AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 29TH NOVEMBER 2016 VENUE: THE BOARD ROOM, 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 meetings of the Board of Directors held on **6th October** and **25th October 2016**.		**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 receive a briefing on key issues in the North Yorkshire Locality.	**Liz Herring, Acting Director of Operations, & Dr. Neil Mayfield, Deputy Medical Director, to attend**	**Presentation**
Item 7	To receive and note the Annual Report on Research and Development.	**NL**	**Attached**
Item 8	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 9	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 10	To receive and note an update report on nurse recruitment, development and retention.	**DL**	**Attached**
Item 11	To consider the report of the Mental Health Legislation Committee.	**RS/EM**	**Attached**
Item 12	To receive and note a progress report on the Composite Staff Action Plan.	**DL**	**Attached**

Item 13	To consider proposals on refreshing the approach to embedding the Trust's values.	**DL**	**Attached**
Item 14	To consider a report on re-accreditation under the Investors in People scheme.	**DL**	**Attached**

Performance (11.15 am)

Item 15	To consider the Finance Report as at 31st October 2016 including the Board self-certification on agency spending required by NHS Improvement.	**DK**	**Attached**
Item 16	To consider the Trust Performance Dashboard as at 31st October 2016.	**SP**	**Attached**
Item 17	To consider the Strategic Direction Performance Report for Quarter 2, 2016/17.	**SP**	**Attached**

Items for Information (11.35 am)

Item 18	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 19 To note that a special meeting of the Board of Directors will be held, in conjunction with a seminar, on Tuesday **20th December 2016** in the Board Room, West Park Hospital, Darlington at 9.30 am.

Confidential Motion (11.40 am)

Item 20 **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 any particular applicant for, or recipient or former recipient of, any financial assistance 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."

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
23rd November 2016

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

MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD ON 6TH OCTOBER 2016 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON COMMENCING AT 12.00 NOON

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Mr. J. Tucker, Deputy Chairman
Dr. H. Griffiths, Non-Executive Director
Mr. D. Jennings, 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, Chief Operating Officer and Deputy Chief Executive
Dr. N. Land, Medical Director
Mrs. E. Moody, Director of Nursing and Governance
Mr. D. Levy, Director of HR and Organisational Development (non-voting)

In Attendance:
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Mrs. M. Pears, Partner, Ward Hadaway LLP

16/244 APOLOGIES

Apologies for absence were received from Mr. M. Hawthorn, Senior Independent Director, Mr. P. Murphy, Non-Executive Director and Mrs. S. Pickering, Director of Planning, Performance and Communications.

16/245 DECLARATIONS OF INTEREST

There were no declarations of interest.

16/246 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 the financial or business affairs of any particular person (other than the Trust).

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, 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.

Following the transaction of the confidential business the meeting concluded at 1.45 pm.

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 25TH OCTOBER 2016 IN THE HILTON YORK, 1 TOWER STREET, YORK COMMENCING AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Mr. J. Tucker, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Dr. H. Griffiths, Non-Executive Director
Mr. D. Jennings, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Dr. N. Land, Medical Director
Mrs. E. Moody, Director of Nursing and Governance
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. N. Ayre
Dr. P. Harrison, Public Governor for York and Selby
Mr. K. Ramsey, Chairman of the Vale of York CCG
Mr. P. Bellas, Trust Secretary
Ms. A. Binns, Communications Manager
Mr. L. Buckley, Director of Operations for Forensic Services (representing Mr. Kilmurray).

16/250 APOLOGIES

Apologies for absence were received from Mrs. S. Richardson, Non-Executive Director, and Mr. B. Kilmurray, Chief Operating Officer and Deputy Chief Executive.

16/251 MINUTES

Agreed *– that the public minutes of the special meeting held on 13th September 2016 and the last ordinary meeting held on 27th September 2016 be approved as correct records and signed by the Chairman.*

16/252 PUBLIC BOARD ACTION LOG

Further to minute 16/183 (21/7/16) the Board noted that proposals to enhance Directors' visits, including increasing staff engagement, were due to be considered by the Executive Management Team (EMT) on 26th October 2016.

There were no other outstanding matters contained in the Action Log.

16/253 DECLARATIONS OF INTEREST

There were no declarations of interest.

16/254 CHAIRMAN'S REPORT

The Chairman reported on her activities since the last ordinary meeting as follows:

(1) Attended a meeting with the Trust Chairmen for the North East Region on 13th October 2016.

It was noted that:
(a) Discussions at the meeting had focussed on the development of the Sustainability and Transformation Plans (STPs) and the implications of financial control totals.
(b) The meeting had been the first to be held for some time and it was intended that regular meetings should be re-instated.

(2) Presented "Living the Values" awards to a nurse on Maple Ward and the KPO team.

(3) Visited the community mental health teams in Harrogate.

16/255 GOVERNOR ISSUES

No issues were raised.

16/256 QUALITY ASSURANCE COMMITTEE

The Board received and noted the report of the Quality Assurance Committee (QuAC) including:
(1) The confirmed minutes of its meeting held on 1st September 2016 (Appendix 1 to the report).
(2) The key issues discussed by the Committee at its meeting held on 6th October 2016.

Dr. Griffiths, the Chairman of the Committee, and Mrs. Moody drew attention to the following matters contained in the report:

(1) The Committee's concerns about waiting times for autism services.

In relation to this matter Mrs. Pickering provided an overview of autism services commissioned across the Trust, which were variable and did not meet demand in any Locality; the action being taken by the Trust to support people waiting for the services; and the discussions being held with Commissioners to improve services.

It was also noted that the EMT had approved a project to develop the Trust's overall strategic and clinical response to autism.

(2) The Committee's discussions on changes to serious incident processes and action planning to improve assurance and learning lessons.

In addition, the Board discussed:

(1) The preparations for the unannounced re-inspection by the Care Quality Commission (CQC) which it was anticipated would take place during Quarter 4, 2016/17.

The Board received assurance that the EMT had approved a programme of actions in preparation for the re-inspection. These, in summary, included:

(a) A briefing provided by the compliance team to the Trustwide matrons' group on the themes arising from the inspection in 2015 and the likely areas to be considered by the CQC during its re-inspection.
(b) The re-instatement of the CQC operational group.
(c) The ongoing programme of mock inspections by peer review.
(d) The provision of additional capacity to support preparations for the re-inspection, including developing communications with staff, through Ms. Christine McCann, Associate Director of Nursing and Governance, who had led on the arrangements for the 2015 inspection, being released from her usual duties.

(2) The action being taken to address the material differences in responses to the staff survey between white and black and minority ethnic (BAME) staff.

Mr. Levy advised that a number of actions were being taken including:

(a) The establishment of a group to seek to strengthen engagement with BAME staff, an issue which the Trust had struggled with in the past.
(b) The commissioning of research to seek to better understand the reasons for the differences in responses to the staff survey between staff groups.
(c) The introduction of training on unconscious bias in recruitment.
(d) Facilitated discussions with the leadership and management network to raise awareness and seek comments on the issue.

(3) The engagement with patients on the management of their complaints.

Mrs. Moody assured the Board that patients raising complaints would receive both verbal and written explanations of how their complaints had been dealt with.

In response to a question, the Board noted that the EIP service in York and Selby was provided under a sub-contract which had been novated to the Trust when it had commenced the contract for the provision of services in the Locality.

16/257 NURSE STAFFING REPORT

The Board received and noted the report on nurse staffing for September 2016 as required to meet the commitments of "Hard Truths", the Government's response to the Public Inquiry into Mid Staffordshire NHS Foundation Trust (the "Francis Review").

The focus of discussions was on the difficulties being experienced by the Trust in recruiting sufficient qualified staff.

The Board recognised that there was a need, nationally, to increase the supply of registered nurses and other qualified staff (e.g. AHPs).

Consideration was given to the risks to the future supply of qualified staff both generally; in learning disability services, where there were particular issues as a result of the universities reducing the in-take of, or closing, specialist training courses and due to the specialty being an unattractive option for students; and for those staff with specific skills in response to the increasing demand for bespoke packages of care for extremely complex patients.

The Board received assurance that the Trust was working with the universities and Local Workforce Action Boards to seek to address these risks.

It was noted that the effect of the withdrawal of the nurse bursary was unknown, at this time, but discussions with Teesside University suggested that it might not be as significant as first thought.

Mrs. Moody highlighted that:

(1) Efforts to increase the supply of qualified staff would not have an impact until 2020 at the earliest, due to the length of university courses, and the Trust's ability to manage in the interim would be crucial.

(2) In addition to increasing supply, the availability of training places needed to be considered as this was becoming more challenging, particularly in learning disability services as a result of the Transforming Care agenda.

Consideration was also given to:

(1) The level of challenging behaviour being experienced at the Westwood Centre.

In response to questions it was noted that:

(a) The level of challenging behaviour at the Centre varied based on the patient mix at any time.

(b) In August 2016 there had been a spike in the use of restraint at the Centre. Whilst this had reduced in September 2016, the ward remained an outlier in comparison to other wards.

In relation to this matter Dr. Land advised that, due to service reductions and closures elsewhere, the complexity of young people referred to the Westwood Centre had increased and, for some, the service was inappropriate for their needs. The Trust was, therefore, working with Commissioners to seek to establish a PICU for those young people who posed a significant risk and who did not fit into existing services.

(2) Whether there were any common factors between Worsley Court, Cherry Tree House and Hamsterley Ward, apart from being MSHOP wards, which could explain the incidence of level 4 serious incidents (SIs) they had experienced during the reporting period.

Mrs. Moody advised that:

(a) Apart from their specialty, there were no common themes connecting the wards.

(b) As MHSOP wards, it was likely that the level 4 SIs related to falls.

(3) Whether there had been any impact on staffing arising from the result of the referendum to leave the European Union (EU).

It was noted that there had been no impact, to date, from the outcome of the referendum and the Trust had been seeking to reassure and support staff from other European counties due to their concerns about being able to continue to work in this country in the future.

However, it was recognised that recruiting staff from other European countries was likely to become more difficult. A number of other factors e.g. the junior doctors' contract dispute, pension changes, etc. were also likely to impact on the medical workforce and make emigration more attractive.

Mr. Levy advised that a coalition of health and social care organisations, the Cavendish Coalition, had been created to ensure sustainable workforce supply and thereby maintain standards of care as Britain withdrew from the EU. This initiative was being supported by the Royal Colleges and NHS England.

16/258 ANNUAL REPORT ON MEDICAL EDUCATION

The Board received and noted the Annual Report on medical education which included:

(1) An update on activity in the last twelve months and an outline of key priorities for the next year.

(2) The annual statement from the Guardian of Safe Working about the plans to meet the conditions set out in the new junior doctor contract that was due to be in place from February 2017 in the Trust.

The Board recognised the Trust's impressive performance on medical education as shown by the results of the HENE GMC Trainee Survey, the GMC Trainee Survey and the GMC Trainer Survey and asked for its appreciation to be passed on to the staff in the medical education department.

The Board's discussions focused on the recruitment of doctors from overseas.

In relation to this matter Dr. Land reported that overseas recruitment had, to date, been concentrated on:

(1) European Countries due to this being considered ethical in the context of the number of doctors trained and freedom of movement.

(2) India, in view of the existing links between medical staff and universities in that country.

In response to a question, it was noted that, in recognition of the ethical issues arising from recruiting doctors from India, the Trust was exploring the development of a partnership approach whereby doctors would undertake training with the Trust before returning to practise in their country.

Dr. Land also agreed with the Chairman's suggestion that it would be beneficial to explore the existing international links of local universities to support overseas medical recruitment.

Action: Dr. Land

In addition, in response to questions, Dr. Land:

(1) Advised that:
   (a) There was an expectation that the Guardian of Safe Working would report to the Board on, at least, an annual basis.
   (b) The Guardian of Safe Working was employed by the Trust but was required to be independent of the medical education department and clinical management.

(2) Provided the Board with an update on the implications for the Trust of the new junior doctors' contract.

The Board noted that the new contract, whilst resulting in additional bureaucracy and expenditure, might have some benefits for the Trust including supporting the retention of core trainees.

16/259 SUMMARY FINANCE REPORT AS AT 30TH SEPTEMBER 2016

The Board received and noted the Summary Finance Report as at 30th September 2016.

16/260 PERFORMANCE DASHBOARD AS AT 30TH SEPTEMBER 2016

The Board received and noted the Performance Dashboard Report as at 30th September 2016.

Mrs. Pickering:

(1) Apologised for the late circulation of the report which had been caused by technical issues.

(2) Advised, with regard to KPI 7, that:
   (a) As discussed under minute 16/126 (24/5/16) as the indicator was based on those people seen who had waited less than four weeks, as the group of people waiting longer than this were seen, there was likely to be a temporary dip in performance.
   (b) Some additional funding had been made available by NHS England to support the reduction of waiting times in children and young people's services and the Trust was working with the CCGs to develop bids for these resources.

Board Members raised the following matters:

(1) Whether there were any particular "hot spots" in relation to sickness absence rates.

It was noted that this issue had been highlighted in the report as a key risk for the first time.

Mr. Levy advised that:

(a) The increase in the sickness absence rates reflected a long term trend and was considered to be linked to the pace of work and the demands being placed on staff.

(b) There were variations between Localities (but these were not consistent over time) and between staff groups with registered nurses and staff in inpatient services having higher sickness absence rates.
(c) The Trust had taken steps to address long-term sickness absence.
(d) Work, in future, would be focussed on prevention and the consistent and robust application of procedures in relation to short-term sickness absence.

(2) Their concerns about admission and occupancy levels.

The Board noted that it was anticipated that the opening of Peppermill Court and the 'reboot' of the Purposeful Inpatient Admissions (PIPA) processes would have a positive impact on performance.

However, the Chairman considered that, unless there were radical changes in the provision of social care provision in the country, it was unlikely that the problems being experienced would be resolved.

In relation to this matter it was noted that:
(a) There were now no MHSOP nursing home beds in Hartlepool and this would have implications for other areas.
(b) Mr. Martin and Mrs. Coulthard (Director of Operations for North Yorkshire) had held discussions with North Yorkshire County Council on the actions which could be taken jointly by the organisations to ameliorate the difficulties being experienced in the Locality.
(c) The issue of nursing home provision had been raised during the Chairman's conversation with Cllr Runciman, the Executive Member for Adult Social Care and Health for York City Council (minute 16/124 – 27/9/16 refers).

Mr. Martin reported that, in the York and Selby Locality, there were approximately 20 patients in Trust beds whose discharges were delayed and that this had been the position since June 2016. He assured the Board that the Trust was working with the local authoritiy to seek to address this matter on a case by case basis.

Mr. Martin also advised that it would be interesting to see if additional resources would be made available for social care in the Autumn Statement.

(3) The referral rates in North Yorkshire as the monthly and year to date figures were the highest of all the Localities.

In response to questions:
(a) Mrs. Pickering undertook to check whether the referral rate in North Yorkshire, as a proportion of the population, was the highest of all the Localities.

Action: Mrs. Pickering

(b) It was noted that the lower investment in NHS services and the social/voluntary sector being less robust than elsewhere, might contribute to the higher levels of referrals in the Locality.

16/261 QUARTERLY WORKFORCE REPORT

The Board received and noted the Workforce Report for the period July to September 2016 including:

(1) Information about the medical workforce (Appendix 1 to the report).
(2) Information about the non-medical workforce (Appendix 2 to the report).
(3) The results of the Trust's Staff Friends and Family Test (FFT) for Quarter 2, 2016/17 (Appendix 3 to the report).

Arising from the report Board Members raised the following matters:

(1) The low levels of applications received during recruitment exercises for medical staff as shown in Appendix 1 to the report.

Dr. Land:

(a) Advised that:
- For 19 positions advertised during July to September 2016 the Trust had only made six good appointments.
- There was still an acceptable level of medical staff in posts, including in comparison to other Trusts.
- The Trust was continuing with its efforts to make TEWV a great place to work.

(b) Assured the Board that robust appointment processes were being maintained.
(c) Reported that, over the last six months, the Trust had changed the way it engaged locums and this had led to a reduction in costs and an improvement in quality.

(2) The statement in Appendix 1 to the report that "… it's quite evident that North Yorkshire and York and Selby highly favour European doctors" in view of concerns that this might be perceived as discriminatory.

Dr. Land assured the Board that recruitment processes were non-discriminatory and consultants, of any nationality, were welcomed. He considered that the statement in the report reflected the comparatively high proportion of doctors from the EU working in the Locality.

(3) The latest position on the number of staff taking five or more episodes of sickness absence in a 12 month period.

Mr. Levy responded that work was being undertaken to seek to identify the present position on this matter and to ensure that Trust procedures were being correctly applied as there were indications that the management of short-term sickness absence might not be robust in some areas.

(4) The performance of duties where consultant vacancies were not covered, as highlighted in Table 2 to Appendix 1 to the report.

Dr. Land explained that in these cases the duties would, usually, be covered by existing consultants through "mind the gap" arrangements.

He also advised that, for junior doctors, the Trust might choose not to provide cover for supernumerary positions.

(5) The timeliness of appeals in view of four of the five submitted cases, which took place between October 2015 and September 2016, remaining to be heard.

Mr. Levy recognised there had been some delays in hearing appeals but advised that this could be due to a number of reasons including the appellants not being available due to ill-health.

(6) The action being taken to ensure that the results of the friends and family test (FFT) were disaggregated so that negative comments, particularly those relating to bullying and harassment, could be addressed.

In response the Board noted the arrangements which had been put in place to improve response rates to the survey; to provide wards and teams with a breakdown of their FFT results enabling them to respond to any issues raised; and for the consideration of FFT results within the Trust's governance structures.

However, Mr. Levy advised that there were variations in the levels of engagement across the Localities and he was seeking to review the Trust's approach to this matter with the Directors of Operations.

(7) Whether further action could be taken by the Trust to support staff with their own mental wellbeing in view of the level of sickness absence attributed to stress and anxiety.

Mr. Levy assured the Board that the Trust had a greater understanding of this issue and had put in place a number of measures to support staff, including the recent decision to strengthen the employee psychology service. However, he recognised that pressure on staff was increasing and the further actions available to the Trust in this area were limited.

16/262 USE OF THE TRUST SEAL

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

16/263 DATE AND TIME OF NEXT MEETING

It was noted that the next ordinary meeting was due to be held, in public, at 9.30 am on Tuesday, 29th November 2016 in the Board Room, West Park Hospital, Darlington.

16/264 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.

The amount of any expenditure proposed to be incurred by the Trust under any particular contract for the acquisition of property or the supply of goods or services.

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.

Following the transaction of the confidential business the meeting concluded at 12.30 pm.

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29th November 2016**
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

Date	Minute No.	Action	Owner(s)	Timescale	Status
26/04/2016	16/94	Report to be provided to the Board on the impact and lessons learnt from the Safe Staffing Project	EM	Nov-16	See Agenda Item 9
24/05/2016	16/121	Dr. Alison Brabban to be invited to provide a briefing on the Recovery Programme when the business case for its next phase of development is due to be considered by the Board	BK/PB	Dec-16	
24/05/2016	16/121	The Experts by Experience to be invited to attend Board Seminars to provide their stories	BK/PB	Dec-16	
24/05/2016	16/123	A briefing on human rights to be provided to a future Board Seminar	DL/PB	Mar-17	
24/05/2016	16/127	A progress report on the Composite Action Plan to be presented to the Board	DL	Nov-16	See Agenda Item 12
21/06/2016	16/160	A further report on nurse recruitment, development and retention. Including forecast data, to be presented to the Board	DL	Nov-16	See Agenda Item 10
21/07/2016	16/176	A briefing on pathways to be provided to a Board Seminar	BK/PB	Apr-17	
21/07/2016	16/181	A Board Seminar to be held on the topic of assurance	CM/PB	Nov-16	Completed
21/07/2016	16/183	The approach taken by East London NHS Foundation Trust to Directors' visits to be revisited to seek further learning	CM	Dec-16	

Date	Minute No.	Action	Owner(s)	Timescale	Status
21/07/2016	16/187	Proposals to be brought forward on refreshing the approach to embedding the Trust's values including working with the DoN&G to ensure it is more aligned to feedback provided by patients and carers	DL	Nov-16	See Agenda Item 13
27/09/2016	16/217	Report to be presented to a future Board meeting to provide assurance that initiatives being undertaken have mitigated staffing risks in Forensic Services	BK	Dec-16	
27/09/2016	16/218	Automatic reporting of seclusion from the PARIS system to be urgently addressed	DK	Dec-16	
27/09/2016	16/219	Future reports on waiting times in CAMHS to include information on the funding of the services in each Locality	BK	Jan-17	
27/09/2016	16/219	A further report on waiting times in CAMHS to be presented to the Board	BK	Jan-17	
27/09/2016	16/222	A further review of the performance dashboard targets to be undertaken	SP	Nov-16	See Agenda Item 16
27/09/2016	16/223	Work to be undertaken to seek further understanding of why some staff are taking positions at lower grades	DL	Jan-17	
25/10/2016	16/258	The existing international links of local universities to support overseas medical recruitment to be explored	NL	Feb-17	
25/10/2016	16/260	The referral rate in North Yorkshire, as a proportion of the population, to be checked to ascertain whether it is the highest of all the Localities.	SP	-	Completed

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

North Yorkshire Locality Board Presentation 29 November 2016

Dr Liz Herring

Acting Director of Operations

making a difference together

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

- Proud
  - CQC Feedback
  - Awards
  - Service developments
    - T3 CAMHS eating disorders
    - Single Point of Access in CAMHS
  - IAPT performance improvement
  - Staff resilience
  - Clinical & service Leadership
- Progressing
  - All age crisis triage & response
  - Memory service model
  - Clinical Leadership
  - Capital development decisions
  - HR CCG – transforming mental health

To continuously improve the quality and value of our work.

- QIS
  - PPCS
  - PIPA reboot within our inpatients
  - LD Transformation
- Participation in research growing across AMH & MHSOP
- Productivity
  - Clearer line of sight on our team efficiency
  - Information is shaping our decision-making on service delivery

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

- Recruitment Issues
  - Qualified nursing staff
  - Medical staff in certain geographic areas
  - Bespoke nursing bank for the localities
- Retention Issues
  - Retirements
  - Career progressions
- Skill, compassion and motivation issues
  - Compassion in practice
  - Nurse development programme
  - Inpatient development days

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

- Local
  - Harrogate Vanguard
  - MHCCC
  - ‘Transforming care’
- National
  - IAPT
- International
  - No formal links internationally

To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of our communities.

- Performance
  - CAMHS waiting times
  - Access performance
  - Financial balance – locum and agency costs
  - Access to nursing homes provision - DTOC
  - Out of Area admissions reducing
  - Geographical challenges linked to workforce
- LMGB
  - Structured oversight & quality assurance
  - QAGs – managing a broad range of issues
  - Good sense of team

ITEM 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29th November 2016**
TITLE:	**Research and Development Annual Report 2016**
REPORT OF:	**Dr Nick Land, Medical Director**
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:

The Trust is committed to supporting and promoting research opportunities across all of our services and localities. The more research active we are as a Trust the better care we will provide. Our involvement in large-scale clinical trials continues to give service users and carers access to treatments at the forefront of knowledge. In our work with the National Institute for Health Research (NIHR) and our collaboration with national and international academic partners, we contribute to the worldwide evidence base for mental health care. We seek to create a culture of enquiry within our services which welcomes innovation and challenge. Research conducted in the Trust is compliant with the NHS Research Governance Framework and meets required quality and governance standards. The Trust's 2015-2020 R&D strategic priorities are being implemented, including the critical area of academic partnership development. This report outlines activity for the period April 2015 to March 2016, and given the rapid rate of change in the local research context, also describes key areas of progress so far in 2016/17.

Recommendations:

The Board is asked to receive the 2016 Research and Development Report.

MEETING OF:	**Board of Directors**
DATE:	**29 November 2016**
TITLE:	**Research and Development Annual Report**

1. INTRODUCTION & PURPOSE:

- To report on Research and Development activity for the period April 2015 to March 2016.
- To give an update on key progress areas during the course of 2016/17.

2. BACKGROUND INFORMATION AND CONTEXT:

In November 2015 the Board approved a new Trust R&D Strategy with the following five goals:

1. Maintain excellent performance in the governance, management and delivery of research.
2. Move from collaboration to leadership in research.
3. Ensure that our research drives improvement in care.
4. Embed research access and participation in all geographies and specialties of the Trust's services
5. Substantial growth in research-related income for the Trust

Three key priority areas for implementation were agreed- public and patient involvement, development of the R&D workforce, and academic leadership of externally funded programmes of research.

In October 2015 the Trust began provision of mental health services to the York and Selby Locality. This brought the clinical academic workforce of the Mental Health and Addictions Research Group at the University of York into the Trust, including Professor Simon Gilbody, Head of the University's Mental Health and Addiction Research Group.

In November 2015 Durham University announced its intentions to review both the function and future of the University's Queen's Campus, where the Mental Health Research Group was sited, and also the future of the School of Medicine, Pharmacy and Health as a whole. In March 2016 the Trust made a decision not to invest further in academic posts at Durham University given strategic uncertainty amongst other considerations.

3. KEY ISSUES:

3.1. Research Governance activity in 2015/16

Research conducted in the Trust remained compliant with the NHS Research Governance Framework and meets required quality and governance standards. In acquiring new services in the York and Selby locality, we worked closely with Leeds and York Partnership NHSFT to ensure a smooth transition in the oversight and support for ongoing research studies and issued letters of access for researchers

who required continued access to research participants in TEWV. In 2015/16 a total of 47 research studies were approved for conduct in the Trust. Of these 20 were on the NIHR portfolio, the national list of externally funded studies of high quality. 27 non-portfolio studies (most frequently undertaken as part of a postgraduate masters or doctoral qualification) were approved. The time from receipt of a valid application to study approval for conduct in the Trust is externally monitored by the NIHR CRN. In 2015/16, the national target was 30 days; the Trust achieved a median approval time of 8 days.

The Trust's Standard Operating Procedures for research are published on the intranet and Principal Investigators agree compliance to these procedures on taking responsibility for a study. Researchers conducting clinical studies within the Trust are required to undergo the Good Clinical Practice training to ensure their knowledge and expertise in research conduct. In 2015/16 the Research Governance Group sought and achieved representation from every Service Development Group to ensure a communication link between the Group and the Trust's specialties, together with advocacy and support for clinicians in research.

3.2. Research study activity 2015/16

Recruitment to NIHR (National Institute of Health Research) studies in 15/16 totalled 404 participants. The recruitment was an increase from the 270 recruits achieved in 14/15 but remained lower than our average for previous years. The TEWV R&D department continued to receive funding for staff to recruit to studies in other NHS Trusts in the region, including 9 recruited participants to new studies at South Tees NHS Foundation Trust and following up a cohort of patients for the PROBAND Parkinson's disease study. Studies currently open to recruitment are listed on the Trust's Research and Development web pages.

3.3. Organisational Change

To prepare for an anticipated reduction in Clinical Research Network funding whilst meeting the requirement to cover a larger geographical area to include the new York and Selby locality, the R&D department undertook an organisational change to improve productivity whilst reducing cost. A new structure has incorporated a more balanced skill mix with locality based research assistants. Clinical Studies Officers remain responsible for providing dedicated support for Specialty groups. The new model was implemented in April 2016.

Dr Paul Blenkiron, consultant in adult psychiatry in York and Selby was appointed to the post of Associate Clinical Director for R&D, succeeding Dr Paul Tiffin on his taking up his NIHR fellowship at the University of York.

3.4. Pharmacy Infrastructure for Clinical Trials

As part of the EMT approved business case to setup a clinical trials pharmacy, we were successful in appointing a Senior Pharmacy Technician in August 2015 and the Senior Pharmacist for R&D in November 2015. The appointment to these posts enabled the refit of the Clinical Trials Pharmacy room at West Park Hospital and the

completion of standard operating procedures for how pharmacy will operate to support future Clinical Trials in the Trust. The pharmacy team are now instrumental in the review of potential new pharmaceutical studies.

3.5. Key Developments April to November 2017

3.5.1. **Research Governance Exception Reporting.** During the course of 2016 new national arrangements for research approvals have been implemented by the Health Research Authority (HRA). The Trust was informed that information governance assessment would in future be conducted centrally, eliminating the need for local Caldicott permissions for research studies in TEWV. The Trust's R&D Department monitored the implementation of this process and concluded that central implementation had not been achieved to the expected timescale. Following discussion with the Caldicott Guardian, it was agreed to reinstate the TEWV Caldicott review process for research studies, which involved the collection or transfer of personal identifiable data outside the organisation. This exception report was included in the Quality and Assurance Committee's report to the Board in October 2016.

3.5.2. **Research results.** The results of two substantial multicentre studies in which the Trust was a site were published in July 2016 with significant clinical implications. The PEPS study of psychoeducation and problem solving in personality disorder showed no impact of this intervention on the social functioning of service users in the community despite its promising effects in earlier research. The COBRA study of behavioural activation compared with cognitive behavioural therapy in primary care depression showed that a simpler intervention could be just as clinically effective and more cost-effective than standard CBT. The study's publication in the Lancet received global attention. Clinicians taking on the role of Principal Investigators for studies are required to summarise results so they can be made available across the Trust where relevant. The dissemination and use of research results will be a focus for the R&D Department during 2017, including a Trust Research Results Day in March.

3.5.3. **Serious Incident Report and Action Plan Completion.** In 2015 a participant in the LABILE trial of lamotrigine versus placebo in borderline personality disorder died during study follow up. The investigation's findings identified a need for improved communication between the R&D Team and clinical teams on the roles and responsibilities of research staff. R&D actions were fully complete by the end of June 2016.

3.5.4. **Patient and Public Involvement**. The R&D team has worked closely with the Trust PPI team to involve a greater number of service users and carers in research. This has included service user representation at the Trust's Research Governance Group and greater involvement in local study management groups. The ARCH Recovery College is hosting a first Research Awareness Course in November 2016 led jointly by R&D staff and a service user with research experience.

3.5.5**. Contribution to NIHR Clinical Research Network**. 2016/17 NIHR participant recruitment has greatly exceeded the previous two years, standing at 615

participants for the period 1 April to 21 November 2016. In line with its R&D strategy, the Trust has engaged in a wider range of studies across specialties, including the highly successful Extending Working Lives study, led by the Trust's Director of Human Resources and Organisational Development, David Levy. At the time of writing the Trust is the leading mental health provider in participant recruitment in the North East and Cumbria, and is 5th highest recruiter of the 13 Trusts in the North East's NIHR Clinical Research Network. The Trust's Non-Executive Director Dr Hugh Griffiths now represents the Trust at the Network's Non-Executives' group. Prof Joe Reilly stepped down from his regional NIHR Clinical Research Network role in July 2016, having established a project to devolve decision-making on dementia and mental health resource allocation to a joint grouping of network leads and Trust R&D directors.

3.5.6. **Esketamine 3004 commercial study**. As part of our aim to gain access to new treatments for service users, the Trust became an active site in this global study of intranasal esketamine for treatment-resistant depression, with Principal Investigator Dr Angus Bell. We have adopted the innovative approach of using the Trust's Ryedale Suite at Roseberry Park to conduct the study. The intensive monitoring required for electroconvulsive therapy conforms very well to the requirements for complex clinical trials, and we have been able to build on Dr Bell's established experience of intravenous ketamine treatment. Having identified an infrastructure to conduct trials of complex treatments in depression, we now have the capacity to be involved in large scale multicentre NIHR grant applications for other new treatments, including direct cranial stimulation.

3.5.7. **Durham University Organisational Change**. After a process of consultation the University confirmed the outcome in July 2016 of its reviews of the Queen's Campus and the School of Medicine, Pharmacy and Health. Undergraduate and postgraduate research will no longer take place at the Queen's Campus, which will be repurposed as an International Foundation Centre. The School of Medicine, Pharmacy and Health will be transferred to the University of Newcastle from August 2017.

The transfer of the School to Newcastle and the end of Trust investment in academic posts will lead to the closure of the Durham University Mental Health Research Group early in 2017. Collaboration with the University will continue, including the supervision of senior Trust clinicians who are completing PhD's. The achievements of the Mental Health Research Group were considerable and our progress as a research organisation would have been much slower without this substantial academic partnership. A number of Group members have been successful in securing new opportunities both within the Trust and with other institutions. Michael Sykes, a previous member of the Group, has recently been awarded an NIHR Doctoral Fellowship with the University of Newcastle. The Mental Health Research Group's first large-scale Chief Investigator-led grant was won by Dr Dave Ekers, Senior Lecturer and Nurse Consultant, in 2016. His CHEMIST study of collaborative care for depression will use community pharmacies as an innovative site of delivery of this intervention, and collaboration will continue with pharmacy academic colleagues on their move to Newcastle. The study will also involve continuing close collaboration with the University of York.

3.5.8. **Closer Collaboration with the University of York**. There have been a significant number of developments over the course of 2016 as follows:

- Dr Paul Tiffin, Reader in Psychometric Epidemiology and Consultant Psychiatrist with the Trust, moved from Durham University to the University of York to take up an £800k five year NIHR Career Development Fellowship in the analysis of health workforce education datasets.
- The University appointed a Reader in Mental Health, Dr Lina Gega, with participation and support from the Trust. Dr Gega is a highly experienced clinical nurse researcher with expertise in digital applications in mental health and the mental health of young people, and will be making a clinical contribution in the Trust.
- The Trust has collaborated with Professor Simon Gilbody to recruit participants to the SCIMITAR PLUS trial of enhanced smoking cessation in severe mental illness.
- Professor Martin Webber of the University's Social Policy unit has been successful together with Prof Stefan Priebe of Queen Mary's University London in winning an NIHR Programme Grant, entitled SCENE. The SCENE programme will develop and trial a social connectedness intervention in people with psychosis. The Trust will be substantially involved as a site over the next five years.
- Dr David Ekers and Prof Joe Reilly have been awarded honorary appointments with the University's Mental Health and Addiction Research Group, as Honorary Senior Clinical Fellow and Honorary Visiting Professor respectively.
- The Trust has indicated its willingness to collaborate closely with the University at senior meetings with the Vice Chancellor and colleagues, and further plans in this regard are expected during 2017. Further large scale collaborative grant applications are in process.

4. IMPLICATIONS/RISKS:

4.1 Compliance with the CQC Fundamental Standards:

Research activity in the Trust is compliant with CQC Fundamental Standards.

4.2 Financial/Value for Money:

The Trusts external research income for 15/16 was £686,317 which was a reduction from the 14/15 income of £849,000. Funding from the Clinical Research Network remained stable but with the anticipation of potentially further reductions in future due to reduced participant recruitment over two years. The main factor underlying reduced income was the expected completion of a number of large scale fixed term external grants from NIHR. The following table shows the type and funding source for external income.

Description	Funder	Amount
Research support funding	NIHR Clinical Research Network North East and North Cumbria	£450,487
TRANSITIONS study	NIHR Programme Grant for Applied Research	£37,535
COBRA Trial	NIHR Health Technology Assessment	£57,521
LABILE Trial	NIHR Health Technology Assessment	£42,273
Esketamine 3004 study	Janssen Pharmaceuticals	£13,184
Improving Lithium Safety	Academic Health Science Network	£50,000
SCIMITAR PLUS Trial	NIHR Health Technology Assessment	£6,276
Additional grant funding		£29,041
Total		**£686,317**

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

The Trust's responsibility for the monitoring and standards of research activity involving its service users, carers and staff are laid down in the Research Governance Framework. The R&D office processes are designed to ensure compliance by all involved via the Trust's Standard Operating Procedures for research. The Trust R&D strategy and its implementation seek to fulfil the NHS Constitution commitment to make research participation accessible to as many service users as possible.

4.4 **Equality and Diversity:**

The Trust's R&D strategy explicitly seeks to ensure that wherever possible there is equity of access to research for service users and carers across the Trust's specialties and geographies. In 15/16 we worked closely with Leeds and York Partnership NHSFT to ensure that York and Selby research studies continued through the transfer of services to TEWV and that through our organisational change, we had staff in place to facilitate research in this locality from 16/17.

4.4 **Other implications:**

The consequences of organisational change at Durham University have required a proactive strategic response from the Trust to ensure continuity of clinical academic leadership and continued growth of externally funded research programmes.

5. RISKS:

Organisational change at Durham University. The move of the University's School for Medicine, Pharmacy and Health to the University of Newcastle presented a potentially large impact on the Trust's capacity to generate and sustain large

research programmes, given our investment over a number of years in clinical academic posts. This has been mitigated by the Trust's strategic decision to develop closer collaboration with the University of York, which has already led to growth in academic posts and grant success.

Income reduction. Although the Trust's external income in 2015/16 was reduced compared to the previous year, this was mitigated in planning for 2016/17 by both the savings made from organisational change and new income streams. We have signed our first substantial contract for a pharmaceutical industry study. Our firm focus in achieving externally funded research grants with academic partners has come to fruition with the award of our first substantial research grant where the Trust is the lead hosting organisation (the CHEMIST Study). In addition to the £467k grant itself the Trust will receive additional Research Capacity Funding from NIHR from 2017/18 onwards. We are also collaborating with a number of other university partners on projects and grant applications, including a dementia collaboration with the University of Hull.

Excess Treatment Costs. As the Trust expands its clinical trials activity, particularly with more local Chief Investigator-led grants, there will be an increased need for agreement in advance of the Excess Treatment Costs associated with this work. During the course of 2016/17 a proposal will be submitted to the Executive Management Team for a process to ensure these costs are considered, with application to the relevant Clinical Commissioning Groups as appropriate.

6. CONCLUSIONS:

The Trust's Research and Development activity continues to enable service users and carers across all Trust localities to access new research opportunities for research involvement and we have engaged in organisational change to ensure equity of access for the York and Selby locality. We have responded to substantial organisational change at Durham University by developing further our collaboration with the University of York, and look forward to a growing and fruitful academic partnership based firmly on shared interests and priorities.

7. RECOMMENDATIONS:

The Board is asked to receive and approve the 2016 R&D annual report.

Professor Joe Reilly
Clinical Director for Research and Development

Background Papers:
Trust R&D Strategy 2015-2020
http://www.tewv.nhs.uk/site/get-involved/research-and-development
CHEMIST study summary- http://www.nets.nihr.ac.uk/projects/phr/1418611
PEPS trial report- http://www.journalslibrary.nihr.ac.uk/hta/volume-20/issue-52#abstract
COBRA trial Lancet publication- http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31140-0/fulltext

Item 8

FOR GENERAL RELEASE

Board of Directors

DATE:	**Tuesday, 29 November 2016**
TITLE:	**To receive the 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 03 November 2016:

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 Tees and North Yorkshire highlighted ongoing concerns around recruitment and retention, acuity on Wards, bed pressures and lack of nursing home placements.
- Updates from the Patient Safety Group and progress on the quarterly Quality Account.
- CQC compliance and Safeguarding and Public Protection 6 monthly update.
- Governance matters were considered and noted through assurance, with reports on Equality, Diversity and Human Rights and the Drug and Therapeutics Committee.
- The QuAC recommended that the Trust wide issues around bed pressures, bed acuity, staffing and future bed provision should be escalated to the Board of Directors.

Recommendations:
That the Board of Directors: • Receive and note the report of the Quality Assurance Committee from its meeting held on 03 November 2016. • Note the confirmed minutes of the meeting held on 06 October 2016 (appendix 1). • Note the issues around the Trust bed provision.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 29 November 2016**
TITLE:	**To receive the 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 03 November 2016.

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 of the Quality Account. Monthly compliance with the Care Quality Commission regulatory standards, with copies of assurance reports to support the regulatory standards, are also considered.

3. KEY ISSUES

The Committee received the bi-monthly updates from the Locality Directors of Operations around the principle risks and concerns, together with assurances and progress from Tees and North Yorkshire localities.

4. QUALITY ASSURANCE - EXCEPTIONS/ASSURANCE REPORTS FROM SUB-GROUPS OF THE COMMITTEE

The Committee received key assurance and exception reports from standing Sub-Groups of the Committee, highlighting any risks and concerns. Key issues raised were:

4.1 TEES LMGB – where key issues raised were:

1. Recruitment and retention - the appointment of 18 staff due to start employment between September 2016 and January 2017. Recruitment from overseas had been considered however, it was decided this would not be a suitable option.
   It was noted that there was significant turnover of nursing staff as well as newly qualified nursing staff on wards, requiring appropriate levels of mentorship and support. Recruitment of medical staff was also highlighted with difficulty replacing some Consultants. There were currently 41 vacancies across the North East region for MHSOP Consultants.
2. Acuity on the Wards continued to be a growing problem, particularly the children's Ward at West Lane. The expected re-opening of Peppermill Court had not completely alleviated the pressures on beds, with the numbers of out of area patients as high as 20 over the last 2 weeks.

3. Patient falls had become a growing problem despite lots of interventions to prevent falls. It was acknowledged that Westerdale South, which had been designed some time ago for a different cohort of patient needs, did not provide the close observation required to prevent falls. Discussions were underway around the potential to swap Westerdale North and South Wards.
4. There had been an increase in out of area admissions in MHSOP as a result of clusters of organic admissions, which were difficult to manage due to relatively small numbers of beds.
5. There continued to be delayed discharges due to the lack of external nursing home places. In the North Tees area a group would be set up to look at this matter, which was being recognised as a growing national issue.
6. The culture of night duty staff on Westerdale South had been addressed following CCTV footage which had revealed a lack of effort at night times. The Committee were assured that since 5 new members of staff had been installed on the ward the work ethic had improved.
7. The Police had released some guidance regarding patient transport, which would impact on the Trust since there would no longer be support from the Police for transferring patients.

- The Committee recommended that the matter of bed pressures, including occupancy, and out of area placements, as well as future bed provision be escalated to the Board of Directors.

4.2 NORTH YORKSHIRE LMGB - where key issues raised were:

1. High levels of activity, sickness and difficulties with recruitment, continued to add extra pressure to staff, in particular affecting Ayckbourn Adult Mental Health services. A stop the line action plan with weekly calls had been implemented, to proactively manage staffing shortages on the inpatient rota.
   The Committee were assured that there was a dedicated Consultant for each ward.
2. In MHSOP services there were currently high levels of enhanced observation on Rowan Lea in Scarborough and Rowan Ward in Harrogate, with the service following their business continuity plan and diverting community staff to support safe staffing levels. There had been 4 individual patients on Rowan Lea since June 2016 requiring high level observations which had added to the pressures.
3. The bed numbers in Scarborough had been reduced from 13 to 11 and nurse leadership had been reviewed, with 2 Ward Managers stepping up to the challenge, with some good feedback received from the CQC.
4. In Tier 3 CAMHS services maintaining standards of service was being affected by highly complex cases, particularly in the Northallerton team.
5. PIPs, the arm's length subsidiary company of the Trust, were currently looking to identify any solutions to providing housing for patients with complex learning disabilities and behaviour that challenges in the community.
6. Access to PICU continued to be challenging and the Committee acknowledged that this matter had been raised with the Director of Operations and would be discussed further at a forthcoming EMT meeting.

4.3 Patient Safety Group & Patient Experience Group

1. The group had received a summary following publication of the national confidential enquiry into suicide and homicide by people with mental illness and this had been included in the month's Lessons Learned bulletin and circulated to all staff.

2. The group were monitoring the fluctuating numbers of control and restraint in Tier 4 CAMHS with a further progress report at the end of Q3.
3. As part of progressing the mortality review process, some data had been received about the actual numbers of service user deaths now being reported through Datix and it had been agreed to review those on CPA only in the first instance. The Trust will adopt the Mazars principle for mortality reviews and this would be discussed in more detail at the November meeting.

4.4 Safeguarding & Public Protection Exception Report

1. There had been a 17% increase in the number of alert contacts made to the safeguarding team in Quarters 1 and 2. A review would be undertaken of the current capacity of the safeguarding teams.
2. There had been 6 allegations of abuse against Trust staff in Q1 and 11 in Q2. These had been dealt with through disciplinary investigations, 6 of the cases were found to have no case to answer, however due to the nature of one concern raised a referral had been made to the DBS. An update on this matter would be brought back to the next QuAC meeting.
3. Updates were heard around the serious case reviews ongoing in Hartlepool, Redcar & Cleveland, Durham, Darlington and Tees.
4. There had been a 6% increase in compliance against level 2 Safeguarding Adults training.

4.5 Quarterly Quality Account Progress Update

1. All Quality Account priorities were reported as on track to be completed as planned, with 1 exception around a milestone within the harm minimisation project.
2. There were 3 areas reported as red in the metrics around patient falls, length of stay in Adult & Older People Mental Health and percentage of complaints that had been resolved satisfactorily.
3. The length of stay for older people was becoming an increased pressure for the Trust, due reduction in beds and the complexity of patient needs including physical health care.
4. Further work would be undertaken around patient falls to understand the significant deterioration in Quarter 2 with 113 falls.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 Compliance with CQC Registration Requirements

1. Since the opening of Peppermill Court in York, there had been an anonymous concern raised to the CQC about the suitability of the 136 suite and soundproofing. This would be rectified imminently.
2. There had been positive feedback for the community Mental Health Team based at Durham HMP, following a HMCIP inspection.
3. An anonymous concern had been raised about Cherry Trees House in York in respect of staffing and medication and the relevant information had been sent to the CQC.
4. Mental Health Act inspections had taken place at Ramsey LD and Kestral/Kite FLD with minor issues identified and a further 7 reports were awaited from the CQC.
5. An unannounced CQC inspection had begun on 01 November 2016 across all core services for adult inpatients. On this matter it was noted that there had been some very positive comments about the level of care seen on the wards and staff attitude.

5.2 Equality, Diversity & Human Rights Report

1. The Equality, Diversity and Human Rights Steering Group had met on 12 October 2016.
2. Key Performance Indicators and other data had been monitored by the Group and data broken down into localities and specialisms in order to highlight EDHR issues of concern. The Group would in future, provide exception reports by locality and specialism with explanatory narrative.
3. The Group looked at the 2012/2016 equality objectives with some requiring further work around cultural competency training, (to train 55 clinical staff to act as 'equality experts'), to decrease by 50% the number of indicators where staff who have long term health conditions have significantly less favourable scores and to develop actions where staff share protected characteristics however score worse than staff in general.
4. There had been a briefing from the Health & Safety Manager on Disability Access audits following an audit of all inpatient premises in Durham and Darlington.
5. The Group had received an update on locality equality objectives.

6. GOVERNANCE

6.1 Drug & Therapeutics Report

1. The Safer Transfer of Prescribing Guidance had now been approved and was available on the Trust website and intranet.
2. There continued to be a risk around TEWV clinical staff accessing blood results. Licences for WebICE, the current solution was extremely limited in each locality however this would be resolved by a Paris solution by April 2017.
3. A comprehensive guide regarding monitoring for all psychotrophic medications would be completed for the D&T meeting in November 2016.
4. There is further work to be undertaken around POMH 14b alcohol detoxification audit, since the report had shown poor compliance with blood tests on admission and the use of parenteral thiamine.
5. There was uncertainty around screening provisions on different wards and a short report explaining this would be included in the next D&T report to the Quality Assurance Committee in February 2017.
6. The Trust would respond to the NHS Improvement Patient Safety alert "Think Kidneys", which set out steps for implementation by April 2017.

7. IMPLICATIONS

7.1 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.

7.2 Financial/value for money

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

7.3 Legal and Constitutional (including the NHS Constitution)

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

7.4 Equality and Diversity

The Committee receives quarterly assurance reports from working groups, one of which is the Equality and Diversity Steering Group.

8. CONCLUSIONS

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

9. RECOMMENDATIONS

That the Board of Directors:

- Note the issues raised at the QuAC meeting on 03 November 2016 and to note the confirmed minutes of the meeting held on 06 October 2016 (appendix 1).
- To note concerns around the matter escalated to the Board of Directors on the Trust bed position.

Mrs Elizabeth Moody
Director of Nursing & Governance/ Quality Governance
November 2016

APPENDIX 1

Item 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 6 OCTOBER 2016, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

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

In attendance:
Mrs Karen Agar, Associate Director of Nursing and Governance (for minute 16/141)
Mr David Levy, Director of Human Resources & Organisational Development (for minute 16/142)
Mrs Donna Oliver, Deputy Trust Secretary
Dr Ingrid Whitton, Deputy Medical Director for County Durham & Darlington (for minutes 16/133, 136, 143)
Dr Steve Wright, Deputy Medical Director, York & Selby (for minute 16/134)

16/130 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs Ruth Hill, Director of Operations, York & Selby, Mr D Gargen, Head of Nursing, York & Selby, Mrs S Richardson, Non-Executive Director and Mr P Scott, Director of Operations, Durham & Darlington.

16/131 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 1 September 2016 be signed as a correct record by the Chairman of the Committee.

16/132 ACTION LOG

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

The following updates were noted:

16/48 "Analysis of dashboard indicators: to discuss with OMT how to ensure that in investigating any breaches we can gain assurance that the care was appropriate".
This action would be deferred to the November QuAC meeting.

16/97 "Following PEG meeting 14 July 2016 page 2, 3.3 look into more detail at the 5 complaints relating to attitude".
This information was covered under minute 16/136.

16/112 "Balanced scorecard for Forensic Services to be circulated to QuAC members".

Completed

16/12 iv) "Number of prone up from 3 in June to 15 in July to be looked into further".
This information had been circulated to QuAC members.

Completed

16/116 "Change to reporting schedule for LMGB reports for 2 to report to QuAC each month".

Completed

16/121 "Falls data to be explored, provide clarification on the definitions of the data on falls used in the quality account report".
This information had been circulated to QuAC members.

Completed

16/121 i) "Look into the funding arrangement for the expert led sleep share and spread event**".**
This information had been circulated to QuAC members.

Completed

16/128 2) "Circulate the QuAC terms of reference for comments by 13.9.16".

Completed

16/133 DURHAM & DARLINGTON LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the Durham & Darlington Services LMGB Assurance/Exception Report.

Dr Whitton highlighted the main concerns at present, which were:

1. A transformation group had been established for the review of West Park Hospital, with key work streams around leadership, philosophy and values, model of care, staff development and training and the environment.
2. The Durham & Darlington Risk register was currently an outlier across the localities, with higher number of risks than other localities and it was noted that all QuAGs were currently reviewing the registers with a view to gaining consistency across the Trust. On this matter it was observed that the risk rating around resuscitation training had increased, however there had been a recent review of the training, which had been approved by EMT and approximately 2000 staff would be prioritised going forward.
3. There had been continued complaints around ASD waiting times. The long wait for assessments had been added to the risk register as the current wait for a child aged over 5 in North Durham was 18 months.
   The Committee acknowledged the good package of care provided recently in exceptional circumstances by the Holly Unit and the staff should be congratulated on their hard work.

Following discussion it was noted that:

i) There had been a lack of progress providing bathrooms on Oak Ward and this was being progressed through Estates and Facilities Management.

ii) The visiting arrangements at West Park for children had been put in place to ensure children did not walk through the general Ward areas.

iii) In Adult Learning Disabilities a GP practice in Stanley had refused to undertake additional monitoring of bloods for patients on anti-psychotics. This was also happening in other areas.
On this matter it was acknowledged that this was a business and clinical risk and would need to be quantified, in terms of the impact on staff, training and future cost implications. Mr Chris Williams, Chief Pharmacist was currently working with GPs on this matter.

iv) There was a current risk around patients being admitted to the inappropriate type of bed or out of the locality and options for using Oak had been explored.

The Committee discussed issues relating to the format and content of the risk registers appended to the LMGB reports. It was noted that there was work ongoing through the risk register project to address the issues raised.

16/134 YORK & SELBY LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the York & Selby LMGB Assurance/Exception Report.

Dr Wright highlighted the main concerns at present, which were:

1. Peppermill had now re-opened and was running well operationally, however it was noted that there were safety issues in connection with accessibility of the roof and individual risk assessments would be undertaken to ensure patient safety.
2. Staffing levels remained an issue in MHSOP services due to sickness and the use of bank and agency staff.
3. There were emerging issues around risk assessments within York District Hospital, which had impacted on CAMHS and trainee doctors and work was ongoing to review possible solutions.
4. Estate issues and response to backlog maintenance, service repair and general repair of buildings was an ongoing problem.

16/135 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Group report for September 2016 and the Patient Safety Group Quality Report for the period July 2016.

It was highlighted from the report that the Patient Safety Group had discussed that some guidance was required for staff when reporting self-harm as an incident on Datix for patients who are repeatedly harming themselves. It had been agreed that views would be sought from other clinical colleagues and brought back to the Group for further discussion.

Arising from discussion it was noted that the levels of control and restraint in Tier 4 CAMHS had shown an upwards trend and Mr Stephen Davison, Project Lead, Nursing had been invited to attend the next Patient Safety Group with some further analysis of these figures.

16/136 PATIENT EXPERIENCE GROUP REPORT

The Committee received and noted the Patient Experience Group report.

Dr Whitton highlighted the following from the report:

1. The Patient Experience Group had met on 19 July 2016 and 20 September 2016 and reviewed all relevant Trust patient experience activities, in line with the group's terms of reference.
2. There had been an increase in PALS issues from Forensic Services due to problems with windows and the inability to manage the temperature control, however it was noted that this issue had since been resolved.
3. There had been investigation into complaints concerning the attitude of staff (Action: 7 July 2016 QuAC, 16/97).
   On this matter it was noted that such issues would be discussed in individual supervision and dealt with informally or via the HR disciplinary process. The complaints team had advised that the codes were quite broad and might not always give an accurate reflection of the issues.

   The Committee were assured that there were no particular clusters or trends in relation to this matter.

It was highlighted that the lack of feedback from local representatives from York & Selby had been a one off and there was now good representation on the Patient Experience Group.

16/137 CLINICAL AUDIT & EFFECTIVENESS PERFORMANCE REPORT

The Committee received and noted the Clinical Audit & Effectiveness Quarterly Performance Report.

Arising from the report it was highlighted that:

1. The Clinical Effectiveness Group had reviewed all Trust clinical effectiveness in line with the Group's terms of reference.
2. Audit North had undertaken an internal audit in Quarter 4 2015/16 (Ref 23/16), which had been issued on 9 September 2016 and had provided the Clinical Audit Department with a significant assurance level.
3. The current completed clinical audit programme was 16% with a further 40% of the programme ongoing and making good progress.
4. Issues escalated by the Clinical Effectiveness Group had been that the C&YPS Clinical Audit Sub Group had not been quorate at 3 successive meetings and this had been escalated appropriately.
5. At the 27 September 2016 there were 4 outstanding action points from 2 action plans, which were overdue > 90 days and this was being addressed.
6. There had been 40 clinical audits completed during Quarter 1 2016/17 and the Committee was assured that those with amber and red status were being followed up.
7. The progress against previous red compliance rated clinical audits had been set out in Section 2 of the appendices to this report, with updates noted.
   On this matter it was noted that audits around physical health were being supported with a pilot for early warning scores.
8. The low compliance with the audit in MHSOP around the posture or safety belts fitted to supportive seating, wheelchairs, hoists and bathroom equipment (4614), had been

discussed with Clinical Matrons to gain standardisation and prevent instructions for equipment being moved around.

Following discussion it was noted audit 4391, preventing suicide through community and emergency healthcare – Trust wide had a compliance rate of 50-79%.
This would be investigated further and the details circulated to the QuAC.

Action: Mrs J Illingworth

16/138 QUALITY STRATEGY UPDATE

The Committee noted and received a verbal update on progress with the Quality Strategy.

It was highlighted that the proposed Quality Strategy was in draft format and the metrics were being considered, which would be circulated to LMGBs for discussion and to set the percentage levels for the targets. The Quality Strategy would come back to QuAC at its meeting on 1 December 2016.

Action: Mrs J Illingworth

16/139 LEARNING LESSONS FROM SIS, ACTION PLANNING AND MORTALITY REVIEW PROCESSES

The Committee received and noted a report on Learning lessons from serious incidents, action planning and the mortality review process.

The Committee received and noted a tabled report, Durham & Darlington July – September 2016.

It was highlighted from the report that:

1. A process of enhanced monitoring, with central collation and review of evidence from SIs would be adopted, providing more assurance around actions being completed in a timely manner and that the evidence to support the actions were both fully completed and relevant.
2. The key change to the SI process would be the separation of 'incidental findings' from the formal SI action plan. The SI action plans would focus on root cause and contributory factors alone, ensuring that the emphasis would be placed on those that would make the biggest difference to improving patient safety. Incidental findings from the reports would be shared in a new format.
3. The 1 page summary demonstrated the number of SIs quarterly, which had been approved by Directors Panel and submitted to Commissioners for the locality Durham and Darlington from July to September 2016. This was an example of a proposed document to be used going forward across all localities.
4. The summary of SIs had been broken down into 4 categories, with key messages for discussion and sharing in clinical teams.

The Committee agreed that this summary of SIs would be a simple and helpful way to enable sharing of information with feedback from clinical leaders and something that could be discussed in team meetings.

Agreed: that an annual report on Serious Incidents should report be provided to the Board of Directors.

Acton: Mrs J Illingworth/Mr P Bellas

The Committee received and noted the Mortality Review, structured case note review and data collection from Humber NHS Foundation Trust.

Mrs Illingworth drew attention to the mortality review, following the recommendations of the Southern Health report and highlighted that:

a) The principles of the new Trust mortality process would be to review deaths, which would not normally have been subject to a formal review, to ensure that the patient care and treatment received had been appropriate and to extend learning to premature or 'potentially preventable' deaths, including those classified as expected or natural.
b) A pilot had been agreed and adapted from the Southern Health report and the new coding would be applied as part of the daily clinical huddle within the Patient Safety Team.

Following discussion the Committee received assurance in relation to the reporting of deaths within the Trust.

16/140 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. There would be an unannounced CQC re-inspection of the Trust to those core services which had received a rating less than 'good', following the inspection in January 2015 and a plan was underway in preparation for this.
2. A mock inspection had been undertaken at Meadowfields, which had identified estate concerns and an action plan had been implemented.
3. The CQC had published a report with an overall rating of 'requires improvement', on York EIP services, which is a contracted service of the Trust.
4. There had been 3 MHA inspections and associated monitoring reports received.

16/141 SAFEGUARDING & PUBLIC PROTECTION EXCEPTION REPORT

The Committee received and noted the Safeguarding and Public Protection Report.

It was highlighted from the report that:

1. The panel had received the first draft of the review of the MAPPA serious case review in Teesside.
2. A serious case review had been initiated in Durham regarding the long term neglect of 2 children.
3. The serious case review in Redcar around child sexual exploitation had been completed. Efforts would be made to ensure anonymity with this high profile case.
4. Redcar and Cleveland had initiated a Domestic Homicide review following the murder of 2 women. One of the victims had been known to the Trust and the perpetrator, had last been seen in 2013 by TEWV.
5. Darlington Safeguarding Adult Board had initiated a serious adult review. The Trust had been involved in the care of the adult, however not in relation to the incident.

16/142 WORKFORCE & STAFFING REPORT

The Committee received and noted the Workforce & Staffing Report.

It was highlighted from the report that:

1. The report provided information about TEWV Equality and Diversity workforce monitoring for 2015/16.
2. NHS England had recently referenced some research suggesting that ethnicity adversely affected the likelihood of the best people being appointed, which could potentially impact on patient care and that there was a strong correlation between how staff were treated with higher staff turnover and absenteeism and lower patient satisfaction.
3. The NHS Workforce Race Equality Standard indicator "percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months", had highlighted TEWV as having the biggest difference (22%) between white and BAME staff.

   On this matter it was noted that:

   i) Within the recruitment monitoring information it had highlighted that shortlisted white job applicants were almost twice as likely to be appointed as shortlisted BAME applicants and at interview stage within TEWV BAME job applicants fared much worse than white job applicants.
   ii) The small number of TEWV BAME staff survey participants could however make drawing conclusions with confidence more difficult.

Following discussion it was noted that:

i) There remained gaps in the Trust monitoring of information around equality and diversity, due to the challenges around engaging particular staff groups for the Trust, and work was underway to try and improve this..
ii) In response to the workforce monitoring information action would be taken to undertake research to enable better understanding of the causes of differences where staff who share similar characteristics reported lower levels of satisfaction, in either the staff Friends and Family test or the annual staff survey and to improve the TEWV score and ranking within the Stonewall Workplace Equality Index. This work would be expected to be formalised in July 2017.
iii) The tables in appendix 1, page 16 should be re-visited for clarity of the information presented.

Action: Mr D Levy

16/143 PHYSICAL HEALTHCARE & WELLBEING REPORT

The Committee received and noted the Physical Health and Wellbeing Report.

Arising from the report it was highlighted that:

1. There had been a mapping exercise of the current physical health work streams and projects, as well as the mapping of resources for physical health Trust wide, which would be completed in December 2016.

2. A discussion had taken place around the most effective assurance route for physical health and how the Physical Health Group could advise on standards and aid education, with future monitoring through QUAGs and LMGBs.

   The Quality Assurance Committee was asked to consider a robust reporting mechanism through existing governance systems for physical health.

   Agreed: That the Physical Health Group would report through to LMGBs and this change would be communicated to the Director of Operations.

Action: Mrs D Oliver

16/144 EXCEPTION REPORTING - RESEARCH GOVERNANCE GROUP REPORT

The Committee received and noted the Research Governance Group Assurance Report.

It was highlighted from the report that:

1. Due to new Health Research Authority approvals an information governance assessment would have to be conducted, which would eliminate the need for Caldicott permissions for research studies in TEWV.
2. The national process had not been fully implemented within the Trust and following a discussion with the Caldicott Guardian it had been agreed to reinstate the TEWV Caldicott review process for research studies, which involved the collection or transfer of personal identifiable data outside the organisation.

16/145 ANY MATTERS ARISING TO BE ESCALATED TO THE TRUST BOARD OR PROPOSED FOR ADDITION TO THE TRUST RISK REGISTER, AUDIT COMMITTEE, INVESTMENT COMMITTEE OR CLINICAL LEADERSHIP BOARD.

There were no matters to escalate to the Board of Directors.

16/146 ANY OTHER BUSINESS

There was no other business to note.

16/147 COMMITTEE MEETING

There was nothing to note.

16/148 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 3 November 2016,
2.00pm – 5.00pm in the Board Room, West Park Hospital.
Email papers/reports to Donna Oliver donnaoliver1@nhs.net
The meeting concluded at 4.35pm.

Dr Hugh Griffiths
CHAIRMAN
3 November 2016

ITEM 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29 November 2016**
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 October 2016 data.

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

- The number of rosters equates to 68 inpatient wards.
- The number of 'red' fill rate indicators highlights Registered Nurses on Days as having the highest number of 'reds' equating to 36 wards.
- The Forensic directorate have the highest level of 'red' fill rates (15 in total)
- The lowest fill rate indicators in October relate to Minster (vacancies), Primrose Lodge (sickness and vacancies) and Danby (vacancies).
- The Highest fill rates in October were observed by Westerdale South (uplift of budget – required roster changes have been made and will be effective from 17th November 2016 (which should normalise the reporting position from that point) , Westwood Centre (high clinical activity) and Langley (high clinical activity and enhanced observations on nights).
- In relation to bank usage there were no wards identified that was utilising in excess of 50% bank during the reporting period. The highest bank user was identified as Westerdale South with 47% in October 2016.
- Agency usage equated to 1.21% a decrease of 0.31% when compared to September.

- In terms of triangulation with incidents and complaints:
  - Cedar Ward – bank usage in excess of 25% in addition to having 2 level 3 incidents, PALS related issues and Datix incident highlighting staffing issues.
  - Cedar (NY) – agency usage in addition to a Datix incident citing staffing concerns.
  - Harrier / Hawk – agency usage in addition to PALS related issues
  - Kestrel / Kite – bank usage in excess of 25% and agency usage in addition to PALS related issues.
  - Langley – high staffing fill rate in addition to having a level 4 incident and PALS related issues
  - Meadowfields – agency usage in addition to raising a Datix incident in relation to staffing levels
  - Northdale – agency usage and PALS related issues.
  - Robin – bank usage in excess of 25% in addition to PALS related issues
  - Sandpiper – highest number of incidents requiring control and restraint in addition to a level 3 incident.
  - Westwood Centre – high staffing fill rate in addition to having bank usage in excess of 25%, a level 3 incident and Datix incidents highlighting staffing issues
  - Worsley Court – agency usage in addition to a level 4 incident and a Datix incident citing staffing issues.

There were 472 shifts (275 related to days and 197 related to nights) allocated in October where a break had not been taken.

There were 21 incidents raised in October (2 were in relation to community services and were raised by Crisis Teams).

A work stream approach to Safe Staffing is underway with a full update provided on page 8 of this report, this includes a review of roster planning efficiencies which is taking place during quarter 3 and 4.

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:	**29 November 2016**
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 October 2016 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. (http://www.tewv.nhs.uk/site/about/how-well-are-we-doing/nurse-staffing). The full monthly data set of day by day staffing for each of the 68 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

3. EXCEPTIONS OCTOBER 2016:

3.1 Safe Staffing Fill Rates

3.1.1 The daily nurse staffing information aggregated for the month of October 2016 are presented at Appendix 1 of this report.

The highest numbers of red fill rate indicators relate to Registered Nurses on day shifts which equates to 36 wards, an increase of 4 when compared to September 2016 (15 wards within Forensic Services).

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
October 2016		
Minster Ward	50.5% for HCA on Days 78.3% for RN on Days	The shortfall is in relation to vacancies and awaiting pre-employment checks. Agency staff have been utilised to back fill the majority of these vacant duties.
Primrose Lodge	57.9% for RN on Days	The shortfall is in relation to sickness and the registered nurse fill rate has remained around 60% since June. The ward have flexed the use of HCA to fill some of the vacant duties, this is evident by the HCA on days fill rate (133.9%). In addition the ward manager and community rehab staff have provided cover also.
Danby Ward	58.4% for RN on Days	This shortfall is in relation to vacancies and staff working in a supernumerary capacity subject to NMC registration. Vacant shifts have been covered by community teams and the Ward Manager. All other fill rate indicators are reporting as 'green' for this ward.

It is also important to review the fill rates that exceed the budgeted establishment (shown in blue). In October there were 60 fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues. This is an increase of 8 when compared to September.

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
October 2016		
Westerdale South	317.4% HCA on Days 240.7% HCA on Nights	Agreed uplift on the budgeted established as a result of enhanced observations and clinical activity. The electronic roster has been amended to reflect this position and will become effective from the 17th November 2016 roster. The benefit of this change will be noticeable in December's report with the full effect being visible in January 2017.

Ward	Fill Rate Indicator	Comments
Westwood Centre	230.5% HCA on Nights 180.3% HCA on Days	The high fill rates are in relation to high clinical activity with a number of enhanced observations.
Langley	214.4% HCA on Nights 158.7% HCA on Days	The high fill rates are in relation to high clinical activity and enhanced observations on nights due to particular client. In addition there was an acute admission for 2 weeks which required additional staffing.

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 October. The highest ward using bank was in relation to Westerdale South (47%) although this may be a misrepresentation due to the pending roster change which will be effective from the 17th November 2016 roster.

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

Westerdale South	47%
Cedar Ward	42%
Merlin	37%
Robin	35%
Birch Ward	29%
Kestrel/Kite.	28%
Bransdale Ward	27%
Westwood Centre	26%

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 October the agency usage equated to 1.21% of the total hours worked. This is a decrease of 0.31% when compared to September (1.56%).

It is positive to note that agency usage is extremely 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 for the month of October with the following reporting as an exception:

- There were 0 Serious Incidents (SI) that occurred within the month.
- There were 2 level 4 incidents that occurred within the reporting period. 1 of these incidents related to Langley who has been cited in the report for having a high fill rate. The other incident was in relation to Worsley Court who has been cited in the report for utilising agency workers.
- There were 10 level 3 incidents (self-harm) that occurred within the reporting period. 1 occurred within Westwood who has been cited within the report for having a high fill rate and bank usage in excess of 25%. 2 incidents occurred within Cedar Ward who has been cited within the report for having bank usage in excess of 25%.
- There were 4 complaints raised within the reporting period. A complaint was raised in relation to Bransdale Ward who has been cited as having bank usage in excess of 25%.
- There were 42 PALS related issues raised with the following featuring within this report as follows:
    - Harrier Hawk (4 PALS) – agency usage in the reporting period
    - Kestrel / Kite (3 PALS) – bank and agency usage
    - Robin (2 PALS) – bank usage in excess of 25%
    - Cedar (1 PALS) – bank usage and 2 level 3 incidents
    - Langley (4 PALS) – high staffing fill rate and a level 4 incident
    - Bransdale (2 PALS) – bank usage and a complaint
    - Northdale (3 PALS) – agency usage
- A number of incidents requiring control and restraint occurred during the reporting period. The highest user was Sandpiper with a total of 76 incidents. Sandpiper has also had a level 3 incident occurring within the reporting period. Historically Westwood and the Evergreen Centre were highlighted as outliers for control and restraint; in September and October they are reporting lower incidents requiring control and restraint.

3.5 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 472 shifts in October 2016 where unpaid breaks had not been taken. This is a reduction of 399 when compared to September 2016. The majority of the shifts where breaks were not taken occurred on day shifts (275 shifts). The number of night shifts where breaks were not taken equated to 197 shifts.

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

3.6 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. Within the reporting period there were 21 incidents raised on Datix citing issues with staffing (2 incidents related to community services; both of which related to Crisis Teams).

In terms of triangulating this data with what has been reported within this report the following is of relevance:

- Meadowfields raised 3 incidents in relation to staffing levels; this ward has also been cited within this report for utilising agency workers.
- Westwood Centre raised an incident in addition to having high staffing fill rate, bank usage and a level 3 incident.
- Worsley Court raised 3 incidents in addition to having utilised agency workers and having a level 4 incident
- Cedar (NY) raised 2 incidents in addition to having utilised agency workers.
- Cedar Ward raised 2 incidents in addition to having bank usage in excess of 25%, having 2 level 3 incidents and PALS related issues.

The staffing concerns escalation process has been updated following a period of consultation and is currently being rolled out trust wide. A review of the new process will be undertaken at the end of quarter 3, including the impact on community teams providing cover to inpatient wards.

3.7 Other

The Forensic directorate have the highest number (15 wards' in total) of 'red' fill rates for registered nurses on day shifts. Pressures contributing to this remain the same as highlighted in the August and September report including the inpatient services vacancy factor at Band 5 that is approximately 20% with the majority of the vacancies being filled by preceptees (who require additional support in the first months of practice) predominantly starting in October 2016 and a number of staff on restricted duties. In line with Transforming care, there are plans to reconfigure a further ward which should ease staffing pressures going forward.

The safer staffing steering group has been established to oversee a work plan to ensure the Trust has robust systems and processes in place to assure them that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards / clinical areas day or night, every day of the week as appropriate. This is being led by the Director of Nursing with the Operational Management Team.

In addition work is being undertaken Trust wide via a work stream approach reporting to OMT. The following update is of relevance:

- Rostering Efficiencies:
  - Standard operating procedures have been developed in relation to the creation and review/approval of the electronic rosters.
  - Reviews of all electronic rosters are underway with an in-progress report being presented to OMT.
  - Requirements gathering will take place in December that will outline the metrics to be displayed within the IIC.
  - Future training and support of those involved in the production of electronic rosters is also being considered.
  - The use of local champions will be considered in future meetings.
- Future Reporting:
  - Care hours per patient day are now being produced in a shadow format for consideration by the group in terms of what 'good' would look like for the trust.
  - Safe staffing information is now being provided for each of the Performance Improvement Groups within the trust.
- Flexibilities of Staff Deployment:
  - Durham and Darlington are in the process of recruiting over and above establishment to produce a flexible on-site staffing response in line with agreement from EMT.
- Escalation:
  - The staffing concerns escalation process has been updated following a period of consultation and is currently being rolled out trust wide. A review of the new process will be undertaken at the end of quarter 3, including the impact on community teams providing cover to inpatient wards.
- Evidence Based Planning:
  - Utilising the Hurst Tool and the mental health multiplier an electronic process is currently being established and a roll out plan agreed with Heads of Nursing.
  - A full implementation plan will be circulated ensuring completion by the end of quarter 3.
  - The trust is also taking part in an approach to test out NHS England evidence based staffing framework and tools for MH wards in agreed in-patient areas. There is considerable national work going on this area to establish a standard approach and consider what the evidence based tools should consist of.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

No direct risks or implications to patient safety from the staffing data have been identified this month, although 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. 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. This work is being progressed and will be a feature of this financial year Safe Staffing work stream referred to above

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.

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 Safe staffing and the risks regarding the Trusts ability to meet planned staffing levels on a daily basis has been escalated to the Trust Risk Register. Risks will be managed and mitigated through operational services and the work being undertaken as highlighted within the safe staffing work streams.

5.2 The national work is continuing on the implementation of evidence based tools and the Trust is now engaged with this.

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.

6.2 A strategic staffing review will commence during the last quarter of 2016/17 which will refine the usage of the data further and offer confidential benchmarking in line with the national pilot of the Mental Health safe staffing tools. The comparative analysis of complaints and incidents, particularly focussing on the areas where staff fell below the planned levels has not shown any significant impact to date although 'hot-spots' will be tracked and work is underway to address shortfalls.

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
November 2016

Appendix 1

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 31 DAYS IN October							
				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	58.4%	116.5%	100.0%	100.2%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	75.4%	103.7%	103.2%	93.5%
Bedale Ward	Teesside	Adults	10	98.0%	186.5%	120.2%	133.5%
Bilsdale Ward	Teesside	Adults	14	82.1%	134.5%	97.9%	103.2%
Birch Ward	Durham & Darlington	Adults	15	99.2%	102.3%	100.0%	163.3%
Bransdale Ward	Teesside	Adults	14	74.6%	127.5%	93.5%	98.4%
Cedar Ward	Durham & Darlington	Adults	10	103.2%	185.6%	100.0%	158.7%
Cedar Ward (NY)	North Yorkshire	Adults	18	94.1%	119.9%	111.9%	153.4%
Ebor Ward	York and Selby	Adults	12	86.8%	77.3%	62.1%	98.3%
Elm Ward	Durham & Darlington	Adults	20	111.2%	103.5%	100.0%	114.5%
Farnham Ward	Durham & Darlington	Adults	20	122.4%	105.1%	106.5%	100.0%
Kirkdale Ward	Teesside	Adults	16	93.8%	98.3%	109.8%	122.6%
Lincoln Ward	Teesside	Adults	20	112.0%	92.9%	94.7%	101.6%
Lustrum Vale	Teesside	Adults	20	90.5%	113.8%	102.0%	102.6%
Maple Ward	Durham & Darlington	Adults	20	92.3%	102.6%	96.8%	109.7%
Minster Ward	York and Selby	Adults	12	78.3%	50.5%	90.3%	93.4%
Overdale Ward	Teesside	Adults	18	92.0%	101.3%	105.6%	103.6%
Primrose Lodge	Durham & Darlington	Adults	15	57.9%	133.9%	100.0%	100.0%

Stockdale Ward	Teesside	Adults	18	100.4%	109.9%	100.8%	95.3%
The Orchards (NY)	North Yorkshire	Adults	10	104.9%	76.2%	85.5%	111.2%
Tunstall Ward	Durham & Darlington	Adults	20	110.7%	96.0%	90.3%	101.6%
Ward 15 Friarage	North Yorkshire	Adults	14	84.4%	115.9%	100.3%	100.1%
Willow Ward	Durham & Darlington	Adults	15	82.5%	165.5%	100.0%	101.6%
Baysdale	Teesside	CYPS	6	119.4%	106.0%	99.8%	103.3%
Holly Unit	Durham & Darlington	CYPS	4	138.1%	131.3%	101.4%	121.5%
Newberry Centre	Teesside	CYPS	14	82.1%	112.1%	112.2%	112.6%
The Evergreen Centre	Teesside	CYPS	16	89.7%	131.6%	105.6%	115.6%
Westwood Centre	Teesside	CYPS	12	101.1%	180.3%	98.8%	230.5%
Clover/Ivy	Forensics	Forensics LD	12	93.5%	128.1%	100.0%	154.8%
Eagle/Osprey	Forensics	Forensics LD	10	90.1%	96.9%	103.2%	107.4%
Harrier/Hawk	Forensics	Forensics LD	10	75.9%	108.6%	100.0%	148.7%
Kestrel/Kite.	Forensics	Forensics LD	16	84.2%	127.1%	103.2%	151.6%
Langley Ward	Forensics	Forensics LD	10	93.6%	158.7%	101.7%	214.4%
Northdale Centre	Forensics	Forensics LD	12	76.0%	124.7%	106.7%	120.2%
Oakwood	Forensics	Forensics LD	8	87.9%	192.8%	100.6%	100.6%
Robin	Forensics	Forensics LD	6	72.8%	142.1%	100.0%	99.0%
Thistle	Forensics	Forensics LD	5	78.4%	114.1%	100.0%	104.9%
Brambling Ward	Forensics	Forensics MH	13	79.7%	121.9%	100.3%	100.1%
Fulmar Ward.	Forensics	Forensics MH	12	87.6%	110.5%	100.6%	113.5%
Jay Ward	Forensics	Forensics MH	5	67.3%	120.1%	110.3%	100.3%
Lark	Forensics	Forensics MH	15	79.1%	119.8%	100.0%	100.0%
Linnet Ward	Forensics	Forensics MH	17	74.1%	140.3%	97.1%	106.7%
Mallard Ward	Forensics	Forensics MH	16	80.5%	122.6%	100.0%	153.8%
Mandarin	Forensics	Forensics MH	16	70.8%	132.1%	100.0%	119.4%
Merlin	Forensics	Forensics MH	10	104.0%	129.4%	100.0%	198.4%

Newtondale Ward	Forensics	Forensics MH	20	96.6%	98.3%	92.1%	108.2%
Nightingale Ward	Forensics	Forensics MH	16	87.1%	103.9%	100.0%	101.6%
Sandpiper Ward	Forensics	Forensics MH	8	100.2%	110.7%	83.9%	153.2%
Swift Ward	Forensics	Forensics MH	10	88.1%	126.6%	103.2%	143.5%
Aysgarth	Teesside	LD	6	114.9%	142.8%	106.5%	97.3%
Bankfields Court	Teesside	LD	19	78.3%	102.4%	91.1%	101.9%
Bankfields Court Unit 2	Teesside	LD	5	138.1%	100.3%	100.1%	109.7%
Bek-Ramsey Ward	Durham & Darlington	LD	11	90.5%	116.4%	100.0%	101.1%
Oak Rise	York and Selby	LD	8	138.9%	78.5%	100.4%	100.3%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	88.3%	109.9%	100.0%	100.0%
Cherry Tree House	York and Selby	MHSOP	18	91.7%	97.5%	87.1%	123.0%
Hamsterley Ward	Durham & Darlington	MHSOP	15	84.5%	148.5%	100.6%	125.8%
Meadowfields	York and Selby	MHSOP	14	80.9%	94.9%	112.9%	96.5%
Oak Ward	Durham & Darlington	MHSOP	12	96.3%	97.6%	100.0%	100.0%
Roseberry Wards	Durham & Darlington	MHSOP	15	83.6%	106.2%	100.0%	100.2%
Rowan Lea	North Yorkshire	MHSOP	20	85.6%	128.9%	108.6%	126.8%
Rowan Ward	North Yorkshire	MHSOP	16	88.7%	135.2%	100.0%	100.0%
Springwood Community Unit	North Yorkshire	MHSOP	14	70.3%	123.5%	100.0%	145.4%
Ward 14	North Yorkshire	MHSOP	9	88.8%	131.0%	104.4%	113.4%
Westerdale North	Teesside	MHSOP	18	98.4%	133.1%	100.0%	106.6%
Westerdale South	Teesside	MHSOP	14	102.2%	317.4%	98.1%	240.7%
Wingfield Ward	Teesside	MHSOP	10	83.2%	160.3%	120.2%	139.5%
Worsley Court	York and Selby	MHSOP	14	90.2%	92.9%	112.6%	168.5%

APPENDIX 2

Scored Fill Rate compared to Quality Indicators - OCTOBER 2016				Agency Usage (Hours)	Bank Usage Vs Actual Hours			Totals for Quality Indicators						Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers		Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Aysgarth	Teesside	LD	6		2412.58	346.50	14%									
Tunstall Ward	Durham & Darlington	AMH	20		2795.83	36.00	1%					1				
Westerdale South	Teesside	MHSOP	14		5246.42	2444.12	47%						6		9	9
Bankfields Court Unit 2	Teesside	LD	5		2363.92	338.70	14%									
Holly Unit	Durham & Darlington	CAMHS	4		1500.92	71.35	5%						3		6	6
Lincoln Ward	Teesside	AMH	20		3109.00	329.00	11%					1	1		1	1
Westerdale North	Teesside	MHSOP	18		2832.67	222.00	8%									
Westwood Centre	Teesside	CAMHS Tier 4	12		6123.08	1592.25	26%			1			39	3	67	70
Farnham Ward	Durham & Darlington	AMH	20		2976.08	157.00	5%					1	2	1	3	4
Hamsterley Ward	Durham & Darlington	MHSOP	15		3461.17	633.83	18%						1		1	1
Mallard Ward	Forensics	FMH	16		3661.50	711.50	19%						6		8	8
Rowan Ward	North Yorkshire	MHSOP	16		2866.97	316.20	11%					1	8		11	11
Ceddesfeld Ward	Durham & Darlington	MHSOP	15		3059.67	156.50	5%						7		10	10
Elm Ward	Durham & Darlington	AMH	20		2910.00	408.00	14%			1	1	4	9		13	13
Stockdale Ward	Teesside	AMH	18		2839.50	551.00	19%					3	5	2	7	9
Northdale Centre	Forensics	FMH	12	168.75	5287.67	1049.67	20%					3	3		4	4
Bedale Ward	Teesside	AMH	10		4039.50	973.50	24%					1	17		25	25
Bek-Ramsey Ward	Durham & Darlington	LD	11		4200.00	48.00	1%									

Brambling Ward	Forensics	FMH	13		2938.80	357.25	12%			2							
Bransdale Ward	Teesside	AMH	14		2593.00	698.00	27%				1	2	4		5	5	
Lustrum Vale	Teesside	AMH	20		2852.17	426.00	15%				1	1					
Bilsdale Ward	Teesside	AMH	14		2731.48	272.00	10%					1					
Birch Ward	Durham & Darlington	AMH	15		3403.43	984.60	29%						1		1	1	
Cedar Ward (NY)	North Yorkshire	AMH	18	471	3603.58	305.75	8%						1		1	1	
Eagle/Osprey	Forensics	FLD	10		3264.40	421.98	13%										
Maple Ward	Durham & Darlington	AMH	20		2766.82	458.50	17%			2			5		7	7	
Primrose Lodge	Durham & Darlington	AMH	15		2625.00	108.00	4%										
Newberry Centre	Teesside	CAMHS Tier 4	14		3602.82	219.07	6%						55		98	98	
The Evergreen Centre	Teesside	CAMHS Tier 4	16		5135.35	446.00	9%			1			46		77	77	
Ward 14	North Yorkshire	MHSOP	9	80.5	2729.48	36.00	1%						4		4	4	
Willow Ward	Durham & Darlington	AMH	15		3040.67	12.00	0%						1		2	2	
Baysdale	Teesside	CAMHS	6		2708.83	243.01	9%										
Langley Ward	Forensics	FLD	10		3007.17	370.50	12%		1			4					
Merlin	Forensics	FMH	10		4624.67	1692.00	37%						2		5	5	
Oak Ward	Durham & Darlington	MHSOP	12		2697.12	44.00	2%										
Oakwood	Forensics	FLD	8	92	2125.30	99.50	5%										
Bankfields Court	Teesside	LD	19		8154.58	317.66	4%						12		15	15	
Cedar Ward	Durham & Darlington	AMH	10		4315.00	1827.00	42%			2		1	19	4	35	39	
Fulmar Ward.	Forensics	FMH	12		3286.13	504.00	15%					1	5		5	5	
Jay Ward	Forensics	FMH	5		2869.62	459.25	16%										
Robin	Forensics	FLD	6		2655.93	932.94	35%					2					
Nightingale Ward	Forensics	FMH	16		2848.13	389.95	14%										
Sandpiper Ward	Forensics	FMH	8		4300.67	1050.00	24%			1			76	9	187	196	

Springwood Community Unit	North Yorkshire	MHSOP	14	270	3218.92	248.17	8%						28		31	31
Thistle	Forensics	FLD	5		3104.17	246.00	8%						5		11	11
Ward 15 Friarage	North Yorkshire	AMH	14		2475.23	246.00	10%				1	1	3		3	3
Overdale Ward	Teesside	AMH	18		2699.00	336.00	12%						11		16	16
Linnet Ward	Forensics	FMH	17		3127.10	662.00	21%						7		8	8
Swift Ward	Forensics	FMH	10		3719.00	761.25	20%						10		16	16
Ayckbourn Unit Esk Ward	North Yorkshire	AMH	11		2689.50	224.00	8%						9		12	12
Ayckbourn Unit Danby Ward	North Yorkshire	AMH	11		2554.00	206.50	8%						6		8	8
Clover/Ivy	Forensics	FLD	12		4706.30	1048.06	22%						14	1	29	30
Kirkdale Ward	Teesside	AMH	16		3287.05	428.50	13%						2		2	2
Roseberry Wards	Durham & Darlington	MHSOP	15		2793.33	562.67	20%					1	1		1	1
Lark	Forensics	FMH	15		2889.67	520.98	18%									
Wingfield Ward	Teesside	MHSOP	10		3051.25	655.75	21%									
Kestrel/Kite.	Forensics	FLD	16	56.25	4801.83	1340.50	28%					3	16		30	30
The Orchards (NY)	North Yorkshire	AMH	10		2272.00	12.00	1%									
Mandarin	Forensics	FMH	16		3124.13	417.50	13%					1	2		2	2
Rowan Lea	North Yorkshire	MHSOP	20		4181.00	174.53	4%					3	13		21	21
Newtondale Ward	Forensics	FMH	20		3769.55	379.30	10%									
Harrier/Hawk	Forensics	FLD	10	236.25	3848.52	917.07	24%					4				
Meadowfields	York & Selby	MHSOP	14	361.5	2915.40	525.50	18%						5		5	5
Oak Rise	York & Selby	LD	8		4195.00	234.43	6%									
Ebor Ward	York & Selby	AMH	12		2256.05	260.00	12%					1	11		17	17
Minster Ward	York & Selby	AMH	12		2466.25	356.50	14%									
Worsley Court	York & Selby	MHSOP	14	1047	3736.00	44.50	1%		1				2		2	2
Cherry Tree House	York & Selby	MHSOP	18		3276.50	222.50	7%					1	22		27	27

ITEM NO. 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29th November 2016**
TITLE:	**Nurse Recruitment & Retention Update**
REPORT OF:	**Director of Human Resources and Organisational Development**
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:

Good progress has been made with implementing a range of recruitment initiatives during 2016 and recruitment fill rates have begun to improve.

The recruitment of nurses continues to be challenging for TEWV and an increase in the number of nurse age retirements over the next five years is anticipated.

Recent national developments including the planned introduction of the apprenticeship levy and the cessation of the nursing bursary have increased uncertainty about future nurse recruitment and retention prospects.

Opportunities for TEWV to 'grow its own' registered nurses are to be pursued further.

The issue of nurse recruitment and retention is expected to be a subject of regular reporting to the Executive Management Team.

Recommendations:

1) To note the contents of the report and to comment accordingly.

2) To receive an update about progress with implementing the Recruitment and Retention Plan at the May 2017 meeting.

MEETING OF:	**Board of Directors**
DATE:	**29th November 2016**
TITLE:	**Nurse Recruitment & Retention Update**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide the Board of Directors with an update about nurse recruitment and retention within TEWV including the Recruitment and Retention Action Plan (Appendix A) that was recently agreed by the Executive Management Team (EMT).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 A number of papers about nurse recruitment and retention have been presented to the Board of Directors and the EMT during the last year.

2.2 TEWV and locality business plans do not indicate a significant change in the level of demand in the near future for nurses compared to the current number of 2,200. However, key strategic projects including Purposeful and Productive Community Teams (PPCS) and Safe Staffing could impact upon the level of future demand for nurses. It is believed that the workforce implications of the Safe Staffing initiative and the PPCS project will be better understood in March and April 2017 respectively.

3. KEY ISSUES:

3.1 A number of new Trust and locality recruitment approaches; that complement existing recruitment practice, and which have taken place so far this year. There have been five bespoke events/activities and these have resulted in 111 offers of nurse employment made.. Though it is early days the recruitment approaches taken do appear to have been successful.

3.3 Past recruitment activity –

3.3.1 The number of band 5, 6 and 7 registered nurses recruited during 2015/16 was:

No of registered nurses recruited	2015/16	2016/17 (6 months data available)
Band 5	287	160
Band 6	288	121
Band 7	88	47
Total	**663**	**328**

3.3.2 The fill rates for band 5 and 6 posts advertised during 2015/16 were 78% following one advertisement and 90% after three advertisements. 74% of recruitment activity was in respect of replacing TEWV staff who moved to other posts within TEWV or providing cover for other staff who were absent from the workplace.

3.3.3 During 2016/17 the fill rates of band 5 and 6 posts have increased to 84% following one advertisement and 92% after three advertisements. 79% of appointments to band 5 registered nurses are external recruits in the year to date 2016/17 which is an increase on the 2015/16 figure of 60%. Fill rate variations between localities are apparent.

3.3.4 There is evidence that the reported increase in successfully recruiting to a Band 5 and band 6 posts following one advertisement or recruitment event is attributable to the centralised recruitment approaches. A significant number of appointments have been made as a direct result of attending recruitment fairs and working more closely with the local universities. The decision to cease using fixed term contracts when recruiting nurses is also believed to have had a positive impact upon fill rates.

3.4 Forecasting

3.4.1 During 2015/16, approximately 70% of band 6 posts were filled by band 5 and band 6 staff, leaving approximately 86 (8.7%) registered nurses to be recruited externally. At this time, there is no data available to understand how many of the band 7 posts were filled by band 6 and band 7 registered nurses

The figures outlined above include internal movement, what is not clear is how many of the internal movements leads to a vacant position from which the employee originated, creating another external vacancy and whether these are captured in the existing external recruitment figures.

Based on the assumption that the Trust would prefer to have an oversupply of nurses, the calculations made would suggest that we require approximately 461 registered nurses to be recruited year on year to help maintain safe staffing levels.

3.5 Retirement forecasts

3.5.1 The Trust is facing a potential spike in nurse age retirement numbers over the next five years given the current age profile and the average nurse retirement age of 56 of previous years.

3.5.2 Of those nurses, who in recent years have left TEWV due to age retirement, approximately 20-25% have returned to work in some capacity. This however, has meant approximately 50 nurses have retired each year and not returned to work for TEWV.

3.5.3 It is estimated that over the next 5 years there be a need to recruit approximately 173 additional qualified nurses compared to previous years in response to the numbers of anticipated retirements, assuming that the demand for nurses remains at its current level and that the number of nurses retiring and returning to work in TEWV remains the same. The table below provides a year by year breakdown of the number of anticipated age retirements over the next five years.

Financial Year	No of extra retirements	No of posts to be recruited
2017-18	6	467
2018-19	39	500
2019-20	49	510
2020-21	37	498
2021-22	42	503
Total	**173**	**2,478**

3.6 **Retention of Nurses**

3.6.1 During 2015/16 some 65 nurses retired from the Trust and only 13 returned to work in some capacity (20%). As highlighted above, and in Appendix B, the numbers of nurses that it is anticipated will retire could significantly increase in 2018/19.

3.6.2 There is growing anecdotal evidence to suggest that TEWV is not providing sufficient retire and return opportunities for nurses and may be missing opportunities to increase nurse workforce supply in addition to retaining key skills and experience for longer. Feedback from a variety of sources including the return to practice initiative, pre-retirement courses and pension workshops is consistent in that a number of nurses report frustration with not having their retire and return requests agreed. At present such requests are made only to an individual line manager and inevitably opportunities will be more limited than if these requests could be considered on a TEWV–wide basis.

3.6.3 Under the auspices of Safe Staffing, Recruitment and Retention and Extending Working Lives, all registered nurses in TEWV have been emailed and asked whether they would wish to meet with their respective Head of Nursing to discuss a range of workforce supply issues. The areas of conversation include whether they would consider:

- increasing their contracted hours
- registering with TEWV nurse bank, if not what would incentivise them to do so
- if already registered with the bank, whether they would be interested in a permanent contract
- future career development plans and thoughts about retire and return

A total of 465 nurses have responded, which is rather more than anticipated, and requested a conversation. This suggests that there is the potential to increase the number of nursing hours available from within the existing workforce. It is expected that the outcomes of these conversations will be known and communicated by March 2017.

3.6.3 The EMT has recently agreed that concerted efforts are made to increase the number of nurses who retire and return and, if so, guidance about what approach we take to a particular related issue, is sought in this paper. A revised TEWV Retire and Return Procedure will be produced in the near future. It is anticipated that national guidance about retire and return will also be produced shortly and , if so, the TEWV guidance ought to complement the national guidance.

3.7 Return to Practice is a national initiative. In 2016, TEWV only managed to recruit 9 registered nurses that had left employment through this programme. Engaging with this group of people is proving difficult for the NHS as a whole and a lack of flexible working opportunities is cited by some as being amongst the key reasons why Return to Practice programmes have not been more successful to date and this information may help to guide future efforts to improve the take up of Return to Practice programmes.

3.8 Sources of Supply

3.8.1 Previously Health Education England representatives have expressed the view that trusts in the North East may have underestimated the number of new nurses that they require when participating in the annual nurse training commissioning process. In response to this it is understood that Health Education England has previously increased the number of student nurse places commissioned. It should be noted that from 2017 Health Education England will no longer commission student nurse places on behalf of providers and that it will be the responsibility of TEWV to commission places for TEWV. The EMT has recently agreed future training numbers commissioned by TEWV should be such that they could result in a small over supply of nurses.

3.8.4 The regional bid made by TEWV to become a first wave test site for the nursing associate role has not been successful, however, TEWV has been included amongst a group of trusts classified as the 'fast followers'. The particular 'fast followers' who are selected will begin the pilot of the nursing associate role in Spring 2017.

3.8.5 The information in paragraph 3.5.3 identified that TEWV will require an extra 173 registered nurses over the next 5 years due to the age profile of the nursing workforce. There are two main sources of future supply of newly qualified nurses. The first group is those nurse students who attend University, usually full time; the second group is existing TEWV staff.

3.8.5.1 Source 1 - Students – The numbers of students currently in the system and due to complete their training is as follows:

Mental Health

University	2017	2018	2019	2020
Teesside	84	84	73	
York	32	32	32	
Open University	3		3	8
Total – MH	**119**	**116**	**108**	**8**

Learning Disability

University	2017	2018	2019
Teesside	44	48	42
York	20	20	20
Total - LD	**64**	**68**	**62**

The figures above are based upon an assumed attrition rate of 20% with the exception of the Open University students who have a much lower attrition rate. This is believed to be due to the fact that the Trust is working with existing employees who are training to becoming a registered nurse.

From the information above, we can conclude that both sources of registered nurses are likely to have slight variations in terms of the numbers graduating during the next 3 years.

3.8.5.2 Source 2 – Existing workforce - The main groups of employed staff that are most likely to want to progress and become a registered nurse are the 89 Associate Practitioners and 1,233 Health Care Support Workers including any other roles/job titles that are similar in duties performed.

3.8.5.3 Information gathered by recently surveying TEWV staff in clinical posts Bands 1 to 4 suggests that out of the 283 responses (20%), 118 staff were interested in becoming a nurse, 39 staff already hold a foundation degree in health and social care, 130 staff possess an NVQ Level 3 in Health and Social Care, 24 have a health related degree, 40 staff stated that they had 2 A Levels, 237 hold a GCSE grade c or above and 225 hold a GCSE in maths at grade c or above. Only one or two survey respondents currently had or are working towards related OU studies. It is concluded that there is significant interest within our existing workforce in developing into registered nurse roles.

3.8.6 The key issue for existing clinical staff in Bands 1 to 4 is that becoming a registered nurse in the shortest possible route (See Appendix E for Routes to Nursing) would require:

- The employee to leave the Trust and go to University full-time for between 2 – 4 years depending upon whether the person has a foundation degree or equivalent. This would mean that they would temporarily give up their annual salary, temporarily cease contributing to the NHS pension scheme, have a break in continuous and reckonable NHS service and incur student fees
- The employee would almost certainly need to apply for a student loan
- The Trust would need to back fill the subsequent vacancies for a period of 2 – 4 years

3.8.7 The EMT has recently agreed that measures, including financial support, to encourage existing TEWV employees to undertake nurse training will be developed further. Without these arrangements being put in place it is thought that there will be little take up of such training by existing TEWV employees.

3.8.8 At present, there is only one route available where the employee can remain in employment and undertake a pre-registration nursing course at the same time. This route is available via the Open University and would involve 0.6 WTE in employment contract and 0.4 WTE student contract. For the person who already has a Foundation Degree or equivalent this would take 3 years to complete, otherwise it would be a 4 year programme. At present only a very small number of staff can pursue this option due to the numbers of places offered. The positive elements to this approach are that it does build a strong commitment and loyalty between the employer and employee, supported by the fact that this route has a low attrition rate because participants are employed, it attracts more mature students and experienced healthcare workers who have excellent insight into the role and what they are getting into, they often value the opportunity for development.

3.8.9 The EMT has recently agreed that TEWV ought to develop proposals for its own nurse training programme that would complement existing nurse training arrangements. Scoping work will be carried out with pace. Learning from the experiences of other NHS organisations who are leaders in this respect will be sought.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

4.1.1 In order to provide confidence and assurance that the Trust can maintain safe staffing levels a proactive and strategic approach to recruitment and retention is required.

4.2 Financial/Value for Money:

4.2.1 It is anticipated that in April 2017 the Trust will incur a cost pressure of approximately £1.4m due to the introduction of a national apprenticeship levy. There are currently no nursing apprenticeships available and therefore it is not possible to offset some of these costs against the apprenticeship levy. A detailed paper about the apprenticeship levy is to be presented to the EMT in January 2017.

4.2.2 Student bursaries will cease with effect from 2017/18 when new students on nursing, midwifery and AHP pre-registration courses and students will be required to take out maintenance and tuition loans.

4.2.3 There is a theoretical risk of an over- supply of nurses at any one point in time arising from the various recruitment initiatives and this could lead to some services being temporarily over-staffed and overspending.

4.3 Legal and Constitutional (including the NHS Constitution):

4.4 Equality and Diversity:

4.4.1 An Equality Assessment will be undertaken to ensure that no protected characteristics groups are disadvantaged by the recently agreed approaches to recruitment.

4.5 Other implications:

4.5.1 There are currently a number of variables and unknowns as the new training and education environment unfolds.

5. RISKS:

5.1 The earliest timeframe for increasing the number of qualified registered nurses is either 2019, in respect of the 2 year programme, and/ 2020 for those completing the 3 year programme. The increase in staff leaving due to retirement will increase in 2018, this is the point at which Trust will need to recruit an extra 40-50 qualified nurses.

5.2 Recent changes to the NHS Pension Scheme mean that it may be difficult to predict how older staff will behave in respect of making retirement and early retirement decisions during the next five years. This uncertainty does create a potential risk to workforce supply.

6. CONCLUSIONS:

6.1 Good progress has been made with the design and implementation of a number of nurse recruitment and retention initiatives during 2016. Despite the good progress made there remains much to do and the issue of nurse recruitment and retention will continue to be addressed by the EMT on a regular basis for the foreseeable future.

6.2 Efforts to develop longer term recruitment and retention solutions are at an early stage and more needs to be done to better understand the impact upon potential solutions of a range of related national initiatives and to better understand the true level of future demand for nurses within TEWV.

7. RECOMMENDATIONS:

7.1 To note the contents of the report and to comment accordingly.

7.2 To receive an update about progress made with implementation of the Recruitment and Retention Action Plan at the May 2017 meeting of the Board of Directors.

Angela Collins, Deputy Director HR and OD
Beverley Vardon-Odonkor, Head of HR and Workforce Information
Stephen Scorer, Deputy Director of Nursing
David Levy, Director of Human Resources and Organisational Development

Background Papers:

EMT paper – Recruitment, Development and Retention of Nurses – June 2016

APPENDIX A

Recruitment and Retention Action Plan

Tasks	Key activities	Date Task to be completed	Responsible person
Recruitment	• Continue to offer permanent contracts to all new nurses and then review	30 September 2017	Beverley Vardon-Odonkor
	• Review the need to offer financial incentives to student nurses at York university	Completed	Angela Collins
	• Engage with Generation Z to align recruitment policy, practice and approach with workforce of the future		Beverley Vardon-Odonkor
Recruitment and Retention Premia (RRP)	• Develop a TEWV RRP business case review process	30 September 2017	Beverley Vardon-Odonkor
	• Review the case for pursuing international recruitment	30 September 2017	Beverley Vardon-Odonkor
Internal movement	• Develop an alternative process to manage the number of nurses seeking to take up a post in the same pay band making links with Talent Management information	30 September 2017	Nicola Rutherford and Michelle Brown
	• Develop registration scheme to manage internal movements	30 September 2017	Beverley Vardon-Odonkor
Extending Working Lives	• Increase the numbers of contracted hours of part-time staff	31 March 2017	Heads of Nursing
	• Complete Nurse Conversations	31 March 2017	Heads of Nursing
Bank	• Increase the numbers of registered nurses on the Central Nurse Bank	30 February 2017	Karen Kendall
	• Pilot - planned overbooking of bank workers in FMH and FLD	Evaluation in December 2016	Karen Kendall
	• Implement bank worker direct booking system	Completed	Karen Kendall
Responsive Workforce Team initiative	Develop a Derbyshire responsive workforce model within TEWV	31 March 2017 model confirmed	Stephen Scorer and Angela Collins

Return to Practice	• Gain greater understanding of current activity • Identify opportunities to maximise activity – how can flexible working play a part in encouraging return to practice	30 September 2017	Stephen Scorer
Retire and Return	• Develop a process to register staff interested in retire and return • Increase awareness of options via Heads of Nursing • Consider developing a trust wide approach to match up part-time hours and signpost	31 March 2017	Nicola Rutherford, Heads of Nursing
HR related activities	• Undertake a review of sickness absence, short and long term, to identify the extent to which working conditions impact upon sickness absence and retention • Review flexible working procedure • Develop relocation policy	30 September 2019 30 September 2017 30 September 2017	Lesley Hodge Nicola Rutherford Lesley Hodge
Information	• Produce new recruitment and retention information reports for localities and TEWV • Produce and circulate TEWV leaver information and exit questionnaire feedback to localities	30 September 2017 January 2017	Beverley Vardon-Odonkor Beverley Vardon-Odonkor

Development activities to Grow Our Own workforce

Tasks	Key activities	Date Task to be completed	Responsible person
Engagement with School and Colleges	Consider and if appropriate, develop an engagement strategy to increase awareness of/interest in working in the NHS	30 September 2019	Stephen Scorer, Jane Buckle, and Angela Collins
Grow Your Own	• Support up to 100 current Band 4 Associate Practitioners to complete two years pre-registration programme • Develop revised nurse training agreements with HEIs to train TEWV	30 September 2020 30 September 2017	Stephen Scorer , Jane Buckle, Judith Hurst and Angela Collins Stephen Scorer

	HCAs as new nurses in addition to commissioned nurse training numbers • Utilise apprenticeship levy to replace current HEE Talent for Care funding for all HCA Career framework, consider links to pre-reg training • Participate in the National Nursing Associate Programme (pilot)	30 September 2017 30 September 2019	Judith Hurst Stephen Scorer, Jane Buckle, Judith Hurst

APPENDIX B Current and Future Nurse Requirements

1.1 The Workforce Task and Finish group highlighted a range of workforce and budgetary information that should help to predict the future demand for registered nurses. The data included reviewing the following data streams:-

- Number of registered nurse band 5, 6 and 7 vacancies filled during the period 2014-15 and 2015-16. The analysis also looked at whether the successful candidate was internal or external. Internal movement at band 5 during the reporting period amounted to between 33% and 40% of filled vacancies.

- The figure is significantly higher for internal movement within band 6 which amounted to 77% of filled vacancies.

- The figures for band 7 is between 83% and 90% of successful candidates were internal. The table below highlights the number of band 5, 6 and 7 registered nurses recruited during the reporting period.

	Trust		Durham & Darlington		Forensic		North Yorks		Teesside		York & Selby	
	2014 -15	2015 -16	2014 -15	2015 -16	2014 -15	2015-16	2014 -15	2015 -16	2014 -15	2015 -16	2014-15	2015-16
Band 5	243	287	83	81	55	45	71	70	31	88		10
Band 6	224	288	69	82	21	38	66	55	66	96		21
Band 7	94	88	29	26	5	7	21	25	39	24		6

- The business planning process undertaken last year indicated very little growth in the workforce so it is reasonable to at this point in time to assume the demand for registered nurses band 5, 6 and 7 will remain as in previous years.

- There are a number of factors which may impact on the demand such as the Safe Staffing work, PPCS project and the ageing workforce.

1.2 WTE vacancy rates based on the budget reports produced by finance each month.

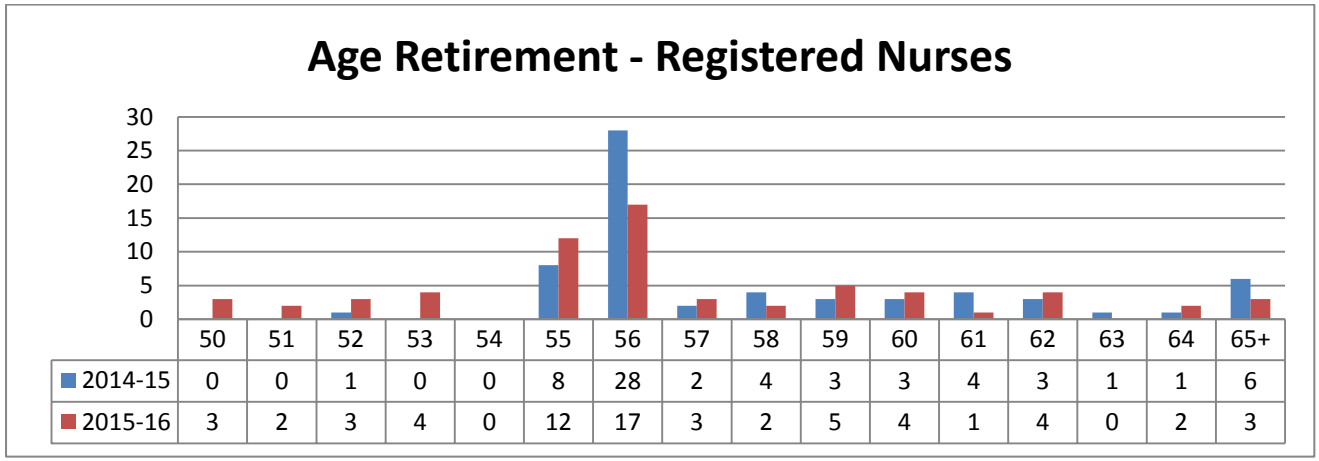
The vacancy rate is calculated based on the difference between the reported budgeted position and the actual position. Whilst this information was considered it was recognised that the reported position should only be used as an indicative vacancy figure as there are a number of variables which impact on the reported position e.g. temporary reduction in hours. The analysis highlights an average monthly vacancy rate of 56 WTE for band 5 which equates to 7% under the identified budgeted requirement and an average monthly vacancy rate of 43 WTE for band 6 which equates to 4.5% under the identified budgeted requirement.

1.3 The turnover rate is based on the number of staff that leave the organisation and excludes internal movement. The table on page 9 identifies the nurse turnover rate over the last two years.

	Trust		Durham & Darlington		Forensic		North Yorks		Teesside		York & Selby	
	2014 -15	2015 -16	2014 -15	2015 -16	2014 -15	2015-16	2014 -15	2015 -16	2014 -15	2015 -16	2014-15	2015-16
Band 5	11.9%	12.3%	9.8%	15.0%	13.1%	9.9%	15.6%	9.5%	10.7%	12.0%		15.5%
Band 6	8.7%	8.0%	10.2%	12.1%	10.1%	6.1%	9.2%	5.6%	6.7%	6.4%		7.5%
Band 7	6.7%	8.0%	11.2%	5.7%	2.7%	11.1%	8.8%	6.6%	3.9%	10.3%		17.2%

1.4 Age retirements of registered nurses over the last two years. The following bar chart highlights the age profile of registered nurses opting to retire over the previous two years. The most prevalent age for retirement is 55 and 56 years old and this is consistent with mental health officer status of many current TEWV nurses.

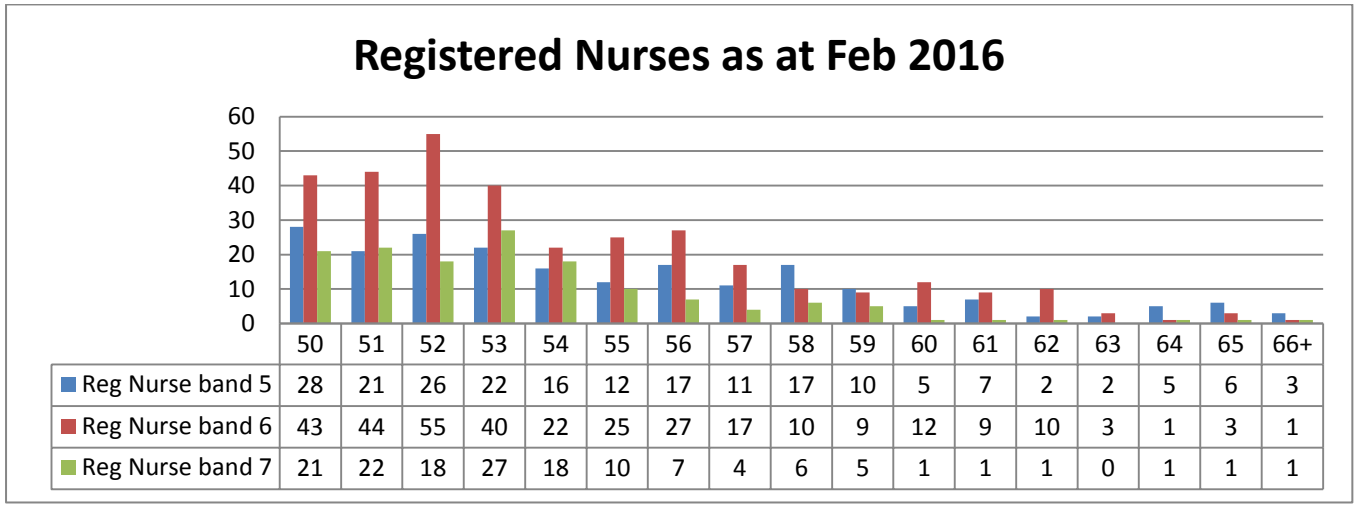
1.4.1 The bar chart refers to staff who could request to retire and return. 16 (25%) staff retired and returned in 2014-15, this figure reduced to 13 (19%) in 2015-16.



	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65+
2014-15	0	0	1	0	0	8	28	2	4	3	3	4	3	1	1	6
2015-16	3	2	3	4	0	12	17	3	2	5	4	1	4	0	2	3

1.4.2 The registered nursing workforce age profile from aged 50 onwards is referred to within the bar chart below. The bar chart highlights that the number of registered nurses reaching the age of 55 and 56 will increase significantly from 2018 onwards which

will impact on the number of registered nurses required. The number of registered nurses aged 55 – 56 in 2016 is 98 and increases steadily to 179 in 2020.



	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66+
Reg Nurse band 5	28	21	26	22	16	12	17	11	17	10	5	7	2	2	5	6	3
Reg Nurse band 6	43	44	55	40	22	25	27	17	10	9	12	9	10	3	1	3	1
Reg Nurse band 7	21	22	18	27	18	10	7	4	6	5	1	1	1	0	1	1	1

ITEM NO. 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 29 November 2016**
TITLE:	**To consider the report of the Mental Health Legislation Committee**
REPORT OF:	**Richard Simpson, Non-Executive Director**
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 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:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 2, 2016-17.

Recommendations:

The Board of Directors is asked to receive and note the assurance report and conclusions, following the MHLC meeting held on October 2016 and to note the approved minutes of the MHLC meeting held on 25 July 2016.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 29 November 2016**
TITLE:	**To consider the report of the Mental Health Legislation Committee**

1. INTRODUCTION & PURPOSE:

1.1 To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 2, 2016-17; through consideration of the work of the Mental Health Legislation Committee, which is a Standing Committee of the Board.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The background to the purpose of this report is held at Appendix 1.

3. KEY ISSUES:

At the meeting held on 24 October 2016

3.1 The minutes of the Committee meeting held on 25 July 2016 were reviewed and agreed as an accurate record. (See Appendix 1 for information).

3.2 It was noted from the summary report for CQC MHA inspections that there were 10 visits in Q2 as compared to 7 in Q1. Reports had been received for 6 of the visits and the September reports had not yet been received. A request was made and agreed that the report in future would include a summary table of actions completed and outstanding.

3.3 The Section 136 report was presented. In total there were 271uses of section 136 across the whole Trust area, a significant increase of 38% in this quarter from 198 in the previous quarter. The two areas that have contributed most to the increase are North Yorkshire and Cleveland – North Yorkshire rising 43% to 123 from 86 and Cleveland rising 55% to 96 from 62. Durham remains stable at 52 this quarter from 50 previously. Those being taken into police custody however, remains low at 7% across the whole Trust area. There were 9 individuals under the age of 18 brought to a TEWV place of safety in the last quarter; 6 were 17 and 3 were 16 years of age from the Harrogate, Darlington, Durham, Middlesbrough and Northallerton area; 1 was formally detained and the remainder were discharged with follow up from MH services.

In terms of Street Triage activity there were 95 contacts in the quarter in Teesside compared to 136 in the previous quarter, of which 1 resulted in the use of section 136, and in York there were 88 contacts compared to 78 last quarter of which 2 resulted in the use of section 136. Scarborough had 101 contacts compared to 84 in the last quarter of which 0 resulted in section 136. The Committee was interested to note the high percentage of contacts by all Street Triage teams with people already known to services – Tees 84% known, Scarborough 94% known and York 63% known.

Within the Crisis Assessment Suite at Roseberry Park activity continues to be significant with 559 assessments compared to 487 assessments undertaken in the previous quarter, (this does not include those assessed subject to section 136). The numbers attending 'voluntarily' with the police and not subject to section 136 continues to be high and far exceeds the number subject to section 136 – in the quarter there were 147 attending voluntarily with the police compared to 94 brought subject to section 136. Of the total 559 assessments 87, 16%, were discharged without mental health follow up or sign-posting to other services

3.4 The Discharge from Detention Report was presented. This report focusses on discharge from detention by either the First Tier Tribunal or the Associate Hospital Managers. Three patients were discharged by the Associate Hospital Managers this quarter equating to 2% from the 142 hearings held. Of the 178 FTTs held, the Tribunal ordered 14 discharges in total (8%) - 7 discharged from section 2, 2 discharged from section 3 and 4 discharged from Community Treatment Orders. There was 1 absolute discharge of a restricted patient with the agreement of the clinical team. Although 2 of the patients discharged had the same RC, they had different Care Coordinators and their cases were heard by different Tribunal Panels. With regard to the FTT panels for each of the discharged patients, although there was some commonality between panels, on no occasion were there the same 2 or 3 people sitting on any of these panels.

3.5 The seclusion report was presented. There are still difficulties in obtaining 'clean' data from Paris and significant manual work is required and there are still some missing data issues. From the information available, there were 23 patients secluded in this period, with 52 reported episodes of seclusion; 12 patients were secluded on multiple occasions between 2 and 6 times. There was some concern expressed regarding the long term nature of some seclusions and whether an escalation process was required internally over and above what the Code of Practice requires. LMGBs and CLODS to be asked to consider what this may look like and feed back.

3.6 Under any other business the minor change to the Terms of Reference was agreed having already been approved by the Board.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
CQC MHA visit reports do not indicate any significant issues with regard to compliance with the Fundamental Standards in terms of the MHA and MCA.

4.2 **Financial/Value for Money:**
No implications.

4.3 **Legal and Constitutional (including the NHS Constitution):**
Non-compliance with the CQC regulatory framework for the Mental Health Act and Mental Capacity Act and DoLS and/or non-compliance with the MHA or

MCA itself would have serious consequences for the organisation and place the organisation at risk of breach of the conditions of the Independent Regulators or potential litigation.

4.4 **Equality and Diversity:**
No implications.

5. CONCLUSIONS:
The MHL Committee received reports and evidence for assurance on all elements of the Mental Health Act administration and implementation, demonstrating compliance with CQC regulatory requirements. This assurance is externally supported by the feedback from the CQC Mental Health Act inspections.

7. RECOMMENDATIONS:
The Board of Directors is asked to receive and note the assurance report and conclusions.

Author: Mel Wilkinson
Title: Head of Mental Health Legislation

Background Papers:
Appendix 1 – Approved minutes of the 25 July 2016 MHL Committee Meeting

Appendix 2

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 25 JULY 2016 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 11.00AM.

Present:
Mr H Griffiths, Non-Executive Director, (Acting Chairman of the Committee)
Dr N Land, Medical Director
Miss J Clark, Public Governor.
Mrs J Illingworth, Director of Nursing & Governance

In Attendance:
Mr D Brown, Director of Operations, Teesside
Ms P Griffin, Mental Health Legislation Advisor
Mrs D Oliver, Deputy Trust Secretary, (Corporate)
Miss M Wilkinson, Head of Mental Health Legislation

Apologies: Apologies for absence were received from Mr B Kilmurray, Director of Operations, Mr R Simpson, Chairman of the Committee, Mrs L Bessant, Chairman of the Trust and Mrs E Moody, Director of Nursing & Governance.

16/18 MINUTES

Agreed – *That the minutes of the last meeting held on 25 April 2016 be approved as a correct record and signed by the Chairman, subject to the following typographical errors:*
Dr H Griffiths to be added to the "present" list as a member.
Page 3, section 16.12 (i),Section 136, ii) "Should someone be admitted under a Section 136 aged ***18 years*** *or under, …"*

16/19 ACTION LOG

The Committee noted there were no outstanding actions from the previous meeting held on 25 April 2016.

16/20 CARE QUALITY COMMISSION (MHA) VISIT FEEDBACK SUMMARY REPORT

The Committee considered and noted the Care Quality Commission (MHA) visit feedback summary report.

Arising from the report it was noted that:

1. There had been 7 CQC MHA inspections during the Quarter, compared to 10 in the previous Quarter. 1 had been to Adult Mental Health, 3 to MHSOP and 3 to Forensic services (MH and LD).
2. Reports had been received for all of the 7 visits and the report for Springwood in the previous Quarter had also been received.
3. There had been issues identified around section 17 leave relating to the absence of risk assessments and evidence that the patient had been given a copy of the leave form.
4. There continued to be issues in relation to patients' rights under section 132 and recording of comprehension had been identified.

5. A comment had been made in one report that care plans appeared to be prescriptive, rather than collaborative.
6. Where issues had been raised, all completed Provider Action Statements had been approved by EMT and returned to the CQC.

Following discussion it was noted that:

i) An MHA audit was included in the Trust wide Clinical Audit programme.
ii) It would be useful to have in future CQC reports the actions attached to the issues raised.

Action: Mrs J Illingworth

16/21 (i) SECTION 136

The Committee considered and noted the Section 136 report.

Arising from the report it was highlighted that:

1. There had been 196 uses of section 136 across Trust localities, (a slight increase from 183 in the previous Quarter), of which 177 (90%) had been brought to a Mental Health Based Place Of Safety (MHBPOS).
2. The use of Section 136 by Cleveland Police appeared to have plateaued; increased across North Yorkshire slightly in comparison to last Quarter by 7% and those taken to a Trust place of safety in North Yorkshire had been 86%.
3. Within Durham and Darlington the numbers had increased by 37% from 35 to 48 episodes in the Quarter and that included missing data for those taken to police custody in June 2016.
4. North Yorkshire total use of section 136 had been 39% higher than Cleveland Police, compared to 31% last Quarter.
5. There had been 9 children or young people brought to a TEWV place of safety in the Quarter, including one 13 year old and one 14 year old. All were either admitted or discharged with follow-up.
6. In terms of Street Triage activity there had been 136 contacts in the Quarter in Teesside, compared to 111 in the previous Quarter, of which none resulted in the use of section 136.
7. In York there had been 78, compared to 57 last Quarter contacts, of which 3 resulted in the use of section 136.
8. Scarborough had 84 contacts of which none resulted in section 136, however data had not been available in the previous Quarter.
9. Within the Crisis Assessment Suite at Roseberry Park activity continued to be significant with 487 assessments compared to 577 assessments undertaken in the previous Quarter, (excluding those assessed subject to section 136).
10. The numbers attending ‘voluntarily’ with the police and not subject to section 136 continued to be high and far exceeded the number subject to section 136 – in the Quarter there had been 127 attending voluntarily with the police, compared to 59 brought subject to section 136.
11. Of the total 487 assessments 71 (15%), had been discharged without mental health follow up or sign-posting to other services.

Following discussion it was noted that the 2% outcome of discharges from April to June 2016 not recorded was due to an instance within a locality where there did not appear to be a coordinator of 136 or documentation had not been completed.

Agreed: That further analysis around CAS, attendance and police involvement should be brought back to the October MHLC meeting.

Action: Mr D Brown

16/22 (ii) MHA DISCHARGES REPORT

The Committee considered and noted the MHA Discharges Report.

Arising from the report it was highlighted that:

1. There had been no patients discharged by the Associate Hospital Managers during the Quarter.
2. Of the FTTs held the Tribunal had ordered 19 discharges in total, 6 discharged from section 2, 3 discharged from section 3 and 5 discharged from Community.
3. There had been 2 conditional Treatment Orders (CTOs), 1 absolute discharge of restricted patients (all with the agreement of the clinical team), 1 section 37N (with the agreement of the clinical team) and 1 section 37.
4. It appeared that although 4 of the patients had the same RC, and a further 2 also had the same RC, all had been different Care Coordinators and their cases had been heard by different Tribunal Panels.
5. Of those discharged from detention, most patients had remained informally for varying periods of between 3 days and 4 weeks and 1 remained informal.
6. There had been only 1 patient readmitted after approximately 3 weeks and re-detained on a section 2, which had been subsequently re-graded to a section 3.

Following discussion it was highlighted that it was difficult to identify any pattern to the discharges that could be addressed or have implications for the Trust.

16/23 SECLUSION REPORT

The Committee considered and noted the MHA Seclusion Report.

Arising from the report it was highlighted that:

1. There continued to be difficulties obtaining 'clean' data from Paris. Significant manual work was still required and there were some missing data issues.
   On this matter it was noted that since procedures had been established for a report to be provided to the MHLC Department monthly, this monitoring would be more timely and comprehensive.
2. From the information available, there had been 23 patients secluded in this period, with 46 reported episodes of seclusion; several patients had been secluded on only one occasion and others had been secluded between 2 and 6 times.

Following discussion the Committee acknowledged that seclusion generally was an ongoing issue for the Trust, particularly at West Park Hospital.

16/24 UPDATE ON YORK & SELBY

Miss Wilkinson gave a verbal update on York & Selby and highlighted the following:

1. Hospital Managers were now in place and information had been transferred onto Paris.
2. The patients currently residing at Roseberry Park Hospital were due to move back to Peppermill Court on re-opening.
3. The capacity and case workload would be monitored for the MH Officer at Bootham Park,

16/25 CONSENT TO TREATMENT

The Committee considered and noted the Consent to Treatment update.

Miss Wilkinson highlighted the following:

1. The letter from Mr Simon Wood, Principal SOAD, from the CQC dated 27 June 2016 had set out further information, in particular to indicate how treatment plans might be recorded using only textual descriptors.
2. The new format for the BNF no longer used familiar numeric categories, which had been replaced by broader textual descriptions.

Following discussion it was felt that there remained ambiguity around the impact of these changes, however it was agreed that some scrutiny of the T Forms in Pharmacy could help.

16/26 ANY OTHER BUSINESS

1. **Informal Patient Leaflets**

   The Committee noted a verbal update around informal patient leaflets, which were currently being updated and refreshed by Communications.

2. **Question to Committee around AMHPs requiring a second doctor to carry out formal MHA assessments**

   "Given the difficulty of finding section 12 doctors nationally is there anything TEWV can do to help resolve the situation locally or nationally?"

   The Committee noted and discussed the question raised by Miss J Clarke regarding the difficulty for AMHPs requiring a second doctor in order to carry out formal MHA assessments.

   On this matter it was noted that:

1. The Trust provided the first doctor through PA and on-call arrangements, however the Trust could not also provide the second doctor. This was a nationally recognised issue and the Trust, through its function of hosting the North of England Approval Panel, had been considering making available the names and contact details of Doctors who wished to gain the necessary experience to become section 12 approved. The Department of Health were supportive of this suggestion.

The meeting concluded at 12.45pm

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Hugh Griffiths
Acting Chairman – Mental Health Legislation Committee
25 July 2016

ITEM NO. 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29TH November 2016**
TITLE:	**Composite Staff Action Plan**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Information and 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:

The report provides information about progress made, as at the end of Q2 2016/17 with implementing locality and corporate action plans and the Trust-wide Composite Staff Action Plan.

Progress made to date with implementation has been good at both local and Trust level.

There is evidence of good engagement on the part of services. Locality and corporate directorate Investors in People leads continue to play an important role by supporting local efforts to implement agreed plans and by providing intelligence and feedback to Trust-wide meetings about a range of staff engagement issues.

Recommendations:

To note the contents of the report and to comment accordingly.

MEETING OF:	**Board of Directors**
DATE:	**29TH November 2016**
TITLE:	**Composite Staff Action Plan**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide Directors with an update about progress made with implementation of the Composite Staff Action Plan and locality/corporate directorate action plans as at the end of Q2 2016/17.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Composite Staff Action Plan was agreed by Directors at the May 2016 meeting of the Board of Directors. Locality and corporate directorate action plans have been in place from June 2016.

3. KEY ISSUES:

3.1 Appendix 1 provides summary information about progress made with implementation of locality and corporate directorate action plans and with the entire Trust-wide Composite Staff Action Plan as at the end of Q2 2016/17.

3.2 There has been good progress made with implementation of locality and corporate directorate action plans during the first two quarters of 2016/17. The total number of locality and corporate directorate actions allocated for completion by the end of Q2 2016/17 was 92 and of these 85 have been achieved, a completion rate of 92%. Those localities and corporate directorates that have the most actions yet to be completed are also amongst those that have completed the most actions to date.

3.3 Progress made with implementing the Composite Staff Action Plan has been good. Of the 36 actions that were due to be completed by the end of Q2 all but one were completed within the target timescale. The outstanding action is due to be completed in Q3. A further 29 actions are due to be completed during Q3 and Q4 of 2016/17.

3.4 The Trust's Investors in People leads, representing localities and corporate directorates, have met regularly to monitor progress and to help promote the importance of agreed actions being implemented at local level and Trust-wide. The leads have been a good source of intelligence and feedback about wider staff engagement issues within TEWV and their views have helped to inform decision making about TEWV people management policy and practice.

3.5 The number of actions within this year's Composite Action Plan, sixty five, is somewhat higher than the forty three actions that were included within the 2015/16 plan. This year's plan seeks to address nine themes arising from the 2015 staff survey results, the Staff Friends and Family Test and the 2014

Investors in People assessment. This figure is a little higher than the seven themes that informed the contents of last year's plan.

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.

4.4 **Other implications:** None identified

5. RISKS: There is a need to ensure that in future the York and Selby locality is fully engaged in these activities to the same extent as other localities presently are. Due to the timing of the York and Selby transfer the locality had no 2015 staff survey results and no Investors in People assessment feedback to use that could form the basis of an action plan for this year.

6. CONCLUSIONS:

6.1 Good progress has been made with implementation of locality and corporate directorate action plans as at the end of Q2 2016/17.

6.2 Good progress has been made with implementation of the Composite Staff Action Plan as at the end of Q2 2016/17 though a significant number of actions are due for completion within Q3 and Q4 of 2016/17.

7. RECOMMENDATIONS:

7.1 To note the contents of the report and to comment accordingly.

David Levy
Director of Human Resources and Organisational Development

Background Papers:

APPENDIX 1

LOCAL ACTION PLANS END OF QUARTER 2 - 2016/17 UPDATE

Service Area	Number of actions allocated to Q1/Q2	Achieved	Yet to be achieved	Examples of Good Practice
1. Durham and Darlington	0	N/A		1. Not applicable.
2. Estates and Facilities Management	3	3		1. Roadshows now take place twice a year to ensure that senior staff are more visible amongst the team.
3. Finance and Information	26	22	4	1. A lean management system has been developed in the form of a daily morning huddle to understand the demands on the teams as well as a cross team huddle. 2. An Ideas Box has been introduced to raise topics relevant to any current issues.
4. Forensic Services	14	14		1. The senior management team have attended a one day Coaching Conversation Event, further cohort scheduled in October. 2. Regular QIS locality report outs. Projects have included CPA process within HMP, mobile phones within low secure services, MDT working and ward managers roster meeting. 3. Annual Forensic Service Nursing Awards presentation event held. Managers identify individuals for their commitment to the service.
5. Human Resources/Organisational Development	27	25	2	1. Equality and Diversity and Human Rights training updated to include the importance of bullying and harassment. 2. QIS event held to review the use of Staff FFT data. Recommendations from event agreed and implemented. 3. A ‘what helped me’ leaflet has been produced by staff that have ‘lived experience’ of mental ill -health.
6. Medical Directorate	0	N/A		1. Not applicable.
7. North Yorkshire	0	N/A		1. Not applicable.
8. Nursing and Governance	7	7		1. Learning Lessons/reporting incidents is a regular agenda item for all Ward Managers and Matron meetings. 2. Actively encourages participation in the Staff FFT survey and results monitored. An increase has been noted in response rates. 3. All survey results are discussed at Directorate Away Days and actions put in place.
9. Planning, Performance and Communications	1	1		1. The directorate have been identifying relevant aspects of QIS daily management and embedding them into their practices.
10. Teesside AMH	11	10	1	1. Staff’s input into the Business Plan was requested via survey monkey. Staff were asked what the focus should be within Teesside AMH. 2. Staff have been encouraged and supported to complete the new DATIX reports following incidents.
11. Teesside MHSOP	3	3		1. Encouraging staff to report bullying and harassment, reporting near misses and discussing survey results are now a regular agenda item at Head of Service meetings.

COMPOSITE STAFF ACTION PLAN 2016-2017
(Developed from the Staff Survey 2015 results, Staff Friends and Family Test results and Investors in People Report)

NO.	THEME	INTENDED OUTCOME/ RESULT	SOURCE OF ACTION			ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
			IIP	SS	SFFT					
1	Encourage more staff to report harassment, bullying or abuse when it happens	Improve related responses in the 2016 Staff Survey results and Staff FFT results. A reduction in reported bullying and harassment cases in the long term. Greater staff awareness of how to report bullying and harassment and of the Trust support available. Improved morale within teams.	X	X	X	Establish a Task and Finish Group to include the following actions: 1. Undertake a survey monkey survey to try to understand why staff do not report harassment, bullying or abuse. Link to the under reporting of errors, near misses or incidents. 2. Report the findings to the Workforce and Development Group and make recommendations for action. 3. Review the way bullying and harassment is covered in the Grievance Procedure and identify if a separate policy is needed. 4. Include reference to the importance of reporting bullying into the refreshed mandatory training on Equality and Diversity and Human Rights. 5. Explore developing the role of the Equality and Diversity champions to become contact officers for bullying and harassment issues. 6. Undertake 'How to handle Productive Conversations' training. 7. Undertake Values based Conversations workshops on request as part of team development. 8. Investigate a potential link between manipulative behaviour at work and management style. **9.** Develop a plan to address if agreed appropriate. **10.** Identify if there is clear evidence of a reduction in reported bullying and harassment cases. .	Kerry Jones Kerry Jones Kerry Jones Sarah Jay Sarah Jay Michelle Brown Michelle Brown Michelle Brown Michelle Brown Beverley Vardon-Odonkor/Emma Haimes	Q3 Q4 Q2 Q2 Q3 Q1-Q4 Q1-Q4 Q2 Q3 Q4	Meeting held with HR Manager - Operations to discuss current process Training updated Training delivered twice so far June and October Delivered as ½ sessions Paper produced for the Board	**Completed** **Completed** **Completed** **Completed** **Completed**
2	Reduce the number of staff experiencing physical violence from patients, relatives or the public	Improve related responses in the 2016 Staff Survey results and Staff FFT results. A reduction in reported violent incidents on Datix. Timely access to PAT training for staff and good training evaluation. More staff confident about ability to report incidents. .	X	X	X	1. Following the creation of an incident dashboard for managers to use via IIC, develop an electronic QUAG report 2. Commence roll out to the QUAGs. 3. Revise the current management of violence and aggression training in conjunction with Force Reduction to include de-escalation and debrief training in accordance with new NICE guidance (NG10). 4. Pilot the new training. 5. Continue the roll out of Positive Behaviour Support Training across MHSOP, AMH and C&YPS (Tier4) until March 2017. 6. From June, run 10 'Behaviour Clinics' every month in locations across the Trust to offer coaching/support to staff in developing/implementing Behaviour Support Plans. Aim for 100 clinics by the end of the year. 7. Hold 4 Safewards sharing practice events over the year to support services to use the Safewards model. These events will offer frontline staff the opportunity to share good practice and support each other in developing the model. 8. Identify if there is clear evidence of a reduction in reported violent incidents.	Emma Haimes Emma Haimes Judith Hurst Judith Hurst Stephen Davison Stephen Davison Emma Haimes	Q1 Q2 Q3 Q3 Q4 Q4 Q4	Dashboard on IIC Rolled out	**Completed** **Completed**

3	Increase the proportion of staff who report errors, near misses or incidents that they witness	Improve related responses in the 2016 Staff Survey results and Staff FFT results. Greater level of staff confidence that incident reports will be acted upon appropriately. .	X	X	X	1. Ensure the revised Incident Reporting and Investigating Policy is ready for re-launch following consultation. 2. Re- launch the revised Incident Reporting and Investigating Policy by holding briefing sessions across the Trust. 3. Monitor the initial impact of the revised Incident Reporting and Investigating Policy and its impact on incident reporting. 4. Prepare for the York and Selby locality move onto the new Datix system wef 1 June by undertaking reinforcement briefing sessions. 5. Identify if there is clear evidence of an increase in staff reporting errors, near misses or incidents that they witness.	Catherine Lee-Cowan Catherine Lee-Cowan Catherine Lee-Cowan Emma Haimes Emma Haimes	Q2 Q3 Q4 Q1 Q4	The policy is now being launched in Q3. Briefing sessions delivered	Expected to be completed in Q3 **Completed**
4	Continue to reduce the numbers of staff suffering from work related stress	Improve related responses in the 2016 Staff Survey results and Staff FFT results. Reduction in sickness absence due to work related stress. Increased staff awareness of support that is available within TEWV. Staff can access TEWV support services in a timely way.	X	X	X	1. Deliver 4 Stress Busting events and monitor take up. 2. Develop a 'What helped me' information leaflet from contributions by Trust staff who have lived experience of mental ill health. 3. Distribute the leaflet. 4. Complete a 12 month review of the Employee Psychology Service pilot and include recommendations regarding the future of the service. 5. Deliver 6 retreats throughout the year and monitor take up. 6. Embed the Employee Support Service in the York and Selby locality. 7. Establish a baseline for the activity levels of the Employee Support Service to measure capacity levels and introduce Key performance Indicators. 8. Design a training package to support managers in embedding health and wellbeing principles in the workplace. 9. Implement the new national CQUIN on Health and Wellbeing 10. Deliver 2 mindfulness programmes during the year to staff in the York and Selby locality with priority given to staff with work related stress 11. Deliver at least 20 days of mindfulness that staff can access to refresh their practice. 12. Pilot 3 month follow up post mindfulness programmes. 13. Run 12, 8 week mindfulness programmes across the year with priority given to staff with work related stress. 14. Identify if there is clear reduction in work related sickness absence.	Lisa Cole Lisa Cole Lisa Cole Barry Speak Paul Walker Lisa Cole Lisa Cole Lisa Cole Sheila Jones Elinor Morgan Elinor Morgan Elinor Morgan Elinor Morgan Beverley Vardon-Odonkor	Q4 Q1 Q2 Q1 Q4 Q3 Q4 Q2 Q4 Q4 Q4 Q1 Q4 Q4	Leaflet on InTouch Report gone to EMT Training updated to include support for staff Report gone to Mindfulness Steering Group	**Completed** **Completed** **Completed** **Completed** **Completed**

5	Supporting managers and staff to deal with high pressure/work-load demands placed on them	Improve related responses in the 2016 Staff Survey results and Staff FFT results. Managers and staff are asked to only generate and act upon information that is necessary. TEWV information enables managers and staff to carry out their roles more effectively than would otherwise be the case.	X	X	X	1. Review and amend team briefing guidance to encourage the discussion and acknowledgement of positive progress and achievement to be discussed and acknowledged during team meetings. (Carried over from 15/16) 2. Develop detailed project plans for final sign off by the Purposeful and Productive Community Services Board. They are: a. Leadership development/coaching b. Information c. IT/Use of technology d. Team processes e. Clinical pathways/workforce design and skills optimisation 3. Develop and communicate a regular requests calendar and adhoc requests log and associated processes/guidance 4. Develop proposals to improve the efficiency and effectiveness of narrative collection and collation regarding standards which are reported to commissioners. 5. Request the Directors of Performance Planning & Communication; Nursing and Governance, HR & OD, Finance and Information and the Director of EFM to review all current reports to ascertain whether any of these can be superseded by use of live data on IIC. 6. Request that the Information Domain Strategy Group decide if they are going to add personalised IIC dashboards for team managers to the IIC development log.	Julie Jones Brent Kilmurray Patrick Scott Ruth Hill Adele Coulthard Ruth Briel Sharon Pickering Sharon Pickering Chris Lanigan Chris Lanigan	Q2 Q2 Q2 Q2 Q2 Q2 Q2 Q4 Q2 Q2	Survey results collated. Recommendations for EMT in Q3 PM3 document approved PM3 document approved PM3 document approved PM3 document approved PM3 document approved Work taken place with IT, require EMT to agree Proposal development, require EMT to agree Reports received from relevant areas Achieved via new IIC	**Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Ongoing** **Completed** **Completed**
6	Ensure that members of the senior management team continue to be visible in the workplace/around the Trust	Improve related responses in the 2016 Staff Survey results and Staff FFT results. More front-line staff involved in Director visits.	X	X	X	1. Review what is 'good communication between senior managers and staff and understand what staff expectations are at local level and take the results and proposed action plan to EMT. (Carried over from 15/16)	Julie Jones	Q2	Survey undertaken, results analysed. Report for EMT in Q3.	**Completed**
7	Improve staff experience for disabled and BAME staff	Improve related responses in the 2016 Staff Survey results and Staff FFT results. TEWV has a better understanding of why disabled and BAME staff experiences are poorer that those of not disabled and white staff. Actions are taken by TEWV that make a positive difference to disabled and BAME staff.	X	X	X	1. Undertake research to better understand the causes of any differences where staff who share similar characteristics report lower levels of satisfaction in either the Staff Friends and Family Test or the Staff Survey and to take steps to reduce or eliminate any lower levels of satisfaction. Specific actions are: 2. Develop actions to be included in the staff survey action plan to address any areas where known differences exist and are understood 3. Establish baseline data based on the 2015 Staff Survey and corresponding Staff Friends and Family Test. 4. Commission and undertake reliable research based on the base line data 5. Report the findings of this research to the Diversity Engagement Group, Workforce and Development Group and the Equality and Diversity Steering Group. 6. Design the format of the protected characteristics mini conferences/workshops for consideration by the Equality and Diversity Steering Group. 7. If agreed, commence the implementation plan.	Sarah Jay Sarah Jay Sarah Jay Sarah Jay Sarah Jay Angela Collins Angela Collins	Q4 Q1 Q2 Q4 Q4 Q4 Q4	Actions included in plan Baseline data established Changed from Q1 to Q4 DEG agreed to wait until research completed	**Completed** **Completed**

8	Improve staff experience amongst the different workforce ages	Improve related responses in the 2016 Staff Survey results and Staff FFT results. More retention of key skills and experience without disadvantaging younger workers.	X	X	X	1. Hold a feedback event following the recently completed first stage of a field study of TEWV clinical staff about extending working lives and gain views to inform recommendations to EMT about our future approach. 2. Take the recommendations regarding our future approach to EMT. 3. Review the findings from the 2015/16 workforce equality monitoring data and identify any areas of concern. 4. Where areas of concern are identified, take recommendations to the Equality and Diversity Steering group, Diversity Engagement Group and WDG	David Levy David Levy Sarah Jay Sarah Jay	Q1 Q2 Q1 Q2	Event held in May and consultation taken place Move to Q3 delay in Trust report Presented to E&D steering group Demographic reports from Picker shared with groups	**Completed** **Completed** **Completed**
9	Improve the impact of the Staff Friends and Family Test and start preparations for the Investors in People reaccreditation.	Ensure the Staff FFT results are user friendly and relevant. Staff FFT results are used by all teams to improve working arrangements. Staff and Patient FFT results are jointly upon.	X	X	X	1. Hold a QIS event to consider the future Trust approach to the Staff FFT including refreshing the non- core questions and the assurance process. 2. Revised proposals are taken to EMT for consideration. 3. Prepare for the implementation of the agreed approach. 4. Arrange for 2 staff to be trained in the revised IiP National Standard Framework and Assessment Process. 5. Undertake the IiP mid-term review with the Lead Assessor. 6. Inform EMT of the options available for the next IiP assessment and agree the way forward. 7. Review the effectiveness of the Local Consultative Committees in implementing organisational change. (Carried over from 15/16)	Sheila Jones David Levy Kerry Jones Sheila Jones Sheila Jones David Levy David Levy	Q1 Q1 Q2 Q1 Q1 Q2 Q4	Event held Report gone to EMT Recommendations in place Training undertaken Mid-term review undertaken Report to Nov Board	**Completed** **Completed** **Completed** **Completed** **Completed** **Completed**

As this is a Trust wide action plan each individual action owner requires reasonable cooperation from others across the Trust to ensure that actions can be implemented as effectively as possible. There will be regular monitoring and reporting of progress made with implementation of the Trust Action Plan and Local Action Plans.

ITEM NO. 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29TH November 2016**
TITLE:	**Refreshing the approach to embedding the Trust's values**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**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 information about measures taken to date to embed the TEWV values and behaviours statement. It proposes that a consultation exercise involving staff, service users and carers is undertaken during 2017 to gather views about the current TEWV values and behaviours.

A revised approach to the reporting of culture metrics that better aligns staff feedback with service user and carer feedback is proposed including team based reports that include qualitative themed information to increase learning and to inform future actions.

Recommendations:

(i) To support the proposed values consultation exercise and to receive a report at the September 2017 meeting of the Board of Directors.
(ii) To support the proposal for production of team based culture metrics reports, including themed qualitative information, by the autumn of 2017.
(iii) To support the proposal that culture metrics reporting is deferred until the autumn of 2017.

MEETING OF:	**Board of Directors**
DATE:	**29TH November 2016**
TITLE:	**Refreshing the approach to embedding the Trust's values**

1. INTRODUCTION & PURPOSE:

1.1 Pursuant with minute 16/187 the purpose of this report is to seek views about proposals to further embed the Trust's values and behaviours statement. In addition a proposal is made with the aim of improving future feedback about the extent to which the values are being lived and experienced within TEWV services.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The current TEWV values and behaviours statement (Appendix 1) was approved by the Board of Directors in March 2010 following a period of consultation that commenced in 2009. TEWV culture metrics, intended to provide information about the extent to which the values are being lived within TEWV, were designed in 2011 and have been reported to the Board of Directors at six monthly intervals since November 2012.

3. KEY ISSUES:

3.1 During 2011 and 2012 actions were agreed by the Board of Directors to assist with embedding the TEWV values and behaviours statement. The actions concerned staff communications/engagement, efforts to incorporate the values within organisational processes, the provision of training and seeking to measure the impact of the values. Amongst the actions were:

(i) Designing and delivering a three day Embedding the Values leadership and management development programme which has to date been attended by 653 managers.

(ii) Designing and delivering the Values Conversations awareness programme that is open to all staff.

(iii) The introduction of values based recruitment and the provision of values based recruitment training.

(iv) The introduction of the Chairman's 'Living the Values' Award.

(v) The inclusion of TEWV values and behaviours as part of the appraisal process to regularly engage employees in reviewing their behaviour against the values using the TEWV behavioural framework.

(vi) The inclusion of the TEWV values and behaviour statement, along with the staff compact, within job descriptions and recruitment packs

(vii) The inclusion of reference to the values and behaviours statement within corporate induction

(viii) The inclusion of questions about the values and behaviours statement during Directors visits

(ix) The development of a structured approach to working with teams that require additional support

(x) The production and reporting to the Board of Directors of culture metrics initially at Trust-level from 2012 and at locality level from 2014

(xi) The inclusion of questions to gauge the level of staff awareness of the TEWV values and behaviour statement, and the extent to which colleagues work by them, within the annual staff survey local questions section

3.2 Since the values refresh in 2009/10 TEWV has changed significantly as an organisation. TEWV now employs some 6,600 staff compared to 5,200 in 2010 and is responsible for the provision of mental health and learning disability services in Harrogate, Hambleton and Richmondshire and in York and Selby whereas in 2010 it was not. The number of staff employed by TEWV today who were employed by TEWV in March 2010 is 3,285 which is approximately half of the current total workforce. The values refresh consultation that was undertaken in 2009 and in early 2010 directly involved approximately four hundred staff, service users, carers and governors. Many of TEWV's current staff, service users, carers and governors were not involved in the values refresh.

3.3 Since 2010 there have been major clinical and operational policy and practice developments within and outside TEWV. These developments have included the adoption of a commitment by TEWV to the recovery approach and to being a learning organisation and pursuing a coaching style of leadership and management. Beyond TEWV the Mid Staffs Hospital Enquiry and the subsequent Freedom to Speak Up review have led to an increased focus upon safe staffing and the importance of NHS organisations creating a just culture in which all staff can feel safe to raise concerns. There is an increasing awareness of the importance of equality, diversity and human rights within mental health services. The developments of the Patient Friends and Family Test and the Staff Friends and Family Test have also taken place since 2010.

3.4 As part of efforts to continue to embed the values and behaviour statement the actions described in paragraph 3.1 ought to be the subject of regular review and indeed this has been the case for a number of these actions. It is proposed that to truly refresh the approach taken to embedding the TEWV values and behaviours statement a consultation ought to be undertaken with staff, service users, carers and governors to seek their views about whether

the current values and behaviours statement still resonates with them, whether they believe that it is being followed and what they base their views upon. As in 2009/10 it is proposed that a significant number of people are engaged in the consultation through locality based consultation meetings, particularly from within the North Yorkshire and York and Selby localities.

3.5 It is believed that a TEWV values consultation exercise would be timely in that it would recognise the numerous changes and developments that have taken place since 2009/10, it would provide an opportunity for TEWV-wide engagement and for a fresh perspective to be obtained. A consultation exercise could be undertaken and completed by July 2017 with the outcomes reported to the Board of Directors at the September 2017 meeting. This timescale would be twice as long as that of the 2009/10 values and behaviours consultation and acknowledges the now larger size of TEWV and the demands upon services that exist. The consultation exercise could be co-ordinated and delivered by members of the Organisational Development team together with colleagues from Nursing and Governance and other services.

3.6 It is proposed that the culture metrics currently produced by TEWV are replaced by six monthly reports at Trust, locality and team level. At present culture metrics are reported every six months at Trust and locality level only. The range of information used to populate the culture metrics reports ought to be reviewed to ensure that it is appropriate for team based reports. This could mean for example removing disciplinary and grievance information from reports given the relatively low probability of this information being relevant for an individual team on a six monthly basis.

3.7 The revised culture metrics could be weighted, unlike now, and themed qualitative information/feedback from staff and service users and carers could be provided to teams, localities and the Trust alongside statistical information. This information could be presented in a format that would enable teams to better understand what the culture metrics are saying which would enable teams to learn more and to take actions in response where appropriate. It is also important to ensure that teams receive more recognition than at present for the positive feedback that is received from staff and service users and carers and it is believed that a revised approach to culture metrics reporting would assist with achieving this aim. It is not proposed that the future culture metrics are subject to RAG rating.

3.8 Should it be agreed that the proposed changes can be made to the culture metrics there will be a need to set aside time for corporate services to undertake detailed preparation and planning to ensure greater alignment of staff feedback with service user and carer feedback. To facilitate this work it is proposed that reporting of the culture metrics ceases until the autumn of 2017. This change would also ensure that the production of the revised culture metrics coincides with and reflects the outcome of the proposed values consultation referred to earlier in this report.

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.

4.4 **Other implications:** None identified.

5. RISKS: None identified.

6. CONCLUSIONS:

6.1 It is believed that the time is right for a concerted effort to further embed the TEWV values and behaviours statement and that seeking the views of staff, service users and carers by means of a consultation exercise would be the most effective approach to adopt.

6.2 The current approach to culture metrics reporting requires revision. It is believed that, along with greater alignment of staff and service user and carer feedback, the production of team based reports with themed qualitative information will support on-going efforts to make TEWV a learning organisation.

7. RECOMMENDATIONS:

7.1 To support the proposed values consultation exercise and to receive a report at the September 2017 meeting of the Board of Directors.

7.2 To support the proposal for production of team based culture metrics reports, including themed qualitative information, by the autumn of 2017.

7.3 To support the proposal that culture metrics reporting is deferred until the autumn of 2017.

David Levy
Director of Human Resources and Organisational Development

Background Papers:

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Statement of values and behaviours

Commitment to quality

We demonstrate excellence in all of our activities to improve outcomes and experiences for users of our services, their carers and families and staff.

Behaviours:

- Put service users first.
- Seek and act on feedback from service users, carers and staff about their experiences.
- Clarify people's needs and expectations and strive to ensure they are exceeded.
- Improve standards through training, experience, audit and evidence based practice.
- Learn from mistakes when things go wrong and build upon successes.
- Produce and share information that meets the needs of all individuals and their circumstances.
- Do what you / we say we are going to do.
- Strive to eliminate waste and minimise non-value adding activities.

Respect

We listen to and consider everyone's views and contributions, maintaining respect at all times and treating others as we would expect to be treated ourselves.

Behaviours:

- Be accessible, approachable and professional.
- Consider the needs and views of others.
- Be open and honest about how decisions are made.
- Observe the confidential nature of information and circumstances as appropriate.
- Be prepared to challenge discrimination and inappropriate behaviour.
- Ask for feedback about how well views are being respected.
- Consider the communication needs of others and provide a range of opportunities to access information.

Involvement

We engage with staff, users of our services, their carers and families, governors, members, GPs and partner organisations so that they can contribute to decision making.

Behaviours:

- Encourage people to share their ideas.
- Engage people through effective consultation and communication.
- Listen to what is said, be responsive and help people make choices.
- Provide clear information and support to improve understanding.
- Embrace involvement and the contribution that everyone can bring.
- Acknowledge and promote mutual interests and the contributions that we can all make at as early a stage as possible.
- Be clear about the rights and responsibilities of those involved.

Wellbeing

We promote and support the wellbeing of users of our services, their carers, families and staff.

Behaviours:

- Demonstrate responsibility for our own, as well as others, wellbeing.
- Demonstrate understanding of individual and collective needs.
- Respond to needs in a timely and sensitive manner or direct to those who can help.
- Be pro-active toward addressing wellbeing issues.

Teamwork

Team work is vital for us to meet the needs and exceed the expectations of people who use our services. This not only relates to teams within Tees, Esk and Wear Valleys NHS Foundation Trust, but also the way we work with GPs and partner organisations.

Behaviours:

- Be clear about what needs to be achieved and take appropriate ownership.
- Communicate well by being open, listening and sharing.
- Consider the needs and views of others.
- Be supportive to other members of the team.
- Be helpful.
- Fulfil one's own responsibilities.
- Always help the team and its members be successful.

ITEM NO 14

GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29th November 2016**
TITLE:	**Investors in People Re-accreditation**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**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:

This report seeks the views of the Board of Directors about whether TEWV ought to seek Investors in people re-accreditation in 2017.
A description of the recently published sixth generation Investors in People Standard is provided together with a review of the reasons why TEWV has previously sought Investors in People accreditation and the benefits realised.
The associated costs, planning and preparation time and resources are not expected to differ greatly from those of the 2014 assessment however, TEWV is now a larger organisation and achieving a successful assessment against what is an enhanced Investors in People Standard in 2017 will not be straightforward.

Recommendations:

To decide whether or not TEWV is to seek Investors in People re-accreditation in November 2017.

MEETING OF:	**Board of Directors**
DATE:	**29TH November 2016**
TITLE:	**Investors in People Re-accreditation**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek the views of Workforce and Development Group members about whether or not to recommend to the Board of Directors that TEWV ought to seek Investors in People reaccreditation by November 2017. The views of Investors in People locality and directorate leads about this issue will also be sought over the coming weeks.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 At present TEWV holds Investors in People Gold Standard accreditation and this status will continue until November 2017 when the standard three year accreditation term comes to an end. Should TEWV wish to retain Investors in People accreditation beyond November 2017 the associated planning and preparation prior to assessment will need to begin shortly, hence the timing of this report.

3. KEY ISSUES:

3.1 The Investors in People standard has recently undergone revision with a sixth generation standard being put in place from September 2015. The revised standard is the most challenging yet and includes nine new indicators and a four stage performance model. In addition a Platinum award level has been introduced. Details can be found within Appendix 1.

3.2 Consultation with a representative of Investors in People North of England has highlighted that participation in the revised standard will not entail any significant amount of bureaucracy. The direct cost of seeking re-accreditation, approximately £20,000, is similar to the cost of the 2014 assessment.

3.3 A limited comparison of the revised standard with current TEWV policy and practice was undertaken in June 2016. The comparison indicated that TEWV is in a strong position, subject to consistency of evidence and the availability of data to demonstrate improvement and embedding of newer practices, to achieve Gold accreditation using the new standard. The integration of staff within services in York and Selby represents a change in the scope of the assessment compared to that undertaken in 2014 and the management of this change would be an obvious point of reference for an assessment. It is expected that only 2% of assessed organisations will achieve Gold accreditation.

3.4 Amongst the reasons why TEWV has sought Investors in People accreditation and re-accreditation since 2010 are:

● A belief that the activities and approaches necessary to meet the Investors in People standard represent good people management policy and practice. In recent years successive TEWV staff survey action plans have included actions identified as part of previous TEWV Investors in People assessments. Previously the Board of Directors has taken the view that obtaining feedback from the Investors in People assessment is an important way of gathering information about staff experience that goes beyond that provided by staff surveys.

● A belief that there is value obtained by having TEWV people management policy and practice subjected to external scrutiny, validation and comparison by a widely recognised independent body. For some TEWV staff the very public commitment to the Investors in People standard is regarded as being evidence of Board support for good people management policy and practice.

● A belief that possession of Investors in People accreditation is of benefit to TEWV from a reputational point of view when working with commissioners and regulators. The 2015 TEWV Care Quality Commission inspection report states that possession of the Investors in People Gold standard is one of the reasons why TEWV achieved an outstanding rating for well led services.

● The absence of a better alternative independent assessment and accreditation system/awarding body. It is not believed that the position has changed significantly in respect of this particular point since 2014.

3.5 By no means all NHS organisations seek Investors in People accreditation however, it is believed that significant numbers still do.

3.6 Should a decision be made to pursue Investors in People re-accreditation preparations will need to commence promptly. A commitment will be required from all localities and corporate directorates to ensure that the necessary time and attention can be given to further embedding good people management policy and practice. A TEWV network of Investor in People leads, representing the localities and corporate directorates, has been in place for a number of years and has worked well. The individual Investor in People leads would however, need further support from their respective teams and key managers to help ensure that an assessment would be successful including the identification of a deputy for each lead.

3.7 In the event that reaccreditation is sought there will be a need for targeted and well planned communications, particularly in the York and Selby locality, including a description of related activities that have been undertaken since the last assessment in 2014.

3.8 Though there has been some research conducted into the impact of Investors in People upon organisations it is difficult to draw any firm conclusions about the impact of the standard itself. There is however, evidence from the Work Foundation and the Institute for Employment Studies that Investors in People accredited organisations are more innovative, have better leadership skills, reduced costs and a competitive edge.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** Possession of Investors in People accreditation is regarded as being positive by the Care Quality Commission though it is not essential.

4.2 **Financial/Value for Money:** The direct cost of seeking Investors in People re-accreditation in November 2017 is estimated to be £20,000.

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:

Despite recent significant changes being made to the structure of the Investors in People Standard anything less than accreditation at Gold standard in November 2017 may be viewed by some as being an indication that people management policy and practice within TEWV has deteriorated. Should TEWV decide not to pursue Investors in People re-accreditation there is a risk that such a decision could be viewed by some staff as being an indication that TEWV may now be less interested in being a good employer than before.

6. CONCLUSIONS:

6.1 There is evidence that Investors in People accreditation has been positive for TEWV however, seeking to retain accreditation above the basic standard will not be straightforward and will require sound planning and preparation between now and November 2017. The level of variation in practice between some services and localities has yet to be fully understood and could well impact upon how TEWV would be rated.

6.2 There is support from operational services, the Workforce and Development Group and locality and directorate Investors in People leads for seeking reaccreditation.

7. RECOMMENDATIONS:

7.1 To decide whether or not TEWV is to seek Investors in People reaccreditation in November 2017.

David Levy
Director of Human Resources and Organisational Development

Background Papers:

Investors in People TEWV Assessment Report - 2014
Investors in People The Standard - 2015
UK Commission for Employment and Skills – Research into evaluation of Investors in People: employer case studies (year 2) - 2013
People and the Bottom Line – P. Tamkin, M. Cowling, W. Hunt – 2008

INVESTORS IN PEOPLE

The Standard for People Management

An introduction

Outperformance:
the ability of an organisation to achieve results that are consistently better than a chosen peer group

Outperformer:
an organisation with a clear purpose that uses benchmarking to continually stay ahead of its peers

www.investorsinpeople.com
@IIP
/InvestorsInPeople.UK

Measure your performance against the standard for people management

Have you noticed how some organisations do better by every measure? How they offer great products and services and deliver impressive results?

We call these organisations the Outperformers.

Since 1991 Investors in People has set the standard for people management. The Investors in People Standard defines what it takes to lead, support and manage people well for sustainable results. With a community of 14,000 organisations across 75 countries, successful accreditation against the Standard is the sign of a great employer, an outperforming place to work and a clear commitment to sustained success.

Based on a tried and tested framework and a rigorous process of assessment, organisations that meet the Investors in People Standard proudly display their accreditation to the world because they understand that it's people that make the difference.

> "Put your people at the heart of your vision and they'll use their talents to achieve it."

Paul Devoy

Paul Devoy
Head of Investors in People

The mark of excellence

Achieving Investors in People accreditation is an outstanding achievement. To employees, accreditation signals a high performing culture. To customers it signals a quality product and service.

Investors in People accreditation levels

In good company

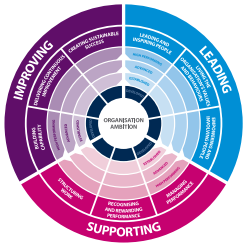
The Investors in People Standard

Based on 25 years of leading practice, the Investors in People the framework sets out the criteria to achieve the Investors in People Standard.

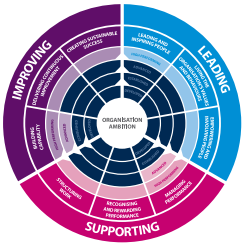
The standard for people management has evolved to keep pace with modern practices. The current sixth generation was launched internationally in 2015.

The framework reflects the latest workplace trends, leading practices and employee conditions required to create outperforming teams. The framework is constantly updated and reviewed by world leading academics, practitioners and industry experts to equip you with the ingredients of success.

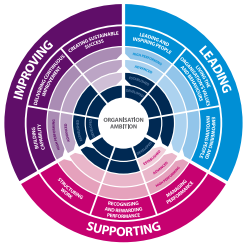
Achieving award levels



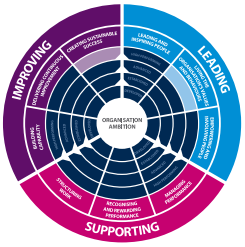
Investors in People Accredited
All nine indicators at '**Developed**' level.



Investors in People Gold
All nine indicators at '**Developed**' and '**Established**' and seven of the nine indicators at '**Advanced**' level.



Investors in People Silver
All nine indicators at '**Developed**' and seven of the nine indicators at '**Established**' level.



Investors in People Platinum
All nine indicators at '**Developed**', '**Established**' and '**Advanced**' and seven of the nine indicators at '**High Performing**' level.

NB The assessment criteria selected in the images above are for illustrative purposes only. They are not the specific indicators required for the performance level criteria.

Take a self-assessment at
www.investorsinpeople.com

Get the benefits

Investors in People accredited organisations are more profitable, sustainable and optimistic about the future.

The facts speak for themselves; 60% of IIP accredited organisations predict business growth compared to the UK establishment average of 47%.*

Understanding performance drives success. Making the right investments in your people is the smart choice.

Explore how different industries compare against the standard by visiting **www.investorsinpeople.com/dashboard**

- **Celebrate your success** by achieving accreditation
- **Understand your performance** by measuring yourself against the management standard
- **Gain new insights** by comparing yourself to others
- **Manage change sustainably** by using a clear framework for improvement
- **Create brand advocates** by listening to employee views

*UKCES Employer Perspectives Survey 2012.

> “Not investing in people is a huge risk; a team isn’t a thing, it’s a group of people all working together to become a team.”

Sir Dave Brailsford
Team Principal, Team Sky Former Performance Director, Great Britain Cycling Team

A journey to success

The Investors in People journey to accreditation is robust yet flexible with minimal disruption.

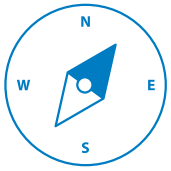
We've refined it over the years to ensure that every step provides the insight and challenge to get ahead. We use a blend of desk analysis, online assessment and face to face activity to simply assess your performance.

Your Investors in People practitioner will be an expert in their field. They will bring experience, knowledge and networks to ensure your assessment against the Standard is a journey to excellence.

With options that integrate with your way of working: being assessed is simpler than you think.

We've undertaken over **56,000** assessments in 25 years

Four steps to accreditation



Step One
Discovery

Exploring online self-assessment and resources.

Visit www.investorsinpeople.com to start your journey online. Take our simple self-assessment to see how you compare.

Step Two
Online Assessment

Understanding your employee's views.

We listen to your employees to collect data to test alignment against the Standard. It's their first chance to be heard and participate in the Investors in People journey.

Step Three
Employee interviews and observation

Exploring key themes emerging from the online assessment through face to face meetings and observations.

Employee interviews identify strengths for accreditation and opportunities for improvement.

Step Four
Accreditation report

Find your award level and benchmark your performance.

Gain insights from the online data, interviews and assessment journey. Compare your performance to the very best organisations and identify your next steps.

NB Employee sample size criteria is based on the size of your organisation and number of assessment units. Different package options are available based on your requirements. Check our website or get in touch to receive a full proposal.

Take a self-assessment at
www.investorsinpeople.com

Trusted by the best

VAUXHALL

"We strive to be the best automotive company in the UK. To do that you have got to work with the best. We view Investors in People as fitting that requirement. They are leading edge when it comes to people practices."

Phil Millward, HR Director
UK and Ireland, Vauxhall Motors

The Landmark LONDON

"Our ultimate goal was to look at changing the culture of the hotel from a directive approach to more of an inclusive approach and Investors in People helped us to do that."

Nicola Forshaw, Director of Human Resources,
The Landmark Hotel

GHA

"There was a need to change culture to one of trust, empowerment and self-belief. Our view was that if we could partner with IIP to bring that ethos it would enable fantastic results."

Martin Armstrong, Chief Executive,
Glasgow Housing Association

It's the ingredients for higher performance

You won't find processes, policies or paperwork. You will find easily understandable principles for outperformance.

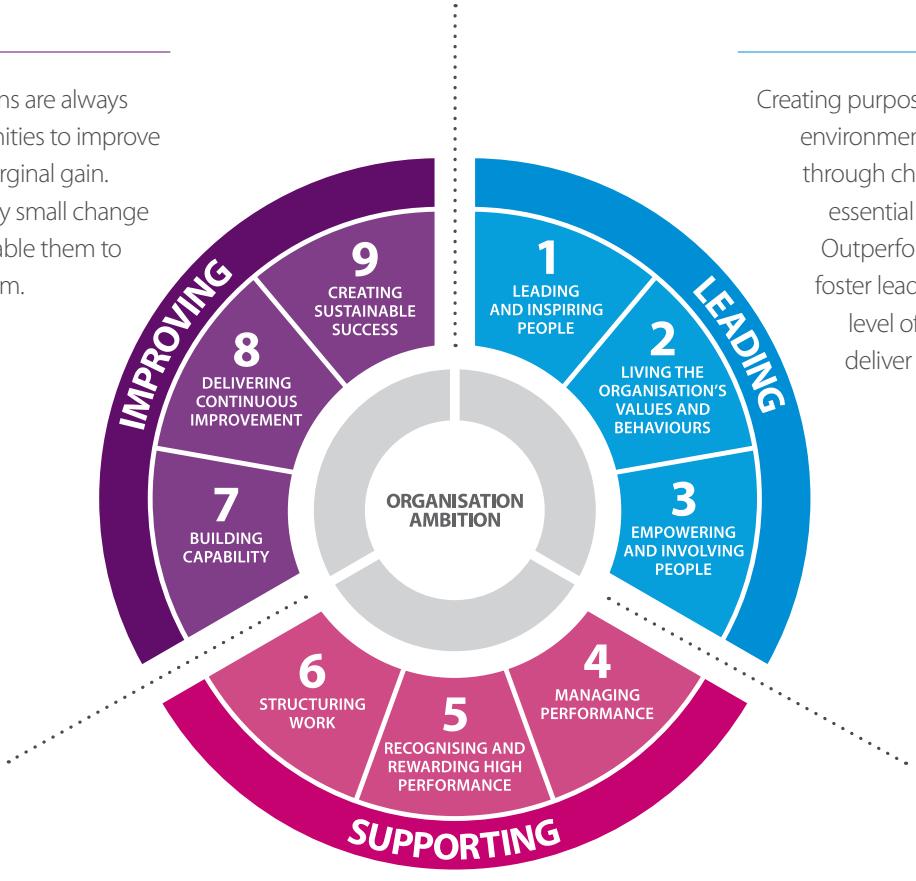
It's a simple roadmap for excellence in any industry. The framework is structured around 9 indicators which are organised under 3 clear headings. It's simple to understand and easy to follow.

Improving

The best organisations are always looking for opportunities to improve by seeking every marginal gain. They know that every small change adds together to enable them to constantly outperform.

Leading

Creating purpose in a fast changing environment, whilst motivating through change, have become essential skills for many roles. Outperforming organisations foster leadership skills at every level of the organisation to deliver outstanding results.



Supporting

Successful organisations are moving towards flatter structures to enable faster decision-making, customer focus and agility. Reduced overheads, better service for customers and more successful organisations are the benefits of this approach.

Take a self-assessment at
www.investorsinpeople.com

Your performance roadmap

Organisations that outperform others understand that high performance is a journey not an event. It requires a commitment to improvement and excellence. Constantly measuring. Constantly improving.

Underpinning each of the nine indicators is the Investors in People performance model. Each level from '**Developed**' to '**High Performing**' describes the practices and outcomes required for higher performance and higher accreditation.

Based on extensive research into the features of organisations that consistently outperform their peers, the Investors in People performance model creates a roadmap for continuous improvement, and a benchmark to strive for.

Each of the nine indicators build through four levels of performance.
Example: Indicator 1

1 Leading and inspiring people

Leaders make the organisations objectives clear. They inspire and motivate people to deliver against these objectives and are trusted by people in the organisation.

Themes	*Developed* *In place and understood*	*Established* *Engaging and activating*	*Advanced* *Creating positive outcomes*	*High Performing* *Embedded and always Improving*
Creating transparency and trust	Leaders provide clarity around the organisation's purpose, vision and objectives	There is clear and regular two way communication between leaders and people at all levels	Leaders ensure that there is a consistent level of trust at all levels of the organisation	Leaders are active role models, leading by example and trusted by people in the organisation
Motivating people to deliver the organisation's objectives	People understand the organisation's objectives	Line managers support people to deliver the organisation's objectives	Leaders are passionate about delivering the organisation's objectives and motivating people to deliver against them	Leaders motivate and inspire people to achieve results above and beyond what is expected of them
Developing leadership capability	Line managers know what is expected of them to lead, manage and develop their people effectively	People know what to expect from their line manager and provide feedback on how they are managed and developed	People have confidence in the leadership and management capabilities within the organisation	Future leadership capabilities are defined in line with the organisation's values and leaders meet these challenges

Understand how you compare

Outperforming organisations are clear about their strengths and weaknesses. Your personal accreditation report will tell you where you are and outline what you need to know to drive performance for higher accreditation.

Set your benchmark

Analysing industry performance will give you an accurate measure relative to your peers. The Investors in People framework provides 27 scales for comparison. Using our online assessment tool, we'll be able to show you how you compare year on year, to ensure you have a clear benchmark for performance. Visit **www.investorsinpeople.com/dashboard** to explore the data for yourself.

Take a self-assessment at
www.investorsinpeople.com

Start your journey

Take a dry run. Start a self-assessment online today and measure your performance against the standard for people management.

Self-assessment – compare your performance and identify how close you are to meeting the Investors in People Standard

Tools and resources – access information on what it takes to be an Investor in People

Attend events – join a workshop to better understand the benefits for your organisation

Get accredited with Investors in People

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INVESTORS IN PEOPLE

Item 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29 November 2016**
TITLE:	**Finance Report for Period 1 April 2016 to 31 October 2016**
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 October 2016 is a surplus of £9,199k, representing 4.7% of the Trust's turnover. The Trust is ahead of plan by £1,623k largely due to vacancies, though active recruitment is ongoing.

Identified Cash Releasing Efficiency Savings at 31 October 2016 are in line with plan. The Trust continues to progress schemes to deliver CRES for future years.

The Use of Resources Rating for the Trust is assessed as 1 for the period ending 31 October 2016 and is in line with plan.

Recommendations:

The Board of Directors are 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:	**29 November 2016**
TITLE:	**Finance Report for Period 1 April 2016 to 31 October 2016**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2016 to 31 October 2016.

2. BACKGROUND INFORMATION

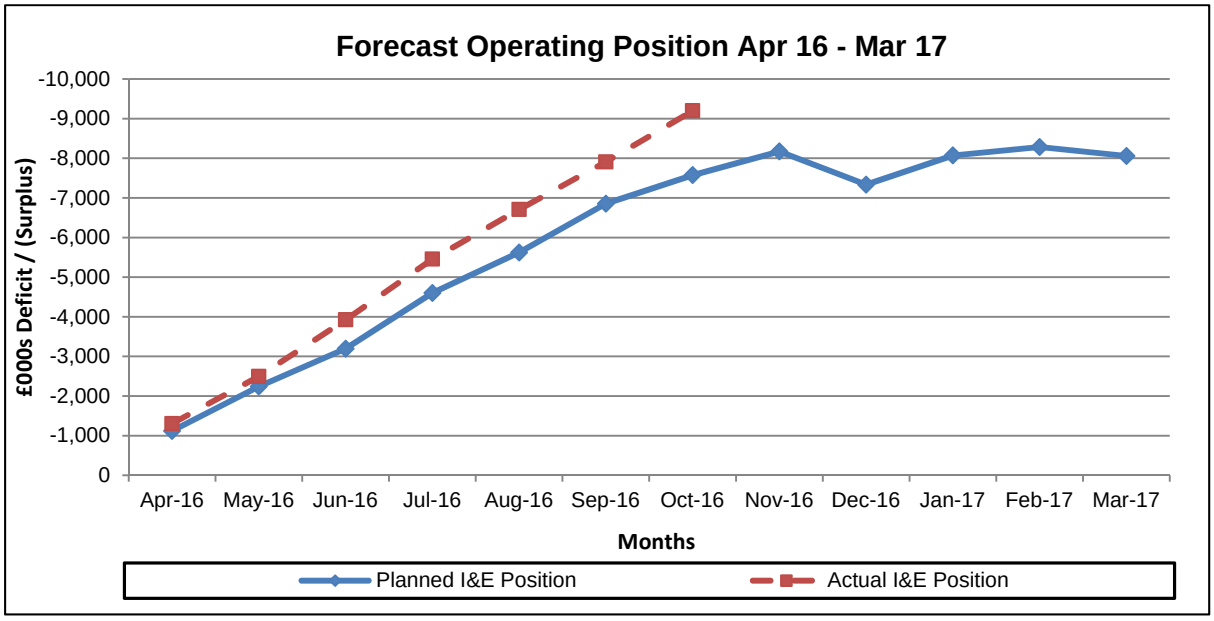
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

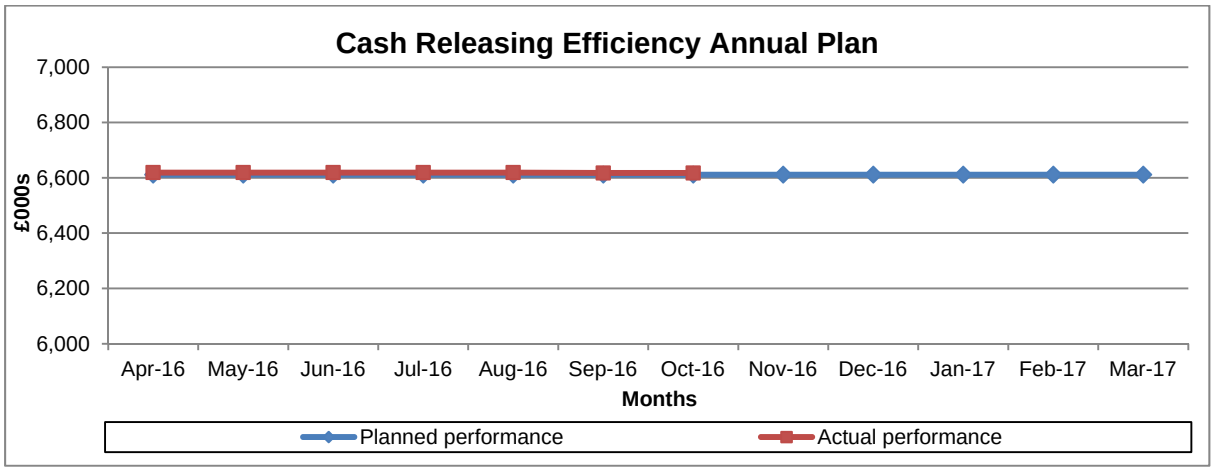
The comprehensive income outturn for the period ending 31 October 2016 is a surplus of £9,199k, representing 4.7% of the Trust's turnover. The Trust is ahead of plan by £1,623k largely due to vacancies across the majority of staffing groups.

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

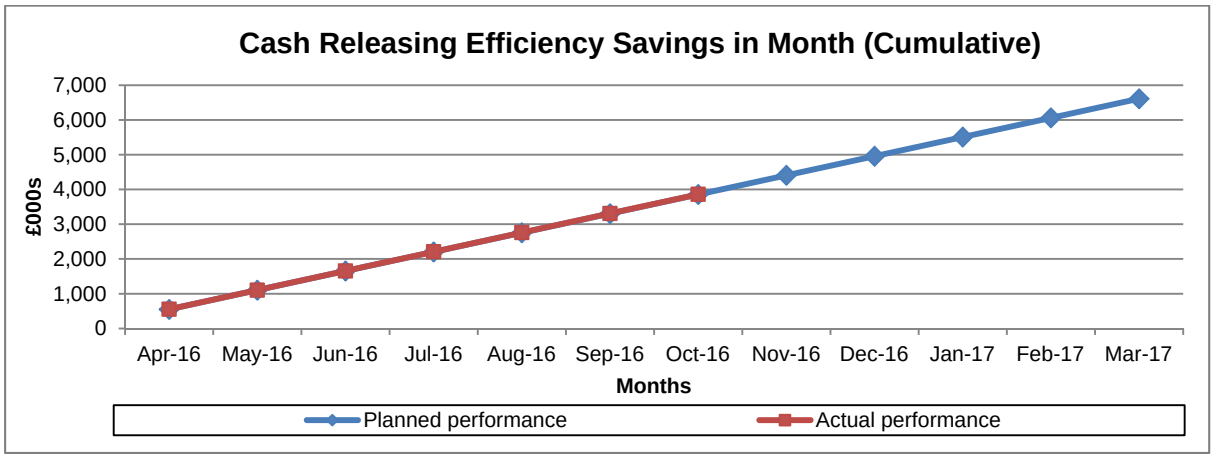


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 October 2016 is £6,617k and is in line with plan. The Trust continues to progress schemes to deliver CRES for future years.

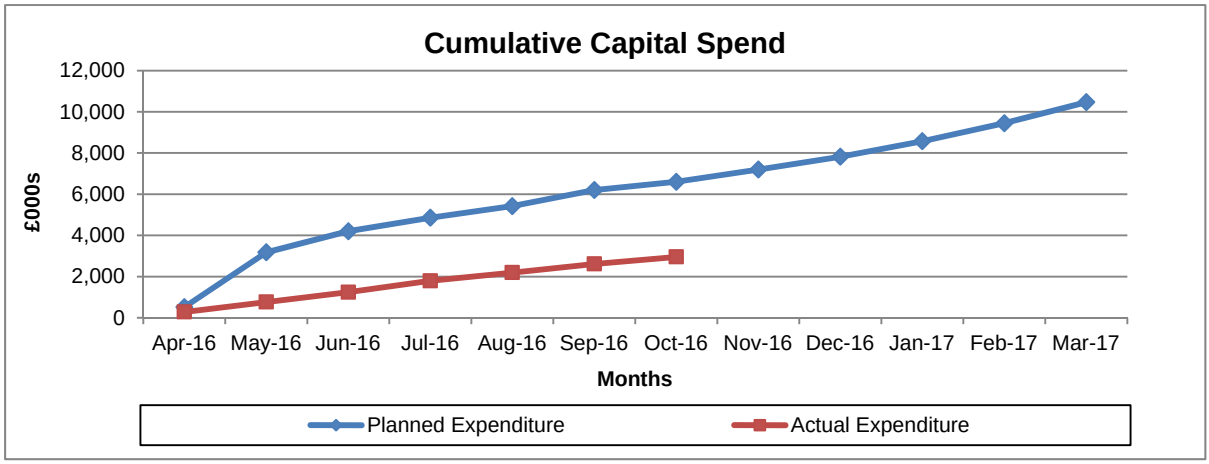


The monthly profile for CRES identified by Localities is shown below.



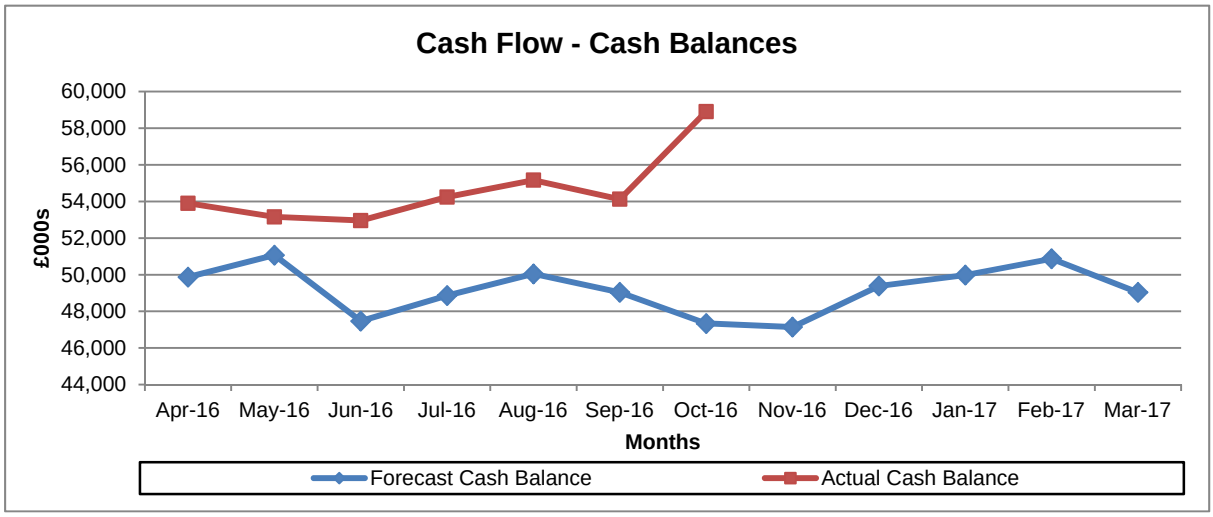
3.3 Capital Programme

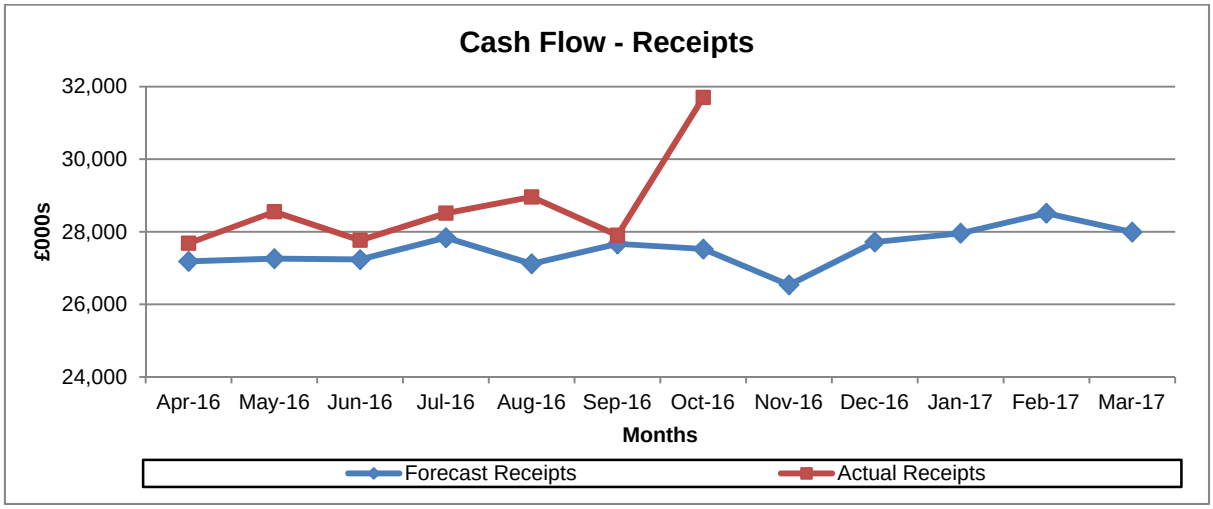
Capital expenditure to 31 October 2016 is £2,954k and is behind plan largely due to the Trust's decision to defer a material scheme.

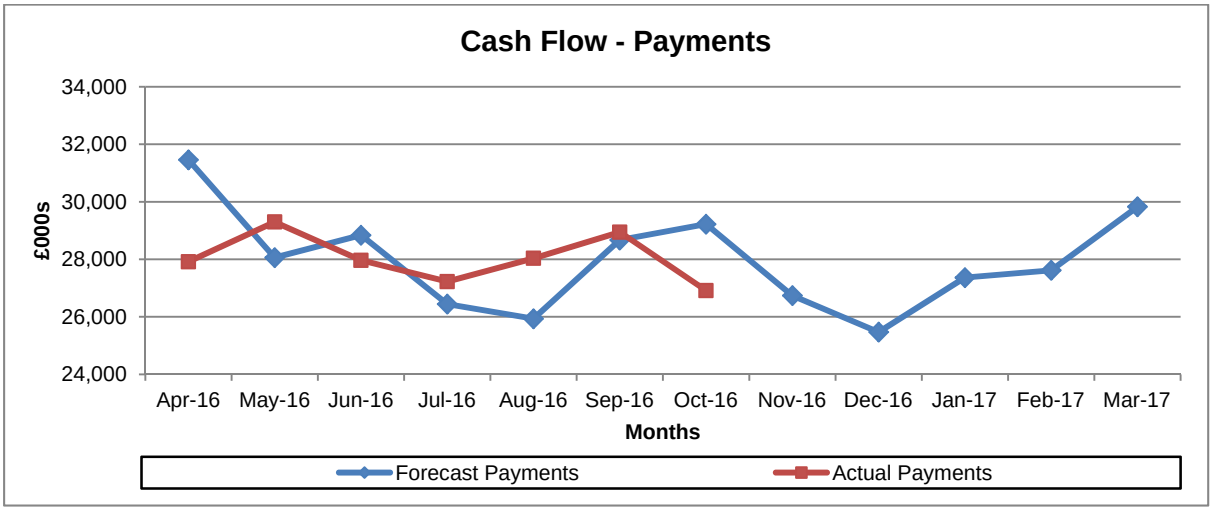


3.4 Cash Flow

Total cash at 31 October 2016 is £58,907k and is ahead of plan largely due to planned delays in the capital programme, the Trusts surplus position and unanticipated cash receipts related to projects.



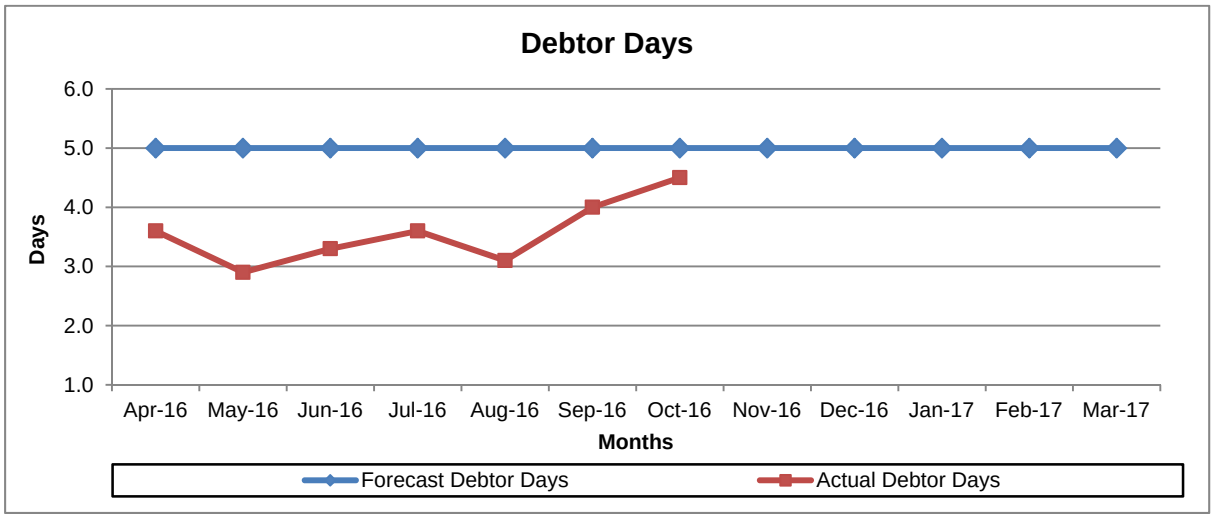




The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.

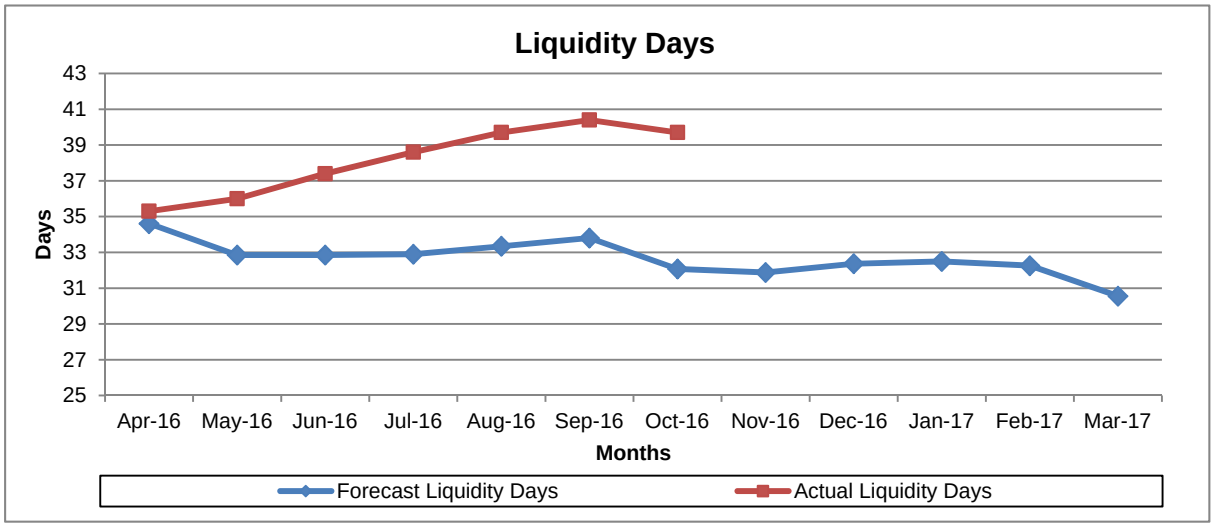
Working Capital ratios for period to 31 October 2016 are:

- Debtor Days of 4.5 days
- Liquidity of 39.7 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 52.51%
  Non NHS 30 Days – 97.58%



The Trust has a debtors' target of 5.0 days, and actual performance of 4.5 days for October, which is ahead of plan.

The liquidity days graph below reflects the metric within NHS Improvement's risk assessment framework. The Trust's liquidity day's ratio is ahead of plan.



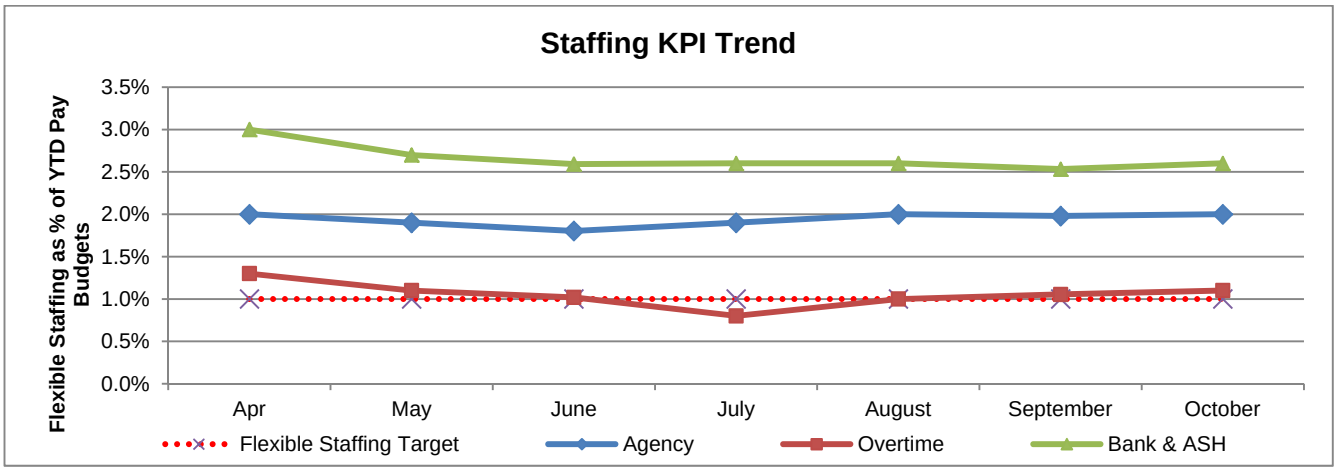
3.5 Financial Drivers

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

Tolerance	May	Jun	Jul	Aug	Sept	Oct
Agency (1%)	1.9%	1.8%	1.9%	2.0%	2.0%	2.0%
Overtime (1%)	1.1%	1.0%	0.8%	1.0%	1.1%	1.1%
Bank & ASH (flexed against establishment)	2.7%	2.6%	2.6%	2.6%	2.5%	2.6%
Establishment (90%-95%)	93.9%	93.8%	94.5%	94.6%	94.3%	94.6%
Total	99.6%	99.2%	99.8%	100.2%	99.9%	100.3%

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 October 2016 the tolerance for Bank and ASH is 3.4% of pay budgets.

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



Additional staffing expenditure is 5.7% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (57%), enhanced observations (16%) and sickness (12%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Single Oversight Framework published by NHS Improvement introduced the Use of Resource Rating (UoRR), which replaces the Financial Sustainability Risk Rating from 01 October 2016. The UoRR consists of the existing FSRR metrics, with an additional metric measuring agency expenditure against set control totals. Each metric will have a 20% weighting.

In addition the scoring has changed. The scale of 1 to 4 remains, however for UoRR the most favourable rating will be 1, with 4 the lowest.

3.6.2 The Use of Resources Rating is assessed as 1 at 31 October 2016, and is in line with plan.

3.6.3 Capital service capacity rating assesses the level of operating surplus generated, to ensure a Trust is able to cover all debt repayments due in the

reporting period. The Trust has a capital service capacity of 1.71x (can cover debt payments due 1.71 times), which is in line with plan and rated as a 3.

3.6.4 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 39.7 days, this is ahead of with plan and is rated as a 1.

3.6.5 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 4.8% and is rated as a 1.

3.6.6 The variance from plan assesses the level of surplus or deficit against plan, excluding exceptional items e.g. impairments. The Trust surplus is 0.8% ahead of plan and is rated as a 1.

3.6.7 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is 20% less than the cap and is rated as a 1.

The margins on Use of Resource Rating are as follows:

- Capital service cover - to increase to a 2 a surplus increase of £298k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £33,208k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £7,225k is required.
- Variance from plan – to reduce to a 2 an operating surplus decrease of £1,281k is required.
- Agency Cap rating – to reduce to a 2 an increase in agency expenditure of £767k is required.

Use of Resource Rating at 31 October 2016

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 variance from plan	20	>=0%	-1%	-2%	<=-2%
Agency	20	<=0%	-25%	-50%	>50%

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	1.71x	3	1.54x	3	
Liquidity	39.7 days	1	33.5 days	1	
I&E margin	4.8%	1	4.0%	1	
I&E variance from plan	0.8%	1	0.0%	1	
Agency	£2,925k	1	£3,692k	1	
Overall Use of Resource Rating		**1.00**		**1.00**	

3.6.8 9.4% of total receivables (£404k) are over 90 days past their due date. This is above the 5% finance risk tolerance, but is not a cause for concern as discussions are ongoing to resolve material debts.

3.6.9 1.7% of total payables invoices (£207k) held for payment are over 90 days past their due date. This is below the 5% finance risk tolerance.

3.6.10 The cash balance at 31 October 2016 is £58,907k and represents 71.4 days of annualised operating expenses.

3.6.11 The Trust does not anticipate the Use of Resources Rating will be higher than 2 in the next 12 months.

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 October 2016 is a surplus of £9,199k, representing 4.7% of the Trust's turnover. The Trust is ahead of plan by £1,623k largely due to vacancies and staff turnover with ongoing recruitment.

6.2 Total CRES identified at 31 October 2016 is £6,617k and is in line with plan. The Trust continues to progress schemes to deliver CRES for future years.

6.3 The Use of Resources Rating for the Trust is a 1 for the period ending 31 October 2016 which is in line with 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.

7.2 The Board of Directors is requested to approve the submission of the agency self-certification checklist to NHS Improvement, which is attached as appendix 1.

Drew Kendall
Interim Director of Finance and Information

	Self-certification checklist Please discuss this in your board meeting	Yes - please specify steps taken	No. We will put this in place - please list actions
	Governance and accountability		
1	Our trust chief executive has a strong grip on agency spending and the support of the agency executive lead, the nursing director, medical director, finance director and HR director in reducing agency spending.	Weekly monitoring reports on price and wage caps are circulated via Exec leads and discussed within governance forums.	
2	Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director.	Maximising recruitment is an objective for Medical and Nursing Director.	
3	The agency executive lead, the medical director and nursing director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending.	Monitored monthly through finance report and weekly update to Exec leads. TEWV performing within Agency control total. Medical agency spend also reviewed in detail monthly at Medical Directorate meeting.	
4	We are not engaging in any workarounds to the agency rules.	No workarounds are being used	
	High quality timely data		
5	We know what our biggest challenges are and receive regular (eg monthly) data on: - which divisions/service lines spend most on agency staff or engage with the most agency staff - who our highest cost and longest serving agency individuals are - what the biggest causes of agency spend are (eg vacancy, sickness) and how this differs across service lines.	Weekly reports on price and wage caps are circulated and discussed with key areas monitored and understood.	
	Clear process for approving agency use		
6	The trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.	Bank is currently booked centrally and proposed procedures to co-ordinate all Nursing agency bookings through the bank, planned to be confirmed by end of November 16. Medical agency contract in place (via Retinue) All medical agency bookings go through Medical Development. Non Clinical agency contract in place via Reed.	
7	There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff.	HR and Medical staffing processes in place with Clinical and Corporate services to consider all alternatives	
8	There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts.	Trust delegated authority for expenditure approval. Weekly monitoring and approvals where appropriate escalated to Nursing and Medical Director.	
	Actions to reducing demand for agency staffing		
9	There are tough plans in place for tackling unacceptable spending; eg exceptional over-reliance on agency staffing services radiology, very high spending on on-call staff.	Monitored monthly through finance report and weekly update to Exec leads. TEWV performing within Agency control total. Key areas known and understood. Medical Director meets monthly with all locality Deputy Medical Directors to understand and challenge agency spend.	
10	There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process.	Bank system in place and used ahead of any agency request.	
11	All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by eRostering.	All are on e-rostering and complete 6 week rosters.	
12	There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled) of less than 21 days.	Monitoring processes are being developed as part of revised booking arrangements.	
13	The board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently.	A Trust Recruitment and Retention Plan has recently been agreed, that includes new approaches to recruitment, and the plan will be the subject of regular monitoring.	
14	The board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions.	Quarterly workforce report is monitored and discussed by the Board.	
	Working with your local health economy		
15	The board and executives have a good understanding of which service lines are fragile and currently being sustained by agency staffing.	Monitored monthly through finance report and weekly update to Exec leads. TEWV performing within Agency control total. Key areas known and understood. Medical Director meets monthly with all locality Deputy Medical Directors to understand and challenge agency spend.	
16	The trust has regular (eg monthly) executive-level conversations with neighbouring trusts to tackle agency spend together.	Yes discussed in relevant forums, awareness of Trust position and neighbouring MH providers. NHSI North region agency report Sept 16 report shared with Exec Team, Trust position performing well relative to others.	

Signed by [Date]

[Signature]

Trust Chief Executive: [Signature]

Please submit signed and completed checklist to the agency inbox (NHSI.agencyrules@nhs.net) by 30 November 2016

Item 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29th November 2016**
TITLE:	**Board Dashboard as at 31st October 2016**
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:

The purpose of this report is to provide the latest performance for the Board Dashboard as at 31st October 2016 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. The dashboard is now inclusive of performance relating to York and Selby.

As at the end of October 2016, 7 (37%) of the indicators reported are not achieving the expected levels and are red, which is a slight decline on the September figure of 6 (32%). Of those red indicators, 2 are showing an improving trend over the previous 3 month period. There are a further 5 indicators which whilst not completely achieving the target levels are within the amber tolerance levels and all show an improving trend over the previous 3 months.

The key issues/risks are:

- Bed Occupancy – (KPI3)
- Access – Waiting Times (KPI 7)
- Out of Locality Admissions (KPI 9)
- %age registered healthcare professional jobs advertised 2 or more times(KPI 15)
- Appraisal (KPI 16)
- %age sickness absence rate

A further review of the targets has been undertaken by the Executive Management

Team and a recommendation is made to increase the target for KPI 1 Total Number of External Referrals into Trust Services

Recommendations:

It is recommended that the Board:

- Consider the content of this paper and raise any areas of concern/query.
- Agree to the recommendation to increase the target for KPI 1 External Referrals as set out in Section 2.3.

MEETING OF:	**Board of Directors**
DATE:	**25th October 2016**
TITLE:	**Board Dashboard as at 31st October 2016**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 31st October 2016 in order to identify any significant risks to the organisation in terms of operational delivery.

2. KEY ISSUES:

2.1 The key issues are as follows:

- As at the end of October 2016, 7 (37%) of the indicators reported are not achieving the expected levels and are red, which is a slight decline on the September figure of 6 (32%). Of those red indicators, 2 are showing an improving trend over the previous 3 month period. There are a further 5 indicators which whilst not completely achieving the target levels are within the amber tolerance levels and all show an improving trend over the previous 3 months.

- The Data Quality Scorecard is included in Appendix B. The six monthly review of the data quality scores has been undertaken and whilst the Scorecard attached shows some improvement in terms of reliability of 3 of the Workforce Indicators (KPIs 16, 17 and 18), this is not sufficient to change the overall data quality score.

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

2.2 The key risks are as follows:

- Bed Occupancy (KPI 3) – Whilst there has been some improvement in the level of bed occupancy in October, linked to the opening of Peppermill Court on 3rd October the position continues to be significantly above target. As Peppermill becomes established as the inpatient unit for Adult Mental health in York there may be further small improvements to the position, however the difficulties in discharging people to appropriate placements is also becoming an increasing factor in the level of bed occupancy. The 'deep dive' work undertaken in North Yorkshire was reported to QuAG in November. As a result of this a report is being prepared for consideration by the Executive Management Team.
- External Waiting Times (KPI 7) – Whilst the Trust remains below the target of 90% there has been a significant improvement in the month of October with performance being at the highest level in the past three years. Indeed performance is now only 2.3% below the target which the Board set. It should be noted that Teesside and Forensic Services continue to exceed

the target by a considerable margin. The main area of concern continues to be Children and Young Peoples services particularly in North Yorkshire and York and Selby however both have seen a significant improvement in performance in October. The action plans in both localities continue to be implemented.

- Out of Locality Admissions (OoL) (KPI 9). The performance against this indicator showed further deterioration in October and continues to be worse than target (by 26%age points). It should be noted that the construction has been amended to reflect the opening of Peppermill so all Adult Mental Health admissions from York and Selby that are not admitted to Peppermill are now classed as an Out of Locality admission. The high occupancy levels described in KPI 3 continue to impact on the number of Out of Locality Admissions.

- %age of registered healthcare professional jobs advertised 2 or more times (KPI 15) – Performance has deteriorated in October although the financial year to date figure is a better position being over target by 3%age points. In order to improve the recruitment of staff the Workforce Group ahs developed a Recruitment Action Plan which has been approved by EMT. This includes undertaking an analysis of difficult to recruit to posts so that actions can be taken to specifically target those. In addition recruitment fairs have been set up in order to recruit individuals to specific localities who will they agree with the individuals the specific posts they will fill, targeting wherever possible the more difficult to appoint to posts.

- Appraisal (KPI 16) – Whilst the Trust is not achieving the target of 95% as at the end October the position remains much higher that the same time in previous years. It is expected however that the figure will decline in November as all those staff who transferred into the Trust on 1 November from York and Selby will be included in the figures as they will have been with the Trust for 12 months. A number of localities, including York and Selby, have included the performance in terms of this indicator into the regular operational management huddles and it is expected that this will have a positive impact. The additional Human resources reports will now not be available on the IIC until the end of November as a second stage of user testing was required.

- %age Sickness Rate (KPI18) – Performance against this KPI was included as an issue for the first time last month given the increase in sicknes over the previous month. However the position has improved in Ocotber such that it is only 0.14% points worse that the target. However the figure continues to be higher than that reported for the same peiord last year and this is liked to a 10% increase in the number of short term epiodes of sickness (excluding York and Selby). In response to this more focussed support is being provided to line managers to mange those staff experiencing 5 or more episodes of short terms absence.

2.3 Review of Targets

As agreed the targets have been further reviewed at the end of September to ensure that assumptions made in setting the targets for the year, particularly in terms of York and Selby performance remain appropriate. Having undertaken this review the Executive Management Team (EMT) recommends that the current targets should remain with the exception of the following:

KPI 1 Total Number of External Referrals into Trust Services – at the time of the setting the target there was no data available in terms of the number of referrals received from the York and Selby locality. Therefore the target was set by increasing the previous years out turn by 13% which represents the proportion of the total population of the CCGs services by the Trust that is covered by Vale of York CCG. On examining the actual levels of referrals that have been received in the first 6 months of the year the proportion that relate to the Vale of York CCG is approximately 21% of all referrals. EMT therefore recommend that the target is increased so that it reflects an increase on the 2015/16 outturn by 20% rather than the estimate of 13% that was used. This would result in the target being **91,759** compared to the 86,407 it is now.

3. RECOMMENDATIONS:

3.1 It is recommended that the Board:

- Consider the content of this paper and raise any areas of concern/query.
- Agree to the recommendation to increase the target for KPI 1 External Referrals as set out in Section 2.3.

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Activity

	October 2016				April 2016 To October 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Total number of External Referrals into Trust Services	7,339.00	8,347.00			50,661.00	57,583.00		86,407.00
2) Caseload Turnover	1.99%	-2.42%			1.99%	-2.42%		1.99%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	93.91%			85.00%	95.44%		85.00%
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	23.00	30.00			162.00	202.00		277.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	15.00%	7.03%			15.00%	7.36%		15.00%
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	22.67			139.00	176.00		237.00

Quality

	October 2016				April 2016 To October 2016			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%	87.69%			90.00%	85.02%		90.00%
8) Percentage of appointments cancelled by the Trust	0.67%	0.72%			0.67%	0.76%		0.67%
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	25.64%			15.00%	20.99%		15.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.44%	92.40%			91.44%	91.95%		91.44%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.16			7.00	4.84		12.00

Trust Dashboard Summary for TRUST

Workforce

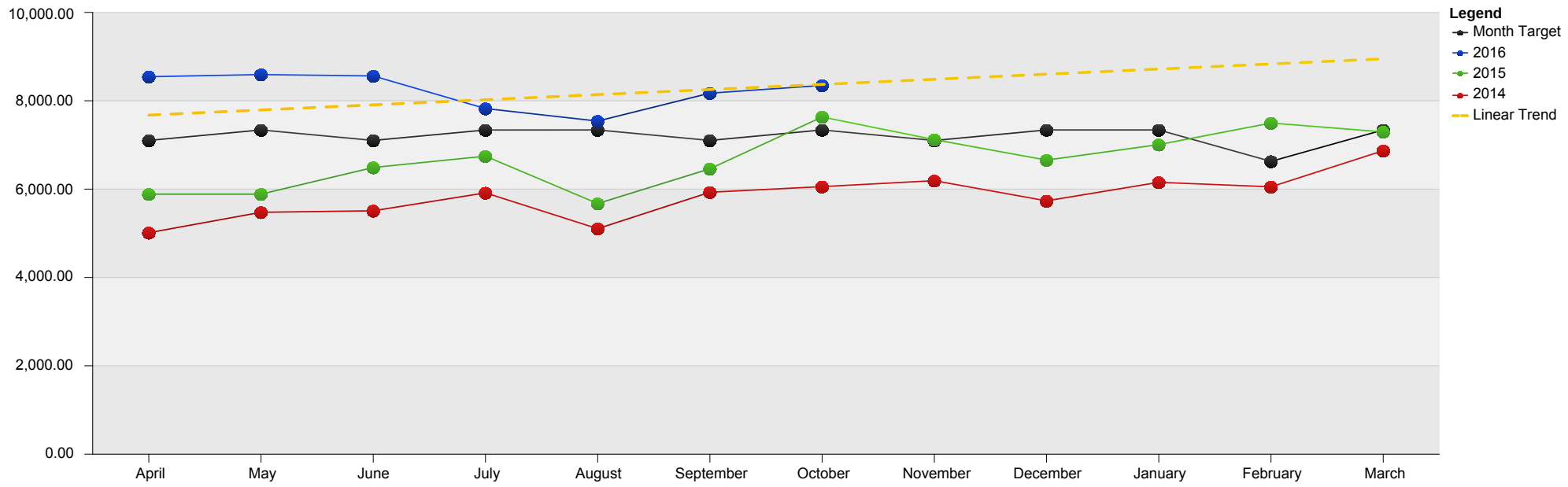
	October 2016				April 2016 To October 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 90%-95%)	100.00%	94.58%			100.00%	94.58%		100.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	20.29%			15.00%	17.93%		15.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	89.94%			95.00%	89.94%		95.00%
17) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	88.87%			95.00%	88.87%		95.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.64%			4.50%	4.75%		4.50%

Money

	October 2016				April 2016 To October 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-721,466.00	-1,291,000.00			-7,575,580.00	-9,199,000.00		-8,057,087.00
20) CRES delivery	550,854.00	551,455.00			3,855,980.00	3,860,185.00		6,610,251.00
21) Cash against plan	47,339,000.00	58,907,000.00			47,339,000.00	58,907,000.00		49,036,000.00

Trust Dashboard Graphs for TRUST

1) Total number of External Referrals into Trust Services

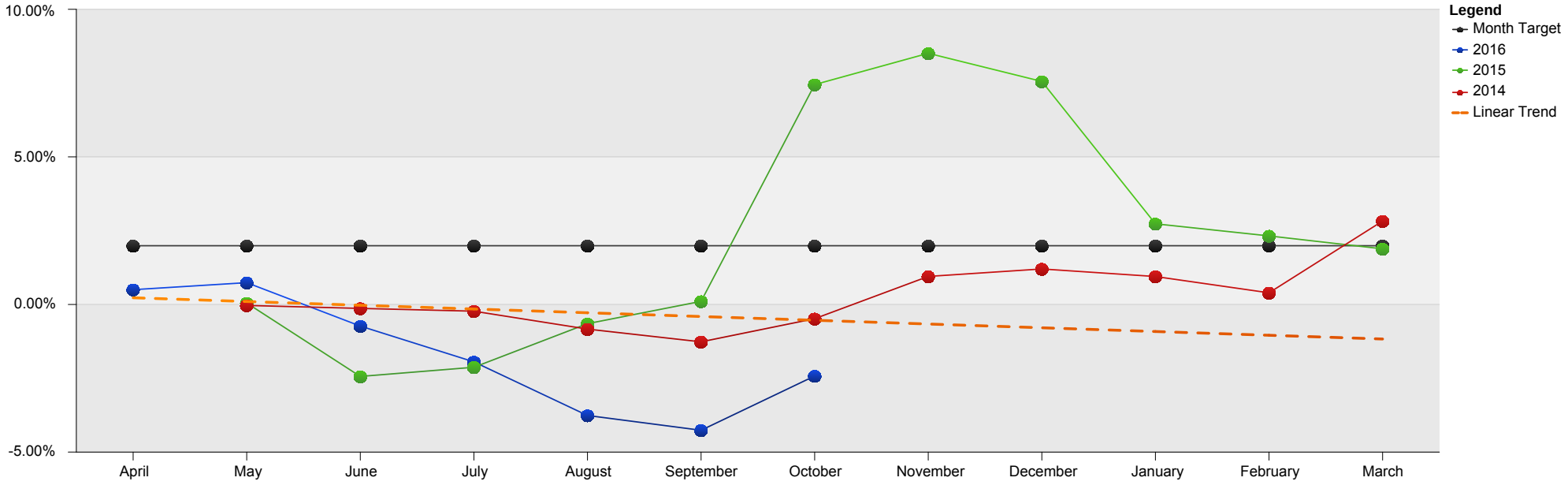


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Total number of External Referrals into Trust Services	8,347.00	57,583.00	2,006.00	13,825.00	1,958.00	13,542.00	2,066.00	14,034.00	567.00	4,279.00	1,747.00	11,888.00

Narrative
The Trust position October 2016 is 8374 which is 1008 above the Trust target of 7339 and an increase compared to that reported in September. The Trust position for the financial year to date is 57583 which is 6922 above target.Data including the York and Selby locality only started to be collected from April 2016. If comparing the remaining 4 localities, the position is 6581 which is lower compared to the same period last year of 6977.Based on the increasing trend reported it is anticipated that we will exceed the annual target of 86,407 referrals by more than 10%.

Trust Dashboard Graphs for TRUST

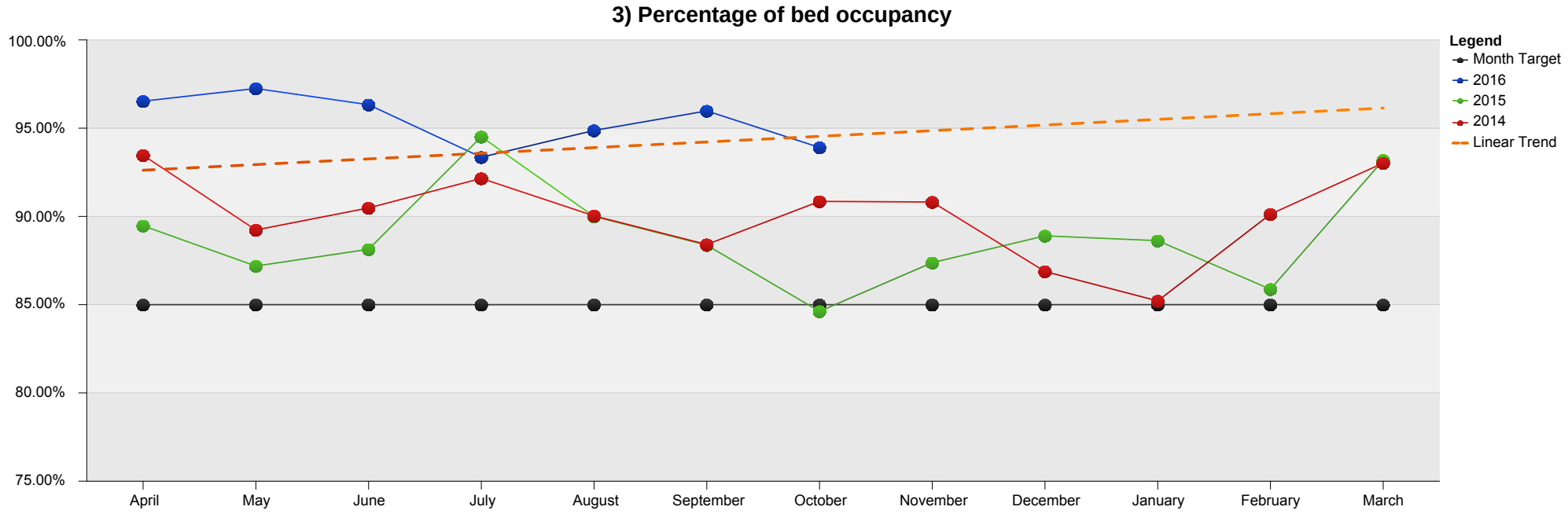
2) Caseload Turnover



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Caseload Turnover	-2.42%	-2.42%	-5.35%	-5.35%	-0.89%	-0.89%	-0.27%	-0.27%	NA	NA	-1.27%	-1.27%

Narrative
The Trust position for October is -2.42% which is within target. All localities are achieving the target. Based on the current trend it is likely we will achieve the annual target of 1.99%

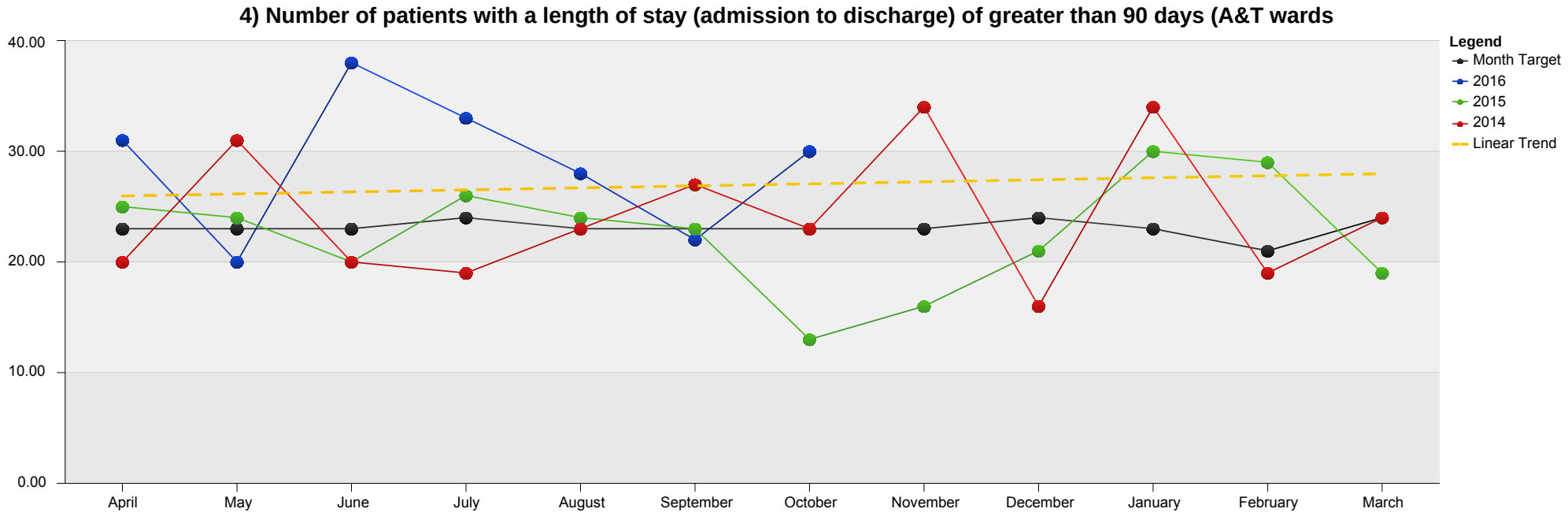
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	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)	93.91%	95.44%	94.20%	91.97%	96.54%	98.03%	93.21%	97.20%	NA	NA	89.59%	94.35%

Narrative
The Trust position for October is 93.91% which is 8.91% over the Trust target of 85% but an improvement on the September position. When compared to October 2015, the current position is also a deterioration. All localities are over target. The Trust position for the financial year to date is 95.44%, which is 10.44% above target.A key factor contributing to this high level of occupancy is linked to the placement of York Adult Mental Health patients requiring inpatient care into beds in other localities within the Trust. The Adult Mental Health beds re opened at Peppermill in York on 3rd October. It is anticipated that now the unit is operational the levels of occupancy will move closer to the target set, however it is recognised that the ability to discharge patients is becoming more difficult and this is also impacting on the bed occupancy

Trust Dashboard Graphs for TRUST



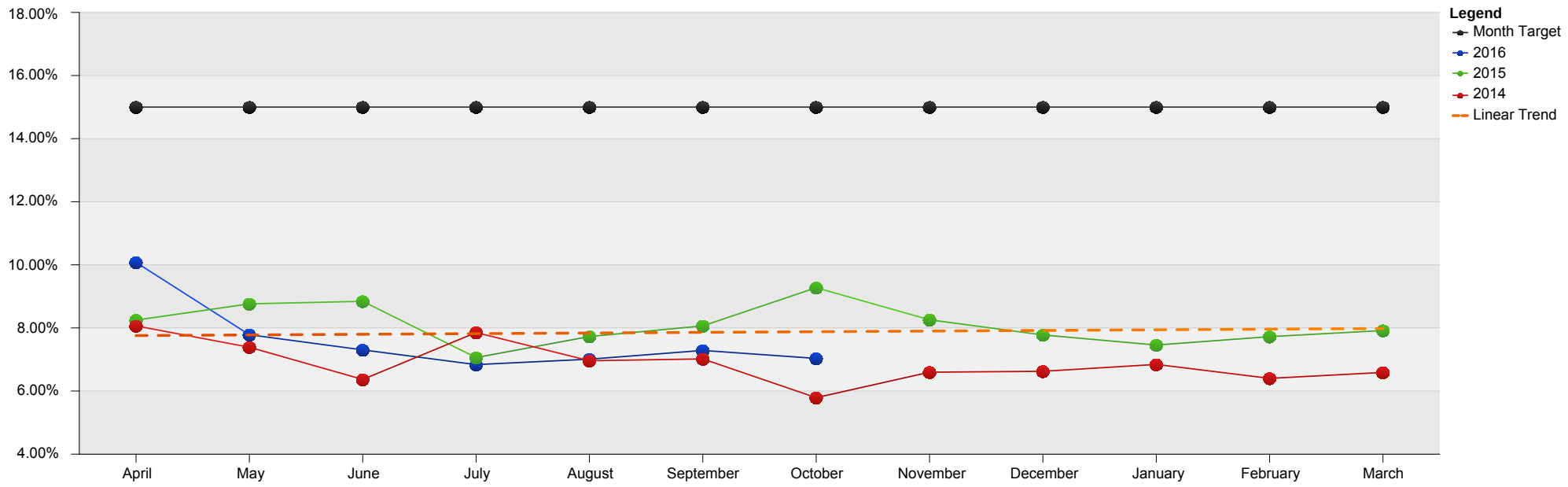
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	30.00	202.00	6.00	49.00	3.00	49.00	8.00	50.00	NA	NA	12.00	45.00

Narrative

The Trust position for October 2016 is 30 which is worse that than the Trust target of 23 and a deterioration on September position. The Trust position for the financial year to date is 202 which is worse than the target of 162.Of the 30 admissions with a LoS greater than 90 days:• 6 (20%) were within Durham & Darlington (3 AMH and 3 MHSOP) • 3 (10%) were within Teesside (2 AMH and 1 MHSOP)• 8 (26.66%) were within North Yorkshire (1 AMH and 7 MHSOP) • 12 (40%) were within York & Selby (3 AMH and 9 MHSOP)• 1 (3.33%) was from an Unknown CCG (1 MHSOP)Comparative data is now included in the dashboard, however York & Selby only started to be collected from April 2016 therefore it is not possible to make a direct comparison with the previous years' data given the indicator measurement is a number.Based on the current trend it is unlikely we will achieve the annual target of 277.

Trust Dashboard Graphs for TRUST

5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)

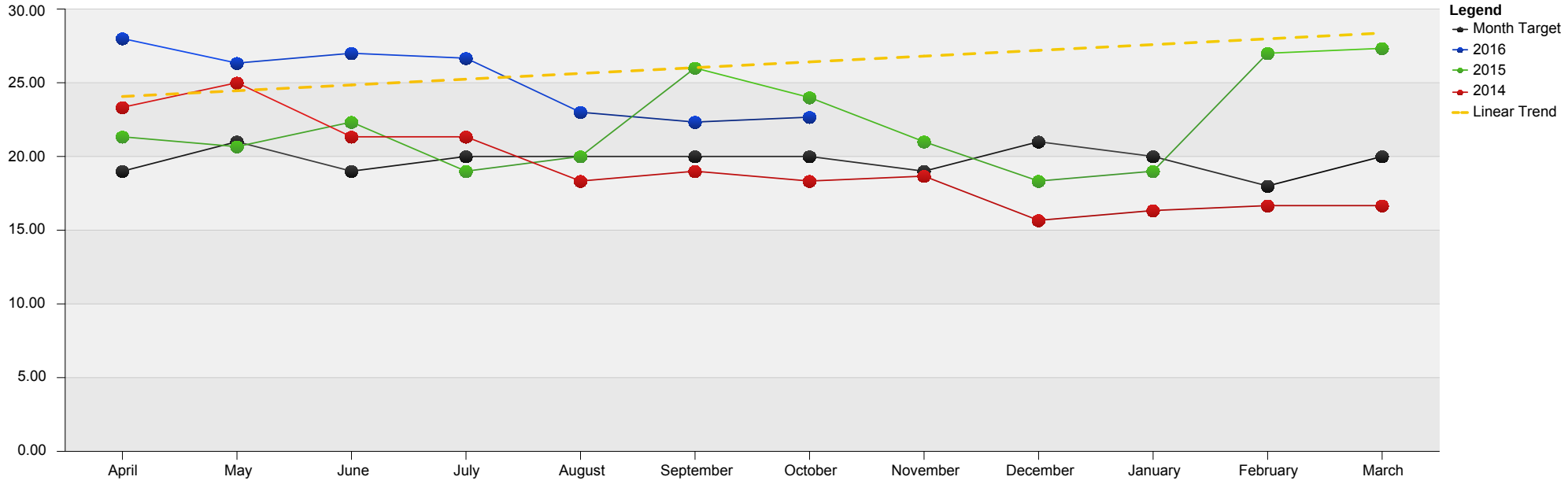


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	7.03%	7.36%	6.48%	6.18%	7.14%	7.77%	6.43%	7.24%	NA	NA	10.53%	10.93%

Narrative
The Trust rolling 3 month position ending October 2016 is.7.03%, which relates to 15.33 patients out of 218 that were readmitted within 30 days. This is better than the target of 15% but a slight deterioration on the position reported in September 2016. The Trust position for the financial year to date is 7.36% which is better than the target of 15%. Of the 15.33 patients:• 4.66 (30.39%) were within Durham & Darlington (3.99 AMH and 0.66 MHSOP) • 4.99 (32.55%) were within Teesside (4.66 AMH and 0.33 MHSOP).• 3.66 (23.87%) were within North Yorkshire (2.99 AMH and 0.66 MHSOP) • 1.99 (12.98%) were within York & Selby (1.66 AMH and 0.33 MHSOP)(*Please note data is displayed in decimal points due to the rolling position being calculated.)Based on the improvement in performance reported earlier in the year and in September, it can be expected that we will achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST

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

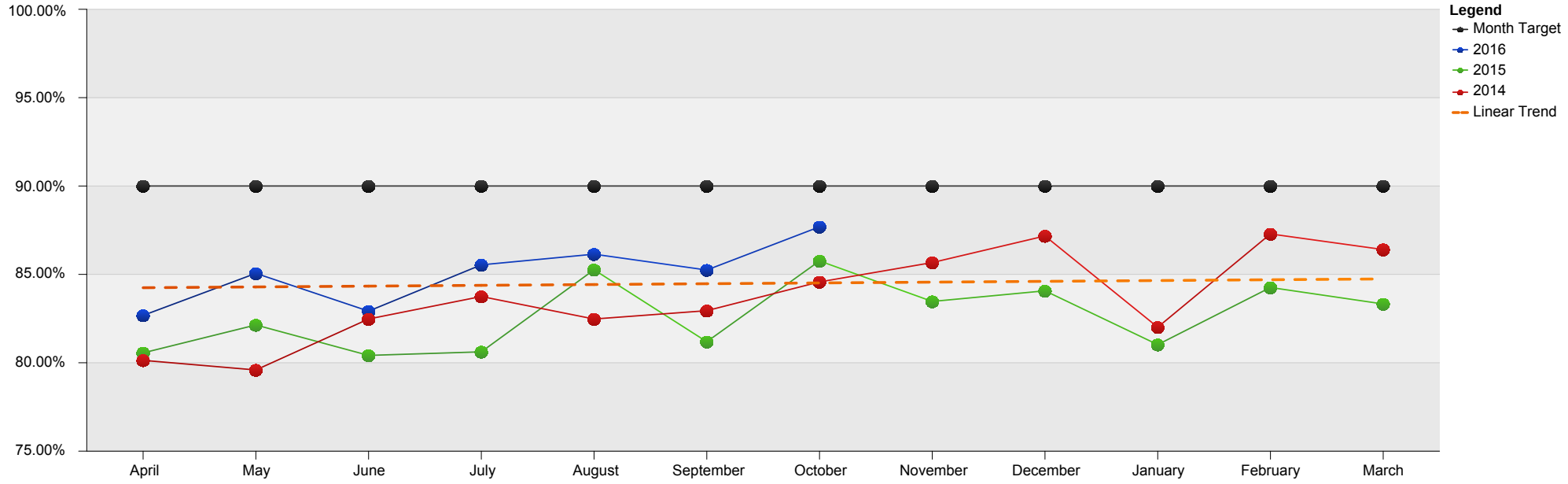


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	22.67	176.00	8.33	67.33	6.00	46.00	5.67	45.67	NA	NA	2.67	17.00

Narrative
The Trust rolling 3 month position ending October 2016 is 22.67, which is 2.67 worse than the target of 20 but the same as the position reported in August. The Trust position for the financial year to date is 176, which is worse than the target of 139.Of the 22.67 instances• 8.33 (36.74%) were within Durham & Darlington (8 AMH and 0.33 MHSOP)• 6 (26.46%) were within Teesside (5.33 AMH and 0.67 MHSOP)• 5.67 (25.01%) were within North Yorkshire (5.33 AMH and 0.67 MHSOP)• 2.67 (1.77%) were within York and Selby (AMH)(*Please note data is displayed in decimal points due to the rolling position being calculated.)Comparative data is now included in the dashboard, however York & Selby only started to be collected from April 2016 therefore it is not possible to make a direct comparison with the previous years' data given the indicator measurement is a number. Based on current and passed performance it is unlikely we will achieve the annual target of 237.

Trust Dashboard Graphs for TRUST

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



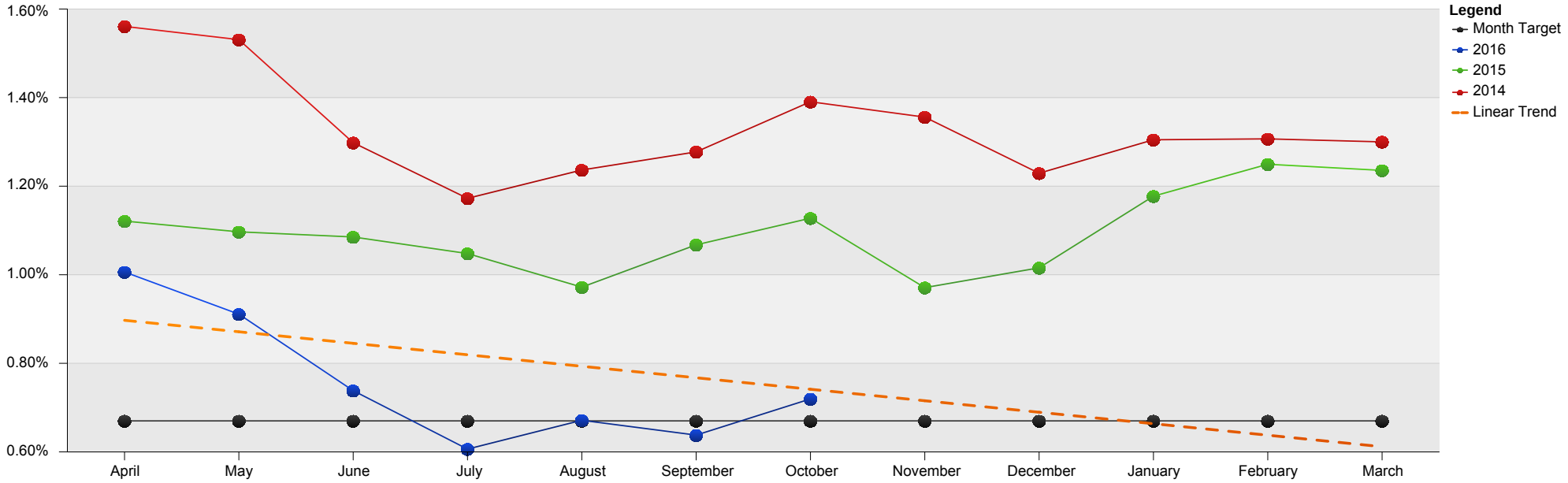
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	87.69%	85.02%	87.47%	79.96%	97.78%	96.32%	75.53%	76.15%	99.49%	99.52%	70.92%	68.97%

Narrative

The position for October 2016 is 87.69%, relating to 538 patients out of 4371 who had waited longer than 4 weeks. This is 2.31% worse than target but an improvement on the position reported in September. The October position is the best it has been in 2016/17 and across the previous 2 financial years. The position for financial year to date is 85.02%, which is 4.98% worse than target.Areas of concern are:• North Yorkshire CYP at 66.36% (73 of 110 patients), this is a 10.54% improvement on September 2016 An action plan is now in place with focused work on capacity and demand analysis and actions to address staff vacancies and sickness. • York & Selby CYP at 41.38% (12 of 29 patients) this is a 16.66% improvement on September 2016. An action plan is progressing with data quality actions being addressed, a single point of access being established and School Well-being workers being established in post (LA Employed) to sign post referrals appropriately into services. There has been an improvement during the year with the number still waiting over 4 weeks at the end of October being 85 compared to 251 at end of April 2016.Based on current performance there is a significant risk that we will not achieve the annual target of 90%, however if the current level continues we could report the best annual position in the past 3 years.

Trust Dashboard Graphs for TRUST

8) Percentage of appointments cancelled by the Trust

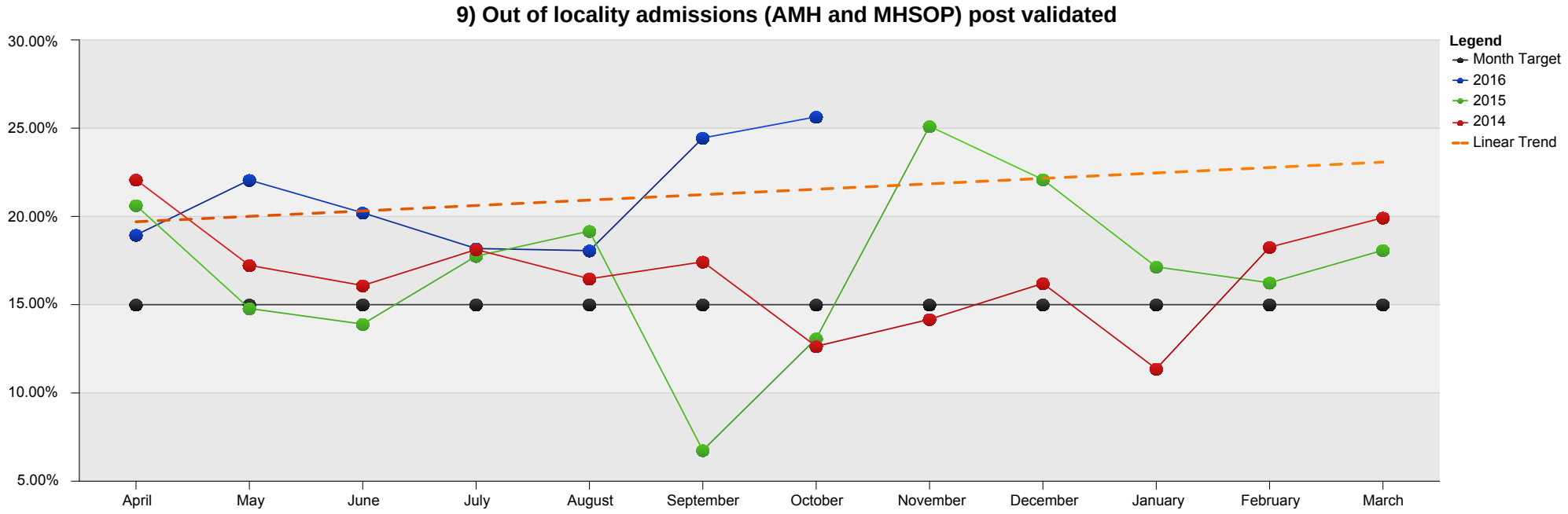


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Percentage of appointments cancelled by the Trust	0.72%	0.76%	0.88%	0.95%	0.56%	0.58%	0.80%	0.94%	0.33%	0.15%	0.70%	0.49%

Narrative

The Trust position for October 2016 is 0.72%, which relates to 634 appointments out of 88,142 that have been cancelled. This is 0.05% worse than the target and a deterioration on the position reported in September. The Trust position for the financial year to date is 0.76%, which is 0.09% worse than the target.Only Durham & Darlington and North Yorkshire are worse than target as a result of vacancies which are going through the recruitment process and sickness which is being managed in line with Trust Policy. Based on current performance it is possible that we could achieve the annual target of 0.67%.

Trust Dashboard Graphs for TRUST



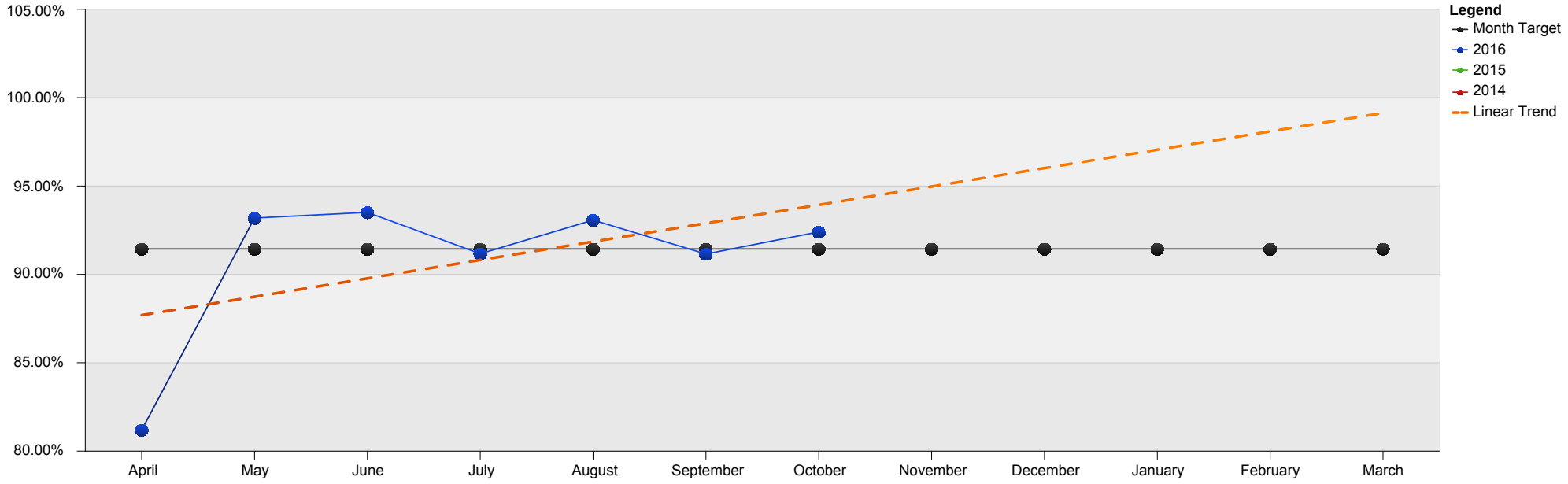
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	25.64%	20.99%	23.96%	20.24%	14.10%	16.03%	30.91%	33.09%	NA	NA	43.18%	15.61%

Narrative

Note: This is the first month this KPI Has included the new rules for AMH in York and Selby. These rules state patients from the York and Selby locality should only be admitted to Peppermill. The Trust position for October 2016 is 25.64%, which relates to 70 admissions out of 273 that were admitted to assessment and treatment wards out of locality. This is 10.65% worse than the target of 15%, and a deterioration on the position reported in September. The Trust position for the financial year to date is 20.99%, which is 5.99% worse than the target. Only Tees (14.10%) are better than target.Of the 70 patients (AMH 47, MHSOP 23) admitted to an 'out of locality' bed, all were due to no beds being available at their local hospital. The high occupancy rates described in KPI 3 continues to impact on this indicator. Data including the York and Selby locality only started to be collected from April 2016. If comparing the remaining 4 localities, the position is 22.27% which is a deterioration of 8.65% compared to October 2015. Based on past performance there is a significant risk that we will not achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST

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



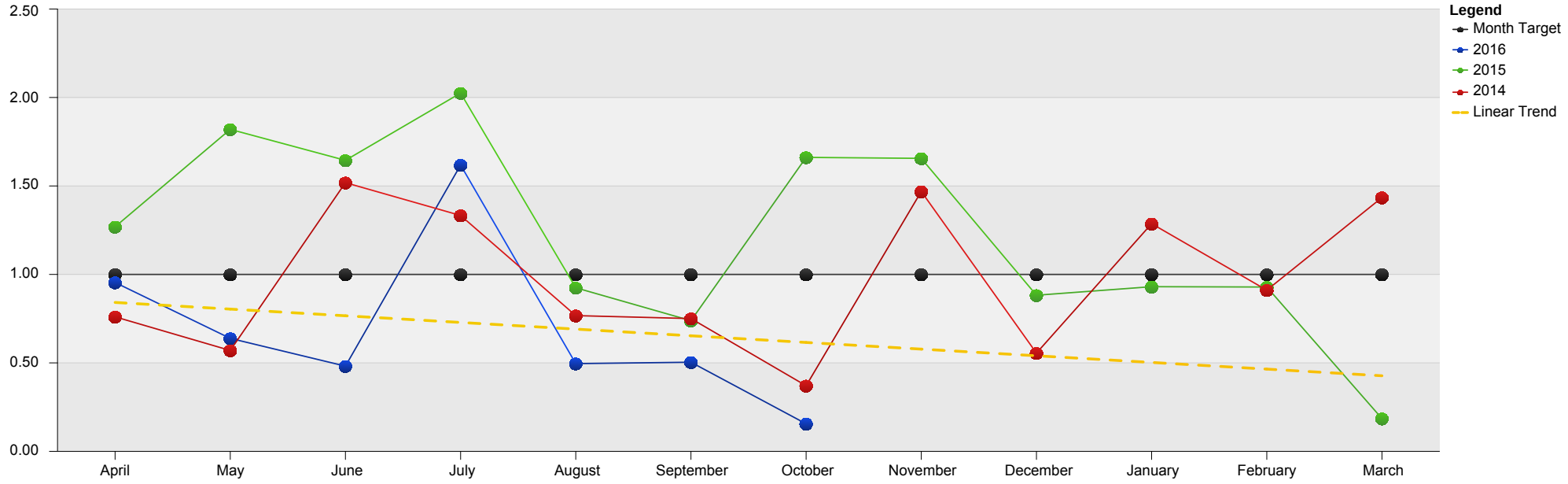
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.40%	91.95%	94.37%	94.24%	93.81%	92.82%	93.73%	92.32%	80.79%	79.32%	87.76%	88.37%

Narrative

The Trust position reported in October relates to September performance. The Trust position for September 2016 is 92.40% which is 0.96% better than the target of 91.44% and an improvement on the position reported for September. The Trust position for the financial year to date is 91.95%, which is 0.5% better than the target.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. If performance continues at the overall levels achieved, it can be expected that we will achieve the annual target of 91.44%.

Trust Dashboard Graphs for TRUST

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

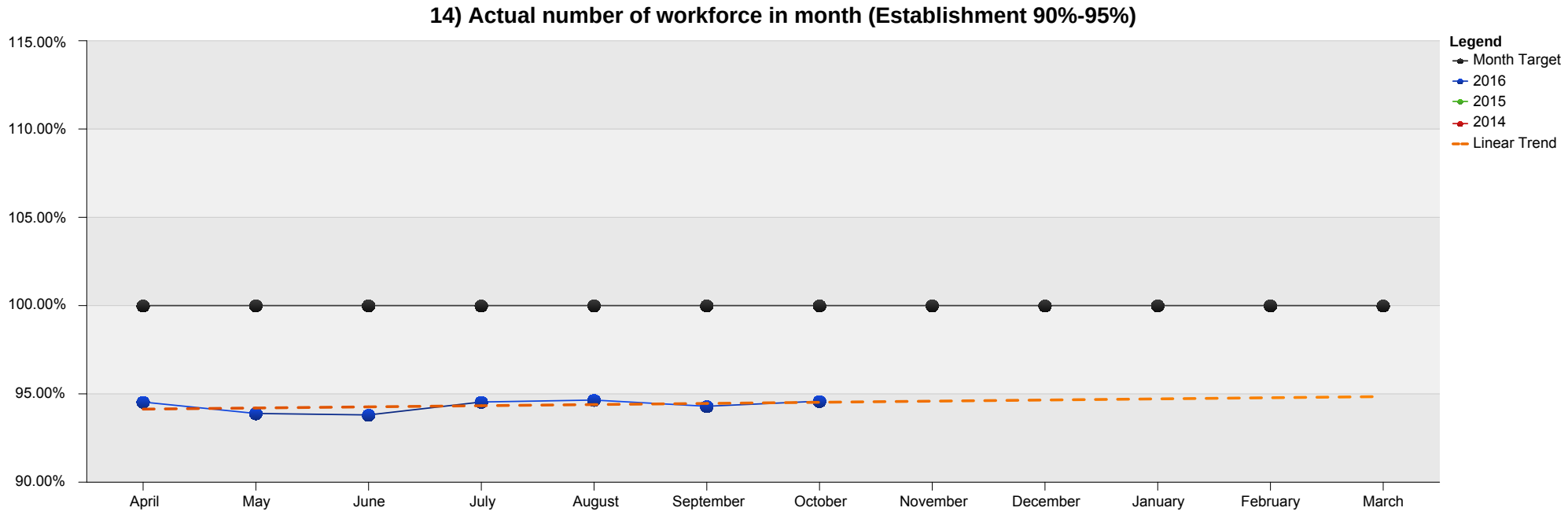


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	0.16	4.84	0.00	3.38	0.00	3.71	0.79	8.50	0.00	0.00	0.00	6.23

Narrative

The Trust position for October 2016 is 0.16, which is 0.84 better than the target of 1.00. This rate relates to 1 unexpected death which occurred in October. The Trust position for the financial year to date is 4.84 which is 2.16 better than the target. Given the 2015/16 data did not include York and Selby data it is not possible to compare the position with previous years totals. However the number of unexpected deaths reported in October 2015 was 5 and therefore the figure of 1 across the Trust area in 2016 is lower. Based on past and current performance, it can be anticipated that we will achieve the annual target of 12.00.

Trust Dashboard Graphs for TRUST

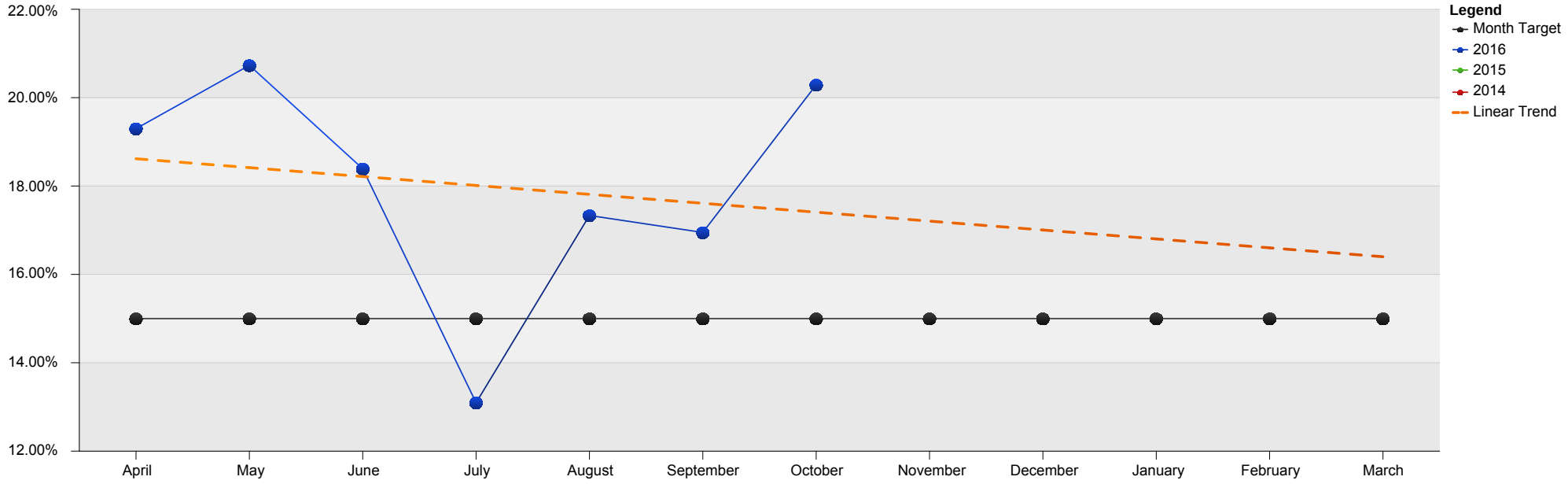


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Actual number of workforce in month (Establishment 90%-95%)	94.58%	94.58%	95.96%	95.96%	96.87%	96.87%	94.51%	94.51%	95.11%	95.11%	89.91%	89.91%

Narrative
The Trust position for October 2016 is 94.58% which is below the targeted establishment level of 95-100%, and a similar level to that reported in September 2016. It is anticipated that this figure will improve following a number of recruitment events where the Trust have successfully appointed to a number of nursing vacancies. Data only started to be reported in the dashboard from April 2016; therefore no comparative data for 2015/16 is available currently in this dashboard. Based on the performance so far during 2016/17, it can be expected that we will achieve the annual target.

Trust Dashboard Graphs for TRUST

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



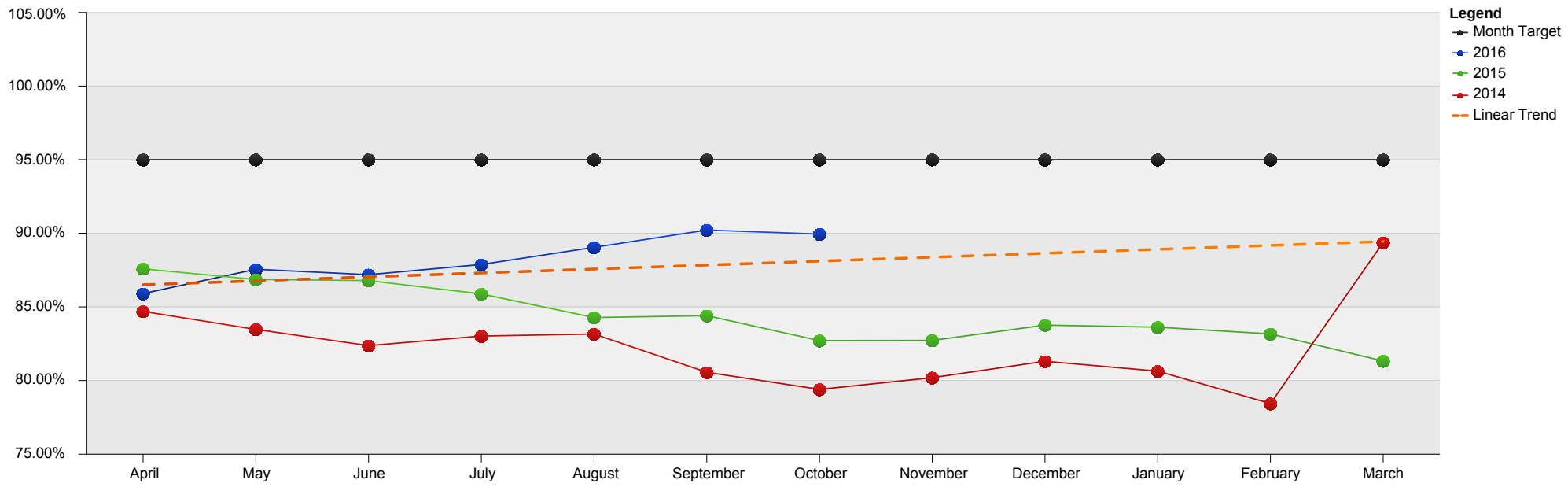
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Percentage of registered healthcare professional jobs that are advertised two or more times	20.29%	17.93%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative

The Trust position for October 2016 is 20.29%, which is an increase on the figure of 16.95% previously reported but remains worse than target of 15.00%. The Trust position for the financial year to date is 17.93%, which is 2.93% worse than the target. There were 11 jobs re-advertised in October for registered healthcare professional jobs. Two of the posts were fixed term/secondment opportunities, one to cover an Occupational Therapist vacancy and one to fill a Psychology post. The other posts were primarily for a range of registered nurse vacancies across a number of specialities and bands throughout the Trust. Data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available.Based on current performance there is a significant risk that we will not achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST

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

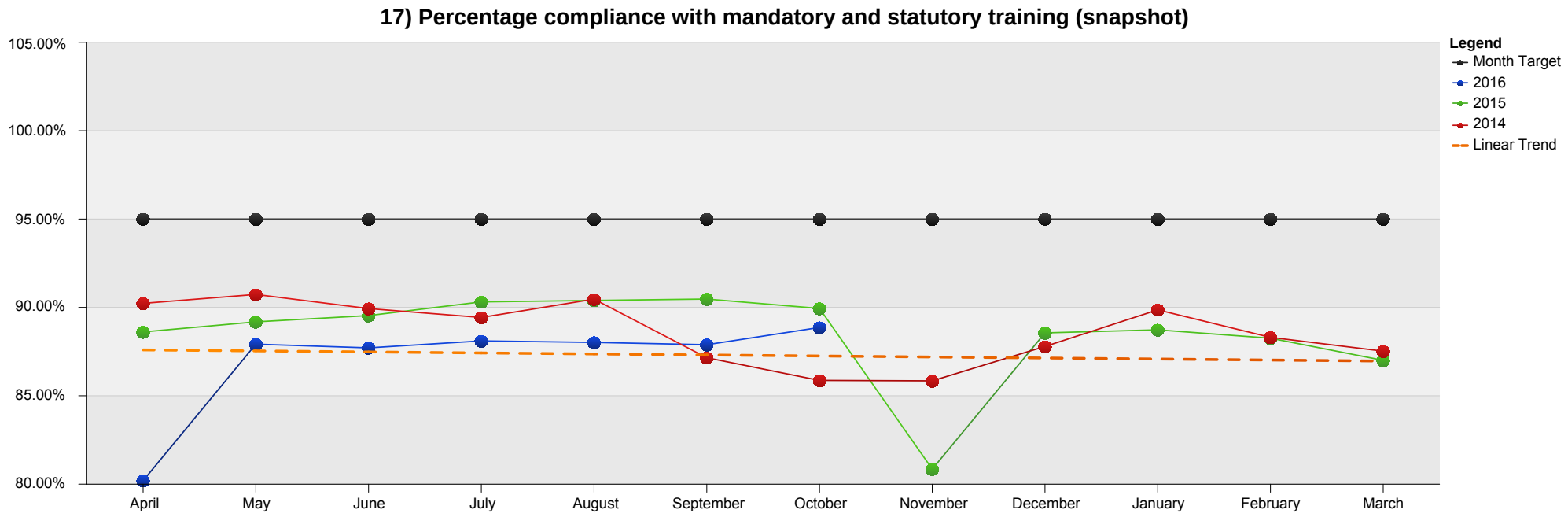


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	89.94%	89.94%	88.33%	88.33%	93.63%	93.63%	84.13%	84.13%	92.80%	92.80%	100.00%	100.00%

Narrative

The Trust position for October 2016 is 89.94% which relates to 521 members of staff out of 5180 that do not have a current appraisal; this is a slight reduction on the figure reported in September. This is 5.06% below target of 95% but demonstrates a continuing sustainability in working towards the target. A number of localities now have regular operational management huddles which include discussions on appraisal compliance levels, this has had a positive impact on performance levels being achieved. The second stage of user testing of the development work to enhance HR related information has started and this will be available to managers by end of November. The enhancement will highlight to managers staff showing as non-compliant and those due to be appraised within the following three months. Managers are able to access compliance reports through the IIC to monitor performance against the target of 95% and this is reviewed at the Performance Improvement Group, where Directors of Operations provide details of actions being taken to improve compliance. Based on past performance and October's performance there is a reducing risk that we may not achieve the annual target of 95%.

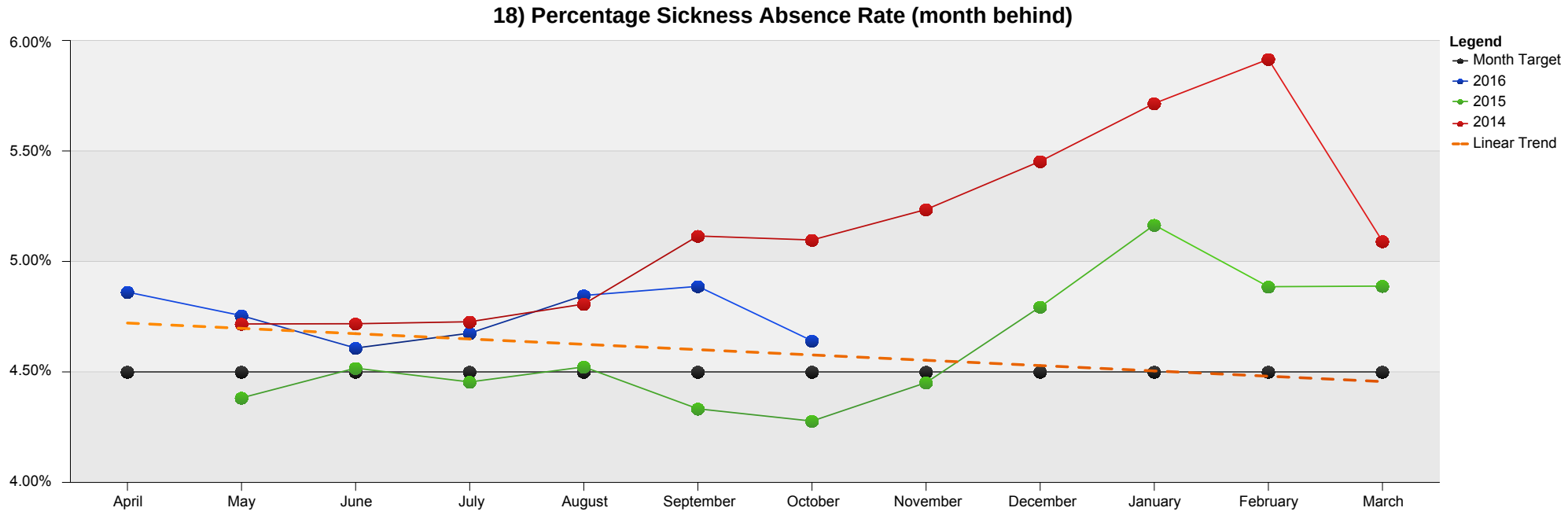
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with mandatory and statutory training (snapshot)	88.87%	88.87%	90.01%	90.01%	91.62%	91.62%	87.38%	87.38%	91.17%	91.17%	69.10%	69.10%

Narrative
The position for October 2016 is 88.87%. This is 6.13% lower than the target of 95% and is a slight improvement on the position reported in September. Tees, Durham and Darlington and Forensics are below target but performing above 90%. North Yorkshire and York and Selby are below 90%. York and Selby are achieving the lowest level at 69.10% which is an improvement on previous months. The work described in KPI16 regarding the additional HR reports will also cover mandatory training. Based on past performance and September's performance, there is a risk that we may not achieve the annual target of 95%.

Trust Dashboard Graphs for TRUST



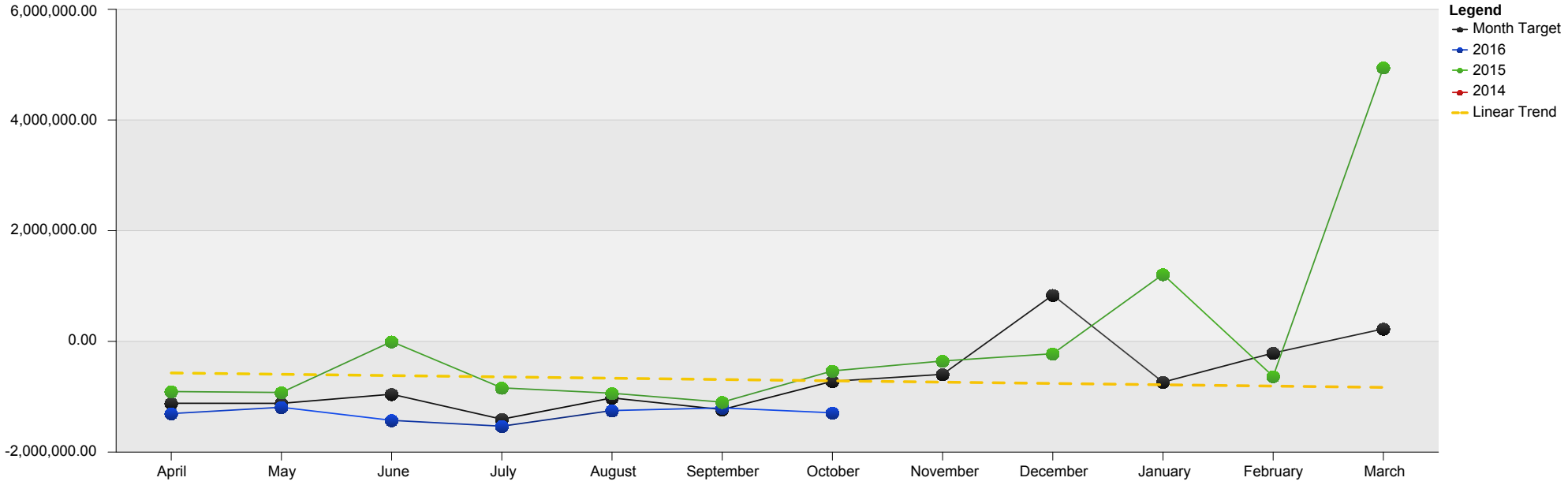
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	4.64%	4.75%	5.37%	5.14%	4.53%	5.20%	3.66%	4.38%	5.78%	5.37%	5.36%	5.03%

Narrative

The Trust position reported in October relates to the September sickness level. The Trust position reported in October 2016 is 4.64%, which is 0.14% worse than the Trust target of 4.50% but an improvement on the figure reported in September. The Trust position for the financial year to date is 4.75%, which is 0.25% worse than the target. The figure reported is higher than the sickness rate recorded for the same period last year. The number of short term episodes of absence has increased by 10% in comparison with the same period 2015. The 10% increase excludes the absence figures for York and Selby. Further analysis is being undertaken to understand the increase in episodes and days lost. The Operational HR team have introduced a more focussed approach to support line managers to manage those staff experiencing 5 or more episodes of short term absence. The long term sickness absence team continues to manage staff on long term sickness, proactively facilitating staff back to work or ultimately to the ending of the employment. The number of staff on long term sickness absence being managed by the long term sickness team is between 150 and 200 at any point in time. 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).Based on past and current performance there is a risk that we will not achieve the annual target of 4.50%.

Trust Dashboard Graphs for TRUST

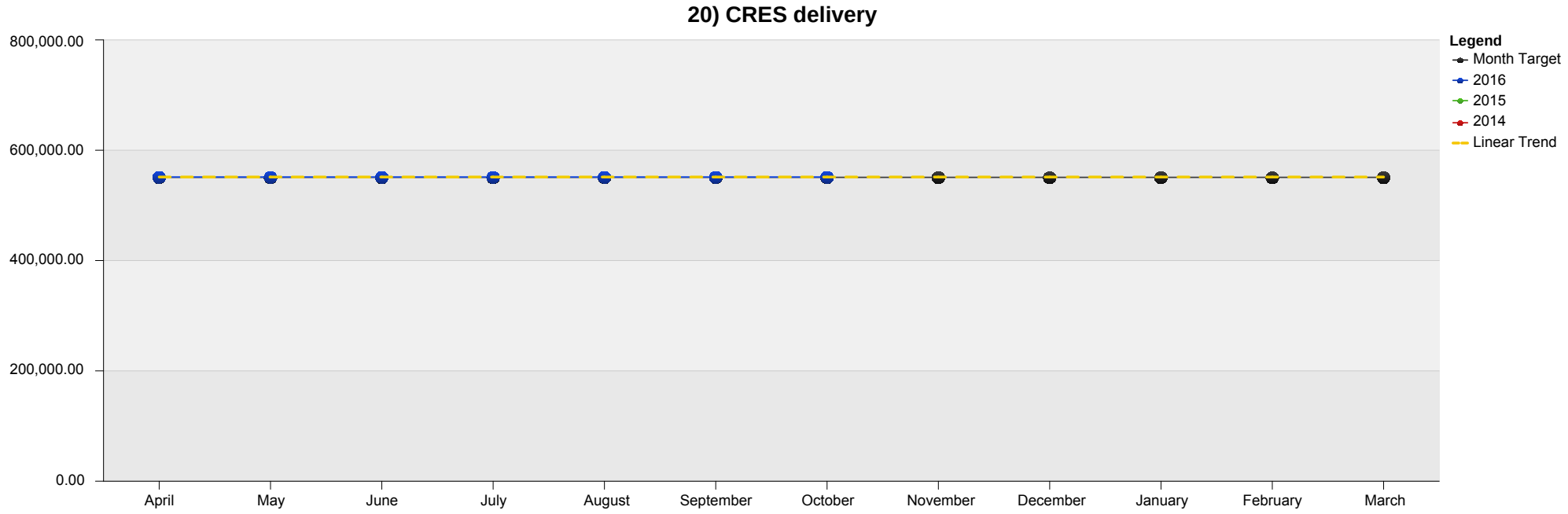
19) Delivery of our financial plan (I and E)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	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)	-1,291,000.00	-9,199,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
The comprehensive income outturn for the period ending 31 October 2016 is a surplus of £9,199k, representing 4.7% of the Trust's turnover. The Trust is ahead of plan by £1,623k largely due to vacancies however active recruitment is on-going.

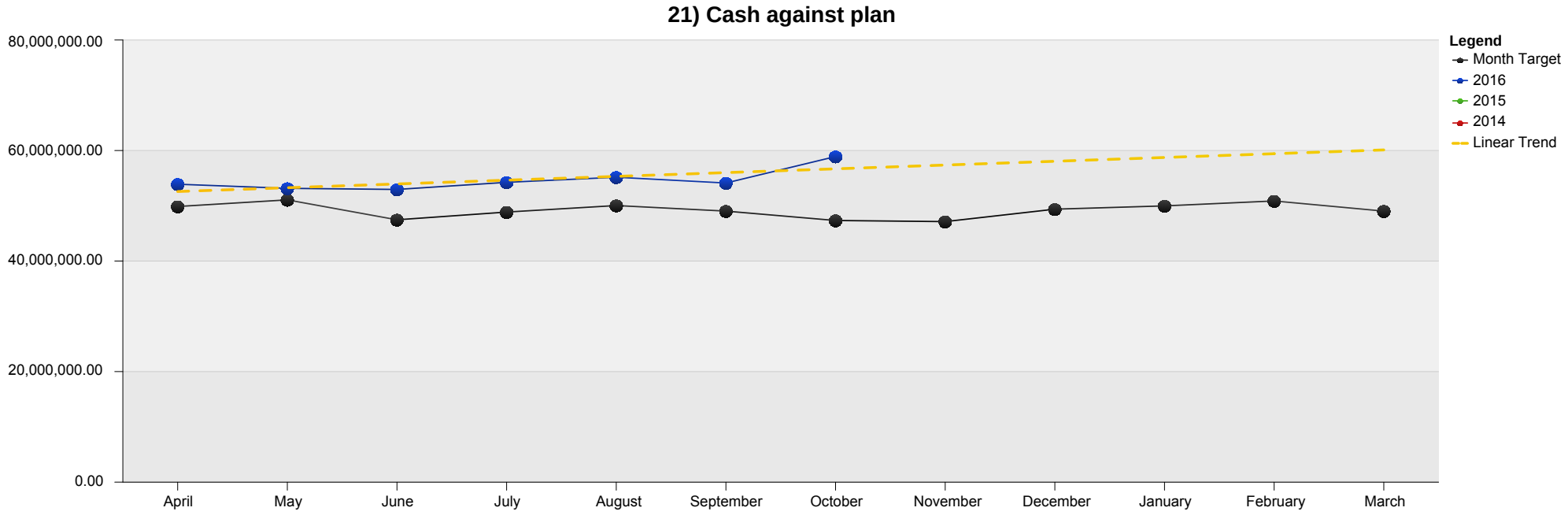
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) CRES delivery	551,455.00	3,860,185.00	196,833.00	1,377,831.00	94,000.00	658,000.00	23,583.00	165,081.00	26,833.00	187,831.00		

Narrative
Total CRES delivery by the Trust for October is £551,455. All localities continue to identify CRES schemes to ensure 100% is delivered recurrently in 2016/17.

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Cash against plan	58,907,000.00	58,907,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
The Trust position at 31 October 2016 is £58,907k and is ahead of plan largely due to delays in the capital programme, the Trusts surplus position and unanticipated cash receipts related to projects.

Trust Dashboard - Locality Breakdown for TRUST

1 - Activity

	October 2016												April 2016 To October 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	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	7,339.00	8,347.00	1,930.00	2,006.00	1,962.00	1,958.00	1,892.00	2,066.00	1,200.00	1,134.00	954.00	1,747.00	50,661.00	57,583.00	13,325.00	13,825.00	13,543.00	13,542.00	13,066.00	14,034.00	8,280.00	8,558.00	6,586.00	11,888.00
2) Caseload Turnover	1.99%	-2.42%	1.99%	-5.35%	1.99%	-0.89%	1.99%	-0.27%	NA	NA	1.99%	-1.27%	1.99%	-2.42%	1.99%	-5.35%	1.99%	-0.89%	1.99%	-0.27%	NA	NA	1.99%	-1.27%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	93.91%	85.00%	94.20%	85.00%	96.54%	85.00%	93.21%	85.00%	NA	85.00%	89.59%	85.00%	95.44%	85.00%	91.97%	85.00%	98.03%	85.00%	97.20%	85.00%	NA	85.00%	94.35%
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	23.00	30.00	8.00	6.00	6.00	3.00	6.00	8.00	NA	NA	3.00	12.00	162.00	202.00	56.00	49.00	44.00	49.00	44.00	50.00	NA	NA	19.00	45.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	15.00%	7.03%	15.00%	6.48%	15.00%	7.14%	15.00%	6.43%	NA	NA	15.00%	10.53%	15.00%	7.36%	15.00%	6.18%	15.00%	7.77%	15.00%	7.24%	NA	NA	15.00%	10.93%
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	22.67	5.00	8.33	5.00	6.00	6.00	5.67	NA	NA	2.00	2.67	139.00	176.00	38.00	67.33	38.00	46.00	46.00	45.67	NA	NA	16.00	17.00

Trust Dashboard - Locality Breakdown for TRUST

2 - Quality

	October 2016												April 2016 To October 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	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%	87.69%	90.00%	87.47%	90.00%	97.78%	90.00%	75.53%	90.00%	99.49%	90.00%	70.92%	90.00%	85.02%	260.00%	79.96%	260.00%	96.32%	260.00%	76.15%	260.00%	99.52%	260.00%	68.97%
8) Percentage of appointments cancelled by the Trust	0.67%	0.72%	0.67%	0.88%	0.67%	0.56%	0.67%	0.80%	0.67%	0.33%	0.67%	0.70%	0.67%	0.76%	0.67%	0.95%	0.67%	0.58%	0.67%	0.94%	0.67%	0.15%	0.67%	0.49%
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	25.64%	15.00%	23.96%	15.00%	14.10%	15.00%	30.91%	NA	NA	15.00%	43.18%	15.00%	20.99%	15.00%	20.24%	15.00%	16.03%	15.00%	33.09%	NA	NA	15.00%	15.61%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.44%	92.40%	91.44%	94.37%	91.44%	93.81%	91.44%	93.73%	91.44%	80.79%	91.44%	87.76%	91.44%	91.95%	91.44%	94.24%	91.44%	92.82%	91.44%	92.32%	91.44%	79.32%	91.44%	88.37%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.16	1.00	0.00	1.00	0.00	1.00	0.79	1.00	0.00	1.00	0.00	7.00	4.84	7.00	3.38	7.00	3.71	7.00	8.50	7.00	0.00	7.00	6.23

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	October 2016												April 2016 To October 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	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 90%-95%)	100.00%	94.58%	100.00%	95.96%	100.00%	96.87%	100.00%	94.51%	100.00%	95.11%	100.00%	89.91%	100.00%	94.58%	100.00%	95.96%	100.00%	96.87%	100.00%	94.51%	100.00%	95.11%	100.00%	89.91%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	20.29%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	17.93%	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%	89.94%	95.00%	88.33%	95.00%	93.63%	95.00%	84.13%	95.00%	92.80%	95.00%	100.00%	95.00%	89.94%	95.00%	88.33%	95.00%	93.63%	95.00%	84.13%	95.00%	92.80%	95.00%	100.00%
17) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	88.87%	95.00%	90.01%	95.00%	91.62%	95.00%	87.38%	95.00%	91.17%	95.00%	69.10%	95.00%	88.87%	95.00%	90.01%	95.00%	91.62%	95.00%	87.38%	95.00%	91.17%	95.00%	69.10%
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.64%	4.50%	5.37%	4.50%	4.53%	4.50%	3.66%	4.50%	5.78%	4.50%	5.36%	4.50%	4.75%	4.50%	5.14%	4.50%	5.20%	4.50%	4.38%	4.50%	5.37%	4.50%	5.03%

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	October 2016												April 2016 To October 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	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)	-721,466.00	-1,291,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	-7,575,580.00	-9,199,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
20) CRES delivery	550,854.00	551,455.00	183,500.00	196,833.00	168,250.00	94,000.00	117,595.00	23,583.00	92,909.00	26,833.00			3,855,980.00	3,860,185.00	1,284,500.00	1,377,831.00	1,177,750.00	658,000.00	823,167.00	165,081.00	650,363.00	187,831.00		
21) Cash against plan	47,339,000.00	58,907,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	343,691,000.00	58,907,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

		Data Source					Data Reliability					KPI Construct/Definition										
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1	Total Score	**Percentage as at April 2016**	**Percentage**	Notes	**Notes**
		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 services	5					5					5					15	**100%**	**100%**		
2	Caseload Turnover	5					5					5					15		**100%**		
3	Number of patients with a length of stay over 90 days (AMH & MHSOP A&T wards)	5					5					5					15		**100%**		
4	Bed occupancy (AMH & MHSOP A&T wards)	5					5					5					15		**100%**		
5	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	5						4				5					14	**93%**	**93%**		York and Selby historic data is not in the system so any admissions prior to 1st April may not be on the system. As a result it may appear that Y&S locality position deteriorates as the year progresses.
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						4				5					14	**100%**	**93%**		York and Selby historic data is not in the system so any admissions prior to 1st April may not be on the system.
7	Number of unexpected deaths classed as a serious incident per 10,000 open cases		4				5					5					14	**67%**	**93%**		Data will be directly extracted from Datix into the IIC; however, this process is not fully embedded. IAPT caseload is currently a manual upload. Data reliability has improved following the introduction of the central approval team
8	Percentage of patients who have not waited longer than 4 weeks following an external referral	5						4				5					14	**93%**	**93%**		Data reliability is 4 due to issues over recording of Did not attends which would stop the clock. Although this is improving, York and Selby locality still have data quality issues to amend following transfer onto PARIS.
9	Percentage of out of locality admissions to assessment and treatment wards (AMH and MHSOP) - post validated		4					4				5					13	**87%**	**87%**		Data is now imported back into IIC following manual validation. This increases reliability; however, there will be some discharges discounted because complete validation has not been possible within the time. These could subsequently be determined to be breaches. In addition there is an issue with staff updating a patient's GP but overwriting historical data - work is underway with Civica in order to amend PARIS to prevent this.
10	Percentage of patients surveyed reporting their overall experience as excellent or good.				2		5					5					12		**80%**		All questionnaires are paper-based, except for some CAMHS units, where patients use a touch screen facility to record their comments. The manual questionnaires from Trust are sent to CRT and scanned into their system. Raw data files are received from CRT, which are accessed by IPT and uploaded into the IIC. TEWV are changing provider during the year. Procurement is currently underway. Transition from CRT to new system will be planned and closely monitored.
11	Percentage of appointments cancelled by the Trust	5									1				2		8	**87%**	**53%**		Codes have been changes and KPIs updated however this is only for outpatient appointments. Community contacts have not been updated and there is an issue because you cannot future date appointments. The release of staff diary on PARIS should resolve this however this will not be until next financial year.

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at April 2016	Percentage	Notes	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	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 have lessened - there appears to be greater confidence in the data being reported. York and Selby staff were transferred on 1st October and will begin to be reported in November through the IIC. Robust process recently implemented within York and Selby to regularly review appraisal compliance information as part of regular management meeting. Fortnightly reports being produced by Workforce Information team to support monitoring.
15	Percentage compliance with mandatory and statutory training – snapshot	5						4				5					14	**93%**	**93%**		Issues with training dates being entered to ESR have lessened - there appears to be greater confidence in the data being reported. York and Selby staff were transferred on 1st October, training information input ESR. There is an ongoing issue associated with idenitification of training requirements linked to training matrix. There is a piece of work being undertaken associated with this which may provide a resolution.
16	Percentage Sickness Absence Rate (month behind)	5						4				5					14	**87%**	**93%**		Whilst the sickness absence data for inpatient services is now being taken directly from the rostering system which should help to eliminate inaccuracies the remainder of the Trust continue to input directly into ESR and there are examples whereby managers are failing to end sickness in a timely manner or inaccurately recording information onto the system – this is picked up and monitored through sickness absence audits that the Operational HR team undertake. York and Selby services are now in line with the remainder of the Trust using MSS or the rostering system - so actions highlighted above will be replicated.
17	Actual number of workforce in month		4				5					5					14		**93%**		Data extracted elecronically but processed manually
18	Percentage of registered health care professional jobs that are advertised two or more times				2			4				5					11		**73%**		Mostly reliable - the form to capture this information has been amended but 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.

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at April 2016	Percentage	Notes	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					
19	Are we delivering our financial plan (I and E)		4				5					5					14	**93%**	**93%**		Mostly reliable - the form to capture this information has been amended but 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.
20	Delivery of CRES against plan				2		5					5					12		**80%**		Data is 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%**		An extract is taken from the system then processed manually to obtain actual performance.

Number of unexpected deaths and verdicts from the coroner April 2016 - March 2017

	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																1					**1**
Hanging					1																**1**
Suicides	2	1	1		1							1	2			1					**9**
Open																					**0**
Drug related death																					**0**
Drowning																					**0**
Misadventure																					**0**
Awaiting verdict	2	1	4		4	1						1	1			1	2	2			**19**
Total	**4**	**2**	**5**	**0**	**6**	**1**	**0**	**0**	**0**	**0**	**0**	**2**	**3**	**0**	**0**	**3**	**2**	**2**	**0**	**0**	**30**

Number of unexpected deaths classed as a serious untoward incident											
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
6	4	3	10	3	3	1					

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
8	6	10	0	6

Number of unexpected deaths and verdicts from the coroner 2015 / 2016

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					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	1																				**1**
Natural causes	1					1															**2**
Hanging	3	1	2								1						1		1		**9**
Suicides	7	3	6										1				1				**18**
Open	1		1																		**2**
Drug related death	1	2																			**3**
Drowning																					**0**
Misadventure	1		1																		**2**
Awaiting verdict	13	9	7	2		2		1			2	2	2			1	6	1	1		**49**
Total	**28**	**15**	**17**	**2**	**0**	**3**	**0**	**1**	**0**	**0**	**3**	**2**	**3**	**0**	**0**	**1**	**8**	**1**	**2**	**0**	**86**

Number of unexpected deaths classed as a serious untoward incident											
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
7	10	9	10*	5	4	9	9	7	6	8	2

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
35	25	22	4	0

Y&S recorded in old Datix not included

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29th November 2016**
TITLE:	**Strategic Direction Performance Report – Quarter 2 2016-17**
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 2 (30th September 2016/17).

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.

This report reflects that three of the Trusts five goals remain in a positive position, whilst still acknowledging that there is work to do to improve some KPI's. For Goals 1 and 2 the positon is more mixed, with slight deteriorations in KPI's and business plan delivery, however, there is significant qualitative intelligence, in terms of how services are improving.

In addition there are some business plan actions that need to be re-profiled in the light of changing circumstances.

Recommendations:

Trust Board are asked to receive this report and provide comment/feedback as appropriate.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**29th November 2016**
TITLE:	**Strategic Direction Performance Report – Quarter 2 2016-17**

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 2 (30th September) 2016/17.

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 The 5 year targets for the Trust Strategic Direction Scorecard were agreed by the Board on the 18th August 2015.

3. KEY ISSUES:

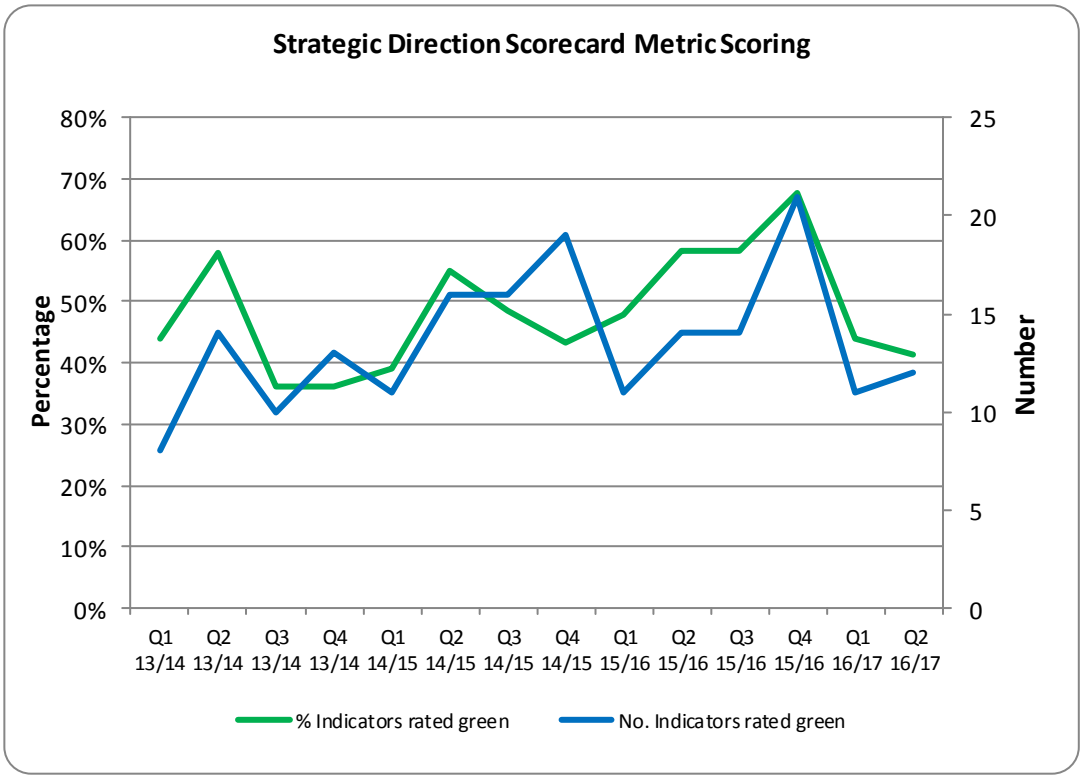
3.1 Trust Strategic Direction Scorecard

The Strategic Direction Scorecard is shown under each strategic goal.

The following table and graph provide a summary of the RAG ratings at quarter 2 compared to the position in the previous quarter and the previous financial years 2014/15 and 2015/16. The Trust is not meeting some of its high ambitions given the number of reds against stretching metrics; this is a deterioration on the percentage reported in both quarter 1 2016/17 and quarter 2 2015/16 (54%) however, the number of indicators that can be RAG rated is greater in both cases and the actual number of those rated green has increased since quarter 1. In addition there are some business plan actions that need to be re-profiled in the light of changing circumstances.

	2014/15 Actual		2015/16 Actual		Q1 2016/17		Q2 2016/17		2016/17 Actual YTD	
	No	%*	No	%*	No	%*	No	%*	No	%*
Indicators rated green	18	42%	21	66%	11	44%	12	41%	12	41%
Indicators rated red	25	58%	11	34%	14	56%	17	59%	17	59%
Indicators with no target	2		3		2		2		2	
Indicators currently under development/being finaliased	1		1		0		0		0	
Indicators where data is not yet available/not applicable in qtr	0		4		12		8		8	

The percentage is based on the number of indicators that can be RAG rated (29 for quarter 2).



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 2, with 2 of those indicators showing an improvement on the quarter 1 position.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17									
	Indicator	Q2 Target 2016/17	Q1 2016/17	Quarter 2 Actual 2016/17	Change on previous quarter/year	YTD Target 2016/17	FYTD 16/17 Actual	Annual Target 2016/17	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	>91.44%	92.59%	92.17%	⇩	>91.44%	92.37%	>15/16 out-turn= 91.37% tbc	>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%	81.77%	85.20%	⇧	90.00%	83.43%	90.00%	98.00%
3	Percentage of patients reporting "yes always" to the question "did you feel safe on the ward?"	85.00%	80.00%	84.39%	⇧	85.00%	82.17%	85.00%	TBC
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	Results delayed - now due in Q3	n/a	n/a	n/a	Surveys: Top 20% of MH Trusts	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	n/a	n/a	n/a	Surveys: Top 10% of MH Trusts	Surveys: Top 10% of MH Trusts
6	Percentage of service users with a recovery focussed action plan (Adult Mental Health)	95.00%	92.59%	92.17%	⇩	95.00%	92.17%	95.00%	95.00%

Indicators of concern are:

- **KPI 2 - Percentage of patients who have not waited longer than 4 weeks from "referral" to "assessment" for external and internal referrals** – the Trust position for quarter 2 is 85.20% against a target of 90% which is an improvement on the quarter 1 position. The target has been changed from 98% to 90% to align the key performance indicator to that reported within the Trust Performance Report.

  Only Forensic Services (99.12%) and Teesside (96.53%) are reporting above target for quarter 2, and York & Selby are reporting the lowest performance at 58.48%.

  Within York and Selby there are a number of issues, relating to both data quality, stemming from the migration of the data onto TEWV systems, and capacity issues within the locality. Capacity issues are a particular concern in CAMHS and the MHSOP memory service, where there is the largest number of waiters. CAMHS are in the process of establishing a Single Point of Access for referrals and have established a team of CAMHS Hospital Liaison workers to release clinician capacity back in to the community teams. Some vacant posts have also been recruited to. MHSOP continue to review the pathway process as well as looking to recruit to the memory service to meet demand.

  Within Durham and Darlington locality (80.54%), the main area of underperformance is in relation to Children and Young People's Services (CYP). However this continues to be an improving picture as the service continue to implement the action plan and the single point of access. There continues to be some staffing gaps due to sickness and vacancies which is impacting on the delivery of the target.

  North Yorkshire locality (81.93%) continues to be impacted by a combination of staffing issues. The services are implementing actions to improve the position further including reviewing the service model, for delivery of Primary care services, via the Purposeful and Productive Community Services Programme (PPCS), to ensure capacity is distributed in response to demand.

- **KPI 6 - Percentage of service users with a recovery focussed action plan (Adult Mental Health)** – the Trust position for quarter 2 is 92.17% against a target of 95% which is a slight deterioration on the quarter 1 position of 92.59%.

  Only North Yorkshire is above target with Durham and Darlington and Tees showing an underperformance at 89.32% and 94.87% respectively. The following should be noted:

  - All localities are achieving target for the Assertive Outreach teams of 95% but this is not the case for the psychosis teams.
  - There have been significant staffing issues experienced in some teams within Durham and Darlington locality which has impacted on performance

into quarter 2. Work is ongoing to address recruitment but staff sickness remains an issue. All leadership hubs continue to work with their teams to ensure that outstanding activity is planned and completed as soon as possible.

- Details of the Tees breaches have been circulated to Team Managers to investigate in detail; however the majority relate to new patients. In the model line process recovery stars are completed at an appropriate point, but within 12 weeks of the patient first being seen; this can result in patients appearing as 'breaches' for some time. Where patients are unwilling to engage in the process clinicians are advised to complete the recovery star from their perspective once 12 weeks have elapsed.

Other Points to note –

- **KPI 1 – Percentage of patients surveyed reporting their overall experience as excellent or good** – The target has been changed from 91.37% to 91.44%, as agreed by Trust Board at the September meeting, to align the key performance indicator to that reported within the Trust Performance Report.

- **KPI 3 – Percentage of patients reporting 'yes always' to the question, 'did you feel safe on the ward?'** – Previously, at the Trust Board in September Board approval was sought to keep the 16/17 target at 85%, which was agreed. Approval is now sought for the successive years, 2017/18, 2018/19 and 2019/20 to report the target at 85%. Board approval is sought to agree this target.

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 2 were rated green (74%) which is a slight deterioration on quarter 1 (78%). There are 13% of the priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

The 13% represents 13 priorities / service developments. Of these:

- 4 required additional time within year (which has been agreed by EMT)
- 4 required changes in actions and metrics (which have been agreed by EMT)
- 5 priorities / service developments cannot yet request a change because an EMT / Board paper or PM form / project plan is in development. These include 3 information technology related service developments.

Where a Board decision is required to change or remove an action, this is contained in Appendix 1 for approval.

3.2.3 Other Qualitative Intelligence

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

- There have been 3 unexpected deaths within the Trust, the circumstances of which have prompted the introduction of new protocols and changes to the way we work.

- Harrogate Borough Council has approved planning permission for the proposed new hospital in Harrogate. The new hospital is planned to replace inpatient facilities that are currently within Harrogate District Hospital. Design workshops are currently being held with the aim of taking proposals to the Board of Directors in the New Year.

- The Trust is the first in the UK to adopt Teepa Snow's **Positive Approach™ to Care for people living with Dementia** - with two members of staff from Tees, Esk and Wear Valley's NHS Foundation Trust (TEWV) being the first NHS staff in the UK to become Certified Positive Approach™ to Care (PAC) trainers.

- Rowan Lea ward for older people at Cross Lane Hospital in Scarborough has received AIMS accreditation from the Royal College of Psychiatrists. AIMS standards cover five areas including general standards, timely and purposeful admission, patient safety, the environment and facilities and the therapies and activities available. All the standards are developed to support services to improve the quality of care for people using them and to demonstrate that they meet national requirements. Rowan Lea ward was particularly commended for the appealing ward environment, layout, well equipped facilities and beautiful outdoor space.

- The Crisis team in North Durham has been accredited as providing good practice and quality care by the Royal College of Psychiatrists Home Treatment Accreditation Scheme (HTAS). The team was praised for its newly adopted written structure for recording sessions, which was described as 'commendable in ensuring every contact is recorded thoroughly'. The 'cohesiveness' of the team and staff 'proactively engaging' with the accreditation process were also commended.

- Scarborough child and adolescent mental health service (CAMHS), Lake House, Scarborough have been recognised for involving their service users in the work that they do. Following a visit by a specialist assessor, the service, received an Investing in Children Membership Award.

- The Trust was approved as one of two pilots nationally to manage the budget for Tier 4 inpatient services for Children and Young People commencing in shadow form in October 2016(currently managed by NHSE)

3.2.4 In conclusion it can be seen for this strategic goal that the slight deterioration in the KPIs and Business Plan are balanced out by the significant qualitative intelligence, in terms of how services are improving, therefore the overall position is positive.

However, further work is required around waiting times, patient experience and recovery focused action plans.

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 6 indicators rated red out of 8 as at quarter 2, with 1 of these indicators showing an improvement on the quarter 1 position.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17									
	Indicator	Q2 Target 2016/17	Q1 2016/17	Quarter 2 Actual 2016/17	Change on previous quarter/year	YTD Target 2016/17	FYTD 16/17 Actual	Annual Target 2016/17	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	17	19	⇩	0	19	0	0
8	Number of action points on action plans for complaints and clinical audit that are outstanding for **more than 31 days**	0	11	15	⇩	0	15	0	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?"	>86.01%	85.96%	86.14%	⇧	>86.01%	86.05%	>15/16 out-turn= 86.01% tbc	> previous year out-turn
10	Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication	50%	37.50%	20.00%	⇩	50.00%	27.78%	50.00%	>=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	n/a	n/a	n/a	>2015/16 (79%) and in top 20%ile of MH/LD trusts tbc	> 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%	81.04%	80.37%	⇩	>82.58%	80.71%	>15/16 out-turn= 82.58% tbc	> 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	50.00%	⇩	80%	50.00%	80%	80%
14	Hospitality Assured Accreditation score*	82.00%	Assessment due in Q2	81.10%	⇧	82.00%	81.10%	82.00%	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 2 is 19 against a target of zero, which is a deterioration on the quarter 1 position. All relate to Level 5 SI's.

  The Patient Safety Team are continuing to implement the new enhanced monitoring system, which was introduced to improve the availability and quality of evidence to demonstrate actions have been completed. However, due to some staffing changes at locality management level several actions are being reallocated

to heads of service to progress as a priority. At the time of writing this report 8 actions have since been completed resulting in 11 remaining as outstanding.

- **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 2 is 15 against a target of zero, which is a deterioration on the quarter 1 position. All relate to Clinical Audit.

  The 15 outstanding action points of more than 31 days at the end of quarter 2 are from 10 audits; 3 actions were past the target date by 122 days, 5 actions were passed by 92 days, 6 actions were passed by 61 days and 1 action was passed by 51 days.

  The leads/specialties are aware of these outstanding actions and are working to achieve implementation. Action plans are routinely monitored by the Clinical Audit Department and the Specialty Clinical Subgroups where outstanding actions are reviewed and support is provided to facilitate completion. Outstanding actions are also discussed with the Service Development Managers and any actions over 90 days are escalated to the Quality Assurance Committee. All outstanding action points are escalated to the Clinical Effectiveness Group but it must be noted that responsibility for completion of the actions lies with the clinical services.

  At the time of writing this report 3 actions have since been completed and 2 have had an extension to the original deadline agreed.

- **KPI 10 - Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication** – the Trust position for quarter 2 is 20% against a target of 50%, which is a deterioration on the quarter 1 position.

  There were 10 baseline assessment tools signed off by CEG; however only 2 were within 6 months of publication.
  - Four were delayed due to the Trust identifying a need to implement a more robust monitoring system to assess compliance against new NICE guidance published. The delays incurred whilst developing the system had an impact on the services ability to deliver within the 6 months.
  - Two were delayed due to the need for additional further reviews being identified prior to submission to CEG for sign off.
  - Two were delayed due to a requirement to collate specialty professional comments, in all localities by each Service Development Manager, individually.

- **KPI 12 - FFT – Staff Friends and Family scores – 'How likely are you to recommend this organisation to friends and family if they needed care or treatment?'** – the Trust position for quarter 2 is 80.37% against a target of 82.58%, which is a slight deterioration on the quarter 1 position.

As reported last quarter reasons provided for not recommending the organisation for care or treatment include; inconsistent quality of care across localities, inadequate staffing, high caseloads, inadequate facilities and low staff morale.

Other Points to note –

- **KPI 14 – Hospitality Assured Accreditation Score** – The Hospitality Assured Accreditation Assessment was planned for quarter 4 2015/16 with a target of 82% but this was delayed due to additional work required in York and Selby locality. The assessment was therefore completed during quarter 1 and the results became available in quarter 2. The associated target of 82% has therefore been applied in quarter 2.

3.3.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 2 were rated green (90%) which is a slight improvement on quarter 1 (89%). There are 10% of the priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

The 10% represents 1 priority/service development. This is the review and refresh of the Quality Strategy which is still in development and which will come to the Trust Board for approval in due course.

3.3.3 Other Qualitative Intelligence

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

- The TEWV Quality Improvement System (QIS) has been shortlisted in the provider trust of the year category of the HSJ Awards 2016.

- The Trust has been shortlisted for **Breakthrough positive practice awards** for its Model Lines work.

- The Trust's research and development team, Flatts Lane Centre, Middlesbrough, has been named the Clinical Research Network North East and North Cumbria's (CRN NENC) clinical research team of the month for August (CRN NENC is part of the National Institute for Health Research, NIHR). The award recognises the team's flexible working across departments and other Trusts. The team is quite unique in that, not only does it work across different specialities with TEWV, it also supports research studies at other Trusts. The team works in collaboration with the Trust's clinical teams to offer high quality research studies to our service users and their work supports service users and clinicians to take part in research studies, which contributes to future evidence based care.

- The Trust has won two awards from Ripon Civic Society. The awards cover new buildings, restored buildings, environmental improvement and craftsmanship. The Trust received awards for the Orchards in two categories; best new building and best environmental scheme.

3.3.4 In conclusion it can be seen for this strategic goal that taking into account the Business Plan and qualitative intelligence, the position remains positive. However further work is needed in terms of progress against the quantitative KPI's, as all reported, with the exception of 'How likely are you to recommend our ward/service to friends and family if they needed similar care or treatment?', require further improvement.

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 5 indicators rated red out of 12 as at quarter 2, with 4 of these indicators reporting an improvement on the quarter 1 position.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17									
	Indicator	Q2 Target 2016/17	Q1 2016/17	Quarter 2 Actual 2016/17	Change on previous quarter/year	YTD Target 2016/17	FYTD 16/17 Actual	Annual Target 2016/17	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%	**70.68%**	**68.15%**	⇩	>70.95%	**69.44%**	>15/16 out-turn= 70.95% tbc	> previous year out-turn
16	Percentage of medical students and junior doctors reporting satisfaction with their placement	88.00%	**95.24%**	**88.89%**	⇩	88.00%	**88.89%**	88.00%	90.00%
17	Percentage of positive nursing placement evaluations received	95.00%	**95.59%**	**96.52%**	⇧	95.00%	**95.78%**	95.00%	95.00%
18	Excess cost of employing medical agency versus substantive	£75,000	**£228,963**	**£163,162**	⇧	£150,000	**£228,963**	**£300k**	zero
19	NHS Employers Assessment of Wellbeing	100%	**100.00%**	**100.00%**	⇔	100%	**100.00%**	100%	100%
20	Percentage of Culture Metrics showing improvement at year end*	100%	due in Q2	**66.67%**	⇧	100%	**66.67%**	100%	100%
21	Percentage of positive staff responses for training/development evaluations received	75.00%	**72.21%**	**74.47%**	⇧	75.00%	**73.15%**	75%	TBC
22	Quality of Appraisals	n/a	Results due in Q4	Results due in Q4	n/a	n/a	n/a	>15/16 out-turn= 3.36	>= 2018/19 & in top 20%
23	Percentage of medical staff successfully revalidated	100%	**100.00%**	**100.00%**	⇔	100%	**100.00%**	100%	100%
24	The variation in percentage responses to the questions in NHS Staff Survey of those who identified themselves as disabled compared to those who did not identified themselves as disabled*	1.0 or 20% difference	Results due in Q4	Results due in Q4	n/a	n/a	n/a	1.0 or 20% difference	TBC
25	Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above	50%	**8.70%**	**18.18%**	⇧	50.00%	**13.33%**	50.00%	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	n/a	n/a	n/a	<2015/16 outturn (28%) & top 20%	< previous year out-turn

Indicators of concern are:

- **KPI 18 - Excess cost of employing medical agency versus substantive** - the Trust position for quarter 2 is £163,162, which is £88,162 worse than the target of £75,000 but is an improvement on the quarter 1 position partially due to anticipated savings following the implementation of a managed agency provision from Retinue.

    - There were 15 vacancies covered by agency as at the end of quarter 2 as detailed below:
        - Durham – Adults (3) and MHSOP (1)
        - Teesside - Adults (3)
        - North Yorkshire – Adults (1) and MHSOP (1)
        - Forensic Services – FMH (1)
        - York and Selby – AMH (1), MHSOP (3), CAMHS (1)

    - A further 2 agency staff were used in North Yorkshire to cover sickness (1 AMH and 1 CAMHS) whilst 1 more agency staff was used in North Yorkshire to support mind the gap (1 MHSOP).

- **KPI 20 – Percentage of Culture Metrics showing an improvement at year end** – The Trust position for quarter 2 is 66.67% which reflects 4 out of 6 of the Culture metrics showing an improvement on the previous assessment in October 2015.

  The metrics showing a reduction at March 2016 are:

    - **Overall Staff Experience** – from 78.6% to 77.0% (based on the national staff survey results 2015)
    - **Wellbeing Value** – from 71.1% to 67% (based on 9 information sources)

- **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 2 is 18.18% against a target of 50% which is an improvement on the quarter 1 position.

  This relates to 4 advertised posts with at least 2 internal candidates out of 22 advertised posts. The rate of internal appointments versus external appointments is still high; 86.9% in the last quarter. There appears to be no increase to the number of posts not being recruited to; however, this trend should be seen as an early warning for these supply risks materialising in the future. Talent management is in a transitional phase where new approaches to accelerated development of internal staff or increased focus on supply of external staff have not been implemented fully implemented. To address this the Talent Management Board will be presented with a draft action plan in November, which has been produced well ahead of it's anticipated deadline of March 2017. In addition, actions are ongoing to increase the focus on exit interviews to ascertain why staff are leaving the organisation and a Kaizen event has been scheduled for February 2017 to review the role and function of Talent Management.

The continued implementation of Talent Management within the Trust will support the delivery of this indicator.

3.4.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 2 were rated green (82%) which is a slight deterioration on quarter 1 (89%). There were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

3.4.3 Other Qualitative Intelligence

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

- The Trust has been shortlisted for **Breakthrough positive practice awards** for Staff Mindfulness EMT Feedback 20th July

- Staff and teams from the Trust are represented in the shortlist for this year's **Royal College of Psychiatrists awards**. A consultant psychiatrist at Bootham Park Hospital, York, the Discharge Liaison team, York and Selby, the North Tees liaison psychiatry team, the University Hospital of North Tees, Stockton-on-Tees and the experts by experience group, are all included.

- The medical development team, Roseberry Park, Middlesbrough, have been praised for their results in the recently published General Medical Council (GMC) survey. The junior doctors surveyed by the GMC rated the Trust as the best in the North East and one of the best in the country for post graduate training.

3.4.4 In conclusion it can be seen for this strategic goal that taking into account progress against the quantitative KPIs, the Business Plan and qualitative intelligence, the overall position is mixed. However, Trust will continue to benefit from an increased focus on talent management.

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 1 indicator rated red out of 6 as at quarter 2.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17									
	Indicator	Q2 Target 2016/17	Q1 2016/17	Quarter 2 Actual 2016/17	Change on previous quarter/year	YTD Target 2016/17	FYTD 16/17 Actual	Annual Target 2016/17	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%	77.78%	81.82%	⇧	90%	80.00%	90%	90%
28	Attendance rate at Statutory Safeguarding Boards & MAPPA Strategic Management Boards	98%	100.00%	100.00%	⇔	98%	100.00%	98%	98%
29	Proportion of student nursing placements provided as a % of placements requested	90%	100.00%	100.00%	⇔	90.00%	100.00%	90.00%	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	34	399	⇧	n/a	433	453	10% increase year on year
31	R&D Outcomes - Annual external R&D income (including external grants and commercial income)	n/a	£139,955	£161,696	⇧	n/a	£301,651	£678,014	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	Signed & Green	n/a	n/a	n/a	n/a	Signed & Green	Signed & Green

- **KPI 27 – Attendance rate at H&WB -** The Trust position for quarter 2 is 81.82%, which is 8.28% below the target of 90% but an improvement on quarter 1 position.

  There were 2 occasions in the quarter when there was no representative from TEWV at H&WBB. On both of these occasions, the Member had to attend other meetings and the named Deputy was on annual leave. It should be noted that only the Member or Named Deputy can attend the meetings, no other representative can be sent.

Other Points to note –

- **KPI 32 – Corporate Governance Statement** - Following the introduction of the Single Oversight Framework, the Trust is no longer required to submit a Corporate Governance Statement. Board approval is sought to remove this indicator from the report pending notification of any further requirements from NHS Improvement.

3.5.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 2 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:

- The TEWV External KPO team have won the **NECS partners award**, having been nominated by a member of the NECS continuous improvement team. The team have been providing extensive training and support on the QIS methodology. This was against a high calibre of nominees, including Nissan and the London School of Economics.

- The Quality Account Stakeholder workshop was held including, governors, local authority members/officers, commissioners and NHS England. The participants gave positive feedback on the openness and honesty of the Trust, and valued the opportunity to meet the leads of the quality improvement priorities in the "market stalls" at the event. In addition they provided suggested priorities for the Quality Account and Business Plan of which, the Board agreed 5, will be fed back to stakeholders in February 2017.

- Mental health professionals from Teesside have worked with researchers from ITV's Emmerdale programme to support a mental health storyline about someone experiencing psychosis. The storyline is a huge opportunity for children's mental health to be covered on primetime television and the advice provided by the team was crucial in this.

- In the National Student Survey, student satisfaction rates, for nursing course at Tees University have been rated top in the country. As a Trust we offer the clinical placements to go alongside the academic studies at the university. This result will hopefully attract good candidates and encourage people to study at Teesside for the nursing degree and therefore may mean that we can recruit more people locally.

- A Cleveland Police officer and colleagues from the Trust's Street Triage Team have been praised for coming to the aid of a vulnerable man who was in distress. By working together and demonstrating professionalism in a challenging situation they were able to bring the incident to a safe conclusion.

- **Leading the way in a new GP pilot** - A one-year pilot, believed to be the first of its kind, is offering patients access to a GP psychologist in their local surgery. A consultant clinical psychologist, is working at Harewood Medical Centre, Catterick as a GP with a remit of mental health rather than physical health. Patients can self-refer, or be referred by their GP, to the post for a wide-range of mental health concerns for assessment, psycho-education, brief intervention, signposting and onward referral where necessary. A, GP from Harewood Medical Centre, said:

"The pilot offers patients direct access to a mental health professional at their surgery. It also sees colleagues benefit from expertise to develop their own working knowledge of mental health to support their patients."

- The mindfulness service, West Park Hospital, Darlington, have been commissioned by Stockton Borough Council to provide mindfulness courses for their staff over a three year period. The service has also recently become a nationally recognised training centre for mindfulness based cognitive therapy (MBCT) therapists.

- The Trust has worked with researchers from Exeter, York and Kings College London Universities on the COBRA (Cost Effectiveness of Behavioural Activation) study, to assess psychological treatments of depression. Funded by the National Institute for Health Research (NIHR) Health Technology Assessment Programme, the study investigated the cost effectiveness of Behavioural Activation (BA) treatment, delivered by non-specialist mental health workers, compared to Cognitive Behavioural Therapy (CBT). CBT can be as effective as antidepressants, it has less risk of side effects and reduces relapse, but is expensive because it needs to be delivered by highly trained psychological therapists. The study found that BA is just as effective as CBT, meaning a workforce could be trained more easily and cheaply. This would improve access to high-quality depression therapy and reduce waiting times.

- 2 members of the mental health team at HMP Low Newton have been recognised by North East Prison After Care Society (NEPACS) for their good work for a particularly challenging incident with someone on prison grounds who had recently left the prison and was very difficult to engage. They received an award for their efforts in September. This work was also recognised by the Prison and in particular the Governor.

3.5.4 In conclusion it can be seen for this strategic goal that taking into account progress against the quantitative KPIs and Business Plan the overall position remains positive

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 2, which is a deterioration on the quarter 1 position.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17									
	Indicator	Q2 Target 2016/17	Q1 2016/17	Quarter 2 Actual 2016/17	Change on previous quarter/year	YTD Target 2016/17	FYTD 16/17 Actual	Annual Target 2016/17	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%	⇔	37.50%	71.43%	<37.50% tbc	<=6.25%
34	Percentage of Information Strategy metrics on target that are reported on Information Strategy Metrics Scorecard	75%	87.50%	75.00%	⇩	75.00%	75.00%	75%	TBC
35	Percentage change in income for Trust contracted services compared to previous year	1.10%	6.72%	6.83%	⇧	1.10%	6.83%	1.10%	Better than deflator
36	Reference Cost Index score for in-scope PbR Services	<=95	Due in Q2	97	⇩	<=95	97	<=95 TBC	TBC
37	Reference Cost Index score for out of scope PbR Services	<=95	Due in Q2	86	⇧	<=95	86	<=95 TBC	TBC
38	EBITDA **	7.16%	8.57%	8.69%	⇧	7.48%	8.69%	6.33%	8.00%
39	Good Corporate Citizenship audit scores*	65.00%	Due in Q4	Due in Q4	n/a	n/a	n/a	65.00%	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 2 is 71.43% which is above the target of 37.50% and is consistent with the quarter 1 position.

  This accounts for 10 metrics out of 14 that are reporting red; however, of these 8 have shown an improvement on quarter 1. Those showing a slight deterioration are the patients recorded on PARIS for which gender is missing and the percentage of records submitted through MHSDS with a valid ethnicity code. There is a data quality action plan which is underway led by the Information Department with the clinical services to address the data quality issues. This is monitored at Trust Data Quality Group and at Trust Performance Improvement Group on a monthly basis.

- **KPI 36 Reference Cost Index Score for in-scope PbR services** – the Trust position is 97 against a target of less than 95. It should be noted that this is the provisional figure derived from the verification process following the Department of Health submission. The final figure will be published in December 2016.

3.6.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 2 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.

3.6.3 Other Qualitative Intelligence

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

- New investment into Tees Crisis Services has been secured following funding awarded from central government for an urgent care base across the 4 Tees Local Authority areas. This will increase capacity and ensure vulnerable people are provided with appropriate support.

- Durham & Darlington Children & Young Peoples services have received £307k non-recurring monies from the Urgent and Emergency Care Vanguard, to provide an Intensive Home Treatment service. An implementation plan is currently being developed with the aim of the service commencing informally immediately and to be fully up and running by 1st January 2017. NHS England recently visited the Tees and D&D crisis service and was extremely impressed with the work of both teams.

3.6.4 In conclusion it can be seen for this strategic goal that taking into account progress against the quantitative KPIs, 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’. This will be reported on in quarter 4.

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 second Strategic Direction Performance Report for 2016/17 and reports progress against the Strategic Direction Scorecard and the Trust Business Plan whilst also considering other forms of qualitative intelligence.

This report reflects that three of the Trusts five goals remain in a positive position, whilst still acknowledging that there is work to do to improve some KPI's. For Goals 1 and 2 the positon is more mixed, with slight deteriorations in KPI's and business plan delivery, however, there is significant qualitative intelligence, in terms of how services are improving.

Overall the scorecard position has deteriorated slightly against the percentages reported in both quarter 1 2016/17 and quarter 2 2015/16 (54%). However, the number of indicators that can be RAG rated is greater in both cases and the actual number of those rated green has increased since quarter 1. In addition there are some business plan actions that need to be re-profiled in the light of changing circumstances

7. RECOMMENDATIONS:

The Board is asked to:

- Approve the changes to the Trust Business Plan detailed in Appendix 1.
- Approve the suggested amendments for key performance indicator targets referenced in section 3.2.1 (KPI 3) and 3.4.1 (KPI's 21, 22 and 24) and 3.6.1 (KPI 33 and 34).

Sharon Pickering
Director of Planning Performance and Communications

Background Papers:

Appendix 1

Requests for Changes to Business Plan

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
1.6	Deliver agreed service developments – **EIP Access Targets (D&D)**	D&D	AMH	To work with other localities to develop a workforce plan to meet NICE therapy guidance	Workforce plan developed	16/17 Q2	Jo Dawson		As EIP developments are being led / co-ordinated on a trust-wide basis **Trust Board are requested to remove the D&D specific EIP actions from the Trust Business Plan**
1.6	Deliver agreed service developments - **Implement a consistent Non Medical Prescribing model**	D&D	AMH	Commence a training plan to deliver the model of practice and delivery	Training plan commenced (linked to University course)	16/17 Q2	Mike Leonard		A workshop was held to start to develop the strategic requirements for NMP across the directorate, however in light of changes linked to PPCS this needs revisiting as part of forthcoming annual plan to ensure number and location of NMPs and their function is still up to date and adds value to the teams where need is identified . In respect of the training plan the HoS does not authorise any NMP training until the above work is completed, this follows work within the service led by the ACD to work with the university who provide the NMP training to improve the MH element of this, unfortunately this has not led to improvements and the service has agreed with the Medical Director that it should explore whether it can provide the training course itself, to ensure that MH component is integral within it. The ACD is developing a PM1 to progress this. **The Board of Directors are requested to delete this as a specific priority because the issues will be picked up as part of Business as Usual and through the PPCS, Model Ward , Safe Staffing and Universities priorities within the 17/18 Business Plan**.

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
1.6	Deliver agreed service developments - **Inpatient Reconfiguration**	Tees	MHSOP	Review the impact of Trust wide work to establish inpatient models	Impacts and implications identified	16/17 Q2	Shaun Mayo		This action cannot be undertaken until the Trustwide review is completed. **Therefore Trust Board is requested to approve the removal of this action from the Trust Business Plan.**
1.6	Deliver agreed service developments - **Triangle of Care**	N&G	NA	Implement ToC in inpatient areas and crisis teams	Carer Link workers in place in all teams	16/17 Q4	Elizabeth Moody		The Trust Steering group agreed that the decision to re-join the Triangle of Care (ToC) membership scheme be delayed to allow for some preparation work to take place with the final decision regarding re-joining the scheme to take place at the October 2016 meeting. A PM2a change request form will be submitted to EMT in October to reflect this delay in timescales. This action will not be delivered until 1 year after the ToC membership commences. **Therefore Trust Board is requested to approve deferment of achievement of this action / metric to 17/18 Q3**

ITEM NO. 18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**22 November 2016**
TITLE:	**Policies and Procedures 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:

2 policies that have undergone full review and require ratification:

- CLIN-0012-v7 Admissions, transfers and discharge framework
- PHARM-0001-v8 NMP policy to practice

2 policies that have undergone minor amendment:

- CLIN-0080-v1.1 Young people admitted to adult inpatient wards policy
- HR-0012-v7.4 Staff development policy

6 strategies, plans and policies requiring an extension to the review date:

- HR-0034-v3 Job evaluation policy
- STRAT/0016 Leadership and management development plan
- STRAT/0019 E-learning plan
- STRAT/0020 Health and wellbeing plan
- STRAT/0027 Volunteering strategy
- CLIN/0020 Policy for the verification of health care employees

Recommendations:

The Board are asked to ratify the decisions made by EMT on 02 November 2016

DATE:	**22 November 2016**
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 and procedures.

2.3 Each policy and procedure 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 The following have undergone full review and require ratification:

CLIN-0012-v7 Admissions, transfers and discharge framework
Review date: 02 November 2019

This policy underwent full review and changes were made throughout:

- Section 3.1 Guidance added regarding planned admissions.
- Section 3.1.4 Pre admission time frame for none urgent cases corrected to 28 days.
- Sections 3.1, 3.3, 3.4 and 7.1.2 Requirement for easy read information to be given to those who require it identified.
- Section 3. Care Coordinator to advise GP practice of admission as soon as practicable and ward staff to take on this responsibility if no Care Coordinator allocated

- Section 6. Need for all Community Care Coordinators and Lead Professionals to be made aware of transfers to other hospital services identified.
- Section 7.1.1 Need for consideration of service users' medication information needs on discharge identified.
- Section 7.1.1 Principle added regarding ensuring safe transfer of care by providing comprehensive information to community services, including GPs.

PHARM-0001-v8 NMP policy to practice
Review date: 02 November 2019

The policy to practise has merged two policies: the NMP Overarching Policy and the Policy to Practise. The overarching policy was outdated and there was repetition in the content so the two documents have been brought together to streamline.

3.2 The following underwent minor amendment:

CLIN-0080-v1.1 Young people admitted to adult inpatient wards policy
Review date: 04 December 2016

Section 5.2 page 6 was amended to include York and Selby.

HR-0012-v7.4 Staff development policy
Review date: 07 May 2017

Page 16 has been amended to reflect that the Appraiser must now enter the appraisal date on ESR through manager self-service within 24 hours. Previously a time frame for data entry was not specified.

3.3 The following require an extension to the review date:

HR-0034-v3 Job evaluation policy
Review date: 31 December 2016

The policy has been extended until after the completion of a Kaizen event which will review the process of job evaluation.

The following HR documents also require extending to allow work to be completed:

STRAT/0016 Leadership and management development plan
STRAT/0019 E-learning plan
STRAT/0020 Health and wellbeing plan
STRAT/0027 Volunteering strategy
CLIN-0020 Policy for the verification of health care employees
CLIN-0051 Care and management of dual diagnosis
CLIN-0033 Transfer of inpatients to acute hospital
Review date: 31 March 2017

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 meetings on 03 August 2016 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

AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 29TH NOVEMBER 2016 VENUE: THE BOARD ROOM, 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 meetings of the Board of Directors held on **6th October** and **25th October 2016**.		**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 receive a briefing on key issues in the North Yorkshire Locality.	**Liz Herring, Acting Director of Operations, & Dr. Neil Mayfield, Deputy Medical Director, to attend**	**Presentation**
Item 7	To receive and note the Annual Report on Research and Development.	**NL**	**Attached**
Item 8	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 9	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 10	To receive and note an update report on nurse recruitment, development and retention.	**DL**	**Attached**
Item 11	To consider the report of the Mental Health Legislation Committee.	**RS/EM**	**Attached**
Item 12	To receive and note a progress report on the Composite Staff Action Plan.	**DL**	**Attached**

Item 13	To consider proposals on refreshing the approach to embedding the Trust's values.	**DL**	**Attached**
Item 14	To consider a report on re-accreditation under the Investors in People scheme.	**DL**	**Attached**

Performance (11.15 am)

Item 15	To consider the Finance Report as at 31st October 2016 including the Board self-certification on agency spending required by NHS Improvement.	**DK**	**Attached**
Item 16	To consider the Trust Performance Dashboard as at 31st October 2016.	**SP**	**Attached**
Item 17	To consider the Strategic Direction Performance Report for Quarter 2, 2016/17.	**SP**	**Attached**

Items for Information (11.35 am)

Item 18	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 19 To note that a special meeting of the Board of Directors will be held, in conjunction with a seminar, on Tuesday **20th December 2016** in the Board Room, West Park Hospital, Darlington at 9.30 am.

Confidential Motion (11.40 am)

Item 20 **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 any particular applicant for, or recipient or former recipient of, any financial assistance 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."

The meeting will adjourn for a refreshment break

Lesley J Bessant.

Mrs. Lesley Bessant
Chairman
23rd November 2016

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