AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 24TH APRIL 2018
VENUE: THE OLD SWAN HOTEL, SWAN ROAD, HARROGATE, HG1 2SR
AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meeting of the Board of Directors held on **27th March 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 the key issues in the North Yorkshire Locality.	**Tim Cate to attend**	**Presentation**
Item 7	To receive and note the report of the Freedom to Speak Up Guardian.	**Dewi Williams to attend**	**Attached**
Item 8	To receive and note the quarterly report of the Guardian of Safe Working.	**Dr. Julian Whaley to attend**	**Attached**
Item 9	To consider the monthly "Hard Truths" Nurse Staffing Report.	**EM**	**Attached**
Item 10	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 11	To receive and note a report on the thematic review of whether patients feels safe and staffing issues.	**EM**	**Attached**

Performance (11.30 am)

Item 12	To consider the summary Finance Report as at 31st March 2018.	**PM**	**Attached**

Item 13	To consider the Trust Performance Dashboard as at 31st March 2018.	**SP**	**Attached**
Item 14	To agree the targets for the Performance Dashboard metrics for 2018/19.	**SP**	**Attached**

Governance (11.45 am)

Item 15	To consider a report on the Single Oversight Framework.	**PB**	**Attached**
Item 16	To consider a Board governance arrangements including: (a) The outcome of the Board Performance Evaluation Scheme for 2017/18. (b) Progress against the recommendations of the External Governance Review.	**PB**	**Attached**

Items for Information (12.00 noon)

Item 17	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 18 To note that the next meeting of the Board of Directors will be held on Tuesday **22nd May 2018** in the Board Room, West Park Hospital Darlington at 9.30 am.

Confidential Motion (12.05 pm)

Item 19 **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
18th April 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 27TH MARCH 2018 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 AM

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

In Attendance:
Ms. D. Cannings QPM, Public Governor for Hambleton and Richmondshire
Mr. P. Bellas, Trust Secretary
Mr. P. Scott, Director of Operations for County Durham and Darlington (representing Mr. Brown)
Mr. L. Buckley, Director of Operations for Forensic Services (minute 18/67)
Mrs. S. Paxton, Communications Manager

18/61 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. D. Brown, Acting Chief Operating Officer.

It was noted that Mr. Kilmurray and Mrs. Moody would be arriving late for the meeting due to other commitments.

18/62 MINUTES

***Agreed** – that the minutes of the last meeting held on 27th February 2018 be approved as a correct record and signed by the Chairman.*

18/63 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

Further to minute 18/39 (27/2/18), it was noted that the deaths of two people with learning disabilities in September 2017, in an acute hospital, had not been reported to the LeDer Programme and this had now been rectified by the Trust.

18/64 DECLARATIONS OF INTEREST

The Board noted the non-pecuniary interests of Mr. Bellas and Mr. Kilmurray, as Directors of TEWV Estates and Facilities Management Ltd, in the matters recorded under minute 18/C/98.

18/65 CHAIRMAN'S REPORT

The Chairman:

(1) Highlighted the success of the "Making a Difference" Awards, held on 16th March 2018, which had been attended by most Board Members.
(2) Reported on her participation in serious incident panels.
(3) Advised that a meeting of the Chairs of local Foundation Trusts was due to be held on 5th April 2018 aligned to a visit to the region by Baroness Dido Harding, the Chair of NHS Improvement.

18/66 GOVERNOR ISSUES

No issues were raised.

18/67 LOCALITY BRIEFING – FORENSIC SERVICES

Mr. Buckley (Director of Operations) gave a presentation on the key issues facing Forensic Services.

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

Arising from the presentation, Board Members sought clarity on the following matters:

(1) The actions being taken within the Locality to ensure the significant number of new staff would be able to articulate the positive position of the services, highlighted in the presentation, during the forthcoming CQC inspection.

    In response, it was noted that this was being addressed in three ways:
    (a) Through CQC preparation sessions with groups of staff.
    (b) Through sessions with consultants to consider actions where gaps were found.
    (c) Through managers talking to individual staff.

(2) Whether the new staff were being successfully integrated into their teams.

    Mr. Buckley advised that:
    (a) The position on integration was mixed.
    (b) In addition to new staff, experienced staff were also being moved between wards.
    (c) In response to the challenges, the Heads of Service and Clinical Directors were developing their own narratives and arranging time for discussions with staff about the vision for their services.

(3) The approach being taken to ensure staff in offender health services in the North West, transferred to the Trust under the TUPE regulations, were assimilated into its culture.

It was noted that significant work was being undertaken in this area and it was evident that the staff appreciated the clarity provided on roles, boundaries, escalation routes, etc.

Mr. Buckley also advised that visits to the services by senior managers had been welcomed by staff and invited a Non-Executive Director to participate in one of those planned in the near future.

The Chairman asked for the dates of the scheduled visits to be forwarded to her PA so that this could be arranged.

Action: Mr. Buckley

(4) Whether the occasional lack of compassion for service users by staff, highlighted as a gap in the presentation, could be identified and addressed other than through incidents.

Mr. Buckley advised that the service was responding to this issue by seeking to create environments both individually, through supervision, and as teams, through the ward improvement groups, where staff could be open about the challenges they faced. However, he recognised that further work was required in this area.

(5) Whether staff frustration with training was solely an issue in forensic services or Trustwide.

It was noted that, whilst a Trustwide issue particularly in relation to information governance training, there were specific issues in offender health services due to the lack of integration between the systems used in prisons and in the Trust. In response to this, the service had introduced training days; however, this did not lessen the importance of resolving the issues with e-learning.

(6) The position on ward handovers as this had been raised previously.

It was noted that the issue had been raised in feedback from visits by the Quality Network and the service recognised that the 15 minutes allotted for handovers was insufficient. However, through the model wards programme and daily lean management, the service was focussing on a structured approach to information sharing so that handovers could be made as effective as possible in the context of the Trust's shift patterns.

(7) How the Locality was responding to feedback, raised regularly from patient experience surveys, that patients did not feel safe on the wards.

In response it was noted that:

(a) This issue had been raised regularly in the Locality's reports to the Quality Assurance Committee.

(b) The Locality Management and Governance Board (LMGB) was seeking greater detail from the Quality Assurance Groups (QuAGs) on the actions being taken by them in response to the feedback received.

In addition, the Board welcomed the work being undertaken to address the removal of IMHA, CQC and complaints information from noticeboards; an issue raised regularly during CQC MHA visits.

On behalf of Board Members, the Chairman thanked Mr. Buckley for his presentation and asked him to pass on their appreciation to staff in the services for their hard work.

18/68 REPORT OF THE QUALITY ASSURANCE COMMITTEE

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

(1) The unconfirmed minutes of its meeting held on 1st February 2018 (Appendix 1 to the report).

(2) The key issues considered by the Committee at its informal meeting held on 8th March 2018.

Dr. Griffiths advised that the meeting of the Committee, scheduled for 1st March 2018, had been postponed due to extreme weather conditions. Whilst he had hoped that the formal meeting would be re-arranged, it had not been possible to find a suitable date at which a quorum of members would be present. In the circumstances it had, therefore, been decided to hold an informal meeting of the Committee on 8th March 2018.

It was noted that, as a consequence of this, the Committee had been unable to approve the Clinical Audit Programme for 2018/19 (Annex 2 to the above report) and this matter had been escalated to the Board.

Assurance was provided that the draft Clinical Audit Programme had been reviewed by Members of the Committee, at the informal meeting, and by the Audit Committee at its meeting held on 15th March 2018.

Agreed- *that the Clinical Audit Programme 2018/19 (Annex 2 to the above report) be approved.*

Action: Mrs. Moody

18/69 WORKFORCE STRATEGY

On the recommendation of the Resources Committee, consideration was given to the approval of the Workforce Strategy.

The Non-Executive Directors considered that it would be more appropriate for the reference to the experiences of BAME and disabled staff being worse than those of white staff and non-disabled staff and the acknowledgement of the need for TEWV to be a more diverse and inclusive employer to be included as a "challenge", rather than under "The TEWV Culture", in section 1 of the draft Strategy.

This proposed amendment was taken on board.

Action: Mr. Levy

It was also noted that the reference in the executive summary to the covering report, that "The report proposes a period of wider consultation in early 2018" had been transposed from a previous iteration and should be disregarded.

Overall, Board Members considered that the draft Strategy was well written and could act as a template for other strategies.

Agreed – *that the Workforce Strategy 2018- 2021, as amended, be approved.*

Action: Mr. Levy

18/70 REPORT OF THE MENTAL HEALTH LEGISLATION COMMITTEE

The Board received and noted the report of the Mental Health Legislation Committee including:

(1) The confirmed minutes of its meeting held on 19th October 2017 (Annex 1 to the report).
(2) The key issues considered by the Committee at its meeting held on 26th February 2018.

18/71 ABUSE OF STAFF

Further to minute 18/10 (30/1/18) consideration was given to a progress report on the development of a new approach to taking action in response to abuse towards Trust employees by service users and carers including:

(1) A draft "Statement of Zero Tolerance" (as set out in Appendix 1 to the report).
(2) A draft "Process for responding to abuse of staff by service users" (as set out in Appendix 2 to the report).

It was noted that the proposals to help address the abuse of staff had been developed taking into account the views expressed at a Trust-wide event, including BAME staff, in January 2018.

Board Members made the following points:

(1) The draft "Statement of Zero Tolerance" required further work to reframe it as a statement of intent and to provide clarity on the Trust's approach.
(2) Whilst the proposal to develop a written compact, covering the behavioural expectations of staff, service users and carers, seemed sensible, clarity was required on how this would work in practice, for example, the stage at which it was proposed to provide it to patients.

Mr. Levy advised that it was intended that the compact would be provided routinely at an early stage in a person's care together with other information.

This approach was questioned due to the risks that it might be difficult to engage with a service user at that time; however, it was also recognised that the nature of the compact, based on "gives" and "gets", should be non-confrontational.

(3) Whether there were any other mental health trusts from which the Trust could learn in relation to this issue.

Mr. Levy advised that no learning from other trusts had been identified to date.

Board Members suggested that, whilst recognising the complexity of mental health services, learning could also be sought from other public sector organisations e.g. the Department of Work and Pensions and local authorities.

(4) The need for the documents to provide clarity on responsibility levels, timescales, etc. in relation to the varying types of abuse suffered by staff.

Mr. Levy considered that the suggested approach would fit with positive behavioural support.

(5) The need for the Trust to recognise, given the feedback from the staff survey, that incidents of staff on staff abuse occurred.

(6) Whilst recognising the need to provide protection, whether placing responsibility, for telling the perpetrator about the report of their behaviour, on the line manager, as set out in the draft process, was appropriate in all cases and might lead to staff being disempowered.

Mr. Levy responded that it might be appropriate to provide options for informing the perpetrator about their behaviour and for requiring line management involvement only in specified circumstances e.g. if abusive behaviour was repeated.

(7) Whether the term "zero tolerance" was appropriate as it could be interpreted in different ways and implied that a person could be removed from services.

Board Members considered that a more subtle and compassionate phrase should be found.

(8) The need to be mindful of the experiences of individual staff as those newly qualified were likely to find it difficult to respond to abuse behaviour.

It was considered that this issue highlighted the importance of role models and mentors.

(9) Whether the policy on abuse of staff should form part of a broader policy e.g. on violence and aggression.

Mr. Levy considered that it was important for there to be a standalone policy initially but he believed that it could be incorporated into the positive behavioural support policy over time.

(10) The importance of empowering staff, through the proposed compact, to be able to raise behaviours, such as a lack of compassion for patients, with colleagues.

(11) With regard to potential sanctions:
(a) Whether discharging patients, as the ultimate sanction, was realistic.

It was noted that this would be appropriate in certain circumstances.
(b) That the possibility of discharge might act as an incentive for some patients to engage in abuse behaviour.

(12) The reason for racial abuse not being specifically mentioned in the documents.

Mr. Levy advised that, at the January 2018 event, it had been recognised that, whilst often racially based, abuse could take a range of other forms.

Board Members considered that racial abuse should be specifically mentioned in the documents.

Agreed *– that a further progress report on tackling the abuse of staff, taking into account the comments made during the above discussions, be presented to the Board at its meeting to be held on 19th July 2018.*

Action: Mr. Levy

(Note: Mrs. Moody joined the meeting during the discussions on the above matter).

18/72 "HARD TRUTHS" MONTHLY NURSE STAFFING EXCEPTION REPORT

The Board received and noted the exception report on nurse staffing for February 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 Non-Executive Directors raised the following matters:
(1) Whether, in the absence of links being found between safe staffing and the triangulation of quality data, learning had taken place from acute providers where triangulation of issues had been identified, for example using data from falls and medication incidents.

The Board noted that:
(a) A full analysis of safe staffing and the triangulation of quality data was provided in the six monthly nurse staffing reports.
(b) Issues had been identified from the analysis, for example in relation to medication errors; however, it was often difficult to draw any meaningful conclusions between staffing data and the direct impact on the patient.

(2) How quality issues linked to safe staffing were identified as there were instances, from serious incident (SI) panels, of information not being recorded on the DATIX system.

Mrs. Moody explained that reports to SI panels should highlight root causes or contributory factors including those linked to safe staffing; however, reporting on safe staffing was focussed on inpatient services only and the issues identified often related to community teams.

The Chairman highlighted a recent serious incident in the County Durham and Darlington Locality where problems relating to the provision of enhanced observations, due to capacity issues, had not been reflected in the report.

Mrs. Moody undertook to look into this matter.

Action: Mrs. Moody

(3) The reasons for the high use of agency staff, rather than bank staff, at Acomb Garth.

The Board noted that there was limited access to bank registered nurses in the York and Selby and North Yorkshire Localities which resulted in the need to engage agency staff.

18/73 STAFFING ESTABLISHMENT REVIEW

Further to minute 17/297 (28/11/17) consideration was given to a report which provided an update and further information on the outcome of the Trust's inpatient ward staffing establishment review which had commenced in February 2017.

The discussions focussed on the recommendation that additional investment, at a total recurring cost of £596,920, should be provided for the 20 bedded adult inpatient services.

Board Members raised the following matters:

(1) The rationale for the additional investment as the analysis provided in the report suggested that there were economies of scale from providing inpatient services based on 20 bedded wards.

Mrs. Moody explained that:

(a) 20 bedded wards were more financially efficient but it was difficult to provide care, in terms of quality and safety, in that size of ward compared to, for instance, a 16 bedded ward.

(b) The work on staffing establishments was at an early stage and reflected the traditional skill mix in inpatient services. It was recognised that further work was required on the provision of services taking into account a multi-professional approach.

(c) The proposed investment would enable a more informed view of staffing requirements by providing equity of nurse staffing between wards of different sizes.

(d) The rationale for the additional investment had been scrutinised by the EMT at its awayday in January 2018.

Dr. Khouja advised that guidance provided by the Royal College of Psychiatrists was that wards should not have more than 18 beds.

Board Members expressed their support for the additional investment from the perspectives of both:
(a) Patient safety and experience.
(b) The need for an incremental approach to, and levelling up of, ward establishments to enable the assessment of quality, safety and outcomes in the absence of national guidance.

(2) The funding of the proposed investment.

In relation to this matter Mr. Martin:
(a) Advised that either CRES requirements would need to be increased or the number of beds would need to be reduced; however, he considered that the latter option was not viable given present bed pressures.
(b) Considered that 14 to 16 beds per ward was the optimum as it was recognised that the provision of care in 20 bedded adult acute inpatient units was challenging.

In view of this the Board noted that the number of beds per ward planned for the York inpatient development, at 18, might need to be revisited.
(c) Assured the Board that the EMT, in supporting the proposal, recognised that the additional costs would be enshrined in the budget and would need to be funded.

It was also noted that the additional costs for temporary staffing, being incurred at present, would be expected to reduce as a result of the proposed investment.

(3) The potential impact of funding the investment on other services.

The Non-Executive Directors cautioned that, as the PPCS Programme was the main source of CRES, any additional requirements to fund the investment might create risks in community services.

Mr. Martin advised that the PPCS Programme had been developed in recognition of the variations between community teams and that, as its focus was on providing both safe and productive community services, cash would not be taken from them unless there was assurance that they could continue to operate safely and effectively.

The Chairman also observed that, whilst a separate issue, CRES was getting more difficult to find and the Board needed to think more radically about how the Trust could deliver effective services within the resources available to it.

It was noted that, within those discussions, the Board would need to consider the thresholds, both in terms of quality and safety and resources, under which it was not prepared to provide services.

(4) The approach to evaluating the outcomes provided by the proposed additional investment.

Mrs. Moody:

(a) Undertook to further consider this matter but suggested that a re-evalution of the wards receiving additional investment could be undertaken after six months and reported to the Board.

(b) Advised that the issue could also be reflected in the key performance indicators, covering both quality and safety, being developed under the Right Staffing Programme.

The Chairman considered that it might be beneficial to invite a university to undertake a project on variations in outcomes, and the reasons for them, between different types and sizes of wards, to enable greater understanding of optimum staffing establishments.

Questions were raised about why, given its financial consequences, the proposed investment had not been initially considered by the Resources Committee.

The Chairman advised that the staffing establishment review sought to inform the Trust's policy on the staffing of its wards and, in that context, it was important for the matter to be considered directly by the Board.

Mr. Hawthorn, the Chairman of the Resources Committee, observed that the issue did not fall within the remit of the Committee's usual business, and that he was content to consider the implications of the proposals within the overall budget and financial plan rather than through a separate paper to the Committee.

In addition, Board Members:

(1) Sought clarity on the action being taken to address the two outliers, Minster and Ebor Wards in the York and Selby Locality, identified from the establishment reviews.

It was noted that:

(a) Further to the application of the professional judgement approach, the outlying scores were challenged by senior nursing and operational staff from the Locality as not being reflective of usual patient activity.

(b) The positions on these wards highlighted the need for oversight of future staffing establishment reviews at the Locality level.

(2) Supported the recommendation to provide equitable and standardised administrative support across all inpatient wards.

(3) Highlighted the mismatch between the results returned by the Hurst Tool and the professional judgement reviews in forensic services and the lack of national guidance for these services.

It was noted that a better understanding of the staffing establishments required in forensic services would be provided by a new Hurst Tool, which was being piloted, and through the Model Wards Programme.

(4) Raised the inability of the Hurst Tool to take into account multi-disciplinary working.

Mrs. Moody advised that:

(a) The Trust was ahead of others in its recognition of multidisciplinary working.
(b) It was planned to undertake an analysis of a small sample of wards to provide an understanding of staffing and the skill mix taking into account the type of ward, pathways, interventions, etc.
(c) The findings of this work would be fed into the Right Staffing Programme.

Agreed-

(1) that the contents of the report with regard to staffing establishments and the recommended actions taken to provide additional investment for the 20-bedded adult inpatient services, at a total recurring cost of £596,920, be approved;
(2) that the provision of equitable and standardised administrative support across all inpatient wards, which would increase the availability of ward staff clinical hours, be approved;
(3) that suggested prioritisation of the phased approach to implementation, as set out in the report, be approved; and
(4) that a university 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.

Action: Mrs. Moody

18/74 MULTI-PROFESSIONAL EDUCATION AND TRAINING

Consideration was given to the Self-Assessment Report (SAR) on multi-professional education and training (appended to the covering report) which had received positive feedback from Health Education England.

***Agreed** – that the Self-Assessment Report (SAR) on Multi-professional education and training be endorsed.*

18/75 FINANCE REPORT AS AT 28TH FEBRUARY 2018

The Board received and noted the Finance Report as at 28th February 2018.

In response to questions, Mr. Kendall:

(1) Confirmed that capital expenditure for 2017/18 would be above plan due to additional expenditure, previously anticipated during the 2018/19 financial year, being brought forward.

(2) Advised in relation to CRES that:
   (a) Non-recurrent mitigations were in place to manage the CRES position in 2017/18.
   (b) The focus during 2018/19 would be to seek to close the recurrent shortfall in CRES; however, non-recurrent schemes were also expected to contribute to the delivery of the annual target.

(3) Reported that visibility on the yearend outturn for both capital expenditure and the delivery of CRES would be provided in the finance reports presented to the Board meeting on 24th April 2018.

In addition the Chairman highlighted the importance of reducing the positions on key financial drivers (agency, overtime, bank staffing, etc.) to below 100%.

(Note: Mr. Kilmurray joined the meeting during the discussions on the above matter).

18/76 PERFORMANCE DASHBOARD AS AT 28TH FEBRUARY 2018

The Board received and noted the Performance Dashboard Report as at 28th February 2018.

18/77 INFORMATION GOVERNANCE TOOLKIT SUBMISSION 2017/18

Consideration was given to the Information Governance (IG) Toolkit submission for 2017/18.

In response to questions it was noted that:

(1) Progress towards the achievement of the target on IG training had only been made recently due to the system not being available between April and August 2017 and the training course being more complex and longer than previously.

Mr. Martin reported that he had undertaken to write to NHS Digital to advise that, in the circumstances, the achievement of the 95% target by 31/3/18 was unreasonable; however, the present compliance rate was 91%, which was of credit to staff, and it was expected that the target would be achieved in the near future.

(2) The reduction in the score on clinical information assurance, from 93% in 2016/17 to 86% (predicted) for 2017/18, was principally related to clinical record keeping.

Mr. Kendall advised that the issue had been discussed by the Audit Committee and there was confidence that the position would improve in 2018/19 with the introduction of the revised CPA audit tool.

(3) With regard to the General Data Protection Regulation (GDPR):
- (a) Leaflets to explain an individual's rights would be provided but it was also recognised that cultural change was required to support discussions between clinicians and patients in relation to this matter.
- (b) The proposed approach to compliance, at an organisational level, was set out in section 3.3. of the report, including for the Board to be able to provide evidence that it had discussed risks and issues relating to compliance with the regulatory requirements.

The Board also discussed the arrangements for the provision of assurance on the delivery of the forward plan for improving compliance with the IG toolkit sequences in 2018/19.

Mr. Kendall explained that the plan would be managed by the Digital Safety Board with issues escalated to the EMT by exception.

Board Members considered that, at Board level, the issue fell within the remit of the Quality Assurance Committee but that the Audit Committee also had a role in providing assurance on the robustness of systems and processes.

Agreed – *that the Information Governance Toolkit submission 2017/18, as predicted for 31st March 2018, be approved.*

Action: Mrs. Moody

18/78 USE OF THE TRUST SEAL

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

18/79 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.

18/80 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 24th April 2018 in The Old Swan Hotel, Harrogate.

18/81 MR. DREW KENDALL

This being his last Board meeting, the Chairman, on behalf of the Board, thanked Mr. Kendall for his tremendous work and contributions to the Trust in his capacity as the Interim Director of Finance and Information.

18/82 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).

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.

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

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

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

Following the transaction of the confidential business the meeting concluded at 4.00 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Forensic Service

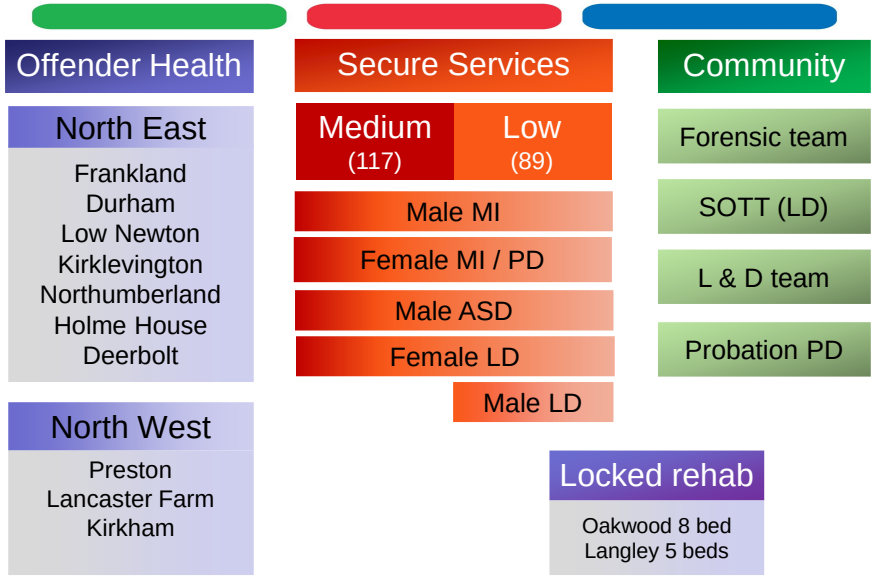
Trust Board Presentation

The Turn of the SCREW

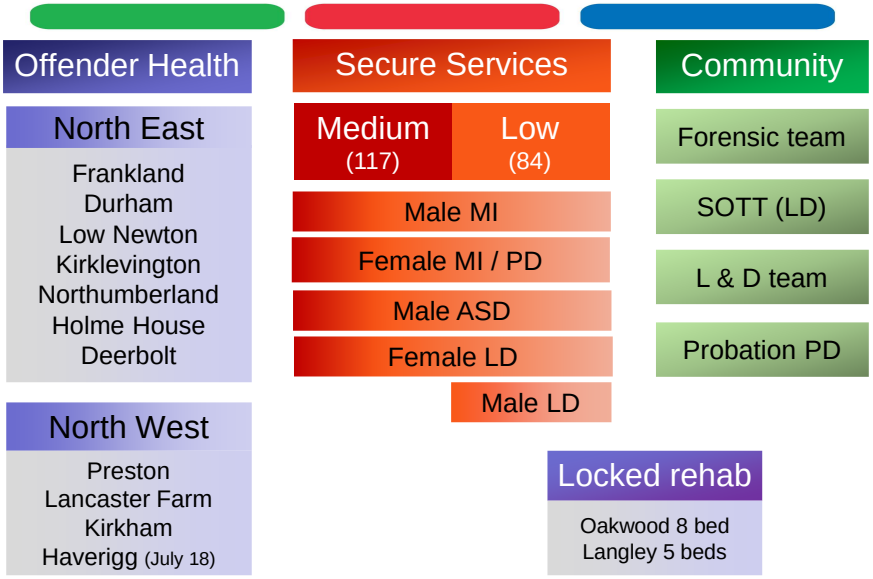
27 March 2018

Levi Buckley
Director of Operations

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust



Tees, Esk and Wear Valleys NHS
NHS Foundation Trust



Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

The Turn of the SCREW

- Safe?
- Caring?
- Responsive?
- Effective?
- Well-led?

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

The Turn of the SCREW

	May 2015 rating
➢ Safe?	Good
➢ Caring?	Outstanding
➢ Responsive?	Good
➢ Effective?	Good
➢ Well-led?	Good

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Safe: you are protected from abuse and avoidable harm.

- Care was provided in a **clean and hygienic environment**.
- Where environmental risks such as ligature risks and blind spots were identified, **they were plans in place to mitigate the risks they could potentially pose**.
- Staffing levels were sufficient to meet the needs of patients, however, **there was some high use of bank staff.**
- Staff had **a good understanding of safeguarding** and the reporting mechanisms.
- There were robust systems in place to ensure that incidents were reported and that **learning from incidents was embedded in the clinical governance systems within the forensic services.**

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Evidence

- Proactive Safeguarding referrals
- Environmental Surveys 100% and positive PLACE scores
- Reductions in restrictive practice (recognised nationally by CQC)
- 100% compliance Emergency Equipment audits
- Mandatory training compliance 91.8% inc. 96% Harm Min, >90% for BLS
- Low vacancies in core establishments and no shifts without registered nurse on duty (IP)
- Cancelled leave (due to staff pressures) 3% or lower
- Continued roll-out of PBS formulations (44 patients) and SafeWard champions on each ward
- Matrons review Datix reports for QuAGs – all level 3 Sis reviewed at QuAG
- Trauma Informed Care in prisons. Service Trauma Lead appointed.

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Gaps

- Level 3 Safeguarding (children) at 83%
- Some wards still have high bank use for additional shifts
- Case-mix on wards (esp. FLD and acute admissions) affects how safe people feel
- Mixed results on Patient Experience scores
- Restraint use has reduced, but still some high usage in female services
- Some concern regarding staff interpretation of blanket restrictions

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NHS Foundation Trust

Gaps

- Nurse recruitment improved, but concern of number of newly qualified and experienced staff
- Recruitment to SALT challenging
- Continued delays in placing people in the community
- Ward handovers 'challenging' timescales
- Staff frustration with training systems – access to ESR, learning, recording of completed training and support for OH teams

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NHS Foundation Trust

Caring: staff involve and treat you with compassion, kindness, dignity and respect.

- **Patients told us that they were treated with dignity, respect and kindness.**
- **We observed high quality care and interaction between staff and patients.**
- Patients were involved in their care and in the way that services were run **including having representation in clinical governance meetings.**
- We saw some excellent examples of patient involvement including patients being involved in 'away days' with staff teams on some **wards and services constantly looking to improve engagement and involvement**.
- People told us that they **knew and understood the services which they were receiving.**

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Evidence

- Positive feedback from carers
- Few complaints (is this a good thing?!)
- Duty of Candour letters shared with patients/carers
- Regular Community Meetings on wards – standard agenda introduced. Prison Patient Forums.
- IP Ward Improvement Groups established and effective.
- Patients attending QuAGs – review through QuAG Kaizen
- ForUS and Our Views Our News service user groups (FLD/FMH)
- Increased Recovery College courses – including patients delivering courses and patient led Recovery Awards
- Patients chairing some CPA meetings and CTR reviews

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Gaps

- External representatives attending CPA meetings
- Varied cultural issues across teams – some examples of a lack of compassion for service users
- Patient's views vary considerably within one unit and with individual member of staff
- Variation in patient's reporting that they have been given a copy of their care plan
- Patients express concern that transforming Care means they are ‘numbers’ not ‘people’
- Staffing pressures, especially additional duties, can mean some activities and leaves are cancelled

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NHS Foundation Trust

Responsive: services are organised so that they meet your needs

- There were clear admission and discharge pathways. However, there were **some delays to discharges when services were not present** in the communities patients were moving back to.
- **The ward environments met people's needs.** There was space for activities and meetings on the wards and all wards had access available to outside areas.
- **There was an activity centre, gym and medical centre on site.**
- The service was responsive to individual needs. There was access to chaplaincy services and spiritual support. **Each division had an equality and diversity lead.**
- **Patients were aware of how to make complaints and staff knew how to manage complaints.**

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Evidence

- Further work on revised pathways inc. embedding recovery
- Joint work with NTW to implement single referral & bed management system –to make best use of resources
- Positive feedback from Quality Network and Independent Monitoring Board re: Jay Prison Transfer Ward and HMP Durham ISU.
- Learning Lessons Bulletins at service and Trust level
- Significant work on 'Take Control' and 'Lean' – healthy eating and exercise programmes
- Maintained smoke free service
- CQUIN – LoS – targets met and positive impact on pathways
- Complex Case panels established – IP and Prison – to support decision making

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Gaps

- Impact of RPH rectification – patient complaints regarding noise and the defects still affecting patients e.g. temperature, drain smells, keys/locks
- Changes in staff – less experienced staff in some roles and movement means organisational knowledge reduced.
- IMHA, CQC and complaints posters regularly removed from noticeboards
- Regular replacement furniture ordered – is an EFM site review required??
- Regional bed capacity and flow – 13 regional prison referrals on the waiting list.

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***Effective*: care, treatment & support achieves good outcomes, helps maintain quality of life, based on best available evidence.**

- Care plans incorporated **appropriate evidence bases.** They were **holistic incorporating medical, nursing, therapeutic, social and physical healthcare needs.**
- **Patients had access to a wide range of psychological therapies, individually and in groups**.
- **Health centre including a GP practice, dentist and a podiatrist as well as meeting other physical healthcare needs.**
- Staff supported with **mandatory** & **specialist training** appropriate to their roles.

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NHS Foundation Trust

***Effective*: care, treatment & support achieves good outcomes, helps maintain quality of life, based on best available evidence.**

- **Most staff had regular supervision and appraisals although there were inconsistent approaches to team meetings.**
- Most staff **had a good understanding of responsibilities under the Mental Health Act and Mental Capacity Act although this training was not mandatory in the trust.**

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Evidence

- MHA visits show care plans and intervention plans comprehensive.
- Clinical supervision meeting targets Q3 and Q4 (93%)
- Appraisal at 97%
- Dedicated physical health service and meeting targets for health checks. Prison Physical health pathway in place.
- Clinical audit programme on track
- Implementing triangle of care and positive assessment against standards.
- Positive feedback from NHSE Quality Visits and RCP Quality Network inspection
- Prison Integrated Management Panel – (get people to right place at right time)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Gaps

- Care plans not consistently written in 'patient voice'
- Further work on quality of supervision required (nursing)
- Early Warning Scores not consistently followed up – Inc. Quality of physical observations
- Some 'hot spots' on medicines management audits
- Generally high compliance with MHA documentation but occasions when paperwork not easily located.
- Gaps in record keeping to assure IMHA referrals and capacity reviews.
- Trust plan for future MHA training and delivery unclear
- AMHP attendance at meetings and S Work provision (M/boro LA)

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***Well-led*: leadership, management and governance provide high-quality care for individual needs, encourages learning and innovation, promoting an open and fair culture.**

- **Staff were enthusiastic about the trust and their management.**
- Staff working in the wards felt engaged by the organisation and were **proud to work for the service.**
- There were systems in place to ensure that **information was available to the service management** and to the trust management teams.
- Where issues had been identified they had been picked up in **action plans with identifiable targets and responsible individuals.**
- **Staff were given the opportunity to develop within the trust and were aware of how to raise concerns.**

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NHS Foundation Trust

Evidence

- Service hosts regular visits from NHSE – regionally and nationally– with positive feedback (IP and OH)
- RCP Quality Network peer review (IP) – 97% standards met (Medium Secure average 88%)
- High performance in draft Prison Quality Network.
- Women's FLD service (Thistle, Ivy, Clover) RCP Team of the Year award.
- Thematic reviews at SDG (e.g. Security, Physical and therapeutic interventions, Restrictive practices, Medicines management)
- Model Ward programme - Daily lean management, Ward daily coordination, 5S - 14 audits/checks removed or reassigned
- Ward/team huddles, weekly directorate and service report-outs Inc. Escalation processes
- Good R&D activity – esp., in prison health.

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Evidence

- Use of IIC to track/monitor performance
- Generally strong leadership at ward and team level
- Talent Management Conversations up to date for senior team.
- Some long serving staff in senior leadership team – positive impact on stakeholder relationship management and external networks
- High level of QIS training uptake:
  - 9 certified leaders
  - QIS for Leaders –– 16 completed –8 in training - 20 due to start April.
  - 105 staff and 13 patients involved in Kaizen events / RPIWs (2017)
- Good visibility of senior managers in wards/teams and prisons.
- 2 Master coaches and further staff completing training
- Resilience training for staff – prisons and roll-out to wards.

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NHS Foundation Trust

Gaps

- Changes in senior team – new SCD, DMD and FLD CD. People developing into roles and future succession planning.
- Changes in FLD medical allocation – further work required.
- Impact of Transforming Care on the morale and development of FLD services.
- Impact of RPH Rectification – requires significant operational input – impact on operational and strategic development of services.
- Releasing capacity at all levels will be key to success of NCM and concerns regarding senior team availability to support developments.
- Prisons – IM&T – access to IIC, ESR, learning poor and variable.

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The Turn of the SCREW

- **Safe?**
- **Caring?**
- **Responsive?**
- **Effective?**
- **Well-led?**

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NHS Foundation Trust

The Turn of the SCREW

	2018 rating ?
➢ Safe?	Good
➢ Caring?	Outstanding
➢ Responsive?	Good
➢ Effective?	Good
➢ Well-led?	Outstanding

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Finally….

- RPH rectification and impact for the service is significant. From an operational perspective i.e. programme of decant, disruption to services and the safe management of services.
- Strategically, there is a risk that opportunities from the Adult Secure NCM cannot be realised due to the timing of the rectification programme. We are aware NTW are requesting capital for secure build that could affect our business plans.
- The MHSR and the continued scrutiny of Transforming Care plans also affects our ability to flexibly utilise existing, and future, beds in the most clinically and cost effective manner.

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24th April 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
28/03/2017	17/62	The potential for expanding the proposed managers' tool, for recording concerns raised to the Freedom to Speak Up Guardian to cover all concerns raised by staff, to be explored	DL	~~Apr-18~~ May-18	
26/09/2017	17/228	Consideration to be given to reviewing the targets in the Strategic Direction Performance Report for 2018/19	SP	~~May-18~~ Jul-18	
26/09/2017	17/230	Reviews of the operational arrangements of the Quality Assurance, Resources and MHL Committees to be undertaken	PB	~~Apr-18~~ May-18	
31/10/2017	17/268	An update report on the Temporary Staffing Service to be presented to the Board	DL	May-18	
28/11/2017	17/295	A paper to be provided to Board Members describing the controls covering commercial studies	Prof. JR	May-18	
28/11/2017	17/299	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	~~Apr-18~~ May-18	
28/11/2017	17/300	A report to be presented to the Board to provide an update on progress towards the completion of the 2017/18 composite staff action plan and to enable consideration of a proposed 2018/19 action plan	DL	May-18	

	Minute No.	Action	Owner(s)	Timescale	Status
28/11/2017	17/301	A further progress report on the implementation of the Recruitment and Retention Action Plan to be presented to the Board	DL	~~May-18~~ July18	
28/11/2017	17/305	A briefing to be provided to the Board on the event in 2018 in relation to sickness absence and whether further action can be taken to support the health and wellbeing of staff	DL	~~Apr-18~~ Jul-18	
28/11/2017	17/307	A report to be presented to the Board on the outcome of the thematic review of whether patients feel safe and staffing issues being undertaken by the patient safety team	EM	Apr-18	See agenda item 11
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	
30/01/2018	18/08	A report to be presented to the Board on the use of enhanced observations (including trends) together with information on contemporary best practice in this area.	EM	Jul-18	
30/01/2018	18/08	A report on the use of prone restraint to be provided to the Quality Assurance Committee	EM	~~Apr-18~~ May-18	
30/01/2018	18/10	The limitations of the national approach, through the EDS2, to be raised with the Equality and Diversity Council, possibly in conjunction with other Trusts	DL	May-18	
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	~~May-18~~ Jul-18	
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	May-18	

	Minute No.	Action	Owner(s)	Timescale	Status
27/03/2018	18/67	The dates of proposed visits to offender health services in the North West to be provided to the Chairman's PA to enable invitations to attend them to be circulated to the Non-Executive Directors	LJB	-	Completed
27/03/2018	18/68	Approval of the Clinical Audit Programme 2018/19	EM	-	To note
27/03/2018	18/69	Approval of the Workforce Strategy 2018-2021 (as amended)	DL	-	To note
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	18/72	The reasons for a recent serious incident in the County Durham and Darlington Locality, where an issue had arisen with enhanced observations due to capacity issues, not being reflected in the monthly nurse staffing report to be looked into	EM	May-18	
27/03/2018	18/73	Arising from the Establishment Review report, approval of - - the contents of the report with regard to staffing establishments and the recommended actions taken to provide additional investment for the 20-bedded adult in-patient services, at a total recurring cost of £596,922 - the provision of equitable and standardised administrative support across all inpatient wards - the suggested prioritisation of the phased approach to implementation as set out in the report	EM	-	To note
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	
27/03/2018	18/74	Endorsement of the Self-Assessment Report (SAR) on Multi-professional education and training	EM	-	To note
27/03/2018	18/77	Approval of the Information Governance Toolkit submission 2017/18	EM	-	To note

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

North Yorkshire Locality Board Presentation

24th April 2018

Tim Cate

Acting Director of Operations

making a difference together

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

- Proud
  - CQC Feedback
  - Awards
  - Service developments
    - T3 CAMHS eating disorders
    - Single Point of Access in CAMHS
  - IAPT performance improvement
  - Staff resilience
  - Clinical & service Leadership
- Progressing
  - All age crisis triage & response
  - Clinical Leadership
  - Capital development decisions
  - Transforming mental health (Hambleton/Richmondshire and Harrogate)
  - Accountable Care Partnership

To continuously improve the quality and value of our work.

- QIS
  - PPCS
    - Daily lean Management / Huddles / Report outs
- Transforming Care Partnership
- Performance
  - Delayed Transfers of Care (DTOCs)
  - Electronic Discharges
  - MHSOP Waiting times

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

- Recruitment Issues
  - Qualified nursing staff
  - Medical staff in certain geographic areas
  - Agency staffing
  - Working arrangements with NYCC
- Retention Issues
  - Retirements
  - Career progressions
- Skill, compassion and motivation issues
  - Compassion in practice
  - Nurse development programme
  - Inpatient development days

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

- Local
  - Harrogate Alliance
  - MHCCC
  - Links with NYCC
- National
  - IAPT
- International
  - No formal links internationally

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

- Performance
  - CAMHS waiting times / CAMHS Eating Disorders
  - Access performance
  - Financial balance – locum and agency costs
  - Improved position with DTOC
  - Out of Area admissions reducing
  - Geographical challenges linked to workforce
- LMGB
  - Structured oversight & quality assurance
  - QUAGs – managing a broad range of issues
  - Good sense of team
- Culture work

ITEM NO. 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24th APRIL 2018**
TITLE:	**FREEDOM TO SPEAK UP GUARDIAN REPORT**
REPORT OF:	**DEWI WILLIAMS, FREEDOM TO SPEAK UP GUARDIAN**
REPORT FOR	**Information**

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

Executive Summary:

This report is for information and outlines the developments within the Freedom to Speak Up Guardian role over the last 6 months.
It discusses local, regional, and national support systems, local developments, and includes an anonymised case example.

Recommendations:

To note the contents of the report and to comment accordingly

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**24th APRIL 2018**
TITLE:	**FREEDOM TO SPEAK UP GUARDIAN REPORT**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board about the last 6 months of the Freedom to Speak Up Guardian's role. The report will outline actions and activity to date and discuss how we intend to further develop the role in the coming year.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 I have been in Post since October 2016. Initially it was a one day a week post, but in April 2017 this increased to 18 ½ hours to support a more proactive roll out which included the training commitment.

2.2 To date there have been 31 referrals of which 9 remain open. As noted in the previous board report, some cases relate to multiples of staff. In the last 6 months we have dealt with 9 new referrals, 4 of which remain open. However we have had 6 referrals anonymously but which have subsequently been withdrawn or are pending as the complainants felt their anonymity would be hard to guarantee, usually because of the size of the team.

3. KEY ISSUES:

3.1 **Training.** The mandatory ½ managers training for band 7 and above staff has, after a slow start now trained 127 staff. As we are still less than ½ way through all staff we have continued to provide twice monthly sessions for the coming year. We continue to offer sessions throughout the trust as well as bespoke sessions for services that have struggled to attend.

3.2 **Support networks.** The role of FTSUG could be quite isolated. We have developed the role of a FTSUF deputy (Barry Speak) to ensure support and continuity should the Guardian be away from work.
I continue to attend the quarterly meetings of the regional support network. Our rolling chair ensures we are up to date with the national developments. Our National team continue to publish weekly Bulletins, offer occasional Webinars on practice development, and offer one-to one contact and support. They also host twice yearly conferences to share good practice.

We continue to do well against the 10 key findings and recommendations identified in the 2017 national Guardians survey of Guardians. However we still have not developed a network of champions/ambassadors. Our hope is to ensure that we have representative for each locality as well as representatives with a range of protected characteristics. Given the challenges of developing a network

of volunteers it was decided to try and develop in tandem with another initiative for staff with a complimentary skill set. The proposed new anti-bullying policy outlines a new approach and role where appropriately trained staff will meet with staff accused of bullying, to ascertain the facts, and to see if there can be a rapid resolution. It is hoped that we can combine these functions.

In March we held a 2 day service improvement workshop to investigate opportunities to share intelligence internally to develop a more proactive response to teams requiring improvement/support. It was attended by a wide range of staff who provide support to staff including myself, staff support services, staff psychology service, chaplaincy, organisational development, ethnicity and diversity, HR, and I.T reporting staff. It became clear that we often individually have concerns but are not necessarily aware that other services are already involved. We were also anxious that we should not need to wait for staff members to feel so marginalised before we find ways to offer proactive help, support, and guidance. Whilst still in development, we agreed that we need to develop a forum of the above staff who meet monthly to share intelligence and work together to provide supportive interventions into teams.

3.3 **Data Management.** The collection and analysis of information is central to ensuring that we manage and respond to all raised concerns equitably, and learn from our experience. Our managers reporting tool is now functional but still occasionally fails. The potential for lost referrals is of concern. Again I have been assured that the latest fix will have sorted the problem. The national office collects data from us quarterly. Results can be viewed on their website.

3.4 **Feedback.** At the end of involvement we ask those who raised concerns if they would raise a concern again in the future. Most have said they would but not because it was without some detriment. As mentioned in my previous report, many complainants believe raising a concern has been at some cost to them. Even when the investigations prove in their favour some have felt the feeling of loss of trust has left them feeling less valued to the point of deciding to leave.

Learning sharable lessons from all staff involved in the concern, investigation, and action plan will be my next priority. One issue I had not considered was the potential detrimental impact on the staff member who is accused of bullying, particularly if it is subsequently not upheld.

3.5 **Case Example.** A very experienced practitioner was in redeployment, and sent to a relatively small team delivering a speciality they were unfamiliar with. They were shocked to find most team members were most unwelcoming, not offering induction, not helping with requests for support, or advice and seamed to go out of their way to make them feel ‘in the way’ and ‘just not up to the job. When the confronted the management they were left feeling like it was their shortcoming, and they

just needed to buck up! On first contact they expressed how this had eroded their self-belief and to question their skills. However, eventually they were offered an alternative placement where they again feel like a competent and valued team member. Following several meetings they have reluctantly chosen to withdraw their concern because they remain in the redeployment process and they fear 'consequences,' they feared being identified because of the size of the team, and they are now out of that environment. However they remain saddened that they were not helping to protect future staff from this environment.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** To date I have only received one anonymous concern from the CQC. Thankfully it related to a service area that we had already received concerns, and had commissioned an investigation. The investigation has now concluded and the action plan has started. The service managers have undertaken to ensure that the CQC receive regular updates.

4.2 **Financial/Value for Money:**

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

4.4 **Equality and Diversity:**

4.4 **Other implications:**

5. RISKS:

6. CONCLUSIONS:

7. RECOMMENDATIONS:

To note the contents of the report and to comment accordingly

Author, Dewi Williams
Title Freedom to Speak Up Guardian

Background Papers:

ITEM NO. 8

CONFIDENTIAL

Trust Board of Directors

DATE:	**April 2018**
TITLE:	**Guardian of safe Working Annual Report**
REPORT OF:	**Julian Whaley, Guardian of Safe Working**
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:

This paper outlines the ongoing work of the 'Guardian of Safe Working' as part of the 2016 Terms and Conditions for Junior Doctors and identifies issues that have arisen for the Trust.
It is the responsibility of the Guardian of Safe Working to provide an Annual report to the Trust Board for assurance that Junior Doctors are safely rostered and working hours that are safe and in compliance with Terms and Conditions of Service.
The 2016 Junior Doctor Contract was implemented for psychiatry trainees starting new contracts in February 2017 and over time more of our trainee workforce are on this contract. Mandated monitoring processes have not identified any breaches to terms and conditions of service requiring the levy of a fine. Lower level concerns are being appropriately addressed and where necessary, changes implemented.

Recommendations:

The Board are asked to read and note this report from the Guardian of Safe Working.

MEETING OF:	**Trust Board**
DATE:	**April 2018**
TITLE:	**Annual report by Guardian of Safe Working for Junior Doctors**

1. INTRODUCTION & PURPOSE:

This paper reviews the background and context around the introduction of the Guardian of Safe Working as part of the 2016 terms and Conditions for Junior Doctors and implementation of that role in the Trust.
The Board will receive an Annual report from the Guardian which will include summation of quarterly reports including data on exception reports, details of fines levied against departments with safety issues, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting good practice and/or persistent concern. (Appendices 1&2 provide quarterly data plus annual narrative of schedule changes). This will provide assurance to the Board and if needed (not on this occasion) ask for approval for action to rectify a safety concern.

2. BACKGROUND INFORMATION AND CONTEXT:

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours and during negotiation, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS doctors in training to oversee the process of ensuring doctors are properly paid for all their work and ensure they are not working unsafe hours. It is a requirement that all doctors on the contract have an individualised schedule of work for each placement, variation from which requires them to place an exception report, based on hours of work and/or educational experience.
The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The guardian is required to levy a fine against a department(s) if a doctor works on average over 48 hours/week, works over 72 hours in 7 days or misses more than 25% of required rest breaks.
The work of the guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by Health Education England.

Regular Commitments of the Guardian to support this agenda includes:

1. Quartely Junior Doctor Forums and 7 Locality Junior Doctor Forums.
2. Attendance at Trust Medical Education meetings and Local Negotiating Committee
3. Membership & engagement of regional (2) and national forums.
4. Junior Doctor induction sessions
5. Process for 1:1 meeting offer with Junior Doctors.
6. Regular sessions on Junior Doctor Teaching Programmes (added following feedback included as appendix 3)

3. KEY ISSUES:

I am satisfied that all exception reports submitted by doctors on the new contract have been actioned within specified timeframes. High levels of exception reports relate to the high degree of variation in out of hours non-resident on call rota work. I am satisfied that all doctors are being paid for the work they are undertaking. However, if the baseline rate of pay for antisocial hours working is low, this has a detrimental effect on pay for certain classes of doctor (part-time, maternity leave). A Champion of Flexible Working is now in post in support of this group of doctors. There has been no justification to levy a fine on any department within the organisation.

The situation in Harrogate was raised in last year's report. A schedule revision and comprehensive action plan following doctors' concerns has had a significant positive impact and reduction in the number of exception reports.

In Scarborough there has been a significant increase in the number of exception reports, which can be explained by a number of factors; more doctors are on the new contract, the culture of exception reporting has improved and good bed management has meant more out of hours admissions to Cross Lane Hospital. A schedule review has been triggered and the opportunity taken to trial a monitoring process to simplify exception reporting for non-resident on-call work.

In York there have been difficulties with vacancies and by negotiation the 'twilight shift' withdrawn and additional locum useage sought. I will monitor to ensure there is not a significant impact on emergency experience, lauded as a positive of the York placements. An additional concern is the use of internal locums working as non-resident in what is ordinarily a resident shift.

I will continue to be part of discussions surrounding the future of Northallerton trainees as part of service reconfiguration.

In Teesside there have been a number of meetings to consider rota redesign bearing in mind vacant posts, Roseberry Park remedial works and financial constraints. A proposed schedule change was stopped due to a lack of shared understanding of impact on daytime training / hours limits.

In County Durham, the impact of seclusion in Darlington will continue to be monitored. Vacant Foundation Doctor posts have adversely impacted on other jobs in Darlington.

Through the support of Medical Development, a Guardian of Safe Working In Touch page is being developed in response to feedback in appendix 3.

Over the past 6 months, there have been a number of concerns raised for the quality of information provided by the Trust switchboard. More recent feedback suggests these issues are now resolved.

On a general note, I believe it is vital that we continue to ensure there is a culture that supports junior doctors to exception report as the fear of reprisal from senior staff, however unfounded, cannot be underestimated. Alongside this, it is in all our interests to ensure calls out of hours are appropriate and coordinated. South Tees Hospitals have embedded a 'Hospital at Night' software package which we have been offered without cost. I would strongly recommend this offer be accepted as the initial IT hardware costs would be offset by greater coordination of work and reduction in inappropriate calls on time.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The work of the guardian will help to inform CQC in the areas of Safety,GoodGovernance, Staffing and Duty of Candour. This report evidences maintenance of these standards.

4.2 Financial/Value for Money:

The new contract is underpinned by the principle that junior doctors are paid for the work they do. Implementation of the contract has cost the organisation a significant amount of money. It is necessary that the Board is aware of the cost considerations of rota designs and the need to ensure appropriate workloads for junior doctors within a model that makes effective use of the whole workforce.

4.3 Legal and Constitutional (including the NHS Constitution):

The Learning and Development Agreement signed by the Trust with Health Education England clearly sets out the expectations on placement providers. The organisation must ensure that the work schedules in the new contract allow junior doctors to fulfil their curriculum needs within a sound learning environment.

4.4 Equality and Diversity:

The revised 2016 terms and conditions included the responsibility of the guardian to oversee issues relating to Equality & Diversity. The Head of Equality and Diversity has therefore been co-opted to the quarterly trustwide Junior Doctor Forum and this is a standing agenda item. A Champion of Flexible Working is also in post.

4.5 Other implications:

GMC surveys have placed our organisation as one of the best training providers for junior doctors in the country. Historically our training schemes have achieved outstanding results in Royal College of Psychiatrists membership examinations. It is important that our junior doctor colleagues continue to believe that we are supporting them in providing an appropriate and safe learning environment.

Recruitment into Psychiatry remains a key concern nationally.

The Trust may be viewed as an outlier in the number of payments made for exception reporting as the preferred response is time off in lieu.

5. RISKS:

Failure to provide systemic solutions in ensuring Junior Doctor duties are not quantitatively or qualitatively onerous will lead to significant cost and reputational risk, impacting on all areas highlighted in section 4. I am satisfied that the systemic processes outlined within this report provide assurance of interventions to mitigate potential risks highlighted.

6. CONCLUSIONS:

The organisation continues to comply with the 2016 Junior Doctor Contract and junior doctors are appropriately submitting exception reports which are being handled appropriately. There are no immediate safety concerns.

Non-resident rotas with high levels of antisocial hours activity have been identified and appropriate systems and processes are in place to revise schedules to best meet the needs of junior doctors and the Trust as a whole.

The organisation continues to work systemically on issues arising from vacancies.

7. RECOMMENDATIONS:

The Board are asked to read and scrutinise this report.

I would welcome support for implementing the ‘Hospital at Night’ package.

Author, Julian Whaley
Title: Guardian of Safe Working

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data

Number of doctors / dentists in training (total):	76
Number of doctors / dentists in training on 2016 TCS (total):	59
Number of clinical supervisors	70
Amount of time available in job plan for guardian to do the role:	2 PA
Admin support provided to the guardian (if any):	4 days per quarter
Amount of job-planned time for educational supervisors: trainee	0.125 PA per

Exception reports (with regard to working hours) from 1st January 2018 up to 31st March 2018

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	0	0	0
F1 –North Durham	N/A	N/A	N/A	N/A
F1 – South Durham	0	0	0	0
F2 - Teesside & Forensic Services Juniors	0	4	4	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	7	7	0
CT1-2 Teesside & Forensic Services Juniors	0	0	0	0
CT1-2 –North Durham	0	6	6	0
CT1-2 – South Durham	0	19	19	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	3	3	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	1	1	0
ST4-6 –North & South Durham Seniors	0	1	1	0
Total	**0**	**41**	**41**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	4	4	0
Teesside & Forensic Senior Registrars	0	3	3	0
North Durham Juniors	0	6	6	0
South Durham Juniors	0	27	27	0
North & South Durham Senior Registrars	0	3	3	3
Total	**0**	**43**	**43**	**3**

Hours monitoring exercises (for doctors on 2002 TCS only)					
Locality	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**
Teesside & Forensic Juniors	Not undertaken within this timeframe.				
Teesside & Forensic Senior Registrars	Not undertaken within this timeframe.				
Teesside CAMHS	Not undertaken within this timeframe.				
Durham & Darlington CAMHS	Not undertaken within this timeframe.				
South Durham Juniors	Not undertaken within this timeframe.				
South Durham Senior Registrars	Not applicable as all Senior Registrars are on the new contract				
North Durham Juniors	Not undertaken within this timeframe.				
North Durham Senior Registrars	Not applicable as all Senior Registrars are on the new contract				

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
Teesside & Forensic Services	CT3	Old	Yes	32	32	0	32	1 GP & 1 F2 until 06/02/18 – no vacancies from 07/02/18
	CT2	New	Yes					
	Trust Doctor	New	No					
	CT2	New	No					
	CT3	Old	Yes					
	CT2	New	Unknown					
	MTI	New	Unknown					
	GP	N/A	Unknown					
	CT3	Old	Yes					

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
North Durham	Specialty Doctor	SAS Doctor	No	5	5	0	5	None
	Trust Doctor	New	Unknown					
	CT2	Old	No					
	CT3	Old	No					
South Durham	CT3	Old	Yes	20	20	0	20	None
	Specialty Doctor	SAS Doctor	No					
	CT3	Old	Yes					
	Specialty Doctor	SAS Doctor	No					
	CT1	New	No					
	F2	New	Unknown					
Total				**57**	**57**	**0**	**57**	**0**

Narrative around Exception Reporting

Durham & Darlington

There were 36 exception reports raised during that period for the Durham & Darlington locality. This includes data from 4 rotas – South Durham junior doctors, North Durham junior doctors, South Durham senior registrars and North Durham senior registrars. There were 3 exception reports raised from the North Durham Senior Registrars over the reported period. The majority of the exception reports were in relation to additional plain and enhanced time worked whilst on-call and 1 exception was logged as educational exception report.

Teesside

There were 7 exception reports raised during that period for the Teesside locality. This included data from 3 rotas – Teesside junior doctors, Teesside senior registrars and Teesside CAMHS senior registrars. There were 4 exception reports raised from the Teesside junior doctor rota and these were for enhanced hours when on non-resident rota (as no time is included in the schedule). The 3 exception reports that were raised from the Teesside CAMHS senior registrar rota were in relation to additional plain and enhanced time worked whilst on-call that exceeded the time included in the work schedules.

Revisions to Work Schedules in the past year

All the North and South Durham junior doctor work schedules (28 in total) were revised in time for the August 2017 rotation to increase the time included in the work schedules. In February 2017 all the trainees were given 1.5 additional plain times in their work schedule which led to a high number of exceptions due to the frequent work over these hours. Additionally, with effect from February 2018 the senior registrars were given the option to increase their on-call frequency and for those who opted for one of these options, their work schedules were amended to reflect that (3 in total).

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data

Number of doctors / dentists in training (total):	52
Number of doctors / dentists in training on 2016 TCS (total):	52
Number of clinical supervisors	42
Amount of time available in job plan for guardian to do the role:	2 PA
Admin support provided to the guardian (if any):	4 days per quarter
Amount of job-planned time for educational supervisors:	0.125 PA per trainee

Exception reports (with regard to working hours) Up to from 1st January 2018 up to 31st March 2018

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F1 - Scarborough	0	0	0	0
F1 - York	0	0	0	0
F2 - Northallerton	No F2 Doctors in North Yorkshire			
F2 - Harrogate				
F2 - Scarborough				
F2 - York	0	0	0	0
CT1-2 - Northallerton	0	6	6	0
CT1-2 - Harrogate	0	6	6	0
CT1-2 - Scarborough	0	19	19	0
CT1-2 - York	0	0	0	0
CT3/ST4-6 – Northallerton	0	3	3	0
CT3/ST4-6 – Harrogate	0	0	0	0
CT3/ST4-6 – Scarborough	0	3	3	0
CT3/ST4-6 – York	0	0	0	0
Trust Doctors - Northallerton	0	8	8	0
Trust Doctors - Harrogate	0	8	8	0
Trust Doctors - Scarborough	0	11	11	0
Trust Doctors - York	0	0	0	0
Total	**0**	**64**	**64**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton	0	17	17	0
Harrogate	0	14	14	0
Scarborough	0	33	33	0
York	0	0	0	0
Total	**0**	**64**	**64**	**0**

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
Northallerton	CT3	Old	Yes	27	27	0	27	Long term sick (x2), Vacancy Short term sickness
	CT3	Old	Yes					
	CT2	New	Yes					
	CT1	New	Unknown					
	Specialty Dr	NA	No					
	Specialty Dr	NA	Yes					
Harrogate	Specialty Dr	NA	Yes	10	10	0	10	New Trust Doctor from overseas not doing on call for first 2 months in post and then doing a reduced number of on calls, short term sickness
	CT1	Yes	Unknown					
	CT2	Yes	No					
	F2	Yes	Unknown					
	Trust Dr	Yes	No					
	Specialty Dr	NA	No					
Scarborough	Trust Dr	Yes	Yes	5	5	0	5	0.2wte of LTFT to cover, short term sickness
	CT3	Yes	Yes					
	Specialty Dr	NA	Yes					
	CT1	Yes	Yes					
York & Selby	CT1	New	Yes	24	24	2	22	To cover X2 Trust doctor posts due to start in Feb but withdrew. Also x1 doctor off on-calls due to pregnancy and x1 doctor off on-calls
	F2	New	Unknown					
	CT1	New	Unknown					
	Trust Dr	New	Unknown					
	CT3	New	Yes					
	F2	New	Unknown					
	Specialty Dr	N/A	Yes					
	F2	New	Unknown					
	Trust Dr	New	Unknown					

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
								following long term sick.
Total				**0**	**0**	**0**	**0**	**0**

Narrative around Exception Reporting

Harrogate:

Non-resident rota - Doctors receive payment for 4 additional hours at plain rate and 1 additional hour at enhanced rate in their work schedule. The majority of exceptions were due to doctors working more hours than in their work schedules however on 7 occasions the exception was due to late finish to the normal working day mostly from one Trust Doctor who was in her first post in the UK. There were 2 occasions when it was not possible for the doctor to have a lunch break and 1 occasion where the doctor was unable to attend teaching.

Scarborough:
Non-resident rota - Doctors receive payment for 2 additional hours at plain rate in their work schedule. All exceptions, except 6, related to working more hours than in their work schedule. The remaining 6 exceptions were due to late finish on a normal working day – 5 from the same GP registrar

Northallerton:
Non-resident rota - Doctors receive payment for 2 additional hours at plain rate in their work schedule. The majority of exceptions related to working more hours than in their work schedule. However 2 exceptions were due to a late finish to the normal working day.

York:
No exception reports submitted.

Revisions to Work Schedules in the past year

A Trust Doctor in Harrogate had her work schedule reviewed in March 2018 as she felt unable to undertake the full quota of on calls. This was supported by the ADME.

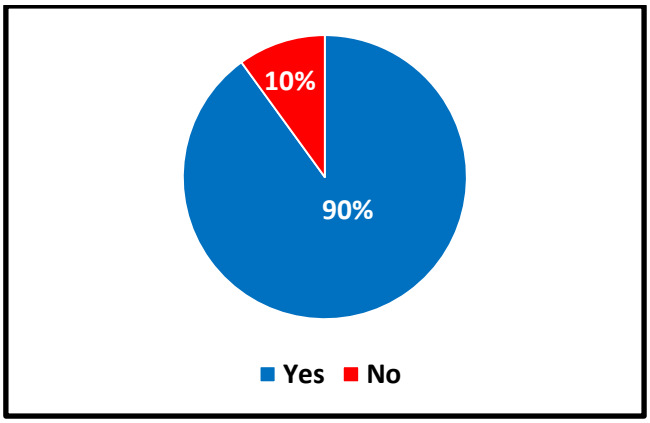
The on call rota in Northallerton was reduced from 1:7 to 1:6 for February – August 2018 due to having a vacant post. Doctors on this rota were given the 1:6 work schedules in accordance with the timescale in the Code of Practice.

The work schedules for Harrogate were revised in April 2017 at the request of the junior doctors. The number of additional hours paid each week was increased from 2 hours at plain rate to 4 hours at plain rate plus 1 hour at enhanced rate

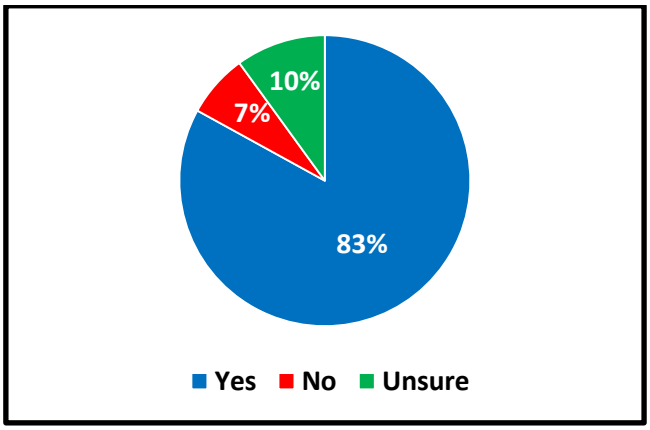
The York schedules haven't been revised during this time frame. However, due to the vacant shifts on the rota from March onwards due to the 2 vacant trust doctor posts, the trainees have agreed to pick these shifts up amongst themselves which they have now done and we have scheduled time to review the work schedules in the coming weeks to account for these extra shifts.

Feedback on the role of the TEWV Guardian of Safe Working

1. Are you aware of who the Guardian of Safe Working is?



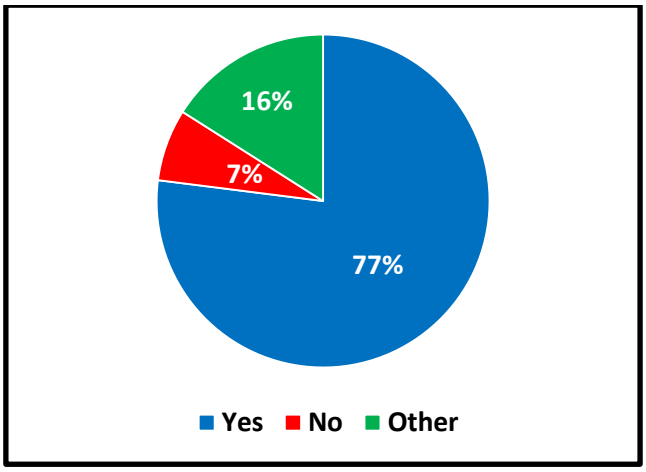
2. Do you know how to contact the Guardian of Safe Working?



Free Text Comments:

- Unsure but could contact through Human Resources

3. Do you feel the Guardian of Safe Working is Independent from the Trust in his role as Guardian?

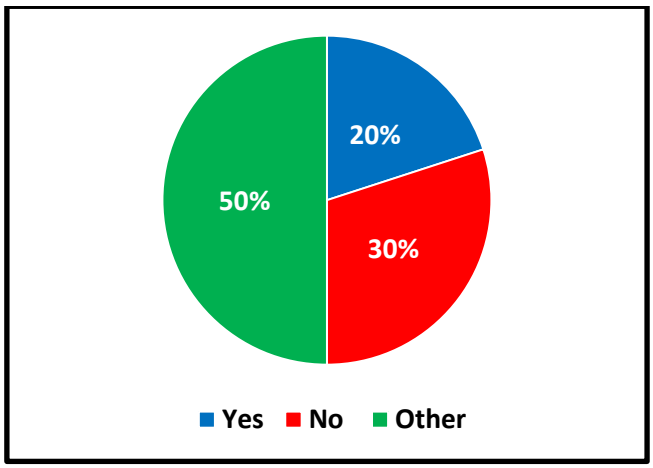


Free Text Comments:

- He works for the Trust

- I think that he will try to be as independent as possible but he is still employed by the Trust in his role as a consultant
- Clearly he can never be completely independent from the Trust whilst also being employed by the Trust however he appears to take an independent position on issues with both the Trust's and Junior Doctors interests equally balanced.

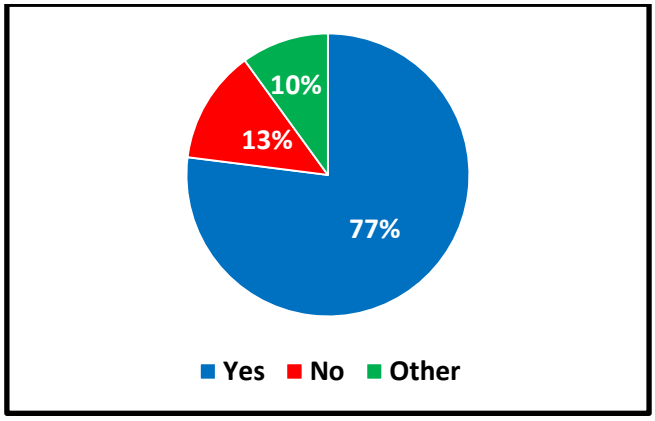
4. Do you see or get access to the reports produced for the Board of Directors by the Guardian of Safe Working?



Free Text Comments:

- Not Sure x5
- Haven't tried to access them
- Possibly but this hasn't been highlighted to me
- I know how to access them if I need to
- Not as yet
- I don't know, I haven't seen one

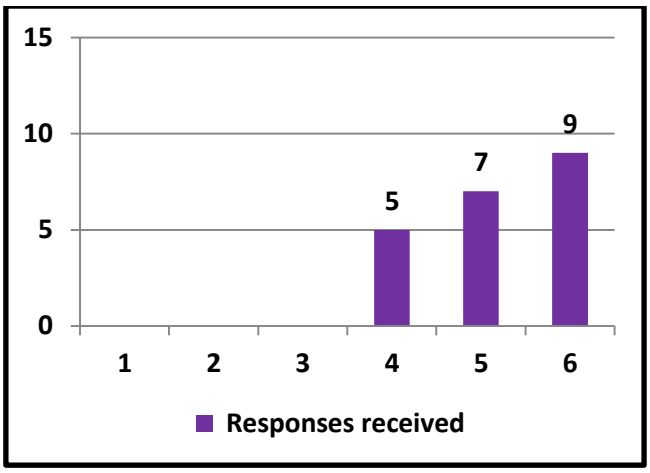
5. Do you feel the Guardian of Safe Working is responsible for protecting the safeguards outlined in the 2016 TCS?



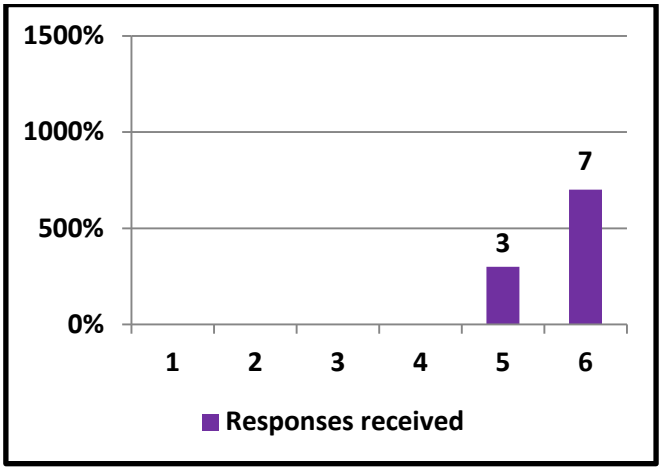
Free Text Comments:

- Not sure about this
- Don't know

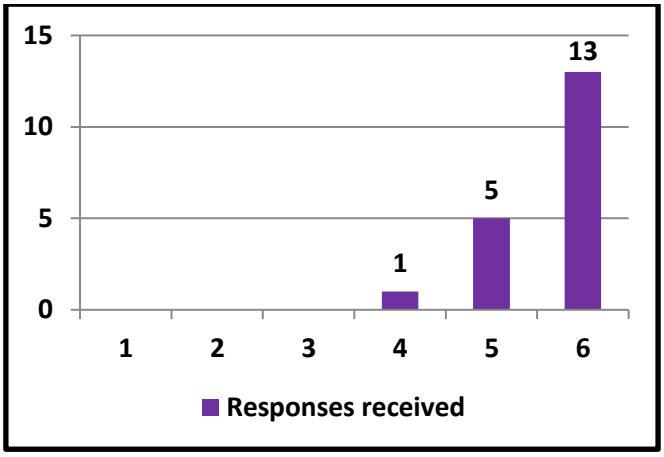
6. Do you feel the Guardian of Safe Working has dealt with issues of compliance effectively, in relation to safe working? (1= not at all and 6 = definitely)



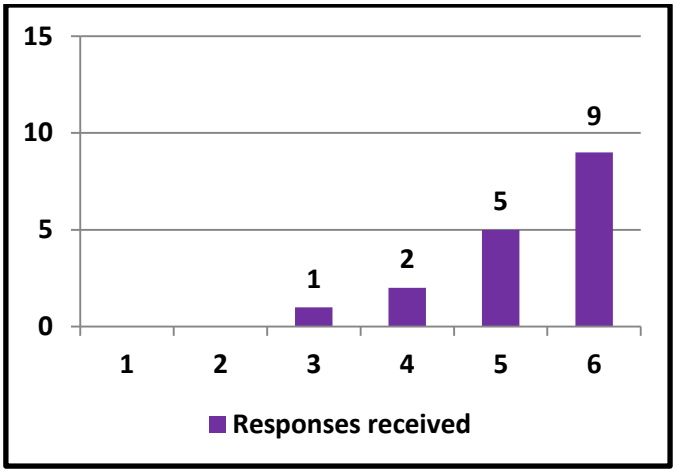
7. If you have raised any issues with the Guardian of Safe Working were they dealt with or answered appropriately? (1= not at all and 6 = definitely)



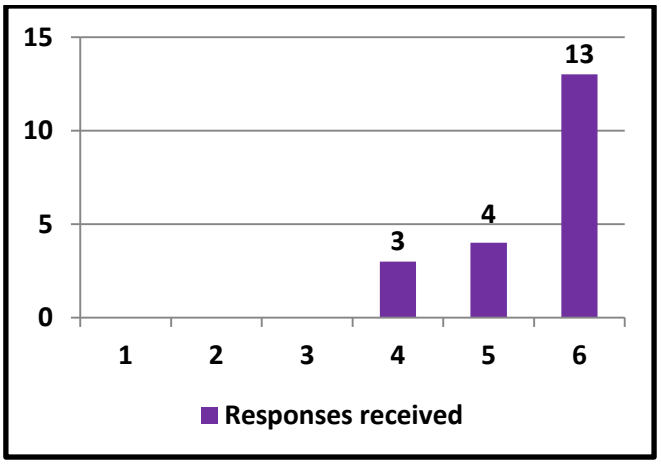
8. From either personal experience or from feedback from colleagues, do you feel any issues with the Guardian of Safe Working are taken seriously? (1= not at all and 6 = definitely)



9. Do you feel that any Exception Reports you have submitted have been dealt with appropriately? (1= not at all and 6 = definitely)



10. Are you confident that the Guardian of Safe Working is managing the issues raised by Junior Doctors effectively? (1= not at all and 6 = definitely)



<u>Free text comments about the Guardian of Safe Working</u>

- Dr Whaley has been very supportive of the Junior Doctors in our locality during a difficult period. He is very approachable and we have had no problems contacting him when required. He has dealt quickly and fairly with issues around compliance with the contact as well as issues regarding the safety of doctors working in the locality. He has taken issues raised very seriously and where he has been unable to help with these he has directed us to the correct person. His support has been much appreciated by all the junior doctors working in out locality.
- Very approachable. Seems very fair and to have junior doctors wellbeing as a main concern.
- I think he is doing as best he can given that there are currently no guidelines from NROC.
- Proactive and helpful approach. Introduced himself to us at the Trust Induction (particularly important for FYs as only in the Trust for 4 months). Pro-active with issue I raised around rota. Made clear that happy to help trainees on old contract as issues will likely effect other trainees on new contract.
- I have heard several positive comments from the Junior Doctors that have had to contact the Guardian directly.

Feedback on the role of the TEWV Guardian of Safe Working

- I have had pretty good on-calls till now but have heard that other people have had bad nights.
- Had an issue regarding time off post weekend on-calls. I felt that Dr Whaley heard my concerns patiently and addressed them extremely effectively. He was kind and approachable. On this particular occasion I had been emailing him and other relevant parties in succession and found it quite stressful as I was sleep deprived that week. He also offered reassurance and support that really makes the whole process a lot easier and less stressful. Glad to have this support available to us trainees as we feel very vulnerable at these times, especially with the new contract and working time directives.
- I am very glad that we have a Guardian of Safe Working and they are so committed and enthusiastic.
- Very impressed with Julian and how he has managed the role since its creation.
- He is very helping and ensures safe working environment for junior doctors.
- I think the Guardian of Safe Working is doing a very good job despite the limitations of the 2016 TCS.
- Approachable, competent and will raise any issues that jeopardise our safety. Really has the Junior Doctor's best interest at heart.
- I saw the Guardian at the beginning of the post during Induction. I think we should have had another face to face meeting (group meeting of all trainees and not only trainee rep) with him mid-placement or towards the end of the placement.
- Haven't had feedback about issues raised yet, hence cannot comment. This is a new way of working hence will be evolving.
- Good email information with contacts etc. in case of issues. Exception reporting usually submitted via Medical Development.

ITEM 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24th April 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 March 2018 data.

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

- The number of rosters equates to 72 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 26 wards.
- The Teesside and Durham & Darlington directorates have the highest level of 'red' fill rates (7 in March)
- The lowest fill rate indicators in March related to Talbot Direct Care (support is being provided by Holly which is reflective in their fill rates), The Orchards NY (sickness), and The Lodge (to support transition of support package)
- The Highest fill rates in March were observed by Westerdale South (high patient acuity), Acomb Garth (high patient acuity/frality) and Newberry (patient acuity)
- In relation to bank usage there were no wards identified those were utilising in excess of 50% bank during March. The highest bank user was in relation to Clover / Ivy with 43.4% bank usage (reasons for bank included: enhanced observations, vacancies and unknown)
- Agency usage equated to 6% in March. The highest user of agency within the reporting period related to Acomb Garth with 60.1% 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 7 and 8 of this report. All complaints were categorised in relation to 'treatment and care' although they did not highlight specific concerns with regards to staffing levels there was 1 in relation to staff attitude, this is currently being investigated. From those serious incidents that went to Directors Panel in March, 1 highlighted concerns regarding safe staffing and a further 2 cases in relation to staff attitude.
- There were 610 shifts allocated in March 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 (484 shifts).
- There were 17 incidents raised in March citing concerns in relation to staffing levels, 11 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 March Elm had the highest score with 11 points awarded. The top 10 for March 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 Clover / Ivy being cited as having the highest score of 87.

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:	**24th April 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 March 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 72 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 – March 2018

3.1.1 The daily nurse staffing information aggregated for the month of March 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 26 in March. This is an increase of 2 when compared to February 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
March 2018		
Talbot Direct Care	2.2% HCA on Nights 5.4% HCA on Days 70.8% RN on Days	Talbot always has a registered nurse on duty 24 hours a day. This is supported by CAMHS team managers,

	90.3% RN on Nights	3 shifts per week from Holly and the Ward Manager. Each shift is also supported by two PIPS HCA staff. A new roster template has been added and will be effective from 28th May 2018.
The Orchards (NY)	51.6% RN on Nights 133.3% HCA on Nights 80.7% RN on Days 93.3% HCA on Days	The ward has been experiencing high levels of sickness. The requirement on Nights has changed from 2 RN's to 1; the roster template has been amended to reflect the agreed establishments and will be effective from 28th May 2018.
The Lodge	59.1% HCA on Days 87.7% RN on Days 87.1% HCA on Nights 79.5% RN on Nights	The shortfall is in relation to the transition of the care package to an external provider and staff working alongside TEWV staff as part of the transition. The roster template needs to be amended to take into account the change in requirement from a Trust perspective.

It is also important to review the fill rates that exceed the budgeted establishment (shown in blue). In March there were 64 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
March 2018		
Westerdale South	418.2% HCA on Nights 79.3% RN on Nights 287.0% HCA on Days 77.8% RN on Days	The over establishment is in relation to high patient acuity with 6-7 enhanced patient observations daily. In addition the ward has experienced RN sickness.
Acomb Garth	351.0% HCA on Nights 98.4% RN on Nights 236.7% HCA on Days 118.4% 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.
Newberry Centre	250.1% HCA on Nights 142.6% RN on Nights 138.1% HCA on Days 126.0% RN on Days	The ward has advised that the reason for the additional staffing was as a result of 3 patients who required PICU and 1 low secure patients who were

		admitted requiring 1:2 nursing staff per patient at any given time day / night.

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 March.

The highest user of bank in March related to Clover / Ivy reporting at 43.4%. The reasons Clover / Ivy gave for requesting bank are as follows:

- Establishment Vacancies (87 shifts)
- Enhanced Observations (57 shifts)
- Sickness (24 shifts)
- Special Leave Cover (8 shifts)
- Overbooked (2 shifts)
- Staff being utilised on other wards (2 shifts)
- Escort / workmen (1 shift)
- Unknown (1 shift)

The ward has advised that they have created additional night shifts due to an individual requiring eyesight/arms reach observations in addition to safeguarding issues. The final beds on Eagle/Osprey collapsed at the end of March (this reporting period) and vacancies were being held on Clover/Ivy for HCA's therefore it is anticipated this position will improve in April's report.

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

Clover/Ivy	43.4%
Birch Ward	37.7%
Mandarin	35.9%
Westerdale South	35.6%
Harrier/Hawk	31.6%
Mallard Ward	30.1%
Maple Ward	30.0%
Kirkdale Ward	29.2%
Oakwood	27.4%
Elm Ward	27.2%
Kestrel/Kite.	27.0%
Merlin	26.6%
Hamsterley Ward	26.0%

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 March the agency usage equated to 6% an increase of 0.9% when compared to February.

The highest user of agency within the reporting period related to Acomb Garth equating to approximately 60.1% of the total hours worked on this ward. The reasons Acomb Garth gave for requesting agency are as follows:

- Enhanced Observations (318 shifts)
- Unknown (19 shifts)
- Establishment Vacancies (3 shifts)
- Sickness (1 shift)

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

Acomb Garth	60.1%
Cedar Ward (NY)	32.7%
Cherry Tree House	26.0%
Westerdale South	21.8%
Westerdale North	17.2%
Rowan Ward	14.9%
Danby Ward	11.3%
Minster Ward	14.6%
Oak Rise	9.5%
Ward 15 Friarage	9.3%
Rowan Lea	8.9%
Birch Ward	8.2%
Springwood	7.9%
Meadowfields	7.6%
Maple Ward	7.0%
The Evergreen Centre	6.8%
Ebor Ward	6.6%
Eagle/Osprey	6.5%
Stockdale Ward	6.2%
Elm Ward	5.2%
Hamsterley Ward	5.2%
Newberry Centre	4.7%
Ceddesfeld Ward	4.0%

Although agency usage remains relatively low within the Trust; this is increasing month on month. The greatest percentage expenditure patient safety remains on agency HCA's (approximately 80%). Due to recent reported patient safety risks of agency usage, the EMT have discussed this and strategies are being put in place to only use agency where essential. This includes recruitment drives (substantive and bank) and overtime use.

3.4 Quality Data Triangulation

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

- There were 3 Serious Incidents (SI) that occurred within inpatient areas during the month of March. 1 of which related to Danby Ward and another in relation to Rowan Lea both of which have been cited in this report for having agency usage in excess of 4%. From those serious incidents that went to Directors Panel in March, 1 highlighted concerns regarding safe staffing and a further 2 cases in relation to staff attitude.
  - There was 1 level 4 incident reported in March which related to the Rowan Lea serious incident identified above.
  - There were 7 level 3 incidents (self-harm) that occurred in March with the following featuring in this report as follows:
    - Cedar (NY) – 1 incidents – cited in this report for agency usage greater than 4%
    - Elm Ward – 1 incident – cited in this report for having bank usage in excess of 25% and agency usage greater than 4%.
    - Ward 15 – 1 incident – cited in this report for having agency usage greater than 4%.
    - The Evergreen Centre – 1 incident – cited in this report for having agency usage greater than 4%.
  - There were 5 complaints raised in March, the following is of relevance:
    - Elm Ward - 1 complaint - cited in this report for having agency usage greater than 4% and bank usage greater than 25%. In addition Elm has been cited for having a level 3 self-harm incident. The complaint raised was not directly in relation to staffing levels however, staff attitude was cited as 1 element of this complaint.
    - Maple Ward – 1 complaint - cited in this report for having agency usage greater than 4% and bank usage greater than 25%.
    - Newberry Centre – 1 complaint – cited in this report for having a high fill rate and agency usage greater than 4%
  - There were 42 PALS related issues raised with the following featuring within this report as follows:
    - Cedar (NY) (2 issues) – cited in this report for having agency usage greater than 4% and also having a level 3 self-harm incident.
    - Elm Ward (3 issues) – cited in this report for having bank usage in excess of 25% and agency usage greater than 4%. In addition

Elm has been cited for having a complaint and a level 3 self-harm incident.

- Maple (1 issue) – cited in this report for having bank usage in excess of 25% and agency usage greater than 4%. In addition a complaint has been raised.
- Minster (1 issue) – cited in this report for agency usage greater than 4%
- Stockdale (1 issue) – cited in this report for having agency usage greater than 4%
- Newberry Centre (1 issue) – cited in this report for having a high fill rate and agency usage greater than 4%. In addition Newberry received a complaint.
- The Evergreen Centre (1 issue) – cited in this report agency usage greater than 4% and for having a level 3 self-harm incident.
- Clover / Ivy (1 issue) – cited in this report having bank usage in excess of 25%
- Harrier / Hawk (1 issue) – cited in this report for having bank usage in excess of 25%
- Kestrel / Kite (4 issues) – cited in this report for having bank usage in excess of 25%
- Mallard (7 issues) – cited in this report for having bank usage in excess of 25%
- Mandarin (1 issue) – cited in this report for having bank usage in excess of 25%
- Merlin (2 issues) - cited in this report for having bank usage in excess of 25%
- Ceddesfeld (1 issue) – cited in this report for having agency usage greater than 4%
- Cherry Tree (1 issue) – cited in this report for having agency greater than 4%
- Rowan Lea (1 issue) – cited in this report for having agency usage greater than 4%
- Rowan Ward (1 issue) - cited in this report for having agency usage greater than 4%
- Westerdale South (1 issue) – cited in this report for having a high fill rate, bank usage in excess of 25% and agency usage greater than 4%.

A number of incidents requiring control and restraint occurred during March. The highest user was the Newberry with a total of 217 incidents. This ward has been cited in this report in relation to a high staffing fill rate and agency usage greater than 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 610 shifts in March where an unpaid break had not been taken. This is an increase of 139 when compared to February.

The majority of the shifts where breaks were not taken occurred on day shifts (484 shifts). The number of night shifts where breaks were not taken equated to 126 shifts in March.

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

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.

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 17 incidents reported in March on Datix citing issues with staffing. 11 of those incidents raised were in relation to inpatient services.

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:

- 55% (6 incidents) relating to inpatient ward incidents raised citing issues with staffing levels were for day shifts
- Forensic Services at Roseberry Park accounted for 45% (5 incidents) of all inpatient incidents raised citing concerns with regards to staffing levels
- Enhanced observations increasing staffing requirements

- Medical Emergency requiring staff to be moved
- Staff sickness
- Agency staff failed to turn up for shift

Issues reported:

- Staff and patient safety compromised
- Quality of service impaired
- Wards not running on required staffing levels/ mix
- Clinical intervention not being able to proceed
- Security checks not undertaken

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
SUI = 1 point
Level 4 = 1 point
Level 3 = 1 point
Complaint = 1 point
Control and Restraint – 11 and 39 incidents requiring C&R = 1 point; 40+ incidents of C&R = 2 points.

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

WARD	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	Level 4 Incidents	Level 3 Incidents	Complaints	Control & Restraint	TOTAL SCORE Mar
Elm Ward	4	1	1	1	2	0	0	1	1	0	**11**
Westerdale South	4	2	0	1	2	0	0	0	0	1	**10**
Bedale Ward	4	2	0	1	1	0	0	0	1	0	**9**
Newberry Centre	0	4	1	1	0	0	0	0	1	2	**9**

Birch Ward	2	2	1	1	2	0	0	0	0	0	**8**
Cedar Ward	4	0	0	1	1	0	0	1	1	0	**8**
Maple Ward	2	1	1	1	2	0	0	0	1	0	**8**
The Orchards (NY)	4	1	1	1	1	0	0	0	0	0	**8**
Ward 15 Friarage	2	2	1	1	1	0	0	1	0	0	**8**
Eagle/Osprey	6	0	0	1	1	0	0	0	0	0	**8**
The Lodge	8	0	0	0	0	0	0	0	0	0	**8**
Rowan Lea	2	2	1	1	0	1	1	0	0	0	**8**

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

WARD	Locality	Speciality	YTD Total Score (Mar - Mar)
Clover/Ivy	Teesside	Forensics LD	**87**
Newberry Centre	Teesside	CYPS	**85**
Bedale Ward	Durham & Darlington	Adults	**81**
Cedar Ward	York and Selby	Adults	**81**
Springwood Community Unit	North Yorkshire	MHSOP	**80**

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

3.8 Other

Teesside and Durham & Darlington directorates have the highest number (7 wards' in March) of 'red' fill rates for registered nurses on day shifts.

A report of progress was submitted to the board in March 2018 with regards to the Establishment Reviews that were undertaken within inpatient services earlier in the year. The need to increase base line establishments in the trusts larger adult inpatient wards has been acknowledged and there is further work required to understand the skill mix within organic older person's wards. A visit to another trust is being arranged to consider the positive impact of a zonal observation pilot on staffing levels. Additionally work is underway to map out how 'Model Ward's' will be implemented across two MHSOP wards (Westerdale North and South) and two AMH wards (Maple and Elm) from September 2018. This work will include observations using QIS methodology and will make recommendations regarding multi-disciplinary skill mix.

As part of the Right Staffing programme, the Trust is now working with National Mental Health Acuity and Dependency Development Group to pilot the Mental Health Optimal Staffing Tool (MHOST) which builds upon the Hurst tool. The adult Eating Disorder Service (Birch Ward) will be contributing to the data collection process for Eating Disorders Services which will involve independent audit and review scheduled for June 2018.

Skill mix reviews in tier 4 CAMH's have taken place with a focus on increased leadership at Band 6 level to support less experienced nurses on a shift by shift basis.

Health roster review and training remains an area of increased focus for the Right Staffing programme. Discussions with the Supporting Users Team for gathering requirements from community teams regarding HealthRoster. Information has commenced in April.

From April 2018 the Trust will be expected to submit monthly data with regards to Care Hours per Patient Day (CHPPD). Clarity has been sought following the initial pilot and this will only include Nursing Staff. This report will be expanded next month to incorporate this additional reporting requirement.

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 3.8 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 were 3 Serious Incidents (SI) that occurred within inpatient areas during the month of March. 1 of which related to Danby Ward and another in relation to Rowan Lea both of which have been cited in this report for having agency usage in excess of 4%. From those serious incidents that were reviewed at Directors Panel in March, 1 highlighted concerns regarding safe staffing and a further 2 cases in relation to 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
April 2017

Appendix 1

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 31 DAYS IN March							
				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)
Holly Unit	Durham & Darlington	CYPS	4	133.2%	167.4%	125.0%	229.9%
Birch Ward	Durham & Darlington	Adults	15	64.2%	168.1%	100.0%	200.0%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	96.2%	121.7%	96.8%	122.7%
Hamsterley Ward	Durham & Darlington	MHSOP	15	94.8%	137.7%	100.4%	143.5%
Tunstall Ward	Durham & Darlington	Adults	20	125.7%	96.8%	100.0%	121.0%
Elm Ward	Durham & Darlington	Adults	20	89.4%	84.0%	103.2%	124.2%
Maple Ward	Durham & Darlington	Adults	20	78.0%	130.3%	97.7%	119.4%
Willow Ward	Durham & Darlington	Adults	15	87.6%	151.4%	103.2%	102.3%
Bek-Ramsey Ward	Durham & Darlington	LD	11	148.2%	106.8%	100.7%	106.5%
Harland Rehab Ward	Durham & Darlington	Rehab	1	120.4%	94.7%	103.5%	98.4%
Cedar Ward	Durham & Darlington	Adults	10	94.4%	79.5%	100.0%	59.4%
Farnham Ward	Durham & Darlington	Adults	20	96.7%	119.5%	100.0%	101.6%
Primrose Lodge	Durham & Darlington	Adults	15	73.3%	119.4%	100.5%	100.0%
Talbot Direct Care	Durham & Darlington	CYPS	1	70.8%	5.4%	90.3%	2.2%
Oak Ward	Durham & Darlington	MHSOP	12	67.7%	103.2%	100.0%	100.0%
Roseberry Wards	Durham & Darlington	MHSOP	15	100.6%	107.6%	104.0%	109.2%
Mallard Ward	Forensics	Forensics MH	14	106.6%	115.3%	136.6%	181.4%
Mandarin	Forensics	Forensics MH	16	94.4%	149.1%	107.7%	179.4%

Clover/Ivy	Forensics	Forensics LD	12	103.7%	95.4%	113.8%	185.1%
Harrier/Hawk	Forensics	Forensics LD	10	99.2%	116.2%	103.2%	167.0%
Kestrel/Kite.	Forensics	Forensics LD	16	91.1%	108.0%	100.0%	143.9%
Jay Ward	Forensics	Forensics MH	5	86.3%	98.6%	109.7%	130.6%
Merlin	Forensics	Forensics MH	10	117.9%	117.5%	108.1%	137.6%
Newtondale Ward	Forensics	Forensics MH	20	98.1%	108.8%	97.8%	138.0%
Sandpiper Ward	Forensics	Forensics MH	8	99.1%	104.6%	96.4%	132.3%
Swift Ward	Forensics	Forensics MH	10	118.8%	101.8%	114.1%	126.1%
Northdale Centre	Forensics	Forensics LD	12	76.8%	130.8%	103.2%	97.5%
Oakwood	Forensics	Forensics LD	8	95.9%	137.6%	100.0%	100.0%
Eagle/Osprey	Forensics	Forensics LD	10	62.9%	69.0%	119.6%	83.5%
Langley Ward	Forensics	Forensics LD	10	88.2%	100.0%	100.3%	100.0%
Thistle	Forensics	Forensics LD	5	74.3%	105.3%	111.4%	95.3%
Brambling Ward	Forensics	Forensics MH	13	99.7%	97.3%	100.0%	95.1%
Lark	Forensics	Forensics MH	17	104.3%	98.6%	109.7%	103.2%
Linnet Ward	Forensics	Forensics MH	17	85.1%	106.5%	101.2%	97.7%
Nightingale Ward	Forensics	Forensics MH	16	91.5%	106.6%	103.2%	107.3%
Ward 15 Friarage	North Yorkshire	Adults	12	83.0%	125.0%	100.9%	120.1%
The Orchards (NY)	North Yorkshire	Adults	10	80.7%	93.3%	51.6%	133.3%
Rowan Lea	North Yorkshire	MHSOP	20	86.7%	125.0%	122.0%	116.1%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	75.1%	147.1%	100.9%	106.0%
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	93.0%	109.3%	90.6%	111.5%
Cedar Ward (NY)	North Yorkshire	Adults	14	96.0%	110.4%	93.9%	117.8%
Rowan Ward	North Yorkshire	MHSOP	6	90.0%	115.5%	100.6%	119.6%
Springwood Community Unit	North Yorkshire	MHSOP	14	76.8%	114.9%	103.5%	148.4%
Ward 14	North Yorkshire	MHSOP	10	75.0%	113.8%	100.0%	100.0%
Newberry Centre	Teesside	CYPS	14	126.0%	138.1%	142.6%	250.1%

Stockdale Ward	Teesside	Adults	18	125.2%	132.0%	103.1%	139.8%
Bedale Ward	Teesside	Adults	10	80.2%	128.3%	72.6%	168.9%
Overdale Ward	Teesside	Adults	18	99.5%	143.3%	100.0%	122.6%
Westwood Centre	Teesside	CYPS	12	92.2%	175.8%	96.5%	222.6%
Westerdale North	Teesside	MHSOP	18	99.4%	120.7%	106.5%	158.1%
Westerdale South	Teesside	MHSOP	14	77.8%	287.0%	79.3%	418.2%
Bankfields Court Unit 2	Teesside	LD	5	120.0%	105.8%	100.2%	126.2%
The Evergreen Centre	Teesside	CYPS	16	77.4%	117.5%	90.7%	123.5%
Thornaby Road	Teesside	Day Unit	5	105.3%	121.1%		100.0%
Bankfields Court Flats	Teesside	LD	6	124.6%	71.9%	100.0%	99.9%
Kiltonview	Teesside	Day Unit	0	128.0%	89.1%		
Bilsdale Ward	Teesside	Adults	14	107.3%	118.1%	112.9%	108.2%
Bransdale Ward	Teesside	Adults	14	114.9%	104.1%	106.7%	105.0%
Kirkdale Ward	Teesside	Adults	16	86.9%	103.0%	96.8%	100.6%
Lustrum Vale	Teesside	Adults	20	92.3%	118.5%	100.0%	100.0%
Baysdale	Teesside	CYPS	6	104.3%	118.7%	100.4%	104.5%
Aysgarth	Teesside	LD	6	93.4%	98.2%	99.9%	97.1%
Bankfields Court Unit 3	Teesside	LD	6	76.4%	98.8%	100.0%	96.8%
Bankfields Court Unit 4	Teesside	LD	6	88.9%	88.8%	116.7%	93.8%
The Lodge	Teesside	LD	1	87.7%	59.1%	79.5%	87.1%
The Orchard	Teesside	Day Unit	0	103.2%	86.5%		
Acomb Garth	York and Selby	MHSOP	14	118.4%	236.7%	98.4%	351.0%
Cherry Tree House	York and Selby	MHSOP	18	98.4%	107.7%	107.3%	189.4%
Ebor Ward	York and Selby	Adults	12	91.7%	124.5%	101.1%	103.9%
Minster Ward	York and Selby	Adults	12	98.9%	111.7%	100.6%	113.8%
Oak Rise	York and Selby	LD	8	98.4%	97.6%	100.0%	98.9%

Meadowfields	York and Selby	MHSOP	14	**95.1%**	**89.0%**	**96.8%**	**100.3%**

APPENDIX 2

Scored Fill Rate compared to Quality Indicators - March 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	SUI	Level 4 Incidents	Level 3 Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	2645.0	299.0	11.3%	2645.0	283.5	10.7%	1								
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2930.7	79.0	2.7%	2930.7	371.25	12.7%						4		4	4
Bedale Ward	Teesside	Adults	10	4124.3	138.0	3.3%	4124.3	677.5	16.4%				1		5	1	6	7
Bilsdale Ward	Teesside	Adults	14	2919.3	0.0	0.0%	2919.3	103.5	3.5%	1					3	2	3	5
Birch Ward	Durham & Darlington	Adults	15	4254.5	347.7	8.2%	4254.5	1603.67	37.7%						2		2	2
Bransdale Ward	Teesside	Adults	14	2807.1	23.0	0.8%	2807.1	124.5	4.4%					2	7		12	12
Cedar Ward	Durham & Darlington	Adults	10	4159.3	12.0	0.3%	4159.3	607.17	14.6%			1	1		7	1	10	11
Cedar Ward (NY)	North Yorkshire	Adults	14	3441.1	1126.3	32.7%	3441.1	254	7.4%			1		2	8	1	19	20
Ebor Ward	York and Selby	Adults	12	2904.5	191.5	6.6%	2904.5	371	12.8%						1		1	1
Elm Ward	Durham & Darlington	Adults	20	2965.8	155.3	5.2%	2965.8	807.27	27.2%			1	1	3	8		10	10
Farnham Ward	Durham & Darlington	Adults	20	2880.8	84.0	2.9%	2880.8	336	11.7%					1	3		6	6
Kirkdale Ward	Teesside	Adults	16	3116.8	22.5	0.7%	3116.8	911	29.2%						1		1	1
Lustrum Vale	Teesside	Adults	20	2797.0	0.0	0.0%	2797.0	640.5	22.9%									
Maple Ward	Durham & Darlington	Adults	20	2927.9	204.0	7.0%	2927.9	878.67	30.0%				1	1	4		4	4
Minster Ward	York and Selby	Adults	12	2887.8	422.5	14.6%	2887.8	138	4.8%					1	10	3	16	19
Overdale Ward	Teesside	Adults	18	3056.3	80.5	2.6%	3056.3	259.25	8.5%					1	2		2	2
Primrose Lodge	Durham & Darlington	Adults	15	2661.2	12.0	0.5%	2661.2	511.33	19.2%									
Stockdale Ward	Teesside	Adults	18	3313.5	207.0	6.2%	3313.5	334.5	10.1%					1	2	1	4	5
The Orchards (NY)	North Yorkshire	Adults	10	2054.8	24.0	1.2%	2054.8	239	11.6%									

Tunstall Ward	Durham & Darlington	Adults	20	3101.7	72.0	2.3%	3101.7	84	2.7%			1			5		7	7
Ward 15 Friarage	North Yorkshire	Adults	12	2776.5	258.8	9.3%	2776.5	662.75	23.9%			1			2		2	2
Willow Ward	Durham & Darlington	Adults	15	2898.8	48.0	1.7%	2898.8	647	22.3%					1	2		2	2
Baysdale	Teesside	CYPS	6	2588.9	0.0	0.0%	2588.9	119.6	4.6%									
Holly Unit	Durham & Darlington	CYPS	4	1492.9	0.0	0.0%	1492.9	250.84	16.8%									
Newberry Centre	Teesside	CYPS	14	5531.4	259.6	4.7%	5531.4	539.57	9.8%				1	1	217	1	296	297
Talbot Direct Care	Durham & Darlington	CYPS	1	643.3	0.0	0.0%	643.3	0	0.0%						2		3	3
The Evergreen Centre	Teesside	CYPS	16	5126.5	348.5	6.8%	5126.5	396.25	7.7%			1		1	98	7	141	148
Westwood Centre	Teesside	CYPS	12	6303.3	0.0	0.0%	6303.3	230	3.6%						26		32	32
Clover/Ivy	Forensics	Forensics LD	12	4366.6	45.0	1.0%	4366.6	1897	43.4%					1	16	2	43	45
Eagle/Osprey	Forensics	Forensics LD	10	2621.0	169.8	6.5%	2621.0	623.75	23.8%									
Harrier/Hawk	Forensics	Forensics LD	10	4608.0	0.0	0.0%	4608.0	1455.94	31.6%					1	3		5	5
Kestrel/Kite.	Forensics	Forensics LD	16	4234.6	0.0	0.0%	4234.6	1143.08	27.0%					4				
Langley Ward	Forensics	Forensics LD	10	2153.5	0.0	0.0%	2153.5	413	19.2%									
Northdale Centre	Forensics	Forensics LD	12	5114.2	11.3	0.2%	5114.2	1132.09	22.1%					1	1	1	4	5
Oakwood	Forensics	Forensics LD	8	1951.3	45.0	2.3%	1951.3	534.25	27.4%									
Thistle	Forensics	Forensics LD	5	2954.4	0.0	0.0%	2954.4	408.67	13.8%						2		5	5
Brambling Ward	Forensics	Forensics MH	13	2782.8	0.0	0.0%	2782.8	361	13.0%									
Jay Ward	Forensics	Forensics MH	5	3018.8	0.0	0.0%	3018.8	363.75	12.0%						1		2	2
Lark	Forensics	Forensics MH	17	2933.5	0.0	0.0%	2933.5	483.75	16.5%					1				
Linnet Ward	Forensics	Forensics MH	17	2823.2	0.0	0.0%	2823.2	45.58	1.6%									
Mallard Ward	Forensics	Forensics MH	14	4129.0	0.0	0.0%	4129.0	1244.48	30.1%					7				
Mandarin	Forensics	Forensics MH	16	3929.1	0.0	0.0%	3929.1	1410.83	35.9%					1	8		9	9
Merlin	Forensics	Forensics MH	10	4214.0	0.0	0.0%	4214.0	1123	26.6%					2	6		18	18
Newtondale Ward	Forensics	Forensics MH	20	4252.4	0.0	0.0%	4252.4	848.25	19.9%					1	1		1	1
Nightingale Ward	Forensics	Forensics MH	16	2959.8	0.0	0.0%	2959.8	366.25	12.4%					1	3		7	7
Sandpiper Ward	Forensics	Forensics MH	8	4150.5	0.0	0.0%	4150.5	754.75	18.2%					1	56	1	124	125
Swift Ward	Forensics	Forensics MH	10	3575.8	0.0	0.0%	3575.8	601	16.8%						7		11	11

Aysgarth	Teesside	LD	6	2277.9	0.0	0.0%	2277.9	278.91	12.2%					1				
Bankfields Court Flats	Teesside	LD	6	2032.8	0.0	0.0%	2032.8	96	4.7%									
Bankfields Court Unit 2	Teesside	LD	5	2661.4	0.0	0.0%	2661.4	410.49	15.4%						1		1	1
Bankfields Court Unit 3	Teesside	LD	6	2313.7	0.0	0.0%	2313.7	132	5.7%						9		13	13
Bankfields Court Unit 4	Teesside	LD	6	2095.3	0.0	0.0%	2095.3	276	13.2%									
Bek-Ramsey Ward	Durham & Darlington	LD	11	4044.3	115.7	2.9%	4044.3	300	7.4%						3		4	4
Harland Rehab Ward	Durham & Darlington	LD	1	2262.5	12.0	0.5%	2262.5	348	15.4%									
Oak Rise	York and Selby	LD	8	3659.0	347.3	9.5%	3659.0	585.6	16.0%						3		5	5
The Lodge	Teesside	LD	1	1422.7	0.0	0.0%	1422.7	0	0.0%									
Acomb Garth	York and Selby	MHSOP	14	6486.5	3898.0	60.1%	6486.5	537	8.3%						6		7	7
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	3565.8	144.0	4.0%	3565.8	317.58	8.9%					1	5		8	8
Cherry Tree House	York and Selby	MHSOP	18	3643.0	948.0	26.0%	3643.0	419	11.5%					1				
Hamsterley Ward	Durham & Darlington	MHSOP	15	3657.8	190.8	5.2%	3657.8	950.34	26.0%									
Meadowfields	York and Selby	MHSOP	14	2843.7	216.2	7.6%	2843.7	437.5	15.4%						2		3	3
Oak Ward	Durham & Darlington	MHSOP	12	2551.3	36.0	1.4%	2551.3	459.33	18.0%									
Roseberry Wards	Durham & Darlington	MHSOP	15	2782.8	48.0	1.7%	2782.8	230.49	8.3%			1						
Rowan Lea	North Yorkshire	MHSOP	20	4117.2	367.1	8.9%	4117.2	357.74	8.7%	1	1			1	1		1	1
Rowan Ward	North Yorkshire	MHSOP	6	2930.3	435.8	14.9%	2930.3	382	13.0%					1	2		2	2
Springwood Community Unit	North Yorkshire	MHSOP	14	3318.3	263.0	7.9%	3318.3	605.83	18.3%						15		18	18
Ward 14	North Yorkshire	MHSOP	10	2553.8	49.0	1.9%	2553.8	127.75	5.0%									
Westerdale North	Teesside	MHSOP	18	3620.7	624.0	17.2%	3620.7	253	7.0%						1		2	2
Westerdale South	Teesside	MHSOP	14	7878.0	1716.5	21.8%	7878.0	2807.5	35.6%					1	19		19	19
Kiltonview	Teesside	LD	0	1929.7	0.0	0.0%	1929.7	131.33	6.8%									
The Orchard	Teesside	LD	0	927.7	0.0	0.0%	927.7	156.16	16.8%									
Thornaby Road	Teesside	LD	5	1926.2	0.0	0.0%	1926.2	52.75	2.7%									

Severity Scoring by Total Score

APPENDIX 3

WARD	Locality	Speciality	No. of Beds	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	Serious Incident	Level 4 Incident	Level 3 Incident	Complaints	Control & Restraint	TOTAL SCORE (Mar)
Elm Ward	Durham & Darlington	Adults	20	4	1	1	1	2	0	0	1	1	0	**11**
Westerdale South	Teesside	MHSOP	14	4	2	0	1	2	0	0	0	0	1	**10**
Newberry Centre	Teesside	CYPS	14	0	4	1	1	0	0	0	0	1	2	**9**
Bedale Ward	Teesside	Adults	10	4	2	0	1	1	0	0	0	1	0	**9**
Eagle/Osprey	Forensics	Forensics LD	10	6	0	0	1	1	0	0	0	0	0	**8**
The Lodge	Teesside	LD	1	8	0	0	0	0	0	0	0	0	0	**8**
The Orchards (NY)	North Yorkshire	Adults	10	4	1	1	1	1	0	0	0	0	0	**8**
Maple Ward	Durham & Darlington	Adults	20	2	1	1	1	2	0	0	0	1	0	**8**
Birch Ward	Durham & Darlington	Adults	15	2	2	1	1	2	0	0	0	0	0	**8**
Cedar Ward	Durham & Darlington	Adults	10	4	0	0	1	1	0	0	1	1	0	**8**
Ward 15 Friarage	North Yorkshire	Adults	12	2	2	1	1	1	0	0	1	0	0	**8**
Rowan Lea	North Yorkshire	MHSOP	20	2	2	1	1	0	1	1	0	0	0	**8**
Evergreen Centre	Teesside	CYPS	16	2	1	0	1	0	0	0	1	0	2	**7**
Springwood	North Yorkshire	MHSOP	14	2	1	1	1	1	0	0	0	0	1	**7**
Talbot Direct Care	Durham & Darlington	CYPS	1	6	0	0	0	0	0	0	0	0	0	**6**
Hamsterley Ward	Durham & Darlington	MHSOP	15	0	2	1	1	2	0	0	0	0	0	**6**
Northdale Centre	Forensics	Forensics LD	12	2	1	1	1	1	0	0	0	0	0	**6**
Esk Ward	North Yorkshire	Adults	11	2	1	1	1	1	0	0	0	0	0	**6**
Holly Unit	Durham & Darlington	CYPS	4	0	4	1	0	1	0	0	0	0	0	**6**
Mandarin	Forensics	Forensics MH	16	0	2	1	0	2	0	0	0	0	0	**5**
Bankfields Unit 4	Teesside	LD	6	4	0	0	0	1	0	0	0	0	0	**5**
Clover/Ivy	Forensics	Forensics LD	12	0	1	0	1	2	0	0	0	0	1	**5**
Kirkdale Ward	Forensics	Adults	16	2	0	0	1	2	0	0	0	0	0	**5**
Willow Ward	Durham & Darlington	Adults	15	2	1	0	1	1	0	0	0	0	0	**5**
Mallard Ward	Forensics	Forensics MH	14	0	2	1	0	2	0	0	0	0	0	**5**
Stockdale Ward	Teesside	Adults	18	0	3	1	1	0	0	0	0	0	0	**5**
Meadowfields	York and Selby	MHSOP	14	2	0	1	1	1	0	0	0	0	0	**5**
Harrier/Hawk	Forensics	Forensics LD	10	0	1	1	0	2	0	0	0	0	0	**4**

Langley Ward	Forensics	Forensics LD	10	2	0	1	0	1	0	0	0	0	0	**4**
Sandpiper Ward	Forensics	Forensics MH	8	0	1	0	0	1	0	0	0	0	2	**4**
Ebor Ward	York and Selby	Adults	12	0	1	1	1	1	0	0	0	0	0	**4**
Oakwood	Forensics	Forensics LD	8	0	1	0	1	2	0	0	0	0	0	**4**
Primrose Lodge	Durham & Darlington	Adults	15	2	0	0	1	1	0	0	0	0	0	**4**
Westwood Centre	Teesside	CYPS	12	0	2	1	0	0	0	0	0	0	1	**4**
Kestrel/Kite.	Forensics	Forensics LD	16	0	1	1	0	2	0	0	0	0	0	**4**
Bankfields Unit 2	Teesside	LD	5	0	2	1	0	1	0	0	0	0	0	**4**
Westerdale North	Teesside	MHSOP	18	0	2	1	1	0	0	0	0	0	0	**4**
Oak Ward	Durham & Darlington	MHSOP	12	2	0	0	1	1	0	0	0	0	0	**4**
Jay Ward	Forensics	Forensics MH	5	2	1	0	0	1	0	0	0	0	0	**4**
Tunstall Ward	Durham & Darlington	Adults	20	0	2	0	1	0	0	0	1	0	0	**4**
Acomb Garth	York and Selby	MHSOP	14	0	2	0	1	0	0	0	0	0	0	**3**
Merlin	Forensics	Forensics MH	10	0	1	0	0	2	0	0	0	0	0	**3**
Cherry Tree House	York and Selby	MHSOP	18	0	1	0	1	1	0	0	0	0	0	**3**
Oak Rise	York and Selby	LD	8	0	0	1	1	1	0	0	0	0	0	**3**
Thistle	Forensics	Forensics LD	5	2	0	0	0	1	0	0	0	0	0	**3**
The Orchard	Teesside	Adults	0	2	0	0	0	1	0	0	0	0	0	**3**
Kilton View	Teesside	Adults	0	2	1	0	0	0	0	0	0	0	0	**3**
Overdale Ward	Teesside	Adults	18	0	2	0	1	0	0	0	0	0	0	**3**
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	0	2	0	1	0	0	0	0	0	0	**3**
Rowan Ward	North Yorkshire	MHSOP	6	0	0	1	1	1	0	0	0	0	0	**3**
Bankfields Flats	Teesside	LD	6	2	1	0	0	0	0	0	0	0	0	**3**
Linnet Ward	Forensics	Forensics MH	17	2	0	1	0	0	0	0	0	0	0	**3**
Harland Rehab Ward	Durham & Darlington	LD	1	0	1	0	1	1	0	0	0	0	0	**3**
Newtondale Ward	Forensics	Forensics MH	20	0	1	1	0	1	0	0	0	0	0	**3**
Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	1	1	0	0	0	1	0	0	**3**
Swift Ward	Forensics	Forensics MH	10	0	1	1	0	1	0	0	0	0	0	**3**
Farnham Ward	Durham & Darlington	Adults	20	0	0	1	1	1	0	0	0	0	0	**3**
Ward 14	North Yorkshire	MHSOP	10	2	0	0	1	0	0	0	0	0	0	**3**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	0	0	0	1	0	1	0	0	0	0	**2**
Bransdale Ward	Teesside	Adults	14	0	0	1	1	0	0	0	0	0	0	**2**
Cedar Ward (NY)	North Yorkshire	Adults	14	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**

Lark	Forensics	Forensics MH	17	0	0	1	0	1	0	0	0	0	0	**2**
Bek-Ramsey Ward	Durham & Darlington	LD	11	0	1	0	1	0	0	0	0	0	0	**2**
Bankfields Unit 3	Teesside	LD	6	2	0	0	0	0	0	0	0	0	0	**2**
Bilsdale Ward	Teesside	Adults	14	0	0	0	0	0	1	0	0	0	0	**1**
Brambling Ward	Forensics	Forensics MH	13	0	0	0	0	1	0	0	0	0	0	**1**
Minster Ward	York and Selby	Adults	12	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**
Lustrum Vale	Teesside	Adults	20	0	0	0	0	1	0	0	0	0	0	**1**
Thornaby Road	Teesside	Adults	5	0	1	0	0	0	0	0	0	0	0	**1**
Baysdale	Teesside	CYPS	6	0	0	0	0	0	0	0	0	0	0	**0**

Severity Scoring by Speciality

APPENDIX 4

WARD	Locality	Speciality	No. of Beds	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	Serious Incident	L4 Incident	L3 Incident	Complaints	Control & Restraint	TOTAL SCORE Mar
Danby Ward	North Yorkshire	Adults	11	0	0	0	1	0	1	0	0	0	0	**2**
Ward	North Yorkshire	Adults	11	2	1	1	1	1	0	0	0	0	0	**6**
Bedale Ward	Teesside	Adults	10	4	2	0	1	1	0	0	0	1	0	**9**
Bilsdale Ward	Teesside	Adults	14	0	0	0	0	0	1	0	0	0	0	**1**
Birch Ward	Durham & Darlington	Adults	15	2	2	1	1	2	0	0	0	0	0	**8**
Bransdale Ward	Teesside	Adults	14	0	0	1	1	0	0	0	0	0	0	**2**
Cedar Ward	Durham & Darlington	Adults	10	4	0	0	1	1	0	0	1	1	0	**8**
Cedar Ward (NY)	North Yorkshire	Adults	14	0	0	0	1	0	0	0	1	0	0	**2**
Ebor Ward	York and Selby	Adults	12	0	1	1	1	1	0	0	0	0	0	**4**
Elm Ward	Durham & Darlington	Adults	20	4	1	1	1	2	0	0	1	1	0	**11**
Farnham Ward	Durham & Darlington	Adults	20	0	0	1	1	1	0	0	0	0	0	**3**
Kirkdale Ward	Teesside	Adults	16	2	0	0	1	2	0	0	0	0	0	**5**
Lustrum Vale	Teesside	Adults	20	0	0	0	0	1	0	0	0	0	0	**1**
Maple Ward	Durham & Darlington	Adults	20	2	1	1	1	2	0	0	0	1	0	**8**
Minster Ward	York and Selby	Adults	12	0	0	0	1	0	0	0	0	0	0	**1**
Overdale Ward	Teesside	Adults	18	0	2	0	1	0	0	0	0	0	0	**3**
Primrose Lodge	Durham & Darlington	Adults	15	2	0	0	1	1	0	0	0	0	0	**4**
Stockdale Ward	Teesside	Adults	18	0	3	1	1	0	0	0	0	0	0	**5**
The Orchards (NY)	North Yorkshire	Adults	10	4	1	1	1	1	0	0	0	0	0	**8**
Tunstall Ward	Durham & Darlington	Adults	20	0	2	0	1	0	0	0	1	0	0	**4**
Ward 15 Friarage	North Yorkshire	Adults	12	2	2	1	1	1	0	0	1	0	0	**8**
Willow Ward	Durham & Darlington	Adults	15	2	1	0	1	1	0	0	0	0	0	**5**
Baysdale	Teesside	CYPS	6	0	0	0	0	0	0	0	0	0	0	**0**
Holly Unit	Durham & Darlington	CYPS	4	0	4	1	0	1	0	0	0	0	0	**6**
Newberry Centre	Teesside	CYPS	14	0	4	1	1	0	0	0	0	1	2	**9**
Talbot Direct Care	Durham & Darlington	CYPS	1	6	0	0	0	0	0	0	0	0	0	**6**
Evergreen Centre	Teesside	CYPS	16	2	1	0	1	0	0	0	1	0	2	**7**
Westwood Centre	Teesside	CYPS	12	0	2	1	0	0	0	0	0	0	1	**4**

Clover/Ivy	Forensics	Forensics LD	12	0	1	0	1	2	0	0	0	0	1	**5**
Eagle/Osprey	Forensics	Forensics LD	10	6	0	0	1	1	0	0	0	0	0	**8**
Harrier/Hawk	Forensics	Forensics LD	10	0	1	1	0	2	0	0	0	0	0	**4**
Kestrel/Kite.	Forensics	Forensics LD	16	0	1	1	0	2	0	0	0	0	0	**4**
Langley Ward	Forensics	Forensics LD	10	2	0	1	0	1	0	0	0	0	0	**4**
Northdale Centre	Forensics	Forensics LD	12	2	1	1	1	1	0	0	0	0	0	**6**
Oakwood	Forensics	Forensics LD	8	0	1	0	1	2	0	0	0	0	0	**4**
Thistle	Forensics	Forensics LD	5	2	0	0	0	1	0	0	0	0	0	**3**
Brambling Ward	Forensics	Forensics MH	13	0	0	0	0	1	0	0	0	0	0	**1**
Jay Ward	Forensics	Forensics MH	5	2	1	0	0	1	0	0	0	0	0	**4**
Lark	Forensics	Forensics MH	17	0	0	1	0	1	0	0	0	0	0	**2**
Linnet Ward	Forensics	Forensics MH	17	2	0	1	0	0	0	0	0	0	0	**3**
Mallard Ward	Forensics	Forensics MH	14	0	2	1	0	2	0	0	0	0	0	**5**
Mandarin	Forensics	Forensics MH	16	0	2	1	0	2	0	0	0	0	0	**5**
Merlin	Forensics	Forensics MH	10	0	1	0	0	2	0	0	0	0	0	**3**
Newtondale Ward	Forensics	Forensics MH	20	0	1	1	0	1	0	0	0	0	0	**3**
Nightingale Ward	Forensics	Forensics MH	16	0	0	1	0	1	0	0	0	0	0	**2**
Sandpiper Ward	Forensics	Forensics MH	8	0	1	0	0	1	0	0	0	0	2	**4**
Swift Ward	Forensics	Forensics MH	10	0	1	1	0	1	0	0	0	0	0	**3**
Aysgarth	Teesside	LD	6	0	0	0	0	1	0	0	0	0	0	**1**
Bankfields Flats	Teesside	LD	6	2	1	0	0	0	0	0	0	0	0	**3**
Bankfields Unit 2	Teesside	LD	5	0	2	1	0	1	0	0	0	0	0	**4**
Bankfields Unit 3	Teesside	LD	6	2	0	0	0	0	0	0	0	0	0	**2**
Bankfields Unit 4	Teesside	LD	6	4	0	0	0	1	0	0	0	0	0	**5**
Bek-Ramsey Ward	Durham & Darlington	LD	11	0	1	0	1	0	0	0	0	0	0	**2**
Harland Rehab Ward	Durham & Darlington	LD	1	0	1	0	1	1	0	0	0	0	0	**3**
Oak Rise	York and Selby	LD	8	0	0	1	1	1	0	0	0	0	0	**3**
The Lodge	Teesside	LD	1	8	0	0	0	0	0	0	0	0	0	**8**
Acomb Garth	York and Selby	MHSOP	14	0	2	0	1	0	0	0	0	0	0	**3**
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	0	2	0	1	0	0	0	0	0	0	**3**
Cherry Tree House	York and Selby	MHSOP	18	0	1	0	1	1	0	0	0	0	0	**3**
Hamsterley Ward	Durham & Darlington	MHSOP	15	0	2	1	1	2	0	0	0	0	0	**6**
Meadowfields	York and Selby	MHSOP	14	2	0	1	1	1	0	0	0	0	0	**5**
Oak Ward	Durham & Darlington	MHSOP	12	2	0	0	1	1	0	0	0	0	0	**4**
Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	1	1	0	0	0	1	0	0	**3**

Rowan Lea	North Yorkshire	MHSOP	20	2	2	1	1	0	1	1	0	0	0	**8**
Rowan Ward	North Yorkshire	MHSOP	6	0	0	1	1	1	0	0	0	0	0	**3**
Springwood	North Yorkshire	MHSOP	14	2	1	1	1	1	0	0	0	0	1	**7**
Ward 14	North Yorkshire	MHSOP	10	2	0	0	1	0	0	0	0	0	0	**3**
Westerdale North	Teesside	MHSOP	18	0	2	1	1	0	0	0	0	0	0	**4**
Westerdale South	Teesside	MHSOP	14	4	2	0	1	2	0	0	0	0	1	**10**
Kilton View	Teesside	Adults	0	2	1	0	0	0	0	0	0	0	0	**3**
The Orchard	Teesside	Adults	0	2	0	0	0	1	0	0	0	0	0	**3**
Thornaby Road	Teesside	Adults	5	0	1	0	0	0	0	0	0	0	0	**1**

Severity Scoring Year to Date Position

APPENDIX 5

WARD	Locality	Speciality	No. of Beds	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	Serious Incident	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	Control & Restraint	TOTAL SCORE (Mar)	YTD Total Score (Mar - Mar)
Clover/Ivy	Forensics	Forensics LD	12	0	1	0	1	2	0	0	0	0	1	**5**	**87**
Newberry Centre	Teesside	CYPS	14	0	4	1	1	0	0	0	0	1	2	**9**	**85**
Bedale Ward	Teesside	Adults	10	4	2	0	1	1	0	0	0	1	0	**9**	**81**
Cedar Ward	Durham & Darlington	Adults	10	4	0	0	1	1	0	0	1	1	0	**8**	**81**
Springwood	North Yorkshire	MHSOP	14	2	1	1	1	1	0	0	0	0	1	**7**	**80**
Sandpiper Ward	Forensics	Forensics MH	8	0	1	0	0	1	0	0	0	0	2	**4**	**78**
Evergreen Centre	Teesside	CYPS	16	2	1	0	1	0	0	0	1	0	2	**7**	**77**
Westerdale South	Teesside	MHSOP	14	4	2	0	1	2	0	0	0	0	1	**10**	**76**
Talbot Direct Care	Durham & Darlington	CYPS	1	6	0	0	0	0	0	0	0	0	0	**6**	**72**
Northdale Centre	Forensics	Forensics LD	12	2	1	1	1	1	0	0	0	0	0	**6**	**72**
Meadowfields	York and Selby	MHSOP	14	2	0	1	1	1	0	0	0	0	0	**5**	**70**
Ward 15 Friarage	North Yorkshire	Adults	12	2	2	1	1	1	0	0	1	0	0	**8**	**68**
Merlin	Forensics	Forensics MH	10	0	1	0	0	2	0	0	0	0	0	**3**	**68**
Mandarin	Forensics	Forensics MH	16	0	2	1	0	2	0	0	0	0	0	**5**	**67**
Westwood Centre	Teesside	CYPS	12	0	2	1	0	0	0	0	0	0	1	**4**	**64**
Maple Ward	Durham & Darlington	Adults	20	2	1	1	1	2	0	0	0	1	0	**8**	**63**
Acomb Garth	York and Selby	MHSOP	14	0	2	0	1	0	0	0	0	0	0	**3**	**63**
Bransdale Ward	Teesside	Adults	14	0	0	1	1	0	0	0	0	0	0	**2**	**63**
Elm Ward	Durham & Darlington	Adults	20	4	1	1	1	2	0	0	1	1	0	**11**	**62**
Eagle/Osprey	Forensics	Forensics LD	10	6	0	0	1	1	0	0	0	0	0	**8**	**61**
Cherry Tree House	York and Selby	MHSOP	18	0	1	0	1	1	0	0	0	0	0	**3**	**59**
Hamsterley Ward	Durham & Darlington	MHSOP	15	0	2	1	1	2	0	0	0	0	0	**6**	**58**
Kestrel/Kite.	Forensics	Forensics LD	16	0	1	1	0	2	0	0	0	0	0	**4**	**58**
Birch Ward	Durham & Darlington	Adults	15	2	2	1	1	2	0	0	0	0	0	**8**	**57**
Danby Ward	North Yorkshire	Adults	11	0	0	0	1	0	1	0	0	0	0	**2**	**56**
Lustrum Vale	Teesside	Adults	20	0	0	0	0	1	0	0	0	0	0	**1**	**56**
Esk Ward	North Yorkshire	Adults	11	2	1	1	1	1	0	0	0	0	0	**6**	**55**
Oak Rise	York and Selby	LD	8	0	0	1	1	1	0	0	0	0	0	**3**	**55**

Rowan Ward	North Yorkshire	MHSOP	6	0	0	1	1	1	0	0	0	0	0	**3**	**55**
The Lodge	Teesside	LD	1	8	0	0	0	0	0	0	0	0	0	**8**	**54**
Ebor Ward	York and Selby	Adults	12	0	1	1	1	1	0	0	0	0	0	**4**	**53**
Cedar Ward (NY)	North Yorkshire	Adults	14	0	0	0	1	0	0	0	1	0	0	**2**	**52**
Holly Unit	Durham & Darlington	CYPS	4	0	4	1	0	1	0	0	0	0	0	**6**	**51**
Newtondale Ward	Forensics	Forensics MH	20	0	1	1	0	1	0	0	0	0	0	**3**	**51**
The Orchards (NY)	North Yorkshire	Adults	10	4	1	1	1	1	0	0	0	0	0	**8**	**50**
Mallard Ward	Forensics	Forensics MH	14	0	2	1	0	2	0	0	0	0	0	**5**	**50**
Harrier/Hawk	Forensics	Forensics LD	10	0	1	1	0	2	0	0	0	0	0	**4**	**49**
Swift Ward	Forensics	Forensics MH	10	0	1	1	0	1	0	0	0	0	0	**3**	**49**
Brambling Ward	Forensics	Forensics MH	13	0	0	0	0	1	0	0	0	0	0	**1**	**49**
Oakwood	Forensics	Forensics LD	8	0	1	0	1	2	0	0	0	0	0	**4**	**47**
Overdale Ward	Teesside	Adults	18	0	2	0	1	0	0	0	0	0	0	**3**	**46**
Lark	Forensics	Forensics MH	17	0	0	1	0	1	0	0	0	0	0	**2**	**46**
Bilsdale Ward	Teesside	Adults	14	0	0	0	0	0	1	0	0	0	0	**1**	**46**
Langley Ward	Forensics	Forensics LD	10	2	0	1	0	1	0	0	0	0	0	**4**	**45**
Nightingale Ward	Forensics	Forensics MH	16	0	0	1	0	1	0	0	0	0	0	**2**	**45**
Primrose Lodge	Durham & Darlington	Adults	15	2	0	0	1	1	0	0	0	0	0	**4**	**44**
Bankfields Flats	Teesside	LD	6	2	1	0	0	0	0	0	0	0	0	**3**	**44**
Stockdale Ward	Teesside	Adults	18	0	3	1	1	0	0	0	0	0	0	**5**	**43**
Bankfields Unit 4	Teesside	LD	6	4	0	0	0	1	0	0	0	0	0	**5**	**39**
Kirkdale Ward	Forensics	Adults	16	2	0	0	1	2	0	0	0	0	0	**5**	**39**
Jay Ward	Forensics	Forensics MH	5	2	1	0	0	1	0	0	0	0	0	**4**	**39**
Thistle	Forensics	Forensics LD	5	2	0	0	0	1	0	0	0	0	0	**3**	**39**
Linnet Ward	Forensics	Forensics MH	17	2	0	1	0	0	0	0	0	0	0	**3**	**39**
Willow Ward	Durham & Darlington	Adults	15	2	1	0	1	1	0	0	0	0	0	**5**	**38**
Minster Ward	York and Selby	Adults	12	0	0	0	1	0	0	0	0	0	0	**1**	**36**
Bek-Ramsey Ward	Durham & Darlington	LD	11	0	1	0	1	0	0	0	0	0	0	**2**	**32**
Bankfields Unit 2	Teesside	LD	5	0	2	1	0	1	0	0	0	0	0	**4**	**30**
Ward 14	North Yorkshire	MHSOP	10	2	0	0	1	0	0	0	0	0	0	**3**	**27**
Bankfields Unit 3	Teesside	LD	6	2	0	0	0	0	0	0	0	0	0	**2**	**27**
Aysgarth	Teesside	LD	6	0	0	0	0	1	0	0	0	0	0	**1**	**27**
Rowan Lea	North Yorkshire	MHSOP	20	2	2	1	1	0	1	1	0	0	0	**8**	**26**
Westerdale North	Teesside	MHSOP	18	0	2	1	1	0	0	0	0	0	0	**4**	**26**
Farnham Ward	Durham & Darlington	Adults	20	0	0	1	1	1	0	0	0	0	0	**3**	**26**

Tunstall Ward	Durham & Darlington	Adults	20	0	2	0	1	0	0	0	1	0	0	**4**	**24**
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	0	2	0	1	0	0	0	0	0	0	**3**	**22**
Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	1	1	0	0	0	1	0	0	**3**	**18**
Oak Ward	Durham & Darlington	MHSOP	12	2	0	0	1	1	0	0	0	0	0	**4**	**16**
The Orchard	Teesside	Adults	0	2	0	0	0	1	0	0	0	0	0	**3**	**16**
Kilton View	Teesside	Adults	0	2	1	0	0	0	0	0	0	0	0	**3**	**13**
Baysdale	Teesside	CYPS	6	0	0	0	0	0	0	0	0	0	0	**0**	**13**
Harland Rehab Ward	Durham & Darlington	LD	1	0	1	0	1	1	0	0	0	0	0	**3**	**7**
Thornaby Road	Teesside	Adults	5	0	1	0	0	0	0	0	0	0	0	**1**	**1**

ITEM 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 24 April 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 informal QuAC meeting held on 05 April 2018:

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

Key matters considered by the Committee are summarised as follows:

- The Locality areas of Durham and Darlington and Tees services where key concerns were around Tier 4 services, illicit substances being used on Wards, medical vacancies and the continued lack of nursing home provision.
- Reports from the Patient Safety Group and Patient Experience Group.
- CQC compliance and Safeguarding & Public Protection assurance updates.
- Note the suggested amendments to the Draft Quality Account 2017/18.
- Clinical Re-Audit of Emergency Response Bags
- Drug and Therapeutics Report.
- The annual Committee Performance Evaluation Results

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 05 April 2018.
- Note the confirmed notes of the informal meeting held on 08 March 2018 (Annex 1).
- Support the recommendation to approve the draft Quality Account 2017/18.
- Note the matters which could impact on the Trust's risks around agency staffing and illicit substances coming onto Wards leading to violence and aggression.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 24 April 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 05 April 2018.

2. BACKGROUND INFORMATION AND CONTEXT

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

3. KEY ISSUES

The Committee received updates from the Locality Directors of Operations around the principal risks and concerns, together with assurances and progress from Durham and Darlington 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 DURHAM AND DARLINGTON LMGB

The Committee discussed the LMGB report for Durham and Darlington.

The top areas of concern discussed were:

1. Tier 4 services and being unable to respond to the needs of complex young people, which resulted in a 16 year old being admitted to an adult ward for a period of 14 nights.

Assurance was provided that this matter is being discussed at EMT and within the Tees locality to try and make improvements, however the issues were wide ranging and were impacted by the national CAMHS provision.

2. Substance misuse on inpatient adult wards

There have been a number of instances in recent months of substance misuse on wards which has resulted in near misses, episodes of violence and inpatient deaths.

The Committee acknowledged that this is a serious growing problem, not only in Durham and Darlington but also in Teesside and actions will be taken to look at preventing the supply of drugs onto wards. A drug detection dog will be brought onto wards and security of the perimeter of wards will also be reviewed. The adult SDG is holding an event to consider the risks and associated actions.

Committee members expressed their concerns with drugs coming into Wards, not only to the detriment of patients but also the impact this will have on staff due to violence and aggression from patients.

It was agreed that this should be added to the locality risk register and the Board risk on violence and aggression be reviewed.

3. CQC visits to Maple Ward and Elm Ward

   There has been considerable negative feedback from the CQC following a mock quality visit regarding Maple Ward, predominantly around processes and the environment.

   Assurance was provided to the Committee that there has been a change in the Ward leadership and there would be work undertaken to ensure more robust processes are being adhered to.

   With regards to Elm Ward, feedback from the CQC on a recent MHA Inspection revealed that patients had verbally raised concerns about staff sleeping on night duty.

   Following an extensive review of CCTV footage there was no conclusive evidence of staff sleeping however some concerns have been raised over the standard of work ethic around agency and a small number of permanent staff.

   This has been followed up with random night visits, there will be further review of CCTV footage and there will be the appointment of a Duty Nurse Coordinator who will provide an on-site presence at night.

The Committee welcomed the agreement of funding for ASD for a two site model for a rapid assessment process based at Stanley Health Centre and Holly Unit. This was following a successful brief pilot period where the team have gone from a concept to a working model within five weeks.

4.2 **TEES LMGB**

The Committee discussed the LMGB report for Tees

The top areas of concern discussed were:

1. Drug related serious incidents.
   There have been two drug related deaths involving inpatients on the same ward at Roseberry Park Hospital. One occurred on the ward whilst the other took place while the patient was on leave.
   The locality will be feeding into discussions at SDG level around the management of substance misuse including drugs being brought onto hospital sites.

2. Medical vacancies.
   There are issues in MHSOP due to medical staffing availability for Westerdale South which is a concern.

Assurance was provided that remedial actions are being taken.

3. Nursing Homes
This well-rehearsed issue continues to cause problems with a lack of nursing homes for older people leading to referrals into nursing homes that are clearly not working as well as they should be.

The Committee acknowledged the dedicated team of staff on Westerdale South who faced many challenging and complex patients, yet morale remains high.

It was a concern however that the issue of the standards from agency staff was raised again and this has been escalated to EMT with plans for a contract review meeting on 26 April 2018 where these and other localities concerns will be fed back.

The Chief Executive noted that all individual case details will be reviewed.

4.3 Patient Safety

The Committee received the assurance report of the Patient Safety Group, the Patient Safety Quality Report for the period 1 to 31 January 2018 and the Never Events List 2018.

The key matters discussed were:

- Patient moving and handling risk assessments.
Concerns have been raised about staff access to patients moving and handling risk assessments and the risk that this can pose to patients and staff.
Assurance was provided that this will be discussed further at the Clinical Leaders Group.

- Ongoing issues regarding competency monitoring for bank and agency staff, in particular around engagement and observation processes.
Risks and potential remedies have been considered and this will be discussed further at OMT.

- Considering 'always events' and how other Trusts are looking at this in terms of a cultural change to make staff think differently.

- Mortality Review
February data was presented to the group using the Mazars tool for death categorisation. The data identified there was a total of 22 expected deaths for patients on CPA reported in February 2018; at the time of the meeting the causes of death for 15 patients was still awaited. The group also reviewed deaths from September 2017, December 2017 and January 2018 for which cause of death had now been established. It was agreed that further investigation was required for 3 of the incidents reviewed.
The group reviewed the updated Structured Judgement Review template and agreed that with some minor adaptation this would be used for future reviews.

- Detailed analysis in relation to: Serious Incidents, Level 3 incidents (Self Harm Only), Use of physical intervention and Seclusions.

- A 13 month breakdown of the number of incidents requiring physical intervention by locality. During the reporting period Tier 4 CAMHS Services reported the most incidents requiring the use of physical intervention with 283 incidents reported in total which is an increase of 16 compared to the figure reported in December 2017. It was noted that two patients accounted for a high level of this activity.

4.4 **Patient Experience**

The Committee received the Patient Experience Group report for information and noted that a full report will be presented to the May 2018 QuAC meeting.

4.5 **Safeguarding and Public Protection**

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

The key matters discussed were:

- There has been a significant amount of activity with external partners around safeguarding and a number of serious case reviews that are taking place, which the Trust is involved with particularly involving the Durham locality.

- A domestic homicide review has commenced in Middlesbrough where the perpetrator was the son of the victim. The Trust has only had contact with the victim and has completed the IMR. Recommendations for the Trust received have been around Domestic Abuse training and the raising of awareness and these have been mostly completed.

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 position of compliance with the CQC and Ofsted registration requirements.

The key matters discussed were:

- The Committee noted that the Trust received the formal Provider Information Request (PIR) on 13 March 2018 and preparations are underway to collate all the necessary documentation.

- There have been six MHA review inspections in the last month with recurrent issues still being reported, such as restrictive practices and blanket restrictions.

- The committee expressed concerns that there seemed to be inconsistency between the outcomes of Trust peer reviews and MHA reviews. It was agreed to look into this as restrictive practices may be being reported under environmental issues.

- Assurance was provided that work is on-going to ensure that blanket restrictions and restrictive practices are agreed, recorded and reviewed through QuAGs.

- It was noted that there are instances where the Trust may take a differing view to the CQC such as a recent visit where it was advised that the courtyard door could be left open at night with additional lights outside. The Trust has taken a position to lock the external doors at night once patients are in bed for security and safety reasons and that patients could have facilitated access dependant on individual needs.

5.2 **Draft Quality Account 2017/18**

The Committee received and considered the Draft Quality Account 2017/18.

The following comments were put forward by Committee members for inclusion in the Quality Account before being considered by the Audit Committee and Board.

1. Page 61: table of single oversight framework be amended to explain that the Trust has not placed people inappropriately out of the Trust, only out of the locality area.
2. Page 57: provide further explanation around patients feeling safe on the Ward and to explain how the stretch targets work.
3. Page 42: learning from deaths and the number of patients that have died, to include the age profiles and in context with the patients we treat.

5.5 **Clinical Audit of Emergency Response Bags (Re-audit)**

The Committee considered the third clinical re-audit of emergency response bags.

The key areas to note are:

- There has been improvement with 31 teams achieving compliance levels for all audit criteria. There are however still 5 teams who remain non-compliant.
- The key areas of risk remain for those who are non-compliant with one instance out of six adult/children areas, where there the proper equipment was not in place. It was also found that there is a lack of daily checks of equipment.
  Assurance was provided that the equipment has now been ordered.

The Committee expressed ongoing concern around the inability to bring this audit up to full compliance and agreed that there will be a focus in locality areas by Matrons fortnightly, random sampling and a quarterly re-audit which will report back into QuAC.

Committee members also queried the Trust criteria for the location of Emergency Response Bags in community bases and staff expectations in areas where the bags are not cited and it was agreed that a report will go back to QuAC in September 2018 outlining this in more detail.

5.6 **Drug and Therapeutics**

The Committee received and noted the report of the Drug and Therapeutics Committee, together with the Pharmacy & Medicines Optimisation Annual Plan.

The key matters raised were:

- The TEWV policy for medicines has been revised and approved by EMT.
- New national guidance has been produced regarding the safe transfer of prescribing responsibilities between secondary and primary care, which is broadly in line with the existing TEWV Safe Transfer of Prescribing Guidance.
- The Annual Plan for Pharmacy and Medicines Optimisation will focus on six key areas aligned to the strategic priorities of the Trust business plan and NICE medicines optimisation guidance.

5.7 **Annual Committee Performance Results 2017/18**

The Committee considered the results of the annual Committee performance assessment.

The key areas for action going forward will be the boundaries between the QuAC, Mental Health Legislation Committee and to some degree the Audit Committee. Communication between QuAC and the LMGBs to standardise and streamline the reporting and to ensure that the Committee is being provided with the key lines of assurance.

This work is currently ongoing and under development, however the overall results of the assessment were very positive and lots of improvement has been made in the last year.

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

The main issue to impact on the Trust's risks is around the supply and misuse of drugs in inpatient areas and the effect this is having both on patients and staff.

The other area of concern is the quality of agency staffing.

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 05 April 2018.*
(ii) *Note the confirmed notes of the informal meeting held on 1 March 2018.*
(iii) *Note the areas of concern that may impact on the Trust's strategic risks around the quality of agency staffing and the issue of drugs on inpatient areas leading to violence and aggression towards staff.*

Elizabeth Moody
Director of Nursing and Quality Governance
April 2018

Annex 1

NOTES OF THE INFORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 8 MARCH 2018, IN STAFF MEETING ROOM 2, WEST PARK HOSPITAL, DARLINGTON AT 9.30AM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mrs Lesley Bessant, Chairman of the Trust
Mr David Brown, Acting Chief Operating Officer
Dr Ahmad Khouja, Medical Director Designate
Mrs Jennifer Illingworth, Director of Quality Governance

In attendance:
Mr Tim Cate, Director of Services for North Yorkshire
Dr Suresh Babu, Clinical Director, Durham & Darlington
Mrs Sarah Daniel, Research & Development Manager
Mr Anthony Davison, Head of Nursing, York & Selby
Mrs Ruth Hill, Director of Services for York & Selby
Mr Chris Lanigan, Head of Planning & Business Development
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mrs Emma Rolfe, Named Nurse for Safeguarding
Mrs Nicki Smith, Named Nurse for Safeguarding
Mrs Leanne McCrindle, Head of Quality Governance and Compliance

18/18 APOLOGIES FOR ABSENCE

Apologies for absence were received from: Mr Colin Martin, Chief Executive, Mrs Karen Agar, Associate Director of Nursing and Governance, Dr Ingrid Whitton, Deputy Medical Director, Durham & Darlington, Mrs Elizabeth Moody, Director of Nursing & Governance, Mr Richard Simpson, Non-Executive Director, Mrs Shirley Richardson, Non-Executive Director, Professor Joe Reilly, Head of Research & Governance and Dr Neil Mayfield, Clinical Director North Yorkshire.

18/19 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 01 February 2018 would be deferred to the 5 April 2018 QuAC meeting to be formally agreed due to the 1 March 2018 meeting being inquorate.

18/20 ACTION LOG

The Committee discussed the QuAC Action Log, noting that the actions would be formally signed off at the 5 April 2018 QuAC meeting.

The following update was noted.

17/163 Patient Safety Group: provide more detailed report on significant increase in the number of restrictive practices in children and young people compared with Q2.
It was noted that Mr Stephen Davison would be providing a presentation on this matter at the April 2018 QuAC meeting.

18/21 NORTH YORKSHIRE SERVICES LMGB REPORT

The Committee noted the North Yorkshire Services LMGB Report.

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

(1) Adult Mental Health inpatient recruitment, particularly Cedar Ward where there had been a 'stop the line' in place over the past couple of months. Interviews were planned, which would hopefully fill some vacancies for band 6 and band 3 posts.

(2) LD Transforming Care with a lack of decisions being made by Commissioners on the development of the enhanced community service.

(3) Challenges meeting the CAMHS eating disorders access and waiting times standards, however there was now a clearer understanding between NHS England and Commissioners.

Committee members expressed concerns (born from a recent SI investigation) over the interaction between Children's crisis teams and community teams and the protocols for the movement of children from one to the other.

Assurance was provided that this issue was being picked up by the Director of Operations - North Yorkshire.

Following discussion other points noted were:

(1) Work was underway around repairing the floor on Rowan Ward which had impacted on bed capacity; however no out of area beds had been required.
(2) Waiting time targets remained challenging for follow up from assessment. A new working group would be progressing improvements following a Kaizen in 2017.
(3) The stop the clock terminology used for Wards experiencing issues was explained to members that there would be daily calls involving managers, review of rotas ad close daily supervision.
(4) A member of the administrative team had walked five miles during the heavy snow to cover work in the Redcar area and members acknowledged the commitment and dedication of TEWV staff.

18/22 YORK AND SELBY SERVICES LMGB REPORT

The Committee noted the York and Selby Services LMGB Report.

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

(1) Managing the transition of services from Humber to TEWV, where cases had been taken on with no significant issues. There were differing expectations around workload, however this would be monitored closely.
(2) Challenges around information governance and maintaining the safety of records, as well as Paris not being used correctly. Messages were being reinforced to staff.
(3) Risk 302 on the Risk Register; that adverse clinical outcomes may occur as a result of historical clinical information being held on three different systems in the York and Selby locality.
On this matter it was noted that there had been some serious incidents where the question had been asked whether the right information has been accessed. Work was underway to improve access to the right information for clinical staff in a timely manner.

(4) Access and Well-being Service and IAPT and commissioning expectations.
(5) Addressing capacity and demand issues with ongoing issues in CAMHS services.

Following discussion the Chairman noted a very positive visit to Peppermill Court in York where the commitment of the Ward Manager and staff was evident, despite the recent changes and challenges.

18/23 INFECTION, PREVENTION AND CONTROL REPORT

The Committee noted the Infection, Prevention and Control quarterly report for October – December 2017.

Arising from the report it was noted that:

(1) Key performance indicators had been agreed for the Essential Steps Monitoring, IPC Audit Compliance, reported infections and the National Specification for Cleanliness.
On this matter it was highlighted that there were still occasions when the Essential Steps data was not returned and this had been found to occur when there was staff movement and changes at Ward Manager level.
(2) One risk had been identified around the cleaning scores from the National Standards of Cleanliness audits undertaken by Hotel Services and Matrons would continue to review the reasons for the declines in scores.
(3) The Infection Control Nurses would be undertaking audits of the Physical Healthcare Clinics in the community and this had been well received with actions being progressed very quickly.

Assurance was provided that there were rigorous Infection, Prevention and Control systems and processes in place.

1824 PATIENT SAFETY GROUP REPORT

The Committee noted the Patient Experience Group assurance report, the Patient Safety Quality Report for December 2017 and the Positive and Safe Update Report for Q3.

Arising from the reports it was noted that:

(1) The locality wide CPA action plan for York and Selby still had some actions outstanding following some serious incidents when the services were first taken over. These would be picked up at the next Patient Safety Group when a representative was present from the locality.
(2) There had been concerns over the results of the Duty of Candour audit where it had been difficult to track evidence where apologies were given or letters sent concerning applicable moderate harm incidents. Audit One were currently undertaking an audit in this area and more detailed information would be provided at a future QuAC meeting.
(3) The level of acuity continued to grow in complexity and it was acknowledged that the risks to staff, as well as service users, skill mix and staffing levels would need to be monitored closely.

Following discussion it was noted that there had been some misinterpretation by nursing staff leading to some emerging themes around safe medication practice. This had been picked up by Mr C Williams, Lead Pharmacist who had included a briefing in the Pharmacy bulletin around the importance of legible handwriting.

Assurance was provided that there was robust monitoring of the quality and performance indicator data, planned work streams and system implementation relating to patient safety.

Members welcomed the updated and improved presentation of the reports.

Mr David Brown left the meeting

18/25 SAFEGUARDING & PUBLIC PROTECTION REPORT

The Committee noted the report for Safeguarding and Public Protection.

Arising from the report it was noted that:

(1) The Trust continued to meet the legal requirements for safeguarding adults and children within the legislative framework.
(2) A SEND inspection (Special Educational Needs and Disabilities) had been announced in Redcar and Cleveland which would commence on 26 February 2018.
(3) There were a number of serious case reviews, particularly in Durham and there had been a significant increase in the number of case reviews put forward for consideration.

Mrs Bessant queried the level of competence around referrals for safeguarding and it was noted that there has been an increase in awareness, evidenced by the amount of advice being sought around complex cases and the increasing numbers of supervisions.

18/26 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee noted the Compliance with CQC Registration Requirements Report.

Arising from the report it was noted that:

(1) There had been two recent CQC Mental Health Act (MHA) inspections; however the final reports had not yet been received.

(2) Following registration with Ofsted, Baysdale Unit had received its first unannounced inspection on 5 February 2018 - the final report had not yet been received.

Following discussion it was noted that preparation was underway for the pending CQC compliance inspections with locality based Champions in place for all specialties. The peer review inspections were continuing and being well received.

Members of the Committee expressed their concerns once again over the repeated issues being raised in MHA inspections and discussed whether there might be any correlation with the use of bank and agency staff.

18/27 DRAFT CLINICAL AUDIT PROGRAMMES 2018/19

The Committee discussed the draft Clinical Audit Programmes for 2018/19 (Appendix 1) and the capacity and demand data (Appendix 2).

Arising from the report it was noted that:

(1) The Trust paid a mandated fee of £10,000 for the national clinical audit of anxiety and depression (NCAAD).
On this matter it was highlighted that this audit would take up a lot of capacity due to data being collected on service users' care and treatment over a period of six months from their date of admission.

(2) The Clinical Audit team was now fully staffed and with the continuation of the annual 20% reduction in the audit programme this would minimise the impact of clinical audits in clinical areas.

(3) The approval of the Clinical Audit Programme would be escalated to the Board of Directors for approval on 27 March 2018 due to QuAC not being quorate after being reviewed and accepted by the Audit Committee on 15 March 2018.

18/28 RESEARCH GOVERNANCE EXCEPTION REPORT

The Committee noted an exception report from the Research Governance Group.

Arising from the report it was highlighted that:

(1) The report had been provided to the Committee for information in relation to a research manuscript publication submitted to the editor of an academic journal by a previous Trust employee where ethical approval had not been sought for the research.
(2) The publication had not been submitted to any other journals.

Assurance was provided to the Committee that following a formal investigation by the Research Governance team, the logging of a Datix incident, a report with recommendations including the production of an SBARD that no patient data has left the Trust. In addition, some guidance would be published Trust wide setting out the differences between clinical audits and research proposals.

18/29 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no exceptions to report.

18/30 ANY MATTERS DISCUSSED TO BE ESCALATED TO THE BOARD OF DIRECTORS THAT MIGHT IMPACT ON THE TRUST'S STRATEGIC OR KEY OPERATIONAL RISKS.

There were no matters of escalation.

18/31 ANY OTHER BUSINESS

Quality Account Mandatory Indicators

The Committee received a tabled briefing note setting out the quality account mandatory indicators.

In particular the following was highlighted:

(1) The new guidance from NHS Improvement sets out that there are mandated indicators for inclusion in the 2018/19 Quality Account.

(2) The Council of Governors had been tasked with choosing a local indicator at the Quality Account Task and Finish Group on 8 March 2018. These were grouped around patient safety measures, clinical effectiveness and patient experience measures.

The local indicator chosen by the Council of Governors was the "number of incidents of physical intervention/restraint per 1000 occupied bed days".

18/32 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 5 April 2018, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

The meeting concluded at 11.40am

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ITEM 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24 April 2018**
TITLE:	**Thematic Review in relation to 'Feeling Safe'**
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 the findings following a thematic review following concerns expressed by patients and or their carers regarding not 'feeling safe' as highlighted within the patient experience feedback received.

Data from Quarter 4 2017/18 highlights that 86% of those surveyed would recommend the service to friends and family. 4,966 surveys were received in Q4 resulting in 6,811 individual coded comments of which 77 (1.13%) negative comments were received regarding 'feeling safe'.

The highest sub categories of 'feeling safe' related to personal illness and other patients.

Elm Ward received the single highest number of negative comments (8 in total) in relation to 'feeling safe' followed by Newberry with 7. Governance arrangements are in place to ensure the effective monitoring of patient experience feedback and escalation where appropriate.

There are a number of initiatives that are in place across the Trust with regards to further exploring and resolving any issues in relation to 'feeling safe'. To enhance the work that is already underway within operational clinical services it is proposed that the Expert's by Experience work with each locality to further develop strategies whereby patient experience concerns can be highlighted and escalated accordingly within the Trust.

Recommendations:

That the Board of Directors note the information within this report and consider any further actions to support the monitoring and escalating of patient experience feedback.

MEETING OF:	**Board of Directors**
DATE:	**24 April 2018**
TITLE:	**Thematic Review in relation to 'Feeling Safe'**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of the findings following a thematic review of the 'feeling safe' category following the coding of the comments from the patient and carer friends and family test survey.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 All services have systems in place to ensure that patients and carers are aware that they can leave feedback on their experience at any time. These include post boxes, paper surveys and or kiosks in reception areas.

2.2 As a **minimum** surveys should be specifically offered by clinicians at the various touchpoints, these are identified in full at Appendix 1 of this report.

2.3 Inpatient services are expected to survey **70%** of all eligible patients. Community services are expected to achieve a **10%** response rate calculated using activity data extracted from the IIC (where available) as the denominator and the total number of patient and parent-carer surveys returned in that month as the numerator.

2.4 Achievement of the targets are monitored by the Patient Experience Group via the Patient & Carer Experience Performance Report submitted monthly and fed back to the locality QuAGs by the service representatives.

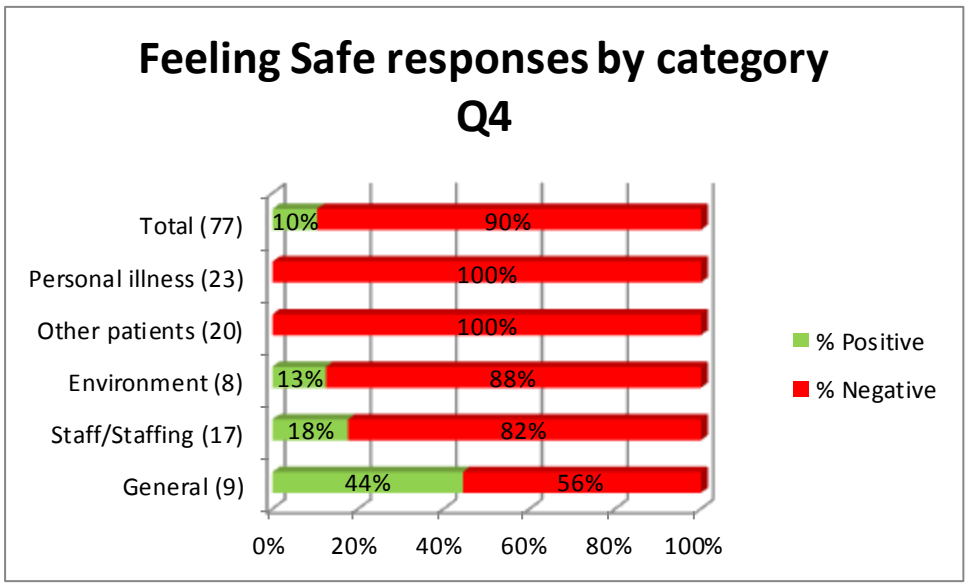
3. THEMATIC REVIEW:

3.1 "Feeling Safe" Data

3.1.1 **4,966** patient and carer experience surveys were completed by patients and or their carers during quarter 4 2017/18 of which **86%** would recommend the services to friends and family.

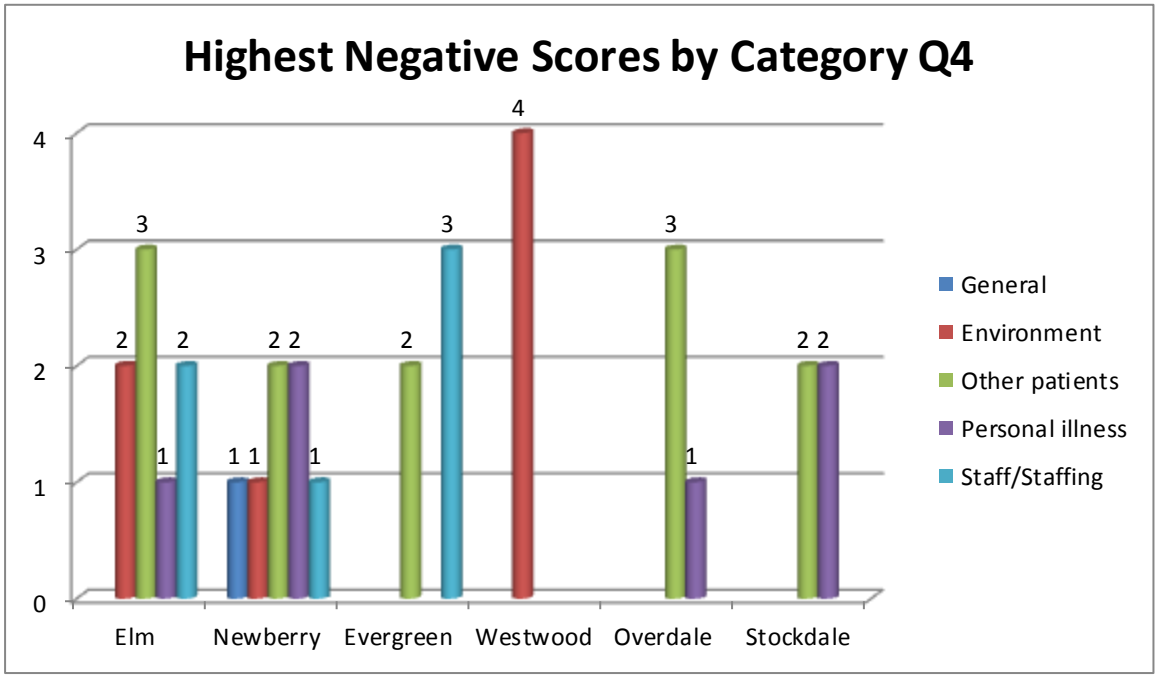
3.1.2 From the completed surveys **6,811** individual codes were applied to the narrative comments received of which **4,827** were positive. The remaining **1,984** comments that were coded negatively only **77** (1.13%) of these were coded against the 'felt safe' category in Q4.

3.1.3 The **77** narrative comments in relation to 'felt safe' can be further broken down providing a rational as to why they did not 'feel safe' as follows:



The highest reported reason related to the patients personal illness followed by the other patients on the ward.

3.1.4 The wards with the highest negative scores for Q4 using the 'felt safe' category, are as follows:



The graph shows that Elm Ward had the single highest number of negative comments in relation to 'felt safe' with a total of 8 of which 3 were in relation to other patients followed by the Environment and Staff. Newberry was the second highest with 7 negative comments during the quarter. This has been highlighted to the respective Head of Nursing and Head of Service for those localities/specialties.

3.2 Feeling Safe Initiatives

3.2.1 The quarterly results from the friends and family test are provided to each locality and are reviewed within each of the locality QuAG's.

3.2.2 The review highlighted that this information is being reviewed and has informed a number of initiatives across the trust a sample of which is detailed below:

Forensic Services:

- The Forensic wards are reviewing their data and where appropriate have individual conversations with service users about feeling safe. This includes exploring these issues in community meetings.
- Service user and carer events have been held using a number of different forums to look at the wider issues as well as looking into specific issues with individuals.
- Organisational Development has carried out some work on 'social safeness' with staff and patients with support and then at intervals this will be re-assessed by some key wards where it is felt this could be beneficial. Throughout April a number of training events have been arranged for the staff to better understand the patients from their perspective. Following these sessions the staff will re-group and see how they can better support the patients.
- The issues regarding 'feeling safe' within Forensic services predominantly relate to perceived risks of peers and individualised plans to support services users are developed in response to this.

Durham and Darlington:

- The Discharge Questionnaire that is completed by Skills for People (Independent Organisation) for all discharges has had an additional question added in relation to 'feeling safe'. In addition to this Skills for People also attend open sessions on the ward and will highlight whether any issues have been raised. This information is then collated into a report that is then shared with the individual services.

Teesside:

- Patient focus groups were held to try and understand the patient experience results further.
- This has become a standard agenda item on their patient meeting agendas to gain further feedback and suggestions for ways in which the services could improve.
- There is a well-established carers group where the services can address any concerns as they are raised by carers on behalf of service users.
- The locality has implemented the 'John's Campaign' within their MHSOP inpatient services which is progressing very well. This is a process that supports the belief that carers should not just be allowed but should be welcomed, and that a collaboration between the patients and all connected with them is crucial to their health and their well-being.

- C&YPS are in the process of developing a carers group which will help the services to understand from parents any concerns allowing for them to be addressed in a timely manner.

3.2.3 In addition, all areas within the Trust are progressing well with the Triangle of Care action plans which support effective communication and provide a further opportunity for concerns to be raised nd addressed in a timely manner.

3.3 **Other**

The Positive and Safe Team provide support trust wide on a range of initiatives which can impact positively on the likelihood of patients feeling safer, these include:

- Working alongside the Equality and Diversity team they are exploring effective ways in which the team can support patients and staff who are experiencing racial abuse.
- The team have provided PBS coaching sessions to all Registered Nurses working at West Park Hospital. The sessions focussed on developing skills in writing behaviour support plans. Feedback to date has been positive
- The Positive Approaches Team continues to deliver the revised curriculum for Prevention and Management of Violence and Aggression training (PMVA). Feedback continues to be positive however staff has identified difficulties in how they would transfer new skills to their clinical practise which the team are working on to address.
- TEWV'S good work on meeting the national Positive & Safe agenda was recently highlighted within a recent CQC publication Mental Health Act; a focus on restrictive intervention reduction programmes in inpatient mental health services.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The Patient and Carer Experience Surveys provide the opportunity for patients and carers to feedback their experiences therefore enabling best practice and highlighting areas where improvements could be made. The locality governance arrangements allow for the monitoring of patient feedback in service and identify improvements.

4.2 Financial/Value for Money:

No direct risk or implications.

4.3 Legal and Constitutional (including the NHS Constitution):

NHS Trusts are required to evidence that they have mechanisms in place to actively seek and act upon feedback from patients and service users to help continuous improvement of the services provided

4.4 **Equality and Diversity:**
Issues identified that are associated with discrimination, are forwarded for review by the Equality and Diversity Lead.

4.5 **Other implications:**

None identified.

5. RISKS:

5.1 No other risks identified.

6. CONCLUSIONS:

6.1 Of those surveyed in Q4 a number of narrative comments were received which allowed for these to be coded in order to further understand any issues or concerns. 77 comments equating to 1.13% were coded against the 'feeling safe' category which is relatively low in comparison to the number of those surveyed and the available coded comments.

6.2 Patient experience data is monitored and reviewed within each of the locality QuAG's and within the Patient Experience Group which reports to QuAC.

6.3 There are a number of initiatives already in operation within the Trust to identify and address any concerns in relation to 'feeling safe'.

7. RECOMMENDATIONS:

7.1 To enhance the work that is already underway within operational clinical services that the Expert's by Experience work with each locality to further develop strategies whereby patient experience concerns can be highlighted and escalated accordingly within the Trust.

7.2 That the Board of Directors note the report and consider any further actions to support the monitoring and escalating of patient experience feedback.

Emma Haimes
Head of Quality Data and Patient Experience
April 2017

Appendix 1

Touch points when a survey should be offered

Service	Touchpoints	Exceptions
AMH/MHSOP Inpatient Assessment & Treatment	Discharge	
AMH Inpatient Recovery	Quarterly	
CYPS Inpatients	Monthly	Holly Ward Baysdale Ward Bi-annually (small, static patient numbers, completed by carers due to complex needs)
Forensic Inpatients	Bi-annually	
Adult Learning Disability	Quarterly	Bi-annually (small, static patient numbers) Thornaby Road Kilton View The Orchard
Community Services	Review & Discharge	OHC Primrose & PIPE Services survey continually but submit surveys bi-annually due to small numbers.
CYPS Transition Survey	At age 17.5	
AMH Post Transition Survey	At 3 months post transition	

Item 12

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**24 April 2018**
TITLE:	**Finance Report for Period 1 April 2017 to 31 March 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 March 2018 was a deficit of £27,983k, which was £38,059k behind the planned £10,076k surplus.

The deficit position includes £41,086k of unplanned asset impairments largely due to a review of Roseberry Park Hospital (RPH) to reflect the cost of rectification works required. Excluding these impairments the Trust's operating surplus was ahead of plan by £3,027k.

The Trust also anticipates it will receive £3,027k of incentivised sustainability and transformational funding matched to the surplus in excess of control total. This amount will be confirmed upon financial accounts submission.

Identified Cash Releasing Efficiency Savings at 31 March 2018 are £1,902k behind plan for the year to date. The shortfall was largely due to slippage on CRES schemes which were due to commence 1 October 2017. The Trust has, and continues to, identify and develop schemes to ensure full delivery of recurrent CRES requirements, and has non-recurrent expenditure mitigations in place to manage the position in 2017/18.

The Use of Resources Rating for the Trust was assessed as 1 for the period ending 31 March 2018 and was in line with plan.

The Trust's annual accounts are subject to external audit and any findings may alter the financial outturn position and associated financial risk rating indicators.

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.
- approve the submission of the NHS Improvement quarter 4 return in accordance with the results detailed in this report.

MEETING OF:	**Board of Directors**
DATE:	**24 April 2018**
TITLE:	**Finance Report for Period 1 April 2017 to 31 March 2018**

1. INTRODUCTION & PURPOSE

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

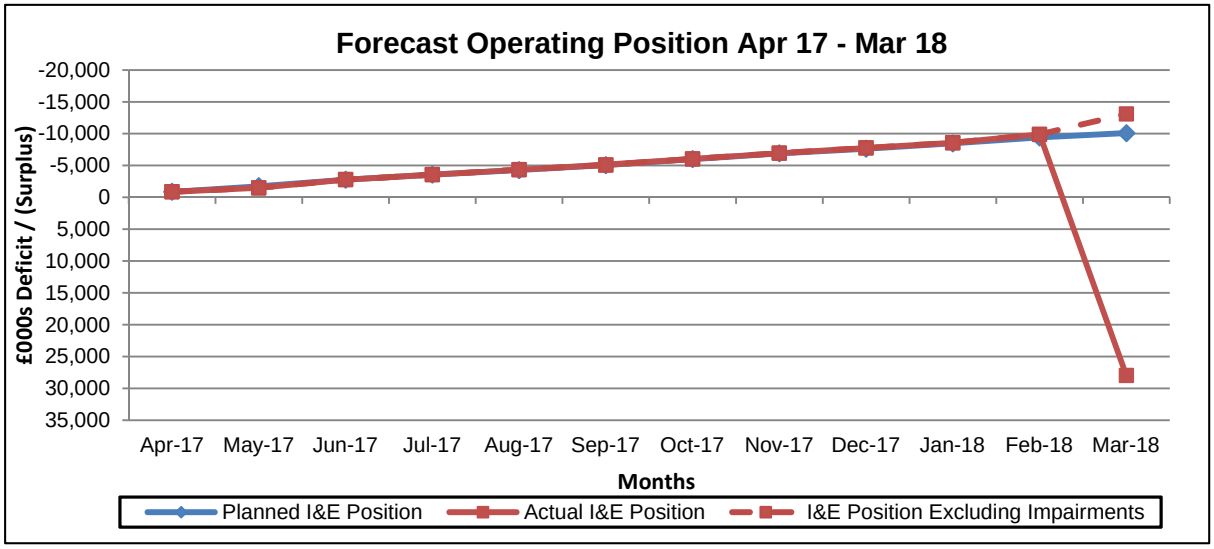
3. KEY ISSUES:

3.1 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 31 March 2018 was a deficit of £27,983k, representing 8.2% of the Trust's turnover and was £38,059k behind the planned £10,076k surplus.

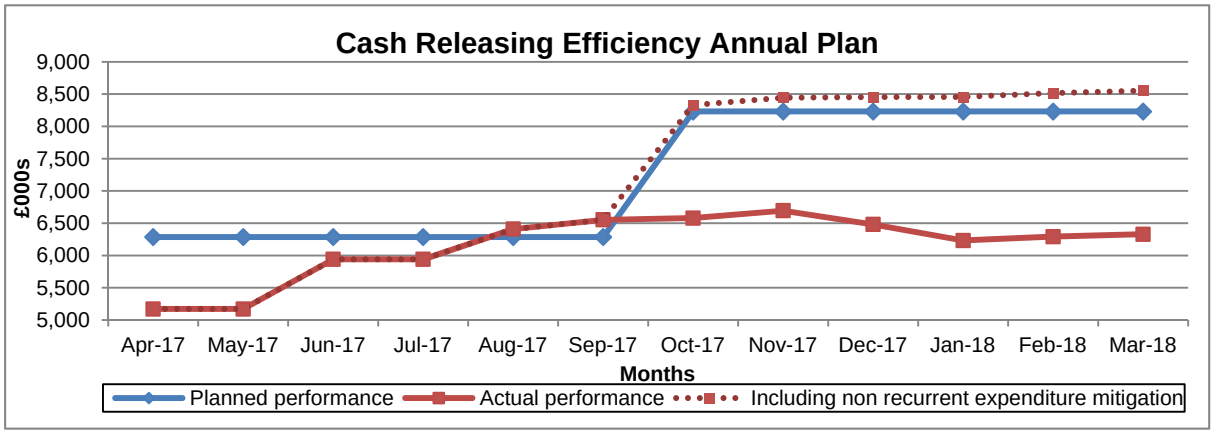
The deficit position includes £41,086k of unplanned asset impairments largely due to a review of Roseberry Park Hospital (RPH) to reflect the cost of rectification works required. Excluding these impairments the Trust's operating surplus was ahead of plan by £3,027k.

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

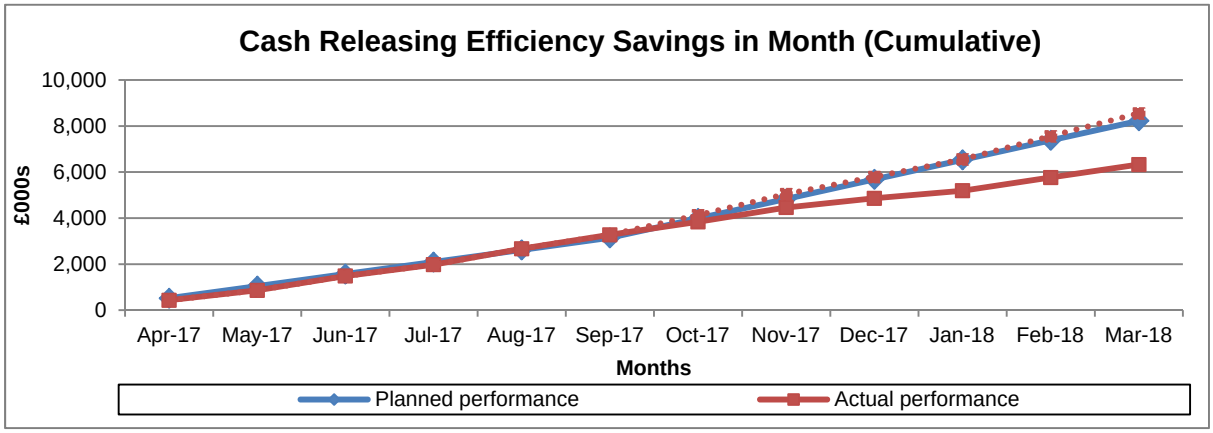


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 March 2018 was £6,328k and was £1,902k behind plan. The shortfall was largely due to slippage on CRES schemes due to commence 1 October 2017. The Trust has, and continues to, identify and progress schemes to deliver CRES in full for future years, and has non-recurrent expenditure mitigations in place to manage the position in 2017/18.

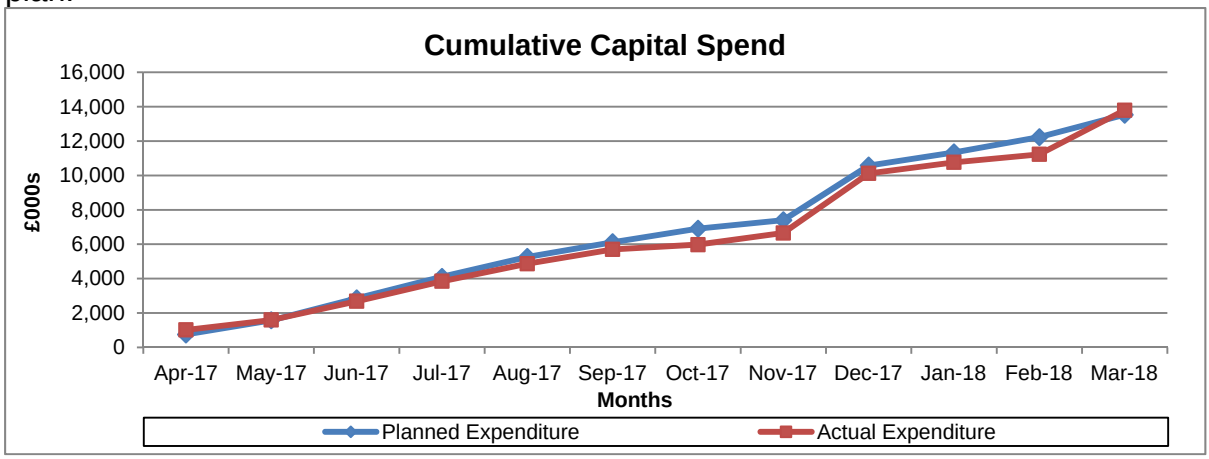


The monthly profile for CRES identified by Localities is shown below.



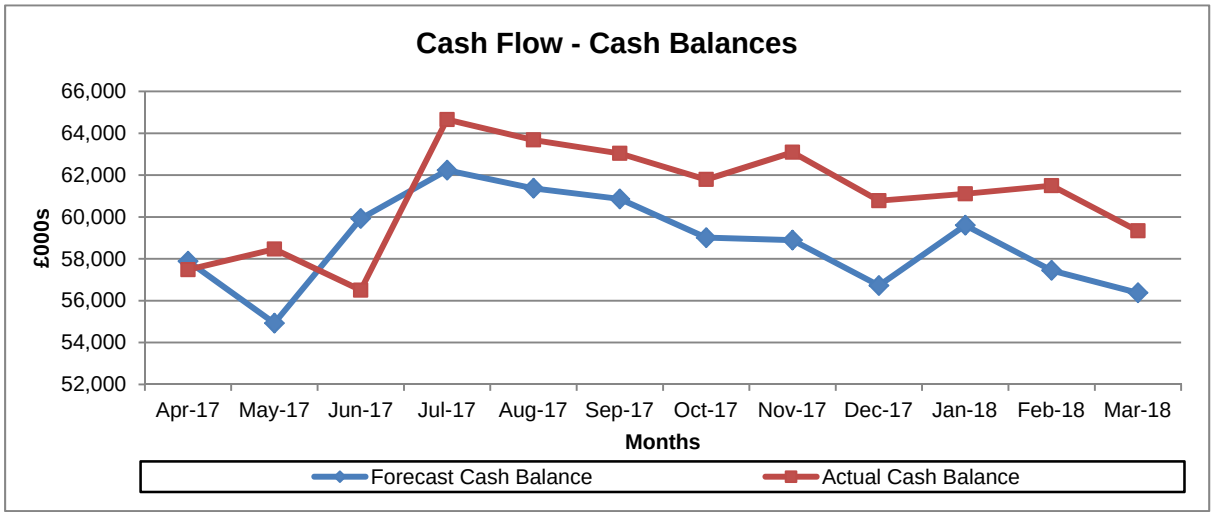
3.3 Capital Programme

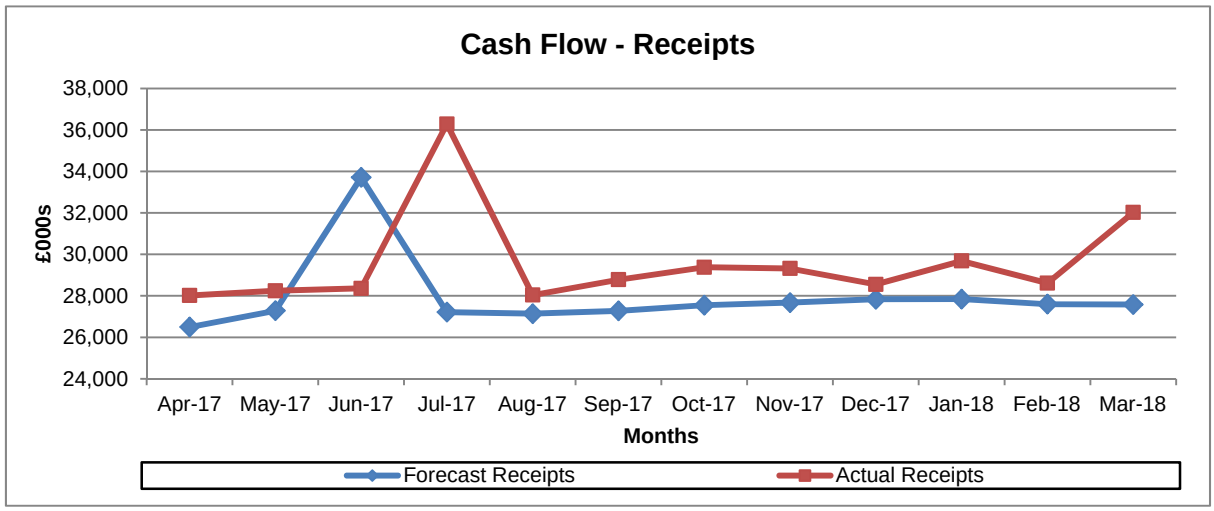
Capital expenditure to 31 March 2018 was £13,793k and was £258k in excess of plan.

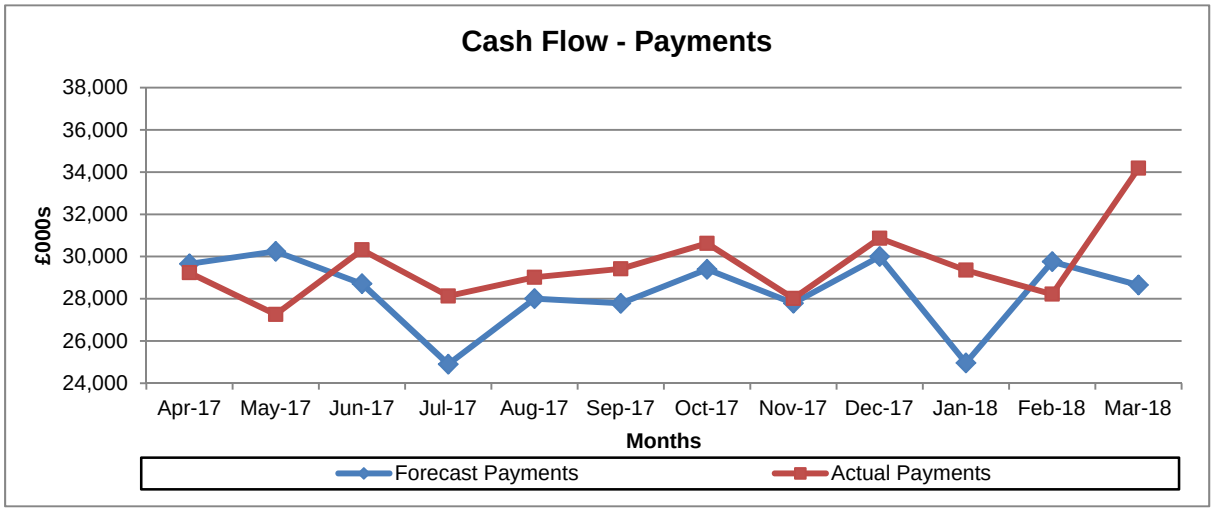


3.4 Cash Flow

Total cash at 31 March 2018 was £59,334k, and was £2,958k ahead of plan largely due to working capital variations.





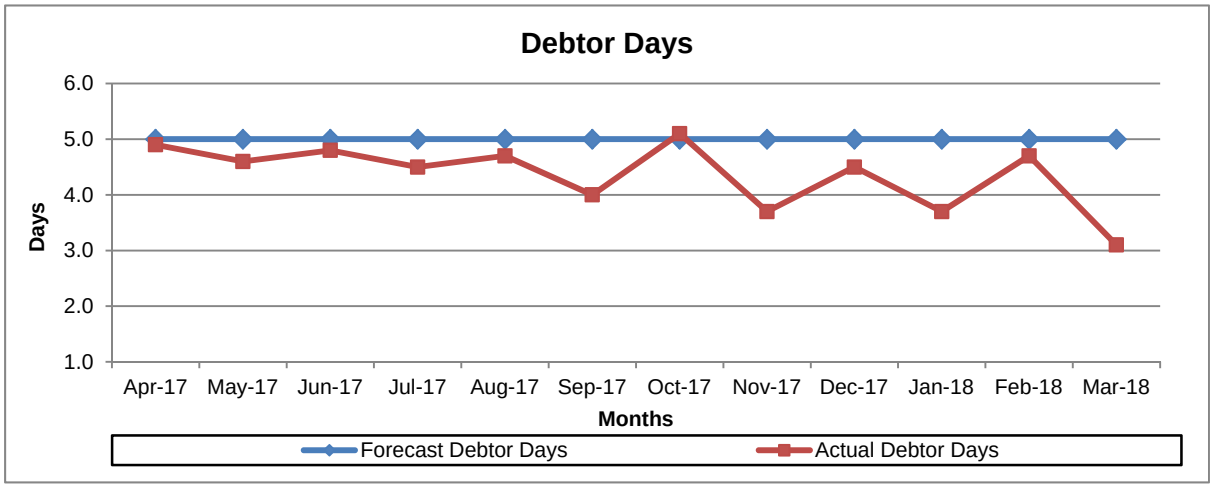


The receipts profile fluctuates over the year for Sustainability and Transformation Fund incentive scheme receipt. The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.

The fluctuations in March's receipts and payments are largely due to the agreement of balances with NHS organisations which is typical of a year end.

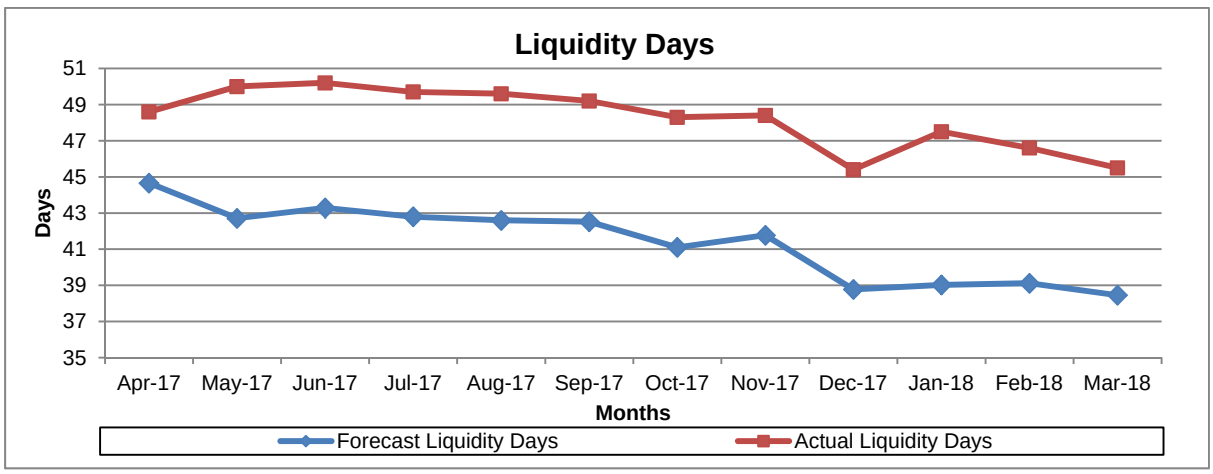
Working Capital ratios for period to 31 March 2018 are:

- Debtor Days of 3.1 days
- Liquidity of 45.5 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 47.84%
  Non NHS 30 Days – 96.92%



The Trust has a debtors' target of 5.0 days, and actual performance of 3.1 days at 31 March 2018, which was ahead of plan.

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



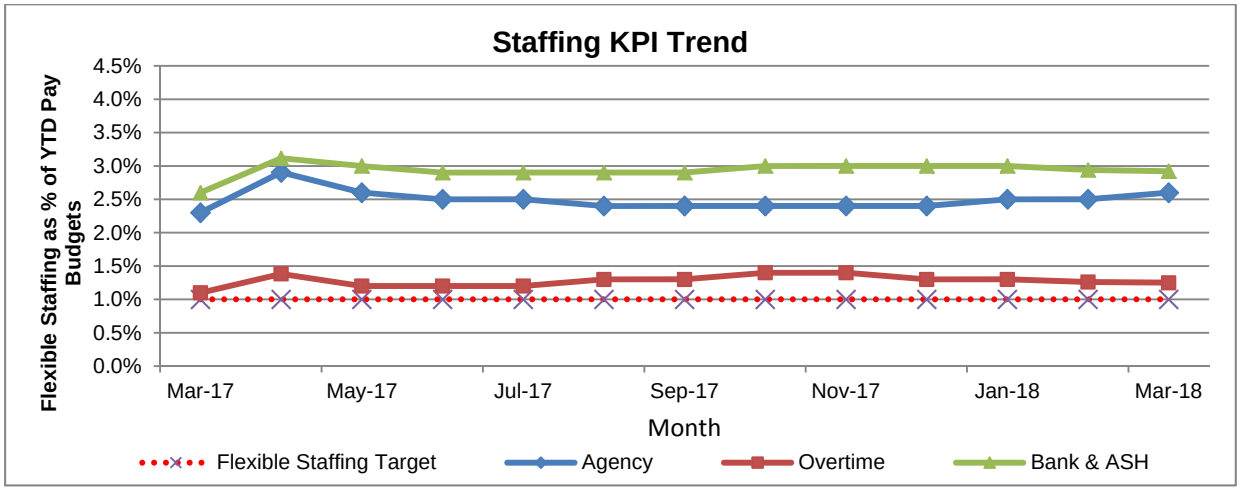
3.5 Financial Drivers

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

Tolerance	Oct	Nov	Dec	Jan	Feb	Mar
Agency (1%)	2.4%	2.4%	2.4%	2.5%	2.5%	2.6%
Overtime (1%)	1.4%	1.4%	1.3%	1.3%	1.3%	1.3%
Bank & ASH (flexed against establishment)	3.0%	3.0%	3.0%	2.9%	2.9%	2.9%
Establishment (90%-95%)	94.3%	94.5%	94.5%	94.2%	93.7%	93.8%
Total	**101.1%**	**101.3%**	**101.2%**	**100.9%**	**100.4%**	**100.6%**

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 March 2018 the tolerance for Bank and ASH was 4.2% of pay budgets.

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



Additional staffing expenditure was 6.8% of pay budgets. The requirement for bank, agency and overtime was due to a number of factors including cover for vacancies (48%), enhanced observations (21%), service need (13%) and sickness (10%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating for the Trust was assessed as 1 for the period ending 31 March 2018 and was in line with plan.

3.6.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.86x (can cover debt payments due 1.86 times), which was ahead of plan and rated as a 2.

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 was 46.7 days; this was ahead of plan and was rated as a 1.

3.6.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 3.8% and was rated as a 1.

3.6.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding STF income. The Trust I&E margin distance from plan was 0.7% and was ahead of plan and was rated as a 1.

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

The margins on Use of Resource Rating are as follows:

- Capital service cover - to improve to a 1 a surplus increase of £1,504k was required.
- Liquidity - to reduce to a 2 a working capital reduction of £40,662k was required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £9,677k was required.
- I&E margin distance from plan – to reduce to a 2 an operating surplus decrease of £2,484k was required.
- Agency Cap rating – to improve to a 1 a reduction in agency expenditure of £605k was required.

Use of Resource Rating at 31 March 2018

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

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	1.86x	2	1.54x	3	
Liquidity	46.7 days	1	38.5 days	1	
I&E margin	3.8%	1	3.1%	1	
I&E margin distance from plan	0.7%	1	0.0%	1	
Agency expenditure	£6,775k	2	£6,170k	1	
Overall Use of Resource Rating		**1**		**1**	

3.6.7 2.9% of total receivables (£206k) are over 90 days past their due date; this was below the 5% finance risk tolerance.

3.6.8 1.5% of total payables invoices (£213k) held for payment are over 90 days past their due date. This was within the 5% finance risk tolerance.

3.6.9 The cash balance at 31 March 2018 was £59,334k and represents 68.1 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.

4.2 The Trust's annual accounts are subject to external audit.

5. RISKS:

5.1 Any findings from the external audit may alter the financial outturn position and associated financial risk rating indicators.

6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 31 March 2018 was a deficit of £27,983k, which was £38,059k behind the planned £10,076k surplus.

The deficit position includes £41,086k of unplanned asset impairments largely due to a review of Roseberry Park Hospital (RPH) to reflect the cost of rectification works required. Excluding these impairments the Trust's operating surplus was ahead of plan by £3,027k.

The Trust also anticipates it will receive £3,027k of incentivised sustainability and transformational funding matched to the surplus in excess of control total. This amount will be confirmed upon financial accounts submission.

6.2 Identified Cash Releasing Efficiency Savings at 31 March 2018 are £1,902k behind plan for the year to date. The shortfall was largely due to slippage on CRES schemes which were due to commence 1 October 2017. The Trust has, and continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements, and has non-recurrent expenditure mitigations in place to manage the position in 2017/18.

6.3 The Use of Resources Rating for the Trust was assessed as 1 for the period ending 31 March 2018 and was in line with plan.

7. RECOMMENDATIONS:

7.1 The Board of Directors is requested to:

- receive the report, to note the conclusions in section 6 and to raise any issues of concern, clarification or interest.

- approve the submission of the NHS Improvement quarter 4 return in accordance with the results detailed in this report.

Patrick McGahon
Director of Finance and Information

ITEM 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24th April 2018**
TITLE:	**Board Dashboard as at 31st March 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 March 2018, 7 (36%) of the indicators reported are not achieving the expected levels and are red. This is a decline on the 5 reported as at the end of February 2018. Two of these indicators are showing an improving position over the previous 3 months. It should be noted that the red rating reported for Bed Occupancy is in fact incorrect due to PARIS not being updated for the opening of beds on Rowan ward which had been previously closed to facilitate estate work that needed to be completed. The correct position for this indicator is 87.82% which would make the RAG rating amber rather than red. Therefore the correct number of reds would be 6 (31%). There are a further 4 indicators reported which whilst not completely achieving the target levels are within the amber tolerance. Correcting the bed occupancy KPI moves this to 5 ambers which is one less than the February position.

In terms of the year as a whole there are 8 indicators that are reporting red which are spread across the 4 Domains.

It should be noted that the target for Mandatory and Statutory training (KPI 17) was achieved in March and whilst the appraisal target (KPI 16) was not quite achieved it was at the highest level in the past three years. This reflects the significant work that services have undertaken, using daily lean management, to improve performance in these two areas.

All of the Single Oversight Framework targets were delivered in March and for Q4

with the exception of the Physical Health Care target that has previously been reported to the Board. In terms of the IAPT recovery rate we achieved 51.56% in March and 51.23% for Q4 at Trust level (compared to a target of 50%).

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:	**24th April 2018**
TITLE:	**Board Dashboard as at 31st March 2018**

1. INTRODUCTION & PURPOSE:

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

2. KEY ISSUES:

2.1 Performance Issues

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

- As at the end of March 2018, 7 (36%) of the indicators reported are not achieving the expected levels and are red. This is a decline on the 5 reported as at the end of February 2018. Two of these indicators are showing an improving position over the previous 3 months. It should be noted that the red rating reported for Bed Occupancy is in fact incorrect due to PARIS not being updated for the re-opening of beds on Rowan ward which had been previously closed to facilitate estate work that needed to be completed. The correct position for this indicator is 87.82% which would make the RAG rating amber rather than red. Therefore the correct number of reds would be 6 (31%)

  It should be noted that there are no red indicators within the workforce domain with the majority of reds being in the activity domain.

  There are a further 4 indicators reported which whilst not completely achieving the target levels are within the amber tolerance levels (which is two less than the number reported as at the end of February). Correcting the bed occupancy KPI moves this to 5 ambers which is one less than the February position.

  In terms of the year as a whole there are 8 indicators that are reporting red which are spread across the 4 Domains.

  It should be noted that the target for Mandatory and Statutory training (KPI 17) was achieved in March and whilst the appraisal target (KPI 16) was not quite achieved it was at the highest level in the past three years. This reflects the significant work that services have undertaken, using daily lean management, to improve performance in these two areas.

- All of the Single Oversight Framework targets were delivered in March and for Q4 with the exception of the Physical Health Care target that has previously been reported to the Board. In terms of the IAPT recovery rate we achieved 51.56% in March and 51.23% for Q4 at Trust level

(compared to a target of 50%). In terms of the March position the target was achieved in 7 CCGs with Scarborough and Rydal and York CCGs not achieving the target.

- Appendix B includes the breakdown of the actual number of unexpected deaths by month. Work is continuing to ensure we can correctly report coroners verdicts and this is expected to be recommenced in April 2018.

2.2 Data Quality Assessment.

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

2.3 Key Risks

- Referrals (KPI1) – The number of referrals received in March has increased which is in line with the trend in 2016/17 and is greater than target. It should be noted however that the position for March is not as high as that in March 2017. It should also be noted that caseload turnover (KPI 2) has deteriorated further in March linked to the high number of referrals particularly in CAMHS in earlier months.
- Bed Occupancy (KPI 3) – As highlighted earlier the position reported is incorrect due to the reopening of beds at Rowan ward in North Yorkshire not being actioned on PARIS resulting in the denominator being understated. The correct position at Trust level is 87.82% which is a similar level to February.
- Number of instances of patient who have 3 or more admissions in a year (KPI 6) – Performance remains worse than target for this indicator as in previous months with a further deterioration in March with only North Yorkshire achieving the target. Following the work undertaken in Durham and Darlington, which was previously reported to the Board, actions are now being put in place and it is expected that the position will be improved. A similar investigation is being undertaken in Tees and has revealed similar issues to those in Durham and Darlington. In York and Selby following a deep dive further work is taking place between the wards and the Assertive Outreach team to ensure the interfaces between these two teams help maintain people in the community.
- Number of Unexpected Deaths classed as a serious incident (KPI 11) – Whilst the rate of unexpected deaths classed as a serious incident has increased slightly in March the actual number of deaths (9) was one lower that the number reported in February (10). The position remains above the expected levels. An analysis of the position across the year is being undertaken and this will highlight key issues/themes.
- Sickness (KPI 18) – There has been a significant improvement in the performance reported in March such that the sickness rate was the best it has been since May 2017. Work has been undertaken to understand the particular spike of sickness reported in December, January and February and it was found that there was a significant increase in short term sickness particularly linked to ‘cold, coughs and flu’. However it should be

noted that overall long term sickness accounts for the majority of the sickness reported.

- Delivery of our Financial Plan (KPI 19) – the position reported for March is significantly worse than target and a deterioration on the February position. This is due to the inclusion of an unplanned asset impairment linked to the expected cost of rectification works at Roseberry Park. Excluding this impairment would result in the delivery of a surplus ahead of plan by £3 million, resulting in a green RAG rating for this indicator.
- CRES Delivery (KPI 20) – the delivery of the CRES is behind plan for the month of March and for the year. The shortfall is mainly due to slippage on CRES schemes due to commence 1 October 2017. The Trust has, and continues to identify and progress schemes to deliver CRES in full for current and future years, and has managed the position in 2017/18 via non-recurrent expenditure mitigations.

3. RECOMMENDATIONS:

3.1 It is recommended that the Board:

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

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Activity

	March 2018				April 2017 To March 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Total number of External Referrals into Trust Services	7,793.00	9,122.00			91,759.00	105,573.00		91,759.00
2) Caseload Turnover	1.99%	3.94%			1.99%	3.94%		1.99%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	90.11%			85.00%	86.63%		85.00%
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	75.00	57.00			75.00	57.00		75.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	8.43%			10.00%	8.87%		10.00%
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	20.00	27.67			237.00	309.00		237.00

Quality

	March 2018				April 2017 To March 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	90.00%	90.43%			90.00%	90.73%		90.00%
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	9.49%			10.00%	8.72%		10.00%
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	13.44%			20.00%	14.08%		20.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	91.12%			92.45%	91.56%		92.45%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.59			12.00	16.34		12.00

Trust Dashboard Summary for TRUST

Workforce

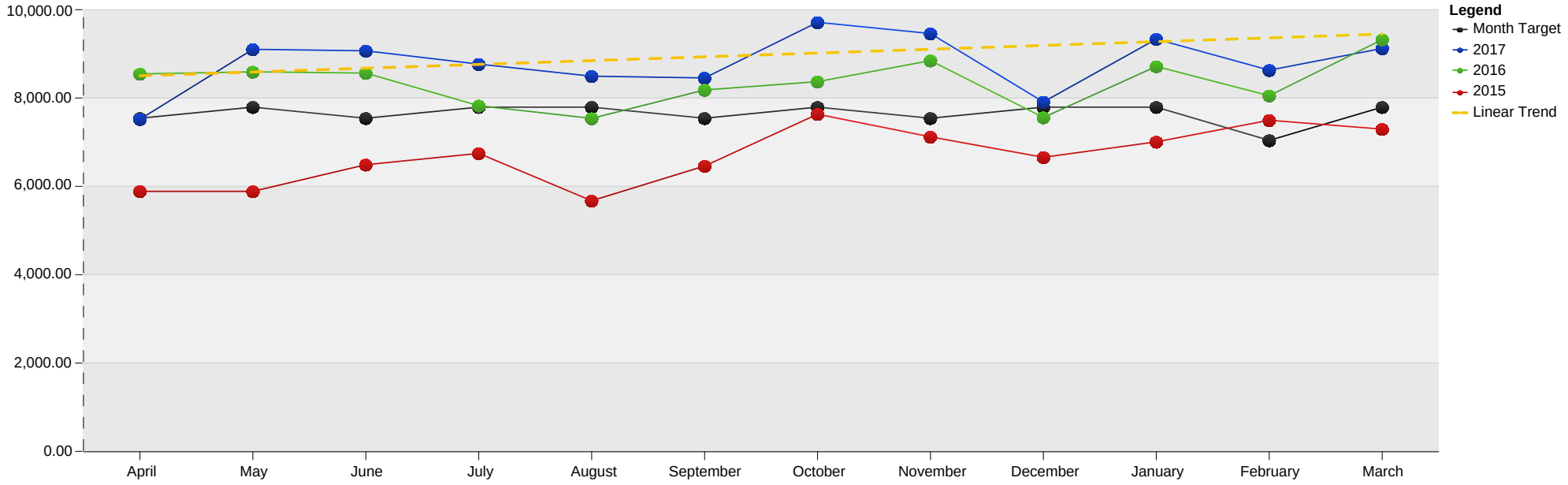
	March 2018				April 2017 To March 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	93.83%			100.00%	93.83%		100.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	13.92%			15.00%	18.32%		15.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	94.21%			95.00%	94.21%		95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	90.75%			90.00%	90.75%		90.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.68%			4.50%	5.18%		4.50%

Money

	March 2018				April 2017 To March 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-677,000.00	37,866,000.00			-10,076,000.00	27,983,000.00		-10,076,000.00
20) CRES delivery	848,000.00	561,132.00			8,230,080.00	6,327,550.61		8,230,080.00
21) Cash against plan	56,376,000.00	59,334,000.00			56,376,000.00	59,334,000.00		56,376,000.00

Trust Dashboard Graphs for TRUST

1) Total number of External Referrals into Trust Services

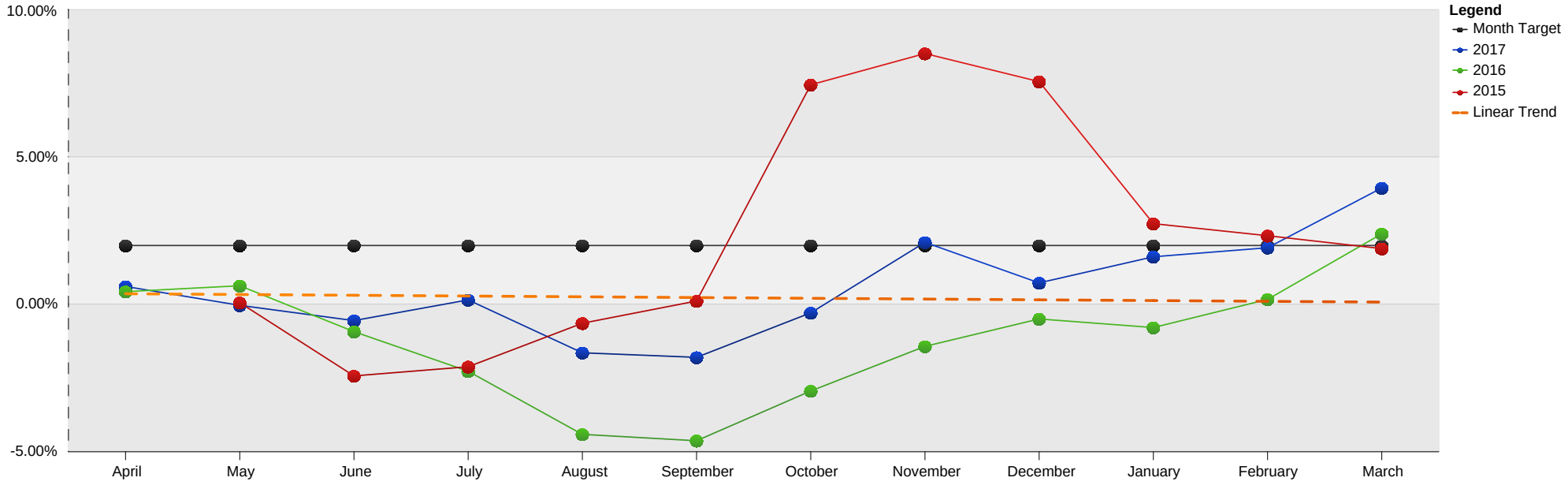


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Total number of External Referrals into Trust Services	9,122.00	105,573.00	2,116.00	24,428.00	2,736.00	31,636.00	2,077.00	24,837.00	663.00	7,591.00	1,530.00	17,078.00		

Narrative
The Trust position for March 2018 is 9122 which is above the Trust target of 7793. This is an increase on the number of referrals received in February 2018 with all localities having seen an increase. York and Selby are the only locality meeting target.The trust position for the financial year is 105,573 which exceeds the target by 13814. This is an increase on the outturn of 100,109 in 2016/17 and continues the increasing trend seen since 2013/14.

Trust Dashboard Graphs for TRUST

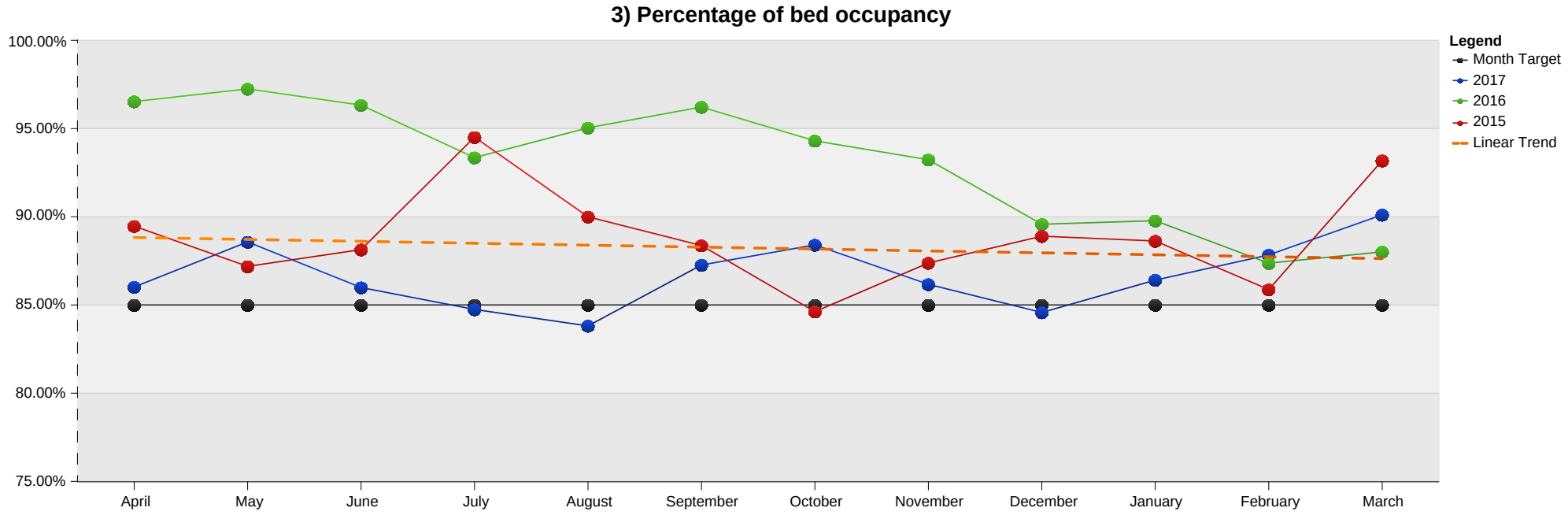
2) Caseload Turnover



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Caseload Turnover	3.94%	3.94%	3.72%	3.72%	4.39%	4.39%	1.07%	1.07%	NA	NA	7.71%	7.71%		

Narrative
The Trust position for March 2018 and financial year is 3.94% which is above the Trust target of 1.99%. This is a deterioration to that reported in February 2018. North Yorkshire are meeting target. Under performance in Durham and Darlington, Tees and York and Selby continues to be within CAMHS services and this is due to an increase in the number of referrals received in at the end of 2017.

Trust Dashboard Graphs for TRUST

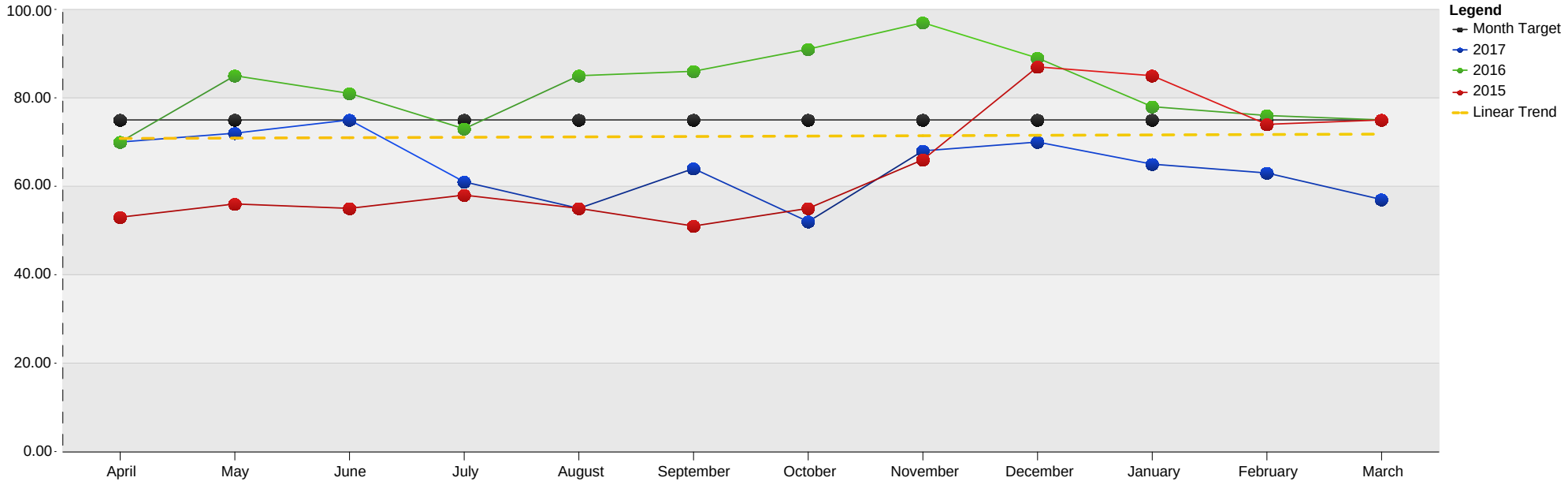


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	90.11%	86.63%	86.90%	88.25%	95.73%	86.29%	97.24%	90.09%	NA	NA	79.91%	79.42%		

Narrative
The Trust position for March 2018 is 90.11% which is worse than target and a deterioration on the position of 87.49% recorded in February 2018.North Yorkshire are reporting the highest bed occupancy at 97.24% which is as a result of MHSOP. This is caused by a recording issue on PARIS around Rowan Ward. The ward reopened 10 beds during March following some repair work on the ward however the PARIS system has not yet been updated to reflect this. This will be rectified in time for the next report. When this issue is corrected the Trust position is 87.82%. Tees have seen a slight deterioration in performance at 95.65% with key pressures remaining within the MHSOP service, this is as a result of patients undergoing ECT and delayed discharges. All patients have commenced discharge planning. The Trust position for financial year is 86.63% which is achieving the target and is a 6.4% improvement on 2016/17. When the recording issue about is corrected the Trust position is 86.44%.

Trust Dashboard Graphs for TRUST

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

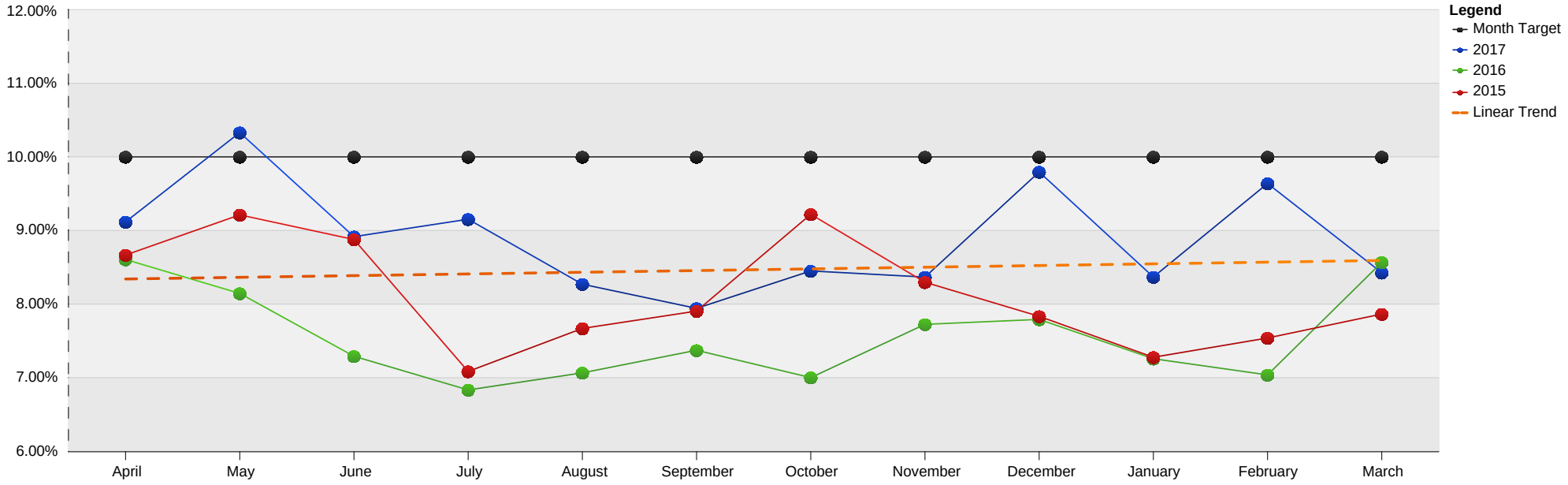


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	57.00	57.00	14.00	14.00	12.00	12.00	16.00	16.00			13.00	13.00		

Narrative
The Trust position for March 2018 is 57 which is meeting the target of 75 and is an improvement compared to that reported in February 2018. Of the 57 patients occupying a bed with a LoS greater than 90 days:• 14 (24.56%) were within Durham and Darlington (6 MHSOP and 8 AMH) • 13 (22.80%) were within York & Selby (13 MHSOP) • 12 (21.05%) were within Teesside (10 MHSOP and 2 AMH) • 16 (28.07%) were within North Yorkshire (4 MHSOP and 12 AMH) • 2 (3.50%) were Unknown CCG but 1 was within AMH and 1 within the MHSOP service. North Yorkshire and Durham and Darlington have the greatest number of patients with a length of stay greater than 90 days. In both localities this is as a result of delayed transfers of care in MHSOP services as a result of patient complexity and in North Yorkshire a further issue around the availability of appropriate placements. Tees are not achieving target but are continuing to see improvements. A focused piece of work is being completed to improve understanding of this issue and findings show the issues are in connection with securing placements for patients. This is being addressed with partner agencies.

Trust Dashboard Graphs for TRUST

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



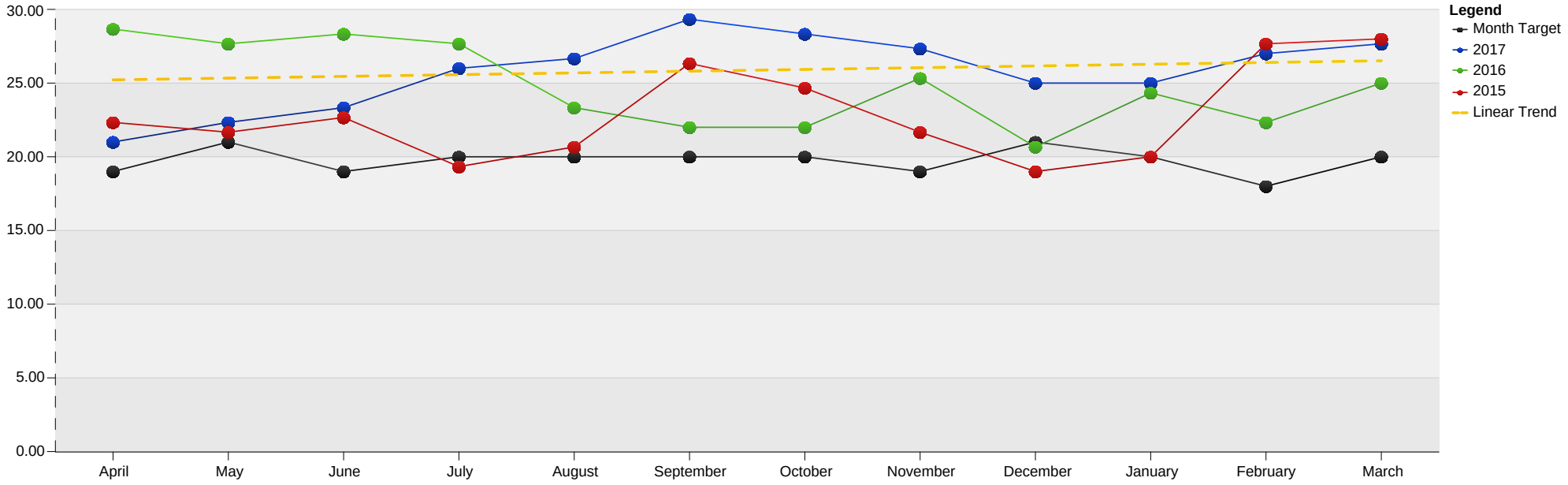
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	8.43%	8.87%	7.22%	7.97%	9.46%	8.99%	7.48%	8.23%			9.91%	10.92%		

Narrative

The Trust rolling 3 month position ending March 2018 is 8.43%, which relates to 22.66 patients out of 269 that were readmitted within 30 days. This is meeting the target of 10% and is an improvement on the position recorded in February 2018.Of the 22.66 patients re-admitted:• 6.99 (30.47%) were within Durham & Darlington (6.99 AMH) • 3.66 (16.15%) were within York and Selby (3.66 AMH)• 3.66 (16.15%) were within North Yorkshire (2.66 AMH and 0.99 MHSOP) • 6.99 (30.47%) were within Teesside (6.99 AMH)• 1.33 (5.86%) were within unknown localities and services(*Please note data is displayed in decimal points due to the rolling position being calculated.)All localities are achieving the target for this indicator. Within Durham and Darlington there are a high number of readmissions and the service have completed focused work to improve the understanding of this issue and actions are in place to address these. Focused work is also ongoing within the remaining localities to address issues around re-admissions. (For further details see Indicator 6) The Trust position for financial year is 8.87% which has met the target of 10% but is a deterioration on the outturn for 2016/17 which was 7.61%

Trust Dashboard Graphs for TRUST

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



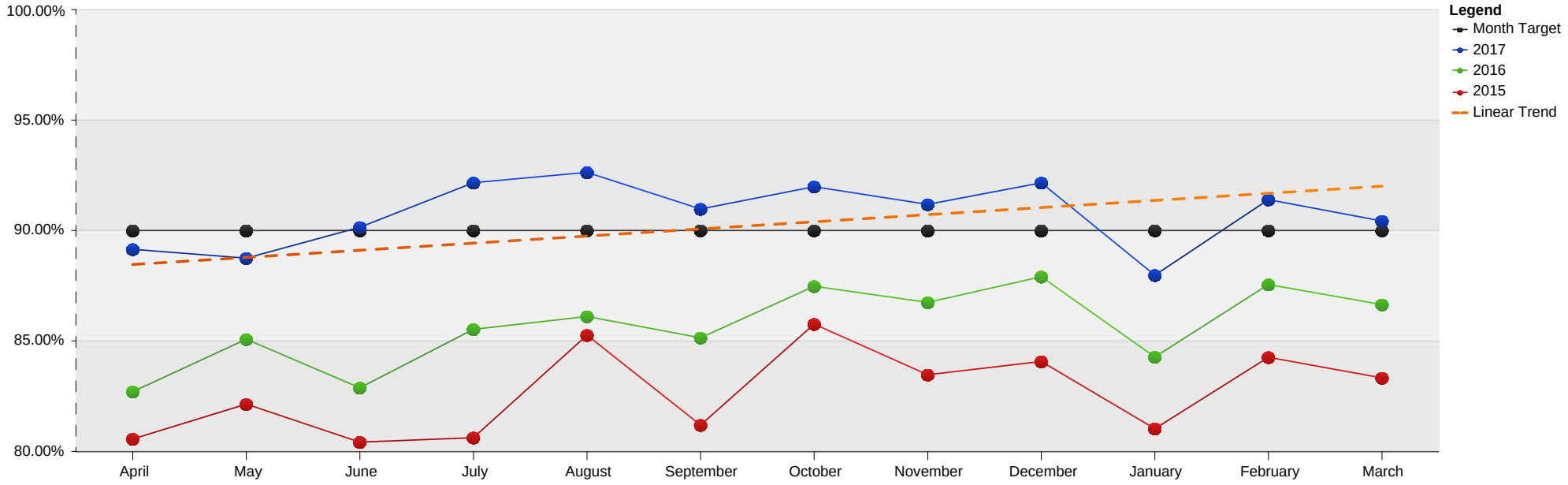
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	27.67	309.00	11.00	114.33	8.33	67.67	3.33	53.67			3.67	57.33		

Narrative

The Trust rolling 3 month position ending March 2018 is 27.67 which is 7.67 worse than the target of 20 and a deterioration compared to the position reported in February 2018. Only North Yorkshire are achieving target. Of the 27.67 readmissions:• 10.99 (39.71%) within Durham & Darlington (10.99 AMH)• 8.33 (30.10%) within Tees (8.33 AMH)• 3.33 (12.03%) within North Yorkshire (2.33 AMH, 0.99 MHSOP)• 3.66 (13.22%) within York and Selby (3.33 AMH, 0.33 MHSOP)• 1.33 within unknown localities but within AMHIn York and Selby, improvements have been seen, a deep dive was completed to review patients admitted and all have been appropriate. The service have carried out work with the Assertive Outreach Team and the Wards to establish interface meetings to review this area on an ongoing basis to provide reassurance all issues have been addressed.In Durham and Darlington a focused work has been completed to improve understanding of this issue and this was fed back to the Board in February. Discussions continue within the Operational Management Team regarding the most appropriate way to monitor this area on an ongoing basis. In Tees further work is ongoing to identify reasons for the re-admissions, similar to that undertaken in Durham and Darlington. The Trust position for financial year is 309 which has not met the target of 237 and is a deterioration on 2016/17 outturn position of 291.66. (*Please note data is displayed in decimal points due to the rolling position being calculated)

Trust Dashboard Graphs for TRUST

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



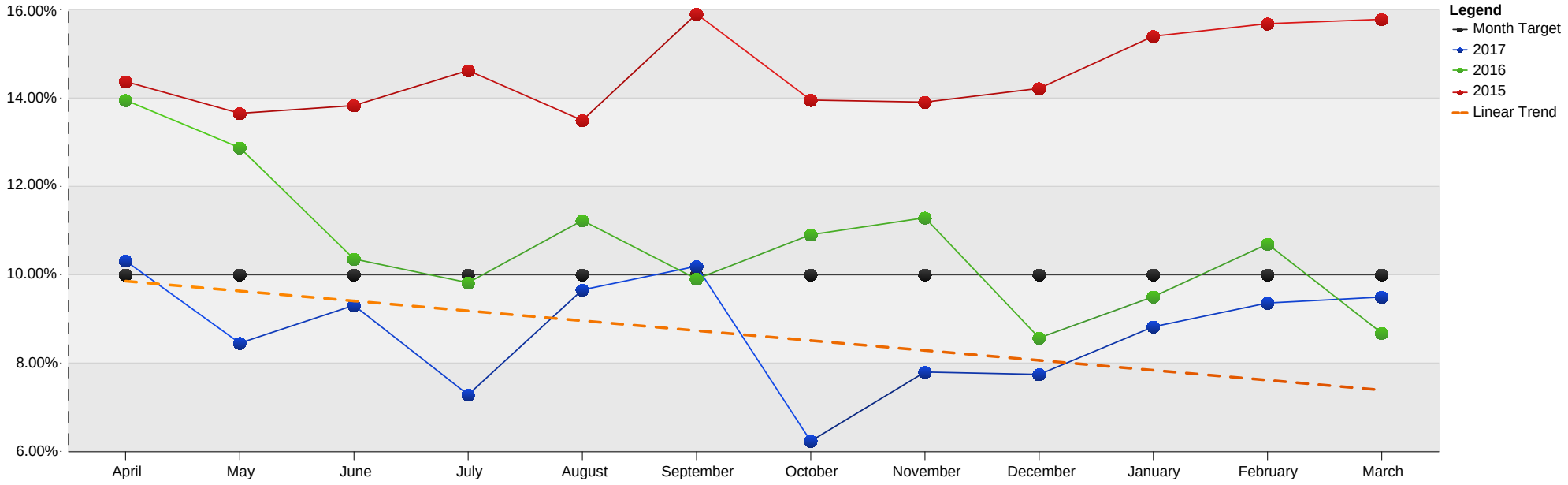
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	90.43%	90.73%	90.76%	90.13%	97.35%	98.20%	82.78%	83.25%	99.81%	99.75%	73.14%	74.07%		

Narrative

The position for March 2018 is 90.94% relating to 554 patients out of 5789 who waited longer than 4 weeks. This is achieving target but is a slight deterioration on the February position. Areas of concern:• York and Selby Adults at 50% (128 of 256 patients). This is an improvement on the February position. Access continues to be the main area of concern (33 of 129 patients) due to a 25% DNA rate. The service have been telephoning patients prior to the appointment as a reminder but this has been unsuccessful. The impact is that patients have to be rebooked and therefore new referrals are not being seen in time. The service are seeking advice from other access teams.• North Yorkshire MHSOP at 79.57%(366 of 460 patients). The service have seen an increase in referrals, particularly from Harrogate, which has impacted on the ability to see all patients in the required time. There continues to be staffing issues due to sickness and vacancies with teams utilising staff from other teams were possible. The Memory Service are the key area of concern with work continuing on the action plan to address issues. Following the bad weather in February/ March a number of patients DNA'd appointments, the team have been trying to accommodate these rearranged sessions alongside new appointments. The position for the financial year is 90.73% which is achieving the target and an improvement on the 2016/17 outturn of 85.65%. This continues the improving trend which has been seen since 2015/16.

Trust Dashboard Graphs for TRUST

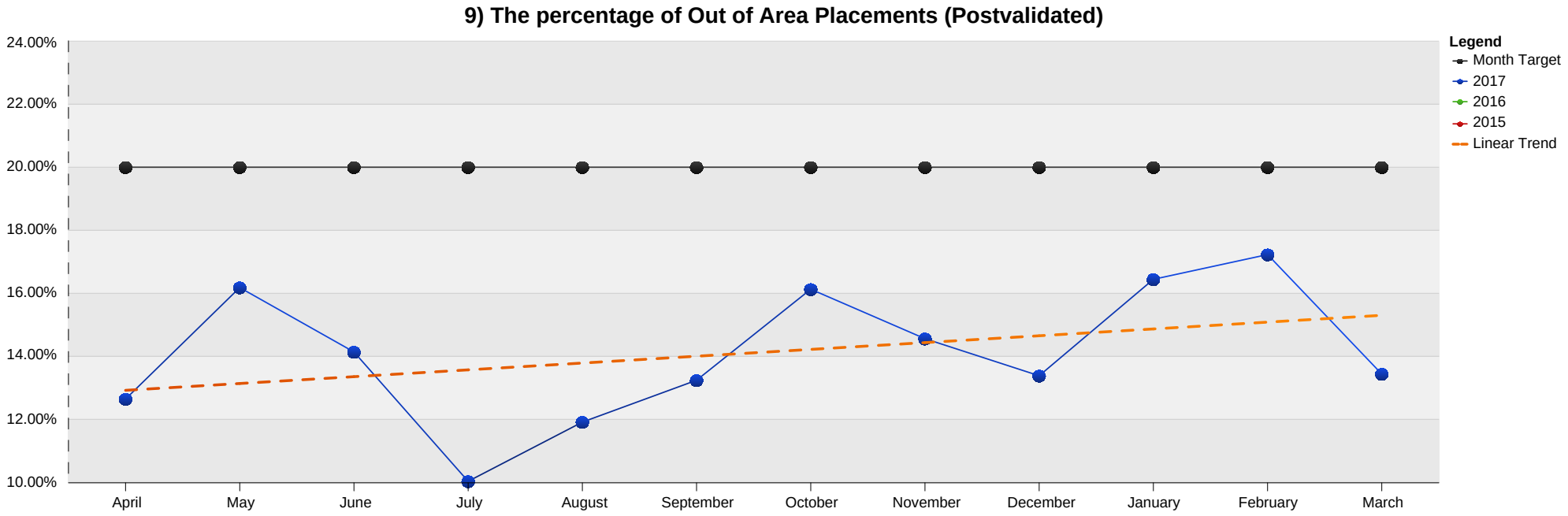
8) Percentage of (Clinic) appointments cancelled by the Trust



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Percentage of (Clinic) appointments cancelled by the Trust	9.49%	8.72%	9.81%	10.58%	4.86%	5.61%	15.86%	11.75%			7.87%	5.24%		

Narrative
The Trust position for March 2018 is 9.49% which relates to 307 clinic appointments out of 3234 that have been cancelled. This is meeting the target of 10% but is deterioration on the position in February. All localities are achieving target with the exception of North Yorkshire. The locality has been impacted by sickness and vacancies within teams particularly in AMH and MHSOP. The teams are working to catch up on missed appointments as soon as possible.

Trust Dashboard Graphs for TRUST

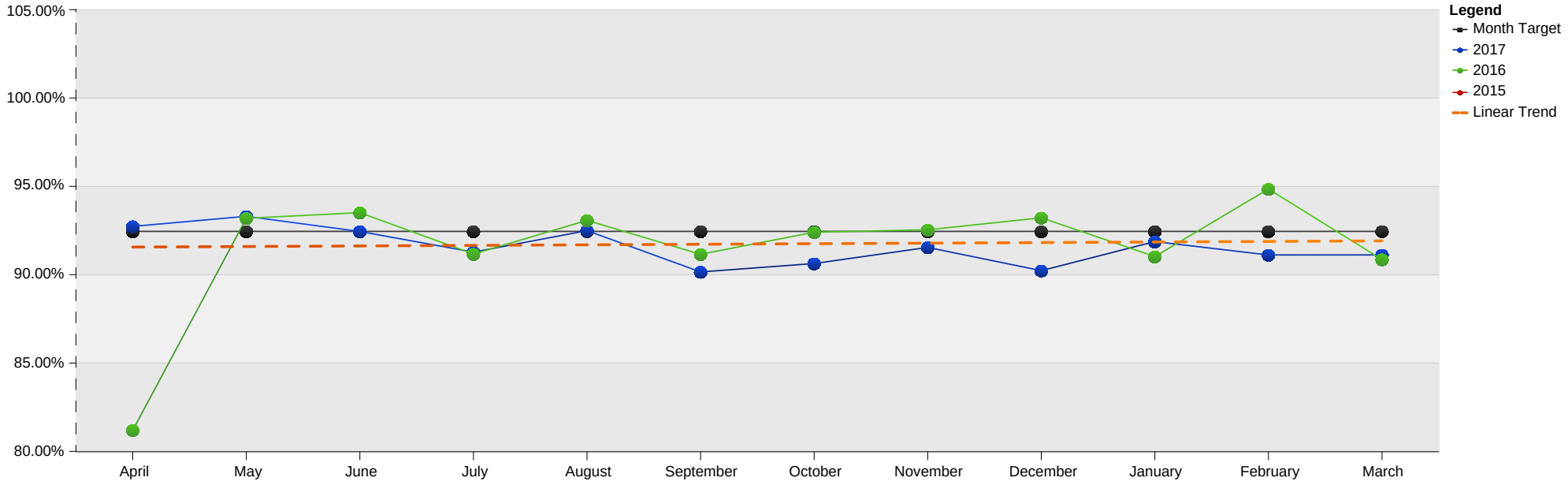


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The percentage of Out of Area Placements (Postvalidated)	13.44%	14.08%	1.94%	5.56%	8.08%	5.32%	37.70%	39.24%			18.52%	22.06%		

Narrative
The Trust position for March 2018 is 13.44% which relates to 43 admissions out of 320 that were inappropriately admitted out of area. This is better than the target of 20% and is a significant improvement on the February 2018 position.All localities are meeting target with the exception of North Yorkshire. Within the locality, the key pressure remains within AMH where high numbers of admissions have impacted on the position. Of the 43 patients (AMH 38, MHSOP 5) all were due to a lack of bed availability.The trust position for financial year is 14.08% which is achieving target of 20%.

Trust Dashboard Graphs for TRUST

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



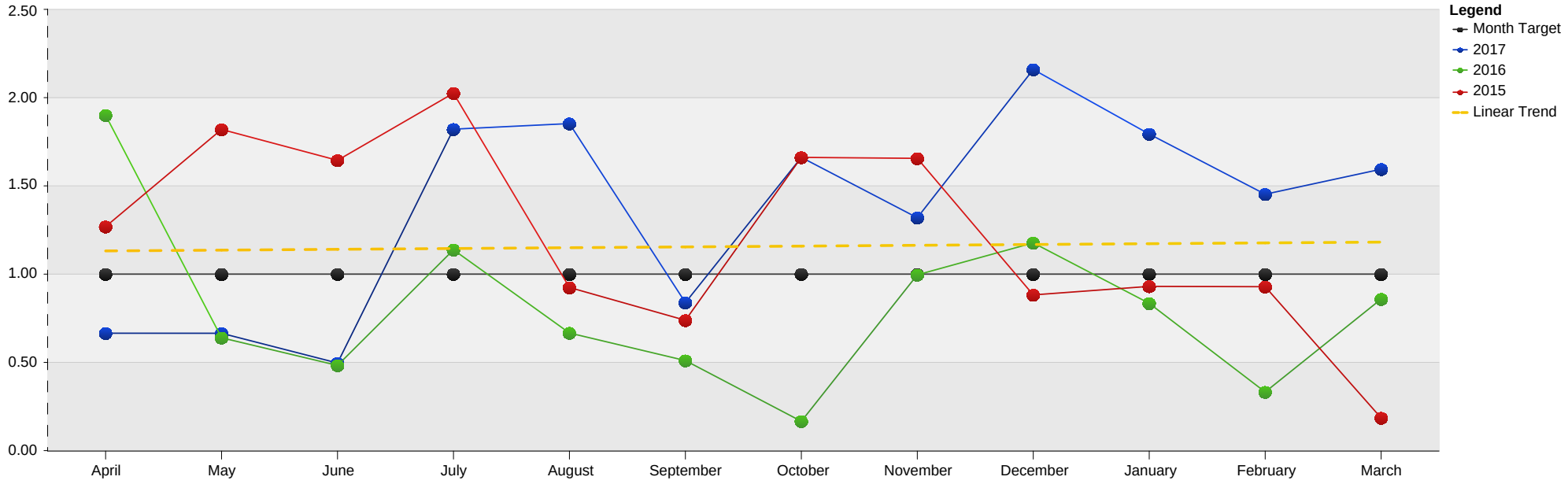
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.12%	91.56%	91.79%	92.40%	94.23%	92.79%	91.32%	91.70%	69.79%	80.50%	90.10%	90.66%		

Narrative

The Trust position reported in March relates to February's performance. The Trust position for February 2018 is 91.12% which is not meeting the target of 92.45% but is within 10% of the target and is the same position as reported in February 2018.Tees are achieving the target whilst Forensics reports the poorest position at 69.79%. All other localities are within 10% of the target. As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive).The Trust position for financial year to date is 91.56% which is within 10% of the target. This is also a slight deterioration on the 2016/17 outturn of 92.45%. Due to an amendment to the indicator for this year, data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available.

Trust Dashboard Graphs for TRUST

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



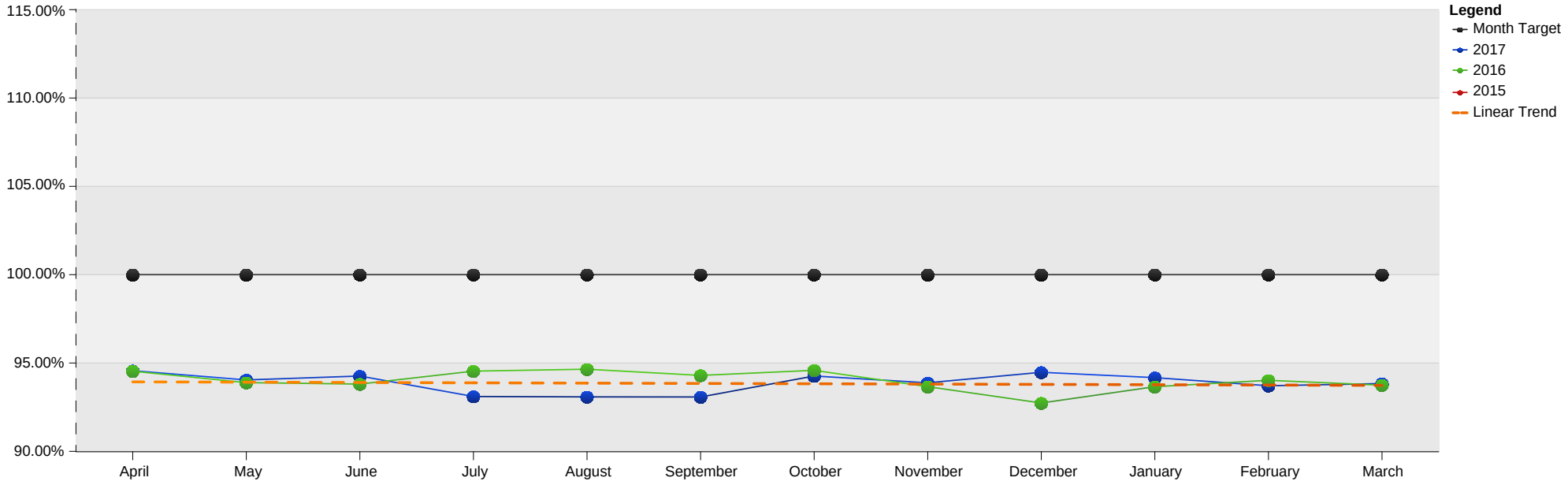
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.59	16.34	0.80	13.08	1.13	13.09	3.59	24.25	0.00	101.57	2.41	15.55		

Narrative

The Trust position for March 2018 is 1.73, which is not meeting the expected number of 1.00. This rate relates to 9 unexpected deaths which occurred in March . This is a decrease on the 10 unexpected deaths reported in February but is still one of the highest levels in the year to date.Of the 9 unexpected deaths the details below shows a breakdown by locality:2 x Tees2 x Durham and Darlington3 x North Yorkshire2 x York and SelbyOf the unexpected deaths that occurred in March 6 occurred in adult services and 3 in MHSOP services. A meeting took place during March between Patient Safety, Corporate Performance Team and Information team to look at how the data around the coroner's verdicts can be reported in a more meaningful and detailed way. Work is underway to ensure this is in place for 2018/19 reporting.

Trust Dashboard Graphs for TRUST

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

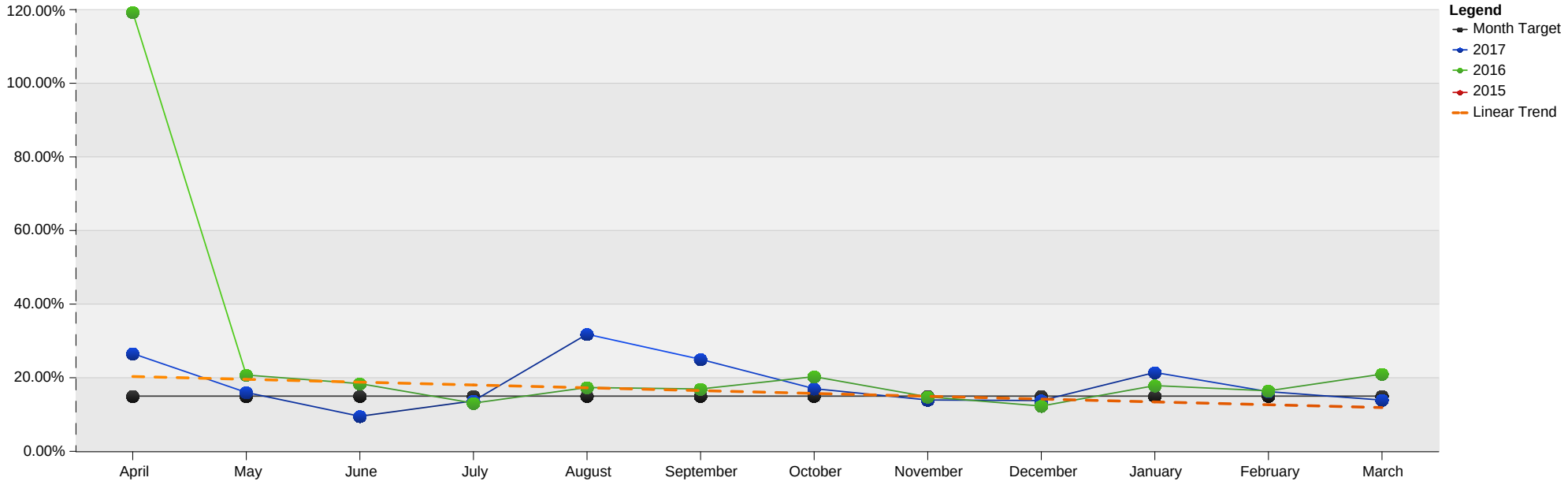


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Actual number of workforce in month (Establishment 95%-100%)	93.83%	93.83%	94.96%	94.96%	97.51%	97.51%	92.99%	92.99%	94.34%	94.34%	86.51%	86.51%		

Narrative
The Trust position for 31 March 2018 is 93.8% which is marginally below the targeted establishment level of 95-100%. It is expected that the establishment rate will continue to improve following the appointment of newly qualified nurses and on-going recruitment events.

Trust Dashboard Graphs for TRUST

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



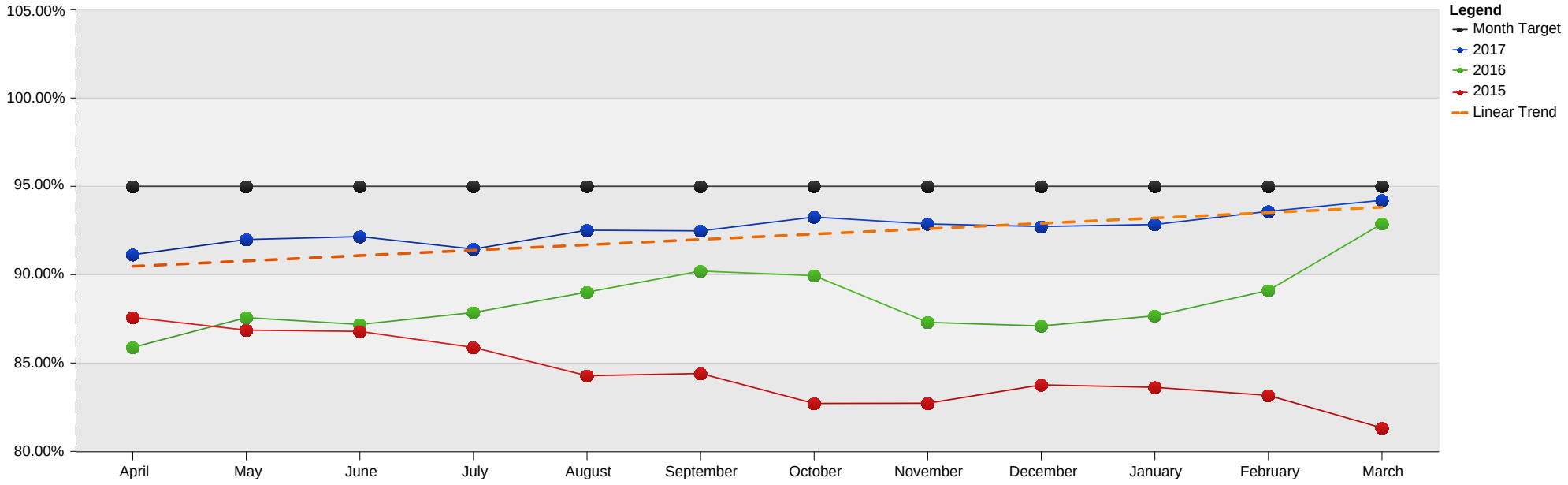
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Percentage of registered healthcare professional jobs that are advertised two or more times	13.92%	18.32%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative

The Trust position for March 2018 has decreased to 13.92% which is below the target of 15.00%. There were 5 non-medical vacancies re-advertised in March out of a total of 72 posts advertised.The posts proving difficult to recruit to are:- • CPN Band 6 Durham AMH• PWP Band 5 – Whitby• CAMHS Crisis Practitioner – Band 6 Scarborough• Staff Nurse – Band 5 MHSOP Scarborough• CAMHS Community Nurse – Band 6 York and SelbyThe figure for the financial year is 18:32% which is higher than the target of 15%. Across the year there have been a number of posts that have been difficult to recruit to. This area will continue to be monitored closely. Data only started to be reported for this dashboard from April 2016, therefore no comparative data for 2015/16 is available.

Trust Dashboard Graphs for TRUST

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

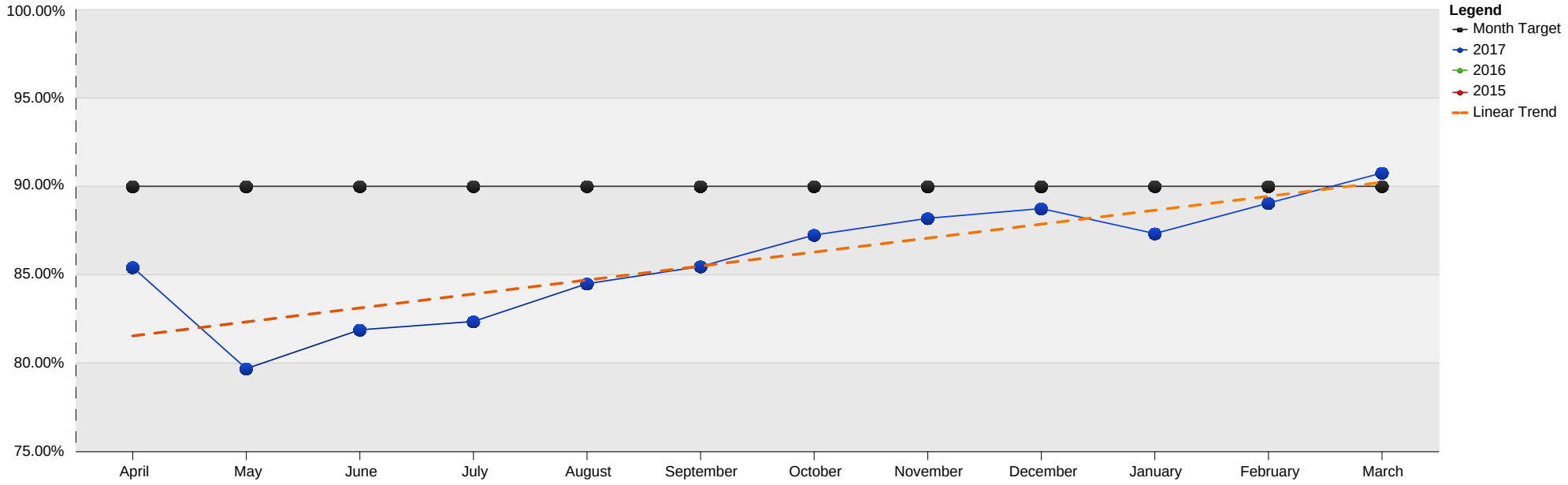


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	94.21%	94.21%	94.44%	94.44%	96.18%	96.18%	91.10%	91.10%	97.63%	97.63%	93.48%	93.48%		

Narrative
The Trust position for March 2018 and financial year is 94.21% which relates to 330 members of staff out of 5695 that do not have a current appraisal. Although this is just below the target of 95% it represents a sustained improvement on the figure reported in February and throughout the year.Forensic services and Teesside are above the target of 95% with all 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

17) Percentage compliance with ALL mandatory and statutory training (snapshot)

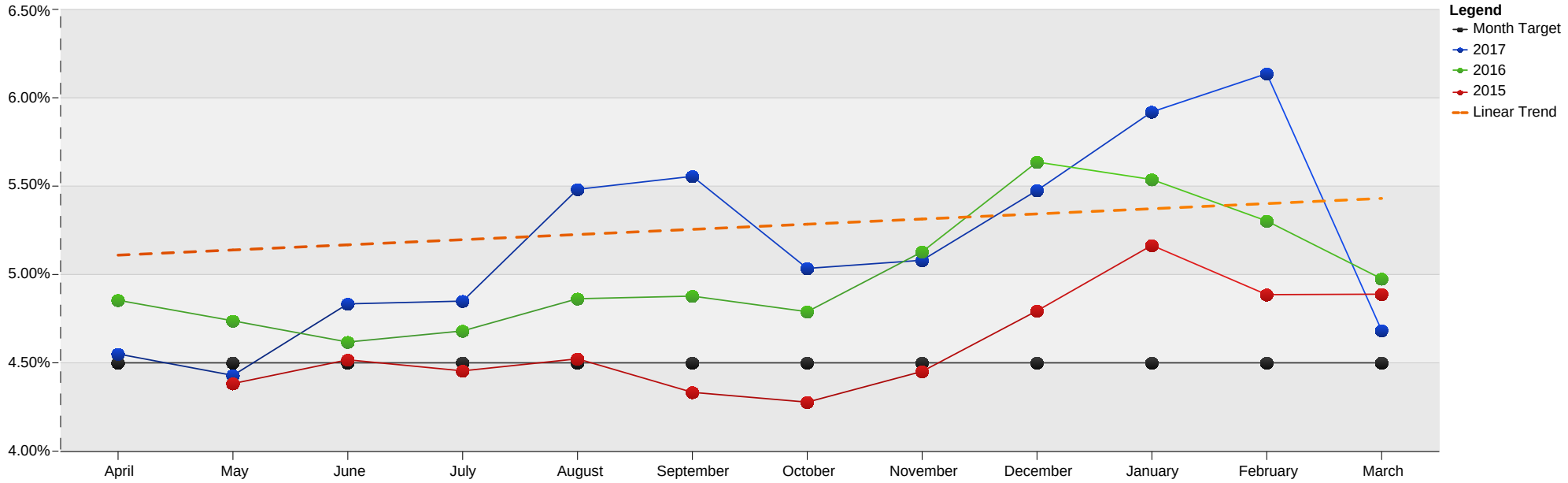


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.75%	90.75%	88.81%	88.81%	91.25%	91.25%	89.49%	89.49%	92.13%	92.13%	92.22%	92.22%		

Narrative
The position for March 2018 and financial year is 90.75%, which is over the target of 90%. 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

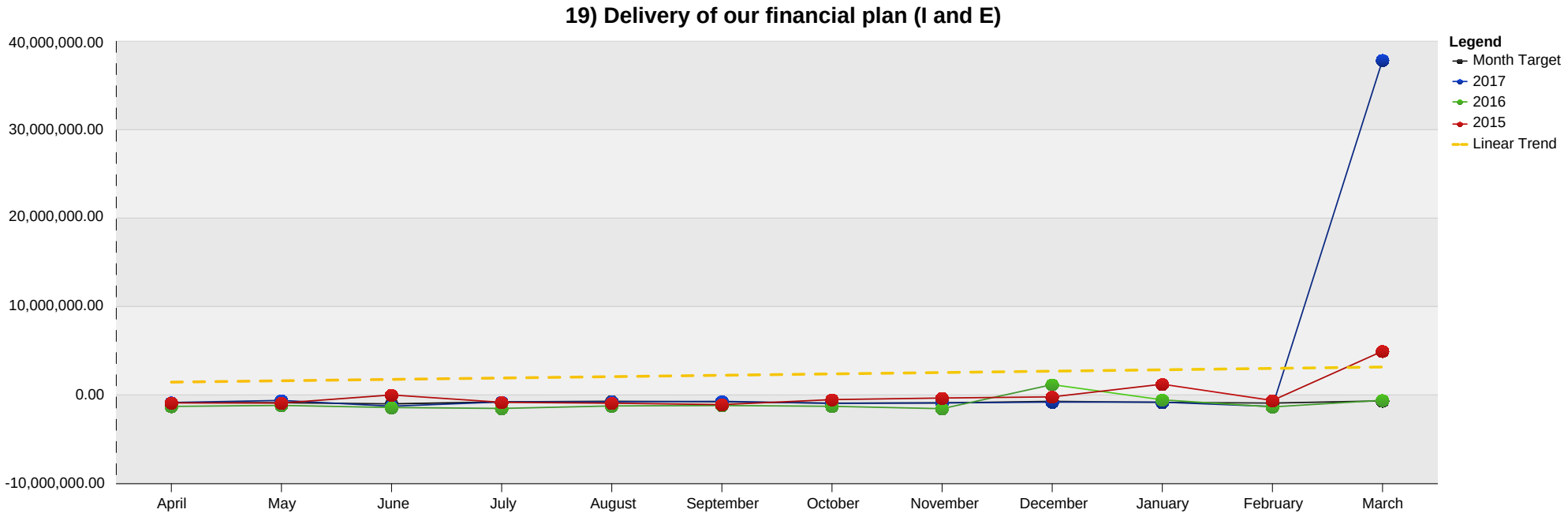
18) Percentage Sickness Absence Rate (month behind)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	4.68%	5.18%	5.31%	5.62%	5.01%	5.77%	3.24%	4.38%	4.68%	5.16%	5.53%	5.69%		

Narrative
The Trust position reported in March relates to the February sickness level. The Trust position reported in March 2018 is a figure of 4.68% which is over the target of 4.50% but represents an improvement on the position since August 2018. A deep dive in to reasons for absence occurring in December, January and February compared with the two previous years highlighted a significant increase in episodes of absence related to colds, coughs and flu. The Trust would normally experience approximately on average 500 episodes during this period but experienced in excess of 800 this year. Short term absence is defined as 1 to 27 days and the Trust would normally experience 1850 episodes between December and February, this increased to 2200 this year. Episodes of long term absence during this period remained as we would expect. The figure for the financial year is 5.18% which is over the target of 4.50% and a slight deterioration of the 2016/17 outturn of 5%.As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive).

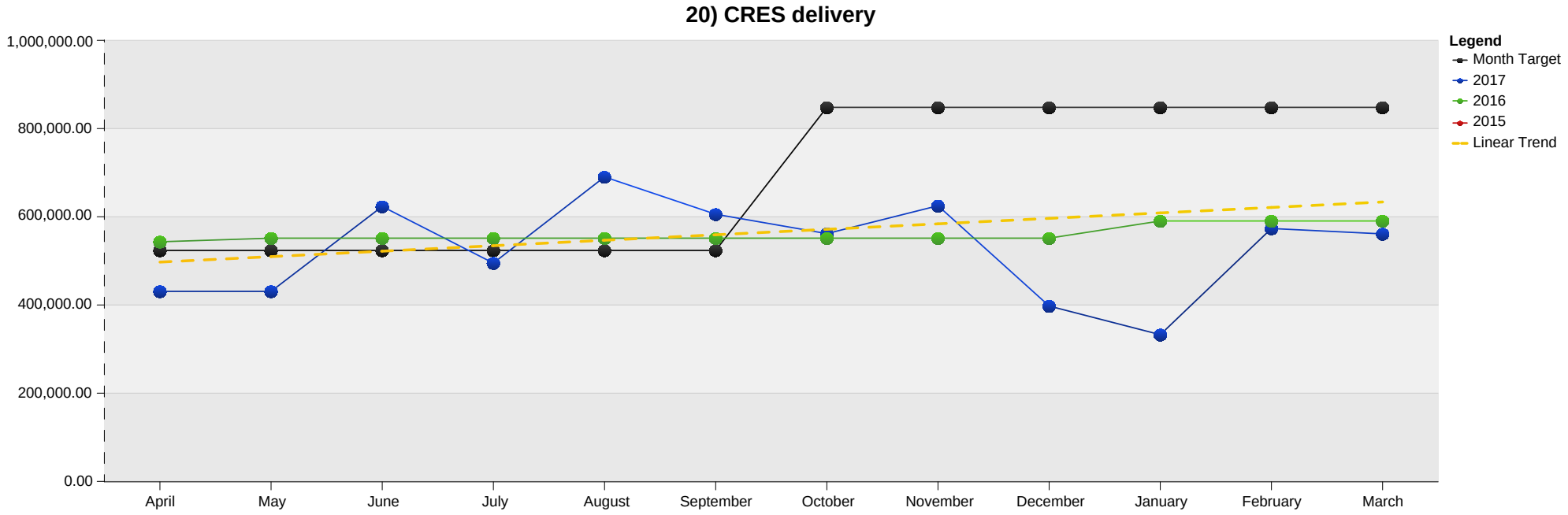
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Delivery of our financial plan (I and E)	37,866,000.00	27,983,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
The comprehensive income outturn for the period ending 31 March 2018 was a deficit of £27,983k, which was £38,059k behind the planned £10,076k surplus. The deficit position includes £41,086k of unplanned asset impairments largely due to a review of Roseberry Park Hospital (RPH) to reflect the cost of rectification works required. Excluding these impairments the Trust's operating surplus was ahead of plan by £3,027k, which represents 8.2% of the Trust's turnover.

Trust Dashboard Graphs for TRUST

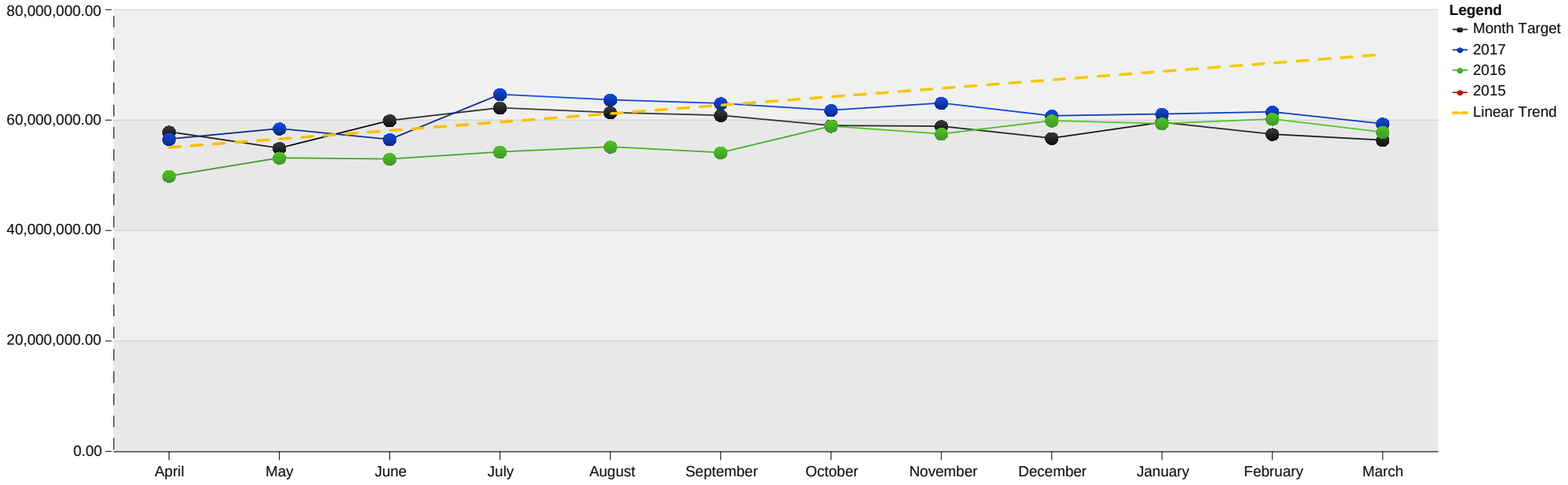


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) CRES delivery	561,132.00	6,327,550.61												

Narrative
Identified Cash Releasing Efficiency Savings at 31 March 2018 are £1,902k behind plan for the year to date. The shortfall was largely due to slippage on CRES schemes which were due to commence 1 October 2017. The Trust has, and continues to, identify and develop schemes to ensure full delivery of recurrent CRES requirements, and has non-recurrent expenditure mitigations in place to manage the position in 2017/18.

Trust Dashboard Graphs for TRUST

21) Cash against plan



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Cash against plan	59,334,000.00	59,334,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
Total cash at 31 March 2018 is £59,334k and is £2,958k ahead of plan largely due to working capital variations.

Trust Dashboard - Locality Breakdown for TRUST

1 - Activity

	March 2018														April 2017 To March 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Total number of External Referrals into Trust Services	7,793.00	9,122.00	1,884.00	2,116.00	1,915.00	2,736.00	1,848.00	2,077.00	586.00	663.00	1,559.00	1,530.00			91,759.00	105,573.00	22,194.00	24,428.00	22,556.00	31,636.00	21,762.00	24,837.00	6,895.00	7,591.00	18,352.00	17,078.00		
2) Caseload Turnover	1.99%	3.94%	1.99%	3.72%	1.99%	4.39%	1.99%	1.07%	NA	NA	1.99%	7.71%			1.99%	3.94%	1.99%	3.72%	1.99%	4.39%	1.99%	1.07%	NA	NA	1.99%	7.71%		
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	90.11%	85.00%	86.90%	85.00%	95.73%	85.00%	97.24%	85.00%	NA	85.00%	79.91%			85.00%	86.63%	85.00%	88.25%	85.00%	86.29%	85.00%	90.09%	85.00%	NA	85.00%	79.42%		
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	75.00	57.00	16.00	14.00	44.00	48.00	22.00	16.00			24.00	13.00			75.00	57.00	16.00	14.00	44.00	48.00	22.00	16.00			24.00	13.00		
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	8.43%	10.00%	7.22%	10.00%	9.46%	10.00%	7.48%			10.00%	9.91%	10.00%		10.00%	8.87%	10.00%	7.97%	10.00%	8.99%	10.00%	8.23%			10.00%	10.92%	10.00%	
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	20.00	27.67	6.00	11.00	6.00	8.33	7.00	3.33			2.00	3.67			237.00	309.00	65.00	114.33	65.00	67.67	79.00	53.67			28.00	57.33		

Trust Dashboard - Locality Breakdown for TRUST

2 - Quality

	March 2018														April 2017 To March 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	90.00%	90.43%	90.00%	90.76%	90.00%	97.35%	90.00%	82.78%	90.00%	99.81%	90.00%	73.14%			90.00%	90.73%	90.00%	90.13%	90.00%	98.20%	90.00%	83.25%	90.00%	99.75%	90.00%	74.07%		
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	9.49%	10.00%	9.81%	10.00%	4.86%	10.00%	15.86%	10.00%		10.00%	7.87%			10.00%	8.72%	10.00%	10.58%	10.00%	5.61%	10.00%	11.75%	10.00%		10.00%	5.24%		
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	13.44%	20.00%	1.94%	20.00%	8.08%	20.00%	37.70%			20.00%	18.52%			20.00%	14.08%	20.00%	5.56%	20.00%	5.32%	20.00%	39.24%			20.00%	22.06%		
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	91.12%	92.45%	91.79%	92.45%	94.23%	92.45%	91.32%	92.45%	69.79%	92.45%	90.10%			92.45%	91.56%	92.45%	92.40%	92.45%	92.79%	92.45%	91.70%	92.45%	80.50%	92.45%	90.66%		
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.59	1.00	0.80	1.00	1.13	1.00	3.59	1.00	0.00	1.00	2.41			12.00	16.34	12.00	13.08	12.00	13.09	12.00	24.25	12.00	101.57	12.00	15.55		

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	March 2018														April 2017 To March 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	93.83%	100.00%	94.96%	100.00%	97.51%	100.00%	92.99%	100.00%	94.34%	100.00%	86.51%			100.00%	93.83%	100.00%	94.96%	100.00%	97.51%	100.00%	92.99%	100.00%	94.34%	100.00%	86.51%		
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	13.92%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA			15.00%	18.32%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA		
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	94.21%	95.00%	94.44%	95.00%	96.18%	95.00%	91.10%	95.00%	97.63%	95.00%	93.48%			95.00%	94.21%	95.00%	94.44%	95.00%	96.18%	95.00%	91.10%	95.00%	97.63%	95.00%	93.48%		
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	90.75%	90.00%	88.81%	90.00%	91.25%	90.00%	89.49%	90.00%	92.13%	90.00%	92.22%			90.00%	90.75%	90.00%	88.81%	90.00%	91.25%	90.00%	89.49%	90.00%	92.13%	90.00%	92.22%		
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.68%	4.50%	5.31%	4.50%	5.01%	4.50%	3.24%	4.50%	4.68%	4.50%	5.53%			4.50%	5.18%	4.50%	5.62%	4.50%	5.77%	4.50%	4.38%	4.50%	5.16%	4.50%	5.69%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	March 2018														April 2017 To March 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
19) Delivery of our financial plan (I and E)	-677,000.00	37,866,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			-10,076,000.00	27,983,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
20) CRES delivery	848,000.00	561,132.00	107,322.17		198,536.25		148,049.17		124,378.00		59,416.00				8,230,080.00	6,327,550.61	1,287,866.00		2,382,435.00		1,776,590.00		1,492,536.00		712,992.00			
21) Cash against plan	56,376,000.00	59,334,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			56,376,000.00	59,334,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Number of unexpected deaths 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

Number of unexpected deaths and verdicts from the Coroner 2016 / 2017

This table has been included into this appendix for comparitive purposes only

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

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

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

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

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

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

ITEM 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24th April 2018**
TITLE:	**Proposed targets for the Trust Dashboard metrics for 2018/19.**
REPORT OF:	**Sharon Pickering, Director of Planning & Performance**
REPORT FOR:	**Discussion and Decision**

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

Executive Summary:

The purpose of this report is to gain approval of the Board to the proposed targets for the agreed Key Performance Indicators (KPIs) for the 2018/19 Trust Dashboard as contained in Appendix A.

Of the 22 KPIs being proposed, there are 7 which are either new or revisions. Targets have not been proposed for these as work is still underway to build these on the IIC and identify baselines. Once baselines are known suitable targets will be proposed for approval.

Recommendations:

The Board of Directors is asked to:

- Discuss and agree the proposed targets contained with Appendix A noting the proposed amendments to a small number of the KPIs as proposed in Section 3.2.
- Agree to receive further proposals on those KPIs where work is still ongoing to obtain baseline positions.

MEETING OF:	**Board of Directors**
DATE:	**24th April 2018**
TITLE:	**Proposed targets for the Trust Dashboard metrics for 2018/19.**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to propose targets for the KPIs within the Trust Dashboard 2018/19 for discussion and approval by the Board of Directors.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 In October 2017, as part of the Board Business Planning Event, members of the Board, EMT, Senior Operational and Clinical Directors and Heads of Nursing discussed the Trust Dashboard for 18/19 as part of the planning process.

2.2 In late November 2017, the Board of Directors discussed and agreed the final set of Key Performance Indicators for inclusion in the 18/19 Trust Dashboard.

3. KEY ISSUES:

3.1 As part of the 18/19 development process, targets must be set for each of the indicators identified. EMT have discussed proposals developed by the Corporate Performance Team and their recommendation for each of the Key Performance Indicators can be found in **Appendix A**. Once the Board of Directors have agreed the final targets the tolerance levels to determine the RAG rating will be calculated reflecting the calculations used in the current RAG tolerance levels.

3.2 EMT are also proposing a small number of changes or updates to the KPIs that the Board of Directors agreed in November 2017 which are:

- The Corporate Performance Team proposed an <u>additional</u> new KPI for inclusion in the 18/19 Trust Dashboard. Whilst undertaking development work it was identified that in order for KPIs 9 and 10 to be meaningful, we would need to have a KPI about the "Number of new unique patients referred in the reporting period". **The proposal from EMT** therefore is that we will replace the current KPI 8 (External Referrals) with this new KPI. This would then be used to identify those with an assessment completed (KPI 9) and those subsequently accepted onto caseload (KPI 10).
- The percentage of inappropriate Out of Area Placements (AMH & MHSOP) has been <u>changed</u> to reflect the national metric ***"The total number of inappropriate OAP days over the reporting period (Rolling 3 months)"*** (KPI 3)
- Outcomes measures are now defined as ***"The % teams achieving the agreed improvement benchmarks for HoNOS total score"*** <u>and</u> ***"The % teams achieving the agreed improvement benchmarks for SWEMWBS"*** (KPIs 6 and 7)

3.3 Of the 22 KPIs being proposed, there are 7 which are either new or revisions. Targets have not been proposed for these as work is still underway to build these on the IIC and identify baselines. Once baselines are known suitable targets will be proposed for approval.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** There are no CQC implications arising from this report.

4.2 **Financial/Value for Money:** Financial measures are included in the key performance indicators for 18/19 and the targets proposed will reflect the financial plan.

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

4.4 **Equality and Diversity:** There are no direct equality and diversity implications arising from this report.

4.4 **Other implications:** There are no other implications arising from this report.

5. RISKS:

5.1 There are no direct risks associated with this report.

6. CONCLUSIONS:

6.1 EMT have discussed the proposed targets for the majority of the Key Performance Indicators in the 18/19 Trust Dashboard and are making recommendations to the Board of Directors for approval as per Appendix A.

6.2 There are 7 indicators where work is continuing to establish a baseline and once this is completed further targets will be proposed for approval by the Board of Directors.

7. RECOMMENDATIONS:

7.1 The Board of Directors is asked to:

- Discuss and agree the proposed targets contained with Appendix A noting the proposed amendments to a small number of the KPIs as proposed in Section 3.2.
- Agree to receive further proposals on those KPIs where work is still ongoing to obtain baseline positions.

Sharon Pickering
Director of Planning, Performance and Communications

Trust Dashboard 18/19 Proposed Targets **Appendix A**

No	KPI	Current Target	17/18 Actual	Comments	EMT Recommendation
1	***Revised*** Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	N/A	N/A	From 18/19 this would exclude clock stops/re-starts in line with other national access standards there current KPI not comparable.	This KPI is still in development therefore baseline data is not currently available. Once available a suitable target will be proposed for approval.
2	***New*** Percentage of patients starting "treatment" within (x) weeks of external referral	N/A	N/A	Development work is underway to "build" the new KPI and determine the appropriate number of weeks for KPI and a suitable target.	Once the KPI is confirmed and the baseline known a suitable target will be proposed for approval.
3	***New*** The total number of inappropriate OAP days over the reporting period (Rolling 3 months)	N/A	N/A	This is a national KPI and the baseline position used in the setting of the national trajectory (leading up to April 2021) was that ending Dec 17 of **2515**	To use the Year 1 trajectory submitted nationally of 2264 by 31 March 19. Interim quarterly targets: Q1 - 2452 Q2 - 2389 Q3 - 2326
4	Percentage of patients surveyed reporting their overall experience as excellent or good *(No change)*	92.45% On target or higher Up to 5% below target 5% or more below target	91.56%	Previous target setting was to maintain out-turn however latest actual FYTD performance is just below this.	Retain 17/18 target of 92.45%

No	KPI	Current Target	17/18 Actual	Comments	EMT Recommendation
5	Number of unexpected deaths classed as a serious incident per 10,000 open cases *(No change)*	12.00 12.00 or less 12.01-13.20 (within 10% of target) 13.20 or more (10% or more above target)	16.34	17/18 Target is consistent with 15/16 and 16/17 targets given nature of indicator. Whilst it is recognised that 17/18 actual is significantly above the expected level given the national zero suicide ambition it would seem inappropriate to increase the expected level.	Retain 17/18 target of 12.00
6	***New*** The % teams achieving the agreed improvement benchmarks for HoNOS total score	N/A	N/A	The average performance across the 4 quarters of 17/18 was 57.25%	Set a target of 67.25% (10% improvement on baseline)
7	***New*** The % teams achieving the agreed improvement benchmarks for SWEMWBS	N/A	N/A	The average performance across the 4 quarters of 17/18 was 68.25%	Set a target of 78.25% (10% improvement on baseline)

No	KPI	Current Target	17/18 Actual	Comments	EMT Recommendation
8	Total number of External Referrals into Trust Services *(No change)*	91,759 Between 87,171 and 96,347 (within 5% of target) Between 82,584 and 87,170 or 96,348 and 100,934 (between 5 and 10% of target) Less than 82,583 or more than 100,935 (10% below or above target)	105,573	The 17/18 target is based on the 16/17 target which included a 20% increase for York & Selby Services. *Previous target setting was to maintain out-turn given pressures on the teams it was not thought appropriate to increase this.	To replace this KPI with the new one indicated below.
*	***Proposed new KPI*** Number of new unique patients referred	N/A	N/A	New KPI being proposed	These new KPIs are still in development therefore baseline data is not currently available. Once the baseline is known a suitable target will be proposed for approval.
9	***New*** The number of external referrals with an Assessment completed	N/A	N/A		
10	***New*** The number of external referrals which were subsequently accepted onto caseload	N/A	N/A		
11	***New*** The number of discharges from total caseload	N/A	N/A		

No	KPI	Current Target	17/18 Actual	Comments	EMT Recommendation
12	Bed Occupancy (AMH & MHSOP A & T Wards) *(No change)*	85% 85-87.5% 65-84.9% or 87.5-90.0% Less than 65% or more than 90%	86.63%	This is the existing bed occupancy target within the Trust for Assessment & Treatment Wards as well as the national recommended occupancy rate	Retain 17/18 target of 85% (however EMT recommend that during 18/19 we do further work to assure ourselves that the national recommended occupancy rate is still appropriate given it was set a number of years ago)
13	Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards (Snapshot) *(No change)*	75 75 or less 76-79 (within 5% of target) 80 or more (exceeds 5% of target)	57	The 17/18 target was based on a 10% improvement on the 2016/17 baseline which is consistent to the approach made in previous years and with other indicators. Whilst the FYTD is considerably lower than the target this was due to some months being exceptionally low.	Reduce the 17/18 target by a further 10% to give 68 (which would also be between current target and FYTD)
14	***Revised*** Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	N/A	N/A	Two changes made from 17/18 metric: • Excludes transfers back from Acute Trust when an inpatient had needed physical healthcare on an Acute Ward • Removed the "rolling 3 months" and report those than occurred in the reporting month	This KPI is still in development with the required changes therefore baseline data is not currently available. Once the baseline is known a suitable target will be proposed for approval.
15	Actual number of workforce in month *(No change)*	100% 95-100% 90-95% or 100-102% Less than 90% or more than 102%	93.83%	The 17/18 target links to the Financial Plan.	Retain 17/18 target of 95-100%

No	KPI	Current Target	17/18 Actual	Comments	EMT Recommendation
16	**New** Vacancy fill rate	N/A	N/A	Baseline 88% (based on a snapshot as at 6th April 18 with 8 week period being posts advertised in January 18).	Given limitation of baseline being based on one snapshot of data set 90% as an interim target and review at end of Q2
17	Percentage of staff in post more than 12 months with a current appraisal *(No change)*	95% 95% or more 88.00% - 94.99% Less than 88%	94.21%	17/18 Target is consistent with 15/16 and 16/17 targets given "Trust standard".	Retain 17/18 target of 95%
18	Percentage compliance with ALL mandatory and statutory training (No change)	90% 90% or more 83.00% - 89.99% Less than 83%	90.75%	This is the first year that the target has been achieved. We have agreed that additional training will become mandatory in 18/19 eg Mental Health Act training, dual diagnosis training	Set the target at 92% for 18/19 with an ambition to increase to 95% in 2019/20
19	Percentage Sickness Absence Rate *(No change)*	4.5% 4.5% or less 4.51-4.99% More than 4.99%	5.18%	17/18 Target is consistent with 15/16 and 16/17 targets as recognised impact of sickness on both quality and finances	Retain 17/18 target of 4.5%
20	Delivery of our financial plan (I&E) *(No change)*	-10,076.00 Within target N/A Outside target	27,983,000	Target based on Financial Plan	As per Financial Plan
21	CRES delivery *No change)*	8,230,080.00 Within target N/A Outside target	6,327,550.61	Target based on Financial Plan	As per Financial Plan
22	Cash against plan *(No change)*	56,376,000.00 Within target N/A Outside target	59,334,000	Target based on Financial Plan	As per Financial Plan

ITEM NO. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24th April 2018**
TITLE:	**Single Oversight Framework**
REPORT OF:	**Phil Bellas, Trust Secretary & Sharon Pickering, Director of Planning, Performance and Communications**
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:

The Single Oversight Framework (SOF) sets out NHS Improvement's approach to identifying the potential support needs of providers as they emerge.

The purpose of this report is to examine the Trust's position against the requirements of the revised SOF at the end of Quarter 4, 2017/18.

Overall, the report provides assurance, to the extent that information is available, that the Trust's segment 1 (maximum autonomy) rating should be maintained.

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**24th April 2018**
TITLE:	**Single Oversight Framework**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to examine the Trust's position against NHS Improvement's (NHSI) Single Oversight Framework (SOF) at the end of Quarter 4, 2017/18.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The SOF (latest version published in November 2017) sets out NHSI's approach to overseeing NHS Trusts/Foundation Trusts and seeks to enable the regulator to identify where providers may benefit from, or require, improvement support.

2.2 NHSI uses a range of information across the following five themes: quality of care; finance and use of resources; operational performance; strategic change; and leadership and improvement capability.

2.3 Providers are placed in segments ranging from 1 (maximum autonomy) to 4 (special measures) based on NHSI's judgement of the seriousness and complexity of the issues they face.

2.4 The Trust has been placed in segment 1 since the introduction of the SOF.

2.5 In previous reports the Board has noted that:

(a) The Trust's position is a significant achievement in comparison to other local mental health providers.

(b) Although the Trust undertakes internal monitoring against the quality of care and operational performance metrics this is hampered by a number of issues principally related to the regulator's use of national data sources.

2.6 The Board is asked to noted that the next Quarterly Review Meeting with NHSI is not due to be held until 27th April 2018 and, therefore, any assurances provided by, or material issues raised by the regulator, will not be available for the meeting.

3. KEY ISSUES:

3.1 The following sections explore the Trust's position against the triggers used by NHSI for determining support to be provided under the SOF and seek to highlight any risks to the maintenance of the segment 1 position.

3.2 The Board is asked to note that changes to the segmentation of providers are not automatic if a trigger occurs. NHSI takes into account a provider's circumstances in determining the nature and extent of any support required.

Quality of Care

Triggers
▪ CQC 'inadequate' or 'requires improvement' assessment in overall rating, or against any of the safe, effective, caring or responsive key question ▪ CQC warning notices ▪ Other material concerns identified or relevant to CQC monitoring processes e.g. civil or criminal cases raised, whistleblowers etc. ▪ Concerns arising from trends in quality indicators ▪ Delivery against an agreed trajectory for the four priority standards for 7-day hospital services ▪ Any other material concerns about a provider's quality of care arising from intelligence gathered by or provided to NHSI

3.3 The Trust's position on the quality indicators is provided in Annex 1 to this report.

3.4 The Board is asked to note that:

(a) The Trust's segmentation reflects its "good" CQC rating.

(b) The implementation of the CQC Action Plan continues to be on track; however, further assurances are being sought on a few issues.

(c) There are no trends on the quality indicators which raise concerns at the present time.

(d) No CQC warning notices have been received since the last report.

(e) Plans to extend relevant services to meet 24/7 requirements are included in the Trust's Business Plan.

(f) There are no known exceptions to bring to the Board's attention.

Finance and Use of Resources

3.5 The Trust's position on the SOF requirements in relation to finance and use of resources is set out in the Finance Report (agenda item 12).

Operational Performance

Triggers
▪ Failure to meet the trajectory for a metric for at least two consecutive months (quarterly for quarterly metrics) ▪ Other factors (eg a significant deterioration in a single month or multiple potential support needs across standards and/or other themes) indicate NHSI needs to get involved before two months have elapsed ▪ Any other material concerns about a providers' operational performance arising from intelligence gathered by or provided to NHS Improvement

3.6 The Trust's position on the operational performance metrics is provided in Annex 2 to this report.

3.7 With regard to "out of area placements" (OAPs):

(a) The Board will recall that, at its last meeting, it was reported that the Trust had agreed a trajectory to reduce the OAPs by 10% each year over the next three years and this had been submitted to NHS England.

(b) Further information is provided in the Performance Dashboard Report (see agenda item 15).

(c) The significant variation between the "national" and "internal" data for September and October 2017 reflects data quality issues as work was undertaken within the Trust to seek to replicate national reporting. As the indicator was not introduced until November 2017 the information for those months should be disregarded.

3.8 There are no known exceptions to bring to the Board's attention.

Strategic Change

Triggers
Material concerns with a provider's delivery against the *local* transformation agenda, including new care models and devolution

3.9 Whilst there is a lack of clarity in the SOF on the assessment and application of the triggers under this theme, the Board will be aware that the Trust continues to engage positively with the local transformation agenda.

Leadership and Improvement Capability (Well-led)

Triggers
▪ CQC 'inadequate' or 'requires improvement' assessment against 'well-led'. ▪ Concerns arising from trends in the organisational health indicators ▪ Other material concerns about a provider's governance, leadership and improvement capability, arising from third-party reports, developmental well-led reviews or other relevant sources

3.10 The Trust's position on the leadership and improvement capability metrics is provided in Annex 3 to this report.

3.11 The Board is asked to note:

(a) That, following the CQC inspection in January 2017, the Trust was rated "good" in the well-led domain.

(b) That no material issues were identified during the external governance review in 2017.

(c) The positions on the staff turnover and the proportion of temporary staff. Neither of these is considered to be material; however, further information on the latter issue is provided in the Finance Report (agenda item 12).

(d) That, at this time, there is no known third party information (e.g. GMC, PHSO, Healthwatch, HSE, complaints, whistleblowers, medical royal colleges) which suggests governance concerns in the Trust.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** There are no direct CQC implications arising from this report; however NHSI's aim is to help providers attain and maintain CQC ratings of "good" or "outstanding".

4.2 **Financial/Value for Money:** Assessments of the Trust's position against the SOF's theme of finance and use of resources are provided in the Finance Reports.

4.3 **Legal and Constitutional (including the NHS Constitution):** The legal basis for enforcement action in relation to NHS Foundation Trusts remains unchanged. This means that, for example, a Foundation Trust will only be in segments 3 or 4 where it has been found to have been in breach or suspected breach of its licence.

4.4 **Equality and Diversity:** Information on delivering Workforce Race Equality Standards (WRES) will be used as part of assessments under the Leadership and improvement capability theme; however, no further information on this matter is included in the SOF.

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are risks arising from the Trust not being able to accurately assess its position against the requirements of the SOF in view of the lack of information on the construction of metrics; information not being available from the national sources identified; and/or data quality issues.

6. CONCLUSIONS:

6.1 Overall, the Trust should expect to maintain its segment 1 position for Quarter 4; however, close monitoring by NHSI is expected to continue.

7. RECOMMENDATIONS:

7.1 The Board is asked to receive and note this report.

Phil Bellas, Trust Secretary
Ashleigh Lyons, Corporate Performance Manager

Background Papers:
Single Oversight Framework published by NHS Improvement in November 2017

SINGLE OVERSIGHT SCORECARD - QUALITY INDICATORS - 2017/18

Annex 1

All Providers																	
Quality Indicators	**SOF Source**	**Other known source**	**Freq.**		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
Written compliants - rate	NHS Digital	n/a	Q		9.7			9.7			10.7						Last published data is December 2017
Staff and Friends and Family test % recommended - care	NHSE	n/a	Q		83%			81%			No Staff FFT in Q3						Next publication of data 24 May 2018 for Quarter 4 2017-18
		Strategic Direction Perf. Report	Q		84%			81%			No Staff FFT in Q3						
Occurrence of Never Event	NHS Improvement	Governance	M		0	0	0	0	0	0	0	0	0	0	0	-	Data published up to 28 February 2018
NHS England/NHS Improvement Patient Safety Alerts outstanding	NHS Improvement	Governance	M		0	0	0	0	0	0	0	0	0	0	0	-	Data published up to 02 March 2018
Mental Health Providers																	
Quality Indicators	**SOF Source**	**Other known source**	**Freq.**		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
CQC inpatient/mental health and community survey	CQC	n/a	A		About the Same' as other Trusts												Trusts are no longer provided with an overall score and are rated as Better, About the Same or Worse on a range of questions in ten categories. Our Trust scored 'About the Same' in every category.
Mental Health scores from Friends and Family Test - % positive	NHSE	n/a	M		88.63%	88.10%	86.97%	89.12%	86.04%	87.15%	88.07%	85.26%	87.70%	86.71%	-	-	Latest published data January 2018
Admissions to adult faciliites of patients who are under 16 years old	NHS Digital	n/a	M														No public data available
		PARIS	M		0	0	0	1	0	0	0	0	0	0	0	0	Data from Paris (reported quarterly)
Quality Indicators	**SOF Source**	**Other known source**	**Freq.**	**Standard**	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
CPA follow up - proportion of discharges from hospital followed up within 7 days (all discharges treated as being on CPA)		UNIFY			96.42%			95.15%			97.21%						Latest published data as at the 31st December 2018
		pre validated IIC		95%	**92.63%**	**95.12%**	**97.93%**	**94.25%**	**95.38%**	**92.54%**	**96.20%**	**96.30%**	**93.43%**	**95.38%**	**96.38%**	**96.86%**	Post validated position stated is from our intenal files which are used to provide the UNIFY submission.
		post validated IIC			**94.74%**	**95.53%**	**98.76%**	**97.31%**	**96.22%**	**93.86%**	**98.72%**	**97.22%**	**95.26%**	**95.38%**	**97.29%**	**97.76%**	
% clients in settled accommodation	NHS Digital	n/a	M		79.05%	77.88%	80.83%	81.50%	82.27%	82.70%	83.51%	83.29%	83.33%				Latest published data December 2017
		IIC	M													81.19%	Percentage of people on CPA in settled accommodation
% clients in employment	NHS Digital	n/a	M		13.36%	13.50%	13.63%	13.56%	13.42%	13.27%	13.44%	13.67%	14.14%				Latest published data December 2017
		IIC	M													13.50%	Percentage of people on CPA in employment
Potential under-reporting of patient safety incidents	NHS England Dashboard	n/a	M														No data is published to reflect 'under-reporting'. Published data reports the Incidents reported between 01 Mar 2017 and 28 Feb 2018 (12 months rolling data), based on the date the report was submitted to the NRLS.

SINGLE OVERSIGHT SCORECARD - OPERATIONAL PERFORMANCE METRICS - 2017/18

Annex 2

Mental Health Providers																					
Operational Performance Metrics	**SOF Identified source**	**Other Identiifed Source**	Freq.	**Standard**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**
Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards	UNIFY2 and MHSDS	n/a	Q	95%	97.56%			97.31%			96.25%						97.56%	97.31%	96.25%		Data has been provided to complete the year's reporting position; however this metric is no longer in the SOF from November 2017
		pre validated IIC			92.41%	97.45%	90.00%	91.98%	91.95%	90.06%	95.17%	90.85%	89.38%	94.01%	93.88%	95.38%	93.29%	91.32%	91.72%	94.46%	
		post validated IIC			97.87%	98.09%	96.82%	97.45%	98.20%	98.20%	96.55%	95.68%	97.39%	97.56%	98.61%	98.82%	98.82%	97.58%	97.55%	98.33%	
People with a first episode of psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral	UNIFY2 and MHSDS	n/a	Q	50%	69.70%	78.26%	70.18%	77.55%	65.96%	71.43%	91.67%	76.36%	72.73%	55.81%	77.50%		72.79%	71.77%	80.27%	67.44%	This data is currently published from the Unify submissions that are made monthly
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **inpatient wards**	Board declaration but can be triangulated with results of CQUIN audit	Trust assessment	Q	90%										92.31%	-	92.50%				92.50%	
		National assessment																			Data has been collected and submitted to National Clinical Audit of Pschosis (NCAP) at the end of December 17 and results are expected May 2018.
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **early intervention in psychosis services**		Trust assessment	Q	90%										85.47%		91.00%				91.00%	
		National assessment																			Data has been collected and will be submitted to College Centre for Quality Improvement(CCQI) by 31st January, it is expected results will be available in May 2018
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **community mental health services (people on CPA)**		Trust assessment	Q	65%										70.73%	-	74.39%				74.39%	
		National assessment																			Data has been collected and submitted to NCAP at the end of December 17 and results are expected May 2018.
Complete and valid submissions of metrics in the monthly MHSDS submissions to NHS Digital - identifier metrics	MHSDS	IIC	M	95%	99.60%	99.57%	99.58%	99.53%	99.49%	99.71%							99.58%	99.71%			This metric is no longer in the SOF from November 2017
Complete and valid submissions of metrics in the monthly MHSDS submissions to NHS Digital - priority metrics	MHSDS	n/a	M	85%																	This metric is no longer in the SOF from November 2017
IAPT/Talking Therapies - proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	IAPT minimum dataset	n/a	Q	50%	50.06%	50.51%	52.60%	51.70%	48.55%	49.11%	52.58%						51.11%	49.76%	50.19%		Data only available until October on IAPT minimum dataset
		Internal Reports		50%	49.49%	50.63%	52.48%	51.10%	48.55%	49.01%	52.12%	51.22%	46.10%	50.54%	51.59%	51.56%	50.92%	49.51%	50.00%	51.23%	
IAPT/Talking Therapies - waiting time to begin treatment (from IAPT minimum dataset) - **within 6 weeks**	IAPT minimum dataset	n/a		75%							98.27%	96.54%	95.36%	97.05%							
		internal IAPT reports		75%							98.26%	96.50%	95.41%	97.07%	99.14%	98.93%	92.85%	93.59%	96.79%	98.36%	Following release of additional guidance in November 17, it is now clear that the IAPT indicator relates wait for treatment and is not linked ot the course of treatment being finished. The internal indicator has been backdated to October.
IAPT/Talking Therapies - waiting time to begin treatment (from IAPT minimum dataset) - **within 18 weeks**	IAPT minimum dataset	n/a	Q	95%							######	99.89%	99.86%	100.00%							IAPT minimum dataset data is only available until January 2018
		internal IAPT reports		95%							99.94%	99.83%	99.85%	100.00%	99.88%	100.00%	99.89%	99.83%	99.87%	99.96%	

SINGLE OVERSIGHT SCORECARD - ORGANISATIONAL HEALTH METRICS - 2017/18

Annex 3

All Providers																	
Quality Indicators	**SOF Source**	**Other known source**	Freq.		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
Staff Sickness	NHS Digital	n/a	M & Q		4.41%	4.79%	4.79%	5.42%	5.53%	5.02%	5.09%	5.44%					ESR Data Warehouse - last published data November 17
		Finance Return	M & Q			4.40%	4.80%	4.79%	4.83%	4.93%	4.66%	5.03%	5.04%	5.19%	5.29%	5.08%	Finance Return to NHS Improvement - not required to report in April. All other figures are a month behind
		Trust Dashboard (month behind)	M & Q		4.55%	4.39%	4.80%	4.85%	5.48%	5.56%	5.03%	5.08%	5.48%	5.92%	6.14%	4.68%	IIC reporting a month behind
Staff turnover (Finance Return)	NHS Digital	Finance Return	M & Q		0.50%	0.50%	0.60%	0.76%	1.10%	0.90%	0.82%	0.68%	0.76%	0.62%	0.68%	1.27%	All figures are a month behind
NHS Staff survey	CQC	n/a	A														Results being finalised - KF1. Staff recommendation of the trust as a place to work or receive treatment - Above (better than) National average
Proportion of temporary staff	Provider Return	n/a	Q		1.49%			1.47%			1.83%			2.57%			Finance Return to NHS Improvement

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24th April 2017**
TITLE:	**Board Performance Evaluation Scheme**
REPORT OF:	**Phil Bellas, Trust Secretary**
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:

This report provides an opportunity for the Board to consider its performance, and that of its Committees, based on the results of the Board Performance Evaluation Scheme which is undertaken each year in accordance with the Code of Governance.

Further to minute 17/C/243 (26/9/17) the report also provides an update on the progress made on the recommendations arising from the External Governance Review, undertaken by Grant Thornton LLP, in 2017.

Overall, the report provides positive assurance on:
(1) The Board's effectiveness and the operation of its Committees.
(2) The progress being made on the External Governance review recommendations.

Recommendations:

The Board is asked to:
(1) Receive and note this report.
(2) Consider whether any further actions are required in response to the performance evaluation or the External Governance review recommendations.

M4EETING OF:	**The Board of Directors**
DATE:	**24th April 2017**
TITLE:	**Board Performance Evaluation Scheme**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to enable the Board to consider:

(a) Its performance, and that of its Committees, based on the results of the Board Performance Evaluation Scheme (BPES) for 2017/18.

(b) The progress made on the recommendations arising from the External Governance Review in 2017.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Main principle B.6.a of the Foundation Trust Code of Governance states that *"The Board of Directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors."*

2.2 The Board uses an approach, known as the Board Performance Evaluation Scheme (BPES), which was originally developed by Deloitte LLP, to undertake the assessment.

2.3 This report focusses on the review of Board effectiveness; however, information is also provided on the assessments of the Board's Committees and the actions being taken forward by them in response to their own results.

2.4 Only summary information is provided in this report. The full schedules of the results have been made available on Boardpad or circulated under separate cover. Please note that the scoring of each question is based on a maximum of 4.0 points.

2.5 In 2017, the Board commissioned Grant Thornton LLP to undertake a review of its governance arrangements based on guidance from NHS Improvement in place at that time.

2.6 Please note that the report, arising from the review, was prepared by the firm on a confidential basis and remains so.

2.7 Whilst a formal action plan was not put in place by the Board, as it was recognised that many of the issues identified were already being taken forward, it was considered that an update should be provided in conjunction with the BPES results.

3. KEY ISSUES:

Board Effectiveness

3.1 The following tables provide a summary of the results of the Board Effectiveness review.

(a) **Overall changes to scores:**

	Number	Percentage
Number of **maximum** scores achieved i.e. 4.0	14	38.9%
Questions showing an **increase** in score on the previous year	19	52.8%
Questions showing a **decrease** in score on the previous year	8	22.2%
Questions showing **no change** on the previous year	9	25.0%

(b) **Average scores by domain:**

	2017/18	2016/17
Board Focus	3.85	3.84
Board Structure and Composition	3.97	3.98
Board Operations	3.80	3.71
Board Relationships	3.99	3.97
Board Learning and Development	3.86	3.78

3.2 Board Members are asked to note that:

(a) The results remain positive.

(b) Most of the changes to the scores were not material either positively or negatively.

(c) The score for question no. 18 (“All reports draw attention to the key pieces of information that require consideration by the Board before it can reach a decision in no more than two sides and clearly state where a matter is for decision, debate or information”), whilst still the lowest scoring question, has increased from 3.00 to 3.21.

(d) The key issue arising from the evaluation is that there has been little change on some of the lower scoring questions, e.g.:

- Question 3 9 (“The Board regularly hears about the needs and expectations of service users and their carers”) with an increase from 3.27 to 3.29.
- Question 17 (“The volume of paper I receive as a Board Member is appropriate”) with an increase from 3.47 to 3.50.

The Board might wish to consider whether further action on these matters is required taking into account the update provided on the

response to the recommendations of the External Governance Review (see below).

The Committees

3..3 A summary of the results of the BPES for the Board's Committees, and action being taken in response to the assessments, is attached as Annex 1 to this report for information.

3.4 The Board is asked to note, with regard to the Resources Committee, that:
(a) 2017/18 was the first year that an evaluation has been undertaken and the comparative changes to the scores in Annex 1 are against those of the Investment Committee in 2016/17.
(b) In its discussions on the results the Committee recognised that its development is continuing and further improvements have been made since the assessment was undertaken in November 2017.

3.5 It is considered that the results provide assurance that the Committees are performing effectively.

3.6 The Board will be aware that a review of the operational arrangements of the Mental Health Legislation, Resources and Quality Assurance Committee is being undertaken and report on this matter is due to be presented to its next meeting.

The External Governance Review

3.6 The present position on the recommendations arising from the External Governance Review is provided in Annex 2 to this report for assurance and discussion.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** Progress made on the recommendations of the External Governance Review is likely to be considered as part of the forthcoming well-led review of the Trust by the CQC.

4.2 **Financial/Value for Money:** None identified.

4.3 **Legal and Constitutional (including the NHS Constitution):** The BPES supports compliance with the Code of Governance as required under the Trust's Constitution.

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 The results of the BPES for 2016/17 provide assurance that the Board and its Committees continue to perform effectively.

6.2 The update provided in the report provides assurance that the Trust is continuing to strengthen its governance arrangements.

7. RECOMMENDATIONS:

7.1 The Board is asked to:

7.2 (a) Receive and note this report.

(b) Consider whether there are any further actions are required in response to the performance evaluation and the recommendations arising from the External Governance Review.

Phil Bellas,
Trust Secretary

Annex 1

Board Performance Evaluation Scheme 2017/18

Summary of the Results and Agreed Actions for the Board's Committees

	Audit Committee		Resources Committee		Quality Assurance Committee		Mental Health Legislation Committee	
	Number	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
Questions achieving **maximum** scores	**50**	**89.3%**	**8**	**40.0%**	**16**	**57.1%**	**6**	**30.0%**
Questions showing an **increase** in score on the previous year	**7**	**12.5%**	**3**	**15.0%**	**10**	**35.7%**	**8**	**40.0%**
Questions showing a **decrease** in score on the previous year	**5**	**8.9%**	**10**	**50.0%**	**5**	**17.9%**	**8**	**40.0%**
Questions showing **no change** on the previous year	**44**	**78.6%**	**7**	**35.0%**	**13**	**46.4%**	**4**	**20.0%**

Key Actions	To increase the level of ongoing assurance provided on whistleblowing. The Director of HR and OD has been asked to provide a report to the Committee's next meeting on this matter.	To further discuss the overall training schedule for Executive and Non-Executive Directors. Sufficient time to be given at each meeting to consider the business as it was acknowledged that the Committee had undergone some changes in the last year, namely the inclusion of Information and Workforce reporting.	To focus on communications between the Committee and the LMGBs including streamlining reports and to consider the key areas of assurance required from the Localities. This action is already underway through the QuAC planning meeting. To review processes to seek the views of staff at all levels, patients, the public and key stakeholders in the Trust's assessment of risks to quality, noting that this was a matter still in development.	*Verbal update to be provided following the Committee's meeting on 19th April 2019*

Annex 2

Update on the Position on the Recommendations arising from the External Governance Review 2017

	Lead	Recommendation	Progress
1	-	Link more clearly the indicators on the Board dashboard with the strategic priorities to which they relate.	This recommendation was not accepted as it was recognised that the purpose of the Performance Dashboard is to monitor operational performance on a month by month basis and the Board also receives a separate quarterly Strategic Direction Performance Report on progress against the Trust's five-year strategic direction in conjunction with the Trust Business Plan and other forms of intelligence.
2	**CEO**	Review and refresh risk management, to include: ▪ better linkages between 'top-down', strategic risks and 'bottom up' operational risks ▪ working with localities to ensure a more consistent interpretation and definition of risks ▪ make risk management a focus of Board development over the next 12 months	▪ A revised Organisational Risk Management Policy, developed in response to the recommendations of an Internal Audit review in 2017 (assignment ref: 18/17), was approved by the Board on 30th January 2018 and came into force on 1st April 2018. ▪ The EMT has agreed the arrangements for the introduction and monitoring of a "Corporate Risk Register" (EMT minute 17/11/32 – 8/11/17). ▪ Additional resources have been provided in the Nursing and Governance Directorate to support risk management in the Trust and a new Risk Manager was appointed on 6th April 2018 (start date to be confirmed). ▪ The Board received a briefing on risk management from the Director of Internal Audit at Audit One at its Seminar held on 14/11/17. ▪ A programme of 1:2:1 coaching for Executive Directors on risk management (provided by the Director of Internal Audit at Audit One) has been completed.

3	**Chairman**	Review duties expected of non-executive directors (NEDs) in view of reducing their number by one from September 2017.	This matter is being kept under review by the Chairman and the Non-Executive Directors.
4	**Trust Secretary**	Heighten the Board's awareness and understanding of quality improvement activity by including QI in new Board Members' inductions and considering adding short presentations and Q&A on a current QI project at the margins of Board meetings or other Board events.	▪ The Non-Executive Director induction programme has been amended to include a briefing by the Head of the KPO. ▪ Board Members continue to be invited to attend the Trustwide six monthly report outs on improvement events. ▪ A briefing by the Senior Clinical Director of the KPO is included in the 2018 Board Seminar Programme.
5	**DoHR&OD**	Seek alternative and more equitable ways of delivering training and meetings to reduce cost in both time and travel expense.	▪ The number of face to face training sessions within Localities has been increased to reduce staff travel time. ▪ The Trust Mandatory Training Needs Analysis has been revised in response to service feedback about eligibility criteria and training needs. ▪ Work to improve the TEWV Training Plan is continuing.
6	**DoHR&OD**	Investigate causes of disproportionate number of disciplinary cases involving black and minority ethnic (BME) staff and identify actions (eg awareness training).	▪ Research has been undertaken by the Trust (approved by the NHS Health Research Authority) which involved 282 staff, including 46 BAME staff. ▪ The results of this research are to be shared with the Board of Directors by July 2018 and will inform future action planning as part of the Trust Workforce Race Equality Standard action plan.
7	**DoHR&OD**	Review the methods used to disseminate learning, to make it more targeted and impactful	▪ The 2017 Investors in People assessment report has been used to enable the Board and EMT to agree the need for a refresh of Trust corporate communications. ▪ The Board Seminar in December 2017 was used to raise

			awareness of the experiences of BAME staff. This is now leading to the development of anew Trust-wide process whereby staff can report verbal abuse by service users and actions can be taken by managers to address this abuse and support staff more effectively.
8	**DoN&G**	Consider enhancing analysis of serious incidents (SIs) by engaging academic expertise.	This matter is to be considered by the Patient Safety Group, and subsequently the QuAC, when the end of year (2017/18) report into Serious Incidents is received in June 2018. This will allow a data set spanning 3 years along with emerging qualitative themes to be reviewed and analysed either internally or by engaging some external academic expertise.
9	**Chairman**	Monitor progress of the Resources Committee to ensure sufficient focus is applied to finance and workforce matters, e.g. review in six months and if necessary consider additional specialist committee(s).	The outcomes of a review of the operational arrangements of the Board's Committees are due to be presented to the Board at its meeting to be held on 22nd May 2018.
10	**CEO**	Consider the introduction of a regular 'service user story' at the start of Board meetings.	The Board recognised the importance of hearing patient and carer experiences but considered that it was more relevant and meaningful to invite service users and carers to participate in presentations, etc to meetings and other events rather than having a regular "story" at the start of Board meetings. Subsequent to discussions by the Board, the Chief Executives for the Yorkshire and Humber Region considered that there would be benefits from sharing and learning from their experiences on this matter. This work is ongoing.

11	**SCD KPO**	Consider the impact on some service users of their participation in training, service reviews etc, and ensure support is available to them.	In the context of delivering a recovery orientated approach, the Trust aims to avoid an overly paternalistic approach. The Experts by Experience("EbyE") are, therefore, not asked if they need special or different measures to 'protect or nurture' them but the Trust considers how it can better support all staff who are required to do difficult and emotionally taxing work (recognising that many of our existing staff have experience of mental distress and of accessing secondary services.) It is recognised that the EbyE role can be particularly demanding in a number of ways. Sharing one's lived experience, and listening to others doing the same can be painful and can leave people feeling very exposed. However, it has been found that there can also be huge benefits to EByEs by going through the process of both writing and sharing their testimony. It has been a powerful experience for many EByEs who have felt it is an opportunity to reclaim their narrative and have their voices heard. With this in mind, it is felt very important that people are offered and supported to make an informed choice about whether or not to participate. The emotional process and difficulties associated with storytelling is acknowledged in the EbyE training. No one is coerced into sharing their experiences and people are always forewarned about the potential impact and then given the choice. As the roles have developed since 2014, the work now incorporates much more than just storytelling. EByEs for example, sit on various project and steering groups, take part in recruitment, contribute to policy, etc. The breath of the role now means people have a greater deal of choice over what they participate in and there are now a number of very active Experts who choose never to tell their story. Continuing to expand the role

			and its remit will support this further. The Recovery Team has also incorporated several procedures into practise in order to offer the group support; ▪ Six days of training with emphasis on self-care and supporting one another. ▪ Debrief after every EbyE storytelling slot. ▪ Emphasis on making it safe for people to leave events at any point and always have choice over whether to tell their story. ▪ Recovery Team having a backup option if no one is available on any given event to share their story. ▪ The development of a group handbook which lays out clear expectations for the EByEs. ▪ A safe environment at monthly meetings so the group feel able to discuss difficulties about the work. ▪ Opportunities for one-to-ones with members of the Recovery Team are offered. People in lived experience paid roles need good co-supervision in order to work through the challenges of using one's lived experience day to day. The Trust also needs to consider how it continues to recognise the value of lived experience but also the potential iatrogenic harms and 'othering' that may occur by having specific ‘EbyE’ roles. As a lot of this work is new ground for TEWV the Trust will continue to learn and develop as the Recovery Programme progresses.
12	**ACOO**	Make service user and / or carer involvement in RPIWs and other QI projects more systematic and consistent.	Work has been undertaken jointly by the Involvement and Engagement Team, the Recovery Team and the KPO on defining levels of participation in TEWV (including in QI projects). The “ladder of participation”, approved by EMT on 14th February

			2018 (and ratified by the Board on 27th February 2018), articulates the roles of service users and carers across a range of activities including recruitment, training and quality improvement projects. Competencies and development plans are being developed. As part of EMT's weekly QIS review this matter is discussed and considered for the individual RPIWs, etc.
13	**All Directors**	Use more selective exception reporting in the analysis and interpretation of Board information to focus the reader on the key issues for the period.	Whilst it was recognised that improvements have been made, the Board believed that further efforts to reduce the length of reports and make them more focussed, would be beneficial. In relation to this matter it was considered that: ▪ Real time feedback on reports at Board meetings should continue. ▪ Information should be provided in appendices or circulated separately to reduce the length of reports.
14	-	Consider introducing more benchmarking information into Board reports, both in the form of national comparative data and potentially more detailed benchmarking with a partner trust, for example East London NHS FT.	The Board considered that additional benchmarking information in Board reports would be useful but also recognised that its availability was limited.
15	**DoN&G**	Further develop the triangulation of ward staffing numbers and outcome / performance information for Quality Assurance Committee (QuAC) and / or the Board.	A report on the strategic staffing establishment review was presented to the Board in March 2018. This included the evidence based Hurst tool, professional judgement approach and comparisons to CHPPD and national benchmarking data. The agreed investment in inpatient ward staffing will be tracked through the 6 monthly safe staffing report to the Board.

			There are future plans to develop a 'right staffing' dashboard through the IIC in order that exception reporting can be enhanced.
16	**DoPP&C**	Consider a more systematic approach to internal audit's work on data quality, augmenting the existing analysis by the Director of Planning, Performance and Communications.	▪ An Internal Audit review of data quality in relation to the KPIs included within the Integrated Information Centre (assignment ref. 29/18) provided substantial assurance. ▪ A rolling programme of reviews of the data quality of a number of KPIs per year has been agreed with Internal Audit.
17	**DoF&I**	Consider establishing a data quality group, potentially a sub-committee of the Audit Committee.	A data quality group has been established which reports to the Digital Transformation Board.

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24 April 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:

- 5 policies that have undergone full revision and require ratification:
    - CLIN-0008-v7 Individuals who decline treatment and/or disengage with services
    - HS-0016-v2 Food Handling Policy
    - PHARM-0002-v6 Medicines Overarching Framework
    - HS-0007-v3 Electrical Safety Policy
- 1 policy has undergone minor amendment and requires re-ratification:
    - CLIN-0014-v7.1 Rapid Tranquillisation Policy

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meeting held on 11 April 2018

DATE:	**24 April 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 require ratification:

CLIN-0008-v7 Individuals who decline treatment and/or disengage with services
Review date: 11 April 2021

Formerly known as the 'Non-Compliance with Treatment' policy, this document has undergone full review. The most significant change has been to the language which now reflects the Trust recovery-focussed approach.

HS-0016-v2 Food Handling Policy
Review date: 11 April 2021

This policy has undergone full review and the section relating to the training of food handlers has been updated.

PHARM-0002-v6 Medicines Overarching Framework
Review date: 11 April 2021

This document has undergone full revision with amendments throughout:

- Format changed from tabular to bullet points
- Essential reading guides added throughout
- Some details removed from within this framework, but are maintained in the procedures noted beneath this framework
- Sections 4.1.71., 4.5, 4.6.4, 4.6.11 & 4.6.12 are new to this document but previously agreed through Drugs and Therapeutics Committee

HS-0007-v3 Electrical Safety Policy
Review date: 11 April 2021

The above document was revised as a procedure within the scope of the Policy Redesign Project. However audit identified that a policy is the appropriate document type as required in our Health Service Technical Memoranda and as such has undergone full revision.

3.2 The following have undergone minor amendment:

CLIN-0014-v7.1 Rapid Tranquillisation Policy
Review date: 07 September 2019

Minor changes have been made to clarify the definition of Rapid Tranquillisation in response to audit findings. Also criteria for acceptable prescribing of RT on admission have been revised.

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 11 April 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