AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 28TH MARCH 2017 VENUE: THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meeting of the Board of Directors held on **28th February 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 a briefing on key issues in Forensic Services.	**Levi Buckley to attend**	**Presentation**
Item 7	To receive and note the report of the Freedom to Speak Up Guardian.	**Dewi Williams to attend**	**Attached**
Item 8	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 9	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 10	To approve the scorecard for the Recovery and Wellbeing Strategy 2017/2020.	**BK**	**Attached**
Item 11	To consider a report on mortality reviews.	**EM**	**Attached**

Performance (11.00 am)

Item 12	To consider the Finance Report as at 28th February 2017.	**DK**	**Attached**

Item 13	To consider the Trust Performance Dashboard as at 28th February 2017.	**SP**	**Attached**

Governance (11.15 am)

Item 14	On the recommendation of the Resources Committee to approve the interim Programme Management Framework.	**SP**	**Attached**
Item 15	On the recommendation of the Resources Committee to approve the model for monitoring progress on the delivery of key/primary strategies.	**SP**	**Attached**
Item 16	To approve the Information Governance Toolkit submission for 2016/17.	**DK**	**Attached**

Items for Information (11.30 am)

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

Item 19 To note that the next meeting of the Board of Directors will be held on Tuesday **25th April 2017** in Lake House, 20 Manor Court, Scarborough Business Park, Eastfield, YO11 3TU at 9.30 am.

Confidential Motion (11.35 am)

Item 20 **The Chairman to move:**

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

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

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

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

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

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

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

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.

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
22nd March 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 28TH FEBRUARY 2017 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Mr. J. Tucker, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Dr. H. Griffiths, Non-Executive Director
Mr. 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
Dr. N. Land, Medical Director
Mr. D. Kendall, Interim Director of Finance and Information
Mrs. E. Moody, Director of Nursing and Governance
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Ms. D. Oliver, Deputy Trust Secretary (Corporate)

17/29 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. D. Jennings, Non-Executive Director.

Issues raised by Mr. Jennings, as set out in an email to the Chairman dated 26th February 2017, were discussed as part of the consideration of relevant agenda items.

17/30 MINUTES

***Agreed** – that the public minutes of the last meeting held on 31st January 2017 be approved as a correct record and signed by the Chairman.*

17/31 PUBLIC BOARD ACTION LOG

Consideration was given to the Public Board Action Log.

Arising from the report:

(1) Further to minute 16/258 (25/10/16) Dr. Land confirmed that he had held discussions with the local universities, including Newcastle University, on the potential use of their existing international links to support medical recruitment.

The Board noted that Teesside University's role in supporting the recruitment of junior doctors by South Tees Hospitals NHS Foundation Trust would be further explored.

(2) Further to minute 17/07 (31/1/17) it was noted that:

(a) Mrs. Pickering would be providing Mrs. Moody with a list of significant service changes contained in the Business Plan, once it had been signed off, together with their expected workforce implications so that visibility on planned and unplanned staffing changes could be referenced in future nurse staffing reports. Reporting on this matter was due to commence from the next six monthly nurse staffing report in July 2017.

Action: Mrs. Picking and Mrs. Moody

(b) Mrs. Moody had reviewed the incidents of medication errors at Lustrum Vale with the Head of Nursing. Whilst no trends had been found the review had identified some competency issues which would be addressed.

17/32 DECLARATIONS OF INTEREST

There were no declarations of interest.

17/33 CHAIRMAN'S REPORT

The Chairman drew attention to her report to the meeting of the Council of Governors held on 21st February 2017.

17/34 GOVERNOR ISSUES

The Board noted that, at its meeting held on 21st February 2017, the Council of Governors had re-appointed Mrs. Bessant as the Chairman of the Trust for a further term of office of three years.

17/35 QUALITY ASSURANCE COMMITTEE

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

(1) The confirmed minutes of its meeting held on 1st December 2016 (Appendix 1 to the report).

(2) The key issues discussed by the Committee at its meeting held on 2nd February 2017.

The Board's decision, in response to the recommendation arising from this meeting, to include a separate risk on medical recruitment in the Board Chapter of the Integrated Assurance Framework and Risk Register is recorded under minute 17/C/52.

Arising from the report:

(1) Mrs. Moody advised that it was intended to undertake a gap analysis and provide a report to the Board on the actions required to meet the CQC's expectations for the implementation of the recommendation aimed at provider organisations in its national report "Learning, Candour and Accountability" once guidance had been provided by the regulator at an event to be held in March 2017.

Action: Mrs. Moody

(2) Mrs. Moody provided assurance that, although the position for Quarter 3, 2016/17, on the percentage of complaints satisfactorily resolved was, at 21%, worse than target and the lowest level of performance for the year to date, no trends had been identified in relation to this matter.

(3) Mr. Levy provided clarity, in relation to section 6.2 of the report, that the Workforce Race Equality Standard (WRES) related to race only and not to other protected characteristics; however, a Workforce Disability Equality Standard was being developed, at present, by NHS England which it was intended to mandate via the NHS Standard Contract from April 2018.

17/36 NURSE STAFFING REPORT

The Board received and noted the exception report on nurse staffing for December 2016 and January 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").

The focus of discussions was on the introduction of severity scores to indicate potential areas of concern from a safe staffing perspective.

Board Members welcomed the introduction of the severity scores but highlighted that, for assurance, knowledge and awareness of the issues faced by individual wards remained vitally important.

This was acknowledged and it was noted that Mrs. Moody and Mr. Kilmurray were working on how the information could be fed into the performance improvement groups to contribute to their understanding of when wards were experiencing difficulties.

With regard to the development of the severity scores, Mrs. Moody explained that:

(1) The scoring methodology was based on professional judgement and took into account the risks arising from issues reported through the DATIX system.

(2) It was proposed that the monthly scores would be shared with operational services to enable exceptions to be highlighted with more comprehensive analyses being provided in the six monthly nurse staffing reports.

Board Members made the following suggestions about the future presentation of the information:

(1) That wards of similar types should be grouped together in the reports to support learning.

Mrs. Moody undertook to introduce this approach in the next nurse staffing report.

Action: Mrs. Moody

(2) That cumulative information should be provided.

Board Members recognised the benefits of this and suggested a number of approaches to reporting the information e.g. by way of a separate table or through the introduction of a separate indicator.

Mrs. Moody undertook to discuss how this could be best achieved with the Head of Quality Data.

Action: Mrs. Moody

(3) That a measure of the familiarity bank and agency staff had with the ward on which they were working should be introduced.

Board Members noted that the collection and analysis of this data would be overly complex and considered that it was more appropriate to continue to follow up concerns and seek assurance from wards with high bank/agency usage with feedback being provided in the narrative of the nurse staffing reports.

In relation to this matter concerns were raised that an "amber" score for bank usage was classed on a par with the receipt of a complaint.

Mrs. Moody explained that the purpose of scoring bank usage was that it provided an indication of whether the staffing and skill mix on a ward was appropriate and undertook to provide further clarity in future reports on this matter.

Action: Mrs. Moody

(4) That, to provide greater understanding and to support the identification of potential correlations, the data for each ward should be grouped into inputs (e.g. fill rates, bank and agency usage) and outcomes (e.g. SUIs, complaints etc).

In response the Chairman considered that the information in the columns in the tables should be arranged under headings for inputs and outcomes.

Action: Mrs. Moody

With regard to the other matters covered in the report:

(1) Mrs. Moody advised that it was intended to provide a report to the Board on the outcome of the comprehensive analysis being undertaken of vacancies and staffing pressures across the North Yorkshire Locality.

Action: Mrs. Moody

(2) In view of the low staffing fill rates, Mr. Martin asked Mrs. Moody to look into the staffing establishment and skill mix at The Orchards compared to other rehabilitation units.

Action: Mrs. Moody

(3) In response to a suggestion from the Non-Executive Directors, Mrs. Moody undertook to RAG rate the data on agency usage in Appendix 2 to the report (Scored Fill Rate compared to Quality Indicators).

Action: Mrs. Moody

(4) In response to a question, the Board noted that reporting on the national metric "care hours per patient day" was likely to commence in April 2017; however, Mrs. Moody advised that the data would need to be treated with caution as the metric had not been designed for mental health settings.

17/37 MENTAL HEALTH LEGISLATION COMMITTEE

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

(1) The confirmed minutes of its meeting held on 19th October 2016 (Appendix 1 to the report).

(2) The key issues discussed by the Committee at its meeting held on 19th January 2017.

The Board:

(1) Welcomed the focus on addressing commonly recurring themes arising from CQC Mental Health Act (MHA) visits and noted that an action plan was due to be presented to the Committee's next meeting with recommendations on how best to take a Trust-wide approach to reducing the incidence of those matters.

(2) Discussed the impact of the number of people voluntarily attending the Crisis Assessment Suite (CAS) at Roseberry Park with the police (131 for Quarter 3, 2016/17, compared to 40 who had been brought to the facility subject to Section 136 of the MHA).

It was noted that:

(a) During his recent visit to Foxrush House, staff had informed Mr. Martin that the voluntary attendance of people with the police was not considered to be problematic and links with the police, including through the street triage service, were improving.

(b) The reduction in the use of Section 136, which was comparatively high nationally, was a positive development.

(c) From the data it was evident that, whichever way they attended, people requiring assessments were being brought to the CAS.

(3) Noted the circumstances which had led the Trust to challenge the legality of a Mental Health Tribunal's decision in relation to a deferred discharge from detention.

The Chairman asked Mrs. Moody to provide Mr. Jennings with details of this case.

Action: Mrs. Moody

(4) Received assurance that patients secluded for lengthy periods were subject to independent assessments.

17/38 FINANCE REPORT AS AT 31ST JANUARY 2017

The Board received and noted the Finance Report as at 31st January 2017.

In response to questions, Mr. Kendall:

(1) Advised that in-year contract variations had contributed to actual performance on the delivery of CRES being ahead of plan.

(2) Provided assurance that the level of total receivables over 90 days past their due date, although above the 5% finance risk tolerance and a deteriorating position, was not a cause for concern as the majority of these debts were as a result of

CCG processes and national reconciliation procedures were in place to clear them by year-end.

17/39 PERFORMANCE DASHBOARD AS AT 31ST JANUARY 2017

The Board received and noted the Performance Dashboard Report as at 31st January 2017.

In accordance with minute 17/14 (31/1/17) the report highlighted that in January 2017 the Trust had not achieved the target for the metric "IAPT Services - Proportion of people completing treatment who move to recovery" included in NHS Improvement's Single Oversight Framework.

Mrs. Pickering reported that:

(1) The target had been achieved in three CCG areas and not two as stated in the report.

(2) A common theme impacting on the achievement of the target in the two CCG areas in County Durham and in the Vale of York was the high dropout rate of service users and that action plans developed by the Localities included measures to reduce this.

(3) Work was being undertaken with the CCG in Scarborough and Ryedale to seek to understand the reasons why GPs were not referring people promptly to the service as those accessing it tended to be more poorly than in other areas and this, therefore, contributed to difficulties in meeting the national definition of recovery.

(4) Although an action plan was in place for the service in York and Selby, this would be updated in response to feedback from the review being undertaken by the national Intensive Support Team which had been jointly hosted by the Trust and the CCG.

The Board considered the overall position of the Performance Dashboard metrics as 10, of 21, had "red" rated trend arrows for the last three months.

It was noted that those metrics of most concern were highlighted in the narrative of the report, together with information on the work being taken to improve performance, and it was for the Board to determine whether the assurances provided were sufficient or whether further actions should be taken.

Mrs. Pickering advised that, of the indicators with red rated trend arrows, only five caused her concern:

(1) KPIs 1 (External referrals); 9 (Out of locality admissions); 14 (Actual number of workforce in month); and 18 (Sickness absence rate) which were covered in the narrative to the report.

(2) KPI 15 (Percentage of registered healthcare professional jobs that are advertised two or more times) in view of the volatility of the data.

The Board discussed concerns raised about external referrals due to the impact on waiting times if these continued to increase.

In relation to this matter:

(1) Mrs. Pickering explained that the key issue was the relationship between GPs and community teams. The Trust had taken the view that services should accept all referrals and, where a person was assessed as not requiring Trust services, they should be signposted elsewhere and the GP informed. This approach was not merely to inform the GP of the action taken but to seek to make them aware of other more appropriate means of responding to their patients' needs in the future.

(2) Dr. Land highlighted the implications of variations in non-statutory community infrastructure across the Trust's area. Where this was limited, for example in North Yorkshire, the Trust tended to hold onto referrals that did not meet the criteria for secondary mental health care as they could not be signposted elsewhere. This could have adverse consequences for both the service user, as they would become embedded in the system, and for the Trust as it created financial pressures.

(3) It was also noted that growth in external referrals also occurred as a result of service developments.

(4) The Non-Executive Directors sought clarity on the implications of the tendency for GPs in Scarborough to hold on to patients on the rate of external referrals.

In response it was noted that the IAPT service in the locality was relatively small and did not skew the external referral rate; however, it did impact on the recovery rate.

Consideration was given to whether the target for the indicator should be amended to reflect the above matters.

The Board noted that it would be difficult to achieve the level of sophistication required to set a more meaningful target as referrals varied by geography and over time.

Dr. Land observed that the key issue was the extent the Trust was able to flex resources in response to greater and lesser demand.

In addition:

(1) The Chairman highlighted that the data on out of locality admissions and bed occupancy raised the question of whether the Trust had sufficient beds.

Mr. Kilmurray responded that work was being undertaken on bed capacity and a report on this matter was due to be provided to the Board, probably at its meeting to be held on 25th April 2017.

(2) In response to a question, it was noted that underperformance on KPI 14 (Number of patients with a length of stay of greater than 90 days) was only partly due to challenges in the social care sector but also arose from the way the indicator was measured.

Mrs. Pickering:

(a) Explained that, at present, the indicator was measured on discharge and the present position reflected the success of ongoing work to improve the management and discharge of people with long lengths of stay.

(b) Advised that it was proposed to change the construction of the indicator for 2017/18 so that it provided assurance that lengths of stay were appropriate or, if this was not the case, that action was being taken whilst the service user was still in receipt of inpatient services.

17/40 STRATEGIC DIRECTION PERFORMANCE REPORT

Consideration was given to the Strategic Direction Performance Report for Quarter 3, 2016/17 including proposals to:

(1) Amend the Trust Business Plan (as set out in Appendix 1 to the report).

(2) Change the construction of KPI 6 ("Percentage of service users with a recovery focused action plan (Adult Mental Health)" to "Number of service users open to psychosis/assertive outreach teams at quarter end, who have been in service for 12 weeks or more" to address the issue reported under minute 16/293 (29/11/16) that, due to the model lines process, recovery stars were completed within 12 weeks of first appointment and this could result in patients being seen as breaches for some time if they had been in service for less than this period of time.

(3) Remove the following metrics from the Strategic Direction Performance Reports:
   (a) KPI 20 (Percentage of Culture Metrics showing an improvement at year end) in response to the decision under minute 16/289 (29/11/16) to cease reporting culture metrics at an organisational level whilst a new set of metrics was developed.
   (b) KPI 32 (Corporate Governance Statement) as the submission of the document was no longer required by NHS Improvement following the introduction of the Single Oversight Framework.

Arising from the report:

(1) It was noted that, with regard to Business Plan ref. 3.5, at its meeting held on 25th January 2017 the EMT had deferred the production of a staff engagement plan until July 2017 in order that it could be considered in the context of the actions to support the priority on "The TEWV Way".

(2) The Non-Executive Directors:
   (a) Highlighted the position on the metrics supporting Strategic Goal 2 where, of eight, three were rated "red" and data for the quarter was not available for four metrics.

   In response Mrs. Pickering:
   - Recognised that the achievement of the KPI targets was challenging but highlighted that the Business Plan priorities relating to the Strategic Goal were, generally, on track.
   - Considered that the metric on the patient survey question "How likely are you to recommend our ward/services to friends and family if they needed similar care or treatment?" under the Friends and Family Test was the most important in terms of the Trust's position on the Strategic Goal and was rated "green" for the Quarter.

   (b) Expressed their disappointment about the changes made by the CQC to the reporting of the results of the annual service user survey (KPI 4) as the

new arrangements did not provide any insight into the Trust's performance.

The Board noted that no consultation had been undertaken by the regulator prior to the changes being made.

In view of the Board's concerns Mrs. Moody offered to write to the CQC to ask for the data to be provided in the previous format or for the raw data from the survey to be supplied.

(c) Highlighted the deterioration on performance on KPI 8 ("Number of action points on action plans for complaints and clinical audit that are outstanding for more than 31 days") in the context of compliance culture issues discussed by the Audit Committee.

In response the Board received assurance that the EMT had recognised these concerns and had acted on them with all of those actions, bar one, due in Quarter 3 now having been completed.

(3) Mr. Levy reported that there were risks that the development of an Extending Working Lives procedure (Business Plan ref 3.5) would not be achieved by the proposed revised completion date of Quarter 4, 2016/17, as there had been delays in receiving the results of the research study conducted by Leicester University.

The Chairman considered that the revised date should be approved but noted Mr. Levy's concerns.

Agreed –

(1) that the changes to the Trust Business Plan detailed in Appendix 1 to the report be approved;

(2) that KPI 6 be amended to be "Number of service users open to psychosis/assertive outreach teams at quarter end, who have been in service for 12 weeks or more"; and

(3) that reporting on KPIs 20 and 32 be ceased.

Action: Mrs. Pickering

17/41 USE OF THE TRUST SEAL

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

17/42 POLICIES AND PROCEDURES RATIFIED BY THE EXECUTIVE MANAGEMENT TEAM

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

17/43 DATE AND TIME OF NEXT MEETING

It was noted that the next meeting of the Board of Directors would be held, in public, at 9.30 am on Tuesday 28th March 2017 in the Board Room, West Park Hospital Darlington.

17/44 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 any particular applicant for, or recipient or former recipient of, any service provided by 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.

Information which is held by the Trust with a view to its publication, by the Trust or any other person, at some future date (whether determined or not), and it is considered reasonable, in all the circumstances, to withhold the information from disclosure until that date.

Following the transaction of the confidential business the meeting concluded at 12.00 noon.

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th March 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

Date	Minute No.	Action	Owner(s)	Timescale	Status
24/05/2016	16/123	A briefing on human rights to be provided to a future Board Seminar	DL/PB	Mar-17	Completed (BoD Seminar held on 14/03/2017)
21/07/2016	16/176	A briefing on pathways to be provided to a Board Seminar	BK/PB	Apr-17	
27/09/2016	16/218	Automatic reporting of seclusion from the PARIS system to be urgently addressed	DK	Jun-17	
29/11/2016	16/284	Report to be provided to assure the Board on future bed capacity taking into account the developments planned in Harrogate and York and the impact of work to reduce bed pressures	BK	~~01/03/2017~~ 25/04/2017	Revised date notified to the BoD at its meeting held on 28/02/2017
29/11/2016	16/286	The significant variation between services in relation to nurse placement activities to be looked into	EM/DL	Mar-17	Verbal update to be provided at the meeting
29/11/2016	16/286	A more refined approach to nurse recruitment focussed on experience as well as numbers to be looked into	DL	May-17	
29/11/2016	16/286	A progress report to be provided to the Board on the Recruitment and Retention Action Plan	DL	May-17	
29/11/2016	16/289	A report to be provided to the Board on the proposed values consultation in early summer 2017 prior to its launch	DL	Jun-17	

Date	Minute No.	Action	Owner(s)	Timescale	Status
29/11/2016	16/289	A report on the findings of the values consultation exercise to be provided to the Board	DL	Mar-18	
29/11/2016	16/289	Team based culture metrics reports to be introduced	DL	Nov-17	
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	
29/11/2016	16/293	A briefing to be provided to a Board Seminar on Teepa Snow's "Positive Approach to Care for people living with Dementia"	CM	~~Mar-17~~ May-17	To be included as part of the MHSOP SDG briefing
20/12/2016	16/311	Further work to be undertaken on the reporting and presentation of assurances in relation to the Quality Strategy	EM	Mar-17	Completed
20/12/2016	16/312	Opportunities to develop RMNs to take responsibility in a learning disability setting to mitigate the lack of specialist nurses for this speciality to be looked into	EM	Apr-17	
20/12/2016	16/312	A report to be provided to the QuAC detailing the proportion of experienced nursing staff versus those on preceptorship on each ward in forensic services	EM	~~Mar-17~~ May-17	The change of date is aligned to the next LMGB report to the QuAC
20/12/2016	16/313	The operation of the Resources Committee to be reviewed in 12 months or sooner if issues arise	PB	Dec-17	
31/01/2017	17/02	An event to be arranged to update Directors and key stakeholders, including the Chief Officers of the CCGs, on the Trust's progress on recovery and future plans	BK	Mar-17	The event is scheduled to be held on 12/05/17
31/01/2017	17/07	A briefing to be provided to the Board on the Trust's position against the Stirling dementia design guidelines and the programme of work to address the gaps identified	BK	Apr-17	

Date	Minute No.	Action	Owner(s)	Timescale	Status
31/01/2017	17/07	Enhanced observations linked to specific packages of care to be identified in nurse staffing reports	EM	Mar-17	This information will be included in future reports when relevant
31/01/2017	17/08	The scorecard to support the Recovery Strategy to be signed off by the Board	BK	Mar-17	See agenda item 10
31/01/2017	17/08	A statement to be included in the Recovery Strategy to demonstrate organisational commitment to recovery; to emphasise that recovery was central to the achievement of the Trust's Strategic Direction; and to recognise that structures and processes need to be aligned to its delivery	BK	Mar-17	Completed
31/01/2017	17/08	Further thought to be given to the alignment of the Recovery Strategy and the work being undertaken on the Triangle of Care in relation to carer training	BK/EM	Mar-17	Verbal update to be provided at the meeting
31/01/2017	17/09	A further report on waiting times in CAMHS, including the Trust's position against the national reporting requirements being introduced by NHS England, to be presented to the Board	BK	Jul-17	
31/01/2017	17/12	A review of the Trust Performance Dashboard targets to be undertaken	SP	Jul-17	
31/01/2017	17/13	A stock take of recruitment activity, including in relation to AHPs and medical staff, to be undertaken	DL	May-17	
31/01/2017	17/13	The indicators included in, and the format of, the summary workforce dashboard to be reviewed	DL	Apr-17	
28/02/2017	17/31	To commence the identification of planned and unplanned staffing changes in nurse staffing reports	SP/EM	Jul-17	

Date	Minute No.	Action	Owner(s)	Timescale	Status
28/02/2017	17/36	The following changes to the presentation of the severity scores in the nurse staffing reports to be introduced: - To group similar wards together - To group the information in columns based on inputs and outcomes - Following discussions with the Head of Quality Data to include cumulative information - To include additional narrative to provide context on the scoring of bank usage	EM	Apr-17	
28/02/2017	17/36	Report to be provided to the Board on the outcome of the comprehensive analysis of vacancies and staffing pressures being undertaken in the North Yorkshire Locality	EM	Jun-17	
28/02/2017	17/36	To review the staffing establishment and skill mix at The Orchards compared to other rehabilitation units	EM	Jun-17	
28/02/2017	17/36	To commence RAG rating data on agency usage in Appendix 2 to the nurse staffing reports	EM	Apr-17	
28/02/2017	17/37	To provide Mr. Jennings with details of the case where the Trust had challenged the legality of a Mental Health Tribunal's decision in relation to a deferred discharge from detention	EM	-	Completed
28/02/2017	17/40	In relation to the Strategic Direction Performance Report, approval: - To change to the Business Plan (as set out in the Appendix to the report) - To amend the construction of KPI 6 - To cease reporting on KPIs 20 and 32	SP	-	Approved

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Trust Board Briefing

Forensic Service

Levi Buckley

28th March 2017

making a difference together

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

- **Inpatient Reconfiguration -** Development of options for configuration of inpatient provision which best places TEWV to respond to the market and effectively meets patient needs
- **Pathways -** Development of pathways and associated standard work in the following specialist areas: Autism, Perinatal, LD and Dementia
- **Implement the Transforming Care agenda in Learning Disability Services -** establishment and development of Secure Outreach Transitions Team, Inpatient Bed Reconfiguration
- **Implement the 5 Year Forward View for Mental Health** as agreed with each of our commissioners - Physical Health: In House Medical Management, Primary Care Interventions, Specialist Clinics, Obesity Strategy and Roseberry Park Site Wide opportunities.

To continuously improve the quality and value of our work

- Evaluation of Daily Lean Management approach to ensure embedded across the Locality

- Further development of Patient Experience/Engagement

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

- Build upon previous learning from across professions and identify 'what works'
- Identification of opportunities for possible income generation in the delivery of training both to our staff and by our staff
- Review of Psychology Service to best meet patient needs

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

- Assess the future market position for Forensic services
- Consider further opportunities for new business in line with agreed OH Business Strategy
- PD Pathway - Submission of bid in line with timescales specified by NOMS
- Arrange workshop to bring together AMH and OH staff and encourage greater joint working where appropriate
- Transfer Fulmar Ward to Tees locality (September 2017)
- To respond to NHSE NE prison procurement
- Implement NW Prisons contract (sub-contractor to Spectrum)
- Expand liaison and diversion service
- To respond to possible NHSE procurement in Forensic Mental Health

To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve

- Daily Lean Management
- Model Ward Project
- Transforming Care Project

ITEM NO. 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th March 2017**
TITLE:	**Report of the Freedom to Speak Up Guardian**
REPORT OF:	**Freedom to Speak Up Guardian**
REPORT FOR:	**Information**

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

Executive Summary:

This report is for information and outlines the development during the first 5 months of the Freedom to Speak Up Guardian's role. It discusses how the role has been established, how the communication strategy has raised awareness of the role, and gives examples of some initial cases. It then goes on to outline proposals to roll out the training programme, develop a managers tool for recording concerns, and how I intend to monitor out comes.

Recommendations:

To note the contents of the report and to comment accordingly

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**28TH MARCH 2017**
TITLE:	**REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board about how the first five months since the post of Freedom to Speak Up Guardian was established have gone. The report will outline actions and activity to date and discuss how we intend to further develop the role in the coming year.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 As noted in the Board minutes of 21st July 2017, the trust was required to establish the role of a trust Freedom to Speak up Guardian by October 2016. I was appointed to the role in October 2016 on a one day a week basis.

2.2 To date eight staff members have raised concerns and two issues have been completed and closed.

3. KEY ISSUES:

3.1 **Visibility and accessibility**. The communications strategy has deliberately been incrementally introduced to allow time for my induction and development of the role. I now have a page on in-touch with contact details, and a picture of me which has proved useful when meeting unknown staff in neutral venues! It also has 3 posters for services to download and display in their work area advertising the service. I have also been featured in the 'Insight' magazine which introduced the role and gave contact details.

3.2 I am notionally based in Flatts lane and have access to the multi-faith room. However meetings to date have mostly been off site at the complainant's request. Of the 8 cases so far, 2 were referred via the staff psychological service, 2 via trade union representative, with the remainder learning of the role through their work place. It is expected that more staff will come forward as the service becomes more widely known and the training proposed training programme starts.

3.3 I have attended a number of trust meetings and events to raise awareness of the role. This includes the Joint consultative committee, the LNC, and 3 Leadership and Management network events. However, the most useful activity in raising the profile of the role has been through site visits informally and speaking with staff. It is proposed that on the half day training sessions with locality managers I will use the opportunity to visit locality teams to raise the profile.

3.4 **External support.** The National Guardian's Office led by Dr Henrietta Hughes, have hosted 2 national conferences to date for all trust guardians. As this remains a new role the majority of the presentations have been about establishing the role and how best to address issues raised. We are expected to commit to attend at least 2 national conferences a year. The national team also hosted a training day for all new guardians to try and establish some shared understanding of the role, and some consistency of approach. Part of the support has been the development of a regional guardians group who have committed to quarterly meetings to share experiences and 'learn the lessons.' To date we have met twice supplemented with regular e-mails seeking support, advice, and reassurance.

3.5 **Training.** In December 2016 myself, David Levy, and Stuart Craig (Ward Hadaway) delivered a test training day for managers on handling concerns/whistleblowing. This appeared to be well received. The initial aspiration was to develop a 'training the trainers' package. However whilst many of the participants felt they could support further training rollout, they felt they could not commit to all the training commitment proposed at the time.

3.6 The trust has committed to rolling out a mandatory half day training programme for all Band 7 and above staff with staff management responsibilities on how to handle raised concerns starting from April. It is proposed to deliver 24 sessions for up to 20 staff to meet the requirement. The aspiration is that all managers will attend next year and then commit to renewal every 5 years. The training department are about to publish dates and venues to be delivered in all localities of the trust. I will deliver the training, and hope to jointly deliver with locality managers who attended the original programme to ensure that local service differences can be reflected.

3.7 **Data management.** The collection and analysis of information is central to ensuring that we manage and respond to all raised concerns equitably and learn from our experience. We know from the leadership and management network that a lot of raised concerns are handled and satisfactorily resolved at the local level. However, we do not capture this information, so have little awareness of the scale of concern, or the rate of successful resolution. However, most importantly we are unable to share the learning. We are currently developing a recording tool for managers to complete. It is anticipated that we will have commissioned this in time to coincide with the rollout of the training for managers. This tool will enable analysis of the data and provide the trust with robust information about trends, 'hotspots' and learning opportunities. It is also anticipated that eventually the National Guardians office will require some anonymised data submission.

3.8 **Time management.** Given the phased publicity of the role, working one day a week has proved manageable initially. This has allowed time for a predominantly reactive service responding to raised concerns. However the trusts ambition is to develop a more proactive service that not only responds

to raised concerns, but delivers training and works with teams to develop a more open and transparent culture that encourages staff to feel empowered to raise concerns as part of their everyday work. To this end the post hours have recently been increased to 2 days a week.

3.9 **Outcome measurement**. Bi- annual reports to the trust will allow for monitoring of performance. Analysis of data from the tool being developed should supply the information on numbers and trends. Numbers of staff trained will also give an indication of time spent. Impacting on our trust staff satisfaction survey remains a reasonable longer term aspiration. However feedback from staff who feel helped by the service and tangible examples of generalisable lessons learned remain the primary goal.

3.10 **Case Examples**. 2 complainants report a 5 year history of working in a team where the manager's attitude and behaviour has eroded their self-confidence. Whist both found it difficult to describe the behaviour as bullying, both were clear that the long term lack of support, and belittling of their concerns had left them and other members of their team feeling unable to address service issues for fear of some non-specified detriment.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** It is expected that the Guardian will be interviewed during CQC visits. (was seen during the last visit)

4.2 **Financial/Value for Money:** The increase in hour will impact on funding allocation.

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

4.4 **Equality and Diversity:** All staff should feel able to raise their concerns. The staff survey identifies differences in the degree to which different staff groups feel able to raise concerns and this needs to be challenged and addressed in conjunction with other trust departments.

4.5 **Other implications:** None identified

5. **RISKS:** Getting all staff through the training programme within the year will be challenging. Regular review should enable us to assess the need for further training dates.

6. **CONCLUSIONS:** It has proved a positive first 5 months. The developments planned regarding the training programme, site visibility, and managers recording tool should support the proactive nurturing of a more open and transparent organisation.

7. RECOMMENDATIONS:

To note the contents of the report and to comment accordingly

Dewi Williams
Freedom to Speak Up Guardian

Background Papers:

Item 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

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

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

Executive Summary:

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

Assurance statement pertaining to QuAC meeting held on 02 March 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 Forensics and North Yorkshire, where key concerns were around patient leave, staffing, security and pressure on in-patient beds.
- Updates from the Patient Safety Group, Clinical Audit & Effectiveness quarterly update and the forward programme for Clinical Audit work for 2017/18.
- CQC compliance and Safeguarding and Public Protection assurance updates.
- Governance matters were considered and noted through assurance, with reports from the Infection, Prevention and Control group and the Clinical Risk and Harm Minimisation Project.
- The National Community Mental Health Survey 2016 results.

Recommendations:

That the Board of Directors:

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

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 28 March 2017**
TITLE:	**To receive the assurance report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting on 02 March 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 of the Quality Account. 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 principle risks and concerns, together with assurances and progress from Forensic Services and North Yorkshire localities.

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

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

4.1 **FORENSIC SERVICES LMGB** – where key issues raised were:

1. An estates security issue, which had led to an independent review of security arrangements of Roseberry Park.
2. A review taking place up until the end of March 2017 of the number of episodes of requested patient leave. The data showed that approximately 1,080 episodes of leave (2.1%) have been cancelled out of 51,000 which was felt to be helpful contextual information and would be shared with commissioners
3. Staffing and recruiting suitable qualified staff, as well as the effects of 'poaching' by other directorates and organisations.

4.2 **NORTH YORKSHIRE LMGB** - where key issues raised were:

1. A deep dive review was underway at AMH Scarborough CMHT following a 'stop the line'.
2. The 'stop the line' at MHSOP Rowan Lea was coming to an end, however there has been an increase in delayed discharges compounded by recent Nursing Home closures.

3. The LD Transforming Care agenda with continued focus on reducing trajectories for inpatient beds with a failure to identify and fund alternative placements.

4.3 **Patient Safety Group Assurance Report**

The key matters raised from the meeting of the Patient Safety Group, held on 20 February 2017 were as follows:

1. Work was underway to improve the development of a standard approach within community teams for reporting self-harm on Datix. A separate paper would be reported to the Quality Assurance Committee in May 2017 to understand the different approaches and to benchmark with other Trusts.
2. The Quality Data report for January 2017 was considered and it was highlighted there had been 13 Serious Incidents in December 2016, an increase of 1 from the previous month.
3. New metrics in the revised Quality Strategy Scorecard would be available from April 2017 and reported through to committees from June 2017.

4.4 **Clinical Audit & Effectiveness Quarterly Report**

The Committee received and noted the update on activities for Quarter 2 and 3 for Clinical Audit.

Assurance was provided to the Committee that any issues around Clinical Audits have been documented and progressed via the appropriate leads and would be closely monitored by the Clinical Effectiveness Group.

4.5 **Draft Clinical Audit Programmes 2017/18**

The key matter raised highlighted that there has been a 20% reduction in the Clinical Audit Programme of work to enable more focus on the key priorities within capacity restraints. It was noted that the programme still included flexibility to allow any ad-hoc in-year requests to be undertaken in response to clinical need.

The Committee approved the Draft Clinical Audit Programmes for 2017/18.

4.6 **Safeguarding & Public Protection Exception Report**

The key matters covered in this report were:

1. The expected publication date for the 3 serious case reviews in Hartlepool has been delayed from March 2017 to April 2017.
2. The reports from the 'Review of Health Services for Children Looked After and Safeguarding' by the CQC in Durham and York has not yet been received and the same review has also taken place in North Yorkshire. Some informal feedback on the latter review has been for enhanced supervision processes for children on child protection plans and focus would be given to this area.

4.7 **Infection, Prevention & Control Assurance Report**

The Committee were provided with assurance on the work streams relating to Infection Prevention and Control for Quarter 3.

The key issues covered in this report were:

1. There has been a reduction in compliance with Essential Steps across localities, as well as non-return of audits. More robust escalation processes are now in place.
2. Detailed action plans were supporting non-compliance with IPC Environmental Audits, however all have returned a green compliance result of above 80%.
3. The newly reported national Specification for Cleanliness, where some sites have not achieved above 80% compliance compared to the 92% national standard. Work was underway to support improving this position.

4.8 National Community Mental Health Survey 2016 Results

The key issues following the National Community Mental Health Survey were:

1. It was difficult to determine any meaningful results from this survey since the Trust had scored as being "about the same" as other organisations, across all 10 parts of the survey.
2. A request for the raw data from the CQC to allow the Trust undertake a more in depth look at the results has not yet been answered.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 Compliance with CQC Registration Requirements

The key issues raised in the report were:

1. Final reports have now been received from the November 2016 CQC unannounced inspections to MHSOP and AMH wards across the Trust.
2. The reports have not yet been received for the visit in January 2017 (Well-Led, Community LD Teams and Rehabilitation Services).
3. West Lane Hospital – NHS England and NHS Wales have visited wards at West Lane Hospital. The initial informal feedback has been very positive.
4. There have been 6 MHA inspections and associated monitoring reports received since the last reporting period.
5. The CQC have published 5 reports following compliance visits to NHS Trust Mental Health services.

6 GOVERNANCE

6.1 Progress Report on the Clinical Risk and Harm Minimisation Project

The key issues raised in this report were:

1. This Project would close at the end of March 2017 and harm minimisation would form a work stream as part of the Recovery Programme.
2. Face to face training of registered staff has not quite reached the expected trajectory of 65%, however has managed to reach 50%. An approved request to EMT would provide resources for a further 6 months training.
3. The Committee supported the on-going developments regarding the proposed changes to the Engagement & Observation protocol, which would go to the Executive Management Team for final approval.

7. IMPLICATIONS

7.1 Quality

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

7.2 **Financial/value for money**

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

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

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

7.4 **Equality and Diversity**

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

8. CONCLUSIONS

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

9. RECOMMENDATIONS

That the Board of Directors:

- Note the issues raised at the Quality Assurance Committee meeting on 02 March 2017 and to note the confirmed minutes of the meeting held on 02 February 2017 (appendix 1).

Jennifer Illingworth
Director of Quality Governance
March 2017

APPENDIX 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 2 FEBRUARY 2017, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

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

In attendance:
Mrs Karen Atkinson,
Mr David Brown, Director of Operations for Teesside, (for minute 17/04)
Mrs Lorraine Ferrier, Lead Senior Nurse, Durham & Darlington
Mr Patrick Scott, Director of Operations for Durham & Darlington, (for minute 17/05)
Mrs Jennifer Illingworth, Director of Quality Governance, (for minute 17/06/07/10)
Dr Neil Mayfield, Deputy Medical Director, North Yorkshire
Mrs Karen Agar, Associate Director of Nursing and Governance, (for minute 17/08)
Mr Chris Lanigan, Head of planning and Business Development (for minute 17/09)
Mr Chris Williams, Chief Pharmacist, (for minute 17/11)
Mr David Levy, Director of Human Resources & Organisational Development, (for minute 17/)
Mrs Donna Oliver, Deputy Trust Secretary
Mr Chris Watson, CQC Inspector

Students from the University of Teesside: Megan Fishburn, Anousha Hafez-Ghorani, Victoria Murphy, Natalie Robdrup, Hannah Walden and Sarah Nixon.

17/01 APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Ingrid Whitton, Deputy Medical Director and Mr Jim Tucker, Non-Executive Director.

17/02 MINUTES OF PREVIOUS MEETING

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

17/03 ACTION LOG

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

The following updates were noted:

16/139 Annual Report on Serious Incidents to report to the Board of Directors.
A date was set by the Committee that this annual report would go to the 1 June 2017 Quality Assurance Committee and 4 July 2017 Board of Directors.

16/153 Further investigation into SI's that had been changed before going to Directors Panel.
This matter had been reviewed and processes tightened to ensure people cited of any changes before SI's going to a Directors Panel.

Completed

16/154 Circulate the CQC thematic review and have a further discussion at December 2016 QuAC meeting.
The CQC thematic review had been circulated to the Quality Assurance Committee on 1 February 2017 and there would be further discussion around taking the recommendations forward at the next Patient Safety meeting.

Completed

16/169 More detail to be provided around 5 incidents in September 2016 graded at level 3 on Cedar Ward.
This matter was covered under minute number:

Completed

16/175 Take back to the Health and Safety session and team briefing the matter raised by the Chairman following a recent ward visit where a housekeeper had been seen not adhering to the safe staff/patient ratio.
The safety of staff adhering to the staff/patient ratio had been reinforced.

Completed

17/04 TEES LMGB REPORT

The Committee received and noted the Tees LMGB Report.

Arising from the report it was highlighted that:

1. Nursing home provision continued to be a concern with no real change in the position expected over the next few months, despite discussions with Hartlepool providers.
2. There had been difficulties finding a placement for an 18 year old male on Westwood due to the inability of specialist commissioners to find a medium secure unit. This matter had been escalated to NTW since this patient was from Newcastle.
3. Recruitment, particularly Consultant medical staff and the PICU vacancy was adding to this pressure.
4. Despite best efforts by staff falls were still rising resulting in SI's and it was now being considered whether close 1-1 observation of patients was in fact counter-productive.

17/05 DURHAM AND DARLINGTON LMGB REPORT

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

Arising from the report it was highlighted that:

1. There were continued workforce pressures around key staffing appointments, with vacancies across all key posts in services.
   These vacancies were leading to pressures around access and waiting times, financial pressures due to the use of agency locums, the ability for existing staff to cover and the management of urgent and high risk work.

   The Head of Nursing was developing a workforce plan and would be linked into Trust initiatives for additional support.

Dr Land reported that medical recruitment had been identified previously on the Trust risk register as a separate risk but had been combined into the strategic risk relating to the recruitment and retention of staff. He suggested that in view of the growing pressures across all localities this issue should be escalated to the Board of Directors as a separate risk.

Agreed: *that the Board of Directors be recommended to include as a separate strategic risk relating to medical recruitment in its chapter of the integrated assurance framework and risk register.*

17/06 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Group report, including the Patient Safety Quality Report for period 1 November 2016 – 30 November 2016.

Arising from the report it was highlighted that:

1. The report covered matters arising following the 2 patient Safety Group meetings, held on 16 December 2016 and 16 January 2017.
2. The Mazars mortality tools for the categorisation of death would be tried for those Trust cases which warranted further scrutiny (EN2 and UN1), based on those patients that had been on CPA at the time of their death, using the data covering the period 1 October 2016 to 15 November 2016, when there had been 145 deaths (26 on CPA) reported through Datix.

   Mrs Moody added that there would be a regional meeting held in February 2017 to develop a decision making framework based on the Mazars principles in partnership with other Trusts.

3. There had been 7 recommendations following the publication of a national report on CQC Learning, Candour and Accountability, 1 of which would be aimed at provider organisations and legislation would be provided in March 2017 to support Trusts going forward to undertake a gap analysis.

   The Committee noted that there were no significant matters of escalation and were satisfied that all programmes of work were being progressed by appropriate leads.

17/07 PATIENT EXPERIENCE GROUP (PEG) REPORT

The Committee received and noted the Patient Experience Group report.

The report covered matters arising following 2 Patient Experience Group meetings, held on 13 December 2016 and 10 January 2017.

Arising from the report it was noted that:

1. The Complaints and PALS team would be holding an Away Day in February 2017, where one of the matters covered would be to look at the lack of lessons learned following responses sent out in January 2017. This had been picked up at the January 2017 PEG meeting.
2. A wide range of information had been shared from representatives of localities, which would be reviewed and discussed further at the February 2017 PEG meeting.

3. The Trust had officially re-joined the Triangle of Care national initiative to improve the experience of carers, with plans in the first year to assess 80% of inpatient areas and all Crisis teams. In years 2 and 3 this would be rolled out to Community Services.

The Committee was assured that the Patient Experience Group had consistently reviewed all relevant Trust patient experience activities in line with the Group's Terms of Reference and any issues were being progressed by the appropriate leads. There were no significant matters of escalation.

17/08 SAFEGUARDING & PUBLIC PROTECTION EXCEPTION REPORT

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

Mrs Agar highlighted the following from the report:

1. The various serious case reviews underway in Teesside, Durham, Darlington and Redcar, were being progressed and the Trust was meeting its legal requirements for safeguarding adults and children within the legislative framework.
2. The CQC inspection of services in 2016 had raised some concerns around Worsley Court, which had been shared with the Local Authority and the ward had taken immediate action to remedy the issues raised.

17/09 QUALITY ACCOUNT QUARTER 3 2016/17 PERFORMANCE REPORT

The Committee received and noted the Quality Account Quarter 3 2016/17 Performance Report.

Arising from the report it was highlighted that:

1. Across Quarter 3, October 2016 to December 2016, 3 out of the 4 quality priorities for 2016/17 were on track.
2. The harm minimisation priority, which was at red status in Quarter 3 had been due to training not being met for staff.

   On this matter it was noted that consideration had been given to whether training on harm minimisation could be aligned with other key training programmes, such as Recovery Focused Care and Management of Violence and Aggression.

3. Patient falls had improved from 113 to 94 in Quarter 3, however still remained below target.

   Mrs Moody advised the Committee on the Trust wide falls review, being led by the Deputy Director of Nursing, following which a report would go to the Senior Clinical Leaders Forum to identify improvements to take forward.
4. Length of stay for adults had increased in Quarter 3, the position had been 0.75% worse than target at 30.95%, however the year to date position continued to be better than target.
5. The position for complaints resolved satisfactorily had been 21% worse than target and at the lowest level of performance in the year to date.
6. The national patient survey results had been published; however the data did not provide meaningful benchmarking.
   Further work would be undertaken to look at these results to try to identify any themes or trends.

17/10 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS REPORT

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

Arising from the report it was noted that:

1. Draft reports had been received from the CQC following 2 unnanounced visits to the MHSOP and Adult inpatient services. A factual accuracy report from the Trust had been sent back to the CQC on 11 January 2017 with further feedback awaited. A summary of the findings had been circulated to all ward Team Managers.
2. A Regulation 17 letter had been received on 24 November 2017 pertaining to the improvement of the standard of services provided, in relation to Worsley Court and Cherry Tree House.
   Mitigating actions had been put in place to address the matters identified in the letter.
3. The CQC had spent a week inspecting community learning disability teams across Darlington, Middlesbrough, North Yorkshire, York, Northallerton and Knaresborough, focusing on the governance of the Trust from 23 January 2017.
4. The NHS Wales Quality Improvement team would visit West Lane Hospital on 9 February 2017 and the outcome would be fed back to QuAC at the 2 March 2017 meeting.

Following discussion it was confirmed that a recent patient on Primrose Lodge had been legally detained, even though the CQC had found that their file had no approved mental health professional (AMHP) report and that the section 3 documentation had not been dated by the AMHP.

17/11 DRUG AND THERAPEUTICS REPORT

The Committee received and noted the Drug and Therapeutics Report.

The report covered matters arising following the 2 meetings of the Drug and Therapeutics Committee held on 24 November 2016 and 26 November 2017.

It was highlighted from the report that:

1. Formulary issues, including details of the EULAST clinical trial which had looked at the effectiveness of 2 long-acting antipsychotics against oral therapy.
2. Responses to NHS Improvement Patient Safety alerts had been signed off, including
   i) 'Think Kidneys' - resources to support the care of patients with acute kidney injury.
   ii) 'Risk of severe harm and death due to withdrawing insulin from pen devices' – an SBARD and supporting information had been cascaded throughout the Trust in December 2016.
3. Following a challenge by the CQC around how medicines management challenges were appropriately escalated through the organisation, an initiative had been launched in January 2017 for inpatients across TEWV.
   a) The initiative would address the large number of audits on the pharmacy audit programme where the same challenging issues remained unresolved after multiple re-audits and action plans.
   b) An accreditation would be developed for wards, dependent on achievement and this would be developed after the initial 3 month pilot phase.
   c) Results would be collated monthly and reported to QuAGs and escalated to LMGBs if necessary.

Mr Williams advised that the outcomes would be reported through to the Drug and Therapeutics Committee and LMGB's in the summer 2017.

Agreed: *that progress on the initiative to manage the escalation of medicine management challenges would be included in the next bi-monthly Drug & Therapeutics report, (April 2017)*

Action: Mr C Williams

17/12 WORKFORCE REPORT

The Committee received and noted the Workforce Report.

Arising from the report it was noted that:

1. Following consideration at the October 2016 QuAC meeting around workforce equality and diversity monitoring information about protected characteristics of ethnicity, gender disability and age, further work had been undertaken and a set of additional actions to the TEWV 2016, Workforce Race Equality Standard (WRES) indicators (1-9) were proposed.
   (Mr Levy provided an explanation to the Committee around the definitions of the WRES indicators 1-9).

   Mr Levy highlighted that there were 3 sub-groups of the Diversity Engagement Group with varying levels of engagement, however disabled staff were notably the most difficult to engage with.

   The Committee was assured that the proposed actions would improve understanding of equality and diversity issues.
2. Following recent CQC feedback, it had been proposed to change the TEWV Equality Delivery System 2 (EDS2) statement back to the previously published EDS2 (2014).
   This was due to the TEWV EDS2 system (2016) being based on self-assessment and not on external feedback as required, since despite efforts to obtain external feedback none had been obtained.

Agreed: *(1) To endorse the proposed actions in section 3.2 of the report – additional actions around the WRES indicators 1-9.*
(2) To endorse the decision to replace the 2016 Equality Delivery System 2 (EDS2) (2016) with the previously published EDS2 (2014), following feedback received during the recent CQC review.

17/13 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no exceptions to report.

17/14 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.

Recommended: *That the Board of Directors consider including a separate strategic risk relating to medical recruitment in its chapter of the integrated assurance framework and risk register.*

Action: Mrs L Bessant

17/15 ANY OTHER BUSINESS

There was no other business to note.

17/16 COMMITTEE MEETING EVALUATION

There was nothing to note.

17/17 DATE AND TIME OF NEXT MEETING:

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

The meeting concluded at 3.55pm

ITEM 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th March 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 February 2017 data.

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

- The number of rosters equates to 68 inpatient wards.
- The number of 'red' fill rate indicators highlights Registered Nurses on Days as having the highest number of 'reds' equating to 29 wards.
- The Forensic directorate have the highest level of 'red' fill rates (14 in February and 10 in January)
- The lowest fill rate indicators in February related to Primrose Lodge (vacancies and sickness), Acomb Garth (vacancies and enhanced observations) and The Orchards (NY) (vacancies and sickness)
- The Highest fill rates in February were observed by Mallard (creation of a twilight shift to support enhanced observations), Bedale (vacancies) and Talbot (enhanced observations and supernumerary working).
- In relation to bank usage there were no wards identified that was utilising in excess of 50% bank during February. The highest bank user was in relation to Elm Ward with 47% bank usage (sickness and enhanced observations were the highest reasons for requesting bank)

- Agency usage equated to 1.38% in February. The highest user of agency within the reporting period related to Ebor, Acomb and Rowan Ward. All of which were reported to be using 21% of the total hours worked utilising agency staff.
- In terms of triangulation with incidents and complaints:
    - There were 1 Serious Incidents (SI) that occurred within the month of February. The ward has not been cited within this report as an exception.
    - There was 1 level 4 incident that occurred in February that was also classified as an SUI.
    - There were 2 level 3 incidents (self-harm) that occurred in February. None of the wards have been cited in this report as an exception.
    - There were 12 complaints raised in February with the following featuring within this report as follows:
        - Bedale Ward – high fill rate and bank usage in excess of 25%
        - Cedar (NY) – reporting 'amber' for agency usage
        - Elm Ward – bank usage in excess of 25%
        - Rowan Ward – reporting 'amber' for agency usage
    - There were 21 PALS related issues raised with the following featuring within this report as follows:
        - Acomb Garth (1 PALS) – reporting 'amber' for agency usage
        - Northdale (8 PALS) – bank usage in excess of 25%
    - A number of incidents requiring control and restraint occurred during February. The highest user was Sandpiper with a total of 71 incidents. Sandpiper has not been cited within this report.

There were 320 shifts allocated in February where an unpaid break had not been taken. From those shifts where breaks were not taken the majority were in relation to day shifts (201 shifts).

There were 11 incidents raised in February citing concern's in relation to staffing levels.

A severity calculation has been applied within this report to highlight any areas of concern from a safe staffing point of view. In February Sandpiper had the highest score with 9 points awarded. A cumulative score has also been applied, this also highlights Sandpiper as having the highest score with 33 points (November to February). The top 10 for February can be found on page 9 of this report along with an explanation of severity scores and appendix 3 shows all scores for all wards. Appendix 4 shows the severity scores by speciality.

A work stream approach to Safe Staffing is underway with a full update provided on page 9 and 10 of this report; this includes a review of roster planning efficiencies which is taking place during quarter 4.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**28th March 2017**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of the exceptions falling out of the monthly information on nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to February 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) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. (http://www.tewv.nhs.uk/site/about/how-well-are-we-doing/nurse-staffing). The full monthly data set of day by day staffing for each of the 68 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

3. EXCEPTIONS:

3.1 Safe Staffing Fill Rates – February 2017

3.1.1 The daily nurse staffing information aggregated for the month of February 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 29 in February. This is an increase of 4 when compared to January.

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

Ward	Fill Rate Indicator	Comments
February 2017		
Primrose Lodge	48.2% for RN on Days	This indicator is a slight improvement on last month whereby it was reporting at 43.6%. The shortfall is in relation to long term sickness and a secondment. They are flexing the HCA staff (129.7%) where appropriate to do so

		as well as utilising community staff.
Acomb Garth	52.4% for RN on Days 78.9% for HCA on Days	The shortfall is in relation to 4 band 5 vacancies. 2 posts have been filled awaiting clearance. As a result the unit has reduced its bed capacity to 7 beds until recruitment is resolved. It has not been possible to allocate a second qualified nurse to each shift. The unit is also using regular agency staff to cover night duties (these staff has been included in all induction sessions prior to the unit opening). Currently the unit has 2 patients who are requiring enhanced observations over 24 hour period and 1 who requires 4 staff to carry out personal care under MOVA holds due to extreme aggression.
The Orchards (NY)	60.0% for HCA on Days 60.0% for RN on Nights	The unit currently has 1 vacant RN post, 1 new starter currently going through their induction and 2 long term sickness. This has been risk assessed and discussed with the locality manager.

It is also important to review the fill rates that exceed the budgeted establishment (shown in blue). In February there were 50 fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues. When compared to January this is a decrease of 8 fill rate indicators (58 in January 2017).

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

Ward	Fill Rate Indicator	Comments
February 2017		
Mallard Ward	225.8% HCA on Nights 155.8% HCA on Days	An acute hospital admission for several weeks that required at all times by 2 staff. On return to the ward an extra day shift and an extra night shift was put into place due to the high acuity of the ward given the physical needs of this particular patient and several other patients. A twilight shift has been introduced due to the high acuity of the ward between these times.
Bedale Ward	192.4% HCA on Days 82.3% RN on Days	The increase in HCA's is to cover a vacant RN post and a RN short term sickness. Recruitment is under way

		to fill the vacancy.
Talbot Direct Care	191.4% HCA on Days 170.9% HCA on Nights	The additional staffing is due to enhanced observations. In addition this is a new staff team who require a period of induction including supernumerary working.

3.2 Bank Usage

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

There were no wards reporting 50% or above for bank usage in February. The highest users of bank in February relate to Elm Ward reporting at 47%. The reasons Elm ward gave for requesting bank are as follows:

- Annual leave (8 shifts)
- Enhanced observations (21 shifts)
- Escort (1 shift)
- Sickness (63 shifts)
- Unknown (17 shifts)

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

Elm Ward	47%
Westerdale South	40%
Mallard Ward	37%
Cedar Ward	31%
Bedale Ward	30%
Merlin	30%
Bransdale Ward	29%
Northdale Centre	29%
Clover/Ivy	29%
Swift Ward	28%
Birch Ward	27%
Fulmar Ward.	25%
Mandarin	25%

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

3.3 Agency Usage

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

In February the agency usage equated to 1.38% a decrease of 0.07% when compared to January.

The highest user of agency within the reporting period related to Ebor, Acomb Garth and Rowan equating to approximately 21% of the total hours worked.

Wards reporting agency usage in February are detailed below:

Ebor Ward	21%
Acomb Garth	21%
Rowan Ward	21%
Cedar Ward (NY)	11%
Springwood Community Unit	10%
Minster Ward	8%
Cherry Tree House	7%
Oak Rise	5%
Kestrel/Kite	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 clinical areas

3.4 Quality Data Triangulation

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

- There were 1 Serious Incidents (SI) that occurred within the month of February. The ward has not been cited within this report as an exception.
- There was 1 level 4 incident that occurred in February that was also classified as an SUI.
- There were 2 level 3 incidents (self-harm) that occurred in February. None of the wards have been cited in this report as an exception.
- There were 12 complaints raised in February with the following featuring within this report as follows:
  - Bedale Ward – high fill rate and bank usage in excess of 25%
  - Cedar (NY) – reporting ‘amber’ for agency usage
  - Elm Ward – bank usage in excess of 25%
  - Rowan Ward – reporting ‘amber’ for agency usage
- There were 21 PALS related issues raised with the following featuring within this report as follows:
  - Acomb Garth (1 PALS) – reporting ‘amber’ for agency usage
  - Northdale (8 PALS) – bank usage in excess of 25%

- A number of incidents requiring control and restraint occurred during February. The highest user was Sandpiper with a total of 71 incidents. Sandpiper has not been cited within this report.

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 320 shifts in February where unpaid breaks had not been taken. This is a decrease of 48 when compared to January.

The majority of the shifts where breaks were not taken occurred on day shifts (201 shifts). The number of night shifts where breaks were not taken equated to 119 shifts in February.

The detailed information in relation to missed breaks has been 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 11 incidents reported in February 2017 on Datix citing issues with staffing.

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

- Elm raised 2 incidents in relation to staffing levels; this ward has used in excess of 25% bank usage and a complaint has been raised
- Lustrum Vale raised 1 incident in relation to staffing levels; this ward has not been cited in this report.
- Nightingale raised 1 incident in relation to staffing levels; this ward has not been cited in this report.
- Westerdale South raised 1 incident in relation to staffing levels; this ward has used in excess of 25% bank usage.
- Clover raised 5 incidents in relation to staffing levels; this ward has used in excess of 25% bank usage.
- Linnet raised 1 incident in relation to staffing levels; this ward has not been cited in this report.

The staffing concerns escalation process is currently undergoing a review, details will be provided in this report once completed.

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 each month:

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 (Feb)	YTD Total Score (Nov-Feb)
Sandpiper Ward	4	1	0	0	1	0	0	0	1	2	**9**	**33**
Acomb Garth	4	2	1	1	0	0	0	0	0	0	**8**	**8**
Kestrel/Kite.	4	2	0	1	1	0	0	0	0	0	**8**	**22**
Northdale Centre	2	1	1	1	1	0	0	0	2	0	**8**	**22**
Fulmar Ward.	2	2	1	0	1	0	0	0	0	1	**7**	**18**
Merlin	2	2	1	0	1	0	0	0	0	1	**7**	**19**
Swift Ward	2	2	1	0	1	0	0	0	0	1	**7**	**24**
Ayckbourn Unit Esk Ward	2	0	1	0	1	0	0	1	1	0	**6**	**18**
Bransdale Ward	2	2	1	0	1	0	0	0	0	0	**6**	**21**
Meadowfields	4	0	0	1	1	0	0	0	0	0	**6**	**23**
Newtondale Ward	4	1	0	0	1	0	0	0	0	0	**6**	**21**
Springwood Community Unit	2	2	0	1	0	0	0	0	0	1	**6**	**28**

3.8 **Other**

The Forensic directorate have the highest number (14 wards' in February) of 'red' fill rates for registered nurses on day shifts. This is a deteriorating picture when compared to January whereby there were 10. In line with Transforming Care, there are plans to reconfigure a further ward which should ease staffing pressures going forward.

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

In addition work is being undertaken Trust wide via a work stream approach which has previously provided an update to the Board in this report.

In March, NHSI published, Safe, sustainable and productive staffing in mental health services which is out for consultation until 28th April 2017. In line with other recently published staffing guidance, the document cited the need for professional judgement in establishing staffing levels, but said it must be cross-checked with data and evidence. The Deputy Director of Nursing will coordinate the trusts response to the consultation.

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 will be 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 impact to date although ‘hot-spots’ are now being tracked through severity scores. Work is underway in localities to address shortfalls where planned establishments are not being met or high levels of registered nurse agency/bank are being used and to provide assurance on how this is being addressed.

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
March 2017

Appendix 1

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

				DAY		NIGHT	
WARD	Locality	Speciality	Bed Numbers	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	76.3%	99.3%	96.3%	94.7%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	86.2%	104.8%	103.6%	96.5%
Bedale Ward	Teesside	Adults	10	82.3%	192.4%	103.6%	112.1%
Bilsdale Ward	Teesside	Adults	14	84.6%	139.6%	100.3%	100.2%
Birch Ward	Durham & Darlington	Adults	15	91.5%	105.6%	96.4%	107.4%
Bransdale Ward	Teesside	Adults	14	86.9%	130.3%	100.0%	123.8%
Cedar Ward	Durham & Darlington	Adults	10	100.9%	176.9%	103.6%	151.8%
Cedar Ward (NY)	North Yorkshire	Adults	18	77.3%	106.0%	94.5%	108.0%
Ebor Ward	York and Selby	Adults	12	91.5%	96.8%	98.8%	120.0%
Elm Ward	Durham & Darlington	Adults	20	95.6%	123.5%	111.3%	150.2%
Farnham Ward	Durham & Darlington	Adults	20	121.3%	100.6%	107.7%	101.6%
Kirkdale Ward	Teesside	Adults	16	87.0%	109.2%	100.0%	103.6%
Lincoln Ward	Teesside	Adults	20	102.7%	99.6%	100.3%	102.1%
Lustrum Vale	Teesside	Adults	20	91.3%	118.3%	100.3%	120.7%
Maple Ward	Durham & Darlington	Adults	20	95.9%	92.8%	92.9%	100.0%
Minster Ward	York and Selby	Adults	12	121.1%	117.5%	104.8%	104.3%
Overdale Ward	Teesside	Adults	18	74.5%	129.7%	100.0%	100.6%
Primrose Lodge	Durham & Darlington	Adults	15	48.2%	129.7%	103.6%	100.0%

Stockdale Ward	Teesside	Adults	18	98.8%	103.7%	104.2%	98.5%
The Orchards (NY)	North Yorkshire	Adults	10	101.2%	60.0%	60.0%	93.6%
Tunstall Ward	Durham & Darlington	Adults	20	113.8%	106.1%	100.0%	100.0%
Ward 15 Friarage	North Yorkshire	Adults	12	81.7%	147.5%	103.9%	99.4%
Willow Ward	Durham & Darlington	Adults	15	92.5%	142.3%	96.4%	101.8%
Baysdale	Teesside	CYPS	6	102.0%	110.8%	109.5%	96.3%
Holly Unit	Durham & Darlington	CYPS	4	118.1%	108.9%	101.3%	117.7%
Newberry Centre	Teesside	CYPS	14	90.4%	110.2%	100.0%	114.3%
Talbot Direct Care	Durham & Darlington	CYPS	1	115.1%	191.4%	101.0%	170.9%
The Evergreen Centre	Teesside	CYPS	16	97.5%	127.6%	100.5%	104.3%
Westwood Centre	Teesside	CYPS	12	100.3%	148.2%	94.1%	212.4%
Clover/Ivy	Forensics	Forensics LD	12	98.0%	121.2%	100.0%	153.6%
Eagle/Osprey	Forensics	Forensics LD	10	82.5%	96.0%	96.9%	100.0%
Harrier/Hawk	Forensics	Forensics LD	10	99.0%	111.0%	89.1%	128.4%
Kestrel/Kite.	Forensics	Forensics LD	16	86.5%	122.5%	82.1%	159.4%
Langley Ward	Forensics	Forensics LD	10	70.9%	125.6%	100.0%	100.0%
Northdale Centre	Forensics	Forensics LD	12	72.5%	122.7%	110.7%	98.2%
Oakwood	Forensics	Forensics LD	8	82.2%	149.7%	100.1%	100.0%
Thistle	Forensics	Forensics LD	5	79.8%	105.4%	100.0%	101.0%
Brambling Ward	Forensics	Forensics MH	13	91.4%	99.5%	100.0%	94.6%
Fulmar Ward.	Forensics	Forensics MH	12	80.3%	127.4%	94.0%	167.9%
Jay Ward	Forensics	Forensics MH	5	85.2%	107.9%	100.3%	98.4%
Lark	Forensics	Forensics MH	15	90.2%	101.5%	100.0%	103.2%
Linnet Ward	Forensics	Forensics MH	17	80.1%	108.8%	100.0%	98.2%
Mallard Ward	Forensics	Forensics MH	16	94.8%	155.8%	102.7%	225.8%
Mandarin	Forensics	Forensics MH	16	85.4%	131.3%	103.6%	145.0%
Merlin	Forensics	Forensics MH	10	96.3%	137.1%	85.9%	162.5%

Newtondale Ward	Forensics	Forensics MH	20	76.5%	113.2%	60.9%	128.6%
Nightingale Ward	Forensics	Forensics MH	16	62.4%	101.1%	100.0%	96.4%
Sandpiper Ward	Forensics	Forensics MH	8	79.6%	106.4%	73.4%	130.4%
Swift Ward	Forensics	Forensics MH	10	82.0%	135.8%	104.2%	156.0%
Aysgarth	Teesside	LD	6	115.1%	145.6%	101.3%	107.8%
Bankfields Court	Teesside	LD	19	83.7%	105.5%	89.1%	100.8%
Bankfields Court Unit 2	Teesside	LD	5	108.0%	100.5%	100.2%	107.9%
Bek-Ramsey Ward	Durham & Darlington	LD	11	102.0%	120.0%	100.0%	101.2%
Oak Rise	York and Selby	LD	8	110.8%	88.1%	97.1%	103.5%
Acomb Garth	York and Selby	MHSOP	14	52.4%	78.9%	154.9%	120.1%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	100.1%	110.6%	100.0%	98.2%
Cherry Tree House	York and Selby	MHSOP	18	90.6%	91.2%	100.3%	130.6%
Hamsterley Ward	Durham & Darlington	MHSOP	15	93.9%	103.8%	100.1%	112.6%
Meadowfields	York and Selby	MHSOP	14	84.0%	78.6%	97.8%	92.3%
Oak Ward	Durham & Darlington	MHSOP	12	97.2%	89.6%	100.0%	100.0%
Roseberry Wards	Durham & Darlington	MHSOP	15	91.3%	96.7%	100.0%	99.9%
Rowan Lea	North Yorkshire	MHSOP	20	103.6%	103.0%	109.0%	109.8%
Rowan Ward	North Yorkshire	MHSOP	16	91.1%	148.5%	96.7%	181.7%
Springwood Community Unit	North Yorkshire	MHSOP	14	66.0%	120.9%	103.6%	148.2%
Ward 14	North Yorkshire	MHSOP	9	63.1%	117.4%	104.0%	102.1%
Westerdale North	Teesside	MHSOP	18	98.6%	136.6%	100.6%	115.1%
Westerdale South	Teesside	MHSOP	14	95.0%	110.3%	100.8%	98.0%
Wingfield Ward	Teesside	MHSOP	10	98.5%	106.3%	106.0%	103.4%

APPENDIX 2

Scored Fill Rate compared to Quality Indicators - February 2017				Agency Usage Vs Actual Hours			Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Nos	Total Actual Hours	Total Agency Hours	% Against actual Hours	Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI	L4 Incidents	Self-Harm Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	2060.50	0.00	0%	2060.50	375.00	18%						2		4	4
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2326.50	0.00	0%	2326.50	275.00	12%			1	1	1	4		5	5
Bedale Ward	Teesside	Adults	10	3309.00	0.00	0%	3309.00	1001.50	30%				1		7	1	8	9
Bilsdale Ward	Teesside	Adults	14	2525.75	0.00	0%	2525.75	173.50	7%						1		2	2
Birch Ward	Durham & Darlington	Adults	15	2929.83	0.00	0%	2929.83	805.00	27%									
Bransdale Ward	Teesside	Adults	14	2646.00	0.00	0%	2646.00	761.00	29%						5		6	6
Cedar Ward	Durham & Darlington	Adults	10	3777.87	0.00	0%	3777.87	1160.67	31%						6		8	8
Cedar Ward (NY)	North Yorkshire	Adults	18	2949.08	317.25	11%	2949.08	143.75	5%				1		9	1	10	11
Ebor Ward	York and Selby	Adults	12	2610.75	542.50	21%	2610.75	114.00	4%						7		8	8
Elm Ward	Durham & Darlington	Adults	20	2777.50	0.00	0%	2777.50	1302.49	47%				1					
Farnham Ward	Durham & Darlington	Adults	20	2636.20	0.00	0%	2636.20	155.67	6%					1				
Kirkdale Ward	Teesside	Adults	16	2918.50	0.00	0%	2918.50	101.25	3%						2		2	2
Lincoln Ward	Teesside	Adults	20	2710.98	0.00	0%	2710.98	99.50	4%						1		1	1
Lustrum Vale	Teesside	Adults	20	2756.00	0.00	0%	2756.00	418.00	15%									
Maple Ward	Durham & Darlington	Adults	20	2395.88	0.00	0%	2395.88	132.00	6%						1		2	2
Minster Ward	York and Selby	Adults	12	2429.58	182.50	8%	2429.58	523.00	22%						1		2	2
Overdale Ward	Teesside	Adults	18	2492.25	0.00	0%	2492.25	262.50	11%									
Primrose Lodge	Durham & Darlington	Adults	15	2275.33	0.00	0%	2275.33	156.00	7%									
Stockdale Ward	Teesside	Adults	18	2422.50	0.00	0%	2422.50	253.00	10%						1		2	2

The Orchards (NY)	North Yorkshire	Adults	10	1744.00	0.00	0%	1744.00	0.00	0%										
Tunstall Ward	Durham & Darlington	Adults	20	2656.33	0.00	0%	2656.33	0.00	0%				1						
Ward 15 Friarage	North Yorkshire	Adults	12	2484.00	0.00	0%	2484.00	476.50	19%					1					
Willow Ward	Durham & Darlington	Adults	15	2662.92	0.00	0%	2662.92	218.50	8%						2		2	2
Baysdale	Teesside	CYPS	6	2322.55	0.00	0%	2322.55	149.33	6%									
Holly Unit	Durham & Darlington	CYPS	4	1133.92	0.00	0%	1133.92	126.43	11%									
Newberry Centre	Teesside	CYPS	14	3420.05	0.00	0%	3420.05	410.50	12%						41	1	65	66
Talbot Direct Care	Durham & Darlington	CYPS	1	2830.50	0.00	0%	2830.50	0.00	0%						16		28	28
The Evergreen Centre	Teesside	CYPS	16	4529.33	0.00	0%	4529.33	268.50	6%						41		49	49
Westwood Centre	Teesside	CYPS	12	5030.67	0.00	0%	5030.67	1208.92	24%						34		60	60
Clover/Ivy	Forensics	Forensics LD	12	4056.42	0.00	0%	4056.42	1175.17	29%						7		11	11
Eagle/Osprey	Forensics	Forensics LD	10	2909.92	0.00	0%	2909.92	472.00	16%									
Harrier/Hawk	Forensics	Forensics LD	10	3743.65	0.00	0%	3743.65	858.50	23%				1	1	2		6	6
Kestrel/Kite.	Forensics	Forensics LD	16	4232.33	45.00	1%	4232.33	923.08	22%						9		23	23
Langley Ward	Forensics	Forensics LD	10	1965.75	0.00	0%	1965.75	399.75	20%					2				
Northdale Centre	Forensics	Forensics LD	12	4443.75	0.00	0%	4443.75	1294.25	29%				2	8	1		3	3
Oakwood	Forensics	Forensics LD	8	1828.75	0.00	0%	1828.75	56.25	3%									
Thistle	Forensics	Forensics LD	5	2707.55	0.00	0%	2707.55	247.42	9%						1		1	1
Brambling Ward	Forensics	Forensics MH	13	2509.25	0.00	0%	2509.25	156.00	6%					1				
Fulmar Ward.	Forensics	Forensics MH	12	3456.77	0.00	0%	3456.77	856.00	25%					1	24		40	40
Jay Ward	Forensics	Forensics MH	5	2497.37	0.00	0%	2497.37	338.00	14%									
Lark	Forensics	Forensics MH	15	2519.63	0.00	0%	2519.63	194.25	8%									
Linnet Ward	Forensics	Forensics MH	17	2543.52	0.00	0%	2543.52	301.75	12%									
Mallard Ward	Forensics	Forensics MH	16	4219.73	0.00	0%	4219.73	1562.25	37%									
Mandarin	Forensics	Forensics MH	16	3090.55	0.00	0%	3090.55	757.25	25%					1				
Merlin	Forensics	Forensics MH	10	3870.40	0.00	0%	3870.40	1173.15	30%						12	1	16	17
Newtondale Ward	Forensics	Forensics MH	20	3389.25	0.00	0%	3389.25	550.50	16%						2		6	6
Nightingale Ward	Forensics	Forensics MH	16	2323.98	0.00	0%	2323.98	220.75	9%									

Sandpiper Ward	Forensics	Forensics MH	8	3433.75	0.00	0%	3433.75	560.75	16%				1	1	71	6	178	184
Swift Ward	Forensics	Forensics MH	10	3486.25	0.00	0%	3486.25	990.75	28%						15		31	31
Aysgarth	Teesside	LD	6	2260.58	0.00	0%	2260.58	419.00	19%									
Bankfields Court	Teesside	LD	19	7448.58	0.00	0%	7448.58	666.99	9%						5		6	6
Bankfields Court Unit 2	Teesside	LD	5	1984.75	0.00	0%	1984.75	333.21	17%									
Bek-Ramsey Ward	Durham & Darlington	LD	11	4038.00	0.00	0%	4038.00	156.00	4%						1		2	2
Oak Rise	York and Selby	LD	8	3611.00	176.00	5%	3611.00	335.33	9%						4		5	5
Acomb Garth	York and Selby	MHSOP	14	1453.00	312.00	21%	1453.00	71.00	5%					1				
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	2827.92	0.00	0%	2827.92	108.00	4%						6		7	7
Cherry Tree House	York and Selby	MHSOP	18	3176.00	234.50	7%	3176.00	97.50	3%			1			4		4	4
Hamsterley Ward	Durham & Darlington	MHSOP	15	2757.83	0.00	0%	2757.83	343.52	12%	1	1				2		2	2
Meadowfields	York and Selby	MHSOP	14	2722.90	0.00	0%	2722.90	597.90	22%									
Oak Ward	Durham & Darlington	MHSOP	12	2403.83	0.00	0%	2403.83	52.00	2%									
Roseberry Wards	Durham & Darlington	MHSOP	15	2535.53	0.00	0%	2535.53	456.60	18%									
Rowan Lea	North Yorkshire	MHSOP	20	3420.00	0.00	0%	3420.00	248.89	7%				2	2	3		4	4
Rowan Ward	North Yorkshire	MHSOP	16	3199.50	663.00	21%	3199.50	316.50	10%				1		11		21	21
Springwood Community Unit	North Yorkshire	MHSOP	14	2911.33	303.00	10%	2911.33	259.42	9%						35		40	40
Ward 14	North Yorkshire	MHSOP	9	2224.50	0.00	0%	2224.50	67.50	3%									
Westerdale North	Teesside	MHSOP	18	2620.35	0.00	0%	2620.35	255.50	10%									
Westerdale South	Teesside	MHSOP	14	3575.33	0.00	0%	3575.33	1413.20	40%						1		2	2
Wingfield Ward	Teesside	MHSOP	10	2387.00	0.00	0%	2387.00	290.00	12%									

Severity Scoring by Total Score

APPENDIX 3

WARD	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	YTD Total Score (Nov-Feb)
Sandpiper Ward	4	1	0	0	1	0	0	0	1	2	**9**	**33**
Acomb Garth	4	2	1	1	0	0	0	0	0	0	**8**	**8**
Kestrel/Kite.	4	2	0	1	1	0	0	0	0	0	**8**	**22**
Northdale Centre	2	1	1	1	1	0	0	0	2	0	**8**	**22**
Fulmar Ward.	2	2	1	0	1	0	0	0	0	1	**7**	**18**
Merlin	2	2	1	0	1	0	0	0	0	1	**7**	**19**
Swift Ward	2	2	1	0	1	0	0	0	0	1	**7**	**24**
Ayckbourn Unit Esk Ward	2	0	1	0	1	0	0	1	1	0	**6**	**18**
Bransdale Ward	2	2	1	0	1	0	0	0	0	0	**6**	**21**
Meadowfields	4	0	0	1	1	0	0	0	0	0	**6**	**23**
Newtondale Ward	4	1	0	0	1	0	0	0	0	0	**6**	**21**
Springwood Community Unit	2	2	0	1	0	0	0	0	0	1	**6**	**28**
Bankfields Court	4	0	1	0	0	0	0	0	0	0	**5**	**19**
Bedale Ward	2	1	0	0	1	0	0	0	1	0	**5**	**17**
Cedar Ward (NY)	2	0	1	1	0	0	0	0	1	0	**5**	**24**
Elm Ward	0	2	0	0	2	0	0	0	1	0	**5**	**15**
Harrier/Hawk	2	1	0	0	1	0	0	0	1	0	**5**	**25**
Mandarin	2	2	0	0	1	0	0	0	0	0	**5**	**21**
Rowan Ward	0	2	0	1	0	0	0	0	1	1	**5**	**21**
Ward 15 Friarage	2	1	1	0	1	0	0	0	0	0	**5**	**17**
Ayckbourn Unit Danby Ward	2	0	1	0	1	0	0	0	0	0	**4**	**20**
Bilsdale Ward	2	1	1	0	0	0	0	0	0	0	**4**	**9**
Cedar Ward	0	2	1	0	1	0	0	0	0	0	**4**	**19**
Cherry Tree House	0	1	1	1	0	0	0	1	0	0	**4**	**11**
Clover/Ivy	0	2	1	0	1	0	0	0	0	0	**4**	**12**
Eagle/Osprey	2	0	1	0	1	0	0	0	0	0	**4**	**11**
Hamsterley Ward	0	0	1	0	1	1	1	0	0	0	**4**	**19**
Jay Ward	2	0	1	0	1	0	0	0	0	0	**4**	**15**
Langley Ward	2	1	0	0	1	0	0	0	0	0	**4**	**17**

Mallard Ward	0	2	1	0	1	0	0	0	0	0	**4**	**15**
Oak Rise	2	0	1	1	0	0	0	0	0	0	**4**	**12**
Oakwood	2	1	1	0	0	0	0	0	0	0	**4**	**13**
Overdale Ward	2	1	1	0	0	0	0	0	0	0	**4**	**14**
Primrose Lodge	2	1	1	0	0	0	0	0	0	0	**4**	**13**
Talbot Direct Care	0	2	1	0	0	0	0	0	0	1	**4**	**7**
The Orchards (NY)	4	0	0	0	0	0	0	0	0	0	**4**	**20**
Westwood Centre	0	2	0	0	1	0	0	0	0	1	**4**	**24**
Ebor Ward	0	1	1	1	0	0	0	0	0	0	**3**	**16**
Linnet Ward	2	0	0	0	1	0	0	0	0	0	**3**	**19**
Minster Ward	0	1	0	1	1	0	0	0	0	0	**3**	**16**
Newberry Centre	0	0	0	0	1	0	0	0	0	2	**3**	**18**
Nightingale Ward	2	0	1	0	0	0	0	0	0	0	**3**	**10**
Oak Ward	2	0	1	0	0	0	0	0	0	0	**3**	**5**
The Evergreen Centre	0	1	0	0	0	0	0	0	0	2	**3**	**12**
Ward 14	2	0	1	0	0	0	0	0	0	0	**3**	**14**
Aysgarth	0	1	0	0	1	0	0	0	0	0	**2**	**9**
Farnham Ward	0	1	1	0	0	0	0	0	0	0	**2**	**7**
Kirkdale Ward	2	0	0	0	0	0	0	0	0	0	**2**	**8**
Lustrum Vale	0	1	0	0	1	0	0	0	0	0	**2**	**7**
Rowan Lea	0	0	0	0	0	0	0	0	2	0	**2**	**5**
Thistle	2	0	0	0	0	0	0	0	0	0	**2**	**9**
Westerdale South	0	0	1	0	1	0	0	0	0	0	**2**	**12**
Willow Ward	0	1	1	0	0	0	0	0	0	0	**2**	**10**
Wingfield Ward	0	0	1	0	1	0	0	0	0	0	**2**	**12**
Bankfields Court Unit 2	0	0	0	0	1	0	0	0	0	0	**1**	**6**
Baysdale	0	0	1	0	0	0	0	0	0	0	**1**	**1**
Bek-Ramsey Ward	0	0	1	0	0	0	0	0	0	0	**1**	**5**
Birch Ward	0	0	0	0	1	0	0	0	0	0	**1**	**9**
Holly Unit	0	0	0	0	1	0	0	0	0	0	**1**	**13**
Lark	0	0	1	0	0	0	0	0	0	0	**1**	**4**
Roseberry Wards	0	0	0	0	1	0	0	0	0	0	**1**	**6**
Stockdale Ward	0	0	1	0	0	0	0	0	0	0	**1**	**5**
Tunstall Ward	0	0	0	0	0	0	0	0	1	0	**1**	**3**
Westerdale North	0	1	0	0	0	0	0	0	0	0	**1**	**6**

Brambling Ward	0	0	0	0	0	0	0	0	0	0	**0**	**11**
Ceddesfeld Ward	0	0	0	0	0	0	0	0	0	0	**0**	**6**
Lincoln Ward	0	0	0	0	0	0	0	0	0	0	**0**	**2**
Maple Ward	0	0	0	0	0	0	0	0	0	0	**0**	**11**

Severity Scoring by Speciality

APPENDIX 4

WARD	Locality	Speciality	Bed Nos	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	L4 Incidents	L3 Incidents	Complaints	Control & Restraint	TOTAL SCORE (Feb)	YTD Total Score (Nov-Feb)
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2	0	1	0	1	0	0	1	1	0	**6**	**18**
Bransdale Ward	Teesside	Adults	14	2	2	1	0	1	0	0	0	0	0	**6**	**21**
Elm Ward	Durham & Darlington	Adults	20	0	2	0	0	2	0	0	0	1	0	**5**	**15**
Cedar Ward (NY)	North Yorkshire	Adults	18	2	0	1	1	0	0	0	0	1	0	**5**	**24**
Ward 15 Friarage	North Yorkshire	Adults	12	2	1	1	0	1	0	0	0	0	0	**5**	**17**
Bedale Ward	Teesside	Adults	10	2	1	0	0	1	0	0	0	1	0	**5**	**17**
Cedar Ward	Durham & Darlington	Adults	10	0	2	1	0	1	0	0	0	0	0	**4**	**19**
Primrose Lodge	Durham & Darlington	Adults	15	2	1	1	0	0	0	0	0	0	0	**4**	**13**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	2	0	1	0	1	0	0	0	0	0	**4**	**20**
The Orchards (NY)	North Yorkshire	Adults	10	4	0	0	0	0	0	0	0	0	0	**4**	**20**
Bilsdale Ward	Teesside	Adults	14	2	1	1	0	0	0	0	0	0	0	**4**	**9**
Overdale Ward	Teesside	Adults	18	2	1	1	0	0	0	0	0	0	0	**4**	**14**
Ebor Ward	York and Selby	Adults	12	0	1	1	1	0	0	0	0	0	0	**3**	**16**
Minster Ward	York and Selby	Adults	12	0	1	0	1	1	0	0	0	0	0	**3**	**16**
Farnham Ward	Durham & Darlington	Adults	20	0	1	1	0	0	0	0	0	0	0	**2**	**7**
Willow Ward	Durham & Darlington	Adults	15	0	1	1	0	0	0	0	0	0	0	**2**	**10**
Kirkdale Ward	Forensics	Adults	16	2	0	0	0	0	0	0	0	0	0	**2**	**8**
Lustrum Vale	Teesside	Adults	20	0	1	0	0	1	0	0	0	0	0	**2**	**7**
Birch Ward	Durham & Darlington	Adults	15	0	0	0	0	1	0	0	0	0	0	**1**	**9**
Tunstall Ward	Durham & Darlington	Adults	20	0	0	0	0	0	0	0	0	1	0	**1**	**3**
Stockdale Ward	Teesside	Adults	18	0	0	1	0	0	0	0	0	0	0	**1**	**5**
Maple Ward	Durham & Darlington	Adults	20	0	0	0	0	0	0	0	0	0	0	**0**	**11**
Lincoln Ward	Teesside	Adults	20	0	0	0	0	0	0	0	0	0	0	**0**	**2**
Talbot Direct Care	Durham & Darlington	CYPS	1	0	2	1	0	0	0	0	0	0	1	**4**	**7**
Westwood Centre	Teesside	CYPS	12	0	2	0	0	1	0	0	0	0	1	**4**	**24**
Newberry Centre	Teesside	CYPS	14	0	0	0	0	1	0	0	0	0	2	**3**	**18**
The Evergreen Centre	Teesside	CYPS	16	0	1	0	0	0	0	0	0	0	2	**3**	**12**
Baysdale	Teesside	CYPS	6	0	0	1	0	0	0	0	0	0	0	**1**	**1**

Holly Unit	Durham & Darlington	CYPS	4	0	0	0	0	1	0	0	0	0	0	**1**	**13**
Kestrel/Kite.	Forensics	Forensics LD	16	4	2	0	1	1	0	0	0	0	0	**8**	**22**
Northdale Centre	Forensics	Forensics LD	12	2	1	1	1	1	0	0	0	2	0	**8**	**22**
Harrier/Hawk	Forensics	Forensics LD	10	2	1	0	0	1	0	0	0	1	0	**5**	**25**
Clover/Ivy	Forensics	Forensics LD	12	0	2	1	0	1	0	0	0	0	0	**4**	**12**
Eagle/Osprey	Forensics	Forensics LD	10	2	0	1	0	1	0	0	0	0	0	**4**	**11**
Langley Ward	Forensics	Forensics LD	10	2	1	0	0	1	0	0	0	0	0	**4**	**17**
Oakwood	Forensics	Forensics LD	8	2	1	1	0	0	0	0	0	0	0	**4**	**13**
Thistle	Forensics	Forensics LD	5	2	0	0	0	0	0	0	0	0	0	**2**	**9**
Sandpiper Ward	Forensics	Forensics MH	8	4	1	0	0	1	0	0	0	1	2	**9**	**33**
Fulmar Ward.	Forensics	Forensics MH	12	2	2	1	0	1	0	0	0	0	1	**7**	**18**
Merlin	Forensics	Forensics MH	10	2	2	1	0	1	0	0	0	0	1	**7**	**19**
Swift Ward	Forensics	Forensics MH	10	2	2	1	0	1	0	0	0	0	1	**7**	**24**
Newtondale Ward	Forensics	Forensics MH	20	4	1	0	0	1	0	0	0	0	0	**6**	**21**
Mandarin	Forensics	Forensics MH	16	2	2	0	0	1	0	0	0	0	0	**5**	**21**
Jay Ward	Forensics	Forensics MH	5	2	0	1	0	1	0	0	0	0	0	**4**	**15**
Mallard Ward	Forensics	Forensics MH	16	0	2	1	0	1	0	0	0	0	0	**4**	**15**
Linnet Ward	Forensics	Forensics MH	17	2	0	0	0	1	0	0	0	0	0	**3**	**19**
Nightingale Ward	Forensics	Forensics MH	16	2	0	1	0	0	0	0	0	0	0	**3**	**10**
Lark	Forensics	Forensics MH	15	0	0	1	0	0	0	0	0	0	0	**1**	**4**
Brambling Ward	Forensics	Forensics MH	13	0	0	0	0	0	0	0	0	0	0	**0**	**11**
Bankfields Court	Teesside	LD	19	4	0	1	0	0	0	0	0	0	0	**5**	**19**
Oak Rise	York and Selby	LD	8	2	0	1	1	0	0	0	0	0	0	**4**	**12**
Aysgarth	Teesside	LD	6	0	1	0	0	1	0	0	0	0	0	**2**	**9**
Bankfields Court Unit 2	Teesside	LD	5	0	0	0	0	1	0	0	0	0	0	**1**	**6**
Bek-Ramsey Ward	Durham & Darlington	LD	11	0	0	1	0	0	0	0	0	0	0	**1**	**5**
Acomb Garth	York and Selby	MHSOP	14	4	2	1	1	0	0	0	0	0	0	**8**	**8**
Meadowfields	York and Selby	MHSOP	14	4	0	0	1	1	0	0	0	0	0	**6**	**23**
Springwood Community Unit	North Yorkshire	MHSOP	14	2	2	0	1	0	0	0	0	0	1	**6**	**28**
Rowan Ward	North Yorkshire	MHSOP	16	0	2	0	1	0	0	0	0	1	1	**5**	**21**
Cherry Tree House	York and Selby	MHSOP	18	0	1	1	1	0	0	0	1	0	0	**4**	**11**
Hamsterley Ward	Durham & Darlington	MHSOP	15	0	0	1	0	1	1	1	0	0	0	**4**	**19**
Oak Ward	Durham & Darlington	MHSOP	12	2	0	1	0	0	0	0	0	0	0	**3**	**5**
Ward 14	North Yorkshire	MHSOP	9	2	0	1	0	0	0	0	0	0	0	**3**	**14**
Rowan Lea	North Yorkshire	MHSOP	20	0	0	0	0	0	0	0	0	2	0	**2**	**5**

Westerdale South	Teesside	MHSOP	14	0	0	1	0	1	0	0	0	0	0	**2**	**12**
Wingfield Ward	Teesside	MHSOP	10	0	0	1	0	1	0	0	0	0	0	**2**	**12**
Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	0	0	1	0	0	0	0	0	**1**	**6**
Westerdale North	Teesside	MHSOP	18	0	1	0	0	0	0	0	0	0	0	**1**	**6**
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	0	0	0	0	0	0	0	0	0	0	**0**	**6**

FOR GENERAL RELEASE **ITEM 10**

Board of Directors

DATE:	**28th March 2017**
TITLE:	**Recovery and Wellbeing Strategy 2017-2020**
REPORT OF:	**Brent Kilmurray, Chief Operating Officer**
REPORT FOR:	**Agreement and Formal sign off**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their 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 draft Recovery and Wellbeing Strategy 2017-2020 was presented and discussed at the Trust Board on 31st January 2017. At this time the Board requested that some additional items were added to the strategy which were as follows:

- To be more explicit about our commitment to carers within the strategy document.
- To ensure we reference the link between recovery and spirituality
- To make a more explicit statement of intent that the organisation is committed to change and will review all systems and processes from a recovery perspective.

It was agreed that the revised strategy and associated scorecard would be re-presented and discussed at the March 2017 trust Board of Directors meeting.

The purpose of this report is to present the revised Recovery and Wellbeing Strategy 2017-2020 and the proposed strategy scorecard for agreement and sign off. The report also provides information on a strategy briefing event which will take place May 12th.

Recommendations:

The Trust Board are being requested to approve and sign off the Recovery and Wellbeing Strategy 2017-2020 and associated score card. The board are also asked to note details of the Recovery Briefing event which will take place on 12th May 2017.

MEETING OF:	**Trust Board**
DATE:	**28th March 2017**
TITLE:	**Recovery and Wellbeing Strategy 2017-2020**

1. INTRODUCTION & PURPOSE:

1.1 This paper presents the revised draft of Recovery and Wellbeing strategy 2017-2020 and the associated score card.

1.2 The purpose of this report is to gain Trust Board approval and sign off of the amendments to the strategy and scorecard.

1.3 The paper also provides details of a Recovery strategy briefing event which will take place on 12th May 2017.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Trust Board confirmed at their 25th October meeting that Recovery remains one of TEWV's 6 Strategic Priorities.

2.2 The draft Recovery and Wellbeing Strategy 2017-2020 was presented and discussed at the Trust Board on 31st January 2017. At this time the Board requested that some additional items were added to the strategy which were as follows:

- To be more explicit about our commitment to carers within the strategy document.
- To ensure we reference the link between recovery and spirituality.
- To make a more explicit statement of intent that the organisation is committed to change and will review all systems and processes from a recovery perspective.

2.3 At the time of the Board meeting in January the Recovery Strategy scorecard was still in development. It was agreed by the board that the scorecard would be presented for discussion and sign off by the end of March 2017.

2.4 It was previously agreed that a briefing event/s on the strategy would be set up for Non-Executive Directors, Governors and other key stakeholders in order to communicate, in greater detail, the plans and actions within the strategy.

3. KEY ISSUES:

3.1 The amendments requested by the Trust Board, have been considered and incorporated into the strategy document. The amended strategy can be found in Appendix 1, with amendments highlighted in red.

3.2 With regards to links between spirituality and recovery the board are requested to note that while there are no specific milestones in this area, there is ongoing partnership work between the recovery team and the spirituality lead for the trust.

3.3 The proposed recovery strategy scorecard is now in place and is presented in Appendix 2. The board are asked to note that, as a result of a number of new metrics being introduced, a period of time to establish accurate baseline measures is required. In response a number of targets for these metrics will need to be set once baseline data has been obtained.

3.4 Work has been conducted to ensure that metrics relevant to both the Recovery and Wellbeing strategy and the Quality Strategy are aligned.

3.5 A briefing event has been set for 12th May 2017 between 1.30-3.30pm and Non-Executive Directors of the Board will have received a letter of invitation prior to this board meeting. The venue of the meeting will be confirmed as soon as possible.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
The Recovery strategy will help us to deliver the person-centred care, dignity & respect and staffing fundamental standards.

4.2 **Financial/Value for Money:** Recovery informed care is likely to be efficient because co-production of care eliminates non-value elements of care provision.

4.3 **Legal and Constitutional (including the NHS Constitution):**
No implications.

4.4 **Equality and Diversity:**
Equality and Diversity Implications will be identified in the individual work streams/projects. Each work-stream/project within the programme will have to undertake an Equality Assessment in line with the current Project Management Framework.

4.5 **Other implications: None**

5. RISKS:

5.1 Co-production, including the development of identified lived experience roles, is central to the success of the recovery strategy. There is a risk that there is insufficient lived experience resource to meet growing demand going forward.

5.2 The Trust is going through a period of transformational change with staff having to adapt and make significant changes to their practice. There is a risk that competing demands on staff at all levels of the organisation will have an inadvertent impact on the successful implementation of the recovery programme.

5.3 TEWV is relatively inexperienced in programme management (as opposed to project management) and this could adversely impact on the implementation of the strategy. To counter this risk, work is currently being conducted to agree an effective programme management approach. External expert consultation is being sought to guide this work

6. CONCLUSIONS:

Recovery is one of the Trust's Six Strategic Priorities. In order to progress this priority there is a requirement for the trust to have a cross-organisational Recovery and Wellbeing strategy for 2017-2020 in place by March 2017. The amended strategy and associated scorecard are being presented to the Trust Board for approval and sign off. The briefing event in May will provide more detailed information about the strategy and associated implementation plan.

7. RECOMMENDATIONS:

The Trust Board is asked to review and approve the proposed Recovery and Wellbeing strategy 2017-2020 and associated scorecard.

Board members who wish to receive more detailed information regarding the strategy and implementation plan are advised to attend the briefing event in May

The score card metrics will be reported on quarterly. It is proposed that the Recovery and Wellbeing strategy scorecard is subject to an annual

review to evaluate whether related metrics and targets remain appropriate.

Author: Alison Brabban
Title: Clinical Lead, Recovery and Wellbeing Programme

Background Papers:

Recovery and Wellbeing Strategy 2013-2016
Engagement Report

Appendix 1

DRAFT VERSION

Recovery and Wellbeing Strategy

2017-2020

Strategy Sponsor / Lead Director: Brent Kilmurray (Chief Operating Officer)		
Strategy Lead: Alison Brabban, Clinical Lead for Recovery		
Version: **STRAT-0030** **Version 2 Refresh**	**Date Completed:**	**Date of Next Review:** March 2020

making a difference together

Contents

The Aim of the Strategy

Supporting the recovery and wellbeing of individuals is the core aim of the services we provide. In 2013 the Trust Board agreed a priority to 'embed a recovery focussed approach across all services'. A Recovery and Wellbeing strategy for 2013-2016 was agreed which recognised that cultivating the required change would take an iterative approach over many years. The Trust recognises that this remains a key priority and is committed to large scale change, ensuring all systems and processes are reviewed from a recovery perspective.

Building on the progress achieved from the 2013-2016 strategy, this strategy sets out the direction for the further embedding of a recovery/wellbeing focussed approach within the organisation over the next three years.

The successful implementation of this strategy is central for the delivery of Trust Strategic Goal one, along with contributing to the delivery of the remaining Trust strategic goals.

Strategic Goal 1

To provide excellent services, working with the individual users of our services and their carers to promote recovery and wellbeing. This means that we make a positive difference to the lives of service users and carers by:

- Supporting individuals to achieve their personal recovery goals
- Delivering safe and effective care (at the right place and right time) that meets individual needs
- Fully engaging people in the development and delivery of their individual care plans
- Ensuring everyone has a positive experience of our services
- Providing high quality, accessible information to help service users manage their own health and care

What do we mean by recovery and wellbeing?

In mental health and learning disability services the term 'recovery' is most frequently used to describe the personal lived experiences and journeys of people as they work towards living a meaningful and satisfying life. Recovery principles focus on the whole person in the context of their life, considering what makes that person thrive.

Evidence based interventions designed to minimise distressing and disabling symptoms are critical but with a range of interventions and support in place,

we recognise that people can have meaningful and satisfying lives often despite the presence of ongoing symptoms. Within a recovery and wellbeing approach we recognise the importance of the individual, social and spiritual aspects of an individual's wellbeing

There are 5 key processes, referred to as CHIME factors, which have been identified as being central to individualised recovery and wellbeing.

CHIME factors

- **Connectedness** – being able to and /or having the opportunity to feel connected to something or other people
- **Hope** - having hope for the future or to feel hopeful that there can be better moments in what can be difficult times.
- **Identity** – maintaining or developing an identity beyond that of a mental health patient and/or diagnosis/someone with a learning disability
- **Meaning** – having meaning in life such as opportunities, roles and things to enjoy. This also includes finding meaning in the distressing experiences people are suffering.
- **Empowerment** – Having choice and control in your life and surrounding your care.

As a Trust we acknowledge that the word 'recovery' may not appear the most suitable term for some individuals, especially for individuals who are experiencing organic mental health problems or who have a learning disability but no mental health problems. However the principles and philosophy that lies behind the concept of a fulfilling life with meaning, remains valid and so this strategy will use the term recovery throughout. Individual specialities may develop more specific working definitions that best suit their client groups. The CHIME factors remain core to wellbeing and offering support in these areas is important for all service users groups accessing our services.

The Case for Change

National Context

- As evidenced in the Five Year Forward View for Mental Health (2016) there are a range of national drivers which require mental health services to offer interventions and approaches which support individuals to live meaningful and fulfilling lives. In order to deliver on these drivers there is a requirement for a co-production approach

working alongside individuals with lived experience of services, their families and carers.

- There is increasing demand on mental health and learning disability services at the same time there is a requirement to provide both efficient and effective services which meet the needs of individuals accessing our services.
- Future national arrangements for funding will increasingly require Trusts to demonstrate high quality outcomes and improvements in patient experience.

Local Context

- Our ability to sustain funding to deliver high quality services is not only reliant upon the clinical outcomes we achieve but will also be contingent on improvements in patient reported outcomes (PROMs) and improvements in service user experience. Embedding a recovery-based approach will play a central role in achieving positive outcomes.
- In the last three years we have conducted a significant amount of work to embed recovery principles and values within both our corporate and clinical services. An overview of the progress made can be found in appendix 1.
- Ensuring that individuals with lived experience have been involved in the design and delivery of core pieces of work has been fundamental to the progress made to date and is central to future developments in this area.
- The Trust is committed to implementing developments which eliminate non-value added activity within service delivery and we have a wealth of expertise within Quality Improvement Systems. There is an opportunity to further align our expertise in this area to support the delivery of more recovery focussed services. Understanding the views of service users and carers on what adds or does not add value to their recovery and wellbeing and co-producing improvements, is central to both QIS activity and broader approaches to developments.
- Engagement with service users, carers, our Experts by Experience group, staff and governors, highlights that while progress has been made, further work is required to embed recovery values and principles across **all** services.
- There is widespread support for the further embedding of this approach at all levels of the organisation and is reflected in Recovery remaining as a priority within the Trust business plan.

A Vision for the Future

Our vision is to deliver services to all service users and carers that are driven and underpinned by the values and principles of a recovery/wellbeing approach.

The core values and principles underpinning our vision are:

- We believe that everyone has the potential to lead a life that is fulfilling and meaningful to them, irrespective of symptoms and diagnosis.
- We recognise and acknowledge the many barriers to recovery that people can face, including social, environmental and economic factors. We offer support to minimise the impact of these on an individual's wellbeing and recovery.
- We don't just tell people what is best for them. We listen to service users and carers and try to understand what is important to them. We take their ideas, concerns and experiences seriously.
- We provide a service which values making shared decisions and seeks to explore options together with service users and provide meaningful choice wherever possible.
- We support people to feel empowered and take charge of their lives. We are aware of the power we hold and always look to share this as much as possible.
- We recognise the value in sitting with, listening and bearing witness to a person's emotional pain, we don't always try to fix people.
- We hold on to hope for people when they feel at their lowest, believing that there is hope for an individual's future and /or that that there can be better moments in what can be difficult times.
- We see the whole person, we see beyond their distress, beyond their 'symptoms' and 'diagnosis' recognising and respecting their individual interests, strengths and beliefs.
- We recognise that we have a lot of professional expertise to offer but equally we respect the expertise of those who have experienced mental distress and who have accessed our services.
- We value working alongside people with lived experience, as partners, at all levels of the organisation from coproduction of individual care plans through to strategic decisions about service design and delivery.
- We are mindful that our actions might harm a person's recovery e.g. losing identity, hope, sense of control. We acknowledge this and try to avoid it at all times. We take a harm minimisation approach.
- We appreciate that people's distress is often an understandable reaction to their life experiences, circumstances and beliefs and not merely symptoms of an illness.

- We acknowledge that many of our service users have experienced trauma and adversity in their lives. We ask about this and respond with compassion. We recognise that people's 'symptoms' and behaviours, while sometimes creating difficulties in their lives, are often creative attempts to survive intolerable situations.
- We support people to come to an understanding of their distress that is meaningful to them.

Objectives

In order to inform the strategy objectives we held a series of workshops with staff, governors, service users, carers and our recovery Experts by Experience group members. The outcomes of the engagement process has informed the strategy objectives and associated area of work. The timeframe for implementing each objective is March 2020.

Objective 1:

We will further embed recovery values and principles into the delivery of our services.

We will achieve this by:

- Building infrastructures to ensure that our leaders have the knowledge and skills to support transformational change and the implementation of the values and practices associated with a recovery and wellbeing approach. This will include the development of community demonstration sites, recovery for leaders training and a recovery accreditation scheme for services.
- Developing models of community and inpatient services which are underpinned by a recovery based approach via the Model Wards programme and the Purposeful, Productive Community Services programme and CPA.
- We will implement triangle of care to support staff, carers and services users to work together towards wellbeing and recovery.
- Ensuring that our Quality Improvement System aligns and supports recovery focussed developments.
- Ensuring key polices and projects support a recovery focussed approach.
- Adopting a consistent language which reflects a recovery focussed approach which is meaningful for different service user groups.
- Ensuring that recovery principles are embedded within the work of other core trust strategies and processes.

- Ensuring that a trauma informed approach is embedded within clinical services.
- Identifying community assets and resources that will support the delivery of recovery in our and partner organisations, and work with all organisations to encompass a recovery-based approach.
- Scoping options for enhancing employment support offered to individuals accessing our services who want support to access education and employment opportunities.

Objective 2

We will further embed infrastructures to support a model of 'co-production'

We will achieve this by:

- Determining how co-production is defined and implemented within TEWV in terms of an individual's own care, as well as service design, delivery and governance.
- Expanding the influence of the Trust's Recovery Experts by Experience programme, ensuring we have a specific carer's programme.
- Increasing the involvement of service users and carers in the recruitment of staff, building on current good practice.
- Increasing the number of unpaid Involvement Peer roles.
- Introducing paid peer roles into a wider range of clinical services.
- Identifying mechanisms to support our workforce to feel more comfortable being open about their own experiences of mental health difficulties.
- Ensuring our Quality Improvement work is informed by the priorities identified by individuals with lived experience and that a co-production approach is embedded within this work.

Objective 3

We will further embed a harm minimisation approach to support an individual's recovery, which engages service users and where appropriate, carers as partners in the process.

We will achieve this by:

- Embedding the Positive and Safe agenda to reduce the use of restrictive interventions and practices and promote the use of positive approaches.
- Reviewing how we approach core Nursing and Governance Directorate processes such as Patient Safety (Serious Incident enquiries / Learning

lessons) and safeguarding, ensuring these are informed by a harm minimisation approach and the views of individuals with lived experience.

- Ensuring staff have continued access to harm minimisation training and support.
- Ensuring that as part of the CPA process, we work with individuals to identify how threats to basic needs (e.g. housing and finances) could harm their recovery and wellbeing, offering support, advice and signposting.

Objective 4

We will have increased access to recovery training programmes which support recovery knowledge and self-management skills for staff, service users and carers

We will achieve this by:

- Consolidating delivery of physical recovery college provision where the Trust is commissioned to provide this.
- Working in partnership with Third Sector providers to support college delivery in locality areas where we do not have contracts to deliver physical recovery college provision.
- Delivering Recovery College Online as a new service. This will provide access to a wide range of self- management information and recovery focussed courses, which will be accessible to all locality areas and specialities.
- Ensuring that training needs analysis meets the aims of the strategy.
- Working to support post registration training for core professional groups being informed by recovery values and principles.

How will we implement this strategy?

Within these overarching objectives key elements will require implementation via a programme of work with the following delivery mechanisms:

- Core pieces of work delivered by a central recovery team and associated business case
- A range of other core business cases/projects which will directly report to recovery and the Recovery Programme Board (e.g. Trauma Informed Care, VRC)

- Ensuring that recovery principles are embedded within other key strategic programmes and projects managed outside of the Recovery Programme Board e.g. PPCS
- A range of business as usual developments led by a number of departments e.g. embedding Positive and Safe agenda

The objectives and deliverables within the strategy will be evaluated via a range of mechanisms including a score card, individual business case benefits realisation (PM4's) and other agreed mechanisms for business as usual developments.

Governance arrangements

It is proposed to establish a Recovery Programme Board to ensure the Recovery Strategy is implemented successfully. The diagram below describes how the different delivery mechanisms will report so that the Programme Board has assurance that the strategy objectives are being delivered. The Programme Board will also identify, agree and monitor the evaluation of strategy implementation.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Line of accountability ⟶ reporting Line for assurance of strategy delivery ⇢

Core PM3 Business cases

(Accountable to Programme Board – Report Monthly)

Trauma Informed Care
Virtual Recovery College

Central Recovery Team business case and Work streams

(Accountable to Programme Board – Report monthly)

Values / Culture work stream, EbyE,
Peer roles, Ensuring specialist consultation and influence into other programmes / BAU, Recovery Colleges

Other core strategic projects/ Programmes influencing embedding of recovery

(Accountable to project/ programme specific agreed board. Provide updates to Recovery programme Board to ensure these are being implemented in line with recovery principles and strategy

PIPA/Model Wards, PPCS, Safe staffing, The 'TEWV Way',

RECOVERY PROGRAMME BOARD

(Accountable to EMT)

Core business as usual developments required to implement the Recovery strategy

Provide updates to Recovery programme Board to provide assurances that these are being implemented in line with recovery principles and strategy)

Harm minimisation, Positive and Safe, pre reg training, 3rd Sector Partnerships,

Executive Management team

Will receive monthly overall programme reports from the Recovery Programme Board with an overall programme RAG status and will hold Programme Board to account

Scorecard

The strategy score card needs to be agreed and developed as well as ensuring it is aligned with other strategy scorecards and core benefits identified within the key areas of work identified. The score card metrics will be discussed at the Recovery Programme Board and presented to EMT for approval before the strategy goes live in March 2017.

Related Strategies / Policies

- **Nursing Strategy 2017-2020**
- **Quality Strategy 2016-2019**
- **Harm Minimisation Policy http://flcintouch:35000/Docs/Documents/Policies/TEWV/Clinical/Harm%20Minimisation%20Policy.pdf**
- **Physical Health care policy** http://flcintouch:35000/Docs/Documents/Policies/TEWV/Clinical/Physical%20healthcare%20(inpatients)%20policy.pdf
- **CPA policy**

Appendix 1

What did we achieve through the implementation of the 2013-2016 Recovery and Well-being strategy?

Objective 1. Moving toward a Recovery focussed culture	
Area of work	**Benefits realised**
Training on Recovery	We have delivered a broad range of introductory recovery training including; Trust Induction, Model Line Teams, a range of other services, Trust Board Seminar, EMT; a range of Corporate Services. • 1268 slots have been attended at specific recovery training sessions / conference • 80% of staff completing evaluations reported an increased knowledge in recovery principles and values • 90 % staff identified 5-10 (on a scale of 1-10) that training would positively impact on their practice • In 2016/2017 100% of new staff have received an introduction to recovery values and principles as part of their trust induction (n=376) • We have recently embedded a recovery slot within the embedding values training • Delivery of team joint care planning workshops • We have trained staff and have rolled out recovery groups and courses across a range of MHSOP and adult community services • We have embedded recovery values and principles within the trust Equality and Diversity training and are currently working to embed principles within the mandatory CPA training
Shared Decision Making (in partnership with Newcastle University and The Health Foundation)	In addition to our original strategy deliverables we secured a bid to work with Newcastle University and the Health Foundation to begin to embed Shared Decision Making within our services. The project is called MAGIC (Making Good Decisions in Collaboration). We have: • Trained a core central group of trainers • Piloted training with two teams and 32 senior medical staff and psychologists. • Developed video training materials specific to mental health • Begun to adapt the MAGIC training programme to meet the needs of mental health provision • We are working to embed Shared Decision Making principles within the new medication optimisation

	mandatory training for nurses • We have designed a workshop for students at ARCH to pilot how we can engage service users
Embedding of Recovery principles in core trust projects an developments	• We embedded recovery principles within other core strategic projects for example the Model Lines psychosis project, the CPA project, Harm minimisation project, Force reduction project, • We have worked to embed recovery within pathways – Functional pathway for Mental Health Services for Older People and the psychosis pathway
Objective 2: To move towards a model of co-production where there are increased opportunities for individuals with lived experience to be involved in the design and delivery of services	
To develop an Expert By Experience Group to support training and project Delivery – (target 8 people)	We have developed adult services Recovery Expert by Experience Group whose input has been fundamental to the progress made to date. • We have trained 4 cohorts of Experts by Experience in storytelling and currently have 26 active members of the group (this group offer input via involvement and engagement processes) • We have created 5 paid expert by Experience Roles (Two posts to co-ordinate the experts group and three expert by Experience trainers) • We will be recruiting to and delivering a 5th Cohort of training by the end of March 2017 • We have plans to commence recovery training with carers to support carers input into the programme • The Expert by Experience group have co-delivered and delivered a broad range of recovery related training throughout phase one using story telling as a mechanism for supporting culture change. This aspect of training is always rated as most impactful overall • The group members have also been involved in consulting on and designing a wide range of service developments • The group has been short listed for a Royal College of Psychiatrists award for service user and carer involvement • We implemented two CQUIN targets in 2014/15 and 2015/16 which focussed in increasing opportunities for individuals with lived experience which secured an income of £360,500
Ensuring systems are in place for an increased	We have: • Reviewed and revised all processes for recruiting and supporting volunteers within the trust, with services now

number of volunteering opportunities for individuals with lived experience	taking increased responsibility for supporting this process • We have offered volunteering placements to 160 individuals who report having lived experience of mental health issues during the lifespan of the strategy.
To ensure lived experience representation on the recovery project steering group and work stream groups	We have had lived experience representation on a wide range of work stream groups examples include; The recovery steering committee; the peer role steering group; the Recovery College steering group; the Virtual Recovery College steering Group; The Harm minimisation steering group and training development groups; The Force Reduction Steering and work stream groups; the involvement in recruitment work stream group; the mindfulness project steering Group; the physical health project; the North Yorkshire recovery development group.
We will standardise practice for involving service users and carers in recruitment	We have conducted work to understand current good practice and models currently in use. We have reviewed reporting arrangements for capturing data on how frequently we are involving service users and carers in the interview process and identified actions for increasing involvement growing forward. Further work is required in phase 2 developments following the current review of recruitment processes within the trust.
To introduce unpaid peer role opportunities	We have set up a structure for Involvement Peer Roles which are managed through our Involvement and Engagement structures. These roles allow individuals, who have experience of a specific course or intervention, the Opportunity to co-facilitate groups/ courses alongside paid staff. We have: • Introduced 36 Involvement peer roles across services and currently have 32 active • Introduced these roles into a wide range of services such as; ARCH Recovery College; a range of DBT skills groups; Mindfulness courses; Recovery the New me Courses running in a variety of community adult services; a Cognitive Stimulation Therapy group; the psychotherapy service within York; hearing voices groups; the forensic recovery college courses; a dual diagnosis inpatient support group. • Initial evaluation of roles these indicates that - 100% of staff would recommend these roles to other services and 88% would like to see expansion into paid peer roles being offered - 87% of service users receiving input found the input beneficial, with 73% reporting a positive impact on their recovery - 100% of Involvement peers responding reported the role as a positive experience which had a positive impact on their own recovery

To scope the introduction of Paid Peer roles within the trust	Work has been conducted to gain a greater understanding of how we can effectively introduce paid peer roles within The organisation. This has involved: • The introduction of 6 paid peer roles (2 peer trainers at ARCH, 3 Peer workers at the Discovery Hub York and 1 Peer Worker within the currency and outcomes department) • 10 individuals have received an introductory training course in peer support and 13 individuals have received an accredited Peer training course • Gaining an in-depth understanding of the training and support structures required to introduce a broader range of Peer Worker roles moving into phase 2
Objective 3: To establish a Recovery Education centre which is co-designed and delivered with staff, service users and partner organisations	
To Develop a Recovery College in Durham and Darlington Locality	ARCH recovery college was launched in September 2014 at St Margaret's Health Centre in Durham. It offers a wide range of self- management courses to staff, service users and carers. It is set up using a co-production approach and all courses are designed and delivered by an Expert by Experience and an Expert by Profession. Since the launch ARCH has: • Now offer 42 different courses/ workshops to students • Enrolled 372 students, with 99% of course evaluations to date indicating students are satisfied with the courses they have sat • 76% of students who complete a baseline and follow up recovery patient related outcome measure (QPR) report an overall improvement
Converge College York / Discovery Hub	Converge is a partnership between York St John University and the trust and delivers educational opportunities to people overcoming mental health difficulties: In contrast to ARCH recovery college the focus of converge is not on self-management courses but rather offering access to educational opportunities such as arts, music, textiles, creative writing, dance, theatre, sports and film within a University environment. Courses are taught by staff and university students. In 2015/2016 140 individuals completed courses and 85 University students were involved in delivering courses. Converge is delivered in partnership with the discovery hub which offers peer support to individuals to access community learning opportunities across the whole locality area

Forensic Services Recovery College	• Our Deputy Medical Director / Senior Clinical Director Forensic Services has been instrumental in setting a National CQUIN target for the development of recovery college provision with secure services. • We have piloted initial recovery college courses throughout 2016 and have recently launched a prospectus of recovery college courses within Ridgeway Forensic services which commenced in September 2016
Development of a Virtual Online Recovery College (recovery college online)	In 2015 the trust was successful in securing a bid for funds to develop a Virtual Recovery College site. We subsequently secured Academic Health Science Network funds to staff the development of initial content. We have now built the online college site which offers two functions 1. Access to a wide range of self-management resources 2. Access to online self-management courses We have recently agreed to fund the virtual recovery college as an innovative service within phase two of recovery developments. This will provide online access to a wide range of recovery resources and courses to staff, service users and carers across all our locality areas.
Objective 4: Transform the way the Trust approaches Risk Assessment and Management	
We will ensure that the Trust review and development of risk management and patient safety policies and frameworks are in line with recovery principles	• We have extended the concept of risk and harm to include experiences that inhibit recovery e.g. lack of autonomy, hopelessness, an identity solely linked to diagnosis, impoverished opportunities and introduced the language of a 'Harm Minimisation approach' to supporting safety • We have reviewed and re-written our risk management policy and now have a trust wide Harm Minimisation policy • We have reviewed our engagement and observation protocol and have a new ' Supportive Engagement and Observation protocol' in place
We will ensure that recovery principles are embedded within the Trust review and development of	• We have designed a face to face harm minimisation training programme for staff and are currently delivering this training to a wide range of clinical services / staff • We have employed 3 harm minimisation lived experience trainers who co-delver the face to face training with professional staff.

Risk Management Training.	• We are currently in the process of reviewing the current mandatory e-learning training on risk management, adapting this so that it encompasses a harm minimisation training approach. It is planned that this will be in place by April 2017

Appendix 2 Strategy Scorecard

Recovery Strategy Scorecard								
Metric		Lead Responsible	Targets				Source of data	Comment
			Baseline 16/17	17/18	18/19	19/20		
1. Embedding Recovery Values and Principles into Services								
	Number of leaders receiving recovery for leaders training	A. Brabban	0		60	60	Recovery Team Training record	
	Percentage of new trust staff receiving an introduction to recovery training as part of their induction	A. Brabban	100%	100%	100%	100%	Trust induction evaluation report	
	Number of teams who have been assessed against the criteria for the TEWV Recovery Accreditation (Corporate and Clinical)	A. Brabban	0			150	Process to be set up	
	Number of staff receiving Trauma Informed Care training	A. Kennedy	100	300	350	350	Trauma informed care project manager	
	Percentage of patients who state they have been involved as much as they wanted to be in the planning of their care?	E. Moody	Baseline to be determined	Baseline to be established 2017	TBC	TBC	Quality strategy report from Quality team	Also quality strategy metric New measure
2. Co-production								
	Number of new involvement peers registered within the Trust financial year	A.Brabban	23	15	15	15	Recovery records	

	Number of new paid peer roles/Expert roles (paid peer/expert)	A Brabban	6	5	TBC March 18	TBC March 19	Recovery records	
	Percentage of staff interviews involving service users and carers (Band 7 posts and above, both clinical and corporate)	D. Levy	New measure, process to be set for collecting data	Baseline to be established by Sept 17	TBC	TBC	Recruitment - report	New measure
	Percentage of staff who report TEWV is supportive of, and values staff members that have lived experience of mental distress?	D. Levy	New measure, process to be set for collecting data	Baseline to be established by Sept 17	TBC	TBC	Staff survey	New measure
	Percentage of carers that report feeling listened to and heard	E. Moody	Data collection commence 1.4.17	Baseline to be established by Oct 2017	TBC	TBC	Quality strategy reports via IIC	New measure
3. Risk/Harm Minimisation								
	Percentage of staff receiving face to face harm minimisation training	E. Moody	39%	65% of staff	Review March 18		Education data report	
	Number of incidents of physical intervention/restraint per 1000 occupied bed days (Quality Strategy Metric)	Elizabeth Moody	Community 0.12, In-patient 16.36	Awaiting info	Awaiting info	Community 0.072, In-patient 12.8	Quality strategy report from Quality team	This is the quality strategy metric. Targets for 17/18 and18/19 not set yet
4. Education and Training								
	Percentage of students accessing ARCH, who complete follow up PROM, who show an improvement in PROM score on graduation	C Chapman	80%	80%	80%	80%	ARCH monitoring	

	Number of new students enrolling at ARCH	C. Chapman	25 per quarter	100	Review March 18	Review Mar 18	ARCH monitoring	
	Number of full courses available via Recovery College Online	C. Chapman	1	7	15	20	VRC data	
	Number of different topics available on public facing self-management pages on Recovery College Online website	C. Chapman	30	50	60		VRC data	
	Number of people accessing online learning via VRC	C. Chapman	0	200	200	200	Recovery College Online monitoring system	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th March 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:

The purpose of this report is to inform the Board of Directors of the new requirements for all NHS trusts to learn from deaths following the publication in December 2016 of the CQC report, *Learning, Candour and Accountability*.

At the end of February 2017, a letter was sent to all Medical Directors, jointly from NHS Improvement and the CQC, setting out the detail behind the requirements which are summarised within this report. Changes to reporting practice come in to effect from April 1st 2017.

Further guidance on learning from deaths has just been published by the National Quality Board (NQB) in march 2017. The Board of Directors should note that for mental health and learning disability trusts, the lack of specificity in the guidance will mean that local agreement on the investigation of deaths will need to be agreed at a local level. A further report will come to QuAC detailing recommendations once this has been agreed through Patient Safety Group.

Recommendations:

The Board of Directors is requested to note the information included within this report.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

MEETING OF:	**Board of Directors**
DATE:	**28th March 2017**
TITLE:	**Learning from deaths**

1. INTRODUCTION & PURPOSE:

The purpose of this report is to inform the Board of Directors of the new requirements for all NHS trusts to report, investigate and learn from deaths following the publication in December 2016 of the CQC report, *Learning, Candour and Accountability*.

2. BACKGROUND INFORMATION AND CONTEXT:

The CQC report, *Learning, Candour and Accountability* set out some broad principles regarding reporting, investigating and learning from deaths with the caveat that more detailed information would be shared with organisations early in 2017. At the end of February 2017, a letter was sent to all Medical Directors, jointly from NHS Improvement and the CQC, providing more detail regarding these requirements which are summarised within this report. The Trust will need to establish these changes to practice from April 1st 2017.

3. KEY ISSUES:

The NHSI and CQC letter to Medical Directors set out recommendations for NHS organisations under four main headings as summarised below:

3.1 Governance and capability

Organisations are expected to adapt their governance processes to ensure deaths are correctly reported, lessons are acted upon and learning is shared. Each Trust is required to identify an executive director to take responsibility for mortality review processes and a non-executive director to have oversight of the whole process.

- It has been agreed that Elizabeth Moody, Director of Nursing and Governance and Hugh Griffiths, Non-Executive Director take on responsibility for these roles.

Training for staff who are involved in the reviewing and investigating of deaths is also recommended. For those staff involved with mortality reviews (rather than SI reviews) the Royal College of Physicians has been commissioned to provide training in case record review skills – it is not clear whether this will apply to mental health and learning disability organisations.

Further guidance is also being developed in how organisations can be more effective in engaging with bereaved families and carers.

3.2 Improved data collection and reporting

From April 2017 all NHS trusts must collect and publish, on a quarterly basis, specified information on deaths, including those that are assessed as more likely than not to be due to problems in care, and also evidence of learning and action happening in consequence of this information.

The data collection should cover:

- All in-patient deaths (a subset of which should be subject to Structured Judgement Review methodology. For MH&LD trusts it suggests that this will require adaptation).
- A paper to the public board on a quarterly basis reflecting the above quarterly data collection which includes relevant qualitative information and organisational learning
- This data will also be required to be published in the Trusts Quality Account from 2018
- Each Trust will be required to publish its policy for undertaking case record reviews.

With regard to the mortality review process, Trusts are encouraged to ensure their policies cover how the scope of numbers of deaths reviewed is determined and how deaths are selected to be part of the process. Guidance has just been released (March 2017) from the NQB providing some clarity to this although there is still a lack of specificity with regards to what MH&LD organisations need to do and much is left to local agreement. Work to provide clarity and consistency in this area will be taken forward through the Northern Collaborative work the trust is leading in conjunction with Mazars.

3.3 **Fit with existing processes**

Each provider's response to any findings from case record reviews must be coordinated within existing clinical governance processes. This means that if a patient safety incident is retrospectively identified it should be reported through the organisations incident management system (Datix) so the learning is reported via the National Reporting and Learning System (NRLS).

3.4 **Next steps**

National Quality Board Guidance, *Learning from Deaths* (March 2017) has just been published and will be formally launched at a conference on March 21st which the Trust Chair and Director of Nursing and Governance are attending.

National training is to be launched for clinicians in the use of the Structured Judgement Review case note methodology.

Further national guidance is expected to follow on setting standards for how Trusts involve and support bereaved families and carers.

The NQB guidance will be reviewed during March and April by the Patient Safety Group and reported through QuAC for assurance with regard to taking forward the recommendations. A link is provided to this guidance document at the end of this report.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The Care Quality Commission monitors Serious Incident activity so it is necessary to address any actions thoroughly and in a timely manner. Extending learning from deaths (for those deaths not classed as SI's) is likely to be a key focus of inspection over the forthcoming year.

4.2 Financial/Value for Money:

Some additional resource may be required once the impact of additional data requirements and mortality review processes has been determined for Mental Health and Learning Disability organisations.

4.3 Legal and Constitutional (including the NHS Constitution):

There is a legal requirement to ensure that sufficient governance and systems are in place to monitor the quality and safety of care to improve and reduce any risks to health, safety and welfare for service users.

4.4 Equality and Diversity:

All individuals are treated with dignity and respect.

4.4 Other implications:

None identified at this stage

5. RISKS:

Reputational risk if we delay responding to any recommendations/actions proposed as part this work.

6. CONCLUSIONS:

Following the publication of the CQC report *Learning, Candour and Accountability,* NHS organisations have been expecting more detailed guidance on how this will be implemented. The recent publication of the National Quality Board report *Learning from Deaths* starts to provide more clarity around what is expected however there remain some elements of ambiguity for MH&LD providers at this time. The Trust Chair and Director of Nursing and Governance are attending a launch event for this on March 21st 2017 which should support the Trusts preparation to implement the recommendations.

7. RECOMMENDATIONS:

The Board of Directors is requested to note the information included within this report.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Jennifer Illingworth,
Director of Quality Governance
March 2017

Background Papers:

CQC *Learning, Candour and Accountability*
https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf
National Quality Board *National Guidance on Learning from Deaths*
https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

Item 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28 March 2017**
TITLE:	**Finance Report for Period 1 April 2016 to 28 February 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 28 February 2017 is a surplus of £11,513k, representing 3.7% of the Trust's turnover. The Trust is ahead of plan by £3,231k largely due to contract variations with commissioners, a refund of historic National Insurance payments linked to widening access trainees, and vacancies. Recruitment to posts is ongoing.

Identified Cash Releasing Efficiency Savings at 28 February 2017 are marginally ahead of plan. The Trust continues to progress schemes to deliver CRES for future years.

The Use of Resources Rating for the Trust is assessed as 1 for the period ending 28 February 2017 and is in line with plan.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**28 March 2017**
TITLE:	**Finance Report for Period 1 April 2016 to 28 February 2017**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2016 to 28 February 2017.

2. BACKGROUND INFORMATION

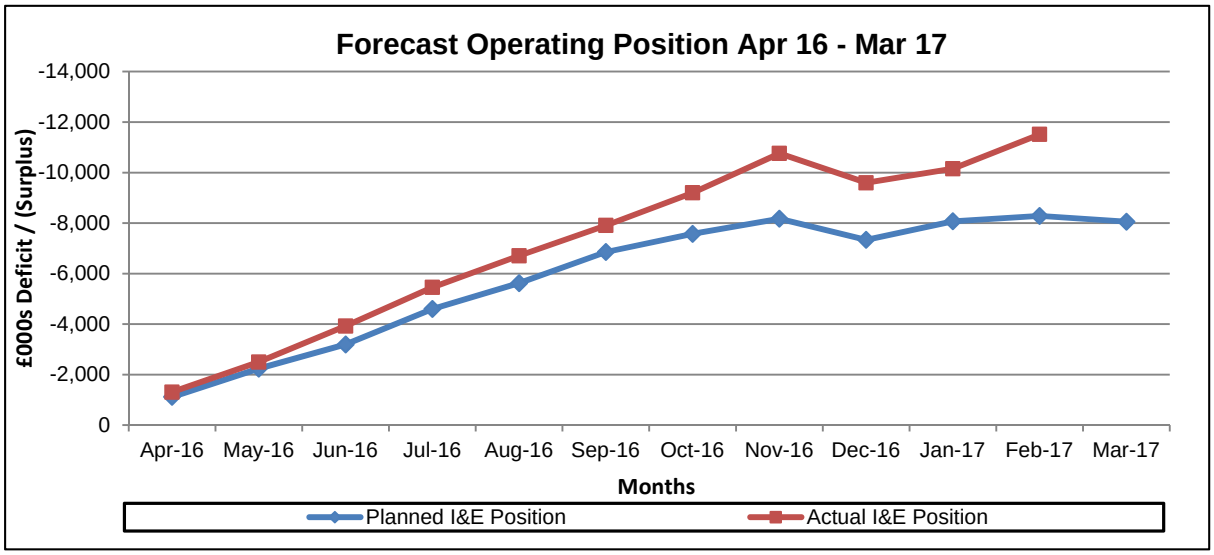
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

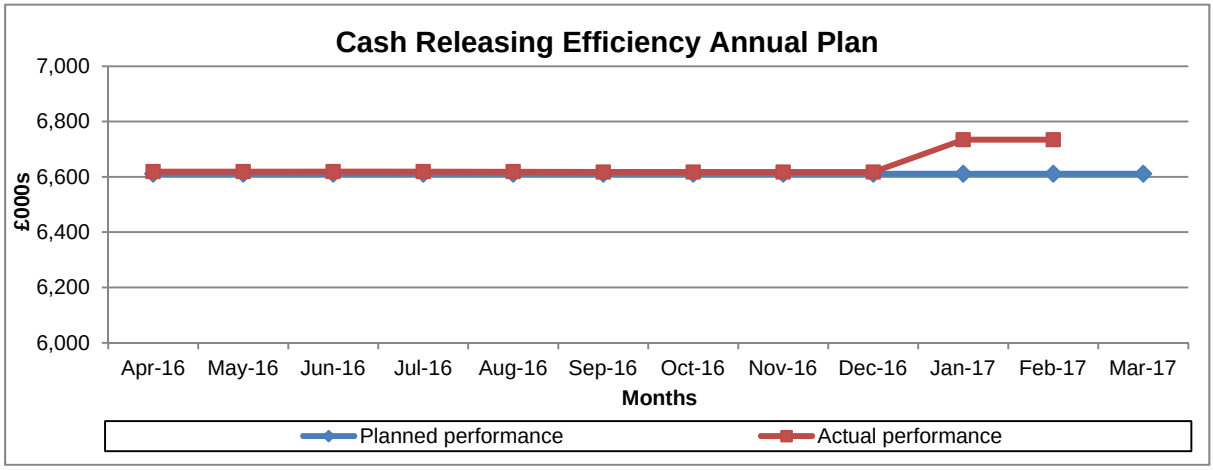
The comprehensive income outturn for the period ending 28 February 2017 is a surplus of £11,513k, representing 3.7% of the Trust's turnover. The Trust is ahead of plan by £3,231k largely due to contract variations with commissioners, a refund of historic National Insurance payments linked to widening access trainees, and vacancies. Recruitment to posts is ongoing.

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

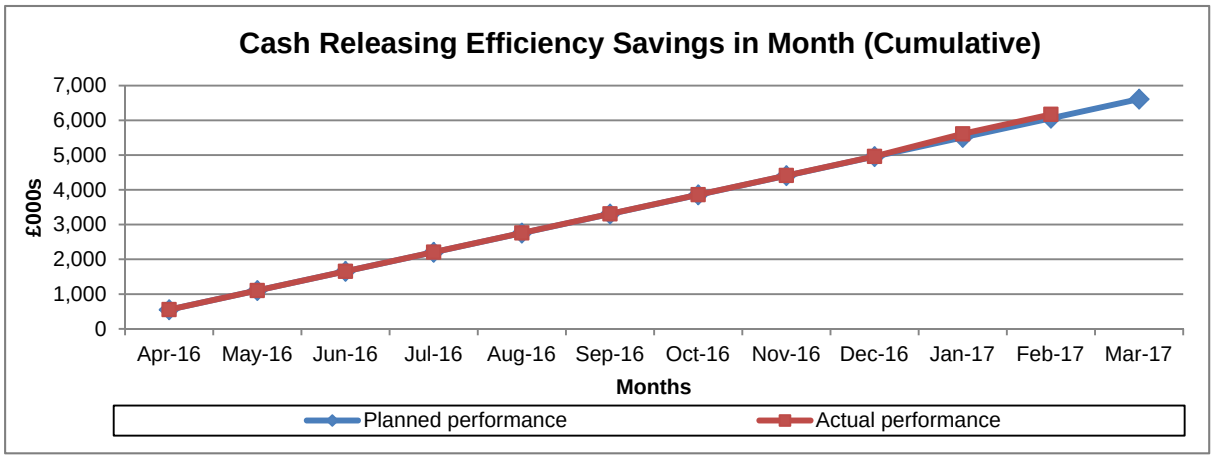


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 28 February 2017 is £6,734k and is ahead of plan. The Trust continues to progress schemes to deliver CRES for future years.

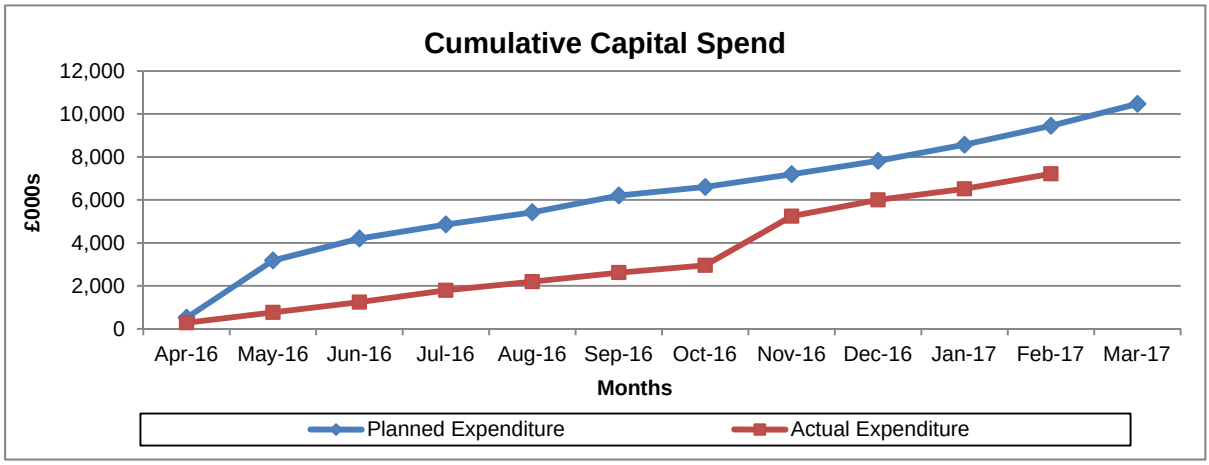


The monthly profile for CRES identified by Localities is shown below.



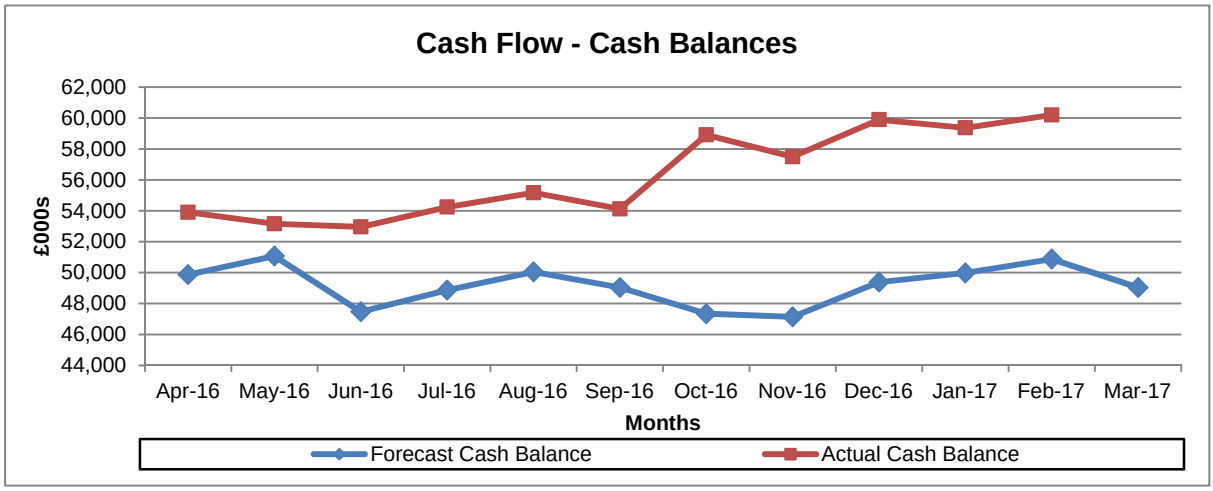
3.3 Capital Programme

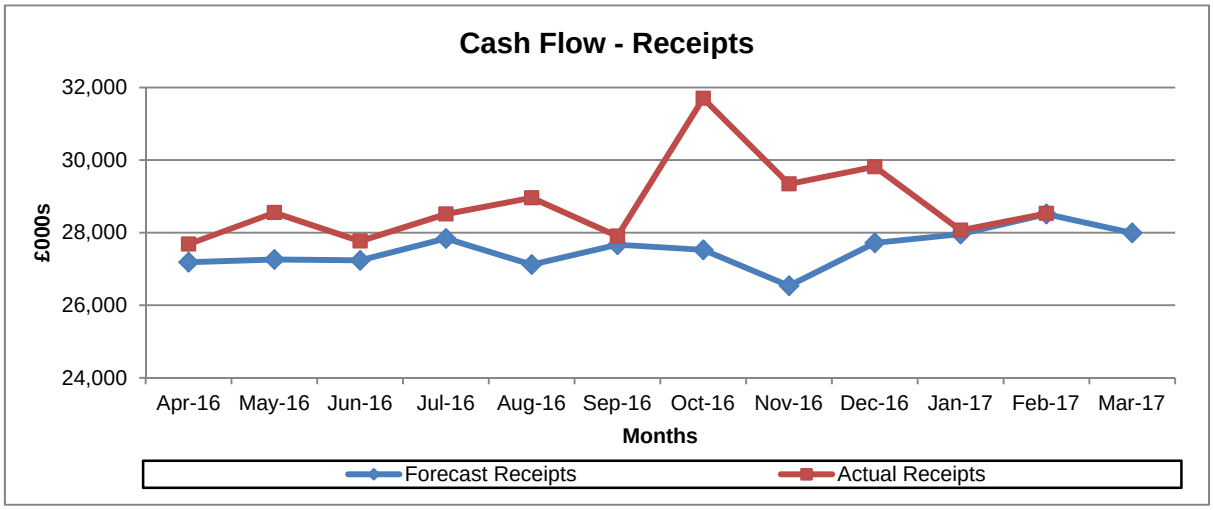
Capital expenditure to 28 February 2017 is £7,213k and is behind plan with schemes now progressing.

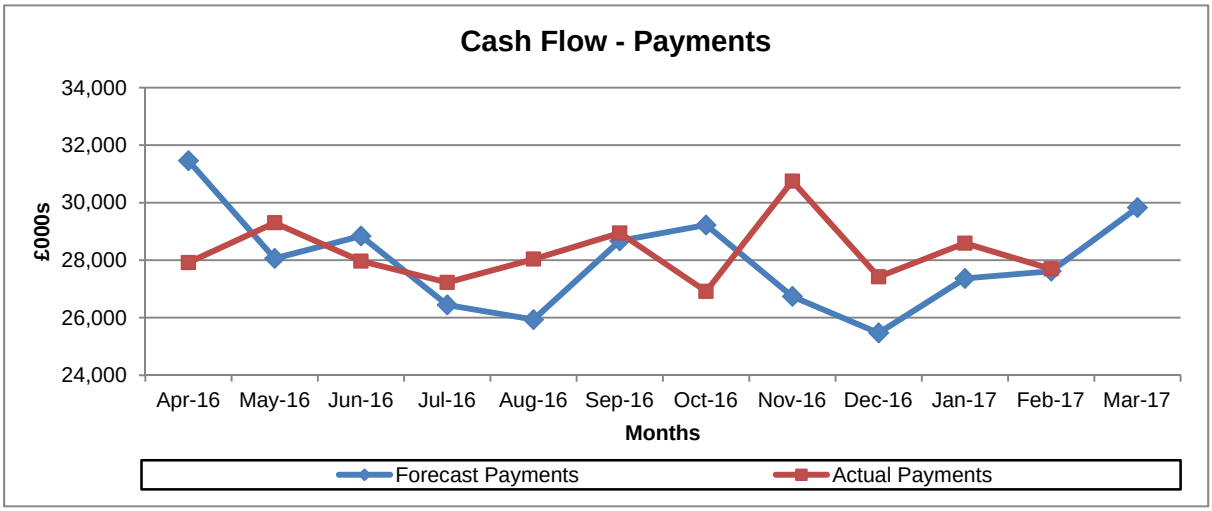


3.4 Cash Flow

Total cash at 28 February 2017 is £60,199k and is ahead of plan largely due to the Trusts surplus position, unanticipated cash receipts related to projects and delays in the capital programme.

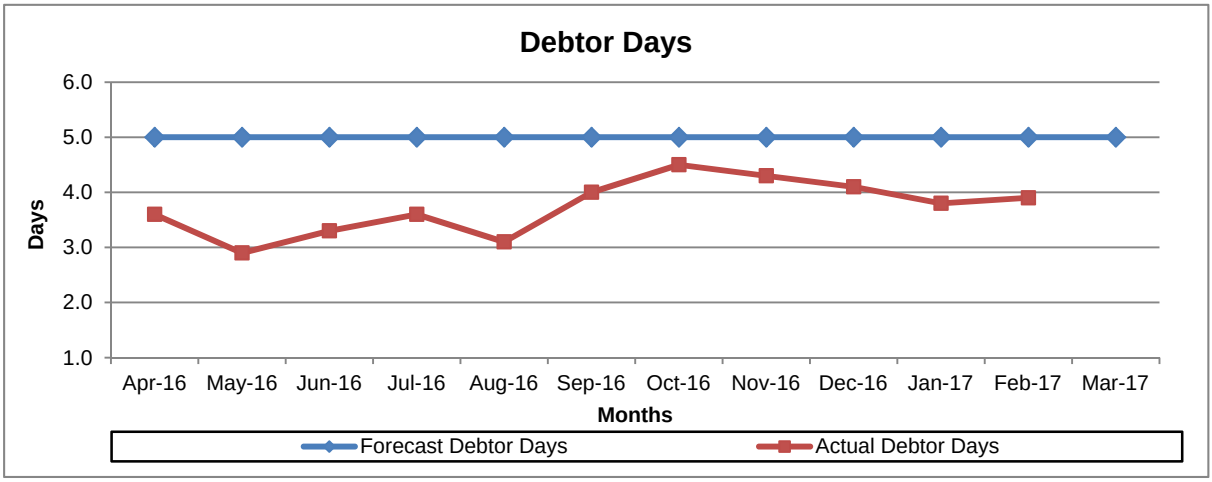






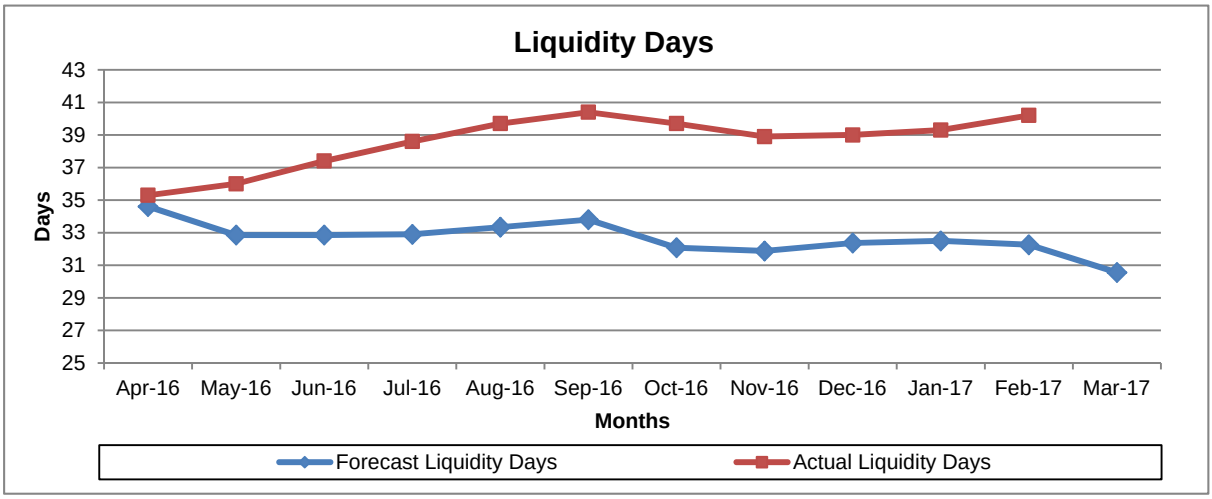
The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.
Working Capital ratios for period to 28 February 2017 are:

- Debtor Days of 3.9 days
- Liquidity of 40.1 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 30.87%
  Non NHS 30 Days – 95.82%



The Trust has a debtors' target of 5.0 days, and actual performance of 3.9 days at 28 February 2017, which is ahead of plan.

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



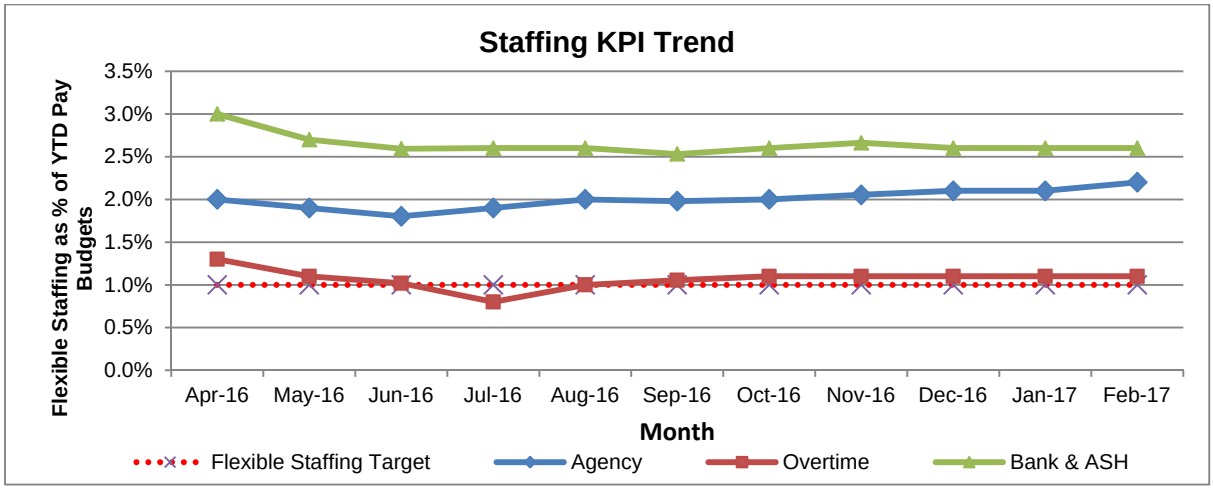
3.5 Financial Drivers

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

Tolerance	Sept	Oct	Nov	Dec	Jan	Feb
Agency (1%)	2.0%	2.0%	2.1%	2.1%	2.1%	2.2%
Overtime (1%)	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
Bank & ASH (flexed against establishment)	2.5%	2.6%	2.7%	2.6%	2.6%	2.6%
Establishment (90%-95%)	94.3%	94.6%	93.7%	93.7%	93.5%	93.9%
Total	**99.9%**	**100.3%**	**99.6%**	**99.5%**	**99.3%**	**99.8%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For February 2017 the tolerance for Bank and ASH is 4.1% of pay budgets.

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



Additional staffing expenditure is 5.9% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (54%), enhanced observations (19%) and sickness (13%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating is assessed as 1 at 28 February 2017, and is in line with plan.

3.6.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.90x (can cover debt payments due 1.90 times), which is ahead of plan and rated as a 2.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 40.1 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 4.5% and is rated as a 1.

3.6.5 The variance from plan assesses the level of surplus or deficit against plan, excluding exceptional items e.g. impairments. The Trust surplus is 1.1% ahead of plan and is rated as a 1.

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

The margins on Use of Resource Rating are as follows:

- Capital service cover - to reduce to a 3 a surplus decrease of £1,927k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £33,987k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £10,660k is required.
- I&E Margin variance from plan – to reduce to a 2 an operating surplus decrease of £2,200k is required.
- Agency Cap rating – to reduce to a 2 an increase in agency expenditure of £707k is required.

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

TEWV Performance	**Actual**		**YTD Plan**		**RAG**
	Achieved	Rating	Planned	Rating	**Rating**
Capital service cover	1.90x	2	1.61x	3	
Liquidity	40.1 days	1	34.4 days	1	
I&E margin	4.5%	1	3.4%	1	
I&E variance from plan	1.1%	1	0.0%	1	
Agency	£4,968k	1	£5,675k	1	
Overall Use of Resource Rating		**1**		**1**	

3.6.7 19.2% of total receivables (£795k) are over 90 days past their due date. This is above the 5% finance risk tolerance, but is not a cause for concern as £682k of debts are supported by a SLA and recent discussions to resolve debts have been positive.

Excluding debts supported by an SLA the ratio reduces to 2.7%.

3.6.8 3.9% of total payables invoices (£451k) held for payment are over 90 days past their due date. This is below the 5% finance risk tolerance.

3.6.9 The cash balance at 28 February 2017 is £60,199k and represents 72.2 days of annualised operating expenses.

3.6.10 The Trust does not anticipate the Use of Resources Rating will deteriorate below a 2 in the next 12 months.

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 28 February 2017 is a surplus of £11,513k, representing 3.7% of the Trust's turnover. The Trust is ahead of plan by £3,231k largely due to contract variations with commissioners, a refund of historic National Insurance payments linked to widening access trainees, and vacancies. Recruitment to posts is ongoing.

6.2 Total CRES identified at 28 February 2017 is £6,734k and is ahead of plan. The Trust continues to progress schemes to deliver CRES for future years.

6.3 The Use of Resources Rating for the Trust is a 1 for the period ending 28 February 2017 which is in line with plan.

7. RECOMMENDATIONS:

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

Drew Kendall
Interim Director of Finance and Information

Item 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th March 2017**
TITLE:	**Board Dashboard as at 28th February 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:

The purpose of this report is to provide the latest performance for the Board Dashboard as at 28th February 2017 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. The dashboard is now inclusive of performance relating to York and Selby.

As at the end of February 2017, 4 (21%) 9 (47%) of the indicators reported are not achieving the expected levels and are red, which is an significant decrease increase on the 9 reported for January 2017. Of those red indicators, 1 is showing an improving trend over the previous 3 month period. There are a further 6 indicators which whilst not completely achieving the target levels are within the amber tolerance levels and 4 of those show an improving trend over the previous 3 months. The Year to Date position has also improved with only 5 KPIs being reported as red which is one less than the position as reported as at the end of January 2017.

The key issues/risks are:

- Bed Occupancy (KPI3)
- Number of patients with a length of stay of greater than 90 days (KPI4)
- Access – Waiting Times (KPI 7)
- Out of Locality Admissions (KPI 9)
- Actual Number of Workforce in the month (KPI14)
- Appraisal (KPI 16)
- %age sickness absence rate (KPI 18)

In respect of performance against the key NHSI operational indicators as at the end of February one was reported as not meeting the targets as follows:

- Proportion of people completing treatment who move to recovery (IAPT services).

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 February 2017**
TITLE:	**Board Dashboard as at 30th January 2017**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 28th February 2017 in order to identify any significant risks to the organisation in terms of operational delivery.

2. KEY ISSUES:

2.1 The key issues are as follows:

- As at the end of February 2017, 4 (21%) of the indicators reported are not achieving the expected levels and are red, which is 5 less than the position reported for December 2016. Of those red indicators, 1 is showing an improving trend over the previous 3 month period. There are a further 6 indicators which whilst not completely achieving the target levels are within the amber tolerance levels and 4 of these show an improving trend over the previous 3 months. It should be noted that there is only 1 indicator within the Quality Domain that is reporting red, all the indicators within the Workforce Domain are reporting amber and all the indicators within the Finance Domain are reporting green.

  In terms of the Year to Date position 5 indicators (26%) are reporting as not achieving the target set, with a further 6 (32%) being amber. This is an improvement compared to the 6 reported at the end January 2017.

- In terms of the Single Oversight Framework we continued not to achieve one of the operational metrics in February as follows:

  - **IAPT Services - Proportion of people completing treatment who move to recovery.** The target is 50% of people should move to recovery and the actual performance for February was 48.08%. In terms of performance delivered by Trust services at CCG level only 3 of the CCGs are achieving the target of 50% (Hambleton, Richmondshire and Whitby, Harrogate and Rural District and Vale of York CCGs). All other services to CCGs are below target with the services in North Durham CCG, Darlington CCG, Durham Easington and Sedgefield CCG, and Scarborough and Ryedale CCG being under target. Within Durham and Darlington the service has developed an action plan to improve performance and this is starting to be implemented. In addition the Commissioners have asked the national IAPT Improving Support Team to come in and review the service and this is planned to take place in May. A detailed action plan has now been agreed with the Vale of York CCG which responds to the verbal feedback we received following the IST visit to the service in February. This will be updated further once the formal report is received if

appropriate. There is also a joint action plan with Scarborough and Ryedale CCG following the IST visit. Whilst the Trust will continue to implement the actions it is responsible for there are some which are out with the control of the Trust as they are commissioner led actions. It has been agreed to establish a Trust wide group to oversee the delivery of the IAPT targets (in a similar way to those established for the new national waiting time targets for EIP and Children's Eating Disorders). This forum will allow for the sharing of good practice from those areas that are achieving the targets as well as identifying actions that could be taken across the Trust to support improvement.

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

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

2.2 The key risks are as follows:

- Bed Occupancy (KPI 3) – The Dashboard shows that there has been further improvement in the Trust wide position which is as a result of a reduction in all localities but more noticeably in Teesside and York and Selby. This position continue however to be understated because the closure of the 14 beds at Worsley Court in December had not been actioned on the electronic system and therefore these beds are still included in the denominator when clearly they were not available for admission. The closure of Worsley Court has now been actioned on the system so that this will not impact upon the indicator in future months.
- Number of patients with a length of stay over 90 days – This indicator is highlighted as an issue as we have already breached the annual target. However we have seen an improvement in the position in February which reflects the work that is being done as part of the weekly report out in localities focusing on patients with long lengths of stay. Durham and Darlington and York and Selby are showing the greatest improvement during February.
- External Waiting Times (KPI 7) – The Trust remains worse than the target of 90% at the end of February however the position has improved compared to that reported for January. Whilst this improvement reflects the 'seasonal' trend the position in February 2017 continues to be better than the same period in the previous 2 years. This improvement is despite an increase in referrals in January to one of the highest levels in the year. There is still the possibility that this increased referrals in January could impact on the waiting time target in March. The areas of concern continue to be Children and Young Peoples Services in North Yorkshire and York and Selby and the agreed action plans are continuing to be implemented. The North Yorkshire service has identified a trajectory for recovery of June 2017.
- Out of Locality Admissions (OoL) (KPI 9). The performance for February continues to be worse that the target but has improved in February from the previous months position North Yorkshire and York and Selby are the

outliers but both have showed an improving position, particularly in North Yorkshire where the performance has improved significantly.

- Actual Number of Workforce in the Month KPI – This indicator is continuing to report as amber and there has been some further slight improvement in the month of February 2017. York and Selby continue to be the areas of greatest concern and work is continuing to improve the recruitment of staff within all localities.
- Appraisal (KPI 16) – Whilst the Trust is not achieving the target of 95% as at the end of February there has been a further improvement from January and the position continues to be significantly higher than the same time in previous years. Teesside is now achieving the target and Forensic services are also above 90%. The area of greatest underperformance continues to be York and Selby however there has been a further improvement in February. Appraisal continues to be one of the issues that are focused on in the weekly performance 'huddles' that are taking place across the localities.
- %age Sickness Rate (KPI 18) – Performance against this KPI continues to be worse than target however we have seen a further significant reduction in the sickness rate reported in February such that the level of sickness was the best it has been since October 2016. There has been a marked increase in the number of short terms episodes of absence and a report is being prepared which will provide further analysis into this. This report will be considered by EMT in May. This report will also provide focus for the working group that has been established to examine what more could be done to try to further prevent short terms sickness across the Trust.

3. RECOMMENDATIONS:

3.1 It is recommended that the Board:

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

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Activity

	February 2017				April 2016 To February 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Total number of External Referrals into Trust Services	7,040.00	7,999.00			83,966.00	90,730.00		91,759.00
2) Caseload Turnover	1.99%	0.32%			1.99%	0.32%		1.99%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	86.00%			85.00%	93.32%		85.00%
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	21.00	25.00			253.00	340.00		277.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	15.00%	7.21%			15.00%	7.50%		15.00%
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	18.00	22.67			217.00	264.66		237.00

Quality

	February 2017				April 2016 To February 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%	87.73%			90.00%	85.57%		90.00%
8) Percentage of appointments cancelled by the Trust	0.67%	0.63%			0.67%	0.72%		0.67%
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	25.28%			15.00%	23.02%		15.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.44%	94.85%			91.44%	92.32%		91.44%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.33			11.00	7.90		12.00

Trust Dashboard Summary for TRUST

Workforce

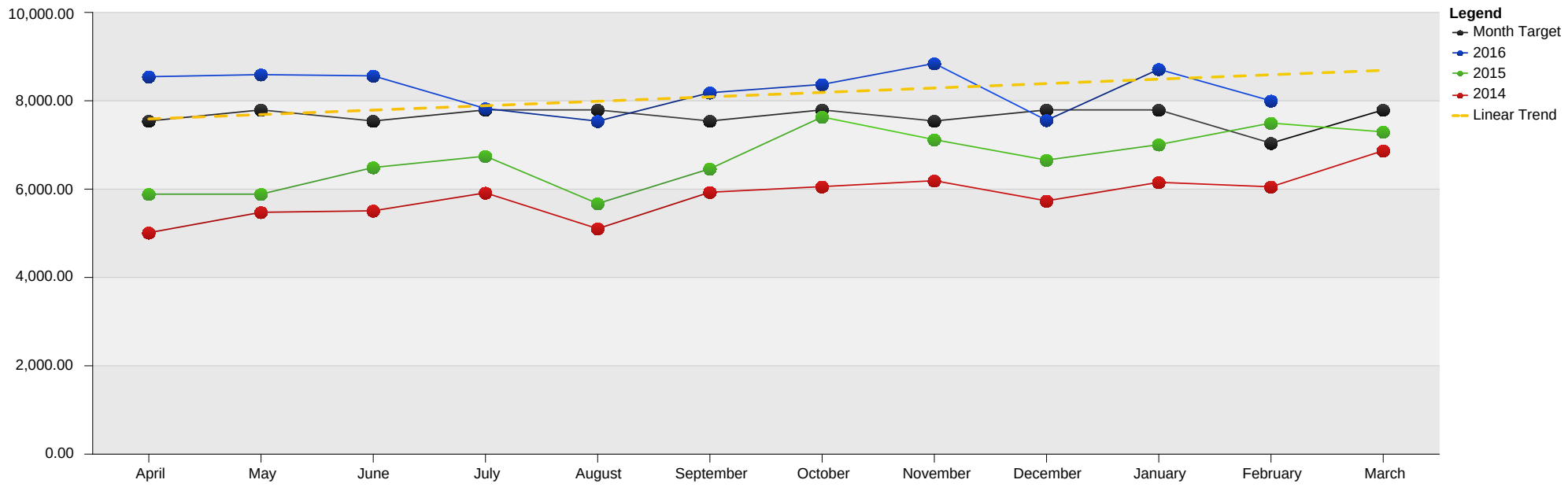
	February 2017				April 2016 To February 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	94.02%			100.00%	94.02%		100.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	16.44%			15.00%	17.03%		15.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	89.10%			95.00%	89.10%		95.00%
17) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	89.18%			95.00%	89.18%		95.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.94%			4.50%	4.97%		4.50%

Money

	February 2017				April 2016 To February 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-210,727.00	-1,358,000.00			-8,282,528.00	-11,513,000.00		-8,057,087.00
20) CRES delivery	550,854.00	590,459.00			6,059,397.00	6,144,013.00		6,610,251.00
21) Cash against plan	50,873,000.00	60,199,000.00			50,873,000.00	60,199,000.00		49,036,000.00

Trust Dashboard Graphs for TRUST

1) Total number of External Referrals into Trust Services

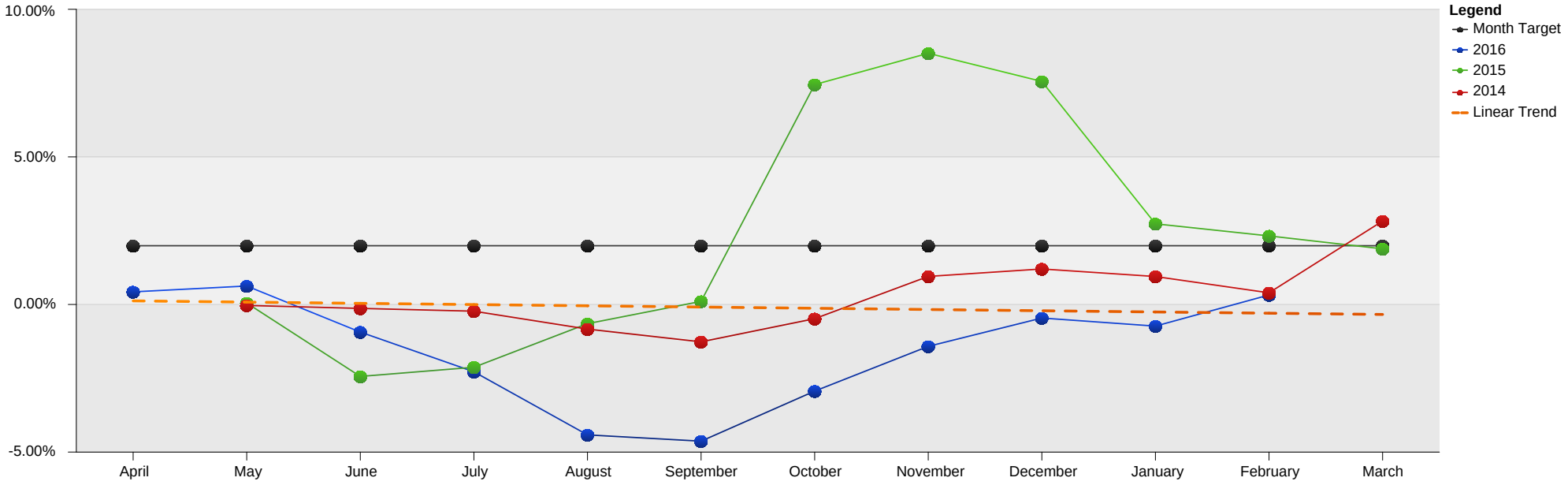


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Total number of External Referrals into Trust Services	7,999.00	90,730.00	1,848.00	21,571.00	2,066.00	21,403.00	2,040.00	22,490.00	561.00	6,474.00	1,473.00	18,763.00

Narrative
The Trust position for February 2017 is 7,999 which is 959 above the Trust target of 7,040 but an improvement on the January position. The Trust position for the financial year to date is 90,730.00 which is 6,764 above the target.The number of referrals has decreased in each locality in line with the reduced number of days in the month of February.Data including the York and Selby locality only started to be collected from April 2016. If comparing the remaining 4 localities, the position is 6,526 which is lower when compared to the same period last year of 7,265.Based on current trends reported it is anticipated that we will exceed the annual target of 91,759 referrals by more than 10%.

Trust Dashboard Graphs for TRUST

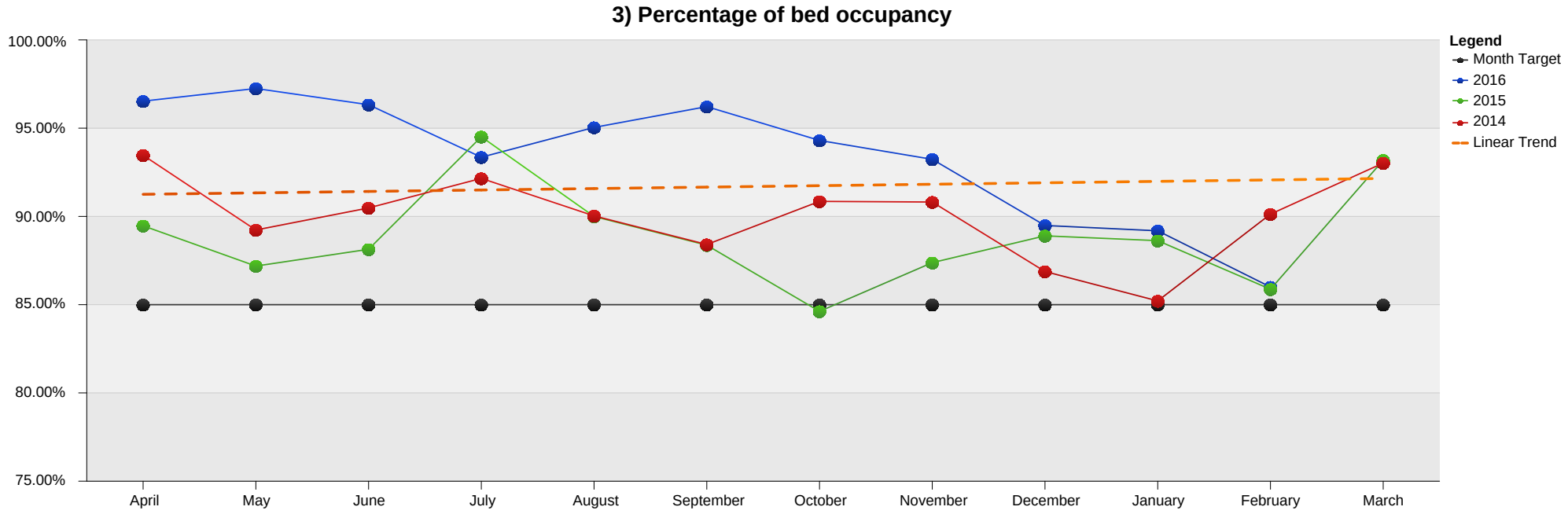
2) Caseload Turnover



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Caseload Turnover	0.32%	0.32%	-1.07%	-1.07%	1.29%	1.29%	-0.18%	-0.18%	NA	NA	2.43%	2.43%

Narrative
The Trust position for February 2017 is 0.32% which is meeting the 1.99% target; however a slight increase to that reported in January. All localities are achieving target with the exception of Tees and York and Selby. The movement of the performance position closer to target maybe an early indicator that the caseload management tool may not be being used as consistently as possible.Based on current trend it is likely we will achieve the annual target of 1.99%

Trust Dashboard Graphs for TRUST

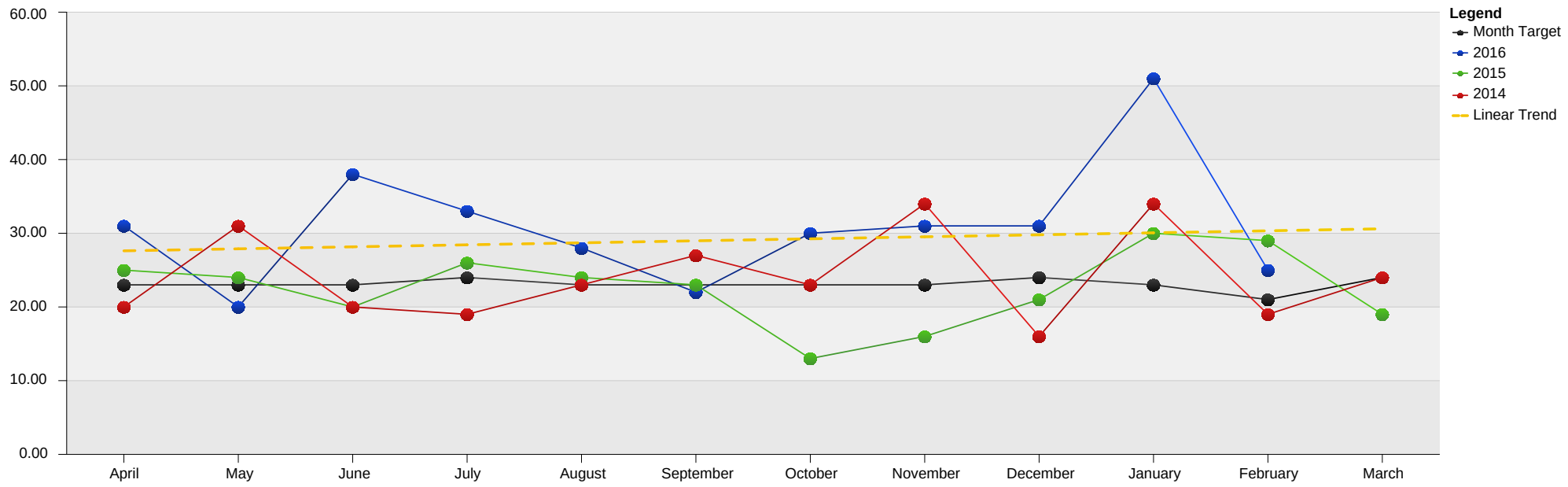


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	86.00%	93.32%	92.08%	92.92%	87.84%	95.62%	94.62%	95.70%	NA	NA	63.65%	85.38%

Narrative
The Trust position for February 2017 is 86.00% which is 1% worse than the Trust target of 85.00% but a continued improvement on the January position. This represents the 4th consecutive month where performance has improved and is the best position in the year to date. All localities are exceeding the 85% target with the exception of York and Selby which had an occupancy level of 63.65%. This position however is understated as although Worsley Court was closed in December it remained open on Trust systems until February therefore the beds are included in the denominator. This issue has now been resolved and will not impact on future reports. Within York and Selby there has also been an improvement in the accessibility and securing of local authority placements which has impacted on bed occupancy. The Trust position for the financial year to date is 93.32%, which is 8.32% worse than target.

Trust Dashboard Graphs for TRUST

4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards



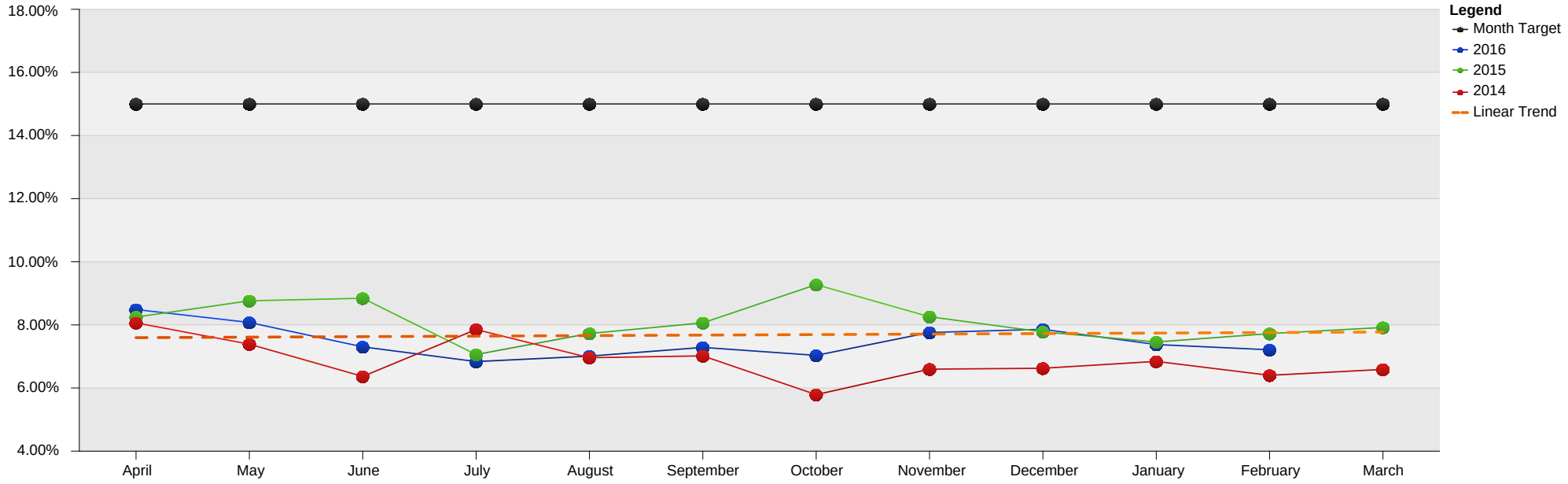
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	25.00	340.00	6.00	85.00	11.00	87.00	3.00	78.00	NA	NA	3.00	74.00

Narrative

The Trust position for February 2017 is 25.00 which is 4.00 worse than the Trust target of 21.00 however is a significant improvement on the January position. This represents the 3rd best position in the year to date. The Trust position for the financial year to date is 340 which has exceeded the target of 253.Only Durham and Darlington and North Yorkshire are meeting target. Of the 25 admissions with a LoS greater than 90 days:• 8 (32%) were within Durham and Darlington (5 MHSOP and 3 ADULTS) • 3 (12%) were within York & Selby (1 MHSOP AND 2 ADULTS) • 11 (44%) were within Teeside (10 MHSOP and 1 ADULTS) • 3 (12%) were within North Yorkshire (2 MHSOP and 1 ADULTS) The greatest reductions have been seen in Durham and Darlington and York and Selby MHSOP services. Both localities report that the availability of local authority placements has contributed to trends with regards to the number of patients discharged with a long length of stay. In addition the weekly report out process has provided greater focus on patients with longer length of stay thereby ensuring concerns are addressed promptly.Comparative data is included in the dashboard, however York & Selby only started to be collected from April 2016 therefore it is not possible to make a direct comparison with the previous years' data.Based on the current trend and performance it is unlikely we will achieve the annual target of 277.

Trust Dashboard Graphs for TRUST

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

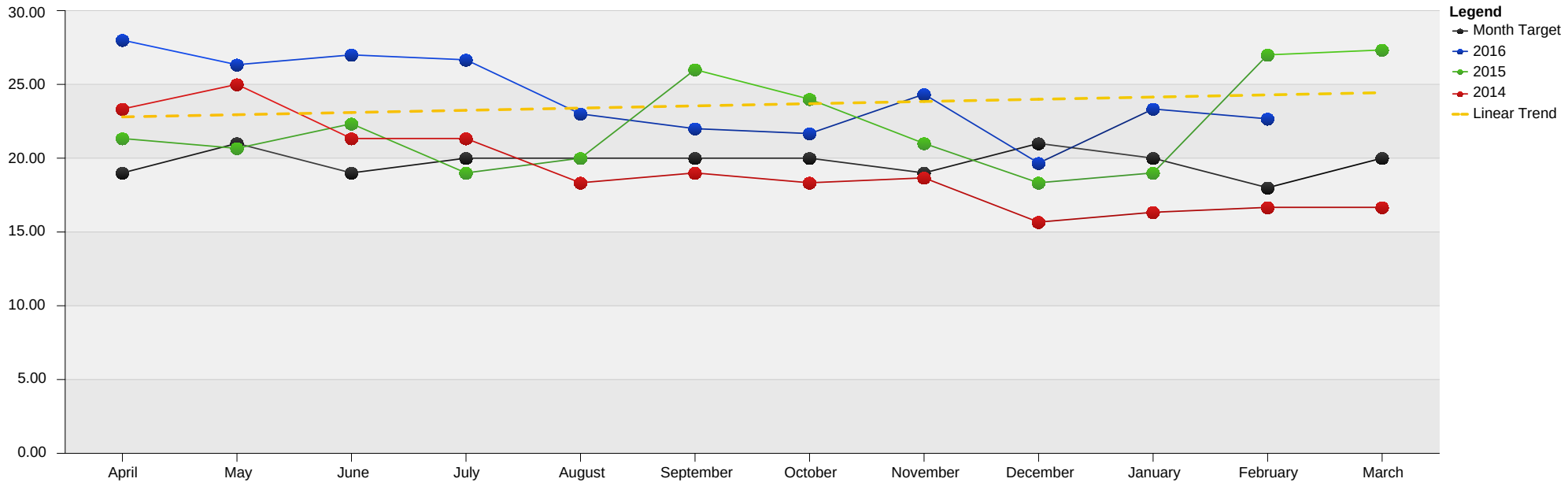


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	7.21%	7.50%	7.79%	7.08%	5.75%	7.08%	4.17%	6.91%	NA	NA	12.32%	11.39%

Narrative
The Trust rolling 3 month position ending February 2017 is 7.21%, which relates to 17.66 patients out of 245 that were readmitted within 30 days. This is meeting the target of 15% and is an improvement on the position reported in January. The Trust position for the financial year to date is 7.50% which is meeting the target of 15%. Of the 17.66 patients:• 5.99 (34%) were within Durham & Darlington (5.66 AMH and 0.33 MHSOP) • 5.66 (32%) were within York and Selby (4.99 AMH and 0.66 MHSOP).• 2.66 (15%) were within North Yorkshire (2.66 AMH) • 3.33 (19%) were within Teeside (3.33 AMH)(*Please note data is displayed in decimal points due to the rolling position being calculated.)All localities are meeting target.Based on current trend and performance, it can be expected that we will achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST

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

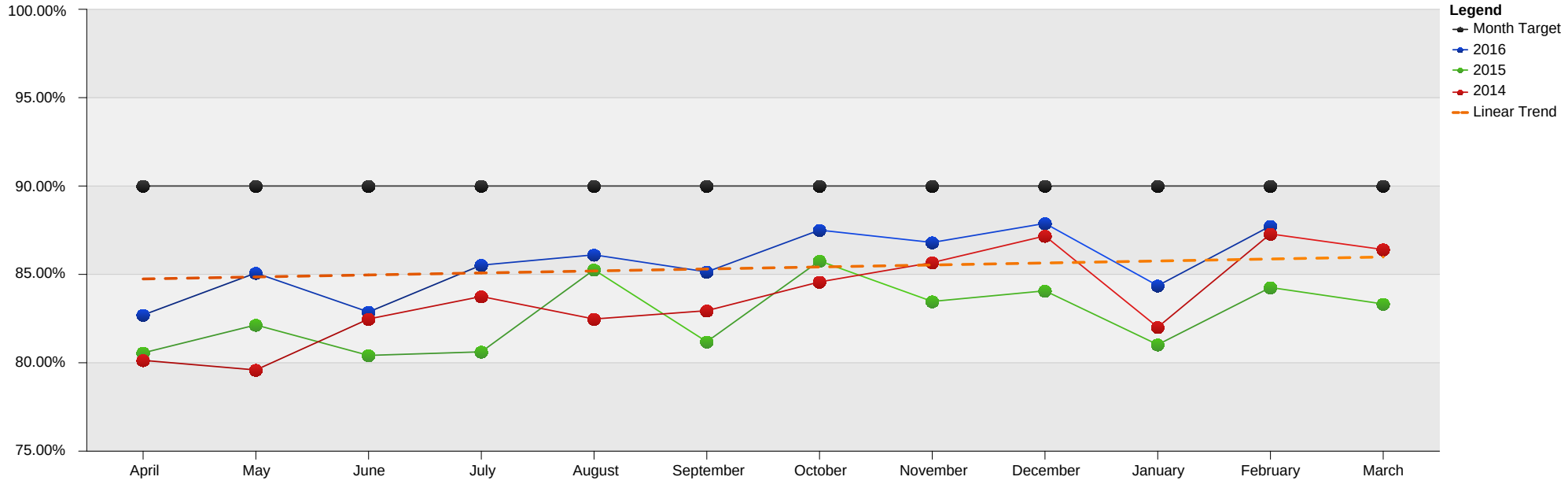


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	22.67	264.66	6.00	88.33	6.33	70.67	5.33	72.00	NA	NA	5.00	33.67

Narrative
The Trust rolling 3 month position ending February 2017 is 22.67, which is 4.67 worse than the target of 18 however a slight improvement on the position reported in January when the target was also not met. The Trust position for the financial year to date is 264.66, which is not meeting the target of 217. Of the 22.67 instances:• 5.99 (26%) were within Durham & Darlington (5.99 AMH)• 6.33 (28%) were within Teesside (5.66 AMH and 0.66 MHSOP)• 5.33 (24%) were within North Yorkshire (4.66 AMH and MHSOP 0.66)• 4.99 (22%) were within York and Selby (4.99 AMH)(*Please note data is displayed in decimal points due to the rolling position being calculated.)Comparative data is now included in the dashboard, however York & Selby only started to be collected from April 2016 therefore it is not possible to make a direct comparison with the previous years' data given the indicator measurement is a number. Based on current trend and performance it is unlikely we will achieve the annual target of 237.

Trust Dashboard Graphs for TRUST

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



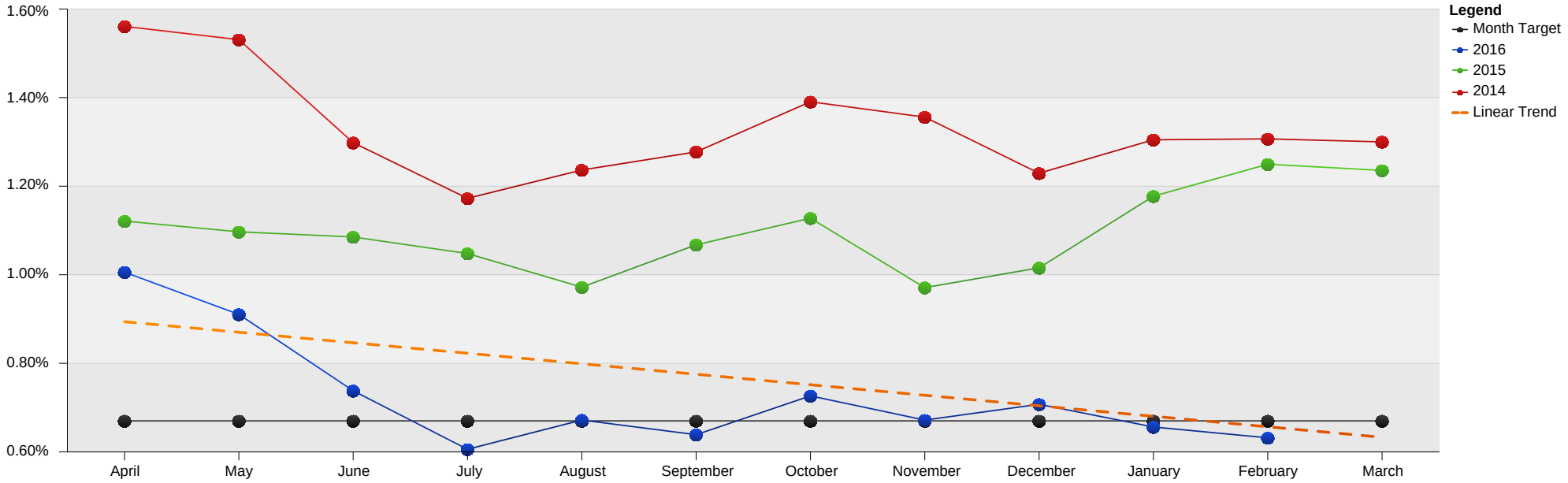
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	87.73%	85.57%	85.12%	81.59%	99.14%	97.02%	75.66%	75.01%	99.73%	99.57%	76.27%	70.86%

Narrative

The position for February 2017 is 87.73%, relating to 734 patients out of 4683 who waited longer than 4 weeks. This is 2.27% worse than target but an improvement on the January position. This follows seasonal trends, but remains a better position than February 2016 and 2015. The position for the financial year to date is 85.57%, which is 4.43% worse than target.Areas of concern:• North Yorkshire CYP at 57.50% (69 of 120 patients). This is 15.14% improvement on the position in January. An action plan is in place with work on capacity and demand analysis taking place with actions to address staff vacancies and sickness. The trajectory for recovery is June 2017.• York & Selby CYP at 23.19% (16 out of 69 patients) this is a 3.20% deterioration on January. An action plan continues to be implemented with data quality actions being addressed, analysis of current waiting lists carried out, utilisation of partnership working and a single point of access established. The reduction in performance is due to improvements required to the single point of access process to ensure suitability to meet demand and required changes have now been made. Based on current trend and performance there is a risk that we will not achieve the annual target of 90%, however if the trend follows previous years we could report the best annual position in the past 3 years.

Trust Dashboard Graphs for TRUST

8) Percentage of appointments cancelled by the Trust

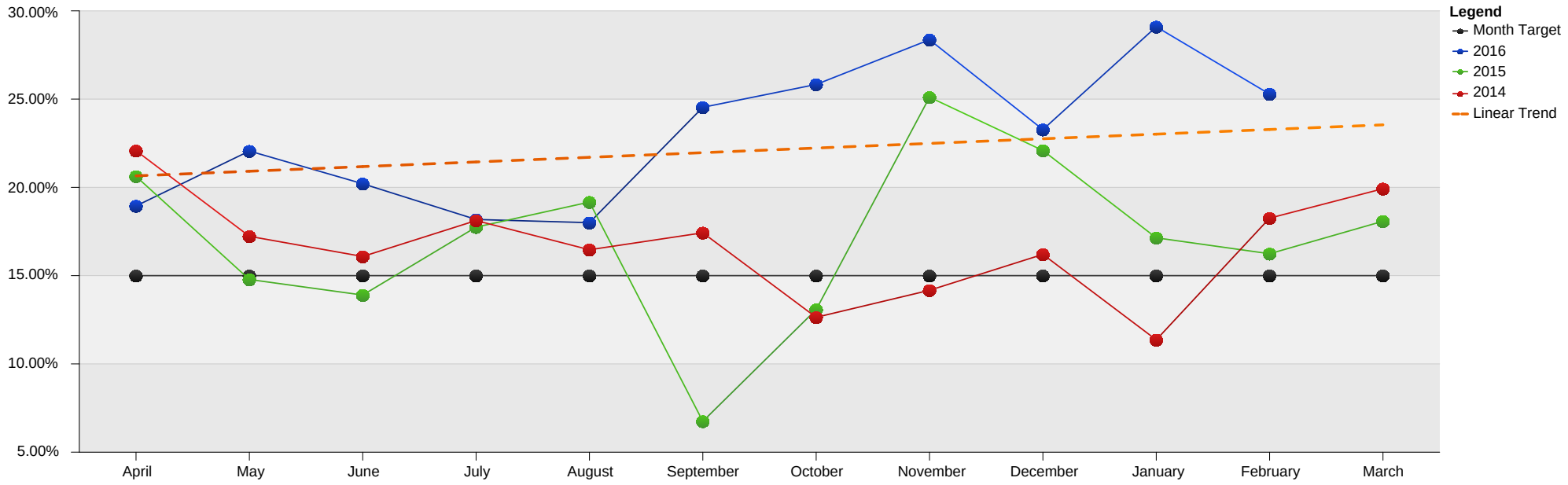


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Percentage of appointments cancelled by the Trust	0.63%	0.72%	0.84%	0.87%	0.44%	0.56%	0.76%	0.93%	0.14%	0.16%	0.40%	0.48%

Narrative
The Trust position for February 2017 is 0.63%, which relates to 545 appointments out of 77,031 that have been cancelled. This is meeting target, however it is a slight deterioration on the position reported in January. The Trust position for the financial year to date is 0.72%, which is 0.05% worse than the target.Only Durham & Darlington and North Yorkshire are worse than target which is as a result of vacancies which are going through the recruitment process and sickness which is being managed in line with Trust Policy. Based on current trend and performance it is possible that we could achieve the annual target of 0.67%.

Trust Dashboard Graphs for TRUST

9) Out of locality admissions (AMH and MHSOP) post validated



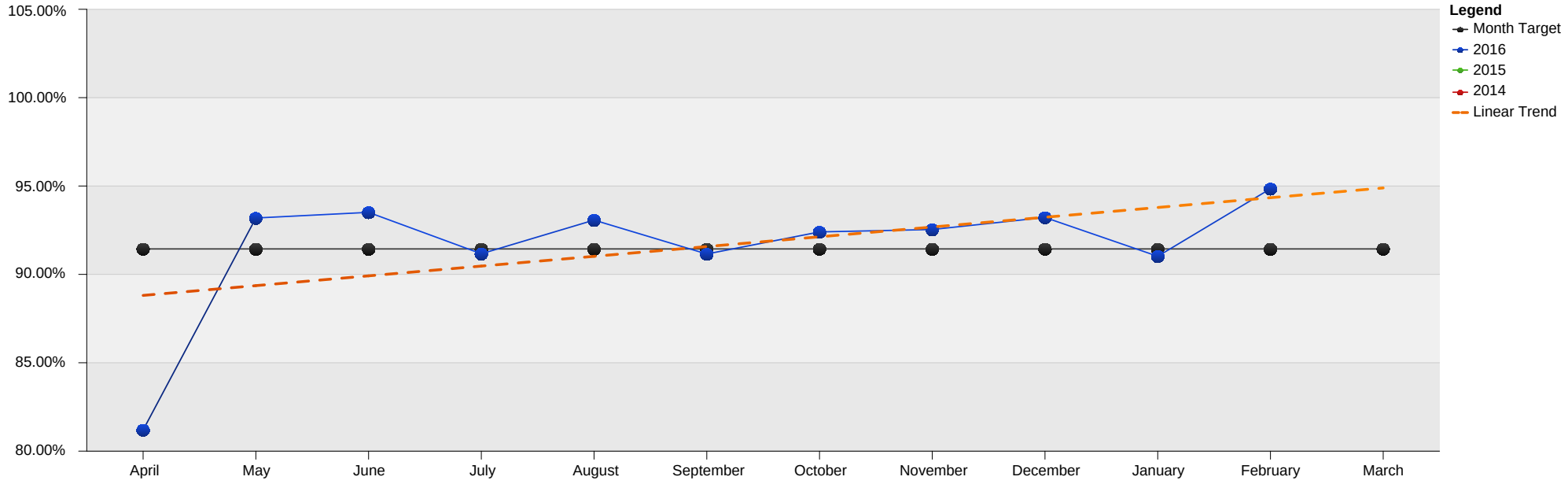
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	25.28%	23.02%	23.66%	20.88%	8.64%	14.55%	38.46%	35.08%	NA	NA	46.15%	28.57%

Narrative

The Trust position for February 2017 is 25.28%, which relates to 67 admissions out of 265 that were admitted to assessment and treatment wards out of locality. This is 10.28% worse than the target of 15%, but an improvement on the position reported in January. The Trust position for the financial year to date is 23.02%, which is 8.02% worse than the target. All localities are worse than target, with the exception of Teesside. The position for Tees is 8.64% which is 6.36% under target. All localities have seen a reduction in OOL admissions for January with the exception of Durham and Darlington. The high level of bed occupancy in Durham and Darlington will be impacting on the ability to admit to local beds.Of the 67 patients (AMH 53, MHSOP 14) admitted to an 'out of locality' bed, all were due to no beds being available at their local hospital with the exception of one admission. Data including the York and Selby locality only started to be collected from April 2016. If comparing the remaining 4 localities, the position is 21.68% which is a deterioration of 5.21% compared to February 2016. Based on current trend and performance we will not achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST

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



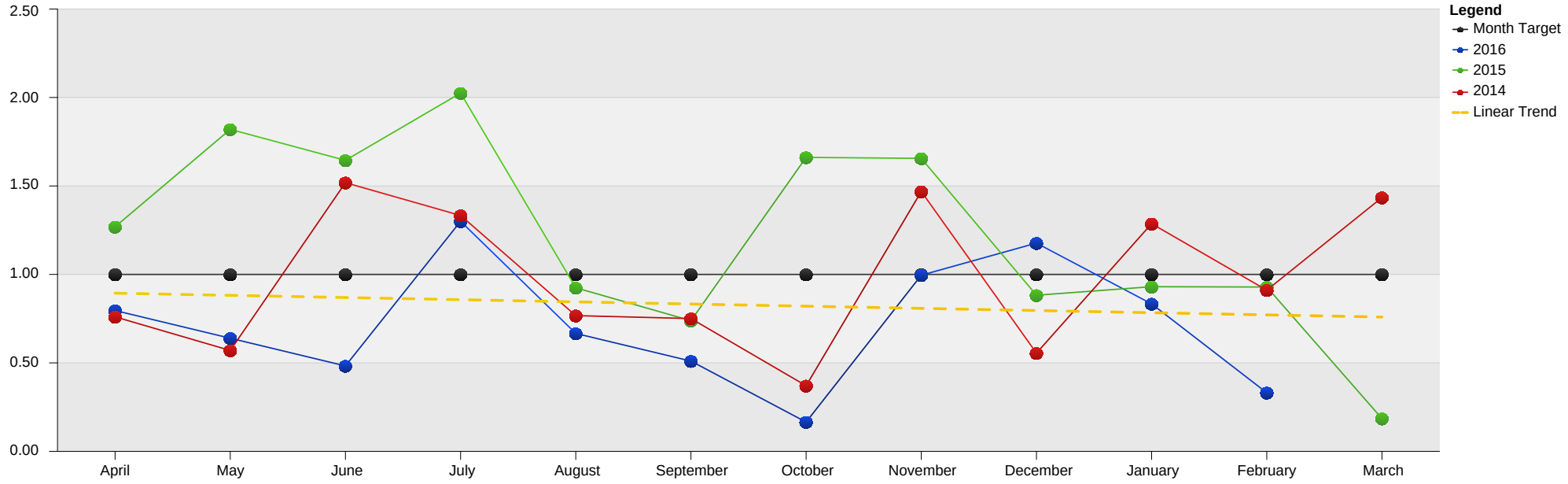
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	94.85%	92.32%	94.65%	93.80%	94.48%	92.99%	97.31%	93.23%	87.50%	80.14%	93.75%	91.70%

Narrative

The Trust position reported in February relates to January performance. The Trust position for January 2016 is 94.85% which is meeting the target of 91.44% and is an improvement on the position reported for December. The Trust position for the financial year to date is 92.32%, which is 0.88% better than the target.All localities are meeting target with the exception of Forensic services who report the poorest performance, however an improvement has been seen compared to the position reported for December. Due to the secure nature of the service performance in this area can fluctuate. As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive).Due to an amendment to the indicator for this year, data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available. If performance continues at the overall levels achieved, it is anticipated that we will achieve the annual target of 91.44%.

Trust Dashboard Graphs for TRUST

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



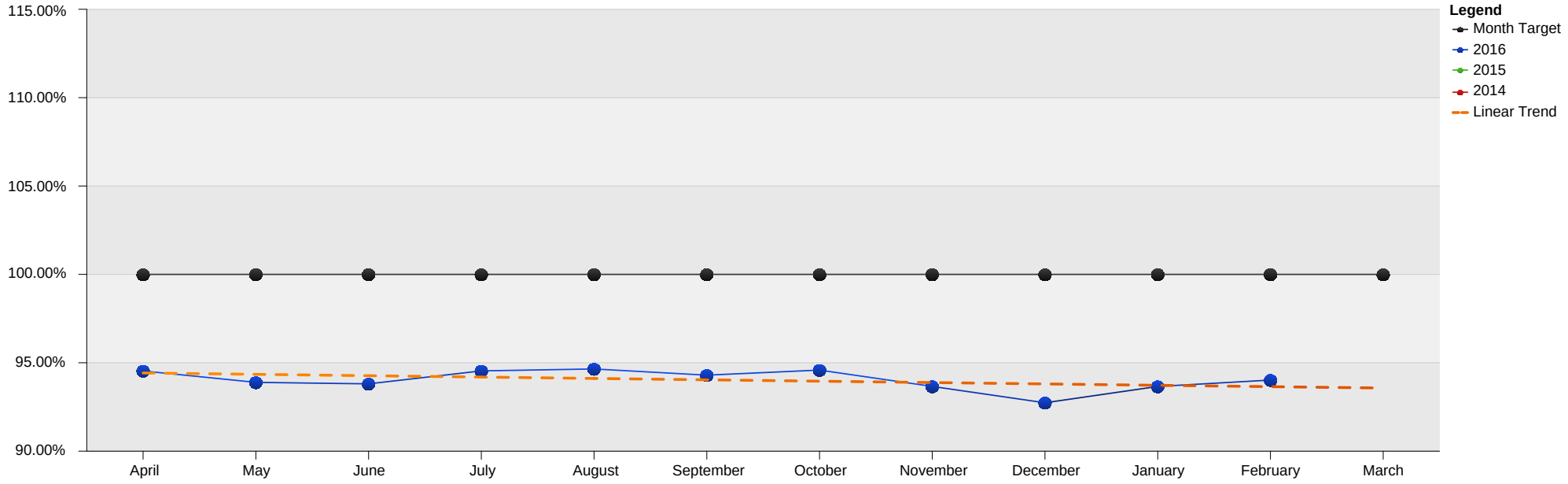
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	0.33	7.90	0.87	5.12	0.00	5.60	0.00	12.24	0.00	49.95	0.00	10.94

Narrative

The Trust position for February 2017 is 0.33, which is meeting the target of 1.00. This rate relates to 2 unexpected deaths which occurred in February. The Trust position for the financial year to date is 7.90 which is 3.10 better than the target.Of the 2 unexpected deaths in February both were in Durham and Darlington (AMH)Given the 2015/16 data did not include York and Selby data it is not possible to compare the position with previous years totals. However the number of unexpected deaths reported in February 2016 was 4 and therefore the figure of 2 across the Trust area (minus York and Selby) in 2017 shows a decrease of 2. Based on current trend and performance, it can be anticipated that we will achieve the annual target of 12.00.

Trust Dashboard Graphs for TRUST

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

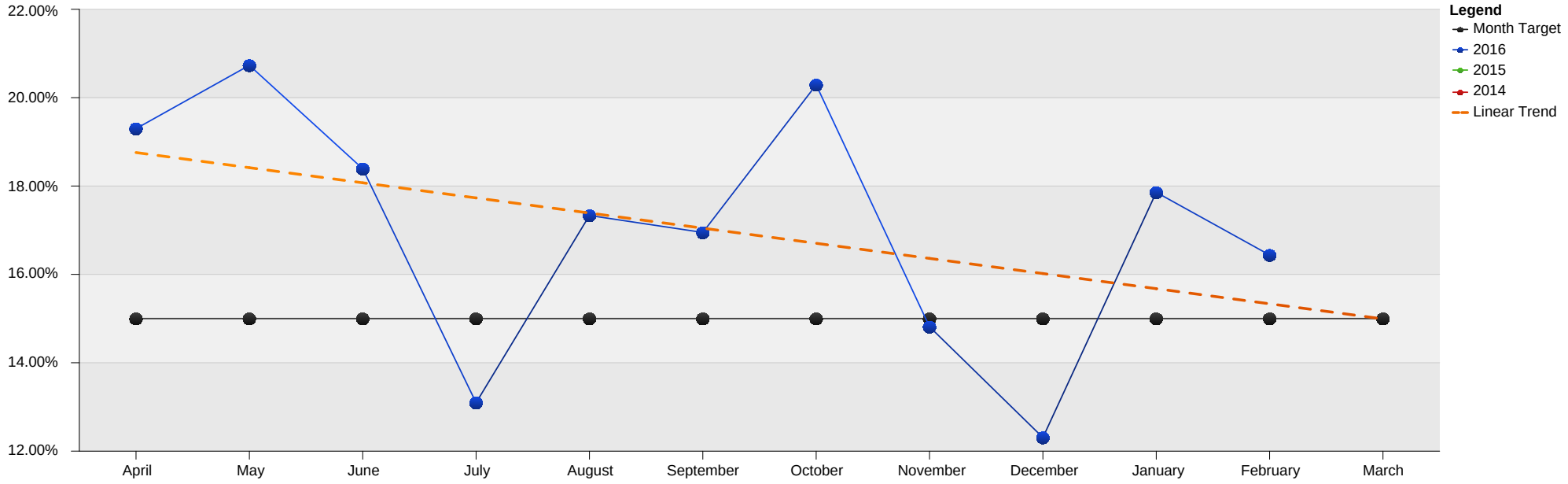


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Actual number of workforce in month (Establishment 95%-100%)	94.02%	94.02%	94.24%	94.24%	96.56%	96.56%	92.68%	92.68%	98.18%	98.18%	89.80%	89.80%

Narrative
The Trust position for February 2017 is 94.02% which is below the targeted establishment level of 95-100% but is a continued improvement on that reported in January. It is anticipated that this figure will continue to improve following a number of recruitment events where the Trust have successfully appointed to a number of nursing vacancies. The recruitment fayre's planned over the next quarter continue to have a focus on registered nursing staff which is expected to improve this position with a planned review of this approach and roll out to non-registered staff if appropriate.Data only started to be reported in the dashboard from April 2016; therefore no comparative data for 2015/16 is available currently in this dashboard. Based on current trend and performance so far during 2016/17, it can be expected that we will not achieve the annual target.

Trust Dashboard Graphs for TRUST

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



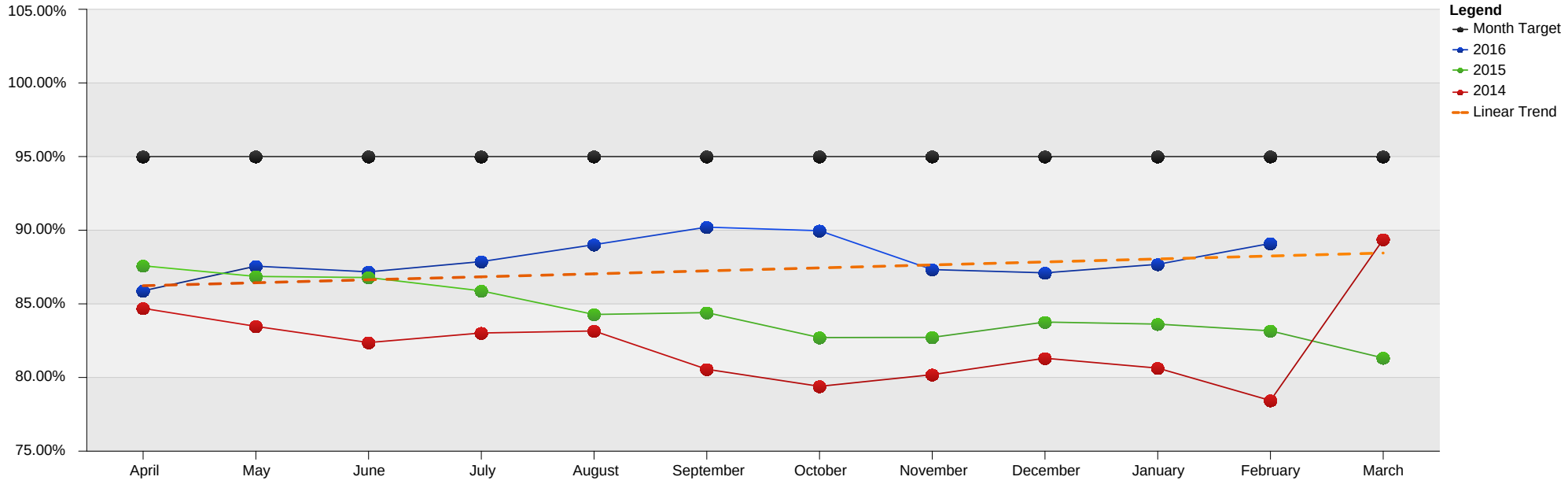
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Percentage of registered healthcare professional jobs that are advertised two or more times	16.44%	17.03%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative

The Trust position for February 2017 is 16.44% which is 1.44% over target however an improvement on the figure of 17.86% reported for January. The Trust position for the financial year to date is 17.03%, which is 2.03% over target. There were 12 jobs re-advertised in February for registered healthcare professional jobs. The majority of the posts were nursing opportunities ranging in band from 5 – 7. Data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available. Based on current trend and performance it is likely that we will not achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST

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

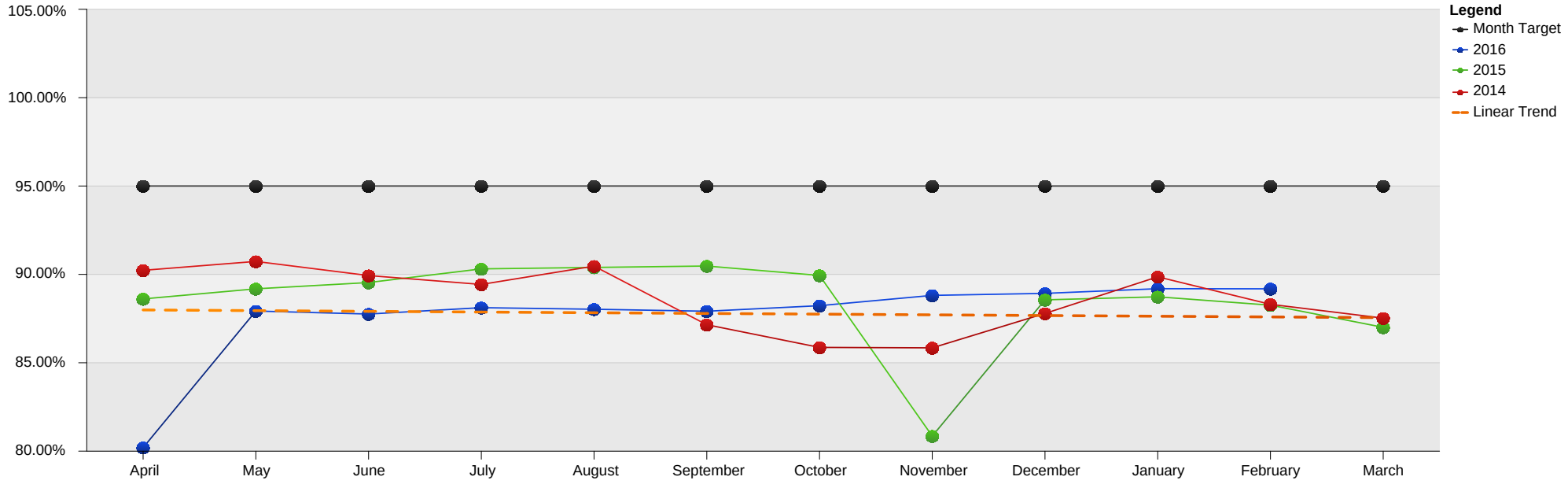


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	89.10%	89.10%	87.64%	87.64%	95.69%	95.69%	84.07%	84.07%	91.91%	91.91%	79.13%	79.13%

Narrative
The Trust position for February 2017 is 89.10% which relates to 620 members of staff out of 5689 that do not have a current appraisal; this is a continued improving position on the figure reported in January however 5.90% below target of 95%.Teesside are the only locality that is still meeting target and York and Selby report the poorest performance, however an improvement when compared to January is seen. All localities now have regular operational management huddles which include discussions on appraisal compliance levels; this has had a positive impact on performance levels being achieved. A new staff dashboard was launched on the IIC in December which highlights to managers those staff reporting as non-compliant and also those due to be appraised within the following three months. Based on current performance there is a significant risk that we may not achieve the annual target of 95%.

Trust Dashboard Graphs for TRUST

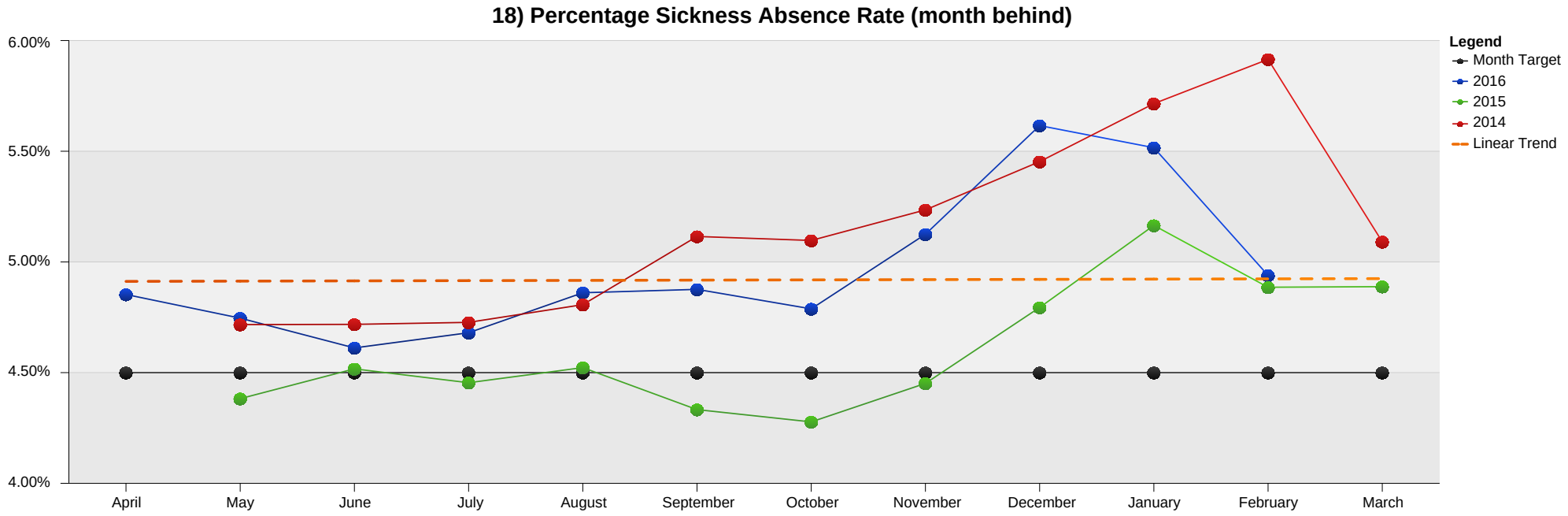
17) Percentage compliance with mandatory and statutory training (snapshot)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with mandatory and statutory training (snapshot)	89.18%	89.18%	87.26%	87.26%	91.46%	91.46%	87.81%	87.81%	89.46%	89.46%	80.76%	80.76%

Narrative
The position for February 2017 is 89.18%. This is 5.82% lower than the target of 95% and similar to the position reported in January. Tees are below target but continue to perform above 90%. Durham and Darlington, North Yorkshire, Forensics and York and Selby are below 90%. York and Selby are achieving the lowest level at 80.76% but an improvement on previous months continues to be seen. The new staff dashboard described in KPI16 regarding the additional HR reports also relates to reports associated with mandatory training. Based on current trend and performance, there is a risk that we may not achieve the annual target of 95%.

Trust Dashboard Graphs for TRUST

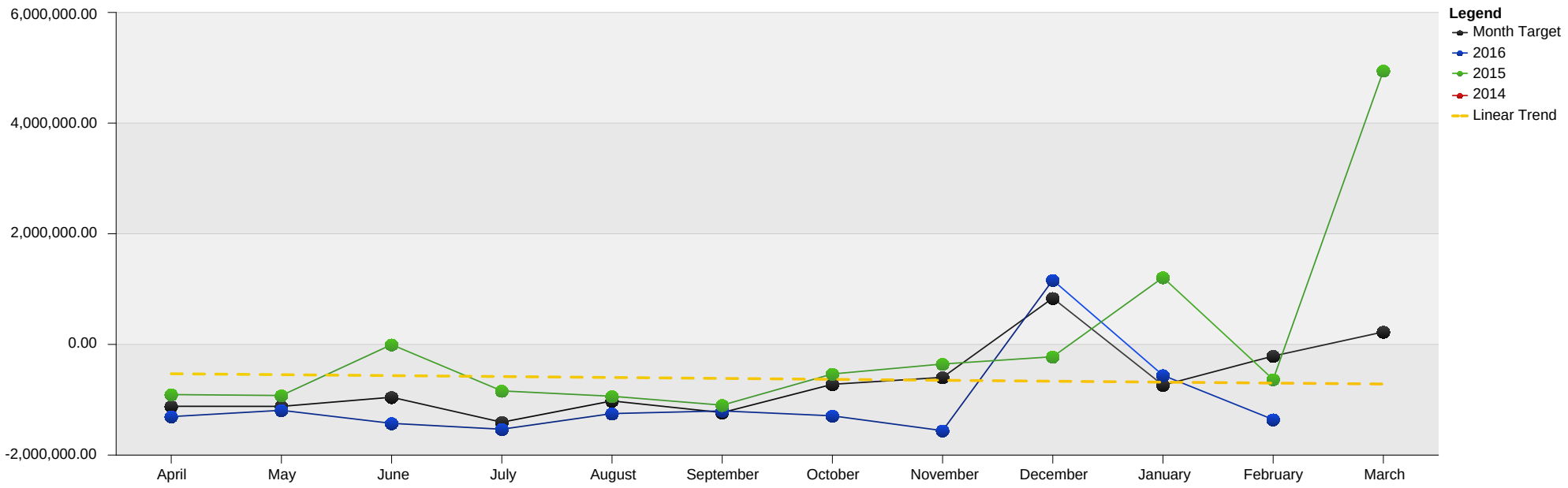


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	4.94%	4.97%	5.42%	5.54%	4.00%	5.04%	4.60%	4.39%	6.12%	5.75%	6.66%	5.64%

Narrative
The Trust position reported in February relates to the January sickness level. The Trust position reported in February 2017 is 4.94%, which is 0.44% worse than the Trust target of 4.50% but represents a continuing improving position on the figure reported in previous three months. The Trust position for the financial year to date is 4.97%, which is 0.47% worse than the target. Only Teesside locality is meeting target, York and Selby continue to report the poorest position. There has been a noticed increase in the number of short term episodes of absence and a marked decrease in the percentage of staff experiencing no absences. Analysis is currently being undertaken on short term absence and a report is due to be presented by EMT in May 2017. The long term sickness absence team continues to manage staff on long term sickness, proactively facilitating staff back to work or ultimately to the ending of the employment. The number of staff on long term sickness absence being managed by the long term sickness team is between 150 and 200 at any point in time. As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive).Based on past and current performance there is a risk that we will not achieve the annual target of 4.50%.

Trust Dashboard Graphs for TRUST

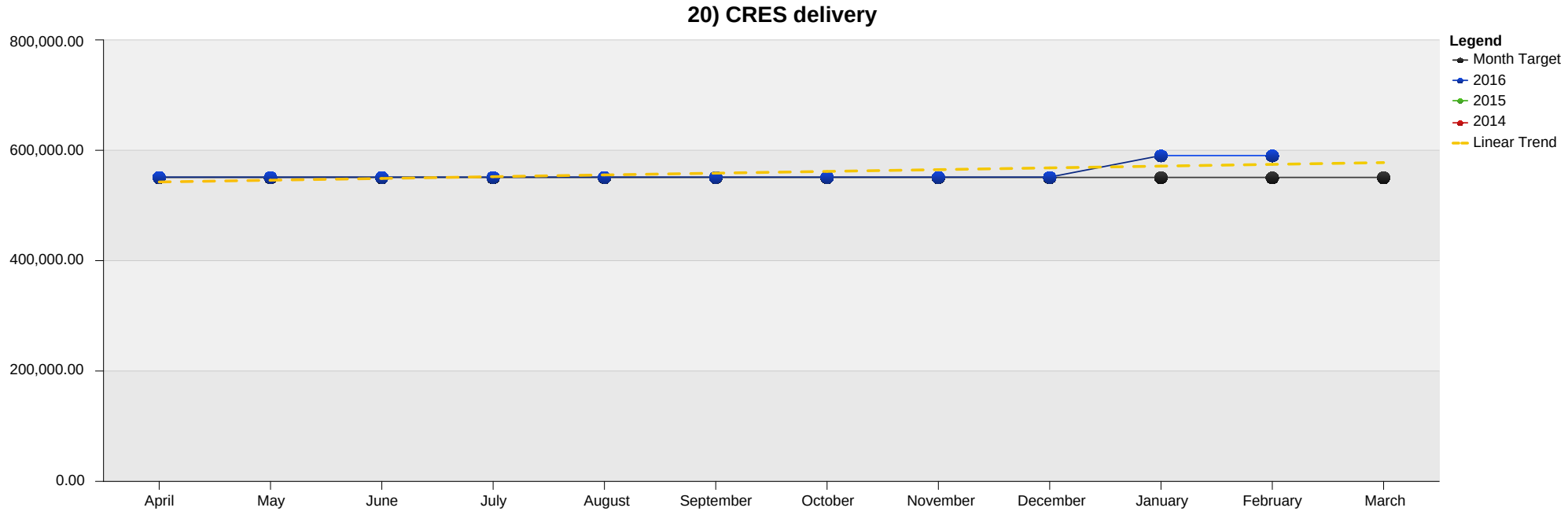
19) Delivery of our financial plan (I and E)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Delivery of our financial plan (I and E)	-1,358,000.00	-11,513,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
The comprehensive income outturn for the period ending 28 February 2017 is a surplus of £11,513k, representing 3.7% of the Trust's turnover. The Trust is ahead of plan largely due to contract variations with commissioners, a refund of historic National Insurance payments linked to widening access trainees, and vacancies. Recruitment to posts is ongoing.

Trust Dashboard Graphs for TRUST

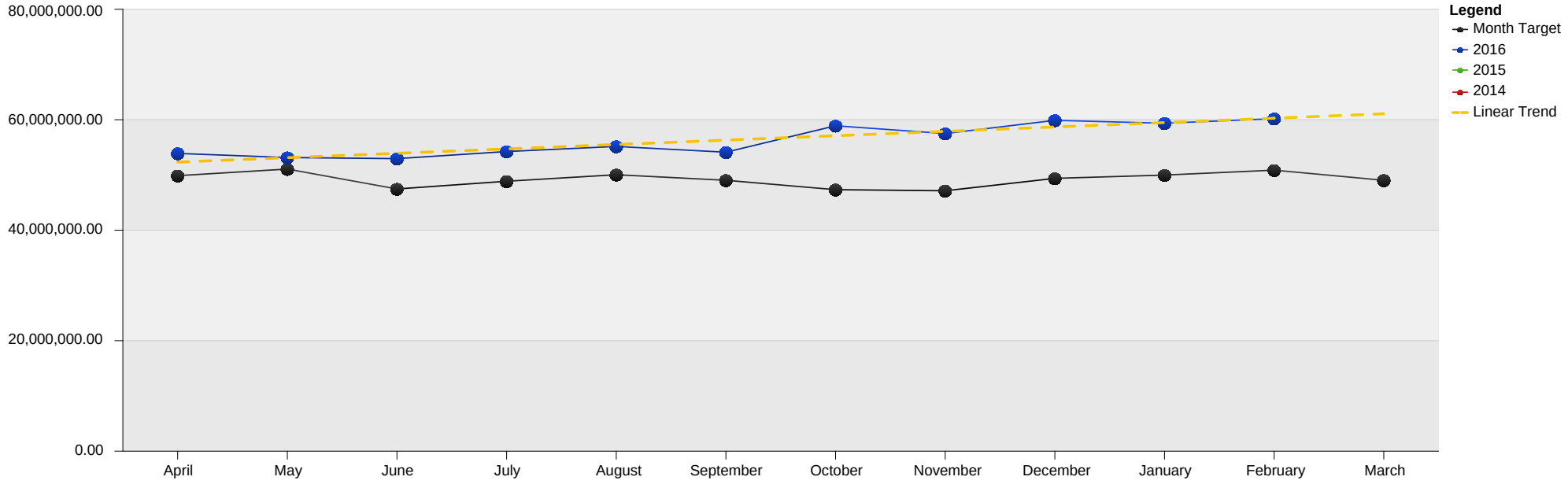


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) CRES delivery	590,459.00	6,144,013.00	196,833.00	2,165,163.00	94,000.00	1,034,000.00	23,584.00	259,415.00	26,834.00	295,165.00		

Narrative
Total CRES delivery by the Trust for 28 February 2017 is £590,461. All localities continue to identify CRES schemes to ensure 100% is delivered recurrently in 2016/17.

Trust Dashboard Graphs for TRUST

21) Cash against plan



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Cash against plan	60,199,000.00	60,199,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
Total cash at 31 February 2017 is £60.2 million and is ahead of plan largely due to planned delays in the capital programme and the Trusts surplus position.

Trust Dashboard - Locality Breakdown for TRUST

1 - Activity

	February 2017												April 2016 To February 2017											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Total number of External Referrals into Trust Services	14,080.00	15,998.00	3,408.00	3,696.00	3,458.00	4,132.00	3,340.00	4,080.00	1,062.00	1,122.00	2,814.00	2,946.00	167,932.00	181,460.00	40,620.00	43,142.00	41,282.00	42,806.00	39,828.00	44,980.00	12,618.00	12,948.00	33,586.00	37,526.00
2) Caseload Turnover	1.99%	0.32%	1.99%	-1.07%	1.99%	1.29%	1.99%	-0.18%	NA	NA	1.99%	2.43%	1.99%	0.32%	1.99%	-1.07%	1.99%	1.29%	1.99%	-0.18%	NA	NA	1.99%	2.43%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	86.00%	85.00%	92.08%	85.00%	87.84%	85.00%	94.62%	85.00%	NA	85.00%	63.65%	85.00%	93.32%	85.00%	92.92%	85.00%	95.62%	85.00%	95.70%	85.00%	NA	85.00%	85.38%
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	21.00	25.00	7.00	6.00	6.00	11.00	6.00	3.00	NA	NA	2.00	3.00	253.00	340.00	87.00	85.00	69.00	87.00	69.00	78.00	NA	NA	29.00	74.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	15.00%	7.21%	15.00%	7.79%	15.00%	5.75%	15.00%	4.17%	NA	NA	15.00%	12.32%	15.00%	7.50%	15.00%	7.08%	15.00%	7.08%	15.00%	6.91%	NA	NA	15.00%	11.39%
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	18.00	22.67	5.00	6.00	5.00	6.33	6.00	5.33	NA	NA	3.00	5.00	217.00	264.66	59.00	88.33	59.00	70.67	72.00	72.00	NA	NA	26.00	33.67

Trust Dashboard - Locality Breakdown for TRUST

2 - Quality

	February 2017												April 2016 To February 2017											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	90.00%	87.73%	90.00%	85.12%	90.00%	99.14%	90.00%	75.66%	90.00%	99.73%	90.00%	76.27%	90.00%	85.57%	90.00%	81.59%	90.00%	97.02%	90.00%	75.01%	90.00%	99.57%	90.00%	70.86%
8) Percentage of appointments cancelled by the Trust	0.67%	0.63%	0.67%	0.84%	0.67%	0.44%	0.67%	0.76%	0.67%	0.14%	0.67%	0.40%	0.67%	0.72%	0.67%	0.87%	0.67%	0.56%	0.67%	0.93%	0.67%	0.16%	0.67%	0.48%
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	25.28%	15.00%	23.66%	15.00%	8.64%	15.00%	38.46%	NA	NA	15.00%	46.15%	15.00%	23.02%	15.00%	20.88%	15.00%	14.55%	15.00%	35.08%	NA	NA	15.00%	28.57%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.44%	94.85%	91.44%	94.65%	91.44%	94.48%	91.44%	97.31%	91.44%	87.50%	91.44%	93.75%	91.44%	92.32%	91.44%	93.80%	91.44%	92.99%	91.44%	93.23%	91.44%	80.14%	91.44%	91.70%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.33	1.00	0.87	1.00	0.00	1.00	0.00	1.00	0.00	1.00	0.00	11.00	7.90	11.00	5.12	11.00	5.60	11.00	12.24	11.00	49.95	11.00	10.94

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	February 2017												April 2016 To February 2017											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	94.02%	100.00%	94.24%	100.00%	96.56%	100.00%	92.68%	100.00%	98.18%	100.00%	89.80%	100.00%	94.02%	100.00%	94.24%	100.00%	96.56%	100.00%	92.68%	100.00%	98.18%	100.00%	89.80%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	16.44%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	17.03%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	89.10%	95.00%	87.64%	95.00%	95.69%	95.00%	84.07%	95.00%	91.91%	95.00%	79.13%	95.00%	89.10%	95.00%	87.64%	95.00%	95.69%	95.00%	84.07%	95.00%	91.91%	95.00%	79.13%
17) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	89.18%	95.00%	87.26%	95.00%	91.46%	95.00%	87.81%	95.00%	89.46%	95.00%	80.76%	95.00%	89.18%	95.00%	87.26%	95.00%	91.46%	95.00%	87.81%	95.00%	89.46%	95.00%	80.76%
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.94%	4.50%	5.42%	4.50%	4.00%	4.50%	4.60%	4.50%	6.12%	4.50%	6.66%	4.50%	4.97%	4.50%	5.54%	4.50%	5.04%	4.50%	4.39%	4.50%	5.75%	4.50%	5.64%

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	February 2017												April 2016 To February 2017									
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
19) Delivery of our financial plan (I and E)	-210,727.00	-1,358,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	-8,282,528.00	-11,513,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
20) CRES delivery	550,854.00	590,459.00	183,500.00	196,833.00	168,250.00	94,000.00	117,595.00	23,584.00	92,909.00	26,834.00			6,059,397.00	6,144,013.00	2,018,500.00	2,165,163.00	1,850,750.00	1,034,000.00	1,293,549.00	259,415.00	1,021,999.00	295,165.00		
21) Cash against plan	50,873,000.00	60,199,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	541,067,000.00	60,199,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

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

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at April 2016	Percentage	Notes	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1					
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined					
14	Percentage of staff in post more than 12 months with a current appraisal – snapshot	5						4				5					14	**93%**	**93%**		Issues with appraisal dates being entered to ESR have lessened - there appears to be greater confidence in the data being reported. York and Selby staff were transferred on 1st October and will begin to be reported in November through the IIC. Robust process recently implemented within York and Selby to regularly review appraisal compliance information as part of regular management meeting. Fortnightly reports being produced by Workforce Information team to support monitoring.
15	Percentage compliance with mandatory and statutory training – snapshot	5						4				5					14	**93%**	**93%**		Issues with training dates being entered to ESR have lessened - there appears to be greater confidence in the data being reported. York and Selby staff were transferred on 1st October, training information input ESR. There is an ongoing issue associated with idenitification of training requirements linked to training matrix. There is a piece of work being undertaken associated with this which may provide a resolution.
16	Percentage Sickness Absence Rate (month behind)	5						4				5					14	**87%**	**93%**		Whilst the sickness absence data for inpatient services is now being taken directly from the rostering system which should help to eliminate inaccuracies the remainder of the Trust continue to input directly into ESR and there are examples whereby managers are failing to end sickness in a timely manner or inaccurately recording information onto the system – this is picked up and monitored through sickness absence audits that the Operational HR team undertake. York and Selby services are now in line with the remainder of the Trust using MSS or the rostering system - so actions highlighted above will be replicated.
17	Actual number of workforce in month		4				5					5					14		**93%**		Data extracted elecronically but processed manually
18	Percentage of registered health care professional jobs that are advertised two or more times				2			4				5					11		**73%**		Mostly reliable - the form to capture this information has been amended but is still reliant on recruiting managers completing the section of the form. The recruitment team are more proactive in recording on the tracking spreadsheet where they are aware it is a readvertisement because they know this is being reported through a KPI. The recording of the information is a manual input into a spreadsheet which has the potential for human error.

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at April 2016	Percentage	Notes	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1					
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined					
19	Are we delivering our financial plan (I and E)		4				5					5					14	**93%**	**93%**		Mostly reliable - the form to capture this information has been amended but is still reliant on recruiting managers completing the section of the form. The recruitment team are more proactive in recording on the tracking spreadsheet where they are aware it is a readvertisement because they know this is being reported through a KPI. The recording of the information is a manual input into a spreadsheet which has the potential for human error.
20	Delivery of CRES against plan				2		5					5					12		**80%**		Data is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
21	Cash against plan		4				5					5					14		**93%**		An extract is taken from the system then processed manually to obtain actual performance.

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

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient and took place in the hospital					Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital					Number of unexpected deaths where the patient was no longer in service					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death																					**0**
Natural causes	1	1															1				**3**
Hanging					1												1				**2**
Suicides	3	1	2		2							1	2					1			**12**
Open			1																		**1**
Drug related death																					**0**
Drowning													1								**1**
Misadventure																					**0**
Awaiting verdict	6	3	6	1	6	1					1	1						1	2	1	**29**
Total	**10**	**5**	**9**	**1**	**9**	**1**	**0**	**0**	**0**	**0**	**1**	**2**	**3**	**0**	**0**	**0**	**2**	**2**	**2**	**1**	**48**

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	8	4	3	1	6	7	5	2	

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
12	9	14	3	10

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

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

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient					Number of unexpected deaths where the patient is an inpatient but the					Number of unexpected deaths where the patient was no longer					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death	1																				**1**
Natural causes	1					1															**2**
Hanging	3	1	2								1						1		1		**9**
Suicides	7	3	6										1				1				**18**
Open	1		1																		**2**
Drug related death	1	2																			**3**
Drowning																					**0**
Misadventure	1		1																		**2**
Awaiting verdict	13	9	7	2		2		1			2	2	2			1	6	1	1		**49**
Total	**28**	**15**	**17**	**2**	**0**	**3**	**0**	**1**	**0**	**0**	**3**	**2**	**3**	**0**	**0**	**1**	**8**	**1**	**2**	**0**	**86**

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

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

Y&S recorded in old Datix not included

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th March 2017**
TITLE:	**Interim Programme Management Framework**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance and Communications**
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 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:

Whilst the Trust has established a robust Project Management Framework there are a number of drivers that suggest we need to enhance our framework for implementation of change by developing an approach to how we implement ***programmes*** of change across the organisation. This paper proposes that we should adopt the Managing Successful Programmes methodology and adapt this to our ways of working in TEWV.

This paper sets out the proposed roles and powers of Trust Board, EMT and Programme Boards vis a vis programme management so that these can be considered and approved.

These proposals have been discussed by EMT (15 February 2017) and Resources Committee (14 March 2017) and their views and advice have been incorporated into this report.

Recommendations:

- It is recommended by the Resources Committee that the Board of Directors endorse the interim programme management framework proposals, including the governance arrangements set out in detail in Appendix 1.

MEETING OF:	**Board of Directors**
DATE:	**28th March 2017**
TITLE:	**Interim Programme Management Framework**

1. INTRODUCTION & PURPOSE:

1.1 This paper sets out proposals for an **Interim** TEWV Programme Management Framework.

1.2 The Framework

- Specifies that, "Trust Board should approve the Programme Vision and / or Strategy document for any programme designed to deliver one of the key strategic priorities within the Business Plan"
- Establishes Programme Boards with specified powers and responsibilities.

1.3 The full set of powers and responsibilities of Trust Board, EMT and Programme Boards is set out in Appendix 1 of this report

1.4 It is important that the Board of Directors are aware of, and support this aspect of the proposals.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 In recent months it has become clear that TEWV requires a programme management framework to supplement the existing project management framework. This is because of:

- The emergence during this year's TEWV business planning process of strategic priorities, several of which require a programme, not project management approach (PPCS, Recovery, Model Wards, Safe Staffing, and possibly Locality-level service redesign priorities such as York, and Hambleton/Richmondshire service redesign);
- Evidence emerging that inter-linked projects or other pieces of work are working in isolation or insufficiently co-ordinated;
- A desire to reduce the "fixed cost" elements of managing and reporting many separate projects;

2.2 These proposals have been discussed by EMT (15 February 2017) and Resources Committee (14 March 2017) and their views and advice have been incorporated into this report.

3. KEY ISSUES:

3.1 The Benefits of Programme Management

3.1.1 Programme management and project management are different tools, which are designed to address different requirements, as set out in the table below. The table shows that both approaches are needed, and that it is important to utilise the correct tool in the right circumstances to successfully implement the Trust's change priorities.

Projects	Programmes
Driven by deliverables	Driven by vision of the end state
Finite – defined start and finish, usually short to medium term duration	More flexibility in end date, and usually medium to long term duration
Narrowly bounded and scoped	Focus on changes to business capability and seeks to influence whatever is relevant to this
Deliver a defined product	Co-ordinates relevant work to deliver defined benefits / outcomes
Benefits usually realized after project closed	Benefits realised during and after the programme

3.1.2 A typical programme will have a number of projects or workstreams within it. These will often be phased – i.e. some projects will close before others open.

3.1.3 Programme management has costs associated with it, and so it not suitable where the costs of programme management infrastructure are greater than the benefits achieved by using it. It is also not suitable for situations where urgent solution generation and implementation are necessary, and should not be used in such situations.

3.2 National Best Practice and local learning

3.2.1 The standard national model is MSP – *Managing Successful Programmes*. This Cabinet Office approved methodology is part of a wider family of products including *PRINCE2* (projects) and *MoP* (Portfolio management). These were originally developed in an information technology context but are widely used across many industries.

3.2.2 There are no aspects of MSP that are not relevant for TEWV, but clearly we need to adapt the model to our operating environment and culture. The following paragraphs explain how we could do this.

3.3 Portfolio, Programme and Project Management – fitting it together

3.3.1 The Trust already has aspects of a portfolio management process in place (the Business Planning framework). It also has an existing project management framework. Introducing programme management will lead to some projects being incorporated into programmes, while others will remain "stand-alone" / "independent" and maintain their current direct reporting relationship to EMT. **Appendix 2** sets out how the governance of the Trust's portfolio of change (i.e. Trust Business Plan) and its delivery through Programmes, Projects and Business as Usual will be linked together.

3.4 Identifying Programmes:

3.4.1 The Trust Board will continue to set the key Trust priorities via the Business Planning Process. EMT will identify (normally as part of the Annual Business Planning process) whether a programme approach is needed to implement any individual Trust Board (or other) priority.

3.4.2 Exceptionally EMT may need to create an additional programme mid way through the Business Planning cycle – for example to meet unexpected external requirements. Such actions should also lead to a request to the Trust Board to amend the TEWV Business Plan.

3.4.3 EMT will agree who the sponsor of each programme shall be. Sponsors must be members of EMT.

3.5 Initial Development Work

3.5.1 The sponsor will bring together a programme development group for the development phase of the programme. The initial development task is to develop a programme vision including expected benefits. This might build on refreshing an existing strategy, be created by developing a new strategy, or producing a vision based on the Board's discussion at the annual Business Planning October workshop.

3.5.2 Trust Board should approve the Programme Vision and / or Strategy document for any programme designed to deliver one of the key strategic priorities within the Business Plan. In doing so, they should ensure that the vision or strategy is aligned to and complements the overarching Strategic Direction of the Trust. Once this approval has been received, the development team should also produce a **Programme Business Case** for consideration by Trust Board (unless Trust Board agrees to delegate this function to EMT for a particular programme), which will include the following appendices:

- **Governance and Control Framework** (including proposed Programme Board membership, Programme Office arrangements, and any variations to the standard tolerances
- **Programme Plan** (including list of projects to be governed by the Programme Board, and other projects / business as usual which the programme will need to influence). This should also make reference to any expected future "tranches" of projects and explain when proposals for these will be developed
- **Resource Requirements** – a clear statement of both the non-cash resources required (and the opportunity costs of these) and any non-recurrent funding required to develop and manage the programme. This would also include any recurring costs which are already clear at this stage of the programme's development;
- **Benefits Map** showing how benefits relate to each other and to the project outputs and business changes that will enable them to be achieved. The dependency relationships in a Benefits Map show how project outputs ultimately lead to the achievement of strategic objectives and a **Benefit Realisation Plan** to show which KPIs will be used to track benefits, and any evaluation-type reviews that may take place during the programme.
- Initial **assumptions, issues and risk log**
- Initial **stakeholder analysis and engagement / communication plan**

3.5.3 Programme development work will be led by the programme sponsor. Assistance will be provided by:

- The Planning and Business Development Team (one individual will be assigned to each programme development team)
- Finance (including PbR team where this can assist with benefits realisation);
- A clinical and / or operational leader who will have an important role in identifying the potential benefits to service users and the measurement of this and who will also ensure the programme and operational services are aligned and that there is clinical / operational service ownership of the change;
- KPO, who will advise on QIS tools that could be used and the role of post-event report outs in collecting data on benefits realised;
- Other individuals who the sponsor / EMT identify can make an important contribution;
- The programme manager and the project managers of any project which are to be governed by the programme, if these individuals are already in post.

3.6 Full Establishment of a Programme Board

3.6.1 Once the development phase is completed and the associated documents approved by EMT and Board, then a Programme Board will be formally constituted, governance powers will be formally delegated to the Programme Board, and the Programme Board formal meetings will commence.

3.6.2 EMT will agree the membership of Programme Boards, having regard to the views of the sponsor, the focus of the programme and whether any suitable individuals have particular knowledge, enthusiasm or skills which should be harnessed.

3.6.3 Quorum arrangements should be set out in the Governance and Control document which forms part of the Programme Business Case that is agreed by EMT.

3.7 Roles of Programme Boards in monitoring and influencing

3.7.1 Our interim framework indicates that the purpose of a programme board will be to:

- Take decisions on the opening, modification and closing of directly governed projects / workstreams, using powers delegated from Trust Board and EMT (**see appendix 1**) To do this, a programme board will need to consider progress reports from each of its workstreams;
- Review the deployment of QIS tools and the impact they are having on key metrics;
- Discuss and resolve interdependencies between the work of separate directly governed workstreams, or different services;
- Co-ordinating stakeholder engagement and communication;

- Propose the allocation / virement resources, from the delegated budgets, and using the delegation powers available to individual Board members; referring to Trust Board where appropriate
- Identify and manage relevant risks;
- Influence the implementation of other projects, initiatives and business as usual which impact upon the achievement of the Vision and Benefits of the program. Where it becomes apparent that benefits realisation is at risk because of issues linked to the delivery of these other projects/BAU, this must be escalated to Executive Management Team;
- Provide assurance to EMT and Trust Board that the Programme is being implemented successfully (including providing a programme RAG rating and comment on issues to EMT as required), and escalating issues to EMT / Trust Board when necessary;
- Commission programme evaluation.

3.7.2 Tolerance levels for reporting from the Programme Board to EMT and Board (if any) should be agreed as part of the Governance and Control document which forms part of the Programme Business Case that is agreed by Trust Board. These should be based on the standard tolerances set out in **Appendix 3**. Tolerance levels for reporting within programmes should be determined by the Programme Board.

3.7.3 EMT will need to consider whether programmes should have dedicated resources and budgets allocated to them (with the programme manager or sponsor as budget holder with a unique cost-centre). Where this is the case, budgets will be monitored and reported corporately in the same way as other cost centres.

3.8 Risk and Issue Management

3.8.1 Each programme should have an AIR Log (assumptions, issues and risk register). This must be reviewed at each Programme Board meeting. Red risks should be escalated to EMT in the next regular EMT progress report along with details of any mitigating action the Programme Board wishes to take (or recommendations for EMT)

3.9 Providing assurance to EMT and Trust Board

3.9.1 EMT will receive regular updates on the progress of each programme. This will consist of an overall RAG rating for that programme, and any risks and issues which are being escalated to EMT. A change request form may also be sent to EMT. Forms for this purpose to be developed based on Project Management Framework forms 2 / 2a and PPCS forms.

3.9.2 To enable this to take place each programme board must:

- Put in place processes which allow it to understand the progress of each directly governed workstreams and also progress against expected benefits trajectories –;
- Agree an “overall RAG” at each Programme Board meeting, along with any issues / change requests to escalate to EMT

- Send these updates to the team in charge of collating the regular programme updates to EMT.

3.9.3 EMT will need to monitor progress against all the programmes and we will also need to ensure that alignment across the programmes is built into the governance arrangements. .

3.9.4 The quarterly Business Plan report for Trust Board will include the RAG for each programme, a summary of any key issues, and a summary of any change requests (with the full change form embedded / attached as an appendix) –

3.9.5 A benefits realisation report covering all programmes will be reported to EMT and Trust Board every 6 months

3.10 Programme Support

3.10.1 Experience has shown that programmes are most likely to be successful where the Sponsor is supported by a Programme Support Team, which is likely to consist of:

- A dedicated programme manager in place (although this is not necessarily a full-time role on its own so can be combined with managing a project within the programme or with another programme management role);
- A dedicated Business Change Manager (a senior clinician who can persuade others of the need to change, and ensure that clinically-valid information and statistics are used in calculating benefits);
- Support offered from the appropriate corporate teams, such as KPO, Planning, OD, Capital Development and Communications
- Sufficient admin capacity.

3.11 Closedown and Post-Programme Evaluation

3.11.1 A programme will be closed when either:

- The benefits have been realised, and there is evidence that the changes brought about by the programme are successfully embedded in business as usual, or
- The benefits have not been (or have only been partially realised) but the Trust does not wish to carry our further work due to:
    - Change in Trust strategy
    - Change in internal or external environment
    - Emergence of more urgent / significant priority
    - Clear evidence that the costs of further work will not produce sufficient further benefit to justify further investment

3.11.2 Only Trust Board have the power to close programmes although it is EMT's role to recommend such a course of action to the Trust Board.

3.11.3 A lessons learnt report should be produced at the same time as a closure request and reported to EMT.

3.11.4 A post-programme review should be scheduled as part of any close-down proposal, and the results of such a review should be reported to EMT and Trust Board after it is conducted.

4. IMPLICATIONS

4.1 **Compliance with the CQC Fundamental Standards:**
None directly but should support overall improvement in services we deliver

4.2 **Financial/Value for Money:**
The establishment of programme support teams could require additional spend unless resources can be transferred from existing Trust budgets. However, these posts will ensure more effective use of resources in the longer term as we will become more successful at embedding change.

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

4.4 **Equality and Diversity:**
The requirements to conduct an Equality Assessment on change proposals will be incorporated into the standard work for Programme Boards.

5. RISKS:

5.1 There is a risk that the suggested arrangements will:

- Increase organisational complexity without improving our implementation of change. This is mitigated by the proposal to adapt the national best practice standard methodology and to train key people in it;
- Reduce Trust Board and EMT grip over change. This is mitigated by clear rules and tolerances about the respective roles of Trust Board, EMT and Programme Boards and the addition of regular periodic reporting of progress and risks to EMT and Trust Board.

6. CONCLUSIONS:

6.1 Adopting the Managing Successful Programmes methodology and adapting this to TEWV will help us to respond to the increasing complexity of the strategic priorities identified by the organisation and also to ensure we are robustly embedding change and realising benefits from that change**.**

6.2 These proposals set out specific roles for Trust Board, EMT and Programme Boards in the governance of programmes.

6.3 In producing this paper it is recognised that we are at the early stages of developing this approach and we are not experts in the implementation of Programme Management. As such EMT is accessing external expertise to review the proposed arrangements with a specific focus on:

- Whether the proposed arrangements outlined in the paper will be sufficient and how can they be improved

- Options on how we can ensure true alignment between the key strategic programmes so that we maximise the benefits delivered, make effective use of programme resources and don't suffer any 'unintended consequences' as a result of actions taken by any of the programmes.

There may be further changes to the Programme Management framework as a consequence of this and of its implementation.

7. RECOMMENDATIONS:

7.1 It is recommended that the Board of Directors endorse the interim programme management framework proposals, including the governance arrangements set out in detail in Appendix 1.

:

Author, Chris Lanigan
Title: Head of Planning and Business Development

Background Papers: none

Appendix 1: TEWV Portfolio, Programme and Project Governance powers, assurance and influence.

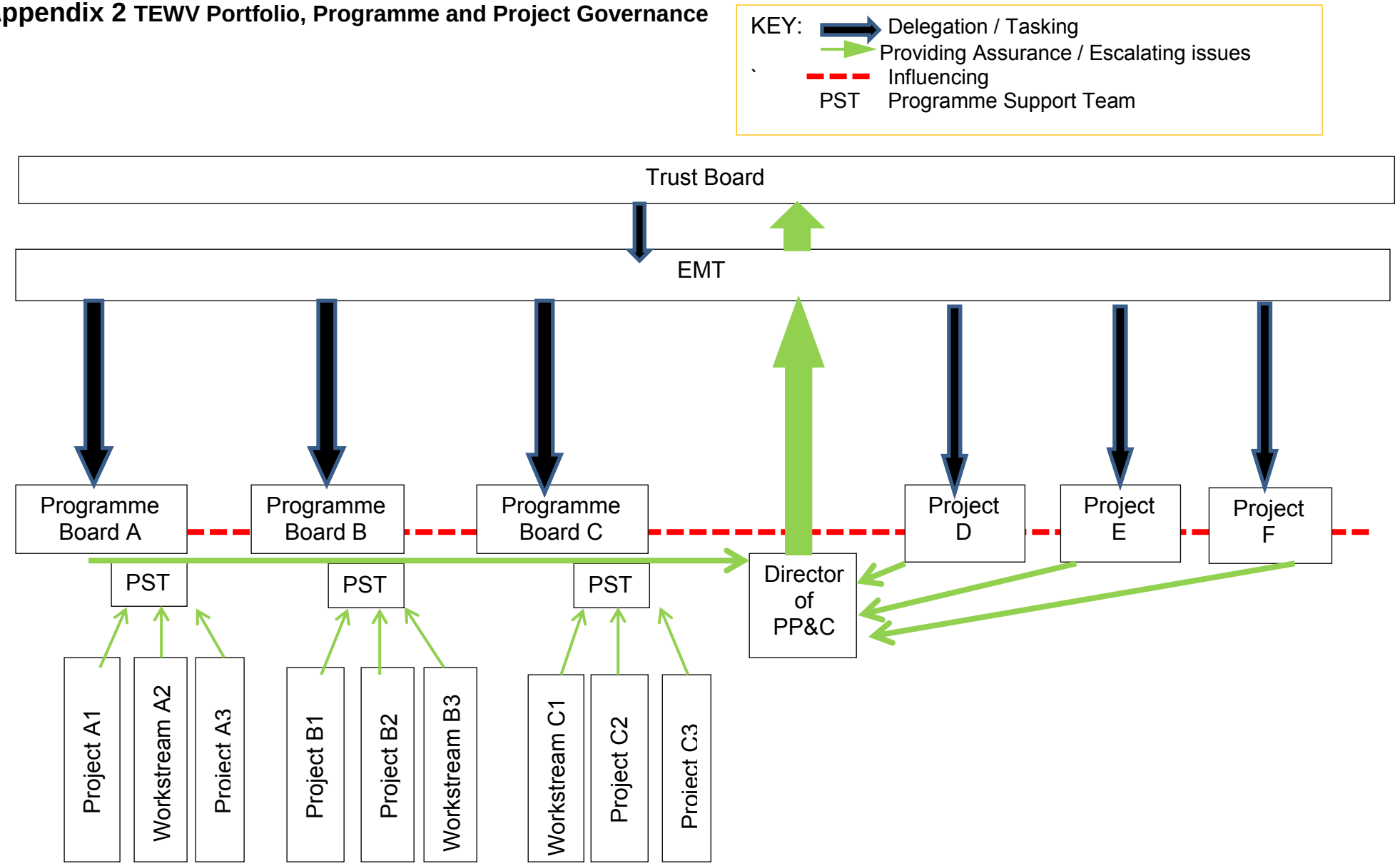
	Powers	Assurance	Influence
Trust Board	Agrees Business Plan priorities – and in year changes to these which go beyond agreed tolerance levels[1] Agree the vision documents for each Programme that relate to a Business Plan priority (or any programme which is outwith the delegated limits of EMT) Agrees spending commitments in line with scheme of delegation Agrees Programme Business Case	Receives regular (quarterly) reports on progress against Business Plan actions (on track) but also twice-yearly report on whether key programme benefits on track	Executive Board members will be members of programme boards and / or sponsors of programmes or Trust Business Plan projects
EMT	Agrees which Business Plan priorities will be programmes and which will be projects Appoints sponsors for each programme and for any Trust Board priority related projects Approve Programme Board members Agree Programme Vision or Strategy for recommendation to the Trust Board Agree Programme Business Case for recommendation to the Trust Board Discuss and agree what actions to take when issues are escalated by a Programme Board or the Director of PP&C (whether in regular update reports or via urgent / specific reports) Agree changes to the Portfolio, Programme or Project Management frameworks. Agree spending commitments in line with Scheme of Delegation	Receives weekly "by exception" update from each Programme sponsor and takes any urgent decisions resulting from this Receives monthly update from each Programme and each Business Plan project in form of "overall RAG" and key issues / benefits realisation summary Can receive more detailed position statements from any Programme or Project at any time by request	All sponsors of Business Plan programmes / Trust Business Plan projects will be EMT members A range of EMT members will sit on each Programme Board DoOs can make connections between Locality-level work and Trust-wide programmes Trust Priorities that have a Locality focus may put in place a Locality-focussed Programme Board (e.g. York service and estate redesign; Northerllerton reconfiguration) which will help DoOs to align and hold to account corporate services.

[1] Please see "current and proposed future tolerance levels" (appendix 3)

	Powers	Assurance	Influence
Prog-ramme Sponsor	A key *responsibility* for programme sponsors is to ensure the benefits are realised. This requires a wide sphere of influence both within and outside the organisation. The Sponsor must also act as a leader / coach for his/her programme support team and Programme Board.	The Programme Sponsor needs to ensure that the programme's own governance processes are working well and that accurate info / RAG position is being reported upwards to EMT.	The programme sponsor can use his / her wide circle of influence to remove barriers to programme success which lie elsewhere within or outside the Trust.
Prog-ramme Boards	Programme Boards will directly govern projects and workstreams which are "core" to realising their benefits. For these projects, the Programme Board has the powers to: • Approve scope, business case, change-requests, and close-downs The Programme Board must report its overall RAG (taking account of benefits realisation as well as milestone progress) to EMT via the Director of PP&C and escalate any issues which are beyond the powers and influence of the Programme Board to address.	Programme Boards will receive regular updates on • Achievement of milestones • Benefits realisation The Director of PP&C will collate this information They can also require updates from related programmes and projects	Programme Boards will seek to influence the work of other programmes, projects and BAU which it not directly governed. This can be by asking to be consulted, or through asking for a report. This will be facilitated by those programme board members who also sit on other relevant boards, and by the Director of PP&C and her team.
Prog-ramme Support Teams	A Programme Support Team has the power to gather the information required for the Programme Board to exercise its assurance and escalation role. The Programme Support Team has the power to challenge and alter information and the interpretation of this information which is given to it prior to reporting to the Programme Board.	The Programme Support Team should seek assurance that the information being fed to it from projects and workstreams is robust (i.e. that appropriate systems are in place and being used). It should also triangulate using its own intelligence / other data sources.	The Programme Support Team can influence vertically through its relationship with the Sponsor and horizontally through the Planning and Business Development Team which will link up intelligence about other programmes / projects and spread good practice

	Powers	Assurance	Influence
Business Plan projects (not within programmes)	Stand-alone projects report directly to EMT. Scope, business case, change-requests, close-downs and post-project evaluations will therefore be reported to / approved by EMT.	The project sponsor is responsible for signing off RAG reports (PM2s) and other project docs prior to EMT.	Project sponsor and project manager can make links with other relevant change work / BAU.
Director of Planning, Performance and Communications (DoPP&C)	The DoPP&C can challenge the information / RAG ratings received from Programme Boards / Project sponsors where this does not match wider intelligence. The DoPP&C also has the responsibility to keep Portfolio, Programme, Programme Management and Project Management arrangements under review and to suggest improvements to EMT	The DoPP&C provides reports to EMT / Board on the achievement of the Business Plan milestones and benefits realisation (whether being delivered by programmes, projects or other methods). She should also bring to EMT's attention any failings / weakness in programme or project governance which emerge over time.	The DoPP&C has an important role in facilitating intelligence exchange between different programmes, projects and LMGBs. Her staff will build relationships which help them to facilitate information exchange, problem solving and good-practice sharing and to challenge proposals / actions which seem to go against the Trust's strategic goals or values.
LMGBs / Corporate SMTs	LMGBs / SMTs directly govern "Local Plan" priorities (as well as their role in managing Business as Usual)	LMGBs / SMTs should develop their own assurance processes for Local Plan priorities.	LMGB members (inc. corporate staff) can use their circles of influence to tackle barriers.

Appendix 2 TEWV Portfolio, Programme and Project Governance



Appendix 3: Proposed tolerance levels

	Current	Future
Programmes	**NA**	Tolerances should be agreed in each Programme Governance document agreed by EMT. However, where this does not take place, the default position is: <u>Time:</u> The date for delivery of key benefits can be delayed by up to 3 months by the Programme Board (EMT can grant up to 11 months, Trust Board for longer than this). Where key deliverables have been set out in the Trust's Business Plan, the Programme Board can only agree to delay these within the financial year that they were scheduled for delivery <u>Resource:</u> Additional resource can be vired into a project from a budget held by the sponsor (or by another EMT member who agrees to this) within the delegation limits set out in Standing Financial Orders. Alternatively additional non-recurrent resource can be added to either a) a cost centre for which the project sponsor is a budget holder or b) a cost centre where the project manager is the budget holder on the agreement of EMT, subsequent to a submission to EMT of a programme scope, blueprint or change form. <u>Benefits</u> Changes to benefits to be realised by the programme cannot be agreed by its Programme Board.

Projects which are not part of programmes but which deliver a Trust Business Plan priority	Milestones can be moved backwards as long as the closure date for the last action in the priority does not move into a later financial year. Additional resource can be vired into a project from a budget held by the sponsor (or by another EMT member who agrees to this) within the delegation limits set out in Standing Financial Orders	No change Add “or, alternatively additional non-recurrent resource can be added to either a) a cost centre for which the project sponsor is a budget holder or b) a cost centre where the project manager is the budget holder on the agreement of EMT, subsequent to a submission to EMT of a PM1(scope), PM2a (change request) or PM3 (business case) form Changes to benefits to be realised cannot be made by the Project Sponsor, Project Manager or steering group – they can only be made by EMT (or another governance group which EMT has delegated this role to)
Projects / workstreams reporting to a Programme Board	**N/A**	Programme Boards can agree their own tolerance level for all (or each) project that reports directly to the Programme Board, however these cannot exceed those set out in the Programmes row above

ITEM 15

BOARD OF DIRECTORS

DATE:	**28TH March 2017**
TITLE:	**Reporting of Strategies**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance and Communications**
REPORT FOR:	**Discussion 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 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:

As part of its recent establishment the Resources Committee considered a paper which outlined the strategies which were felt to be particularly relevant to the Committee and set out proposals on the frequency of reporting progress to the Committee. In order that a total context was provided the paper also highlighted a range of other current strategies and proposed reporting routes. The Resources Committee discussed the proposals and made a recommendation that a paper outlining the total strategy portfolio and reporting mechanisms should be considered and approved by the Board.

Recommendations:

The Resources Committee recommends that the Board of Directors:

- Discuss the contents of this paper
- Agree to the proposed routes for reporting progress against the individual strategies.
- Agree a timescales within which all the strategies listed in Section 2.1 and their associated scorecards will be in place.

MEETING OF:	**Board of Directors**
DATE:	**28th March 2017**
TITLE:	**Reporting of Strategies**

1. INTRODUCTION & PURPOSE:

1.1 This report presents to the Board of Directors a proposal for how progress against relevant Strategies will be reported.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 At the first meeting of the Resources Committee a paper was considered which set out a proposal in terms of which strategies are aligned to the business of the Resources Committee and how progress against those strategies will be reported to the Committee. In considering the paper the full portfolio of strategies was presented and the Resources Committee agreed that the Board should consider a similar paper to approve the reporting requirements for the full portfolio of strategies.

3. KEY ISSUES:

3.1 The Trust has a Strategic Direction that is articulated via our mission, vision and five Strategic Goals. The Strategic Goals are set out below:

Strategic Goal 1: To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing
Strategic Goal 2: To continuously improve the quality and value of our work
Strategic Goals 3: To recruit, develop and retain a skilled, compassionate and motivated workforce
Strategic Goal 4: To have effective partnerships with local, national and international organisations for the benefit of the communities we serve
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.

3.2 Delivery of the Strategic Direction is underpinned by a set of Strategies that have been developed across the organisation. Appendix 1 provides a list of the current strategies that either exist or are in development. It should be noted that a number of these strategies could better be described as plans however they are called strategies because there is an external requirement to have a strategy!

The following table identifies the Strategic Goal that the individual strategies underpin however it is clear that some are more directly relevant/critical to the delivery of the Strategic Goal than others. The table below proposes which are these key/primary strategies that relate to the Strategic Goals and where the progress of each strategy should be reported to.

Strategic Goal	Relevant Strategies	Progress Reported to:
1	**Recovery and Well being**	Board of Directors
2	**Quality** Research and Development	QuAC QuAC
3	**Workforce** Library Nursing	Resources Committee Medical Education Quality and Assurance Committee EMT (by exception)
4	No particular strategies but number of plans eg Stakeholder Engagement Plan	
5	Data Quality **Equality** **Finance** **Information** **Leadership and Development** Records Lifecycle Management	EMT(by exception via Data Quality Group) Board of Directors (via E&D Group) Resources Committee Resources Committee EMT(via Workforce and Development Group) EMT (via Information Strategy Governance Group)

Note: **Bold text** represents key/primary strategies for each Strategic Goal

3.3 Whilst not all Strategy Scorecards will be reported to the Board directly issues can be escalated to the Board via the quarterly Strategic Direction Performance Report, by the relevant report of any sub- committee to the Board or by a standalone report to the Board as appropriate.

3.4 The delivery of the Strategic Direction is currently monitored quarterly via the Board of Directors via a report that provides performance against a set of KPIs, progress against the milestones within the Business Plan and other qualitative data that refers to the quarter in question.

In terms of monitoring progress against the individual strategies each strategy should contain a Scorecard which shows the key metrics that will be used to monitor the progress made against the objectives within the strategy. These scorecards should then be reported to the various Committees/groups as set out in the table above. At present not all the above strategies have an agreed scorecard and this will need to be addressed if the Board is to have assurance that appropriate progress in implementing the relevant strategy is being made. The Resources Committee agreed that for those that are aligned to it the Strategies and scorecards will be finalised by June 2017. The Board need to consider what is a reasonable timescales for other strategies and their scorecards where these are not already in place. Once this is agreed a schedule of reporting can be put in place.

Once this system is in place and embedded (for all Strategies) it will be necessary to review the current quarterly progress report on the Strategic Direction that goes to Board and agree any relevant changes.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
There are no direct implications with regard to CQC Fundamental Standards but having clear oversight and assurance of implementation of our strategies as part of driving forward the Strategic Direction will contribute to our overall governance arrangements.

4.2 **Financial/Value for Money:**
There are no direct financial/value for money implications although the oversight of the delivery Financial Strategy via the resources committee is key.

4.3 **Legal and Constitutional (including the NHS Constitution):**
There are no direct legal and constitutional implications of the paper.

4.4 **Equality and Diversity:**
There are no direct legal and constitutional implications of this paper however it should be noted that the paper proposes that the Board should monitor progress of the Equality Strategy.

5. RISKS:

The main risk to the model proposed in this paper is that not all strategies are currently in place and of those that are not all have an agreed scorecard through which progress can be monitored. It is proposed that the Board agree a reasonable timescale within which this is addressed.

6. CONCLUSIONS:

6.1 The creation of the Resources Committee has highlighted that the organisation needs to be clear on what its key/primary strategies are and how progress against these will be monitored. This paper sets out some proposal on this for consideration.

7. RECOMMENDATIONS:

The Resources Committee is asked to discuss this paper and agree the following:

- That the key strategies that it will monitor progress against are the Workforce, Finance and Information Strategies.
- To task the Director of HR&OD and the Director of Finance & information to ensure there is an agreed Strategy and Scorecard for each of these in place by end June. The scorecard should include baseline data and trajectories for improvement over the lifetime of the strategy.

- To receive quarterly progress reports for each of the three strategies which includes performance against the scorecard metrics and any additional qualitative data that is pertinent. These will be presented to the resources Committee in the second month of each quarter.
- Whether a similar paper to this should be presented to the Board of Directors to ensure there is Board agreement on the model proposed for the other key/primary strategies such that it is standard across all strategies.

Sharon Pickering
Director of Planning, Performance and Communications

Background Documents

Appendix 1

List of current strategies and those in development

Strategy	Comment
Data Quality Strategy	Scorecard reported to Data Quality Group
Equality Strategy	Scorecard is currently in development
Food and Drink	We had planned to include this in the EFM Framework however may need to be a standalone Strategy following visit of CQC
Finance	In development
Health and Wellbeing	Currently considering including within the overall Workforce Strategy – will be bespoke H&WB plan within the Workforce strategy
Information	No scorecard available
Leadership and Development	Currently being redrafted
Library	Required as part of National Library Standards. In development
Nursing	Currently being redrafted
Quality	Revised strategy approved Dec 2016. New scorecard being finalised. Existing scorecard being reported to QuAC
Records Lifecycle Management	
Recovery and Well being	Scorecard in development. Will be presented to Board in March 2017
Research and Development	
Volunteering	Currently considering including within the overall Workforce Strategy – will be a bespoke Volunteering Plan within the Workforce Strategy
Workforce	Performance currently reported quarterly to the Board

ITEM NO 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th March 2017**
TITLE:	**To approve the Information Governance Toolkit submission for 2016/17.**
REPORT OF:	**Drew Kendall, Director of Finance and Information**
REPORT FOR:	**Decision**

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

Executive Summary:

The report identifies the IG Toolkit scores as predicted for the 31st March 2017.

	Version13 2015-2016	Version 14 Predicted
Information Governance Management	**100**	**100**
Confidentiality and Data Protection Assurance	**85**	**81**
Information Security Assurance	**91**	**91**
Clinical Information Assurance	**93**	**93**
Secondary Use Assurance	**87**	**70**
Corporate Information Assurance	**77**	**77**
Total	**89**	**85**

The Toolkit has been completed and achieved an overall score of 85% which is 4% less than last year's submission of 89%. The score has dropped mainly because of the changes made to the evidence required in the 500 sequences (Secondary Use Assurance), however the Trust Level 2 score remains unchanged.

Recommendations:

The Board of Directors is asked to note the contents of this report and approve the IG Toolkit submission for 2016/17.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**28th March 2017**
TITLE:	**To approve the Information Governance Toolkit submission for 2016/17.**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide the Board of Directors with assurance of the Trust's compliance across all sequences with the IG Toolkit. All sequences have to reach level 2 of the Toolkit and this has been achieved.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 It is a requirement for all NHS Trusts that adequate information governance is in place to ensure clinical and corporate business functions are compliant with both national legislation (Data Protection Act 1998) and the resulting government directives. The Trust's overall compliance in this area is monitored annually through the Information Governance Toolkit (IGT) assessment submitted through NHS Digital.

3. KEY ISSUES:

3.1 Information Governance (IG)

The final out turn for the 2016/17 version 14 Toolkit will be as follows:

	Version13 2015-2016	Version 14 Predicted
Information Governance Management	**100**	**100**
Confidentiality and Data Protection Assurance	**85**	**81**
Information Security Assurance	**91**	**91**
Clinical Information Assurance	**93**	**93**
Secondary Use Assurance	**87**	**70**
Corporate Information Assurance	**77**	**77**
Total	**89**	**85**

The Information Strategy and Governance Group (ISGG) approved all supporting evidence on the 15th March for final upload ahead of the submission 31st March 2017.

3.2 Senior Information Risk Owner – Risk Management Report 2016/17

The annual report to the SIRO outlining the risk profile for information assets has been completed and is currently indicating an overall amber rating.

The main areas of concern remain the lack of engagement with the risk management systems and the number of incidents that are being raised due to disclosures made in error. Mitigating actions are being considered by ISGG in the coming months as part of the forward plan for 2017/18 to be shared with ISGG in May 2017.

There have been four level 2 incidents reported to the Information Governance incident reporting tool up to 10 March and all have been closed. Three of the four events occurred due to break glass incidents.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Completion of the Toolkit to an acceptable standard is monitored as part of the CQC evidence when an inspection takes place. In this way they are assured that the Trust has the correct governance and assurance processes in place to demonstrate adherence to the Data Protection Act 1998.

4.2 Financial/Value for Money:

There are no direct financial implications from this report. There are significant financial risks if information security breaches occur or information systems fail, impacting on the regulation and business of the Trust. The risk is also reputational and could affect the Trust's licence to practice depending upon the scale of a breach.

4.3 Legal and Constitutional (including the NHS Constitution):

There are no imminent changes in regulation either legal or constitutional that the Directors should be aware of at this time. The new DPA regulations will be expected to be introduced during 2018. However, there are no radically new systems to be put in place; rather that we will be changing from having the option to carry out some tasks e.g. privacy impact assessments to being required to complete as part of the legislation.

4.4 Equality and Diversity:

There have been no equality and diversity issues raised as part of the reporting of the IG Toolkit.

4.5 Other implications:

None identified

5. RISKS:

The upcoming changes to the Data Protection Act 1998 will mean that the asset registers and data flows that are embedded in these registers will become an essential component of Trust compliance evidence.

6. CONCLUSIONS:

6.1 The Toolkit has been completed and achieved an overall score of 85% which is 4% less than last year's submission of 89%. The score has dropped mainly because of the changes made to the evidence required in the 500 sequences (Secondary Use Assurance), however the Trust Level 2 score remains unchanged.

7. RECOMMENDATIONS:

7.1 The Board of Directors are asked to note the content of this report and approve the IG toolkit submission for 2016/17.

Author: Drew Kendall
Title Director of Finance and Information

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th March 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 March 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
289	28.2.17	Underlease relating to Coatham Road Health Centre, Coatham Road, Redcar	Colin Martin, Chief Executive Phil Bellas, Trust Secretary
290	28.2.17	Extension to standstill agreement relating to the Roseberry Park PFI contract	Colin Martin, Chief Executive Brent Kilmurray, Chief Operating Officer
291	9.3.17	Deed of release of an overage deed relating to land at the former County Hospital, North Road, Durham	Colin Martin, Chief Executive Drew Kendall, Interim Director of Finance and Information
292	15.3.17	Escrow deed in relation to the Beckwith Knowle site, Harrogate	Brent Kilmurray, Chief Operating Officer Drew Kendall, Interim Director of Finance and Information

4. IMPLICATIONS:

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

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

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

4.4 **Equality and Diversity:** None identified.

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

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

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution (October 2015)
Seals Register

ITEM NO. 18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29 March 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:

1 policy underwent full review and required ratification:

- **CLIN-0034-v4 Delayed Transfers of Care in the Non-Acute and Mental Health Sectors Protocol**

2 policies underwent full review but required no changes. The review date was therefore extended 3 years.

- **IT-0020-v5 IT & Telephony Procurement, Re-assignment and Disposal Policy**
- **IT-0014-v5 NHS Number policy**

1 strategy requiring an extension to the review date:

- **STRAT-0001-v5(1) Records Lifecycle Management Strategy**

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meeting held on 1 March 2017

DATE:	**29 March 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 has undergone full review and required ratification:

CLIN-0034-v4 Delayed Transfers of Care in the Non-Acute and Mental Health Sectors Protocol
Review date: 01 March 2020

This protocol has undergone full review and updated to meet the requirements of the Mental Health Act 1983: Code of Practice.

3.2 The following have undergone full review but required no changes. The review date is therefore to be extended 3 years.

IT-0020-v5 IT & Telephony Procurement, Re-assignment and Disposal Policy
Review date 1 March 2020

IT-0014-v5 NHS Number policy
Review date 1 March 2020

3.3 The following require an extension to the review date:

STRAT-0001-v5(1) Records Lifecycle Management Strategy
Review date 1 September 2017

This strategy will be reviewed following the implementation of organisational change within Information Department.

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 1 March 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