AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 24TH MAY 2016
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 **26th April 2016**.		**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 consider the report of the Quality Assurance Committee.	**HG/JI**	**Attached**
Item 7	To consider the monthly Nurse Staffing Report.	**JI**	**Attached**
Item 8	To consider the report of the Mental Health Legislation Committee.	**RS/JI**	**Attached**
Item 9	To consider a progress report on the Waiting Times Action Plan.	**BK**	**To follow**
Item 10	To consider a report on the refresh of the Trust's Composite Staff Action Plan.	**DL**	**Attached**
Item 11	To consider a report on the appointment of the Freedom to Speak Up Guardian.	**DL**	**Attached**

Strategic Items (10.45 am)

Item 12	**NHS Foundation Trust Annual Report and Accounts 2015/16:**		
	(1) To approve the Annual Report,	**CM/DK**	**Previously**

	including the Quality Report, and Annual Accounts 2015/16.		**circulated**
	(2) To approve the Letter of Representation.		
	(3) To authorise the sign-off of: ▪ The Performance Report ▪ The Accountability Report ▪ The Statement on Quality ▪ The Statement on Directors' Responsibilities for Preparing the Quality Report ▪ The Annual Governance Statement ▪ The Remuneration Report ▪ The Statement on the Accounting Officer's Responsibilities ▪ The Statement of the Financial Position ▪ The Letter of Representation ▪ Any certificates relating to the above as required by NHS Improvement.		
	(4) To approve the submission of the Annual Report, including the Quality Report, and Annual Accounts, to NHS Improvement and Parliament.		
	(5) To authorise the submission of the Quality Account to the Department of Health.		
	(Notes: (1) The recommendations of the Audit Committee on the above matters will be reported verbally to the meeting.	**MH**	**Verbal**
	(2) The report of the Acting Director of Finance on the Annual Accounts is attached).	**DK**	**Attached**
Item 13	To approve the Annual Report and Accounts of the Charitable Trust Funds for 2015/16.	**DK**	**Previously circulated (Cover report attached)**
	(Note: The recommendations of the Audit Committee on the above matters will be	**MH**	**Verbal**

reported verbally at the meeting.)

(*Note: With regard to items (12) and (13) above Board Members are asked to note the documentation circulated with the agenda for the Audit Committee meeting to be held on 19th May 2016 including the draft External Auditors' Audit Completion Report, External Assurance Report on the Quality Report and the Summary of Findings of the Independent Review of the Charitable Funds prepared by Mazars LLP. Any additional information or updated documents received from the External Auditors will be tabled at the meeting).*

Performance (11.10 am)

Item 14	To consider the Finance Report as at 30th April 2016.	**DK**	**Attached**
Item 15	To consider the Trust Performance Dashboard as at 30th April 2016.	**SP**	**To follow**
Item 16	To consider the Strategic Direction Performance Report for Quarter 4, 2015/16.	**SP**	**To follow**

Governance (11.30 am)

Item 17	On the recommendation of the Audit Committee to sign-off the annual Board certificates and statements required by NHS Improvement. (Note: Board Members are asked to read this report in conjunction with the Audit Committee Report provided in the Confidential Agenda).	**PB**	**Attached**
Item 18	To receive and note the Information and Information Governance Strategy Update Report for Q3/Q4 2015/16 .	**DK**	**Attached**

Items for Information (11.50 am)

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

Item 21 To note that the next meeting of the Board of Directors will be held on Tuesday **21st June 2016** in the Board Room, West Park Hospital, Darlington at 9.30 am.

Confidential Motion (11.55 am)

Item 22 **The Chairman to move:**

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

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

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

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

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.

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
18th May 2016

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 26TH APRIL 2016 IN THE OLD SWAN HOTEL, SWAN ROAD, HARROGATE AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Director of Finance and Chief Executive Designate
Mr. J. Tucker, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Dr. H. Griffiths, Non-Executive Director
Mr. D. Jennings, Non-Executive Director
Mrs. B. Matthews, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mr. B. Kilmurray, Chief Operating Officer
Dr. N. Land, Medical Director
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
Mr. D. Kendall, Associate Director of Finance
Mrs. R. Hill, Director of Operations for York and Selby (minute 16/92)

16/86 APOLOGIES

Apologies for absence were received from Mr. M. Barkley, Chief Executive.

16/87 MINUTES

***Agreed** – that the public minutes of the meeting held on 22nd March 2016 be approved as a correct record and signed by the Chairman.*

16/88 PUBLIC BOARD ACTION LOG

Consideration was given to the Public Board Action Log noting the relevant reports provided to the meeting.

Arising from the report:

(1) Mr. Levy sought the Board's permission to amend the date for the presentation of the next report on the Trust's culture metrics (minute 15/346 – 15/12/15 refers) as he considered that it would be beneficial to include the information in a future Quarterly Workforce Report.

It was agreed that the information should be presented as part of the Workforce Report to the Board meeting to be held on 21st July 2016.

(2) It was noted that discussions on the arrangements for providing a briefing to a Board Seminar on the project on engaging with GPs and their teams as partners in care (minute 16/33 – 23/2/16 refers) were due to be held on 28th April 2016.

Mr. Bellas undertook to make the above changes to the Action Log.

Action: Mr. Bellas

16/89 DECLARATIONS OF INTEREST

Mrs. Pickering declared her interest in the report on the outcome of the consultation on the location and configuration of inpatient assessment and treatment beds for people with dementia in County Durham and Darlington (see minute 16/95 below) in view of her husband being a senior officer of the Durham Dales, Easington and Sedgefield CCG.

No matters were raised which placed any impediment on Mrs. Pickering's ability to participate in the discussions on the above matter.

16/90 CHAIRMAN'S REPORT

The Chairman reported that, since the last meeting, she had presented "Living the Values" Awards to:

(1) Dr Zoë Gilder, consultant child and adolescent psychiatrist, and Ruth Newton, child, adolescent mental health services community nurse and systemic practitioner, at Dover House, Hartlepool.

(2) Angela Barnett and Freda Cairns, housekeepers at West Park Hospital, Darlington.

It was noted that the presentation of the awards had also enabled Mrs. Bessant to visit and meet with staff at the facilities.

16/91 GOVERNOR ISSUES

No issues were raised.

16/92 LOCALITY BRIEFING – YORK AND SELBY

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

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

Arising from the presentation, Board Members raised the following issues:

(1) Staff morale in the Locality.

Mrs. Hill reported that, from her visits to services, the staff morale was, generally, high.

The Board noted that action taken by the Trust to address a number of long standing issues had contributed to this position; however, it was also recognised that some staff had concerns about the amount of change taking place within the Locality and from specific issues which would impact on their personal circumstances e.g. the introduction of a 12 hour shift system.

(2) The response of staff to the changes being made in the Locality.

It was noted that:

(a) In general, staff were positive about the changes being made in the Locality including the introduction of the Quality Improvement System and the implementation of the Purposeful and Productive Community Services Programme.

(b) When introducing changes the Trust had sought to fully engage with staff and this approach had been appreciated.

(3) The views of local residents on the future provision of mental health services at Bootham Park Hospital.

Mrs. Hill advised that, as shown in the contributions to the Healthwatch report "Bootham Park Hospital: What next for mental health in York?" (previously circulated to Board Members), there was a diverse range of opinions about the future use of the building for the provision of mental health services.

(4) The action being taken by the Locality to reduce waiting times.

It was noted that, although demand had increased, the key issue impacting on waiting times was the flow of patients through services and the Locality was redesigning ways of working to address this.

Mrs. Pickering advised that the greater transparency, and the ability to interrogate data, provided by the Integrated Information Centre would help the Trust gain further understanding of, and respond to, this issue.

(5) The availability of support to respond to the tenders for the provision of specialist services in the Locality which were due to be advertised later in the year.

The Board noted that staff within the Locality had the skills necessary to support the development of the tenders.

(6) Staff recruitment particularly to MHSOP wards.

It was noted that more work was required to understand staffing requirements taking into account future bed numbers, the introduction of a 12 hour shift system and changes to the ways of working and culture of services.

(7) The reasons for the high levels of "Out of Locality" admissions.

Mrs. Hill reported that there was a relatively low threshold of acuity for admitting patients "Out of the Locality" or to The Retreat in York.

To address this:

(a) A culture was being promoted that if a patient was from York they should receive care and treatment in the Locality.

(b) All those patients admitted to The Retreat had been assessed. The outcome of this was that many were not eligible for continuing healthcare

funding and discussions were being held with the Commissioning Support Unit on this matter. However, in doing so, the Trust was mindful of the need to avoid any perceptions that it was seeking to transfer costs.

In addition, at the request of the Chairman, Mrs. Hill provided an update on the discussions on the closure of Bootham Park Hospital in September 2015 at the meeting of the Adult Social Care Policy and Scrutiny Committee of the City of York Council held on 25th April 2016.

The Board noted that few questions and no criticisms had been directed towards the Trust at the meeting.

At the conclusion of the discussions, the Chairman thanked Mrs. Hill for her briefing and asked her to pass on the Board's appreciation to the staff in her Locality for their work.

16/93 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 3rd March 2016 (Appendix 1 to the report).
(2) The key issues discussed by the Committee at its meeting held on 7th April 2016.

Dr. Griffiths, the Chairman of the Committee, reported that, at the request of the Board (minute 15/324 – 24/11/15 refers) the Committee had considered an analysis of performance on three Trust Dashboard indicators (i.e. percentage of people readmitted to Assessment and Treatment Wards within 30 days; the number of instances where a patient had 3 or more admissions in the past year; and the median number of days from a patient being discharged to their next admission) in order to identify whether there were any clinical concerns.

The Board noted that:

(1) The Committee had considered that the use of rolling averages would improve understanding of performance against the indicators.
(2) The report had highlighted that the number of people with a diagnosis of Borderline Personality Disorder, for whom repeated short-term admissions might represent appropriate care, had had a significant impact on performance against the indicators. The Committee, therefore, considered that changes were required to the targets to reflect this.

    Mrs Pickering advised that the AMH Specialty Development Group had commenced a review of the broader aspects of the care of patients with a Borderline Personality Disorder to understand if there were any differences in approach across the Localities or whether differences could be due to natural variation, and the outcome of this work would need to be taken into account in discussions on future targets.

Mrs. Pickering also advised that the SDG's review of the data had not highlighted any concerns about clinical care.

In addition, at the request of Board Members, Mrs. Moody provided an update on the event hosted by the Trust and Mazars LLP for North East, North Yorkshire and Humber provider trusts which had focused on seeking a consistent approach to the implementation of the recommendations arising from the firm's "Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust."

Mrs. Moody offered to circulate a paper on the matters discussed at the event to Board Members.

Action Mrs. Moody

The Board noted that:

(1) The event, which had included presentations from the two authors of the report and the CQC, had gone very well.

(2) The CQC had provided an update on its approach to undertaking its thematic review of how NHS Trusts investigate and learn from deaths.

Mrs. Moody advised that the CQC recognised that further work was required on defining the categories of unexpected deaths and would be focussing its thematic review on seeking to identify best practice.

(3) Following discussions with the Chief Executives' Group for Yorkshire and the Humber, it had been agreed to facilitate a further workshop to seek to develop a consistent approach to the investigation and reporting of unexpected deaths across the Region. The outcome of this work would be reported, in due course, to the Chief Executives' Group.

With regard to the report:

(1) In response to a question from the Non-Executive Directors, Mrs Moody advised that the CQC had not expressed a view on the Trust's position on the reporting of unexpected deaths; however, Mazars LLP had considered the Trust's processes in compiling its report.

(2) The Chairman suggested that it might be worthwhile to work with local universities on developing the regional approach to investigating and reporting unexpected deaths.

Mrs. Moody undertook to consider this matter; however, she advised that the Trust had been asked to participate in a number of reviews linked to the Mazars' report and needed to be mindful of capacity issues.

Action: Mrs. Moody

16/94 NURSE STAFFING REPORT

The Board received and noted the report on nurse staffing for March 2016 as required to meet the commitments of "Hard Truths", the Government's response to the Public Inquiry into Mid Staffordshire NHS Foundation Trust (the "Francis Review").

Mrs. Moody highlighted the following matters contained in the report:

(1) The information on nurse staffing for the York and Selby Locality (Appendix 8 to the report) which was provided separately from the remainder of the Trust.

(2) For the other Localities:

(a) The continued decline on the month on month trend for the registered nurse fill rate for days. The fill rate, at 85.9% for the month, was below the target of 89.9% and a marked reduction on the position in March 2015 of 91.99%.

(b) The fill rated for registered nurses at night which was reporting "green"; an improvement on the previous "red" rated position.

(c) The increase in the number of "red" rated wards in March 2016 from 50 to 55. North Yorkshire had the lowest and Forensic Services the highest number of red "rated" wards.

(d) Westerdale South Ward continued to have the highest fill rate. The reasons for this had been investigated and a report had been provided to the Board at its meeting held on 15th December 2015 (minute 15/344 refers).

(e) Primrose Lodge had reported the third lowest fill rate for the month. This was due to vacancies being maintained to support the redeployment of staff from Earlston House.

(3) The data on missed breaks.

Mrs. Moody advised that there had been a significant variation between data on missed breaks reported through the HealthRoster and that collected manually in the Tees Locality and work was being undertaken to seek to understand the reasons for this.

(4) The report on the desktop review of safe staffing tools in the County Durham and Darlington Locality, provided in accordance with minute 16/07 (26/1/16).

It was noted that:

(a) The safer staffing tools had been removed from the NHS England website and it was expected that updated versions would be available later in the year.

(b) Following the desk top review it had been agreed to conduct a trial of the Hurst and the professional judgement (Telford) approaches to safe staffing in three wards at West Park Hospital over a three day period. The outcome of this work would be used to inform the staffing and skill mix workstream of the Safe Staffing Project.

(c) A further report on this matter would be provided to the Board in due course.

Action: Mrs. Moody

(5) The workstreams and objectives for the Safe Staffing Project (as set out in Appendix 9 to the report) which was presented in accordance with minute 16/07 (26/1/16).

Mrs. Moody reported that the terms of reference of the Safer Staffing Steering Group had been agreed and the first of its monthly meetings had been held on 19th April 2016.

The Chairman asked for a report to be provided to the Board at its meeting to be held on either 25th October or 29th November 2016 on the impact and lessons learnt from the project.

Action: Mrs. Moody

Arising from the report:

(1) Board Members raised concerns about the reasons provided for the use of bank staff as "annual leave" and "unknown" in the table in section 3.2 of the report

It was noted that:

(a) The use of "unknown" reflected that the ward had not provided a reason for its use of bank staff.

Board Members considered that this was unacceptable.

(b) Further understanding of the use of bank staff to cover annual leave was required as, although this approach should be avoided, there were instances where staff had difficulty in level loading leave across a year e.g. due to the high levels of acuity of patients on their ward.

(2) The Non-Executive Directors sought clarity on the reasons for the deterioration on the daytime fill rate for registered nurses and whether this raised concerns.

Mrs. Moody responded that a number of contributory factors had been identified e.g. rostering, the skill mix on certain wards, sickness absence and problems with recruitment to organic wards; however, the picture was complicated and there were no consistent reasons for the deterioration. Further understanding of the issues would, therefore, be sought through the workstreams of the Safer Staffing Project.

(3) It was suggested that it might beneficial to report the data on missed breaks as absolute numbers and as percentages of all shifts to aid understanding.

Mrs. Moody:

(a) Undertook to look into the feasibility of the suggestion.

Action: Mrs. Moody

(b) Observed that there was no obvious correlation between staffing levels and missed breaks.

(c) Advised that, from the manual data collection undertaken in the Tees Locality, further understanding of the reasons for missed breaks was required.

(4) Mrs. Pickering considered that a contributory factor to wards having low fill rates was that vacancies were held when it was known that staff numbers were going to be reduced as a result of service changes (e.g. Picktree Ward) and asked whether the Safer Staffing Steering Group could look into whether there were actions which could be taken to ameliorate this.

Mr. Kilmurray responded that further thought needed to be given to this matter.

Action: Mr. Kilmurray

16/95 CONSULATION ON THE LOCATION AND CONFIGUARATION OF INPATIENT ASSESSMENT AND TREATMENT BEDS FOR PEOPLE WITH DEMENTIA IN COUNTY DURHAM AND DARLINGTON

Further to minute 15/C/268 (29/9/15) consideration was given to the report on the feedback received from the public consultation on the future location and configuration of assessment and treatment beds for people with dementia in County Durham and Darlington. This included a paper (Annex 1 to the covering report) which provided detailed information on the consultation process, feedback received and issues raised by local people and staff, together with responses to the main issues.

The Board noted that:

(1) The consultation had been based on three options for the future delivery of the services:
   (a) Option 1 – The provision of 30 beds in two 15 bed wards (a male and female ward) at Auckland Park Hospital, Bishop Auckland (and the closure of Picktree Ward at Bowes Lyon Unit, Lanchester Road Hospital, Durham).
   (b) Option 2 – The provision of separate male and female wards on separate sites – one ward at Auckland Park Hospital, Bishop Auckland and one ward at Bowes Lyon Unit, Lanchester Road Hospital, Durham (and the closure of one of the wards at Bishop Auckland).
   (c) Option 3 – The provision of a mixed sex ward at Bowes Lyon Unit, Lanchester Road Hospital, Durham and a mixed sex ward at Auckland Park Hospital, Bishop Auckland (and the closure one of the wards at Bishop Auckland).

(2) The final decision on which option would be implemented would be made by the governing bodies of the three CCGs covering the Locality but, prior to this, a report would be provided to the Local Authority Health Overview and Scrutiny Committees to provide assurance on the robustness of the consultation process.

Mr. Kilmurray advised that, in developing the options, the Trust had recognised the difficulties in achieving both privacy and dignity standards and reasonable access to services.

He reported that the outcome of the consultation had been fairly balanced between options 1 and 3 with 31 and 29 written responses being received in favour of each option, respectively. Option 2 was the least preferred option with only six responses received in its favour.

The Board noted that responses to the consultation had also highlighted a number of key issues including travel/access to the services (options 1 and 2); the provision of mixed sex accommodation (option 3); and the isolation of the ward at Bishop Auckland (options 2 and 3). Proposals to reduce the potential impact of these on services users, their families and carers were set out in the report.

Whilst, at face value, option 1 appeared to be the most appropriate option, as it had received a marginally more favourable response from the public consultation exercise; it was the preferred option of mental health professionals at the Trust; and it provided the greatest financial savings, the Board considered:

(1) Whether the concerns raised about the provision of mixed sex accommodation (in relation to option 3) were material in view of the approach being considered acceptable in discussions on the development of inpatient services elsewhere.

On this matter:

(a) Dr. Land advised that the Board needed to be cautious when comparing different types of services. He explained that mixed sex accommodation might be appropriate for functional services but it was, generally considered to be undesirable for organic services (e.g. dementia) due to the levels of disinhibition often exhibited by patients.

(b) It was noted that a recent data analysis had highlighted the additional staffing requirements of mixed sex wards compared to single sex wards. The Clinical Director for Mental Health Services for Older People (MHSOP) in the Locality had also raised concerns about the need for frequent 1:2:1 nursing on mixed sex wards and the potential detrimental impact of this on the provision of recovery focussed care.

(c) Mrs. Pickering reported that, during the consultation, feedback had been received from a small number of people, who had experienced both single and mixed sex accommodation, that they preferred the former approach.

(2) The issues raised during the consultation about potential difficulties in accessing services at Auckland Park Hospital.

It was noted that maintaining ease of access to services (particularly from areas in North Durham) and the difficulties which would be experienced by people in having to travel to Bishop Auckland had been cited in the responses to the consultation in favour of option 3.

The Non-Executive Directors also highlighted that the carers of patients using the services could be frail and dependant on public transport.

The Board recognised that:

(a) There would be potential difficulties in accessing services under option 1 but noted that locating both wards at Auckland Park Hospital had a number of benefits, namely that:

- It mitigated the clinical risks of having an isolated ward at Auckland Park Hospital without support from other wards for emergency and short term staffing.
- It was the most cost effective option.

Dr. Land advised that the differential level of savings between option 1 and option 3 was likely to be greater than that stated in the report (approximately £120,000 p.a.) due to the additional staffing levels required for mixed sex accommodation under the latter option.

(b) If option 1 was approved, it was imperative that action was taken to successfully implement mitigations to address the concerns about access to services.

The Board noted that:

- As part of the consultation the Trust had given a commitment that it would do all it could to support people accessing the services including:
  - Flexible visiting times.
  - Support with travel arrangements including developing a pool of volunteer drivers and using taxis if appropriate (support to be agreed on an individual basis).
  - Maintaining good communications with families (e.g. through the staff already provided on wards who work closely with families and also by investigating how we can use technology to help families keep in touch).
- The Trust also had a track record in successfully taking action to address difficulties with travel arrangements as a result of service changes, for example, through the provision of support for people from York when patients were transferred to Roseberry Park in Middlesbrough as a result of the closure of Bootham Park Hospital.

The Non-Executive Directors considered that, in view of the issues raised, it would be beneficial to provide further assurance on the mitigations to be taken by the Trust if option 1 was implemented.

In addition, the Board Members:

(1) Questioned the sustainability of locating the services at Auckland Park Hospital.

With regard to this matter it was noted that:

(a) Auckland Park Hospital was in a good condition.
(b) No issues had been raised about the suitability of providing the services at the Hospital either previously by local residents or during the consultation.
(c) Through maintaining services in Bishop Auckland the Trust would be acting as a good corporate citizen.

However, Mr. Kilmurray advised that there was a need to optimise the use of Lanchester Road Hospital, as a PFI funded and good quality facility, and the use of the estate would need to be reviewed in the medium to long term in response to the Transforming Care Agenda and other opportunities which might arise.

(2) Raised concerns about potential HR issues in the services, e.g. the use of fixed term contracts, as a result of the service changes.

Mr. Levy assured the Board that, barring exceptional circumstances, the Trust was committed to not employing nurses on fixed term contracts.

However, the Chairman highlighted that issues could arise for other staff groups who were equally important to the provision of patient care.

At the conclusion of the debate the Board considered that it would be helpful to make a recommendation on its preferred option to the CCGs to support their discussions and to provide them with a copy of the minute of its meeting to provide assurance that the feedback received from the consultation had been carefully examined.

It was, therefore:

Agreed -

(1) that the CCGs in County Durham and Darlington be recommended to approve option 1 for the future provision of inpatient assessment and treatment beds for people with dementia in the Locality i.e. 30 beds in two 15 bed wards (a male and female ward) at Auckland Park Hospital, Bishop Auckland (and the closure of Picktree Ward at Bowes Lyon Unit, Lanchester Road Hospital, Durham); and

(2) that information on the proposed actions to mitigate the key issues for each option raised during the consultation exercise, as set out in the report but recognising that further assurance might be required on the detailed arrangements for assisting with access/travel to services at Auckland Park Hospital, be provided to the CCGs to support their consideration of the consultation report.

Action: Mrs. Pickering

16/96 FRANCIS 2 ACTION PLANS

The Board received and noted a progress report on the implementation of actions arising from the Francis 2 Report as at April 2016.

It was noted that, in accordance with minute 15/319 (24/11/15), the report had been provided as a final "stock take" and included proposals for the further monitoring of the seven outstanding actions.

In response to questions Mr. Martin:

(1) Considered that, based on previous assignments, Audit North had the skills required for the review of the "Ward Manager Project".

(2) Confirmed that the proposed role of the Audit Committee was to track the review to be undertaken by Audit North and not the "Ward Manager Project" itself.

(3) Advised that the Trust had not been required to develop the action plans and they were not performance managed externally; however, many of the recommendations arising from the Francis 2 report had been embedded in regulations.

Mrs. Moody advised that, although the action "To review the ways in which lessons learned from complaints and SUI investigations are shared and learnt from" had been completed and safety bulletins were regularly issued (as stated in the report) this would be an ongoing objective that the Learning Lessons Project would seek to address and highlighted the importance of this, in line with the Business Plan priority, to implement the recommendations of the "Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust" undertaken by Mazars LLP.

Mr. Martin considered that it would be appropriate for the actions to be included with those for future monitoring set out in the report.

Agreed – *that the monitoring arrangements for the remaining actions in the Francis 2 Action Plans be as follows:*

Action	Monitoring mechanism
Learning lessons from complaints and serious incident investigations	Lessons Learned Project Project Completion Form – benefits realised
Community Discharge Letters	▪ Project Completion Form – benefit realised ▪ Audit
Roll out of new staff appraisal arrangements	Business Plan end of year progress report
Preventing deterioration of MH	Performance reports and annual "Service Resource and Analysis reports"
User and Carer Involvement	The Chief Executive's report to the Board
The "Ward Manager Project" is going to be the subject of an audit by Audit North	Audit to be tracked by Audit Committee
Community Team Leadership Model	Business Plan end of year Board progress report and completion of Project Report
Talent Management	The Trust's Talent Management Board

Action: Mr. Martin

16/97 SUMMARY FINANCE REPORT AS AT 31ST MARCH 2016

Consideration was given to the summary Finance Report as at 31st March 2016 including the declaration on the Financial Sustainability Risk Rating for Quarter 4, 2015/16 as required under NHS Improvement's Risk Assessment Framework.

Mr. Kendall reported that the Trust's end of year position was a deficit of £297k (representing 0.1% of turnover and behind plan); however, this was largely due to the impairment of Trust properties (£10.98m above plan). Excluding these impairments, the Trust's financial position was ahead of plan due to non recurrent surplus within projects and higher than planned contract income.

Arising from the report:

(1) Dr. Land highlighted that, excluding the impairments and additional income, the Trust's financial position for 2015/16 was marginally ahead of plan and this

demonstrated impressive performance in the context of the overall position of the NHS.

(2) The Non-Executive Directors highlighted the importance of ensuring external understanding of the reasons for the change from a forecast surplus, in year, to the year-end deficit position.

(3) In response to a question, Mr. Kendall advised that the Trust's year-end cash position was due to a number of factors including the in-year surplus and additional income received from CCGs linked to national priorities.

Agreed –

(1) that the report be received and noted; and

(2) that the following declaration for Quarter 4, 2015/16, be signed off and submitted to NHS Improvement:
"The Board anticipates that the Trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months."

Action: Mr. Martin

16/98 PERFORMANCE DASHBOARD AS AT 31ST MARCH 2016

The Board received and noted the Performance Dashboard Report as at 31st March 2016 including:

(1) The Trust Dashboard Report (Appendix A).
(2) The Dashboard Report for the York and Selby Locality (Appendix B).
(3) The Data Quality Scorecard (Appendix C).
(4) The report providing further details of unexpected deaths (Appendix D) including a breakdown of the data by Locality.
(5) The Monitor Scorecard (Appendix E)

Mrs. Pickering:

(1) Apologised for the late circulation of the report.
(2) Reported that performance against the indicator "Percentage compliance with statutory and mandatory training" (which was omitted from the report as originally published) was 87.45% as at 31st March 2016 and "red" rated; however, if the data from the York and Selby Locality was removed, performance improved to 91% ("amber" rated).
(3) Drew attention to the action being taken to address underperformance on the waiting time indicators (KPIs 1 and 2), highlighted in the report as a key risk with C&YP services being the highest concern, as follows:
    (a) In the Tees Locality, in addition to ongoing improvement work, staff had been transferred from the IAPT service (which had been closed to new referrals) to provide additional capacity in C&YP services. This had led to all referrals received in April 2016 being allocated a first appointment within four weeks; however, there remained some referrals, made previously, where waiting times exceeded the target.
    (b) In the County Durham and Darlington Locality, the implementation of an action plan to address waiting times was continuing. A key factor impacting on the position was the level of staff vacancies and sickness in C&YP services. Whilst there had been some improvement on these matters, and the number of people waiting had reduced from 924 to 749 between 22nd March 2016 and 19th April 2016, waiting times remained a significant challenge.

16/99 QUARTERLY WORKFORCE REPORT

The Board received and noted the Workforce Report for the period January to March 2016 including:

(1) Performance information about the whole Trust workforce (Appendix 1 to the report).
(2) Information about medical staffing issues and performance (Appendix 2 to the report).
(3) The results of the Trust's Staff Friends and Family Test (FFT) for Quarter 4, 2015/16 (Appendix 3 to the report).

In introducing the report Mr. Levy:

(1) Advised that the sickness absence rate, at 4.49%, was the lowest recorded since the establishment of the Trust and that it was encouraging that actions taken on this matter appeared to be having an impact.

The Non-Executive Directors congratulated the Executive Management Team on this achievement.

(2) Suggested that the focus of future reporting on workforce issues should be changed with a greater emphasis on the Trust's ability to recruit and retain staff; the most significant workforce risk to the Trust.

Board Members supported the proposed review of reporting arrangements but also asked that, in addition to recruitment, information should be provided in future reports on staff experience due to the potential risks arising from recently qualified staff leading shifts.

Mr. Levy took this on board and advised that his intention in undertaking the review was to provide workforce information which would contribute to the assurances available to the Board for other key areas e.g. safe staffing.

(3) Drew attention to the inclusion of the Friends and Family Test results for the York and Selby Locality, in Appendix 3 to the report, for the first time.

He advised that:

(a) The results for the Locality were, generally, about 10% worse than the Trust average.
(b) From the narrative information provided it was apparent that staff were being circumspect in their responses.
(c) The results provided a useful benchmark to track progress.

Arising from the report:

(1) The Board discussed the Trust's approach to apprenticeships.

Mr. Levy advised that:

(a) To date the Trust's approach had been cautious with interest being expressed mostly in relation to administrative and housekeeping apprenticeships.

(b) A consultation exercise had not shown a lot of support for the introduction of clinical apprenticeships partly as the Trust had the Healthcare Assistants' (HCA) Career Framework in place.
(c) A further review would be undertaken, taking into account the issue of access to funding from Health Education North East (HENE) and how the Trust could build on arrangements already in place.

It was also noted that:
(a) Mr. Kilmurray and Mrs. Moody had a meeting arranged during the week commencing 2nd May 2016 to consider this issue.
(b) The Tees Locality had mapped out a career framework and consideration was needed on how this could be supported.
(c) The apprenticeship levy was also an issue and consideration would be given to whether the HCA Framework could be used as part of the Trust's future approach to apprenticeships.

(2) Dr. Land drew attention to the medical staff profile in Appendix 2 to the report which showed that approximately 20% of consultant positions were not filled substantively.

He reported that:
(a) Work had been undertaken with Northumbria Healthcare NHS Foundation Trust (NHFT) on this issue but the ability to appoint consultants was being hampered by the lack of doctors, in the pipeline, to fill the positions.
(b) Further work would be undertaken over the next couple of months, including reviewing recruitment and retention initiatives in each Locality together with considering more imaginative approaches such as using other staff groups, where clinically appropriate, to reduce the demand for consultants.
(c) NHFT had recently recruited 20 doctors from India and this might also be an approach for the Trust to consider in the future.
(d) Overall there had been a steady deterioration in substantive consultant appointments, both locally and nationally.
(e) Although training schemes were not full, there appeared to be more applications for round 1 specialty training, at present, than for some time. Further clarity on the position would be available in the summer.

In response to a question, Dr. Land advised that the Trust was in a comparatively good position on consultant appointments, given its geographical location, with that of other areas (e.g. the Humber region) being far worse; however, despite significant work the trend remained downward and posed a risk in the future.

16/100 RISK ASSESSMENT FRAMEWORK REPORT

Further to minutes 16/97 and 16/98 above, consideration was given to the Risk Assessment Framework Report for Quarter 4, 2015/16.

Agreed –

(1) that the Quarter 4, 2015/16 Risk Assessment Framework submission be approved including:

(a) confirmation of the following governance statements:

- "*The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards."*
- *"The Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Risk Assessment Framework page 21 Diagram 6) which have not already been reported."*

(b) the declaration that no subsidiaries were consolidated in the financial information provided;

(c) the information required on Executive Team turnover, as included in the above report;

(d) the Election Report, as included in the above report;

(e) the exception report set out in Annex 2 to the above report; and

(2) that the Quarter 4, 2015/16 Risk Assessment Framework return be submitted to NHS Improvement by 29th April 2016.

Action: Mr. Kendall and Mr. Bellas

16/101 GOVERNANCE ACTION PLANS

The Board received and noted the progress report on the Governance action plans (Annex 1 to the covering report).

It was noted that, at its meeting held on 27th October 2015 (minute 15/293 refers), the Board has asked for the report to be last presented on this topic and that any remaining actions should be taken forward and reported in other ways. Proposals to do this were included in the report.

Mrs. Bessant highlighted the need for the Trust to become more adept at implementing action plans and mainstreaming developments to ensure that there was no loss of impact.

Agreed -

(1) that the proposed arrangements for tracking attainment of the outstanding actions be approved as follows:

Action	Monitoring mechanism
Increase service user involvement	Chief Executive's Report to the Board
Update Directorate Risk Registers	Quality Assurance Committee and Internal Audit
Regarding role and "standard work" of ward managers	Review by Audit North with a report to Audit Committee
Local Induction compliance	Workforce Report
Frequency and content of ward meetings	Review by Audit North with a report to Audit Committee
Training on SMART action planning	Arrangements to be considered by the EMT including whether this action remains relevant

(2) that the report be shared with the Trust's Relationship Manager at NHS Improvement.

Action: Mr. Martin

16/102 USE OF THE TRUST SEAL

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

16/103 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.

16/104 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 21st June 2016 in the Board Room, West Park Hospital Darlington.

16/105 CONFIDENTIAL MOTION

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

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

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

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

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

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.

Following the transaction of the confidential business the meeting concluded at 12.30 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

York & Selby Locality Board Presentation 26th April 2016

Ruth Hill

Director of Operations

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Issues
  - Bootham Park Hospital – ongoing business continuity - making Peppermill a reality
  - High profile/ service impact across AMH rehab & recovery/ MHSOP beds
  - Emerging issues around waiting times/ activity/ ways of working
  - Transforming Care
  - Future in Mind
- Exchange Events & Symposium
- Converge and Discovery Hub

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To continuously improve the quality and value of our work.

- QIS work
  - IAPT
  - Rehab & Recovery
  - PIPA for MHSOP
  - CAMHS
- Purposeful Productive Community Services
- Training & skills
- IT roll out to support / provide information (current gaps)

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Recruitment & Retention Issues
  - Nursing gaps
- Context of Management of Change
  - Rostering changes
  - Change of unit/ team
  - Leadership structure
  - Change Fatigue
- Public Relations issues
- Skills within Teams

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Local
  - Three Local Authorities
  - One CCGs
  - One Acute Trusts
  - Three HWBBs
  - VCS Input via "Connect"
  - Police and Crime Commissioner
- National
  - No formal links nationally
- International
  - International Mental Health Collaborating Forum (IMHCF)

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Financial Pressures
  - Capped Contract
  - OOA risks
  - CCG / System pressures
- LMGB
  - Embedding systems
  - Transfer from LYPFT

making a difference together

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24th May 2016**
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
26/05/2015	15/133	Consideration to be given to providing greater flexibility within the Trust's 12 hour shift system as part of the Working Longer Review	DL	Jun-16	
23/06/2015	15/170	Information on the three wishes raised by teams to be included in future reports on Directors' visits	BK	~~01/06/2016~~ July - 16	
24/11/2015	15/321	In future assurance on the self-assessment ratings of the Core Standards for Emergency Preparedness, Resilience and Response to be provided to the Board by the Audit Committee	BK	Sep-16	
15/12/2015	15/346	Reporting of the culture metrics, including the provision of information on trends, to be reviewed	DL	Jul-16	
26/01/2016	16/12	The Equality Data Document to be used in the 2016/17 Annual Planning Cycle	SP	Oct-16	
23/02/2016	16/33	Briefing on the project on engaging with GPs and their teams as partners in care to be provided to a Board Seminar	CM	Briefing provided at the Board Seminar held on 10th May 2016	Completed
23/02/2016	16/36	A paid for advertisement, linked to the Peppermill Court refurbishment, to be taken out in the York Press	DL	May-16	
23/02/2016	16/39	The composite staff action plan, refreshed to take into account the 2015 staff survey results, to be presented to the Board	DL	May-16	See agenda item 10
23/02/2016	16/39	The Trust's 2015 staff survey results to be compared to all mental health and learning disability trusts	DL	May-16	See agenda item 10

Date	Minute No.	Action	Owner(s)	Timescale	Status
23/02/2016	16/39	A data document on the 2015 staff survey results to be provided to Board Members	DL	May-16	See agenda item 10
22/03/2016	16/64	Report to be provided to the Board on the Trust's approach to improving the recruitment, development and retention of nurses, and to provide assurance that longer term plans were not impacting on the present actions to address these issues in services	DL	Jun-16	
22/03/2016	16/65	The action plans and governance arrangements to take forward the Trust's equality objectives for 2016/2020 to be more explicit on the carrying forward and embedding of work to support the 2012 objectives	DL	Sep-16	
26/04/2016	16/93	A write up of the event hosted by the Trust and Mazars LLP, on 21st April 2016, with regard to the firm's review of unexpected deaths at Southern Health NHS Foundation Trust to be circulated to Board Members.	EM	-	Completed
26/04/2016	16/93	Consideration to be given to involving local universities in developing a regional approach to investigating and reporting unexpected deaths	EM	-	Completed
26/04/2016	16/94	Report to be provided to the Board on the outcome of the trial of the Hurst and Telford approaches to safe staffing at West Park Hospital	EM	Jun-16	
26/04/2016	16/94	Report to be provided to the Board on the impact and lessons learnt from the Safe Staffing Project	EM	Nov-16	
26/04/2016	16/94	Consideration to be given to the feasibility of reporting data on missed breaks as both absolute numbers and percentages.	EM	Jun-16	
26/04/2016	16/94	Consideration to be given to whether action could be taken to ameliorate the impact of vacancies being held as a result of service changes on fill rates	BK	-	Completed
26/04/2016	16/95	Approval of the recommendation and information to be provided to the CCGs in County Durham and Darlington to support their consideration of the future location and configuration of inpatient services for people with Dementia in the Locality	SP	-	Approved
26/04/2016	16/96	Approval of the monitoring arrangements for the remaining actions in the Francis 2 Action Plans (as amended)	CM	-	Approved
26/04/2016	16/97 and 16/100	Approval of the Trust's Risk Assessment Framework return for Quarter 4, 2015/16 for submission to NHS Improvement	DK/PB	-	Approved

Date	Minute No.	Action	Owner(s)	Timescale	Status
26/04/2016	16/101	Approval of the monitoring arrangements for the remaining actions in the Governance Action Plans	CM	-	Approved
26/04/2016	16/101	The progress report on the Governance Action Plans to be shared with the Trust's Relationship Manager at NHS Improvement	CM	-	Completed

FOR GENERAL RELEASE

Board of Directors

DATE:	**Tuesday, 24 May 2016**
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 5 May 2016:
The Quality Assurance Committee have 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.

The key issues during the reporting period are summarised as follows:

- The Locality areas of Forensics and North Yorkshire highlighted ongoing concerns around seclusion, capacity and demand, lack of funding for the Transforming Care agenda, the use of legal highs and staffing and recruitment.
- The Infection Prevention and Control annual report for 2015/16 was noted, as was the Annual Programme for 2016/17.
- Work was being undertaken by the Patient Safety Group to analyse the apparent increase of serious incidents occurring when patients are on planned leave. A thematic review of these incidents is being scoped, which will be undertaken by an external reviewer, to identify common learning points to be shared across the Trust.
- The Trust initially received an Order from the High Court which granted permission to the Claimants to proceed against the CQC in respect of the Judicial Review, but refused permission against TEWV and LYFPT. However the Claimants have made an application to review the Judge's decision and a hearing for this will take place on 20th May.

- Governance matters were noted through assurance and work streams of the Drug & Therapeutics Committee, Equality, Diversity & Human Rights Steering Group and the Force Reduction Group. There were no significant areas of concern.

Recommendations:

That the Board of Directors receive and note the report of the Quality Assurance Committee from its meeting held on 5 May 2016.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 24 May 2016**
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 5 May 2016.

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 are also considered.

3. KEY ISSUES

The Committee received the bi-monthly updates from the Locality Directors of Operations around the principle risks and concerns, together with assurances and progress from the Forensic Services and North Yorkshire.

3.1 Forensics LMGB – where key issues raised were:

1. The use of novel psychotic substances (legal highs) in prison continued to have an impact on patients, as well as staff having to manage behaviours related to this.
2. Seclusion continued to be an issue, which had been escalated to CLODS and a piece of work was underway to look at future solutions to capacity and demand issues across Directorates.
3. It was noted that there remained uncertainty around funding and lack of clarity around the Transforming Care agenda both nationally and regionally.
4. Agency nurses were now being used in Forensics for the first time to help with ongoing qualified nurse staffing/recruitment issues.

3.2 North Yorkshire LMGB - where key issues raised were:

1. Issues were raised regarding access to PICU beds in Middlesbrough with 2 recent episodes where there had been reluctance by PICU staff to accept North Yorkshire patients. This had been escalated to AMH risk register and would be discussed further at CLODs.
2. Staffing and recruitment continues to be an issue with long term sickness and vacancies proving difficult to fill.
3. Funding restraints by the CCG would reduce the amount of investment into the Children's transformation plan with a contract variation of £384k still awaited for 2016/17. This was linked to the specialist children's eating disorder service.

4. INFECTION PREVENTION AND CONTROL REPORT, ANNUAL REPORT 2015/16 AND ANNUAL PROGRAMME 2016/17

1. The Committee noted the quarterly report for January – March 2016, noted the Infection, Prevention and Control Annual Report 2015/16 and approved the Infection, Prevention and Control Annual Programme for 2016/17.

2. It was highlighted to the Committee that there had been a reduction in the number of patients admitted from Acute Trusts with MRSA.

3. Significant assurance has been received by Audit North, following a review of the IPC service.

5 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. Key issues raised were:

5.1 Patient Safety Group – The Committee was assured on the monitoring of quality and performance indicator data, planned work streams and system implementation relating to patient safety.

1. It was noted that new up dated "smoke Free" posters would be installed across the Trust at hospital sites and premises.
2. Regional work was underway to agree a consistent approach to mortality reviews following recommendations from the Southern Health Report and an event hosted by the Trust and Mazars in April 2016.
3. Work was being undertaken to analyse the apparent increase of serious incidents occurring when patients are on planned leave. A thematic review of these incidents is being planned, which will be undertaken by an external reviewer, to identify common learning points to be shared across the Trust.

5.2. Patient Experience Group – this report provided information relating to the PEG meeting held on 19 April 2016.

1. During March 2016 there had been an increase in complaints with 25 received Trust wide, which was an increase of 14 on the previous month.
2. The procurement process to tender for the new patient experience system is underway with a decision due July/August 2016.

5.3 Safeguarding & Public Protection – This was the first newly presented report, which amalgamated the information around safeguarding children and adults into one report.

1. The Committee were updated with regard to serious case reviews, with 3 in Hartlepool - 2 children's and 1 adult review. In Redcar & Cleveland there is an ongoing serious case review regarding the exploitation of 3 young people.
2. Compliance with Level 3 safeguarding training stands at 73% and concerns have been raised within the Clinical Quality Review Groups. Actions are in place to improve this figure and are monitored via the Trust Safeguarding & Public Protection board.

6. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

Compliance with CQC Registration Requirements.

1. The Trust initially received an Order from the High Court which granted permission to the Claimants to proceed against the CQC in respect of the Judicial Review, but refused permission against TEWV and LYFPT. However the Claimants have made an application to review the Judge's decision and a hearing for this will take place on 20th May.
2. A request was made in March to the CQC Registration Department to change the name of Bootham Park location to include the ECT suite – to date a response has not been received despite attempts to expedite this.
3. There have been 2 MHA inspections and associated monitoring reports in the last month.
4. A Trust wide programme of mock inspections have been taking place, with 43 wards and teams visited, which had been very positive. An overview report will be produced with key areas of good practice and learning highlighted. Each ward/team visited received an individual action plan to be monitored through locality governance structures.

7. GOVERNANCE

7.1 Drugs & Therapeutics Committee – assurance was given on planned work streams and system implementation for the safe, effective and economic use of medicines at the Drug and Therapeutics Committee meetings held in December 2016 and January 2016.

1. The use of drugs for rapid tranquilisation in the York 136 suite was discussed at length and following advice from the MHA office the decision was made to remove these drugs. This would not impact on patient care.

7.2 Equality Diversity and Human Rights – The Committee noted statements from the Equality, Diversity and Human Rights Steering Group meetings from 27 January 2016 and 13 April 2016.

1. There were significant differences in the experience between patients of different ethnicities and patients who identified as gay or lesbian, despite the presence of 55 clinical staff acting as 'equality experts' in these areas. Further work would be undertaken to understand the reasons for this and an action plan would be developed.
2. It was noted that all CQC inspectors would be receiving human rights training to enable them to take a human rights based approach to inspection in the future. This

would be linked into the Mental Health Act team to promote a Trust wide narrative for staff around human rights.

3. The Board of Directors would receive a briefing at future Board Seminar during 2016 to understand the strategic issues of human rights training and the interface with the recovery work underway in the Trust.

7.3 Force Reduction Update – the Force reduction project remained on track to fully implement the core interventions set out within the restraint reduction plan by Quarter 1 2016/17.

1. Assurance was given that there was adequate support for staff who are routinely exposed to challenging patients through supervision and weekly reflective practice groups for nurses.
2. Environmental issues were currently being reviewed to improve alarm sounds on wards with the aim of reducing further potential trauma to surrounding patients, especially those with autism difficulties.
3. The impact on the complexity of patient care, due to the use of legal highs was highlighted as an issue for consideration in conjunction with the use of seclusion and this would also be followed up by the Drug & Therapeutics Committee.
4. A supplementary paper was noted on the Restrictive Intervention Benchmarking Exercise, which included the results from the 4th phase on the use of restraint in patient settings, covering CAMHS and the learning disability wards.
5. The Committee considered and noted the Draft Policy for Harm Minimisation and the Draft Supportive Engagement and Observations Procedure. The Draft Policy and Procedure would go to EMT for formal approval.

8. IMPLICATIONS

8.1 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.

8.2 Financial/value for money

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

8.3 Legal and Constitutional (including the NHS Constitution)

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

8.4 Equality and Diversity

The Committee receives quarterly assurance reports from working groups, one of which is the Equality and Diversity Steering Group. (Item 7:Governance:7.2).

9. 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.

10. RECOMMENDATIONS

That the Board of Directors note the issues raised at the QuAC meeting on 5 May 2016 and to note the confirmed minutes of the meeting held on 7 April 2016 (appendix 1).

Jennifer Illingworth
Director of Quality Governance
May 2016

APPENDIX 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 7 APRIL 2016, 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
Mrs Jennifer Illingworth, Director of Quality Governance
Dr Nick Land, Medical Director
Mr Brent Kilmurray, Chief Operating Officer
Mrs Elizabeth Moody, Director of Nursing & Governance
Mr David Jennings, Non-Executive Director
Mr Jim Tucker, Non-Executive Director, Deputy Chairman of the Trust
Mr Richard Simpson, Non-Executive Director

In attendance:
Mrs Karen Atkinson, Head of Nursing, Teesside
Mrs Karen Agar, Associate Director of Nursing and Governance (for minute 16/50)
Dr Ruth Briel, Deputy Medical Director, York & Selby (for minute 16/44)
Mr David Brown, Director of Operations, Teesside (for minute 16/42)
Mrs Lorraine Ferrier, Head of Nursing for Durham & Darlington
Mr Darren Gargen, Head of Nursing, York & Selby
Mrs Donna Oliver, Deputy Trust Secretary
Mrs Sharon Pickering, Director of Planning, Performance & Communications (for minutes 16/47 & 16/48)
Mr Patrick Scott, Director of Operations, Durham & Darlington (for minute 16/43)
Dr Ingrid Whitton, Deputy Medical Director for County Durham & Darlington (for minute 16/46)

16/39 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr Martin Barkley, Chief Executive, Mrs Barbara Matthews, Non-Executive Director and Mrs Ruth Hill, Director of Operations, York & Selby.

16/40 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 3 March 2016 be signed by the Chairman of the Committee.

16/41 ACTION LOG

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

The following updates were noted:

16/30 "Check out high levels of self-harming, suspected to be in connection with Tier 4 children's services".

Completed

16/30b "Show patient safety figures around self-harm with and without adolescents - included in patient safety data report".

Completed

16/30d "Circulate report relating to sexually inappropriate behaviour in MHSOP".

Completed

16/30d "Graphs on the patient safety report to include rolling averages for better understanding".

Completed

16/42 TEES LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the Tees LMGB assurance/exception report.

Mr Brown highlighted the main concerns at present, which were:

1. The recruitment of sufficient qualified nurses, as well as medical and AHP staff. There was also an issue about the proportion of newly qualified staff on inpatient areas.
   On this matter it was noted that:

   a) Various actions and work streams were underway to try to forward plan and find resolutions to these issues. The Committee was assured that the Director of Finance and Director of Operations had fully supported implementation of proposed changes and EMT would be monitoring recruitment carefully.
   b) Work had been started by Heads of Nursing and Modern Matrons to develop a Trust escalation protocol to help at ward or service level to ensure consistency around safe staffing.
2. In C&YPS waiting times were not consistent across the locality against the 4 and 9 week targets. Screening assessment slots had been introduced to address this.

Arising from the report it was noted that:

i) The number of AMHPs in Middlesbrough had reduced and this could potentially impact on the responsiveness to Mental Health Act assessment requests.
ii) There had been significant increase in referrals to all Access and Primary Care services and this would be monitored carefully.
iii) There had been an SUI following a patient suffering a fractured neck of femur on Wingfield Ward with significant concern around the care provided shortly before the fall. A disciplinary investigation had been initiated.
iv) There had been discussion at QuAG about the use of mobile phones for patient contact and an SBARD had been circulated outlining an agreed standard for managing messages.
v) There had been some improvements on progressing SWEMWEBS in relation to effectively communication outcomes with patients. This had been heard in a presentation recently to MHSOP QuAG.

16/43 DURHAM & DARLINGTON LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the Durham & Darlington Services LMGB assurance/exception report.

Mr Scott highlighted the main concerns at present, which were:

1. Anonymous concerns had been raised around leadership and staff behaviours within MHSOP at Picktree Ward. A new manager had been installed to lead the team and an improvement action plan was being implemented and monitored.
2. C&YPS capacity due to issues around staff sickness and absence, which were impacting on the ability to deliver the expected waiting times.
3. The care provided at Danshell Nursing homes. These issues had been raised with relevant Commissioners who also shared these concerns.
   On this matter assurance was given to the Committee that these issues had been dealt with fully and that the 2 patients in Danshell were receiving a proper standard of care. This would be reflected in the next LMGB report to the Quality Assurance Committee.

Following discussions it was noted that:

i) The issues around improving the risk register continued with the current review ongoing. It was anticipated that there would be some development by May 2016.
ii) Smoking cessation on wards had gone very well, however there were some areas that required further input from the smoking cessation project lead working with Ward Managers and Modern Matrons.
iii) The number of senior posts tendered in Children & Young People's Services reflected the current workload pressures.
   On this matter it was felt that the situation was no longer tenable and community teams should be dealt with in a similar way to Inpatient wards. Some work was underway to look at the dramatically increased demand in C&YPS with alerts set up within the referral system.

16/44 YORK & SELBY LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the York & Selby locality Assurance/Exception Report.

Dr Briel highlighted the main concerns at present, which were:

1. The reporting of information for the locality continued to be limited at this time, however the roll out of PARIS was expected to be completed by the end of April 2016, which would improve the situation.
2. There were significant changes within the locality, which could have an impact on service delivery and quality, such as the temporary closure of Acomb Gables and the large number of staff under Management of Change.
3. Public engagement events regarding service changes had recently gone very well with high levels of participation.

Following discussion it was noted that:

i) The highlighted skills gap in some teams, particularly MHSOP was a mixed picture and something that was being investigated further. QuAC would be kept informed of progress.

16/45 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Experience Group report.

Arising from the report it was noted that:

1. There had been unexpected pressures in the Patient Safety Team due to staff sickness and delays in recruitment, combined with a significant increase in activity. Mitigating actions had been agreed and instigated and it was noted that a positive difference had already been seen.
2. Two SBARD safety alerts had been received by the Patient Safety Group, 1 relating to methadone toxicity, which was immediately circulated Trust-wide and 1 relating to the use of mobile phones for patient contact, which needed further consideration.
3. An event would be held on 21 April 2016, hosted by TEWV and Mazaars for North East, North Yorkshire and Humber provider Trusts to focus on how to consistently implement the recommendations from the Southern Healthcare report.

Arising from discussion it was noted that:

i) The table on page 8 of the Patient Safety Group Quality report, looking at the trends around prone incidents should be reviewed.

Action: Mrs J Illingworth

ii) The NHS benchmarking data on restraint would be brought back to the QuAC meeting in May 2016, together with a breakdown by Directorates.

Action: Mrs J Illingworth

16/46 PATIENT EXPERIENCE GROUP REPORT

The Committee received and noted the Patient Experience Group report.

Arising from the report it was noted that:

1. All localities were underperforming in relation to Indicator 5 on the Quality Strategy Scorecard (percentage of patients being given a copy of their care plan). It was expected that this would improve once upgrades had been implemented onto PARIS.
2. All areas and localities had reviewed their patient experience and complaints data and action plans were in place to address any shortfalls or issues identified.

16/47 DRAFT QUALITY ACCOUNT 2015/16

The Committee received and noted the first Draft of the Quality Account for 2015/16..

Mrs Pickering drew attention to the following:

1. This was the first draft of the Quality Account for 2015/16, which would now be shared with stakeholders and Commissioners.
2. Governors would be involved in reviewing the Draft Quality Account before it went to stakeholders.
3. York & Selby data had been included, where it had been possible to apply priorities, however more
4. There would be revised quality metrics for the 2016/17 Quality Account, following the current review of the quality strategy and quality strategy scorecard indicators.

Arising from the report it was highlighted that:

Agreed:

1. That further work be completed in relation to the indicator metrics and targets on page 22 of the Draft Quality Account.

Action: Mrs S Pickering

2. That the Draft Quality Account 2015/16 be shared (following amendments) with Stakeholders.

16/48 REPORT ON ANALYSIS OF PERCENTAGE OF PEOPLE READMITTED TO ASSESSMENT AND TREATMENT WARDS WITHIN 30 DAYS AND NUMBER OF INSTANCES WHERE A PATIENT HAS HAD 3 OR MORE ADMISSIONS IN THE PAST YEAR AND MEDIAN NUMBER OF DAYS FROM WHEN A PATIENT IS DISCHARGED TO THEIR NEXT ADMISSION TO AN ASSESSMENT AND TREATMENT WARD.

The Committee considered a report on the analysis of 3 indicators within the Trust Dashboard and whether any further analysis would be required.

Arising from the report it was highlighted that:

1. This report had followed a request from the Board of Directors for further work to be undertaken to understand the level of performance around 3 Trust Dashboard indicators - percentage of people readmitted to Assessment and Treatment Wards within 30 days, number of instances where a patient has had 3 or more admissions in the past year and median number of days from a patient being discharged to their next admission.
2. These 3 indicators had been designed to highlight any potential concerns with regard to community teams being able to maintain people out of hospital.
3. If the Trust continued to report in 2016/17 against these indicators in the same way as 2015/16 it would be likely that targets would not be achieved.
4. The SDG had not felt that the deep dive information had highlighted any areas of clinical concern, however noted the work that was ongoing in Harrogate

Agreed:

1) That people with a diagnosis of Personality Disorder should continue to be included within the indicators.
2) That the indicators be reported on a 3 month rolling position.
3) That there would be further discussion at OMT around how to ensure that when investigating any breaches assurance could be gained that the appropriate care had been provided.

Action: Mrs S Pickering

4) That further work would be undertaken at the end of Quarter 1 when the targets would be revisited within the Dashboard, taking into account an understanding of the further work that was taking place in Harrogate.

Action: Mrs S Pickering

16/49 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

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

Arising from the report it was noted that:

4. The judicial review information provided was currently being assessed by a Judge to determine whether there was sufficient merit to grant permission to the claimant to proceed to a formal hearing.
5. There had been 2 MHA inspections and associated monitoring reports since March 2016 with 1 internal mock inspection and 1 revisit to follow up on an action plan.
6. The final report, commissioned by NHS England, relating to lessons learned from the Bootham Park transfer would go to the Overview and Scrutiny Committee on 25 April 2016.

   On this matter it was noted that there had been no recommendations for TEWV in the report, and whilst it was recognised the OSC could be quite challenging, it was not anticipated that there would be any further come back for the Trust on this matter.

16/50 SAFEGUARDING & PUBLIC PROTECTION REPORT

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

It was highlighted from the report that:

1. Trust was meeting all legal requirements for safeguarding adults and children within the legislative framework.
2. The workload of the safeguarding team had continued to increase, due to the multi-agency safeguarding hub which had been established in Durham.
3. There had been an increase in the number of safeguarding adult alerts in Selby and an action plan had been implemented for this, which would be monitored by the Safeguarding and Public Protection sub-group.
4. The feedback from the CQC Safeguarding and Looked after Children inspection in Hartlepool had been very positive for TEWV services with some recommendations for CAMHS and Adult services.
   On this matter it was noted that an action plan had been put in place.
5. The criminal proceedings relating to the Hartlepool case involving both CAMHS and AMH would be due to end soon, however the exact date was unknown. Following this there would be the start of 3 serous case reviews, 2 children and 1 adult, all of which had been known to services at TEWV.

16/51 EXCEPTION REPORTING (LMGBs, QuAC sub groups)

There was nothing to note under this item.

16/52 ANY MATTERS ARISING TO BE ESCALATED TO THE BOARD OF DIRECTORS, AUDIT COMMITTEE, INVESTMENT COMMITTEE OR TO THE CLINICAL LEADERSHIP BOARD

There were no matters to be escalated to the Board.

16/53 ANY OTHER BUSINESS

The Committee considered any potential impact on the pending strike action by Junior Doctors.

It was noted that:

1. Emergency cover had been provided, however due to the nature of services provided by TEWV, there would be much less impact than for an Acute Trust.

2. There had been some cancellation of clinics, however consultant cover had mostly been provided.
3. Directorates had been asked for detailed plans on the potential impact of the 2 – 9 hour strikes on successive days and those plans would be taken to the next LMGB meeting for consideration.
4. The referrals from TEWV to the Acute Trust would be minimised during the strike action.

Mrs E Moody raised the CQC Action Plan for York & Selby, which would be brought back to the Quality Assurance Committee in May 2016.

Action: Mrs E Moody

16/54 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 7 May 2016, 2.00pm – 5.00pm in the Board Room, West Park Hospital.
Email to Donna Oliver donnaoliver1@nhs.net
The meeting concluded at 4.40pm

……..

Dr Hugh Griffiths
CHAIRMAN

7 April 2016

Enc

ITEM 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24th May 2016**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Update 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 the report is to advise the Board 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 April 2016 data.

Please note that York and Selby data has been incorporated into the full report.

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

- The number of rosters has increased from 66 to 69 in April. This is due to the inclusion of York and Selby. In addition there have been a number of roster changes during the reporting period which is outlined on page 3 and 4 of this report.
- In terms of the month on month trend this is showing as 'green' across all fill rates. This is largely due to the inclusion of York and Selby data.
- The number of wards showing as 'red' has decreased in April from 55 to 38.
- The number of 'red' wards by locality is showing as 'green' across all localities. Forensics remains to have the highest at 13 which is a significant reduction when compared to March where there were 27.
- The lowest fill rate relates to White Horse View but this is due to the discharge of patients as they work towards the closure of the unit.
- The second lowest fill rate can be observed by Bek, Talbot and Ramsey but this is due to a reduction in the number of beds as part of the transformation of care agenda.
- The Highest fill rate was observed by Westerdale South in April where it has been agreed to uplift the budgeted establishment to support enhanced observations. The HealthRoster template needs to be amended to reflect this position.

- There were 3 wards who had bank usage in excess of 50% (Cedar Ward, Westerdale South and Merlin)
- Agency usage equates to 1% of the total hours worked. This was 2 wards using agency staff (Worsley Court and Springwood).
- In terms of the triangulation:
    - There was 1 PALS related issue that related to Merlin ward, the ward has been highlighted in the report as having a high fill rate and high bank usage.
    - There was 1 PALS related issue that related to Cedar Ward, the ward has been highlighted in the report as having high bank usage.
    - Westwood had the highest number of incidents requiring control and restraint in April. It should be highlighted that the number of incidents in April is a significant reduction when compared to March.
- There were 1146 shifts allocated in April where a break had not been taken. This is a significant increase when compared to March. The increase is largely due to the inclusion of the York and Selby data. Had York and Selby being excluded from the data we would have seen a 15% reduction when compared to March. The highest number of shifts where an unpaid break had not been taken was within the Teesside locality. There is no correlation between shortage of staffing and no breaks given.
- There were 14 incidents raised in April citing staffing levels. Page 10 of the report summarises the issues that were cited.

Triangulation of staffing and quality data has not identified any direct risks or implications to patient safety or experience within the reporting period.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**24th May 2016**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Update Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board 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 April 2016 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. (www.tewv.nhs.uk/nursestaffinginfo). The full monthly data set of day by day staffing for each of the 69 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

Work continues to rationalise the report to ensure that the monthly report focusses exclusively on providing assurance that the staffing levels were safe.

York and Selby data has now been incorporated into the main body of the report and is no longer reported separately as an appendix.

3. KEY ISSUES:

3.1 Safe Staffing Fill Rates

3.1.1 The daily nurse staffing information aggregated for the month of April 2016 is presented in Appendices 1 and 2 with locality information in appendix 3.

The total number of inpatient rosters during the month of April 2016 is 69 wards which is an increase of 3 on the previous month. There have been a number of changes within inpatient areas which can be summarised as follows:

- Recovery Unit Acomb closed on the 24th March
- Park House closed on the 31st March
- Earlston House closed on the 6th April and merged with Willow ward. There are still staff assigned to the roster hence there are fill rates being reporting in April.

- White Horse View closed on the 31st March again there are still staff assigned to the roster hence there is a fill rate being reported in April.
- Kirkdale Ward moved from Forensics Services to Adult Mental Health (Teesside).

The month on month trend report in April 2016 shows an improvement in all fill rates with each reporting as 'green'. The table below shows the trend over the last 3 months:

Month	Day			Night				
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
Feb-16	88.80	↑	111.40	↓	95.30	↓	111.50	↓
Mar-16	86.70	↓	110.00	↓	97.00	↑	110.00	↓
Apr-16	92.90	↑	113.50	↑	99.60	↑	113.00	↑

The numbers of wards reporting a fill rate of less than 89.9% in April 2016 equates to 38 which is a significant decrease on the previous reporting period of March 2016.

Month	April	March	February	January	December	November
No. of Red Indicators	38	55	50	47	47	44

The majority of the red wards fall into the Registered Nurse on Day shifts category where there were 25 wards shown as red in April compared to 39 in March 2015.

An improvement can be observed across all localities. Forensic Services continue to have the highest number of red wards. The table below shows the split across all localities over the last 6 months with the full detail available in appendix 3 of this report:

Locality	Number of wards red across all metrics						Trend on previous month
	Apr-16	Mar-16	Feb-16	Jan-16	Dec-15	Nov-15	
Durham and Darlington	10	10	9	9	7	4	↔
Teesside	4	10	9	10	10	7	↓
North Yorkshire	7	8	8	8	6	9	↓
Forensics	13	27	24	20	24	24	↓
York and Selby	4	10	11	11	11	10	↓

3.1.2 **April 2016**

The lowest staffing fill rate relates to White Horse View who are reporting 52.7% for HCA on Day Shifts. The breakdown for the last 6 months is as follows:

	Apr-16	Mar-16	Feb-16	Jan-16	Dec-15	Nov-15
HCA Day Shifts	52.7%	79.5%	78.5%	88.0%	99.0%	77.8%

The ward have articulated that they have lower fill rates due to having less patient in the service due to some having being discharged prior to the closure of the unit.

The second lowest fill rate was observed by Bek, Talbot and Ramsey who had a HCA fill rate on nights at 60.8%. The breakdown over the last 6 months is as follows:

	Apr-16	Mar-16	Feb-16	Jan-16	Dec-15	Nov-15
HCA Night Shifts	60.8%	68.3%	79.8%	73.9%	100%	104.8%

The ward has articulated that the low fill rate is as a result of a reduction in the number of beds available, lower occupancy levels and a revised position regarding staffing levels in response to these circumstances as part of the transforming of care agenda.

The third lowest fill rate was observed by Linnet Ward who are reporting 61.7% for RN on Day Shifts. The breakdown for the last 6 months is as follows:

	Apr-16	Mar-16	Feb-16	Jan-16	Dec-15	Nov-15
RN Day Shifts	61.7%	54.8%	84.5%	102.6%	80.2%	85.3%

The ward has articulated that on some duties in April they have ran under planned staffing due to vacancies and sickness. All vacant duties were sent to central bank but some remained unfilled.

There was 1 other ward that had a low fill rate of 64.2%, as shown below:

	Apr-16	Mar-16	Feb-16	Jan-16	Dec-15	Nov-15
Earlston House	64.2%	76.0%	97.6%	99.4%	99.7%	115.1%

The low fill rate is following the closure of the unit and merger with Willow Ward. There are still staff attached to the Roster hence the fill rates that are being reported.

It is also important to review the fill rates that exceed the budgeted establishment (shown in blue). During the month of April there were 40 indicators that had staffing in excess of their planned requirements to address specific nursing issues. This is an increase when compared to March where there were 37.

Westerdale South saw the highest fill rate indicators during the month of April (293.6% and 209.8%). This is now the seventh month in a row they have been in this position. April fill rates are as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Westerdale South	**108.0%**	**293.6%**	**100.3%**	**209.8%**

The additional staffing are in relation to an agreed uplift on the budgeted establishment as a result of enhanced observations not generally falling below 3 and 4 on occasions. Again the rostering system requires amendment to reflect this arrangement.

The second highest fill rate indicator was in relation to Worsley Court who had an Unregistered fill rate for night shifts of 266.8%. The April fill rate return is as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Worsley Court	**103.7%**	**153.7%**	**114.8%**	**266.8%**

At the time of writing this report feedback had not been submitted to explain the increase.

The third highest fill rate indicator was in relation to Merlin with 236.7% as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Merlin	**94.2%**	**168.7%**	**91.7%**	**236.7%**

The ward has articulated that the increase was in relation to seclusion and enhanced observations.

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 is work ongoing to ensure all bank workers achieve the required competencies.

Appendix 6 highlights the usage of bank staffing, as a proportion of actual hours. These are 'RAG' rated independently of the overall fill rate.

Those wards using greater than 50% bank staffing to deliver their fill rates in April 2016 are identified below:

Locality	Ward	Bank Usage Apr-16	Reason for Bank Usage	Comments
Durham & Darlington	Cedar Ward	70%	Annual leave, enhanced observations, establishment vacancies and unknown	This is a significant increase this month when compared to March (26%)
Teesside	Westerdale South	68%	Enhanced observations, unknown and establishment vacancies.	An increase can be observed this month when compared to March (64%)
Forensics	Merlin	63%	Annual leave, enhanced observations, establishment vacancies, sickness and unknown	This is an increase when compared to March (46%)

49 wards were reported as Amber (between 10 and 40%) in April 2016, this is a sustained position when compared to March.

From those wards highlighted within this report as the biggest users of bank, the month on month trend is identified as follows:

	April	March	February	January	December	November
Cedar Ward	70%	26%	38%	18%	44%	67%
Westerdale South	68%	64%	66%	67%	68%	91%
Merlin	63%	46%	47%	60%	47%	50%

3.3 Agency Usage

When considering staffing levels it is also important to consider the amount of agency worked within the reporting period. In April 2016 there was a total of 214,671.87 hours worked across the trust of which 2,138 were agency hours, equating to 1% of the total hours worked.

The table below shows the breakdown of usage during the reporting period by locality and ward:

Locality	Ward	Total Agency Hours (Apr-16)	Reason for using Agency
York & Selby	Worsley Court	1950.5	Establishment vacancies, sickness, enhanced observations, annual leave, maternity and service need.
North Yorkshire	Springwood	187.5	Vacancies, sickness, enhanced observations, annual leave and training.

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 a feature of this monthly report for several months now and to date it has not identified any direct risks or implications to patient safety or experience. A summary is provided on a monthly basis with the detail contained within the appendices. The following is of relevance:

- There were 4 SUI's that occurred within the month of April 2016 from 4 different wards. None of the wards who had SUI's have been cited in this report so far.
- There were 1 level 4 incidents that occurred in April. This ward has not been cited in this report so far.
- There were 13 level 3 incidents (self-harm) that occurred within the reporting period none of which were relating to wards that have been identified to date within this report.
- There were 4 complaints that occurred within the reporting period of which none of the wards have been cited within this report.
- There were 38 PALS related issues raised during April of which 1 related to Merlin who have been highlighted as having a high fill rate and high bank usage. 1 related to Cedar Ward ward who have been highlighted as having high bank usage.
- A number of incidents requiring control and restraint occurred during the reporting period. The highest user was the Westwood Centre with a total of 53 incidents requiring control and restraint. To date the Westwood Centre has not been highlighted within this report as having either a high or low staffing fill rate, bank or agency usage.

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 1146 shifts in April 2016 where unpaid breaks had not been taken. This is an increase on the previous month whereby there were 859 shifts. This increase is largely due to York and Selby, had this data been excluded then a 15% would have been observed from last month.

The majority of the shifts where breaks were not taken occurred on day shifts (847 shifts in total). The number of night shifts where breaks were not taken was equated to 299 shifts.

The breakdown by locality is as follows:

Locality	Total number of shifts whereby a break was not taken				Trend on Previous Month
	Apr-16	Mar-16	Feb-16	Jan-16	
Durham & Darlington	16	16	18	16	↔
Forensics	100	104	232	188	↓
North Yorkshire	172	231	239	221	↓
Teesside	443	496	441	476	↓
York and Selby	416	0	583	618	↑

The highest number of shifts by locality where a break was not taken was within Teesside services with 443 shifts. The top 3 wards within Teesside are as follows:

Ward	Total No. of Shifts	No. of Shifts Days	No. of Shifts Nights	Trend on Previous month
Aysgarth	190	130	60	↓
Bankfields Court Unit 2	123	121	2	↓
Baysdale	40	40	0	↓

The lowest number of shifts by locality where a break was not taken was Durham & Darlington with 16 shifts.

In terms of triangulating this information with the staffing fill rates it is difficult to draw any meaningful conclusions in that looking at the top 10 wards where breaks have not been taken on days there is 1 out of 20 metrics that are showing as ‘red’ whilst all the others are reporting as either ‘green’ or ‘blue’. In terms of the top 10 wards from those night shifts where a break has not been taken the staffing fill rates are either ‘green’ or ‘blue’ with none reporting as ‘red’ suggesting that missed breaks may not only occur as a result of staffing shortages. The full triangulation for all inpatient wards where a break has not been taken can be found at Appendix 7.

It is not possible to highlight the reasons as to why breaks are not given due to this not being reported within the HealthRoster system. It is therefore not possible to separate whether this is due to clinical need or customary practice.

A task and finish and finish group led by HR has recently been established which will provide focus on staff breaks and adherence to EU Working time directives.

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. Within the reporting period there were 14 incidents raised citing issues with staffing (12 relating to inpatients and 2 relating to community services). This is an increase when compared to March where there were 8.

The incidents citing staffing problems were from the following localities:

Locality	Total Number of Incidents				Trend on Previous Month
	Apr-16	Mar-16	Feb-16	Jan-16	
North Yorkshire	3	5	2	4	↓
Durham & Darlington	4	1	4	0	↑
Teesside	4	1	0	1	↑
Forensics	0	1	5	6	↓
York and Selby	4	0	2	2	↑

The Datix incidents citing staffing issues can be summarised as follows:

- Staff conduct issue which impacted upon staffing levels
- Due to sickness there was only 1 nurse to cover 2 shifts which resulted in no referrals been accepted from 16.30pm.
- There was no available medic to assess the ECG results
- 2 members of staff had to be taken off level 1 observations to assist with another patient.
- There were no staff to facilitate therapeutic leave activities for the patients. No staff breaks were given and no response team was available. Leave had to be denied to a sectioned patient due to having very few staff.
- Low levels of staff around the ward due to sickness, the ward saw an increase in observations as well.
- 2 members of staff short for the late shift
- Staffing levels were 3 for the night shift with 2 patients on enhanced observations with admissions expected.
- The shift was planned with 5 members of staff; the shift ran with 3 due to sickness. There were 2 patients on enhanced observations, 1 was going to the general hospital leaving the ward with 2 members of staff.
- HCA night shift was unable to covered with regular or bank staff.
- There were 3 members of staff on duty with a patient on enhanced observations. Also required were 3 members of staff to attend to the hygiene of patients.
- A detained patient being nursed at hospital on enhanced observations due to risk of absconding. The patient was demadnding to be allowed off the ward for a cigarette but the ward were unable to support this therefore nurse in charge of the shift escorted the patient. The nurse in charge is pregnant and a concerned staff member thought that they should attend also to ensure security.
- A patient broke the ward doors and absconded. Only 1 member of staff attended the alarms which meant that 2 female members of staff were unable to restrain male patient.
- On the 29th April the ward ran with 1 member of staff down

Analysis of the above information would suggest that the escalation of incidents relating to staffing levels is not currently consistently applied across the Trust and it is not clear from the initial incident report how risks related to staffing are resolved, managed or mitigated.

Discussion has taken place at the Operational Management Team meeting regarding staffing escalation processes in order that a standard approach can be adopted across the Trust and a timely response to ensure patient safety is not compromised.

3.7 Other

Although the Board did not agree to a dedicated Safe Staffing project for this year's Annual Plan (2015/16), this piece of work will be managed under business as usual within the Nursing and Governance Directorate in 2016/17. The safer staffing steering group has been established to oversee a work plan to ensure the trust has robust systems and processes in place to assure themselves that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards / clinical areas / community services day or night, every day of the week as appropriate. This is being discussed by the Director of Nursing with the Operational Management Team.

In addition a pilot will be undertaken within Durham & Darlington and will:

- Test out NHS England evidence based staffing framework and tools for MH wards in agreed in-patient areas.
- To ensure above indicators are compliant with emerging NICE guidance or other DH documentation
- To put in place Triangulation and hot spot systems for predicting planned requirements
- To implement regular reporting and monitoring systems within services to enable timely and informed intervention to occur

The output from the project will have a bearing on the format and quality of reports ultimately received by Board on this issue.

Work has commenced to review the process of validation and context information being sought from the wards as this is currently a manual process; any information collected is retained within the department for reference, outliers will be followed up and consideration is being given as to how best to use this information to present it in a more meaningful summary for future reports.

The Chief Nursing Officer has issued further directives regarding the Safe Staffing returns in relation to the direct clinical contact time nursing staff spend with patients. A number of tools have been suggested for use to produce data that is required to be included in the six monthly Board reports to demonstrate contact time. These will be explored as part of the Safe Staffing review.

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 this month, although the following is of relevance:

- The number of rosters has increased from 66 to 69 in April. This is due to the inclusion of York and Selby. In addition there have been a number of roster changes during the reporting period which is outlined on page 3 and 4 of this report.
- In terms of the month on month trend this is showing as 'green' across all fill rates. This is largely due to the inclusion of York and Selby data.
- The number of wards showing as 'red' has decreased in April from 55 to 38.
- The number of 'red' wards by locality is showing as 'green' across all localities. Forensics remains to have the highest at 13 which is a significant reduction when compared to March where there were 27.
- The lowest fill rate relates to White Horse View but this is due to the discharge of patients as they work towards the closure of the unit.
- The second lowest fill rate can be observed by Bek, Talbot and Ramsey but this is due to a reduction in the number of beds as part of the transformation of care agenda.
- The Highest fill rate was observed by Westerdale South in April where it has been agreed to uplift the budgeted establishment to support enhanced observations. The HealthRoster template needs to be amended to reflect this position.
- There were 3 wards who had bank usage in excess of 50% (Cedar Ward, Westerdale South and Merlin)
- Agency usage equates to 1% of the total hours worked. This was 2 wards using agency staff (Worsley Court and Springwood).
- In terms of the triangulation:
  - There was 1 PALS related issue that related to Merlin ward, the ward has been highlighted in the report as having a high fill rate and high bank usage.
  - There was 1 PALS related issue that related to Cedar Ward, the ward has been highlighted in the report as having high bank usage.
  - Westwood had the highest number of incidents requiring control and restraint in April. It should be highlighted that the number of incidents in April is a significant reduction when compared to March.
- There were 1146 shifts allocated in April where a break had not been taken. This is a significant increase when compared to March. The increase is largely due to the inclusion of the York and Selby data. Had York and Selby being excluded from the data we would have seen a 15% reduction when compared to March. The highest number of shifts where an unpaid break had not been taken was within the Teesside locality. There is no correlation between shortage of staffing and no breaks given.
- There were 14 incidents raised in April citing staffing levels. Page 10 of the report summarises the issues that were cited.

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 years Safe Staffing project 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.

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 The current lack of an evidence based tool for workforce planning and monitoring in mental health and learning disability nursing increases the risk that the publication of the workforce data will be compared to other Trust's data without appreciation of context. Information published on the Trust website will assist with provision of contextual information. NICE are expected to publish further guidance on evidence based approaches to staffing by the end of this year 2015

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.

A review of safe staffing will be undertaken during the financial year 2016/17 which will refine the usage of the data further. The comparative analysis of complaints and incidents, particularly focussing on the areas where staff fell below the planned levels has not shown any significant trend or impact.

6.2 It is difficult to draw any meaningful conclusions from the data presented within this report.

7. RECOMMENDATIONS:

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

Emma Haimes
Head of Quality Data
May 2016

Appendix 1

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 30 DAYS IN April

				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)**
The Orchards (NY)	North Yorkshire	Adults	10	101.6%	91.7%	69.0%	156.7%
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	13	74.9%	134.6%	99.5%	108.3%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	13	101.1%	99.6%	100.0%	100.0%
Bedale Ward	Teesside	Adults	10	95.9%	182.7%	106.3%	125.3%
Bilsdale Ward	Teesside	Adults	14	105.0%	105.5%	130.0%	88.1%
Birch Ward	Durham & Darlington	Adults	15	76.3%	112.6%	100.0%	133.3%
Bransdale Ward	Teesside	Adults	14	97.3%	105.8%	106.7%	98.3%
Cedar Ward	Durham & Darlington	Adults	10	107.8%	156.0%	106.7%	157.2%
Cedar Ward (NY)	North Yorkshire	Adults	18	110.6%	98.5%	112.6%	92.7%
Earlston House	Durham & Darlington	Adults	0	64.2%	100.0%	80.0%	80.0%
Elm Ward	Durham & Darlington	Adults	20	103.0%	91.5%	100.0%	105.0%
Farnham Ward	Durham & Darlington	Adults	20	96.3%	100.0%	107.2%	103.3%
Kirkdale Ward	Teesside	Adults	16	83.3%	100.1%	100.0%	98.3%
Lincoln Ward	Teesside	Adults	20	98.8%	105.7%	93.3%	108.3%
Lustrum Vale	Teesside	Adults	20	96.4%	128.7%	100.0%	100.0%
Maple Ward	Durham & Darlington	Adults	20	107.6%	90.5%	100.0%	101.7%
Overdale Ward	Teesside	Adults	18	86.3%	126.9%	101.4%	110.5%
Primrose Lodge	Durham & Darlington	Adults	14	84.1%	99.5%	103.3%	111.7%
Stockdale Ward	Teesside	Adults	18	94.5%	108.9%	102.3%	100.9%
Tunstall Ward	Durham & Darlington	Adults	20	92.5%	118.9%	103.3%	101.6%

Ward 15 Friarage	North Yorkshire	Adults	13	100.8%	114.5%	103.3%	111.0%
Willow Ward	Durham & Darlington	Adults	15	104.3%	179.3%	100.0%	100.0%
Baysdale	Teesside	CYPS	6	123.2%	99.1%	100.5%	100.0%
Holly Unit	Durham & Darlington	CYPS	5	129.4%	135.3%	104.8%	119.0%
Newberry Centre	North Yorkshire	CYPS	14	77.0%	123.9%	105.3%	105.6%
The Evergreen Centre	North Yorkshire	CYPS	12	100.5%	109.9%	109.6%	96.2%
Westwood Centre	North Yorkshire	CYPS	12	85.3%	135.1%	82.9%	121.7%
Clover/Ivy	Forensics	Forensics LD	12	104.2%	119.6%	107.0%	165.0%
Eagle/Osprey	Forensics	Forensics LD	10	102.8%	97.0%	97.9%	97.7%
Harrier/Hawk	Forensics	Forensics LD	10	78.3%	103.0%	100.0%	100.0%
Kestrel/Kite.	Forensics	Forensics LD	16	77.1%	99.4%	100.0%	96.5%
Robin	Forensics	Forensics LD	6	74.2%	129.3%	100.0%	101.8%
Langley Ward	Forensics	Forensics LD	10	80.6%	125.4%	101.2%	198.1%
Northdale Centre	Forensics	Forensics LD	12	87.5%	99.5%	87.2%	95.2%
Oakwood	Forensics	Forensics LD	8	87.5%	132.1%	96.7%	100.0%
Thistle	Forensics	Forensics LD	5	76.6%	127.0%	100.0%	99.6%
Brambling Ward	Forensics	Forensics MH	13	97.4%	106.0%	100.0%	100.0%
Fulmar Ward.	Forensics	Forensics MH	10	95.0%	102.5%	100.6%	102.0%
Jay Ward	Forensics	Forensics MH	5	74.9%	114.0%	96.7%	98.3%
Lark	Forensics	Forensics MH	15	93.7%	106.6%	100.0%	100.0%
Linnet Ward	Forensics	Forensics MH	17	61.7%	115.4%	100.1%	98.3%
Mallard Ward	Forensics	Forensics MH	16	97.2%	100.6%	106.7%	130.9%
Mandarin	Forensics	Forensics MH	16	96.7%	95.5%	100.0%	98.3%
Merlin	Forensics	Forensics MH	10	94.2%	168.7%	91.7%	236.7%
Newtondale Ward	Forensics	Forensics MH	20	92.4%	99.6%	88.2%	103.3%
Nightingale Ward	Forensics	Forensics MH	16	109.0%	86.0%	96.6%	101.7%
Sandpiper Ward	Forensics	Forensics MH	8	83.9%	113.9%	95.0%	144.3%
Swift Ward	Forensics	Forensics MH	10	92.8%	109.8%	97.8%	112.3%

Aysgarth	Teesside	LD	6	104.8%	138.9%	100.0%	100.0%
Bankfields Court Unit 2	Teesside	LD	8	112.3%	102.5%	100.2%	114.7%
Bankfields Court	Teesside	LD	18	101.4%	106.3%	104.2%	97.3%
Bek,Talbot Wards	Durham & Darlington	LD	16	89.3%	73.0%	100.0%	60.8%
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	101.4%	112.8%	100.0%	100.0%
Hamsterley Ward	Durham & Darlington	MHSOP	12	91.2%	136.1%	100.1%	98.3%
Oak Ward	Durham & Darlington	MHSOP	12	83.9%	98.9%	96.7%	100.0%
Picktree Ward.	Durham & Darlington	MHSOP	10	77.0%	137.7%	100.0%	100.0%
Roseberry Wards	Durham & Darlington	MHSOP	15	90.6%	93.4%	100.0%	100.0%
Rowan Lea	North Yorkshire	MHSOP	20	85.3%	116.8%	100.0%	102.2%
Rowan Ward	North Yorkshire	MHSOP	16	90.5%	132.2%	113.3%	101.7%
Springwood Community Unit	North Yorkshire	MHSOP	14	92.1%	99.5%	100.0%	146.6%
Ward 14	North Yorkshire	MHSOP	9	82.7%	119.5%	100.3%	100.3%
Westerdale North	Teesside	MHSOP	16	100.9%	126.3%	100.3%	99.0%
Westerdale South	Teesside	MHSOP	16	108.0%	293.6%	100.3%	209.8%
Wingfield Ward	Teesside	MHSOP	9	75.3%	108.9%	103.3%	98.5%
Meadowfields	York and Selby	MHSOP	18	90.4%	115.7%	106.9%	130.0%
Oak Rise	York and Selby	LD	8	117.6%	140.9%	100.0%	106.7%
White Horse View	York and Selby	LD	0	68.8%	52.7%	86.7%	86.7%
Worsley Court	York and Selby	MHSOP	14	103.7%	153.7%	114.8%	266.8%
Cherry Tree House	York and Selby	MHSOP	16	99.5%	139.1%	111.7%	214.3%

Appendix 2

April	TRUSTWIDE DAILY POSITION –all wards	
	Difference between what was planned on roster and actually worked – RNs	Difference between what was planned on roster and actually worked – HCAs
1	-11%	5%
2	-5%	7%
3	-7%	9%
4	-7%	13%
5	-6%	14%
6	-9%	16%
7	-8%	13%
8	-14%	11%
9	-7%	11%
10	-7%	14%
11	-7%	13%
12	-2%	12%
13	-3%	13%
14	-4%	14%
15	-5%	13%
16	-2%	12%
17	-7%	15%
18	-5%	13%
19	-2%	16%
20	-1%	14%
21	-2%	16%

22	-4%	12%
23	-5%	13%
24	-6%	17%
25	-4%	13%
26	1%	12%
27	-2%	15%
28	-3%	15%
29	-7%	14%
30	-3%	12%
31	0%	0%

Appendix 3

DURHAM & DARLINGTON LOCALITY REPORT - April 2016									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Birch Ward	15	805.5	360	1080	720	614.98	360	1216.5	960	76.3%	100.0%	112.6%	133.3%
Elm Ward	20	820.5	360	717.33	720	845.17	360	656.66	756	103.0%	100.0%	91.5%	105.0%
Maple Ward	20	872.33	360	693.66	720	938.25	360	628	732	107.6%	100.0%	90.5%	101.7%
Farnham Ward	20	831.5	360	684	720	800.33	386	684	744	96.3%	107.2%	100.0%	103.3%
Tunstall Ward	20	877.5	360	636	720	811.5	372	756	731.33	92.5%	103.3%	118.9%	101.6%
Willow Ward	15	776.5	360	552	720	810.17	360	990	720	104.3%	100.0%	179.3%	100.0%
Earlston House	0	142.5	60	96	120	91.5	48	96	96	64.2%	80.0%	100.0%	80.0%
Primrose Lodge	14	877.5	360	720	720	738	372	716.5	804	84.1%	103.3%	99.5%	111.7%
Holly Unit	5	332.27	199.5	405.13	199.5	430.07	209	548.02	237.5	129.4%	104.8%	135.3%	119.0%
Cedar Ward PICU	10	822	360	693	1068	886	384	1081	1679.33	107.8%	106.7%	156.0%	157.2%
Ceddesfeld Ward	10	877.5	360	637.5	720	889.67	360	719.33	720	101.4%	100.0%	112.8%	100.0%
Roseberry Wards	15	877.5	360	937.5	720	795.33	360	875.67	720	90.6%	100.0%	93.4%	100.0%
Oak Ward	12	859.73	360	720	720	721.73	348	711.97	720	83.9%	96.7%	98.9%	100.0%
Picktree Ward.	10	864.2	360	625.17	720	665.86	360	860.82	720	77.0%	100.0%	137.7%	100.0%
Hamsterley Ward	12	877.5	360	536.01	720	800	360.5	729.34	708	91.2%	100.1%	136.1%	98.3%
Bek,Talbot Wards	16	817.5	360	2832	1776	729.67	360	2066	1080	89.3%	100.0%	73.0%	60.8%

FORENSICS LOCALITY REPORT - April 2016									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Lark	15	831.5	337.5	941.25	675	778.72	337.5	1003.3	675	93.7%	100.0%	106.6%	100.0%
Brambling Ward	13	832.5	337.5	978.75	675	811.17	337.5	1037	675	97.4%	100.0%	106.0%	100.0%
Fulmar Ward.	10	823.25	337.5	1247.95	667	782.03	339.5	1278.75	680.25	95.0%	100.6%	102.5%	102.0%
Jay Ward	5	827.37	337.5	972.7	675	619.62	326.25	1108.44	663.75	74.9%	96.7%	114.0%	98.3%
Linnet Ward	17	811.42	337.25	976.75	675	500.92	337.67	1126.7	663.75	61.7%	100.1%	115.4%	98.3%
Mallard Ward	16	828.25	337.5	1247	675	804.75	360	1254.5	883.75	97.2%	106.7%	100.6%	130.9%
Mandarin	16	806.28	337.5	952.58	675	779.38	337.5	910	663.75	96.7%	100.0%	95.5%	98.3%
Merlin	10	828.13	675	1241.15	675	780.21	618.75	2093.4	1597.5	94.2%	91.7%	168.7%	236.7%
Newtondale Ward	20	832.5	668	1578.25	675	769.5	589.25	1572.25	697.5	92.4%	88.2%	99.6%	103.3%
Nightingale Ward	16	834	337.5	960.38	675	908.83	325.92	825.88	686.25	109.0%	96.6%	86.0%	101.7%
Sandpiper Ward	8	828.75	670.25	1567.95	668.25	695	636.5	1785.58	963.98	83.9%	95.0%	113.9%	144.3%
Swift Ward	10	828.25	333.73	1248.75	675	769	326.25	1371	758	92.8%	97.8%	109.8%	112.3%
Clover/Ivy	12	715.76	337.5	1857.5	675	746.11	361	2221.68	1114.01	104.2%	107.0%	119.6%	165.0%
Eagle/Osprey	10	744.5	337.5	1524.5	668	765.67	330.5	1478.58	652.5	102.8%	97.9%	97.0%	97.7%
Harrier/Hawk	10	776.75	337.5	1862.92	675	608	337.5	1918.5	675	78.3%	100.0%	103.0%	100.0%
Kestrel/Kite.	16	768	337.5	2059.08	675	592.5	337.5	2046.18	651.25	77.1%	100.0%	99.4%	96.5%
Robin	6	757	337.5	852	641.25	561.42	337.5	1101.75	652.5	74.2%	100.0%	129.3%	101.8%
Northdale Centre	12	832.37	337.5	2023.57	1338.75	728.71	294.25	2013.17	1274.75	87.5%	87.2%	99.5%	95.2%
Oakwood	8	832.5	337.5	337.5	337.5	728.5	326.25	446	337.5	87.5%	96.7%	132.1%	100.0%
Thistle	5	759.59	337.5	1189.5	675	582.02	337.5	1510.75	672	76.6%	100.0%	127.0%	99.6%

Langley Ward	10	832	337.5	863.5	337.5	670.59	341.5	1083.08	668.5	80.6%	101.2%	125.4%	198.1%

NORTH YORKSHIRE LOCALITY REPORT - April 2016									AMH	CAMHS	PICU	MHSOP	LD
WARD	**Bed Numbers**	**Planned RN - Days**	**Planned RN - Nights**	**Planned HCA - Days**	**Planned HCA - Nights**	**Actual Worked RN - Days**	**Actual Worked RN - Nights**	**Actual Worked HCA - Days**	**Actual Worked HCA - Nights**	**Fill Rate RN - Days**	**Fill Rate RN - Nights**	**Fill Rate - HCA Days**	**Fill Rate - HCA Nights**
Ayckbourn Unit Danby Ward	13	827	330	723	660	619.5	328.5	973.5	715	74.9%	99.5%	134.6%	108.3%
Ayckbourn Unit Esk Ward	13	933.5	330	730.5	660	943.5	330	727.5	660	101.1%	100.0%	99.6%	100.0%
Ward 15 Friarage	13	840	337.5	670.48	675	846.5	348.75	767.73	749	100.8%	103.3%	114.5%	111.0%
Cedar Ward (NY)	18	1037	322.5	952	958.5	1146.5	363.25	937.84	888.42	110.6%	112.6%	98.5%	92.7%
The Orchards (NY)	10	877.5	720	360	360	891.5	496.5	330	564	101.6%	69.0%	91.7%	156.7%
Newberry Centre	14	1243.4	285	1241.5	570	957.37	300	1538.1	601.84	77.0%	105.3%	123.9%	105.6%
Westwood Centre	12	1313	690	1356	689.48	1120.42	571.75	1832	838.98	85.3%	82.9%	135.1%	121.7%
The Evergreen Centre	12	1655.75	345	1381	1032.25	1663.95	378	1518.25	993.5	100.5%	109.6%	109.9%	96.2%
Rowan Lea	20	1024.41	349.1	1261.83	1050	873.45	349.1	1473.86	1073.34	85.3%	100.0%	116.8%	102.2%
Rowan Ward	16	945	360	720	720	855.5	408	952	732	90.5%	113.3%	132.2%	101.7%
Springwood Community Unit	14	920.5	337.5	898.75	675	848.17	337.5	894.18	989.25	92.1%	100.0%	99.5%	146.6%
Ward 14	9	844.25	337.5	528.75	675	698	338.5	631.75	677	82.7%	100.3%	119.5%	100.3%

TEESSIDE LOCALITY REPORT - April 2016										AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Bedale Ward	10	844	333.5	690	1023.5	809.5	354.5	1260.75	1282.5	95.9%	106.3%	182.7%	125.3%
Bilsdale Ward	14	847.5	345	678.5	690	889.5	448.5	716	608	105.0%	130.0%	105.5%	88.1%
Bransdale Ward	14	847.5	345	690	690	824.5	368	730.17	678.5	97.3%	106.7%	105.8%	98.3%
Lincoln Ward	20	810.5	375	1087	690	801.17	350	1149	747.5	98.8%	93.3%	105.7%	108.3%
Lustrum Vale	20	993.5	345	667	655.5	957.5	345	858.5	655.5	96.4%	100.0%	128.7%	100.0%
Overdale Ward	18	786.5	345	787.5	667	678.75	350	999.33	737	86.3%	101.4%	126.9%	110.5%
Stockdale Ward	18	847.5	345	846.5	690	800.5	353	922	696	94.5%	102.3%	108.9%	100.9%
Kirkdale Ward	16	832.5	337.5	1245.25	675	693.75	337.5	1247	663.75	83.3%	100.0%	100.1%	98.3%
Baysdale	6	461.68	335.1	935.5	669.9	568.85	336.85	927.28	669.65	123.2%	100.5%	99.1%	100.0%
Westerdale North	16	851	345	672.75	690	858.5	346	850	683	100.9%	100.3%	126.3%	99.0%
Westerdale South	16	793.75	345	686.93	667	857	346	2016.67	1399.5	108.0%	100.3%	293.6%	209.8%
Wingfield Ward	9	738	351	624	690	555.5	362.5	679.5	679.5	75.3%	103.3%	108.9%	98.5%
Aysgarth	6	509	300	800.5	300	533.67	300	1111.51	300	104.8%	100.0%	138.9%	100.0%
Bankfields Court Unit 2	8	522.67	300	1008.64	290	586.81	300.5	1033.65	332.5	112.3%	100.2%	102.5%	114.7%
Bankfields Court	18	1436.17	720	3560.33	2156.17	1455.56	750.5	3786.07	2097.66	101.4%	104.2%	106.3%	97.3%

YORK AND SELBY LOCALITY REPORT - April 2016									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Meadowfields	18	960.7	333	1222	660	868.73	356	1413.3	858	90.4%	106.9%	115.7%	130.0%
Oak Rise	8	898.75	322.5	894.25	645	1057.02	322.5	1260.06	688	117.6%	100.0%	140.9%	106.7%
White Horse View	0	899	322.5	1345	322.5	618.25	279.5	709	279.5	68.8%	86.7%	52.7%	86.7%
Worsley Court	14	819	330	1188	660	849	379	1826	1761	103.7%	114.8%	153.7%	266.8%
Cherry Tree House	16	823.8	330	1164	693	820	368.5	1618.96	1484.98	99.5%	111.7%	139.1%	214.3%

Appendix 4

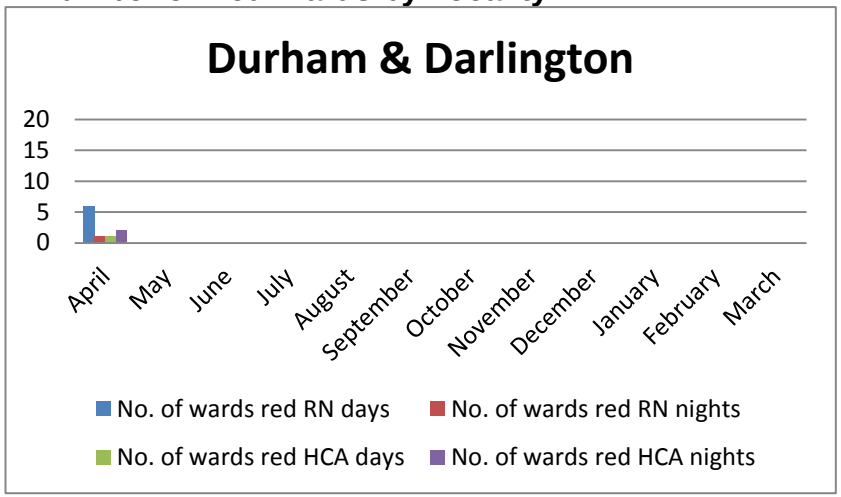
Month on Month Trend Analysis

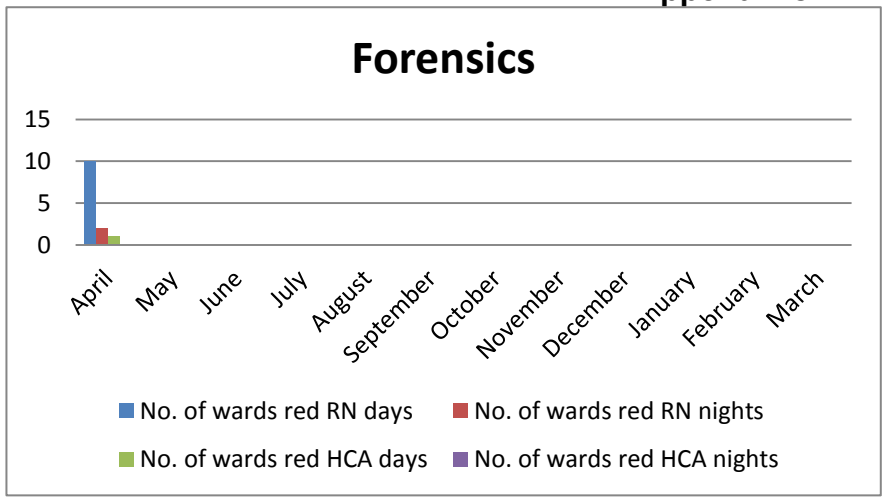
Month	Actual Submission							
	Day				Night			
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
Apr-15	93.12	↑	111.42	↑	101.19	↑	111.20	↑
May-15	93.00	↓	110.34	↓	102.27	↑	110.09	↓
Jun-15	93.12	↑	109.50	↓	100.62	↓	112.27	↑
Jul-15	90.80	↓	114.10	↑	99.40	↓	115.30	↑
Aug-15	87.90	↓	112.60	↓	98.10	↓	110.10	↓
Sep-15	90.3	↑	113.6	↑	98.20	↑	112.6	↑
Oct-15	89.8	↓	119.0	↑	99.01	↑	113.8	↑
Nov-15	90.72	↑	118.47	↓	96.82	↓	114.52	↑
Dec-15	87.70	↓	114.20	↓	96.60	↓	113.30	↓
Jan-16	88.60	↑	114.00	↓	96.40	↓	112.00	↓
Feb-16	88.80	↑	111.40	↓	95.30	↓	111.50	↓
Mar-16	86.70	↓	110.00	↓	97.00	↑	110.00	↓
Apr-16	92.90	↑	113.50	↑	99.60	↑	113.00	↑

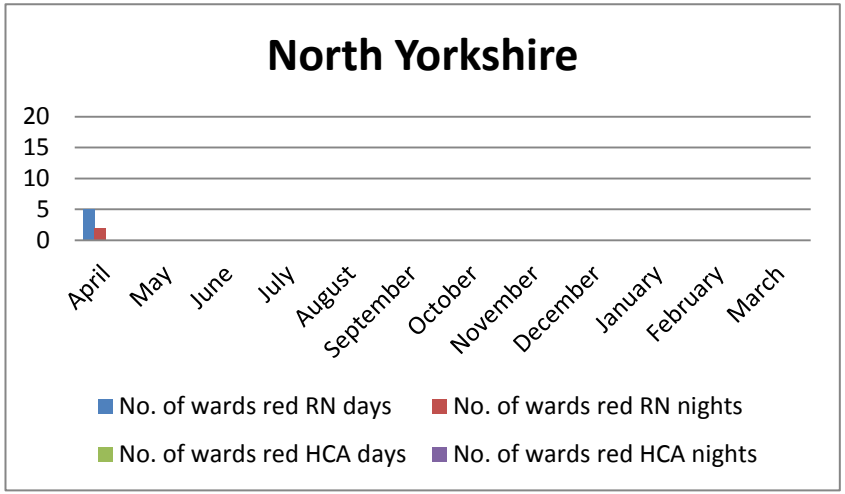
**** April 2016 fill rate now includes York and Selby**

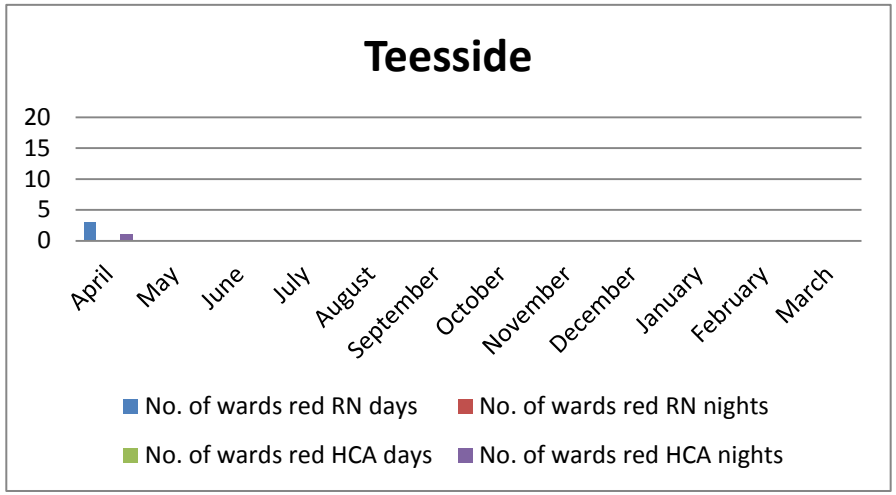
Number of Red Wards by Locality

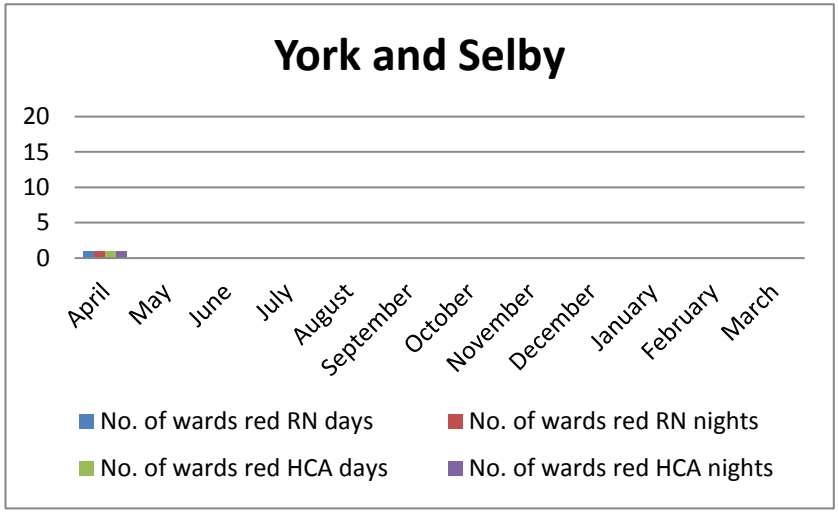
Appendix 5

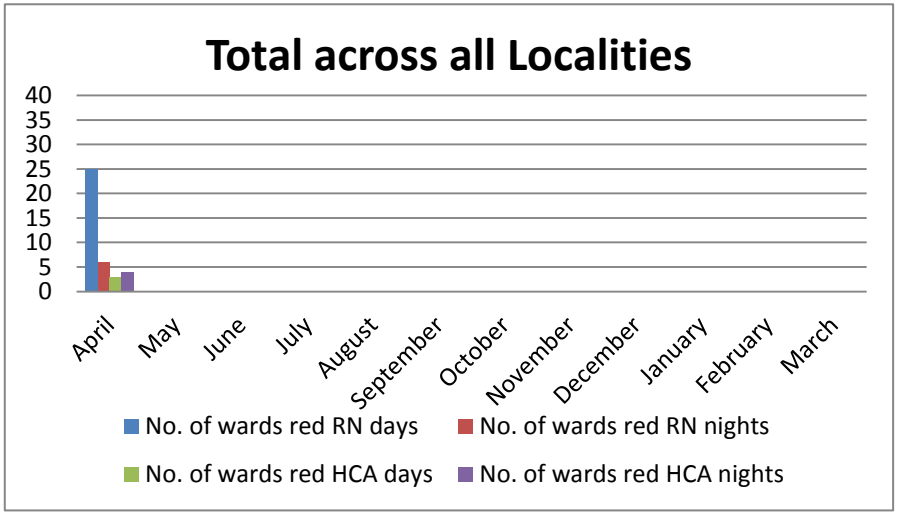









York and Selby
20
15
10
5
0
April
May
June
July
August
September
October
November
December
January
February
March
No. of wards red RN days
No. of wards red RN nights
No. of wards red HCA days
No. of wards red HCA nights


Total across all Localities
40
35
30
25
20
15
10
5
0
April
May
June
July
August
September
October
November
December
January
February
March
No. of wards red RN days
No. of wards red RN nights
No. of wards red HCA days
No. of wards red HCA nights

Appendix 6

Scored Fill Rate compared to Quality Indicators - APRIL 2016					Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers	Total score	Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI (TAKEN FROM IIC)	Level 4 Incidents (TAKEN FROM IIC)	Level 3 (Sen-Harm) Incidents (TAKEN FROM IIC)	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Aysgarth	Teesside	LD	6	9	2245.18	833	37%						1		4	4
Tunstall Ward	Durham & Darlington	AMH	20	8	2670.83	216	8%			3		4	1		2	2
Westerdale South	Teesside	MHSOP	16	10	4619.17	3118.84	68%						3		4	4
Bankfields Court Unit 2	Teesside	LD	8	8	2253.46	564.36	25%						1		1	1
Holly Unit	Durham & Darlington	CAMHS	5	8	1424.59	104.67	7%									
Lincoln Ward	Teesside	AMH	20	8	3047.67	236.5	8%	1		1			2		2	2
Westerdale North	Teesside	MHSOP	16	9	2737.5	200	7%					1	1		1	1
Westwood Centre	North Yorkshire	CAMHS Tier 4	12	8	4363.15	1215.5	28%					1	53	2	96	98
Farnham Ward	Durham & Darlington	AMH	20	8	2614.33	194.66	7%						4		5	5
Hamsterley Ward	Durham & Darlington	MHSOP	12	9	2597.84	606.01	23%						1		1	1
Mallard Ward	Forensics	FMH	16	9	3303	749.25	23%					2				
Rowan Ward	North Yorkshire	MHSOP	16	8	2947.5	624	21%						2		2	2
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	8	2689	256.5	10%						3		9	9
Elm Ward	Durham & Darlington	AMH	20	8	2617.83	384	15%			1	1		4	1	4	5
Stockdale Ward	Teesside	AMH	18	8	2771.5	869.5	31%						9	1	13	14
Northdale Centre	Forensics	FMH	12	6	4310.88	697.75	16%					1	5		8	8
Bedale Ward	Teesside	AMH	10	10	3707.25	1182.5	32%			1			36	1	60	61
Bek,Talbot Wards	Durham & Darlington	LD	16	5	4235.67	252.17	6%						4		6	6

Brambling Ward	Forensics	FMH	13	8	2860.67	403	14%									
Bransdale Ward	Teesside	AMH	14	8	2601.17	376.84	14%			1		1	1	1	2	3
Lustrum Vale	Teesside	AMH	20	9	2816.5	46	2%									
Bilsdale Ward	Teesside	AMH	14	8	2662	556	21%				1	1	2		3	3
Birch Ward	Durham & Darlington	AMH	15	8	3151.48	1272	40%									
Cedar Ward (NY)	North Yorkshire	AMH	18	8	3336.01	247	7%	1		1		1	20	2	31	33
Eagle/Osprey	Forensics	FLD	10	8	3227.25	371.5	12%									
Maple Ward	Durham & Darlington	AMH	20	8	2658.25	552	21%					2	3		7	7
Picktree Ward.	Durham & Darlington	MHSOP	10	8	2606.68	1075.67	41%						4		10	10
Primrose Lodge	Durham & Darlington	AMH	14	7	2630.5	60	2%									
Newberry Centre	North Yorkshire	CAMHS Tier 4	14	8	3397.31	204.51	6%			2		1	15		19	19
The Evergreen Centre	North Yorkshire	CAMHS Tier 4	12	8	4553.7	605.5	13%			1			59		95	95
Ward 14	North Yorkshire	MHSOP	9	5	2345.25	0	0%	1					4		6	6
Willow Ward	Durham & Darlington	AMH	15	9	2880.17	192	7%									
Baysdale	Teesside	CAMHS	6	9	2502.63	262.97	11%									
Langley Ward	Forensics	FLD	10	9	2763.67	1341	49%					2	2		1	1
Merlin	Forensics	FMH	10	10	5089.86	3205	63%					1	36	1	55	56
Oak Ward	Durham & Darlington	MHSOP	12	7	2501.7	135.83	5%									
Oakwood	Forensics	FLD	8	8	1838.25	155.5	8%									
Bankfields Court	Teesside	LD	18	8	8089.79	1154.38	14%						21	1	36	37
Cedar Ward	Durham & Darlington	AMH	10	10	4030.33	2814.66	70%					1	13	3	22	25
Fulmar Ward.	Forensics	FMH	10	8	3080.53	504.75	16%					1	3		3	3
Jay Ward	Forensics	FMH	5	7	2718.06	477.75	18%					1	1		1	1
Robin	Forensics	FLD	6	8	2653.17	1074	40%									
Nightingale Ward	Forensics	FMH	16	7	2746.88	639.5	23%									
Sandpiper Ward	Forensics	FMH	8	8	4081.06	1481.71	36%					2	15		37	37

Springwood Community Unit	North Yorkshire	MHSOP	14	9	3069.1	631.75	21%						39		40	40
Thistle	Forensics	FLD	5	8	3102.27	661.75	21%					1	2		2	2
Ward 15 Friarage	North Yorkshire	AMH	13	8	2711.98	354.5	13%						5		6	6
Overdale Ward	Teesside	AMH	18	8	2765.08	222.16	8%			2		2	1		2	2
Linnet Ward	Forensics	FMH	17	7	2629.04	1161.75	44%						1		1	1
Swift Ward	Forensics	FMH	10	8	3224.25	542.75	17%						9		13	13
Ayckbourn Unit Esk Ward	North Yorkshire	AMH	13	8	2661	158	6%	1	1			1	9		15	15
Ayckbourn Unit Danby Ward	North Yorkshire	AMH	13	8	2636.5	747.5	28%									
Clover/Ivy	Forensics	FLD	12	7	4442.8	1638.95	37%						2		5	5
Kirkdale Ward	Forensics	FMH	16	7	2942	255	9%									
Roseberry Wards	Durham & Darlington	MHSOP	15	8	2751	401.67	15%						2		2	2
Lark	Forensics	FMH	15	8	2794.52	598.5	21%					2				
Wingfield Ward	Teesside	MHSOP	9	7	2277	277.5	12%						1		2	2
Kestrel/Kite.	Forensics	FLD	16	7	3627.43	1185.08	33%					1	2		5	5
The Orchards (NY)	North Yorkshire	AMH	10	8	2282	120	5%									
Mandarin	Forensics	FMH	16	8	2690.63	651.25	24%					3	1		1	1
Rowan Lea	North Yorkshire	MHSOP	20	7	3769.75	214.2	6%				1		12		21	21
Newtondale Ward	Forensics	FMH	20	7	3628.5	540.25	15%					1				
Harrier/Hawk	Forensics	FLD	10	7	3539	596.5	17%						1		1	1
Meadowfields	York & Selby	MHSOP	18	9	3496.03	255.5	7%					1	4		5	5
Oak Rise	York & Selby	LD	8	9	3327.58	357	11%						1		1	1
White Horse View	York & Selby	LD	0	4	1886.25	47	2%									
Worsley Court	York & Selby	MHSOP	14	10	4815	242	5%					2	1		1	1
Cherry Tree House	York & Selby	MHSOP	16	10	3790.94	1039	27%					1	1		1	1
AMH IP BPH Ward 2 Male	York & Selby										1					

Appendix 7

Staffing fill rate and Number of shifts whereby a Break has not ben given

WARD	Locality	Speciality	DAY			NIGHT		
			FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	NUMBER OF SHIFTS WHEREBY A BREAK HAS NOT BEEN GIVEN	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	NUMBER OF SHIFTS WHEREBY A BREAK HAS NOT BEEN GIVEN
The Orchards (NY)	North Yorkshire	Adults	101.6%	91.7%	130	69.0%	156.7%	60
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	74.9%	134.6%	1	99.5%	108.3%	0
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	101.1%	99.6%	0	100.0%	100.0%	0
Bedale Ward	Teesside	Adults	95.9%	182.7%	1	106.3%	125.3%	8
Bilsdale Ward	Teesside	Adults	105.0%	105.5%	4	130.0%	88.1%	3
Birch Ward	Durham & Darlington	Adults	76.3%	112.6%	0	100.0%	133.3%	0
Bransdale Ward	Teesside	Adults	97.3%	105.8%	1	106.7%	98.3%	0
Cedar Ward	Durham & Darlington	Adults	107.8%	156.0%	0	106.7%	157.2%	0
Cedar Ward (NY)	North Yorkshire	Adults	110.6%	98.5%	38	112.6%	92.7%	13
Earlston House	Durham & Darlington	Adults	64.2%	100.0%	0	80.0%	80.0%	0
Elm Ward	Durham & Darlington	Adults	103.0%	91.5%	0	100.0%	105.0%	0
Farnham Ward	Durham & Darlington	Adults	96.3%	100.0%	0	107.2%	103.3%	0
Kirkdale Ward	Teesside	Adults	83.3%	100.1%	0	100.0%	98.3%	0
Lincoln Ward	Teesside	Adults	98.8%	105.7%	13	93.3%	108.3%	3
Lustrum Vale	Teesside	Adults	96.4%	128.7%	0	100.0%	100.0%	0

Maple Ward	Durham & Darlington	Adults	107.6%	90.5%	3	100.0%	101.7%	0
Overdale Ward	Teesside	Adults	86.3%	126.9%	4	101.4%	110.5%	3
Park House	Teesside	Adults	0.0%	0.0%	0	0.0%	0.0%	0
Primrose Lodge	Durham & Darlington	Adults	84.1%	99.5%	0	103.3%	111.7%	0
Stockdale Ward	Teesside	Adults	94.5%	108.9%	7	102.3%	100.9%	11
Tunstall Ward	Durham & Darlington	Adults	92.5%	118.9%	0	103.3%	101.6%	0
Ward 15 Friarage	North Yorkshire	Adults	100.8%	114.5%	8	103.3%	111.0%	2
Willow Ward	Durham & Darlington	Adults	104.3%	179.3%	0	100.0%	100.0%	0
Baysdale	Teesside	CYPS	123.2%	99.1%	40	100.5%	100.0%	0
Holly Unit	Durham & Darlington	CYPS	129.4%	135.3%	4	104.8%	119.0%	0
Newberry Centre	North Yorkshire	CYPS	77.0%	123.9%	29	105.3%	105.6%	34
The Evergreen Centre	North Yorkshire	CYPS	100.5%	109.9%	10	109.6%	96.2%	9
Westwood Centre	North Yorkshire	CYPS	85.3%	135.1%	7	82.9%	121.7%	10
Clover/Ivy	Forensics	Forensics LD	104.2%	119.6%	3	107.0%	165.0%	0
Eagle/Osprey	Forensics	Forensics LD	102.8%	97.0%	3	97.9%	97.7%	0
Harrier/Hawk	Forensics	Forensics LD	78.3%	103.0%	3	100.0%	100.0%	0
Kestrel/Kite.	Forensics	Forensics LD	77.1%	99.4%	1	100.0%	96.5%	0
Robin	Forensics	Forensics LD	74.2%	129.3%	0	100.0%	101.8%	0
Langley Ward	Forensics	Forensics LD	80.6%	125.4%	2	101.2%	198.1%	4
Northdale Centre	Forensics	Forensics LD	87.5%	99.5%	14	87.2%	95.2%	0
Oakwood	Forensics	Forensics LD	87.5%	132.1%	2	96.7%	100.0%	0
Thistle	Forensics	Forensics LD	76.6%	127.0%	1	100.0%	99.6%	0
Brambling Ward	Forensics	Forensics MH	97.4%	106.0%	0	100.0%	100.0%	0
Fulmar Ward.	Forensics	Forensics MH	95.0%	102.5%	16	100.6%	102.0%	4
Jay Ward	Forensics	Forensics MH	74.9%	114.0%	1	96.7%	98.3%	0
Lark	Forensics	Forensics MH	93.7%	106.6%	2	100.0%	100.0%	0
Linnet Ward	Forensics	Forensics MH	61.7%	115.4%	1	100.1%	98.3%	0

Mallard Ward	Forensics	Forensics MH	97.2%	100.6%	5	106.7%	130.9%	0
Mandarin	Forensics	Forensics MH	96.7%	95.5%	2	100.0%	98.3%	0
Merlin	Forensics	Forensics MH	94.2%	168.7%	7	91.7%	236.7%	0
Newtondale Ward	Forensics	Forensics MH	92.4%	99.6%	6	88.2%	103.3%	0
Nightingale Ward	Forensics	Forensics MH	109.0%	86.0%	4	96.6%	101.7%	0
Sandpiper Ward	Forensics	Forensics MH	83.9%	113.9%	1	95.0%	144.3%	0
Swift Ward	Forensics	Forensics MH	92.8%	109.8%	18	97.8%	112.3%	0
Aysgarth	Teesside	LD	104.8%	138.9%	130	100.0%	100.0%	60
Bankfields Court Unit 2	Teesside	LD	112.3%	102.5%	121	100.2%	114.7%	2
Bankfields Court	Teesside	LD	101.4%	106.3%	5	104.2%	97.3%	0
Bek,Talbot Wards	Durham & Darlington	LD	89.3%	73.0%	1	100.0%	60.8%	0
Ceddesfeld Ward	Durham & Darlington	MHSOP	101.4%	112.8%	1	100.0%	100.0%	0
Hamsterley Ward	Durham & Darlington	MHSOP	91.2%	136.1%	0	100.1%	98.3%	0
Oak Ward	Durham & Darlington	MHSOP	83.9%	98.9%	2	96.7%	100.0%	0
Picktree Ward.	Durham & Darlington	MHSOP	77.0%	137.7%	1	100.0%	100.0%	0
Roseberry Wards	Durham & Darlington	MHSOP	90.6%	93.4%	3	100.0%	100.0%	0
Rowan Lea	North Yorkshire	MHSOP	85.3%	116.8%	8	100.0%	102.2%	0
Rowan Ward	North Yorkshire	MHSOP	90.5%	132.2%	0	113.3%	101.7%	0
Springwood Community Unit	North Yorkshire	MHSOP	92.1%	99.5%	0	100.0%	146.6%	0
Ward 14	North Yorkshire	MHSOP	82.7%	119.5%	0	100.3%	100.3%	3
Westerdale North	Teesside	MHSOP	100.9%	126.3%	5	100.3%	99.0%	4
Westerdale South	Teesside	MHSOP	108.0%	293.6%	5	100.3%	209.8%	4
Wingfield Ward	Teesside	MHSOP	75.3%	108.9%	7	103.3%	98.5%	2
Meadowfields	York and Selby	MHSOP	90.4%	115.7%	5	106.9%	130.0%	26
Oak Rise	York and Selby	LD	117.6%	140.9%	291	100.0%	106.7%	94
White Horse View	York and Selby	LD	68.8%	52.7%	Not Avail	86.7%	86.7%	Not Avail

Worsley Court	York and Selby	MHSOP	**103.7%**	**153.7%**	0	**114.8%**	**266.8%**	0
Cherry Tree House	York and Selby	MHSOP	**99.5%**	**139.1%**	0	**111.7%**	**214.3%**	0

ITEM NO. 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 24 May 2016**
TITLE:	**To consider the report of the Mental Health Legislation Committee**
REPORT OF:	**Richard Simpson, Non-Executive Director**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 4, 2015-16.

Recommendations:

The Board of Directors is asked to receive and note the assurance report and conclusions

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 24 May 2016**
TITLE:	**To consider the report of the Mental Health Legislation Committee**

1. INTRODUCTION & PURPOSE:

1.1 To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 4, 2015-16; through consideration of the work of the Mental Health Legislation Committee, which is a Standing Committee of the Board.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The background to the purpose of this report is held at Appendix 1.

3. KEY ISSUES:

At the meeting held on 25 April 2016

3.1 The minutes of the Committee meeting held on 25 January 2016 were reviewed and agreed as an accurate record. (See Appendix 2 for information).

3.2 It was noted from the summary report for CQC MHA inspections that there were 10 visits in the quarter compared to 16 in the previous quarter. There were 3 to AMH, 3 to MHSOP 3 to Forensic services (MH and LD) and 1 to LD services. Of the 10 visits, reports had been received for 9 of them and the report for Springwood was awaited. The visit to Westerdale North resulted in no issues identified. Some gaps in the reiteration of patients' rights under section 132 were identified and also some issues around the absence of RCs assessments of capacity regarding medication. Where issues were raised, all completed Provider Action Statements have been approved by EMT and returned to CQC

3.3 The Section 136 report was presented. In total there were 183 uses of section 136 across the whole Trust area (a slight decrease again this quarter from 186 in the previous quarter) of which 164 (90%) were brought to a MHBPOS. Cleveland Police total use of section 136 has decreased by 1.5% compared with the previous quarter and appears to have plateaued; use of section 136 across North Yorkshire has decreased slightly in comparison to last quarter by 4.5% and those taken to a Trust place of safety in North Yorkshire is 85%. Within Durham and Darlington the numbers are relatively static though use of the police station has increased from 6% to 14% though the numbers are still small. North Yorkshire total use of section 136 is now 31% higher than Cleveland Police

In terms of Street Triage activity there were 111 contacts in the quarter in Teesside compared to 146 in the previous quarter, of which 0 resulted in the use of section 136, and in York there were 57 contacts of which 1 resulted in

the use of section 136. Scarborough information was not available at the time of reporting.

Within the Crisis Assessment Suite at Roseberry Park activity continues to be significant with 577 assessments compared to 481 assessments undertaken in the previous quarter, however the quarter prior to that was 597 (this does not include those assessed subject to section 136). The numbers attending 'voluntarily' with the police and not subject to section 136 continues to be high and far exceeds the number subject to section 136 – in the quarter there were 194 attending voluntarily with the police compared to 61 brought subject to section 136. Of the total 577 assessments 73, approximately 13%, were discharged without mental health follow up or sign-posting to other services.

3.4 There is no seclusion report for this quarter as we are awaiting the production of a report by the Information Team to enable the extraction of the data from Paris since the recording of seclusion became part of the electronic care record and no longer a manual record.

3.5 The Discharge from Detention Report was presented. This report focusses on discharge from detention by either the First Tier Tribunal or the Associate Hospital Managers. No patients were discharged by the Hospital Managers this quarter. Of the FTTs held the Tribunal ordered 7 absolute discharges and 1 deferred discharge (5 of which were subject to section 2, 2 subject to section 3 and 1 CTO). None of the patients had the same RC or Care Coordinator. 4 patients remained informally for several days following discharge from detention. None have been re-admitted to date.

3.6 The CQUIN relating to Avoidable Mental Health Act Detentions was discussed and the suggested parameters proposed. These have been reviewed since the Committee and following some clarity from the CCGs. The CQUIN will include all those within services across all localities over the age of 18 years, including LD and MHSOP services but excluding Forensic MH and LD, who have been detained on multiple occasions subject to Sections 2 and 3 over the past 2 years dating back from 31 March 2016. The Committee will be updated periodically on the progress of the CQUIN.

3.7 The Policing and Crime Bill is currently progressing through parliament and one of the areas within it is 'to amend the powers of the police under the Mental Health Act 1983'. The key changes are:

- to reduce the amount of time a section 136 can be in place from 72 hours to 24 hours with the ability to extend by a further 12 hours in specific circumstances
- to remain at a private dwelling as a place of safety to conduct the assessment when a section 135(1) warrant is executed if it is agreed as a 'suitable place' on application of set criteria

- removal of the requirement to be found in a place to which the public have access for section 136 purposes (other than private dwellings) and to provide a power of entry
- to prohibit the use of police stations as places of safety for those aged under 18 years
- to set down in regulations when an adult can be taken to a police station as a place of safety and make arrangements with regard to the review of their detention there
- requirement for police to consult, where practicable, with a doctor, nurse, AMHP or other before using powers under s136

The Trust prepared a response to the request for views in the consultation stage of the Bill which included a proposal to amend Section 136(2) to state the purpose of s136 as …. *enabling examination by a Section 12(2) approved registered medical practitioner and interview by an appropriately qualified and registered professional, or AMHP, and of making any necessary arrangements for treatment or care. Where the RMP examination and registered professional interview indicates that admission to hospital is required, the person must also be interviewed by an AMHP.*

This would remove the necessity for every section 136 detainee to be interviewed by an AMHP which can cause significant delays, particularly out of hours, and would still allow for necessary follow-up to be arranged. Unfortunately the consultation closed early on 12th April instead of 14th April and the Trust submission was too late, the Committee are exploring alternative means of having our response considered.

4. IMPLICATIONS:

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

4.2 **Financial/Value for Money:**
No implications.

4.3 **Legal and Constitutional (including the NHS Constitution):**
Non-compliance with the CQC regulatory framework for the Mental Health Act and Mental Capacity Act and DoLS and/or non-compliance with the MHA or MCA itself would have serious consequences for the organisation and place the organisation at risk of breach of the conditions of the Independent Regulators or potential litigation.

4.4 **Equality and Diversity:**
No implications.

6. CONCLUSIONS:

At their meeting in April 2016, the MHL Committee received reports and evidence for assurance on all elements of the Mental Health Act administration and implementation, demonstrating compliance with CQC regulatory requirements. This assurance is externally supported by the feedback from the CQC Mental Health Act inspections.

7. RECOMMENDATIONS:

The Board of Directors is asked to receive and note the assurance report and conclusions.

Author: Mel Wilkinson
Title: Head of Mental Health Legislation

Background Papers:
Appendix 1 – Background Information
Appendix 2 – Approved minutes of the 25 January 2016 MHL Committee Meeting

Appendix 1

Background Information

The Mental Health Act 1983 is the primary legislation that directs and regulates the management, including the assessment and treatment under compulsion, of those whose mental disorders may cause risk to their own health or safety or where the protection of others is necessary.

The Mental Capacity Act 2005 is the primary legislation which provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. This includes decisions around care and treatment, accommodation and financial matters. Within Schedule 1 of the Mental Capacity Act are the Deprivation of Liberty Safeguards (DoLS) which further allow for people who lack capacity to be deprived of their liberty in order to provide care and treatment in their best interests.

The Board of Directors, who may be defined as the Hospital Managers for the purposes of the Act, require assurance that the Trust is compliant with Mental Health Act legislation and regulation. Following the implementation of the Trust Integrated Assurance Framework in 2008, the Mental Health Act Committee was approved as a Standing Committee of, and directly accountable to, the Board of Directors. The quarterly committee is chaired by a non-executive director and the committee receive regular themed performance reports from the corporate Mental Health Legislation administrative team.

The Trust is registered with the CQC for the regulated activity of 'Assessment or medical treatment for persons detained under the 1983 Act'. CQC therefore have a programme of regulatory inspection visits to areas with detained patients and to community teams to assess compliance with the Essential Standards that apply to that regulated activity. Those inspections also feedback intelligence into the CQC compliance processes for all Essential Standards further to observations in clinical areas. Since the review of the MHL Committee in April all reports, including the MHA specific visit reports, are now received and managed by the CQC Registration and Assurance Team.

In addition any areas of concern relating to detained patients or issues related to implementation of the Act are brought to the Committee. Quarterly assurance reports are made to the Board of Directors and forwarded to the Quality and Assurance committee for information in relation to monitoring of CQC registration compliance.

Appendix 2

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 25 JANUARY 2016 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 11.00AM.

Present:
Mrs L Bessant, Chairman of the Trust
Mr R Simpson, Non-Executive Director, (Chairman of the Committee)
Dr N Land, Medical Director
Mrs E Moody, Director of Nursing and Governance

In Attendance:
Ms P Griffin, Mental Health Legislation Advisor
Mrs J Illingworth, Director of Quality Governance
Dr H Griffiths, Non-Executive Director
Mrs D Oliver, Deputy Trust Secretary, (Corporate)
Miss Zoe Sherry, Public Governor, Hartlepool
Miss M Wilkinson, Head of Mental Health Legislation
Mr K Marsden, Public governor

Apologies: Apologies for absence were received from Mr B Kilmurray, Chief Operating Officer and Miss J Clark, Public Governor.

16/01 MINUTES

Agreed – *That the minutes of the last meeting held on 26 October 2015, be approved as a correct record and signed by the Chairman, subject to a minor typographical error on page 3, 15/30 (4), which should have read, "it was interesting to note the significant dip in December* ***2014****…"*

16/02 ACTION LOG

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

15/29	"CQC feedback summary report to show ward areas against the number of actions outlined in the action plan". **Completed**
15/30(4)	"Relevant issues or anomalies in the Health & Social Care Information Centre (HSCIC) report to be brought back to the MHL Committee". No anomalies had been found in the HSCIC report. **Completed**
15/30(d)	"Update around funding for street triage to come back to the MHL Committee following a discussion with Commissioners". Due to apologies from Mr B Kilmurray, this update would be brought back to the April 2016 MHLC meeting
15/34	"Recording capacity assessments – change in practice to be communicated to Modern Matrons and to be added to the mock CQC visit template". This had been added to the Modern Matrons meeting agenda and Dr N Land had also communicated this to medical staff.

Completed

16/03 CARE QUALITY COMMISSION (CQC) FEEDBACK SUMMARY REPORT: 1 October 2015 to 31 December 2015

The Committee considered and noted the Care Quality Commission (MHA) visit feedback summary report for the period 1 October to 31 December 2015.

Arising from the report it was noted that:

1. There had been 16 visits to the Trust in the last quarter, compared to 13 visits in July to September 2015.
2. There had been visits to 5 Mental Health Services, 2 to Mental Health Services for older people, 7 to Forensic MH, including LD Forensics, 1 to Learning Disability Services and 1 to Children & Young Peoples Services.
3. There had been 3 reports from the CQC for Harland, White Horse View and Barnsdale with no issues raised.
4. There had been 52 issues raised in total from the 12 reports received from the CQC, with 4 issues raised by patients.

Following discussion it was noted that:

i) There had been 3 visits to York & Selby.
ii) The CQC had picked up on some staff not trained around amendments to the Code of Practice.
On this matter Miss Wilkinson gave assurance that updates on the Code of Practice had been issued to all wards and all staff would be trained by the end of the financial year.
Mrs E Moody would also add this to forthcoming discussions with Matrons and Ward Managers.

Action: Mrs E Moody

iii) The issue of signage about the presence of CCTV had recurred, however the Trust did not feel that such notices should be displayed on every door in patient areas and wards. This had also been raised at EMT.
iv) Assurance was given to the Committee that there had been no recurrent themes in the 52 points raised by the CQC and that the numbers of reports with no issues picked up by the CQC had increased.
v) Ward Managers were working hard to ensure that basic errors, which had been picked up by the CQC, for example not signing leave forms, did not reoccur.
On this matter it was noted that with the introduction of a new module on PARIS, (date yet to be confirmed), basic errors would reduce further.

16/04 MHA PERFORMANCE REPORTS

The Committee considered and noted the Section 136 report.

Arising from the report it was highlighted that:

1. The number of individuals being taken under Section 136 by Cleveland Police to a place of safety, in both a police station and TEWV had decreased by approximately 29%, compared with the previous quarter.
2. Those taken to a place of safety in North Yorkshire had significantly increased by approximately 69%.

3. 11 individuals under the age of 18 had been brought to TEWV under Section 136, 1 of whom had been brought on 5 separate occasions, 10 had been discharged and followed up with assessment, 1 was admitted to an inpatient ward informally and 1 detained in the C&YPS.

Arising from discussion it was noted that:

i) The decrease in individuals going into police custody could be due to police training, however it was not clear.
On this matter it was felt that it would be useful to look at the overall rates, compared to the same time in 2015.

Action: Ms P Griffin

ii) The numbers of individuals presenting under the age of 18 had increased, with the highest numbers ever reported. It was unclear whether this had been linked to the Christmas 2015 period. These numbers would be presented in the next Section 136 report.

Action: Ms P Griffin

iii) It had been anticipated that there would be an increase of individuals presenting at the newly opened Section 136 Suite in York, however there had only been 3. Additional resources had been put into street triage in York and these figures would be included in the next Section 136 report.

Action: Ms P Griffin

The Committee considered and noted the MHA Discharges Report.

Arising from the report it was noted that:

1. There had been 178 meetings held in the Quarter with 1 patient discharged.
2. In the Quarter there had been 7 patients discharged following a First-tier Tribunal with 1 conditional discharge, on agreement by the clinical team and 1 deferred discharge.
3. Evidence revealed that the Trust had been providing comprehensive reports and giving good clear evidence around any reasons for recommending continued detention.
4. There was no pattern to support a view that patients discharged by the Tribunal were disadvantaged in any way due to the clinical team in charge of their care and the average number of those discharged, (8%) which was below the national average of 10%.

Arising from discussion it was noted that this report had been presented to the MHL Committee to look for any emerging patterns, which over the last 18 months had not revealed anything significant.

Committee members agreed that this report was still of interest and would continue to be presented quarterly to the MHL Committee.

16/05 DEPARTMENT OF HEALTH (DOH) RESPONSE TO THE LAW COMMISSION'S CONSULTATION ON MENTAL HEALTH CAPACITY AND DEPRIVIATION OF LIBERTY

The Committee noted the DOH response to the Law Commission's Consultation on Mental Capacity and Deprivation of Liberty.

Miss Wilkinson highlighted that:

1. The response from the Department of Health had been circulated to Committee members for awareness that the DOH was not necessarily in favour of all the proposals contained in the Consultation document.
2. Most colleagues working in DOLs were finding that matters were being further complicated rather than being simpler.
3. The Consultation document on Mental Health Capacity and Deprivation of Liberty would now be re-drafted by the Law Commission and would be brought back to the MHL Committee in summer 2016.

16/06 AUDIT REPORT – MENTAL HEALTH ACT COMPLIANCE 2015/16

The Committee considered and noted the outcome of the draft report from Audit North undertaken around Trust compliance with the Mental Health Act and Code of Practice compliance.

Miss Wilkinson highlighted the following:

1. Audit North had undertaken a high level review of the overall arrangements and assurance mechanisms in place to ensure compliance with the Mental Health Act and Code of Practice.
2. Audit North had found significant assurance that the overall arrangements for ensuring compliance were being adequately met by the Trust, with only 1 issue arising around the lack of a formal Standard Operating procedure in place to outline the arrangements in place.
   On this matter it had been pointed out to Audit North that the Standard Operating Procedure was currently being developed and therefore t this matter would not be a formal recommendation by Audit North.

Following discussion it was noted that there had only been 3 patient case files picked for review and reconciliation from the PARIS system, (page 7 of the report) which was felt to be quite a low number. This would be raised at the next Audit Committee meeting on 12 May 2016.

Action: Mr R Simpson

16/07 UPDATE ON YORK AND SELBY

Miss Wilkinson gave a verbal update on York & Selby and highlighted the following:

1. Recruitment was underway to appoint staff in the York & Selby Mental Health team; however in the interim period Ms Griffin had been covering 3 days per week at the York office.
2. Assurance was given that all documents and files were now in order and the issues around the paperwork on detained patients had now been resolved.
3. There were ongoing issues around the lack of information, due to the different system in York, however the roll out of PARIS was expected shortly to bring York onto the same system as the rest of the Trust.
4. Links were being made with clinical teams and relationships were being developed.
5. The number of detained patients in York & Selby was high, at 60, given that they did not have acute inpatient services.

16/08 ANY OTHER BUSINESS

Dr Land briefed the Committee members on the issue around medical escorts for patients.

1. Under the amended Code of Practice AMPHs could no longer escort a patient to hospital in their own vehicle. Should a private vehicle be in use then a medical doctor had to be present.
2. The Committee felt that there should be clearer definition by the Department of Health on what was meant by a "medical escort" and whether this meant a trained mental health professional. Miss Wilkinson would contact the DOH for further clarity.

Action: Miss M Wilkinson

Arising from discussion it was noted that:

i) Following a recent coroner's inquest York and Leeds Foundation Trust had undertaken some work around developing guidance on the transportation of patients. NHS England were currently looking at this issue and a copy of the guidance had been requested.

The meeting concluded at 1.10pm

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Richard Simpson
Chairman – Mental Health Legislation Committee
25 January 2016

ITEM NO 10.

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24TH MAY 2016**
TITLE:	**Composite Staff Action Plan**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Decision**

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

Executive Summary:

This report provides Directors with information about progress made with implementing the current Composite Staff Action Plan and locality action plans and proposes a new Composite Staff Action Plan in response to the Trusts 2015 staff opinion survey results and Staff Friends and Family test results.
Overall good progress has been made during the last twelve months though the proposed plan includes more actions than the plan agreed by Directors last year.

Recommendations:

(1) To note the contents of the report and to comment accordingly.
(2) To endorse the proposed Composite Staff Action Plan subject to any change being made by Directors.
(3) To receive a progress report at the November 2016 meeting.

MEETING OF:	**Board of Directors**
DATE:	**24th May 2016**
TITLE:	**Composite Staff Action Plan**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide Directors with an update about progress made with completion of the current Staff Feedback Action Plan and a summary of locality action plans progress (Appendix 1). A proposed Trust action plan in response to the 2015 annual staff survey opinion results and the last three Staff Friends and Family Test results and the 2014 Investors in People assessment report (Appendix 2) is attached.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The current Composite Staff Action Plan was agreed by Directors in May 2015 and an update about progress made with implementation was provided at the November 2015 meeting.

3. KEY ISSUES:

3.1 Good progress has been made with completion of the current action plan (Appendix 1) with 40 of the 46 actions being completed (87%). The outstanding actions will be addressed in the coming year. The delays in completion that have been experienced can be attributed to either workload demands or decisions being made independently of the action plan that have had the effect of changing some completion timescales.

3.2 The amount of progress made by localities and corporate directorates with implementing local action plans during 2015/16 has been encouraging with 91% of actions completed.

3.3 The draft Trust Composite Staff Action Plan 2016/17 (Appendix 2) has been put together in response to the 2015 annual staff opinion survey, the last three Staff Friends and Family Test results and the 2014 Investors in People assessment report. The plan includes a total of 57 actions arising from 9 themes. The new themes in the plan include staff reporting errors, incidents and near misses, reducing work related stress, work pressure, senior management visibility and pursuing a more age friendly approach to employment. Though the Trust recently won a national award for its Staff Friends and Family Test work it is believed that more can be done to improve the approach taken and that the issue of Investors in People re-accreditation, due in the latter half of 2017, needs to be addressed during 2016/17.

3.4 The Investors in People Leads have continued to provide valuable locality and corporate directorate input into the production of the draft Composite Staff Action Plan. Localities and corporate directorates continue to develop their

own 2016/17 action plans and these are expected to be completed next month.

3.5 The intention is to provide Directors with an update about progress made with both the Trust Composite Staff Action Plan and locality and corporate directorate actions plans at the November 2015 meeting.

3.6 A review of the Trust staff survey results from 2010 to 2015 highlights that progressively fewer key findings can be compared year on year throughout this period due to frequent changes in the composition of the key findings. The following key finding trends from 2010 to 2015 can be observed:

I) That during each of the last four years between 68% and 69% of staff have worked extra hours compared to 60% (2010) and 62% (2011).
2) That the increase in the number of staff completing appraisals in the last four years (94% in 2015) has been sustained and compares to previous rates of 80% in 2010 and 83% in 2011.
3) That support from immediate line managers has improved steadily throughout the last six years from 3.80 (out of 5) in 2010 to 4.03 in 2015.
4) The percentage of staff suffering work related stress has fluctuated appreciably during the last six years. The latest rate of 28% is the lowest during the last six years and compares to a previous high of 425 (20120 and a previous low of 29% (2011).
5) The percentage of staff experiencing physical violence from patients, relatives or the public has been between 21% and 23% in every year except for 2011 when the rate fell to 16%.
6) The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public increased from 17% and 15% in 2010 and 2011 respectively to between 28% and 30% in each of the last four years.
7) The percentage of staff able to contribute towards improvements at work has increased from 68% and 67% in 2010 and 2011 respectively to between 77% and 79% in each of the last four years.
8) The proportion of staff who would recommend the Trust as a place to work and receive treatment improved in 2011 and 2012 and has remained largely unchanged during the last three years.
9) The percentage of staff believing that the Trust provides equal opportunities for career progression and promotion is now at its lowest rate for the six years reporting period from a high of 96% in 2010 to the current rate of 92%.
10) The percentage of staff experiencing discrimination at work was 11% in 2010 and has been either 8% or 9% each year thereafter.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The proposed action plan will assist efforts to ensure continuing compliance with the various CQC workforce regulations.

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

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

4.4 **Equality and Diversity:** The need to continue to address the disparity in the experiences of disabled and BAME staff remains a subject of particular attention.

4.4 **Other implications:** None identified.

5. RISKS: None identified.

6. CONCLUSIONS:

6.1 Good progress has been made with completing the current Trust and locality action plans. The proposed Composite Staff Action Plan addresses nine themes and includes some fifty seven actions compared to the previous plan that addressed eight themes and included forty three actions.

7. RECOMMENDATIONS:

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

7.2 To endorse the proposed Composite Staff Action Plan, subject to any changes being made by Directors.

7.3 To receive a progress report at the November 2016 meeting.

Sheila Jones
Head of Staff health and Wellbeing
David Levy
Director of Human Resources and Organisational Development

Background Papers: 2010 to 2015 TEWV Annual Staff Survey Results
Staff Friends and Family Test results Q1,Q2 and Q4 2015/16
Investors in People Assessment Report 2014

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX 1

TRUST COMPOSITE ACTION PLAN 2015-2016 – ANNUAL UPDATE AS OF END OF QUARTER 4 (Developed from the Investors in People Report, Staff Survey 2014 Results and Staff Friends and Family Test Results)

NO.	THEME	INTENDED OUTCOME/ RESULT	SOURCE OF ACTION			ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
			IIP	SS	SFFT					
1	Improve high workload/ work pressure demands placed on managers and staff	Improve related responses in the 2016 Staff Survey results and Staff FFT results Improved related feedback in the next IiP accreditation.	X	X	x	1. Communicate Trust Performance Management Framework to all staff within the Trust. 2. Produce guidance for managers and staff relating to 'no request without explanation'. 3. Identify any waiting lists and activity increases for staff support services to establish if there is a problem. 4. IiP links to promote the range of staff support services in their area. 5. Implement the technical solution for ESR and Healthroster to avoid duplication of effort for managers. 6. Understand more about the root causes of sickness absence and review how much we can do as an organisation. 7. Understand the impact of 12 hour shifts further. 8. Review the Return to Work mechanisms for community team staff V ward based staff and identify any recommended changes. 9. Improve the length of time and experience of the disciplinary process by: a. Establish an investigations team to reduce the length of time of an investigation b. EMT to agree the reviewed Disciplinary Process c. Implement the reviewed Disciplinary Process d. Review the support available to staff during the disciplinary process.	Sarah Theobald Julie Jones Sheila Jones IiP links Lorraine Sellers Lesley Hodge Deborah Newman Lesley Hodge/Helen Cooke David Levy Sheila Cowan Sheila Cowan Sheila Cowan	Q2 Q2 Q2 Q2 Q1 Q3 Q4 Q3 Q2 Q2 Q3 Q2	Information circulated Core brief, eBulletin Emails received. Local plans. Sickness inputted onto Health Roster for clinical staff. Event held Aug 2015, info sent to EMT Reported at WDG Policy amended Team appointed. Went to EMT Jan 16 Uploaded onto InTouch Investigations Team	**Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed**
2	Improve the experience of staff during organisational change	Improve related responses in the 2016 Staff Survey results and Staff FFT results Improved related feedback in the next IiP accreditation.	**X**	**X**	**X**	1. Review the Business Planning guidance in relation to involving staff in developing the local Business Plans and sharing the final plan with them. 2. Undertake the Organisational Change Policy Kaizen event including the importance of high quality, timely information. 3. Produce guidance for managers regarding effective communication in organisational change 4. Implement the changes from the Organisational Change Policy Kaizen event. 5. Review the effectiveness of the Local Consultative Committees in implementing organisational change.	Chris Lanigan David Levy Sheila Cowan David Levy David Levy	Q3 Q1 Q2 Q3 Q2	Guidance updated and circulated to senior staff Event took place 30/4/15 & 1/5/15 As above. Changes implemented To be included within the Trust Partnership Agreement review due in Q4 2016/17.	**Completed** **Completed** **Completed** **Completed** **Deferred to Q4 2016/17.**
3	Improve access to training and development opportunities and the evaluation of e learning	Improve related responses in the 2016 Staff Survey results and Staff FFT results Improved related feedback	X	X	X	1. Consider the opportunity for staff to book face to face training via ESR at the Staff Domain Group and RAADA. 2. If agreed, restructure OLM to accommodate. 3. Scope the possibility to facilitate community teams to undertake their mandatory/statutory training within their geographical area by closing the team to undertake the	Susan Leightley Susan Leightley Susan Leightley	Q1 Q3 Q1	Discussed at relevant groups. Restructure complete Scoping exercise undertaken.	**Completed** **Completed** **Completed**

		in the next IiP accreditation.				training. 4. If agreed, commence roll out to community teams. 5. Identify if there have been any risks associated with e-learning and a lack of knowledge content of that e- learning package. 6. Look at ways in which we can survey staff on their opinions of e-learning in relation to knowledge increase. 7. Consider the use of new technologies for training including apps, videos, learning forums and intranet team learning.	Susan Leightley Judy Hurst Susan Leightley Judy Hurst	Q2 Q2 Q2 Q4	Commenced. Scoping exercise undertaken. Options considered, survey to be circulated Nov. Ideas developed, videos started	**Completed** **Completed** **Completed** **Completed**
NO.	**THEME**	**INTENDED OUTCOME/ RESULT**	**SOURCE OF ACTION**			**ACTION**	**ACTION OWNER**	**TARGET DATE FOR ACTION COMPLETION**	**EVIDENCE (TO BE RETAINED BY ACTION OWNER)**	**PROGRESS UPDATE**
4	Improve levels of communication	Improve related responses in the 2016 Staff Survey results and Staff FFT results Improved related feedback in the next IiP accreditation.	X	X	X	1. Review and amend team briefing guidance to encourage the discussion and acknowledgement of positive progress and achievement to be discussed and acknowledged during team meetings. 2. Review the Whistle blowing Policy to encourage staff to feel secure in raising concerns about clinical practice. 3. Review what is 'good communication between senior managers and staff' and understand what staff expectations are at local level and take the results and proposed action plan to EMT. 4. Map improvement events with teams and identify where QIS events have not taken place to help engage with hard to reach groups through targeted involvement. 5. Report on the evaluation of the Facilitators programme. (Carried over from 14/15)	Julie Jones David Levy Julie Jones Maureen Raine Michelle Brown	Q2 Q1 Q4 Q2 Q2	 Review underway Mapping exercise complete Evaluation Survey results obtained	**Not completed due to workload. Move to 16/17** **Completed** **Not completed due to workload. Move to 16/17** **Completed** **Completed**
5	Reduce levels of staff experiencing physical violence from patients/relatives or the public AND reduce levels of staff experiencing harassment, bullying or abuse from patients, relative or the public.	Improve related responses in the 2016 Staff Survey results and Staff FFT results Improved related feedback in the next IiP accreditation.		X	X	Complete the implementation of the agreed action plan in the Trust's new Force Reduction Strategy during 2015/16. This includes: 1. Increase the number of services using the Institute of Psychiatry Safewards approach. 2. Review the effectiveness of the Safewards approach 3. Further development of PBS approaches to reduce challenging behaviour. 4. Review the MoVA training model and present findings to EMT. 5. Participate in the anticipated national benchmarking network on the reduction of Control and restraint and learn from any best practice highlighted in the process. 6. Re-audit changes delivered in the Force Reduction action plan.	Stephen Davison Stephen Davison Stephen Scorer/Stephen D Stephen Davison/Jane Christie Stephen Scorer/Stephen Davison Stephen Scorer	Q1 Q2 Q4 Q1 Q3 Q4	Increased from 10 to 20 Work completed Training events facilitated Exercise completed and submitted to DOH Audit completed March 2016	**Completed** **Completed** **Completed** **Completed** **Completed** **Completed**
6	Reduce levels of staff experiencing harassment, bullying or abuse from staff			X		1. Develop a Trust-wide voluntary binding arbitration model for consideration by EMT. (Carried over from 14/15) 2. Increase leadership and management development programmes focus upon addressing and preventing bullying 3. Develop 'Contact Officer' proposals for consideration by the JCC/EMT	David Levy Michelle Brown David Levy	Q3 Q3 Q3	 LAMD, productive & value based conversations sessions	**No longer being progressed.** **Completed** **Not completed. Propose to include as part of the Equality and Diversity Champion role in 16/17.**
7	Improve the appraisal experience	Improve related responses in the 2016 Staff Survey results and Staff FFT results Improved related feedback	X	X		1. Design a process that will implement the new appraisal system in a less resource intensive way. 2. Implement the new process. 3. Monitor and evaluate the new process.	Angela Collins Angela Collins Angela Collins	Q1 Q2 Q4	Process developed Training for new process being rolled out	**Completed** **Completed** **Moved to Q4 2016/2017**

		in the next IiP accreditation.								
8	Improve staff experience for disabled and Black, Asian and Minority Ethnic (BAME) staff.	Improve related responses in the 2016 Staff Survey results and Staff FFT results Improved related feedback in the next IiP accreditation.		X	X	1. Review the different definitions of 'disabled staff' and agree the definition to be used by the organisation. 2. Identify any statistically significant differences between disabled and non-disabled staff from the staff survey results and make recommendations for improvement. 3. Review datix cases for BAME staff and identify any improvements that can be made. 4. Hold a Kaizen event sponsored by the Medical Director to improve the cultural appropriateness of Induction for doctors from oversees. 5. Agree an action plan of how to implement the findings from the Kaizen event and make recommendations on other HR processes that can benefit from the learning.	Angela Collins/ Simon Marshall Angela Collins/ Simon Marshall Simon Marshall Simon Marshall Simon Marshall	Q2 Q2 Q3 Q3 Q4	Datix Took to E&D steering group Embedded in work of steering group Work group undertook work without need for Kaizen event Small team created action plan	**Completed** **Completed** **Completed** **Completed** **Completed**

As this is a Trust wide action plan each individual action owner requires reasonable cooperation from others across the Trust to ensure that actions can be implemented as effectively as possible.

There will be regular monitoring and reporting of progress made with implementation of the Trust Action Plan and Local Action Plans.

Total: 46 actions in total
40 completed and 5 outstanding
1 action no longer being progressed

LOCAL ACTION PLAN 15/16 SUMMARY. ANNUAL UPDATE AS OF END OF QUARTER 4

Service Area	Number of Action Areas covered during 15/16	Number Green	Number Identified Red	Examples of Actions
1. Durham and Darlington	9 areas covered – approx. 33 actions in total	30	3	A visual aid 'safety cross' is being used within the inpatient setting to monitor restraints, which will indicate trends in relation to restraints carried out. This is also discussed at the daily report out to support staff. A daily report out and monthly critical incident analysis and lessons learned discussions take place for inpatient staff. Investors in People champions have promoted staff support services via team meetings, supervisions and e bulletin. Task and Finish groups and Kaizen events have taken place regarding pathways of care.
2. Teesside	8 areas covered- approx. 33 actions in total	31	2	All SUI reports go to the locality governance meetings for discussion and learning is disseminated. Lessons learned bulletin is circulated to all staff**.** Datix incidents are discussed at each locality governance meeting and also staff are encouraged to discuss potential risk management strategies within supervision. To improve levels of communication, Interface meetings have been established between community / inpatients / crisis. Early Intervention Psychosis teams work closely with colleagues to implement access and waiting time standards. The range of staff support services in the Trust are discussed in team meetings and the Locality Governance Group.
3. North Yorkshire	8 areas covered – approx. 20 actions in total	17	3	The introduction of 'Positive Behavioural Support' to staff on acute wards has been rolled out across AMH inpatient services and has been positively received. Safe Wards was introduced on Rowan Lea in MHSOP. Behaviours that Challenge pathway remains ongoing with a phased planned roll out across North Yorkshire. Deep dives into datix take place, staff are supported by line managers if issues occur or are raised and plans are put in place. Reports are discussed at QUAGs.
4. Forensic Services	9 areas covered- approx. 44 actions in total	34	10 (includes 6 partially completed and 2 to carry forward).	Staff engagement forums, rolling programme of quarterly events. Staff consultation meetings regarding the Transforming Care Programme. Commencement of the FLD Development Programme. Incident Debriefing - links with the Force Reduction Project work streams, staff representation from the Forensic Service.
5. Estates and Facilities Management	9 areas covered- approx. 16 actions in total.	16	0	Pilot of an EFM communication board in all main sites completed and will be continued. Introduced senior manager drop in sessions and will be rolled out trust wide next year. Improved team briefing by introducing into 'toolbox talks'.
6. Nursing and Governance	9 areas covered- approx. 14 actions in total	14	0	Weekly report outs have taken place in some of the directorate teams to monitor workloads. Team plans have included issues to improve communications such as putting change into context and make sure people are involved in consultation.

				Mandatory training was available to staff at the September Directorate event including a bespoke Equality and Diversity session.
7. Planning, Performance and Communications	5 areas covered- approx.24 actions in total	22	1 (and 1 grey as no longer required)	Helped to improve work pressure demands on staff by stopping radar charts from service resource analysis and replacing with correlation charts. Used QIS tools to identify areas to improve which resulted in having an RPIW on reviewing patient and carer information which has significantly improved process/reduced waste.
8. HR/OD	9 areas covered- approx. 51 actions in total	46	5 (4 carried forward and 1 no longer applicable)	Heads of Service to discuss at team meetings, 1:1 and appraisals what makes their team members feel valued and feed back to a wider discussion. Encourage staff to report inappropriate behaviour via team briefing, 1:1 supervision etc and abuse not to be accepted as the norm. Understand the impact of 12 hour shifts further.
9. Finance and Information	12 areas covered- approx. 32 actions in total	32	0	Team meetings reviewed to encourage the discussion and acknowledgement of positive progress and achievement. Kaizen culture promoted within department to ensure it is fit for purpose and all staff contribute.
10. Medical Directorate	16 areas covered- approx.19 actions in total	19	0	The Medical Development Department have introduced regular workload update meetings for all members of the team. This meeting provides staff with the opportunity to update their manager with current workload and work pressures and discuss and agree action plans where necessary. The Research and Development Manager seeks feedback from staff regarding current levels and means of communication and evaluates in order to ensure the team are receiving appropriate communications.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX 2
DRAFT TRUST COMPOSITE ACTION PLAN 2016-2017
(Developed from the Investors in People Report, Staff Survey 2015 Results and Staff Friends and Family Test Results)

NO.	THEME	INTENDED OUTCOME/ RESULT	SOURCE OF ACTION			ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
			IIP	SS	SFFT					
1	Encourage more staff to report harassment, bullying or abuse when it happens	Improve related responses in the 2017 Staff Survey results and Staff FFT results. Improved related feedback in the next IiP accreditation.	X	X	X	Establish a Task and Finish Group to include the following actions: 1. Undertake a survey monkey survey to try to understand why staff do not report harassment, bullying or abuse. Link to the under reporting of errors, near misses or incidents. 2. Report the findings to the Workforce and Development Group and make recommendations for action. 3. Review the way bullying and harassment is covered in the Grievance Procedure and identify if a separate policy is needed. 4. Include reference to the importance of reporting bullying into the refreshed mandatory training on Equality and Diversity and Human Rights. 5. Explore developing the role of the Equality and Diversity champions to become contact officers for bullying and harassment issues. 6. Undertake 'How to handle Productive Conversations' training. 7. Undertake Values based Conversations workshops on request as part of team development. 8. Investigate a potential link between manipulative behaviour at work and management style. 9. Develop a plan to address if agreed appropriate. .	Kerry Jones Kerry Jones Kerry Jones Sarah Jay Sarah Jay Michelle Brown Michelle Brown Michelle Brown Michelle Brown	Q3 Q4 Q2 Q2 Q3 Q1-Q4 Q1-Q4 Q2 Q3		
2	Reduce the number of staff experiencing physical violence from patients, relatives or the public	Improve related responses in the 2017 Staff Survey results and Staff FFT results. Improved related feedback in the next IiP accreditation.	X	X	X	1. Following the creation of an incident dashboard for managers to use via IIC, develop an electronic QUAG report 2. Commence roll out to the QUAGs. 3. Revise the current management of violence and aggression training in conjunction with Workforce Development to include de-escalation and debrief training in accordance with new NICE guidance (NG10). 4. Pilot the new training. 5. Continue the roll out of Positive Behaviour Support Training across MHSOP, AMH and C&YPS (Tier4) until March 2017. 6. From June, run 10 'Behaviour Clinics' every month in locations across the Trust to offer coaching/support to staff in developing/implementing Behaviour Support Plans. Aim for 100 clinics by the end of the year. 7. Hold 4 Safewards sharing practice events over the year to support services to use the Safewards model. These events will offer frontline staff the opportunity to share good practice and support each other in developing the model.	Emma Haimes Emma Haimes Stephen Davison Stephen Davison Stephen Davison Stephen Davison Stephen Davison	Q1 Q2 Q3 Q3 Q4 Q4 Q4		

3	Increase the proportion of staff who report errors, near misses or incidents that they witness	Improve related responses in the 2017 Staff Survey results and Staff FFT results. Improved related feedback in the next IiP accreditation.	X	X	X	1. Ensure the revised Incident Reporting and Investigating Policy is ready for relaunch following consultation. 2. Relaunch the revised Incident Reporting and Investigating Policy by holding briefing sessions across the Trust. 3. Monitor the initial impact of the revised Incident Reporting and Investigating Policy and its impact on incident reporting. 4. Prepare for the York and Selby locality move onto the new datix system wef 1 June by undertaking reinforcement briefing sessions.	Catherine Lee-Cowan Catherine Lee-Cowan Catherine Lee-Cowan Emma Haimes	Q2 Q3 Q4 Q1		
4	Continue to reduce the numbers of staff suffering from work related stress	Improve related responses in the 2017 Staff Survey results and Staff FFT results. Improved related feedback in the next IiP accreditation.	X	X	X	1. Deliver 4 Stress Busting events and monitor take up. 2. Develop a 'What helped me' information leaflet from contributions by Trust staff who have lived experience of mental ill health. 3. Distribute the leaflet. 4. Complete a 12 month review of the Employee Psychology Service pilot and include recommendations regarding the future of the service. 5. Deliver 6 retreats throughout the year and monitor take up. 6. Embed the Employee Support Service in the York and Selby locality. 7. Establish a baseline for the activity levels of the Employee Support Service to measure capacity levels and introduce Key performance Indicators. 8. Design a training package to support managers in embedding health and wellbeing principles in the workplace. 9. Implement the new national CQUIN on Health and Wellbeing 10. Deliver 2 mindfulness programmes during the year to staff in the York and Selby locality with priority given to staff with work related stress 11. Deliver at least 20 days of mindfulness that staff can access to refresh their practice. 12. Pilot 3 month follow up post mindfulness programmes. 13. Run 12, 8 week mindfulness programmes across the year with priority given to staff with work related stress.	Lisa Cole Lisa Cole Lisa Cole Barry Speak Paul Walker Lisa Cole Lisa Cole Lisa Cole Sheila Jones Elinor Morgan Elinor Morgan Elinor Morgan Elinor Morgan	Q4 Q1 Q2 Q1 Q4 Q3 Q4 Q2 Q4 Q4 Q4 Q1 Q4		
5	Support managers and staff to deal with high pressure/work-load demands placed on them	Improve related responses in the 2017 Staff Survey results and Staff FFT results. Improved related feedback in the next IiP accreditation.	X	X	X	1. Review and amend team briefing guidance to encourage the discussion and acknowledgement of positive progress and achievement to be discussed and acknowledged during team meetings. (Carried over from 15/16) 2. Develop detailed project plans for final sign off by the Purposeful and Productive Community Services Board. They are: a. Leadership development/coaching b. Information c. IT/Use of technology d. Team processes e. Clinical pathways/workforce design and skills optimisation 3. Develop and communicate a regular requests calendar	Julie Jones Brent Kilmurray Patrick Scott Ruth Hill Adele Coulthard Ruth Briel Sharon Pickering	Q2 Q2 Q2 Q2 Q2 Q2 Q2		

						and ad hoc requests log and associated processes / guidance. 4. Develop proposals to improve the efficiency and effectiveness of narrative collection and collation regarding standards which are reported to commissioners. 5. Request the Directors of Performance Planning & Communication; Nursing and Governance, HR & OD, Finance and Information and the Director of EFM to review all current reports to ascertain whether any of these can be superseded by use of live data on IIC. 6. Request that the Information Domain Strategy Group decide if they are going to add personalised IIC dashboards for team managers to the IIC development log.	Sharon Pickering Chris Lanigan Chris Lanigan	Q4 Q2 Q2		
6	Ensure that members of the senior management team continue to be visible in the workplace/around the Trust	Improve related responses in the 2017 Staff Survey results and Staff FFT results. Improved related feedback in the next IiP accreditation.	X	X	X	1. Review what is 'good communication between senior managers and staff' and understand what staff expectations are at local level and take the results and proposed action plan to EMT. (Carried over from 15/16)	Julie Jones	Q2		
7	Improve staff experience for disabled and BAME staff	Improve related responses in the 2017 Staff Survey results and Staff FFT results. Improved related feedback in the next IiP accreditation.	X	X	X	1. Undertake research to better understand the causes of any differences where staff who share similar characteristics report lower levels of satisfaction in either the Staff Friends and Family Test or the Staff Survey and to take steps to reduce or eliminate any lower levels of satisfaction. Specific actions are: 2. Develop actions to be included in the staff survey action plan to address any areas where known differences exist and are understood 3. Establish baseline data based on the 2015 Staff Survey and corresponding Staff Friends and Family Test. 4. Commission and undertake reliable research based on the base line data 5. Report the findings of this research to the Diversity Engagement Group, Workforce and Development Group and the Equality and Diversity Steering Group. 6. Design the format of the protected characteristics mini conferences/workshops for consideration by the Equality and Diversity Steering Group. 7. If agreed, commence the implementation plan.	Simon Marshall Simon Marshall Simon Marshall Simon Marshall/Sarah Jay Simon Marshall/Sarah Jay Angela Collins Angela Collins	Q4 Q1 Q2 Q4 Q4 Q1 Q4		
8	Improve staff experience amongst the different workforce ages	Improve related responses in the 2017 Staff Survey results and Staff FFT results. Improved related feedback in the next IiP accreditation.	X	X	X	1. Hold a feedback event following the recently completed first stage of a field study of TEWV clinical staff about extending working lives and gain views to inform recommendations to EMT about our future approach. 2. Take the recommendations regarding our future approach to EMT. 3. Review the findings from the 2015/16 workforce equality monitoring data and identify any areas of concern 4. Where areas of concern are identified, take recommendations to the Equality and Diversity Steering	David Levy David Levy Simon Marshall Simon Marshall	Q1 Q2 Q1 Q2		

						group, Diversity Engagement Group and the Workforce and Development Group.				
9	Improve the impact of the Staff Friends and Family Test and start preparations for the Investors in People reaccreditation.	Ensure the Staff FFT results are user friendly and relevant. Ensure the smooth preparation of the next IiP accreditation.	X	X	X	1. Hold a QIS event to consider the future Trust approach to the Staff FFT including refreshing the non- core questions and the assurance process. 2. Revised proposals are taken to EMT for consideration. 3. Prepare for the implementation of the agreed approach. 4. Arrange for 2 staff to be trained in the revised IiP National Standard Framework and Assessment Process. 5. Undertake the IiP mid-term review with the Lead Assessor. 6. Inform EMT of the options available for the next IiP assessment and agree the way forward. 7. Review the effectiveness of the Local Consultative Committees in implementing organisational change. (Carried over from 15/16)	Sheila Jones David Levy Kerry Jones Sheila Jones Sheila Jones David Levy David Levy	Q1 Q1 Q2 Q1 Q1 Q2 Q4		

As this is a Trust wide action plan each individual action owner requires reasonable cooperation from others across the Trust to ensure that actions can be implemented as effectively as possible. There will be regular monitoring and reporting of progress made with implementation of the Trust Action Plan and Local Action Plans.

ITEM NO.11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24TH May 2016**
TITLE:	**Freedom To Speak Up Guardian**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Decision**

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

Executive Summary:

This report provides Directors with information and proposed actions concerning the establishment of a TEWV Freedom To Speak Up Guardian. The need for each NHS Trust to have a Freedom To Speak Up Guardian was amongst the recommendations of the February 2015 'Freedom To Speak Up' review report produced by Robert Francis. Subsequent national guidance has been produced and the requirement for every Trust to nominate a Freedom To Speak Up Guardian by 1st October 2016 is stated within the Department of Health contract with Trusts and Foundation Trusts.

A TEWV consultation exercise about the Freedom To Speak Up Guardian during June and early July is proposed followed by an appointment process during August and September 2016.

Recommendations:

(1) To note the contents of the report and to comment accordingly.
(2) To endorse the proposed consultation exercise with TEWV staff that would take place during June and early July 2016.
(3) To receive a report with final proposals for the establishment of a TEWV Freedom To Speak Up Guardian at the July 2016 meeting of the Board of Directors.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**24TH May 2016**
TITLE:	**Freedom To Speak Up Guardian**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to propose arrangements that will lead to the appointment of a TEWV Freedom To Speak Up Guardian.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Public Enquiry into the Mid Staffordshire NHS Foundation Trust exposed unacceptable levels of patient care and a culture that deterred staff from raising concerns. This led to the 'Freedom To Speak Up' review led by Robert Francis that was published in February 2015. The review highlighted the importance of every NHS organisation developing a culture in which all staff are positively encouraged to raise issues about safety, quality and the effectiveness of services, and that staff ought to be supported by their employer when they do raise issues.

2.2 Amongst the recommendations of the Freedom To Speak Up review was that a National Freedom To Speak Up Guardian be appointed and that every Trust should have a Freedom To Speak Up Guardian. This recommendation was accepted by the Secretary of State for Health and the 2016/17 NHS contract now includes a provision that every Trust should nominate a Freedom To Speak Up Guardian by 1st October 2016. Until recently the position was that Trusts had until September 2016 to finalise local plans and that the appointment of a Freedom To Speak Up Guardian needed to be made before the end of March 2017.

3. KEY ISSUES:

3.1 Guidance about establishing a Trust Freedom To Speak Up Guardian was published by the National Guardian's Office in March 2016 and a role description (Appendix 1) has also been produced to assist Trusts with establishing this important role.

3.2 The appointment of a TEWV Freedom To Speak Up Guardian ought to be seen as being part of a range of measures to help create a culture in which the raising of concerns and speaking up is considered to be a part of normal working life. Within TEWV the Quality Improvement System 'stop the line', the electronic Raising Concerns facility, the Values and Behaviours statements and the Living the Values Awards are intended to help create such a culture along with to the revised whistleblowing procedure and associated training.

3.3 The 2015 staff survey results highlighted that 76% of TEWV staff would feel secure raising concerns about unsafe clinical practice. This figure is better than the average for mental health and learning disability trusts (70%) and is an improvement upon the Trust's 2014 position (72%) however, there is clearly much more to do to improve staff confidence about reporting concerns.

3.4 Prior to finalising plans for making a Freedom To Speak Up Guardian appointment the Trust is advised by the National Guardian's Office to consult with a broad range of staff about the following:

- whether the appointment should be internal or external
- how staff will have access to support and advice across seven days a week and different shift patterns
- how staff can access independent external advice in addition to the Freedom To Speak Up Guardian
- whether a network of roles underneath the Freedom To Speak Up Guardian may be needed given the size and complexity of the Trust

3.5 The consultation exercise will also provide an opportunity to help raise awareness amongst staff of the Freedom To Speak Up review and related issues within TEWV. The views of service users and carers could also be gathered and considered as part of the consultation exercise. It is suggested that consultation takes place during June and early July with the intention of presenting final proposals to the Board of Directors at its July meeting. The appointment process would be undertaken during August and September to ensure that the new national deadline for the appointment to be made by 1st October 2016 can be met.

3.6 Consideration needs to be given to whether the appointment ought to be part-time or whole-time, what the level of financial investment in the role will be and how the Freedom To Speak Up Guardian can best work with individual TEWV staff and liaise with key groups such as the Board of Directors, staff forums and leadership networks. The role entails a combination of responding to individual and/or collective staff concerns, participating in related Trust-wide educational activities, providing regular reports to the Board of Directors and liaising with peers and the National Freedom To Speak Up Guardian. Though the precise amount of time required for such a role in TEWV is difficult to quantify at present it is thought unlikely that a designated time commitment of less than 0.5 WTE will be sufficient.

3.7 Evidence provided by early implementers of the Freedom To Speak Up Guardian role suggests that to be effective designated time must be made available, that the role ought to complement the activities described in paragraph 3.2 rather than operate in isolation, that there ought to be regular contact with the Chief Executive and the Board of Directors and that the role should not be part of a corporate function such as HR.

3.8 'Freedom to speak up: raising concerns(whistleblowing) policy for the NHS' (Appendix 2) was published by NHS Improvement and NHS England in April 2016. The production of this policy was one of the recommendations of the Freedom To Speak Up review and all Trusts are expected to adopt the policy. Within TEWV the Policy Sub-group has been asked to make proposals that will incorporate the TEWV procedure within the new national policy. These proposals can then be considered by the Audit Committee, the Joint Consultative Committee and the Executive Management Team.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** Establishing a Freedom To Speak Up Guardian within TEWV will support efforts to meet several related CQC regulations.

4.2 **Financial/Value for Money:** A minimum investment of £40,000 p.a. is envisaged though this amount has yet to be confirmed.

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

4.4 **Equality and Diversity:** Enabling all TEWV staff to have access to the Freedom To Speak Up Guardian regardless of locality and job role will be a key requirement.

4.4 **Other implications:** None identified.

5. RISKS: None identified.

6. CONCLUSIONS:

6.1 National guidance about the Freedom To Speak Up Guardian role has recently been received and we are now in a better position to establish this important new role within the Trust albeit within a shorter timescale than was originally communicated.

6.2 Consulting with TEWV staff about this new role ought to help raise awareness about the overall issue of staff speaking up as well as informing whether the Freedom To Speak Up Guardian role should be an internal or external appointment.

6.3 A review of the Trust's Whistleblowing/Raising Concerns Procedure is to be undertaken in response to publication of the national 'Freedom to speak up: raising concerns (whistleblowing) policy for the NHS' that was published last month.

7. RECOMMENDATIONS:

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

7.2 To endorse a proposed consultation with TEWV staff that would take place during June and early July 2016.

7.3 To receive a report with final proposals for the establishment of a TEWV Freedom To Speak Up Guardian at the July 2016 meeting of the Board of Directors.

David Levy
Director of Human Resources and Organisational Development

Background Papers: 'A Guide for NHS Trusts & Foundation Trust in establishing the Freedom To Speak Up Guardian' National Guardian's Office March 2016.
'Freedom to speak up: raising concerns (whistleblowing) policy for the NHS' NHS Improvement, NHS England April 2016.
National Guardian's Office (Freedom To Speak Up) CQC letter 28th April 2016.
2015 National Staff Survey Results

Role specification for the Freedom to Speak Up Guardian

Acting in a genuinely independent capacity, the Freedom to Speak Up Guardian will be appointed by the Board, working alongside them and members of the executive team to help support the organisation to become a more open, transparent place to work.

In particular the Freedom to Speak Up Guardian will:

- Work with the chief executive and Board to help create an open culture which is based on listening and learning and not blaming.

- Develop, alongside the Board, chief executive and executive team a range of mechanisms, in addition to the formal processes, which empower and encourage staff to speak up safely.

- Ensure that staff with disabilities and those from black and other minority ethnic backgrounds are encouraged to speak out and are not disadvantaged by doing so.

- Participate in the organisation's educational programme for all staff so that they understand how they can raise concerns and for managers about how they respond to concerns and supporting the member of staff appropriately.

- Be entirely independent of the executive team, so they are able to challenge senior members of staff, reporting to the Board or externally as required.

- Be a highly visible individual, who spends the majority of their time with 'front line' staff, providing expertise in developing a safe culture which supports and encourages staff to speak up using the local procedures and if necessary advising them on how to raise concerns, including externally.

- Act in an independent and impartial capacity, listening to staff and supporting them to raise concerns they may have by using the available structures and policies, both within the organisation and outside.

- Independently review any complaints from members of staff about the way they have been treated as a result of raising a concern and report back to the individual and, with their agreement, to their manager, the chief executive and the director of human resources.

- Ensure members of staff who speak up are treated fairly through the investigation, inquiry and or review and that there is effective and open communication during this time.

- Ensure that information about those who speak up is kept confidential at all times, subject to requirements around safeguarding and illegality.

- Meet quarterly with the chief executive to feedback themes from the concerns raised and to share positive and negative experiences and outcomes.

- Report at least every six months to the Board and the organisation as a whole.

- Participate in the national network for the guardians, sharing and helping to develop excellent practice in supporting members of staff who speak up.

Those appointed as Freedom to Speak Up Guardian should have these characteristics:

- Understand the trust, its values and key priorities and challenges.

- Have a track record of supporting and listening to staff and in demonstrating the values of the trust and the NHS constitution in their daily working lives.

- Be able to facilitate a conversation between members of staff and their managers.

- Have a good understanding of how to raise concerns and the barriers that can exist for those who speak up.

- Be an approachable, trusted, non-judgemental individual, who is comfortable with talking with ‘front line’ staff from all disciplines and all grades and can build a rapport which demonstrates compassion and understanding.

- Have the ability to set boundaries, be concise, synthesise and present information and be able to write reports for the chief executive and the Board.

- Have an understanding of mediation and managing confidential matters; this includes an understanding of managing and keeping confidential records of cases.

- Be responsive and resilient.

- Have an ability to work with a range of stakeholders, especially those responsible for patient safety and patient and staff experience, to ensure that lessons are learnt, themes identified and necessary changes are made.

- Confident in speaking at internal and external events.

March 2016

NHS Improvement
NHS England

Freedom to speak up: raising concerns (whistleblowing) policy for the NHS

April 2016



Contents

Speak up – we will listen

Speaking up about any concern you have at work is really important. In fact, it's vital because it will help us to keep improving our services for all patients and the working environment for our staff.

You may feel worried about raising a concern, and we understand this. But please don't be put off. In accordance with our duty of candour, our senior leaders and entire board are committed to an open and honest culture. We will look into what you say and you will always have access to the support you need.

This policy

This 'standard integrated policy' was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, aimed at improving the experience of whistleblowing in the NHS. It is expected that this policy (produced by NHS Improvement and NHS England) will be adopted by all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients.

Our local process has been integrated into the policy/adheres to the principles of this policy and provides more detail about how we will look into a concern *[insert link].*

What concerns can I raise?

You can raise a concern about **risk, malpractice or wrongdoing** you think is harming the service we *deliver/commission* [delete as appropriate]. Just a few examples of this might include (but are by no means restricted to):

- unsafe patient care
- unsafe working conditions
- inadequate induction or training for staff
- lack of, or poor, response to a reported patient safety incident
- suspicions of fraud (which can also be reported to our local counter-fraud team *[insert contact details])*
- a bullying culture (across a team or organisation rather than individual instances of bullying).

For further examples, please see the Health Education England video.

Remember that if you are a healthcare professional you may have a professional duty to report a concern. **If in doubt, please raise it.**

Don't wait for proof. We would like you to raise the matter while it is still a concern. It doesn't matter if you turn out to be mistaken as long as you are genuinely troubled.

This policy is not for people with concerns about their employment that affect only them – that type of concern is better suited to our grievance policy *[insert link].*

Feel safe to raise your concern

If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action.

Provided you are acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.

Confidentiality

We hope you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity. Therefore, we will keep your identity confidential, if that is what

you want, unless required to disclose it by law (for example, by the police). You can choose to raise your concern anonymously, without giving anyone your name, but that may make it more difficult for us to investigate thoroughly and give you feedback on the outcome.

Who can raise concerns?

Anyone who works (or has worked) in the NHS, or for an independent organisation that provides NHS services can raise concerns. This includes agency workers, temporary workers, students, volunteers and governors.

Who should I raise my concern with?

In many circumstances the easiest way to get your concern resolved will be to raise it formally or informally with your line manager (or lead clinician or tutor).[1] But where you don't think it is appropriate to do this, you can use any of the options set out below in the first instance.

If raising it with your line manager (or lead clinician or tutor) does not resolve matters, or you do not feel able to raise it with them, you can contact one of the following people:[2]

- our Freedom to Speak Up Guardian (or equivalent designated person) *[insert name(s) and contacts details]* – this is an important role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation

- our risk management team *[insert contact details].*

If you still remain concerned after this, you can contact:

- our executive director with responsibility for whistleblowing *[insert name and contact details]*

- our non-executive director with responsibility for whistleblowing *[insert name and contact details]*.

All these people have been trained in receiving concerns and will give you information about where you can go for more support.

If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies, listed on page 8.

[1] The difference between raising your concern formally and informally is explained in our local process. In due course NHS England and NHS Improvement will consider how recording could be consistent nationally, with a view to a national reporting system.

[2] Annex A sets out an example of how a local process might demonstrate how a concern might be escalated.

Advice and support

Details on the local support available to you can be found here *[link to organisation intranet]*. However, you can also contact the Whistleblowing Helpline for the NHS and social care, your professional body or trade union representative.

How should I raise my concern?

You can raise your concerns with any of the people listed above in person, by phone or in writing (including email).

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concern.

What will we do?

We are committed to the principles of the Freedom to Speak Up review and its vision for raising concerns, and will respond in line with them (see Annex B).

We are committed to listening to our staff, learning lessons and improving patient care. On receipt the concern will be recorded and you will receive an acknowledgement within two working days. The central record will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback.

Investigation

Where you have been unable to resolve the matter quickly (usually within a few days) with your line manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of). Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident[3]). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.

We may decide that your concern would be better looked at under another process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you.

[3] If your concern suggests a Serious Incident has occurred, an investigation will be carried out in accordance with the Serious Incident Framework.

Any employment issues (that affect only you and not others) identified during the investigation will be considered separately.

Communicating with you

We will treat you with respect at all times and will thank you for raising your concerns. We will discuss your concerns with you to ensure we understand exactly what you are worried about. We will tell you how long we expect the investigation to take and keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others).

How will we learn from your concern?

The focus of the investigation will be on improving the service we provide for patients. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

Board oversight

The board will be given high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The board supports staff raising concerns and wants you to feel free to speak up.

Review

We will review the effectiveness of this policy and local process at least annually, with the outcome published and changes made as appropriate.

Raising your concern with an outside body

Alternatively, you can raise your concern outside the organisation with:

- NHS Improvement for concerns about:
    - how NHS trusts and foundation trusts are being run
    - other providers with an NHS provider licence
    - NHS procurement, choice and competition
    - the national tariff
- Care Quality Commission for quality and safety concerns
- NHS England for concerns about:
    - primary medical services (general practice)
    - primary dental services
    - primary ophthalmic services
    - local pharmaceutical services
- Health Education England for education and training in the NHS
- NHS Protect for concerns about fraud and corruption.

Making a ‘protected disclosure’

There are very specific criteria that need to be met for an individual to be covered by whistleblowing law when they raise a concern (to be able to claim the protection that accompanies it). There is also a defined list of ‘prescribed persons’, similar to the list of outside bodies on page 8, who you can make a protected disclosure to. To help you consider whether you might meet these criteria, please seek independent advice from the Whistleblowing Helpline for the NHS and social care, Public Concern at Work or a legal representative.

National Guardian Freedom to Speak Up

The new National Guardian (once fully operational) can independently review how staff have been treated having raised concerns where NHS trusts and foundation trusts may have failed to follow good practice, working with some of the bodies listed above to take action where needed.

Annex A: Example process for raising and escalating a concern

Step one

If you have a concern about a risk, malpractice or wrongdoing at work, we hope you will feel able to raise it first with your line manager, lead clinician or tutor (for students). This may be done orally or in writing.

Step two

If you feel unable to raise the matter with your line manager, lead clinician or tutor, for whatever reason, please raise the matter with our local Freedom to Speak Up Guardian(s):

[Name]

[Contact details]

This person has been given special responsibility and training in dealing with whistleblowing concerns. They will:

- treat your concern confidentially unless otherwise agreed
- ensure you receive timely support to progress your concern
- escalate to the board any indications that you are being subjected to detriment for raising your concern
- remind the organisation of the need to give you timely feedback on how your concern is being dealt with
- ensure you have access to personal support since raising your concern may be stressful.

If you want to raise the matter in confidence, please say so at the outset so that appropriate arrangements can be made.

Step three

If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact *[chief executive, medical director, responsible officer, nursing director, nominated non-executive director].*

Step four

You can raise concerns formally with external bodies *[relevant list of prescribed bodies to be provided, similar to that on page 8].*

Annex B: A vision for raising concerns in the NHS

Source: Sir Robert Francis QC (2015) *Freedom to Speak Up: an independent report into creating an open and honest reporting culture in the NHS*.

NHS Improvement
NHS England

Contact us

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NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change Team and the Intensive Support Teams.

This publication can be made available in a number of other formats on request.

NHS Improvement (April 2016) Publication code: Policy 01/16
Publications Gateway Reference: 04877

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 12 (Note: 2)

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24 May 2016**
TITLE:	**Approval of accounts for the financial year ended 31 March 2016**
REPORT OF:	**Drew Kendall, Acting Director of Finance and Information**
REPORT FOR:	**Approval**

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

Executive Summary:

The Board is required to approve and formally adopt the accounts for the period ended 31 March 2016 for submission to NHS Improvement.

The Trust achieved an operating surplus of £269k, however excluding technical accounting adjustments for impairments the Trust achieved an operating surplus of £13,387k largely due to higher than planned contract income and a non-recurrent surplus within projects.

Recommendations:

The Board of Directors is requested to adopt the accounts and authorise the auditors to submit them as the audited accounts of the Trust for the period ended 31 March 2016 to NHS Improvement.

The Board of Directors is requested to adopt the recommendation of the Audit Committee that the Trust should be considered as a going concern and that the year end accounts should be prepared on that basis.

MEETING OF:	**Board of Directors**
DATE:	**24 May 2016**
TITLE:	**Approval of accounts for the financial year ended 31 March 2016**

1. PURPOSE OF REPORT

1.1 The purpose of this report is to ask the Board of Directors to approve the accounts for the period ended 31 March 2016 to the Trust Board.

2. BACKGROUND

2.1 In line with statutory requirements the Board is required to approve and formally adopt the accounts for the period ended 31 March 2016 for submission to NHS Improvement, the Independent Regulator for NHS Foundation Trusts.

2.2 Mazars LLP has carried out an audit of the accounts and they presented the outcome of the audit to the Audit Committee on the 19 May 2016.

3. KEY ISSUES

3.1. Statutory Obligations

The Trust achieved all of the requirements of a Foundation Trust as set out in the Trusts authorisation, in relation to finance;

- Remain as a going concern
- Ensure financial planning incorporates surpluses
- Achieve a risk rating in line with plan and above a 3 rating. The Trust achieved a rating of 4 in 2015-16.
- Pay Public dividend capital repayments to the Department of Health, currently defined as 3.5% on net relevant assets.

3.2 Key areas of Performance

The Audit Committee received a copy of the audited accounts on 19 May 2016. A copy of the latest audited accounts for 2015-16 are enclosed within Appendix 1 (please note at time of delivery these are not signed off by Audit – any changes will be tabled). The highlights are summarised below;

Income
Total operating income for the twelve months ended 31 March 2016 was £312,312k which was higher than the previous year mainly due to the commencement of the contract to provide MH and LD services to York and Selby.

Operating Expenses
Total operating expenses increased during 2015-16, mainly due to the commencement of the York and Selby contract, and the Trust incurring higher impairment charges than realised in 2014-15. Excluding these items operating expenses remained consistent with 2014-15.

Operating Surplus
The Trust achieved an operating surplus of £269k, however excluding technical accounting adjustments for impairments the Trust achieved an operating surplus of £13,387k largely due to higher than planned contract income and a non-recurrent surplus within projects.

Statement of Financial Position
Property, Plant and Equipment have decreased over the year by net £8,536k due mainly to impairments resulting from a Modern Equivalent Asset (MEA) Valuation.

Cash at Bank and in hand has increased by £7,001k to £54,148k. The increase in cash is mainly due the underlying operating surplus.

3.3 Items of note in the accounts

There are items of special note in the accounts for 2015-16 which have been discussed with the Trust's auditors.

- The Trust commissioned a full MEA valuation of Property, Plant & Equipment by the Trusts external valuer's Cushman and Wakefield in line with the 3 yearly review required by NHS Improvement. This was then reviewed by Mazars LLP, who concluded the treatment was appropriate and reasonable. This ensured Property Plant & Equipment is carried at fair value in the financial statements.

3.4 Explanations to some notes in the accounts

Some of the notes contained in the accounts require some guidance and the following explanation may be of assistance;

- After the main statements in the accounts there are notes on accounting policy (commencing page 5) which describe the basis on which the accounts have been completed. It summarises the methodology used and highlights any change in policy from last year.
- The supporting note to property, plant and equipment (note 12.1) shows a column headed 'assets under construction' this relates to schemes in the capital programme that were not completed at 31 March 2016 and in line with capital accounting policy these can not be capitalised. The £1,305k at the end of 2015-16 related to developments at Parkside and other smaller schemes.
- The 'financed by' section of the statement of financial position is predominately supported by the Statement of Changes in Taxpayers' Equity (page 3) and details the changes in the year.
- Details of the Trusts PFI schemes in operation are shown under note 36, page 27.

3.5 Annual Governance Statement

The Annual Governance Statement included within item 12 of the agenda has been reviewed by Mazars LLP and the Audit Committee.

3.6 Going Concern

NHS Foundation Trusts are required to prepare their accounts in accordance with relevant accounting rules. One of the requirements is to prepare the accounts on a going concern basis unless an organisation is to cease trading or there are significant doubts on the organisations ability to continue as a going concern.

Those charged with governance (i.e. the Board) need to consider whether this Trust is clearly a going concern. A Trust is considered a Going Concern provided it meets the following criteria:

"The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."

The Audit Committee recommended that the Trust should be considered as a going concern and that the year end accounts should be prepared on that basis

4. IMPLICATIONS

4.1 There are no direct financial implications associated with this paper.

4.2 The Trust is required within the terms of its authorisation as a Foundation Trust to submit accounts to Parliament by 24 June 2016.

5. RISKS

5.1 There are no risks associated with this paper.

6. CONCLUSION BASED ON KEY ISSUES AND FINANCIAL IMPLICATIONS

6.1 The Trust has achieved all of its statutory and non statutory financial obligations with the audit process only making minor changes from the accounts submitted on the 22 April 2016.

7. RECOMMENDATIONS

7.1 The Board of Directors is requested to adopt the accounts and authorise the auditors to submit them as the audited accounts of the Trust for the period ended 31 March 2016 to NHS Improvement.

7.2 The Board of Directors is requested to adopt the recommendation of the Audit Committee that the Trust should be considered as a going concern and that the yearend accounts should be prepared on that basis.

7.3 The Board of Directors is asked to confirm that as far as they are aware, there is no relevant information of which the Trust's auditors are unaware.

Drew Kendall
Acting Director of Finance and Information

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 12 (Note: 2)

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24 May 2016**
TITLE:	**Approval of accounts for the financial year ended 31 March 2016**
REPORT OF:	**Drew Kendall, Acting Director of Finance and Information**
REPORT FOR:	**Approval**

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

Executive Summary:

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Recommendations:

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The Board of Directors is requested to adopt the recommendation of the Audit Committee that the Trust should be considered as a going concern and that the year end accounts should be prepared on that basis.

MEETING OF:	**Board of Directors**
DATE:	**24 May 2016**
TITLE:	**Approval of accounts for the financial year ended 31 March 2016**

1. PURPOSE OF REPORT

1.1 The purpose of this report is to ask the Board of Directors to approve the accounts for the period ended 31 March 2016 to the Trust Board.

2. BACKGROUND

2.1 In line with statutory requirements the Board is required to approve and formally adopt the accounts for the period ended 31 March 2016 for submission to NHS Improvement, the Independent Regulator for NHS Foundation Trusts.

2.2 Mazars LLP has carried out an audit of the accounts and they presented the outcome of the audit to the Audit Committee on the 19 May 2016.

3. KEY ISSUES

3.1. Statutory Obligations

The Trust achieved all of the requirements of a Foundation Trust as set out in the Trusts authorisation, in relation to finance;

- Remain as a going concern
- Ensure financial planning incorporates surpluses
- Achieve a risk rating in line with plan and above a 3 rating. The Trust achieved a rating of 4 in 2015-16.
- Pay Public dividend capital repayments to the Department of Health, currently defined as 3.5% on net relevant assets.

3.2 Key areas of Performance

The Audit Committee received a copy of the audited accounts on 19 May 2016. A copy of the latest audited accounts for 2015-16 are enclosed within Appendix 1 (please note at time of delivery these are not signed off by Audit – any changes will be tabled). The highlights are summarised below;

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The Trust achieved an operating surplus of £269k, however excluding technical accounting adjustments for impairments the Trust achieved an operating surplus of £13,387k largely due to higher than planned contract income and a non-recurrent surplus within projects.

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Property, Plant and Equipment have decreased over the year by net £8,536k due mainly to impairments resulting from a Modern Equivalent Asset (MEA) Valuation.

Cash at Bank and in hand has increased by £7,001k to £54,148k. The increase in cash is mainly due the underlying operating surplus.

3.3 Items of note in the accounts

There are items of special note in the accounts for 2015-16 which have been discussed with the Trust's auditors.

- The Trust commissioned a full MEA valuation of Property, Plant & Equipment by the Trusts external valuer's Cushman and Wakefield in line with the 3 yearly review required by NHS Improvement. This was then reviewed by Mazars LLP, who concluded the treatment was appropriate and reasonable. This ensured Property Plant & Equipment is carried at fair value in the financial statements.

3.4 Explanations to some notes in the accounts

Some of the notes contained in the accounts require some guidance and the following explanation may be of assistance;

- After the main statements in the accounts there are notes on accounting policy (commencing page 5) which describe the basis on which the accounts have been completed. It summarises the methodology used and highlights any change in policy from last year.
- The supporting note to property, plant and equipment (note 12.1) shows a column headed 'assets under construction' this relates to schemes in the capital programme that were not completed at 31 March 2016 and in line with capital accounting policy these can not be capitalised. The £1,305k at the end of 2015-16 related to developments at Parkside and other smaller schemes.
- The 'financed by' section of the statement of financial position is predominately supported by the Statement of Changes in Taxpayers' Equity (page 3) and details the changes in the year.
- Details of the Trusts PFI schemes in operation are shown under note 36, page 27.

3.5 Annual Governance Statement

The Annual Governance Statement included within item 12 of the agenda has been reviewed by Mazars LLP and the Audit Committee.

3.6 Going Concern

NHS Foundation Trusts are required to prepare their accounts in accordance with relevant accounting rules. One of the requirements is to prepare the accounts on a going concern basis unless an organisation is to cease trading or there are significant doubts on the organisations ability to continue as a going concern.

Those charged with governance (i.e. the Board) need to consider whether this Trust is clearly a going concern. A Trust is considered a Going Concern provided it meets the following criteria:

"The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."

The Audit Committee recommended that the Trust should be considered as a going concern and that the year end accounts should be prepared on that basis

4. IMPLICATIONS

4.1 There are no direct financial implications associated with this paper.

4.2 The Trust is required within the terms of its authorisation as a Foundation Trust to submit accounts to Parliament by 24 June 2016.

5. RISKS

5.1 There are no risks associated with this paper.

6. CONCLUSION BASED ON KEY ISSUES AND FINANCIAL IMPLICATIONS

6.1 The Trust has achieved all of its statutory and non statutory financial obligations with the audit process only making minor changes from the accounts submitted on the 22 April 2016.

7. RECOMMENDATIONS

7.1 The Board of Directors is requested to adopt the accounts and authorise the auditors to submit them as the audited accounts of the Trust for the period ended 31 March 2016 to NHS Improvement.

7.2 The Board of Directors is requested to adopt the recommendation of the Audit Committee that the Trust should be considered as a going concern and that the yearend accounts should be prepared on that basis.

7.3 The Board of Directors is asked to confirm that as far as they are aware, there is no relevant information of which the Trust's auditors are unaware.

Drew Kendall
Acting Director of Finance and Information

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24 May 2016**
TITLE:	**Approval of Charitable Trust Fund accounts for the financial year ended 31 March 2016**
REPORT OF:	**Drew Kendall, Acting Director of Finance and Information**
REPORT FOR:	**Approval**

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

Executive Summary:

In line with statutory requirements the Board is required to approve and formally adopt the Charitable Trust Fund accounts for the period ended 31 March 2016 for submission to The Charities Commission.

The Charitable Trust Fund had a closing balance of £544k.

Recommendations:

The Board of Directors is requested to approve the Accounts and Annual Report for submission to the Charities Commission.

The Board of Directors is requested to sign and date the Statement of Trustee Responsibilities and the Balance Sheet within the Charitable Trust Fund accounts.

MEETING OF:	**Board of Directors**
DATE:	**24 May 2016**
TITLE:	**Approval of Charitable Trust Fund accounts for the financial year ended 31 March 2016**

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide the Board of Directors with the final Charitable Trust Fund Accounts and Annual Report for the period ended 31 March 2016 to the Trust Board.

2. BACKGROUND

2.1 The Trust has one General Charitable Umbrella Trust Fund registered with the Charities Commission. This charity was formed as a result of the former Tees & North East Yorkshire NHS Trust merger with County Durham and Darlington Priority Services NHS Trust.

2.2 The Accounts and Report comply fully with the Statement of Recommended Accounting Practice: Accounting and Reporting by Charities (SORP FRS 102), issued in January 2015, UK Accounting Standards and the Charities Act 2011.

2.3 In line with statutory requirements the Board is required to approve and formally adopt the Charitable Trust Fund accounts for the period ended 31 March 2016 for submission to The Charities Commission.

2.4 Mazars LLP has carried out an independent examination of the accounts and they presented the outcome of this to the Audit Committee on 19 May 2016.

3. KEY ISSUES

3.1 The Charitable Trust Fund had a closing balance of £544k.

The attached accounts and annual report have been subject to an independent review by Mazars LLP with the outcome reported to the Audit Committee on 19 May 2016.

4. FINANCIAL, LEGAL AND EQUALITY & DIVERSITY IMPLICATIONS

4.1 There are no direct financial implications associated with this paper.

4.2 The Trust is required to submit Charitable Trust Fund accounts to The Charities Commission by 31 January 2017.

5. CONCLUSION BASED ON KEY ISSUES AND FINANCIAL IMPLICATIONS

5.1 The Trusts external auditors completed an independent examination concluding there are no significant areas of concern for the Trust with regards the Charitable Trust Funds at 31 March 2016.

6. RECOMMENDATIONS

6.1 The Board of Directors is requested to approve the Accounts and Annual Report for submission to the Charities Commission.

6.2 The Board of Directors is requested to sign and date the Statement of Trustee Responsibilities and the Balance Sheet within the Charitable Trust Fund accounts.

Drew Kendall
Acting Director of Finance and Information

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24 May 2016**
TITLE:	**Finance Report for Period 1 April 2016 to 30 April 2016**
REPORT OF:	**Drew Kendall, Acting 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 30 April 2016 is a surplus of £1,305k, representing 4.8% of the Trust's turnover. The Trust is ahead of plan by £186k largely due to higher than anticipated performance against CQUIN targets.

Identified Cash Releasing Efficiency Savings at 30 April 2016 are in line with plan. The Trust continues to progress schemes to deliver CRES for future years.

The Financial Sustainability Risk Rating for the Trust is assessed as 2 for the period ending 30 April 2016 and is in line with plan. The rating is planned to increase to 4 by 31 May 2016.

Recommendations:

The Board of Directors are requested to receive the report, to note the conclusions in section 5 and to raise any issues of concern, clarification or interest.

MEETING OF:	**Board of Directors**
DATE:	**24 May 2016**
TITLE:	**Finance Report for Period 1 April 2016 to 30 April 2016**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2016 to 30 April 2016.

2. BACKGROUND INFORMATION

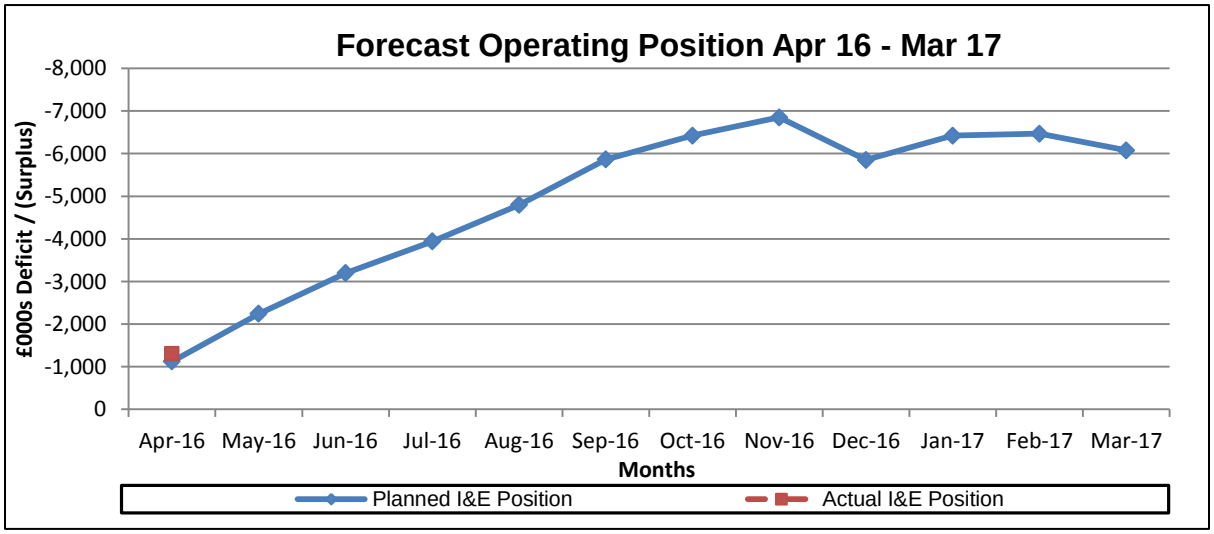
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

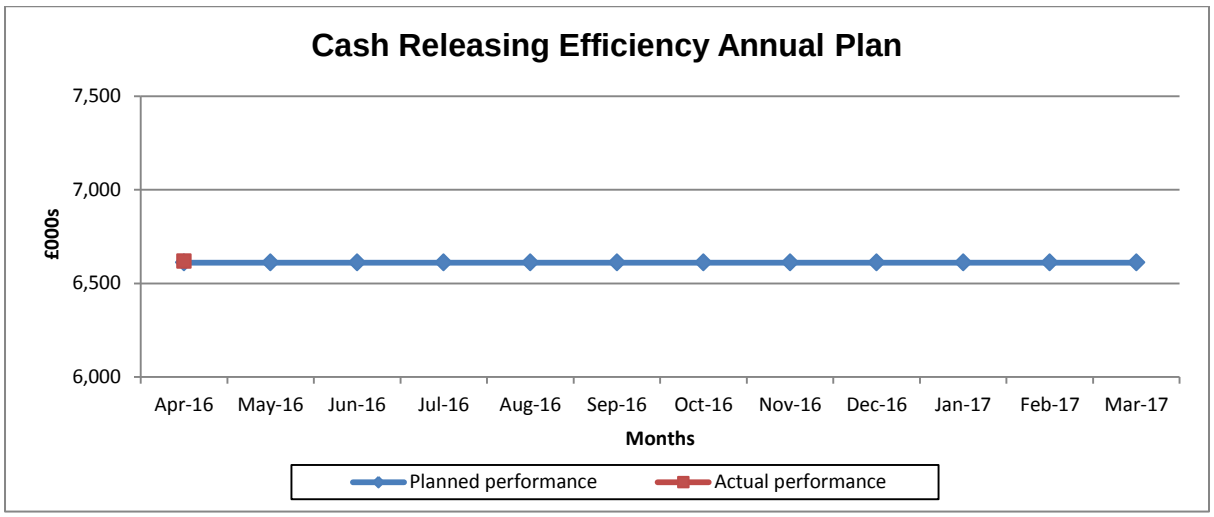
The comprehensive income outturn for the period ending 30 April 2016 is a surplus of £1,305k, representing 4.8% of the Trust's turnover. The Trust is ahead of plan by £186k largely due to higher than anticipated performance against CQUIN targets.

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

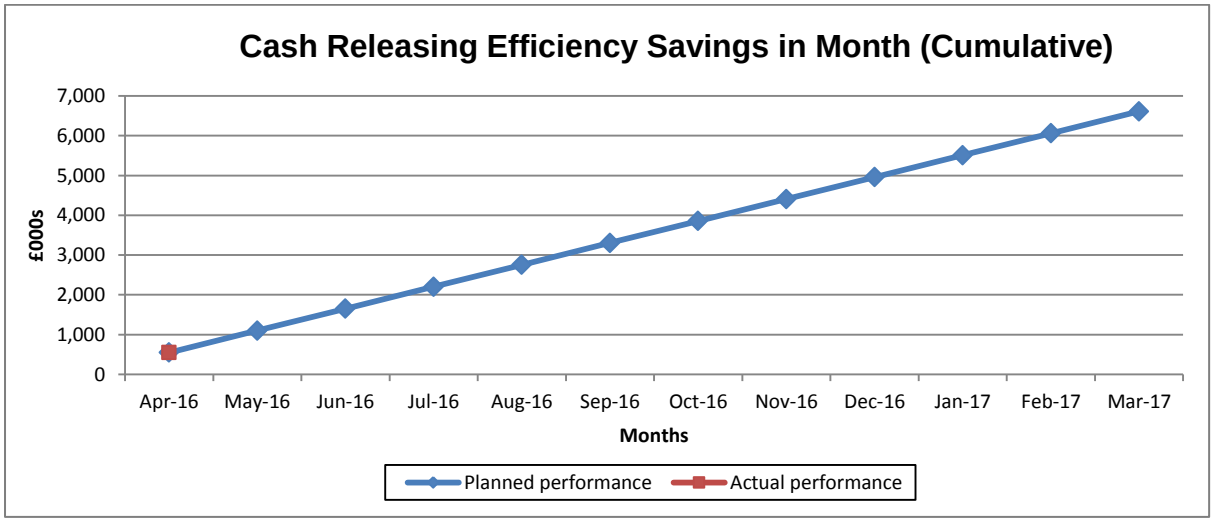


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 30 April 2016 is £6,618k and is in line with plan. The Trust continues to progress schemes to deliver CRES for future years.

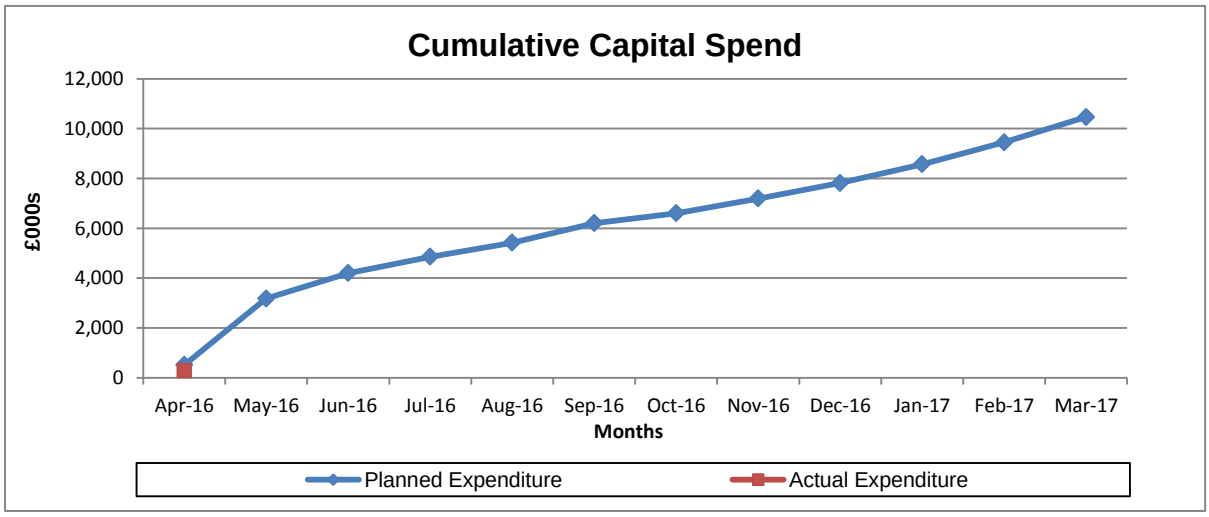


The monthly profile for CRES identified by Localities is shown below.



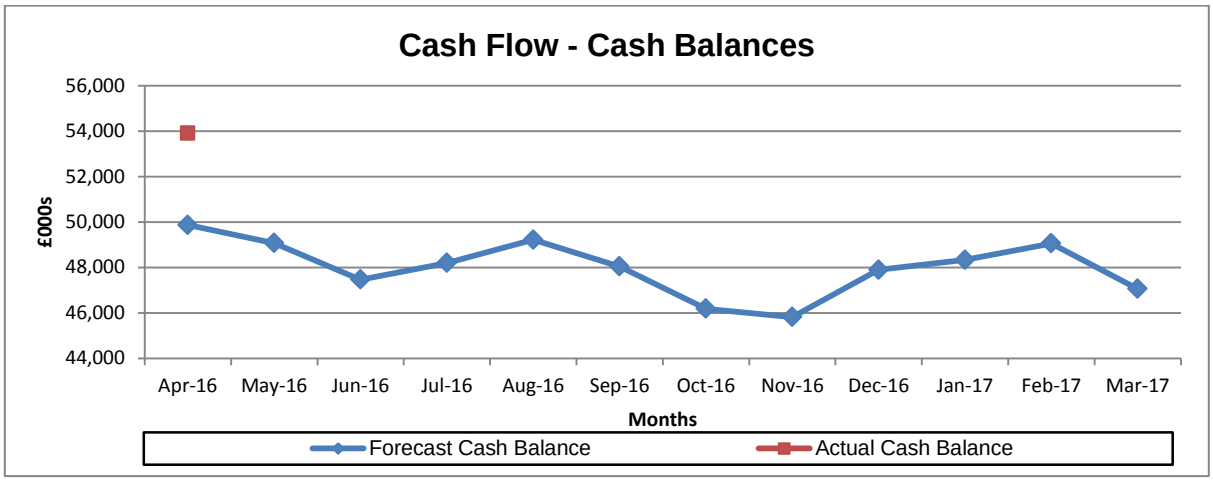
3.3 Capital Programme

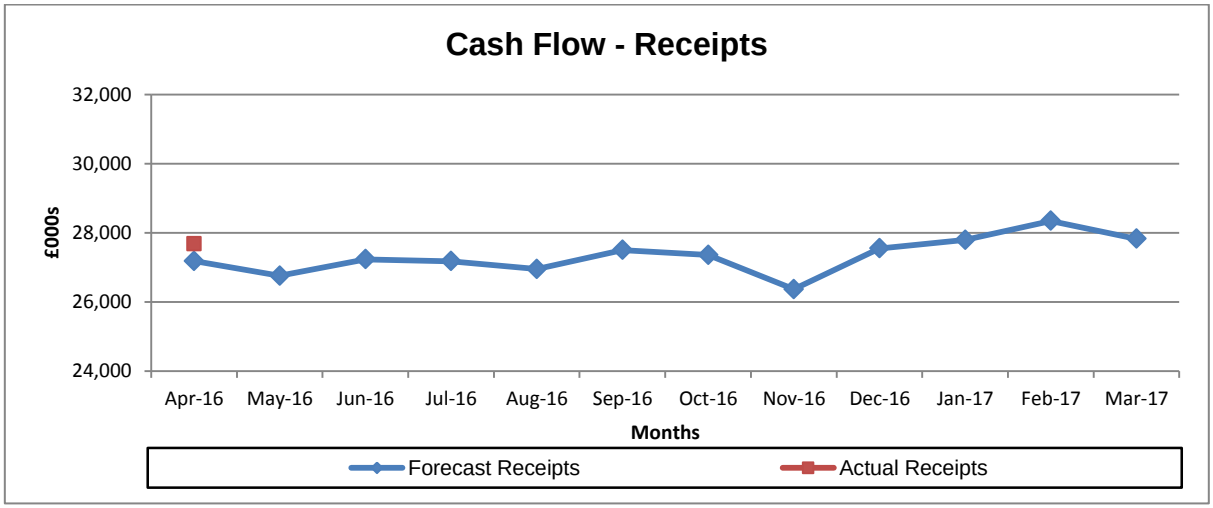
Capital expenditure to 30 April 2016 is £281k and is marginally behind plan.

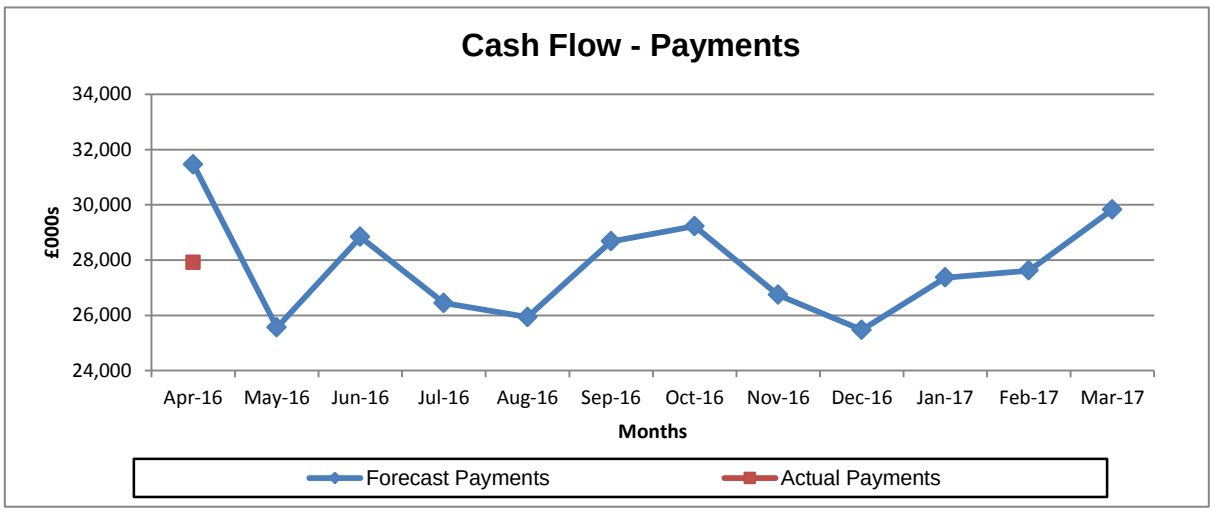


3.4 Cash Flow

Total cash at 30 April 2016 is £53,902k and is ahead of plan due to variances against the planned working capital cycle, predominantly within trade payables and accruals where supplier invoices have not yet been received.



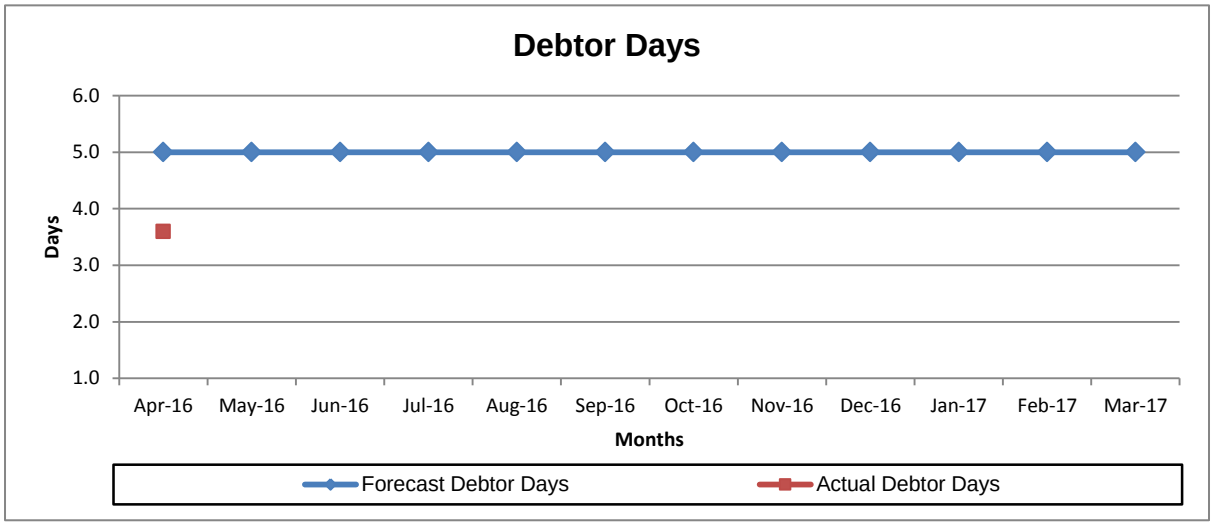




The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.

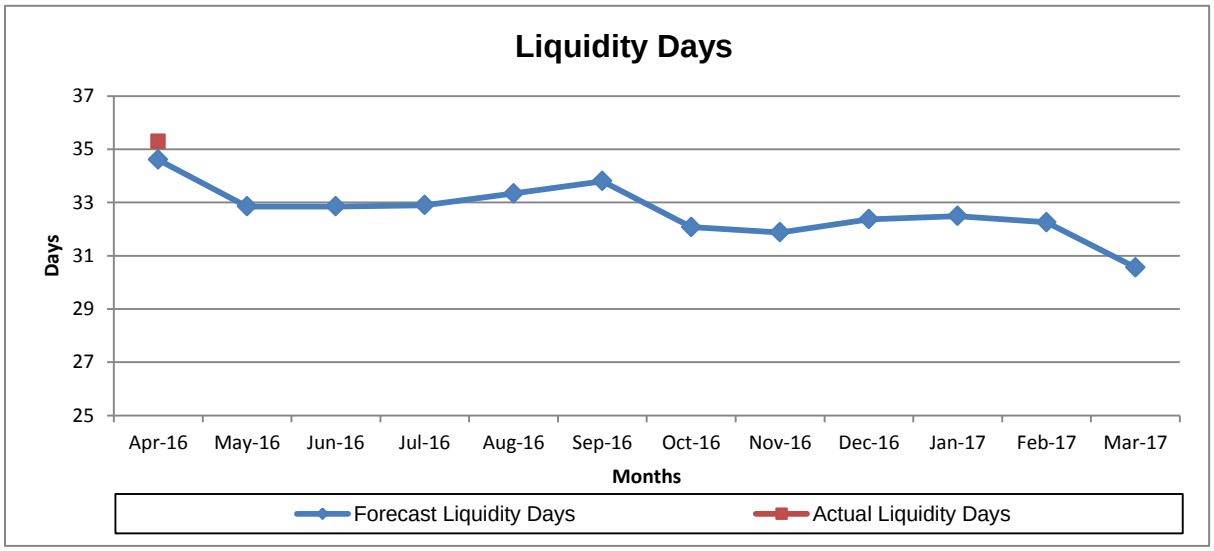
Working Capital ratios for period to 30 April 2016 are:

- Debtor Days of 3.6 days
- Liquidity of 35.3 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 62.00%
  Non NHS 30 Days – 97.14%



The Trust has a debtors' target of 5.0 days, and actual performance of 3.6 days for April, which is ahead of plan.

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



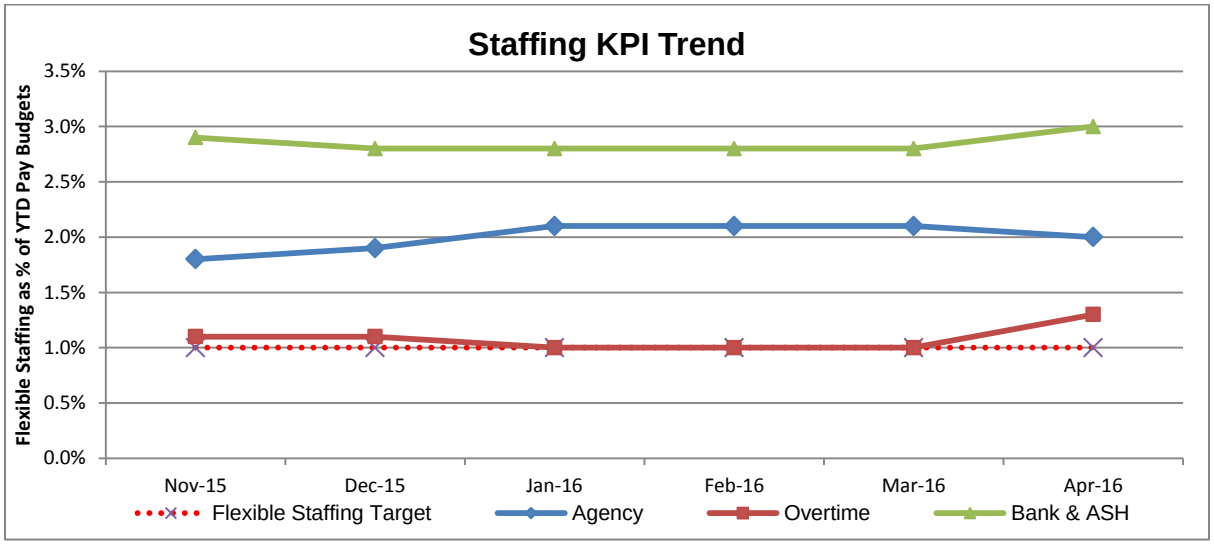
3.5 Financial Drivers

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

Tolerance	Dec	Jan	Feb	Mar	Apr
Agency (1%)	1.9%	2.1%	2.1%	2.1%	2.0%
Overtime (1%)	1.1%	1.0%	1.0%	1.0%	1.3%
Bank & ASH (flexed against establishment)	2.8%	2.8%	2.8%	2.8%	3.0%
Establishment (90%-95%)	93.0%	94.2%	93.1%	92.7%	94.5%
Total	**98.8%**	**100.1%**	**99.0%**	**98.6%**	**100.8%**

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 & ASH. For April 2016 the tolerance for Bank and ASH is 3.5% of pay budgets.

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



Additional staffing expenditure is 6.3% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (58%), enhanced observations (16%) and sickness (12%).

3.6 Risk Ratings and Indicators

3.6.1 The Financial Sustainability Risk Rating is assessed as 2 at 30 April 2016, and is in line with plan.

The rating is planned to increase to 4 by 31 May 2016.

3.6.2 Capital service capacity rating assesses the level of operating surplus generated, to ensure a Trust is able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 0.94x (can cover debt payments due 0.94 times), which is in line with plan and rated as a 1.

The rating of 1 is due to planned repayment of loan capital. The trusts annual plan anticipates this metric to increase to a rating of 2 by 31 May 2016.

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 35.3 days, this is in line with plan and is rated as a 4.

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 4.8% and is rated as a 4.

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 0.7% ahead of plan and is rated as a 4.

The margins on Financial Sustainability Risk Rating are as follows:

- Capital service cover - to increase to a 2 a surplus increase of £766k is required.
- Liquidity - to reduce to a 3 a working capital reduction of £29,221k is required.
- I&E Margin – to reduce to a 3 an operating surplus decrease of £1,033k is required.
- Variance from plan – to reduce to a 3 an operating surplus decrease of £187k is required.

Financial Sustainability Risk Rating at 30 April 2016

NHS Improvement's Rating Guide	Weighting	Rating Categories			
	%	4	3	2	1
Capital service Cover	25	2.50	1.75	1.25	<1.25
Liquidity	25	0.0	-7.0	-14.0	<-14.0
I&E Margin	25	1%	0%	-1%	<=-1%
Variance from plan	25	0%	-1%	-2%	<=-2%

TEWV Performance	Actual		Annual Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service Cover	0.94x	1	0.89x	1	0
Liquidity	35.3 days	4	34.6 days	4	0
I&E Margin	4.8%	4	4.1%	4	0
Variance from plan	0.7%	4	0.0%	4	0

Overall Financial Sustainability Risk Rating	2.00

3.6.7 5.2% of total receivables (£193k) are over 90 days past their due date. This is above the 5% finance risk tolerance, but is not a cause for concern as negotiations are ongoing to resolve.

3.6.8 2.1% of total payables invoices (£281k) 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 30 April 2016 is £53,902k and represents 65.9 days of annualised operating expenses.

3.6.10 Actual capital expenditure is marginally behind plan.

3.6.11 The Trust does not anticipate the Financial Sustainability Risk Rating will be less than 3 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 30 April 2016 is a surplus of £1,305k, representing 4.8% of the Trust's turnover. The Trust is ahead of plan by £186k largely due to higher than anticipated performance against CQUIN targets.

6.2 Total CRES identified at 30 April 2016 is £6,618k and is in line with plan. The Trust continues to progress schemes to deliver CRES for future years.

6.3 The Financial Sustainability Risk Rating for the Trust is a 2 for the period ending 30 April 2016 which is in line with plan.

The Trust plans to achieve a Financial Sustainability Risk Rating of 4 by 31 May 2016, and maintain this to the end of the financial year.

7. RECOMMENDATIONS:

7.1 The Board of Directors are requested to receive the report, to note the conclusions in section 5 and to raise any issues of concern, clarification or interest.

Drew Kendall
Acting Director of Finance and Information

ITEM NO. 17

CONFIDENTIAL

BOARD OF DIRECTORS

DATE:	**24th May 2016**
TITLE:	**Annual Board Statements**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Assurance/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:

Each year the Board is required to sign-off certain statements and certificates and submit them to NHS Improvement.

Assurance on the Board's ability to confirm the annual statements and certificates has been provided by the Audit Committee.

Recommendations:

The Board is asked to:

(1) Confirm the Certificate on Compliance with General Condition 6 of the Provider Licence.

(2) Confirm the Corporate Governance Statement as set out in Annex 1 to this report.

(3) Advise NHS Improvement that the Certificate on Academic Health Science Centres (AHSCs) and Governance is not applicable to the Trust.

(4) Confirm the Certificate on the Training of Governors.

MEETING OF:	**Board of Directors**
DATE:	**24th May 2016**
TITLE:	**Annual Board Statements**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek the Board's confirmation of the annual statements and certificates required by NHS Improvement.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 NHS Improvement requires the Boards of Foundation Trusts to self-certify, annually, the following certificates and statements:

(a) The Certificate on Compliance with General Condition 6 of the Provider Licence.
(b) The Corporate Governance Statement.
(c) The Certificate on Academic Health Science Centres (AHSC) and Governance
(d) The Statement on the Training of Governors.

2.2 The Board is asked to note that, at its meeting held on 12th May 2016, the Audit Committee reviewed the assurances available to support the signing off of the relevant statements and certificates and has recommended to the Board that they should be confirmed (see private agenda item 8).

(Note: Copies of the assurance schedules are provided on Boardpad (in relation to the above meeting of the Audit Committee) or are available to Board Members on request).

3. KEY ISSUES:

Certificate on Compliance with General Condition 6 of the Provider Licence

3.1 The Board is required to confirm or not confirm:

(a) That *"Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution."*

(b) A declaration that the Licensee continues to meet the criteria for holding a licence.

3.2 Following its review the Audit Committee concluded that there was sufficient assurance to confirm Compliance with General Condition 6 of the Provider Licence and has recommended to the Board that the Certificate should be confirmed.

Corporate Governance Statement

3.3 The Corporate Governance Statement (CGS) is made up of a number of components which the Board is required to "confirm" or "not confirm" together with reporting any relevant risks and mitigating actions.

3.4 Board Members will recall that a CGS was provided to Monitor in January 2016 in relation to the York and Selby transaction.

3.5 The Audit Committee has reviewed an updated version of the CGS (attached as Annex 1 to this report), which takes into account progress on the mitigating actions to address the risks previously identified, and has recommended that it should be approved, based on the confirmation of each component, for submission to NHS Improvement.

The Certificate on Academic Health Science Centres (AHSC) and Governance

3.6 The Board is asked to note that, as the Trust is not part of a major joint venture or AHSC, this certificate is not applicable to the Trust and NHS Improvement should be advised accordingly.

Statement on the Training of Governors

3.7 The Board is required to "confirm" or "not confirm" the following statement:

"*The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.*"

3.8 Taking into account the Trust's involvement in the national "Governwell" training scheme and relevant feedback received under the Council of Governor's Performance Evaluation 2015/16, the Audit Committee has recommended to the Board that the statement should be confirmed and submitted to NHS Improvement.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The Trust is required to be registered with the CQC under Licence Condition G7.

4.2 **Financial/Value for Money:** Under the Licence, the Trust has a duty to operate efficiently, economically and effectively.

4.3 **Legal and Constitutional (including the NHS Constitution):** The Trust is required to hold a Licence in order to provide NHS services. Failure to comply with the Licence conditions can result in enforcement action.

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

4.5 **Other implications:** The Board is required to submit the signed certificates under the direction of NHS Improvement.

5. RISKS:

5.1 NHS Improvement will take the responses to the self-certifications into account in determining the risks of the Trust breaching its Licence.

6. CONCLUSIONS:

6.1 Based on the assurances provided by the Audit Committee it is considered that the Board is able to confirm the relevant certificates and statements.

7. RECOMMENDATIONS

The Committee is asked to:

(1) Confirm the following statements and certificates:
   (a) The Certificate of Compliance with General Condition 6 of the Provider Licence.
   (b) The Corporate Governance Statement (attached as Annex 1 to this report)
   (c) The Statement on the Training of Governors.

(2) Agree that NHS Improvement should be informed that the Certificate on Academic Health Science Centres (AHSCs) and Governance is not applicable to the Trust.

(3) Authorise the Chairman and Chief Executive to sign off the annual statements and certificates, as approved, for submission to NHS Improvement.

Phil Bellas, Trust Secretary

Background Papers: The Trust's Provider Licence

Annex 1

Corporate Governance Statement

	Corporate Governance Statement Component	Risks & Mitigating Actions	Proposed Response (Confirm/Not Confirm)
1	The Board is satisfied that Tees, Esk & Wear Valleys NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	1 It is a risk that the culture in York and Selby may not yet be aligned to that of the rest of the Trust. *Mitigating Action:* ▪ *Programme of work implemented to embed the Trust's culture in the York and Selby Locality (March 2017).* 2 It is a risk that the Trust may not yet have a full understanding of issues in the York and Selby Locality (e.g. the true extent of the poor quality estate excluding Bootham Park Hospital). *Mitigating Action:* ▪ *Letter of Assurance from the Vale of York that it will cover any costs incurred by the Trust following the closure of Bootham Park Hospital in York.*	Confirm
2	The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	None	Confirm
3	The Board is satisfied that Tees, Esk and Wear Valleys NHS Foundation Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and	1 It is a risk that certain policies and procedures in the York and Selby Locality are not aligned to the rest of the Trust. *Mitigating Action:* ▪ *Implementation of a programme to apply Trust policies and procedures to the York*	Confirm

	accountabilities throughout its organisation.	*and Selby Locality where practicable taking into account TUPE regulations (September 2016).* (2) It is a risk that the Trust may not yet have a full understanding of issues in the York and Selby Locality. <u>*Mitigating Action:*</u> ▪ *Letter of Assurance from the Vale of York that it will cover any costs incurred by the Trust following the closure of Bootham Park Hospital in York.*	
4	The Board is satisfied that Tees, Esk and Wear Valleys NHS Foundation Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern; (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and	None	Confirm

	Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements		
5	The Board is satisfied that: (a) There is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) The Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) It receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) Tees, Esk & Wear Valleys NHS Foundation Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) There is clear accountability for quality of care throughout the Tees, Esk & Wear Valleys NHS Foundation Trust including, but not restricted to, systems and/or processes for escalating and resolving quality issues including escalating them to the	None	Confirm

	Board where appropriate.		
6	The Board is satisfied that there are systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	1. It is a risk that there is a lack of assurance on safe staffing arrangements in the York and Selby Locality (issue raised in the CQC report on Bootham Park Hospital following the visit in September 2015). *<u>Mitigating Actions:</u>* ▪ *Further growth of the staff bank.* ▪ *Completion of checks on staff transferred from Leeds and York Partnership NHS Foundation Trust (July 2016).*	Confirm

FOR GENERAL RELEASE **ITEM 18**

BOARD OF DIRECTORS

Date of Meeting: **24th May 2016**

Title: **Information and IG Strategy Update 2015/2016 Q3/4**

Lead Director: **Drew Kendall Acting Director of Finance and Information.**

Report for: **Information and approval**

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	✓
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 our communities	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users		Consent to care and treatment			
Personalised care, treatment and support					
Care and welfare of people who use services		Meeting nutritional needs		Co-operating with other providers	✓
Safeguarding and safety					
Safeguarding people who use services from abuse		Cleanliness and infection control		Management of medicines	✓
Safety and suitability of premises		Safety, availability and suitability of equipment	✓		
Suitability of staffing					
Requirements relating to workers		Staffing		Supporting workers	
Quality and management					
Statement of purpose		Assessing and monitoring quality of service provision		Complaints	
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA		Notification of other incidents	
Records	✓				
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

BOARD OF DIRECTORS

Date of Meeting: **24th May 2016**

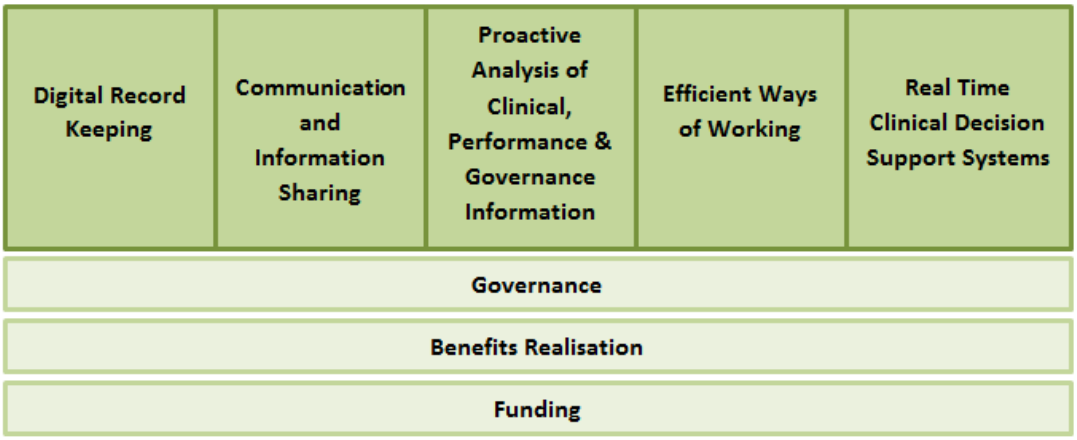
Title: **Information and IG Strategy Update 2015/2016 Q3/4**

1. INTRODUCTION & PURPOSE

1.1 This report outlines the progress made in the second half of 2015/16 against the Trust's Information Strategy. The report highlights any business as usual, project developments or notable achievements made across each of the key theme areas identified in the strategy.

2. BACKGROUND INFORMATION

2.1 Following a period of consultation within the Trust, the Information Strategy 2015-2020 was approved at EMT on 23rd March. This strategy takes account of strategic changes at a national and local level in NHS care delivery and is structured around five key themes, underpinned by three enablers, as below.



2.2 The delivery of the strategy is underpinned by the Information Domain Roadmaps. The current version of the roadmaps focuses upon the two years from 2016 to 2018. Progress against these roadmaps is routinely monitored through the Trust's project management framework and in the Information Domain Groups.

2.3 The current roadmaps have been reviewed to ensure that they align with the change in environment, the NHS information strategy and the Trust priorities over the coming year and are presented in Appendix B – Domain Roadmaps.

3. KEY ISSUES:

3.1 Digital Record Keeping

3.1.1 Clinical digital record keeping

The release management approach for Paris has led to fewer, more co-ordinated releases and upgrades in the last six months, thereby keeping planned downtime to a minimum. There was an internal release of 5 changes to Paris on 2nd December 2015 with no system downtime. There was planned downtime on 3rd February 2016 to upgrade to Paris 5.1 Build 85 to address technical issues. The internal release to

implement the new way of working on Paris was successfully completed on 30th March 2016. This planned downtime in March was also used to expand the infrastructure required to support the additional users from York and Selby.

The overarching aim of the new way of working in Paris is to enable the system to be an intuitive and user friendly system, which mirrors the patient journey and allows the clinician to undertake planned, collaborative person-centred care. Paris now enables patient centred information recording of referral, assessment, Care Plan review, risk and care planning. Additionally the changes aim to help improve the safety and quality of patient care leading to better outcomes for patients and their carers, and to increase time for more face to face contact with people who access our services, by reducing the amount of time needed to record clinical information.

3.1.2 Corporate digital record keeping

Under the KMS project, the platform for the new Trust website was successfully tested by an independent tester and then moved to this secure environment in September 2015. Subsequently there has been ongoing development on the website to integrate into the document management system which will be launched as part of the Intranet release in Q2 2016.

The KMS project successfully completed a Trust wide engagement programme on the new intranet system and Phase 1 of the development of the solution is now complete. The new KMS homepage will be released to staff in Q2 following configuration of the solution. The new system will provide a seamless integration of intranet, documents and website on a single interface.

3.2 Communication and Information Sharing

To support the national agenda of paper free at the point of care by 2020, work has continued alongside the GP Engagement project to develop the capability to send e-discharge summaries to GP practices. This is now in place for sending to GPs who wish to receive via NHSmail or direct into an EMIS system. Sending the e-discharge summaries into SystmOne practices is dependent upon TPP working in collaboration and TPP are being lobbied at a Trust and a wider level.

A website and online learning platform is being developed to support the Trust's Recovery College following a successful bid to NHS England for funds. This Virtual Recovery College is part of the KMS platform, giving efficiencies for both IT infrastructure and the content management process. Good feedback has been received about the design and the positive look and feel of the site from experts by experience and also when the site was demonstrated at the Recovery College Workshop in March.

3.3 Proactive Analysis of Clinical, Performance & Governance Information

IIC developments have continued with the following notable additions to the functionality of the system:

- Patient Legacy Dashboard, allowing users to search for patients from old patient systems;
- Occupied Bed Days, Inpatient Spells, Contacts and Interventions Dashboards;

- Datix Incident Dashboard (featuring hourly updates);
- North Yorkshire Looked After Children;
- Tees LD commissioner reports;
- ETL performance improvement, meaning that the daily data load is 5 hours quicker and the monthly data load is 24 hours quicker.

The QUAG interactive dashboard to support Quality Data on the IIC, and the Finance Operations Dashboard have been developed and are in the User Acceptance Testing phase. The Access and Waiting Time indicator and supporting patient tracker for Early Intervention in Psychosis are also in development.

Paris Dashboards are being developed to deliver: Inpatient Spell - Admissions/Discharges/Length of Stay; Ward Stay - Admissions/Discharges/Length of Stay; Finished Consultant Episodes; Interventions; Referrals; Equality and Diversity; Mental Health Act.

Two major benefits arose from the development of the Patient Legacy Dashboard. The first benefit is that the data is within the IIC rather than a separate isolated system. Secondly, doing this in house with the IIC team avoided a potential one-off cost of approximately £100,000 and £55,000 per annum in licencing costs which had been quoted by a supplier for developing a database and migrating the data.

Work has completed on the new Mental Health Services Dataset (MHSDS) and the first submission including CAMHS data has been made. In addition a MHSDS Data Quality Summary file has been produced to provide a proactive mechanism to support quality data at first submission.

Following the launch of the new DATIX incidents module in September, incident data is now available to view within the IIC where it is updated hourly. This allows it to be triangulated and analysed alongside data from clinical and staff systems. New PALS & Complaints, Claims and Risk modules have also gone live. Developments are in process to ensure this information where appropriate is also available real time within the IIC.

The QUAD project was closed down in December and the Form 4 agreed that the outstanding DATIX development work to the live modules would be carried out the Corporate Products Team as business as usual. The Strategy Team are assessing the benefits of implementing the DATIX Safety Alerts module and are investigating how action plans and lessons learned could be captured and monitored within DATIX as well as considering the potential use of the Request for Information module by the FOI and DPA teams.

3.4 Efficient Ways of Working

Within the Next Generation Devices project, the competitive procurement process for the Virtual Desktop Infrastructure has been completed and a business case was approved at EMT on 16th March and approved at the Trust's Investment Committee on 12th April. The project will link into the Purposeful and Productive Community Services program and will enable real time access to Paris whilst in the community from any device and location (coverage permitting). It will also allow all staff to have access to the corporate desktop and applications from any device securely, whilst also enabling access to all applications via a single sign on. A proposal for a

managed print service for the Trust is also being developed which will rationalise printing within the Trust by introducing a more cost effective solution. This will be submitted to EMT when the proposal is complete. This will also address IG concerns by a “tap & print” print method, meaning that the printing does not start until the requestor “taps” their smartcard on the printer.

In order to pilot Telemedicine to determine if it can successfully be used in patient care, a clinical pilot group has been defined to test Skype for Business in a clinical setting. The pilot group will incrementally test the solution starting from clinicians’ meeting and building up to a full clinical telemedicine solution with the patient connecting from home and the clinician connecting at their place of work. This work is currently being aligned to the Next Generation Device Project to help deliver this solution in the most strategic way. This will include the choice of device and the platform used for the solution. A full To Be business process is currently being developed.

All Trust computers are now on Windows 7 Enterprise, removing the risk from running on Windows XP, and Internet Explorer 11 is now fully rolled out across the Trust, providing staff with a more modern browser which is also compatible with national Spine applications.

To provide detailed IT hardware and software inventory and improve future roll out of applications, the Microsoft SCCM (System Center Configuration Manager) tool has been implemented.

The range of supported devices has been extended to improve workforce efficiency and speed of data collection:

- Patient and Carer feedback tablet devices are now able to connect to the Trust network to allow easier collation of patient experience survey results;
- A tablet device, the Microsoft Surface is now offered as a supported product and Hotel Services will be using these to record cleanliness inspections in real time over the Trust wi-fi;
- Estates and Facilities Management will be using a mobile device over the Trust wi-fi to connect to the BacktraqFM, removing the need for paper job sheets.

To help embed technology, IT Drop-in sessions for Desktop products were held throughout the Trust. Unfortunately take up by staff was low and we will be considering other ways to engage with staff to improve their use of IT products.

After a review of the contract for mobile telephony, the Trust will move to a new contract with Vodafone in Q2 2016 offering the following benefits:

- More predictable fixed costs and a minimum saving of £40k per annum;
- Potential to use BT Open zone wi-fi which would support mobile working;
- 4G coverage being extended in 2016;
- Access to a technology fund that could be used to purchase new devices from Vodafone.

The Information Service Managers have continued to support the Purposeful and Productive Community Services program (PPCS) by carrying out observations.

Discussions are ongoing with the KPO Team as to how the Paris Programme, KMS and Next Generation Device can support PPCS.

The implementation of Assure in the Information Department has enabled a number of improvements to ways of working and provided a leaner process:

- Automatic integration of information from ESR to Active Directory removing the manual process of requesting and creating accounts for new starters;
- Introduction of the ONEform allows access to systems to be requested via a single online form, removing the 12 paper forms previously in use;
- Change control is now managed via the workflow available via Assure, removing the manual process;
- Development of a standard suite of reports to enable Information Department to manage the performance of IT Services;
- Introduction of a framework for managing standard work, technical operating instructions and skills matrix. This will ensure that Information Department staff have the skills and tools required to deliver user support consistently and effectively.

Some benefits are to be measured at 6 months post-closure of the project (July 2016). However the introduction of the ONEform has:-

- Reduced the lead time for account creation from 5 days after starting with the Trust to 1 day before start date;
- Reduced the number of rejected forms from 19% to 0%;
- Replaced 12 paper forms with 2 online forms – 1 for new starters and 1 for access to additional systems.

Guest Wi-Fi access (Businet) has been rolled out across all existing Trust sites allowing key partners and contractors on-site access to their own systems and e-mails.

The Virtual Server Infrastructure project is complete giving the Trust a robust and resilient server infrastructure to reduce unplanned downtime and ensure data integrity. This will also support future developments with the ability to create new virtual servers within hours rather than days or even weeks.

3.5 Real Time Clinical Decision Support Systems

This is the newest element in the Information Strategy and as a result the least mature in terms of delivered developments. As part of building up a common understanding of what Clinical Decision Support Systems could bring to clinical services, the feedback from interviews which took place with selected clinicians in Q2 2015/16 is being used to review potential requirements and will feed into the development of this theme of the Information Strategy.

Under the Decision Support capability in the Local Digital Roadmap work that the Trust will be undertaking with CCGs by the end of June 2016, ‘real-time data analytics at the point of care’ is one of the items in the vision that Local Digital Roadmaps are asked to address.

There are several developments in the Paris Programme that will support this element of the Information Strategy. One is receiving pathology results into Paris.

Civica continue to work on the design with testing due to commence in April 2016. Following successful testing there will be a staggered approach to implementation from July 2016.

A second development that will support this element of the Strategy is Pathways, planned to commence in Q1 2016/17.

E-prescribing can also bring benefits in clinical decision support such as guidance on medication dosage, drug interactions and contra-indications. Beta testing has commenced with the e-prescribing module in Paris, the results of which will feed into a Business Case.

3.6 Information Governance

Data Protection Act 1998 - Subject Access requests Received April 2015 to March 2016

In 2015/16, the Trust received 1198 valid requests which is broadly the same as the previous year. The Trust did not meet the legal deadline of 40 days on 2 occasions which is equal to a 0.17% non-compliance rate. The Trust receives approximately 120 requests per month.

Information Security Incidents

The Trust has dealt with 585 incident evaluations this year of which the greatest cause for concern are those that occurred because information was disclosed in error either by correspondence being addressed incorrectly or fax and printer issues.

Information Governance Toolkit – 2016 submission

The Trust reported an overall score of 89% compliance which is one percentage point higher than last year. Audit North's audit of twelve sequences in the IG Toolkit resulted in a rating of Full Assurance with no recommendations.

Freedom of Information Act Requests

The total number of requests in Q3 and Q4 2015/16 was 117 which was a reduction of 58 compared with the same period for 2014/15 when the number of FOIs was 175. Some of the emphasis on FOI requests over the last quarter has been around unexpected deaths, which Nursing and Governance have been able to provide full responses to.

The 20 day response deadline for providing information was exceeded on 5 occasions in Q3 and on only 1 occasion in Q4.

3.7 Additional Key Developments or Information Strategy Enablers

A Business case to upgrade the Trust's "site to site" network infrastructure has been approved and has commenced. This project provides substantial savings whilst reducing risk from ageing equipment and provides greater resilience at a site level. It also has the major benefit of enabling all York and Selby sites to be connected into the Trust network by the end of June 2016. Once connected to the Trust network,

the York and Selby sites can be moved on to the Phones 4 TEWV phone system, giving a single phone system across the whole Trust.

Significant work has been undertaken by the department to facilitate the merger with York and Selby. Principal achievements include:

- an interim network solution developed in conjunction with Leeds & York Partnership FT, York Teaching Hospital and York City Council to ensure TEWV connection for all sites with the successful deployment commencing on 31st March 2016;
- a Telecoms solution developed in conjunction with BT N3 and York service teams;
- all York and Selby staff moved to the TEWV PC Desktop and Paris system by 19th April 2016. The number of active network accounts as of 12th April was 565 and 447 users had actively logged into Paris by 20th April.

4. IMPLICATIONS / RISKS:

4.1 **Quality:** The ongoing management and delivery of the Information Strategy underpins the Trust's priorities.

4.2 **Financial:** The financial implications of each of the schemes are outlined within the project documentation and management approach.

4.3 **Legal and Constitutional:** A number of developments need to be procured through the OJEU framework due to the nature and size of them – this approach is being followed as required.

4.4 **Equality and Diversity:** Equality and Diversity needs are reviewed during project initiation by carrying out an initial Equality and Diversity assessment which is maintained during the project.

4.5 **Other Risks:** none noted

5. RECOMMENDATIONS

5.1 The Board of Directors is asked to receive this report on the progress made to date against the delivery of the Information Strategy priorities.

Authors:
Carole Walker-Jones - Head of Information for Product Strategy & Development
Louise Eastham - Head of Information Governance and Records Management

Background Papers:
Appendices:
Appendix A - Information Projects RAG Report - March 2016
Appendix B - Information Strategy Roadmaps 2016-2018
Appendix C - Glossary

Appendix A

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
2	**INFORMATION Domain**							**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
3	**Project Title**	**Project Manager/Lead**	**Project Sponsor**	**Project Start Date**	**Project End Date**	**Current Position**	**This months update**												
4	**Integrated information Centre** - Phase 1 = Trust Dashboard, Contract Management and Payment by Results	Richard Yaldren	Sharon Pickering	Jan-09	Jun-16	Open	The IIC faced major database issues which affected its availability and the monthly performance run. Also the 'New ways of working in Paris' required the team to assess the impact of the change on the ETL and design the changes required.	Green	Green	Green	Green	Green	Amber/Green	Amber/Green	Amber/Green	Amber/Green	Amber/Green	Amber/Green	Amber/Red

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	**PATIENT Domain**							**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
2	**Project Title**	**Project Manager/Lead**	**Project Sponsor**	**Project Start Date**	**Project End Date**	**Current Position**	**This months update**												
3	**Paris Programme**	Sue Whitehead	Dr Khouja	Aug-13	Jan-17	Open	**New way working with referrals, assessments, care plan review, risk and care planning** Training commenced on 15.2.16. The new way of working has been well received. Generally good attendance, but low intake in some inpatient areas due to staff not being released. This was discussed at Patient Domain to look at alternatives. Care planning will be included in July release. Full testing commenced 14.3.15. Go live 30.3.15 is dependent on completion of successful testing.	Amber/Green	Red	Green	Amber/Green	Amber/Green	Amber/Green	Red	Red	Green	Green	Green	Green
4	**Telemedicine**	Ian Saunderson	Dr Khouja	Aug-13	Jul-16	Open	A new project plan is currently being developed aligning with the Next Generation Device Project. A pilot of Skype for Business is being set up in Information department to confirm that the product will work across TEWV's infrastructure.	Red	Red	Green	Green	Green	Green	Green	Green	Green	Red	Green	Green
5																			

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	**STAFF Domain**							**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
2	**Project Title**	**Project Manager/Lead**	**Project Sponsor**	**Project Start Date**	**Project End Date**	**Current Position**	**This months update**												
3	**e-SIS** - E-Rostering - Self Service - E-Learning	Emma Haimes	Paul Newton	Oct-10	May-15	Complete		Green	Green	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed
4																			
5																			

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	**DESKTOP Domain**							**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
2	**Project Title**	**Project Manager/Lead**	**Project Sponsor**	**Project Start Date**	**Project End Date**	**Current Position**	**This months update**												
3	**Patient Access to the Internet** - Managed process for giving	Jerry Daniel	Chris Stanbury	Jun-11	May-15	Complete		Green	Green	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed
4	**Knowledge Management** - Procurement - File Management and Records Cleansing - Website improvements - inTouch Stabilisation	Charles Adigo	Elizabeth Moody	Oct-11	Oct-16	Open	Key critical tasks such as the dedicated connection between the Trust and Vodafone datacentre is delayed thereby making the project RAG status Red, the delays were originally the inability of Vodafone to complete the site survey and installation on time. All installations are now complete and a further configuration is required to ensure the line is active and useable.	Amber/Red	Amber/Green	Amber/Red	Amber/Red	Amber/Red	Amber/Green	Red	Red	Red	Green	Amber/Green	Red
5	**Service Desk Support Requirements** - Review of services offered by the Information Service Desk	Andrea Brodie	Linda Blenkinsopp	Nov-11	Nov-15	Open	Awaiting acceptance of PM4 and formal closure of project.	Green	Green	Green	Green	Amber/Green	Green	Green	Green	Green	Grey	Grey	Grey
6	**Governance Information Reporting and Management renamed to Quality Assurance and DATIX Expansion (QuAD)**	Nichola Watkins	Elizabeth Moody	Sep-13	Jan-16	Complete		Green	Amber/Red	Amber/Red	Green	Green	Green	Green	Green	Amber/Green	Closed	Closed	Closed
7	**Smartphones**	Michelle Ferguson	Elizabeth Moody	Mar-14	Apr-15	Complete		Green	Green	Green	Green	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed
8	**Digital Input Development**	Jo Turner	Elizabeth Moody	Oct-11	Mar-15	Complete	Project closed at EMT on 16th March 2016.	Green	Green	Green	Green	Green	Grey	Grey	Grey	Grey	Grey	Grey	Closed
9	**Patient Experience**	Michelle Ferguson	Elizabeth Moody	Aug-15		Open	Received allocation from Procurement, had kick off meeting and going to use the NOECPC Framework for the proposed solution - awaiting draft timeline from Procurement - when received will update PM2 with new dates					Green	Amber/Green	Amber/Green	Red	Red	Red	Red	Green

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	**INFRASTRUCTURE Domain**							**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
2	**Project Title**	**Project Manager/Lead**	**Project Sponsor**	**Project Start Date**	**Project End Date**	**Current Position**	**This months update**												
3	**Phones 4 TEWV**	Bob Matheson	David Brown	Nov-11	Mar-15	Closed		Green	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed
4	**EFM Software Review**	Ian Saunderson	David Brown	Feb-14	Dec-15	Closed		Green	Red	Green	Green	Green	Amber/Green	Amber/Green	Amber/Green	Red	Red	Green	Closed
5	**Next Generation Device**	Jerry Daniel	David Brown (phase 1) Elizabeth Moody (phases 2 and 3)	Dec-12	Apr-17	Open	Phase 1 - Server Virtusalisation complete, a few remaining physical server remain and will be migrated as part of BAU Phase II - Form 3 approved by EMT. Paper to go to Investment Comittee on 12/4 Phase III - Printer Rationalisation. Tender document with framwork for final review, awaiting publication date.	Amber/Green	Amber/Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
6	**Coin Project**	Ian Colledge	David Brown	Oct-15	Apr-17	Open	The two gateway sites Flatts Lane Centre and Lanchester Road Hospital have now been installed. Migration of these two sites are scheduled for 24/04/2016. All remote site surveys will be completed by mid April.							Green	Green	Green	Green	Green	Green

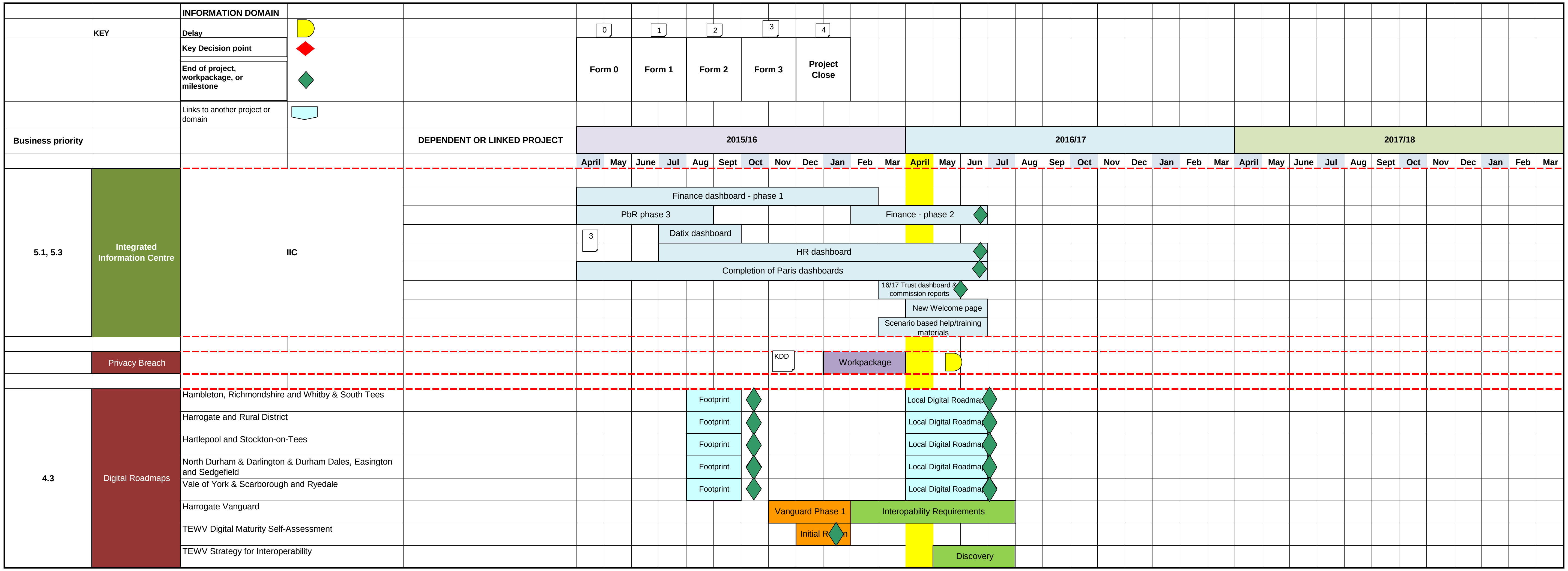
Information Projects RAG Report

% of Information Strategy on track for delivery i.e. GREEN or AMBER/GREEN
The target is <10% AMBER/RED or RED

DOMAIN	NUMBER OF PROJECTS	ON TRACK
Information	1	0
Patient	2	2
Staff	0	0
Desktop	2	1
Infrastructure	2	2
TOTAL	**7**	**5**

% of Information Strategy projects on track for delivery i.e. GREEN or AMBER/GREEN is 71%

Appendix B


INFORMATION DOMAIN
KEY
Delay
Key Decision point
End of project, workpackage, or milestone
Links to another project or domain
0
1
2
3
4
Form 0
Form 1
Form 2
Form 3
Project Close
Business priority
DEPENDENT OR LINKED PROJECT
2015/16
2016/17
2017/18
April May June Jul Aug Sept Oct Nov Dec Jan Feb Mar April May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar April May June Jul Aug Sept Oct Nov Dec Jan Feb Mar
5.1, 5.3
Integrated Information Centre
IIC
Finance dashboard - phase 1
PbR phase 3
Finance - phase 2
Datix dashboard
HR dashboard
Completion of Paris dashboards
16/17 Trust dashboard & commission reports
New Welcome page
Scenario based help/training materials
Privacy Breach
KDD
Workpackage
4.3
Digital Roadmaps
Hambleton, Richmondshire and Whitby & South Tees
Harrogate and Rural District
Hartlepool and Stockton-on-Tees
North Durham & Darlington & Durham Dales, Easington and Sedgefield
Vale of York & Scarborough and Ryedale
Harrogate Vanguard
TEWV Digital Maturity Self-Assessment
TEWV Strategy for Interoperability
Footprint
Local Digital Roadmap
Vanguard Phase 1
Interopability Requirements
Initial R n
Discovery

					Form 0	Form 1	Form 2	Form 3	Project Close
		PATIENT DOMAIN							
		KEY	Delay		0	1	2	3	4
			Key Decision point						
			End of project, workpackage, or milestone						
			Links to another project or domain						
Business priority				DEPENDENT OR LINKED PROJECT	2015/16				
					April	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
5.3	Tele-Medicine	Teleconsulations with service users		Link to Telephony Strategy; CQUIN 3 million lives	t of We	2a	Pilot commercial Skype							2a	Pilot Skype for Business	
							Evaluate N3 SeeYou & NHSmail Skype for Business									
4.1, 5.1, 5.3	PARIS Programme	Accessing PDS through Paris (pilot - 1 team)					Prep & sign off from HSCIC									
		MIG e-Discharge					Design, test and release into Pa									
		New assessment and risk management proces					Design & test							Staff Training		
		Pathlabs Phase 1					Design & test							Staff Training		
		Recording of Leave					Design & test							Staff Training		
		Letters/Document attachment pilot inc DOLs								Design & test			Implement in MHA team			
		Care Planning												Design & test		
		Pathlabs Release 2												Design & test		
		Staff Diary												Design & test		
		Force Reduction												Design & test		
		Mental Health Act (section 136/132)												Design & test		
		Mental Health clustering tool												Design & test		
		Allergy Module												Design & test		
		Scanning & attachment in Paris													Design & test	
		e-Referrals (Choose and Book)									Scoping				Design & test	
		Pathways/workflow														
		e-Prescribing beta													Design and Planning	
		Beta Testing Paris Version 6	TBC													
		Standard CPA Documentation	TBC													
5.3	Patient Systems business as usual	Paris Upgrade v5.1									Testing					
		Paris Advanced Printing														
		SystmOne in Ridgeway														
		Care Records legacy integration (Maracis & ePEX)												IIC Legacy lookup		
		Care Records legacy integration (PIMS & PBIS)												IIC Legacy lookup		
	COMPLETED OR CANCELLED PROJECTS	Completed projects will be in Benefits Monitoring phase														
	GPS tracking															
	Paris Upgrades and Programme of Developments: Workstream 1 (Mandatory system upgrade plus improved navigation)	Paris Upgrade v5.1	Office 2007 upgrade (precursor)													
		Review of Paris training and Paris refresher training	E-Learning project													
	Summary Care Record	Summary Care Record														

					2016/17												2017/18											
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
5.3	Tele-Medicine	Teleconsulations with service users		Link to Telephony Strategy; CQUIN 3 million lives				KDD																			
4.1, 5.1, 5.3	PARIS Programme	Accessing PDS through Paris (pilot - 1 team)																									
		MIG e-Discharge																									
		New assessment and risk management proces																									
		Pathlabs Phase 1			Test	Training		1 lab	Other lab roll-out																		
		Recording of Leave				Training																					
		Letters/Document attachment pilot inc DOLs					Pilot MHA		Roll-out																		
		Care Planning				Staff Training																					
		Pathlabs Release 2				Staff Training		Test		Train																	
		Staff Diary				Staff Training																					
		Force Reduction				Staff Training																					
		Mental Health Act (section 136/132)				Staff Training																					
		Mental Health clustering tool				Staff Training																					
		Allergy Module				Staff Training																					
		Scanning & attachment in Paris				Staff Training																					
		e-Referrals (Choose and Book)				Staff Training																					
		Pathways/workflow				Design & test				Staff Training																	
		e-Prescribing beta					Testing																				
		Beta Testing Paris Version 6	TBC																								
		Standard CPA Documentation	TBC																								
5.3	Patient Systems business as usual	Paris Upgrade v5.1																									
		Paris Advanced Printing																									
		SystmOne in Ridgeway																									
		Care Records legacy integration (Maracis & ePEX)																									
		Care Records legacy integration (PIMS & PBIS)																									
	COMPLETED OR CANCELLED PROJECTS	Completed projects will be in Benefits Monitoring phase																									
	GPS tracking																										
	Paris Upgrades and Programme of Developments: Workstream 1 (Mandatory system upgrade plus improved navigation)	Paris Upgrade v5.1	Office 2007 upgrade (precursor)																								
		Review of Paris training and Paris refresher training	E-Learning project																								
	Summary Care Record	Summary Care Record																									

STAFF DOMAIN

KEY

Delay

Key Decision point

End of project, workpackage, or milestone

Links to another project or domain

0 Form 0 | 1 Form 1 | 2 Form 2 | 3 Form 3 | 4 Project Close

Business Priority			DEPENDENT OR LINKED PROJECT
	Working from home	Consider any legal or H.R. requirements of allowing staff to work from home upon the I.T. solution	Telephony Strategy, Unified Access Thin client review, PC Operating System review
	Staff system review	Requirements of a staff system 2015 -> Review ESR 2	
	HR Case Management	Electronic HR support, advice and admin tracking system	Service Desk Review
3.1	Talent Management	Recording of Talent Management Data	ESR 2 review
	Electronic Lease Car System	Electronic system for managing lease car mileage returns	
5.3	Corporate Systems Business as usual	Electronic Staff Record	
		Healthroster	
5.3	E-Learning Hosting	Hosting solution for locally created e-learning content	Links to Server Virtualisation Project
	Nurse Revalidation	Investigation of electronic systems to support Nurse Revalidation	
	Staff System Market Analysis	Market Analysis of Staff Systems for Rostering and production of data files to support payroll	
	Volunteers	System required for the management of Volunteers information	
5.1	Direct Booking of Bank Shifts	Workpackage to implement functionality so users can direct book themselves onto bank shifts	
	Not yet approved	Listed below form 0's proposals not yet approved	
	COMPLETED PROJECTS		
	Revalidation	Revalidation for medical staff	
	IIM	Integrated ID Management UIM (scope longer term requirements)	Active Directory (potential link)
	Competency testing	Competency testing as part of recruitment and selection	Running alongside project in H.R. to consider I.T. solution for the testing
	ESIS Project	E-Learning requirements gathering	
		Implementation of additional training tools	
		Self Service- revised timescales	
		Smart Cards	
		Additonal functionality including enabling E&T and Annual Leave	
		E-rostering- revised timescales	Start up slipped by two months due to delay in PM start date
		Version 10 Health Roster	
		Centralised Rostering Pilot	
		Benefits Realisation	

2015/16: April May June Jul Aug Sept Oct Nov Dec Jan Feb Mar

2016/17: Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

2017/18: April May June Jul Aug Sept Oct Nov Dec Jan Feb Mar

Awaiting development of Next Generation Device Project

IBM take over ESR Management

ESR move to IBM Infrastructure

ESR V 2 Live

Service Desk Requirements OBC approved - workstream will be monitored through the Desktop Domain Strategy

Implementation

Milestones identifed in Busniness Plan for roll out of Talent Management - All B7/6 Q3, All of Trust Q4 16/17

0 Virtualised Server Environment

Develop Spec for Server requirements

0 KDD

Develop ESR Guidance to support export of info

1st Nurses to Revalidate

0 Market Analysis KDD Requirements Gathering Contract Negotiation

0 Requirements Gathering KDD

1 Workpackage Delivery

Embed functionality within the

4

Propo sal to extend

DESKTOP DOMAIN

KEY	
Delay	(yellow delay symbol)
Key Decision point	(red diamond)
End of project, workpackage, or milestone	(green diamond)
Links to another project or domain	(light blue tab)

Gates: 0 Form 0 | 1 Form 1 | 2 Form 2 | 3 Form 3 | 4 Project Close

Timeline: 2015/16 (April – Mar), 2016/17 (April – Mar), 2017/18 (April – Mar)

Business Priority			DEPENDENT OR LINKED PROJECT	Timeline entries
1.2, 5.3	Knowledge Management	Procurement	Network Security Review - internet gateway (possible precursor)	
		Website	KMS dependant on successful testing of Nuxeo drive in the vurtual environment	Proof of conc (April 2015); Interim Website Go-Live (June 2015); Website Go-Live Phase 1 (Sept 2015)
		Document Management	KMS project on the NUXIO solution working to its full extent on the ability of NGD to virtuliase the NUXIO software	3; Go-Live Group 1 (Jul 2016); Go-Live Group 2 (Oct 2016); Go-Live Group 3 (Jan 2017)
		Intranet		Proof of conc (April 2015); Trust Wide Dashboard (Feb – Mar 2016)
		Extranet		Proof of conc (April 2015)
		Virtual Recovery College - phases 1 & 2	SQL environment	Discovery (Oct – Nov 2015); Procurement (Dec 2015 – Jan 2016); Develop (Feb – April 2016); UAT (May – June 2016); Go-Live (Jul 2016)
	Digital / scanned signatures	Scanned signatures (workpackage) & digital signatures	Digital signatures - Active Directory and possibly to Smartcards	
5.1, 5.3	QUAD	Governance Data Redesign		Transitio (April 2015)
		Datix phase 1 - Incidents and PALS & Complaints Module		Config & Requirements (April – June 2015); Upgrade DATIX to V 12.3 (Jul – Aug 2015); Transition to Ops (Sept – Nov 2015); 4; 5
		Datix phase 2 - Risk & Claims,		Implement additional modules (Jul – Oct 2015); Transition to Ops (Nov – Dec 2015)
		Safety alerts, Medical Devices, DPA & FOI Modules		Requirements (Jan – Mar 2016)
		Document attachment/linkages in DATIX		Requirements (Jan – Mar 2016)
		Datix phase 3 - Requirements from DILL, Force Reduction & Harm Minimisation projects considering use of Action plans, investigations, lessons learned.		Requirements (Jan – Mar 2016)
5.1	DATIX BAU Work	V14 upgrade		UAT (Mar 2016); Upgrade DATIX to V 14 (April – June 2016)
		Support Risk Management Project		Requirements phase 1 (Jan – Mar 2016); Requirements phase 2 (April – June 2016)
		Create archive of CDDPS following Y&S move to New Datix		Go-Live. Create Archive and apply (April – June 2016)
	Patient Experience	Existing devices to be able to use Wi-Fi		3
		Electronic solution for collection of Patient Safety data	Third party use of TEWV WiFi - possible for workstream 1	Recruitment (April – May 2015); Requirements (June – Sept 2015); 3; Procurement and setup (Nov 2015 – Jan 2016); Transition to Ops (Feb – Mar 2016)
5.3	Service Desk Review	Review of services offered by the Information Service Desk	Potential link to KMS Telephony Strategy; SQL environment	Implementation (April 2015 – Jan 2016)
		System Development		System Development Phase 2 (April – Sept 2015); Ops (Oct 2015)
		QIS work		KPIs (Sept 2015)
	Handheld devices on the patient access network	Investigate requirements to connect trust owned handheld devices to the patient access network		3 Awaiting outcome of Next Generation Device project
5.3	Smart phones phase 2	Workstream 1 - replace Galaxy Ace Plus devices		
		Workstream 2 - deploy Smartphones to support Digital Voice Dictation project		4
		Workstream 3 - user roles, central management, consider Apps, tethering, MDM		
5.3	Records Management			1; Procurement (Jul – Dec 2015); Workpackage to develop SQL database (Jan – April 2016)
	Not yet approved	Listed below form 0's proposals not yet approved		

COMPLETED PROJECTS

Digital Voice Dictation		4
Trust funded NHSmail SMS texting service		
Patient Access to the Internet	Patient Access- revised timescales	4

H:\4. DOCS FOR SP, DK & CM\DK\Trust Board Docs\May 2016\Appendix B Information Strategy domain roadmaps April 2016 v0.1
Desktop

INFRASTRUCTURE

KEY

Delay

Key Decision point

End of project, workpackage, or milestone

Links to another project or domain

Form 0 | Form 1 | Form 2 | Form 3 | Project Close

Business Priority			DEPENDENT OR LINKED PROJECT	2015/16											2016/17												2017/18											
				April	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
1.1, 5.3	NGD Phase 1	Project Initiation																																			
		Server Virtualization	E-Learning Hosting	Implementation																																	
	NGD Phase2	Desktop Virtualization	KMS dependant on successful testing of Nuxeo drive in the virtual environment	Procurement										3 Assesment/baseline																							
		BYOD	KMS project on the NUXEO solution working to its full extent on the ability of NGD to virtuliase the NUXEO software											Design,build & test																							
		MDM														500 user pilot																						
		Spine persistence																				Pilot Evaluation															
		VDI																										User migration phase										
		Licence compliance																																			
		Single Sign On																																			
	NGD Phase 3	Printer rationalisation							Requirements							Procurement				3																	
5.3	COIN Upgrde	Implementation of new data network												York & Selby implementation																							
														Gateway sites LRH & FLC																							
															Remote sites phase 1																						
																Remote sites phase 2																					
																			Remote sites phase 3																	
																						Remote sites phase 4													
																							Closedown													
5.3	Trust Switchboard Services	Review of switchboard services for the Trust																																			
5.3	BAU Work	Security review recommendations													Resource and capacity assesment																						
		A.D. integration and data quality review								ESR integration requirements & data quality assesment			KDD		Implementation				Post implementation data quality assesment																			
	COMPLETED PROJECTS	These projects are now in a Benefits Monitoring phase																																			
	Network and Security Review	*Unified Access (complete)*	Firewall security configuration (precursor) Security assessment of LAN (precursor)																																		
		Network Security																																			
		VLAN		Operational Product & Benefits Monitoring																																		
		Authentication, Authorisation and Accounting (complete)																																			
		Network Monitoring Enhancement Upgrade (complete)																																			
		Quality of Service (network priority for key systems)																																			
		Voice Over IP preparation (switch upgrade)																																			
	Sharing wifi with Partners and Third Party use	Review how we can use wireless access infrastructure with partners and guests incorporates Third party use of TEWV wifi	Infrastructure config & security review								Busines 'guest access' was delivered with the new wifi network - installed in Summer 2015																										
	Phones 4 TEWV			4 Operational Product & Benefits Monitoring																																		
	EFM Software Requirements	EDI Billing		EDI Billing supplier passed pen test in																																		
		EFM Software Review - review of EFM software requirements				2a						3																										
		Electronic solution for collection of cleanliness data																																			

Version	Changes	Date
0.1	Initial version created (IS)	11/04/2016
0.1	Updated Digital Roadmaps	13/04/2016
0.1	Update Patient - Draft 1 to be checked with SW	15/04/2016
0.1	Updated VRC on Desktop Domain (IS)	19/04/2016
0.1	Updated Information Domain (IS) - included the 5 LDRs TEWV is part of; updated IIC	19/04/2016
0.1	Update Patient - Draft 2	21/04/2016
0.1	updated Infarstructure BAU, COIN and NGD	21/04/2016
0.1	Updated Desktop timecales	21/04/2016

Appendix C – Glossary

Active Directory	A Microsoft directory service for managing networks running Windows operating system.
Assure	System used by TEWV Information Servicedesk for logging and managing calls, and for managing change requests for IT systems.
BacktraqFM	An electronic system used by Estates and Facilities Management for fault management and planned maintenance.
BT N3	Supplier of telecommunications, networking and computer services to the NHS.
BT Open zone	Public wi-fi access provided by BT.
Civica	The supplier of the Paris electronic patient record system.
DATIX	TEWV'S incident management system.
DPA	Data Protection Act
EMIS	Electronic patient record system used in primary care.
ETL	Extract Transport Load – used to move data into the IIC from the source systems.
ESR	Electronic Staff Records – national system used in NHS for managing staff records.
FOI	Freedom of Information
IIC	Integrated Information Centre – TEWV performance management system incorporating patient data from Paris, staff data from ESR and incidents from DATIX.
KMS	Knowledge Management Solution - a document and records management system which will replace Trust shared folders and the intranet. It is used to provide the Trust's external website and will also host the Virtual Recovery College.
ONEform	Electronic form used for requesting access to IT systems and shared folders and for requesting changes to access.
PALS	Patient Advice and Liaison Service
SCCM	Microsoft's System Center Configuration Manager – systems management product for managing computers and smartphones.
SystmOne	Electronic patient record system used in primary care.
VRC	Virtual Recovery College – an online system to support the Recovery approach. It will provide access to information and online training to support Recovery for service users, carers and Trust staff.

ITEM NO. 19

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24th May 2016**
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:	**24th May 2016**
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
263	3.5.16	Contract documents relating to Peppermill Court, York.	Mr. C. Martin, Chief Executive Mr. D. Kendall, Acting Director of Finance

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.

4.4 **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)

ITEM NO. 20

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24 May 2016**
TITLE:	**Policies and Procedures 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:

2 new procedures requiring ratification to replace 1 existing policy:

Organisational Change Procedure HR-0018-v6
Redeployment Procedure HR-0049-v1

1 policy and 3 procedures requiring ratification after significant amendment:

Lease Car Policy FIN-0005-v4
Grievance Procedure HR-0002-v6
Flexible Working Procedure HR-0045-v2
Special Leave Procedure HR-0028-v5

2 policies and 3 procedures requiring re-ratification after minor amendment:

Rapid Tranquilisation Policy CLIN-0014-v6
Rapid Tranquilisation Procedure (post administration and monitoring) CLIN-0014-02 v1.1
Administration of oxygen in an emergency situation for adults and children Protocol PHARM-0020-v4
Option to Increase Annual Leave HR-0035-003
End of Employment Procedure HR-0044-v2

2 policies and 3 procedures requiring extension for 3 years having undergone review

and not needing any change:

IT-0030-v1 Data Management Policy
CLIN-0074-v1 Ear Irrigation Guidelines
HR-0016-v5 Responsibility for Providing References
HR-0029-v3 Retirement and Long Service Procedure
HR-0020-v2 Standards of Business Conduct

1 procedure requiring its review date to be extended:

HR/0041/001/v1 Appraisal Procedure for Medical Staff

1 policy and 3 PGDs are to be removed from the policy portfolio.

HR/0018/v5(1) Organisational Change Policy
PGD 13 Zopiclone 7.5 mg tablets to adult inpatients requiring medication for the short term treatment of insomnia
PGD 14 Lorazepam 1 mg tablets to adult inpatients for the treatment of acute agitation
PGD 15 Influenza Vaccine to Adult Patients

The Responsible Directors for 42 strategies, policies and procedures have changed.

Recommendations:

The Board are asked to ratify the decisions made by EMT on 04 May 2016

DATE:	**24 May 2016**
TITLE:	**Policies and Procedures Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

1. INTRODUCTION & PURPOSE:

The purpose of this report is to advise the Board of Directors on the policies and procedures that have been ratified by the Executive Management Team.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 It is important that the Trust policy portfolio is updated and revised in a timely way to ensure best practice, current legislation and regulation is reflected in policy content. Policies no longer required to control and assure practice should be terminated and withdrawn from the portfolio.

2.2 Following the last revision of the Trust's Integrated Governance arrangements, it was agreed that the Executive Management Team ratify all new and revised Trust policies and procedures.

2.3 Each policy and procedure ratified by the Executive Management Team will have gone through the Trust's consultation process.

2.4 Currently all corporate Trust policies are ratified by the EMT on behalf of the Board of Directors, following approval by the appropriate specialist committees and groups. All decisions regarding the management of the policy framework must be ratified by the EMT.

3. KEY ISSUES:

3.1 The following new documents have been produced and required ratification:

HR-0018-v6 Organisational Change Procedure
HR-0049-v1 Redeployment Procedure
Review date 4 May 2019

The above procedures have been developed to replace the single Organisational Change Policy.

3.2 The following have undergone significant amendment and required ratification:

FIN-0005-v4 Lease Car Policy
Review date 4 May 2019

This policy now has addition sections to allow salary sacrifice as a method of payment, as previously agreed by EMT 27 January 2016.

HR-0002-v6 Grievance Procedure
Review date 4 May 2019

In addition to minor amendments throughout the document, the process flowcharts have undergone a major review:

- The individual who the grievance is against, will be called to the Stage1 in an attempt to resolve the grievance
- In cases of bullying and harassment – if attempts to resolve the situation during the stage 1 or via mediation is not possible then formal investigation will be required
- When investigation is required in the case of alleged bullying and harassment, this will be conducted under Trust Disciplinary Procedure.
- Stage 1 adjourned – changed fact finding to suspend hearing for additional information to be gathered
- On the conclusion of any Disciplinary Procedure the individual who raised the grievance will receive appropriate feedback by the Manager from the Stage 1 hearing. Also included that the person who the grievance was against will receive a copy of the outcome letter.

HR-0045-v2 Flexible Working Procedure
Review date 4 May 2019

This has undergone review in line with the Flexible Working Regulations 2014, and new process flowchart added.

HR-0028-v5 Special Leave Procedure
Review date 4 May 2019

This procedure has had a number of significant changes:

- Inclusion of Career break scheme and associated application form/flowchart
- Age of eligibility (of children) for Parental Leave – under age 18 years (disabled or able-bodied) from April 2015
- Addition of up to 10 days bereavement leave (pro rata for part time employees)
- Reference made to “Shared Parental Leave”.

3.3 The following policy and procedures have undergone minor amendment and required re-ratification:

Rapid Tranquilisation Policy CLIN-0014-v6
Rapid Tranquilisation Procedure (post administration and monitoring) CLIN-0014-02 v1.1

Administration of oxygen in an emergency situation for adults and children Protocol PHARM-0020-v4

These documents all required minor amendment following revision of the EWS: Procedure for Using the Early Warning Score for the Early Detection and Management of the Deteriorating Patient.

HR-0035-003 Option to Increase Annual Leave
Review date 4 May 2019

Salary calculations have been amended to reflect Agenda for Change pay scales.

HR-0044-v2 End of Employment Procedure
Review date 4 May 2019

Wording has been added to the amount of notice required if retiring and claiming NHS pension.

3.4 The following underwent full review and needed no change. They therefore required extension for 3 years:

IT-0030-v1 Data Management Policy
CLIN-0074-v1 Ear Irrigation Guidelines
HR-0016-v5 Responsibility for Providing References
HR-0029-v3 Retirement and Long Service Procedure
HR-0020-v2 Standards of Business Conduct
Review date 4 May 2019

3.5 The following document required the review date to be extended:

HR/0041/001/v1 Appraisal Procedure for Medical Staff
Review date 27 November 2016

This has undergone full review and is currently with the Trust's solicitors for verification.

3.6 The following documents are to be removed from the policy portfolio.

HR/0018/v5(1) Organisational Change Policy

This policy is to be removed from the policy portfolio having been replaced by the Organisational Change Procedure (HR-0018-v6) and Redeployment Procedure (HR-0049-v1)

PGD 13 Zopiclone 7.5 mg tablets to adult inpatients requiring medication for the short term treatment of insomnia
PGD 14 Lorazepam 1 mg tablets to adult inpatients for the treatment of acute agitation
PGD 15 Influenza Vaccine to Adult Patients

These Patient Group Directions have been removed and will not be replaced.

3.7 The Responsible Director for a number of documents has changed.

Responsibility for the following has changed from Martin Barkley to Colin Martin:

Quality Strategy	STRAT/0029

Responsibility for the following has changed from Colin Martin to Drew Kendall:

Telephone Usage Policy	IT-0022
Records Management Policy	CLIN/0013
Information Governance Policy	CORP/0006
Internet Policy	IT/0007
NHSmail Policy	IT/0006
Information Security Policy	IT/0010
Travel and Subsistence Policy	FIN/0004
Lease Car Policy	FIN/0005
Confidentiality and Sharing Information	CORP/0010
P&P for the Development of Policies, Procedures, Standards and Guidelines	CORP/0001
Data Management Policy	IT-0030
Maintenance of IT Systems	IT-0032
Anti-Fraud, Bribery and Corruption Policy	FIN/0003
Access to Information Systems	IT-0031
CCTV Policy	CORP/0003
Records Lifecycle Management Strategy	STRAT/0001
Smartcard (CIS) User procedure	IT-0031-006
Email procedure	IT-0006-001
IT and Telephony Reassignment and Disposal Procedure	IT-0020-002
Information Asset Register Procedure	CORP-0056

Patient Access to IT	IT/0002
NHS No. Procedure	IT/0014
Maintenance of IT Systems	IT-0032
Monitoring and auditing service user confidentiality	CORP-0063
Minimum standards for corporate record keeping	CORP/0033
Network User Access Procedure	IT-0004
Introduction or Upgrade of an Information System(s) Procedure	IT-0019-001
Electronic Staff Record (ESR) User Procedure	IT-0031-003
Health Roster (RosterSuite) procedure	IT-0031-005
Use of Visual and Audio Recordings in Clinical Procedures	CLIN-0013-001
Retention and disposition of records procedure	CORP/0026
Procedure for Creating and Retrieving Clinical Records Care Records	CORP/0027
Availability of Records Procedure	CORP/0030
Unified Record Procedure	CORP/0028
Procedure for Moving Records and Other Sensitive Information	CORP/0029
Receipt of Cash, Cheques, Receipts and Other Valuables	FIN-0006
Guidance for handling patients' monies and valuables	FIN-0007
Receipt of Cash, Cheques, Receipts and Other Valuables	FIN-0008

Responsibility for the following changed from Dr Land to Elizabeth Moody:

Trust responses to Regulation 28 reports from Coroners	CORP/0047/v2
Supporting staff in clinical negligence claims procedure	CORP-0011-001
Supporting staff in personal injury claims procedure	CORP-0011-002

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 meetings on 04 May 2016 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