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

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meeting held on **27th February 2018.**		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To receive a briefing on key issues in Forensic Services.	**Levi Buckley to attend**	**Presentation**
Item 7	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 8	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 9	To consider a report on the staffing establishment reviews.	**EM**	**Attached**
Item 10	On the recommendation of the Resources Committee to approve the Workforce Strategy.	**DL**	**Attached**
Item 11	To consider the report of the Mental Health Legislation Committee.	**RS/EM**	**Attached**
Item 12	To consider a report on proposed actions in response to the abuse of staff.	**DL**	**Attached**
Item 13	To sign off the Self-Assessment Report in relation to Multi-professional Education and Training.	**EM**	**Attached**

Performance (11.20 am)

Item 14	To consider the Finance Report as at 28th February 2018.	**DK**	**Attached**
Item 15	To consider the Trust Performance Dashboard as at 28th February 2018.	**SP**	**Attached**

Governance (11.35 am)

Item 16	To approve the Information Governance Toolkit submission for 2017/18.	**DK**	**Attached**

Items for Information (11.40 am)

Item 17	To receive and note a report on the use of the Trust's seal.	**CM**	**Attached**
Item 18	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 19 To note that the next meeting of the Board of Directors will be held on **24th April 2018** in The Old Swan Hotel, Harrogate at 9.30 am.

Confidential Motion (11.45 am)

Item 20 **The Chairman to move:**

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

Information relating to 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.

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
21st March 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 FEBRUARY 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. D. Kendall, Interim Director of Finance and Information
Mr. B. Kilmurray, Deputy Chief Executive
Dr. N. Land, Medical Director
Mrs. E. Moody, Director of Nursing and Governance
Mr. D. Brown, Acting Chief Operating Officer (non-voting)
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Dr. A. Khouja, Medical Director (Designate)
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Mr. L. Buckley, Director of Operations for Forensic Services

18/31 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. R. Simpson, Non-Executive Director.

18/32 MINUTES

***Agreed** – that the minutes of the last meeting held on 30th January 2018 be approved as a correct record and signed by the Chairman.*

18/33 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

Arising from the report:

(1) Further to minute 17/269 (31/10/17) Mrs. Moody provided an update on the response to the issues raised in a letter to the local authorities about their interpretation and application of the MHA and DOLS.

The Board noted that, whilst no written response had yet been received:

(a) The Head of Mental Health Legislation had met with the Approved Mental Health Practitioners (AMHPs) in York and they had taken the views of the Trust on board.

(b) North Yorkshire County Council was taking legal advice on the issues raised in the letter.

(2) It was noted that, with regard to the specific case of alleged inappropriate behaviour by a taxi driver, raised in the report of the Guardian of Safe Working to the Board meeting on 31/10/17 (minute 17/264 refers), an investigation had provided no further detail or clarification and the Medical Development Department would continue to monitor the issue in forums with Junior Doctors.

(3) Mr. Brown provided a report on his review, undertaken in accordance with minute 17/271 (31/10/17), of the number of patients who had three or more admissions in a year in County Durham and Darlington.

The Board noted that:

(a) 19 patients (7 females and 12 males) had had three or more admissions in the last 12 months.

(b) The trends and common issues were:

- For the female patients - personality disorder and the robustness of their community plans and crisis plans.
- For the male patients - drug and alcohol misuse, psychosis and personality disorder (including significant self-harm), non-compliance/limited engagement and the robustness of their community plans and crisis plans.

(c) Action being taken by the Locality in response to these issues included:

- A review of crisis plans/care plans or specific community review/reformulation by the respective community teams.
- Work to refresh and re-embed the personality disorder protocol once it had been reviewed.
- Work being led by the Locality Manager with Durham Constabulary to establish multiagency complex case reviews.
- The attendance of the Police at weekly huddles.
- Monitoring of readmissions through daily lean management with oversight by the Operational Management Team and Executive Management Team (EMT).

(4) Further to minute 17/298 (28/11/17) the Board noted that:

(a) Although discussions had been held with the LeDer Programme, there were still issues to be resolved.

(b) Mrs. Moody and Mr. O'Hare (the Executive Director of Nursing and Chief Operating Officer at Northumberland, Tyne and Wear NHS Foundation Trust) had written to the Programme and the local area contacts (within the CCGs) to invite them to a meeting to seek to take matters forward.

(5) It was noted that a review by the Head of Nursing in Tees had found that the medication errors at the Westwood Centre (minute 18/08 – 30/1/18 refers) related to recording issues and had resulted in no harm to patients. The issues found had been raised with the team.

18/34 DECLARATIONS OF INTEREST

There were no declarations of interest.

18/35 CHAIRMAN'S REPORT

The Chairman drew attention to her report to the meeting of the Council of Governors held on 22nd February 2018.

18/36 GOVERNOR ISSUES

The Chairman reported on the matters discussed at her meeting with Governors which preceded the Council of Governors' meeting held on 22nd February 2018.

Mrs. Bessant advised that:

(1) The discussions at the meeting had focussed on operational arrangements within the Council of Governors as it had become clear that there was a divergence of views between some of the new Governors, elected in 2017, and those longer standing.

(2) Governors had felt that they did not know the Non-Executive and Executive Directors and actions had been agreed to seek to remedy this.

(3) There was also evidence that some Governors had an unrealistic expectation of the time available from Executive Directors and the limitations had been explained.

(4) Overall, Governors remained generally content and were very supportive of the Trust but it was clear that there were some issues which would need to be managed going forward.

18/37 REPORT OF THE QUALITY ASSURANCE COMMITTEE

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

(1) The minutes of its meeting held on 7th December 2017 (Appendix 1 to the report).

(2) The key issues considered by the Committee at its meeting held on 1st February 2018.

Dr. Griffiths, the Chairman of the Committee:

(1) Drew attention to the discussions on the results of the re-audit (the third) of emergency response bags.

The Board noted that, although the results had improved, the Trust was still not achieving the required level of compliance and it had been agreed to undertake a further re-audit in March 2018.

(2) Advised that a decision on the postponement of the meeting of the Committee, scheduled to be held on 1st March 2018, due to the present serious weather conditions, would be taken over the next 24 hours.

In addition:

(1) Clarity was provided, in relation to paragraph 4.3 of the report, that the Committee had requested further details, at a future meeting, on the number of suicides where the financial issues of the patient had been a significant factor.

(2) Mr. Jennings, the Chairman of the Audit Committee, drew attention to the links between the work of that Committee and the QuAC in relation to record keeping

and the importance of gaining assurance, for both, in relation to compliance with policy and processes.

(3) The Board discussed the target for safeguarding level 3 training.

In response to questions, Mrs. Moody explained that:

(a) The contractual target was 98%; however, as this did not make allowances for sickness absence and maternity leave, the Trust used a target of 95%.

(b) There were risks of contractual penalties if the target was not achieved and performance improvement notices had been received, previously, when the compliance rate was around 70%.

(c) At present, performance was in the mid-80% range.

(d) It was considered that Commissioners would be satisfied if the 95% target was achieved, overall, and there was evidence of improvements in compliance across all Localities.

18/38 "HARD TRUTHS" MONTHLY NURSE STAFFING EXCEPTION REPORT

The Board received and noted the exception report on nurse staffing for December 2017 and January 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").

Arising from the report:

(1) In response to a question, it was noted that the statement in the report that "Eagle had a bed collapse in December reducing the requirement which was not reflected in the electronic rostering system" referred to the reduction in five beds on the ward as a result of the Transforming Care agenda; however, changes to staffing levels, in response to this, had not been reflected in the roster as the beds had not been closed under the contract.

(2) Concerns were raised about whether the backfill arrangements provided for Talbot Direct Care by the Holly Unit were sustainable.

The Board noted that confirmation of the registration of the package of care by Ofsted, which was anticipated in the next couple of weeks, would resolve the situation.

(3) Board Members sought clarity on the position on Westerdale South as, despite the establishment of the ward having been previously increased, it had the highest fill rate in excess of the budgeted establishment for the reporting period.

Mr. Brown advised that:

(a) Additional staff had been provided but not to the level required to meet demand for all enhanced observations.

(b) It had not been considered appropriate to provide sufficient permanent staff in the baseline establishment to cover all additional duties as they would not have been available at the right times and flexible staffing was used in an effective way to enhance baseline establishments as required.

(c) The relocation of the ward from Roseberry Park to Sandwell Park; sickness absence and maternity leave; and the need for high levels of enhanced observations had impacted on staffing requirements.
(d) Further consideration of the staffing establishment of the ward might be needed.

In relation to this matter:
(a) Mrs. Moody also drew attention to the pattern of other Trust organic wards having high fill rates.
(b) The Board noted the importance of having:
- Staff committed to working in these services.
- Consistency of staff so that they were known by, and understood, the patients.

(4) The Board discussed the incidents citing staffing levels.

On this matter, whilst welcoming the information provided, Board Members considered that:
(a) The correlation between staffing levels and quality, the reason for the report, was becoming less evident.
(b) It would be helpful to understand:
- The seriousness of incidents escalated by staff in relation to safe staffing.
- Whether these incidents represented the perceptions of ward staff or whether the risks arising from them were assessed and recorded.

In response to these issues Mrs. Moody advised that:
(a) Having visibility on the escalation of safe staffing was important; however, it was also recognised that further work was required to provide assurance on how the issues raised had been addressed.
(b) The report provided a summary of the issues raised from these incidents; however, further details were available on the DATIX system and also forwarded to Locality Heads of Nursing.
(c) For the majority of cases, the incidents were not only recorded on the DATIX system but followed up by the ward manager or via on-call arrangements.
(d) For those occurring at night, the incidents would also be escalated to the Duty Nurse Co-ordinator, once in place, for review.

(5) The Non-Executive Directors highlighted the five occasions during January 2018, mainly in York, where agency or bank staff had not turned up for agreed shifts and questioned whether this indicated difficulties with the agency provider.

Mr. Levy reported that staff not turning up for work was amongst the issues being experienced with the agency provider; however:
(a) Agency staff not turning up accounted for only about 1% of shifts.
(b) The agency provider would not use workers if they failed to turn up for two shifts and, to date, this rule had not been required to be used.

18/39 LEARNING FROM DEATHS

Further to minute 17/298 (28/11/17) the Board received and noted the Learning from Deaths report which set out the Trust's approach towards the identification, categorisation and investigation of deaths.

In her introduction to the report, Mrs. Moody drew attention to a revised copy of the Learning from Deaths Dashboard (Appendix 1 to the report) which showed that there had been six inpatient deaths in total and none in learning disability inpatient services (rather than 10 inpatient deaths and 1 death in learning disability inpatient services as stated in the original version of the report).

The Board noted that, of the six deaths:

(1) Three related to patients who had been transferred from an inpatient unit to an acute hospital where they had subsequently died of natural physical health causes.

(2) Two related to patients who had died on an inpatient ward from expected physical health causes.

(3) One related to a patient who had died from an unnatural unexpected cause and this had been categorised as a serious incident and was being investigated accordingly.

Mrs. Moody advised that it was good practice to record the deaths of patients transferred to an acute hospital as relating to the Trust's inpatient services as, having not been discharged, they remained under the care of the Trust.

The Board supported this approach.

It was noted that a copy of the report, including the revised version of the Dashboard (as amended to also reflect the impact of the changes on the total number of deaths) would be published on the Trust's website.

Action: Mrs. Moody and Mr. Bellas

Board Members raised the following matters:

(1) Whether the two deaths of people with learning disabilities during September 2017, reviewed internally, had been reported to the LeDer Programme.

Mrs. Moody agreed to check this matter.

Action: Mrs. Moody

(2) The arrangements for sharing learning from deaths.

Mrs. Moody advised that:

(a) No work appeared to be being undertaken, nationally, on sharing learning from deaths in mental health.

(b) The Trust was planning to work with the nine other mental health Trusts, in the Northern Collaborative, to share learning and to identify issues for thematic reviews.

(c) Within the Trust:
- Serious incident processes (focussing on the identification of root causes and contributory factors) with action planning and associated monitoring arrangements supported learning lessons.
- The patient safety team undertook thematic reviews and was seeking to link this approach into longer term pieces of work.
- The Annual Report on Patient Safety provided assurance on learning from serious incidents.
- Quarterly reports for operational services were prepared by the patient safety team on learning by Specialty and Locality.

(3) The treatment of corporate issues identified by Directors' Panels.

On this matter it was noted that:
(a) There was, at present, no robust audit trail to enable the patient safety team to monitor corporate actions and recommendations made by the Panels.
(b) The identification of themes by the Panels was improving and this was reflected in their reports.
(c) The response to corporate issues arising from Directors' Panels would need to be reflected in longer term work programmes.

(4) The benefits, in terms of public accountability, of:
(a) Reformatting the Dashboard so that the total number of deaths could be fully reconciled with the review process or other response taken by the Trust to them.
(b) Providing assurance, possibly in the form of a flowchart, on how learning linked to other quality improvement processes.

Mrs. Moody undertook to consider how to respond to the above suggestions in the next learning from deaths report.

Action: Mrs. Moody

18/40 MAKING A DIFFERENCE TOGETHER PRIORITY

Further to minutes 16/289 (29/11/16) and 17/194 (20/7/17) consideration was given to a report on the outcomes of the values and staff compact consultation exercise in 2017 and other activities related to the Making a Difference Together business plan priority.

The focus of discussions was on the recommendations contained in the report that:
(1) A further values and staff compact consultation exercise should be undertaken amongst staff, service users, carers, Governors and other interested parties during 2018 using crowdsourcing and face to face sessions.
(2) The consultation should include the question 'what are your beliefs and values?'

Board Members questioned the purpose of the further consultation in the context of the business plan priority.

The following points were made on this matter:

(1) When previously discussed, the Board had considered that the purpose of the priority was to reconnect the organisation with its values.
(2) It was expected that the priority would focus on how to ensure the values were "lived" by staff, for example, in terms of their response to the abuse of colleagues as reported by BME staff at the Board Seminar in December 2017. It was not considered that the values needed to be changed, apart from making them more understandable and relevant to staff in that context.
(3) There were risks that, if further consultation was undertaken, staff might believe that the Trust was not serious about taking action.

In response Mr. Levy:

(1) Advised that the recommendations contained in the report reflected changes since the agreement of the priority, namely:
    (a) The concerns raised at the Board Seminar in December 2017.
    (b) The potential benefits of using crowdsourcing.
    (c) The feedback, provided by the Investors in People (IIP) Assessor, that many nurses and healthcare assistants were unaware of both the values and compact consultation exercise and corporate communications.
(2) Drew attention to the outline timetable of activities, as set out in paragraph 3.13 of the report, which included the approval of the TEWV Bullying and Harassment Resolution Procedure; the provision of guidance for managers and staff about tackling abuse from service users and members of the public; and the provision of associated training/awareness sessions.
(3) Observed that staff often only recognised that they had been abused when the issue was raised with them.

Board Members also questioned:

(1) The relevance of the proposed question for the proposed further consultation exercise in the context of the above discussions.
(2) The use of the word "belief" as it could, unless defined, have a broad range of meanings including "faith".

In response the Board noted that:

(1) The question had been proposed by the IIP Assessor and, therefore, required due consideration.
(2) Further clarity on the wording of the question could be sought from the IIP Assessor.
(3) The proposed further consultation was not intended to focus exclusively on the proposed question and additional ones could be included in it.

The Board also noted:

(1) The importance of the tone and culture provided by team leaders and the need for clarity on the sanctions which the Trust was prepared to take if someone was unwilling to act in accordance with, and promote, the values.
(2) The benefits of being more explicit about the links between the Trust's values and those of the NHS.

In addition, the report also highlighted the Ladder of Participation (Appendix 1 to the report), developed as part of phase 2 of the Recovery Strategy, which had been endorsed by the Council of Governors and the Executive Management Team.

Whilst welcoming the approach, clarity was sought on:

(1) How the starting point on the "ladder" would be chosen.

Mr. Levy undertook to raise this matter with the Recovery Programme.

Action: Mr. Levy

(2) How it applied to the participation of patients in clinical matters.

Dr. Khouja advised that this was being taken forward through the work of:

(a) Dr. Briel and the KPO team, on service user and carer involvement in quality improvement activities.

(b) Dr. Boylan (Director of Medical Education) on shared decision making which was, in effect, part of the same approach as the Ladder of Participation.

Agreed -

(1) that the proposed further values and staff compact consultation exercise be not undertaken;

(2) that future work on the Making a Difference Together business plan priority be focussed on the delivery of actions to reconnect the Trust with its values and to ensure the values were "lived" by staff;

(3) that the use of crowdsourcing, or a similar approach, to support the delivery of (2) above, and in other areas, be supported;

(4) that developments in respect of the draft Leadership and Management Development Strategy, the draft Bullying and Harassment Resolution Procedure and the planned provision of guidance to help tackle abuse from service users and members of the public be noted;

(5) that the intention to present a report, on proposed actions to tackle the abuse of staff, to the Board Meeting to be held on 27th March 2018 be noted ; and

(6) that the Ladder of Participation (as set out in Appendix 1 to the report) be endorsed.

Action: Mr. Levy

18/41 FINANCE REPORT AS AT 31ST JANUARY 2018

The Board received and noted the Finance Report as at 31st January 2018.

In response to a question, it was noted that the slippage on CRES schemes was due to inpatient wards linked to Roseberry Park.

18/42 PERFORMANCE DASHBOARD AS AT 31ST JANUARY 2018

The Board received and noted the Performance Dashboard Report as at 31st January 2018.

The focus of discussions was on the Trust's position on the NHS Improvement (NHSI) Single Oversight Framework metric "Ensure that cardio metabolic assessment and treatment for people with psychosis is delivered routinely in EIP service".

Mrs. Pickering explained that the sample of cases sent to the centre had been analysed internally and performance had been calculated at 85.47% (below the target of 90%); however, an internal analysis of the data for all patients across the Trust's EIP services (for the same period as the sample) showed the Trust's performance at 93%. The latter position, therefore, provided good mitigation if the Trust's performance, which was a component of the CQUIN scheme, was challenged. The final level of performance was due to be confirmed by the centre in May 2018.

In response to questions it was noted that:
(1) The issue had arisen from the sample of cases taken and this matter would be discussed with NHSI.
(2) The issue related to EIP services only. Based on other samples the Trust had achieved the targets for the equivalent indicators for inpatient and community services.

Dr. Land highlighted the improvements which had been made to the physical healthcare of patients over the last couple of years.

In addition, the Chairman questioned the number of unexpected deaths in 2016/17 where a verdict from the Coroner was still awaited as shown in Appendix B to the report.

In response the Board noted that:
(1) The time taken for Coroners to reach a verdict varied and could be lengthy.
(2) In some cases, information to enable them to be closed off was not received.

Mrs. Pickering undertook to check the position on the outstanding cases included in the report.

Action: Mrs. Pickering

18/43 STRATEGIC DIRECTION PERFORMANCE REPORT

Consideration was given to the Strategic Direction Performance Report for Quarter 3, 2017/18 including proposals to approve changes to the Trust Business Plan (as set out in Appendix 1 to the covering report).

The Board concurred with Mrs. Pickering's assessment that the mixed picture provided by the performance metrics was offset by the progress being made on the delivery of the Business Plan and the qualitative intelligence provided in the report.

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

Action: Mrs. Pickering

18/44 USE OF THE TRUST SEAL

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

18/45 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.

18/46 DATE OF NEXT MEETING

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

18/47 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 documents relating to the Trust's forward plans prepared in accordance with paragraph 27 of schedule 7 of the National Health Service Act 2006.

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

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

Information which is held by the Trust with a view to its publication, by the Trust or any other person, at some future date (whether determined or not), and it is

considered reasonable, in all the circumstances, to withhold the information from disclosure until that date.

Following the transaction of the confidential business the meeting concluded at 12.56 pm.

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th March 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	
26/09/2017	17/228	Consideration to be given to reviewing the targets in the Strategic Direction Performance Report for 2018/19	SP	~~Apr-18~~ May-18	
26/09/2017	17/230	Reviews of the operational arrangements of the Quality Assurance, Resources and MHL Committees to be undertaken	PB	~~Mar-18~~ Apr-18	
31/10/2017	17/268	An update report on the Temporary Staffing Service to be presented to the Board	DL	~~Apr-18~~ May-18	
31/10/2017	17/269	A further report to be provided to the Board on the interpretation and application of the MHA and DOLS once the local authorities have responded to the solicitors' letter	EM	-	See private agenda item 3
28/11/2017	17/295	A paper to be provided to Board Members describing the controls covering commercial studies	Prof. JR	May-18	
28/11/2017	17/297	Information on wards not regularly meeting their fill rates to be included in the reports on the Establishment Review	EM	Mar-18	See agenda item 9

	Minute No.	Action	Owner(s)	Timescale	Status
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	~~Mar-18~~ Apr-18	(See also minute 17/230)
28/11/2017	17/300	A report to be presented to the Board to provide an update on progress towards the completion of the 2017/18 composite staff action plan and to enable consideration of a proposed 2018/19 action plan	DL	May-18	
28/11/2017	17/301	A further progress report on the implementation of the Recruitment and Retention Action Plan to be presented to the Board	DL	May-18	
28/11/2017	17/305	A briefing to be provided to the Board on the event in 2018 in relation to sickness absence and whether further action can be taken to support the health and wellbeing of staff	DL	Apr-18	
28/11/2017	17/307	A report to be presented to the Board on the outcome of the thematic review of whether patients feel safe and staffing issues being undertaken by the patient safety team	EM	Apr-18	
19/12/2017	17/327	A report to be presented to the Board on the outcome of the review of the 12 hour shift system	DL	Jan-19	
19/12/2017	17/329	A briefing document to be produced to raise understanding and awareness of the issues impacting on ASD waiting times	DB	Mar-18	Completed
30/01/2018	18/08	A report to be presented to the Board on the use of enhanced observations (including trends) together with information on contemporary best practice in this area.	EM	Jul-18	
30/01/2018	18/08	A report on the use of prone restraint to be provided to the Quality Assurance Committee	EM	Apr-18	
30/01/2018	18/10	A report on the outcomes of the recent event involving BME staff (a follow up to the discussions at the December 2017 Board Seminar), in relation to how the Trust should respond when staff have been abused, to be presented to the Board	DL	Mar-18	See agenda item 12

	Minute No.	Action	Owner(s)	Timescale	Status
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	A revised version of the Learning from Deaths report to be published on the Trust's website	EM/PB	-	Completed
27/02/2018	18/39	A check to be made of whether the deaths of two people with learning disabilities in September 2017 have been reported to the LeDer Programme	EM	Mar-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	
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	
27/02/2018	18/40	To note that: - The proposed further values and staff compact consultation exercise is not to be undertaken - Future work on the Making a Difference Together business plan priority is to be focussed on the delivery of actions to reconnect the Trust with its values and to ensure the values are "lived" by staff - The use of crowdsourcing, or a similar approach, to support the delivery of the business plan priority, and in other areas, was supported by the Board - The Ladder of Participation was endorsed by the Board	DL	-	To note
27/02/2018	18/43	The position on the unexpected deaths in 2016/17, where a Coroner's verdict is outstanding, is to be checked	SP	-	Completed

	Minute No.	Action	Owner(s)	Timescale	Status
27/02/2018	18/44	Approval of changes to the Business Plan	SP	-	Approved

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

Offender Health

North East

Frankland
Durham
Low Newton
Kirklevington
Northumberland
Holme House
Deerbolt

North West

Preston
Lancaster Farm
Kirkham

Secure Services

Medium (117)
Low (89)

Male MI
Female MI / PD
Male ASD
Female LD
Male LD

Community

Forensic team
SOTT (LD)
L & D team
Probation PD

Locked rehab

Oakwood 8 bed
Langley 5 beds

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Offender Health

North East

Frankland
Durham
Low Newton
Kirklevington
Northumberland
Holme House
Deerbolt

North West

Preston
Lancaster Farm
Kirkham
Haverigg (July 18)

Secure Services

Medium (117)
Low (84)

Male MI
Female MI / PD
Male ASD
Female LD
Male LD

Community

Forensic team
SOTT (LD)
L & D team
Probation PD

Locked rehab

Oakwood 8 bed
Langley 5 beds

The Turn of the SCREW

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

The Turn of the SCREW

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

***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.**

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.

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

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

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.**

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

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

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.**

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

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.

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.

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.**

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)

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)

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.**

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.

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.

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.

The Turn of the SCREW

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

The Turn of the SCREW

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

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.

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 27 March 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 01 March 2018:

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

Key matters considered by the Committee are summarised as follows:

The Locality areas of North Yorkshire and York and Selby services where key concerns were around AMH Inpatient recruitment, LD Transforming Care, CAMHS eating disorders, the transition of services from Humber to TEWV, capacity and demand and commissioning expectations.

- Reports from the Patient Safety Group and the Infection, Prevention and Control Assurance Report.
- CQC compliance and Safeguarding & Public Protection assurance updates.
- Draft Clinical Audit Programmes (Annex 2). This was approved by the Audit Committee on March 15th 2018.

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its informal meeting held on 01 March 2018.
- Note the unconfirmed minutes of the meeting held on 01 February 2018 (Annex 1).
- Consider and approve the draft Clinical Audit Programmes for 2018/19. (Annex 2).

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 27 March 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 informal meeting on 01 March 2018. The meeting was informal due to not being quorate.

2. BACKGROUND INFORMATION AND CONTEXT

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

3. KEY ISSUES

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

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

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

4.1 NORTH YORKSHIRE LMGB

The Committee discussed the LMGB report for North Yorkshire noting the top concerns which were Adult Mental Health inpatient recruitment, particularly Cedar Ward where there has been a 'stop the line' in place over the past couple of months. Interviews were pending in the next week with hopefully some vacancies to be filled for band 6 and band 3 posts.

LD Transforming Care continues to see lack of decisions from Commissioners on the development of the enhanced community service.

There are challenges meeting the CAMHS eating disorders access and waiting times standards.

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.

4.2 **YORK & SELBY LMGB**

The Committee discussed the LMGB report for York & Selby noting the top concerns which were; managing the transition of services from Humber to TEWV, addressing capacity and demand issues with ongoing issues in CAMHS services, Access and Well-being Service and IAPT and commissioning expectations.

The key issue discussed was around risk 302 of 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. There have been some serious incidents where the question has been asked whether the right information has been accessed and work was underway to improve access to the right information for clinical staff in a timely manner.

4.4 **Infection, Prevention and Control**

The Committee discussed the Infection, Prevention and Control report for Quarter 3.

Assurance was provided that there are rigorous Infection, Prevention and Control systems and processes in place. One risk identified is around the cleaning scores from the National Standards of Cleanliness audits undertaken by Hotel Services and Matrons will continue to review the reasons for the declines in scores.

4.5 Patient Safety

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

The key matter discussed was around concerns over the results of the Duty of Candour audit where it is difficult to track evidence where apologies are given or letters sent concerning applicable moderate harm incidents. Audit One are currently undertaking an audit in this area and more detailed information will be provided at a future QuAC meeting.

The Committee was assured that there was robust monitoring of the quality and performance indicator data, planned work streams and system implementation relating to patient safety and welcomed the updated and improved presentation of the reports.

4.6 **Safeguarding and Public Protection**

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

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

A query was raised by members around the level of competence around referrals for safeguarding and it was noted that there has been an increase in awareness, which can be evidenced by the amount of advice being sought around complex cases and the increasing numbers of supervisions.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 **Compliance with CQC Requirements Report**

The Committee noted that there had been two recent CQC Mental Health Act (MHA) inspections; however the final reports have not yet been received.

Following registration with Ofsted, Baysdale Unit received its first unannounced inspection on 5 February 2018 - the final report had not been received at the time of writing the report.

The key matters discussed were around the preparation activities for the pending CQC compliance inspections with locality based Champions in place for all specialties. The peer review inspections are 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.

5.2 **Draft Clinical Audit Programmes 2018/19**

The Committee discussed the draft Clinical Audit Programmes for 2018/19.

The key matters considered were around the mandatory national clinical audit of anxiety and depression (NCAAD) which the Trust is required to pay a £10k mandated fee and it was noted that this audit will take up a lot of capacity as data will be collected on service users care and treatment over a period of six months from their date of admission.

Assurance was given that the Clinical Audit team is now fully staffed and with the continuation of the annual 20% reduction in the audit programme this will minimise the impact of clinical audits in clinical areas.

Due to the Committee not being quorate it was agreed that the Clinical Audit Programme would be escalated to the Board of Directors for approval on 27 March 2018, (see Annex 2)

The Board is asked to note that the Clinical Audit Programmes for 2018/19 was reviewed and accepted by the Audit Committee on 15 March 2018.

The covering report for the draft Clinical Audit Programmes 2018/19 to the Quality Assurance Committee is available on either Boardpad or on request.

5.3 **Research Governance Exception Report**

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

The report was 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.

The key matter for the Board to note is that ethical approval had not been sought for the research.

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 will be published Trust wide setting out the differences between clinical audits and research proposals.

5.4 **Exception Reporting**

Quality Account Mandatory Indicators 2017/18

The Committee received a tabled briefing note setting out the quality account mandatory indicators. The new guidance from NHS Improvement means that they have mandated the indicators for inclusion in 2018/19.

The Council of Governors were then 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".

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

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

6. IMPLICATIONS

6.1 **Quality**

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

6.2 **Financial/value for money**

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

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

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

6.4 **Equality and Diversity**

There are no issues to note.

7. CONCLUSIONS

The Quality Assurance Committee considered 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.

The Committee noted that the actions and minutes from the 1 February 2018 QuAC meeting will be ratified at the 5 April 2018 meeting.

8. RECOMMENDATIONS

That the Board of Directors is asked to:

(i) Note the issues raised at the Informal Quality Assurance Committee meeting on 01 March 2018.

(ii) Note the unconfirmed minutes of the meeting held on 01 February 2018 (appendix 1).

(iii) Consider and approve the draft Clinical Audit Programmes for 2018/19. (Annex 2).

Jennifer Illingworth
Director of Quality Governance
March 2018

Annex 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 1 FEBRUARY 2018, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

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

In attendance:
Mr Dominic Gardner, Acting Director of Operations, Tees (for minute 18/04)
Mrs Karen Atkinson, Head of Nursing, Tees
Mr Chris Lanigan, Head of Planning & Business Development (for minute 18/12)
Mr Chris Williams, Chief Pharmacist (for minute 18/13)
Mr Richard Morris, Deputy Chief Pharmacist
Mr John Savage, Head of Nursing, Durham and Darlington
Mr Lenny Cornwall, Deputy Medical Director, Tees
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mr Mac Williams JP, Governor, Durham
Mr Graham Robinson, Governor, Durham

Student Nurses: Grace Russell, Courtney Harland, Lucy Dawson, Helen Empson and Sarah Lumley

18/01 APOLOGIES FOR ABSENCE

Apologies for absence were received from: Mrs Sharon Pickering, Director of Planning, Performance & Communications, Mrs Karen Agar, Associate Director of Nursing and Governance, Dr Ingrid Whitton, Deputy Medical Director, Durham & Darlington, and Mr Patrick Scott, Director of Operations, Durham and Darlington.

18/02 MINUTES OF THE PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 07 December 2017 be signed as a correct record by the Chairman of the Committee.

18/03 ACTION LOG

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

17/97 b) D&D LMGB report: page 6 adult LD non-compliance due to referrals being rejected – to add more context to this in future reports.

Completed

17/128 Include in D&D LMGB report update in 6 months on research by Dave Ekers on implementation of Behavioural Activation (BA) and what has been learnt from this.

It was noted that a programme of training was currently being put together for trainers to ensure the Trust was in line with the model.

Completed

17/145 Tees LMGB report: more detail in next report around episodes of primary restraint.

It was noted that discussion had taken place around intentional versus unintentional restraint; the numbers of prone restraint overall had reduced and this work would continue.

The Committee requested that this be brought back in the next Tees LMGB report for a more detailed understanding.
Mrs Illingworth noted that there would be a piece of work around restrictive practice in young people and this would be reported through to the Patient Safety Group and then to QuAC.

17/147 Follow up the low 11 responses from Ward Managers following audit of "is there anything we could do to make the service better?"
It was noted that following review of the audit a process of email reminders to non – responders would be sent and copied to Heads of Service by way of escalation. This process would be included in the first audit in Q3.

Completed

17/163 Patient Safety Report: to amend the wording around "expected/unexpected deaths" for clearer understanding.
It was noted that the wording would be amended for the March 2018 Patient Safety Report.

Completed

17/166 A crib sheet of the top five CQC recurring issues to be incorporated into Director Visits.

Completed

17/166 CQC Compliance Report: look into the four environmental issues raised following a peer review inspection.
It was noted that the issues had included some door handles in bathrooms on Oak Ward that were a ligature risk, there were uneven floors, a tear in the floor of a shower room and a fridge with no lock.

Assurance was provided to the Committee that all matters had been rectified.

Completed

17/169 Bring back results of re-audit of Clinical Emergency Response Bags to QuAC.
This matter was covered on the agenda (see minute 18/10).

18/04 DURHAM AND DARLINGTON SERVICES LMGB REPORT

The Committee received and noted the Durham and Darlington Services LMGB Report.

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

(1) Staffing pressures.
There were various issues contributing to this issue, including high levels of sickness absence, both short and long term, as well as significant changes to senior leaders across the locality. Recruitment had also been unsuccessful for a Psychological Lead.
On this matter assurance was provided to the Committee that short and long term sickness was being managed very robustly and in line with policy, with excellent links to HR for support.

It had been a difficult period over the previous months with various illnesses, however the safety of patients had not been compromised due to the energy and time invested by Matrons and Locality Managers to provide cover.

(2) Pressure in Children and Young People's services.
The main challenge faced had been the high numbers of referrals plus the need to reduce waiting times for ASD.
On this matter it was noted that discussions would take place at OMT to ask for some Trust wide support.

(3) Changes to senior clinical leadership team.
It had been disappointing that recruitment had not been successful for both the Deputy Medical Director and Locality Psychology Lead positions. Further changes at Clinical Director level had taken place in LD services and were planned in CAMHS in the next few months.
The key issue for focus would be management of these transitions.

Following discussion it was noted that:

(1) Some investigatory work was underway to make comparisons with those members of staff that had received the flu jab and those that were off sick with flu.
On this matter it was noted that ESR recorded flu type illness grouped in one category 'cold and flu', with the ability to add more detail, however this would be dependent on whether it was completed by the individual entering the episode.
Mrs Moody gave assurance that this was currently being looked at.

(2) Medication Management audits at West Park (except Cedar Ward) had scored consistently red.
Assurance was given that work had taken place Leadership teams and reports would go to QuAG with re-audits undertaken every month.

(3) The CQC actions relating to MH services for older people had been completed as best they could with ongoing concerns relating to personalised care plans, which were being addressed through a Trust wide piece of work.

(4) The long waiters in Adult Mental health had been attributable to a sharp increase in referrals to a couple of teams, particularly Easington, together with sickness affecting Access Services.

(5) The rapid tranquilisation audit had scored red however local audits had confirmed that all areas were now fully compliant with the policy.
On this matter assurance was provided that these audits were undertaken on a monthly basis by clinical staff.

Clarification was sought on risk 380: "that failure to access Tier 4 beds for children and young people that staff would need to manage young people with high risks within community settings. This had a significant impact for on-call medical staff and the CAMHS crisis/liaison/IHT team where resource was already tight".

Assurance was provided to members that there was now good access to Tier 4 beds and that the issue was more related to access to PICU beds for children and young people.

Agreed: *that risk 380 should be re-described on the Locality Risk Register*.

Action: Mr P Scott

Members of the Committee welcomed the updated risk egister overall for the locality, which had been significantly improved to make better reading and understanding.

18/05 TEES SERVICES LMGB REPORT

The Committee received and noted the Tees Services LMGB Report.

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

(1) The provision of independent sector placements for older people and those with learning difficulties.
(2) Recruitment, particularly Consultant medical Staff.
(3) Access to placements in Children and Young People's PICU and Medium Secure settings due to the care required to treat the levels of acuity and complexity.

Following discussion it was noted that:

(1) There had been increased concern voiced by Teesside Suicide Prevention Taskforce regarding the number of suicides where finance had been a significant factor.
On this matter it was noted that Carers Together had been looking at this factor and it was felt that it would be helpful to have more information to establish any evidence from the data to link finance with suicide.

Action: Mr D Gardner

(2) There was significant impact on the care pathway linked to the provision of CT scans from the Acute sector for patients with dementia, which could sometimes lead to delays.
On this matter it was noted that the timeliness of CT scans was crucial for providing individual care, however not all patients required a CT scan in order for a diagnosis to be made.
Dr Cornwall noted that a new approach was currently being taken through QuAG, together with the CT scan results to be available on Paris.

(3) The increase in the number of formal and informal complaints in CAMHS Tier 4 services had been attributable to difficulties with staffing experience and retention with 70% of staff that were less than two years qualified. The complexity and acuity had greatly changed for these services, with no access to PICU.
On this matter it was noted that the effectiveness of rostering was being considered, along with the introduction of a Band 6 on duty 24 hours a day.

(4) Within MHSOP there had been a safeguarding incident concerning a member of administrative staff on a temporary contract. A family member had contacted the Trust regarding their father and alleged that he had been financially abused by the member of staff. The patient had not made a complaint, however this incident had happened on a previous occasion whilst the member of staff had been working in a Doctors surgery and this had been reported to the Police.

Members of the Committee congratulated Dr Krish who had won Communicator of the Year at the recent Royal College of Psychiatry Awards.

It was noted that the Quality Scorecard had been missing from the LMGB report and this would be included in the next report.

18/06 PATIENT SAFETY GROUP ASSURANCE REPORT

The Committee received and noted the following reports:

(1) The assurance report of the Patient Safety Group for Q1 and Q2 2017/18.
(2) The Patient Safety Quality Data Reports for October and November 2017.
(3) An assurance report following a safeguarding adult specialist case review.

(4) The data published by National Reporting and Learning System (NRLS) for November 2016 to October 2017.
The results had shown that the Trust reported more incidents with severity of either no harm or low harm and comparatively the Trust stood in a mid- table position from a national perspective.
(5) An in depth audit of the quality of care programme approach had been undertaken over a period of two months and the results would be brought back to the April 2018 QuAC meeting.

Action: Mrs E Moody

Following discussion the Committee noted their concerns over the lack of improvement around record keeping, which had been repeatedly raised in Serious Incident reports.

Agreed:

To include more detail on record keeping issues in the Annual Patient Safety Report to be reported to the Quality Assurance Committee at its meeting to be held in June 2018.

Action: Mrs J Illingworth

18/07 PATIENT EXPERIENCE GROUP REPORT

The Committee received and noted the Patient Experience Group report.

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

Arising from the report it was noted that:

(1) During October 2017 there had been 24 complaints, an increase of two from the previous month.
(2) There had been 166 PALS, an increase of 41 from the previous month.
(3) There had been a 'deep dive' exercise undertaken to identify why the Durham & Darlington locality had received consistently high numbers of complaints and PALS over the previous 13 months.
This had been due to the complaints relating to Adult Mental Health Services provided within the Community where there were a higher number of Affective Disorder Services which had featured most frequently in the complaints received.

Following discussion it was queried how service users and carers were involved in the Patient Experience Group.

Agreed:

That further information should be brought back to the Quality Assurance Committee on the level of involvement with service users and carers in the Patient Experience Group and whether this was representative and effective.

Action: Dr S Wright

18/08 SAFEGUARDING & PUBLIC PROTECTION EXCEPTION REPORT

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

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

Arising from the report it was noted that the risk of contractual penalties by not achieving Safeguarding Level 3 training continued and although improvements had been made, the target of 98% had not been reached.
Non-Executive Directors sought clarification on the minimal involvement by CAMHS in the serious case review published by Durham LSCB and the MAPPA serious case review regarding a young person residing in Durham that had stabbed a person in London.

It was clarified that the Trust undertook a chronology of events regarding the level of involvement with any serious case review and any issues would be highlighted in the reports.

18/09 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

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

Arising from the report it was noted that:

(1) There had been five CQC Mental Health Act (MHA) inspections with three reports received and all actions were being taken forward.

(2) Preparation was underway for the unannounced CQC inspection, with feedback and learning from internal CQC Peer Review Mock inspections. There had been 29 internal Peer Review inspections since July 2017 and the programme had been found to be mutually beneficial for both those being inspected, in terms of identifying good practice and issues where improvements could be made and respectively for those undertaking the inspection for observing practice in other areas that could be shared.

(3) There had been an Ofsted inspection of Holly and Baysdale Unit since the registration of those units and feedback received was that the overall experience for children and young people was good. Issues to focus on going forward would be documentation as this was currently felt to be more focussed towards a healthcare model rather than that of social care.

Following discussion the key matters discussed were:

(1) Continued concerns around the repeated issues coming up in MHA inspections.
On this matter it was suggested that some benchmarking with Sussex Partnership NHS FT might be helpful since their rating had gone from needs improving to good.

(2) The difficulty around room keys being lost by patients resulting in staff locking and unlocking bedrooms.
(3) Patient rooms being searched daily in what was termed a ‘room sweep’ despite the fact that a Staff Nurse had confirmed to the CQC that there would be no random personal searches, only where there was a specific reason to do so.

On this matter it was confirmed that it was important for staff to know that risks should be managed on an individual basis and this would be a key area of focus going forward.

18/10 CLINICAL AUDIT OF EMERGENCY RESPONSE BAGS (RE-AUDIT 2017)

The Committee noted the re-audit of Emergency Response Bags Report.

Arising from the report it was noted that:

(1) The results of the second re-audit 5388CEN17 had been disappointing given that 12% of cases had been found to have no extra oxygen cylinder in the department and in 21% of cases, in the two weeks prior to completion of the audit, the emergency response bags and automated external defibrillator had not been checked daily.
(2) The re-audit had demonstrated practice improvements, with some policy compliance issues still noted and a new assurance process had been proposed for the ongoing monitoring of emergency response equipment with a tiered audit process and defined governance reporting arrangements.

Following discussion the Committee:

(1) Welcomed the draft proposal for the proposed new assurance process for the ongoing monitoring of emergency response equipment with quarterly validation checks.
(2) Acknowledged the importance of ownership by Ward Managers and Matrons with weekly report outs and inclusion in performance indicators.
(3) Expressed concern that the compliance rate was still not acceptable given the potential risk to patient safety.

Agreed:

That a further re-audit be undertaken in March 2018 and reported to the Quality Assurance Committee in April 2018.

Action: Mrs E Moody

18/11 CLINICAL AUDIT AND EFFECTIVENESS PERFORMANCE REPORT

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

Arising from the report it was noted that:

(1) The current clinical audit programmes completed at the end of December 2017 was 38.46%.

(2) There were two programmed clinical audit action points outstanding over three months and this was being addressed.

(3) There were no NICE action points over 90 days outstanding for escalation.

(4) Audit 4895: Children and Young People's Service, restraint in Tier 4 CAMHS had scored red at 0-49%.
Assurance was provided that work was underway to look at the recording issues around this audit which was thought to be a contributory factor to the low score and to make it more meaningful to differentiate between the intervention of restraint versus arm hold.

18/12 QUALITY ACCOUNT UPDATE REPORT, QUARTER 3

The Committee received and noted the Quality Account Update Report for Quarter 3.

Arising from the report it was highlighted that:

(1) All of the five quality priorities for 2017/18 were on track.

(2) Three out of nine (33%) of the quality metrics were reported as green with six out of nine (67%) reported as red.

(3) All three of the patient experience domain metrics were below target and two of these, along with patient reported perceptions of safety would need significant improvement if the full year target was to be achieved.

Following discussion it was noted that:

(1) The length of stay on older people's Wards had gone back down to the Quarter 1 position due to a small number of patients with extremely long stays, one of which was 504 days.
On this matter it was noted that some detailed work had been undertaken showing the complexity of people's needs and the lack of availability of finding suitable placements.

(2) Setting attainable targets and metrics did have its difficulties and it was recognised that the Quality Account was a key early warning system to highlight any trends, which were sometimes more important than achieving the actual target.

These discussions would be taken to the Quality Account Stakeholder meeting on 6 February 2018.

Action: Dr H Griffiths

18/13 DRUG AND THERAPEUTICS BI-MONTHLY REPORT

The Committee received and noted the Drug and Therapeutics report.

Arising from the report it was noted that:

(1) The terms of reference of the Drug & Therapeutics Committee had been updated to reflect the removal from membership of the Chief Operating Officer and that an SAS Doctor representative would become a permanent member of the Committee.
(2) New arrangements had been included under the duties of the Committee, (section 12); to review the recommendations form the Regional Medicines Optimisation Committee (RMOC), the North of England Treatment Advisory Group (NTAG) and Durham and Darlington Area Prescribing Committee (APC) and to make recommendations about the availability of mental health treatments and their instruction to the Quality Assurance Committee for ratification.

The Committee approved the revised terms of reference.

18/14 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no exceptions to report.

18/15 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.

18/16 ANY OTHER BUSINESS

The Committee noted a recent press article around a Paediatrician that had made an error on the first day back from maternity leave, which had subsequently led to the death of a six year old child.

The key matter of concern for the Trust was around the use of reflective notes and this would be discussed further with the Director of Nursing and Governance to identify any future potential implications.

18/17 DATE AND TIME OF NEXT MEETING:

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

The meeting concluded at 4.30pm

Annex 2

MEETING OF:	**Board of Directors**
DATE:	**28 March 2018**
TITLE:	**To consider the Draft Clinical Audit Programmes 2018/19**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board of Directors of the requirements of the 2018/19 clinical audit forward programmes.

1.2 To provide an update report on the Clinical Effectiveness Team capacity/ resources and planning for 2018/19.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Clinical audit is one of the key methodologies recommended nationally to deliver both quality improvement and quality assurance. CQC, Monitor and other external agencies require robust clinical audit programmes to be delivered by Trusts. The Trust annual clinical audit forward programme includes the clinical audits to be performed as required by national guidance and local Trust priorities. This incorporates compliance checks and assurance monitoring of key clinical risk/ quality issues.

2.2 The Trust Clinical Audit Programmes are approved annually by the Quality Assurance Committee and will be formally monitored via the Clinical Effectiveness Working Group. Programmes are subject to amendment in year if risk, quality or developmental issues arise that require such monitoring or measurement.

2.3 The Clinical Audit programmes are facilitated by the corporate operational team in partnership with the clinical and other corporate services as appropriate. The established systems and processes within the Clinical Audit and Effectiveness Team and in operation across the Trust received significant assurance from AuditOne in 2016.

3. KEY ISSUES:

3.1 The 2018/19 clinical audit programme requirements were identified by the corporate Clinical Audit & Effectiveness Department in collaboration with Service Development Managers (SDMs), Clinical Audit Sub Groups, Specialty Development Groups (SDGs) and individual Directorate Groups/ Leads.

3.2 The clinical audit programme requirements for 2018/19 are presented as Appendix 1 of this report. A total of 98 clinical audits were identified for inclusion. As in previous years this includes capacity for 15 unallocated programme topics which allows flexible capacity to respond to emergent in year quality and risk priorities.

3.3 Whilst all identified priorities apparent to date have been incorporated into these programmes, it must be noted that there may be other potential priorities which are yet to be identified e.g. CQUINs/ contract QIs and further clinical audit activity

highlighted in response to CQC inspections, through tendering processes and new contracts.

3.4 The current staffing establishment to support organisational Clinical Audit and Effectiveness programme delivery is:

1 WTE	Band 6:	Clinical Audit and Effectiveness Lead
2 WTE	Band 5:	Senior Clinical Audit and Effectiveness Coordinator
6.8 WTE	Band 4:	Clinical Audit Facilitators

3.5 The Team were successful in the recruitment of the Band 6 Clinical Audit and Effectiveness Lead from December 2017.

3.6 Capacity and demand data has been utilised and has identified anticipated resources required within the Clinical Audit & Effectiveness Team to support delivery of the 2018/19 clinical audit programmes (Appendix 2).
Based on the current identified clinical audit programme requirements and other departmental activities, it is anticipated this can be achieved within the current Departmental establishment.

3.7 It should however be noted that the delivery requirements will need to be reviewed/ recalculated once the full requirements of new priorities such as CQUINs and CQC audits are confirmed. If additional programme priorities are identified or existing priorities change this would need to be reassessed.

3.8 In line with Trust governance processes draft programme priorities have been presented to and agreed by Specialty Development Groups.

3.9 The Clinical Effectiveness Group reviewed and endorsed the draft Clinical Effectiveness Programme content 19th February 2018.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
Quality assurance and improvement delivered via clinical audit programmes is mandated by both the CQC and Monitor. Clinical audit and effectiveness work programmes are required to monitor and demonstrate that the Trust is delivering high quality, safe and effective services in line with national best practice standards including the CQC Fundamental Standards.
National audit findings are utilised by the CQC to inform the organisational quality and risk profile.

4.2 **Financial/Value for Money:**
Clinical audit and effectiveness programmes support delivery of safe, clinically and cost effective service delivery.

There are financial risks associated with failure of the Trust to achieve agreed CQUIN targets, national contract requirements and the requirements of regulators.

4.3 **Legal and Constitutional (including the NHS Constitution):**
The Trust has legal and Constitutional duties in respect of delivering safe and effective services and maintaining consistently high quality service provision.

In addition there are mandatory clinical audits that the Trust is required to complete both for the Quality Account and commissioned contractual requirements.
Failure to appropriately measure and monitor quality of service delivery parameters may result in patient safety, clinical effectiveness and/ or patient experience risks and failure to provide required levels of internal and external quality assurance and improvement.
The monitoring of the clinical effectiveness of services and interventions is an essential element of quality improvement and quality assurance – the risks of providing sub-effective care are both litigious and loss of reputation.

4.4 **Equality and Diversity:**
Clinical effectiveness monitoring includes ensuring Trust services are accessible to all and respond to diversity.

4.5 **Other implications:**
There are implications for clinical services if quality improvement is not achieved where indicated as required as a result of clinical audit. This could result in suboptimal patient experience/ outcome which may ultimately affect organisational reputation, existing contracts and tenders.

5. RISKS:

5.1 There may be potential quality / risk issues that arise in respect of patient safety, clinical effectiveness and patient experience if clinical audit and effectiveness programmes are not appropriately utilised to deliver required quality assurance and improvements.

6. CONCLUSIONS:

6.1 Draft Clinical Audit Programmes for 2018/19 as approved by the Clinical Effectiveness Group and relevant SDGs (or equivalent Committees) are presented as Appendix 1 of this report.

6.2 It is anticipated that the current clinical audit activities scheduled for 2018/19 can be supported within the current Clinical Audit & Effectiveness Team establishment. If additional programme priorities are identified or existing priorities change this would need to be reassessed.

7. RECOMMENDATIONS:

7.1 The Board of Directors are asked to note the contents of this report and provide approval of the proposed clinical audit programmes for 2018/19.

Leanne McCrindle
Head of Quality Governance & Compliance

Annex 2

AMH 2018/19 Draft Clinical Effectiveness Programme

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Key clinical system	3	High Priority	Service Evaluation of Perinatal Mental Health Services	To measure the outcomes of the perinatal mental health team.	Best Practice	Nicola Hutchinson	Apr-18	May-18	Jul-18
Key clinical system	3	High Priority	Re-audit of Supervision within Durham Adult Mental Health Community Teams (Using TEWV and DCC Supervision Policy)	DCC Local Authority requirement (to be completed every 2 years).	Trust policy, D&D Policy, SI lessons learnt	Stuart Tweddle	Apr-18	May-18	Jul-18
National Audit Programme, Quality Account	20	Mandatory	National Clinical Audit of Psychosis (NCAP) - Spotlight Audit in EIP Services	National audit to assess quality of care delivered for people with psychosis. The audit includes: physical health, health promotion, prescribing practice, use of evidence-based psychological treatments and access to services at times of crisis.	NICE	Steph Common	Sep-18	Oct-18	Apr-19

Central 2018/19 Draft Clinical Effectiveness Programme

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Key Clinical System	8	High Priority	Clinical Audit of Nasogastric Tube Insertion and Management	Audit to assess compliance with NICE Guidance for Nasogastric feeding. Peer audit of Evergreen/Birch clinical practices for NG feeding.	NICE Guidance, NHS Standard Contract requirements	Emma Rolfe	Mar-18	Apr-18	Jun-18
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	3	High Priority	Clinical Audit of Protocol for the Distribution of Safety Alert Broadcasts, Rapid Response Reporting and Trust Safety Notices	To assess assurance of Trust compliance with the updated SABs protocol issued Nov-17.	Trust Policy	Anne Lowery	Apr-18	May-18	Aug-18
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Triennial Review	To assess compliance with NMC Standards for Learning and Assessment in Practice	Practice Placement Capacity Supply of Future Nursing Workforce	Bernadette Wallace	Dec-18	Jan-19	Apr-19
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	3	High Priority	Clinical Audit of Preceptorship	To assess Trust compliance with the Preceptorship Framework. Assurance requirement for HEE.	Trust Policy	Bernadette Wallace	Dec-18	Jan-19	Apr-19
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical Audit of Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)	To assess compliance with MCA procedures and DoLS legislation	Mental Health Act, CQC	Rachel Ann Down	Aug-18	Oct-18	Feb-19

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Key Clinical System	8	High Priority	Clinical Audit of Care Programme Approach (CPA) Policy	Audit to assess policy application. Audit will focus on quality of care documents.	SI theme, policy review, PPCS	Michael Cowan	Nov-18	Jan-19	Mar-19
Key Clinical System	8	High Priority	Clinical Audit of Diabetes Management Guideline Adults and Young People (CLIN-0081-v2.1)	To assess compliance Trust wide with the Diabetes Management Guideline to ensure that all inpatients with type 1 and type 2 diabetes are monitored and treated in accordance with the guideline on admission / during an inpatient stay, and also appropriately managed during a diabetic emergency situation.	SI, Trust Guidance	Ann Thomas	Apr-18	May-18	Aug-18
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	3	High Priority	Clinical Audit of Head of Service Review Forms for Moderate Harm Incident reporting	Audit to assess the completeness of the Head of Service Review Form for Moderate Harm incidents - Ref CORP-0043-v8.1	Trust Policy	Anne Lowery	Aug-18	Sep-18	Nov-18
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical Audit of Duty of Candour	To re-assess compliance with the Trust Duty of Candour systems and processes.	Trust Policy, CQC	Anne Lowery	Jun-18	Jul-18	Sep-18
Key Clinical System	8	High Priority	Clinical Audit of Seclusion and Segregation Procedure	To assess compliance with the Trust Seclusion and Segregation Procedure CLIN-0019-001.v1 and use of the Seclusion/Segregation module on PARIS which launched October 2017.	Trust Policy	Simon Marriott	Apr-18	Jun-18	Sep-18

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
National Audit Programme, Quality Account	**20**	**Mandatory**	National Clinical Audit of Anxiety and Depression (NCAAD)	A retrospective audit of service users admitted to an inpatient mental health service for anxiety and/or depression. Data will be collected on service users care and treatment over a period of six months from their date of admission.	National Audit	Leanne McCrindle	Jan-18	Jun-18	Mar-19
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	**8**	**High Priority**	Clinical Audit of Nurse Revalidation NMC Requirements	To assess compliance with NMC Nurse revalidation requirements. This will be a qualitative audit to review the consistency of application of professional standards.	Safe Staffing, NMC Professional Standards	Stephen Scorer	Apr-18	May-18	Jul-18
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	**3**	**High Priority**	Clinical Audit of the Claims Management Policy	To assess closed cases of Clinical Negligence claims and closed cases of Litigation claims against the Trust Policy and NHSLA Reporting Guidance.	Trust Policy, NHSLA guidance	Elaine Radford	Oct-18	Dec-18	Feb-19
National Audit Programme, Quality Account	**20**	**Mandatory**	National Audit of Care at the End of Life (NACEL) 2018	NACEL will focus on progress against achieving the Five Priorities for Care as outlined in 'One Chance to Get it Right', on progress against the NICE Quality Standards, and the CQC domains. It will also consider whether progress on key measures as outlined in the previous iteration of the audit has been made. All patients aged 18+ that die during April 2018 will be included in the audit that meet the inclusion criteria.	National Audit, HQIP	Leanne McCrindle	Feb-18	Aug-18	Mar-19

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical Re-audit of Manual Handling of People	To ensure the appropriate management of risks relating to manual handling of people, specifically ensuring appropriate risk assessment and action taken.	HSE (Legislation)	Louis Bell	Apr-18	Apr-18	Mar-19
Key Clinical System	8	High Priority	Clinical Audit of DNA Management in Adult Services for over 18s	To assess adherence to Trust DNA Policy to provide assurance of consistent policy application.	SI theme, Trust policy	Shaun Mayo	Aug-18	Sep-18	Dec-18
Key Clinical System Patient Safety (inc. Risk Management)	8	High Priority	Re-audit of Physical Health Assessment	Audit to assess use of the new Physical Health Assessment format in Paris.	Physical Healthcare Team	Alexia Pearce	Nov-18	Dec-18	Mar-19
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical Audit of Section 17 Leave Documentation and Process in Inpatient Teams	Clinical audit to assess compliance with the Section 17 Leave guidelines following the Code of Practice guidance and Mental Health Act 1983.	CQC	Simon Marriott	Aug-18	Sep-18	Nov-18
Key Clinical System	8	High Priority	Early Warning Score (EWS)	This Clinical audit will assess the compliance of the Procedure for Using the Early Warning Score for the Early Detection and Management of the Deteriorating Patient (CLIN-0076-v.2)	Trust Policy	Alexia Pearce	Jul-18	Sep-18	Jan-19
Key Clinical System	8	High Priority	Clinical Audit of Emergency Equipment	Re-audit to ensure compliance with the standards in relation to the continual availability/ readiness of emergency equipment in line with the Trust Resuscitation Policy.	Trust Policy	Alexia Pearce	Aug-18	Oct-18	Jan-19

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
National Audit Programme, Quality Account	8	Mandatory	National Clinical Audit of Anxiety and Depression (NCAAD) - Psychological Therapies Spotlight Audit	As part of the National Clinical Audit of Anxiety and Depression (NCAAD), there will be a Spotlight Audit on Psychological Therapies which follows on from the NAPT audit undertaken 2010-2014. The audit will be focusing on Access, Waiting times, Training and Supervision of Therapists, Measuring and Monitoring service user outcomes, and Provision of NICE recommended therapies of an appropriate modality and for a sufficient duration.	National Audit	Leanne McCrindle	Aug-18	Nov-18	Mar-19
Key Clinical System	8	High Priority	Clinical Audit of Hand Hygiene	Annual audit to assess compliance with the Trust Hand Hygiene Policy/procedure - Ref IPC-0001-006 v2	IPC, Trust Policy	Joanne Dunmore	Sep-18	Dec-18	Feb-19
Key Clinical System	8	High Priority	Implementation of the Smoking Cessation and Nicotine Management Project	To identify how many patients who have been admitted to an inpatient unit are current smokers and if they have been offered and subsequently accepted Very Brief Advice, further individual/group behavioural support and Nicotine Replacement Therapy (NRT), medication or e-cigarettes.	CQUIN	Lesley Colley	Oct-18	Dec-18	Mar-19
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical Audit of Positive and Safe Trustwide	The Trustwide Positive and Safe Steering group have been requested to provide a Trust position on Positive and Safe Practice across the Trust.	Positive and Safe Report	Stephen Davison	Nov-18	Jan-19	Mar-19

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	**20**	**High Priority**	Clinical Audit of the Safety Summary on PARIS	To assess compliance with the completion of the Trust's Safety Summary and its 4 domains. To focus on compliance with the new narrative based risk assessment and the level of patient input into the Safety Summary.	National Confidential Inquiry into Suicides and Homicides, NHSLA, Trust Policy	Denise Colmer/ Vanessa Cunliffe	Dec-18	Feb-19	May-19
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	**8**	**High Priority**	Clinical Audit of Dual Diagnosis	To assess compliance with the updated Trust Dual Diagnosis Policy following publication of new NICE guidance for dual diagnosis.	NICE, Trust Policy	Jo Dawson	TBC	TBC	TBC

CQUIN 2018/19 Draft Clinical Effectiveness Programme

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Data Validation, Quality and Contracting (inc. Quality Account)	8	Mandatory	NHS Safety Thermometer 2018/19 Q1	To gather monthly information from LD and MHSOP inpatient and community teams regarding the 4 harms with onward submission to the HSCIC.	Contract Requirement	Angela Ridley, Emma Rolfe	Apr-18	Apr-18	Jun-18
Data Validation, Quality and Contracting (inc. Quality Account)	8	Mandatory	Specialist Services Clinical Supervision Quality Indicator 2018/19 Qtr1	Audit to be conducted as part of the requirements for the Quality Dashboard. The Trust is required to report the percentage of eligible staff who have received clinical supervision as per Trust/Organisation policy.	Quality Dashboard	Jennifer Illingworth	Apr-18	Jul-18	Jul-18
Data Validation, Quality and Contracting (inc. Quality Account)	8	Mandatory	NHS Safety Thermometer 2018/19 Q2	To gather monthly information from LD and MHSOP inpatient and community teams regarding the 4 harms with onward submission to the HSCIC.	Contract Requirement	Angela Ridley, Emma Rolfe	Jul-18	Jul-18	Sep-18
Data Validation, Quality and Contracting (inc. Quality Account)	8	Mandatory	Clinical Re-Audit of Transitions from Child and Adolescent Services to adult services or discharge 2018/19 Quarter 2	To support the implementation of the transitions from CYPS CQUIN.	CQUIN	Sam Clement	Jul-18	Aug-18	Sep-18
Data Validation, Quality and Contracting (inc. Quality Account)	8	Mandatory	Clinical Re-Audit of Transitions from Child and Adolescent Services to adult services or discharge 2018/19 Quarter 4	To support the implementation of the transitions from CYPS CQUIN.	CQUIN	Sam Clement	Jan-19	Feb-19	Mar-19
Data Validation, Quality and Contracting (inc. Quality Account)	8	Mandatory	Specialist Services Clinical Supervision Quality Indicator 2018/19 Qtr2	Audit to be conducted as part of the requirements for the Quality Dashboard. The Trust is required to report the percentage of eligible staff who have received clinical supervision as per Trust/Organisation policy.	Quality Dashboard	Jennifer Illingworth	Apr-18	Oct-18	Oct-18

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Data Validation, Quality and Contracting (inc. Quality Account)	8	Mandatory	NHS Safety Thermometer 2018/19 Q3	To gather monthly information from LD and MHSOP inpatient and community teams regarding the 4 harms with onward submission to the HSCIC.	Contract Requirement	Angela Ridley, Emma Rolfe	Oct-18	Oct-18	Dec-18
Data Validation, Quality and Contracting (inc. Quality Account)	8	Mandatory	Specialist Services Clinical Supervision Quality Indicator 2018/19 Qtr3	Audit to be conducted as part of the requirements for the Quality Dashboard. The Trust is required to report the percentage of eligible staff who have received clinical supervision as per Trust/Organisation policy.	Quality Dashboard	Jennifer Illingworth	Apr-18	Jan-19	Jan-19
Data Validation, Quality and Contracting (inc. Quality Account)	8	Mandatory	NHS Safety Thermometer 2018/19 Q4	To gather monthly information from LD and MHSOP inpatient and community teams regarding the 4 harms with onward submission to the HSCIC.	Contract Requirement	Angela Ridley, Emma Rolfe	Jan-19	Jan-19	Mar-19
Data Validation, Quality and Contracting (inc. Quality Account)	8	Mandatory	Specialist Services Clinical Supervision Quality Indicator 2018/19 Qtr4	Audit to be conducted as part of the requirements for the Quality Dashboard. The Trust is required to report the percentage of eligible staff who have received clinical supervision as per Trust/Organisation policy.	Quality Dashboard	Jennifer Illingworth	Apr-18	Apr-19	Apr-19

CYPS 2018/19 Draft Clinical Effectiveness Programme

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical Audit of the Pathway Flower	To assess implementation of the Pathway Flower in CYPS Services.	Trust Policy/ Pathway	TBC	Apr-18	May-18	Jul-18
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical Audit of Care Planning	Re-audit of Clinical audit of Care documents (4440CYPS15). This audit will be extended to include care planning, formulation and "My Plan".	Serious case review, Trust Policy	Lynne Brown, Carol Redmond and Martinas Andrijevskis	Jul-18	Aug-18	Oct-18
Key clinical system	8	High Priority	Clinical Audit of Autism in CYPS	To assess NICE guidance implementation and Trust Policy adherence.	NICE/ Trust Policy	TBC	Oct-18	Nov-18	Feb-19
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical re-audit of Discharge and DNA Management	Re-audit of 2016/17 audit cycle. To assess if actions have been fully implemented.	SI/ Trust Policy	Guru Udpa, Sumeet Gupta, Shashi Kiran	Oct-18	Nov-18	Feb-19
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical re-audit of Self-Harm Pathway in CYPS	Re-audit of 2016 audit. To assess if actions have been fully implemented. To include C&YPS Crisis teams in this audit cycle.	NICE/ Trust Policy	Melanie Willets, Martin Andrijevskis	Dec-18	Feb-19	Mar-19

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical Re-Audit against Depression Pathway	Re-audit of 2015/16 audit cycle. To assess if actions have been fully implemented with regards to Depression Pathway implementation.	NICE/ Trust Policy	Veenu Gupta, Juliette Kennedy	Dec-18	Feb-19	Mar-19
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical Re-Audit of MARSIPAN Guidance	Re-audit to assess all zones of MARSIPAN guidance.	NICE/ Trust Policy	Joe Walker	Dec-18	Feb-19	Mar-19
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical Re-Audit of ADHD Prescribing	The previous audit for POMH13b was red and the national re-audit is not yet timetabled. To audit in Q4 after actions of previous audit have been implemented.	POMH-UK, Trust Policy	Kathryn Currah	Dec-18	Feb-19	Mar-19

Forensic and Offender Health 2018/19 Draft Clinical Effectiveness Programme

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Key clinical system	8	High Priority	Clinical Audit of T2/T3 Documentation	Annual audit component of Medication Management Workstream	Trust policy, MH legislation, CQC	Moushumi Storey	Jul-18	Aug-18	Oct-18
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical Audit of Assessment Documentation within Offender Health HMP	Audit requested by Commissioners to assess the clinical record keeping, consent and completion of the Offender Health Assessment documentation in prison teams.	Legislation	Richard Hand	Oct-18	Dec-18	Feb-19
Key Clinical System	8	High Priority	Clinical Audit of the Use of Soft Restraint Devices	Identified from October-16 SDG following Neil Woodward's thematic review of security. Assurance of compliance against procedure / protocol required. Results to be reported to SDG.	Trust Policy/ procedures	Neil Woodward	Mar-18	Apr-18	Jul-18
Key Clinical System	8	High Priority	Clinical Audit of Antipsychotic prescribing within Offender Health HMP	Review of new patients already prescribed antipsychotic medication and indication as to why medication is prescribed	Trust policy	Chris Smart	Oct-18	Dec-18	Feb-19

LD 2018/19 Draft Clinical Effectiveness Programme

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Key Clinical System	8	High Priority	Clinical Audit of Adult LD Core Pathway & CLiPs	ALD introduced a core pathway from April-17. A pathway refresh is ongoing in Feb-18. This audit will assess outcomes from the pathway refresh.	Trust policy	Kirsty Passmore TBC	Aug-18	Nov-18	Jan-19
Key clinical system	8	High Priority	Service Evaluation of PPCS Clinical Outcome measures	Awaiting agreement regarding PROMs & CROMs at SDG	Trust Policy	TBC	Nov-18	Feb-19	Mar-19
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical Audit of Prescribing Practice and STOMP	This audit aims to review standards of prescribing for patients including STOMP LD (Stopping Overmedication of People with a Learning Disability, Autism or both)	Trust policy	TBC	Aug-18	Nov-18	Jan-19
Key clinical system	8	High Priority	Clinical Audit of Falls Clinical Linked Pathway (CLiP) in LD Services	This audit aims to assess whether practice is consistent with the recommendations of NICE CG 161: Falls: assessment and prevention of falls in older people and Falls Clinical Link Pathway (CLiP) approved October 2014	NICE, Trust Policy	Christiana Liddle TBC	Sep-18	Jan-19	Mar-19
Key clinical system	8	High Priority	AHP (Allied Health Professionals) Audit	TBC Capacity allocated as requested by LD Clinical Audit Subgroup.	TBC	TBC	Jul-18	Oct-18	Mar-19
Key clinical system	8	High Priority	Audit of Physical Health in Learning Disability Services	TBC – awaiting outcomes of Physical health related audits in central programme	NICE, Trust Policy	TBC	Oct-18	Jan-19	Mar-19

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Key clinical system	8	High Priority	Audit of Assessment and Treatment in Learning Disability Services (SENATE standards)	TBC - following review of SENATE documentation and standards & plans of Operational Delivery Network to scrutinise implementation of standards	SENATE, Trust Policy, NICE	TBC	Apr-18	Jul-18	Sep-18

MHSOP 2018/19 Draft Clinical Effectiveness Programme

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Key Clinical System	8	High Priority	Clinical Audit of Environmental Standards in MHSOP Community bases used by patients	To date MHSOP have focused on Stirling Environmental standards in ward settings. To apply similar principles for community bases used by MHSOP patients	Patient Safety, Clinical Effectiveness and Patient Experience, CQC Inspection Findings	Sharon Tufnell/ Amy Smith	Jun-18	Jul-18	Oct-18
Key clinical system	8	High Priority	Clinical audit of Post Falls Proforma in Mental Health Services for Older People	High levels of incidents leading to harm (including FNFs) to patients have been acknowledged by the service. Patient Safety risk issue acknowledged by SIs and high levels of incidents reported. Previous red compliance audits. This audit will assess use of the post falls proforma.	CQC, SI Theme, Patient Safety, Patient Clinical Outcomes and Patient Experience, Risk Register Priority, QA Priority	Jane Blakey	May-18	Jun-18	Sep-18
Key clinical system	8	High Priority	Clinical audit of Functional Care Pathway Implementation in MHSOP Community Teams	This audit will assess compliance with the MHSOP functional care pathway.	PPCS implementation (pathway implementation, clinical outcomes and service productivity)	Alan Gemski	Aug-18	Oct-18	Mar-19
Key clinical system	8	High Priority	Clinical Audit of Challenging Behaviour CLiP (Acute Liaison Services)	This audit will assess implementation of the new Challenging Behaviour CLiP.	Patient Safety, Patient Clinical Outcomes and Patient Experience	Graeme Flaherty	Aug-18	Oct-18	Jan-19
Data Validation, Quality and Contracting (inc. Quality Account)	8	High Priority	Clinical Audit of MHSOP Operational Policies – Age Equality and Discrimination	To assess the Trusts position in terms of age discrimination between services (AMH - MHSOP). This audit will review policies not audited as part of the previous cycle in 4954.	Equality and Diversity	Sarah Jay	Apr-18	May-18	Aug-18

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Key clinical system	8	High Priority	Clinical Audit of Activities in MHSOP wards	A service evaluation in 2017/18 identified areas for improvement in activities in MHSOP wards. This audit will utilise an adapted RCOT tool developed for activities in care homes	NICE, Pathway	Sharon Tufnell	Sep-18	Oct-18	Jan-19

Pharmacy 2018/19 Draft Clinical Effectiveness Programme

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Key Clinical System	8	High Priority	Clinical Audit of Trust Clozapine Guidance	To assess clozapine prescribing against Trust Guidance.	Trust Policy	Ann Cranke	Apr-18	Apr-18	Jun-18
Data Validation, Quality and Contracting (inc. Quality Account)	20	Mandatory	POMH Topic 18a: Prescribing Clozapine	RCPsych National Audit to assess clinical practice relating to clozapine prescribing practices.	RCPsych POMH programmed national audit.	Ann Cranke	Apr-18	Jun-18	Mar-19
Data Validation, Quality and Contracting (inc. Quality Account)	20	Mandatory	POMH Topic 6d: Assessment of the side effects of depot antipsychotics	RCPsych National Audit to assess practice against National guidance for assessment of side effects for patients receiving depot antipsychotic medication.	RCPsych POMH programmed national audit.	Steph Magee	Aug-18	Sep-18	Jun-19
Key Clinical System	8	High Priority	Re-audit of Rapid Tranquilisation - Post Administration Monitoring	To assess the use of rapid tranquillisation against the Trust policy and NICE guidelines	Trust Policy	Linda Johnstone	Sep-18	Oct-18	Dec-18
Key Clinical System	8	High Priority	Re-audit of High Dose Antipsychotic Treatment (HDAT)	To assess monitoring of patients on or at risk of high dose antipsychotic prescribing against the Trust policy	Trust Policy	Richard Morris	Dec-18	Jan-19	Mar-19
Key Clinical System	8	High Priority	Clinical Audit of the use of Clopixol acuphase (Zuclopenthixol acetate)	TBC	TBC	Pre-Reg Pharmacist	Sep-18	Oct-18	Jan-19
Key Clinical System	8	High Priority	Clinical Audit of Methadone Prescribing in Inpatients	Audit against medication safety series.	Trust Policy	TBC	May-18	Jul-18	Oct-18
Key Clinical System	8	High Priority	Clinical Audit of PRN medication review	TBC	TBC	TBC	Sep-18	Oct-18	Dec-18

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Key Clinical System	3	High Priority	Re-audit of Controlled Drugs Quarter 1 - 4 2018/19	To assess compliance with controlled drugs legislation, Trust policy and standard operating procedures. Quality checks to identify any stock discrepancies.	Legislation, Commissioning Indicator.	Chris Williams	Apr-18	Apr-18	May-19
Data Validation, Quality and Contracting (inc. Quality Account)	20	Mandatory	POMH Topic 7f: Monitoring of Patients Prescribed Lithium	RCPsych National Audit to assess clinical practice relating to lithium prescribing.	RCPsych POMH programmed national audit.	Richard Morris	Jan-19	Feb-19	Sep-19

Safeguarding 2018/19 Draft Clinical Effectiveness Programme

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Service Evaluation of Safeguarding Adult Procedure and Patient Experience - "Making Safeguarding Personal"	Service evaluation to review regular supervision requirements according to policy and Patient Experience.	Trust Policy	Andrea Bland	Aug-18	Oct-18	Mar-19
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical re-audit of Safeguarding Casefiles AMH	Case file audit in respect of Safeguarding Clinical Notes in AMH. Audit will assess full Safeguarding process, and will be undertaken monthly by the Senior Safeguarding Nurse reviewing 2 cases. Data will be submitted on an ongoing basis to the Clinical Audit team to collate and identify themes and trends. The sample will be increased dependant on caseload of teams to be reflective of the number of cases held.	QSG04, QSG05	Theresa Flaherty	Aug-18	Oct-18	Mar-19
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Service Evaluation of the (Children's) Safeguarding Team	Service evaluation to review Safeguarding Team	Quality Indicator for Commissioners	Gary Thompson	Apr-18	May-18	Jul-18
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical Audit of Safeguarding Children's Policy	Audit to assess the implementation and staff awareness of the Safeguarding Children Policy. This audit will be undertaken via survey monkey	NHSLA, Trust Policy	Jane Middleton	Dec-18	Jan-19	Mar-19

Plan Segment	Complexity (days)	Type	Project Title	Scope and rationale	Links to Key Risks	Project Lead	Date to be initiated	Planned data collection start date	Date to be completed
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	3	High Priority	Clinical re-audit of Referrals to Social Care	Audit to provide assurance evidence that practitioners are assessing and describing the risk to children and families when making referrals to children's social care. Initially required as part of CQC Action plan. The audit will ensure that risks are identified within referrals and clearly communicated.	Trust Policy	Demetria Parker	Jul-18	Aug-18	Dec-18
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical re-audit of Safeguarding Casefiles CYPS	Case file audit in respect of Safeguarding Clinical Notes in CYPS. Data will be submitted on an ongoing basis to the Clinical Audit team to collate and identify themes and trends. The sample will be increased dependant on caseload of teams to be reflective of the number of cases held.	QSG04, QSG05	Theresa Flaherty	Jul-18	Aug-18	Dec-18
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Service Evaluation of Safeguarding Supervision	To assess the implementation of the revised Supervision Policy in relation to Safeguarding practice.	Trust Policy	Gary Thompson	Dec-18	Jan-19	Mar-19
Clinical Governance, Quality Assurance, Patient Safety (inc. Risk Management)	8	High Priority	Clinical Audit of Parental Mental Health	Audit to monitor practice in relation to assessment/consideration of parental mental health and the impact upon children and young people	Trust Policy	Gary Thompson/ Jackie Adams	Dec-18	Jan-19	Mar-19

Annex 3

Clinical Audit and Effectiveness Team Resources Required to Support Delivery of the Clinical Audit Programmes 2018/19

The following prioritisation matrix demonstrates how clinical audit programme priorities are derived and categorised within the Trust:

Prioritisation Category	Audits for inclusion	
Mandatory Priority These audits are compulsory requirements for the Trust and must be undertaken as agreed by appropriate Trust Committees. These high level requirements may pose significant risk to patient safety, clinical effectiveness or patient experience.	Care Quality Commission Outcome or action plan priority CQUIN Contract Requirements NPSA Alerts Commissioning Priorities	National Clinical Audit and Patient Outcome Programme (NCAPOP)/ POMH-UK National Audits Monitor Requirement Quality Account Indicators Mandated Statements
High Priority These audits are of precedence to the Trust. Good practice indicates that these areas are audited to mitigate potential high risk to patient safety, clinical effectiveness or patient experience	Risk Register Priorities High Level Inquiries/Enquiries NICE Quality Standards and Guidance National Policy/ Strategies Emerging themes/risks from SIs, incidents and complaints	
Desirable Priority These audits are of lower priority and do not pose significant risk to patient safety, clinical effectiveness or patient experience	Other National initiatives (e.g. Professional Body Initiatives) Other Locality/ Specialty Issues Local Initiatives	

The breakdown of clinical effectiveness projects by Programme is as follows:

Programme	Total number of clinical effectiveness projects
AMH	5
CYPS	10
CQUIN/ QI/ Contract Requirements	11*
Central	27
Forensic	6
LD	9
MHSOP	8
Pharmacy	11
Safeguarding Adults and Children	11
Total	**98**

It should be noted that Offender Mental Health Audits have been incorporated into the Forensic programme.

*National and local CQUIN audit requirements are not confirmed at time of programme planning and are therefore subject to change.

By category of clinical audit, there are currently:

- 17 Mandatory clinical audits
- 66 High Priority clinical audits

58 of the clinical audit programme priorities identified for 2018/19 are re-audits.

Since 2013/14 it was agreed that identified clinical audit programmes would include programmed audits for which no scheduled topic activity was assigned in order to provide flexibility to respond to high level risk and/or quality issues which arose in year. 15 programmed audits across services have been allocated for this purpose for 2018/19.
It should be noted that without this flexible programme capacity being scheduled and available, the Clinical Audit and Effectiveness Team would not have been able to respond to and deliver these requirements in previous years.

It has been agreed by the Clinical Effectiveness Group that consideration has been given to audits having a two-year cycle rather than an annual cycle to allow actions to be implemented and embedded in practice.

ITEM 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th March 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 February 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 24 wards.
- The Forensic directorate have the highest level of 'red' fill rates (10 in November)
- The lowest fill rate indicators in February related to Talbot Direct Care (support is being provided by Holly which is reflective in their fill rates), The Orchards NY (sickness), and Primrose Lodge (sickness)
- The Highest fill rates in February were observed by Westerdale South (high patient acuity), Acomb Garth (high patient acuity) and Westwood (seclusion, enhanced observations and supporting a neighbouring ward)
- In relation to bank usage there were no wards identified that were utilising in excess of 50% bank during February. The highest bank user was in relation to Clover / Ivy with 40.5% bank usage (reasons for bank included: establishment vacancies and enhanced observations)
- Agency usage equated to 5.1% in February. The highest user of agency within the reporting period related to Acomb Garth with 53.4% of the total hours worked

within this ward (reasons for agency included: enhanced observations and sickness)

- In terms of triangulation with incidents and complaints the full analysis can be found on page 7 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.
- There were 471 shifts allocated in February 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 (348 shifts).
- There were 12 incidents raised in February 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 February Eagle/Osprey had the highest score with 9 points awarded. The top 10 for February can be found on page 9 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 86, followed by Sandpiper with 83.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**27th March 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 February 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 – February 2018

3.1.1 The daily nurse staffing information aggregated for the month of February 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 24 in February. This is an increase of 4 when compared to January 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
February 2018		
Talbot Direct Care	29.8% HCA on Nights 37.6% HCA on Days 54.4% RN on Days	The ward has advised that Holly is providing support to Talbot which is not being reflected within HealthRoster. This is evident within Holly's fill rates.

The Orchards (NY)	51.8% RN on Nights 125% HCA on Nights 77.6% RN on Days 85.7% HCA on Days	The ward has been experiencing high levels of sickness. The requirement on Nights has changed from 2 RN's to 1 and this has not been reflected on HealthRoster.
Primrose Lodge	56.6% RN on Days 131.5% HCA on Days	The shortfall is in relation to sickness and often had to run with only 1 RN on duty due to not being able to cover the vacant shifts via bank, agency or overtime. The increase in HCA has been used to backfill some of the RN duties where it was appropriate to do so.

It is also important to review the fill rates that exceed the budgeted establishment (shown in blue). In February there were 59 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
February 2018		
Westerdale South	381.9% HCA on Nights 80.4% RN on Nights 265.4% HCA on Days 91.9% RN on Days	The shortfall on RN on Days and Nights is due to sickness. The increase of HCA's is in relation to the increased ward acuity (6/7 enhanced observations). Assurance has been given by the ward that all shifts did have a nurse in charge on duty.
Acomb Garth	324.1% HCA on Nights 121.7% RN on Nights 203.0% HCA on Days 85.7% RN on Days	The over establishment is in relation to high patient acuity. At times they have up to 5 staff on constant 'line of sight' observations. The excess RN's on nights is reflective of a recent service change to have a locality floating RN based on the ward (person in post prior to budget). The day time RN shortfall is due to 'off framework' agency RN's being utilised which have not been reflected onto Health Roster.
Westwood Centre	205.7% HCA on Nights 100.0% RN on Nights 169.6% HCA on Days 91.0% RN on Days	The ward have young individual being nursed in seclusion awaiting transition to adult services. In addition there have been enhanced observations and they have overstaffed the ward to provide support to Evergreen in relation to providing nutritional feeds.

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 February. The highest user of bank in February related to Clover / Ivy reporting at 40.5%.

The reasons Clover / Ivy gave for requesting bank are as follows:

- Establishment Vacancies (93 shifts)
- Enhanced Observations (37 shifts)
- Unknown (7 shifts)
- Overbooked (6 shifts)
- Sickness (6 shifts)
- Annual Leave (3 shifts)
- Training (2 shifts)
- Escort (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.

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

Clover/Ivy	40.5%
Merlin	34.2%
Mandarin	33.9%
Kestrel/Kite.	32.0%
Birch Ward	29.9%
Maple Ward	29.8%
Westerdale South	29.6%
Langley Ward	28.9%
Kirkdale Ward	26.5%
Hamsterley Ward	26.2%
Oakwood	26.1%
Ward 15 Friarage	25.3%
Sandpiper Ward	25.2%

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 February the agency usage equated to 5.1% an increase of 0.7% when compared to January.

The highest user of agency within the reporting period related to Acomb Garth equating to approximately 53.4% of the total hours worked on this ward. The reasons Acomb Garth gave for requesting agency are as follows:

- Enhanced Observations (229 shifts)
- Unknown (21 shifts)
- Sickness (4 shifts)
- Training (2 shifts)
- Annual Leave (2 shifts)
- Maternity (1 shift)

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

Acomb Garth	53.4%
Cedar Ward (NY)	26.6%
Westerdale South	23.9%
Westerdale North	22.9%
Cherry Tree House	21.3%
Springwood	13.3%
Rowan Lea	10.9%
Ayckbourn Unit Danby Ward	10.8%
Hamsterley Ward	10.1%
Meadowfields	9.5%
Rowan Ward	8.5%
Maple Ward	7.3%
Eagle/Osprey	6.3%
Minster Ward	5.4%
Oak Rise	5.0%
Ebor Ward	4.8%
Ward 15 Friarage	4.6%
Birch Ward	4.0%

It is positive to note that agency usage remains relatively low within the Trust however; this is increasing month on month. It is important to continue to monitor this on an ongoing basis due to the potential risks that high agency working has on individual clinical areas.

3.4 Quality Data Triangulation

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

- There were 2 Serious Incidents (SI) that occurred within inpatient areas during the month of February. 1 of which related to Cherry Tree who have been cited in this report for having agency usage in excess of 4%.
- There was 1 level 4 incident reported in February which related to the Cherry Tree serious incident identified above.
- There were 7 level 3 incidents (self-harm) that occurred in February with the following featuring in this report as follows:
  - Cedar (NY) – 3 incidents – cited in this report for agency usage greater than 4%
  - Talbot Direct Care – 1 incident – cited in this report for having a low staffing fill rate
- There were 4 complaints raised in February of which 1 related to Minster Ward who have been cited in this report for having agency usage greater than 4%.
- There were 33 PALS related issues raised with the following featuring within this report as follows:
  - Cedar (NY) (1 issue) – cited in this report for having agency usage greater than 4% and also having 3 self-harm incidents
  - Kirkdale (1 issue) – cited in this report for having bank usage in excess of 25%
  - Maple (2 issues) – cited in this report for having bank usage in excess of 25% and agency usage greater than 4%
  - Clover / Ivy (1 issue) – cited in this report for being the highest user of bank
  - Kestrel / Kite (2 issues) – 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%
  - Cherry Tree (1 issue) – cited in this report agency usage greater than 4% and for having a serious incident.

A number of incidents requiring control and restraint occurred during November. The highest user was the Newberry with a total of 167 incidents. This ward has not been cited in this report to date.

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 471 shifts in February where an unpaid break had not been taken. This is a reduction of 64 when compared to January.

The majority of the shifts where breaks were not taken occurred on day shifts (348 shifts). The number of night shifts where breaks were not taken equated to 123 shifts in February.

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

3.6 Incidents raised citing Staffing Levels

It is also important to look at the number of incidents that have been raised and categorised in relation to staffing levels. There were 12 incidents reported in February on Datix citing issues with staffing. All but 1 of the 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:

- 58% (7 incidents) citing staffing levels were for night duty
- Forensic Services at Roseberry Park accounted for 42% (5 incidents) of all incidents citing staffing levels
- Enhanced observations increasing staffing requirements
- Staff with patient at acute hospital
- Agency staff not turning up for shift
- Staff sickness

Issues reported:

- Staff and patient safety compromised
- Quality of service impaired.
- Wards not running on required staffing levels.
- Staff in difficulty restraining patient.
- Unable to offer emergency response to other wards
- Perimeter checks not being competed

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	Serious Incident	Level 4 Incidents	Level 3 Incidents	Complaints	Control & Restraint	TOTAL SCORE Feb
Eagle/Osprey	6	0	1	1	1	0	0	0	0	0	**9**
Westerdale South	2	2	1	1	2	0	0	0	0	1	**9**
The Orchards (NY)	6	1	0	1	0	0	0	0	0	0	**8**
Mandarin	2	2	1	0	2	0	0	0	0	1	**8**
The Lodge	8	0	0	0	0	0	0	0	0	0	**8**
Acomb Garth	2	3	1	1	0	0	0	0	0	1	**8**
Bilsdale Ward	0	2	1	1	1	1	0	1	0	0	**7**
Birch Ward	2	2	0	1	2	0	0	0	0	0	**7**
Maple Ward	2	2	0	1	2	0	0	0	0	0	**7**
Newberry Centre	0	3	0	1	0	0	0	1	0	2	**7**
Talbot Direct Care	6	0	0	0	0	0	0	1	0	0	**7**

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

WARD	Locality	Speciality	YTD Total Score (Feb - Feb)
Clover/Ivy	Teesside	Forensics LD	**86**
Sandpiper Ward	Forensics	Forensics MH	**83**
Newberry Centre	Teesside	CYPS	**79**
Springwood	North Yorkshire	MHSOP	**79**
Cedar Ward	York and Selby	Adults	**77**
Bedale Ward	Durham & Darlington	Adults	**77**

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

3.8 **Other**

The Forensic directorate have the highest number (10 wards' in February) of 'red' fill rates for registered nurses on day shifts.

The safer staffing steering programme is reviewing its current work-streams following feedback from business planning and is likely to be re-named to reflect its multi-professional focus.

A report of progress has been submitted to the board 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 persons wards. 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.

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.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

No direct risks or implications to patient safety from the staffing data have been identified within this report, although 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 wards meeting their planned staffing levels on a regular basis particularly with regard to registered nursing staff fill rates on days. This issue has been highlighted as a concern by the CQC in recent inspection reports for other Mental Health Trusts and may pose a risk as to our ratings.

4.2 Financial/Value for Money:

It has been identified that there is little spare capacity in nursing establishments as they have been planned for maximum efficiency – it is therefore implied that the workforce deployment needs closer scrutiny to ensure those efficiencies do not constitute risks. This work is being progressed and will be a feature of this financial year'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 The comparative analysis of complaints and incidents, particularly focussing on the areas where staff fell below the planned levels has not shown any significant quality or safety impact to date as gaps are being mitigated through the use of temporary staff and/or reviewing skill mix on a daily basis. Work continues in localities 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
March 2017

Appendix 1

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 28 DAYS IN February

				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	186.4%	109.0%	140.1%	203.9%
Birch Ward	Durham & Darlington	Adults	15	66.2%	117.5%	127.3%	133.9%
Cedar Ward	Durham & Darlington	Adults	10	100.1%	180.9%	105.6%	126.5%
Maple Ward	Durham & Darlington	Adults	20	89.7%	130.4%	103.6%	125.0%
Hamsterley Ward	Durham & Darlington	MHSOP	15	96.9%	169.0%	100.3%	171.4%
Primrose Lodge	Durham & Darlington	Adults	15	56.6%	131.5%	100.0%	100.0%
Willow Ward	Durham & Darlington	Adults	15	86.9%	139.8%	100.0%	100.0%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	95.9%	122.4%	107.3%	101.7%
Elm Ward	Durham & Darlington	Adults	20	96.6%	83.8%	103.8%	107.3%
Farnham Ward	Durham & Darlington	Adults	20	98.8%	102.4%	100.6%	105.0%
Tunstall Ward	Durham & Darlington	Adults	20	106.1%	105.3%	100.0%	100.0%
Talbot Direct Care	Durham & Darlington	CYPS	1	54.4%	37.6%	102.3%	29.8%
Bek-Ramsey Ward	Durham & Darlington	LD	11	115.0%	113.7%	96.4%	101.2%
Oak Ward	Durham & Darlington	MHSOP	12	90.6%	97.4%	100.0%	98.2%
Roseberry Wards	Durham & Darlington	MHSOP	15	101.8%	93.8%	100.5%	101.7%
Harland Rehab Ward	Durham & Darlington	Rehab	1	109.4%	100.0%	100.0%	100.1%
Mandarin	Forensics	Forensics MH	16	84.7%	163.0%	110.7%	193.2%
Merlin	Forensics	Forensics MH	10	109.6%	150.4%	99.9%	201.8%

Clover/Ivy	Forensics	Forensics LD	12	90.8%	112.0%	108.8%	186.2%
Harrier/Hawk	Forensics	Forensics LD	10	86.1%	118.3%	104.8%	148.2%
Kestrel/Kite.	Forensics	Forensics LD	16	92.5%	115.9%	100.0%	142.3%
Brambling Ward	Forensics	Forensics MH	13	88.8%	113.4%	104.0%	128.6%
Mallard Ward	Forensics	Forensics MH	14	89.7%	107.3%	102.9%	136.5%
Newtondale Ward	Forensics	Forensics MH	20	116.7%	109.3%	97.1%	147.7%
Sandpiper Ward	Forensics	Forensics MH	8	98.2%	113.1%	101.8%	174.4%
Northdale Centre	Forensics	Forensics LD	12	102.5%	136.4%	121.4%	118.3%
Oakwood	Forensics	Forensics LD	8	93.6%	159.4%	100.0%	100.0%
Eagle/Osprey	Forensics	Forensics LD	10	73.7%	73.4%	110.7%	85.9%
Langley Ward	Forensics	Forensics LD	10	89.2%	105.4%	100.4%	100.2%
Thistle	Forensics	Forensics LD	5	83.3%	106.3%	100.0%	98.2%
Jay Ward	Forensics	Forensics MH	5	85.1%	101.2%	100.0%	98.2%
Lark	Forensics	Forensics MH	17	98.7%	108.0%	103.6%	98.1%
Linnet Ward	Forensics	Forensics MH	17	87.6%	100.9%	103.6%	96.4%
Nightingale Ward	Forensics	Forensics MH	16	82.6%	112.0%	100.0%	98.2%
Swift Ward	Forensics	Forensics MH	10	90.3%	105.9%	103.6%	109.5%
The Orchards (NY)	North Yorkshire	Adults	10	77.6%	85.7%	51.8%	125.0%
Springwood Community Unit	North Yorkshire	MHSOP	14	92.7%	100.6%	100.0%	172.8%
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	81.9%	114.7%	82.1%	109.3%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	83.5%	118.9%	100.0%	100.0%
Cedar Ward (NY)	North Yorkshire	Adults	14	106.0%	97.2%	96.8%	115.9%
Ward 15 Friarage	North Yorkshire	Adults	12	91.1%	119.2%	103.6%	105.4%
Rowan Lea	North Yorkshire	MHSOP	20	97.8%	114.4%	108.4%	114.3%
Rowan Ward	North Yorkshire	MHSOP	16	96.2%	104.0%	100.6%	118.5%
Ward 14	North Yorkshire	MHSOP	10	99.2%	98.7%	100.0%	100.0%
Newberry Centre	Teesside	CYPS	14	98.5%	148.2%	120.1%	174.7%

Bilsdale Ward	Teesside	Adults	14	110.7%	138.8%	103.9%	147.6%
Overdale Ward	Teesside	Adults	18	100.3%	147.1%	100.0%	150.2%
Westwood Centre	Teesside	CYPS	12	91.0%	169.6%	100.0%	205.7%
Westerdale North	Teesside	MHSOP	18	104.5%	136.4%	103.6%	173.2%
Westerdale South	Teesside	MHSOP	14	91.9%	265.4%	80.4%	381.9%
Bankfields Court Unit 2	Teesside	LD	5	135.5%	103.5%	103.8%	122.1%
Bransdale Ward	Teesside	Adults	14	114.0%	108.3%	103.7%	125.9%
Stockdale Ward	Teesside	Adults	18	129.1%	137.6%	128.6%	100.0%
Bedale Ward	Teesside	Adults	10	110.3%	176.8%	139.3%	96.4%
Bankfields Court Unit 4	Teesside	LD	6	94.7%	86.6%	130.0%	88.0%
Lustrum Vale	Teesside	Adults	20	92.7%	129.6%	100.0%	100.0%
Kirkdale Ward	Teesside	Adults	16	76.4%	109.6%	100.6%	103.6%
Baysdale	Teesside	CYPS	6	117.5%	112.3%	100.0%	101.9%
The Evergreen Centre	Teesside	CYPS	16	82.2%	100.5%	97.7%	113.3%
Aysgarth	Teesside	LD	6	88.5%	99.9%	99.8%	103.3%
Bankfields Court Flats	Teesside	LD	6	101.2%	91.3%	85.7%	102.4%
Bankfields Court Unit 3	Teesside	LD	6	105.6%	103.1%	100.0%	103.3%
The Lodge	Teesside	LD	1	86.2%	70.9%	80.8%	57.1%
Kiltonview	Teesside	Day Unit	0	100.8%	89.2%		
The Orchard	Teesside	Day Unit	0	81.8%	99.5%		
Thornaby Road	Teesside	Day Unit	5	110.9%	118.4%		107.4%
Acomb Garth	York and Selby	MHSOP	14	85.7%	203.0%	121.7%	324.1%
Cherry Tree House	York and Selby	MHSOP	18	96.6%	100.8%	96.4%	155.1%
Ebor Ward	York and Selby	Adults	12	88.2%	124.6%	92.9%	105.4%
Minster Ward	York and Selby	Adults	12	92.9%	148.2%	100.6%	102.4%
Oak Rise	York and Selby	LD	8	119.5%	89.0%	110.8%	96.4%

Meadowfields	York and Selby	MHSOP	14	**93.3%**	**96.2%**	**100.0%**	**103.6%**

APPENDIX 2

Scored Fill Rate compared to Quality Indicators - February 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	L4 Incidents	L3 Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	2336.0	253.0	10.8%	2336.0	160.75	6.9%						1		1	1
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2419.8	0.0	0.0%	2419.8	290.5	12.0%			1			7	1	9	10
Bedale Ward	Teesside	Adults	10	3381.5	80.5	2.4%	3381.5	241.5	7.1%					1	2	1	6	7
Bilsdale Ward	Teesside	Adults	14	2905.5	103.5	3.6%	2905.5	396	13.6%	1		1			2		2	2
Birch Ward	Durham & Darlington	Adults	15	3009.8	120.0	4.0%	3009.8	900	29.9%						2		2	2
Bransdale Ward	Teesside	Adults	14	2592.7	34.5	1.3%	2592.7	253	9.8%				1	1	11		18	18
Cedar Ward	Durham & Darlington	Adults	10	4144.2	0.0	0.0%	4144.2	785	18.9%					1	14	1	20	21
Cedar Ward (NY)	North Yorkshire	Adults	14	3051.7	813.3	26.6%	3051.7	204.92	6.7%			3		1	8		10	10
Ebor Ward	York and Selby	Adults	12	2590.8	125.3	4.8%	2590.8	229.5	8.9%						3		3	3
Elm Ward	Durham & Darlington	Adults	20	2623.9	72.0	2.7%	2623.9	539.99	20.6%					1	2		2	2
Farnham Ward	Durham & Darlington	Adults	20	2447.3	16.7	0.7%	2447.3	159.5	6.5%						2		3	3
Kirkdale Ward	Teesside	Adults	16	2848.0	11.3	0.4%	2848.0	753.75	26.5%					1	2		3	3
Lustrum Vale	Teesside	Adults	20	2715.8	0.0	0.0%	2715.8	562.33	20.7%						2		2	2
Maple Ward	Durham & Darlington	Adults	20	2783.4	204.0	7.3%	2783.4	828.33	29.8%					2				
Minster Ward	York and Selby	Adults	12	2758.5	149.5	5.4%	2758.5	203	7.4%				1					
Overdale Ward	Teesside	Adults	18	2931.1	115.0	3.9%	2931.1	264.5	9.0%						6		8	8
Primrose Lodge	Durham & Darlington	Adults	15	2357.0	0.0	0.0%	2357.0	360	15.3%									

Stockdale Ward	Teesside	Adults	18	2888.5	11.5	0.4%	2888.5	115	4.0%					2	2		2	2
The Orchards (NY)	North Yorkshire	Adults	10	1787.3	36.0	2.0%	1787.3	132	7.4%									
Tunstall Ward	Durham & Darlington	Adults	20	2534.8	0.0	0.0%	2534.8	0	0.0%					1	3		4	4
Ward 15 Friarage	North Yorkshire	Adults	12	2451.5	112.5	4.6%	2451.5	620.5	25.3%						6		6	6
Willow Ward	Durham & Darlington	Adults	15	2562.0	12.0	0.5%	2562.0	427.5	16.7%						2		2	2
Baysdale	Teesside	CYPS	6	2420.4	0.0	0.0%	2420.4	70.36	2.9%									
Holly Unit	Durham & Darlington	CYPS	4	1428.1	0.0	0.0%	1428.1	59	4.1%									
Newberry Centre	Teesside	CYPS	14	4405.7	91.0	2.1%	4405.7	229.58	5.2%			1		3	167		238	238
Talbot Direct Care	Durham & Darlington	CYPS	1	1225.8	0.0	0.0%	1225.8	0	0.0%			1						
The Evergreen Centre	Teesside	CYPS	16	4454.2	144.8	3.2%	4454.2	474	10.6%						120		186	186
Westwood Centre	Teesside	CYPS	12	5465.1	0.0	0.0%	5465.1	207	3.8%						30		41	41
Clover/Ivy	Forensics	Forensics LD	12	4049.4	37.3	0.9%	4049.4	1638.77	40.5%					1	19	1	37	38
Eagle/Osprey	Forensics	Forensics LD	10	2510.6	157.5	6.3%	2510.6	382	15.2%									
Harrier/Hawk	Forensics	Forensics LD	10	4017.7	0.0	0.0%	4017.7	957.67	23.8%				1					
Kestrel/Kite.	Forensics	Forensics LD	16	3915.8	0.0	0.0%	3915.8	1254.73	32.0%					2	5		9	9
Langley Ward	Forensics	Forensics LD	10	1976.6	11.3	0.6%	1976.6	571	28.9%									
Northdale Centre	Forensics	Forensics LD	12	5222.4	78.8	1.5%	5222.4	1089.17	20.9%				1	5	2		2	2
Oakwood	Forensics	Forensics LD	8	1835.5	33.8	1.8%	1835.5	478.5	26.1%									
Thistle	Forensics	Forensics LD	5	2741.4	33.8	1.2%	2741.4	371.25	13.5%						5		7	7
Brambling Ward	Forensics	Forensics MH	13	2855.3	0.0	0.0%	2855.3	506.5	17.7%					1	6		8	8
Jay Ward	Forensics	Forensics MH	5	2527.8	0.0	0.0%	2527.8	103.75	4.1%									
Lark	Forensics	Forensics MH	17	2588.2	0.0	0.0%	2588.2	288.75	11.2%					1				
Linnet Ward	Forensics	Forensics MH	17	2549.8	0.0	0.0%	2549.8	240	9.4%									
Mallard Ward	Forensics	Forensics MH	14	3118.2	0.0	0.0%	3118.2	390.75	12.5%					4	1		1	1
Mandarin	Forensics	Forensics MH	16	3698.1	0.0	0.0%	3698.1	1252	33.9%						14		17	17

Merlin	Forensics	Forensics MH	10	4494.4	0.0	0.0%	4494.4	1538	34.2%					2	10		20	20
Newtondale Ward	Forensics	Forensics MH	20	3996.2	0.0	0.0%	3996.2	970	24.3%					1	1		1	1
Nightingale Ward	Forensics	Forensics MH	16	2590.5	0.0	0.0%	2590.5	307.5	11.9%						1		2	2
Sandpiper Ward	Forensics	Forensics MH	8	4153.8	0.0	0.0%	4153.8	1046.25	25.2%					1	70	4	144	148
Swift Ward	Forensics	Forensics MH	10	2954.0	0.0	0.0%	2954.0	387.5	13.1%									
Aysgarth	Teesside	LD	6	2070.3	0.0	0.0%	2070.3	329.16	15.9%									
Bankfields Court Flats	Teesside	LD	6	1940.6	0.0	0.0%	1940.6	194.13	10.0%									
Bankfields Court Unit 2	Teesside	LD	5	2409.3	0.0	0.0%	2409.3	399.49	16.6%									
Bankfields Court Unit 3	Teesside	LD	6	2292.3	0.0	0.0%	2292.3	156	6.8%						3		6	6
Bankfields Court Unit 4	Teesside	LD	6	1864.8	0.0	0.0%	1864.8	224.33	12.0%									
Bek-Ramsey Ward	Durham & Darlington	LD	11	3498.1	84.0	2.4%	3498.1	315	9.0%						1		1	1
Harland Rehab Ward	Durham & Darlington	LD	1	2048.0	48.0	2.3%	2048.0	264	12.9%									
Oak Rise	York and Selby	LD	8	3361.5	168.8	5.0%	3361.5	444.71	13.2%						1		1	1
The Lodge	Teesside	LD	1	1270.0	0.0	0.0%	1270.0	0	0.0%									
Acomb Garth	York and Selby	MHSOP	14	5304.6	2831.0	53.4%	5304.6	411.25	7.8%						23		31	31
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	2993.7	36.0	1.2%	2993.7	173.83	5.8%						3		4	4
Cherry Tree House	York and Selby	MHSOP	18	3108.9	662.5	21.3%	3108.9	336	10.8%	1	1			1	2		3	3
Hamsterley Ward	Durham & Darlington	MHSOP	15	3763.6	379.0	10.1%	3763.6	986.5	26.2%						4		4	4
Meadowfields	York and Selby	MHSOP	14	2657.4	253.5	9.5%	2657.4	422.7	15.9%									
Oak Ward	Durham & Darlington	MHSOP	12	2448.2	60.0	2.5%	2448.2	477.91	19.5%									
Roseberry Wards	Durham & Darlington	MHSOP	15	2434.8	12.0	0.5%	2434.8	261	10.7%									
Rowan Lea	North Yorkshire	MHSOP	20	3635.7	395.8	10.9%	3635.7	343.98	9.5%						3		3	3
Rowan Ward	North Yorkshire	MHSOP	6	2543.5	217.0	8.5%	2543.5	292.75	11.5%						4		6	6
Springwood	North Yorkshire	MHSOP	14	3130.8	416.3	13.3%	3130.8	428.83	13.7%						11		12	12
Ward 14	North Yorkshire	MHSOP	10	2291.0	0.0	0.0%	2291.0	94.5	4.1%									
Westerdale North	Teesside	MHSOP	18	3504.5	803.0	22.9%	3504.5	193	5.5%						2		2	2
Westerdale South	Teesside	MHSOP	14	6795.3	1623.0	23.9%	6795.3	2011	29.6%						30		31	31
Kiltonview	Teesside	LD	0	1926.0	0.0	0.0%	1926.0	217.33	11.3%									
The Orchard	Teesside	LD	0	865.6	0.0	0.0%	865.6	165	19.1%									

Thornaby Road	Teesside	LD	5	1802.2	0.0	0.0%	1802.2	104.17	5.8%									

Severity Scoring by Total Score

APPENDIX 3

WARD	Locality	Speciality	Bed Numbers	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	Control & Restraint	TOTAL SCORE Feb
Westerdale South	Durham & Darlington	MHSOP	14	2	2	1	1	2	0	0	0	0	1	**9**
Eagle/Osprey	Forensics	Forensics LD	10	6	0	1	1	1	0	0	0	0	0	**9**
Acomb Garth	Teesside	MHSOP	14	2	3	1	1	0	0	0	0	0	1	**8**
Mandarin	Forensics	Forensics MH	16	2	2	1	0	2	0	0	0	0	1	**8**
The Orchards (NY)	Durham & Darlington	Adults	10	6	1	0	1	0	0	0	0	0	0	**8**
The Lodge	Teesside	LD	1	8	0	0	0	0	0	0	0	0	0	**8**
Newberry Centre	Teesside	CYPS	14	0	3	0	1	0	0	0	1	0	2	**7**
Talbot Direct Care	Durham & Darlington	CYPS	1	6	0	0	0	0	0	0	1	0	0	**7**
Maple Ward	York and Selby	Adults	20	2	2	0	1	2	0	0	0	0	0	**7**
Birch Ward	North Yorkshire	Adults	15	2	2	0	1	2	0	0	0	0	0	**7**
Bilsdale Ward	North Yorkshire	Adults	14	0	2	1	1	1	1	0	1	0	0	**7**
Clover/Ivy	Teesside	Forensics LD	12	0	1	1	1	2	0	0	0	0	1	**6**
Sandpiper Ward	Forensics	Forensics MH	8	0	1	1	0	2	0	0	0	0	2	**6**
The Evergreen Centre	Durham & Darlington	CYPS	16	2	0	1	1	0	0	0	0	0	2	**6**
Ayckbourn Unit Danby Ward	Durham & Darlington	Adults	11	4	0	1	1	0	0	0	0	0	0	**6**
Langley Ward	Forensics	Forensics LD	10	2	0	1	1	2	0	0	0	0	0	**6**
Bankfields Court Unit 4	York and Selby	LD	6	4	1	0	0	1	0	0	0	0	0	**6**
Springwood Community Unit	North Yorkshire	MHSOP	14	0	1	1	1	1	0	0	0	0	1	**5**
Cedar Ward	York and Selby	Adults	10	0	2	1	0	1	0	0	0	0	1	**5**
Northdale Centre	Forensics	Forensics LD	12	0	2	0	1	1	0	0	0	1	0	**5**
Merlin	Forensics	Forensics MH	10	0	2	1	0	2	0	0	0	0	0	**5**
Oak Rise	Durham & Darlington	LD	8	2	0	1	1	1	0	0	0	0	0	**5**
Hamsterley Ward	York and Selby	MHSOP	15	0	2	0	1	2	0	0	0	0	0	**5**
Harrier/Hawk	Forensics	Forensics LD	10	2	1	0	0	1	0	0	0	1	0	**5**
Oakwood	Forensics	Forensics LD	8	0	1	1	1	2	0	0	0	0	0	**5**
Thistle	Forensics	Forensics LD	5	2	0	1	1	1	0	0	0	0	0	**5**
Kirkdale Ward	Durham & Darlington	Adults	16	2	0	0	1	2	0	0	0	0	0	**5**
Willow Ward	North Yorkshire	Adults	15	2	1	0	1	1	0	0	0	0	0	**5**
Bransdale Ward	Durham & Darlington	Adults	14	0	1	0	1	0	0	0	0	1	1	**4**

Westwood Centre	Teesside	CYPS	12	0	2	1	0	0	0	0	0	0	1	**4**
Cherry Tree House	Teesside	MHSOP	18	0	1	0	1	0	1	1	0	0	0	**4**
Elm Ward	Teesside	Adults	20	2	0	0	1	1	0	0	0	0	0	**4**
Ayckbourn Unit Esk Ward	Teesside	Adults	11	2	0	0	0	1	0	0	1	0	0	**4**
Cedar Ward (NY)	Durham & Darlington	Adults	14	0	0	0	1	0	0	0	3	0	0	**4**
Ebor Ward	Teesside	Adults	12	2	1	0	1	0	0	0	0	0	0	**4**
Mallard Ward	Forensics	Forensics MH	14	2	1	0	0	1	0	0	0	0	0	**4**
Brambling Ward	Forensics	Forensics MH	13	2	1	0	0	1	0	0	0	0	0	**4**
Overdale Ward	North Yorkshire	Adults	18	0	2	1	1	0	0	0	0	0	0	**4**
Nightingale Ward	Forensics	Forensics MH	16	2	0	1	0	1	0	0	0	0	0	**4**
Primrose Lodge	Forensics	Adults	15	2	1	0	0	1	0	0	0	0	0	**4**
Stockdale Ward	Durham & Darlington	Adults	18	0	3	0	1	0	0	0	0	0	0	**4**
Minster Ward	North Yorkshire	Adults	12	0	1	1	1	0	0	0	0	1	0	**4**
Aysgarth	Forensics	LD	6	2	0	1	0	1	0	0	0	0	0	**4**
Bedale Ward	Durham & Darlington	Adults	10	0	2	0	1	0	0	0	0	0	0	**3**
Meadowfields	York and Selby	MHSOP	14	0	0	1	1	1	0	0	0	0	0	**3**
Ward 15 Friarage	Teesside	Adults	12	0	0	0	1	2	0	0	0	0	0	**3**
Kestrel/Kite.	Forensics	Forensics LD	16	0	1	0	0	2	0	0	0	0	0	**3**
Holly Unit	Teesside	CYPS	4	0	3	0	0	0	0	0	0	0	0	**3**
Jay Ward	Forensics	Forensics MH	5	2	0	1	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**
Bankfields Court Unit 2	Teesside	LD	5	0	2	0	0	1	0	0	0	0	0	**3**
Westerdale North	Durham & Darlington	MHSOP	18	0	2	0	1	0	0	0	0	0	0	**3**
Oak Ward	Durham & Darlington	MHSOP	12	0	0	1	1	1	0	0	0	0	0	**3**
The Orchard	North Yorkshire		0	2	0	0	0	1	0	0	0	0	0	**3**
Kiltonview	North Yorkshire		0	2	0	0	0	1	0	0	0	0	0	**3**
Lustrum Vale	Teesside	Adults	20	0	1	0	0	1	0	0	0	0	0	**2**
Rowan Ward	Teesside	MHSOP	6	0	0	0	1	1	0	0	0	0	0	**2**
Swift Ward	Forensics	Forensics MH	10	0	0	1	0	1	0	0	0	0	0	**2**
Bankfields Court Flats	Forensics	LD	6	2	0	0	0	0	0	0	0	0	0	**2**
Farnham Ward	Durham & Darlington	Adults	20	0	0	1	1	0	0	0	0	0	0	**2**
Ceddesfeld Ward	Teesside	MHSOP	15	0	1	0	1	0	0	0	0	0	0	**2**
Harland Rehab Ward	Durham & Darlington	LD	1	0	0	0	1	1	0	0	0	0	0	**2**
Newtondale Ward	Forensics	Forensics MH	20	0	1	0	0	0	0	0	0	0	0	**1**
Lark	Forensics	Forensics MH	17	0	0	0	0	1	0	0	0	0	0	**1**

Bek-Ramsey Ward	Teesside	LD	11	0	0	0	1	0	0	0	0	0	0	**1**
Ward 14	York and Selby	MHSOP	10	0	0	1	0	0	0	0	0	0	0	**1**
Rowan Lea	North Yorkshire	MHSOP	20	0	0	0	1	0	0	0	0	0	0	**1**
Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	0	1	0	0	0	0	0	0	**1**
Baysdale	Teesside	CYPS	6	0	0	1	0	0	0	0	0	0	0	**1**
Bankfields Court Unit 3	Teesside	LD	6	0	0	0	0	0	0	0	0	0	0	**0**
Tunstall Ward	Teesside	Adults	20	0	0	0	0	0	0	0	0	0	0	**0**
Thornaby Road	Teesside		5	0	0	0	0	0	0	0	0	0	0	**0**

Severity Scoring by Speciality

APPENDIX 4

WARD	Locality	Speciality	Bed Numbers	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	Control & Restraint	TOTAL SCORE Feb
The Orchards (NY)	Durham & Darlington	Adults	10	6	1	0	1	0	0	0	0	0	0	**8**
Maple Ward	York and Selby	Adults	20	2	2	0	1	2	0	0	0	0	0	**7**
Birch Ward	North Yorkshire	Adults	15	2	2	0	1	2	0	0	0	0	0	**7**
Bilsdale Ward	North Yorkshire	Adults	14	0	2	1	1	1	1	0	1	0	0	**7**
Ayckbourn Unit Danby Ward	Durham & Darlington	Adults	11	4	0	1	1	0	0	0	0	0	0	**6**
Cedar Ward	York and Selby	Adults	10	0	2	1	0	1	0	0	0	0	1	**5**
Kirkdale Ward	Durham & Darlington	Adults	16	2	0	0	1	2	0	0	0	0	0	**5**
Willow Ward	North Yorkshire	Adults	15	2	1	0	1	1	0	0	0	0	0	**5**
Bransdale Ward	Durham & Darlington	Adults	14	0	1	0	1	0	0	0	0	1	1	**4**
Elm Ward	Teesside	Adults	20	2	0	0	1	1	0	0	0	0	0	**4**
Ayckbourn Unit Esk Ward	Teesside	Adults	11	2	0	0	0	1	0	0	1	0	0	**4**
Cedar Ward (NY)	Durham & Darlington	Adults	14	0	0	0	1	0	0	0	3	0	0	**4**
Ebor Ward	Teesside	Adults	12	2	1	0	1	0	0	0	0	0	0	**4**
Overdale Ward	North Yorkshire	Adults	18	0	2	1	1	0	0	0	0	0	0	**4**
Primrose Lodge	Forensics	Adults	15	2	1	0	0	1	0	0	0	0	0	**4**
Stockdale Ward	Durham & Darlington	Adults	18	0	3	0	1	0	0	0	0	0	0	**4**
Minster Ward	North Yorkshire	Adults	12	0	1	1	1	0	0	0	0	1	0	**4**
Bedale Ward	Durham & Darlington	Adults	10	0	2	0	1	0	0	0	0	0	0	**3**
Ward 15 Friarage	Teesside	Adults	12	0	0	0	1	2	0	0	0	0	0	**3**
Lustrum Vale	Teesside	Adults	20	0	1	0	0	1	0	0	0	0	0	**2**
Farnham Ward	Durham & Darlington	Adults	20	0	0	1	1	0	0	0	0	0	0	**2**
Tunstall Ward	Teesside	Adults	20	0	0	0	0	0	0	0	0	0	0	**0**
Newberry Centre	Teesside	CYPS	14	0	3	0	1	0	0	0	1	0	2	**7**
Talbot Direct Care	Durham & Darlington	CYPS	1	6	0	0	0	0	0	0	1	0	0	**7**
The Evergreen Centre	Durham & Darlington	CYPS	16	2	0	1	1	0	0	0	0	0	2	**6**
Westwood Centre	Teesside	CYPS	12	0	2	1	0	0	0	0	0	0	1	**4**
Holly Unit	Teesside	CYPS	4	0	3	0	0	0	0	0	0	0	0	**3**
Baysdale	Teesside	CYPS	6	0	0	1	0	0	0	0	0	0	0	**1**
Eagle/Osprey	Forensics	Forensics LD	10	6	0	1	1	1	0	0	0	0	0	**9**

Clover/Ivy	Teesside	Forensics LD	12	0	1	1	1	2	0	0	0	0	1	**6**
Langley Ward	Forensics	Forensics LD	10	2	0	1	1	2	0	0	0	0	0	**6**
Northdale Centre	Forensics	Forensics LD	12	0	2	0	1	1	0	0	0	1	0	**5**
Harrier/Hawk	Forensics	Forensics LD	10	2	1	0	0	1	0	0	0	1	0	**5**
Oakwood	Forensics	Forensics LD	8	0	1	1	1	2	0	0	0	0	0	**5**
Thistle	Forensics	Forensics LD	5	2	0	1	1	1	0	0	0	0	0	**5**
Kestrel/Kite.	Forensics	Forensics LD	16	0	1	0	0	2	0	0	0	0	0	**3**
Mandarin	Forensics	Forensics MH	16	2	2	1	0	2	0	0	0	0	1	**8**
Sandpiper Ward	Forensics	Forensics MH	8	0	1	1	0	2	0	0	0	0	2	**6**
Merlin	Forensics	Forensics MH	10	0	2	1	0	2	0	0	0	0	0	**5**
Mallard Ward	Forensics	Forensics MH	14	2	1	0	0	1	0	0	0	0	0	**4**
Brambling Ward	Forensics	Forensics MH	13	2	1	0	0	1	0	0	0	0	0	**4**
Nightingale Ward	Forensics	Forensics MH	16	2	0	1	0	1	0	0	0	0	0	**4**
Jay Ward	Forensics	Forensics MH	5	2	0	1	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**
Swift Ward	Forensics	Forensics MH	10	0	0	1	0	1	0	0	0	0	0	**2**
Newtondale Ward	Forensics	Forensics MH	20	0	1	0	0	0	0	0	0	0	0	**1**
Lark	Forensics	Forensics MH	17	0	0	0	0	1	0	0	0	0	0	**1**
The Lodge	Teesside	LD	1	8	0	0	0	0	0	0	0	0	0	**8**
Bankfields Court Unit 4	York and Selby	LD	6	4	1	0	0	1	0	0	0	0	0	**6**
Oak Rise	Durham & Darlington	LD	8	2	0	1	1	1	0	0	0	0	0	**5**
Aysgarth	Forensics	LD	6	2	0	1	0	1	0	0	0	0	0	**4**
Bankfields Court Unit 2	Teesside	LD	5	0	2	0	0	1	0	0	0	0	0	**3**
Bankfields Court Flats	Forensics	LD	6	2	0	0	0	0	0	0	0	0	0	**2**
Harland Rehab Ward	Durham & Darlington	LD	1	0	0	0	1	1	0	0	0	0	0	**2**
Bek-Ramsey Ward	Teesside	LD	11	0	0	0	1	0	0	0	0	0	0	**1**
Bankfields Court Unit 3	Teesside	LD	6	0	0	0	0	0	0	0	0	0	0	**0**
Westerdale South	Durham & Darlington	MHSOP	14	2	2	1	1	2	0	0	0	0	1	**9**
Acomb Garth	Teesside	MHSOP	14	2	3	1	1	0	0	0	0	0	1	**8**
Springwood Community Unit	North Yorkshire	MHSOP	14	0	1	1	1	1	0	0	0	0	1	**5**
Hamsterley Ward	York and Selby	MHSOP	15	0	2	0	1	2	0	0	0	0	0	**5**
Cherry Tree House	Teesside	MHSOP	18	0	1	0	1	0	1	1	0	0	0	**4**
Meadowfields	York and Selby	MHSOP	14	0	0	1	1	1	0	0	0	0	0	**3**
Westerdale North	Durham & Darlington	MHSOP	18	0	2	0	1	0	0	0	0	0	0	**3**
Oak Ward	Durham & Darlington	MHSOP	12	0	0	1	1	1	0	0	0	0	0	**3**

Rowan Ward	Teesside	MHSOP	6	0	0	0	1	1	0	0	0	0	0	**2**
Ceddesfeld Ward	Teesside	MHSOP	15	0	1	0	1	0	0	0	0	0	0	**2**
Ward 14	York and Selby	MHSOP	10	0	0	1	0	0	0	0	0	0	0	**1**
Rowan Lea	North Yorkshire	MHSOP	20	0	0	0	1	0	0	0	0	0	0	**1**
Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	0	1	0	0	0	0	0	0	**1**
The Orchard	North Yorkshire		0	2	0	0	0	1	0	0	0	0	0	**3**
Kiltonview	North Yorkshire		0	2	0	0	0	1	0	0	0	0	0	**3**
Thornaby Road	Teesside		5	0	0	0	0	0	0	0	0	0	0	**0**

Severity Scoring Year to Date Position

APPENDIX 5

WARD	Locality	Speciality	Bed Numbers	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	Control & Restraint	TOTAL SCORE Feb	YTD Total Score (Feb - Feb)
Clover/Ivy	Teesside	Forensics LD	12	0	1	1	1	2	0	0	0	0	1	**6**	**86**
Sandpiper Ward	Forensics	Forensics MH	8	0	1	1	0	2	0	0	0	0	2	**6**	**83**
Newberry Centre	Teesside	CYPS	14	0	3	0	1	0	0	0	1	0	2	**7**	**79**
Springwood Community Unit	North Yorkshire	MHSOP	14	0	1	1	1	1	0	0	0	0	1	**5**	**79**
Cedar Ward	York and Selby	Adults	10	0	2	1	0	1	0	0	0	0	1	**5**	**77**
Bedale Ward	Durham & Darlington	Adults	10	0	2	0	1	0	0	0	0	0	0	**3**	**77**
Northdale Centre	Forensics	Forensics LD	12	0	2	0	1	1	0	0	0	1	0	**5**	**74**
The Evergreen Centre	Durham & Darlington	CYPS	16	2	0	1	1	0	0	0	0	0	2	**6**	**73**
Merlin	Forensics	Forensics MH	10	0	2	1	0	2	0	0	0	0	0	**5**	**72**
Meadowfields	York and Selby	MHSOP	14	0	0	1	1	1	0	0	0	0	0	**3**	**71**
Talbot Direct Care	Durham & Darlington	CYPS	1	6	0	0	0	0	0	0	1	0	0	**7**	**70**
Westerdale South	Durham & Darlington	MHSOP	14	2	2	1	1	2	0	0	0	0	1	**9**	**68**
Acomb Garth	Teesside	MHSOP	14	2	3	1	1	0	0	0	0	0	1	**8**	**68**
Bransdale Ward	Durham & Darlington	Adults	14	0	1	0	1	0	0	0	0	1	1	**4**	**67**
Mandarin	Forensics	Forensics MH	16	2	2	1	0	2	0	0	0	0	1	**8**	**67**
Ward 15 Friarage	Teesside	Adults	12	0	0	0	1	2	0	0	0	0	0	**3**	**65**
Westwood Centre	Teesside	CYPS	12	0	2	1	0	0	0	0	0	0	1	**4**	**64**
Kestrel/Kite.	Forensics	Forensics LD	16	0	1	0	0	2	0	0	0	0	0	**3**	**62**
Cherry Tree House	Teesside	MHSOP	18	0	1	0	1	0	1	1	0	0	0	**4**	**60**
Ayckbourn Unit Danby Ward	Durham & Darlington	Adults	11	4	0	1	1	0	0	0	0	0	0	**6**	**58**
Lustrum Vale	Teesside	Adults	20	0	1	0	0	1	0	0	0	0	0	**2**	**57**
Eagle/Osprey	Forensics	Forensics LD	10	6	0	1	1	1	0	0	0	0	0	**9**	**57**
Rowan Ward	Teesside	MHSOP	6	0	0	0	1	1	0	0	0	0	0	**2**	**57**
Elm Ward	Teesside	Adults	20	2	0	0	1	1	0	0	0	0	0	**4**	**56**
Oak Rise	Durham & Darlington	LD	8	2	0	1	1	1	0	0	0	0	0	**5**	**56**
Hamsterley Ward	York and Selby	MHSOP	15	0	2	0	1	2	0	0	0	0	0	**5**	**56**

Maple Ward	York and Selby	Adults	20	2	2	0	1	2	0	0	0	0	0	**7**	**55**
Ayckbourn Unit Esk Ward	Teesside	Adults	11	2	0	0	0	1	0	0	1	0	0	**4**	**55**
Cedar Ward (NY)	Durham & Darlington	Adults	14	0	0	0	1	0	0	0	3	0	0	**4**	**55**
Newtondale Ward	Forensics	Forensics MH	20	0	1	0	0	0	0	0	0	0	0	**1**	**54**
Swift Ward	Forensics	Forensics MH	10	0	0	1	0	1	0	0	0	0	0	**2**	**53**
Ebor Ward	Teesside	Adults	12	2	1	0	1	0	0	0	0	0	0	**4**	**52**
Birch Ward	North Yorkshire	Adults	15	2	2	0	1	2	0	0	0	0	0	**7**	**50**
Harrier/Hawk	Forensics	Forensics LD	10	2	1	0	0	1	0	0	0	1	0	**5**	**50**
Bilsdale Ward	North Yorkshire	Adults	14	0	2	1	1	1	1	0	1	0	0	**7**	**49**
Mallard Ward	Forensics	Forensics MH	14	2	1	0	0	1	0	0	0	0	0	**4**	**49**
Brambling Ward	Forensics	Forensics MH	13	2	1	0	0	1	0	0	0	0	0	**4**	**48**
Overdale Ward	North Yorkshire	Adults	18	0	2	1	1	0	0	0	0	0	0	**4**	**47**
Oakwood	Forensics	Forensics LD	8	0	1	1	1	2	0	0	0	0	0	**5**	**47**
The Orchards (NY)	Durham & Darlington	Adults	10	6	1	0	1	0	0	0	0	0	0	**8**	**46**
Holly Unit	Teesside	CYPS	4	0	3	0	0	0	0	0	0	0	0	**3**	**46**
Nightingale Ward	Forensics	Forensics MH	16	2	0	1	0	1	0	0	0	0	0	**4**	**46**
The Lodge	Teesside	LD	1	8	0	0	0	0	0	0	0	0	0	**8**	**46**
Langley Ward	Forensics	Forensics LD	10	2	0	1	1	2	0	0	0	0	0	**6**	**45**
Lark	Forensics	Forensics MH	17	0	0	0	0	1	0	0	0	0	0	**1**	**45**
Primrose Lodge	Forensics	Adults	15	2	1	0	0	1	0	0	0	0	0	**4**	**44**
Bankfields Court Flats	Forensics	LD	6	2	0	0	0	0	0	0	0	0	0	**2**	**41**
Stockdale Ward	Durham & Darlington	Adults	18	0	3	0	1	0	0	0	0	0	0	**4**	**39**
Jay Ward	Forensics	Forensics MH	5	2	0	1	0	0	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**
Minster Ward	North Yorkshire	Adults	12	0	1	1	1	0	0	0	0	1	0	**4**	**38**
Thistle	Forensics	Forensics LD	5	2	0	1	1	1	0	0	0	0	0	**5**	**38**
Kirkdale Ward	Durham & Darlington	Adults	16	2	0	0	1	2	0	0	0	0	0	**5**	**36**
Willow Ward	North Yorkshire	Adults	15	2	1	0	1	1	0	0	0	0	0	**5**	**35**
Bankfields Court Unit 4	York and Selby	LD	6	4	1	0	0	1	0	0	0	0	0	**6**	**34**
Bek-Ramsey Ward	Teesside	LD	11	0	0	0	1	0	0	0	0	0	0	**1**	**31**
Aysgarth	Forensics	LD	6	2	0	1	0	1	0	0	0	0	0	**4**	**28**
Bankfields Court Unit 2	Teesside	LD	5	0	2	0	0	1	0	0	0	0	0	**3**	**27**
Ward 14	York and Selby	MHSOP	10	0	0	1	0	0	0	0	0	0	0	**1**	**27**
Farnham Ward	Durham & Darlington	Adults	20	0	0	1	1	0	0	0	0	0	0	**2**	**25**
Bankfields Court Unit 3	Teesside	LD	6	0	0	0	0	0	0	0	0	0	0	**0**	**25**

Westerdale North	Durham & Darlington	MHSOP	18	0	2	0	1	0	0	0	0	0	0	**3**	**23**
Tunstall Ward	Teesside	Adults	20	0	0	0	0	0	0	0	0	0	0	**0**	**21**
Rowan Lea	North Yorkshire	MHSOP	20	0	0	0	1	0	0	0	0	0	0	**1**	**20**
Ceddesfeld Ward	Teesside	MHSOP	15	0	1	0	1	0	0	0	0	0	0	**2**	**19**
Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	0	1	0	0	0	0	0	0	**1**	**16**
Oak Ward	Durham & Darlington	MHSOP	12	0	0	1	1	1	0	0	0	0	0	**3**	**15**
Baysdale	Teesside	CYPS	6	0	0	1	0	0	0	0	0	0	0	**1**	**14**
The Orchard	North Yorkshire		0	2	0	0	0	1	0	0	0	0	0	**3**	**13**
Kiltonview	North Yorkshire		0	2	0	0	0	1	0	0	0	0	0	**3**	**10**
Harland Rehab Ward	Durham & Darlington	LD	1	0	0	0	1	1	0	0	0	0	0	**2**	**4**
Thornaby Road	Teesside		5	0	0	0	0	0	0	0	0	0	0	**0**	**0**

Item 9

BOARD OF DIRECTORS

DATE:	**27th March 2018**
TITLE:	**Right Staffing: An evidence based establishment review of inpatient wards using the Hurst Ward Multiplier Tool and professional judgement approaches.**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance and Joe Bergin, Right Staffing Programme Manager.**
REPORT FOR:	**Decision**

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

Executive Summary:

Staffing safely is fundamental to the delivery of good quality care and this paper sets out the trusts approach to its annual strategic staffing review. This paper provides further update and information to the Trust Board, following the initial paper presented 19th December 2017 regarding the outcome of the Trust's inpatient wards staffing establishment review commenced in February 2017. This was based on the Trust wide application of the Hurst "*Ward Multiplier Tool for Mental Health* and the subsequent professional judgement meetings thereafter. The previous paper set out the methodology and caveats to be considered as well as detailing the phased approach to the reviews and agreed investment in staffing to date (summarised in this paper).

In January 2018, EMT considered the findings of the strategic staffing review in order to better understand the relationship between patient dependency, nursing requirements and current utilisation of budgeted resources in the context set out within section 4 of this report and within the overall financial plan.

Data from the Hurst Tool was reviewed against the acuity and activity described by the ward; bed numbers; Care Hours Per Patient Day (CHPPD); current budgeted establishment; current and previous year spend and WTEs used, including overtime, bank, and agency utilisation and national benchmarking for registered nursing staff. This indicated that some additional investment is required in relation to some Adult Mental Health in–

patient staffing establishments/registered nursing ratios when examined in conjunction with the professional judgement approach.

Additionally, a recommendation was made to review the current status of the ward based administration provision and needs analysis following professional judgement discussions from the Hurst review exercise, which had shown that administrative provision on the wards was varied across the Trust. NQB guidance (2017) recognises the requirement for sufficient administrative provision to support clinical staff in their duties – utilising skill mix for the right staff with the rights skills for the required task. It is anticipated that ensuring adequate administration support is in place will provide an increase the available clinical time for the clinical staff to deliver quality care to patients. It will ensure that the optimal use of staff skills and expertise is delivered from the right person with those right skills, enabling effective use of staff time in delivering care, and therefore providing value for money and efficiencies.

Recommendations:

For the Trust Board to:

- Consider and approve the contents of the report with regard to staffing establishments and recommended actions taken to provide additional investment for the 20-bedded adult in-patient services at a total recurring cost of £596,920.
- Consider and approve the recommendations to providing equitable and standardised administrative support across all inpatient wards which will increase the availability of ward staff clinical hours.
- Approve the suggested prioritisation of the phased approach to implementation as set out in the paper.

MEETING OF:	**Trust Board**
DATE:	**27th March 2018**
TITLE:	**Safe Staffing: An evidence based establishment review of inpatient wards using the Hurst Ward Multiplier Tool**

1. INTRODUCTION & PURPOSE:

1.1 This paper provides further update and information to the Trust Board, following the initial paper presented 19th December 2017 regarding the outcome of the Trust's inpatient wards staffing establishment review commenced in February 2017. This was based on the Trust wide application of the Hurst "*Ward Multiplier Tool for Mental Health* and the subsequent professional judgement meetings thereafter. The previous paper provides detail regarding the methodology and caveats to be considered, which are summarised here. The paper delivers recommendations to the Board in line with the approach set out within NQB staffing guidelines.

1.2 Staffing safely is fundamental to the delivery of good quality care and the CQC will therefore always include a focus on staffing in their inspection frameworks for NHS providers. The paper sets out the trusts approach.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Stepping forward to 2020/21 workforce plan (NHS, 2017) looks to establish 21,000 mental health posts and employ 19,000 additional members of staff by 2020. It suggests 11,000 of these will be drawn from the 'traditional' pools of professionally regulated staff, e.g. nurses, occupational therapists, or doctors. In addition, there will be 8,000 people moving into new roles e.g. peer support workers, personal wellbeing practitioners, call handlers, or nursing associates, utilised to support clinical staff to work to their fullest potential using their full range of their skills. The growing proportion of support staff represents both a broadening of the talent pool as we develop new roles. It is clear that as services expand, more mental health nurses will be needed to fill the new posts.

.

2.2 The number of available posts for qualified mental health nurses is reported to have fallen. In 2016 it was nearly 12% below the 2009 level, in contrast to nursing as a whole which has grown over the same period (Figure 1 – page 4).

Figure 1. Comparative growth of mental health nursing and all nursing fields (NHS, 2017)

2.3 The long term trend shows a sustained increase in the nursing leaver rate (increase 6.2% to 8.5% in the past 7 years with around 7k more nurses leaving each year). The aim of NHS employers and NHSI is to stabilise the nursing leaver rates and increase the mental health workforce. The National Quality Board (NQB) has defined and finalised a set of guidelines for mental health (NQB, 2018). Its aim is to outline the expectations and framework within which decisions on safe and sustainable staffing should be made to improve health outcomes for patients and aid retention of staff.

2.4 It states that Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement and comparison with peers). The expectation is that this will be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate and should include a review following service change or where quality or workforce concerns are identified.

2.5 It is noted that whilst ensuring an adequate number of skilled staff is vital for providing therapeutic mental healthcare, research in mental health settings indicates this is only part of what creates safe staffing and implies other factors need to be considered such as consistency of staff, optimal use of staff time and staff skills. There is potential to increase patient facing time from registered nursing staff by ensuring sufficient resource for support roles such as ward based administrative support. Education, recruitment and retention, and other work supply issues also need to be considered and examined.

2.6 Although evidence is limited within a mental health setting, for nursing generally there is a growing body of evidence in relation to the increased ratio of qualified

nurse staffing leading to improved patient outcomes, reduced mortality and safer care. Evidence in the literature links low staffing levels and skill mix ratios to adverse patient outcomes (Rafferty et al, 2007; NPSA, 2009; NICE, 2014). An international research study by Aiken et al, 2016, concluded that deskilling occurs by adding assistants without adding more RN's or by reducing RN's. NQB (2018) states that staff numbers are central to all healthcare settings, and supports the view that lower staffing levels in mental health services can affect staff morale, increase stress, decrease job satisfaction and increase concerns about personal safety.

2.7 The nationally recognised and a validated approach to gauging nurse staff requirements, the Hurst Multiplier tool, for the data collection exercise undertaken by the Trust for the tool is detailed in the Trust Board Report dated 19th December 2017. In summary, the ward multiplier tool developed by Professor Keith Hurst provides detailed workforce information and will benchmark staffing numbers calculated on the dependency or levels of need of the patients (HEE, 2015), and was used by the Trust to calculate staffing need based on the patients acuity and dependency levels to determine a workload index.

2.8 Professional judgement (consensus) and knowledge is an established approach to setting safe staffing levels and is recommended by the Royal College of Nursing and NICE as integral to the establishment review process to inform the skill mix of staff. It is used at all levels to inform real-time decisions about staffing taken to reflect changes in acuity/dependency and activity, and is therefore crucial in providing the local context and the needs of the patient. The triangulation of this experience and expertise, care quality indicators and performance data in conjunction with the Hurst tool outcomes can then provide a balanced and meaningful view of the staffing requirements.

2.9 The trusts 6 monthly safe staffing report to the trust board shows that there were 36 wards (over 50%) of wards who had fill rates of less than 89.9% (shown as red) for registered nurses on daytime shifts. In terms of unregistered nurses this equated to only 6 wards on days that had a fill rate below 89.9%. This demonstrates that although the trust usually meets its planned staffing numbers there is often a deficit of the planned skill mix from registered to non-registered. This limits the quality and safety of interventions that can be offered from a registered nursing perspective and presents risks in terms of CQC compliance with planned staffing levels.

2.10 In addition, the 6 monthly report highlights a month on month increase in the number of duties created over the standard rosters (or budgeted establishment) with a reason of 'enhanced observations'.10,185 additional duties were created which was an increase of 1,458 when compared to the previous 6 month period. This is a key area for further exploration and analysis to better understand the problem.

2.11 Triangulation of patient safety data within the 6 monthly report has consistently demonstrated that there has been no direct impact of staffing levels on patient safety however a number of quality care issues have been repeatedly flagged up in compliance and MHA inspections which may be considered to be impacted on by staffing levels along with increased acuity and expectations of the registered nursing role within in-patient settings.

3. INITIAL OUTPUTS AND CONSIDERATIONS

3.1 The methodology of the Hurst Tool is detailed in the December 2017 Board paper, and is briefly summarised here. The resultant Hurst Tool calculations have been compared against the current budgeted establishment for the wards included in the exercise, across speciality and locality. The current budgeted establishment generally employed by the Trust of RN to HCA ratio is approximately 40%:60% respectively across the majority of wards. This means that on a typical daytime shift, less than half the nursing staff on duty on the trusts wards are registered nurses. With this skill mix it is recognised there is a risk that care giving may be inappropriately delegated, with few RNs feeling they have the time to supervise health care assistants properly.

3.2 The version of the tool used is a nursing multiplier tool, and does not take into account multi-disciplinary working. Quality care and treatment should be delivered by the appropriate staff with the required skill set. Further work through the Right Staffing programme will need to be undertaken in line with inpatient care pathways, future bed model and needs analysis to agree the multi-professional skill mix required. Calculations for this exercise were based on Registered Nurse (RN) to Health Care Assistant (HCA) ratios recommended by the version of the Hurst Tool used as below:

Speciality	RN to HCA ratio
Adult Mental Health	58% : 42%
Mental Health Services for Older People	48% : 52%
Children and Young Persons Services	66% : 34%

3.3 Using the Hurst model on its own will therefore for the trust, produce an increased requirement for RN's above their current establishment and conversely a potential reduction in the HCA establishment. The Hurst data however is to be viewed in context with, and to support professional judgement outcomes; it is not intended or recommended to be used in isolation of other factors ensuring good quality care.

3.4 For this first phase of the review process it is suggested the tool is used to define the day shift staffing establishment only. As described in the previous paper, there is a potential towards unreliable results when using the Hurst Tool with smaller/specialist areas. A recommendation was made based upon professional judgement for this phase of the staffing review to maintain the current establishment for nightshift, pending further analysis and exploration of alternative models and strategies for building in flexible nursing resource to meet unplanned but largely predictable episodes of high acuity, dependency and risk 'out of hours'.

3.5 Following the outcomes of a recent RPIW regarding the role of the Duty Nurse Coordinator, and subsequently approved by the Trust, additional resources have already been provided as well as the reconfiguration of availability of senior staff over the seven day period. This represents considerable additional investment in registered nurse complements at a relatively senior level. These roles will provide support to more junior or less experienced staff at these times and as such enable effective decision making in a timely manner for 'out of hours' periods, which will

provide overall increased support and cover at these times. The additional band 6 roles will feature in the revised establishments within localities and will increase the RN ratio across specialties within the Tees, Durham and Darlington, York and North Yorkshire localities.

3.6 Staffing levels for PICU were recently adjusted and agreed by the Trust in response to CQC recommendations and national guidelines. As such the PICU establishments are already implemented and will only feature in 6 monthly establishment reviews.

3.7 In order to provide triangulation from a range of sources, data from the Hurst Tool was reviewed against the acuity and activity described by the ward; bed numbers; CHPPD; current budgeted establishment; current and previous year spend and WTEs used, including overtime, bank, and agency utilisation and national benchmarks. Initial analysis of the information indicated some trends within adult and MHSOP wards which indicated that some additional investment may be required in relation to in–patient staffing establishments/registered nursing ratios when examined in conjunction with the professional judgement approach; however the data also presented some apparent outliers and areas to explore regarding the accuracy of the results.

3.8 The accuracy and relevance of the Hurst outcomes for CYPS in these highly specialised services provided by the Trust has been discussed, and it is recommended that professional judgement is to take precedence in determining staffing levels at this time and for further work to be undertaken with regard to considering other evidence based tools within this area in a subsequent phase of this review.

3.9 It is recognised that there are potential changes regarding the restructuring of Adult Rehabilitation Services Trust wide to enhance the community provision for this speciality; and additionally in respect to Teesside services due to planned work at the Roseberry Park Hospital site. Again, this will need to be factored into the subsequent planned establishment reviews and to be and reviewed on a 6 monthly basis. Adult Rehabilitation service units Primrose Lodge and Willow Ward were not captured in the initial review but will be reviewed in a subsequent phase alongside the speciality as a whole. The total spend on substantive and temporary staffing for 2016/17 and the forecast for 2017/18 for The Orchards' (North Yorkshire) is ~1%-2%.above the current budgeted establishment respectively; and has an average CHPPD metric that is on a par nationally and is well above the national median for similar wards. It is suggested that professional judgment should be used to determine staffing establishment in Adult Rehabilitation Services for this interim period alongside the use of temporary staffing may be best is employed for the interim pending further review.

3.10 The results returned by the Hurst Tool for Forensic Learning Disability Services (FLD) show to have significant variation to the view held by professional and clinical judgement of ward requirements; this clinical view is supported by the current spend on substantive and temporary staffing to provide a safe environment and deliver quality care. Whilst that of Forensic Mental Health Services (FMH) showed to have less variation in the expected results, following professional discussions it is the

recommendation for FLD and FMH services that a further and more focussed review which will explore different approaches and tools will be undertaken in a subsequent phase of the project, collaborating with the Model Ward programme.

3.11 The Hurst Tool multipliers used for FMH and FLD were the same as AMH. Feedback from the author, Professor Keith Hurst, said that this approach would suffice; however HEE have developed a specific set of multipliers specifically for forensic services and are soon to be published and made available, and so provide a more accurate view of the acuity and dependency this client/service user group. As previously highlighted, the tool has limitations in smaller/specialist areas and there has been further discussion with the author about mitigating the issues around the tool's functionality to assess staffing requirements for smaller sized wards, which we will need to be taken into consideration.

3.12 It is noted however that the current RN to HCA ratio in Forensic Services has shown to be approximately 33% to 67% RN to HCA ratio (as identified during the CHPPD data collection in September 2017) against the 58%:42% recommended by this version of the Hurst Tool.

3.13 As part of the re-provision and restructuring of services to accommodate work at Roseberry Park Hospital, the adult mental health ward and MHSOP ward at Sandwell Park Hospital are currently closed; and it has been confirmed that there will be a re-provision of Acute Adult Mental health (AMH) and Mental Health Services for Older People (MHSOP) from The Friarage Hospital. Likewise, current developments about future in-patient provision at Harrogate and the new hospital staffing model in York. These have been factored into consideration regarding staffing establishments. Additionally it is to be considered that there is a contingency of staff that have moved to Roseberry Park Hospital from AMH and MHSOP wards at Sandwell Park Hospital following the temporary ward closure, and this will also need to be considered into decision making.

3.14 Since the Hurst data was collated, Teesside MHSOP services have undergone environmental change due to estates work at Roseberry Park which has involved a change in ward establishments following the realignment of inpatient provision. Staff have been reallocated to Westerdale North and Westerdale South wards resulting in an increase in the staffing establishments. It was ascertained at the Tees MHSOP professional judgement meeting that due to the now substantive reallocation of resources that staffing was sufficient for the MHSOP wards in Teesside at this current time shown in Figure D (Appendix 3). Additional resources may still be required to manage the observation and engagement levels currently being experienced within organic older persons wards. At present this is largely being provided by the use of temporary staffing. This will need to be factored into the establishment reviews and reviewed on a 6 monthly basis in accordance with NQB guidance. Acomb Garth, MHSOP York, was not open at the time of the initial review and will require review in the forthcoming phase.

3.15 Professional judgement discussions for MHSOP services with Durham and Darlington, North Yorkshire, and York and Selby localities had stated that the initial Hurst results appeared to reflect the need upon the wards sufficiently. Rowan Lea, a

20 bedded MHSOP ward in North Yorkshire, since has an additional HCA and an additional twilight shift worker; the other MHSOP wards range between 14 – 16 beds.

3.16 The financial outlay figures for these MHSOP wards, the 2016/17 outturn and the 2017/18 forecast, is consistent across the two year period (Figure F, Appendix 3). Whilst the current budget for MHSOP is always lower than these figures, the budgeted establishment closely matches the forecasted spend for 2017/18 with the exception of the Durham and Darlington organic wards.

3.17 Following EMT review in January 2018, where in consideration of the outcomes of the professional judgement discussions and Hurst results discussed above, it was agreed that in line with the phased approach previously supported that the staffing establishments for the 20 bedded Acute AMH wards were prioritised; the details for this rationale are discussed further in section 4 below. MHSOP is to be further reviewed as a priority in the second phase in three months.

4. FURTHER OUTCOMES AND ANALYSIS

4.1 Revised outcome analysis and results AMH

4.1.1 There shows to be level of variation in the results obtained which have been influenced by the caveats summarised above and detailed in the previous paper. Different approaches were explored to address this and develop a consistent set of results that could be safely and equitably employed to provide a revised baseline staffing establishment pending further review.

4.1.2 The Hurst Tool captures the Daily Average Number of Patients (DANP) over the period of the data collection. This metric relates to the number of patients that have been assessed and scored according to the Hurst criteria, and averaged across the 14 day period. This has a direct relationship to the occupancy of the ward. These results are displayed for each ward as a percentage of the available beds.

4.1.3 The DANP for the 2 weeks of the data collection exercise is shown in Figure 2 (page 10) for Adult Acute Mental Health. It is noted that 2 wards were significantly low at this time; no rationale for this was recorded in the professional judgement meetings other than it being remarked upon as being lower than expected. DANP will have an impact upon the resultant staffing requirements as previously highlighted. The average DANP for the adult acute wards was ~88%. Subsequently, Lincoln ward inpatient admissions are being absorbed into Roseberry Park and Lanchester Road Hospitals as part of the Sandwell park Temporary changes. Occupancy will need to be taken into consideration to achieve optimum results at future reviews.

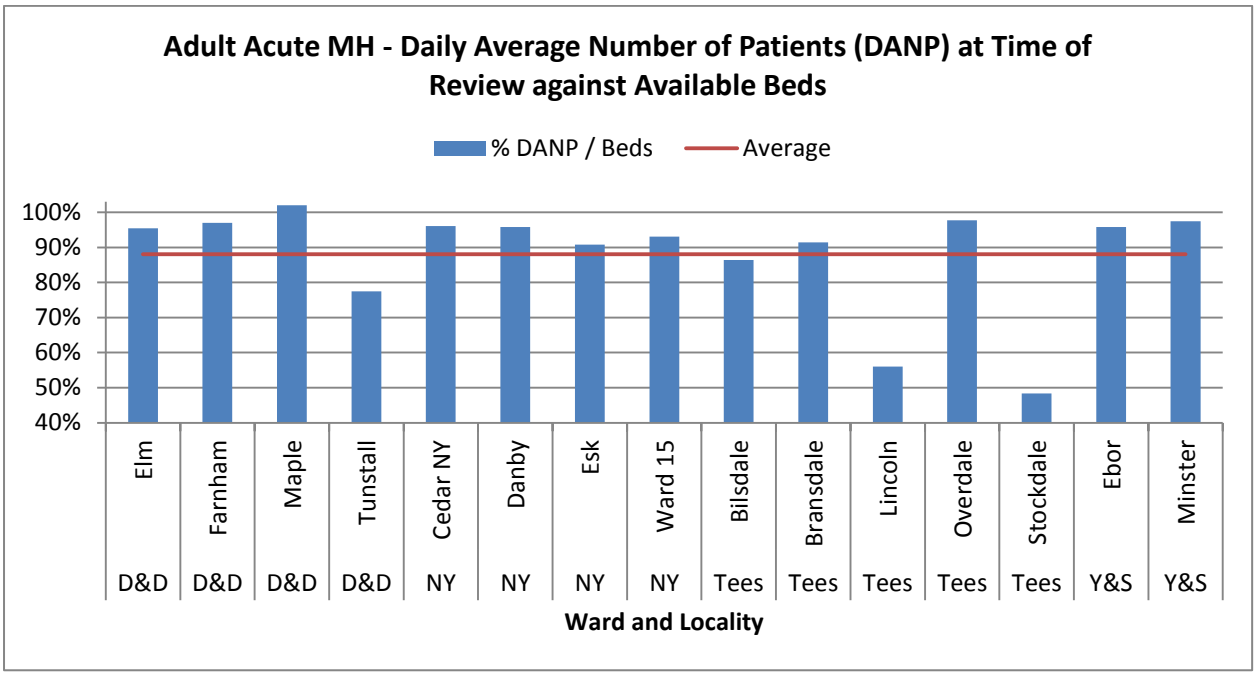


Figure 2 – Daily average Number of Patients to available beds - Adult Acute MH

4.1.4 Figure 3 shows the model employed; it assumes a linear relationship (which would benefit from further exploration), hence the trend line displayed is based on a linear regression model. Basically it is a line of best fit to the scatter plot of the data. The original results data set are the X's on this graph. The "revised" view is effectively according to the "line of best fit".

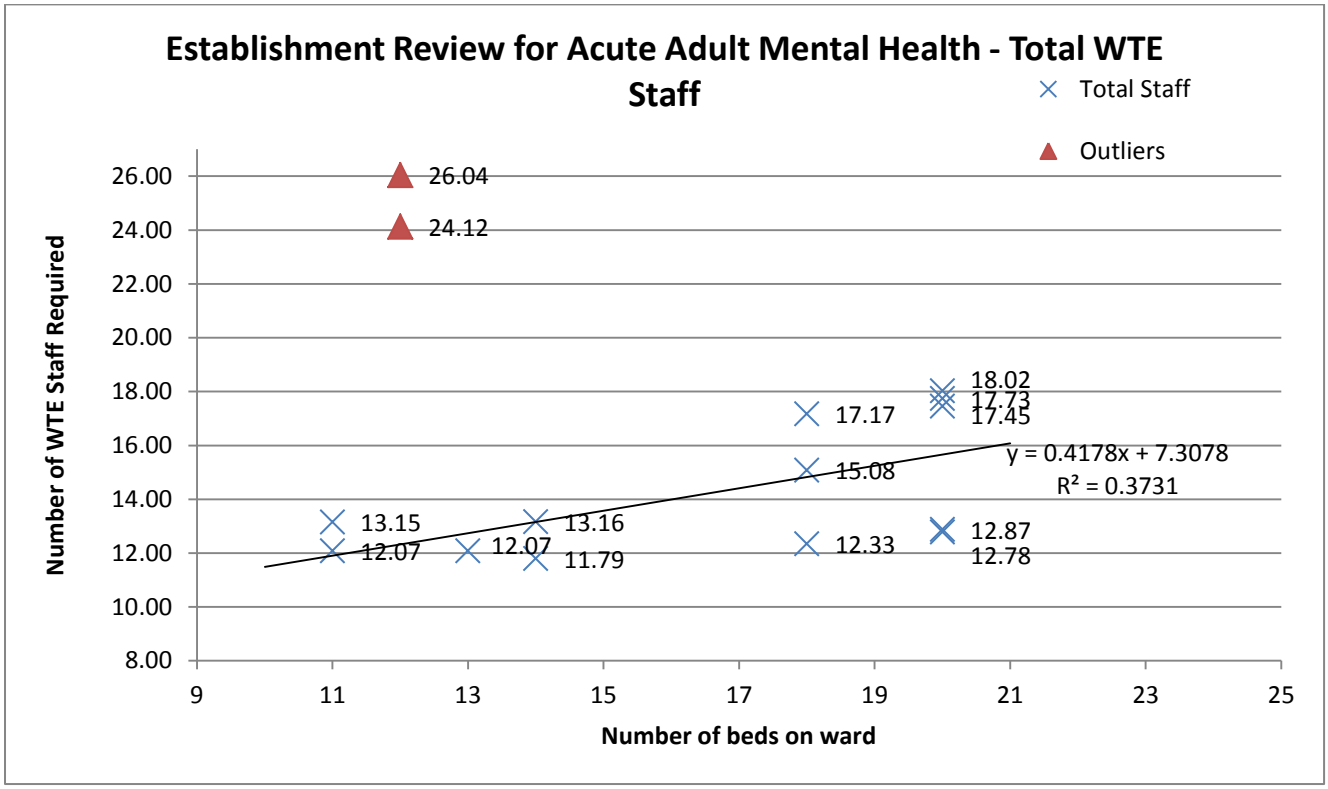


Figure 3 – Linear regression model for AMH

4.1.5 It can be seen that there are two outlying data elements (denoted by red triangles) which relate to the York & Selby data for Minster and Ebor wards. These two wards had shown, from the Hurst Tool results, a considerable increase in staffing requirements. Upon further professional judgement discussion, this was seen to exceed actual requirements; their initial resultant staffing requirement value was almost double that of the mean and median of the national benchmarking; as a result it is reasonable to suggest that this subset of results to be considered as outlying data.

4.1.6 This model of linear relationship attempts to assert a relationship with the number of beds to the number of staff required, i.e. is directly proportional to each other and therefore the number of patients assuming a consistent level of occupancy. This would only be valid from a certain point, i.e. there will always be a minimum staffing establishment required irrespective of beds for example, that it will still need 2 RNs + 2 HCAs for 10 beds as for 15 beds; and as such it is advised not to extrapolate beyond the current range of data values - there is always a minimum threshold of staffing establishment to provide a safe staffing level regardless of patient numbers; professional judgement should continue to advise and support results obtained from any tools used.

4.1.7 It is recognised that there may be other more sophisticated models of approach that if further explored may be successfully applied. The initial results were applied to a linear model to rationalise the variation in data due to the data inconsistencies experienced. It is not anticipated to be the definitive solution going forward, but rather as a starting point to address immediate requirements to accommodate the data issues.

4.1.8 In this instance, the statistical characteristics suggest that this trend is not strongly correlated. Correlation shows how strong the line fits the data. Here we have the low occupancy/low DANP wards at the time of the review (the lower X's at 12.87, 12.78 and 12.33) "dragging" the data down. If these wards are removed then the correlation (i.e. how closely the line matches the data) improves considerably to show a strong relationship between bed numbers and staff requirements to the data being used in this instance. It was felt that removing these low occupancy figures may compromise the integrity of the data and introduce bias and loss of objectivity, therefore this was not actioned and the low DANP wards remain constituent to the results.

4.1.9 Professional judgement discussions with Durham & Darlington and North Yorkshire localities had felt the initial results appeared to reflect the need upon the wards sufficiently; and as discussed, York & Selby AMH wards presented results that were said to be in excess of the actual required establishment. Teesside had also reported that the results were in line with requirements. As described previously redeployment of staff due to environmental changes within the Teesside locality, have at this point in time temporarily supported the Teesside AMH ward provision.

4.1.10 Figure 4 shows the comparative values of the current budgeted position for staffing establishments, alongside the initial Hurst tool results and the results obtained from the linear model. This is also displayed against the financial outturn for 2016/17, the

forecasted figures for 2017/18. It is to be noted that these figures include nightshifts and the outturn and forecast figures also include costings for bank, agency and overtime). The 2016/17 outturn for the York & Selby wards is impacted due to data only being available from 08/2016. With Ward 15 Friarage Hospital and Lincoln Ward SPH being part of a reconfiguration of services at this present time, they therefore are not considered, and the data has been removed from the results.

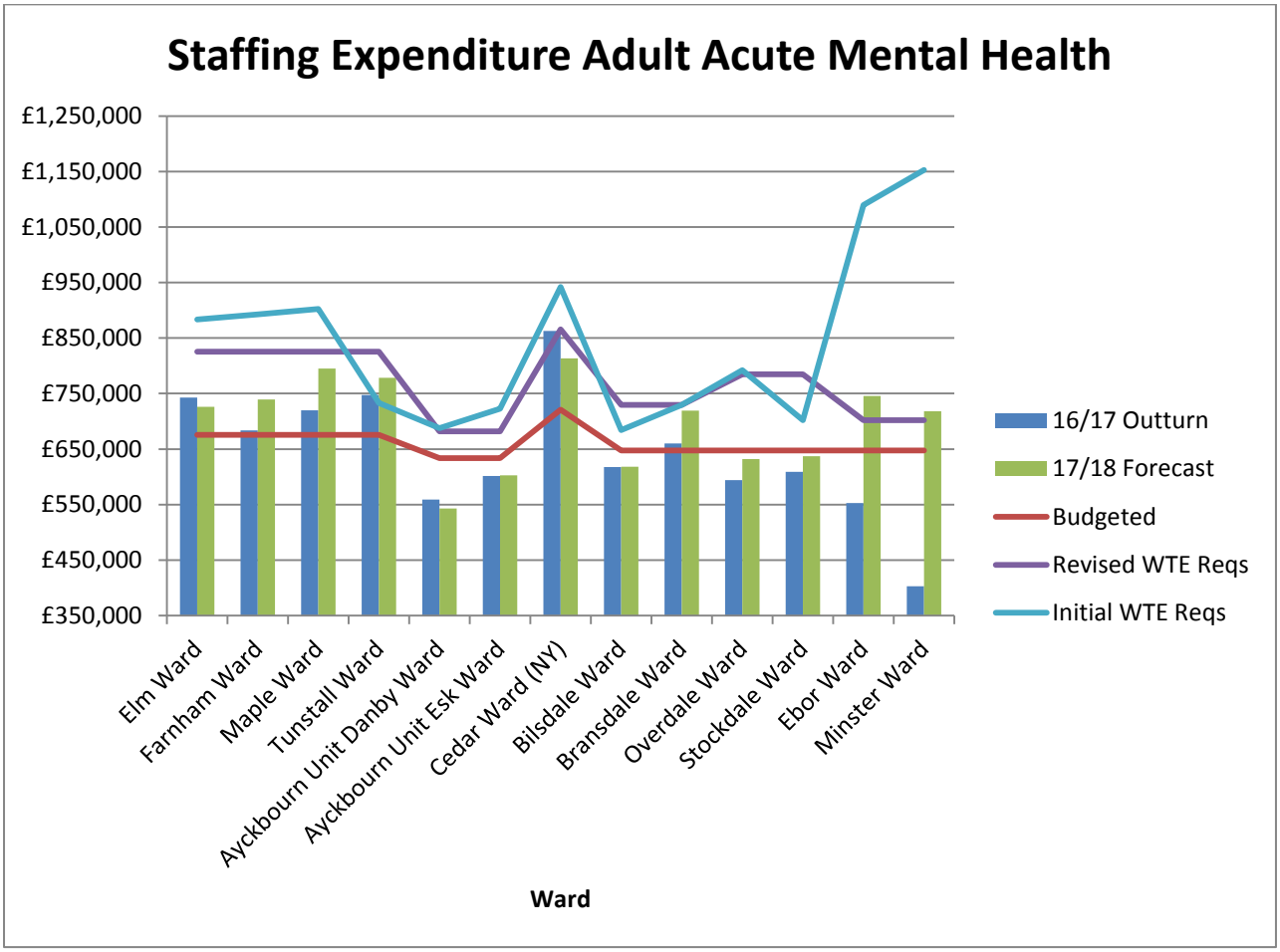


Figure 4 – Staffing expenditure for Adult Acute MH

4.1.11 The financial spend for 2016/17 and 2017/18 show to be reasonably consistent over the two year span. The revised results from the application of the linear model tracks the actual demand defined by the outturn and forecast figures, more closely than that of the initial set of Hurst results.

4.1.12 The result of using this model is that similar bed sized wards will have their establishments equally defined. For example, all 20 bedded wards will have an improved staff provision that is the same. This will have a proportional increase for Care Hours Per Patient Day across each of the wards, a metric fully described in the original paper, which is defined as the “Number of occupied beds / Number of staff”.

4.1.13 Currently, all Adult AMH wards are budgeted on the basis of 4 rostered nursing staff team (days) and 3 rostered nursing staff team (nights). This establishment is the same for all bed numbers in a range of 12 – 20 beds (average 16 beds).

4.1.14 As an example, a day shift of four nursing staff will provide capacity for 48 hours of patient care time over the 12 hour period. For a 20 bed ward this means 2.40 hours per patient. Increasing the number of rostered nursing team in the day to 5 from 4 for 20 bed wards would increase the care hours over the 12 hour period to 3.00 hours per patient which would improve equity comparable to a 16 bed ward.

Day Shift (based on 12 hours)	20 beds (Current)	16 beds (Current)	20 beds (Proposed)
On shift (rostered nursing workforce)	4	4	5
Hours per shift	12	12	12
Total Care Hours	48	48	60
Number of beds	20	16	20
Care Hours per bed (patient) per day shift	**2.40**	**3.00**	**3.00**

Figure 5 – CHPPD increase assuming maximum capacity

4.1.15 It is worth commenting there has been seen to be an increase in occupancy on the four AMH 20 bed wards in Durham and Darlington attributed to an increase in out of area admissions resultant from the restructuring of services within Teesside, which further supports the decision to increase the establishment to these wards.

4.1.16 In line with the revised requirements as suggested by the Hurst Tool and the professional judgement discussions, the recommendation from EMT was to prioritise investment in the four 20 bedded wards across Durham and Darlington. This suggests an additional 3.40 RN WTEs and 0.82 HCA WTEs for each of the wards which equates to an increase of 1.19 RN WTEs and 0.29 HCA WTEs extra on each day shift. This is detailed in Appendix One, figures A -D provides this detail. The total recurring cost of this investment in additional staff is £596,920.

4.1.17 The latest national benchmarking in November 2017 shows the Trust's ratio for AMH RN's per 10 beds as 7.1 (as shown in Figure D, Appendix 2). This is below the national mean and median values of 7.5 and 8.0 respectively. With the suggested increase in staffing as detailed above, and the current reduction in bed numbers from the environmental changes described for Teesside and North Yorkshire localities, the Trust ratio would increase from 7.1 to approximately 8.8. As seen in Figure D (Appendix 2), this will place the Trust's benchmarking ratio above the national mean and median, and just below the upper quartile.

4.2 Ward based administrative provision

4.2.1 Professional judgement discussion from the Hurst review exercise had shown that administrative provision on the wards was varied across the Trust. NQB guidance (2018) recognises the requirement for sufficient administrative provision to support clinical staff in their duties – utilising skill mix for the right staff with the rights skills for the required task. Ensuring that adequate administration support is in place will provide an increase the available clinical time for the clinical staff to deliver quality

care to patients. At a time where registered nursing resources are scarce, it will ensure that the optimal use of staff skills and expertise is delivered from the right person with those right skills, enabling effective use of staff time to deliver care, and therefore providing value for money and efficiencies.

4.2.2 An undertaking of a ward clerk administrative review has been initiated in order to review the functions and administrative arrangements of the Ward Clerk role, and is committed to standardise the role and provision of ward clerks across the Trust. As a result, EMT has approved the finances for Ward Clerk provision for each inpatient unit in the Trust. A baseline of the current provision and utilisation is being performed, so that the dependent costings can be fully understood from the requirements obtained from the needs analysis. The analysis phase is expected to be complete by July 2018.

5. AGREED ACTIONS AND NEXT STEPS

5.1 A phased approach has been adopted, as agreed on presentation of the previous paper 19th December 2017, to address the outcomes delivered by the establishment review.

5.2 Phase One of the establishment reviews is complete. It addressed:

	Actions agreed and progress update
1	Undertaking establishment reviews using the Hurst Tool
2	Providing increased provision of staff resource to meet needs identified in PICUs which resulted in the addition of a Band 5 registered nurse on each day shift and each night shift at Cedar ward and Bedale ward; an increase of **11.44 WTE** at an additional cost of **£436,000 per annum.**
3	Establishing a duty nursing system across the trust, providing senior nurse cover across locality groups. This is to provide a consistent, 24/7, senior nursing presence for staff across designated sites (and satellite units). This requires additional staffing of **10.44 WTE Band 6** registered nurses to cover seven nights per week and mobilisation of ward managers and modern matrons across seven days per week in each Locality at an additional total cost of **£733,030 per annum**. Recruitment has begun and is ongoing to fully establish these posts.

5.3 Further discussion by EMT in January 2018 presented recommendations and priorities for Phase Two in line with NQB guidelines and in consideration of the review findings and assessing the relationship between patient dependency, nursing requirements and current utilisation of budgeted resources in the context of the previously discussed considerations and the overall financial plan. Priorities identified within Phase Two by EMT are listed 1-7 in the table below.

Priority	**Action- next steps**
1	EMT have prioritised the substantive staffing requirements following review in January 2018 to address equity of staffing across the 20 bedded wards in Acute AMH in Durham and Darlington (as detailed in Section 4).

2	Review of ward based administrative requirements, needs analysis and role of the ward clerk to support clinical teams. EMT has committed to support ward clerk provision on each inpatient ward. This is detailed in paragraph 3.4.
3	Further review of organic and functional MHSOP staffing establishments and requirements recommended in the following 3 months.
4	Review of evidence based tools to support the Trust in its ongoing evidence based reviews. NHSI in conjunction with the Optimal Staffing project (HEE) is in the process of finalising its revised and updated "multiplier" tool developed by Professor Hurst. This is expected to be published nationally Q3 2018. The Trust is working with NHSI and HEE in supporting this. The updated version of the tool includes specific Forensic "multipliers" that have been tested and developed across low medium and high security forensic wards. A level 3 review is planned with HEE to support the development of an Eating Disorder Ward Multiplier Tool. Exploring the potential for the Safecare module with Health Roster to support continuing and dynamic review of patient acuity and dependency which will provide robust metrics to inform ongoing establishment reviews.
5	Further review of all Forensic Services wards collaborating with Model Ward Programme, utilising the best tool and approach to support the determination of required staffing levels. This will include the updated version of the tool developed by the HEE Optimal Staffing project.
6	Develop a program to gain a better understanding of the current practice around patient acuity and observation levels. This may take use the QIS approach to review this subject area.
7	Ongoing work with respect to delivering and maintaining HealthRoster quality and efficiency will continue to be an active aspect of the Safe Staffing Trust wide programme to ensure appropriate and efficient deployment of staff.
8	Develop a plan and framework for ongoing and regular establishment reviews annually for all wards, utilising "lessons learnt" i.e. the value of "challenge meetings" to review the recorded data daily and discuss; consideration the collection period with regard to the size of the Trust and the number of wards involved.
9	Evaluate PICU establishments following recent uplift staffing – review with NQB revisiting in 6 months – review environments staffing etc.
10	Explore the potential of a stepwise approach to meeting recommended RN to HCA ratios and staffing levels as per speciality if proven they are realistic to achieve in respect to the difficulties experienced nationally in recruiting to RNs to post and financially feasible.
11	As part of the Right Staffing programme, develop a framework that will consider the broader range of multi-professional and support roles, working flexibly together to ensure that services are purposeful, productive and clinically effective. This will include development and definition of new roles such as multi-professional Consultant level roles including Accountable Clinicians (AC), Physician Associates (PA),

	Nursing Associates, Psychology Assistants roles and the development of skills and knowledge bases for existing roles.
12	Develop a framework in conjunction with the model wards programme that determines staffing establishments that are based upon the clinical services required for treatment as stated by the clinical pathway of the patient's journey to deliver outstanding quality care, rather than traditional role definitions.

5.4 **Phase Three** (December 18- June 19) – Priorities to be defined.

Item	Action
1	Review of Learning Disability wards, utilising the best tool and approach to support the determination of required staffing levels. Consideration of the national Transforming care programme will be required during this process.
2	Further review of Adult Rehabilitation Services wards utilising the best tool and approach to support the determination of required staffing levels, which will be aligned with the Trust wide review of rehabilitation services.
3	Review of CYPS wards utilising the best tool and approach to support the determination of required staffing levels.
4	Revisit nightshift establishments for further review in line with the evaluation of the Duty Nurse Coordinator role.

6. IMPLICATIONS

6.1 Compliance with the CQC Fundamental Standards:

6.1.1 In order to provide confidence and assurance that the Trust can maintain safe staffing levels a proactive and evidence based approach to staffing establishments is required. Safe staffing is a fundamental part of good quality care and CQC will therefore always include a focus on staffing in their inspection frameworks for NHS providers.

6.2 Financial/Value for Money:

6.2.1 This evidence based establishment review has indicated an initial financial impact to the Trust. Regarding the provision of nurse staffing it highlights a required investment of **(£596,920 recurring)** for Acute Adult Mental Health inpatient services. There will be an additional cost (to be determined) to provide equitable and standardised administrative support to the wards. It is however anticipated that current incurred costs from overspending on flexible staffing to meet patient needs will be reduced as a result of these actions which may reduce the financial impact to the Trust and be offset against this outlay. It should be reinforced that over the last 12 months, priority areas for investment such as PICU staffing and out of hours duty

nurse provision have already resulted in significant additional registered nursing resource.

6.2.2 By ensuring that adequate administration support is in place, this will increase the available clinical time for the clinical staff to deliver quality care to patients. It will ensure that the optimal use of staff skills and expertise is delivered from the right person with the right skills, enabling efficient and effective use of staff time in delivering care, therefore providing value for money.

6.2.3 There are factors to balance and consider against the preliminary view of RN requirements suggested by the Hurst Tool output that may include changes to the way in which we work such as: staffing according to delivery of care to clinical pathways and models of care; efficient and effective methodologies utilising daily lean management principles; examining the MDT alternatives to simply increasing nursing establishment that may free up the clinical time of the registered nursing staff i.e. increased administration provision; AHP staffing provision; review of the definition of clinical and non-clinical roles; reduction in bed base on wards to increase clinical hours in the patient day. Any additional resources will require evaluation through the 6-monthly safe staffing report to the Board.

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

6.3.1 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.

6.3.2 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 2016/18 NQB guidance has also been taken into account in the Trust approach.

6.4 **Equality and Diversity:**

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

7. RISKS:

7.1 EMT have reviewed and assessed the risks from the paper presented in January 2018 and have prioritised mitigations accordingly in relation to information presented regarding the outcomes from the professional judgement reviews and results from the Hurst Tool to support these decision making processes.

7.2 Availability of funding to provide additional staffing establishments will need to be balanced against ongoing requirements to provide a safe staffing establishment for the current bed numbers within inpatient services. This is currently partially mitigated by the current and forecast Trust spend on temporary staffing and overtime.

7.3 There are national issues regarding recruiting to registered nurse posts as described in section 2 which may impact upon the ability to fulfil the required WTEs in a timely manner despite the investment from the Board however there is also a strong case to state that increasing RN ratios will improve morale and retention in addition to improving quality of care.

8. CONCLUSIONS:

8.1 The Hurst tool has provided initial results for the staffing requirements for the Trust on those wards participating in the Trust wide exercise. The outputs from the tool are contingent on robust input data. It has been indicated that there are issues of data quality in regard to the data collection process which may influence the obtained results. However even when considering these issues there are patterns and trends that are apparent from the data and as such value remains in these results when examined in conjunction with a triangulated approach including professional judgement.

8.2 The establishment review remains a snapshot view of a point in time against a backdrop of increasing patient acuity; evolving models of delivering effective care; and innovative methodologies for working more efficiently. In order to be responsive to these requirements that these challenges place upon us, and also to the demand upon staffing resources, we require a dynamic and flexible approach to meet these needs in safe and consistent way that will allow for ongoing review of the required staffing establishment.

8.3 In conjunction with the lessons learnt from this initial exercise which can be effectively carried forward on undertaking further establishment reviews, a change in culture and process on the wards is required in line with care pathways and model wards. It is suggested that this will benefit from further assessment, analysis and discussion before considering an approach to fully assess the value and benefit for the Trust of whichever model of staffing is adopted.

8.4 Improved quality of care and better outcomes for service users has a clear link to appropriate levels of staffing and skill mix in which to deliver this care. The actual staffing demand, represented by the expenditure over 2016/17 and that forecast for 2017/18, shows a relatively strong degree of consistency for this 2 year period. It would suggest that this may provide an indication of the required staffing establishment to provide a safe and high quality level of care to service users. Substantively staffing to the current expenditure as opposed to using temporary staffing (bank and agency staff) would improve the consistency of the ward team, enhance the care of the patient and improve staff morale and wellbeing.

8.5 The current staffing establishments of the 20 bedded wards in Acute AMH are currently relatively similar as that for lower bedded wards. This has an impact upon the ability to deliver quality care to the patients that are resident on the 20 bed wards, and will be reflected in the new national benchmark metric of Care Hours Per patient Day; it was also apparent in the National Benchmarking outcomes. The action to substantively increase staffing resources for these 20 bed wards will

improve both of these measured values and therefore the quality of care delivered to the service users.

8.6 The provision of an increased and standardised approach to ward clerk and administrative support on the inpatient wards will allow the ward clinical staff to have increased availability to undertake clinical practice rather than being utilised in admin duties. This supports the viewpoint to ensure that the right person with the right and appropriate skillset for the required task is utilised – and therefore allow the best use skills and time thereby providing value for money

9. RECOMMENDATIONS:

9.1 For the Board to:

- Consider and approve the contents of the report with regard to staffing establishments and recommended actions taken to provide additional investment for the 20-bedded adult in-patient services at a total recurring cost of £596,920.
- Consider and approve the recommendations to providing equitable and standardised administrative support across all inpatient wards which will increase the availability of ward staff clinical hours.
- Approve the suggested prioritisation of the phased approach to implementation as set out in the paper.

Appendix 1

Registered Nurses – excluding Lincoln ward and Ward 15								
Locality	**Ward**	**Beds**	Total WTE Budgeted	Initial WTE Required	Revised WTE Required	Difference Revised & Budgeted WTE	Number extra staff per shift	Additional Cost £ (Recurring)
D&D	Elm Ward	20	5.72	10.12	9.12	3.40	1.19	£127,500
	Farnham Ward	20	5.72	10.29	9.12	3.40	1.19	£127,500
	Maple Ward	20	5.72	10.45	9.12	3.40	1.19	£127,500
	Tunstall Ward	20	5.72	7.47	9.12	3.40	1.19	£127,500
N Yorks	Ayckbourn Danby Ward	11	5.37	7.00	6.89	1.52	0.57	£57,000
	Ayckbourn Esk Ward	11	5.37	7.63	6.89	1.52	0.57	£57,000
	Cedar Ward (NY)	18	5.37	9.96	8.63	3.26	1.22	£122,250
Teesside	Bilsdale Ward	14	5.48	6.83	7.64	2.16	0.79	£81,000
	Bransdale Ward	14	5.48	7.63	7.64	2.16	0.79	£81,000
	Overdale Ward	18	5.48	8.74	8.63	3.15	1.15	£118,125
	Stockdale Ward	18	5.48	7.15	8.63	3.15	1.15	£118,125
Y&S	Ebor Ward	12	5.48	13.98	7.14	1.66	0.61	£62,250
	Minster Ward	12	5.48	15.10	7.14	1.66	0.61	£62,250
	Totals	**208**	**71.87**	**122.35**	**105.71**	**33.84**	**12.19**	**£1,269,000**

Figure (A) Acute Adult MH – Revised RN WTE figures and costings for wards being reviewed

HCAs - excluding Lincoln ward and Ward 15								
Locality	**Ward**	**Beds**	Total WTE Budgeted	Initial WTE Required	Revised WTE Required	Difference Revised & Budgeted WTE	Number extra staff per shift	Additional Cost £ (Recurring)
D&D	Elm Ward	20	5.72	7.33	6.54	0.82	0.29	£21,730
	Farnham Ward	20	5.72	7.45	6.54	0.82	0.29	£21,730
	Maple Ward	20	5.72	7.57	6.54	0.82	0.29	£21,730
	Tunstall Ward	20	5.72	5.41	6.54	0.82	0.29	£21,730
N Yorks	Ayckbourn Danby Ward	11	5.37	5.07	5.01	-0.36	-0.13	-£9,540
	Ayckbourn Esk Ward	11	5.37	5.52	5.01	-0.36	-0.13	-£9,540
	Cedar Ward (NY)	18	5.37	7.21	6.20	0.83	0.31	£21,995
Teesside	Bilsdale Ward	14	5.48	4.95	5.52	0.04	0.01	£1,060
	Bransdale Ward	14	5.48	5.53	5.52	0.04	0.01	£1,060
	Overdale Ward	18	5.48	6.34	6.20	0.72	0.26	£19,080
	Stockdale Ward	18	5.48	5.18	6.20	0.72	0.26	£19,080
Y&S	Ebor Ward	12	5.48	10.14	5.18	-0.30	-0.11	-£7,950
	Minster Ward	12	5.48	10.94	5.18	-0.30	-0.11	-£7,950
	Totals	**208**	**71.87**	**88.63**	**76.18**	**4.31**	**1.53**	**£114,215**

Figure (B) Acute Adult MH – Revised HCA WTE figures and costings for wards being reviewed

20 Bed Acute AMH wards								
Grade	**Ward**	**Beds**	Total WTE Budgeted	Initial WTE Required	Revised WTE Required	Difference Revised & Budgeted WTE	Number extra staff per shift	Additional Cost £ (Recurring)
RN	Elm Ward	20	5.72	10.12	9.12	3.40	1.19	£ 127,500
	Farnham Ward	20	5.72	10.29	9.12	3.40	1.19	£ 127,500
	Maple Ward	20	5.72	10.45	9.12	3.40	1.19	£ 127,500
	Tunstall Ward	20	5.72	7.47	9.12	3.40	1.19	£ 127,500
Totals			22.88	38.32	36.48	13.60	4.76	£510,000
HCA	Elm Ward	20	5.72	7.33	6.54	0.82	0.29	£21,730
	Farnham Ward	20	5.72	7.45	6.54	0.82	0.29	£21,730
	Maple Ward	20	5.72	7.57	6.54	0.82	0.29	£21,730
	Tunstall Ward	20	5.72	5.41	6.54	0.82	0.29	£21,730
Totals			22.88	27.75	26.16	3.28	1.15	£86,920
Grand Total RNs + HCAs			45.76	66.08	62.64	16.88	5.91	£596,920

Figure (C) Acute Adult MH – 20 bed wards

Appendix 2

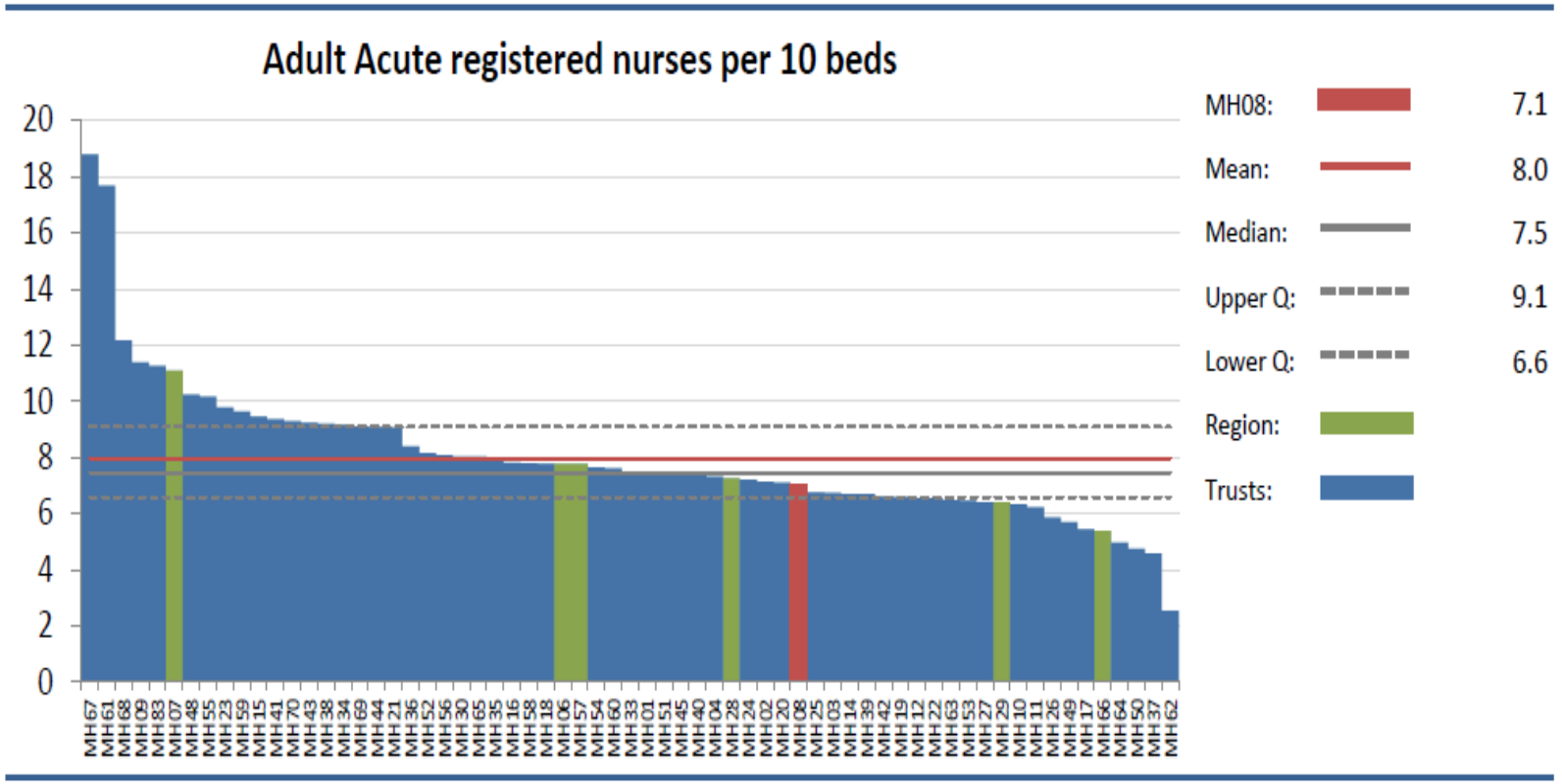


Figure (D) Acute Adult MH – RNs per 10 beds, (NHS Benchmarking Network, 2017)

Appendix 3

	Ward Name	Locality	Speciality	Shift	Staff Day Total	RN Split	HCA Split	Staff Night Total	RN Split	HCA Split
Existing	Westerdale North	Teesside	MHSOP	Mon-Fri	4.00	2.00	2.00	3.00	1.00	2.00
				Sat-Sun	4.00	2.00	2.00	3.00	1.00	2.00
Existing	Westerdale South	Teesside	MHSOP	Mon-Fri	5.00	3.00	2.00	3.00	1.00	2.00
				Sat-Sun	5.00	3.00	2.00	3.00	1.00	2.00
Revised	Westerdale North	Teesside	MHSOP	Mon-Fri	5.00	3.00	2.00	3.00	1.00	2.00
				Sat-Sun	5.00	2.00	3.00	3.00	1.00	2.00
Revised	Westerdale South	Teesside	MHSOP	Mon-Fri	6.00	3.00	3.00	4.00	2.00	2.00
				Sat-Sun	6.00	2.00	4.00	4.00	2.00	2.00
Difference	Westerdale North	Teesside	MHSOP	Mon-Fri	**1.00**	**1.00**	0.00	0.00	0.00	0.00
				Sat-Sun	**1.00**	0.00	**1.00**	0.00	0.00	0.00
Difference	Westerdale South	Teesside	MHSOP	Mon-Fri	**1.00**	0.00	**1.00**	**1.00**	**1.00**	0.00
				Sat-Sun	**1.00**	**-1.00**	**2.00**	**1.00**	**1.00**	0.00

Figure (E) – MHSOP Teesside inpatients reconfiguration

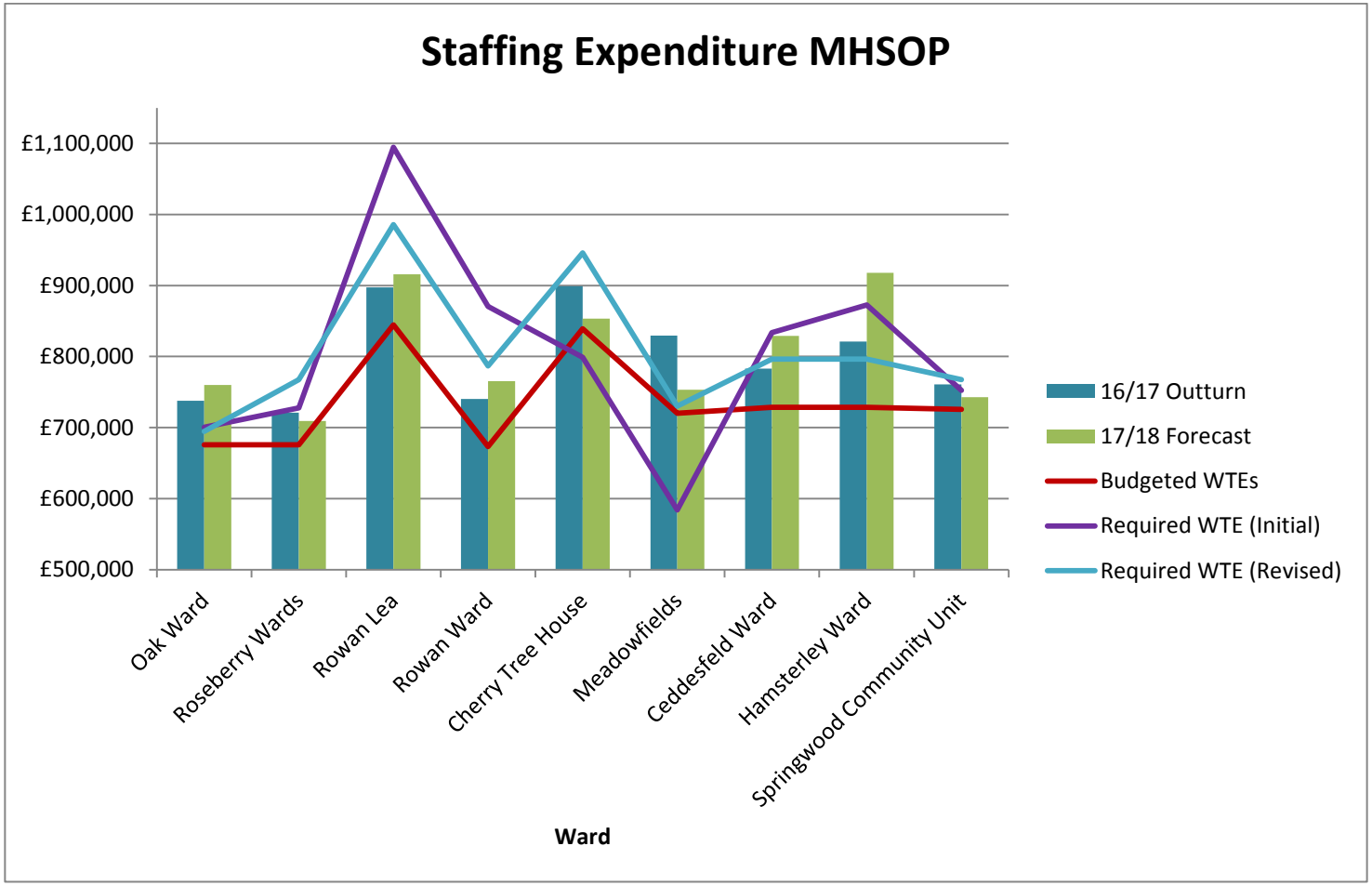


Figure (F) – Staffing expenditure for MHSOP

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th March 2018**
TITLE:	**Workforce Strategy**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Decision**

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

Executive Summary:

This report is about the draft TEWV Workforce Strategy. Committee member views about the draft strategy contents are sought. The report proposes a period of wider consultation in early 2018. The report highlights that potentially important related information arising from the recent TEWV values and compact consultation exercise, Investors in People assessment and a Health Foundation funded staff engagement case study exercise has yet to be received. An NHS Workforce Strategy is due for publication.

Recommendations:

1) To approve the attached workforce strategy on the recommendation of the Resources Committee.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**27th March 2018**
TITLE:	**Workforce Strategy**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek Board of Directors approval of the attached Workforce Strategy.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The strategy has been developed in response to Resources Committee member comments during 2017 and early 2018 and feedback received from Trust leadership and management network meetings held in February 2018.

2.2 The attached strategy was endorsed, subject to several amendments that have been included, by the Resources Committee at its meeting earlier this month.

2.3 A national consultation exercise has recently been undertaken in respect of a draft NHS workforce strategy and the final version is expected to be published later this year.

3. KEY ISSUES:

3.1 The strategy identifies the key workforce issues for TEWV as being recruitment, retention, development, health and wellbeing and having an optimistic and compassionate culture. It is believed that addressing these key issues successfully will help to make TEWV a great place to work which in turn will benefit our staff and the people who use our services.

3.2 The strategy seeks to be both aspirational and realistic. There is much good people management and policy and practice within TEWV and there is clearly scope for more improvement. There is increasing recognition and awareness of the work pressures that our staff face and the ability of TEWV to directly address the causes of these work pressures will vary.

3.3 There are a number of related TEWV strategies including leadership and management development, equality and diversity, digital transformation, research and development and nursing. The workforce strategy does not seek to replicate the contents of these strategies but hopefully it complements them. An attempt has been made to ensure that the strategy is generic and not focused upon a particular staff discipline.

3.4 The feedback generated by the values and staff compact consultation exercise was appreciated however, it was also limited due to the low numbers of staff who participated and it was not possible to draw any firm conclusions that would impact upon the strategy contents. The ladder of participation, that was recently endorsed by the Board of Directors and the Executive Management Team as part of the Making a Difference Together business plan priority and the Recovery Strategy is included within the strategy.

3.5 The Investors in People assessment was completed in November 2017 and the outcome was positive. The assessment report highlighted however, feedback about the need to do more to enhance corporate communications and provided positive messages from staff who took part in the associated interviews/focus groups about the working environment that exists within TEWV. This feedback has been included within the strategy.

3.7 The December 2017 Board of Directors seminar included feedback from three TEWV BAME staff which highlighted the need to take more action to support staff who are abused by service users, carers and the public. The strategy has been amended to include reference to this important issue.

3.8 The views of members of the TEWV leadership and management network have been sought. Some seventy five people participated and gave their views though due to poor weather the network meeting that was planned to take place on Teesside was cancelled which meant that it was not possible to consult with the ninety people who were due to attend. The feedback received indicated that there is a consensus that the objectives within the strategy are the right ones. The Workforce and Development Group and the Joint Consultative Committee have also been included in the consultation process.

4. IMPLICATIONS:

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

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

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

4.4 **Equality and Diversity:** None identified

4.5 **Other implications:** None identified

5. RISKS: None identified

6. CONCLUSIONS:

6.1 The attached strategy seeks to addresses what are believed to be the key workforce issues for TEWV and recent consultation feedback suggest that the objectives within the strategy are the right ones.

6.2 The issues and approaches described within the strategy are compatible with the contents of the draft NHS Workforce Strategy that is currently the subject of national consultation.

7. RECOMMENDATIONS:

7.1 To approve the attached workforce strategy on the recommendation of the Resources Committee.

David Levy
Director of Human Resources and Organisational Development

Background Papers:

Tees, Esk and Wear Valleys
NHS Foundation Trust

Draft Workforce Strategy

2018-2021

Strategy Sponsor: David Levy, Director of Human Resources and Organisational Development		
Strategy Lead: Angela Collins, Deputy Director of Human Resources and Organisational Development		
Version: 3	**Date approved**	**Date of Next Review:**

Preface

How the workforce performs is fundamental to determining whether we are able to achieve our mission of improving people's lives by minimising the impact of mental-ill health or a learning disability. We need to continuously improve the quality of services and this entails taking a strategic approach to workforce supply, development, health and wellbeing and engagement activities.

Our vision is to be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations. Implementing this strategy will support achievement of the Trusts Strategic Goal 3 'To recruit, develop and retain a skilled, compassionate and motivated workforce'. Delivering the Trust vision through Strategic Goal 3 means:

- Promoting a culture where our staff feel engaged and valued
- Ensuring all our staff work in line with the Trust values, behaviours and compact
- Promoting and supporting the health and wellbeing of our staff
- Ensuring we have effective leadership and management throughout the organisation
- Providing appropriate education, training, development and leadership opportunities for all staff
- Providing high quality placements for student health care professionals and trainees as the future workforce

We want TEWV to be a great place to work. Staff survey feedback and the outcomes of externally led assessments provide evidence of good employment policy and practice, sometimes amongst the best within the NHS. An increasingly challenging environment, that includes greater expectations and work demands and tighter resourcing, means that we need to do more to make TEWV a place where people want to work.

A commitment to enhanced employee engagement is at the heart of the Workforce Strategy as there is good evidence that having an engaged workforce benefits staff and patients.

For further information about this strategy please contact David Levy, Director of Human Resources and Organisational Development at d.levy@nhs.net or Angela Collins at angela.collins@nhs.net

Contents

1. Where are we now

TEWV employs approximately 6,700 staff (5,850 WTE). Registered nurses are the largest single workforce group within TEWV (33%) followed by healthcare assistants (24%), administrative and clerical staff (19%) and estates and facilities directorate staff (6%). Medical (4%), professional scientific and technical (6.5%) and allied health professionals (5%) are our other workforce groups. The majority of TEWV clinical staff work within community based services.

Amongst TEWV-wide workforce related initiatives that will impact upon our ability to deliver the Trust vision are:

● **The TEWV Recovery Strategy** includes the development of peer workers and the embedding of recovery practice within the everyday work of TEWV staff. This will have major implications for service users and the workforce. The way in which staff work with service users to embed recovery practice and principles will entail changes to job roles, competency requirements and training.

● **The Right Staffing business plan priority** is a programme of work that seeks to make TEWV a compassionate, fair and just organisation where staff want to work and excel; and where patients have choice and confidence in working with the right staff having the right skills at the right place and time to receive outstanding care and treatment.

● **The TEWV culture** – we promote our values, behaviours and staff compact along with a coaching based approach to leadership and embedding the TEWV Recovery Strategy. These three key pieces of work will help us to improve the way that care is provided and services managed for the benefit of patients and staff. The experiences of BAME and disabled staff are worse than those of white staff and not disabled staff and the need for TEWV to be a more diverse and inclusive employer is acknowledged.

● **TEWV Purposeful and Productive Community Services (PPCS)** – this initiative will change the way that community teams, and the staff within them, work to deliver services.

Our **STRENGTHS** include:

We have a stable workforce – the annual labour turnover rate is typically 10% compared to an NHS mental health trust average labour turnover rate of 12.75%. There are variations between the TEWV localities with labour turnover rates ranging from 7.6% to 16.5%. In a twelve month period approximately 650 staff will leave TEWV and a similar number will join. Age retirement accounts for the highest proportion of leavers (20.3%).

We do much to engage staff – as measured by the annual staff opinion survey and the three times per year Staff Friends and Family Test staff engagement is better than most other mental health and learning disability trust. The TEWV Quality Improvement System has proved to be an important way of ensuring that we directly involve our staff in activities that improve their working lives and the experiences of the people that we care for.

We have good employment relations – constructive TEWV-wide and locality based consultation forums are in place and relationships with staff representatives are positive. The numbers of disciplinary and grievance cases are low with less than 2% of the TEWV workforce being the subject of formal proceedings in any one year.

Access to education and training is good – staff regularly tell us that they are often supported to access development opportunities and that this is one of the best things about working for TEWV. Completion of statutory and mandatory training has never been higher than it is now at 90% or more within some localities. More needs to be done however, to ensure that all training needs are fully captured and responded to.

Managing organisational change – typically some 150 to 200 staff will formally enter the TEWV redeployment process each year due to organisational change and many more staff will be affected indirectly by organisational change each year. We acknowledge the importance of continuing to improve how we work with our staff to bring about successful change and to better address the health and wellbeing impact of change upon our staff.

The working environment is a positive one – the most recent Investors in People assessment identified TEWV as having a demonstrable commitment to developing people, providing a wealth of wellbeing support and a working environment where people are mutually supportive and respectful.

Our **CHALLENGES** include:

Our workforce age profile is rising - 52.4% of all TEWV staff are 44 or older. There are significant variations between localities/services e.g. 39.5% of Forensic Services staff are aged 44 or over compared to 73.9% of Estates and Facilities staff. The TEWV nursing workforce is particularly affected by the increasing age profile due to the Mental Health Officer status of many nurses that includes a normal pension age of 55 years.

Maintaining and improving workforce health and wellbeing is becoming more challenging - the overall annual sickness absence rate has averaged 5.0% during the last two years. A combination of stress, anxiety and depression accounts for some one third of all sickness absence reported within TEWV. There are variations in sickness absence rates between localities rates ranging from up to 6% to below the TEWV target of no more than 4.49%. Though sickness absence is higher than we would wish our positive approach to supporting the health and wellbeing of the workforce is well regarded. The cost to TEWV of sickness absence is approximately £10m per annum.

Recruiting healthcare professionals is becoming harder - within the last two years nursing, medical and allied health professional recruitment has become a major issue for TEWV. Overall vacancy fill rates are typically 85% but vary between localities from 65% to almost 100%. The TEWV Recruitment and Retention Action Plan, which was agreed in 2016, is regularly reviewed, updated and implemented using a **P**lan **D**o **S**tudy **A**ct approach.

Demand for temporary nurse and healthcare assistant staffing is higher than ever before – despite having more staff in post and stable or lower rates of sickness absence the demand for temporary staffing increased by up to 20% during 2017 compared to 2016.

Variable levels of performance and experience are apparent - there is clear evidence of there being significant differences between the performance levels of some teams, including staff and patient experience measures and the resources that are available. Initiatives such as Purposeful and Productive Services and Model Wards, and the products of the TEWV-wide Safe Staffing Programme, ought to assist efforts to reduce the scale of variation between teams and improve performance overall.

Making the most of information technology systems – staff and clinical record systems offer great opportunities to improve the way that we work as individuals and as teams. For example we have used e-learning to help increase statutory and mandatory training compliance from 45% to 90%. We still have more to do to increase staff confidence and competence when using information technology systems to fully realise service delivery benefits. The Digital Transformation Strategy captures our approach to this key issue.

Corporate communications with clinical staff – the most recent Investors in People assessment highlighted that corporate communications with the great majority of TEWV nursing and healthcare assistant staff are proving to be ineffective. The volume of corporate communications, a heavy reliance upon electronic communication, a lack of time for these staff to read corporate communications and a lack of access to computers have been identified as contributory factors.

Environmental Analysis and the drivers for change

The following externally driven workforce issues are expected to have an impact upon delivery of the Trust vision during the next three years:

● Workforce changes in response to the NHS Five Year Forward View are anticipated over the next three years and are expected to affect Integrated Care Systems and TEWV workforce planning.

●The draft mental health workforce plan for England published by Health Education England and NHS England in July 2017 provides for an increased mental health workforce and a basis for regional and CCG based mental health workforce plans up to 2021. The impact of these plans for TEWV ought to become clearer in 2018.

● There are currently national funding incentives (Commissioning for Quality and Innovation) to help improve staff health and wellbeing are available to enhance health and wellbeing policy and practice within TEWV. These incentives help to focus attention upon local health and wellbeing activities and outcomes as well as providing an opportunity to enhance TEWVs financial position by up to £400,000.p.a.

● As part of the public sector TEWV is expected to engage an average of up to 150 apprentices per annum over the next four years. The apprenticeship levy provides opportunities to create new roles for apprentices and to improve access to training for the local population. The associated costs for TEWV are significant, approximately £1m per annum, though there are also opportunities to reclaim much of this amount to invest in TEWV workforce development.

●There are concerns that the numbers of people choosing mental health or learning disabilities nurse training in the future may be adversely affected by the recent national move from bursaries to student loans though the evidence about impact is not yet definitive. The Government commitment to increase nationally the number of health professional training places by 10,000 is expected to increase the demand for placement opportunities and trainee supervision on the part of TEWV and other providers.

● TEWV is a nursing associate 'fast follower' and is piloting 20 nursing associate roles as part of national piloting arrangements. The physician associate role is also being piloted within TEWV. These nationally led developments provide local opportunities to influence the design new roles to enhance service delivery.

● The NHS Improvement review of efficiency and productivity in the NHS, led by Lord Carter, could influence future participation by TEWV in shared services initiatives and help us to better understand how cost effective our clinical and corporate services are.

● The NHS England Workforce Race Equality Standard will be joined by the Workforce Disability Equality standard from 2018/19 as part of national measures to help tackle inequality of access and outcomes. This new measure will further highlight the experiences of disabled staff within TEWV and what we are doing in response to this information.

● The Care Quality Commission has published its equality objectives for 2017-19. Objective 3: Equality and the well led provider highlights the links between equality for health and social care staff and providing good quality care. Future well led inspections of providers will include more focus upon workforce equality issues.

● The national Social Partnership Forum collective call to action, about tackling bullying in the NHS, has an agreed goal for NHS organisations to do more to provide excellent, compassionate leadership in a supportive culture where staff can flourish and problem behaviours disappear. TEWV is a signatory to this call to action.

● National and regional shortages of healthcare professionals are expected to continue for the foreseeable future. Good recruitment and retention policy and practice at local level is more important than ever.

● National mandated reporting requirements including Gender Pay Gap reporting and the annual publication of trade union duties and employer funding reports are examples of the need to dedicate more time and resources within TEWV to gathering, collating and publishing workforce information.

2. Our Vision

To be a recognised centre of excellence with highly quality staff providing high quality services that exceed peoples expectations

3. Objectives

To give ourselves the best chance of making our vision a reality we will:

Implement new approaches to recruitment to increase by 10% each year the proportion of posts filled with high quality candidates in a timely way

We will achieve this by:

Continuously identifying and implementing new values based ways of recruiting staff.

Producing and sharing high quality information with services about recruitment and retention related activities that improves understanding of staff flows into, within and out of TEWV

Offering student placement opportunities as agreed with partner universities

Increasing the use of social media for recruitment purposes by 50%

Involving service user/carer representatives as recruitment interview panel members on 50% of interview panels

Facilitating 'sideways' career moves for staff via a TEWV staff transfer scheme rather than following conventional recruitment processes

We will know that we are achieving this by measuring and reporting the:

% of times that we appoint to healthcare professional posts without needing to re-advertise the post

Average time taken to recruit healthcare professional staff from date of advertisement to unconditional offer being made

% of new to TEWV appointees to healthcare professional roles in a 12 month rolling period that have prior NHS employment

Identify ways to improve our ability to retain staff by 10% each year

We will achieve this by:

Involving staff in decisions about how their work is organised and delivered through participation in quality improvement activities

Continuously reviewing, updating and implementing our approach to rewarding and recognising our staff as described in the TEWV Pay and Reward Statement

Providing flexible working opportunities that meet the needs of our staff and services

Providing education and training opportunities based upon staff and service need

Offering all staff regular values based appraisal/talent conversations

Providing values based corporate and local induction programmes and preceptorship arrangements where relevant

Interviewing all new staff to gather feedback about their work experiences during their first six months of their starting date with TEWV

Offering mid-career reviews to all staff in their forties and fifties

Providing flexible retirement opportunities through the operation of a TEWV retire and return to work scheme

Offering exit interviews to all healthcare professionals who choose to leave TEWV

We will know that we are achieving this by measuring and reporting the:

Overall labour turnover rate

% of staff employed by TEWV for more than one year

% of staff leaving TEWV and the% of leavers where we know the reason for leaving

Implement new ways to increase staff knowledge and skills development

We will achieve this by:

Providing job descriptions that clarify what the expectations of the post-holder are

Develop new roles in response to service need including extending scope of practice and enabling staff to develop new skills to take on enhanced roles and responsibilities

Develop TEWV pre-registration training programmes with universities that meet professional registration requirements

Undertaking values based appraisal, including personal development planning, aligned to team and/or TEWV objectives

Producing and regularly updating a multi-disciplinary TEWV Training Plan based upon feedback from all services

Aligning training budgets and spending with the Training Plan

Developing a TEWV career path that people can take from non-registered to highly skilled and specialist posts

Evaluating the effectiveness of Continuous Professional Development using the Kirkpatrick evaluation model

Using 75% of the TEWV apprenticeship levy contribution to fund eligible education and training activities

Creating opportunities for staff to participate in research and development activities when this will be of benefit to staff and service provision

We will know that we are achieving this by measuring and reporting the:

% of staff able to access non-mandatory training/CPD

% of Training Needs Plan met

Increase workforce supply and service continuity by reducing sickness absence by 14% over the next 3 years

We will achieve this by:

Increasing access to mindfulness training courses for staff

Ensuring that all staff receive high quality supervision

Designing, promoting and providing access to physical activity schemes and weight management support for staff in all TEWV localities

Working with York University to undertake research into the impact of 12 hour shift working on staff health and wellbeing and organisational outcomes

Reviewing and updating the TEWV staff flu vaccination programme to increase take up to more than 70%

Introducing health and wellbeing impact assessments as part of all organisational change initiatives

Managers undertaking daily wellbeing checks with their team members

Undertaking a TEWV-wide review to understand the causes of work-related ill health

Developing a TEWV Bullying and Harassment Reporting and Resolution Procedure and associated training programme

Undertaking evaluations of the impact of TEWV health and wellbeing interventions and support services

We will know that we are achieving this by measuring and reporting the:

TEWV sickness absence rate

% of sickness absence due to stress/anxiety

Demand for occupational health and wellbeing services

Enhance TEWV culture through better staff engagement to improve staff experience and service user experience

We will achieve this by:

Taking action to support staff to report abuse and to minimise the likelihood of abuse being repeated

Using the TEWV ladder of participation (page 16) to design and implement our approach to recruitment, training and quality improvement activities

Putting in place a TEWV-wide network of locality based Freedom to Speak Up Guardians/Cultural Ambassadors

Providing a Black and Asian Minority Ethnic staff leadership and management development programme

Being a ‘Disability Confident’ employer

Producing a clear strategic narrative that tells staff the ‘story’ of TEWVs vision and goals

Designing and delivering training programmes that enable leaders and mangers to coach staff to improve the way that they work and to work with greater autonomy

Refreshing our approach to communications including putting in place a crowdsourcing communication platform for use with staff, service users, carers, governors and partner organisations

We will know that we are achieving this by measuring and reporting the:

Staff FFT results in respect of recommending TEWV as a place to receive treatment, as a place to work, staff motivation at work, staff ability to contribute towards improvements at work and corporate communications

Measuring the extent to which the values of TEWV are being lived every two years

Datix information regarding abuse of staff from other staff and service users, carers and the public

4. Outcomes Scorecard

Workforce Strategy Scorecard							
Metric		Lead Responsible	Baseline 17/18	Targets			
				18/19	19/20	20/21	Source of data
1. Implement new approaches to recruitment to increase by 10% each year the proportion of posts filled with high quality candidates in a timely way							
	First recruitment episode fill rate target for all healthcare professional staff	Beverley Vardon-Odonkor	82.8%	85%	90%	95%	NHS Jobs
	Average time taken to recruit healthcare professional staff from date of advertisement to unconditional offer	Beverley Vardon-Odonkor	11.4 weeks	<11 weeks	<10 weeks	< 9 weeks	NHS Jobs
	% of appointees to healthcare professional roles in a rolling 12 month period with prior NHS employment	Beverley Vardon-Odonkor	55.55 %	>60%	>65%	>70%	ESR
2. Identify ways to improve our ability to retain staff by 10% each year							
	% rolling 12 month TEWV labour turnover rate	Beverley Vardon-Odonkor	10.8%	10%	9%	8%	ESR
	Stability Index – rolling 12 month period	Beverley Vardon-Odonkor	89.2%	92%	93%	95%	ESR
	% people leaving TEWV and reasons known	Beverley Vardon-Odonkor	82.4%	90%	95%	100%	ESR
3. Implement new ways to increase staff knowledge and skills development							
	Staff able to access non-mandatory training/CPD	Kerry Jones	80%	85%	90%	95%	Quarterly Staff Friends and Family Test
	% of Training Plan achieved	Judy Hurst	New measure	75%	80%	90%	Training reports
4. Increase workforce supply and service continuity by reducing sickness absence by 14% over the next 3 years							
	% rolling TEWV sickness absence rate	Beverley Vardon-Odonkor	5.02%	<4.5%	<4.4%	<4.3%	ESR
	% of sickness absence due to stress/anxiety	Beverley Vardon-Odonkor	36.35 %	<30%	<25%	<20%	ESR
5. Enhance TEWV culture through better staff engagement to improve staff experience and service user experience							
	% staff recommending TEWV as place to work	Kerry Jones	71%	73%	76%	80%	Quarterly Staff Friends and Family Test
	% staff that are positive about TEWV corporate communications	Julie Jones	New measure	TBC	TBC	TBC	Quarterly Staff Friends and Family Test
	% reduction in reports of abuse experienced by staff	Sarah Jay	New measure	+ 50%	- 25%	- 25%	Datix reports

5. Glossary

Term	Description
Crowdsourcing	An on-line and face to face communication/engagement facility used to gather and feedback the views of staff, service users, cares, governors and partner organisations about key issues
Datix	An independent electronic incident reporting system used by TEWV
Disability Confident	A national scheme designed to help employers recruit and retain disabled people that TEWV is committed to
ESR	An NHS-wide electronic payroll and workforce information gathering and reporting system used by TEWV
Investors in People	An internationally recognised accreditation standard for better people management used by TEWV
NHS Jobs	A dedicated on-line recruitment service for the NHS used by TEWV
Participation ladder	Defines the different forms and degrees of involvement and participation of service users/carers in TEWV processes e.g. quality improvement, recruitment and training
Staff Friends and Family Test	An NHS-wide staff feedback opportunity that is provided three times per year to all staff within TEWV

Staff compact

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

The psychological or cultural relationship that exists between staff and the trust

Trust	Staff
Communications The trust will strive to ensure honest and timely communications at all times.	**Alignment** To work in accordance with the values of the trust and its strategic goals, mission (purpose) and vision.
Recognition The trust will recognise staff who have achieved excellence and show commitment to value adding work.	**Responsive** To respond to the changing needs of patients and people who use our services, as well as changes to the requirements of other "customers" and changes in demand for services.
Training and development The trust will invest in the continuing professional development, training and education of staff in the skills and competencies required and adhere to all agreed training commitments.	**Technical expertise** To keep skills and competencies up to date and relevant to their work, all of which will be evidence based.
Support The trust will ensure that staff will be involved in and supported through the process of change and managing the process of change.	**Embrace and engage** Willingness to support, co-operate with and contribute to quality improvement activities and especially with the testing of new ideas and innovations.
Work environment The trust will strive to provide a positive, healthy workplace for all staff which is characterised by enthusiasm and not cynicism; staff having the right equipment; the right colleagues and a good physical environment in which to work.	**Team work** To be supportive, positive and a good communicator with staff, people who use our services and all other "customers" e.g. GPs, CCGs, Social Services, etc.
Choice The trust will give staff choices to ensure no compulsory redundancies should job numbers reduce as a consequence of quality improvement activities.	**Flexibility** In the context of significant change taking place in society and the NHS, staff will be flexible with regard to the breadth of work undertaken and the location of their work.
"The trust will endeavour to be a great organisation to work for"	***"My job is to provide the best possible customer experience"***

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Statement of values and behaviours

Commitment to quality

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

Behaviours:

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

Respect

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

Behaviours:

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

Involvement

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

Behaviours:

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

Wellbeing

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

Behaviours:

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

Teamwork

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

Behaviours:

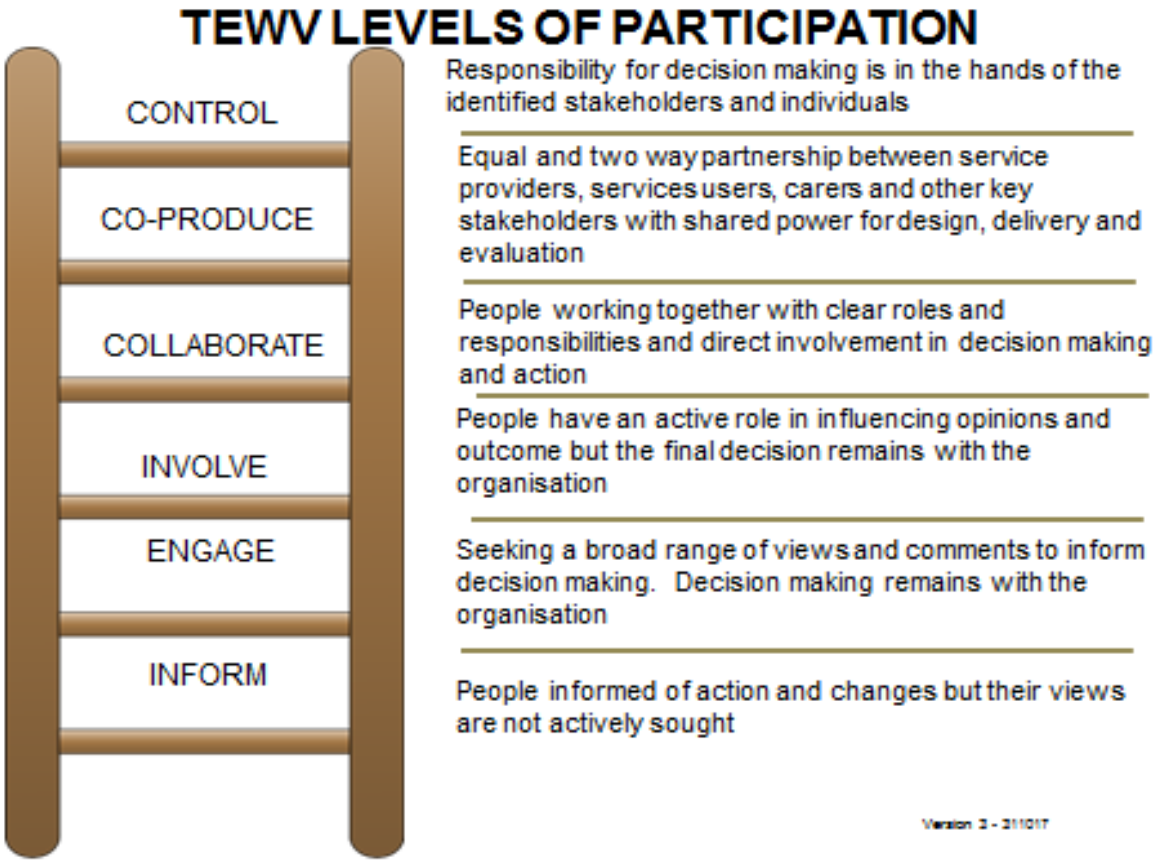
- Be clear about what needs to be achieved and take appropriate ownership.
- Communicate well by being open, listening and sharing.
- Consider the needs and views of others.
- Be supportive to other members of the team.
- Be helpful.
- Fulfil one's own responsibilities.
- Always help the team and its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

Trust Definition of the Levels of Participation

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

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

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



Examples of levels of participation in practice

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

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

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

ITEM NO 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 27 March 2018**
TITLE:	**Report of the Mental Health Legislation Committee**
REPORT OF:	**Richard Simpson, Non-Executive Director**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 3, 2017-18.

- **Key areas for consideration:**
- Report on use of Section 136, Street Triage and CAS activity
- Reports on Discharges from Detention by Associate Hospital Managers and MHT
- Seclusion activity report
- Report on MCA and DoLS update and activity
- CQC MHA specific inspections summary report
- Patient case study
- Review of MHLC and forward planning
- Unlawful detention

Recommendations:

The Board of Directors is asked to:

i) Receive and note the assurance report, following the MHLC meeting held on 26 February 2018 and to note the approved minutes of the MHLC meeting held on 19 October 2017. (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 27 March 2018**
TITLE:	**Report of the Mental Health Legislation Committee**

1. INTRODUCTION & PURPOSE:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for Quarter 3, 2017-18; through consideration of the work of the Mental Health Legislation Committee at its meeting held on 26 February 2018.

2. BACKGROUND INFORMATION AND CONTEXT:

The Mental Health Legislation Committee has been established as a formal Committee of the Board of Directors under the Constitution.

The Terms of Reference of the MHLC require the minutes of its meetings to be formally presented to the Board.

3. KEY ISSUES:

The confirmed minutes of the Mental Health Legislation Committee held on 19 October 2017 are attached as Annex 1.

The MHLC also met on 26 February 2018. The key issues considered at this meeting were as follows:

3.1 Seclusion Report

The Committee discussed the seclusion report.

- In Q3 there were 82 episodes of seclusion with multiple episodes for 19 patients. Of the 83 episodes, 33 (40%) were less than 24 hours and of those, 15 of which were under 12 hours.

Assurance was provided that robust reporting mechanisms are in place for the escalation of prolonged periods of seclusion and there will be further work undertaken around reporting on IIC.

The Committee requested that future reporting around seclusion include data with annual comparisons.

3.2 Discharges Report

The Committee discussed the Discharges report.

- Discharge from detention by either the First Tier Tribunal or the Associate Hospital Managers. In Quarter 3 there were 145 Associate Hospital Managers reviews held which resulted in no patients being discharged from the MHA.

- The total number of Mental Health Tribunals held in Quarter 3 was 138, of the MHTs held, one resulted in discharge from section two, four were discharged from section three (one deferred), there was one conditional discharge and one discharge from a Community Treatment Order (CTO).

The Committee was assured that there were no trends identified in relation to RC or team where a MHT discharges contrary to the clinical view of the team.

3.3 Section 136

The Committee considered data and trends around S136.

- There were 153 uses of s136 across the Trust compared to 188 in the previous quarter. Significant decreases noted in Cleveland and Durham force areas and a slight increase in North Yorkshire.

- Of those, 42 people (44 in the last quarter) were formally detained and 16 accepted informal admissions (compared to 37 in the last quarter)

- Those taken into police custody reduced to zero in December 2017 for all three Police areas. The changes to s136 coming into effect in December 2017 raised the criteria for the use of the police station as a place of safety.

- There were four individuals under the age of 18 held under section 136 one aged 15 and three aged 17.

- There was one under 17 year old held under section 136 for just over 18 hours who was taken to the Acute Trust emergency department due to increased heart rate. It was disappointing that a Section 12 Doctor was unavailable for assessment of this person until the next afternoon.

- No s136 detention exceeded the 72 hour maximum time limit pre 11th December and none exceeded the 24 hour maximum time limit post 11th December.

The Committee expressed their concerns over the delays with the assessment of the under 18 year old and it was noted that there is reluctance for Doctors to undertake assessments without an AMHP present. The other contributory factor was the inability to identify a CAMHS bed for this individual who did eventually transfer to a Children and Young People's services three days later.

Assurance was given that further investigation will take place to understand the processes that were followed around this care and the Committee would be informed at its next meeting.

The Committee noted that the implementation of the changes to s136 made by the Policing and Crime Act 2017, had commenced on 11 December 2017 and the impact of the changes would be considered in more detail at the April 2018 MHLC meeting.

3.4 Mental Capacity Act and DoLS Report

The Committee noted the quarterly update report on the key issues with regards to Mental Capacity Act compliance within the Trust and the use of DoLS.

The key matters discussed were around:

- Further improvements have been made with recording DoLS through the Mental Health Act module in Paris, however there are still some problems with interpretation and application of DoLS where the eligibility criteria is not being used properly by the Local Authorities. Assurance was given that discussions have taken place with colleagues in York and North Yorkshire to improve understanding around this.

- In terms of DoLS activity, in Q3 there were 16 applications made for Standard Authorisations and 13 were granted, the other 3 were withdrawn as they were made subject to MHA whilst awaiting DoLS assessment. There are currently 50 active DoLS cases across the Trust, most of whom are in LD respite services.

3.5 CQC MHA Visits Feedback Summary Report

The Committee considered the CQC MHA Visits Feedback report**.**

- There were six visits to the Trust in Quarter 3 with 30 issues raised in the inspection feedback summaries. The review of the themes raised following visits continued to raise similar issues as in previous inspections.
  The Committee was assured that the Quality Compliance Group would be focusing closely on the issues raised at its next meeting.

3.6 Case Study

The Committee noted a case study in relation to a person who had been subject to long term seclusion within a PICU.

3.7 Policies and Procedures

The Committee approved the following policies and procedures:

- Section 135 (2) Procedure.
- Deprivation of Liberty Safeguards (DoLS) Procedure
- Deprivation of Liberty Policy
- Advance Decisions and Statements Policy.

3.8 Forward Planning for MHLC

The Committee is currently undertaking a review of its terms of reference and it was agreed that further meetings will take place to discuss future reporting arrangements and a revised agenda.

3.9 Department of Health review of Mental Health Act

The Committee noted that the Trust has submitted a response to the Department of Health regarding a review of the Mental Health Act. This was at the request of NHS Providers to be included with their response. Two feedback sessions have also been held with Service Users and Carers as a response to the DH request for services to facilitate this nationally. A report setting out the Trust response and the service user and carer response will be taken to the MHL Committee in April 2018.

3.9 Unlawful Detention

The Committee was informed of an unlawful detention of a young lady from out of the area where the renewal of detention was missed following a complex transfer into TEWV. The appropriate steps to rectify the issue and regain lawful detention were taken and Duty of Candour was complied with. The individual has been offered support to seek legal assistance if they wish.

Assurance was provided to the Committee that a review of all transfers had taken place with no further issues noted and lessons have been learned.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

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

4.2 Financial/Value for Money:

There are no implications.

4.3 Legal and Constitutional (including the NHS Constitution):

Non-compliance with the CQC regulatory framework for the Mental Health Act and Mental Capacity Act and DoLS and/or non-compliance with the MHA or MCA itself would have serious consequences for the organisation and place the organisation at risk of breach of the conditions of the Independent Regulators or potential litigation.

4.4 Equality and Diversity:

There are no implications.

5. CONCLUSIONS:

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

6. RECOMMENDATIONS:

The Board of Directors is asked to:

(i) Receive and note this report including the confirmed minutes of the meeting of the MHLC held on 19 October 2017.

Richard Simpson
Chairman of the Committee

Background Papers:
Annex 1 – Confirmed minutes of the 19 October 2017 MHL Committee Meeting

Annex 1

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 19 OCTOBER 2017 IN SEMINAR ROOM 3, WEST PARK HOSPITAL, DARLINGTON AT 1 PM.

Present:
Mr R Simpson, Non-Executive Director, Chairman of the Committee
Dr N Land, Medical Director
Mr B Kilmurray, Chief Operating Officer.
Mrs E Moody, Director of Nursing & Governance
Mr P Murphy, Non-Executive Director
Mrs S Richardson, Non-Executive Director
Mrs J Illingworth, Director of Quality Governance

In Attendance:
Mrs D Oliver, Deputy Trust Secretary, (Corporate)
Miss M Wilkinson, Head of Mental Health Legislation
Mrs R Downs, Mental Health Legislation Advisor (MCA Lead)
Mr C Allison, Public Governor

Apologies: Apologies for absence were received from Ms S Talbot-Landon, Governor and Ms P Griffin, Mental Health Legislation Advisor.

17/32 MINUTES OF LAST MEETING

Agreed – *That the minutes of the last meeting held on 13 July 2017 be approved as a correct record and signed by the Chairman.*

Mr Simpson, on behalf of the Committee expressed thanks and appreciation to Ms P Griffin for her support to the Mental Health Legislation Committee and wished her well in her future retirement.

17/33 ACTION LOG

The Committee noted the actions and following updates:

17/07 Update to the Committee on the uptake of SOAD's.
It was noted that there were currently two SOAD's with a further two Doctors currently undergoing the training.
Completed

17/15 Seclusion report: Cross check information on Paris with Datix for discrepancies.
Completed

17/19 Ensure that the Food and Drink Strategy and Access and Exit Policy can be found on InTouch.
It was noted that the Access and Exit policy was now available on InTouch and the Food and Drink Strategy was currently under review with Mr Rob Cowell.
Completed

17/24 CQC Report: work underway on the leave module on PARIS – check with NTW CQC inspectors response to previous work they undertook around scanning and documentation.
Completed

17/25 Section 136 report: deeper look over the last 12 months at the under 18's and the length of time they spent in 136.
This matter was covered under agenda item number 5.3, (minute 17/35).
Completed

17/27 Seclusion: pattern of seclusion and gathering data on seclusion to be benchmarked with other Trusts.

Miss Wilkinson noted that this had proven difficult since NTW had not responded and it was likely that this was the most comparable Trust, however she would speak to Mr Lanigan to try and take benchmarking forward.

Action: Miss Wilkinson

17/27b Couple of case studies to be provided from Heads of Nursing demonstrating the complex individuals that may be under long periods of seclusion.
Case studies were circulated for Committee members to provide a deeper understanding around the complexity of individuals and the care required.

The Committee welcomed further case studies to future meetings and suggested that this might be something to consider as a topic for a Governor developmental day.

Action: Mrs Ord

17/34 CARE QUALITY COMMISSION (MHA) VISIT FEEDBACK SUMMARY REPORT

The Committee noted the Care Quality Commission MHA visit feedback report.

In introducing the report Mrs Moody highlighted the following:

(1) There were ten visits to the Trust in Quarter 2 with 28 issues raised in seven reports. The review of the themes raised following visits continued to raise similar issues as in previous inspections.
(2) There were two new Compliance Managers appointed to the team.
(3) The key themes coming from the Mental Health Act visits were being sent to localities on a quarterly basis and were also being discussed at the CQC compliance group.

The Committee was assured that these themes were being addressed with action plans in place that will be monitored by the Quality Compliance Group with a monthly report going to LMGBs to communicate the themes by speciality and locality.

The Committee agreed that there should be formal feedback in six months' time to provide an update on progress to rectify the regular issues that were repeatedly raised at MHA inspections, such as discussion with patients around care plans

Action: Mrs Illingworth

17/35 SECTION 136 REPORT

The Committee received and noted the Section 136 report.

Miss Wilkinson drew attention to the following:

(1) In total there were 44 people (32 in the last quarter) formally detained and 37 accepted informal admissions (21 in the last quarter), an increase of 37 % this quarter.

(2) Those being taken into police custody continued to be low with one to Cleveland, one to North Yorkshire and one to Durham.

(3) There were five under 18 year olds brought to a mental health hospital based place of safety between the ages of 15 to 17.

(4) Street Triage teams were aiming to reduce the number of people detained under Section 136 in the last quarter there were 18 s136's following Street Triage contact for Scarborough and York.

(5) Within the Crisis Assessment Suite (CAS) at Roseberry Park activity continued to be significant with 574 assessments undertaken, an average of 191 per month. 98 individuals were brought 'voluntarily' by the police, 359 individuals self-referred and 41 were admitted to MH inpatient services.

(6) Of the total assessments, 21% were discharged without mental health follow up or sign-posting to other services, this was unchanged from last quarter.

The Committee noted that the implementation of the changes to s136 made by the Policing and Crime Act 2017, would commence from 11 December 2017 and the impact of the changes would be considered in more detail at the January 2018 MHLC meeting.

17/36 MHA DISCHARGES FROM DETENTION REPORT

The Committee considered and noted the MHA Discharges from Detention Report.

Miss Wilkinson drew attention to the following matters:

(1) Discharge from detention by either the First Tier Tribunal or the Associate Hospital Managers. In Quarter 2 there had been 133 Associate Hospital Managers reviews held which resulted in no patients being discharged from the MHA.

(2) The total number of Mental Health Tribunals held in Quarter 2 was 175, of the MHTs held, one resulted in discharge from section 2, four were discharged from section 3 and there had been one conditional discharge.

(3) A new piece of case law around conditional discharge which would be implemented from March 2017 could potentially see patients in the community being recalled to hospital. NHS England would be working with the Trust to look at a test case patient and the implications.

The Committee was assured that there were no trends to be found where a tribunal disagrees with the clinical team to proceed to discharge. The Medical Director gave assurance that on occasion tribunals had been challenged by the Trust where it was felt necessary due to risk.

17/37 SECLUSION REPORT

The Committee considered and noted the Seclusion Report.

Miss Wilkinson highlighted the following:

(1) There had been 83 episodes of seclusion involving patients with multiple episodes for 15 patients.
Of the 83 episodes, 26 (31%) were under 24 hours and of those, 9 of which were under 12 hours.

(2) Of those in excess of 24 hours, the longest was just under 39 days, however there has one patient who had been in long term seclusion since 15 August 2016.

The Committee was assured that where seclusion was used for prolonged periods, risk assessments were undertaken and patients may be allowed to receive visitors, brief periods of access to secure outside areas and meals in the general ward areas.

17/38 MENTAL CAPACITY ACT AND DOLS REPORT

The Committee received and noted the Mental Capacity Act and DoLS Update Report.

Arising from the report it was noted that:

(1) The recording DoLS was now operational on the new Paris module.

On this matter it was noted that it would be crucial that in obtaining compliance within the legislative requirements and for the reporting of accurate statistical information that there was support not only from the Nursing and Governance Directorate but also within Operational Services in their key role as care providers.

(2) The Champions programme had been going well and it was anticipated there would be 20 trained Champions across the Trust by the end of the year.

(3) There was ongoing concern around the interpretation of DoLS when applying the eligibility criteria, with problems arising in some Local Authorities across the localities, particularly in York and North Yorkshire, where the eligibility criteria around DoLS was not being applied correctly.

Following discussion the Committee agreed that this matter should be escalated to Director level for further consideration around the implications for TEWV and the potential for unlawful detentions and consideration be given to working with Beachcroft Solicitors to try to resolve the issues.

Action: Mrs Moody

17/39 HUMAN RIGHTS, EQUALITY AND DIVERSITY POLICY

The Committee received the revised Human Rights, Equality and Diversity Policy for consideration.

Mrs Jay highlighted the following:

(1) Section 3.15 of the Mental Health Act Code of Practice stipulated that providers should have in place a human rights and equality policy for service provision in relation to the Act, which should be reviewed at Board level at least annually.

(2) For assurance purposes it was recommended that in order to comply with the requirements of the Mental Health Act Code of Practice around the monitoring of equalities there would be annual publication of equality information including analysis of detentions under the MHA by gender and ethnicity.

(3) The report proposed that the MHL Committee monitor the action plan arising from compliance with the Policy.

Following discussion the Committee did not feel that it was within the terms of reference of the Committee to monitor the action plan arising from compliance with the policy.

The Committee recommended:

> *That the Human Rights, Equality and Diversity Policy be presented to the Board of Directors for formal ratification at its meeting to be held in January 2018, subject to a caveat around the governance arrangements for the monitoring of the action plan, which should be picked up through the Equality and Diversity Steering Group.*

17/40 ANY OTHER BUSINESS

MHLC Development Workshop

It was noted that the Committee would hold a Development Workshop immediately following the meeting to discuss future reporting and assurance to the Committee.

Case Studies

The Committee received and noted two case studies on patients requiring long term seclusion and agreed that future case studies should be presented to the Committee on those patients that had been in seclusion for the longest periods of time.

Action: Mrs Moody

ITEM 12

BOARD OF DIRECTORS

DATE:	**27th March 2018**
TITLE:	**Proposed actions in response to the abuse of staff**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Consultation and Decision**

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

Executive Summary:

This report provides Directors with an update about progress made with developing a new approach to taking action when service users are abusive toward TEWV employees. This is an important issue and is work in progress. It is vital that a well thought through approach is developed to responding to what can sometimes be complex and difficult situations.

The views of Directors are sought about a number of related matters that are highlighted in the report including a draft Zero Tolerance Statement and a draft process that describes how instances of abuse toward employees by service users could be responded to.

Recommendations:

1) To note the progress made to date with this developing issue
2) To comment upon the draft statement in Appendix 1
3) To comment upon the draft process described in Appendix 2
4) To receive an update at the July 2018 meeting

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**27th March 2018**
TITLE:	**Proposed actions in response to the abuse of staff**

1.0 INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide Directors with information about the outcomes of the event held in January that considered how the Trust should respond when staff report being verbally abused by service users or carers.

2.0 BACKGROUND INFORMATION AND CONTEXT:

2.1 The Workforce Race Equality Standard (WRES) has highlighted that Black Asian Minority Ethnic (BAME) staff experience higher levels of harassment, bullying and abuse from patients, relatives and the public than White staff. The latest figures (2017 staff opinion survey) tell us that 28% of white staff and 34% of BAME staff have experienced bullying, harassment and abuse from patients, relatives and the public.

2.2 The Board seminar in December 2017 included attendance by three BAME staff who each described their experiences of racial abuse when working within TEWV and a lack of effective action on the part of managers and TEWV as the employer. The Board of Directors committed to the development of a trustwide process to address this issue for all staff, regardless of ethnicity, recognising that all staff can experience verbal abuse.

2.3 In January 2018 a TEWV-wide event was held, with twenty four participants including five BAME staff. The purpose of the vent was to develop proposals to help address the issue of staff being verbally abused by service users or carers. The event included attendance of representatives from forensic services, older people's services, learning disabilities services, adult mental health services, the heads of nursing, the medical consultant body, Positive Approach to Training (PAT) trainers, the Health and Safety team and the Equality Diversity and Human Rights team.

2.4 The issue of how best to respond to abuse of staff by service users was the subject of consultation with members of the TEWV leadership and management networks during February 2018.

3.0 KEY ISSUES:

3.1 Participants at the event in January 2018 highlighted the amount of verbal abuse that they experience at work and how this had become normalised. There was strong agreement amongst participants that TEWV needs to develop an effective way of addressing and reducing instances of abuse of staff by service users, relatives and the public and that the approach taken

should receive clear support from the Board of Directors and the Executive Management Team.

3.2 TEWV manages and supports service users who behave in ways that challenge through the use of the Person Centred Behaviour Support Policy. Behaviours that challenge include physical and/or verbal aggression. The proposals being developed to help better address instances of verbal abuse on the part of service users ought to complement the person Centred Behaviour Support Policy.

3.3 A draft statement about TEWV adopting a zero tolerance approach to aggression, violence or intimidation has been developed and can be found in Appendix 1. The intention is to display such a statement on the TEWV website and within all TEWV service areas. The views of Directors about this draft statement are welcomed.

3.4 It is proposed that a written compact is developed between TEWV and service users and carers that will clarify the behavioural expectations of staff, service users and carers. It is proposed that the development of this compact is undertaken on the basis of consultation with staff, service users and carers over the coming months.

3.5 A standard TEWV process that could be followed when a member of staff is verbally abused by a service user is described in Appendix 2. This proposed process will require consultation, including with the Executive Management Team and clinical services, and the views of Directors are welcomed. Amongst the issues that require further consideration is whether written TEWV-wide guidance is needed about when a service user could be safely moved to another service location or discharged. During the consultation events staff expressed concern about how the risks to the service user, particularly if they were very unwell and/or an inpatient, could be balanced with the risk of further psychological harm to the member of staff who is abused.

3.6 Consideration needs to be given to the challenges of using the Datix system to report abuse incidents. Issues identified include:

- If not at work at the time of the incident the team manager might not be aware immediately on their return that an incident has occurred as they need to look for incident
- For a victim to complete a Datix report immediately following an incident can be re traumatising. Could this be done by other staff?

3.7 It is suggested that a standard reporting tool could be developed as an alternative to the Datix reporting system to record abuse incidents and their subsequent management. Views about developing a bespoke reporting tool will be sought and the opinions of Directors welcomed.

3.8 During the consultation process staff identified that verbal abuse can also be initiated by carers and relatives. This issue can occur in all services and is

particularly difficult to address when the patient does not have capacity due to illness or age. In response it is proposed that:

- Relatives and carers are involved in the development of a compact as described in paragraph 3.4
- A process for addressing abuse by relatives and carers is developed

3.9 Event participants highlighted the importance of police involvement when appropriate and the difficulties that some services have experienced with securing prosecutions when these are thought to be appropriate. Some locality representatives reported particularly good relationships with police liaison services. The need to improve engagement with the police about this issue was agreed by event participants and views will be sought about how to do this. The views of Directors are welcomed.

3.10 Following consultation about the process described in Appendix 2, and any subsequent amendments, it is planned to provide training sessions for all ward managers, community team managers , modern matrons and locality managers/ deputy managers during 2018/19. The provision of this training will help to raise awareness of this important issue and provide participants with more knowledge and confidence to feel better able to take actions in response to reports of abuse.

3.11 There are a number of options for the future location of the process when it is agreed and these include:

- As part of a Zero Tolerance Policy
- Inclusion in the relevant parts of the Criminal Incident Reporting Policy
- Inclusion in the Person- Centred Behavioural Support Policy
- Inclusion in the Bullying, Harassment and Conflict Resolution Policy

3.12 The views of the Directors are sought on the placement of the process once it is fully developed and agreed.

3.13 The proposed process will be considered by the Executive Management Team in April 2018 and the intention is that the compact and associated policy developments will be completed by June 2018.

4 IMPLICATIONS:

4.1 **Compliance with the CQC fundamental Standards:** It is a requirement of the CQC fundamental standards that the Trust meets its obligations under the Equality Act 2010 and the Human Rights Act 1998.

4.2 **Financial/Value for Money:** Financial penalties can be incurred for non-compliance with the legislative requirements of both the Equality Act and the Human Rights Act. This may also result in reputational loss for the Trust

4.3 **Legal and Constitutional (including the NHS Constitution):** The Trust must demonstrate compliance with statutory equality and humans requirements. Failure to do so may result in legal action and subsequent financial penalties and damage to the Trust's reputation as both an employer of choice and a provider of quality healthcare.

4.4 Equality and Diversity: The Trust must demonstrate compliance with statutory equality requirements and failure to do so may result in legal action and subsequent financial penalties and damage to the Trust's reputation.

4.5 Other implications: None identified

4.4 **RISKS:** None identified

5 CONCLUSIONS:

5.1 The issue of supporting staff by taking action in response to abuse from service users directed at employees is an important and complex one. The consultation process undertaken to date has highlighted the importance of achieving the right balance between challenging service users behaviour when it is poor and supporting employees who are the subject of abusive behaviour. Further consultation is required over the coming months to help ensure that the approach taken within TEWV in the future is well founded and the importance of moving with pace to address this issue is recognised.

6 RECOMMENDATIONS:

6.1 To note the progress made to date with this developing issue

6.2 To comment upon the draft statement in Appendix 1

6.3 To comment upon the draft process described in Appendix 2

6.4 To receive an update at the July 2018 meeting

Sarah Jay
Head of Equality and Human Rights

David Levy
Director of Human Resources and Organisational Development

Background Papers:

APPENDIX 1

ZERO TOLERANCE PROCESS

Tees, Esk and Wear Valleys NHS Foundation Trust believes that any act of aggression, violence or intimidation, both physical and non-physical from any member of staff, service user, carer, visitor or member of the public is unacceptable. The trust is committed to the creation of a culture and environment where employees can undertake their duties without fear of abuse or violence.

As an organisation, we are committed to introducing measures, through the Zero Tolerance Policy and relevant guidelines, to reduce risk and to have procedures in place that enable staff to manage and respond appropriately to an aggressive, violent or abusive incident should it arise.

Lesley Bessant

Trust Chairman

Colin Martin

Trust Chief Executive

APPENDIX 2

PROCESS FOR RESPONDINGTO ABUSE OF STAFF BY SERVICE USERS

1. Initial verbal abuse of an employee by a service user

1.1 Incident of verbal abuse of staff by service user reported verbally to the employees line manager and using incident reporting system.

1.2 A decision about the service user's capacity will be made and if they are believed to have capacity the following process to be followed.

1.3 The line manager will take responsibility for action in relation to the service user and employee including any reporting or escalation of the incident that is additional to Datix system reporting

1.4 The line manager, or designated deputy, immediately tells the perpetrator about the report of their behaviour, that this has been noted and that such behaviour is not acceptable. The victim should not have to challenge the perpetrator about the alleged incident unless absolutely unavoidable. A designated senior manager will have a face to face discussion as soon as possible with the service user, during which the service user will be given the opportunity to explain their behaviour and actions. The behaviours expected will be clearly described and a written agreement will be produced detailing the behaviours expected of all parties.

1.5 During the Multi-Disciplinary Team (MDT) meeting an intervention plan will be developed for the behaviour that the patient has exhibited using the Positive Behavioural Support (PBS) framework.

Further episode(s) of verbal abuse

1.6 A senior manager will meet with the service user and explain that if the behaviour continues the trust will need to make changes to the way their (the service user's) service is delivered. It is recognised that there will be circumstances when making such changes could be more difficult. This meeting will be followed up by a letter to the service user confirming the discussion and any outcomes.

Potential discharge or move to an alternative location

1.7 Should the abuse continue the trust will consider discharging or moving the service user to an alternative location and may contact the police to inform them of the service users behaviour to enable a decision to be made about whether criminal proceedings ought to be pursued. Any decision about a service users potential discharge, relocation or referral to the police will be made by the MDT having considered all relevant factors including risk and Mental Health Act status.

Support for the member of staff affected and the rest of the staff team

2 Support for member of staff who has been abused to include:

- Debrief immediately following incident and offered the opportunity to take a break from the ward or team. Recognise what has taken place and take seriously the psychological impact of verbal abuse. Verbal abuse should not be normalised or minimised.
- Encourage staff to report abuse
- Encourage and support staff to go to the police should they want to and to support any prosecution
- Offer additional supervision – possibly with someone who is not part of staff team
- Consider offering peer support
- Should abuse be repeated carry out a stress risk assessment and develop a support plan
- Make staff aware that they can access the Employee Support Service, the counselling service, the Employee Psychology Service
- Provide staff with a safe space to talk and allow them to express the full impact of abuse upon them

3 Offer de-briefs to other staff team members and support them to challenge and manage the service users behaviour and give support to the member of staff affected.

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 13

FOR GENERAL RELEASE / CONFIDENTIAL

BOARD OF DIRECTORS

DATE:	**28th March 2018**
TITLE:	**Self-Assessment Report in relation to Multi-professional Education and Training**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Sign off**

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 attached report is the comprehensive Self-Assessment Report (SAR) required as part of the Health Education England educational governance process for non-medical multi-professional education and training
- It is an annual requirement to submit this multi-professional return. Information is requested from all non-medical professional leads , and the Workforce development team, and consolidated into a single report by the Nursing and Governance Directorate
- The information is assessed by HEE and then ordinarily taken to a scrutiny meeting with HEE colleagues for further questions and assurance, known as the Annual Dean's Quality Meeting (ADQM)
- There is a separate but parallel process for reporting on Medical education.
- As part of the governance process for this report, HEE ask that an Executive Director signs off the non-medical training report and it is presented to the Trust Board.
- On this occasion, the joint ADQM meeting was cancelled by HEE, and we subsequently received notification that they were sufficiently assured by the Trust's approach not to require to rearrange the formal meeting, but to send a written report and hold an informal meeting with the Trust later in the year to discuss any remaining issues.

Recommendations:

The Board are recommended to receive and endorse the multi-professional SAR report attached, and note the positive interim response received from Health Education England

MEETING OF:	**Board of Directors**
DATE:	**28th March 2018**
TITLE:	**Self-Assessment Report in relation to Multi-professional Education and Training**

1. INTRODUCTION & PURPOSE:

1.1 This paper summarises the process around the attached report, which comprises the Trust response to the annual Health Education England education assessment process for multi-professional (non-medical) training

1.2 As part of the governance framework for this process, it is required that there is Executive sign off and that the report has been reviewed by the Trust Board

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Heath Education England (HEE) require a comprehensive assessment from provider Trusts of the quality of the training and educational environment provided to our learners. There is comprehensive guidance on the level of evidence required, which the Trust complies with. This includes attachments of various policies, training formats and content, and overview of processes.

2.2 the information is compiled by the Nursing and governance Directorate following information exchanges with the various Heads of Profession, the Workforce Development team, and research and Library services. There is a parallel but currently separate process for reviewing medical education, HEE are seeking to bring this increasingly together (for example with a shared ADQM meeting) and colleagues internally work together on the meeting.

2.3 The multi-professional information SAR is reviewed externally by HEE including the involvement of their own professional advisors in certain fields. Questions are framed regarding the Trust response for further clarity

2.4 Ordinarily the report and these questions are taken to an Annual Dean's Quality review Meeting chaired by HEE (ADQM) for further scrutiny and discussion. The meeting is attended by a small team of professional heads and HR colleagues from the Trust. On this occasion the original ADQM meeting was postponed.

2.5 Subsequently the Trust received a message from HEE to the effect that they were sufficiently assured by the Trusts approach not to require to rearrange the formal meeting, but instead to send a written report and hold an informal meeting with the trust later in the year to discuss any remaining issues

3. KEY ISSUES:

3.1 The attached report is a substantial document with multiple embedded attachments, which requires considerable time to co-ordinate. However we have received good verbal feedback from HEE on the approach we take, and are aware some other organisations have been asked to provide further evidence in the past. HEE are trialling a slightly different approach currently where some information is collected directly from professional leads, we will review our approach during the year in the light of this.

3.2 The report illustrates the wide range of work required to maintain educational standards across the various professions, and a governance framework to support this.

3.3 The key challenge highlighted within the report refers to maintaining Mentor numbers and clinical placements across the Trust for the increasing numbers of learners, this remains an ongoing issue which we strive to achieve as detailed in the Challenges section however the standard is currently being met as described therein. Increasing our uptake of the more limited post-graduate training menu is a further focus for us.

3.4 In terms of future development, it is recognised that greater work is required in the field of Simulation-based training, and there is a sub-group of the Education and Training Steering group set up to look at multi-disciplinary approaches to this, jointly with Medical Education colleagues. This method of training is increasingly a focus within future models of Nurse education linked to the forthcoming NMC standards.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
The focus on safe staffing increasingly requires evidence of staff having the right skills, and a strong education development framework is a key component of this. CQC standards inform the ongoing placement assessments and any issues are raised with the Universities and HEE.

4.2 **Financial/Value for Money:**
The Trust receives a tariff for its role in supporting pre-registration training and this assessment report is part of the governance framework around that income and expenditure.

4.3 **Legal and Constitutional (including the NHS Constitution):**
The SAR document relates to several areas of the Constitution , including not least the principle that; 'The NHS aspires to the highest standards of excellence and professionalism'.

4.4 **Equality and Diversity:**
The SAR assessment incudes factors relating to equality and diversity.

4.5 **Other implications:**

5. RISKS:

There is a potential risk to the organisation were it receive an adverse report from HEE on the standard of education and placement practice. This would have reputational damage and also limit our ability to offer educational placements which are a key part of our future recruitment strategy. The attached report reflects our processes to manage this risk within the organisation.

6. CONCLUSIONS:

6.1 The attached report is the comprehensive Self-Assessment Report required as part of the Health Education England educational governance process for non-medical multi-professional education and training.

6.2 It is an annual requirement to submit this multi-professional return. Information is requested from all non-medical professional leads , and the Workforce development team, and consolidated into a single report by the Nursing and Governance Directorate.

6.3 The information is assessed by HEE and then ordinarily taken to a scrutiny meeting with HEE colleagues for further questions and assurance, known as the Annual Dean's Quality Meeting (ADQM). There is a separate but parallel process for reporting on Medical education.

6.4 As part of the governance process for this report, HEE ask that an Executive Director signs off the non-medical training report and it is presented to the Trust Board.

6.5 On this occasion, the joint ADQM meeting with medical colleagues was postponed by HEE, and we subsequently received notification that they were sufficiently assured by the Trust's approach not to require to rearrange the formal meeting, but to send a written report and hold an informal meeting with the Trust later in the year to discuss any remaining issues.

7. RECOMMENDATIONS:

7.1 The Board are recommended to receive and endorse the multi-professional SAR report attached, and note the positive interim response received from Health Education England.

Name Stephen Scorer
Title Deputy Director of Nursing

Background Papers:

2017 SAR Report for Health Education England

Tees, Esk and Wear Valleys
NHS Foundation Trust

2017 Self-Assessment Report (SAR)

Multi-professional Education and Training

(excluding Postgraduate Medical & Dental Education*)

Reporting Period: 01 August 2016 to 31 July 2017

Deadline for submission to HEE NE – 15 December 2017

Trust's name:	Tees Esk and Wear Valley Foundation Trust
Trust Chief Executive's name:	Colin Martin
Non-Medical Education & Training placement tariff received from HEE NE for 2016-2017:	£624,008
Director of Education's name (or equivalent, please state job title):	Elizabeth Moody, Director of Nursing and Governance
Report compiled by:	Stephen Scorer/Jane Buckle
Report signed off by:	Elizabeth Moody, Director of Nursing and Governance
Date signed off:	20/12/2017
Board Approval: 1. **Date seen at or scheduled for Board meeting** 2. **Approved by / on behalf of the Trust Board: (date / details)**	Scheduled for February Trust Board. Elizabeth Moody has been involved as Executive Lead

The SAR is aligned to the HEE Quality Framework and from 2018 will be linked directly to the LDA:

https://hee.nhs.uk/our-work/planning-commissioning/commissioning-quality

** Please note there is a separate 2017 SAR process for Postgraduate Medical & Dental Education.*

Organisation overview linked to HEE Standards

1. Successes the organisation is most proud of achieving during the reporting period

*This section should be used to document a **high level summary** of the successes your organisation is most proud of achieving during the reporting period and highlight any challenges or important issues you would like HEE NE to be aware of now.*

Domain 1 Learning Environment and Culture *For additional guidance refer to HEE Quality Framework, page 10*
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users. 1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours. 1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence based practice (EBP) and research and innovation (R&I). 1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative. 1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge. 1.6 The learning environment promotes inter-professional learning opportunities.
Response: • TEWV NHS Foundation Trust has an overall rating from the CQC of Good. http://www.cqc.org.uk/provider/RX3. • Staff surveys are used to review the Trusts position against national benchmarks for working environment and produce focussed action plans. This includes improving links to staff engagement and the employee support service • The Trust has a Recovery Programme as a Board priority, within the Annual Plan, which focuses on the principles of well-being and person-centeredness, highlighted through the CHIME factors – Connectedness, Hope, identity, Meaning and Empowerment. The key strands of the Trusts programme approach are; - Culture to be more recovery focused. - Embed coproduction at all levels. - Move from risk averse perspective to consider long term harm minimisation - Establish Recovery Colleges – promote empowerment & self-management A recent presentation on the recovery programme is attached as further information and evidence • The Trust has a substantial Staffing and Workforce Programme, based around the NQB 2016 guidance “Right Staff, Right Skills, Right Place and Time” and the subsequent more specific draft guidance for Mental Health and Learning Disability Services. This programme has recently expanded from its initial focus on in-patient settings, to include a strand focussing on Workforce development issues across all settings and disciplines, and includes medical colleagues in its development. A joint approach to recruitment, retention and development will be a major focus of the programme which is also a Trust Board Priority • TEWV has a high national profile around Quality Improvement System with a

substantial Kaizen Production Office component. Staff have access to QIS training and support on a number of levels: Certified Leader Training: QIS for Leaders: QIS for Admin. Learners of all levels and disciplines have opportunity to engage with QIS events: Kaizen: 3 P events (Production, Preparation, and Process): RPIW (Rapid Process Improvement Workshop. Teams are involved in the production and testing of ideas in a collaborative process with structured report-out of progress

- Each HEI provides details of raising and escalating concerns: Evidence is found within the student handbook: The Trust reinforces the expectations they have of students to raise and escalate concerns; student responsibility for raising and escalating concerns whilst in practice placement; expectation that students will work to the spirit of the professional Codes whilst in practice placement; This is evidenced through Home Trust Student Induction – for nursing students. All Learners have access to Trust Policies Whistle Blowing Policy, Freedom to Speak Up through the Trust intranet site
- The Trust has an internal Leadership and Management Development Programme LMDP aimed at supporting Trust managers and those aspiring to become managers and leaders to be effective role models and to enhance practical skills in the Trust core value based leadership approach
- TEWV has a major programme of Coaching Developments, with a structured approach of various levels of coaching seniority and support framework. The coaching style is used to frame high-quality questions within the organisation . The coaching training is available to every member of staff in the trust and is encouraging inter professional working.
- TEWV library and information service exists to help staff and all students on practice placement experience d information to support them in the in the workplace and in their educational activity related to their role in the Trust. The service offers help with books, searches, journal articles, documents, current awareness and useful websites. All web resources can be accessed on smart devices via the web based pages on Protopage except for In Touch. There are library services available in Durham: Middlesbrough: Scarborough: Darlington. The service has a generic e mail tewv.library@nhs.net. Library Services facilitate access to Personal NHS Open Athens Accounts: Online Library Catalogues and Book Requests: Healthcare Databases: electronic journals: NICE Apps – BNF, BNFc, Guideline
- TEWV has implemented and embedded the National Care Certificate to provide assurance that all care staff have achieved a minimum standard of competency. The booklet provides information and guidance for Health Care Assistants and managers.
- The Health Care Assistant Framework embedded in TEWV inpatient areas exceeds minimum standards and is being rolled out across community services.

Additional Nursing factors

1.1 The learning environment is evidenced through educational audit for Teesside University and University of York, also through student evaluation (TSD evidence), Arc Pep and PPQA
Student evaluations reflect student perceptions of the learning environment

1.2 Comment is as above

1.3 All pre-registration nursing students have 2 week placement in year 3 for service improvement. Some students on the service improvement placement will have the opportunity to spend this time with the KPO team and some with the research team. This promotes an understanding of the nurse's role in service/quality improvement
Student induction includes session from peer support worker and service users
Students from U of Y are supported in practice 5 with service improvement project – session delivered at U of Y by KPO team

1.4 Service users and carers deliver a session for new student nurses on the Home Trust

Induction, also are involved in the multi professional preceptorship programme for newly registered professionals to provide an opportunity to learn from the experiences of service users and carers

1.5 Students receive timely training in PARIS system. Dedicated laptops provided to students in recent move to HH in York.
Students receive timely training in PARIS system. Dedicated laptops provided to students in recent move to HH in York.

1.6 Students are exposed to inter professional learning opportunities in practice placement

Psychology

- All trainees start with an induction period in the Trust environment where they complete the core induction, and mandatory and stat training.
- They are offered the opportunity to complete organisational placements in their third year and all trainees have to maintain some organisational competences across the three years of training.
- The local psychology doctorate at Teesside has just been through an accreditation process and received special commendation on the quality of its leadership teaching which is predominantly provided by TEWV staff.

Workforce Development

- An Investors in People visit is scheduled for December 2017, so hope to add the outcomes from this to the SAR after the visit, or update in advance of the next ADQM meeting.
- Following on from Friends and Family Test staff results we have introduced social safeness training for staff. We have undertaken Health and Wellbeing sessions in October 2017 and met 200 staff.
- We have established a TEWV YouTube video site and one of the videos has a topic of Compassionate Care and Social Safety.

Physiotherapy

- Students are involved in any planned or unplanned learning opportunities that arise on their placement. They work in multidisciplinary or integrated teams either in the community or on wards and so often access learning with other professions.
- Students have access to trust libraries, and have network and internet access and usually are guided in their learning topics related to the placement and often given planned study time to complete mini projects. They are encouraged to present their learning to their work place colleagues – doing a presentation at professional meetings.
- Learners can also be involved in any opportunities outside of the immediate placement e.g. students placed with older peoples service at Roseberry Park Hospital have the opportunity to do 1 day a week on the forensic unit thus extending their learning opportunities.

Occupational Therapy

- OT Students receive specific training in our electronic records system at the beginning of placement
- Students receive additional security training at the beginning of placement in forensic areas
- All students complete the student induction in the OT student handbook
- Students are encouraged to complete SWOT analysis on starting placement and/or bring their current University learning plan so that learning needs can be worked on continuously between placement and University learning, and student strengths can be used on placement where appropriate and possible

- Students are expected attendees at and contributors to OT learning and governance networks monthly, and are encouraged to present/lead a part of these sessions at least once during placement. The breadth and types of learning opportunity are demonstrated via the terms of reference embedded below
- Students are encouraged to lead on the setting of their own objectives and to reflect on their own learning throughout placement and to use a variety of models of reflection – see embedded list of reflective models below
- Students are supported if in agreement with their educator through the use of standard TEWV objectives and supporting forms linked to university objectives – see embeds below for example/s – These have been developed for Teesside and YSJ MSc and BSc courses but have not yet been developed for Northumbria due to the very small number of students we take from Northumbria University
- Students are encouraged to use outcome measures in practice and this includes the use of our OT patient experience measure. As well as GAS light, MOHOST, OSA, COSA, SCOPE which we have available on the PARIS electronic system
- All students have access to TEWV library services, and depending on placement location the resources of other local Trusts
- Student placements are in majority in multi-disciplinary teams and OT students are encouraged to spend time with other professionals to gain an understanding of their work, the therapies and interventions they provide, and to identify any overlap areas with occupational therapy provision and practice
- Students may complete short pieces of project/development work whilst on placement, linked to the placement speciality e.g. group development, audit work, compiling service evaluations

Dietetics

- Students attend TEWV for a maximum of 12 weeks. During this time they are involved in direct clinical work and have opportunities to work with numerous other professionals to gain knowledge of the role of the MDT.
- Students on the first placement are asked to carry out a catering project on the food provision in the Trust.
- Students on the year 2 and 3 placements are asked to carry out a care plan presentation on a specific area of dietetics or patient case study.


AB organisational approach to recovery


leadership and development network


Agenda PPCS PB December 17 DRAFT

2.1. The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.
2.2. The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.
2.3. The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.
2.4. Education and training opportunities are based on principles of equality and diversity.
2.5. There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.

Response:

- The mission statement and strategic objectives of TEWV are explicit in supporting an effective developmental environment and culture. This relates to all staff and learners.
- The Education and Training Steering Group , is multi-disciplinary in nature and

ensures that the Trust has a Learning and Development Training Plan. This links in to the Workforce and Development group which itself reports to the Executive Management Team

Additional Nursing factors

2.1 TSD scorecard reporting on the quality of placements evidenced by student nurse evaluations has a target performance rating of 95%, this is reported quarterly to the trust board and is achieved

2.2 Partnership activities with education providers

2.4 There are established policies relating to equality and diversity, all employees of the trust must complete training on an annual basis. There are protocols in place at the HEIs to support and manage students with disabilities, including making reasonable adjustments to support students in the HEI and in the clinical practice placement. The annual nurse mentor update includes supporting and managing students with disabilities as standard and is an NMC requirement for the updates. This provides nurse mentors with opportunities to stay up to date with policy and legislation relating to equality and diversity, it reinforces the requirement to create reasonable adjustments to support students with disabilities in practice and also promotes peer support.

2.5 There are established procedures to manage performance issues with learners including a cause for concern policy – this is also a standard topic in the annual mentor update. This provides nurse mentors with the relevant information and also to give and receive peer support. In addition to the annual mentor update, the Practice Placement Facilitators offer an optional workshop 'supporting the underachieving student', providing mentors with support and/or improving knowledge and confidence in managing students who are poorly performing. There is also a standard process to identify student nurses who are involved in reported incidents in the trust via Datix. The PPF follows up with the student and the clinical team on any safety concerns and creates a report for the appropriate HEI.

Psychology

- Trainees are actively supported by both clinical and academic staff when there are concerns about standards or competence.
- Placements are evaluated through a standard audit and the process of feeding this back to clinical services has been the subject of debate this year between clinical and academic staff, with a commitment to address any problems together.
- When trainees are struggling with placements for personal reasons the course and TEWV work together to provide a supportive learning environment

Additional Workforce Development

- The trust has undertaken Health and Wellbeing sessions in October 2017 and met 200 staff.
- There is an established TEWV YouTube video site and one of the videos refers to Compassionate Care and Social Safety.
- An Investors in People visit is scheduled for December 2017, so we hope to add to the SAR after the visit, or update in advance of the next ADQM meeting.
- Following on from Friends and Family Test staff results the Trust has introduced social safeness training for staff. We have undertaken Health and Wellbeing sessions in October 2017 and met 200 staff.

Physiotherapy

- If a student is involved in a patient safety incident they are supported to report it through DATIX and to report it to the university, they are also given debriefing and encouraged to reflect on their experience. They are given additional supervision if required during which any performance issues are explored.

Occupational Therapy

- Liaison with relevant Universities re; NHSLA requirements for OT students now allows for smooth processes – see headings for information collated re; all students prior to placement via spreadsheet embedded below
- All B6 therapists are expected to take students as part of job description and we aim for 20 weeks of student education per year per WTE and we monitor against this
- We aim for one student only in a placement area at a time to ensure staff members have capacity to give students a quality placement. An educator having more than one student at a time has been successful in the past, however resources e.g. space and computer access has been a limiting factor.
- Move to whole academic year student placement allocation for Teesside OT students has been successful and is now used for YSJ and Northumbria – full offers are made for the academic year ahead and the Universities allocate into these over the academic year. There are some changes throughout the year, but the year ahead offer system allows a baseline to work from. The offers are made following discussion with the Universities re; how many placements they need and how many of these are in-patient or community – TEWV is one of first organisations to pilot and go live
- Bespoke training in PARIS electronic record organised for OT students to match dates placements start and number of offers made to each cohort.
- Bulk upload system for student access to PARIS teams and also to relevant share drives agreed with IT helpdesk
- Vast majority of student evaluations positive/no issues – evaluations raising areas of concern are addressed individually with educators through clinical/professional supervision structures and include line manager where necessary – we are no longer able to maintain a central issues log as educators access their feedback individually and it is not sent to a central area – only feedback of particular concern is fed through to the Trust Professional Head of Occupational Therapy for discussion and action, so oversight in the same way as previous is no longer possible.
- Volume of placements provided is a strength
- Flexibility when placement changes are required is a strength, and TEWV try to rearrange within Trust and offer like for like placements where changes are needed due to TEWV changes/requirements
- OT students encouraged to lead sessions in the relevant OT learning and governance network for their clinical area – see above section for terms of reference
- Use of multi-professional roles forms after time spent with other team members introduced as part of TEWV standard OT student objective support documents (one set linked to Teesside students and one to YSJ students – similar for Northumbria, not yet complete)
- OT learning an governance networks fully embedded across all areas – students contribute and attend alongside staff members – see above section for terms of reference
- Educational meeting feedback is given through OT clinical leadership structure and issues re; student education raised via this forum or via clinical/professional supervision routes to practice placement organiser who is also Trusts professional head of occupational therapy so students/education remain fully embedded in usually clinical/professional governance structures and processes.
- Standard TEWV student packs and educator packs are in use – see embeds below – these are currently being updated for 2018-2019 by one of the Trust occupational therapy clinical leads
- Patient safety incidents involving students are reported through both Trust and University processes and debriefing is provided where appropriate – additional

support if required is discussed with the student and the University.
- Reflection on practice both completed and observed is encouraged throughout placement (see list of potential reflective models for use in section above)

Dietetics:

- Students are assessed against the learning outcomes for each specific placement which are set by Leeds Beckett University. Placements are based in one of the following areas: Teesside, Durham and Darlington and North Yorkshire. We try to ensure that students are placed as close to their accommodation as possible.
- Students will cover a variety of specialisms within the Trust during their placement to ensure they are provided with the best possible learning environment.
- Prior to placement starting we ask students to complete a questionnaire so we are aware of their own learning style and any difficulties. This allows us to tailor the placement to individual student's needs prior to the commencement of their placement.

Domain 3 Supporting and Empowering Learners
For additional guidance see HEE Quality Framework, page 13 - 14

3.1. Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.
3.2. Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.
3.3. Learners feel they are valued members of the healthcare team within which they are placed.
3.4. Learners receive an appropriate and timely induction into the learning environment.
3.5. Learners understand their role and the context of their placement in relation to care pathways and patient journeys.

Response:

- Supporting students with disabilities, as recognised by the Equality Act 2010, is about making reasonable adjustments on practice placements. For nursing; Joint work based assessments are carried out by a representative from practice and the University to ensure the appropriate adjustments are put in place
- The Trust takes a proactive approach to equality and diversity and gives fair and equal consideration to all nine protected characteristics
- All TEWV employees are required to complete equality and diversity training on an annual basis as part of statutory and mandatory training

Additional Nursing factors

Specific;

3.2 The Triennial review process at Teesside University evidences support for students and mentors
3.3 This is reflected in the student evaluation process
3.4 Reflected in the above evaluations
3.5 This takes place within Home trust induction as well as local induction
3.6 Reflected in evaluations

General points in support;

- Students on NMC approved pre-registration nursing education programmes, leading to registration on the nurses' part of the register, must be supported and assessed by Practice Mentors and a sign off mentor. However the new Standards expected to be in place from Spring of next year will lead to changes in this model which are to be confirmed subsequently
- An NMC mentor is a registrant who, following successful completion of an NMC

approved mentor preparation programme meeting the NMC mentor requirements – has achieved the knowledge, skills and competence required to meet the defined outcomes. There is assurance through the local mentor register that all practice mentors and sign off mentors have successfully completed an NMC mentorship course. Again this model is subject to change in the light of the new NMC standards once these are confirmed and in place

- Each pre-registration nursing student is allocated a practice mentor for each practice placement experience: Practice Mentors have completed a NMC Each pre-registration. Students are allocated a sign off mentor in year one of the Teesside programme. The student maintains contact with the sign off mentor throughout the three year programme and returns to their first placement area for their final placement for final sign off. This receives positive feedback from students, practice mentors and highlighted as good practice by external examiners and NMC
- Achievement of learner outcomes are facilitated and monitored through a tripartite approach. This involves the establishment of a relationship between practice mentor; zoned/link academic and the student in the practice placement area

Psychology

- TEWV staff are active participants in the process of evaluating written, research and presentation assignments. This provides a direct link between the clinical and academic elements of their training.
- Through their organisational competences they are encouraged to take an active part in service development and audit.
- We have recently completed work on outlining the specific leadership behaviours that bands 7-8b demonstrate on a daily basis and, linked to previous work on the same for trainees, this has provided a clear map for moving to a qualified role.

Workforce Development

- All Health Care Assistants and Business Admin apprentices are offered IAG and ongoing summative and formative assessments.
- We have become a ROAT registered Apprentice training provider to provide apprenticeships in-house, and since May 2017 have started 4 programmes.
- All apprenticeship programmes provide detailed induction and support and all have individual learning records.
- A learners handbook developed by Workforce Development team provides advice and guidance for the non-registered workforce and their managers on accessing relevant development opportunity

Physiotherapy

- Learners undergo a planned induction during which their previous experiences, expectations, strengths and development areas are explored so that the placement can be tailored to their individual needs whilst meeting the set trust learning objectives for the placement. From these discussions their personal learning objectives are set.
- A series of learning topics per week are presented to learners and they are asked to study them whilst on placement using examples from practice and to present them to their clinic educator at the end of each week. One topic is chosen to study in greater depth to be more formally presented to colleagues at a professional meeting.
- We encourage continuous feedback students but also have a formal supervision session each week during which educational and pastoral support is given.

Occupational Therapy

- The OT points are covered in the submission for section 1 above

Dietetics:

- Students are allocated a supervisor who meets with them weekly to provide supportive feedback and guidance.
- Students are allocated a separate portfolio manager to help them with this. They are also offered an independent mentor who will support them with any additional needs they have.

Domain 4 Supporting and Empowering Educators

For additional guidance see HEE Quality Framework, page 15

4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.
4.2 Educators are familiar with the curricula of the learners they are educating.
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.
4.4 Formally recognised educators are appropriately supported to undertake their roles.

Response:

Nursing specific points

4.1 Nurse mentors must complete a mentor qualification in order to assess/support learner and also must attend an annual mentor update according to NMC requirements, a mentor database is maintained that records all mentor statuses, including those acting in a supervisory role, it also indicates mentors who are out of date and alerts are sent to mentors to book a workshop and informs the mentor and manager if the mentor is no longer able to provide mentor support to nursing students
4.2 Nurse mentors stay up to date with the curriculum through annual mentor updates
4.3 Mentors must complete a triennial review each year as part of their appraisal, providing evidence that they have met the NMC standard for mentoring

Additional Nursing points

- 2.6 WTE Senior Nurse Practice Placement Facilitators are employed in TEWV to support mentors and nursing students in practice placement. Contact details are available for all mentors and students in mentor and student handbooks and in TEWV staff Directory
- Mentor development is addressed through appraisal process with potential practice mentors. Potential changes in preparation for this area could follow the new NMC Standards
- TEWV nurses have access to mentorship courses from the following providers: Teesside York: Sunderland: Sheffield Hallam. In future such courses will have a multi professional focus but will continue to meet profession specific requirements. It is quite possible that from a nursing perspective, following the NMC changes this will not be NMC approved as such in future
- The local mentor register and Trust practice placement database maintains details of current practice mentors whilst Arc Pep and the PPQA provides resource back up in the provider HEI's.
- Student Dialogue sheets (Teesside) and Pebble Pad (York) record learner need and progress as well as formative and summative decisions around progression or achievement of practice competencies. They are also used to record concerns about progression, and/or behaviour and professional development. The dialogue sheets and Pebble Pad are thus used for continuous monitoring as they are available to the practice and zoned/link academic in each new placement area. The documentation contributes to assessment decisions
- Placement capacity and capability is monitored quarterly through reporting for the Trust Strategic Direction Score Card; local mentor register; Placement data base.

Regular meetings take place between the Head of Professional Nursing and Education; Senior Nurse PPF and Director of Placements (Teesside): Professional Head of Nursing and Education and Deputy Head of Nursing and Midwifery Programmes, Placements (York). Placement capacity and capability is monitored and assured through the educational audit process which are part of the ARC Pep and PPQA system

Workforce development

- All apprenticeships follow national standards and curriculum. Assessors and trainers have self-assessed against all competencies to ensure knowledge of all curricula.

Physiotherapy

- Clinical educators have access to a range of training materials and opportunities to help them develop their skills as an educator ranging from written materials, educator workshops, educator level 7 training, and mentor masterclasses.
- Learners have electronic access to student handbooks which identify curricula. They have regular supervision during which their role as clinical educator is examined.
- All grades are involved in supporting students on placement. All band 6s are expected to be clinical educators and any band 5s co work with clinical educators and their readiness to become a clinical educator is explored both in supervision and appraisal identifying their learning needs.

Occupational Therapy

- We work towards all our educators having APPLE accreditation – all registered OT practitioners after finishing preceptorship and being qualified for one year are appraised in relation to readiness to undertake APPLE and to become a practice placement facilitator (PPF) – we may also buddy up a therapist with an experienced PPF for their first placement
- Over the last year YSJ have offered to complete educator's courses leading to APPLE accreditation within Trust for us and the first one of these sessions is pending. We continue to be able to access these courses at both Teesside and YSJ (Occupational Therapy Practice Educators Course OPEC and Supporting Learning in Practice respectively SLiP), and they have expanded routes to APPLE reaccreditation
- Educators receive additional support and training through their OT learning and governance networks. This is protected half a day a month personal development time that is supported and structured. University lecturers may attend to provide extra training e.g. around course updates, failing students
- Educators have standard job and diary plans matched against their standard job descriptions which give time for personal and service development and are monitored against these, and extra time for particular projects/research can be negotiated with line management if necessary.
- During placement, student progress and the educators development is discussed at every clinical/professional supervision
- Educators are supported by their OT clinical lead with struggling students and liaison with the Universities as needed
- Students spend time understanding occupational therapy delivery at B3, B5 and B6 and may also spend time with B7 clinical leads – this is in addition to time spent with members of the MDT (see above sections)

Dietetics:

- Students are allocated a supervisor who meets with them weekly to provide supportive feedback and guidance.

- Students are allocated a separate portfolio manager to help them with this. They are also offered an independent mentor who will support them with any additional needs they have.

Domain 5 Developing and Implementing Curricula and Assessments
For additional guidance see HEE Quality Framework, page 16

5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.

Response:

- TEWV staff continue to work in partnership with HEI's to develop; validate and deliver new programmes at all levels
- Patients and carers are represented in consultation and stakeholder events around curriculum development.
- The programmes are reviewed and monitored through: Programme Boards: Annual Contract Reviews: Partnership Groups. Student evaluation of modules and practice placement: national student survey.
- TEWV staff are active participants in University recruitment fairs and are invited into the HEI's to talk to students/learners about employment opportunity and first post destination
- Placement providers are engaged with partnership activities with education providers.
- There is collaborative working with HEI's in development of curricula including the newly established working groups developing responses to the new NMC standards for Education at Teesside and York Universities
- Practitioners provide teaching sessions within the local HEI's
- Service users are involved in the Home Trust Induction for pre-registration nursing students, service users also contribute to the assessment of nursing students through the 360 degree assessment tool
- Trust staff are members of the curriculum revision and planning group at Teesside University, and York University, for Pre-registration Nurse training, developing the changes required in line with the new NMC standards for Education. This is at both strategic overview level and within the working groups focusing on practical elements of the course design
- Trust staff were involved in the planning group for the newly opened campus of Coventry University at Scarborough, and supported the NMC validation event for the Adult branch pre-registration nurse training. Placements will be offered to adult branch learners.
- Dialogue continues with Coventry University over a potential Mental Health programme for nurse training, and professional / vocational modules for local delivery

Workforce Development

- All apprenticeships follow national standards and curriculum. Assessors and trainers have self-assessed against all competencies to ensure knowledge of all curricula.

Physiotherapy

- Clinical educators have access to a range of training materials and opportunities to help them develop their skills as an educator ranging from written materials,

educator workshops, educator level 7 training, and mentor masterclasses.

- Learners have electronic access to student handbooks which identify curricula. They have regular supervision during which their role as clinical educator is examined. All grades are involved in supporting students on placement.
- All band 6s are expected to be clinical educators and any band 5s co work with clinical educators and their readiness to become a clinical educator is explored both in supervision and appraisal identifying their learning needs.

Occupational Therapy

- See responses in above section, in particular re; objective support and forms/documentation to assist, thinking, organisation and reasoning of students in conjunction with their educators
- OT learning and governance networks ensure that practitioners and students regularly appraise evidence and consider new policy and developments – implementation of changes are discussed here and standard work of use may be completed
- OT staff are active members of the course board at Teesside University and link with educators meetings regularly at Teesside University and York St John
- OT staff often assist with interviews, Vivas, seminars and lectures at both Teesside University and York St John
- The Trusts professional head of occupational therapy recently met with the new placement lead for Northumbria University, and although more placements may not be needed, there is great interest in e.g. visiting lectures, update sessions within Trust and other shared learning. 3 occupational therapy clinical leads in the Durham and Darlington area will be facilitating sessions from Northumbria University re; potential joint working within their OT learning and governance networks
- OT staff link with Universities in relation to recruitment fairs/support when aware/requested
- OT staff have been involved in the development of course content
- OT staff link with University service users/carers through the above

Psychology

- TEWV staff are active in developing and providing the Psychology curricula – the effectiveness of this link is evidenced by the recent accreditation process. Each specialty links to the various academic strands and we are key members of both recruitment and assessment panels

Dietetics:

- The Professional Head of Dietetics meets twice yearly with the senior leaders from Leeds Beckett University to discuss and develop the programme.
- The Professional Head of Dietetics is currently chairing a steering group to develop a new MSc Dietetics programme at Teesside University. This was set up in response to a significant recruitment crisis at band 5 and 6 in the North East. It is a particular concern within the two NE Mental Health and LD Trusts.

Domain 6 Developing a Sustainable Workforce

For additional guidance see HEE Quality Framework, page 17

6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.

6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.

6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.

6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

Response:

- A workforce task and finish group is in place to deliver a recruitment and retention strategy
- The Trust has a high level programme as a Board Priority, to deliver the safe staffing agenda alongside the NQB 2016 framework and associated guidance. This include a workstream looking at multi-disciplinary workforce development and linked to recruitment and retention, including of newly registered staff
- First post destination is identified and monitored on appointment to TEWV

6.1 Education providers and placement providers work in partnership to recruit suitable candidates to the pre-registration nursing programme using NHS values and behaviours as a framework. There are protocols for nursing students to raise concerns about poor practice and/or poor learning experiences, standard processes are in place to investigate any complaints

6.4 Preceptorship is provided by the Trust for all newly registered professionals Collaborative working is in place with the HEI's to support under achieving students.

- Recruitment to healthcare programmes follows HEE Standards for values based recruitment
- Representatives from practice are actively involved in joint selection of candidates for professional nursing programmes with all HEI providers for TEWV
- The student's journey through practice is planned using a hub and spoke; base and spoke model of practice placement. This model reflects the patient's journey through services providing the student with opportunity for learning across service and organizational boundaries, this includes alternative fields of practice.

6.4 Additionally we have implemented a large scale new appraisal process to all Bands 5 and above which looks at measuring performance values and behaviours and as such emphasises characteristics which will support the transition to employment.

Psychology

- We work closely with the course to make sure that problem are picked up early and supported before they reach the point of significant problems. Professional psychology courses have a very low attrition rate.
- We provide significant input regarding organisational and leadership competencies, and career planning. We have been invited back next year to provide a session on gender and career development which we will be providing with our Trust E&D lead.
- We closely monitor the recruitment of trainees to our own and other courses every year.

Physiotherapy

- All efforts are made to support students on placement especially if they are at risk of failing.
- The head of physio is involved in both regional and trust workforce planning.
- The trust have preceptorship and probationary policies which are used to help student transition to the workplace.
- In physiotherapy we have clinical competencies that the new employee have to work through.

Occupational Therapy

- The above domain is monitored and implemented via HR, workforce development and training department staff as well as by the Universities e.g. first destination employment

- Additional OT specific training and attrition post-employment is monitored by the Trust professional Head of OT and attrition addressed via our governance structure and clinical/professional supervision. Exit interviews are completed formally or informal feedback gained.
- Students progression on placement is monitored via clinical/professional supervision with educators and fed up to the relevant OT clinical lead and to the Trust professional Head of Occupational Therapy via the same route – these networks are also available for support outside of the formal dates arranged, and Universities are involved as early as possible when any issues begin to show that may have bearing on a student's ability to progress on placement.
- Preceptorship is in place to support students from learners into employees, and we have been working on improving the quality of preceptorship offered over the last 6 months – the new policy and related guidance/documentation are due to be published soon. OT staff members are using the newly developed guidance specific to OT preceptorship ahead of finalisation of policy as it constitutes a significant improvement on previous support and process. This approach was approved by the Trust Head of AHP`s and psychology. There are now also clear links to observed practice
- Work is planned for the year ahead to further develop OT specific competencies linked to the new RCOT career development framework and the TEWV OT training plan

2. Challenges or important issues that HEE NE should be aware of:

*This section should be used to document a **high level summary** any challenges or important issues you would like HEE NE to be aware of now.*
A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section.
Please also include any inspections or findings such as ratings from the CQC.

Domain 1 Learning Environment and Culture *For additional guidance refer to HEE Quality Framework, page 10*
1.1. Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users. 1.2. The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours. 1.3. There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence based practice (EBP) and research and innovation (R&I). 1.4. There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative. 1.5. The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge. 1.6. The learning environment promotes inter-professional learning opportunities.
Response: 1.1 There are challenges within the clinical learning environments with many community teams working in an increasingly mobile manner and limited physical space, leaving little room or facilities for learners who are not permanent members of the team 1.2 The Trust has a large scale and cross-cutting improvement programme underway for community services, PPCS, - Positive and Productive Community Services this is

managed through a rigorous Programme approach. There is a workforce and Pathways sub-group within this programme, which is linked in to the Trust safe staffing approach which is focussing on developing the right staff with the right skills for modern community services. This particular branch is at an early phase but can be updated on later for the ADQM process as matters develop. Overall, his will be a major change programme for the organisation to implement over several years and the full impact on community services and learner placements is not yet fully understood, but will be managed within the programme office

1.3 A maximum of 4 student nurse placements per year are offered in our Research and Development department for a 2 week placement, the amount of direct patient research exposure offered can be dependent on the studies open at that time.

1.5 The Trust has a wide range of IT related projects and developments, this includes a next generation device project , which is testing out approaches such as single sign-on and mobile working approaches, and improvements in mobile working approaches, which will in due course improve efficiency in a range of working settings, and will both free up time to care and provide enhanced IT facilities for learners on placement. Laptops have been allocated in the York locality

The Trust has a CQC Action plan in place in support of an overall Good rating

Occupational Therapy

- Hot desking and lack of access to computers at appropriate times can be an issue at times however the above IT approaches are intended to assist with this.
- The efficiency agenda needs ongoing attention to balance quality, safety and responsiveness as part of efficiency work At present, time taken for student education/the PPF role is not accounted for in baseline job and diary planning for B6 occupational therapy PPF`s – we need to ensure it is accounted for adequately and that the work students also do for us on placement is accounted for too. We do acknowledge that a session may take half the time again when a learner is involved and account for this in financial returns, but have not yet accounted for this in diary/job planning.

Psychology

- There are specific issues at the moment related to how the clinical psychology course is situated within the university and we are working closely with the course director to support the resolution of this.
- Some specific issues relate to the governance of the course being managed by the university within a typical undergraduate model (modular, placement evaluation forms etc) but trying to maintain the doctoral and professional ethos and standards that are required. There are also problems with it being distanced from the other psychology courses within the university due to its position within a different school.
- The course also faces an uncertain future regarding the funding of places beyond this academic year.

Research and Development

- A maximum of 4 student nurse placements per year are offered in our R&D department for a 2 week placement, the amount of direct patient research exposure offered can be dependent on the studies open at that time.

Domain 2 Educational Governance and Leadership

For additional guidance see HEE Quality Framework, page 11 -12

2.1. The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.
2.2. The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.
2.3. The educational governance structures promote team-working and a multi-professional

approach to education and training where appropriate, through multi-professional educational leadership.
2.4. Education and training opportunities are based on principles of equality and diversity.
2.5. There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.

Response:

Occupational Therapy

- Some teams give a number for the number of students they can accept across an MDT team at any one time – changes in dates/cohorts/timings of student placements for other professions may impact on team managers willingness to accept students – there is concern that higher profile NHS staff shortages may lead to placements from certain professions being prioritised over others – this has not yet caused significant difficulty but concern remains
- Our purposeful and productive community services work has not yet adequately accounted for the impact of being a PPF of the time taken to complete work in its costings/statistics – this needs to catch up with the tariff which does give this attention and will be fed into the programme
- We are keen to maintain balance between training and development that is appropriate for the MDT and that which is specific to those learning to provide a particular governed therapy or to increase skill in provision of that therapy

Domain 3 Supporting and Empowering Learners
For additional guidance see HEE Quality Framework, page 13 - 14

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.
3.2. Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.
3.3. Learners feel they are valued members of the healthcare team within which they are placed.
3.4. Learners receive an appropriate and timely induction into the learning environment.
3.5. Learners understand their role and the context of their placement in relation to care pathways and patient journeys.

Response:

- There are remaining concerns around balancing demand and supply of practice placements. There is evidence to suggest that placement areas are increasingly being asked to take learners above audited numbers. We are unsure of the further future impact post-bursary removal at this point. We are also working with an increasing range of educational providers as part of our diversifying approach which may bring additional pressures. However student evaluation of practice placement experience is monitored in partnership with the HEI to assure quality of learning experience in practice.
- All Psychology trainees have study time within their placement to ensure that they have sufficient time to make the study/practice links and complete assignments

Domain 4 Supporting and Empowering Educators
For additional guidance see HEE Quality Framework, page 15

4.1. Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.
4.2. Educators are familiar with the curricula of the learners they are educating.
4.3. Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.

4.4. Formally recognised educators are appropriately supported to undertake their roles.

Response:

Nursing

- The general theme of the current 1:1 model of practice mentorship for pre-registration nursing students is not sustainable. This is being reviewed in partnership with Teesside and York (and shortly with Sunderland) in line with new NMC standards which may suggest different models. Mentor numbers for increasing numbers of learners, remains an ongoing issue which we strive to achieve. We do always achieve this but often requires a lot of personal attention and focus to maintain and is an increasing pressure in terms of diversifying the number of courses and providers we work with This is a general theme throughout this update report on which it is expected there will be greater clarity in the short term.
- We are continuing to have high numbers of nurses on the training which is of course overall positive but can be challenging. We are anticipating new standards from the NMC which will change this picture, along with changes to the curriculum. We are piloting some alternative approaches to mentorship in the meantime
- There is uncertainty around governance aspects of supervisor and assessor preparation going forward with new NMC standards. Potential for each HEI to set own standards around "suitable preparation" programmes which could lead to variation across four countries.
- Uncertainty also around future of annual updates which is current mechanism of assurance that mentors are familiar with curriculum – again linked to new NMC standards.
- There is current dialogue with Sunderland University over the development of Apprenticeship based roles and we are working through what the implications of this for joint support will be , including the potential development of a link role to support the Apprentices between the organisations, this is a at very early stage however

Occupational Therapy

- As educators increasingly need to account for their time in a very specific way we need to be able to demonstrate that the impact of having a student e.g. taking more time provides important benefits e.g. In terms of recruitment. Clearer risk/benefit analysis.
- Training budgets are negligible – particularly when applied to AHP`s where the training they often require is only specific to the therapy they deliver, can be expensive and economies of scale are not often possible – see embed for OT training required

Training strategy grid final 2017.doc

- We have many occupational therapists employed in wider roles who do not deliver any occupational therapy – we need to think of better ways for them to contribute to occupational therapy student education
- We need to further extend the research knowledge and skills of our educators and promote use of these in practice

Domain 5 Developing and Implementing Curricula and Assessments
For additional guidance see HEE Quality Framework, page 16

5.1. The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.
5.2. Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.
5.3. Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.

Response:

Nursing

5.1 Each HEI has different documentation and documentation requirements around assessment, learning outcomes and portfolio requirements. This is potentially confusing for mentors, and would benefit from standardisation.

5.2 Care provision is a rapidly changing environment and placement models must be flexible to account for the rapid changes in practice

Occupational Therapy

- It would be useful if students could be trained in the use of some of the specific theories and assessment tools we use in practice whilst at university e.g. AMPS, Allen, MOHO tools, COPM –YSJ have begun a move in this direction and now provide AMPS training as part for their course however in the HENE area neither Northumbria or Teesside Universities do this.

Domain 6 Developing a Sustainable Workforce
For additional guidance see HEE Quality Framework, page 17

6.1. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.
6.2. There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.
6.3. The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.
6.4. Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

Response:

Nursing

- Concern remains around recruitment to the pre-registration nursing programme for Learning Disability; Numbers of applicants are relatively low; offers to students are frequently made via clearing. However in response the trust has led on or been involved in a number of initiatives as follows
- The organisation has sponsored ten health care assistants to take up Learning Disability training at local Universities – they will be paid a secondment salary and the Trust is meeting their student costs – this is to help bridge over the current difficult situation while a longer term strategy is developed with the HEI's
- The Trust supported the establishment of a new learning disability programme at Sunderland University which recently obtained NMC approval

- The Trust contributes to a regional group considering Learning disability workforce issues, and will be contributing to a new national task and finish group set up by NHS England in conjunction with the national Nursing Directors Forum

Workforce Development

LM HR Manager, working with Project Choice Initiative – we have just started work placements for individuals with Learning Disabilities, to encourage, support and develop them and introduce them into the workplace. Hoping this will be a sustainable initiative.

Occupational Therapy

- There are concerns that removal of bursary funding will affect volume and quality of applications and potentially the quality of students coming on placement – to date indications are that there are less applications from mature students who bring with them a breadth of wider knowledge and skills that are often a great benefit to them as students and subsequently employees
- When new graduates are employed directly into non-OT posts, these individuals do not always trigger into governance structures and preceptorship may be delayed on missed – HR have yet to agree a system for notifying through OT governance structures when this happens
- The preceptorship policy update has yet to be signed off and we are using tools developed as part of this process ahead of publication

3. Good Practice items

Focus on innovative and breakthrough ideas, including new approaches, which have potential for wider dissemination and development, thus sharing good practice and driving improvement

Also supporting the standards, please list any good practice items that you would like to highlight as an exception over and above the supporting profession/workforce group unit information. These may include trust wide initiatives as well as profession/working group unit examples. When considering items to list here, please consider the third guiding principle from the NHS Constitution:

"The NHS aspires to the highest standards of excellence and professionalism
It provides high quality care that is safe, effective and focused on patient experience; in the people it employs, and in the support, education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population. Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported."

You do not need to duplicate items from the successes section of the SAR.

HEE Quality Domain 1 Learning Environment and Culture	
1.1. Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**

• Compassion/social safeness Training – trauma informed care, led by Senior Psychologist,- Angela Kennedy • The above mentioned Coaching training is also good practice, in guiding the day to day interactions between staff, improving quality of supervision and the framing of questions to help tackle problems and move developments on- Sarah Dexter-Smith	Available for all staff, easily accessible, TEWV developed. It is an accredited and externally supported approach which is available to all staff and links in to the trust overall Quality Improvement methodology
1.2. The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Policies are in place around bullying and harassment, and a procedure for students raising concerns • Educational Audit considers this area within format	
1.3. There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence based practice (EBP) and research and innovation (R&I).	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Some students have the opportunity to undertake their service improvement placement with the KPO team, the Research Nurses and other nurses working in the corporate directorate • Student nurses can select a 2 week service improvement placement in Research and Development where they are able to gain understanding of the research process and shadow Research and Development staff undertaking research visits with study participants. Students will gain an understanding of the principals for good Clinical Practice for Research and receive information on a number of research assessment tools. Individual timetables are produced for students to provide a range of experiences during their placement.	Provides the opportunity for nursing students to engage with nurses who are leading on service and quality improvement Provide the opportunity for nursing students to engage with research nurses and develop awareness of this role as well as how nursing research informs practice. Provides a practical experience of observing how and why research is conducted and considers key issues such as informed consent, good clinical practice and importance of dissemination and applying research findings into practice.
1.4. There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**

• There is Service User involvement in the Home Trust Induction for nursing students • Service Users are involved in the curriculum review group at Teesside University	Uses the service user experience to embed learning, allows for powerful stories to be shared
1.5. The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
Nursing students have access to library facilities and support in the trust • The Trust has a programme of next generation devices with user involvement feedback, which is seeking to free up time to care by more effective use of technology including single sign on and improved mobile working – Steven Foster (IT Project Manager)	Access to library support whilst on long placements away from the HEI Freeing up time to care and learn
1.6. The learning environment promotes inter-professional learning opportunities.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• The Education and training steering group has set up a sub-group to look at enhanced shared learning albeit this is early stage • The Trust Safe Staffing Programme includes a work stream considering multi-disciplinary workforce development linking all medical and non-medical professions within an overall plan ultimately (Joe Bergin, Programme Manager)	It is in line with the NQB 2016 guidance which asks us to move beyond a consideration of numbers of nursing staff towards a more developmental and multi-disciplinary approach, including the training and recruitment . The Trust has invested in a specific programme in response to this (presentation outlining the approach is attached to document)
HEE Quality Domain 2 Educational Governance and Leadership	
2.1. The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Educational audit is complete every two years or triggered by an event such as feedback • Feedback from students or other sources such as CQC reports trigger a response that may include an action plan for the clinical placement, and are shared with the relevant HEI	Regular reviews of clinical placements, assessing the suitability against the standard in the audit Timely response to feedback to address identified issues in clinical placement to give assurance that placements achieve the standard for quality education
2.2. The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	
Description of good practice (and a named	**Description of why this is considered to be**

contact for further information)	good practice
• Heads of Nursing for each locality and Specialty provide feedback to the Education and training Steering group on training needs analysis progress , providing a link for locality governance arrangements to the corporate trust, chaired by Executive Nurse, following a process established by the Trust Quality Improvement system	Provides an overview of the training needs narrative based on local information and links into an overall trust-wide improvement process
2.3. The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• The Education and Training group has recently commenced a sub group looking at multi-professional approaches, this will also be a feature of the above-mentioned Safe Staffing programme which reports to Executive team	
2.4. Education and training opportunities are based on principles of equality and diversity.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
2.5. There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• There is a Standard process for managing reported incidents through Datix and reporting to HEI	Identifies potential need to support the nursing student – student wellbeing and to improve attrition Identifies potential risk in the learning environment - provide an environment that delivers safe, effective, compassionate care.
HEE Quality Domain 3 Supporting and Empowering Learners	
3.1. Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Well established mentor and sign-off mentor programme • Heads of Nursing have an educational component to their role and get involved as required to support learners at all levels • PPF support is available from an experienced team • Bernadette Wallace as contact	Senior support available in addition to standard practice

3.2. Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Triennial review process – Teesside University • Well prepared mentors support this process through the training course and the structured annual update programme they receive • ILR records for all apprentices. Led by Linda Setterfield.	Robust approach which meets NMC standards Equitable, fair, transparent and can change practice of training quickly
3.3. Learners feel they are valued members of the healthcare team within which they are placed.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Local induction to prepare for placements, with close support from mentor following this.	
3.4. Learners receive an appropriate and timely induction into the learning environment.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Home Trust Induction programme, which is carried out before practice. This includes service user and carer involvement, and a welcome from a senior member of the Trust. Positive Approaches to behaviour which may challenge are also taught, including breakaway techniques • Local Induction follows from and builds on above Bernadette Wallace	To welcome the student nurse to the clinical placement provider aiming to make them feel welcome and valued and also prepared for the placement. Includes issues students may encounter early in their experience
3.5. Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Hub and Spoke placement model lends itself to this, following a patient journey across settings. We also have a cross-age continuum approach which cuts across inpatient and community settings	It meets all NMC standards, and it embeds the student in the range of services which can support the patient pathway and promote understanding of holistic care
HEE Quality Domain 4 Supporting and Empowering Educators	
4.1. Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Nurse Mentors must have undertaken an NMC approved	This is required by the NMC for student assessment in practice , we offer a robust

mentor course to enter the local mentor register • All mentors must attend an annual mentor update, this is recorded on the mentor register • All mentors must undertake a triennial review as part of their annual appraisal, the date is recorded in the mentor register	approach to this
4.2. Educators are familiar with the curricula of the learners they are educating.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Current mentor awareness of curriculum is maintained through attendance at the annual mentor update • The Tri-partite meetings also support this process of updating • New educators skills audit introduced for new awards Judith Hurst	Assessors/trainers in Workforce Development complete a skills audit against new apprenticeship – identifies gaps and fills
4.3. Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• The appraisal of nurses who are mentors must include a triennial review each year to demonstrate that they meet the NMC standards for assessing and learning in practice • Audits and educators programme (Judith Hurst)	• It maintains standardised quality checks and provides constructive feedback
4.4. Formally recognised educators are appropriately supported to undertake their roles.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Staff are released for the mentor update, and the initial mentoring course • A proportion of time, 40% is available for student support for mentors • Clinical staff are involved in delivering sessions at Teesside University and are supported in time for this • Staff are supported to be involved in pre-recruitment activities	Demonstrates support to maintain the roles and also fosters the good links with Universities
HEE Quality Domain 5 Developing and Implementing Curricula and Assessments	
5.1. The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional	

standards.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
5.2. Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Clinicians are invited to get involved in partnership activity with the HEIs e.g. pre-registration sub group, essential skills, curriculum development, recruitment activity	
5.3. Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Service Users are involved in the Induction programme (service users are also involved in some of the teaching at the Universities which is organised through the HEI's)	
HEE Quality Domain 6 Developing a Sustainable Workforce	
6.1. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Involved in pre-recruitment as above • Close support from mentors for learners • We have a workshop to support mentors in managing the under-achieving student, including practical and emotional support elements. Focus on identifying struggling students at an early opportunity and developing individual action plans to ameliorate	Poster for this process was presented at an RCN conference as identified good practice
6.2. There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Senior member of nursing team goes in to University in final weeks to talk about career options. Recruitment approaches commence at a relatively early stage	

• Implementation of Talent Management conversations for all staff as part of staff development programme – identifying strengths and aspirations and helping to deliver a career plan Michelle Brown	All staff can access, Trustwide strategy
6.3. The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Trust-wide Training Neds Analysis process developed from an RPIW approach within the trust Quality Improvement process (Kaizen) Judith Hurst	Specific to addressing development required for changing service needs. Locally owned process feeding into existing governance and developmental meetings in the trust.
6.4. Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
• Multiprofessional preceptorship programme that maps to Health Education England standards, a combination of attended development days and work based individualised approach	Improves the experience of transition from student to practitioner Includes recognised benefits such as improved rates of absence, improved rates of retention, patient safety, job satisfaction

4. Professions or workforce areas at highest risk of not meeting a standard

*Please list any professions or workforce groups that are not fully meeting a standard. Please **list** the profession or workforce group and the standard*

*Please **list** any professions or workforce groups that are not fully meeting a standard. Please **list** the profession or workforce group and the standard.*

This section is a list only – detail should be in challenges by domain

Mentor numbers and placements for increasing numbers of learners, remains an ongoing issue which we strive to achieve as detailed in the Challenges section however the standard is currently being met as described therein.

5. Summary of LEP Policies and processes (self-assessment) against the standards

The section will need completing once, in subsequent annual returns only changes and updates will need to be highlighted.
Please ensure that the narrative includes a list of associated key trust policies and processes which supports how the organisation meets the standards

HEE Quality Domain 1 Learning Environment and Culture *For additional guidance refer to HEE Quality Framework, page 10*
1.1. Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.
Health and Safety Workbooks and Policy Compassion focussed training CQC outcome and action plan Friends and Family Test Staff Survey Evaluation of placement by student – compiled into a report with key features highlighted in a scorecard Educational Audit competed every two years
1.2. The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.
Trust values and behaviours Trust Compact Equality and Diversity Policy Staff Development Policy Appraisal Procedures
1.3. There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence based practice (EBP) and research and innovation (R&I).
• QIS Tools and methodology – from within the Trust's overall Kaizen approach to quality improvement managed through a KPO (Kaizen Promotion Office) • Student placements in service improvement area (evidenced within students journey) • The New curriculum development group at Teesside University, at which trust is represented, is looking to take QIS approaches further within pavements in line with new NMC programme standards as a future development. • The Research and Development highlights the provision of research training which included good Clinical Practice training either online or face to face provided by the Clinical Research Network North East and North Cumbria.
1.4. There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.
• Patent safety bulletin with key messages from learning points • SBARD messages re lessons learned – standard format to highlight immediate actions • FFT outcomes are followed up in services • Revalidation – nurses required to obtain 5 pieces of feedback and reflect on this. Trust has a robust approach to revalidation which was supported by workshops and

Heads of Nursing personal support to early applicants to ensure a successful start to the approach.

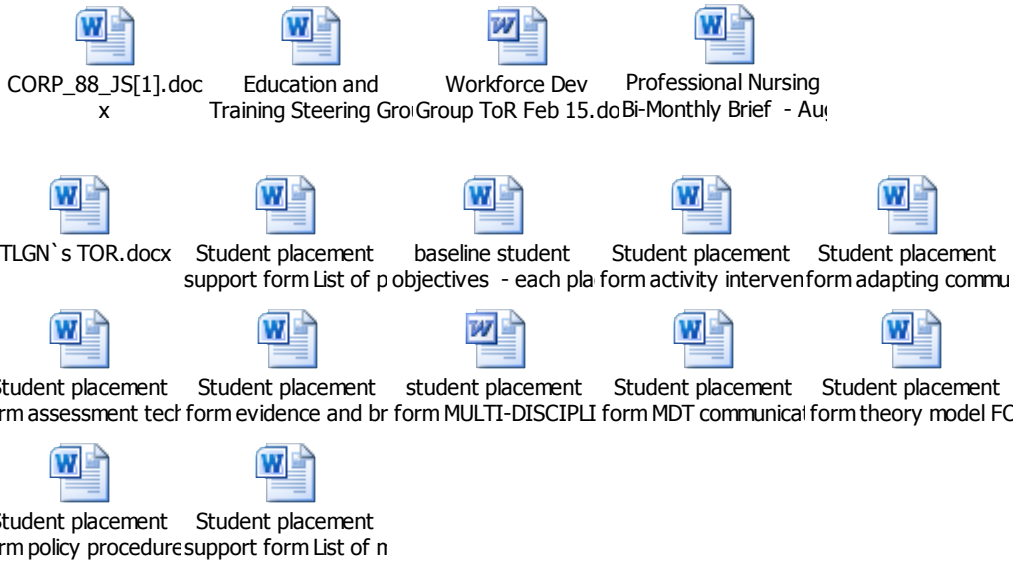
- Service Users present on the induction programme which is based around their experiences of services and powerful stories to assist learning

1.5. The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.

- Further information in the Library appendix
- Trust libraries have IT facilities
- Laptops were allocated to students for York locality
- I.T. work streams within the trust including new generation devices, single sign –off , improved mobile working, releasing time to care and learn

1.6. The learning environment promotes inter-professional learning opportunities.

- The teams hosting placements are multi-disciplinary in nature
- The safe staffing programme work requires us to think MDT increasingly – evidence from the programme plan (presentation attached) this has a workforce development strand which is required to consider organisation-wide development including training, and recruitment and retention
- Education and Training group has established a sub – group to look at multi-disciplinary training (which will feed into the programme above)
- RAMPPS programme including simulation training as set out in Appendix 3 – this will in future include Physiotherapy and Dietetics



HEE Quality Domain 2 Educational Governance and Leadership
For additional guidance see HEE Quality Framework, page 11 -12

2.1. The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.

- R.O.I methodology – copies available. Lead is Judith Hurst. (return on investment)
- Structures include the Education and Training group, chaired by the Executive Nurse, and Workforce Development group, which reports into EMT
- Educational Audit – with action plan against any areas of concern jointly with service.
- Process in place for managing evaluations where students highlight concerns, jointly with the HEI's
- TSD Scorecard which is based around quality of placements, we consistently achieve the 95% target. This information is raised at the Directorate Management

Team report out chaired by the Executive Nurse

2.2. The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.

- Training Needs Analysis process linked to RPIW developments, reported to the Education and Training group which is chaired by the Executive Nurse
- Partnership groups in place with the local HEI which consider issues of quality and content arising

2.3. The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.

- Safe Staffing Programme has a workstream which will develop this topic further in future, with a project timeline in support of this for 2018-19
- Trustwide Education and Training Steering Groups terms of reference, sub-group to consider future further developments in this area of multi-disciplinary working

2.4. Education and training opportunities are based on principles of equality and diversity.

- Staff Development Policy
- Opportunities for nursing development are always advertised through NHS jobs even when short term or trainee support developments (e.g. the TNA, and LD sponsorship processes) rather than expressions of interest, to ensure due process. These are carried out in partnership with HEI's etc through a structured process with Human resources guidance
- Trainee Nursing Associate recruitment was monitored for E and D compliance regionally, led by the regional pilot team (South Tees Acute are the lead agency) via the HR departments

2.5. There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.

- Service Level Agreements in place with stakeholders
- DATIX system
- Standard process in place linked to Datix for student issues, descriptor in place used by PPF's. Recent RPIW to streamline process

TEWV Trust Strategic Direction Score Card | TSD quarter 2 2017.xlsx | Full Educational Audit Doc TU.doc | Copy of Q3 TSD Final 1.xlsx

TEWV OT Student_Pack 2016-2 | TEWV OT Practice Educators Handbook | Student governance checklist - headings.x

HEE Quality Domain 3 Supporting and Empowering Learners
For additional guidance see HEE Quality Framework, page 13 -14

3.1. Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.

- Pre –registration nursing this is covered in student handbooks setting out expectations and process
- Student induction programme in place as above
- Student portfolios with mentor input
- Tri-partite meetings process
- Initial assessments mandatory for all HCAs.

IAG available for all who ask.

3.2. Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.
• Ofsted/EFSA funding rules include this • Evidenced in portfolios for students, e-portfolio's such as PebblePad • Student Evaluations • Assessment tools in student handbook
3.3. Learners feel they are valued members of the healthcare team within which they are placed.
• Trust Values and Behaviours. • Student Evaluations to evidence this • Three key items from the Evaluations are reported on a Trust Score Card which is represented at the DMT report out as above
3.4. Learners receive an appropriate and timely induction into the learning environment.
• Mandatory for all apprentices – funding rules • Home trust induction (Tees) – standard format • Student induction – (York Students) • Local induction for which there is a standard template • Forensic specific induction e.g. security related aspects) • Student evaluations evidence this with a question regarding induction
3.5. Learners understand their role and the context of their placement in relation to care pathways and patient journeys.
• Placement model for nursing "Hub and Spoke" Tees "Base and spoke" York encourages this in terms of a journey. • Portfolios (students own) as evidence including PebblePad • Competency benchmarks – assessment against these – evidence in Mentor handbooks Induction Day 28th June 2017.docx 28 06 17 Programme.doc WDT Learners Handbook 2017.docx baseline student objectives - each pla
HEE Quality Domain 4 Supporting and Empowering Educators *For additional guidance see HEE Quality Framework, page 15*
4.1. Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.
• Identified through the appraisal process • Staff values and Behaviours, Compact • Mentorship programme for Nurses which is NMC approved
4.2. Educators are familiar with the curricula of the learners they are educating.
• Identified through annual mentor updates (nursing) to ensure mentors as educators are up to date and familiar with pre-registration curriculum • PPF;s have evidence o workshops and numbers updated, and records of current mentors on the register and up to date • University offer mentor briefing and updates – e.g. for the new TNA roles to ensure workplaces fully prepared and cognisant of programme requirements
4.3. Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.
• TEWV Assessors/Trainers regularly supervised/appraised

- Supervision Policy
- Local Skills Checklist
- Triennial review Process – which is an NMC standard and is also an agenda item in their appraisal

4.4. Formally recognised educators are appropriately supported to undertake their roles.

- Approval Procedure
- Talent Management Strategy
- Mentor workshops and updates
- Under-achieving learner workshops
- Preceptorship workshops
- Local preceptee development programmes in localities
- Individual support to Mentors and PPF's supplements above

Preceptorship Workshops.docx

Tees Uni Evaluation Form April 2017 -.xls›

York Uni Evaluation Form April 2017 -.xls›

HEE Quality Domain 5 Developing and Implementing Curricula and Assessments
For additional guidance see HEE Quality Framework, page 16

5.1. The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.

- NMC validation events with stakeholder involvement (e.g. Sunderland, Coventry University at Scarborough, OU)
- Membership of Curriculum planning groups including to meet new NMC standards
- Partnership meetings with HEI's to share and resolve issues

5.2. Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.

- Involvement in the new curriculum planning groups to meet NMC standards e.g. Teesside (examples of agenda attached)
- Partnership groups established with local HEI's

5.3. Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.

- Experts by Experience involvement in delivery of the student induction programmes and lead on aspects of this
- Stakeholders in curriculum development – e.g. the new curriculum at Teesside has service user and student reps (arranged by the University)

Agenda Steering Group.pdf

HEE Quality Domain 6 Developing a Sustainable Workforce
For additional guidance see HEE Quality Framework, page 17

6.1. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.

- Use of Trustwide SLA Template (Judy Hurst)
- Robust selection process jointly with University – with values based approach
- Flexible programmes to maximise retention. Trainee Nursing Associate and

sponsorship onto Learning disability programmes support existing staff to develop their careers with high probability of retention
- Open University part-time distance learning to support those in work place learning, is supported by the organisation (approx. 16 students currently on either pre-registration or access modules)
- Apprenticeships being developed by OU/Sunderland University with active participation from trust , more information to follow as programmes develop

6.2. There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.

- As above in section 6.2
- Mentors also provide bespoke advice to individuals

6.3. The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.

- Involved in curriculum development as above
- Training needs analysis – new standard process
- Appraisal and talent management
- Workforce development strand of safe staffing programme
- PPCS workforce strand re community provision and future models of care

6.4. Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

- Preceptorship policy
- Preceptor development programme
- Work based preceptee programme
- Preceptee development locality programme (band 5 development) which meets HEE standards
- Preceptee workbook aligned to policy


OT preceptorship flowchart Jan 17.doc


OT preceptorship overview and monitor

Appendices for Additional Information/Questions
Appendix A - Continuous Workforce Development

Continuous Workforce Development

Appendices (i) and (ii) below provide high level information on the CWD accessed by your organisation in 2016/17. Please review the information and respond to the questions below.

Please provide answers to the following questions.

Questions	Trust's response
Q1. What value and impact do you think accessing this provision has brought to your organisation? *Please consider the following:* ➢ *Benefits to patients and service provision* ➢ *Capacity and skill mix* ➢ *Knowledge and skills* ➢ *Improvement projects*	• It has been developed to link with our business need so ultimately patients benefit • It is more flexible to meet our needs
We have worked in close partnership with all foundation trusts to improve the efficiency of the CWD contracts. In 2016/17 the non-attendance for your trust was £1,990 (2% of usage). The CWD policy outlines the processes each trust has agreed to put in place (e.g. standard study leave wording, study bonds, tracking mechanisms for applications and monitoring students' progress, tracking mechanisms for cancellations. **Q2. How would you assess your trust's progress in implementing these processes?**	• Policy in place with study bond/standard wording • Tracking process • Progress – Judy Hurst follows up letters of those who DNA/fail to submit
The CWD portfolio is compiled from trusts' workforce education requirements, which are submitted annually. The robustness of this process is dependent on capturing the needs of the workforce across the service areas of each organisation. **Q3. How far do you feel awareness of and participation in the CWD commissioning process has been embedded across your organisation?** *Please consider any good practice and further improvements to take forward.*	• Specialty Leads now more aware – Heads of Nursing also involved, linked into Education and Training group.
Additional comments	

Tees, Esk and Wear Valleys
NHS Foundation Trust

Appendix (i) – CWD module data

The table below shows the number of CWD modules accessed by your organisation from August 2016 to July 2017. Note this data is indicative and a final outturn dashboard will be provided to your organisation later in the autumn. Your CWD lead receives detailed raw data reports by student each month.

	Northumbria		Sunderland		Teesside		Sheffield Hallam		TOTAL		Value (£)	Wastage	
	Attended	Not attended (charged to contract)	Attended	Not attended (charged to contract)	Attended	Not attended (charged to contract)	Attended	Not attended (charged to contract)	Attended	Not attended (charged to contract)		£	%
Modules	3	1	10		115	2	9		137	3	£86,000	£1,990	2%

Appendix (ii) – modules accessed by title and university

HEI	Module Name
Northumbria University	Mentor/Educator Preparation (Level 6 APEL)
	Prevention and Early Intervention in CAMH
	Understanding Common Presenting Problems in CAMH
University of Sunderland	Cognitive Behavioural Therapy Informed Practice
	Working with the Emotionally Dysregulated Individual (DBT)
Teesside University	Advanced Personal Effectiveness
	Advanced Physical Assessment and Disease Management Skills
	Advancing Leadership in Health and Social Care
	Advancing Learning in Health and Social Care Practice
	Advancing Non-medical Prescribing
	Leading Service Improvement in Health and Social Care
	Mentoring in Practice
	Non-medical Prescribing
	Physical Assessment Skills (Adult)
Sheffield Hallam University	Mentor Preparation for the Health Professions (Distance Learning)

Appendix B - Library and Knowledge Services

Q1. What funding (in addition to the educational tariff funding) is your Trust putting in to the library and knowledge service to deliver on the Health Education England Policy? (see https://www.hee.nhs.uk/sites/default/files/documents/Knowledge%20for%20Healthcare%20Policy%20Statement%20Nov%202016.pdf)

Response:

Q2. Describe how your Trust is implementing the HEE library and knowledge services policy namely:

"To ensure the use in the health service of evidence obtained from research, Health Education England is committed to:

- Enabling all NHS workforce members to freely access library and knowledge services so that they can use the right knowledge and evidence to achieve excellent healthcare and health improvement.
- Developing NHS librarians and knowledge specialists to use their expertise to mobilise evidence obtained from research and organisational knowledge to underpin decision-making in the National Health Service in England
- Developing NHS library and knowledge services into a coherent national service that is proactive and focussed on the knowledge needs of the NHS and its workforce."

Response:

Research and Development

TEWV have entered into a 15 year research partnership with the University of York. As part of this initial partnership work, Rachel Churchill, Professor from the Centre for Reviews and Dissemination at the University and who leads the Cochrane Collaboration for common mental health disorders has received a fellowship to work at TEWV to catalyse knowledge exchange. Rachel Steele, Clinical librarian from TEWV was a co-applicant on this application and will be working collaboratively to amongst other projects, develop a clinical question and answer service to enhance the current Clinical Evidence summaries produced in TEWV.

Q3. What is your Trust's most recent NHS Library Quality Assurance Framework (LQAF) compliance score?

(see http://www.libraryservices.nhs.uk/forlibrarystaff/lqaf/)

Response:

- 2016 Amber Status 82% (66% in 2015)

Q4. If your LQAF compliance is below the Learning and Development Agreement's requirements of a minimum of 90% what actions is the Trust taking to improve the compliance level?
Response: As the rating is below the standard set by the Learning and Development Agreement of 90% compliance, HCLU will be working closely with the library team to provide support and jointly agree plans for improvement • There will be a calendar of educational activities that will focus on information skills, critical appraisal and evaluation skills. • More investment in books, journals and online resources. • Development of an outreach calendar so that the whole Trust is served rather than the northern part of the Trust. • Postal loans implemented to sites around the Trust where no library service is located.

Appendix C - Simulation Training

This year we would like to map and describe in more detail the activity and support for simulation based education across the region. In order to support this, please consider and populate each section below; considering the following standards which are used to quality assure simulation based education and investment.

Noting the multi-professional nature of simulation, you may wish to liaise with colleagues across clinical professions. Some of this information may also be with colleagues within medical education, who will also have the opportunity to comment on simulation activity, engagement and investment as part of their reporting return.

Governance, Organisational & Management: **Active participation in all forms of governance. Continuous improvement in the quality and outcomes of training.** • Does your facility have a designated individual with overall responsibility for the strategic delivery of all simulation based education programmes? • What processes are in place with regard to management of simulation activity and equal access to facilities across healthcare learners? • Is the mission of the facility aligned to the wider organisational and stakeholders' needs, in particular with respect to acting as a quality and risk management resource for organisations to help achieve the goals of improved patient safety and care quality?
This is a developing area for us outside of existing medical training approaches which are more established, and there are processes in place within mandatory and statutory training within the trust. There is an emerging approach within the workforce development component of the safe staffing programme, to link in to Medical simulation training as a co-ordinated approach (i.e. the work led by Dr. Jim Boylan) Example of existing approach; <u>RAMPS training in Durham Locality - Recognising and Assessing Medical Problems in Psychiatric Settings</u> (RAMMPS) RAMPPS is a simulation based training that involves collaboration amongst health care assistants, nurses and doctors in order to recognise and manage acutely developing medical problems in psychiatric settings. Course participants use tools including SBARD, ABCDE and EWS charts. The emphasis is on using a multidisciplinary approach to identify and manage medical conditions that have been known to lead to death amongst our patients in TEWV and other mental health trusts. RAMPPS is already a well-established training course in Yorkshire and is being adopted nationally. It runs as a half day or full day training event with up to 10 scenarios. High fidelity mannequins and/or actors are used for the scenarios. The course can take place in simulation centres, ordinary training centres, meeting rooms, lecture theatres and ward side

rooms.

RAMPPS has a regional steering committee with an established handbook, training for facilitators, scenarios and a pool of experienced actors/role players for simulation. There is an e-learning package that is already adopted by NHS England which can be accessed freely on ESR. Scenarios are being developed to incorporate child and adolescent cases

The TEWV RAMPPS working party with the support of the Faculty of Medical Education organised two small pilots, each with two scenarios and simulated actors on the 10th and 30th of March 2017, in Stockton-on-Tees and Harrogate. They were well attended with successful outcomes as shown by feedback from participants. However the sample size and data from the feedback was relatively small.

We believe that the majority of the scenarios could be done with actors/role players without mannequins (indeed using an actor was identified by several pilot course delegates as an advantage to the course, making it more life-like than mannequin-based courses such as ILS). Using actors makes it a low cost training course for the Trust which we believe can be managed by the existing clinical and technical expertise in the Trust. We already have a number of suitable venues in the Trust that could be used for the programme. As part of the pilot, a number of medical and nursing staff has been trained to be facilitators.

Simulation at a lower level than this also takes place within;

- Resuscitation, and Moving and Handling training.
- MoVA and positive approaches to Behaviours training – this is externally accredited via General Services Association
- Medication administration and management training

Student and Nursing Associate also access simulation training through the University programmes including the excellent facilities at the Tees and Darlington campus, and the facilities for the forthcoming programme at Sunderland University.
The organisation is in dialogue with the Universities over increasing access to the extensive simulation training facilities which are currently being used as part of the Nursing Associate pilot programme for students seconded from the organisation. There is also dialogue with Coventry University over potential access to their newly established facilities as the mental health programmes become established

Supporting Trainers

Appropriately trained educators/trainers are developed to reflect their training responsibilities

- For facilitators delivering simulation based education, what process is in place to ensure that they are suitably trained to deliver such sessions, in particular maintaining the principles of the safe learning environment and conducting effective debriefing?
- What process is in place to ensure faculty engage in appropriate continuous professional development, including regular peer and learner evaluation?
- For centres with dedicated simulation technicians and technologists, whose primary

role is to support delivery of simulation based education, what provisions are in place in relation to continuous professional development opportunities to allow them to work towards professional registration with the Science Council?
Supporting Learners: **Learners receive training to meet requirements of learning outcomes expected of the relevant professional standards** • How does the facility ensure simulation-based education programmes are developed in alignment with formal curriculum mapping or learning/training needs analysis undertaken in clinical or educational practice? • How many healthcare learner groups have access to the simulation facilities within your organisation? • What opportunities for inter-professional simulation based education session or courses are provided by your facility?

Item 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27 March 2018**
TITLE:	**Finance Report for Period 1 April 2017 to 28 February 2018**
REPORT OF:	**Drew Kendall, Interim Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 28 February 2018 is a surplus of £9,882k, representing 3.2% of the Trust's turnover and is £483k ahead of plan.

Identified Cash Releasing Efficiency Savings at 28 February 2018 are £1,939k behind plan for the year to date. The shortfall is largely due to slippage on CRES schemes which were due to commence 1 October 2017. The Trust has, and continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements, and has non-recurrent expenditure mitigations in place to manage this position in 2017/18.

The Use of Resources Rating for the Trust is assessed as 2 for the period ending 28 February 2018 and is due to agency expenditure being higher than plan. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year, which is behind plan.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**27 March 2018**
TITLE:	**Finance Report for Period 1 April 2017 to 28 February 2018**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2017 to 28 February 2018.

2. BACKGROUND INFORMATION

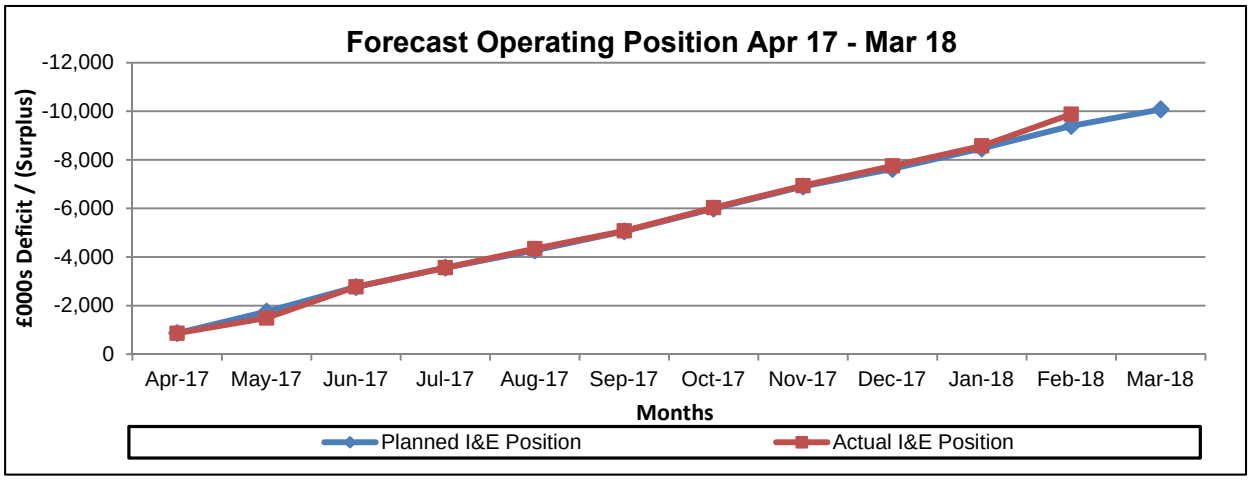
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 28 February 2018 is a surplus of £9,882k, representing 3.2% of the Trust's turnover and is £483k ahead of plan.

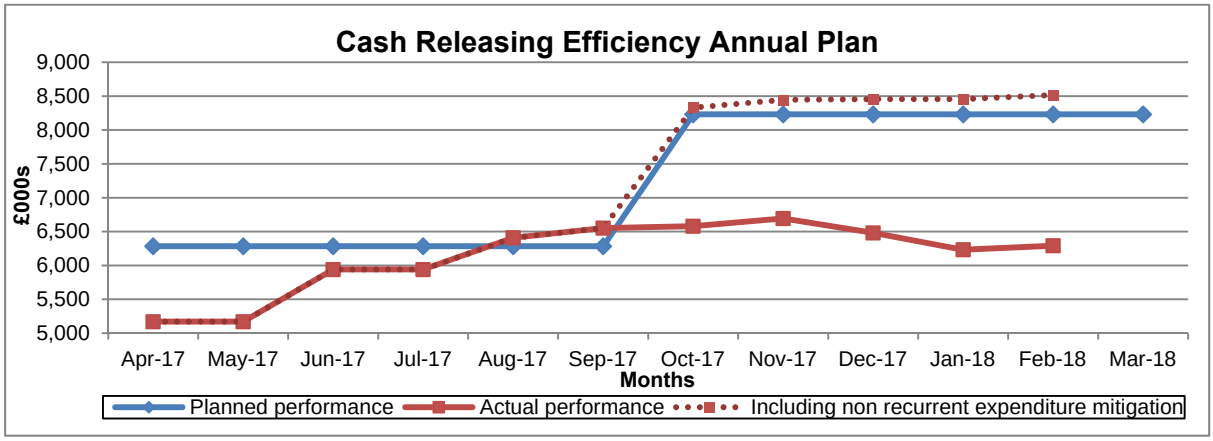
The graph below shows the Trust's planned operating surplus against actual performance.



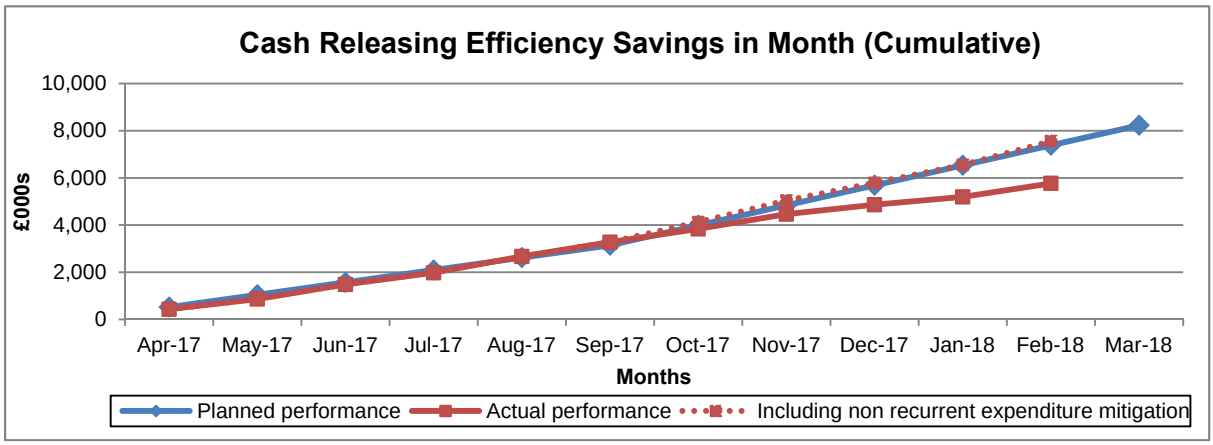
3.2 Cash Releasing Efficiency Savings

Total CRES identified at 28 February 2018 is £6,291k and is £1,939k behind plan. The shortfall is largely due to slippage on CRES schemes due to commence 1 October 2017. The Trust has, and continues to identify and progress schemes to deliver CRES in full for current and future years, and

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

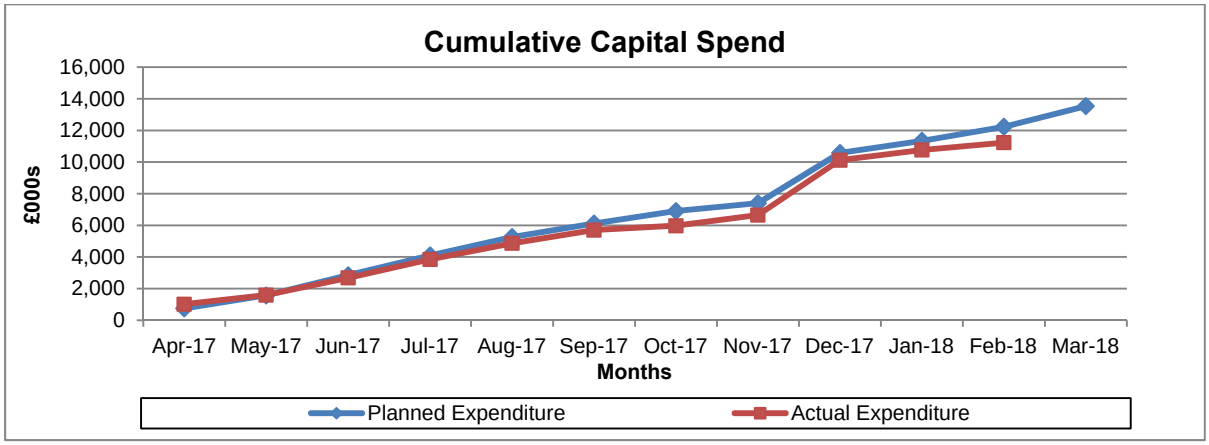


The monthly profile for CRES identified by Localities is shown below.



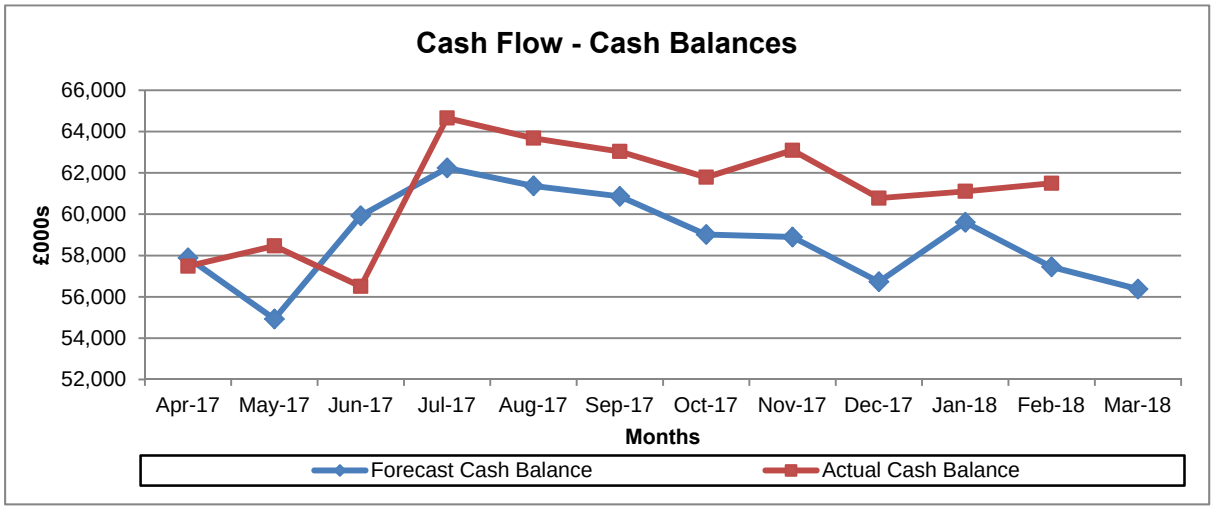
3.3 Capital Programme

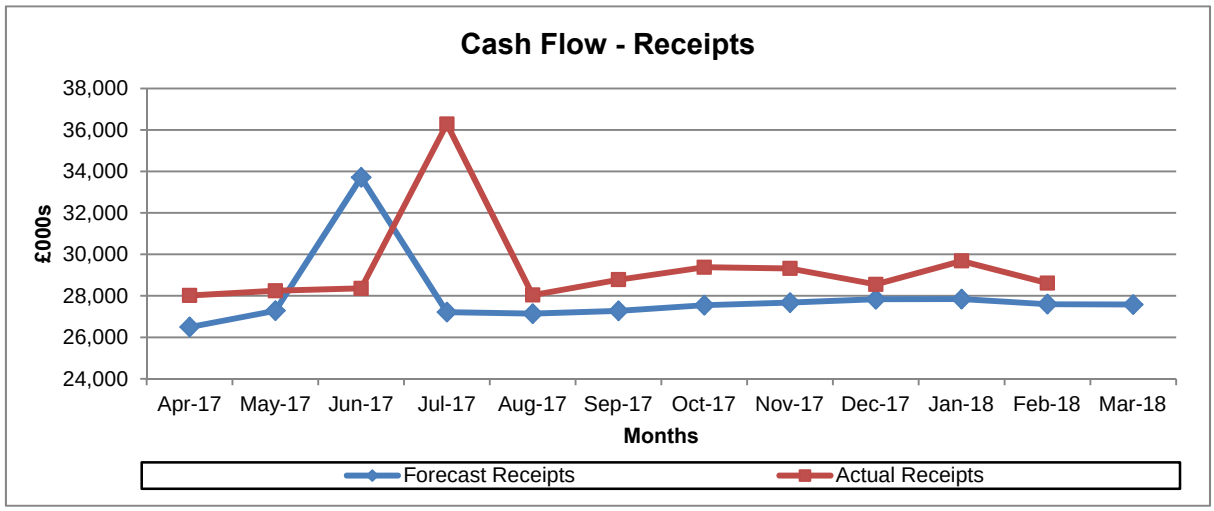
Capital expenditure to 28 February 2018 is £11,230k and is £1,002k behind plan due to delays against identified developments. The year end forecast is £15,492k; which is £1,958k in excess of plan and is due to additional expenditure previously anticipated in 2018/19 financial year.

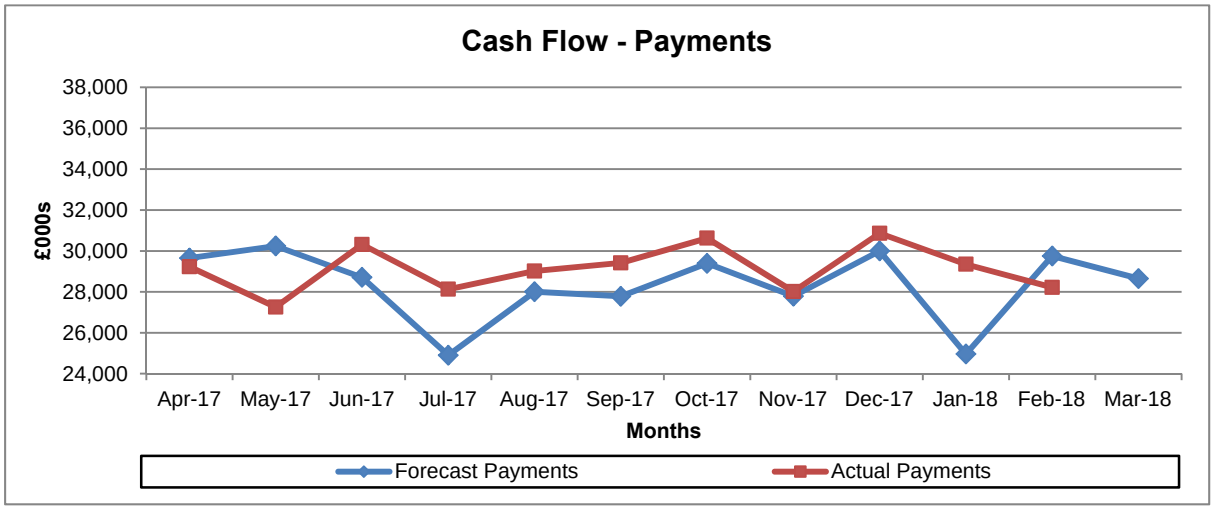


3.4 Cash Flow

Total cash at 28 February 2018 is £61,498k, and is £4,050k ahead of plan largely due to working capital variations.



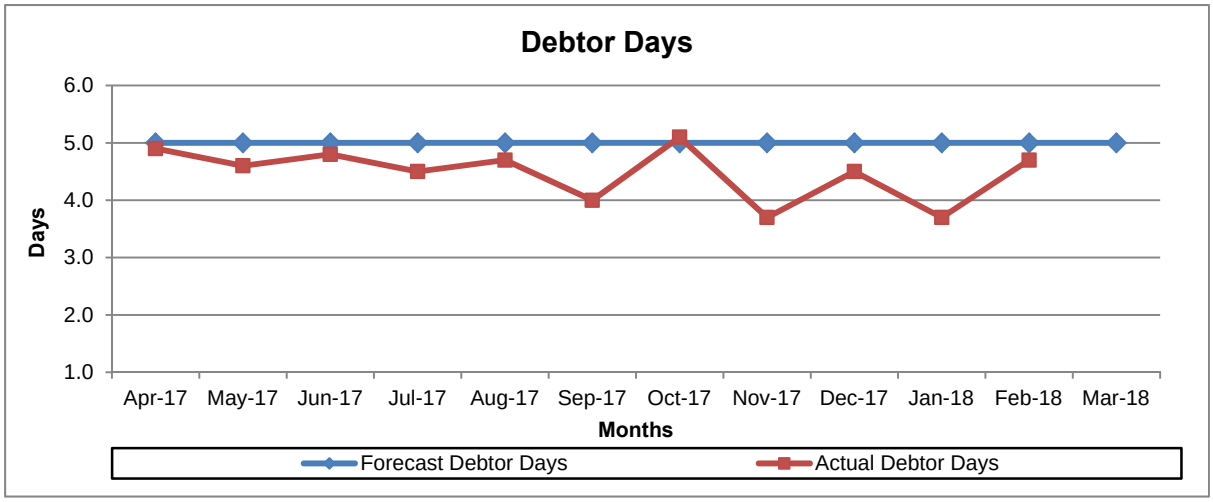




The receipts profile fluctuates over the year for Sustainability and Transformation Fund incentive scheme receipt. The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.

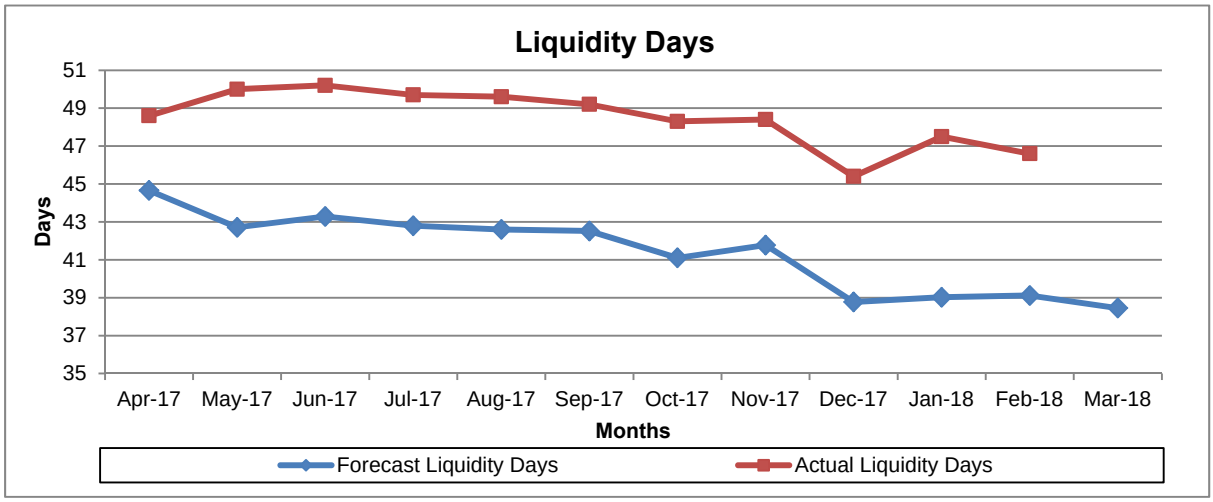
Working Capital ratios for period to 28 February 2018 are:

- Debtor Days of 4.7 days
- Liquidity of 46.6 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 49.39%
  Non NHS 30 Days – 96.86%



The Trust has a debtors' target of 5.0 days, and actual performance of 4.7 days at 28 February 2018, which is ahead of plan.

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



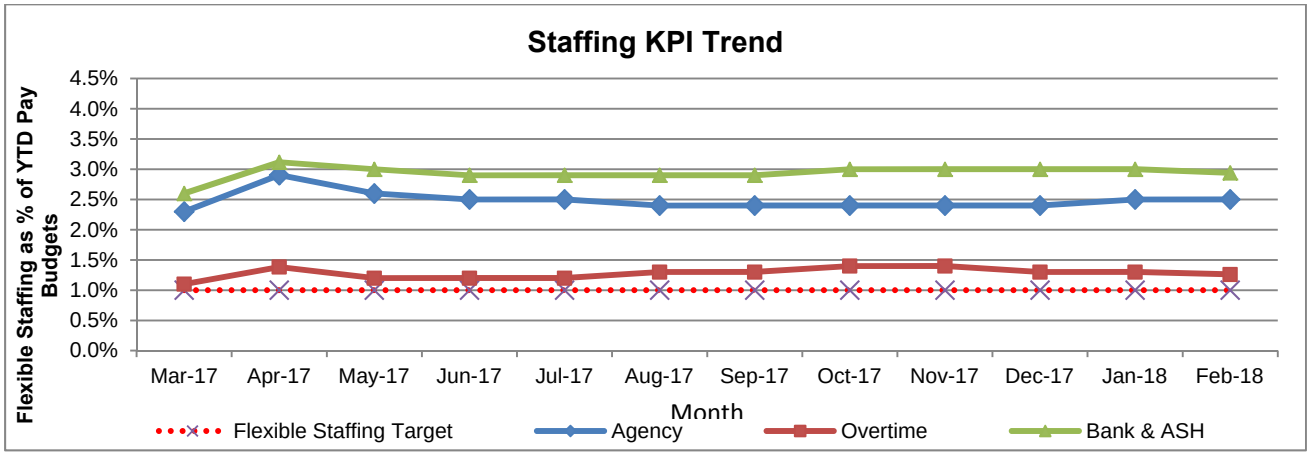
3.5 Financial Drivers

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

Tolerance	Sept	Oct	Nov	Dec	Jan	Feb
Agency (1%)	2.4%	2.4%	2.4%	2.4%	2.5%	2.5%
Overtime (1%)	1.3%	1.4%	1.4%	1.3%	1.3%	1.3%
Bank & ASH (flexed against establishment)	2.9%	3.0%	3.0%	3.0%	2.9%	2.9%
Establishment (90%-95%)	93.1%	94.3%	94.5%	94.5%	94.2%	93.7%
Total	**99.7%**	**101.1%**	**101.3%**	**101.2%**	**100.9%**	**100.4%**

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

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



Additional staffing expenditure is 6.7% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (48%), enhanced observations (21%), service need (12%) and sickness (10%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating for the Trust is assessed as 2 for the period ending 28 February 2018 and is due to agency expenditure being behind plan. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year, which is behind plan.

3.6.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.62x (can cover debt payments due 1.62 times), which is ahead of plan and rated as a 3.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 46.6 days; this is ahead of plan and is rated as a 1.

3.6.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 3.2% and is rated as a 1.

3.6.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding STF income. The Trust I&E margin distance from plan is 0.1% and is ahead of plan and is rated as a 1.

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

The margins on Use of Resource Rating are as follows:

- Capital service cover - to improve to a 2 a surplus increase of £1,854k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £40,277k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £6,759k is required.
- I&E margin distance from plan – to reduce to a 2 an operating surplus decrease of £257k is required.
- Agency Cap rating – to improve to a 1 a reduction in agency expenditure of £310k is required.

Use of Resource Rating at 28 February 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 YT		D Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	1.62x	3	1.54x	3	
Liquidity	46.6 days	1	39.1 days	1	
I&E margin	3.2%	1	3.1%	1	
I&E margin distance from plan	0.1%	1	0.0%	1	
Agency expenditure	£5,966k	2	£5,655k	1	
Overall Use of Resource Rating		**2**		**1**	

3.6.7 4.1% of total receivables (£175k) are over 90 days past their due date; this is below the 5% finance risk tolerance.

3.6.8 1.4% of total payables invoices (£171k) held for payment are over 90 days past their due date. This is within the 5% finance risk tolerance.

3.6.9 The cash balance at 28 February 2018 is £61,498k and represents 71.3 days of annualised operating expenses.

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUS IONS:

6.1 The comprehensive income outturn for the period ending 28 February 2018 is a surplus of £9,882k, representing 3.2% of the Trust's turnover and is £483k ahead of plan.

6.2 Identified Cash Releasing Efficiency Savings at 28 February 2018 are £1,939k behind plan for the year to date. The shortfall is largely due to slippage on CRES schemes which were due to commence 1 October 2017. The Trust has, and continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements, and has non-recurrent expenditure mitigations in place to manage this position in 2017/18.

6.3 The Use of Resources Rating for the Trust is assessed as 2 for the period ending 28 February 2018 and is due to agency expenditure being behind plan. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year, which is behind plan.

7. RECOMMENDATIONS:

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

Drew Kendall
Interim Director of Finance and Information

ITEM 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th March 2018**
TITLE:	**Board Dashboard as at 28th February 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 February 2018 5 (26%) of the indicators reported are not achieving the expected levels and are red. This is an improvement on the 7 that was reported as at the end of January 2018. One of these indicators is showing an improving position over the previous 3 months. There are a further 6 indicators which whilst not completely achieving the target levels are within the amber tolerance levels (which is one more than the number reported as at the end of January).

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

All of the Single Oversight Framework targets were delivered in February with the exception of the Physical Health Care target that was reported in last months Dashboard. In terms of the IAPT recovery rate we achieved 51.6% at Trust level (compared to a target of 50%), with all CCGs but Vale of York achieving the target.

The 5 Year Forward View for Mental Health contains an aspiration to eliminate all inappropriate Out of Area Placements within the next three years. As such STPs were required to submit a trajectory to NHSE to reduce the number of Out of Area Placements to zero over the next 3 years. The Trust in conjunction with Commissioners has developed and submitted a trajectory to reduce the number of out of area placements by 10% per year over the next three years. Whilst it is recognised that this will not achieve the expected reduction to zero it is considered that this would not be achievable given the reduction in beds linked to the Roseberry

Park defect rectification and the known under-provision of Adult Mental Health beds in the interim provision at Peppermill for the population of York and Selby. The draft trajectory was discussed with both NHSE and NHSI prior to submission who did not raise any concerns however formal feedback on the final submission has not yet been received.

Recommendations:

It is recommended that the Board:

- Consider the content of this paper and raise any areas of concern/query.
- Note the Out of Area Trajectory that has been submitted to NHSE and that the dashboard indicator for 2018/19 will be aligned to the NHSE definition to enable the Board to monitor progress.

MEETING OF:	**Board of Directors**
DATE:	**27th March 2018**
TITLE:	**Board Dashboard as at 28th February 2018**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 28th February 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 February 2018 5 (26%) of the indicators reported are not achieving the expected levels and are red. This is an improvement on the 7 that was reported as at the end of January 2018. One of these indicators is showing an improving position over the previous 3 months.

  It should be noted that the 5 reds are split across all 4 domains, with the activity domain having 2 and the other 3 domains having 1 each.

  There are a further 6 indicators which whilst not completely achieving the target levels are within the amber tolerance levels (which is one more than the number reported as at the end of January).

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

- All of the Single Oversight Framework targets were delivered in February with the exception of the Physical Health Care target that was reported in last months Dashboard. In terms of the IAPT recovery rate we achieved 51.6% at Trust level (compared to a target of 50%), with all CCGs but Vale of York achieving the target.

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

2.2 Out of Area Placements

The 5 Year Forward View for Mental Health contains an aspiration to eliminate all **inappropriate** Out of Area Placements within the next three years. As such STPs were required to submit a trajectory to NHSE to reduce the number of Out of Area Placements to zero over the next 3 years. The Trust in conjunction with Commissioners has developed and submitted a trajectory to reduce the number of out of area placements by 10% per year over the next three years. Whilst it is recognised that this will not achieve the expected reduction

to zero it is considered that this would not be achievable given the reduction in beds linked to the Roseberry Park defect rectification and the known under-provision of Adult Mental Health beds in the interim provision at Peppermill for the population of York and Selby. The draft trajectory was discussed with both NHSE and NHSI prior to submission who did not raise any concerns however formal feedback on the final submission has not yet been received. Within the Trust Dashboard 2018/19 the Board have identified an Out of Area KPI and the construction and target for this will be aligned to the national indicator and trajectory submitted in order to support the Board in gaining assurance of progress.

2.3 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.

2.4 Key Risks

- Referrals (KPI1) – The number of referrals received in February has decreased which is in line with the trend in 2016/17. It should be noted however that it remains higher than the target and higher than the previous two years. It should also be noted that caseload turnover (KPI 2) has deteriorated further in February which is likely to be linked to the high number of referrals particularly in CAMHS in earlier months.
- 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. However February shows a deterioration on the improvement that had been seen since September, with only North Yorkshire achieving the target. Work has been undertaken in Durham and Darlington to understand the position and this was reported to the Board last month. A similar investigation is being undertaken in Tees. 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 number of unexpected deaths classed as a serious incident has reduced further in February the rate still remain above the expected levels. There were 9 unexpected deaths classed as a serious incident in February compared to 10 in January. Work has been completed in January to establish if there were any trends looking at a longer period of time (October to December 2017) and further discussion is planned in March to understand the findings from this.
- Sickness (KPI 18) – There has been a further deterioration in the performance reported in February such that the sickness rate was significantly worse than it has been in the previous three years.
- CRES Delivery (KPI 20) – the delivery of the CRES is behind plan for the month of February and year to date. The deterioration in month is due to slippage on CRES schemes due to commence 1 October 2017. The Trust has, and continues to identify and progress schemes to deliver CRES in

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

3. RECOMMENDATIONS:

3.1 It is recommended that the Board:

- Consider the content of this paper and raise any areas of concern/query.
- Note the Out of Area Trajectory that has been submitted to NHSE and that the dashboard indicator for 2018/19 will be aligned to the NHSE definition to enable the Board to monitor progress.

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Activity

	February 2018				April 2017 To February 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Total number of External Referrals into Trust Services	7,040.00	8,625.00			83,966.00	96,447.00		91,759.00
2) Caseload Turnover	1.99%	1.87%			1.99%	1.87%		1.99%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	87.84%			85.00%	86.33%		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	63.00			75.00	63.00		75.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	9.64%			10.00%	8.91%		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	18.00	27.33			217.00	281.66		237.00

Quality

	February 2018				April 2017 To February 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%	91.43%			90.00%	90.79%		90.00%
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	9.19%			10.00%	8.64%		10.00%
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	17.23%			20.00%	14.18%		20.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	91.12%			92.45%	91.60%		92.45%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.45			11.00	14.40		12.00

Trust Dashboard Summary for TRUST

Workforce

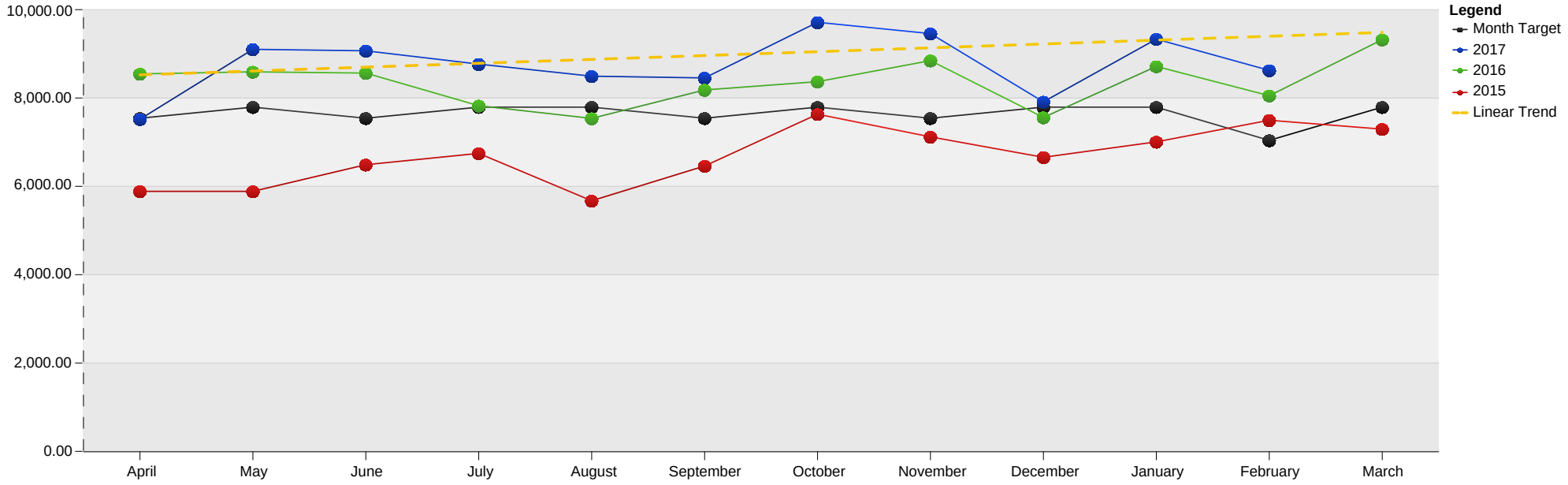
	February 2018				April 2017 To February 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	93.71%			100.00%	93.71%		100.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	16.22%			15.00%	18.87%		15.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	93.57%			95.00%	93.57%		95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	89.04%			90.00%	89.04%		90.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	6.09%			4.50%	5.21%		4.50%

Money

	February 2018				April 2017 To February 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-926,000.00	-1,310,000.00			-9,399,000.00	-9,883,000.00		-10,076,000.00
20) CRES delivery	848,000.00	573,380.68			7,382,080.00	5,766,418.61		8,230,080.00
21) Cash against plan	57,448,000.00	61,498,000.00			57,448,000.00	61,498,000.00		56,376,000.00

Trust Dashboard Graphs for TRUST

1) Total number of External Referrals into Trust Services

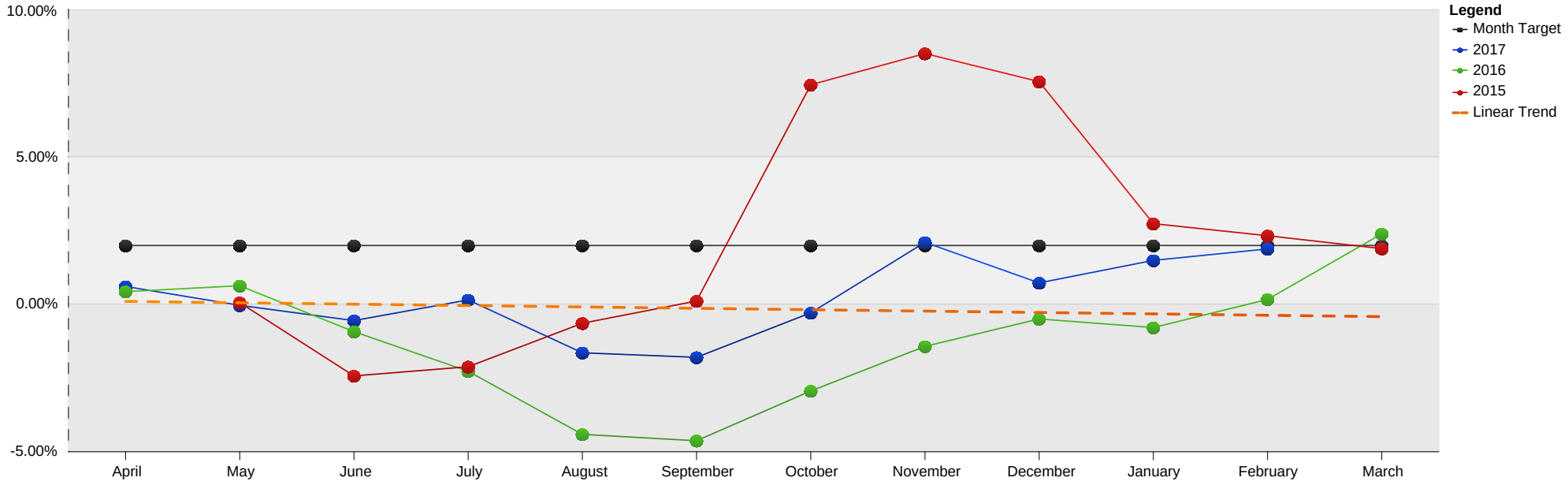


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Total number of External Referrals into Trust Services	8,625.00	96,447.00	2,024.00	22,313.00	2,667.00	28,898.00	1,940.00	22,758.00	586.00	6,928.00	1,408.00	15,547.00		

Narrative
The Trust position for February 2018 is 8625 which is above the Trust target of 7040. This is a reduction on the number of referrals received in January 2018 with all localities having seen a reduction.
This position is an increase to that reported in February 2017 with all localities with the exception of Tees showing an increase.
York and Selby are the only locality meeting target.
Based on current trends it is anticipated that we will exceed the annual target of 91,759.

Trust Dashboard Graphs for TRUST

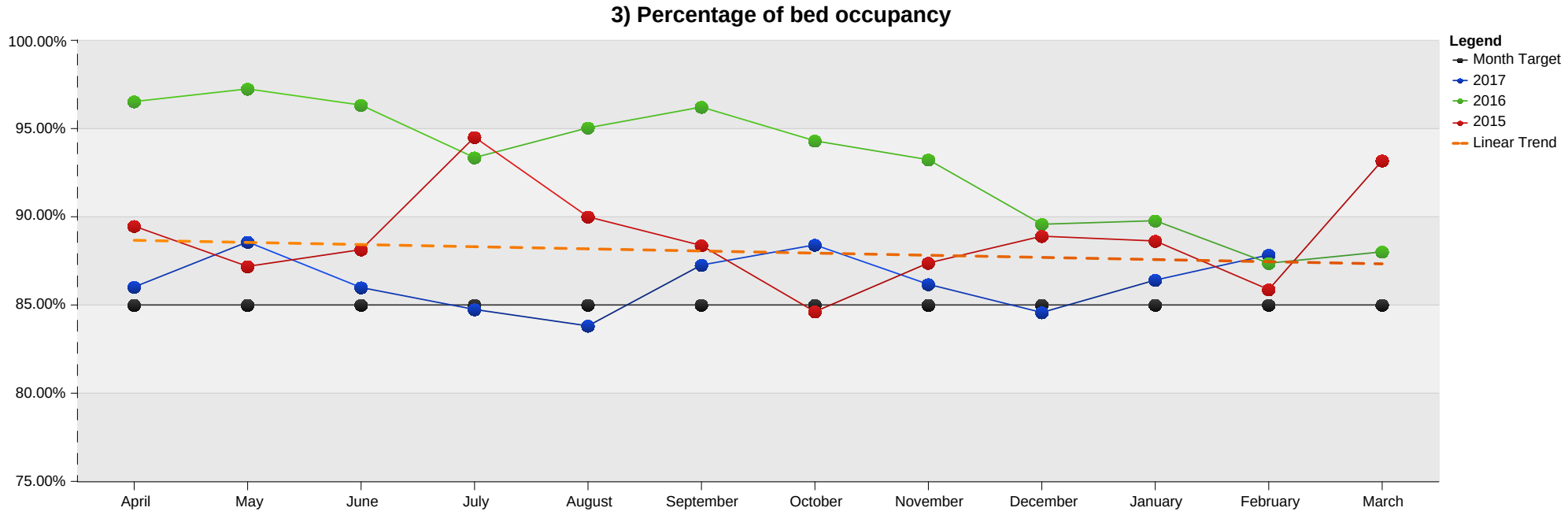
2) Caseload Turnover



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Caseload Turnover	1.87%	1.87%	3.25%	3.25%	2.34%	2.34%	-2.95%	-2.95%	NA	NA	4.22%	4.22%		

Narrative
The Trust position for February 2018 is 1.87% which is meeting the Trust target of 1.99%. This is a deterioration to that reported in January 2018. North Yorkshire are meeting target. Under performance in Durham and Darlington, Tees and York and Selby is within CAMHS services and this is due to an increase in the number of referrals received in October and November. Based on current trends it is anticipated that we will meet the annual target of 1.99%.

Trust Dashboard Graphs for TRUST

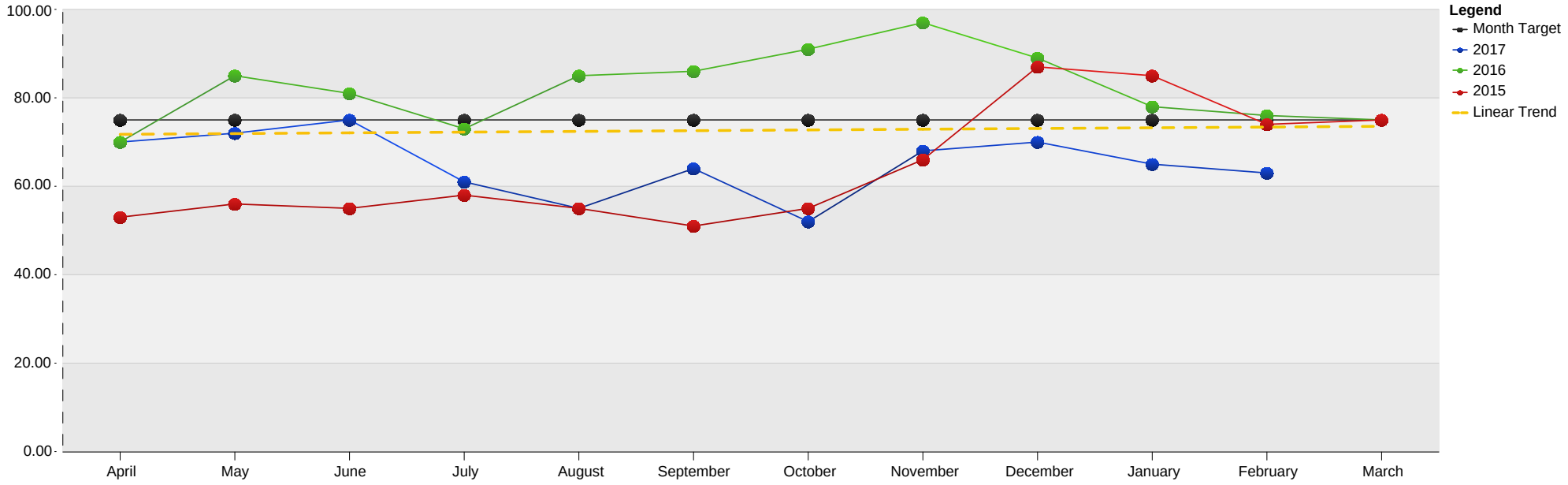


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	87.84%	86.33%	84.78%	88.37%	95.65%	85.58%	86.97%	89.50%	NA	NA	84.08%	79.38%		

Narrative
The Trust position for February 2018 is 87.84% which is worse than target and a deterioration on the position of 86.44% recorded in January 2018. Tees are reporting the highest bed occupancy at 95.65% with key pressures within the MHSOP service, this is as a result of patients undergoing ECT and delayed discharges. Actions are in place to address this and all patients have commenced discharge planning. North Yorkshire have seen a slight deterioration in performance which is as a result of pressures on male beds within AMH, a position which is replicated across the Trust.

Trust Dashboard Graphs for TRUST

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



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	63.00	63.00	14.00	14.00	15.00	15.00	17.00	17.00			16.00	16.00		

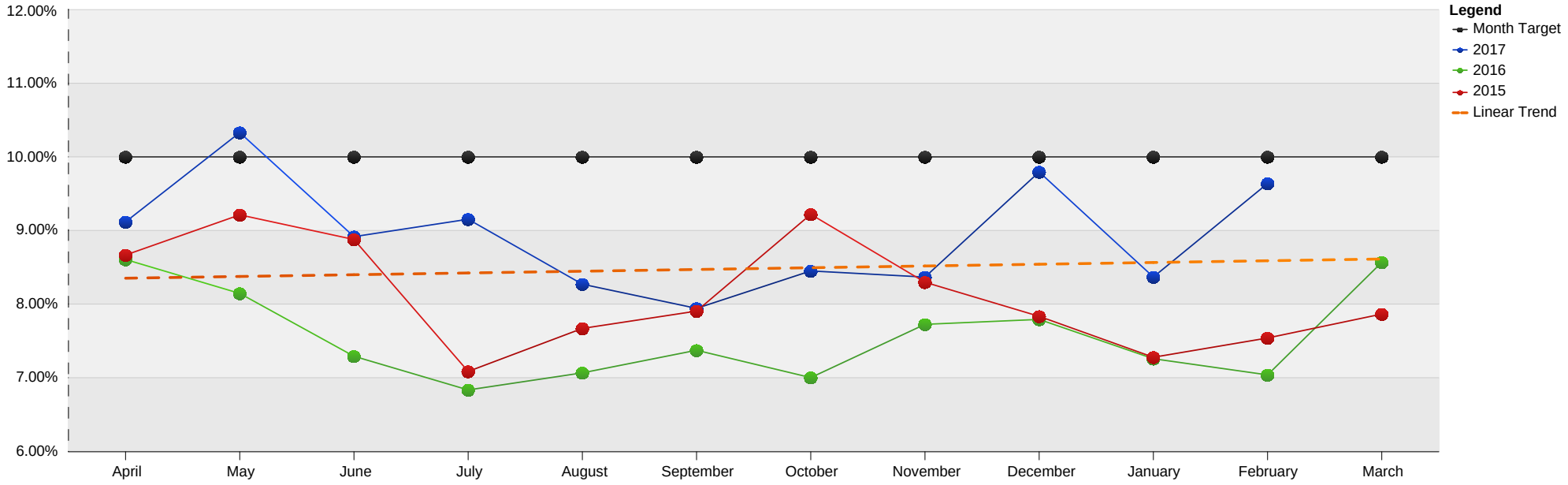
Narrative
The Trust position for February 2018 is 63 which is meeting the target of 75 but is an improvement compared to that reported in January 2018. Of the 63 patients occupying a bed with a LoS greater than 90 days: • 14 (22.22%) were within Durham and Darlington (5 MHSOP and 9 AMH) • 16 (25.39%) were within York & Selby (14 MHSOP and 2 AMH) • 15 (23.80%) were within Teesside (10 MHSOP and 5 AMH) • 17 (26.98%) were within North Yorkshire (5 MHSOP and 12 ADULTS) • 1 (1.58%) was Unknown CCG but was within the MHSOP service North Yorkshire and York and Selby 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 appropriate placements. Tees are not achieving target although are starting 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

Trust Dashboard Graphs for TRUST

Narrative
patients. This is being addressed with partner agencies as soon as possible. Based on current trends it is expected that we will meet the annual target of 75.

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	9.64%	8.91%	8.17%	8.04%	10.38%	8.95%	8.13%	8.30%			13.73%	11.00%		

Narrative

The Trust rolling 3 month position ending February 2018 is 9.64%, which relates to 23.99 patients out of 249 that were readmitted within 30 days. This is meeting the target of 10% but is a deterioration on the position recorded in January 2018.

Of the 23.99 patients re-admitted:

- 8.33 (34.72%) were within Durham & Darlington (8.33 AMH)
- 4.66 (19.42%) were within York and Selby (3.99 AMH and 0.66 MHSOP)
- 3.33 (13.88%) were within North Yorkshire (2.99 AMH and 0.33 MHSOP)
- 6.33 (26.38% were within Teesside (6.33 AMH)

(*Please note data is displayed in decimal points due to the rolling position being calculated.)

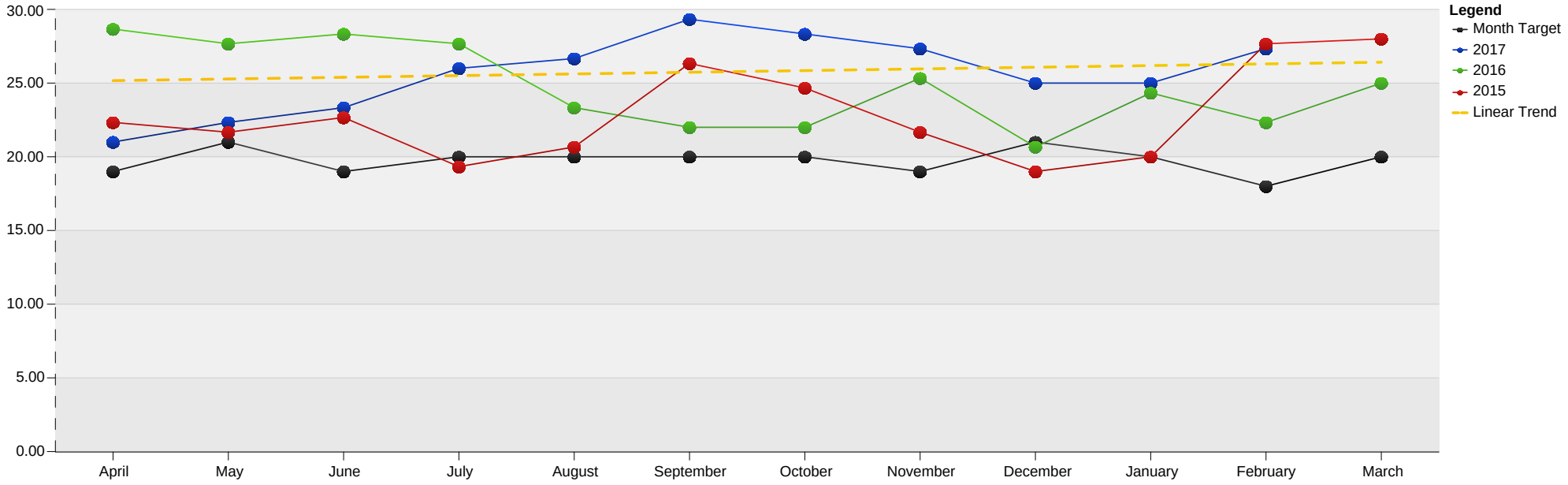
Durham and Darlington and North Yorkshire are achieving target for this indicator. Within Durham and Darlington there are a high number of readmissions and the service have completed focused work to improve the understanding of this issue and set appropriate actions to address these.

Trust Dashboard Graphs for TRUST

Narrative
Tees and York and Selby are within 10% of target. Both localities have seen a deterioration in performance within the AMH service. Focused work is ongoing within each locality to address issues around re-admissions. (For further details see Indicator 6).

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	27.33	281.66	11.33	103.33	6.67	59.33	3.00	50.33			4.67	53.67		

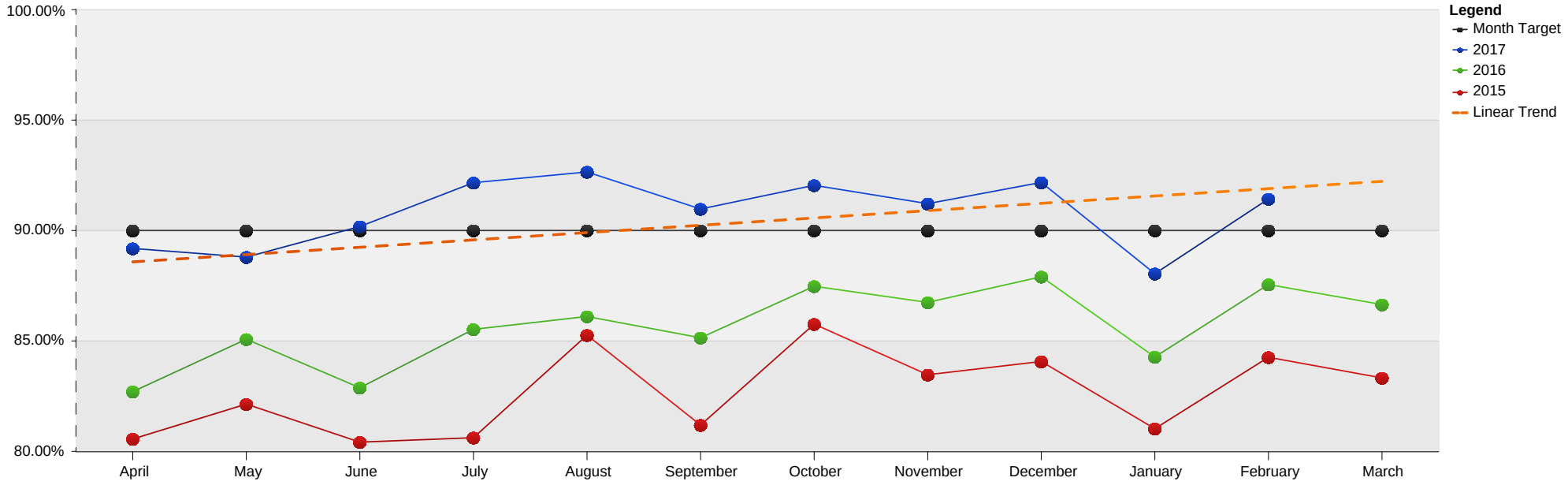
Narrative
The Trust rolling 3 month position ending February 2018 is 27.33 which is 9.33 worse than the target of 18 and a deterioration compared to the position reported in January 2018. Only North Yorkshire are achieving target. Of the 27.33 or more readmissions: • 11.33 (41.45%) within Durham & Darlington (11.33 AMH) • 6.66 (24.36%) within Tees (6.33 AMH and 0.33 MHSOP) • 2.99 (10.94%) within North Yorkshire (2.33 AMH and 0.66 AMH) • 4.66 (17.05%) within York and Selby (4.33 AMH and 0.33 MHSOP) In York and Selby a deep dive has been completed to review patients admitted and all have been appropriate. The service are carrying out further work on this area with the Assertive Outreach Team and the Wards establishing interface meetings to review this area on an ongoing basis to provide reassurance that all issues have been addressed. In Durham and Darlington work has been completed to improve understanding of this issue and this was fed back to the Board in February. Further discussions are underway within the Operational Management Team regarding the most

Trust Dashboard Graphs for TRUST

Narrative
appropriate way to monitor this at an operational level. The Director of Operations is to progress this further.
In Tees further work is being carried out to look at this and identify reasons for the re-admissions, similar to that undertaken in Durham and Darlington.
(*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.	91.43%	90.79%	95.25%	90.13%	97.95%	98.28%	81.32%	83.35%	100.00%	99.75%	74.10%	74.20%		

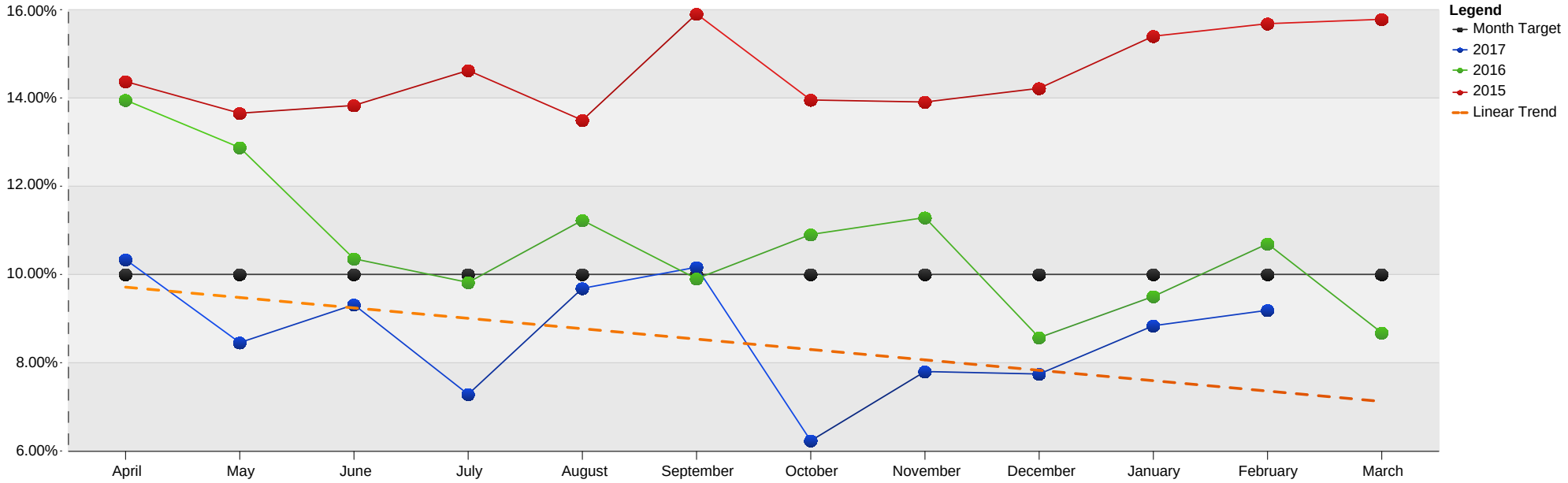
Narrative

The position for February 2018 is 91.43% relating to 503 patients out of 5868 who waited longer than 4 weeks. This is achieving target and an improvement on the January 2018 position. This improvement is across all Localities.

Areas of concern:
• York and Selby Adults at 48.97% (142 of 290 patients). This is an improvement on the January position. The majority of the new referrals are seen within the Access team (164 of the 290 first appointments). This team have seen an increased demand and working at full capacity carrying out 65-70 assessments per week. New referrals are currently being booked in 32 days after referral. The new service (Humber) have impacted on the other teams as patients who have transferred are appearing as new referrals, this is being addressed.
• North Yorkshire AMH at 76.25%(289 of 379 patients). There has been an error in the process within the Primary Care team which has contributed to this. This has been escalated accordingly with the request of urgent remedial action to take place. This is now being addressed and the position should improve over the coming weeks.

Trust Dashboard Graphs for TRUST

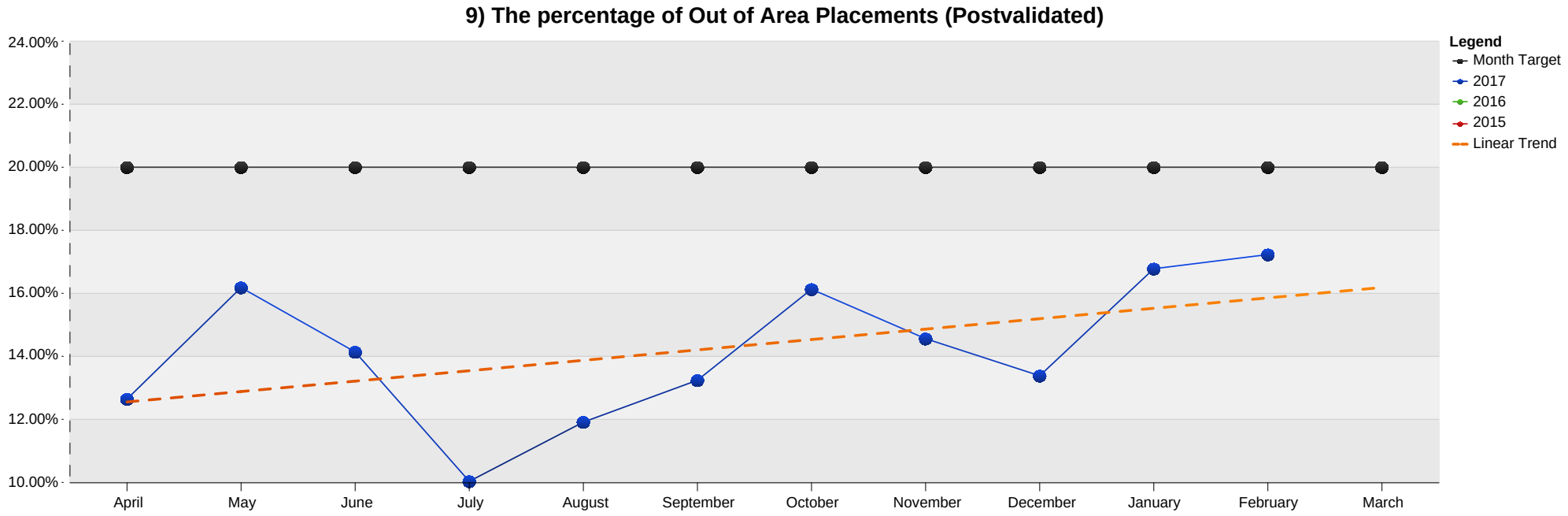
8) Percentage of (Clinic) appointments cancelled by the Trust



	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	9.19%	8.64%	11.24%	10.63%	3.66%	5.69%	14.98%	11.37%			6.17%	5.05%		

Narrative
The Trust position for February 2018 is 9.19% which relates to 259 clinic appointments out of 2819 that have been cancelled. This is meeting the target of 10% but is deterioration on the position in January. Across the Trust, clinic appointments were affected by the weather and travel disruption at the end of the month. All localities are achieving target with the exception of North Yorkshire. In additional to the weather and travel issues, 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

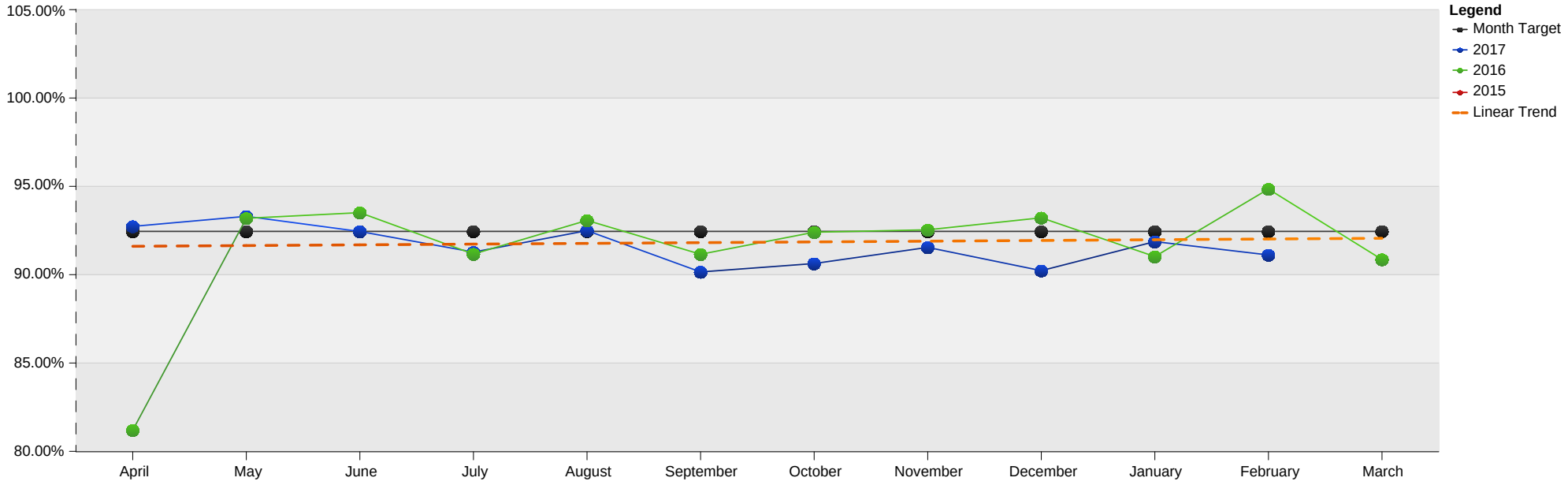


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The percentage of Out of Area Placements (Postvalidated)	17.23%	14.18%	4.44%	5.89%	6.06%	5.04%	36.67%	39.34%			33.33%	22.73%		

Narrative
The Trust position for February 2018 is 17.23% which relates to 46 admissions out of 267 that were inappropriately admitted out of area. This is better than the target of 20% but a deterioration on the January 2018 position. All localities are meeting target with the exception of North Yorkshire and York and Selby. Within North Yorkshire the key pressure remains within AMH where high demand from patients in Harrogate has impacted on the position. Within York and Selby the pressures remain within MHSOP caused be the high number of delated discharges within the locality area (see indicator 4). Of the 46 patients (AMH 38, MHSOP 8) all were due to a lack of bed availability.

Trust Dashboard Graphs for TRUST

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

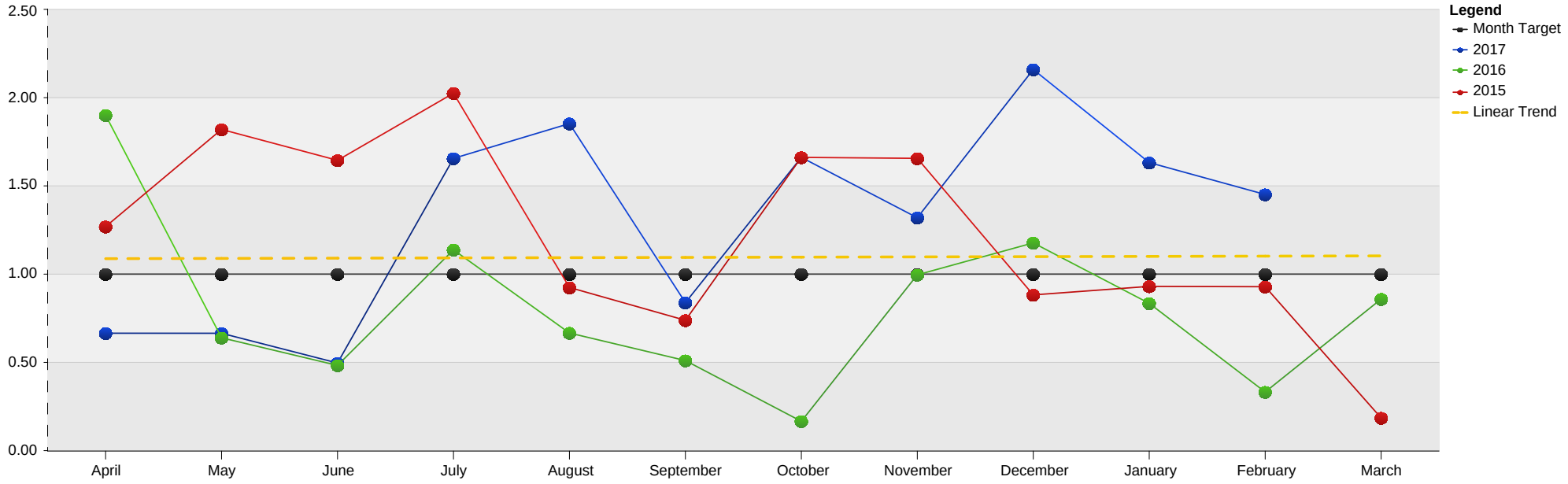


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.12%	91.60%	92.23%	92.45%	89.83%	92.67%	93.01%	91.72%	90.91%	81.51%	89.80%	90.71%		

Narrative
The Trust position reported in February relates to January's performance. The Trust position for January 2018 is 91.12% which is not meeting the target of 92.45% and is a slight deterioration on both the position reported in January 2018.
North Yorkshire are meeting target for this indicator with Tees reporting the poorest performance at 89%, all other localities are within 10% of the target. Work continues within each locality to review performance against this indictor and identify any areas of concern.
As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive).
Due to an amendment to the indicator for this year, data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available.

Trust Dashboard Graphs for TRUST

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



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.45	14.40	0.94	12.52	1.15	11.96	2.74	20.66	0.00	102.15	2.45	11.95		

Narrative

The Trust position for February 2018 is 1.73, which is not meeting the expected number of 1.00. This rate relates to 9 unexpected deaths which occurred in February. This is a decrease on the 10 unexpected deaths reported in January but is still one of the highest levels in the year to date.

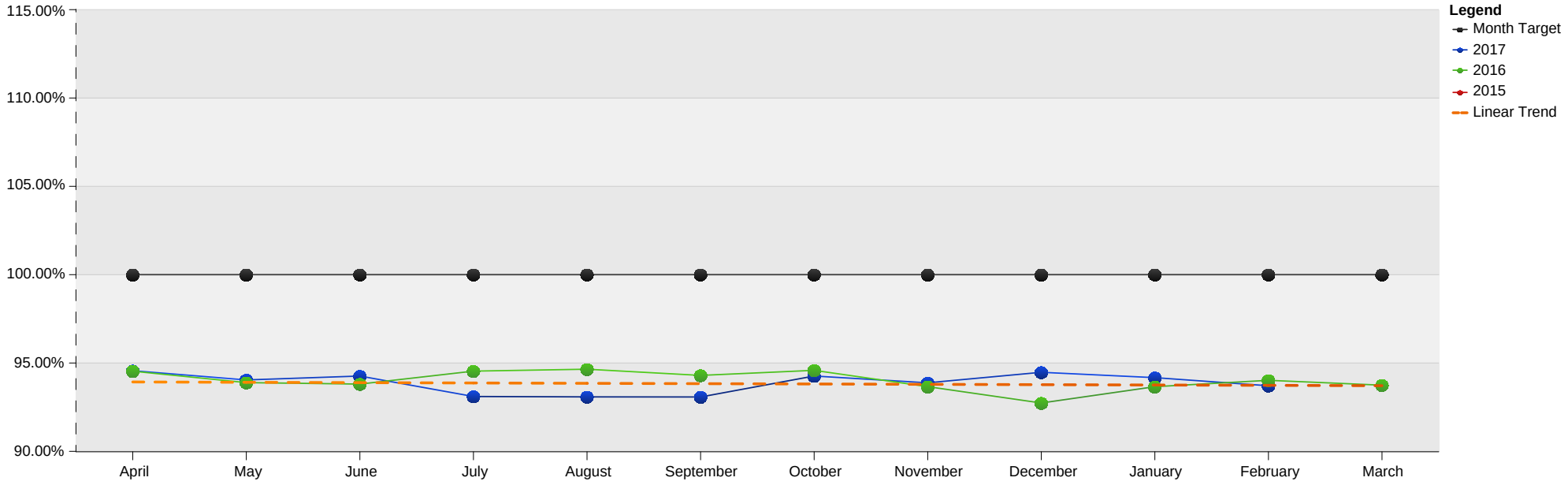
Of the 9 unexpected deaths the details below shows a breakdown by locality:

2 x Tees
2 x Durham and Darlington
3 x North Yorkshire
2 x York and Selby

Of the unexpected deaths that occurred in February 6 occurred in adult services and 3 in MHSOP services. A piece of work is to be completed in January that will review the information from October to December 2017 to establish if there are any themes over a longer time period and a meeting is arranged for March between Patient Safety, Corporate Performance Team and Information team to discuss these findings and the data reported in this indicator.

Trust Dashboard Graphs for TRUST

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

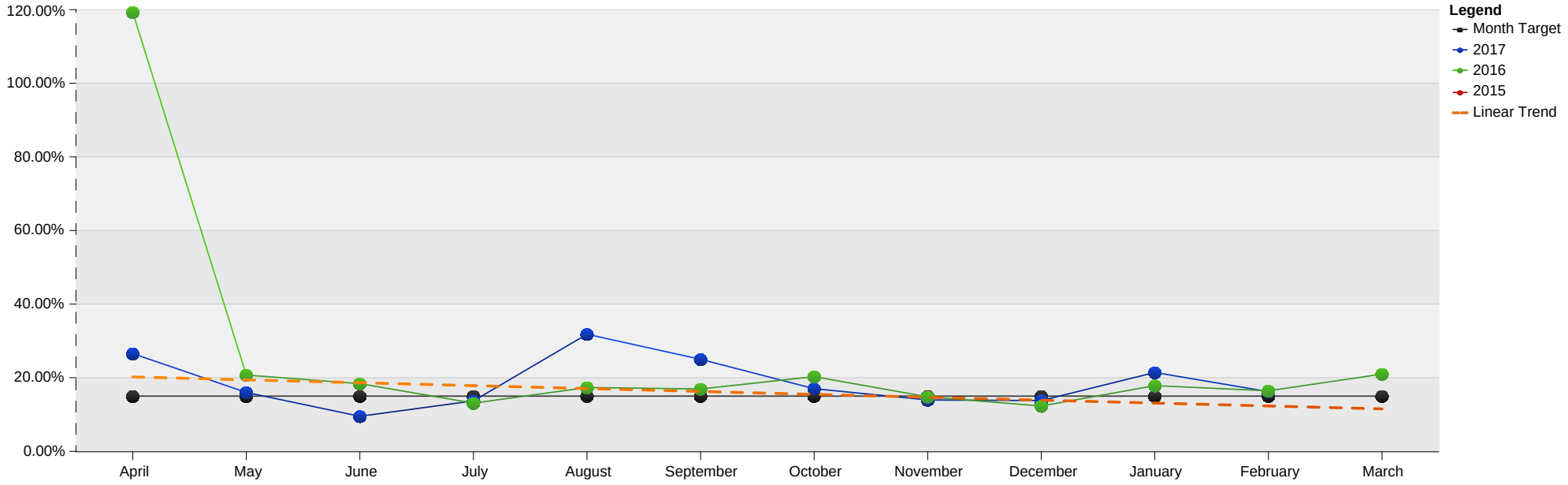


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Actual number of workforce in month (Establishment 95%-100%)	93.71%	93.71%	94.76%	94.76%	97.72%	97.72%	93.01%	93.01%	94.22%	94.22%	84.82%	84.82%		

Narrative
The Trust position for 28 February 2018 is 93.71% which is marginally below the targeted establishment level of 95-100%. The establishment rate reduced in February due to newly agreed contract variations not yet fully recruited to. It is expected that the establishment rate will continue to improve following the appointment of newly qualified nurses (12 currently progressing through pre-employment checks) 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	16.22%	18.87%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative

The Trust position for February 2018 has decreased to 16.22% which is not meeting the target of 15.00%.

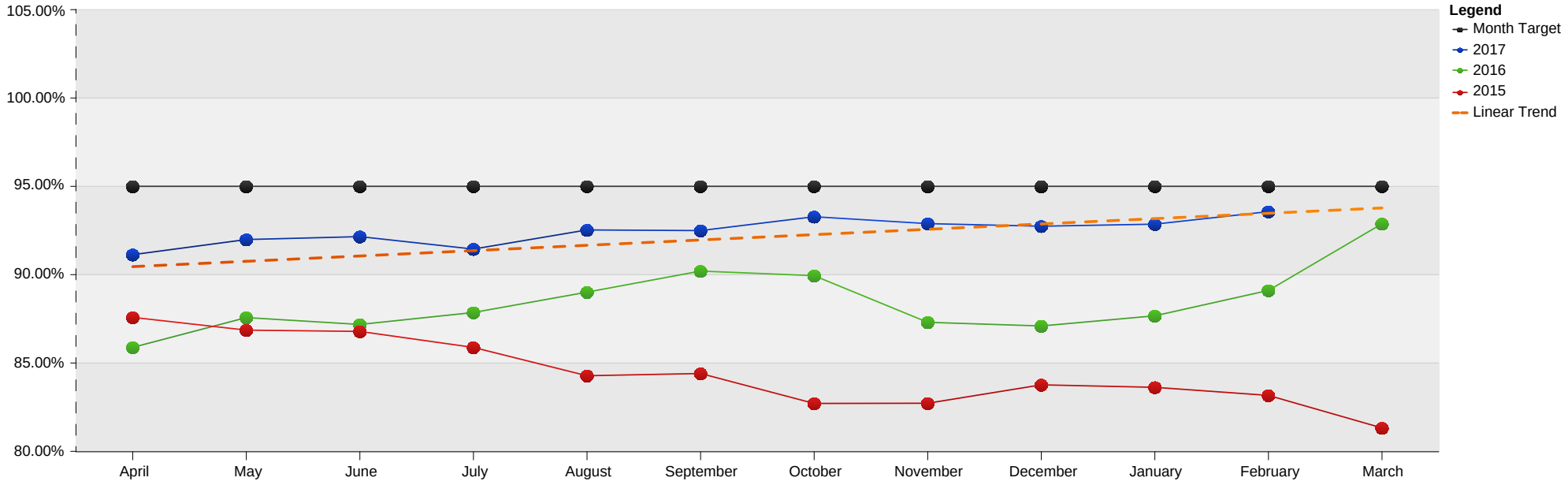
There were 9 non-medical posts re-advertised in February out of a total of 67 posts advertised.

The posts proving difficult to fill are a
- 3 x Staff Nurses – MHSOP in Scarborough,
- 1 x Care Co-ordinator – band 5 – Chester-le-Street,
- A number of registered nurse vacancies from bands 5 to 7 on the Briary Unit, Harrogate
- 1 x Lead Practitioner Counsellor in York.

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)

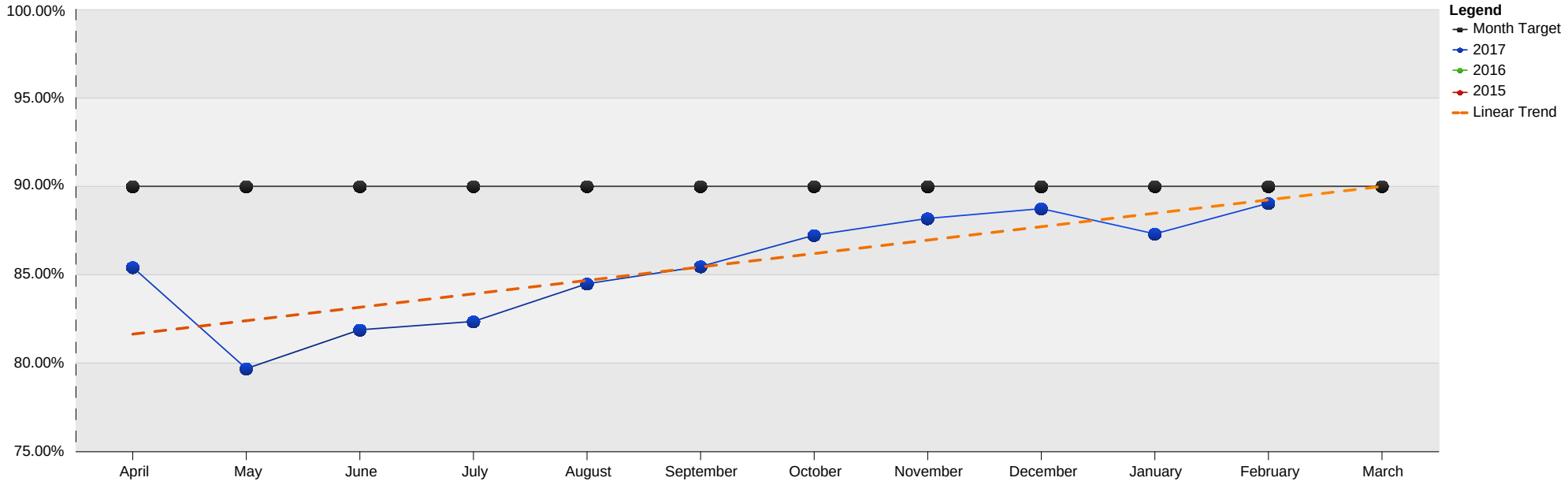


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	93.57%	93.57%	93.88%	93.88%	95.40%	95.40%	91.60%	91.60%	97.48%	97.48%	92.31%	92.31%		

Narrative
The Trust position for February 2018 is 93.57% which relates to 365 members of staff out of 5675 that do not have a current appraisal. This is not meeting the target of 95% and represents a slight improvement on the figure reported in January. It is however the best sustainable positions reported since 2015/16 to date. 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.

Trust Dashboard Graphs for TRUST

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

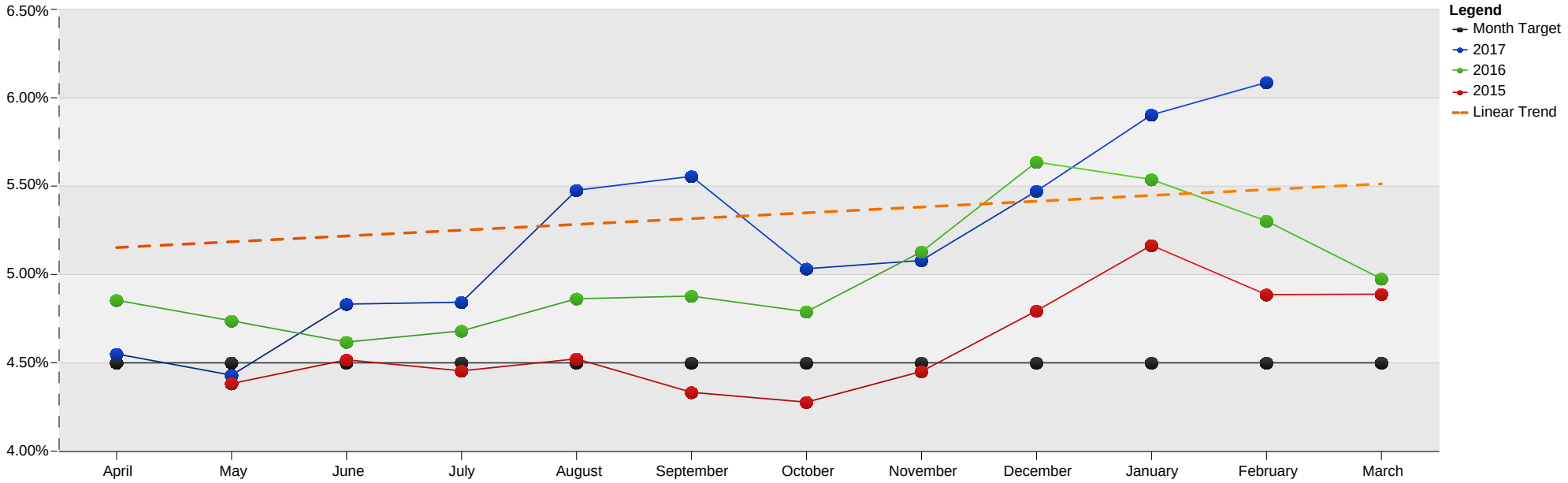


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	89.04%	89.04%	86.63%	86.63%	89.57%	89.57%	88.36%	88.36%	90.72%	90.72%	91.79%	91.79%		

Narrative
The position for February 2018 is 89.04%, which is 0.96% lower than the target of 90%. This figure represents a sustained increase in compliance since April 2017. Problems had been experienced linked to Information Governance reporting figures which have now been rectified which is likely to account for the decrease in compliance in January. The availability of face to face training is impacting on compliance levels and this is being addressed to ensure attendance is maximised at available training courses. It is planned to review the Trusts approach to recording mandatory and statutory training to identify any system improvements to drive efficiencies in the process. This KPI was discussed at the Performance Improvement Group in January 2018 where a number of actions were agreed to address areas of concern. 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)

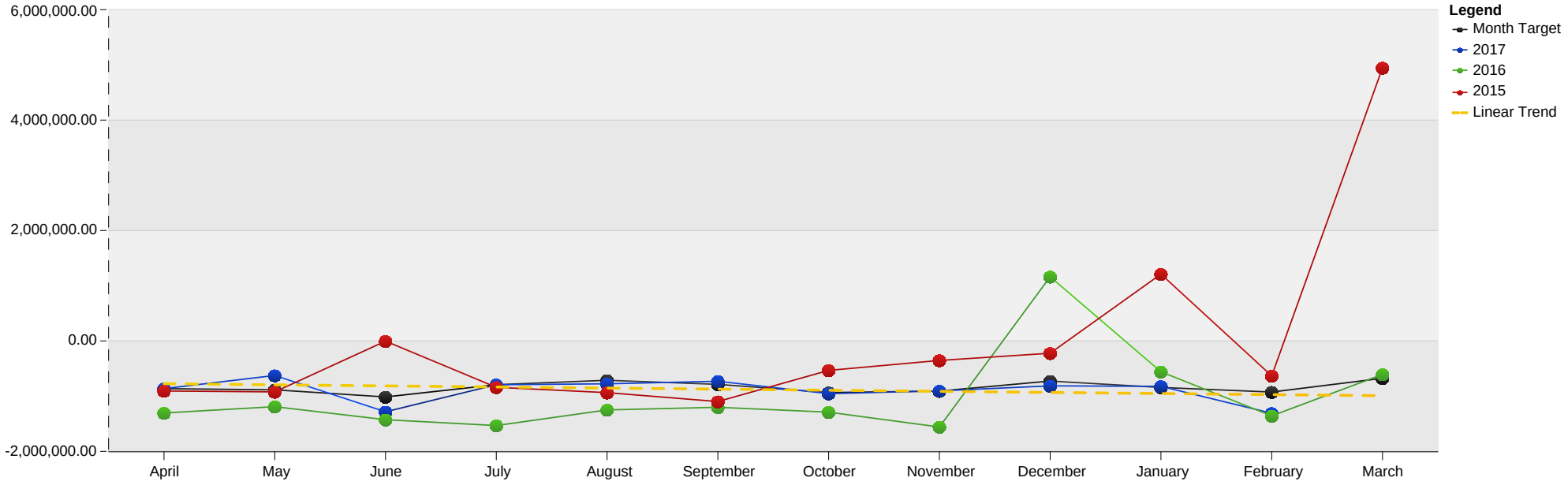


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	6.09%	5.21%	6.24%	5.63%	7.04%	5.83%	4.59%	4.48%	5.73%	5.21%	6.63%	5.69%		

Narrative
The Trust position reported in February relates to the January sickness level. The Trust position reported in February 2018 is a figure of 6.09% which is not meeting target of 4.50% and is a continuing deteriorating position on that reported in January 2018 and is the highest since April 2015. An event was held in November to look at how we can better understand the reasons for the increase in sickness absence we have seen this year and broadly focused on health and well-being within the organisation. The event was productive and identified a number of areas to explore. There is an event scheduled in early April to review Occupational Health provision in TEWV which will also provide an opportunity to pick up discussions and progress actions from the November event. 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

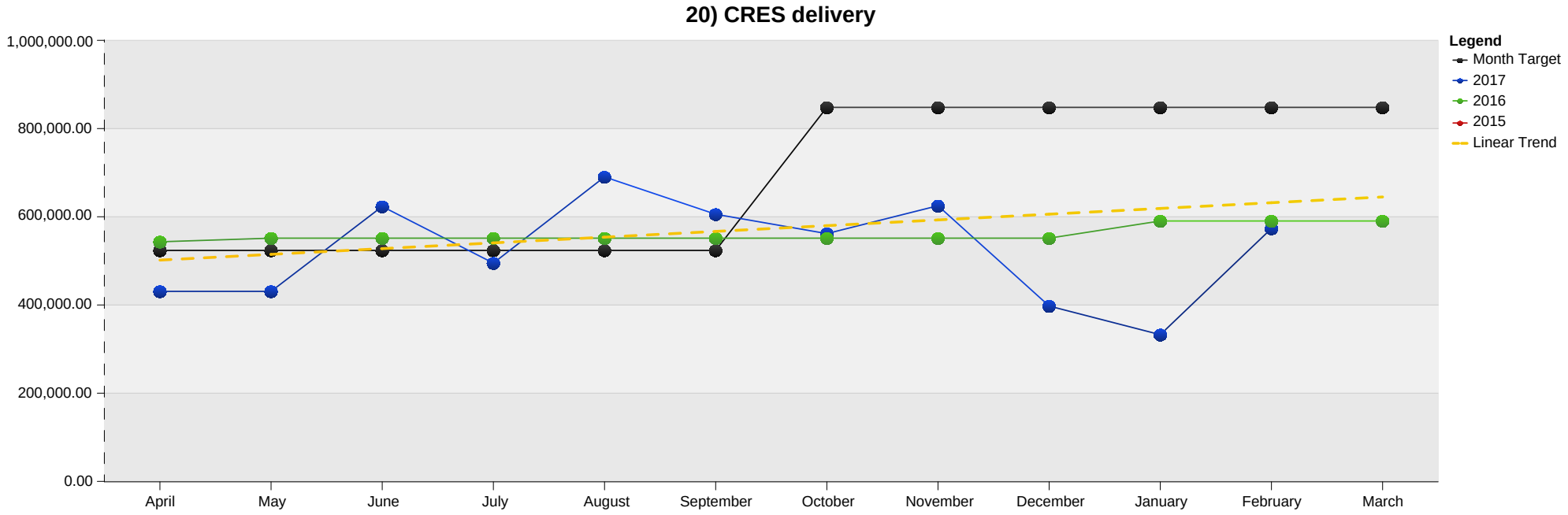
19) Delivery of our financial plan (I and E)



	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)	-1,310,000.00	-9,883,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
The comprehensive income outturn for the period ending 28 February 2018 is a surplus of £9,882k, representing 3.2% of the Trust's turnover and is £483k ahead of plan.

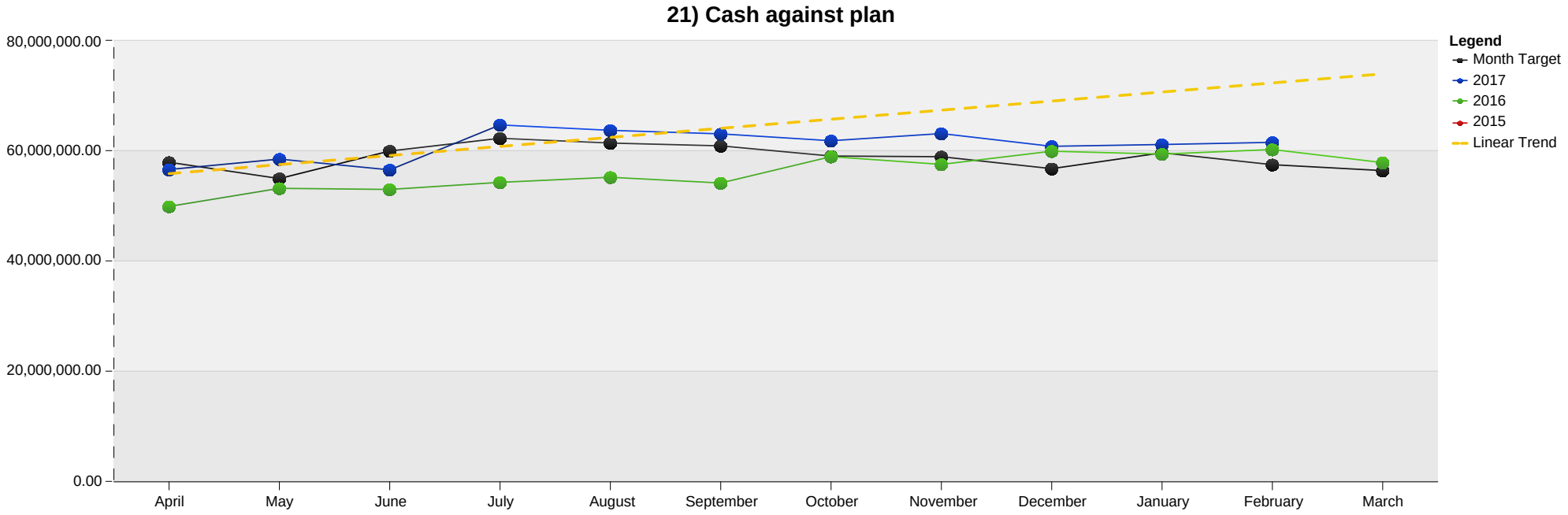
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) CRES delivery	573,380.68	5,766,418.61	138,796.08	1,401,640.99	188,487.00	2,002,947.08	32,242.42	354,665.34	50,195.50	215,237.16	61,672.42	670,065.76		

Narrative
Total CRES identified at 28 February 2018 is £5,767k and is £1,615k behind plan for the year to date. The deterioration is due to slippage on CRES schemes due to commence 1 October 2017. The Trust has, and continues to identify and progress schemes to deliver CRES in full for current and future years, and has non-recurrent expenditure mitigations in place to manage this position in 2017/18.

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Cash against plan	61,498,000.00	61,498,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
Total cash at 28 February 2018 is £61,498k and is £4,050k ahead of plan largely due to working capital variations.

Trust Dashboard - Locality Breakdown for TRUST

1 - Activity

	February 2018														April 2017 To February 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	7,040.00	8,625.00	1,704.00	2,024.00	1,729.00	2,667.00	1,670.00	1,940.00	531.00	586.00	1,407.00	1,408.00			83,966.00	96,447.00	20,310.00	22,313.00	20,641.00	28,898.00	19,914.00	22,758.00	6,309.00	6,928.00	16,793.00	15,547.00		
2) Caseload Turnover	1.99%	1.87%	1.99%	3.25%	1.99%	2.34%	1.99%	-2.95%	NA	NA	1.99%	4.22%			1.99%	1.87%	1.99%	3.25%	1.99%	2.34%	1.99%	-2.95%	NA	NA	1.99%	4.22%		
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	87.84%	85.00%	84.78%	85.00%	95.65%	85.00%	86.97%	85.00%	NA	85.00%	84.08%			85.00%	86.33%	85.00%	88.37%	85.00%	85.58%	85.00%	89.50%	85.00%	NA	85.00%	79.38%		
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	63.00	16.00	14.00	11.00	15.00	22.00	17.00			24.00	16.00			75.00	63.00	16.00	14.00	11.00	15.00	22.00	17.00			24.00	16.00		
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	9.64%	10.00%	8.17%	10.00%	10.38%	10.00%	8.13%			10.00%	13.73%	10.00%		10.00%	8.91%	10.00%	8.04%	10.00%	8.95%	10.00%	8.30%			10.00%	11.00%	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	18.00	27.33	5.00	11.33	5.00	6.67	6.00	3.00			3.00	4.67			217.00	281.66	59.00	103.33	59.00	59.33	72.00	50.33			26.00	53.67		

Trust Dashboard - Locality Breakdown for TRUST

2 - Quality

	February 2018														April 2017 To February 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%	91.43%	90.00%	95.25%	90.00%	97.95%	90.00%	81.32%	90.00%	100.00%	90.00%	74.10%			90.00%	90.79%	90.00%	90.13%	90.00%	98.28%	90.00%	83.35%	90.00%	99.75%	90.00%	74.20%		
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	9.19%	10.00%	11.24%	10.00%	3.66%	10.00%	14.98%	10.00%		10.00%	6.17%			10.00%	8.64%	10.00%	10.63%	10.00%	5.69%	10.00%	11.37%	10.00%		10.00%	5.05%		
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	17.23%	20.00%	4.44%	20.00%	6.06%	20.00%	36.67%			20.00%	33.33%			20.00%	14.18%	20.00%	5.89%	20.00%	5.04%	20.00%	39.34%			20.00%	22.73%		
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	91.12%	92.45%	92.23%	92.45%	89.83%	92.45%	93.01%	92.45%	90.91%	92.45%	89.80%			92.45%	91.60%	92.45%	92.45%	92.45%	92.67%	92.45%	91.72%	92.45%	81.51%	92.45%	90.71%		
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.45	1.00	0.94	1.00	1.15	1.00	2.74	1.00	0.00	1.00	2.45			11.00	14.40	11.00	12.52	11.00	11.96	11.00	20.66	11.00	102.15	11.00	11.95		

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	February 2018														April 2017 To February 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%	93.71%	100.00%	94.76%	100.00%	97.72%	100.00%	93.01%	100.00%	94.22%	100.00%	84.82%			100.00%	93.71%	100.00%	94.76%	100.00%	97.72%	100.00%	93.01%	100.00%	94.22%	100.00%	84.82%		
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	16.22%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA			15.00%	18.87%	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%	93.57%	95.00%	93.88%	95.00%	95.40%	95.00%	91.60%	95.00%	97.48%	95.00%	92.31%			95.00%	93.57%	95.00%	93.88%	95.00%	95.40%	95.00%	91.60%	95.00%	97.48%	95.00%	92.31%		
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	89.04%	90.00%	86.63%	90.00%	89.57%	90.00%	88.36%	90.00%	90.72%	90.00%	91.79%			90.00%	89.04%	90.00%	86.63%	90.00%	89.57%	90.00%	88.36%	90.00%	90.72%	90.00%	91.79%		
18) Percentage Sickness Absence Rate (month behind)	4.50%	6.09%	4.50%	6.24%	4.50%	7.04%	4.50%	4.59%	4.50%	5.73%	4.50%	6.63%			4.50%	5.21%	4.50%	5.63%	4.50%	5.83%	4.50%	4.48%	4.50%	5.21%	4.50%	5.69%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	February 2018														April 2017 To February 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)	-926,000.00	-1,310,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			-9,399,000.00	-9,883,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
20) CRES delivery	848,000.00	573,380.68	107,322.17	138,796.08	198,536.25	188,487.00	148,049.17	32,242.42	124,378.00	50,195.50	59,416.00	61,672.42			7,382,080.00	5,766,418.61	1,180,543.83	1,401,640.99	2,183,898.75	2,002,947.08	1,628,540.83	354,665.34	1,368,158.00	215,237.16	653,576.00	670,065.76		
21) Cash against plan	57,448,000.00	61,498,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			57,448,000.00	61,498,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

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

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

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
28	19	24	6	10

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

Y&S recorded in old Datix not included

		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 NO 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th March 2018**
TITLE:	**To approve the Information Governance Toolkit submission for 2017/2018**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance** **Drew Kendall, Director Finance and Information**
REPORT FOR:	**Decision**

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

Executive Summary:

This report identifies the predicted IG Toolkit scores as predicted for the 31st March 2018.

	Version14 2016-2017	**Version 14.1 2017/2018 Predicted (non compliant)**
Information Governance Management	**100**	**86**
Confidentiality and Data Protection Assurance	**81**	**81**
Information Security Assurance	**91**	**95**
Clinical Information Assurance	**93**	**86**
Secondary Use Assurance	**83**	**83**
Corporate Information Assurance	**77**	**77**
Total	**88**	**87**

The IG Toolkit has been completed and achieved an overall score of 87%. The score will be unsatisfactory at 87% due to non-compliance with IG training even though we are fully compliant in all other sequences.

The on-line IG training was unavailable for a number of months last year due to the training being updated nationally and ESR issues. A recovery plan has been agreed by EMT to achieve 95% by end of June 2018. This will be agreed by NHS Digital as part of our submission.

The Trust has improved its score in the area of Information Security Assurance from 91% to 95%.

Recommendations:
The Board of Directors is asked to note the contents of this report and approve the IG Toolkit submission for 2017/2018 as predicted for the 31st March 2018.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**28th March 2018**
TITLE:	**To approve the Information Governance Toolkit submission for 2017/2018**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide the Trust Board with assurance of the Trust's compliance across all sequences with the IG Toolkit. All sequences have to reach level 2 of the Toolkit. The Trust will, for the first time in many years, not reach level 2 on all sequences. If this occurs the Trust will show as not satisfactory within the IG Toolkit.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 It is a requirement for all NHS Trusts that adequate information governance is in place to ensure clinical and corporate business functions are compliant with both national legislation (Data Protection Act 1998) and the resulting government directives. The Trust's overall compliance in this area is monitored annually through the Information Governance Toolkit (IGT) assessment submitted through NHS Digital.

3. KEY ISSUES:

3.1 Information Governance (IG)

The final out turn for the 2017/2018 version 14.1 IG Toolkit is anticipated to be as follows although minor improvements may be made prior to March 31st 2018:

	Version14 2016-2017 % score	**Version 14.1 2017/2018 Predicted (not satisfactory)**
Information Governance Management	**100**	**86**
Confidentiality and Data Protection Assurance	**81**	**81**
Information Security Assurance	**91**	**95**
Clinical Information Assurance	**93**	**86**
Secondary Use Assurance	**83**	**83**
Corporate Information Assurance	**77**	**77**
Total	**88%**	**87%**

The Digital Safety Board (DSB) approved all supporting evidence on the 7th March 2018 for final upload ahead of the end of March submission.

As a result of posting this result the Trust will need to post a recovery plan and EMT have agreed that training for IG will reach 95% compliance by the

end of June 2018. The Trust has also discovered that other Trusts in the region are facing a non-satisfactory result, due largely to the lateness of publishing the new training tool but also because of issues that have become apparent with ESR. The Trust has also written to NHS Digital highlighting the system unavailability issue as a mitigating factor.

3.2 Senior Information Risk Owner – Risk Management Report 2017/2018

The annual report to the SIRO outlining the risk profile for information assets has been completed and is currently indicating an overall **amber** rating.

The main areas of concern remain the lack of engagement with the risk management systems and the number of incidents that are being raised due to disclosures made in error. Mitigating actions are being considered by the Digital Safety Board (DSB) in the coming months and a forward plan for 2018/19 will be shared with DSB in May 2018.

The Information and Information Governance teams have worked hard this year to improve communication with Trust staff and to support services during a turbulent year, as a result of organisational changes in the Information department. The risks that continue to be identified in the report have been improved as far as possible by working on the people and process aspects of the systems. Some of the risks identified in the report will not improve further without consideration of investment in improved software and this is being pursued.

There have been 15 incidents reported on the IG Toolkit as level 2. No incidents have been reported above level 2. One incident remains open at this time.

The ICO have been in contact regarding 9 of these 15 incidents, either to request further information or to issue a closure notice. Three of these were referred to the ICO's Criminal Investigations Dept.

3.3 Information Governance concerns 2018/2019

The introduction of the General Data Protection Regulation in May 2018 places a requirement on the Trust to demonstrate compliance with data protection law. The new legislation places much more direct onus on the Trust to ensure that patients explicitly know and understand how their information is being used and processed. In the same way as MHA legislation places a legal duty on Trusts to inform patients about their rights, the Data Protection legislation does the same with Information rights. Workshops are being run during March and April to encourage staff to consider how their processes may need to change in this area.

The new toolkit (2018/19) looks at 'assertions' that the Trust will be required to respond to. There is much greater emphasis in these assertions on being able to provide evidence that risks and issues are discussed at Board level as part of their standard agenda. This includes evidence of conversations, such as:

- the top 3 data security and protection risks have been discussed at Board level
- the percentage of Board members that have undertaken level 3 training in data security and awareness.

It is not so much that Board don't discuss matters now but more that it is not explicitly evident in minutes. The work being presented in May for the forward plan will give consideration to how best to develop a work programme that includes Board members.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Completion of the Toolkit to an acceptable standard is monitored as part of the CQC evidence when an inspection takes place. In this way they are assured that the Trust has the correct governance and assurance processes in place to demonstrate adherence to the Data Protection Act 1998. In this year we will report the Trust as not satisfactory with the IG Toolkit. The Trust has a recovery plan in place but will still have to apply to NHS Digital individually for certain actions such as use of secondary use data (SUS) when flowing information between Health and Social care. The recovery plan will be available for CQC and CCG's to view and understand.

4.2 Financial/Value for Money:

There are no direct financial implications from this report. There are significant financial risks if information security breaches occur or information systems fail, impacting on the regulation and business of the Trust. The risk is also reputational and could affect the Trust's licence to practice depending upon the scale of a breach. The impact of becoming not satisfactory in the area of training will further enhance the level of risk in this area.

4.3 Legal and Constitutional (including the NHS Constitution):

There are no imminent changes in regulation either legal or constitutional that the Directors should be aware of at this time. The new DPA regulations will be expected to be introduced during 2018. However, there are no radically new systems to be put in place; rather that we will be changing from having the option to carry out some tasks *e.g.* privacy impact assessments to being required to complete as part of the legislation.

4.4 Equality and Diversity:

There have been no equality and diversity issues raised as part of the reporting of the IG Toolkit.

4.5 Other implications:

None identified.

5. RISKS:

The upcoming changes to the Data Protection Act 1998 will mean that the asset registers and data flows that are embedded in these registers will become an essential component of Trust compliance evidence.

The introduction of robust processes with clinical staff so that patients and carers understand their information rights is key to the Trust embedding the new legislation successfully.

6. CONCLUSIONS:

6.1 The Toolkit has been completed and achieved an overall score of 87%. The overall rating will show as unsatisfactory due to non-compliance with sequence 112 IG Training. All other sequences are fully compliant.

6.2 The Trust has improved its score in the area of Information Security Assurance from 91% to 95%.

7. RECOMMENDATIONS:

7.1 The Board of Directors of directors are asked to note the content of the report and approve the IG toolkit submission for 2017/18.

Author: Elizabeth Moody and Drew Kendall
Title: Director of Nursing and Governance (Caldicott Guardian) and Director of Finance and Information (SIRO)

Background Papers:

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

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

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

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

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board of Directors of the use of the Trust's Seal in accordance with Standing Orders.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 An entry of every sealing is made and numbered consecutively in a Register specifically provided for the purpose. It is signed by the persons who have approved and authorised the document and those who attested the seal.

3. KEY ISSUES:

3.1 The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
331	13.03.18	TR1 form (Transfer of Registered Title) in relation to land on the east side of Haxby Road, York	Colin Martin, Chief Executive Drew Kendall, Interim Director of Finance and Information

4. IMPLICATIONS:

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

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

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

4.4 **Equality and Diversity:** None identified.

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

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

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution
Seals Register

ITEM NO. 18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27 March 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:

- One procedure and two policies that have undergone full review and require ratification:
  - CLIN-0078-v2 Nasogastric Insertion and Management Procedure
  - MHA-0012-v6 Deprivation of Liberty Policy
  - CORP-0006-v7 Information Governance Policy

- Two policies that have undergone minor amendment:
  - CLIN-0012-v7.2 Admission, Transfer and Discharge of service users within hospital and residential settings Policy
  - IA-0002-v6.1 Care Programme Approach (CPA) Policy

- Two policies to be extended:
  - PHARM-0002-v6 Medicines Overarching Framework
  - CLIN-0051-v5 Care and Management of Dual Diagnosis Policy

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meeting held on 14 March 2018

DATE:	**27 March 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-0078-v2 Nasogastric Insertion and Management Procedure
Review date: 14 March 2021

This procedure has been reintroduced to compliment the Royal Marsden Manual On-line (RMMO) tool and detail specific Trust considerations giving oversight of the training and competency measures within the Trust.

MHA-0012-v6 Deprivation of Liberty Policy
Review date: 14 March 2021

This policy has undergone full review with minor amendments.

CORP-0006-v7 Information Governance Policy
Review date: 14 March 2021

This policy has been updated in line with the Data Protection Act 2018 (GDPR) and to reflect current Trust governance arrangements.

3.2 The following have undergone minor amendment:

Minor amendments have been made to the following as required for a homicide action plan for NHS England.

CLIN-0012-v7.2 Admission, Transfer and Discharge of service users within hospital and residential settings Policy
Review date: 02 November 2019

IA-0002-v6.1 Care Programme Approach (CPA) Policy
Review date: 6 April 2019

3.3 The following are requested to be extended:

PHARM-0002-v6 Medicines Overarching Framework
Review date: 30 April 2018

This framework is currently under review and will be presented to EMT for ratification at the meeting to be held on 11 April 2018. An extension is required to enable this work to be completed.

CLIN-0051-v5 Care and Management of Dual Diagnosis Policy
Review date: 30 April 2018

This policy is currently under review and an extension is required while this work is ongoing.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Sound policy development improves patient experience and enhances patient safety and clinical effectiveness.

4.2 Financial/Value for Money:

Any financial implications from the proposals arising from operational and/or practice changes will be managed by the Directorates responsible for policy implementation.

4.3 Legal and Constitutional (including the NHS Constitution):

The Trust requires a contemporary policy portfolio to ensure practice is compliant with legislation, regulation and best practice. The policy ratifications, review extensions and withdrawals will ensure the portfolio is managed to provide the necessary evidence based operational and practice frameworks.

4.4 Equality and Diversity:

The current policy portfolio ensures the Trust meets the required legislative and regulatory frameworks and all policies are impact assessed for any equality and diversity implications. Policy revision and /or specific implementation plans would result from any adverse impact assessments.

4.5 Other implications:

None identified

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meeting on 14 March 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