AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 30TH OCTOBER 2018 VENUE: THE HILTON YORK, 1 TOWER STREET, YORK, YO1 9WD 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 **25th September 2018**.		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To receive a briefing on the key issues in the York and Selby Locality.	**Patrick Scott to attend**	**Presentation**
Item 7	To receive and note the report of the Freedom to Speak Up Guardian.	**Dewi Williams to attend**	**Attached**
Item 8	To consider the monthly "Hard Truths" Nurse Staffing Report.	**EM**	**Attached**
Item 9	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 10	To consider any matters of urgency arising from the meeting of the Mental Health Legislation Committee held on 18th October 2018.	**EM**	**Verbal**
Item 11	To receive and note the annual report on Medical Education.	**AK**	**Attached**

Performance (11.00 am)

Item 12	To consider the summary Finance Report as at 30th September 2018.	**PM**	**Attached**

Item 13	To consider the Trust Performance Dashboard as at 30th September 2018.	**SP**	**To Follow**
Item 14	To approve the targets for the agreed Key Performance Indicators for the 2018/19 Strategic Direction Scorecard.	**SP**	**Attached**

Governance (11.20 am)

Item 15	To consider a report on the Single Oversight Framework.	**PB/SP**	**Attached**
Item 16	To consider an amendment to the Trust's Constitution to merge the Staff Classes for North Yorkshire and York and Selby. *(Note: Subject to a recommendation to the Council of Governors)*	**PB**	**Attached**
Item 17	To receive and note a progress report on Information Governance Toolkit.	**EM**	**Attached**

Items for Information (11.50 am)

Item 18	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 19 To note that the next meeting of the Board of Directors will be held on Tuesday **27th November 2018** in the Board Room, West Park Hospital Darlington at 9.30 am.

Confidential Motion (11.55 am)

Item 20 **The Chairman to move:**

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

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

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

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

Information which, if published would, or be likely to, inhibit -

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

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

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
24th October 2018

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 25TH SEPTEMBER 2018 IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Dr. H. Griffiths, Deputy Chairman
Mr. D. Jennings, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mrs. R. Hill, Chief Operating Officer
Dr. A. Khouja, Medical Director
Mr. P. McGahon, Director of Finance and Information
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Mrs. J. Illingworth, Director of Quality Governance (representing Mrs. Moody)
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications

18/232 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. M. Hawthorn, Senior Independent Director and Mrs. E. Moody, Director of Nursing and Governance and Deputy Chief Executive.

18/233 MINUTES

Agreed *– that the minutes of the meetings held on 3rd and 19th July 2018 be approved as correct records and signed by the Chairman.*

18/234 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

Arising from the report:

(1) Further information was sought on the project to be undertaken with the University of York in relation to variations in outcomes, and the reasons for them, between different types and sizes of wards (minute 18/73 – 27/3/18 refers).

Action: Mrs. Moody

(2) The position on the action under minute 18/146 (22/5/18), on whether patients on leave were included in the CHPPD data provided to NHS Improvement, was reviewed as part of the "Hard Truths" Monthly Nurse Staffing Exception Report (minute 18/239 refers).

18/235 DECLARATIONS OF INTEREST

There were no declarations of interest.

18/236 CHAIRMAN'S REPORT

The Chairman reported on the recent recipients of "Living the Values" Awards including a nurse on Elm Ward where the presentation was due to take place after the meeting.

Mrs. Bessant also formally reported her intention to step down as the Chairman of the Trust on 31st March 2019.

18/237 GOVERNOR ISSUES

No issues were raised.

18/238 REPORT OF THE QUALITY ASSURANCE COMMITTEE

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

(1) The confirmed minutes of the meeting held on 5th July 2018 (Annex 1 to the report).

(2) The key issues considered by the Committee at its meeting held on 6th September 2018.

Dr. Griffiths, the Chairman of the Committee, drew attention to:

(1) The revised format of the report which was aligned to the CQC's Fundamental Standards and supporting key lines of enquiry (KLOE) and mirrored the format of agendas for its meetings.

The Board noted that:

(a) The approach was intended to enable the Committee to better map and track the Trust's position against the Fundamental Standards and strengthen the assurances it was able to provide to the Board.

(b) It was recognised that there was a need to refocus reporting to the Committee to be more explicitly aligned with the KLOEs.

(c) Although the changes had not made a material difference to discussions at meetings of the Committee, to date, it was considered that the approach would evolve over time.

Board Members welcomed the new format of the report.

(2) The approval of the criteria for the location of emergency response bags in community units and the placing of automated defibrillators (AEDs) into non-patient areas.

In response to a question, Mrs. Illingworth advised that the reference to the increase in the amount of specific patient issues raised since April 2018 (paragraph 4.3 of the

report), related to those brought up by service users during Mental Health Act visits and, generally, covered areas such as leave, environmental issues, etc.

18/239 "HARD TRUTHS" MONTHLY NURSE STAFFING EXCEPTION REPORT

The Board received and noted the exception report on nurse staffing for August 2018 as required to meet the commitments of "Hard Truths", the Government's response to the Public Inquiry into Mid Staffordshire NHS Foundation Trust (the "Francis Review").

Further to minute 18/234, Mrs. Illingworth recognised that the information in the report did not fully cover the issue of whether patients on leave were included in the CHPPD data and agreed to provide clarity on the matter in the next report.

Action: Mrs. Illingworth

Board Members commended the new format of the report.

The following additional suggestions were made to further develop monthly reporting:

(1) To provide additional information on incidents citing staffing levels (e.g. the identification of the wards on which incidents had occurred) to support triangulation.

In response it was noted that the Board had previously agreed to include further information on this matter in the six monthly nurse staffing reports as it recognised that a longer time period was required to support the meaningful analysis of the data.

(2) To provide the raw data in an appendix or via a reading room on the Boardpad system.

The Chairman reminded the Board that it had previously requested that the monthly reports only provide summary information.

(3) To provide clarity on the purpose and background of the reports and their context in relation to the six monthly reports.

Mrs. Illingworth undertook to provide a covering paper on these matters in the future.

Action: Mrs. Illingworth

The Chairman asked that the covering paper provide a basic assurance statement on whether or not the staffing of the wards was safe.

Action: Mrs. Illingworth

In addition:

(1) Mr. Levy observed that there would be benefits of providing additional contextual information on the use of temporary staffing in the six monthly reports as the significance of this issue could look different over a longer time period.

(2) The Chairman recognised that, due to the changes to monthly reporting, the preparation of the six monthly reports would be challenging and asked for those reports to focus on an analysis of the data rather than collate information.

With regard to the information provided in the report, Board Members:

(1) Discussed the correlation between incidents and staffing levels.

The Chairman highlighted that, although recent reviews of serious incidents where staffing issues had been cited, had not identified them as root causes or contributory factors, it had been apparent, in some cases, that they had compromised the quality of care. There were risks, in those circumstances, that where staffing issues arose, and remained uncorrected, they could result in a serious incident in the future.

It was noted that inconsistency which compromised quality had also been raised by Governors during the discussions on the Business Plan priorities.

Mrs. Illingworth undertook to review this matter and provide a response in the next six monthly report.

Action: Mrs. Illingworth

(2) Sought clarity on the reasons for the spike in agency usage at Meadowfields.

Mrs. Illingworth undertook to look into this matter and provide a response to Board Members.

Action: Mrs. Illingworth

(3) Noted, in response to a question, that the private provider working into The Lodge, as part of a transition, was Positive Independent Proactive Support Ltd.

18/240 REPORT OF THE MENTAL HEALTH LEGISLATION COMMITTEE

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

(1) The confirmed minutes of its meeting held on 19th April 2018 (Annex 1 to the report).

(2) The key issues considered by the Committee at its meeting held on 12th July 2018.

It was noted that the nomination of an Expert by Experience to become a member of the Committee was still being sought.

18/241 LEARNING FROM DEATHS

Further to minute 18/183 (3/7/18) the Board received and noted the Learning from Deaths Report which set out the approach being taken by the Trust towards the identification, categorisation and investigation of deaths.

The Board noted:

(1) The absence of information on learning in the report.

Mrs. Illingworth explained that learning had been detailed in the end of year report (minute 18/183 – 3/7/18 refers) and that information would also be included in the Quarter 2 report. In future, there might also be benefits in only providing the information every six months (i.e. at Quarters 2 and 4).

(2) The "Guidance for NHS trusts on working with bereaved families and carers" (Appendix 3 to the report) which had been recently published by the National Quality Board (NQB).

It was noted that an action plan for the implementation of the Guidance was being prepared for sign off by that Patient Safety Group, in September and October 2018, and this would be reported to the Board via the Quality Assurance Committee.

Dr. Griffiths asked for the action plan to be presented to the Committee.

Action: Mrs. Illingworth

Arising from the report:

(1) Mr. Jennings, the Chairman of the Audit Committee, sought clarity on compliance with the Duty of Candour in the context of:
   (a) the NQB guidance that "Bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one"; and
   (b) the decision of management (reported to the last meeting of the Committee) not to accept a recommendation from the Internal Auditors that the Duty of Candour should be applied early and throughout the process rather that only at the end.

In relation to the above matter, and in response to questions from the Non-Executive Directors, Mrs. Illingworth explained that:

(a) Assurance on the Trust's compliance with the Duty of Candour had been provided by the findings of the recent CQC inspection.
(b) In accordance with the Duty of Candour the Trust apologised at the earliest opportunity when something had gone wrong with a patient's care.
(c) There were both statutory and cultural aspects to the Duty of Candour.
(d) When a serious incident occurred and a patient died, the Trust needed to determine whether to make a record in a statutory register; however, this could not be undertaken until the investigation had been completed.
(e) This requirement to include details in the statutory register was separate from the cultural approach taken by the Trust to be as open as possible and to apologise when something had gone wrong. This was captured for serious incidents rated moderate or above through the 72 hour reports.
(f) In accordance with the NQB guidance the Trust also wrote to families/carers to ask them to raise any issues or concerns about the care provided to the patient.

(g) Conversations had been held with the Internal Auditors to seek to explain the Trust's approach to both the legal and cultural application of the Duty of Candour.

(2) Mr. Simpson suggested that, in support of its culture of openness, the Trust should hold an annual service/event to remember people who had died in its services.

He advised that, to support learning, Virginia Mason held a day, annually, where families, carers and staff were brought together as a way of acknowledging that the patient was paramount; to reinforce the culture of transparency and openness; and to support closure.

Board Members also recognised that some hospitals and hospices held similar events during the Christmas period.

It was agreed that the Executive Management Team should give further thought to this matter.

Action: Mr. Martin

(3) The Board supported Dr. Khouja's suggestion for a briefing, either by way of a report or at a Seminar, to be provided on the work being undertaken system-wide on learning from deaths.

Action: Dr. Khouja

(4) Board Members sought clarity on the data relating to learning disability deaths reviewed under the serious incident framework or by mortality reviews, together with the number of learning points from them, as set out in Appendix 1 to the report.

Mrs. Illingworth advised that:

(a) The figures for those deaths reviewed internally (7) and via the LeDer Programme (10) reflected the time lag between the two processes and work had been undertaken to seek to align reporting.

(b) The column entitled "Total Number of Learning Points" should be disregarded as this had been included in the table in error.

18/242 ENHANCED OBSERVATIONS

Further to minute 18/08 (30/1/18), the Board received and noted a report which provided an overview of:

(1) The key evidence relating to the practice of observation and engagement.

(2) Trust policy and the context of current use.

The report also sought to inform the Board of current developments in terms of new approaches to observation being adopted and tested and highlighted areas for regarding future work in this area.

The Chairman considered that it was important to look at the issue from an alternative perspective i.e. the reassurance provided to patients by staff being visible on wards.

The Board noted that the policy on staff visibility was not written down but alluded to the need for staff to be on the ward and only absent for a valid reason.

The Chairman's proposal, that the development of a policy on staff visibility should be included in the report's recommendation, was supported.

The Board also discussed:

(1) Decision making processes in relation to providing and removing enhanced observations.

Assurance was provided that the Trust's policy was intended to provide flexibility and that nurses had the authority to remove enhanced observations, requested by a doctor, if circumstances changed.

However, it was recognised that processes were not always applied and patients could be subject to enhanced observations for longer than was necessary, e.g. from one shift to the next without a conscious review.

Mr. Levy raised the issue of whether there was a correlation between the proportion of recently qualified staff on a ward and the use of enhanced observations in view of their lower levels of experience and confidence.

(2) The variations in enhanced observations between similar wards and whether there was learning between them.

Mr. Martin highlighted the variation between wards, for example, wards in the County Durham and Darlington Locality, notwithstanding identical staffing levels and patient groups, did not have the same level of enhanced observations as those in other Localities.

He considered that the main differences in the County Durham and Darlington Locality related to the empowerment of nurses; the attitude to risk; and the visibility of staff on wards.

(3) NICE guidance and whether the Trust's approach to enhanced observations should be more aligned to it.

On this matter it was noted that:

(a) Whilst the Trust's policy was compliant with NICE guidance, there were variations in practice based on clinical need.
(b) Further consideration would be given to the application and operationalisation of the NICE guidance in the forthcoming review of the Engagement and Observation Policy.

Action: Mrs. Illingworth

(c) The MHSOP Speciality Development Group had highlighted some evidence that enhanced observations to prevent falls could be counterproductive and this supported the piloting of zonal observations.

The Chairman considered that the Trust needed to clearly articulate the reasons why a different approach was followed in particular circumstances and, if there were concerns, staff should follow the NICE guidance.

(4) Noting the additional resources already made available to reduce agency usage, how the Trust intended to take forward the balance between supporting staff and variability in the use of enhanced observations.

Mr. Martin responded that:

(a) Additional staffing resources had been made available following three reviews: the establishment review of the PICUs; the review of staffing resources at night; and the establishment review which concluded that additional staffing was required in the larger wards in County Durham and Darlington to provide a comparative level of resource to other units.

(b) The report provided evidence which supported the analysis of resources and work to be undertaken in MHSOP.

The Chairman observed that, when units were busy, it was easy to fall back on enhanced observations and, in the present circumstances, it would be difficult to tackle.

In addition:

(1) Dr. Griffiths asked to be provided with a copy of the metrics being collated to support the evaluation of the pilot of zonal care.

Action: Mrs. Moody

(2) It was noted, in response to a question, that the significant increase in the use of enhanced observation in the York and Selby Locality during September 2017 was due to all the beds being opened.

Agreed - *that the focus on observation and engagement practice, through the Right Staffing and Model Ward programmes, be continued based on the following areas:*

(a) commencing the pilot of Zonal care and engagement, exploring how this is supported via policy and if there are opportunities to extend its use;

(b) reviewing current recording of levels of engagement and observations across services to ensure they are in line with policy;

(c) considering prospective recording processes to accurately understand the number of engagements and observations above general on a daily basis by ward in order to target variation and practice;

(d) carrying out an accurate financial assessment of the costs of engagements and observations above general;

(e) gathering, through Model Ward, further data to understand and contextualise the apparent disproportionate number of initiations, reviews and reductions in levels of engagement and observations within Forensic Services;

(f) *gathering further information on the processes in place in the service for initiating, reviewing and reducing engagement and observation levels;*

(g) *reviewing current recording to ascertain if there is evidence of reviews each shift and address any deficits in reviews in line with policy;*

(h) *considering whether, in line with recommendations from the work carried out by the National Mental Health Nurse Leaders and Directors Forum and NHS Improvement, there should be an escalation outside the immediate team and a peer review process commenced where continuous observations exceed 14 days duration;*

(i) *undertaking focused work with service users to understand their experience of being on enhanced / continuous engagement and observations;*

(j) *undertake focused work with nursing staff to understand their experience of carrying out enhanced / continuous engagement and observations; and*

(k) *developing a policy on staff visibility on wards.*

Action: Mrs. Moody

18/243 FREEDOM TO SPEAK UP SELF-REVIEW

Consideration was given to a report on the outcome of the self-review of the Trust's position on Freedom to Speak Up (F2SU) and proposed actions to help embed speaking up within the Trust taking into account the Guidance for Boards and the self-review tool published by the National Guardian's Office and NHS Improvement in May 2018 (both documents appended to the report).

In his introduction to the report, Mr. Levy advised that he had a telephone call booked with the National Guardian's Office in order to seek to understand expectations relating to the development of a TEWV Freedom to Speak Up vision and strategy.

Board Members:

(1) Considered that the self-review tool had been completed correctly but that the process felt over-engineered.

(2) Highlighted the benefits, for triangulation, from the provision of additional information on cases, issues and lessons learnt.

The Chairman observed that there was a need to balance the information provided to the Board and the Executive Management Team with the focus of the former being on whether cases had been properly managed.

Recognising the Chairman's views, it was considered that further information should be provided, in aggregate, on cases referred to the Freedom to Speak Up Guardian (F2SUG).

(3) Highlighted the issue raised by the F2SUG, in his last report, that staff in smaller teams were reticent about raising concerns due to risks of them being identified, and the need to give further thought to this matter.

Mr. Martin advised that:

(a) Triangulation was undertaken between the FTSUG and teams dealing with concerns within the Trust.

(b) Many issues raised with the F2SUG were personnel issues and grievances.

(c) National research suggested that, in larger acute trusts, one-third of staff who had raised a concern, considered that doing so had resulted in some detriment to them.

(4) Considered that, whilst the Trust might need to develop a strategy in line with external expectations, the key areas of focus should be on implementing the actions arising from the self-review and embedding awareness and knowledge of F2SU in the Trust.

(5) Highlighted previous discussions on the benefits of providing a statement on the various routes for raising concerns, and the alignment between them, to provide staff with choice on which was the most appropriate for them to follow.

Mr. Levy advised that the proposed approach could be considered as part of the communications plans to support the introduction of the Dignity at Work Champions.

It was also suggested that the approach could underpin a policy statement about listening to staff.

(6) Observed that a number of staff could be leaving the Trust as a result of unexpressed concerns.

Mr. Levy agreed that receiving quality feedback on the reasons people were leaving the Trust was difficult due to notice periods and leave; however, work was being undertaken with the Heads of Nursing to seek to get greater access to this valuable source of information.

(7) Expressed the importance of the scope of the proposed audit of the TEWV Whistleblowing Policy being carefully considered in order that it added value rather than led to confusion and additional burden.

Mr. Levy responded that it was considered that the review of the Trust's Whistleblowing policy should continue to be undertaken every three years rather than annually as suggested in the self-review tool.

In response to a question it was noted that F2SU arrangements also applied to temporary workers; however, Mr. Levy advised that further thought needed to be given to how to raise awareness amongst those staff.

Agreed -

(1) that the draft responses to the self-review be considered reasonable;

(2) that the following actions, in response to the self-review, be endorsed:

(a) *to confirm the future planned contact arrangements between the Freedom to Speak Up Guardian and senior leaders in addition to the existing six monthly Board reports and current contacts with the Chief Executive and the Director of Human Resources and Organisational Development;*

(b) *to routinely include information on lessons learnt and outcomes in future Board reports about raising concerns, whether from the Freedom to Speak Up Guardian or from others;*

(c) *to include a strong emphasis on the importance of learning from concerns that are raised in the contents of future TEWV leadership and management development programmes;*

(d) *to undertake an audit of compliance with the TEWV Whistleblowing Policy;*

(e) *to further increase awareness of the issue of raising concerns amongst TEWV staff during visits by Directors and through further corporate communications;*

(f) *to actively support the newly established TEWV Dignity at Work Champions network;*

(g) *for the Executive Management Team to consider whether TEWV is to adopt the use of the NHS Improvement Just Culture Guide;*

(h) *to include summary information about raising concerns within the 2018/19 TEWV annual report;*

(i) *to produce a simple statement for staff describing the various routes for raising concerns within the Trust and how they are aligned;*

(3) *that a decision on the development of a TEWV Freedom to Speak Up vision and strategy be deferred until national guidance is available; and*

(4) *that the TEWV Whistleblowing Policy continue to be reviewed every three years rather than annually as suggested within the self-review tool.*

Action: Mr. Levy

17/244 CORE STANDARDS FOR EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

Consideration was given to the Trust's submission to NHS England (as set out in Annex 1 to the report) with regard to compliance with the Core Standards for Emergency Preparedness, Resilience and Response.

Following discussions at the meeting of the Audit Committee on 13th September 2018 Mrs. Hill confirmed that it was intended to invite members of the Committee to observe emergency planning exercises to provide additional visibility and assurance on the Trust's position against the core standards.

Agreed – *that the self-assessment and Statement of Compliance with the Core Standards for Emergency Preparedness, Resilience and Response (Appendices 1 and 2 respectively to the above report) be approved for submission to NHS England.*

Action: Mrs. Hill

18/245 FINANCE REPORT AS AT 31ST AUGUST 2018

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

The focus of the discussions was on concerns about the Trust's CRES position and, particularly the use of non-recurrent schemes to address the variance in the programme (£324k behind plan) stated in the report.

The Non-Executive Directors highlighted the importance of this issue as a cultural inability to drive out recurring savings could provide risks, in the future, if they were required by the financial position of the Trust.

In response, Mr. McGahon advised that:

(1) The Trust would meet its CRES requirement for 2018/19.
(2) The focus of present work was to identify and plan for CRES savings for the next two years.
(3) This was being taken forward through:
    (a) Recurrent savings from estate adjustments with a full year effect from 2019/20.
    (b) CRES workshops being held with corporate and clinical services.

        It was noted that the corporate services' workshop, held on 24th September 2018, had indicated that 4% savings could be found over the next two years and had highlighted a number of further options to make additional savings if required.
    (c) The examination of other potential schemes including those relating to the termination of the PFI Agreement at Roseberry Park.

The Chairman raised concerns that, to achieve the level of savings required in the future, major service changes, rather than piecemeal schemes, would be required. The difficulties of implementing these service changes had been shown by the PPCS programme as, whilst staff were working differently, the environment had changed resulting in additional resources being required. In view of this the Trust should be considering the type of services it would need to provide, and could afford, in five or six years' time to enable work on the development of the schemes to commence now.

Mr. Martin responded that:

(1) The matter might be further discussed at the forthcoming Board Business Planning event.
(2) In practice there were now regional positions on the provision of services, and the standards to be achieved, enabling greater understanding of the consequences of withdrawal from them.
(3) However, before that position was reached, the Trust needed to reduce variation between its services.
(4) The efficiency targets within the 10 year NHS settlement also needed to be considered, once published, and might bring some urgency to finding additional CRES savings.

The Non-Executive Directors, noting that there was likely to be a greater focus on service re-engineering, questioned the extent technology was being considered in the identification of potential CRES schemes.

In response it was noted that:

(1) Technology should provide a means of delivering CRES both corporately (e.g. the use of skype to reduce travel time and cost) and operationally (e.g. through the implementation of the CITO clinical information management system).

(2) Digital Catapult had also run a workshop at Acklam Green, which had focussed on possible digital solutions to present issues, which might provide some benefits.

18/246 PERFORMANCE DASHBOARD AS AT 31ST AUGUST 2018

Consideration was given to the Performance Dashboard Report as at 31st August 2018.

The report included a recommendation, from the Executive Management Team, to approve a target of 60% for the new KPI "Percentage of patients starting treatment within 6 weeks of external referral".

Mr. Martin explained that the EMT had had a robust debate on whether to stretch the timescale for the indicator to nine weeks, with a higher target, or, as recommended, to base the indicator on six weeks recognising that the performance would not be as high initially. Taking into account the impact on patient experience it had been decided to recommend a target of 60% against a six week timescale and to consider increasing it over time.

In response to a question, he advised that present performance against the indicator was at the mid 40% level and the 60% target was considered to provide a reasonable stretch.

In addition, the Non-Executive Directors raised concerns about the position on the outcomes indicators (KPIs 6 and 7), where performance had dipped in August, in view of their importance for quality improvement and recovery.

Mrs. Pickering advised that:

(a) Although performance had dipped during the month it had improved generally during the year.

(b) The position on completion of outcome scores was monitored weekly; however, it was better to take a more longitudinal view to seek to understand if actions to improve performance had been effective.

(c) At this time it was unknown whether the position, in August, reflected something unusual which had happened during the month or represented the start of a trend.

The Executive Directors also highlighted the importance of ensuring the tools (i.e. CITO), and the support available to clinicians to use them effectively, in improving performance on the indicators.

***Agreed** - that a target of 60% for the new KPI "Percentage of patients starting treatment within 6 weeks of external referral" be approved.*

Action: Mrs. Pickering

17/247 STRATEGIC DIRECTION PERFORMANCE REPORT

Consideration was given to the Strategic Direction Performance Report for Quarter 1, 2018/19 including proposals to change the Trust Business Plan (as shown in Appendix 1 to the report).

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

Action: Mrs. Pickering

17/248 NON-EXECUTIVE DIRECTORS - COMMITTEE AND SERIOUS INCIDENT PANEL MEMBERSHIP

Consideration was given to the appointment of the Non-Executive Directors as the Chairmen and Members of the Board's Committees and Serious Incident Panels.

In response to a question it was noted that one Non-Executive Director seat on the Quality Assurance Committee had been vacant for some time.

***Agreed** – that, with effect from 1st October 2018, the Non-Executive Directors be appointed as the Chairmen and Members of the Board's Committees and to the Serious Incident Panel as set out in the schedule attached as Annex 1 to these minutes.*

17/249 BOARD BUSINESS CYCLE

Consideration was given to the Board Business Cycle, which comprised the matters due for consideration at formal Board meetings (Annex 1 to the report) and Board Seminars and Training and Development Sessions (Annex 2 to the report), for the period October 2018 to December 2019.

The following changes to the Seminar Programme, in response to comments received from Board Members, were taken on board:

(1) The briefing on restraint and restrictive practices (scheduled for February 2019) to focus specifically on CAMHS.

Action: Mrs. Moody

(2) The inclusion of a briefing and discussions on recovery at the December 2018 Seminar, with an invitation for Experts by Experience to attend, and consequential changes to the timings of the briefings on outcome measures (to March 2019) and veterans services (to July 2019).

Action: Mr. Bellas

Agreed *– that the Board Business Cycle for the period October 2018 to December 2019, as amended, be approved.*

Action: Mr. Bellas

18/250 REGISTER OF INTERESTS OF THE BOARD OF DIRECTORS

The Board received and noted the revised Register of Interests of the Board of Directors.

18/251 USE OF THE TRUST SEAL

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

18/252 POLICIES AND PROCEDURES RATIFIED BY THE EXECUTIVE MANAGEMENT TEAM

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

18/253 DATE OF NEXT MEETING

It was noted that the next meeting of the Board of Directors was due to be held at 9.30 am on Tuesday 30th October 2018 in the York Hilton, 1 Tower Street, York, YO1 9WD.

18/254 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.

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

Following the transaction of the confidential business the meeting concluded at 1.05 pm.

Annex 1

Non-Executive Director Committee and SUI Panel Membership from 1st October 2018

	Audit Committee	Resources Committee	Mental Health Legislation Committee	Quality Assurance Committee	Commercial Oversight Committee	SUI Panel
Maximum Number of Non-Executive Director seats (inc. the Chair of the Committee) excluding Ex Officio Members	4	3	3	4	**All Ex Officio Members**	-
Lesley Bessant		**Ex Officio Member**	**Ex Officio Member**	**Ex Officio Member**	**Ex Officio Member**	**Ex Officio Member**
Dr. Hugh Griffiths	✓			**Chair**		✓
Marcus Hawthorn	✓	**Chair**			**Ex Officio Member**	
David Jennings	**Chair**	✓			**Ex Officio Member**	
Richard Simpson			**Chair**	✓		
Paul Murphy	✓	✓	✓			✓
Shirley Richardson			✓	✓		✓

(Note: All Non-Executive Directors are members of the Board Nomination and Remuneration Committee)

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th October 2018**
TITLE:	**Board Action Log**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information/Assurance**

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

Board of Directors Action Log

RAG Ratings:

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

	Minute No.	Action	Owner(s)	Timescale	Status
27/02/2018	18/40	The need for guidance on how the starting point on the Ladder of Participation will be chosen to be raised with the Recovery Programme	DL	Nov-18	
22/05/2018	18/144	The objectives of the Research and Development Strategy to be used as the framework for future annual reports	Prof. JR	May-19	
22/05/2018	18/153	A Board Seminar to be held on outcome measures including a personal view on patient reported outcome measures and their impact on recovery	CM	Mar-19	
03/07/2018	18/185	Discussions to be held with the regional group on the provision of benchmarking information on serious incidents	EM	Dec-18	
19/07/2018	18/208	A briefing to be provided to a Board Seminar on the use of restraint and physical interventions in Tier 4 CAMHS	PB	Feb-19	
19/07/2018	18/209	A briefing on the findings of the research conducted by York University on 12 hour shifts to be provided to a Board Seminar	PB	Nov-18	
19/07/2018	18/216	Appropriate KPIs to be identified from the scorecards of the Leadership and Management Development Strategy and the Equality and Diversity Strategy to be added to those to be used to monitor progress (under Strategic Goals 3 and 5) against the Strategic Direction	DL	Nov-18	

	Minute No.	Action	Owner(s)	Timescale	Status
19/07/2018	18/218	A further review of the Board's committee arrangements to be undertaken	PB	Dec-18	
25/09/2018	18/234	Further information on the research project with the University of York, in relation to variations in outcomes, and the reasons for them, between different types and sizes of wards, to be provided to Board Members	EM	Oct-18	Verbal update to be provided to the meeting
25/09/2018	18/239	The monthly nurse staffing report to provide clarity on whether patients on leave are included in the CHPPD data	EM	Oct-18	See Agenda Item 8
25/09/2018	18/239	To note that: - A covering paper is to be provided with the monthly nurse staffing reports - The covering paper to include an assurance statement on whether staffing on the wards is safe	EM	Oct-18	See Agenda Item 8
25/09/2018	18/239	The impact of staffing issues on the quality of care and the risks of serious incidents arising from this matter is to be reviewed and reported in the next six monthly nurse staffing report	EM	Jan-19	
25/09/2018	18/239	Board Members are to be informed of the reasons for the spike in agency usage at Meadowfields.	EM	Oct-18	See Agenda Item 8
25/09/2018	18/241	The Quality Assurance Committee is to be provided with a copy of the action plan developed in response to the NQB Guidance on working with bereaved families and carers	EM	Dec-18	
25/09/2018	18/241	The EMT to further consider the suggestion that the Trust should hold an annual service/event to remember people who had died in its services	CM	Nov-18	
25/09/2018	18/241	A report/seminar briefing to be provided on the system-wide work being undertaken on learning from deaths	AK	Feb-19	
25/09/2018	18/242	Further consideration to be given to the application and operationalisation of NICE guidance in the forthcoming review of the Engagement and Observation Policy	EM	Apr-19	

	Minute No.	Action	Owner(s)	Timescale	Status
25/09/2018	18/242	Dr Griffiths to be provided with a copy of the metrics being collated to support the evaluation of the pilot of zonal care	EM	Nov-18	
25/09/2018	18/242	To note that the focus on observation and engagement practice, through the Right Staffing and Model Ward programmes, to continue to be based on areas recommended in the report but, in addition, a policy is to be developed on staff visibility on wards	EM	-	To note
25/09/2018	18/243	To note that: - The draft responses to the self-review of freedom to speak up arrangements were considered reasonable - The actions to be taken forward arising from the self-review were endorsed but an additional action is to be taken in relation to the provision of a statement to staff on the routes available to them to raise concerns and the alignment between them - The decision on whether to produce a TEWV freedom to speak up vision and strategy was deferred until national guidance is available - The TEWV Whistleblowing Policy is to continue to be	DL	-	To note
25/09/2018	18/244	The Statement of Compliance with the Core Standards for Emergency Preparedness, Resilience and Response to be submitted to NHS England	RH	Sept-18	Completed
25/09/2018	18/246	To note that a target of 60% was approved for the new KPI “Percentage of patients starting treatment within 6 weeks of external referral”	SP	-	To note
25/09/2018	18/247	To note the approval of the changes to the Trust Business Plan as set out in Appendix 1 to the Strategic Direction Performance Report	SP	-	To note
25/09/2018	18/249	To note that the briefing to the Board Seminar in February 2019 on restraint and restrictive practices is to focus specifically on CAMHS	EM	-	To note
25/09/2018	18/249	To note approval of the Board Business Cycle subject to a briefing and discussion on recovery at the Board Seminar in December 2018 and consequential amendments	PB	-	To note

ITEM NO. 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday 30 October 2018**
TITLE:	**Freedom to Speak Up Guardian Report**
REPORT OF:	**Dewi Williams, Freedom to Speak Up Guardian**
REPORT FOR:	

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

Executive Summary:

This report is for information and outlines developments within the Freedom to Speak Up role over the last six months.

It discusses local, regional and national issues, and concludes with an anonymised case study.

Recommendations:

To note the contents of the report and comment accordingly

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**Tuesday 30 October 2018**
TITLE:	**Freedom to Speak Up Guardian Report**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 I have been in post since October 2016 and continue to work 18.5 hours a week;

2.2 Over the last six months there have been 7 new cases. As noted in previous reports, some refer to multiple complainants; 5 relate to a culture of bullying, 1 patient safety/care quality, 1 processes and 2 wished to remain anonymous. To date, one has been resolved, 1 has not yet moved to investigation as the person remains concerned about detriment unless more colleagues come forward, and the remainder are still under investigation.

3. KEY ISSUES:

3.1 **Training:** The mandatory half day training for Band 7 and above staff continues to be offered. There has been a significant increase in demand following a concerted effort by many to highlight the previous slow uptake. Many extra sessions have been added to the training plan to accommodate the increase in demand. To date around 300 staff have attended;

The course concentrates on generating ideas on how best to support the third of staff who, through survey, tell us they would not feel safe to raise concerns. Sharing current and proposed plans on encouraging an open and transparent work place has proved most useful. One example is a team who keep a box in the tea room where staff can anonymously drop suggestions to be discussed at their monthly meeting.

3.2 **Support networks:** Locally, Barry Speak continues to act as deputy FTSUG. This has proved invaluable following a further period of sickness this summer. He has continued to provide guardian support to a number of staff who also see him professionally. This addition has enhanced the service we offer and maintains a ready flexibility to ensure continuity of service;

I continue to attend our quarterly regional support network. Currently we are looking to develop a number of standardised tools to aid consistency. We also hosted the National Chair Henrietta Hughes who came to give an update.

Our national team continue to provide updates through weekly bulletins which offer developments, training opportunities, and share evidence and learning from their reviews. They also provide twice yearly conferences for more in depth information exchange;

As noted in the previous Report, a number of our support teams like the FTSUG, employee support OD, and staff psychological services work in isolation. We recognised that we needed a support network, and an opportunity to share intelligence and work more proactively to offer support even when no staff have registered concerns. Following our 2 day service improvement workshop in March we continue to develop our network which now meets monthly. This information sharing has proved most useful and has recently prompted an investigation that may have missed our individual attention.

3.3 **Development of Champions:** As noted in the previous Report, this remains an opportunity to improve our alignment with the 10 key findings and recommendations from the 2017 national survey of Guardians. We are committed to combining our champions with the proposed champions charged with supporting the new bullying and harassment approach. They are to be called 'Dignity at Work' champions. To date we have held 1 introductory day with another planned soon. The aspiration is to have one for each locality as well as representatives from a range of protected characteristics to support accessible and acceptable options.

3.4 **Data Management:** The collection and analysis of data is central to ensuring that we can learn from experience. Our Manager's reporting tool appears to be working more consistently of late. However it has only occasionally been used by staff. During our training all agree that we should gather this information to enable the development of a sharing and learning library, but to date we have had precious few entries. We may have to reconsider how best to gather this information.

3.5 **Feedback:** As mentioned in the previous Report the experience of perceived detriment remains a concern. Some have said that their feelings are more about a loss of trust in the organisation to treat them well and protect them rather than identifiable failings. This continued sense of trauma has demonstrated itself by a continuing requirement to request support after completion of any investigation. This service requirement was an unexpected, but clearly required addition.

3.6 **Case Example:** An experienced Care Worker in a small team made contact to ask if they had to do their exit interview with their Line Manager. It may have been simple to say that they could ask a range of people. However I chose to speak to them. They said they could not speak to their Line Manager because they felt they had to leave a job they loved because of bullying from their Manager. They also felt that a number of other staff had left recently for the same reason and the remaining team members wanted to leave. They felt they were not eligible to speak up as they were leaving.

We have now requested an investigation which asks that all staff are interviewed including those off sick or who have recently left the Trust;

Clearly we would not have been made aware of this concern without the chance conversation. Lessons learned, we need to consider our information and training for all staff not our Managers. Currently we give all training attendees a copy of the training slides with the hope that they offer a version to their teams, however this is very reliant on others.

3.7 **Freedom to Speak Up Month:** The national team asked us to use the October initiative to raise awareness. Locally I have worked closely with Sarah Everett from our Communications team to review our Communications Strategy. We have revamped the In-touch page which now has some improved posters and links to the Manager's reporting tool. We have also produced a short video which is now available on Facebook outlining the service and how to contact us. I would like to thank her for her patience.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**

4.2 **Financial/Value for Money:**

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

4.4 **Equality and Diversity:**

4.4 **Other implications:**

5. RISKS:

6. CONCLUSIONS:

7. RECOMMENDATIONS: To note the contents of the report and to comment accordingly

Dewi Williams
Freedom to Speak Up Guardian

Background Papers:

Safe Staffing – September 2018

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

"To be a compassionate, fair and just organisation where all staff want to work and excel and where patients have choice and confidence in working with the right staff having the right skills at the right place and time to receive outstanding care and treatment".

Six workstreams exist to provide a framework to support the implementation of the Right Staffing Programme - based on the NQB Guidance

Safe Staffing Fill Rates September 2018:

- The number of rosters equated to 69 inpatient wards in September.
- The highest number of red fill rate indicators relate to Registered Nurses on day shifts. This equated to 26 in September 2018, an increase of 3 when compared to August 2018.
- The top 3 inpatient areas where a low staffing fill rate has been reported are:
  - The Lodge – 24.4% HCA on Days; 88.5% RN on Nights; 60% HCA on Nights – the shortfall is in relation to a private provider who is working into the Lodge as part of the transition.
  - Esk Ward – 50.3% RN on Days; 87% RN on Nights – the shortfall in RN is due to vacancies. They have also experienced some episodes of sickness for RN. The ward is using agency and bank where possible. Unqualified nurses have been used to cover some of the shortfall where it has been safe to do so. There have been no shifts without a RN despite the fill rate figures.
  - The Orchards (NY) – 55.2% RN on Nights; 76.4% RN on Days – the shortfall is in relation to a reduction in the number of RN's required to work which has still not been reflected on HealthRoster.
- There were 65 fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues.
- The top 3 inpatient areas where a high staffing fill rate has been reported are:
  - Holly Unit – 387.6% HCA on Days; 303.2% HCA on Nights; 272.8% RN on Days; 201.4% RN on Nights – the increase is due to enhanced observations and additional staff required to support young people coming in during the day.
  - Oakwood – 278% HCA on Days – additional staffing was to support leave and attendance at activities. Roster review has been scheduled to take place in October 2018.
  - Acomb Garth – 256.7% HCA on Nights; 189% HCA on Days – additional staffing was necessary due to high acuity (in terms of both frailty and aggression). The staffing levels are reviewed daily with ward and senior management.

Bank Usage:

- The bank usage across the trust equated to 17.9% in September, an increase of 0.4% when compared to August.
- There were no wards reporting 50% bank usage in September.
- Mandarin reported the highest bank usage at 38.8% of the actual hours worked. Enhanced observations were the highest reason given (95 shifts).
- There were 15 wards that reported greater than 25% bank usage.

Agency Usage:

- The agency usage across the trust equated to 7.6% in September, an increase of 0.4% when compared to August.
- Cedar Ward (NY) reported the highest equating to approximately 58.3% of the total hours worked. Vacancies were cited as the highest reason for this (73 shifts). The ward is using regular agency where possible.
- Those wards reporting 4% or more agency usage in August equated to 23 wards.
- Total demand has increased by 89% since the contract started and filled shifts demand has increased by 169%. September saw the largest number of shifts filled since the contract with Retinue began (1483).

Produced: 12th October 2018

The purpose of this document is to present to the Board by 'exception' the monthly safe staffing information as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to September 2018 data.

- Fulfilment for HCAs increased from 82% to 85% during September.
- Usage across Acomb Garth and Cedar Ward (NY) increased in September. Other areas with high demand are Oak Rise, Rowan Lea, Rowan Ward, Springwood and Ward 15.
- Areas with lowest fulfilment – Birch Ward, Elm Ward, Langley Ward, Oak Ward, Ward 14 and Willow Ward. These are areas with fewer requests than other areas with larger fulfilment. A similar trend seen most months.
- The total number of no shows reported for September reduced from 19 to 13.
- Average monthly spend of £270k from Oct – September 2018 – an increase of £6k on last month
- Overall spend now sits at £3.24m.
- HCA attributes to 77% of overall spend
- All shifts booked during this period have been booked below cap with zero breaches recorded.

Missed Breaks:

- There were 349 shifts in September where an unpaid break had not been taken. This is an increase of 15 when compared to August 2018.
- The majority of the shifts where breaks were not taken occurred on day shifts (254 shifts). The majority of those not taking breaks relate to Registered Nurses on Days.
- The number of night shifts where breaks were not taken equated to 95 shifts in September 2018. The majority of those not taking breaks relate to HCA on Nights.
- This information is being monitored daily as part of the operational services huddle process.

Incidents Raised Citing Staffing Levels:

- There were 23 incidents reported in September 2018 citing issues with staffing.
- Issues reported were as follows:
  - Staff and patient safety compromised
  - Observations not carried out
  - Only 1 member of staff left on duty
  - Unable to respond to alarms from other wards in difficulty
  - Unable to contact on call doctor

Severity Rating:

- Using a severity rating scale to identify potential outliers, the top 5 is as follows:
  - Bedale Ward – 9 points awarded
  - Ward 15 – 9 points awarded
  - Hamsterley Ward – 9 points awarded
  - The Evergreen Centre – 8 points awarded
  - Meadowfields – 8 points awarded
- Using the YTD score (Sept 17 to Sept 18) the following appear in the top 5:
  - Cedar (D&D) – 102 points awarded
  - Bedale Ward – 100 points awarded
  - Westerdale South – 97 points awarded
  - The Evergreen Centre – 95 points awarded
  - Ward 15 – 85 points awarded

Care Hours per Patient Day:

- This metric tracks the total number of direct nursing care hours compared to the number of patients as a count at midnight.
- Reporting of AHP's CHPPD data will commence in November 2018 and will be reported alongside our current fill rate and nursing CHPPD.
- CHPPD overall rating for September is reporting at 10.30 (3.6 registered nurses and 6.7 unregistered nurses) this is a decrease of 2.2 when compared to August.
- Using standard deviation (Sep 17 to Sep 18) the following appear as positive outliers:
  - Bankfields Court The Lodge – registered nurses
  - Jay Ward – registered nurses
  - Westerdale South – unregistered nurses
- Oakwood appear negatively under the lower bracket for unregistered nurses.
- A local quality dashboard will be developed as part of the Right Staffing Programme which will enhance this data.

Conclusion:

- The Trust continues to comply with the requirements of NHS England and the CQC in relation to the Hard Truths commitments.
- The operational risks identified have been managed and mitigated at service level. Strategic risks are being addressed through the implementation of the Right Staffing programme and related workstreams.

Key links to documents & guidelines:

Monthly and Daily Staffing Report –September 2018

NQB Guidance July 2016

For more information on the content of this report please contact elizabeth.moody1@nhs.net

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th October 2018**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

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

- The highest number of red fill rate indicators relate to Registered Nurses on day shifts
- The top 3 inpatient areas where a low staffing fill rate has been reported are The Lodge, Esk Ward and The Orchards (NY)
- The top 3 inpatient areas where a high staffing fill rate has been reported are Holly Unit, Oakwood and Acomb Garth
- Bank usage is reporting at 17.9% and Agency usage is reporting at 7.6% in September
- There were 349 shifts in September where an unpaid break wasn't taken
- There were 23 incidents reported in September 2018 citing issues with staffing
- In September the severity rating highlights Bedale Ward, Ward 15, Hamsterley Ward, The Evergreen Centre and Meadowfields as the highest.
- CHPPD overall rating for September is reporting at 10.30 this is a decrease of 2.2 when compared to August.

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:	**30th October 2018**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of the exceptions arising from the monthly information on nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to September 2018 data.

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013 and subsequent update of the guidance in 2016) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. (Nurse staffing - Tees Esk and Wear Valleys NHS Foundation Trust).

3. EXCEPTIONS:

3.1 Safe Staffing Fill Rates – September 2018

- The highest number of red fill rate indicators relate to Registered Nurses on day shifts
- The top 3 inpatient areas where a low staffing fill rate has been reported are The Lodge, Esk Ward and The Orchards (NY)
- The top 3 inpatient areas where a high staffing fill rate has been reported are Holly Unit, Oakwood and Acomb Garth

3.2 Bank Usage

- Bank usage is reporting at 17.9% an increase of 0.4%when compared to August 2018.

3.3 Agency Usage

- Agency usage is reporting at 7.6% in September an increase of 0.4% when compared to August 2018.

3.4 **Missed Breaks**

- There were 349 shifts in September where an unpaid break wasn't taken. This is an increase of 15 when compared to August 2018.

3.5 **Incidents raised citing Staffing Levels**

- There were 23 incidents reported via Datix in September 2018 citing issues with staffing

3.6 **Severity**

In September the severity rating highlights Bedale Ward (9 points), Ward 15 (9 points), Hamsterley Ward (9 points), The Evergreen Centre (8 points) and Meadowfields (8 points). With regards to the Board action from the previous meeting I can advise that the reasons given for booking Agency workers at Meadowfields was largely attributable to Enhanced Observations with 47 shifts (2 patients increasing to 4 patients at times to ensure line of sight). In September again Enhanced Observations was the highest reason for agency (50 shifts in total) followed by Sickness with 28 shifts. The ward is also reporting that they are supporting a Care Home and the Dementia Team.

3.7 **Care Hours per Patient Day (CHPPD)**

- CHPPD overall rating for September is reporting at 10.30 (3.6 registered nurses and 6.7 unregistered nurses) this is a decrease of 2.2 when compared to August.

  Further to discussion at the last Board meeting it has been confirmed that leave is excluded in the final count of occupied beds.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**

There are a number of areas that have had high levels of clinical activity necessitating increased observation and engagement levels with patients in addition to sickness and vacancies. This has resulted in difficulties in some wards meeting their planned staffing levels particularly with regard to registered nursing staff fill rates on days. In some ward areas this has resulted in high levels of agency and bank HCA's. This issue has been highlighted as a concern by the CQC in our recent inspection report and poses a risk to compliance under the safe domain.

4.2 **Financial/Value for Money:**

It has been identified that there is little spare capacity in nursing establishments as they have been planned for maximum efficiency – it is

therefore implied that the workforce deployment needs closer scrutiny to ensure those efficiencies do not constitute risks. This work is being progressed and will be a feature of this financial year's Right Staffing work stream referred to above.

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

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

The March 2013 NHS England and CQC directives set out specific requirements that will be checked through inspection and contractual monitoring as they are also included in standard commissioning contracts. The Trust has complied with these directives to date. The 2016 NQB guidance has also been taken into account in the Trust approach

4.4 **Equality and Diversity:**

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

4.5 **Other implications:**

From the data presented it is essential that a consistent reporting framework is maintained in particular the assigning of severity ratings.

5. RISKS:

5.1 Safe staffing and the risks regarding the Trusts ability to meet planned staffing levels on a daily basis have been escalated to the Trust Risk Register. Risks are managed and mitigated through operational services and the work being undertaken as highlighted within the Right Staffing work streams.

6. CONCLUSIONS:

6.1 The Trust continues to comply with the requirements of NHS England and the CQC in relation to the Hard Truths commitments and continues to develop the data collation and analysis to monitor the impact of nurse staffing on patient safety, clinical effectiveness and experience.

6.2 The report sets out the work that continues in localities and through the Right Staffing programme to address shortfalls where planned establishments are not being met and to address capacity and capability in line with severity scores.

7. RECOMMENDATIONS:

7.1 That the Board of Directors notes the exception report and the issues raised within the attached Safe Staffing Report for further investigation and development.

Emma Haimes
Head of Quality Data and Patient Experience
October 2018

Appendix 1

Safe Staffing Report – September 2018:

Safe Staffing
September Report us

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 30 October 2018**
TITLE:	**Assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to update the Board of Directors on any current areas of concern in relation to quality and to provide assurance on the systems and processes in place.
Assurance statement pertaining to the QuAC informal meeting held on 04 October 2018 due to being inquorate.

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

- The Locality areas of Forensic and Tees services and top concerns.
- Patient Safety update.
- Verbal updates on CQC compliance and clinical supervision following the 90 day report out.
- Safeguarding & Public Protection.
- Drug and Therapeutics.
- Verbal update on clinical audit of emergency response bags.

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its informal meeting held on 04 October 2018.
- Note the confirmed notes of the meeting held on 06 September 2018 (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 30 October 2018**
TITLE:	**Assurance report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting held on 04 October 2018.

2. BACKGROUND INFORMATION AND CONTEXT

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

3. KEY ISSUES

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

ARE OURSERVICES WELL-LED?

How do we gain assurance from each locality that they have effective systems and processes in place to ensure standards of care, compliance with relevant standards, quality, risk and assurance arrangements?

The Committee received key assurance and exception reports from LMGBs.

4.1 FORENSIC SERVICES LMGB

The Committee discussed the LMGB report for Forensic Services.

The top areas of concern highlighted were:

- The proposal by NHS Digital Transformation to roll out Wi-Fi across the Trust from October 2018. Forensic Services currently rely on the restrictive practice framework and look at individual risk and this will continue until there have been further discussions and national agreement about internet usage on the wards.
- The increasing levels of violence and aggression in HM Prisons and the risks for visiting clinical staff. Assurance was provided that staff do not see individuals alone to minimise risk.
- The use of IM Clozapine on an individual who was extremely unwell, which lasted for a period of 14 days, with a break for a week and then a further 28 days. This was used due to the exceptional clinical circumstances and all the appropriate governance arrangements with regards to the unlicensed route of administration had been in place.

4.2 **TEES SERVICES LMGB**

The Committee received the LMGB report for Tees.

The top areas of concern highlighted were:

- The ongoing lack of nursing home provision and the impact this was having on inpatient bed capacity, as well as concerns relating to safeguarding.
- High levels of bed occupancy within Adult MH Services, which is now a focus for EMT.
- Recruitment within Children and Young People's Services without any Locum cover available. Directorates have been tasked with reporting to LMGB with a staffing plan on potential reconfiguration and manging current workforce in a different way.

The Committee sought assurance that those patients being discharged from MHSOP with dementia but no other additional identified needs did have a clear plan for returning to services if required.

4.3 Compliance with CQC Requirements

The Committee received a verbal update on the significant piece of work over the last few weeks checking for factual accuracy following receipt of the initial inspection report from the CQC on 17 September 2018. The factual inaccuracies had been submitted back to the CQC. Advice was taken from Beechcroft Solicitors about the content of the CQC report and how to respond appropriately.

The Board is assured that the Trust continues to maintain full registration with the CQC with no conditions.

4.4 Clinical Supervision following the 90 day report out

The Committee received a verbal update on the positive staff feedback following a Kaizen event on clinical supervision with staff now booking in regular supervision sessions and the quality of supervision improving.

Training has also had an impact with the expectation to be fully compliant against the performance target by November/December 2018. The training for newly qualified preceptorship nurses commencing in Tees has also been introduced.

ARE OUR SERVICES SAFE?

Are lessons learned and improvements made when things go wrong?

5.1 Patient Safety

The Committee discussed the Patient Safety Group report from July 2018.

The key matters discussed were:

- A leaflet for families to be used following bereavement has been drafted based on NQB Guidance Learning from Deaths. This will be finalised and then sent out for wider Trust wide consultation.

- The appropriate use of mobile phones in the community setting, which has arisen following a patient not able to contact the community service by telephone. Assurance was provided that this will be discussed by adult SDG and some Trust wide guidance will be issued.
- Learning from suicide related claims. A thematic review of suicide related claims has been undertaken by NHS Resolution and the recommendations are being considered with an action plan to be devised of any areas that the Trust needs to take forward.

Members of the Committee expressed concerns over the high numbers of incidents of prone restraint and how to look for assurance between the cases of intentional and unintentional prone. It was noted that Tees were currently looking at every incident of prone across the service and were also checking for recording errors. This will be picked up through LMGB.

There are no significant risks to escalate to the Board.

5.2 Clinical Audit of Emergency Response Bags

The Committee received a verbal update with a request to defer this matter to the December 2018 Quality Assurance Committee meeting following revision of the Resuscitation Policy and some further work required to establish a comprehensive list of the location of all response bags.

5.3 Safeguarding and Public Protection

The Committee discussed Safeguarding and Public Protection.

- There are various serious case reviews underway across the locality areas with 16 in Durham. There is no known reason why Durham is currently an outlier with the higher number than the other localities, however it is clear that there could be some improvements made to the legal processes surrounding case reviews and this will be followed up by the Safeguarding team.

The Committee requested that it would be useful to set out some risk factors around the vulnerability of individuals from others and this could be done at assessment stage and feed into the harm minimisation work.

Assurance was provided that both the safeguarding adult and children teams continues to deliver a comprehensive safeguarding service within the Trust and were compliant with legislation

5.3 Drug and Therapeutics Report

The Committee considered the Drug and Therapeutics Report.

The key matters raised were:

- The impact on processes and any financial implications that are being worked through following a change in legislation, the ‘Falsified Medicines Directive’, which will mean that all medicines manufactured from 2019 will have a barcode for scanning and verification.
- Two recommendations from the CQC Safer Management of Controlled Drugs Annual Report around minimising the risk of overprescribing and consideration of regular

monitoring and auditing for controlled drugs. For the latter an electronic support system is being considered.

- There have been difficulties maintaining the Lithium register due to a shortage of pharmacy staff. The Chief Pharmacist provided assurance that recruitment was underway to increase the administrative staffing to support this.

5.6 **Exceptions to report to the Board**
There are no exceptions to report to the Board.

6. IMPLICATIONS

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

6.2 **Financial/value for money**
There were no direct financial implications arising from the agenda items discussed.

6.3 **Legal and Constitutional (including the NHS Constitution)**
The terms of reference, reviewed annually, outline compliance requirements that are addressed by the Quality Assurance Committee.

6.4 **Equality and Diversity**
There are no issues to note.

7. CONCLUSIONS

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

8. RECOMMENDATIONS

That the Board of Directors is asked to:

(i) Note the issues raised at the Quality Assurance Committee meeting on 04 October 2018.
(ii) Note the confirmed notes of the meeting held on 06 September 2018.

Mrs J Illingworth
Director of Quality Governance
October 2018

Item 1

NOTES OF THE FORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 06 SEPTEMBER 2018, IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mrs Lesley Bessant, Chairman of the Trust
Mr Colin Martin, Chief Executive
Mrs Elizabeth Moody, Director of Nursing & Governance
Mrs Shirley Richardson, Non-Executive Director
Dr Ahmad Khouja, Medical Director

In attendance:
Mrs Karen Agar, Associate Director of Nursing and Governance
Mr Patrick Scott, Director of Operations, York and Selby
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mrs Ruth Hill, Chief Operating Officer
Mr Craig Hill, Service Manager, North Yorkshire
Mrs Emma Haimes, Head of Quality Data and Patient Experience
Mrs Leanne McCrindle, Head of Quality Governance and Compliance
Dr Steven Wright, Medical Director, York and Selby
Dr Suman Ahmed, Consultant Psychiatrist, North Yorkshire
Mrs N Lonergan, Head of MHSOP Services, North Yorkshire

18/103 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr Richard Simpson, Non-Executive Director, Mrs Jennifer Illingworth, Director of Quality Governance and Mr Tim Cate, Director of Operations, North Yorkshire.

18/104 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 05 July 2018 were agreed as true and correct, subject to the addition of Dr Griffiths being listed as present.

18/105 ACTION LOG

The Committee discussed the QuAC action log, noting the following updates:

18/42 Quarterly re-audit to be undertaken of emergency response bags.
This would be deferred to the 4 October 2018 QuAC meeting.

18/42 Report on the Trust criteria for the location of response bags in the community bases and staff expectations where no bags are cited.
This matter was covered under agenda item number 6 (minute 18/ 110 refers)

Completed

18/75 Chief Executive to be informed of instances where Blik alarms not working.
The Chief Executive noted that he had been informed of one instance when an alarm had not worked since the previous QuAC meeting and a further update would be brought back to the Committee in October 2018 when the Tees locality reported on the agenda.

18/77 Patient Experience Report: future reporting of statistics/data sets to include rolling averages in order to view information in the context of the previous year.
It was noted that this was current being looked at with re-work to the relevant spread sheets and it was anticipated that this would be included in the report for the 1 November 2018 QuAC meeting.

18/92 Check to confirm whether Crisis House was closed or temporarily closed.
It was confirmed that Crisis House was still open for business and that a paper had subsequently been reported to EMT. At the time of the September 2018 QuAC meeting Crisis House had been empty, however subsequent referrals had been received.

Completed

18/92 D&D report: risk register regarding medical staffing scored at 20, however to be aligned to the BoD risk register and scored at a similar level of 25.
Since the Durham locality was not present at the meeting this would be checked and confirmed at the October QuAC meeting.

18/93 Patient Safety Report: page 3, 1.2, performance summary: arrows to be amended.

Completed

18/106 NORTH YORKSHIRE SERVICES LMGB REPORT

The Committee received and noted the North Yorkshire Services LMGB Report.

Arising from the report it was highlighted that the top issues to note were:

(1) Management capacity in MHSOP services affecting the stability of both AHLS teams in Northallerton and Harrogate, as well as the Hambleton and Richmondshire CMHT and Ward 14.
Assurance was provided that mitigating plans were in place, however capacity would be significantly reduced and there were concerns regarding the resilience of band 7 staff.

(2) The risks around the future provision of the Community Crisis Intervention Services.
On this matter it was noted that some contingency planning would take place whilst the Trust waited for clarification from NHS England on the transforming care trajectories.

(3) Ongoing challenges to meet the eating disorder waiting times and access standards with the expectation from NHS England that this service would be a specialist 'stand-alone' service in the coming months. This was not felt to be achievable.
On this matter It was noted that a business case was currently being prepared to look at an option appraisal.

Following discussion it was noted that:

(1) The key risks outlined on page six of the report stated that there were concerns around the Crisis team, which had been passed on to Mr D Gardner and that the Service Manager did not attend the QuAG meetings. There was a need for clarification over who held clinical responsibility for the service and Mrs Lonergan undertook to find this out.

Action: Mrs N Lonergan/Mr T Cate

(2) There were a number of mandated indicators for Adult Mental Health MHSOP services that were deteriorating in performance and the Committee requested that further narrative and explanation be provided in the next report.

Action: Mrs N Lonergan/Mr T Cate

(3) The risks and top concerns outlined in the LMGB report, page six, should in future provide additional information around the actions and next steps that were being taken to address the issues. Mrs Lonergan undertook to take this on board for the next report.

Action: Mrs N Lonergan/Mr T Cate

(4) Further clarity was requested on the statement around gaps in the adult eating disorder service, page six and what the current issues were. This would be clarified and emailed to members of the Committee.

Action: Mrs N Lonergan/Mr T Cate

18/107 YORK AND SELBY SERVICES LMGB REPORT

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

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

- The ongoing challenges for IAPT services linked to recruitment and retention and meeting the locally agreed prevalence target and recovery rate. A deep dive report into recovery rates would address some of the issues found and a new clinical leadership structure had been introduced.
- Significant financial pressures in MHSOP due to the use of bank and agency staff in three inpatient units, out of locality admissions where a new admission process has been introduced and the need for a locum consultant due to unsuccessful recruitment.
- Capacity and demand in CAMHS with the roll out of group programmes as a first line of treatment choice for children and young people who require emotional intervention. These were different CBT groups, which aimed to release capacity for clinicians to offer more intensive interventions for the most serious presentations.
- There had been some recent investment into autism services which was a positive step forward to reducing the long waiting times.
- Statutory and mandatory training compliance was currently at 87.2%.
  On this matter it was noted that there had been problems with smart cards and there was a lack of face to face training, however assurance was provided that a new Band 7 post had commenced which would support moving things in the right direction.

Following discussion it was noted that:

(1) It was hoped to improve the figure for carers being offered the opportunity to take up focused education and support programmes from 22% to 100%.
Dr Wright noted that the quality standard set out that CBTD should be offered, however there was currently no capacity to do this, all carers were however offered the education package.
(2) The sickness absence rate of 1%, despite the challenges across the locality was a tremendous credit to the staff and teams.
(3) There had recently been two band 5 posts that had withdrawn following recruitment into CAMHS and Mr Scott undertook to find out the reasons for this.

Action: Mr P Scott

18/108 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

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

The following matters were highlighted from the report:

- The Trust had received the draft report from the CQC for rehabilitation services, which was currently being checked for factual accuracy.
- There had been two requirement notices from the CQC regarding nurse call points and environmental blind spots. An action plan would be drawn up very quickly for these and returned to the regulator.
- The introduction of an intelligence tool 'CQC Insight' had been developed to support the regulatory function of the CQC to help monitor any potential changes to the quality of care provided and to support regulatory decision making. The Trust would receive bi-monthly intelligence reports.

  Members requested that as this data set developed that the Committee be provided with an explanatory narrative.

  Action: Mrs J Illingworth

  The Medical Director added that it would be helpful for the relevant leads to get together to look at the intelligence tool jointly.

- There had been four MHA inspections and one social care inspection since June 2018 and all recommendations were being addressed.
- Since April 2018 there had been a notable increase in the amount of specific patient issues raised. These issues related to four different wards and due to the anonymity of the information it could not be identified whether the issues raised were by the same individual on each ward.

18/109 PATIENT SAFETY REPORT

The Committee received and noted the Patient Safety Report and the Patient Safety Quality Reports for May 2018 and June 2018.

The key matters highlighted were:

(1) The Patient Safety Group had agreed a template for serious incident fractured neck of femur reports which would be trialled over a six month period.
(2) There had been issues regarding the Aligned Professional Service (APS) raised as a result of Serious Incident Reviews and this was being picked up by the Locality Manager.
(3) Work would be taken forward on guidance for NHS Trusts received in August 2018 around working with bereaved families from the National Quality Board.
(4) Assurance was provided that following a report by the Healthcare Safety Investigation Board – 'Investigation into the transition from child and adolescent mental health services to adult MH services', the findings which applied to the Trust would be followed up, including an RPIW.
(5) There had been five SI's reported in May and 15 in June 2018.
Following discussion members considered how the Committee was assured around the numbers of serious incidents.

Mrs Moody noted that there was work underway to look at the statistical data of SI's in more detail to check for repeated root causes and contributory factors, which would provide a better understanding and further assurance.

The Committee requested that future reporting around SI's include, for audit trail purposes, any previous incidents raised that were still being progressed.

Action: Mrs J Illingworth

(6) There remained an ongoing risk around establishing processes in the absence of clear national guidance for MH providers on mortality reviews.

Following discussion members sought assurance that all 18 deaths in June 2018 had been reviewed, even though only the cause of death had been established for three and it was clarified that the Trust reviews all deaths regardless of the cause. It was noted that some deaths were difficult to categorise and assign a level of review to due to delays on cause of death from the coroners.

18/110 TRUST CRITERIA FOR THE LOCATION OF EMERGENCY RESPONSE BAGS IN COMMUNITY UNITS AND POTENTIAL OF PLACING AUTOMATED DEFIBRILATORS INTO NON-PATIENT AREAS

The Committee received and noted a report on the location of emergency response bags in Community units and the potential of placing automated defibrillators into non-patient areas.

The following matters were highlighted from the report:

(1) The location of emergency response bags in community units had been discussed at Operational Management Forum and EMT.

(2) It was recommended that those community units with a Clozapine clinic or those who administer antipsychotic drugs to patients should have an emergency response bag in the clinic and that all other bags could be removed.
Staff working in the community setting would be expected to undertake CPR training and BLS training in those settings with access to an emergency equipment bag.

On this matter assurance was provided to the committee that the standardisation of emergency response bags in the community and related training would not introduce any new risks and would ensure that the Trust had a consistent and defensible approach by maintaining a level of competence training appropriate to an individual's employed role.

Agreed: *the criteria for those community units that administer anti-psychotic medication to have emergency response bags in their clinics.*

(3) It was recommended that stand alone AEDs be made available in non-clinical areas for community teams when there were no emergency response bags. In numbers this would involve the need for around 80 to 90 defibrillators; however it was noted that the Trust currently already had approximately 40 machines.

Agreed: *that AEDs be made available in non-clinical areas for community teams where there were no emergency response bags and that this option be developed fully and costed and taken to EMT for formal ratification.*

18/111 DRUG AND THERAPEUTICS (D&T) REPORT

The Committee received and noted the Drug and Therapeutics Report following the D&T meeting held on 25 July 2018.

The key matters highlighted were:

- The launch of bi-monthly assessments by Pharmacists on in-patient units to focus on rapid tranquilisation, covert administration, unlicensed medicines and Lithium. The first assessment had taken place in July 2018 and the reports had gone to QuAGs for consideration. An update would be reported to the QuAC at its meeting to be held in October 2018.
- Following consideration by D&T of the risks and benefits of holding Flumazenil on Wards, it had been agreed that it should be removed with the safest approach going forward to be adopted, which would be to ring (9)999.
- The pharmacy supply contract would expire at the end of October 2019 and a business case would be presented to EMT to look at future options, which included re-tendering or an internal pharmacy network.
- There had been some development of a section on the pharmacy intranet page for Patient Decision Aids, which would signpost to nationally available mental health related aids.

Committee members welcomed the one sided concise update with the key matters highlighted.

18/112 INFECTION, PREVENTION AND CONTROL QUARTERLY REPORT

The Committee received and noted the quarterly report for the period April to June 2018.

Some members of the Committee reported that the report had not been available for reading before the meeting on Boardpad and Ms Oliver uploaded the report during the meeting.

The Chairman requested that should members have any concerns after considering the report that they email Mrs Moody following the meeting.

The key matter highlighted from the report was the exception and risk concerning the cleaning scores from the National Standards of Cleanliness audits undertaken by Hotel Services. An escalation process was in place which would be monitored in localities by Matrons and Heads of Service and through QuAGs. A number of actions had been taken forward and Hotel services would be reviewing the scores for Quarter 2, 2018 and an action plan would be discussed at the next meeting of the IPCC.

18/113 SAFEGUARDING & PUBLIC PROTECTION REPORT

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

Arising from the report it was noted that:

(1) There had been a higher number of external CQC inspections including the recent Joint Targeted Area Inspections and serious case reviews in the Durham locality. No themes had been identified for the SCR's and there was no known reason for the increase in Durham.
(2) There had also been an increased demand for inter-agency working which had meant competing priorities for the safeguarding team with an increase in the number of cases coming through for consideration.

Assurance was provided that both the safeguarding adult and children teams continued to deliver a comprehensive safeguarding service within the Trust and were compliant with legislation.

18/114 PATIENT EXPERIENCE REPORT

The Committee received and noted the Patient Experience Group report.

Arising from the report it was noted that:

(1) There had been Issues with the Meridian feedback system for the completion of surveys in teams and roll out into the community with problems for staff trying to use the mobile phone app. In response to the question, "had you seen this comment on Meridian?" – only 43% of inpatient managers and 42% of community managers answered "yes".
On this matter it was noted that there would be further training for managers during September 2018.
(2) Service user and Governor representation at the Patient Experience Group over the last few months had been limited following the resignation of the appointed Governors and difficulty in securing a new appointee. There was however a wish to have a stronger presence and representation at the Group by service users and carers and this would be taken forward at the next meeting and discussed with the Involvement and Engagement Lead.
(3) A final response to a complex complaint had been composed where the subsequent action plan contained 23 individual action points, however only some of these were related to the Trust.

Assurance was provided that robust systems were in place for monitoring patient and carer feedback and when problems were identified, actions were being taken to make improvements.

18/115 CLINICAL AUDIT AND EFFECTIVENESS REPORT

The Committee received and noted the Clinical Audit and Effectiveness Update Report.

Arising from the report it was noted that clinical audit programmes of work were on track with no risks identified.

Following discussion concerns were raised where clinical outcome measures continued to indicate significant variation between teams and across Specialties and Directorates. This was due to a variation in completion rates with little confidence when looking at the results of one team against another.

Assurance was provided that work was underway to support the improvement around clinical practice and ensure consistent engagement with SDG's.

18/116 QUALITY ACCOUNT QUARTER 1 PROGRESS REPORT

The Committee received and noted the Quarter 1 Progress Report on the Quality Account.

The key matters highlighted were:

(1) The four key quality priorities were largely on track.
(2) There were seven out of the nine quality metrics reported as red.
On this matter it was noted that there had been little change in the position from the previous year with no significant deterioration, however what had been apparent over the last few years was the increasing complexity and acuity of individuals requiring care.

In addition to the report Mrs Moody drew attention to a national NHSI programme that would look at reducing restrictive practices and three Wards at West Lane had been put forward, hopefully to be included in this work.

18/117 QUALITY ACCOUNT STAKEHOLDER EVENT OUTCOMES AND POSSIBLE PRIORITES FOR 2018/19 QUALIY ACCOUNT

The Committee considered the quality priorities from the Quality Stakeholder Event held on 10 July 2018 and the suggestions put forward for future quality improvement priorities.

The following comments were raised by Committee members:

- That the existing four Trust quality priorities be considered by the Board Planning Workshop on 2nd and 3rd October 2018 for inclusion in the next Quality Account, unless there was assurance that work on the current priorities would be completed by March 2019.
- Crisis and "pre-crisis" services should be recommended to the Board Workshop as a possible priority.
- That improved consistency of care co-ordination be suggested as a further potential priority for 2019/20; however that this could possibly be subsumed into the care planning improvement priority or a different priority within the Trust Business Plan.
- That further consideration be given to improved reporting around the impact that the quality improvement priorities were having.

18/118 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no matters of exception to note.

18/119 ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD

There were no matters to escalate to the Board.

18/120 INTRODUCTION OF QUALITY ASSURANCE COMMITTEE ASSURANCE TRACKER

The Committee received a draft Quality Assurance Committee Assurance Tracker.

It was noted that the purpose of the Assurance Tracker would be to improve the levels of assurance to the Committee and to monitor areas of exception and progress.

***Agreed**: that the Assurance Tracker be populated following each meeting and reported back to the Committee on a monthly basis.*

18/121 COMMITTEE EVALUATION

Members expressed no concerns around the meeting, agenda and reports and acknowledged that the Quality Assurance Committee was still under a period of development to ensure standardisation of reports and improved reporting of assurance and exceptions from services.

18/122 ANY OTHER BUSINESS

There was no other business to discuss.

18/123 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 04 October 2018, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

The meeting concluded at 4.40pm

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Dr Hugh Griffiths
Chairman
04 October 2018

ITEM NO. 11

FOR GENERAL RELEASE

Trust Board

DATE:	**November 2018**
TITLE:	**Annual Review of Medical Education in the Trust**
REPORT OF:	**Dr Ahmad Khouja, Medical Director**
REPORT FOR:	**Information**

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

Executive Summary:

This annual update provides an overview of medical education activity in the proceeding twelve months and outlines the faculty of medical education key priorities for the next year.

The intention of the report is to provide assurance to board members regarding medical education and library activity in the Trust.

Recommendations:

It is recommended that the Trust Board note the content of this paper.

MEETING OF:	**Trust Board**
DATE:	**November 2018**
TITLE:	**Annual Review of Medical Education Activity in the Trust**

1. INTRODUCTION & PURPOSE:

1.1 This annual update will provide an overview of the core medical education activity over the last twelve months and outline the key priorities for the next year. The intention of the report is to provide assurance that the Trust is meeting its commitment set out in the Learning and Development Agreement towards the provision of medical education training.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Trust has approximately 150 junior doctor placements approved for training in the different programmes; foundation, GP, core and higher training. The number of trust grade doctor posts is also increasing through the overseas recruitment initiative and now totals 16.

2.2 Earlier this year, the Trust was delighted to hear that the bid from Sunderland University to create a new Medical School was approved by the GMC and the Trust has already began work to understand how it will offer placements using the Sunderland curriculum. Pilot community models are ongoing across the Trust as we look to maximise exposure of placements.

2.3 Internal governance of postgraduate medical education continues through the Trust psychiatry specialist training committees and these represent the four localities in the Trust and they oversee the delivery of all educational programmes. An undergraduate forum is also held and these groups report to the Medical Education Quality and Strategy Committee that oversees the locality groups and sets the strategic direction within the Trust. The ongoing cycle of quality control continues through the self-assessment report (SAR) and quality improvement plans (QIP). These reports set out how the Trust meets the GMC standards for delivering training.

2.4 In Autumn, the Trust will be inspected by the GMC. This rigorous inspection will seek to understand how we meet their standards for medical education and what governance we have in place. The visit will be akin to a CQC inspection but focus solely on training.

2.5 Over the last few years it is clear that far less doctors are able to contribute to the teaching and assessment of medical students and junior doctors. A significant cause of this is the number of vacant senior medical posts that result in colleagues having to prioritise clinical work. In addition, short term locum cover is often unable to provide the formal one hour supervision and whilst approved clinicians can cover some duties of a consultant psychiatrist, the formal weekly supervision is not one of those, as stipulated by the Royal Colleges and Health Education England.

2.6 During the summer, the Director of Medical Education distributed a survey to all consultant colleagues to try and understand why there are less colleagues volunteers to support medical teaching and training. The concern was that should this continue or decline further, the Trust would be unable to sustain the number of medical student and junior doctors in future years. The core themes from the survey included:

- Insufficient medical (psychiatrist) consultants to provide supervision to junior doctors.
- Very low numbers are able to contribute to external commitments such as ARCP panels, teaching at acute trust about mental health etc.
- Significant time spent by medical development trying to contact and persuade colleagues to contribute to medical student teaching and fill gaps.
- Low and dwindling number of consultants attending junior doctor local teaching programme.
- Lack of role modelling for medical students leads to poor evaluation.

2.7 Teaching and training is a fundamental part of a medical (psychiatrist) consultant role. This role must continue to be protected and acknowledged as fundamental to our efforts in attracting future psychiatrists to the Trust.

3. ACHIEVEMENTS IN MEDICAL EDUCATION

3.1 The quality improvement schedule for medical education is set out in the 2017/18 Quality Improvement Plan and Self-Assessment Report. The library service has a separate governance process entitled the library quality and assurance framework.

Ref 1 : 2017/18 Quality Improvement Plan (QIP)
Ref 2 : 2017/18 Self-assessment Report (SAR)
Ref 3 : 2017/18 Library Quality and Assurance Framework (LQAF)

3.2 The national GMC survey provides an opportunity for junior doctors and clinical supervisors to provide feedback to the Trust. It allows the Trust to benchmark the level of training provided against other similar organisations. This year the Trust has again demonstrated an ***exceptionally high level of training across the programmes.*** The most significant include:

The Trust was ranked as number one when compared to the 9 other Trusts in the North East. This is now the sixth consecutive year that TEWV has been ranked as number one in the North East.

Ref 4 : HENE GMC Trainee Survey Trust Report

The Trust was rated as the 5th best training provider in England and 8th best across the UK from of all acute, mental health and community based Trusts (more than 200) and remained in the Top Ten providers within the UK.

Ref 5 : GMC Trainee Survey Trust Report

As in previous years the GMC slightly modified the trainer survey. Overall when compared to all organisations, the Trust was ranked as fourth best in the UK. We were particularly pleased to learn that we were the top ranked organisation for trainer development in the whole of the UK and third raked for support for trainers. The Trust was also ranked third for one of the most important domains, overall satisfaction.

Indicator	Response Rate 2017 78.00% 2017 National Ranking (out of 463 organisations)	2017 %	Response Rate 2018 65.75% 2018 National Ranking out of 290 organisations	2018 %	Variation +/-
Overall Satisfaction	54 (Top 15%)	80.93	3	83.65	+ 2.72
Workload	69 (Top 15%)	48.58	52	49.35	+ 0.77
Handover	15 (Top 5%)	78.11	42	72.87	- 5.24
Supportive	147	76.94	20	75.74	- 1.20
Curriculum Coverage	60 (Top 15%)	79.44	11	80.06	+ 0.62
Educational Governance	25 (Top 10%)	82.89	5	79.37	- 3.52
Time for Training	60 (Top 15%)	68.68	17	67.96	- 0.72
Rota Design	13 (Top 5%)	73.52	19	71.95	- 1.57
Resources for Trainers	76 (Top 20%)	79.34	8	79.73	+ 0.39
Support for Trainers	78 (Top 20%)	77.82	3	80.88	+ 3.06
Trainer Development	48 (Top 15%)	80.00	1	83.11	+ 3.11

Ref 6 : GMC Trainer Survey Report Local Ranking
Ref 7 : GMC Trainer Survey Report National Ranking

3.4 In relation to medical student teaching, progress remains largely positive across the three medical schools.

Leeds Medical School
Students generally really enjoyed their placements at Harrogate and particularly commented on the friendliness of staff. A high standard of scheduled teaching was provided with supervision and students felt that teachings sessions regularly gave opportunities to perform MSEs, risk assessments and history taking. Students also enjoyed the flexibility in their placements and the opportunity to visit specialist services such as our forensic hospital services and visits to prison with the Crisis Team. The overall rating for students' placement recommendation has continued to rise in Harrogate; 69% (2015-16), 94% (2016-17) to 100% this year.

Hull & York Medical School
Scarborough continues to receive excellent feedback and is even described by HYMS as their 'gold standard' placement. Particularly strong feedback relates to the standard of teaching, organisation and the variety of experience

offered to enable students meet their learning outcomes. Students increasingly feel welcomed onto our inpatients areas and all students would now recommend the placement to others. Students regularly express that the placement has increased their interest in psychiatry. Those students with a special interest in psychiatry can access services in other areas of the Trust that are not available, such as ECT in York and forensic services in Middlesbrough.

Student feedback for our York site describes the placement as 'excellent quality', using a variety of formal and informal interactive teaching styles, delivered by enthusiastic tutors and pitched at the right level. Students felt the attachment was 'much more organised' than others, and particularly valued the structured placements with a variety of inpatient, acute, liaison and community teams which allowed them to see plenty of patients. Difficulties with ongoing service reconfiguration have been minimised by clinicians to the extent that the placement has increased in overall satisfaction in the last two years.

Newcastle Medical School
Feedback from the fifth year medical students highlighted that teaching was relevant to the course & served as a useful recap of core topics that were taught in the third year. Weekly tutorial sessions offered structured teaching and allowed open discussions in small groups to focus on management planning, investigations, summarise cases & talk through more complex cases. Students felt staff in clinical areas/teams were involved with teaching and took time to explain cases and help to develop skills. Formative appraisal in practice increased confidence for end of rotation assessment developed history taking & summarising skills.

Feedback from third year students highlights that there was good variety in teaching which was well organised, pitched at the correct level and delivered efficiently. Students felt encouraged to study on topics in more detail to further enhance their learning and knowledge. An area to consider over the next few months was that some students felt they would like to move away from traditional 'classroom' didactic style teaching & more towards interactive 'flipped classroom' style teaching based on case studies. Feedback from overall satisfaction was as follows:

5th year medical students	**3rd year medical students**
Rotation 1 = 95%	**Rotation 1 = 93%**
Rotation 2 = 84%	**Rotation 2 = 48%**
Rotation 3 = 51%	**Rotation 3 = 75%**
Rotation 4 = 83%	**Rotation 4 = 92%**
	Rotation 5 = 100%
	Rotation 6 = 95%

3.5 The initiatives outlined in previous board reports as good practice are now embedded into operational process and are therefore not included in this update. The two core themes from the previous year has been a focus on the

quality of experience provided and a focus on morale, satisfaction and wellbeing.

3.5 Focus on Quality of Experience

This year we appointed a Champion of Less than Full time Working in line with the requirements in the new Junior Doctor Contract. Dr Ruth Briel was appointed to this role and has convened three groups to date. The group has identified priority areas including the creation of a booklet for those thinking about pursuing less than full time working, a salary calculator so that junior colleagues understand the financial implications of less than full time training, a guide to annual leave and also consideration of an re-orientation programme for those on maternity leave who come back to work after a considerable time away from work.

The in house teaching programme that was developed in 2017 has continued to develop to meet the needs of the trainee and trainer workforce. The programme was first developed in recognition of the new standards for training framework introduced by the GMC in 2017, and the programme has continued to develop and will now also include sessions on Dual Diagnosis / Substance Use, Undergraduate Teaching Skills and also an introduction to coaching skills for medics based on the “Think On” approach adopted by TEWV. This will have been a significant contributing factor as to why the Trust was ranked number one in the trainer survey for trainer support.

The faculty has been able to offer sponsorship opportunities to four senior registrars to take the certificate in postgraduate medical education courses available locally. These are individuals who were involved in delivering significant student teaching. The one year programme provides educational rigour to the clinical knowledge already acquired and requires participants to produce a poster for the Trust on a project of their choice that will improve the delivery of medical education. The aim is that these, together with those produced by higher trainees on the Trust leadership and management programme, are used to showcase the Trust at regional and national conferences and events.

This year our SAS doctors agreed to pilot the introduction of senior registrars to their established development support programme. The SAS programme is a trust-wide event which is held every two months and because of the strength of the programme and reputation it has developed, senior registrars were keen to access some of the teaching and also network with career grade colleagues. The pilot is going well and agreement has been made for it to continue in 2019. In relation to the in house CESR programme, the framework for the programme has been written and commended by the Royal College of Psychiatrists. Unfortunately, given the recruitment challenges for seniors mentioned earlier we have been unable to recruit supervisors to oversee the progress of individual SAS doctors on the programme so there remains work to be done to get the programme running as we hoped it would.

In relation to the Trust doctors, many of which join the Trust from the overseas recruitment initiative, we are now able to offer bespoke English language training from IELTS assessors to help support communication skills and the regional differences in dialect. We also provide some support to doctors who are appointed to the programme but are unable to reach the required IELTS score. This score is necessary to be able to work in the UK and assess written and verbal communication. Our experience shows that many colleagues are borderline and often just fall short on one of the domains assessed. To support them, a focussed short programme, often over skype, can make the difference and allow them to join the programme and work for the Trust.

3.6 Focus on Morale, Satisfaction and Wellbeing

Over the last year, a number of publications that relate to the wellbeing and general satisfaction of junior doctors on placement have been written.

Health Education England (HEE) released a progress report on Enhancing Junior Doctors' Working Lives which followed a report last year to understand best practice working environments for junior doctors. The College paper 'Supported and Valued' set out some best practice principles to create a supportive environment and more recently NHS Employers provided guidance on rostering. There was also two reports about OOH working focussed on fatigue and sleep deprivation.

The Faculty reviewed these documents and agreed that the themes and recommendations were useful in order to help us create quality placements in an environment where junior doctors feel supported and valued.

Over the summer we asked for expressions of interest and following the appointment of new junior doctor representatives, we hope the groups will commence in Autumn 18'. The themes include:

- Sleep deprivation and fatigue (to include OOH facilities)
- Improved communication and feedback (to develop the 'You Said We Did' principle further and create a form that enables clearer feedback from accountable leads and actions/dates identified)
- Junior doctor Compact (setting out what it is like to work in the Trust and what you will receive by way of support and development)
- Rostering Protocol (to develop timescales, clear communication and consultation both prior to developing rotas and ongoing throughout the placement)
- Enhancing Junior doctors Working Lives (recommending areas of improvement in line with Supported & Valued and best practice working environments)

During the year, a core trainee led on some work to develop an outdoor one day leadership programme for registrars. The junior doctor was supported by medical development and organised the teaching part of the programme and work with facilitated outdoor leadership.

A key component of the work of the faculty continues to be how it can attract future psychiatrists. More specifically, the Trust has continued to work on the overseas programme for trust doctors. As the number of trust doctors grow, many of which have studied overseas, the support that is required to enable them to settle into both the work place and life in the UK is better understood. Whilst we have a well developed programme, there remains much to do on this agenda and it will be a continuing focus over the next year.

Recently we created trust doctor representatives that mirror those in training posts and have established an agenda item as part of the postgraduate education forum. We now have a senior and deputy tutor role to oversee this group of doctors which is now a substantial cohort, almost matching the numbers of GP Registrars in training within the trust.

The GMC trainee survey results in 2018 demonstrated that whilst the overall satisfaction of junior doctors increased, there are some challenging agendas to work through over the next year. The introduction of a new junior doctor bank which will fix pay rates across the region and the ongoing difficulty in having a supervisor protected for the one hour supervision will be significant agendas to work through.

4. Library and information service

4.1 The Library and Information Services (LIS) is a service that is available, visible and accessible to all TEWV staff and students which nurtures and supports lifelong learning and ensures that everyone can access high quality knowledge and information to ensure that the care of service users is always informed by evidence, used at the right time, in the right place.

Since TEWV introduced the joint library management system with funding from Health Education England in September 2017 has recorded the following loans across TEWV

	CLH	LRH	RPH	WPH	Outreach	**Total**
Oct-17	30	388	128	142	21	**709**
Nov-17	106	300	91	208	14	**719**
Dec-17	32	196	29	74	0	**331**
Jan-18	104	302	63	163	51	**683**
Feb-18	24	181	14	39		**258**
Mar-18	134	133	60	124		**451**
Apr-18	71	148	50	78		**347**
May-18	77	139	76	152		**444**
Jun-18	233	147	68	58		**506**
Jul-18	195	64	15	168	150	**592**
Aug-18	172	99	12	53	27	**363**
Sep-18	124	28	7	219	113	**491**
total	**1302**	**2125**	**613**	**1478**	**376**	**5894**

4.2 The library team have recently introduced an Outreach/Pop Up Library service across the Trust and this has resulted in 376 loans at non-library buildings.

There are 7500 total books in TEWV stock and recently all book stock was reviewed as part of the agreement to join the OLIB library management system. Through the introduction of the joint library management system (LMS) shared between several organisations in the North East, TEWV staff have access to 33,790 books. The library service purchased 1200 books in 2017-2018, with 200 titles purchased as direct replacements for dated library stock. 945 books purchased as a request from library users.

The "Pop Up libraries" have been successful and supported events and ensured that the service supports rural geographical sites with no direct access to library services: The Pop Up Libraries have increased the number of book issues and has generated 45 literature searches and 14 evidence summaries.

• Autism Strategy Launch • Bootham Park • Eastfield Clinic • Family Therapy Conference • Forensics Conference • Grand Rounds (Durham and York) • Green Lane Effective Disorders • Huntingdon House • Junior Doctor Inductions	• Lime Trees • Malton • Nurses Conference • NVQ Study Days (FLC/LRH/WPH) • Peppermill Court • Preceptorship Study Days • Research Hub • Schwartz Rounds • Social Workers Events

4.3 The library service continues to offer Literature Searches and Evidence Summaries. In 2017/18 351 Literature Searches and Evidence Summaries completed. The library continues to produce a monthly Current Awareness Bulletin and now produced a Quarterly MEQAS Bulletin. The CAB has over 500 subscribers this is slightly down on last year due to the changes to GDPR regulations recently introduced.

Through a grant from HEE the library service was able to expand the paper journal collection to include Lancet Psychiatry, Psychology and Behavioral Sciences, and American Journal of Psychiatry. Through the Yorkshire and Humberside Library Managers Network the TEWV library service has been worked with the Leeds & York Partnership NHS Foundation Trust to improve its paper journal collection.

The service has also provided training sessions including 168 1-2-1 training sessions, 351 literature searches and 24 Critical Appraisal Training and Evidence Based Practice Sessions with over 150 delegates.

4.4 The library service has also participated in several new developments including **Books On Prescription.** Reading Well for Mental Health is the 2018 theme and the selection panel includes Dr Paul Blenkiron. The BOP scheme helps people to understand and manage their health and wellbeing

through helpful reading. All the titles are recommended by health experts and people with lived experience of the conditions covered on each list.

KnowledgeShare is a web application that makes NHS library and knowledge services more accessible. It allows library and knowledge services to manage requests for evidence searches and share the results of searches more widely. It will allow the service to run information skills teaching sessions and give participants the opportunity to book, cancel bookings, download course materials and generate certificates of attendance. It will also provide regular, targeted, personalised evidence updates to staff and subject-specific bulletins can also be produced. KnowledgeShare can also be matched to staff according to their interests and allows NHS colleagues to connect with one another based on shared interests.

5. IMPLICATIONS / RISKS:

5.1 Quality:

The QIP outlines the quality objectives to be delivered in the next cycle.

6. Financial:

The Trust receives £5.5 million each year to support the salaries of junior doctors and educational infrastructure required to deliver quality medical training placements for students and doctors.

7. Legal and Constitutional:

The Trust has a responsibility through the Learning and Development Agreement to quality assure the delivery of medical education.

8. Equality and Diversity:

There are no implications to consider.

9. Other Risks:

The Trust will need to ensure that medical education leads are involved in any service changes to ensure that the core training posts have sufficient exposure in all specialities to meet the curriculum.

10. CONCLUSIONS

The Trust continues to have a pro-active and strong faculty of medical education. Feedback demonstrates that we continue to achieve positive results in relation to the delivery of medical education programmes.

11. RECOMMENDATIONS:

It is recommended that the Trust Board note the content of this paper.

Authors **Bryan O'Leary, Associate Director of Medical Development**
Dr Jim Boylan, Director of Medical Education

Item 12

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**30 October 2018**
TITLE:	**Finance Report for Period 1 April 2018 to 30 September 2018**
REPORT OF:	**Patrick McGahon, Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 30 September 2018 is a surplus of £3,698k, representing 2.2% of the Trust's turnover and is £212k ahead of plan.

Performance Against Plan – year to date (3.2)

	Variance £000	Monthly Movement £000	Movement
The Trust is currently £212k **ahead** of its year to date financial plan.	-212	-196	↑

Cash Releasing Efficiency Savings (CRES) (3.3)

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the financial year are £296k **behind** financial plan.	Recurrent	4,607	↑
	Non recurrent	-4,311	→
	Target	0	
	Variance	296	↑

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the rolling 3 year period are £15,214k **behind** the £21,000k CRES target.	Recurrent	15,214	→

A Waste Reduction Programme has been established to assist the Trust in delivering the recurrent CRES requirements in full, and a 3 year CRES plan.

Capital (3.4)

The Trust is currently £1,243k **in excess** of its capital plan.	**Variance £000**	**Monthly Movement £000**	**Movement**
	1,243	947	↓

The Trust received a capital rebate relating to prior year schemes (£2,289k), with this included, capital expenditure is £1,046k behind plan.

Workforce (3.5)

The Trust is currently £1,298k (45%) **in excess of** its agency cap.	**Variance £000**	**Movement £000**	**Movement**
	1,298	378	↓

Agency expenditure remains high in month 6 across all localities and is largely required for nursing agency to support enhanced observations with complex clients.

Use of Resources Risk Rating (UoRR) (3.7)

	Plan	**Actual**	**Movement**
The Trust is currently **behind** its planned UoRR which is rated 1 to 4 with 1 being good.	1	2	↓
The Trust is forecasting to be **behind** its planned UoRR at the financial year end.	1	2	→

The Trust is forecasting to be behind plan due to agency expenditure being in excess of the capped target.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**30 October 2018**
TITLE:	**Finance Report for Period 1 April 2018 to 30 September 2018**

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for 1 April 2018 to 30 September 2018.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report will enable the Board of Directors to monitor the Trust's key financial duties and performance indicators which are both statutory requirements.

2.2 NHS Improvement's Use of Resources Rating (UORR) evaluates Trusts based on ability to service debt, liquidity, I&E margin, achievement of planned I&E margin and agency expenditure.

3. KEY ISSUES:

3.1 Key Performance Indicators

The Trust is achieving the control total set by NHSI, the Use of Resources Rating for the Trust is behind plan due to agency expenditure exceeding the capped target. The amount of CRES identified is marginally below required levels, and actions taken to rectify are detailed in section 3.3.

3.2 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 30 September 2018 is a surplus of £3,698k, representing 2.2% of the Trust's turnover and is £212k ahead of plan.

Table 1

	Annual Plan	Year to Date Plan	Year to Date Actual	YTD Variance
	£000	£000	£000	£000
Income From Activities	(332,904)	(163,331)	(163,021)	310
Other Operating Income	(16,751)	(9,165)	(9,279)	(114)
Total Income	**(349,655)**	**(172,496)**	**(172,301)**	**195**
Pay Expenditure	262,892	131,444	130,907	(537)
Non Pay Expenditure	68,582	31,912	32,186	274
Depreciation and Financing	11,317	5,655	5,509	(145)
Variance from plan	**(6,864)**	**(3,486)**	**(3,698)**	**(212)**

3.3 Cash Releasing Efficiency Savings (CRES)

The Trust's performance against the 2018/19 CRES target is shown in table 2 below. The Trust is behind plan (£296k) and continues to identify schemes to ensure full delivery of recurrent CRES requirements.

Table 2	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the financial year are £296k **behind** financial plan.	Recurrent	4,607	↑
	Non recurrent	-4,311	→
	Target	0	
	Variance	296	↑

3.4 Capital

Expenditure against the capital programme to 30 September 2018 is £5,966k and is £1,243k in excess of plan largely due to expenditure incurred on the Roseberry Park MIST system being offset by delays on the York and Selby Inpatient facility.

The Trust received a capital rebate relating to prior year schemes (£2,289k), with this included, capital expenditure is £1,046k behind plan.

3.5 Workforce

Table 3 below shows the Trust's performance on some of the key financial drivers identified by the Board.

Table 3	Pay Expenditure as a % of Pay Budgets						
Tolerance	Tolerance Sep-18	Apr	May	Jun	Jul	Aug	Sep
Establishment (a) (90%-95%)	92.3%	94.60%	93.70%	93.41%	92.77%	92.72%	92.31%
Agency (b)	1.0%	2.70%	2.80%	2.80%	2.98%	3.05%	3.19%
Overtime (c)	1.0%	1.60%	1.20%	1.12%	1.12%	1.13%	1.11%
Bank & ASH (flexed against establishment) (100%-a-b-c)	5.7%	3.30%	2.90%	3.08%	2.93%	2.98%	3.09%
Total	**100.0%**	**102.20%**	**100.60%**	**100.41%**	**99.80%**	**99.88%**	**99.70%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For September 2018 the tolerance for Bank and ASH is 5.7% of pay budgets.

NHS Improvement monitors agency expenditure against a capped target. Agency expenditure at 30 September 2018 is £4,193k which is £1,298k (45%) in excess of the agreed year to date capped target of £2,895k. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

3.6 Cash

Total cash at 30 September 2018 is £68,362k, and is £228k higher than planned, largely due to working capital variations.

3.7 Use of Resources Risk Rating (UoRR) and Indicators

3.7.1 The Use of Resources Rating for the Trust is assessed as 2 for the period ending 30 September 2018 and is behind plan (table 4). Agency expenditure increased again in September which is higher than anticipated and in excess of the NHSI capped target. Work is on-going; and continues to be monitored, in order to improve this position.

Table 4 - Use of Resource Rating at 30 September 2018

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

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	1.41x	3	1.43x	3	
Liquidity	50.4 days	1	52.8 days	1	
I&E margin	2.2%	1	2.1%	1	
I&E margin distance from plan	0.1%	1	0.0%	1	
Agency expenditure	£4,193k	3	£2,895k	1	
Overall Use of Resource Rating		**2**		**1**	

3.7.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.41x (can cover debt payments due 1.41 times), which is marginally behind plan and rated as a 3. This rating is in line with the plan for quarter 2.

3.7.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 50.4 days; this is marginally behind plan and is rated as a 1.

3.7.4 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 2.2% and is rated as a 1, which is in line with plan.

3.7.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding STF income. The Trust I&E margin distance from plan is 0.1% which is ahead of plan and is rated as a 1.

3.7.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is higher than the capped target and is rated as a 3.

The margins on Use of Resource Rating are as follows:

- Capital service cover - to improve to a 2 a surplus increase of £2,254k is required.

- Liquidity - to reduce to a 2 a working capital reduction of £44,917k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £1,931k is required.
- I&E margin distance from plan – to reduce to a 2 an operating surplus decrease of £80k is required.
- Agency Cap rating – to improve to a 2 a reduction in agency expenditure of £575k is required.

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 At the end of September the Trust is £212k ahead of the control total set by NHSI.

6.2 The amount of CRES identified for the financial year and rolling 3 year period is below required levels; however, the Trust continues to identify schemes to ensure full delivery of recurrent CRES requirements.

6.3 The Use of Resources Rating for the Trust is assessed as 2 for the period ending 30 September 2018 and is behind plan. The Trust is forecasting a rating of 2 at the end of the financial year which is behind plan due to the agency expenditure rating.

7. RECOMMENDATIONS:

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

Patrick McGahon
Director of Finance and Information

ITEM 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th October 2018**
TITLE:	**Board Dashboard as at 30th September 2018**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communication**
REPORT FOR:	**Assurance**

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

Executive Summary:

As at the end of September 2018, 8 (47%) of the indicators reported are not achieving the expected levels and are red. This is the same position as at the end of August. 50% of these are within the 'quality' domain, however it should be noted that one of these (KPI 2) is new and has only recently been reported against. In addition there are 7 KPIs (41%) that whilst not achieving the target are within the 'amber' tolerance levels, which again is the same position as at the end August.

Of the 15 indicators that are either red or amber 7 (41%) are showing an improving trend over the previous 3 months.

The year to date position is that there are 8 KPIs (47%) which are reported as red which is the same position as at the end August.

In terms of the Single Oversight Framework targets the Trust achieved all the operational and quality targets in September and for Q2 as a whole, however there was variance in terms of achievement across the CCGs.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**30th October 2018**
TITLE:	**Board Dashboard as at 30th September 2018**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 30th September 2018 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. Definitions of the KPIs within the dashboard are provided in Appendix B.

2. KEY ISSUES:

2.1 Performance Issues

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

- As at the end of September 2018, 8 (47%) of the indicators reported are not achieving the expected levels and are red. This is the same position as at the end of August. 50% of these are within the 'quality' domain, however it should be noted that one of these KPI (KPI 2) is new and has only recently been reported against. In addition there are 7 KPIs (41%) that whilst not achieving the target are within the 'amber' tolerance levels, which again is the same position as at the end August.

  Of the 15 indicators that are either red or amber 7 (41%) are showing an improving trend over the previous 3 months.

  The year to date position is that there are 8 KPIs (47%) which are reported as red which is the same position as at the end August.

- In terms of the Single Oversight Framework targets the Trust achieved all the operational and quality targets in September and for Q2 as a whole. Specific issues are as follows:
  - The 7 day follow up following discharge was not achieved in 3 CCGs in September but there are no specific concerns in terms of trends. Indeed the target was achieved for Quarter 2 in all CCGs.
  - IAPT/Talking Therapies – proportion of people completing treatment who move to recovery" – as a Trust performance was just at the target level for the Quarter as a consequence of low performance in the month of July. In terms of CCGs there were two CCG were the target was not achieved in September (DDES CCG and Vale of York CCG). In terms of the Quarter 2 position we did not achieve the target in 3 CCGs (DDES, Vale of York and Hambleton, Richmondshire and Whitby CCGs).
  - Access to Early Intervention in Psychosis - the Trust as a whole significantly overachieved against the target in September and for Quarter 2 due to some strong performances across Durham, Darlington and Teesside teams. However the North Yorkshire

Services and York and Selby Services failed to achieve the target for Quarter 2 although the York and Selby service did achieve it in September unlike the North Yorkshire services. There has been particularly challenges regarding staffing across all these services however the York and Selby services have got new staff coming into post.

- Inappropriate Out of Area Occupied Bed Days – the target was not achieved in 3 CCGs in September and Quarter 2.These all related to 'Internal' Out of Area admissions i.e. admissions within other areas of the Trust. There were no patients admitted externally from the Trust due to pressure on beds.

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

2.3 Key Risks

- Waiting times (KPI 1 and 2) – The %age patients sees within 4 weeks of Referral (KPI1) has seen a deteriorating position since May 2018 mainly as a consequence of low performance in North Yorkshire and York and Selby localities. Whilst KPI2 (waiting times for treatment) is a new indicator and as such focus is now being given to it there is a risk that if KPI 1 shows a deteriorating position then this will have a negative impact on delivery of the waiting time to treatment as well.

- Bed Occupancy (KPI 12) – The pressures on beds has continued in September with occupancy levels remaining similar to those in August. There has been a slight improvement in the % of patient readmitted within 30 days and the number of inappropriate Out of Area days however the number of patients with a length of stay greater than 90 has remain slightly above target. All localities are monitoring bed occupancy daily and are ensuring that admissions over 30 day length of stay are reviewed to ensure they remain appropriate or if further action is required to support discharge however there are a number of complex patients on the wards who do required longer lengths of stay. In addition within North Yorkshire and York there are a number of patients whose discharge is delayed as no suitable placement has been identified.

- Number of Unexpected Deaths Classed as a Serious Incident (KPI 5) – Whilst the rate per 10,000 open cases improved in September it still remains above target and the absolute number was the same as in August.

- Outcome Indicators (KPIs 6 and 7) – Performance against the two outcome indicators (clinically reported (HONOS) and patient reported (SWEMWEBS)) continues to be considerably worse than target. The PBR team continue to share reports with services to allow them to focus on the reasons for the 'breaches' and work is being undertaken in all localities on reemphasising the need to record outcome scores in order to be able to demonstrate improvement made. Following the Performance Improvement

Group in May, chaired by the COO, a further discussion was held at the October PIG meeting regarding how we can improve the recording of outcome scores. A number of actions were agreed including gaining an understanding of the variation in where outcomes have not been recorded due to it not being clinically appropriate; a review by the Service Development Groups of the validity of the outcomes being used and ensuring that the presentation of the data is improved to support and understanding of the positon and a focus in terms of action.

- Sickness Absence Rate (KPI 19) – whilst performance has improved in the position reported in September (August sickness) it is still at one of the highest position for the year to date (although it is still better than the position reported in September 2017). A review of the Trusts approach to managing sickness absence is underway and it is expected that a new procedure will be available in the coming months. The main outliers are Forensic and Durham and Darlington.

- Financial Targets (KPIs 21) – In the month of September (and Year to Date) we have not achieved the target for CRES delivery although an improvement has been seen over the past few months. Work is ongoing via the Programme Board to identify further recurrent CRES schemes and it is expected that the target will be achieved by the year end.

2.4 Data Quality Assessment.

The data quality assessment of the Dashboard indicators is included in Appendix D. There have been no changes to it from that reported in September.

3. RECOMMENDATIONS:

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

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Quality

	September 2018				April 2018 To September 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	90.00%	85.79%			90.00%	86.98%		90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral	60.00%	41.62%			60.00%	28.29%		60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	2,389.00	2,080.00			2,389.00	2,080.00		2,389.00
4) Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	92.01%			92.45%	91.05%		92.45%
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.26			6.00	9.21		12.00
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	67.25%	55.29%			67.25%	55.93%		67.25%
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	78.25%	67.90%			78.25%	65.12%		78.25%

Activity

	September 2018				April 2018 To September 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	94.17%			85.00%	94.96%		85.00%
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	68.00	73.00			68.00	73.00		68.00
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.93%	24.14%			23.93%	21.97%		23.93%

Workforce

Trust Dashboard Summary for TRUST

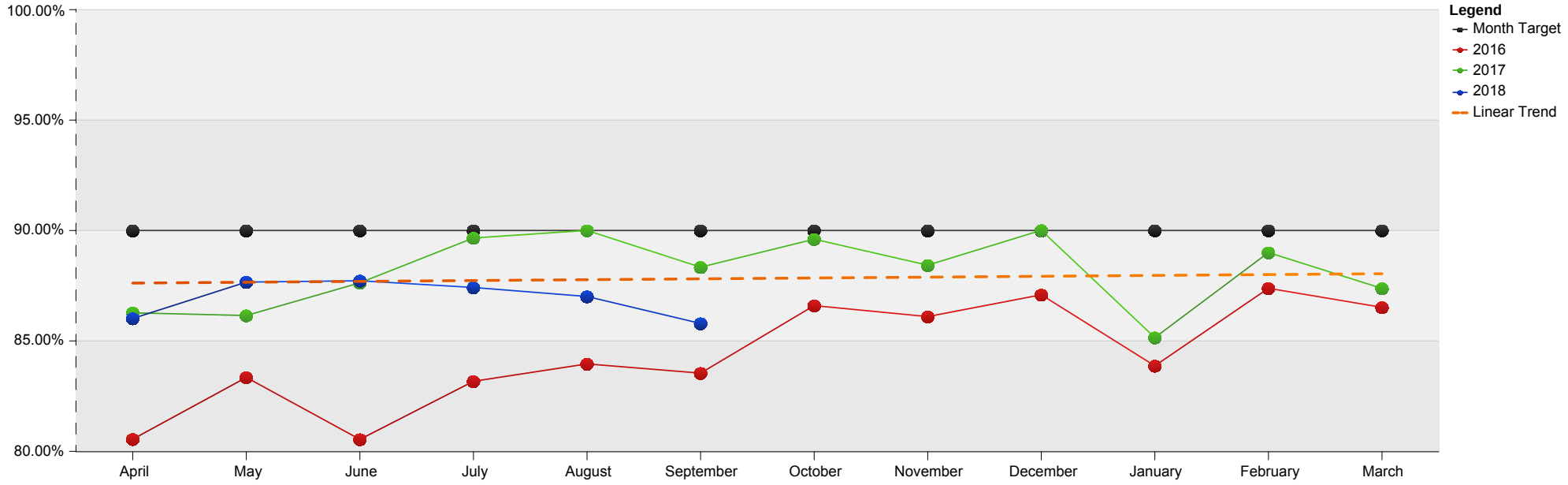
	September 2018				April 2018 To September 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
15) Actual number of workforce in month (Establishment 95%-100%)	95.00%	92.32%			95.00%	92.32%		95.00%
16) Vacancy fill rate	90.00%	76.29%			90.00%	76.07%		90.00%
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	90.40%			95.00%	90.40%		95.00%
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	90.11%			92.00%	90.11%		92.00%
19) Percentage Sickness Absence Rate (month behind)	4.50%	4.90%			4.50%	4.81%		4.50%

Money

	September 2018				April 2018 To September 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
20) Delivery of our financial plan (I and E)	-648,000.00	-845,476.00			-3,486,000.00	-3,699,446.00		-6,864,000.00
21) CRES delivery	686,782.00	532,724.00			4,120,692.00	3,126,654.00		8,241,384.00
22) Cash against plan	66,684,000.00	68,362,000.00			66,684,000.00	68,362,000.00		56,640,000.00

Trust Dashboard Graphs for TRUST

1) % of patients who were seen within 4 weeks for a 1st appointment following an external referral



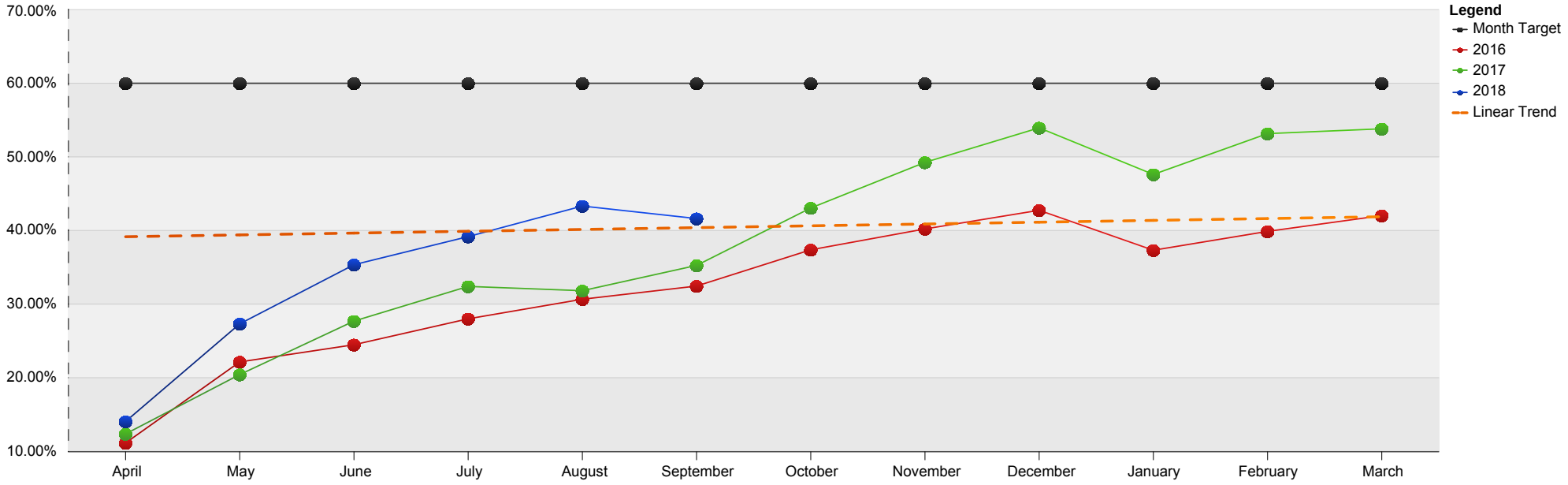
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	85.79%	86.98%	85.58%	87.09%	90.64%	92.42%	71.27%	74.75%	99.54%	99.41%	84.53%	78.28%		

Narrative

The position for September 18 is 85.79% relating to 4818 patients of 5616 who were seen within 4 weeks. This is below target of 90% and a slight deterioration on the position reported in August 18. Areas of concern:• York AMH at 81.90% (190 of 232 patients) 42 patients were not seen within 4 weeks which is a slight improvement on the 81.25% reported in August 18. Performance continues to be impacted by the high DNA rate within the Access Team and discussions are underway about ways to address this. In addition, the team are trying to fit patients in to the cancelled slots in order to use this capacity and support throughput.• North Yorkshire AMH at 65.53% (270 of 412 patients) 142 patients were not seen within 4 weeks. This is a deterioration compared to the position reported in August. There continues to be issues particularly within Harrogate and Ripon teams around sickness and vacancies and agency staff are being brought in to help manage demand. • North Yorkshire MHSOP at 67.74% (273 of 403 patients) 130 patients were not seen within 4 weeks. MHSOP have a number of staffing issues (Sickness and Vacancies) particularly within the memory service and as a result had to rearrange a number of appointments during the month. Actions are in place to prevent this from re-occurring.

Trust Dashboard Graphs for TRUST

2) Percentage of patients starting treatment within 6 weeks of an external referral

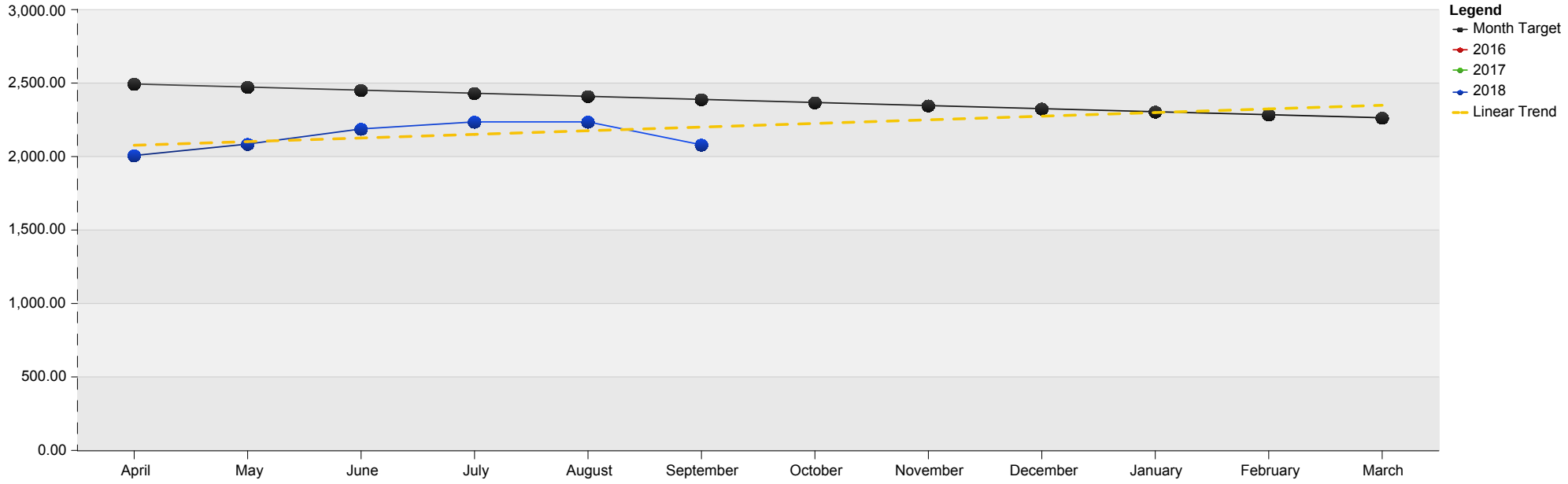


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients starting treatment within 6 weeks of an external referral	41.62%	28.29%	35.56%	23.64%	46.20%	33.66%	36.91%	23.57%	94.29%	81.56%	43.72%	24.88%		

Narrative
The Trust position for September 2018 is 41.62%, which is below target and a deterioration on the 42.90% reported in August. All localities with the exception of forensic services are below target. This is a new indicator and all localities have now started to look at this data and work is underway to identify reasons for under performance.

Trust Dashboard Graphs for TRUST

3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)



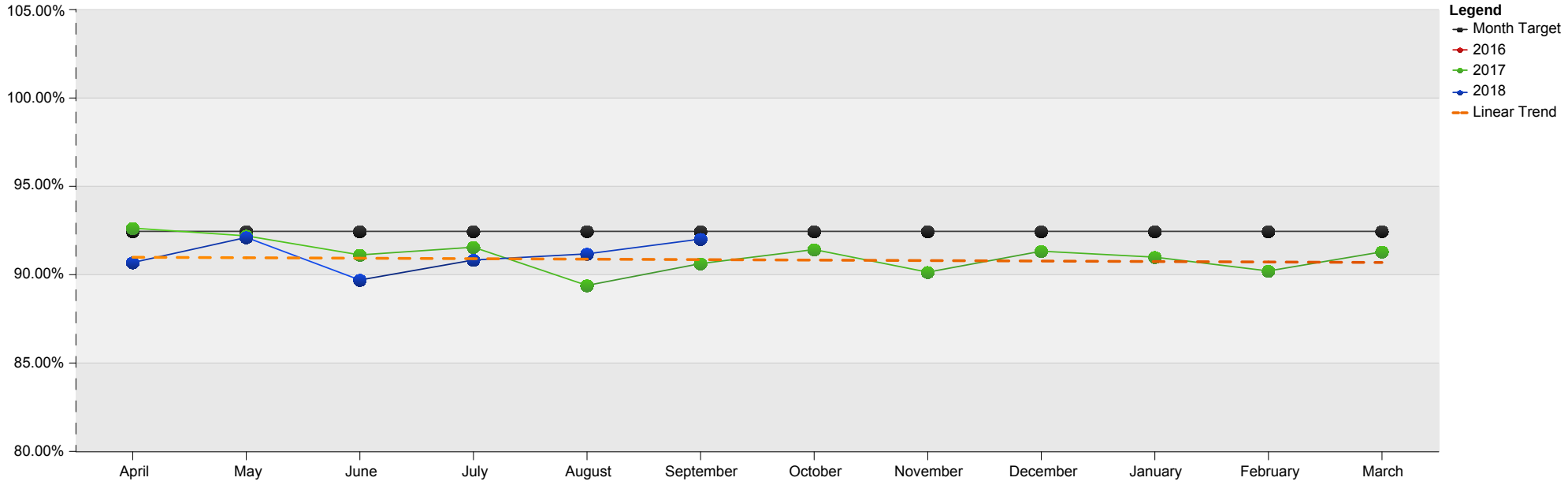
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	2,080.00	2,080.00	202.00	202.00	828.00	828.00	723.00	723.00			327.00	327.00		

Narrative

The Trust position for September 18 is 2,198 which is meeting the target of 2,389 and is an improvement on the August position.The following localities are not meeting target: - • Durham and Darlington–202 occupied bed days (169 AMH and 33 MHSOP). This relates to 80 patients admitted out of area (beds within D&D) over the 3 month period (63 AMH, 17 MHSOP)• Tees–828 occupied bed days (299 AMH and 529 MHSOP).This relates to 31 patients admitted out of area (beds within Tees) over the 3 month period (30 AMH, 1 MHSOP) Both localities continue to have a number of patients from the other 3 localities admitted to their beds. As a result they have had to find alternative beds for patients from the home areas. Within York, there have been a number of 'out of area' patients who have remained in beds elsewhere due to delayed transfers of care and issues around finding suitable accommodation, mainly care home placements. Work is underway to return patients to their home area and it is expected improvements will be seen in the next couple of months. All localities are monitoring this on a continual basis with actions agreed in daily huddles. There are two action plans agreed with commissioners (one for Durham & Darlington & Tees and one for North Yorkshire & York). These are managed jointly with the CCGs via the Contract Management Boards.

Trust Dashboard Graphs for TRUST

4) Percentage of patients surveyed reporting their overall experience as excellent or good

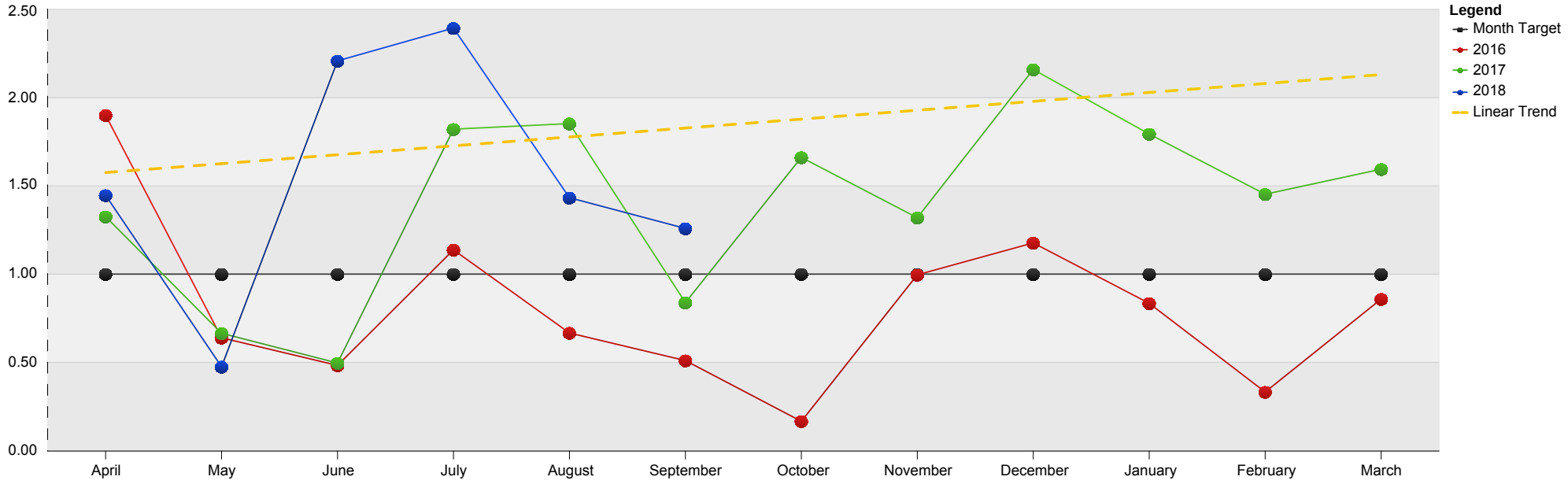


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of patients surveyed reporting their overall experience as excellent or good	92.01%	91.05%	93.28%	92.36%	92.27%	91.86%	91.76%	92.30%	82.50%	80.19%	90.40%	89.16%		

Narrative
The Trust position for September 2018 is 92.01% which is not meeting the target of 92.45% but is within 10% of the target and is an improvement on the position reported in August (July data).Forensic Service are below target for this indicator whilst Durham and Darlington are meeting the target and the remaining localities achieved within 10% of the target. Work continues within each locality to review performance against this indicator and identify any areas of concern. Please note due to changes with this indicator in 2016, this year is not displayed on the graph above.

Trust Dashboard Graphs for TRUST

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



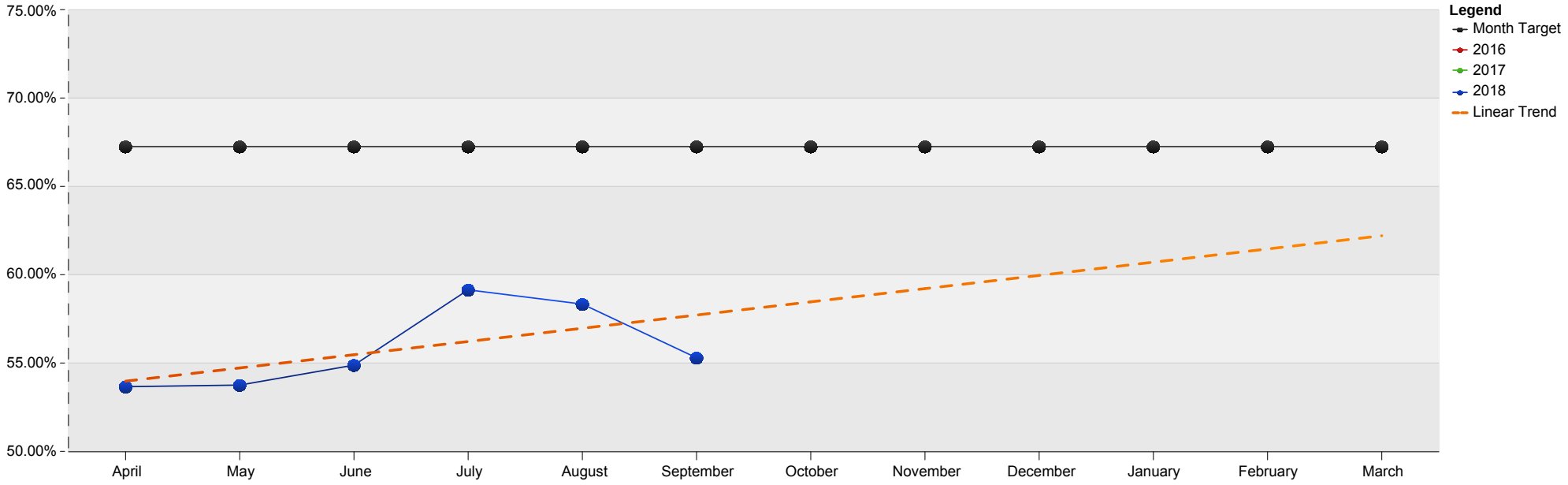
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.26	9.21	0.00	8.30	1.65	6.69	2.73	13.61	16.72	66.26	1.23	7.40		

Narrative

The Trust position for September 2018 is 1.51, which is not achieving the expected number of 1.00. This rate relates to 8 unexpected deaths in September which is the same number as in August. The rate has reduced as a result of an increase in open cases. Of the 8 unexpected deaths the details below shows a breakdown by locality:3 x North Yorkshire3 x Tees1 x York1x ForensicsOf the unexpected deaths that occurred in September, 5 occurred in AMH, 2 in MHSOP and 1 in Offender Health.

Trust Dashboard Graphs for TRUST

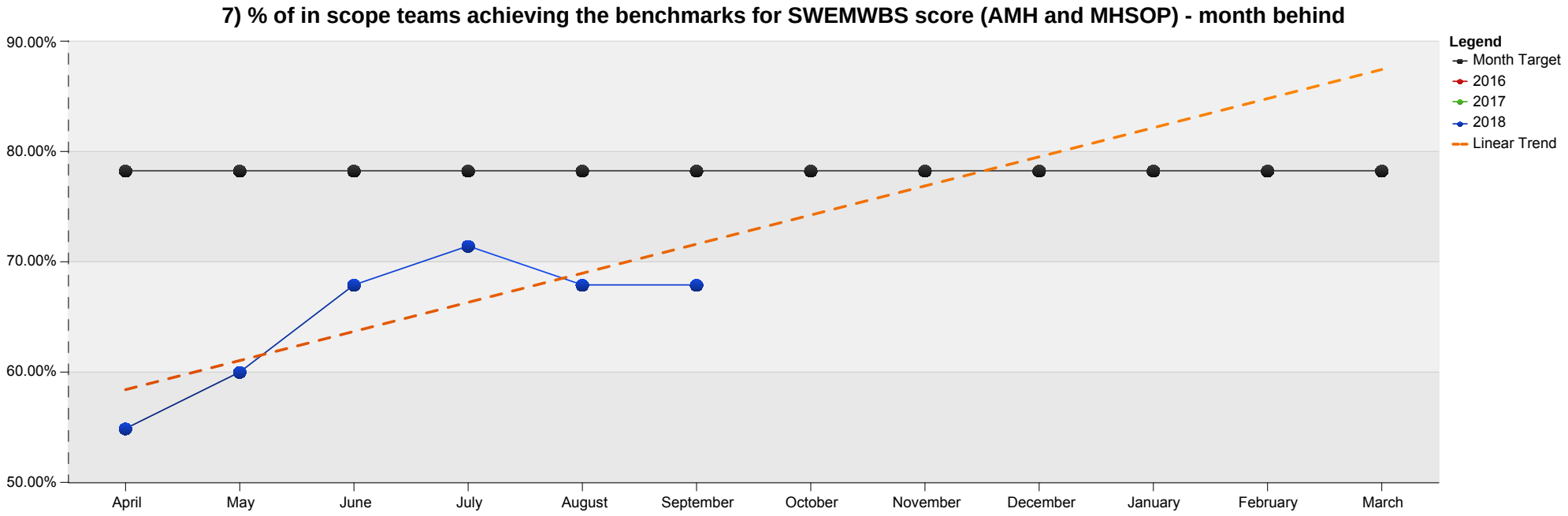
6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	55.29%	55.93%	50.00%	46.15%	64.00%	65.28%	54.17%	59.86%			50.00%	49.15%		

Narrative
The Trust position for September 2018 is 55.29%, which is not meeting the target of 67.25% and is a deterioration on the position reported in August. Within this KPI an improvement in HONOS is shown by a decrease in the patient's actual HONOS score on PARIS. The change is identified by comparing the first HONOS score calculated on admission to TEWV, and the score on discharge.All localities are below target with the exception of Tees who are within 10% of the target. The PBR team provide services with weekly breach reports to allow issues to be addressed. Services are working to increase the number of patients they report outcomes for and to report them in a timely way. Focusing on this will enable teams to improve performance against this KPI. A follow up session focused on the outcome indicators took place in the Performance Improvement Group meeting in October, it was agreed to have further discussions at Executive Management Team and Service Development Group meetings around the use of the tools, their clinical benefits and any alternatives that exist.

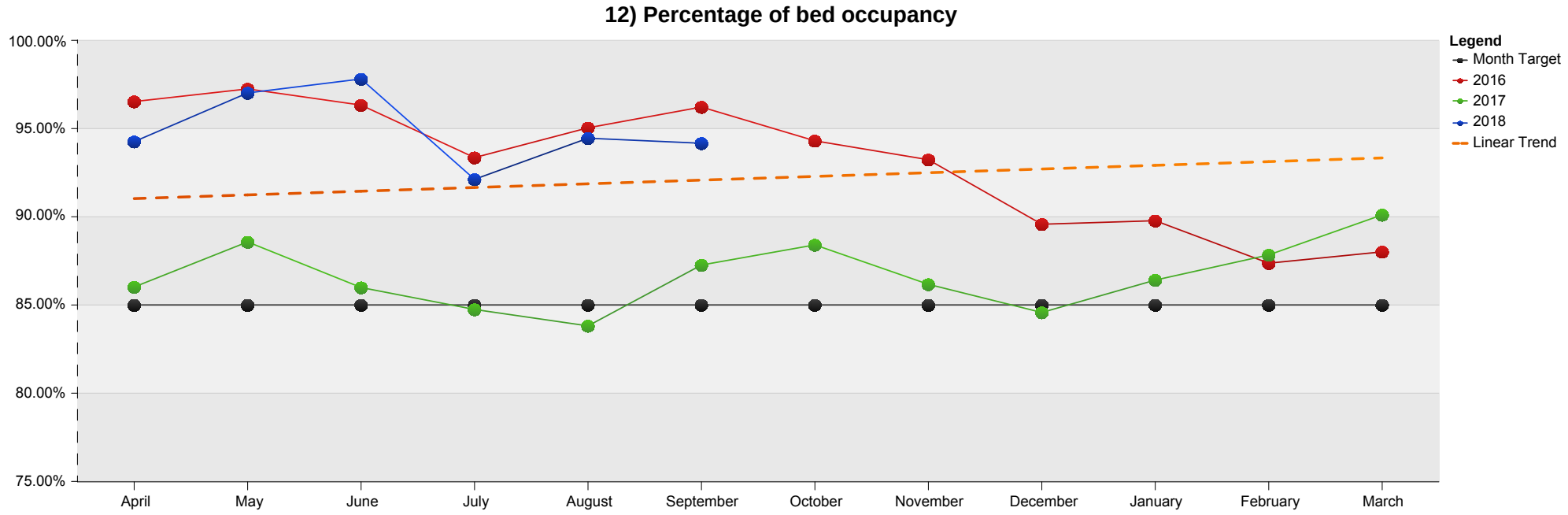
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	67.90%	65.12%	61.54%	62.82%	63.64%	63.83%	82.61%	71.33%			60.00%	58.93%		

Narrative
The Trust position for September 2018 is 67.90%, which is not meeting the target of 78.25% but is the same as the position reported in August.Within this KPI, an improvement in SWEMWBS (which is a patient experience measure) is shown by an increase in the patient's actual SWEMWBS score. The change is identified by comparing the first SWEMWBS score calculated on admission, and the score on discharge.All localities are below target with the exception of North Yorkshire. The PBR team provide services with weekly breach reports to allow issues to be addressed. Services are working to increase the number of patients they report outcomes for and to report them in a timely way. Focusing on this will enable teams to improve performance against this KPI. A follow up session focused on the outcome indicators took place in the Performance Improvement Group meeting in October, it was agreed to have further discussions at Executive Management Team and Service Development Group meetings around the use of the tools, their clinical benefits and any alternatives that exist.

Trust Dashboard Graphs for TRUST

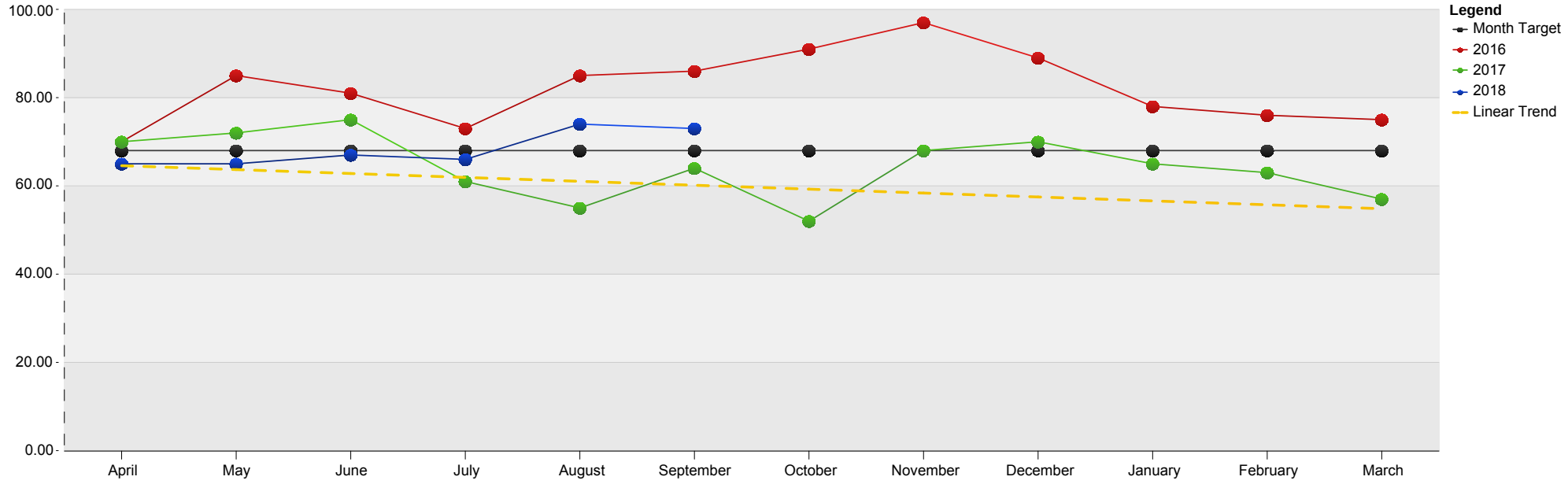


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	94.17%	94.96%	92.31%	92.42%	102.07%	102.36%	94.26%	94.58%	NA	NA	86.52%	90.00%		

Narrative
The Trust position for September 2018 is 94.17% which is worse than target but a slight improvement on the position of 94.55% recorded in August 2018.All localities are over target with York and Selby being within 10% of target. Tees are reporting the highest bed occupancy at 102.07%.This KPI is impacted by the number of patients occupying a bed with a length of stay greater than 90 days (KPI 13) and percentage of patients readmitted within 30 days (KPI 14) Within MHSOP in Tees there has been an increase in organic and functional admissions during the month which is impacting on this area. In addition, within both AMH and MHSOP in Tees there is also a number of complex patients who require long lengths of stay as well as a small number of patients whose transfer of care has been delayed. Steps are in place to ensure these patients are transferred as soon as possible All localities are monitoring this on a continual basis and actions are discussed and agreed in daily huddles.

Trust Dashboard Graphs for TRUST

13) No. of patients occupying a bed with a LoS (from admission) > 90 days (AMH and MHSOP A&T Wards)

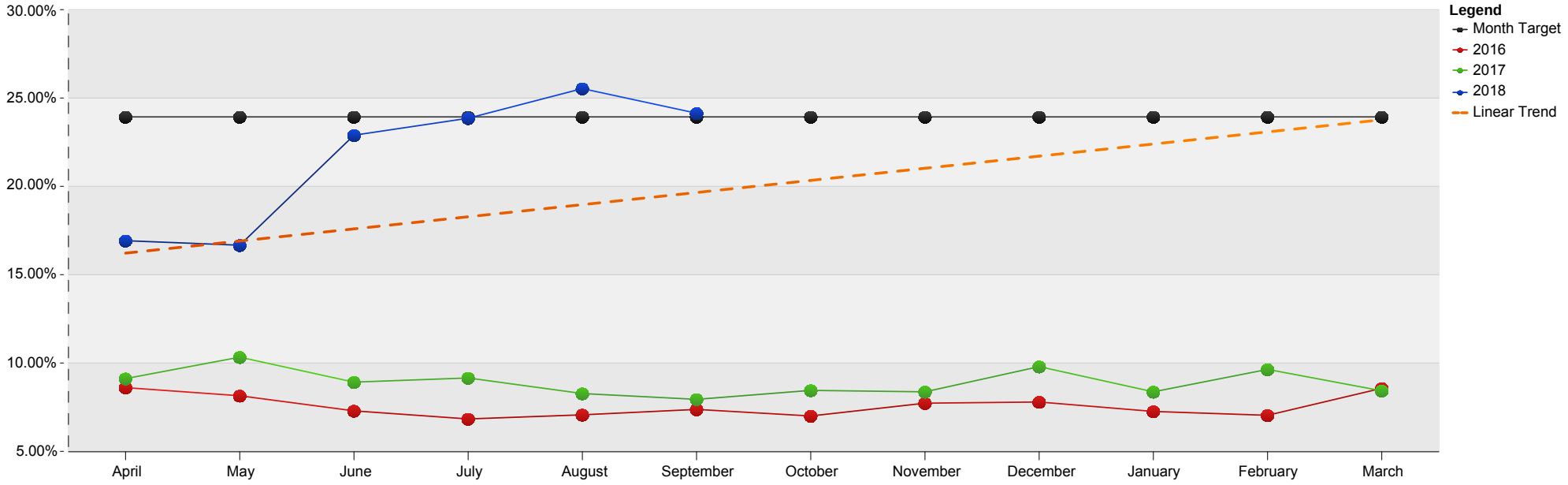


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	73.00	73.00	12.00	12.00	14.00	14.00	23.00	23.00			21.00	21.00		

Narrative
The Trust position for September 2018 is 73 which is worse than target of 68 but is a very slight improvement on the 74 achieved in August 2018. The following localities are not meeting target: • North Yorkshire – 23 patients (15 AMH and 8 MHSOP)• York and Selby – 21 patients (2 AMH and 19 MHOSP)North Yorkshire are worse than target due to issues around finding suitable packages of care and care home placements for patients upon discharge. York are worse than target due to delayed transfers of care because of problems in finding suitable placements. There continues to be an ongoing issue around care home placements as a result of a number of care homes closing and this situation is not improving. Patients from other localities admitted out of area are also impacting but work continues to ensure patients are returned to beds in their home area as soon as possible and the speed at which this is happening is improving.

Trust Dashboard Graphs for TRUST

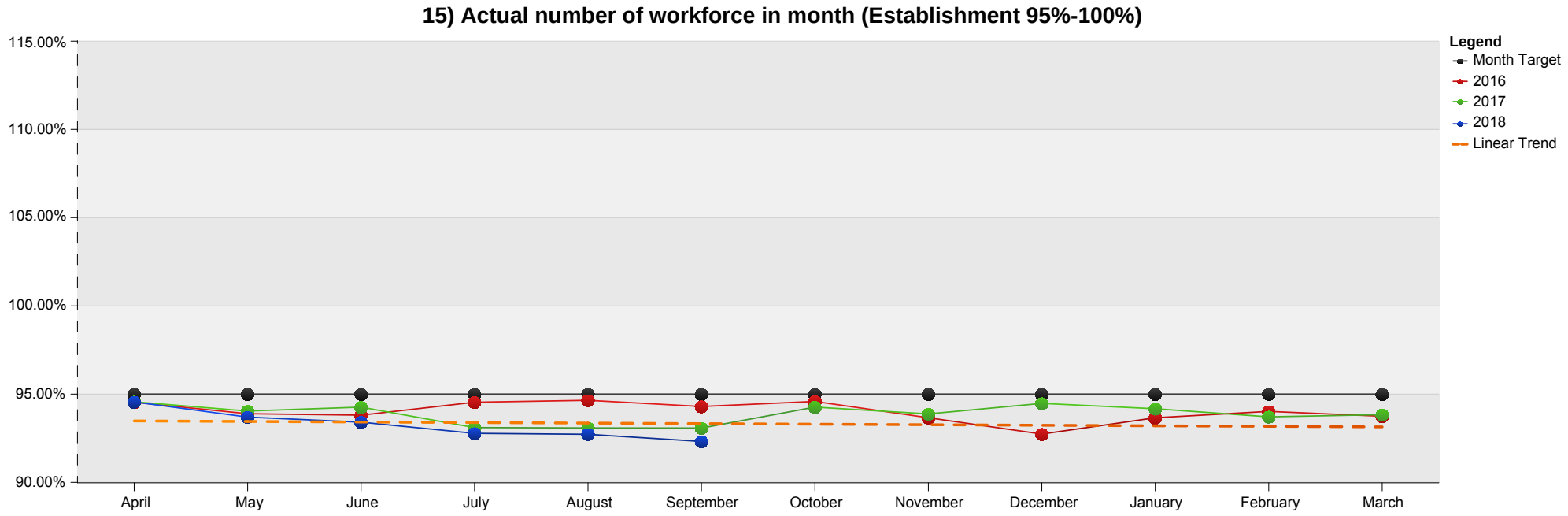
14) % of patients re-admitted to A&T wards within 30 days (AMH & MHSOP) - in reporting month



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	24.14%	21.97%	14.29%	21.08%	9.09%	21.38%	50.00%	22.83%			35.71%	22.35%		

Narrative
The Trust position ending September 2018 is 24.14%, which relates to 21 patients out of 87 that were readmitted within 30 days. This is within 10% of the target of 23.93% and is an improvement on the position achieved in August 2018. North Yorkshire are worse than target with a position of 50%, this is 7 patients out of 14 in AMH. York are also worse than target with a position of 35.71%, this is 5 patients out of 14, 4 AMH and 1 MHSOP. All readmissions were clinically appropriate and care plans followed. This is being monitored closely within the locality to ensure where it is appropriate a readmission is avoided. This indicator has been revised from the previous year and is no longer a rolling 3 month position, as a result of this the data in the graphs looks higher for 2018 than previous years.

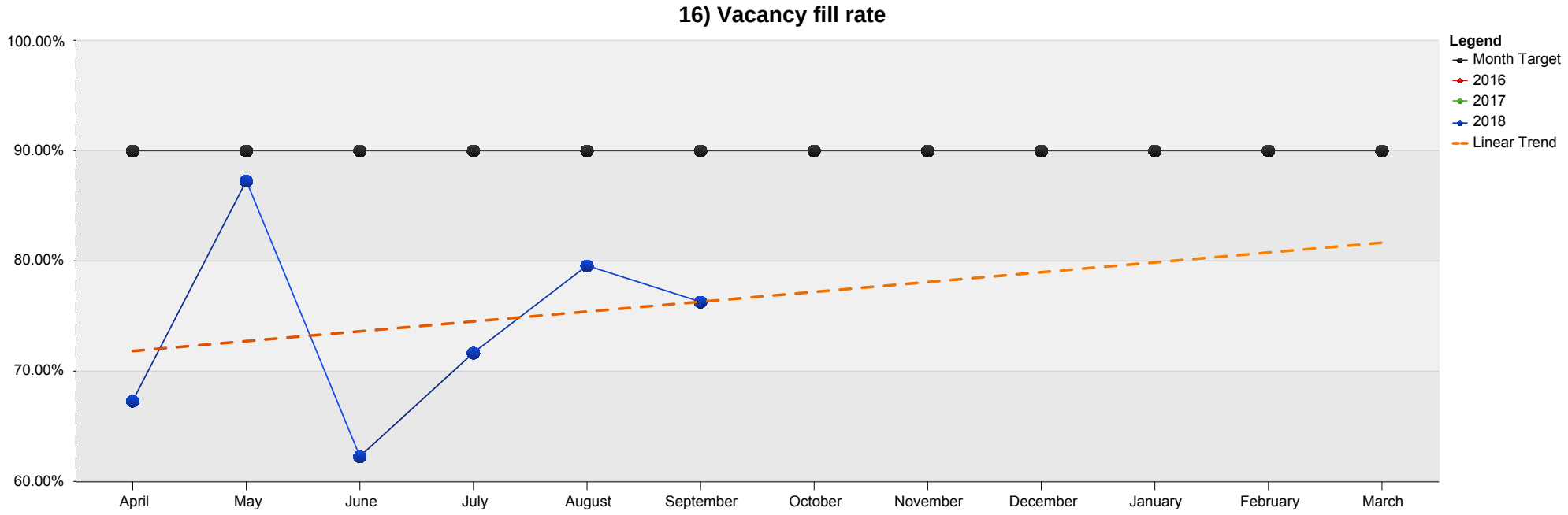
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Actual number of workforce in month (Establishment 95%-100%)	92.32%	92.32%	91.80%	91.80%	97.49%	97.49%	92.53%	92.53%	92.93%	92.93%	85.11%	85.11%		

Narrative
The Trust position for 30 September 2018 is 92.32% which is within 10% of the targeted establishment level of 95-100%. It is expected that the establishment rate improve over the next couple of months due to on-going recruitment events. At the last events held earlier in the summer a number of applicants were Student nurses who qualified in September and are now starting to take up their roles in the Trust.

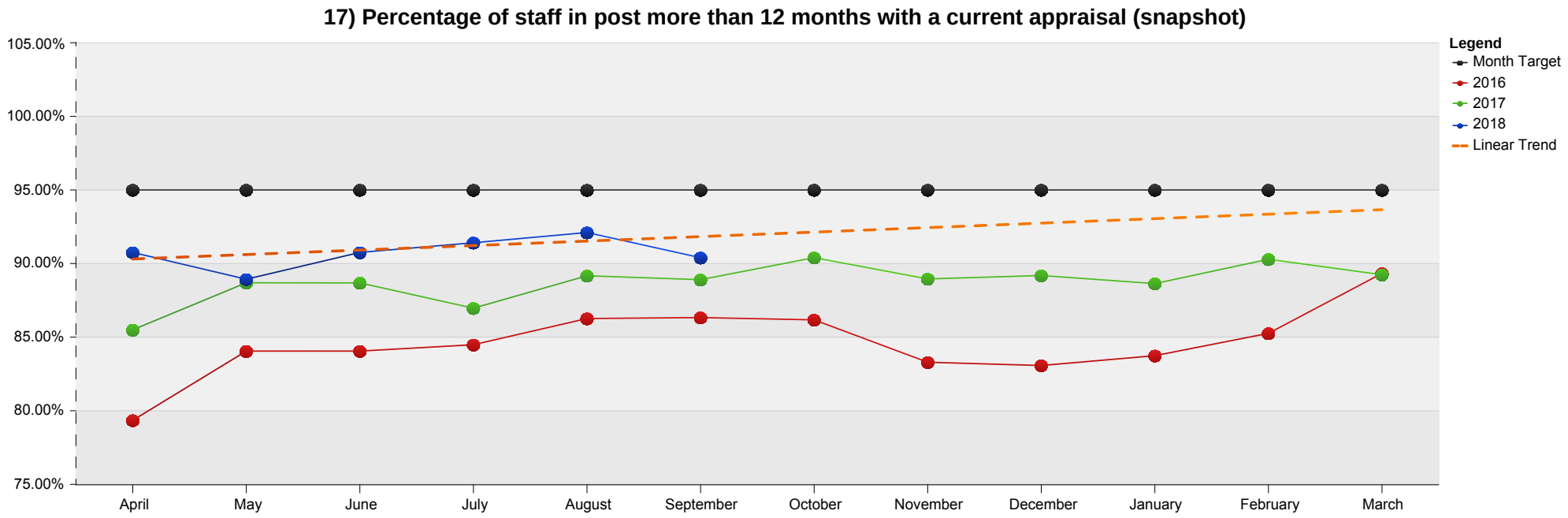
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Vacancy fill rate	76.29%	76.07%	50.00%	82.01%	87.80%	80.91%	77.78%	62.50%	80.00%	85.37%	72.73%	72.22%		

Narrative
The vacancy fill rate reports the percentage rate of health care professional vacancies band 5 and above with a conditional offer of employment made within 8 weeks of the post being advertised. The rate for September reduced to 76.29% from 79.57% in August. This figure is worse than target. This figure represents 74 vacancies with a conditional offer made out of 97. During the 8 week reporting period 1 vacancy was reported as not filled – this was due to no applicants being appointed at interview. This vacancy does not form part of the above calculation as they are considered closed, although they were not successfully appointed to. The vacancy was a Care Co-ordinator band 6 role in York and Selby.

Trust Dashboard Graphs for TRUST

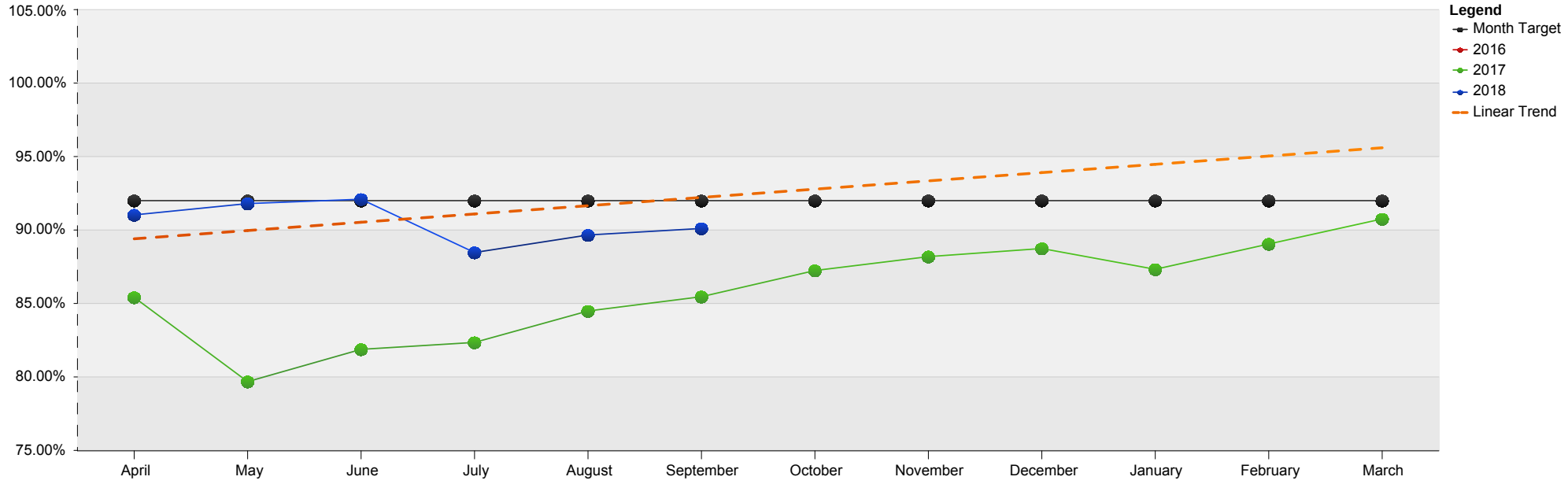


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	90.40%	90.40%	93.41%	93.41%	92.18%	92.18%	80.99%	80.99%	94.30%	94.30%	90.23%	90.23%		

Narrative
The Trust position for September 2018 has decreased from 91.37% in August to 90.40% which relates to 570 members of staff out of 5759 that do not have a current appraisal.North Yorkshire are below target as a result of staffing issues which have led to reduced staff levels in both community and inpatient which has meant a focus on delivering clinical care rather than completing appraisals. Steps are in place to ensure these are completed as soon as possible. All other localities are reporting within 10% of target. The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels.

Trust Dashboard Graphs for TRUST

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

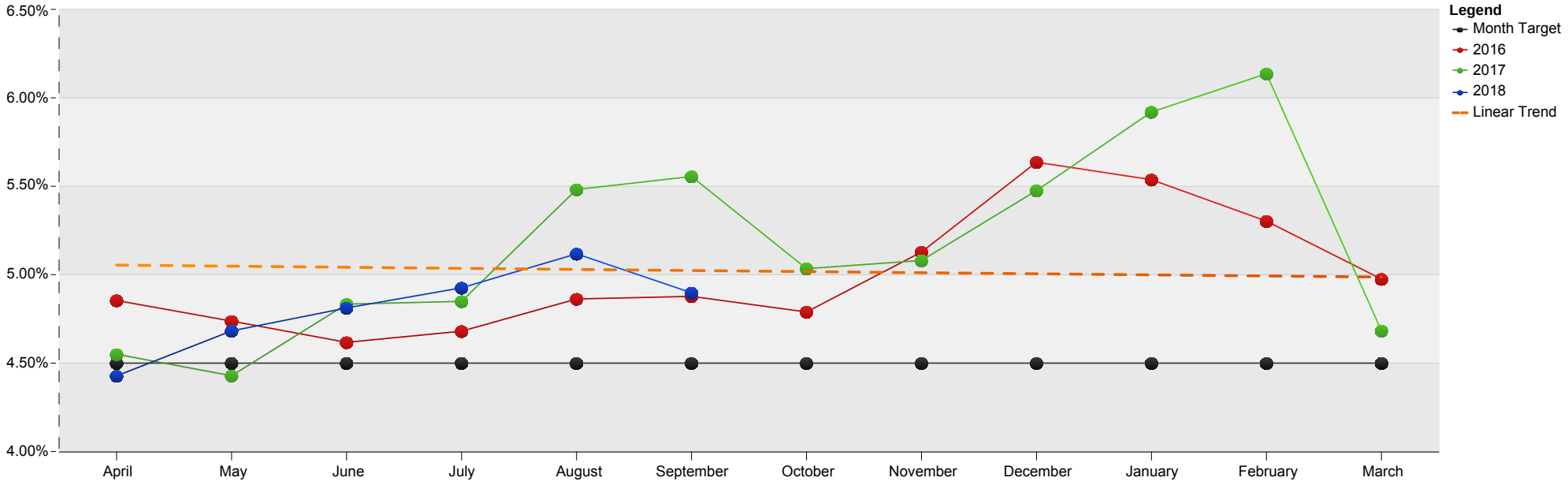


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.11%	90.11%	88.20%	88.20%	91.46%	91.46%	86.25%	86.25%	92.66%	92.66%	92.12%	92.12%		

Narrative
The position for September 2018 continues to improve and has increased to 90.11% from 89.66% in August 2018. The operational management huddles continue to drive improvements in performance. The improved frequency of the IIC refresh also allows a timelier update of accurate performance information to managers, enabling proactive action to take place.

Trust Dashboard Graphs for TRUST

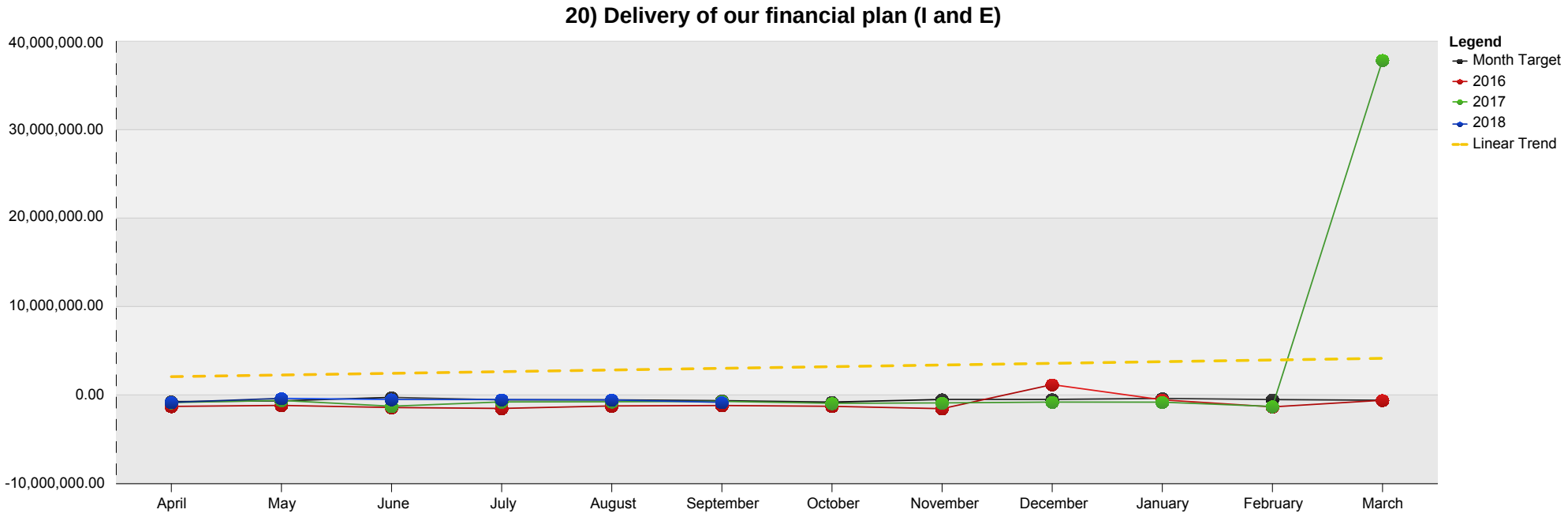
19) Percentage Sickness Absence Rate (month behind)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Percentage Sickness Absence Rate (month behind)	4.90%	4.81%	5.44%	5.33%	4.46%	4.27%	4.51%	4.16%	6.75%	6.49%	4.08%	4.54%		

Narrative
The Trust position reported in September relates to the August sickness level. The Trust position reported in September 2018 has decreased to 4.90% which is worse than the target of 4.50%. A review of the approach to managing sickness absence is currently underway and it is envisaged a new procedure will be available in the coming months. Work is also underway to review the Occupational Health provision which is due for retendering in the next 12 months.

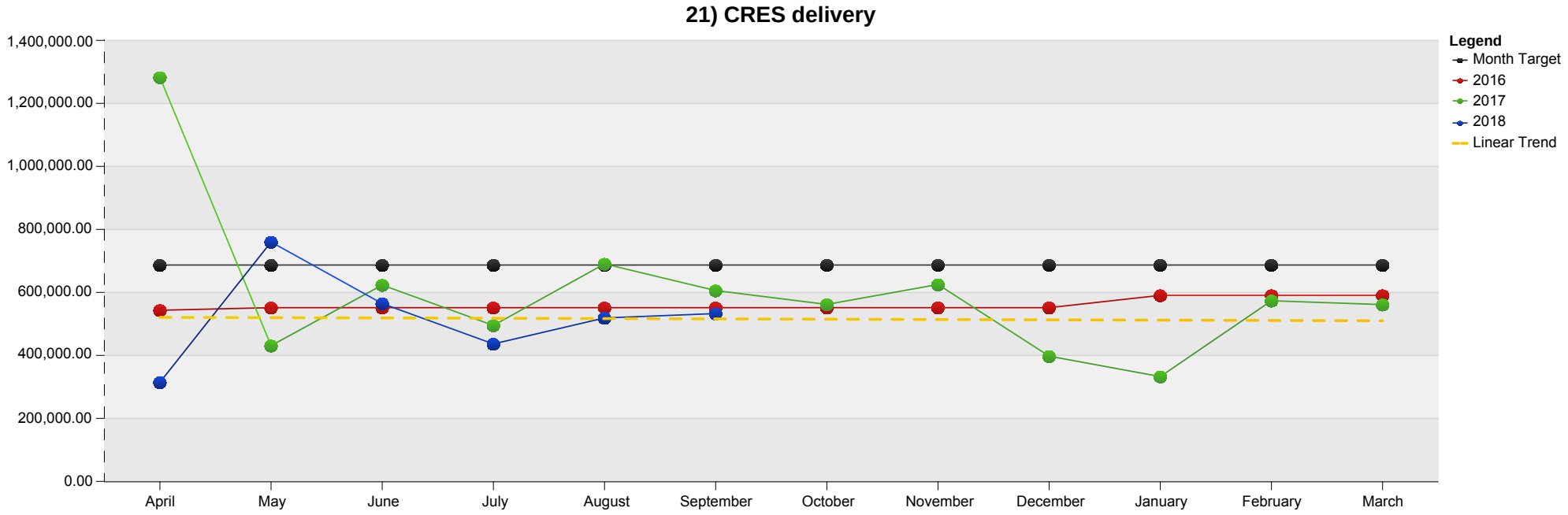
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) Delivery of our financial plan (I and E)	-845,476.00	-3,699,446.00	-142,033.00	-94,842.00	107,439.00	635,755.00	144,493.00	583,352.00	268,602.00	1,160,602.00	-136,322.00	324,584.00		

Narrative
The comprehensive income outturn for the period ending 30 September 2018 is a surplus of £3,698k, representing 2.2% of the Trust's turnover and is £212k ahead of the revised plan.

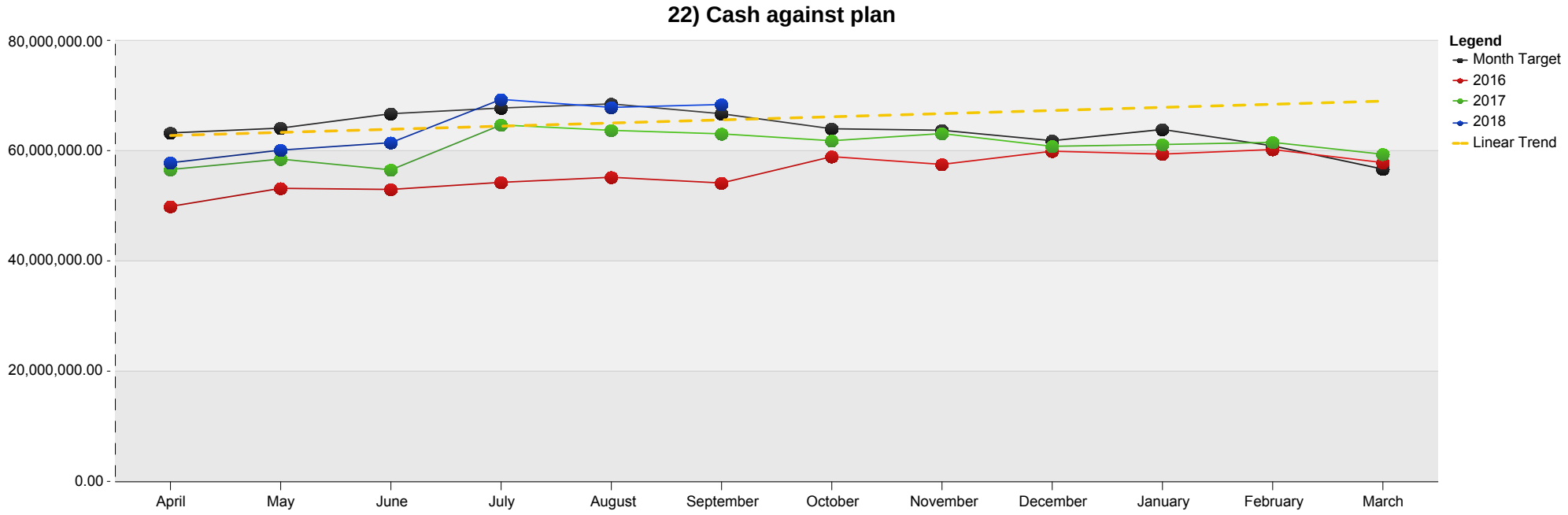
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) CRES delivery	532,724.00	3,126,654.00	93,364.00	508,682.00	38,153.00	228,917.00	10,264.00	61,584.00	18,278.00	109,667.00	78,293.00	469,758.00		

Narrative
Identified Cash Releasing Efficiency Savings at 30 September 2018 is £3,127k and is £995k behind plan for the year to date. NHS Improvement has confirmed a reduction in the Trust's annual control total (£1,692k) which is non-recurrently mitigating CRES delivery at month 6 (£778k). As a result year to date CRES is £217k behind plan. The Trust continues to identify and develop schemes to ensure the full delivery of the next 3 years CRES requirements.

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
22) Cash against plan	68,362,000.00	68,362,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
Total cash at 30 September 2018 is £68,362k, and is £228k higher than planned, largely due to the Trust's surplus.

Trust Dashboard - Locality Breakdown for TRUST

1 - Quality

	September 2018														April 2018 To September 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral		85.79%		85.58%		90.64%		71.27%		99.54%		84.53%				86.98%		87.09%		92.42%		74.75%		99.41%		78.28%		
2) Percentage of patients starting treatment within 6 weeks of an external referral		41.62%		35.56%		46.20%		36.91%		94.29%		43.72%				28.29%		23.64%		33.66%		23.57%		81.56%		24.88%		
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)		2,080.00		202.00		828.00		723.00				327.00				2,080.00		202.00		828.00		723.00				327.00		
4) Percentage of patients surveyed reporting their overall experience as excellent or good		92.01%		93.28%		92.27%		91.76%		82.50%		90.40%				91.05%		92.36%		91.86%		92.30%		80.19%		89.16%		
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated		1.26		0.00		1.65		2.73		16.72		1.23				9.21		8.30		6.69		13.61		66.26		7.40		
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind		55.29%		50.00%		64.00%		54.17%				50.00%				55.93%		46.15%		65.28%		59.86%				49.15%		
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind		67.90%		61.54%		63.64%		82.61%				60.00%				65.12%		62.82%		63.83%		71.33%				58.93%		

Trust Dashboard - Locality Breakdown for TRUST

2 - Activity

	September 2018														April 2018 To September 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)		94.17%		92.31%		102.07%		94.26%	NA	NA		86.52%				94.96%		92.42%		102.36%		94.58%	NA	NA		90.00%		
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)		73.00		12.00		14.00		23.00				21.00				73.00		12.00		14.00		23.00				21.00		
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month		24.14%		14.29%		9.09%		50.00%				35.71%				21.97%		21.08%		21.38%		22.83%				22.35%		

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	September 2018														April 2018 To September 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
15) Actual number of workforce in month (Establishment 95%-100%)		92.32%		91.80%		97.49%		92.53%		92.93%		85.11%				92.32%		91.80%		97.49%		92.53%		92.93%		85.11%		
16) Vacancy fill rate		76.29%		50.00%		87.80%		77.78%		80.00%		72.73%				76.07%		82.01%		80.91%		62.50%		85.37%		72.22%		
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)		90.40%		93.41%		92.18%		80.99%		94.30%		90.23%				90.40%		93.41%		92.18%		80.99%		94.30%		90.23%		
18) Percentage compliance with ALL mandatory and statutory training (snapshot)		90.11%		88.20%		91.46%		86.25%		92.66%		92.12%				90.11%		88.20%		91.46%		86.25%		92.66%		92.12%		
19) Percentage Sickness Absence Rate (month behind)		4.90%		5.44%		4.46%		4.51%		6.75%		4.08%				4.81%		5.33%		4.27%		4.16%		6.49%		4.54%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	September 2018														April 2018 To September 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
20) Delivery of our financial plan (I and E)		-845,476.00	NA	-142,033.00	NA	107,439.00	NA	144,493.00	NA	268,602.00	NA	-136,322.00				-3,699,446.00	NA	-94,842.00	NA	635,755.00	NA	583,352.00	NA	1,160,602.00	NA	324,584.00		
21) CRES delivery		532,724.00		93,364.00		38,153.00		10,264.00		18,278.00		78,293.00				3,126,654.00		508,682.00		228,917.00		61,584.00		109,667.00		469,758.00		
22) Cash against plan		68,362,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA				68,362,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Trust Dashboard 2018/19

KPI Guide

	KPI	***Target***	***Definition***
1	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	90%	This measures, the number of patients who attend their first appointment in 4 weeks of their referral date out of the total number of people who attend their first appointment following their referral. This KPI has been amended for 2018/19 and the clock will now NOT restart if the patient DNAs or the patient cancels an appointment. This looks at patients with an external referral only. This Excludes IAPT patients.
2	Percentage of patients starting “treatment” within 6 weeks of external referral	TBC	This measures, the number of people starting treatment within 6 weeks of an external referral against number of people starting treatment. This looks at patients with an external referral only.
3	The total number of inappropriate OAP days over the reporting period (Rolling 3 months)	2,494	This measures, the total number of days patients have spent in an out of area bed inappropriately. In line with national reporting this measures a rolling 3 months time frame
4	Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	Within all inpatient and community services, this measures: Of the number of people in the Patient Survey who answered the question: - "Overall how would you rate the care you have received?," the number of patients who have scored "excellent" or "good".
5	Number of unexpected deaths classed as a serious incident per 10,000 open cases	12	This measure looks at the number of unexpected deaths classed as a serious incident per 10,000 open cases. This mirrors the data that is reported to the National Reporting and Learning System (NRLS)
6	The % teams achieving the agreed improvement benchmarks for HoNOS total score	67.25%	This measure relates to patients discharged from TEWV In Scope services (Spells ended with a Adult or MHSOP subject to Currency & Tariff National requirements). Patients total HoNOS scores are compared from the first rating against the last. A reduction in total HoNOS score is classified as improvement. 80% of patients in the Non Psychotic and Psychotic superclass and 40% in the organic superclass are expected to achieve this reduction. Teams are subject to the measure if they discharge more than 5 patients in any of the superclasses. The measure will report against the team the patient was with at the point they are discharged entirely from TEWV not if they are transferred to a different In Scope team.

Trust Dashboard 2018/19

KPI Guide

7	The % teams achieving the agreed improvement benchmarks for SWEMWBS	78.25%	This measure relates to patients discharged from TEWV In Scope services (Spells ended with a Adult or MHSOP subject to Currency & Tariff National requirements). Patients total SWEMWBS scores are compared from the first rating against the last. An increase in SWEMWBS score is classified as improvement. 80% of patients in the Non Psychotic and Psychotic superclass and 50% in the organic superclass are expected to achieve this reduction. Teams are subject to the measure if they discharge more than 5 patients in any of the superclasses. The measure will report against the team the patient was with at the point they are discharged entirely from TEWV not if they are transferred to a different In Scope team.
8	*Number of new unique patients referred*	*TBC*	*This measures the number of new individual patients referred ie a patient is only counted once. This is when the patient is not open to any other team in the Trust.* *This Excludes IAPT patients.*
9	*The number of external referrals with an Assessment completed*	*TBC*	*This measures the number of all external referrals into Trust with an assessment completed* *This Excludes IAPT patients.*
10	*The number of external referrals which were subsequently accepted onto caseload*	*TBC*	*This measures all external referrals to all services that have been accepted onto teams caseload.* *This Excludes IAPT patients.*
11	*The number of discharges from total caseload*	*TBC*	*This measures **all discharges** excluding* • *Patients who were not appropriate to accept onto caseload* • *Patients who had a referral closed without being seen* • *Patients who were assessed but not offered treatment.* • *IAPT patients.*
12	Bed Occupancy (AMH & MHSOP A & T Wards)	85%	This measures the number of days beds that are occupied out of the number of possible bed days available. (The calculation is on the number of beds available and the days in the month). This looks at AMH and MHSOP Assessment and Treatment wards only
13	Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards (Snapshot)	68	This measures the number of patients occupying a bed with a length of stay longer than 90 days from the day they were admitted. This looks at AMH and MHSOP Assessment and Treatment wards only

Trust Dashboard 2018/19

KPI Guide

14	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	TBC	This measures the number of patients who are readmitted onto a ward within 30 days of their last discharge. This looks at AMH and MHSOP Assessment and Treatment wards only
15	Actual number of workforce in month	95%	This measures the total number of contracted staff against the number of budgeted staff.
16	Vacancy fill rate	90%	This measures the number of vacancies where an offer of employment has been made out of the number of vacancies that are being recruited to. There are vacancies that have been advertised and not filled due to no applicants or no one shortlisted, however from a recruitment vacancy perspective are closed off as an episode – These are not included in the figures as they do not go over the 8 week time frame. This looks at posts that have been vacant longer than 8 weeks. This KPI will exclude bank staff and only include professional health care posts of Band 5 and above
17	Percentage of staff in post more than 12 months with a current appraisal	95%	This measures the number of staff in post more than 12 months and of those how many have a current appraisal. For medical staff this is monitored against 13 months.
18	Percentage compliance with ALL mandatory and statutory training	92%	This measures the total number of courses completed by each member of staff for ALL mandatory and statutory training out of the number of courses due to be completed for each member of staff
19	Percentage Sickness Absence Rate	4.50%	This measures the number of days lost to sickness out of the number of days within the month
20	Delivery of our financial plan (I&E)	-8556,000	This shows the Trusts surplus or deficit position (£). The target is the planned surplus position.
21	CRES delivery	8,241,384	This shows the CRES Identified against the planned amount
22	Cash against plan	56,640	This shows the actual cash held by the Trust against the amount of cash forecasted to be held

Number of unexpected deaths and verdicts from the Coroner April 2018 - March 2019

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
10	4	14	15	9	9						

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
22	13	15	4	7

Number of unexpected deaths and verdicts from the Coroner April 2017 - March 2018

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
4	3	1	7	11	5	11	10	10	10	10	10

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
28	20	27	6	11

Number of unexpected deaths and verdicts from the Coroner 2016 / 2017
This table has been included into this appendix for comparitive purposes only

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

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

Y&S recorded in old Datix not included

Appendix D

		Data Source					Data Reliability					KPI Construct/Definition					KPI amended/ Tested	KPI requires testing - programmed test date	Total Score	**Percentage**	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1					
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined	Y/N				
1	Pergentage of patients who were seen within 4 weeks for a first appointment following an external referral	5					5					5					Y		15	**100%**	
3	Total number of inappropriate OAP days over the reporting period (rolling 3 months)		4				5					5					Y		14	**93%**	Data is extracted electronically, validated manually and reuploaded into the system. Work is underway to amend PARIS to enable this to be recrrded completely on the system.
4	Percentage of patients surveyed reporting their overall experience as excellent or good.				2		5					5					Y		12	**80%**	Patient and carer experience feedback is managed by the PaCE Team supported by the Meridian system, provided by an external provider; Optimum Contact. The system was implemented trust-wide on 1 April 2017. Data is collected via electronic devices for inpatient areas, on paper surveys for community teams as well as via kiosks in team bases where there are large footfalls. There is also a phone Application now where clinicians can send the survey to patients and carers phones via email or SMS. The Data Quality Team access the system to generate reports.
5	Number of unexpected deaths classed as a serious incident per 10,000 open cases		4				5					5					Not required - manual return		14	**93%**	Data will be directly extracted from Datix into the IIC; however, this process is not fully embedded. IAPT caseload is currently a manual upload. Data reliability has improved following the introduction of the central approval team
6	The percentage of teams achieving the agreed improvement benchmarks for HoNOS total score		4					4				5					Y		13	**87%**	Data is extracted electronically and then processed manually. Work is underway with the services to ensure the data recorded on PARIS is accurate and this will improve data reliability.
7	The percentage of teams achieving the agreed improvement benchmarks for SWEMWBS total score		4					4				5					Y		13	**87%**	Data is extracted electronically and then processed manually. Work is underway with the services to ensure the data recorded on PARIS is accurate and this will improve data reliability.
12	Bed Occupancy (AMH & MHSOP A&T wards)	5					5					5					Y		15	**100%**	
13	Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards)	5					5					5					Y		15	**100%**	
14	Percentage of patients readmitted to Assesement and treatment wards within 30 days	5					5					5					Y		15	**100%**	

		Data Source					Data Reliability					KPI Construct/Definition					KPI amended/ Tested	KPI requires testing - programmed test date	Total Score	**Percentage**	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1					
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined	Y/N				
15	Actual number of workforce in month		4				5					5					Y		14	**93%**	Data extracted elecronically but processed manually
16	Vacancy Fill rate				2		5					5					Not required - manual return		12	**80%**	Data recorded on the recruitment tracker database and manually uploaded into the system
17	Percentage of staff in post more than 12 months with a current appraisal	5						4				5					Y		14	**93%**	Issues with appraisal dates being entered to ESR have lessened considerably. Compliance levels are effectively being monitored via monthly Huddle meetings. There feels to be greater confidence in the data being reported through IIC.
18	Percentage compliance with ALL mandatory and statutory training	5						4				5					Y		14	**93%**	Issues with training compliance figures being reported have lessened - there appears to be greater confidence in the data being reported.
19	Percentage Sickness Absence Rate (month behind)	5						4				5					N	To be agreed in Managing Business Sub group	14	**93%**	Whilst the sickness absence data for inpatient services is now being taken directly from the rostering system which should help to eliminate inaccuracies the remainder of the Trust continue to input directly into ESR. There are some data quality issues concerned with failing to end sickness in a timely manner– this is picked up and monitored through sickness absence audits that the Operational HR team undertake.
20	Delivery of our financial plan (I and E)		4				5					5					Not required - manual return		14	**93%**	Data is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
21	CRES Delivery				2		5					5					Not required - manual return		12	**80%**	Data is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
22	Cash against plan		4				5					5					Not required - manual return		14	**93%**	An extract is taken from the system then processed manually to obtain actual performance.

ITEM 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th October 2018**
TITLE:	**Proposed Strategic Direction Scorecard Targets**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communications**
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 purpose of this report is to provide the Trust Board with the proposed targets for the agreed Key Performance Indicators (KPIs) for the Strategic Direction Scorecard for approval.

Recommendations:

The Board are asked to:

- Approve the targets in Appendix A noting those that are not yet available and the work that is due to take place to support the development of these targets.
- Approve the proposed KPI from the Leadership Strategy to be included in the SDS(KPI 11 in Appendix A)

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**30th October 2018**
TITLE:	**Proposed Strategic Direction Scorecard targets**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide the Trust Board with the proposed targets for the agreed Key Performance Indicators (KPIs) for the future Strategic Direction Scorecard.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Within the previous Strategic Direction Scorecard (SDS) we reported 39 metrics against the 5 Strategic Goals, which were chosen as "proxy measures" in the absence of underpinning strategies with scorecards. As the Trust now has in place a number of prime/core strategies each with their own individual scorecard, it was agreed with the Board of Directors that we would review the KPIs within the SDS.

2.3 In July 2018, the Board of Directors discussed and agreed the final set of Key Performance Indicators for inclusion in the future SDS.

3. KEY ISSUES:

3.1 Of the 24 agreed metrics, 12 were suggested from existing strategies, 2 were currently reported in the Trust Dashboard, 4 (2 Leadership and 2 Equality & Diversity) were to be agreed and 6 were to be taken forward as new developments.

3.2 Of the 12 metrics to be derived from existing strategies the majority already had targets within their scorecard and therefore these have been replicated for the SDS. However 4 metrics from the Digital Transformation Strategy will not be reported until later in the year and do not yet have agreed targets attached to them:

- All clinical teams to be able to access pathology results via PARIS and order test by PARIS

  A solution is being implemented and a pilot of approximately 10% of teams in the Trust will be in place until the end of December 2018. Subject to this being successful there will then be a roll out plan such that all teams will be live by 1 April 2019. It is therefore proposed that the target for Q3 and Q4 of 2018/19 is 10% with the target increasing to 100% from April 2019.

- All service users being able to access care plan online or digitally.

  The new Care Planning capability on Paris became available in September and a small subset of CAMHS are piloting the new functionality. The plan is to expand this pilot further and a requirement has been added to record if a care plan has been delivered to the patient in an electronic format. This is expected to be in place by the end of the financial year. The longer term plan is that Care Planning will be built in CITO and patients will receive access to the plan via an online shared portal. Timescales on this are currently unknown but once they are a target and trajectory will be established

- 100% clinical pathways developed and in use within PARIS.

  This metric is dependent on the CITO programme, which will be delivered for testing in January 2018 and will include level one and two pathways. The plan is that the pilot teams for CITO will include this high level pathways functionality; however a kick off date is yet to be confirmed. Once this is know a target and trajectory will be established.

- All Trust clinicians to have access to their key service/team/patient information in near to real time.

  This metric will be measured in terms of percentage of milestones delivered; however only the Datix dashboard is planned for 2018/19. The commencement date for rollout has yet to be confirmed. Once it is confirmed then a target and trajectories will be established,

3.3 Of the 4 to be identified the following recommendation is made in terms of the key indicator from the Leadership Strategy:

Report and increase the % of frontline multi-professional leadership and management teams that have trained in the core skills identified.

Work is ongoing to collect the baseline for this indicator and once this available a target will be proposed.

In terms of the Equality and Diversity Strategy there is no current Scorecard and further work is required to refresh the strategy and develop and associated scorecard.

3.4 Planning has been undertaken on the 6 new metrics to agree a construction, target and data collection mechanisms; however some concern has been raised with a number of these metrics as the data is not available. Those metrics that cannot currently be monitored as part of the scorecard are:

- Number of patients who said we helped them achieve the goals they set

This metric is being taken forward as part of a review to add/replace a number of the questions in the Patient Experience Questionnaire for Recovery. It is envisaged this will go to the Patient Experience Group in November, after which work will be undertaken with Meridian to facilitate a go-live from April 2019. It will then be possible to collect a baseline on which to set a target.

- Percentage delayed transfers of care due to non-Trust issues

  Delayed transfers of care are aggregated according to whether responsibility is attributable to Social Services, NHS or Both. As NHS could be either the CCG or the Trust there is no electronic way of identifying those delays solely responsible to non-Trust issues. Options will be included in the Quarter 2 report for the Trust Board to consider and make recommendations.

- Percentage referrals received from GPs using the standard electronic referrals template relevant for the speciality

  This metric is not available and is not something that is being taken forward as part of the CITO project. Work is being led by the Head of Information Services – IT and Systems over the coming weeks to review the Digital Transformation Strategy and a possible alternative will be considered as part of that. Once this is done a recommendation will come back to the Board in the appropriate quarterly report.

3.5 Where available, baseline data has been obtained for the remaining 3 metrics and this has been used as the basis for the 2018/19 targets; these are detailed below:

Indicator	2017/18 Baseline	Target
Percentage joint bids with CCGs that are successful	100% (7 successful bids out of 7)	80%
Percentage of mental health and learning disability budget covered by a ring-fenced budget	The ring fenced budget was not applicable for 2017/18 so there is no historic data.	85% .
Achieve an NHSI SOF rating of 1		1*

*This will need to be reviewed if NHSI amend the SOF

A complete list of the 2018/19 Key Performance Indicators can be found in **Appendix A**.

4. IMPLICATIONS:

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

4.2 **Financial/Value for Money:** Financial measures are included in the key performance indicators for 18/19.

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

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

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

5. RISKS:

5.1 There are no direct risks associated with this report.

6. CONCLUSIONS:

6.1 The Corporate Performance Team and Finance Department have proposed targets for three of the new Key Performance Indicators in the Strategic Direction Scorecard. These have been discussed by EMT and the proposals in this report are recommended by EMT. Further work is required for a number of the indicators before targets and reporting can be established. Progress on these will be reported to the Board in the relevant quarterly progress reports

7. RECOMMENDATIONS:

The Board are asked to approve the targets in Appendix A noting those that are not yet available and the work that is due to take place to support the development of these targets.

Ashleigh Lyons
Corporate Performance Manager - Specialist

Background Papers:

Strategic Direction Scorecard 3 year Proposed Targets **Appendix A**

	Indicator	Source	Proposed Target 2018/19	Proposed Target 2019/20	Proposed Target 2020/21	Notes
1	Percentage of teams achieving the agreed improvement benchmarks for HoNOS total score	Trust Dashboard	67.25%	Dependent on 18/19 outturn	Dependent on 19/20 outturn	As established by the Trust Dashboard
2	Percentage of teams achieving the agreed improvement benchmarks for SWEMWBS	Trust Dashboard	78.25%	Dependent on 18/19 outturn	Dependent on 19/20 outturn	As established by the Trust Dashboard
3	Number of patients who said we helped them achieve the goals they set	TBC				To be taken forward as part of a review to add/replace a number of the questions in the Patient Experience Questionnaire for Recovery. This will go to the Patient Experience Group in November, after which work will be undertaken with Meridian to facilitate a go-live from April 2019.
4	Percentage of carer that report feeling listened to and heard	Quality Strategy	TBC	TBC	TBC	Target yet to be agreed by the Patient Experience Group; this will be addressed at the October Meeting
5	Percentage of staff reporting that they can contribute towards improvement at work	Quality Strategy	87.00%	87.00%	87.00%	As established by the Quality Strategy
6	Percentage of patient who report feeling supported by staff to feel safe	Quality Strategy	TBC	TBC	TBC	Target yet to be agreed by the Patient Experience Group; this will be addressed at the October Meeting
7	Percentage of patient who report their overall experience as excellent or good	Quality Strategy	94.00%	94.00%	94.00%	As established by the Quality Strategy

8	Percentage rolling 12 month TEWV labour turnover rate	Workforce Strategy	10%	9%	8%	As established by the Workforce Strategy
9	Percentage rolling sickness absence rate	Workforce Strategy	4.50%	4.40%	4.30%	As established by the Workforce Strategy and in line with the Trust Dashboard
10	Percentage staff recommending TEWV as a place to work	Workforce Strategy	73%	76%	80%	As established by the Workforce Strategy
11	Report and increase the % of frontline multi-professional leadership and management teams that have trained in the core skills identified.	Leadership Strategy				Baseline data is being collected and once available a target will be proposed.
12	Percentage joint bids with CCGs that are successful	Planning & Business Development	80%	80%	80%	Based on a 2017/18 baseline of 7 out of 7 successful bids
13	Percentage of mental health and learning disability budget covered by a ring-fenced budget	Finance	85%	85%	85%	The ring fenced budget was not applicable for 2017/18 so there is no historic data.
14	Percentage delayed transfers of care due to non Trust issues	CICC				Responsibility for delayed transfers of care is aggregated to Social Services, NHS or Both. As NHS could be either the CCG or the Trust there is no electronic way of identifying those delays solely responsible to non-Trust issues. Options will be included in the Quarter 2 report for Board of Directors to consider.
15	Percentage referrals received from GPs using the standard electronic referrals template relevant					This metric is not available and is not being taken forward as part of the CITO project. Work is being led by the Head of Information Services – IT and Systems over the coming weeks to review the

	for the speciality					Digital Transformation Strategy and a possible alternative will be considered as part of that.
16	Delivery of control total in full as per NHSI financial plan	Finance Strategy	£6,864,000	£6,864,000	£6,864,000	As established by the Finance Strategy
17	Achieve an NHSI SOF rating of 1	Phil Bellas	1	1	1	As defined by the metric
18	All clinical teams to be able to access pathology results via PARIS and order test by PARIS	Digital Transformation Strategy	10%	100.00%	100.00%	A solution is being implemented within PARIS; however the individual localities are driving their own projects. Baseline figures are currently being obtained for the number of teams that require access, they will be available early October and then implementation can start. This metric will be based on the percentage of teams that were expected to implement each quarter.
19	All service users being able to access care plan online or digitally	Digital Transformation Strategy	tbc	100.00%	100.00%	This will not be available until the CITO programme commences. This metric will measure the number of e-pathways on CITO against the total number of pathways within the Trust
20	100% clinical pathways developed and in use within PARIS	Digital Transformation Strategy	tbc	tbc	tbc	Data will not be available until quarter 4 2018/19.
21	All Trust clinicians to have access to their key service/team/patient information in near to real time	Digital Transformation Strategy	100.00%	100.00%	100.00%	This is measured in terms of percentage of milestones delivered. Only the Datix dashboard is planned for 18/19.
22	Placeholder: E&D Strategy					Metric to be agreed
23	Placeholder: E&D Strategy					Metric to be agreed

ITEM NO. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th October 2018**
TITLE:	**Single Oversight Framework**
REPORT OF:	**Phil Bellas, Trust Secretary & Sharon Pickering, Director of Planning, Performance and Communications**
REPORT FOR:	**Information & Assurance**

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

Executive Summary:

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

The purpose of this report is to examine the Trust's position against the requirements of the SOF at the end of Quarter 2, 2018/19.

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

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**30th October 2018**
TITLE:	**Single Oversight Framework**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to examine the Trust's position against NHS Improvement's (NHSI) Single Oversight Framework (SOF) at the end of Quarter 2, 2018/19.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

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

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

2.5 In previous reports the Board has noted that:

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

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

2.6 The Board is asked to note that the next Quarterly Review Meeting with NHSI is due to be held on 26th October 2018 and, therefore, any assurances provided by, or material issues raised by the regulator, will be reported verbally to the meeting.

3. KEY ISSUES:

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

3.2 Changes to the segmentation of providers are not automatic if a trigger occurs. NHSI takes into account a provider's circumstances in determining the nature and extent of any support required.

Quality of Care

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

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

3.4 The Board is asked to note that:

(a) The Trust's segmentation reflects its "good" CQC rating. This rating was reaffirmed in October 2018.

(b) The Trust's overall ratings for the five themes assessed by the CQC (safe, effective, caring, responsive, well-led) have not changed following the inspection in 2018.

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

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

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

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

Finance and Use of Resources

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

Operational Performance

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

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

3.7 As previously noted by the Board, although the Trust met the IAPT recovery target for Quarter 2, performance on this metric remains an area of risk.

Updates on the position against the indicator, by CCG area, are provided in the Performance Dashboard Report under agenda item 13.

3.8 Board Members will recall that, at its meeting held on 19th July 2018, it was noted that clarity was being sought from NHS England on how the Trust's performance on the indictor ""Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services" was calculated in view of the discrepancy between the Trust's submission in December 2017 (90.67%/above target) and the initial feedback from NHS England based on an assessment by the Royal College of Psychiatry's Centre for Quality Improvement (88.20%/below target).. As shown in the scorecard, performance for the period has now been confirmed at 90.2% and above target.

Strategic Change

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

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

Leadership and Improvement Capability (Well-led)

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

3.9 The Trust's position on the organisation health metrics is provided in Annex 3 to this report.

3.10 In relation to this theme:

(a) The Trust's overall well-led rating, provided by the CQC, remained as "good" following the inspection in July 2018.

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

(c) The data provided in Annex 3 highlights the increasing proportion of temporary staff used by the Trust.

The Board is asked to note that:

- The Trust's use of temporary staff, whilst a concern, remains relatively low compared to other providers.
- The EMT has recently agreed actions to seek to reduce reliance on temporary staffing with an update report due to be provided in February 2019.

- Further information on the position on temporary staffing is provided in the Finance Report at agenda item 12.

(d) There are no trends in relation to the other organisational health metrics which raise concerns at the present time.

(e) No issues have been raised by third parties (e.g. Healthwatch, HSE, complaints, whistleblowers, medical royal colleges) which suggest governance concerns in the Trust.

4. IMPLICATIONS:

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

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

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 The key risks identified relate to:

(a) Performance against the IAPT recovery indicator.

(b) The continuing increase in temporary staffing.

6. CONCLUSIONS:

6.1 Overall, the Trust should expect to maintain its segment 1 position for Quarter 2, 2018/19; however, close monitoring by NHSI is expected to continue.

7. RECOMMENDATIONS:

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

Phil Bellas, Trust Secretary
Ashleigh Lyons, Corporate Performance Manager

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

SINGLE OVERSIGHT SCORECARD - QUALITY INDICATORS - 2018/19

All Providers																	
Quality Indicators	**SOF Source**	**Other known source**	Freq.	Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
Written compliants - rate	NHS Digital	N/A	Q	N/A			9.49										Last published data June 2018
Staff and Friends and Family test % recommended - care	NHSE	Trust assessment	Q	N/A			86.59%			88.34%							
		N/A	Q	N/A			70.17%										Last published data June 2018
Occurrence of Never Event	NHS Improvement	Governance - verified	M	N/A	0	0	0	0	0								Data published up to 31 August 2018
NHS England/NHS Improvement Patient Safety Alerts outstanding	NHS Improvement	Governance - verified	M	N/A	0	0	0	0	0	0							Data published up to 30 September 2018
Mental Health Providers																	
Quality Indicators	**SOF Source**	**Other known source**	Freq.	Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
CQC inpatient/mental health and community survey	CQC	N/A	A	N/A													Trusts are no longer provided with an overall score and are rated as Better, About the Same or Worse on a range of questions in ten categories. Our Trust scored 'About the Same' in every category for 2017.
Mental Health scores from Friends and Family Test - % positive	NHSE	N/A	M	N/A	87.58%	87.75%	84.83%	88.48%	88.19%								Latest published data August 2018
Admissions to adult faciliites of patients who are under 16 years old	NHS Digital	Trust assessment	M	N/A	0	0	0	0	0	0							
		N/A	M	N/A													No public data available
Quality Indicators	**SOF Source**	**Other known source**	Freq.	Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
Proportion of discharges from hospital followed up within 7 days (all discharges treated as being on CPA)		Trust assessment - pre validated IIC	M	95%	**98.54%**	**97.07%**	**97.51%**	**95.85%**	**94.27%**	**95.83%**							Pre-validated position is reported direct from the IIC
		Trust assessment - post validated IIC			**98.54%**	**97.07%**	**98.57%**	**96.54%**	**97.49%**	**97.07%**							Post validated position stated is from our intenal files which are used to provide the UNIFY submission.
		UNIFY	Q		**98.16%**												Latest published data as at 30th June 2018
% clients in settled accommodation	NHS Digital	Trust assessment	M	N/A			82.95%	83.42%	83.21%	82.82%							
		NHS Digital	M	N/A	82.54%	82.63%	83.13%										Latest published data June 2018
% clients in employment	NHS Digital	Trust assessment	M	N/A			14.34%	14.53%	14.62%	14.99%							
		NHS Digital	M	N/A	13.86%	14.20%	14.30%										Latest published data June 2018
Potential under-reporting of patient safety incidents	NHS England Dashboard	N/A	M	N/A													No data is published to reflect 'under-reporting'. Published data reports the Incidents reported between 01 September 2017 and 31 August 2018 reports 2173 incidents submitted to the NRLS over the rolling 12 month period.

SINGLE OVERSIGHT SCORECARD - OPERATIONAL PERFORMANCE METRICS - 2018/19

Mental Health Providers																				
Operational Performance Metrics	**SOF Identified source**	**Other Identified Source**	Freq.	**Standard**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**
People with a first episode of psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral	UNIFY2 and MHSDS	Trust assessment	Q	53%	**57.14%**	**48.84%**	**72.41%**	**63.41%**	**60.00%**	**70.21%**							**61.03%**	**64.49%**			
		NHS Digital	Q		**57.14%**	**48.84%**	**71.93%**	**63.41%**	**59.18%**								**60.74%**	**61.11%**			Last published data August 2018
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **inpatient wards**	Board declaration but can be triangulated with results of CQUIN audit	Trust assessment	Q	90%	Data for 2018/19 has been collated and sent to the NCAP Team. A sample will be generated and then returned to us for internal analysis and national submission in Quarter 3																2018/19 data yet to be submitted 2017/18 Data was submitted to National Clinical Audit of Pschosis (NCAP) **December 17**. Internal analysis indicated **92.50%**.
		National assessment			National data not available until Quarter 4																2017/18 Audit results as assessed by the Royal College of Psychiatry's 2017/18 Centre for Quality Improvement report **94.90%**.
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **early intervention in psychosis services**		Trust assessment	Q	90%	Data for 2018/19 has been collated and sent to the NCAP Team. A sample will be generated and then returned to us for internal analysis and national submission in Quarter 3																2018/19 data yet to be submitted 2017/18 Data was submitted to National Clinical Audit of Pschosis (NCAP) **December 17**. Internal analysis indicated **90.67%**.
		National assessment			National data not available until Quarter 4																2017/18 Audit results as assessed by the Royal College of Psychiatry's 2017/18 Centre for Quality Improvement report 90**.2%**.
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **community mental health services (people on CPA)**		Trust assessment	Q	65%	Data for 2018/19 has been collated and sent to the NCAP Team. A sample will be generated and then returned to us for internal analysis and national submission in Quarter 3																2018/19 data yet to be submitted 2017/18 Data was submitted to National Clinical Audit of Pschosis (NCAP) **December 17**. Internal analysis indicated **74.39%**.
		National assessment			National data not available until Quarter 4																2017/18 Audit results as assessed by the Royal College of Psychiatry's 2017/18 Centre for Quality Improvement report **74.40%**.
IAPT/Talking Therapies - proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	IAPT minimum dataset	Trust assessment	M	50%	**51.48%**	**52.52%**	**51.77%**	**47.29%**	**51.86%**	**51.08%**							**51.93%**	**50.08%**			
		PAVE Reports	Q		**51.29%**	**52.76%**	**51.43%**	**49.12%**									**51.47%**				Latest PAVE data July 2018
IAPT/Talking Therapies - waiting time to begin treatment (from IAPT minimum dataset) - **within 6 weeks**	IAPT minimum dataset	Trust assessment	M	75%	**99.49%**	**98.99%**	**99.04%**	**99.35%**	**98.81%**	**98.01%**							**99.17%**	**98.76%**			
		PAVE Reports	Q		**99.43%**	**98.87%**	**99.05%**	**98.62%**									**99.12%**				Latest PAVE data July 2018
IAPT/Talking Therapies - waiting time to begin treatment (from IAPT minimum dataset) - **within 18 weeks**	IAPT minimum dataset	Trust assessment	M	95%	**99.77%**	**100.00%**	**99.83%**	**100.00%**	**100.00%**	**100.00%**							**99.87%**	**100.00%**			
		PAVE Reports	Q		**99.72%**	**100.00%**	**99.83%**	**100.00%**									**99.85%**				Latest PAVE data July 2018
Data Quality Maturity Index (DQMI) – Mental Health Services Data Set Data Score	MHSDS	N/A	M	95																	Latest published data Quarter 4 2017/18, which reported **95.9**.
Inappropriate out of area placements for adult mental health services	MHSDS	Trust assessment	M	2389	**2007**	**2085**	**2188**	**2236**	**2236**	**2080**							**2188**	**2080**			
		NHS Digital	M	N/A	1945	2040	2195	2180													Latest published data July 2018

SINGLE OVERSIGHT SCORECARD - Organisational Health 2018/19

All Providers																	
Quality Indicators	**SOF Source**	**Other known**	**Freq.**	**Standard**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Comments**
Staff Sickness	NHS Digital	Trust assessment (month behind)	M	N/A	4.43%	4.68%	4.81%	4.93%	5.12%	4.90%							IIC reporting a month behind
		Finance Return	M & Q	N/A													Finance Return to NHS Improvement - not required to report in April. All other figures are a month behind
		N/A	M & Q	N/A	4.68%	4.77%											Last published data May 2018
Staff turnover (Finance Return)	NHS Digital	Finance Return	M & Q	N/A	0.85%	0.58%	1.00%	0.97%	0.97%	0.75%							All figures are a month behind
NHS Staff survey	CQC	N/A	A	N/A													
Proportion of temporary staff	Provider Return	N/A	Q	N/A	2.65%	2.79%	2.81%	3.02%	3.06%	3.20%							Finance Return to NHS Improvement

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th October 2018**
TITLE:	**Constitutional Change – Staff Constituency**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Decision/Recommendation**

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 Staff Constituency, described in Annex 2 of the Constitution, is divided into classes based on the Trust's Localities with a separate class for staff in corporate services. These arrangements are also reflected in the Composition of the Council of Governors (Annex 4 to the Constitution) with each staff class represented by one Governor.

At its meeting held on 25th September 2018 (minute 18/C/262 refers) it was agreed to merge the North Yorkshire and York and Selby Localities.

This report proposes amending the Staff Constituency so that it mirrors the revised Locality structure.

Under the NHS Act 2006 (as amended) changes to the Trust's Constitution require the approval of both the Board of Directors and the Council of Governors.

Recommendations:

(1) To approve the changes to Annexes 2 and 4 of the Trust's Constitution (as highlighted in Appendix 1 to this report):
   (a) To remove the North Yorkshire and York and Selby classes within the Staff Constituency.
   (b) To establish a new staff class, "North Yorkshire and York", represented by one Governor.

(2) To recommend the above changes to the Constitution to the Council of Governors for approval.

MEETING OF:	**The Board of Directors**
DATE:	**30th October 2018**
TITLE:	**Constitution Change – Staff Constituency**

1. INTRODUCTION & PURPOSE:

1.1 To seek the approval of changes to Annexes 2 and 4 to the Trust's Constitution arising from the Board's decision to merge the North Yorkshire and York and Selby Localities.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Staff Constituency (described in Annex 2 to the Constitution) is divided into classes based on the Trust's Localities with a separate class for staff working in corporate services.

2.2 Under these arrangements each class is represented by one Governor as shown in Annex 4 to the Constitution (Composition of the Council of Governors).

2.3 At its meeting held on 25th September 2018 (minute 18/C/262 refers), the Board approved the merger of the North Yorkshire and York and Selby Localities.

2.4 This report seeks to bring the Trust's Constitutional arrangements into line with the revised Locality structure.

2.6 Under the NHS Act 2006 (as amended), changes to the Constitution require the approval of both the Board of Directors and the Council of Governors.

3. KEY ISSUES:

3.1 It is proposed to replace the staff classes for North Yorkshire and York and Selby with a new class, "North Yorkshire and York". The new staff class would be represented by one Governor.

3.2 Details of the changes, including consequential amendments, to Annexes 2 and 4 to the Constitution are shown in Appendix 1 to this report.

3.3 The Board is asked to note that:

(a) The proposal would result in a reduction in the overall size of the Council of Governors, by one, from 55 to 54.

(b) There are no implications arising from the proposed changes for current Governors as both seats are, at present, vacant.

(c) If approved, the election of the Governor for the new staff class will held during 2019 as part of the Annual Elections.

(d) The membership of the revised staff classes would be as follows (September 2018):

Class	No. of Members
Corporate	1099
County Durham and Darlington	1497
Forensic	883
Teesside	1435
North Yorkshire and York	*1677*

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):** Changes to the Constitution must be approved by both the Board of Directors and Council of Governors under the NHS Act 2006 (as amended).

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 The proposed changes will mean that the staff classes continue to be aligned to the operational arrangements of the Trust.

7. RECOMMENDATIONS:

7.1 The Board is recommended:

(1) To approve the changes to Annexes 2 and 4 of the Trust's Constitution (as highlighted in Appendix 1 to this report):

(a) To remove the North Yorkshire and York and Selby classes within the Staff Constituency.

(b) To include a new staff class, "North Yorkshire and York", represented by 1 Governor.

(2) To recommend the above changes to the Constitution to the Council of Governors for approval.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution
The NHS Act 2006 (as amended)

Appendix 1

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 8.3 and 8.4)

1. **The Staff Constituency**

The Staff Constituency is divided into ~~6 (six)~~ 5 (five) classes based on the Corporate Directorates and Operational Directorates of the Trust. These are:

Class	Minimum number of members	Number of Elected Governors
Corporate	90	1
Forensic	60	1
County Durham and Darlington	150	1
Teesside	180	1
~~North Yorkshire~~	~~80~~	~~1~~
~~York and Selby~~	~~70~~	~~1~~
North Yorkshire and York	200	1

2. Should an individual class within the Staff Constituency fail to achieve the above minimum numbers, no election shall take place in that class, until such time as the minimum number is reached. An election within that class will then take place within a time period determined by the Chairman of the Trust.

3. Staff will only be able to become a member and vote in one class within the Staff Constituency.

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 11.2 and 11.3)

COMPOSITION OF THE COUNCIL OF GOVERNORS		
Constituency		**Number of Governors from ~~1/6/17~~ 1/1/19**
Public	Stockton-on-Tees	3
	Hartlepool	2
	Darlington	2
	Durham	8
	Middlesbrough	2
	Redcar & Cleveland	2
	Scarborough and Ryedale	3
	Hambleton and Richmondshire	2
	Harrogate and Wetherby	3
	City of York	3
	Selby	2
	Rest of England	1
Staff	Corporate	1
	Forensic	1
	~~North Yorkshire~~	~~1~~
	County Durham and Darlington	1
	Teesside	1
	~~York and Selby~~	~~1~~
	North Yorkshire and York	1
Appointed Governors	Durham County Council	1
	Darlington Borough Council	1
	Hartlepool Borough Council	1
	Stockton-on-Tees Borough Council	1
	Middlesbrough Borough Council	1
	Redcar & Cleveland Borough Council	1
	North Yorkshire County Council	1
	City of York Council	1
	University of Teesside	1*
	Durham University	1*
	University of York	1*
	University of Newcastle	1*
	Northern Specialist Commissioning Group	1*
	North Durham Clinical Commissioning Group Durham Dales, Easington and Sedgefield Clinical Commissioning Group Darlington Clinical Commissioning Group	1*
	Hartlepool and Stockton-on-Tees Clinical Commissioning Group South of Tees Clinical Commissioning Group	1*
	Hambleton, Richmondshire and Whitby Clinical Commissioning Group Scarborough and Ryedale Clinical Commissioning Group Harrogate Clinical Commissioning Group Vale of York Clinical Commissioning Group	1*
TOTAL		~~55~~ ~~54~~

(Notes:

1 The terms of Governors holding office on ~~1st June 2017~~ 1st January 2019 are unaffected by any changes to the Constitution which come into force on that day.

2 The appointing organisations marked (*) in the above schedule are specified for the purposes of sub-paragraph 9(7) of Schedule 7 for the 2006 Act (as amended).

3 The arrangements for the appointment of Governors by Clinical Commissioning Groups are set out in Annex 6.)

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th October 2018**
TITLE:	**To receive an update on progress with the Digital Security and Protection Toolkit and GDPR**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Information**

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

Executive Summary:

The IG Toolkit has been fully revised and renamed the Data Security and Protection (DS&P) Toolkit for the year 2018-19. The new toolkit measures performance against the National Data Guardian's 10 data security standards.

The toolkit comprises 10 standards, each of which is broken down into a number of assertions. Each assertion comprises a number of evidence items, most of which are mandatory for an NHS trust of our size.

Of the non-mandatory evidence items, 17 relate to evidence that will be provided via data extract from the Data Security and Protection e-learning module which replaced the Information Governance mandatory training from 1st April 2018.

49 evidence items have been completed so far. 60 mandatory and 39 non mandatory items are awaiting completion. This equates to a current position of 59% completion for the Trust. This is the position that will be reported at the 31st October with a predicted 100% completion of mandatory evidence.

The General Data Protection Regulation 2016 (GDPR) and the Data Protection Bill 2018 replaced the Data Protection Act 1998 (DPA1998) on the 25th May 2018. The new legislation, whilst very similar to the DPA 1998 has introduced some fundamental changes in regard to transparency of processing, privacy rights and compliance monitoring.

The second quarter has seen a 24% increase in subject access requests with the

result that the one month timeframe has been breached on two occasions.
There are encouraging indications that privacy notices are being sent out to patients in a more pro-active manner.

Recommendations:

The Executive Management Team are asked to consider this report and accept the conclusions drawn in section 6.

MEETING OF:	**Board of Directors**
DATE:	**30th October 2018**
TITLE:	**To receive an update on progress with the Digital Security and Protection Toolkit and GDPR**

1. INTRODUCTION & PURPOSE:

1.1 This report is to provide the Board with an update on progress with the Data Security and Protection Toolkit and the implementation of GDPR.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Data Security and Protection Toolkit replaces the previous Information Governance toolkit from April 2018. The Data Security and Protection Toolkit is an online self-assessment tool that enables organisations to measure and publish their performance against the National Data Guardian's ten data security standards. In October 2018 the first assessment of progress and prediction of final scores will be submitted

2.2 The General Data Protection Regulation 2016 (GDPR) and the Data Protection Bill 2018 replaced the Data Protection Act 1998 (DPA1998) on the 25th May 2018. The new legislation, whilst very similar to the DPA 1998 has introduced some fundamental changes in regard to transparency of processing, privacy rights and compliance monitoring.

This legislation will give individuals more control over how organisations use their personal information, setting new standards of protection.

3. KEY ISSUES:

Data Security and Protection Toolkit

3.1 Data Security and Protection Toolkit Update

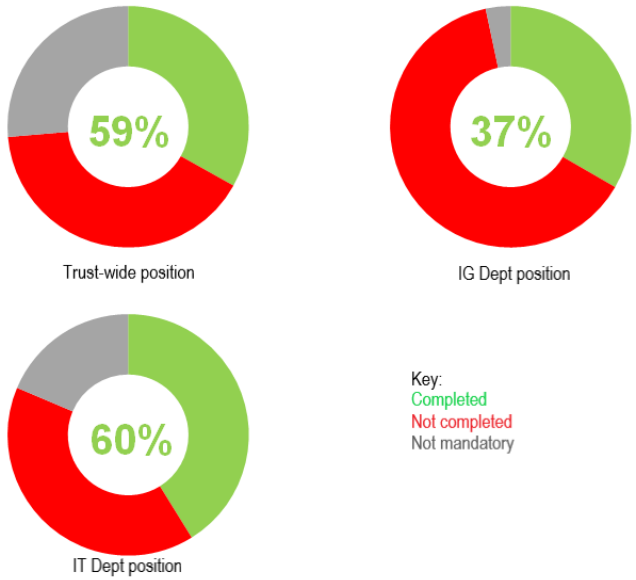
As at the 31 October 2018 the Trust will submit its first assessment against the new toolkit. The Trust is predicting 100% compliance with all mandatory assertions.

3.2 The current position against the 10 standards is as follows:

Standard	Assertions	Evidence items	Mandatory evidence items
1 Personal confidential data	8	50	41
2 Staff	3	11	4

responsibilities			
3 Training	5	12	10
4 Managing data access	3	9	5
5 Process reviews	3	4	1
6 Responding to incidents	4	18	11
7 Continuity planning	2	14	6
8 Unsupported systems	3	9	9
9 IT protection	4	12	9
10 Accountable suppliers	5	9	3
	40	148	99

3.3 This is represented as follows:



There are 5 assertions that have responsible officers outside of the IG and IT departments. Support is provided to the responsible officers as needed by both departments. The assertions are as follows:

- Estates – Physical controls in place when entering buildings (Personal Confidential Data)
- HR – Contracts have data security clauses (staff responsibilities) and confirmation that the Trust holds a record of all staff and their roles (data access)

- Communications – Draft press materials in the event of a cyber security incident and the date of last review (business continuity)

3.4 Actions being taken to progress completion of assertions

- A business continuity test using a cyber security scenario is scheduled for 4th March 2019
- A data security and protection training needs analysis is in progress which includes leaders and Board members. This requires SIRO sign-off
- Staff knowledge has been identified as one of the Trust's top 3 security risks, with data quality and use of fax machines
- An audit of pseudonymisation controls is to be scheduled
- 5S of information flows is nearing completion and will be presented to Digital Safety Board in December for approval prior to EMT sign-off
- Information asset registers are now supported by improved IT department reporting regarding hardware and software in use in the Trust. A PC/laptop 'amnesty' is in progress to dispose of or repurpose unused PCs and laptops

GDPR Update

3.5 Management and Staff Awareness

NHS Digital have introduced a training session for delivery to Boards. This session is 90 minutes long and has been received favourably by other Boards across the UK.

The mandatory training sessions for IG are currently running at 88% which is a good position for this time of year.

3.6 Contractors **–** This work is not complete. However, key contractors that process personal data on behalf of the Trust have been contacted and assurances of their compliance given. Letters will also be sent to other suppliers. The standard NHS contracts are also being revised.

Meetings with the principle supplier of the care record are scheduled for November.

3.7 Keep records of data processing activities

It is anticipated that the first draft of information flows and recording activities will be signed off by the Digital Safety Board in December.

3.8 Data protection by design and default and Data Protection Impact Assessment's (DPIA)

The DPIA process has been built into the project management processes and change board that processes changes to information systems. The register of DPIA's is held by the incident management team on behalf of the Data Protection Officer. The work that is undertaken outside of these processes needs to be captured and is more problematic but good awareness raising sessions have brought it to staff attention.

3.9 Comply with more stringent transparency requirements

The privacy notice is the platform for all processing activity in the Trust as it tells patients and staff how we will be using, storing and sharing their information for the purposes of their care. The Trust has developed a range of notices that are relevant not only for services but also staff, volunteers, students, members and governors.

There are encouraging indications that the privacy notices are being received by patients and a survey will be conducted in the 3rd and 4th quarters to establish how well patients understand their rights.

3.10 Manage subject access requests and support individual's rights

People requesting access to their records has increased in quarter 2 by 24% and this has been coupled by an increase in the number of people requesting corrections to their records.

This increase in workload has put the department under significant pressure which is going to be carefully monitored over the next quarter.

A first intervention is a team review of workflow to see if there are any opportunities for removal of waste. The number of requests will continue to be monitored to see if the trend continues to be upward.

The Trust has breached the legal duty to disclose records within one month on 2 occasions in the last quarter.

3.11 Detect, report and investigate personal data breaches

There has been no requirement to post a 72hr report with the ICO since the 25th May 2018.

Incidents continue to be monitored and will be reported on in full through the Cyber Security Update report in November.

3.12 Overall Compliance with GDPR

The Trust is compliant in all key areas of the new legislation. Audit One are currently undertaking an overarching audit to provide external assurance in

this regard. The results of the audit will be reported when they become available.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

There are no known issues regarding compliance with CQC fundamental standards.

4.2 Financial/Value for Money:

There are no direct financial implications from this report. The Executive Director of Nursing and Governance is working closely with the Data Protection Officer to monitor increases in workload and any requests for increases in resource will be reported in due course.

4.3 Legal and Constitutional (including the NHS Constitution):

There are no issues to be raised within this report.

4.4 Equality and Diversity:

There have been no equality and diversity issues raised within this report.

4.5 Other implications:

The IG Toolkit provided a training tool specifically for the Senior Information Risk Owner (SIRO). The DS&P Toolkit does not but still has a mandatory requirement for specific SIRO training.

The whole system penetration test will be reported within the upcoming cyber security report in November. It should be noted that vulnerabilities have been identified and their impact, if realised, could impact upon the Trust's compliance with GDPR

5. RISKS:

The increase in subject access requests is being closely monitored and has to date led to 2 breaches in the legislation. This situation could if not halted lead to the imposition of a fine.

A number of requests for amendments to records that are not deemed accurate by the service user are being received and responded to.

The Trust should procure additional training for the SIRO and the SIRO network as part of the Trust's duties to raise awareness of responsibilities within the Trust.

6. CONCLUSIONS:

6.1 The assertions for the new Toolkit have been allocated to responsible officers and action plans are in place to conclude the provision of evidence by the 31st March 2019. This position will be reported on the 31st October 2018.

6.2 The impact of the GDPR will be kept under review and any implications particularly for the IG team in terms of increased activity and workload will be monitored.

6.3 A training programme for the SIRO and the IAO and IAA network will be developed or procured.

6.4 Trust Board should consider taking up the NHS Digital Cyber Security Training.

7. RECOMMENDATIONS:

7.1 The EMT are asked to consider this report and accept the conclusions drawn in section 6.

Author: Elizabeth Moody
Director of Nursing and Governance

Background Papers:
NHS Digital Cyber Security Board Training

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30 October 2018**
TITLE:	**Policies Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

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

Executive Summary:

The policy paper contains the following information:

- 2 policies that have undergone full review and require ratification:
  - CORP-0034-v3 Energy and Water Management Policy
  - CORP-0050-v4 Research Governance Policy
- 2 policies that has undergone significant amendment or had creation of significant associated procedure:
  - IT-0031-v2.1 Access to Information Systems Policy
  - CLIN-0019-003-v1 Procedure for addressing verbal aggression towards staff by patients, carers and relatives
- 2 policies that have undergone minor amendment:
  - CLIN-0012-v7.4 Admission, Transfer and Discharge Framework
  - CORP-0003-v7.4 CCTV Policy
- 1 plan that has had its review date extended:
  - Cleaning Plan

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meetings held on 10 October 2018

DATE:	**30 October 2018**
TITLE:	**Policies and Procedures Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

1. INTRODUCTION & PURPOSE:

The purpose of this report is to advise the Board of Directors on the policies and procedures that have been ratified by the Executive Management Team.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 It is important that the Trust policy portfolio is updated and revised in a timely way to ensure best practice, current legislation and regulation is reflected in policy content. Policies no longer required to control and assure practice should be terminated and withdrawn from the portfolio.

2.2 Following the last revision of the Trust's Integrated Governance arrangements, it was agreed that the Executive Management Team ratify all new and revised Trust policies.

2.3 Each policy ratified by the Executive Management Team will have gone through the Trust's consultation process.

2.4 Currently all corporate Trust policies are ratified by the EMT on behalf of the Board of Directors, following approval by the appropriate specialist committees and groups. All decisions regarding the management of the policy framework must be ratified by the EMT.

3. KEY ISSUES:

3.1 The following policies have undergone full review and require ratification:

Ref and Title	CORP-0034-v3 Energy and Water Management Policy
Review date	10 October 2021
Reviewed by	Sharon Pickering
Approved by	Health, Safety, Security and Fire Group 06 September 2018
Description of change	Amended to combine the following two documents:- • Water Management Policy CORP-0040 • Energy and Water Management Procedure Full revision in line with current legislation and best practice.

Ref and Title	CORP-0050-v4 Research Governance Policy
Review date	10 October 2021
Reviewed by	Ruth Briel
Approved by	Research Governance Group 06 September 2018
Description of change	Updated Research Governance Framework (DoH, 2005) to UK Policy Framework for Health and Social Care Research (November, 2017). Additional information regarding training needs and how the policy will be monitored.

3.2 The following has had a significant amendment or creation of new procedure:

Ref and Title	IT-0031-v2.1 Access to Information Systems Policy
Review date	06 April 2019
Reviewed by	Phil Bellas
Approved by	Digital Safety and Information Governance Board 03 October 2018
Description of change	Section 3.5 has been added regarding the use of Skype for Business within the Trust

Ref and Title	CLIN-0019-003-v1 Procedure for addressing verbal aggression towards staff by patients, carers and relatives
Review date	10 October 2021
Reviewed by	Levi Buckley
Approved by	(Requires EMT approval)
Description of change	Creation of new procedure to support existing policy (Person Centred Behaviour Support)

3.3 The following have undergone minor amendment:

Ref and Title	CLIN-0012-v7.4 Admission, Transfer and Discharge Framework
Review date	02 November 2019
Reviewed by	Jennifer Illingworth
Approved by	Tees QuAG September 2018
Description of	This policy had discrepancies between the title of the document, the title on the front cover, and the title given in

change	the footer. The front cover identified the policy as Admission, Transfer and Discharge of Service Users within Hospital and Residential Settings, and on the footer as Admissions, Transfer and Discharge Policy. This led to some confusion particularly as the title on the document indicated it only applies to hospital and residential settings whereas the full document is beyond this scope. The title and the footer have been amended to Admission, Transfer and Discharge Framework.

Ref and Title	CORP-0003-v7.4 CCTV Policy
Review date	06 April 2019
Reviewed by	Colin Martin
Approved by	Digital Safety and Information Governance Board 03 October 2018
Description of change	References to the Data Protection Act amended from 1998 to 2018 (GDPR)

3.4 The following have had their review date extended:

Ref and Title	Cleaning Plan
Review date	01 March 2019
Rationale	The plan is currently up to date with current requirements. However a new publication is anticipated which may result in changes to the plan. Therefore this has been extended pending publication of the new requirements.

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 08 August 2018 and 12 September 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