinical Risk Training	85%	91.5%	▲	94.2%	91.7%	92.1%			68.2%		
Clinical Supervision Training	85%	84.9%	▲	89.0%	83.7%	85.5%			71.6%		
Safeguarding Children Training	85%	94.6%	▼	97.5%	95.1%	97.8%	93.7%	42.6%	96.4%	92.6%	97.5%
Safeguarding Adults Training	85%	95.5%	▲	97.1%	94.0%	95.7%	93.7%	51.2%	95.4%	96.3%	97.5%
Equality and Diversity Introduction	85%	93.9%	▼	96.6%	93.7%	95.7%	92.2%	52.7%	90.9%	96.3%	96.2%
Hand Hygiene Training	85%	92.8%	▲	95.0%	91.2%	95.6%	93.0%	50.4%	88.6%	96.3%	95.6%
Medicines Management Training	85%	88.5%	▼	93.9%	85.8%	89.7%	83.3%		83.0%		
Rapid Tranquilisation Training	85%	84.2%	▼	91.1%		86.0%			48.9%		
MHCT Clustering Training	85%	91.1%	▲	88.0%	92.0%	85.6%					
Mental Capacity Act/ Mental Health Act/ DOLS Combined Training	85%	83.2%	▼	90.0%	85.8%	84.4%			50.8%		
Seclusion Training (Priority Areas)	85%	93.7%	▼	93.3%		94.1%					
Dual Diagnosis Training (80% target)	80%	89.1%	▲	94.8%	92.0%	90.7%			59.2%		
PMVA Basic Training	85%	78.9%	▲	82.1%		83.0%			66.3%		
PMVA Breakaway Training	85%	89.4%	▼	100.0%	85.6%	93.6%					
Information Governance Training	95%	91.4%	▼	93.7%	91.8%	93.0%	88.6%	42.6%	91.6%	85.2%	
Records and Record Keeping Training	85%	97.8%	▼	99.5%	98.5%	99.1%	96.4%	55.8%	98.2%	96.3%	100.0%

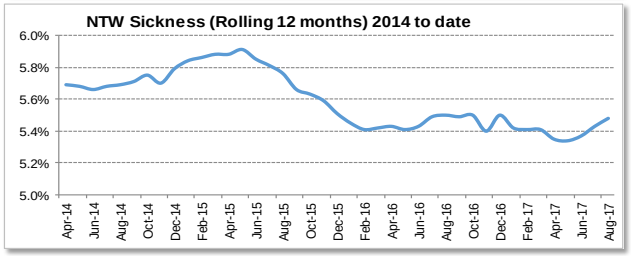
* NB Prior learning may not be reflected in these figures and is being investigated

Appraisals	85%	82.6%	▲	86.8%	82.0%	86.2%	59.5%				96.7%

Managing Attendance - includes NTW Solutions	Target	M5 position	Trend
In Month sickness	<5%	5.57%	▼
Short Term sickness (rolling)		0.14%	
Long Term sickness (rolling)		5.33%	
Average sickness (rolling)	<5%	5.48%	▼

NB - NTW Solutions Sickness absence in the month was 5.52%





Best Use of Resources	Target	M5 position	Trend
Agency Spend		£391,821	▲
Admin & Clerical Agency (included in above)		£102,250	▼
Overtime Spend		£169,604	▼
Bank Spend		£890,441	▼

Recruitment, Retention & Reward	Target	M5 position	Trend
Corporate Induction	100%	100.0%	—
Local Induction	100%	95.1%	▲
Staff Turnover (includes NTW Solutions)	<10%	*16.49%	▼
Current Headcount		6313	

*this is a rolling 12 month figure

Behaviours and Attitudes	M5 position
Disciplinaries (new cases since 1/4/17)	78
Grievances (new cases since 1/4/17)	14

*The Doctors in training figures have been investigated and a number of issues have been reported from this. Trainee Doctors rotate every 4-6 months and it takes approx. one month for them to complete all of the training they are required to complete. There have been issues identified relating to ESR which includes adding new trainees and removing outgoing trainees, there may be multiple ESR accounts for some and ESR not recognising some valid completion dates. Time delays are incurred when receiving information from other organisations when training has been completed outside of NTW. Time delays in the collation and updated on ESR.

The issues are currently being addressed and this involves streamlining the process, part of this work has involved the recent activation between ESR and Intrepid which is undergoing testing. This interface will allow previously completed training to be viewed. Staff are undergoing training and will be updating ESR

7. Quality Goals/Quality Priorities/Quality Account Update August 2017

Progress towards the quarter two requirements for each of the 2017-18 quality priorities is summarised below.

Two of the seven priorities are currently rated green and three are rated amber against the Quarter 2 milestones.

Quality Goal:	2017-18 Quality Priority:		Quarterly Forecast Achievement:				
			Q1	Q2	Q3	Q4	Comments
Keeping you safe	1	Embedding the Positive & Safe Strategy (includes Risk of Harm Training which continues from 2016/17)					There is slippage into quarter 2 on some elements of this quality priority
Working with you, your carers and your family to support your journey	2	Improve waiting times for referrals to multidisciplinary teams.					There are continuing challenges in maintaining waiting times, particularly in Children's and Young People's Community Services.
	3	Implement principles of the Triangle of Care					Progressing as planned
	4	Co-production and personalisation of care plans					Progressing as planned
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					There is slippage on reporting compliance regarding reading of rights due to enhancements made to RiO

8. 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:
	Overall Rating	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
		4	4			4	4			4	4			
Quality Governance	Performance against National Standards:	1	1			1	1			1	1			
	CQC Information:	2	2			1	1			2	2			Inpatient Group - All actions have now been completed
	Performance against Contract Quality Standards:	1	1			2	1			2	3			The Community Group was below target on 1 contract metric at the end of August. It is envisaged that this will be met at the end of Q2
	Clinical Quality Metrics:	4	4			4	4			4	4			Inpatient Group - Action plans have now been developed for all under performing metrics Community Group - The Community Group was below target on a number of internal metrics at the end of August. Although it is envisaged that progress will be made by the quarter end the Group will remain at level 4 rating.
Use of Resources	YTD Contribution	4	3			2	2			4	3			
	Forecast Contribution	2	2			2	2			2	1			
	Agency Spend	2	2			1	1			1	1			

		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

9. Monthly activity update (Currently in development)

10. Service User & Carer Experience Monthly Update August 2017

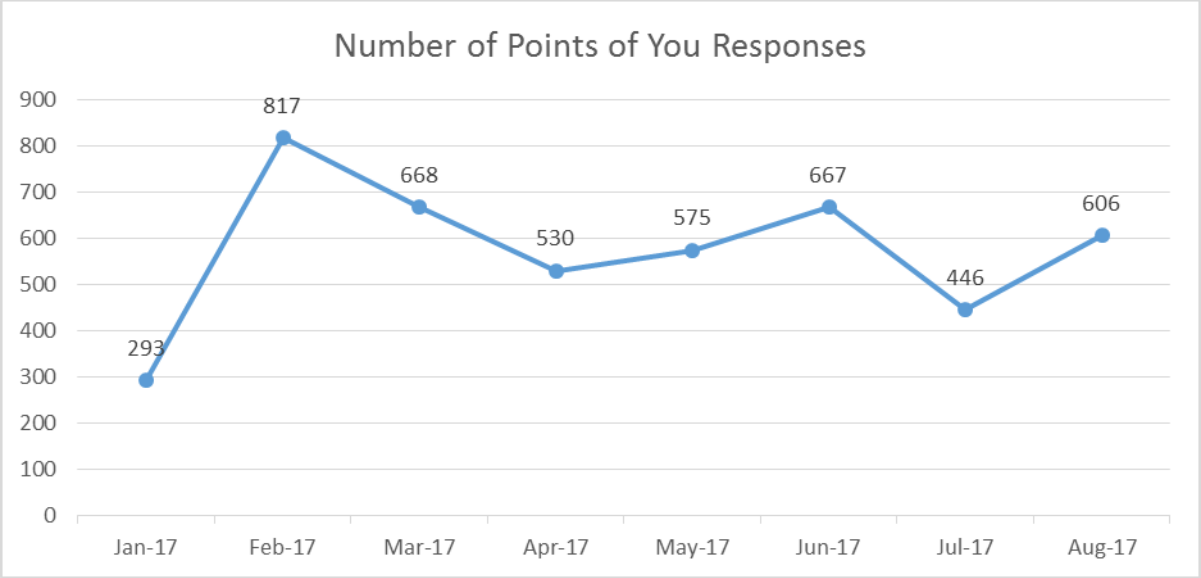
Experience Feedback:

Feedback received in the month – August 2017:

	Responses received August 2017	Results August 2017
Points of You Feedback from Service Users ('Both' option included here)	398	Overall, did we help? Scored: 8.5 out of 10* (8.7 in July)
Points of You Feedback from Carers	208	
Friends and Family Test (FFT) (now a subset of the Points of You responses)	606	Recommend Score**: 87% (86% in July)

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

Graph showing Points of You responses received by month:



In August the number of Points of You responses increased compared to the previous month of July. The results have also shown an increase with 87% of respondents identifying they would recommend our services to family or friends, this figure is above July's recommend score and below the national average.

11. 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%	See Below									
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 revised local rights recording form went 'live' on the 5th June 2017. The dashboard metrics for rights have been amended to link with the structure of the new form. However due to some issues that have been flagged regarding inconsistencies in the data the MHA dashboard metrics are currently under investigation and rigorous testing.

In May 2017 compliance with the metric (918) was 92.4%. Due to the above, the data for August cannot be presented however at 11/09/17 compliance was 92.9%.

Compliance with rights having been revisited within the past 3 month period (metric 993) for May 2017 was 93.5%. As with the above metric an accurate figure for August is not available however at 11/09/17 compliance was recorded as 95.1%.

Compliance has been consistently 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 included within the Rights Quality Priority for 2017/2018. As at 11/09/17 compliance was recorded as 82.5% which represents some improvement and exceeds the quarter 1 and quarter 2 'Rights Quality Priority' trajectories

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.

Awareness sessions to support the introduction of the new form and the changes in practice required in relation to the provision of rights have been delivered by members of the 'MHA Local Forms and Practice Group' since June and are scheduled to continue until the end of November 2017. Registered Nurses are required to attend. The sessions to date have been for the most part well attended and feedback has been good. On completion of the scheduled awareness sessions it is anticipated that any registered staff who have not attended an awareness session will have their session delivered via a cascade model. E learning will also be an option.

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 (metric 998) was not sustained throughout the reporting period for 2016/2017 (1st April 2016 – 31st May 2017). In May 2017 compliance had dipped to 33.3%. However significant improvement in compliance has been noted (following manual review of the forms) since the introduction of the revised form and associated training. The dashboard for this metric is also under investigation. At 11/9/17 compliance was recorded as 73 .7%.

Compliance with the provision of further explanations within a three month period (metric 985) has been consistently lower than the related metric for detained patients, In April 2017, compliance was 45.7%. Some improvement has been noted. Compliance as at 15/08/17 was 68.6% and at 11/09/17 was recorded as 72%.

The CTO Task and Finish Group has been merged with the Local Forms Review Group. The new Group (The MHA Local Forms and Practice Group) will continue to monitor compliance and consider other options to improve compliance.

As noted above the 'new' rights form is now live and further awareness sessions are scheduled to be delivered throughout until the end of November 17.

The provision of 'rights' to detained and CTO patients has been agreed as a Quality Priority for this year. The lead for this priority is Dr R Nadkarni.

Compliance in relation to recording capacity assessments/discussions about consent to treatment (at the point of detention – metric 916) - 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 42.44.This is despite a prompt to undertake this, from the MHA office when the section papers are received. Compliance for June 2017 has gone up to 55.1% however compliance for July 2017 is down to 49.1. As at 11/09/17 compliance was recorded as 38.3%

The review of the recording form and associated practice issues is underway by the MHA Local Forms & Practice Review Group. As with the 'The Provision of Rights' the group will develop measures for improvement and a communication strategy.

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

Benchmarking

The NHS Benchmarking Team have now released the draft report relating to the Mental Health collection. This is currently under review and any amendments to the data are required to be submitted back the national team by 2nd October 2017.

The CAMHS collection has been submitted and work is ongoing within the organisation to review the submitted data prior to release of the draft report.

The data collection has commenced in relation to the Corporate Functions benchmarking and the submission is due to the NHS Benchmarking team by 30th September 2017.

The Trust has registered to participate in the Learning Disability Benchmarking and collection will commence when the final specification is released. The collection is due to run between 18th September 2017 until 10th November 2017.

The dates of the NHS Benchmarking Conferences are:

Good Practice in Mental Health Services Conference – 9th November 2017

Good Practice in CAMHS Services Conference – 16th November 2017

Learning Disability – March 2018

Improving Access to Psychological Therapies (IAPT)

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

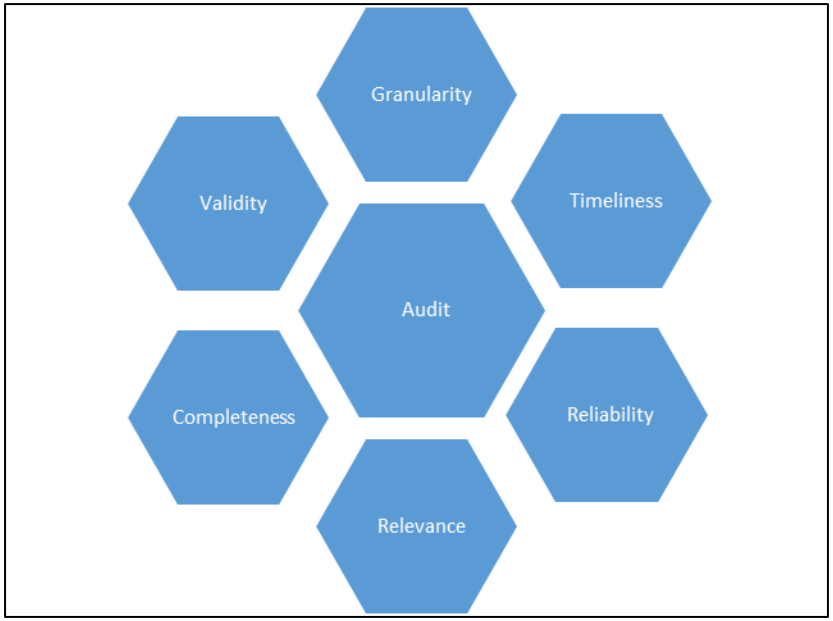
SUNDERLAND CCG PATIENTS - IAPT Only Patients - Quality Metrics in 2017-2018

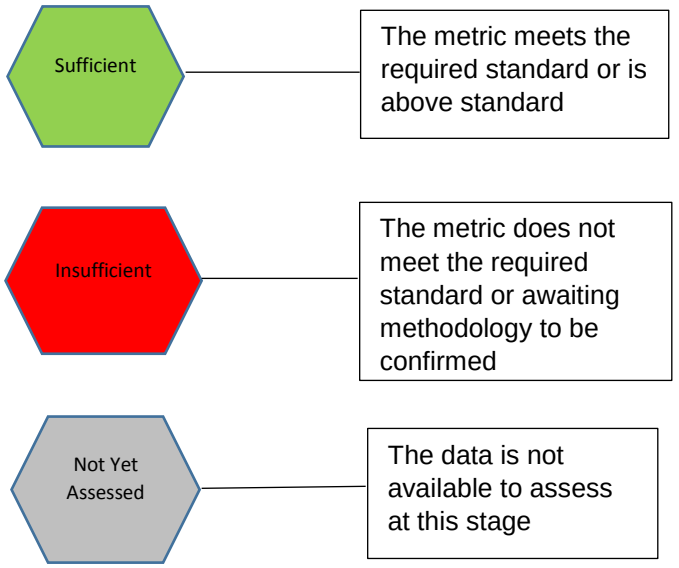
Outcome Measure	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Access - BAME (% of total service users entering treatment)	TBA	4.44%	2.53%	2.41%	2.04%	2.32%							
Access - Over 65 (% of total service users entering treatment)	TBA	7.71%	6.94%	7.94%	7.95%	7.65%							
Access - Specific Anxieties (% of total service users entering treatment)*	TBA	14.09.%	10.68%	10.30%	11.17%	10.13%							
Choice - % answering no	TBA	0%	0%	0%	0.37%	0%							
Choice - % answering partial	TBA	1.94%	5.26%	4.85%	0.38%	1.27%							
Choice - % answering yes	TBA	98.06%	94.74%	95.15%	99.25%	98.73%							
Employment Outcomes - Moved from Unemployment into Employment or Education	TBA	2	2	6	1	2							
Patient Satisfaction (Average Score)	TBA	19.31	19.34	19.36	19.42	19.51							
Recovery	50% of patients completing treatment	53.57%	51.20%	49.78%	51.50%	51.64%							
Reduced Disabilty Improved Wellbeing	TBA	36.31%	32.00%	30.90%	33.19%	32.16%							
Reliable Improvement	TBA	73.53%	68.73%	72.53%	71.06%	67.32%							
Self Referrals (% of discharges who had self referred)	TBA	73.81%	75.60%	73.82%	77.87%	78.43%							
Waiting Times	95% entering treatment within 18 weeks	100%	100%	100%	100%	100%							
Waiting Times	75% entering treatment within 6 weeks	99.61%	100%	99.83%	99.66%	100%							

An element of the IAPT contract payment will be linked to these outcomes from April 2018

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