AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 3RD JULY 2018
VENUE: THE DIRECTORS' LOUNGE, MIDDLESBROUGH FOOTBALL CLUB, RIVERSIDE STADIUM, MIDDLESBROUGH, TS3 6RS
AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the last meeting held on **22nd May 2018.**		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To receive a briefing on key issues in the Tees Locality.	**Dominic Gardner to attend**	**Presentation**
Item 7	To consider the report of the Quality Assurance Committee.	**HG/JI**	**Attached**
Item 8	To consider the monthly Nurse Staffing Report.	**JI**	**Attached**
Item 9	To receive and note a progress report on the Recruitment and Retention Action Plan.	**DL**	**Attached**
Item 10	To receive and note a report on learning from deaths.	**JI**	**Attached**
Item 11	To receive and note the Annual Report on Patient Safety.	**JI**	**Attached**

Performance (11.05 am)

Item 12	To consider the Finance Report as at 31st May 2018.	**PM**	**Attached**
Item 13	To consider the Trust Performance Dashboard as at 31st May 2018.	**SP**	**Attached**

Governance (11.20 am)

Item 14	On the recommendation of the Resources Committee to approve the Data Quality Strategy.	**PM**	**Attached**

Items for Information (11.30 am)

Item 15	To receive and note a report on the use of the Trust's seal.	**BK**	**Attached**
Item 16	Policies and Procedures ratified by the Executive Management Team.	**BK**	**Attached**

Item 17 To note that the next meeting of the Board of Directors will be held on Thursday 19th July 2018 in the Board Room, West Park Hospital, Darlington at 9.30 am.

Confidential Motion (11.35 am)

Item 18 **The Chairman to move:**

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

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

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

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

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
27th June 2018

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 22ND MAY 2018 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 AM

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

In Attendance:
Ms. H. Griffiths, Public Governor for Harrogate and Wetherby
Mr. P. Bellas, Trust Secretary
Prof. J. Reilly, Clinical Director for Research and Development (minute 18/144 refers).
Mrs. S. Paxton, Communications Manager

18/138 APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr. H. Griffiths, Deputy Chairman.

18/139 MINUTES

Agreed *– that the minutes of the special meeting held on 10th April 2018 and the last ordinary meeting held on 24th April 2018 be approved as correct records and signed by the Chairman.*

18/140 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

18/141 DECLARATIONS OF INTEREST

Mr. Kilmurray and Mr. Bellas declared non-pecuniary interests, as Directors of TEWV Estates and Facilities Management Ltd, in the matters considered under minute 18/C/164.

18/142 CHAIRMAN'S REPORT

The Chairman:

(1) Drew attention to her report to the meeting of the Council of Governors held on 16th May 2018.

(2) Reported on her discussions with the Experts by Experience at a recent meeting.

It was noted that the key issue arising from the meeting was that the Experts by Experience felt that the Trust was not responding appropriately to their activities as they did not seem to be making a discernible impact.

In response to this feedback the Chairman considered that the Board needed to discuss how the recovery programme should be given greater impetus.

18/143 GOVERNOR ISSUES

No issues were raised.

18/144 ANNUAL REPORT ON RESEARCH AND DEVELOPMENT

The Board received and noted the Annual Report on Research and Development.

An assurance report on the controls covering commercial research studies, prepared in accordance with minute 17/295 (28/11/17), was provided as Appendix 1 to the above report.

Prof. Reilly also informed the Board that David Ekers (Nurse Consultant) had been confirmed as an Honorary Visiting Professor at York University.

The Board congratulated Prof. Ekers on his appointment.

Arising from the report:

(1) Board Members, whilst recognising there was a lot to celebrate in the report, sought assurance that action had been taken in relation to ethical standards following concerns raised by an international journal about an article submission which included work conducted in the Trust.

In response Prof. Reilly provided background information on the incident where a research integrity investigation, undertaken in March 2018 and reported to the Quality Assurance Committee, had found that the research had been conducted using clinical data without the consent of service users and without either independent ethical approval or research governance approval within the Trust.

He advised that, whilst not being able to provide full assurance that a similar incident could not happen in the future, controls had been strengthened through:

(a) The circulation of an SBARD to inform staff that all research required approval and to encourage them to contact the Research and Development Department if they had any concerns or questions about ethics.

It was noted that there had been a significant increase in staff contacting the Department following its publication which confirmed that the action had been appropriate.

(b) The logging of all calls to, and advice provided by, the Research and Development Department.

(c) The introduction of briefings on research governance during inductions for trainee psychiatrists.

The Board noted that, although the doctor who had undertaken the research was now overseas, the GMC had been contacted and the Trust's concerns would remain on file.

(2) Mrs. Moody sought further discussions, outside the meeting, on the findings of the transitions study as the CQUIN target relating to this matter had had a limited impact and sharing and spreading best practice remained a challenge.

Prof. Reilly welcomed these discussions as he had personally led the research project.

(3) It was suggested that, in future, the objectives of the Research and Development Strategy should be used as the framework for the annual reports.

Prof. Reilly took this on board.

Action: Prof. Reilly

(4) Board Members highlighted the need for the Trust to maintain a balance between research and clinical delivery in view of the increase in the former activities.

(5) Clarity was sought on the number of participants needed for studies as there were examples in the report where only two had been required to meet the agreed recruitment target.

Prof. Reilly advised that:

(a) The number of participants varied between studies.

(b) The cases cited, with low recruitment targets, were global studies across a number of sites.

(c) Recruiting participants to meet the requirements of studies was challenging but the ability to do so provided organisations with an advantage in attracting commercial studies.

(6) In relation to the controls governing commercial research, clarity was also sought on who would assess the feasibility and clinical appropriateness of a study where the person proposing it was also the SDG research lead.

Prof. Reilly outlined the approach to the approval of studies but recognised that there was the need for an additional step in the process in the circumstances described.

In response to a question, it was also noted that the Trust did not publish a register, similar to that for conflicts of interests, for staff involved in research studies.

(7) Dr. Khouja reported that he and Prof. Reilly were discussing how the Trust could utilise the University of York's expertise in health economics.

At the conclusion of the discussions the Board thanked Prof. Reilly for his report and congratulated him and the staff of the Research and Development Department for their achievements over the last year.

18/145 REPORT OF THE QUALITY ASSURANCE COMMITTEE

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

(1) The confirmed minutes of the meeting held on 5th April 2018 (Annex 1 to the report).

(2) The key issues considered by the Committee at its meeting held on 3rd May 2018.

The Board's attention was drawn to:

(1) The report on the clinical audit of CPA principles.

Mrs. Moody advised that:

(a) The clinical audit had examined the extent that recovery was embedded in CPA processes and had been co-designed with the Experts by Experience.

(b) The findings of the audit, including the need to improve record keeping, were as expected.

(c) Action was being taken to make improvements including linking the CPA principles to the Trust's overarching priorities.

(2) The presentation provided to the Committee on "Positive and Safe" which focused on reducing the use of restrictive interventions.

It was noted that:

(a) Overall the use of prone restraint by some specialities had reduced significantly but there were still some "hot spots".

(b) The Committee had discussed the use of rapid tranquilisation in CAMHS and had received assurance that a "deep dive" review would be undertaken on this matter with the outcome reported to it in due course.

18/146 "HARD TRUTHS" MONTHLY NURSE STAFFING EXCEPTION REPORT

The Board received and noted the exception report on nurse staffing for April 2018 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 Board's discussions focussed on the following matters:

(1) The competency of agency staff.

With regard to serious incident ref. 2018-3650, referenced in the report, the Non-Executive Directors sought clarity on the assurances provided to ward managers that agency workers were fully qualified and had the required competencies to work in the Trust.

Mr. Levy advised that:

(a) The Trust had engaged a neutral vendor to provide assurance that agency staff met minimum standards and to remove the need for ward managers to satisfy themselves.
(b) There had been some cases, including that highlighted by the serious incident, where concerns about the competency of agency staff had been raised and investigated.
(c) A range of responses were available where agency staff failed to meet minimum standards, for example, education could be provided in response to concerns about compliance with policy.
(d) In response to risks that agency staff, lacking required competencies, could work for other Trusts and vice versa, the neutral vendor had been requested not to allocate workers to the Trust if concerns about them had been raised elsewhere.

The Board also noted that the Directors' Panel, which had reviewed the above serious incident, had recognised that the nurse had not practised to the expected level and this had been fed back to the neutral provider. This finding had led to questions about whether agency staff, due to their working arrangements, had the knowledge and experience to act appropriately in a range of circumstances and to the level of expertise required of staff by the Trust.

Board Members recognised that the lack of fully developed staff banks for the North Yorkshire and York and Selby Localities contributed to agency staff usage. Clarity was, therefore, sought on what further actions could be taken to address this.

Mrs. Moody advised that:

(a) The Temporary Staffing Service continued to explore the development of the staff banks in the Localities.
(b) A number of other options were also being examined, for example, the Trust was engaging with acute providers on the potential development of a regional staff bank.
(c) Notwithstanding these initiatives, the Trust wanted to recruit sufficient staff and work was being undertaken with the Universities, e.g. in Scarborough, to achieve this.

Mr. Levy considered that the Trust needed a new approach to temporary staffing and, to facilitate this, to understand the growth in demand as the Trust employed more nurses than ever before.

Mr. Martin supported this view of needing a fresh approach to the supply and deployment of staff highlighting that 78% of expenditure on agency staff was for healthcare assistants.

(2) Care Hours per Patient Day (CHPPD)

The Board noted the Trust's first submission of data for this metric to NHS Improvement as presented in Appendix 6 to the report.

In relation to this matter, Mr. Martin:

(a) Sought clarity on whether patients on leave were included in the information as, if they were, they could skew the data.

Mrs. Moody advised that the patients counted were those occupying a bed at midnight, each day, but undertook to check whether those on leave had been included.

Action: Mrs. Moody

(b) Agreed with the view, expressed in the report, that the data should be grouped by type of ward but also recognised, further to this, that there was a need to understand the level of performance to which the Trust aspired.

It was noted that NHS Improvement would be undertaking benchmarking of the data which would inform the Trust's position.

The Non-Executive Directors also:

(a) Questioned the use of the data.

Mrs. Moody highlighted the adult wards in the County Durham and Darlington Locality which, at present, scored relatively low on the metric but would be expected to increase in response to the additional investment provided in response to the establishment review (minute 18/73 – 27/3/18 refers).

(b) Sought clarity on whether performance against the metric could be tracked over time.

Mrs. Moody undertook to consider how this could be best achieved.

Action: Mrs. Moody

(c) Highlighted that Occupational Therapists (OTs), who spent significant time with patients and provided a valuable resource, were not included in the data.

Mrs. Moody explained that the CHPPD provided by OTs could be captured if they were included in the rosters; however, most of these staff worked across wards.

It was also noted that NHS Improvement was keen for the CHPPD metric to be based on multi-professional working. The regulator had previously sought data on the contribution of OTs and was undertaking further work in this area.

In addition:

(1) The Chairman highlighted Cedar Ward in North Yorkshire as an outlier due to its high agency staff usage; blue fill rate; and a level three incident and a complaint during the reporting period.

The Board noted that the ward was under continuing pressure with staff leaving and recruitment difficulties.

(2) The Non-Executive Directors asked whether changes in the data for wards could be tabulated in future reports.

Mrs. Moody responded that:

(a) The severity scores (included in Appendix 4 to the report) represented an attempt to do this.
(b) Information on how the Trust was responding to the changes, at both a Trustwide and local level, was included in the report.
(c) The six monthly reports provided further analysis of the changes experienced by wards.

18/147 COMPOSITE STAFF ACTION PLAN 2017/18

Further to minute 17/300 (28/11/17) the Board received and noted a progress report on the implementation of the Composite Staff Action Plan and locality and corporate directorate action plans (Appendix 1 to the covering report).

Whilst recognising the work undertaken, the Non-Executive Directors highlighted that, in some cases, further assurance was required on whether the actions taken had delivered their intended outcome.

Mr. Levy explained that, as previously discussed by the Board, the length of time between the surveys and the measurement of the impact of actions taken in response to their findings was too short; however, it was expected that the improvements should be reflected in the results of the 2018 staff survey.

18/148 REPORT OF THE MENTAL HEALTH LEGISLATION COMMITTEE

Consideration was given to the report of the Mental Health Legislation Committee including:

(1) The confirmed minutes of the meeting held on 26th February 2018 (Annex 1 to the report).
(2) The key issues considered by the Committee at its meeting held on 19th April 2018.
(3) A recommendation to confirm the Scheme of Delegation in respect of the Mental Health Act 1983 (appended to the report).

Mr. Simpson, the Chairman of the Committee, reported that the meeting on the 19th April 2018 was the first to be based on a new format, structured around high quality questions, which was aimed at aligning the business transacted more closely with legislation, including at an operational level, the Scheme of Delegation.

He thanked Mrs. Moody and her staff for the work undertaken on this matter.

> **Agreed** – *that the Scheme of Delegation in respect of the Mental Health Act 1983, appended to the above report, be confirmed.*

18/149 ANNUAL REPORT AND ACCOUNTS 2017/18

On the recommendation of the Audit Committee consideration was given to the approval of:

(1) The draft Annual Report, including the Quality Report/Account, and Accounts 2017/18.
(2) The Letter of Representation 2018.
(3) The Modern Slavery Act Statement (included in the draft Annual Report).

A revised version of the disclosures on the analysis of staff costs and numbers (in the Staff Report section of the Annual Report), to reflect changes to the notes to the Accounts, was tabled at the meeting.

With regard to the above matters the Board took into account:

(1) The External Auditors' Audit Completion Report (ISA 260) which incorporated an update letter, dated 17th May 2018, on the resolution of outstanding matters.

It was noted that, following the special meeting of the Audit Committee on 18th May 2018, the External Auditors had issued a further letter (tabled at the meeting and to be included in the ISA 260) in relation to an error in the Trust valuers' calculations and further uncertainty about the valuation of an asset.

Mr. McGahon provided the Board with a detailed explanation of the above matters.

Assurance was provided that the External Auditors considered that management's decision not to amend the financial statements, on the grounds of materiality and practicality, was reasonable.

(2) The External Auditors' draft report on the contents and indicators included in the Quality Report 2017/18 and their limited (scope) Assurance Opinion.

(3) The report of the Director of Finance noting that in approving the Annual Report:
  (a) Each Board Member would be confirming that, as far as they were aware, there was no relevant information of which the Trust's External Auditors were unaware.
  (b) The Board would be approving the Trust's Modern Slavery Statement.

(4) The report of the Chairman of the Audit Committee on the Committee's review of the Quality Account/Report, the Annual Report and Accounts, and related matters, and the reports of the External Auditors at its meetings held on 10th and 18th May 2018.

Mr. Jennings, the Chairman of the Audit Committee, summarised the matters it had taken into account in making its recommendations to the Board, namely:

(a) At its meeting held on 10th May 2018:
- The consideration of the counter fraud plan.
- The Internal Auditors' Progress Report.
- The receipt of the Head of Internal Audit's Annual Report and Opinion which provided "good" assurance.
- The review of the assurances supporting sign off of the annual Board Certificates (see minute 18/151 below).
- The review of the Annual Governance Statement.
- An update on the progress of the audit provided by the External Auditors.

(b) At its special meeting held on 18th May 2018, the consideration of the draft Annual Report and Accounts and the Quality Account/Report together with the External Auditors' reports relating to them.

It was noted that:
- The Committee had received a detailed response, in writing, to questions on the Accounts raised prior to the meeting.
- Amendments had been made to the draft Annual Report arising from the Committee's discussions which were reflected in the version presented to the meeting.
- The External Auditors had provided assurance on the content and format of the Quality Account/Report.
- The External Auditors, subject to the Board's approval, intended to issue an unqualified opinion on the Annual Report and Accounts.

Members of the Audit Committee advised that, at the special meeting held on 18th May 2018:

(1) The attendance of a Governor had been very helpful.
(2) It had been recognised that, to aid understanding, thought needed to be given to the presentation of the reasons for the impairment (minute 18/118 – 24/4/18 refers) at the Annual General Meeting.
(3) The need for consistency in the language used to describe the issues at Roseberry Park had also been highlighted.

Board Members questioned the statement made in the feedback provided by the Joint Durham, Darlington and Teesside CCGs to the Quality Account/Report that "… it has been disappointing to note during 2017/18 that many of the Trust's Serious Incident reports do not identify root causes or contributory factors …"

Mrs. Pickering advised that:

(1) The feedback provided by the CCGs had been drawn to the attention of the Audit Committee.

(2) The CCGs had been reminded, at a recent contract management meeting, of the opportunity for them to be involved in the Directors' Panels and that this would assist them to understand why root causes and contributory factors were not always found and to challenge the findings of investigations.

(3) The CCGs had agreed to improve their attendance at Directors' Panels and it was hoped that this would provide them with greater assurance on the Trust's processes.

Agreed –

(1) that the Annual Report 2017/18, including the Quality Report, be approved;

(2) that the Annual Accounts 2017/18 be adopted;

(3) that the Modern Slavery Act Statement be approved;

(4) that the Letter of Representation 2017/18 be approved;

(5) that the Chairman, the Chief Executive and the Director of Finance and Information be authorised to sign, as appropriate, the Annual Report, the Accounts, the Statement of Financial Position, the Annual Governance Statement, the Remuneration Report, the Statement of the Chief Executive as Accounting Officer, the Chief Executive's Statement on the Quality Report/Account, the Statement on the Responsibilities of Directors for preparing the Quality Report/Account, the Letter of Representation and any other necessary statements and certifications;

Action: Mrs. Bessant, Mr. Martin and Mr. McGahon

(6) that the Annual Report 2017/18 including the Annual Accounts and the Quality Report be submitted to NHS Improvement and Parliament; and

Action: Mr. McGahon and Mr. Bellas

(7) that the Quality Account 2017/18 be submitted to the Department of Health and Social Care.

Action: Mrs. Pickering

18/150 ANNUAL REPORT AND ACCOUNTS OF THE CHARITABLE TRUST FUNDS 2017/18

Consideration was given to the Annual Report and Accounts of the Charitable Trust Funds 2017/18 taking into account:

(1) The recommendation from the Audit Committee, arising from its meeting held on 18th May 2018, that the above documents should be approved.

(2) The summary report of the findings arising from the External Auditors' independent examination of the Annual Report and Accounts.

The Board noted the Independent Examiner's statement made for and on behalf of Mazars LLP that:

"In connection with my examination, no matter has come to my attention:

(1) which gives me reasonable cause to believe that in any material respect the requirements to keep accounting records in accordance with section

130 of the 2011 Act; and to prepare accounts which accord with the accounting records and comply with the accounting requirements of the 2011 Act have not been met; or

(2) to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached."

Agreed -

(1) that the Annual Report and Accounts for the Charitable Trust Funds 2017/18 be approved;

(2) that the Statement of Trustee Responsibilities and the Balance Sheet within the Charitable Trust Fund Accounts be signed and dated on behalf of the Board; and

Action: Mrs. Bessant and Mr. Martin

(3) that the Annual Report and Accounts of the Charitable Trust Funds 2017/18 be submitted to the Charities Commission.

Action: Mr. McGahon

18/151 ANNUAL BOARD CERTIFICATES

Consideration was given to the confirmation and sign off of the annual Board certificates required by NHS Improvement.

On the recommendation of the Audit Committee, subsequently supported by the Council of Governors at its meeting held on 16th May 2018, it was:

Agreed -

(1) that the Certificate on Systems for Compliance with Licence Conditions be confirmed in the following form:
"Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution."

(2) that the Corporate Governance Statement (as set out in Annex 1 to the above report) be approved;

(3) that the Certificate on the Training of Governors be confirmed in the following form:
"*The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in S.151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role."*

(4) that the Certificate on the Availability of Resources (as set out in Annex 2 to the above report) be approved;

(5) that the Chairman and Chief Executive be authorised to sign off the above certificates; and

Action: Mrs. Bessant and Mr. Martin

(6) that the signed Certificate on the Availability of Resources be published on the Trust's website.

Action: Mr. Bellas

(Note: The Board recorded its appreciation to the staff who had contributed to the preparation of the documents approved under minutes 18/149 to 18/151 above).

18/152 FINANCE REPORT AS AT 30TH APRIL 2018

The Board received and noted the Finance Report as at 30th April 2018.

In response to a question it was noted that loan repayments, which had impacted on the Use of Resources Rating, were made twice per year and the loan would be fully paid down in 18 months' time.

18/153 PERFORMANCE DASHBOARD AS AT 30TH APRIL 2018

The Board:
(1) Received and noted the Performance Dashboard Report as at 30th April 2018.
(2) Considered, further to minute 18/120 (24/4/18), proposed targets for Trust Dashboard metrics 1 and 14.

The Non-Executive Directors:
(1) Sought clarity, in relation to unexpected deaths, on the differences between coronial verdicts of a patient taking their own life and suicide.

Mrs. Moody explained that the former was a narrative verdict whilst a verdict of suicide required a clear demonstration of intent.

(2) Considered that it would be beneficial to hold a Board Seminar on outcome measures and interesting to have a personal view on patient reported outcome measures and their impact on recovery.

Mr. Martin agreed to find an appropriate slot on the Board Seminar programme for these discussions.

Action: Mr. Martin

Agreed – *that the proposed targets for KPIs 1 and 14 as set out in the following table be approved:*

No.	KPI	Proposal
1	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	To maintain the target of 90%
14	Percentage of patients readmitted To Assessment & Treatment wards within 30 days (AMH & MHSOP)	To set a target of 23.93%.

Action: Mrs. Pickering

18/154 STRATEGIC DIRECTION PERFORMANCE REPORT

Consideration was given to the Strategic Direction Performance Report for Quarter 4, 2017/18 including proposals to approve changes to the Trust Business Plan (as set out in Appendix 1 to the covering report).

The Board noted that the Executive Management Team (EMT), at its "Time Out" on 30th May 2018, was due to consider the Strategic Direction scorecard KPIs and it was hoped to present recommendations to the Board in July 2018.

Board Members welcomed the positive qualitative intelligence provided in the report.

The Non-Executive Directors raised the following matters:

(1) The difficulties in understanding the implications of certain metrics included in the scorecards.

In response it was noted that:

(a) This was one of the reasons for the review of the KPIs being undertaken by the EMT.

(b) The range of strategies and scorecards had increased, since the agreement of some of the KPIs, and the need for greater alignment between them and to reflect them in reporting was recognised.

(2) The deterioration on KPI 33 ("Percentage of data quality issues reported on Data Quality Scorecard - reds on scorecard") and whether this raised concerns about the data underpinning the assurances provided to the Board.

Mrs. Pickering advised that

(a) The present Data Quality Strategy had been agreed some time ago and the position shown by the metrics might not be representative of data quality in the organisation.

(b) The Strategy was being redrafted and was due to be presented to the Resources Committee in the near future.

(c) Regular reviews of data sets were undertaken by, and a rolling annual programme to review the data quality of the Trust Dashboard KPIs had been agreed with, the Internal Auditors.

(d) The Internal Auditors had not found any evidence that data quality within the organisation was deteriorating.

(3) The impact of staffing issues impacting on performance against KPI 6 ("Percentage of service users with a recovery focused action plan- Adult Mental Health")

Mr. Brown advised that the key issue was the discipline required by staff to complete the action plans and the Board was correct to raise this issue.

It was noted that work being undertaken through the CPA review and care planning was focussing on ensuring consistent engagement with service users.

Agreed – *that the changes to the Trust Business Plan (as set out in Appendix 1 to the report) be approved.*

Action: Mrs. Pickering

18/155 EQUALITY ACT 2010 – PUBLICATION OF INFORMATION

Consideration was given to the report which sought the ratification of the information contained in the Equality Data Document (Appendix 1 to the covering report) for publication as required by the Equality Act 2010.

The Chairman advised that the purpose of the report was to seek the Board's approval for the publication of the information and the data was due to be fully considered by the Resources Committee.

At the request of Mr. Hawthorn, the Chairman of the Resources Committee, Mr. Levy undertook, if practicable, to condense the information provided in the report when presented to the Committee.

Action: Mr. Levy

The Board also noted:

(1) That the total number of patients in relation to short stay/respite stay in the table in paragraph 2.4.5 was 231 and not 226 as stated in the document.

(2) The deterioration in the percentage of service users who had not provided information on their sexual orientation, included in the report as 20.83%, did not represent a reduction by percentage point.

Agreed -

(1) that the publication of the Equality Data Document (as amended) be ratified;

(2) that the changes to the workforce equality objective (as set out in paragraph 3.2.6 of the Equality Data Document) be approved; and

(3) that the differences in outcomes and experiences for staff from protected groups outlined in the paper on staff equality and the proposed actions set out in paragraphs 7.2 and 7.3 of the Equality Data Document, be noted.

Action Mr. Levy

18/156 USE OF THE TRUST SEAL

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

18/157 POLICIES AND PROCEDURES RATIFIED BY THE EXECUTIVE MANAGEMENT TEAM

The Board received and noted the report on the Executive Management Team's ratification of policies and procedures.

18/158 DATE OF NEXT MEETING

It was noted that the next meeting of the Board of Directors was due to be held at 9.30 am on Tuesday 3rd July 2017 in the Directors' Lounge, Middlesbrough Football Club Riverside Stadium, Middlesbrough.

18/159 CONFIDENTIAL MOTION

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

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

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

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

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 terms proposed or to be proposed by or to the Trust in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.

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

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

Following the transaction of the confidential business the meeting concluded at 12.50 pm.

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**3rd July 2018**
TITLE:	**Board Action Log**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information/Assurance**

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

Board of Directors Action Log

RAG Ratings:

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

	Minute No.	Action	Owner(s)	Timescale	Status
26/09/2017	17/228	Consideration to be given to reviewing the targets in the Strategic Direction Performance Report for 2018/19	SP	19/07/2018	
26/09/2017	17/230	Reviews of the operational arrangements of the Quality Assurance, Resources and MHL Committees to be undertaken	PB	19/07/2018	
31/10/2017	17/268	An update report on the Temporary Staffing Service to be presented to the Board	DL	19/07/2018	
28/11/2017	17/299	The outcome of the workshop held by the MHLC to be included in the review of the operational arrangements of the Board's committees	PB	19/07/2018	
28/11/2017	17/301	A further progress report on the implementation of the Recruitment and Retention Action Plan to be presented to the Board	DL	Jul-18	See Agenda Item 9
28/11/2017	17/305	A briefing to be provided to the Board on the event in 2018 in relation to sickness absence and whether further action can be taken to support the health and wellbeing of staff	DL	Jul-18	
19/12/2017	17/327	A report to be presented to the Board on the outcome of the review of the 12 hour shift system	DL	Jan-19	

	Minute No.	Action	Owner(s)	Timescale	Status
30/01/2018	18/08	A report to be presented to the Board on the use of enhanced observations (including trends) together with information on contemporary best practice in this area.	EM	19/07/2018	
27/02/2018	18/39	Consideration to be given, for the next Learning from Deaths report, on the most appropriate ways of: - Reformatting the Dashboard so that the total number of deaths can be fully reconciled with the review process or other response taken by the Trust to them - Providing assurance, possibly in the form of a flowchart, on how learning is linked to other quality improvement processes	EM	Jul-18	See Agenda Item 10
27/02/2018	18/40	The need for guidance on how the starting point on the Ladder of Participation will be chosen to be raised with the Recovery Programme	DL	31/07/2018	
27/03/2018	18/71	A further progress report on tackling the abuse of staff, taking into account the comments made at the meeting, to be presented to the Board	DL	19/07/2018	
27/03/2018	18/73	A university to be invited to undertake a project for the Trust in relation to variations in outcomes, and the reasons for them, between different types and sizes of wards	EM	Sept-18	
22/05/2018	18/144	The objectives of the Research and Development Strategy to be used as the framework for future annual reports	Prof. JR	May-19	
22/05/2018	18/146	Whether patients on leave were included in the CHPPD data provided to NHS Improvement to be checked	EM	Sept-18	
22/05/2018	18/146	Consideration to be given to the best way of tracking performance against the CHPPD metric over time	EM	Sept-18	
22/05/2018	18/148	To note the confirmation of the Scheme of Delegation in respect of the Mental Health Act 1983	EM	-	To note

	Minute No.	Action	Owner(s)	Timescale	Status
22/05/2018	18/149	To note the approval of the Annual Report and Accounts, the Letter of Representation and the statement in relation to Modern Slavery and authorisation to sign off the documents, certificates, etc as required	Chairman/CM/PM	-	To note
22/05/2018	18/149	The Annual Report and Accounts to be submitted to NHS Improvement and Parliament	PB	Jul-18	
22/05/2018	18/149	The Quality Report to be submitted to the DoHSC	SP	Jun-18	Completed
22/05/2018	18/150	To note approval of the Annual Report and Accounts of the Charitable Trust Funds and authorisation to sign the Statement of Trustees Responsibilities and the Balance Sheet	Chairman/CM	-	To note
22/05/2018	18/150	The Annual Report and Accounts for the Charitable Trust Funds to be submitted to the Charities Commission	PM	Jul-18	
22/05/2018	18/151	To note approval of, and authorisation to sign off, the annual certificates required by NHS Improvement	Chairman/CM	-	To note
22/05/2018	18/151	The signed Certificate on the Availability of Resources to be published on the Trust's website.	PB	Jun-18	Completed
22/05/2018	18/153	A Board Seminar to be held on outcome measures including a personal view on patient reported outcome measures and their impact on recovery	CM	Sep-18	
22/05/2018	18/153	To note approval of the proposed targets for Trust Dashboard KPIs 1 and 14	SP	-	To note
22/05/2018	18/154	To note approval of the changes to the Trust Business Plan (as set out in Appendix 1 to the Strategic Direction Performance Report)	SP	-	To note
22/05/2018	18/155	The equality data to be condensed, if practicable, when presented to the Resources Committee	DL	Jul-18	
22/05/2018	18/155	The Equality Data Document, as amended, to be published	DL	-	Completed
22/05/2018	18/155	To note the approval of the changes to the Workforce Equality Objective	DL	-	To note

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Tees Locality Board Presentation
3rd July 2018

Dominic Gardner

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

- Previously
  - Peer Support Workers, CYP Home Treatment, Delirium and Frequent Attender Work in Liaison
  - Support to independent providers
- Now
  - Urgent Care Centre, Street Triage and Police Force Control Room Pilot, Perinatal, CYPS CRHTT
  - Support to independent providers (Transforming Care / ACP)
  - MHSOP & AMH RPH Implications

To continuously improve the quality and value of our work.

- Previously
  - One team left for PPCS Phase 1
  - Locality Report Out - to help share and spread
  - CD sponsorship / QIS with partners
- Now
  - PPCS Phase 2 Pilot Teams
  - Coaching
  - QIS with Partners – Dual Diagnosis / Transforming Care

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

- Previously
  - Ability to recruit consultant medical staff a serious concern
  - Proportion of newly qualified and < 24 months post qualification nurses very high
  - Potential for unintended consequences from PPCS
- Now
  - Ability to recruit consultant medical staff a serious concern (CYPS/AMH)
  - Embedding roles of AC
  - Proportion of newly qualified and < 24 months post qualification nurses high

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

- Local
  - Crisis Care Concordat, Suicide Prevention Task Force
  - LA Health and Wellbeing Boards and Sub-groups
  - MBC Trauma Informed Care
- National
  - No formal links nationally on Tees
- International
  - Asklepios – Peer Support Workers / Transcultural Psychiatry

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

- **Financial Issues**
  - Previously, enhanced observations in MHSOP and nursing home capacity, CYP and CRES
  - Now, LD Respite Services, Crisis Review, Enhanced Observations in MHSOP and DToC's, Enhanced Observations in CYPS Tier 4 (Acuity / Pathways)
- **LMGB**
  - Daily lean management
  - QuAGs managing broad range of issues still
  - LMGB revised after Tier 4 transferred

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 03 July 2018**
TITLE:	**Assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
REPORT FOR:	**Assurance**

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

Executive Summary:

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

Assurance statement pertaining to the QuAC meeting held on 07 June 2018:

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

Key matters considered by the Committee are summarised as follows:

- The Locality areas of North Yorkshire and Tees services and top concerns.
- Patient Safety Group Report and Annual Report.
- Patient Experience Group Report and Annual Report.
- CQC compliance Report.
- Safeguarding & Public Protection Exception Report and six Monthly Assurance Report
- Infection, Prevention and Control Report, Annual Report and Annual Programme for 2018/19.
- Drug and Therapeutics.
- Health Safety, Security and Fire.
- Clinical Audit and Effectiveness.

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 07 June 2018.
- Note the confirmed notes of the informal meeting held on 03 May 2018 (Annex 1).

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 03 July 2018**
TITLE:	**Assurance report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting held on 07 June 2018.

2. BACKGROUND INFORMATION AND CONTEXT

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

3. KEY ISSUES

The Committee received updates from the Locality Directors of Operations around the principal risks and concerns, together with assurances and progress from North Yorkshire and Tees Services.

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

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

4.1 NORTH YORKSHIRE SERVICES LMGB

The Committee discussed the LMGB report for North Yorkshire Services.

The top areas of concern highlighted were:

- A recent increase in unexpected deaths in Scarborough.
  A thematic review of serious incidents in North Yorkshire has been undertaken and the resulting action plans are being taken forward. A clinically led task force will concentrate over the next six months on the lessons learned.

  The serious incident reports revealed that three of the serious incidents had a root cause, three cases had contributory findings, and there were 54 care/service delivery problems, with 104 contributory factors.

  The Committee agreed that an update on this serious matter will be brought back to the 4 December 2018 QuAC meeting.

- MHSOP Transformation.

A workshop has been held with Harrogate staff to discuss the impact of service changes and there is a risk of staff disengagement. Continued support will be given to staff through communication and participation in the process going forward.

- CAMHS – challenges with meeting the eating disorder waiting times and access standards. A medic post remains vacant and there are challenges to recruitment, particularly in Scarborough.

4.2 **TEES SERVICES LMGB**

The Committee received the LMGB report for Tees.

The top areas of concern highlighted were:

- Medical recruitment in CYP (Community), MHSOP and Adult Directorates.
- Sustained high levels of occupancy in Adult Acute Inpatient Services and MHSOP.
- The ongoing problem regarding the lack of nursing home accommodation for older people with a learning disability.

In addition members discussed:

- The repercussions for patients and staff caused by the use of illicit substances in inpatient areas.
- Significant risks to patients and staff at the Ridings with fighting outside the building and drug users leaving needles in the driveway. This has been escalated to the Head of Estates and Facilities.
- Occasional reports of Blik alarms not working, which will be reported to the Chief Executive.
- Medication errors reported in the strategy scorecard, which have been moved to weekly reporting to monitor more closely.

4.3 Patient Safety

The Committee discussed the following reports:

(i) Assurance report of the Patient Safety Group;
(ii) Patient Safety Quality Report for the period 1 to 31 March 2018;
(iii) Patient Safety Annual Report 2017/18;
(iv) Positive and Safe Annual Report.

There are no significant risks to escalate to the Board, only to note that the Quality Assurance Committee agreed to consider in more detail the following documents:

- NHSI: Patient Safety Alert: Resources to support the safe adoption of the revised Early Warning Score (NEWS2).

- NHSI: How to understand and improve your patient safety incident reporting to the National Reporting and Learning System (NRLS). This recent NRLS report allows Trusts to better understand incident reporting with comparisons with previous years. The results for the Trust were positive in that reporting incidents continues to increase over the reporting period.
  These reports will be discussed at the 5 July 2018 Quality Assurance Committee (QuAC) meeting.

- NHS Improvement: A Just Culture.
  The Committee agreed that further work will be undertaken by the Patient Safety Group to see how this could fit with what the Trust already does and to identify any potential gaps in order that the Trust can progress with this. A paper will be presented to the September 2018 QuAC meeting.

4.4 Patient Experience

The Committee received the following reports:

(i) Assurance Report of the Patient Experience Group.
(ii) Patient and Carer Experience Team Annual Report 2017/18.
(iii) PALS and complaints Annual Report 2017/18.

From the discussions held it was noted that there has been a rise in complaints from MP's and constituents. These complaints have been locality specific featuring issues such as the waiting times for autism assessments in Durham and also complaints from York. It was pleasing to note however that through recent initiatives there have been recent improvements around the waiting times for autism.

The Board is asked to note that robust systems are in place for monitoring patient and carer feedback and timescales and compliance rates for the review of complaints and collection of patient experience data is, in the majority of cases being met.

4.5 Safeguarding and Public Protection

The Committee discussed the exception report and the six monthly assurance reports of the Safeguarding and Public Protection Sub-Group.

The Board is to note:

- There has been an increase in the number of serious case reviews with some recommendations for the Trust following a domestic homicide in Redcar. Improvements are being made with communication between GPs and community mental health teams.
- Training for Safeguarding levels 1-3 has made some improvements, however there is a risk of not meeting the level 3 training compliance with the possibility of contractual penalties. Level 3 is currently at 88% compliance against the target of 98%. This is now part of daily management within teams with weekly visibility at OMT level.

Assurance was provided that the Trust is meeting its legal requirements for safeguarding adults and children within the current legislative framework.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 Compliance with CQC Requirements Report

The Committee received the CQC update report.

The key matters discussed were:

- The CQC inspection and timetable commencing on 23 July 2018 with preparatory activities ongoing.

- Close down of the CQC action plan following the 2017 inspection.
- The need to include registration and compliance advice and action early into the tendering or contractual stages when taking on new or reconfigured services.

5.2 **Infection, Prevention and Control**

The Committee received the following reports:

(i) Infection Prevention and Control (IPC) quarterly report for January to March 2018;
(ii) Infection Prevention and Control Annual Programme 2018/19;
(iii) Infection Prevention and Control Annual Report 2017/18.

The IPC Annual Report and IPC Programme will be published on the Trust website in accordance with the Health and Social Care Act.

The key areas of risk discussed were:

- A lack of assurance following poor compliance scores for ADL kitchens in Wards, following patient cooking sessions and Hotel Services have been informed.
- Some wards and sites have failed to achieve the required National Standard of Cleanliness and the IPC Committee have worked through the top 10 reasons for these failings, following which a Kaizan event was held to look at making improvements.
- The water quality in two Ward areas which is being closely monitored and managed by the Water Safety Group.

Overall there is a good level of monitoring and assurance being received by the IPC in relation to compliance with the Health and Social Care Act 2008 and CQC fundamental standards with identified risks being managed appropriately.

5.3 **Drug and Therapeutics Report**

The Committee considered the Drug and Therapeutics Report and the Medicines Optimisation Annual Report 2017-18.

Committee members discussed the good progress that has been made with the six pharmacy and medicines optimisation work streams that provide a framework to support the implementation of NICE Medicines Optimisation guidance and welcomed the two page Annual report which set out concisely and clearly the good levels of improvement and assurance for the last year.

5.4 **Health, Safety, Security and Fire**

The Committee considered the Health, Safety, Security and Fire report.

There are no new risks or concerns to raise, however the Committee requested a more in depth look into the background of smoking incidents on Kirkdale Ward, which have gone up from 22 in 2016/17 to 75 in 2017/18.

5.5 Clinical Audit and Effectiveness

The Committee considered the progress of Clinical Audits and the year-end clinical audit completion status for the end of April 2018.

Committee members discussed:

- There is a marginal decline in the year end position of completed audits at 82.76% (72/87), however this was due to capacity issues in Quarter 1 and 2 from 2017, which were now fully resolved.

- Clinical audit of Restraint in Tier 4 CAMHS was showing red status, 0-49% compliance, which is due to a disparity between incident reports and what is written in the clinical record. Assurance was provided that this is being addressed and some improvements have already been made around the recording process.

5.6 **Exceptions to report to the Board**

The Committee received notification of a Patient Safety Alert from NHS Improvement around the insertion of nasogastric tubes. Any actions for the Trust to pick up will be reported back to the 5 July 2018 meeting.

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

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

6. IMPLICATIONS

6.1 **Quality**

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

6.2 **Financial/value for money**

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

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

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

6.4 **Equality and Diversity**

There are no issues to note.

7. CONCLUSIONS

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

8. RECOMMENDATIONS

That the Board of Directors is asked to:

(i) Note the issues raised at the Quality Assurance Committee meeting on 07 June 2018.
(ii) Note the confirmed notes of the meeting held on 03 May 2018.

Elizabeth Moody
Director of Nursing and Governance
July 2018

Annex 1

NOTES OF THE INFORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 3 MAY 2018, IN STAFF MEETING ROOM 2, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

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

In attendance:
Mrs Karen Atkinson, Head of Nursing, Teesside
Dr Suresh Babu, Clinical Director, Durham and Darlington
Mr Levi Buckley, Director of Forensic Services
Mr Anthony Davison, Head of Nursing, York and Selby
Mrs Ruth Hill, Director of Operations for York and Selby
Mr Chris Lanigan, Head of Planning & Business Development
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Professor J Reilly, Head of Research and Governance
Mr Stephen Davison, Lead Nurse, Nursing and Governance
Mr David Levy, Director of Human Resources, Organisational Development
Mrs Sarah Jay, Equality and Diversity Lead

18/51 APOLOGIES FOR ABSENCE

Apologies for absence were received from: Mrs Karen Agar, Associate Director of Nursing and Governance, Mrs Shirley Richardson, Non-Executive Director and Dr Ahmad Khouja, Medical Director.

18/52 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 05 April 2018 were agreed as true and correct, subject to a typographical error to minute18/35: "*with the use of clozapine in unlicensed injectable form*.." and signed by the Chairman.

18/53 ACTION LOG

The Committee discussed the QuAC Action Log, noting the following updates:

17/150 Talk to NHS Employers, Diversity and Inclusion partners for advice on how to tackle racial abuse of staff by service users.

Completed

18/06 To bring a report to QuAC outlining the results of the Care Programme Approach.
This was covered under agenda item number 9 (minute 18/60)

Completed

18/35 Add to Trust risk register the impact of drugs being brought into inpatient wards.

Completed

18/36 Individual cases concerning standards of agency staff to be sent to the Chief Executive.

Completed

18/40 Undertake some analysis of potential inconsistency between the outcomes of Trust peer reviews and MHA reviews.
This work would be brought back to the June QuAC meeting.

18/41 Amendments to the Draft Quality Account

Completed

18/44 Positive and Safe presentation.
This was covered under agenda item number 13 (minute)

18/54 FORENSIC SERVICES LMGB REPORT

The Committee received and noted the Forensic Services LMGB Report.

Arising from the report it was highlighted that the top issues to note were:

1. The Roseberry Park rectification programme had caused considerable operational and clinical involvement to support the design of Block 16, rectification of existing estate and the security management of the works programme. There had been disquiet over uncertainty around time lines of any changes and the decant schedule. A briefing had been sent round to provide information.

2. CQC preparation.
   The preparations for the forthcoming CQC visit had been going well and the Heads of Service were facilitating drop in sessions within Ridgeway for all Forensic staff to provide briefings to highlight key messages and to promote positive communication opportunities.

3. Triangle of Care.
   Some good progress had been made on the action plan that was developed following submission of the self-assessments. Preliminary discussions had taken place with Forensic community based services and the Prisons regarding roll out within these services.

Following discussion it was noted that:

(1) Since the writing of the report one seclusion room was now free and the number of seclusion episodes had decreased, demonstrating that the actions taken following the IP staffing work stream and Kaizen events were becoming embedded.
(2) Following an incident in the service a safeguarding alert had been raised and escalated to the Local Authority relating to an incident where tear proof clothing had been used.
On this matter it was noted that the use of tear proof clothing, whilst it can be clinically indicated does not currently have robust governance arrangements to ensure compliance with the MHA Code of Practice and this would be picked up by a task and finish group.

Members of the Committee raised the following concerns:

(1) The results of the rapid tranquilisation audit had been disappointing with a red rating. It was noted that the training for rapid tranquilisation was currently above target, however when the audit was carried out it had been found that the observations had not been done to the standard of the policy. This would be monitored through the QuAGs.
(2) Confidence levels around the outcome of the RPIW in prisons. On this matter it was noted that following the last RPIW results had been sustained over 120 days and improvements had been made to the reception process and mental health screening on arrival to prison.
(3) Staff concerns in Forensic Learning Disabilities regarding allegations and abuse. Mr Buckley advised that there were patients that had made malicious allegations and blackmail threats to staff leading to staff members needing to work in pairs with certain individuals.
(4) Lack of clarity in relation to staff availability to drive Trust vehicles in order to facilitate leave, due to concerns regarding liabilities and financial implications.

18/55 YORK AND SELBY SERVICES LMGB REPORT

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

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

1. Capacity and demand issues with ongoing problems with CAMHS services and IAPT.

2. Staffing with gaps in the workforce.

3. Commissioning expectations and meeting the contract requirements in the current financial restraints.

Following discussion members expressed concern over level 3 safeguarding training compliance, which was currently at 82%.

Assurance was provided that additional training courses had been planned and all mitigating actions were being monitored through LMGB and QuAG to minimise risks.

18/56 PATIENT SAFETY REPORT

The Committee received and noted the assurance report of the Patient Safety Group and the Patient Safety Quality Report for the period 1 to 28 February 2018.

Arising from the report it was noted that:

- The Falls Executive Group had agreed two revised KPI's in relation to the frailty pathway, which had been discussed and agreed by SDG. The pathway document would be taken back to a future meeting for further discussion.
- Care would be taken around secretaries generating prescriptions for clinicians to sign with clear guidelines put in place. There had been concerns highlighted that clinicians were batching the process and signing lots of prescriptions in one go which could lead to errors.
- Any trust wide patient safety issues resulting from either the Directors Panel or another group in the organisation would be discussed at the Patient Safety Group going forward with an assigned owner to take any actions forward.

Members sought clarification on:

(1) The reduction in the level of self-harm incidents given the rising acuity of the individuals that are cared for and further detail will be provided to the Committee in June 2018.

Mrs Illingworth undertook to look into the reduction in self-harm incidents and report back to the 07 June QuAC meeting.

Action: Mrs Illingworth

(2) Whether there was sufficient focus on the transitioning from CAMHS to adult services, which had been a quality priority for the last three years.
Mrs Moody noted that a review had been requested to see if there were any improvements to be made.

18/57 SAFEGUARDING & PUBLIC PROTECTION REPORT

The Committee received and noted the report for Safeguarding and Public Protection.

Arising from the report it was noted that:

(1) There were a number of serious case reviews underway, particularly in Durham, which had seen unusually high numbers lately; however they were all appropriate and quite different in presentation.

(2) A targeted inspection of Stockton Local Authority had taken place by OFSTED regarding their permanence planning for children and young people, with extremely positive feedback.

Assurance was provided that the Trust continued to meet its legal requirements for safeguarding adults and children within the current legislative framework.

18/58 PROGRESS WITH CLINICAL SUPERVISION AND IMPLEMENTATION REPORTING

The Committee received and noted the update on progress with clinical supervision and implementation reporting.

Arising from the report it was noted that:

- Following the introduction of the new policy and process introduced in 2016 to improve the uptake and awareness of clinical supervision there were still inconsistencies with implementation.
- This safety topic was currently a focus of the CQC and it would be vital that senior managers and the Executive team have sight of progress around compliance with the policy.
- Ongoing summary updates would be reported to QuAC through the Clinical audit and effectiveness group report.
- Following a recent Kaizen event focused on the Tees locality area there would be a pilot of model supervision with key actions including training and the upskilling of staff including a two day supervision course.

18/59 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:

- The timelines and process around preparations for the CQC well-led announced inspection were well underway.
  In order for Non-Executive Directors to be prepared a briefing pack would be circulated.

Action: Mrs Illingworth

- There had been a visit in April 2018 from the CQC Lead Inspector, who had attended three EMT report out sessions, which had been positively received.
- Each locality would prepare a presentation for the CQC to showcase the quality of patient care, as part of the inspection on 1 June 2018.
- There had been one MHA review inspection in the last month to North Yorkshire locality, Rowan Ward, MHSOP, however at the time of QuAC the report had not been received.
- There had been two CQC prison inspections to MH Prison Low Newton and HM Prison Deerbolt Young Offenders Institution and feedback was awaited.

Members of the Committee expressed concern over the CQC findings on Newtondale, Forensic MH where a door had been locked, however staff had been unclear of the reasons.

Assurance was provided to the Committee that there had been a review of the blanket restriction policy following discrepancies around locked doors, and the importance of staff awareness.

18/60 CPA AUDIT REPORT

The Committee received and noted the CPA Audit Findings.

Arising from the report it was noted that:

(1) The audit had been designed to assess clinicians with regards to the practices and processes associated with the Care Programme Approach policy.

(2) Whilst there had been some evidence of good practice the results so far were disappointing with 61% of care planning with no documented evidence of involvement and one third (32%) of cases not meeting the standards set out in the harm minimisation policy.

Members of the Committee expressed their disappointment that the fundamental principles of the recovery approach were not embedded and that there were variations across the localities.

Assurance was provided to the Committee that work was underway to make improvements, such as the co-production work stream to make changes to the care plan template and that the CPA principles would be linked into the triangle of care work as well as the recovery programme with an update back to the Quality Assurance Committee in due course.

18/61 TEMPORARY STAFFING PRESENTATION

The Committee agreed that the Temporary Staffing presentation would be taken to the Resources Committee, in accordance with its terms of reference, at its next meeting to be held on 12 June 2018.

18/62 EQUALITY, DIVERSITY AND HUMAN RIGHTS STEERING GROUP REPORT

The Committee received an update on the outcome of the Equality, Diversity and Human Rights steering group from January 2018 – April 2018.

Arising from the report it was noted that:

(1) Localities continue to work with their equality objectives and all actions for the 2017/18 scorecard had been completed.

(2) Work was underway to try to address the issue of the differing outcomes and experience for BAME staff compared to white staff, through the support of EMT.

(3) A procedure was currently being developed to address metric five in the WRES, which is the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

(4) A dignity and respect work statement has been drafted which would be implemented to communicate the message to staff that there will be zero tolerance around aggressive and violent behaviour.
On this matter it was suggested that the wording be amended to make the message simpler and clearer and Mrs Jay undertook to revise the statement.

(5) There were concerns over the deterioration of metric six – percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

It was interesting to note that there had been an increase in the number of incidents reported during February and March 2018, which could be due to the presentations at the Leadership and management networks, which highlighted the need to record incidents of abuse related to race, sexual orientation, gender etc.

18/63 RESEARCH GOVERNANCE GROUP REPORT

The Committee received a six monthly update from the Research Governance Group.

Arising from the report it was noted that:

(1) The Trust continued to be compliant with the Research Governance Framework and from 7 November 2017 the 'UK policy framework for health and social care research' would replace the Research Governance Framework.

(2) The collaboration between TEWV and the University of York was progressing well with the signing of a Memorandum of Understanding on research collaboration with a 15 year vision.

Following discussion, it was requested that a report detailing the outcomes of earlier pieces of research would be useful and this would be reported back to QuAC in November 2018.

Action: Prof Reilly

18/64 POSITIVE AND SAFE

The Committee received a presentation from Mr Stephen Davison, Lead Nurse Positive and Safe on reducing the use of restrictive interventions.

Members expressed concern over the high numbers in the use of rapid tranquilisation in CAMHS and incidents of restraint.

On this matter it was noted that whilst there had been a lot of support into the service there were presently 66% of newly trained staff with less than two years' experience and it would be useful to look further into the details around these matters.

Agreed: *That QuAG would be asked to facilitate some work around the high numbers in the use of rapid tranquilisation in CAMHS and incidents of restraint, to be led by a Clinical Director and the outcome would be reported to QuAC in the next quarter.*

Action: Mrs E Moody

18/65 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no exceptions to report.

18/66 ANY MATTERS DISCUSSED TO BE ESCALATED TO THE BOARD OF DIRECTORS THAT MIGHT IMPACT ON THE TRUST'S STRATEGIC OR KEY OPERATIONAL RISKS.

The Committee noted that there were no issues that could impact on the Trust's risks.

18/67 ANY OTHER BUSINESS

There was no other business to discuss.

18/70 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 7 June 2018, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

The meeting concluded at 5.02pm

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ITEM 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**03 July 2018**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

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

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

- The number of rosters equates to 71 inpatient wards (includes those inpatient wards not submitted to UNIFY for internal assurance).
- The number of 'red' fill rate indicators highlights Registered Nurses on Days as having the highest number of 'reds' equating to 21 wards, an increase of 5 when compared to the previous month.
- North Yorkshire and Teesside locality had the highest level of 'red' fill rates (5 in May)
- The lowest fill rate indicators in May related to The Orchards NY (Healthroster change has been implemented from 23rd May 2018), Cedar D&D (vacancies), and The Lodge (transition to private provider)
- The Highest fill rates in May were observed by Westerdale South (high patient acuity), Acomb Garth (high patient acuity/frailty) and Holly Unit (training, observations and control and restraint plan)
- In relation to bank usage there were no wards identified who were utilising in excess of 50% bank during May. The highest bank user was in relation to Mallard with 40.6% bank usage (reasons for bank included: enhanced observations vacancies and sickness)

- Agency usage equated to 5.9% in May. The highest user of agency within the reporting period related to Acomb Garth with 50.9% of the total hours worked within this ward (reasons for agency included: enhanced observations, unknown and vacancies)
- In terms of triangulation with incidents and complaints the full analysis can be found on pages 6 to 8 of this report. All complaints were categorised in relation to 'treatment and care, Communication and Null' and did not highlight any specific concerns with regards to staffing levels or staff attitude. From those serious incidents that went to Directors Panel in May, 1 highlighted concerns regarding a number of concerns in relation to staffing; a full list has been added to page 7 of the report.
- There were 623 shifts allocated in May where an unpaid break had not been taken, this is a reduction when compared to the previous month. From those shifts where breaks were not taken the majority were in relation to day shifts (452 shifts).
- There were 14 incidents raised in May citing concerns in relation to staffing levels, all of which related to Inpatient Services.
- A severity calculation has been applied and highlights any areas of concern from a safe staffing point of view. In May Cedar D&D had the highest score with 13 points awarded. The top 10 for May can be found on page 10 of this report along with an explanation of severity scores and appendix 3 shows all scores for all wards. Appendix 4 shows the severity scores by speciality. Appendix 5 shows the year to date position with Cedar D&D being cited as having the highest score of 93.
- Care Hours per Patient Day for May can be found at Appendix 6. Standard deviation has been included which allows us benchmark similar types of wards. Positive outliers include Bransdale, The Lodge, Jay, Meadowfields and Westerdale South. Although there were no negative outliers Oakwood was close. Further information can be found on Page 11 and at Appendix 7.

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:	**03 July 2018**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of the exceptions arising from 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 May 2018 data.

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013 and subsequent update of the guidance in 2016) 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/content/About/How-well-are-we-doing/Nurse-staffing). The full monthly data set of day by day staffing for each of the 71 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

3. EXCEPTIONS:

3.1 Safe Staffing Fill Rates – May 2018

3.1.1 The daily nurse staffing information aggregated for the month of May 2018 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 21 in May. This is an increase of 5 when compared to April 2018.

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
May 2018		
The Orchards (NY)	51.6% RN on Nights 145.2% HCA on Nights 85.8% RN on Days	The HealthRoster system does not match the budgets. The system has been updated and will be effective from

	122.2% HCA on Days	23rd May 2018 roster.
Cedar Ward (D&D)	62.3% HCA on Days 136.4% RN on Days 70.3% HCA on Nights 102.5% RN on Nights	The shortfall in HCA's is in relation to existing vacancies. This is being offset using overtime and additional hours of registered nurses which is reflective of in the fill rate.
The Lodge	64.9% HCA on Days 74.6% RN on Days 76.8% HCA on Nights 95.8% RN on Nights	The shortfall is in relation to a private provider who is working into the Lodge as part of the transition.

It is also important to review the fill rates that exceed the budgeted establishment (shown in blue). In May there were 67 fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues.

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

Ward	Fill Rate Indicator	Comments
May 2018		
Westerdale South	355.7% HCA on Nights 89.8% RN on Nights 263.6% HCA on Days 99.6% RN on Days	The over establishment is in relation to high patient acuity with 4-5 enhanced patient observations during the month. In addition the ward has experienced RN long term sickness and HCA short term sickness.
Acomb Garth	292.1% HCA on Nights 98.4% RN on Nights 218.7% HCA on Days 75.8% RN on Days	The ward continues to experience high acuity and high levels of enhanced engagement and observation. This acuity is seen in both frailty/vulnerability/high care needs and agitation. Staffing needs are reviewed each weekday in the locality and a plan is in place to support the unit more intensively.
Holly Unit	283.2% HCA on Days 207.7% RN on Days 220.3% HCA on Nights 140.0% RN on Nights	The ward has advised that the reason for the additional staffing was due to attending training, school observations and supporting an admission where additional staffing was required to support control and restraint plans.

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 May.

The highest user of bank in May related to Mallard Ward reporting at 40.6%. The reasons Mallard gave for requesting bank are as follows:

- Enhanced Observations (60 shifts)
- Establishment Vacancies (33 shifts)
- Sickness (33 shifts)
- Business Contingency Planning (20 shifts)
- Redeployment (2 shifts)
- Emergency Annual Leave (1 shift)

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

Mallard Ward	40.6%
Clover/Ivy	39.9%
Westerdale South	39.7%
Mandarin	37.4%
Elm Ward	33.0%
Ward 15 Friarage	32.0%
Merlin	30.6%
Northdale Centre	29.2%
Harrier/Hawk	27.4%
Kestrel/Kite.	25.1%

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

3.3 Agency Usage

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

In May the agency usage equated to 5.9% which is the same usage that was reported in April.

The highest user of agency within the reporting period related to Acomb Garth equating to approximately 50.9% of the total hours worked on this ward. The reasons Acomb Garth gave for requesting agency are as follows:

- Enhanced Observations (255 shifts)
- Unknown (13 shifts)
- Establishment Vacancies (3 shifts)

The ward is using regular agency where possible as there is limited availability of bank nurses within the York locality and North Yorkshire locality. This can be seen in the wards below where 7 of the top 10 are in these areas of the trust.

Wards reporting 4% or more agency usage in May are detailed below:

Acomb Garth	50.9%
Cedar Ward (NY)	37.3%
Meadowfields	36.1%
Cherry Tree House	20.3%
Rowan Ward	19.4%
Elm Ward	14.4%
Westerdale South	14.1%
Springwood	12.9%
Westerdale North	12.8%
Rowan Lea	11.9%
Bedale Ward	10.3%
Ward 15 Friarage	7.5%
Oak Rise	7.5%
Esk Ward	7.2%
Minster Ward	7.2%
FLD Eagle ASD	7.0%
Danby Ward	6.9%
Tunstall Ward	5.0%
Farnham Ward	4.6%
The Evergreen Centre	4.5%
Bransdale Ward	4.2%

Although agency usage remains relatively low within the Trust; this is significantly higher when compared to the usage 12 months ago. The greatest percentage expenditure patient safety remains on agency HCA's at 78% for the period. Band 5 demand has remained consistent with the previous months. Directors of Operations with Heads of Nursing for each locality have reviewed and considered the pattern of unregistered nursing use and a number of posts are being recruited to that are over-establishment with the aim to reduce this cost and improve consistency and quality. In Durham locality 11 HCA posts have been approved to go out to advert.

There has been an average monthly spend of £241k from Oct – Apr 2018 across the trust on nurse agency with an increase over this reporting period of £18k on last month. The trusts agency provider reported there have been no agency price cap breaches.

3.4 Quality Data Triangulation

The triangulation of the staffing data against a range of quality metrics has been undertaken for the month of May with the following reporting as an exception:

- There was 1 Serious Incidents (SI) that occurred within inpatient areas during the month of May and related to Rowan Ward who have been cited in this report for having agency usage in excess of 4%.
- From those incidents that were reviewed at Directors Panel in May, there was 1 case (2018-1835) recorded against the Psychosis Team in Durham. The case highlighted the following concerns with regards to staffing:
  - Staff working under pressure due to staff vacancies
  - The patient's care coordinator was often asked to visit other patients, who were not being care coordinated who required face to face contacts due to lack of staff,
  - The care coordinator felt that clinical time to see patients was reduced due to clinicians undertaking single point of access assessments, attending team meetings and duty worker responsibilities.
  - The patient's care coordinator stated he had to cancel his clinical and management supervision on several occasions due to service demands. Clinical and management supervision may have detected the fact that the patient's care documents were not completed prior to him being discharged.
- There was 1 level 4 incident reported in May which was also reported as a SI and related to Rowan Ward.
- There were 8 level 3 incidents (self-harm) that occurred in May with the following featuring in this report as follows:
  - Danby Ward – 1 incident – cited in this report for agency usage greater than 4%
  - Cedar Ward (D&D) – 3 incidents – cited in this report for having a low staffing fill rate.
  - Ward 15 – 1 incident – cited in this report for having bank and agency usage.
- There were 6 complaints raised in May, the following is of relevance:
  - Cedar (NY) - 1 complaint - cited in this report for having agency usage greater than 4%.
  - Elm Ward – 1 complaint - cited in this report for having agency usage greater than 4% and bank usage.
  - The Evergreen Centre – 1 complaint – cited in this report for having agency usage greater than 4%.
- There were no complaints raised in May citing concerns regards to staffing or staff attitude.
- There were 34 PALS related issues raised with the following featuring within this report as follows:
  - Danby (1 issue) – cited in this report for agency usage greater than 4%, and a level 3 incident.
  - Esk Ward (1 issue) – cited in this report for having agency usage greater than 4%.
  - Bedale (1 issue) – cited in this report for having agency usage greater than 4%.
  - Cedar Ward D&D (1 issue) – cited in this report for having a low staffing fill rate and 3 level 3 incidents

- Cedar Ward NY (1 issue) – cited in this report for having agency usage in excess of 4% and a complaint
- Elm Ward (2 issues) – cited in this report for having bank and agency usage
- Farnham Ward (1 issue) – cited in this report agency usage greater than 4%.
- Tunstall (4 issues) – cited in this report having agency usage greater than 4%
- Harrier/Hawk (3 issues) – cited in this report for having bank usage in excess of 25%
- Mallard (2 issues) – cited in this report for being the highest user of bank
- Merlin (1 issue) – cited in this report for having bank usage in excess of 25% and for having a complaint
- Rowan Lea (2 issues) – cited in this report for having agency usage greater than 4%.

A number of incidents requiring control and restraint occurred during May. The highest user was the Evergreen Centre with a total of 235 incidents. This ward has been cited in this report for having agency usage in excess of 4%.

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 623 shifts in May where an unpaid break had not been taken. This is an increase of 91 when compared to April.

The majority of the shifts where breaks were not taken occurred on day shifts (452 shifts). The number of night shifts where breaks were not taken equated to 171 shifts in May.

The detailed information in relation to missed breaks continues to be shared with the localities for discussion and is being closely monitored in daily lean management processes and on visual control boards.

Following discussion with staff-side representatives and discussion at EMT, directorates have been asked for evidence of any of the requirements that are laid down within the Trust's rest break guidance not being met in practice within individual wards, departments or units.

Where such evidence exists, services have been asked to confirm:

- What the relevant rest break requirements are that are not being met:
- The number and type of staff affected;
- The locations affected;

- Whether the situation described is continuing and what actions have been taken, or are planned, to ensure that the requirements of the rest breaks guidance can be met in the future.

This request is made as part of efforts to improve understanding about the scale of these issues. A new target has been agreed that will form part of the EMT report out. This will focus on those wards who have achieved less than 98% compliance with breaks in a monthly period.

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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. There were 14 incidents reported in May for inpatient services on Datix citing issues with staffing.

All staffing incidents are reviewed and shared with Heads of Nursing to identify themes across wards and address any issues arising from these. Concerns related to staffing incidents over the reporting period were as follows:

Key themes:

- 77% (10) of incidents citing staffing levels were for day duty
- Staff Shortages
- Enhanced observations increasing staffing requirements
- Staff failed to turn up for shift x4
- Wards not running on required staffing levels/ mix.

Issues reported:

- Staff and patient safety compromised
- Quality of service impaired
- Observations not carried out
- Dangerously low staffing levels
- Unable to respond to planned restraint
- PBS plans not followed

3.7 Severity

Utilising the data contained within this report it is possible to assign a scoring system to highlight any potential areas of concern. The total score for each inpatient area is contained within Appendix 3 with a speciality view at Appendix 4. The higher the score the higher the number of episodes they have been cited in relation to the number of ‘red’ fill rate indicators, any over establishment, bank & agency usage and the quality metrics.

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

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

The top 10 wards cited utilising the above scoring mechanism is identified below for the reporting period:

WARD	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SI	L4 Incidents	L3 Incidents	Complaints	Control & Restraint	TOTAL SCORE (May)
Cedar Ward	4	1	1	1	1	0	0	3	0	2	**13**
Elm Ward	2	2	1	1	2	0	0	0	1	1	**10**
The Evergreen Centre	2	2	1	1	0	0	0	0	1	2	**9**
Westerdale South	2	2	0	1	2	0	0	0	0	1	**8**
Rowan Ward	2	2	0	1	1	1	1	0	0	0	**8**
Rowan Lea	2	2	1	1	1	0	0	0	0	1	**8**
Ward 15 Friarage	2	1	1	1	2	0	0	1	0	0	**8**
Bedale Ward	2	2	0	1	1	0	0	0	0	1	**7**
Clover/Ivy	0	2	0	1	2	0	0	0	0	2	**7**
Merlin	0	3	1	0	2	0	0	0	1	0	**7**
Acomb Garth	2	2	1	1	0	0	0	0	0	1	**7**
Cherry Tree House	2	2	1	1	1	0	0	0	0	0	**7**
Westwood Centre	2	2	1	0	0	0	0	0	0	2	**7**

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

WARD	Locality	Speciality	YTD Total Score (May - May)
Cedar Ward	Durham & Darlington	Adults	**93**
Westerdale South	Teesside	MHSOP	**89**
Clover/Ivy	Forensics	Forensics LD	**88**
The Evergreen Centre	Teesside	CYPS	**83**
Bedale Ward	Teesside	Adults	**83**

The year to date position for all inpatient wards has been included in full at appendix 5 of this report.

3.8 Care Hours per Patient Day (CHPPD)

From April 2018, all MH trusts reported CHPPD for the first time to NHS Improvement. This is the first step in developing the methodology as a tool that can contribute to a review of staff deployment. Work has begun to consider appropriate application of this metric in other healthcare groups such as allied health professionals (AHP's). We will be submitting pilot data in relation to AHP's that are rostered in TEWV in July 2018.

This metric tracks the total number of direct nursing care hours compared to the number of patients as a count at midnight. The trust's submission can be found at Appendix 6 covering the month of May 2018.

We have considered the presentation of the CHPPD information and have used standard deviation over a rolling 13 month period. This allows us to rank in order the average care hours within the period and benchmark the information against similar types of wards. These calculations have been split into registered and unregistered and show the mean, the upper and lower quartile in order to identify potential outliers either positively or negatively.

The standard deviation covering the period of May 2017 to May 2018 highlights the following positive outliers:

- Bransdale (acute unregistered staff)
- The Lodge (adult LD registered staff); this ward has been cited in this report for having a low staffing fill rate.
- Jay Ward (forensic low secure registered staff)
- Meadowfields (older acute registered staff); this ward has been cited in this report for having agency usage in excess of 4%.
- Westerdale South (older acute unregistered staff); this ward has been cited in this report for having a high fill rate, bank and agency usage above the tolerance.

There are no wards that appear negatively under the lower bracket although Oakwood (forensic LD unregistered staff) was very close.

It is important to highlight that the NQB guidance states that CHPPD should never be viewed in isolation but as part of a local quality dashboard that includes patient outcome measures alongside workforce and finance indicators. This will be further developed as part of the Right Staffing Programme and will be considered in more detail within the 6 monthly safe staffing report.

3.9 Other

North Yorkshire and Teesside have the highest number (5 wards' each in May) of 'red' fill rates for registered nurses on day shifts.

The Right Staffing programme Board has agreed a suite of metrics that will indicate delivery of intended benefits. Terms of reference and have been

agreed for the following task and finish groups who will deliver the agreed objectives for each workstream. Each sub-group will be chaired by a Director. The workstreams are:

- Recruitment and Retention (chaired by Deputy Director of HR and OD)
- Training, development and leadership (chaired by Director of N&G)
- Temporary Staffing Services Workstream (chaired by Deputy Director of HR and OD)
- Staffing establishment workstream (chaired by COO)
- New roles and development of consultant workforce (Co-chaired by Medical Director and Director of Therapies)

Following analysis of staffing and recent interviews for Band 5 nurses, Forensic services have agreed to recruit to 6 new Band 6 posts in FLD described as "development posts to assist with retention" and had agreement to over recruit to Band 5 nurses in FMH where interviews for 4 B5 vacancies had 8 appointable candidates. This will off-set maternity leaves and staff turnover and will be monitored as part of the financial accountability process.

Further analysis of the usage of 'enhanced observations' in relation to budgeted establishments is required to fully understand the level of clinical need and practices at ward level and to seek an effective solution to bank usage. The Right Staffing programme has facilitated the liaison with peers to better understand the benefits of zonal engagement and observation practices to support effective utilisation of staff to better support service users and deliver high quality care. The programme manager and some Heads of Nursing visited Lancashire Care Trust to understand the work that had taken place around zonal observation as part of their involvement in the NHSI Collaborative. Our staff, were very impressed to see evidence of significant reductions in violence and aggression and resultant staffing levels which has also been the experience of Mersey Care trust with this approach. Senior staff from Acomb Garth and Westerdale South have participated in this exercise, the outcomes of which will be presented to the Right Staffing Programme Board for consideration of utilising in the Trust. This will form an ongoing and key part of the proposed work plan for right staffing programme. NHSI have recently announced a mental health observation and engagement collaborative and the Right Staffing programme will seek to learn from this and link in to Model Ward methodology.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

There are a number of areas that have had high levels of clinical activity necessitating increased observation and engagement levels with patients in addition to sickness and vacancies. This has resulted in difficulties in some wards meeting their planned staffing levels particularly with regard to registered nursing staff fill rates on days. In some ward areas this has resulted in high levels of agency and bank HCA's. 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 however the actions set out in section 3.9 aim to mitigate these risks going forward.

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's Right 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. The 2016 NQB guidance has also been taken into account in the Trust approach

4.4 **Equality and Diversity:**

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

4.5 **Other implications:**

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

5. RISKS:

5.1 Safe staffing and the risks regarding the Trusts ability to meet planned staffing levels on a daily basis have been escalated to the Trust Risk Register. Risks are managed and mitigated through operational services and the work being undertaken as highlighted within the Right Staffing work streams.

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 Comparative analysis of complaints and incidents, particularly focussing on the areas where staff fell below the planned levels has been undertaken for the period. Short term risks are being mitigated through the use of temporary staff and/or reviewing skill mix on a daily basis. There was 1 serious incident (SI) that occurred within inpatient areas during the month of May and related to Rowan Ward who was cited for having agency usage in excess of 4%. From those incidents that were reviewed at Directors Panel in May, there was 1 case (2018-1835) recorded against the Psychosis Team in Durham. The case highlighted the following concerns with regards to staffing:

- Staff working under pressure due to staff vacancies
- The patient's care coordinator was often asked to visit other patients, who were not being care coordinated due to lack of staff, who required face to face contacts
- The care coordinator felt that clinical time to see patients was reduced due to clinicians undertaking single point of access assessments, attending team meetings and duty worker responsibilities.
- The patient's care coordinator stated he had to cancel his clinical and management supervision on several occasions due to service demands. Clinical and management supervision may have detected the fact that the patient's care documents were not completed prior to him being discharged.

There were no complaints raised in May citing concerns regards to staffing or staff attitude.

6.3 The report sets out the work that continues in localities and through the Right Staffing programme to address shortfalls where planned establishments are not being met and to address capacity and capability in line with severity scores.

7. RECOMMENDATIONS:

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

Emma Haimes
Head of Quality Data and Patient Experience
May 2018

Appendix 1

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 31 DAYS IN May							
				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	102.3%	106.7%	80.6%	103.2%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	71.5%	142.8%	100.3%	107.0%
Bedale Ward	Teesside	Adults	10	98.2%	154.1%	85.0%	238.0%
Bilsdale Ward	Teesside	Adults	14	105.8%	132.9%	116.4%	111.4%
Birch Ward	Durham & Darlington	Adults	15	72.1%	102.2%	100.2%	107.8%
Bransdale Ward	Teesside	Adults	14	122.3%	132.1%	113.2%	126.0%
Cedar Ward	Durham & Darlington	Adults	10	136.4%	62.3%	102.5%	70.3%
Cedar Ward (NY)	North Yorkshire	Adults	14	122.6%	102.5%	118.0%	109.7%
Ebor Ward	York and Selby	Adults	12	87.5%	90.9%	100.0%	101.6%
Elm Ward	Durham & Darlington	Adults	20	89.9%	142.9%	104.2%	162.9%
Farnham Ward	Durham & Darlington	Adults	20	100.5%	119.2%	91.2%	111.5%
Kirkdale Ward	Teesside	Adults	16	88.9%	102.6%	106.5%	103.2%
Lustrum Vale	Teesside	Adults	20	101.2%	103.5%	100.3%	104.8%
Maple Ward	Durham & Darlington	Adults	20	91.3%	121.4%	99.8%	108.1%
Minster Ward	York and Selby	Adults	12	89.2%	82.3%	100.8%	105.5%
Overdale Ward	Teesside	Adults	18	118.6%	96.1%	100.0%	101.6%
Primrose Lodge	Durham & Darlington	Adults	15	76.3%	129.7%	100.0%	100.0%

Stockdale Ward	Teesside	Adults	18	117.3%	100.9%	119.4%	106.5%
The Orchards (NY)	North Yorkshire	Adults	10	85.8%	122.2%	51.6%	145.2%
Tunstall Ward	Durham & Darlington	Adults	20	113.7%	110.8%	100.0%	119.4%
Ward 15 Friarage	North Yorkshire	Adults	12	88.3%	140.3%	110.0%	98.4%
Willow Ward	Durham & Darlington	Adults	15	96.3%	144.3%	103.2%	100.0%
Baysdale	Teesside	CYPS	6	95.1%	115.9%	96.8%	103.2%
Holly Unit	Durham & Darlington	CYPS	4	207.7%	283.2%	140.0%	220.3%
Newberry Centre	Teesside	CYPS	14	97.6%	124.1%	169.8%	163.8%
The Evergreen Centre	Teesside	CYPS	16	79.2%	114.0%	138.1%	130.1%
Westwood Centre	Teesside	CYPS	12	89.4%	146.5%	100.2%	214.8%
Clover/Ivy	Forensics	Forensics LD	12	104.3%	106.7%	154.4%	192.3%
FLD Eagle ASD	Forensics	Forensics LD	1	108.3%	167.1%	103.3%	89.1%
Harrier/Hawk	Forensics	Forensics LD	10	104.9%	121.3%	116.1%	139.9%
Kestrel/Kite.	Forensics	Forensics LD	16	103.8%	116.0%	112.1%	148.8%
Langley Ward	Forensics	Forensics LD	10	73.9%	112.8%	100.3%	100.0%
Northdale Centre	Forensics	Forensics LD	12	127.2%	97.3%	128.7%	95.0%
Oakwood	Forensics	Forensics LD	8	93.0%	136.8%	100.0%	100.5%
Thistle	Forensics	Forensics LD	5	83.5%	91.7%	109.7%	96.8%
Brambling Ward	Forensics	Forensics MH	13	109.7%	83.4%	100.3%	96.6%
Jay Ward	Forensics	Forensics MH	5	104.8%	120.0%	119.6%	132.5%
Lark	Forensics	Forensics MH	17	107.0%	89.7%	103.5%	91.5%
Linnet Ward	Forensics	Forensics MH	17	87.1%	105.4%	103.9%	93.7%
Mallard Ward	Forensics	Forensics MH	14	113.2%	101.0%	115.2%	169.6%
Mandarin	Forensics	Forensics MH	16	101.9%	155.4%	110.1%	172.6%
Merlin	Forensics	Forensics MH	10	131.1%	144.8%	99.3%	210.4%
Newtondale Ward	Forensics	Forensics MH	20	101.2%	93.6%	95.3%	95.4%
Nightingale Ward	Forensics	Forensics MH	16	100.3%	97.7%	103.2%	100.4%

Sandpiper Ward	Forensics	Forensics MH	8	102.9%	109.2%	96.0%	131.7%
Swift Ward	Forensics	Forensics MH	10	97.1%	92.6%	100.3%	93.7%
Aysgarth	Teesside	LD	6	94.0%	101.1%	99.9%	100.5%
Bankfields Court Flats	Teesside	LD	6	111.6%	82.3%	142.9%	94.1%
Bankfields Court Unit 2	Teesside	LD	5	111.6%	110.8%	84.3%	135.5%
Bankfields Court Unit 3	Teesside	LD	6	85.1%	87.1%	91.7%	95.1%
Bankfields Court Unit 4	Teesside	LD	6	94.9%	99.2%	116.7%	90.4%
Bek-Ramsey Ward	Durham & Darlington	LD	11	166.0%	106.3%	106.5%	100.0%
Oak Rise	York and Selby	LD	8	103.6%	101.2%	103.7%	103.2%
The Lodge	Teesside	LD	1	74.6%	64.9%	95.8%	76.8%
Acomb Garth	York and Selby	MHSOP	14	75.8%	218.7%	98.4%	292.1%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	97.1%	133.0%	100.0%	112.9%
Cherry Tree House	York and Selby	MHSOP	18	133.4%	111.3%	89.9%	172.1%
Hamsterley Ward	Durham & Darlington	MHSOP	15	95.7%	125.9%	100.3%	129.0%
Meadowfields	York and Selby	MHSOP	14	85.4%	138.7%	100.5%	232.4%
Oak Ward	Durham & Darlington	MHSOP	12	84.5%	112.6%	110.3%	111.4%
Roseberry Wards	Durham & Darlington	MHSOP	15	99.8%	99.7%	100.0%	108.0%
Rowan Lea	North Yorkshire	MHSOP	20	80.8%	128.1%	100.0%	126.7%
Rowan Ward	North Yorkshire	MHSOP	6	87.2%	128.2%	99.7%	141.2%
Springwood Community Unit	North Yorkshire	MHSOP	14	90.1%	122.4%	100.6%	202.1%
Ward 14	North Yorkshire	MHSOP	10	97.3%	105.8%	100.0%	100.0%
Westerdale North	Teesside	MHSOP	18	109.6%	127.6%	109.7%	143.5%
Westerdale South	Teesside	MHSOP	14	99.6%	263.6%	89.8%	355.7%
Harland Rehab Ward	Durham & Darlington	Rehab	1	100.0%	95.8%	99.7%	96.8%
Kiltonview	Teesside	Day Unit	0	78.2%	73.5%		
The Orchard	Teesside	Day Unit	0	86.4%	93.9%		

Thornaby Road	Teesside	Day Unit	5	**112.9%**	**161.6%**		**101.3%**

APPENDIX 2

Scored Fill Rate compared to Quality Indicators - May 2018				Agency Usage Vs Actual Hours			Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers	Total Actual Hours	Total Agency Hours	% Against actual Hours	Total Actual Hours	Total Bank Hours	% Against actual Hours	SI's	L4 Incidents	L3 Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	2712.5	188.00	6.9%	2712.5	142	5.2%			1		1	5	1	9	10
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2697.0	194.00	7.2%	2697.0	518	19.2%					1	8		13	13
Bedale Ward	Teesside	Adults	10	5218.8	536.50	10.3%	5218.8	1083.25	20.8%					1	18		39	39
Bilsdale Ward	Teesside	Adults	14	3081.1	46.00	1.5%	3081.1	80.5	2.6%					1	5		8	8
Birch Ward	Durham & Darlington	Adults	15	3243.5	24.00	0.7%	3243.5	726.63	22.4%						3		6	6
Bransdale Ward	Teesside	Adults	14	2996.8	124.50	4.2%	2996.8	312.25	10.4%						4		8	8
Cedar Ward	Durham & Darlington	Adults	10	4427.1	24.00	0.5%	4427.1	752.34	17.0%			3		1	52	3	81	84
Cedar Ward (NY)	North Yorkshire	Adults	14	3596.6	1341.83	37.3%	3596.6	221.25	6.2%					1	5		8	8
Ebor Ward	York and Selby	Adults	12	2701.3	80.50	3.0%	2701.3	297.5	11.0%					1	5		6	6
Elm Ward	Durham & Darlington	Adults	20	3871.3	556.00	14.4%	3871.3	1277.2	33.0%				1	2	16	1	18	19
Farnham Ward	Durham & Darlington	Adults	20	2867.6	132.00	4.6%	2867.6	157.34	5.5%					1	2		3	3
Kirkdale Ward	Teesside	Adults	16	3199.0	0.00	0.0%	3199.0	528.75	16.5%			1						
Lustrum Vale	Teesside	Adults	20	2998.2	34.50	1.2%	2998.2	110.17	3.7%									
Maple Ward	Durham & Darlington	Adults	20	2852.6	12.00	0.4%	2852.6	641	22.5%					1				
Minster Ward	York and Selby	Adults	12	3035.3	218.50	7.2%	3035.3	207	6.8%						4		8	8
Overdale Ward	Teesside	Adults	18	2920.5	11.50	0.4%	2920.5	11.5	0.4%					2	2		3	3
Primrose Lodge	Durham & Darlington	Adults	15	2774.6	3.92	0.1%	2774.6	415	15.0%									
Stockdale Ward	Teesside	Adults	18	3022.8	80.50	2.7%	3022.8	92	3.0%			1		2	5		6	6
The Orchards (NY)	North Yorkshire	Adults	10	2254.5	0.00	0.0%	2254.5	84	3.7%									

Tunstall Ward	Durham & Darlington	Adults	20	3103.8	154.67	5.0%	3103.8	100	3.2%					4	3		3	3
Ward 15 Friarage	North Yorkshire	Adults	12	2810.5	211.25	7.5%	2810.5	900.75	32.0%			1						
Willow Ward	Durham & Darlington	Adults	15	3026.1	24.00	0.8%	3026.1	404.5	13.4%					1	1	1	0	1
Baysdale	Teesside	CYPS	6	2424.4	0.00	0.0%	2424.4	208.47	8.6%									
Holly Unit	Durham & Darlington	CYPS	4	1586.8	0.00	0.0%	1586.8	155.17	9.8%									
Newberry Centre	Teesside	CYPS	14	4696.6	114.67	2.4%	4696.6	503	10.7%					2	133	1	169	170
The Evergreen Centre	Teesside	CYPS	16	5547.0	248.00	4.5%	5547.0	457.75	8.3%						235	17	334	351
Westwood Centre	Teesside	CYPS	12	5745.5	0.00	0.0%	5745.5	161	2.8%						50	2	85	87
Clover/Ivy	Forensics	Forensics LD	12	4770.2	113.50	2.4%	4770.2	1902.19	39.9%						40	1	82	83
FLD Eagle ASD	Forensics	Forensic LD	1	1614.9	112.50	7.0%	1614.9	257.17	15.9%						2		2	2
Harrier/Hawk	Forensics	Forensics LD	10	4572.0	0.00	0.0%	4572.0	1253.73	27.4%					3	2		2	2
Kestrel/Kite.	Forensics	Forensics LD	16	4498.0	0.00	0.0%	4498.0	1128	25.1%				1		1		1	1
Langley Ward	Forensics	Forensics LD	10	2134.3	22.50	1.1%	2134.3	443	20.8%									
Northdale Centre	Forensics	Forensics LD	12	4910.3	135.50	2.8%	4910.3	1433.5	29.2%						8		11	11
Oakwood	Forensics	Forensics LD	8	1989.6	0.00	0.0%	1989.6	302.75	15.2%									
Thistle	Forensics	Forensics LD	5	2889.3	0.00	0.0%	2889.3	248.25	8.6%			1			2		4	4
Brambling Ward	Forensics	Forensics MH	13	2737.4	0.00	0.0%	2737.4	256.75	9.4%						7		10	10
Jay Ward	Forensics	Forensics MH	5	3431.0	0.00	0.0%	3431.0	749.75	21.9%						6		9	9
Lark	Forensics	Forensics MH	17	2794.4	0.00	0.0%	2794.4	357.75	12.8%					1				
Linnet Ward	Forensics	Forensics MH	17	2838.1	0.00	0.0%	2838.1	205.75	7.2%						3		3	3
Mallard Ward	Forensics	Forensics MH	14	3849.0	0.00	0.0%	3849.0	1562.5	40.6%					2	1		1	1
Mandarin	Forensics	Forensics MH	16	3979.2	0.00	0.0%	3979.2	1488.2	37.4%						13		15	15
Merlin	Forensics	Forensics MH	10	5161.4	0.00	0.0%	5161.4	1579.5	30.6%				1	1	7		12	12
Newtondale Ward	Forensics	Forensics MH	20	3695.0	0.00	0.0%	3695.0	513.5	13.9%					2				
Nightingale Ward	Forensics	Forensics MH	16	2894.2	0.00	0.0%	2894.2	373.2	12.9%									
Sandpiper Ward	Forensics	Forensics MH	8	4239.5	0.00	0.0%	4239.5	494.75	11.7%						66	3	129	132
Swift Ward	Forensics	Forensics MH	10	3048.5	0.00	0.0%	3048.5	191.25	6.3%									

Aysgarth	Teesside	LD	6	2320.7	0.00	0.0%	2320.7	335.57	14.5%						1		1	1
Bankfields Court Flats	Teesside	LD	6	2084.3	0.00	0.0%	2084.3	48	2.3%									
Bankfields Court Unit 2	Teesside	LD	5	2635.3	0.00	0.0%	2635.3	409.99	15.6%									
Bankfields Court Unit 3	Teesside	LD	6	2192.7	0.00	0.0%	2192.7	107.67	4.9%						9		15	15
Bankfields Court Unit 4	Teesside	LD	6	2160.2	0.00	0.0%	2160.2	51	2.4%									
Bek-Ramsey Ward	Durham & Darlington	LD	11	4218.5	96.00	2.3%	4218.5	277	6.6%						26	5	38	43
Harland Rehab Ward	Durham & Darlington	LD	1	2175.3	72.00	3.3%	2175.3	300.5	13.8%									
Oak Rise	York and Selby	LD	8	3769.3	281.67	7.5%	3769.3	728.16	19.3%						2		2	2
The Lodge	Teesside	LD	1	1461.8	0.00	0.0%	1461.8	36	2.5%						1		2	2
Acomb Garth	York and Selby	MHSOP	14	6055.1	3080.50	50.9%	6055.1	528.8	8.7%						19		23	23
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	3516.6	24.00	0.7%	3516.6	315.25	9.0%						4		6	6
Cherry Tree House	York and Selby	MHSOP	18	3607.0	731.50	20.3%	3607.0	463	12.8%									
Hamsterley Ward	Durham & Darlington	MHSOP	15	3416.3	60.00	1.8%	3416.3	750.42	22.0%						2		2	2
Meadowfields	York and Selby	MHSOP	14	4250.9	1532.75	36.1%	4250.9	445	10.5%						2		2	2
Oak Ward	Durham & Darlington	MHSOP	12	2848.2	74.67	2.6%	2848.2	441.5	15.5%						1		1	1
Roseberry Wards	Durham & Darlington	MHSOP	15	2816.8	24.00	0.9%	2816.8	228	8.1%					1				
Rowan Lea	North Yorkshire	MHSOP	20	4144.6	494.50	11.9%	4144.6	684.49	16.5%					2	16		26	26
Rowan Ward	North Yorkshire	MHSOP	6	3189.0	618.50	19.4%	3189.0	500.25	15.7%	1	1				2		2	2
Springwood Community Unit	North Yorkshire	MHSOP	14	4017.7	518.00	12.9%	4017.7	505.25	12.6%						29		47	47
Ward 14	North Yorkshire	MHSOP	10	2623.8	0.00	0.0%	2623.8	33.75	1.3%									
Westerdale North	Teesside	MHSOP	18	3692.0	471.50	12.8%	3692.0	253	6.9%						14		21	21
Westerdale South	Teesside	MHSOP	14	7159.7	1007.00	14.1%	7159.7	2844	39.7%						22		22	22
Kilton View	Teesside	LD	0	1781.4	0.00	0.0%	1781.4	262.5	14.7%									
The Orchard	Teesside	LD	0	906.4	0.00	0.0%	906.4	104.17	11.5%									
Thornaby Road	Teesside	LD	5	2192.2	0.00	0.0%	2192.2	102.5	4.7%									

Severity Scoring by Total Score

APPENDIX 3

WARD	Locality	Speciality	Bed Numbers	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SI's	L4 Incidents	L3 Incidents	Complaints	Control & Restraint	TOTAL SCORE (May)
Cedar Ward	Durham & Darlington	Adults	10	4	1	1	1	1	0	0	3	0	2	**13**
Elm Ward	Durham & Darlington	Adults	20	2	2	1	1	2	0	0	0	1	1	**10**
The Evergreen Centre	Teesside	CYPS	16	2	2	1	1	0	0	0	0	0	2	**8**
Westerdale South	Teesside	MHSOP	14	2	2	0	1	2	0	0	0	0	1	**8**
Rowan Ward	North Yorkshire	MHSOP	6	2	2	0	1	1	1	1	0	0	0	**8**
Rowan Lea	North Yorkshire	MHSOP	20	2	2	1	1	1	0	0	0	0	1	**8**
Ward 15 Friarage	North Yorkshire	Adults	12	2	1	1	1	2	0	0	1	0	0	**8**
Bedale Ward	Teesside	Adults	10	2	2	0	1	1	0	0	0	0	1	**7**
Clover/Ivy	Forensics	Forensics LD	12	0	2	0	1	2	0	0	0	0	2	**7**
Merlin	Forensics	Forensics MH	10	0	3	1	0	2	0	0	0	1	0	**7**
Acomb Garth	York and Selby	MHSOP	14	2	2	1	1	0	0	0	0	0	1	**7**
Cherry Tree House	York and Selby	MHSOP	18	2	2	1	1	1	0	0	0	0	0	**7**
Westwood Centre	Teesside	CYPS	12	2	2	1	0	0	0	0	0	0	2	**7**
The Lodge	Teesside	LD	1	6	0	0	0	0	0	0	0	0	0	**6**
Mandarin	Forensics	Forensics MH	16	0	2	1	0	2	0	0	0	0	1	**6**
Newberry Centre	Teesside	CYPS	14	0	3	0	1	0	0	0	0	0	2	**6**
The Orchards (NY)	North Yorkshire	Adults	10	4	2	0	0	0	0	0	0	0	0	**6**
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2	1	1	1	1	0	0	0	0	0	**6**
Meadowfields	York and Selby	MHSOP	14	2	2	1	1	0	0	0	0	0	0	**6**
Springwood Community Unit	North Yorkshire	MHSOP	14	0	2	1	1	1	0	0	0	0	1	**6**
Northdale Centre	Forensics	Forensics LD	12	0	2	1	1	2	0	0	0	0	0	**6**
FLD Eagle ASD	Forensics	Forensics LD	1	2	1	1	1	1	0	0	0	0	0	**6**
Primrose Lodge	Durham & Darlington	Adults	15	2	1	1	1	1	0	0	0	0	0	**6**
Birch Ward	Durham & Darlington	Adults	15	2	0	1	1	1	0	0	0	0	0	**5**
Hamsterley Ward	Durham & Darlington	MHSOP	15	0	2	1	1	1	0	0	0	0	0	**5**
Sandpiper Ward	Forensics	Forensics MH	8	0	1	1	0	1	0	0	0	0	2	**5**
Minster Ward	York and Selby	Adults	12	4	0	0	1	0	0	0	0	0	0	**5**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	2	0	1	1	0	0	0	1	0	0	**5**

Harrier/Hawk	Forensics	Forensics LD	10	0	2	1	0	2	0	0	0	0	0	**5**
Kestrel/Kite.	Forensics	Forensics LD	16	0	1	1	0	2	0	0	0	1	0	**5**
Bransdale Ward	Teesside	Adults	14	0	3	1	1	0	0	0	0	0	0	**5**
Bankfields Court Unit 2	Teesside	LD	5	2	1	1	0	1	0	0	0	0	0	**5**
Oak Ward	Durham & Darlington	MHSOP	12	2	0	1	1	1	0	0	0	0	0	**5**
Bankfields Court Unit 3	Teesside	LD	6	4	0	1	0	0	0	0	0	0	0	**5**
Kiltonview	Teesside	Day Unit	0	4	0	0	0	1	0	0	0	0	0	**5**
Willow Ward	Durham & Darlington	Adults	15	0	1	1	1	1	0	0	0	0	0	**4**
Holly Unit	Durham & Darlington	CYPS	4	0	4	0	0	0	0	0	0	0	0	**4**
Maple Ward	Durham & Darlington	Adults	20	0	1	1	1	1	0	0	0	0	0	**4**
Westerdale North	Teesside	MHSOP	18	0	2	0	1	0	0	0	0	0	1	**4**
Mallard Ward	Forensics	Forensics MH	14	0	1	1	0	2	0	0	0	0	0	**4**
Kirkdale Ward	Teesside	Adults	16	2	0	0	0	1	0	0	1	0	0	**4**
Jay Ward	Forensics	Forensics MH	5	0	2	1	0	1	0	0	0	0	0	**4**
Langley Ward	Forensics	Forensics LD	10	2	0	0	1	1	0	0	0	0	0	**4**
Bankfields Court Flats	Teesside	LD	6	2	1	1	0	0	0	0	0	0	0	**4**
Ebor Ward	York and Selby	Adults	12	2	0	0	1	1	0	0	0	0	0	**4**
Lark	Forensics	Forensics MH	17	2	0	1	0	1	0	0	0	0	0	**4**
Thistle	Forensics	Forensics LD	5	2	0	1	0	0	0	0	1	0	0	**4**
Cedar Ward (NY)	North Yorkshire	Adults	14	0	1	1	1	0	0	0	0	0	0	**3**
Bek-Ramsey Ward	Durham & Darlington	LD	11	0	1	0	1	0	0	0	0	0	1	**3**
Bilsdale Ward	Teesside	Adults	14	0	1	1	1	0	0	0	0	0	0	**3**
Linnet Ward	Forensics	Forensics MH	17	2	0	1	0	0	0	0	0	0	0	**3**
Brambling Ward	Forensics	Forensics MH	13	2	0	1	0	0	0	0	0	0	0	**3**
The Orchard	Teesside	Day Unit	0	2	0	0	0	1	0	0	0	0	0	**3**
Harland Rehab Ward	Durham & Darlington	Rehab	1	0	0	0	1	1	0	0	0	0	0	**2**
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	0	1	0	1	0	0	0	0	0	0	**2**
Oakwood	Forensics	Forensics LD	8	0	1	0	0	1	0	0	0	0	0	**2**
Stockdale Ward	Teesside	Adults	18	0	0	0	1	0	0	0	1	0	0	**2**
Nightingale Ward	Forensics	Forensics MH	16	0	0	1	0	1	0	0	0	0	0	**2**
Oak Rise	York and Selby	LD	8	0	0	0	1	1	0	0	0	0	0	**2**
Farnham Ward	Durham & Darlington	Adults	20	0	0	1	1	0	0	0	0	0	0	**2**
Thornaby Road	Teesside	Day Unit	5	0	1	1	0	0	0	0	0	0	0	**2**
Tunstall Ward	Durham & Darlington	Adults	20	0	0	1	1	0	0	0	0	0	0	**2**
Newtondale Ward	Forensics	Forensics MH	20	0	0	0	0	1	0	0	0	0	0	**1**

Bankfields Court Unit 4	Teesside	LD	6	0	0	1	0	0	0	0	0	0	0	**1**
Overdale Ward	Teesside	Adults	18	0	0	0	1	0	0	0	0	0	0	**1**
Ward 14	North Yorkshire	MHSOP	10	0	0	1	0	0	0	0	0	0	0	**1**
Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	0	1	0	0	0	0	0	0	**1**
Aysgarth	Teesside	LD	6	0	0	0	0	1	0	0	0	0	0	**1**
Baysdale	Teesside	CYPS	6	0	0	1	0	0	0	0	0	0	0	**1**
Lustrum Vale	Teesside	Adults	20	0	0	0	1	0	0	0	0	0	0	**1**
Swift Ward	Forensics	Forensics MH	10	0	0	1	0	0	0	0	0	0	0	**1**

Severity Scoring by Speciality

APPENDIX 4

WARD	Locality	Speciality	Bed Numbers	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SI's	L4 Incidents	L3 Incidents	Complaints	Control & Restraint	TOTAL SCORE (May)
Cedar Ward	Durham & Darlington	Adults	10	4	1	1	1	1	0	0	3	0	2	**13**
Elm Ward	Durham & Darlington	Adults	20	2	2	1	1	2	0	0	0	1	1	**10**
Ward 15 Friarage	North Yorkshire	Adults	12	2	1	1	1	2	0	0	1	0	0	**8**
Bedale Ward	Teesside	Adults	10	2	2	0	1	1	0	0	0	0	1	**7**
The Orchards (NY)	North Yorkshire	Adults	10	4	2	0	0	0	0	0	0	0	0	**6**
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2	1	1	1	1	0	0	0	0	0	**6**
Primrose Lodge	Durham & Darlington	Adults	15	2	1	1	1	1	0	0	0	0	0	**6**
Birch Ward	Durham & Darlington	Adults	15	2	0	1	1	1	0	0	0	0	0	**5**
Minster Ward	York and Selby	Adults	12	4	0	0	1	0	0	0	0	0	0	**5**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	2	0	1	1	0	0	0	1	0	0	**5**
Bransdale Ward	Teesside	Adults	14	0	3	1	1	0	0	0	0	0	0	**5**
Willow Ward	Durham & Darlington	Adults	15	0	1	1	1	1	0	0	0	0	0	**4**
Maple Ward	Durham & Darlington	Adults	20	0	1	1	1	1	0	0	0	0	0	**4**
Kirkdale Ward	Teesside	Adults	16	2	0	0	0	1	0	0	1	0	0	**4**
Ebor Ward	York and Selby	Adults	12	2	0	0	1	1	0	0	0	0	0	**4**
Cedar Ward (NY)	North Yorkshire	Adults	14	0	1	1	1	0	0	0	0	0	0	**3**
Bilsdale Ward	Teesside	Adults	14	0	1	1	1	0	0	0	0	0	0	**3**
Stockdale Ward	Teesside	Adults	18	0	0	0	1	0	0	0	1	0	0	**2**
Farnham Ward	Durham & Darlington	Adults	20	0	0	1	1	0	0	0	0	0	0	**2**
Tunstall Ward	Durham & Darlington	Adults	20	0	0	1	1	0	0	0	0	0	0	**2**
Overdale Ward	Teesside	Adults	18	0	0	0	1	0	0	0	0	0	0	**1**
Lustrum Vale	Teesside	Adults	20	0	0	0	1	0	0	0	0	0	0	**1**
The Evergreen Centre	Teesside	CYPS	16	2	2	1	1	0	0	0	0	0	2	**8**
Westwood Centre	Teesside	CYPS	12	2	2	1	0	0	0	0	0	0	2	**7**
Newberry Centre	Teesside	CYPS	14	0	3	0	1	0	0	0	0	0	2	**6**
Holly Unit	Durham & Darlington	CYPS	4	0	4	0	0	0	0	0	0	0	0	**4**

Baysdale	Teesside	CYPS	6	0	0	1	0	0	0	0	0	0	0	**1**
Kiltonview	Teesside	Day Unit	0	4	0	0	0	1	0	0	0	0	0	**5**
The Orchard	Teesside	Day Unit	0	2	0	0	0	1	0	0	0	0	0	**3**
Thornaby Road	Teesside	Day Unit	5	0	1	1	0	0	0	0	0	0	0	**2**
Clover/Ivy	Forensics	Forensics LD	12	0	2	0	1	2	0	0	0	0	2	**7**
Northdale Centre	Forensics	Forensics LD	12	0	2	1	1	2	0	0	0	0	0	**6**
FLD Eagle ASD	Forensics	Forensics LD	1	2	1	1	1	1	0	0	0	0	0	**6**
Harrier/Hawk	Forensics	Forensics LD	10	0	2	1	0	2	0	0	0	0	0	**5**
Kestrel/Kite.	Forensics	Forensics LD	16	0	1	1	0	2	0	0	0	1	0	**5**
Langley Ward	Forensics	Forensics LD	10	2	0	0	1	1	0	0	0	0	0	**4**
Thistle	Forensics	Forensics LD	5	2	0	1	0	0	0	0	1	0	0	**4**
Oakwood	Forensics	Forensics LD	8	0	1	0	0	1	0	0	0	0	0	**2**
Merlin	Forensics	Forensics MH	10	0	3	1	0	2	0	0	0	1	0	**7**
Mandarin	Forensics	Forensics MH	16	0	2	1	0	2	0	0	0	0	1	**6**
Sandpiper Ward	Forensics	Forensics MH	8	0	1	1	0	1	0	0	0	0	2	**5**
Mallard Ward	Forensics	Forensics MH	14	0	1	1	0	2	0	0	0	0	0	**4**
Jay Ward	Forensics	Forensics MH	5	0	2	1	0	1	0	0	0	0	0	**4**
Lark	Forensics	Forensics MH	17	2	0	1	0	1	0	0	0	0	0	**4**
Linnet Ward	Forensics	Forensics MH	17	2	0	1	0	0	0	0	0	0	0	**3**
Brambling Ward	Forensics	Forensics MH	13	2	0	1	0	0	0	0	0	0	0	**3**
Nightingale Ward	Forensics	Forensics MH	16	0	0	1	0	1	0	0	0	0	0	**2**
Newtondale Ward	Forensics	Forensics MH	20	0	0	0	0	1	0	0	0	0	0	**1**
Swift Ward	Forensics	Forensics MH	10	0	0	1	0	0	0	0	0	0	0	**1**
The Lodge	Teesside	LD	1	6	0	0	0	0	0	0	0	0	0	**6**
Bankfields Court Unit 2	Teesside	LD	5	2	1	1	0	1	0	0	0	0	0	**5**
Bankfields Court Unit 3	Teesside	LD	6	4	0	1	0	0	0	0	0	0	0	**5**
Bankfields Court Flats	Teesside	LD	6	2	1	1	0	0	0	0	0	0	0	**4**
Bek-Ramsey Ward	Durham & Darlington	LD	11	0	1	0	1	0	0	0	0	0	1	**3**
Oak Rise	York and Selby	LD	8	0	0	0	1	1	0	0	0	0	0	**2**
Bankfields Court Unit 4	Teesside	LD	6	0	0	1	0	0	0	0	0	0	0	**1**
Aysgarth	Teesside	LD	6	0	0	0	0	1	0	0	0	0	0	**1**
Westerdale South	Teesside	MHSOP	14	2	2	0	1	2	0	0	0	0	1	**8**
Rowan Ward	North Yorkshire	MHSOP	6	2	2	0	1	1	1	1	0	0	0	**8**
Rowan Lea	North Yorkshire	MHSOP	20	2	2	1	1	1	0	0	0	0	1	**8**
Acomb Garth	York and Selby	MHSOP	14	2	2	1	1	0	0	0	0	0	1	**7**

Cherry Tree House	York and Selby	MHSOP	18	2	2	1	1	1	0	0	0	0	0	**7**
Meadowfields	York and Selby	MHSOP	14	2	2	1	1	0	0	0	0	0	0	**6**
Springwood Community Unit	North Yorkshire	MHSOP	14	0	2	1	1	1	0	0	0	0	1	**6**
Hamsterley Ward	Durham & Darlington	MHSOP	15	0	2	1	1	1	0	0	0	0	0	**5**
Oak Ward	Durham & Darlington	MHSOP	12	2	0	1	1	1	0	0	0	0	0	**5**
Westerdale North	Teesside	MHSOP	18	0	2	0	1	0	0	0	0	0	1	**4**
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	0	1	0	1	0	0	0	0	0	0	**2**
Ward 14	North Yorkshire	MHSOP	10	0	0	1	0	0	0	0	0	0	0	**1**
Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	0	1	0	0	0	0	0	0	**1**
Harland Rehab Ward	Durham & Darlington	Rehab	1	0	0	0	1	1	0	0	0	0	0	**2**

Severity Scoring Year to Date Position

APPENDIX 5

WARD	Locality	Speciality	Bed Numbers	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SI	L4 Incidents	L3 Incidents	Complaints	Control & Restraint	YTD Total Score (May - May)
Cedar Ward	Durham & Darlington	Adults	10	4	1	1	1	1	0	0	3	0	2	**93**
Westerdale South	Teesside	MHSOP	14	2	2	0	1	2	0	0	0	0	1	**89**
Clover/Ivy	Forensics	Forensics LD	12	0	2	0	1	2	0	0	0	0	2	**88**
Bedale Ward	Teesside	Adults	10	2	2	0	1	1	0	0	0	0	1	**83**
The Evergreen Centre	Teesside	CYPS	16	2	2	1	1	0	0	0	0	0	2	**82**
Newberry Centre	Teesside	CYPS	14	0	3	0	1	0	0	0	0	0	2	**82**
Mandarin	Forensics	Forensics MH	16	0	2	1	0	2	0	0	0	0	1	**78**
Springwood Community Unit	North Yorkshire	MHSOP	14	0	2	1	1	1	0	0	0	0	1	**77**
Sandpiper Ward	Forensics	Forensics MH	8	0	1	1	0	1	0	0	0	0	2	**74**
Elm Ward	Durham & Darlington	Adults	20	2	2	1	1	2	0	0	0	1	1	**72**
Northdale Centre	Forensics	Forensics LD	12	0	2	1	1	2	0	0	0	0	0	**71**
Ward 15 Friarage	North Yorkshire	Adults	12	2	1	1	1	2	0	0	1	0	0	**70**
Talbot Direct Care	Durham & Darlington	CYPS	0	0	0	0	0	0	0	0	0	0	0	**69**
The Lodge	Teesside	LD	1	6	0	0	0	0	0	0	0	0	0	**69**
Merlin	Forensics	Forensics MH	10	0	3	1	0	2	0	0	0	1	0	**68**
Maple Ward	Durham & Darlington	Adults	20	0	1	1	1	1	0	0	0	0	0	**66**
Meadowfields	York and Selby	MHSOP	14	2	2	1	1	0	0	0	0	0	0	**66**
Westwood Centre	Teesside	CYPS	12	2	2	1	0	0	0	0	0	0	2	**65**
Birch Ward	Durham & Darlington	Adults	15	2	0	1	1	1	0	0	0	0	0	**64**
Acomb Garth	York and Selby	MHSOP	14	2	2	1	1	0	0	0	0	0	1	**63**
Bransdale Ward	Teesside	Adults	14	0	3	1	1	0	0	0	0	0	0	**61**
Cherry Tree House	York and Selby	MHSOP	18	2	2	1	1	1	0	0	0	0	0	**61**
Hamsterley Ward	Durham & Darlington	MHSOP	15	0	2	1	1	1	0	0	0	0	0	**61**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	2	0	1	1	0	0	0	1	0	0	**60**
Kestrel/Kite.	Forensics	Forensics LD	16	0	1	1	0	2	0	0	0	1	0	**57**
Rowan Ward	North Yorkshire	MHSOP	6	2	2	0	1	1	1	1	0	0	0	**56**

Holly Unit	Durham & Darlington	CYPS	4	0	4	0	0	0	0	0	0	0	0	**55**
Eagle/Osprey	Forensics	Forensics LD	0	0	0	0	0	0	0	0	0	0	0	**55**
The Orchards (NY)	North Yorkshire	Adults	10	4	2	0	0	0	0	0	0	0	0	**52**
Harrier/Hawk	Forensics	Forensics LD	10	0	2	1	0	2	0	0	0	0	0	**52**
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2	1	1	1	1	0	0	0	0	0	**51**
Ebor Ward	York and Selby	Adults	12	2	0	0	1	1	0	0	0	0	0	**51**
Bankfields Court Flats	Teesside	LD	6	2	1	1	0	0	0	0	0	0	0	**51**
Oak Rise	York and Selby	LD	8	0	0	0	1	1	0	0	0	0	0	**50**
Lustrum Vale	Teesside	Adults	20	0	0	0	1	0	0	0	0	0	0	**49**
Langley Ward	Forensics	Forensics LD	10	2	0	0	1	1	0	0	0	0	0	**49**
Cedar Ward (NY)	North Yorkshire	Adults	14	0	1	1	1	0	0	0	0	0	0	**48**
Mallard Ward	Forensics	Forensics MH	14	0	1	1	0	2	0	0	0	0	0	**47**
Brambling Ward	Forensics	Forensics MH	13	2	0	1	0	0	0	0	0	0	0	**47**
Newtondale Ward	Forensics	Forensics MH	20	0	0	0	0	1	0	0	0	0	0	**47**
Bilsdale Ward	Teesside	Adults	14	0	1	1	1	0	0	0	0	0	0	**46**
Kirkdale Ward	Teesside	Adults	16	2	0	0	0	1	0	0	1	0	0	**45**
Oakwood	Forensics	Forensics LD	8	0	1	0	0	1	0	0	0	0	0	**44**
Swift Ward	Forensics	Forensics MH	10	0	0	1	0	0	0	0	0	0	0	**44**
Stockdale Ward	Teesside	Adults	18	0	0	0	1	0	0	0	1	0	0	**43**
Lark	Forensics	Forensics MH	17	2	0	1	0	1	0	0	0	0	0	**43**
Nightingale Ward	Forensics	Forensics MH	16	0	0	1	0	1	0	0	0	0	0	**43**
Bankfields Court Unit 4	Teesside	LD	6	0	0	1	0	0	0	0	0	0	0	**43**
Primrose Lodge	Durham & Darlington	Adults	15	2	1	1	1	1	0	0	0	0	0	**42**
Minster Ward	York and Selby	Adults	12	4	0	0	1	0	0	0	0	0	0	**41**
Willow Ward	Durham & Darlington	Adults	15	0	1	1	1	1	0	0	0	0	0	**41**
Overdale Ward	Teesside	Adults	18	0	0	0	1	0	0	0	0	0	0	**40**
Jay Ward	Forensics	Forensics MH	5	0	2	1	0	1	0	0	0	0	0	**38**
Thistle	Forensics	Forensics LD	5	2	0	1	0	0	0	0	1	0	0	**37**
Linnet Ward	Forensics	Forensics MH	17	2	0	1	0	0	0	0	0	0	0	**37**
Rowan Lea	North Yorkshire	MHSOP	20	2	2	1	1	1	0	0	0	0	1	**36**
Bankfields Court Unit 3	Teesside	LD	6	4	0	1	0	0	0	0	0	0	0	**33**
Bek-Ramsey Ward	Durham & Darlington	LD	11	0	1	0	1	0	0	0	0	0	1	**33**
Westerdale North	Teesside	MHSOP	18	0	2	0	1	0	0	0	0	0	1	**33**
Bankfields Court Unit 2	Teesside	LD	5	2	1	1	0	1	0	0	0	0	0	**32**
Aysgarth	Teesside	LD	6	0	0	0	0	1	0	0	0	0	0	**26**

Ceddesfeld Ward	Durham & Darlington	MHSOP	15	0	1	0	1	0	0	0	0	0	0	**26**
Farnham Ward	Durham & Darlington	Adults	20	0	0	1	1	0	0	0	0	0	0	**24**
Tunstall Ward	Durham & Darlington	Adults	20	0	0	1	1	0	0	0	0	0	0	**24**
Ward 14	North Yorkshire	MHSOP	10	0	0	1	0	0	0	0	0	0	0	**24**
Oak Ward	Durham & Darlington	MHSOP	12	2	0	1	1	1	0	0	0	0	0	**21**
Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	0	1	0	0	0	0	0	0	**20**
The Orchard	Teesside	Day Unit	0	2	0	0	0	1	0	0	0	0	0	**19**
Kiltonview	Teesside	Day Unit	0	4	0	0	0	1	0	0	0	0	0	**18**
Harland Rehab Ward	Durham & Darlington	Rehab	1	0	0	0	1	1	0	0	0	0	0	**14**
Baysdale	Teesside	CYPS	6	0	0	1	0	0	0	0	0	0	0	**13**
FLD Eagle ASD	Forensics	Forensics LD	1	2	1	1	1	1	0	0	0	0	0	**8**
Thornaby Road	Teesside	Day Unit	5	0	1	1	0	0	0	0	0	0	0	**4**

Care Hours per Patient Day – May

Appendix 6

CARE HOURS PER PATIENT DAY TRUSTWIDE ACROSS 31 DAYS IN May							
				CARE HOURS PER PATIENT DAY (CHPPD)			
WARD	**Locality**	**Speciality**	**Bed Numbers**	**Cumulative Count over the month of patients at 23:59 each day**	**Registered Nurses**	**Care Staff**	**Overall**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	**341**	**3.6**	**4.4**	**8.0**
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	**319**	**2.9**	**5.6**	**8.5**
Bedale Ward	Teesside	Adults	10	**187**	**9.2**	**18.7**	**27.9**
Bilsdale Ward	Teesside	Adults	14	**549**	**2.4**	**3.2**	**5.6**
Birch Ward	Durham & Darlington	Adults	15	**402**	**3.3**	**4.8**	**8.1**
Bransdale Ward	Teesside	Adults	14	**476**	**2.9**	**3.4**	**6.3**
Cedar Ward	Durham & Darlington	Adults	10	**283**	**7.7**	**7.9**	**15.6**
Cedar Ward (NY)	North Yorkshire	Adults	14	**423**	**3.6**	**4.9**	**8.5**
Ebor Ward	York and Selby	Adults	12	**380**	**3.2**	**3.9**	**7.1**
Elm Ward	Durham & Darlington	Adults	20	**563**	**2.1**	**4.7**	**6.9**
Farnham Ward	Durham & Darlington	Adults	20	**561**	**2.1**	**3.0**	**5.1**
Kirkdale Ward	Teesside	Adults	16	**466**	**2.4**	**4.4**	**6.9**
Lustrum Vale	Teesside	Adults	20	**572**	**2.6**	**2.6**	**5.2**
Maple Ward	Durham & Darlington	Adults	20	**533**	**2.2**	**3.1**	**5.4**
Minster Ward	York and Selby	Adults	12	**336**	**3.8**	**5.2**	**9.0**
Overdale Ward	Teesside	Adults	18	**443**	**3.0**	**3.6**	**6.6**
Primrose Lodge	Durham & Darlington	Adults	15	**402**	**2.7**	**4.2**	**6.9**
Stockdale Ward	Teesside	Adults	18	**540**	**2.6**	**3.0**	**5.6**
The Orchards (NY)	North Yorkshire	Adults	10	**221**	**5.7**	**4.5**	**10.2**

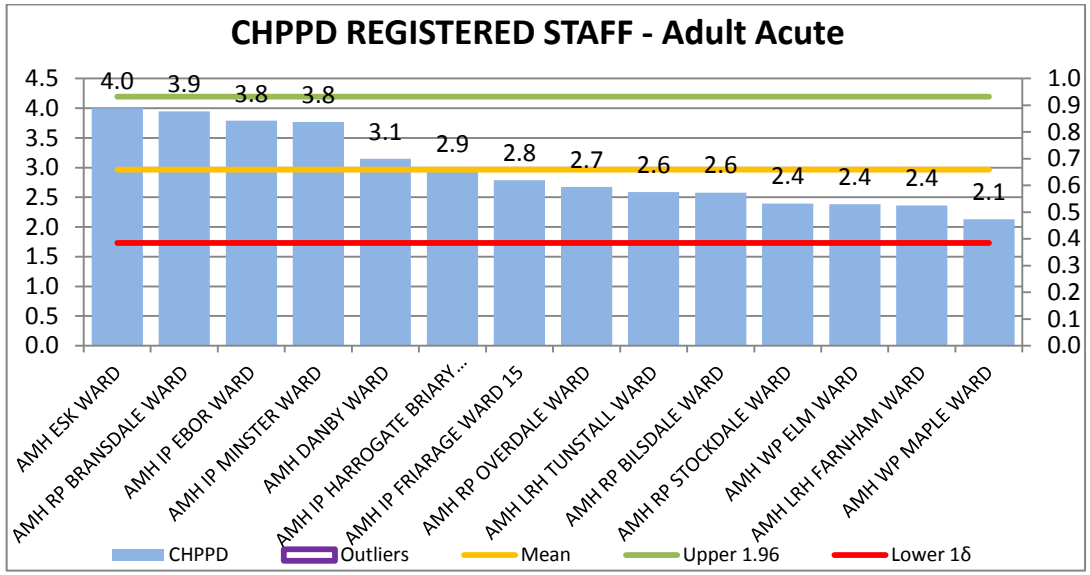
Tunstall Ward	Durham & Darlington	Adults	20	**587**	**2.4**	**2.9**	**5.3**
Ward 15 Friarage	North Yorkshire	Adults	12	**358**	**3.2**	**4.6**	**7.9**
Willow Ward	Durham & Darlington	Adults	15	**326**	**3.7**	**5.6**	**9.3**
Baysdale	Teesside	CYPS	6	**121**	**5.9**	**14.1**	**20.0**
Holly Unit	Durham & Darlington	CYPS	4	**64**	**9.9**	**14.9**	**24.8**
Newberry Centre	Teesside	CYPS	14	**330**	**6.5**	**7.7**	**14.2**
The Evergreen Centre	Teesside	CYPS	16	**448**	**5.7**	**6.7**	**12.4**
Westwood Centre	Teesside	CYPS	12	**289**	**7.6**	**12.3**	**19.9**
Clover/Ivy	Forensics	Forensics LD	12	**310**	**4.7**	**10.7**	**15.4**
FLD Eagle ASD	Forensics	Forensics LD	1	**31**	**23.4**	**28.7**	**52.1**
Harrier/Hawk	Forensics	Forensics LD	10	**305**	**4.3**	**10.7**	**15.0**
Kestrel/Kite.	Forensics	Forensics LD	16	**494**	**2.6**	**6.5**	**9.1**
Langley Ward	Forensics	Forensics LD	10	**151**	**6.6**	**7.5**	**14.1**
Northdale Centre	Forensics	Forensics LD	12	**403**	**3.9**	**8.3**	**12.2**
Oakwood	Forensics	Forensics LD	8	**248**	**4.7**	**3.3**	**8.0**
Thistle	Forensics	Forensics LD	5	**155**	**7.0**	**11.6**	**18.6**
Brambling Ward	Forensics	Forensics MH	13	**375**	**3.3**	**4.0**	**7.3**
Jay Ward	Forensics	Forensics MH	5	**145**	**9.1**	**14.6**	**23.7**
Lark	Forensics	Forensics MH	17	**525**	**2.4**	**2.9**	**5.3**
Linnet Ward	Forensics	Forensics MH	17	**527**	**2.1**	**3.3**	**5.4**
Mallard Ward	Forensics	Forensics MH	14	**403**	**3.4**	**6.1**	**9.6**
Mandarin	Forensics	Forensics MH	16	**441**	**2.9**	**6.1**	**9.0**
Merlin	Forensics	Forensics MH	10	**303**	**6.0**	**11.0**	**17.0**
Newtondale Ward	Forensics	Forensics MH	20	**619**	**2.5**	**3.5**	**6.0**
Nightingale Ward	Forensics	Forensics MH	16	**465**	**2.6**	**3.6**	**6.2**
Sandpiper Ward	Forensics	Forensics MH	8	**248**	**6.2**	**10.9**	**17.1**
Swift Ward	Forensics	Forensics MH	10	**310**	**3.9**	**6.0**	**9.8**
Aysgarth	Teesside	LD	6	**130**	**6.4**	**11.5**	**17.9**
Bankfields Court Flats	Teesside	LD	6	**93**	**6.8**	**15.6**	**22.4**
Bankfields Court Unit 2	Teesside	LD	5	**140**	**6.4**	**12.4**	**18.8**
Bankfields Court Unit 3	Teesside	LD	6	**71**	**7.4**	**23.5**	**30.9**

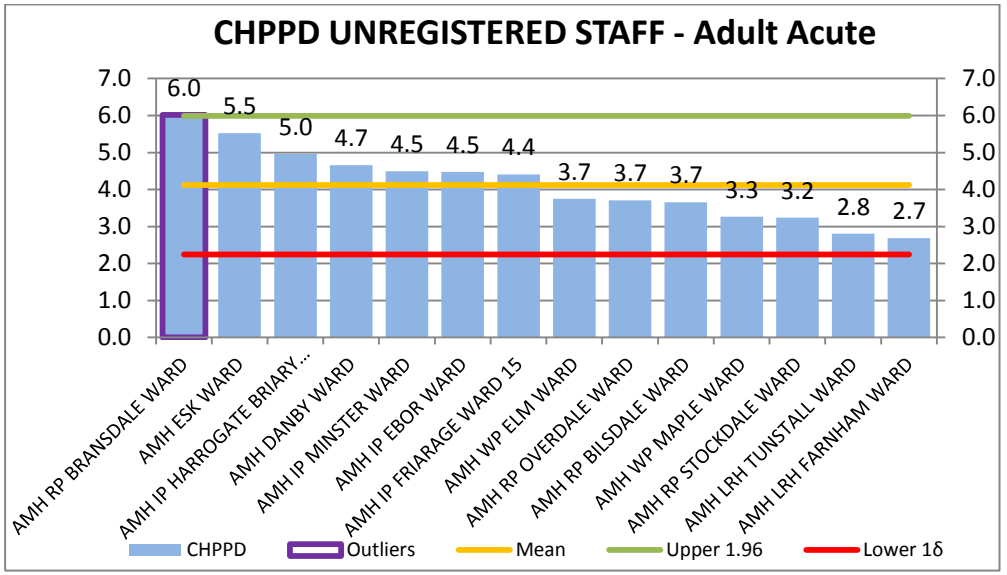
Bankfields Court Unit 4	Teesside	LD	6	**129**	**4.6**	**12.1**	**16.7**
Bek-Ramsey Ward	Durham & Darlington	LD	11	**165**	**7.0**	**18.5**	**25.6**
Oak Rise	York and Selby	LD	8	**126**	**9.2**	**20.8**	**29.9**
The Lodge	Teesside	LD	1	**31**	**22.4**	**24.7**	**47.2**
Acomb Garth	York and Selby	MHSOP	14	**420**	**3.9**	**10.5**	**14.4**
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	**426**	**2.9**	**5.3**	**8.3**
Cherry Tree House	York and Selby	MHSOP	18	**565**	**2.5**	**3.9**	**6.4**
Hamsterley Ward	Durham & Darlington	MHSOP	15	**270**	**4.4**	**8.3**	**12.7**
Meadowfields	York and Selby	MHSOP	14	**385**	**2.9**	**8.2**	**11.0**
Oak Ward	Durham & Darlington	MHSOP	12	**368**	**2.9**	**4.9**	**7.7**
Roseberry Wards	Durham & Darlington	MHSOP	15	**330**	**3.9**	**4.7**	**8.5**
Rowan Lea	North Yorkshire	MHSOP	20	**543**	**2.5**	**5.1**	**7.6**
Rowan Ward	North Yorkshire	MHSOP	6	**496**	**2.5**	**3.9**	**6.4**
Springwood Community Unit	North Yorkshire	MHSOP	14	**217**	**6.7**	**11.9**	**18.5**
Ward 14	North Yorkshire	MHSOP	10	**245**	**4.9**	**5.8**	**10.7**
Westerdale North	Teesside	MHSOP	18	**557**	**2.9**	**3.7**	**6.6**
Westerdale South	Teesside	MHSOP	14	**463**	**3.7**	**11.7**	**15.5**
Harland Rehab Ward	Durham & Darlington	Rehab	1	**31**	**24.0**	**46.2**	**70.2**
Thornaby Road	Teesside	Day Unit	5	**155**	**3.6**	**10.6**	**14.1**

Care Hours per Patient Day – Standard Deviation (May 2017- May 2018)

Appendix 7

Adult Acute:





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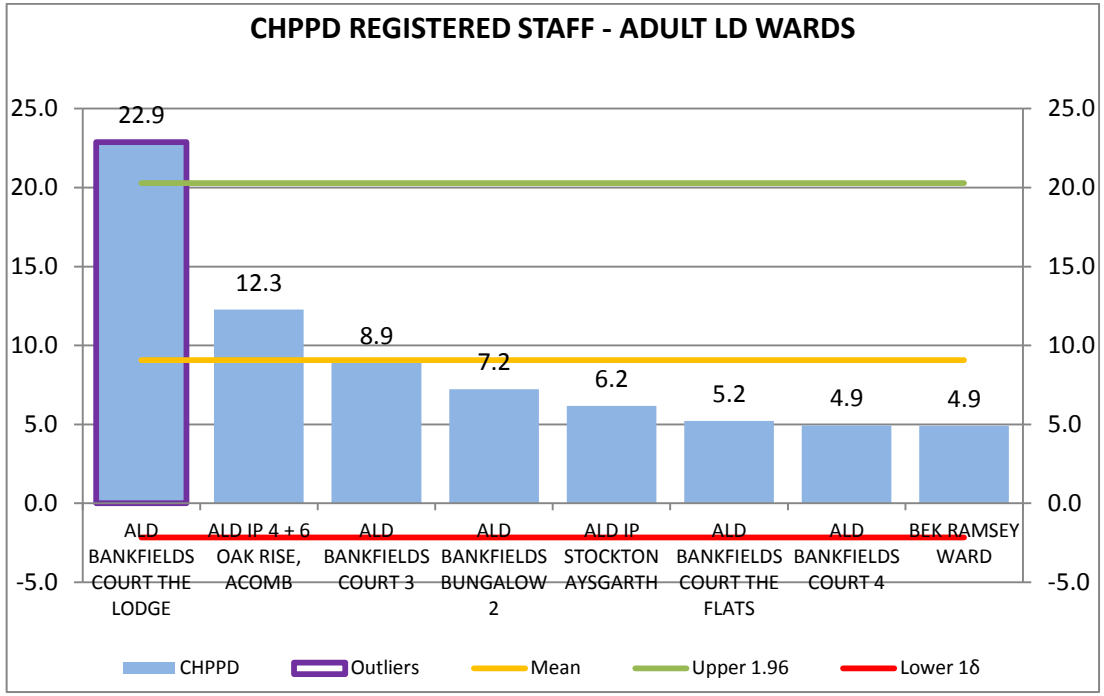
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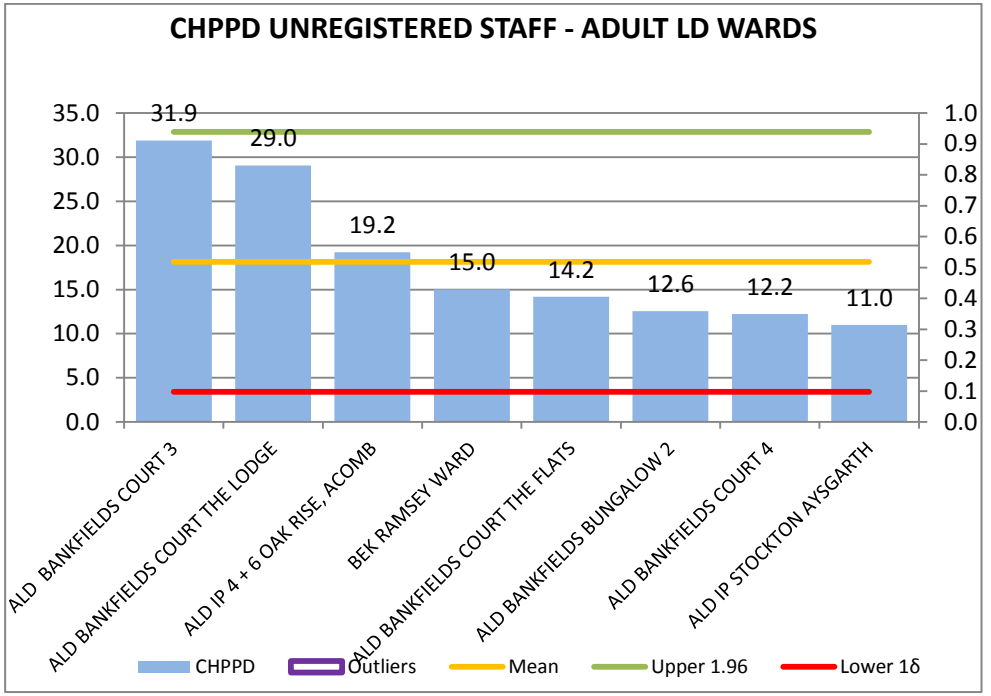
-5.0
22.9
12.3
8.9
7.2
6.2
5.2
4.9
4.9
ALD BANKFIELDS COURT THE LODGE
ALD IP 4 + 6 OAK RISE, ACOMB
ALD BANKFIELDS COURT 3
ALD BANKFIELDS BUNGALOW 2
ALD IP STOCKTON AYSGARTH
ALD BANKFIELDS COURT THE FLATS
ALD BANKFIELDS COURT 4
BEK RAMSEY WARD
CHPPD
Outliers
Mean
Upper 1.96
Lower 1δ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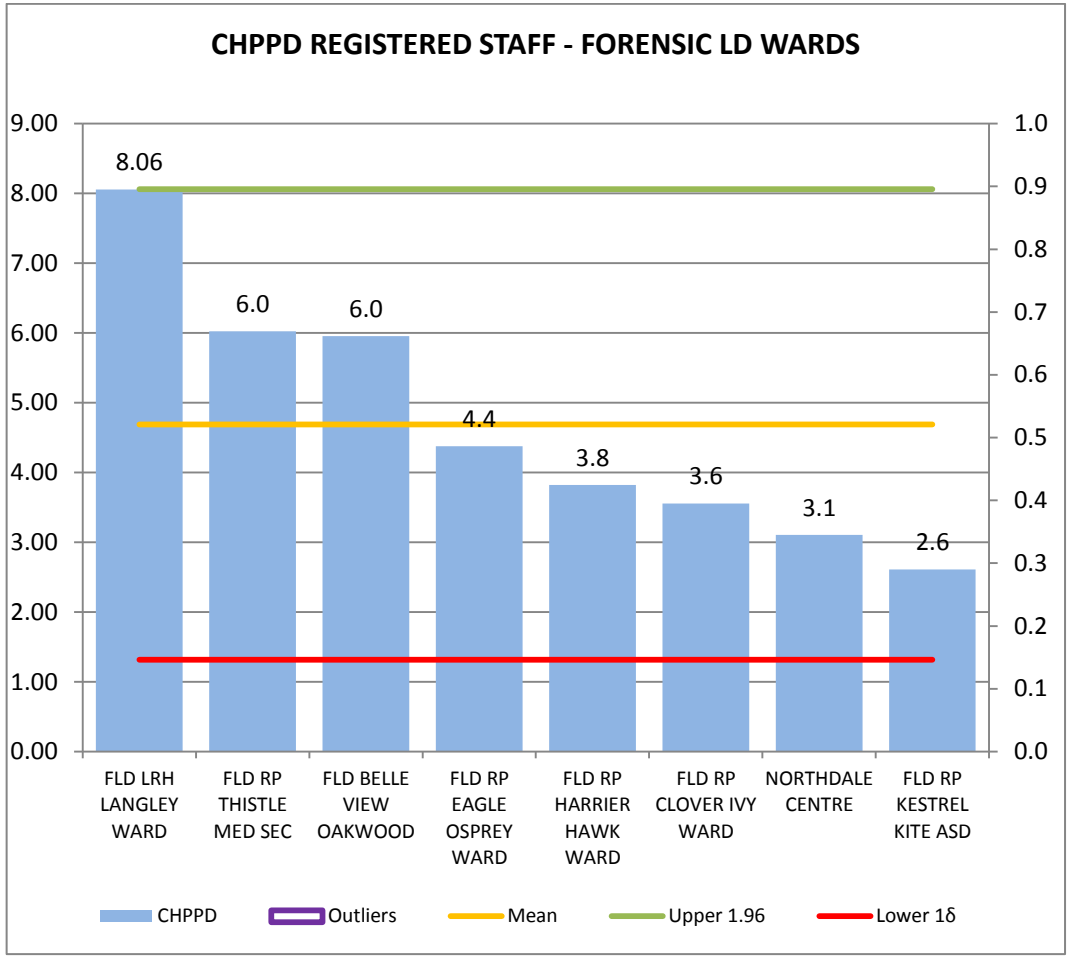
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0.0
31.9
29.0
19.2
15.0
14.2
12.6
12.2
11.0
ALD BANKFIELDS COURT 3
ALD BANKFIELDS COURT THE LODGE
ALD IP 4 + 6 OAK RISE, ACOMB
BEK RAMSEY WARD
ALD BANKFIELDS COURT THE FLATS
ALD BANKFIELDS BUNGALOW 2
ALD BANKFIELDS COURT 4
ALD IP STOCKTON AYSGARTH
CHPPD
Outliers
Mean
Upper 1.96
Lower 1δ

Forensic LD: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0.00
1.0
0.9
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0.5
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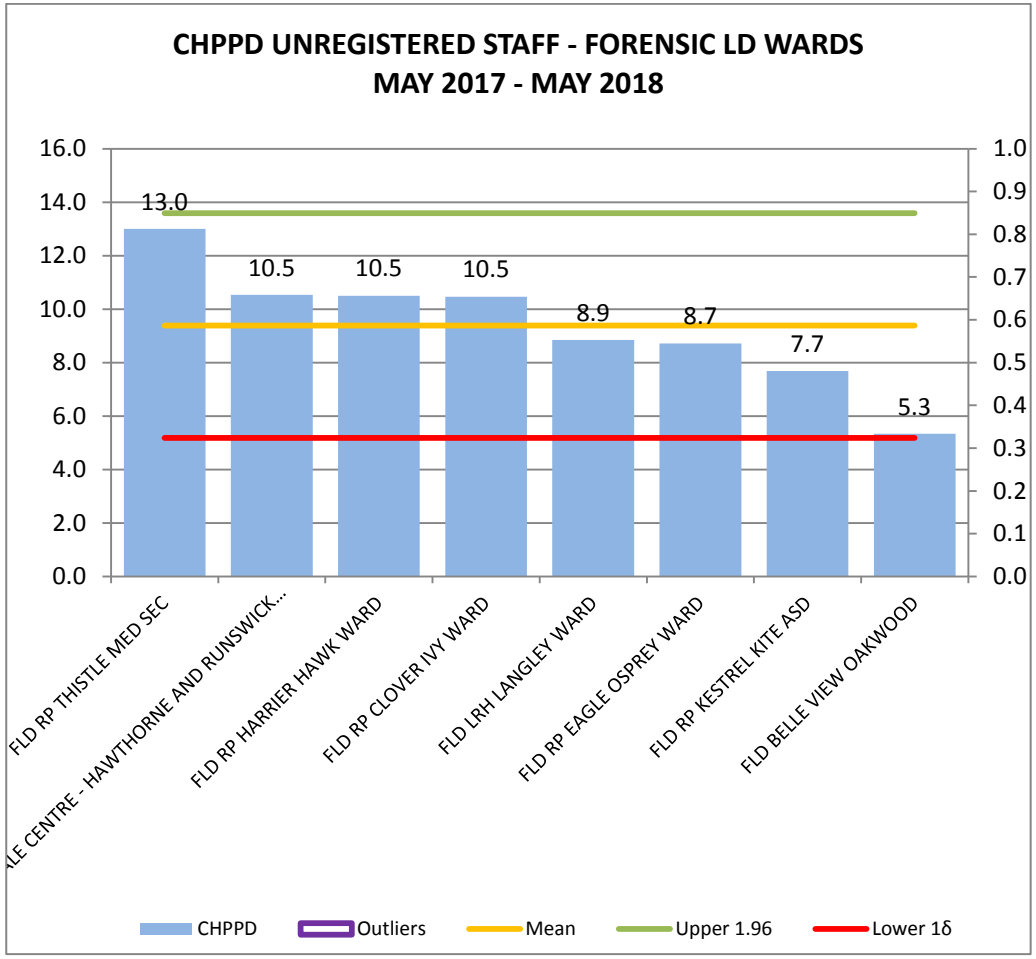
0.1
0.0
8.06
6.0
6.0
4.4
3.8
3.6
3.1
2.6
FLD LRH LANGLEY WARD
FLD RP THISTLE MED SEC
FLD BELLE VIEW OAKWOOD
FLD RP EAGLE OSPREY WARD
FLD RP HARRIER HAWK WARD
FLD RP CLOVER IVY WARD
NORTHDALE CENTRE
FLD RP KESTREL KITE ASD
CHPPD
Outliers
Mean
Upper 1.96
Lower 1δ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8.0
6.0
4.0
2.0
0.0
1.0
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0.0
13.0
10.5
10.5
10.5
8.9
8.7
7.7
5.3
LE CENTRE - HAWTHORNE AND RUNSWICK...
FLD RP THISTLE MED SEC
FLD RP HARRIER HAWK WARD
FLD RP CLOVER IVY WARD
FLD LRH LANGLEY WARD
FLD RP EAGLE OSPREY WARD
FLD RP KESTREL KITE ASD
FLD BELLE VIEW OAKWOOD
CHPPD
Outliers
Mean
Upper 1.96
Lower 1δ

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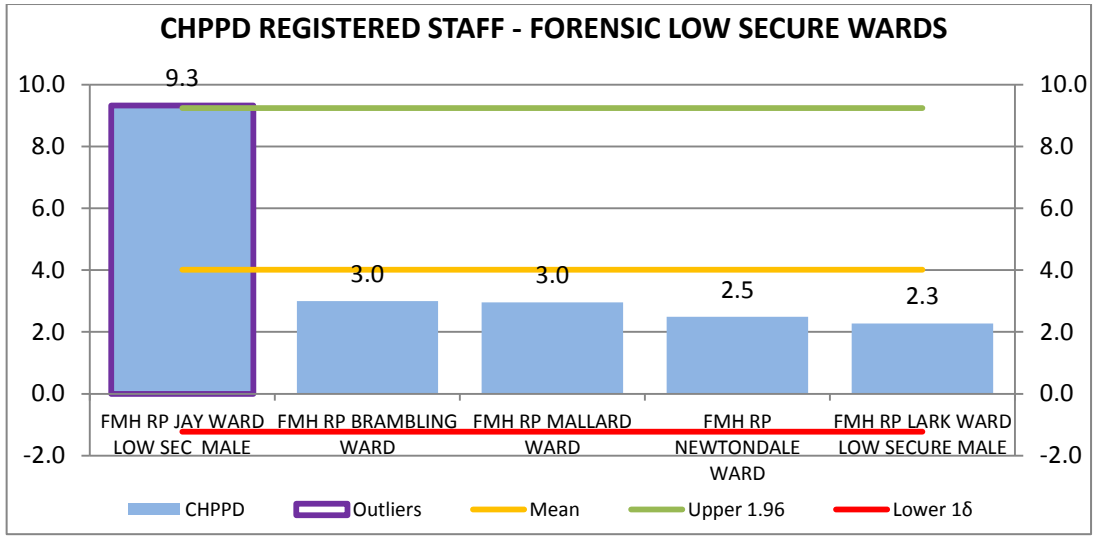

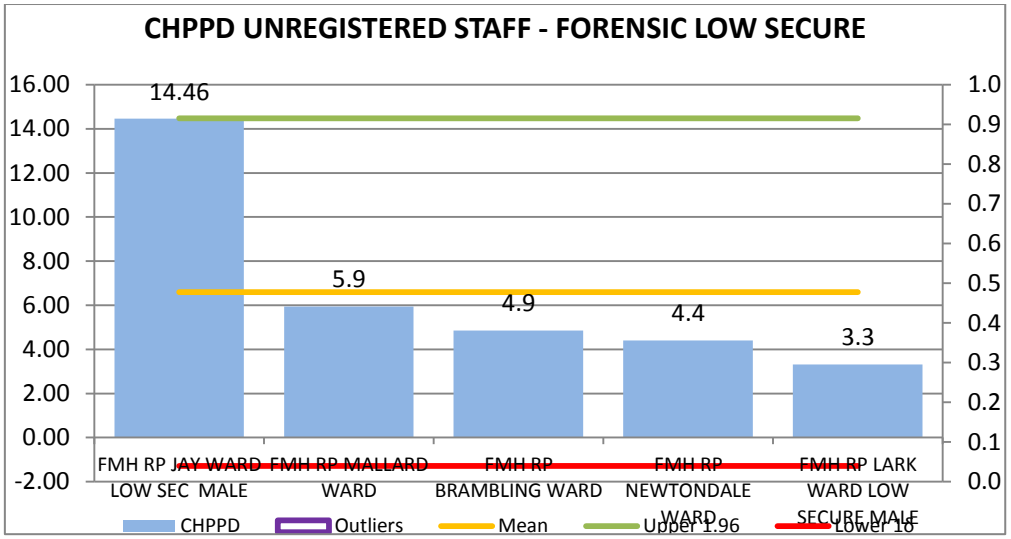

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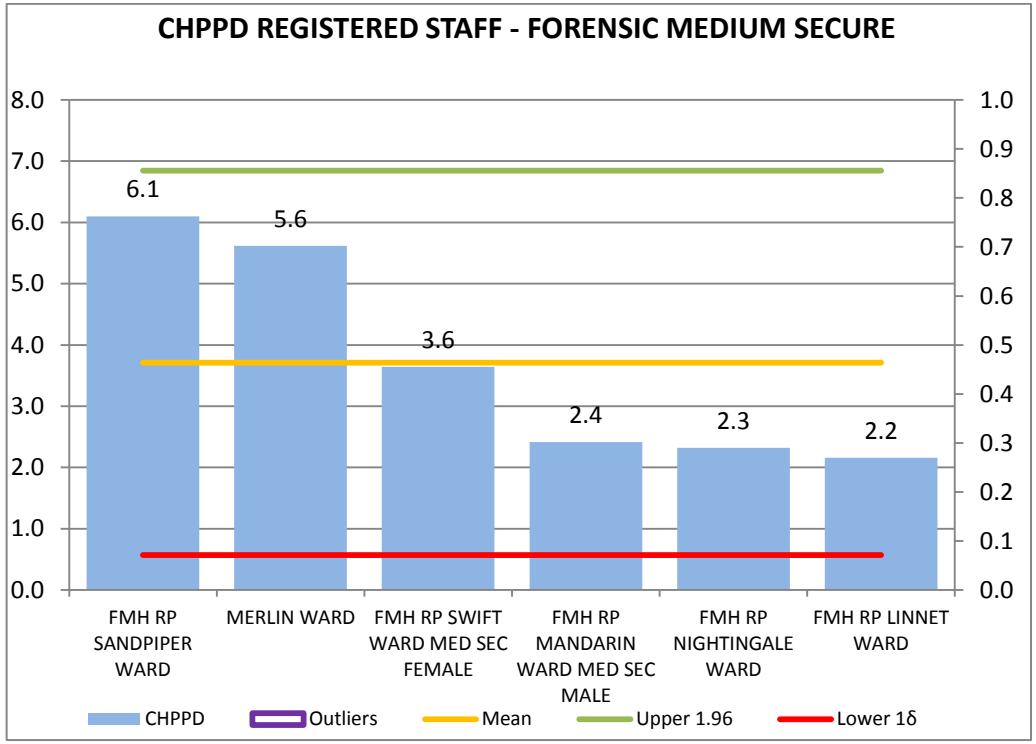

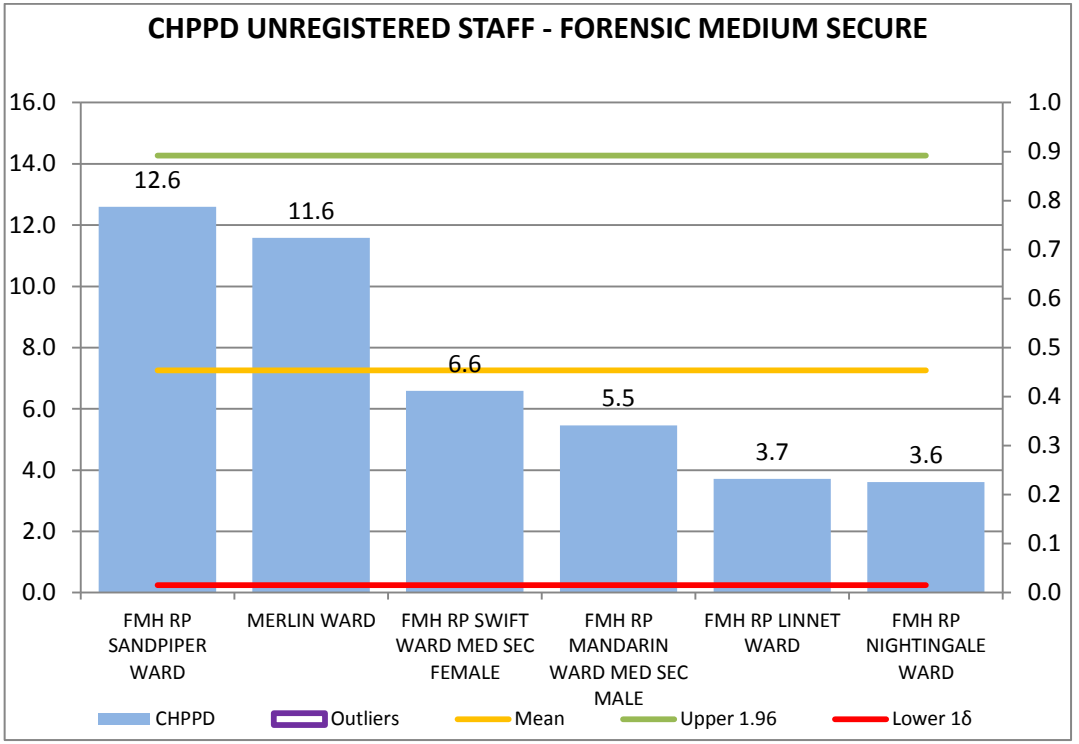

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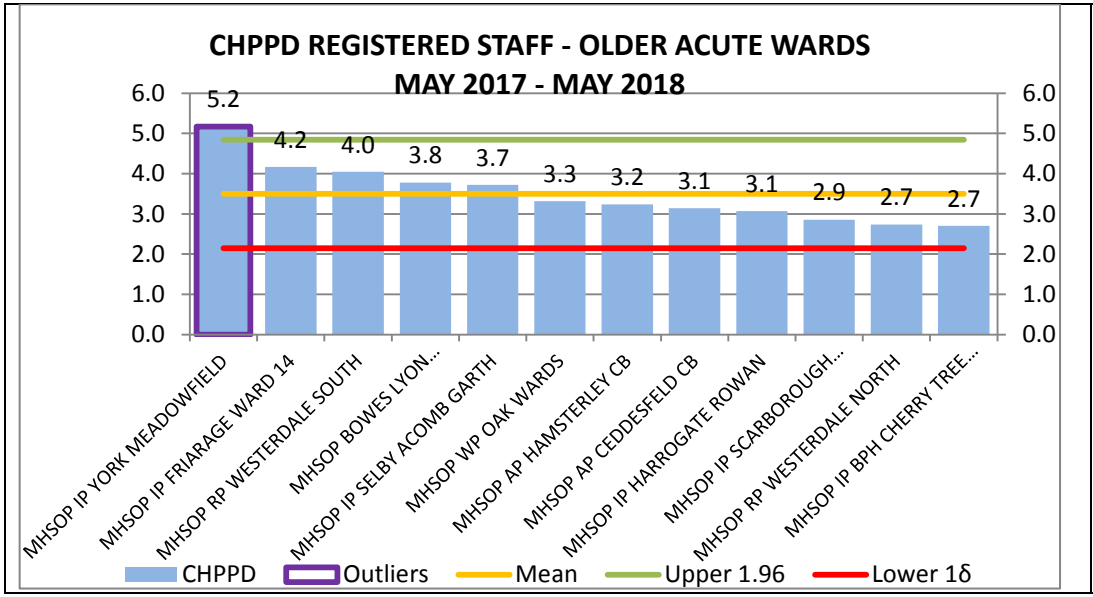
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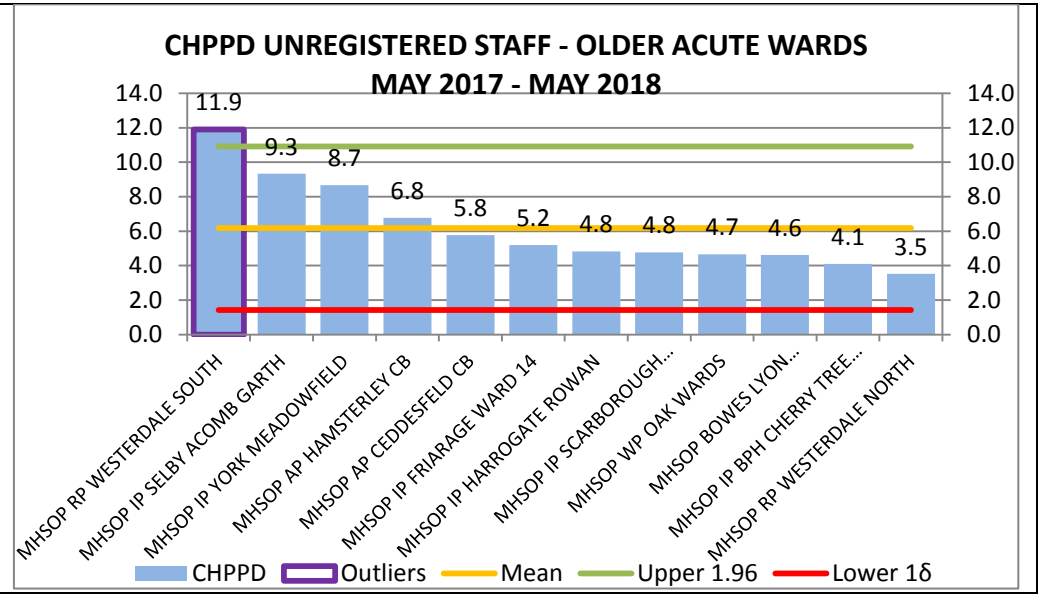
4.0
3.0
2.0
1.0
0.0
5.2
4.2
4.0
3.8
3.7
3.3
3.2
3.1
3.1
2.9
2.7
2.7
MHSOP IP YORK MEADOWFIELD
MHSOP IP FRIARAGE WARD 14
MHSOP RP WESTERDALE SOUTH
MHSOP BOWES LYON...
MHSOP IP SELBY ACOMB GARTH
MHSOP WP OAK WARDS
MHSOP AP HAMSTERLEY CB
MHSOP AP CEDDESFELD CB
MHSOP IP HARROGATE ROWAN
MHSOP IP SCARBOROUGH...
MHSOP RP WESTERDALE NORTH
MHSOP IP BPH CHERRY TREE...
CHPPD
Outliers
Mean
Upper 1.96
Lower 1δ


CHPPD UNREGISTERED STAFF - OLDER ACUTE WARDS
MAY 2017 - MAY 2018
14.0
12.0
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4.0
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MHSOP RP WESTERDALE SOUTH
MHSOP IP SELBY ACOMB GARTH
MHSOP IP YORK MEADOWFIELD
MHSOP AP HAMSTERLEY CB
MHSOP AP CEDDESFELD CB
MHSOP IP FRIARAGE WARD 14
MHSOP IP HARROGATE ROWAN
MHSOP IP SCARBOROUGH...
MHSOP WP OAK WARDS
MHSOP BOWES LYON...
MHSOP IP BPH CHERRY TREE...
MHSOP RP WESTERDALE NORTH
CHPPD
Outliers
Mean
Upper 1.96
Lower 1δ

ITEM NO.9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**3rd JULY 2018**
TITLE:	**RECRUITMENT AND RETENTION ACTION PLAN** **What else could we possibly do to increase the recruitment and retention of staff?**
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:

This report provides information about progress made with implementation of the TEWV Recruitment and Retention Action Plan and revisions that have recently been approved by the Executive Management Team. The report also highlights the participation of TEWV in the NHS Improvement Staff Retention Support programme.

During the last 12-18 months there have been significant changes to the nurse Education and training environment, in particular, the ending of nursing bursaries and the introduction of the apprenticeship levy. These developments alongside the cap on pay arrangements and changes to the pension arrangements over recent years may have contributed to nurse recruitment and retention challenges.

The plan presented in this report will primarily address the short term issues, i.e. next 3 years. It is also intended that longer term measures will be pursued to help secure the future workforce supply.

Recommendations:

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

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**3rd JULY 2018**
TITLE:	**RECRUITMENT AND RETENTION ACTION PLAN** **What else could we possibly do to increase the recruitment and retention of staff?**

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, and;
- to raise awareness of the revised recruitment and retention plan that was recently agreed by the Executive Management Team.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Since 2015, the recruitment and retention action plan has focussed primarily on increasing the numbers of nurses both joining and staying with the Trust. Regular updates have been provided to EMT and the Board of Directors, the last update was provided on 1 November 2017. The majority of those activities set out in the plan have now been actioned. See **Appendix A**.

2.1.1 The plan identified 22 actions, as at 18 June 2018, 18 actions were completed, 1 actions was on hold and 4 actions were carried forward to the new plan.

2.2 Since the last update in November 2017, the Right Staffing Programme Board has been established. The Board clearly set out a requirement to broaden the remit of this work to focus on recruitment and retention across staff groups linked to service provision.

2.3 In March 2018, the Trust Workforce Strategy 2018 - 2021 was approved, detailing 5 key objectives, these are:

- implement new approaches to recruitment to increase by 10% each year the proportion of pots filled with high quality candidates in a timely way
- identify ways to improve our ability to retain staff by 10% each year
- implement new ways to increase staff knowledge and skills development
- increase workforce supply and service continuity by reducing sickness absence by 14% over the next 3 years
- enhance TEWV culture through better staff engagement to improve staff experience and service user experience

2.3.1 Each objective is supported by a number of key enabling activities. These have been taken into consideration in the development of the new recruitment and retention plan for staff groups linked to service provision.

2.4 Recently the Deputy Director HR and OD has been participating in the 'Workforce Supply: Innovate, Engage and Exchange Network'. The programme, delivered by NHS Employers, includes 4 workshop sessions over the period of one year focussing on recruitment. This is proving to be a very useful networking group where we share and discuss our latest approaches to improving recruitment activity to resolve workforce supply challenges

2.5 TEWV is participating in the NHS Improvement staff retention support programme, the aim of which is to increase the retention of clinical staff, in particular registered nurses. The emphasis on retention highlights that there are likely to be diminishing returns experienced with efforts to focus upon only recruitment, and that patient safety can sometimes be better provided by the retention of high quality experienced staff. The emphasis is on improving internal support, well-being, internal development routes and offering career options increases the likelihood of retaining such staff. The Trust appears in cohort three of the NHS Improvement programme , indicating relatively low levels of concern by comparison with the early cohorts, and our is regarded as comparing well with peer mental health trusts. Contact with NHS Improvement representatives has been positive to date. The Trust is required to submit an action plan to NHS Improvement by July 4th describing a small number of key focus issues to improve our retention of staff, with a one year timeline for initial implementation, review and reporting of outcomes. The key features of the trust action plan are expected to be drawn from the appendices of this document.

2.6 Feedback received from Health Education England indicates that the current position regarding recruitment difficulties being experienced within the NHS is not expected to change significantly until 2022 at the earliest. This feedback supports the belief that an increased focus upon staff retention will be key to maintaining workforce supply over the coming years.

2.7 Two internal TEWV recruitment and retention events have recently been held with the aim of producing a detailed recruitment and retention action plan, identifying key activities over the next 12-18 months and beyond.

2.8 Reviewing the numbers of nurses that have started, left and returned over the past 3 years, at bands 5, 6 and 7, the data is as follows:

Starters	**2015/16**	**2016/17**	**2017/18**
Band 5	78	76	110
Band 6	35	64	87
Band 7	12	15	19
Total	**125**	**155**	**216**

Leavers	**2015/16**	**2016/17**	**2017/18**
Band 5	81	75	87
Band 6	79	82	106
Band 7	28	29	37
Total	**188**	**186**	**230**

Returners	**2015/16**	**2016/17**	**2017/18**
Band 5	22	30	36
Band 6	16	32	47
Band 7	4	16	8
Total	**42**	**78**	**91**

The numbers of nurses employed by the Trust is as follows:

- 2015/16 – 2114
- 2016/17 – 2158 (increase 44)
- 2017/18 – 2219 (further increase 61)

2.9 There was an increase of an extra 44 nurses during 2016/17 and a further 61 nurses in 2017/18. This is at a time when the organisation is continuously requesting that we recruit more and more nurses.

2.10 Registered nurse turnover was 10.4% during the period June 2017 to May 2018, a total of 239 leavers. There was a significant variation between locality turnover rates ranging from 6.5% (20 leavers) in Forensic Services to 13.5% (87 leavers) in the Durham and Darlington locality. The overall nurse turnover figure during the previous 12 months period of June 2016 to May 2017 was 9.1%, a total of 206 leavers. Forensic services reported the lowest turnover rate of 4.5% (13 leavers) with the highest rate reported by York and Selby at 13.5% (30 leavers). When age retirement is excluded from the turnover figures the rate for the period June 2017 to May 2018 is 6.6% and 4.8% for the period June 2016 to May 2017. It is clear that registered nurse labour turnover has been increasing since 2016

2.11 The percentage of registered nurses that left TEWV within a year of joining was 13.8% (33 leavers) during the period June 2017 to May 2018. This compares to a figure of 7.3% (15 leavers) during the period June 2016 to May 2017. There were significant variations between localities with the lowest percentage of leavers within one year reported with Tees at 7.1% (4 leavers) and the highest being York and Selby at 30.8% (8 leavers). These figures indicate a worsening position with regard to retaining registered nurses during their first year with TEWV.

3. KEY ISSUES:

3.1 The aim of the revised plan is to facilitate recruitment and retention activities for staff groups linked to service provision, therefore the number of key stakeholders has significantly increased

3.2 As part of the Right Staffing Programme, there are five work streams. Recruitment and Retention will be one of the five work streams.

3.3 Activities set out in the Workforce Strategy that are relevant to the Right Staffing work streams, will be delivered through the relevant work stream, in this case, the recruitment and retention work stream. Progress made with implementing the recruitment and retention plan will report into the Right Staffing Programme Board.

3.4 The attached plan outlines the key activities that it is are proposed are undertaken over the next three years. It is important to mention that as our environment changes there will be a need to adapt our plans accordingly. Any recommended changes will be reported to the Right Staffing Programme Board.

3.5 All activities outlined in the recruitment and retention plan will be delivered by the Recruitment and Retention work stream of the Right Staffing programme.

3.6 The difficult challenge of securing a regular supply of clinical professionals in both the Scarborough and York and Selby localities remains a particular concern despite improved links with the Universities and assertive recruitment activities.

3.7 As highlighted in paragraphs 2.10 and 2.11 overall registered nurse retention and our ability to help new to TEWV nurses settle successfully are issues that will require particular focus.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The standards state that we must have enough suitably qualified, competent and experienced staff to make sure they can meet the CQC standards. Maintaining and increasing the workforce supply with the right skills is an essential component to satisfying this standard.

4.2 **Financial/Value for Money:** It is unclear at the time of writing this paper, whether there will be any additional costs associated with the delivery of the plan. The area where this may be requested is the activity associated with Social Media. Should EMT approve this activity, further work will be required to understand any associated costs and bring back to EMT for further consideration.

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

4.4 **Equality and Diversity:** None identified

4.5 **Other implications:** None identified

5. RISKS:

5.1 As outlined in previous papers, it is difficult to predict how the changes to the NHS Pension Scheme will impact on the decisions current employees make in respect of retirement and early retirement during the next 4 years

6. CONCLUSIONS:

6.1 Over the last 12-18 months there have been significant changes to the educational and training environment, in particular, the ending of nursing bursaries and the introduction of the apprenticeship levy. These developments alongside NHS pay arrangements, changes to NHS pension arrangements and higher level of demand for nurses compared to the numbers of new nurses being trained will no doubt have had some impact upon recruitment and retention within TEWV.

6.2 As we gain a greater understanding on the impact of the externally driven changes that are referred to in paragraph 6.1 and the impact of local recruitment and retention actions taken we will have an opportunity to better address longer term workforce supply issues.

6.3 The plan presented in this report will help to address recruitment and retention in the short term issues i.e. over the next 3 years.

7. RECOMMENDATIONS:

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

Angela Collins
Deputy Director HR and OD

Background Papers:

- EMT Paper – How well is TEWV recruiting and retaining staff – 1st November 2017

APPENDIX A

Nurse Recruitment and Retention Action Plan

Tasks	Key activities	Thoughts/Comments/Update as at June 2018
Recruitment	• Continue to offer permanent contracts to all new nurses and then review	As agreed in November 2017, this activity is completed and we continue to offer permanent contracts to all new nurses – bands 5 and 6. **Completed**
	• Review the need to offer financial incentives to student nurses at York university	We no longer offer financial incentives as the issues back in 2015 when we first took on York and Selby services have been resolved. Much closer links with York University have been established and are on-going. **Completed**
	• Engage with Generation Z to align recruitment policy, practice and approach with workforce of the future	**On hold**
Recruitment and Retention Premia (RRP)	• Develop a TEWV RRP business case review process	A paper outlining the findings and any recommendations will be prepared for EMT consideration in January 2018.**Completed.**
	• Review the case for pursuing international recruitment	The November 2017 EMT paper outcome stated that this was to be put on hold until April 2018. **Action carried forward to new action plan**
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	Internal Transfer Scheme has been designed and was sent out in June 2018 for 6 weeks consultation. To be piloted with Nurses band 5 and 6 plus Healthcare Assistants. Further roll out to all staff will take place once we have learned how the process works in the pilot areas. **Completed**
	• Develop registration scheme to manage internal movements	
Extending Working Lives	• Increase the numbers of contracted hours of part-time staff.	The Trust participated in an Extending Working Lives research project undertaken by Leicester University and the report has been received and shared within the Trust. **Completed**
	Complete Nurse Conversations	**Completed**
Bank	• Increase the numbers of registered nurses on the Central Nurse Bank	A rolling advert for external RNs is on-going. **Activity completed**
	• Pilot - planned overbooking of bank workers in FMH and FLD	Fully implemented and extremely successful. The majority of bank workers use this method of booking shifts resulting in one admin post contributing to CRES savings as a result due to the reduction in shift related activity within the office.

	• Implement bank worker direct booking system	**Completed** **Activity completed**
Workforce responsive team	Develop a Derbyshire responsive workforce model within TEWV	2 day Innovation event held on 4th and 5th June 2018 using Think On Methodology. Paper in the process of being drafted for QUAG. Discussed at D&D LMGB where the outcome was positively received. **Further work to implement concept**
Return to Practice (RTP)	• Gain greater understanding of current activity • Identify opportunities to maximise activity – how can flexible working play a part in encouraging return to practice	At the moment there is no financial incentive to return to practice. Other Trusts offer a temporary 6 month HCA band 3 to support returnee to get in their designated hours. Would the Trust be willing to fund such an incentive. EMT agreed in November that we do not offer RTP participants a salaried position as part of RTP during their return to work period The number of RTPs are: • 2015/16 - 2 • 2016/17 - 6 • 2017/18 - 2 **Completed**
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.	A Retire and Return Procedure was developed and implemented in July 2017. A review and evaluation of the new process has been completed and further Plan Do Study Act activities have been agreed. Changes to presented to Policy Working Group on 29 June 2018 **Original action completed**
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	As at 18 June, activity is on-going. Further work is required. **Carry over to new plan.** Procedure has been reviewed, considered by the Policy Working Group and is out for 6 weeks consultation commencing 7 June 2018. **Completed** A Relocation Procedure was ratified in November 2017. **Action completed**

Development activities to Grow Our Own workforce

Tasks	Key activities	Comments/Update
Engagement with School and Colleges	Consider and if appropriate, develop an engagement strategy to increase awareness of/interest in working in the NHS	Engagement with schools and colleges is sporadic at the moment and this action is not seen as a priority at this moment in time due to capacity. **Outstanding**
Grow Your Own	• Subject to EMT decision, support up to 100 current Band 4 Associate Practitioners to complete two years pre-registration programme	EMT paper in November 2017 but this action **on Hold**
	• Develop revised nurse training agreements with HEIs to train TEWV HCAs as new nurses in addition to commissioned nurse training numbers	Working closely with all partners as the new nursing training environment emerges. **Action completed and is Business as Usual**
	• Utilise apprenticeship levy to replace current HEE Talent for Care funding for all HCA Career framework, consider links to pre-reg training	**Action completed and is now Business as Usual**
	• Participate in the National Nursing Associate Programme (pilot)	Two cohorts have now been recruited to. **Action completed**

APPENDIX B

RECRUITMENT

AIM	SECONDARY DRIVER	CHANGE IDEA/ACTION	OUTCOME
WORKFORCE STRATEGY OBJECTIVE 1 To implement new approaches to recruitment to increase by 10% each year the proportion of posts filled with high quality candidates in a timely way	Continuously identifying new values based ways of recruitment staff	Undertake a review of the current approach to suing values based questions in recruitment. (Q4 Review all recruitment and promotional materials to ensure they are all aligned to Trust values. (Q4 – 2019/20) Work in partnership with universities to ensure students are fit for purpose. (Q4 – 2019/20)	By Q4 2019, all recruitment activities/materials are clearly aligned and support the Trust values – leading to the recruitment of high quality candidates
	Producing and sharing high quality information with services about recruitment and retention related activities that improve understanding of staff flow both internal and external to the Trust	Develop a process to regularly review turnover data, analysing information at a locality and speciality level to better understand why staff are leaving. (Q4 – 2018/19) Increase the percentage of times that we appoint to a health care professional post without needing to re-advertise the post, including nurses, AHPs. Medics, pharmacists, psychology. (Q4 – 2018/19) Recruitment initiatives – proactively promote initiatives identified through a broad range of mediums (Q4 – 2019/20)	More people recruited with NHS experience and 10% more posts are filled with high quality candidates

RECRUITMENT

AIM	SECONDARY DRIVER	CHANGE IDEA/ACTION	OUTCOME
WORKFORCE STRATEGY OBJECTIVE 1 To implement new approaches to recruitment to increase by 10% each year the proportion of posts filled with high quality candidates in a timely way	Develop clear career pathways to attract and retain staff.	Design and develop clearly defined career pathways for all staff groups. (Q4 2018/19)	New recruits will understand future career development opportunities
	To offer student placement opportunities in partnership with universities	Establish the current baseline and work with services to identify opportunities to increase activity. (Q2 2018/19	More students experiencing placements with TEWV
		Consider the new NMC standards and the impact on the Trust (Q2 2018/19)	
		Explore the feasibility of implementing talent management spotting opportunities for students. (Q4 2019/20	
	Increase the use of social media for recruitment purposes by 50%	Explore how the Trust might better utilise social media to promote recruitment opportunities. (Q4 – 2018/19)	Improved communication with potential applicants
		Work in partnership with IT colleagues to ensure the IT infrastructure is able to fully support this approach. (Q4 – 2018/19)	
		Liaise with other NHS network groups to identify what other Trusts are currently using and what has the most impact. (Q4 – 2018/19)	

RECRUITMENT

AIM	SECONDARY DRIVER	CHANGE IDEA/ACTION	OUTCOME
WORKFORCE STRATEGY OBJECTIVE 1 To implement new approaches to recruitment to increase by 10% each year the proportion of posts filled with high quality candidates in a timely way	50% of interview panels to incorporate meaningful involvement of a service user/carer representative	Establish level of current activity. (Q4 2018/19) Work in partnership with the involvement team and service user representatives to review current system, deliver recruitment training to enable service users to participate in the process. (Q4 – 2020/19) Review recruitment training to ensure it promotes service user involvement. (Q4 – 2020/19)	A distinct increase in service user involvement on interview panels
	Reduce the number of staff that move sideways i.e same job role, same band who currently have to follow the conventional recruitment process	Establish the baseline and communicate internal transfer scheme. (Q3 2018/19) Explore the opportunities to offer temporary job swaps to allow staff to gain experience in an alternative speciality (Q3 2019/20)	More staff able to move around the Trust quicker

RECRUITMENT

AIM	SECONDARY DRIVER	CHANGE IDEA/ACTION	OUTCOME
WORKFORCE STRATEGY OBJECTIVE 1 To implement new approaches to recruitment to increase by 10% each year the proportion of posts filled with high quality candidates in a timely way	Improve and secure the future workforce supply	Review the option to consider international recruitment to address skill shortages (Q4 2018/19) Explore the opportunities to establish a partnership approach with schools, providing real experiential learning at recruitment and career fairs. (Q4 2020/21) Consider pop up recruitment shows. (Q4 2020/21) Communicate 'the day in the life of'. (Q4 2020/21) Participate in Step into health working with veterans. (Q4 2020/21) Fully utilise Apprenticeship Levy to support new roles. (Q4 2020/21)	By Q4 2021, influencing workforce supply at the earliest opportunity

RETENTION

AIM	SECONDARY DRIVER	CHANGE IDEA/ACTION	OUTCOME
WORKFORCE STRATEGY OBJECTIVE 3B Over 12 month period, reduce the amount of clinical staff leaving the Trust by 10% of the overall current leave rate	To understand why people are leaving the Trust. Review the exit process	Identify the top 5 areas that are reporting unknown reasons at exit stage. Raise awareness of the importance of documenting reason. As at 31.3.18, 17.8% unknown reasons. (Q3 2018/19) Review the whole exit questionnaire/interview process from employee notifying the Trust of their intention to leave through to providing feedback to services on exit information in a timely manner. (Q4 2018/19) Raise awareness with managers the importance of holding exit interviews and recording the reason on ESR (Q3 2018/19)	By Q2 2019, All healthcare professionals are offered an exit interview i.e. nurses, AHPs, medics, pharmacists, psychologists and health care assistants
	To improve the retention of an experienced workforce	Facilitate focus groups involving bands 5 nurses to establish what other possible solutions we could consider to retain the next generation (Q4 2018/19) Interview all new staff after 6 months of starting employment to seek views on retention (Q3 2019/20) Implement mid-career reviews for those staff in their 40s and 50s (Q4 2019/20)	Greater understanding of key components to retaining staff including: • Number of staff retained after one year has improved • Retain staff as a result of mid-career reviews • Improve number of staff that retire and return

RETENTION

AIM	SECONDARY DRIVER	CHANGE IDEA/ACTION	OUTCOME
WORKFORCE STRATEGY OBJECTIVE 3B Over 12 month period, reduce the amount of clinical staff leaving the Trust by 10% of the overall current leave rate	To improve the retention of an experienced	Develop clearly defined career pathways. (Q4 2018/19) Review the retire and return scheme, implementing agreed changes as part of the Plan Do Study Act process Q3 2018/19) Consider the concept of 'Stay'Interviews. (Q2 2019/20) Explore the opportunities to allocate 'protected time' for CPD training (Q4 2019/20) Review flexible rostering arrangements - Establishment workstream. (Q4 2019/20) Test out flexible working approach in a locality to understand local barriers and identify solutions (Q4 2019/20)	Greater understanding of key components to retaining staff including: • Number of staff retained after one year has improved • Retain staff as a result of mid-career reviews • Improve number of staff that retire and return
	To improve staff wellbeing at work to aide overall retention	Explore the opportunity to allocate 'Protected time' for clinical supervision – focussing on quality as well as quantity (pilot in Tees by Q3 2018/19) Develop a procedure for staff to report abuse (Q4 2018/19)	Staff feel safe, valued and motivated, we understand those wellbeing interventions that support staff in the workplace.

RETENTION

AIM	SECONDARY DRIVER	CHANGE IDEA/ACTION	OUTCOME
WORKFORCE STRATEGY OBJECTIVE 3B Over 12 month period, reduce the amount of clinical staff leaving the Trust by 10% of the overall current leave rate	To improve staff wellbeing at work to aide overall retention	Managers undertake daily well-being checks (Q4 2019/20) Undertake evaluation of the impact of TEWV health and wellbeing interventions and support services (Q4 2018/19)	
	To reduce the reliance on temporary staffing	Set up establishment reviews with all services – (Q4 2019/20) Consult about extending notice periods for Bands 5 and above – (Q3 2018/19) Streamline recruitment process to match notice periods – (Q4 2018/19)	Gain a greater understanding of the demand for temporary staffing The time posts are vacant is reduced

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM No. 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**3rd July 2018**
TITLE:	**Learning from deaths**
REPORT OF:	**Jennifer Illingworth, Director of Quality Governance**
REPORT FOR:	**Information**

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

Executive Summary:

The Learning from Deaths report and sets out the approach the Trust is taking towards the identification, categorisation and investigation of deaths. The current mortality dashboard is included at Appendix 1 and from Q1 2018/19 this will be presented in a new format (see Appendix 3 for an example).

During 2017/18 a total of 106 cases were reviewed via the mortality review process. The majority of deaths reviewed (68%) were service users aged between 71-100yrs and the commonest primary diagnoses were dementia (62 cases) and depression (24 cases).

The process for learning from these reviews is still being established however emerging areas for improvement would appear to be similar to those incidental findings from our Serious Incident reviews (communication, family involvement, multi-agency working). A flowchart has been provided at Appendix 4 to demonstrate how the learning from these reviews will be taken forward in conjunction with that of our other investigations.

Recommendations:

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

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**3rd July 2018**
TITLE:	**Learning from deaths**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

3.1 **Identification of deaths to be reviewed**

We have noted an ongoing increase of the numbers of deaths that are now reported through our incident management system. This has allowed a greater number of incidents to be channelled through our mortality review process which, in turn, should lead to greater opportunities for learning. The age range of those service users who died in 2017/18 can be found at Appendix 2.

3.2 **Classification of deaths to be investigated**

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

For people with a Learning Disability the Trust supports the approach of the LeDer programme (national learning disabilities mortality review process). We continue to

link in with the regional LeDeR team to improve our internal processes and also to receive feedback from the LeDeR reviews which have been completed.

3.4 **Mortality Review**

In the absence of national guidance in this area our current approach to mortality review is to identify those service users on the Care Programme Approach who have died but do not fall into the category of a Serious Incident. A case summary is prepared for a multi-disciplinary team review. For any cases where further investigation is required to make a decision we have adopted a more detailed approach of structured judgement review.

During 2017/18 a total of 106 cases were reviewed via the mortality review process. The majority of deaths reviewed (68%) were in service users aged between 71-100yrs and the commonest primary diagnoses were dementia (62 cases) and depression (24 cases).

The process for learning from these reviews is still being established however emerging areas for improvement would appear to be similar to those incidental findings from our Serious Incident reviews (communication, family involvement, multi-agency working). A flowchart has been provided at Appendix 4 to demonstrate how the learning from these reviews will be taken forward in conjunction with the other reviews we undertake.

3.5 **Appendix 1: Dashboard**

The learning from deaths dashboard is attached at Appendix 1 – it should be noted that this information will be presented both numerically and in the form of a graphs/charts in a dashboard style from the Q1 2018/19 report. There are still some data quality issues that need to be addressed with regards to the timeliness and accuracy of reporting deaths that are not classed as Serious Incidents.

The headings in the dashboard are currently defined as follows:

Total deaths as reported on Patient Admin System	Total number of service users who have died in the period – this information will be subject to robust quality checking to ensure its accuracy
Total number of deaths – community service users	Total number of community service users who have died in the reporting period (included in numbers above)
Total number of deaths - In-Patient	Number of in-patient service users who have died in the period (included in numbers above)
Total number of deaths - LD In-Patient	Number of LD in-patient service users who have died in the period (included in numbers above)
Total number of deaths in scope for learning from deaths policy	Total number of deaths of service users who meet the criteria for being 'in scope' as per the learning from deaths policy
Total deaths reviewed as an SI	Number of Serious Incident investigations completed and signed off by directors panel in the period
Total deaths reviewed as mortality reviews	Number of cases reviewed via the mortality review process (excluding SI numbers above)
Total LD deaths reviewed internally	Total number of service users with a Learning Disability who have died and have had their

	care reviewed in the period
LD Deaths Reported to LeDer	Total number of service users with a Learning Disability who have died and have had their case referred for review by the LeDeR programme
Total no of deaths (SI) where there had been learning identified that has led, or would likely lead, to change	Number of individual cases where learning was identified from Serious Incidents completed in the period

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

4.0 NEXT STEPS

As previously mentioned within this report this is an enhanced process of reporting which is still being refined and defined and therefore the information should be considered with this in mind. We plan to review our approach to this report in the Patient Safety Group meeting in August 2018 to determine if any alterations to our processes are required.

5.0 IMPLICATIONS:

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

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

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

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

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

6. RISKS:

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

7. CONCLUSION:

This report contains the trust information relating to the national learning from deaths agenda. Ongoing work continues to ensure the numbers of deaths reported (both in and out of scope) are as accurate as possible to allow us to gain maximum learning from this process.

8. RECOMMENDATIONS:

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

Jennifer Illingworth
Director of Quality Governance

July 2018

Background Papers:

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

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

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

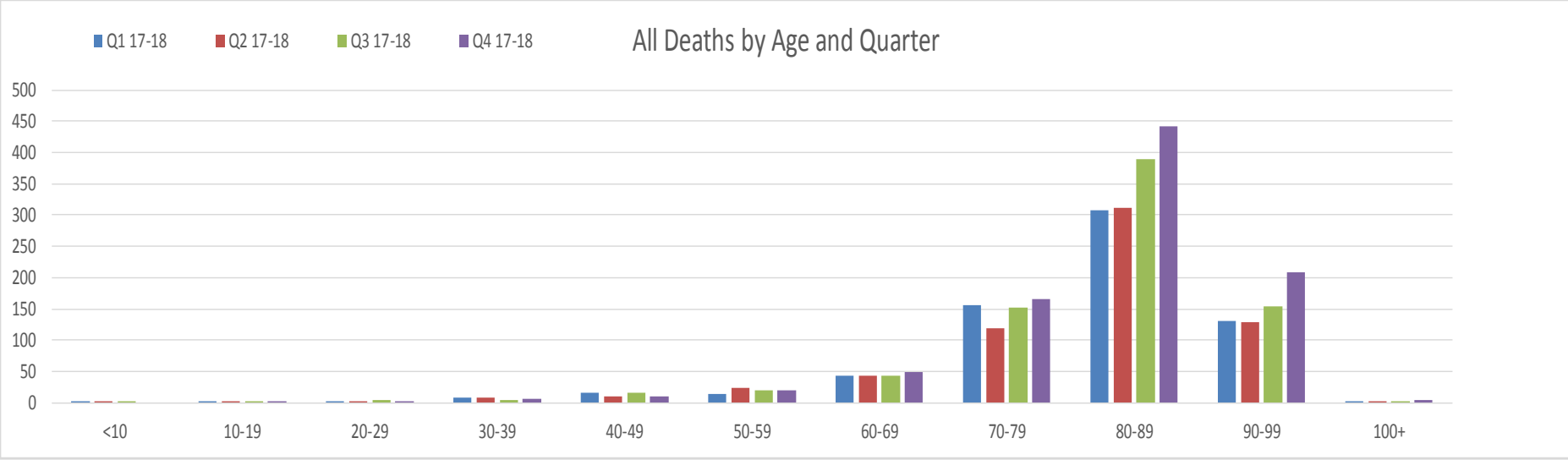
Serious Incident Framework
https://www.england.nhs.uk/?s=serious+incident+framwework

Appendix 1

	Total deaths as reported on Patient Admin System	Total number deaths - community service users	Total number deaths - In-Patient	Total number deaths - LD In-Patient	Total deaths in scope of learning from deaths policy		Total deaths reviewed as an SI	Total deaths reviewed as mortality review	Total LD deaths reviewed internally	LD deaths reported to LeDer	Total no of deaths (SI) where learning identified that has led, or was likely to, change
April	**211**	**210**	**1**	0	**60**		**7**	**8**	0	0	**4**
May	**189**	**188**	**1**	0	**117**		**4**	**8**	0	3	**3**
June	**141**	**141**	**0**	0	**101**		**6**	**10**	0	2	**2**
Q1 total	**541**	**539**	**2**	**0**	**278**		**17**	**26**	**0**	**5**	**9**
July	**197**	196	1	0	121		6	13	0	2	3
August	**161**	160	1	0	134		7	9	1	2	3
September	**166**	165	1	0	107		3	4	2	0	1
Q2 total	**524**	**521**	**3**	**0**	**362**		**16**	**26**	**3**	**4**	**7**
October	206	205	1	0	129		11	7	0	2	4
November	167	165	2	0	118		9	10	1	2	5
December	201	198	3	1	146		10	11	2	3	3
Q3 total	**574**	**568**	**6**	**1**	**393**		**30**	**28**	**3**	**7**	**12**
January	283	281	2	0	186		9	8	2	2	7
February	222	221	1	0	168		13	4	1	1	5
March	178	176	2	0	114		14	16	3	1	4
Q4 total	**683**	**678**	**5**	**0**	**468**		**36**	**26**	**6**	**4**	**16**
TOTAL	**2322**	**2306**	**16**	**1**	**1501**		**104**	**106**	**12**	**20**	**44**

Appendix 2

Age profile of deaths reported on Patient Administration System by quarter 2017/18



Appendix 3 – mock dashboard for 2018/19

Learning from Deaths Dashboard - Data Taken from Trust's Risk Management System
Reporting Period - Quarter 4 - January - March 2018

Tees, Esk and Wear Valleys NHS Foundation Trust

Summary of total number of deaths and total number of cases reviewed under the SI Framework or Mortality Review

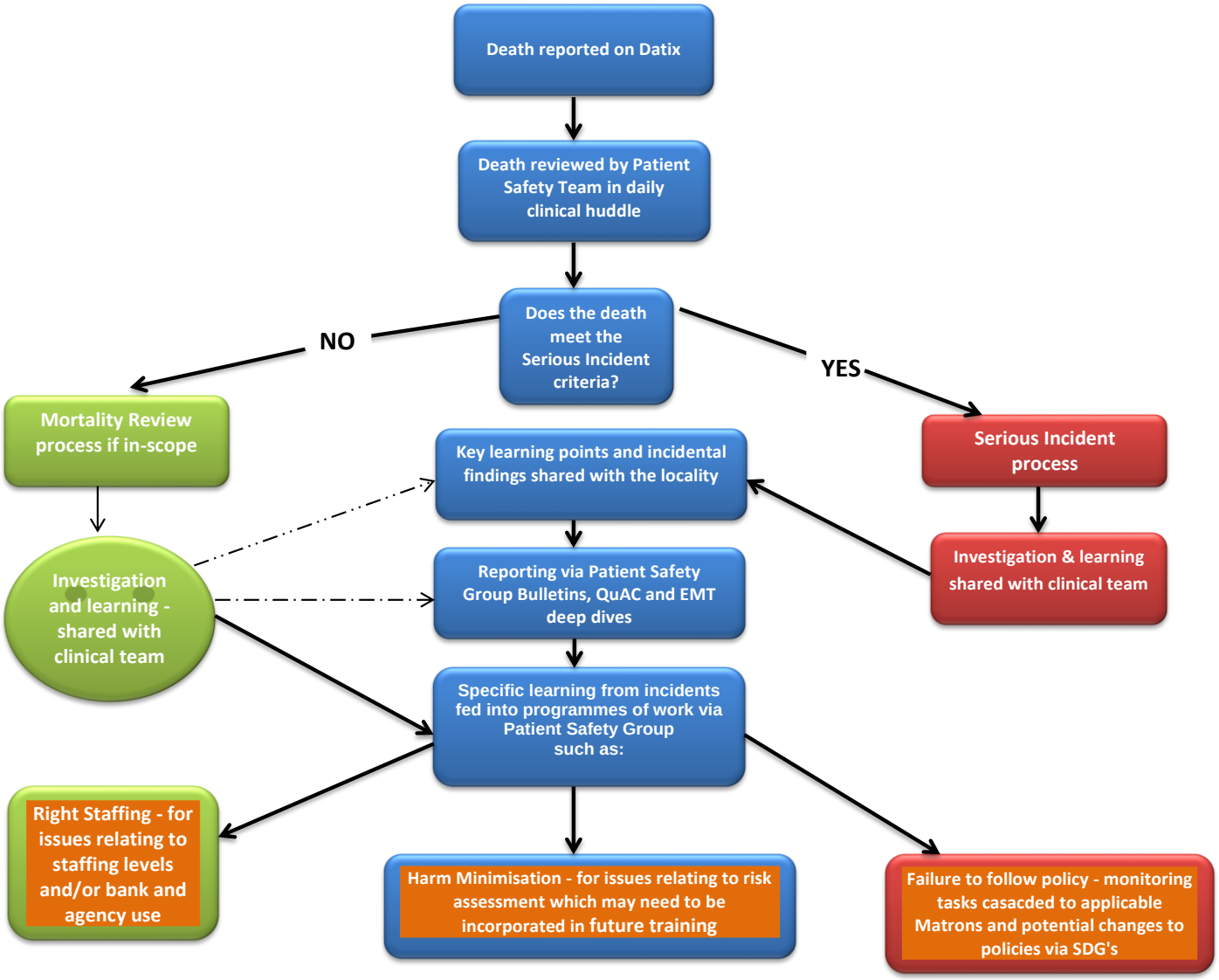
Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)

Total Number of Deaths	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework	Total number of deaths subject to Mortality Review	Total number of new learning points
Q1	Q1	Q1	Q1	Q1
541	2	17	36	278
Q2	Q2	Q2	Q2	Q2
524	3	16	26	362
Q3	Q3	Q3	Q3	Q3
574	10	30	28	393
Q4	Q4	Q4	Q4	Q4
0	0	0	0	0
YTD	YTD	YTD	YTD	YTD
1639	15	63	90	1033

Summary of total number of Learning Disability deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Learning Disability Deaths, and total number reported through LeDer

Total Number of Learning Disability Deaths	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework or Subject to Mortality Review	Total number of deaths reported through LeDer	Total number of new learning points
Q1	Q1	Q1	Q1	Q1
10	0	0	5	9
Q2	Q2	Q2	Q2	Q2
12	0	3	4	7
Q3	Q3	Q3	Q3	Q3
14	1	3	7	12
Q4	Q4	Q4	Q4	Q4
0	0	0	0	0
YTD	YTD	YTD	YTD	YTD
36	1	6	16	28


Death reported on Datix
Death reviewed by Patient Safety Team in daily clinical huddle
Does the death meet the Serious Incident criteria?
NO
YES
Mortality Review process if in-scope
Serious Incident process
Key learning points and incidental findings shared with the locality
Investigation and learning - shared with clinical team
Reporting via Patient Safety Group Bulletins, QuAC and EMT deep dives
Investigation & learning shared with clinical team
Specific learning from incidents fed into programmes of work via Patient Safety Group such as:
Right Staffing - for issues relating to staffing levels and/or bank and agency use
Harm Minimisation - for issues relating to risk assessment which may need to be incorporated in future training
Failure to follow policy - monitoring tasks casacded to applicable Matrons and potential changes to policies via SDG's

Tees, Esk and Wear Valleys
NHS Foundation Trust

Item 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**3rd July 2018**
TITLE:	**Patient Safety Annual Report 2017/18**
REPORT OF:	**Jennifer Illingworth, Director of Quality Governance**
REPORT FOR:	**Information**

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

Executive Summary:

The report highlights activity and learning in relation to Patient Safety for 2017/18. There were 130 Serious Incidents reported in total which is an increase of 28 on the previous year. The most common themes from the Serious Incidents reviewed were:

- Inadequate risk assessment
- Failure to follow policy
- Communication/Information Sharing

The locality with the highest proportion of individual reports with root causes and/or contributory findings was York & Selby with 61% followed by North Yorkshire with 48%. North Yorkshire had the most Serious Incidents during 2017/18 when compared to numbers of open caseload. The Executive Management Team has requested a targeted piece of work commence in the North Yorkshire locality looking at the specific themes emerging from the reviewed incidents.

Work continues to refine our mortality review processes and the Trust will also be considering emerging themes from the latest National Confidential Inquiry report during 2018/19 (Eating Disorders, ASD and Dementia) to ensure we are providing the safest possible care to these groups.

Recommendations:

The Board of Directors is requested to note the content of this report.

Patient Safety Annual Report (2017/18)

Contents: Page Number

Part 1 - Data

Part 2 - Learning

Part 1 – Data

This report provides a look back over the 2017/18 financial year with regard to incident reporting and associated Patient Safety activities. It includes details on all incident types reported, serious incidents and identifies themes that are emerging from the data.

All Serious Incidents (SI's) which occur are reported to the Executive Management Team (EMT) on a weekly basis to ensure any immediate patient safety issues requiring urgent action are addressed. EMT reviews a monthly performance report out in relation to Serious Incidents and emerging themes and also has a quarterly 'deep dive' in to patient safety issues. All other incidents are reported in line with the incident reporting policy and investigated by the operational services in which they occur.

There were a total of 25,415 incidents reported during 2017/18 of which 130 were categorised as Serious Incidents.

1. Incident Activity and Analysis

A total of 25,415 incidents were reported via the electronic incident management system (Datix). This is an increase of 4,219 incidents when compared to the previous financial year (2016/17) where there were 21,196 incidents reported. TEWV is recognised by the National Reporting and Learning System (NRLS) as a good reporter of incidents.

The following table indicates the numbers of incidents over the last 3 years showing a trend (where possible) on the previous financial year:

Financial Year	Total number of incidents	Trend on incidents (previous year)
2015/16	15,758	↗ 487
2016/17	21,196	↗ 5,438
2017/18	25,415	↗ 4,219

The table below shows the 25,415 incidents split into the number of incidents and the number of Serious Incidents:

	2017/18	2016/17	2015/16	Trend on 2016/17
Number of incidents	25,415	21,196	15,758	↗ 4,219
Serious incidents (as reported on STEIS)	130	102	111	↗ 28

Chart 1 below shows the total number of incidents reported by each locality:

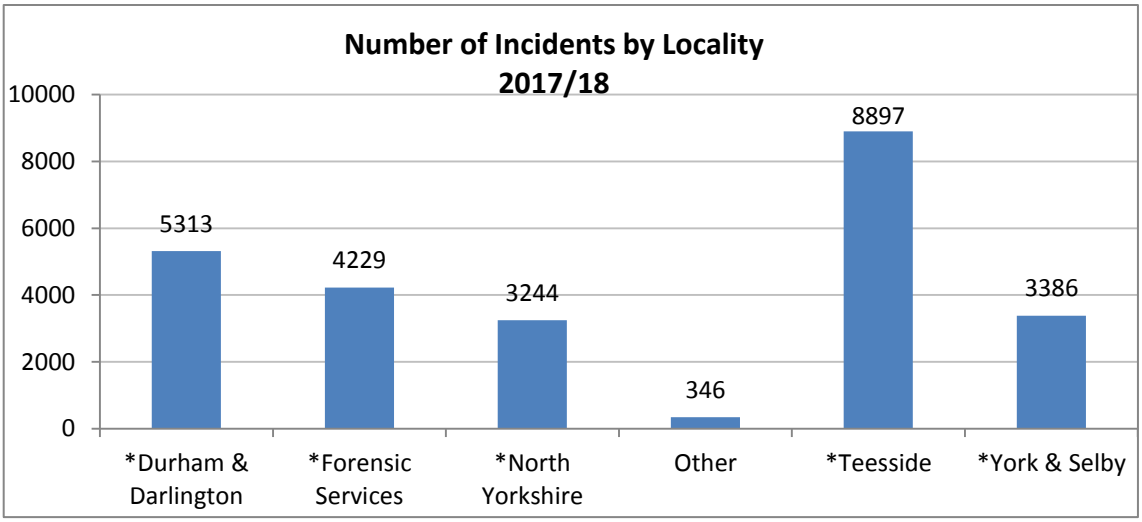


Chart 1

*NOTE: * includes management teams*

Teesside reported the highest number of patient incidents with 8,897 followed by Durham & Darlington with 5,313 incidents. Teesside locality has the most inpatient beds and the only Tier 4 CYPS beds which may account for the increased numbers.

Chart 2 below shows the total number of incidents reported by speciality;

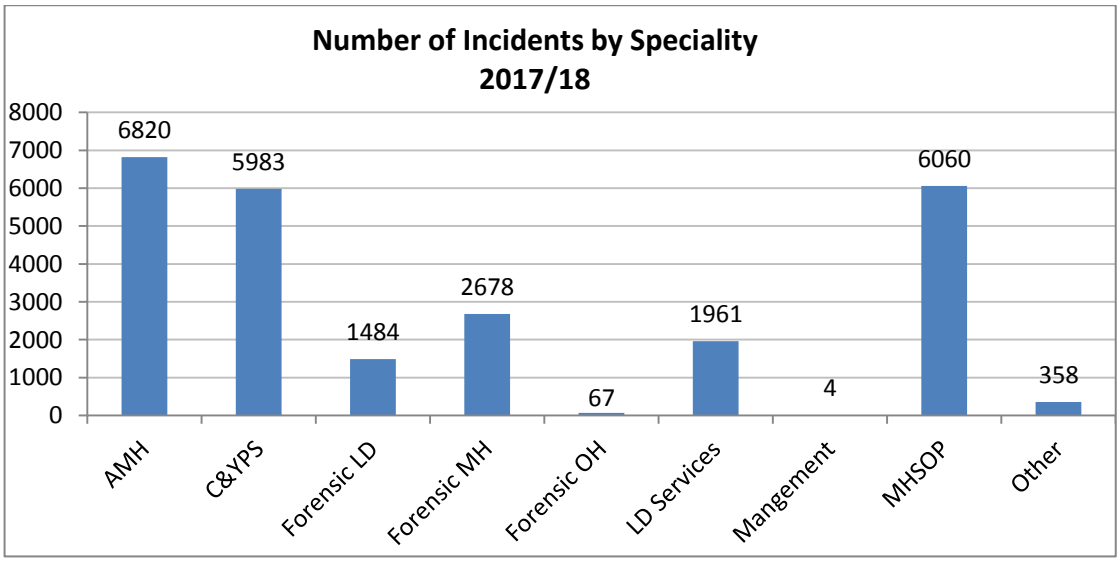


Chart 2

Adult Mental Health Services reported the highest number of incidents during 2017/18 with a total of 6,820. This was closely followed by Mental Health Services for Older People who reported 6,060. The numbers reported reflect predominantly (although not exclusively) in-patient services particularly for AMH and MHSOP.

Incidents per 1000 OBD – Inpatient incidents only

The following section uses the incidents recorded against directorates with occupied bed days (OBD) to allow a like for like comparison against the other directorates across the Trust.

Locality	13 month locality rate	Adults	Child and YP	LD Services	MHSOP	Forensic LD	Forensic MH
Durham & Darlington	30.14	23.45	-	92.76	31.17	-	-
Forensic Services	28.45	-	-	-	-	34.01	25.74
North Yorkshire	34.12	28.38	-	-	40.69	-	-
Teesside	37.37	24.91	74.55	48.37	27.89	-	-
York and Selby	53.10	38.54	-	165.16	49.25	-	-
Trust 13 month rates	**34.01**	**25.88**	**78.27**	**70.98**	**36.82**	**34.01**	**25.74**

The above highlights that CYPS, LD and MHSOP services all report more incidents per occupied bed day than the Trust average of 34.01.

Incidents per 1000 caseload

The following section uses the incidents recorded against directorates compared to caseload to allow a like for like comparison against the other directorates across the Trust.

Locality	13 month locality rate	Adults	Child and YP	LD Services	MHSOP	Forensic LD	Forensic MH	Offender Health
Durham & Darlington	8.65	12.68	6.57	4.33	8.12	-	-	-
Forensic Services	47.06	-	-	-	-	49.51	104.07	37.70
North Yorkshire	10.36	8.27	17.79	12.41	9.45	-	-	-
Teesside	9.75	10.05	8.16	10.74	10.80	-	-	-
York and Selby	11.06	12.25	7.34	13.39	11.91	-	-	-
Trust 13 month rates	**9.80**	**10.99**	**8.42**	**7.45**	**9.58**	**49.51**	**104.07**	**37.70**

The above highlights that overall the Forensics locality and AMH report more incidents per open caseload when compared to the Trust average of 9.80.

Chart 3 below shows the total number of incidents reported by severity:

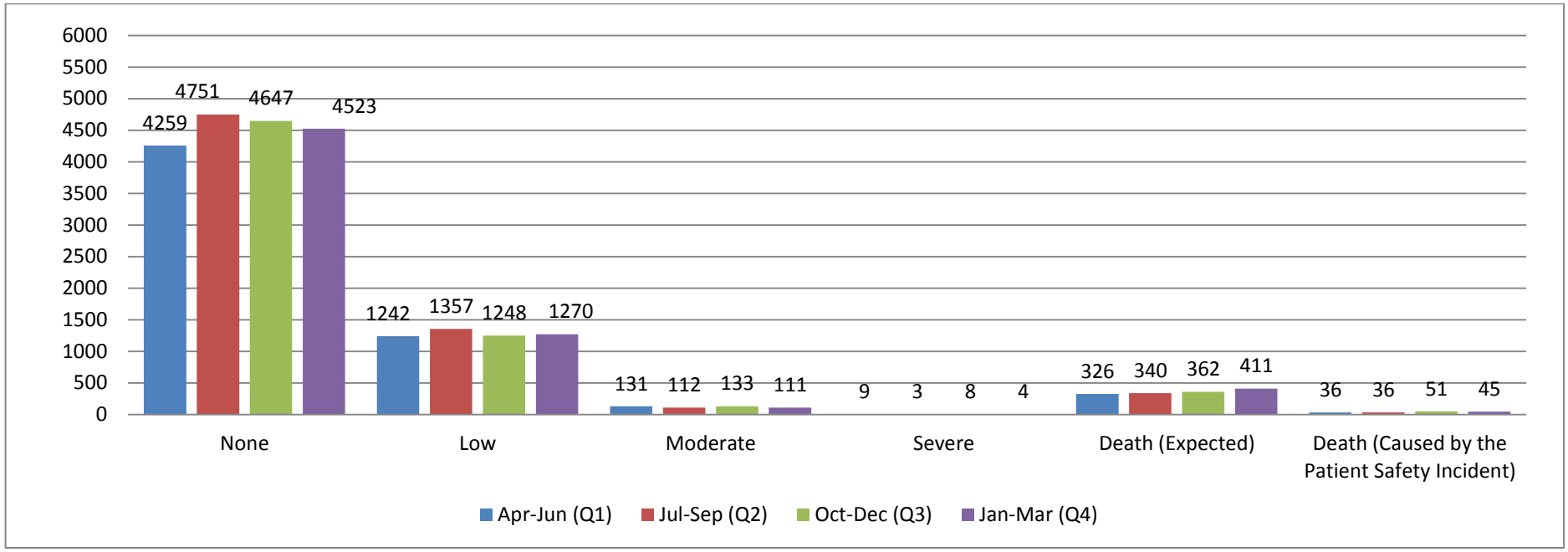


Chart 3

The vast majority of the incidents reported within the Trust have been defined as 'None' (72%) or 'Low' (20%) harm. For the 192 incidents categorised as either 'severe' or 'death (caused by the PS incident)' 130 (68%) were defined as Serious Incidents.

The top 10 highest reported incident types within the Trust were categorised as shown in chart 4 below:

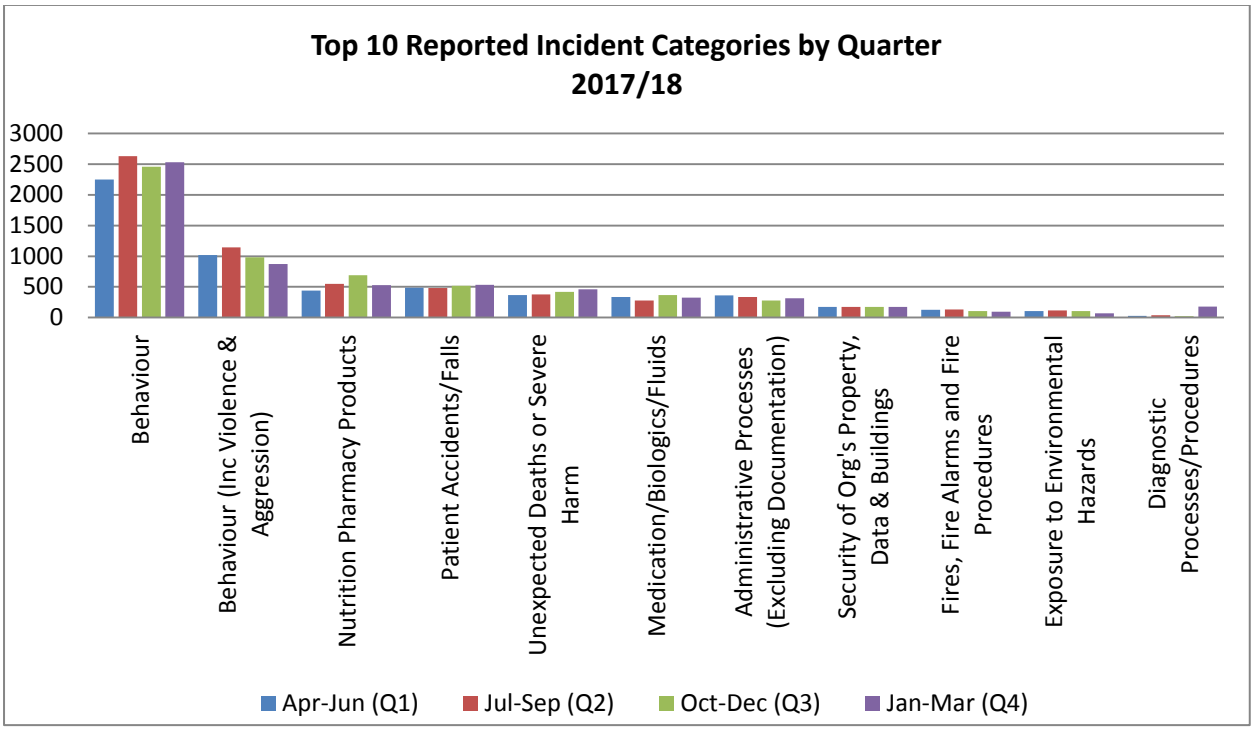


Chart 4

Behaviour incidents were the highest category with 9,873 incidents being reported. The second highest category was Behaviour (Including Violence & Aggression) equating to 4,018 incidents.

Incidents categorised as 'Behaviour' only relate to those in which a patient has been affected by the incident 'inappropriate/aggressive behaviour', 'missing patients', 'self-harming behaviour', 'patient refusal of diagnostic/therapeutic interventions', 'patient restraint processes', 'persons performing unauthorised acts' and 'use or possession of prohibited or stolen goods'.

The incidents categorised as 'Behaviour (including Violence and Aggression)' are those in which Staff/Contractors have been affected by the incident. There are 5 sub-categories that fall under this and examples include 'inappropriate/aggressive behaviour', 'persons performing unauthorised acts' and 'use or possession of prohibited or stolen goods'.

It is important that when looking at the incident process that we also consider the timeliness of reporting, reviewing and approval of incidents. Since the introduction of the Central Approval Team and the upgraded Datix system greater emphasis has been given to this process.

Within the reporting period from the incident occurring to it being reported is on average taking 2.6 days. In terms of when the incident has been reported to it being finally approved has taken on average 7.5 days. This is largely due to the year on year increase in number of incidents being reported which is a positive thing. Process improvement work within the Central Approval Team is ongoing which will see this average falling in line with SLA (4 days) by Q2 18/19.

2. Serious Incidents

There were a total of 130 serious incidents recorded across the Trust during 2017/18. This is an increase of 28 when compared to the same period during 2016/17 when there were 102 serious incidents recorded.

The breakdown of serious incidents by locality for 2017/18 is shown in chart 5 below:

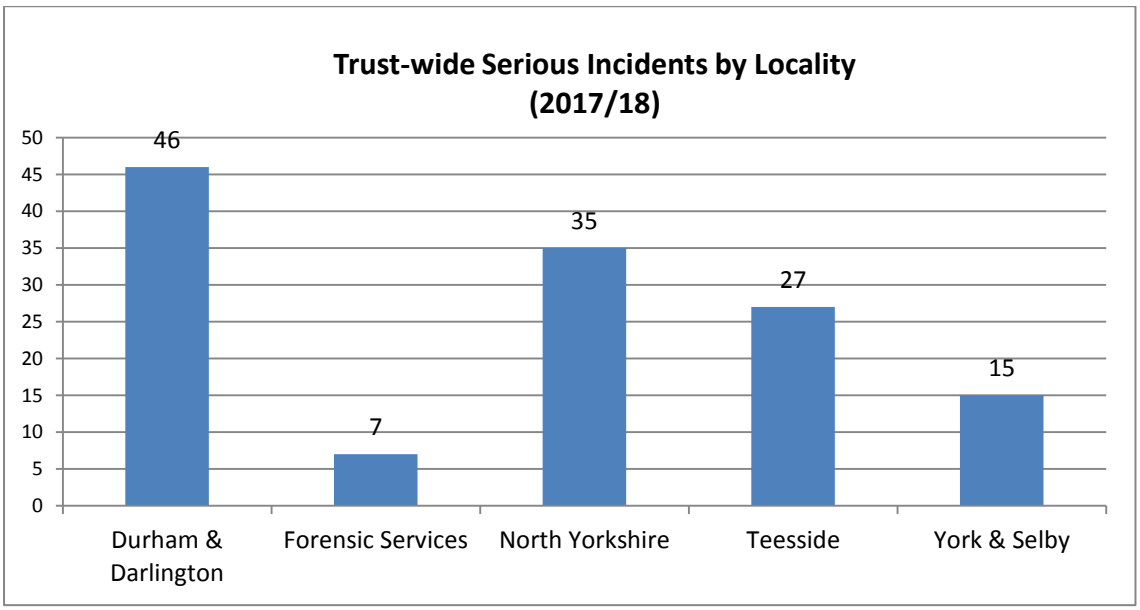


Chart 5

Of the 130 serious incidents 22 were recorded within MHSOP services and 0 reported within LD services. Adult Mental Health Services reported the most Serious Incidents with 99 being reported during the reporting period, an increase of 31 compared to the figure reported in 2016/17. CAMHS reported 2 SI's and Forensic Services reported 7 (all from the offender health liaison service where the Trust had no previous contact with any of the people).

When the SI's are presented as a percentage of open caseload the locality position changes to make North Yorkshire the highest and Durham & Darlington the lowest (see chart 6):

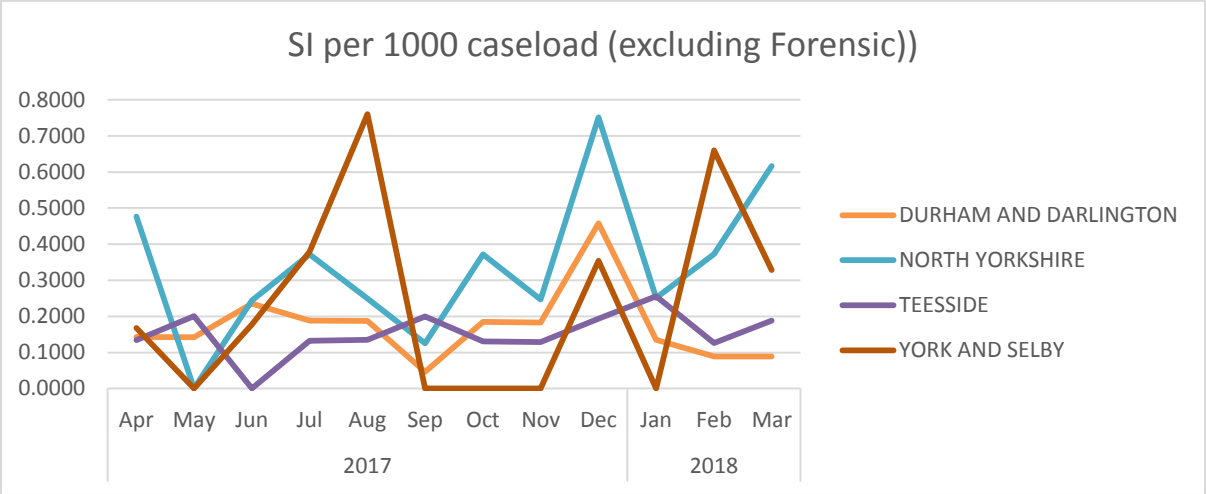


Chart 6 (Forensics were excluded from this as the low numbers of patients in the service distorts the figures).

The type of patient at the time of the Serious Incident is outlined as follows in chart 7:

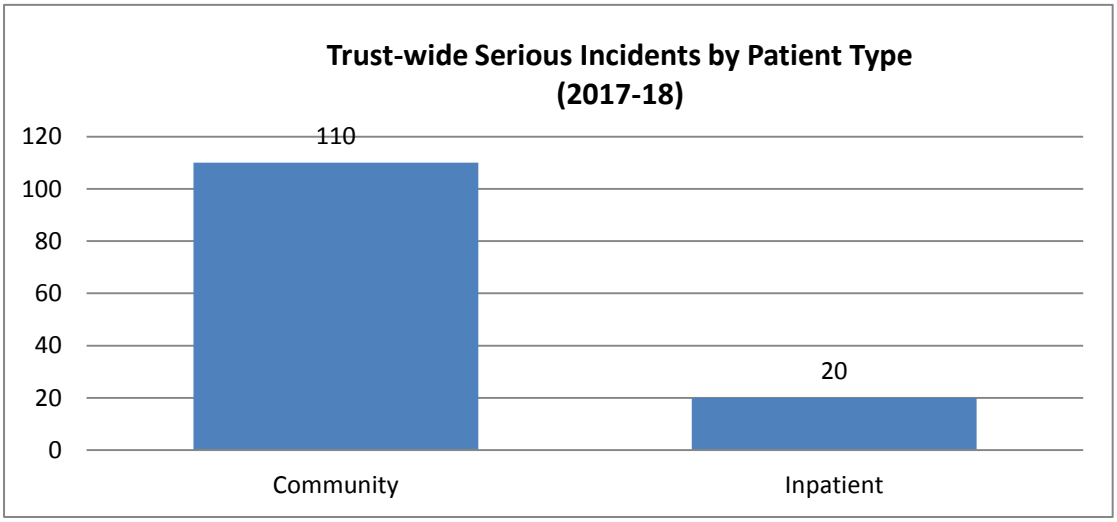


Chart 7

The majority of the Serious Incidents were from patients who were receiving treatment from our community teams. Of those 110 Community serious incidents there were 16 that related to MHSOP services. In terms of those relating to inpatient Serious Incidents there were 6 that related to MHSOP services. From the data presented, 3 of the 20 inpatient Serious Incidents related to fractured neck of femur which is a decrease from 12 the previous year.

Of the Serious Incidents reported during the reporting period, 4 occurred when the service user was on a period of planned leave and 1 when the service user was AWOL.

The following information has been collated from analysis of the Serious Incidents that have occurred during the last 3 financial years:

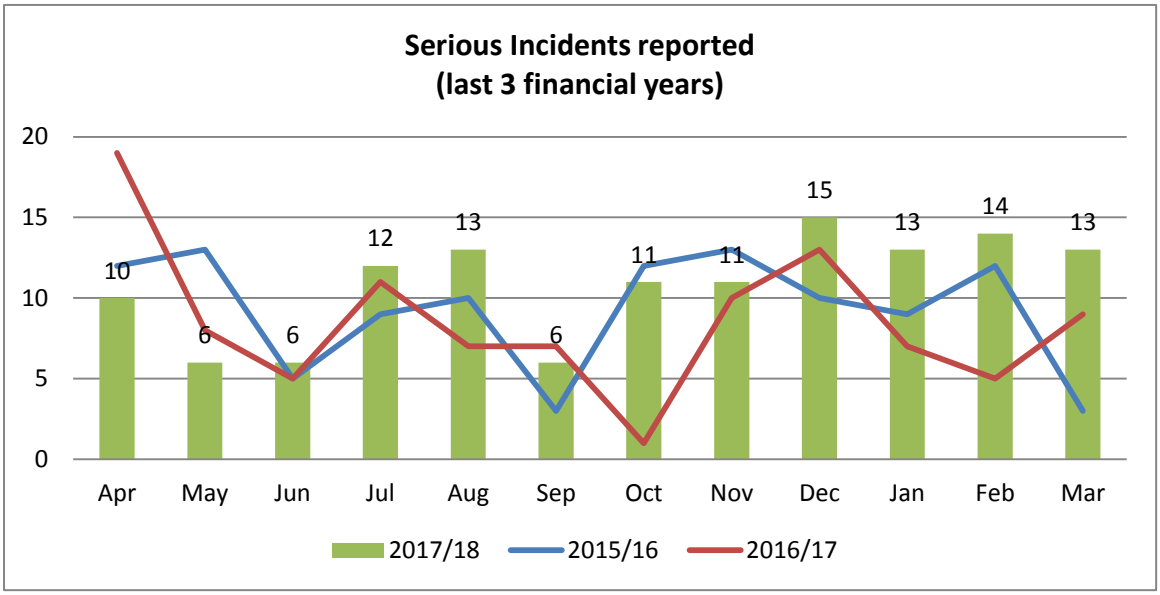


Chart 8

Chart 8 above shows that there are 6 months whereby the numbers reported in 2017/18 has exceeded those from previous financial years with common trends in activity.

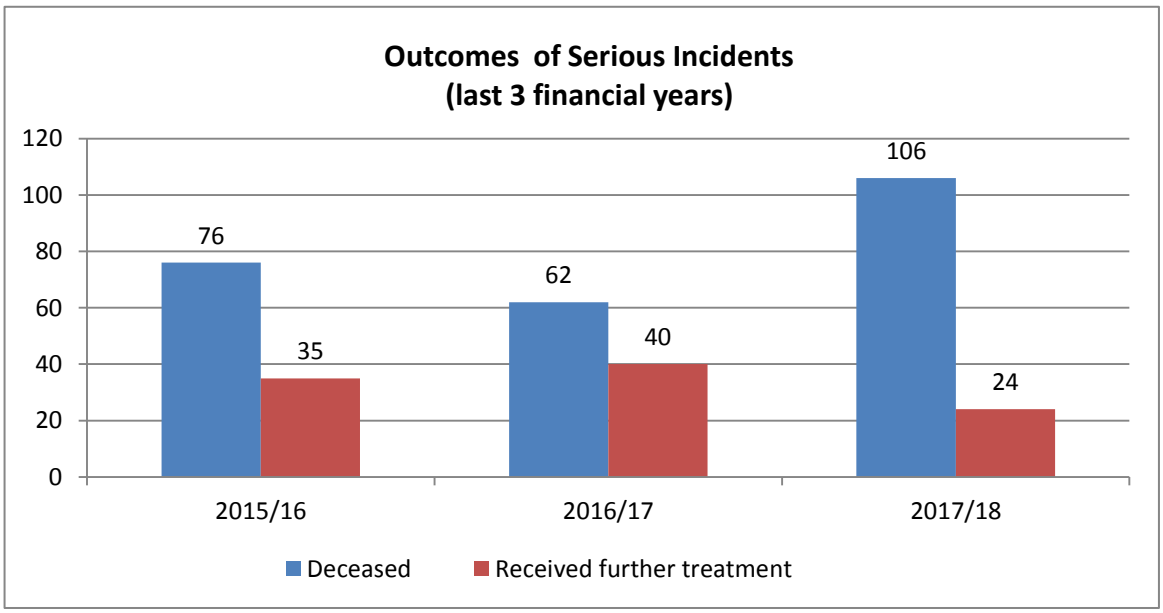


Chart 9

Chart 9 above shows the categories of serious incidents which resulted in death versus those that did not during the past 3 financial years. This shows that the proportion of incidents which do not result in death (shown in red) has

decreased during the reporting period. The Trust is reporting a total of 24 incidents that did not result in death as at the end of 2017/18 financial year. This compares to 40 incidents that did not result in death reported during 2016/17.

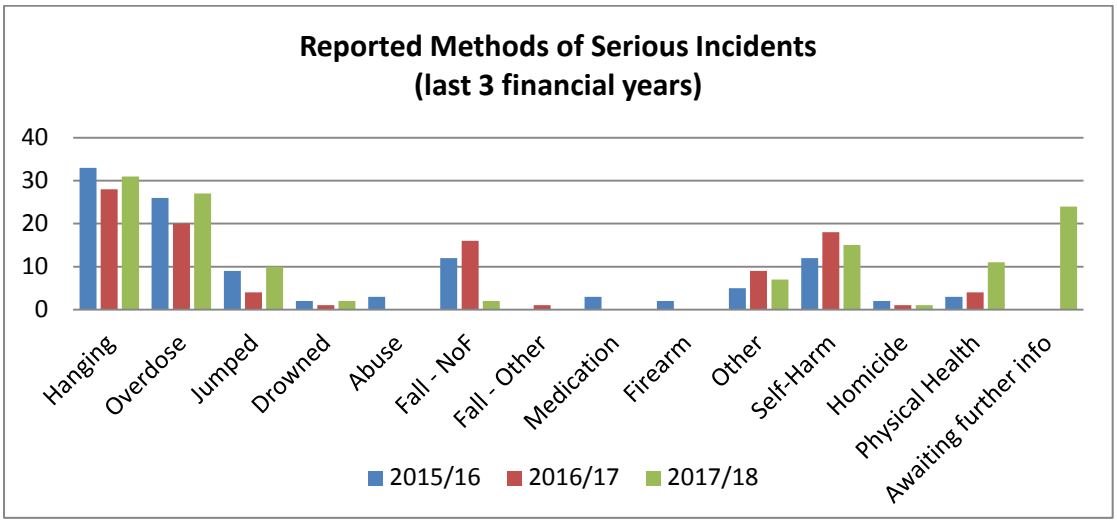


Chart 10

Chart 10 above shows the categories of serious incidents over the past 3 financial years. Hanging is consistently the most common method of suicide closely followed by overdose. This mirrors the findings from the latest National Confidential Inquiry report. At the time of writing the Trust await further information relating to method/cause of death regarding 24 Serious Incidents.

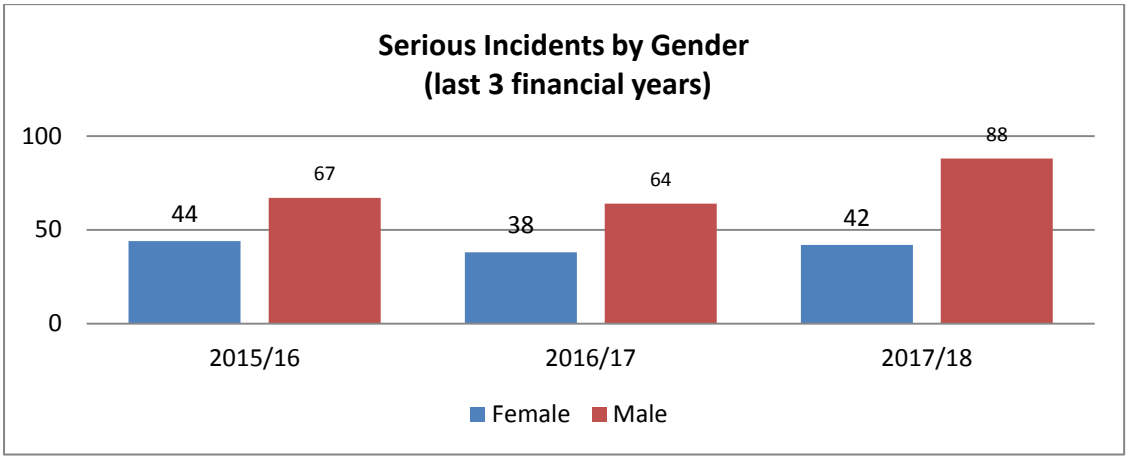


Chart 11

Chart 11 above shows the split by male/female for serious incidents reported. There was an increase of 24 serious incidents relating to males reported during 2017/18 compared to those reported in 2016/17 with 75 of the incidents (85%) resulting in death. During 2016/17, 31 of the 42 female incidents (74%) also resulted in death.

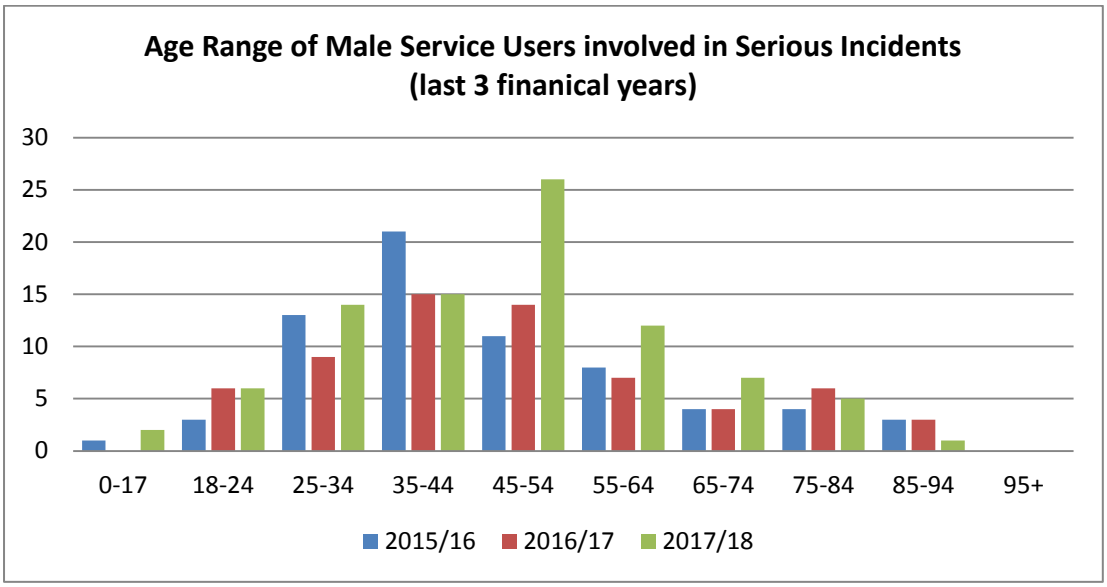


Chart 12

Chart 12 looks at the male age range. Within the reporting period the most common age range for males has been 45-54yrs with 26 SI's reported in total, this is followed by the 35-44yrs age group where 15 SI's have been reported during the same period. Recent figures from the National Confidential Inquiry also reflect the national trend is in the 45-54yr age group. Of the 26 incidents in the 45-54yrs age range 21 incidents resulted in death.

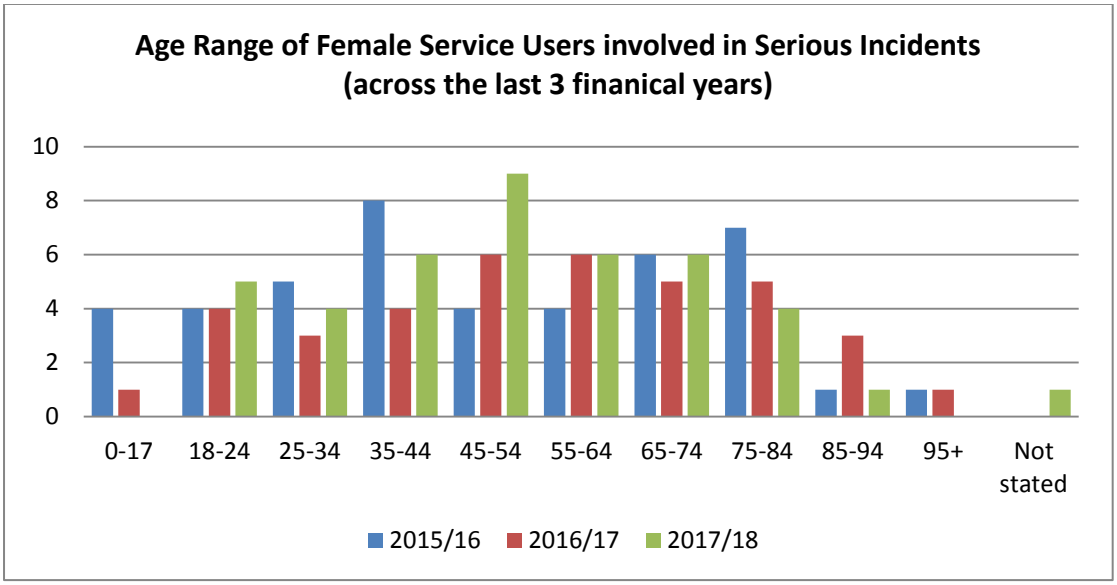


Chart 13

Chart 13 above shows that during the reporting period the commonest age range for females continues to be 45-54yrs with 9 SI's being reported in total against that age bracket; this is closely followed by older females between 55-64yrs and 65-74yrs as well as younger females between 35-44yrs where 6

SI's have been reported in each age bracket during the same period. Of the 10 incidents in the 45-54yrs age range, 9 incidents resulted in death.

3. Patient Safety Alerts

Patient safety alerts are issued via the Central Alerting System (CAS), a web-based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations, including independent providers of health and social care.

During the reporting period the Trust has received 104 alerts which is a decrease of 12 when compared to the same period 2016/17 where there were 116 alerts. Action was not required for the majority of these alerts and where action was required it was carried out accordingly. Details of the alerts received which required Trust action during the reporting period can be found at **Appendix 1**.

4. Patient Safety Team KPI's

The introduction of the upgraded Datix system in October 2015 has enabled robust systems to record key patient safety activity. In turn this has been translated into specific measurable indicators whereby the performance of the patient safety team can be monitored. From October 2015, 3 key metrics have been reported monthly to the Patient Safety Group and are listed below:

- Percentage of SI's that are reported on STEIS within 2 working days
- Percentage of initial reports received within 3 working days (72 hours) for all SI's to be reported onto STEIS
- Percentage of action plans forwarded to CCG's within 60 days (unless extension agreed)

Appendix 2 provides a monthly breakdown of the Trust's compliance against the KPI's listed above during financial year 2017/18.

Part 2 – Learning

5. Learning from Incidents

This section of the report summarises the themes from 104 Serious Incidents (SI's) that were completed and signed off by the TEWV Directors panels during 2017/18 for all localities. The numbers, therefore, will not correlate with those *reported* during the same time period as the reports from the beginning of the financial year will have been incidents that occurred in the previous year and those reported at the end of]the year would not yet have been completed.

The actions discussed within this report relate to contributory and root cause findings only. **Appendix 3** provides a trust wide overview of the incidental findings (smaller issues picked up during the course of the investigation which had no bearing on the incident occurring) from 2017/18.

Locality	Total no of SI reports completed in year	Total no of SI reports with actions*	No of separate contributory findings	No of separate root causes
Teesside	19	7 (37%)	11	-
Durham & Darlington	38	16 (42%)	34	3
York & Selby	13	8 (61%)	16	4
N Yorks	27	13 (48%)	18	4
Forensic Offender Health	7	0 (0%)	-	-
Total	104	44 (42%)	79	11

*these actions are those classed as contributory or root cause only

The above shows that the number of SI reports with actions highlights that proportionately York & Selby have the highest number of actions compared to the numbers of SI's that occurred in that locality followed by North Yorkshire, Durham & Darlington and Teesside.

Duty of Candour

The formal statutory requirement of the Duty of Candour was applied in 44 of the 104 serious incident cases (42%) which were signed off by Directors Panel during 2017/18.

Themes

The themes from all of the action points have been gathered and are summarised in the following table. As some of the root or contributory findings recommendations documented within the action plans are made up of a number of separate individual points the total number of findings is higher than the actual number of recommendations:

Root Cause or Contributory Findings	Tees	D&D	Y&S	North Yorks	Combined Total
Inadequate risk assessment, formulation, intervention planning, management	4	10	8	12	**34**
Failure to follow procedure/policy/pathway	4	9	3	3	**19**
Communication/information sharing issues	2	6	1		**9**
Physical health deterioration/recognition of symptoms	1	4	-	1	**6**
Family Involvement	-	3	2	1	**6**
Access to services/referral	-	1	2	2	**5**
Poor record keeping	-	1	4		**5**
Medicines Management	-	-	-	2	**2**
Delay in accessing treatment	**-**	2	**-**	**-**	**2**
Staffing issues	-	-	-	1	**1**
Training		1	**-**	**-**	**1**
Total per locality	**11**	**37**	**20**	**22**	**90**

The most common finding overall from all Serious Incidents in the period relates to the risk assessment, formulation and intervention planning. The second highest category relates to failure to follow policy, followed by communication / information sharing.

For actions relating to risk assessment, formulation and intervention planning (and family involvement)

In June 2016 the Trust ratified the new Harm Minimisation: A recovery-orientated approach to clinical risk assessment and management Policy and Supportive Engagement and Observation Protocol. Two experts by experience were employed as part of the Harm Minimisation Project team to co-produce and co-deliver face to face harm Minimisation training. Harm Minimisation is mandatory training for all

clinical staff of all specialities and the face the face training is continuing through 2018 supported by one hour safety summary training which is available as direct team training.

The Trust CPA Project Lead is currently undertaking work in relation to care/intervention planning. For example:

- A review of leaflets that are currently in circulation about 'The Care Programme Approach' and 'What is a Care Plan?'
- Developed CPA Principles of care planning which will be issued as a guide to be used when clinicians see patients. The principles have been used to audit 12 teams across all services and the results will inform an improvement action plan which will be monitored during 2018
- Examples of good care planning have been distributed
- The CPA Policy will be re written and published followed by a training programme to embed the new Policy and principles.

Both the CPA and Harm Minimisation Projects support the principles of family involvement and shared decision making which are also core principles of the Trust Recovery Strategy. There is currently an audit of the new Safety Summary on PARIS being carried out by the Clinical Audit Team to both assess compliance with the Safety Summary completion and to establish the level of service user/carer involvement in the process. The Trust's aim is to create an 'individualised' formulation which is produced with the service user/carer and provides a detailed understanding of potential factors that contribute towards harms and are recovery focussed.

There is to be an Executive Management Team 'deep dive' session on the topic of risk assessment and associated issues in August 2018.

For actions relating to failure to follow policy

For any instances whereby an individual staff member has been found to be not following policy targeted supervision and training will be implemented as part of the action plan. In teams where particular issues have arisen with regards to policy non-compliance a series of spot checks will be undertaken for a number of months to ensure the issue has been resolved. These will be undertaken by a variety of staff such as Heads of Nursing, Modern Matrons or the Clinical Audit Team. Occasionally it is found that a policy needs to be amended or strengthened following an incident and in such cases this would be quickly cascaded through the SBARD process and then followed up by locality management to ensure all staff are aware.

During 2017/18 the main policies which were not always adhered to were:

- Did Not Attend policy
- Clinical Record Keeping policy
- Clinical Supervision policy
- Engagement & Observation policy

One of the themes identified in the 2016/17 report was inadequate leave planning. A key piece of work was undertaken across the Trust to remind clinical staff of their responsibilities in relation to this – it included an immediate SBARD, training for all registered nurses and a policy refresh. This does not appear in the list of themes identified in 2017/18 which suggests that the shared learning from these incidents has been successful.

It is expected that each team involved in a Serious Incident Review will share the learning points in team meetings and/or supervision and this will also be discussed in the locality management meetings. For any urgent issues that need to be shared across the organisation rapidly the SBARD process is adopted. Patient Safety bulletins are also circulated with key lessons learned for staff (see section below).

For actions relating to communication/information sharing

This can be a multi-faceted issue as our services interact with many external agencies and providers notwithstanding the fact that we also have communication issues between internal teams. Some of the issues that have arisen in this area are:

- Incorrect GP details recorded/not updated on initial contact therefore key information not shared with relevant agencies
- Pertinent patient information being held on other organisations systems that staff do not have access to or cannot access quickly if a person is in crisis
- All appropriate staff are not always present at discharge meetings which means they do not have access to all required information
- GP's not being updated in a timely manner when we have changed a person's medication (and vice versa)
- Safeguarding information not being shared with the Trust Safeguarding Lead and/or directly with the Local Authority Safeguarding Team
- No evidence of the consideration of the involvement of other agencies in a person's care/life such as drug & alcohol services, probation services, local authority etc

When a communication issue is so significant that it is classed as a contributory finding or root cause to a serious incident then it will form part of the formal action plan and be addressed accordingly with all involved parties.

Patient Safety Bulletins and SBARD's

Due to the vast geographical nature of the Trust there is a requirement to use various methods of communication to share learning when incidents happen and try to prevent them from re-occurring. Two of the ways we do this are to issue Patient Safety bulletins and SBARD alert notices – during 2017/18 the following topics were covered in this way:

Did not Attend procedure	Community Depot Injection procedure
Engagement and Observation procedure	Admission into a PICU environment
Patients with weapons	Common Sense Confidentiality
Duty of Candour	Allergy status recording
Minimum standards for record keeping	CPA policy requirements

Many of the above areas are also the subject of clinical audits which allows us to monitor the effectiveness of sharing information in this way.

6. Independent Investigations Summary

Independent Investigations relate to mental health homicide cases and are managed by NHS England according to the NHS England Serious Incident Framework (2015). There are currently 6 open homicide investigations relating to the Trust. One review is not yet completed by the independent review team, 3 cases are concluded but still have actions for completion and 2 cases are awaiting completion of actions from other organisations.

7. Mortality Reviews & Learning from Deaths

In September 2017 the Trust Board ratified the 'Learning from Deaths' policy which is publicly available on the Trust's website. The policy sets out our intentions towards mortality reviews, learning from deaths and family engagement.

As part of this work the Trust has been involved in a 'northern' regional group of mental health and learning disability providers to try and establish some consistency in reporting deaths, in the absence of any current national guidance in this area.

Whilst the regional work continues, the Trust's Patient Safety Group reviews all deaths of service users on CPA (other than those that result in an SI) on a monthly basis and decides whether or not the circumstances fit the criteria for a mortality review. For those that do, a member of the Patient Safety Team carries out a structured judgement case review and the findings are taken back to the Patient Safety Group for discussion and agreement of any learning to be shared (including good practice).

During 2017/18 the Trust reviewed 106 cases as part of its mortality review process.

The majority of service users reviewed were over the age of 80 and the highest primary diagnosis was that of dementia – many had resided in care homes. Where medical cause of death was known pneumonia was the highest individual cause followed by heart failure, dementia and cancer.

The process for learning from these reviews is still being established as is the involvement of family members. The most notable learning point from the reviews so far is that of good practice/care and this has been fed back to the teams involved. Emerging areas for improvement would appear to be similar to those from some of the incidental findings from our serious incident investigations (communication to/from GP, family involvement, early warning score monitoring and multi-agency working).

8. Conclusion

The report highlights activity and learning in relation to Patient Safety for 2017/18. There were 130 Serious Incidents reported in total which is an increase of 28 on the previous year.

The most common themes from the 104 Serious Incidents reviewed in the year were:

- Inadequate risk assessment
- Failure to follow policy
- Communication/Information Sharing

The locality with the highest proportion of individual reports with root causes and/or contributory findings was York & Selby with 61% followed by North Yorkshire with 48%.

North Yorkshire had the most Serious Incidents during 2017/18 when compared to numbers of open caseload. The Executive Management Team has requested a targeted piece of work commence in the North Yorkshire locality looking at the specific themes emerging from the reviewed incidents.

Work continues to refine our mortality review processes and the Trust will also be considering emerging themes from the latest National Confidential Inquiry report during 2018/19 (Eating Disorders, ASD and Dementia) to ensure we are providing the safest possible care to these groups.

Jennifer Illingworth
Director of Quality Governance
June 2018

Appendix 1

Patient Safety Alerts 2017/18

Patient Safety Alerts 1718

Appendix 2

Patient Safety Team KPIs 2017/18

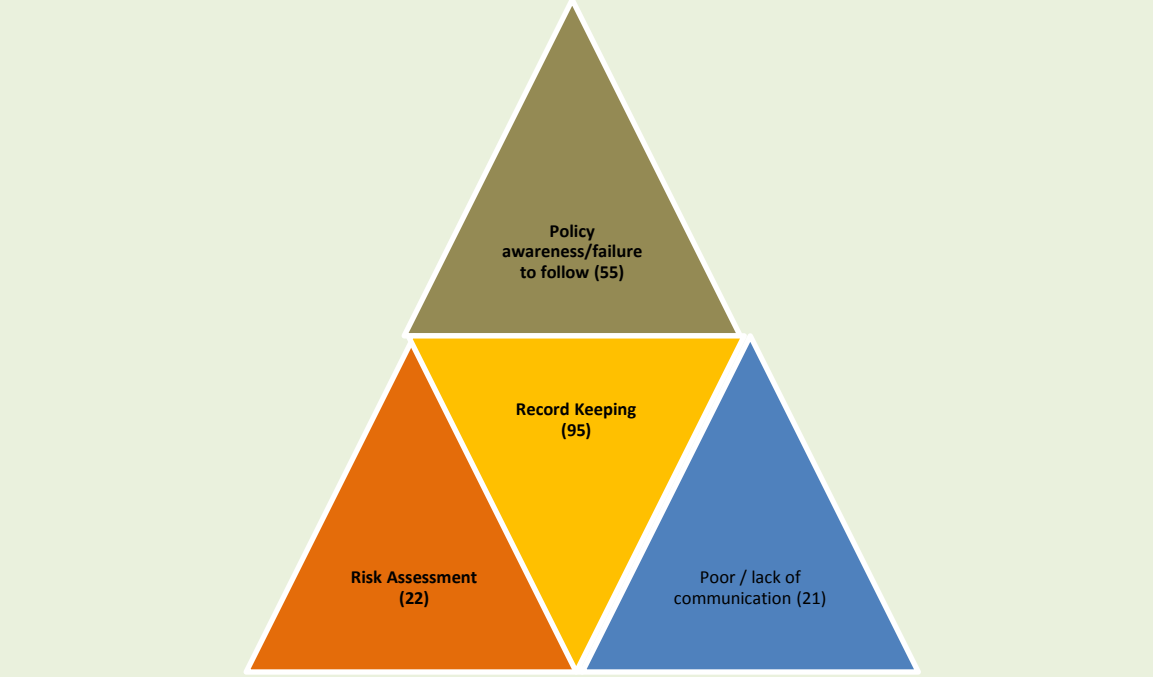
	Apr-17		May-17		Jun-17		Jul-17		Aug-17		Sep-17		Oct-17		Nov-17		Dec-17		Jan-18		Feb-18		Mar-18		YTD
	%	Traffic Light	%	Traffic Light	%	Traffic Light	%	Traffic Light	%	Traffic Light	%	Traffic Light	%	Traffic Light	%	Traffic Light	%	Traffic Light	%	Traffic Light	%	Traffic Light	%	Traffic Light	
All serious incidents to be reported on STEIS within 2 working days of a serious incident being identified, in line with NHSE SI Framework.	100%		100%		100%		100%		100%		100%		100%		100%		100%		100%		100%		100%		129
All initial reports received within 72 hours (3 working days) of all SIS reported onto STEIS	50%		67%		50%		75%		67%		67%		62%		100%		88%		100%		91%		100%		129
A detailed and comprehensive action plan is required within 60 days of reporting on STEIS	100%		100%		100%		89%		100%		86%		86%		89%		60%		67%		88%		65%		115

Appendix 3

Incidental Findings overview 2017/18

Trust wide summary of Incidental Findings

Between April 2017 and March 2018 there were 104 Serious Incident reports completed, approved by Directors panel and submitted to Commissioners which included incidental findings. There were a total of 363 incidental findings from the 104 reports which fall into the following 4 main categories:



Incidental findings are minor issues which are picked up as part of the investigation process that need to be learnt from however did not directly contribute to the incident occurring.

Key issues regarding record keeping

No next of kin recorded

No rationale for decisions made recorded

No details of contact with carers recorded

Key telephone contacts with service user and/or family members/carers not recorded

Early Warning Scores not recorded

Datix incident form not completed for untoward patient incidents

Incorrect GP details recorded causing a delay in information sharing

Engagement and Observation levels not recorded/updated

These finding are shared in each locality with key messages via the LMGB meeting. The idea is that they are discussed and then cascaded to Ward/Team Manager level so the information can be shared across all services via team meeting discussions. This is a simple way of sharing learning across the organisation.

Appendix 1

Patient Safety Alerts 2017/2018 (relevant to the Trust)

Hazard Number	Subject	Date of Issue	Deadline	Response Date	Response
MDA/2017/005	Comprehensive Reverse Titanium Shoulder Tray (Specific Lots) - Risk Of Device Fracture	04/04/2017	27/06/2017	11/04/2017	Action Not Required
NHS/PSA/RE/2017/002	Resources To Support The Safety Of Girls And Women Who Are Being Treated With Valproate	06/04/2017	06/10/2017	29/09/2017	Action Completed
MDA/2017/006	All Alaris™ GS, GH, CC, TIVA, PK, enteral syringe pumps & Asena™ GS, GH, CC, TIVA, PK, syringe pumps – risk of uncontrolled bolus of medicine	12/04/2017	12/07/2017	04/07/2017	Action completed
MDA/2017/007	LMA® MAD Nasal™ intranasal mucosal atomization device – might not deliver a fully atomised plume of medication	21/04/2017	21/06/2017	25/04/2017	Action Not Required
MDA/2017/008	LMA mucosal atomization devices - topical anaesthesia may not be delivered in a fully atomised spray	24/04/2017	26/06/2017	25/04/2017	Action Not Required
MDA/2017/009	Bd Plastipak 100ml Catheter Tip Syringe With Luer Slip Adaptor, Specific Lots - Risk Of Leakage And Delayed Therapy	24/04/2017	31/05/2017	30/05/2017	Action Not Required
MDA/2017/010	BD Plastipak 100ml catheter tip syringe with Luer slip adaptor, specific lots – risk of leakage and delayed therapy	02/05/2017	06/06/2017	11/05/2017	Action Not Required
MDA/2017/011	Biological replacement pericardial aortic heart valve: Mitroflow LX (sizes 19mm and 21mm) – risk of early structural valve deterioration	03/05/2017	11/08/2017	11/05/2017	Action Not Required
EFN/2017/07	High Voltage Hazard Alert - National Equipment Defect Report (Neder) - Siemens - Argus 1 Platform - Protection	09/05/2017	06/06/2017	09/05/2017	Action Not Required
EFN/2017/08	Low Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - UPDATE - SICAME - Low Voltage Link Box	15/05/2017	12/06/2017	18/05/2017	Action not Required

EFN/2017/09	High Voltage Hazard Alert - NATIONAL EQUIPMENT DEFECT REPORT (NEDeR) - Prysmian - 11 kV Single Core 300mm2 XLPE Insulation - Cable	16/05/2017	13/06/2017	17/05/2017	Action Not Required
EFN/2017/10	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Reyrolle - ROKSS/CC - Ring Main Unit	17/05/2017	13/06/2017	18/05/2017	Action Not Required
MDA/2017/012	V60 ventilator – potential for unexpected shutdown	17/05/2017	17/08/2017	24/05/2017	Action Not Required
MDA/2017/013	All LIFEPAK 1000 automatic external defibrillators (AEDs) - risk of device shutting down unexpectedly during patient treatment and possible failure to deliver therapy	18/05/2017	19/06/2017	16/06/2017	Action Completed
MDA/2017/014	All Heartstart Mrx Defibrillators - Possible Failure To Deliver A Shock, Cardioversion, Pacing Or Monitoring	24/05/2017	23/06/2017	22/06/2017	Action Completed
EFN/2017/11	High Voltage Hazard Alert - NATIONAL EQUIPMENT DEFECT REPORT (NEDeR) - UPDATE - Areva T&D Automation & Information Services - MICOM P123 - Protection	31/05/2017	28/06/2017	01/06/2017	Action Not Required
EFN/2017/12	High Voltage Hazard Alert - National Equipment Defect Report (Neder) - Lucy Switchgear - Sabre Vrn2a - Ring Main Unit	31/05/2017	28/06/2017	01/06/2017	Action Not Required
EFN/2017/13	High Voltage Hazard Alert - Dangerous Incident Notification (Din) - Lucy Switchgear - Sabre Vrn2a - Ring Main Unit	01/06/2017	29/06/2017	01/06/2017	Action Not Required
EFN/2017/14	High Voltage Hazard Alert - Dangerous Incident Notification (Din) - Update - Schneider Electric - Rn2c - Ring Main Unit	01/06/2017	29/06/2017	05/06/2017	Action Not Required
EFN/2017/04(U)	High Voltage Hazard Alert - National Equipment Defect Report (Neder) - Update - Brush Switchgear - Vtd - Circuit Breaker	05/06/2017	03/07/2017	05/06/2017	Action Not Required
EFN/2017/15	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Schneider Electric - RN6c - Ring Main Unit	05/06/2017	03/07/2017	06/06/2017	Action Not Required

EFN/2017/16	High Voltage Hazard Alert - National Equipment Defect Report (Neder) - Abb - Vd4/Zs1 - Circuit Breaker	06/06/2017	04/07/2017	06/06/2017	Action Not Required
EFN/2017/17	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Reyrolle - C7T - Circuit Breaker	06/06/2017	04/07/2017	07/06/2017	Action Not Required
EFN/2017/18	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Lucy Switchgear - FRMU Mk II - Ring Main Unit	07/06/2017	05/07/2017	07/06/2017	Action Not Required
EFN/2017/19	High Voltage Hazard Alert - Suspension Of Operational Practice (Sop) - Reyrolle - Lmi - Ring Main Unit	07/06/2017	05/07/2017	08/06/2017	Action Not Required
MDA/2017/015	Solus Flexible Wire Reinforced Laryngeal Mask Airway – risk of hypoxia due to partial or total occlusion of the airway tube after inflating the cuff	09/06/2017	23/06/2017	15/06/2017	Action Not Required
EFN/2017/20	High Voltage Hazard Alert - National Equipment Defect Report (Neder) - Long &Amp; Crawford - Lcgt - Ring Main Unit	12/06/2017	10/07/2017	12/06/2017	Action Not Required
EFN/2017/21	Low Voltage Hazard Alert - Dangerous Incident Notification (Din) - Schneider Electric - Transformer Mounted - Lv Cabinet	12/06/2017	03/07/2017	04/07/2017	Action Completed
MDA/2017/016	Depuy Synthes Radial Head Elbow Prosthesis System: Risk Of Post-Operative Loosening Of The Radial Stem	12/06/2017	03/07/2017	16/06/2017	Action Not Required
EFN/2017/22	High Voltage Hazard Alert - NATIONAL EQUIPMENT DEFECT REPORT (NEDeR) - Long & Crawford - T4GF3 - Ring Main Unit	13/06/2017	11/07/2017	14/06/2017	Action Not Required
EFN/2017/23	High Voltage Hazard Alert - NATIONAL EQUIPMENT DEFECT REPORT (NEDeR) - Hawker Siddeley Switchgear Ltd - Eclipse - Circuit Breaker	21/06/2017	19/07/2017	26/06/2017	Action Not Required
MDA/2017/017	BVM (Bag-Valve-Mask) manual resuscitation systems – risk of delay to emergency treatment	21/06/2017	19/07/2017	18/07/2017	Action Completed
MDA/2017/018	MHRA is updating advice provided in MDA/2012/036, to assist the early detection of soft tissue reactions in	29/06/2017	27/07/2017	03/07/2017	Action Not Required

	patients implanted with metal-on-metal (MoM) hip replacements				
NHS/PSA/W/2017/003	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	05/07/2017	16/08/2017	10/07/2017	Action Not Required
MDA/2017/019	Unomedical high concentration oxygen masks (specific lots) - risk of hypoxia as the tubing can disconnect from the oxygen mask	10/07/2017	31/07/2017	25/07/2017	Action Not Required
MDA/2017/020	Haemofiltration machine: all Prismaflex systems installed with software version 6.10 – risk of under-infusion of anticoagulant	11/07/2017	01/08/2017	18/07/2017	Action Not Required
EFN/2017/24	High Voltage Hazard Alert - Dangerous Incident Notification (Din) - Hawker Siddeley Switchgear Ltd - Hawkgas Hg12 - Circuit Breaker	18/07/2017	15/08/2017	18/07/2017	Action Not Required
EFN/2017/25	High Voltage Hazard Alert - Suspension Of Operational Practice (Sop) - Hawker Siddeley Switchgear Ltd - Hawkgas Hg12 - Circuit Breaker	20/07/2017	17/08/2017	21/07/2017	Action Not Required
EFN/2017/15 (U)	High Voltage Hazard Alert - Dangerous Incident Notification (Din) - Update - Schneider Electric - Rn6c - Ring Main Unit	04/08/2017	01/09/2017	14/08/2017	Action Not Required
EFN/2017/26	High Voltage Hazard Alert - National Equipment Defect Report (Neder) - Abb - Series 2 Sdaf - Ring Main Unit	07/08/2017	04/09/2017	08/08/2017	Action Not Required
EFN/2017/26R	High Voltage Hazard Alert - National Equipment Defect Report (Neder) - Abb - Series 2 Sdaf - Ring Main Unit	07/08/2017	04/09/2017	14/08/2017	Action Not Required
NHS/PSA/RE/2017/004	Resources to support safe transition from the Luer connector to NRFit for intrathecal and epidural procedures, and delivery of regional blocks	11/08/2017	11/12/2017	11/08/2017	Action Not Required
EFN/2017/27	High Voltage Hazard Alert - Dangerous Incident Notification (Din) - Hawker Siddeley Switchgear Ltd - Urv12 - Circuit Breaker	11/08/2017	08/09/2017	14/08/2017	Action Not Required
EFN/2017/28	High Voltage Hazard Alert - Dangerous Incident Notification (Din) - Schneider Electric - Genie Evo - Circuit Breaker	14/08/2017	11/09/2017	14/08/2017	Action Not Required

EFN/2017/29	High Voltage Hazard Alert - National Equipment Defect Report (Neder) - Hawker Siddeley Switchgear Ltd - Eclipse - Circuit Breaker	14/08/2017	11/09/2017	15/08/2017	Action Not Required
MDA/2017/021	VITEK®2 Identification (ID) / Antimicrobial Susceptibility Test (AST) Cards – potential false resistance for antibiotics on the AST panel, leading to false negative ESBL test or false positive urea (URE) reaction on ID cards	14/08/2017	14/09/2017	17/08/2017	Action Not Required
MDA/2017/022	DePuy Synthes Impactor for PFNA (Proximal Femoral Nail Anti-rotation) Blade: risk of infection	17/08/2017	15/09/2017	21/08/2017	Action Not Required
MDA/2017/023	Shoulder system: Comprehensive Nano Humeral Components – increased risk of revision when used in reverse configuration	18/08/2017	18/09/2017	21/08/2017	Action Not Required
EFA/2017/002	Anti-Barricade Devices: Risk Of Ineffectivity In Certain Circumstances	21/08/2017	19/02/2018	05/02/2018	Action Completed
MDA/2017/024	Insulin Pens: Novopen Echo And Novopen 5 (Certain Batches) - Risk Of Hyperglycaemia Due To Cartridge Holder Weakening When Exposed To Certain Household Chemicals	24/08/2017	25/09/2017	22/09/2017	Action Not Required
MDA/2017/025	Nail intramedullary fixation system: Trauma guide wires 70cm – risk of infection	24/08/2017	25/09/2017	30/08/2017	Action Not Required
MDA/2017/026	Overhead hoist: Freeway Easy Fit system with a swivelling trolley – risk of fixing pin moving or splaying	24/08/2017	25/09/2017	22/09/2017	Action Not Required
MDA/2017/027	Intra-aortic balloon pump (IABP): CS100, CS100i and CS300 – risk of haemodynamic instability to patients with critical conditions due to a delay in or sudden interruption of therapy	24/08/2017	15/09/2017	30/08/2017	Action Not Required
MDA/2017/028	Replacement Bileaflet Mechanical Heart Valves - Risk Of Inverted Implantation	31/08/2017	12/10/2017	04/09/2017	Action Not Required
MDA/2017/028R	Replacement Bileaflet Mechanical Heart Valves - Risk Of Inverted Implantation	31/08/2017	12/10/2017	06/09/2017	Action Not Required
EFA/2017/ 003	Guidance for the Correct Use and Disposal of Batteries used in Health and Social Care Equipment	06/09/2017	29/11/2017	24/11/2017	Action Completed
MDA/2017/029	Lung ventilators: Astral 100, 100SC and 150 –	13/09/2017	14/11/2017	18/09/2017	Action Not

	potential power loss due to faulty battery				Required
MDA/2017/030	All Accu-Chek® Insight Insulin Pumps - Risk Of Alarm Failure	20/09/2017	18/10/2017	13/10/2017	Action Not Required
NHS/PSA/W/2017/005	Risk of severe harm and death from infusing total parenteral nutrition too rapidly in babies	27/09/2017	08/11/2017	28/09/2017	Action Not Required
MDA/2017/031	IntelliVue patient monitors used with 12-lead ECG – risk of ECG trace distortion Specific models and software versions affected.	28/09/2017	26/10/2017	05/10/2017	Action Not Required
MDA/2017/032	Intra-Aortic Balloon Pump (Iabp): Maquet/Datascope Cs100, Cs100i And Cs300 - Potential For Interruption Or Delay To Therapy Of Critically Ill Patients	03/10/2017	14/11/2017	05/10/2017	Action Not Required
MDA/2017/033	Professional use HIV test: Alere HIV Combo – risk of false positive results	03/10/2017	14/11/2017	09/10/2017	Action Not Required
EFA/2017/004	Ideal Standard (Armitage Shanks) A4129a Contour 21 Thermostatic Built In Shower Valve (Supplied Separately And As Part Of Armitage Shanks S6960xx Doc M Shower Packs): Safety Inspections Required	24/10/2017	24/01/2018	31/10/2017	Action Not Required
EFN/2017/16 (U)	High Voltage Hazard Alert - National Equipment Defect Report (Neder) - Update - Abb - Vd4/Zs1 - Circuit Breaker	30/10/2017	27/11/2017	31/10/2017	Action Not Required
EFN/2017/30	High Voltage Hazard Alert - Dangerous Incident Notification (Din) - Reyrolle - Cgt - Circuit Breaker	30/10/2017	27/11/2017	31/10/2017	Action Not Required
EFN/2017/17/(U)	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Reyrolle - C7T - Circuit Breaker	31/10/2017	28/11/2017	31/10/2017	Action Not Required
NHS/PSA/D/2017/006	Confirming Removal or Flushing of Lines and Cannulae after Procedures	09/11/2017	09/08/2018	10/11/2017	Action Not Required
EFN/2017/31	High Voltage Hazard Alert - National Equipment Defect Report (Neder) - Alstom T&Amp;D Protection And Control - P142 Protection Relay	14/11/2017	12/12/2017	15/11/2017	Action Not Required
EFA/2017/005	Unbranded LED decorative lighting chains, model CL100: risk of electric shock due to inadequate construction - remove from use	21/11/2017	21/12/2017	19/12/2017	Action Completed

MDA/2017/034	ThermoScientificTM OxoidTM CAZ10 CEFTAZIDIME, CT1629B Antimicrobial Susceptibility Test Disc – Concentration of antibiotic decreases if not frozen potentially leading to false resistance results.	23/11/2017	21/12/2017	28/11/2017	Action Not Required
EFN/2017/32	High Voltage Hazard Alert - National Equipment Defect Report (Neder) - Hawker Siddeley Switchgear Ltd - Eclipse - Circuit Breaker	27/11/2017	27/12/2017	28/11/2017	Action Not Required
EFN/2017/33	High Voltage Hazard Alert - Dangerous Incident Notification (Din) - Mid Central Electric - 11/0.110 Kv 500 Va - Pole Mounted Vt	27/11/2017	27/12/2017	01/12/2017	Action Not Required
EFN/2017/34	High Voltage Hazard Alert - National Equipment Defect Report (Neder) - Efacec - 11 Kv/433 V Transformers (Various Ratings)	05/12/2017	02/01/2018	06/12/2017	Action not Required
EFN/2017/35	High Voltage Hazard Alert - NATIONAL EQUIPMENT DEFECT REPORT (NEDeR) - UPDATE - Schneider Electric - RN2c - Ring Main Unit	06/12/2017	03/01/2018	06/12/2017	Action not Required
EFN/2017/36	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Hawker Siddeley Switchgear Ltd - HG12 - Circuit Breaker	06/12/2017	03/01/2018	06/12/2017	Action not Required
EFA/2017/006	Supply Of Cna 2000 Pipeline Gaskets: Presence of Asbestos	07/12/2017	08/02/2018	05/02/2018	Action Completed
MDA/2017/035	Nasogastric (NG) feeding tubes – recall due to risk of neonatal or paediatric patient choking on ENFIT connector cap	19/12/2017	20/04/2018	09/04/2018	Action Not Required
MDA/2017/036	Syringe pumps – required user actions in the event of PL3 alarm to prevent risk of interrupted infusion	20/12/2017	23/03/2018	21/12/2017	Action Not Required
MDA/2017/036R	Syringe Pumps - Required User - Actions In The Event Of Pl3 Alarm To Prevent Risk Of Interrupted Infusion.	20/12/2017	23/04/2018	09/04/2018	Action Not Required
MDA/2017/037	Alterg Anti-Gravity Treadmill, Model M320, Used For Rehabilitation After Surgery - Unexpected Surge To Maximum Speed And Failure Of The Emergency Stop	21/12/2017	12/04/2018	13/02/2018	Action Not Required
EFN/2017/37	Low Voltage Hazard Alert - Dangerous Incident Notification (Din) - Henley - Pc400 - Pole Mounted	28/12/2017	25/01/2018	04/01/2018	Action Not Required

	Fuse Cut-Out				
EFN/2017/38	Low Voltage Hazard Alert - National Equipment Defect Report (Neder) - Abb - Sace - Emax En2 12 - Circuit Breaker	28/12/2017	25/01/2018	04/01/2018	Action Not Required
NHS/PSA/W/2018/001	Risk Of Death And Severe Harm From Failure To Obtain And Continue Flow From Oxygen Cylinders	09/01/2018	20/02/2018	15/02/2018	Action Completed
EFN/2018/01	Low Voltage Hazard Alert - National Equipment Defect Report (Neder) - Lucy Switchgear - Aculock - Low Voltage Cabinet	11/01/2018	08/02/2018	16/01/2018	Action Not Required
MDA/2018/001	Pacemakers And Crt-P - Oversensing Of Minute Ventilation Sensor Signal Leading To Risk Of Syncope And Pre-Syncope	12/01/2018	12/07/2018	15/02/2018	Action not Required
EFN/2017/38 (A)	Low Voltage Hazard Alert - NATIONAL EQUIPMENT DEFECT REPORT (NEDeR) - AMENDMENT - ABB - SACE - EMAX - ES2 16 - Circuit Breaker	16/01/2018	13/02/2018	16/01/2018	Action Not Required
EFN/2018/02	High Voltage Hazard Alert - SUSPENSION OF OPERATIONAL PRACTICE (SOP) - Schneider Electric - RN2d - Ring Main Unit	16/01/2018	13/02/2018	17/01/2018	Action Not Required
MDA/2018/002	All Philips HeartStart MRx monitors/defibrillators – significant delay in the supply of batteries	15/01/2018	05/02/2018	23/01/2018	Action not Required
MDA/2018/003	In Vitro Fertilisation (Ivf) And Assisted Reproduction Technologies (Art) Products - Precautionary Measure	22/01/2018	19/02/2018	24/01/2018	Action not required
NHSI/2018/001	Reporting Of Defects And Failures And Disseminating Estates And Facilities Alerts	25/01/2018	22/03/2018	26/01/2018	Action Completed
EFN/2018/03	Low Voltage Hazard Alert - National Equipment Defect Report (Neder) - Lucy Switchgear - Aculock - Low Voltage Cabinet	29/01/2018	26/02/2018	01/02/2018	Action Not Required
EFN/2018/04	High Voltage Hazard Alert - National Equipment Defect Report (Neder) - Schneider Electric - Rn2c - Ring Main Unit	29/01/2018	26/02/2018	01/02/2018	Action Not Required
EFN/2018/05	High Voltage Hazard Alert - Dangerous Incident Notification (Din) - Update - Gec Alsthom - Hwx - Circuit Breaker	13/02/2018	13/03/2018	13/02/2018	Action Not Required

EFN/2018/06	High Voltage Hazard Alert - Dangerous Incident Notification (Din) - Update - Lucy Switchgear - Frmu Mk Ii - Ring Main Unit	13/02/2018	13/03/2018	15/02/2018	Action Not Required
EFN/2018/07	High Voltage Hazard Alert - Dangerous Incident Notification (Din) - Schneider Electric - Rn2c - Ring Main Unit	14/02/2018	14/03/2018	15/02/2018	Action Not Required
MDA/2018/004	Recall Of Specific Lots Of Rusch Sensor (Series 400) Silicone And Non-Sterile Rectal/ Pharyngeal Temperature Sensors	14/02/2018	07/03/2018	19/02/2018	Action Not Required
MDA/2018/005	Roche Tissue Diagnostics (Ventana Medical Systems) - Optiview Dab Ihc Detection Kit, Ultraview Universal Dab Detection Kit, Optiview Amplification Kit And Hematoxylin Ii - Dispenser Failure Of Hematoxylin Ii And Horseradish Peroxidase Reagents.	15/02/2018	15/03/2018	16/02/2018	Action Not Required
MDA/2018/006	Plum 360 Infusion Pumps - User Actions Required To Prevent Risk Of Interrupted Infusion Or Delay To Treatment	15/02/2018	15/03/2018	16/02/2018	Action Not Required
MDA/2018/007	Zimmer Biomet, Specific Hip And Trauma Instruments: Risk Of Infection	15/02/2018	15/03/2018	16/02/2018	Action Not Required
MDA/2018/008	Aquilon Series Of Nebulisers - Ce Mark Withdrawn And Supply Ceased	22/02/2018	05/04/2018	26/03/2018	Action Not Required
MDA/2018/009	Bag Valve Mask (Bvm) Manual Resuscitation System - Risk Of Damage To Lungs By Delivery Of Excessive Pressure	02/03/2018	17/04/2018	26/03/2018	Action Not Required
EFN/2018/08	High Voltage Hazard Alert - National Equipment Defect Report (Neder) - Schneider Electric - Rn2c - Ring Main Unit	05/03/2018	03/04/2018	09/03/2018	Action Not Required
CHT/2018/001	Alert From The Central Alerting System Helpdesk Team - Upcoming Changes To The Central Alerting System	23/03/2018	03/04/2018	26/03/2018	Action Completed
MDA/2018/010	All T34 Ambulatory Syringe Pumps - Risk Of Unintended Pump Shutdown And Delay To Treatment	28/03/2018	25/06/2018	25/06/2018	Action Completed

Item 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**3 July 2018**
TITLE:	**Finance Report for Period 1 April 2018 to 31 May 2018**
REPORT OF:	**Patrick McGahon, 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 May 2018 is a surplus of £1,240k, representing 2.2% of the Trust's turnover and is £196k behind the original plan (a) largely due to flexible staffing supporting enhanced observations and complex clients (£666k) partially mitigated by vacancies. However, NHS Improvement has confirmed a reduction in the Trust's control total (£1,692k) which is non-recurrently mitigating CRES delivery by £282k at month 2. Adjusting for this change means the variance to revised plan, taking into account the control total, is marginally ahead of plan by £86k (b).

	Annual Plan	**Year to Date Plan**	**Year to Date Actual**	**YTD Variance**
	£000	£000	£000	£000
Income From Activities	(324,471)	(53,217)	(53,184)	33
Other Operating Income	(15,503)	(3,236)	(3,228)	9
Total Income	**(339,974)**	**(56,453)**	**(56,412)**	**42**
Pay Expenditure	255,908	42,877	42,955	78
Non-Pay Expenditure	64,194	10,255	10,372	117
Depreciation and Financing	11,317	1,885	1,845	(40)
Variance from original plan (a)	**(8,556)**	**(1,436)**	**(1,240)**	**196**
Impact of revised control total	1,692	282	0	(282)
Variance after revised control total (b)	**(6,864)**	**(1,154)**	**(1,240)**	**(86)**

Identified Cash Releasing Efficiency Savings (CRES) at 31 May 2018 are £1,797k behind plan, reflecting an improvement of £2,673k largely due to non-recurrent mitigations following confirmation of lower than planned public dividend capital dividend payments and depreciation. The Trust continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements.

Including the adjustment to the control total as a mitigation against CRES means it is £105k behind plan.

To manage this risk and enable the Trust to achieve its 2018/19 financial plan, non-recurrent mitigations are being developed, and will include items such as expenditure reduction schemes and re-profiling of non-recurrent projects.

The Use of Resources Rating for the Trust is assessed as 3 for the period ending 31 May 2018 and is in line with plan. The 3 rating arises due to a loan repayment made during April 2018, which impacts on the Capital Service Cover score.

The rating is planned to return to a 1 by the end of quarter 2.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**3 July 2018**
TITLE:	**Finance Report for Period 1 April 2018 to 31 May 2018**

1. INTRODUCTION & PURPOSE

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

2. BACKGROUND INFORMATION

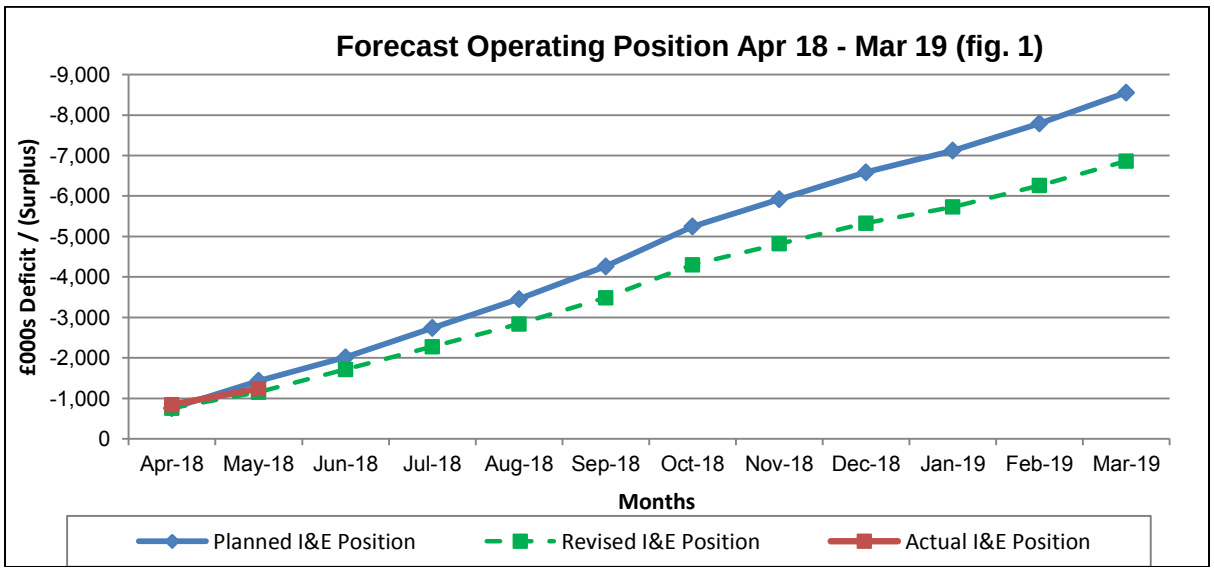
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 31 May 2018 is a surplus of £1,240k, representing 2.2% of the Trust's turnover and is £196k behind the original plan largely due to flexible staffing supporting enhanced observations and complex clients (£666k) partially mitigated by vacancies. However, NHS Improvement has confirmed a reduction in the Trust's control total (£1,692k) which is non-recurrently mitigating CRES delivery by £282k at month 2. Adjusting for this change means the variance to revised plan, taking into account the control total, is marginally ahead of plan by £86k.

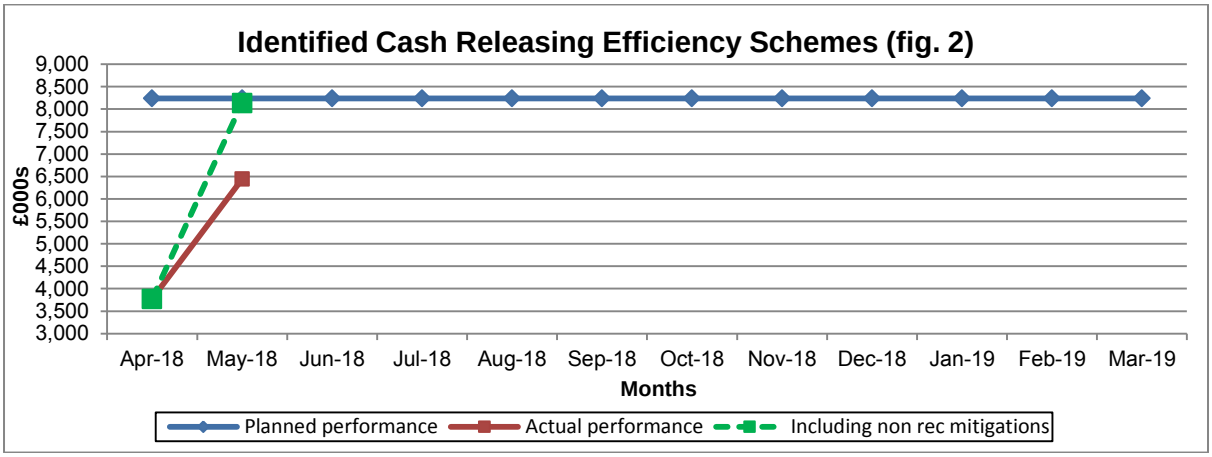
The graph below (fig. 1) shows the Trust's planned operating surplus against actual performance.



3.2 Cash Releasing Efficiency Savings

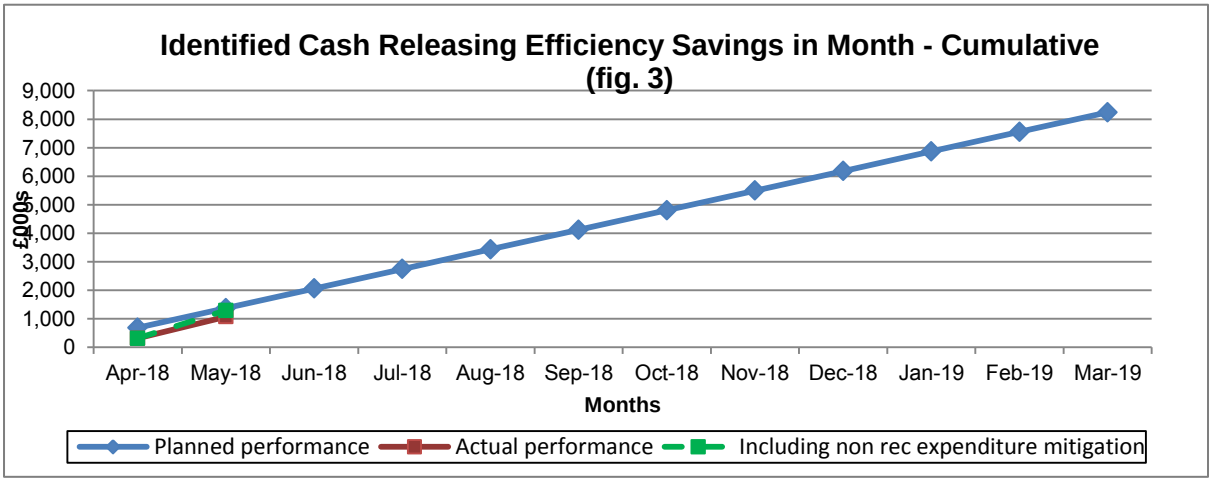
Total CRES identified at 31 May 2018 is £6,445k and is £1,797k behind plan, reflecting an improvement of £2,673k largely due to confirmation of lower than planned PDC dividend payments and depreciation (fig. 2).

NHS Improvement has confirmed a reduction in the Trust's control total (£1,692k) which is non-recurrently mitigating CRES delivery. Including this mitigation CRES is £105k behind plan.



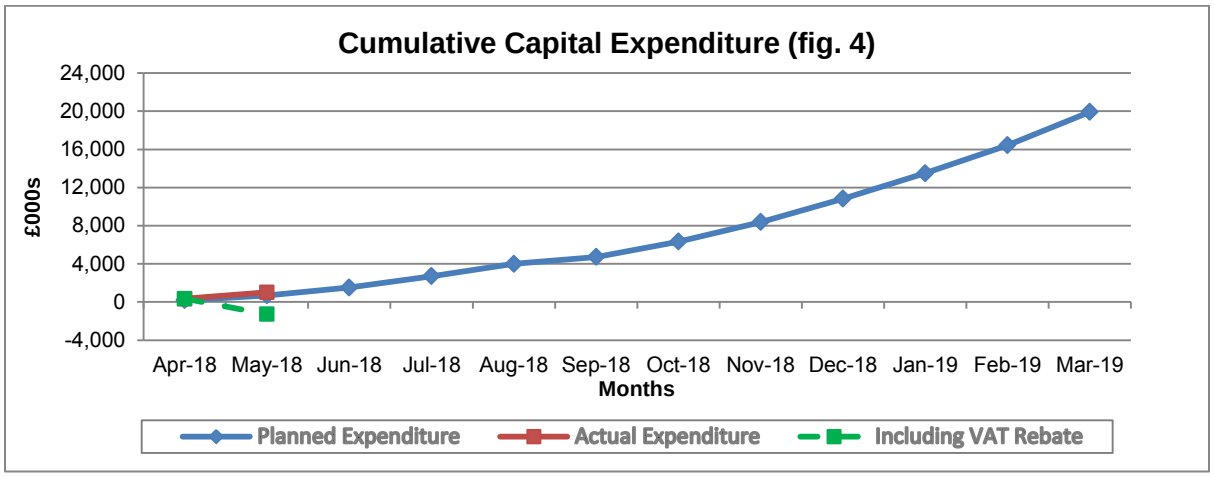
The monthly profile for CRES identified by Localities is shown below (fig. 3).

Total CRES savings delivered at 31 May 2018 is £1,074k and is £300k behind plan. Including mitigating items discussed in 3.2 the Trust is £81k behind plan. The Trust continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements.



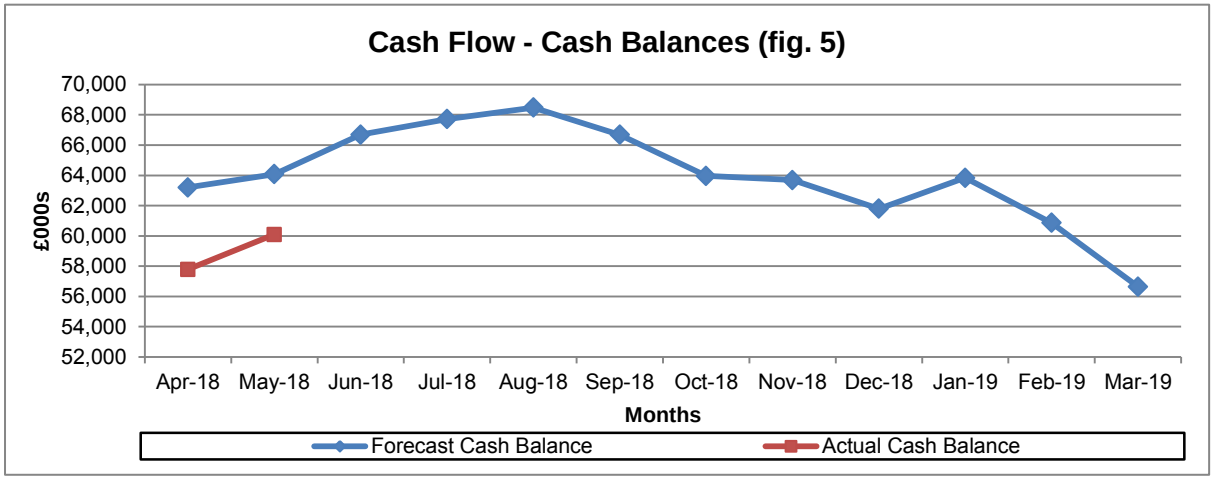
3.3 Capital Programme

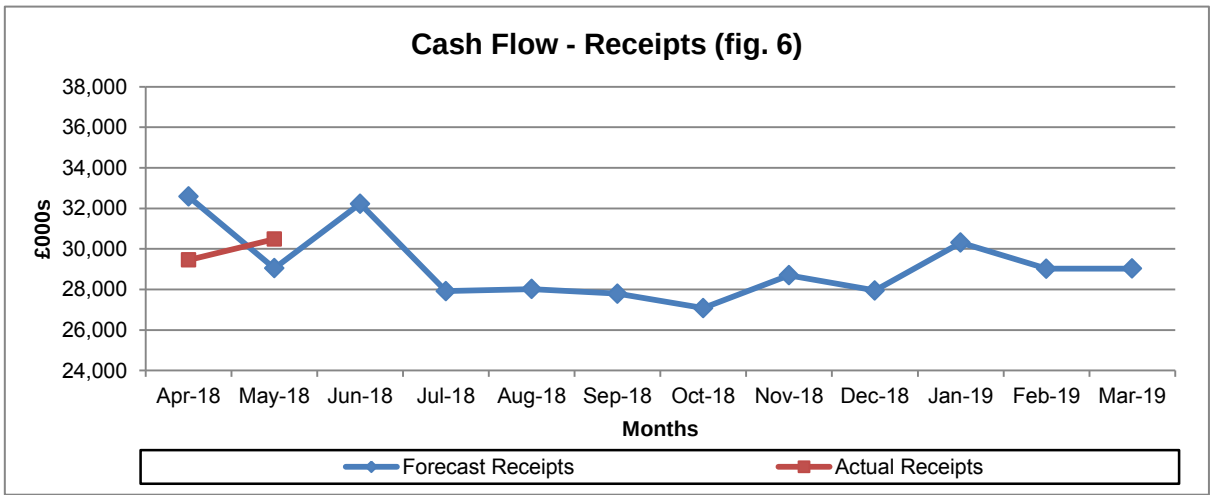
Expenditure against the capital programme to 31 May 2018 is £1,019k and is £320k ahead of plan due to the carry forward of a number of minor schemes that did not complete in 2017/18 financial year (fig. 4). The Trust received a capital rebate relating to prior year schemes (£2,289k), with this included, capital expenditure is £1,969k behind plan.

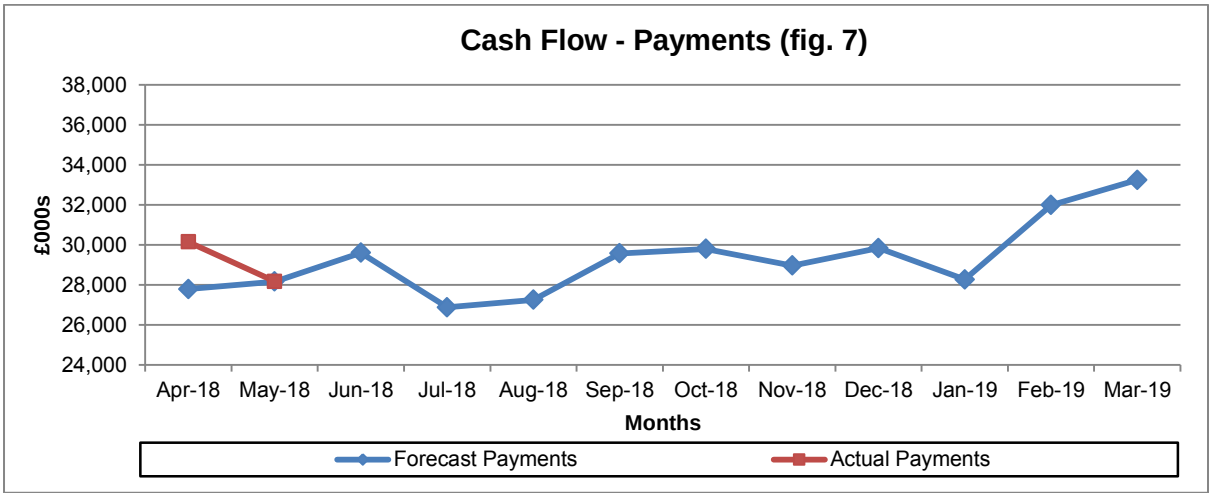


3.4 Cash Flow

Total cash at 31 May 2018 is £60,093k, and is £3,985k behind plan largely due to working capital variations, e.g. receipts from commissioner contract settlements were anticipated in April but remain outstanding. Discussions to resolve this debt have been positive, a meeting has been arranged to finalise any outstanding issues, with payment now anticipated during July (fig. 5).





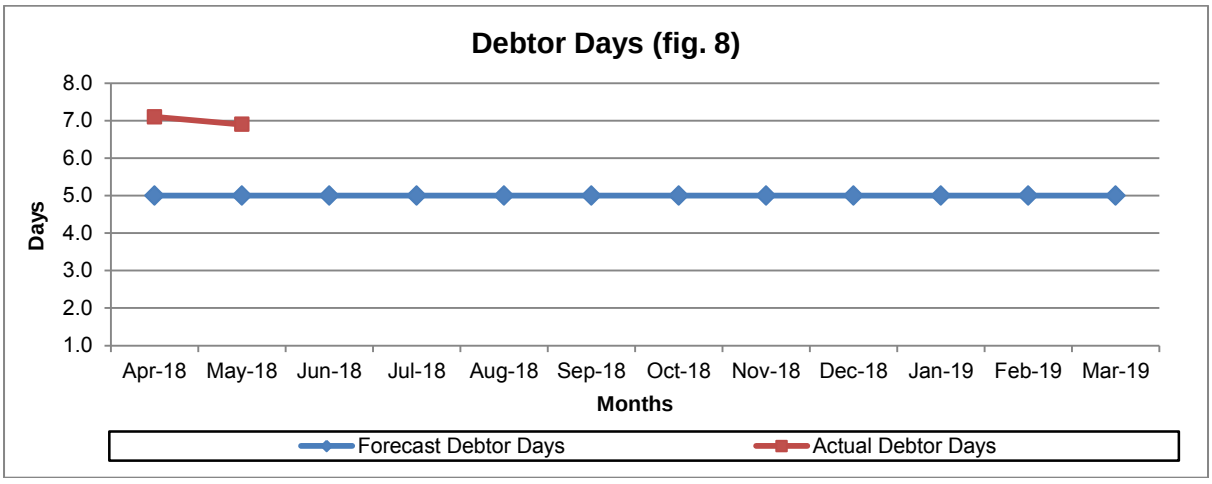


The receipts profile (fig. 6) fluctuates over the year for Sustainability and Transformation Fund incentive scheme receipt (June). The payments profile fluctuates over the year for PDC dividend payments (September and March), financing repayments (April and October) and capital expenditure.

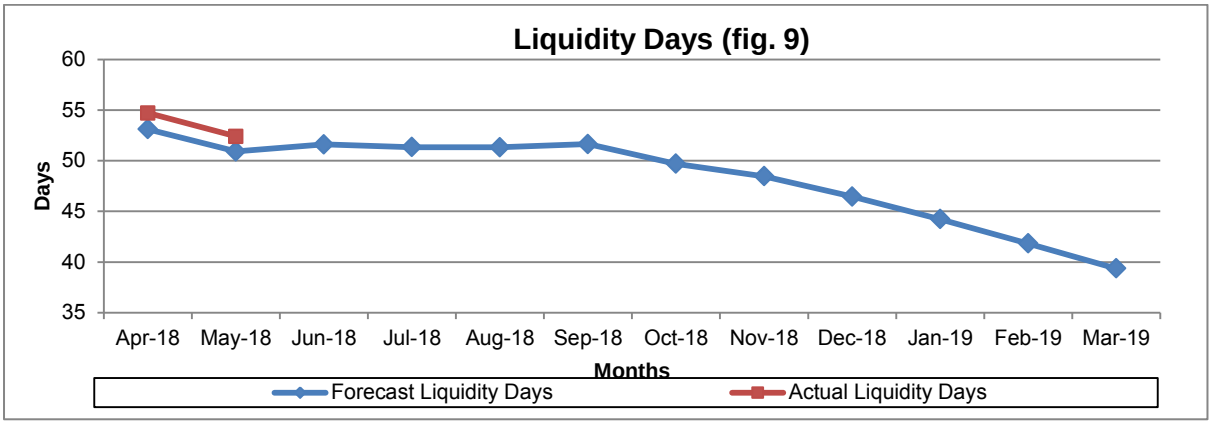
Working Capital ratios for period to 31 May 2018 are:

- Debtor Days of 6.9 days
- Liquidity of 52.4 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 60.93%
  Non NHS 30 Days – 96.54%

The Trust has a debtors' target of 5.0 days, and actual performance of 6.9 days at 31 May 2018, which is behind plan (fig. 8). This is due to contract variations raised in March anticipated April but remain outstanding with payment now expected during June.



The liquidity days graph (fig. 9) below reflects the metric within NHS Improvement's single oversight framework. The Trust's liquidity day's ratio is marginally ahead of plan.



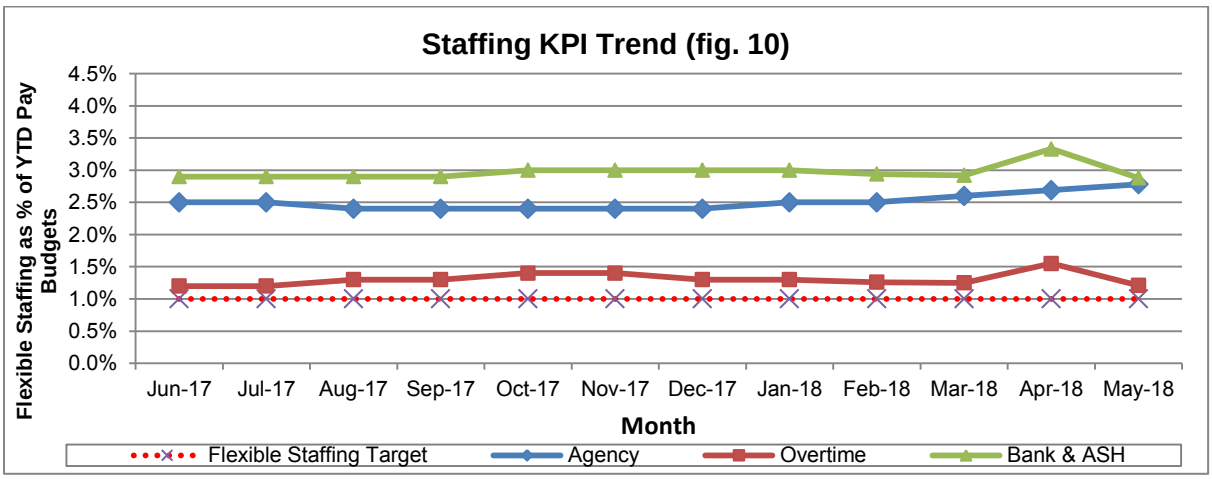
3.5 Financial Drivers

The following table (table 1) and chart (fig. 10) show the Trust's performance on some of the key financial drivers identified by the Board.

Pay Expenditure as a % of Pay Budgets (table 1)							
Tolerance	Tolerance May-18	Dec	Jan	Feb	Mar	Apr	May
Establishment (a) (90%-95%)	93.7%	94.50%	94.20%	93.70%	93.80%	94.60%	93.70%
Agency (b)	1.0%	2.40%	2.50%	2.50%	2.60%	2.70%	2.80%
Overtime (c)	1.0%	1.30%	1.30%	1.30%	1.30%	1.60%	1.20%
Bank & ASH (flexed against establishment) (100%-a-b-c)	4.3%	3.00%	2.90%	2.90%	2.90%	3.30%	2.90%
Total	**100.0%**	**101.20%**	**100.90%**	**100.40%**	**100.60%**	**102.20%**	**100.60%**

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 May 2018 the tolerance for Bank and ASH is 4.3% of pay budgets.

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



Additional staffing expenditure is 6.9% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (53%), enhanced observations (26%) and sickness (9%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating for the Trust is assessed as 3 for the period ending 31 May 2018 and is in line with plan (table 2). The 3 rating arises due to a loan repayment made during April 2018, which impacts on the Capital Service Cover score.

The rating is planned to return to a 1 by the end of quarter 1.

3.6.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 0.98x (can cover debt payments due 0.98 times), which is in line with plan and rated as a 4. The planned deterioration in this rating from March 2018 arises due to a loan repayment made during in April 2018.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 52.4 days; this is ahead of plan and is rated as a 1.

3.6.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 2.2% and is rated as a 1, which is in line with plan.

3.6.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding STF income. The Trust I&E margin distance from plan is 0.4% and is behind plan and is rated as a 2.

3.6.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is marginally higher than the cap and is rated as a 2.
The margins on Use of Resource Rating are as follows:

- Capital service cover - to improve to a 3 a surplus increase of £881k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £45,810k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £667k is required.
- I&E margin distance from plan – to improve to a 1 an operating surplus increase of £196k is required.
- Agency Cap rating – to improve to a 1 a reduction in agency expenditure of £232k is required.

Use of Resource Rating at 31 May 2018 (table 2)

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

TEWV Performance	Actual Achieved	Actual Rating	YTD Plan Planned	YTD Plan Rating	RAG Rating
Capital service cover	0.98x	4	1.11x	4	
Liquidity	52.4 days	1	50.9 days	1	
I&E margin	2.2%	1	2.6%	1	
I&E margin distance from plan	-0.4%	2	0.0%	1	
Agency expenditure	£1,197k	2	£965k	1	
Overall Use of Resource Rating		**3**		**3**	

3.6.7 6.1% of total receivables (£377k) are over 90 days past their due date; this is above the 5% finance risk tolerance, but is not a cause for concern as £249k of debts are supported by a SLA. Discussions to resolve key debts have been positive, and a meeting has been arranged to finalise any outstanding issues, with payment now anticipated during July.

Excluding debts supported by an SLA the ratio reduces to 2.0%.

3.6.8 3.5% of total payables invoices (£374k) held for payment are over 90 days past their due date. This is within the 5% finance risk tolerance.

3.6.9 The cash balance at 31 May 2018 is £60,093k and represents 68.7 days of annualised operating expenses.

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 31 May 2018 is a surplus of £1,240k, representing 2.2% of the Trust's turnover and is £196k behind the original plan largely due to flexible staffing supporting enhanced observations and complex clients (£666k) partially mitigated by vacancies. However, NHS Improvement has confirmed a reduction in the Trust's control total (£1,692k) which is non-recurrently mitigating CRES delivery by £282K at month 2. Adjusting for this change means the variance to revised plan, taking into account the control total, is marginally ahead of plan by £86k.

6.2 Identified Cash Releasing Efficiency Savings (CRES) at 31 May 2018 are £1,797k behind plan, reflecting an improvement of £2,673k largely due to non-

recurrent mitigations following confirmation of lower than planned public dividend capital dividend payments and depreciation. The Trust continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements.

Including the adjustment to the control total as a mitigation against CRES means it is £105k behind plan.

To manage this risk and enable the Trust to achieve its 2018/19 financial plan, non-recurrent mitigations are being developed, and will include items such as expenditure reduction schemes and re-profiling of non-recurrent projects.

6.3 The Use of Resources Rating for the Trust is assessed as 3 for the period ending 31 May 2018 and is in line with plan. The 3 rating arises due to a loan repayment made during April 2018, which impacts on the Capital Service Cover score.

The rating is planned to return to a 1 by the end of quarter 2.

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.

Patrick McGahon
Director of Finance and Information

ITEM 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**3 July 2018**
TITLE:	**Board Dashboard as at 31st May 2018**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communication**
REPORT FOR:	**Assurance**

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

Executive Summary:

As at the end of May 2018, 5 (29%) of the indicators reported are not achieving the expected levels and are red. This is an improvement on the 7 indicators that were reported red as at the end of April. The indicators which are rated red are spread across 3 of the domains with no red indicators in the workforce domain. In addition there are 6 KPIs (35%) that whilst not achieving the target are within the 'amber' tolerance levels.

Of the 11 indicators that are either red or amber 8 (73%) are showing an improving trend over the previous 3 months which is encouraging.

In terms of the SOF indicators the Trust did not achieve the target for the Access Standard to Early Intervention in Psychosis services. This was due to the target not being achieved in 3 CCG areas; DDES, Vale of York and Scarborough. The IAPT Recovery rate was achieved across the Trust.

There are a number of KPIs where performance is of concern and further detail is given in Section 2.4 of the report

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**3rd July 2018**
TITLE:	**Board Dashboard as at 31st May 2018**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 31st May 2018 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery.

2. KEY ISSUES:

2.1 General Issues

Following Board approval at the last meeting the targets for KPI 1 and 14 are now included within the Dashboard. There are still 5 KPIs which are in the development phase and therefore not yet included within the Dashboard at this point, these are highlighted in italics in Appendix B which provides definitions for all indicators within this report.

2.2 Performance Issues

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

- As at the end of May 2018, 5 (29%) of the indicators reported are not achieving the expected levels and are red. This is an improvement on the 7 indicators that were reported red as at the end of April. The indicators which are rated red are spread across 3 of the domains with no red indicators in the workforce domain. In addition there are 6 KPIs (35%) that whilst not achieving the target are within the 'amber' tolerance levels.

  Of the 11 indicators that are either red or amber 8 (73%) are showing an improving trend over the previous 3 months which is encouraging.

  The year to date position is that there are 7 KPIs (41%) which are reported as red.

- In terms of the Single Oversight Framework targets the Trust did not achieve the Access Standard for Early Intervention in Psychosis Teams in May. As a Trust we achieved 48.84% against the target of 50%. In terms of the Year to Date figure we are still achieving the target. There were three CCG areas where the performance was worse than target in May; DDES, Vale of York and Scarborough and Ryedale. The key reasons for this are that in some cases patients are cancelling/not attending their appointment (this does not stop the clock and makes it difficult to rearrange the appointment within the two weeks) and staff capacity. In York and Selby whilst a number of staff have recently been appointed they will not take up post until September and therefore it is not expected that the position will improve significantly before then. In Scarborough a new member of staff has commenced work within the team which should

improve performance once they are operating at full capacity. In terms of the IAPT recovery target the Trust achieve 52.48% with all CCG achieving the target.

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

2.3 Data Quality Assessment.

This will be completed for the indicators that have been included in the Trust Dashboard and will be included in the July report.

2.4 Key Risks

- Number of Bed Days of Inappropriate Out of Area Placements (KPI 3) – whilst this indicator is currently showing green the position has deteriorated in May and there has continued to be significant bed pressures in June. Daily conversations have taken place as part of managing the bed position within the total capacity of the Trust.
- Outcome Indicators (KPIs 6 and 7) – Performance against the two outcome indicators (clinically reported (HONOS) and patient reported (SWEMWEBS)) is considerably below target. The PBR team are sharing reports with services to allow them to focus on the reasons for the 'breaches' and work is being undertaken in all localities on reemphasising the need to record outcome scores in order to be able to demonstrate improvement made. The Performance Improvement Group in May, chaired by the COO, focused on how we can improve the reporting of both outcome indicators.
- Bed Occupancy (KPI 12) – Performance is worse than the target in May with the rate being at the highest level since May 2016. There has been significant pressure on beds across the Trust during the month. Teesside have had the highest occupancy levels but the position in North Yorkshire and York and Selby has also deteriorated in month. Within all three localities there are pressures due to the numbers of very complex patients and the ability to identify appropriate placements to support their discharge from the wards. This position is monitored daily in terms of managing the day to day pressure but is also discussed in depth at the Operational Management Team on a fortnightly basis.
- Sickness Absence Rate (KPI 19) – Following the significant reduction in sickness reported in April (relating to March) there was an increase in May such that the performance was worse than target (and worse than the corresponding position in May 2017). Whilst this is still within the amber RAG rating range it is of concern as in previous years there has been an improvement reported in May compared to April. A review of the approach to managing sickness absence is currently underway.
- Financial Targets (KPIs 20 and 21) – Whilst in the month of May we overachieved in the identification and delivery of CRES we remain £300k behind plan for the Year to Date. This is impacting on the delivery of the financial plan (I&E) which is also behind plan for the month of May and the

YTD. The internal CRES Delivery Team is now established and the first Programme Board will be held on 23 June 2018.

3. RECOMMENDATIONS:

3.1 It is recommended that the Board:

- Consider the content of this paper and raise any areas of concern/query.

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Quality

	May 2018				April 2018 To May 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	90.00%	87.70%			90.00%	86.93%		90.00%
3) The total number of inappropriate new OAPs in the reporting period	2,473.00	2,085.00			2,473.00	2,085.00		2,473.00
4) Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	91.99%			92.45%	91.45%		92.45%
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.47			2.00	1.91		12.00
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	67.25%	53.75%			67.25%	53.70%		67.25%
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	78.25%	60.00%			78.25%	57.41%		78.25%

Activity

	May 2018				April 2018 To May 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	96.98%			85.00%	95.64%		85.00%
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	68.00	65.00			68.00	65.00		68.00
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.93%	16.67%			23.93%	16.77%		23.93%

Workforce

Trust Dashboard Summary for TRUST

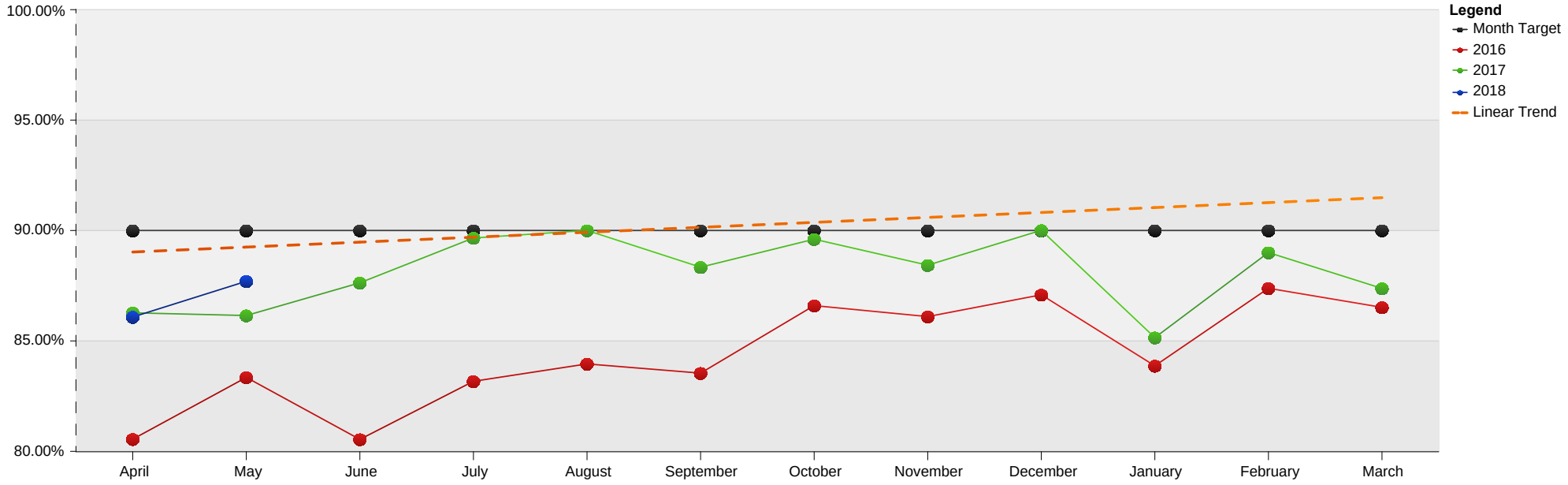
	May 2018				April 2018 To May 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
15) Actual number of workforce in month (Establishment 95%-100%)	95.00%	93.70%			95.00%	93.70%		95.00%
16) Vacancy fill rate	90.00%	87.25%			90.00%	83.20%		90.00%
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	93.74%			95.00%	93.74%		95.00%
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	92.21%			92.00%	92.21%		92.00%
19) Percentage Sickness Absence Rate (month behind)	4.50%	4.66%			4.50%	4.54%		4.50%

Money

	May 2018				April 2018 To May 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
20) Delivery of our financial plan (I and E)	-675,000.00	-394,000.00			-1,436,000.00	-1,240,000.00		-8,556,000.00
21) CRES delivery	686,782.00	759,871.00			1,373,564.00	1,074,243.00		8,241,384.00
22) Cash against plan	64,078,000.00	60,093,000.00			64,078,000.00	60,093,000.00		56,640,000.00

Trust Dashboard Graphs for TRUST

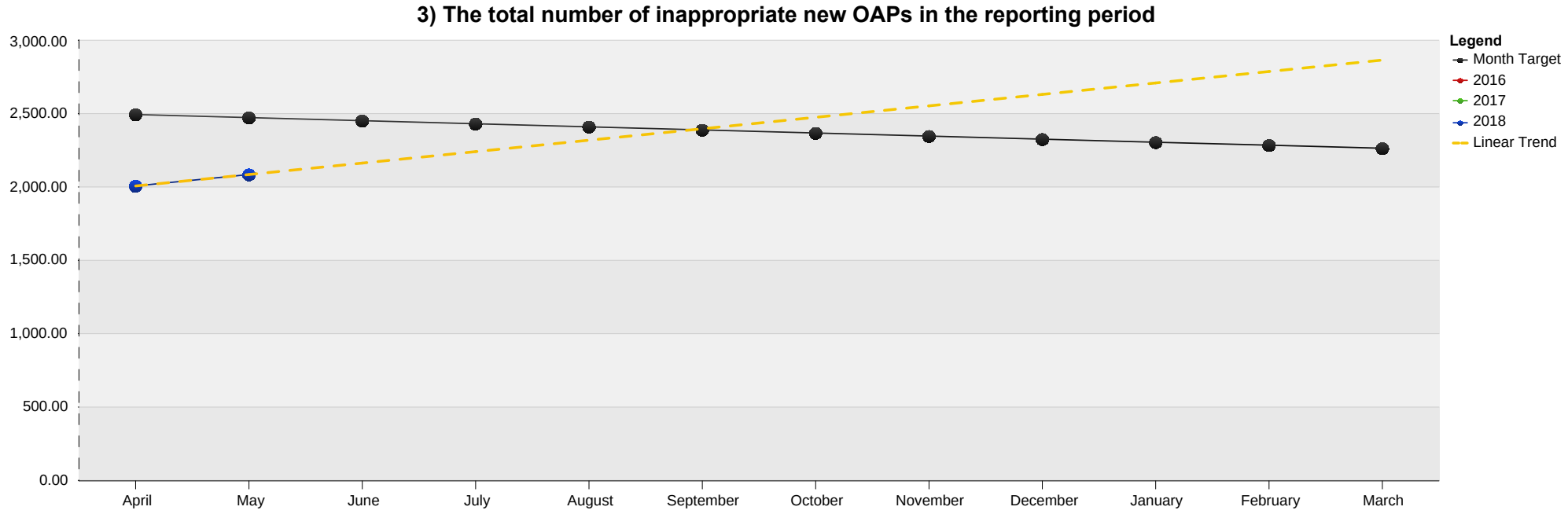
1) % of patients who were seen within 4 weeks for a 1st appointment following an external referral



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	87.70%	86.93%	88.12%	86.72%	92.74%	92.83%	77.47%	76.74%	99.49%	99.38%	75.31%	72.70%		

Narrative
The position for May 2018 is 87.70% relating to 5690 patients out of 6488 who were seen within 4 weeks for a first appointment. This is below target of 90% but an improvement on the position reported in April 2018. Areas of concern:• York AMH at 62.56% (142 of 227 patients) –85 patients were not seen within 4 weeks which is an improvement on the 127 reported in April 18. This indicator is impacted by the high DNA rate within the Access Team. In order to improve this, the service are continuing to seek advice and ideas from other access teams.• North Yorkshire AMH at 73.73% – (306 of 415 patients) -109 patients were not seen within 4 weeks. In the Primary Care team there have been some issues in the processes within the team which have led to a backlog of waiters. This has now been addressed and the position is improving. However in addition to this issue there are sickness and vacancies within the Harrogate and Ripon teams which are also having an impact.

Trust Dashboard Graphs for TRUST

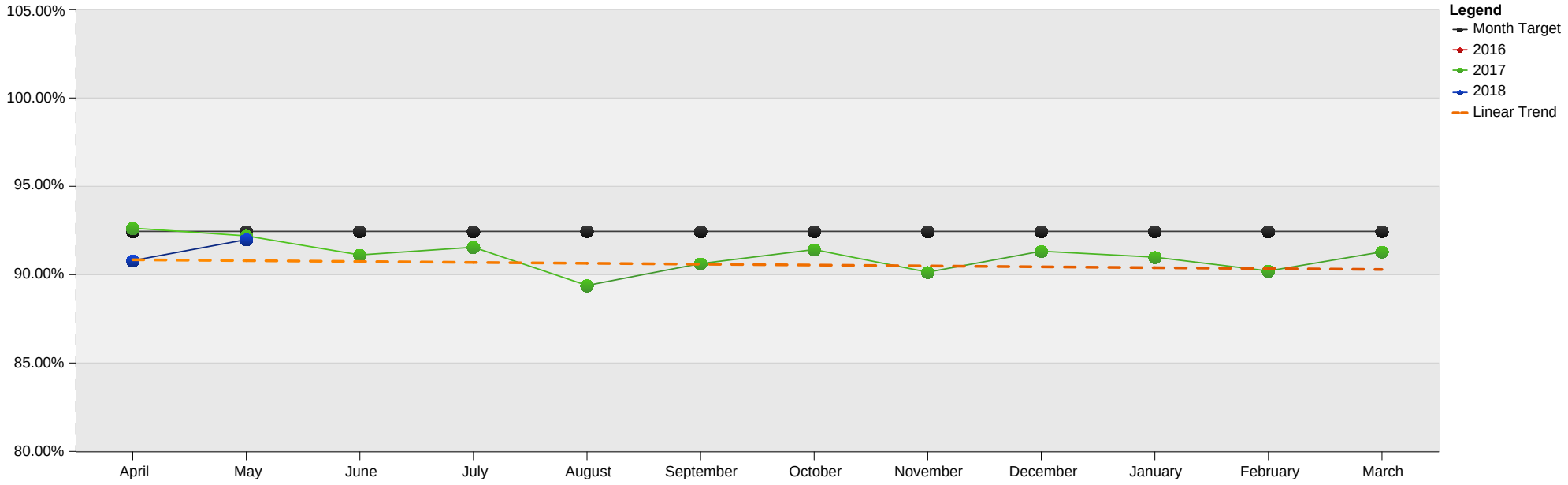


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) The total number of inappropriate new OAPs in the reporting period	2,085.00	2,085.00	138.00	138.00	422.00	422.00	844.00	844.00			569.00	569.00		

Narrative
The Trust position for May 2018 is 2,085 which is meeting the target of 2,473 and is a deterioration on the April Position.The following locality is not meeting target: - • York and Selby – 569 occupied bed days (306 AMH and 263 MHSOP). This relates to 27 patients admitted out of area over the 3 month period (23 AMH and 4 MHSOP) All localities are monitoring this on a continual basis with actions discussed and agreed in daily huddles.

Trust Dashboard Graphs for TRUST

4) Percentage of patients surveyed reporting their overall experience as excellent or good

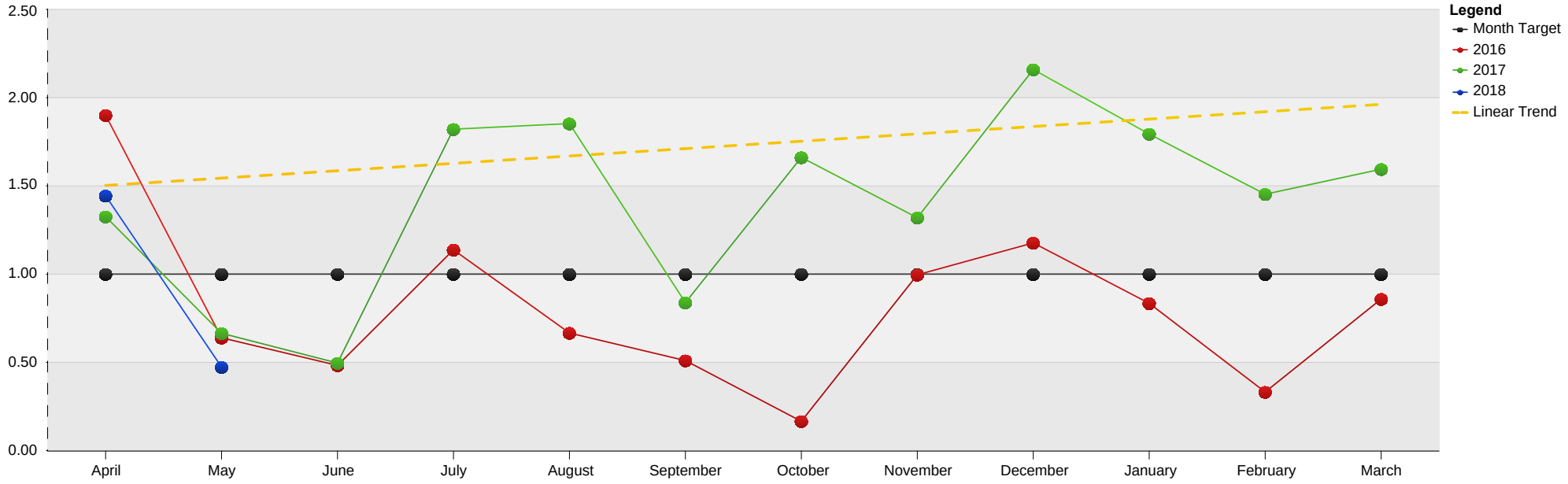


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of patients surveyed reporting their overall experience as excellent or good	91.99%	91.45%	93.21%	92.38%	92.13%	92.60%	90.87%	92.15%	86.89%	82.51%	90.51%	87.03%		

Narrative
The Trust position for May 2018 is 91.99% which is not meeting the target of 92.45% but is an improvement on the position reported in April (March data)Durham and Darlington are meeting the target for this indicator with Forensic reporting the poorest performance at 86.89%. The three remaining localities are within 10% of the target. Work continues within each locality to review performance against this indicator and identify any areas of concern. Please note due to changes with this indicator in 2016, this year is not displayed on the graph above.

Trust Dashboard Graphs for TRUST

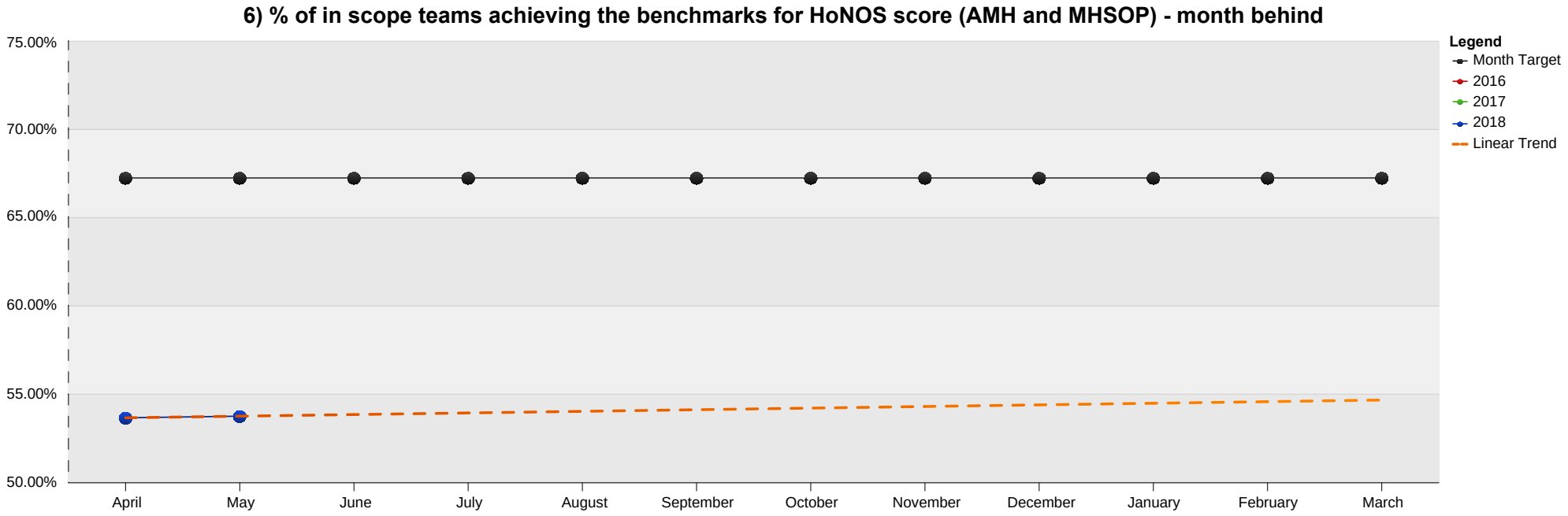
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	0.47	1.91	0.39	0.80	0.00	0.56	0.90	6.32	0.00	0.00	1.22	2.43		

Narrative
The Trust position for May 2018 is 0.47, which is achieving the expected number of 1.00. This rate relates to 3 unexpected deaths which is a significant reduction in the position in April 2018. Of the 3 unexpected deaths the details below shows a breakdown by locality:1 x Durham and Darlington1 x North Yorkshire1 x York and SelbyOf the unexpected deaths that occurred in May all 3 occurred in AMH services

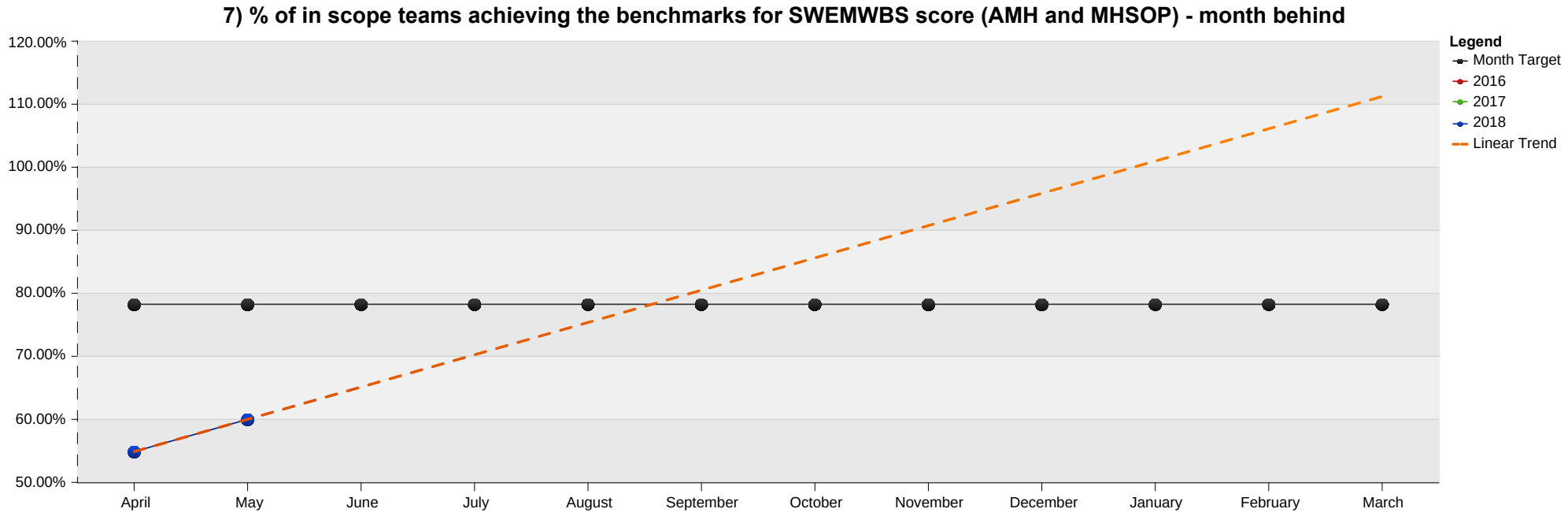
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	53.75%	53.70%	36.00%	40.00%	72.73%	67.39%	62.50%	62.50%			33.33%	33.33%		

Narrative
The Trust position for May 2018 is 53.75%, which is not meeting the target of 57.25% but is the same as the position reported in April. Within this KPI an improvement in HONOS is shown by a decrease in the patient's actual HONOS score on PARIS. The change is identified by comparing the first HONOS score calculated on admission to TEWV, and the score on discharge.All localities are below target with the exception of Tees. The PBR team provide services with weekly breach reports to allow issues to be addressed. A detailed discussion took place at the Performance Improvement Group in June to look at ways services can improve the number of patients it is possible to report outcomes for and to report them in a timely way. Focusing on this will enable teams to improve performance against this KPI.

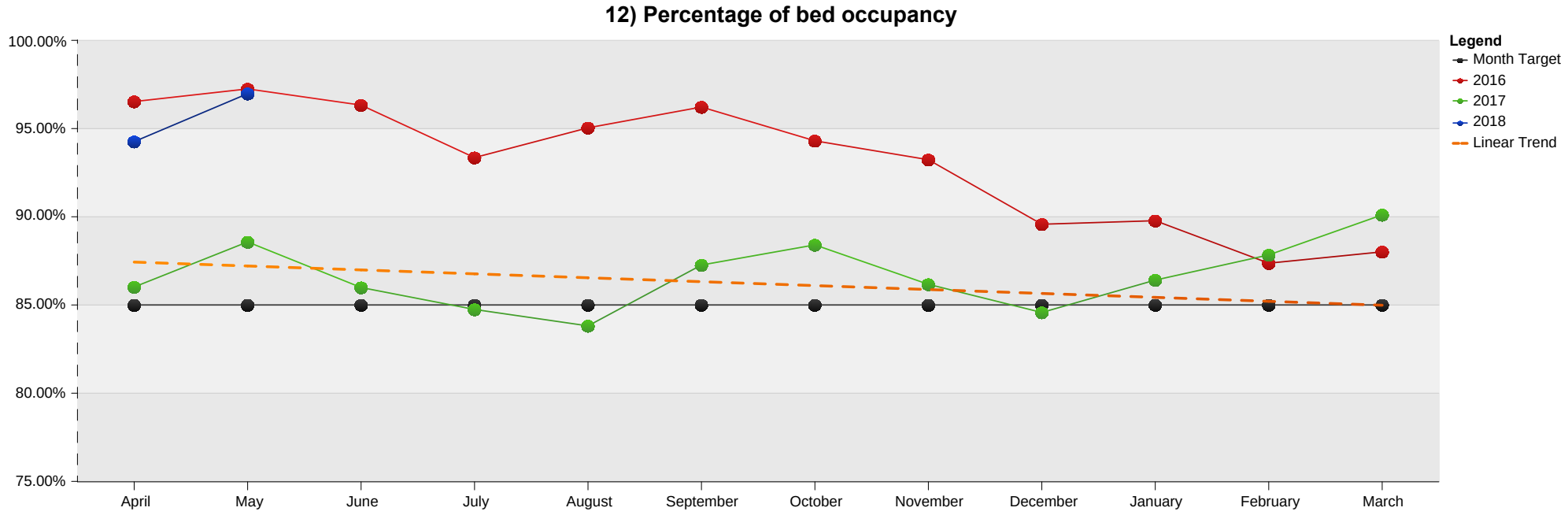
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	60.00%	57.41%	48.00%	55.77%	68.18%	59.09%	70.83%	60.42%			44.44%	50.00%		

Narrative
The Trust position for May 2018 is 60%, which is not meeting the target of 78.25% but is an improvement on the position reported in April.Within this KPI, an improvement in SWEMWBS (which is a patient experience measure) is shown by an increase in the patients actual SWEMWBS score. The change is identified by comparing the first SWEMWBS score calculated on admission, and the score on discharge.All localities are below target. The PBR team provide services with weekly breach reports to allow issues to be addressed. A detailed discussion took place at the Performance Improvement Group in June to look at ways services can improve the number of patients it is possible to report outcomes for and to report them in a timely way. Focusing on this will enable teams to improve performance against this KPI.

Trust Dashboard Graphs for TRUST

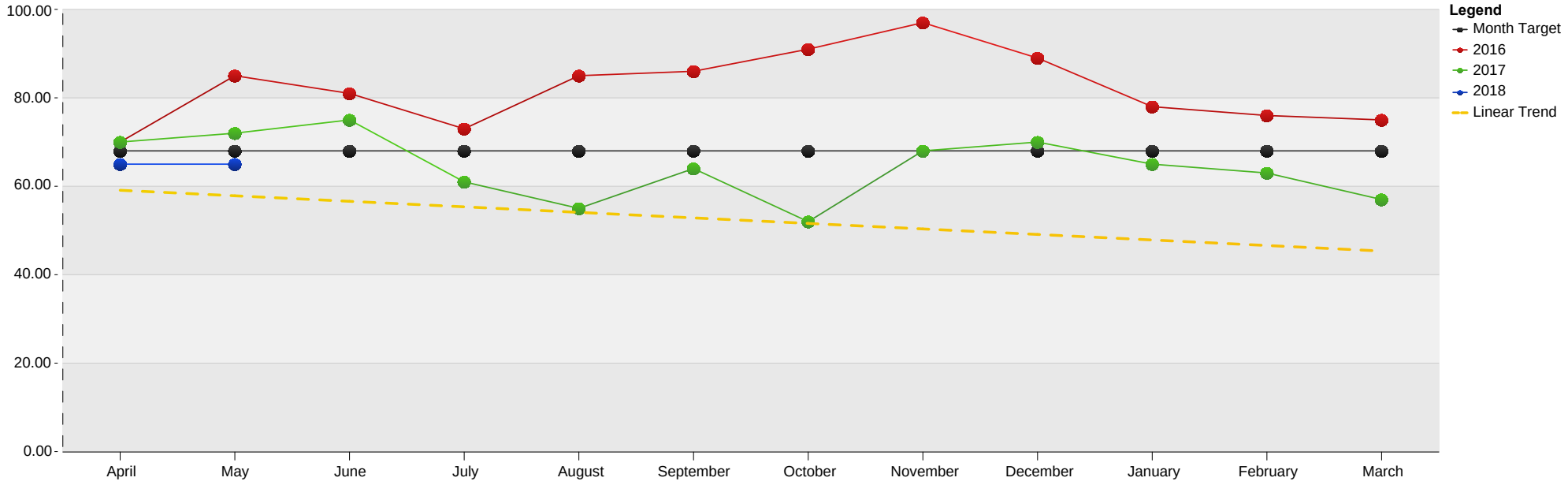


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	96.98%	95.64%	91.60%	92.82%	105.79%	102.14%	96.05%	95.47%	NA	NA	96.18%	92.18%		

Narrative
The Trust position for May 2018 is 96.98% which is worse than target and a deterioration on the position of 94.28% recorded in April 2018.Tees are reporting the highest bed occupancy at 105.79%. Within AMH this is due to difficulties in finding appropriate discharge locations for a small number of patients. Work is underway to ensure places are found. In addition there are a number of complex patients who have long lengths of stay. Within MHSOP this is as a result of complex patients who require long lengths of stay as well as one patient who's transfer or care has been delayed. Steps are in place to ensure this patient is transferred as soon as possible. North Yorkshire and York are both reporting a deterioration compared to the positions reported in April. Within North Yorkshire, there have been an increased number of admissions. Within York, this has been impacted by a number of patients being admitted from other localities. Work is ongoing to ensure that patients are returned to beds in their home area as soon as possible. All localities are monitoring this on a continual basis and actions are discussed and agreed in daily huddles.

Trust Dashboard Graphs for TRUST

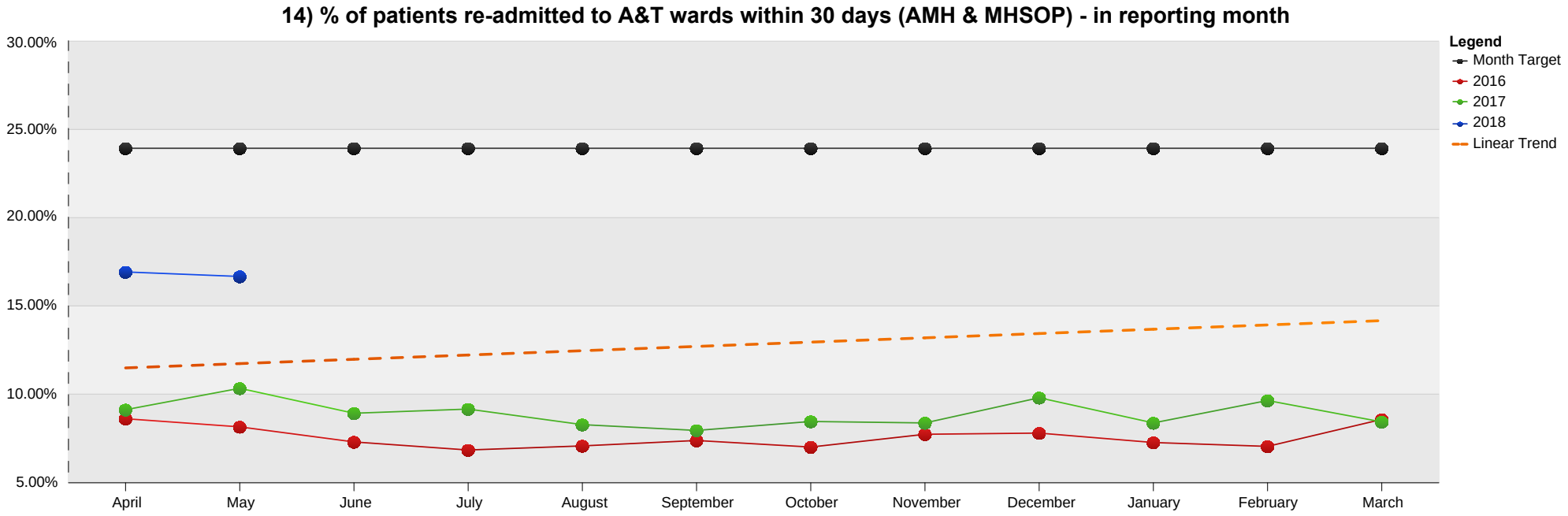
13) No. of patients occupying a bed with a LoS (from admission) > 90 days (AMH and MHSOP A&T Wards)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	65.00	65.00	18.00	18.00	10.00	10.00	17.00	17.00			18.00	18.00		

Narrative
The Trust position for May 2018 is 65 which is achieving the target of 68 and is the same as that achieved in April 2018. The following localities are not meeting target: • North Yorkshire– 17 patients (11 AMH and 6 MHOSP)• York and Selby – 18 patients (2 AMH and 16 MHOSP)North Yorkshire have the greatest number of patients with a length of stay greater than 90 days. In AMH this is mainly due to delayed transfers of care. Actions are in place to address this. Within MHSOP this is also as a result of delayed transfers of care as a result of patient complexity and the availability of appropriate placements. York and Selby are also worse than target as a result of delayed transfers of care due to problems in finding suitable placements. Actions are in place to address this and work is ongoing with partnership agencies. The locality is also impacted by those patients (as above) from other localities admitted out of area. Work remains ongoing to ensure patients are returned to beds in their home area as soon as possible.

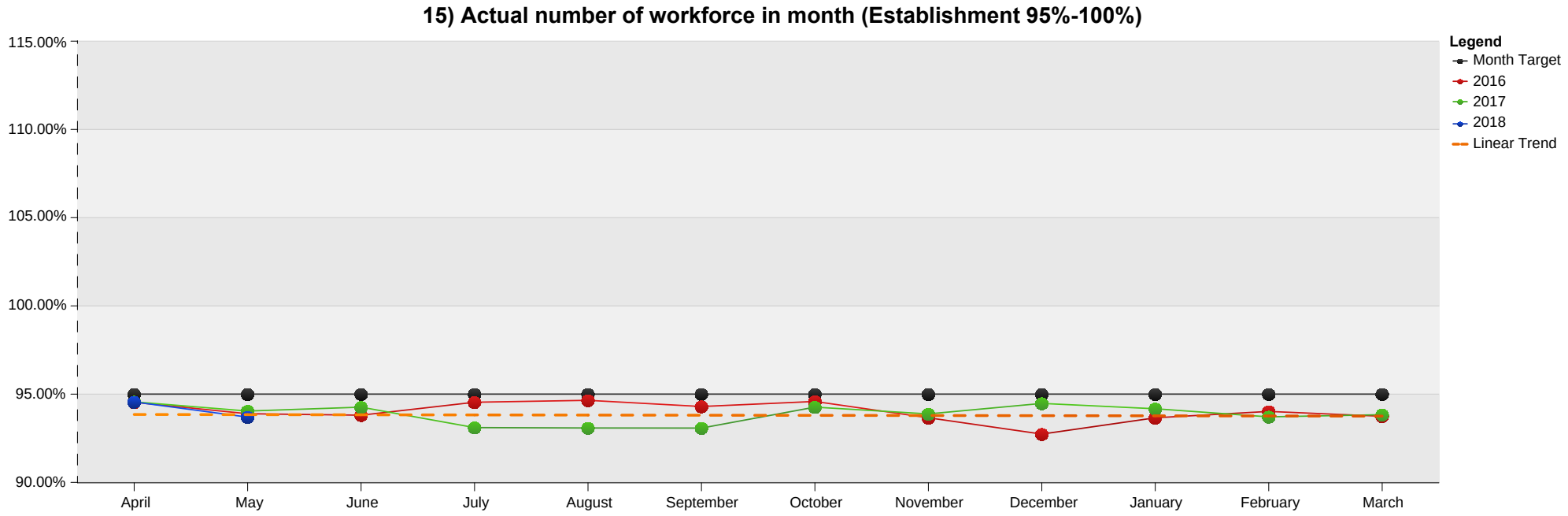
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	16.67%	16.77%	9.38%	18.18%	14.29%	13.04%	23.53%	20.00%			25.00%	13.64%		

Narrative
The Trust position ending April 2018 is 16.67%, which relates to 15 patients out of 90 that were readmitted within 30 days. This is achieving target of 23.93% and is a slight improvement on the position achieved in April 2018. This indicator has been revised from the previous year and is no longer a rolling 3 month position, as a result of this the data in the graphs looks higher for 2018 than previous years.

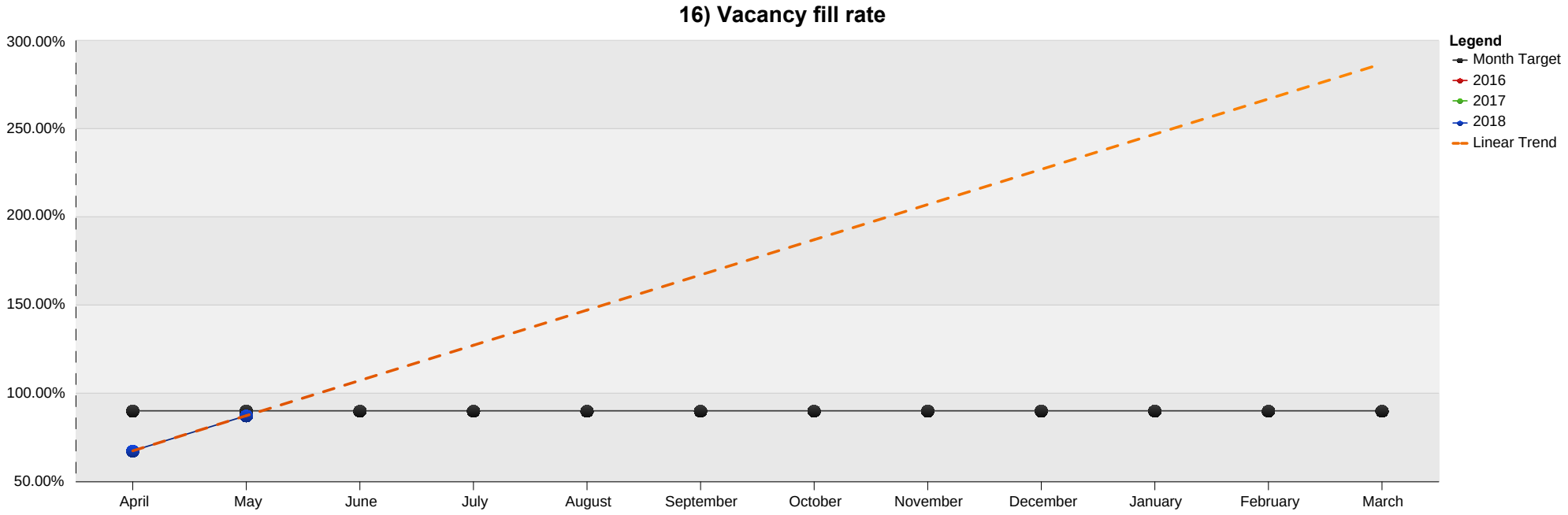
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Actual number of workforce in month (Establishment 95%-100%)	93.70%	93.70%	93.39%	93.39%	98.82%	98.82%	93.49%	93.49%	96.42%	96.42%	86.58%	86.58%		

Narrative
The Trust position for 31 May 2018 is 93.7% which is marginally below the targeted establishment level of 95-100%. It is expected that the establishment rate will continue to improve due to on-going recruitment events. In May and June there were two recruitment fairs for registered nurses within Durham and Darlington, Teesside and Forensic. The recruitment fairs were successful and resulted in a total of 94 nurses being offered employment. The pre-employment screening process is underway and applicants will move into vacancies over the coming months. A number of the applicants are student nurses due to qualify in September.

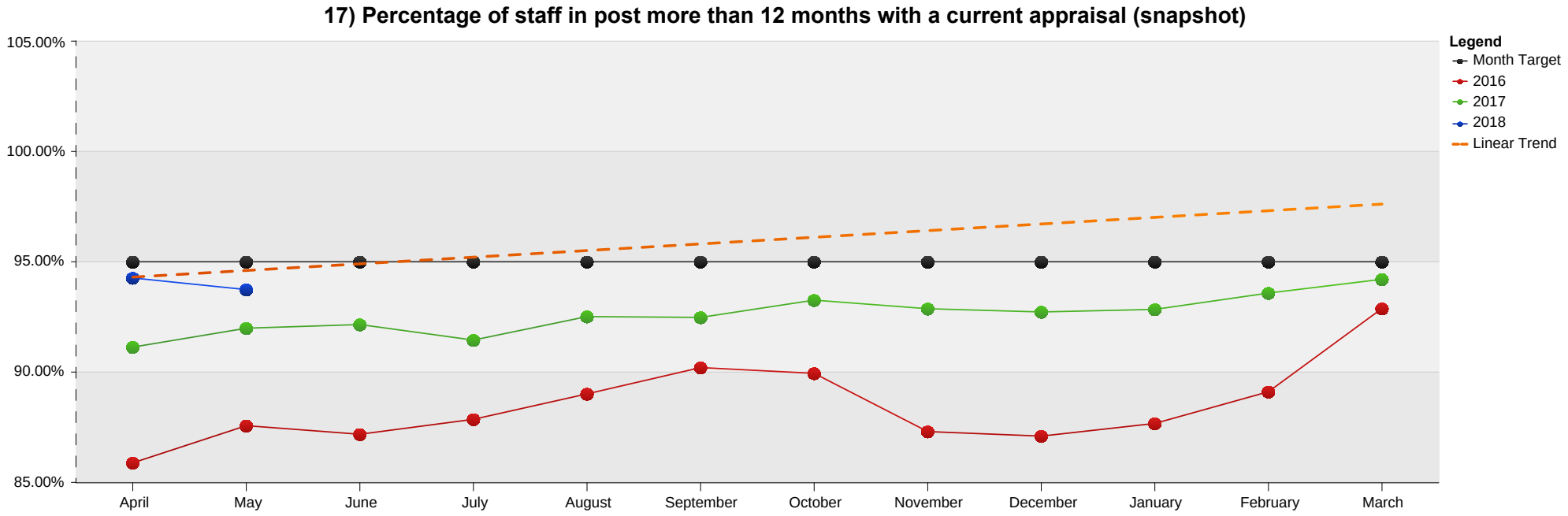
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Vacancy fill rate	87.25%	83.20%	91.67%	91.67%	84.62%	84.62%	89.29%	89.29%	77.78%	77.78%	84.62%	84.62%		

Narrative
The vacancy fill rate is a new key performance indicator which will report the percentage rate of health care professional vacancies band 5 and above with a conditional offer of employment made within 8 weeks of the post being advertised. The rate for May 2018 is 87.25% which is slightly below target but an improvement on the April position. This figure represents 89 vacancies with a conditional offer made out of 102. 13 vacancies are showing as waiting to be informed of interview outcome or interviews are scheduled. During the 8 week reporting period 33 vacancies were not filled – this was due to no applicants, no applicants meeting shortlisting requirements or no applicants being appointed at interview. These vacancies do not form part of the above calculation as they are considered closed, although they were not successfully appointed to. The vacancies included a number of CPN band 6 posts within Durham and Darlington AMH, Speech and Language Therapists x 3 in Durham and Darlington and Teesside, Staff Nurses x 2 band 5 the Friarage and 3 x Crisis Clinicians in York and Selby.

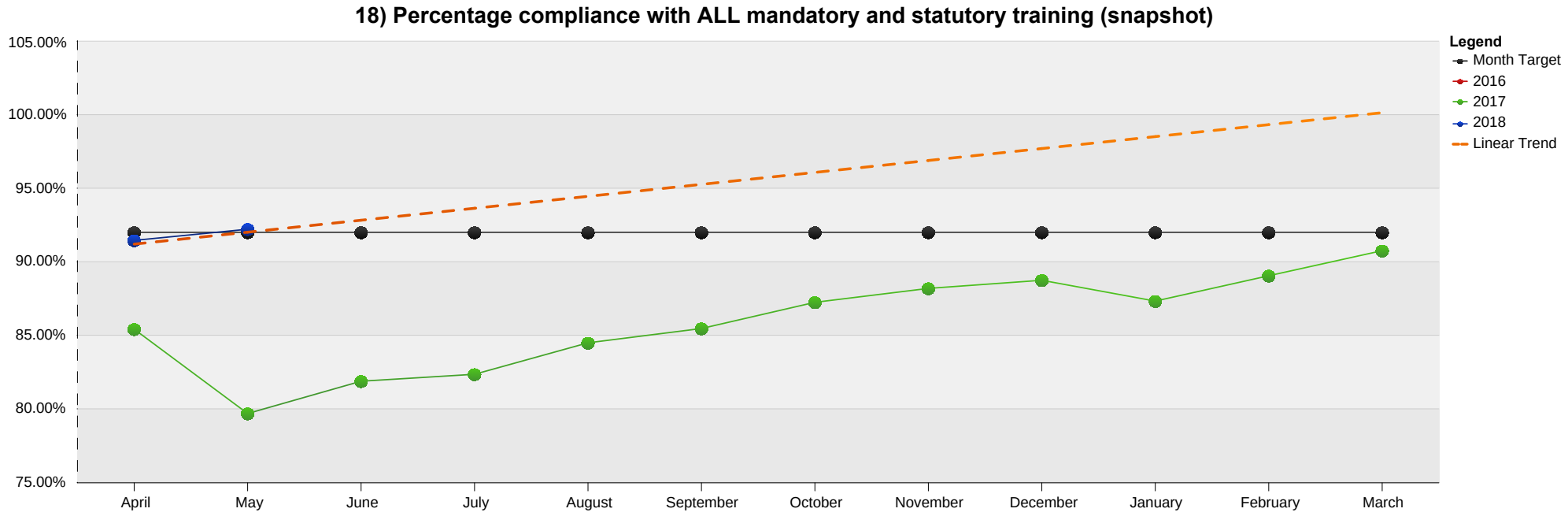
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	93.74%	93.74%	92.79%	92.79%	95.53%	95.53%	87.76%	87.76%	98.06%	98.06%	94.20%	94.20%		

Narrative
The Trust position for May 2018 is 93.74% which relates to 357 members of staff out of 5701 that do not have a current appraisal. This represents a slight deterioration on the figure of 94.27% in April 2018. Forensic services and Teesside are above the target of 95% with the majority of other localities reporting over 90%.The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels. When comparing the current position with 2016/17 outturn an improvement of 1.33% can be seen and this continues the increasing trend seen since 2014/15.

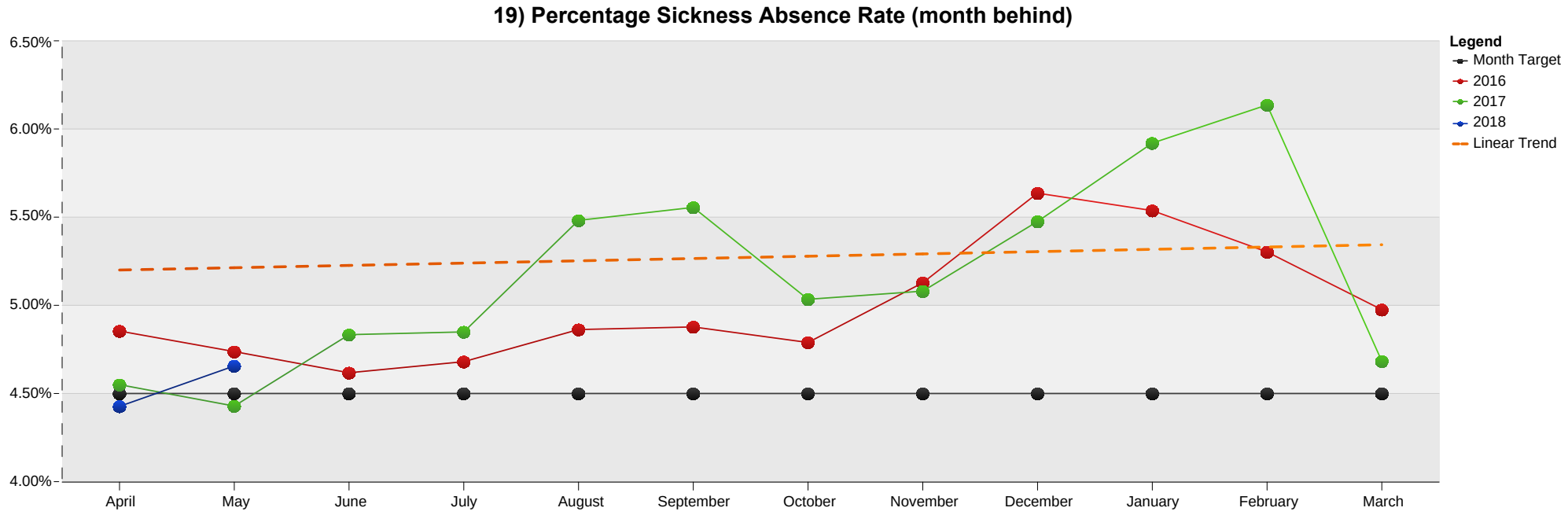
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.21%	92.21%	90.74%	90.74%	92.74%	92.74%	90.23%	90.23%	92.97%	92.97%	94.32%	94.32%		

Narrative
The position for May 2018 continues to improve at 92.21%, which is above the target of 92%. This figure represents a sustained increase in compliance since April 2017. The operational management huddles continue to drive improvements in performance. The improved frequency of the IIC refresh allows a timelier update of accurate performance information to managers.

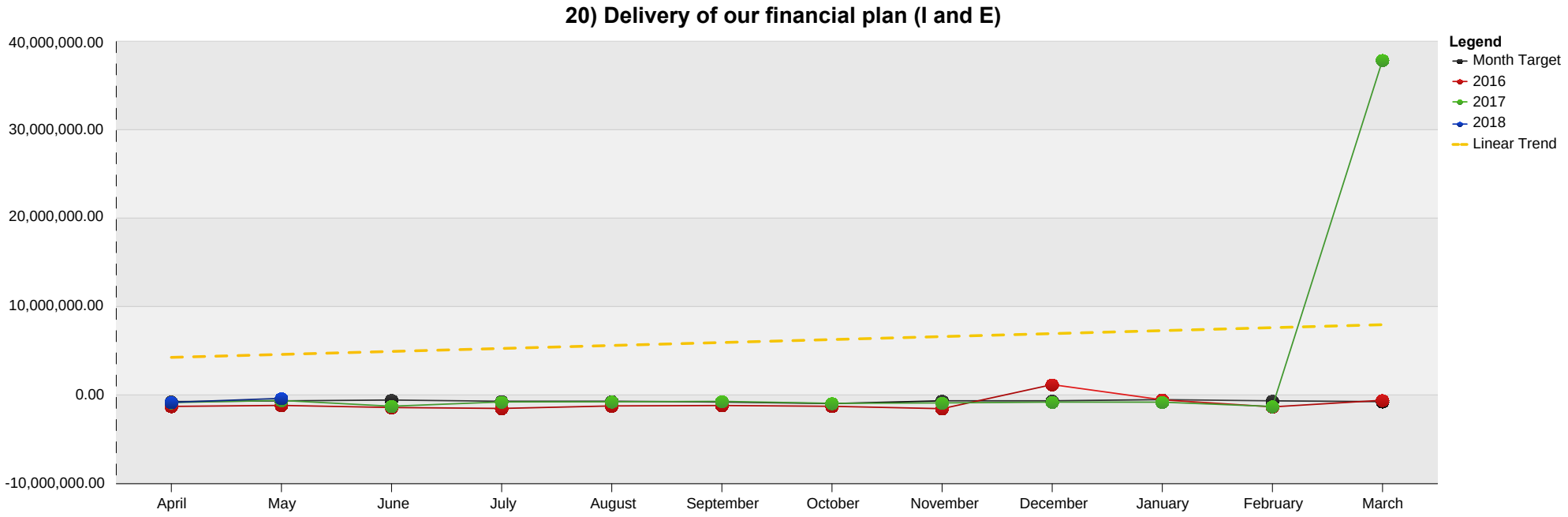
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Percentage Sickness Absence Rate (month behind)	4.66%	4.54%	5.28%	5.13%	4.02%	4.37%	4.40%	3.79%	5.78%	5.19%	5.00%	4.75%		

Narrative
The Trust position reported in May relates to the April sickness level. The Trust position reported in May 2018 has increased slightly to 4.66% which is higher than the target of 4.50%. A review of the approach to managing sickness absence is currently underway and it is envisaged a new procedure will be available from September 2018. Work is also underway to review the Occupational Health provision which is due for retendering in the next 12 months.As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive).

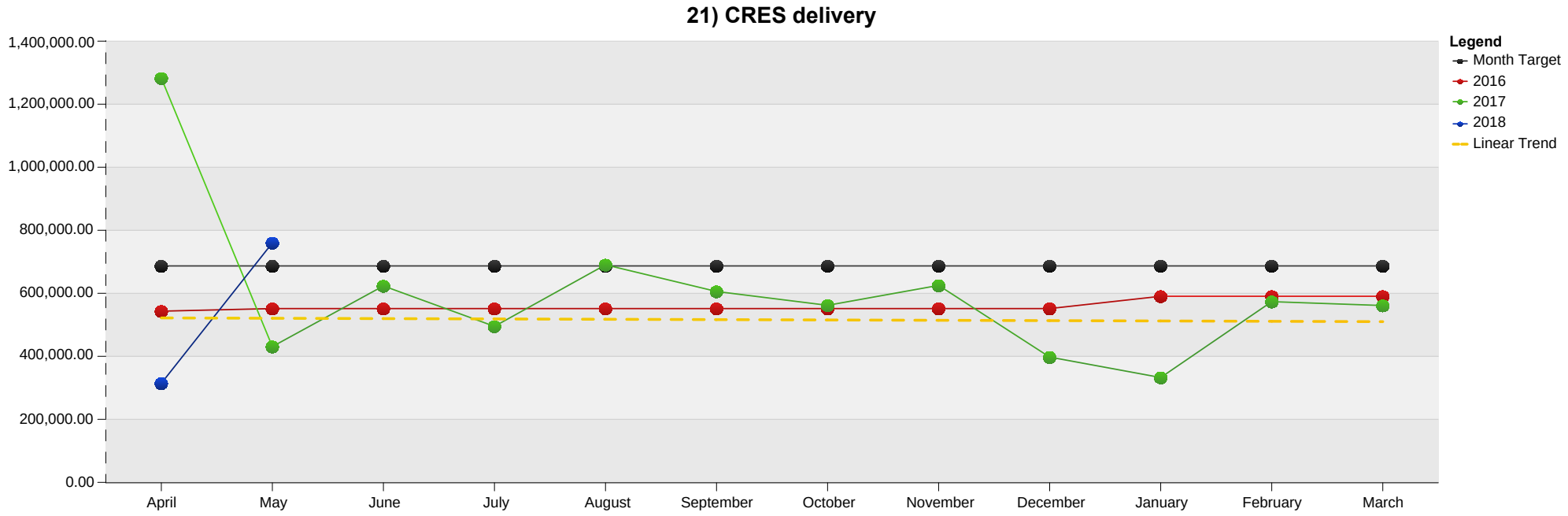
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) Delivery of our financial plan (I and E)	-394,000.00	-1,240,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
The comprehensive income outturn for the period ending 31 May 2018 is a surplus of £1,240k, which is £196k behind the planned £1,436k surplus and represents 2.2% of the Trust's turnover.

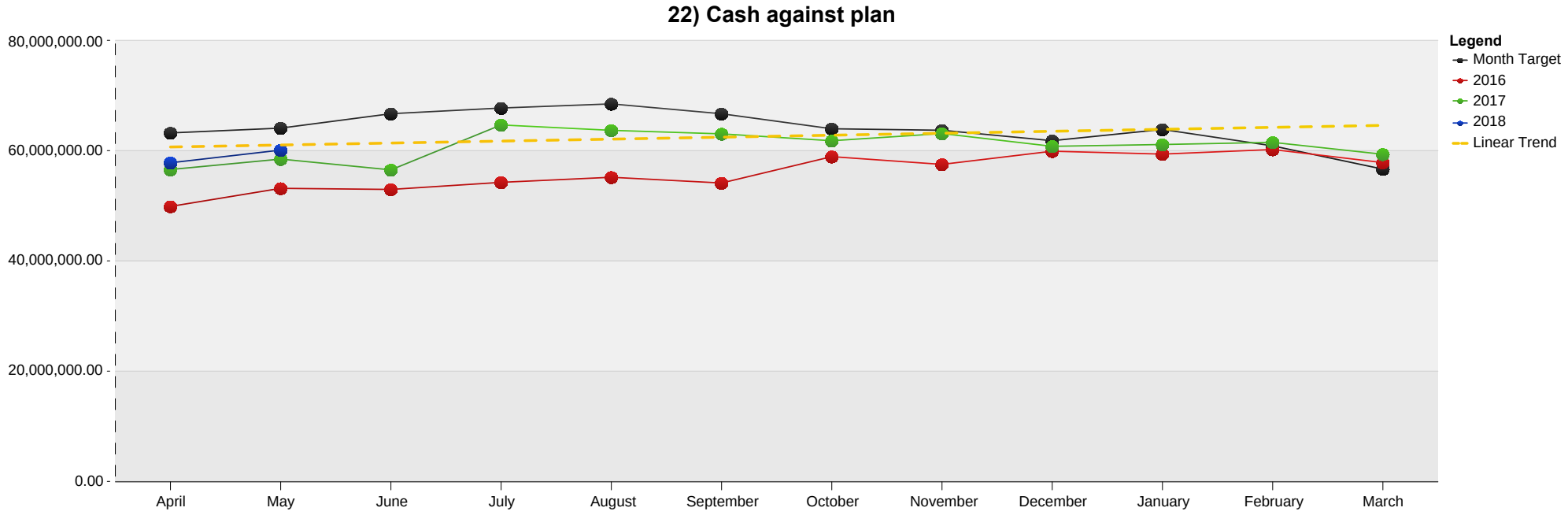
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) CRES delivery	759,871.00	1,074,243.00	111,977.00	223,954.00	37,486.00	74,972.00	10,264.00	20,528.00	9,132.00	18,264.00	77,528.00	155,056.00		

Narrative
Identified Cash Releasing Efficiency Savings at 31 May 2018 is £1,074k and is £300k behind plan for the year to date although above target for the month of May. The Trust continues to identify and develop schemes to ensure the full delivery of the next 3 years CRES requirements.

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
22) Cash against plan	60,093,000.00	60,093,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
Total cash at 31 May 2018 is £60,093k, and is £3,985k behind plan largely due to working capital variations, e.g. receipts from commissioner contract settlements anticipated in April, but remain outstanding with payment now expected during June.

Trust Dashboard - Locality Breakdown for TRUST

1 - Quality

	May 2018														April 2018 To May 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	90.00%	87.70%	90.00%	88.12%	90.00%	92.74%	90.00%	77.47%	90.00%	99.49%		75.31%			90.00%	86.93%	90.00%	86.72%	90.00%	92.83%	90.00%	76.74%	90.00%	99.38%		72.70%		
3) The total number of inappropriate new OAPs in the reporting period	2,473.00	2,085.00	147.00	138.00	737.00	422.00	1,205.00	844.00			383.00	569.00	2,473.00		2,473.00	2,085.00	147.00	138.00	737.00	422.00	1,205.00	844.00			383.00	569.00	2,473.00	
4) Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	91.99%	92.45%	93.21%	92.45%	92.13%	92.45%	90.87%	92.45%	86.89%	92.45%	90.51%			92.45%	91.45%	92.45%	92.38%	92.45%	92.60%	92.45%	92.15%	92.45%	82.51%	92.45%	87.03%		
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.47	4.00	1.57	4.00	0.00	4.00	3.61	4.00	0.00	4.00	4.87			2.00	1.91	8.00	3.18	8.00	2.25	8.00	25.27	8.00	0.00	8.00	9.73		
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	67.25%	53.75%	67.25%	36.00%	67.25%	72.73%	67.25%	62.50%				33.33%			67.25%	53.70%	67.25%	40.00%	67.25%	67.39%	67.25%	62.50%				33.33%		
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	78.25%	60.00%	78.25%	48.00%	78.25%	68.18%	78.25%	70.83%				44.44%			78.25%	57.41%	78.25%	55.77%	78.25%	59.09%	78.25%	60.42%				50.00%		

Trust Dashboard - Locality Breakdown for TRUST

2 - Activity

	May 2018														April 2018 To May 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	96.98%	85.00%	91.60%	85.00%	105.79%	85.00%	96.05%	85.00%	NA	85.00%	96.18%			85.00%	95.64%	85.00%	92.82%	85.00%	102.14%	85.00%	95.47%	85.00%	NA	85.00%	92.18%		
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	68.00	65.00	17.00	18.00	14.00	10.00	19.00	17.00			16.00	18.00			68.00	65.00	17.00	18.00	14.00	10.00	19.00	17.00			16.00	18.00		
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.93%	16.67%	23.93%	9.38%	23.93%	14.29%	23.93%	23.53%			23.93%	25.00%	239.30%		23.93%	16.77%	23.93%	18.18%	23.93%	13.04%	23.93%	20.00%			23.93%	13.64%	239.30%	

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	May 2018														April 2018 To May 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
15) Actual number of workforce in month (Establishment 95%-100%)	95.00%	93.70%	95.00%	93.39%	95.00%	98.82%	95.00%	93.49%	95.00%	96.42%		86.58%			95.00%	93.70%	95.00%	93.39%	95.00%	98.82%	95.00%	93.49%	95.00%	96.42%		86.58%		
16) Vacancy fill rate	90.00%	87.25%	90.00%	91.67%	90.00%	84.62%	90.00%	89.29%	90.00%	77.78%		84.62%			90.00%	83.20%	90.00%	91.67%	90.00%	84.62%	90.00%	89.29%	90.00%	77.78%		84.62%		
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	93.74%	95.00%	92.79%	95.00%	95.53%	95.00%	87.76%	95.00%	98.06%	95.00%	94.20%			95.00%	93.74%	95.00%	92.79%	95.00%	95.53%	95.00%	87.76%	95.00%	98.06%	95.00%	94.20%		
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	92.21%	90.00%	90.74%	90.00%	92.74%	90.00%	90.23%	90.00%	92.97%	90.00%	94.32%			92.00%	92.21%	90.00%	90.74%	90.00%	92.74%	90.00%	90.23%	90.00%	92.97%	90.00%	94.32%		
19) Percentage Sickness Absence Rate (month behind)	4.50%	4.66%		5.28%		4.02%		4.40%		5.78%		5.00%			4.50%	4.54%		5.13%		4.37%		3.79%		5.19%		4.75%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	May 2018														April 2018 To May 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
20) Delivery of our financial plan (I and E)	-675,000.00	-394,000.00	0.00	NA	0.00	NA	0.00	NA	0.00	NA	0.00	NA			-1,436,000.00	-1,240,000.00	0.00	NA	0.00	NA	0.00	NA	0.00	NA	0.00	NA		
21) CRES delivery	686,782.00	759,871.00	92,714.00	111,977.00	131,481.00	37,486.00	183,271.00	10,264.00	165,920.00	9,132.00	56,518.00	77,528.00			1,373,564.00	1,074,243.00	185,428.00	223,954.00	262,962.00	74,972.00	366,542.00	20,528.00	331,840.00	18,264.00	113,036.00	155,056.00		
22) Cash against plan	64,078,000.00	60,093,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			127,284,000.00	60,093,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Trust Dashboard 2018/19

KPI Guide

	KPI	***Target***	***Definition***
1	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	TBC	This measures, the number of patients who attend their first appointment in 4 weeks of their referral date out of the total number of people who attend their first appointment following their referral. This KPI has been amended for 2018/19 and the clock will now NOT restart if the patient DNAs or the patient cancels an appointment. This looks at patients with an external referral only. This Excludes IAPT patients.
2	*Percentage of patients starting "treatment" within (x) weeks of external referral*	*TBC*	*This measures, the number of people starting treatment within X weeks of an external referral against number of people starting treatment.* *This looks at patients with an external referral only.*
3	The total number of inappropriate OAP days over the reporting period (Rolling 3 months)	2,494	This measures, the total number of days patients have spent in an out of area bed inappropriately. In line with national reporting this measures a rolling 3 months time frame
4	Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	Within all inpatient and community services, this measures: Of the number of people in the Patient Survey who answered the question: - "Overall how would you rate the care you have received?," the number of patients who have scored "excellent" or "good".
5	Number of unexpected deaths classed as a serious incident per 10,000 open cases	12	This measure looks at the number of unexpected deaths classed as a serious incident per 10,000 open cases. This mirrors the data that is reported to the National Reporting and Learning System (NRLS)
6	The % teams achieving the agreed improvement benchmarks for HoNOS total score	67.25%	This measure relates to patients discharged from TEWV In Scope services (Spells ended with a Adult or MHSOP subject to Currency & Tariff National requirements). Patients total HoNOS scores are compared from the first rating against the last. A reduction in total HoNOS score is classified as improvement. 80% of patients in the Non Psychotic and Psychotic superclass and 40% in the organic superclass are expected to achieve this reduction. Teams are subject to the measure if they discharge more than 5 patients in any of the superclasses. The measure will report against the team the patient was with at the point they are discharged entirely from TEWV not if they are transferred to a different In Scope team.

Trust Dashboard 2018/19

KPI Guide

7	The % teams achieving the agreed improvement benchmarks for SWEMWBS	78.25%	This measure relates to patients discharged from TEWV In Scope services (Spells ended with a Adult or MHSOP subject to Currency & Tariff National requirements). Patients total SWEMWBS scores are compared from the first rating against the last. An increase in SWEMWBS score is classified as improvement. 80% of patients in the Non Psychotic and Psychotic superclass and 50% in the organic superclass are expected to achieve this reduction. Teams are subject to the measure if they discharge more than 5 patients in any of the superclasses. The measure will report against the team the patient was with at the point they are discharged entirely from TEWV not if they are transferred to a different In Scope team.
8	*Number of new unique patients referred*	*TBC*	*This measures the number of new individual patients referred ie a patient is only counted once. This is when the patient is not open to any other team in the Trust.* *This Excludes IAPT patients.*
9	*The number of external referrals with an Assessment completed*	*TBC*	*This measures the number of all external referrals into Trust with an assessment completed* *This Excludes IAPT patients.*
10	*The number of external referrals which were subsequently accepted onto caseload*	*TBC*	*This measures all external referrals to all services that have been accepted onto teams caseload.* *This Excludes IAPT patients.*
11	*The number of discharges from total caseload*	*TBC*	*This measures **all discharges** excluding* • *Patients who were not appropriate to accept onto caseload* • *Patients who had a referral closed without being seen* • *Patients who were assessed but not offered treatment.* • *IAPT patients.*
12	Bed Occupancy (AMH & MHSOP A & T Wards)	85%	This measures the number of days beds that are occupied out of the number of possible bed days available. (The calculation is on the number of beds available and the days in the month). This looks at AMH and MHSOP Assessment and Treatment wards only
13	Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards (Snapshot)	68	This measures the number of patients occupying a bed with a length of stay longer than 90 days from the day they were admitted. This looks at AMH and MHSOP Assessment and Treatment wards only

Trust Dashboard 2018/19

KPI Guide

14	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	TBC	This measures the number of patients who are readmitted onto a ward within 30 days of their last discharge. This looks at AMH and MHSOP Assessment and Treatment wards only
15	Actual number of workforce in month	95%	This measures the total number of contracted staff against the number of budgeted staff.
16	Vacancy fill rate	90%	This measures the number of vacancies where an offer of employment has been made out of the number of vacancies that are being recruited to. There are vacancies that have been advertised and not filled due to no applicants or no one shortlisted, however from a recruitment vacancy perspective are closed off as an episode – These are not included in the figures as they do not go over the 8 week time frame. This looks at posts that have been vacant longer than 8 weeks. This KPI will exclude bank staff and only include professional health care posts of Band 5 and above
17	Percentage of staff in post more than 12 months with a current appraisal	95%	This measures the number of staff in post more than 12 months and of those how many have a current appraisal. For medical staff this is monitored against 13 months.
18	Percentage compliance with ALL mandatory and statutory training	92%	This measures the total number of courses completed by each member of staff for ALL mandatory and statutory training out of the number of courses due to be completed for each member of staff
19	Percentage Sickness Absence Rate	4.50%	This measures the number of days lost to sickness out of the number of days within the month
20	Delivery of our financial plan (I&E)	-8556,000	This shows the Trusts surplus or deficit position (£). The target is the planned surplus position.
21	CRES delivery	8,241,384	This shows the CRES Identified against the planned amount
22	Cash against plan	56,640	This shows the actual cash held by the Trust against the amount of cash forecasted to be held

Number of unexpected deaths and verdicts from the Coroner April 2018 - March 2019

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
9	3										

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
2	1	7	0	2

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

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
4	4	3	11	11	5	10	8	13	11	9	10

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
31	21	28	6	13

ITEM NO 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**3rd July 2018**
TITLE:	**Data Quality Strategy**
REPORT OF:	**Patrick McGahon, Director of Finance and Information**
REPORT FOR:	**Approval**

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:

On the 12th June 2018 The Resources Committee considered and approved the new Data Quality Strategy (DQS) to be considered by the Board of Directors for final approval.

The strategy supports the Trust's vision and the successful implementation of the strategy will contribute to the delivery of all the Trust's strategic goals, in particular, goal 5:

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

This strategy sets out an ambition to achieve excellence in data quality. It will do this by ensuring that:

- Our systems align with care pathways, are intuitive and enable 'self-service' analysis.
- Operational staff members are fully competent at using information systems with their training needs being met, enabling information to be entered accurately and in a timely manner to ensure reduced risk.
- Stakeholders will be confident in information provided; data will be meaningful and use a shared language.

Recommendations:

- The Board of Directors are asked to approve the Data Quality Strategy as recommended by the Resources Committee.

MEETING OF:	**Board of Directors**
DATE:	**3rd July2018**
TITLE:	**Data Quality Strategy**

1. INTRODUCTION & PURPOSE:

1.1 The Trusts previous data quality strategy covered the period 2013-2016. A comprehensive refresh of the strategy has been undertaken.

1.2 The Data Quality Strategy sets out an ambition to achieve excellence in data quality by 2021.

1.3 To seek the Board of Directors approval of the Data Quality Strategy for the period June 2018 to May 2021.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 As part of the strategy refresh, investigation into the current data quality levels has been undertaken. This has evidenced generally 'good' data quality, with some scope for improvement. Strengths include strong governance arrangements, alignment with the Digital Transformation plan and good corporate support. Areas requiring attention include mistrust of data, incomplete data items, a lack of visibility of data and improving training and awareness.

2.2 The refreshed strategy has been written in conjunction with a key 'focus' group with representatives from HR, Finance, Information, Planning and Performance, Nursing and Governance and two clinical areas. In addition, service user involvement has been sought and feedback has been obtained from groups including the Managing the Business, LMGB's, Data Quality working group and OMT.

2.3 The environmental analysis undertaken showed a number of key themes including a greater emphasis on sharing and interrogating data, partnership working, reducing data collection requirements, standardising data, using technology to its full potential and ensuring staff members have appropriate skills and expertise to effectively analyse data to support decision making.

2.4 Five key objectives have been identified to allow the achievement of excellent data quality. These are:

- We will improve the understanding and need for high quality data throughout the Trust.
- We will ensure that the clinical effort required for inputting accurate, complete data into systems will be minimal.
- We will reduce the volume of reports currently produced, improve consistency and standardisation.

- We will have systems in place that enable Trust staff to 'self-serve' their own information requirements.
- We will improve the satisfaction of partner organisations in regards to the information provided by the Trust.

2.5 Each objective has specific actions to support delivery and scorecard metrics. Baseline metrics will be identified for each metric and associated improvement targets will be monitored throughout the life time of this strategy.

3. KEY ISSUES:

3.1 A challenge exists to promote positive behaviours towards data quality in everyday practice and embed a culture that recognises that data quality is part of everyone's role without it being seen as a 'burden'. There is a need to consider more innovative approaches to disseminating key messages, to raising understanding and awareness and to stimulate positive action.

3.2 It is vital to work in collaboration with key partners and stakeholders to ensure a commitment to change is embedded.

3.3 The use of technology needs to assist in improving data quality levels. Processes should be automated with systems design ensuring that mistakes are minimised as much as possible.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

4.1.1 Reputational damage can occur if service users are not given appropriate timely data regarding their care. There is an ever increasing expectation of quality regarding patient experience data. Patients can choose a different provider if they cannot evidence that the Trust is performing well. Good quality data providing up to date timely evidence of successful treatment and outcomes is essential. Poor data quality may increase risk to staff and patient safety.

4.1.2 Data access has improved substantially and social norms now mean that expectations of accessible timely and responsive data are higher than ever; patients expect to be able to 'pull' information on demand.

4.1.3 Low data quality will mean potential financial and reputational penalties for the organisation and increased scrutiny from CQC with a more burdensome performance focus.

4.2 Financial/Value for Money:

4.2.1 The Trust needs to ensure that it is compliant with new changes and developments to national data standards. This will become increasingly more important as data is published and comparisons made between and across organisations.

4.2.2 Data needs to be able to be responsive, complete and accurate to meet and evidence the constantly changing outcomes agenda otherwise financial consequences can result.

4.2.3 Data quality is an integral part of the Trusts contract requirements with its commissioners; expectations are of data quality issues being speedily acknowledged and addressed. The Trust requires timely and accurate data to facilitate this, otherwise financial penalties for lack of progress or development (e.g. DQIP's) can occur and the Trust may not be successful in obtaining or retaining tenders / bids for services.

4.3 Legal and Constitutional (including the NHS Constitution):

With the introduction of GDPR there is an increased financial and potential legal consequence if data safety, consent and integrity are not of a high level.

4.4 Equality and Diversity:

As an organisation, the Trust needs to consider how it equips staff with the right skills, expertise, techniques and technology to effectively analyse data and support clinical and business decision making. A successful approach will be adaptable to the differing needs of various groups of staff.

4.5 Other implications:

None identified

5. RISKS:

5.1 Data needs to be readily available and improvements in data quality evidenced over time otherwise potential contractual penalties and lack of demand for service provision may result.

5.2 The Trust may be subject to increased centralised monitoring if it cannot evidence improvements in quality. Shortages within the clinical workforce may impact on the ability to enter and record data correctly and quickly.

6. CONCLUSIONS:

6.1 Without good data quality the organisation is not able to deliver high quality patient care, understand outcomes, make informed decisions, meet legislative and regulatory requirements and successfully plan for the future.

6.2 The strategy has attempted to appreciate the vital contribution of data in the delivery of service excellence and is intended to initiate a programme of change across the Trust, promoting positive cultures and attitudes towards data quality.

6.3 With this in mind, the scope of this strategy has been extended to consider other broader areas of our business functions where high quality data is essential (HR, Finance, Risk and Governance).

7. RECOMMENDATIONS:

7.1 The Board of Directors is asked to approve the Data Quality Strategy.

Author: Patrick McGahon
Title: Director of Finance and Information

Background Papers:

Data Quality Strategy

Tees, Esk and Wear Valleys
NHS Foundation Trust

Item No 14

Data Quality Strategy

2018-2021

Strategy Sponsor: Patrick McGahon (Director of Finance and Information)		
Strategy Lead: Bob Craig (Associate Director of Information)		
Version: 1	**Date approved**	**Date of Next Review:** May 2021

making a difference together

Preface

Good data quality is fundamental to the achievement of the Trust's strategic goals. Without good data quality the organisation is not able to:

- Deliver continuous high quality patient care
- Fully understand the outcomes and services that we provide
- Successfully plan for the future
- Make informed decisions
- Meet legislative and regulatory requirements

This strategy aims to challenge the organisation to think differently about data quality and to appreciate the vital contribution of data in the delivery of service excellence. This strategy is intended to initiate a programme of change across the Trust, promoting positive cultures and attitudes towards data quality.

With this in mind, the scope of this strategy has been extended to consider other areas of our business where high quality data is essential.

Previous strategies have focused purely on our patient information systems. However, as the organisation moves towards integrated systems and increased use of technology to support our business processes the impact of data quality on broader business functions, such as HR, Finance, Risk and Governance, needs to be considered.

Executive Summary

This Data Quality Strategy sets out the direction of travel for Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) for the period June 2018 to May 2021.

The strategy supports the Trust's vision;

"To be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations"

The successful implementation of this strategy is central to strategic goal five;

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

along with contributing to the delivery of the remaining trust strategic goals.

This strategy sets out an ambition to achieve excellence in data quality by 2021.

The organisation can currently be described as having 'good' data quality , with some scope for improvement. The strengths of our current approach include; we have seen an improvement in some data quality items, strong governance arrangements, a Digital Transformation Plan that aligns with this agenda and good corporate support. The key areas that require attention include; mis-trust in the data available, incomplete data, making the best use of technology, lack of visability of data and improving training and awareness.

The environmental analysis showed a number of key themes including; a greater emphasis on partnership working, integration and sharing of data, a requirement to ensure that technology is used to its full potential to leverage good data quality, reduction in data collection requirements, standardisation and an increased emphasis on ensuring staff have the right skills, expertise, tools and technology to effectively analyse data to support clinical and business decision making.

Following this assessment on the internal and external environment five key objectives were identified that we believe will have the biggest impact on achieving excellent data quality.

The five objectives are:

1) We will improve the understanding and need for high quality data throughout the Trust.
2) We will ensure that the clinical effort required for inputting accurate, complete data into systems will be minimal.
3) We will reduce the volume of reports currently produced, improve consistency and standardisation.

4) We will have systems in place that enable Trust staff to 'self-serve' their own information requirements.
5) We will improve the satisfaction of partner organisations in regards to the information provided by the Trust.

Each objective has specific actions to support delivery and scorecard metrics. The latter will enable a baseline measure to be identified and associated improvement targets that will monitor progress during the life time of this strategy.

Contents

1 Introduction to Data Quality

Data Quality is an assessment of data's fitness to serve its purpose in a given context. This includes both for internal and external purposes and involves a wide range of stakeholders such as service users, staff, commissioners and partner organisations.

Issues of data quality are a primary consideration in areas of work such as:

- Patient choice, supporting decision making and service user progress
- Compliance with legislative and regulatory requirements
- Planning and delivery by clinical and corporate services
- Clinical and business decision making
- Service performance/patient care & recovery
- Research, innovation and service improvement
- Accurate payment and outcome measures
- Maximising the use of resources for the benefit of patient and staff

The Audit Commission has identified 6 characteristics that have to be present for data to be considered high quality:

1. **Accuracy -** Data should be sufficiently accurate for its intended purpose. It should be captured only once and accuracy is most likely to be achieved if it is captured as close to the point of activity as possible. Automated capture as part of routine clinical care is usually more accurate and always more consistent than manual capture systems.
2. **Validity -** Data should be used in compliance with relevant requirements including the correct application of rules or definitions
3. **Reliability -** Data should reflect stable and consistent data collection processes over time.
4. **Timeliness -** Data should be captured as quickly as possible after the event and should be made available to support information needs and to influence service or management decisions.
5. **Relevance -** Data captures should be relevant to the purposes for which they are used.
6. **Completeness -** Data should be clearly specified based on the information needs of the users.

Inaccurate patient information could also have potentially very serious consequences in terms of the care a patient receives. Poor data quality puts organisations at significant risk of: damaging stakeholder trust and confidence; weakening frontline service delivery; incurring financial loss; and poor value for money and inefficient use of resources.

The Data Protection Act 1998, principle 4 also sets out an obligation for organisations to ensure that 'data is kept accurate and up-to-date'.

2 Where are we now?

The Trust board recently approved the Digital Transformation Strategy and Scorecard. This strategy and associated governance arrangements will help provide a strong foundation for improving data quality within the organisation.

All new technology/system developments now follow a robust governance process to ensure the development aligns with best practice. From a data quality perspective this means:

- Integration rather than duplication/Single version of truth
- Where possible automation/pre-population of data
- Entry of records as close to point of activity (e.g. mobile devices)
- Mistake proofing built into systems (mandatory fields)
- Co-production of developments to ensure technology aligns with business/clinical processes

Currently the organisation may be described as having good data quality, although with some scope for improvement:

Our strengths include:

The previous strategy and underpinning work has provided a good foundation for the Trust, including:

- *Data Quality performance* - in key data quality items we have seen an improvement, such as:
    - Missing Patient Ethnicity – this has reduced from 2.33% in 13/14 to 0.69% as at November 2017
    - Missing Patient NHS number – this has reduced from 0.13% in 13/14 to 0.04% as at November 2017
    - Assessment date is before Referral received date – this applied to 261 records in 13/14 but only 105 records were incorrect as at November 2017
    - Percentage of records submitted through MHMDS with a valid ethnicity code – this has improved from 94.17% in 13/14 to 97.53% as at November 2017
    - The Data Quality Maturity Index (DQMI), a quarterly publication intended to highlight the importance of data quality in the NHS, shows an overall rating of 95.5%.
    - The latest clinical coding audit (August 2017) achieved a level 3 which is the highest level of attainment. The audit results included; 98% success rate in correct primary diagnosis coding and 87.7% in correct secondary diagnosis coding.
    - As part of the Information Governance toolkit national submission a number of sequences obtained a level 3 (highest attainment), these

included – use of external data quality reports to improve data quality, national data definitions and standards being incorporated into key systems.

- *Governance arrangements* – strong governance arrangements exist within the organisation to support the data quality agenda, including; managing the business (MTB - director led meeting), technical change board (reviews system changes) and the data quality working group, who have a broad membership undertaking key work packages assigned by MTB group. Standard operating procedures also exist for a range of practices relating to data quality, including data set submissions and validation.

  The Digital Transformation Strategy, Records Lifecycle Management Strategy and associated policies and procedures also provide a clear direction of travel and guidance for staff.

- *Digital Transformation Development Plan* - this has a number of projects underway that will support staff with their data quality responsibilities:

  - IIC developments – enables clinicians to monitor the delivery of their care via a range of KPI's, Data Quality breaches, clinical activity and interventions, clinical outcomes and key quality assurance measures and patient experience. The IIC also support teams with daily lean management and visual control.
  - Next generation devices – a project that offers a variety of products that improve patient experience and reduce the time spent by clinicians on administrative activities. This approach will enable the collection and recording of clinical information at the point of care which is known to improve the accuracy of data.
  - Development of the electronic patient record to include electronic care pathways, a service user access portal and improved document handling. This will enable the monitoring of care delivered against agreed pathways.

- *Guidance and support* - Corporate services (Performance, Information, Finance and HR), have staff that are aligned to each clinical locality. This enables relationships and understanding of the localities issues to be better known and understood. These locality links input into appropriate governance groups, assist with key work packages and support the dissemination of good practice in relation to data quality.

  A range of resources are also available to assist staff in understanding the correct process to follow when entering data into systems – via e-learning, self-help guides, videos, individual guided support etc.

Our challenges & issues include:

- *Mistrust of data* - Trust staff regularly question the accuracy of data that is published on IIC and presented through various reporting mechanisms. This often generates a significant amount of re-work for staff checking/validating the information source against the published data. A number of examples of where this happens include:

    - Appraisal data and the accuracy of recording on ESR
    - Mandatory & Statutory Training – compliance levels
    - Paris – confusion of where and what information should be entered

- *Completeness of data* – the information that is pulled from source systems does not always represent a full reporting picture. Requirements change on a regular basis (e.g. contractual/statutory) and Trust systems may require developments to accommodate this – in the meantime staff develop 'work arounds' and alternative systems that might result in an incomplete data set.

- *System improvements* – a number of opportunities exist within the current systems to adopt QIS techniques. This would ensure that wherever possible new system/technology developments use automation to best effect to reduce the possibility of errors/defects occurring. The direction of travel towards inter-operable systems also provides a further focus for the trust to improve its data quality, which will utilised by outside agencies and partners.

- *Visibility of data* – The IIC system has been in use within the Trust since 2013, with an increasing amount of data being published for all staff to access. However, staff members regularly make specific requests for data already publicly available. Many staff members appear to be uncomfortable with navigating around IIC in order to find the information they require. Further work is required to fully embed the IIC within the organisation to ensure full benefits can be realised – including the use of the analysis framework for staff to self-serve.

- *Scale of data* – Over the last few years we have seen a significant increase in the demand for information reports, from both internal and external sources. Some of this information is available on IIC and some still needs to be manually extracted from the source system. This places pressure on clinical and corporate services to co-ordinate within existing resources and ensure that data accuracy is maintained, and is presented consistently. As part of the annual business planning cycle the requirements for IIC development and the automation of manual reports outstrips the existing resource available.

- *Quality standard* - There is no single benchmark/measure in place to determine our data quality assessment and provide quality assurance. Currently evidence for this is sourced from many sources such as internal audit, IG toolkit performance, internal KPIs and DQMI scores.

- *Sources of Information* - Within the organisation a number of teams are completing analysis, reporting and business intelligence functions. This could have implications in terms of; inconsistency in reported data, confusion over which is the 'one version of the truth', variation in analysis capabilities, different data definitions being utilised etc. For example, a request for an information report may produce different responses due to a difference in interpretation of the requirements, ie. different data items selected, timeframes the information is collected over, the way information is compiled and statistical tools employed, filters on the report etc.

- *Known Data concerns* – There are a number of areas that remain a challenge for the trust, these include:

    - Number of "system breaches"[1] for Crisis Gatekeeping in 14/15 was 139 and increased to 140 in 16/17.
    - Number of "system breaches" for CPA 7 day follow up in 14/15 was 75 and 87 in 16/17.
    - Number of GP practice codes missing or incorrect in 14/15 was 0.15% and 0.19% in 16/17.
    - Missing Patient Accommodation Status in 14/15 was 6.33% and 10.6% in 16/17.
    - Missing Employment status in 14/15 was 5.78% and 8.12% in 16/17.

- *Culture and training* – A real challenge exists as to how we can promote positive behaviours and attitudes towards data quality within the organisation. We need to embed a culture that recognises the importance of good data quality, that its part of everyone's role without being seen as a 'burden' and 'another thing to do'. We need to ensure that the training, support and guidance that members of staff receive encourages a positive mind-set and impacts positively on their daily practice. We need to consider more innovative approaches to disseminating key messages, to raise understanding and awareness resulting in engaged individuals and stimulate positive action.

In summary, this assessment shows that:

- We must build on our existing strengths and ensure they are fully embedded and sustainable going forward. The use of baseline measures and quality standards will enable this to be monitored through the lifetime of the strategy.
- We must explore possibilities to utilise the TEWV Quality Improvement System to identify opportunities where positive practice can be taken forward.
- It is important to work in collaboration with partners/key stakeholders to ensure an understanding and commitment to change is embedded and that staff have confidence in their contribution towards data quality excellence.
- Data quality needs to be embedded into system design from conception right the way through to deployment.

[1] This indicator looks at the number of admissions to the trust's acute wards with face to face contact with Crisis Team on either day of admission or day before within the month

3 Environmental Analysis and the drivers for change

A PESTLE[2] analysis was completed to understand what external drivers would potentially have an impact on the successful delivery of this strategy. In addition to this, a number of key documents, policies and national bodies were reviewed/considered for potential impact on this strategy. The key areas included:

- Health & Wellbeing boards
- The Independent Mental Health Taskforce
- The five year forward for Mental Health
- New national governance arrangements for information standards (April 2017)
- NHS Digital – Data & Information Strategy 2016
- NHS Improvement
- Care Quality Committee

This review identified the following themes:

- *Greater emphasis on partnership working* – Organisations will need to work collaboratively sharing data and in some instances integrating systems. This provides a real opportunity for the Trust to learn from other organisations, provides a further driver to improve the Trusts data quality and enables joined up strategic decision making based on shared data intelligence. Increasing amounts of data will also be published and organisations will need to standardise the way this is presented.

- *Utilising technology to leverage 'good' data quality* – The digital transformation strategy and associated plans are key to ensuring that processes are automated as much as possible and systems minimise the potential for data quality defects. The organisation will also need to plan for maintaining infrastructure and systems that enable data and information to be shared across organisational boundaries. Technology will need to fully support the collection, integration, analysis and presentation of information to support business decision making.

- *Reduce the unnecessary data collection requirements* – We will need to work with key stakeholders to identify unnecessary data collection requirements, and encourage the use of national data flows rather than locally produced data. This will require a detailed examination of what

[2] PESTLE – This is an analysis of the Political, Environmental, Social, Technological, Legal and environment that the Trust operates within. The PESTLE analysis was developed within a workshop held with a range of key stakeholders. The full PESTLE analysis can be found in Appendix 1.

internal and external reports are produced, for what purpose and benefit. This should provide an opportunity to focus efforts on pro-active measures to improve data quality.

- *Standardisation* – we will need to ensure that we are compliant with new changes and developments to national data standards. This will become increasingly more important as the data is published and comparisons are made between and across organisations.

- *Increased emphasis on data analysis* – As an organisation we will need to consider how we equip staff with the right skills, expertise, tools, techniques and technology to effectively analyse the data available and support clinical and business decision making.

4 Our Ambition

This strategy sets out an ambition to achieve excellence in data quality. By 2021 we will have an organisation where individuals' understand their responsibilities in relation to data quality and act upon these upon within their everyday practice.

Systems will align with care pathways, be intuitive and enable 'self service' analysis on a wider range of requirements. They will store data securely in line with national standards and best practice.

Operational staff members will be fully competent at using information systems with their training needs being met, to enable information to be entered accurately and in a timely manner to ensure reduced risk.

Stakeholders both internal and external to the Trust will be confident in information provided to them; data will be meaningful and use a shared language understood by everyone.

The future state allows the right people to be involved in partner conversations at the right time, with a reduced internal reporting burden.

5 Objectives

To achieve our ambition the following objectives have been set:

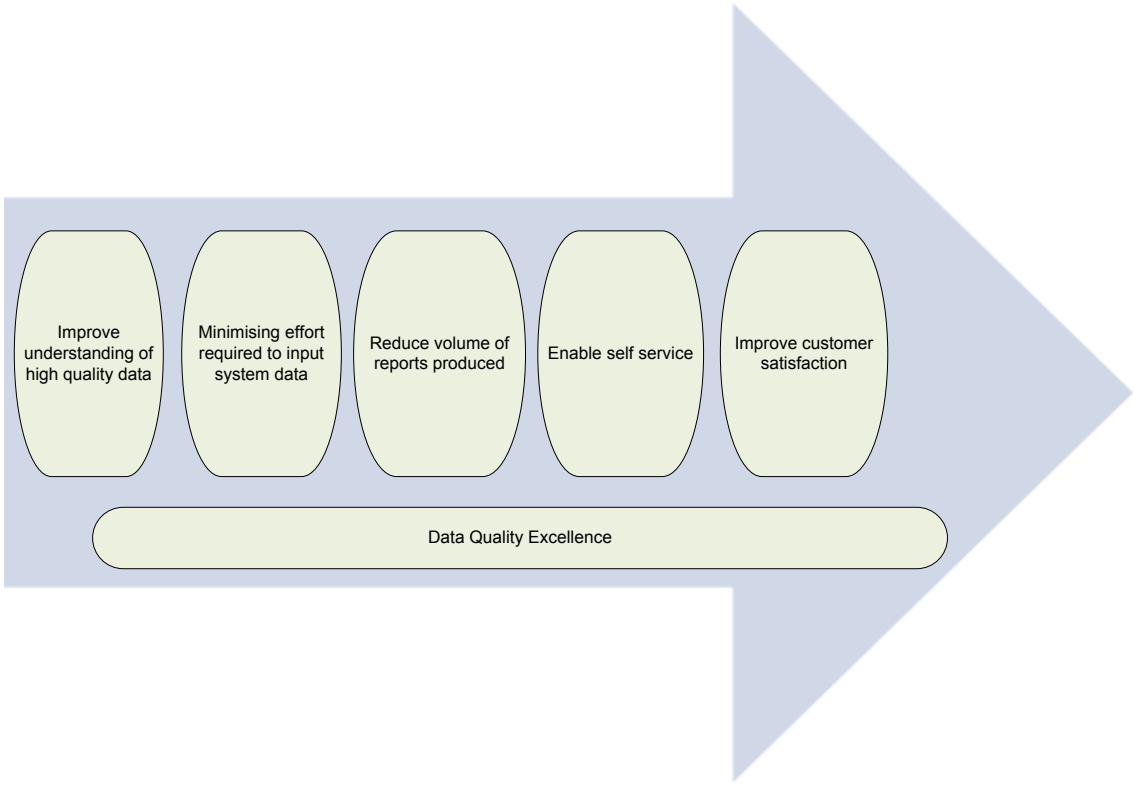


Figure 1 – DQ objectives

5.1 By 2021, we will improve the understanding and need for high quality data throughout the Trust.

This objective will ensure that all staff are clear about their roles, responsibilities and actions necessary to achieve data quality excellence. We will achieve this objective by the following initiatives:

- Data quality will be embedded into daily lean management and discussed regularly at senior level meetings.
- There will be clear identification of personal data quality responsibilities for all roles and the benefits of good data quality and consequences of poor data quality will be shared.
- Managers will ensure all staff members have the appropriate skills, knowledge and resources to ensure data quality excellence.

This will be measured by the following metrics:

1. **By September 2019 80% of new job descriptions created will include a section on data quality roles and responsibilities.**
2. **By March 2019 senior leadership network and leadership events will include key messages on data quality.**

5.2 By 2021, we will ensure that clinical effort required for inputting accurate, complete data into systems will be minimal.

We will achieve this objective by aligning with initiatives contained within the Digital Transformation Strategy and by undertaking the following initiatives:

- Reviewing systems to ensure mistake proofing will be undertaken automatically at data entry point.
- Designing new systems to provide intuitive help buttons or knowledge prompts within data entry forms.
- Removing unnecessary duplicated data entry within system processes – data will be entered once and pulled through to relevant sections.
- Reviewing the number of systems in operation and encouraging Inter-operability.
- Identifying spreadsheets and databases kept locally and understanding additional requirements for core system functionality.
- Planning timely coding updates for all core systems.
- Faster, appropriate level access to required information systems will be granted with customers easily able to identify what they need.

This will be measured by the following metrics:

1. **By September 2019 we will complete a mapping exercise of all locally kept corporate spreadsheet/databases and develop a plan for taking this forward.**
2. **By September 2020 we will complete a mapping exercise of all locally kept clinical spreadsheet/databases and develop a plan for taking this forward.**
3. **By March 2020, 90% of all coding updates required for core systems will be applied within 30 days.**

5.3 By 2021, we will reduce the volume of reports currently produced, improve consistency and standardisation.

This objective will ensure that all reports produced have a clear purpose and can demonstrate they add value and positive outcomes. We will achieve this objective by undertaking the following initiatives:

- There will be an emphasis when working with partners to align new and existing contractual reporting requirements to national NHS obligations (as per NHS Digital strategy), we will not expect additional data quality reports to be requested - unless there is an exceptional need identified.
- Working with commissioners/partners to develop a shared understanding of report requirements to reduce data error likelihood and increase confidence in data interpretation.
- There will be a much reduced but more targeted focus on internal and external KPI metrics removing over-production of data.

- A common language/data dictionary will be developed to reduce variations in data interpretation and ensure information analysis is relevant and value adding.

This will be measured by the following metrics:

1. **By March 2021 a standard suite of commissioner/partner reports will be developed electronically.**
2. **By September 2019 a standard data dictionary will be developed and in use across the trust.**
3. **A 30% reduction by 2021 of KPI's actively monitored within the Trust.**

5.4 By 2021, we will have systems in place that enable Trust staff to 'self-serve' their own information requirements.

This objective aims to encourage self-analytics and focus efforts on standardised, meaningful and accurate information. It will be achieved by the following initiatives:

- A targeted move to a self-service information analysis culture – providing support and awareness to staff members of how to access, interpret and manipulate data and how to best use the IIC system.
- A systematic process will be put in place with key internal stakeholders to ensure the IIC DQ dashboard is regularly updated with relevant information to help identify areas for improvements and aid review of data quality levels.
- We will ensure that the current approach to IIC training is regularly reviewed and a plan for developing a more innovative/creative approach is developed.

This will be measured by the following metrics:

1. **By October 2019 80% of all relevant staff will access IIC reports at least once a month.**
2. **By December 2020 50% of all relevant staff will have received guidance on 'my metrics'.**
3. **By December 2021 75% of all relevant staff will have received guidance on 'my metrics'.**
4. **By March 2021 a 30% reduction in data quality errors in the IIC data quality dashboard (key fields).**

5.5 We will improve the satisfaction of partner organisations in regard to the information provided by the Trust

This objective aims to increase accuracy and confidence in data, improve co-production and integration and improve the Trust's reputation. It will be achieved by the following:

- The fulfilment of mandatory and statutory reporting requirements alongside contractual reporting obligations to timescale - with associated improvements in data quality scores such as the DQMI.

- The achievement of required DQIP targets to improve data completeness and accuracy as agreed with commissioner colleagues.
- The process for requesting external information will become more streamlined and reactive (with inappropriate requests being challenged).
- An improved range of communication tools and feedback methods used with external stakeholders to improve customer satisfaction.

This will be measured by the following metrics:

1. **By June 2019 the average time taken to complete agreed external information requests will reduce by 75%.**
2. **By March 2019 an annual survey will be established and distributed for completion by key external stakeholders.**
3. **By March 2021 20% improvement in data quality scores for key data set submissions.**
4. **Commencing April 2018 100% of agreed DQIP targets will be completed each quarter.**

6. Outcomes Scorecard

Strategic Theme	Strategic Metrics	Base-line Q4 17/18	Q'terly Target	18/19 Target	Actual	19/20 Target	Actual	20/21 Target	Actual
Improve understanding of high quality data	By Sep 19, 80% of new job descriptions created will include a section on data quality responsibilities	0							
	By Mar 19, senior leadership network and leadership events will include key messages on data quality	0							
Minimising effort required to input system data	By September 2019 we will complete a mapping exercise of all locally kept corporate spreadsheet/databases and develop a plan for taking this forward	Unknown							
	By September 2020 we will complete a mapping exercise of all locally kept clinical spreadsheet/databases and develop a plan for taking this forward	Unknown							
	By Mar 20, 90% of all coding updates for core systems will be applied within 30 days	TBC							
Reduce volume of reports produced	By Mar 21, a standard suite of commissioner/partner reports will be developed electronically	0							
	By Sep 19, a standard data dictionary will be developed and in use across the Trust	0							
	A 30% reduction by 2021, of KPI's actively monitored within the Trust	TBC							
Enable self service	By Oct 19, 80% of all staff will access IIC reports at least monthly	TBC							
	By December 2020 50% of all relevant staff will have received guidance on 'my metrics'	TBC							
	By December 2021 75% of all relevant staff will have received guidance on 'my metrics'								
	By March 21 an 30% reduction in data quality errors in the IIC data quality dashboard **Key fields to be included:** GP practice Invalid postcodes	TBC							

Strategic Theme	Strategic Metrics	Base-line Q4 17/18	Q'terly Target	18/19 Target	Actual	19/20 Target	Actual	20/21 Target	Actual
	Patients with a missing CPA level, Missing Patient Accommodation Status Missing Patient Employment Status Missing Patient Ethnicity and Patients with an unknown Ethnicity Patients on standard care without Lead Professional Patients DOB missing EIP Care Co-ordinator and Lead Professional allocation dates Assessments with no contact recorded DTOC missing or incorrect codes								
Improve customer satisfaction	By Jun 19, the average time taken to complete agreed external information requests will reduce by 75%	27 days							
	By Mar 19, an annual survey will be established and distributed for completion by key external stakeholders	0							
	By Mar 21, 20% improvement in data quality issues for key dataset submissions DQMI MHSDS PAVE IAPT NRLS	TBC							
	Commencing Apr 18, 100% of agreed DQIP targets will be completed each quarter								

7. Glossary

Term	Description
IIC	Integrated Information Centre
DQMI	Data Quality Maturity Index (NHS Digital publication to rate data quality of key data items within commissioning datasets)
CRES	Cash releasing efficiency savings
QIS	Quality Improvement System
HSCIC	Health and Social Care Information Centre
CQUIN	Commissioning for Quality and Innovation
DQUIP	Data Quality Improvement Plan
LA	Local Authority
JSNA	Joint Strategic Needs Assessment
STP	Sustainable Transformation Partnerships
ASCOF	Adult Social Care Outcome Framework
QOF	Quality Outcome Framework
CCG	Clinical Commissioning Group
PIPA	Purposeful Inpatient Admissions
PPCS	Purposeful and Productive Community Service
PROM	Patient Related Outcome Measure
CQC	Care Quality Commission

Appendix 1 – PESTLE

	Description of the issue	What could the consequence be?	What are we doing already?
Political 1	Increased level of cyber security threats and increased scrutiny of assurance standards being met	Data within systems is compromised and/or unavailable. Loss of reputation/financial impact to Trust if involved in incidents.	Emergency planning IT security measures / audits New NHS Digital Cyber Security service (Nov 2017) Digital Safety Board – Cyber security sub group
Political 2	Changing workforce environment - possible shortage of registered and clinical professional groups	Clinical staff have wider choice in job roles and employers than ever before. Registered staff have a professional responsibility for data quality - difficulties in recruiting appropriately qualified staff can impact data completeness and accuracy. Bank and agency staff can be required to cover vacancies, sickness or enhanced observations and may not have full timely access to all data systems or be aware of all standard processes to follow. Financial impact of paying overtime or agency costs as well as additional training requirements can add to pressures above.	TEWV now only offers permanent contracts to nurses and undertakes a tailored programme of recruitment. TEWV offers retire and return to allow experienced staff to continue to work for the Trust and to mitigate effect of an aging workforce.
Political 3	Increased focus on integrated partnership working	Need to ensure collaborative working with partner organisations - LA's JSNA's, Social Care, STP's Inter-operability is a huge factor to ensure good data quality across the area the Trust operates in - it is critical that data is robust and complete as well as being readily	Accountable Care Partnership set up with LD services Digital Transformation Strategy approved

	Description of the issue	What could the consequence be?	What are we doing already?
		available in a timely manner.	
Political 4	Increased performance focus within NHS with 5 year forward view	Data needs to be able to be responsive, complete and accurate to meet constantly changing outcomes agenda - e.g. ASCOF, CQUIN's and QOF - otherwise potential damage to Trusts reputation and financial consequences can result.	Regular commissioning meetings and engagement Input into NHS digital data collection consultations
Political 5	Conflict between need to be open and transparent for service users and commissioners/partners whilst ensuring patient safety and security and consent regulations are adhered to	Financial and potential legal consequences of not being able to ensure data safety, consent and integrity - particularly with introduction of GDPR. Trust reputational damage if service users are not given appropriate timely data regarding their care. Need to ensure patient confidentiality does not impact ability to share data across organisations and with staff members	Duty of candor awareness Safe staffing programme GDPR working group/mobilisation Mortality reviews
Economic 1	NHS Financial position – there is an expectation within the 5 year forward plan of increased efficiency alongside reduced costs of corporate services, reductions in bed numbers and improvements in clinical quality.	Latest provider deficit figures are c.£800m and CCG's are under increasing pressure (particularly Vale Of York). Robust high quality data which is reliable is critical to allow service provision and planning decisions to be made. Reduced levels of funding within the area in which the Trust operates means it is vital to be able to obtain data to evidence 'lean' processes and high outcomes.	Planning to achieve CRES requirements on a recurring basis QIS plans in place – PIPA, PPCS focus Providing information on benchmarking services and engagement in pilot groups for information and performance metrics.

	Description of the issue	What could the consequence be?	What are we doing already?
		Increased drive towards tendering for new and existing services the Trust operates means robust relationship with commissioners is important and expectations of good quality data being reliable, complete and timely must be met. The Trust may be subject to increased centralised monitoring if it cannot evidence improvements in quality.	
Economic 2	Patient choice – patients can choose where they want to receive treatment and will use available performance and quality data analysis to help inform decisions in larger numbers as expectations of involvement in own care and greater shared decision making increase	Patients, particularly those close to the boundaries of neighbouring providers could choose to go out of Trust, or internally out of locality - creating pressure on both service standards and financially –if they do not believe that TEWV is performing well. Good quality data providing appropriate up to date evidence of successful treatment and outcomes is essential.	Plans in place to deliver purposeful and productive services in a standard way. This should reduce unwarranted variation in processes and standardise pathways - improving data quality and performance metrics, therefore reducing risk of patient choice impact.
Economic 3	Development of currency and tariffs for MH Services	Increased focus on clinical outcome delivery within services. Data quality impact on collection of data and understanding of analysis, particularly around terminology and language used. Potential large financial impact on the organisation if outcome measures (PROM's etc) are not robustly evidenced.	Dedicated currency and outcomes team providing support to services
Social 1	Brexit	Potential impact on TEWV workforce due to unclear future regulation and status of	The Trust has communicated that it values our EU staff, and is running a medic recruitment campaign in

	Description of the issue	What could the consequence be?	What are we doing already?
		EU nationals. Shortages within workforce will impact on ability to enter and record data correctly. Potential future requirement to charge EU citizens for services accessed - data would need to be timely, reliable and complete to do so. The pounds value has fallen and inflation increased meaning economic growth has slowed.	India. Inflationary pressures will continue to be reviewed and CRES requirements set accordingly.
Social 2	Increased demand for services due to reduced stigma around MH; possible increased prevalence due to economic and social issues; increasing aging population and reduced capacity of primary care to cope with more complex health needs and their increasing austerity impacting on secondary care	Increased demand for services but no additional income. National focus on CAMHS services increasing; this requires data robustness and accuracy to evidence improvement - linked to financial gains. More 'touch points' for data between services to be recorded, less time to do so and increased demand for information.	Introducing more sophisticated monitoring of referral trends in summer 2017 Continue to work with commissioners to develop services fit for the demographics of the population the Trust serves and meet MH minimum investment standards. PPCS / QIS work to increase team efficiency to support patient flow and demand management.
Social 3	Increased Patient expectations e.g. Individual / personalised care with 7 day services close to home	Increased expectations of good quality data to support decision making - both for commissioners and patients Higher data requirements on patient experience and expectation of quality. Increased demand for services but no additional income.	PPCS / QIS work to increase team efficiency to support patient flow and demand management. Recovery strategy Well being strategy Enhanced monitoring of patient experience data and added to 18/19 IIC development plan

	Description of the issue	What could the consequence be?	What are we doing already?
Technological 1	NHS requirement to utilise technology for improved service delivery	Increased requirement for sharing data and robust data analysis to plan and monitor services - if data is not complete and available services will not be efficiently provisioned and utilised Inter-operability is critical as systems need to be able to link together to provide a complete patient experience, and sharing data requires data to be timely and accurate both in perception and reality	Digital transformation agenda within TEWV in place 3 year information audit programme agreed
Technological 2	Increased technical age/ability	Data access has improved substantially with smart phones, ipads, computers etc being usual for all ages. Social norms mean that expectations of accessible timely and responsive data are high and patients expect to be able to 'pull' information (whether financial, service delivery, outcomes, waiting times etc) on demand.	Patient portal plans for Paris Publication of staff survey and friends and family surveys
Legal 1	Compliance with increased national guidelines and legislation e.g. CQC inspections, Safe staffing requirements, HR employment law, MH Act requirements	Low data quality will mean potential financial and reputational penalties for the organisation and increased scrutiny from CQC with a more burdensome performance focus. Poor data quality may increase risk to staff and patient safety.	CQC mock inspection programme. Safe staffing programme.
Legal 2	Information Governance	Increasing information governance	GDPR preparations/working group

	Description of the issue	What could the consequence be?	What are we doing already?
	increased requirements e.g. GDPR	requirements may result in severe financial penalty for the Trust if evidence of robust data processing, consent and security cannot be given.	
Legal 3	Contract compliance	Data quality is an integral part of the Trusts contract requirements with its commissioners; expectations are of data quality issues being speedily acknowledged and addressed. The Trust requires timely and accurate data to facilitate this, otherwise financial penalties for lack of progress or development (e.g. DQIP's) may result.	Development plans for DQIPs and CQUINs in place
Environmental	Greater scrutiny from public, service users, governors and commissioners	Data needs to be readily available and improvements in quality evidenced over time to satisfy increased expectations - otherwise potential contractual penalties and lack of demand for service provision.	

Appendix 2 – Useful links

NHS Digital Performance Evidence Delivery Framework
http://content.digital.nhs.uk/media/21886/Performance-evidence-delivery-framework/pdf/Performance_evidence_delivery_framework__august_2016.pdf

Next Steps on the 5 Year Forward View
https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

Data Quality Guidance for providers and commissioners NHS Digital
https://www.england.nhs.uk/wp-content/uploads/2016/03/local-commissioning-data-quality-guidance.pdf

HSCIC Data Quality Assurance Strategy
http://content.digital.nhs.uk/media/19015/Data-Quality-Assurance-Strategy-2015-2020/pdf/DQA-strategy-on-a-page.pdf

NHS Digital Data and Information Strategy
https://digital.nhs.uk/data-and-information/strategy

Tees Esk and Wear Valleys NHS Foundation Trust Digital Transformation Strategy
http://flc-intouch:35000/Docs/Documents/Strategies/Digital%20Transformation%20Strategy%202017-2020.pdf

ITEM NO. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**3rd July 2018**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**3rd July 2018**
TITLE:	**Report on the Register of Sealing**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board of Directors of the use of the Trust's Seal in accordance with Standing Orders.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 An entry of every sealing is made and numbered consecutively in a Register specifically provided for the purpose. It is signed by the persons who have approved and authorised the document and those who attested the seal.

3. KEY ISSUES:

3.1 The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
336	6.5.18	TR1 form (transfer of registered title) relating to 181 Coniscliffe Road, Darlington	Colin Martin, Chief Executive Patrick McGahon, Director of Finance and Information
337	13.6.18	Deed of variation of transfer relating to land at James Cook University Hospital, Middlesbrough	Patrick McGahon, Director of Finance and Information David Brown, Acting Chief Operating Officer
338	13.6.18	Deed of covenant relating to transfer of land at James Cook University Hospital, Middlesbrough	Patrick McGahon, Director of Finance and Information David Brown, Acting Chief Operating Officer
339	15.6.18	Lease renewal in relation to Stewart House, 53 Church Street, Hartlepool	Patrick McGahon, Director of Finance and Information Phil Bellas, Trust Secretary

340	15.6.18	TP1 form (transfer of part of registered title) relating to land at Hunden's Lane, Darlington	Patrick McGahon, Director of Finance and Information Phil Bellas, Trust Secretary
341	15.6.18	Facilities management agreement in relation to Roseberry Park	Colin Martin, Chief Executive Patrick McGahon, Director of Finance and Information
342	15.6.18	Support services agreement	Colin Martin, Chief Executive Patrick McGahon, Director of Finance and Information
343	15.6.18	Facility agreement: intra-group	Colin Martin, Chief Executive Patrick McGahon, Director of Finance and Information

4. IMPLICATIONS:

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

4.2 **Financial/Value for Money:** None identified.

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

4.4 **Equality and Diversity:** None identified.

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

7.1 The Board is asked to receive and note this report.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution
Seals Register

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**3rd July 2018**
TITLE:	**Policies Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

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

Executive Summary:

The policy paper contains the following information:

- Four policies and one framework that have undergone full review and required ratification:
  - CORP-0010-v10 Confidentiality and Sharing Information Policy
  - CORP-0043-v8.2 Incident Reporting and Serious Incident Review Policy
  - HR-0012-v7.8 Staff Development Policy
  - EFM Framework 2017-2022
  - CORP-0026-v6 Records Management Policy

- Two policies and one procedure that have undergone minor amendment:
  - CLIN-0012-v7.3 Admission, Transfer and Discharge Policy
  - MHA-0002-v4.1 Death of a Patient Subject to the Mental Health Act 1983
  - IPC-0001-v2.1 Infection Prevention and Control Policy

- One policy that has been downgraded to a procedure:
  - CLIN-0026-007-v1 Records Management and Safe Haven

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meeting held on 13 June 2018

DATE:	**3rd July 2018**
TITLE:	**Policies and Procedures Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

1. INTRODUCTION & PURPOSE:

The purpose of this report is to advise the Board of Directors on the policies and procedures that have been ratified by the Executive Management Team.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 It is important that the Trust policy portfolio is updated and revised in a timely way to ensure best practice, current legislation and regulation is reflected in policy content. Policies no longer required to control and assure practice should be terminated and withdrawn from the portfolio.

2.2 Following the last revision of the Trust's Integrated Governance arrangements, it was agreed that the Executive Management Team ratify all new and revised Trust policies.

2.3 Each policy ratified by the Executive Management Team will have gone through the Trust's consultation process.

2.4 Currently all corporate Trust policies are ratified by the EMT on behalf of the Board of Directors, following approval by the appropriate specialist committees and groups. All decisions regarding the management of the policy framework must be ratified by the EMT.

3. KEY ISSUES:

3.1 The following policies have undergone full review and required ratification:

CORP-0010-v10 Confidentiality and Sharing Information Policy
Review date: 13 June 2021

This policy has been reviewed in line with the General Data Protection Regulation 2016 and Data Protection Act 2018 and describes the lawful basis for processing information.

CORP-0043-v8.2 Incident Reporting and Serious Incident Review Policy
Review date: 18 January 2020

Section 4.6 has been revised regarding reporting of information security incidents and breaches in line with the Data Protection Act 2018 (GDPR).

EFM Framework 2017-2022

The EFM Framework has been fully revised. The framework supports the Trust's mission, vision and strategic goals by assisting in delivering the highest standards of operational services in a quality patient care and staff working environment.

CORP-0026-v6 Records Management Policy
Review date: 13 June 2021

This policy has undergone full revision and updated with new data subject rights under Data Protection Act 2018 (GDPR). Job titles and responsibilities have been reviewed. The policy has been renumbered from CLIN-0013 to reflect that records management is not solely a clinical responsibility.

3.2 The following have undergone minor amendment:

CLIN-0012-v7.3 Admission, Transfer and Discharge Policy
Review date: 02 November 2019

Appendix 4 Transfer guidelines from AMH to MHSOP was previously restricted to Durham and Darlington locality but has now been approved for Trust-wide use.

MHA-0002-v4.1 Death of a Patient Subject to the Mental Health Act 1983
Review date: 13 June 2021

This procedure has undergone full review. Minor amendment reflects that notification is now done via a portal. The procedure is required to be re-ratified for 3 years.

IPC-0001-v2.1 Infection Prevention and Control Policy
Review date: 02 March 2019

This policy has had minor amendment to contact details and insertion of the Multi Resistant Gram negative Bacteria procedure hyperlink to the list of IPC approved documents.

3.3 The following has been downgraded from a policy to a procedure.

CLIN-0026-007-v1 Records Management and Safe Haven
Review date: 06 June 2018

The above has been downgraded from a policy to a procedure as it discusses how to apply safe haven principles in practice. The document number has been revised to show that it sits under the Records Management Policy.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Sound policy development improves patient experience and enhances patient safety and clinical effectiveness.

4.2 Financial/Value for Money:

Any financial implications from the proposals arising from operational and/or practice changes will be managed by the Directorates responsible for policy implementation.

4.3 Legal and Constitutional (including the NHS Constitution):

The Trust requires a contemporary policy portfolio to ensure practice is compliant with legislation, regulation and best practice. The policy ratifications, review extensions and withdrawals will ensure the portfolio is managed to provide the necessary evidence based operational and practice frameworks.

4.4 Equality and Diversity:

The current policy portfolio ensures the Trust meets the required legislative and regulatory frameworks and all policies are impact assessed for any equality and diversity implications. Policy revision and /or specific implementation plans would result from any adverse impact assessments.

4.5 Other implications:

None identified

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meeting on 13 May 2018 have been presented for ratification.

7. RECOMMENDATIONS:

The Board is required to ratify the decisions of the Executive Management Team and is requested to accept this report.

Author: Colin Martin
Title: Chief Executive