AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 27TH FEBRUARY 2018 VENUE: THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meeting held on **30th January 2018.**		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 7	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 8	To receive and note a report on learning from deaths.	**EM**	**Attached**
Item 9	To consider a report on the outcome of the engagement on the Making a Difference Together priority and to agree next steps.	**DL**	**Attached**

Performance (11.00 am)

Item 10	To consider the Finance Report as at 31st January 2018.	**DK**	**Attached**
Item 11	To consider the Trust Performance Dashboard as at 31st January 2018.	**SP**	**Attached**
Item 12	To consider the Strategic Direction Performance Report for Quarter 3, 2017/18.	**SP**	**Attached**

Items for Information (11.20 am)

Item 13	To receive and note a report on the use of the Trust's seal.	**CM**	**Attached**
Item 14	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 15 To note that the next meeting of the Board of Directors will be held on **27th March 2018** in the Boardroom, West Park Hospital, Darlington at 9.30 am.

Confidential Motion (11.25 am)

Item 16 **The Chairman to move:**

"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:

Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.

Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.

Information relating to the financial or business affairs of any particular person (other than the Trust).

Any documents relating to the Trust's forward plans prepared in accordance with paragraph 27 of schedule 7 of the National Health Service Act 2006.

Information which, if published would, or be likely to, inhibit -
(a) the free and frank provision of advice, or
(b) the free and frank exchange of views for the purposes of deliberation, or
(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.

Any advice received or information obtained from legal or financial advisers appointed by the Trust or action to be taken in connection with that advice or information.

Information which is held by the Trust with a view to its publication, by the Trust or any other person, at some future date (whether determined or not), and it is considered reasonable, in all the circumstances, to withhold the information from disclosure until that date.

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
21st February 2018

Contact: Phil Bellas, Trust Secretary Tel: 01325 552312/Email: p.bellas@nhs.net

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 30TH JANUARY 2018 IN THE DURHAM CENTRE, BELMONT INDUSTRIAL ESTATE, DURHAM AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Dr. H. Griffiths, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Mr. D. Jennings, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mr. D. Kendall, Interim Director of Finance and Information
Mr. B. Kilmurray, Deputy Chief Executive
Dr. N. Land, Medical Director
Mrs. E. Moody, Director of Nursing and Governance
Mr. D. Brown, Acting Chief Operating Officer (non-voting)
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Mr. A. Williams, Public Governor for Durham
Dr. A. Khouja, Medical Director (Designate)
Mr. P. Scott, Director of Operations for County Durham and Darlington (minute 18/06 refers)
Dr. J. Whaley, Guardian of Safe Working (minute 18/07 refers)
Mr. L. Buckley, Director of Operations for Forensic Services
Mr. P. Bellas, Trust Secretary
Ms. D. Oliver, Deputy Trust Secretary (Corporate)
Mrs. J. Jones, Head of Communications

Mr. A. Morford, member of the public

18/01 MINUTES

Agreed *– that, subject to the correction of the date of the meeting of the Quality Assurance Committee to 1st February 2018 in subparagraph (1)(e) of minute 17/328 (19/12/17), the public minutes of the last ordinary meeting held on 28th November 2017 and the special meeting held on 19th December 2017 be approved as correct records and signed by the Chairman.*

18/02 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

Arising from the report:

(1) It was noted that the Locality Staff Action Plans, amended to identify the relevant locality in accordance with minute 17/300 (28/11/17), had been circulated to Board Members.

(2) Mr. Martin advised that, further to the discussions under minute 17/301 (28/11/17), he would be distributing a further communication to staff from other EU states.

18/03 DECLARATIONS OF INTEREST

There were no declarations of interest.

18/04 CHAIRMAN'S REPORT

The Chairman:

(1) Drew attention to her report to the meeting of the Council of Governors held on 25th January 2018.

(2) Advised that meetings of the Foundation Trust Chairs and the North Chairs Network were due to be held on 1st and 2nd February 2018, respectively, and undertook to provide updates on the matters discussed at the events in her next report.

18/05 GOVERNOR ISSUES

No issues were raised.

18/06 LOCALITY BRIEFING – COUNTY DURHAM AND DARLINGTON

Mr. Scott (Director of Operations) gave a presentation on the key issues facing the County Durham and Darlington Locality.

A copy of the slides used in the presentation is attached as Annex 1 to these minutes.

In response to questions Mr. Scott advised that:

(1) Although challenges remained, he was proud of the progress being made on the West Park review.

(2) He had concerns about the position on Autistic Spectrum Disorder (ASD) services (although there was now the potential for progress and helpful meetings had been held with Commissioners) and the impact of recent changes to the Locality's senior leadership team.

(3) The Locality had engaged in succession planning and talent management; however, the key learning from the recent changes to the senior leadership team was the need for greater local ownership focussing on mentoring and creating opportunities to prepare staff to take on those roles.

The Chairman asked for the Locality's experience to be shared with others as the Trust could not afford for the challenges it had faced to be repeated elsewhere.

(4) The statement in his presentation "Move away from discussing profession specific competencies" referred to thinking creatively and looking for opportunities to fulfil certain roles.

(5) In relation to ASD services:

(a) Work was being undertaken across the Trust, through the Autism Strategy for adults, and the Executive Management Team had discussed the approach to the provision of the services to young people.

(b) Engagement with Commissioners and Health and Wellbeing Boards was continuing.

(c) The clinical team, within the Locality, had developed a five day rapid assessment process which had led to improvements for a large proportion of young people.

At the request of the Board, Mr. Scott, recognising that the implementation of the clinical model was still at an early stage, undertook to share it with other Localities if it proved to be effective.

Mr. Martin considered that Mr. Scott, personally, and the team, should take credit for Commissioners having the confidence to take this matter forward.

(6) The work of the national intensive support team had been beneficial in highlighting the issues being experienced within IAPT services in the Locality.

It was noted that a key issue identified was the significant investment in primary care counselling services which detracted from people receiving NICE approved therapies through IAPT services.

Whilst the removal of the counselling services would be beneficial, Mr. Scott recognised that the IAPT service needed to be more productive, learning from the Purposeful and Productive Community Services (PPCS) programme, and highly accessible by GPs.

At the conclusion of the discussions, the Chairman recognised the leadership provided by Mr. Scott in making improvements in the Locality over the last two years and asked him to pass on the Board's appreciation to staff in the Locality for their hard work.

18/07 REPORT OF THE GUARDIAN OF SAFE WORKING

Dr. Whaley presented his quarterly report, as the Guardian of Safe Working, and provided assurance to the Board that no junior doctors were working unsafe hours.

Dr. Land:

(1) Recognised the hard work undertaken by colleagues to address difficulties with core trainee recruitment (minute 17/328 – 19/12/17 refers).

(2) Advised that some issues had arisen with the Trust's approach to covering vacant shifts.

It was noted that, during its introduction, the Trust had sought to interpret the 2016 Junior Doctors' Contract as positively as practicable for junior doctors;

however, in doing so, it had been decided not to pay them to cover vacant shifts but to pay more for day to day work.

(3) Highlighted the continuing need to support the junior doctors as they remained bruised and upset by the imposition of the Contract.

The Board's discussions focused on:

(1) How the Trust compared to other Trusts.

In response Dr. Whaley advised that:

(a) From discussions at national and regional forums it was evident that the Trust had greater engagement with junior doctors than others.

(b) The Trust had been very proactive in making sure he had sufficient time to undertake his role.

Dr. Whaley also recognised the high level of support he received from the medical development department.

(c) The reasons for, and numbers of, exception reports received by Trusts varied.

He explained that:

- In some Trusts, exception reporting arose from cultural issues; however, this had not been experienced in TEWV.
- Exception reports in the Trust tended to reflect its rural nature and, unlike other Trusts, its use of non-resident rotas.

On the latter point Dr. Land assured the Board that the approach taken by the Trust to the development of the rotas had been reasonable as resident rotas would have created long shifts; required significant additional resources; and impacted on the time available for junior doctors to undertake training.

Dr. Whaley agreed that he would be concerned about long working days and missed breaks and was looking for ways of refocus exception reporting on those areas.

It was also suggested that access to training should also be included in his review.

(2) How the Trust could gain credit for the way it had introduced the 2016 Contract and overcome the hurt feelings of, and lack of trust from, the junior doctors.

Dr. Whaley considered that the junior doctors' lack of trust arose from the national imposition of the Contract. He hoped that over time, through discussions at both formal and informal forums, they would gain greater understanding and appreciation of the approach taken by the Trust and, with the support of the medical development department, seek to make improvements. The introduction of the flexible working champion would also be a positive development.

(3) How the Trust was also ensuring safe working amongst other medical and non-medical staff.

In response it was considered that:
(a) Feeling valued and having a sense of being in control were important for all staff.
(b) For medical staff, positive support had been provided by the mentor initiative.

(4) The position in South Durham which appeared to be an outlier.

Dr. Whaley advised that:
(a) A vacant post in inpatient services had impacted on the junior doctors in South Durham.
(b) The area also tended to require significant out of hours work, at unsocial times, but this was not at a rate which would cause problems under the Contract.

18/08 NURSE STAFFING REPORT

The Board received and noted the six monthly review report, for the period 1st June 2017 to 31st November 2017 , in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire NHS Foundation Trust ("Francis Review") and in line with National Quality Board (NQB) guidance.

Board Members considered that the overall increase in registered nurses in post, the development of nursing associate band 4 roles and the introduction of the duty nurse co-coordinators were positive developments and the increase in the commissioning of training places provided opportunities for the Trust.

The Non-Executive Directors raised the following matters:
(1) The action being taken to address the continuing increase in additional duties for enhanced observations.

Mrs. Moody advised that the increase in the use of enhanced observations was related to the greater acuity and complexity of patients but the Trust needed to understand if this approach provided the best way of protecting vulnerable people. Discussions were due to be held at the EMT "awayday" on 31st January 2018 on the prioritisation of work to be undertaken as part of phase two of the establishment reviews (minute 17/327 – 19/12/17 refers). This included the development of a QIS programme to gain better understanding of current practice around patient acuity and observation levels.

In addition, in relation to this matter:
(a) It was noted that services were examining different ways to address specific pressures, for example, forensic services were seeking to reduce the number of staff required to escort patients to James Cook Hospital for physical health appointments.

(b) The Non-Executive Directors questioned whether the use of enhanced observations could be planned and reflected in the rosters; a matter raised by staff during Directors' visits.

Mrs. Moody responded that the issue had been identified from work on the establishment reviews. For most wards, capacity for one enhanced observation was built into the baseline establishment; however, this was proving insufficient, for example organic wards in MHSOP now regularly had more than one patient on this level of engagement and observation. Further understanding was needed of the impact of the acuity and complexity of patients so that appropriate capacity for enhanced observations could be built into the rosters.

(c) It was noted that one of the reasons for the 50% increase in enhanced observations during the reporting period was the implementation of the New Care Model in Tier 4 CAMHS which had resulted in the inpatient services receiving patients with greater acuity and complexity than previously.

The Chairman asked for a report to be presented to the Board on the use of enhanced observations including trends. Board Members also asked for the paper to include information on contemporary best practice in this area.

Action: Mrs. Moody

(2) The reasons for the reduction in the number of registered and unregistered nurses in some Localities.

Assurance was provided that the changes to the staffing establishment related to planned service developments e.g. the introduction of the 12 hour shift system in the York and Selby Locality.

(3) The value of the national metric on care hours per patient day (CHPPD).

Mrs. Moody advised that feedback from colleague directors of nursing in acute providers, where the metric had been used for a longer period, had highlighted limitations with its value unless used with triangulation of quality data; however, it was recognised that it did provide a national benchmark.

(4) Compliance with mandatory training on Maple Ward.

The Board noted that this matter was being looked into; however, work on improving compliance with mandatory training was continuing and oversight had been improved.

(5) Whether any Trusts had ceased the use of prone restraint and how this had been achieved.

In relation to this matter it was noted that:

(a) Mersey Care NHS Foundation Trust had stated that it had significantly reduced the use of prone restraint and eliminated its use in learning

disability services. The Trust's positive and safe team had visited the Trust to learn from its experiences.

(b) Some Trusts, who had stated that they had eliminated the use of prone restraint, did not provide forensic, CAMHS, PICU services, etc. It was, therefore, important to make comparisons based on the type of unit in order to learn in a focussed way.

(c) Work had been undertaken in Tier 4 CAMHS on reducing the use of prone restraint for the purpose of administering rapid tranquillisation, one of the more common situations for which it was used, and the extension of the approach into adult services was being explored.

(d) A total ban on the use of prone restraint would be concerning as, in certain circumstances, it provided the safest option for service users and staff.

The Chairman emphasised that prone restraint should only be used in exceptional circumstances and questioned whether there were systems and processes in place to provide assurance on this matter.

Mrs. Moody explained that the use of prone restraint was scrutinised by the patient safety group on a quarterly basis with an update report provided to the Quality Assurance Committee; however, a presentation by the Lead Nurse, Positive and Safe, could also be provided.

It was agreed that the report should be considered by the Quality Assurance Committee.

Action: Mrs. Moody

(6) The number of medication errors at the Westwood Centre.

Mrs. Moody undertook to look into this matter and provide a report to the next Board meeting.

Action: Mrs. Moody

18/09 REPORT OF THE QUALITY ASSURANCE COMMITTEE

The Board received and noted the report of the Quality Assurance Committee including:

(1) The minutes of its meeting held on 2nd November 2017.

(2) The key issues considered by the Committee at its meeting held on 7th December 2017.

Dr. Griffiths, the Chairman of the Committee, highlighted the discussions at the latter meeting on the compliance issues arising from the clinical audit of emergency response bags, which had been escalated to the Board at its meeting held on 19th December 2017 (minute 17/328 refers) and the positive approach taken by forensic services to achieve full compliance.

In response to a question, it was noted that the reduction of the standard of cleanliness audits by hotel services, to below 80%, was due to both the new electronic method of scoring, which had brought increased consistency, and the need to take a more focused

approach, through training and awareness raising, to improve the scores. Assurance was provided that both these matters were being addressed.

18/10 EQUALITY AND DIVERSITY

Consideration was given to an update report on equality and diversity which included:

(1) Progress against the Workforce Race Equality Scheme (WRES) Action Plan (Appendix 1 to the report).

The report also sought approval for the detailed plans for indicators 2 ("Relative likelihood of staff being appointed from shortlisting across all posts"), 3 ("Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation") and 4 ("Relative likelihood of staff accessing non-mandatory training and CPD") as set out in Appendix 2 to the report.

The Board considered that, as a public document, the clarity of the wording of indicator 9 ("Percentage difference between the organisations' Board voting membership and its overall workforce") needed to be improved.

Mr. Levy took this on board but advised that there were constraints on the Trust's ability to amend the document.

Action: Mr. Levy

(2) The Trust's Equality Delivery System (EDS) 2 document (Appendix 3 to the report).

The Board noted that it had been agreed with the Joint Consultative Committee that the action plans to address the issues identified in relation to the workforce focused EDS2 metrics (graded as "developing") would be those in place for the WRES and the Disability confident scheme (as detailed in the report).

Board Members:

(a) Expressed their frustration that, whilst the Trust was aware of the issues, (e.g. from discussions at the Board Seminar held on 19th December 2017) the document focussed on undertaking further analysis rather than providing a commitment to taking forward practical and available actions to tackle them.

Mr. Levy shared these frustrations but considered that it would be wrong to disregard the findings of recent research undertaken with BME staff which should be available in March 2018.

(b) Considered that an urgent response was required to the issues raised at the Board Seminar in December 2017, in relation to the belief that incidents of abuse from patients, etc were not dealt with proactively and urgently, so that there was clarity for all staff on the Trust's stance.

In response it was noted that BME staff, at a recent follow up event to the Board Seminar, had developed practical recommendations for the Trust to consider on how it should respond when staff had been abused.

The Chairman asked for a report on the outcomes of the event to be provided to the Board.

Action: Mr. Levy

(c) Considered that information on the Trust's approach to engaging with BME communities, particularly where difficulties were being experienced, was missing from the document and suggested that it would be worthwhile to seek learning from other organisations.

The Chairman considered that:

- Rather than seeking to address this matter itself the Trust should work with other organisations (e.g. local authorities) who were better placed to engage with BME communities.
- The Trust needed to consider how to further expand its membership in BME communities recognising the limited resources available to do this.
- For the Board, there were opportunities through the appointment of Associate Non-Executive Directors to raise understanding and awareness of the Trust amongst BME communities.

With regard to this matter, Mr. Simpson, the Chairman of the Mental Health Legislation Committee, advised that he was seeking to increase the number of associate hospital managers from BME communities but this was difficult to achieve through the recruitment practices used to fill these positions.

(d) Considered that the good practice in involvement and engagement in the Trust, in addition to that through the experts by experience, should be reflected in the document.

Action: Mr. Levy

(e) Sought clarity on how the outcomes included in the EDS2 had been graded.

Mr. Levy explained that the gradings were based on an assessment of the extent people "fared well" against the defined outcomes based on the nine protected characteristics included in the Equality Act.

He advised that, to inform the assessment, the Trust had sought to engage with other organisations, the public and staff about how well the Trust was doing on each of the outcomes; however, eliciting external feedback had been challenging due to capacity issues in other organisations (e.g. local authorities, healthwatch organisations) and the relatively low proportion of the public who had experience of the Trust's

services. These issues had impacted on the Trust's ability to make informed judgements on the public and patient focussed outcomes.

It was noted that greater feedback had been received from staff so there was more confidence in the grading of the relevant outcomes included in the self-assessment.

Board Members recognised the limitations of the national approach to improving services provided to local communities and working environments through the EDS2.

Mr. Levy advised that he had previously raised concerns on this matter with the Equality and Diversity Council but had received no response. He undertook to do so again, possibly in conjunction with other Trusts.

Action: Mr. Levy

Overall, the Board considered that, based on the information available to it, the grading of the outcomes set out in the document were reasonable.

(3) The Trust's Equality, Diversity and Human Rights Policy as required by the Mental Health Act Code of Practice (Appendix 4 to the report).

Board Members made the following comments:

(a) Section 8.5 ("Trust Services – Planning Services") should reflect that the Trust would challenge commissioners where differential funding impacted on its ability to fulfil its duties under the Equality Act.

Mr. Levy responded that the Trust had previously engaged with Commissioners in relation to age equality issues.

(b) The language used in the document should be more assertive e.g. it should include a definitive statement that a zero tolerance approach would be taken to abusive behaviour.

(c) The statement in the "F.R.E.D.A. Human Rights in Healthcare" document (Appendix 1 to the Policy), that people should not be treated differently because of their beliefs, was incorrect as the beliefs of communities in relation to mental ill-health needed to be acknowledged and the Trust's approach to treatment tailored to them.

Whilst recognising that the term "treating" was ambiguous, given its medical connotations, the Board considered that the statement referred to everyone being entitled to the right standard of care which was appropriate for their needs and free from discrimination.

Agreed –

(1) that the detailed plan for the WRES indicators 2, 3 and 4 as set out in Appendix 2 to the above report be approved;

(2) that the EDS2 document, as set out in Appendix 3 to the above report, as amended, be approved and published on the Trust's website;

(3) that the EDS2 metrics relating to staff be reviewed in two years' time and those relating to patients in three years' time; and

(4) that the Equality, Diversity and Human Rights Policy (Appendix 4 to the above report) be approved subject to:

(a) the inclusion of a statement that the Trust will challenge Commissioners where differential funding arrangements impact on its ability to fulfil its duties under the Equality Act;

(b) the wording of the document being made more assertive; and

(c) the wording of the "F.R.E.D.A. Human Rights in Healthcare" document being reviewed to seek to remove ambiguity.

Action: Mr. Levy

18/11 IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES

Further to minute 17/271 (31/10/17) the Board received and noted a report which provided a summary of the current issues for the three Improving Access to Psychological Therapies (IAPT) services provided by, on jointly by, the Trust in County Durham and Darlington, North Yorkshire and York and Selby together with information on the main themes arising from, and action taken in response to, the support provided to them by the National Intensive Support Team (IST).

Arising from the report, the Board:

(1) Sought clarity on the impact on the North Yorkshire IAPT service as the cohorts of trainees, who represented 38% of the present workforce, left for permanent post qualifying work from January 2018.

Mr. Brown advised that the training places had been funded by Health Education England and the resources would need to be replaced either by self-funded trainees or by the CCG.

(2) Questioned the strategic importance of IAPT services to the Trust and whether they could be better provided by other organisations.

In response it was noted that:

(a) IAPT services had a place in the range of services offered by the Trust if it could make them work either by itself or with other organisations; however, this depended on the approach to commissioning.

(b) The service was also important in the context of the Trust's overall offer and the links between the IAPT services and secondary care e.g. in areas where the Trust did not provide IAPT services boundary issues tended to emerge with the service providers.

(c) In relation to the position in each Locality:

- In County Durham and Darlington, although in a good position to deliver the important aspects of the service, difficulties could be created if, as part of the re-procurement, investment was made in well-being services rather than high intensity interventions.
- In North Yorkshire there was insufficient funding to provide the service and, if additional resources were not made available, the Board would need to consider its future sustainability.

- In York and Selby, the service worked with other organisations to meet demand and it might be beneficial to develop this model in other areas.

(3) Discussed whether IAPT services provided the most appropriate means of responding to the needs of people with common mental health issues given the number of serious incidents relating to the service and the relatively low national target (50%) for recovery.

On this matter it was noted that:

(a) The definition of "recovery", as set out in national guidance, was important. If a service user did not meet the required criteria, even though they had improved, it would not be classed as recovery.

(b) A thematic review was being undertaken of the serious incidents involving the services; however, to an extent, it was recognised that there were risks due to the high volume of activity and from the services responding to people with previously unmet needs.

(4) Sought clarity on the number of performance improvement notices received by the Trust and the governance arrangements relating to them.

Mrs. Pickering advised that:

(a) The Trust did not receive many performance notices.

(b) They tended to be received via discussions at contract management boards.

(c) Their use by CCGs varied with some Commissioners preferring the formal process whilst others took an informal approach.

(d) There were also difficulties, at times, in understanding the expectations of Commissioners from a performance notice.

The Board noted that where performance issues arose the Trust would take action to address them. This would be sufficient for some CCGs; however, others would issue a formal notice. In the latter cases it was difficult to understand what more the Commissioners expected from the Trust.

It was recognised that there should be greater visibility on the receipt of performance notices and it was considered that this could be provided through the reportable issues log.

Action: Mr. Martin

18/12 SUMMARY FINANCE REPORT AS AT 31ST DECEMBER 2017

Consideration was given to the summary Finance Report as at 31st December 2017 including the Trust's Quarter 3, 2017/18, submission to NHS Improvement.

The focus of the Board's discussions was on the Trust's CRES position. In response to questions Mr. Kendall advised that:

(1) The delivery of CRES schemes was subject to ongoing monitoring by the Finance Directorate and discussed regularly by the EMT.
(2) The present national requirement was to achieve an efficiency target of 2%, the lowest rate ever set.
(3) As discussed at the Board Business Planning event in January 2018 the achievement of the target of £3m, which included unmet CRES carried forward from previous years, was becoming more difficult and discussions had been held with NHS Improvement on this matter.
(4) The implications for the future financial sustainability of the Trust would be worked through in the development of the budget setting paper which was due to be presented to the Board on 27th March 2018.

Mr. Martin highlighted that the use of non-recurrent resources to support achievement of the Trust's CRES requirements had opportunity costs. This approach to the delivery of CRES, rather than through recurrent savings, would result in a steady decline in the Trust's finances and there were risks that it could lead to a rapid deterioration. The Board, when considering the Trust's CRES schemes, therefore, needed to consider their impact on the Trust's overall financial position.

***Agreed** – that the Trust's Quarter 3, 2017/18 submission to NHS Improvement, in accordance with the results detailed in the above report, be approved.*

Action: Mr. Kendall

18/13 PERFORMANCE DASHBOARD AS AT 31ST DECEMBER 2017

The Board received and noted the Performance Dashboard Report as at 31st December 2017.

Board Members raised the following issues:
(1) Whether the impact of flu had reached its peak.

Mrs. Moody:
(a) Advised that this appeared to be the case as the number of admissions to acute Trusts had reduced.
(b) Considered that it would be helpful to review the number of staff who had been off work with flu and to, potentially, use this information as part of next year's vaccination campaign.

(2) The impact of the increase in the acuity of patients on wards on patient experience.

On this matter:
(a) It was noted that November 2017 had not been perceived as a difficult month.
(b) Mr. Martin, noting the significant reduction in performance on KPI 10 ("Percentage of patients surveyed reporting their overall experience as excellent or good - mth behind)" from 91.54% in October 2017 to 68.63% in November 2017, asked for the position to be checked in case there had been changes to data collection processes.

Action: Mrs. Pickering

(3) The position on caseload turnover (KPI 2) which had halved during December 2017.

Mrs. Pickering explained that, as part of the PPCS programme, the caseload management tool was being used to make sure that services did not hold on to patients for longer than was necessary and a reduction on the metric should be viewed positively.

Dr. Land highlighted the increase in referrals by 12%, which taking into account the Trust's CRES requirements, meant that services needed to make a 14% increase in productivity during 2017/18.

The Board recognised importance of this matter in the context of contract negotiations with Commissioners and the level of activity which the Trust was expected to provide rather than absorb.

18/14 SINGLE OVERSIGHT FRAMEWORK

The Board received and noted the report on the Trust's indicative position against NHS Improvement's revised Single Oversight Framework for Quarter 3, 2017/18.

The Board noted that at the Quarterly Review Meeting with NHS Improvement on 25th January 2018:

(1) Commissioning, the Trust's financial position, the issues being experienced at Roseberry Park and the new metrics for out of locality admissions had been discussed.
(2) No material issues had been raised by the regulator.

18/15 ORGANISATIONAL RISK MANAGEMENT POLICY

Consideration was given to the draft revised Organisational Risk Management Policy which had been prepared in response to the recommendations arising from a review undertaken by the Internal Auditors (assignment ref. 18/17) and the External Governance Review in 2017.

The report recommended that the revised Policy should come into force on 1st April 2018 to enable the provision of additional resources to support risk management in the Trust.

The Chairman sought assurance from the Board that the Trust's risk appetite statement (section 4.2 of the draft policy) was appropriate.

In relation to this matter, clarity was sought on whether the Trust's approach to balancing, often competing, clinical risks should be reflected in the statement.

In response Board Members recognised that, as no intervention was risk free, all clinical decision making involved balancing risk; however, it was not considered necessary to specifically reference this issue in the risk appetite statement.

Taking this into account the Board confirmed the proposed risk appetite statement.

Board Members also questioned the delegation arrangements, based on risk grade, set out in the draft policy.

Mr. Bellas explained that, although the management of risks was allocated to governance groups by risk grade, oversight and monitoring of risks would be undertaken through the organisational roles and responsibilities and escalation arrangements described in the document.

> ***Agreed –*** *that the Organisational Risk Management Policy be approved to come into force on 1st April 2018.*
>
> **Action: Mr. Bellas**

18/16 USE OF THE TRUST SEAL

The Board received and noted the report on the use of the Trust Seal in accordance with Standing Orders.

18/17 DATE OF NEXT MEETING

It was noted that the next meeting of the Board of Directors was due to be held at 9.30 am on Tuesday 27th February 2018 in the Board Room, West Park Hospital, Darlington.

18/18 CONFIDENTIAL MOTION

> ***Agreed*** *– that representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:*
>
> *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.*
>
> *Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.*
>
> *Information relating to the financial or business affairs of any particular person (other than the Trust).*
>
> *Information which, if published would, or be likely to, inhibit -*
> *(a) the free and frank provision of advice, or*
> *(b) the free and frank exchange of views for the purposes of deliberation, or*

(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.

Any advice received or information obtained from legal or financial advisers appointed by the Trust or action to be taken in connection with that advice or information.

Following the transaction of the confidential business the meeting concluded at 1.20 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Durham and Darlington Locality:
That Difficult Second Season

Patrick Scott

Director of Operations

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Themes – PPCS…..But Don't take your eye off the ball!!

- Changing commissioner landscape
- ACP
- External world
- Redefining the team…….again!
- Leadership team
- Workforce

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To provide excellent services, working with the individual users of our services and their carers, to promote recovery and well being

- Involvement……but not as we know it
- Lassoing the whirlwind – CAMHS
  - Individual packages
  - New models of delivery
  - Strategic commissioning
- IAPT and Primary Care
- Urgent Care
- The bigger picture!.....RP/Friarage/

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To continuously improve the quality and value of our work

- PPCS
  - The right thing to do…….but the ask is getting tougher
- QIS
  - Daily Lean Management - constantly evolving….the Truth Is Out There

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To recruit, develop and retain a skilled, compassionate and motivated workforce

- Challenges and opportunities
  - Significant change in senior leadership team……new team starting to take shape
  - All groups all grades!
  - Move away from discussing profession specific competencies
  - Recruit, retain, develop
  - Talent management – embedding within locality

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To have effective partnerships with local, national and international organisations for the benefit of our communities

- Local
  - Urgent Care Vanguard / Crisis Care Concordat
  - Local Authorities
  - System leadership – Clinical, Operational and Strategic
  - HWB's and Integration Boards
- National
  - Input into NICE Guidelines and other national work, e.g. IAPT Trailblazer pilot
  - Member of National Collaborative for Positive Practice in Mental Health
  - Parent rep's C&YPS presented to House of Lords on impact of self harm and experiences with CAMHS
  - National conferences
- International
  - Virginia Mason

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To be recognised as an excellent and well governed Foundation Trust that makes best use of it's resources for the benefit of our communities

- Financial Issues
  - Tough year
  - Flexible staffing
  - CRES
  - Continue work to tidy up budgets
  - Notable successes (Street triage, Core 24, community rehab, CAMHS ED, 24/7 Liaison and CAMHS Crisis, EIP, LD)
- LMGB
  - Review and PDSA of Governance structures – Season 2

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

And finally….

making a difference together

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th February 2018**
TITLE:	**Board Action Log**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information/Assurance**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	✓
To continuously improve the quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	✓

Executive Summary:

This report allows the Board to track progress on agreed actions.

Recommendations:

The Board is asked to receive and note this report.

Board of Directors Action Log

RAG Ratings:

	Action completed/Approval of documentation
	Action due/Matter due for consideration at the meeting.
	Action outstanding but no timescale set by the Board.
	Action outstanding and the timescale set by the Board having passed.
	Action superseded
	Date for completion of action not yet reached

	Minute No.	Action	Owner(s)	Timescale	Status
29/11/2016	16/289	Team based culture metrics reports to be introduced	DL	Feb-18	See agenda item 9
28/03/2017	17/62	The potential for expanding the proposed managers' tool, for recording concerns raised to the Freedom to Speak Up Guardian to cover all concerns raised by staff, to be explored	DL	Apr-18	
20/07/2017	17/194	A full report (and recommendations) on the values, behaviours and staff compact consultation events to be provided to the Board	DL	Feb-18	See agenda item 9
26/09/2017	17/228	Consideration to be given to reviewing the targets in the Strategic Direction Performance Report for 2018/19	SP	Apr-18	
26/09/2017	17/230	Reviews of the operational arrangements of the Quality Assurance, Resources and MHL Committees to be undertaken	PB	~~Feb-18~~ Mar-18	

	Minute No.	Action	Owner(s)	Timescale	Status
31/10/2017	17/264	A report to be provided on the Trust's taxi contracts including the incidence of alleged inappropriate behaviour by taxi drivers and the measures in place to protect vulnerable people.	DB	Feb-18	Information on the Trust's taxi contracts was provided to Board Members on 23/11/17. Investigtions into the specific case raised by the Guardian of Safe Working has resulted in no further detail or clarification and the medical development department will continue to monitor this issue in forums with Junior Doctors
31/10/2017	17/268	An update report on the Temporary Staffing Service to be presented to the Board	DL	Apr-18	
31/10/2017	17/269	A further report to be provided to the Board on the interpretation and application of the MHA and DOLS once the local authorities have responded to the solicitors' letter	EM	-	A timescale cannot be set for this action as it is dependent on the response from the local authorities
31/10/2017	17/271	The position on Performance Dashboard KPI 6 ("Number of instances of patients who have 3 or more admissions in a year") in County Durham and Darlington to be reviewed	DB	Feb-18	Verbal update to be provided to the meeting
28/11/2017	17/295	A paper to be provided to Board Members describing the controls covering commercial studies	Prof. JR	May-18	
28/11/2017	17/297	An update on the performance of the nurse agency provider to be provided to the Board	DL	Feb-18	See private agenda item 4

	Minute No.	Action	Owner(s)	Timescale	Status
28/11/2017	17/297	Information on wards not regularly meeting their fill rates to be included in the reports on the Establishment Review	EM	Mar-18	
28/11/2017	17/298	The age profile of people who had died to be included in future "learning from deaths" reports	EM	Feb-18	See agenda item 8
28/11/2017	17/298	To aid transparency consideration to be given to including the following matters in future "learning from deaths" reports: - A “question and answer” section (possibly as an appendix to the report) to support understanding of the scope of those deaths within policy and the triggers for the different types of review - A formal statement on the scope of the policy and to provide assurance that all relevant deaths have been reviewed	EM	Feb-18	See agenda item 8
28/11/2017	17/298	The issues being experienced with the LeDer programme to be brought to the attention of the National Quality Board	EM	Mar-18	Completed
28/11/2017	17/299	The outcome of the workshop held by the MHLC to be included in the review of the operational arrangements of the Board's committees	PB	~~Feb-18~~ Mar-18	(See also minute 17/230)
28/11/2017	17/300	A report to be presented to the Board to provide an update on progress towards the completion of the 2017/18 composite staff action plan and to enable consideration of a proposed 2018/19 action plan	DL	May-18	
28/11/2017	17/301	A report to be provided to the Board on the use of fixed term contracts in the Trust including how they are being used and for which staff groups	DL	Feb-18	Information provided to the Resources Committee (See private agenda item 10)
28/11/2017	17/301	A further progress report on the implementation of the Recruitment and Retention Action Plan to be presented to the Board	DL	May-18	
28/11/2017	17/305	A briefing to be provided to the Board on the event in 2018 in relation to sickness absence and whether further action can be taken to support the health and wellbeing of staff	DL	Apr-18	

	Minute No.	Action	Owner(s)	Timescale	Status
28/11/2017	17/307	A report to be presented to the Board on the outcome of the thematic review of whether patients feel safe and staffing issues being undertaken by the patient safety team	EM	Apr-18	
19/12/2017	17/327	A report to be presented to the Board on the outcome of the review of the 12 hour shift system	DL	Jan-19	
19/12/2017	17/329	A briefing document to be produced to raise understanding and awareness of the issues impacting on ASD waiting times	DB	Mar-18	
30/01/2018	18/08	A report to be presented to the Board on the use of enhanced observations (including trends) together with information on contemporary best practice in this area.	EM	Jul-18	
30/01/2018	18/08	A report on the use of prone restraint to be provided to the Quality Assurance Committee	EM	Apr-18	
30/01/2018	18/08	The number of medication errors at the Westwood Centre to be reviewed and a report provided on this matter to the Board	EM	Feb-18	Verbal report to be provided at the meeting
30/01/2018	18/10	A report on the outcomes of the recent event involving BME staff (a follow up to the discussions at the December 2017 Board Seminar), in relation to how the Trust should respond when staff have been abused, to be presented to the Board	DL	Mar-18	
30/01/2018	18/10	The limitations of the national approach, through the EDS2, to be raised with the Equality and Diversity Council, possibly in conjunction with other Trusts	DL	May-18	
30/01/2018	18/10	The wording of indicator 9 (“Percentage difference between the organisations’ Board voting membership and its overall workforce”) of the WRES Action Plan to be reviewed	DL	Feb-18	Completed *(Note: advice has been recevied that the wording of the indictor cannot be changed)*
30/01/2018	18/10	Approval of the action plans for WRES indicators 2, 3 and 4	DL	-	Approved

	Minute No.	Action	Owner(s)	Timescale	Status
30/01/2018	18/10	Approval of the EDS2 document, as amended, for publication	DL	-	Approved
30/01/2018	18/10	Approval for the EDS2 metrics relating to staff be reviewed in two years' time and those relating to patients in three years' time	DL	-	Approved
30/01/2018	18/10	Approval of the Equality, Diversity and Human Rights Policy subject to: - The inclusion of a statement that the Trust will challenge Commissioners where differential funding arrangements impact on its ability to fulfil its duties under the Equality Act - The wording of the document being made more assertive - The wording of the "F.R.E.D.A. Human Rights in Healthcare" document being reviewed to seek to remove ambiguity	DL	-	Approved
30/01/2018	18/11	To note that the Board is to be informed of the receipt of contract performance notices through the Reportable Issues Log	CM	-	To note
30/01/2018	18/12	Approval of the Trust's Quarter 3, 2017/18 submission to NHS Improvement	DK	-	Approved
30/01/2018	18/13	The position on Performance Dashboard KPI 10 to be checked	SP	-	Completed *(Note: a revised version of the report was provided to Board Members and published on the Trust's website on 7/2/18)*
30/01/2018	18/15	Approval of the Organisational Risk Management Policy to come into force on 1st April 2018.	PB	-	Approved

ITEM 6

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 27 February 2018**
TITLE:	**Assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
REPORT FOR:	**Assurance**

This report supports the achievement of the following Strategic Goals:	
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	✓
To continuously improve the quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	✓

Executive Summary:

The purpose of this report is to update the Board of Directors on any current areas of concern in relation to quality and to provide assurance on the systems and processes in place.

Assurance statement pertaining to QuAC meeting held on 01 February 2018:

The Quality Assurance Committee has consistently reviewed all relevant Trust quality related processes, in line with the Committee's Terms of Reference. Issues to be addressed have been documented, are being progressed via appropriate leads and monitored via the appropriate sub-groups of QuAC.

Key matters considered by the Committee are summarised as follows:

The Locality areas of Durham & Darlington and Tees services where key concerns were around staffing pressures, pressure in children's services and challenges relating to changes to senior clinical leadership team (Durham & Darlington) and difficulty accessing placements in Children and Young People's PICU (Tees)

- Reports from the Patient Safety Group and Patient Experience Group and the Clinical Audit and Effectiveness Performance Report.
- Quality Account Update report, Quarter 3.
- Bi-monthly update on Drug & Therapeutics.
- CQC compliance and Safeguarding & Public Protection assurance updates and the re-audit of Emergency Response Bags.

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 01 February 2018.
- Note the confirmed minutes of the meeting held on 07 December 2017 (appendix 1).

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 27 February 2018**
TITLE:	**Assurance report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting on 01 February 2018.

2. BACKGROUND INFORMATION AND CONTEXT

This report makes reference to the regular assurance reports from the clinical governance infrastructure, which includes the Locality Management and Governance Boards, together with the corporate assurance working groups of the Quality Assurance Committee, including progress reports. Monthly compliance with the Care Quality Commission regulatory standards, with copies of assurance reports to support the regulatory standards were also considered.

3. KEY ISSUES

The Committee received updates from the Locality Directors of Operations around the principal risks and concerns, together with assurances and progress from Durham & Darlington and Tees.

4. QUALITY ASSURANCE - EXCEPTIONS/ASSURANCE REPORTS FROM THE LOCALITY MANAGEMENT GOVERNANCE BOARDS (LMGBS) AND SUB-GROUPS OF THE COMMITTEE

The Committee received key assurance and exception reports from LMGBs and standing Sub-Groups of the Committee, highlighting any risks and concerns.

4.1 DURHAM AND DARLINGTON LMGB

The Committee noted the LMGB report for Durham and Darlington noting the top concerns which were staffing pressures, pressure in children's services and challenges relating to changes to senior clinical leadership team.

Assurance was provided to the Committee that mitigating actions were in place to address these concerns.

4.2 TEES SERVICES LMGB

The Committee noted the LMGB report for Tees noting the top concern which was the difficulty accessing placements in Children and Young People's PICU and Medium Secure settings. This resulted in the long term seclusion of a young woman within Westwood Low Secure Ward and increased levels of acuity being managed within Newbury Assessment and Treatment Ward.

Assurance was provided to the Committee that discussions were underway with EMT around long term seclusion and plans to develop a PICU on West Lane site.

The Committee requested at a future meeting more detail around the number of suicides where finance has been a significant factor.

4.4 **Patient Safety**

The Committee noted the assurance report of the Patient Safety Group for Q1 and Q2 2017/18, the Patient Safety Quality Data Reports for October and November 2017 and an assurance report following a safeguarding adult specialist case review.

In addition the Committee noted the data published by National Reporting and Learning System (NRLS) for November 2016 to October 2017, which shows the total number of incidents reported. The results show that the Trust reports more incidents with severity of either no harm or low harm and comparatively the Trust stands in a mid- table position from a national perspective.

The Committee noted their concerns over the lack of improvement around record keeping, which was repeatedly being raised in Serious Incident reports. It was agreed to include more detail on record keeping issues in the Annual Patient Safety Report due to the committee in June 2018.

4.5 **Patient Experience**

The Committee noted the Patient Experience assurance report.

Assurance was provided that the Patient Experience Group has reviewed all relevant Trust patient experience activities in line with the Group's terms of reference and any issues were being progressed by appropriate leads.

The Committee requested further information on the involvement of service users and carers at the Patient Experience Group and whether this was representative and effective. This will be reported to the April 2018 Quality Assurance Committee meeting.

4.6 **Safeguarding and Public Protection**

The Committee noted the exception report of the Safeguarding and Public Protection Sub-Group.

The risk of contractual penalties by not achieving Safeguarding Level 3 training continues and although improvements have been made, we are not hitting the target of 98%.

The Committee was assured that the Trust continues to meet the legal requirements for safeguarding adults and children within the legislative framework.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 **Compliance with CQC Requirements Report**

The Committee was assured that all actions raised following recent CQC Mental Health Act (MHA) inspections were being addressed following three reports received.

There has also been an Ofsted inspection of Holly and Baysdale Unit since the registration of Trust premises and feedback received was that the overall experience for children and young people was good. Issues to focus on going forward will be documentation as this is more focussed towards a healthcare model rather than that of social care.

There was discussion around the preparations in place for the expected CQC compliance inspection.

5.2 **Clinical re-audit of Emergency Response Bags**

The Committee received the results of the re-audit of Emergency Response Bags.

The results were disappointing given that 12% of cases were found to have no extra oxygen cylinder in the department and in 21% of cases, in the two weeks prior to completion of the audit, the emergency response bags and automated external defibrillator were not being checked daily.

The Committee requested that due to the serious potential risk to patient safety that the audit be undertaken again in March 2018 and reported to the Quality Assurance Committee in April 2018.

5.3 **Clinical Audit and Effectiveness Performance Report**

The Committee noted the quarterly Clinical Audit and Effectiveness Performance Report.

The current clinical audit programmes completed as at end of December 2017 was 38.46%. There are 2 programmed clinical audit action points outstanding over three months and this is being addressed.

The key matter discussed was audit 4895: Children and Young People's Service, restraint in Tier 4 CAMHS scoring 0-49%. Work was underway to look at the recording issues around this which was thought to be a contributory factor to the low score.

There were no matters for escalation.

5.4 **Quality Account – Quarter 3**

The Committee noted the update report on the Quality Account for Quarter 3.

Assurance was provided to the Committee that all of the five quality priorities for 2017/18 were on track.

In terms of the quality metrics three out of nine (33%) were reporting green with six out of nine (67%) reporting as red. All three patient experience domain metrics were below target and two of these, along with patient reported perceptions of safety will need significant improvement if the full year target is to be achieved.

The Committee discussed the setting and attainability of targets and metrics and recognised that the Quality Account is a key early warning system to highlight any trends. These discussions will be taken to the Quality Account Stakeholder meeting on 6 February 2018.

5.5 **Drug and Therapeutics**

Assurance was provided on the monitoring of quality and performance data, planned work streams for the implementation of safe and economic use of medicines and compliance with best practice standards.

The Committee noted the update and the revised terms of reference for the Drug and Therapeutics Committee.

There were no matters for escalation.

5.5 **Issues that impact on the Trust's strategic or key operational risks.**

There were no issues that will impact on the Trust's strategic or operational risks.

6. IMPLICATIONS

6.1 **Quality**

One of the key objectives within the QuAC terms of reference is to provide assurance to the Board of Directors that the organisation is discharging its duty of quality in compliance with section 18 of the Health Act 1999. This is evidenced by the quality assurance and exception reports provided, with key priorities for development and actions around any risks clearly defined.

6.2 **Financial/value for money**

There were no direct financial implications arising from the agenda items discussed.

6.3 **Legal and Constitutional (including the NHS Constitution)**

The terms of reference, reviewed annually, outline compliance requirements that are addressed by the Quality Assurance Committee.

6.4 **Equality and Diversity**

There are no issues to note.

7. CONCLUSIONS

The Quality Assurance Committee considered and noted the corporate assurance and performance reports that were received. The Committee were assured that as far as practicable, all risks highlighted were being either managed or addressed with proposed mitigation plans.

8. RECOMMENDATIONS

That the Board of Directors is asked to note the issues raised at the Quality Assurance Committee meeting on 01 February 2018 and to note the confirmed minutes of the meeting held on 07 December 2017 (appendix 1).

Jennifer Illingworth
Director of Quality Governance
February 2018

Item 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 7 DECEMBER 2017, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Mrs Lesley Bessant, Chairman of the Trust
Dr Hugh Griffiths, Chairman of the Committee
Mr David Brown, Acting Chief Operating Officer
Dr Nick Land, Medical Director
Mr Colin Martin, Chief Executive
Mrs Elizabeth Moody, Director of Nursing & Governance
Mr Richard Simpson, Non-Executive Director
Mrs Jennifer Illingworth, Director of Quality Governance

In attendance:
Mrs Karen Agar, Associate Director of Nursing and Governance
Mr Levi Buckley, Director of Operations, Forensic Services (for minute 17/162)
Mr Dominic Gardner, Acting Director of Operations, Tees
Mrs Linda Parsons, Associate Director, Operational Services (for minute 17/167)
Mrs Ruth Hill, Director of York & Selby Services (for minute 17/161)
Mr Chris Williams, Chief Pharmacist (for minute 17/170)
Ms Donna Oliver, Deputy Trust Secretary (Corporate)

17/158 APOLOGIES FOR ABSENCE

Apologies for absence were received from: Dr Ingrid Whitton, Deputy Medical Director, Durham & Darlington, Mrs Shirley Richardson, Non-Executive Director and Dr A Khouja, Deputy Medical Director, Forensic Services.

17/159 MINUTES OF THE PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 2 November 2017 be signed as a correct record by the Chairman of the Committee.

17/160 ACTION LOG

The Committee updated the QuAC Action Log, taking into account relevant reports provided to the meeting.

17/86 Future Health, Safety and Security reports to show fire incidents broken down by hospital location.

Completed

17/97 b)	D&D LMGB report – more context around adult LD non-compliance due to rejection of referrals. This would come back to the meeting in April 2018.
17/146	Incidents of prone restraint to be appended to Patient Safety Report. **Completed**
17/147	Follow up on low (11) responses from Ward Managers following audit: "is there anything we could do to make the service better". This would come back to the meeting in February 2018.
17/146 i)	Forensic reports to reflect instances of suicides associated with Liaison and Diversion services that the Trust is required to report as SI's. **Completed**
17/149	Check on the inclusion of NE community MH teams in peer review visits. **Completed**

17/161 YORK AND SELBY SERVICES LMGB REPORT

The Committee received and noted the York and Selby Services LMGB Report.

Arising from the report it was highlighted that the top concerns at present were:

(1) Transition of services from Humber to TEWV.
The Humber contract notice would be brought forward following operational discussions to 1 February 2018. This would affect the Pocklington geography and service plans were being developed.
(2) Capacity and demand issues with ongoing problems with CAMHS services, Access and Wellbeing Service and IAPT.
(3) Staffing
There were vacancies in nursing rosters due to the complexity of patients and the need for enhanced observations. This had led to increased anxiety amongst Ward staff, particularly on Oak Rise due to the complexity of patients. In addition there were concerns over safe staffing levels. This had been escalated to Human Resources.
There were also concerns from bed based specialties over the responsiveness of Retinue to meet temporary staffing needs.

Non-Executive Directors noted their disappointment that Retinue had not been fit for purpose. A counter measure had been introduced to give Retinue access to the Trust roster which should help to address issues.

In response to a query around the use of a private company to undertake a waiting list initiative in CAMHS it was noted that this would be a company run by ex TEWV staff so there was a degree of confidence in the quality of the work that would be done.

Following discussion it was noted that the high number of falls was partly attributable to the reporting methods around falls and that the service was not an outlier.

17/162 FORENSIC SERVICES LMGB REPORT

The Committee received and noted the Forensic Services LMGB Report.

Arising from the report it was highlighted that the top concerns at present were:

(1) Staffing – with a combination of factors including acuity of the patient population, clinical complexity and subsequent levels of interventions requiring intensive nursing input.
On this matter it was noted that FMH and FLD were looking at joined up working to manage pressures across the site.

(2) Emergency Equipment Audit
Assurance was provided that following the results of the audit, which had revealed only seven areas out of twenty one had achieved 100% compliance, Forensic Services had taken immediate action to rectify the position. Modern Matrons would be monitoring respective clinical areas on a regular basis to ensure standards were met.

The Committee was assured that areas of concern were being addressed with mitigating actions in place to ensure 100% compliance with the emergency equipment standard.

(3) Clinical Supervision
The results of Quarter 1 2017/18 Clinical Supervision audit had indicated the Service was not meeting the required standard in all areas and the issue had been identified in discussions with NHS England Specialist Commissioners.

Following some focused work to explore the issues impacting on supervision the service had achieved 100% compliance in Quarter 2.

17/163 PATIENT SAFETY GROUP ASSURANCE REPORT

The Committee received and noted:

(1) The assurance report of the Patient Safety Group, pertaining to the meeting held on 20 November 2017.
(2) The Patient Safety Group Quality Report for period 1 to 30 September 2017.
(3) Thematic Review of Durham City Affective Disorder Service.
(4) Positive and Safe Update Report for Quarter 2, 2017/18.
(5) Falls Report for Quarter 2, 2017.

The Committee was provided assurance on the monitoring of quality and performance indicators, planned work streams and system implementation on the safety of care, incident and alert management.

Following discussion it was noted that:

(1) The action plan associated with the Durham Effective Disorder Service would be monitored through QuAG, the locality meeting and the Patient Safety Group on a quarterly basis.
(2) Following the mortality review there had been 13 unexpected deaths on CPA, however it was felt that these were probably due to unexpected natural causes. Mrs Illingworth noted that the wording around unexpected deaths could be made clearer in future reports.
(3) There had been a significant increase in the number of restrictive practices in children and young people's services compared to Quarter 2 2016/17.

Agreed: i) To look at the wording around unexpected deaths.
ii) To provide more detail in future reports around the number of restrictive practices in children and young people's services.

Action: Mrs Illingworth

17/164 INFECTION, PREVENTION AND CONTROL QUARTERLY REPORT

The Committee received and noted the Infection, Prevention and Control Quarterly report.

The Committee received assurance on the work streams relating to Quarter 2.
Following discussion concern was noted around the standard of cleanliness audits by hotel services which had reduced to below 80%.

A Kaizen event had revealed that a new electronic method of scoring had contributed to the decline in scores and the top 10 areas were being addressed.

17/165 SAFEGUARDING & PUBLIC PROTECTION EXCEPTION REPORT

The Committee received and noted the following:

(a) The Safeguarding and Public Protection Exception report
The key matter highlighted was the potential risk of not achieving the agreed trajectories for Safeguarding Level 3 training with penalties attached.

Assurance was provided that the compliance rate was at its highest to date however had not reached the 98% target and all efforts were being made to improve the position.

(b) Annual report of the Safeguarding and Public Protection Group

There had been an increase in safeguarding activity across the year for the Trust and the team continued to act as a single point of contact for Multi-Agency Safeguarding Hubs (MASH).
The challenges for the coming year would be capacity within the team to address the increase in work.

Non-Executive Directors sought clarity on the differentiation across Local Authorities for progressing Multi-Agency Safeguarding Hubs.

Mrs Moody noted that South Tees Local Authorities were not progressing with the proposed joint MASH as they were looking at their own model and there was no standardisation. Various models and processes had however been agreed through Safeguarding Boards.

(c) Assurance report of the Safeguarding and Public Protection Sub-Group.

An overview of the activity from the Safeguarding and Public Protection team provided assurance on compliance with the required standards and legislation and for the CQC Fundamental Standards.

17/166 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee received and noted the Compliance with CQC Registration Requirements Report.

Arising from the report it was noted that:

(1) All actions raised by CQC Mental Health Act (MHA) inspections were being addressed following three reports received.
(2) There had been a CQC Engagement meeting held, which had been positive.
(3) Following formal Ofsted registration approval the independent monthly review inspections had commenced in line with Regulation 44 recommendations and these would be formally submitted to Ofsted for review. The findings from the inspections had been positive.
(4) Recurring themes continued across areas, which were being raised following inspections.

Following discussion the Committee requested:

(1) Further information on Oak Ward where four environmental issues had been raised at Ward level following peer review inspection.

(2) That a "crib sheet" to be produced for Directors visits of the top five areas for focus coming out of inspections in January 2018.

Action: Mrs J Illingworth

17/167 HEALTH, SAFETY, SECURITY AND FIRE REPORT

The Committee noted the Health, Safety, Security and Fire Assurance Report.

Arising from the report it was noted that:

(1) Following a request by the Quality Assurance Committee the details of fire incidents had been included in the report.
(2) There were no issues of concern or matters of escalation.

17/168 CQC MENTAL HEALTH COMMUNITY SURVEY RESULTS

The Committee received and noted the results from the National Community Mental Health Survey 2017.

Arising from the report it was noted that:

(1) There had been a slight improvement on the response rate of 29%, compared to 28% last year, which was above the national response rate of 26%. When comparing the Trust with other organisations the scores were identified as being "about the same" as others across all 10 sections.

(2) The main issue of note was the declining rating around care experience which had dropped from 74.3% in 2016 to 70.9%. Further scrutiny of how this would be improved was underway.

17/169 CLINICAL AUDIT OF EMERGENCY RESPONSE BAGS (RE-AUDIT 2017)

The Committee received and noted the Clinical Audit of Emergency Response Bags.

Arising from the report it was highlighted that:

(1) The annual clinical audit had been completed in September 2017 and was rated as red.
(2) The compliance position had improved from 48% to 66% to date.
(3) EMT would be picking up this matter of concern and immediate actions would be taken to rectify this position to 100%.

The Committee noted concerns over failure to meet 100% compliance for all areas Trust wide as there was a potential safety risk for patients and requested a further assurance report to be brought back to the February 2018 QuAC meeting.

Action: Mrs J Illingworth

17/170 DRUG AND THERAPEUTICS BI-MONTHLY REPORT

The Committee received and noted the Drug and Therapeutics report.

Arising from the report it was noted that:

(1) A number of Medication Safety initiatives were well underway in the form of medication safety documents, a refresh of historic alerts and a deep dive into why the number of high risk medication incidents was decreasing. Checks were being made that this was for positive reasons and not because of a drop in reporting.
(2) The terms of reference for the Drug and Therapeutics Committee had been updated, which would be brought to the February 2018 QuAC meeting.
(3) There would be a new Chairman, Dr Baxi Sinha from January 2018.

Following discussion it was noted that following a national campaign launched over a year ago efforts were being made to stop medication for people with Learning Difficulties where appropriate.

On this matter it was noted that the Trust had carried out lots of audits on LD patients and their medication and that a further report with more detailed information would be presented to the April 2018 QuAC meeting.

Action: Mr C Williams

17/171 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no exceptions to report.

17/172 ANY MATTERS DISCUSSED TO BE ESCALATED TO THE BOARD OF DIRECTORS THAT MIGHT IMPACT ON THE TRUST'S STRATEGIC OR KEY OPERATIONAL RISKS.

The Committee noted two concerns to be escalated to the Board of Directors:

(1) Recruitment of core trainees and the low take up of numbers.
(2) Lack of compliance with the Emergency Equipment response bags.

Action: Dr H Griffiths

17/173 ANY OTHER BUSINESS

There was no other business to note.

17/174 COMMITTEE MEETING EVALUATION

There was nothing to note.

17/175 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 1 February 2018,
2.00pm – 5.00pm in the Board Room, West Park Hospital.

The meeting concluded at 4.35pm

ITEM 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th February 2018**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	✓
To continuously improve to quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

The purpose of this report is to present to the Board by 'exception' the monthly safe staffing information as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to December 2017 and January 2018 data.

Key issues during the reporting period can be summarised as follows:

- The number of rosters equates to 72 inpatient wards.
- The number of 'red' fill rate indicators highlights Registered Nurses on Days as having the highest number of 'reds' equating to 29 in December and 20 in January 2018.
- The Forensic directorate have the highest level of 'red' fill rates (14 in December and 7 in January)
- The lowest fill rate indicators in December related to Talbot Direct Care (sickness, carers leave and annual leave), Bedale (vacancies) and Eagle/Osprey (vacancies and sickness)
- The lowest fill rate indicators in January related to Talbot Direct Care (sickness and annual leave), Cherry Tree (ward requirements have changed from 2 RN's to 1 (night shifts only) and The Orchards (ward requirements have changed from 2 RN's to 1 (night shifts only)
- The Highest fill rates in December were observed by Westerdale South (high level observations and additional staffing required for relocation), Acomb Garth (high clinical need) and Oakwood (additional HCA staff to cover RN shortfall).

- The highest fill rates in January were observed by Westerdale South (sickness, maternity leave and enhanced observations); Acomb Garth (high clinical need due to aggression and physical frailty and dependency) and Bankfields Unit 4 (providing cover to The Lodge where they are vacancies due to transition of clients)
- In relation to bank usage there were no wards identified that were utilising in excess of 50% bank during December and January however 6 wards in December and 10 in January were over 25% bank usage. The highest bank user identified in December was Cedar Ward (D&D) with a bank usage of 31.7%. In January the highest bank user was Brambling with 38.9% bank usage.
- In December the agency usage equated to 4.7% and 4.4% in January. This is a significant increase when compared to the same period last year (1.5% in December 2016 and 1.1% in January 2017). The highest user of agency in both December and January related to Acomb Garth. The reasons given for agency usage in January relate mostly to enhanced observations followed by vacancies.
- In terms of triangulation with incidents and complaints:

December 2016:

  - There were 4 Serious Incidents (SI) that occurred within the month of December. None of these wards have been cited within this report.
  - There were 2 level 4 incidents that occurred in December that were also classified as an SI.
  - There were 6 level 3 incidents (self-harm) that occurred in December. None of which have been cited within this report to date.
  - There were 3 complaints raised in December. None of these areas have been cited within the report to date.
  - There were 30 PALS related issues raised with the following featuring within this report as follows:
    - Bedale Ward (1 PALS) – cited in this report for having a low staffing fill rate
    - Cedar Ward (2 PALS) – cited in this report for having bank usage in excess of 25%.

- A number of incidents requiring control and restraint occurred during December. The highest user was the Newberry Centre with a total of 144 incidents. The Newberry Centre has not been cited in this report to date.

January 2017:

  - There was 1 Serious Incidents (SI) that occurred within the month of January. The ward has not been cited within this report to date.
  - There were 0 level 4 incidents that occurred in January.
  - There were 2 level 3 incidents (self-harm) that occurred in January. One of these related to Lustrum Vale who has also been cited in this report for their bank usage.
  - There were 3 complaints raised in January one of which relates to Maple Ward who have been cited in this report in relation to their bank usage.
  - There were 37 PALS related issues raised with the following featuring within this report as follows:
    - Clover/Ivy (3 PALS) – bank usage

- Harrier/Hawk (5 PALS) – bank usage
- Cherry Tree (1 PALS) – low staffing fill rate
  - A number of incidents requiring control and restraint occurred during the reporting period. The highest user was the Newberry Centre with a total of 111 incidents. Newberry Centre has not been cited within this report when looking at the January data.

There were 742 shifts allocated in December and 535 in January where a break had not been taken. From those shifts where breaks were not taken the majority were in relation to day shifts (570 in December and 396 in January).

There were 33 incidents raised in December and 11 in January citing concern's in relation to staffing levels.

A severity calculation has been applied within this report and can be used to highlight any areas of concern from a safe staffing point of view. In December, Cedar Ward (D&D) had the highest score whilst Westerdale South, Danby Ward and Bankfields Court Unit 4 were highlighted in January. The top 10 can be found on page 10 of this report along with an explanation of severity scores and appendices 3 and 6 shows all scores for all wards.

There will be a requirement for the Trust to submit Care Hours per Patient Day (CHPPD) from April 2018. This will only feature nurse staffing.

Recommendations:

That the Board of Directors note the outputs of the report and the issues raised for further investigation and development.

MEETING OF:	**Board of Directors**
DATE:	**27th February 2018**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of the exceptions falling out of the monthly information on nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to December 2017 and January 2018 data.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Further to the emergent lessons from the Francis review there were a number of issues raised about the impact of the nurse staffing arrangements upon the poor quality of care and increased patient mortality exposed in that organisation.

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. (www.tewv.nhs.uk/site/content/about/how-well-are-we-doing/nurse-staffing). The full monthly data set of day by day staffing for each of the 72 areas split in the same way is available by web link on the Trust Nurse Staffing webpage. This report also includes for internal assurance those wards that sit outside of the national reporting.

3. EXCEPTIONS:

3.1 Safe Staffing Fill Rates – December 2017 and January 2018

3.1.1 The daily nurse staffing information aggregated for the month of December 2017 and January 2018 are presented at Appendix 1 and 4 of this report.

The highest numbers of red fill rate indicators relate to Registered Nurses on day shifts which equates to 29 in December and 20 in January. The January 'red' fill rate is a reduction of 6 when compared to November 2017.

The top 3 inpatient areas within the reporting periods where a low staffing fill rate has been reported along with an explanation for each is as follows:

Ward	Fill Rate Indicator	Comments
December 2017		
Talbot Direct Care	41.4% for RN on Days 52.3% for HCA on Days 46.2% HCA on Nights	The shortfall in the fill rates are as a result of sickness, carers leave and annual leave. Back fill arrangements are being provided by Holly Unit, this is evident in their fill rates. In addition support is being provided to ensure appropriate recording of hours worked on Talbot Direct Care within the electronic rostering system by the Corporate Products Team. The ward manager has confirmed that there was a RN on duty on each shift.
Bedale	60.4% for RN on Nights 197.5% HCA on Nights 85.7% for RN on Days 139.2% for HCA on Days	The shortfall in RN's is due to 3.7 WTE vacancies. The shortfall in RN shifts has been covered by HCA's where it has been appropriate to do so. This is evidence in the HCA fill rates. There has been at least 1 qualified on duty on each shift.
Eagle / Osprey	64.3% for RN on Days 79.3% for HCA on Days	The shortfall is in relation to vacancies and sickness. Eagle had a bed collapse in December reducing the requirement which was not reflected in the electronic rostering system.
January 2018		
Talbot Direct Care	31.2% for HCA on Nights 42.6% for HCA on Days 52.7% for RN on Days	The shortfall in the fill rates are as a result of sickness and annual leave. Back fill arrangements are being provided by Holly Unit, this is evident in their fill rates. In addition support is being provided to ensure appropriate recording of hours worked on Talbot Direct Care within the electronic rostering system by the Corporate Products Team.
Cherry Tree	56.2% RN on Nights 155.6% HCA on Nights	The shortfall in RN's is due to a decision being made to move the 2nd RN from Cherry Tree to Acomb Garth (night shifts only). The electronic system has not been updated to reflect this. This has been raised with the Corporate Products.
The Orchards (NY)	58.3% RN on Nights 148.4% HCA on Nights	The shortfall in RN's is due to a reduction in the ward requirements moving away from 2 RN's per duty to 1 (night shifts only) and the electronic

		system has not been amended to reflect this. This has been raised with the Corporate Products Team. The shortfall in RN shifts has been covered by HCA's where it has been appropriate to do so. This is evident in the HCA fill rate which is reporting at 148.4%.

It is also important to review the fill rates that exceed the budgeted establishment (shown in blue). In December there were 61 (71 in November) and 52 in January fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues.

The top 3 inpatient areas whereby a staffing fill rate indicator in excess of the budgeted establishment along with an explanation for each is as follows:

Ward	Fill Rate Indicator	Comments
December 2017		
Westerdale South	332.4% HCA on Nights 75.0% RN on Nights 205.0% HCA on Days	The ward has advised that there were a high level of enhanced observations during the month. In addition due to the relocation of the ward during the month additional staffing was required to support this transition.
Acomb Garth	272.6% HCA on Nights 138.7% RN on Nights 160.2% HCA on Days	High staffing levels continue to be required due to high clinical need; this includes high patient acuity, aggression and physical frailty and dependency.
Oakwood	209.2% HCA on Days 64.6% RN on Days	The unit is established for 2 RN's but often run with only 1 due to vacancies. These shifts are sent to bank but if they remain unfilled they are using HCA's where appropriate to cover the RN shortfall. The vacancies are being held for 3 RN's from Eagle/Osprey who will be joining the unit from April 2018.
January 2018		
Westerdale South	322.9% HCA on Nights 67.7% RN on Nights 206.8% HCA on Days	Due to sickness and maternity leave the ward are unable to facilitate 2 RN's on Nights. However, there has always being a nurse in charge on all shifts. The additional HCA staffing continues to be in relation to enhanced observations.

Acomb Garth	287.1% HCA on Nights 193.5% RN on Nights 184.8% HCA on Days	High staffing levels continue to be required due to high clinical need; this includes high patient acuity, aggression and physical frailty and dependency.
Bankfields Court Unit 4	227.3% RN on Nights 62.4% HCA on Nights 134.5% RN on Days 71.9% HCA on Days	The shortfall in HCA's is due to vacancies at the Lodge. These posts have not been replaced due to the ongoing transition of service users to a new service. Staff from the receiving organisation is working with TEWV staff which may account for some of the shortfall. In addition vacancies exist within unit 4 which they have recruited to but awaiting start dates.

3.2 Bank Usage

There are recognised risks in high use of bank and agency working although these are mitigated by the use of regular bank and agency staff who know the clinical areas.

There were no wards reporting 50% or above for bank usage in December 2017 and January 2018. The highest users of bank in December related to Cedar Ward (D&D) reporting at 31.7%. In January, Brambling Ward reported the highest at 38.9% for their bank usage.

Wards reporting over 25% and above for bank usage in December and January are detailed below:

December 2017	
Cedar Ward	31.7%
Hamsterley Ward	27.6%
Maple Ward	27.3%
Brambling Ward	26.1%
Mandarin	26.0%
Westerdale South	25.1%

January 2018	
Brambling Ward	38.9%
Maple Ward	32.8%
Clover/Ivy	31.7%
Mandarin	30.5%
Merlin	29.6%
Westerdale South	28.6%
Hamsterley Ward	27.8%
Harrier/Hawk	26.1%
Lustrum Vale	26.1%
The Orchard	25.1%

Bank usage is shown in full within the appendices of this report alongside the staffing fill rate.

3.3 Agency Usage

When considering staffing levels it is also important to consider the amount of agency worked within the reporting period.

In December the agency usage equated to 4.7% and 4.4% in January. This is a significant increase when compared to the same period last year (1.5% in December 2016 and 1.1% in January 2017). This is largely attributable to the electronic recording of agency usage and an increase in reliance.

The highest user of agency in December and January related to Acomb Garth with approximately 2130.5 hours (**42.7% of the total hours worked**) in December and 5727.5 hours (**52.9% of the total hours worked**) in January. The reasons given to agency usage was largely Enhanced Observations (203 shifts) with the second highest category recorded as Vacancies (14 shifts).

It is positive to note that generally agency usage is low within the Trust. It is important to continue to monitor this on an ongoing basis due to the potential risks that high agency working has on clinical areas

The full ward breakdown is available within the appendices of this report.

3.4 Quality Data Triangulation

The triangulation of the staffing data against a range of quality metrics has been undertaken covering the reporting period. The following are reporting as an exception:

December 2017:

- There were 4 Serious Incidents (SI) that occurred within the month of December. None of these wards have been cited within this report.
- There were 2 level 4 incidents that occurred in December that were also classified as an SI.
- There were 6 level 3 incidents (self-harm) that occurred in December. None of which have been cited within this report to date.
- There were 3 complaints raised in December. None of these areas have been cited within the report to date.
- There were 30 PALS related issues raised with the following featuring within this report as follows:
    - Bedale Ward (1 PALS) – cited in this report for having a low staffing fill rate
    - Cedar Ward (2 PALS) – cited in this report for having bank usage in excess of 25%.
- A number of incidents requiring control and restraint occurred during December. The highest user was the Newberry Centre with a total of 144 incidents. The Newberry Centre has not been cited in this report to date.

January 2018:

- There was 1 Serious Incidents (SI) that occurred within the month of January. The ward has not been cited within this report to date.
- There were 0 level 4 incidents that occurred in January.
- There were 2 level 3 incidents (self-harm) that occurred in January. One of these related to Lustrum Vale who has also been cited in this report for their bank usage.
- There were 3 complaints raised in January one of which relates to Maple Ward who have been cited in this report in relation to their bank usage.
- There were 37 PALS related issues raised with the following featuring within this report as follows:
    - Clover/Ivy (3 PALS) – bank usage
    - Harrier/Hawk (5 PALS) – bank usage
    - Cherry Tree (1 PALS) – low staffing fill rate
- A number of incidents requiring control and restraint occurred during the reporting period. The highest user was the Newberry Centre with a total of 111 incidents. Newberry Centre has not been cited within this report when looking at the January data.

3.5 Incidents raised citing Staffing Levels

It is also important to look at the number of incidents that have been raised and categorised in relation to staffing levels. There were 33 incidents reported in December and 11 in January 2018 raised on Datix citing issues with staffing. A summary of the key themes and issues reported can be found as follows:

December 2017:

- Key themes:

    - 51% (17) incidents of all incidents citing staffing levels were for night duty
    - All services at Roseberry Park accounted for 40% (13) of all incidents citing staffing levels
    - North Yorkshire accounted for 27% (9) of all incidents.
    - Moving staff around to cover shortfalls on other wards
    - Enhanced observations (1:1 and 2:1) increasing staffing requirements
    - Patients in seclusion requiring observation and reviews
    - Agency and bank staff not turning up for shifts
    - Short notice sickness also caused issues across the trust

- Issues reported:

    - Observations unable to be carried out
    - Breaks not being taken
    - Staff and patient safety compromised
    - Quality of service impaired
    - Undue stress and anxiety for staff causing fatigue
    - Wards not running on required staffing levels
    - Patient activities being cancelled
    - Patient leave not being facilitated

January 2018:

- Key themes:

    - 82% (9 incidents) of incidents citing staffing levels were for night duty
    - North Yorkshire accounted for 63% of all incidents citing staffing levels as a concern
    - The majority of incidents were felt necessary due to enhanced observations and the need to increase staffing
    - During January there were 5 occasions reported where agency or bank staff had not turned up for agreed shifts. This was mainly in York and a shift in North Yorkshire
    - Short notice sickness also caused issues

- Issues reported:

    - Staff and patient safety compromised
    - Quality of service impaired
    - Wards not running on required staffing levels
    - Patient activities being cancelled

It is important to note that Datix records whether incidents are reported to managers; however at present the system does not capture any actions taken to mitigate risks. Further work is required to gain assurance with regard to how the issues raised have been addressed. For nightshift it is expected that incidents will be escalated to the Duty Nurse Coordinator, once in place, who will be able to provide a summary of this information.

3.6 Missed Breaks

The working time directive guarantees the right for all workers to have a rest break during working hours if the worker is on duty for longer than 6 hours. Inadequate rest time taken during duty hours is linked to staff burn out, exhaustion and the risk that this may ultimately impact on patient care.

A thorough analysis of the HealthRoster system has identified that there were 742 shifts in December and 535 in January where unpaid breaks had not been taken. The January position shows a decrease of 207 when compared to December.

The majority of the shifts where breaks were not taken occurred on day shifts (570 shifts in December and 396 shifts in January). The number of night shifts where breaks were not taken equated to 172 shifts in December and 139 in January.

The detailed information in relation to missed breaks has been shared with localities for discussion and monitoring at their clinical huddle.

3.7 **Severity**

Utilising the data contained within this report it is possible to assign a scoring system to highlight any potential areas of concern. The total score for each inpatient area is contained within Appendix 3 and 6. The higher the score the higher the number of episodes they have been cited in relation to the number of 'red' fill rate indicators, any over establishment, bank & agency usage and the quality metrics.

The severity rating has been compiled on a very basic model as follows:

- A 'red' fill rate = 2 points given for each occurrence
- A 'blue' fill rate = 1 point given for each occurrence
- Missed breaks = where there was no improvement from the previous month = 1 point awarded
- Any episode of agency worked = 1 point
- Bank usage = amber score = 1 point and a red rated score equals 2 points
- SUI = 1 point
- Level 4 = 1 point
- Level 3 = 1 point
- Complaint = 1 point
- Control and Restraint – 11 and 39 incidents requiring C&R = 1 point; 40+ incidents of C&R = 2 points.

The top 10 wards cited utilising the above scoring mechanism is identified below for each month:

December 2017:

WARD	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SI	L4 Incidents	L3 Incidents	Complaints	Control & Restraint	TOTAL SCORE (Dec)
Cedar Ward (PICU)	4	2	1	0	2	0	0	0	0	1	**10**

Bedale Ward (PICU)	4	2	1	0	1	0	0	0	0	0	**8**
The Evergreen Centre	2	2	0	0	0	0	0	1	0	2	**7**
The Lodge	6	0	1	0	0	0	0	0	0	0	**7**
The Orchards	6	0	0	0	1	0	0	0	0	0	**7**
Newberry Centre	0	3	0	0	0	0	0	1	0	2	**6**
Talbot Direct Care	6	0	0	0	0	0	0	0	0	0	**6**
Mandarin	2	2	0	0	2	0	0	0	0	0	**6**
Westerdale South	2	2	0	0	2	0	0	0	0	0	**6**
Cherry Tree House	4	1	0	0	0	0	0	0	1	0	**6**
Danby Ward	4	1	1	0	0	0	0	0	0	0	**6**
Holly Unit	0	4	1	0	1	0	0	0	0	0	**6**
Clover/Ivy	2	1	1	0	1	0	0	0	0	1	**6**
Bankfields Court Flats	4	1	1	0	0	0	0	0	0	0	**6**

In terms of looking at the year to date position (December to December) the following are the top 5 wards cited:

WARD	Locality	Speciality	YTD Total Score (Dec - Dec)
Sandpiper Ward	Forensics	Forensics MH	**92**
Springwood	North Yorkshire	MHSOP	**86**
Clover/Ivy	Forensics	Forensics LD	**79**
Newberry Centre	Teesside	CYPS	**78**
Cedar Ward	Durham & Darlington	Adults	**77**
Meadowfields	York and Selby	MHSOP	**77**

January 2018:

WARD	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	L4 Incidents	L3 Incidents	Complaints	Control & Restraint	TOTAL SCORE (Jan)
Westerdale South	2	2	1	1	2	0	0	0	0	0	**8**
Ayckbourn Unit Danby Ward	4	0	1	1	0	0	0	0	0	2	**8**
Bankfields Unit 4	4	2	1	0	1	0	0	0	0	0	**8**
Merlin	0	2	1	0	2	0	0	0	0	2	**7**
Talbot Direct Care	6	0	1	0	0	0	0	0	0	0	**7**
Lustrum Vale	0	2	1	1	2	0	0	1	0	0	**7**
Hamsterley Ward	0	2	0	1	2	0	0	0	0	2	**7**
Maple Ward	0	1	1	1	2	0	0	0	1	1	**7**
Eagle/Osprey	4	0	1	1	1	0	0	0	0	0	**7**
Clover/Ivy	2	1	0	1	2	0	0	0	0	0	**6**

In terms of looking at the year to date position (January to January) the following are the top 5 wards cited:

WARD	Locality	Speciality	YTD Total Score (Jan - Jan)
Sandpiper Ward	Forensics	Forensics MH	**85**
Clover/Ivy	Forensics	Forensics LD	**82**
Springwood	North Yorkshire	MHSOP	**81**
Bedale Ward	Teesside	Adults	**79**
Cedar Ward	Durham & Darlington	Adults	**77**

3.8 Other

The Forensic directorate have the highest number (14 wards' in December and 7 in January) of 'red' fill rates for registered nurses on day shifts. This is a declining picture.

From observing the fill rates it is important to highlight Ebor who is reporting a 'red' fill rate for both registered and unregistered shifts on days for both December and January. In addition Minster is reporting a 'red' fill rate for registered nurses on days in December and January. This has been highlighted and a response is being sought to understand why this has been the case.

A further red flag is Acomb Garth who are using approximately 50% agency usage within the reporting period. This has been highlighted and further work will be undertaken to make sure that we are doing everything that we can to get this to a better position.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

There are a number of areas that are not able to meet their planned staffing levels on a regular basis particularly with regard to registered nursing staff fill rates on days, however there does not appear to be any direct triangulation with patient safety incidents or patient experience. This may be attributed to flexible staffing being utilised to agreed establishment numbers (although not necessarily skill mix due to lack of availability of registered nursing staff). This issue has been highlighted as a concern by the CQC in recent inspection reports for other Mental Health Trusts and may pose a risk as to our ratings.

4.2 Financial/Value for Money:

It has been identified that there is little spare capacity in nursing establishments as they have been planned for maximum efficiency – it is therefore implied that the workforce deployment needs closer scrutiny to ensure those efficiencies do not constitute risks. An updated report on the staffing establishment review which has been undertaken will be presented to the Board in March 2018.

4.3 **Legal and Constitutional (including the NHS Constitution):**

The Care Quality Commission and NHS England have set regulatory and contractual requirements that the Trust ensures adequate and appropriate staffing levels and skill mix to deliver safe and effective care. Inadequate staffing can result in non-compliance action and contractual breach.

The March 2013 NHS England and CQC directives set out specific requirements that will be checked through inspection and contractual monitoring as they are also included in standard commissioning contracts. The Trust has complied with these directives to date. The 2016 NQB guidance has also been taken into account in the Trust approach

4.4 **Equality and Diversity:**

Ensuring that patients have equal access to services means staffing levels should be appropriate to demand and clinical requirements.

4.5 **Other implications:**

From the data presented it is essential that a consistent reporting framework is maintained in particular the assigning of severity ratings.

5. RISKS:

5.1 There is a risk to the delivery of high quality, safe care if the trust is unable to provide the right staff in the right place at the right time. Related to this are quality and financial risks associated with increased use of flexible staffing and difficulties with recruitment and retention. Over the past few months there has been a reported national decline in uptake of registered nurse training placements and more registered nursing staff leaving the register than joining it. Mitigation and monitoring of these risks is being addressed through various Trust initiatives that will now be delivered by the adoption of a programme approach following the appointment of a programme manager for Right Staffing.

A lack of flexibility in staffing is particularly noticeable at night time when the majority of staffing incidents are reported. The role of the Duty Nurse Coordinator is being introduced to provide senior clinical oversight during night-shift and to build some flexibility into the system across sites.

6. CONCLUSIONS:

6.1 The Trust continues to comply with the requirements of NHS England and the CQC in relation to the Hard Truths commitments and continues to develop the data collation and analysis to monitor the impact of nurse staffing on patient safety, clinical effectiveness and experience.

7. RECOMMENDATIONS:

7.1 That the Board of Directors note the exception report and the issues raised for further investigation and development.

Emma Haimes
Head of Quality Data and Patient Experience
February 2018

DECEMBER 2017 DATA

Appendix 1

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 31 DAYS IN December							
				DAY		NIGHT	
WARD	Locality	Speciality	Bed Numbers	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	84.4%	101.2%	64.5%	122.7%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	93.9%	106.7%	110.9%	92.2%
Bedale Ward	Teesside	Adults	10	85.7%	139.2%	60.4%	197.5%
Bilsdale Ward	Teesside	Adults	14	113.3%	137.6%	110.0%	125.8%
Birch Ward	Durham & Darlington	Adults	15	74.0%	106.8%	100.0%	126.2%
Bransdale Ward	Teesside	Adults	14	118.2%	137.3%	137.0%	129.5%
Cedar Ward	Durham & Darlington	Adults	10	166.9%	88.9%	176.5%	85.4%
Cedar Ward (NY)	North Yorkshire	Adults	18	102.1%	103.9%	111.5%	106.5%
Ebor Ward	York and Selby	Adults	12	88.2%	74.6%	103.5%	98.5%
Elm Ward	Durham & Darlington	Adults	20	91.6%	94.5%	106.9%	104.8%
Farnham Ward	Durham & Darlington	Adults	20	117.7%	109.3%	100.0%	108.2%
Kirkdale Ward	Teesside	Adults	16	103.5%	92.6%	100.0%	116.4%
Lustrum Vale	Teesside	Adults	20	84.3%	124.2%	101.1%	106.5%
Maple Ward	Durham & Darlington	Adults	20	79.2%	121.0%	90.4%	116.1%
Minster Ward	York and Selby	Adults	12	74.6%	99.5%	103.5%	100.0%
Overdale Ward	Teesside	Adults	18	105.9%	115.1%	109.7%	96.7%

Primrose Lodge	Durham & Darlington	Adults	15	92.7%	100.0%	100.0%	100.0%
Stockdale Ward	Teesside	Adults	18	109.4%	113.7%	119.5%	110.4%
The Orchards (NY)	North Yorkshire	Adults	10	98.6%	102.0%	74.6%	119.4%
Tunstall Ward	Durham & Darlington	Adults	20	102.4%	102.9%	101.4%	109.9%
Ward 15 Friarage	North Yorkshire	Adults	12	80.5%	115.9%	100.0%	101.6%
Willow Ward	Durham & Darlington	Adults	15	80.0%	162.2%	106.9%	129.0%
Baysdale	Teesside	CYPS	6	116.5%	105.0%	103.8%	100.0%
Holly Unit	Durham & Darlington	CYPS	4	188.2%	162.1%	163.5%	185.8%
Newberry Centre	Teesside	CYPS	14	109.6%	137.5%	124.4%	193.7%
Talbot Direct Care	Durham & Darlington	CYPS	1	41.4%	52.3%	91.3%	46.2%
The Evergreen Centre	Teesside	CYPS	16	85.5%	131.4%	100.0%	130.1%
Westwood Centre	Teesside	CYPS	12	101.5%	150.3%	103.6%	195.2%
Clover/Ivy	Forensics	Forensics LD	12	87.4%	94.2%	109.7%	138.2%
Eagle/Osprey	Forensics	Forensics LD	10	64.3%	79.3%	96.8%	93.5%
Harrier/Hawk	Forensics	Forensics LD	10	80.4%	115.2%	100.4%	150.6%
Kestrel/Kite.	Forensics	Forensics LD	16	77.5%	113.8%	100.4%	142.4%
Langley Ward	Forensics	Forensics LD	10	76.7%	111.2%	100.3%	100.0%
Northdale Centre	Forensics	Forensics LD	12	78.1%	121.6%	96.9%	116.5%
Oakwood	Forensics	Forensics LD	8	64.6%	209.2%	100.0%	100.0%
Thistle	Forensics	Forensics LD	5	80.4%	104.6%	106.5%	94.4%
Brambling Ward	Forensics	Forensics MH	13	91.3%	138.9%	107.7%	152.1%
Jay Ward	Forensics	Forensics MH	5	86.2%	99.7%	97.9%	95.1%
Lark	Forensics	Forensics MH	15	85.2%	97.5%	100.3%	79.1%
Linnet Ward	Forensics	Forensics MH	17	89.5%	120.4%	119.4%	119.8%

Mallard Ward	Forensics	Forensics MH	16	96.8%	93.5%	111.0%	121.3%
Mandarin	Forensics	Forensics MH	16	88.1%	143.9%	106.5%	168.4%
Merlin	Forensics	Forensics MH	10	97.8%	129.0%	92.5%	161.8%
Newtondale Ward	Forensics	Forensics MH	20	98.6%	97.7%	80.6%	106.6%
Nightingale Ward	Forensics	Forensics MH	16	75.0%	93.5%	100.0%	88.9%
Sandpiper Ward	Forensics	Forensics MH	8	92.6%	100.0%	76.6%	127.6%
Swift Ward	Forensics	Forensics MH	10	89.5%	92.0%	97.1%	103.6%
Aysgarth	Teesside	LD	6	110.8%	96.4%	99.4%	99.8%
Bankfields Court Flats	Teesside	LD	6	105.7%	86.2%	150.0%	87.5%
Bankfields Court Unit 2	Teesside	LD	5	112.6%	109.2%	100.0%	125.0%
Bankfields Court Unit 3	Teesside	LD	6	69.4%	99.1%	100.0%	90.3%
Bankfields Court Unit 4	Teesside	LD	6	101.5%	97.1%	125.0%	86.7%
Bek-Ramsey Ward	Durham & Darlington	LD	11	122.9%	111.9%	100.0%	99.1%
Harland Rehab Ward	Durham & Darlington	LD	1	100.0%	99.9%	100.0%	100.0%
Oak Rise	York and Selby	LD	8	113.3%	86.7%	99.8%	146.6%
The Lodge	Teesside	LD	1	79.4%	82.1%	96.0%	85.5%
Acomb Garth	York and Selby	MHSOP	14	93.1%	160.2%	138.7%	272.6%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	86.6%	123.3%	100.0%	120.9%
Cherry Tree House	York and Selby	MHSOP	18	110.5%	86.6%	80.3%	142.1%
Hamsterley Ward	Durham & Darlington	MHSOP	15	91.0%	139.3%	101.0%	116.9%
Meadowfields	York and Selby	MHSOP	14	93.1%	93.7%	91.0%	129.1%
Oak Ward	Durham & Darlington	MHSOP	12	100.0%	98.8%	100.0%	105.0%
Roseberry Wards	Durham & Darlington	MHSOP	15	101.8%	105.5%	103.2%	98.4%
Rowan Lea	North Yorkshire	MHSOP	20	94.4%	113.5%	108.0%	119.1%

Rowan Ward	North Yorkshire	MHSOP	16	98.9%	132.9%	106.3%	122.0%
Springwood Community Unit	North Yorkshire	MHSOP	14	91.2%	111.0%	103.2%	152.8%
Ward 14	North Yorkshire	MHSOP	10	91.8%	92.7%	100.5%	100.3%
Westerdale North	Teesside	MHSOP	18	122.3%	91.1%	106.5%	138.7%
Westerdale South	Teesside	MHSOP	14	98.8%	205.0%	75.0%	332.4%
Kiltonview	Teesside	LD	0	127.0%	85.5%		
The Orchard	Teesside	LD	0	89.9%	110.6%		
Thornaby Road	Teesside	LD	5	102.7%	119.9%		98.4%

APPENDIX 2

Scored Fill Rate compared to Quality Indicators - December 2017				Agency Usage Vs Actual Hours			Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Nos	Total Actual Hours	Total Agency Hours	% Against actual Hours	Total Actual Hours	Total Bank Hours	% Against actual Hours	SI	L4 Incidents	L3 Incident	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	2547.0	347.0	13.6%	2547.0	156	6.1%					1	2		2	2
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2725.5	0.0	0.0%	2725.5	58.5	2.1%						3		3	3
Bedale Ward	Teesside	Adults	10	4427.8	253.0	5.7%	4427.8	844.33	19.1%					1	7		8	8
Bilsdale Ward	Teesside	Adults	14	3194.3	69.0	2.2%	3194.3	257.25	8.1%						1		2	2
Birch Ward	Durham & Darlington	Adults	15	3182.9	84.0	2.6%	3182.9	720	22.6%						1		1	1
Bransdale Ward	Teesside	Adults	14	3244.8	69.0	2.1%	3244.8	261	8.0%					1	6	1	6	7
Cedar Ward	Durham & Darlington	Adults	10	4816.0	0.0	0.0%	4816.0	1527.5	31.7%					2	22	5	36	41
Cedar Ward (NY)	North Yorkshire	Adults	18	3296.4	666.8	20.2%	3296.4	294.75	8.9%			2			9		17	17
Ebor Ward	York and Selby	Adults	12	2581.0	76.5	3.0%	2581.0	255.5	9.9%						10		16	16
Elm Ward	Durham & Darlington	Adults	20	2923.8	120.0	4.1%	2923.8	545.86	18.7%	1	1				8		9	9
Farnham Ward	Durham & Darlington	Adults	20	2809.2	60.0	2.1%	2809.2	246.5	8.8%	2	1				1		1	1
Kirkdale Ward	Teesside	Adults	16	3223.8	85.5	2.7%	3223.8	652.5	20.2%				1	2				
Lustrum Vale	Teesside	Adults	20	2879.8	18.5	0.6%	2879.8	596	20.7%									
Maple Ward	Durham & Darlington	Adults	20	2814.6	84.0	3.0%	2814.6	768	27.3%						1		1	1
Minster Ward	York and Selby	Adults	12	2620.5	299.0	11.4%	2620.5	149.5	5.7%						7		8	8

Overdale Ward	Teesside	Adults	18	2737.7	0.0	0.0%	2737.7	46	1.7%	1				1	1		2	2
Primrose Lodge	Durham & Darlington	Adults	15	2695.3	24.0	0.9%	2695.3	336	12.5%									
Stockdale Ward	Teesside	Adults	18	2765.6	103.5	3.7%	2765.6	161	5.8%						2		2	2
The Orchards (NY)	North Yorkshire	Adults	10	2240.5	12.0	0.5%	2240.5	48	2.1%									
Tunstall Ward	Durham & Darlington	Adults	20	2829.2	72.0	2.5%	2829.2	60	2.1%			1		1				
Ward 15 Friarage	North Yorkshire	Adults	12	2533.6	101.3	4.0%	2533.6	513.5	20.3%			1	1		2		2	2
Willow Ward	Durham & Darlington	Adults	15	3127.1	129.7	4.1%	3127.1	540	17.3%					1	5	1	4	5
Baysdale	Teesside	CYPS	6	2327.4	0.0	0.0%	2327.4	108.36	4.7%									
Holly Unit	Durham & Darlington	CYPS	4	1211.1	0.0	0.0%	1211.1	148.59	12.3%									
Newberry Centre	Teesside	CYPS	14	4865.4	222.5	4.6%	4865.4	376.16	7.7%			1		2	85	1	119	120
Talbot Direct Care	Durham & Darlington	CYPS	1	1584.5	0.0	0.0%	1584.5	0	0.0%									
The Evergreen Centre	Teesside	CYPS	16	5513.0	432.3	7.8%	5513.0	593.99	10.8%			1			41		59	59
Westwood Centre	Teesside	CYPS	12	5983.6	0.0	0.0%	5983.6	180	3.0%						26		44	44
Clover/Ivy	Forensics	Forensics LD	12	3881.0	0.0	0.0%	3881.0	926.5	23.9%						12	1	19	20
Eagle/Osprey	Forensics	Forensics LD	10	2781.9	112.5	4.0%	2781.9	246.75	8.9%									
Harrier/Hawk	Forensics	Forensics LD	10	4271.2	0.0	0.0%	4271.2	951.74	22.3%					4	5	1	11	12
Kestrel/Kite.	Forensics	Forensics LD	16	4244.6	0.0	0.0%	4244.6	871	20.5%						1	1	2	3
Langley Ward	Forensics	Forensics LD	10	2125.1	0.0	0.0%	2125.1	292.5	13.8%									
Northdale Centre	Forensics	Forensics LD	12	5205.5	56.5	1.1%	5205.5	1194.1	22.9%						1		1	1
Oakwood	Forensics	Forensics LD	8	1973.5	0.0	0.0%	1973.5	349	17.7%									
Thistle	Forensics	Forensics LD	5	2902.6	22.5	0.8%	2902.6	243	8.4%						3		4	4
Brambling Ward	Forensics	Forensics MH	13	3571.3	0.0	0.0%	3571.3	931	26.1%						12		28	28
Jay Ward	Forensics	Forensics MH	5	2720.3	0.0	0.0%	2720.3	110.75	4.1%									

Lark	Forensics	Forensics MH	15	2569.4	0.0	0.0%	2569.4	300	11.7%										
Linnet Ward	Forensics	Forensics MH	17	3246.3	0.0	0.0%	3246.3	511	15.7%										
Mallard Ward	Forensics	Forensics MH	16	3141.8	0.0	0.0%	3141.8	391.25	12.5%					4					
Mandarin	Forensics	Forensics MH	16	3721.9	0.0	0.0%	3721.9	966.5	26.0%						3		5	5	
Merlin	Forensics	Forensics MH	10	4246.6	0.0	0.0%	4246.6	966	22.7%					1	5		13	13	
Newtondale Ward	Forensics	Forensics MH	20	3618.2	0.0	0.0%	3618.2	498.63	13.8%					2	2		3	3	
Nightingale Ward	Forensics	Forensics MH	16	2549.5	0.0	0.0%	2549.5	235.5	9.2%										
Sandpiper Ward	Forensics	Forensics MH	8	3849.7	0.0	0.0%	3849.7	252.75	6.6%					3	34	2	69	71	
Swift Ward	Forensics	Forensics MH	10	2985.0	0.0	0.0%	2985.0	265.25	8.9%						2		3	3	
Aysgarth	Teesside	LD	6	2040.3	0.0	0.0%	2040.3	278.25	13.6%										
Bankfields Court Flats	Teesside	LD	6	2047.4	0.0	0.0%	2047.4	112.5	5.5%										
Bankfields Court Unit 2	Teesside	LD	5	2384.6	0.0	0.0%	2384.6	238.83	10.0%										
Bankfields Court Unit 3	Teesside	LD	6	2195.8	0.0	0.0%	2195.8	144.92	6.6%						7		7	7	
Bankfields Court Unit 4	Teesside	LD	6	2168.6	0.0	0.0%	2168.6	190	8.8%										
Bek-Ramsey Ward	Durham & Darlington	LD	11	3972.2	24.0	0.6%	3972.2	277.83	7.0%						16		18	18	
Harland Rehab Ward	Durham & Darlington	LD	1	2231.2	12.0	0.5%	2231.2	276	12.4%										
Oak Rise	York and Selby	LD	8	3902.9	789.8	20.2%	3902.9	335.14	8.6%						16		32	32	
The Lodge	Teesside	LD	1	1643.3	0.0	0.0%	1643.3	43.17	2.6%										
Acomb Garth	York and Selby	MHSOP	14	4992.3	2130.5	42.7%	4992.3	302	6.0%						20		23	23	
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	3323.8	108.0	3.2%	3323.8	301.5	9.1%						1		2	2	
Cherry Tree House	York and Selby	MHSOP	18	3496.9	1037.0	29.7%	3496.9	302.5	8.7%				1	1	2		2	2	
Hamsterley Ward	Durham & Darlington	MHSOP	15	3345.4	192.2	5.7%	3345.4	924.33	27.6%						1		1	1	
Meadowfields	York and Selby	MHSOP	14	3054.4	424.0	13.9%	3054.4	272.25	8.9%										

Oak Ward	Durham & Darlington	MHSOP	12	2744.2	12.0	0.4%	2744.2	200	7.3%						7		13	13
Roseberry Wards	Durham & Darlington	MHSOP	15	2691.4	12.0	0.4%	2691.4	434.5	16.1%									
Rowan Lea	North Yorkshire	MHSOP	20	3948.8	193.7	4.9%	3948.8	340.4	8.6%						6	1	13	14
Rowan Ward	North Yorkshire	MHSOP	16	3177.0	353.2	11.1%	3177.0	323.5	10.2%						1		1	1
Springwood Community Unit	North Yorkshire	MHSOP	14	3368.4	292.5	8.7%	3368.4	483.92	14.4%						5		5	5
Ward 14	North Yorkshire	MHSOP	10	2555.8	0.0	0.0%	2555.8	0	0.0%						5		6	6
Westerdale North	Teesside	MHSOP	18	3330.1	69.0	2.1%	3330.1	164	4.9%									
Westerdale South	Teesside	MHSOP	14	6703.9	1483.0	22.1%	6703.9	1681.77	25.1%						5		5	5
Kiltonview	Teesside	LD	0	1523.8	0.0	0.0%	1523.8	252.84	16.6%									
The Orchard	Teesside	LD	0	741.1	0.0	0.0%	741.1	135	18.2%									
Thornaby Road	Teesside	LD	5	1989.9	0.0	0.0%	1989.9	61.5	3.1%									

APPENDIX 3

SEVERITY SCORING BY TOTAL SCORE – DECEMBER 2017

WARD	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	Control & Restraint	TOTAL SCORE (Dec)
Cedar Ward	4	2	1	0	2	0	0	0	0	1	**10**
Bedale Ward	4	2	1	0	1	0	0	0	0	0	**8**
The Evergreen Centre	2	2	0	0	0	0	0	1	0	2	**7**
The Lodge	6	0	1	0	0	0	0	0	0	0	**7**
The Orchard	6	0	0	0	1	0	0	0	0	0	**7**
Newberry Centre	0	3	0	0	0	0	0	1	0	2	**6**
Talbot Direct Care	6	0	0	0	0	0	0	0	0	0	**6**
Mandarin	2	2	0	0	2	0	0	0	0	0	**6**
Westerdale South	2	2	0	0	2	0	0	0	0	0	**6**
Cherry Tree House	4	1	0	0	0	0	0	0	1	0	**6**
Ayckbourn Unit Danby Ward	4	1	1	0	0	0	0	0	0	0	**6**
Holly Unit	0	4	1	0	1	0	0	0	0	0	**6**
Clover/Ivy	2	1	1	0	1	0	0	0	0	1	**6**
Bankfields Court Flats	4	1	1	0	0	0	0	0	0	0	**6**
Maple Ward	2	1	0	0	2	0	0	0	0	0	**5**
Ward 15 Friarage	2	0	0	0	1	0	0	1	1	0	**5**
Brambling Ward	0	2	0	0	2	0	0	0	0	1	**5**
Willow Ward	2	2	0	0	1	0	0	0	0	0	**5**
Lark	4	0	0	0	1	0	0	0	0	0	**5**
Northdale Centre	2	1	1	0	1	0	0	0	0	0	**5**
Sandpiper Ward	2	1	1	0	0	0	0	0	0	1	**5**
Birch Ward	2	1	1	0	1	0	0	0	0	0	**5**
Harrier/Hawk	2	1	1	0	1	0	0	0	0	0	**5**
Nightingale Ward	4	0	1	0	0	0	0	0	0	0	**5**

Ceddesfeld Ward	2	2	1	0	0	0	0	0	0	0	**5**
Ebor Ward	4	0	0	0	0	0	0	0	0	0	**4**
Eagle/Osprey	4	0	0	0	0	0	0	0	0	0	**4**
Kestrel/Kite.	2	1	0	0	1	0	0	0	0	0	**4**
Linnet Ward	2	1	0	0	1	0	0	0	0	0	**4**
Oak Rise	2	1	0	0	0	0	0	0	0	1	**4**
Oakwood	2	1	0	0	1	0	0	0	0	0	**4**
Acomb Garth	0	3	0	0	0	0	0	0	0	1	**4**
Lustrum Vale	2	1	0	0	1	0	0	0	0	0	**4**
Bankfields Court Unit 4	2	1	1	0	0	0	0	0	0	0	**4**
Hamsterley Ward	0	1	1	0	2	0	0	0	0	0	**4**
Westwood Centre	0	2	1	0	0	0	0	0	0	1	**4**
Elm Ward	0	0	1	0	1	1	1	0	0	0	**4**
Newtondale Ward	2	0	1	0	1	0	0	0	0	0	**4**
Kiltonview	2	1	0	0	1	0	0	0	0	0	**4**
Bransdale Ward	0	3	0	0	0	0	0	0	0	0	**3**
Merlin	0	2	0	0	1	0	0	0	0	0	**3**
Langley Ward	2	0	0	0	1	0	0	0	0	0	**3**
Farnham Ward	0	0	0	0	0	2	1	0	0	0	**3**
Springwood Community Unit	0	1	1	0	1	0	0	0	0	0	**3**
Bilsdale Ward	0	2	1	0	0	0	0	0	0	0	**3**
Westerdale North	0	2	1	0	0	0	0	0	0	0	**3**
Minster Ward	2	0	1	0	0	0	0	0	0	0	**3**
Thistle	2	0	1	0	0	0	0	0	0	0	**3**
Bankfields Court Unit 3	2	0	1	0	0	0	0	0	0	0	**3**
Cedar Ward (NY)	0	0	1	0	0	0	0	2	0	0	**3**
Swift Ward	2	0	0	0	0	0	0	0	0	0	**2**
Mallard Ward	0	1	0	0	1	0	0	0	0	0	**2**
Bek-Ramsey Ward	0	1	0	0	0	0	0	0	0	1	**2**
Rowan Ward	0	2	0	0	0	0	0	0	0	0	**2**
The Orchards (NY)	2	0	0	0	0	0	0	0	0	0	**2**
Jay Ward	2	0	0	0	0	0	0	0	0	0	**2**

Kirkdale Ward	0	0	0	0	1	0	0	0	1	0	**2**
Bankfields Court Unit 2	0	1	1	0	0	0	0	0	0	0	**2**
Tunstall Ward	0	0	1	0	0	0	0	1	0	0	**2**
Aysgarth	0	0	1	0	1	0	0	0	0	0	**2**
Roseberry Wards	0	0	1	0	1	0	0	0	0	0	**2**
Primrose Lodge	0	0	0	0	1	0	0	0	0	0	**1**
Meadowfields	0	1	0	0	0	0	0	0	0	0	**1**
Overdale Ward	0	0	0	0	0	1	0	0	0	0	**1**
Harland Rehab Ward	0	0	0	0	1	0	0	0	0	0	**1**
Ayckbourn Unit Esk Ward	0	0	1	0	0	0	0	0	0	0	**1**
Baysdale	0	0	1	0	0	0	0	0	0	0	**1**
Rowan Lea	0	0	1	0	0	0	0	0	0	0	**1**
Stockdale Ward	0	0	0	0	0	0	0	0	0	0	**0**
Oak Ward	0	0	0	0	0	0	0	0	0	0	**0**
Ward 14	0	0	0	0	0	0	0	0	0	0	**0**

Severity Scoring by Speciality

WARD	Locality	Speciality	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SI	Level 4	Level 3	Complaints	Control & Restraint	TOTAL SCORE Dec
Cedar Ward	Durham & Darlington	Adults	4	2	1	0	2	0	0	0	0	1	**10**
Bedale Ward	Teesside	Adults	4	2	1	0	1	0	0	0	0	0	**8**
Bransdale Ward	Teesside	Adults	0	3	0	0	0	0	0	0	0	0	**3**
Ward 15 Friarage	North Yorkshire	Adults	2	0	0	0	1	0	0	1	1	0	**5**
Cedar Ward (NY)	North Yorkshire	Adults	0	0	1	0	0	0	0	2	0	0	**3**
Elm Ward	Durham & Darlington	Adults	0	0	1	0	1	1	1	0	0	0	**4**
Esk Ward	North Yorkshire	Adults	0	0	1	0	0	0	0	0	0	0	**1**
Danby Ward	North Yorkshire	Adults	4	1	1	0	0	0	0	0	0	0	**6**
Ebor Ward	York and Selby	Adults	4	0	0	0	0	0	0	0	0	0	**4**
Maple Ward	Durham & Darlington	Adults	2	1	0	0	2	0	0	0	0	0	**5**
Lustrum Vale	Teesside	Adults	2	1	0	0	1	0	0	0	0	0	**4**
Overdale Ward	Teesside	Adults	0	0	0	0	0	1	0	0	0	0	**1**
The Orchards (NY)	North Yorkshire	Adults	2	0	0	0	0	0	0	0	0	0	**2**
Birch Ward	Durham & Darlington	Adults	2	1	1	0	1	0	0	0	0	0	**5**
Bilsdale Ward	Teesside	Adults	0	2	1	0	0	0	0	0	0	0	**3**
Primrose Lodge	Durham & Darlington	Adults	0	0	0	0	1	0	0	0	0	0	**1**
Minster Ward	York and Selby	Adults	2	0	1	0	0	0	0	0	0	0	**3**
Kirkdale Ward	Forensics	Adults	0	0	0	0	1	0	0	0	1	0	**2**
Stockdale Ward	Teesside	Adults	0	0	0	0	0	0	0	0	0	0	**0**
Willow Ward	Durham & Darlington	Adults	2	2	0	0	1	0	0	0	0	0	**5**
Farnham Ward	Durham & Darlington	Adults	0	0	0	0	0	2	1	0	0	0	**3**
Tunstall Ward	Durham & Darlington	Adults	0	0	1	0	0	0	0	1	0	0	**2**
Newberry Centre	Teesside	CYPS	0	3	0	0	0	0	0	1	0	2	**6**
Westwood Centre	Teesside	CYPS	0	2	1	0	0	0	0	0	0	1	**4**
Evergreen Centre	Teesside	CYPS	2	2	0	0	0	0	0	1	0	2	**7**
Talbot Direct Care	Durham & Darlington	CYPS	6	0	0	0	0	0	0	0	0	0	**6**

Holly Unit	Durham & Darlington	CYPS	0	4	1	0	1	0	0	0	0	0	**6**
Baysdale	Teesside	CYPS	0	0	1	0	0	0	0	0	0	0	**1**
Clover/Ivy	Forensics	Forensics LD	2	1	1	0	1	0	0	0	0	1	**6**
Northdale Centre	Forensics	Forensics LD	2	1	1	0	1	0	0	0	0	0	**5**
Kestrel/Kite.	Forensics	Forensics LD	2	1	0	0	1	0	0	0	0	0	**4**
Harrier/Hawk	Forensics	Forensics LD	2	1	1	0	1	0	0	0	0	0	**5**
Eagle/Osprey	Forensics	Forensics LD	4	0	0	0	0	0	0	0	0	0	**4**
Langley Ward	Forensics	Forensics LD	2	0	0	0	1	0	0	0	0	0	**3**
Oakwood	Forensics	Forensics LD	2	1	0	0	1	0	0	0	0	0	**4**
Thistle	Forensics	Forensics LD	2	0	1	0	0	0	0	0	0	0	**3**
Sandpiper Ward	Forensics	Forensics MH	2	1	1	0	0	0	0	0	0	1	**5**
Merlin	Forensics	Forensics MH	0	2	0	0	1	0	0	0	0	0	**3**
Mandarin	Forensics	Forensics MH	2	2	0	0	2	0	0	0	0	0	**6**
Newtondale Ward	Forensics	Forensics MH	2	0	1	0	1	0	0	0	0	0	**4**
Swift Ward	Forensics	Forensics MH	2	0	0	0	0	0	0	0	0	0	**2**
Mallard Ward	Forensics	Forensics MH	0	1	0	0	1	0	0	0	0	0	**2**
Linnet Ward	Forensics	Forensics MH	2	1	0	0	1	0	0	0	0	0	**4**
Nightingale Ward	Forensics	Forensics MH	4	0	1	0	0	0	0	0	0	0	**5**
Brambling Ward	Forensics	Forensics MH	0	2	0	0	2	0	0	0	0	1	**5**
Lark	Forensics	Forensics MH	4	0	0	0	1	0	0	0	0	0	**5**
Jay Ward	Forensics	Forensics MH	2	0	0	0	0	0	0	0	0	0	**2**
Oak Rise	York and Selby	LD	2	1	0	0	0	0	0	0	0	1	**4**
Bankfields Flats	Teesside	LD	4	1	1	0	0	0	0	0	0	0	**6**
The Lodge	Teesside	LD	6	0	1	0	0	0	0	0	0	0	**7**
Bek-Ramsey Ward	Durham & Darlington	LD	0	1	0	0	0	0	0	0	0	1	**2**
Aysgarth	Teesside	LD	0	0	1	0	1	0	0	0	0	0	**2**
Bankfields Unit 2	Teesside	LD	0	1	1	0	0	0	0	0	0	0	**2**
Bankfields Unit 3	Teesside	LD	2	0	1	0	0	0	0	0	0	0	**3**
Bankfields Unit 4	Teesside	LD	2	1	1	0	0	0	0	0	0	0	**4**
Harland	Durham & Darlington	LD	0	1	0	0	0	0	0	0	0	1	**2**
Springwood	North Yorkshire	MHSOP	0	1	1	0	1	0	0	0	0	0	**3**
Meadowfields	York and Selby	MHSOP	0	1	0	0	0	0	0	0	0	0	**1**

Rowan Ward	North Yorkshire	MHSOP	0	2	0	0	0	0	0	0	0	0	**2**
Westerdale South	Teesside	MHSOP	2	2	0	0	2	0	0	0	0	0	**6**
Cherry Tree House	York and Selby	MHSOP	4	1	0	0	0	0	0	0	1	0	**6**
Acomb Garth	York and Selby	MHSOP	0	3	0	0	0	0	0	0	0	1	**4**
Hamsterley Ward	Durham & Darlington	MHSOP	0	1	1	0	2	0	0	0	0	0	**4**
Ward 14	North Yorkshire	MHSOP	0	0	0	0	0	0	0	0	0	0	**0**
Westerdale North	Teesside	MHSOP	0	2	1	0	0	0	0	0	0	0	**3**
Rowan Lea	North Yorkshire	MHSOP	0	0	1	0	0	0	0	0	0	0	**1**
Ceddesfeld Ward	Durham & Darlington	MHSOP	2	2	1	0	0	0	0	0	0	0	**5**
Roseberry Wards	Durham & Darlington	MHSOP	0	0	1	0	1	0	0	0	0	0	**2**
Oak Ward	Durham & Darlington	MHSOP	0	0	0	0	0	0	0	0	0	0	**0**

JANUARY 2018 DATA

Appendix 4

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 31 DAYS IN January							
				DAY		NIGHT	
WARD	Locality	Speciality	Bed Numbers	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	84.4%	104.2%	87.4%	107.0%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	87.1%	114.5%	97.1%	98.7%
Bedale Ward	Teesside	Adults	10	88.5%	118.6%	66.9%	151.6%
Bilsdale Ward	Teesside	Adults	14	110.2%	123.0%	119.4%	112.1%
Birch Ward	Durham & Darlington	Adults	15	69.7%	108.2%	96.7%	101.6%
Bransdale Ward	Teesside	Adults	14	113.4%	129.6%	135.5%	119.7%
Cedar Ward	Durham & Darlington	Adults	10	108.2%	72.5%	118.2%	66.5%
Cedar Ward (NY)	North Yorkshire	Adults	18	95.0%	106.8%	111.8%	108.3%
Ebor Ward	York and Selby	Adults	12	81.8%	78.5%	97.1%	98.5%
Elm Ward	Durham & Darlington	Adults	20	98.9%	91.3%	102.8%	110.5%
Farnham Ward	Durham & Darlington	Adults	20	116.8%	117.6%	100.0%	100.0%
Kirkdale Ward	Teesside	Adults	16	92.6%	98.3%	96.7%	100.0%
Lustrum Vale	Teesside	Adults	20	92.1%	161.0%	100.3%	145.7%
Maple Ward	Durham & Darlington	Adults	20	95.6%	125.8%	100.4%	114.6%
Minster Ward	York and Selby	Adults	12	83.7%	125.8%	103.5%	105.0%
Overdale Ward	Teesside	Adults	18	103.6%	109.7%	109.7%	101.6%

Primrose Lodge	Durham & Darlington	Adults	15	82.4%	110.6%	100.0%	100.0%
Stockdale Ward	Teesside	Adults	18	115.9%	115.4%	116.1%	96.8%
The Orchards (NY)	North Yorkshire	Adults	10	105.1%	93.3%	58.3%	148.4%
Tunstall Ward	Durham & Darlington	Adults	20	118.0%	102.6%	96.3%	103.2%
Ward 15 Friarage	North Yorkshire	Adults	12	83.4%	115.2%	100.3%	98.5%
Willow Ward	Durham & Darlington	Adults	15	92.0%	126.1%	100.0%	113.0%
Baysdale	Teesside	CYPS	6	139.0%	88.0%	100.0%	101.5%
Holly Unit	Durham & Darlington	CYPS	4	115.3%	145.9%	126.5%	163.4%
Newberry Centre	Teesside	CYPS	14	102.8%	141.8%	114.6%	185.9%
Talbot Direct Care	Durham & Darlington	CYPS	1	52.7%	42.6%	91.4%	31.2%
The Evergreen Centre	Teesside	CYPS	16	78.9%	114.7%	100.4%	133.4%
Westwood Centre	Teesside	CYPS	12	90.6%	159.6%	87.1%	216.4%
Clover/Ivy	Forensics	Forensics LD	12	79.7%	101.0%	109.7%	168.2%
Eagle/Osprey	Forensics	Forensics LD	10	75.5%	74.6%	103.2%	91.9%
Harrier/Hawk	Forensics	Forensics LD	10	79.0%	123.5%	106.0%	147.5%
Kestrel/Kite.	Forensics	Forensics LD	16	94.7%	105.5%	103.2%	141.9%
Langley Ward	Forensics	Forensics LD	10	71.6%	121.1%	96.8%	100.0%
Northdale Centre	Forensics	Forensics LD	12	98.2%	127.3%	106.2%	124.2%
Oakwood	Forensics	Forensics LD	8	76.5%	185.9%	100.0%	100.0%
Thistle	Forensics	Forensics LD	5	83.9%	102.1%	96.8%	95.7%
Brambling Ward	Forensics	Forensics MH	13	118.7%	162.2%	117.6%	198.4%
Jay Ward	Forensics	Forensics MH	5	97.4%	93.9%	101.1%	96.0%
Lark	Forensics	Forensics MH	15	91.9%	103.7%	100.0%	96.8%
Linnet Ward	Forensics	Forensics MH	17	95.8%	103.2%	100.0%	101.9%

Mallard Ward	Forensics	Forensics MH	16	104.5%	109.5%	113.5%	168.7%
Mandarin	Forensics	Forensics MH	16	100.0%	151.9%	109.7%	184.5%
Merlin	Forensics	Forensics MH	10	103.1%	134.8%	97.2%	189.1%
Newtondale Ward	Forensics	Forensics MH	20	114.4%	92.0%	85.5%	116.1%
Nightingale Ward	Forensics	Forensics MH	16	81.9%	99.3%	100.0%	95.2%
Sandpiper Ward	Forensics	Forensics MH	8	92.8%	104.7%	93.5%	133.9%
Swift Ward	Forensics	Forensics MH	10	95.2%	94.2%	103.2%	118.4%
Aysgarth	Teesside	LD	6	92.9%	96.2%	99.9%	99.7%
Bankfields Court Flats	Teesside	LD	6	107.4%	83.0%	100.0%	102.1%
Bankfields Court Unit 2	Teesside	LD	5	104.7%	112.5%	100.5%	131.2%
Bankfields Court Unit 3	Teesside	LD	6	90.3%	99.1%	93.6%	98.4%
Bankfields Court Unit 4	Teesside	LD	6	134.5%	71.9%	227.3%	62.4%
Bek-Ramsey Ward	Durham & Darlington	LD	11	119.0%	113.5%	100.0%	100.0%
Oak Rise	York and Selby	LD	8	116.7%	88.6%	118.4%	124.4%
The Lodge	Teesside	LD	1	77.5%	71.3%	91.3%	90.0%
Acomb Garth	York and Selby	MHSOP	14	106.8%	184.8%	193.5%	287.1%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	83.7%	112.9%	100.1%	110.5%
Cherry Tree House	York and Selby	MHSOP	18	109.9%	95.4%	56.2%	155.6%
Hamsterley Ward	Durham & Darlington	MHSOP	15	100.6%	149.7%	100.9%	128.0%
Meadowfields	York and Selby	MHSOP	14	97.9%	92.8%	100.0%	142.0%
Oak Ward	Durham & Darlington	MHSOP	12	95.0%	98.2%	100.0%	100.0%
Roseberry Wards	Durham & Darlington	MHSOP	15	101.4%	101.8%	100.0%	103.2%
Rowan Lea	North Yorkshire	MHSOP	20	102.1%	105.6%	106.7%	113.2%
Rowan Ward	North Yorkshire	MHSOP	16	95.2%	94.8%	100.6%	108.2%

Springwood Community Unit	North Yorkshire	MHSOP	14	78.6%	109.3%	103.2%	145.2%
Ward 14	North Yorkshire	MHSOP	10	90.8%	97.2%	106.7%	96.6%
Westerdale North	Teesside	MHSOP	18	119.1%	126.4%	114.0%	177.0%
Westerdale South	Teesside	MHSOP	14	95.5%	206.8%	67.7%	322.9%
Harland Rehab Ward	Durham & Darlington	Rehab	1	99.5%	104.8%	100.4%	100.0%
Kiltonview	Teesside	Day Unit	0	128.2%	95.1%		
The Orchard	Teesside	Day Unit	0	98.1%	96.0%		
Thornaby Road	Teesside	Day Unit	5	94.6%	119.9%		100.0%

APPENDIX 5

Scored Fill Rate compared to Quality Indicators - January 2018				Agency Usage Vs Actual Hours			Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Nos	Total Actual Hours	Total Agency Hours	% Against actual Hours	Total Actual Hours	Total Bank Hours	% Against actual Hours	SI	L4 Incidents	L3 Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	2581.0	308.0	11.9%	2581.0	158	6.1%						1		2	2
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2750.0	0.0	0.0%	2750.0	303	11.0%				1	1	3		4	4
Bedale Ward	Teesside	Adults	10	3937.0	0.0	0.0%	3937.0	553	14.0%					2	7		13	13
Bilsdale Ward	Teesside	Adults	14	2884.5	34.5	1.2%	2884.5	126.5	4.4%						2		2	2
Birch Ward	Durham & Darlington	Adults	15	2973.5	0.0	0.0%	2973.5	621.67	20.9%									
Bransdale Ward	Teesside	Adults	14	2986.6	23.0	0.8%	2986.6	203.5	6.8%					1	1	1	2	3
Cedar Ward	Durham & Darlington	Adults	10	4302.7	0.0	0.0%	4302.7	840	19.5%						4	1	6	7
Cedar Ward (NY)	North Yorkshire	Adults	18	3265.2	707.6	21.7%	3265.2	263	8.1%						4		6	6
Ebor Ward	York and Selby	Adults	12	2531.8	69.0	2.7%	2531.8	239	9.4%						2		3	3
Elm Ward	Durham & Darlington	Adults	20	3024.3	95.4	3.2%	3024.3	582.33	19.3%					5	1		1	1
Farnham Ward	Durham & Darlington	Adults	20	2812.8	19.5	0.7%	2812.8	193.83	6.9%									
Kirkdale Ward	Teesside	Adults	16	3101.8	0.0	0.0%	3101.8	697.5	22.5%						1		2	2
Lustrum Vale	Teesside	Adults	20	3440.0	92.0	2.7%	3440.0	897	26.1%			1			1		1	1
Maple Ward	Durham & Darlington	Adults	20	3035.4	83.3	2.7%	3035.4	996	32.8%				1		3		4	4
Minster Ward	York and Selby	Adults	12	2884.4	230.0	8.0%	2884.4	264.5	9.2%					1				
Overdale Ward	Teesside	Adults	18	2807.5	23.0	0.8%	2807.5	23	0.8%									

Primrose Lodge	Durham & Darlington	Adults	15	2687.2	0.0	0.0%	2687.2	482	17.9%									
Stockdale Ward	Teesside	Adults	18	2835.9	46.0	1.6%	2835.9	402.5	14.2%					2	4	1	4	5
The Orchards (NY)	North Yorkshire	Adults	10	2284.8	0.0	0.0%	2284.8	204	8.9%									
Tunstall Ward	Durham & Darlington	Adults	20	2874.4	0.0	0.0%	2874.4	36	1.3%				1					
Ward 15 Friarage	North Yorkshire	Adults	12	2566.8	56.3	2.2%	2566.8	496	19.3%					1	2		3	3
Willow Ward	Durham & Darlington	Adults	15	2952.8	0.0	0.0%	2952.8	338	11.4%									
Baysdale	Teesside	CYPS	6	2655.6	0.0	0.0%	2655.6	88.61	3.3%									
Holly Unit	Durham & Darlington	CYPS	4	1158.3	0.0	0.0%	1158.3	58	5.0%									
Newberry Centre	Teesside	CYPS	14	4961.9	26.5	0.5%	4961.9	477.18	9.6%						111		138	138
Talbot Direct Care	Durham & Darlington	CYPS	1	1394.3	0.0	0.0%	1394.3	0	0.0%									
The Evergreen Centre	Teesside	CYPS	16	5263.3	471.5	9.0%	5263.3	681.75	13.0%						94		141	141
Westwood Centre	Teesside	CYPS	12	6001.6	0.0	0.0%	6001.6	340	5.7%			1			21		31	31
Clover/Ivy	Forensics	Forensics LD	12	4207.2	11.3	0.3%	4207.2	1335.26	31.7%					3	23	1	39	40
Eagle/Osprey	Forensics	Forensics LD	10	2820.0	67.5	2.4%	2820.0	482.75	17.1%									
Harrier/Hawk	Forensics	Forensics LD	10	4405.7	0.0	0.0%	4405.7	1148.42	26.1%					5	3		6	6
Kestrel/Kite.	Forensics	Forensics LD	16	4228.4	101.3	2.4%	4228.4	790	18.7%									
Langley Ward	Forensics	Forensics LD	10	2150.8	11.3	0.5%	2150.8	451.5	21.0%									
Northdale Centre	Forensics	Forensics LD	12	5522.7	123.8	2.2%	5522.7	1070.62	19.4%					2				
Oakwood	Forensics	Forensics LD	8	2051.2	33.8	1.6%	2051.2	423.75	20.7%									
Thistle	Forensics	Forensics LD	5	2893.6	0.0	0.0%	2893.6	232.42	8.0%					1	1		1	1
Brambling Ward	Forensics	Forensics MH	13	4317.6	0.0	0.0%	4317.6	1681.25	38.9%						15		31	31
Jay Ward	Forensics	Forensics MH	5	2813.4	0.0	0.0%	2813.4	189.07	6.7%									
Lark	Forensics	Forensics MH	15	2845.8	0.0	0.0%	2845.8	376.75	13.2%									
Linnet Ward	Forensics	Forensics MH	17	2950.3	0.0	0.0%	2950.3	330.5	11.2%									
Mallard Ward	Forensics	Forensics MH	16	3837.2	0.0	0.0%	3837.2	826.75	21.5%					5				

Mandarin	Forensics	Forensics MH	16	4068.4	0.0	0.0%	4068.4	1239.75	30.5%						8		12	12
Merlin	Forensics	Forensics MH	10	4644.6	0.0	0.0%	4644.6	1373	29.6%						8		14	14
Newtondale Ward	Forensics	Forensics MH	20	3826.1	0.0	0.0%	3826.1	686.13	17.9%					4				
Nightingale Ward	Forensics	Forensics MH	16	2729.0	0.0	0.0%	2729.0	204.75	7.5%						1		1	1
Sandpiper Ward	Forensics	Forensics MH	8	4086.8	0.0	0.0%	4086.8	568.75	13.9%						39	1	98	99
Swift Ward	Forensics	Forensics MH	10	3243.5	0.0	0.0%	3243.5	271.25	8.4%					1	12		18	18
Aysgarth	Teesside	LD	6	2164.0	0.0	0.0%	2164.0	335.58	15.5%						1		1	1
Bankfields Court Flats	Teesside	LD	6	2031.8	0.0	0.0%	2031.8	113.16	5.6%									
Bankfields Court Unit 2	Teesside	LD	5	2583.3	0.0	0.0%	2583.3	449.91	17.4%									
Bankfields Court Unit 3	Teesside	LD	6	2397.6	0.0	0.0%	2397.6	253.33	10.6%	1					7		10	10
Bankfields Court Unit 4	Teesside	LD	6	2066.8	0.0	0.0%	2066.8	295.17	14.3%									
Bek-Ramsey Ward	Durham & Darlington	LD	11	4162.2	12.0	0.3%	4162.2	171	4.1%						8		10	10
Harland Rehab Ward	Durham & Darlington	LD	1	2268.0	12.0	0.5%	2268.0	192	8.5%									
Oak Rise	York and Selby	LD	8	4024.7	474.3	11.8%	4024.7	358.34	8.9%						7		11	11
The Lodge	Teesside	LD	1	1568.7	0.0	0.0%	1568.7	12	0.8%									
Acomb Garth	York and Selby	MHSOP	14	5727.5	3027.5	52.9%	5727.5	400.85	7.0%						54		91	91
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	3254.5	48.0	1.5%	3254.5	192	5.9%						2		5	5
Cherry Tree House	York and Selby	MHSOP	18	3440.8	549.3	16.0%	3440.8	445	12.9%					1	1		1	1
Hamsterley Ward	Durham & Darlington	MHSOP	15	3658.8	108.0	3.0%	3658.8	1018.75	27.8%						4		4	4
Meadowfields	York and Selby	MHSOP	14	3228.2	620.8	19.2%	3228.2	379.5	11.8%									
Oak Ward	Durham & Darlington	MHSOP	12	2742.5	36.0	1.3%	2742.5	474	17.3%					1	2		2	2
Roseberry Wards	Durham & Darlington	MHSOP	15	2812.3	12.0	0.4%	2812.3	349	12.4%					1	1		1	1
Rowan Lea	North Yorkshire	MHSOP	20	3933.6	299.2	7.6%	3933.6	293.87	7.5%						5		10	10
Rowan Ward	North Yorkshire	MHSOP	16	2773.3	126.5	4.6%	2773.3	337.75	12.2%									

Springwood Community Unit	North Yorkshire	MHSOP	14	3279.1	225.0	6.9%	3279.1	594.17	18.1%						10		14	14
Ward 14	North Yorkshire	MHSOP	10	2458.1	11.3	0.5%	2458.1	11.25	0.5%						2		2	2
Westerdale North	Teesside	MHSOP	18	4061.3	844.0	20.8%	4061.3	240.5	5.9%						3		3	3
Westerdale South	Teesside	MHSOP	14	6399.4	1114.5	17.4%	6399.4	1829.22	28.6%						14		14	14
Kiltonview	Teesside	LD	0	2175.5	0.0	0.0%	2175.5	340.67	15.7%									
The Orchard	Teesside	LD	0	972.5	0.0	0.0%	972.5	244.5	25.1%									
Thornaby Road	Teesside	LD	5	1885.2	0.0	0.0%	1885.2	6.5	0.3%									

APPENDIX 6

SEVERITY SCORE BY TOTAL SCORE – JANUARY 2018

WARD	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	Control & Restraint	TOTAL SCORE (Jan)
Westerdale South	2	2	1	1	2	0	0	0	0	0	**8**
Ayckbourn Unit Danby Ward	4	0	1	1	0	0	0	0	0	2	**8**
Bankfields Court Unit 4	4	2	1	0	1	0	0	0	0	0	**8**
Merlin	0	2	1	0	2	0	0	0	0	2	**7**
Talbot Direct Care	6	0	1	0	0	0	0	0	0	0	**7**
Lustrum Vale	0	2	1	1	2	0	0	1	0	0	**7**
Hamsterley Ward	0	2	0	1	2	0	0	0	0	2	**7**
Maple Ward	0	1	1	1	2	0	0	0	1	1	**7**
Eagle/Osprey	4	0	1	1	1	0	0	0	0	0	**7**
Clover/Ivy	2	1	0	1	2	0	0	0	0	0	**6**
Bedale Ward	4	1	0	0	1	0	0	0	0	0	**6**
Cherry Tree House	2	1	1	1	1	0	0	0	0	0	**6**
Ebor Ward	4	0	1	1	0	0	0	0	0	0	**6**
Harrier/Hawk	2	2	0	0	2	0	0	0	0	0	**6**
Oakwood	2	1	1	1	1	0	0	0	0	0	**6**
Springwood Community Unit	2	1	0	1	1	0	0	0	0	0	**5**
Cedar Ward	4	0	0	0	1	0	0	0	0	0	**5**
The Evergreen Centre	2	1	0	1	1	0	0	0	0	0	**5**
Westwood Centre	2	2	0	0	0	0	0	1	0	0	**5**
Acomb Garth	0	3	1	1	0	0	0	0	0	0	**5**
Brambling Ward	0	2	1	0	2	0	0	0	0	0	**5**
Langley Ward	2	1	0	1	1	0	0	0	0	0	**5**
Minster Ward	2	1	1	1	0	0	0	0	0	0	**5**
Ceddesfeld Ward	2	0	1	1	0	0	0	0	0	1	**5**

Meadowfields	0	1	1	1	1	0	0	0	0	0	**4**
Northdale Centre	0	2	0	1	1	0	0	0	0	0	**4**
Ward 15 Friarage	2	0	0	1	1	0	0	0	0	0	**4**
Mandarin	0	2	0	0	2	0	0	0	0	0	**4**
Kestrel/Kite.	0	1	1	1	1	0	0	0	0	0	**4**
Ayckbourn Unit Esk Ward	2	0	0	0	1	0	0	0	1	0	**4**
Oak Rise	2	1	0	1	0	0	0	0	0	0	**4**
Holly Unit	0	3	1	0	0	0	0	0	0	0	**4**
The Lodge	4	0	0	0	0	0	0	0	0	0	**4**
Newberry Centre	0	2	0	1	0	0	0	0	0	0	**3**
Bransdale Ward	0	2	0	1	0	0	0	0	0	0	**3**
Rowan Ward	0	0	1	1	1	0	0	0	0	0	**3**
Newtondale Ward	2	0	0	0	1	0	0	0	0	0	**3**
Mallard Ward	0	1	1	0	1	0	0	0	0	0	**3**
The Orchards (NY)	2	1	0	0	0	0	0	0	0	0	**3**
Birch Ward	2	0	0	0	1	0	0	0	0	0	**3**
Primrose Lodge	2	0	0	0	1	0	0	0	0	0	**3**
Bankfields Court Flats	2	0	1	0	0	0	0	0	0	0	**3**
Stockdale Ward	0	0	1	1	1	0	0	0	0	0	**3**
Thistle	2	0	1	0	0	0	0	0	0	0	**3**
Bankfields Court Unit 2	0	1	1	0	1	0	0	0	0	0	**3**
Westerdale North	0	2	0	1	0	0	0	0	0	0	**3**
Roseberry Wards	0	0	1	1	1	0	0	0	0	0	**3**
Baysdale	2	1	0	0	0	0	0	0	0	0	**3**
The Orchard	0	0	0	0	2	0	0	0	0	1	**3**
Kiltonview	0	1	0	0	1	0	0	0	0	1	**3**
Sandpiper Ward	0	1	0	0	1	0	0	0	0	0	**2**
Cedar Ward (NY)	0	0	1	1	0	0	0	0	0	0	**2**
Elm Ward	0	0	0	1	1	0	0	0	0	0	**2**
Bilsdale Ward	0	1	0	1	0	0	0	0	0	0	**2**
Nightingale Ward	2	0	0	0	0	0	0	0	0	0	**2**
Lark	0	0	1	0	1	0	0	0	0	0	**2**

Kirkdale Ward	0	0	1	0	1	0	0	0	0	0	**2**
Willow Ward	0	1	0	0	1	0	0	0	0	0	**2**
Ward 14	0	0	1	1	0	0	0	0	0	0	**2**
Bankfields Court Unit 3	0	0	1	0	0	1	0	0	0	0	**2**
Tunstall Ward	0	0	0	0	0	0	0	0	1	1	**2**
Oak Ward	0	0	0	1	1	0	0	0	0	0	**2**
Swift Ward	0	0	1	0	0	0	0	0	0	0	**1**
Overdale Ward	0	0	0	1	0	0	0	0	0	0	**1**
Linnet Ward	0	0	0	0	1	0	0	0	0	0	**1**
Bek-Ramsey Ward	0	0	0	1	0	0	0	0	0	0	**1**
Aysgarth	0	0	0	0	1	0	0	0	0	0	**1**
Farnham Ward	0	0	0	1	0	0	0	0	0	0	**1**
Rowan Lea	0	0	0	1	0	0	0	0	0	0	**1**
Harland Rehab Ward	0	0	0	1	0	0	0	0	0	0	**1**
Jay Ward	0	0	0	0	0	0	0	0	0	0	**0**
Thornaby Road	0	0	0	0	0	0	0	0	0	0	**0**

SEVERITY SCORING BY SPECIALITY

WARD	Locality	Speciality	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SI	Level 4	Level 3	Complaints	Control & Restraint	TOTAL SCORE Jan
Bedale Ward	Teesside	Adults	4	1	0	0	1	0	0	0	0	0	**6**
Bransdale Ward	Teesside	Adults	0	2	0	1	0	0	0	0	0	0	**3**
Danby Ward	N.Yorkshire	Adults	4	0	1	1	0	0	0	0	0	2	**8**
Cedar Ward (NY)	N.Yorkshire	Adults	0	0	1	1	0	0	0	0	0	0	**2**
The Orchards (NY)	N.Yorkshire	Adults	2	1	0	0	0	0	0	0	0	0	**3**
Stockdale Ward	Teesside	Adults	0	0	1	1	1	0	0	0	0	0	**3**
Kirkdale Ward	Teesside	Adults	0	0	1	0	1	0	0	0	0	0	**2**
Farnham Ward	Durham & Darlington	Adults	0	0	0	1	0	0	0	0	0	0	**1**
Primrose Lodge	Durham & Darlington	Adults	2	0	0	0	1	0	0	0	0	0	**3**
Bilsdale Ward	Teesside	Adults	0	1	0	1	0	0	0	0	0	0	**2**
Birch Ward	Durham & Darlington	Adults	2	0	0	0	1	0	0	0	0	0	**3**
Overdale Ward	Teesside	Adults	0	0	0	1	0	0	0	0	0	0	**1**
Minster Ward	York and Selby	Adults	2	1	1	1	0	0	0	0	0	0	**5**
Willow Ward	Durham & Darlington	Adults	0	1	0	0	1	0	0	0	0	0	**2**
Ward 15 Friarage	N.Yorkshire	Adults	2	0	0	1	1	0	0	0	0	0	**4**
Esk Ward	N.Yorkshire	Adults	2	0	0	0	1	0	0	0	1	0	**4**
Elm Ward	Durham & Darlington	Adults	0	0	0	1	1	0	0	0	0	0	**2**
Lustrum Vale	Teesside	Adults	0	2	1	1	2	0	0	1	0	0	**7**
Ebor Ward	York and Selby	Adults	4	0	1	1	0	0	0	0	0	0	**6**
Tunstall Ward	Durham & Darlington	Adults	0	0	0	0	0	0	0	0	1	1	**2**
Cedar Ward	Durham & Darlington	Adults	4	0	0	0	1	0	0	0	0	0	**5**
Maple Ward	Durham & Darlington	Adults	0	1	1	1	2	0	0	0	1	1	**7**
The Evergreen Centre	Teesside	CYPS	2	1	0	1	1	0	0	0	0	0	**5**
Talbot Direct Care	Durham & Darlington	CYPS	6	0	1	0	0	0	0	0	0	0	**7**
Newberry Centre	Teesside	CYPS	0	2	0	1	0	0	0	0	0	0	**3**
Westwood Centre	Teesside	CYPS	2	2	0	0	0	0	0	1	0	0	**5**

Holly Unit	Durham & Darlington	CYPS	0	3	1	0	0	0	0	0	0	0	**4**
Baysdale	Teesside	CYPS	2	1	0	0	0	0	0	0	0	0	**3**
Northdale Centre	Forensics	Forensics LD	0	2	0	1	1	0	0	0	0	0	**4**
Kestrel/Kite.	Forensics	Forensics LD	0	1	1	1	1	0	0	0	0	0	**4**
Harrier/Hawk	Forensics	Forensics LD	2	2	0	0	2	0	0	0	0	0	**6**
Eagle/Osprey	Forensics	Forensics LD	4	0	1	1	1	0	0	0	0	0	**7**
Brambling Ward	Forensics	Forensics LD	0	2	1	0	2	0	0	0	0	0	**5**
Langley Ward	Forensics	Forensics LD	2	1	0	1	1	0	0	0	0	0	**5**
Oakwood	Forensics	Forensics LD	2	1	1	1	1	0	0	0	0	0	**6**
Thistle	Forensics	Forensics LD	2	0	1	0	0	0	0	0	0	0	**3**
Sandpiper Ward	Forensics	Forensics MH	0	1	0	0	1	0	0	0	0	0	**2**
Merlin	Forensics	Forensics MH	0	2	1	0	2	0	0	0	0	2	**7**
Mandarin	Forensics	Forensics MH	0	2	0	0	2	0	0	0	0	0	**4**
Newtondale Ward	Forensics	Forensics MH	2	0	0	0	1	0	0	0	0	0	**3**
Swift Ward	Forensics	Forensics MH	0	0	1	0	0	0	0	0	0	0	**1**
Mallard Ward	Forensics	Forensics MH	0	1	1	0	1	0	0	0	0	0	**3**
Nightingale Ward	Forensics	Forensics MH	2	0	0	0	0	0	0	0	0	0	**2**
Lark	Forensics	Forensics MH	0	0	1	0	1	0	0	0	0	0	**2**
Linnet Ward	Forensics	Forensics MH	0	0	0	0	1	0	0	0	0	0	**1**
Bankfields Court Flats	Forensics	Forensics MH	2	0	1	0	0	0	0	0	0	0	**3**
Jay Ward	Forensics	Forensics MH	0	0	0	0	0	0	0	0	0	0	**0**
Aysgarth	Forensics	Forensics MH	0	0	0	0	1	0	0	0	0	0	**1**
Oak Rise	York	LD	2	1	0	1	0	0	0	0	0	0	**4**
Harland Rehab Ward	Durham & Darlington	LD	0	0	0	1	0	0	0	0	0	0	**1**
Acomb Garth	York and Selby	LD	0	3	1	1	0	0	0	0	0	0	**5**
The Lodge	Tees	LD	4	0	0	0	0	0	0	0	0	0	**4**
Bek-Ramsey Ward	Durham & Darlington	LD	0	0	0	1	0	0	0	0	0	0	**1**
Bankfields Court Unit 2	Teesside	LD	0	1	1	0	1	0	0	0	0	0	**3**
Bankfields Court Unit 3	Teesside	LD	0	0	1	0	0	1	0	0	0	0	**2**
Ceddesfeld Ward	Durham & Darlington	LD	2	0	1	1	0	0	0	0	0	1	**5**
Bankfields Court Unit 4	Tees	LD	4	2	1	0	1	0	0	0	0	0	**8**
Westerdale South	Tees	MHSOP	2	2	1	1	2	0	0	0	0	0	**8**

Westerdale North	Tees	MHSOP	0	2	0	1	0	0	0	0	0	0	**3**
Roseberry Wards	Durham & Darlington	MHSOP	0	0	1	1	1	0	0	0	0	0	**3**
Oak Ward	Durham & Darlington	MHSOP	0	0	0	1	1	0	0	0	0	0	**2**
Springwood	North Yorkshire	MHSOP	2	1	0	1	1	0	0	0	0	0	**5**
Rowan Lea	North Yorkshire	MHSOP	0	0	0	1	0	0	0	0	0	0	**1**
Rowan Ward	North Yorkshire	MHSOP	0	0	1	1	1	0	0	0	0	0	**3**
Cherry Tree House	York and Selby	MHSOP	2	1	1	1	1	0	0	0	0	0	**6**
Meadowfields	York and Selby	MHSOP	0	1	1	1	1	0	0	0	0	0	**4**
Hamsterley Ward	Durham & Darlington	MHSOP	0	2	0	1	2	0	0	0	0	2	**7**
Ward 14	North Yorkshire	MHSOP	0	0	1	1	0	0	0	0	0	0	**2**

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM No. 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27 February 2018**
TITLE:	**Learning from deaths**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	✓
To continuously improve to quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

This is the second Learning from Deaths report and sets out the approach the Trust is taking towards the identification, categorisation and investigation of deaths. The current mortality dashboard is also included although from Q1 2018/19 this will be presented in a dashboard format (Appendix 1).

Key themes from the learning points identified from the Serious Incidents reviewed in Q3 2017/18 is attached at Appendix 3.

A formal statement on the scope of the Learning from Deaths policy and information to support understanding of the scope of those deaths and the triggers for the different types of reviews is included at Appendix 4.

Recommendations:

The Board of Directors is requested to note the content of this report and the areas for ongoing improvement/refinement.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**27 February 2018**
TITLE:	**Learning from deaths**

1. INTRODUCTION & PURPOSE:

1.1 To formally report to the Board of Directors key information on 'Learning from deaths' in line with national guidance and the Trust 'Learning from deaths: the right thing to do' policy (CORP 00-65). The Trust has prioritised working more closely with families and carers of patients who have died and to ensure meaningful support and engagement with them at all stages, from the notification of the death of their loved one right through to actions taken following from an investigation (if deemed appropriate). Understanding the data around the deaths of our service users is a vital part of our commitment to learning from deaths. We will also learn from developments nationally as these occur.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Following the publication of the Southern Health report in 2015 there has been enhanced national scrutiny on how all NHS organisations respond to the deaths of service users in their care. This culminated in the release of a 'Learning from deaths framework' which was published by the National Quality Board (NQB) earlier in 2017. The ongoing implementation of the requirements of this framework will be monitored on a quarterly basis via the Patient Safety Group.

All NHS Trusts are now required to publish a dashboard (Appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis, which are in-scope of the learning from deaths policy, and also the proportion of those deaths which were subject to any investigation or mortality review. It is important to note that when reviewing the data presented in the dashboard all of the deaths categorised as 'in scope for the learning from deaths policy' are subject to an initial clinical review before determining if they require further investigation.

3. KEY ISSUES:

3.1 Identification of deaths to be reviewed

We continue to work with staff in all of our community teams (including Learning Disabilities) to ensure they report any deaths they become aware of – regardless of cause - via our internal incident management system (Datix). As this additional reporting improves so will the accuracy of the data we publish to ensure we are working within the scope of our learning from deaths policy.

3.2 Classification of deaths to be investigated

The Trust collects data on all known deaths and has a process in place to determine the scope of deaths which require further review or investigation. There is no change to how we investigate unexpected deaths, classed as serious incidents, which are managed under the NHS England Serious Incident Framework (2015). Appendix 4 has more information on this matter.

For people with a Learning Disability the Trust supports the approach of the LeDer programme (national learning disabilities mortality review process). Recent figures received by the central LeDer team indicate that 16 of the 41 learning disability deaths occurring during Q1-3 were registered with LeDer. We continue to link in with the regional LeDeR team to improve our processes and also to streamline the process of receiving feedback from the LeDeR reviews which have been completed.

3.3 **Mortality Review**

The current Trust approach to mortality review at this time is to identify those service users on the Care Programme Approach who have died but do not fall into the category of a Serious Incident. A case summary is prepared for a multi-disciplinary team review. For any cases where further investigation is required to make a decision we have adopted a more detailed approach of structured judgement review. Any learning points identified are shared with the clinical team involved and will be considered in thematic reports of patient safety issues. A shortened, anonymised example of a completed structured judgement review is attached at Appendix 2.

3.3 Appendix 1: Dashboard

The second version of the learning from deaths dashboard is attached at Appendix 1 – it should be noted that this information will be presented both numerically and in the form of a graphs/charts in a dashboard style report from April 2018 onwards.

The headings in the dashboard are currently defined as follows:

Total deaths as reported on Patient Admin System	Total number of service users who have died in the period – this information will be subject to robust quality checking to ensure its accuracy
Total number of deaths – community service users	Total number of community service users who have died in the reporting period (included in numbers above)
Total number of deaths - In-Patient	Number of in-patient service users who have died in the period (included in numbers above)
Total number of deaths - LD In-Patient	Number of LD in-patient service users who have died in the period (included in numbers above)
Total number of deaths in scope for learning from deaths policy	Total number of deaths of service users who meet the criteria for being 'in scope' as per the learning from deaths policy
Total deaths reviewed as an SI	Number of Serious Incident investigations completed and signed off by directors panel in the period
Total deaths reviewed as mortality reviews	Number of cases reviewed via the mortality review process (excluding SI numbers above)
Total LD deaths reviewed internally	Total number of service users with a Learning Disability who have died and have had their care reviewed in the period
LD Deaths Reported to LeDer	Total number of service users with a Learning Disability who have died and have had their case referred for review by the LeDeR programme
Total no of deaths (SI) where there had been learning identified that	Number of individual cases where learning was identified from Serious Incidents completed in

has led, or would likely lead, to change	the period

For the purpose of this report the learning identified from Serious Incidents has been categorised as those cases which concluded with either a root cause or contributory finding meaning the outcome *may* have been different if different decisions had been made or different circumstances in place. Themes from the learning points identified in Q3 have been included within this report at Appendix 3.

4.0 Next Steps

As previously mentioned within this report this is an enhanced process of reporting which is still being refined and defined and therefore the information should be considered with this in mind.

We are still working towards the best approach to reporting what are described in general hospital services as "avoidable deaths." This is because there is currently no research base on this for mental health services and no consistent accepted basis for calculating this data. We also consider that if we restricted our reporting to inpatient services only this would give a misleading picture of the majority of services we provide which are predominately community focused. We will review this approach before April 2018 and will continue to support work to develop our data, reporting and general understanding of the issues.

5.0 IMPLICATIONS:

5.1 **Compliance with the CQC Fundamental Standards:**
CQC look at a range of data to help them monitor trusts that provide mental health services. This report provides evidence in respect of Regulation 17 – Good Governance.

5.2 **Financial/Value for Money:**
There are financial and reputational implications associated with poor standards of quality service.

5.3 **Legal and Constitutional (including the NHS Constitution):**
CQC's Fundamental Standards in respect of Regulation 17 - Good Governance.

5.4 **Equality and Diversity:**
Feedback received associated with discrimination is, where this is apparent, forwarded for review by the Equality and Diversity lead.

5.5 **Other implications:** No other implications identified.

6. RISKS: There is a risk that the data published is compared by others with the data of other organisations who may not provide similar services.

7. CONCLUSION:
This report is the second version of the trust information relating to the national learning from deaths agenda. There will be ongoing work required to ensure the numbers of deaths reported (both in and out of scope) are as accurate as possible.

8. RECOMMENDATIONS:

The Board of Directors is requested to note the content of this report and the areas for ongoing improvement/refinement.

Jennifer Illingworth
Director of Quality Governance
February 2018

Background Papers:

Learning From Deaths Framework
https://www.england.nhs.uk/?s=Learning+from+Deaths

Trust Learning from deaths policy
http://www.tewv.nhs.uk/site/search-results?query=learning+from+deaths+policy

Southern Health Report
https://www.england.nhs.uk/2015/12/mazars/

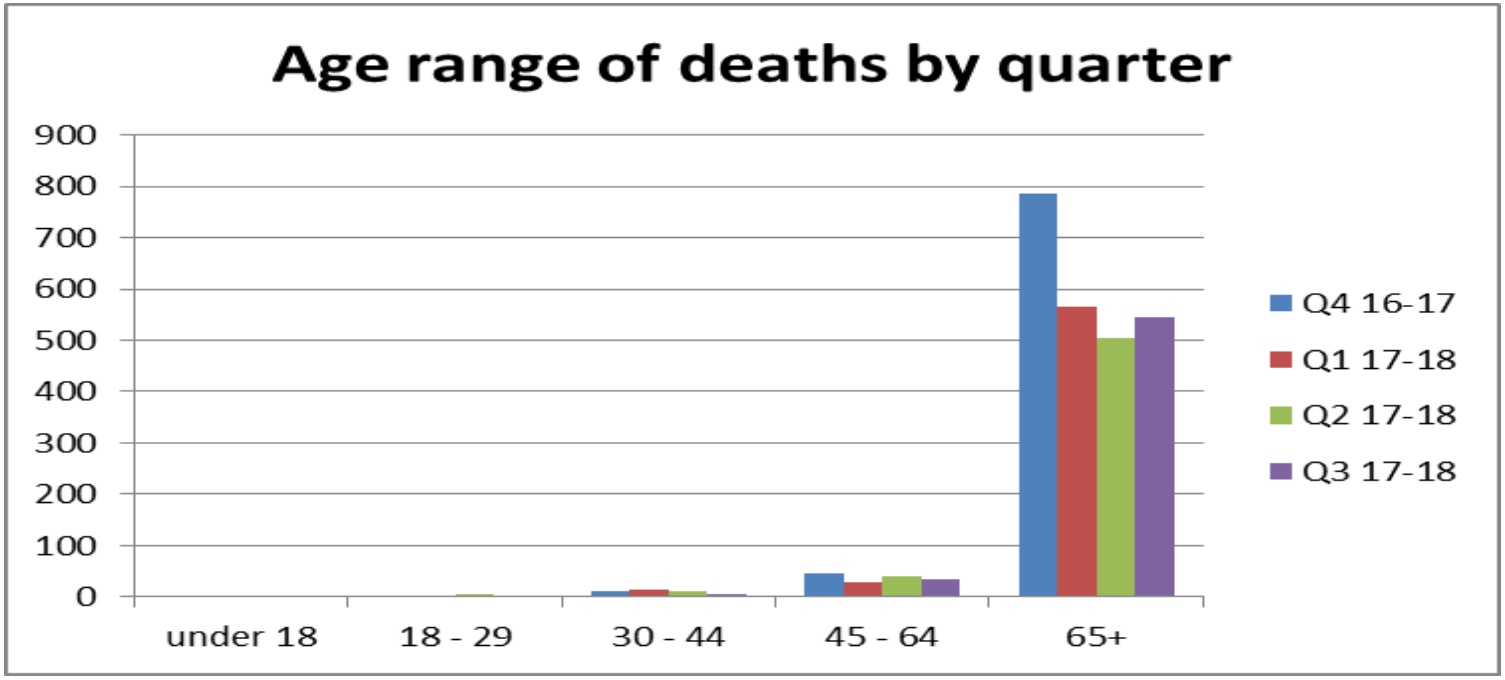
Serious Incident Framework
https://www.england.nhs.uk/?s=serious+incident+framwework

Appendix 1

	Total deaths as reported on Patient Admin System	Total number deaths - community service users	Total number deaths - In-Patient	Total number deaths - LD In-Patient	Total deaths in scope of learning from deaths policy		Total deaths reviewed as an SI	Total deaths reviewed as mortality review	Total LD deaths reviewed internally	LD deaths reported to LeDer	Total no of deaths (SI) where learning identified that has led, or was likely to, change
April	**211**	**210**	**1**	0	**60**		**7**	**12**	0	0	**4**
May	**189**	**188**	**1**	0	**117**		**4**	**9**	0	3	**3**
June	**141**	**141**	**0**	0	**101**		**6**	**15**	0	2	**2**
Q1 total	**541**	**539**	**2**	**0**	**278**		**17**	**36**	**0**	**5**	**9**
July	**197**	196	1	0	121		6	13	0	2	3
August	**161**	160	1	0	134		7	9	1	2	3
September	**166**	165	1	0	107		3	4	2	0	1
Q2 total	**524**	**521**	**3**	**0**	**362**		**16**	**26**	**3**	**4**	**7**
October	206	205	1	0	129		11	7	0	2	4
November	167	164	2	0	118		9	10	1	2	5
December	201	195	3	0	146		10	11	2	3	3
Q3 total	**574**	**568**	**6**	**0**	**393**		**30**	**28**	**3**	**7**	**12**

For the 6 in-patient deaths in Q3 – 3 patients were transferred from an in-patient ward to an acute hospital where they subsequently died, 2 patients died on an in-patient ward from expected physical health causes and 1 in-patient died from an unnatural cause - this was categorised as a Serious Incident and is being investigated accordingly.

Age profile of deaths reported on Patient Administration System by quarter



Appendix 2 - Example of Mortality Structured Judgement Review

This case involved a female in her late 70's who was open to a Mental Health Services for Older People Community Team and died from pulmonary embolism. She was known to services from early 2016 and had two short admissions for assessment of deterioration in her mental health and medication management.

The structured judgement review was undertaken and scored the following phases of care:
Assessment of risk
On-going care
Care during admission
Follow up management/discharge.

Good Practice

Areas of good practice identified during the case note review were evidence of up to date and well documented care plans which indicated multi-disciplinary input and communication which included the patient's family and GP. It was also evident that there was good standard of care overall provided via regular and consistent contact with her CPN who clearly had a good rapport and understanding of patient. The patient's wishes were supported by caring for her in the community rather than as an inpatient and deterioration in mental and physical health were identified and managed at an early stage.

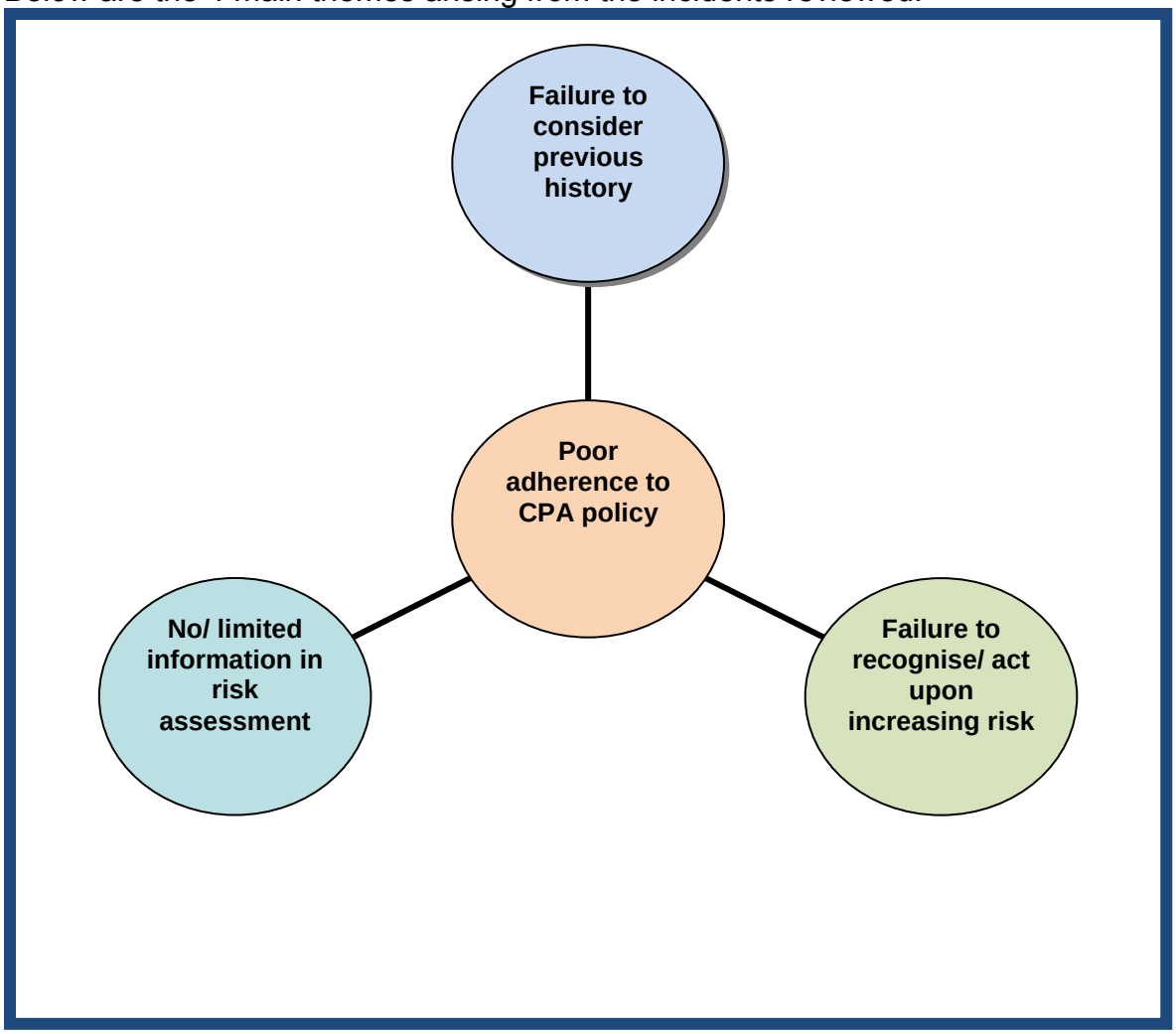
Learning points

Learning points included that the safety summary was well written but mainly related to the last admission to inpatient services. This meant that whilst the care plans had been updated to respond to risks in the community the safety summary did not reflect the changes in risk. It was also difficult from the notes to identify exactly which dates changes in medication had occurred following prescribing advice.

This information was discussed at the Trust Patient Safety Group and also shared with the clinical team responsible for the care of this patient. The learning points will be fed into Trust wide patient safety reports.

Appendix 3 – Key Learning Points from Q3 2017/18 Serious Incidents

Below are the 4 main themes arising from the incidents reviewed:



Other points of note were:

- Changes to medication not always communicated in a timely manner
- Discharge planning not always being as robust as it should be

Appendix 4 - A formal statement on the scope of the Learning from Deaths policy and information to support understanding of the scope of those deaths and the triggers for the different types of reviews

Scope of the Learning from Deaths policy:

In March 2017 the National Quality Board published National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. The Trust Learning from Deaths Policy fulfils the requirements of the NQB guidance as it includes:

i. How its processes respond to the death of an individual with a learning disability or mental health needs

ii. The Trust's approach to undertaking case record reviews. Since 2014 hospitals in Yorkshire and the Humber have been working together with the AHSN Improvement Academy to refine a mortality review method called Structured Mortality Review (SJR), a method proposed for all acute hospitals in England. Within TEWV this approach is also being piloted as an evidence-based methodology for reviewing the quality of care provided to those patients who die.

iii. Categories and selection of deaths in scope for case record review: The rationale for the scope selected by Trusts will need to be published and open to scrutiny. TEWV's Learning from Deaths Policy has been developed with other mental health trusts in the north of England and reflects both the NQB requirements as well as the categorisation of deaths within the 2015 Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015.

Q. How are deaths identified and reported?

A. The Trust has systems that identify and capture the known deaths of its service users on its electronic patient administration system (PAS) and where appropriate on its risk management systems. This is to help ensure that the Trust Board has a comprehensive picture of the deaths of all its services users and the opportunities to learn from them.

Trust staff must report all deaths that they are made aware of on Datix or by email (MHSOP services only due to volume) to the Patient Safety team within 24 hours of being informed and provide the cause of death where known. Once the Datix is completed staff must immediately attempt to engage with the family and or carers unless otherwise instructed. In the first instance this would take the form of a condolence letter with contact numbers for contacting the service.

This applies to all deaths of patients open to TEWV services.

Q. How is the decision made to investigate or review?

A. As per the 2017 National Quality Board Guidance on Learning from Deaths the Trust collects data on all known deaths and has a process in place to determine the scope of deaths which require further review or investigation.

All Datix reports for deaths are reviewed by the Patient Safety Team on a daily basis and any unnatural unexpected deaths are taken forward through the Serious Incident process as per the NHS England Serious Incident Framework (2015). A summary of all other reported deaths for those patients on CPA or have a Learning Disability are taken to the Patient Safety Group (which is a multi-disciplinary forum) where each death is reviewed using the Mortality Review coding methodology below to establish the category of death and the level of review required:

Expected Natural (EN1)	A group of deaths that were expected to occur in an expected timeframe. E.g. people with terminal illness or in palliative care services. These deaths would not be investigated but could be included in a mortality review of early deaths amongst service users.
Expected Natural (EN2)	A group of deaths that were expected but were not expected to happen in that timeframe. E.g. someone with cancer but who dies much earlier than anticipated These deaths should be reviewed and some cases would benefit from further investigation – usually in the form of a structured judgement review (see Appendix 2)
Expected Unnatural (EU)	A group of deaths that are expected but not from the cause expected or timescale E.g. some people on drugs or dependent on alcohol or with an eating disorder These deaths should be investigated via a Head of Service Review or a Serious Incident investigation
Unexpected Natural (UN1)	Unexpected deaths which are from a natural cause e.g. a sudden cardiac condition or stroke. These deaths should be reviewed and some may need an investigation.
Unexpected Natural (UN2)	Unexpected deaths which are from a natural cause but which didn't need to be e.g. some alcohol dependency and where there may have been care concerns. These deaths should all be reviewed and a proportion will need to be investigated via a Head of Service Review or a Serious Incident investigation
Unexpected Unnatural (UU)	Unexpected deaths which are from unnatural causes e.g. suicide, homicide, abuse or neglect. These deaths are likely to need a full serious incident investigation

For all deaths of people with a Learning Disability the Trust supports the approach of the LeDer program and these incidents will be reported accordingly to LeDer by the Patient Safety Team.

Q. What happens if a further review is required (not unexpected Unnatural)

A. Determining which of those deaths that require further review is undertaken by the Trust Patient Safety Group as it undertakes the function of a Mortality Review Group. This group receives a summary of all known deaths of patients who:

• Were an in-patient at time of their death
• Had a Learning Disability
• Were on CPA at time of their death

To support the review process, a summary will be provided which will include a brief synopsis of the persons care and treatment including a medication history and any known physical health issues. Each of these deaths will be subject to a multi-disciplinary review and, if it is decided that there is cause for a higher level of scrutiny they will then be put forward for a Structured Judgment Review (SJR).

A SJR blends traditional a clinical judgement based review with a standard format that enables reviewers to make safety and quality judgements over phases of care and which provides explicit written comments and a score for each phase. A SJR provides a relatively short but rich set of information about each case in a format that can be aggregated to provide knowledge about clinical services and systems of care. This will be undertaken by a clinical professional in conjunction with the team responsible for the care and treatment of the deceased. The completed SJR will be brought back to the following Patient Safety Group for discussion and any learning points captured and shared as appropriate.

Q. How will the Trust demonstrate Learning

A.

For serious incidents the following will be undertaken:

- Analysis of trends emerging from high numbers of incidents involving either a specific type of incident, an individual member of staff, an individual patient or particular service.
- Serious incident reviews will involve a root cause analysis
- A quarterly review of incidents will be carried out
- Lessons learnt from incidents will be shared by Action Plan Owners via the Quality Assurance Committee (QuAC) and QUAG's
- Lessons requiring instant dissemination will be cascaded through the Trusts Safety Alert Broadcast System
- Locality Service Development Leads, critical incident review meetings and patient safety sub groups
- As part of the incident review process operational services will seek to identify lessons learned in addition to those arising from the serious incident investigation.

The reporting of incident analysis and lessons learned to Trust Board will be through the QuAC from the relevant working or assurance groups. For non-clinical incidents the reporting of incident analysis and lessons learned to Trust Board will be through the EMT following analysis by the various relevant working groups.
The Trust will ensure that lessons learnt result in change in organisational culture and practice by; identifying themes and trends from data presented; commissioning thematic reviews on a regular basis by the Patient Safety Committee or Quality Assurance Committee

and ensuring that associated action plans are implemented. The Trust also looks to track recurring themes to be able to demonstrate if patient safety is improving in key areas.

We will ensure learning is cascaded to frontline clinical staff on a regular basis by use of Patient Safety Bulletins, Learning Lessons information and Incidental Findings thematic summaries.

For those cases which are subject to a SJR the review identifying any lessons to be learned will be presented to the Patient Safety Group as a standard agenda item to be reviewed and approved. Any actions required would be agreed and monitored in the first instance through the Patient Safety Group and cascaded through the operational management structure as appropriate. This could take the form of a formal request for a review of a particular theme or topic or more general learning in the Patient Safety bulletin.

ITEM NO.9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th FEBRUARY 2018**
TITLE:	**MAKING A DIFFERENCE TOGETHER**
REPORT OF:	**DAVID LEVY, DIRECTOR OF HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT**
REPORT FOR:	**INFORMATION, CONSULTATION AND DECISION**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	√
To continuously improve to quality and value of our work	√
To recruit, develop and retain a skilled, compassionate and motivated workforce	√
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	√
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	√

Executive Summary:

The report provides feedback about the outcomes of the TEWV values and staff compact consultation exercise in 2017 and other activities that are related to the Making a Difference Together business plan priority. The consultation exercise, and the recent Investors in People assessment process, provided helpful information about the views of staff, service users, carers, governors and other interested parties thought he level of engagement in the consultation was lower than had been hoped for.

Recommendations:

That the contributions made by those people who participated in the values and staff compact consultation exercise during 2017 are acknowledged by an expression of thanks through a variety of different TEWV communications.

That a further values and staff compact consultation exercise is undertaken amongst staff, service users, carers, governors and other interested parties during 2018 using crowdsourcing and face to face sessions. The consultation to include the question ‘what are your beliefs and values?’

That the feedback for both consultations is collated and reported, along with recommendations to the Board of Directors at its September 2018 meeting.

That the recent decision of the Executive Management Team to endorse the participation ladder and associated definitions described in Appendix 1 is noted.

That developments in respect of the draft Leadership and Management Development Strategy, the draft Bullying and Harassment Procedure and the planned production of guidance to help tackle abuse from service users and members of the public are noted.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**27th FEBRUARY 2018**
TITLE:	**MAKING A DIFFERENCE TOGETHER**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide Directors with information about the outcome of the TEWV values and staff compact consultation exercise that was undertaken as part of the Making a Difference Together business plan priority.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 TEWV developed its current values and behaviours statements during 2009/10. These statements have been used ever since to articulate the way in which we seek to do things within TEWV.

2.2 The Board of Directors agreed that a consultation exercise about the TEWV values and staff compact be undertaken during 2017 with staff, service users, carers and partner organisations as part of the Making a Difference Together business plan priority.

2.3 During 2017 it was identified that three key TEWV commitments and their related activities resonate strongly with and link to the Making a Difference Together business plan priority. These are:

- **The TEWV Quality Improvement System (QIS)** – a methodology and philosophy designed to ensure that improving the quality and value of services is at the core of what we do.

- **The Recovery Strategy** – based around a theory of personal recovery and the process of building a meaningful and satisfying life with or without ongoing difficulties/symptoms. Personal recovery is believed to be much more relevant when considering mental health and distress, as often it is not the diagnosed symptoms which are most troubling but the desire for a greater sense of purpose, an understanding of their distress or the need for more control.

- **Leadership and Management Development** – ongoing work to engage all leaders and managers within TEWV to develop a coaching culture as part of everyday work and conversations and in doing this ensure that services are recovery focused and optimise service user outcomes and experience. This approach has been developed as part of TEWV Purposeful and Productive services activities.

2.4 The TEWV values and staff compact consultation exercise was completed in November 2017, the same month that TEWV was assessed against the Investors in People (IiP) Standard. The IiP assessment included consideration of the TEWV values and staff compact consultation exercise and helpful feedback has been received as a consequence.

3. KEY ISSUES:

3.1 Despite much planning and effort the number of staff participating in the values and staff compact consultation was less than hoped for. Only 30 staff attended the 13 consultation sessions arranged , a further 135 staff visited a stand about the consultation exercise at either the TEWV nursing conference, the TEWV clinical leaders conference or the Alright Teesside event that was held in Stockton. A total of 207 staff responded to the opportunity to take part in a values and staff compact electronic survey. The Board of Directors also participated in the consultation.

3.2 The consultation was not limited to TEWV staff. A total of 62 service users and representatives of partner organisations participated in the consultation sessions along with 17 TEWV governors and 17 commissioner representatives. Though the overall number of people participating in the consultation sessions was lower than hoped for the diversity of participants was welcome.

3.3 The consultation survey told us that 64% of respondents believed the current values represent TEWV today with 17% believing that they do not and 19% stating that they were unsure. When asked whether the behaviour statements were still relevant for TEWV 71% stated that they believed they were still relevant with 10% disagreeing and 19% stating that they were unsure.

3.4 The feedback provided through the consultation events included:

- There are too many related documents/publications and this can cause some confusion i.e. the TEWV values and behaviours statements, the TEWV staff compact, the TEWV recovery principles, the NHS Constitution values
- The documents ought to be easier to read and less corporate and less clinical in tone
- The references in the staff compact to TEWV ‘striving’ to address communications and work environment issues and of TEWV ‘endeavouring to be a great organisation to work for’ were contrasted with the somewhat more precise expectations of TEWV staff that are stated within the compact.
- Both TEWV and its staff need to listen and respond more to what is being said by staff and service users. The need for more action to tackle behaviours was highlighted.
- There was broad support for the current values and behaviours statements

themselves though there was also a belief that they could be improved.

- There was support for the development of a compact between TEWV and service users as an alternative to continuing to use the existing recovery values and principles document. The suggestion that we incorporate the staff compact within the values and behaviours statements was also supported by a number of people.

3.5 The Investors in People assessment report provides helpful feedback to Complement the feedback received from the consultation exercise. The assessment process highlighted that many nurses and healthcare assistants were unaware of the values and compact consultation exercise. A lack of awareness of corporate communications amongst these staff groups, that come to some 3,000 staff, was identified as being present and poses a risk to future staff engagement. The Communications Team had independently identified the need for a TEWV-wide communications refresh. The Investors in People feedback provides further evidence to support this view. The Executive Management Team has recently supported the use of crowdsourcing as a means of improving our ability to communicate and engage with staff, service users, carers, governors, partner organisations and other interested parties.

3.6 Crowdsourcing is a blend of safe online workshops or summits, supported by focus groups and surveys through which participants can openly share their ideas on a small number of powerful 'challenge questions.' Ideas can be rated and commented upon by others and the views expressed analysed to co-create consensus, insight and solutions. This approach can be used to engage and communicate with not only staff but also service users, carers, TEWV governors, GPs, commissioners, other partners and the public. There is Executive Management Team support for using crowdsourcing to help address a number of key TEWV engagement and communication issues during 2018/19 and then evaluating the impact. The Finance and IT Directorate is currently co-ordinating efforts to improve access to desktop PC's on wards in response to the Investors in People report feedback that some staff experience difficulties with being able to access a PC. This work ought to help to improve staff access to e-communications in the future.

3.7 The evidence from the Investors in People assessment was that the current values are widely publicised throughout TEWV and are embedded in a number of strategies, procedures and processes. Everyone who was interviewed knew that TEWV has values and where they could see them. Recall of the values was mixed with some staff not being able to recall any or all of the values. When asked 'what do you think is important to the Trust'? most interviewees responded with words such as 'patient care' or 'patient centred' or 'compassion' and these were identified as being their own values.

3.8 The Investors in People assessment report includes consideration of the following suggestions for the future development of TEWV values:

- Values should be bespoke rather than very generic.

- Values should be specific and descriptive, single word values can be open to translation or lose meaning

- TEWV values should resonate with individuals values. Consultation with staff could be around 'what are your own beliefs and values?' rather than 'what do you think of the Trust's values?'

- Values should be aspirational. Values can simply reflect the current culture or seek to influence it.

3.9 Work has been undertaken to develop future culture metrics that could be used within TEWV. Feedback received has been that measuring culture may be something best done over a less frequent timescale than that previously used within TEWV. Instead of measuring organisational culture every six months, as has happened previously in TEWV, some NHS organisations now regard measuring culture every two years as being proportionate. Most culture measurement methodologies include surveying staff and avoiding survey fatigue amongst staff is regarded as being important.

3.10 As stated earlier in this report a key component of the Making a Difference Together priority is implementation of the TEWV Recovery Strategy. Phase 2 of the Recovery Strategy includes a requirement for TEWV to determine how co-production is defined and implemented. Having a shared understanding of the different types and forms of participation that can take place within TEWV is important. The Recovery team have worked with TEWV involvement and engagement leads and the KPO team to produce a ladder of participation and associated definitions. The ladder of participation and the associate definitions, that were recently approved by the Executive Management Team, can be found in Appendix 1.

3.11 The draft TEWV Leadership and Management Development Strategy is expected to be approved by the Executive Management Team by the end of March 2018. The strategy will provide the basis for future leadership and management development within TEWV including the promotion of a coaching based approach to leadership and management.

3.12 Efforts to improve how conflict between TEWV staff is managed are underway and a new Bullying and Harassment Resolution Procedure is currently the subject of consultation. It is anticipated that this new procedure will be agreed in April 2018 and its introduction ought to increase the number of staff who are willing to come forward and highlight instances of poor behaviour that can then be resolved, potentially without the need for those affected to have to participate in investigations and formal hearings that can be adversarial. The development of this new approach to conflict resolution and the planned guidance to support managers and other staff to be able to take action in response to abuse from service users and members of the public are part of efforts to bring about cultural change by tackling poor behaviour within TEWV, whoever the perpetrators may be.

3.13 An outline timetable of Making a Difference Together activities, alongside monthly monitoring by the Executive Management Team, could include:

- March 2018 – approval of the TEWV Leadership and Management Development Strategy and the TEWV Workforce Strategy
- March 2018 – confirm the topics to be the subject of TEWV Crowdsourcing, in addition to the TEWV values and staff compact Consultation ,during 2018/19 and procure crowdsourcing facility
- April 2018 – approval of the TEWV Bullying and Harassment Resolution Procedure and guidance for managers and staff about tackling abuse from service users and embers of the public. Associated training/awareness sessions to be provided
- May to August 2018 – undertake a further TEWV values and staff compact consultation exercise using crowdsourcing
- September 2018 – report outcomes and recommendations of the exercise to the Board of Directors, including future culture metrics
- October 2018 - review and report progress made, via the Recovery Programme Board, with implementation of the participation ladder
- March 2019 - evaluate and report the impact of crowdsourcing activities to the Board of Directors

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** None identified.

4.2 **Financial/Value for Money:** The cost of using crowdsourcing as part of future TEWV engagement and communications activities has yet to be quantified though it is estimated that it will be tens of thousands of pounds per annum.

4.3 **Legal and Constitutional (including the NHS Constitution):** None identified

4.4 **Equality and Diversity:** None identified

4.4 **Other implications:** None identified

5. RISKS:

That activities arising from the Making a Difference Together priority and other related priority issues are not addressed in a co-ordinated manner leading to the potential for confusion and/or duplication of effort**.**

6. CONCLUSIONS:

6.1 The values and staff compact consultation exercise generated helpful feedback though the level of staff engagement was lower than had been hoped for. The outcomes of the consultation exercise with regard to the values and staff compact do need to be treated with some caution due to the small number of staff who participated in the face to face consultation sessions and it is difficult to draw clear conclusions from the exercise. It is believed that the consultation exercise has nonetheless provided valuable feedback that can be used to help improve staff engagement and communication within TEWV

6.2 The Investors in People assessment report complemented the values and staff compact consultation exercise and also provided useful feedback. The feedback was mainly positive though it is clear that a refreshed approach to communications is needed and that this will benefit future efforts to engage and communicate with staff, service users, carers, governors and other interested parties.

6.3 The proposed ladder of participation and associated definitions creates an opportunity to increase co-production within TEWV by providing clarity about expectations when undertaking quality improvement, recruitment and training activities.

6.4 Good progress is being made with adopting a more co-ordinated approach to leadership and management development is emerging and this will support future efforts to embed a coaching culture within TEWV. It is believed that these efforts ought to help improve how staff and services are developed and delivered in the future. .

6.5 There have been positive developments in respect of the production of a draft TEWV Bullying and Harassment Resolution Procedure and a commitment to provide more organisational support to staff who are abused by service users and the public. These initiatives are expected to progress from development stage to implementation by April 2018.

7. RECOMMENDATIONS:

7.1 That the contributions made by those people who participated in the values and staff compact consultation exercise during 2017 are acknowledged by an expression of thanks through a variety of different TEWV communications.

7.2 That a further values and staff compact consultation exercise is undertaken amongst staff, service users, carers, governors and other interested parties during 2018 using crowdsourcing and face to face sessions. The consultation to include the question ‘what are your beliefs and values?’

7.3 That the feedback from both consultations is collated and reported, along with recommendations to the Board of Directors at its September 2018 meeting.

7.4 That the recent decision of the Executive Management Team to endorse the participation ladder and associated definitions described in Appendix

1is noted.

7.5 That developments in respect of the draft Leadership and Management Development Strategy, the draft Bullying and Harassment Resolution Procedure and the planned provision of guidance to help tackle abuse from service users and members of the public are noted.

David Levy
Director of Human Resources and Organisational Development

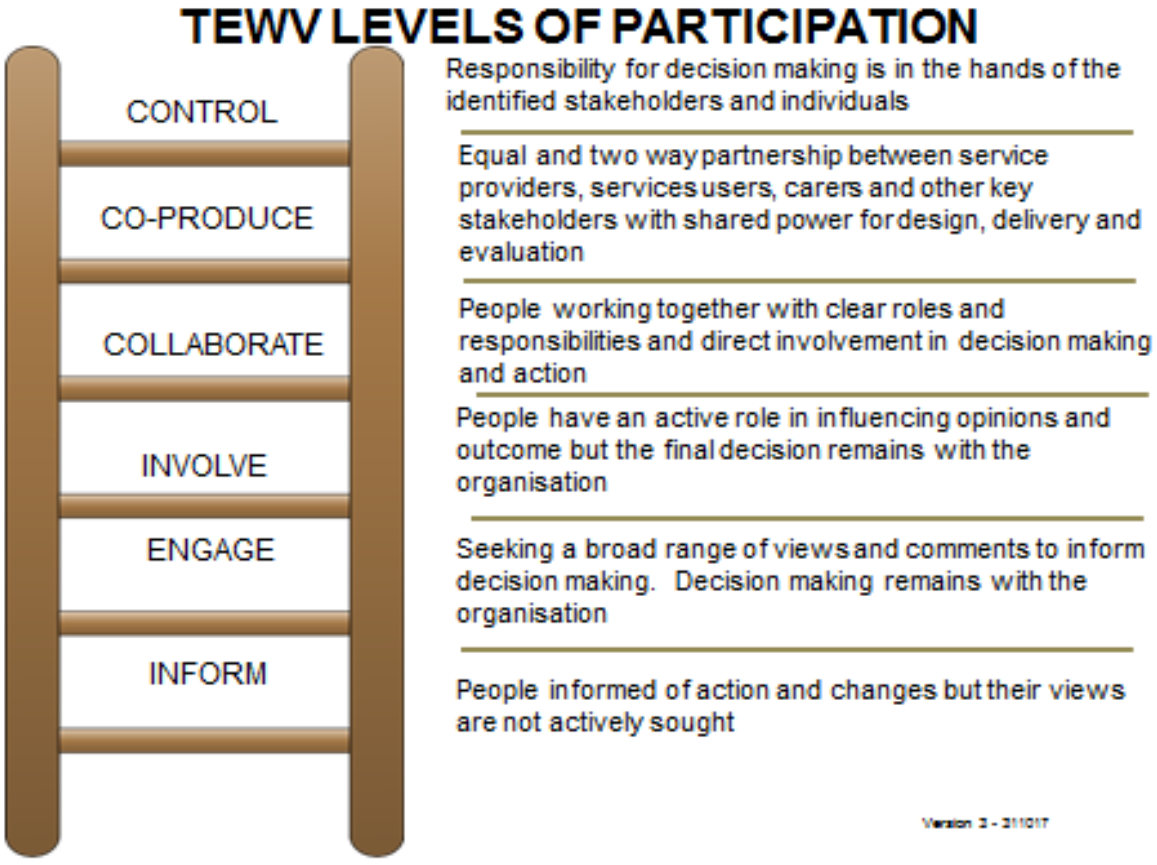
Background Papers:

Appendix 1 Trust Definition of the Levels of Participation

There are many different ways in which people, including service users, carers, public and stakeholder may participate in health service design and delivery. The ladder of participation is widely recognised nationally for understanding different forms and degrees of involvement and engagement. It is important to recognise that providing a voice and an opportunity for participation at every level is valuable and important. The level of participation and the degree to which the organisation shares power with others increases with each step.

There are a number of considerations that need to be taken into account in order to support participation in a meaningful way.

In developing the TEWV levels of participation ladder below, a number of models have been considered



Appendix 2 **Examples of levels of participation in practice**

Descriptor	Links to Recruitment
Control	• Service user/ carer in leadership role may have responsibility as appointing officer. • Lived experienced leader may develop job role, interview process including who sits on the panel e.g. for a peer service.
Co-Produce	• Under current policy and legal framework, there is a requirement for the appointing officer to hold the responsibility for decision making and appointment to job roles. Therefore shared decision making and coproduction within recruitment is not possible. • In the future it may be that within TEWV policy we still adhere to legal framework but stipulate a shared decision must be made alongside that requirement. • People in lived experience roles may identify the need for new posts/ share decisions about what the role entails.
Collaborate	• Service users/carers given training about recruitment procedures and trust policy. • Invite service users / carers and staff to develop job descriptions or parts of a job description and advert. • Ensure service users / carers have relevant information about the job role and candidates prior to the interview • Service users / carers and staff actively involved in developing the 'question set' and selecting appropriate questions that may wish to ask • Service users/carers asked to contribute to setting the presentation title/ interview task. • Ensure service users / carers are fully engaged in the interview and have a say in decision making
Involve	• To invite service users / carers to assist in the shortlisting of candidates. • Service users / carers invited to sit on recruitment panel and can influence the decision. • Inform users / carers when date identified for interview panel to ensure sufficient notice to organise • Ensure honorarium and travel expenses are available for attending interview. • To make available relevant candidate information, job role and timetable information to service users / carers to allow for interview preparation • Inform all service users and carers that were involved of who was appointed.

Engage	• Service users/ carers engaged in consultation exercise to ask about what is included in job descriptions/ what values we look for in staff. • Service users/carers engaged in consultation about what the recruitment process consists of/ what questions we ask. • Send out recruitment documentation more broadly than NHS job as a mechanism to engage broader groups, e.g. to third sector service user organisations/ recovery colleges.
Inform	• Inform service users / carers that a 'recruitment exercise' is taking place. • Inform the public/ relevant service users or carers who has been appointed to which roles.

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DESCRIPTOR	LINKS TO *QIS*
CONTROL	• Service user/carer having total control over a QIS event eg. to improve outcomes of a peer support service
CO-PRODUCE	• Service user / carer identifying topics for QIS • Service user / carer leading QIS projects within teams • Service user / carer having defined roles in the process eg. as sponsor/process owner • Service user / carer leading the decision making process in conjunction with clinical staff • Service user / carer are partners in the scoping and planning meetings as well as 30/60/90/365 day follow up • Service user / carer are paid members of the KPO team
COLLABORATIVE	• Service user / carer are team members at QIS events • Service user / carer are fully briefed beforehand and clear links made as to their experience and the topic • Sponsor/Process Owner/Workshop Lead/Team Lead have a clear understanding of why service user / carers are in attendance, articulate their expectations of them and provide space for them to contribute and influence decision making • Involved in scoping and planning meetings • Evidence that ideas put forward by service user / carer has influenced decision making
INVOLVE	• Attendance of service user / carer at an improvement event either part-time or full-time • Service user / carer Given space within the event to tell their story / give an account of their experience relevant to the scope of the improvement project • Service User / carer assist in testing out products/outputs with other service users / carers and obtain feedback
ENGAGE	• Service user / carer asked for their ideas to improve services • Service user / carer involved in focus group discussions to obtains views prior or during

	improvement event • Questionnaires to service users to ask specific questions about their experience of the service under review
INFORM	• Inform service user /carer that improvement work is taking place • Inform service user / carer that changes are happening to services

DESCRIPTOR	LINKS TO *TRAINING*
CONTROL	• Service user/carer has full control over designing/delivering/evaluating relevant training. • This may happen where a Service User led organisation is commissioned to provide training.
CO-PRODUCE	• Service users/carers have an equal voice in identifying the need for training. • The outcomes of a training package would be determined by both service users/carers and professionals together. • Service users/carers would co-develop the content of the training. • Service users would/carers co-deliver the training. • Service users would/carers co-evaluate the training. • Service users/carers paid the same rate as professionals for their time.
COLLABORATIVE	• Service users/carers and staff may work together on developing the content or parts of the content. • Service users/carers may deliver sections of the training in partnership with staff. • Service users/ carers offered payment for their contributions. • Service user may be involved in evaluating the training.
INVOLVE	• Service users/carers might be invited to contribute to parts of the session for example sharing their story/ doing a q+a. • Service user/carer may be asked for feedback on the content of the training. • Service users invited to attend training and given relevant information beforehand • Reasonable adjustments considered and travel expenses covered in order to make training accessible for service users/carers.

ENGAGE	• Service users invited to attend and participate in training alongside staff e.g. contribute to workshops or discussion. • Service users/carers consulted for their opinion on what training should cover/how it should be delivered.
INFORM	• Inform service users /carers that staff training is taking place and what it covers • Service users/carers to attend training to receive information.

Item 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27 February 2018**
TITLE:	**Finance Report for Period 1 April 2017 to 31 January 2018**
REPORT OF:	**Drew Kendall, Interim Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	
To continuously improve to quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

The comprehensive income outturn for the period ending 31 January 2018 is a surplus of £8,573k, representing 3.0% of the Trust's turnover and is £100k ahead of plan.

Identified Cash Releasing Efficiency Savings at 31 January 2018 are £1,998k behind plan for the year to date. The shortfall is largely due to slippage on CRES schemes which were due to commence 1 October 2017. The Trust has, and continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements, and has non-recurrent expenditure mitigations in place to manage this position in 2017/18.

The Use of Resources Rating for the Trust is assessed as 2 for the period ending 31 January 2018 and is behind plan due to the I&E margin and agency expenditure being marginally behind plan. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year, which is behind plan.

Recommendations:

The Board of Directors is requested to receive the report, to note the conclusions in section 6 and to raise any issues of concern, clarification or interest.

MEETING OF:	**Board of Directors**
DATE:	**27 February 2018**
TITLE:	**Finance Report for Period 1 April 2017 to 31 January 2018**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2017 to 31 January 2018.

2. BACKGROUND INFORMATION

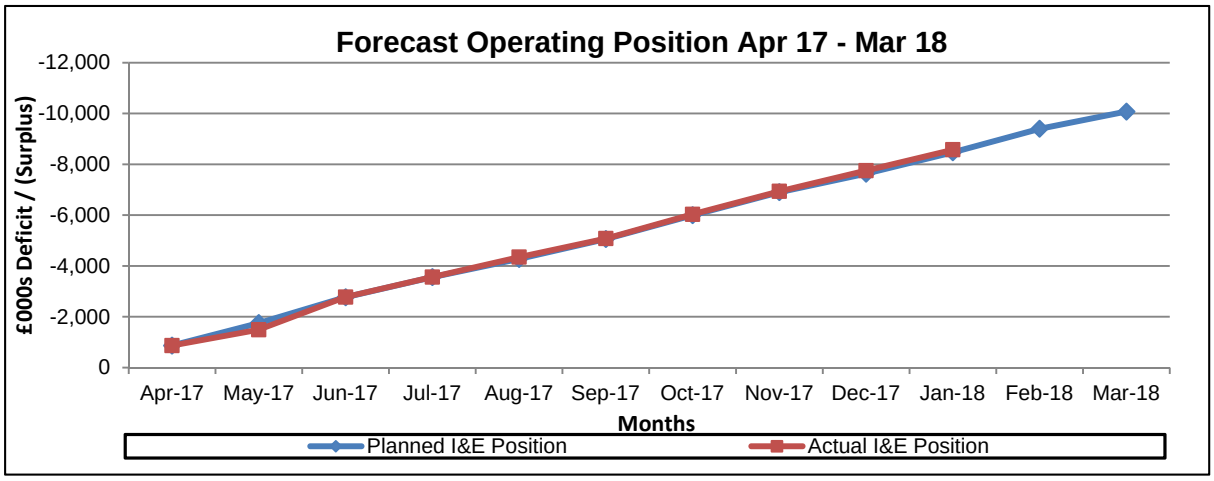
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis on a quarterly basis.

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 31 January 2018 is a surplus of £8,573k, representing 3.0% of the Trust's turnover and is £100k ahead of plan.

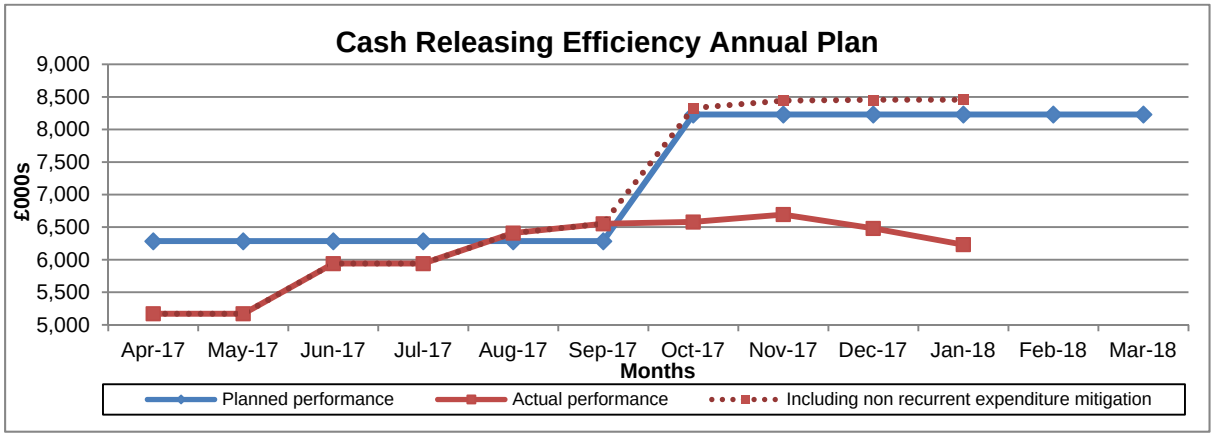
The graph below shows the Trust's planned operating surplus against actual performance.



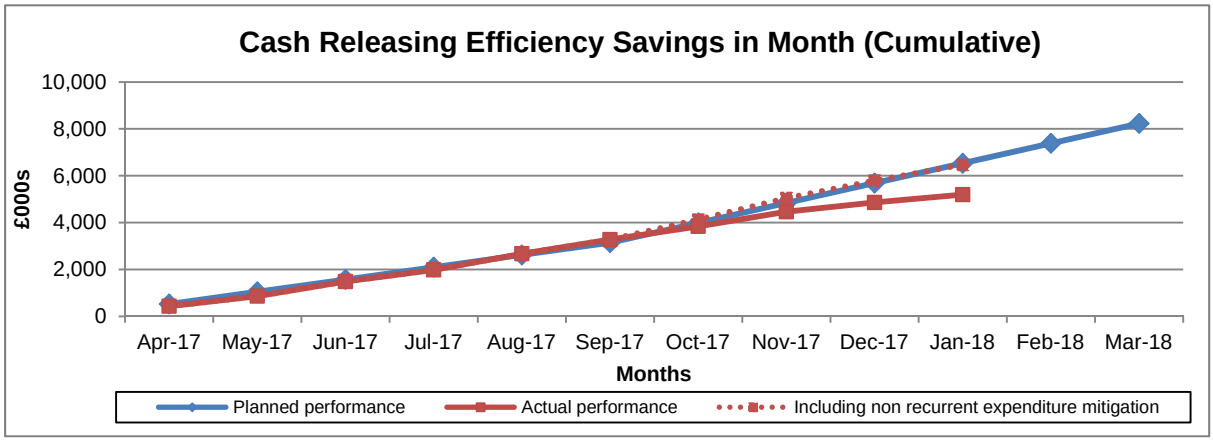
3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 January 2018 is £6,232k and is £1,998k behind plan for the year to date. The shortfall is largely due to slippage on CRES schemes due to commence 1 October 2017. The Trust has, and continues to identify and progress schemes to deliver CRES in full for current and future

years, and has non-recurrent expenditure mitigations in place to manage this position in 2017/18.

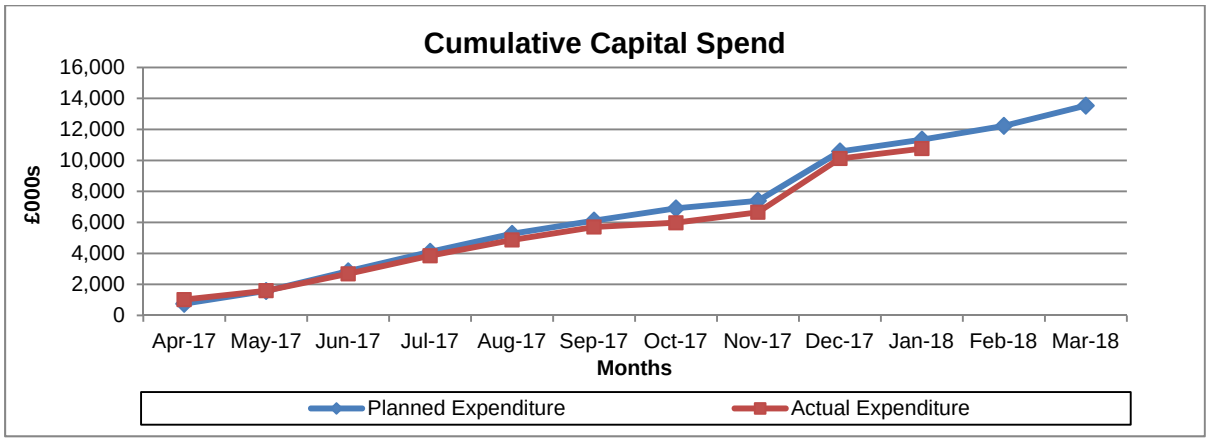


The monthly profile for CRES identified by Localities is shown below.



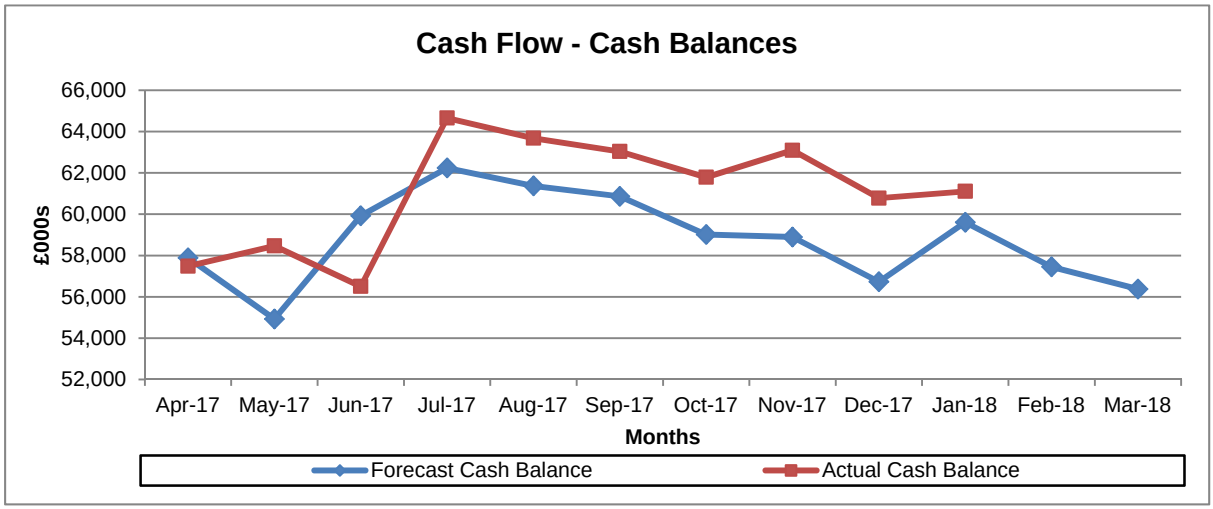
3.3 Capital Programme

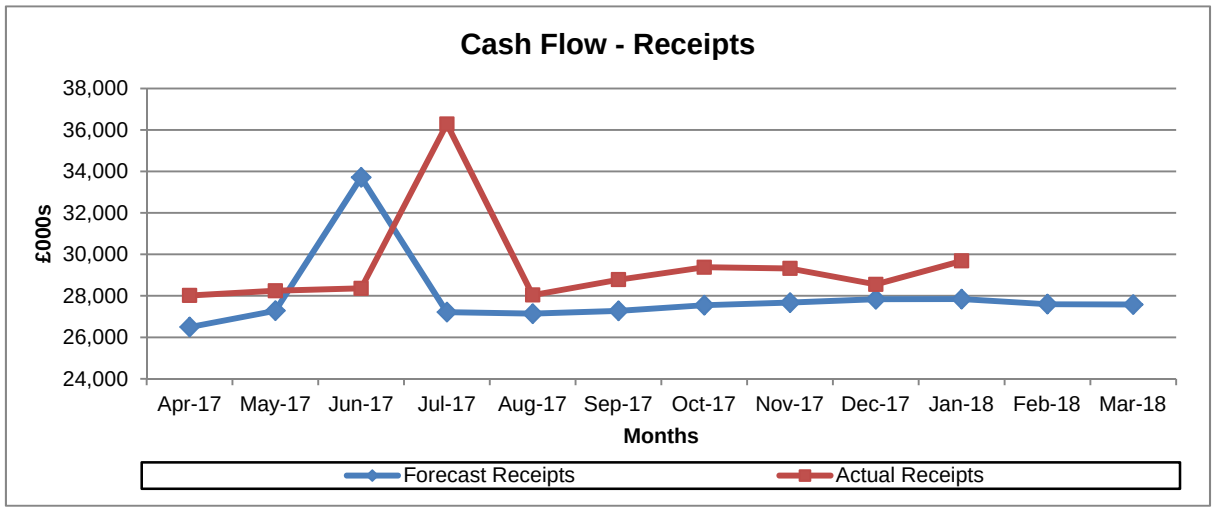
Capital expenditure to 31 January 2018 is £10,764k and is £577k behind plan due to delays against identified developments. The year end forecast is £15,492k; which is £1,958k in excess of plan and is due to additional expenditure previously anticipated in 2018/19 financial year.

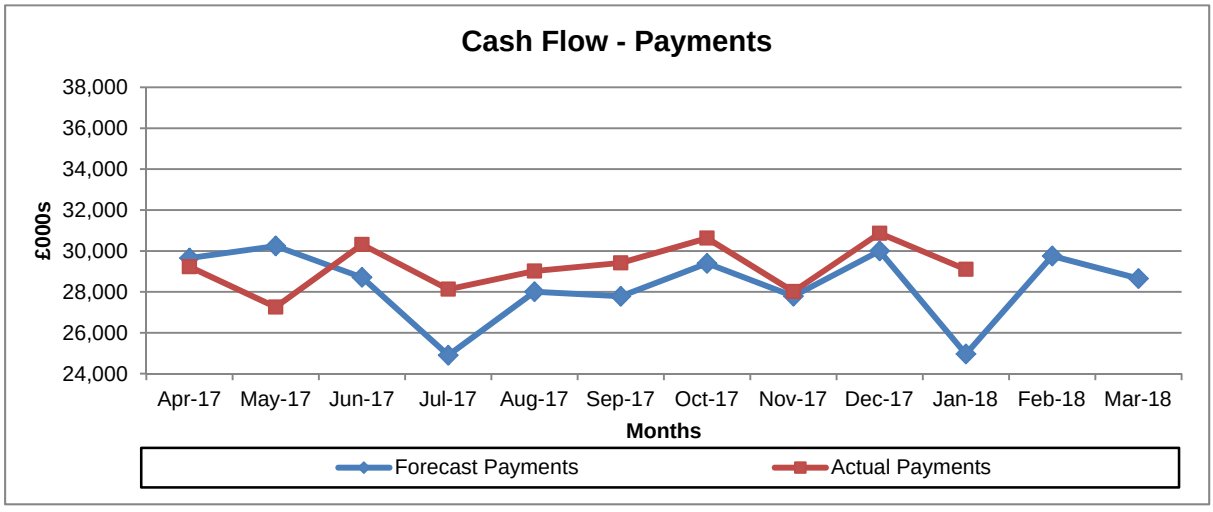


3.4 Cash Flow

Total cash at 31 January 2018 is £61,105k, and is £1,500k ahead of plan largely due to working capital variations.



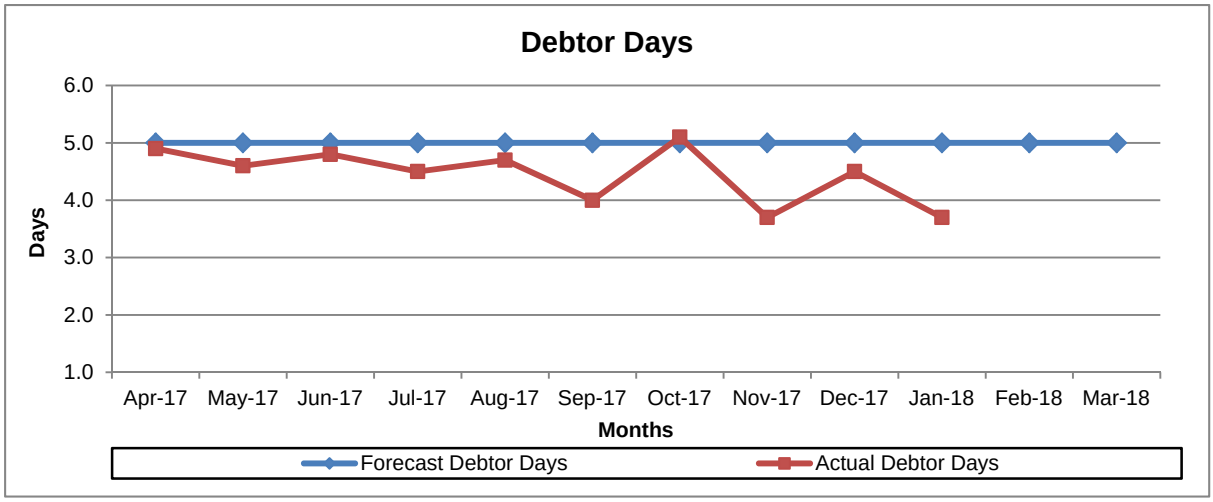




The receipts profile fluctuates over the year for Sustainability and Transformation Fund incentive scheme receipt. The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.

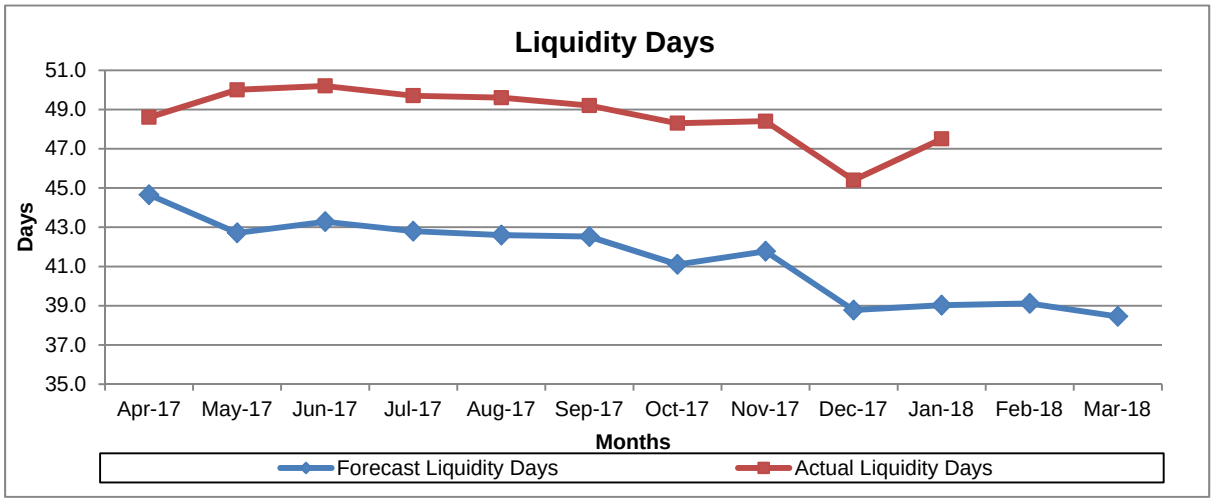
Working Capital ratios for period to 31 January 2018 are:

- Debtor Days of 3.7 days
- Liquidity of 47.9 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 49.60%
  Non NHS 30 Days – 96.78%



The Trust has a debtors' target of 5.0 days, and actual performance of 3.7 days at 31 January 2018, which is ahead of plan.

The liquidity days graph below reflects the metric within NHS Improvement's single oversight framework. The Trust's liquidity day's ratio is ahead of plan due to higher than planned net current assets.



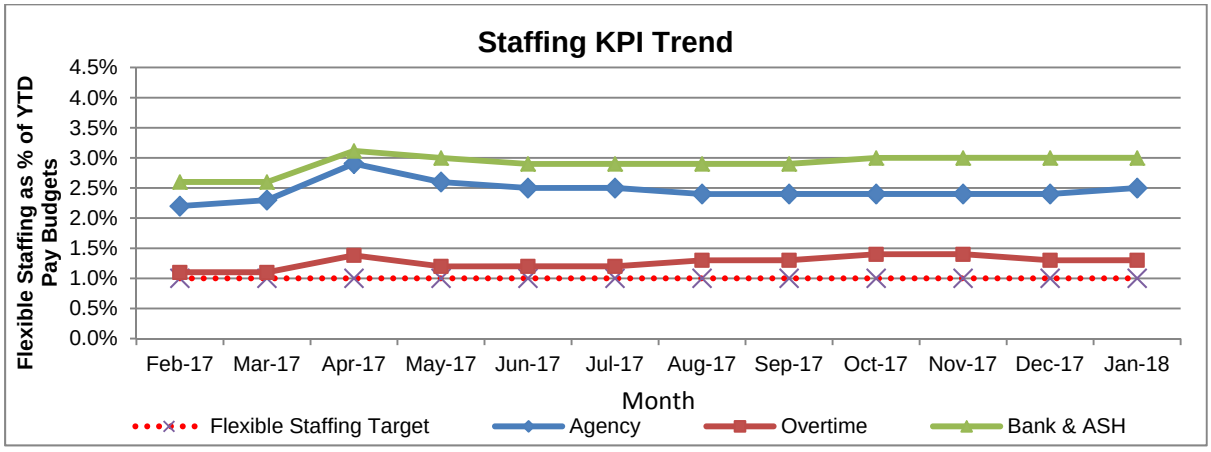
3.5 Financial Drivers

The following table and chart show the Trust's performance on some of the key financial drivers identified by the Board.

Tolerance	Aug	Sept	Oct	Nov	Dec	Jan
Agency (1%)	2.4%	2.4%	2.4%	2.4%	2.4%	2.5%
Overtime (1%)	1.3%	1.3%	1.4%	1.4%	1.3%	1.3%
Bank & ASH (flexed against establishment)	2.9%	2.9%	3.0%	3.0%	3.0%	2.9%
Establishment (90%-95%)	93.1%	93.1%	94.3%	94.5%	94.5%	94.2%
Total	**99.7%**	**99.7%**	**101.1%**	**101.3%**	**101.2%**	**100.9%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For January 2018 the tolerance for Bank and ASH is 3.8% of pay budgets.

The following chart shows performance for each type of flexible staffing.



Additional staffing expenditure is 6.7% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (48%), enhanced observations (20%), service need (11%) and sickness (11%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating for the Trust is assessed as 2 for the period ending 31 January 2018 and is behind plan due to the I&E margin and agency expenditure being marginally behind plan. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year, which is behind plan.

3.6.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.56x (can cover debt payments due 1.56 times), which is ahead of plan and rated as a 3.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 45.9 days; this is ahead of plan and is rated as a 1.

3.6.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 3.0% and is rated as a 1.

3.6.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding STF income. The Trust I&E margin distance from plan is -0.1% and is behind plan and is rated as a 2.

3.6.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is marginally higher than the cap and is rated as a 2.

The margins on Use of Resource Rating are as follows:

- Capital service cover - to improve to a 2 a surplus increase of £2,509k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £39,299k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £5,739k is required.
- I&E margin distance from plan – to improve to a 1 an operating surplus increase of £151k is required.
- Agency Cap rating – to improve to a 1 a reduction in agency expenditure of £172k is required.
-

Use of Resource Rating at 31 January 2018

NHS Improvement's Rating Guide	Weighting	Rating Categories			
	%	1	2	3	4
Capital service Cover	20	>2.50	1.75	1.25	<1.25
Liquidity	20	>0	-7.0	-14.0	<-14.0
I&E margin	20	>1%	0%	-1%	<=-1%
I&E margin distance from plan	20	>=0%	-1%	-2%	<=-2%
Agency expenditure	20	<=0%	-25%	-50%	>50%

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	1.56x	3	1.50x	3	
Liquidity	45.9 days	1	39.4 days	1	
I&E margin	3.0%	1	3.1%	1	
I&E margin distance from plan	-0.1%	2	0.0%	1	
Agency expenditure	£5,311k	2	£5,140k	1	
Overall Use of Resource Rating		**2**		**1**	

3.6.7 5.7% of total receivables (£190k) are over 90 days past their due date; this is marginally above the 5% finance risk tolerance. The Trust has received

confirmation of payment for the majority of this debt and therefore does not give cause for concern.

3.6.8 1.4% of total payables invoices (£166k) held for payment are over 90 days past their due date. This is within the 5% finance risk tolerance.

3.6.9 The cash balance at 31 January 2018 is £61,105k and represents 70.9 days of annualised operating expenses.

4. IMPLICATIONS:

4.1 There are no direct CQC, quality, legal or equality and diversity implications associated with this paper.

5. RISKS:

5.1 There are no risks arising from the implications identified in section 4.

6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 31 January 2018 is a surplus of £8,573k, representing 3.0% of the Trust's turnover and is £100k ahead of plan.

6.2 Identified Cash Releasing Efficiency Savings at 31 January 2018 are £1,998k behind plan for the year to date. The shortfall is largely due to slippage on CRES schemes which were due to commence 1 October 2017. The Trust has, and continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements, and has non-recurrent expenditure mitigations in place to manage this position in 2017/18.

6.3 The Use of Resources Rating for the Trust is assessed as 2 for the period ending 31 January 2018 and is behind plan due to the I&E margin and agency expenditure being marginally behind plan. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year, which is behind plan.

7. RECOMMENDATIONS:

7.1 The Board of Directors is requested to receive the report, to note the conclusions in section 6 and to raise any issues of concern, clarification or interest.

Drew Kendall
Interim Director of Finance and Information

ITEM 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th February 2018**
TITLE:	**Board Dashboard as at 30th January 2018**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communication**
REPORT FOR:	**Assurance**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	✓
To continuously improve to quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

As at the end of January 2018 7 (37%) of the indicators reported are not achieving the expected levels and are red. This is a decline on the 4 that was reported as at the end of December 2017. Only two of these indicators are showing an improving position over the previous 3 months.

It should be noted that the 7 reds are split across all 4 domains, with the quality domain having 1 and the other 3 domains having 2 each.

In terms of the year to date position there are 6 indicators that are reporting red, the same number reported last month.

In respect of performance against the key NHSI operational indicators for January 2018 the Trust has analysed the sample of cases sent to the centre and calculated that the Trust has not met the indicator 'Ensure that cardio metabolic assessment and treatment for people with psychosis is delivered routinely in EIP service'. The final level of performance will be confirmed by the centre in May as a component of the CQUIN scheme, however from the sample submitted we have calculated the performance at 85.47% of patients had received assessment and treatment compared to the target of 90%. However we have been able to extract the data for **all** patients across the Trust EIP services (for the same period as the sample) and whether they received assessment and treatment. Using this to calculate the position shows that the Trust has achieved 93%.

The IAPT recovery rate of 50% was achieved in December at the Trust level and in four CCGs which is a significant improvement on the position reported in December 2017. The sustainable achievement of this target does remain a concern due to a number of issues that were articulated in a paper which the Board received in January 2018.

There remain a number of risks around achievement of the targets within the Dashboard and these are described in Section 2.3 of the report.

Recommendations:

It is recommended that the Board consider the content of this paper and raise any areas of concern/query.

MEETING OF:	**Board of Directors**
DATE:	**27th February 2018**
TITLE:	**Board Dashboard as at 30th January 2018**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 30th January 2018 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery.

2. KEY ISSUES:

2.1 Performance Issues

The key issues in terms of the performance reported are as follows:

- As at the end of January 2018 7 (37%) of the indicators reported are not achieving the expected levels and are red. This is a decline on the 4 that was reported as at the end of December 2017. Only two of these indicators are showing an improving position over the previous 3 months.

  It should be noted that the 7 reds are split across all 4 domains, with the quality domain having 1 and the other 3 domains having 2 each.

  There are a further 5 indicators which whilst not completely achieving the target levels are within the amber tolerance levels (which is one more than the number reported as at the end of December).

  In terms of the year to date position there are 6 indicators that are reporting red, the same number reported last month.

- In respect of performance against the key NHSI operational indicators for January 2018 the Trust has analysed the sample of cases sent to the centre and calculated that the Trust has not met the indicator '**Ensure that cardio metabolic assessment and treatment for people with psychosis is delivered routinely in EIP service'**. The final level of performance will be confirmed by the centre in May as a component of the CQUIN scheme, however from the sample submitted we have calculated the performance at 85.47% of patients had received assessment and treatment compared to the target of 90%. However we have been able to extract the data for **all** patients across the Trust EIP services (for the same period as the sample) and whether they received assessment and treatment. Using this to calculate the position shows that the Trust has achieved 93%.

  The IAPT recovery rate of 50% was achieved in December at the Trust level and in four CCGs which is a significant improvement on the position reported in December 2017. It was not achieved in DDES CCG, Scarborough and Ryedale CCG and Vale of York CCG. The sustainable

achievement of this target does remain a concern across the North Yorkshire CCGs in particular although as the paper received by the Board in January demonstrated there are challenges in each of the localities.

- Appendix B includes the breakdown of the actual number of unexpected deaths.

2.2 Data Quality Assessment.

The Data Quality Scorecard is included in Appendix C. There has been no change from the previous month to highlight to the Board.

2.3 Key Risks

- Referrals (KPI1) – The number of referrals received in January has increased significantly in January 2018 which is in line with trends in previous years. In terms of the year to date position the actual number of referrals received is significantly above the expected number. It is important to understand the number of these referrals that receive an assessment and then are taken onto caseload and these indicators have been included in the 2018/19 Trust Dashboard in order to give more clarity on the increased demand on services. It should be noted that caseload turnover (KPI 2) remains better than target.
- Percentage of patients seen within 4 weeks for their first appointment (KPI 7) – performance against this indicator has declined sharply in January and whilst this follows the trend in previous years it does take performance to the lowest level in the year to date. All localities and services have seen a deterioration during January although there is a particular issue in Adult Services in York and Selby where a breakdown in process has led to a backlog of referrals not being seen. This has been addressed and it is expected that performance will improve in February 2018.
- Number of Unexpected Deaths classed as a serious incident (KPI 11) - Whilst the number of unexpected deaths classed as a serious incident has reduced in January the rate still remain above the expected levels. There were 10 unexpected deaths classed as a serious incident in January. Work has been completed in January to establish if there were any trends looking at a longer period of time (October to December 2017) and this will be reported to the Patient Safety Group.
- Mandatory Training (KPI 17) – there has been a decline in the percentage of compliance with all mandatory and statutory training in January which is the first decline since May 2017. A key contributor to this is that we are now reporting those people who stopped being compliant with the required Information Governance training when the new national training was not available (previously we had not reported these as non-compliant as they could not undertake the training). The national e-learning is now available and staff have been alerted to this and reminded that they need to complete their IG training as soon as possible.
- Sickness (KPI 18) – As expected there has been a further deterioration in the performance reported in January such that the sickness rate was the worse it has been in the previous three years. Following an event held in

November to look at how we can better understand the reasons for the increase in sickness absence we have seen this year further work/events are planned.

- CRES Delivery (KPI 20) – the delivery of the CRES is behind plan for the month of January and year to date. The deterioration in month is due to slippage on CRES schemes due to commence 1 October 2017. The Trust has, and continues to identify and progress schemes to deliver CRES in full for current and future years, and has non-recurrent expenditure mitigations in place to manage this position in 2017/18.

3. RECOMMENDATIONS:

3.1 It is recommended that the Board consider the content of this paper and raise any areas of concern/query.

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Activity

	January 2018				April 2017 To January 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Total number of External Referrals into Trust Services	7,793.00	9,331.00			76,926.00	87,820.00		91,759.00
2) Caseload Turnover	1.99%	1.75%			1.99%	1.75%		1.99%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	86.44%			85.00%	86.20%		85.00%
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	75.00	65.00			75.00	65.00		75.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	8.37%			10.00%	8.84%		10.00%
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	20.00	25.67			199.00	255.00		237.00

Quality

	January 2018				April 2017 To January 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	90.00%	87.98%			90.00%	90.69%		90.00%
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	8.78%			10.00%	8.59%		10.00%
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	16.50%			20.00%	13.85%		20.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	91.87%			92.45%	91.65%		92.45%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.63			10.00	12.94		12.00

Trust Dashboard Summary for TRUST

Workforce

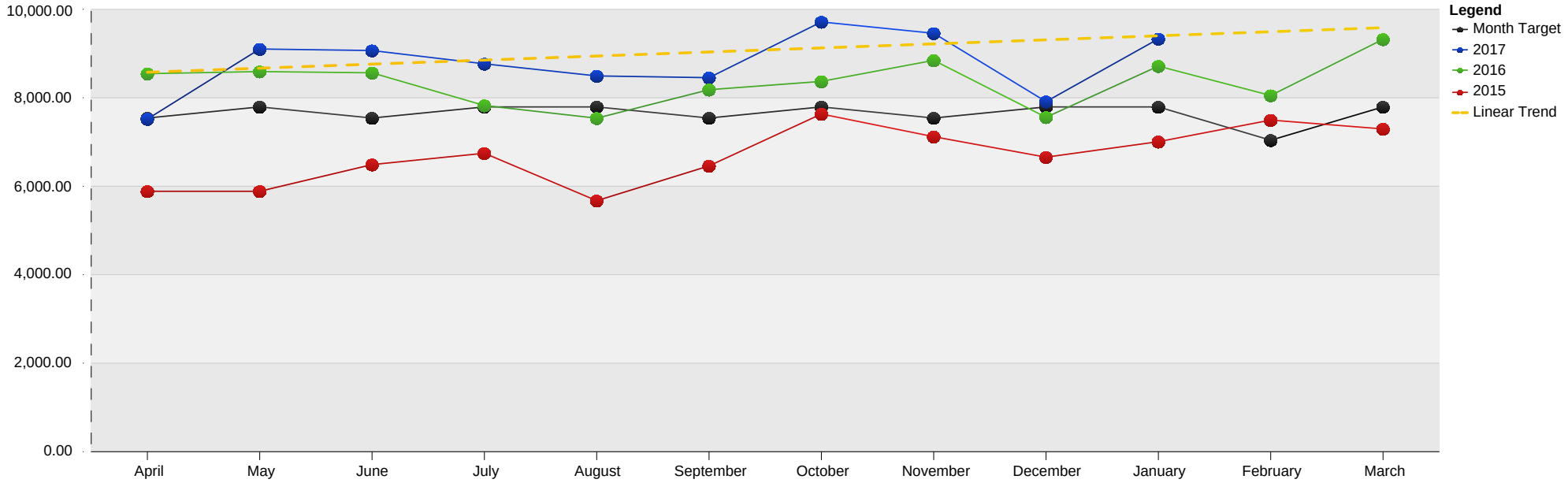
	January 2018				April 2017 To January 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	94.17%			100.00%	94.17%		100.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	21.43%			15.00%	19.22%		15.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	92.86%			95.00%	92.86%		95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	87.32%			90.00%	87.32%		90.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	5.88%			4.50%	5.13%		4.50%

Money

	January 2018				April 2017 To January 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-843,000.00	-823,000.00			-8,473,000.00	-8,573,000.00		-10,076,000.00
20) CRES delivery	848,000.00	332,640.00			6,534,080.00	5,193,037.93		8,230,080.00
21) Cash against plan	59,605,000.00	61,105,000.00			59,605,000.00	61,105,000.00		56,376,000.00

Trust Dashboard Graphs for TRUST

1) Total number of External Referrals into Trust Services

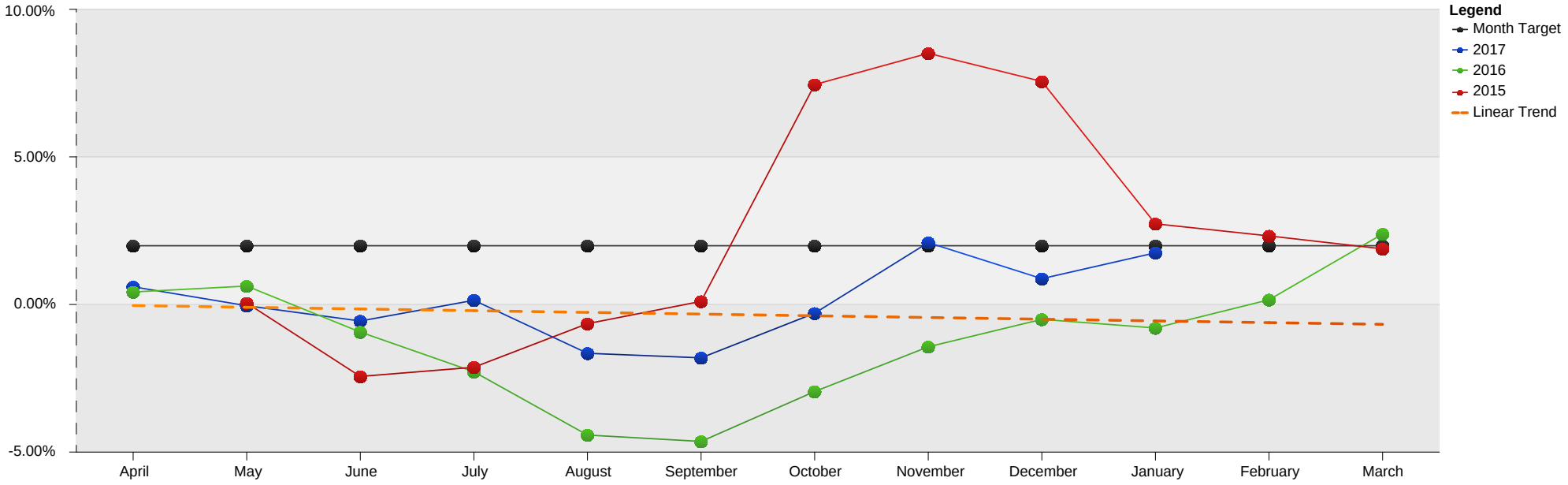


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Total number of External Referrals into Trust Services	9,331.00	87,820.00	2,134.00	20,289.00	2,842.00	26,230.00	2,079.00	20,818.00	662.00	6,341.00	1,614.00	14,139.00		

Narrative
The Trust position for January 2018 is 9331 which is above the Trust target of 7,793. This is an increase on the number of referrals received in December 2017, which follows a seasonal trend where referrals decrease over the Christmas period. This position is an increase to that reported in January 2017 with Durham and Darlington (All services) and Tees (Adults and MHSOP) reporting the most significant increase. York and Selby are the only locality meeting target.Based on current trends it is anticipated that we will exceed the annual target of 91,759

Trust Dashboard Graphs for TRUST

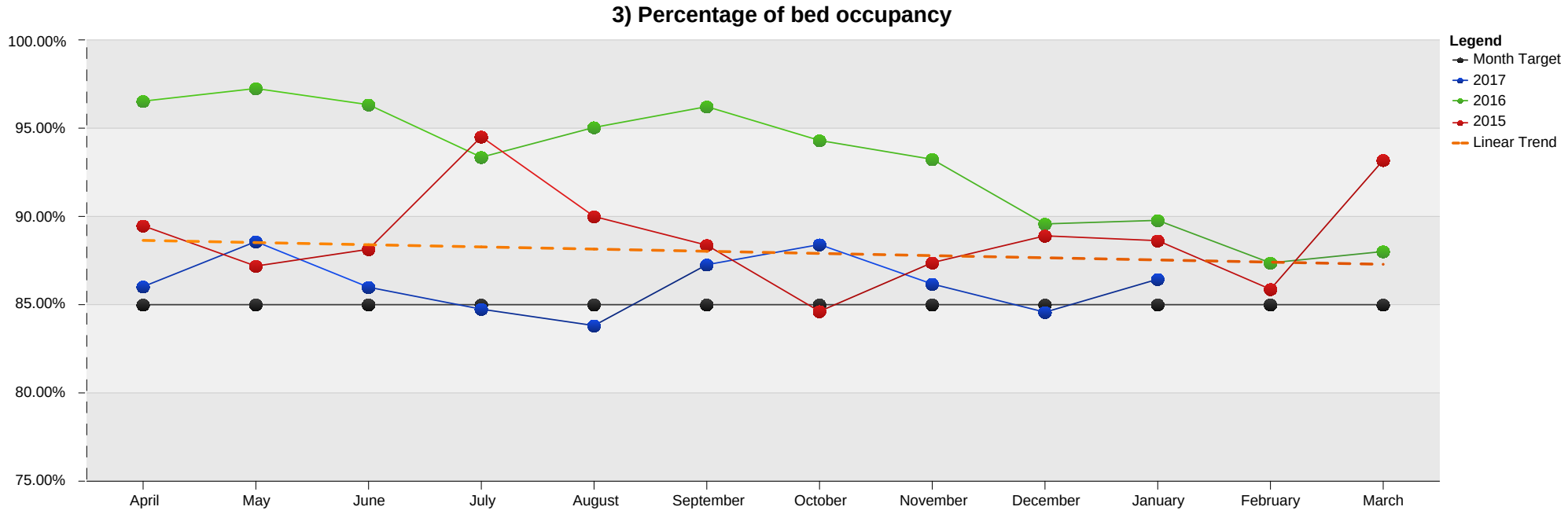
2) Caseload Turnover



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Caseload Turnover	1.75%	1.75%	3.01%	3.01%	2.48%	2.48%	-1.23%	-1.23%	NA	NA	1.23%	1.23%		

Narrative
The Trust position for January 2018 is 1.75% which is meeting the Trust target of 1.99%. This is a deterioration to that reported in December 2017 and an improvement on the trend seen since September 2017. North Yorkshire and York and Selby are meeting target. Under performance in Durham and Darlington continues to be within CAMHS services and this is due to an increase in the number of referrals received. In Tees, this is due to issues within the LD service and an update on this will be provided prior to the Board Meeting. Based on current trends it is anticipated that we will meet the annual target of 1.99%

Trust Dashboard Graphs for TRUST

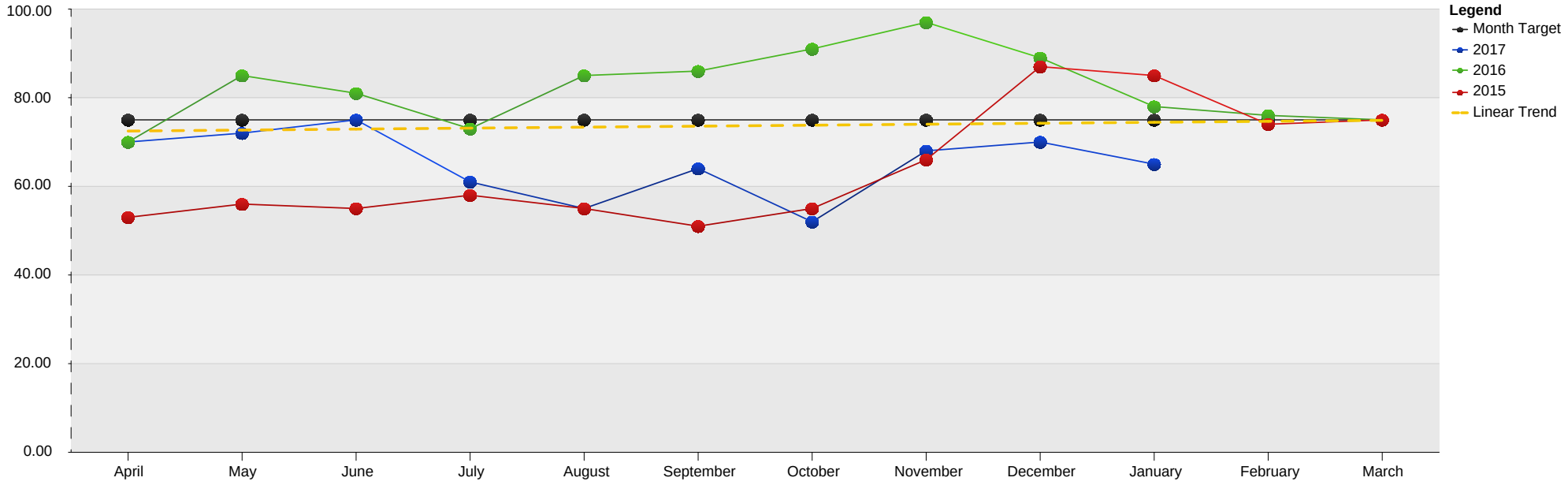


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	86.44%	86.20%	92.92%	88.70%	83.66%	84.85%	81.71%	89.73%	NA	NA	84.42%	78.94%		

Narrative
The Trust position for January 2018 is 86.44% which is meeting target and but is a slight deterioration on the position of 86.75% recorded in December 2017.Durham and Darlington reports the highest bed occupancy at 92.92% which is a slight improvement from December 2017. Key pressures continue to be seen in adult services and in particularly in male beds. An RPIW in Durham has been held to improve patient flow and further improvements in performance are expected. There continues to be a dedicated focus on this issue in the huddle to proactively address delays and improve links with the Local Authority via the TEWV Accommodation Officer.North Yorkshire have continued to see an improvement and are reporting the lowest bed occupancy at 81.71% which is as a result if improvements within MHSOP services. AMH continue to report pressures particularly around male beds, a trend which can be seen across the Trust.

Trust Dashboard Graphs for TRUST

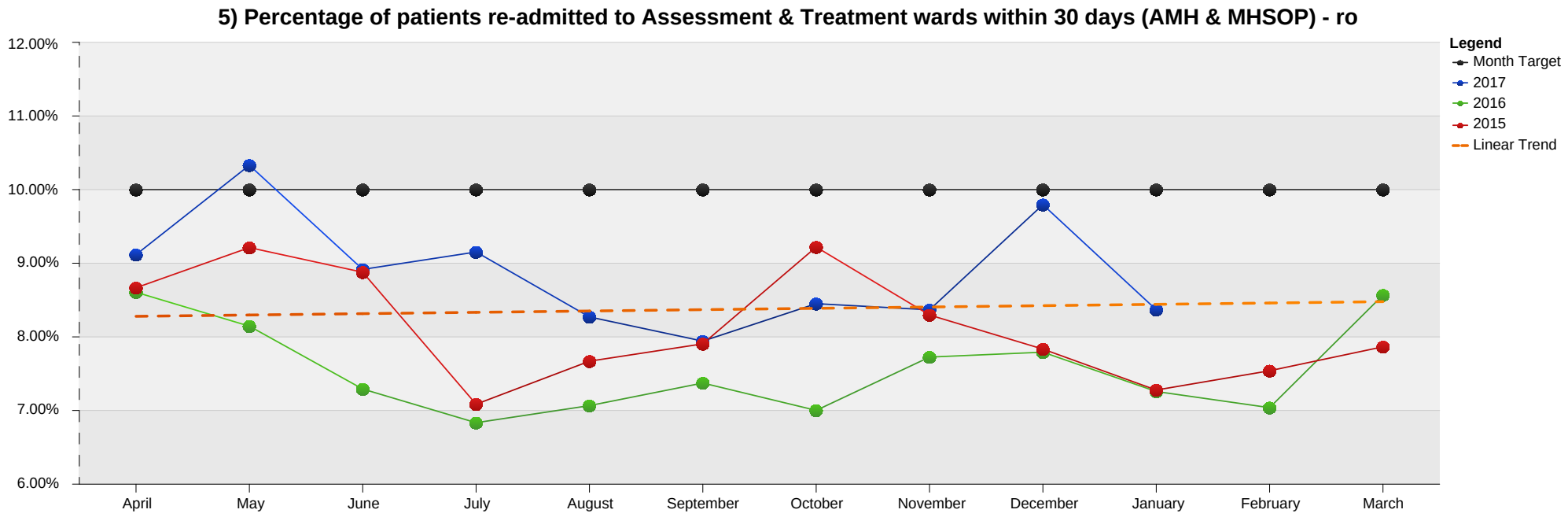
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	65.00	65.00	13.00	13.00	14.00	14.00	18.00	18.00			19.00	19.00		

Narrative
The Trust position for January 2018 is 65 which is meeting the target of 75 and is an improvement compared to that reported in December 2017. Of the 65 patients occupying a bed with a LoS greater than 90 days:• 13 (20%) were within Durham and Darlington (4 MHSOP and 9 ADULTS) • 19 (29%) were within York & Selby (17 MHSOP and 2 AMH) • 14 (22%) were within Teesside (11 MHSOP and 3 ADULTS) • 28 (18%) were within North Yorkshire (3 MHSOP and 15 ADULTS) Tees are not achieving target. A focused piece of work is being completed in to improve understanding of this issue and once completed an update on the findings will be provided. In addition the locality are focusing on this area in their weekly huddle to ensure patients are discharged as soon as appropriate. Based on current trends it is expected that we will meet the annual target of 75.

Trust Dashboard Graphs for TRUST

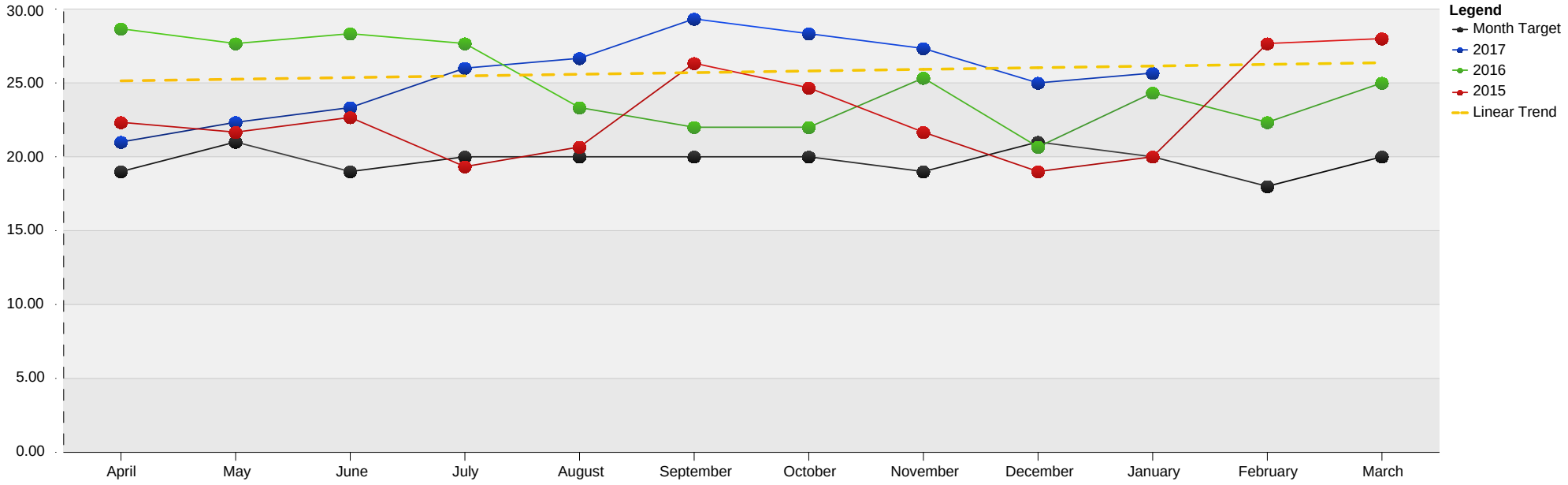


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	8.37%	8.84%	7.80%	8.03%	8.50%	8.82%	8.33%	8.32%			9.76%	10.76%		

Narrative
The Trust rolling 3 month position ending January 2018 is 8.37%, which relates to 19.99 patients out of 239 that were readmitted within 30 days. This is meeting the target of 10% and is an improvement on the position recorded in December 2017.Of the 19.66 patients re-admitted:• 7.33 (37%) were within Durham & Darlington (6.66 AMH and 0.66 MHSOP) • 3.99 (20%) were within York and Selby (2.99 AMH and 0.99 MHSOP)• 3.66 (18%) were within North Yorkshire (2.99 AMH and 0.66 MHSOP) • 4.33 (22%) were within Teesside (4.33 AMH)(*Please note data is displayed in decimal points due to the rolling position being calculated.)All localities are achieving target for this indicator.

Trust Dashboard Graphs for TRUST

6) Number of instances of patients who have 3 or more admissions in a year (AMH and MHSOP)

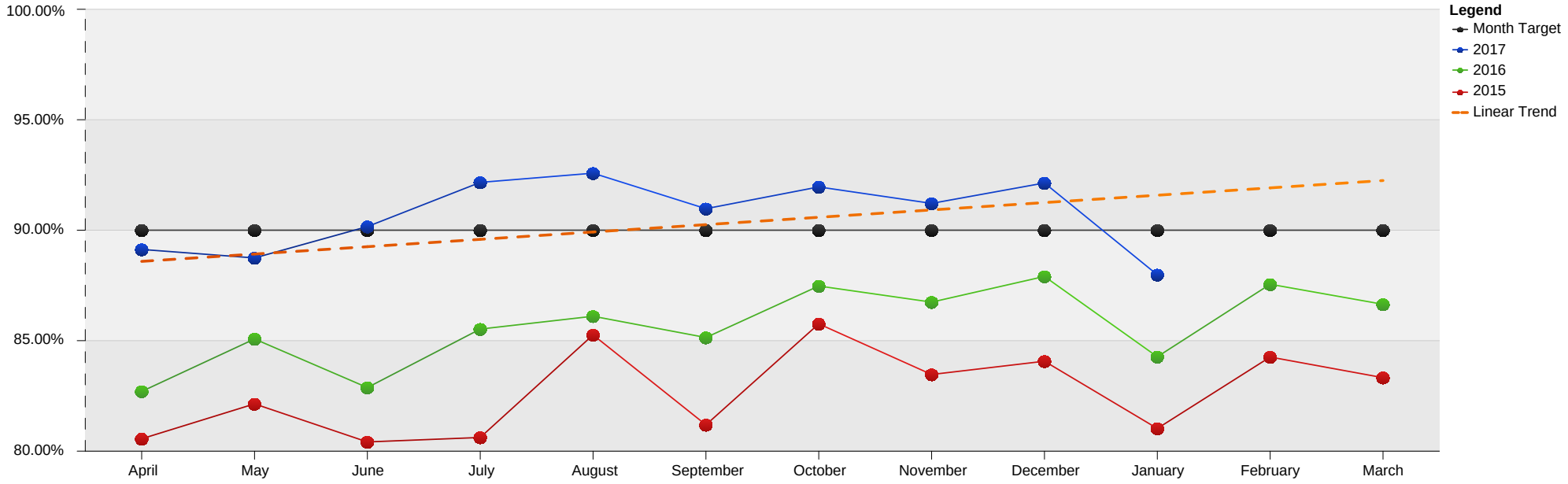


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	25.67	255.00	9.33	92.67	5.33	52.67	4.67	47.33			5.00	49.00		

Narrative
The Trust rolling 3 month position ending January 2018 is 25.67 which is 5.67 worse than the target of 20 and a slight deterioration compared to the position reported in December 2017. Only North Yorkshire are achieving target. Of the 25.67 or more readmissions:• 9.33 (36%) were within Durham & Darlington (9.33 AMH)• 5.33 (21%) were within Tees (4.99 AMH and 0.33 MHSOP)• 4.66 (18%) were within North Yorkshire (3.99 AMH and 0.66 AMH)• 4.99 (19%) were within York and Selby (4.66 AMH and 0.33 MHSOP)In York and Selby a deep dive has been completed to review patients admitted on three or more occasions and all have been appropriate. However further work is to be completed to provide reassurance that all issues have been addressed.In Durham and Darlington a focused piece of work has been completed to improve understanding of this issue led by the Director of Operations. An update on this will be provided at the Board meeting. (*Please note data is displayed in decimal points due to the rolling position being calculated.)

Trust Dashboard Graphs for TRUST

7) Percentage of patients seen within 4 weeks for a first appointment (external referral)



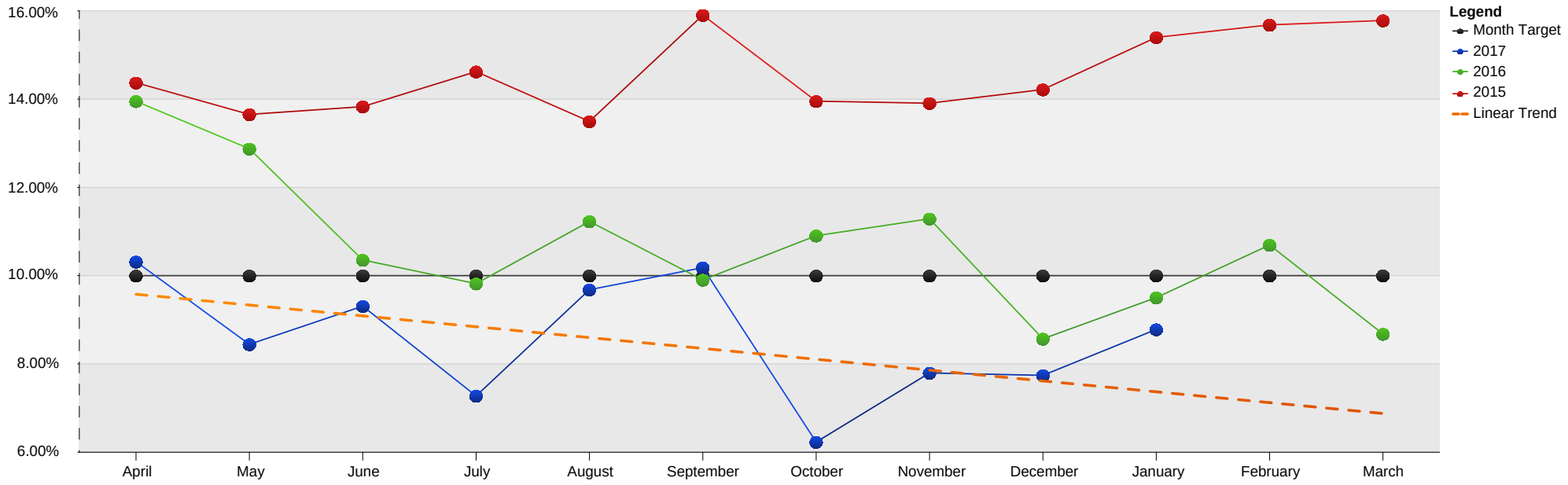
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	87.98%	90.69%	88.59%	89.55%	97.02%	98.30%	75.66%	83.49%	99.44%	99.73%	70.17%	74.13%		

Narrative

The position for January 2018 is 87.98% relating to 726 patients out of 6041 who waited longer than 4 weeks. This is below target and a deterioration on the December 2017 position. This deterioration is across all Localities and Services.Areas of concern:• York and Selby Adults at 46.34% (154 of 287 patients). This is a deterioration on the December position. The main area of concern is within the access team where a breakdown in process caused a backlog. This has been addressed and an action plan is in place. The trajectory is for the target to be met is February 18.• York and Selby MHSOP, Memory Service at 80.57% (54 of 278 patients). A review of the service has taken place and has identified the need for additional staff in order to meet demand. This is being managed by the management of change process which will see additional staff placed in the Memory Service.• North Yorkshire MHSOP at 76.48%(103 of 438 patients). An action plan following the deep dive in November is underway however due to factors beyond the services control including patients cancelling appointments at short notice or DNAs, this impacts on the productivity of the team and so the service are concerned they will fail to achieve their targets. This will continue to be monitored. • Durham and Darlington Adults at 74.28%. (135 of 525 patients) This is a deterioration on the December position. Work continues to progress the ongoing action plan with targets expected to be met by the end of February 18.

Trust Dashboard Graphs for TRUST

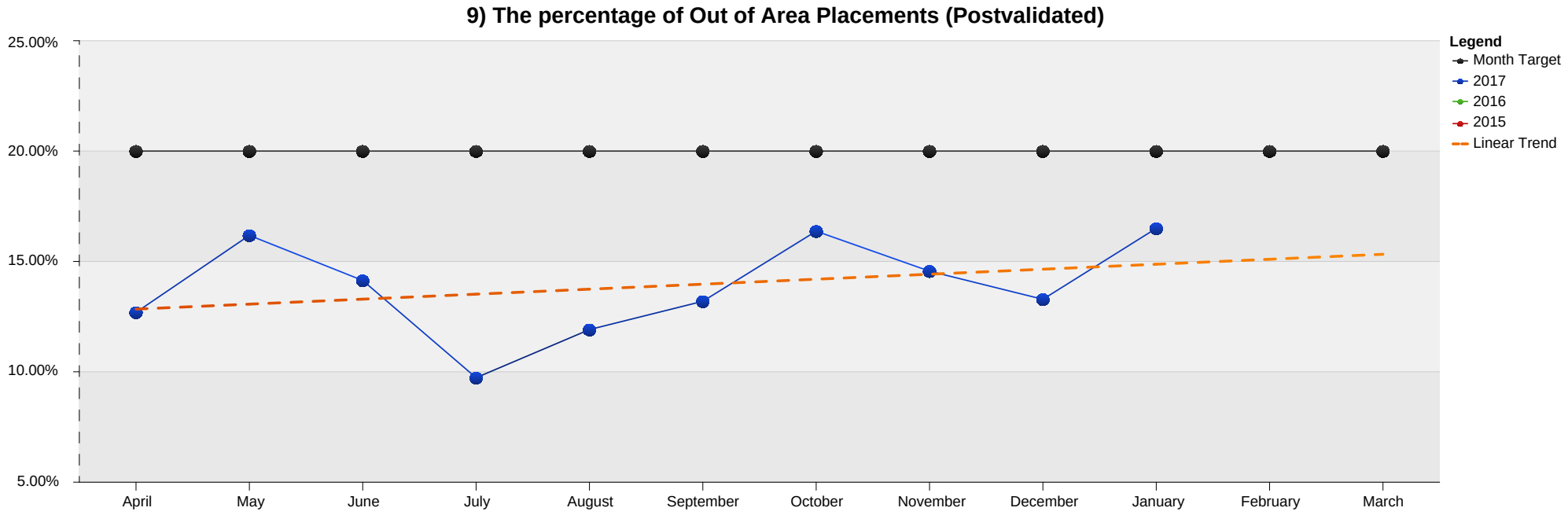
8) Percentage of (Clinic) appointments cancelled by the Trust



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Percentage of (Clinic) appointments cancelled by the Trust	8.78%	8.59%	9.71%	10.57%	7.43%	5.87%	9.83%	11.07%			7.98%	4.97%		

Narrative
The Trust position for January 2018 is 8.78% which relates to 286 clinic appointments out of 3257 that have been cancelled. This is meeting the target of 10% but is a deterioration on the position in December.All localities are achieving target.

Trust Dashboard Graphs for TRUST

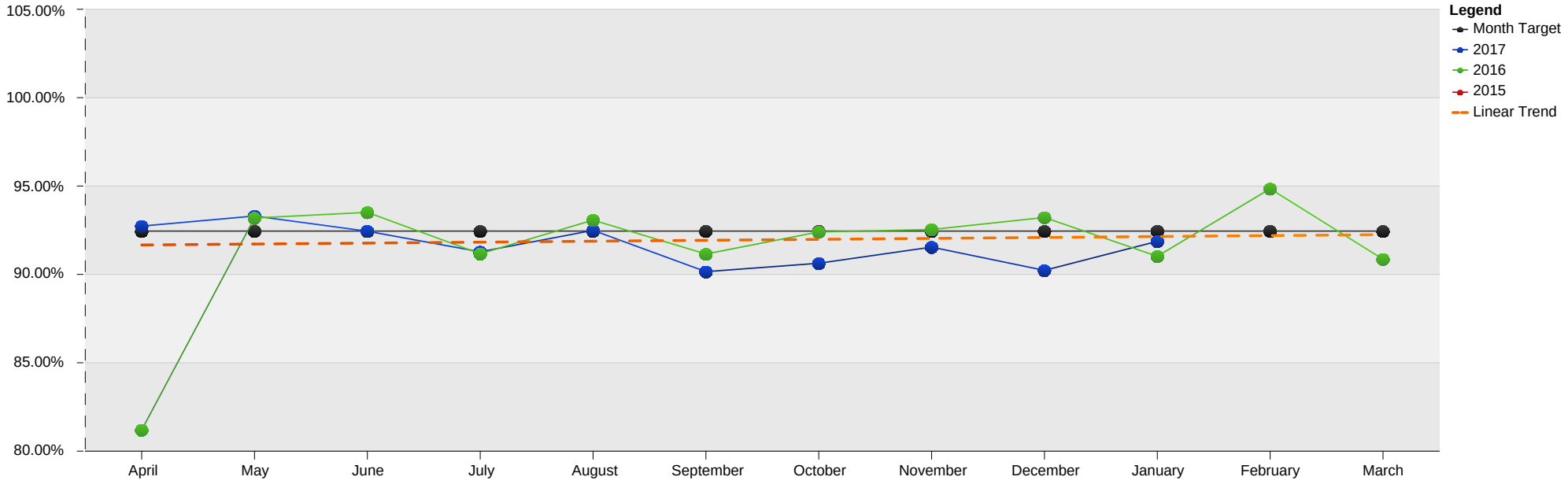


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The percentage of Out of Area Placements (Postvalidated)	16.50%	13.85%	8.85%	6.02%	6.45%	4.86%	56.52%	39.45%			16.67%	21.43%		

Narrative
The Trust position for January 2018 is 16.50% which relates to 49 admissions out of 297 that were inappropriately admitted out of area. This is better than the target of 20% but a deterioration on the December 2017 position.All localities are meeting target with the exception of North Yorkshire, where the key pressure is in adult services and the high level of bed occupancy within adults is impacting on this position. Of the 49 patients (AMH 31, MHSOP 18) all were due to a lack of bed availability.

Trust Dashboard Graphs for TRUST

10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)

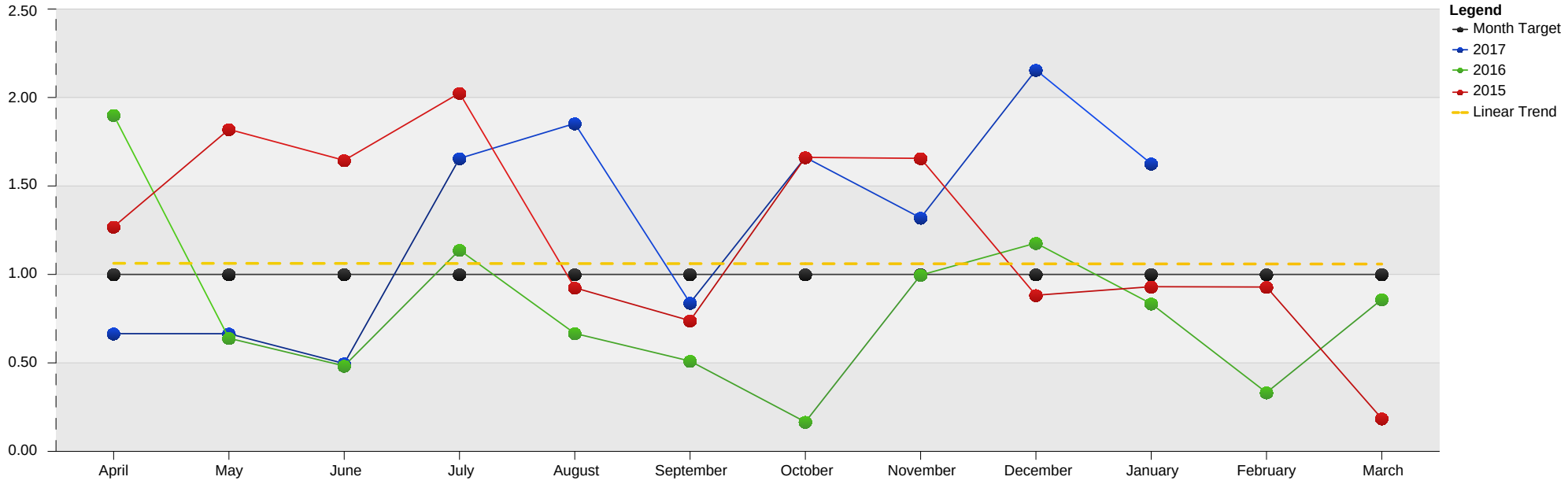


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.87%	91.65%	90.34%	92.47%	94.14%	93.02%	92.12%	91.62%	85.84%	80.56%	92.11%	90.83%		

Narrative
The Trust position reported in January relates to December's performance. The Trust position for December 2017 is 91.87% which is not meeting the target of 92.45% but is an improvement on both the position in December 2017 and that in December 2016. Tees are meeting target for this indicator with Forensic Services reporting the poorest performance at 85.84%, however this is an improvement on the 78.08% reported in November 2017. Work continues within each locality to review performance against this indictor and identify any areas of concern. As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive).Due to an amendment to the indicator for this year, data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available.

Trust Dashboard Graphs for TRUST

11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated



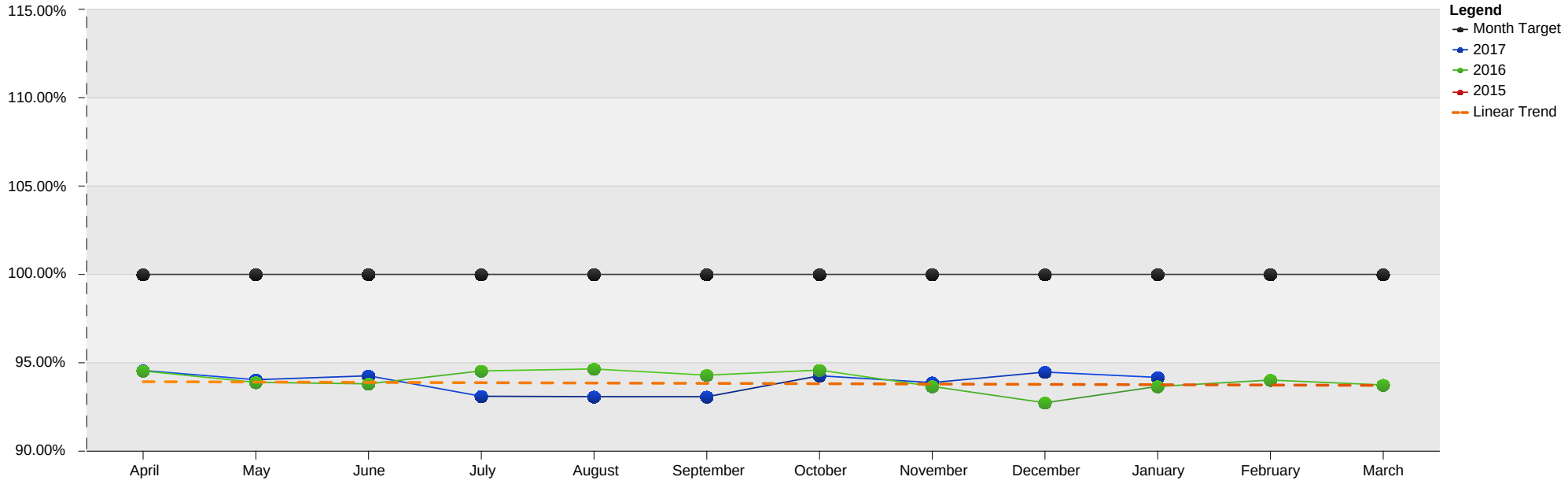
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.63	12.94	1.43	11.56	2.32	11.41	0.91	17.03	32.47	101.49	0.00	9.52		

Narrative

The Trust position for January 2018 is 1.63, which is not meeting the expected number of 1.00. This rate relates to 10 unexpected deaths which occurred in January. This is a decrease on the 13 unexpected deaths reported in December.Of the 10 unexpected deaths the details below shows a breakdown by locality:4 x Tees3 x Durham and Darlington2x Forensics1 x North YorkshireOf the unexpected deaths that occurred in December 10 occurred in adult services. A piece of work is to be completed in January that will review the information from October to December 2017 to establish if there are any themes over a longer time period and a meeting is arranged for early March between Patient Safety, Corporate Performance Team and Information team to discuss these findings and the data reported in this indicator.

Trust Dashboard Graphs for TRUST

14) Actual number of workforce in month (Establishment 95%-100%)

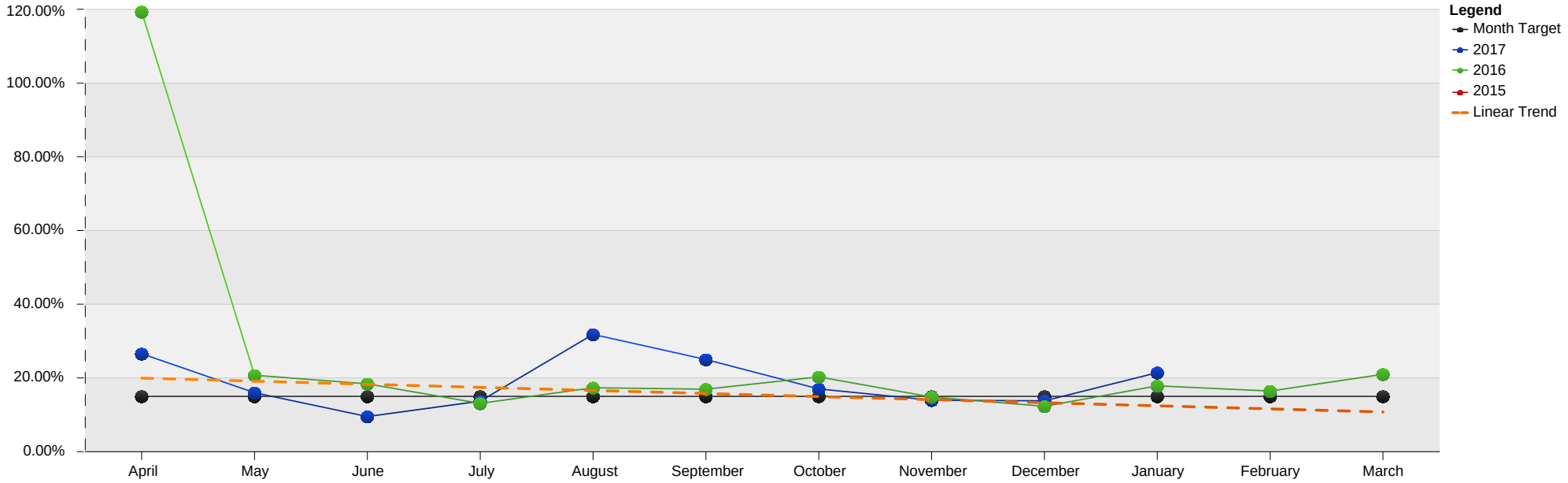


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		UNKNOWN		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Actual number of workforce in month (Establishment 95%-100%)	94.17%	94.17%	95.00%	95.00%	98.06%	98.06%	93.41%	93.41%	93.79%	93.79%			88.27%	88.27%

Narrative
The Trust position for 31 January 2018 is 94.17% which is marginally below the targeted establishment level of 95-100%. It is expected that the establishment rate will continue to improve following the appointment of newly qualified nurses and on-going recruitment.

Trust Dashboard Graphs for TRUST

15) Percentage of registered healthcare professional jobs that are advertised two or more times



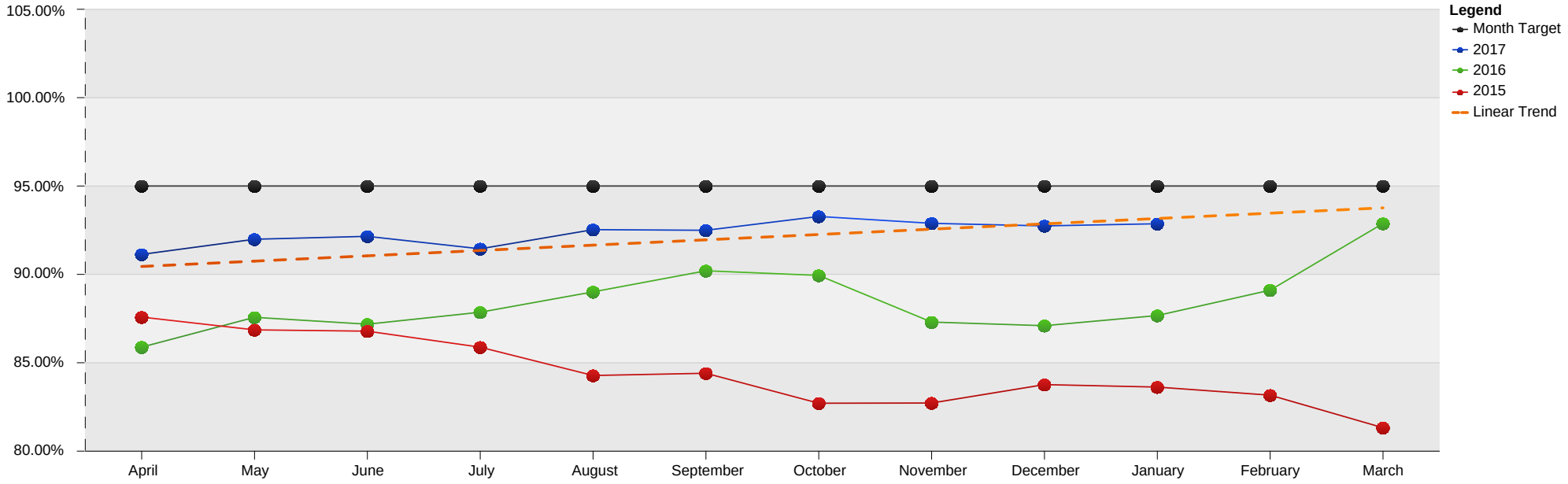
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		UNKNOWN		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Percentage of registered healthcare professional jobs that are advertised two or more times	21.43%	19.22%	NA	NA	NA	NA	NA	NA	NA	NA			NA	NA

Narrative

The Trust position for January 2018 has increased to 21.43% and is significantly over the target of 15.00%. There were 9 non-medical posts re-advertised in January out of a total of 41 posts advertised. The posts proving difficult to fill are:• 3 x Staff Nurses – Scarborough, • Care Co-ordinator – band 6 – Chester-le-Street, • Senior Psychological Wellbeing Practitioner in York, • Staff Nurse – York, • Specialist OT – band 6 in Hartlepool, • Psychological Therapist band 7 in North Yorkshire and • Highly Specialist Psychologist band 8a in North Yorkshire.Further work is being undertaken by HR to understand the key areas of concern and themes and this work is planned to be completed in February 2018.Data only started to be reported for this dashboard from April 2016, therefore no comparative data for 2015/16 is available.

Trust Dashboard Graphs for TRUST

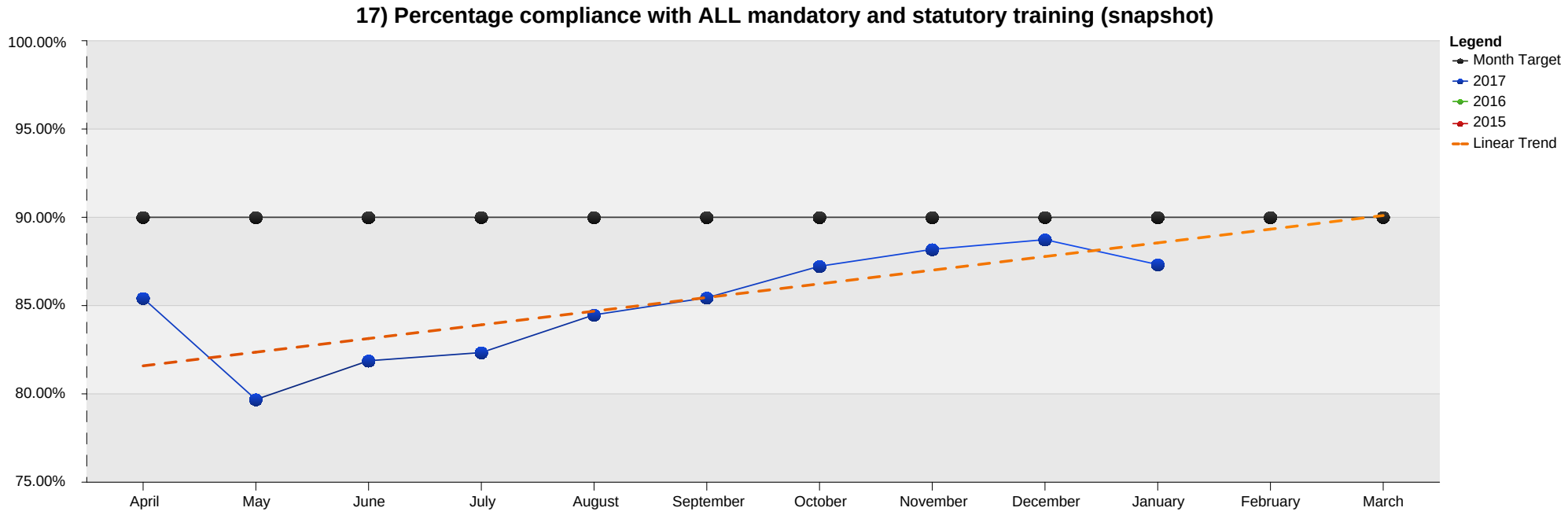
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	92.86%	92.86%	93.71%	93.71%	94.14%	94.14%	91.21%	91.21%	97.04%	97.04%	89.63%	89.63%		

Narrative
The Trust position for January 2018 is 92.86% which relates to 405 members of staff out of 5676 that do not have a current appraisal. This is not meeting the target of 95% and represents a slight deterioration on the 92.75% reported in December. It is however one of the best positions reported since 2015/16 to date.Forensic services are the only locality meeting target and York and Selby report the poorest performance at 89.63%.The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels.

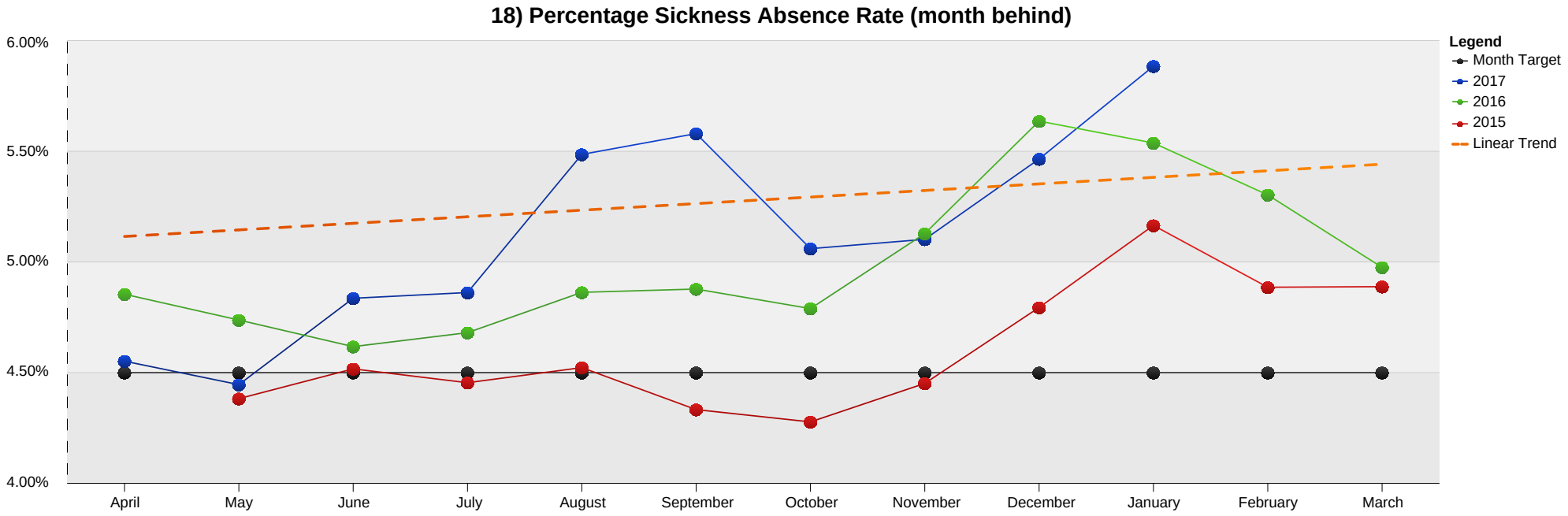
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	87.32%	87.32%	84.66%	84.66%	87.92%	87.92%	86.78%	86.78%	89.17%	89.17%	90.52%	90.52%		

Narrative
The position for January 2018 is 87.32%, which is 2.68% lower than the target of 90%. This figure represents a decrease in compliance since April 2017. Problems had been experienced linked to Information Governance reporting figures which have now been rectified which is likely to account for the decrease in compliance. In addition the availability of face to face training is impacting on compliance levels and this is being addressed to ensure attendance is maximised at available training courses. It is planned to review the Trusts approach to recording mandatory and statutory training to identify any system improvements to drive efficiencies in the process. This KPI was discussed at the Performance Improvement Group in January 2018 where a number of actions were agreed to address areas of concern and the majority of these have now been actioned.The operational management huddles continue to drive improvements in performance. The improved frequency of the IIC refresh allows a timelier update of accurate performance information to managers.

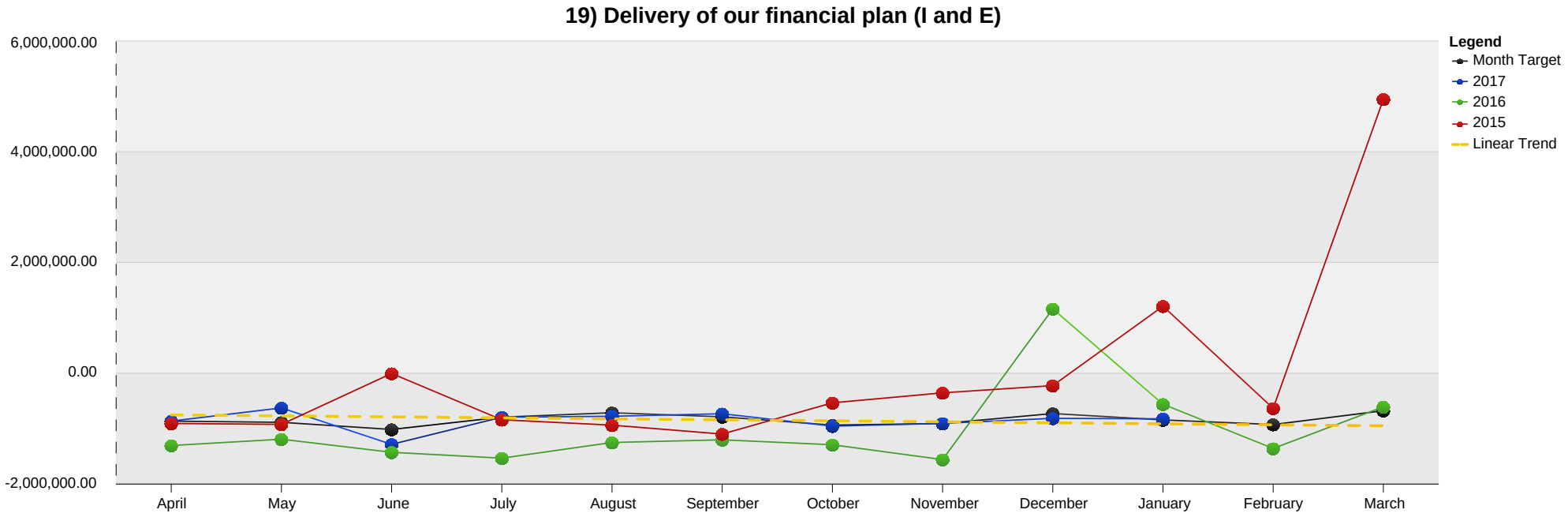
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	5.88%	5.13%	6.61%	5.60%	6.44%	5.73%	4.84%	4.46%	5.75%	5.11%	6.12%	5.63%		

Narrative
The Trust position reported in January relates to the December sickness level. The Trust position reported in January 2018 is 5.88% which is not meeting target of 4.50% and is a significant deterioration on that reported in December 2017. An event was held in November to look at how we can better understand the reasons for the increase in sickness absence we have seen this year and broadly focused on health and well-being within the organisation. The event was productive and identified a number of areas to explore. Further events are planned for January and February to continue the discussions. North Yorkshire is the only locality meeting target with Durham and Darlington reporting the poorest position at 6.61%. As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive).

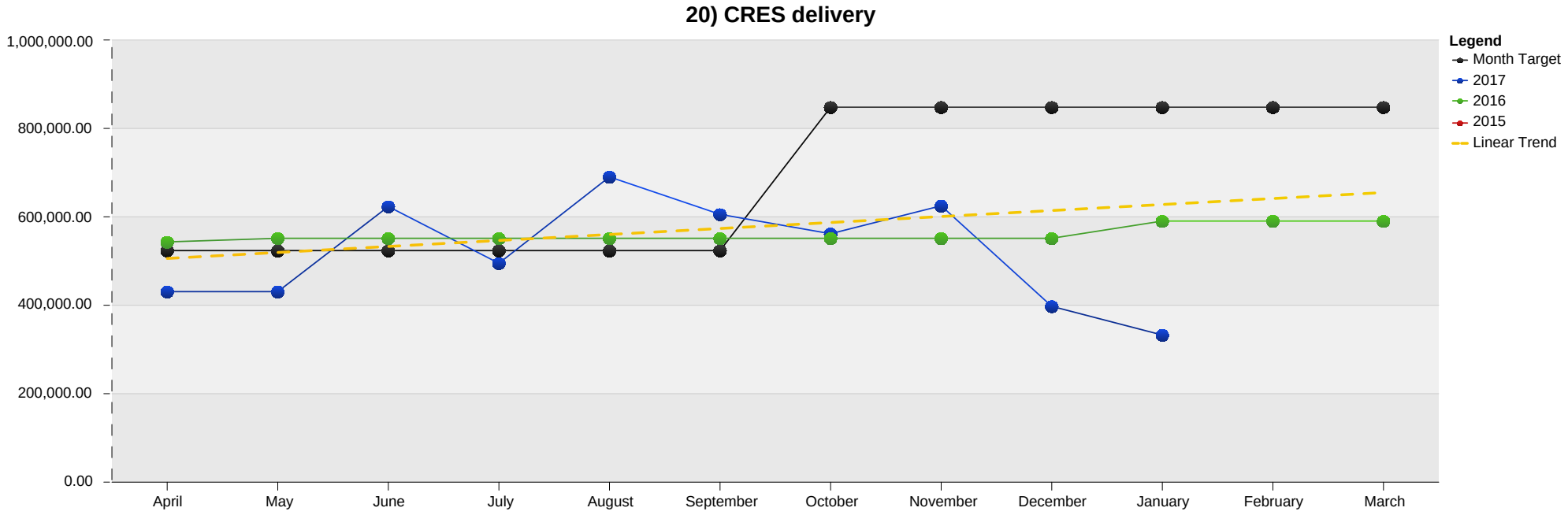
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Delivery of our financial plan (I and E)	-823,000.00	-8,573,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
The comprehensive income outturn for the period ending 31 January 2018 is a surplus of £8,573k, representing 3.0% of the Trust's turnover and is £100k ahead of plan.

Trust Dashboard Graphs for TRUST

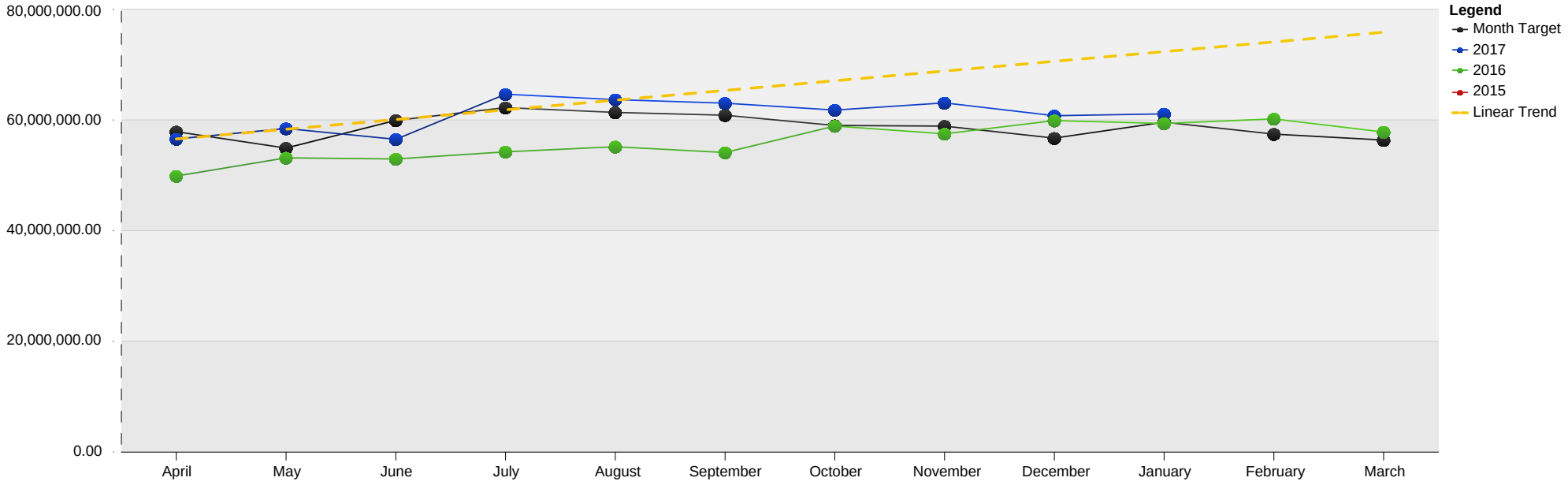


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) CRES delivery	332,640.00	5,193,037.93	126,372.00	1,262,844.91	181,446.00	1,814,460.08	32,242.00	322,422.92	16,504.00	165,041.66	61,588.00	608,393.34		

Narrative
Total CRES identified at 31 January 2018 is £5,193k and is £1,073k behind plan for the year to date. The deterioration is due to slippage on CRES schemes due to commence 1 October 2017. The Trust has, and continues to identify and progress schemes to deliver CRES in full for current and future years, and has non-recurrent expenditure mitigations in place to manage this position in 2017/18.

Trust Dashboard Graphs for TRUST

21) Cash against plan



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Cash against plan	61,105,000.00	61,105,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
Total cash at 31 January 2018 is £61,105k and is £1,500k ahead of plan largely due to working capital variations.

Trust Dashboard - Locality Breakdown for TRUST

1 - Activity

	January 2018														April 2017 To January 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Total number of External Referrals into Trust Services	7,793.00	9,331.00	1,885.00	2,134.00	1,916.00	2,842.00	1,848.00	2,079.00	585.00	662.00	1,559.00	1,614.00			76,926.00	87,820.00	18,606.00	20,289.00	18,912.00	26,230.00	18,244.00	20,818.00	5,778.00	6,341.00	15,386.00	14,139.00		
2) Caseload Turnover	1.99%	1.75%	1.99%	3.01%	1.99%	2.48%	1.99%	-1.23%	NA	NA	1.99%	1.23%			1.99%	1.75%	1.99%	3.01%	1.99%	2.48%	1.99%	-1.23%	NA	NA	1.99%	1.23%		
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	86.44%	85.00%	92.92%	85.00%	83.66%	85.00%	81.71%	85.00%	NA	85.00%	84.42%			85.00%	86.20%	85.00%	88.70%	85.00%	84.85%	85.00%	89.73%	85.00%	NA	85.00%	78.94%		
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	75.00	65.00	16.00	13.00	11.00	14.00	22.00	18.00			24.00	19.00			75.00	65.00	16.00	13.00	11.00	14.00	22.00	18.00			24.00	19.00		
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	8.37%	10.00%	7.80%	10.00%	8.50%	10.00%	8.33%			10.00%	9.76%	10.00%		10.00%	8.84%	10.00%	8.03%	10.00%	8.82%	10.00%	8.32%			10.00%	10.76%	10.00%	
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	20.00	25.67	5.00	9.33	5.00	5.33	6.00	4.67			2.00	5.00			199.00	255.00	54.00	92.67	54.00	52.67	66.00	47.33			23.00	49.00		

Trust Dashboard - Locality Breakdown for TRUST

2 - Quality

	January 2018														April 2017 To January 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	90.00%	87.98%	90.00%	88.59%	90.00%	97.02%	90.00%	75.66%	90.00%	99.44%	90.00%	70.17%			90.00%	90.69%	90.00%	89.55%	90.00%	98.30%	90.00%	83.49%	90.00%	99.73%	90.00%	74.13%		
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	8.78%	10.00%	9.71%	10.00%	7.43%	10.00%	9.83%	10.00%		10.00%	7.98%			10.00%	8.59%	10.00%	10.57%	10.00%	5.87%	10.00%	11.07%	10.00%		10.00%	4.97%		
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	16.50%	20.00%	8.85%	20.00%	6.45%	20.00%	56.52%			20.00%	16.67%			20.00%	13.85%	20.00%	6.02%	20.00%	4.86%	20.00%	39.45%			20.00%	21.43%		
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	91.87%	92.45%	90.34%	92.45%	94.14%	92.45%	92.12%	92.45%	85.84%	92.45%	92.11%			92.45%	91.65%	92.45%	92.47%	92.45%	93.02%	92.45%	91.62%	92.45%	80.56%	92.45%	90.83%		
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.63	1.00	1.43	1.00	2.32	1.00	0.91	1.00	32.47	1.00	0.00			10.00	12.94	10.00	11.56	10.00	11.41	10.00	17.03	10.00	101.49	10.00	9.52		

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	January 2018														April 2017 To January 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	94.17%	100.00%	95.00%	100.00%	98.06%	100.00%	93.41%	100.00%	93.79%	100.00%	88.27%			100.00%	94.17%	100.00%	95.00%	100.00%	98.06%	100.00%	93.41%	100.00%	93.79%	100.00%	88.27%		
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	21.43%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA			15.00%	19.22%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA		
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	92.86%	95.00%	93.71%	95.00%	94.14%	95.00%	91.21%	95.00%	97.04%	95.00%	89.63%			95.00%	92.86%	95.00%	93.71%	95.00%	94.14%	95.00%	91.21%	95.00%	97.04%	95.00%	89.63%		
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	87.32%	90.00%	84.66%	90.00%	87.92%	90.00%	86.78%	90.00%	89.17%	90.00%	90.52%			90.00%	87.32%	90.00%	84.66%	90.00%	87.92%	90.00%	86.78%	90.00%	89.17%	90.00%	90.52%		
18) Percentage Sickness Absence Rate (month behind)	4.50%	5.88%	4.50%	6.61%	4.50%	6.44%	4.50%	4.84%	4.50%	5.75%	4.50%	6.12%			4.50%	5.13%	4.50%	5.60%	4.50%	5.73%	4.50%	4.46%	4.50%	5.11%	4.50%	5.63%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	January 2018														April 2017 To January 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
19) Delivery of our financial plan (I and E)	-843,000.00	-823,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			-8,473,000.00	-8,573,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
20) CRES delivery	848,000.00	332,640.00	107,322.17	126,372.00	198,536.25	181,446.00	148,049.17	32,242.00	124,378.00	16,504.00	59,416.00	61,588.00			6,534,080.00	5,193,037.93	1,073,221.67	1,262,844.91	1,985,362.50	1,814,460.08	1,480,491.67	322,422.92	1,243,780.00	165,041.66	594,160.00	608,393.34		
21) Cash against plan	59,605,000.00	61,105,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			59,605,000.00	61,105,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Number of unexpected deaths and verdicts from the Coroner April 2017 - March 2018

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient and took place in the hospital					Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital					Number of unexpected deaths where the patient was no longer in service					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death																					**0**
Natural causes																					**0**
Hanging																	1				**1**
Suicides																					**0**
Open																					**0**
Drug related death																					**0**
Drowning																					**0**
Misadventure																					**0**
Awaiting verdict	17	13	14	4	5	1	3									8	1	6	2	3	**77**
Total	**17**	**13**	**14**	**4**	**5**	**1**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**2**	**6**	**2**	**3**	**78**

Number of unexpected deaths classed as a serious untoward incident											
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
4	4	3	10	11	5	10	8	13	10		

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
26	18	20	6	8

Number of unexpected deaths and verdicts from the Coroner 2016 / 2017
This table has been included into this appendix for comparitive purposes only

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient					Number of unexpected deaths where the patient is an inpatient but the					Number of unexpected deaths where the patient was no longer in					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death																					**0**
Natural causes	1	1															1				**3**
Hanging					1												1				**2**
Suicides	5	2	2		2							1	2					1			**15**
Open			1																		**1**
Drug related death																					**0**
Drowning													1								**1**
Misadventure			1																		**1**
Awaiting verdict	7	2	7	2	6	1					1						1	1	2	1	**31**
Total	**13**	**5**	**11**	**2**	**9**	**1**	**0**	**0**	**0**	**0**	**1**	**1**	**3**	**0**	**0**	**0**	**3**	**2**	**2**	**1**	**54**

Number of unexpected deaths classed as a serious untoward incident											
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
5	4	3	7	5	3	1	6	7	5	3	5

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
15	9	16	4	10

Y&S recorded in old Datix not included

Number of unexpected deaths and verdicts from the Coroner 2015 / 2016
This table has been included into this appendix for comparitive purposes only

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	% as at October 2016	% as at July 17	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1				
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined				
1	Total number of external referrals into trust (same)services	5					5					5					15	**100%**	**100%**	
2	Caseload Turnover (same)	5					5					5					15	**100%**	**100%**	
3	Bed occupancy (AMH & MHSOP A&T wards) (same)	5					5					5					15	**100%**	**100%**	
4	Number of patients occupying a bed with a length of stay (from admission) over 90 days (AMH & MHSOP A&T wards)	5					5					5					15	**100%**	**100%**	This KPI has been amended to include patients currently occupying a bed, rather than those subject to discharge. This allows for more pro active monitoring of patients with a longer length of stay to enable a review of the appropriateness of the length of impatient spell and this is monitored in the report out process. The change to this KPI does not impact on the score previously applied, which remains unchanged.
5	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	5						5				5					15	**93%**	**100%**	Historic data for York and Selby prior to 1st April 2016 was not on Trust systems and this impacted on the reliability score applied to this KPI. However due to the new reporting year this concern no longers applies. T and therefore the scoring of this KPI has improved from 93% to 100%
6	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	5						5				5					15	**93%**	**100%**	The previous comments about the lack of historic data on the system with regards to York and Selby data no longer applies and therefore the scoring of this KPI has improved from 93% to 100%
7	Percentage of patients who have not waited longer than 4 weeks following an external referral	5						4				5					14	**93%**	**93%**	Data reliability is remains at 4 due to issues over the recording of DNA's. Although this continues to improve issues are still reported, particularly in the North Yorkshire locality and these are being addressed through the report out process

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	**% as at October 2016**	**% as at July 17**	**Notes**
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1				
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined				
8	Percentage of clinic appointments cancelled by the Trust	5					5					5					15	**87%**	**100%**	This KPI has been changed to clinic appointments as the previous use of community contacts was unreliable as you could not future date appointments, and therefore clinicians were likely to record these inaccurately. This KPI now uses the outpatients module on PARIS and there are no concerns of the reliability of this data. The use of a drop down menu to clearly state cancellation reasons provides a high degree of confidence in data quality.
9	The percentage of Out of Area Placements (post validated)		4				5								5		14	**N/A**	**93%**	Data is imported back into the IIC following manual validation. This increases reliability however introduces a manual element into the process. Validation for all breaches must be completed within the timeframe to support a national return, which prevents concerns about some breaches being inappropriately discounted. Therefore the data reliability has been amended from 4 to 5. A change to PARIS with the inclusion of drop downs to eradicate the manual element of the process is planned.

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	% as at October 2016	% as at July 17	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1				
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined				
10	Percentage of patients surveyed reporting their overall experience as excellent or good.				2		5					5					12	**80%**	**80%**	Questionnaires continue to be are a mix of paper and electronic. All inpatient wards are electronic data collection, however there is also a number of kiosks in a range of services which complement the paper collection. A new provider (Optimum Health Technology) is in place and data collection commenced on 1st April 2017 . Paper surveys are sent to the new provider and entered into their Meridian system. There is a manual upload of the data accessed from Meridian into the IIC (this was the case for the most recent data by the Data Quality Team) but work is ongoing to integrate this data with the IIC.
11	Number of unexpected deaths classed as a serious incident per 10,000 open cases		4				5					5					14	**93%**	**93%**	Data continues to be directly extracted from Datix into the IIC; however, this process is not fully embedded. IAPT caseload is a manual upload.
16	Percentage Sickness Absence Rate (month behind)	5						4				5					14	**93%**	**93%**	Sickness absence data for inpatient services is taken directly from the rostering system which helps to eliminate inaccuracies, the remainder of the Trust continue to input directly into ESR and there continues to be examples where managers are failing to end sickness in a timely manner or inaccurately recording information onto the system. These issues are picked up and monitored through sickness absence audits that the Operational HR team undertake.

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	% as at October 2016	% as at July 17	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1				
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined				
14	Actual number of workforce in month		4				5					5					14	**93%**	**93%**	Data continues to be extracted electronically but processed manually
15	Percentage of registered health care professional jobs that are advertised two or more times				2			4				5					11	**73%**	**73%**	The form to capture this information is still reliant on recruiting managers completing the section of the form. The recruitment team are more proactive in recording on the tracking spreadsheet where they are aware it is a readvertisement because they know this is being reported through a KPI. The recording of the information is a manual input into a spreadsheet which has the potential for human error.
19	Are we delivering our financial plan (I and E)		4				5					5					14	**93%**	**93%**	Information is extracted from and electronic system but is then subject to a manual process.
16	Percentage of staff in post more than 12 months with a current appraisal – snapshot	5						4				5					14	**93%**	**93%**	Issues with appraisal dates being entered to ESR continue to improve - there appears to be greater confidence in the data being reported and operational clinical services have incorporated the monitoring of compliance into the daily lean management process. Performance has improved and the Trust compliance rate has consistently been above 90%
17	Percentage compliance with mandatory and statutory training – snapshot **	5						4				5					14	**93%**	**93%**	The key issue that impacts on the reliability of the data is that staff do not follow the correct procedures to ensure training is recorded accurately on the source system as being completed and this is being addressed. In terms of training requirements there have been issues with Resus and PAT training and work is underway to resolve these issues
20	Delivery of CRES against plan				2		5					5					12	**80%**	**80%**	Data continues to be collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
21	Cash against plan		4				5					5					14	**93%**	**93%**	An extract continues to be taken from the system then processed manually to obtain actual performance.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th February 2018**
TITLE:	**Strategic Direction Performance Report – Quarter 3 2017/18**
REPORT OF:	**Sharon Pickering, Director of Planning and Performance**
REPORT FOR:	**Assurance**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	✓
To continuously improve the quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	✓

Executive Summary:

The purpose of this report is to present to the Board of Directors the Strategic Direction Performance Report as at Quarter 3 (31st December 2017).

The Trust has identified key performance indicators to monitor and report progress against its 5 year strategic direction in conjunction with the Trust Business Plan and other forms of intelligence.

Overall the scorecard position has shown an improvement when compared to quarter 2; however data is not available for all KPIs. This report reflects that two of the Trust's five goals are in a positive position, whilst still acknowledging that there is work to do to improve some KPI's. There has been an increase in the number of greens reported; however of the 12 KPIs reporting red at quarter 3, 4 have reported a deterioration. Whilst 4 goals have reported an improvement in the numbers of reds compared to the position in quarter 2, it should be noted that within Goals 1 and 3 there has been a deterioration in individual KPI performance.

Recommendations:

Board of Directors are asked to:

- Approve the changes to the Trust Business Plan in Appendix 1.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**27th February 2018**
TITLE:	**Strategic Direction Performance Report – Quarter 3 2017/18**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to the Board of Directors the Strategic Direction Performance Report as at Quarter 3 (31st December 2017).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report demonstrates progress against the Strategic Direction Scorecard and the Trust Business Plan as well as other forms of qualitative intelligence.

2.2 The 5 year targets for the Trust Strategic Direction Scorecard were agreed by the Board on the 18th August 2015, with any amendments being approved in subsequent relevant quarterly reports.

3. KEY ISSUES:

3.1 Trust Strategic Direction Scorecard

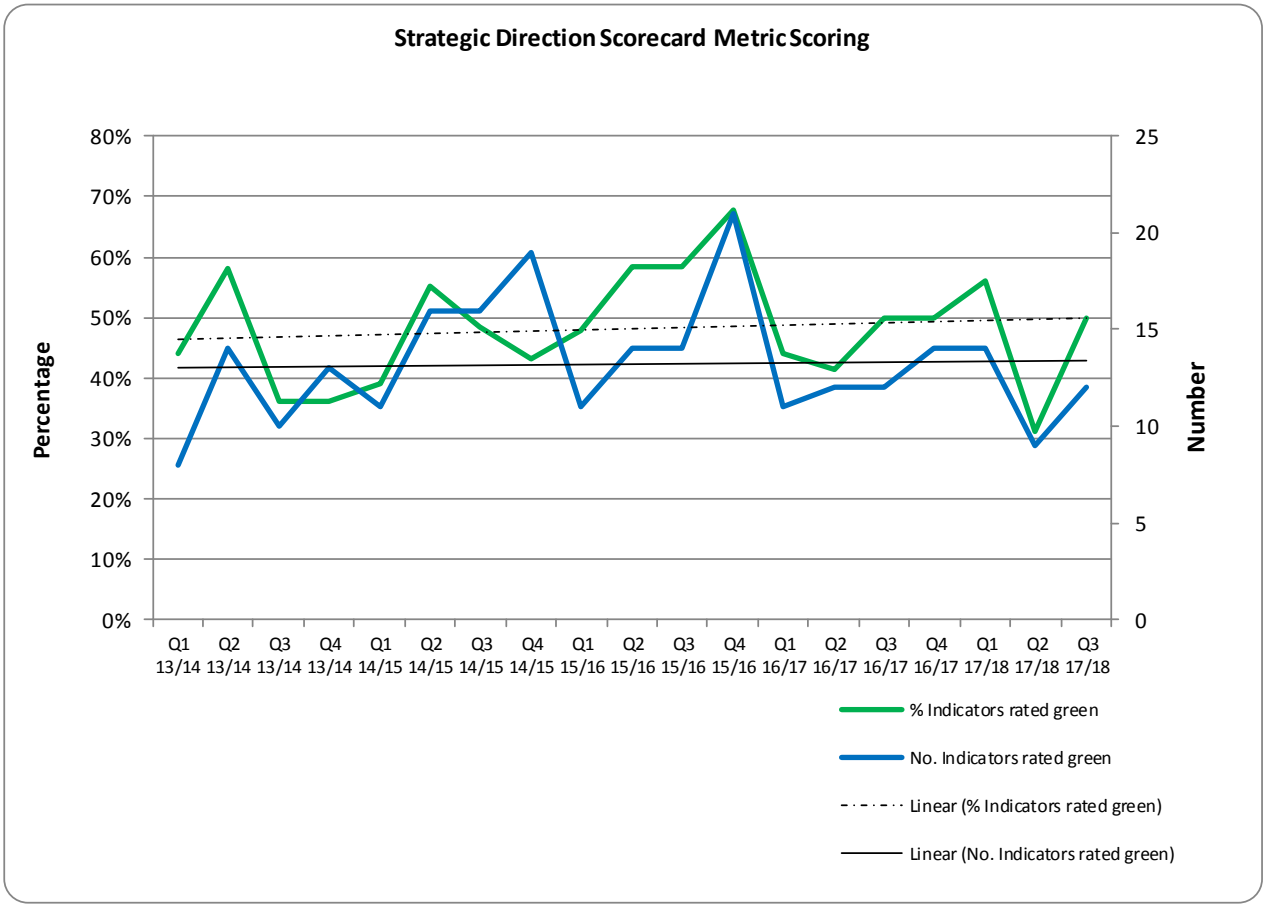
The Strategic Direction Scorecard is shown under each strategic goal with further detail, by exception, in Appendix 1.

The following table and graph provide a summary of the RAG ratings at quarter 3 compared to the position in the previous quarters and the previous financial years 2015/16 and 2016/17. The Trust is not meeting some of its high ambitions given the number of reds against stretching metrics. The actual number of those rated green has increased since last quarter and the number rated red has decreased. There is a significant number (12) that are not being RAG as they are not required to be reported in this quarter.

	2015/16		2016/17		Q1 2017/18		Q2 2017/18		Q3 2017/18		2017/18 YTD	
	No	%*	No	%*	No	%*	No	%*	No	%*	No	%*
Indicators rated green	21	66%	16	55%	14	56%	9	31%	12	50%	13	45%
Indicators rated red	11	34%	17	59%	11	44%	15	52%	12	50%	14	48%
Indicators with no target	3		2		2		2		3		2	
Indicators currently under development/being finaliased	1		0		0		0		0		0	
Indicators where data is not yet available/not applicable in qtr	4		2		12		11		12		12	

The percentage is based on the number of indicators that can be RAG rated (24 for quarter 3).

The graph below shows that there has been a general slowly improving trend in the percentage of greens since 2013/14.



3.2 **Strategic Goal *1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)***

3.2.1 Trust Strategic Direction Scorecard

This strategic goal is showing 3 indicators rated red out of 6 as at quarter 3; which the same as reported in quarter 2.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18												
	Indicator	Q2 Target 2017/18	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)												
1	Percentage of patients surveyed reporting their overall experience as excellent or good	>92.45	92.74%	91.33%	84.57%	⇩	>92.45	89.77%	92.48%	91.37%	90.14%	>18/19 out-turn
2	Percentage of patients who have not waited longer than 4 weeks from "referral " to "assessment" for external and internal referrals	90.00%	88.19%	90.41%	90.30%	⇩	90.00%	89.63%	84.76%	83.17%	84.50%	98.00%
3	Percentage of patients reporting "yes always" to the question "did you feel safe on the ward?"	85.00%	64.57%	62.37%	63.20%	⇧	85.00%	63.40%	82.29%	79.96%	82.11%	85.00%
4	The Trust ranks in the top 20th percentile of all mental health Trusts for the CQC Service User Survey (annual)	Surveys: Top 20% of MH Trusts	Results due in Q2	not yet published	National scoring has changed	n/a	Surveys: Top 20% of MH Trusts	National scoring has changed	Better or About the Same as other Trusts	Yes	Survey - top 25th %ile	Surveys: Top 20% of MH Trusts
5	The Trust ranks in the top 10th percentile of all mental health Trusts for the NHS Staff Survey (annual)	Surveys: Top 10% of MH Trusts	Results due in Q4	Results due in Q4	Results due in Q4	n/a	Surveys: Top 10% of MH Trusts	Results due in Q4	Ranked 4th	Yes - top MH/LD trust	Survey - top 25th %ile	Surveys: Top 10% of MH Trusts
6	Percentage of service users with a recovery focused action plan (Adult Mental Health)	92.00%	90.72%	89.34%	88.40%	⇩	92.00%	89.34%	89.73%	93.00%	93.16%	95.00%

Indicators of concern are:

- **KPI 1 Percentage of patients surveyed reporting their overall experience as excellent or good. –** The Trust position for quarter 3 is 84.57%, which is a deterioration on the quarter 2 position of 91.33% and below the trust target by 7.88%.

  All localities are reporting below target; Durham and Darlington (85.76%), York and Selby (79.87%), Teesside (86.02%) and North Yorkshire (85.26%), with the Forensic services reporting lowest at 74.91%. This directorate has historically reported a lower positon, due to the nature of the service. The Patient Experience Subgroup is undertaking some work to understand the deteriorating position.

- **KPI 3 – Percentage of patients reporting 'yes always' to the question 'did you feel safe on the ward?'** – The Trust position for quarter 3 is 63.20% which relates to 517 patients out of 818 patient survey responses who confirmed they always felt safe on our wards. This is 21.8% below the target of 85% and a slight improvement on quarter 2 when we reported 62.37%. All localities are reporting below target; Durham and Darlington (74.5%), York and Selby (65.4%), Teesside (64.56%), North Yorkshire (64.84%) and Forensic Services (54.74%). However, Durham and Darlington, York and Selby and Forensics are all showing an improvement on quarter 2.

  The table below shows a brief summary of the reasons cited by patients for feeling unsafe, not all patients provide a reason and some can give more than one.

Locality	Reason	Number responding	Total responses for locality
Durham & Darlington	General	0	11
	Environment	1	
	other patients	8	
	own illness	2	
	Staff/staffing	0	
North Yorkshire	General	5	13
	Environment	2	
	other patients	6	
	own illness	0	
	Staff/staffing	0	
Tees	General	4	12
	Environment	2	
	other patients	5	
	own illness	1	
	Staff/staffing	0	
Forensics	General	5	27
	Environment	5	
	other patients	14	
	own illness	3	
	Staff/staffing	4	
York & Selby	General	1	7
	Environment	0	
	other patients	4	
	own illness	3	
	Staff/staffing	0	

- **KPI 6 - Percentage of service users with a recovery focused action plan (Adult Mental Health)** – The Trust position for quarter 3 is 88.40% which is 3.60% below the target of 92%.

  Only Teesside (91.11%) is achieving the commissioner target. The following should be noted:

  - Within Durham and Darlington (85.64%) the position has been affected by engagement issues and new staff within some teams and whilst some training has taken place there has also been further training requirements identified. These issues are being addressed directly with staff and within clinical and team meetings.

  - Within North Yorkshire (89.74%), there is a focus on all recovery star plans being completed; however, they have experienced engagement issues with patients unwilling to take part in the process, which has affected performance. It should be noted that the position only accounts for 4 patients, 3 of which have now re-engaged with the service. Training requirements

have been identified within the Scarborough Assertive Outreach Team; however all training is on hold pending a review of service user feedback.

Neither the commissioner target (90%) nor the Strategic Direction Scorecard target (92%) was achieved.

Other points to note:

- **KPI 4 – The Trust ranks in the top 20th percentile of all mental health Trusts for the CQC Service User Survey (annual)** – the national scoring for this indicator has changed and MH providers are no longer provided with an overall score and are instead rated as Better, About the Same or Worse on a range of questions in ten categories. Our Trust scored 'About the Same' in every category, which was also the overall rating.

  However, there was a slight decline this year in the responses of some of the questions. Out of the 32 scored questions 10 were within the top 20%, 18 were in the middle range and 4 were in the bottom 20%. In comparison, last year's survey reported 16 questions within the top 20% or Trusts and 16 in the mid range.

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 3 were rated green (83%) which is a similar position as Quarter 2 (82%) position.

There are 4 priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

- 1 Priority (1.76 PICU), which impacts on four metrics, requires additional time which moves into the next financial year 2018/19 (to be agreed by Board).
- There are currently 2 priorities rated Grey (Perinatal and CORE 24) due to external factors, which could have an impact on overall timescales.
- 1 priority has identified that the benefits will not be achieved under the current plan, therefore significant re-plan has taken place during Q3. The PPCS programme Board met January 18 and discussed the progress of the 12 teams and the benefits metrics to be used in future. The proposed changes will be presented to the PPCS Programme Board in February 18 and SCOB in March 18.

There are 2 metrics (1.3a and 1.3b) that require removal from the business plan as the metrics have been subsumed within the North Yorkshire Transformation Programme (Hambleton & Richmondshire and Harrogate) (to be agreed by Board)

Where a Board decision is required to change or remove an action, this is contained in Appendix 2 for approval.

3.2.3 Other Qualitative Intelligence

In addition to the reported position the following point should be noted:

- **Esk and Danby** wards, Cross Lane Hospital, Scarborough, achieved their AIMS accreditation from the Royal College of Psychiatrists.
- **Bedale Ward, Stockdale Ward** and **Bilsdale Ward, Roseberry Park,** Middlesbrough have achieved AIMS accreditation.
- **Mindfulness team**, West Park Hospital, Darlington were the winners of the 'psychological therapies for people with common MH problems' category of the Positive Practice in MH Awards 2017.
- **Rollercoaster parent / carer support group**, North End House, Durham were highly commended in the 'Co-production of Care', 'Innovation in children and young people's mental health' and 'Specialist services' categories of the Positive Practice in MH Awards 2017.
- **TEWV employee support service**, Flatts Lane Centre, Middlesbrough were highly commended in the 'Mental wellbeing of staff' category of the Positive Practice in MH Awards 2017.
- **Vanguard new care model**, Harrogate were highly commended in the 'Integration of physical and mental health' category of the Positive Practice in MH Awards 2017.
- The **memory service team in Hambleton and Richmondshire** were presented with a certificate in October from the Hambleton and Richmondshire Carers Centre recognising that the service is "an effective communicator and has delivered a significant number of highly appropriate early referrals, and is an inclusive stakeholder". The certificate was awarded by Helen Hunter, chief executive officer of the Carers Centre.
- CQC has published five examples from mental health trusts, of which **TEWV** is one, who share good practice that has worked for them to help reduce restrictive interventions. These examples show that a positive and therapeutic culture across the organisation can reduce the need for restrictive interventions.
- **Forensic Learning Disability Women's Service** won the Royal College of Psychiatry Team of the Year (non-age specific category).
- City of York Council has granted us planning permission for a **new mental health hospital**. The 72 bed hospital will be located off Haxby Road in the city. It will provide two adult, single sex wards and two older people's wards - one for people with

dementia and one for people with mental health conditions such as psychosis, severe depression or anxiety.

3.2.4 In conclusion it can be seen for this strategic goal that that the number of KPIs rated red on the scorecard has remained the same as last quarter, with two of those rated red showing a deterioration on the previous quarter. The percentage rated green in the Business plan has remained broadly the same as the previous quarter, but there are a number of actions which are showing some level of risk to delivery. Further work is required both around recovery star and patient experience to drive up performance and with the business plan to ensure achievement. However, there is a significant amount of positive qualitative intelligence which is encouraging.

3.3 Strategic Goal 2 - *To continuously improve the quality and value of what we do*

3.3.1 Trust Strategic Direction Scorecard

This strategic goal is showing 3 indicators rated red out of 8, which is an improvement on quarter 2 when we reported 5 rated red. Furthermore, 2 of the 3 red indicators are showing an improving position.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18

	Indicator	Q2 Target 2017/18	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 2 (To continuously improve the quality and value of what we do)												
7	Number of outstanding action points for **more than 31 days** for Level 5 SIs and action points for safeguarding serious case reviews and domestic homicide reviews	0	8	13	11	⇧	0	32	23	0	n/a (indicator changed)	0
8	Number of action points on action plans for complaints and clinical audit that are outstanding for **more than 31 days**	0	2	5	2	⇧	0	9	24	13	8	0
9	Friends & Family Test - **Patient** Survey Question: "How likely are you to recommend our ward/services to friends and family if they needed similar care or treatment?"	>86.56	87.68%	87.58%	87.00%	⇩	>86.56	87.42%	86.56%	86.01%	89.75%	> previous year out-turn
10	Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication	50%	14.29%	0.00%	16.67%	⇧	50.00%	13.33%	17.14%	53.57%	34.48%	>=75%
11	Percentage of staff reporting that they can 'contribute towards improvements at work'*	>2015/16 (79%) and in top 20%ile of MH/LD trusts	Results due in Q4	Results due in Q4	Results due in Q4	n/a	>2015/16 (79%) and in top 20%ile of MH/LD trusts	Results due in Q4	76.00%	79% and in top 20%	77% but in top 20%	> 2018/19 and in top 20%ile for MH/LD Trusts
12	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family if they need care or treatment?"	>82.58%	83.98%	80.59%	No Staff FFT in Q3	n/a	>82.58%	82.18%	81.22%	82.58%	n/a	> previous year out-turn
13	For Trust hospital sites with over 10 beds, the trust score for each category (Cleanliness, Food, Privacy & Dignity, Condition, Appearance & Maintenance, Dementia Friendly, Learning Disability) > national average PLACE (new PEAT) assessments.	80%	Assessment due in Q2	33.33%	Assessment completed in Q2	n/a	80%	33.33%	50.00%	80.00%	75.00%	80%
14	Hospitality Assured Accreditation score*	82.00%	No scoring for 2017/18	No scoring for 2017/18	No scoring for 2017/19	n/a	82.00%	No scoring for 2017/18	81.10%	Assessment now due Q1 16/17 & results in Q2	80.5% (Mar 2015)	86.00%

Indicators of concern are:

- **KPI 7 - Number of outstanding action points on action plans for more than 31 days for Level 5 SI's and action points for safeguarding serious case reviews and domestic homicide reviews**– The Trust position for quarter 3 is 11

against a target of zero, which is an improvement on quarter 2 when we reported 13. All relate to Level 5 SIs.

The 11 outstanding actions are from a total of 7 action plans. At the time of writing this report only 5 of these action points remain outstanding; 2 for York & Selby CAMHS, 2 for Durham & Darlington AMH and 1 for Durham & Darlington MHSOP.

- **KPI 8 - Number of action points on action plans for complaints and clinical audit that are outstanding for more than 31 days** – The Trust position for quarter 3 is 2 outstanding action points against a target of zero, which is an improved position on quarter 2 position when we reported 5.

  Both actions points relate to Clinical Audit. One action for the Prescribing in Substance Misuse: Alcohol Detoxification (re-audit) is dependent on a wider review of Substance Misuse prescribing guidelines. One action for the Clinical Audit of Emergency Equipment was initially behind due to delays in the clinical service ordering equipment and annual leave of the action owner. This has been subsequently superseded by changes and removal of equipment in the areas involved. Outstanding actions are monitored each month by the Clinical Effectiveness Group and where appropriate any actions >90 days are escalated to the Quality Assurance Committee. Where actions are outstanding >31 days it is usual for these to achieve completion by the following reporting period.

- **KPI 10 - Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication** –The Trust position for quarter 3 is 16.67%, against a target of 50%, which reflects 1 baseline assessment tools out of 6 being signed off by CEG within 6 months of publication. This is an improved position than the quarter 2 position of 0%.

  Following concerns being raised about the continued validity of this indictor, the CEG are being asked to identify a more appropriate indicator.

3.3.2 Trust Business Plan

There were 27 business plan actions due to be completed by the end of quarter 3 of which 23 were rated green (85%) compared to the 16 actions due to be completed in Quarter 2, 15 actions rated green (94%).

There are 2 priorities / service development in the Business Plan at high risk of failure to deliver on-time or within budget.

- The 2 priorities, which contain 4 metrics, require removal from the business plan as the metrics have been subsumed within the operational and strategic programmes for North Yorkshire Transformation and New Care Models Project (to be agreed by Board).

There is a further metric in the Right Staff Priority which the Board is asked to remove.

Where a Board decision is required to change or remove an action, this is contained in Appendix 2 for approval

3.3.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- **Westwood Centre**, West Lane Hospital, Middlesbrough achieved accreditation for the next three years from the Quality Network for inpatient child and adolescent mental health services (CAMHS).
- The first of 3 CPA Kaizen events linked to the Model Ward project within Forensic Mental Health Services has been held. The event was attended by 2 service users who provided fantastic feedback.
- Some services have recently seen a 20% decrease in total incidents and there's been a 70% reduction in prone restraints in some wards. The Trust also works with our patients on 'positive behaviour support plans' to help prevent episodes of aggression from happening by understanding a person's behaviour.

3.3.4 In conclusion it can be seen for this strategic goal, that of the four KPIs that can be compared to quarter 1, three are rated red but all three have improved on the previous quarter. There are two Business Plan actions at high risk; however qualitative intelligence provides a more encouraging position. Further work is required around several KPIs including the number of outstanding action points for level 5 SIs to achieve a more positive position.

3.4 **Strategic Goal 3** - ***To recruit, develop and retain a skilled, compassionate and motivated workforce***

3.4.1 Trust Strategic Direction Scorecard

This strategic goal is showing 3 indicators rated red as at quarter 2 out of a possible 7 that could be rated. Whilst this indicates an improvement on the quarter 2 position, one of those rated last quarter could not be rated this month. Of those rated red, two have reported an improvement.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18												
	Indicator	Q2 Target 2017/18	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 3 (To recruit, develop and retain a skillled, compassionate and motivated workforce)												
15	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family as a place to work?"	>70.95%	72.00%	70.33%	No Staff FFT in Q3	n/a	>70.95%	71.11%	70.45%	70.95%	n/a	> previous year out-turn
16	Percentage of medical students and junior doctors reporting satisfaction with their placement	89.00%	90.77%	83.06%	83.51%	⇧	89.00%	86.04%	89.97%	89.09%	87.25%	90.00%
17	Percentage of positive nursing placement evaluations received	95.00%	95.20%	96.60%	95.40%	⇩	95.00%	95.20%	95.69%	95.17%	94.93%	95.00%
18	Excess cost of employing medical agency versus substantive	£75,000	£129,656	£102,028	£134,389	⇩	£150,000	£366,073	£697,684	£200k	n/a	zero
19	NHS Employers Assessment of Wellbeing	100%	100.00%	100.00%	100.00%	⇔	100%	100.00%	100.00%	100.00%	100.00%	100%
20	Percentage of Culture Metrics showing improvement at year end*	n/a	no longer reported	no longer reported	no longer reported	n/a	n/a	no longer reported	no longer reported	To be reported at July 16 Trust Board	16.67%	100%
21	Percentage of positive staff responses for training/development evaluations received (data is a month behind	75.00%	77.66%	82.57%	76.55%	⇩	75.00%	79.56%	74.18%	75.30%	deferred	TBC
22	Quality of Appraisals	>4.0	Results due in Q4	Results due in Q4	Results due in Q4	n/a	>4.0	Results due in Q4	4.00	3.36	49% but in top 20%	>= 2018/19 & in top 20%
23	Percentage of medical staff successfully revalidated	100%	100.00%	N/A	100.00%	n/a	100%	n/a	90.00%	98.15%	100.00%	100%
24	Percentage of indicators in the NHS Staff Survey for which there was no noticeable or sufficient different in responses of those who identified themselves as disabled, compared to those who did not identify themselves as disabled	>93.75%	Results due in Q4	Results due in Q4	Results due in Q4	n/a	>93.75%	Results due in Q4	93.75%	n/a		TBC
25	Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above	50%	34.29%	27.78%	30.77%	⇧	50.00%	25.00%	8.08%	32.00%	34.02%	80.00%
26	Percentage of staff reporting that they 'suffered work related stress in last 12 months'*	<2015/16 outturn (28%)	Results due in Q4	Results due in Q4	Results due in Q4	n/a	<2015/16 outturn (28%)	Results due in Q4	33.00%	28% and top 20% (best for MH/LD Trusts)	38% but in top 20% (DEC 14)	< previous year out-turn

Indicators of concern are:

- **KPI 16 – Percentage of medial students and junior doctors reporting satisfaction with their placement –** the Trust position of 83.51% is a slight improvement on 83.06% reported in quarter 2, but is below target by 5.49%

  Key themes in the narrative include:
  - The unavailability of patients to engage with students.
  - Travel issues between placements, time taken and expense incurred (no access to transport).
  - Lack of observed history taking opportunities
  - IT Induction too lengthy and not relevant
  - Formal Teaching intense over first 2 days
  - Lack of experience with community teams, mainly in-patient areas
  - No local induction to the wards (West Park)
  - Difference with supervisors/examiners across sites

Feedback is reviewed and some improvements have been made including the development of a new induction presentation, a review of the formal teaching content and monitoring of local induction techniques.

- **KPI 18 - Excess cost of employing medical agency versus substantive** - the Trust position for quarter 3 is £134,389 against a target of £75,00.

  As at the end of quarter 3, 12 agency staff were required to support vacancies in Durham and Darlington (2 MHSOP and 1 AMH), Teesside (1 CYPS), Forensic (1 FMH), North Yorkshire (2 MHSOP and 2 AMH) and York and Selby (2 MHSOP and 1 CYPS).

  Additional cover was also required to cover sickness in York and Selby (1 CYPS).

  As at month 9 (quarter 3) there would be a (£769k) surplus. However, this is due to 49.52 WTE vacancies which were offset by 13.85 WTE medical agency staff.

- **KPI 25 - Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above** – The Trust position for quarter 3 is 30.77%, which reflects 9 advertised posts out of 13 that did not have at least 2 internal candidates above the line for Band 7 posts and above. This is 19.23% below the target of 50% but is an improvement on the quarter 2 position of 27.78%

  Although still below target, there has been a small improvement in this quarter compared to the previous Trust positions. The month of October saw 40% of recruitment process for Band 7 and above management position that had 2 internal candidates above the line and November identified 33.3%. The Talent Management Board are continuing to focus on the development of internal staff. The combined appraisal and talent management documentation has also been launched in January 2018.

3.4.2 Trust Business Plan

There were 6 business plan actions due to be completed by the end of quarter 3 of which 5 were rated green (83%) compared to the 5 actions rated green (71%) in Quarter 2.

There were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget

.

There is 1 metric (3.7aa) that requires removal from the business plan due to the EFM Feasibility Study outcome (to be agreed by Board)

Where a Board decision is required to change or remove an action, this is contained in Appendix 2 for approval

3.4.3 Other Qualitative Intelligence

- **Simon Reidmilligan**, forensic psychologist, Roseberry Park, Middlesbrough and **Kate Freshwater,** lead for cognitive analytic therapy, Wessex House, Stockton-on-Tees presented the Using the model from Cognitive Analytic Therapy to aid relational thinking within staff teams and organisations – an example from a Forensic Setting workshop at the British Psychological Society annual conference for the Faculty of Psychosis and Complex Mental Health on 20 November in London.

- **Dr Mani Santhanakrishnan**, consultant psychiatrist, Lustrum Vale, Stockton won the Psychiatric Communicator of the Year award in the Royal College of Psychiatrists Awards.

- **Dr Megan Brown** won the Foundation Doctor of the Year award in the Royal College of Psychiatrists Awards, whilst completing her psychiatry rotation within the early intervention in psychosis team and the liaison psychiatry team in York.

- TEWV has been awarded Investors in People Gold Standard accreditation for a period of three years.

- **Dave Elletson**, York assertive outreach team, Huntington House Mental Health Resource Centre, York has been elected as Chair of the National Forum for Assertive Outreach.

- **Rebecca West,** York assertive outreach team, Huntington House Mental Health Resource Centre, York has been elected as Regional Representative for the National Forum for Assertive Outreach.

- The uptake of flu vaccination by 31.12.2017 was greater than the 2016/17 rates, with 57.35% of healthcare workers having been vaccinated (compared to 55.43 achieved in 2016/17).

3.4.4 In conclusion it can be seen for this strategic goal that the number of red KPIs has decreased by 1 since last quarter, with only one KPI rated red reporting an improvement. The Trust will continue to benefit from an increased focus on talent management. In addition, the Business Plan is showing a positive position, however one metric requires removal from the Business Plan due to the EFM Feasibility Study outcome. There is significant qualitative intelligence for this goal which adds to the very positive position.

3.5 Strategic Goal 4 - *To have effective partnerships with local, national and international organisations for the benefit of the communities we serve*

3.5.1 Trust Strategic Direction Scorecard

This strategic goal is showing no indicators rated red at quarter 3, which is an improvement on what we reported for quarter 2.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18												
	Indicator	Q2 Target 2017/18	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 4 (To have effective partnerships with local, national and international organisations for the benefit of the communities we serve)												
27	Attendance rate at H&WB Boards	90%	81.25%	75.00%	100.00%	⇧	90%	#VALUE!	85.71%	87.50%	97.06%	90%
28	Attendance rate at Statutory Safeguarding Boards & MAPPA Strategic Management Boards	98%	100.00%	100.00%	100.00%	⇔	98%	100.00%	100.00%	100.00%	98.59%	98%
29	Proportion of student nursing placements provided as a % of placements requested	90%	99.58%	97.51%	98.86%	⇧	90.00%	98.65%	100.26%	99.12%	99.77%	90.00%
30	R&D Outcomes - Annual number of recruits to National Institute of Health Research studies supported by TEWV R&D staff	n/a	539	393	153	⇩	n/a	1085	1105	412		10% increase year on year
31	R&D Outcomes - Annual external R&D income (including external grants and commercial income)	n/a	£168,674	£199,499	£154,590	⇩	£678,014	£154,590	£585,215	£616,376	n/a	10% increase year on year
32	Corporate Governance Statement signed off annually by Board with no conditions* and Monitor Governance Risk Rating maintained at 'GREEN' each quarter	n/a	no longer reported	no longer reported	No longer reported	n/a	n/a	No longer reported	No longer reported	Signed & Green	Signed & Green	Signed & Green

3.5.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 3 were rated green (100%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

3.5.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- A new centre for people experiencing a mental health crisis has opened in York. Organisation Mental Health Matters is to run **The Haven**, which opened in October and will give people somewhere to go for help and support out-of-hours. The centre was set up by the Trust after a joint bid by TEWV, City of York Council, and the Vale of York Clinical Commissioning.

- **Dementia Friendly Hartlepool**, a partnership group which includes TEWV, has been shortlisted as a finalist at the Alzheimer's Society Awards, Dementia Friendly Community of the Year category.

- The **consortium led by South Staffordshire and Shropshire FT** (the lead for the consortium of which TEWV is a member) were successful in the application to

retain provision of inpatients services for forces personnel. The new contract commences 1st December.

- NTW have been identified as the Lead Provider for CAMHS Forensic Outreach Services for the North East and TEWV will continue to provide services in Durham, Darlington and Teesside.

- **County Durham and Street Triage team**, have been shortlisted as a finalist in the NHS Collaboration award of the Health Business Awards 2017.

- The Trust was unsuccessful in its bids for the Durham Substance Misuse tender with Changing Lives and the Veterans tender with Northumberland, Tyne & Wear Foundation NHS Trust.

3.5.4 In conclusion, whilst two of the six KPIs have reported a deterioration compared to the previous quarter, taking into account progress against the Business Plan and the qualitative intelligence the overall position remains positive for this strategic goal.

3.6 Strategic Goal 5 - *To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve*

3.6.1 Trust Strategic Direction Scorecard

This strategic goal is showing 2 indicators rated red out of 7 as at quarter 3, which is the same as was reported in quarter 2.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18												
	Indicator	Q2 Target 2017/18	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 5 (To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve)												
33	Percentage of data quality issues reported on Data Quality Scorecard (reds on scorecard)	37.50%	71.43%	71.43%	71.43%	⇔	37.50%	71.43%	64.29%	57.14%	75.00%	<=6.25%
34	Percentage of Information Strategy metrics on target that are reported on Information Strategy Metrics Scorecard	81.25%	85.71%	71.43%	85.71%	⇧	81.25%	71.43%	81.25%	5 yr Strategy & metrics approved EMT March 2016	n/a	TBC
35	Percentage change in income for Trust contracted services compared to previous year	0.10%	-0.27%	-0.27%	0.43%	⇩	0.10%	0.43%	7.42%	8.09%	0.90%	Better than deflator
36	Reference Cost Index score for in-scope PbR Services	<=95	104	N/A	100	n/a	<=95	100	100	92	n/a	TBC
37	Reference Cost Index score for out of scope PbR Services	<=95	82	N/A	88	n/a	<=95	88	88	95		TBC
38	EBITDA **	7.00%	7.70%	7.20%	7.10%	⇧	7.70%	7.10%	7.79%	8.22%	8.73%	8.00%
39	Good Corporate Citizenship audit scores*	n/a	Due in Q4	Due in Q4	Due in Q4	n/a	70.00%	Due in Q4	66%	66.00%	51% (March 15)	75.00%

Indicators of concern are:

- **KPI 33 - Percentage of data quality issues reported on Data Quality Scorecard (reds on scorecard)** – The Trust position for quarter 3 is 71.43%, which is the same as reported in quarter 2 and 33.93% more than expected and therefore an underperformance.

  Of the 10 metrics reporting red, all have shown some improvement on quarter 2, with the exception of Missing Patient Gender and Assessment Date is before Referral Received data. The data quality scorecard will continue to be monitored at the Data Quality Working group and escalated to the Managing the Business Sub group as required.

- **KPI 36 – Reference cost index score for in-scope PbR services** - The Trust position for quarter 3 is 100%, which is 5% more than the target of <=95%, but is an improvement on the 104 reported for quarter 1.

  The reference cost index is based on all submissions across the country and hence is influenced by other providers' submissions. The in scope index has worsened primarily as a result of including the York and Selby locality for the first time.

3.6.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 3 were rated green (100%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

There is 1 metric (5.5) rated Grey that requires removal from the business plan as the actions have been subsumed within the Digital Transformation programme (to be agreed by Board).

3.6.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- **Roseberry Park** has won a safer car parks award.

- Winter Pressures Funding - Notification was received on 6th December that £20 million non-recurrent revenue funding had been identified from this year's winter resilience budget to be spent specifically on mental health-related system pressures. The focus of the investment was to secure improvements in A&E performance and patient care. A total of £275,707 was successfully bid for by the Trust, which will support additional activity in the following areas:

Teesside – C&YP Crisis & IHT
York – Admin Support to A&E Liaison
York – Digital Dictation
York – VCS Drug & Alcohol Support
North Yorkshire – A&E Liaison
North Yorkshire – Psychology in Primary Care

- In addition VoY CCG received an additional £65k which they intend to pass onto TEWV. NHSE will now be monitoring implementation on a fortnightly basis

3.6.4 In conclusion it can be seen for this strategic goal that of the 4 KPIs that could be compared to the previous quarter 2 have improved. Together with progress against the Business Plan and qualitative intelligence, the overall position remains positive.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
There are no issues of compliance with the CQC fundamental standards.

4.2 **Financial/Value for Money:**
The report highlights that none of the Sustainability metrics are below target.

4.3 **Legal and Constitutional (including the NHS Constitution):**
There are no direct legal or constitutional implications from this paper.

4.4 **Equality and Diversity:**
There are no direct equality and diversity implications from this paper, however, one metric does measure the variance in the responses of staff in the NHS Staff Survey who report as 'disabled' compared to those reporting 'non-disabled'.

4.4 **Other implications:**
There are no other implications associated with this paper.

5. RISKS:

There are no identified risks associated with this paper.

6. CONCLUSIONS:

This is the third Strategic Direction Performance Report for 2017/18 and reports progress against the Strategic Direction Scorecard and the Trust Business Plan whilst also considering other forms of qualitative intelligence.

Overall the scorecard position has shown an improvement when compared to quarter 2; however data is not available for all KPIs. This report reflects that two of the Trust's five goals are in a positive position, whilst still acknowledging that there is work to do to improve some KPI's. There has been an increase in the number of greens reported; however of the 12 KPIs reporting red at quarter 3, 4 have reported a

deterioration. Whilst 4 goals have reported an improvement in the numbers of reds compared to the position in quarter 2, it should be noted that within Goals 1 and 3 there has been a deterioration in individual KPI performance.

7. RECOMMENDATIONS:

Board of Directors is asked to:

- Approve the changes to the Trust Business Plan in Appendix 1.

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Sharon Pickering
Director of Planning & Performance

Background Papers:

Board requests for changes:

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Specialit y	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
1.7b	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - CAMHS PICU	Tees	CAMHS	Agree preferred option, financial / commissioning arrangements and timescales	Outline Business Case agreed by Resources Committee and Trust Board	Q3 17/18	Leah Allinson/Lis Stamp	**R**	PICU has now been paused to scope another option due to the current business case not being financially viable. **Trust board are therefore requested to a grant an extension to the business case to Q1 2018/19 this will have subsequent effect to other timescales which will be addressed in the Business case and once approved the key milestone will be incorporated in 18/19-20/21 business plan.**
1.7b	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - CAMHS PICU	Tees	CAMHS	Agree preferred option, financial / commissioning arrangements and timescales	Final Business Case agreed by Resources Committee and Trust Board	Q1 18/19	Leah Allinson / Lisa Stamp		**As per the above comment the Trust board are therefore requested to a grant an extension to 2018/19 Q3**
1.7b	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - CAMHS PICU	Tees	CAMHS	Building work starts	Construction commenced	~~Q1 18/19~~ Q3 18/19	Leah Allinson / Lisa Stamp		**As per the above comment the trust board are therefore requested to a grant an extension to 2019/20 Q1**
1.7b	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners -	Tees	CAMHS	PICU opens	Patients admitted to TEWV CAMHS PICU	~~Q3 18/19~~ Q4 18/19	Leah Allinson / Lisa Stamp		**As per the above comment the trust board are therefore requested to a grant an extension to 2019/20 Q3**

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Specialit y	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
	CAMHS PICU								
1.3a	Deliver a new model of care for Adult Mental Health and Mental Health Services for Older People in Harrogate	NY	AMH / MHSOP	Develop revised Service Model	Revised Service Model approved by TEWV Board and HaRD CCG	Q3 17/18	Adele Coulthard	R	**Trust Board are requested to approve the removal of this priority and action due to the work been subsumed in the Harrogate Transformation project (Service Reprovision) New actions are been drafted to be included in the 18/19-20/21 Business plan**
1.3b	Deliver a new model of care for Adult Mental Health and Mental Health Services for Older People in Hambleton and Richmondshire	NY	AMH/ MHSOP	Develop revised Service Model	Revised Service Model approved by TEWV Board and HRW CCG	Q3 17/18	Adele Coulthard	R	**Trust Board are requested to approve the removal of this priority and action due to the work been subsumed in the Hambleton & Richmondshire Transformation project New actions are been drafted to be included in the 18/19-20/21 Business plan**
2.7j	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - New models of care / Enhanced community services in NY	NY	AMH	Implement the new model of AMH community services	New service model in place	Q3 17/18	Liz Herring	R	**Trust Board are requested to approve the removal of this priority and action due to the work been subsumed in the North Yorkshire Transformation work**
2.7r	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners -	Forensic		Development of business case for a forensic community step-down facility	Business case submitted for approval at EMT	Q3 17/18	Steve Barlow	R	It is being discussed that this action should be incorporated within the New Care Models work (a similar element is included in the business case for

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Specialit y	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
	Community Step Down Facilities			based in the TEWV area					the Durham area) and as an element of the future bid for community services. **Therefore Trust Board are requested to approve the removal of this priority and action due to the work been subsumed in the New Care Models programme**
2.7r	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - Community Step Down Facilities	Forensic		Implement the project plan as set out in the business case	Planned actions delivered to timetable	TBC	Steve Barlow		**Trust Board are requested to approve the removal of this priority and action due to the work been subsumed in the New Care Models programme**
2.7r	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - Community Step Down Facilities	Forensic		Forensic step down community facility opens	Service users admitted to new Forensic step down community facility	TBC	Steve Barlow		**Trust Board are requested to approve the removal of this priority and action due to the work been subsumed in the New Care Models programme**
5.5	Ensure we address the issues with PARIS and clinical recording and maximise the benefits of existing Information Technology	COO	NA	ePR system able to generate full suite of patient letters	PARIS able to automatically generate standard letters to patients	Q3 17/18	David Brown	**GY**	**Trust Board are requested to approve the removal of this action due to the work been subsumed in the Digital transformation programme**
3.7aa	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners -	Estates	N/A	Implement recommendations and actions identified from feasibility study	Actions plan developed	Q4 17/18	Dave Turner	R	The Feasibility Study has been now been completed and has identified that a start from home system is not currently viable for EFM. It also identified that this

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Specialit y	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
	Start from Home process for identified facilities staff								will remain the situation for the near future. **Trust Board are requested to approve the removal of this priority and its associated actions on the basis of the Feasibility Study outcome**
2.4	Ensure we have Safe Staffing in all our services	Nursing and Governanc e	NA	Introduce a new report for ward managers which brings together data on staffing and other quality and recognised quality safety indicators	Report introduced	Q3 17/18	Elizabeth Moody	R	**Request that Trust Board approve the removal of this action due to the work been subsumed in the Right Staffing Programme –A programme of work has been summarised in the 2018/19-20/21 business plan**
1.2	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	COO	NA	Introduce new leadership development programme	New leadership development programme launched	Q3 17/18	David Brown	R	The sign off for this was delayed and some additional changes have been made following comments raised in the Recovery PB. The next opportunity for sign off by EMT will be Talent Management Board on the 31.1.18 **EMT have approved the extension of time to Q4 17/18**

ITEM NO. 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th February 2018**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	
To continuously improve the quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	✓

Executive Summary:

This report provides information on the use of the Trust Seal as required under Standing Order 15.6.

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**27th February 2018**
TITLE:	**Report on the Register of Sealing**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board of Directors of the use of the Trust's Seal in accordance with Standing Orders.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 An entry of every sealing is made and numbered consecutively in a Register specifically provided for the purpose. It is signed by the persons who have approved and authorised the document and those who attested the seal.

3. KEY ISSUES:

3.1 The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
330	13.02.18	Underlease relating to Gibraltar House, Northallerton	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** None identified.

4.2 **Financial/Value for Money:** None identified.

4.3 **Legal and Constitutional (including the NHS Constitution):** None identified.

4.4 **Equality and Diversity:** None identified.

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

7.1 The Board is asked to receive and note this report.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution
Seals Register

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27 February 2018**
TITLE:	**Policies Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	✓
To continuously improve to quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

The policy paper contains the following information:

- Two requests for authorisation to develop new policies
    - Information Incident Management Policy
    - Scanning Policy
- 5 policies requiring ratification:
    - IT-0022-v4 Telephone Usage Policy
    - CLIN-0020-v6 Professional Registration Policy
    - CORP-0058-v3 Intellectual Property Policy
    - IT-0010-v5 Information Security and Risk Policy
    - CLIN-0031-v5 Preceptorship Policy
- One policy that has undergone minor amendment:
    - IT-0011-v6.1 Registration Authority Policy
- One framework that has undergone full review with minor amendment:
    - Information Governance Handbook
- Two policies to be extended:
    - CORP-0038-v2 Interpreting and Translation Policy

- CORP-0011-v4 Claims Management Policy

- One strategy to be removed from the policy portfolio:
  - STRAT-0027-v1 Volunteering Strategy

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meeting held on 14 February 2018

DATE:	**27 February 2018**
TITLE:	**Policies and Procedures Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

1. INTRODUCTION & PURPOSE:

The purpose of this report is to advise the Board of Directors on the policies and procedures that have been ratified by the Executive Management Team.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 It is important that the Trust policy portfolio is updated and revised in a timely way to ensure best practice, current legislation and regulation is reflected in policy content. Policies no longer required to control and assure practice should be terminated and withdrawn from the portfolio.

2.2 Following the last revision of the Trust's Integrated Governance arrangements, it was agreed that the Executive Management Team ratify all new and revised Trust policies.

2.3 Each policy ratified by the Executive Management Team will have gone through the Trust's consultation process.

2.4 Currently all corporate Trust policies are ratified by the EMT on behalf of the Board of Directors, following approval by the appropriate specialist committees and groups. All decisions regarding the management of the policy framework must be ratified by the EMT.

3. KEY ISSUES:

3.1 Two requests were received for authorisation to develop new policies:

2018-01 Information Incident Management Policy

The Trust's Incident Reporting and Serious Incident Review Policy has been written to meet CQC guidelines, regulations and requirements for patient safety, and no longer contains requirements for managing information incidents.

General Data Protection Regulation strengthens the requirement for appropriate management of information incidents and learning lessons. This is supported by the Information governance toolkit which requires the reporting of incidents that are level 2 and above.

The Head of Patient Safety, Complaints, Legal and Claims, and Information Security Officer identified a separate policy specifically relating to information incidents would be the preferred option.

2018-02 Scanning Policy

The Trust is implementing multi-function devices which provide a scanning facility. However the Trust does not currently use scanning as part of its records management strategy. EMT approved strengthening the Records Management Policy to identify the Trust position regarding what staff can and can not do to ensure compliance with legal requirements with respect to scanning.

Records lifecycle management is a prime focus of the General Data Protection Regulation (GDPR). The fines that can be imposed under GDPR for information incidents can be up to 4% of annual turnover depending on severity.

3.2 The following policies have undergone full review and required ratification:

IT-0022-v4 Telephone Usage Policy
Review date: 14 February 2021

This policy has undergone full review with changes to job titles throughout.

CLIN-0020-v6 Professional Registration Policy
Review date: 14 February 2021

Section 2.2 0 has been reviewed and some of the boxes have been combined. Each appendix has been reviewed with the relevant professional lead to ensure information is up to date and accurate. The NMC new revalidation process has been included in Appendix 2.

CORP-0058-v3 Intellectual Property Policy
Review date: 14 February 2021

Full review with amendments following changes to research governance framework.

IT-0010-v5 Information Security and Risk Policy
Review date: 14 February 2021

This policy underwent full review in line with General Data Protection Regulation (GDPR). New section 3.2 regarding cyber security and technical measures. Roles and responsibilities revised.

CLIN-0031-v5 Preceptorship Policy
Review date: 14 February 2021

Full review in line with current professional requirements

3.3 The following underwent minor amendment:

IT-0011-v6.1 Registration Authority Policy
Review date: 14 February 2021

Full review with minor amendments.

3.4 The following framework underwent full review with minor amendment:

Information Governance Handbook and Framework

This was reviewed to include the following:

- Recent changes in the management of Information Governance areas. This has resulted from the Information Department re-structure which became effective on the 1st April 2017. For example, records management is now the responsibility of the Information Department's Systems Team.
- Describes the new governance structure.
- Making staff aware of the importance of confidentiality – raising awareness that privacy breaches are a criminal offence and that the Information Commissioner will take cases to court and pursue a prosecution
- Making staff aware of the imminent change in data protection law on the 25th May 2018 – General Data Protection Regulation will come into effect. This law strengthens the rights of 'data subjects'.
- Strengthening the importance and understanding cyber security.

3.5 The following were requested to be extended:

CORP-0038-v2 Interpreting and Translation Policy
Review date: 31 March 2019

This policy has been extended pending a contract review of the current service provision.

CORP-0011-v4 Claims Management Policy
Review date: 30 April 2018

This policy and related procedures are being reviewed in line with GDPR. An extension to the review date is required to enable this work to be completed.

3.6 The following is to be removed from the policy portfolio:

STRAT-0027-v1 Volunteering Strategy

This strategy is no longer relevant and will be replaced with a high level action plan

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Sound policy development improves patient experience and enhances patient safety and clinical effectiveness.

4.2 Financial/Value for Money:

Any financial implications from the proposals arising from operational and/or practice changes will be managed by the Directorates responsible for policy implementation.

4.3 Legal and Constitutional (including the NHS Constitution):

The Trust requires a contemporary policy portfolio to ensure practice is compliant with legislation, regulation and best practice. The policy ratifications, review extensions and withdrawals will ensure the portfolio is managed to provide the necessary evidence based operational and practice frameworks.

4.4 Equality and Diversity:

The current policy portfolio ensures the Trust meets the required legislative and regulatory frameworks and all policies are impact assessed for any equality and diversity implications. Policy revision and /or specific implementation plans would result from any adverse impact assessments.

4.5 Other implications:

None identified

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meeting on 14 February 2018 have been presented for ratification.

7. RECOMMENDATIONS:

The Board is required to ratify the decisions of the Executive Management Team and is requested to accept this report.

Author: Colin Martin
Title: Chief Executive