AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 28th NOVEMBER 2017 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 **31st October 2017**.		**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 and note the Annual Report on Research and Development.	**NL**	**Attached**
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 receive and note a report on learning from deaths.	**EM**	**Attached**
Item 10	To receive the report of the Mental Health Legislation Committee.	**RS/EM**	**Attached**
Item 11	To receive and note a progress report on the composite staff action plan.	**DL**	**Attached**
Item 12	To receive and note a progress report on recruitment and retention action plan.	**DL**	**Attached**
Item 13	To approve the closure of Earlston House.	**BK**	**Attached**

Strategic Items (11.15 am)

Item 14	On the recommendation of the Resources Committee to approve the Digital Transformation Strategy.	**DK**	**Attached**

Performance (11.25 am)

Item 15	To consider the Finance Report as at 31st October 2017.	**DK**	**Attached**
Item 16	To consider the Trust Performance Dashboard as at 31st October 2017.	**SP**	**Attached**
Item 17	To approve the key performance indicators for the Performance Dashboard for 2018/19.	**SP**	**Attached**
Item 18	To consider the Strategic Direction Performance Report for Quarter 2, 2017/18.	**SP**	**Attached**

Items for Information (11.45 am)

Item 19	To receive and note a report on the use of the Trust's seal.	**CM**	**Attached**
Item 20	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 21 To note that a special meeting of the Board of Directors will be held (in conjunction with a seminar) on **Tuesday 19th December 2017** in the Boardroom, West Park Hospital, Darlington at 9.30 am.

Confidential Motion (11.50 am)

Item 22 **The Chairman to move:**

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

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

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

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

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

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

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
22nd November 2017

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 31ST OCTOBER 2017 IN THE HILTON YORK, 1 TOWER STREET, YORK COMMENCING AT 9.30 AM

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

In Attendance:
Mrs. D. Cannings QPM, Public Governor for Hambleton and Richmondshire
Mrs. H. Griffiths, Public Governor for Harrogate and Wetherby
Mrs. R. Hill, Director of Operations for York and Selby (minute 17/263 refers)
Dr. J. Whaley, Guardian of Safe Working (minute 17/264 refers)
Mr. D. Williams, Freedom to Speak Up Guardian (minute 17/265 refers)
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications

Cllr. J. Chilvers, Mrs. S. Carse, Mrs. B. Hughes, Mrs M. Langhan and Mr. R. Samuels, members of the public

17/257 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. M. Hawthorn, Senior Independent Director, and Mr. D. Levy, Director of HR and Organisational Development.

17/258 MINUTES

Agreed *– that the public minutes of the last ordinary meeting held on 26th September 2017 and the special meeting held on 10th October 2017 be approved as correct records and signed by the Chairman.*

17/259 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

It was noted that the correct due date for the provision of further information on the lack of a registered nurse on Harland Ward on 5th August 2017 (night shift), in accordance with minute 17/221 (26/9/17), was November 2017.

17/260 DECLARATIONS OF INTEREST

There were no declarations of interest.

17/261 CHAIRMAN'S REPORT

The Chairman reported on her activities since the last meeting which included:

(1) An update on her visits to Locality management teams.

Mrs. Bessant advised that:

(a) With the exception of forensic services, her present round of visits to locality senior management teams had been completed.

(b) During her latest visit to the Tees Locality:

- The concerns raised, in relation to CRES and activity levels, had been consistent with other localities.
- Staff had been very positive, resilient and proud of their work.

(c) Her visits to the localities would continue and be extended to include other layers of management.

(2) The presentation of a "Living the Values Award" to the CAMHS team in Stockton.

It was noted that discussions during the visit had focused on autism services, waiting times and the development of partnerships.

(3) The presentation of "Long Service Awards" which had included one recipient who had completed 37 years' service for the NHS.

(4) Attendance at the Governor Development Day on 25th October 2017.

The Board noted that the event had been well attended and the Governors had received briefings on a range of issues.

17/262 GOVERNOR ISSUES

No issues were raised.

17/263 LOCALITY BRIEFING – YORK AND SELBY

Mrs. Hill (Director of Operations) gave a presentation on the key issues facing the York and Selby Locality.

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

The Board recognised the significant progress which had been made in the relatively short period of time since the Trust had become responsible for the provision of services in the Locality.

The focus of discussions was on the availability, quality and use of data in the Locality.

In relation to these matters the Board received assurances that:

(1) The availability of data, through the Integrated Information Centre (IIC), and its use by managers had improved and there was an ambition to further develop the sophistication of reporting.

(2) Improvement work was being undertaken, through the PPCS programme, to ensure routine information provided through the IIC met the requirements of ward and team managers.

It was noted that positive feedback had been received from the Leadership and Management Network on the work undertaken.

(3) Data quality was being constantly challenged, and issues escalated, through daily lean management arrangements.

(4) The IIC was achieving its potential.

The Board also noted that:

(1) The engagement of clinical services in the development of IT systems had improved providing a more balanced bottom up/top down approach.

(2) There was a greater emphasis on teams working with systems through the PPCS programme and other service improvements.

The Chairman reported that, whilst mobile working was still a challenge, it was clear from her visits to services that staff were interested in getting the most out of technology and the Trust needed to think about how it could support them to do this.

In addition, clarity was sought on the following matters:

(1) The biggest challenges facing the Locality.

Mrs. Hill advised that the key issues facing the Locality related to managing financial resources and delivering safe services in the context of the challenges facing the CCG. For example, there were risks to the sustainability of liaison services, when time limited national funding ceased, if resources were not able to be released within the local health system.

(2) The work being undertaken by CAMHS in schools in partnership with the City of York Council.

It was noted that:

(a) The Trust's CAMH services supported and supervised the Wellbeing Workers in schools funded by the Local Authority.

(b) Opportunities to develop services (e.g. for children in need in the care system) in partnership with the Local Authority were also being explored.

(3) Whether work was being undertaken with employers on mental health; an objective of the Local Authority's Health and Wellbeing Strategy.

It was noted that:

(a) This work was not being taken forward, at the present time, due to other priorities.

(b) Assistance might be available, following a recent appointment by the DWP, to take this matter forward but any work would need to be paced.

At the conclusion of the discussions the Board thanked Mrs. Hill for her presentation and asked her to pass on its appreciation to staff in the Locality for their continuing hard work.

17/264 REPORT OF THE GUARDIAN OF SAFE WORKING

The Board received and noted the quarterly report of the Guardian of Safe Working.

Arising from the report:

(1) Concerns were expressed about an incident where a Junior Doctor had been allegedly propositioned by a taxi driver.

Board Members also highlighted the potential risks to medical staff and other groups (e.g. Governors and service users) who depended on taxis provided by the Trust.

In relation to this matter:

(a) The difficulties being experienced more widely with regard to the use of taxis by Junior Doctors (e.g. the lack of firms covering isolated areas and problems with the availability of taxis after 9 pm) were noted.

(b) Assurance was provided that the Trust took action, including the cancellation of contracts, where issues arose with taxi firms.

The Board asked for a report to be provided on the Trust's taxi contracts including the incidence of alleged inappropriate behaviour by taxi drivers and the measures in place to protect vulnerable people.

Action: Mr. Kilmurray

(2) Board Members sought clarity on whether the arrangements put in place in the County Durham and Darlington Locality, with the "newly formalised band 6 stand-in nurse" had the potential to address the common and longstanding frustration of Junior Doctors about the coordination and appropriateness of call-outs.

Dr. Whaley advised that considerable thought had been given to how to respond to the introduction of the European Working Time Directive and arrangements had become more co-ordinated. However, the system relied on staff being of sufficient seniority and experience to make appropriate judgements on call outs and the newly established post would support this.

The Board received assurance that the proposed arrangements covered the whole Trust and not just the County Durham and Darlington Locality.

(3) The Chairman, noting the protections provided to junior doctors, questioned whether the Trust was taking sufficient action to address excessive working hours amongst other clinical and non-clinical staff groups.

(4) The Board discussed the level of junior doctor vacancies in the Trust; a matter included on the Trust's strategic risk register.

Dr. Land reported that the Trust could manage with 10 junior doctor vacancies; however, in February 2018, the number of vacancies could increase to 23 or 24 and, at that level, the ability to run rotas would be at risk.

He assured the Board that action was being taken to seek to mitigate these risks and thought would be given to any further options available once the full picture was known.

In response to a question, it was noted that the fundamental issue was the attractiveness of psychiatry with the specialism only being chosen by approximately 2% of medical students, locally, compared to the national requirement of 4%.

Dr. Land reported that:

(a) There was variation in the number of medical students specialising in psychiatry with the Hull York Medical School doing particularly well.

(b) The expansion of medical schools provided opportunities but it was recognised that there was significant work to be undertaken to increase the numbers of medical students specialising in psychiatry to the required level.

The Chairman thanked Dr. Whaley for his report.

17/265 REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN

The Board received and noted the report of the Freedom to Speak Up Guardian.

Board Members raised the following matters:

(1) The actions being taken to address two recommendations arising from the survey of Guardians, undertaken by the national Guardian's office, relating to the development of a local network of champions/ambassadors and to ensure staff had access to support to speak up irrespective of their protected characteristics.

In response it was noted that:

(a) Internal discussions had been held on the development of a network of champions including whether it would be appropriate to combine the role with those of the 'Investors in People' champions or the champion role being considered to support the anti-bullying and harassment procedure.

(b) In addition to a locality based network, it was hoped to have cross-cutting champions to provide access to representatives with a wide range of protected characteristics.

(2) How issues arising from the two case studies included in the report had been addressed and learning from them shared across the Trust.

Mr. Williams advised that:

(a) In the first case, which involved patient safety/quality issues being raised by 10 staff members, a "stop the line" approach had been used. Whilst all the concerns raised by the staff had been addressed, they had provided feedback that the process had left other staff feeling wary of them. Most of the staff had now moved to other roles; however, he had asked for improvement plans to continue to be implemented.

(b) In the second case, a key learning point had been that the manager considered that they had been denied the opportunity to rebut the allegations or learn from the concerns raised. The manager had now moved to another role but feedback had been provided.

(c) Learning from the cases would be compiled and widely publicised across the Trust.

Mr. Martin considered that the report demonstrated the benefits of the role and Mr. Williams's commitment to it.

Overall the Board considered that the role of the Freedom to Speak Up Guardian had been very positive in its first year.

17/266 REPORT OF THE QUALITY ASSURANCE COMMITTEE

Consideration was given to the report of the Quality Assurance Committee (QuAC) including:

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

(2) The key issues discussed by the Committee at its meeting held on 5th October 2017.

The Non-Executive Directors sought assurance on the appropriateness of using the unlicensed injectable form of Clozapine; a matter arising from discussions on the Drug and Therapeutics Report at the latter meeting.

Dr. Land explained that, at present there was one patient who had previously used, but was now refusing, the drug in its oral form. Approval had, therefore, been given to administer the drug by injection for two weeks to enable the patient's condition to improve to the extent that they would have capacity to make a decision on taking the medication. In addition to the limited time period, a number of other protections had been put in place including that the injectable form of the drug should only be used on patients lacking capacity and for those in forensic services.

He also advised that, whilst the oral form of Clozapine was licensed, it was unlikely, due to costs and limited usage, that drug companies would seek a license for the injectable form of the drug.

17/267 "HARD TRUTHS" MONTHLY NURSE STAFFING EXCEPTION REPORT

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

Mrs. Moody undertook to recirculate copies of the Trust's data submission to NHS Improvement on "Care Hours per Patient Day" (Appendix 6 to the report) due to difficulties experienced by Board Members in accessing the information.

Action: Mrs. Moody

17/268 ANNUAL REPORT OF THE TEMPORARY STAFFING SERVICE

Further to minutes 17/98 (24/4/17) and 17/128 (23/5/17) the Board received and noted the Annual Report of the Temporary Staffing Service.

It was noted that the report covered both 2016/17 and the first five months of the 2017/18 financial year in view of the significant increase in the number of requests to fill shifts and the consequent effect on the fill rate during the latter period.

The Non-Executive Directors raised the following matters:

(1) Whether compliance with mandatory training requirements by bank workers, particularly the low level for harm minimisation training, raised risks that they did not have the same culture and behaviours as permanent members of staff.

Mrs Moody responded that:

(a) There was nothing to indicate that bank workers were behaving differently to permanent members of staff.

(b) It was presumed that having consistency amongst the staff on wards provided greater quality and for this reason:

- It was preferable to use substantive staff as bank workers.
- In forensic services and at West Park Hospital there was a regular pool of bank workers enabling them to be familiar with the wards on which they worked and to feel part of teams.

(c) It was expected that compliance with harm minimisation training requirements would improve due to the introduction of e-learning.

(2) Whether the pay penalty for those staff not compliant with mandatory training requirements was applied.

In response it was noted that:

(a) The pay penalty prompted conversations with staff about training and there was anecdotal evidence that these had a positive impact on compliance rates.

(b) The pay penalty had been applied to medical staff in a couple of cases.

(c) Discussions had been held about whether clinical staff should be able to continue to work if they did not comply with mandatory training requirements.

The Chairman considered that the pay penalty should be applied consistently and robustly.

Agreed *– that an update report on the temporary staffing service be presented to the Board at its meeting to be held on 24th April 2018.*

Action: Mr. Levy

17/269 MENTAL HEALTH LEGISLATION COMMITTEE

Mr. Simpson, the Chairman of the Mental Health Legislation Committee, reported that, at its meeting held on 19th October 2017, concerns about the interpretation and application of Deprivation of Liberty Safeguards (DOLS) by local authorities, particularly in North Yorkshire and York, had been discussed.

The Board noted that:

(1) In some cases AMHPs were unwilling to approve applications under the MHA, where a patient lacked capacity, as they considered that the DOLS should be applied instead; however, the Trust considered that only the MHA could be used when the patient was objecting.

(2) In these circumstances there were risks that, once the maximum duration of detention had elapsed, the patient would be unlawfully detained. This would result in the Trust being in breach of Article 5 of the Human Rights Act providing an automatic right to compensation together with potential implications for the Trust's insurance cover through the NHSLA.

(3) From discussions with the local authorities it was clear that they had a different view of the application of the MHA and DOLS. It was considered that this stemmed from most of their work being undertaken in care home settings rather than in hospitals.

(4) Risks had also been identified with regard to the availability of DOLS authorisations within the required timescale and the potential implications of this for unlawful detentions.

Mrs. Moody advised that in response to these risks (which remained with the Trust as it would be responsible for the unlawful detention) DCA Beechcroft, solicitors, had been asked to draft a letter to the local authorities to provide guidance on the correct interpretation of the legislation.

In response to questions it was noted that:

(1) Cases where it was considered the DOLS were being incorrectly applied tended to be escalated to the MHL team rapidly; however, there was a risk if they were not.

(2) The case, which had prompted the discussions at the meeting of the MHLC, had been resolved and it was understood that there were no similar cases at the present time; however, this was being constantly reviewed.

(3) The Trust had been clear with the local authorities about the use of the MHA instead of DOLS.

(4) The use of DOLS by local authorities, instead of the MHA, also had implications for the provision of Section 117 aftercare.

The Chairman asked for a further report to be provided to the Board once the local authorities had responded to the solicitors' letter.

Action: Mrs. Moody

17/270 SUMMARY FINANCE REPORT AS AT 30TH SEPTEMBER 2017

Consideration was given to the summary Finance Report as at 30th September 2017 including the Trust's Quarter 2, 2017/18, submission to NHS Improvement.

> ***Agreed*** *– that the Trust's Quarter 2, 2017/18, submission to NHS Improvement, in accordance with the results detailed in the above report, be approved.*
>
> **Action: Mr. Kendall**

17/271 PERFORMANCE DASHBOARD REPORT AS AT 30TH SEPTEMBER 2017

The Board received and noted the Performance Dashboard Report as at 30th September 2017.

The report included a recommendation that the Patient Experience Sub Group of the Quality Assurance Committee should be asked to undertake a further analysis into KPI 10 ("Percentage of patients surveyed reporting their overall experience as excellent or good") due to the target not being achieved in September 2017; performance declining since August 2017; and the position being the worst since that reported in April 2016.

The Board's discussions focussed on underperformance on the IAPT recovery indicator, for Quarter 2, in view of the potential risks to the maintenance of the Trust's segment 1 position under the Single Oversight Framework (see minute 17/273 below).

Mrs. Pickering advised that:

(1) The risks that the Trust might not achieve target on the indicator had been reported under minute 17/227 (26/9/17).
(2) The Trust had not achieved target for September 2017 and for Quarter 2; however, year to date performance was slightly above the 50% target.
(3) Whilst most CCG areas were not achieving target, the main challenges were in York and Scarborough and support had been received by the services in those areas from the National Intensive Support Team (IST).
(4) In York, an action plan had been developed and the Locality was working with Mental Health Matters to increase capacity.
(5) In Scarborough, the service was having difficulty in achieving target for both the recovery and prevalence indicators. Although there were concerns about resource levels, the key issue, as found by the IST, was that people tended to have higher levels of need than would be expected and, therefore, it was more difficult to achieve recovery. Discussions with local GPs, to encourage them to make referrals earlier, had not had a material impact.
(6) Whilst improvements were expected in York, there was considered to be little prospect of the position changing in Scarborough.

(7) It was, therefore, expected that the Trust would need to rely on other areas to achieve the overall target.

In response to questions on the position in Scarborough, it was noted that:

(1) The contractual position in the locality was different to that in Tees where the Trust had withdrawn from providing the service under the any qualified provider model.
(2) The CCG was under financial pressure.
(3) The IST had not found that referrals were inappropriate but had confirmed that they were skewed towards those with a greater level of need.

In addition, the Non-Executive Directors:

(1) Sought clarity on whether there was a correlation between the increase in activity on KPI 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") and bed occupancy and length of stay.

Mrs. Pickering responded that the County Durham and Darlington Locality, as an outlier, had reviewed readmissions to its services and all had been found to be for sound clinical reasons. The services had also not highlighted any instances where a patient had been discharged too early.

Mr. Kilmurray undertook to review the position again in view of risks arising from bed pressures.

Action: Mr. Kilmurray

(2) Highlighted the potential risks to the provision of services arising from referrals in September 2017 being 11% above target.

Agreed -

(1) that the Patient Experience Sub Group of the Quality Assurance Committee be asked to undertake a further analysis into KPI 10; and

Action: Mrs. Moody

(2) that a report be presented to the Board meeting to be held on 30th January 2018 on the Trust's position, including trends, for each CCG area and the actions being taken to improve performance on the IAPT recovery indicator.

Action: Mr. Kilmurray and Mrs. Pickering

17/272 ANNUAL REPORT ON MEDICAL EDUCATION

The Board received and noted the Annual Report on Medical Education.

17/273 SINGLE OVERSIGHT FRAMEWORK REPORT

The Board received and noted the report on the Trust's indicative position against NHS Improvement's Single Oversight Framework for Quarter 2, 2017/18.

The Board noted that, at the Quarterly Review Meeting with NHS Improvement (NHSI) held on 26th October 2017:

(1) Discussions had focussed on IAPT services and the Trust's financial position; however, there were no material issues to bring to the Board's attention.

(2) NHSI had been very complimentary about the Trust's open and transparent approach in its relationship with the regulator.

17/274 USE OF THE TRUST SEAL

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

17/275 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 28th November 2017 in the Board Room, West Park Hospital, Darlington.

17/276 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 1.20 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Trust Board Briefing

Ruth Hill
Director of Operations

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

A year in Pictures….

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Acomb Garth

Acomb Health Centre

Huntington House

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Issues
  - High profile/ service impact across AMH rehab & recovery/ MHSOP beds
  - Ongoing issues around waiting times/ activity/ ways of working
  - Transforming Care
  - Future in Mind
- Consultation/ Exchange Events & Symposium
- Service user and carer input – https://youtu.be/9ESFg_Xtcxw

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To continuously improve the quality and value of our work.

- Purposeful Productive Community Services
  - Shift to Pathways
  - Picking up pace
  - Gemba/ daily lean management
- Training & skills
  - QIS leaders
- IT
  - Data quality

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Recruitment & Retention Issues
  - Nursing / IAPT/ CAMHS
  - Working with other providers eg Mental Health Matters
- Context of Management of Change (in a public arena)
- Skills within Teams
- Skills of our population
  - Carers/ Volunteers/ Governors etc

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Local
  - Planning for Pocklington change from Humber to TEWV
  - Universities
  - Safe Haven
  - VCS Input via “Connect” e.g.
  - https://www.youtube.com/watch?v=1jnc1l4fXlg
- National
- International – Trieste Twinning

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Financial Pressures
  - Capped Contract
  - OOA risks
  - CCG / System pressures and legal directions
- LMGB
  - Embedding systems

making a difference together

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th November 2017**
TITLE:	**Board Action Log**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information/Assurance**

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

Board of Directors Action Log

RAG Ratings:

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

	Minute No.	Action	Owner(s)	Timescale	Status
29/11/2016	16/289	Team based culture metrics reports to be introduced	DL	Jan-18	
29/11/2016	16/290	Subject to the EMT being assured that sufficient resources are available to support the process, the Trust seek re-accreditation under the Investors in People scheme	DL	Nov-17	The findings of the review to be reported to the Board meeting in January 2018 as part of the report on the outcome of the values, etc. consultation events
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	~~Nov-17~~ Apr-18	
23/05/2017	17/128	Additional narrative to be provided on the graph on recruitment in future reports on the Recruitment and Retention Action Plan	DL	28/11/2017	See agenda item 12
23/05/2017	17/128	A progress report on the Recruitment and Retention Action Plan to be presented to the Board	DL	28/11/2017	See agenda item 12
23/05/2017	17/137	Time to be set aside at a Board meeting or Seminar for a full discussion on the equality data	DL/PB	Dec-17	

	Minute No.	Action	Owner(s)	Timescale	Status
20/07/2017	17/193	A further report on managing waiting times in C&YPS to be presented to the Board	~~BK~~ DB	Dec-17	
20/07/2017	17/194	A full report (and recommendations) on the values, behaviours and staff compact consultation events to be provided to the Board	~~BK~~ DB	Jan-18	
20/07/2017	17/199	Comparative information to be provided to Board Members on the levels of bullying, harassment, etc of BAME staff	DL	~~Nov-17~~ Jan-18	
26/09/2017	17/221	Further information to be provided to Board Members on the lack of a registered nurse on Harland Ward on 5th August 2017 (night shift)	EM	Nov-17	Completed
26/09/2017	17/227	A further review of the Performance Dashboard targets to be undertaken	SP	Nov-17	See agenda item 16
26/09/2017	17/228	Consideration to be given to reviewing the targets in the Strategic Direction Performance Report for 2018/19	SP	Apr-18	
26/09/2017	17/229	The appointment of Dr. Griffiths as the Deputy Chairman of the Trust to be recommended to the Council of Governors' Nomination and Remuneration Committee	PB	Nov-17	Completed
26/09/2017	17/230	Reviews of the operational arrangements of the Quality Assurance, Resources and MHL Committees to be undertaken	PB	Dec-17	
31/10/2017	17/264	A report to be provided on the Trust's taxi contracts including the incidence of alleged inappropriate behaviour by taxi drivers and the measures in place to protect vulnerable people.	~~BK~~ DB	Jan-18	
31/10/2017	17/267	Copies of the data submission to NHSI on care hours per patient day (Appendix 6 to the Nurse Staffing Report) to be recirculated to Board Members	EM	-	Completed
31/10/2017	17/268	An update report on the Temporary Staffing Service to be presented to the Board	DL	Apr-18	

	Minute No.	Action	Owner(s)	Timescale	Status
31/10/2017	17/269	A further report to be provided to the Board on the interpretation and application of the MHA and DOLS once the local authorities have responded to the solicitors' letter	EM	-	A timescale cannot be set for this action as it is dependent on the response from the local authorities
31/10/2017	17/270	Approval of the Trust's Quarter 2, 2017/18, submission to NHSI	DK	-	Approved
31/10/2017	17/271	The position on Performance Dashboard KPI 6 ("Number of instances of patients who have 3 or more admissions in a year") in County Durham and Darlington to be reviewed	~~BK~~ DB	Dec-17	
31/10/2017	17/271	The Patient Experience Sub Group of the QuAC to be asked to undertake a further analysis of Performance Dashboard KPI 10	EM	-	Completed
31/10/2017	17/271	A report to be presented to the Board on the Trust's position, including trends, for each CCG area, and action being taken to improve performance, on the IAPT recovery indicator	~~BK~~DB/SP	Jan-18	

ITEM 6

CONFIDENTIAL

BOARD OF DIRECTORS

DATE:	**28th November 2017**
TITLE:	**Research and Development Annual Report 2017**
REPORT OF:	**Dr Nick Land, Medical Director**
REPORT FOR:	**Information**

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

Executive Summary:

The Trust is committed to supporting and promoting research opportunities across all of our services and localities. The more research active we are as a Trust the better care we will provide. Our involvement in large-scale clinical trials continues to give service users and carers access to treatments at the forefront of knowledge. In our work with the National Institute for Health Research (NIHR) and our collaboration with national and international academic partners, we contribute to the worldwide evidence base for mental health care. We seek to create a culture of enquiry within our services which welcomes innovation and challenge. Research conducted in the Trust is compliant with the NHS Research Governance Framework and meets required quality and governance standards. The Trust's 2015-2020 R&D strategic priorities are being implemented, including the critical area of academic partnership development. This report outlines activity for the period April 2016 to March 2017, and given the rapid rate of change in the local research context, also describes key areas of progress so far in 2017/18.

Recommendations:

The Board is asked to receive the 2017 Research and Development Report.

MEETING OF:	**Board of Directors**
DATE:	**28 November 2017**
TITLE:	**Research and Development Annual Report**

1. INTRODUCTION & PURPOSE:

- To report on Research and Development activity for the period April 2016 to March 2017.
- To give an update on key progress areas during the course of 2017/18.

2. BACKGROUND INFORMATION AND CONTEXT:

In November 2015 the Board approved a new 5 year Trust R&D Strategy with the following five goals:

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

The Trust's formal collaboration with the University of Durham ended in 2016 with the completion of its commitments to the Mental Health Research in the Young (MeHRY) programme. The University subsequently decided to transfer its School of Medicine, Pharmacy and Health to the University of Newcastle from August 2017. All academic staff in the mental health research group at the Queen's Campus successfully moved to new posts at other institutions, including the University of York, with ongoing collaboration with the Trust.

The Trust has supported a scoping project during this year to explore the potential for formal partnership at scale with the University of York, which has committed itself to mental health as a major priority area for research.

3. KEY ISSUES:

3.1. Research Governance activity in 2016/17

On 1st April 2016 a new national research approvals system was implemented by the Health Research Authority (HRA), requiring all research to be reviewed for ethics and governance by the HRA with local capability and capacity confirmation at Trust level. As part of the implementation of this new system, the Information Governance section of the IRAS application form was to be updated nationally to incorporate new questions which had previously been reviewed at a Trust level. As there has been a delay in implementing the new Information Governance questions into the IRAS form, an agreement with our Information Governance team was made to continue to

seek Caldicott approvals for studies where identifiable information was leaving the Trust to ensure robust governance and assurance.

Research conducted in the Trust remained compliant with the NHS Research Governance Framework and meets required quality and governance standards.
In 2016/17 a total of 46 research studies were confirmed for conduct in the Trust. Of these 23 were on the NIHR portfolio, the national list of externally funded studies of high quality. 23 non-portfolio studies (most frequently undertaken as part of a postgraduate masters or doctoral qualification) were approved. The time from when the Trust is selected as a site to run the study to local confirmation of capacity and capability for conduct in the Trust is externally monitored by the NIHR CRN. In 2016/17, the national target was 40 days; the Trust achieved an average approval time of 18 days.

The Trust's Standard Operating Procedures for research were updated in December 2016 and are published on the intranet. Principal Investigators agree compliance to these procedures on taking responsibility for a study. Researchers conducting clinical studies within the Trust are required to undergo the Good Clinical Practice training to ensure their knowledge and expertise in research conduct.

In February 2017 Audit One conducted an internal audit of effectiveness of controls over research activity undertaken within the Trust. The final report concluded that governance, risk management and control arrangements provide a good level of assurance and that the risks identified are managed effectively. A high level of compliance with the control framework was found to be taking place. Minor remedial action was required and completed.

3.2. Research study activity 2016/17

Recruitment to NIHR (National Institute of Health Research) studies in 16/17 totalled 1,191 participants. The recruitment was an increase from the 409 recruits achieved in 15/16 which was significantly higher than our average for previous years, making TEWV the top Trust in the region for increased recruitment to trials (168%). The TEWV R&D department continued to receive funding for staff to recruit to studies in other NHS Trusts in the region, including 63 recruited participants to new studies at South Tees NHS Foundation Trust and following up a cohort of patients for the PROBAND Parkinson's disease study. Studies currently open to recruitment are listed on the Trust's Research and Development web pages.

The CHEMIST study, a large-scale Chief Investigator-led grant was won by Dr Dave Ekers, Senior Lecturer and Nurse Consultant, in 2016. His study of collaborative care for depression will use community pharmacies as an innovative site of delivery of this intervention. Sponsorship for this study was transferred from Durham University to TEWV in 2016, this will not only provide the grant income for the study but we will also receive additional Research Capability funding from April 2018 for hosting this study

3.3. Contribution to NIHR Clinical Research Network. 2016/17

In addition to the NIHR participant recruitment activity demonstrated above, the Trust have had representation in a number of Clinical Research Network groups and meetings. The Trust's Non-Executive Director Dr Hugh Griffiths now represents the Trust at the Network's Non-Executives' group. Sarah Daniel was a member of the Operational Managers Group from June 2016 to March 2017 to represent the regional R&D managers. Prof Joe Reilly stepped down from his regional NIHR Clinical Research Network role in July 2016, having established a project to devolve decision-making on dementia and mental health resource allocation to a joint grouping of network leads and Trust R&D directors. This pilot project identified regional strategic funding which benefited TEWV by supporting a research assistant post to promote the Join Dementia Research initiative for our region and supporting funding for Dr Tolu Olusoga in a commercial research mentoring scheme with experienced commercial Principal Investigators in Northumberland Tyne and Wear NHS Foundation Trust.

3.4. University of York Research Partnership 2016/17

A discussion paper was shared at a joint meeting of senior colleagues at both the Trust and the University on 22 February 2016. It was agreed to proceed with a Memorandum of Understanding, and to establish a scoping project over 12 months to develop an options appraisal for substantial development of a York Mental Health Research Partnership. It was agreed that both organisations would contribute to shared project management of the process. The University expressed an intention to invest in a partnership with ambitious goals.

3.5. Patient and Public Involvement 2016/2017

The R&D team worked closely with the Trust PPI team to engage service users and carers in all interviews for staff selection in R&D. We have also offered involvement opportunities for PPI members to participate in study oversight working groups, providing advice and guidance to researchers and the R&D team on successful study delivery. 3 PPI members are also represented in our Research Governance Group and are keen to be involved in further R&D activity including advice on the R&D webpages and co-facilitating research courses.

In November 2016 a Research Awareness course was co-designed and co-delivered at the ARCH recovery college with positive feedback from students. This course will now become a regular part of the syllabus for the college.

3.6 Research Results

A successful research dissemination conference was held in March 2016 to share results of key research studies that have taken place in TEWV. Speakers included

- Dave Ekers presenting the results of the COBRA study of behavioural activation compared with cognitive behavioural therapy in primary care depression which showed that a simpler intervention could be just as clinically effective and more cost effective than standard CBT.

- Hannah Crawford sharing the results of her PhD research 'Understanding family experiences living with people with profound intellectual and multiple disabilities and eating and drinking difficulties' along with one of the study participants who shared the story of the importance of working with professionals to create choices for her son.
- Paul Blenkiron presented the REQUOL study, A DoH commissioned development of a new national outcome measure for Mental Health Services. A short (10 item) scale has been developed for use in UK NHS services to assess quality of life and the outcome of recovery in people over age 16 with different mental health conditions. Also a long version (20-40 items) created for research.
- Prof Joe Reilly shared the national results of the LABILE Lamotrigine and Borderline Personality Disorder study which showed that Lamotrigine did not show any benefits to mental health over placebo and therefore Lamotrigine is not recommended for people with BPD
- Sarah Daniel and Hannah Crawford shared their work on the process for supporting the research cycle in TEWV from initial ideas for research through to dissemination and implementation
-

The day was closed by Professor Joe Reilly whose key message was that to ensure that our research drives improvement in care.

3.7 Commercial Research

3.7.1 Esketamine 3004 commerical study As part of our aim to gain access to new treatments for service users, the Trust became an active site in this global study of intranasal esketamine for treatment-resistant depression, with Principal Investigator Dr Angus Bell. We have adopted the innovative approach of using the Trust's Ryedale Suite at Roseberry Park to conduct the study. The intensive monitoring required for electroconvulsive therapy conforms very well to the requirements for complex clinical trials, and we have been able to build on Dr Bell's established experience of intravenous ketamine treatment.

3.7.2 MK4305-061 Insomnia study for Alzheimer's disease. In December 2016 we were selected to be a site for a commercial study considering a new compound for treating insomnia in Alzheimer's disease. This study has been led by Dr Tolu Olusoga as Principal Investigator in collaboration with Dr Paul Reading, Consultant Neurologist at South Tees NHS Trust leading on the overnight sleep assessments. Site selection for commercial dementia studies is extremely competitive so this study will provide us with the opportunity to demonstrate to other companies that we are able to host dementia research thus providing future dementia treatment studies for our patients.

3.8 Key Developments April 2017 to November 2017

3.8.1 University of York Research Partnership.

Further key meetings with senior leaders from University of York and TEWV have taken place, with shared enthusiasm and a vision to develop a partnership together. A York Mental Health Partnership Document was discussed at EMT on 12 April. The

two institutions' executive teams have supported Sarah Daniel R&D manager from TEWV and Jess Hendon Research Development Manager from University of York to be seconded 0.5WTE each for the next 12 months to progress the development of this partnership.

The University of York/TEWV partnership project has progressed with working group meetings held on 18/7/17, 5/9/17 and 14/11/17 with continued enthusiasm and activity from both organisations. Conversations have been brokered between Trust clinicians and managers, and York academics, which have already led to successful internal University pump priming funding and have potential for large scale grant applications.

Professor Rachel Churchill from the University of York has been successful in an Economic and Social Science Research Council (ESRC) Impact Accelerator grant award to spend 1 day per month at TEWV working together with library services to enhance knowledge mobilisation in the Trust.

Dr Jane Suter, Dr Tina Kowalski and Professor Rowena Jacobs have also been successful in a Centre for Future Health (CFH) application to support a study to consider the impact of shift changes to a 12hr shift pattern in York and Selby with David Levy.

A further pump priming grant application is being prepared to by researchers in the Centre for Health Economics to consider outsourcing vs in house dispensing of pharmacy services with Chris Williams, Chief Pharmacist.

Further work streams including R&D finance and contracts are also underway to identify additional support that will be required from the Trust to be able expand to sponsor Chief Investigator led studies and support increased commercial research activity.

The Memorandum of Understanding is in final draft and is expected to be formally signed by both organisations on 5th December.

We have shared Trust plans for its new mental health hospital in York with the University's leadership team and invited them to consider their shared investment in the proposed Clinical Research Facility. Discussions with the University's Directors of Finance and Estates have been very positive and their commitment is anticipated.

A successful World Mental Health event was held at the University of York in partnership with TEWV on 10th October. Key speakers included Trust Clinicians Dr Dave Ekers, Prof Simon Gilbody and Dr Lina Gega. Innovative virtual reality environment technologies were showcased along with short films produced by the University and Trust. 3 TEWV PPI representatives were invited to the event and a specific programme to introduce them to key academics at the University was arranged. We have invited these representatives to join our TEWV/UoY working group to help shape the development of the partnership.

3.8.2 Commercial research activity

The development of the Clinical Trials Pharmacy facilities and staffing has been key to our increased activity and the new planned Clinical Research Facility in the new hospital in York will enable us to expand the number of commercial treatment studies that we are able to offer in the Trust.

Since April 2017 we have been selected as a site for the following commercial research studies:

- Roche Monoclonal Antibody treatment study for patients with Prodromal to Mild Alzheimer's Disease – PI Dr Tolu Olusoga
- Takeda study for Treatment Resistant Depression – PI Dr Baxi Sinha
- Janssen Treatment resistant Depression Cohort study – PI Dr Sumeet Gupta

3.8.3 Patient and Public Involvement

A second Research Awareness Course at the ARCH recovery college has taken place co-delivered by the research team and a 2 service users with research experience. The course has been evaluated and updated from feedback and a 1 hour workshop was delivered to share this work at the recent TEWV AHP conference. Members of the R&D team along with PPI members were nominated as finalists for the NHS Innovations North Bright Ideas in Health awards.

3.8.4 Contribution to the NIHR Clinical Research Network.

Dr Dave Ekers has been appointed as Mental Health Specialty lead for the Clinical Research Network North East and North Cumbria. His role is key in increasing research activity and support for PI's across the 3 mental health Trusts in the region.

The Mental Health/DeNDRoN pilot has received support from the Clinical Research Network Executive team to continue past the pilot stage to become a Mental Health/DeNDRoN delivery partnership within the CRN, giving us greater flexibility for resourcing study support and delivery across the region.

3.8.5 Research Governance

The new Framework for UK Health and Social Care research was launched on 16th October 2017 replacing the Research Governance Framework. The new framework brings together a UK wide set of principles and includes increased PPI involvement, registering research and making it publicly available, reporting results back to those who have taken part in the research and providing a more proportionate approach to risk. R&D policies and procedures will be updated to reference the new framework.

4. IMPLICATIONS/RISKS:

4.1 Compliance with the CQC Fundamental Standards:

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

4.2 Financial/Value for Money:

The Trusts external research income for 16/17 was £579,215 which was a reduction from the 15/16 income of £686,317. Due to the transfer of sponsor responsibilities for the CHEMIST research study from Durham University to TEWV, we will see an increase in funding in 17/18, due not only to the income from this grant award but also the additional associated Research Capability Funding provided for sponsoring NIHR research studies. The following table shows the type and funding source for external income for 16/17

Description	Funder	Amount
Research support funding	NIHR Clinical Research Network North East and North Cumbria	£394,908
Transitions grant funding	NIHR Programme Grant for Applied Research	£20,332
LABILE grant funding	NIHR Health Technology Assessment	£22,346
SCIMITAR + grant funding	NIHR Health Technology Assessment	£36,024
CYGNUS grant funding	Innovate UK	£34,672
Esketamine commercial funding	Janssen Pharmaceuticals	£11,250
CHEMIST grant funding	NIHR Public Health Research	£45,063
Additional grant funding	Various	£14,620
Total		**£579,215**

4.3 Legal and Constitutional (including the NHS Constitution):

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

4.4 Equality and Diversity:

The Trust's R&D strategy explicitly seeks to ensure that wherever possible there is equity of access to research for service users and carers across the Trust's specialties and geographies.

4.4 Other implications:

5. RISKS:

Income reduction. Although the Trust's external income in 2016/17 was reduced compared to the previous year, we have demonstrated success in attracting research with associated income streams including 4 new commercial pharmaceutical studies. Our firm focus continues to be in achieving externally funded research grants with academic partners and this has come to fruition with the award of our first substantial research grant where the Trust is the lead hosting organisation (the CHEMIST Study). In addition to the £467k grant itself the Trust will receive additional Research Capacity Funding from NIHR from 2018/19 onwards. We also have a further grant application at the second stage of competition and will find out if this has been funded in December 2017.

Excess Treatment Costs. As the Trust expands its clinical trials activity, particularly with more local Chief Investigator-led grants, there will be an increased need for agreement in advance of the Excess Treatment Costs associated with this work. During the course of 2016/17 we have successfully secured Excess Treatment costs to deliver an intervention group for individuals diagnosed with dementia for £6212 from each CCG in Durham/Darlington, Teesside, York and Harrogate and an application for a further study has also been submitted, however it has been suggested that CCG's will not be able to fund all applications for ETC's and we will put forward a proposal to consider options for how to manage this in the Trust.

6. CONCLUSIONS:

The Trust's Research and Development activity continues to enable service users and carers across all Trust localities to access new research opportunities for research involvement. We have made substantial progress with the University of York partnership to develop an academic collaboration based firmly on shared interests and priorities.

7. RECOMMENDATIONS:

The Board is asked to receive and approve the 2017 R&D annual report.

Professor Joe Reilly
Clinical Director for Research and Development

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 28 November 2017**
TITLE:	**Assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
REPORT FOR:	**Assurance**

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

Executive Summary:

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

Assurance statement pertaining to QuAC meeting held on 02 November 2017:

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

Key matters considered by the Committee are summarised as follows:

- The Locality areas of North Yorkshire and Tees services where key concerns were around medical and non-medical staffing levels, waiting times in CAMHS and the lack of provision of nursing care home placements.
- Reports from the Patient Safety and Patient Experience Groups.
- Quarterly update from Equality Diversity and Human Rights Steering Group, the Quality Account Update and Research Governance.
- CQC compliance and Safeguarding & Public Protection assurance updates.

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 02 November 2017.
- Note the confirmed minutes of the meeting held on 05 October 2017 (appendix 1).

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 28 November 2017**
TITLE:	**Assurance report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting on 02 November 2017.

2. BACKGROUND INFORMATION AND CONTEXT

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

3. KEY ISSUES

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

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 received the LMGB report for North Yorkshire noting the top concerns which were:

(1) MHSOP – critical medical staffing levels across Scarborough, Whitby and Ryedale, together with a Locality Manager vacancy in Harrogate and a WTE reduction in Consultants. Interim plans have been arranged for a Locality Manager and Locum Consultants to be employed.
(2) Issues with Harrogate and Ripon community team patient safety and capacity in Adult Mental Health. Agency staff have been employed to support the pressures.
(3) LD Transforming Care with continued difficulties and poor Commissioner engagement.
(4) Challenges meeting waiting times in CAMHS eating disorders.

4.2 TEES SERVICES LMGB

The Committee received the LMGB report for Tees Services noting the top concerns which were:

(1) Medical Recruitment and retention across inpatient areas.

(2) Care homes and the failing quality and capacity of the care home sector, particularly for MHSOP and the impact this was having on LD services.
(3) Tier 4 CAMHS and concerns with acuity on all three wards, Evergreen, Newbury and Westwood, bed pressures coupled with newly employed inexperienced staff.

4.4 **Patient Safety Group Report**

The key matters discussed were:

(1) Concerns around the monitoring of E-cigarettes in CAMHS where family members were bringing into the Trust non-regulated devices for under 18 year olds. Discussions with neighbouring Trusts regarding the issue would take place and be discussed at the next Patient Safety Group meeting.

(2) The number of offender health suicides has risen, with 7 so far in the calendar year. There will be a Trust wide event in Quarter 1 2018/19 where colleagues from the locality Police Forces will be invited with the aim to raise staff awareness since in most of these cases the individuals will not have been previously open to MH services.

(3) The 60 incidents that required prone restraint and how they were analysed. It was noted that these figures were analysed through a quarterly report to the Patient Safety and Analysis Board and it would be appended to the Patient Safety Report for the next QuAC meeting.

4.5 Patient Experience Group Report

The key matters highlighted were:

(1) Complaints and PALS quality reports have been reviewed for August and September 2017 with York and Selby receiving the highest number with six in August, followed by Durham and Darlington with four.

(2) There has been some work undertaken to standardise the Patient Experience reports with the Patient Safety Group, where the same processes will be followed of sharing outlier reports with individual teams and wards.

4.6 Safeguarding and Public Protection Report

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

All serious case reviews across the locality areas were progressing with action plans being monitored within respective safeguarding boards with oversight by the Safeguarding and Public Protection sub-Group.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 **Compliance with CQC Requirements Report**

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

The key matters discussed were:

(1) Following inspections to Ebor, Danby and Bedale PICU wards the CQC have found continuation of the recurring themes such as care plans not being personalised and Section 17 leave forms missing from notes. Work is ongoing to make improvements.

(2) Following publication of 'The State of health care and adult social care in England 2016/17' by the CQC concerns have been raised around the high number of people in locked rehabilitation wards and this was subsequently followed up by a request to all Trust MH providers for information. This data will be used by the CQC to drive improvements in this area.

5.2 **Equality, Diversity and Human Rights (EDHR) Steering Group Report**

The Committee received the quarterly Equality, Diversity and Human Rights Steering Report.

The key matters discussed were:

(1) The Equality, Diversity and Human Rights Steering Group has reviewed information in line with the Groups terms of reference with agreed KPI's and any issues identified are being progressed via appropriate leads and services with monitoring by the EDHR Steering Group.

(2) The data presented to the Steering Group as part of the Key Performance Indicators has raised concerns over the number of incidents where patients have expressed hostile views towards Muslims and that some staff have been repeatedly targeted. This will continue to be monitored closely and reporting encouraged.

5.3 **Quality Account Quarterly Update Report**

The key matters highlighted were:

(1) For the quality metrics three out of nine (33%) were reporting as green. All three patient experience domain metrics were currently below target and two of those, along with patient reported perceptions of safety would need significant improvement if the full year target is to be achieved.

(2) For Quarter 2 there were 62% of patients that reported 'yes' 'always' to the question 'do you feel safe on the ward'. A piece of work will be undertaken to look into this further due to the consistently low scores.

5.4 **Research Governance Quarterly Report**

The Committee received the quarterly update on Research Governance.

Highlights noted were that there has been development around the implementation plan for the Research and Development Strategy, good progress with collaboration with York University and there were developments underway around potential future commercial research activity.

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**

The Committee noted the update from the Quality, Diversity and Human Rights Steering Group.

7. CONCLUSIONS

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

8. RECOMMENDATIONS

That the Board of Directors is asked to note the issues raised at the Quality Assurance Committee meeting on 02 November 2017 and to note the confirmed minutes of the meeting held on 05 October 2017 (appendix 1).

Jennifer Illingworth
Director of Quality Governance
November 2017

Item 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 5 OCTOBER 2017, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Dr Nick Land, Medical Director
Mr Brent Kilmurray, Chief Operating Officer
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 Steve Dawson, Interim Head of Nursing for York and Selby
Mrs Lorraine Ferrier, Head of Nursing for Durham and Darlington (for minute 17/128)
Mrs Ruth Hill, Head of Service for York and Selby (for minute 17/129)
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mrs Donna Sweet, Service Development Manager for Durham and Darlington
Mr Steve Wright, Deputy Medical Director
Mr Christopher Williams, Chief Pharmacist (for minute 17/135)

17/125 APOLOGIES FOR ABSENCE

Apologies for absence were received from: Mrs Lesley Bessant, Chairman of the Trust, Mr Colin Martin, Chief Executive, Mr Patrick Scott, Head of Service for Durham and Darlington and Mrs Karen Agar, Associate Director of Nursing & Governance.

17/126 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 7 September 2017 be signed as a correct record by the Chairman of the Committee.

17/127 ACTION LOG

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

17/81 Safeguarding: check whether HM Prisons require to undertake level 3 safeguarding training.

Completed

17/84 Further work required around indicator 5 of TEWV, WRES information before being presented to the BoD.

Completed

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

This action would be brought forward to December 2017 when the next Health, Safety, Security and Fire report would be presented to QuAC.

17/97 D&D LMGB report: page 6, adult LD non-compliance due to referrals being rejected - add more context to this in future reports.
This information would be incorporated into the next Durham and Darlington Services LMGB report and brought back to QuAC in February 2018.

17/110 Concerns and implications of decommissioning locked rehab beds be taken to EMT at the end of September 2017 for further consideration and to gain a better understanding of the overall position.

Due to Mr Martin not being present at the meeting this action would be deferred to the 2 November 2017 QuAC meeting.

17/128 DURHAM AND DARLINGTON 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 across the locality.

(i) There were pressures across all services, particularly inpatients and West Park Hospital. In addition, there were high numbers of retirements expected in the forthcoming year and recruitment continued to be difficult.
On this matter it was noted that agency staff were helping to alleviate the pressures and the recruitment position was expected to improve by the end of October 2017 with some new registered nurses in place.

(2) Bankfields Staffing

(i) There were ongoing issues with trying to cover the unit with qualified staff.
On this matter it was noted that contingency plans were in place to help alleviate the staffing shortages, due to sickness, skill mix and maternity leave, however this was having an impact upon the Crisis Team and the Team managers who were working shifts in Bankfields.
This matter had been escalated to the Durham and Darlington locality risk register.

(ii) With regard to the Ofsted registration for Bankfields, this was expected to take around 16 weeks, however the Trust had tried to expedite this and a reference for Mr Paul Newton, Director of PIPS had been completed recently and returned.

(3) Access to CAMHS Tier 4 beds.

(i) A root cause analysis had been undertaken of a 14 year old that had been admitted to Cedar ward and had been classed as a 'never event'. Some lessons had been learned and an action plan had been produced.
There had also been another recent incident of a 17 year old admitted to an adult ward and this remained an area of concern.
On this matter it was noted that discussions were underway to find solutions to this problem, including how Tier 3 and 4 could work better together.

Committee members sought clarification on the following matters:

(i) A significant serious incident had taken place at the crisis house at Shildon and staff had dealt extremely well with a very difficult situation.
Members expressed their thanks and appreciation to the staff that had been affected by the incident.

(ii) Behavioural Activation (BA) awareness would be rolled out across AMH teams, which had been found to be effective in dealing with depression and it was anticipated would be included in the new NICE guidelines for depression.
The Committee requested a stand-alone report on progress with the implementation of BA in six months' time at its meeting to be held on 5 April 2017.

Action: Mr P Scott

(iii) The risk register, (page 12), item 98, "…failure to effectively manage bed compliment could result in patients being admitted out of the locality or to the 'wrong' type of bed that does not meet their needs…"
This risk was showing a high target risk, whilst also showing improvement and needed to be unpicked and clarified.

Action: Mr P Scott

17/129 YORK AND SELBY SERVICES LMGB REPORT

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

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

(1) Capacity and demand issues and ongoing issues in CAMHS.
On this matter it was noted that the CCG had identified some concerns around the delivery of the service and a meeting would take place to review the service issues, which had been identified following analysis of the capacity and demand.

(2) Staffing, with gaps in workforce and the associated operational and contractual implications encompassing IAPT, CAMHS Consultants and MHSOP inpatient staffing. Recruitment initiatives were ongoing and all inpatient posts had been advertised.

(3) Ongoing estate challenges around the quality of work and responsiveness to reporting of estate issues via NHS Property Services.

In addition the Committee discussed the following matters:

(1) The significant improvement around the relationship with Local Authorities and delayed discharges.
There were regular weekly delayed transfer discussions as there were still a large number of blocked beds and there would be a review of MH services for older people towards the end of 2017, which would encompass all the challenges around this issue.

(2) The impact on staff following the Management of Change.
On this matter it was noted that within LD the introduction of 12 hour shifts had caused mixed feelings, staff had been given choice over the start and end times of shifts and Mr D Levy would be undertaking a research project on this to incorporate staff experiences as well as the inpatient perspective.

17/130 PATIENT SAFETY GROUP ASSURANCE REPORT

The Committee received a verbal update on Patient Safety.

Mrs Illingworth noted the following:

(1) The Patient Safety Group had not met in September 2017 due to a clash with the TEWV annual Nursing Conference. A further meeting would take place during October 2017.

(2) There were no matters of escalation to the Quality Assurance Committee.

(3) Assurance was provided to the Committee that the Learning from Deaths Policy had been formally ratified by the Board of Directors at its meeting held on 26 September 2017.

17/131 SAFGUARDING & PUBLIC PROTECTION EXCEPTION REPORT

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

Arising from the report it was noted that:

(1) All serious case reviews across the locality areas were progressing with action plans being monitored within respective safeguarding boards, with oversight by the Safeguarding and Public Protection sub-Group.
(2) Formal notice had been received of the NHS England led independent care and treatment investigation following the homicide of a young person in York. It was expected that the independent investigation would be completed in six months.
(3) Middlesbrough would undertake a Domestic Homicide Review into the death of woman and the trial was expected to be around December 2017.
On this matter Mrs Illingworth confirmed that the Trust did not have any involvement with the perpetrator.

17/132 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

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

Key matters highlighted from the report were that the Ofsted registration had been approved for Holly and Baysdale to be social care based residences for children. An inspection was expected between 1 October 2017 and 31 March 2018.
On this matter it was noted that there would be monthly reviews undertaken by the Trust as well as the annual inspection by Ofsted.

Following discussion the following matter was noted:

(1) The potential overlap between the CQC information received by QuAC and the Mental Health Legislation Committee.

(i) Mr Simpson noted that the MHL Committee was currently reviewing its terms of reference and this matter would be picked up in those discussions.

(ii) It was recognised that the MHA inspections from a qualitative perspective would be fed through to QuAC, whereas the Mental Health Act Committee

would gain the legislative point of view ensuring that the Trust adhered with Mental Health Legislation and policy.

(iii) Mrs Richardson highlighted that one of the key governance drivers would be about who delivers change.

17/133 WORKFORCE AND STAFFING QUARTERLY REPORT

The Committee received and noted the Workforce and Staffing Quarterly Report.

Arising from the report it was noted that:

(1) The draft Workforce Disability Equality Standard (WDES) paper, detailing metrics being piloted in a number of NHS organisations, would become operational for all NHS organisations from 1 April 2018. The first public report would be made available from April 2019.

(2) The Trust already reported some of the information set out in the WDES metrics, however there would be additional focus upon the experiences of disabled staff within the NHS and actions would be taken by employers in response to feedback from and about disabled staff.

Mr Levy highlighted that the experience of disabled staff was quite poor compared to staff that were not disabled and that 36% of staff did not make a declaration as to whether they see themselves as disabled or not.

Following discussion the following comments were raised:

(1) The wording of the information in the staff equality data (page 11) around being over represented for age groups would read better with some benchmarking data.
(2) The indicator on page 7, table 16, “the percentage difference between the Trust Board, voting, non-voting and NED membership is -8% in all categories” should be re-worded to enable better understanding of the meaning.

Action: Mr D Levy

17/134 CLINICAL EFFECTIVENESS QUARTERLY REPORT

The Committee noted the Clinical Audit and Effectiveness quarterly report.

Arising from the report it was noted that:

(1) There were currently eight audits that were behind schedule and mitigating actions were in place to address this. The completion status of the clinical audit programme was 21.55%.
On this matter it was noted that performance against audits normally picked up pace towards the end of the financial year. In addition, there were four new members of staff to support the clinical audit programme of work.

(2) The clinical audit of Emergency Response Bags had rated as red due to low compliance and the potential to cause risk.

All teams with missing equipment had been followed up to ensure that emergency bags were complete and a validation audit had been proposed for 10% of teams.

On this matter it was agree that:

(i) Talking to colleagues in Pharmacy following their successful audits would help improve this audit.
(ii) That the 10% validation audit should be increased and a stand-alone report should be brought back to the Quality Assurance Committee at its meeting to be held on 7 December.

Action: Mrs J Illingworth/Mrs E Moody

17/135 DRUG & THERAPUETICS REPORT

The Committee received and noted the Drug and Therapeutics (D&T) Report.

Arising from the report it was highlighted that:

- A range of actions had been agreed by the D&T to support improved and standardised allergy recording across TEWV. This would be monitored by EMT.

- Clozapine intramuscular injection (unlicensed) had been approved for use in named patient applications.
  On this matter it was noted that:

  (i) This drug was not experimental as Clozapine is typically used in oral doses, however it would be specifically the injection form used that was unlicensed. This method of administration of the drug would be to enable patients to go back to taking oral Clozapine within a given time period (of around 10 days) and would only be used in Forensic Services.
  (ii) A review of the use of this drug would go back to the D&T Committee in six months and be reported back to QuAC at that time.

- The increase in price for Olanzapine and Quetiapine drugs going up from £2 for 28 tablets to a range in cost from £32 to £108 for 28 tablets. The Committee was assured that this was expected to be a short term issue.

In addition the Committee noted that the current Chairman of the Drug & Therapeutics Committee Dr Paul Walker would continue to Chair the meetings until the end of the financial year.

17/136 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no exceptions to report.

17/137 ANY MATTERS ARISING TO BE ESCALATED TO THE BOARD OF DIRECTORS OR PROPOSED FOR ADDITION TO THE TRUST RISK REGISTER, AUDIT COMMITTEE, RESOURCES COMMITTEE OR CLINICAL LEADERSHIP BOARD.

There were no matters to be escalated to the Board.

17/138 ANY OTHER BUSINESS

There was no other business to note.

17/139 COMMITTEE MEETING EVALUATION

There was nothing to note.

17/140 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 2 November 2017,
2.00pm – 5.00pm in the Board Room, West Park Hospital.
Email papers/reports by Thursday 26 October 2017 to Donna Oliver donnaoliver1@nhs.net

The meeting concluded at 4.15pm

……..

Dr Hugh Griffiths
Chairman
2 November 2017

ITEM 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th November 2017**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

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

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

- The number of rosters equates to 71 inpatient wards.
- The number of 'red' fill rate indicators highlights Registered Nurses on Days as having the highest number of 'reds' equating to 32 wards.
- The Forensic directorate have the highest level of 'red' fill rates (14 in October)
- The lowest fill rate indicators in October related to Talbot Direct Care (reduction of bed occupancy), Bedale (vacancies) and Thistle (vacancies)
- The Highest fill rates in October were observed by Westwood (high clinical activity), Acomb Garth (high patient acuity) and Westerdale South (vacancies and enhanced observations)
- In relation to bank usage there were no wards identified that were utilising in excess of 50% bank during October. The highest bank user was in relation to Cedar (D&D) with 41% bank usage (reasons for bank included: enhanced Observations and vacancies)
- Agency usage equated to 2.51% in October. The highest user of agency within the reporting period related to Cedar (NY). This equated to 20% of the total hours worked within this ward.

- In terms of triangulation with incidents and complaints the full analysis can be found on pages 6 and 7 of this report. There was one complaint that had been raised that is complaining about the lack of staff to supervise a relative. This was in relation to Westwood who have also been cited in this report for having a high fill rate and a level 3 self-harm incident.
- There were 687 shifts allocated in October where an unpaid break had not been taken. From those shifts where breaks were not taken the majority were in relation to day shifts (471 shifts).
- There were 23 incidents raised in October citing concerns in relation to staffing levels, 16 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 October Bilsdale had the highest score with 10 points awarded. The top 10 for September 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 Sandpiper being cited as having the highest score of 91, followed by Springwood with 82.

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:	**28th November 2017**
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 October 2017 data.

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013 and subsequent update of the guidance in 2016) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. (http://www.tewv.nhs.uk/site/content/About/How-well-are-we-doing/Nurse-staffing). The full monthly data set of day by day staffing for each of the 71 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

3. EXCEPTIONS:

3.1 Safe Staffing Fill Rates – October 2017

3.1.1 The daily nurse staffing information aggregated for the month of October 2017 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 32 in October. This is a reduction of 2 when compared to September 2017.

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

Ward	Fill Rate Indicator	Comments
October 2017		
Talbot Direct Care	49.8% HCA on Days 67.8% HCA on Nights 70.8% RN on Days	RN shortfall is being covered by Holly, the community team and the ward manager. HCA shortfall is being

		covered by PIPS. Staffing levels are continuously being reviewed based on the needs of the service user.
Bedale Ward	52.6% RN on Nights 170.4% HCA on Nights 80.2% RN on Days 132.3% HCA on Days	The RN shortfall is due to vacancies. 3 RN's have been appointed and started work at the end of October 2017. The shortfall has been covered by HCA's, community and staff from other wards.
Thistle	56% RN on Days 115.5% HCA on Days	The unit are budgeted for 2 RN's but have only run with one due to existing vacancies.

It is also important to review the fill rates that exceed the budgeted establishment (shown in blue). In October there were 59 fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues. This is an increase of 9 when compared to September.

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

Ward	Fill Rate Indicator	Comments
October 2017		
Westwood Centre	243.7% HCA on Nights 177.4% HCA on Days	The additional staffing is in relation to high clinical activity (enhanced observations). Shifts that cannot be filled with HCAs, are then filled by qualified staff.
Acomb Garth	215% HCA on Nights 129.1% HCA on Days	The ward are experiencing a high level of patient acuity and are often having to run with up to double the number of budgeted staff on a night shift. They do review staffing needs on a daily basis utilising their report out mechanism.
Westerdale South	198% HCA on Days 163.4% HCA on Nights 77.5% RN on Days	The increase in staffing is in relation to high acuity (6 enhanced observations). In addition the ward has 3 RN vacancies.

3.2 Bank Usage

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

There were no wards reporting 50% or above for bank usage in October. The highest user of bank in October related to Cedar Ward (D&D) reporting at 41%.

The reasons Cedar gave for requesting bank are as follows:

- Establishment Vacancies (103 shifts)
- Enhanced Observations (44 shifts)
- Sickness (13 shifts)
- Special Leave Cover (2 shifts)
- Emergency Annual Leave (1 shift)
- Unknown (1 shift)

3 newly qualified RMN's have now been recruited to Cedar which should impact on bank usage.

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

Cedar Ward (D&D)	41.0%
Westerdale South	37.9%
Merlin	36.9%
Northdale Centre	30.6%
Mandarin	28.1%
Bilsdale Ward	27.8%
Clover/Ivy	27.8%
Swift Ward	27.8%
Elm Ward	27.3%
Lustrum Vale	27.3%
Hamsterley Ward	27.2%
Birch Ward	26.4%

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 September the agency usage equated to 2.51% an increase of 0.10% when compared to September. The increase may be attributable to the introduction of the electronic recording of Agency usage.

The highest user of agency within the reporting period related to Acomb Garth and Cedar Ward (NY) equating to approximately 20% of the total hours worked on these wards.

Wards reporting agency usage in October are detailed below:

North Yorkshire	Cedar Ward (NY)	20%
York and Selby	Acomb Garth	20%

York and Selby	Cherry Tree House	15%
York and Selby	Oak Rise	11%
North Yorkshire	Rowan Ward	11%
North Yorkshire	Springwood Community Unit	10%
Durham & Darlington	Hamsterley Ward	8%
York and Selby	Minster Ward	7%
York and Selby	Meadowfields	6%
North Yorkshire	Ward 15 Friarage	5%
Teesside	The Evergreen Centre	5%
Teesside	Westerdale South	5%
North Yorkshire	Ayckbourn Unit Danby Ward	4%
York and Selby	Ebor Ward	4%
Forensics	Northdale Centre	4%
Teesside	Bedale Ward	3%
Durham & Darlington	Maple Ward	3%
Forensics	Eagle/Osprey	3%
Teesside	Westerdale North	3%
Durham & Darlington	Elm Ward	2%
North Yorkshire	Rowan Lea	2%
Teesside	Bilsdale Ward	1%
Durham & Darlington	Birch Ward	1%
Teesside	Kirkdale Ward	1%
Teesside	Stockdale Ward	1%
Teesside	Newberry Centre	1%
Forensics	Langley Ward	1%
Durham & Darlington	Bek-Ramsey Ward	1%

It is positive to note that agency usage is extremely low within the Trust. It is important to continue to monitor this on an ongoing basis due to the potential risks that high agency working has on 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 October with the following reporting as an exception:

- There were 1 Serious Incidents (SI) that occurred within inpatient areas during the month of October. This ward has not been cited in this report to date. The SI investigation is currently underway and to date no concerns have been highlighted as a result of staffing. The report is due for completion at the end of December 2017.
- There were no level 4 incidents reported in October.
- There were 9 level 3 incidents (self-harm) that occurred in October with the following featuring in this report as follows:

  - Bilsdale – 1 incident – cited in this report for bank usage in excess of 25%
  - Ebor – 1 incident – cited in this report for utilising agency
  - Elm – 2 incidents – cited in this report for bank usage in excess of 25%
  - Ward 15 – 3 incidents – cited in this report for utilising agency
  - Westwood Centre – 1 incident – cited in this report for having a high fill rate
  - Clover/Ivy – 1 incident – cited in this report for have bank usage in excess of 25%
- There were 6 complaints raised in October with the following featuring in this report as follows:
  - Bilsdale – cited in this report for bank usage in excess of 25% and having a level 3 incident of self-harm
  - Birch – cited in this report for bank usage in excess of 25%
  - Cedar – cited in this report for bank usage in excess of 25%
  - Elm - cited in this report for bank usage in excess of 25% and a level 3 incident of self-harm
  - Westwood – cited in this report for having a high fill rate and a level 3 incident of self-harm. The complaint was in relation to the lack of staff being able to supervise a relative.
  - All of the other complaints have not cited any further issues in relation to staffing.
- There were 47 PALS related issues raised with the following featuring within this report as follows:
  - Danby (2 occurrences) – cited in this report for utilising agency
  - Birch (2 occurrences) – cited in this report for bank usage in excess of 25% and having a complaint
  - Bransdale (4 occurrences) – cited in this report for utilising agency
  - Cedar (1 occurrence) – cited in this report for bank usage in excess of 25% and having a complaint
  - Cedar (NY) (4 occurrences) – cited in this report for utilising agency
  - Ebor (1 occurrence) – cited in this report for utilising agency
  - Elm (4 occurrences) – cited in this report for bank usage, level 3 incident and a complaint
  - Maple (2 occurrences) – cited in this report for utilising agency
  - Overdale (1 occurrence) – cited in this report for utilising agency
  - Ward 15 (1 occurrence) – cited in this report for utilising agency and having a level 3 incident
  - Northdale (1 occurrence) – cited in this report for bank usage in excess of 25%
  - Thistle (3 occurrences) – cited in this report for having a low fill rate
  - Mandarin (2 occurrences) – cited in this report for having bank usage in excess of 25%
  - Merlin (2 occurrences) – cited in this report for having bank usage in excess of 25%
  - Rowan Lea (1 occurrence) – cited in this report for utilising agency
  - Westerdale North (1 occurrence) – cited in this report for utilising agency.

A number of incidents requiring control and restraint occurred during October. The highest user was the Evergreen Centre with a total of 160 incidents, related to restraint to administer treatment/NG feeding. This ward has been cited in this report for utilising agency.

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 687 shifts in October where an unpaid break had not been taken. This is a reduction of 100 when compared to September (787 shifts).

The majority of the shifts where breaks were not taken occurred on day shifts (471 shifts). The number of night shifts where breaks were not taken equated to 216 shifts in October.

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 23 incidents reported in October 2017 on Datix citing issues with staffing. 7 related to community based teams whilst the remaining 16 related to Inpatient services.

All staffing incidents are reviewed and it has been agreed in future that they will be shared with Heads of Nursing to identify themes across wards and address any issues arising from these. Concerns related to staffing incidents over the period included a reduced response to other wards, a visit was cancelled, security checks not being carried out and breaks not being taken. Eight incidents were raised as a result of agency staff not attending for duty leaving the ward short staffed. The main reason for staffing shortages appears to be short term sickness.

3.7 Severity

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

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

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

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

WARD	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	Level 4 Incidents	Level 3 Incidents	Complaints	Control & Restraint	TOTAL SCORE (Oct)
Bilsdale Ward	2	2	0	1	2	0	0	1	1	1	**10**
Bedale Ward	4	2	0	1	1	0	0	0	0	1	**9**
Swift Ward	4	2	0	0	2	0	0	0	0	1	**9**
Springwood Community Unit	2	2	1	1	1	0	0	0	0	1	**8**
Clover/Ivy	2	1	1	1	2	0	0	1	0	0	**8**
Mandarin	2	2	1	0	2	0	0	0	0	1	**8**
Elm Ward	0	0	1	1	2	0	0	2	1	1	**8**
Westerdale South	2	2	0	1	2	0	0	0	0	0	**7**
The Evergreen Centre	0	3	0	1	1	0	0	0	0	2	**7**
Ward 15 Friarage	2	0	0	1	1	0	0	3	0	0	**7**
Newberry Centre	2	2	0	1	0	0	0	0	0	2	**7**
Talbot Direct Care	6	0	1	0	0	0	0	0	0	0	**7**
Cedar Ward	0	2	1	0	2	0	0	0	1	1	**7**
Northdale Centre	2	1	1	1	2	0	0	0	0	0	**7**
Birch Ward	0	2	1	1	2	0	0	0	1	0	**7**

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

WARD	Locality	Speciality	YTD Total
Sandpiper Ward	Forensics	Forensics MH	**91**
Springwood Community Unit	North Yorkshire	MHSOP	**82**
Meadowfields	York and Selby	MHSOP	**77**
Clover/Ivy	Forensics	Forensics LD	**74**
Newberry Centre	Teesside	CYPS	**70**
Northdale Centre	Forensics	Forensics LD	**70**

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 (14 wards' in October) of 'red' fill rates for registered nurses on day shifts. Fulmar Ward has now shut and it is hoped this will positively impact on staffing on the remaining wards.

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.

The bank module was expanded on the 1st October 2017 to include the electronic recording of agency usage (nursing only). This development will have addressed any data quality issues that may have existed with the reporting of this particular metric. Problems with the new agency provider have been encountered which are being addressed through the nurse procurement process.

The initial Hurst review report has been received and further work is taking place with regard to applying the professional judgement approach, including Directors of Operations and Heads of Nursing prior to the report being received at the trust board in December. The analysis of CHPPD data undertaken by NHSI from trust data gathered in September will also be utilised as part of the professional judgement approach.

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 are not able to meet their planned staffing levels on a regular basis particularly with regard to registered nursing staff fill rates on days. This issue has been highlighted as a concern by the CQC in recent inspection reports for other Mental Health Trusts and may pose a risk as to our ratings.

4.2 Financial/Value for Money:

It has been identified that there is little spare capacity in nursing establishments as they have been planned for maximum efficiency – it is therefore implied that the workforce deployment needs closer scrutiny to ensure those efficiencies do not constitute risks. This work is being progressed and will be a feature of this financial year Safe Staffing work stream referred to above.

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

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

The March 2013 NHS England and CQC directives set out specific requirements that will be checked through inspection and contractual monitoring as they are also included in standard commissioning contracts. The Trust has complied with these directives to date. 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 safe 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 is underway 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
November 2017

Appendix 1

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 31 DAYS IN October

				DAY		NIGHT	
WARD	Locality	Speciality	Bed Numbers	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	65.2%	120.4%	70.9%	108.1%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	72.4%	120.8%	103.2%	95.2%
Bedale Ward	Teesside	Adults	10	80.2%	132.3%	52.6%	170.4%
Bilsdale Ward	Teesside	Adults	14	77.5%	154.8%	100.8%	154.1%
Birch Ward	Durham & Darlington	Adults	15	100.7%	131.6%	100.0%	128.9%
Bransdale Ward	Teesside	Adults	14	74.5%	173.5%	100.0%	151.8%
Cedar Ward	Durham & Darlington	Adults	10	127.2%	92.8%	141.9%	97.3%
Cedar Ward (NY)	North Yorkshire	Adults	18	94.5%	114.3%	153.1%	114.8%
Ebor Ward	York and Selby	Adults	12	90.3%	81.7%	101.5%	102.3%
Elm Ward	Durham & Darlington	Adults	20	94.5%	111.5%	97.9%	107.1%
Farnham Ward	Durham & Darlington	Adults	20	112.2%	106.4%	106.5%	108.6%
Kirkdale Ward	Teesside	Adults	16	90.2%	103.2%	103.2%	108.1%
Lincoln Ward	Teesside	Adults	20	97.1%	112.9%	96.8%	98.4%
Lustrum Vale	Teesside	Adults	20	86.4%	120.3%	100.3%	98.7%
Maple Ward	Durham & Darlington	Adults	20	93.3%	95.1%	97.3%	121.8%
Minster Ward	York and Selby	Adults	12	95.3%	91.1%	101.4%	103.6%
Overdale Ward	Teesside	Adults	18	80.1%	132.3%	103.2%	101.9%
Primrose Lodge	Durham & Darlington	Adults	15	80.4%	124.3%	100.0%	100.0%

Stockdale Ward	Teesside	Adults	18	102.2%	103.3%	106.5%	98.3%
The Orchards (NY)	North Yorkshire	Adults	10	96.8%	88.4%	74.2%	119.4%
Tunstall Ward	Durham & Darlington	Adults	20	101.6%	103.2%	100.0%	103.2%
Ward 15 Friarage	North Yorkshire	Adults	12	84.2%	116.1%	119.2%	108.9%
Willow Ward	Durham & Darlington	Adults	15	101.0%	135.3%	106.7%	106.5%
Baysdale	Teesside	CYPS	6	126.5%	105.6%	100.6%	100.0%
Holly Unit	Durham & Darlington	CYPS	4	147.0%	119.1%	130.8%	131.3%
Newberry Centre	Teesside	CYPS	14	84.9%	138.5%	119.5%	147.6%
Talbot Direct Care	Durham & Darlington	CYPS	1	70.8%	49.8%	99.6%	67.8%
The Evergreen Centre	Teesside	CYPS	16	95.2%	173.1%	154.6%	178.6%
Westwood Centre	Teesside	CYPS	12	107.2%	177.4%	92.6%	243.7%
Clover/Ivy	Forensics	Forensics LD	12	83.1%	115.4%	103.2%	164.8%
Eagle/Osprey	Forensics	Forensics LD	10	68.8%	97.9%	100.0%	100.0%
Harrier/Hawk	Forensics	Forensics LD	10	79.1%	104.2%	100.0%	98.5%
Kestrel/Kite.	Forensics	Forensics LD	16	79.1%	118.1%	100.0%	153.4%
Langley Ward	Forensics	Forensics LD	10	88.1%	113.8%	100.0%	154.8%
Northdale Centre	Forensics	Forensics LD	12	72.4%	121.3%	110.2%	95.4%
Oakwood	Forensics	Forensics LD	8	85.1%	162.8%	100.0%	100.0%
Thistle	Forensics	Forensics LD	5	56.0%	115.5%	100.0%	96.5%
Brambling Ward	Forensics	Forensics MH	13	95.0%	93.2%	104.3%	111.3%
Fulmar Ward.	Forensics	Forensics MH	12	94.4%	80.8%	96.8%	91.9%
Jay Ward	Forensics	Forensics MH	5	83.4%	104.5%	106.5%	104.8%
Lark	Forensics	Forensics MH	15	83.0%	109.5%	100.0%	102.4%
Linnet Ward	Forensics	Forensics MH	17	81.6%	98.3%	103.2%	104.8%
Mallard Ward	Forensics	Forensics MH	16	91.1%	109.1%	104.3%	142.7%
Mandarin	Forensics	Forensics MH	16	82.1%	155.4%	108.6%	183.8%
Merlin	Forensics	Forensics MH	10	98.7%	154.3%	92.7%	212.6%

Newtondale Ward	Forensics	Forensics MH	20	99.1%	111.3%	81.8%	145.7%
Nightingale Ward	Forensics	Forensics MH	16	71.3%	107.6%	100.0%	101.6%
Sandpiper Ward	Forensics	Forensics MH	8	90.9%	104.9%	87.1%	140.7%
Swift Ward	Forensics	Forensics MH	10	83.8%	123.3%	83.9%	158.1%
Aysgarth	Teesside	LD	6	84.3%	104.6%	100.6%	100.6%
Bankfields Court Flats	Teesside	LD	6	84.6%	90.3%	125.0%	106.9%
Bankfields Court Unit 2	Teesside	LD	5	118.9%	110.7%	110.0%	122.6%
Bankfields Court Unit 3	Teesside	LD	6	80.9%	99.9%	95.6%	96.2%
Bankfields Court Unit 4	Teesside	LD	6	101.2%	95.3%	115.6%	94.7%
Bek-Ramsey Ward	Durham & Darlington	LD	11	146.4%	120.0%	100.0%	99.6%
Oak Rise	York and Selby	LD	8	106.6%	94.7%	100.5%	153.5%
The Lodge	Teesside	LD	1	93.9%	83.9%	100.4%	87.1%
Acomb Garth	York and Selby	MHSOP	14	92.3%	129.1%	100.0%	215.0%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	99.5%	119.9%	100.0%	100.0%
Cherry Tree House	York and Selby	MHSOP	18	98.9%	97.0%	109.3%	106.1%
Hamsterley Ward	Durham & Darlington	MHSOP	15	90.4%	182.3%	100.7%	179.9%
Meadowfields	York and Selby	MHSOP	14	95.5%	89.6%	102.8%	100.0%
Oak Ward	Durham & Darlington	MHSOP	12	92.0%	98.3%	100.0%	100.0%
Roseberry Wards	Durham & Darlington	MHSOP	15	100.3%	98.4%	103.2%	103.2%
Rowan Lea	North Yorkshire	MHSOP	20	95.3%	126.1%	107.0%	110.1%
Rowan Ward	North Yorkshire	MHSOP	16	92.5%	157.0%	109.7%	154.8%
Springwood Community Unit	North Yorkshire	MHSOP	14	57.4%	134.8%	100.0%	148.4%
Ward 14	North Yorkshire	MHSOP	10	89.5%	99.8%	103.9%	99.1%
Westerdale North	Teesside	MHSOP	18	107.5%	111.6%	100.8%	105.3%
Westerdale South	Teesside	MHSOP	14	77.5%	198.0%	100.0%	163.4%
Wingfield Ward	Teesside	MHSOP	10	87.6%	106.0%	100.3%	102.4%

APPENDIX 2

Scored Fill Rate compared to Quality Indicators - October 2017				Agency Usage Vs Actual Hours			Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers	Total Actual Hours	Total Agency Hours	% Against actual Hours	Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI	Level 4 Incidents	Level 3 (Low Harm) Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	2451.1	91.50	4%	2451.1	223	9.1%					2	3		7	7
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2637.8	0.00	0%	2637.8	217.75	8.3%					1	7		11	11
Bedale Ward	Teesside	Adults	10	4029.7	138.00	3%	4029.7	763.17	18.9%						12		24	24
Bilsdale Ward	Teesside	Adults	14	3242.8	46.00	1%	3242.8	900.33	27.8%			1	1		11	1	20	21
Birch Ward	Durham & Darlington	Adults	15	3609.4	36.00	1%	3609.4	951.99	26.4%				1	2				
Bransdale Ward	Teesside	Adults	14	3310.0	11.50	0%	3310.0	759	22.9%					4	4		4	4
Cedar Ward	Durham & Darlington	Adults	10	4754.1	0.00	0%	4754.1	1946.93	41.0%				1	1	21	1	44	45
Cedar Ward (NY)	North Yorkshire	Adults	18	3200.0	633.50	20%	3200.0	204.3	6.4%					4	6		10	10
Ebor Ward	York and Selby	Adults	12	2671.5	111.00	4%	2671.5	219	8.2%			1		1	2		2	2
Elm Ward	Durham & Darlington	Adults	20	3139.5	48.00	2%	3139.5	856.18	27.3%			2	1	4	18	3	25	28
Farnham Ward	Durham & Darlington	Adults	20	2917.7	0.00	0%	2917.7	420	14.4%	1				2	2		2	2
Kirkdale Ward	Teesside	Adults	16	3184.0	33.75	1%	3184.0	518.5	16.3%						2		2	2
Lincoln Ward	Teesside	Adults	20	3247.1	0.00	0%	3247.1	409	12.6%					3				
Lustrum Vale	Teesside	Adults	20	2860.0	0.00	0%	2860.0	779.5	27.3%									
Maple Ward	Durham & Darlington	Adults	20	2787.3	96.00	3%	2787.3	654.33	23.5%					2				
Minster Ward	York and Selby	Adults	12	2597.5	172.50	7%	2597.5	250.5	9.6%						8	1	14	15
Overdale Ward	Teesside	Adults	18	2692.1	11.50	0%	2692.1	437	16.2%					1	3		3	3
Primrose Lodge	Durham & Darlington	Adults	15	2762.0	0.00	0%	2762.0	240	8.7%									
Stockdale Ward	Teesside	Adults	18	2606.7	23.00	1%	2606.7	296.8	11.4%						10		14	14

The Orchards (NY)	North Yorkshire	Adults	10	2205.0	0.00	0%	2205.0	48	2.2%										
Tunstall Ward	Durham & Darlington	Adults	20	2801.3	0.00	0%	2801.3	60	2.1%					1					
Ward 15 Friarage	North Yorkshire	Adults	12	2713.5	135.00	5%	2713.5	398.25	14.7%			3		1	2		2	2
Willow Ward	Durham & Darlington	Adults	15	2976.2	0.00	0%	2976.2	216	7.3%						5		7	7
Baysdale	Teesside	CYPS	6	2564.9	0.00	0%	2564.9	144.79	5.6%									
Holly Unit	Durham & Darlington	CYPS	4	979.3	0.00	0%	979.3	9.5	1.0%									
Newberry Centre	Teesside	CYPS	14	4305.5	39.00	1%	4305.5	315.74	7.3%						94	2	121	123
Talbot Direct Care	Durham & Darlington	CYPS	1	1918.9	0.00	0%	1918.9	0	0.0%						7		14	14
The Evergreen Centre	Teesside	CYPS	16	6746.5	361.75	5%	6746.5	1069.25	15.8%						160		279	279
Westwood Centre	Teesside	CYPS	12	6408.5	0.00	0%	6408.5	896	14.0%			1	1		23		32	32
Clover/Ivy	Forensics	Forensics LD	12	4380.3	19.25	0%	4380.3	1218.75	27.8%			1			1		1	1
Eagle/Osprey	Forensics	Forensics LD	10	3166.3	80.75	3%	3166.3	524.5	16.6%									
Harrier/Hawk	Forensics	Forensics LD	10	3709.3	0.00	0%	3709.3	460.92	12.4%					3				
Kestrel/Kite.	Forensics	Forensics LD	16	4425.5	0.00	0%	4425.5	923.25	20.9%					1				
Langley Ward	Forensics	Forensics LD	10	2444.2	22.50	1%	2444.2	509.5	20.8%									
Northdale Centre	Forensics	Forensics LD	12	4860.3	183.50	4%	4860.3	1487.25	30.6%					1	3		5	5
Oakwood	Forensics	Forensics LD	8	2038.2	0.00	0%	2038.2	169.25	8.3%									
Thistle	Forensics	Forensics LD	5	2871.7	0.00	0%	2871.7	388.25	13.5%					3	8		15	15
Brambling Ward	Forensics	Forensics MH	13	2883.5	0.00	0%	2883.5	412.48	14.3%						2		4	4
Fulmar Ward.	Forensics	Forensics MH	12	2719.6	0.00	0%	2719.6	380.25	14.0%									
Jay Ward	Forensics	Forensics MH	5	2865.5	0.00	0%	2865.5	355.5	12.4%					1	2	1	3	4
Lark	Forensics	Forensics MH	15	2791.1	0.00	0%	2791.1	544.5	19.5%				1					
Linnet Ward	Forensics	Forensics MH	17	2771.0	0.00	0%	2771.0	206.25	7.4%						2		3	3
Mallard Ward	Forensics	Forensics MH	16	3518.8	0.00	0%	3518.8	602.25	17.1%					2	3		3	3
Mandarin	Forensics	Forensics MH	16	3910.9	0.00	0%	3910.9	1100.42	28.1%					2	14		14	14
Merlin	Forensics	Forensics MH	10	4963.3	0.00	0%	4963.3	1833.58	36.9%					2	8		10	10
Newtondale Ward	Forensics	Forensics MH	20	4171.5	0.00	0%	4171.5	925.26	22.2%									
Nightingale Ward	Forensics	Forensics MH	16	2736.6	0.00	0%	2736.6	310.75	11.4%									

Sandpiper Ward	Forensics	Forensics MH	8	4059.8	0.00	0%	4059.8	832.42	20.5%					1	24	1	69	70
Swift Ward	Forensics	Forensics MH	10	3699.3	0.00	0%	3699.3	1027	27.8%						12		19	19
Aysgarth	Teesside	LD	6	2293.8	0.00	0%	2293.8	489.66	21.3%									
Bankfields Court Flats	Teesside	LD	6	2078.5	0.00	0%	2078.5	289	13.9%									
Bankfields Court Unit 2	Teesside	LD	5	2677.5	0.00	0%	2677.5	263.67	9.8%									
Bankfields Court Unit 3	Teesside	LD	6	2288.5	0.00	0%	2288.5	24	1.0%						22		34	34
Bankfields Court Unit 4	Teesside	LD	6	2140.5	0.00	0%	2140.5	163.33	7.6%									
Bek-Ramsey Ward	Durham & Darlington	LD	11	4404.4	60.00	1%	4404.4	293.17	6.7%						23	2	28	30
Oak Rise	York and Selby	LD	8	4202.7	456.00	11%	4202.7	370.91	8.8%						24		45	45
The Lodge	Teesside	LD	1	1741.7	0.00	0%	1741.7	129.5	7.4%									
Acomb Garth	York and Selby	MHSOP	14	4058.5	796.50	20%	4058.5	360	8.9%						12		13	13
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	3230.0	0.00	0%	3230.0	315.66	9.8%						7		10	10
Cherry Tree House	York and Selby	MHSOP	18	3383.0	517.50	15%	3383.0	234.5	6.9%						2		2	2
Hamsterley Ward	Durham & Darlington	MHSOP	15	4335.9	354.67	8%	4335.9	1180.76	27.2%						8		8	8
Meadowfields	York and Selby	MHSOP	14	2876.5	172.25	6%	2876.5	391.25	13.6%									
Oak Ward	Durham & Darlington	MHSOP	12	2794.8	0.00	0%	2794.8	60	2.1%									
Roseberry Wards	Durham & Darlington	MHSOP	15	2761.7	0.00	0%	2761.7	473.08	17.1%						7		8	8
Rowan Lea	North Yorkshire	MHSOP	20	3938.8	70.00	2%	3938.8	373.07	9.5%					1	12		15	15
Rowan Ward	North Yorkshire	MHSOP	16	3449.5	391.00	11%	3449.5	415	12.0%						13		30	30
Springwood Community Unit	North Yorkshire	MHSOP	14	3219.8	311.25	10%	3219.8	459.42	14.3%						17		18	18
Ward 14	North Yorkshire	MHSOP	10	2561.5	11.25	0%	2561.5	90	3.5%						8		11	11
Westerdale North	Teesside	MHSOP	18	2881.5	80.50	3%	2881.5	40.5	1.4%					1				
Westerdale South	Teesside	MHSOP	14	5173.8	260.50	5%	5173.8	1961.54	37.9%						6		8	8
Wingfield Ward	Teesside	MHSOP	10	2487.5	11.50	0%	2487.5	494.5	19.9%									

Severity Scoring by Total Score

APPENDIX 3

WARD	Locality	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 (Oct)
Bilsdale Ward	Teesside	2	2	0	1	2	0	0	1	1	1	**10**
Bedale Ward	Teesside	4	2	0	1	1	0	0	0	0	1	**9**
Swift Ward	Forensics	4	2	0	0	2	0	0	0	0	1	**9**
Springwood Community Unit	North Yorkshire	2	2	1	1	1	0	0	0	0	1	**8**
Clover/Ivy	Forensics	2	1	1	1	2	0	0	1	0	0	**8**
Mandarin	Forensics	2	2	1	0	2	0	0	0	0	1	**8**
Elm Ward	Durham & Darlington	0	0	1	1	2	0	0	2	1	1	**8**
Westerdale South	Teesside	2	2	0	1	2	0	0	0	0	0	**7**
The Evergreen Centre	Teesside	0	3	0	1	1	0	0	0	0	2	**7**
Ward 15 Friarage	North Yorkshire	2	0	0	1	1	0	0	3	0	0	**7**
Newberry Centre	Teesside	2	2	0	1	0	0	0	0	0	2	**7**
Talbot Direct Care	Durham & Darlington	6	0	1	0	0	0	0	0	0	0	**7**
Cedar Ward	Durham & Darlington	0	2	1	0	2	0	0	0	1	1	**7**
Northdale Centre	Forensics	2	1	1	1	2	0	0	0	0	0	**7**
Birch Ward	Durham & Darlington	0	2	1	1	2	0	0	0	1	0	**7**
Westwood Centre	Teesside	0	2	0	0	1	0	0	1	1	1	**6**
Bransdale Ward	Teesside	2	2	0	1	1	0	0	0	0	0	**6**
Ayckbourn Unit Danby Ward	North Yorkshire	4	1	0	1	0	0	0	0	0	0	**6**
Sandpiper Ward	Forensics	2	1	1	0	1	0	0	0	0	1	**6**
Overdale Ward	Teesside	2	1	1	1	1	0	0	0	0	0	**6**
Lustrum Vale	Teesside	2	1	0	0	2	0	0	0	0	0	**5**
Hamsterley Ward	Durham & Darlington	0	2	0	1	2	0	0	0	0	0	**5**
Rowan Ward	North Yorkshire	0	2	0	1	1	0	0	0	0	1	**5**
Langley Ward	Forensics	2	1	0	1	1	0	0	0	0	0	**5**
Bankfields Court Flats	Teesside	2	1	1	0	1	0	0	0	0	0	**5**
Lark	Forensics	2	0	1	0	1	0	0	0	1	0	**5**
Kestrel/Kite.	Forensics	2	1	1	0	1	0	0	0	0	0	**5**
Ebor Ward	York and Selby	2	0	1	1	0	0	0	1	0	0	**5**

Bek-Ramsey Ward	Durham & Darlington	0	2	1	1	0	0	0	0	0	1	**5**
The Lodge	Teesside	4	0	1	0	0	0	0	0	0	0	**5**
The Orchards (NY)	North Yorkshire	4	0	1	0	0	0	0	0	0	0	**5**
Wingfield Ward	Teesside	2	0	1	1	1	0	0	0	0	0	**5**
Meadowfields	York and Selby	2	0	0	1	1	0	0	0	0	0	**4**
Merlin	Forensics	0	2	0	0	2	0	0	0	0	0	**4**
Acomb Garth	York and Selby	0	2	0	1	0	0	0	0	0	1	**4**
Newtondale Ward	Forensics	2	1	0	0	1	0	0	0	0	0	**4**
Eagle/Osprey	Forensics	2	0	0	1	1	0	0	0	0	0	**4**
Nightingale Ward	Forensics	2	0	1	0	1	0	0	0	0	0	**4**
Oakwood	Forensics	2	1	1	0	0	0	0	0	0	0	**4**
Rowan Lea	North Yorkshire	0	1	1	1	0	0	0	0	0	1	**4**
Jay Ward	Forensics	2	0	1	0	1	0	0	0	0	0	**4**
Aysgarth	Teesside	2	0	1	0	1	0	0	0	0	0	**4**
Oak Rise	York and Selby	0	1	0	1	0	0	0	0	0	1	**3**
Bankfields Court Unit 3	Teesside	2	0	0	0	0	0	0	0	0	1	**3**
Primrose Lodge	Durham & Darlington	2	1	0	0	0	0	0	0	0	0	**3**
Maple Ward	Durham & Darlington	0	1	0	1	1	0	0	0	0	0	**3**
Ayckbourn Unit Esk Ward	North Yorkshire	2	1	0	0	0	0	0	0	0	0	**3**
Harrier/Hawk	Forensics	2	0	0	0	1	0	0	0	0	0	**3**
Holly Unit	Durham & Darlington	0	3	0	0	0	0	0	0	0	0	**3**
Fulmar Ward.	Forensics	2	0	0	0	1	0	0	0	0	0	**3**
Thistle	Forensics	2	0	0	0	1	0	0	0	0	0	**3**
Ward 14	North Yorkshire	2	0	0	1	0	0	0	0	0	0	**3**
Stockdale Ward	Teesside	0	0	1	1	1	0	0	0	0	0	**3**
Mallard Ward	Forensics	0	1	1	0	1	0	0	0	0	0	**3**
Kirkdale Ward	Forensics	0	0	1	1	1	0	0	0	0	0	**3**
Cedar Ward (NY)	North Yorkshire	0	1	1	1	0	0	0	0	0	0	**3**
Farnham Ward	Durham & Darlington	0	0	1	0	1	1	0	0	0	0	**3**
Linnet Ward	Forensics	2	0	0	0	0	0	0	0	0	0	**2**
Cherry Tree House	York and Selby	0	0	1	1	0	0	0	0	0	0	**2**
Bankfields Court Unit 2	Teesside	0	1	1	0	0	0	0	0	0	0	**2**
Brambling Ward	Forensics	0	0	1	0	1	0	0	0	0	0	**2**
Willow Ward	Durham & Darlington	0	1	1	0	0	0	0	0	0	0	**2**
Westerdale North	Teesside	0	0	1	1	0	0	0	0	0	0	**2**

Minster Ward	York and Selby	0	0	0	1	0	0	0	0	0	0	**1**
Lincoln Ward	Teesside	0	0	0	0	1	0	0	0	0	0	**1**
Roseberry Wards	Durham & Darlington	0	0	0	0	1	0	0	0	0	0	**1**
Baysdale	Teesside	0	1	0	0	0	0	0	0	0	0	**1**
Tunstall Ward	Durham & Darlington	0	0	1	0	0	0	0	0	0	0	**1**
Ceddesfeld Ward	Durham & Darlington	0	0	0	0	0	0	0	0	0	0	**0**
Bankfields Court Unit 4	Teesside	0	0	0	0	0	0	0	0	0	0	**0**
Oak Ward	Durham & Darlington	0	0	0	0	0	0	0	0	0	0	**0**

Severity Scoring by Speciality

APPENDIX 4

WARD	Locality	Speciality	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 (Oct)
Bilsdale Ward	Teesside	Adults	2	2	0	1	2	0	0	1	1	1	**10**
Bedale Ward	Teesside	Adults	4	2	0	1	1	0	0	0	0	1	**9**
Elm Ward	Durham & Darlington	Adults	0	0	1	1	2	0	0	2	1	1	**8**
Ward 15 Friarage	North Yorkshire	Adults	2	0	0	1	1	0	0	3	0	0	**7**
Cedar Ward	Durham & Darlington	Adults	0	2	1	0	2	0	0	0	1	1	**7**
Birch Ward	Durham & Darlington	Adults	0	2	1	1	2	0	0	0	1	0	**7**
Bransdale Ward	Teesside	Adults	2	2	0	1	1	0	0	0	0	0	**6**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	4	1	0	1	0	0	0	0	0	0	**6**
Overdale Ward	Teesside	Adults	2	1	1	1	1	0	0	0	0	0	**6**
Lustrum Vale	Teesside	Adults	2	1	0	0	2	0	0	0	0	0	**5**
Ebor Ward	York and Selby	Adults	2	0	1	1	0	0	0	1	0	0	**5**
The Orchards (NY)	North Yorkshire	Adults	4	0	1	0	0	0	0	0	0	0	**5**
Primrose Lodge	Durham & Darlington	Adults	2	1	0	0	0	0	0	0	0	0	**3**
Maple Ward	Durham & Darlington	Adults	0	1	0	1	1	0	0	0	0	0	**3**
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	2	1	0	0	0	0	0	0	0	0	**3**
Stockdale Ward	Teesside	Adults	0	0	1	1	1	0	0	0	0	0	**3**
Kirkdale Ward	Forensics	Adults	0	0	1	1	1	0	0	0	0	0	**3**
Cedar Ward (NY)	North Yorkshire	Adults	0	1	1	1	0	0	0	0	0	0	**3**
Farnham Ward	Durham & Darlington	Adults	0	0	1	0	1	1	0	0	0	0	**3**
Willow Ward	Durham & Darlington	Adults	0	1	1	0	0	0	0	0	0	0	**2**
Minster Ward	York and Selby	Adults	0	0	0	1	0	0	0	0	0	0	**1**
Lincoln Ward	Teesside	Adults	0	0	0	0	1	0	0	0	0	0	**1**
Tunstall Ward	Durham & Darlington	Adults	0	0	1	0	0	0	0	0	0	0	**1**
The Evergreen Centre	Teesside	CYPS	0	3	0	1	1	0	0	0	0	2	**7**
Newberry Centre	Teesside	CYPS	2	2	0	1	0	0	0	0	0	2	**7**
Talbot Direct Care	Durham & Darlington	CYPS	6	0	1	0	0	0	0	0	0	0	**7**
Westwood Centre	Teesside	CYPS	0	2	0	0	1	0	0	1	1	1	**6**
Holly Unit	Durham & Darlington	CYPS	0	3	0	0	0	0	0	0	0	0	**3**

Baysdale	Teesside	CYPS	0	1	0	0	0	0	0	0	0	0	**1**
Clover/Ivy	Forensics	Forensics LD	2	1	1	1	2	0	0	1	0	0	**8**
Northdale Centre	Forensics	Forensics LD	2	1	1	1	2	0	0	0	0	0	**7**
Langley Ward	Forensics	Forensics LD	2	1	0	1	1	0	0	0	0	0	**5**
Kestrel/Kite.	Forensics	Forensics LD	2	1	1	0	1	0	0	0	0	0	**5**
Eagle/Osprey	Forensics	Forensics LD	2	0	0	1	1	0	0	0	0	0	**4**
Oakwood	Forensics	Forensics LD	2	1	1	0	0	0	0	0	0	0	**4**
Harrier/Hawk	Forensics	Forensics LD	2	0	0	0	1	0	0	0	0	0	**3**
Thistle	Forensics	Forensics LD	2	0	0	0	1	0	0	0	0	0	**3**
Swift Ward	Forensics	Forensics MH	4	2	0	0	2	0	0	0	0	1	**9**
Mandarin	Forensics	Forensics MH	2	2	1	0	2	0	0	0	0	1	**8**
Sandpiper Ward	Forensics	Forensics MH	2	1	1	0	1	0	0	0	0	1	**6**
Lark	Forensics	Forensics MH	2	0	1	0	1	0	0	0	1	0	**5**
Merlin	Forensics	Forensics MH	0	2	0	0	2	0	0	0	0	0	**4**
Newtondale Ward	Forensics	Forensics MH	2	1	0	0	1	0	0	0	0	0	**4**
Nightingale Ward	Forensics	Forensics MH	2	0	1	0	1	0	0	0	0	0	**4**
Jay Ward	Forensics	Forensics MH	2	0	1	0	1	0	0	0	0	0	**4**
Fulmar Ward.	Forensics	Forensics MH	2	0	0	0	1	0	0	0	0	0	**3**
Mallard Ward	Forensics	Forensics MH	0	1	1	0	1	0	0	0	0	0	**3**
Linnet Ward	Forensics	Forensics MH	2	0	0	0	0	0	0	0	0	0	**2**
Brambling Ward	Forensics	Forensics MH	0	0	1	0	1	0	0	0	0	0	**2**
Bankfields Court Flats	Teesside	LD	2	1	1	0	1	0	0	0	0	0	**5**
Bek-Ramsey Ward	Durham & Darlington	LD	0	2	1	1	0	0	0	0	0	1	**5**
The Lodge	Teesside	LD	4	0	1	0	0	0	0	0	0	0	**5**
Aysgarth	Teesside	LD	2	0	1	0	1	0	0	0	0	0	**4**
Oak Rise	York and Selby	LD	0	1	0	1	0	0	0	0	0	1	**3**
Bankfields Court Unit 3	Teesside	LD	2	0	0	0	0	0	0	0	0	1	**3**
Bankfields Court Unit 2	Teesside	LD	0	1	1	0	0	0	0	0	0	0	**2**
Bankfields Court Unit 4	Teesside	LD	0	0	0	0	0	0	0	0	0	0	**0**
Springwood Community Unit	North Yorkshire	MHSOP	2	2	1	1	1	0	0	0	0	1	**8**
Westerdale South	Teesside	MHSOP	2	2	0	1	2	0	0	0	0	0	**7**
Hamsterley Ward	Durham & Darlington	MHSOP	0	2	0	1	2	0	0	0	0	0	**5**
Rowan Ward	North Yorkshire	MHSOP	0	2	0	1	1	0	0	0	0	1	**5**
Wingfield Ward	Teesside	MHSOP	2	0	1	1	1	0	0	0	0	0	**5**
Meadowfields	York and Selby	MHSOP	2	0	0	1	1	0	0	0	0	0	**4**

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

Severity Scoring Year to Date Position

APPENDIX 5

WARD	Locality	Speciality	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	YTD Total
Sandpiper Ward	Forensics	Forensics MH	8	8	8	9	6	8	4	10	11	6	7	6	**91**
Springwood Community Unit	North Yorkshire	MHSOP	6	9	7	6	6	7	5	6	8	6	8	8	**82**
Meadowfields	York and Selby	MHSOP	4	5	8	6	8	6	9	8	6	6	7	4	**77**
Clover/Ivy	Forensics	Forensics LD	4	2	2	4	5	8	7	7	10	10	7	8	**74**
Newberry Centre	Teesside	CYPS	6	6	3	3	7	8	6	6	10	4	4	7	**70**
Northdale Centre	Forensics	Forensics LD	4	5	5	8	7	4	5	5	9	6	5	7	**70**
Westwood Centre	Teesside	CYPS	5	8	7	4	4	5	3	5	8	8	6	6	**69**
Bedale Ward	Teesside	Adults	5	2	5	5	7	6	5	4	6	5	7	9	**66**
Bransdale Ward	Teesside	Adults	5	4	6	6	5	4	5	6	6	6	6	6	**65**
Cedar Ward (NY)	North Yorkshire	Adults	6	8	5	5	6	7	8	6	5	3	2	3	**64**
Merlin	Forensics	Forensics MH	4	4	4	7	5	7	7	5	6	5	6	4	**64**
Rowan Ward	North Yorkshire	MHSOP	6	4	6	5	6	5	6	6	6	5	3	5	**63**
Cedar Ward	Durham & Darlington	Adults	6	4	5	4	6	5	4	5	5	6	6	7	**63**
Newtondale Ward	Forensics	Forensics MH	5	6	4	6	6	4	5	6	6	4	4	4	**60**
Kestrel/Kite.	Forensics	Forensics LD	5	4	5	8	5	3	3	6	7	5	4	5	**60**
Swift Ward	Forensics	Forensics MH	7	4	6	7	2	4	4	6	5	3	3	9	**60**
Mandarin	Forensics	Forensics MH	6	4	6	5	0	2	3	8	5	5	7	8	**59**
The Evergreen Centre	Teesside	CYPS	4	4	1	3	5	5	6	8	5	4	5	7	**57**
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	6	2	4	6	10	5	5	3	4	5	3	3	**56**
Ward 15 Friarage	North Yorkshire	Adults	3	5	4	5	5	5	4	5	4	4	5	7	**56**
Elm Ward	Durham & Darlington	Adults	4	3	3	5	4	1	3	5	5	7	6	8	**54**
Fulmar Ward.	Forensics	Forensics MH	3	3	5	7	4	3	7	5	5	4	2	3	**51**
Harrier/Hawk	Forensics	Forensics LD	4	8	8	5	3	2	3	3	5	4	3	3	**51**
Hamsterley Ward	Durham & Darlington	MHSOP	6	6	3	4	2	5	2	1	7	5	5	5	**51**

Overdale Ward	Teesside	Adults	4	6	0	4	5	5	7	4	4	3	3	6	**51**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	8	4	4	4	4	2	5	2	4	3	4	6	**50**
Westerdale South	Teesside	MHSOP	5	4	1	2	2	3	4	3	4	8	7	7	**50**
Cherry Tree House	York and Selby	MHSOP	2	4	1	4	5	4	6	6	4	7	3	2	**48**
Acomb Garth	York and Selby	MHSOP				8	5	6	2	4	6	8	5	4	**48**
Mallard Ward	Forensics	Forensics MH	3	4	4	4	6	5	4	3	4	3	4	3	**47**
The Orchards (NY)	North Yorkshire	Adults	5	2	9	4	6	4	3	1	3	3	2	5	**47**
Lustrum Vale	Teesside	Adults	4	1	0	2	3	6	5	4	4	8	5	5	**47**
Talbot Direct Care	Durham & Darlington	CYPS			3	4	6	3	0	4	5	7	8	7	**47**
Oak Rise	York and Selby	LD	4	2	2	4	5	4	9	1	2	5	5	3	**46**
Ebor Ward	York and Selby	Adults	4	4	5	3	2	6	2	4	2	5	3	5	**45**
Primrose Lodge	Durham & Darlington	Adults	3	3	3	4	4	5	4	3	4	3	4	3	**43**
Linnet Ward	Forensics	Forensics MH	4	6	6	3	3	3	3	4	3	3	2	2	**42**
Jay Ward	Forensics	Forensics MH	5	4	2	4	4	4	2	4	3	4	2	4	**42**
Holly Unit	Durham & Darlington	CYPS	3	3	6	1	2	3	5	5	3	4	3	3	**41**
Langley Ward	Forensics	Forensics LD	5	4	4	4	3	0	3	2	3	5	2	5	**40**
Birch Ward	Durham & Darlington	Adults	4	2	2	1	3	2	1	4	6	4	4	7	**40**
Eagle/Osprey	Forensics	Forensics LD	2	2	3	4	4	2	2	2	6	5	3	4	**39**
Nightingale Ward	Forensics	Forensics MH	1	2	4	3	4	2	2	6	3	5	3	4	**39**
Bilsdale Ward	Teesside	Adults	1	0	4	4	4	1	0	3	5	4	3	10	**39**
Minster Ward	York and Selby	Adults	2	8	3	3	3	2	4	2	3	3	4	1	**38**
Maple Ward	Durham & Darlington	Adults	3	4	4	0	5	1	1	3	5	6	3	3	**38**
Lark	Forensics	Forensics MH	0	3	0	1	4	4	0	5	6	5	5	5	**38**
Brambling Ward	Forensics	Forensics MH	4	2	5	0	0	5	3	7	4	4	1	2	**37**
Oakwood	Forensics	Forensics LD	4	4	1	4	4	4	1	2	3	3	3	4	**37**
Ward 14	North Yorkshire	MHSOP	3	5	3	3	3	4	3	3	3	1	0	3	**34**
Kirkdale Ward	Forensics	Adults	1	3	2	2	0	2	3	6	4	4	2	3	**32**
Thistle	Forensics	Forensics LD	2	2	3	2	3	3	2	3	3	4	2	3	**32**

Stockdale Ward	Teesside	Adults	2	1	1	1	2	2	2	3	6	5	4	3	**32**
Wingfield Ward	Teesside	MHSOP	5	4	1	2	3	1	2	1	1	4	1	5	**30**
Aysgarth	Teesside	LD	2	2	3	2	2	2	1	1	4	3	2	4	**28**
Bek-Ramsey Ward	Durham & Darlington	LD	2	2	0	1	2	3	3	2	3	2	3	5	**28**
Bankfields Court Flats	Teesside	LD							2	3	5	7	6	5	**28**
Bankfields Court	Teesside	LD	4	6	4	5	3	5							**27**
Willow Ward	Durham & Darlington	Adults	4	3	1	2	5	2	1	3	1	3	0	2	**27**
The Lodge	Teesside	LD							4	4	4	5	2	5	**24**
Bankfields Court Unit 2	Teesside	LD	2	1	2	1	3	2	2	1	2	3	2	2	**23**
Farnham Ward	Durham & Darlington	Adults	2	2	1	2	2	3	1	3	3	0	0	3	**22**
Rowan Lea	North Yorkshire	MHSOP	2	1	0	2	1	1	0	1	3	3	3	4	**21**
Bankfields Court Unit 3	Teesside	LD							2	2	5	2	5	3	**19**
Tunstall Ward	Durham & Darlington	Adults	0	1	1	1	1	1	2	5	2	1	2	1	**18**
Westerdale North	Teesside	MHSOP	2	2	1	1	1	0	3	0	3	1	0	2	**16**
Roseberry Wards	Durham & Darlington	MHSOP	2	2	1	1	0	1	1	2	1	1	1	1	**14**
Lincoln Ward	Teesside	Adults	0	1	1	0	0	1	2	3	1	2	1	1	**13**
Oak Ward	Durham & Darlington	MHSOP	0	1	1	3	1	1	1	2	2	0	0	0	**12**
Ceddesfeld Ward	Durham & Darlington	MHSOP	2	3	1	0	2	0	0	0	1	1	2	0	**12**
Worsley Court	York and Selby	MHSOP	4	6	0										**10**
Bankfields Court Unit 4	Teesside	LD							0	5	0	5	0	0	**10**
Baysdale	Teesside	CYPS	0	0	0	1	2	1	0	1	1	3	0	1	**10**
Robin	Forensics		6	1	0										**7**

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM No. 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28 November 2017**
TITLE:	**Learning from deaths**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Information**

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

Executive Summary:

Following the publication of the Southern Health report in 2015 there has been enhanced national scrutiny on how all NHS organisations respond to the deaths of service users in their care. This culminated in the release of a 'Learning from deaths framework' which was published by the National Quality Board earlier in 2017.

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from deaths and the Trust has prioritised working more closely with families and carers of patients who have died and to ensure meaningful support and engagement with them at all stages.

This report sets out the approach the Trust is taking towards the identification, categorisation and investigation of deaths and has an initial draft of a mortality dashboard (Appendix 1). Links to the relevant Trust policy and associated national guidance have been included at the end of the report for information and greater context.

Recommendations:

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

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**28 November 2017**
TITLE:	**Learning from deaths**

1. INTRODUCTION & PURPOSE:

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

Working with eight other mental health trusts in the north of England we have developed a reporting dashboard that brings together important information that will help us to do that. We will continue to develop this over time, for example by looking in to some areas in greater detail and by talking to families and carers about what is important to them. We will also learn from developments nationally as these occur.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

3.1 Identification of deaths to be reviewed

In mental health and learning disability services the vast majority of our service users are cared for in the community and often we have very minimal contact with them. This means that there can be a delay in the notification of a death and occasionally we do not find out at all. We are working with staff in all of our community teams (including Learning Disabilities) to ensure they report any deaths they become aware of – regardless of cause - via our internal incident management system (Datix). As this additional reporting improves so will the accuracy of the data we publish to ensure we are working within the scope of our learning from deaths policy.

3.2 Classification of deaths to be investigated

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

For people with a Learning Disability the Trust supports the approach of the LeDer programme (national learning disabilities mortality review process). The reporting of deaths to LeDeR has traditionally been undertaken by clinicians in our services so we are not currently in a position to report an accurate figure in the attached dashboard – it is anticipated that we will be able to report this centrally from Q3 onwards. We are working with the regional LeDeR team to improve our processes and also to streamline the process of receiving feedback from the LeDeR reviews which have been completed.

To ensure a consistent approach to the classification of deaths the Trust has been working in collaboration with other mental health organisations across the North East and North West to agree the following:

We are the main provider at the time of death if the patient was subject to:

- An episode of in-patient care within our service
- An episode of community treatment under Care Programme Approach
- An episode of community treatment due to identified mental health, learning disability or substance misuse needs
- A community treatment order
- A conditional discharge
- An in-patient episode or community treatment package within 6 months prior to their death
-

There is more detail relating to this agreed criteria and any exceptions in the Trust 'Learning from deaths: the right thing to do' policy (CORP 00-65).

There are 3 types of investigation depending on the circumstances of the death reported:

- Serious Incident Framework - comprehensive internal investigation – these are our serious incident investigations which are carried out by a central, dedicated team of reviewers. The incidents are reported externally to commissioners and signed off internally by a formal panel of directors and other key clinicians. Families and carers are invited to be part of the review process and their questions are welcomed and included within the report. Our reviewers, and other senior managers, also visit families and carers to share the findings of the completed report with them.
- Serious Incident Framework - Independent Investigation – these infrequent reviews relate to homicide investigations or serious case reviews and are likely to be investigated externally by NHS England.
- Mortality Review – the Trust approach to mortality review at this time is to identify those service users on the Care Programme Approach who have died but do not fall into the two investigation categories above. A case summary is prepared for a multi-disciplinary team review. For any cases where further investigation is required to make a decision we have adopted a more detailed approach of structured judgement review. Any learning points identified are shared with the clinical team involved and will be considered in thematic

reports of patient safety issues. A shortened, anonymised example of a completed structured judgement review is attached at Appendix 2.

3.3 Appendix 1: Dashboard

The first draft of the learning from deaths dashboard is attached at Appendix 1 – it should be noted that this is likely to be amended/ revised over time as our internal information and processes improve.

The headings in the dashboard are currently defined as follows:

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

For the purpose of this report the learning identified from Serious Incidents has been categorised as those cases which concluded with either a root cause or contributory finding meaning the outcome *may* have been different if different decisions had been made or different circumstances in place. From Q3 onwards the themes from the learning points identified will be reported and monitored and included within this report.

We are still working towards the best approach to reporting what are described in general hospital services as "avoidable deaths." This is because there is currently no research base on this for mental health services and no consistent accepted basis for calculating this data. We also consider that if we restricted our reporting to inpatient services only this would give a misleading picture of the majority of services we

provide which are predominately community focused. We will review this approach before April 2018 and will continue to support work to develop our data, reporting and general understanding of the issues.

3.4 The role of Non-Executive Directors

Trust Boards are accountable for ensuring compliance with the 2017 NQB guidance on Learning from Deaths and working towards achieving the highest standards in mortality governance. They must ensure quality improvement remains key by championing and supporting learning that leads to meaningful and effective actions that continually improve patient safety and experience and supports cultural change. Tees, Esk and Wear Valleys NHS Foundation Trust has identified both its Chair, Lesley Bessant, and another Non-Executive Director, Shirley Richardson, to take lead responsibility for oversight of progress to act as a critical friend holding the organisation to account for its approach in learning from deaths.

The Trust already has a very well-established process in place for the final review of Serious Incident investigation. This is a panel of directors and other senior clinical staff and always includes a non-executive director. We are now looking to further expand the non-executive directors contributions in this area by including them within the mortality review process too.

4.0 Next Steps

As previously mentioned within this report this is an enhanced process of reporting which is still being refined and defined and therefore the information should be considered with this in mind. The next report will be prepared for the February 2018 Board of Directors and will aim to include:

- More accurate numbers of 'in scope' deaths following a period of data cleansing
- Information on any learning disability deaths that have been reported to LeDeR
- Themes from learning points in Serious Incident investigations and examples of changes to practice as a result

Moving forward we will also be seeking to engage with families and carers to ensure their views are reflected in future work.

5.0 IMPLICATIONS:

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

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

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

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

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

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

7. **CONCLUSION:**
This report is the first iteration of the trust information relating to the national learning from deaths agenda. There will be ongoing work required to ensure the numbers of deaths reported (both in and out of scope) are as accurate as possible. Future reports will also include themes from deaths reported and lessons learned.

7. **RECOMMENDATIONS:**

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

Jennifer Illingworth
Director of Quality Governance
November 2017

Background Papers:

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

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

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

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

Appendix 1

	Total deaths as reported on Patient Admin System	Total number deaths - community service users	Total number deaths - In-Patient	Total number deaths - LD In-Patient	Total deaths in scope of learning from deaths policy		Total deaths reviewed as an SI	Total deaths reviewed as mortality review	Total LD deaths reviewed internally	LD deaths reported to LeDer	Total no of deaths (SI) where learning identified that has led, or was likely to, change
April	**211**	**210**	**1**	0	**60**		**7**	**12**	0	not available	**4**
May	**189**	**188**	**1**	0	**117**		**4**	**9**	0	not available	**3**
June	**141**	**141**	**0**	0	**101**		**6**	**15**	0	not available	**2**
Q1 total	**541**	**539**	**2**	**0**	**278**		**17**	**36**	**0**		**9**
July	**197**	196	1	0	121		6	13	0	not available	3
August	**161**	160	1	0	134		7	9	1	not available	3
September	**166**	165	1	0	107		3	4	0	not available	1
Q2 total	**524**	**521**	**3**	**0**	**362**		**16**	**26**	**1**		**7**

- Of the 5 in-patient deaths, 4 were from expected natural causes and 1 was categorised as a Serious Incident and investigated accordingly.

Example of Mortality Structured Judgement Review

This case involved a male in his late 40's who was open to an adult mental health community team and who died from alcohol related illness. He had been physically unwell for many years, including living with enduring pain for 10 years following an accident. He also had a history of self-harm and suicidal thoughts.

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

Good Practice
From the review areas of good practice were identified as evidence of multi-disciplinary team input and communication, comprehensive record keeping and the fact that patient was supported by regular members of staff which ensured consistency of approach.

Learning points
Learning points included lack of meaningful multiagency working to help with alcohol intake and environmental/social issues which impacted negatively on the service user's physical and mental health. There was no escalation of risk in relation to pain medication being stopped by the service users GP which may have been a factor in subsequent decisions made.

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

ITEM NO 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 28 November 2017**
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 2, 2017-18.

Key areas for consideration:

- Patient case studies
- CQC MHA specific inspections summary report
- 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
- Human Rights, Equality and Diversity Policy

Recommendations:

The Board of Directors is asked to:

i) Receive and note the assurance report, following the MHLC meeting held on 19 October 2017 and to note the approved minutes of the MHLC meeting held on 13 July 2017. (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 28 November 2017**
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 2, 2017-18; through consideration of the work of the Mental Health Legislation Committee at its meeting held on 19 October 2017.

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 13 July 2017 are attached as Annex 1.

The MHLC also met on 19 October 2017. The key issues considered at this meeting were as follows:

3.2 Patient Case Studies

Further to minute 17/27b) (13.07.17) the Committee received two case studies of patients that had been in seclusion for extended periods of time.

- The case studies provided the background and nursing care required by individuals on Merlin Ward, Roseberry Park and Low Secure CAMHS Service at West Lane Hospital.

- The Committee agreed that two case studies would be considered at future quarterly MHLC meetings to provide a deeper level of understanding of the complexities around seclusion and to provide assurance around the qualitative information behind the statistics reported through to the Committee.

3.3 CQC MHA Visits Feedback Summary Report

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

- There were eight 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.
- 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

3.4 Section 136, Crisis Assessment Suite (CAS) and Street Triage Report

The Committee considered data and trends around S136, CAS and Street Triage.

- 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.
- Those being taken into police custody continues to be low with one to Cleveland, one to North Yorkshire and one to Durham.
- There were five under 18 year olds brought to a mental health hospital based place of safety between the ages of 15 to 17.
- Street Triage teams are 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.
- Within the Crisis Assessment Suite (CAS) at Roseberry Park activity continues 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.
- Of the total assessments, 21 % were discharged without mental health follow up or sign-posting to other services, this is 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 on 11 December 2017 and the impact of the changes would be considered in more detail at the January 2018 MHLC meeting.

3.5 Discharges Report

The Committee discussed the Discharges report.

- Discharge from detention by either the First Tier Tribunal or the Associate Hospital Managers. In Quarter 2 there were 133 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 2 was 175, of the MHTs held, one resulted in discharge from section 2, four were discharged from section 3 and there was one conditional discharge.
- A new piece of case law around conditional discharge handed down in march 2017 could potentially see patients in the community being recalled to

hospital. NHS England will 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.

3.6 Seclusion Report

The Committee discussed the seclusion report.

- There were 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.
- Of those in excess of 24 hours, the longest was just under 39 days, however there is one patient who has been in long term seclusion since 15 August 2016.

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

3.7 Mental Capacity Act and DoLS Report

The Committee was given assurance that the implementation of the Mental Capacity Act and monitoring of DoLS activity across the Trust continues to improve.

The key matters discussed were around:

- Audit, recording DoLS on the new module on Paris and training.

  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.

- The Champions programme was going well and it was anticipated there would be 20 trained Champions across the Trust by the end of the year.

The Committee discussed the 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 N Yorkshire, where the eligibility criteria around DoLS was not being applied correctly.

That this matter 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.

3.8 Human Rights, Equality and Diversity Policy

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

The key matters discussed were:

- Section 3.15 of the Mental Health Act Code of Practice stipulates 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.

- 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 will be annual publication of equality information including analysis of detentions under the MHA by gender and ethnicity.

- The report proposed that the MHL Committee monitor the action plan arising from compliance with the Policy, however the Committee did not feel that this was within the terms of reference of the Committee

The Committee agreed: *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.*

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 20 April 2017.*
(ii) *Note the matter of escalation to Director level around*
(iii) *Note the recommendation to review and approve the Human Rights, Equality and Diversity Policy as required by the Mental Health Act Code of Practice, with the caveat that the monitoring of any future action plan will be through the Equality and Diversity Steering Group.*

Richard Simpson
Chairman of the Committee

Background Papers:
Annex 1 – Approved minutes of the 20 April 2017 MHL Committee Meeting

Annex 1

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 20 APRIL 2017 IN SEMINAR ROOM 4, WEST PARK HOSPITAL, DARLINGTON AT 1 PM.

Present:
Mr R Simpson, Non-Executive Director, Chairman of the Committee
Dr N Land, Medical Director
Mrs E Moody, Director of Nursing & Governance
Mr P Murphy, Non-Executive Director
Mrs S Richardson, Non-Executive Director

In Attendance:
Mrs D Oliver, Deputy Trust Secretary, (Corporate)
Mrs J Illingworth, Director of Quality Governance
Miss M Wilkinson, Head of Mental Health Legislation
Mrs R Down, Mental Health Legislation Advisor (MCA Lead)
Ms P Griffin, Mental Health Legislation Advisor
Mrs R Hill, Director of Operations for York & Selby

Apologies: Apologies for absence were received from Mrs L Bessant, Chairman of the Trust, Mr B Kilmurray, Chief Operating Officer, Miss J Clarke, Governor and Ms S Talbot-Landon, Governor.

17/10 MINUTES

Agreed – *That the minutes of the last meeting held on 19 January 2017 be approved as a correct record, subject to a minor typographical error and signed by the Chairman.*

17/11 ACTION LOG

The Committee noted the actions and following updates:

16/29 Summary table of actions following MHA inspections.
This matter was covered under agenda item number 4 (see minute 17/12)
Completed

16/29 Repeated issues raised by the CQC: Solution for scanning forms.
Scanning machines had been delivered to the Trust with the first to be piloted in Middlesbrough. All existing patients' documentation would be scanned onto PARIS and future section papers, with the aim of eradicating repeated issues raised by the CQC around paperwork errors.
Completed

16/29 The lack of uptake around Code of Practice training, which had been mandated by EMT.
This matter was covered under agenda item number 9 (see minute 17/19)
Completed

17/04 Report on the impact of the Police and Crime Bill – This matter was covered under agenda item number 7 (see minute 17/17)
Completed

17/06 Update on assurance around processes in place around seclusion over 24 hours.
Mrs Moody provided a verbal update on the developments around the additional safeguards in place for seclusion periods over 12, 24 and 72 hours. A paper would

be presented to the 4 May 2017 Quality Assurance Committee and a copy of this report would be circulated to the MHLC members for information.

Action: Mrs E Moody

17/07 Response to CQC letter regarding SOAD's.
Dr Land reported that currently the Trust had 2 SOAD's, however the aim was to have around 4 to 5. The Senior Medical Staff Committee had been notified and correspondence had been sent to all Consultants, with 1 request for a reference put forward so far. An update would be brought back to the 13 July 2017 MHLC meeting.

Action: Dr N Land

17/08 Report to MHLC showing basic record of section 49 assessments requested.
The Committee agreed that this would be a standing item to be reported to the MHLC on a quarterly basis, to outline the activity and context of issues around Section 49 assessments.

Action : Mrs J Illingworth

17/08 Following results of internal audit on Mental Capacity Act and staff questionnaire action plan to be received by MHLC.
This matter was covered under agenda number 6 (see minute17/16)

Completed

17/12 CARE QUALITY COMMISSION (MHA) VISIT FEEDBACK SUMMARY REPORT

The Committee discussed:

(1) The MHA Visits - 1 January to 31 March 2017.

(a) There had been10 MHA visits across the Trust, eight of which had been reported on, which was a similar number of visits compared to the last quarter.
(b) There had been 37 issues raised, including 1 patient issue (the full details of issues raised were provided in section 3.2 of the report).
(c) The actions arising from the issues raised would be monitored through EMT with Provider Action Statements returned to the CQC.
(d) The Quality Assurance Committee would monitor actions where the original deadline date had not been met.

(2) The Thematic review of MHA visits since April 2016.

(a) The top five themes from April 2016 - April 2017 had been identified from the data following the Mental Health Act Reviewer visits.

In relation to this matter it was noted that:

- There were 59 ongoing actions across 11 separate wards.
- The recurring themes would be communicated across the Trust to create awareness amongst staff and wards to prevent repeated non-compliance issues.
- The compliance group would be distributing a 1 page summary of the top five themes across all localities as well as going to LMGB's for information sharing.

Mrs Richardson advised that a proactive approach was needed, working with the Compliance team, Heads of Nursing and other key leads to help prevent recurring issues being raised by the CQC.

(3) Bankfields - where no issues had been raised by the CQC.

The Committee agreed that the staff on Bankfields should be thanked and congratulated following no issues having been found by the CQC on the MHA inspection.
Mrs Moody undertook to write a letter of congratulations to the staff on Bankfields.

Action: Mrs E Moody

17/13 SECTION 136 REPORT

The Committee received and noted the Section 136 report.

Ms Griffin drew attention to the impact of the use of S.136.

(a) The number of S 136 brought to Trust Places of Safety had increased in all areas in the last quarter and this is reflected in the reduction in the use of Police stations as places of safety.
(b) The Crisis Assessment Suite (CAS) had continued to see high numbers of people, with 43 individuals going on to be admitted to an inpatient ward.
(c) Street Triage in Scarborough, York and Teesside, despite reduced availability continued to provide professional support, with 201 contacts across all areas resulting in the use of S 136 on only 6 occasions.
It was noted that information gathering across teams was variable due to the demands from the various Commissioners and some work would be undertaken to standardise reporting.

The Chairman acknowledged the important work of street triage and asked whether the data could be analysed in further detail to demonstrate the benefits of this service and how it impacted on the CAS and use of TEWV places of safety.

Mrs Hill advised that the increase in the use of TEWV places of safety and the Crisis Assessment Suites, due to the reduction in the numbers of individuals taken to a Police place of safety was an operational matter and it would be useful to discuss this further at OMT to understand the impact on services going forward.

Agreed: that the matter of the increased use of TEWV places of safety, Street Triage and Crisis Assessment Suites be discussed at OMT.

Action: Mr B Kilmurray

17/14 MHA DISCHARGES FROM DETENTION REPORT

The Committee considered and noted the MHA Discharges Report.

Ms Griffin drew attention to the following matters:

(1) The report showed activity for the year 1 April 2016 to 31 March 2017 as opposed to the last quarter, following a request at the last MHLC meeting.
(2) No trends had been identified with regard to Hospital Manager's panels, Mental Health Tribunal or clinicians.
(3) The Trust was below the national average at just under 8% for discharges from detention by MHT.

The Committee was assured that comprehensive reports with good clear evidence for the reasons recommending continued detention were being provided, however there were occasions when the Tribunal disagreed with the clinical team in a minority of cases.

Mrs Moody advised that it would be helpful to understand the reasons why on 6 occasions the Care Coordinator had a different view to that of the RC as to whether the patient should remain subject to the MHA.

Agreed: That there should be an escalation process when this occurs to the Head of Service to review and provide assurance.

Action: Miss M Wilkinson

17/15 SECLUSION REPORT

The Committee considered and noted the Seclusion Report.

Ms Griffin advised that there had been 75 episodes of seclusion reported, involving 40 patients with multiple episodes for 16 patients, with 2 long-term episodes.

The Committee considered that cross checking the information provided to the Mental Health Office and the information pulled from PARIS against the information stored on DATIX would be useful.

Mrs Illingworth undertook to cross check the data on seclusion on DATIX and feedback to the MHL Committee at its meeting on 13 July 2017.

Action: Mrs J Illingworth

The Committee sought assurance that seclusion was not being used for inappropriate reasons, such as the unavailability of staff, when no other accommodation was available.

Mrs Moody responded that all individual cases were regularly reviewed under the Code of Practice to ensure that seclusion was the most appropriate intervention in each case, however there had been a recent incident of a long term seclusion for a service user on Westwood, which had been due to waiting for a suitable adult facility with a seclusion room.

17/16 DEPRIVATION OF LIBERTY LAW COMMISSION PROPOSALS REPORT

The Committee received and noted the Deprivation of Liberty Law Commission Proposals Report.

Arising from the report it was noted that:

(1) Based on the recommendations in the recently published Law Commissions report, there would potentially be a new legislative system replacing on the current DoLS regime.

The following areas would be included in the new scheme:

(a) It would apply to all settings, hospitals and care homes, as well as the supported living arrangements and individual's own homes.
(b) 16-17 year olds would also be included.
(c) Transient care arrangements and transportation.
(d) CCG, NHS and LA responsibility for the arrangements.
(e) Detailed list of criteria for deprivation to be authorised
(f) Scrutiny of proposed care arrangements and rigorous scrutiny should the individual object to arrangements.
(g) Once deprivation authorised entitlement to ongoing rights of advocacy.

(2) The risk of non-compliance in following the legislation could lead to an unlawful deprivation occurring, or penalties through breach of Article 5, involving the automatic right to compensation to anyone unlawfully deprived.

(3) The Department of Health had a 12 month consultation period to respond to the Law Commission, and it was anticipated that there would be no likely impact on DoLS for the next 3 years.

Mrs Down advised that DoLs recording would go live on PARIS in the next couple of weeks, which would enable easier monitoring of the application of DoLS.

17/17 IMPACT OF THE POLICE & CRIME BILL

The Committee received and noted the Impact of the key Mental Health Act Changes made by the Policing and Crime Act 2017.

Miss Wilkinson drew attention to the following matters:

(1) Significant amendments to Sections 135 – 138 of the Mental Health Act 1983, in light of the introduction of the Policing and Crime Act 2017: Mental Health Provisions.

(a) A revised S 136 policy had been drafted taking into account the amendments to the MHA and impact of the Police and Crime Bill and was currently out for consultation to a wide multi-agency circulation list, including, LAs, acute Trusts, all CCG Commissioners and key staff within TEWV.
(b) Operationally the changes would be taken through various forums, including the Crisis Care Concordat.
(c) The original implementation date for the revised S 136 policy of May 2017 had been postponed due to Purdah.

(2) The impact of the implementation of the Police and Crime Bill included:

(a) The reduction of the time limit for S 136 from up to 72 hours to up to 20 hours, which would have potentially significant impact on trying to locate and access appropriate beds for under 18 year olds, who were unmanageably violent within the reduced timeframe.
(b) Extending places of safety, meaning that AMHP's and Trust doctors might need to attend a person's home to carry out a S136 assessment.
(c) Potential breaches of the 24 hour time period due to the reduction in LD beds under the Transforming Care agenda.
(d) Securing a bed for under 18s would be extremely difficult and it was recognised that this was a local and national issue.

The Committee agreed that, whilst not a matter for formal escalation, the potential risk of breaches to the 24 hour time period and of securing LD beds for under 18's should be highlighted to the Board of Directors at its meeting on 23 May 2017.

Action: Mr Simpson

17/18 MENTAL CAPACITY ACT AND DOLS REPORT

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

Arising from the report it was noted that:

(1) Monitoring DoLS performance across the Trust and further work around the implementation of the Mental Capacity Act continued.

(2) Trust wide during July 2016 there had been 65 case file audits undertaken, as well as staff questionnaires to analyse the Trust approach to assessing the consistency of the implementation of patient's capacity to consent. The results of these audits would

be used as part of the Trust's wider business priorities in addressing future business plans.

On this matter it was noted that Audit One had also been involved externally to audit and review current progress around MCA and DoLS work.

(3) There were currently delays with Local Authorities not reacting to DoLS applications, with the longest wait being 2 years in Middlesbrough. TEWV staff were carrying out due process with regard to DoLS applications, however there was the need for a debate as to the option of DoLS champions across the Trust to support the work, as well as the importance of training.

Mrs Moody undertook to take the matter of the long waits with LA's for DoLS applications and consideration of Trust champions for DoLs to OMT for discussion.

Action: Mrs E Moody

17/19 CODE OF PRACTICE IMPLEMENTATION AND TRAINING UPDATE REPORT

The Committee received and noted the Update report on the implementation of the MHA Code of Practice.

Arising from the report it was noted that:

(1) A further review of Trust policies, procedures, guidance and arrangements required by the Code of Practice were now in a position of almost total compliance.
(2) Training around the Code of Practice was ongoing (currently at 85% compliance).

Miss Wilkinson highlighted that the version of the Access to and Exit for Wards Procedure on in Touch did not appear to have been updated and the food and drink strategy could not be easily located on the Trust intranet.

Mrs Illingworth undertook to ensure that that this matter was addressed.

Action: Mrs Illingworth

17/20 ANNUAL COMMITTEE PERFORMANCE ASSESSMENT RESULTS

The Committee discussed:

(1) That the Committee had made improvement in 10 areas overall, however there were 10 areas that had gone down in score.
(2) Comments which had scored lower were around providing assurance to the Board of Directors on the Code of Practice, overlap with the Quality Assurance Committee and the need for the Committee to gain more assurance around being compliant with the Mental Health Act and the Mental Capacity Act and members having sufficient knowledge of the MHA and MCA to identify risk areas and to be able to challenge management on critical and sensitive matters.

It was noted that not all members of the Committee had received a copy of the Annual Performance Assessment results before the meeting.

Mrs Oliver undertook to circulate the Annual Committee Performance Assessment results to all Committee members with an invitation for comments and feedback by the 9 May 2017.

Action: Mrs Oliver

17/21 ANY OTHER BUSINESS

The Committee noted that recurrent funding had been secured for the Mental Health Legislation Advisor to become a substantive post.

The Committee welcomed the additional support of Mrs Down, as the MHA Legislation Advisor which would be a pivotal role in the collation and monitoring of information around the MHA Code of Practice and DoLS.

Miss Wilkinson advised the Committee of a piece of case law (MM and PJ) that had been published at the end of March 2017 and an update would be brought to the 13 July 2017 MHLC meeting on the potential impact this might have on the transforming care agenda and conditional discharge of patients.

Action: Miss Wilkinson

The meeting concluded at 2.50pm

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ITEM NO. 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th November 2017**
TITLE:	**Progress Report – Composite Staff Action Plan**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their 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 information about progress made, as at quarter 2, with implementing the Composite Staff Action Plan and locality and corporate directorate action plans produced in response to the 2016 annual staff opinion survey results and Staff Friends and Family Test results.

There has been a good deal of activity both Trust-wide within corporate directorates and localities with the great majority of actions that were due for completion by quarter 2 being undertaken. Where there have been delays these have been for good reasons and the actions that are behind plan will be completed by March 2018.

Recommendations:

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

2) To receive a report at the May 2018 Board of Directors meeting about progress made with completion of the 2017/18 action plan and to consider a proposed 2018/19 action plan.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**28TH November 2017**
TITLE:	**Progress Report – Composite Staff Action Plan**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide Directors with an update about progress made with completion of the Composite Staff Action Plan and locality and corporate directorate action pans (Appendix 1) developed in response to the 2016 staff opinion survey results and Staff Friends and Family Test results. A summary of locality and corporate directorate progress can be found at Appendix 2.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Composite Staff Action Plan was agreed by Directors at the May 2017. Locality and corporate directorate action plans have been in place since June 2017.

3. KEY ISSUES:

3.1 Excellent progress has been made with completion of the actions described in the locality and corporate directorate action plans. Forty three locality and corporate directorate actions were completed during quarters 1 and 2 compared to a planned total of forty six actions, a completion rate of 93%.

3.2 One hundred and six actions are planned to be completed by localities and corporate directorates during the last two quarters of 2017/18 compared to the forty six actions that were due to be completed during the first two quarters.

3.3 The TEWV Composite Staff Action Plan includes a total of seventeen actions of which fourteen are due to be completed in quarters 3 and 4. Of the three actions due for completion by quarter 2 one has been completed and the other two, each relating to the development of a new anti-bullying and harassment procedure, were not completed by the end of quarter 2. A draft Bullying and harassment Reporting and Resolution Procedure has now been produced and is expected to be discussed at the Joint Consultative Committee on 2nd January 2018 and then by the Executive Management Team with the aim of the revised approach to this issue being endorsed and implemented by March 2018. Developing a new way of resolving conflict within TEWV will be an important part of TEWVs response to the national call to action to do more to tackle bullying and harassment within the NHS.

3.4 As part of addressing the issue of presenteeism discussions have taken place with researchers about potential research being undertaken into the causes of presenteeism within TEWV. This issue is still under consideration however, as part of these discussions with York University it was agreed that a bid for research funding be made to undertake research into the impact of 12 hour

shift working upon employees health and wellbeing and TEWV organisational outcomes. The bid was successful and research is now getting underway within the York locality and is expected to be completed by October 2018.

3.5 An RPIW that will help to identify how and when to share and triangulate key staff experiences/engagement information and other intelligence between the Organisational Development Team and other staff support services will now take place in quarter 4 and not in quarter 3 as originally planned. The revised RPIW date has been arranged to allow more time to extend the scope of the improvement work to include the Freedom to Speak Up Guardian and Nursing and Governance in this important work.

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:** The need to continue to address the disparity in the experiences of disabled and BAME staff remains an issue requiring particular attention.

4.4 **Other implications:** None identified.

5. RISKS: None identified.

6. CONCLUSIONS:

6.1 Overall excellent progress has been made with implementation of actions due for completion as at quarter 2 though many more actions are planned to be completed by the end of March 2018.

7. RECOMMENDATIONS:

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

7.2 To receive a report at the May 2018 Board of Directors meeting about progress made with completion of the 2017/18 action plan and to consider a proposed 2018/19 action plan.

David Levy
Director of Human Resources and Organisational Development

Background Papers:

Composite Action Plan 2017/2018 - Appendix 1

No	Theme	Staff Survey	Staff FFT	Action Owner	Completion date	Action	Intended outcome/result	Progress update	Evidence (To be retained by action owner)
1	Prevention of bullying and harassment	√		Nicola Rutherford	Q2	Develop a separate draft TEWV-wide anti bullying and harassment procedure, via the Policy Working Group, that will apply to all TEWV staff.	That staff will be more willing and confident to report incidences of bullying and harassment. That the experience of staff seeking to challenge bullying and harassment will be more positive and staff will feel more supported by TEWV. That managers will feel more confident about responding to allegations of bullying and harassment and supporting staff. That there will be a noticeable increase in the number of reported allegations of bullying and harassment during 2017/18 and 2018/19 followed by a reduction in the number of allegations thereafter.	Draft Bullying and Harassment reporting and resolution procedure presented to PWG 27.10.17. Awaiting comments from the group, procedure will be presented to the group 24.11.17	
				Nicola Rutherford	Q2	Ensure that there is appropriate consultation about the draft procedure at the relevant forums.		Draft Bullying and Harassment reporting and resolution procedure presented to PWG 27.10.17. Awaiting comments from the group, procedure will be presented to the group 24.11.17	
				David Levy	Q3	Secure Joint Consultative Committee and Executive Management Team support for the proposed terms of the anti bullying and harassment procedure.			
				Julie Jones	Q3	Develop and implement a communications plan to raise awareness amongst TEWV staff of the anti-bullying and harassment procedure and related actions			
				Michelle Brown	Q4	Incorporate the key issues and requirments of the anti bullying and harassment procedure within Trust leadership and management development Programmes.			
				Beverley Vardon-Odonkor	Q4	Design and deliver informal training sessions to staff on how to use and interpret the procedure.		To be arranged upon ratification of procedure	
2	Understanding the impact of presenteeism within the Trust	√		Paul Walker	Q2	Arrange and facilitate focus groups with registered nurses and health care assistants within the York & Selby, Durham & Darlington and Forensic Directorate to establish contributing factors which make staff feel under pressure to attend work when feeling unwell.	A reduction in staff reporting for work despite feeling unwell indicator within the Staff Survey 2018 survey.	Completed.	
				Paul Walker	Q3	From the data identify themes that could be contributing to the way staff have reported in the staff survey 2016 results.			
				David Levy	Q3	Explore with local higher education institutes the potential for and interest in undertaking research with TEWV into the causes of presenteeism.			
				David Levy	Q3	Share findings of the focus groups with the Executive Management Team and identify what additional support can be put in place.			
				Lesley Hodge	Q3	Understand from managers their intepretation of the sickness absence management procedure, if necessary provide refresh sessions on the key messages of the procedure.			
				Michelle Brown	Q4	Include information to assist managers to recognise presenteeism and to discourage a culture of staff working when unwell within TEWV leadership and management development programmes.			
				Sheila Jones	Q3	Pilot the introduction of short term reasonable adjustments in the identified hotspots for staff who are exhibiting symptoms of 'presenteeism'.			
				Russell Smith	Q3	Work in collaboration with the Health and Wellbeing CQUIN Project Manager to further promote opportunities within the identified areas.			
3	Improving staff engagement across the Trust	√	√	David Levy	Q3	Arrange and faciliate an RPIW to identify how and when to share/triangulate key staff experience/engagement information/intelligence between the Organisational Development Team and other staff support services. Agree which delegates to invite including HR staff, employee support, Union representatives, contact officers etc.	An increase in the staff engagement indicator within the Staff Survey 2018. Improved co-ordination of TEWV staff support/engagement activities. Greater assurance that key staff experience/engagement issues are being identified, acted upon and outcomes communicated and understood.		
				Michelle Brown	Q4	As a result of the RPIW develop a standard process for how and when to share key staff experience/engagement information and with whom whilst maintaining the confidence of those who share			
				Michelle Brown	Q3	Develop electronic guidance for managers and other staff providing information about the TEWV staff engagement resources that are available.			

Local Action Plan
Jane Marron-Shepard

No	Theme	Intended outcome/result	Source of Action	Action	Action owner	Target date for completion	Evidence (To be retained by action owner)	Progress update
			Staff Survey					
1	Improving Staff Engagement	Staff are involved in decisions which affect their work; Staff are able to make improvements happen in their place of work; managers ask for staff opinions before making decisions that affect their work.	√	Ensure that staff at all levels are able to contribute to QIS work in their own areas;	All Heads of Service All Ward and Team Managers	Q3		
				Continue to use Daily Lean Management to pick up any issues or concerns quickly and take appropriate action to address,	All Heads of Service All Ward and Team Managers	Q3		
				Embed a robust process for supervision in order that staff have opportunities to discuss such decisions/improvements in their work area	Head of Nursing	Q3		
				Continue to ensure that staff are involved in business planning processes	Director of Operations All Heads of Service	Q3		
2	Safe Staffing	Staff have the necessary resources to do their job; there are enough staff to do the job properly.	√	Continue to monitor and report on Safe Staffing metrics for the Locality and take appropriate corrective actions;	Director of Operations Head of Nursing All Heads of Service All Modern Matrons	Q2		All staffing issues are discussed during DLM and staff deployed to ensure safe cover across all inpatient environments. Monthly safe staffing report is received and actioned.
				Complete Hurst tool across all inpatient areas and consider outcomes;	Head of Nursing	Q2		Hurst Tool completed within all in patient wards. Clinical validation within the Trust taken place.
				Explore re use of Community Nurse Bank;	Head of Nursing	Q2		Head of Nursing has an RPIW planned for w/c 6.11.17 to consider developing a pool of staff.
				Continue to embed and improve processes in community services to allow staff to spend more time in clinical care	Director of Operations Head of Nursing All Heads of Service	Q4		
				Continue to explore new methods for recruitment and retention of staff e.g Recruitment Fairs, Retire and Return scheme; develop the Workforce Plan for the Locality	Head of Nursing	Q2		Recruitment fairs held in various venues on nursing and AHPs. Continue to promote retire and return scheme. All band 5 posts are recruited to permanently. Draft workforce plan developed.
3	Senior Management visibility	Staff know who senior managers are; communication between staff and senior managers is effective; senior managers try to involve staff in important decisions; senior managers act on staff feedback; staff are satisfied with recognition for good work.	√	Produce and cascade a Locality 'Who's Who' for senior managers;	Operational Support Manager	Q3		
				Continue to offer opportunities for staff to be involved in QIS work	All Heads of Service All Ward and Team Managers	Q3		
				Consider new methods to communicate and refresh Local Brief;	Director of Operations Operational Support Manager	Q3		
				Consider new methods for staff to feedback;	Director of Operations Operational Support Manager	Q4		
				Consider new staff recognition schemes and assess for effectiveness	Director of Operations Operational Support Manager	Q4		
4	Health and Wellbeing	The Locality takes positive action on health and well being	√	Publicise the staff well being initiatives on a regular basis e.g. mindfulness training, staff yoga, staff walks,LRH 'boot camp' etc; as necessary.	Director of Operations Operational Support Manager	Q2	Local brief	Well-being intiatives in the locality are promoted through the locality team brief.
				Remind managers re staff stress assessments.	All Heads of Service All Locality Managers	Q2	Local brief	A reminder of the value of staff stress assessments was included in Aug/Sept local brief.
				Continue to monitor sickness rates to quickly identify any potential 'hot spots' and take action	Director of Operations All Heads of Service	Q2		Sickness rates are moniored as part of Daily Lean Management and reported weekly at Heads of Services report out and OMT report out.
5	Opportunities for development	Staff are supported by their manager to receive training, learning or development and this is identified in appraisals	√	Embed a robust process for supervision in order that staff have opportunities to discuss and developmental needs on a regular basis;	Head of Nursing	Q3		
				Continue to monitor mandatory and statutory training compliance and identify any 'hot spots' and take corrective action as necessary	Director of Operations Operational Support Manager All Heads of Service	Q3		

Local Action Plan - Esates and Facilities Manager
Yvonne Watson

No	Theme	Intended outcome/result	Source of Action		Action	Action owner	Target date for completion	Evidence (To be retained by action owner)	Progress update
			Staff Survey	Staff FFT					
1	Communication with immediate managers	Encourage staff to feel they are supported by their immediate manager	√	√	Discuss at Roadshows, Team Briefs and Tool Box Talks – open conversation and sharing staff survey results	Yvonne Watson Graham Nellis Paul Shoulder Brian Jarvis Keith Legg	Q2	Agenda from Roadshows Agenda from Tool Box Talk Team Brief	Completed
2	Appraisals	Review how we deliver appraisal process for staff	√	√	Open conversation with staff regarding appraisal process via Roadshows, Tool Box Talks and appraisal	Yvonne Watson Graham Nellis Paul Shoulder Brian Jarvis Keith Legg	Q3	Agenda from Roadshows Agenda from Tool Box Talk	
					Discuss 1:1 appraisal -v- group appraisal				
3	Understanding the impact of presenteeism within EFM	A reduction in staff reporting for work despite feeling unwell		√	Share findings from staff survey results (Your Health, Wellbeing and Safety at Work 9d, 9e, 9g)	Yvonne Watson Graham Nellis Paul Shoulder Brian Jarvis Keith Legg	Q4	Roadshow presentation notes Agenda from Tool Box talk	
			√	√	Explore findings from above			Roadshow presentation notes Agenda from Tool Box talk	
					Share and discuss at EFM DMT to produce action plan			Roadshow presentation notes Agenda from Tool Box talk	
					Report back to staff			Roadshow presentation notes Agenda from Tool Box talk	

Local Action Plan
Gillian Duffy
Sarah Gray

No	Theme	Intended outcome/result	Source of Action	Action	Action owner	Target date for completion	Evidence (To be retained by action owner)	Progress update
			Staff Survey					
1	Improving Staff Engagement	Staff are involved in decisions which affect their work; Staff are able to make improvements happen in their place of work; managers ask for staff opinions before making decisions that affect their work.	√	A cross-functional working group has been established that will build on the suggestions for improvement made at the department away day. The group will develop an action plan incorporating actions identified within this document.	Working group (Information)	Q2		Group has been established with cross department representation. A draft terms of reference are in the process of being finalised.
				Ensure that staff at all levels are able to contribute to QIS work	Associate Director of Finance	Q2		New associate director of information appointed 1/10/17. A number of actions have been identified on the business plan which will be monitored by the AD.
				Continue to use Daily Lean Management to pick up any issues or concerns quickly and take appropriate action to address	Associate Director of Finance Heads of Information Heads of Service Team managers and supervisors	Q2		Huddles in place across the department along with visual display boards.
				Embed a robust process for 1:1's in order that staff have opportunities to discuss such decisions/improvements in their work area	Associate Director of Finance Heads of Information Heads of Service Team managers and supervisors	Q3		
				Re-measure the individual engagement survey that was undertaken as part of the cultural barometer work. This will measure the degree to which staff are involved, committed and psychologically invested in their work, their job and the Trust, and help direct action to be focused on where support is needed and those areas that need improvement.	Information Risk, Policy and Records Standards Manager	Q4		
2	Opportunities for development	Staff are supported by their manager to receive training, learning or development and this is identified in appraisals	√	Continue to monitor mandatory and statutory training compliance and take corrective action as necessary	Associate Director of Finance	Q2		Monitored through Huddles, Q2 figures 89% remedial action in place.
				Embed a robust process for 1:1's in order that staff have opportunities to discuss and developmental needs on a regular basis;	Associate Director of Finance	Q3		
				To develop individual skills matrices to identify any gaps in training, knowledge and skills. This will be used to inform a department training plan	Heads of Information Heads of Service Team managers and supervisors	Q3		
				Ensure that those who conduct appraisals have received training in the Trust process and expected values and behaviours	Heads of Information Heads of Service Team managers and supervisors	Q2		Some appraisal training is still outstanding.
				Gather feedback from staff to identify how to improve appraisals and improve the way managers provide positive feedback to staff	Associate Director of Finance	Q4		
3	Harassment bullying and abuse; raising concerns	Reduction in the number of staff experiencing harassment, bullying or abuse; Staff feel secure raising concerns	√	Raise awareness within the department of the TEWV-wide anti bullying and harassment procedure and whistleblowing/raising concerns process	Heads of Information Working group	Q3		
				Raise awareness of the Equality and Diversity champions as contact officers for bullying and harassment issues.	Heads of Information Working group	Q2		Link identified and work ongoing to promote.
				Review and analysis of DATIX information to identify themes and trends of staff experiencing harassment, bullying and abuse.	Senior managers	Q4		
4	Senior Management visibility	Staff know who senior managers are; communication between staff and senior managers is effective; senior managers try to involve staff in important decisions; senior managers act on staff feedback; staff are satisfied with recognition for good work.	√	Update and cascade department organisation chart;	Business Administration Team	Q1		Completed
				Embed a series of mechanisms that enable two way communication to occur across the department at all levels	Working group	Q2		Huddles and core meetings inplace, weekly communication published.
				Determine prioritised plan of who should undertake training (process owner, sponsor, QIS for leaders, Certified leaders, observation training, QIS for admin)	Heads of Information Heads of Service Team managers and supervisors	Q2		QIS trained staff identified along with those who require training. Work underway to esbalish a baseline level of knowledge across department.
				Consider new methods for staff to feedback	Working group	Q4		Ideas box in place.
				Consider new staff recognition schemes and assess for effectiveness	Associate Director of Finance Heads of Information Heads of Service Team managers and supervisors	Q4		

Local Action Plan
Sue Sirrell

No	Theme	Intended outcome/result	Staff Survey	Staff FFT	Action	Action owner	Target date for completion	Evidence (To be retained by action owner)	Progress update
1	Team effectiveness and communication	To increase staff opportunity to meet to discuss team effectiveness and achieve the team objectives.	√	√	Opportunity for clinical teams/MDT to facilitate development days.	Service Development Manager	Q4	Model ward updates Attendance at Schwartz rounds Staff Development Days Implementation of daily huddles	
					Incorporate within the Model Ward Project: Daily Huddles				
					Staff attendance at Schwartz Rounds				
2	Physical violence from patients, their relatives or other members of the public	Reduce the number of staff experiencing physical violence.	√	√	Continue the implementation of Safe Wards and PBS training.	Emma Phipps	Q2	Safe Ward Up Dates PBS/PAT Training attendance registers	Safe Ward updates and PBS/PAT training attendance registers.
					Implementation of the Positive Approaches Training-(PAT)	Emma Phipps	Q2		
3	Involving staff in important decision making	Staff involvement in important decisions.	√	√	Implementation of daily huddles /weekly huddles for Ward Managers	Service Development Manager & Jenny Marshall	Q4	Model ward updates Staff Development Days Attendance at Coaching Events	
					Incorporate within the Model Ward Project		Q4		
					Team Meetings and staff development days		Q4		
					Coaching conversations and use of high quality questions.		Q4		
					Roll out of the Compassionate Leadership training		Q4		
4	Acting on staff feedback	Senior Managers to review and act upon feedback from Staff Friends and Family	√	√	Senior Managers to review FFT feedback and narrative	Ward Managers & Service Development Manager	Q3	Action Plans Creating Compassionate Care Steering group Minutes	
					Discuss FFT feedback with ward teams and collaboratively		Q3		
					Developed action to be taken if identified.		Q3		
					Review findings of the FFT within the Creating Compassionate Care Steering Group		Q3		
5	Taking action to learn from errors	Reduction in the number of errors repeated.	√	√	Innovation Event to review communication and learning lessons	Service Development Manager	Q4	Output from Innovation Event	
6	Harassment, bullying or abuse	Reduction in the number of staff experiencing harassment, bullying or abuse.	√	√	Review and analysis of DATIX information to identify themes and trends of staff experiencing harassment, bullying and abuse.	Service Development Manager & Ward Managers	Q4		
					Datix analysis findings to be reported at the Creating Compassionate Care Meeting.		Q4		
					Discussion of incidents within MDT/.Ward Rounds.		Q4		

Local Action Plan 2017/2018

No	Theme	Intended outcome/result	Staff Survey	Staff FFT	Action	Action owner	Target date for completion	Evidence (To be retained by action owner)	Progress update
1	Support from within the Directorate	To enable staff to feel 'safe' to raise any concerns within the team and with their manager without the fear of reprisals. For any concerns raised to be taken seriously and dedication for such issues to be resolved/alleviated.	√	√	Deliver a Social Safeness session at the next HR Directorate Away Day.	Paul Walker Abigail Holder	Q3		
					Offer coaching to those Directorate staff that show an interest and ask what more can be done.	Paul Walker Abigail Holder	Q3		
2	Prevention of Bullying and harassment	That staff will be more willing and confident to report incidences of bullying and harassment and other areas of concern. That the experience of staff seeking to challenge bullying and harassment will be more positive and staff will feel more supported by TEWV. That managers will feel more confident about responding to allegations of bullying and harassment and supporting staff. That there will be a noticeable increase in the number of reported allegations of bullying and harassment during 2017/18 and 2018/19 followed by a reduction in the number of allegations thereafter.	√		Develop a separate draft TEWV-wide anti bullying and harassment procedure, via the Policy Working Group, that will apply to all TEWV staff.	Nicola Rutherford	Q3		Agreement with DL to amend target date. Draft procedure in process of being developed and will be presented to Policy Working Group on 27.10.17
					Ensure that there is appropriate consultation about the draft procedure at the relevant forums.	Nicola Rutherford	Q4		Aim to take to January 2018 JCC
					Secure Joint Consultative Committee and Executive Management Team support for the proposed terms of the anti bullying and harassment procedure.	David Levy	Q3		
					Incorporate the key issues and requirments of the anti bullying and harassment procedure within Trust leadership and management development Programmes.	Michelle Brown	Q4		
					Design and deliver informal training sessions to staff on how to use and interpret the procedure.	Beverley Vardon-Odonkor	Q4		
3	Presenteeism	Encourage flexibility and compassion amongst the HR/OD directorate to provide a more supportive working environment. The staff survey results indicated that directorate staff feel under pressure to attend work when feeling unwell, creating presenteeism. This can be more evident in a conscentious workforce.	√		Strengthen existing processes such as appraisals and supervision to include discussions on an individual's wellbeing, performance and workload pressures. Ensuring actions are put in place to help alleviate any issues raised.	Heads of Service	Q4		S Jay - Discussions take place during supervision on staff's wellbeing including any work pressures. Staff aware of occupational health and other support.
					Reinforce the support mechanisms in place for staff including Occupational Health, counselling services, physiotherapy and Employee Support to ensure staff are 'well' enough to be at work.		Q4		
					Hold focus groups across the Directorate to gain feedback on what support staff would benefit from in relation to presenteeism and maintaining attendance at work.	Paul Walker	Q3	Focus groups faciliated 21 & 22nd Nov 17	
					Arrange and facilitate focus groups with registered nurses and health care assistants within the York & Selby, Durham & Darlington and Forensic Directorate to establish contributing factors which make staff feel under pressure to attend work when feeling unwell.	Paul Walker	Q2		
					From the data identify themes that could be contributing to the way staff have reported in the staff survey 2016 results.	Paul Walker	Q3		
					Share findings of the focus groups with the Executive Management Team and identify what additional support can be put in place.	David Levy	Q3		
					Pilot the introduction of short term reasonable adjustments, if any, in the identified hotspots for staff who are exhibiting symptoms of 'presenteeism'.	Sheila Jones	Q3		Querying what the pilot would be and Q3?
					Understand from managers their intepretation of the sickness absence management procedure, if necessary provide refresh sessions on the key	Lesley Hodge	Q3		
					Include information to assist managers to recognise presenteeism and to discourage a culture of staff working when unwell within TEWV leadership and	Michelle Brown	Q4		
					Explore with local higher education institutes the potential for and interest in undertaking research with TEWV into the causes of presenteeism.	David Levy	Q3		
					Work in collaboration with the Health and Wellbeing CQUIN Project Manager to further promote opportunities within the identified areas.	Russell Smith	Q3		
4	Improving staff engagement across the Trust	An increase in the staff engagement indicator within the Staff Survey 2018. Improved co-ordination of TEWV staff support/engagement activities. Greater assurance that key staff experience/engagement issues are being identified, acted upon and outcomes communicated and understood.		√	Arrange and faciliate an RPIW to identify how and when to share/triangulate key staff experience/engagement information/intelligence between the Organisational Development Team and other staff support services. Agree which delegates to invite including HR staff, employee support, Union representatives, contact officers etc.	David Levy	Q3		
					As a result of the RPIW develop a standard process for how and when to share key staff experience/engagement information and with whom whilst maintaining the confidence of those who share the information.	Michelle Brown	Q4		
					Develop electronic guidance for managers and other staff providing information about the TEWV staff engagement resources that are available.	Michelle Brown	Q3		

Local Action Plan
Jenny Miller

No	Theme	Intended outcome/result	Source of Action		Action	Action owner	Target date for completion	Evidence (To be retained by action owner)	Progress update
			Staff Survey	Staff FFT					
1	Bullying & Harassment	To reduce the number of people who are bullied or harassed in the workplace.	√		Undertake survey to understand what people mean by bullying and harassment. Managers to speak with staff at 1:1's. Discussions to take place at Senior Management Team.	Medical Development	Q4		
2	Presentism	To try and help staff reduce the pressure they put on themselves to come to work when ill.	√		Managers ask staff about pressure coming back to work in return to work interviews.	Medical Development Line Managers (Bryan O'Leary, Julie Khan, Elaine Corbyn, Samantha Gavaghan, Hayley Lonsdale, Val Holmes, Emma Tootle & Dawn Carter)	Q4		
3	Feedback/Suggestions on improving work of the Medical Development Department	Staff feel it is valuable to make suggestions in the workplace.	√	√	Introduction of suggestion box. Associate Director of Medical Development to meet with staff on a 1:1 basis to discuss feedback/suggestions to help improve work of team/department.	Associate Director of Medical Development & IIP Focus Group	Q2		Suggestions are being put forward and discussed. Associate Director of Medical Development has been meeting staff informally to discuss feedback and suggestions.
4	Team Objectives	Staff are clear about Team Objectives.	√		Staff understand the objectives of the Team. Team objectives are displayed within the Medical Development Department. Associate Director of Medical Development to meet with staff on a 1:1 basis to discuss team objectives.	Medical Development	Q3		
5	IIP Accreditation	Staff are prepared for IIP Accreditation			Staff undertake the online assessment and are prepared to take part in interviews with IIP Assessors. Evidence is gathered ahead of IIP accreditation. Invite a member of Research & Development to attend the future IIP Focus Group meetings.	IIP Focus Group	Q2		Staff were encouraged to complete the online assessment. Staff are briefed ahead of the IIP Visit in November at Team Briefs.

Local Action Plan 2017/2018

No	Theme	Intended outcome/result	Source of Action			Action	Action owner	Target date for completion	Evidence (To be retained by action owner)	Progress update
			IIP	Staff Survey	Staff FFT					
1	Succession planning/Career progression	Improvement in score for staff agreeing that learning and development activities helped to improve their career chances. Able to provide accurate data for staff progressing in their careers in the Directorate/Trust and external to the Trust.		√	√	Managers to ensure that conversations regarding career planning are included in appraisal processes and learning and development opportunities are identified wherever possible.	Elizabeth Moody	Q4		
						Carry out an audit of a sample of appraisal documents to establish if this is happening including where shadowing secondment opportunities have been discussed.	Elizabeth Moody	Q4		
						Review what training directorate staff have attended over and above mandatory training.	Elizabeth Moody	Q4		
						Talent management conversations to continue.	Elizabeth Moody	Q4		
						Identify staff turnover in the Directorate and where staff are moving to/ from.	Elizabeth Moody	Q4		
						Line managers to access coaching training to support teams in their own development.	Elizabeth Moody	Q4		
2	Bullying and Harassment	Reduce the % of staff who report personally experiencing harassment bullying or abuse at work.		√		All managers to revisit Trust values and behaviours with their teams and document this in team meeting minutes.	Elizabeth Moody	Q3		
						All staff to consider methods of communicating with each other is e-mail always the best can we have more conversations.	Elizabeth Moody	Q3		
						Information regarding the range of staff support processes that are available in the Trust to be publicised.	Elizabeth Moody	Q3		
3	Extra hours worked	Reduce the number of staff working extra hours.		√		Use of Huddles and DLM to review workloads and identify pressure points in teams and increase support where appropriate.	Elizabeth Moody	Q3		
						All Managers to identify QIS opportunities to reduce waste and time spent on non-value added activities/processes in teams	Elizabeth Moody	Q3		

Local Action Plan 2017/2017 Bev Thompson

No	Theme	Intended outcome/result	Source of Action			Action	Action owner	Target date for completion	Evidence (To be retained by action owner)	Progress update
			IIP	Staff Survey	Staff FFT					
Violence, Bullying and Harassment										
1	Violence	To improve the number of colleagues reporting most recent experience of violence	√	√		Current Daily Management Huddle will identify any staff related incidents whereby Violence and Aggression has been a factor. These incidents will trigger a datix report and evidence of Datix number will be collated from Daily Huddle report	Modern Matron	Ongoing		Incidents captured on a daily basis and being reviewed.
2	Bullying and Harassment	Increase the reporting of most recent experience of harassment, bullying or abuse	√	√		All areas will have an identifed area for staff to access Health and Wellbeing information to increase the visabilty of Employee Support services, information, posters and relevant contact information.	Ward and Team Managers	Q2		Team managers have been requested to evidence the areas they have identified for their team. A hyperlink has been provided for easy access.
						All staff information areas will display a copy of Trust Values and Behaviours and Staff Compact and signpost staff to the Grievance procedure.	Ward and Team Managers	Q2		The Trust values and compact are visable on each PC and have also been displayed in all areas.
3	Violence	To reduce the number of staff experiencing physical violence from patients, relatives or the public in last 12 months	√	√		Ensure all staff who have been employed for 12 months or more will be compliant for PAT training. Ward and Team Managers will report complaince against this target via reports to QUAG	Team/Ward Manager	Monthly ongoing		Current achievement rate is at 84% , training compliance monitored weekly.
						Evaluation of the impact of the Behaviour Support Plans on Organic Ward in reducing incidents relating to violence and aggression. To embed the roll out of the Fuctional Care Pathway which includes the Behaviours that Challenge CLIP	GFJ/ET/KS	Q3		
Presenteeism										
4	Health and Wellbeing	To reduce the number of staff reporting thay they do additional unpaid hours per week, over and above contracted hours	√			To consider the phased introduction of a shorter shift system on the Organic In-Patient Wards - to evaluate the impact on efficiency and effectivness of working time.	Modern Matron/Ward manger	ongoing		Mixture of shifts available and flexible working requests are being reviewed in line with policy.
						Ensure a 100% staff in MHSOP will meet the minimum standards for clinical and managerial supervision. A randon sample of supervision record will be undertaken to establish to evaluate this.	Modern Matron	Q2		Supervision is monitored against trust policy on a monthly basis, standard item on QUAG.
						100% of staff will be asked about their general wellbeing in the supervision and this will be recorded in the supervison. This will be audited	Supervisors	Q2		Supervision template is prepopulated and during 1:1 all staff's wellbeing is considered during process.
						Evaluation of the Band 4 Community Services role and impact on service provision.	Head of Nursing/locality manager	Q3		
						To hold an RPIW that will look to reduce the current time required to input assessment and reviews on the PARIS system.	Alison Cook	Q3		
						Promoting the concept and Value of Mindfullness training and skills development to staff via staff information areas.	Ward manager/team lead	Q2		Mindfulness dates are updated on Intranet and made available. Leaflet displayed and made available to staff.
						Evaluation of the impact of phase one of the purposeful and productive community Service - relating to diary management, workloads and job planning.	Locality Managers/Service Managers	Q2		All CMHTs have been assessed against products and progression. Phase 2 underway.
						PlpA refresh to be undertaken and rolled out to in patient services	Modern Matron	Q3		Phase 1 of roll out currently underway on Westerdale South, progression to Westerdale North and Wingfield in Q3.
5	Health and wellbeing	To decrease the percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves		√		100% of staff will be asked about their general wellbeing within managerial or clinical supervison.	Team/Ward Managers	ongoing		Supervision template is prepopulated within wellbeing question. Current organisational change process is capturing staff wellbeing in informal 1:1 sessions.
						100% of staff returning to work will have a return to work interview documented.	Team/Ward Managers	ongoing		Return to work interviews are completed. HR to aduit against sickness management procedure.
						To raise awareness of stress management and resilience training across staffing groups and evaluate the % of staff who have accessed this training in 2017.	Team/Ward Managers	Q4		
Errors & Incidents										
6	Errors and incidents	To improve upon reporting errors, near misses or incidents witnessed in the last month		√		Monitor via Modern Matrons Daily Huddle Teleconference	Modern Matron	ongoing		
7	Errors and incidents	To promote a culture of fairness and effectiveness of procedures for reporting errors, near misses and incidents		√		Regular group supervision is to be introduced on in-patient wards to allow for discussion and peer support in regards to incidents and lessons learnt. This will also ensure debriefs are carried out at an appropriate time when an incident has occurred and are seen as safe and supportive forum for staff. Working in collaboration and with Force Reduction Model	Modern Matron	Q2		Has commenced and de-brief templates have been provided to support and assist staff.
Staff Engagement										
8	Job Satisfaction	To increase Staff satisfaction with level of responsibility and involvement	√	√	√	100% of staff will have a SMART appraisal linked to Organisation and Directorate Business goals, in addition to personal objectives.	All Managers/team leads	Q4		Appraisal rates monitored weekly. New training programme introduced in 2016 to support staff to complete meaningful appraisals.
						Review attendance over the last 12 months at Quality Improvement events to understand if this a fair representation of staffing groups within MHSOP.	Locality Managers	Q3		
9	Job Satisfaction	To increase Staff satisfaction with resourcing and support	√	√	√	Continue to use and evaluate data from thr adapted Hurst tool to evaluate staffing and workload information. Consider the potential for staff to access a workshop on "developing personal and team resilience"	Ward managers	ongoing		Staffing/roster meetings are carried out monthly to ensure forward planning. Daily discussion ensures unforeseen circumstances and clinical demand can be met.

Local Action Plan 2017/2018 - Rebecca O'Keefe

No	Theme	Intended outcome/result	Source Staff Survey	Action	Action owner	Target date for completion	Evidence (To be retained by action owner)	Progress update
1	**Health Wellbeing and safety at work**: ensure staff involved in errors are treat fairly	All those involved in errors at work feel like they have been treat fairly and that all staff are informed that that the process of incident review should be open, honest and transparent as outlined in the Incident Review policy	√	Managers to ensure Incident reporting policy is adhered to and staff members are encouraged to report incidents	Team/Ward Managers - via Assistant Locality Managers	Q2 - ongoing	Team meeting minutes	
				Members of staff to discuss errors openly as part of supervision processes and adhoc support meetings and managers to treat individuals fairly with respect	Team/Ward Managers - via Assistant Locality Managers	Ongoing action	Team meeting minutes Supervision records (where appropriate)	
2	**Health Wellbeing and safety at work:** staff experiencing harrassment, bullying or abuse from patients/service users their relatives or members of the public	Reduce the occurrence of harrassment, bullying or abuse from patients/service users their realtives or members of the public	√	Staff members to ensure expectations of conduct from patients/service users and relatives or members of the public are discussed with patients and their carers when there is an issue	Team/Ward Managers - via Assistant Locality Managers	Ongoing action	Team Meeting minutes and supervision records (where appropriate)	
				Occurences of incidents of this nature to be raised within management structures to enable mitigation actions to be taken				
				Where appropriate seek support from Trust Security Lead or outside agencies e.g. Police				
3	**Health Wellbeing and safety at work:** staff experiencing discrimination from patients/service users their relatives or members of the public	Reduce the occurrence of discrimination from patients/service users their relatives or members of the public	√	Staff members to ensure expectations of conduct from patients/service users and relatives or members of the public are clear	Team/Ward Managers - via Assistant Locality Managers	Ongoing action	Team Meeting minutes and supervision records (where appropriate)	
				Occurences of incidents of this nature to be raised within management structures to enable mitigation actions to be taken				
				Where appropriate seek support from Trust Security Lead or outside agencies e.g. Police				
4	**Health Wellbeing and safety at work**: staff treated fairly in terms of career progression	Ensure all members of staff have, where required, discussions within managerial supervision and their Personal Development aspirations regarding their career progression	√	Managers to ensure career progression aspirations are discussed as part of supervision and to have talent management conversations where applicable	Team/Ward Managers - via Assistant Locality Managers	Discussions with staff members by end September and ongoing action	Managerial clinical supervision records and Appraisal documentation	
				Ensure training is considered as part of an individuals' career progression where appropriate				
				Recruitment and selection processes utilised for all appointments to ensure fair selection of an individual	Appointing Officers	Ongoing	HR recruitment documentation	

Local Action Plan 2017/2018 - Carol Redmond

No	Theme	Intended outcome/result	Source of Action			Action	Action owner	Target date for completion	Evidence (To be retained by action owner)	Progress update
			IIP	Staff Survey	Staff FFT					
Overarching York and Selby Locality										
1	Staff feel they have adequate equipment to do their work	Staff feel they have the right equipment to do their job and feel confident in using it		√	√	Survey to identify what equipment people feel they need to do their job better and also identify any training needs to use the equipment to maximum effect.	Assistant Locality Manager MHSOP	Q2	Survey results	This has been delayed pending the move to Huntington House where additional technology has been introduced Survey to be carried out when move to Huntingon House embedded.
						Training programme to be developed to train staff on use of all equipment as identified from the aforementioned		Q3	Training evaluation	
2	Communication between staff and senior management is effective and staff know who the senior managers are	Staff to be more familiar with the management team and therefore more readily able to approach them		√	√	Devise/update locality management chart with staff photos, to include TM/CD/Assistant locality managers/modern matrons/service managers/HoS/DOO	HoS	Q3	Charts	
						Develop an organisational chart of all corporate staff supporting Y&S locality	HoS	Q3	Charts	
						Develop a monthly newsletter, sharing positive stories as well as key messages from LMGB and QUAGS.Each Speciality to have a link person to update on a monthly basis. Newsletter to be circulated 2 weeks after LMGB	Assistant Locality Manager/ Locality Support Manager	Q2	Monthly Newsletters	First newsletter delayed but will be circulated end of November.
Learning Disability Services										
3	Staff feel Trust response to errors is not fair and there is no feedback	Staff to feel confident that any reported errors are dealt with fairly and transparently and they will receive a response	√	√	√	Reflective practice sessions to include review of incidents ad errors	Team Managers	Q3	Evidence of reflective practice sessions and sign in sheets	Ongoing run by Consultant Psychologist
		To see increase in staff response that errors are treated				Staff meetings to include review of datix reports with opportunity for learning	Team Managers	Q3	Evidence in team meeting minutes	Included in QuAG and CLDT, yet to be implemented in Oak Rise
4	Staff experience physical violence from service users	Improved responses in staff FFT				Ensure all staff are up to date with PAT 2 training	Team Managers	Q2	Evidence in IIC	Now at 91% - only outstanding staff are on LTS
		Less incidents reported				Ensure all staff have received harm minimisation training	Team Managers	Q3	Evidence in IIC	This is at 96%
						Ensure PBS pathway is used in inpatient setting	Consultant Psychologist	Q3	Evidence in care docs	Ongoing work with PBS champion and Consultant Psychologist
						Identify PBS champion on ward.	Team Managers	Q2	Evidence via QuAG	Identified and in training
						Introduce regular incident reviews via team meetings	Team Managers	Q3	Evidence in team meeting minutes	
Mental Health Services for Older People										
5	Communication between senior management and staff as effective	Senior managers are more visible to staff and communication is more effective.		√	√	All members of the locality senior management team (Head of Service, Locality Manager, Modern Matron and Assistant Locality Manager) will carry out a Gemba visit to each teams/wards at least 8 times per year. The feedback will be shared live following the visit with the team/ward and discussed in the report out.	HoS	Q4	Gemba visit checklists saved into locality shared drive	Gemba walks are continuing according to a planned schedules across both Inpatient and Community Services.
6	Organisation definitely takes positive action on health and well being	All staff have an increased awareness of the health and well being support that is available				A one page guide to all health and well being support that is available is developed and circulated to all staff and a copy displayed in each ward and team office.	Assistant Locality Manager	Q2	Copy of one page guide saved into locality shared drive and a copy of the email circulated to all staff	Poster has been developed and circulated for display in all MHSOP wards and teams.
Adult Mental Health Services										
7	Senior Managers to be more visible on the Gemba across all teams and wards.	Improve related responses in the 2017 Staff Survey results and Staff FFT results.		√	√	Diary Management schedule of team/ward visits from Hos and Locality Managers.	HoS and Locality Managers supported by Admin	Q4	Diary schedule completed.	Completed
		Improved related feedback in the next IiP accreditation.				Senior Management attendance at Huddles/report outs and/or team meetings to discuss work demands and engage in coaching conversation opportunities.			Update to QuAG/LMGB	Completed
						Leadership Teams presence on Gemba offering coaching conversations for improvement	Leadership Teams	Q4		Completed
8	To reduce the numbers of staff suffering from work related stress	Improve related responses in the 2017 Staff Survey results and Staff FFT results.		√	√	Human Resource representative to monitor any trends reported to HR and feedback to Senior Leadership Team	HR Manager	Q4	HR Update reports	
9	Support managers and staff to deal with high pressure/work-load demands placed on them	Improve related responses in the 2017 Staff Survey results and Staff FFT results.				Development of the B7 management and leadership passport pilot.	Debi Whalen – OD	Q3	Schedule of OD sessions	
						Improve use if IIC	Mick Batters	Q4		
						Review of Clinical /Management Supervision across teams and wards.	Locality Psychology Lead/Head of Nursing	Q3	report	
						Increase uptake of reflective supervision	Locality Psychology Lead/Head of Nursing	Q4	report	
						Continue to roll out new appraisal process with reflective learning	Managers	Q4	Appraisal data	
Child and Adolescent Mental Health Services										
10	Staff feel they are able to manage their competing demands and have enough capacity in the service to deliver high quality services	Improved related feedback in the next IiP accreditation		√	√	Roll out of job plans, supported by caseload management supervision to understand C&D issues	Team Managers and HoS	Q3	Evaluations	
		Capacity and demand work to be better understood, with clear expectation from commissioners on realistic					Team Managers	Q4	CMB minutes, caseload supervsion records	

Local Action Plan 2017/2018 - Julie Jones

No	Theme	Intended outcome/result	Source of Action			Action	Action owner	Target date for completion	Evidence (To be retained by action owner)	Progress update
			IIP	Staff Survey	Staff FFT					
1	Staff Survey: Reduce pressures on staff to work excessive unpaid hours by improving focus / tasking on core work (i.e. to improve understanding across organisation of each team's focus and what we should not be asked to assist with)	Develop specificationn for Planning and Business Development team			√	P&BD specification developed	Chris Lanigan	Q3		
		Test specification for Planning and Business Development team				P&BD specification tested against expecations of EMT, Chief Exec, COO, Directors of Operations	Chris Lanigan	Q3		
		Approval received for P&BD team specification				Director of PP&C approves team specification	Chris Lanigan	Q4		
		Dissemination of P&BD team specification				New specification distributed to all EMT members and Heads of Service. Other activities as per Comms Plan	Chris Lanigan	Q4		
		Develop specificationn for Corporate Performance team role				CPT team specification developed	Sarah Theobald	Q3		
		Share the specifications with EMT and obtain agreement on them				specs discussed with EMT and EMT signed up to them	Sharon Pickering			
2	Staff Survey: Feel my role makes a difference to patients and the services	Brief a joint meeting of the Planning and Comms teams on the outcomes and outputs of the pre-engagemetn Kaizen event and emphasise the role of both teams in supporting co-produiction of service-users in solution generation and the postiive impacts this has on recovery.			√	P&BD / Comms joint meeting on outputs of engagement Kaizen held	Julie Jones / Chris Lanigan	Q3		
		Encourage the "committees" who develop Team Development Day agendas to put in items that increase understanding of front line services and our role in supporting these				At least one "front-line" related item in each Team Development Day				
		Review the use of protected time to support engagement with and learning of clinical services: • Individual to consider and raise in quarterly supervision • Manager to prompt in q'ly supervision meeting for consideration				1:1 paperwork to be reviewed and updated	Kassie Greenwood	Q2		Completed
		Review the induction process to include awareness of the clinical services				Induction checklist and file reviewed and refreshed	Kassie Greenwood	Q2		Completed
		Improve feedback from services to understand better how the work of the performance lead has made a difference				Action plan to be produced to capture identified improvements	Penny Pinder	Q2	Discussions with team identified this no longer required.	Completed
		Improve the process to set team away day agenda to strengthen focus on patient / carer / clinical services				Recommendations from review to be agreed by SMT	Kassie Greenwood	Q2		Completed
3	Pressure to work additional hours	Review huddle process to improve effectiveness			√	Currently within CPT business plan		Q2		Completed
		Consider the appropriateness of challenges to commissioners in relation to narrative / detail / feedback required				Process agreed with HOCP in relation to agreeing deadlines for non routine information requests from commisisoners	Allison Bowery	Q2	Discussions with team identified this no longer required.	Completed
		Review QIS timescales and improve management of extra workload				Currently within CPT business plan - To monitor the Quality improvement work within the team	Allison Bowery/Ashleigh Lyons/Victoria Reed	Q1		Completed
		Review home working arrangements to support staff wellbeing				Guidance relating to home working in CPT be produced	Allison Bowery/Ashleigh Lyons/Victoria Reed	Q2	TBA in October	
		Review processes to ensure we capture issues that may cause staff to feel pressure to work when ill				Pressures to routinely discussed in 1:1's, daily huddles and return to work interviews	Allison Bowery/Ashleigh Lyons/Victoria Reed	Q1		
4	Staff Survey: Feel my role makes a difference to patients and the services	Produce standard work for process for taking on work to support services (to ensure that we're taking on work that adds value) to include mechanisms for escalation			√	standard work in place	Angie Binns	Q3		
5	Staff Survey: Feel my role makes a difference to patients and the services	Develop proposal for revised raising concerns process (to promote more appropriate use of the mechanism) and submit to EMT				Proposal submitted to EMT for consideration	Julie Jones	Q3		

Local Action Plan 2017/2018

Belinda Goode MHSOP, Carla Pawson LD, Liz Herring AMH, Bridget Lentell LD

No	Theme	Intended outcome/result	Source of Action			Action	Action owner	Target date for completion	Evidence (To be retained by action owner)	Progress update
			IIP	Staff Survey	Staff FFT					
1	Prevention of bullying and harassment	Encourage more staff to report harassment, bullying or abuse when it happens		√		To raise the issue within Team meetings and ensure staff are aware of support mechanisms within the trust as and when required.	LD Team managers	Q1		June 2017, on-going agenda item. No incidents reported to date.
						To discuss in management supervision sessions	LD Team managers	Q1		
2	Physical Violence	Reduce the number of staff experiencing physical violence from patients, relatives or the public			√	Staff aware of reporting mechanisms (Datix) and then ties into answer above re staff been informed of staff support mechanisms as required.	LD Team managers	Q1		June 17: Staff FFT results have declined this year. Follow up visit made by HR. Low morale attributed to the wider organisation, and commissioning relationships within NY, rather than at Service level. Internal action plan being developed to support staff, following a meeting between representatives of the SWR LD Team, and trust reps to discuss the issues highlighted in more detail.
		Increase the proportion of staff who report errors, near misses or incidents that they witness			√	Ensure that staff are aware of the reporting mechanism and are advised of importance regarding capturing near miss and error to enable learning across the wider trust.	LD Team managers	Q2		
3	Work related stress	Continue to reduce the numbers of staff suffering from work related stress		√	√	To complete individual stress assessments as required if staff are reporting increased stress and to consider support mechanisms in trust and within teams.	LD Team managers	ongoing		
						To consider team building exercises - linked with OD team as required	HoS/ Service manager/ Team managers	ongoing		AMH - OD supporting Harrogate and Ryedale teams. Resilience workshops planned for AMH team and ward managers and QuAG members in Q4.
4	Work load pressures	Support managers and staff to deal with high pressure/work-load demands placed on them		√		For staff to be supported in developing improved skills in relation to time/ case management/ for teams to consider service demand and ensure any increased demand is reported via QUAG/ Business meetings so it can be escalated as required and if necessary to consider developing business cases.	All staff	Q4		AMH - issue log reflecting teams with recruitment challenges. 'Stop the Clock' days being encouraged to support staff manage workload and Paris activity. requirements.
						Consider need for some externally facilitated sessions regarding time/ diary management	HoS/ Service Manager	Q3		
5	Senior management visability	Ensure that members of the senior management team continue to be visible in the workplace/around the Trust		√		For HoS and Service Manager to have a regular attendance at team bases and attend team meetings to allow opportunity for teams to ask questions in an open forum.	HoS/ Service Manager	Q1-Q4		AMH - additional monthly listening events set up for HoS to attend the localities.
						For Team leadership team to be visible and supportive in relation to teams and meeting the demands placed upon them – to lead from the front and encourage a 'can do positive attitude' to any forthcoming challenges.	Whole/ LD team manager team	Q1-Q4		

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX 2

LOCAL ACTION PLANS END OF QUARTER 2 - 2017 UPDATE

Service Area	Number of actions allocated to Q1/Q2	Achieved	Yet to be achieved	Examples of Good Practice
1. Durham and Darlington	7	7		• An RPIW to explore the possibility of a Community Nurse Bank took place w/c 6th November. • The Hurst Tool has been undertaken in all in-patient areas.
2. Estates and Facilities Management	1	1		• Roadshows have taken place across the Trust to promote the support available to staff within the Directorate.
3. Finance and Information	8	8		• A cross functional working group across the two departments has been established and the terms of reference are due to be agreed. • Huddles are now established along with visual display boards.
4. Forensic Services	2	2		• Safe wards and PBS training continues to take place along with Positive Approaches Training.
5. Human Resources/Organisational Development	2	2		• Data has been collated from teams involved in team days which provides contributing factors of why staff feel under pressure to attend work when ill. Further work to be undertaken.
6. Medical Directorate	2	2		• A suggestions box has been introduced to help support changes within the department along with regular 1:1 meetings with Associate Director.
7. North Yorkshire	4	2	2	• Enquiring with staff if they require support following incidents is now a regular agenda item for meetings. This ensures that staff are aware of the mechanisms of support available to them in a timely manner.
8. Nursing and Governance	0	N/A		
9. Planning, Performance and Communications	8	7	1	• The induction process within the directorate now includes 'awareness of clinical services'. • The process to set team away day agendas has been strengthened to focus more on the patient, carer and clinical services.
10. Teesside AMH	0	N/A		
11. Teesside MHSOP	7	7		• The supervision template has been amended to ensure that staff's wellbeing is recorded within every session and signposting offered accordingly.
12. York and Selby Directorate	5	5		• A PBS champion has been identified for the LD ward and is attending training. • A diary management schedule for all team/ward visits has been developed to improve Gemba.

ITEM NO 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th November 2017**
TITLE:	**Nurse Recruitment & Retention Update**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Information and Consultation**

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:

Significant progress has been made with implementing a range of recruitment initiatives identified within the Recruitment and Retention action plan.

The Recruitment and Retention Action Plan has recently been updated following Executive Management Team (EMT) consultation. The scope of the plan is to be extended beyond its previous focus upon nursing to include other professional healthcare staff groups.

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

Recommendations:

1) To note the contents of the report.
2) To provide feedback about the approach being taken toward recruitment and retention.
3) To receive an update on progress made with implementing the actions identified within the Recruitment and Retention Action Plan in May 2018.

MEETING OF:	**Board of Directors**
DATE:	**28th November 2017**
TITLE:	**Nurse Recruitment & Retention Action Plan Update**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide the Board of Directors with information about nurse recruitment and retention within TEWV and to share decisions recently made by the EMT to update the Recruitment and Retention Action Plan (Appendix A).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Concerns relating to the ability to attract and retain registered nursing staff has been an ongoing issue for a significant period of time. A number of papers relating to this topic about nurse recruitment and retention have been presented to the Board of Directors, the EMT and the Workforce and Development Group. A Workforce Task and Finish group was established to focus on this issue. The group were charged with developing a Recruitment and Retention action plan which was subsequently authorised by the Executive Management Team.

2.2 The following report provides an update on a range of activities that have been explored and/or implemented. A copy of the updated action plan is contained at appendix A. The report also includes information on vacancy fill rates and labour turnover rates for registered nurse staff.

3. KEY ISSUES:

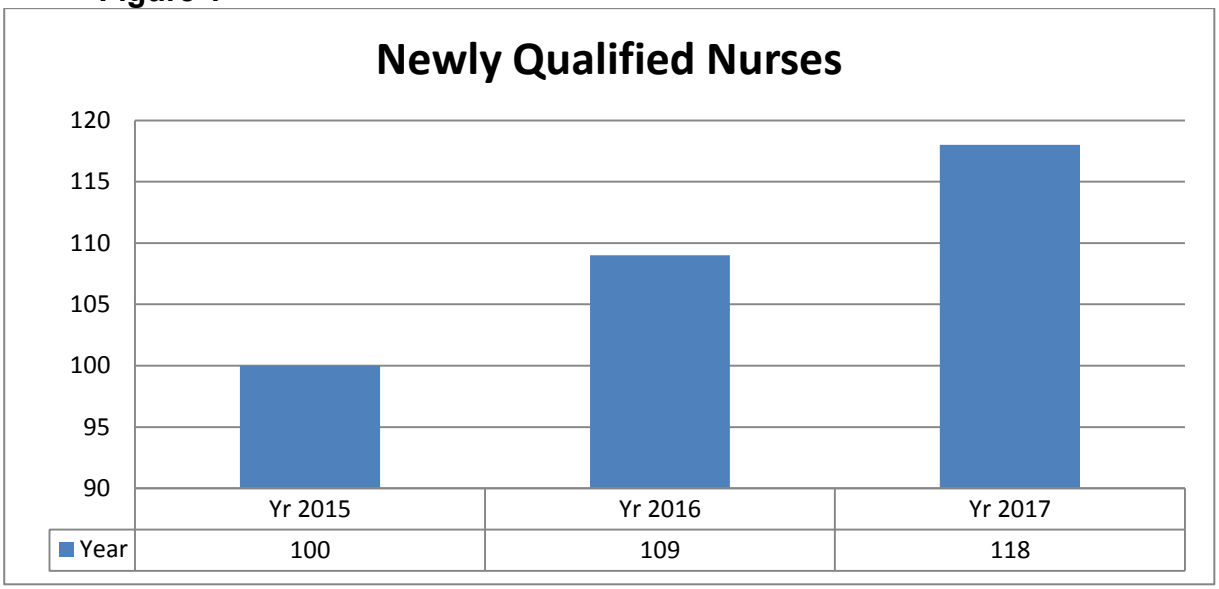
3.1 EMT agreed to £50k of non-recurring monies for 12 months to support recruitment and retention activities. The money has been used to fund a band 5 Assistant Project Manager and supporting a range of recruitment activities such as recruitment fairs, promotional materials etc. The Assistant Project Manager is a key enabler to ensuring a focussed approach to recruitment activities on a large scale and supporting the Heads of Nursing with student recruitment and reconnection events. The non-recurring funding was received for both this year and the preceding year.

3.2 An evaluation of the success of participating in external and internal recruitment fairs was undertaken. It was determined that participating in externally organised fairs did not result in attracting the numbers of registered nurses that we had hoped for. It was agreed the focus should be on internally organised fairs which have proved to be successful in attracting nurses to come and work for the Trust. Since March 2017 we have held 3 recruitment events.

- 110 students were offered employment subject to qualification in September 2017. 33 initially accepted the offer but subsequently withdrew. **60** of the newly qualified students have taken up post and 17 are awaiting pre-employment clearance.
- 13 experienced nurses have also been recruited through the recruitment fairs.

3.3 Figure 1below highlights number of newly qualified registered nurses the Trust has historically recruited between January and December 2015, 2016 and year to date 2017. (The figure for 2017 includes the 17 newly qualified nurses due to take up employment in the near future).

Figure 1



3.4 The graph at figure 2 highlights the vacancy fill rate for bands 5 and 6 registered nurse vacancies advertised April 2017 - September 2017. The graph at figure 3 highlights the vacancy fill rate position as at each quarter.

Figure 2

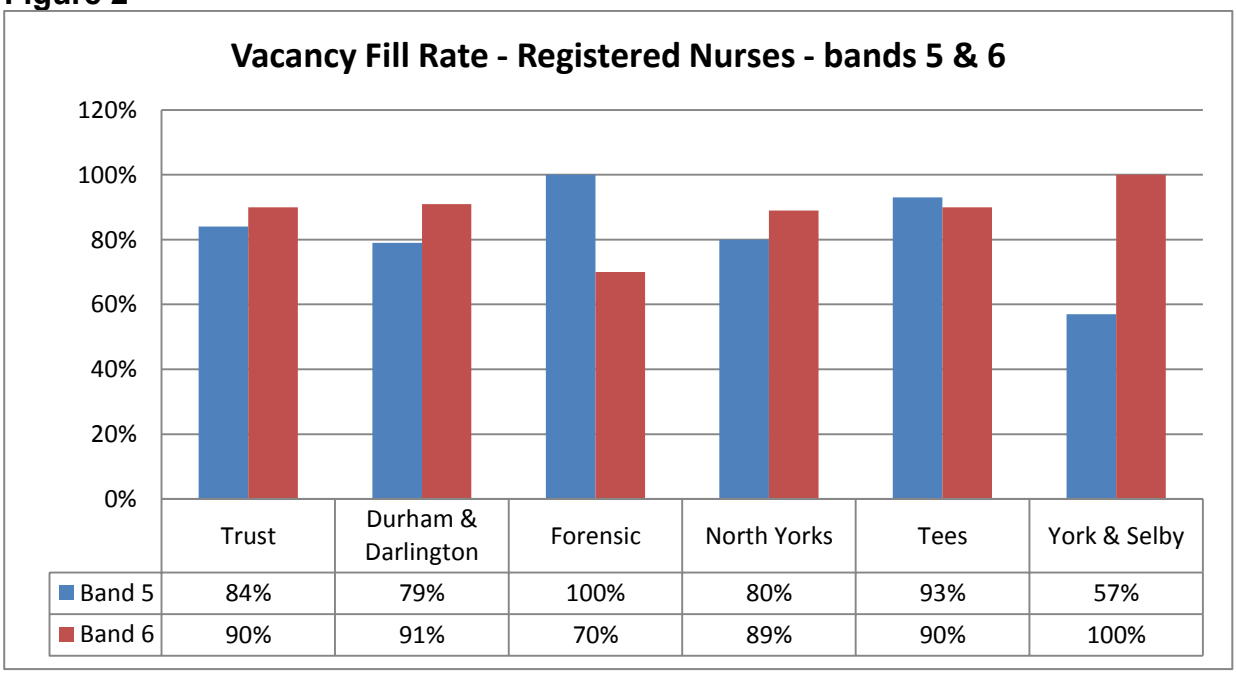
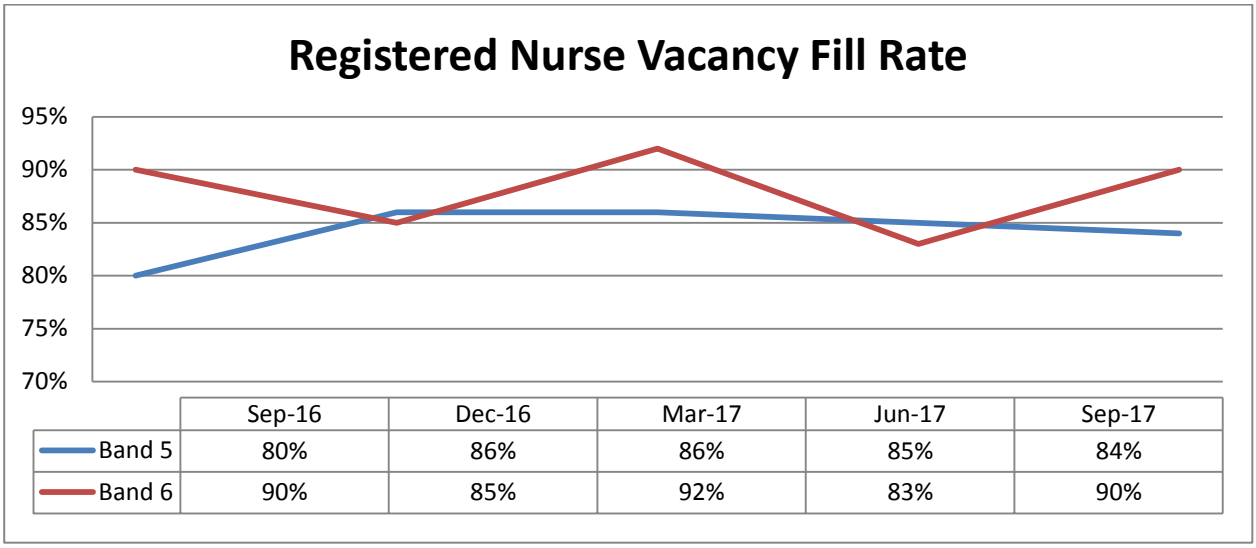


Figure 3



	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17
Band 5	80%	86%	86%	85%	84%
Band 6	90%	85%	92%	83%	90%

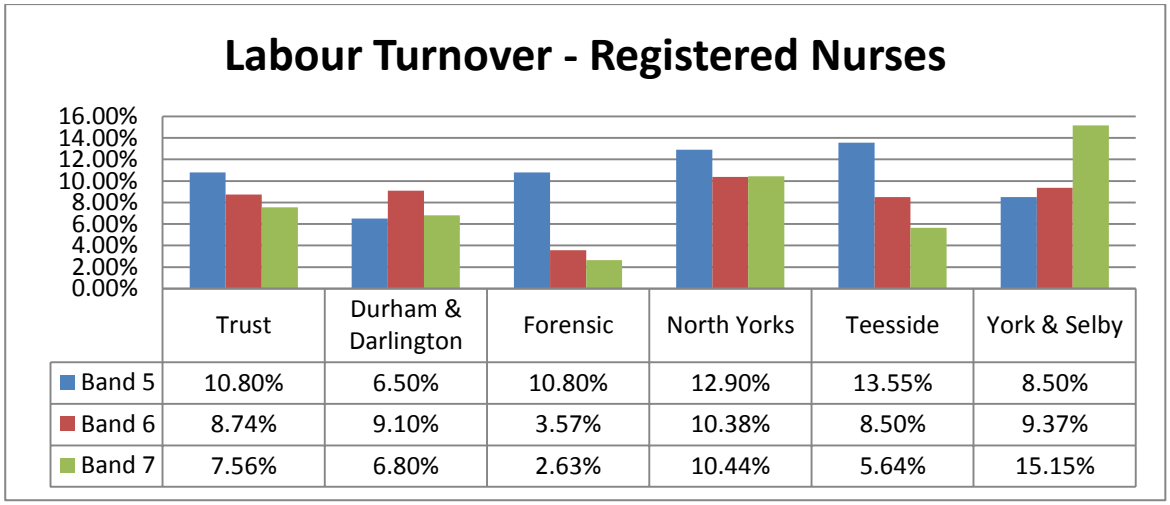
3.5 A total of 212 registered nurses left the Trust in the last 12 months (Oct 16 – Sept 17).

- 21 (10%) of those staff opted to retire and return to continue working for the Trust.
- 81 (38%) registered nurses retired. The average age of the retirees was 60 years old.
- 16 (7.5%) registered nurses left the Trust and highlighted the reason for leaving as being health or work life balance.

During the last 12 months a total of 162 experienced band 5 and band 6 registered nurses have been recruited from other organisations, NHS providers and the private sector. This is a greater number than the number of newly registered nurses recruited by TEWV.

The graph at figure 4 highlights the turnover rate of registered nurses band 5 and band 6 by Locality. Registered Nurse band 5 turnover in certain Localities is higher than one would like and warrants further investigation. It has recently been agreed that the Heads of Nursing will offer all registered nurses leaving the Trust the opportunity to meet to undertake an exit interview.

Figure 4



	Trust	Durham & Darlington	Forensic	North Yorks	Teesside	York & Selby
Band 5	10.80%	6.50%	10.80%	12.90%	13.55%	8.50%
Band 6	8.74%	9.10%	3.57%	10.38%	8.50%	9.37%
Band 7	7.56%	6.80%	2.63%	10.44%	5.64%	15.15%

3.6 An updated Recruitment and Retention Action Plan can be found at Appendix A. Significant progress has been made against a number of the agreed actions and changes made to the action plan following recent consultation with the EMT have been included within the attached document.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

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

4.2 Financial/Value for Money:

4.2.1 As previously highlighted within the report EMT agreed non-recurring funding of £50k to support the work associated with the activities outlined within the action plan. Part of the funding has been used to fund a band 5 Assistant Project Manager post with the remainder funding recruitment fair activities.

4.3 Legal and Constitutional (including the NHS Constitution):

4.4 Equality and Diversity:

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

4.5 Other implications:

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

5. RISKS:

5.1 Significant progress has been made in relation to the achieving the identified actions in the action plan. The Heads of Nursing have identified that the funding of the post to support them with recruitment fairs and reconnection events has been invaluable. There is a risk if the funding were to end the effectiveness of this focussed approach would be compromised.

6. CONCLUSIONS:

6.1 Good progress has been made with the design and implementation of a number of nurse recruitment and retention initiatives during 2017. Despite this progress there remains much to do and the issue of nurse recruitment, and particularly retention, will continue to be addressed by the EMT on a regular basis for the foreseeable future.

6.2 Efforts to develop longer term recruitment and retention solutions are progressing and there is a recognition the work needs to continue to help gain a better understanding of the specific recruitment and retention challenges being experienced and how they may be best resolved.

6.3 There is a need to broaden the scope of the Recruitment and Retention Action Plan to include other health care professional staff groups in addition to nursing and this work is underway.

7. RECOMMENDATIONS:

7.1 To note the contents of the report.

7.2 To provide feedback about the approach that is being taken toward recruitment and retention.

7.2 To receive an update about progress made with implementation of the Recruitment and Retention Action Plan in May 2018.

Beverley Vardon-Odonkor
Head of HR and Workforce Assurance

APPENDIX A

Nurse Recruitment and Retention Action Plan (November 2017)

Tasks	Key activities	Date Task to be completed	Responsible person	Update as at October 2017
Recruitment	• Continue to offer permanent contracts to all new nurses and then review	Completed	Beverley Vardon-Odonkor	The initiative has been successful, a total of **56** band 5 and 6 registered nurses have been recruited to fixed term posts and **16** have been successfully moved into permanent posts. The remaining 40 are currently in fixed term posts. They are registered in the pool, the Heads of Nursing and Assistant Project Manager regularly monitor permanent vacancies to match with registrants. **The EMT has agreed that permanent contracts should continue to be offered to all new to TEWV nurses at pay bands 5 and 6.**
	• Review the need to offer financial incentives to student nurses at York university	Completed	Angela Collins	A total of 10 newly qualified staff were recruited with a financial incentive in October 2016. **8** continue to be employed within the organisation. **The EMT has agreed that there is now no need to continue to offer this incentive and it has been withdrawn.**
	• Engage with Generation Z to align recruitment policy, practice and approach with workforce of the future	30 September 2018	Beverley Vardon-Odonkor	It is recognised that there is value in reviewing the research available pertaining to Generation Z and their expectations from an employee perspective.
Recruitment and Retention	• Develop a TEWV RRP business case	30 January 2018	Beverley Vardon-	A review of the provisions for RRP

Premia (RRP)	review process		Odonkor	within Agenda for Change has been undertaken and links with other NHS Trusts have been made to identify where local RRP arrangements have been implemented. **Analysis of posts that have proved difficult to recruit to over the last 12 months is being undertaken with a view to gaining a better understanding any presenting issues. A paper outlining the findings and any recommendations will be prepared for EMT consideration in January 2018.**
	• Review the case for pursuing international recruitment	31st May 2018	Beverley Vardon-Odonkor	Feedback from discussions with other providers regarding work they have undertaken linked to international recruitment indicates that it requires significant investment and can have a lead time measured in years. **The EMT has agreed to put a decision on hold about whether to pursue international recruitment until the Spring of 2018.**
Internal movement	• Develop an alternative process to manage the number of nurses seeking to take up a post in the same pay band making links with Talent Management information	31st December 2017	Nicola Rutherford and Michelle Brown	A questionnaire (281) was sent to band 5 & 6 registered nursing staff that had moved internally over the preceding 12 months. A response rate of 24.9% received. 59% of respondents moved band with 41% moving sideways to the same band. The analysis highlighted the majority of band 5 movement was linked to a promotion to band 6. The majority of band 6 movement was to a band 6. 67% moved to broaden experience. 34% moved due to workload. 30% moved to achieve better work/life

				balance 28% moved due to lack of job satisfaction. Further work needs to be undertaken to design an internal registration scheme in response to the volume of work that internal movement creates within TEWV.
Extending Working Lives	• Increase the numbers of contracted hours of part-time staff. • Complete Nurse Conversations • Share Extending Working Lives research	Completed Completed Completed	David Levy Heads of Nursing David Levy	The nurse conversations exercise has now been completed. Only a small proportion of the 300 plus nurses who had indicated they wanted a conversation actually followed up their interest by attending a group meeting led by a Head of Nursing. The Trust participated in an Extending Working Lives research project undertaken by Leicester University and the report has been received and shared within the Trust. A review of the findings will be undertaken and a paper will be presented to JCC and EMT in November 2017.
Bank	• Increase the numbers of registered nurses on the Central Nurse Bank • Pilot - planned overbooking of bank	Completed Completed	Karen Kendall Karen Kendall	A rolling advert for external RNs has proved successful. A total of 26 external and 100 internal appointments have been made during 2017. It is hoped that the move to agency before overtime will attract more of our employees to the bank in the near future. The evaluation is complete and the fill

	workers in FMH and FLD			rate of short notice (within 24 hour requests) has increased by 15%. It is hoped this initiative can be rolled out across TEWV.
	• Implement bank worker direct booking system	Completed	Karen Kendall	Fully implemented and extremely successful. The majority of bank workers use this method of booking shifts resulting in one admin post contributing to CRES savings as a result due to the reduction in shift related activity within the office.
Responsive Workforce Initiative	Develop a Derbyshire responsive workforce model within TEWV	31st March 2018	Angela Collins	An improvement event is to take place by March 2018 to consider how such a model may be implemented within the Durham and Darlington locality.
Return to Practice	• Gain greater understanding of current activity	Completed	Stephen Scorer	Involvement in regional group specifically focussing on LD nurses. In the last year 9 registered nurses have returned to practice nurses. **The EMT considered whether Return to Practice ought to be incentivised by the offer of temporary employment contracts and decided not to offer such an incentive.**
	• Identify opportunities to maximise activity – how can flexible working play a part in encouraging return to practice	31st March 2018	Kate Newton/Gemma Reeve	**The EMT agreed a new action that social media/radio be used to proactively promote return to practice opportunities.**
Retire and Return	• Develop a process to register staff interested in retire and return • Increase awareness of options via Heads of Nursing.	Completed	Nicola Rutherford, Heads of Nursing	A Retire and Return Procedure was developed and implemented in July 2017. **19** staff registered an interest to retire and return since implementation. **2** registrants have successfully retired and returned. **3** are in the process of completing pre-employment screening.

	• To review the impact of the Retire and Return Scheme and report findings to the EMT	31st December 2017.	Nicola Rutherford	**This is a new action agreed by the EMT.**
	• Consider developing a trust wide approach to match up part-time hours and signpost.	**Date to be determined**	To be confirmed	
HR related activities	• Undertake a review of sickness absence, short and long term, to identify the extent to which working conditions impact upon sickness absence and retention	30 September 2018	Lesley Hodge	A Health and Wellbeing consultation meeting is taking place on 23rd November 2017 prior to an improvement event in January/February 2018.
	• Review flexible working procedure	30 September 2017	Nicola Rutherford Lesley Hodge	A questionnaire was developed and sent out to a group of line managers to better understand how flexible working requests are considered within the organisation and whether there are barriers to support such requests. The questionnaire was sent to 24 Managers and responses were received from 11 giving a 46% response rate. **Analysis of responses will be considered by the Workforce Task and Finish group in November 2017.**
	• Develop relocation policy	Completed	Nicola Rutherford	A Relocation Policy has been developed by the HR Policy Working Group. **The policy was ratified at the JCC on 7th November 2017.**

Development activities to Grow Our Own workforce

Tasks	Key activities	Date Task to be completed	Responsible person	Comments/Update
Engagement with School and Colleges	Consider and if appropriate, develop an engagement strategy to increase awareness of/interest in working in the NHS	30 September 2019	Stephen Scorer, Jane Buckle, and Angela Collins	Engagement with schools and colleges is sporadic at the moment and this action is not seen as a priority at this moment in time due to capacity.

Grow Your Own	• Subject to EMT decision, support up to 100 current Band 4 Associate Practitioners to complete two years pre-registration programme	30 September 2020	Stephen Scorer , Jane Buckle, Judith Hurst and Angela Collins	A paper was approved by EMT to fund 10 current employees to undertake their registered nurse training in Learning Disability. 9 places were awarded. **The EMT has decided to put on hold until the Spring of 2018 work to support up to 100 Associate Practitioners to complete pre-registration programme**
	• Utilise apprenticeship levy to replace current HEE Talent for Care funding for all HCA Career framework, consider links to pre-reg training	Completed	Judith Hurst	
	• Participate in the National Nursing Associate Programme (pilot)	Underway	Stephen Scorer, Jane Buckle, Judith Hurst	The Trust is participating in national pilot and has successfully recruited 10 x Nursing Associates. It is envisaged a second cohort of Nursing Associates will be recruited in the new year.

ITEM NO 13

PUBLIC

BOARD OF DIRECTORS

DATE:	**28 November 2017**
TITLE:	**Proposal to permanently close Earlston House, Darlington**
REPORT OF:	**Brent Kilmurray**
REPORT FOR:	**Decision**

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

Executive Summary:

The purpose of the report is to provide Board of Directors with details of the outcome of the engagement with stakeholders regarding the proposal to permanently close Earlston House, Darlington. The engagement provided details of the evaluation of the merger of Earlston and Willow rehabilitation units and a report was shared with County Durham and Darlington CCGs who have led the engagement process. This included attendance at the County Durham Overview and Scrutiny Committee (OSC) and at the Darlington OSC informal briefing session. Neither raised any issues or concerns in relation to the proposal.

Feedback from stakeholders has confirmed their support to permanently close Earlston. The three CCGs in County Durham and Darlington have confirmed their support to permanently close Earlston.

Recommendations:

Trust Board are asked to receive this report and confirm the recommendation to permanently close Earlston House.

MEETING OF:	**Board of Directors**
DATE:	**28 November 2017**
TITLE:	**Proposal to permanently close Earlston House, Darlington**

1. INTRODUCTION & PURPOSE:

1.1 To provide the Board with the outcome of the engagement process that has been completed with stakeholders within County Durham and Darlington in regarding the proposal to permanently close Earlston House, Darlington The Board of Directors are requested to confirm their approval for its permanent closure.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The proposal to review Earlston and Willow wards was identified in the directorate business plan for 2015 -16. This was the next phase within the strategic development of rehabilitation services to ensure a focus on challenging behaviour and recovery and to further develop the pathway which supports clients across their continuum of need. The Board of Directors agreed to the merger of Willow and Earlston units at the end March 2016, reducing beds from 30 to 15 which enabled the temporary closure of Earlston unit. An initial evaluation of the temporary closure was completed in October 2016 and a paper submitted to Board that month. This highlighted that 15 beds is sufficient to meet the demand for rehabilitation beds for people needing inpatient care for up to 2 years with complex and challenging needs. It was agreed that the evaluation would be shared with Commissioners to agree with them an engagement process with stakeholders.

2.2 At the same time a Trust wide review of rehabilitation services commenced and it was agreed that this process should be completed prior to engagement with stakeholders to ensure that any other relevant service and/or system changes could be included in any agreed engagement process regarding the future provision of rehabilitation inpatient services.

2.3 The current 15 bed active rehabilitation unit at Primrose Lodge, Durham is outside this proposal and these beds remain unchanged.

3. KEY ISSUES:

3.1 The Trust wide rehabilitation review confirmed the current bed numbers (which reflected the reduction of 15 Earlston beds) was consistent with an expected bed complement based on prevalence levels for the TEWV population size.

3.2 A further evaluation of the merger of Willow ward and Earlston House was completed at end of Quarter 1 2017/18 and this confirmed the initial

evaluation findings which supported the ability to manage demand within 15 beds. (The evaluation is shown in Appendix 1)

3.3 In September 2017 Commissioners confirmed their support for recurring funding for the County Durham community rehabilitation and recovery service which provides further assurance of the ability to meet demand with 15 beds. The community rehabilitation service provides intensive support to individuals with rehabilitation needs as an alternative to admission, and works into inpatient services to reduce the length of stay. The service also support patients to achieve independent community living and achieve their rehabilitation and recovery goals and outcomes and reduces the risk of relapse through longer term intensive treatment

3.4 A paper was shared with Commissioners in September 2017 (Appendix 2) setting out the Trust's proposal to permanently close Earlston House and requesting Commissioners lead an engagement process with stakeholders prior to a final recommendation and decision. The paper and approach was supported by the Commissioners.

3.5 The engagement process has included:

- Attendance at Darlington Overview and Scrutiny Committee (OSC) informal briefing meeting in October 2017
- Attendance at County Durham OSC meeting November 2017
- Commissioners engagement with their Patient Reference Groups

3.6 Both OSCs did not raise any issues or concerns regarding the proposal. Commissioners have also provided their formal support for permanent closure.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Earlston House will be de-registered once formal agreement with all stakeholders to close is completed.

4.2 Financial/Value for Money:

The value of savings in Year 1 was in line with the Locality 2016/17 Financial plan (planned £477k.). The expenditure on care packages was £96k of planned expenditure however delays in achieving redeployment for some team members meant that £185k of staff costs were incurred. A total net saving of £490k.
The capital planning department has confirmed that the building is surplus to Trust requirements and will be sold.

4.3 Legal and Constitutional (including the NHS Constitution):

There are no legal or constitutional implications to this paper.

4.4 **Equality and Diversity:**

There are no direct equality and diversity implications to this paper. Inpatient rehabilitation services for people in County Durham and Darlington with complex and challenging behaviour will continue to be provided. An equality analysis was completed to support the decision making process.

4.5 **Other implications:**

None.

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5. CONCLUSIONS:

The evaluation has demonstrated that the provision of 15 beds (Willow ward) is sufficient to meet the rehabilitation needs of people with complex and challenging behaviour and that there continues to be throughput across the rehabilitation pathway. The confirmation of recurrent funding for the community rehabilitation team in Durham is further assurance of the ability to manage within a reduced bed complement and offers an effective alternative to admission and reduction in length of stay.

The engagement process with stakeholders and their feedback has supported the proposal to permanently close Earlston House. This has been formally supported by the 3 CCGs in County Durham and Darlington and the two OSCs.

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6. RECOMMENDATIONS:

The Board of Directors is asked to approve the permanent closure of Earlston House, Darlington

Patrick Scott
Director of Operations– Durham and Darlington

Background Papers:
EMT report – Earlston and Willow, November 2015 **BoD report – Earlston and Willow, March 2016** **BoD report – Earlston and Willow, October 2016**

Evaluation

The Trust made the decision to temporarily close Earlston House in April 2016. At that time most patients were working towards a planned discharge. The temporary closure gave the Trust the opportunity to assess whether the improvements made would, as expected, reduce the need for inpatient beds The service completed an evaluation (June 2017) which considered a range of information using the following indicators and qualitative information:

Quantitative:

- The number of admissions and bed occupancy across the rehabilitation pathway
- Number of readmissions – linked to placement outcome (those patients who were transferred to a placement in line with their care plan before end March 16)
- Referrals and activity undertaken by the community rehabilitation and recovery team (County Durham only due to commissioning arrangements)

Qualitative:

- Feedback from care coordinators of patients who are in a placement on the effectiveness/suitability of this
- Comments from patients and their families on how the placement is working for them
- Staff comments – indirectly via team away day events and with clinical and management leaders, along with feedback from staff via supervision.
- Feedback from regulators (CQC) and accreditation bodies (AIMS)

The table below provides details of the evaluation.

Criteria	How have we measured the impact	Comments on the impact of the change
Maintenance of placements	Readmissions to mental health inpatient service	Of the 14 people who were discharged from inpatient rehabilitation services either to their family home or to a community placement in the lead up to the temporary closure of Earlston House in April 2016, three have been re-admitted to TEWV inpatient services: • One patient who had been living with a family member had deteriorated and was unable to remain safely with family (readmitted to West Park Hospital). A placement suitable to the patient's needs was identified and transfer completed. • The second readmission was a patient who was in a supported housing placement, Due to deterioration in the individual's mental health this individual was readmitted and remains in Primrose Lodge. Work is ongoing to identify a placement which allows own tenancy with more supervision. • The third patient was readmitted to an acute ward at West Park Hospital from a care home and remains there. Work continues to identify a placement that meets the required level of support. Two people were admitted to acute hospital for physical symptoms (which had also occurred when they were at Earlston House). Sadly one person has died (linked to physical issues). The second patient is now back in their placement.
Quality of individual placement	Feedback from care coordinator, family and/or patient to determine if the placement is meeting their needs	Examples of feedback about three individuals indicates that they are settled in their placement and examples are given of established trips to the leisure centre for football, regular contact with siblings, and one individual who is attending college. There are a number of people who had been in hospital beds for many years with no realistic discharge plan, or only discharge options being 24 hour care, who are now living enjoyable, productive lives. For example, some older former patients with more chronic needs continue to receive appropriate packages of care in their new homes, and recent reviews have found them to be doing well and satisfied with the care they are receiving.
Fit for purpose rehabilitation service	Number of referrals to the rehab service, Number of admissions, Number managed by	A streamlined referral process has been introduced to ensure that all referrals are assessed by experienced clinicians within a week. This enables us to accurately match an individual's needs to the appropriate service. In 2016/17 there were 85 accepted referrals to the rehab service with 46 managed via the community rehabilitation and recovery team,

	the community rehab and recovery service (County Durham only)	36 patients were admitted to a rehab bed (3 assessments pending at year end). 54% of people referred were able to be supported by the community rehab and recovery team in a community setting who may previously have had either a longer length of stay in acute wards or been admitted to a rehab bed. Following the introduction of the community rehabilitation and recovery team an evaluation of its impact and effectiveness was completed in January 2016. This outlined a range of benefits that this team provides using intensive community input to maximise service user independence. The evaluation included comments from staff who commented positively on the service impact, for example:
	Staff comments on the Impact of the community rehab and recovery service	"*The introduction of the community rehabilitation team has allowed the essential levels of additional support for complex patients after discharge from acute admission wards and avoided the need for referrals to inpatient rehabilitation services and the associated lengthy waiting times. This has positively reduced stay in acute admission wards and freed up availability of beds for those in essential need. Furthermore this has promoted patient choice and allowed recovery within the home environment".* *"The community rehabilitation and recovery team have filled a gap of transition where community teams are unable to provide intensive home care for patients but require support after leaving hospital working effectively with a patient post discharge. They have been effective in assessing level of needs and initiating community activity the patient would otherwise have struggled to access."*
	Bed occupancy : Willow & Primrose Lodge	We continue to monitor bed occupancy to ensure that we can meet need for admission. Following the temporary closure of Earlston House in April 2016 the occupancy level in Willow ward was 95% and in Primrose Lodge was 83%, for the 12 months ending March 2017. This compared to 84% at Willow and 77% at Primrose Lodge in 2015/16. Even with the slight increase in occupancy, bed capacity has remained manageable, assessments are completed within required timescales and the service has been able to facilitate new admissions in a timely way. The service has identified that there remains a small number of complex high risk individuals who are on Willow ward and do not meet the rehab profile, will not achieve independent living and will continue to need long term intensive support. We are currently working with identified agencies e.g.: housing, nursing care to ensure each individual's

		ongoing care needs can be met. Once each individual's transfer has been successfully completed this will increase the capacity within Willow Ward.
Greater multi-disciplinary working and recovery focus	Via feedback from staff, regulators (CQC), other accreditation bodies	The benefits from the introduction of improved ways of working within the service, along with innovative developments such as the non-medical approved clinician (AC) role are now being seen. The psychologist (AC role) is able to support five patients at each unit (Willow ward and Primrose Lodge) and the consultant psychiatrist supports 10 patients at each. This means patients receive more intensive input particularly those who benefit from having a psychologist lead their care. With fewer units there is increased input from consultant, occupational therapy and psychology staff. All staff report that this improves multidisciplinary team working. There is a training programme in place for staff which includes positive behaviour support (PBS), harm minimisation and observation and engagement training, along with sessions on intervention planning. Staff report that the PBS and harm minimisation training have had a positive impact across the team. Staff from the PBS team have attended formulation meetings when intervention plans are being developed. Staff report feeling more confident in the team's approach to support patients with challenging behaviours and complex needs (articulated via supervision). Students have reported that they have found the ward a useful learning experience and receive good mentoring. The CQC inspection from earlier in 2017 confirmed an overall rating of Good and the report recognised the improvement methodologies used by the ward and highlighted the example of improvements to the ward layout The ward has also retained its AIMS accreditation in 2017.
Impact of new service models	Patient feedback	Specific feedback from patients and their families on the range of services currently available, and the impact on their mental health and recovery, has been sought. Some examples are included below: *"Before the valuable on going assistance given to both my wife and myself by the Rehab and Recovery team we had been left to fend for ourselves with sporadic support and*

		guidance from the community health teams. I can only say that their dedication and experience have enabled my wife to begin to see a life beyond her illness and I dread to think what progress could have been made without their assistance" **Carer** *"The services the mental rehab team provided for me were second to none and went way over what I expected of them- they were excellent in boosting my self-confidence and self-esteem and motivating to do things to get me out of myself- get me better"* **Patient** "*The rehab team were on board with my sister for a 12 week period and throughout this time they gave her a lot of support, time and help to encourage her to be independent and motivated her to partake in various social events and activities. This extra input was very valuable both to her and myself as I could have a small break and see her improve and therefore she was able to attend the recovery college too and gain confidence in herself*" **Carer** *"The rehab team have been very helpful in supporting me while on leave and getting me ready for discharge. They are great, friendly and very professional at their job. The team are making it a lot easier for me to do the next step from hospital to the community and have been very understanding when I need more help too. If it wasn't for the team I think I would find the transition much harder"* **Patient** *"Just a note to say I find it useful that the team visits me, helping socially and hope the service can continue"* **Patient** *"My family wish to express our heartfelt appreciation for your kindness and excellent support you give to our mother. Your daily input let us feel reassured knowing mum is not on her own. This also gives me some free time which has been difficult over the last year, I feel support and I think this service is invaluable to service users and their carer's. Thank you very much"* **Carer**

		"I would like to thank you all, I know this is a long process, and some days feel better than others, but knowing I have you calling and giving me support really does help, you take me to coffee afternoons, and support groups which I do appreciate, you are a team which I know are there to help me and support me. Thank you" **Patient** *"With the support of the rehab and recovery team, who have worked with my son intensively and assertively in addressing his motivation whilst improving his social inclusion by supporting him attending the gym twice weekly and hobbies of interest such as fishing activities, thus building his confidence and self-esteem which in turn promotes independence and reduce the burden and stress on ourselves as carers. The team have been excellent in liaising with ourselves as carers/family, keeping us involved and well informed in his care and recovery goals, recognising and highlighting the role we play in his recovery and the ongoing stress associated with same. Staff involved have been most professional and understanding and have demonstrated the utmost compassion throughout. They evidently understand the importance of developing a therapeutic relationship with both patient and families! I cannot thank the team enough, and I hope this service continues to be commissioned and funded, keep up the good work guys".* **Carer** *"The community staff team have been fantastic. They have explained everything to tenants in plain English, they had done a rota for one tenant, the community team would support tenants any time of the day, one tenant is now accessing the community independently." how marvellous is that" without the community team it would have taken us much longer to develop her skills in the community, they are very approachable and friendly and gave good advice. Thank you so much for their support."* **Manager of Supported Living Scheme**

NHS North Durham Clinical Commissioning Group

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group

NHS Darlington Clinical Commissioning Group

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

Improving mental health rehabilitation services for adults – merger of Earlston House and Willow Ward, Darlington

1. Purpose

The paper sets out the Trust's proposal to permanently close Earlston House, Darlington. The unit, which was closed on a temporary basis in April 2016, provides rehabilitation inpatient support to patients with complex needs. The Trust continues to provide 15 rehabilitation inpatient beds in Willow Ward, West Park, Darlington, for patients with complex needs. The Trust also provides a 15 bed rehabilitation unit (Primrose Lodge in Chester-le-Street, County Durham) for people whose needs are not as complex.

Following evaluation of the impact of the temporary closure of Earlston House the Trust believes that it can meet the needs of individuals with complex needs who require rehabilitation within the 15 beds at West Park. The Trust wishes to engage with stakeholders to seek their views on the proposal during September and October, prior to final decision, which we would expect to make in November 2017.

2. Introduction

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) provide specialist mental health rehabilitation services across County Durham and Darlington. Their focus is on the treatment and care of people with severe and complex mental health problems whose needs cannot be met by acute assessment and treatment inpatient services. Current service provision is:

Unit	Location	Number of Beds	Type of service
Primrose Lodge	Chester le Street	15 beds	Active rehabilitation unit Target length of stay: up to 9 months
Earlston House	Darlington	15 beds (temporarily closed April 2016)	Bespoke and specialist, slower stream rehabilitation for complex/challenging patients Target length of stay: 1-2 years
Willow Ward	West Park, Darlington	15 beds	Bespoke and specialist, slower stream rehabilitation for very complex/challenging patients Target length of stay: 1-3 years
Specialist Community Rehabilitation	County Durham wide	N/A	Bespoke and individualised 7 day community based intensive support for individuals with complex needs,

Team	(operational since May 2014)		significant levels of risks and significant reduced ability to function in their own home/community. Average duration of contact: 70 days

There are also two beds for County Durham and Darlington patients in TEWV's non-forensic low secure male unit in Middlesbrough.

Over the past decade the Trust has continued to develop and modernise its rehabilitation services in line with national guidance and best practice, including Royal College of Psychiatry guidelines, working with individual service users to maximize their quality of life. This makes sure people get the care they need in the most appropriate environment. This includes (when appropriate) supporting people to live as independently as possible in a community setting, away from NHS based care. In particular, the focus has been on providing the appropriate community support so that patients can move from being in hospital to living in the community and being able to access a range of community services.

Work to date has included:

- much greater focus on rehabilitation goals, outcomes, individual needs and recovery
- more effective discharge planning with patients, family and carers
- working with providers of nursing care, residential care and supported living accommodation to help them support patients with complex mental health needs (this means patients have more choice about where they live)
- working to maximise the independence of patients so that they can live as independently as possible
- being clear about the aims and purpose of admission to the rehabilitation service so that the right patients receive intensive rehabilitation support to maximise their independence
- a community rehabilitation and recovery (intensive support) service to provide an alternative to bed based care or support transition into the community. The service was introduced in 2014.

These developments mean that we have much more streamlined service from assessment and treatment wards into our rehabilitation wards. As people get the type of support when and where they need it this has resulted in less time spent in hospital. The community rehabilitation and recovery service team now responds to over 50% of referrals to the rehabilitation service and has been effective in reducing lengths of stay and admissions. As a result of these developments there is less reliance on inpatient beds.
During the period of the evaluation, the Trust separately undertook a Trustwide review of rehabilitation services to look at the type of provision we provide and its effectiveness. This highlighted that other areas within the Trust have similarly benefitted from community based services in reducing reliance on inpatient based rehabilitation.

Evaluation

The Trust made the decision to temporarily close Earlston House in April 2016. At that time most patients were working towards a planned discharge. The temporary closure gave the Trust the opportunity to assess whether the improvements made would, as expected, reduce

the need for inpatient beds The service completed an evaluation (June 2017) which considered a range of information using the following indicators and qualitative information:

Quantitative:

- The number of admissions and bed occupancy across the rehabilitation pathway
- Number of readmissions – linked to placement outcome (those patients who were transferred to a placement in line with their care plan before end March 16)
- Referrals and activity undertaken by the community rehabilitation and recovery team (County Durham only due to commissioning arrangements)

Qualitative:

- Feedback from care coordinators of patients who are in a placement on the effectiveness/suitability of this
- Comments from patients and their families on how the placement is working for them
- Staff comments – indirectly via team away day events and with clinical and management leaders, along with feedback from staff via supervision.
- Feedback from regulators (CQC) and accreditation bodies (AIMS)

The table below provides details of the evaluation.

Criteria	How have we measured the impact	Comments on the impact of the change
Maintenance of placements	Readmissions to mental health inpatient service	Of the 14 people who were discharged from inpatient rehabilitation services either to their family home or to a community placement in the lead up to the temporary closure of Earlston House in April 2016, three have been re-admitted to TEWV inpatient services: • One patient who had been living with a family member had deteriorated and was unable to remain safely with family (readmitted to West Park Hospital). A placement suitable to the patient's needs was identified and transfer completed. • The second readmission was a patient who was in a supported housing placement, Due to deterioration in the individual's mental health this individual was readmitted and remains in Primrose Lodge. Work is ongoing to identify a placement which allows own tenancy with more supervision. • The third patient was readmitted to an acute ward at West Park Hospital from a care home and remains there. Work continues to identify a placement that meets the required level of support. Two people were admitted to acute hospital for physical symptoms (which had also occurred when they were at Earlston House). Sadly one person has died (linked to physical issues). The second patient is now back in their placement.
Quality of individual placement	Feedback from care coordinator, family and/or patient to determine if the placement is meeting their needs	Examples of feedback about three individuals indicates that they are settled in their placement and examples are given of established trips to the leisure centre for football, regular contact with siblings, and one individual who is attending college. There are a number of people who had been in hospital beds for many years with no realistic discharge plan, or only discharge options being 24 hour care, who are now living enjoyable, productive lives. For example, some older former patients with more chronic needs continue to receive appropriate packages of care in their new homes, and recent reviews have found them to be doing well and satisfied with the care they are receiving.
Fit for purpose rehabilitation service	Number of referrals to the rehab service, Number of admissions, Number managed by	A streamlined referral process has been introduced to ensure that all referrals are assessed by experienced clinicians within a week. This enables us to accurately match an individual's needs to the appropriate service. In 2016/17 there were 85 accepted referrals to the rehab service with 46 managed via the community rehabilitation and recovery team,

	the community rehab and recovery service (County Durham only)	36 patients were admitted to a rehab bed (3 assessments pending at year end). 54% of people referred were able to be supported by the community rehab and recovery team in a community setting who may previously have had either a longer length of stay in acute wards or been admitted to a rehab bed. Following the introduction of the community rehabilitation and recovery team an evaluation of its impact and effectiveness was completed in January 2016. This outlined a range of benefits that this team provides using intensive community input to maximise service user independence. The evaluation included comments from staff who commented positively on the service impact, for example:
	Staff comments on the Impact of the community rehab and recovery service	"*The introduction of the community rehabilitation team has allowed the essential levels of additional support for complex patients after discharge from acute admission wards and avoided the need for referrals to inpatient rehabilitation services and the associated lengthy waiting times. This has positively reduced stay in acute admission wards and freed up availability of beds for those in essential need. Furthermore this has promoted patient choice and allowed recovery within the home environment".* *"The community rehabilitation and recovery team have filled a gap of transition where community teams are unable to provide intensive home care for patients but require support after leaving hospital working effectively with a patient post discharge. They have been effective in assessing level of needs and initiating community activity the patient would otherwise have struggled to access."*
	Bed occupancy : Willow & Primrose Lodge	We continue to monitor bed occupancy to ensure that we can meet need for admission. Following the temporary closure of Earlston House in April 2016 the occupancy level in Willow ward was 95% and in Primrose Lodge was 83%, for the 12 months ending March 2017. This compared to 84% at Willow and 77% at Primrose Lodge in 2015/16. Even with the slight increase in occupancy, bed capacity has remained manageable, assessments are completed within required timescales and the service has been able to facilitate new admissions in a timely way. The service has identified that there remains a small number of complex high risk individuals who are on Willow ward and do not meet the rehab profile, will not achieve independent living and will continue to need long term intensive support. We are currently working with identified agencies e.g.: housing, nursing care to ensure each individual's

		ongoing care needs can be met. Once each individual's transfer has been successfully completed this will increase the capacity within Willow Ward.
Greater multi-disciplinary working and recovery focus	Via feedback from staff, regulators (CQC), other accreditation bodies	The benefits from the introduction of improved ways of working within the service, along with innovative developments such as the non-medical approved clinician (AC) role are now being seen. The psychologist (AC role) is able to support five patients at each unit (Willow ward and Primrose Lodge) and the consultant psychiatrist supports 10 patients at each. This means patients receive more intensive input particularly those who benefit from having a psychologist lead their care. With fewer units there is increased input from consultant, occupational therapy and psychology staff. All staff report that this improves multidisciplinary team working. There is a training programme in place for staff which includes positive behaviour support (PBS), harm minimisation and observation and engagement training, along with sessions on intervention planning. Staff report that the PBS and harm minimisation training have had a positive impact across the team. Staff from the PBS team have attended formulation meetings when intervention plans are being developed. Staff report feeling more confident in the team's approach to support patients with challenging behaviours and complex needs (articulated via supervision). Students have reported that they have found the ward a useful learning experience and receive good mentoring. The CQC inspection from earlier in 2017 confirmed an overall rating of Good and the report recognised the improvement methodologies used by the ward and highlighted the example of improvements to the ward layout The ward has also retained its AIMS accreditation in 2017.
Impact of new service models	Patient feedback	Specific feedback from patients and their families on the range of services currently available, and the impact on their mental health and recovery, has been sought. Some examples are included below: *"Before the valuable on going assistance given to both my wife and myself by the Rehab and Recovery team we had been left to fend for ourselves with sporadic support and*

		guidance from the community health teams. I can only say that their dedication and experience have enabled my wife to begin to see a life beyond her illness and I dread to think what progress could have been made without their assistance" **Carer** *"The services the mental rehab team provided for me were second to none and went way over what I expected of them- they were excellent in boosting my self-confidence and self-esteem and motivating to do things to get me out of myself- get me better"* **Patient** "*The rehab team were on board with my sister for a 12 week period and throughout this time they gave her a lot of support, time and help to encourage her to be independent and motivated her to partake in various social events and activities. This extra input was very valuable both to her and myself as I could have a small break and see her improve and therefore she was able to attend the recovery college too and gain confidence in herself*" **Carer** *"The rehab team have been very helpful in supporting me while on leave and getting me ready for discharge. They are great, friendly and very professional at their job. The team are making it a lot easier for me to do the next step from hospital to the community and have been very understanding when I need more help too. If it wasn't for the team I think I would find the transition much harder"* **Patient** *"Just a note to say I find it useful that the team visits me, helping socially and hope the service can continue"* **Patient** *"My family wish to express our heartfelt appreciation for your kindness and excellent support you give to our mother. Your daily input let us feel reassured knowing mum is not on her own. This also gives me some free time which has been difficult over the last year, I feel support and I think this service is invaluable to service users and their carer's. Thank you very much"* **Carer**

		"I would like to thank you all, I know this is a long process, and some days feel better than others, but knowing I have you calling and giving me support really does help, you take me to coffee afternoons, and support groups which I do appreciate, you are a team which I know are there to help me and support me. Thank you" **Patient** *"With the support of the rehab and recovery team, who have worked with my son intensively and assertively in addressing his motivation whilst improving his social inclusion by supporting him attending the gym twice weekly and hobbies of interest such as fishing activities, thus building his confidence and self-esteem which in turn promotes independence and reduce the burden and stress on ourselves as carers. The team have been excellent in liaising with ourselves as carers/family, keeping us involved and well informed in his care and recovery goals, recognising and highlighting the role we play in his recovery and the ongoing stress associated with same. Staff involved have been most professional and understanding and have demonstrated the utmost compassion throughout. They evidently understand the importance of developing a therapeutic relationship with both patient and families! I cannot thank the team enough, and I hope this service continues to be commissioned and funded, keep up the good work guys".* **Carer** *"The community staff team have been fantastic. They have explained everything to tenants in plain English, they had done a rota for one tenant, the community team would support tenants any time of the day, one tenant is now accessing the community independently." how marvellous is that" without the community team it would have taken us much longer to develop her skills in the community, they are very approachable and friendly and gave good advice. Thank you so much for their support."* **Manager of Supported Living Scheme**

Conclusion

The information demonstrates that:

- The development of the rehabilitation service has had a positive impact on the ability to offer an alternative to admission or reduce the length of time individuals remain as inpatients and has significantly increased the number of people who are supported in the community.
- Current throughput and occupancy levels confirm that 15 beds is sufficient to meet the demand for rehab beds for people needing inpatient care for up to 2 years with complex and challenging needs. Occupancy levels at Primrose Lodge demonstrate that the service has the ability to transfer people once they are ready for this element of the pathway.
- There have been 3 readmissions to mental health inpatient services of those people who were discharged from Earlston prior to its temporary closure. The readmissions were as a result of a relapse in their mental health, which would not be unexpected given the chronicity of their problems.
- We recognise that we have lost a community based facility through the temporary closure of Earlston. Neither Earlston House nor Willow ward are purpose built rehabilitation environments. The environment at West Park has a number of benefits however for patients in Willow ward, such as access to PICU and some local amenities.
- There are a number of patients whose needs cannot be met within the current Willow ward. These include patients who need to be managed within a single sex rehabilitation environment, and those individuals who remain in the unit beyond the agreed rehabilitation timescale, need intensive support and will be unable to live independently. However, staff across rehabilitation and community services have been working proactively with local authority and other agencies to identify appropriate homes for them with positive results in that some of these individuals are now moving towards discharge. (some discharge dates now confirmed).

The Trust has been able to successfully manage demand since the temporary closure of Earlston House within the scope of the commissioned service on Willow Ward, West Park Darlington and support from the community rehabilitation and recovery team. We will however need to continue to monitor this to ensure that patients are receiving the care and support they need when and where they need it.

3. Recommendations

The paper outlines the continued development of the rehabilitation service to provide more responsive, needs led and recovery focused options for patients. This means that we have been able to reduce 15 beds with no adverse impact on the ability of the rehabilitation service to offer inpatient support when this is required.

The Trust recommends that Earlston House, Darlington is closed on a permanent basis in light of the changing needs of the service and patient group, and development of more recovery focused alternatives to specialist inpatient rehabilitation and recovery care.

We are seeking to engage with stakeholders during September and October 2017 to share this proposal and discuss any issues or concerns prior to making a final decision in November 2017.

Patrick Scott
Locality Director
County Durham and Darlington

Appendix 1

Proposed Engagement Process

ACTION	**BY WHEN**	**LEAD**
Initial discussion with Durham and Darlington OSCs to agree process	End June 2017	Director of Operations
To discuss at AMH QUAG	August 2017	Head of Service
Share focussed engagement paper with CCGs	September 2017	Director of Operations
Share paper with OSCs	October 2017	Director of Operations/ Head of Service
Respond to engagement with follow up meetings with stakeholders as required	1 October 2017 – 31 October 2017	Director of Operations/ Head of Service
Submit proposal to CCGs following engagement recommending preferred outcome for Earlston	November 2017	Director of Operations

Tees, Esk and Wear Valleys
NHS Foundation Trust

Item 14

CONFIDENTIAL

BOARD OF DIRECTORS

DATE:	**28th November 2017**
TITLE:	**Digital Transformation Strategy April 2017 to March 2020**
REPORT OF:	**Drew Kendall, Director of Finance and Information**
REPORT FOR:	**Information and approval**

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

Executive Summary:

The Board of Directors are asked to consider and approve the Digital Transformation Strategy for the period April 2017 to March 2020. The strategy has been approved at the Digital Transformation Board, Executive Management Team and recent Resources Committee Meeting in November 2017.

The Digital Transformation Strategy supports a number of strategic goals but specifically focusses on goal 5: To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.

The strategy scorecard proposes the key metrics to support delivery of the Digital Strategy and these will continue to be developed and monitored by the Digital Transformation Board, and Executive Team via the monthly Strategic Change Oversight Board **(**SCOB.)

Recommendations:

The Board of Directors are asked to approve the Digital Transformation Strategy.

MEETING OF:	**Board of Directors**
DATE:	**28 November 2017**
TITLE:	**Digital Transformation Strategy April 2017 to March 2020**

1. INTRODUCTION & PURPOSE

The Board of Directors are asked to consider and approve the Digital Transformation Strategy for the period April 2017 to March 2020.

2. BACKGROUND INFORMATION

The Digital Transformation Strategy supports a number of strategic goals but specifically focusses on goal 5: To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve. The drafts of the strategy have been reviewed by the Digital Transformation Board and EMT and the final strategy was reviewed by the Resources Committee on the 14th November 2017. The Resources Committee recommends that the Board of Directors approve the Digital Transformation Strategy 2017-2020.

3. KEY ISSUES:

The Digital Transformation Strategy aims to deliver a cultural change in the design, development and implementation of technology to support staff, service user and partners. The following principles support the development of the strategy scorecard, as well as recognising the organisations ambitions for digital technology;

- The strategy reflects the current environment that the Trust operates within and the development of digital technology within the Trust and the local NHS.
- The pace of digital innovation is quick and as such the strategy will be reviewed on a regular basis to ensure it remains relevant and affordable for the needs of the Trust.
- The development of partnerships with existing suppliers and other stakeholders will enable the pace of digital innovation to become more responsive to the needs of the Trust, Service Users and Partners.
- The membership of the Digital Transformation Board has recently been revised in order to enable cultural change in the use of digital technology in the Trust and to shape future developments.
- The Digital Transformation Board membership will be key in supporting communication and implementation of the strategy across the wider Trust governance, and alignment with other key Trust Business priorities.

4. RECOMMENDATIONS:

The Board of Directors are asked to consider and approve the Digital Transformation Strategy attached for the period April 2017 to March 2020.

Drew Kendall
Interim Director of Finance and Information

Tees, Esk and Wear Valleys
NHS Foundation Trust

Digital Transformation Strategy

2017-2020

Strategy Sponsor: Drew Kendall (Director of Finance and Information) Mark Lovell (Chief Clinical Informatics Officer)		
Strategy Lead: Drew Kendall (Director of Finance and Information)		
Version: 1	**Date approved**	**Date of Next Review:** April 2020

making a difference together

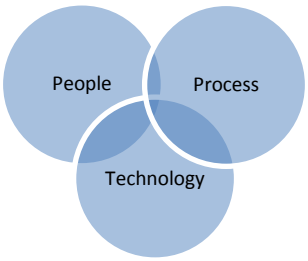
Preface

This document is Tees, Esk and Wear Valleys NHS FT (TEWV) Digital Transformation Strategy for the period April 2017 to March 2020.

The vision for TEWV is to be recognised as a centre of excellence and to place service users at the centre of all we do. To achieve this, the Trust needs to have in place a Digital Transformation Strategy that delivers the internal, local and national digital agenda.

This document provides a refresh of the previous Information Strategy and takes into account changes to external drivers since 2015.

The Trust's Digital Transformation Strategy vision is "to provide a cultural and digital environment that enables transformation of care delivery to service users and carers". In order to maximise this environment we need to ensure the alignment of our "**people, process and technology"**.



- People- leadership and engagement, particularly in clinical teams are necessary for improvements to care delivery
- Process- these need to be clear, consistent and recovery driven processes of care to ensure that improvements to care delivery are widespread and deliver quality and efficiency benefits
- Technology- this will be designed to support processes and people to enable improvements to care delivery that is widespread, consistent and delivers efficiency benefits

In order to maximise the benefits of this approach it is essential that all digital developments are co-produced.

This strategy will build on the already firm foundations that are in place in respect of technology, lean management and leadership to ensure the Digital Transformation programme of initiatives continues to support the organisation in delivering the Trust business plan priorities.

Should you require any further information on the detail of the Digital Transformation Strategy then you should contact Drew Kendall, Director of Finance and Information (drew.kendall@nhs.net) or Dr Mark Lovell, Chief Clinical Informatics Officer (mark.lovell@nhs.net).

D Kendall

Director of Finance and Information

Dr Mark Lovell Consultant Child and Adolescent Learning Disability Psychiatrist & Chief Clinical Informatics Officer (CCIO) for TEWV

Contents

1. Where are we now

The TEWV Digital Transformation Strategy aims to deliver an excellent, well supported informatics infrastructure and resources to enable and support delivery of TEWV's strategic vision.

The following goals were identified in the Information Strategy (2015-2017) written in 2015 and these have been reviewed for relevance in the new Digital Transformation Strategy:

- integrate information technology and the use of digital information into the culture of the organisation to inform and improve the way we deliver Trust services to the populations we serve;
- reduce paper centric processes over a period of time and replace with electronic workflows, digital templates and e-forms to enable staff to reduce processing time and waste within current processes;
- improve communication of digital information to GPs and social care and other partner organisations by linking external systems to the Trust's electronic care record;
- introduce safe, secure means of digital communication between service users and those staff delivering their care, including online access to appointment booking, care records and online consultations
- provide a reliable, secure infrastructure that enables better accessibility to information for all staff from wherever they work (including mobile workers);
- ensure that our data and information is held securely and conforms to data and record keeping standards.

The *current* strategy has already delivered the following:

- the development of the Paris electronic care record with the establishment of Paris Connect which links Paris to GP systems and pathology laboratories across the patch. This has allowed us to increase the number of e-discharge letters being sent to GPs with an end of year figure of **76%** of Inpatient discharge letters being sent electronically.
- the roll out of a new, upgraded network infrastructure (COIN) to improve connectivity and network speeds with **87%** of Trust **sites** migrated to the new network that provides increased download and upload capacity and speed. [The remaining 7 sites are accessed via other networks or dedicated links]
- the implementation of a remote access solution for remote and mobile workers allowing secure access to the Trust network from non-Trust sites and non-Trust devices, with **25 GP surgeries** having remote secure access to the Trust network and Paris using non-Trust devices
- expansion of Trust WIFI across the patch with **64** trust sites having flexi-net (WI FI) access
- introduction of guest WIFI for business visitors with **2317** registered users since its implementation (**implemented in December 2015)**

- expansion in the number of mobile devices such as smart phones and laptops enabling mobile working with **7422 PCs/laptops** in use and **1684 smartphones** registered to trust staff
- delivery and ongoing development of Trust Business Intelligence solution (IIC) with **3424 unique users** logging into the IIC over the last 12 months
- expansion in the use of audio and video conferencing enabling smarter working and less travel with an **increase of 40% usage** of audio and web based conferencing by the final quarter of 2016/17 equating to **1758 instances** of use.
- development of Recovery Online- an online resource with a learning management system for patients and staff focused on recovery

This progress along with the updated analysis of the internal and external environment provides a firm foundation upon which to deliver the 2017-20 Digital Transformation Strategy.

In 2015 the Trust undertook a self-assessment of our Digital Maturity. This identified three key areas for improvement:

- Leadership and governance
- Clinical engagement
- Interoperability between systems

The work that has been undertaken since to improve in these areas includes the following:

- Information department restructure to align with clinical and corporate services strategic priorities- with more staff focused on supporting co-production
- Appointment of Chief Clinical Informatics Officer- who is a Consultant Psychiatrist for Child LD in TEWV
- Development of a Digital TEWV ("tube") map showing interconnections of different technological developments and trust strategic programmes
- Review of Trust governance processes for the Digital Transformation Programme with alignment to Trust strategic programmes
- Review of engagement strategy underway to align clinical staff with technology staff to co-produce new system designs to support standardised clinical processes
- Negotiated new Paris ePR contract that includes new software and hardware to support the delivery of the Digital Transformation Strategy

This new Digital Transformation Strategy aims to build on these foundations by ensuring future initiatives to support the Trust's strategic objectives align people, processes and technology developments. The new programme management approach recently approved by EMT, seeks to align all key strategic programmes so that the interdependencies between programmes can be identified and managed appropriately.

2. Environmental Analysis and the drivers for change

In developing this strategy the Trust has considered and assessed the relevant government and regulatory policies in order to determine the likely level of change in the following fields during the lifetime of the strategy:

- Political
- Economic
- Social and Demographic
- Technological
- Legal and Regulatory
- Environmental

This has built on the work done by the Trust when compiling the Trust Business Plan**. (Appendix 1)**

Key areas of the PESTLE that the Digital Transformation Strategy will focus on include:

- Supporting the implementation of the 5 Year Forward View for Mental Health by enabling clinicians to work digitally from any location including GP practices and local authority buildings (P1)
- Supporting the PPCS work stream in providing consistent clinical care and services by co-development of electronic systems that support standardised work and information reporting systems that report variations to standard work (E4)
- Improve access to services for patients by providing an online platform for online booking of appointments and online consultations (S3)
- Implementing co-developed digital solutions for clinicians to support National and Local Digital agenda of improving efficiencies and standardised care. (T1)
- Ensuring the Trust is compliant with national and local reporting requirements including MHDS

2.1 National position

The Next Steps on the Five Year Forward View outlines a 10 point plan for the next two years to increase efficiency in the NHS. One of the key enablers identified in the report is how trusts can harness technology to deliver efficiencies and improvements in healthcare delivery. In particular there is emphasis upon[1]:

- Enabling patients to access online booking for appointments
- Ensuring the right information is available to clinicians wherever they are
- Increasing the use of approved apps for patients to manage their own health care
- Ensuring all digital technology is underpinned by secure infrastructure and systems by achieving the Cyber Essentials Plus Standards

[1] Next Steps Five Year Forward View March 2017

2.2 Overview of TEWV Foundation Trust

TEWV provides a range of inpatient and community mental health and learning disability services for approximately 2 million people of all ages living in County Durham, Darlington, the four Teesside boroughs of Hartlepool, Stockton, Middlesbrough and Redcar and Cleveland, the Scarborough, Whitby, Ryedale, Hambleton, Richmondshire, Selby and Harrogate areas of North Yorkshire, the City of York and the Wetherby area of West Yorkshire. Our specialist services also serve other local health economies.

The expanse of the Trust patch means that we have a variety of different connectivity needs ranging from rural working where mobile and remote working is essential but often problematic due to the poor mobile reception in those areas, to inner city areas where signal strength is good and there are multiple options available to connect to the network.

Trust services are also delivered in a variety of different settings such as patient homes, local authority buildings, educational establishments, police stations and acute hospitals as well as our own estate.

Because of this we believe that there is not a *one size to fit all* and so are adopting a user profile approach to the information technology services we deliver. Dependent upon the need of the team or the user we aim to have a range of options that we can customise to meet their connectivity needs. This will be underpinned by a dedicated team of staff with knowledge of a variety of technology products who can help support clinicians get the best use of the technology available.

3. Our Vision – where do we need to be

The Trust's vision is:

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

The Digital Transformation Strategy aims to support the Trust vision by working together with service users, staff, partners and commissioners to identify better ways to use technology to deliver a quality service.

Information Technology – Working together supporting everyone.

We will engage with service users, clinical and corporate teams, commissioners and partner organisations to develop and co-produce technology solutions to achieve our digital transformation objectives. We will work and support staff to enable more efficient use of time and improved ways of delivering services digitally to our service users.

4. Objectives

The Digital Transformation Strategy aims to deliver co-produced information technology developments and support in the following key areas:

4.1 Digital record keeping

We will improve digital record keeping by delivering the following initiatives:

- improve clinical electronic record keeping systems to support Trust strategic programmes including: Purposeful and Productive Community Services (PPCS), Clinical Pathways, Model Wards and Recovery. In addition work on the Paris New ways of Working (NWoW) to co-develop more intelligent system design to support the Care Programme Approach
- reduce paper centric processes utilising work flow engines in systems
- improve non-clinical record keeping systems by utilising work flow engines and electronic record solutions
- introduce electronic forms and electronic approval workflow to replace paper forms
- make available a digital input device for every clinician designed to support different ways of working (mobile, voice driven, phone, etc)

Scorecard Measures:

1. **All specialty care plans to be developed within electronic care record that follow the patient by 2018**
2. **100% of MHA paperwork to be scanned into the electronic record by 2019**
3. **50% reduction in printing in the Trust by 2020**
4. **100% of clinicians having a digital device available at the point of care that can be used to access the patient record by 2020**
5. **All clinical staff to be able to access pathology results via Paris and order results via Paris by end of 2018**

4.2 Communication and information sharing

We will improve communication and information sharing by delivering the following initiatives:

- Expand and introduce E-discharge and e-communications initiative using Paris Connect
- Implement E-referrals Service
- Develop patient portal for service users to have access to their Care Plan online, online appointment booking and online consultations and support
- Develop policies and protocols to increase use of electronic contact and correspondence with service users (NHSmail texting, email, social media tools)
- Develop the Recovery College Online to provide service users access to online tools and information to support and maintain their recovery
- Work with NHS England to use open source mental health apps with a kite mark e.g. for therapy and intervention
- Develop a Community Sharing Portal so that TEWV systems can connect and exchange information with external health and social care systems to ensure

safer sharing of key clinical information between health care providers (interoperability)

- Develop integrated digital care plans through increased collaborative work with the CCGs and other service providers, including social care to provide view access to care plans or key elements of each other's care plans

Scorecard measures:

1. **All correspondence to be digitally available to be sent to GPs and other partner agencies electronically by 2020**
2. **All service users to have access to their Care Plan online by 2019**
3. **All service users to have the choice of receiving communications about their care electronically by 2018**
4. **All service users to have access to a range of information and tools to support self-care by 2019**
5. **All service users to have access to online consultations and appointment booking by 2020**
6. **All referrals from GPs to be received via the Electronic Referrals Service by 2019**
7. **Reduction in printing and postage costs by 2019 from baseline position 2017**

4.3 Proactive analysis of clinical, performance and governance information

We will improve analysis of information by delivering the following initiatives:

- Improve provision of clinical, performance and governance information on a near real time basis to managers to enable more effective decision making and support quality improvements
- provision of training on the use of the IIC to enable them to incorporate it into their daily lean management processes

Scorecard measures:

1. **100% of Trust clinical staff to have access to their key service and patient information in near real time by 2019**

4.4 Efficient ways of working

We will enable more efficient ways of working by delivering the following initiatives:

- Improve the digital infrastructure of the Trust including devices that enable mobile and dispersed working, more efficient data collection and can be used in a variety of applications with service users including therapy and gathering feedback
- Develop further 'meet often travel less using technology' - e-learning and video conferencing solutions to reduce unnecessary travel supporting the Trust's objective to reduce travel
- Provide simpler access to Trust systems via single authentication credentials
- Expand the sharing of wireless capability between NHS and social care providers

Scorecard measures:

1. **All clinical staff have available to them the appropriate device for their ways of working by 2020**
2. **All staff have access to technology to enable them to reduce their travel time for meetings and training by 2019**
3. **Reduction in the time taken to input data into the electronic record by 2019 across all clinical specialties**
4. **Reduce the number of password resets received for access to Trust systems**

4.5 Real time clinical decision support systems

We will provide real time decision support by delivering the following initiatives:

- Real time clinical decision support and diagnostic interaction within PARIS by development of e-pathways and decision support
- the development of analytics of unstructured data such as case note entries
- implement SNOMED for mental health data with NHS Digital by 2020
- implementation of near real time data from Paris into the IIC to inform management huddles on key clinical metrics

Scorecard measures:

1. **100% of clinical pathways available digitally by 2020**
2. **Real time data reporting to be available by 2019 to all staff who access IIC**

4.6 Maintaining and delivering a safe, secure and reliable service to our customers

We will maintain a safe and secure reliable digital service by delivering the following initiatives:

- Ensure robust practices are in place to support the cyber security of Trust systems, infrastructure and technology
- Implementing a process for monitoring cyber threats and taking action accordingly to prevent threats to Trust systems and technology including scheduled and unscheduled maintenance of those systems
- Implementing a robust change control process to ensure changes to systems and technology do not have unintended consequences for end users and the Trust as a whole
- Support the preparation of clinical safety cases for changes to clinical systems and technology

Scorecard measures:

1. **Achieve the Cyber Essentials Plus Standard by 2018**
2. **All staff who access trust systems to be have access to cyber security awareness information/training by 2018**
3. **Ensure that all changes to Trust information technology infrastructure and trust systems adhere to industry recognised security standards by 2019**

These developments will enable the Trust to deliver electronic referrals and discharges, patient choice and involvement, increase accessibility for a more mobile workforce, improve standards of electronic record keeping whilst reducing risks and improving the circulation of information about how we are meeting our service delivery objectives.

Appendix 2 shows the strategic objectives and the links to current or planned developments on the Trusts Digital Transformation Programme Plan.

5. Outcomes Scorecard

The scorecard below includes the outcomes to be measured for future planned initiatives within the strategy that have not yet started. They are included as placeholders so when these initiatives commence the baseline position and targets will be agreed. Some of these indicators are also enabling pieces of work for other strategic programmes and as such the pace of implementation and return needs to be agreed with the programme owners. Therefore the targets for these initiatives are not yet agreed and will need to be added once the plans are agreed. **This scorecard will be reviewed monthly as part of the Digital Transformation Programme governance processes.**

Strategic Theme	Strategic Metrics	Base-line 16/17	Q'terly Target	Q4 17/18	17/18 Target	18/19 Target	19/20 Target
Digital Record Keeping	All specialty care plans to be developed within electronic care record that follow the patient by 2018	0	1	1	1	5	5
	Reduction in printing in the Trust by 2020: Measured by number of pages printed in B&W and Colour from baseline position.	B&W 126927 pm Colour 31875	10%	10%	10%	50%	75%
	All community team clinicians having a digital device available at the point of care that can be used to access the patient record by 2020. Measure of number of devices per team that will be agreed via PPCS IT workstream.	To be calculated	tbc	tbc	tbc	tbc	tbc
	100% of MHA paperwork to be scanned into the electronic record. Baseline positon as at end Q4 31/3/17.	0	25%	100%	100%	n/a	n/a
	All clinical teams to be able to access pathology results via Paris and order results via Paris by end of December 2018	0	4	4	4	All	All

Strategic Theme	Strategic Metrics	Base-line 16/17	Q'terly Target	Q4 17/18	17/18 Target	18/19 Target	19/20 Target
Communication and information sharing	All service users being able to access care plans online or digitally by 2019	0	n/a	n/a	n/a	Digital /online care plans available for all service users	Digital /online care plans available for all service users
Communication and information sharing	Numbers of patients requesting access to Patient Portal: Measured by patient requests/total patients on caseloads	0	5%	n/a	n/a	20%	50%
Communication and information sharing	Numbers of patients booking online appointments. Measured by number of non-urgent appointment slots booked online/total non-urgent appointment slots available	0	10%	n/a	n/a	10%	40%
Communication and information sharing	% of patients who request to receive SMS from their clinical team. Measured by number of patients receiving SMS/total patients	tbc	10%	10%	10%	40%	80%
Communication and information sharing	% of patients who request to receive emails from their clinical team. Measured by number of patients receiving emails/total patients	0	10%	0	0	20%	60%
Communication and information sharing	All correspondence to be made available digitally to GPs. Measured by total number of e-letters developed and on Paris/total number of GP letters required	1	1	tbc	tbc	tbc	tbc
Communication and information sharing	All correspondence to be made available digitally to partner agencies by 2020	0	tbc	tbc	tbc	tbc	tbc

Strategic Theme	Strategic Metrics	Base-line 16/17	Q'terly Target	Q4 17/18	17/18 Target	18/19 Target	19/20 Target
Communication and information sharing	Number of community teams who are offering online consultations with service users.	0	n/a	n/a	0	12	tbc
Communication and information sharing	All referrals to be received digitally via E-Referral Service. Measured by number of teams where e-referrals has been implemented.	0	tbc	0	0	tbc	tbc
Communication and information sharing	Reduction in Trust postage costs to reduce from baseline position in 2017	tbc	tbc	tbc	tbc	tbc	tbc
Real time decision support	100% of clinical pathways developed and in use within Paris. Measured by total number of e-pathways on Paris/total number of pathways available.	0	2	0	0	4	8
Real time decision support	All trust clinicians to have access to their key service/team/patient information in near to real time by 2019	0	tbc	0	0	tbc	tbc
Proactive analysis of clinical, performance and governance information	Number of users actively using IIC dashboards, favourites and my metrics in clinical teams	2000	10% increase	3000	4200	5880	6000
Efficient ways of working	Number of clinical community staff trained to use mobile tethering for laptops during clinical appointments in non-Trust buildings	Needs to be calculated	10% increase	tba	tba	tba	tba
Efficient ways of working	Increase in mobile data usage by community teams measured from baseline position	Needs to be calculated	10% increase	tba	tba	tba	tba

Strategic Theme	Strategic Metrics	Base-line 16/17	Q'terly Target	Q4 17/18	17/18 Target	18/19 Target	19/20 Target
Efficient ways of working	Number of staff using technology that enables them to "meet" without travel by 2019. Measured by number of audio calls and web meetings compared to Q1 17/18 and	To be calculated	To be calculated	tba	tba	tba	tba
Efficient ways of working	Decrease in mileage for teams. Measured by comparison from baseline mileage Q1 17/18	tbc	tbc	tbc	tbc	tbc	tbc
Efficient ways of working	Number of Inpatient teams using e-prescribing solution from within Paris	0	2	n/a	n/a	8	16
Efficient ways of working	Reduce support calls in relation to password re-sets to reduce waste and idle time for trust staff	1500	10%	1350	1350	900	0

6. Glossary

Term	Description
EPR	Electronic Patient Record
MHDS	Mental Health Dataset
COIN	Community of Interest network
VDI	Virtual Desktop Interface
MHA	Mental Health Act
IIC	Integrated Information Centre
SNOMED	**SNOMED** CT (Systematized Nomenclature of Medicine -- Clinical Terms) is a standardized, multilingual vocabulary of clinical terminology that is used by physicians and other health care providers for the electronic exchange of clinical health information.

7a. Appendix 1 – PESTLE

	Description of the issue	What could the consequence be?	What are we doing already?
Political 1	Implementing the 5 Year Forward View for Mental Health	Potential new funding in primary care psychological therapies, employment support for people with MH etc. Softening of purchaser-provider split through new models of care (NMOC).	CAMHS T4 New Models of Care (NMOC) pilot; bid for Forensic NMOC pilot and Accountable Care Partnership. Intensive Team Support clinical lead identified Pilots of TEWV clinicians placed within GP practices in South Durham and Catterick Supporting the implementation of the 5 Year Forward View for Mental Health by enabling clinicians to work digitally from any location including GP practices and local authority buildings
P2	Prime Minister's priorities – Theresa May known to want to prioritise CAMHS (though with emphasis on schools) and workplace MH. Both Conservative and Labour election manifestos promise extra money for health and social care, but not at the historic 4% p.a. uplift that health economists argue is necessary to meet increasing demand	Theresa May known to want to prioritise CAMHS (though with emphasis on schools) and workplace MH. Some protection for MH budgets due to NHSI monitoring of the issue Continued pressure on NHS budgets regardless of June 8th election result	Recent investment by CCGs into 24/7 CAMHS Crisis & Intensive Home Treatment services and seeking better VFM from specialist CAMHS spend through NMOC Planning to deliver to NHSI set control totals Planning to achieve CRES requirements on a recurring basis
P3	Sustainability and Transformation Plans – TEWV split over 4 STPs,	Was a danger of STPs looking for one MH provider each – this has been mitigated in	Engaging with the established STPs and influencing their plans.

	Description of the issue	What could the consequence be?	What are we doing already?
	which have lack of any focus on MH. The most advanced STPs will aspire to be an Accountable Care System (ACS) and work as a locally integrated health system, taking on clear collective responsibility for resources	north of patch by moves to create one STP for whole of North East and North Cumbria ACSs may lead to establishment of Accountable Care Organisations. This is where commissioners have a contract with a single organisation for the majority of health and care services.	Support the development of the Accountable Care Partnership across Durham and Teesside currently and other models of care as they develop.
P4	End of nursing bursaries	Pressure on providers to subsidise courses themselves or to offer starting bonuses. Possible nursing shortages if numbers on courses fall	TEWV has considered paying recruitment bonuses on some parts of our patch and now only offers permanent nursing post contracts even when the post is temporary.
P5	Terrorism / e-crime	Pressure on services / financial loss. Also reputational damage if a TEWV service user were ever to be involved in any such incident.	Emergency planning IT security measures Prevent duties awareness training for relevant clinical staff
Economic 1	NHS Financial position Funding and Efficiency – the 5YFV – Next steps outlines a 10 point plan to increase efficiency in the NHS. This includes: Reduce hospital beds Reduce temporary staffing costs Participate in the Carter programme for procurement	Latest provider deficit figures are c.£800m CCGs also under pressure with Vale of York in Special Measures The Trust has already delivered recurrent savings year on year in most of these areas and therefore some of the controls and targets set could be a challenge and therefore bring reduced autonomy and increased monitoring by NHSI.	Planning to deliver to NHSI set control totals Planning to achieve CRES requirements on a recurring basis Plans in place and trust goals set to deliver purposeful and productive services e.g. PIPA, PPCS Providing information at a national level on

	Description of the issue	What could the consequence be?	What are we doing already?
	clout Reduce unwarranted variation in clinical quality and efficiency Reduce the cost of corporate services and admin		benchmarking corporate services. Watching brief on others who have already gone down the contracted out services route. Ensuring the Trust is compliant with national and local reporting requirements including MHDS
Eco 2	Pensions	The NHS Pension scheme was amended by the Coalition government and contributions made since April 2015 are on a career average, not final salary basis. It is planned that employers' contributions will rise in 2019 from 14.38% to 16.37% and a revaluation of the scheme is due next year. Post 2022 "protection" runs out and the normal retirement age will be tied to the state pension age (which will be 67 or higher). To reduce running costs, the Department of Health is proposing to transfer administration of the scheme to health providers. If this takes place there could be a £200k additional cost to TEWV. If employers and employee contribution rates continue to rise there may start to be issues around sustainability.	Retire and Return scheme approved by EMT Increases in cost constantly reviewed to ensure efficiency requirements are understood
Eco 3	Apprentice Levy	An apprenticeship levy for all employers commences in April 2017. Public sector organisations will be expected to have apprentices constituting 2% of workforce. There is a financial pressure of approx.	EMT has been considering options for mitigating this levy and have a digital drawdown account in place to ensure the Trust maximises the amount of levy that can be offset against existing training schemes, as well as future new schemes through the regional

	Description of the issue	What could the consequence be?	What are we doing already?
		£1m although this pressure applies to all employers and so all providers will be affected.	Apprentice Levy Group.
Eco 4	Impact of choice – patients can choose where they want to receive treatment	Patients, particularly those close to the boundaries of neighbouring providers could choose to go out of Trust, or internally out of locality creating pressure on both service standards and financially.	Plans in place and trust goals set to deliver purposeful and productive services in a standard way. This should reduce unwarranted variation in clinical quality and efficiency, therefore reducing risk of patient choice impact. Supporting the PPCS work stream in providing consistent clinical care and services by co-development of electronic systems that support standardised work and information reporting systems that report variations to standard work
Eco 5	Increased pressure and expectation in social care and independent sector providers	This issue could result in increased pressure in NHS services particularly in the transfer of patients in older peoples services and LD to more appropriate care settings	Engaging in the Transforming care agenda and delivery of enhanced community care in older persons services.
Social 1	Brexit	The status of EU nationals living in the UK is still unclear (and vice versa). This could impact on TEWV staff from the EU. The value of the pound has fallen by approx 12% against the Euro and US Dollar. This is feeding through to inflation, which we see in products such as IT equipment and software Economic growth has continued at around 0.6% pa but has slowed in the last quarter.	The Trust has communicated that it values our EU staff, We are running a medic recruitment campaign in India Inflationary pressures will continue to be reviewed and CRES requirements set accordingly.
S2	Increased referrals (due to reduced stigma around MH;	Increased demand for services but no additional income.	Introducing more sophisticated monitoring of referral trends in summer 2017

	Description of the issue	What could the consequence be?	What are we doing already?
	possible increased prevalence due to economic and social issues; and reduced capacity of primary care to cope with "borderline" patients		Continue to work with commissioners to develop services fit for the demographics of the population the Trust serves and meet MH minimum investment standards. PPCS / QIS work to increase team efficiency to support patient flow and demand management.
S3	Patient expectations e.g. Individual / personalised care Access to services i.e. expecting services closer to home 7 day services – work life balance	Increased demand for services but no additional income.	PPCS / QIS work to increase team efficiency to support patient flow and demand management. Enhanced monitoring of patient experience Improving access to services Improve access to services for patients by providing an online platform for online booking of appointments and online consultations
Technological 1	NHS Digital Roadmap	TEWV bid for Digital Exemplar funding was unsuccessful but facilitated the development of a new IT Strategy and Digital Programme.	Clear 18 month development timeline for PARIS in place. Clinicians engaging in PPCS observations will help define future requirements. PPCS recognises that financial savings will rely on staff time spent on data entry to be reduced. Implementing co-developed digital solutions for clinicians to support National and Local Digital agenda of improving efficiencies and standardised care.
Legal / Regulatory 1	CQC - new Inspection Strategy says that inspections and intelligent monitoring will remain core to their approach, but that their resources will be directed more towards poor services and away from those where "care	CQC may continue to make binding recommendations which TEWV would regard as poor value for money	Seeking to increase CQC understanding of TEWV and of QIS. Develop estate solutions that allow us to exit sub-standard facilities in Northallerton, York and Harrogate which are not owned by TEWV.

	Description of the issue	What could the consequence be?	What are we doing already?
	quality is good and likely to remain so"[2]. The CQC's Board have stated that, while it recognises that providers are facing a "tight financial environment", it will not be "flexing" its regulatory approach in response, and will not "inflate" ratings to assist NHS cost-cutting		Mock inspection programme
L2	Safe Staffing	There is a risk that any review of staffing establishments in line with national standards and evidence based guidance (once produced) will be unaffordable and / or impossible to implement due to shortages of qualified nursing staff.	Identified as a TEWV Business Plan Strategic Priority. Programme Manager appointed June 2017.
Environment 1	In December 2015 a new global climate deal was signed in Paris. This committed governments to seeking to limit global temperature rises to 1.5 degrees Celsius. The implication of this is that the global economy will need to be carbon neutral by 2050, and possibly earlier. Although the USA federal government is seeking to withdraw from the agreement, most other developed and developing	During 2016 global temperature records have been broken several times. One of the likely impacts of this for the UK will be increased instances of intense rainfall. There was such a rainfall episode over Christmas 2015 which resulted in widespread flooding – including in York where Bootham Park's basement flooded and transport and telephony in the City were seriously affected for several days. This could lead to: Operational service delivery issues	Considering flood risk in our York hospital options appraisal Some use of ground source heat pumps and solar panels in TEWV estate.

[2] Shaping the Future: CQC's Strategy for 2016-2021 p6 (www.cqc.org.uk/ourstrategy)

	Description of the issue	What could the consequence be?	What are we doing already?
	nations around the globe (and large US states and cities) are maintaining their support for it	Estate rectification costs More expensive design requirements for new builds Increased insurance costs Increased energy costs Public pressure to demonstrate commitment to carbon reduction (not currently a political priority but may increase, particularly if prosperity increases)	

7b. Appendix 2 Strategic Objectives

The table below shows the strategic objectives and the links to current or planned developments on the Trusts Digital Transformation Programme Plan.

Strategic Objective	Description	Planned or in-flight project	Timescale
Digital Record Keeping	improvements to clinical electronic record keeping systems to support the clinical transformation work undertaken within Trust strategic programmes	NWoW- safety summary, initial assessment on Paris- record follows the patient so removes duplication	In place-delivered in 2016 Further training and support ongoing for end users
		Support for PPCS IT workstream reviewing content and use of initial assessment	June 2017- end user support for initial assessment process in Paris including use of tethering to support mobile working
		Care planning process review workshops- to identify improvements to e-care plans	June-July 2017- process review workshops to improve current care plan design on Paris
		E-pathways discovery workshops	Proposed to commence in 2017 as part of new Civica contract
		e-pathways development and new user interface (Clinician Online/Patient Online)	Proposed to commence in 2017/18 as part of new Civica contract
	reduction in paper centric processes utilising work flow engines in systems	Proposed Civica development for workflow in Paris	Proposed to commence 2018/19
		EDRM solution to provide workflow for corporate records	Proposed to commence 2018/19
	improvements to non-clinical record keeping systems	EDRM solution to provide workflow for corporate records	Review of requirements 2017/18
	electronic forms and electronic approval workflow to replace paper forms	Proposed Civica development to implement e-forms and workflow in Paris	Proposed to commence 2018/19
	A digital input device for every clinician designed to support different ways of working (mobile, voice driven,	Next Generation Device project- to provide device agnostic access to	In flight- virtual desktop being piloted across trust.

Strategic Objective	Description	Planned or in-flight project	Timescale
	phone, etc)	network	Mobile solutions being scoped currently
		Digital Dictation devices	Implemented in 2014
		Voice integration in Paris as part of new programme	Proposed as part of new contract 2018/19
Digital Communication & Information Sharing	correspondence with GPs to be electronic	e-discharge summaries	Delivered- API to GP System EMIS in place
		e-comms to GPs	Workshop to improve quality of letters to GPs with GP Communications Lead
	service users to have access to their Care Plan online	Paris/VRC programme to look at patient online access to care information	Patient Portal to be developed 2017/8
	increase in electronic contact and correspondence with service users (NHSmail texting, email, social media tools)	Current scorecard monitors usage	Delivered and in use Task and finish group to be established to look at expansion of use of current tools 2017
	service users to have access to online tools and information to support and maintain their recovery	Recovery College Online	Delivered March 2017 Programme to be scoped for further expansion of content
	work with NHS England to use open source mental health apps with a kite mark e.g. for therapy and intervention	Recovery College Online and Recovery Programme	Programme to be scoped for further expansion of content
	linking TEWV systems with external health and social care systems to ensure safer sharing of key clinical information between health care providers (interoperability)	NHS Summary Care Record and MIG viewer provides view access to patient data held in GP systems	Delivered and in use
		Paris Connect to link with pathology labs and GP systems and eventually social care	Connect is delivered and pathology pilot –June/July 2017 Expansion of connectivity possible with social care

Strategic Objective	Description	Planned or in-flight project	Timescale
	developing integrated digital care plans through increased collaborative work with the CCGs	Local Digital Roadmaps in conjunction with CCGs	Developed and in use
Proactive Analysis of Clinical, Performance & Management Information	provision of the clinical, performance and governance information on a daily basis to managers to enable more effective decision making and support quality improvements	IIC programme	Delivered and in use. Ongoing changes to make improvements in support of PPCS
	a workforce trained to be proficient in use of this management information and able to incorporate it into their way of working	Supporting Users training and support programme	New teams established April 2017
Efficient Ways of Working	improvements to infrastructure including devices that enable mobile and dispersed working, more efficient data collection and can be used in a variety of applications with service users including therapy and gathering feedback	Next Generation Device project	In-flight 2016/17
		Digital Dictation	Delivered 2014
		Voice integration into Paris and e-form development	Proposed in new contract 2018/19
	meet often travel less using technology' - e-learning and video conferencing solutions to reduce unnecessary travel supporting the Trust's objective to reduce travel	Tele and audio conferencing facilities in place. Current review of Skype for business underway for use within TEWV for staff to staff communication	In place Autumn 2017- proposals
		Online Patient Portal development as part of new Paris Contract	Proposed new contract for a Patient Portal to be developed 2017/8
	simpler access to Trust systems via single authentication credentials sharing wireless capability between NHS and social care providers	Next Generation Device project piloting single sign on – plans to roll out across trust after pilot evaluation	In pilot phase currently- planned roll out Autumn 2017
		TEWV businet – allows access to Trust WIFI for business visitors to trust premises	In place and in use

Strategic Objective	Description	Planned or in-flight project	Timescale
Real Time Decision Support	Real time clinical decision support and diagnostic interaction within PARIS	IIC development to implement new software for real time information	November 2017
		e-prescribing planned as part of new Paris contract	Q1 2018/19
		e-pathways discovery workshops to design e-pathways in Paris	2017/18 discovery workshops
	the development of analytics of unstructured data such as case note entries	SNOMED implementation as part of new Paris contract	2019/20

7c. Appendix 3 – useful links

Single Oversight Framework

Five Year Forward View

Five Year Forward View for Mental Health

Next Steps for Five Year Forward View

Item 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28 November 2017**
TITLE:	**Finance Report for Period 1 April 2017 to 31 October 2017**
REPORT OF:	**Drew Kendall, Interim Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 31 October 2017 is a surplus of £6,031k, representing 3.1% of the Trust's turnover and is £36k ahead of plan.

Identified Cash Releasing Efficiency Savings at 31 October 2017 are £1,651k behind plan for the year to date. The deterioration in month is due to slippage on CRES schemes which were due to commence 1 October 2017. The Trust has, and continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements, and has non-recurrent expenditure mitigations in place to manage this position in 2017/18.

The Use of Resources Rating for the Trust is assessed as 2 for the period ending 31 October 2017 and is behind plan due to the I&E margin being marginally behind plan. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year.

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:	**28 November 2017**
TITLE:	**Finance Report for Period 1 April 2017 to 31 October 2017**

1. INTRODUCTION & PURPOSE

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

2. BACKGROUND INFORMATION

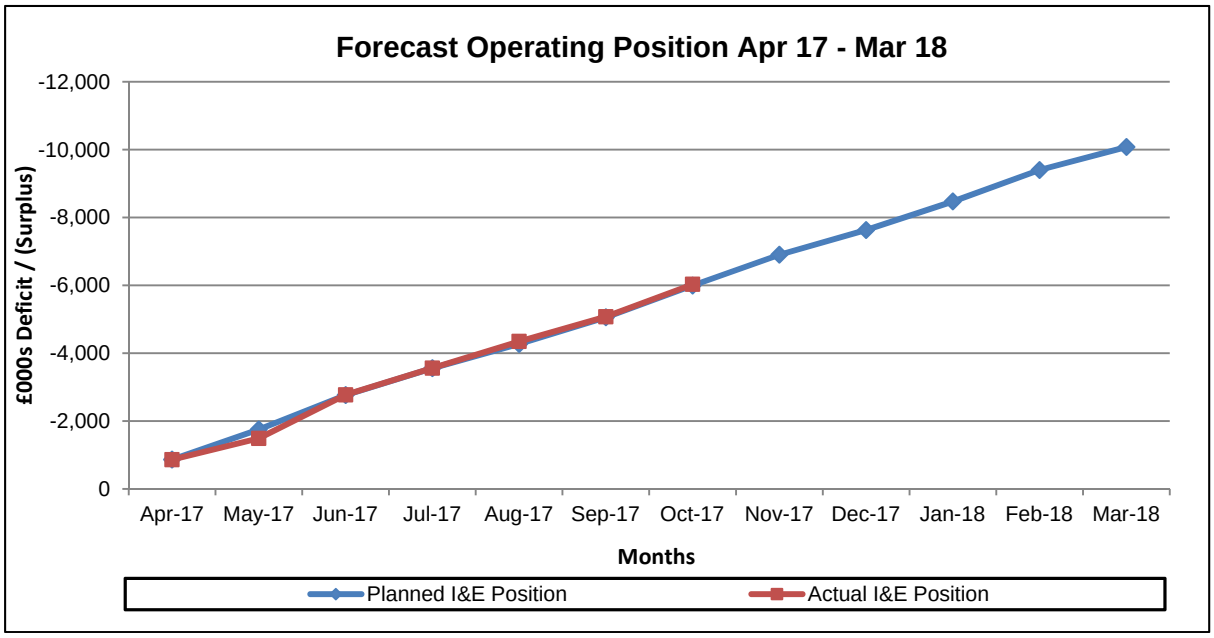
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

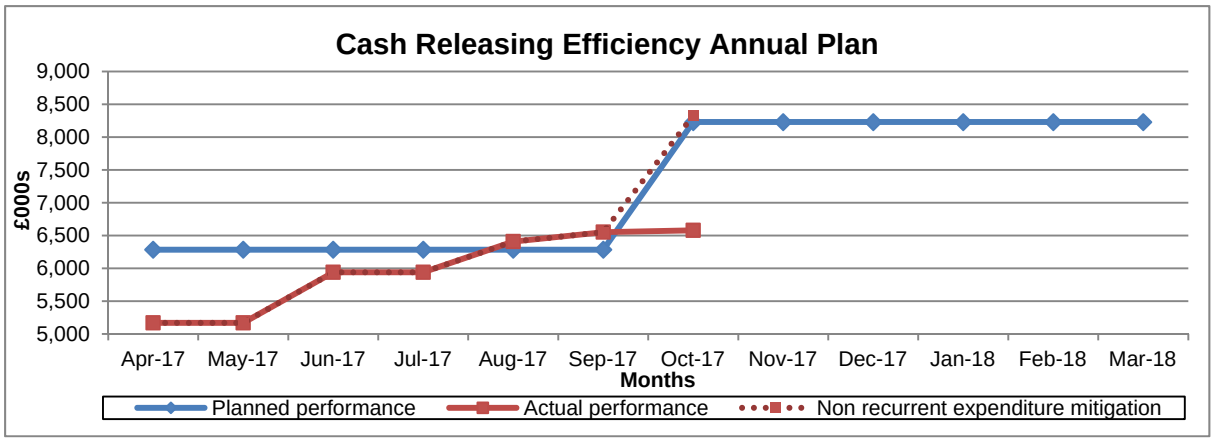
The comprehensive income outturn for the period ending 31 October 2017 is a surplus of £6,031k, representing 3.1% of the Trust's turnover and is £36k ahead of plan.

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

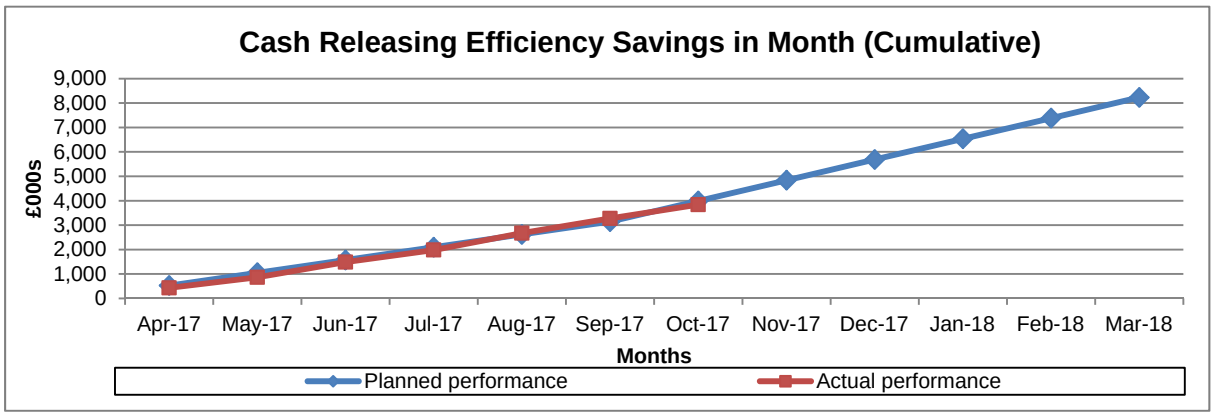


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 October 2017 is £6,579k and is £1,651k behind plan for the 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.

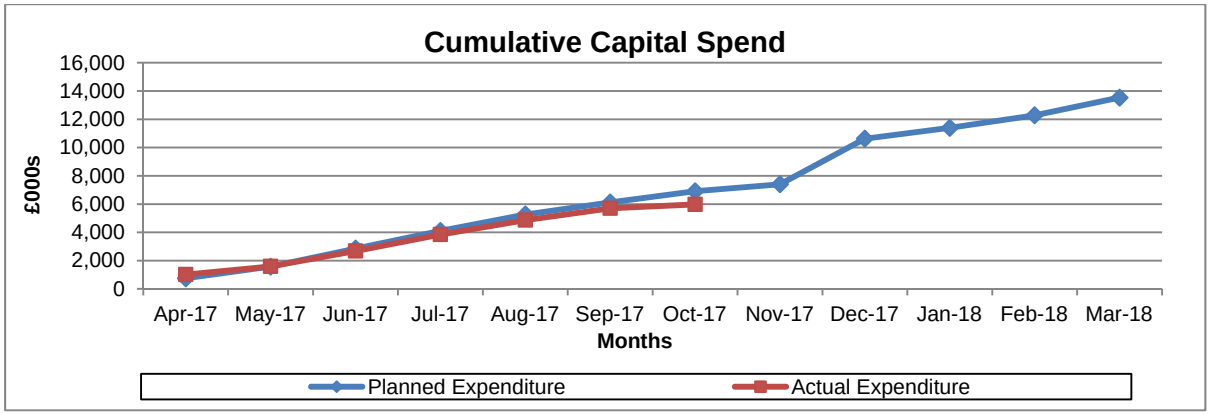


The monthly profile for CRES identified by Localities is shown below.



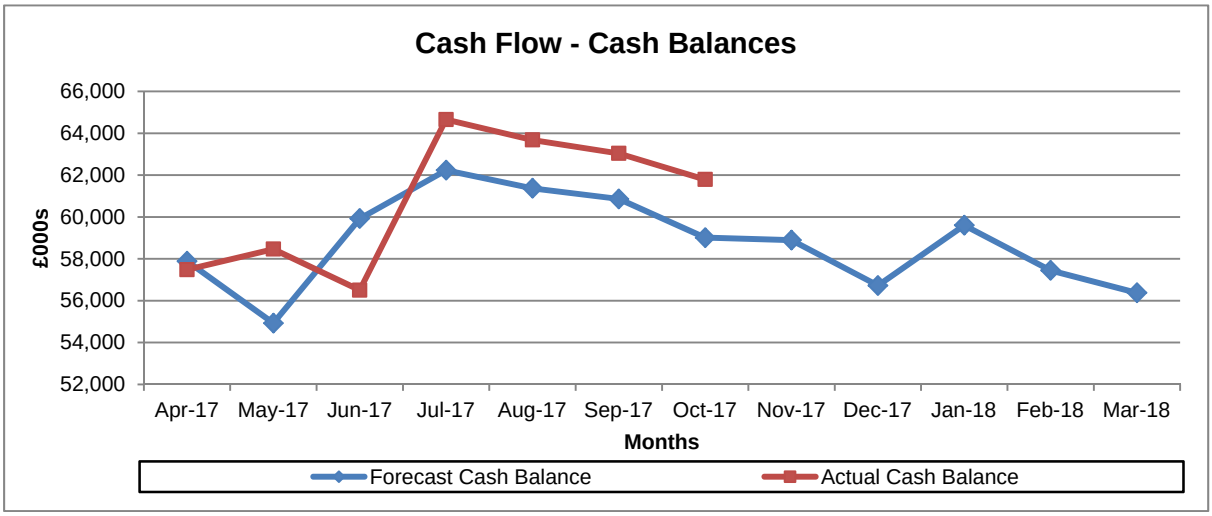
3.3 Capital Programme

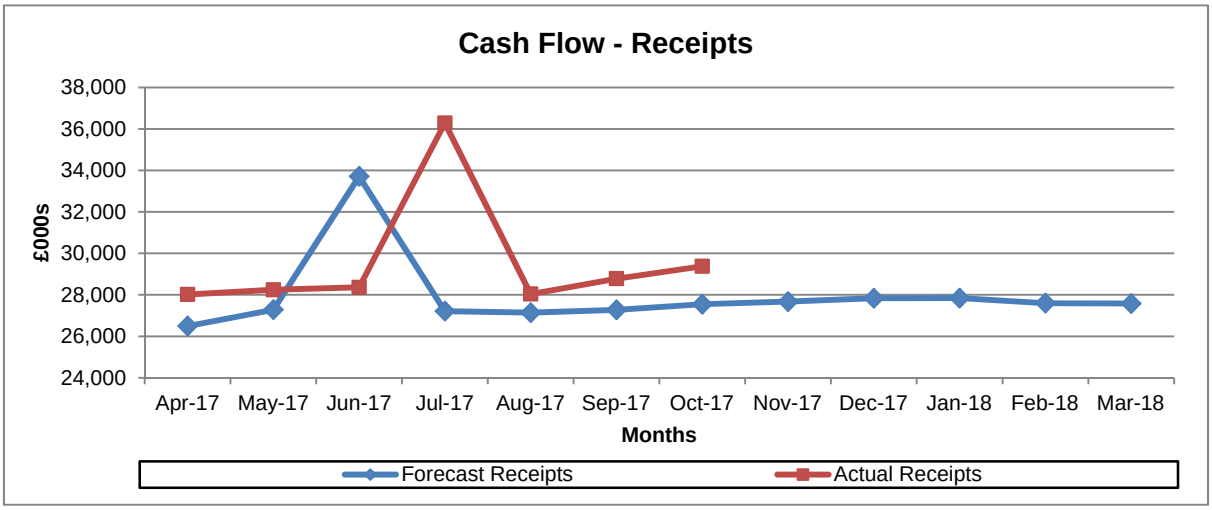
Capital expenditure to 31 October 2017 is £5,973k and is £933k behind plan due to delays against identified developments.

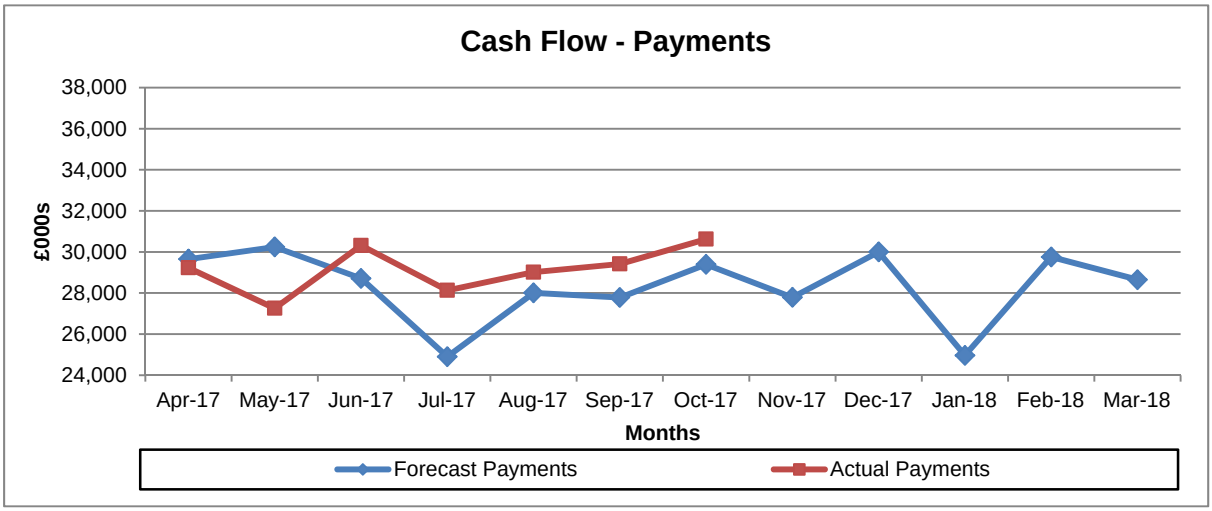


3.4 Cash Flow

Total cash at 31 October 2017 is £61,789k, and is £2,777k ahead of plan largely due to working capital variations.



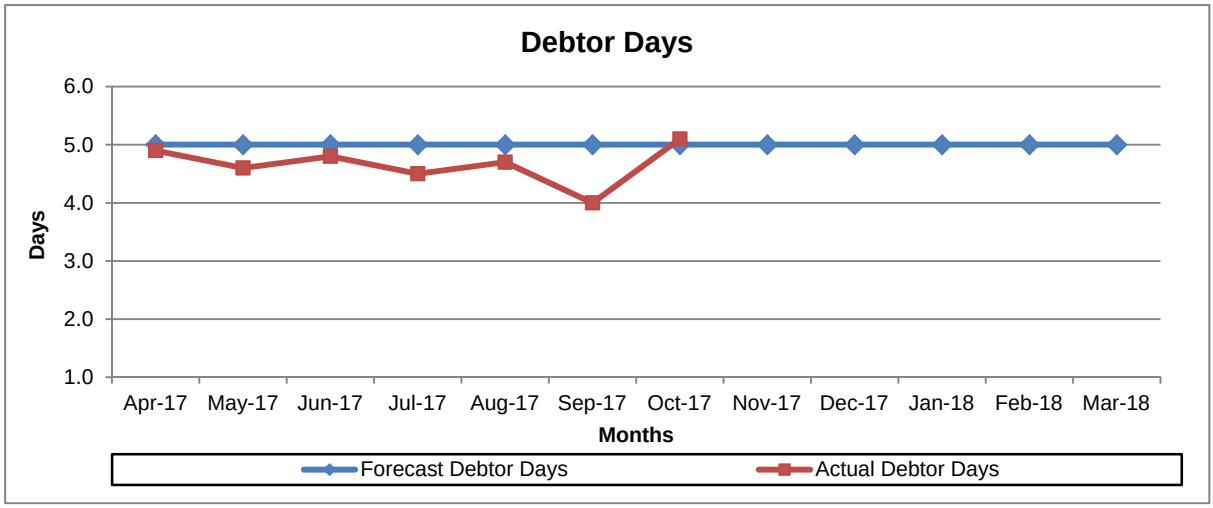




The receipts profile fluctuates over the year for 2016/17 Sustainability and Transformation Fund incentive scheme receipt. The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.

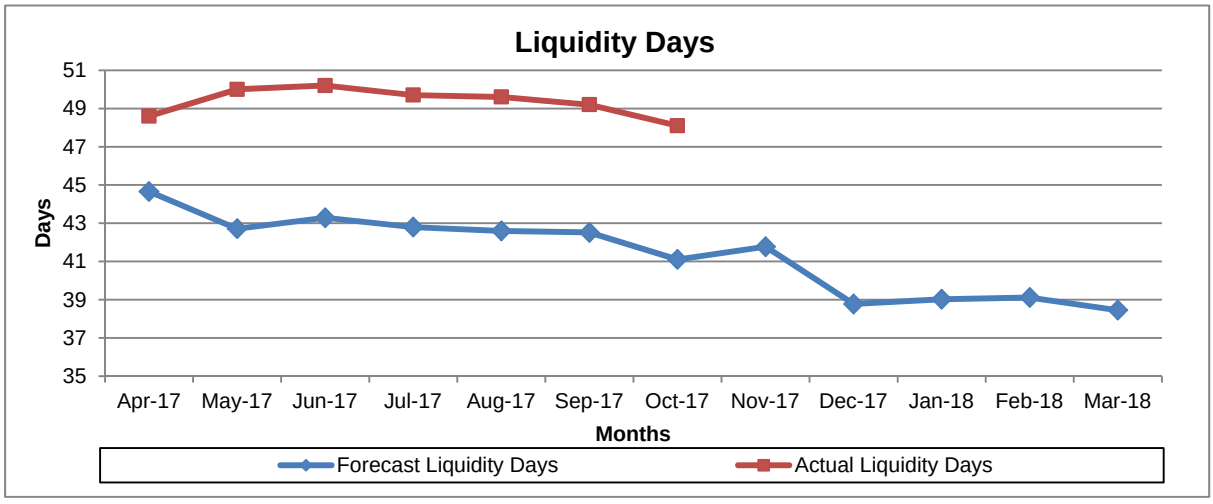
Working Capital ratios for period to 31 October 2017 are:

- Debtor Days of 5.1 days
- Liquidity of 48.3 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 56.8%
  Non NHS 30 Days – 97.1%



The Trust has a debtors' target of 5.0 days, and actual performance of 5.1 days at 31 October 2017, which is marginally behind 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.



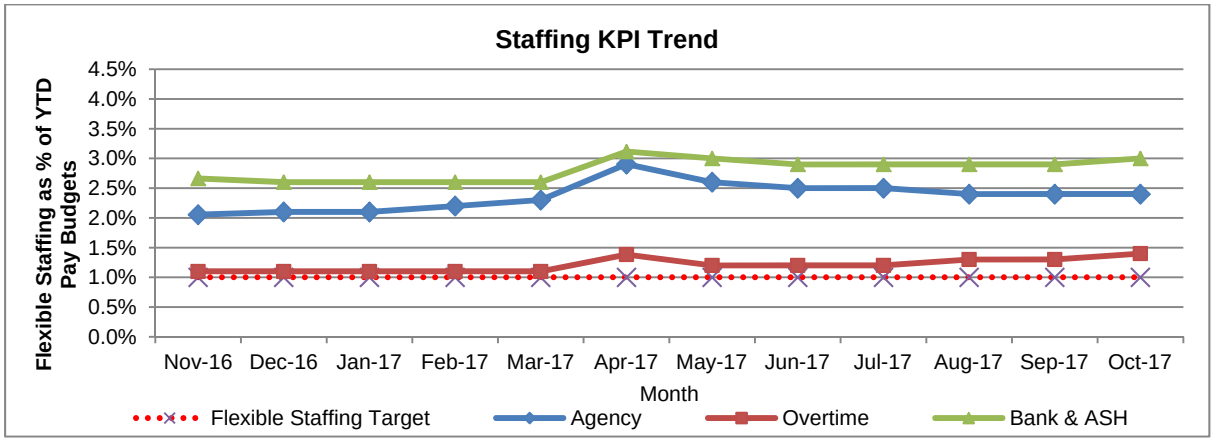
3.5 Financial Drivers

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

Tolerance	May	June	July	August	Sept	Oct
Agency (1%)	2.6%	2.5%	2.5%	2.4%	2.4%	2.4%
Overtime (1%)	1.2%	1.2%	1.2%	1.3%	1.3%	1.4%
Bank & ASH (flexed against establishment)	3.0%	2.9%	2.9%	2.9%	2.9%	3.0%
Establishment (90%-95%)	94.0%	94.2%	93.1%	93.1%	93.1%	94.3%
Total	**100.8%**	**100.9%**	**99.7%**	**99.7%**	**99.7%**	**101.1%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For October 2017 the tolerance for Bank and ASH is 3.7% of pay budgets.

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



Additional staffing expenditure is 6.8% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (49%), enhanced observations (19%), service need (14%) and sickness (11%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating is assessed as 2 at 31 October 2017, and is behind plan. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year.

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 1.44x (can cover debt payments due 1.44 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 48.3 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 3.1% and is rated as a 1.

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

3.6.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is marginally lower than the cap and is rated as a 1.

The margins on Use of Resource Rating are as follows:

- Capital service cover - to improve to a 2 a surplus increase of £3,156k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £41,056k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £4,058k is required.
- I&E margin distance from plan – to improve to a 1 an operating surplus increase of £196k is required.
- Agency Cap rating – to reduce to a 2 an increase in agency expenditure of £5k is required.

Use of Resource Rating at 31 October 2017

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%
Variance from control total	20	>=0%	-1%	-2%	<=-2%
Agency expenditure	20	<=0%	-25%	-50%	>50%

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	1.44x	3	1.37x	3	
Liquidity	48.3 days	1	41.6 days	1	
I&E margin	3.1%	1	3.2%	1	
Variance from control total	-0.1%	2	0.0%	1	
Agency expenditure	£3,593k	1	£3,598k	1	
Overall Use of Resource Rating		**2**		**1**	

3.6.7 13.38% of total receivables (£619k) are over 90 days past their due date; this is above the 5% finance risk tolerance. The Trust has received confirmation of payment for £264k of this debt. Excluding debts with confirmation to pay the ratio reduces to 7.66%, which represents 0.14% of the Trusts turnover at 31 October 2017. £194k of the remaining debt at risk is with other NHS organisations, and discussions are ongoing to arrange payment.

Internal controls have been reviewed and improved to ensure future issues are resolved before the 90 day threshold.

3.6.8 3.8% of total payables invoices (£411k) held for payment are over 90 days past their due date. This is within the 5% finance risk tolerance.

3.6.9 The cash balance at 31 October 2017 is £61,789k and represents 72.0 days of annualised operating expenses.

3.6.10 The Use of Resource Rating is forecast to remain a 2 at the end of the financial year.

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 31 October 2017 is a surplus of £6,031k, representing 3.1% of the Trust's turnover and is £36k ahead of plan.

6.2 Identified Cash Releasing Efficiency Savings at 31 October 2017 are £1,651k behind plan for the year to date. The deterioration in month is 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 a 2 for the period ending 31 October 2017 which is behind plan due to the I&E margin being marginally behind plan. The rating is forecast to remain a 2 at the end of the financial year.

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 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th November 2017**
TITLE:	**Board Dashboard as at 31st October 2017**
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 October 2017, 4 (21%) of the indicators reported are not achieving the expected levels and are red. This is a slight improvement on the 5 that was reported as at the end of September 2017. One of these indicators is showing an improving position over the previous 3 months.

There are a further 7 indicators which whilst not completely achieving the target levels are within the amber tolerance levels (which is two more than the number reported as at the end of September.)

In terms of the year to date position there are 4 indicators that are reporting red.

In respect of performance against the key NHSI operational indicators in October the Trust achieved the targets on all of the indicators including IAPT recovery where we achieve 52.12% against the target of 50%.

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

Recommendations:

It is recommended that the Board:

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

MEETING OF:	**Board of Directors**
DATE:	**28th November 2017**
TITLE:	**Board Dashboard as at 31st October 2017**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 31st October (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 October 2017, 4 (21%) of the indicators reported are not achieving the expected levels and are red. This is a slight improvement on the 5 that was reported as at the end of September 2017. One of these indicators is showing an improving position over the previous 3 months.

  It should be noted that the 4 reds are split across 3 of the 4 domains with only the Workforce Domain not having any indicators reported as red.

  There are a further 7 indicators which whilst not completely achieving the target levels are within the amber tolerance levels (which is two more than the number reported as at the end of September.)

  In terms of the year to date position there are 4 indicators that are reporting red.

- In respect of performance against the key NHSI operational indicators in October the Trust achieved the targets on all of the indicators including IAPT recovery where we achieved 52.12% against the target of 50%. We did not achieve the 50% target in two CCG areas, Hambleton, Richmondshire and Whitby CCG and Harrogate and Rural District CCG. Whilst this is a significant improvement on the September position performance on this indicator does remain fragile.

  Action plans are in operation in all areas where performance is not achieving target and support from the National Intensive Support Team is still being accessed. However it should be noted that availability of staff and levels of investment will continue to impact on the position in North Yorkshire and the Vale of York.

  A detailed report is being developed on the delivery of IAPT services and the performance requirements for the Board meeting in January 2018.

- As agreed at the last Board meeting the Patient Experience Sub Group of the QuAC discussed the position in terms of the percentage of patients reporting their overall experience as excellent or good. The group have actioned some further analysis of the performance to inform what action could be taken going forward.

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

2.2 Data Quality Assessment.

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

2.3 Key Risks

- Referrals (KPI1) – The number of referrals received in October has increased significantly compared to the previous months resulting in this position being the highest number of referrals received in a month in the past 3 years. All localities have seen an increase but in terms of specialities the greatest increase has been seen in CAMHS services. It is not clear whether there is a specific reason for this and it is suggested that if the position remains the same in December that some targeted work around understanding the increase is undertaken.
- Percentage Bed Occupancy (KPI 3) – Following an improvement in the position from May to August we have seen a declining position in September and October. The particular outliers in October were Teesside and North Yorkshire. In North Yorkshire this is linked to a number of delayed discharges however it is expected that a number of these will be discharged in November thus improving this position. The locality has instigated daily calls to address concerns around accessing community placements. In Teesside there has been a particular package of care delivered that has meant that a number of beds were classed as occupied when in reality they weren't. This has put a degree of pressure on the remaining beds within the locality. A new package of care has now been agreed for this individual.
- Number of instances of patients who have had 3 or more admissions in a year (KPI 6) – the performance against this KPI has improved in October for the first time since the beginning of the year however the performance continues to be worse than target. Durham and Darlington locality is a significant outlier when compared to the other localities. A verbal update will be provided at the Board meeting.
- Percentage of Out of Area Placements (KPI 9) - Whilst the performance against this indicator is achieving target there has been a worsening of performance since July linked to the increase in bed occupancy since August. It is expected that improvements in occupancy levels reporting during November should have a positive impact on the position which will be reported for November.
- Sickness (KPI 18) – There has been an improvement in performance reported in October which reverses the monthly increasing position since

May. However the position is still significantly worse than the target as we go into the winter period. An event is being planned for November to get greater understanding of the reasons for the increase in sickness together with looking at what more we can do to support the health and well-being of staff.

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

3. RECOMMENDATIONS:

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

Sharon Pickering
Director to Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Activity

	October 2017				April 2017 To October 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Total number of External Referrals into Trust Services	7,793.00	9,695.00			53,798.00	61,128.00		91,759.00
2) Caseload Turnover	1.99%	-0.18%			1.99%	-0.18%		1.99%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	88.45%			85.00%	86.50%		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	52.00			75.00	52.00		75.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	8.39%			10.00%	8.82%		10.00%
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	20.00	28.67			139.00	178.00		237.00

Quality

	October 2017				April 2017 To October 2017			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%	92.05%			90.00%	90.82%		90.00%
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	6.22%			10.00%	8.78%		10.00%
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	16.08%			20.00%	13.38%		20.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	90.63%			92.45%	91.81%		92.45%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.33			7.00	6.99		12.00

Trust Dashboard Summary for TRUST

Workforce

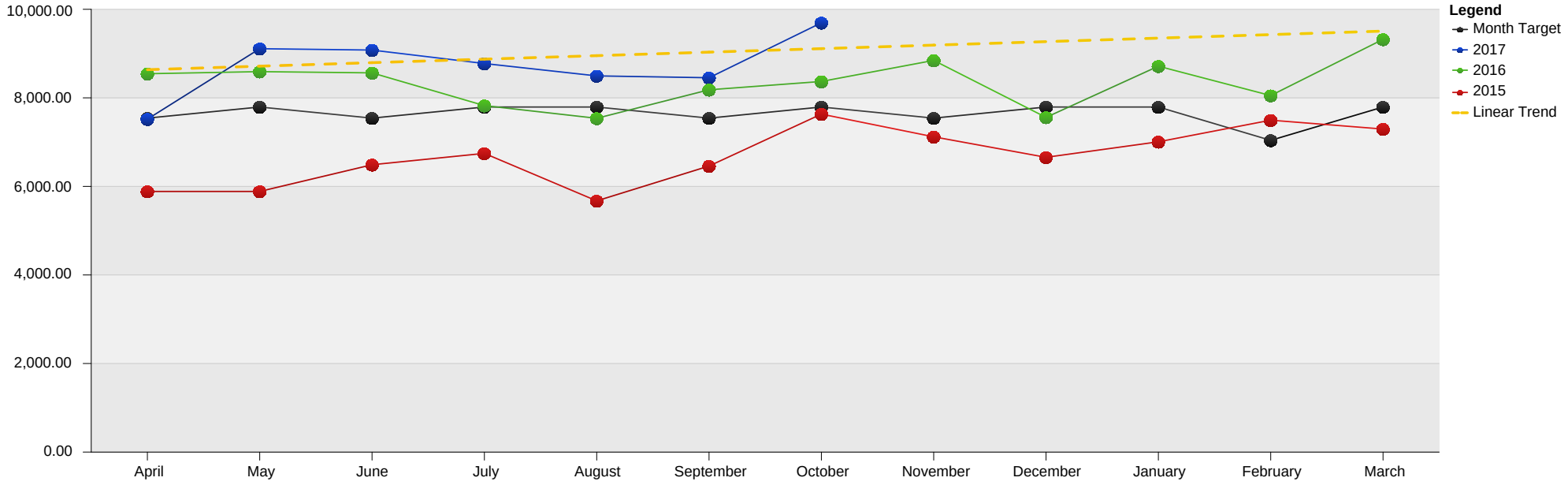
	October 2017				April 2017 To October 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	94.26%			100.00%	94.26%		100.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	17.02%			15.00%	19.87%		15.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	93.28%			95.00%	93.28%		95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	87.23%			90.00%	87.23%		90.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.97%			4.50%	4.93%		4.50%

Money

	October 2017				April 2017 To October 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-936,000.00	-955,000.00			-5,995,000.00	-6,031,000.00		-10,076,000.00
20) CRES delivery	848,000.00	561,784.00			3,990,080.00	3,837,807.93		8,230,080.00
21) Cash against plan	59,012,000.00	61,789,000.00			59,012,000.00	61,789,000.00		56,376,000.00

Trust Dashboard Graphs for TRUST

1) Total number of External Referrals into Trust Services

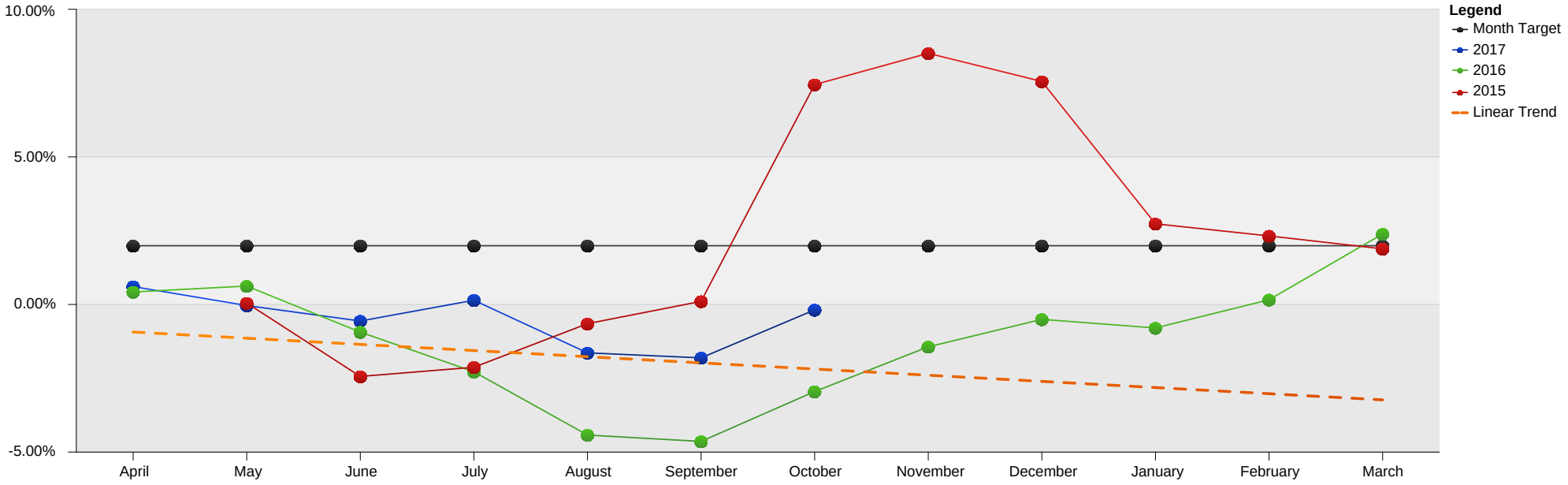


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Total number of External Referrals into Trust Services	9,695.00	61,128.00	2,132.00	14,079.00	3,014.00	17,986.00	2,332.00	14,748.00	619.00	4,431.00	1,596.00	9,881.00		

Narrative
The Trust position for October 2017 is 9,695 which is not meeting the Trust target of 7,793. This is a significant increase on the number of referrals received in September 2017 and an increase on that reported in October 2016. This figure is also the highest number of referrals recorded since 15/16. York and Selby are the only locality that are meeting target.Overall CAMHS services show the greatest percentage increase of 22%. When split by locality North Yorkshire shows the greatest increase at 62%, however the reason behind this increase is not known.All localities have also seen an increase in referrals, however the levels of increase differs. The greatest increases are seen at 31.14% in York and Selby, North Yorkshire at 18.56% and Tees at 16.69%. Within each of these localities at a service level CAMHS shows the greatest increases. Durham and Darlington and Forensic Services report the lowest increases at 2.85% and 8.1% respectively.Based on current trends it is anticipated that we will exceed the annual target of 91,759

Trust Dashboard Graphs for TRUST

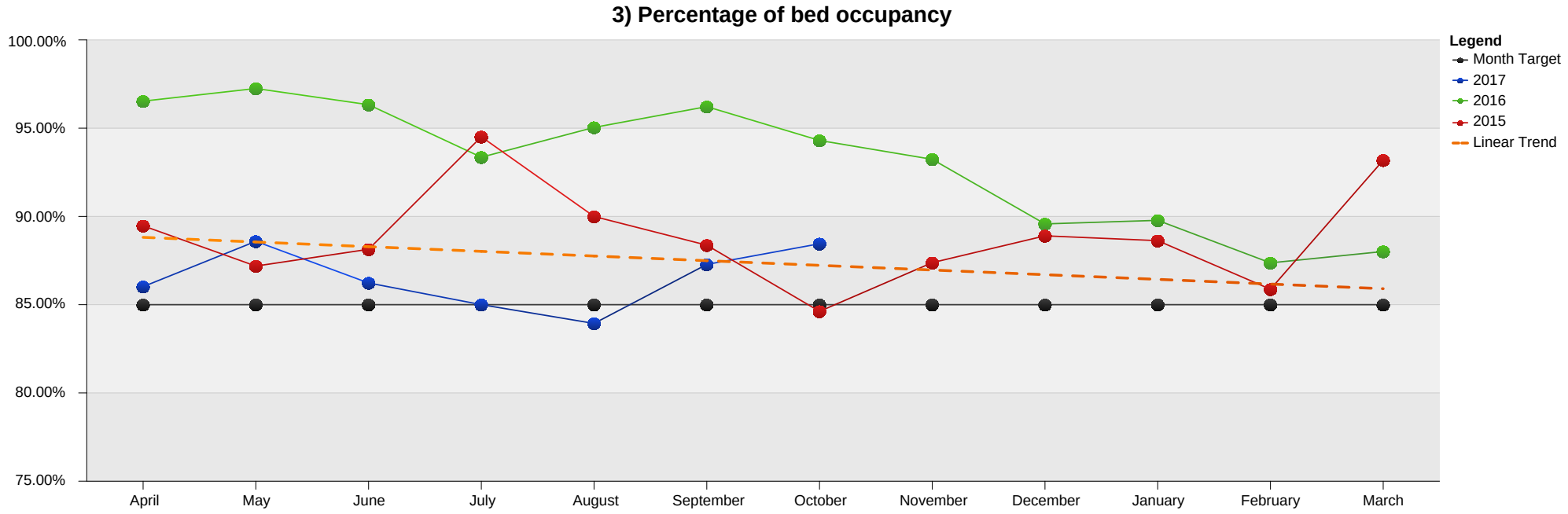
2) Caseload Turnover



	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	-0.18%	-0.18%	1.49%	1.49%	1.20%	1.20%	-0.56%	-0.56%	NA	NA	-6.16%	-6.16%		

Narrative
The Trust position for October 2017 is -0.18% which is meeting the Trust target of 1.99%, however this is a slight deterioration to that reported in September 2017.All localities are meeting target.Based on current trends it is anticipated that we will meet the annual target of 1.99%

Trust Dashboard Graphs for TRUST

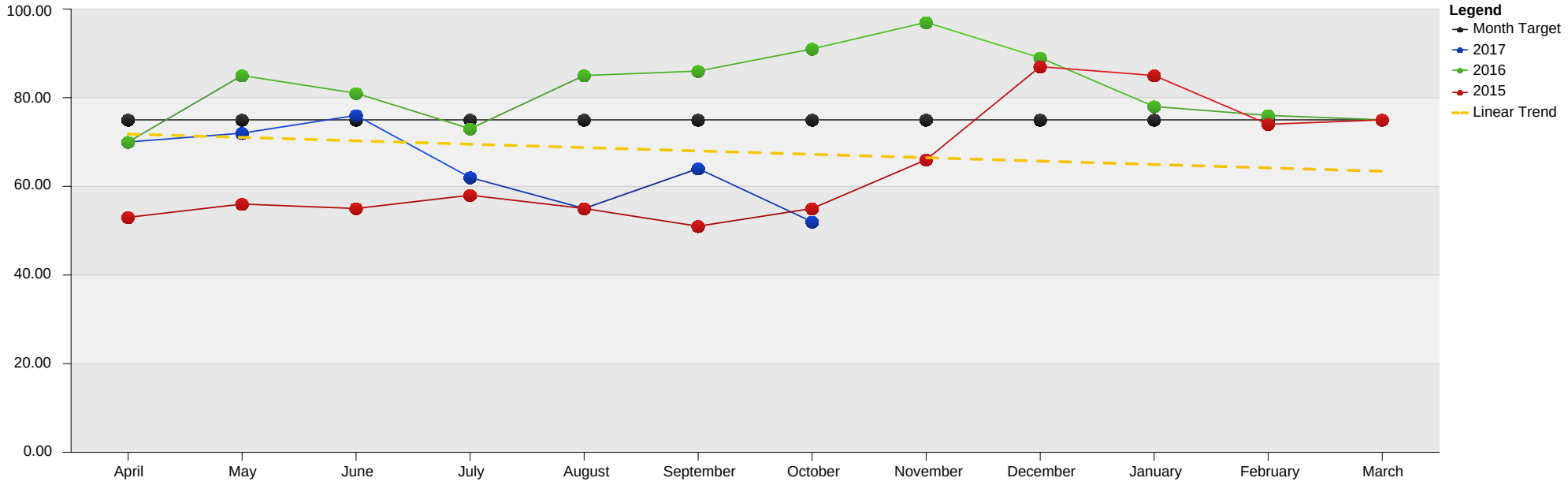


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	88.45%	86.50%	87.48%	87.66%	89.22%	87.31%	92.59%	90.80%	NA	NA	83.36%	76.89%		

Narrative
The Trust position for October 2017 is 88.45% which is not meeting the Trust target of 85.00% and is a deterioration on the position in September 2017 when the target was also not met, however this is an improvement to that reported in October 2016.North Yorkshire reports the highest bed occupancy at 92.59%. A piece of work is to be completed by the end of November to improve understanding of the issues behind this position. A number of delayed discharges are planned for November and this position is expected to improve. Daily calls are in place to address concerns around accessing community placements.York and Selby report the lowest bed occupancy at 83.36% which is due to the low occupancy in MHSOP (Meadowfields). This is due to the positive impact of the care home liaison team.

Trust Dashboard Graphs for TRUST

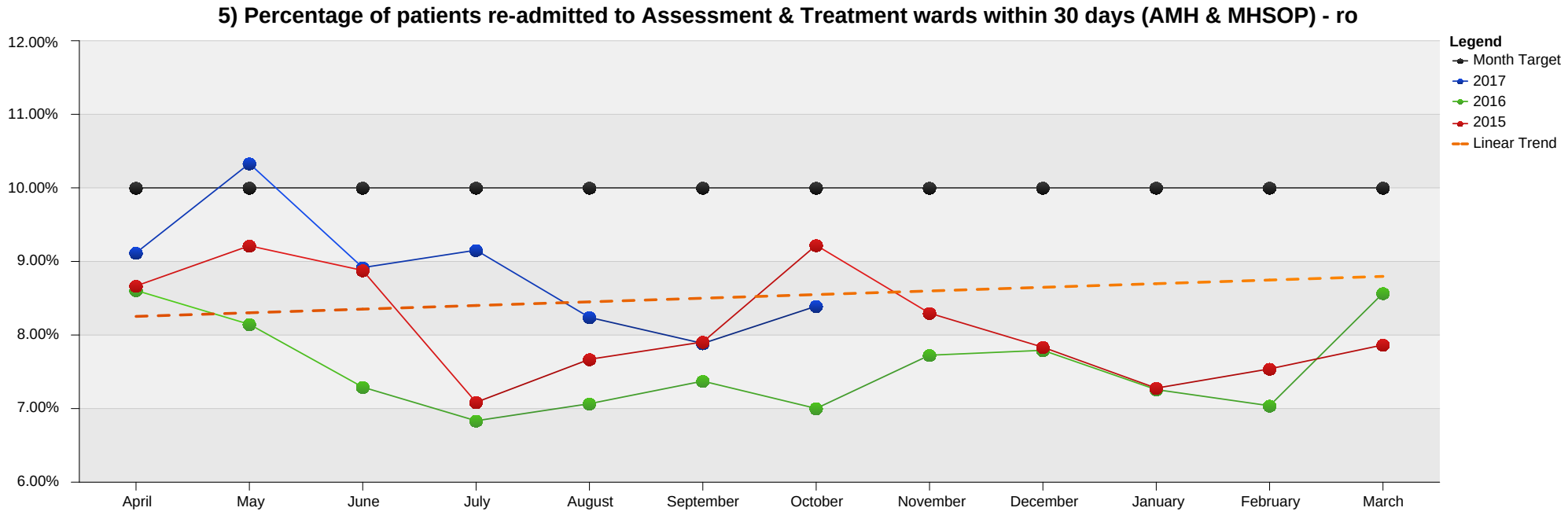
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH



	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)	52.00	52.00	16.00	16.00	10.00	10.00	18.00	18.00			8.00	8.00		

Narrative
The Trust position for October 2017 is 52 which is meeting the target of 75 and an improvement compared to that reported in September 2017. This position is the second best recorded since 2015/16.All localities are achieving target. Of the 52 patients occupying a bed with a LoS greater than 90 days:• 16 (31%) were within Durham and Darlington (6 MHSOP and 10 ADULTS) • 8 (15%) were within York & Selby (8 MHSOP) • 10 (19%) were within Teesside (5 MHSOP and 5 ADULTS) • 18 (34%) were within North Yorkshire (8 MHSOP and 10 ADULTS) In North Yorkshire a lack of permanent medical staff has impacted on the effectiveness of the discharge process, however permanent staff have now been recruited to vacant posts and improvements are anticipated.Based on current trends it is expected that we will meet the annual target of 75.

Trust Dashboard Graphs for TRUST

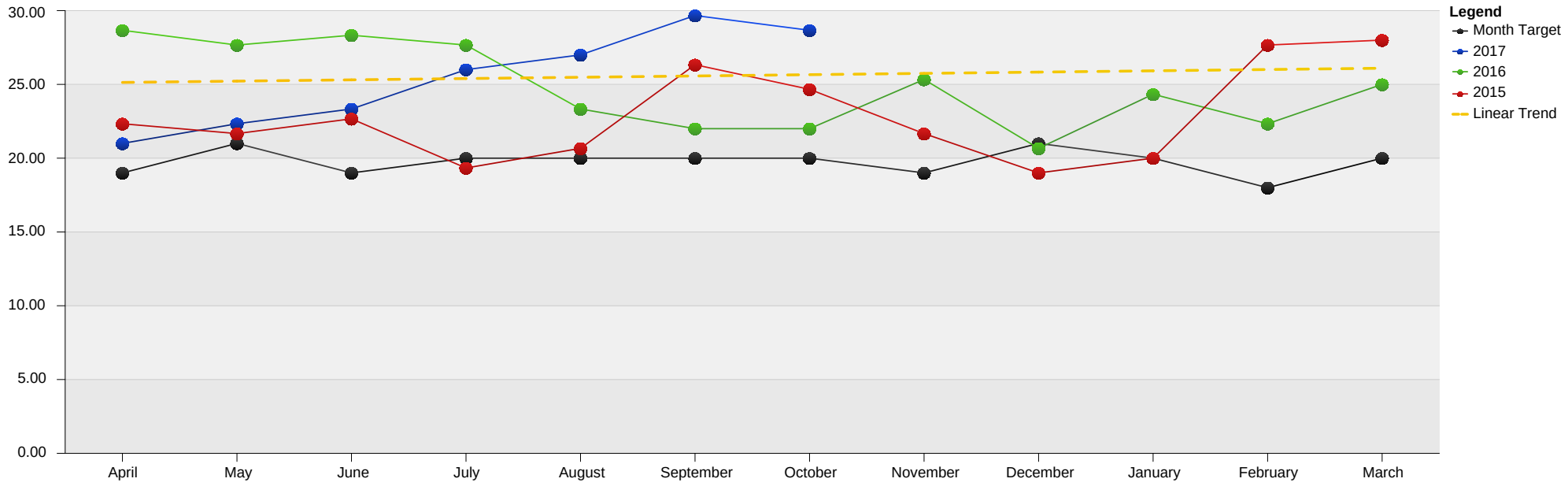


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	8.39%	8.82%	7.75%	8.14%	9.22%	9.28%	8.08%	7.35%			7.41%	11.36%		

Narrative
The Trust rolling 3 month position ending October 2017 is 8.39%, which relates to 23.99 patients out of 286 that were readmitted within 30 days. This is meeting the target of 10% however is a deterioration on the position recorded in September 2017 and worse than the position recorded in October 2016.Of the 23.99 patients re-admitted:• 6.66 (28%) were within Durham & Darlington (5.66 AMH and 0.99 MHSOP) • 2.66 (12%) were within York and Selby (1.66 AMH 0.99 MHSOP)• 5.33 (23%) were within North Yorkshire (4.66 AMH and 0.66 MHSOP) • 8.66 (37%) were within Teesside (8.33 AMH 0.33 MSOP)(*Please note data is displayed in decimal points due to the rolling position being calculated.)All localities are meeting target for this indicator.

Trust Dashboard Graphs for TRUST

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

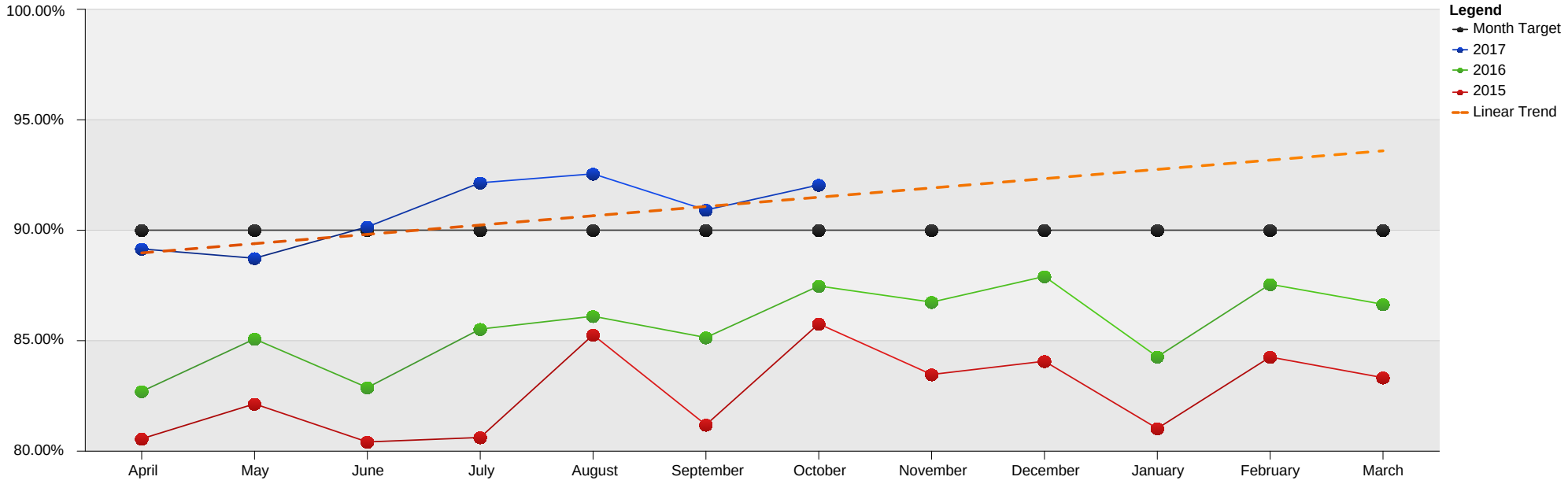


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	28.67	178.00	10.67	68.67	7.67	38.00	4.67	34.00			4.67	31.67		

Narrative
The Trust rolling 3 month position ending October 2017 is 28.67, which is 8.67 worse than the target of 20 but a slight improvement compared to the position reported in September 2017, and worse than that in October 2016. This position has ended the trend which has been seen over 2017/18 from April to September.Only North Yorkshire are achieving target. Of the 28.67 or more readmissions:• 10.66 (38%) were within Durham & Darlington (9.99 AMH and 0.66 MHSOP)• 7.66 (28%) were within Teesside (7.33 AMH 0.33 MHSOP)• 4.66 (17%) were within North Yorkshire (4.66 AMH)• 4.66 (17%) were within York and Selby (4.33 AMH 0.33 MHSOP)In Durham and Darlington a focused piece of work is to be completed to improve understanding of this issue, however complex patients relating to substance misuse and dual diagnosis are impacting on admission rates.(*Please note data is displayed in decimal points due to the rolling position being calculated.)

Trust Dashboard Graphs for TRUST

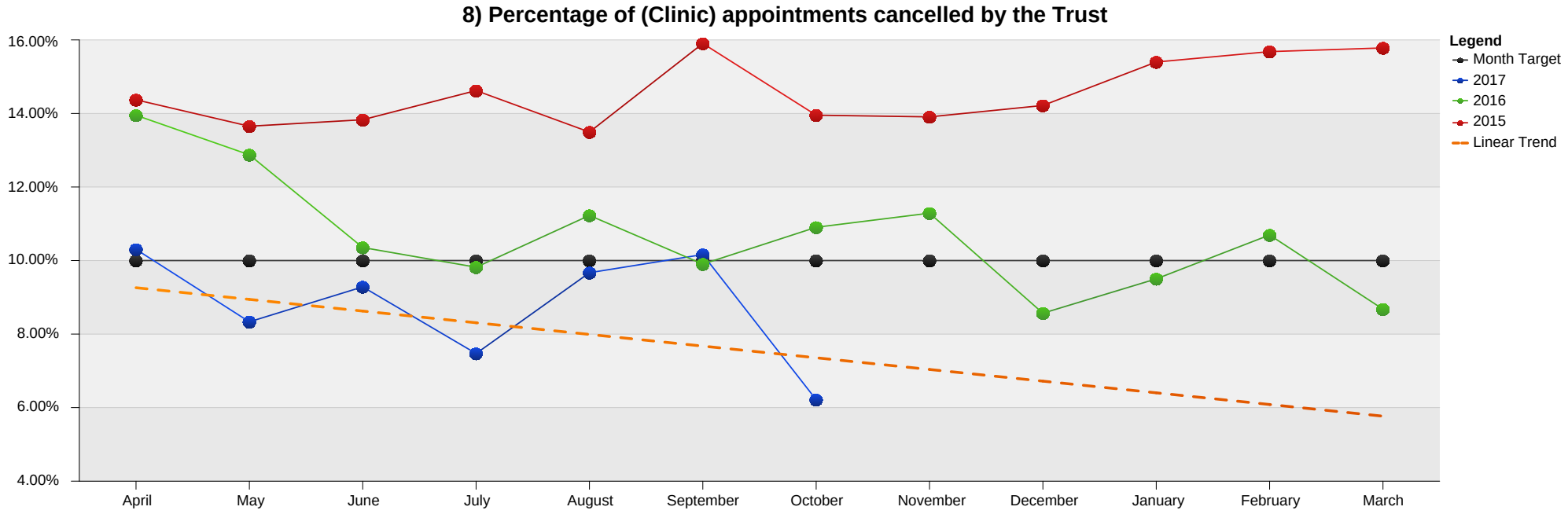
7) Percentage of patients seen within 4 weeks for a first appointment (external referral)



	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.	92.05%	90.82%	90.40%	89.03%	98.56%	98.41%	84.49%	84.31%	99.81%	99.69%	81.18%	74.69%		

Narrative
The position for October 2017 is 92.05%, relating to 496 patients out of 5480 who waited longer than 4 weeks. This is meeting target and an improvement on the September 2017 position. This is the fifth consecutive month that the target has been met since the 4 week indicator was introduced.Areas of concern:• York and Selby Adults at 69% (99 out of 143 patients). This is a continued improvement on the September position and an action plan is in place to address areas of concern. The trajectory for targets to be met is February 2018 and an RPIW is planned for November 2017.• North Yorkshire MHSOP at 78% (376 out of 481 patients) This is the same as the September position, an action plan continues to address performance concerns.• Durham and Darlington Adults at 75%. (384 out of 511 patients) This is an improvement on the September position and the availability of medic appointments has increased.

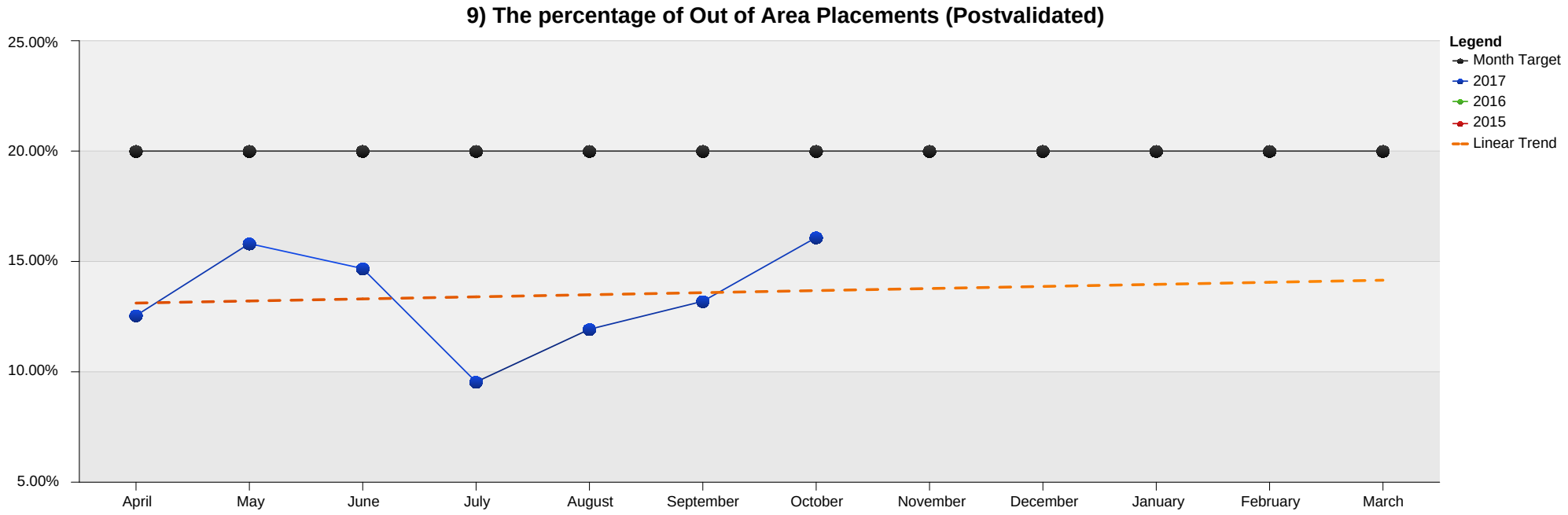
Trust Dashboard Graphs for TRUST



	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
8) Percentage of (Clinic) appointments cancelled by the Trust	6.22%	8.78%	6.18%	11.24%	2.81%	5.66%	10.73%	11.11%			5.80%	4.77%		

Narrative
The Trust position for October 2017 is 6.22% which relates to 201 clinic appointments out of 3234 that have been cancelled. This is meeting the target of 10% and is a significant improvement on both the position in September 2017 and the figure reported for October 2016. This is also the best performance since 2015/16.North Yorkshire is the only locality not meeting target. This is due to difficulties being experienced by staff in using the PARIS system in relation to the re scheduling of appointments. Support will be provided by the information department to resolve this issue.

Trust Dashboard Graphs for TRUST

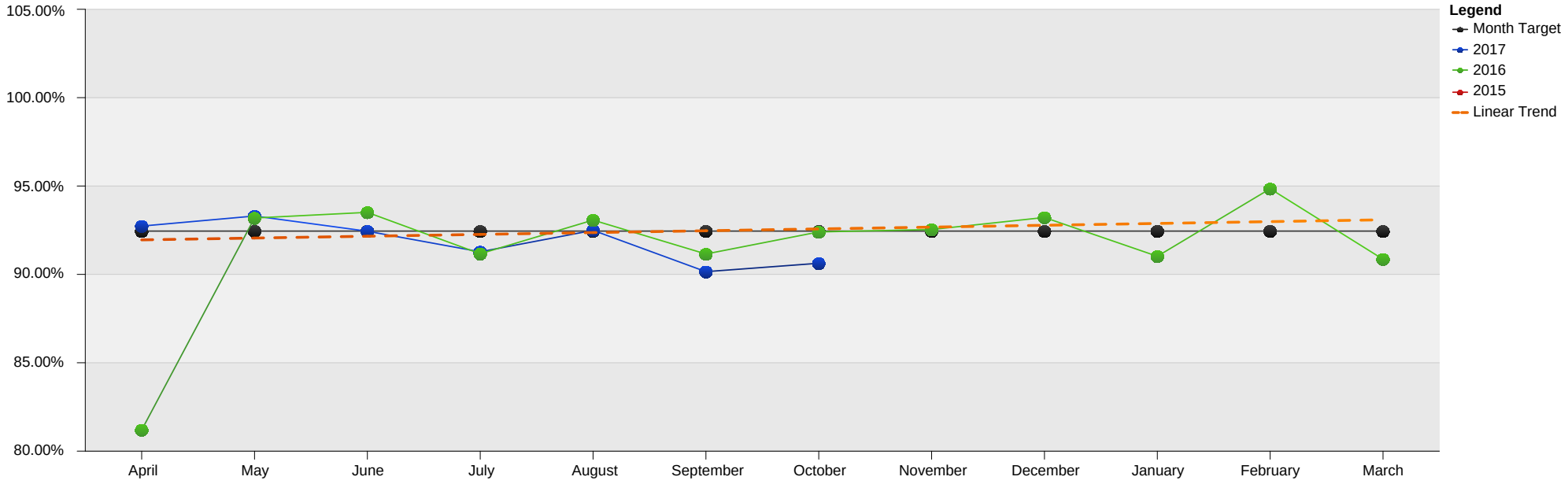


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		UNKNOWN		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The percentage of Out of Area Placements (Postvalidated)	16.08%	13.38%	4.71%	5.99%	14.85%	4.17%	38.46%	36.75%					13.95%	22.83%

Narrative
The Trust position for October 2017 is 16.08%, which relates to 46 admissions out of 286 that were inappropriately admitted out of area. This is better than the target of 20%, but represents a continued deterioration since July 2017 on the improving trend seen earlier in the year.The construction of this indicator has been amended so that it now matches that of the national definition. Therefore there is no historic data available to compare previous performance.All localities are meeting target with the exception of North Yorkshire. The high level of bed occupancy in North Yorkshire is impacting on this position. Of the 46 patients (AMH 32, MHSOP 14) 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)



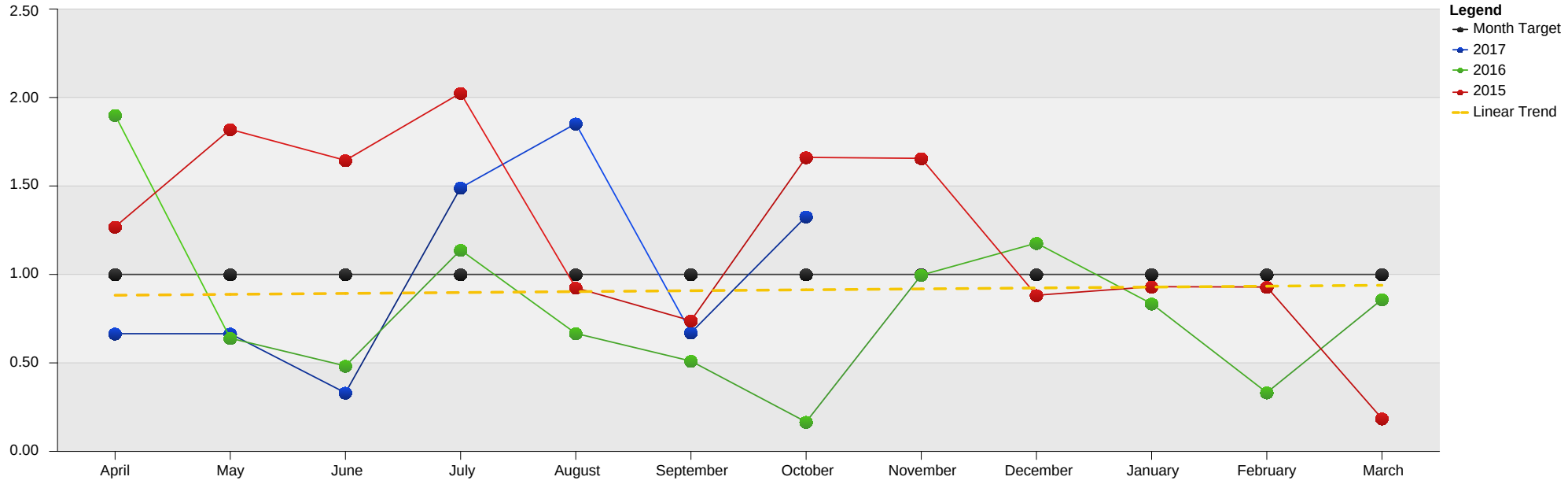
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	90.63%	91.81%	91.28%	92.87%	94.51%	93.10%	93.20%	91.92%	74.34%	79.72%	88.32%	91.06%		

Narrative

The Trust position reported in October relates to Septembers performance. The Trust position for September 2017 is 90.63% which is not meeting the target of 92.45% however it is a slight improvement on the position in August 2017 but a deterioration on that in September 2016. This represents the third worst position since 2016/17.Forensic services continue to report the poorest performance and a deterioration has been seen from the previous month, which is attributable to Forensic Mental Health. The Patient Experience Group has commenced a piece of work to improve understanding of this issue. North Yorkshire and Teeside are the only localities to meet target.As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive).Due to an amendment to the indicator for this year, data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available.

Trust Dashboard Graphs for TRUST

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

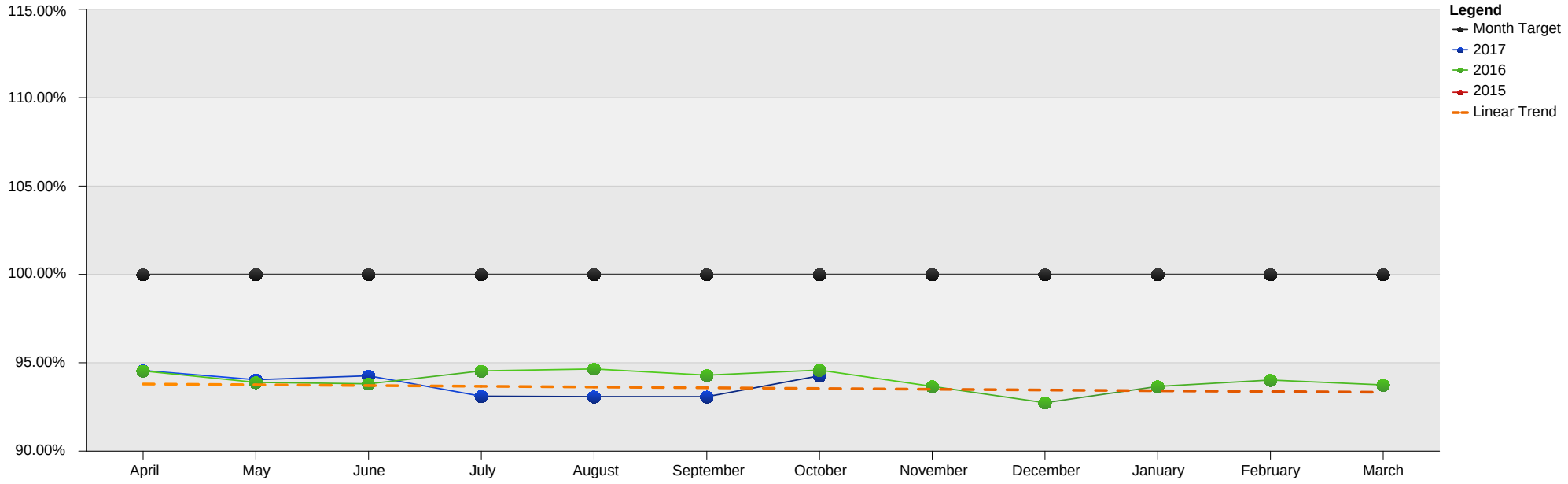


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		UNKNOWN		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.33	6.99	0.42	5.60	0.59	5.47	2.69	9.84	49.92	68.29			0.00	5.80

Narrative
The Trust position for October 2017 is 1.33, which is not meeting the expected number of 1.00. This rate relates to 8 unexpected deaths which occurred in October. This is a deterioration on the position of 4 unexpected deaths that was reported in September 2017. Of the 8 unexpected deaths the table below shows a breakdown by locality:• 3 x North Yorkshire• 3 x Forensics• 1 x Teesside• 1 x Durham and Darlington

Trust Dashboard Graphs for TRUST

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

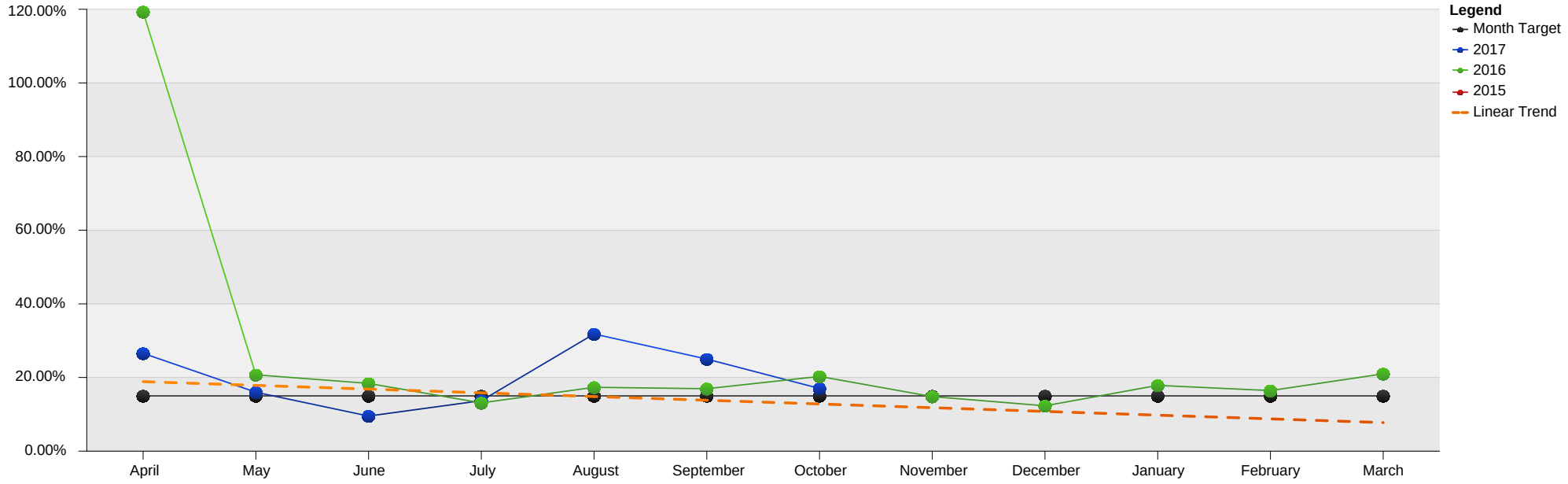


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Actual number of workforce in month (Establishment 95%-100%)	94.26%	94.26%	96.28%	96.28%	97.59%	97.59%	93.31%	93.31%	90.78%	90.78%	90.31%	90.31%		

Narrative
The Trust position for 31 October 2017 is 94.26% which is below the targeted establishment level of 95-100%. The establishment rate has improved following the appointment of newly qualified nurses and further recruitment events are planned, with the next one taking place in November 2017.

Trust Dashboard Graphs for TRUST

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



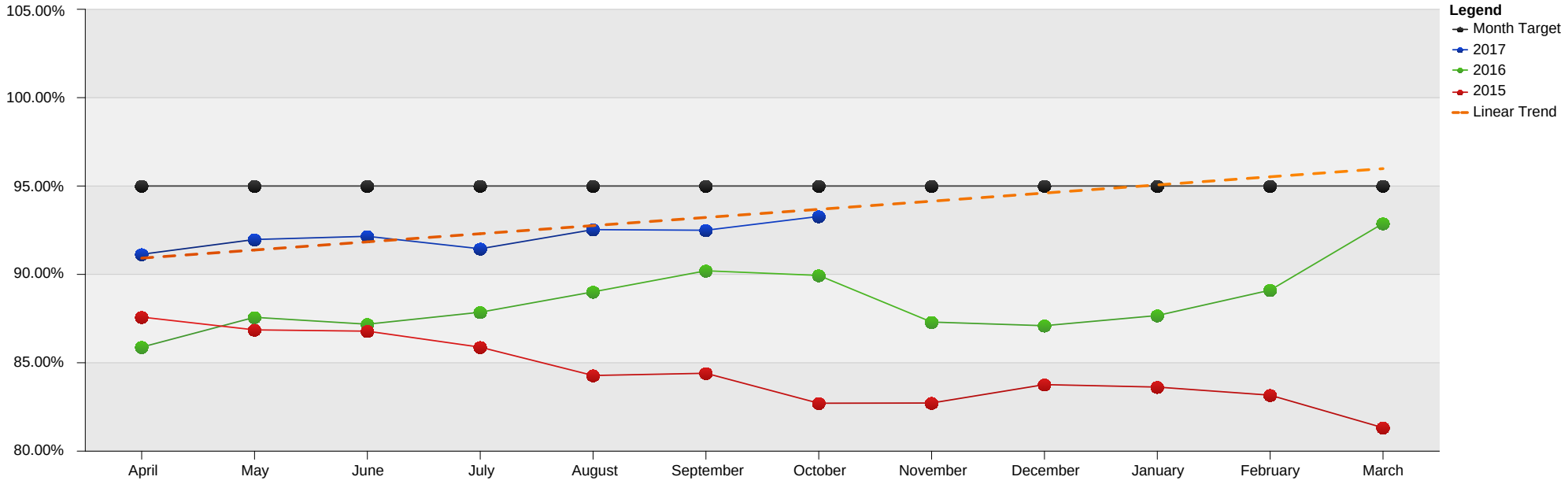
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		UNKNOWN		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Percentage of registered healthcare professional jobs that are advertised two or more times	17.02%	19.87%	NA	NA	NA	NA	NA	NA	NA	NA			NA	NA

Narrative

The Trust position for October 2017 is 17.02% which is not meeting the target of 15.00%, however an improvement on both the previous month's position and that in October 2016. There were 5 non medical posts re-advertised in October out of a total of 39 posts advertised The posts proving difficult to fill are Specialist Dietician, Community MH nurses, Applied Psychologist and a Staff Nurse post based in Malton. Further work is to be completed by HR to understand the key areas of concern and themes and this work is planned to be completed in January 2018.Data only started to be reported for this dashboard from April 2016, therefore no comparative data for 2015/16 is available.

Trust Dashboard Graphs for TRUST

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

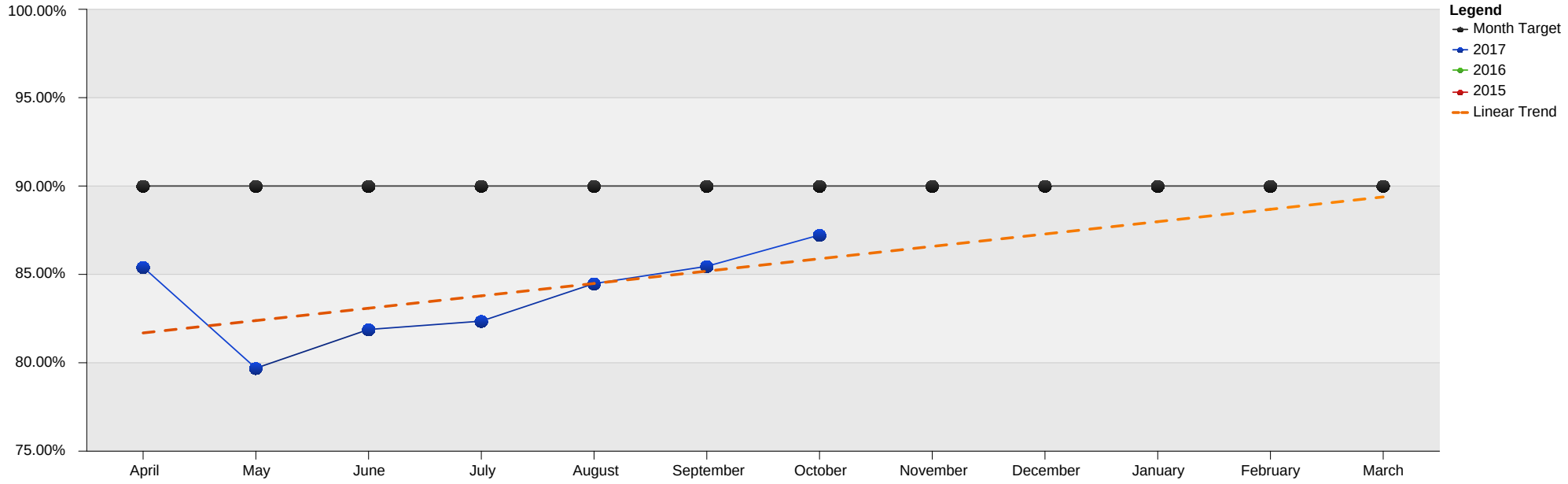


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	93.28%	93.28%	95.09%	95.09%	95.26%	95.26%	91.48%	91.48%	96.19%	96.19%	88.89%	88.89%		

Narrative
The Trust position for October 2017 is 93.28% which relates to 382 members of staff out of 5683 that do not have a current appraisal. This is not meeting the target of 95%, however is a further improvement on the figure reported in September and the best position reported since 2015/16 to date.Durham and Darlington, Tees and Forensic services are meeting target and York Selby report the poorest performance at 88.89%.The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels; this continues to have a positive impact on performance levels being improved.

Trust Dashboard Graphs for TRUST

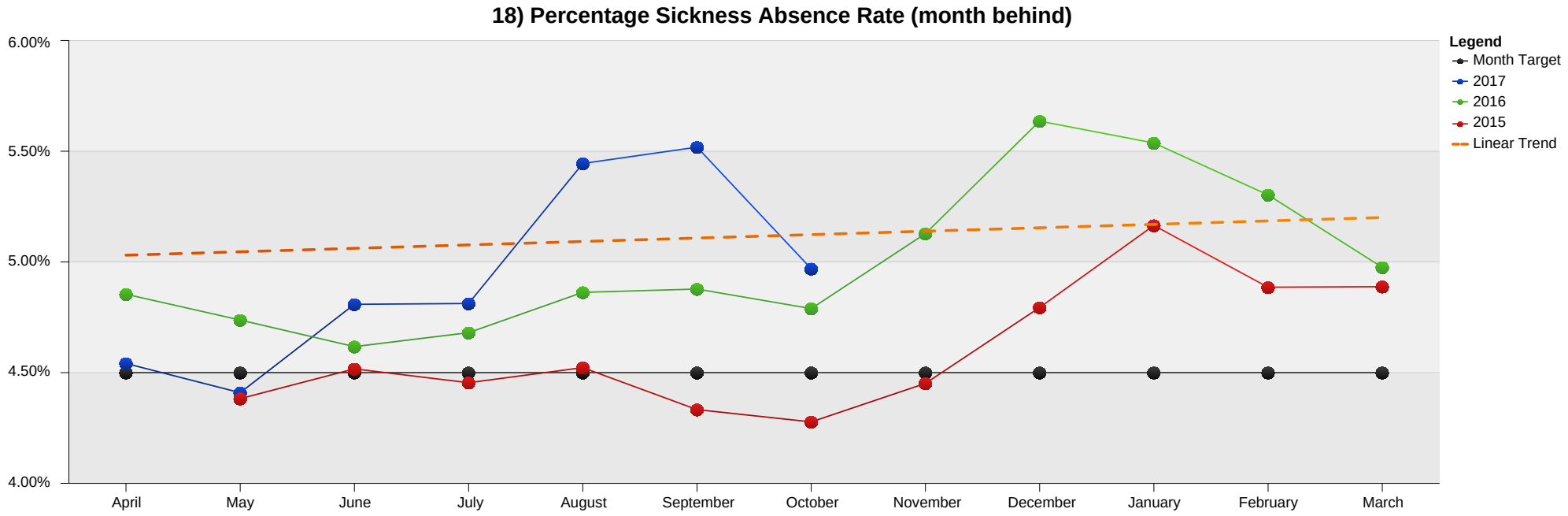
17) Percentage compliance with ALL mandatory and statutory training (snapshot)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		UNKNOWN		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	87.23%	87.23%	84.85%	84.85%	88.30%	88.30%	87.75%	87.75%	87.10%	87.10%			86.52%	86.52%

Narrative
The position for October 2017 is 87.23%, which is 2.77% lower than the new target of 90%. This figure represents a continuing improvement in compliance since April 2017. The key performance indicator has changed to measure compliance against all mandatory training rather than the Core 7. 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.The operational management huddles continue to drive improvements in performance. The improved frequency of the IIC refresh allows a timelier update of accurate performance information to managers.

Trust Dashboard Graphs for TRUST

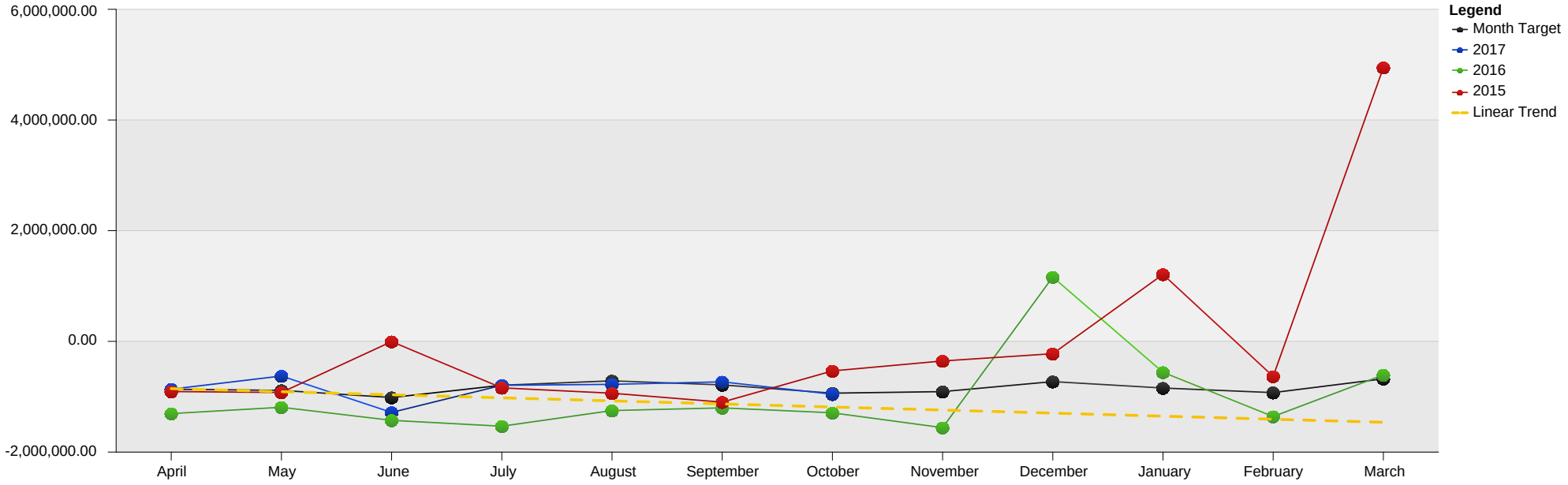


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	4.97%	4.93%	5.60%	5.08%	5.72%	5.72%	4.07%	4.48%	4.86%	4.98%	4.62%	5.52%		

Narrative
The Trust position reported in October relates to the September sickness level. The Trust position reported in October 2017 is 4.97% which is not meeting target of 4.50% however is a significant improvement on that reported in September 2017, but a deterioration compared to that reported in October 2016. An event is planned in November to look at how we can better understand the reasons for the increase in sickness absence we have seen this year and this will more broadly focus on health and well-being within the organisation.North Yorkshire is the only locality meeting target with Tees reporting the poorest position at 5.72%, however this position has improved to that reported in September 2017. 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

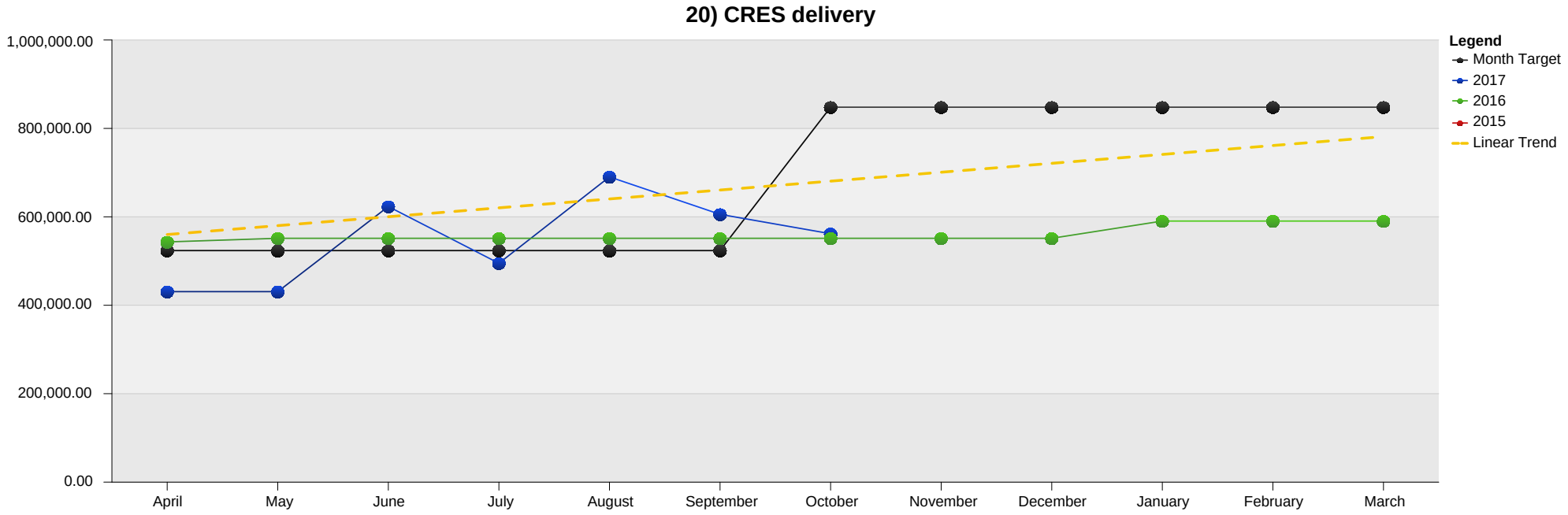
19) Delivery of our financial plan (I and E)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		UNKNOWN		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Delivery of our financial plan (I and E)	-955,000.00	-6,031,000.00	NA	NA	NA	NA	NA	NA	NA	NA			NA	NA

Narrative
The comprehensive income outturn for the period ending 31 October 2017 is a surplus of £6,031k, representing 3.1% of the Trust's turnover and is £36k ahead of plan.

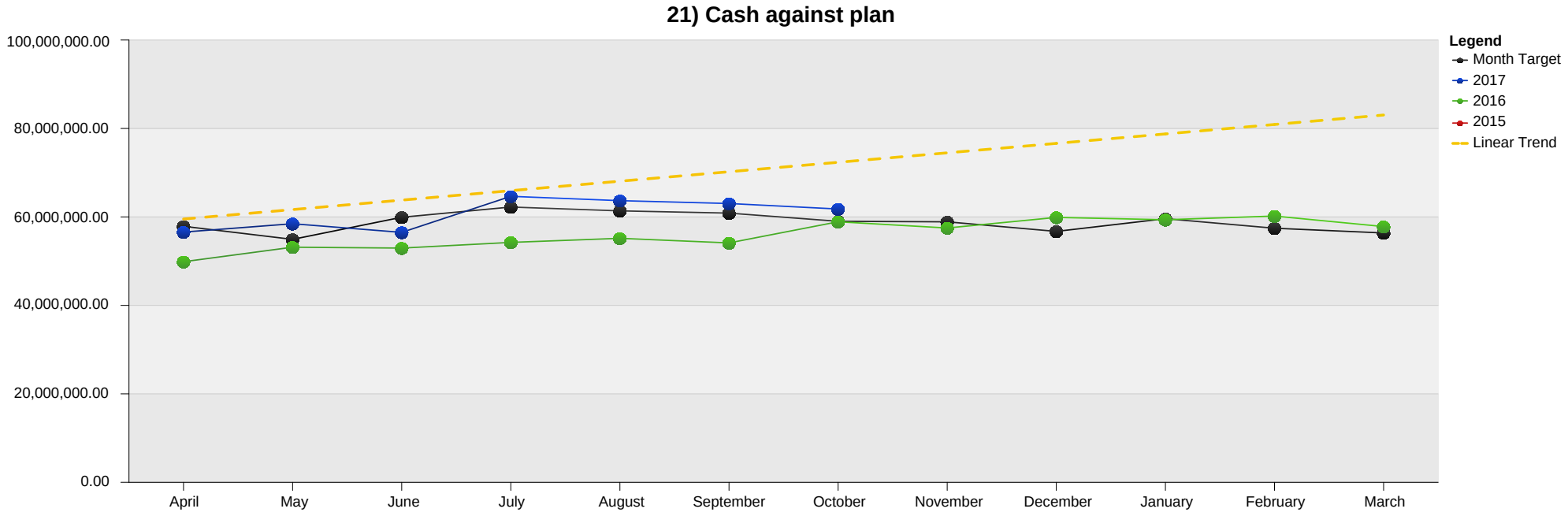
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		UNKNOWN		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) CRES delivery	561,784.00	3,837,807.93	143,505.00	949,450.91	202,279.00	1,415,955.08	35,258.00	225,696.92	16,504.00	115,529.66				

Narrative
Total CRES identified at 31 October 2017 is £6,579k and is £1,651k behind plan for the 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.

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		UNKNOWN		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Cash against plan	61,789,000.00	61,789,000.00	NA	NA	NA	NA	NA	NA	NA	NA			NA	NA

Narrative
Total cash at 31 October 2017 is £61,789k and is £2,777k ahead of plan largely due to working capital variations.

Trust Dashboard - Locality Breakdown for TRUST

1 - Activity

	October 2017														April 2017 To October 2017											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Total number of External Referrals into Trust Services	7,793.00	9,695.00	1,885.00	2,132.00	1,916.00	3,014.00	1,848.00	2,332.00	585.00	619.00	1,559.00	1,596.00			53,798.00	61,128.00	13,012.00	14,079.00	13,226.00	17,986.00	12,759.00	14,748.00	4,041.00	4,431.00	10,760.00	9,881.00		
2) Caseload Turnover	1.99%	-0.18%	1.99%	1.49%	1.99%	1.20%	1.99%	-0.56%	NA	NA	1.99%	-6.16%			1.99%	-0.18%	1.99%	1.49%	1.99%	1.20%	1.99%	-0.56%	NA	NA	1.99%	-6.16%		
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	88.45%	85.00%	87.48%	85.00%	89.22%	85.00%	92.59%	85.00%	NA	85.00%	83.36%			85.00%	86.50%	85.00%	87.66%	85.00%	87.31%	85.00%	90.80%	85.00%	NA	85.00%	76.89%		
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	52.00	16.00	16.00	11.00	10.00	22.00	18.00			24.00	8.00			75.00	52.00	16.00	16.00	11.00	10.00	22.00	18.00			24.00	8.00		
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	8.39%	10.00%	7.75%	10.00%	9.22%	10.00%	8.08%			10.00%	7.41%	10.00%		10.00%	8.82%	10.00%	8.14%	10.00%	9.28%	10.00%	7.35%			10.00%	11.36%	10.00%	
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	20.00	28.67	5.00	10.67	5.00	7.67	6.00	4.67			2.00	4.67			139.00	178.00	38.00	68.67	38.00	38.00	46.00	34.00			16.00	31.67		

Trust Dashboard - Locality Breakdown for TRUST

2 - Quality

	October 2017														April 2017 To October 2017											
	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%	92.05%	90.00%	90.40%	90.00%	98.56%	90.00%	84.49%	90.00%	99.81%	90.00%	81.18%			90.00%	90.82%	90.00%	89.03%	90.00%	98.41%	90.00%	84.31%	90.00%	99.69%	90.00%	74.69%		
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	6.22%	10.00%	6.18%	10.00%	2.81%	10.00%	10.73%	10.00%		10.00%	5.80%			10.00%	8.78%	10.00%	11.24%	10.00%	5.66%	10.00%	11.11%	10.00%		10.00%	4.77%		
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	16.08%	20.00%	4.71%	20.00%	14.85%	20.00%	38.46%			20.00%	13.95%			20.00%	13.38%	20.00%	5.99%	20.00%	4.17%	20.00%	36.75%			20.00%	22.83%		
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	90.63%	92.45%	91.28%	92.45%	94.51%	92.45%	93.20%	92.45%	74.34%	92.45%	88.32%			92.45%	91.81%	92.45%	92.87%	92.45%	93.10%	92.45%	91.92%	92.45%	79.72%	92.45%	91.06%		
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.33	1.00	0.42	1.00	0.59	1.00	2.69	1.00	49.92	1.00	0.00			7.00	6.99	7.00	5.60	7.00	5.47	7.00	9.84	7.00	68.29	7.00	5.80		

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	October 2017														April 2017 To October 2017											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	94.26%	100.00%	96.28%	100.00%	97.59%	100.00%	93.31%	100.00%	90.78%	100.00%	90.31%			100.00%	94.26%	100.00%	96.28%	100.00%	97.59%	100.00%	93.31%	100.00%	90.78%	100.00%	90.31%		
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	17.02%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA			15.00%	19.87%	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%	93.28%	95.00%	95.09%	95.00%	95.26%	95.00%	91.48%	95.00%	96.19%	95.00%	88.89%			95.00%	93.28%	95.00%	95.09%	95.00%	95.26%	95.00%	91.48%	95.00%	96.19%	95.00%	88.89%		
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	87.23%	90.00%	84.85%	90.00%	88.30%	90.00%	87.75%	90.00%	87.10%	90.00%	86.52%			90.00%	87.23%	90.00%	84.85%	90.00%	88.30%	90.00%	87.75%	90.00%	87.10%	90.00%	86.52%		
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.97%	4.50%	5.60%	4.50%	5.72%	4.50%	4.07%	4.50%	4.86%	4.50%	4.62%			4.50%	4.93%	4.50%	5.08%	4.50%	5.72%	4.50%	4.48%	4.50%	4.98%	4.50%	5.52%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	October 2017														April 2017 To October 2017											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		UNKNOWN		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		UNKNOWN		YORK AND SELBY	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
19) Delivery of our financial plan (I and E)	-936,000.00	-955,000.00	NA	NA	NA	NA	NA	NA	NA	NA			NA	NA	-5,995,000.00	-6,031,000.00	NA	NA	NA	NA	NA	NA	NA	NA			NA	NA
20) CRES delivery	848,000.00	561,784.00	107,322.17	143,505.00	198,536.25	202,279.00	148,049.17	35,258.00	124,378.00	16,504.00			59,416.00		3,990,080.00	3,837,807.93	751,255.17	949,450.91	1,389,753.75	1,415,955.08	1,036,344.17	225,696.92	870,646.00	115,529.66			415,912.00	
21) Cash against plan	59,012,000.00	61,789,000.00	NA	NA	NA	NA	NA	NA	NA	NA			NA	NA	399,993,000.00	61,789,000.00	NA	NA	NA	NA	NA	NA	NA	NA			NA	NA

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

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient and took place in the hospital					Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital					Number of unexpected deaths where the patient was no longer in service					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death																					0
Natural causes																					0
Hanging																	1				1
Suicides																					0
Open																					0
Drug related death																					0
Drowning																					0
Misadventure																					0
Awaiting verdict	9	6	9	2	3	1	1									3		3	2	2	41
Total	9	6	9	2	3	1	1	0	0	0	0	0	0	0	0	3	1	3	2	2	42

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
4	4	2	9	11	4	8					

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
13	8	12	4	5

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

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

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

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

Y&S recorded in old Datix not included

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

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

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

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

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

ITEM 17

BOARD OF DIRECTORS MEETING

DATE:	**28TH November 2017**
TITLE:	**Proposed Key Performance Indicators for the 18/19 Trust Dashboard**
REPORT OF:	**Sharon Pickering, Director of Planning & Performance**
REPORT FOR:	**Discussion and Decision**

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

Executive Summary:

The purpose of this report is to present to the Board of Directors the output from the Board Business Planning Event on the proposed Key Performance Indicators for the 2018/19 Trust Dashboard for discussion and agreement.

Recommendations:

The Board of Directors are asked to discuss the proposed indicators in Appendix A and agree the final list for the 2018/19 Trust Dashboard.

MEETING OF:	**Board of Directors Meeting**
DATE:	**28th November 2017**
TITLE:	**Proposed Key Performance Indicators for the 18/19Trust Dashboard**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to the Board of Directors the output from the Board Business Planning Event on the proposed Key Performance Indicators for the 2018/19 Trust Dashboard for discussion and agreement.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Example of good practice set out in NHS Improvement's "Well-led Framework for Governance Reviews" (2015) which was used by Grant Thornton to assess the Trust's governance arrangements in 2017 is that:

"An integrated reporting approach, appropriate to the size and complexity of the trust, is used by the Board to ensure that the impact on all areas of the organisation is understood before decisions are made.

Monthly reporting is supported by a 'dashboard' of the most important metrics. The Board is able to justify the selected metrics as being:

- relevant to the organisation given the context within which it is operating and what it is trying to achieve
- linked to the trust's overall strategy and priorities
- covering all the trust's major focus areas
- the best available ones to use
- useful to review"

2.2 The Trust Dashboard provides a monthly high level overview of operational delivery throughout the financial year using a range of key performance indicators. These indicators are then measured from Ward/Team level through to Board level (where relevant).

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

3. KEY ISSUES:

3.1 At the Board Business Planning Workshop and as part of the 18/19 development process, senior leaders discussed the current key performance indicators and agreed which ones to retain, add, remove or revise.

3.2 The Corporate Performance Team have taken the output from the event and have followed up the changes identified. Executive Management Team reviewed the proposals identified by the Corporate Performance Team on the 1st November 2017 and asked for some minor changes. The final list of suggested indicators is detailed in Appendix A.

3.3 Once the Board of Directors have agreed the list of key performance indicators for 2018/19, work will commence to develop the new indicators and dashboard and it is planned to bring proposed targets back to the Board of Directors at the end of January 2018.

4. IMPLICATIONS:

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

4.2 **Financial/Value for Money:** Financial measures are included in the key performance indicators for 18/19.

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

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

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

5. RISKS:

5.1 There are no direct risks associated with this report.

6. CONCLUSIONS:

6.1 As part of the planning process, senior leaders have discussed and suggested a range of indicators to be included in the 18/19 Trust Dashboard which the Corporate Performance Team have reviewed and progressed further (Appendix B). .

7. RECOMMENDATIONS:

7.1 The Board of Directors are asked to discuss the proposed indicators in Appendix A and agree the final list for the 2018/19 Trust Dashboard.

Sarah Theobald
Head of Corporate Performance

Background Papers:

Appendix A

Recommended KPIs for the 18/19 Trust Dashboard

NO	KPI	PROPOSALS
QUALITY		
1	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	No change from 17/18; however proposal would be to exclude clock stops/re-starts in line with other national access standards from 18/19.
2	*New* Percentage of patients starting "treatment" within x weeks of external referral	• This requires further work to define the start of treatment for each service. The Head of Corporate Performance is attending SDGs starting in November with Information and Currency leads. We will also discuss what an appropriate timescale would be for the start of treatment following receipt of referral and assessment being completed. The output from these meetings will be brought back to EMT for discussion. • We would propose to calculate the start of treatment from referral date as this is consistent with other national access standards as opposed to time between first appointment and the start of treatment. • We would also suggest excluding clock stops/re-starts as again this is line with other national waiting time standards.
3	The percentage of inappropriate Out of Area Placements (AMH & MHSOP)	No change from 17/18 but will be reviewed once the new national metric is published
4	Percentage of patients surveyed reporting their overall experience as excellent or good	No change from 17/18
5	Number of unexpected deaths classed as a serious incident per 10,000 open cases	No change from 17/18
6	Outcome measures	Currently in development but will link to Payment Mechanism work
7	Outcome measures	Currently in development but will link to Payment Mechanism work

NO	KPI	PROPOSALS
ACTIVITY		
8	Total number of External Referrals into Trust Services	No change from 17/18
9	*New* The number of external referrals with an Assessment completed	Suggest using the relevant intervention codes specific to assessments as this should be a more accurate reflection than using contacts or assessment documents. Work would need to be undertaken to agree and communicate this to services. Suggest for all services/specialities.
10	*New* The number of external referrals which were subsequently accepted onto caseload	This would be a subset of no. 2 where an assessment had been completed and the patient was accepted onto caseload. There is a specific intervention code for this. Suggest for all services/specialities.
11	*New* The number of discharges from total caseload	This would be the total number of discharges from the Trust for all services/specialities.
12	Bed Occupancy (AMH & MHSOP A & T Wards)	No change from 17/18
13	Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards	No change from 17/18
14	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	Minor change from 17/18 in that it would exclude transfers back from Acute Trust when an inpatient had needed physical healthcare on an Acute Ward and remove the “rolling 3 months” and report those than occurred in the reporting month
WORKFORCE		
15	Actual number of workforce in month	No change from 17/18
16	*New* Vacancy fill rate	The proposed calculation is the total number of successful appointments to healthcare professional vacancies over the total number of advertised healthcare professional vacancies as a percentage (for all registered healthcare professionals). The source will be the recruitment tracking data base which is currently a manual feed in to the IIC.
17	Percentage of staff in post more than 12 months with a current appraisal	No change from 17/18

NO	KPI	PROPOSALS
18	Percentage compliance with ALL mandatory and statutory training	No change from 17/18
19	Percentage Sickness Absence Rate	No change from 17/18
MONEY		
20	Delivery of our financial plan (I and E)	No change from 17/18
21	CRES delivery	No change from 17/18
22	Cash against plan	No change from 17/18

KPIs Removed from 17/18 Trust Dashboard

- Caseload Turnover
- Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment Wards (AMH and MHSOP)
- Percentage of clinic appointments cancelled by the Trust
- Percentage of healthcare professional jobs that are advertised two or more times

ITEM NO. 18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th November 2017**
TITLE:	**Strategic Direction Performance Report – Quarter 2 2017/18**
REPORT OF:	**Sharon Pickering, Director of Planning and Performance**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to present to the Board of Directors the Strategic Direction Performance Report as at Quarter 2 (30th September 2017).

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

This report reflects that two of the Trust's five goals are in a positive position, whilst still acknowledging that there is work to do to improve some KPI's. There has been a deterioration in KPI performance within Goals 1, 2 and 3; however it is noted that there is a much more positive position reported when considering the business plan and qualitative intelligence reported for these goals.

Recommendations:

Board of Directors are asked to:

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

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**28th November 2017**
TITLE:	**Strategic Direction Performance Report – Quarter 2 2017/18**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to the Board of Directors the Strategic Direction Performance Report as at Quarter 2 (30th September 2017).

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

3.1 Trust Strategic Direction Scorecard

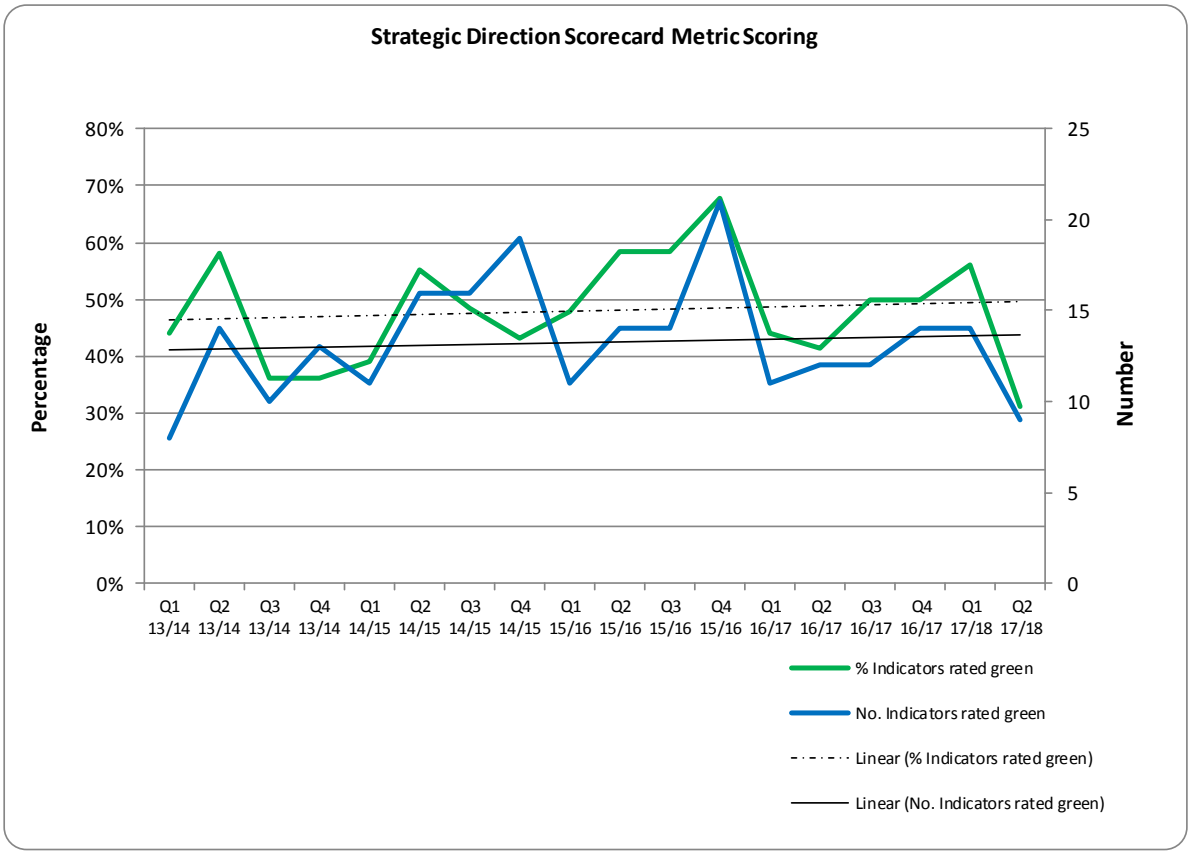
The Strategic Direction Scorecard is shown under each strategic goal with further detail, by exception, in Appendix 1.

The following table and graph provide a summary of the RAG ratings at quarter 2 compared to the position in the previous quarter (Q1 2017/18) and the previous financial years 2015/16 and 2016/17. The Trust is not meeting some of its high ambitions given the number of reds against stretching metrics. The actual number of those rated green has decreased since last quarter and the number rated red has increased. There is a significant number (11) that are not being RAG as they are not required to be reported in this quarter, or in the case of the CQC survey indicator, the data has not yet been published. There are some business plan actions that need to be re-profiled in the light of changing circumstances.

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

The percentage is based on the number of indicators that can be RAG rated (24 for quarter 2).

The graph below shows that there has been a general improving trend in the percentage of greens since 2013/14. Following a significant downward trend in quarter 1 2016/17, this improving trend returned but this quarter is showing a further reduction in those rated green.



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

3.2.1 Trust Strategic Direction Scorecard

This strategic goal is showing 3 indicators rated red out of 6 as at quarter 2; which the same as reported in quarter 1.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18											
	Indicator	Q2 Target 2017/18	Quarter 1 Actual	Quarter 2 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)											
1	Percentage of patients surveyed reporting their overall experience as excellent or good	>92.45	92.74%	91.33%	⇩	>92.45	91.97%	92.48%	91.37%	90.14%	>18/19 out-turn
2	Percentage of patients who have not waited longer than 4 weeks from "referral " to "assessment" for external and internal referrals	90.00%	88.18%	90.39%	⇧	90.00%	89.28%	84.76%	83.17%	84.50%	98.00%
3	Percentage of patients reporting "yes always" to the question "did you feel safe on the ward?"	85.00%	64.57%	62.37%	⇩	85.00%	63.49%	82.29%	79.96%	82.11%	85.00%
4	The Trust ranks in the top 20th percentile of all mental health Trusts for the CQC Service User Survey (annual)	Surveys: Top 20% of MH Trusts	Results due in Q2	not yet published	n/a	Surveys: Top 20% of MH Trusts	0.00%	Better or About the Same as other Trusts	Yes	Survey - top 25th %ile	Surveys: Top 20% of MH Trusts
5	The Trust ranks in the top 10th percentile of all mental health Trusts for the NHS Staff Survey (annual)	Surveys: Top 10% of MH Trusts	Results due in Q4	Results due in Q4	n/a	Surveys: Top 10% of MH Trusts	Results due in Q4	Ranked 4th	Yes - top MH//LD trust	Survey - top 25th %ile	Surveys: Top 10% of MH Trusts
6	Percentage of service users with a recovery focussed action plan (Adult Mental Health)	92.00%	90.03%	88.40%	⇩	92.00%	88.40%	89.73%	93.00%	93.16%	95.00%

Indicators of concern are:

- **KPI 1 Percentage of patients surveyed reporting their overall experience as excellent or good. –** The Trust position for quarter 1 is 91.33%, which is a slight deterioration on the quarter 1 position of 92.74% and below the trust target by 1.12%.

  Both Durham and Darlington and Teesside are above target, with York and Selby and North Yorkshire both reporting above 90% at 91.16% and 90.43% respectively. The overall position is affected by the lower position of Forensics at 80.87%. This directorate has historically reported a lower positon, due to the nature of the service.

- **KPI 3 – Percentage of patients reporting 'yes always' to the question 'did you feel safe on the ward?'** – The Trust position for quarter 2 is 62.37% which relates to 552 patients out of 885 patient survey responses who confirmed they always felt safe on our wards. This is 22.63% below the target of 85% and a slight deterioration on quarter 1 when we reported 64.57%. All localities are reporting below target; Durham and Darlington (74.5%), York and Selby (65.4%), Teesside (61.4%), North Yorkshire (57.3%) and Forensic Services (48.8%). However, Durham and Darlington, York and Selby and Forensics are all showing an improvement on quarter 1.

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

Locality	Reason	Number responding	Total responses for locality
Durham & Darlington	General	1	15
	Environment	0	
	other patients	7	
	own illness	3	
	Staff/staffing	4	
North Yorkshire	General	1	11
	Environment	1	
	other patients	6	
	own illness	1	
	Staff/staffing	2	
Tees	General	1	18
	Environment	1	
	other patients	11	
	own illness	5	
	Staff/staffing	0	
Forensics	General	2	27
	Environment	0	
	other patients	20	
	own illness	1	
	Staff/staffing	4	
York & Selby	General	1	13
	Environment	2	
	other patients	4	
	own illness	5	
	Staff/staffing	1	

- **KPI 6 - Percentage of service users with a recovery focused action plan (Adult Mental Health)** – The Trust position for quarter 2 is 88.40% which is 3.60% below the target of 92%.

  Only Teesside (92.21%) is achieving the target; Durham & Darlington reports 84.94% and North Yorkshire reports 83.78%.

  - Within Durham and Darlington the position has been affected by engagement issues and new staff within the teams as well as some non compliance by social worker staff. These issues are being addressed directly with staff and within clinical and team meetings.

  - Within North Yorkshire, there is a focus on all recovery star plans being completed, however, they have experienced a number of engagement issues with patients unwilling to take part in the process, which has affected performance. In addition, they have had some data quality issues which they are addressing.

Other points to note:

- **KPI 4 – The Trust ranks in the top 20th percentile of all mental health Trusts for the CQC Service User Survey (annual)** – the survey has not yet been published and so will be included in the quarter 3 Strategic Direction report.

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 2 were rated green (82%) which is an improvement on the Quarter 1 (73%) position.

There are 5 priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

- 1 priority (PPCS) has identified that the benefits will not be achieved under the current plan, therefore work has started to re-plan PPCS work. Any changes to the Business Plan proposed will be made following approval by EMT SCOB or Trust Board depending upon the nature of the proposed changes
- 1 Priority requires an agreed change in wording, from Board and additional time within year (which has been agreed by EMT) (Business Plan ref 1.3a)
- 1 priority, rated Grey, requires removal from the business plan as the actions have been superseded by external changes and proposals (to be agreed by Board). (Business plan ref 1.7t)
- There are currently 2 further priorities rated Grey due to external factors, which could have an impact on overall timescales. Any changes to the Business Plan proposed will be made following approval by EMT SCOB or Trust Board depending upon the nature of the proposed changes

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

3.2.3 Other Qualitative Intelligence

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

- **Scarborough, Whitby, Ryedale crisis and intensive home treatment team, Cross Lane Hospital, Scarborough** has maintained its Royal College of Psychiatrists' HTAS (home treatment assessment standard) accreditation.

- **Esk and Danby wards at Cross Lane Hospital, Scarborough** have both successfully been accredited with AIMS (Accreditation for Mental Health Inpatient Services) from the Royal College of Psychiatrists

- The Trust has recently opened a new property in Redcar for the provision of Mental Health for Older People Services; **Reed Marsh House.**

- The IST has revisited **Durham & Darlington IAPT Services** to present feedback on progress following their initial review. They were impressed with the progress and integrity of the service, noting positive engagement of the

workforce and the current leadership regime and approach. The team were very interested in the recent application of PPCS within the IAPT service and the service was in a position to demonstrate that no-one has to wait more than 3 days and generally 24 hours for an assessment.

- **The learning disability forensic service activity centre**, Roseberry Park, Middlesbrough organised a fantastic celebration of the Bradhope allotment site, which has been developed collaboratively by the staff and service users over the past year.

- The **PIPE team at HMP/YOI Low Newton** have been awarded the Enabling Environment Award by the Royal College of Psychiatrists.

- The **Teesside crisis service / Crisis assessment suite** and **Teesside rehabilitation services** have been shortlisted in the Psychiatric Team of the Year: Working-age adults category in the Royal College of Psychiatrists awards.

- The **Mental health services for older people, Durham and Darlington** has been shortlisted in the Psychiatric Team of the Year: Older-age adults category in the Royal College of Psychiatrists awards.

- The **Women's forensic learning disabilities secure service** has been shortlisted in the Psychiatric Team of the Year: Non age-specific in the Royal College of Psychiatrists awards.

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

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

3.3.1 Trust Strategic Direction Scorecard

This strategic goal is showing 5 indicators rated red out of 8, which is a deterioration on quarter 1 when we reported 3 rated red.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18											
	Indicator	Q2 Target 2017/18	Quarter 1 Actual	Quarter 2 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 2 (To continuously improve the quality and value of what we do)											
7	Number of outstanding action points for **more than 31 days** for Level 5 SIs and action points for safeguarding serious case reviews and domestic homicide reviews	0	8	13	⇩	0	21	23	0	n/a (indicator changed)	0
8	Number of action points on action plans for complaints and clinical audit that are outstanding for **more than 31 days**	0	2	5	⇩	0	7	24	13	8	0
9	Friends & Family Test - **Patient** Survey Question: "How likely are you to recommend our ward/services to friends and family if they needed similar care or treatment?"	>86.56	87.68%	87.58%	⇩	>86.56	87.63%	86.56%	86.01%	89.75%	> previous year out-turn
10	Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication	50%	14.29%	0.00%	⇩	50.00%	11.11%	17.14%	53.57%	34.48%	>=75%
11	Percentage of staff reporting that they can 'contribute towards improvements at work'*	>2015/16 (79%) and in top 20%ile of MH/LD trusts	Results due in Q4	Results due in Q4	n/a	>2015/16 (79%) and in top 20%ile of MH/LD trusts	Results due in Q4	76.00%	79% and in top 20%	77% but in top 20%	> 2018/19 and in top 20%ile for MH/LD Trusts
12	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family if they need care or treatment?"	>82.58%	83.98%	80.59%	⇩	>82.58%	82.18%	81.22%	82.58%	n/a	> previous year out-turn
13	For Trust hospital sites with over 10 beds, the trust score for each category (Cleanliness, Food, Privacy & Dignity, Condition, Appearance & Maintenance, Dementia Friendly, Learning Disability) > national average PLACE (new PEAT) assessments.	80%	Assessment due in Q2	33.33%	n/a	80%	33.33%	50.00%	80.00%	75.00%	80%
14	Hospitality Assured Accreditation score*	82.00%	No scoring for 2017/18	No scoring for 2017/18	n/a	82.00%	No scoring for 2017/18	81.10%	Assessment now due Q1 16/17 & results in Q2	80.5% (Mar 2015)	86.00%

Indicators of concern are:

- **KPI 7 - Number of outstanding action points on action plans for more than 31 days for Level 5 SI's and action points for safeguarding serious case reviews and domestic homicide reviews**– The Trust position for quarter 2 is 13 against a target of zero, which is a significant deterioration on quarter 1 when we reported 8. All relate to Level 5 SIs.

  The 13 outstanding actions are from a total of 4 action plans. Of those that were reported in quarter 1 there remain 2 outstanding actions.

- **KPI 8 - Number of action points on action plans for complaints and clinical audit that are outstanding for more than 31 days** – The Trust position for quarter 2 is 5 outstanding action points against a target of zero, which is worse than the quarter 1 position we reported 2.

  One relates to a complaint. The action required further resource and has subsequently been resolved.

  Four relate to Clinical Audit. Two actions for the Clinical Audit of Prescription and Administration Records are dependent on completion of a prescription chart review which has been subject to several delays. One action for the Clinical Audit of High Dose Antipsychotic Treatment was dependent on updates to the Trust's High Dose Antipsychotic Monitoring Sheet and is anticipated to be completed by the end of October. One action is outstanding for the POMH Quality Improvement Programme (QIP) 14b: Prescribing in Substance Misuse: Alcohol Detoxification (re-audit). That is dependent on a wider review of Substance Misuse prescribing guidelines and the policy update tied to this audit

action is timetabled for October 2017. Outstanding actions are monitored each month by the Clinical Effectiveness Group and where appropriate any actions >90 days are escalated to the Quality Assurance Committee. Where actions are outstanding >31 days it is usual for these to achieve completion by the following reporting period.

- **KPI 10 - Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication** –The Trust position for quarter 2 is 0%, against a target of 50%, which reflects 0 baseline assessment tools out of 2 being signed off by CEG within 6 months of publication. This is a worse position than the quarter 1 position of 14.29%.

  There were 2 baseline assessment tools signed off by the Clinical Effectiveness Group (CEG); however neither was within 6 months of publication.

  Following concerns being raised about the continued validity of this indictor, Board have approved that the CEG consider and propose an alternative KPI. This will be an agenda item in December's CEG.

- **KPI 12 - FFT - Staff Friends and Family scores - "How likely are you to recommend this organisation to friends and family if they need care or treatment?"** - The Trust position for quarter 2 is 80.59%, against a target of 82.58%, which 594 surveys out of 3060 where staff did not respond they were likely to recommend the Trust for care or treatment. This is a worse position than the quarter 1 position of 83.98%.

  Key themes in the narrative include, staffing levels, safety and low morale due to work load pressures and caseloads.

- **KPI 13 – For Trust hospital sites with over 10 beds, the trust score for each category (Cleanliness, Food, Privacy & Dignity, Condition, Appearance & Maintenance, Dementia Friendly, Disability) > national average PLACE (new PEAT) assessments –** The Trust position for 2017 for quarter 2 is 33.33%, which accounts for the Trust being over the national average in 2 of the 6 categories assessed. For the four categories where we are below the national average: Dementia, Disability, Cleanliness and Condition, Appearance & Maintenance, we are reporting below the national average by 6.73%, 5.70%, 2.70% and 2.68% respectively.

  Kaizen events are planned for Cleanliness and Food and other improvement events, including undertaking GAP analysis are to be undertaken in the remaining areas, to assess what needs to be done to improve.

3.3.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 2 were rated green (95%) which is an improvement on the Quarter 1 (92%) position.

There is 1 priority / service development in the Business Plan at high risk of failure to deliver on-time or within budget.

- 1 Priority requires additional time within year (which has been agreed by EMT)

3.3.3 Other Qualitative Intelligence

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

- The **suicide prevention training team**, part of mental health services for older people, were shortlisted in the Patient Safety Awards in the 'mental health award' category.
- The Trust has presented a video detailing its experiences in quality improvement to the King's Fund to support a report that explores how to embed quality improvement across whole organisations. In the video, staff talk about their experiences and offer insights about how to make quality improvement the routine way of working.
- The **Adult learning disability unit, Durham** and **Durham and Darlington child and adolescent mental health services senior management team** have been shortlisted in the Psychiatric Team of the Year: Quality Improvement category in the Royal College of Psychiatrists awards.

3.3.4 In conclusion it can be seen for this strategic goal, that of the five KPIs that can be compared to quarter 1, four are rated red and none have improved on the previous quarter. The Business Plan actions and qualitative intelligence provide a more encouraging position but further work is required around several KPI's including the number of outstanding action points for level 5 SI's to achieve a more positive position.

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

3.4.1 Trust Strategic Direction Scorecard

This strategic goal is showing 4 indicators rated red out of 12 as at quarter 2, which is deterioration on quarter 1 when we reported 2; only one of these indicators is reporting an improvement.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18											
	Indicator	Q2 Target 2017/18	Quarter 1 Actual	Quarter 2 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 3 (To recruit, develop and retain a skillled, compassionate and motivated workforce)											
15	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family as a place to work?"	>70.95%	72.00%	70.33%	⇩	>70.95%	71.11%	70.45%	70.95%	n/a	> previous year out-turn
16	Percentage of medical students and junior doctors reporting satisfaction with their placement	89.00%	90.77%	83.06%	⇩	89.00%	87.01%	89.97%	89.09%	87.25%	90.00%
17	Percentage of positive nursing placement evaluations received	95.00%	95.20%	96.60%	⇧	95.00%	95.20%	95.69%	95.17%	94.93%	95.00%
18	Excess cost of employing medical agency versus substantive	£75,000	£129,656	£102,028	⇩	£150,000	£231,684	£697,684	£200k	n/a	zero
19	NHS Employers Assessment of Wellbeing	100%	100.00%	100.00%	⇔	100%	100.00%	100.00%	100.00%	100.00%	100%
20	Percentage of Culture Metrics showing improvement at year end*	n/a	no longer reported	no longer reported	n/a	n/a	no longer reported	no longer reported	To be reported at July 16 Trust Board	16.67%	100%
21	Percentage of positive staff responses for training/development evaluations received (data is a month behind	75.00%	77.66%	82.57%	⇧	75.00%	80.80%	74.18%	75.30%	deferred	TBC
22	Quality of Appraisals	>4.0	Results due in Q4	Results due in Q4	n/a	>4.0	Results due in Q4	4.00	3.36	49% but in top 20%	>= 2018/19 & in top 20%
23	Percentage of medical staff successfully revalidated	100%	100.00%	N/A	n/a	100%	n/a	90.00%	98.15%	100.00%	100%
24	Percentage of indicators in the NHS Staff Survey for which there was no noticeable or sufficient different in responses of those who identified themselves as disabled, compared to those who did not identify themselves as disabled	>93.75%	Results due in Q4	Results due in Q4	n/a	>93.75%	Results due in Q4	93.75%	n/a		TBC
25	Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above	50%	22.86%	27.78%	⇧	50.00%	22.86%	8.08%	32.00%	34.02%	80.00%
26	Percentage of staff reporting that they 'suffered work related stress in last 12 months'*	<2015/16 outturn (28%)	Results due in Q4	Results due in Q4	n/a	<2015/16 outturn (28%)	Results due in Q4	33.00%	28% and top 20% (best for MH/LD Trusts)	38% but in top 20% (DEC 14)	< previous year out-turn

Indicators of concern are:

- **KPI 16 – Percentage of medial students and junior doctor4s reporting satisfaction with their placement –** the Trust position of 83.06% is, a deterioration on 90.77% reported in quarter 1 and below target by 5.94%

  The low satisfaction was particularly related to one of the training sites in the North Yorkshire locality and dissatisfaction at that time in relation to the inception of the Junior Doctor contract, related to workload and intensity. An action plan has been developed to address the trainees concerns and internal rotation. For the current trainees in those posts we have received improved ratings evidenced in the local feedback as part of the internal post reviews mid-point.

- **KPI 15 - FFT - Staff Friends and Family scores - "How likely are you to recommend this organisation to friends and family as a place to work?"** – The Trust position for quarter 2 is 70.33%, against a target of 70.95%, with 908 surveys out of 3060 where staff **did not** respond they were likely to recommend the Trust as a place to work. This is a worse position than the quarter 1 position of 72.00%.

  Key themes in the narrative include staffing levels, safety and low morale due to work load pressures and caseloads.

- **KPI 18 - Excess cost of employing medical agency versus substantive** - the Trust position for quarter 2 is £102,028 against a target of £50,00.

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

  A further agency member of staff was used to cover sickness in York and Selby (CYPS).

- **KPI 25 - Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above** – The Trust position for quarter 2 is 27.78%, which reflects 13 advertised posts out of 18 that did not have at least 2 internal candidates above the line for Band 7 posts and above. This is 22.22% below the target of 50% but is an improvement on the quarter 1 position of 22.86%

  Further improvement has been made against this target in this quarter; in July we identified 50% of recruitment processes that had 2 internal candidates above the line for Band 7 posts and above, potentially as a result of the increased focus on talent management and the investment and development of internal staff now emerging.

  Work is ongoing with regard to the publication of a new Value Stream Map following the redesign of talent management, with the aim to publish this in January 2018.

Other points to note:

- **KPI 23 Percentage of medical staff successfully revalidated** – There have been no revalidations due in quarter 2 and quarter 1 has been updated to reflect that 1 revalidation was due and undertaken..

3.4.2 Trust Business Plan

There were 7 business plan actions due to be completed by the end of quarter 2 of which 5 were rated green (71%) compared to the 4 actions rated green (100%) in Quarter 1.

There is 1 priority / service development in the Business Plan at high risk of failure to deliver on-time or within budget.

- 1 Priority requires additional time which moves into the next 18/19 financial year (to be agreed by Board).

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

3.4.3 Other Qualitative Intelligence

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

- **Dr Sarah Dexter-Smith**, Director of Therapies, Flatts Lane Centre, Middlesbrough, on being awarded the 2017 Faculty of Psychology for Older People's Bill Downes award.

- **Teresa Purvis**, clinical lead and **Joanne Pendleton**, clinical lead at HMP/YOI Low Newton delivered a fantastic workshop and poster presentation on our perinatal pathway at the Prison Quality Network' Annual Forum, Royal College of Psychiatrists, London. The excellent standard of their work was praised in writing by a representative from the Network.

- **Rollercoaster group, mindfulness team** and **employee support team** have been shortlisted in the Positive Practice in Mental Health Awards.

- **Dr Megan Brown** from Hull York Medical School is a finalist in the Foundation Doctor category in the Royal College of Psychiatrists awards, nominated by colleagues at TEWV when she was working with our York and Selby early intervention team.

- Our **employee support team** have been shortlisted in the mental wellbeing of staff category of the Positive Practice in Mental Health Awards.

- To support our **purposeful and productive community services** (PPCS) project, 10 members of staff have recently completed training to become master coaches.

- **Dr Mani Santhanakrishnan** has been shortlisted in the Psychiatric Communicator of the Year category in the Royal College of Psychiatrists awards.

- **Dr Ajith Suryadevara** has been shortlisted in the Specialty Doctor / Associate Specialist of the Year category in the Royal College of Psychiatrists awards.

- **Sheena Foster** and **Hazel Griffiths (Governor for the Trust)** have been shortlisted in the Carer Contributor of the Year category in the Royal College of Psychiatrists awards.

3.4.4 In conclusion it can be seen for this strategic goal that the number of red KPIs has increased by 2 since last quarter, with only one KPI rated red reporting an improvement. Of the seven KPIs that can be compared to quarter 1, three have improved and one has remained the same. The Trust will continue to benefit from an increased focus on talent management. In addition, the Business plan is showing a fairly positive position, however additional time is requested to allow one action to be completed. There is significant qualitative intelligence for this goal which provides a very positive position.

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

3.5.1 Trust Strategic Direction Scorecard

This strategic goal is showing one indicator rated red at quarter 2, which is the same as we reported for quarter1.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18											
	Indicator	Q2 Target 2017/18	Quarter 1 Actual	Quarter 2 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 4 (To have effective partnerships with local, national and international organisations for the benefit of the communities we serve)											
27	Attendance rate at H&WB Boards	90%	81.25%	75.00%	⇩	90%	78.26%	85.71%	87.50%	97.06%	90%
28	Attendance rate at Statutory Safeguarding Boards & MAPPA Strategic Management Boards	98%	100.00%	100.00%	⇔	98%	100.00%	100.00%	100.00%	98.59%	98%
29	Proportion of student nursing placements provided as a % of placements requested	90%	99.58%	97.51%	⇩	90.00%	98.60%	100.26%	99.12%	99.77%	90.00%
30	R&D Outcomes - Annual number of recruits to National Institute of Health Research studies supported by TEWV R&D staff	n/a	539	317	⇩	n/a	856	1105	412		10% increase year on year
31	R&D Outcomes - Annual external R&D income (including external grants and commercial income)	n/a	£168,674	£199,499	⇧	£678,014	£368,173	£585,215	£616,376	n/a	10% increase year on year
32	Corporate Governance Statement signed off annually by Board with no conditions* and Monitor Governance Risk Rating maintained at 'GREEN' each quarter	n/a	no longer reported	no longer reported	n/a	n/a	No longer reported	No longer reported	Signed & Green	Signed & Green	Signed & Green

Indicator of concern is:

- **KPI 27 Attendance at Health and Well Being Boards** – The Trust position for quarter 2 is 75.0%, which is a deterioration on 81.25% reported in quarter 1 and 15% below target.

  There were 9 H&WB Boards attended out of 12, with 2 unattended in County Durham and Darlington and 1 in Tees.

3.5.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 2 were rated green (100%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

3.5.3 Other Qualitative Intelligence

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

- The Trust's mental health team at **HMP YOI Low Newton**, Durham has been successful in being shortlisted for a Nursing Times Awards in the nursing for mental health category for Developing a perinatal mental health pathway within a female prison - a collaborative, cross-agency approach.

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

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

3.6.1 Trust Strategic Direction Scorecard

This strategic goal is showing 2 indicators rated red out of 7 as at quarter 2, which is the same as was reported in quarter 1.

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

Indicators of concern are:

- **KPI 33 - Percentage of data quality issues reported on Data Quality Scorecard (reds on scorecard)** – The Trust position for quarter 2 is 71.43%, which is the same as reported in quarter 1 and 33.93% more than expected and therefore an underperformance.

  Of the 10 metrics reporting red, all have shown some improvement on quarter 1, with the exception of 'Number of "system breaches" for CPA 7 day follow up' – which is reporting the same as quarter 1. The quality scorecard will continue to be monitored at the Data Quality Working group and escalated to the Managing the Business Sub group if required.

- **KPI 34 - Percentage of Information Strategy metrics on target that are reported on Information Strategy Metrics Scorecard –** the Trust position for quarter 2 is 71.43%, which is a deterioration on the quarter 1 position of 85.71%.

However, this will be the last time that this Information Strategy scorecard will be reported on. The measures within it are to be changed with the approval of the new scorecard and strategy, which is expected to be in November.

3.6.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 2 were rated green (100%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

3.6.3 Other Qualitative Intelligence

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

- The Vale of York CCG has agreed the Trust plans to build a 72 bed hospital in Haxby Road to replace Bootham Park Hospital.
- The External Governance Review was carried out by Grant Thornton as part of the NHSI requirement for all FTs to have an external review every three years. Overall it was very positive and the Board discussed and agreed the action it would take in response to the recommendations.

3.6.4 In conclusion it can be seen for this strategic goal that all of the KPIs that could be compared to the previous quarter have stayed the same or deteriorated; however taking into account progress against the Business Plan and qualitative intelligence, the overall position remains positive.

4. IMPLICATIONS:

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

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

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

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

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

5. RISKS:

There are no identified risks associated with this paper.

6. CONCLUSIONS:

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

This report reflects that two of the Trust's five goals are in a positive position, whilst still acknowledging that there is work to do to improve some KPI's. There has been a deterioration in KPI performance within Goals 1, 2 and 3; however it is noted that there is a much more positive position reported when considering the business plan and qualitative intelligence reported for these goals.

Overall the scorecard position has shown a deterioration when compared to quarter 1; however data is not available for all KPIs. There has been a reduction in the number of greens reported. Of the 15 KPIs reporting red at quarter 2, 12 have reported a deterioration. In comparison to the quarter 1 position for those indicators where data can be compared 5 have improved, 16 have deteriorated and 4 remained the same.

7. RECOMMENDATIONS:

Board of Directors are asked to:

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

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Sharon Pickering
Director of Planning & Performance

Background Papers:

Board requests for changes:

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
1.3a	Deliver a new model of care for Adult Mental Health and Mental Health Services for Older People in Harrogate	NY	AMH / MHSOP	Develop revised Service Model	Revised Service Model approved by TEWV Board and HaRD CCG	Q3 17/18	Adele Coulthard	**R**	The pre engagement and early conversations are just beginning in Harrogate. Formal consultation will then be required and a service model will not be developed by the end of Q3. **Trust Board is requested to agree a change in the wording of this metric to "Service principles agreed" EMT are also requested to agree an extension in timescale to Q4 17/18**
1.7t	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - NE Prison Cluster	Forensic		Following notification of commissioner intent to re-procure service by end of 17/18, respond in line with required timescales	Tender documents submitted as required	Q2 17/18	Lisa Taylor	**GY**	Following the commencement of the process, notification was then received from commissioners that they were abandoning the procurement. It is anticipated that the current contract will be extended for an additional 2 years. Therefore **Trust Board is requested to approve removal of this action from the business plan.**
3.7aa	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - Start from Home process for identified facilities staff	Estates	N/A	Implement recommendations and actions identified from feasibility study	Actions plan developed	Q4 17/18	Dave Turner	**R**	Due to the ongoing issues of the reliability of the hand held solution for implementing a start from home process for identified facilitates staff. **Trust Board is requested to extend the completion date to Q2 18/19**

ITEM NO. 19

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th November 2017**
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:	**28th November 2017**
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
319	14.11.17	Underlease for part of Seaham Primary Care Centre	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
320	14.11.17	Appointment agreement in relation to civil and structural design services for the York Inpatient Facility	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
321	14.11.17	Appointment agreement in relation to building engineering services and BREEAM assessment services for the York Inpatient Facility	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary

4. IMPLICATIONS:

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

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

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

4.4 **Equality and Diversity:** None identified.

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

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

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution
Seals Register

ITEM NO. 20

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28 November 2017**
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 new policy required ratification:

- **IT-0034-v1 Printing Policy**

Two policies have undergone minor amendment and required re-ratification:

- **PHARM-0001-v8.2 NMP Policy to Practice**
- **CLIN-0026-v2.1 Child Visiting Policy**

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meeting held on 01 November 2017

DATE:	**28 November 2017**
TITLE:	**Policies and Procedures Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

1. INTRODUCTION & PURPOSE:

The purpose of this report is to advise the Board of Directors on the policies and procedures that have been ratified by the Executive Management Team.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 It is important that the Trust policy portfolio is updated and revised in a timely way to ensure best practice, current legislation and regulation is reflected in policy content. Policies no longer required to control and assure practice should be terminated and withdrawn from the portfolio.

2.2 Following the last revision of the Trust's Integrated Governance arrangements, it was agreed that the Executive Management Team ratify all new and revised Trust policies and procedures.

2.3 Each policy and procedure ratified by the Executive Management Team will have gone through the Trust's consultation process.

2.4 Currently all corporate Trust policies are ratified by the EMT on behalf of the Board of Directors, following approval by the appropriate specialist committees and groups. All decisions regarding the management of the policy framework must be ratified by the EMT.

3. KEY ISSUES:

3.1 The following new policy has been added to the policy portfolio and requires ratification:

IT-0034-v1 Printing Policy
Review date: 01 November 2020

This new policy sets out the approved methods of using print devices, and printing within the Trust, whilst maintaining cost-effectiveness and efficiency. EMT ratified the new policy and reclassified the document as a procedure.

3.2 The following have undergone minor amendment and require re-ratification:

PHARM-0001-v8.2 NMP Policy to Practice
Review date: 02 November 2019

The policy has additional essential criteria that level 2 NMPs should evidence before considering applying for level 3.

CLIN-0026-v2.1 Child Visiting Policy
Review date: 22 February 2020

The policy now cross-references the Child Visiting Protocol: Forensic Services.

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 07 June 2017 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