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

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the last meeting held on **30th October 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 and note the report of the Guardian of Safe Working.	**Dr. Whaley to attend**	**Attached**
Item 7	To consider the report of the Quality Assurance Committee.	**HG/JI**	**Attached**
Item 8	To consider the monthly Nurse Staffing Report.	**JI**	**Attached**
Item 9	To consider the report of the Mental Health Legislation Committee.	**RS/JI**	**Attached**
Item 10	To sign off the Self-Assessment Report in relation to Multi-professional Education and Training.	**JI**	**Attached**

Performance (11.00 am)

Item 11	To consider the Finance Report as at 31st October 2018.	**PM**	**Attached**
Item 12	To consider the Trust Performance Dashboard as at 31st October 2018.	**SP**	**Attached**

Item 13 To consider the Strategic Direction Performance Report for Quarter 2, 2018/19. **SP** **Attached**

Items for Information (11.20 am)

Item 14 Policies and Procedures ratified by the Executive Management Team. **CM** **Attached**

Item 15 To note that a special meeting of the Board of Directors will be held (in conjunction with a seminar) on **Tuesday 18th December 2018** in the Boardroom, West Park Hospital, Darlington at 9.30 am.

Confidential Motion (11.25 am)

Item 16 **The Chairman to move:**

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

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

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

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

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

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
21st November 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 30TH OCTOBER 2018 IN THE YORK HILTON, 1 TOWER STREET, YORK 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
Mrs. R. Hill, Chief Operating Officer
Dr. A. Khouja, Medical Director
Mr. P. McGahon, Director of Finance and Information
Mrs. E. Moody, Director of Nursing and Governance and Deputy Chief Executive
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Ms. H. Griffiths, Public Governor for Harrogate and Wetherby
Mrs. C. Hodgson, Public Governor for York
Prof. T. McGuffog, Public Governor for York
Mr. P. Scott, Director of Operations for York and Selby (minute 18/278 refers)
Mr. D. Williams, Freedom to Speak Up Guardian (minute 18/279 refers)
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Ms. E. Devanney, Shadow Board Member
Mr. J. Venables, Member of the Trust
Ms. H. Sinclair, GMC Employer Relations Adviser, North of England

18/272 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. M. Hawthorn, Senior Independent Director, and Mr. R. Simpson, Non-Executive Director.

18/273 MINUTES

***Agreed** – that the minutes of the last meeting held on 25th September 2018 be approved as a correct record and signed by the Chairman.*

18/274 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

Further to minute 18/234 (25/9/18), Mrs. Moody reported that Dr. Paul Tiffin of the University of York had been approached with regard to undertaking a research project on variations in outcomes, and the reasons for them, between different types and sizes of wards. Although keen and interested, he had advised that there was no capacity to

undertake the project at the present time; however, some of the issues were covered by a bid to the NIHR.

The Board noted that, unfortunately, the bid had been unsuccessful at the first attempt and needed to be reworked. It was anticipated that this would be completed in early January 2019 and Mrs. Moody would be contacting him, after that time, to review the position.

Action: Mrs. Moody

18/275 DECLARATIONS OF INTEREST

There were no declarations of interest.

18/276 CHAIRMAN'S REPORT

The Chairman:

(1) Drew attention to the email circulated to all Board Members which provided the timetable for the recruitment of the new Chairman which had commenced on 29th October 2018.

(2) Reported on the recent presentation of Long Service Awards.

Mrs. Bessant:

(a) Highlighted the passion and commitment of the recipients.

(b) Advised that a further awards ceremony was to be held for staff in North Yorkshire and York.

(3) Observed that the presentations to, and the discussions at, the Governor Development Day on 16th October 2018 had been very good and had been appreciated by Governors.

18/277 GOVERNOR ISSUES

No issues were raised.

18/278 LOCALITY BRIEFING – YORK AND SELBY

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

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

Arising from the briefing:

(1) It was considered that the refreshed and streamlined approach to reporting from the QuAGs (example provided in the slides) should be shared with the other Localities and could provide a template for the LMGB reports to the Quality Assurance Committee.

Mrs. Moody undertook to ask the Director of Quality Governance to follow up this matter.

Action: Mrs. Moody

(2) In response to a question, Mr. Scott advised that his main concern was the length of waiting times in CAMHS.

In relation to this matter, Board Members sought an update on the joint work being undertaken with the City of York Council to provide mental health support in schools.

It was noted that:

(a) The wellbeing service had been introduced, and was expanding, with the ambition to mainstream support in all schools.

(b) A recent meeting with CCG and local authority leaders on children's IAPT services, where an agreement had been reached to look at workforce planning across the system, had provided reassurance on progress.

(c) There were risks that the present focus could wane as had happened previously on the issue of pooled budgets for children's services.

Mr. Scott responded that the value of the work, particularly for the children, was recognised; there was momentum; and the CCG was stimulating conversations on taking it forward.

(3) Clarity was sought on the extent of the problem of answerphone usage; an issue highlighted by Mr. Scott to be tackled by the use of more robust PDSA cycles rather than set piece improvement events.

It was noted that the difficulties experienced by service users and their carers in contacting staff, arising from the use of answerphones, were not confined to the York and Selby Locality but were Trustwide.

Mr. Scott considered that services needed to be proactive in engaging with people who were waiting for services. He emphasised that the present situation was not intentional but reflected the energy staff were putting into their work.

On this matter Board Members highlighted:

(a) The risks of serious incidents whilst people were waiting.

(b) The benefits of providing advice and support during waiting times, particularly to parents of CAMHS' service users. It was considered that more could be done on this issue through the Trust's website.

(4) Board Members sought assurance on the plans to tackle the high usage of agency staff in the Locality.

Mr. Scott responded that, in addition to continuing to support the work of the Right Staffing Programme:

(a) The consolidation of the estate, through the building of the new hospital, provided part of the plan to reduce agency costs.

(b) Recruitment fayres in the Locality had been reasonably successful.

(c) The high acuity of patients needed to be looked into as this provided one of the main reasons for engaging agency workers.

(d) The offer provided by the Locality was also being reviewed as it was considered that a different way of working could reduce requirements for agency staff.
(e) The Locality was also considering professional roles and the establishment of multi-professional leadership teams throughout its services.

18/279 REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN

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

During his introduction to the report, Mr. Williams drew attention to the case study relating to an experienced care worker, in a small team, who had contacted him to ask if they were required to have an exit interview with their Line Manager.

He advised that the reason for the member of staff raising this matter was that they felt they had to leave the job, they loved, because of bullying from their Manager. They also believed that a number of other staff had left recently for the same reason and the remaining team members wanted to leave.

Mr. Williams assured the Board that an investigation had been requested, involving interviews with all staff including those on sick leave and those who had recently left the Trust, in response to the concerns raised.

The Chairman:
(1) Observed that the case highlighted the extent that exit interviews were fraught with difficulty and the fragility of the Trust's present approach to them.

Mr. Levy responded that an improvement event was being held to look at how feedback from staff leaving the Trust was received including how further information could be gained and how the process linked to the work of the FTSUG.

(2) Sought clarity on whether feedback received from exit interviews was used to trigger conversations with teams.

Mr. Levy advised that the present focus was on how the Trust could become more aware of issues sooner.

It was also noted that feedback from the Freedom to Speak Up training events suggested that exit interviews were not the best way to identify issues in teams.

(3) Questioned whether technology could be used to improve feedback.

It was noted that electronic questionnaires had been used previously; however, staff tended to leave before they could be provided to them. Part of the scope of the improvement event was, therefore, to examine how information gathering could be improved.

In addition Board Members raised the following matters:

(1) Whether the issues raised to the Trust's FTSUG were similar to those in other trusts and the response, at regional and national levels, to them.

It was considered that this latter issue was important as advice would assist learning and the development of a proactive approach to responding to concerns.

Mr. Williams advised that:

(a) Analyses of trends of issues were circulated by the National Guardians Office based on local submissions.
(b) The level of bullying, etc. within the Trust was average compared to others.
(c) Over time, as more cases were dealt with, understanding should increase and local Guardians should be better able to support staff.
(d) There was an aspiration, at national and regional levels, to be more proactive but no timescale had been set to achieve this.
(e) Learning was a regular topic of discussion at regional and national events but no breakthrough had yet been made.
(f) There were significant differences between mental health and learning disability trusts and acute trusts with the former having a greater focus on pastoral care and, through this, identifying feelings of detriment.

(2) How the Trust's approach to leadership development was being used to support the culture of raising concerns.

It was noted that:

(a) The importance of responding to concerns would feature more prominently in the leadership development programme from 2019.
(b) The topic was included in the training event on freedom to speak up.

(3) How the impact of bullying and harassment on patient care, for example staff being fearful of reporting unsafe clinical practice, was being raised and addressed.

Mr. Williams assured the Board that, where bullying was alleged, conversations were held with staff on its impact on the care they were able to provide.

It was also noted that:

(a) The Executive Management Team had recently adopted the Just Culture Guidance published by NHS Improvement and it was hoped that, when embedded, this would provide reassurance to staff that the Trust would look into issues raised about clinical practice.
(b) There were other mechanisms by which staff could, and did, raise concerns about clinical practice both internally, through raising concerns processes, and externally, to the CQC.
(c) The triangulation of issues raised by staff via the number of routes available to them, including the FTSUG, had commenced.

At the conclusion of the discussions Mr. Martin recorded his appreciation:
(1) For the work undertaken by Mr. Barry Speak, the deputy FTSUG, during the summer when Mr. Williams was on sick leave.
(2) To Mr. Williams for his conscientiousness and for working over and above his contractual requirements.

18/280 "HARD TRUTHS" MONTHLY NURSE STAFFING EXCEPTION REPORT

The Board received and noted the exception report on nurse staffing for September 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 18/239 (25/9/18):
(1) Mrs. Moody confirmed that patients on leave were excluded from the Care Hours Per Patient Day (CHPPD) data.

It was noted that further work was being undertaken to seek to understand the reasons why, for some wards, the number of patients included in the data exceeded the number of beds. This was important as, from January 2019, the data would be used for benchmarking under the Model Hospital initiative.
(2) At the request of the Chairman, Mrs. Moody undertook to provide an assurance statement in future reports on whether the staffing of the Trust's inpatient services was safe.

Action: Mrs. Moody

The Non-Executive Directors raised the following matters:
(1) Whilst recognising that longer term strategic issues were being managed through the Right Staffing Programme, whether there was assurance that day to day staffing matters were being addressed.

Mrs. Moody responded that:
(a) Day to day staffing issues were dealt with by operational services.
(b) Daily huddles were held enabling managers to review acuity and staffing numbers supported by escalation processes.
(c) It was difficult to fully address the day to day matters such as acuity and changing clinical need until the strategic issues (e.g. zonal care, the consolidation of ward establishments, recruitment and retention, etc.) had been resolved.

In relation to this matter clarity was sought on how the strategic and operational issues were brought together to address their underlying causes.

It was noted that:
(a) The updates provided on the Right Staffing Programme in the six monthly nurse staffing reports provided opportunities for the Board to examine this issue in more depth.
(b) NHS Improvement had recently published "Developing Workforce Safeguards", a framework for trusts to strengthen their evidence-based

approach to workforce planning, which also included new recommendations on governance processes and formal reporting from ward to Board.

The regulator would be formally assessing trusts against the framework which was due to come into effect from April 2019. A summary would be provided to the Board at its meeting on 18th December 2018 and in the next six monthly nurse staffing report.

Action: Mrs. Moody

(c) Following the Board Business Planning event in October 2018, the plans including timescales, of the Right Staffing Programme were being refreshed and were due to be presented to the Board event in January 2019.

The Non-Executive Directors highlighted the importance of time being made available to enable the Board to consider how it gained assurance that the underlying causes of staffing issues were being addressed.

(2) The issues raised by NHSI about HCAs and agency spend.

It was noted that:

(a) NHSI had highlighted the Trust's comparatively high levels of expenditure on agency HCAs.
(b) The key issues, which principally related to the North Yorkshire and York and Selby Localities, included:
- Recruitment difficulties.
- The use of HCAs to backfill registered nursing hours.
- Retention challenges in the Localities due to other employment opportunities.

(c) The Trust's retention plan had been shared with the regulator.
(d) Over recruitment was also taken forward to reduce dependency on agency workers.

18/281 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 6th September 2018 (Annex 1 to the report).
(2) The key issues considered by the Committee at its informal meeting held on 4th October 2018.

Dr. Griffiths, the Chairman of the Committee:

(1) Confirmed that the meeting on 4th October 2018 had been inquorate, and held informally, due to the absence of a number of Executive Directors.
(2) Highlighted potential problems for Forensic Services with the proposal by NHS Digital Transformation to roll out Wi-Fi across the Trust from October 2018.

It was noted that Forensic Services were currently relying on the restrictive practice framework, based on an assessment of individual risk, and this would continue until there had been further discussions and national agreement about internet usage on the wards.

Mr. Martin advised that the Trust would not switch on the Wi-Fi until there was assurance that the signal could be changed to restrict access in certain areas.

Board Members raised the following issues:

(1) The visibility provided to the Board on the use of mechanical restraint; an issue raised by the CQC following its inspection of the Trust in July 2018.

Mrs. Moody advised that:

(a) In future, the use of mechanical restraint reported by the LMGBs, or in the Patient Safety Group's report, would be included in the Committee's report to the Board.

(b) Where no use was reported a statement could also be included, for assurance, in the Board report.

(2) The significant challenges facing Trust staff working in prisons.

(3) The concerns raised by the Committee about the high number of prone restraints together with the difference between intentional and unintentional prone restraint.

Mrs. Moody advised that:

(1) The issues had been raised during the Committee's discussions on the report of the Patient Safety Group.

(2) Within the Trust and nationally all prone restraint was classed as such whether it was intentional or unintentional; however, a statement was expected recognising the difference between restraint and placing hands on a patient to provide personal care.

(3) Following improvement work, a pilot was being undertaken, and progressing well, in the Tees Locality where debriefing was provided for all instances of prone restraint.

18/282 MENTAL HEALTH LEGISLATION COMMITTEE

The Board noted that there were no matters of urgency arising from the meeting of the Mental Health Legislation Committee held on 18th October 2018.

Mr. Murphy reported that:

(1) The meeting had become inquorate and this had led to questions as to whether there were capacity issues amongst the Executive Directors at the present time.

(2) The most material issue discussed was the Seclusion and Segregation Procedure which would be presented the Board for approval in due course.

18/283 ANNUAL REPORT ON MEDICAL EDUCATION

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

The following issues were raised:

(1) Concerns about consultants being less willing to support medical teaching and training.

Dr. Khouja explained that:

(a) Following discussions by the EMT, the Director of Medical Education had distributed a survey to all consultant colleagues to seek further understanding of this issue.

(b) The results of the survey were that consultants were less willing to provide supervision due to the level of day to day work pressures.

(c) Although the issue was not yet significant, in order to prevent it from becoming so, the position would continue to be monitored and innovative approaches would be sought on how to deliver supervision.

(2) The position on the funding of training posts in the Trust compared to its neighbours.

Dr. Khouja advised that the Trust would continue to highlight the inequity of the present arrangements, which were of detriment to the Trust, and seek to influence a change in the funding allocation.

18/284 SUMMARY FINANCE REPORT AS AT 30TH SEPTEMBER 2018

The Board received and noted the summary Finance Report as at 30th September 2018 including the Quarter 2, 2018/19, submission to NHS Improvement.

The Board noted that the Trust's use of resources rating had reduced to 2 as a result of agency staffing expenditure being higher than planned and in excess of NHSI's capped target.

Mr. McGahon advised the Board that, at the last Quarterly Review Meeting, NHSI had suggested that its Agency Team might be able to provide support to the Trust on this matter and this was being explored.

The Board also noted that the Trust was clear on the reasons for staffing pressures and was seeking innovative solutions to them e.g. the medical development department was seeking to bolster recruitment by introducing the area to the families of prospective employees.

***Agreed** – that the Trust's Quarter 2, 2018/19 submission to NHS Improvement, in accordance with the results detailed in the above report, be approved.*

Action: Mr. McGahon

18/285 PERFORMANCE DASHBOARD AS AT 30TH SEPTEMBER 2018

Consideration was given to the Performance Dashboard Report as at 30th September 2018.

The focus of the discussions was on waiting times where performance on KPI 1 (percentage of patients seen within 4 weeks) had deteriorated since May 2018.

On this matter it was noted that:
(1) There were risks that the position would negatively impact on delivery of waiting times to treatment (new indicator KPI 2).
(2) Workforce and capacity were considered to be the key underlying issues impacting on performance.
(3) The work being undertaken, particularly in CAMHS, provided greater understanding of referral patterns and demand on performance.
(4) The discussions on the integration of, and early intervention in, CAMHS provided learning for other areas.

Mrs. Pickering also highlighted the importance of the initial data on three new KPIs (number of unique patients referred, the number of external referrals with an assessment completed and the number of external referrals which resulted in treatment commencing), which were not yet reported, in understanding demand and conversion rates.

The Chairman:
(1) Highlighted previous work which had led to the Trust achieving better control of waiting times.
(2) Considered that, in the circumstances, it was necessary for this work to be repeated and for the Trust to gain a full understanding of the issues contributing to the increase in waiting times.

The Board supported the Chairman's proposal that a report providing an analysis of waiting times, taking into account "hot spots", areas of concern and outcome measures, should be presented to its meeting to be held on 29th January 2019 in order to support learning and the development of sustainable solutions.

Action: Mrs. Hill

In addition, the Non-Executive Directors questioned whether the position on readmission rates (KPI 14) was of concern.

The Board noted that:
(1) The rate had increased in May 2018 but, since that time, performance had hovered around the target.
(2) There was also a downward trend on the indicator over the last three years.
(3) The position on the indicator had been discussed by the EMT at its last performance report out and appeared to reflect a small number of exceptional cases.

Mr. Martin advised that the matter would be kept under review.

18/286 STRATEGIC DIRECTION SCORECARD TARGETS

Further to minute 18/216 (19/7/18) consideration was given to the proposed targets for the key performance indicators (KPIs) for the Strategic Direction Scorecard (as set out in Appendix A to the covering report).

Agreed –

(1) that the targets for the key performance indicators for the Strategic Direction Scorecard (as set out in Appendix A to the report) be approved noting those that are not yet available and the work that is due to take place to support their development; and

(2) that KPI 11 (as set out in Appendix A to the report) be the key performance indicator from the Leadership and Management Development Strategy to be included in the Strategic Direction Scorecard.

Action: Mrs. Pickering

18/287 SINGLE OVERSIGHT FRAMEWORK

The Board received and noted a report on the Trust's indicative position against the requirements of NHS Improvement's Single Oversight Framework for Quarter 2, 2018/19.

The Board also noted that the Quarterly Review Meeting with NHSI held on 26th October 2018 had been positive with the main matters discussed being the findings of the CQC inspection in June/July 2018; agency staff usage; and the position at Roseberry Park Hospital.

18/288 CONSTITUTIONAL CHANGE – STAFF CONSTITUENCY

Consideration was given to amending the provisions relating to the Staff Constituency in the Constitution in order that, following the decision to merge the York and Selby and North Yorkshire Localities, the staff classes continued to be aligned to the Trust's Locality arrangements.

Revised versions of Annexes 2 and 4 to the Constitution, detailing the proposed changes, where attached as Appendix 1 to the report.

***Agreed** – that the changes to Annexes 2 and 4 to the Trust's Constitution (as highlighted in Appendix 1 to this report) be approved, namely:*

(a) to remove the North Yorkshire and York and Selby classes within the Staff Constituency; and

(b) to establish a new staff class, "North Yorkshire and York", represented by one Governor.

***Recommended to the Council of Governors** – that the agreed changes to the staff classes in Annexes 2 and 4 to the Constitution be approved.*

Action: Mr. Bellas

18/289 SECURITY AND PROTECTION TOOLKIT AND GDPR

The Board received and noted a progress report on the Data Security and Protection Toolkit (formerly known as the Information Governance Toolkit) and the implementation of the General Data Protection Regulation (GDPR).

The Board noted that:

(1) NHS Digital had introduced a training session (approximately 90 minutes in length) for delivery to Boards which had been received favourably elsewhere.

It was noted that, in addition, a session on cyber security would be provided to the Board Training event in April 2019.

(2) The number of Subject Access Requests had increased by 24% in Quarter 2, 2018/19, which had been coupled with a rise in the number of people asking for changes to their care records.

The Non-Executive Directors asked for further information, in due course, on the themes relating to requests for changes to care records and the number agreed.

Mrs. Moody advised that there was a range of reasons for people seeking to change their records, including to correct historical inaccuracies, and suggested that it might be useful, to aid understanding, for Board Members to receive some case studies on this matter.

Action: Mrs. Moody

18/290 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.

18/291 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 25th November 2018 in the Boardroom, West Park Hospital, Darlington.

18/292 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.

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.

Following the transaction of the confidential business the meeting concluded at 12.45 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Trust Board Briefing
York and Selby

Patrick Scott
Director of Operations

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

TIMES THEY ARE A CHANGING…

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

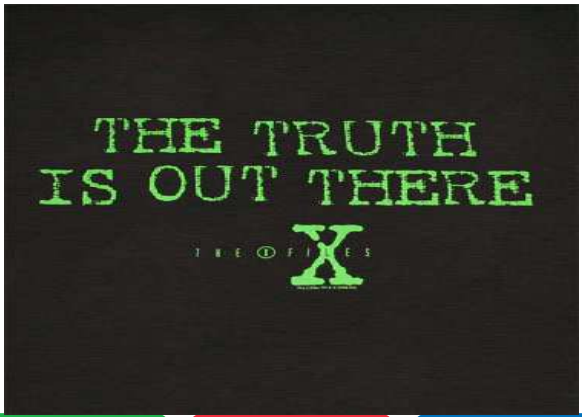
To provide excellent services, working with the individual users of our services and their carers to promote recovery and well being

- Issues
  - Access and navigation
  - Space and time for compassion and recovery
  - Distraction of new beginnings
  - Opportunity to create new alliances with primary care and others
  - New Hospital
  - Trieste, tag line or transformation

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To continuously improve the quality and value of our work.



making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To continuously improve the quality and value of our work. Our side of the Deal

- Align QIS and Coaching with locality priorities
- PDSA V Set Piece improvement events
- Refresh locality report outs
- True co-production
- Research and relationships

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Recruitment & Retention Issues
  - Nursing / IAPT/ CAMHS/Medics
  - New approach to delivering consultant level workforce
  - System workforce
  - Talent management at local level
  - Time to breathe, space to think

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Local
  - New approach to working with system-CAMHS, MHSOP
  - Leadership
  - Engagement with commissioners
  - Clinical network leads
  - ICS ETC….
- International – Trieste Twinning- Need to Mainstream

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Financial Pressures
  - CCG / System pressures
- LMGB
  - Refresh approach

making a difference together

FOR GENERAL RELEASE

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Title/Division: York & Selby MHSOP Service QUAG Report for LMGB

Lead: Dr Jeff Clarke & Sarah Gill
QuAG Discussion: 4th October 2018
Date of LMGB: 11th October 2018
Report for: Assurance and Information
Time Period: 1st – 30th September 2018

Information source: *QuAG discussion, trust quality scorecard, quality & assurance report, IIC and service governance structures*

Purpose: *To provide assurance that the services understand the service pressures, risks, underperformance and mitigating actions are in place.*

Top 3 areas for LMGB to note:

Memory Service
- From the 15th October the team will only have 0.6wte B5 nurse to complete assessments due to planned and unplanned sick leave, vacancy and mat leave.
- 113 waiters, 400 on caseload and approx. 62 referrals per month.
- Short term plans agreed to increase assessment capacity

NE CMHT
- Ongoing plan in place to support the team's ability to manage demand and flow
- Stop the clock planned

Community Medical Staff
- 1 WTE consultant psychiatrist position re-advertised with incentives
- 0.7wte locum position advertised until 31st March 2019
- Exploring opportunities for alternative positions should we not recruit.

Service Developments & priorities:

The 2nd service redesign workshop took place 28/09/18. Came away with 2 models and a number of PDSAs to start testing from November such as:
- MHSOP access service
- Use of Band 3 HCAs
- Development of staff cells against clusters

- Project steering group to be set up from this month
- **EMT paper** submitted for approval to merge the two organic units earlier than planned which in turn will reduce the number fo beds, offer the opportunity to participate in the zonal engagement pilot and significantly reduce the use of bank and agency.
- **Physiotherapy review** ongoing with a meeting of HoS (AMH/MHSOP) and clinical leads in October.
- HoN and LM leading on the **Band 7 ANP job description** standardisation.
- Directorate brief shared

Sept Directorate Brief - Inpatient focus.doc

Financial Key Priorities:
- **Reduction of OOA** – now under control with new admissions process in place
- **Use of bank & agency** – continues to be challenging due to acuity and observation levels
- **Medical Overspend** – further attempts to recruit and alternative roles being explored.

Top 3 Risks from the service risk log: (Very high)
- **Memory service:** Very high risk that we are unable to provide a service
- **NE CMHT/ Consultant psychiatry:** Very high risk of the team unable to manage and sustain their demand without adequate consultant input.

Good News:
- Progress with service redesign
- Acomb Garth features in a Health estate journal for their participation and work on improving the environment

Workforce:
- **Sickness: 7.03%** slowly improving as people are returning from long-term sickness.
- **Inpatient recruitment for qualified staff** frozen until a decision has been made on the merging of the organic units.

External Assurance (CQC, quality visits)
- **CQC MHA monitoring at Meadowfields 13/09/18.** Issues raised -
  - Inability to locate info re: IMCA
  - Tidiness of notice boards
  - Leave forms absent of parameter detail
  - Miscommunication re: role of the nurse and scrutinising detention documents. Since been clarified.

Contract quality and performance:
- Key point of discussion was with the **memory service** given the waiting position and inability to expand its offer to other forms of organic assessment such as alcohol related dementias. Even with the team fully established, unable to respond as expect to meet the demand.
- Meeting planned between **TEWV and CCG** 24/10/18 to discuss possible business case.

Patient Experience & Safety
- 4 level 3 reported in September
- 104 incidents of which 16 were falls, 24 physical restraints/interventions
- Recent thematic review undertaken by patient safety following 3 SIs within the NE CMHT. Initial themes indicate issues with transference of services in Pocklington and the processes to support. Learning to be shared with the team, leadership and commissioners.
- 1 complaint – NE CMHT
- Patient Satisfaction & experience **93.36%** (43 people)
- Carer satisfaction: **87.18%** (35)
- FFTs: **83.33%**

Expert by Experience attended QuAG to provide feedback on

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A Nod To The Future….

making a difference together

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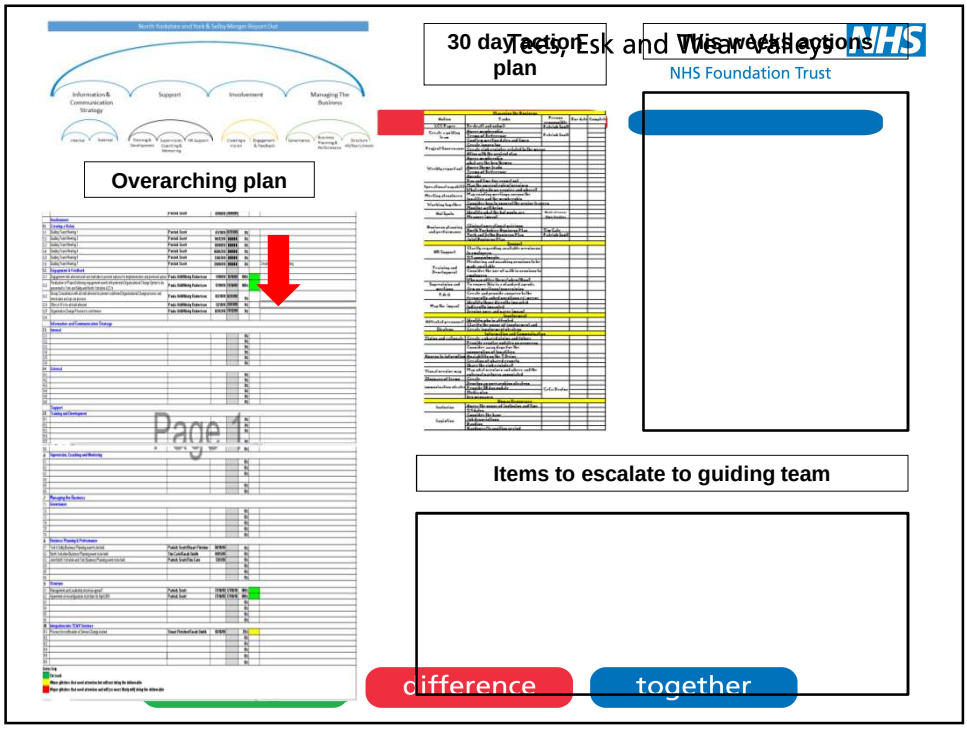
We Will Be…….

- More creative in our use of technologies, processes and systems
- Better at engaging with and attending to the welfare of our people
- More creative and committed to coproduction and recovery
- More focused on our position within the systems we work within

making a | difference | together



ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th November 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	Completed
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	Completed

	Minute No.	Action	Owner(s)	Timescale	Status
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	Completed in relation to the KPI from the Leadership and Management Development Strategy. The KPI is included in the report under Agenda Item 13. At present there is no Trustwide measure from the Equality and Diversity Strategy for inclusion in the Strategic Direction Scorecard. The Director of HR and OD considers that the matter should be deferred until June 2019 by which time the Strategy will have been refreshed
19/07/2018	18/218	A further review of the Board's committee arrangements to be undertaken	PB	Dec-18	
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	18/241	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	Completed (The Director of Therapies to discuss the approach to be taken with the Chaplains)

	Minute No.	Action	Owner(s)	Timescale	Status
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	
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~~ Jan-19	
30/10/2018	18/274	The position on the research bid by Dr. Paul Tiffin of York University, in relation to supporting the Trust's understanding of the variations in outcomes, and the reasons for them, between different types and sizes of wards, to be reviewed	EM	Jan-19	
30/10/2018	18/278	The Director of Quality Governance to be asked to consider whether the streamlined approach to reporting from the QuAGs in the York and Selby Locality could provide a template for LMGB reports to the QuAC	EM	Mar-19	
30/10/2018	18/280	The monthly 'Hard Truths' reports to include an assurance statement on whether the staffing of the Trust's inpatent services is safe	EM	To commence Nov-18	See Agenda Item 8
30/10/2018	18/280	A summary of NHS Improvement's publication “Developing Workforce Safeguards” to be provided to the Board	EM	Dec-18	
30/10/2018	18/284	To note that the Trust’s Quarter 2, 2018/19 financial submission to NHS Improvement was approved	PM	-	To note
30/10/2018	18/285	A report is to be presented to the Board providing an analysis of waiting times, taking into account “hot spots”, areas of concern and outcome measures, in order to support learning and the development of sustainable solutions	RH	Feb-19	

	Minute No.	Action	Owner(s)	Timescale	Status
30/10/2018	18/286	To note that the Board approved: - The targets for the key performance indicators for the Strategic Direction Scorecard (as set out in Appendix A to the report) recognising those that are not yet available and the work that is due to take place to support their development - KPI 11 (as set out in Appendix A to the report) as the key performance indicator from the Leadership and Management Development Strategy to be included in the Strategic Direction Scorecard	SP	-	To note
30/10/2018	18/288	To note the Board's approval of the changes to the staff constituency in the Constitution in response to the merger of the York and Selby and North Yorkshire Localities	PB	-	To note
30/10/2018	18/288	The changes to the staff constituency, in response to the merger of the York and Selby and North Yorkshire Localities, to be presented to the Council of Governors for approval	PB	Nov-18	Included on the agenda for the Council of Governors meeting to be held on 29/11/18
30/10/2018	18/289	Case studies on requests to change care records to be provided to the Board	EM	Mar-19	

ITEM NO. 6

CONFIDENTIAL

Trust Board of Directors

DATE:	**November 2018**
TITLE:	**Guardian of safe Working Quarterly Report**
REPORT OF:	**Julian Whaley, Guardian of Safe Working**
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:

This paper outlines the ongoing work of the 'Guardian of Safe Working' as part of the 2016 Terms and Conditions for Junior Doctors and identifies issues that have arisen for the Trust.
It is the responsibility of the Guardian of Safe Working to provide a Quarterly report to the Trust Board for assurance that Junior Doctors are safely rostered and working hours that are safe and in compliance with Terms and Conditions of Service.
The 2016 Junior Doctor Contract was implemented for psychiatry trainees starting new contracts in February 2017 and most of our trainee workforce are now on this contract. Mandated monitoring processes have not identified any breaches to terms and conditions of service requiring the levy of a fine. Processes allow identification of concerns which are being appropriately addressed and where necessary, changes implemented.

Recommendations:

The Board are asked to read and note this report from the Guardian of Safe Working.

MEETING OF:	**Trust Board**
DATE:	**November 2018**
TITLE:	**Quarterly report by Guardian of Safe Working for Junior Doctors**

1. INTRODUCTION & PURPOSE:

The Board receive a quarterly report from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for Junior Doctors. This includes aggregated data on exception reports, details of fines levied against departments with safety issues, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting good practice and/or persistent concern. This will provide assurance to the Board and if needed ask for approval for action to rectify a safety concern.

2. BACKGROUND INFORMATION AND CONTEXT:

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours and during negotiation, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS doctors in training to oversee the process of ensuring doctors are properly paid for all their work and ensure they are not working unsafe hours. It is a requirement that all doctors on the contract have an individualised schedule of work for each placement, variation from which requires them to place an exception report, based on hours of work, alteration of work pattern and/or educational experience.
The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The guardian is required to levy a fine against a department(s) if a doctor works on average over 48 hours/week, works over 72 hours in 7 days or misses more than 25% of required rest breaks.
The work of the guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by Health Education England.

Regular Commitments of the Guardian to support this agenda includes:

1. Quarterly Junior Doctor Forums and 7 Locality Junior Doctor Forums.
2. Attendance at Trust Medical Education meetings and Local Negotiating Committee
3. Membership & engagement of regional (2) and national forums.
4. Junior Doctor induction sessions
5. Process for 1:1 meeting offer with Junior Doctors.
6. Regular sessions on Junior Doctor Teaching Programmes

3. KEY ISSUES:

I am satisfied that all exception reports submitted by doctors on the new contract have been actioned within specified timeframes. High levels of exception reports relate to the high degree of variation in out of hours non-resident on call rota work with isolated areas reporting additional daytime hours identified in the appendices. I am satisfied that all doctors are being paid for the work they are undertaking and

have verbal assurance that agreement for time off in lieu is achieved. There has been no justification to levy a fine on any department within the organisation.
The change to the South Durham rota to resident from August has had a positive impact on morale but has negatively impacted on ability to attend local teaching and has decreased community workplace experience. Therefore, consideration is being given to moving the day of local teaching and community doctors are no longer expected to participate in the daytime rota at West Park.
The North Durham rota has seen a spike in antisocial hours activity, disproportionately affecting two GP trainees who expressed safety concerns. This triggered a schedule review. Quantitative data reveals no hours breech but the qualitative impact, especially on transient trainees (GP & Foundation) requires consideration in rota design. The Guardian has written to North Durham medics reaffirming the requirement to provide support and supervision out of hours. It is understood our GP Tutor is liaising with the relevant GP Programme Director in relation to this matter.
During discussions with Tees trainees, it transpired that some were not aware to exception report additional antisocial hours activity; this is a complex rota with resident and non-resident components. This is now resolved.
Workforce issues in Northallerton (medical and non-medical) have impacted on daytime and on-call work. The confirmed date for Friarage wards closure allows consideration of future schedules for Northallerton and Harrogate. Trainees have been appropriately engaged in coordinated meetings sharing concerns and helping to provide solutions.
The Junior Doctor Forum has agreed to the implementation of on-call log forms for non-resident work from February 2019. This received agreement in principle at the Local Negotiating Committee.
Junior Doctors across the organisation continue to express isolated concerns relating to switchboard. The need to report these concerns has been reiterated.
There also continue to be concerns relating to access to acute hospital ‘ICE’ systems. Access for Scarborough trainees has now improved in line with York trainees.
Assurance has been given by Medical Staffing that inequalities in night-shift allocation over the course of a placement will be identified and affected trainees advised how to place an exception report.
Ability to complete e-learning within specified timeframes remains a concern for trainees.
A trustwide cost code for taxi use is now in place.
Updated guidance is awaited identifying when it is appropriate to call a junior doctor.
The Guardian continues to work closely with the Freedom to Speak Up Guardian where issues raised relate to patient safety.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The work of the guardian will help to inform CQC in the areas of Safety,GoodGovernance, Staffing and Duty of Candour. This report evidences maintenance of these standards. No concerns were raised in recent CQC report.

4.2 Financial/Value for Money:

The new contract is underpinned by the principle that junior doctors are paid for the work they do. Implementation of the contract has cost the organisation a significant amount of money. It is necessary that the Board is aware of the cost considerations of rota designs and the need to ensure appropriate workloads for junior doctors within a model that makes effective use of the whole workforce.

4.3 **Legal and Constitutional (including the NHS Constitution):**
The Learning and Development Agreement signed by the Trust with Health Education England clearly sets out the expectations on placement providers. The organisation must ensure that the work schedules in the new contract allow junior doctors to fulfil their curriculum needs within a sound learning environment.

4.4 **Equality and Diversity:**
The revised 2016 terms and conditions included the responsibility of the guardian to oversee issues relating to Equality & Diversity. The Head of Equality and Diversity is co-opted to the quarterly trustwide Junior Doctor Forum and E&D is a standing agenda item. A Champion of Flexible Working is also in post and positive feedback has been received from trainees.

4.5 **Other implications:**
GMC surveys continue to place our organisation as one of the best training providers for junior doctors in the country. The Guardian is building a good understanding of local training enviroments and can add value to consideration of potential issues raised in surveys. Historically our training schemes have achieved outstanding results in Royal College of Psychiatrists membership examinations. It is important that our junior doctor colleagues continue to believe that we are supporting them in providing an appropriate and safe learning environment.
Recruitment into Psychiatry remains a key concern nationally.
The Guardian has recently met with Audit One, providing assurance.

5. RISKS:

Failure to provide systemic solutions in ensuring Junior Doctor duties are not quantitatively or qualitatively onerous will lead to significant cost and reputational risk, impacting on all areas highlighted in section 4. The loss of GP Trainees in North Durham would have significant implications.

7. CONCLUSIONS:

The organisation continues to comply with the 2016 Junior Doctor Contract and junior doctors are appropriately submitting exception reports which are being handled appropriately. Qualitative safety concerns raised in North Durham have triggered a review, although there has been no contractual breech.
Planned changes to North Yorkshire services include whole system processes to advise schedule revisions to best meet the needs of junior doctors.
The organisation continues to work both systemically and individually on issues arising from vacancies.

7. RECOMMENDATIONS:

The Board are asked to read and scrutinise this report.

Author, Julian Whaley
Title: Guardian of Safe Working

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data

Number of doctors / dentists in training (total):	89
Number of doctors / dentists in training on 2016 TCS (total):	83
Number of clinical supervisors	68
Amount of time available in job plan for guardian to do the role:	2 PA
Admin support provided to the guardian (if any):	5 days per quarter
Amount of job-planned time for educational supervisors: trainee	0.25 PA per

Exception reports (with regard to working hours) from 1st July 2018 to 30th September 2018.

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	0	0	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	1	1	0
F2 - Teesside & Forensic Services Juniors	0	3	3	0
F2 –North Durham	0	3	3	0
F2 – South Durham	0	0	0	0
CT1-2 Teesside & Forensic Services Juniors	0	5	5	0
CT1-2 –North Durham	0	20	20	0
CT1-2 – South Durham	0	8	8	0
Trust Doctors Teesside	0	0	0	0
Trust Doctors – North Durham	0	1	1	0
Trust Doctors – South Durham	0	2	2	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	7	7	0
CT3 – North Durham	0	2	2	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	2	2	0
Total	**0**	**54**	**54**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	10	10	0
Teesside & Forensic Senior Registrars	0	5	5	0
North Durham Juniors	0	26	26	0
South Durham Juniors	0	10	10	0
North & South Durham Senior Registrars	0	2	2	0
Total	**0**	**53**	**53**	**0**

Hours monitoring exercises (for doctors on 2002 TCS only)					
Locality	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**
Teesside & Forensic Juniors	Registrars	43.5	43.5	1B	Yes
Teesside & Forensic Senior Registrars				N/A	
Teesside CAMHS				N/A	
Durham & Darlington CAMHS	Senior Registrars			1B	Yes
South Durham Juniors	Registrars			1B	Yes
South Durham Senior Registrars	Registrars			1C	

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
Teesside & Forensic Services	Trust	New	Unknown	35	35	0	35	x1 vacancy in July x2 vacancies in August (late starters)
	CT1/2	New	Unknown					
	CT3	Old	Unknown					
	CT3	New	Unknown					
	Trust	New	Unknown					
	Trust	New	Unknown					
	CT3	Old	Unknown					
	CT1/2	New	Unknown					
	CT1/2	New	Unknown					
	CT1/2	New	Unknown					
	Trust	New	Unknown					
	F2	New	Unknown					
	Trust	New	Unknown					
	CT1/2	New	Unknown					

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
North Durham	Specialty Doctor	N/A	No	14	14	0	14	0
	GP Registrar	New	No					
	Registrar	New	Yes					
	Registrar	Old	No					
	Registrar	New	Yes					
	Specialty Doctor	N/A	No					
	GP Registrar	New	No					
South Durham	Registrar	Old	Not known	29	29	0	29	x2 until August 2018 and x1 from August 2018 and up until December 2018
	Trust Doctor	New	Yes					
	GP Registrar	New	Not known					
	Registrar	New	Yes					
	Registrar	Old	No					
	Specialty Doctor	N/A	No					
	Trust Doctor (MTI)	New	No					
	Specialty Doctor	n/a	No					
	Registrar	New	Not known					
	Registrar	Old	Not known					
Total				**78**	**78**	**0**	**78**	**6**

Narrative around Exception Reporting

Durham & Darlington

There were 39 exception reports raised during that period for the Durham & Darlington locality. This includes data from 3 rotas – South Durham junior doctors, North Durham junior doctors and North and South Durham Senior Registrars. The majority of the exception reports (26) have come from the North Durham Junior doctor rota as this is a non-resident rota and trainees have been advised to fill an exception report when their on-call work exceeds the additional time that they have been given in their work schedules. The South Durham junior doctor rota has become a resident rota from August 2018.

Teesside

All the exception reports were for work done outside of the work schedule (e.g. enhanced time which isn't included in the schedule for on calls). There were no reports of finishing late, not able to attend educational activities and no achieving breaks, etc.

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data

Number of doctors / dentists in training (total):	51
Number of doctors / dentists in training on 2016 TCS (total):	44
Number of clinical supervisors	47
Amount of time available in job plan for guardian to do the role:	2 PA
Admin support provided to the guardian (if any):	5 days per quarter
Amount of job-planned time for educational supervisors:	0.25 PA per trainee

Exception reports (with regard to working hours) from 1st July 2018 to 30th September 2018.

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F1 - Scarborough	0	7	7	0
F1 - York	0	0	0	0
F2 - Northallerton	No F2 Doctors in North Yorkshire			
F2 - Harrogate				
F2 - Scarborough				
F2 - York	0	0	0	0
CT1-2 - Northallerton	0	3	3	0
CT1-2 - Harrogate	0	10	10	0
CT1-2 - Scarborough	0	18	18	0
CT1-2 - York	0	0	0	0
CT3/ST4-6 – Northallerton	0	3	3	0
CT3/ST4-6 – Harrogate	0	5	5	0
CT3/ST4-6 – Scarborough	0	0	0	0
CT3/ST4-6 – York	0	0	0	0
Trust Doctors - Northallerton	0	13	13	0
Trust Doctors - Harrogate	0	9	9	0
Trust Doctors - Scarborough	0	13	13	0
Trust Doctors - York	0	0	0	0
Total	**0**	**81**	**81**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton	0	19	19	0
Harrogate	0	24	24	0
Scarborough	0	38	38	0
York	0	0	0	0
Total	**0**	**81**	**81**	**0**

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
Northallerton	Trust Dr	Yes	No	2	2	0	2	x1 vacancy from 21/9/18
	Trust Dr	Yes	No					
	Trust Dr	Yes	Yes					
	CT3	No	Yes					
	CT3	No	Unknown					
	Specialty Dr	No	Yes					
Harrogate	Trust Dr	Yes	Yes	21	21	3	18	x1.4 Trust Doctor from Overseas unable to do on call in August & 0.4 vacancy part of a LTFT Post
	Trust Dr	Yes	No					
	Trust Dr	Yes	No					
	Specialty Dr	No	Yes					
	Specialty Dr	No	Yes					
	CT1	Yes	Yes					
	CT2	Yes	Yes					
	CT3	No	Yes					
	CT3	Yes	Yes					
	CT3	Yes	Yes					
	ST5	Yes	Yes					
	ST6	Yes	Yes					
Scarborough	Specialty Dr	No	Yes	18	18	0	18	X1 Vacancy & 0.5 to vacancy part of a LTFT Post
	CT2	Yes	Yes					
	CT3	Yes	Yes					

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
York & Selby	Trust Dr	Yes	No	37	37	3	6	x3 2 not able to do on calls for health reasons.
	Specialty Dr	No	Yes					
	CT1	Yes	Yes					
	CT1	Yes	Yes					
	CT2	Yes	Yes					
	CT3	No	Yes					
	CT3	Yes	Yes					
	CT3	Yes	Yes					
Total				**78**	**78**	**6**	**44**	**6.9**

Narrative around Exception Reporting

York & Selby
There were 0 exceptions during the reporting period in the York & Selby locality, due to York & Selby rota being a resident rota whereby the doctors are paid for every hour they work. The twilight shift has been replaced by a 12noon – 6pm shift on Saturdays and Sundays. Locum shifts arise mainly due to 2 doctors being off night shifts upon the advice from Occupational Health.

Scarborough
During the reporting period there were 38 exceptions from the Scarborough locality. 16 exceptions were due to additional hours worked during the out of hours on call period. However 16 exceptions were submitted as a result of late finishes to the normal working day. These exceptions were mainly from a FY1 doctor and a Trust Doctor in the same service and occurred early into their tenure of post. Those on the Scarborough rota received 2 hours plain time and 1 hour enhanced time paid in their work schedule. Locum shifts have arisen as one of the doctors is not doing on call work and another is LTFT.

Northallerton
There were 19 exception reports raised during the reporting period in the Northallerton locality. The majority of exceptions were due to additional hours worked during the out of hours on call period. Doctors in this locality are paid 2 additional hours at plain rate in their work schedule. There has been a vacancy on the rota since 21 September 2018.

Harrogate
There were 24 exception reports in the reporting period due largely working additional hours when on call out of hours. Doctors on this rota receive 4 hours at plain rate and 1 hour at enhanced rate. Six exceptions were due to late finishes to the normal working day. From 1 August 2018 the rota frequency has increased from 1:7 to 1:6 and as a result of the hours worked when on call doctors on the rota are automatically given a half day rest on the day following their on call. Locums have been needed mainly due to occupational health advice and LTFT doctors.

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 27 November 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 formal meeting held on 01 November 2018

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

Key matters considered by the Committee are summarised as follows:

- The Locality areas of Durham and Darlington and York and Selby and top concerns.
- Patient Safety update
- Compliance with CQC
- Safeguarding & Public Protection
- Positive and Safe report
- Patient Experience
- Progress with the Quality Account Q2

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 01 November 2018.
- Discuss the matter of the lack of an escalation process in community teams.
- Note the confirmed notes of the informal meeting held on 04 October 2018 (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 27 November 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 01 November 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 Durham and Darlington and York and Selby 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 DURHAM AND DARLINGTON SERVICES LMGB

The Committee discussed the LMGB report for Durham and Darlington Services.

The top areas of concern highlighted were:

- A serious staff assault with a weapon on Willow Ward.
- Three serious incidents in CAMH's (unexpected deaths)
- Ongoing bed pressures.

Committee members raised concerns around the following:

- A whistle blowing incident around staff behaviour where student nurses had raised concerns after working on the LD Unit at Lanchester Road Hospital in July 2018.

Assurance was provided that this has been thoroughly investigated and disciplinary action has been taken where necessary. There has also been positive feedback from student nurses since that time.

The Chairman of the Trust sought assurance on the escalation processes surrounding these kind of events which the Board of Directors needs to be cited on at the earliest opportunity.

- The stability of Birch Ward.
  The high use of temporary staffing and the Ward Manager had been off sick for a period of seven months; however recent recruitment has been successful.

4.2 YORK AND SELBY SERVICES LMGB

The Committee discussed the LMGB report for York and Selby.

The top areas of concern highlighted were:

- IAPT challenges linked to agreed prevalence target and recovery rates.
- Financial pressures due to high agency and bank use across the inpatient areas.
- Challenges in CAMHS with capacity, demand and environmental issues.
- Ongoing acuity pressures and delayed transfers of care in Oak Rise.

Action plans and mitigating actions are in place to try to make improvements in these areas.

The main area of concern for Board to note is around the relationship between high caseloads, sickness absence levels and what seems to be the lack of an early warning system when community teams get into difficulties.

The Committee recommended that this matter be escalated to the Board.

4.3 Compliance with CQC Requirements

The Board is asked to note that:

- The Trust has maintained a 'Good' overall rating following the CQC well-led inspection for 2018. It was disappointing to note that the CQC did not amend any of the ratings based on the contested points raised by the Trust.

- An issue has been identified in the CQC Long Stay/Rehabilitation report where staff on Talbot Ward did not identify all ligature points during the environmental risk assessments. The Board can be assured that this Ward is an appropriate environment for the client group and that there is a discrepancy between the CQC inspector's view point and the Trust. Further assurance will come from the Trust wide work on low level ligature points following the recent publication of a Patient Safety Alert.

- In relation to issues raised in CQC Mental Health Act Review inspections during August and September 2018 and problems with patients accessing the Independent mental health advocacy service (IMHA) it was noted that the Trust does have a clear process and policy for this, however it is acknowledged that there is some further reinforcement required to ensure that staff are documenting the information and reviewing the need with service users on a regular basis.

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

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 August 2018.

The key matters of assurance provided to the Board are around several issues that have been raised in Directors Panels and these are currently being tackled at SDG level. Issues identified include the need for relative's family/carers to be involved in attending appointments with the patient, notifications through Paris not being followed up with a telephone call to the service and information sharing between street triage and mental health teams.

Other key matters to highlight are:

- Following a recent inquest a Coroner has written to the Trust suggesting that if Trust staff discover a patient at home in circumstances that could be suspicious that we have a duty to notify the police. It is felt that this would ordinarily be undertaken by ambulance crew but that this matter would be looked into further before responding to the Coroner.

- The draft leaflet, '**Information for families following bereavement'** based on guidance published from the National Quality Board, has been discussed and circulated to some families/carers and other staff groups to gain some additional feedback. The final draft will be brought back to the Patient Safety Group in December 2018.

- A GAP analysis of the National Quality Board guidance on family engagement in learning from deaths has been carried out and is now with the Director of Quality Governance and the Medical Director to agree the action owners. This will be brought back to the Patient Safety Group in November 2018.

There are no significant risks to escalate to the Board.

5.3 Safeguarding and Public Protection

The key matter for the Board to be aware of is a draft report has been received from NHS England following the review of a homicide in York and comments have been submitted by the Trust; there is no confirmed date for publication, however there will be a learning event held with the Trust and other agencies.

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

5.3 Positive and Safe Report

The key matters for the Board to be aware of are:

- Three wards, Evergreen, Westwood and Newberry Centres have been successfully placed into a national collaborative led by NHS England and NHS Improvement to look at improving the reduction of restrictive practice.

- From July to September 2018, the most commonly cited reasons for the use of restrictive intervention were to administer nutrition pharmacy products to patients, which represented 33% of total incidents. In addition incidents involving self-harm were also cited as high contributing 29%. Following a kaizen event last year, recommended changes to the Datix system have now been implemented, significantly, a mechanism has been added to identify if a physical intervention was planned as part of patient care, i.e. NG feed or if it was an unplanned response, i.e. violent incident.

- Comparison between Q2 17/18 and Q2 18/19 shows increases across some of the localities. Services within Tier 4 CAMHS rose the most with a 48% increase. The current Q2 figures identify that the Tier 4 services represent 59% of the Trust total usage.

- It was identified that 10 wards account for 73% of incidents that involved the use of physical intervention. The Evergreen Centre (Tier 4 CAMHS) reported as the highest user for physical intervention with 708 incidents, 29% of the Trust total usage, closely followed by The Westwood Centre with 555. If Evergreen and Westwood Centres figures were to be combined this would represent 52% of the Trust total usage.

- There have been 64 incidents of the use of tear proof clothing in Q2. Some individuals are choosing to go into this clothing, especially at night as it gives them a feeling of safety. Dignity for individuals is protected by the use of de-escalation techniques, however protecting an individual's life is the priority.

- Prone restraint - From July to September 2018, there were 150 incidents that involved the use of prone physical intervention, these incidents involved 58 patients Total figures for last financial year were 579. If incidents were to occur at similar rates as seen during Q2 an estimated annual figure of 684 could be reached, a potential 18% increase.

- Use of prone physical interventions has decreased in a number of localities between Q1 and Q2 18/19. Services in Durham and Darlington have significantly fallen decreasing by 74%, T4 CAMHS services have seen decreases of 18% however use remains high. Increases of 47% within Tees based services can be attributed to AMH services based at Roseberry Park Hospital.

Use of Mechanical Restraint Devices

Following feedback the use of mechanical restraint has been added as a restrictive intervention to be included as part of the on-going Positive and Safe updates. The intervention takes two different forms, firstly as an emergency response cuff (ERC), similar in design to a set of handcuffs made of durable Teflon like material. Secondly as an emergency response belt (ERB), this consists of a long strap 25cm wide, which wraps around the chest, arms and legs of a patient's body fixed with heavy duty Velcro.

Whilst always identified as a last resort typical situations / clinical needs where you may require use of mechanical restraint are as follows:

- The transfer or escort of patients to prison/general hospital/court hearing,
- The prevention of serious harm to the patient/staff or other
- To avoid a prolonged manual physical restraint

For the reporting period, mechanical restraint devices were used on 17 occasions. The highest reported user was Merlin Ward with six episodes followed by Northdale with five episodes and Bedale Ward with four episodes. Collectively the three wards represent 88% of the Trust total usage of mechanical restraint devices.

The 17 reported incidents were reported across only two localities, all 17 incidents were identified as the use of soft restraint cuffs, therefore were likely required to support high risk patients transferring from place to place. There was no reported use of emergency response belts across the quarter.

The first joint Positive and Safe conference was held on 7 November 2018 alongside the Positive and Safe team from Northumberland, Tyne & Wear NHS Foundation Trust.

5.4 **Patient Experience (PEG)**

The Patient Experience report provided assurance that robust systems are in place for monitoring patient and carer feedback and any issues relating to patient experience, with assurances on the monitoring of quality and performance indicator data and planned work streams.

The Board is to note that the style and layout of the PEG report is currently under review to bring out the elements of data and information that are the key matters of assurance and exception for QuAC to discuss, however it will be key that the emphasis is placed on the narrative analysis of the statistics and data for a meaningful discussion to take place between members in the Committee.

5.5 **Quality Account Q2 Progress Report**

The Committee reviewed the progress in Quarter 2 for the Quality Account and Metrics.

The key matter for the Board to note is that further consideration will be given to the narrative in the Quality Account around the numbers of restraints (Metric 3: Number of incidents of physical intervention/restraint per 1000 occupied bed days) to ensure that this is contextualised before sharing with Stakeholders.

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

5.7 **Matters to be escalated to the Board**

- The lack of an early warning system when community teams get into difficulties and how problems are escalated to the Board.

This was in relation to discussion following a Serious Incident in the York and Selby locality where concerns were expressed caseloads, staffing levels and recruitment problems, sickness and absence levels.

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 01 November 2018.
(ii) Note the informal notes of the meeting held on 04 October 2018.
(iii) Note the matter of escalation around the lack of early warning system in community teams in difficulty.

Mrs E Moody
Director of Nursing and Governance
November 2018

Item 1

NOTES OF THE INFORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 04 OCTOBER 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 Shirley Richardson, Non-Executive Director
Mr Richard Simpson, Non-Executive Director
Mrs Jennifer Illingworth, Director of Quality Governance

In attendance:
Mrs Karen Agar, Associate Director of Nursing and Governance
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mr Chris Williams, Chief Pharmacist
Dr Pratish Thakkar, Deputy Medical Director, Forensic Services
Mrs Rachel Weddle, Head of Nursing, Forensic Services
Dr Lenny Cornwall, Deputy Medical Director, Tees Services
Mrs Karen Atkinson, Head of Nursing, Tees Services

18/124 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs Ruth Hill, Chief Operating Officer, Mrs Lisa Taylor, Director of Operations, Forensic Services, Mrs Elizabeth Moody, Director of Nursing & Governance, Mr Dominic Gardner, Director of Operations, Tees and Dr Ahmad Khouja, Medical Director.

18/125 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 06 September 2018 were agreed as true and correct, subject to the correction of action 18/92: which should state Mr Levi Buckley as the action owner.

18/126 ACTION LOG

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

18/75 Chief Executive to be informed of instances where Blik alarms not working.
It was noted that there had been no reported incidents of any alarms not working, however staff did have alternatives should this arise. It would be important to communicate quickly to staff once the fire rectification works (mist system) were completed at Roseberry Park.

18/92 Durham and Darlington risk register regarding medical staffing currently scored at 20 to be aligned to the risk on the Board of Directors' risk register and scored at same level.
Since the Durham locality was not present at the meeting this would be checked and confirmed at the November 2018 QuAC meeting.

18/106 NY LMGB service: clarification needed on page 6 and page 3 of the report with further assurances and the risks around adult eating disorders.
This information was circulated to Committee members following the meeting.

Completed

18/107 Y&S LMGB report: look into the reasons why two recruited band five posts had withdrawn their applications.
This information had been circulated to Committee members.

Completed

18/110 Placing automated defibrillators into non-patient settings: develop and cost proposals further for EMT to consider and report back to QuAC.
This matter was deferred to the November 2018 QuAC meeting.

18/117 Quality Account: advice and recommendations from QuAC to be provided for the Board Business Planning Workshop.

Completed

18/112 Infection, Prevention and Control Report to be uploaded to Boardpad for those members that had not received the report.

Completed

18/118 Issues around mechanical restraint to be included in future LMGB reports.
It was noted that an email had been sent to the Lead Directors to request this in future reports, however the action would be left on the action log to check that this was taking place.

18/127 FORENSIC SERVICES LMGB REPORT

The Committee received and noted the Forensic Services LMGB Report.

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

(1) New care models.
The partnership goal to deliver a shared vision across the North East to improve patient care had seen a substantial amount of work undertaken in the first 12 months, with most notably the strengthening of partnership working across services in the two organisations of NTW and TEWV.

(2) Business Planning
Following the annual Forensic Business Planning Away Day in September 2018 an ongoing priority for the service would be to embed recovery and a third recovery focused RPIW event had been planned for January 2019.

(3) Tear proof clothing
The Forensic Head of Nursing and Positive and Safe Lead Nurse were developing a clinical procedure initially with a Tees/Forensic task and finish group which would ultimately go out for Trust Wide consultation.

On this matter it was noted that one individual within Thistle had specifically requested tear proof clothing in order to prevent self-harm and an individualised and collaborative plan had been devised. In this kind of instance the use of tear proof clothing would not be considered a restrictive intervention.

(4) NHS Digital transformation and the roll out of Wi-Fi across the Trust from October 2018.
There were concerns around potential open access to Wi-Fi for some devices, which could reach into secure wards.
Over the last year Forensic services had relied on the restrictive practice framework and looked at individual risk. This matter would be discussed further at the Specialist Network meeting and an update brought back to the November 2018 QuAC meeting.
Assurance was provided that open Wi-Fi access would not be granted to all wards.

Following discussion concerns were raised over:

(1) The increased levels of violence and aggression in Holme House due to prisoners taking drugs and the impact this had on visiting clinical staff, meaning they had not been able to see patients at times.
The Deputy Medical Director noted that safety measures were taken when visiting the patients and that clinical staff did not see individuals alone.
(2) The use of IM Clozapine on an individual over a prolonged period of time.
On this matter it was noted that the appropriate approval and governance arrangements had been in place for the use of IM Clozapine for 14 days, with a gap of seven days and then a further 28 days of using the drug. This had been the first time that this treatment had been tried and the individual was unfortunately one of the most unwell that the Service had ever seen. The treatment had been discontinued.
(3) Low staffing with the submission of 11 datix incidents.
This mainly related to one of the FLD units in Middlesbrough where there were issues around staff breaks on night shifts and whether it was a break if taken on the ward area as the ward does not currently have an allocated staff room. Appropriate Trust processes are being followed to address these concerns.
(4) The use and impact of non-recovery focused terminology.
The Head of Nursing explained that service users and staff were using words such as "strongs", instead of tear proof clothing, not necessarily recognising that this was not recovery focused. Assurance was provided that challenges would be made in a gentle and subtle way to try and discourage habitual language.

18/128 TEES SERVICES LMGB REPORT

The Committee received and noted the Tees Services LMGB Report.

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

(1) The ongoing issue of lack of nursing home provision and the impact this was having on inpatient bed capacity as well as concerns relating to safeguarding.
(2) High levels of bed occupancy within Adult Mental Health Services and the previously raised issue of bed capacity across the Trust as a whole, which is an area of focus for EMT.
(3) Consultant Psychiatrist recruitment within Children and Young People's Services and the inability to recruit locum cover.
On this matter it was noted that there had been discussions around asking other Directorates to report to LMGB with a staffing plan on how potential staff reconfiguration and managing differently might support the shortage.

Following discussion it was noted that:

(1) It was disappointing to note that the introduction of the MCA forms had not gone well with Consultant staff in inpatient areas, reporting a negative impact on people's time and limited resource.
Committee members asked how this would be reviewed and this would be followed up by the Head of Mental Health Legislation.
(2) There would be adequate future support in place for patients discharged back to their GP with dementia and no additional identified needs.
On this matter it was noted that there were over 200 individuals currently on the MHSOP caseload and should patients have vascular dementia with no change in symptoms then they

could be discharged back to their GP with a very clear plan on how they could return to services if required.

(3) A serious incident report had identified a number of learning points in relation to the management of Lithium, care planning and the use of the Lithium register. This would be picked up and monitored through QuAG.

(4) The matter concerning the provider in Loftus (PIPS) and safeguarding which had been referred to the CQC had been resolved with no outstanding issues or concerns.

The Committee congratulated the team in MHSOP services for being shortlisted within three categories for Royal College of Psychiatry Awards.

18/129 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee received a verbal update on Compliance with CQC Registration Requirements.

The following matters were highlighted:

(1) The Trust had undergone a significant piece of work over the last few weeks to check for factual accuracy following receipt of the initial inspection report from the CQC on 17 September 2018. A substantial document detailing factual inaccuracies had been submitted back to the CQC. Advice had also been taken from Beechcroft Solicitors about the content of the CQC report, which had caused the Trust some concerns.

(2) The timescale for the final CQC report was not known, however for the November 2018 QuAC meeting there would be a fuller report.

The Chief Executive expressed on behalf of the Trust, appreciation for the time and effort that members of staff had spent working through the CQC report.

18/130 CLINICAL SUPERVISION FOLLOWING THE 90 DAY REPORT OUT

The Committee received a verbal update on Clinical Supervision following the 90 day report out.

The key matters highlighted were:

(1) There had been extremely positive staff feedback following a Kaizen event on clinical supervision with staff now booking in regular supervision sessions, with the biggest turn around amongst HCAs.

(2) Training had also had an impact with the expectation to be fully compliant against the performance standard by November/December 2018. The training for newly qualified preceptorship nurses commencing in Tees had also been introduced. The training package would be reviewed with the possibility of a 'train the trainer' approach to be explored, which would support training and the roll out of the work across the organisation.

18/131 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Group Report and the Patient Safety Group Quality Report for July 2018.

The following matters were highlighted from the report:

- A leaflet for families to be used following bereavement had been drafted based on NQB Guidance Learning from Deaths. This would be discussed at the Patient Safety Group and then sent out for wider Trust wide consultation.
- The appropriate use of mobile phones in the community setting, which had arisen following a patient not able to contact the community service by telephone.
  Assurance was provided that this had been discussed by adult SDG and some guidance would be issued for use Trust wide.
- Learning from suicide related claims. A thematic review of suicide related claims had been undertaken by NHS Resolution and the recommendations were being considered with an action plan to be devised.

Members expressed concern over the high numbers of prone incidents and how the Committee could differentiate between the significance of intentional prone and unintentional prone restraint.

It was noted that Tees were looking at every incident of prone across the service and were also checking for recording errors and the information would be reported through to LMGB.

Mrs Illingworth undertook to contact the reporting team to establish any prone restraint used for feeding in order to clarify and improve recording errors.

18/132 UPDATE ON CLINICAL AUDIT OF EMERGENCY RESPONSE BAGS

The Committee received a verbal update on the Clinical Audit of Emergency Response bags with a request to defer this item to the December 2018 QuAC meeting following revision of the Resuscitation Policy and some work required to establish a comprehensive list of the location of all response bags.

18/133 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 there were various serious case reviews underway across the locality areas with 16 in Durham.
On this matter it was noted that there was no known reason why Durham was an outlier and higher than the other localities, however it was clear that there could be some improvements made to the legal processes and this would be followed up by the Safeguarding team.

Following discussion around identifying risks and vulnerability from others to individuals, members considered that it would be useful to set out some risk factors around vulnerability for the use in assessment of individuals, which would be fed into the harm minimisation work.

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.

18/134 DRUG AND THERAPEUTICS REPORT

The Committee received and noted the Drug and Therapeutics report.

The main issues highlighted were:

(1) Consideration was being given to the 'Falsified Medicines Directive', which involves a change in legislation for all medicines that were manufactured from February 2019 to have a barcode for scanning to verify that they are legitimate. The ramifications around processes and any

financial implications to ensure compliance would be worked through, but it was noted that this will not be for the February timescale.

(2) A recommendation from the CQC Safer Management of Controlled Drugs Annual Report around consideration of regular monitoring and auditing for controlled drugs in the lower schedules. For the latter an electronic support system would be considered.

A query was raised which linked to the previous Tees LMGB report where it stated that there had been difficulties due to a shortage of pharmacy staff.

The Chief Pharmacist noted that this was in relation to the lithium registers which had been maintained by three members of administrative staff. Since the path lab results had not yet been successfully placed onto Paris and the staffing numbers had reduced, recruitment to a three day post had commenced.

18/135 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no matters of exception to note.

18/136 ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD

There were no matters to escalate to the Board.

18/137 ISSUES DISCUSSED THAT MIGHT IMPACT ON THE TRUST'S STRATEGIC OR KEY OPERATIONAL RISKS

There were no issues that impacted on the Trust's risks.

18/138 INTRODUCTION OF QUALITY ASSURANCE COMMITTEE ASSURANCE TRACKER

The Committee received a draft Quality Assurance Committee Assurance Tracker.

Following discussion various suggestions were put forward for improvement to the Tracker, such as including more narrative around the assurance provided, any matters that were referred to the Board and to provide a reference link to the minute from which the matter relates. It was acknowledged that the tracker would be a work in progress and it would be helpful to consider the Audit Committee tracker with the next agenda and papers. Ms Oliver undertook to take this forward.

18/139 COMMITTEE EVALUATION

Members expressed no concerns around the meeting, agenda and reports.

18/140 ANY OTHER BUSINESS

There was no other business to discuss.

18/141 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 01 November 2018, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

The meeting concluded at 4.00pm

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th November 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:

This report is an exception report for the Trust Board, regarding the monthly staffing of in-patient wards across the Trust.

Assurance Statement:
The Trust is meeting its requirements for safe staffing within the current legislative framework as set out in section 2.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**28th November 2018**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**

1. INTRODUCTION & PURPOSE:

1.1 This report is to provide a monthly written exception report to the Trust Board to highlight any issues of note or concern.

1.2 This is in addition to the report required by the Board on a six monthly basis. This report refers to October 2018 data.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The monthly reporting of daily staffing levels is a requirement of NHSE and the National Quality Board in order to appraise the Trust Board and the public of staffing levels within inpatient wards.

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013 and subsequent update of the NQB 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

Staffing related to inpatient units has been coordinated during October, through the participation of inpatient services in daily huddles to review and understand staffing levels across sites and specialties. This has allowed for the staffing resource to be used in the most effective way to ensure high quality, patient centred care continues to be delivered safely across all inpatient units.

Themes remain consistent with previous issues that the Board have been appraised of with planned staffing not always met due to sickness, vacancies and high levels of patient acuity.

Where green fill rates were not achieved, patient safety on in-patient wards was maintained by nurses working additional unplanned hours, staff cross covering across wards, temporary staffing, the multi-disciplinary team and ward manager supporting nursing staff in the delivery of planned care and patient care being prioritised over non-direct care activities. Specific exceptions where safety concerns have arisen have been reported through Datix and escalated through operational management to action.

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
November 2018

Appendix 1

Safe Staffing Report – October 2018:

Safe Staffing November Report usi

Safe Staffing – October 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 October 2018:

- The number of rosters equated to 69 inpatient wards in October.
- The highest number of red fill rate indicators relate to Registered Nurses on day shifts. This equated to 19 in October 2018, a decrease of 7 when compared to September 2018.
- The top 3 inpatient areas where a low staffing fill rate has been reported are:
  - The Lodge – 38.5% HCA on Days and 67.7% HCA on Nights – the shortfall is in relation to a private provider who is working into the Lodge as part of the transition.
  - The Orchards (NY) – 51.6% RN on Nights; 81.6% 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.
  - Esk Ward – 55.4% RN on Days – the shortfall is in relation to vacancies. The shifts are being filled utilising HCA, bank, agency and overtime. The ward has confirmed that all shifts had a nurse in charge.
- There were 75 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:
  - Acomb Garth – 295.4% HCA on Nights and 209% HCA on Days – the increase is due to meeting clinical demand with high levels of acuity and close levels of observations. Staffing levels are verified with senior managers each week day.
  - Westerdale South – 287.1% HCA on Nights and 209.7% HCA on Days – the increase is due to high acuity including 4 x enhanced observations for the majority of the month.
  - Springwood – 254.1% HCA on Nights and 127.6% HCA on Days - the increase is due to patients having a high level of dependency and sustained high levels of enhanced observation.

Bank Usage:

- The bank usage across the trust equated to 16.9% in October, a reduction of 1% when compared to September.
- There were no wards reporting 50% bank usage in October.
- Lark reported the highest bank usage at 36.1% of the actual hours worked. Sickness was the highest reason given for requesting bank (41 shifts) followed by vacancies (29 shifts).
- There were 14 wards that reported greater than 25% bank usage.

Agency Usage:

- The agency usage across the trust equated to 7.2% in October, a decrease of 0.4% when compared to September.
- Cedar Ward (NY) reported the highest equating to approximately 54.8% of the total hours worked. Vacancies were cited as the highest reason for this (141 shifts). The ward is using regular agency where possible.
- Those wards reporting 4% or more agency usage in October equated to 27 wards.
- Retinue key highlights:
  - Fulfilment levels dropped by 3% to 80% in October.
  - Total demand has increased by 95% since the contract started and filled shifts demand has remained the same at a 169% increase since October 2017. October saw the largest number of shifts filled since the contract

Produced: 14th November 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.

began (1487) 4 more than the previous amount
  - Fulfilment for HCA's decreased from 85% to 82% during October with 18 more shift requests being observed in October.
  - Increase in shifts filled for RN's with record numbers of shifts filled in October. RN fulfilment is up to 73% in October.
  - Usage across Acomb Garth increased in October. Other areas with high demand are Meadowfields, Oak Rise, Rowan Ward and Springwood. Much the same as September.
  - Areas with lowest fulfilment – Birch ward, Elm ward, Langley, Oak, Ward 14 and Willow ward. These are the areas with fewer requests than other areas with larger fulfilment. A similar trend seen most months.
  - The total number of no shows reported for October increased from 13 to 18. 'No shows' as a percentage of shifts filled is 1.21%.
  - Average monthly spend of £262k from October 2017 to October 2018; a decrease of £8k on last month.
  - Overall spend now sits at £3.41m. HCA attributes to 75% of the overall spend.

Missed Breaks:

- There were 355 shifts in October where an unpaid break had not been taken. This is an increase of 6 when compared to September 2018.
- The majority of the shifts where breaks were not taken occurred on day shifts (270 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 85 shifts in October 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 29 incidents reported in October 2018 citing issues with staffing.
- Issues reported were as follows:
  - Staff and patient safety compromised
  - Only 1 member of staff left on duty
  - Unable to take required breaks
  - Patient needs not being met.
  - Insufficient staff leaving ward environment unsafe

Severity Rating:

- Using a severity rating scale to identify potential outliers, the top 5 is as follows:
  - Newberry Centre – 11 points awarded
  - Eagle ASD – 9 points awarded
  - The Evergreen Centre- 9 points awarded
  - Birch Ward – 9 points awarded
  - Northdale Centre – 9 points awarded
- Using the YTD score (Oct 17 to Oct 18) the following appear in the top 5:
  - Cedar (D&D) – 104 points awarded
  - The Evergreen Centre – 101 points awarded
  - Bedale Ward – 99 points awarded
  - Westerdale South – 97 points awarded
  - Ward 15 – 87 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 December 2018 (delayed due to a technical issue with the template) and will be reported alongside our current fill rate and nursing CHPPD.
- CHPPD overall rating for September is reporting at 13.24 (5.0 registered nurses and 8.2 unregistered nurses) this is an increase of 2.94 when compared to September.
- Using standard deviation (Oct 17 to Oct 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 –October 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 Foundation Trust

ITEM NO 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

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

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

Executive Summary:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 2, 2018/19.

- **Key areas for consideration:**
- Report on Discharges from Detention, use of Section 136, AWOL Report
- Seclusion activity report
- Seclusion and Segregation Procedure
- Section 5 MHA 1983 (Holding Powers)
- CQC report
- Report on MCA and DoLS
- How we might improve diversity of Associate Hospital Manager Body through recruitment practices
- Patient case study

Recommendations:

The Board of Directors is asked to receive and note the assurance report, following the MHLC meeting held on 18 October 2018 and to note the approved minutes of the MHLC meeting held on 12 July 2018. (Annex 1)

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

1. INTRODUCTION & PURPOSE:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for Quarter 2, 2018-19; through consideration of the work of the Mental Health Legislation Committee at its meeting held on 18 October 2018.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

The confirmed minutes of the Mental Health Legislation Committee held on 12 July 2018 are attached as Annex 1.

The MHLC also met on 18 October 2018. The key issues considered at this meeting were as follows:

COMPLIANCE WITH MHA PROCESSES

3.1 Discharges from Detention

The Committee considered the Discharges report.

- In Quarter 2 there were 138 Associate Hospital Managers reviews held which resulted in one patient being discharged from a section 3. This was against the recommendation of the clinical team. The individual remained informally, was discharged five days later with no re-admission.
- The total number of Mental Health Tribunals held in Quarter 2 was 135, of the MHTs held, 5 resulted in discharge from section 2, 5 patients from section 3 and 3 patients discharged from a CTO, 2 patients were conditionally discharged from section 37/41 (including 1 deferred.

The Board can be assured that there continues to be comprehensive reports and clear evidence for the reasons in recommending continued detention/community treatment, despite there being occasions when the Tribunal disagrees with the clinical team and proceeds to discharge the patient.

3.2 Section 136

The Committee considered data and trends around s136.

- There were 188 uses of s136 across the Trust compared to 189 in the previous quarter. There has been a sharp increase for Durham who had 31 (16 in the previous quarter) and a decrease for Harrogate 29 (41 in the previous quarter) and York 29 (40 previous quarter).

- Of those, 40 people were formally detained and 40 accepted informal admission. 68 were followed up in the community and 39 returned to the community without follow up.
- There were 7 individuals under the age of 18 years of age held under section 136, all aged 16 or 17.
- Assurance was provided that the overall use of s136 across the Trust shows a TEWV place of safety being used as the optimum choice and police stations were only used 3 times in the last quarter.

3.3 **Absence without Leave (AWOL)**

The Committee discussed this new report, which will be provide six monthly data to the MHL Committee showing the details, frequency, type and outcomes of all patients absent without leave reported on Datix or to the Mental Health Legislation Team.

Assurance was provided that there was no correlation between patients absent without leave and patient leave that had been cancelled. Also, that for all patients absent without leave Section 18 of the Mental Health Act had been used appropriately.

COMPLIANCE WITH KEY CODE OF PRACTICE REQUIREMENTS

3.4 **Seclusion**

The Committee discussed the seclusion report.

- In Q2 there were 89 episodes of seclusion with multiple episodes for patients. Of the 82 episodes, 38 were less than 24 hours, of which 12 were under 12 hours.
- The highest number for multiple seclusion was 8 episodes.

The Board can be assured that there are no exceptions to note.

3.5 **Seclusion and Segregation Procedure**

The Committee approved the revised Seclusion and Segregation procedure.

Assurance was sought that all periods of seclusion are constantly observed and a record made every 15 minutes and this was confirmed.

3.6 **Section 5 MHA 1983 (Holding Powers)**

The Committee received a new report around the use of Section 5(4) nurses holding power and section 5(2) doctors or AC holding power.

- This six monthly exception report will detail occasions where Section 5(4) and Section 5(2) has been allowed to lapse or where the outcome was not usual or lawful.

- There have been 368 uses of Section 5(4) and 5(2) within the last year and assurance was provided that the Trust can demonstrate it captures information regarding the use of these holding powers and that any lapses or issues are investigated to ensure there have been no adverse effects.

EFFECTIVE IMPLEMENTATION OF THE MCA AND DOLS

3.7 Mental Capacity Act and DoLS

The Committee discussed the quarterly update report.

The key matters discussed were:

- In terms of DoLS activity, in Q2 there were 2 applications in Middlesbrough in respite services and 8 in Stockton, also for respite services.
- There were 42 active cases across the Trust, however there were still delays on assessments being completed by Middlesbrough Council and this would be pursued.
- An audit of Mental Capacity Act compliance will commence in November 2018 to examine individual case records to assess the quality of information recorded to determine if there have been any improvements in quality since the new documentation and mandatory training.
  At the time of the MHL Committee meeting this had not yet taken place and an update will be taken back to the MHL Committee in January 2019.

KEY GOVERNANCE INFORMATION

4.0 CQC Report

The Committee discussed the CQC update report.

The key matters highlighted were:

- There were 16 MHA inspections in 2018/19 year to date and a review of key themes has been undertaken.
- Care planning (raised 7 times on 7 wards) has been over taken by issues raised by patients (raised 12 times on 4 different wards).
- Where issues have been raised a Provider Action Statement has been completed, approved by EMT and returned to the CQC to provide assurance that actions were being resolved.

HOW IS PARTNERSHIP WORKING ARRANGEMENTS WITH OTHER AGENCIES WHO ARE INVOLVED IN THE MHA MANAGED LOCALLY?

5.0 How we might improve the diversity of Associate Hospital Manager body through recruitment processes

The Committee discussed a question prompted by a Governor regarding the recruitment process for Associate Hospital Managers.

The key issues are:

- Recruiting is difficult and new Hospital Managers often come from recommendations from the existing pool of Hospital Managers and there is a lack of diversity around ethnicity and age for these roles.

- To increase the diversity of the Associate Hospital Managers, the Committee agreed that it could be beneficial to make inroads into the Asian community in Teesside and this would be taken forward by the Equality and Diversity Lead.

HOW THE EXPERIENCES AND VIEWS OF DETAINED PATIENTS FORM PART OF THE COMMITTEES CONSIDERATIONS

6.0 Case Study

The Committee noted the regular case study, which was in relation to an individual transferred from seclusion on one site to seclusion at another site.
Assurance was provided that the care provided to the complex individual had been challenging, with assault to staff members and a table top exercise was arranged to look at any lessons that could be learnt.

6.1 Issues that could impact on the Trust's Strategic or key operational risks

There were no concerns at present, however the progress with MHA information being made available on IIC would be pursued.

7.0 IMPLICATIONS:

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

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

7.2 **Financial/Value for Money:**

There are no implications.

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

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

7.4 **Equality and Diversity:**

There are no implications.

8. CONCLUSIONS:

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

9. RECOMMENDATIONS:

The Board of Directors is asked to:

(i) Receive and note this report including the confirmed minutes of the meeting of the MHLC held on 12 July 2018.

Richard Simpson
Chairman of the Committee
27 November 2018

Background Papers:
Annex 1 – Confirmed minutes of the 12 July 2018 MHL Committee Meeting

Annex 1

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 12 JULY 2018 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM.

Present:
Mr R Simpson, Non-Executive Director, Chairman of the Committee
Mr P Murphy, Non-Executive Director
Mrs S Richardson, Non-Executive Director
Mrs E Moody, Director of Nursing & Governance
Dr A Khouja, Medical Director
Mr C Allison, Public Governor, Durham

In Attendance:
Mrs D Oliver, Deputy Trust Secretary, (Corporate)
Miss M Wilkinson, Head of Mental Health Legislation
Mrs J Illingworth, Director of Quality Governance

Apologies: Apologies for absence were received from Mrs J Ramsey, Mental Health Team Manager and Mr D Brown, Acting Chief Operating Officer.

18/33 MINUTES OF LAST MEETING

Agreed – *That the minutes of the last meeting held on 19 April 2018 be approved as a correct record and signed by the Chairman.*

18/34 ACTION LOG

The Committee noted the actions and following updates:

17/33 Benchmarking – talk to NTW about seclusions.
It was noted that there had still been no response from NTW and this would be chased again and brought back to the October 2018 meeting.

18/06 Discussion with SDG's and SDM's about importance of completion of formal capacity assessment on MCA1 form.

It was noted that the Medical Director had sent out communication regarding this matter.

Completed

18/13 Issue with AMP's sourcing doctors for assessments leading to delays. Then to be raised at Director of Ops meeting and LMGBs.
Following discussion around this ongoing issue, Miss Wilkinson undertook to go to the Operational Group meeting and quarterly Partnership meetings to find out the extent of the problem and then report back to MHLC by exception.

Completed

18/18 Discharges from Detention report to highlight safeguarding patients and that patients are exercising their rights linked to the number of tribunals held.

Completed

18/19 To check all information is reviewed for patients waiting over 12 hours.

Completed

18/19a Report in the case study the individual taken to a police station when Scarbrough and York were full to look at the levels of escalation and processes followed.
This matter was covered under agenda number 8 (minute 18/ refers)

Completed

18/19b Further discussion to take place around why S 136 being used more in York and North Yorkshire. To be raised at the next York Operational Group meeting. Mr D Brown to ensure that there is locality representation on that group.

It was noted that this meeting had been adjourned due to being inquorate, and a subsequent date was also cancelled.
Mrs Moody undertook to escalate this to the Director of Ops meeting to ensure attendance going forward.

Action: Mrs E Moody

18/20 Separate out CQC Feedback Report and frame sections around high quality questions.
This was deferred to the October 2018 MHLC meeting.

18/22a Thematic review and key themes to be communicated to medical staff via an exceptional Medical Director's bulletin.

Completed

18/23 CQC report: embedded documents (page 8) with information sent to localities contained in the report to be placed in the reading room on Boardpad.

Completed

18/24 Schedule of audit reports: Internal audit reports to be presented to MHLC as required in liaison with Head of Quality Governance and Compliance.

Completed

18/35 DISCHARGES FROM DETENTION REPORT

The Committee considered and noted the MHA Discharges Report.

The following was highlighted from the report:

(1) In Quarter 1 there were 142 Associate Hospital Managers reviews held which resulted in one patient being discharged from a CTO. This was against the recommendation of the Community RC and Care Coordinator.

(2) The total number of Mental Health Tribunals held in Quarter 1 was 128, of the MHTs held, seven resulted in discharge from section 2, two patients from section 3 and one patient discharged from a CTO.

(3) There had been no trends identified in relation to RC or team where a MHT had discharged contrary to the clinical view.

Following discussion it was noted that the Trust was below the national average for the rate of discharge and the lower rate provided assurance with compliance with the Mental Health Act. Members requested that future reports state the national figure for comparisons to be made.

Action: Mrs J Ramsey

Assurance was provided that there continued to be comprehensive reports and clear evidence for the reasons in recommending continued detention/community treatment, despite there being occasions when the Tribunal disagreed with the clinical team and proceeded to discharge the patient. This however continued to be in only a minority of cases.

18/36 SECTION 136 REPORT

The Committee received and noted the Section 136 report.

The following was highlighted from the report:

- There had been 189 uses of s136 across the Trust compared to 180 in the previous quarter. There had been increases for North Yorkshire (99 to 110) and Cleveland (34 to 42).
  Of those, 47 people were formally detained and 21 accepted informal admission. 87 were followed up in the community and 34 returned to the community without follow up.
- The overall use of section 136 across the Trust had shown a TEWV place of safety (PoS) being used as the optimum choice with police stations only being used five times across the whole Trust area in the last two quarters.
- There were 13 individuals under the age of 18 years of age held under section 136, all aged between 14 and 17, one was held on a 136 twice in the quarter and another four times, both are open to services.

Following discussion the following was highlighted:

(1) Members expressed concerns over the use of police stations as places of safety and requested some further analysis. Mrs Ramsey undertook to investigate this further and provide some further explanatory narrative in future reports.

Action: Mrs J Ramsey

(2) An individual had been held on a Section 136 in York for 24 hours and 46 minutes, which had not been extended due to the fact they were asleep for ten hours and could not be roused. Mrs Ramsey undertook to check the details of this case and circulate the information to Committee members.

Action: Mrs J Ramsey

Assurance was provided that there were escalation processes in place for anyone held over eight hours and in this case the time could have been extended when the individual was asleep. This was something that would be fed back to the clinician.

18/37 EXAMPLE OF A SECTION 18 REPORT – RETURN OF PATIENTS ABSENT WITHOUT LEAVE

The Committee received for consideration an example of a previous Section 18: Absent without Leave Report that had been reported to the Mental Health Legislation Committee.

As part of the overall review of the Committee and reporting and assurance levels this report was considered as something that could be included in future meetings. It had also been an issue raised previously by the Council of Governors.

Agreed: *that the Mental Health Legislation Committee would receive a six monthly report on Section 18: Absent without leave commencing in October 2018.*

18/38 SECLUSION REPORT

The Committee considered and noted the Seclusion Report.

The following was highlighted:

- In Q1 there had been 82 episodes of seclusion with multiple episodes for 13 patients. Of the 82 episodes, 29 were less than 24 hours, of which 15 were under 12 hours.
- It was noted that the revised Seclusion Policy was currently out for consultation and would be taken to the 18 October 2018 Mental Health Legislation Committee meeting.

Action: Miss M Wilkinson

Assurance was provided that there were no exceptions to note.

18/39 CARE QUALITY COMMISSION (MHA) VISIT FEEDBACK SUMMARY REPORT

The Committee received a verbal update on the Care Quality Commission MHA visit feedback with no exceptions to note.

The key matter to note was some work that would take place on the future reporting of CQC MHA visits to the Committee and how this would feature on the MHLC agenda in future. This would evolve over the next few meetings.

18/40 CODE OF PRACTICE POLICY SCHEDULE

The Committee received a verbal update on the code of Practice Policy Schedule.

Assurance was provided to the Committee that all policies had been reviewed to ensure compliance against the Code of Practice and were within date.

It was proposed that going forward the MHL Team would liaise with the Trust Policy Manager in order to keep up to date on policies coming up for review and then a decision would be made as to the relevance for the MHL Committee.

18/41 MENTAL CAPACITY ACT AND DOLS REPORT

The Committee received and noted the quarterly update report on the Mental Capacity Act and the use of DoLS.

Arising from the report it was noted that:

- The TEWV Deprivation of Liberty Safeguards data was now being captured electronically.

- Mental Capacity Act training would now be mandatory for staff of all disciplines; would be provided via e-learning with some face to face training and the MCA policy had been updated.
- Paper recording had been replaced by forms MCA 1 and MCA2 being uploaded onto Paris and had been well received by staff.
- In terms of DoLS activity, in Q1 there were 49 active cases.

18/42 DRAFT ANNUAL SCHEDULE OF REPORTS TO MHLC

The Committee received and noted the draft annual schedule of reports to the Mental Health Legislation Committee.

Following discussion around Section 62 and emergency treatment for detained patients and the responsible clinician the Medical Director undertook to initiate further discussion around the process for SOADs and that a report would be provided to the January 2019 MHLC meeting.

Agreed*: the Annual Schedule of Reports to the Committee, including an annual report to be included on Section 62.*

Action: Miss M Wilkinson

18/43 CASE STUDY

The Committee received and noted a case study in relation to an individual taken to a Police station on Section 136 in March 2018 due to Scarborough and York places of safety being full.

Assurance was provided that that the patient had been detained appropriately.

18/44 TRUST'S STRATEGIC RISKS

There were no issues raised that might impact on the Trust's strategic risks, however members discussed ongoing concerns around the MHA information not being available on the Trust system IIC. This matter would be pursued with an update at the October MHLC meeting.

18/45 ANY OTHER BUSINESS

Revised Procedures

The Committee received for approval the following procedures:

(i) Independent Mental Health Advocacy (IMHA)
(ii) Section 132/132A MHA – providing information to patients and patients' nearest relatives
(iii) Patients' correspondence – section 134 Mental Health Act 1983

Agreed: *to approve the procedures.*

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th November 2018**
TITLE:	**Self-Assessment Report in relation to Multi-professional Education and Training – Health Education England**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Sign off**

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

Executive Summary:

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

- It is an annual requirement to submit this multi-professional return. Information is requested from professional leads, and the Workforce Development and other HR teams, and consolidated into a single joint report by the Medical Development and Professional Nursing Education teams, supported by the Director of Therapies.

- The emphasis this year has been on a single joint report from all professions, whereas in previous years there was a separate medical report which was then taken to a joint review meeting process. Colleagues have worked across the professions to identify the key Trust developments and issues for this latest report and confirmed these with relevant Directors.

- The information is assessed by HEE and then ordinarily taken to a scrutiny meeting with HEE colleagues for further questions and assurance, known as the Annual Dean's Quality Meeting (ADQM).

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

- The meeting with HEE to scrutinise the report will be held on the 22nd March 2019. The Trust has previously enjoyed overall positive feedback on its approach at these meetings, and last year's meeting was ultimately stood down as HEE were satisfied from the report and other indicators they have, that a formal review was not required.

Recommendations:
The Board are recommended to receive and endorse the multi-professional SAR report attached, and raise any associated questions regarding the educational framework across the Trusts professions

MEETING OF:	**Board of Directors**
DATE:	**27th November 2018**
TITLE:	**Self-Assessment Report in relation to Multi-professional Education and Training – Health Education England**

1. INTRODUCTION & PURPOSE:

1.1 The paper summarises the process around the attached report, which comprises the Trust response to the annual Health Education England education assessment process for multi-professional training.

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 In previous years there has been a separate Medical Development report. For this year, a single report was requested, which maintains detail on medical and non-medical requirements in some of the sections but asks for an overall Trust position on the key issues. There were also individual profession templates submitted during the process to help capture the various perspectives.

2.3 The information was compiled by the Medical Development team and Nursing and Governance Directorate following information exchanges with the Director of Therapies, Heads of Profession, the Workforce Development and other HR teams, and Library services.

2.4 The multi-professional information within the SAR is reviewed externally by HEE including the involvement of their own professional advisors in certain fields. Questions are framed regarding the Trust response for further clarity These indicative questions are taken to an Annual Dean's Quality review Meeting chaired by HEE (ADQM) for further scrutiny and discussion, and any actions agreed.

3. KEY ISSUES:

3.1 The attached report provides a summary of key issues agreed within the working group, followed by specific questions related to medical and nonmedical multi-professional development.

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

3.3 Key successes highlighted within the report include;

- The 2018 GMC annual survey of trainees in which the Trust was ranked 5th in England and 8th overall in the UK. It has continued to be the first ranked trust for medical training in the North East region over the last 6 years.

- The Trust extensive approach to widening access to professional education and training including the use of the apprenticeship levy. Within this, the Trust has worked in collaboration with a local University and other local Trusts to establish a part-time Pre-Registration Nurse Apprenticeship programme which was commended for innovation by the Nursing and Midwifery Council at the validation event.

- Dietetics development- The Trust instigated discussions with Teesside University to develop the first pre-registration Dietetics degree in the North East region. The first cohort of students will commence in January 2019 and this is a major achievement for the locality and the profession.

- The major commitment to enhance the level of coaching and supervision within services, including “Think-on Coaching” which is helping our teams move towards a culture of continuous learning, adopting a solution focussed framework, and asking high-quality questions about their work.

3.4 The key challenges highlighted within the report refer to;

- Continuing difficulties in recruitment of senior medical staff and significant persisting consultant level vacancies which pose the biggest challenge to maintaining our established excellence in supervision and training to medical undergraduates and trainees at all levels.

- The potential difficulties caused if the local Universities move to the new NMC nurse training curriculum at different points, although the Trust is closely involved with the curriculum development groups in response to this.

- Continuing to rise to the challenge of effective multi-disciplinary training, which we are developing via our Right Staffing programme, building joint simulation and clinical skills training into this, and linking this to the new roles such as Associates and Advanced Practitioners in a clear structure.

- Responding to the Equality and Diversity challenge, continually working towards the development of an organisational culture in which diversity is valued.

4. IMPLICATIONS:

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

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

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

4.4 **Equality and Diversity:**
The SAR assessment incudes factors relating to equality and diversity at section 6.

5. RISKS:

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

6. CONCLUSIONS:

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

6.2 It is an annual requirement to submit this multi-professional return, which this year is in the form of a single joint report.

6.3 The information is assessed by HEE, initial questions formulated and then taken to a scrutiny meeting with HEE colleagues for further questions and assurance, known as the Annual Dean's Quality Meeting (ADQM). As part of the governance process for this report, HEE ask that an Executive Director signs off assessment report and it is also presented to the Trust Board.

6.4 The ADQM meeting with Health Education England will be held on March 22nd 2019.

7. RECOMMENDATIONS:

The Board are recommended to receive and endorse the multi-professional SAR report attached, and raise any associated questions regarding the educational framework across the Trusts professions.

Name - Stephen Scorer
Title - Deputy Director of Nursing

Background Papers:

2018 SAR Report for Health Education England

TEWV
Self-Assessment Rep

Health Education England

2018 Education & Training

Self-Assessment Report (SAR)

Reporting Period: 1 August 2017 to 31 July 2018

Deadline for submission to HEE: 31 October 2018

Trust's name:	**Tees, Esk and Wear Valleys NHS Foundation Trust**
Value of contract / funding with HEE:	1. Total initial 18/19 LDA value *(including undergraduate)*: **£6,379,999.53** 2. Total for salaries for doctors in training in 18/19: **£2,584,280.00** 3. Total estimated Medical placement tariff in 18/19: **£1,480,837.00** 4. Total estimated Non-medical placement tariff in 18/19: **£832,209.60**
Trust Chief Executive's name:	**Colin Martin**
Director(s) of Education's name: **(or equivalent, please state job title):**	**Dr Jim Boylan**
Name of Board Level Exec/Non-exec Director responsible for Education and Training strategy within your organisation:	**Elizabeth Moody, Director of Nursing and Governance**
Report compiled by (responsible for completion of):	**Stephen Scorer/ Val Holmes/Dr Jim Boylan**
Report signed off by:	**Elizabeth Moody**
Date signed off:	**26th October 2018**
Board Approval: 1. **Approved by / on behalf of the Trust Board: (date / details)** 2. **Date seen at or scheduled for Board meeting**	**Scheduled for Board meeting in November 2018**

Contents

Section 1: Organisation overview linked to the HEE Quality Framework

1.1. Statement of how the HEE Quality Domains are being met organisationally

This SAR is aligned to the HEE Quality Framework: https://hee.nhs.uk/our-work/quality
For medical education the SAR is also aligned to the GMC Standards: http://www.gmc-uk.org/education/index.asp

Trust's response (max of 500 words)

The Trust has a long-established record as major provider of high quality learning experiences both internally and in partnership with the local Universities and beyond. There is a focus on continuing improvement which is monitored and robustly reported up to Executive level, including the use of performance monitoring report-out systems and huddles. Trust representatives are involved in the key partnership Board and sub-group meetings with the HEI's and are involved in ensuring curricula meet our services user's needs. The key initiatives and work streams which demonstrate the Trusts approach to the educational quality are featured throughout the document, but some examples to highlight follow below

The Trust has made a major commitment to enhance the level of coaching and supervision within its services, this includes a programme developed with an independent organisation "Think-on Coaching" which is helping our teams move towards a culture of continuous learning, adopting a solution focussed framework, and asking high-quality questions about their work. Over 1300 people have been involved in events/meetings/coaching across the Trust. We still have plenty to learn about where the frameworks bring the most value, but we have had very positive feedback about the impact of the coaching tools for individuals and teams.

The Trust is also now working on a core offer of leadership training to all staff which will enhance our offer to students of all professions – because all our leadership groups will be able to talk about and model the daily behaviours of collective leadership, think about that in relation to the HLM, and be able to talk about the three areas of accountability (quality, performance and resources) which applies to all leaders regardless of background.

The Trust is proud to have as two of its central work streams, a 10 year recovery approach to mental health care and treatment and creating an organisational culture of trauma informed care. These are co-produced with Experts by Experience. As part of this there have been further developments this year of on-line recovery and trauma training accessible for patients, families/carers and staff through the Recovery College On-line, Durham.

We are committed to making sure staff feel and function well both physically and mentally. A range of support covering mental health, musculoskeletal health (including physiotherapy) and physical wellbeing is available, including access to employee support services, occupational health and mindfulness sessions

Our commitment to Improving Access to Psychological Therapies (IAPT) has been outstanding in extending training in specific therapies across specialties, leadership and the development of IAPT team-based curricular for Children and Young People. TEWV psychologists are working with HEE and NHS England to

develop the national curricular for team-based inpatient CYPS- IAPT training. We are creating an environment to support training in specific evidence-based therapies across specialities each year

The Trust has an extensive approach to widening access to professional education and training including the use of the apprenticeship levy. This has been recognised nationally where the Trust was congratulated at a House of Commons event and over-achieved on its NHS Employers targets. The Trust has worked in collaboration with a local University and other local Trusts to establish a part-time Pre-Registration Nurse Apprenticeship programme which was commended by the Nursing and Midwifery Council at the validation event. The Executive team have agreed to fund backfill and support costs for 30 apprentices to undergo professional training, (in addition to the access to the apprentice levy to fund training). We are also actively involved in the Nursing Associate pilot developments in the region, with three cohorts.

The organisation has increased the number of learners it supports, particularly as regards pre-registration nurse training, as part of developing a sustainable workforce. This and other staff development issues feed into a Right staffing Programme which has been established as a Board level annual plan priority with 4 work streams: Recruitment and retention, Staffing establishments, Development and training, and Workforce roles. The programme board reports monthly to the Executive team and includes a focus on advanced practice role development, including practitioner roles in support of medical profession, Approved Clinician, and consultancy roles in multi-professional capacity.

The Trust instigated discussions with Teesside University to develop the first pre-registration Dietetics degree in the North East region. The Head of Dietetics chaired the steering group for the new pre-registration Master's Degree in Dietetics which was approved by the HCPC and British Dietetic Association in June 2018. The first cohort of students will commence in January 2019 and this is a significant development for the locality and the profession, with leadership from the Trust.

In terms of the quality of training and supervision offered to medical students and medical postgraduate trainees at all levels the Trust has over the last 6 years continued to sustain and even improve it's high regional and national rankings in the annual GMC surveys of trainees and trainers.

1.2. Top three successes

This section should be used to document a high-level summary of the successes your organisation is most proud of achieving during the reporting period.

Description of success	Domain(s)	Standard(s)
In the 2018 GMC annual survey of trainees the Trust was ranked 5th in England and 8th overall in the UK. It has continued to be the first ranked trust for medical training in the North East region over the last 6 years. The Trainer Survey ranked 4th Nationally and No 1 for Trainer Development.	Learning Environment and Culture Supporting and Empowering Learners	
The Trust has an extensive approach to widening access to professional education and training including the use of the apprenticeship levy. This has been recognised	Learning Environment and Culture	

nationally where the Trust was congratulated at a House of Commons event, and over-achieved on its NHS Employers targets. The Trust has worked in collaboration with a local University and other local Trusts to establish a part-time Pre-Registration Nurse Apprenticeship programme which was commended by the Nursing and Midwifery Council at the validation event. The Executive team have agreed to fund backfill and support costs for 30 apprentices to undergo professional training, (in addition to the access to the apprentice levy to fund the training)	Delivering a Sustainable Workforce Supporting and Empowering Learners	
Dietetics development- The Trust instigated discussions with Teesside University to develop the first pre-registration Dietetics degree in the North East region. The need was identified due to recruitment difficulties at bands 5 and 6 across the North East, particularly in mental health and learning disabilities services. The Head of Dietetics chaired the steering group for the new pre-registration Master's Degree in Dietetics which was approved by the HCPC and British Dietetic Association in June 2018. The first cohort of students will commence in January 2019 and this is a major achievement for the locality and this profession	Delivering a Sustainable Workforce Learning Environment and Culture Educational Governance and Leadership	

1.3. Top three challenges or prominent issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section.

Description of challenges	Domain(s)	Standard(s)
Continuing difficulties in recruitment of senior medical staff and significant persisting consultant level vacancies pose the biggest challenge to maintaining our established excellence in supervision and training to medical undergraduates and trainees at all levels.	1,2	
The potential difficulties caused if the local Universities move to the new NMC nurse training curriculum at different points, e.g. from September 2019 onwards. This will result in a range of different supervision and assessment requirements from two different curricula across up to five HEIs accessing placements in our services, although the Trust is closely involved with the curriculum development groups in response to this	3,4	
Rising to the challenge of effective multi-disciplinary training, which we are developing via our Right Staffing programme, building joint simulation and clinical skills training into this and linking this to the new roles such as Associates and Advanced Practitioners in a clear structure	1,3,4,6	

1.4. Strategic Workforce Plan

Does your organisation have a strategic workforce plan (delete as appropriate)?

Yes √	No

Who within your organisation is responsible?

Name and job title	David Levy, Director of Human Resources and OD

Section 2: Exception Reporting against HEE Quality Domains

2.1. Multi-professional

2.1.1. Organisation overview linked to the HEE Quality Domains

Please report, by exception, where your organisation does not meet the HEE Quality Framework within the reporting period for the groups listed in the guidance notes. In addition, please provide an overall narrative along with some organisational / departmental / unit examples which support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

There are no Director level concerns regarding the meeting of the HEE standards to highlight within this section, although some lower level issues are identified within the domains

In terms of the narrative around meeting the standards overall, some of the following multi-disciplinary examples are highlighted, with more domain-specific examples of meeting the standards within the relevant sections of the report;

- The Trust has an extensive approach to widening access to professional education and training including the use of the apprenticeship levy and additional funding. This has been recognised nationally where the Trust was congratulated at a House of Commons event and over-achieved on its NHS Employers targets. The Trust has worked in collaboration with a local University and other local Trusts to establish a part-time Pre-Registration Nurse Apprenticeship programme which was commended by the Nursing and Midwifery Council at the validation event. The Executive team have agreed to fund backfill and support costs for 30 apprentices to undergo professional training, (in addition to the access to the apprentice levy to fund training) and also funded ten places for Health Care Assistants on a local HEI Learning Disability pre-registration nursing course to help maintain this provision.

- Dietetics - The Trust instigated discussions with Teesside University to develop the first pre-registration Dietetics degree in the North East region. The need was identified due to recruitment difficulties at bands 5 and 6 across the North East, particularly in mental health and learning disabilities services. The Head of Dietetics chaired the steering group for the new pre-registration Master's Degree in Dietetics which was approved by the HCPC and British Dietetic Association in June 2018. The first cohort of students will commence in January 2019

- The organisation has increased the number of learners it supports, particularly as regards pre-registration nurse training, as part of developing a sustainable workforce. This and other staff development issues feed into a Right staffing Programme which has been established as a Board level annual plan priority with 4 work streams: Recruitment and retention, Staffing establishments, Development and training, and Workforce roles. The programme vision is;
"*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*."

- The programme board reports monthly to the Executive team and includes a focus on advanced practice role development, including practitioner roles in support of medical profession, Approved Clinician, and consultancy roles in multi-professional capacity, and an Education and Development work stream which is reviewing the Trust-wide requirements to enable learners and staff to develop into these future roles, with the potential to create a Centre of Excellence type approach.

- Trust representatives are involved in the key partnership Board and sub-group meetings with the HEI's and are involved in ensuring curricula are developed to meet our services user's needs and those of the regulatory bodies.

- Our commitment to Improving Access to Psychological Therapies (IAPT) has been outstanding in extending training in specific therapies across specialties, leadership and the development of IAPT team-based curricular for Children and Young People. We have submitted a further IAPT tender with partnership organisations in October 2018. TEWV psychologists are working with HEE and NHS England to develop the national curricular for team-based inpatient CYPS- IAPT training. We are creating an environment to support training in specific evidence-based therapies across specialities each year, and embedding a culture of using routine outcome measures to improve therapeutic relationships and clinical effectiveness. Clinicians and managers are completing IAPT leadership programs across the specialties

- As regards the leadership standards, Psychology services have a comprehensive input to both Tees and Newcastle courses about leadership and this fits in with the collective leadership model in the Trust, we also offer organisational placements in year 3 to Tees which enables trainees to develop their understanding of leadership and organisations.

- The Trust is now working on a core offer of leadership training to all staff (starting with those in leadership groups of team level services) which will enhance our offer to students of all professions – because all our leadership groups will be able to talk about and model the daily behaviours of collective leadership, think about that in relation to their role, and be able to talk about the three areas of accountability (quality, performance and resources) which applies to all leaders regardless of background.

- The therapies leads (AHP, Psychology, chaplaincy, social work) have all been part of a day on collective leadership as part of this development" Psychologists and psychological therapists across Children and Young People's services had a similar collective leadership and action planning event in April 2018.

- The Trust has made a major commitment to enhance the level of coaching and supervision within its services, this includes a programme developed with an independent organisation "Think-on Coaching" which is helping our teams move towards a culture of continuous learning, adopting a solution focussed framework, and asking high-quality questions about their work

- The Trust has well-established procedures for managing and learning from patient safety incidents, including supporting staff involved and being open and transparent with services users in line with national practice, which are described further in section 8

- A review of locality wide Occupational therapy services was commissioned to assess access and provision across inpatient areas across Durham and Darlington, rehabilitation services, & community intervention teams, with the expressed aim of improving access to occupational therapy, and supporting Occupational Therapists to deliver therapy, with an associated project plan

- The Trust achievement of Gold status in the IIP ‘Investors in People’ programme, is obtained by only a small percentage of organisations, and this independent assessment illustrates the approach taken to staff, educator and learner support and development among a wide range of other staff investment factors such as culture, leadership and benchmarking

HEE Domain 1 Learning Environment and Culture

For additional guidance refer to HEE Quality Framework, page 10

HEE priority for 2018 reporting in this domain is:

- *A focus on workplace behaviours and strategies for resolution of issues of concern*

- We have a culture of innovation and proactively managing new ways of working, and continuous service improvement as a feature of the long-established Kaizen-based QIS system which includes staff participation and generation of workplace-based improvement ideas in service development, and is managed by a dedicated Kaizen office.

- As regards the HEE focus on workplace behaviours, we have introduced 'whistleblowing' as mandatory face-to-face training for bands 7 managers and above, along with recruitment of Dignity at Work support roles.

- The Trust has introduced "Dignity at Work" Champions. These roles reinforce the work of the Freedom to Speak Up Guardian, offering support to those who may be experiencing issues in their workplace and somewhere safe to raise concerns. The champions offer confidential, non-judgemental support, aim to resolve issues quickly and fairly and signposting for further help as required

- The health and wellbeing of all Trust staff including learners is one of our key priorities for creating a positive caring and learning environment, and we are committed to making sure staff feel and function well both physically and mentally. A range of support covering mental health, musculoskeletal health (including physiotherapy) and physical wellbeing is available, including access to employee support services, occupational health and mindfulness sessions. There were broadly positive results from the staff survey and the Trust aims to continue to build on this and hope that many more people feel able to say that we support their health and wellbeing. If staff feel their health and wellbeing is not being supported they are encouraged to raise this with their line manager in the first instance or contact the Health and well-being project manager, who will be able to advise on the support available within the Trust. Information on this was further publicised in the staff magazine Insight and via the bulletin system.

- Intensive OD work supported by the corporate development team has taken place within some of our services. There is a development programme for new managers which includes session on governance and quality focus in the work place, and providing a sense of direction and hope within teams

- There is a Talent management system in place.

- The Trust has a structured approach to Coaching development using the "Think-on" methodology across all staff groups. The first 10 master coaches have completed their accreditation (with another 19 in progress). Our aim is to enable all staff including those who support learners, to use a solution focused framework in their work, to think about change in relation to themselves, colleagues, services users and carers.
  We have worked with over 1300 people and the process has been involved in events and meetings across the Trust. We still have plenty to learn about where the frameworks bring the most value, but we have had very positive feedback about the impact of the coaching tools for individuals and teams. The four key areas of impact have been:
  -increased confidence for individuals that the coaches have worked with,
  - the value of really good goal setting,
  - increased ability to work in and lead teams, and
  - improved staff wellbeing (from an increased ability to make choices, tackle problems, and being happier at work).

Nursing additional

- To mitigate avoidable learner and early career attrition and contribute to a supportive learning environment, the Trust has a range of measures in place including working with the HEIs to recruit suitable learners on all programmes and engagement activities with local schools and colleges. Appropriate careers advice features in the preceptorship programmes and patients/service users routinely engage with student nurse assessment through the 360 degree tool for interpersonal skills. The Trust has a well-established preceptorship programme to support the transition from student nurse learner to Registered Nurse.

Additionally for the HEE quality standards;

- 1.1- the policy for the escalation of quality concerns within HEE in the North east and North Cumbria mentors is well established and managers are familiar with the HEI cause for concerns processes
- 1.3- all clinical practice areas are involved in continuous improvement activity. Student nurses have a service improvement placement in year 3; some student nurses have the opportunity to spend the service improvement placement with the research team.
- 1.4- all students attend a Trust induction and have a session with service users and carers, also a session with the patient safety team including key lessons learned
- 1.5 -library access for student nurses is at all hospital sites, also accessible online and increasingly the online support from Universities is becoming a feature of pre-registration training
- 1.6 -placement journeys reflect the patient pathway - locality based community and inpatient care, through multi professional teamwork. Students have opportunities to work with a range of professionals delivering patient care, and this is paving the way for the new NMC Standards and the supervision and assessment environment which accompanies these including the promotion of multi-disciplinary supervision for pre-registration nurse learners

Psychology

For psychology we have a comprehensive input to both Tees and Newcastle courses about leadership and this fits in with the collective leadership model in the Trust, we also offer organisational placements in year 3 to Tees which enables trainees to develop their understanding of leadership and organisations

Physiotherapy/AHP

- Obtaining timely access to IT systems in Local Authority in integrated services (SSID) due to lack of availability of training slots can be a concern. This concern is managed by arranging bespoke training sessions as required

- The Trust is signed up to MDT simulation training via RAMMPS and AHP leads are engaged in developing scenarios to deliver to learners - students can be invited to the training sessions. There is more on simulation in section 8 of the report

- As a challenge in this domain, the Trust is making every effort to expand training places and diversifying training roles, to develop a sustainable workforce with the right skills, in line with some of the initiatives above. This does put some pressure on services regarding training placements particular where there are curriculum and assessment variation from the different institutions. However in mitigation this is mapped out by the PPF team, jointly with the Universities, and in addition we are preparing for the new NMC standards approach with changes to supervision and assessment role and we continue to expect to manage this as part of our strategic approach to widening access to training and supporting recruitment.

- Staff are able to access a variety of in-service training over and above mandatory training, specific to the needs of their patients and families across the Trust. There are excellent examples of training being delivered across CYPS inpatient services in relational security, attachment and impact of trauma, positive behaviour support, Safewards (which aims to reduce tensions and help inpatient settings to be calmer, safer places), orientation to Dialectical Behaviour Therapy (DBT), compassionate care and eating support/motivational enhancement. Training is jointly facilitated by MDT professionals and regular co-facilitation with Experts by Experience.

  There are CPD opportunities and in-service-training relating to a variety of specific therapy approaches and at different levels. This includes Cognitive Behaviour Therapy, Cognitive Analytic Therapy, DBT, Systemic/Behavioural family therapy, psychodynamic, integrative psychotherapy and trauma based therapies.

  The Trust is proud to have as two of its central work streams a 10 year recovery approach to mental health care and treatment and creating an organisational culture of trauma informed care. These are co-produced with Experts by Experience. As part of this there have been further developments this year of on-line recovery and trauma training accessible for patients, families/carers and staff through the Recovery College On-line, Durham. Recovery/discovery on-line training is being developed this year for Children and Young People to promote mental health, wellbeing and reduce stigma

- As a concern, we are aware of issues regarding diversity of BAME and disabled persons in staff development opportunities, and perhaps amongst the older male group - action groups have been commenced in light of this. There are further updates on equality and diversity within section 6 of the report
- There was an issue in a complaint being made by some adult nursing learners doing a one week placement in an inpatient ward for people with a learning disability. Concern was raised about specific interactions with service users and an observed use of restraint. This has been an important learning experience in supporting and empowering learners raising the concern and taking steps as an organisation to fully investigate this and taking action to protect the safety of service users and support compassionate care. In partnership with the university we made improvements to induction for short placements and develop packages of on line learning resources to support nurse placements. Feedback from subsequent learners on placement has been very positive.

HEE Domain 2 Educational Governance and Leadership

For additional guidance see HEE Quality Framework, page 11 -12

HEE is keen to understand new models of learning in practice and the impact this is having on your organisation. Please include within your response:

- *Have you increased capacity for learners in your organisation?*
- *Have you increased your numbers of supervisors/mentors?*

HEE priority for 2018 reporting in this domain is:

- *Monitoring of LEP use of financial resources provided by HEE to support training. The new Learning Development Agreement (LDA) will be used to link financial resource to quality of training. (See SAR section 4, page 18)*
- *Governance of programmes with complex structures (e.g. Pharmacy & Healthcare Science) where nationally coordinated processes can impact on local delivery within HEE.*
- *Clear identification through STEIS (Live Flow) reporting of trainees/learners involved in Never Events and SUIs for both pastoral support and revalidation reasons. (See SAR section 8.1, page 26)*

- Section 8 of the report provides information on the HEE priority regarding involvement of trainees in Never events and revalidation

- The organisation has increased the number of learners it supports, particularly as regards pre-registration nurse training. In terms of increasing capacity for learners, for example 125 mental health pre-registration nursing students places have been placed from Teesside University in the 2018 intakes, by comparison with 109 the previous year. There was a modest drop-off in learning disability places in early 2018 in line with the national picture, however the Trust supported this programme by making available funding for ten existing HCA's to attend the programme including backfill funding for services, which was a significant local investment to maintain the viability of these programmes and was acknowledged as such by the HEI's. The most recent intake (no.1809) has seen numbers return to previous typical levels, which is encouraging and suggests the Trust's support for these programmes was well placed. In addition up to 20 additional places are being offered on the new partnership BSc programme for mental health and learning disability nursing which has been established this year at Sunderland University. A further additional 25 apprentices will be supported onto the parallel new Sunderland Apprenticeship route including backfill funding agreed by the Executive team (this is on top of the standard BSc route at Sunderland referred to). 5 more places have been offered on to the Open University pre-registration nursing apprenticeship course, which are an excellent way of increasing the diversity of training opportunity and growing our own registered workforce supporting staff who are more likely to be retained.

- The local Universities have mostly indicated that they will be offering the new NMC curriculum from September 2019, although yet to confirm, this curriculum changes the requirements around the previous mentorship and sign-off mentor model considerably, and rather than change numbers of mentors the Trust is planning to put the measures in place to communicate and then support the necessary changes to the new model in line with this (to include a supervisor and practice assessment role). It will be a challenge in terms of consistency if the Universities opt to switch to the new arrangements at different times beyond September 2019, as indicated in the Top Challenges in section 1 of the report.

- The governance of the Education and Training process is via an established sub-committee of the Right Staffing board, the Education and Training Sub-group. This reports into the Right Staffing Board, which in turn reports to the Executive Team. Monthly reports from the Programme Board are reviewed in a dedicated Strategic Overview Executive meeting, and there is a twice-yearly "deep-dive" challenge into a sub-topic from the programme.
  Examples of programme documentation can be provided on request

- The Trust has made substantial use of the Apprenticeship levy, as part of its intention to widen participation in professional training and create a sustainable workforce. This has helped increased capacity for staff to develop further- for example as student pre-registration nurses, nursing associates, leadership development, and health care support staff framework.

- Investment has been made into increasing supervisors, coaches and mentors including within the Think-on coaching programme

- The Trust has a major programme, PPCS which is reviewing the best way to provide community based services and the staffing structures to support this, and as part of this there has been continued roll-out of daily huddles/ MDT supercells in order to structure development.
- In support of the Leadership element of this domain, "Think On" coaching methodology is being rolled out as referred to in more detail in the Domain 1 section above ;
  ' To enable all staff to use a solution focused framework in their work to think about change in relation to themselves and their development, their colleagues, services users and carers'

Nursing

- Patients/service users routinely engage with student nurse assessment through the 360 degree tool for interpersonal skills. Service users and carers engage with the student nurses during the Trust induction

Additionally for the quality standards;

- 2.1 -governance measures include educational audit in partnership with the HEIs, student evaluations, escalation policy (HEE), audits of mentor register, annual triennial review audit, quarterly reports of placement use and number of mentors and sign off mentors, monthly reviews of Datix reports
- 2.2 -there is Trust representation at partnership meetings with HEIs and at regional level
- 2.5 -mentors and managers are familiar with the cause for concerns processes and how to escalate concerns about student performance. Processes are in place to monitor student involvement in incidents through Datix reporting
- Processes are in place in partnership with HEIs to manage concerns raised by student nurses regarding quality of care on placement and can access the Freedom to Speak Up Guardian
- Student evaluations are shared with practice areas
- Systems in place to identify concerns about practice education through 'trigger questions', the practice area receives this feedback and will provide a response to the concern
- The policy for the escalation of quality concerns with HEE in the North East and North Cumbria is embedded

Psychology and Trust-wide

Clinical Psychology has a comprehensive input to both Tees and Newcastle courses on leadership, and this fits in with the collective leadership model in the Trust, we also offer organisational placements in year 3 to Tees University which enables trainees to develop their understanding of leadership and organisations.

The Trust is now working on a core offer of leadership training to all staff (starting with those in leadership groups of team level services) which will enhance our offer to students of all professions – because all our leadership groups will be able to talk about and model the daily behaviours of collective leadership, think about that in relation to their role, and be able to talk about the three areas of accountability (quality, performance and resources) which applies to all leaders regardless of background.

The Therapies leads (AHP, Psychology, chaplaincy, social work) have all been part of a day on collective leadership as part of this development. Psychologists and psychological therapists across Children and Young People's services did a similar collective leadership and action planning event in April 2018.

Pharmacy

The Pharmacy service has some challenges in accessing consistent post qualification training for pharmacy technicians and postgraduate pharmacist training as funding arrangements change, exacerbated by 25% of our staff working within former HEYH. We welcome the creation of the North School of Pharmacy and Medicines Optimisation and the appointment of Regional Head of Pharmacy who has engaged with us on a number of occasions

Organisational Development

The Organisational Development (OD) team deliver a Trust-wide range of leadership and management programmes. These include;

- 'Firm Foundations for Leadership' - A two day programme to help Band 5 frontline staff explore their leadership role
- 'Leadership Building Blocks' - A three day programme to support Band 6 frontline staff
- 'Developing Facilitative Leadership'- A two day programme to support managers to achieve key skills in relation to planning, facilitating and embedding actions from their team events
- 'Great Leaders, Great Team, Great Results'- to support development of effective leadership strategies and engagement of teams
- 'New Managers Programme' - This peer development session supports band 7 managers in their new roles
- '360 Diagnostic feedback for leadership development'

Further information on these and other leadership options is available.

HEE Domain 3 Supporting and Empowering Learners

For additional guidance refer to HEE Quality Framework, page 13-14

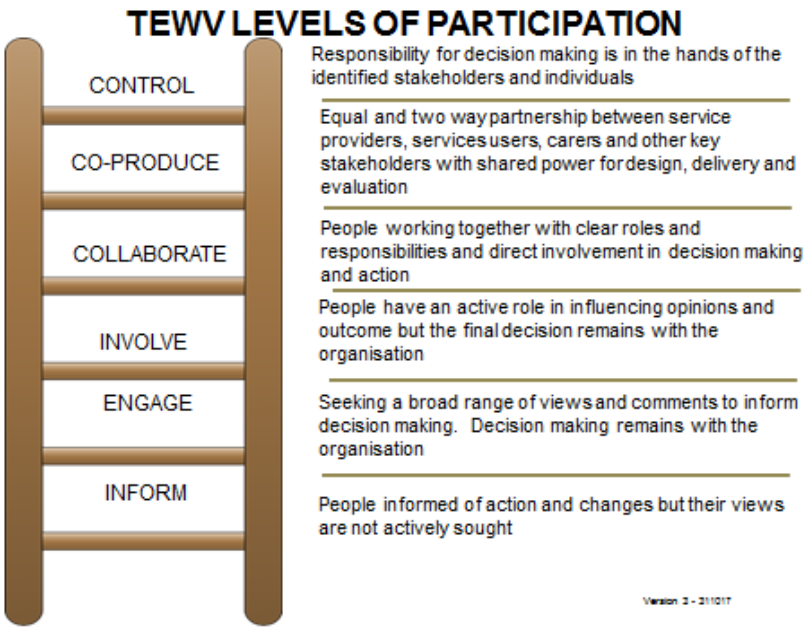
HEE priority for 2018 reporting in this domain is:

- *Improving support given to learners/trainees involved in Never Events/other adverse outcomes and subsequent clinical governance processes including Root Cause Analysis, Coronial Inquiries etc. (See SAR section 8.1, page 26)*

- See SAR section 8.1 on, for Patient Safety, RCA, Coronial process etc. priority comments requested above

Additionally;

- The Trust participates in the Project Choice scheme, encouraging training and employment for young people with a Learning Disability, in partnership with HEE. We offer supported internships, and the first cohort of trainees have produced a short film about their experience to help share the message. We are shortly to commence a second cohort in support of this development.
- The Workforce Development team provide an information, advice and guidance service for learners at all levels and promotes further personal development.
- The Trust has a Ladder of Participation model as an overall framework for clarifying and driving up levels of empowerment and involvement for service users and all colleagues including learners, as pictorially follows;



The terms of reference for the Training and Development work stream are attached to illustrate an example of reference to the involvement ladder model in a formal committee setting linked to training governance

Additional Nursing;

- 3.1- Each student nurse on a long placement is allocated a suitably prepared mentor. Students on a short placement are allocated a supervisor (Registered Nurse). Associate mentors are routinely allocated. All mentors have an NMC approved qualification and attend annual updates. All student nurses work alongside the mentor for at least 40% of practice learning time, supervised directly or indirectly at all times.
- 3.4- All student nurses attend a Trust induction prior to starting first placement. all students also receive a local induction in practice areas
- 3.5- information about patient pathways is included in the educational audit completed every two years

- All students have initial, mid-point and final tripartite interviews each year
- The PPF team will be supporting the move towards the new NMC curriculum, and assessment criteria and multi-disciplinary method during 2019, and the Trust is involved in the curriculum development groups at the local Universities including working towards the new NMC standards and assessment models.

Pharmacy

- Pharmacists undertaking a clinical pharmacy diploma have been additionally supported this year in their learning and reflection by the introduction of a Foundation Pharmacist Development framework which aligns to the Royal Pharmaceutical Society competencies, with 6 band 6/7 pharmacists piloting the framework since April 18. Our senior pharmacists have also been supported as mentors / assessors in the new framework to ensure consistency. Pre-registration pharmacists during their placement in TEWV undertook an audit / service evaluation which was presented as a poster at the inaugural Great North Pharmacy Research Collaborative Conference in July 18.

HEE Domain 4 Supporting and Empowering Educators

For additional guidance refer to HEE Quality Framework, page 15

HEE priority for 2018 reporting in this domain is:

- *Use of the LDA to link the control/distribution of the financial resources provided by HEE to those managing training placements and the individual support to those providing educational supervision. (See SAR section 4)*

- Master coaches have been trained in support of the above-mentioned 'Think-On' programme and use their coaching methods to support staff and learners in the workplace with coaching, high quality questions, and possibility thinking
- Support is provided for NHS graduate programme trainees
- The Trust achievement of Gold status in the IIP 'Investors in People' programme, is obtained by only a small percentage of organisations, and this independent assessment illustrates the approach taken to staff, educator and learner support and development among a wide range of other staff investment factors such as culture, leadership and benchmarking

Nursing factors;

- 4.1 All mentors assessing student nurses have a formal NMC approved teaching qualification and are entered on the local mentor register.
- 4.2 All mentors attend an annual mentor update and this includes updates on the new NMC standards and approaches to assessment forthcoming
- 4.3 All mentors complete a triennial review as part of the annual appraisal
- 4.4 Mentors are allocated study time to attend the annual mentor update. Nurses are allocated study time to attend an NMC approved mentoring course
- The Trust has carried out a QIS improvement event on Clinical Supervision, this is being piloted in five areas and will be rolled-out Trust wide during 2019, this includes identified protected time and standardised approaches which will benefit all nursing staff including those in an educator role.
- The Leadership development opportunities outlined in domain 2 would apply here also , in terms of a focus on developing a facilitative and empowering approach, for leaders and supervisors who are also in a supporting or developmental role with our learners at all levels

HEE Domain 5 Delivering Curricula and Assessments

For additional guidance refer to HEE Quality Framework, page 16

HEE priority for 2018 reporting in this domain is:

- *Assessment of the effects of 'Winter Pressures' on the ability to deliver training curricula across LEPs and the strategies being developed to mitigate impact across individual training placements and programmes. (See SAR Section 8.2, page 27)*

- The Trust has produced a yearly capacity and demand process for all mandatory training to try to mitigate potential winter concerns. However there were no reported issues for the winter of 2017/18 regarding delivery of training. (also section 8.2)

- Further examples of flexible training delivery include taking a bespoke resuscitation training focus, with weekly reports and review by Executive team members at a huddle report, with training amended weekly to go to areas of concern to maintain patient safety.

Nursing

- 5.2- The Trust is involved in partnership and in the curriculum planning groups for the new NMC standards for pre-registration training, at three local Universities, and the curriculum for Advanced Practice at one university, helping to shape the content to include mental health and learning disability expertise, and towards service user requirements and the recovery model.

- The Trust supported Sunderland University as a partner, with other local Trusts, to develop the programme and then obtain NMC approval at the validation event, for the Pre-registration nursing apprenticeship programme which commences next year. This validation event included commendation by the NMC for its level of innovation and non-traditional entry point and is a key component of growing our own workforce

- The Trust is engaged in dialogue with a new entrant to the local training field, Coventry University at Scarborough, to develop a new Pre-registration nurse training programme (most likely at this stage to be an Apprenticeship) and a Nursing Associate training programme, as well as some vocational training support for the North East Yorkshire locality and beyond

- The Trust is part of a North – east partnership which has delivered Nursing Associate training and we are currently preparing the first cohort of trainees to take up their roles and enter the newly confirmed NMC Register for NA's. We will shortly be commencing our third cohort, and this will include an emphasis on developing staff from Learning Disability services, both as Associates in their own right and to increase access to pre-registration programmes, in line with the HEE sponsorship funding. We are in dialogue with a local university over a possible integrated programme to give a roadmap for HCA and support worker colleagues through to first level registration.

- 5.3- patients/service users routinely engage with student nurse assessment through the 360 degree tool for interpersonal skills. service users and carers engage with the student nurses during the Trust induction

- We are involved in Advance Clinical Practice multi-disciplinary curriculum development and workforce planning groups

Dietetics

- The Trust instigated discussions with Teesside University to develop the first pre-registration Dietetics degree in the North East region. The need was identified due to recruitment difficulties at bands 5 and 6 across the North East, particularly in mental health and learning disabilities services. The Head of Dietetics chaired the steering group for the new pre-registration Master's Degree in Dietetics which was approved by the HCPC and British Dietetic Association in June 2018. The first cohort of students will commence in January 2019. This will be a major boost for the profession and for recruitment within our region.

- The Trust is proud to have as two of its central work streams, a 10 year recovery approach to mental health care and treatment and creating an organisational culture of trauma informed care. These are co-produced with Experts by Experience. As part of this there have been further developments this year of on-line recovery and trauma training courses accessible for patients, families/carers and staff through the Recovery College On-line, Durham. There was a target for this year of 229 staff receiving trauma-informed care linked to Recovery, this was exceeded.

Pharmacy

- During this period we have had over 50 pharmacy 3rd year students from Durham and Sunderland universities, we have received good feedback and develop our placements in collaboration with student experience, our pharmacy professionals and placement leads.

HEE Domain 6 Developing a Sustainable Workforce

For additional guidance refer to HEE Quality Framework, page 17

HEE priority for 2018 reporting in this domain is:

- *Monitoring placement capacity where the LEP's own service workforce may be insufficient to deliver training, especially for 'at risk' placements.*
- *Triangulation of training data with exception reporting data regarding implementation of the Junior Doctor contract.*
- *LEP engagement with HEE across the STP/Integrated Care System for all training & workforce planning to avoid loss of training approval in changing clinical services.*

- A Right staffing Programme board has been established as a Board level annual plan priority with 4 work streams: Recruitment and retention, Staffing establishments, Development and training, and Workforce roles (including Advanced Practice). The programme vision is;
  "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."

- The programme board reports monthly to the Executive team via an oversight process SCOB (Strategic Change Oversight Board) and deep dives into areas of progress are carried out within this. The programme progress is then reported at a Trust Board level

- The programme includes a focus on Recruitment and Retention issues and a plan has been produced as part of the NHS-I national initiative on Retention (building on existing Trust work which was commended by NHS-I representatives at site visit). It includes a work stream focussing on advanced practice role development, including practitioner roles in support of medical profession, Approved Clinician, and consultancy roles in multi-professional capacity, and an Education and Development work stream which is reviewing the Trust-wide requirements to enable learners and staff to develop into these future roles

- The Trust has developed several approaches to sustaining its workforce arising from this framework, including;

- Support for the Nursing Associate programme, with three cohorts in place, which includes staff who see this as an opportunity to access pre-registration training as well as a valuable role in its own right
- Executive team support for backfill funding to enable up to 30 Apprentices to attend a local part-time Pre-Registration programme, which was developed jointly with Sunderland University, ourselves and three other local Trusts in response to sustainable workforce issues (recently commended by the Nursing and Midwifery Council for its innovative approach)
- Access to Open University foundation modules and pre- registration apprenticeships
- Dialogue with Coventry University at Scarborough, and York University regarding development of mental health and learning disability training programmes at Associate level and above
- Review of Advanced Practice requirements and role standardisation
- Quality improvement event to review the Trusts approach to Leavers and the lessons learned from this information, to contribute to improved Retention plan

Nursing

- Commencement of the Apprentice Nurse Degree programme at Sunderland University, commended for innovative approach by the NMC at validation event, and additionally increased access to the Open University RNDA programme.
- The Trust is supporting up to 30 HCA's to access the Apprenticeship routes on a part time backfilled basis to assist with future recruitment and retention and offer a development route to "grow our

own" staff, including the associated service backfill costs. This is an innovative approach as it has more flexibility of access and prior learning recognition, and allows for non-traditional access to pre-registration learning, also accessing the apprenticeship levy and allowing part-time study towards nurse registration. It was commended as an innovative approach by the Nursing and Midwifery Council at validation. This applies to both Mental Health and Learning Disability strands and represents considerable financial investment and support for these programmes by the organisation, contributing to the learning environment and sustainable workforce

- Further cohorts of Nursing Associates as Apprentices are training at Teesside University, building on the existing pilot programme. The Trust will then have 30 Associates at different stages of learning. Support group for students developed and internal review of medication practice underway in line with emerging national guidance. The Nursing Associates are a new role within the Nursing family which will ultimately support the practice of registered nurses freeing up time for expert care, and we will be evaluating the best use of their skills across Trust settings within the Right Staffing Programme. For the next cohort there will be an emphasis upon Learning Disability services, which builds further on the Trusts' commitment to maintaining these programmes locally as a major employer

- The Trust has developed a nursing staff Retention plan based on focus group and driver diagram quality improvement methods. This is part of a national programme and includes staff development aspects within it in order to develop and retain our nursing workforce. Our retention rates and development actions to date have been commended by NHS-I at a site visit to the Trust. This plan is currently in early stages of implementation so data are unavailable however monitoring of this is required for NHS-I purposes to allow retention trend analysis and will form part of the plan evaluation in 2019 for NHS-I

Dietetics

- As an example of continuing efforts to produce a sustainable workforce, The Dietetics Team has worked with Teesside University to offer a paid (band 4) third year placement for a student undertaking the BSc (hons) Food and Nutrition course. The first student started their 12 month placement in June 2018 as a Trainee Nutritionist, working to support the implementation of "A Weight off Your Mind" (the regional weight management plan for people with mental ill health and/or learning disabilities). This will improve the local talent pool of Nutritionists who can apply for band 5 Nutritionist roles within the organisation (we have not been able to recruit to these posts in the past).

Occupational Therapy

- As a challenge, there is a lack of available B5 posts in some areas, and therefore "growing" band 6 posts from this, is becoming increasingly difficult. We see some very promising students on placement who demonstrate the potential to be good clinicians, but they aren't always able to be recruited to TEWV, although hopefully we have supported their development for the NHS family overall. The Trust has a Right Staffing programme and staff retention plan which the Head of OT and Director of Therapies will feed these issues into, for further development.
- As good practice in this field, there is a wide variety of learning opportunities for AHPS's that can be offered in an organisation of this type and with a wide range of specialist provision, OTLGN, OT specific training, access to in-house training, opportunities for learning and networking, including in York and Selby area where this has assisted recruitment in a previously difficult to recruit area.
- A review of locality wide occupational therapy services was commissioned to assess access and provision across inpatient areas (Lanchester Road Hospital & West Park Hospital), rehabilitation services, & community intervention teams, with the expressed aim of improving access to occupational therapy and supporting Occupational Therapists to deliver therapy, with an associated project plan

Speech Therapy

- As a concern, the Speech and Language Therapy department may not at times be able to offer placements due to vacant posts and/or maternity leaves, for the BSc and MSc programmes. Placements are however offered when staffing allows. The Director of Therapies is aware of and monitoring this situation, and further in response, it was agreed at the Executive Management Team to appoint a floating band 7 specialist therapist to help overcome these gaps, which is currently out to advert. This post should also help alleviate some of the pressures, as that person can move into any area and could take a student at that point.

Pharmacy

- Two pre-registration pharmacists have worked in TEWV for 6 months each, both staying in NHS in acute hospitals. TEWV has worked with two acute Trusts South Tees NHSFT / County Durham and Darlington NHSFT to give opportunities for band 6 pharmacists to rotate / work in mental health, with our 1st placement starting in Sept 18. This is seen as a more sustainable option to recruit and retain band 6 pharmacists in mental health, having unsuccessfully recruited and retained band 6 pharmacists directly into TEWV in 2017; plus it supports the concept of portfolio foundation pharmacist careers

2.1.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include Trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2).

Description of good practice and profession(s) it relates to (and a named contact for further information)	Description of why this is considered to be good practice	HEE Domain(s)	HEE Standard(s)
The Trust has an extensive approach to widening access to professional education and training including the use of the apprenticeship levy. The Trust has worked in collaboration with a local University and other local Trusts to establish a part-time Pre-Registration Nurse Apprenticeship programme which was commended by the Nursing and Midwifery Council at the validation event. The Executive team have agreed to fund backfill and support costs for 30 apprentices to undergo professional training, (in addition to the access to the apprentice levy to fund training). We are also actively involved in the Nursing Associate pilot developments in the region, with three cohorts.	TEWV has been pro-active in the development of new courses to meet an identified need around a sustainable workforce, and the widening of access to professional training via non-traditional routes in support of its existing workforce. The Executive team have made substantial funding available to support these developments beyond that available from the normal apprenticeship levy.	1,4,6	
The 'Think-on' coaching approach is being embedded – this enables all staff to use a solution focused framework in their work to think about change in relation to themselves, their colleagues, services users and carers – to help create a sustainable, solution focused learning culture	Over 1300 staff have been involved in some level of coaching activity, and the organisation is continuing to fund and support the development of Master Coaches to embed this further in the organisation. This is helping our teams move towards a culture of continuous learning, adopting a solution focussed framework, and asking high-quality questions about their work	1,3,4, 6	
Extending the success of Improving Access to Psychological Therapies (IAPT) through: •Creating an environment to support training in specific evidence-based	This work has produced significant gains in the areas of Learning Environment and Culture	All	

therapies across specialities each year •Embedding a culture of using routine outcome measures to improve therapeutic relationships and clinical effectiveness •Clinicians and managers completing IAPT leadership programs across specialties •TEWV psychologists working with HEE and NHS England to develop the national curricular for team-based inpatient CYPS- IAPT training. The Midlands Collaborative are now providing this training for the North East from this year. •Eating Disorder CYPS Outpatient Service completed team-based IAPT training. •Recent tender for IAPT, including medically unexplained physical symptoms and long term conditions. TEWV as lead provider, working in partnership with Mental Health Matters and Sunderland Counselling Service. •Development of job descriptions and career progression of psychological therapists	Developing curricula and assessments Education governance and leadership Developing a sustainable work force		
The Right Staffing programme – Board level initiative includes Retention and workforce development strands including new roles, review of advanced practice, education work stream – using "Think on" principles to guide work. [links to good feedback from our NHS-I site visit on our Retention programme, and the approach to Nursing Associates recruitment – Trust invited to present as a case study on national webinar (Possibly good practice section)]	The programme board approach is a comprehensive programme which goes well beyond the national safe staffing reporting requirements and co-ordinates it with staff retention and development approaches	1,6	
IIP Investors in People, the Trust achievement of Gold status is obtained by only a small percentage of organisations, and this independent assessment illustrates the approach taken to staff and learner support and development	This is a nationally recognised independent assess met which includes the overall culture of an organisation	1,2,3,4	

2.1.3. Challenges or important issues that HEE should be aware of.

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the profession / professions)	HEE Domain(s)	HEE Standard(s)
Potential placement pressures for the increased training capacity and widening of roles we are offering, although largely managed in-house and joint working with the Universities, and we will be working towards the new NMC models for pre-registration nurse training in 2019	1,3,4	
The potential disruption caused if the local Universities move to the new NMC nurse training curriculum at different points, e.g. from September 2019 onwards. This will result in a range of different supervision and assessment requirements from two different curricula across up to five HEIs accessing our services including the Open University	1, 3,4	
Learning Disability nurse training, we are aware of national issues and that one local course has closed. As noted in earlier sections, Executive Management Team made Trust funding available to help support a bridging period at one University for a cohort of in-house staff. We are also accessing the HEE Nursing Associate support funding in response to this issue and will be running our third cohort shortly	6	
Responding to the Equality and Diversity challenge – this is referred to in section 6 of the report and the Trust is developing further actions in response.		
Challenges remain from TEWV perspective working across two HEE faculties, in the transition period despite the improvements with more regional overarching governance and leadership of HEE North	2	2.1, 2.2, 2.3

2.2. Postgraduate Medical

2.2.1. Organisation overview linked to the HEE and GMC Standards

Please report, by exception, where your organisation does not meet the HEE Quality Framework/GMC Standards within the reporting period for postgraduate medical training. In addition, please provide an overall narrative along with some organisational / departmental / unit examples may support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

The Trust's faculty of medical development have significant concerns that we will not be able to meet the GMC requirements of developing a sustainable workforce in Psychiatry in the longer term.

Despite the many initiatives included in this report and our high rankings in the GMC trainee and trainer survey in 2018, there remain insufficient numbers of higher training posts in the region to meet expected consultant recruitment needs.
The Trust is further disadvantaged in both the North East and Yorkshire because of the low proportion of higher training posts that are placed in the Trust compared to those elsewhere, particularly NTW and Leeds MH Trusts.

Our capacity to meet both service and training needs for senior medical staff continues to be a high priority topic at present; and the Medical Director is currently working with the Chief Executive to produce a workforce strategy. Our medical development faculty continue to monitor the situation and take whatever measures it can to alleviate the worst impacts of consultant level shortages.

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Emerging Concerns requiring further triangulation /action in 2018-2019
During the 2017-18 Training Cycle, areas of potential concern have been identified which require further triangulation following which formal escalation may result if these concerns are confirmed:

- *Core Psychiatry – General Psychiatry – Lanchester Road Hospital*

This year results have shown a 45% increase from 52.08 (RED outlier) to 75.00 for Educational Governance by all Core Trainees at Lanchester Road, and 38% increase from 62.50 (PINK outlier) to 86.90 (GREEN Indicator) for Educational Governance overall by all Trainees, so it is unclear why this is showing as a concern when the survey results intimates that any issues have been resolved.

Emerging Workforce Concerns Identified by Trust as impacting on Training placements/programme
The following programmes and placements have been identified by the Trust as being affected by issues within the Trust's own workforce for service (i.e. NOT numbers of trainees/placements) and thereby at risk of being unable to deliver the relevant curricula if not addressed by the Trust.

- *Community Services*

Consultant vacancies continue to be an issue of concern for the trust and active efforts continue at all levels of the organisation to try to address this in the short, medium and longer terms.
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GMC theme 1 Learning Environment and Culture
For additional guidance refer to http://www.gmc-uk.org/education/index.asp
HEE priority for 2018 reporting in this domain is:
A focus on workplace behaviours and strategies for resolution of issues of concern

Both career and training grade medical staff have protected time in their timetables to ensure that all junior doctors receive the protected one hour supervision each week. Protected time is also incorporated to allow attendance at weekly psychiatry teaching programmes.

Teaching sessions are held in either an education centre or lecture theatre providing a safe and relevant environment in which learning objectives can be met.

The Trust has a robust study leave recording and monitoring procedure in place and junior doctors are actively encouraged to attend learning events to support their curriculum outcomes. The Trust works closely with Health Education England, the Lead Employer Trust and Local Acute Trusts to ensure that study leave is accessible for all junior doctors and that it is approved within a timely manner and accurately recorded. Junior doctors are asked to provide feedback during their end of placement review or registrar clinic and this ensures they have been able to take study leave in their rotation. No negative feedback has been received to date in this regard.

The local in house training programme for trainees now provides opportunities for learning outside the normal weekly postgraduate programmes and topics include emotional intelligence, quality improvement, interview skills, leadership etc.

The Executive Management Team have approved training sessions in RAMPPS (Recognising and Assessing Medical Problems in a Psychiatric Setting). RAMPPS is simulation based training that involves collaboration amongst health care assistants, nurses, allied health professionals and doctors in order to recognise and manage acutely developing medical problems in psychiatric settings. The emphasis is on using a multidisciplinary approach to identify and manage medical conditions that have been known to lead to death amongst our patients in TEWV and other mental health trusts. The established Independent Assessment of Clinical Skills Programme (IACS) makes extensive use of role play simulations in delivering clinical skills training to junior doctors.

Governance of Medical Education (as outlined in the Operating Framework Policy) Committees

There are a number of committees that oversee the quality control and strategic direction of medical education in the Trust. The Medical Education Quality & Assurance Committee (MEQAS) is the most senior of these meetings and it oversees the progress of all educational agendas and sets the strategic direction for the Trust.

The Trust uses the quality improvement plan (QiP) to set direction and ensure progress against all of the actions that are set. Each of the committees set their own QiP for the relevant area of their work and this is tabled and updated at each committee. It is the expectation that in the case of non-attendance by key members at any of the committee meetings a report is completed and submitted to enable updates and discussions to continue.

Mid-term Reviews of Placements

Mid-term reviews were conducted by the FP Tutor within each locality following two months in post. It provided a unique insight into the post, the opportunity it provided to gain experience, access to community experience, supervision, feedback to trainer etc. etc. Such was the value in this, that it core training posts and additionally used as a way of placement planning.

Foundation & GP end of placement reviews

All FP and GP end of placement reviews are conducted by the relevant FP / GP locality tutor when the Foundation Doctor / GP Registrar is in the last few weeks of their post. The meetings are arranged by the Medical Education Team and an email invitation is sent to the Foundation Doctors / GP Registrars advising them that they must attend the mandatory review appointment to enable TEWV to quality assure their training post and subsequently action any concerns or issues they may wish to raise. The email invite includes an end of placement review form that the Foundation Doctor/ GP Registrar completes and submits prior to the review meeting. The FP / GP locality tutor uses the feedback received on the end of placement review form to conduct the review meeting and will ask the Foundation Doctor / GP Registrar to elaborate on the written feedback provided.

The FP and GP tutor meets with the Medical Education Officer each September to review the feedback received throughout the last academic year for each individual post. Feedback is then provided to each clinical supervisor with areas of good practice and areas for address detailed within the feedback letters.

Registrar and Trust Doctor Clinics

Registrar Clinics are held every six months to assess individual progress in training and also to quality assure each placement. The clinics consist of a 20 minute consultation with the Training Programme Director and the Medical Education Officer.

Senior Registrar Clinics

Senior Registrar Clinics will be introduced in the autumn of 2018 and will be conducted by the Senior Tutor for Senior Registrars and the Medical Education Officer. The Senior Registrar Clinics will mirror the format of the Registrar clinics but will be held on an annual basis as opposed to every 6 months.

GMC theme 2 Educational Governance and Leadership

For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Monitoring of LEP use of financial resources provided by HEE to support training. The new Learning Development Agreement (LDA) will be used to link financial resource to quality of training. (See SAR section 4, page 18)*
- *Governance of programmes with complex structures (e.g. Pharmacy & Healthcare Science) where nationally coordinated processes can impact on local delivery within HEE. Clear identification through STEIS (Live Flow) reporting of trainees/learners involved in Never Events and SUIs for both pastoral support and revalidation reasons. (See SAR section 8.1, page 26)*

The medical education operating framework outlines the effective, transparent and clearly understood educational governance in place within the Trust.

Junior doctor placements are continually monitored and evaluated. All Junior doctors complete an end of placement review form. This feedback is analysed on an annual basis by the Training Programme Directors, relevant tutors and Medical Development. Locality action plans are created to capture issues and areas of concern raised. Anonymised feedback is provided to the clinical supervisor. The locality Associate DME receives a copy of the report to oversee progress.

Each registrar within the Trust is allocated an educational supervisor by Medical Development. The registrar is provided with the contact details and encouraged to make contact early in their placement. The School of Psychiatry is provided with an educational supervisor allocation list at the beginning of each rotation.

Forums have been established within the Trust to understand the needs of doctors at different stages of training. Trust grade level, FP, core and GP and higher training. These forums ensure that posts provide sufficient opportunities for training and provide ongoing assurance and opportunities to enhance training further. A recent example of this was the outward bound leadership away day that was organised by a core trainee.

The Trust encourages academic opportunities for junior doctors and has previously offered Medical Education Teaching Fellow roles within the Trust. The Trust also provides an opportunity for senior registrars to apply for funding to complete a Postgraduate Certificate in Medical Education.

GMC theme 3 Supporting Learners

For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Improving support given to learners/trainees involved in Never Events/other adverse outcomes and subsequent clinical governance processes including Root Cause Analysis, Coronial Inquiries etc. (See SAR section 8.1, page 26)*

In 2017 the Trust worked in collaboration with North Tees and Hartlepool Foundation Trust to deliver a Trust Grade Doctors Physical Healthcare Competencies Training Programme. The programme is aimed at improving physical examination and procedural skills to develop the competencies of our overseas trained doctors. The programme includes Calgary Cambridge communication skills sessions, practical clinical skills sessions including Venepuncture, Cannulation, Arterial puncture, IV Medications, ECG's, local anaesthetics and peak flow. The participants also undertake OSCE and MOSLER style examinations.

Feedback for the 2017 programme was analysed and it has been agreed that the 2018 programme will include additional practical sessions within the Emergency Admissions Unit to allow the Trust Doctor to shadow a Foundation Year 2 doctor.

Junior Doctors are provided with an electronic version of the Trust junior doctor handbook upon commencement in post. The handbook is an invaluable resource and provides learners with information including, pastoral support, counselling services, occupational health services and careers advice. All junior doctors have an allocated educational supervisor who is available to provide advice and career support upon request.

GMC theme 4 Supporting Educators

For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Use of the LDA to link the control/distribution of the financial resources provided by HEE to those managing training placements and the individual support to those providing educational supervision. (See SAR section 4)*

The Trust continues to ensure that the four key groups of doctors in secondary care who are responsible for training medical students and doctors are approved. Colleagues have a number of opportunities to access training both in house and externally.

The Trust has recently introduced an In-House Training programme which is intended to support the professional development of our whole medical community and will continue to evolve in both content and scope. The programme is divided into three components: trainer support, clinical skills and additional skills. Educators are strongly encouraged to attend sessions within the programme to further enhance their skills.

The Director of Medical Education provides a Medical Education update at every Trust wide Senior Medical Staff Committee meeting which is held four times per year. Peer support groups for Foundation Programme and GP Registrar clinical supervisors are also in place within the localities. A pilot peer supervision group for clinical supervisors of registrars and senior registrars is in early planning stages

GMC theme 5 Developing and implementing curricula and assessments

For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Assessment of the effects of 'Winter Pressures' on the ability to deliver training curricula across LEPs and the strategies being developed to mitigate impact across individual training placements and programmes. (See SAR Section 8.2, page 27)*

Time for all recognised trainers is included in job plans and the Trust has also agreed a 'time currency' for medical education roles.

In addition to the in house teaching programme, Faculty development sessions are run twice yearly where trainers receive updates about curricula, assessments and placements. The DME also has a regular update session at the Trust wide consultant meeting that is held quarterly.

The Trust has developed the Duties of Doctor and Communication Skills Programme. The Duties of a doctor programme is run in partnership with the GMC and is particularly aimed at overseas doctors new to the UK.

The Trust ensures that each junior doctor job description details their mandatory training courses in conjunction with their relevant training programme. The junior doctor job descriptions are updated on an annual basis by the clinical supervisor as part of an ongoing quality assurance exercise.

The Trust also provides psychiatry modules to foundation stage doctors at the acute trust's local teaching programme. Consultant psychiatrists and senior registrars deliver sessions and include sessions on the treatment of suicidal and delirious patients in an acute setting, other psychiatric emergencies and common psychiatric presentations. The teaching sessions are very well received and provide foundation doctors who have not undertaken a psychiatry rotation with a valuable insight into mental health.

Postgraduate curriculum requirements are serviced by individual supervision and training from accredited clinical supervisors, locality teaching programmes with a variety of educational opportunities, our in house teaching programme modules, the regional MRC Psych programme and a variety of other educational and research opportunities for junior doctors.

HEE Theme 6 Developing a sustainable workforce

For additional guidance refer to HEE Quality Framework, page 17

HEE priority for 2018 reporting in this domain is:

- *Monitoring placement capacity where the LEP's own service workforce may be insufficient to deliver training, especially for 'at risk' placements.*
- *Triangulation of training data with exception reporting data regarding implementation of the Junior Doctor contract.*
- *LEP engagement with HEE across the STP/Integrated Care System for all training & workforce planning to avoid loss of training approval in changing clinical services.*

An overseas initiative has been active throughout the year for recruiting doctors from Europe. A panel of medical education professionals from medical development have been part of the recruiting team and in September 2018 from interviews in Budapest we were able to make offers to 6 doctors to take up trust grade positions within the trust in 2019. Our past experience is that many of these doctors go on to take up core training places in Psychiatry in the UK and mainly, though not exclusively, in the Northern region.
The Guardian Of Safe Working Role is now supported by a Less than Full Time Flexible Champion which in the first instance has been appointed for a year's tenure.

2.2.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include Trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2). When considering items to list here, please consider the GMC definition of good practice.

Description of good practice (and a named contact for further information)	Description of why this is considered to be good practice	HEE/GMC Domain(s)	HEE/GMC Standard(s)
Management & Leadership programme for trainee doctors to be developed	To be piloted in York and Nth Yorkshire localities and led by the ADME's. Champions for trainees to be sought.	2	Educational Governance & Leadership
Discharge Summary pilot has been implemented in Teesside following a RPIW (Rapid Process Improvement Workshop)	Successful pilot to be shared across Durham & Darlington locality too.	2	Educational Governance & Leadership
Development has taken place with a programme for SAS doctors undertaking CESR programme. Tutor role introduced –CESR development overseas tutor for a fixed term period.	The CESR in house programme underway with a programme booklet developed which continues to be updated on an ongoing basis	6	Developing a sustainable workforce.
Overseas doctors continue to be recruited from Budapest with a further visit planned for the autumn,	This gives the Trust the opportunity to engage the skills of overseas colleagues to enhance the service which TEWV offer	6	Developing a sustainable workforce.
SpR's invited to attend SAS away days for further educational development, programme and topics to be agreed.	Improves joint communication and learning across the two disciplines	6	Developing a sustainable workforce.
MERG group (Medical Education Research Group) formed by Dr Juliette Kennedy		1	Learning Environment & Culture
Implementation of whiteboard for Jnr Doctors to improve handover process.	Pilot being undertaken at Roseberry Park, whiteboard provided as an interim process, whilst an IPad is procured to assist and improve communication and the handover process		Patient safety
Annual Trainee Led Symposium	Planned for January 2019 to be organised and led by trainees	5	Developing & Implementing Curricula & Assessments
Seclusion Training to be developed following a concern raised by a trainee	Tutor for Snr Higher Trainees investigating the process to provide a suitable training session.	1	Learning Environment & Culture

Hosting of FP CPD Sessions for FP clinical supervisors with a view to including in locality teaching.	Annual clinics to be set up to allow peer support for clinical supervisors. Also the opportunity for FP tutors to discuss documentation and policies with clinical supervisors. Sessions to be included as part of TEWV In House Teaching programme	3	Supporting Learners
FP/GP clinics to be set up to obtain local feedback	Medical Education Manager to set up regular meetings with FP & GP tutors discuss last 12 months feedback and directed to clinical supervisors for address	2	Educational Governance

2.2.3. Challenges or important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
Due to ongoing recruitment challenges for substantive consultant staff there are fewer experienced supervisors to support the trainees across both Durham and Teesside localities.		
Consultant engagement at locality teaching sessions has been raised as a concern; attendance from consultants and Senior registrars is poor particularly at case presentations and journal cases. Also supporting their trainees when their junior doctor is presenting. This is being monitored and actions being taken to improve attendance Trustwide.	1	Learning environment and culture
Recruitment is a significant issue for all training posts locally and we regularly encounter shortfall in core trainees numbers. We have managed to fill many of these gaps with Trust grade doctors who tend to be IMGs with additional support needs as they settle in to practice in the UK.	6	Developing a sustainable workforce
Balint group pilot. Supportive space for the discussion of trainee experience aimed at addressing aspects of clinical patient interaction that the trainees find difficult or challenging. Ongoing difficulty with low numbers attending, therefore unable to run a group. Situation is being monitored. There is the suggestion of the numbers being made up by Trust Grade Doctors	3	Supporting & Empowering Learners

2.2.4. Medical faculty roles, organisation and accountability

If there have been any changes to your organisation's educational governance structures within the reporting period please detail this here, otherwise please state 'no changes'.
If there are any vacant roles, or risks to medical education please describe these here, including any plans to mitigate that risk.

This year has seen a change in leadership in the form of a new Medical Director, Dr Ahmad Khouja who has taken on the role from Dr Nick Land.

New Trustwide roles created
Senior Undergraduate Tutor
Senior Trust Doctor Tutor

New Trustwide roles in development
SpR Tutor – North
SpR Tutor – South

Expired Roles (June 2018)
Overseas Tutor CESR

2.2.5. Staff and Specialty Grade Doctors (SASG) and Locally Employed Doctors (LEDs) Faculty development

Please provide answers to the following questions. You may wish to include funding details, as required. For further information in relation to LEDs please review the following NACT document LEDs across the UK http://www.nact.org.uk/documents/national-documents/.

Questions	Trust's answer
Number of SASG doctors within the Trust	**44** as confirmed by medical staffing
Total SASG funding received	**£39k**
Is the SASG funding ring-fenced to support SASG doctors only? (Y/N)	Yes
Please describe the process by which the development needs of SASG doctors within your organisation were individually and collectively identified. Using funding allocated for SASG development; How were priorities decided?	The training needs of SAS doctors are identified through clinical supervision meetings and at appraisal. Their needs are then collated, discussed and prioritised by the tutor on behalf of the committee and this informs the development days. Comprehensive programme for trust doctors and those appointed to the CESR programme.
SASG nominated lead within the Trust	Dr Huma Aazer

Please provide a description of how the Trust makes decisions about the allocation of funding (1-5 below)

	Spending	Detail
1. Individual doctor's development (i.e. details of spending used to support the development of individual doctors including an anonymised list of amounts and what it was used for)	£10k	
2. Courses/meetings arranged which are open to all SAS doctors (number of sessions, attendance and topics covered)	£20K	Bi-monthly SAS Away Days SAS Programme Royal College E-Resources CESR programme Leadership and management
3. Payment for SAS tutors/leads sessions	£25k	4 Tutors
4. Administrative costs to support SAS tutors	£ 5k	Quality & Events officer, plus admin support
5. Miscellaneous (i.e. any other use of the funding which falls outside the above with details of amounts and what it has been used for)	£ 5k	Pro rata share towards annual conference

2.3. Undergraduate Medical

2.3.1. Organisation overview linked to the HEE and GMC Standards

Please report, by exception, where your organisation does not meet the HEE Quality Framework/GMC Standards within the reporting period for undergraduate medical training. In addition, please provide an overall narrative along with some organisational / departmental / unit examples may support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

GMC standard theme 1 – Learning Environment and Culture
▪ Students were provided with sufficient opportunities to meet learning outcomes ▪ Students received sufficient feedback to track and direct their learning ▪ Students were satisfied with the overall organisation of the placement ▪ Students were satisfied with the overall quality of the Stage ▪ Clinical teachers were punctual and reliable in their attendance. (Due regard will be given to mitigating circumstances of urgent clinical need) ▪ The overall quality of the teaching was of a consistently high standard
The Trust has a medical education governance structure and tutors for each stage of training. Part of this structure encompasses educational committees for each stage of training. A responsibility of the committees is to ensure information about learner's performance, progression and their outcomes are analysed. Actions are set where weaknesses are identified. The Undergraduate team are informed by the Base Unit about any mitigating circumstances, issues or concerns regarding forthcoming medical students who are due to commence their rotation. This includes analysing data from evaluation and understanding assessment trends. Medical development is also a conduit to share information about the medical education agenda. The Faculty also come together for two sessions annually. The interpretation and analysis of local data intelligence is used to inform and improve the delivery of UG education. As data is no longer collected live a local template was developed in order to record outcomes, this in turn allows action plans to be developed and implemented by the UG committee. Formal feedback is provided to medical students during their weekly Tutorial sessions where they individually present a case history and are given feedback on the case in line with the assessment domains for their stage of learning. Formal feedback is also given following a Formative Appraisal of Practice which each student receives during their rotation. Students are observed taking a psychiatric history from a patient in the clinical areas using the framework of the Calgary Cambridge Guide to the Medical Interview. Students are encouraged to reflect on the assessment and feedback in order to improve their practice in the future, they are also encouraged to obtain informal feedback when they are on placement within their clinical areas from the whole range of health professionals within the team.

GMC standard theme 2 – Educational Governance and Leadership

- Trust systems are in place to detect and investigate patient harm involving or as a result of student activity
- Trust systems are in place to ensure informed consent is taken in areas where patients may encounter students
- Clinicians / teachers are appraised against their teaching

The medical education operating framework outlines the effective, transparent and clearly understood educational governance in place within the Trust.

The Trust have an Undergraduate Committee where tutors, clinicians and administrators involved in medical student teaching meet quarterly to discuss areas of good practice, consider processes and systems and discuss areas that require improvement within the learning environment.
The undergraduate education team regularly meet following each rotation to discuss evaluation data and feedback to identify areas which may need improvement to ensure that the standards required by the medical school.

Medical students are encouraged during their induction to raise any ethical concerns and advice is provided also about the Duty of Candour. This provides a process if students raise concerns or if they believe that harm has resulted from actions, omissions or mistakes. Students are informed that they need to inform Medical Education or a member of the clinical team where they are based should they have concerns relating to patient safety or wellbeing. They are informed of the support that is provided and the process of reporting an incident via the Trusts' Datix incident reporting system.

GMC standard theme 3 – Supporting Learners

- Appropriate guidance and support was available outside of formal teaching
- Students were satisfied with the overall quality of the facilities for students.
- Teaching took place in appropriate settings and surroundings
- Good quality learning resources were available to support learning
- Access to IT facilities was adequate
- The programme of study outlined for the course was delivered

All medical students are required to comply with the Newcastle University School of Medical Education Learning Agreement. Within this agreement, students are required to adhere to specific principles with regard to recognising the limits of their competence and asking for help where necessary.
Students are also directed to have a discussion with their supervisors about their placement and about informing patients and carers that they are a medical student.

All clinical areas that host students are informed verbally and in writing of the stage of training they are at. This includes details of their learning outcomes that relate to the curriculum and the type of clinical activities they are expected to undertake.

GMC standard theme 4 – Supporting Educators

- Clinicians / teachers have time in job plans for teaching including educational supervision.

The Trust ensures that the four groups of doctors in secondary care, responsible for training medical students and doctors are approved for their roles as set out in the GMC Trainer Accreditation

The Trust has recently introduced an In-House Training programme which is intended to support the professional development of our whole medical community and will continue to evolve in both content and scope. The programme is divided into three components: trainer support, clinical skills and additional skills. Educators are strongly encouraged to attend sessions within the programme to further enhance their skills.

The Director of Medical Education provides a Medical Education update at every Trust wide Senior Medical Staff Committee meeting which is held four times per year. Peer support groups for Foundation Programme and GP Registrar clinical supervisors are also in place within the localities. A pilot peer supervision group for clinical supervisors of registrars and senior registrars is in early planning stages.

GMC standard theme 5 – Developing and implementing curricula and assessments

- The Trust has processes to ensure those undertaking summative assessments are appropriately trained
- The Trust has a system in place to provide educational supervision
- The Trust has an executive or non-executive director at board level responsible for supporting training programmes

All clinicians involved in undergraduate education with medical students from Newcastle Medical School are provided with Staff Development training sessions which cover a comprehensive range of topics. These sessions support clinicians and help to ensure their ability to deliver training.

Clinicians who deliver teaching and assessment to undergraduate medical students are provided with full briefings in regards to the specific teaching they will be delivering and all teaching material is sent in advance of teaching sessions.
Training for summative assessments is provided and facilitated by the undergraduate education team annually and a full briefing is delivered prior to all MOSLER assessments. All clinicians who have facilitated teaching or assessments are provided with PDP letters and the feedback from the students that attended their sessions.

HEE Theme 6 Developing a sustainable workforce

For additional guidance refer to HEE Quality Framework, page 17

Expansion Of Student Places

This year a new medical school in Sunderland has been approved by the GMC which will have 100 students in each year group starting from 2020. With an acknowledged emphasis on developing interest in primary care and psychiatry and local recruitment of students it is hoped that this may improve recruitment to psychiatry in the longer term. This will however also provide a challenge to deliver appropriate and high standard training to these new students while also maintaining our excellent reputation for training Newcastle University medical students.

2.3.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include Trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2). When considering items to list here, please consider the GMC definition of good practice.

Description of good practice (and a named contact for further information)	Description of why this is considered to be good practice	HEE/GMC Domain(s)	HEE/GMC Standard(s)
PEEPS : Psychiatry Early Experience Programme	5 year programme CT mentor students/buddy system to be implemented June 2018	1	Learning environment & culture
Community Apprenticeship/Placement Model - developed for pilots across Teesside, Wear and Harrogate	Model adapted to suit each locality and medical school curriculum with a view to going fully live in September 2018 following a successful pilot.	2	Educational Governance & Leadership
Balint group pilot in place on Teesside	Supportive space for the discussion of student experience aimed at addressing aspects of clinical patient interaction that the students find difficult or challenging.	3	Supporting & Empowering Learners
Easier Student access for HYMS students to teaching resources.	Scarborough's clinical staff who provide teaching sessions to HYMS students have been invited to record seminars and place on HYMS virtual learning environment.	4	Supporting & Empowering Educators
Consultant Assessor Training and facilitation of the MOSLER assessments.	Newcastle director for Mental Health attended an exam session for a review, and gave positive feedback on the training and assessment process at Tees Base Unit.	4	Supporting & Empowering Educators
Medical Education Annual Conference: Psychiatry in the Undergraduate Curriculum	Event well organised, successfully planned and well attended.	5	Developing & delivering curricula & assessment
Appointment of Trustwide Senior Undergraduate Tutor role within medical education faculty.		6	Developing a sustainable workforce

2.3.3. Challenges or important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
HYMS plan to increase undergraduate numbers by 70, which will bring its own challenges to plan and resource within the York locality	2	Educational governance & leadership
Development of a pilot Balint group at the request of Newcastle Medical School has come with its own challenges, around attendance numbers, timing and location, further information will be provided once feedback evaluated.	6	Developing & delivering curricula & assessment
Significant change to service reconfiguration in Yorkshire. We need to understand the landscape first as to what the impact will be on training resources and the delivery of training.		
Medical vacancies for teaching to be delivered, along with the ability to deliver the training.		
Decanting of services and patients at Roseberry Park Hospital – impact of training posts and also delivery of training.		

2.4. Academic Training

Please describe how your organisation supports academic learners, including Integrated Academic Training Programmes e.g. NIHR, clearly highlighting any challenges or good practice items.

Good Practice

MoD trainee (higher trainee) in Teesside
TEWV resident rota supported ACF in clinical placements
Establishment of a Medical Education Research Group
Developing relationships with York University school of health and HYMS medical education faculty.

Challenges

Challenges from the region to support integrated academic training programmes in our locality as we fall between 2 major academic centres (Newcastle and Leeds)
Not having enough suitable academic clinicians to support research for higher trainees
Lack of consultant academic consultant posts to recruit ACF trainees upon completion of training.

Section 3: Reference List of Supporting Information

Organisational policies and processes in support of delivery of the HEE Quality Framework.

This section will need completing once, in subsequent annual returns only changes and updates will need to be highlighted.
Please list key policies and processes and provide a brief narrative how the policy helps the organisation to meet the domains and standards. Add as many rows as required.
Please advise which domains and standards are being supported the policy.
Please note, we do not require copies of documents. Please do not embed documents or insert links. If required the quality team will request a copy by exception.
Please advise if you have made a reference to a policy/process in other section(s) of the SAR.

Description of supporting information	HEE/GMC Domain(s)	HEE/GMC Standard(s)	Please advise if document referenced in the SAR e.g. *SAR, section 1.4 and 2.1.1*
As referred to in the HEE guidance on completion, these documents were listed in detail in the previous year 2017/18 return, with embedded examples or links. However key examples as outlined below			
New 2018 Workforce Strategy (DL/AC)	Domain 1, 6		
Health and Safety Workbooks and Policy CQC outcome report and action plan Friends and Family Test Staff Survey Evaluation of placement by student Educational Audit competed every two years Trust values and behaviours Trust Compact Equality and Diversity Policy Staff Development Policy	Domain 1		
QIS Tools and methodology – from within the Trust's overall Kaizen approach to quality improvement managed through a KPO (Kaizen Promotion Office) Student placements in service improvement area (evidenced within students journey) The New NMC curriculum development groups at HEI's, ToR, minutes etc.	Domain 1		

Patent safety bulletin with key messages from learning points SBARD messages re lessons learned – standard format to highlight immediate actions			
Educational Audit – with action plan against any areas of concern jointly with service. Process in place for managing evaluations where students highlight concerns, jointly with the HEI's TSD Scorecard which is based around quality of placements, we consistently achieve the 95% target. This information is raised at the Directorate Management Team report out chaired by the Executive Nurse Training Needs Analysis process Service Level Agreements in place with stakeholders Standard process in place linked to Datix for incidents with student issues, descriptor spreadsheet in place, used by PPF's.	HEE Domain 2		
Pre –registration nursing is covered in student handbooks setting out expectations and process Student induction programme in place as above Student portfolios with mentor input Tri-partite meetings process Initial assessments mandatory for all HCAs Evidence in portfolios for students, e-portfolio's such as 'PebblePad' Student Evaluations Assessment tools in student handbook	Domain 3		
Staff values and Behaviours, Trust Compact Mentorship programme for Nurses which is NMC approved	Domain 3		
PPF;s have evidence of workshops and numbers updated, and records of current mentors on the register and up to date University offer mentor briefing and updates – e.g. for the new TNA roles to ensure workplaces fully prepared and cognisant of programme requirements Supervision Policy Local Skills Checklist Triennial review Process – which is an NMC standard and is also an agenda item in their appraisal	Domain 4		

Membership of Curriculum planning groups to meet new NMC standards and shape programmes to MH/LD requirements, TofR, minutes available	Domain 5		
Robust selection process jointly with University – with values based approach Flexible programmes to maximise retention. Trainee Nursing Associate and sponsorship onto Learning disability programmes support existing staff to develop their careers with high probability of retention Open University part-time distance learning to support those in work place learning, is supported by the organisation (approx. 20 students currently on either pre-registration or access modules) Programme framework and reporting requirements for overall Right Staffing Programme (reported at Executive level; Preceptorship policy Preceptor development programme Work based preceptee programme Preceptee development locality programme (band 5 development) which meets HEE standards	Domain 6		
In House Training Programme	1, 4, 5	Learning Environment & Culture:/Supporting Educators: / Developing & Implementing curricula & assessments	2.2.1 2.3.1
QiP	1	Learning Environment & Culture	2.2.1
Medical Education Operating Framework	2	Educational Governance & Leadership	2.2.1 2.3.1

Section 4: 17/18 and 18/19 LDA Funding

		Total paid in 17/18	Estimated 18/19 funding
Total paid to the Trust in 17/18:		£4,174,871.00 (NE) £2,536,886.00 (YH) (total: £6,711,757.33)	n/a
Total initial 18/19 LDA value *(including undergraduate)*:		n/a	£6,379,999.53
Total for salaries for doctors in training:		£1,710,207.00 (NE) £865,851.00 (YH) (total: £2,576,058.00)	£2,584,280.00
Tariff for placement activity			
Postgraduate Medical	Tariff *(as per DoH guidance* £12,152 + MFF)*	£973,012.00 (NE) £502,079.00 (YH) (total: £1,475,091.00)	£1,480,837.00
	Contribution to basic salary costs *(as per DoH Annex A*)*	£1,710,207.00 (NE) £865,851.00 (YH) (total: £2,576,058.00)	£2,584,280.00
	Total	£4,051,149.00	£4,065,117.00
Total Non-medical placement tariff: *(as per DoH guidance* £3,112 + MFF)*		£610,168.16 (NE) £222,045.00 (YH) (total: £832,213.16)	£832,209.60

**2017-18 Education & training placement tariffs: Tariff guidance and prices from 1st April 2017*

A placement in England that attracts a tariff payment must meet each of the criteria in line with the DoH guidance*. Please provide details of how you utilised your 17/18 placement tariff within the financial year April 17 to March 18 to support learners and educators.
Please note figures entered below should reconcile to the 17/18 tariff figures shown in the table above. Please provide details of expenditure and associated costs.

	Trust's Response
Postgraduate Medical Placement Tariff *The E&T placement tariffs cover funding for all direct costs involved in delivering E&T by the provider, for example (please see DoH guidance page 6):* *Direct staff teaching time within a clinical placement* *Teaching and student facilities, including access to library services* *Administration costs* *Infrastructure costs*	The NHSi cost collection exercise outlines the cost associated with the training of medical students and junior doctors. Activity and expenditure in relation to training remain largely consistent with last year. Work is currently underway to understand a placement model for the anticipated expansion of students with Sunderland Medical School
Non-Medical Placement Tariff *As above*	The funding has remained the same since the last return 17/18. The cost collection for each professional group costings and expenditure covers: • Pre Placement planning and support • Direct Teaching • Teaching staff time spent on training courses

	• Staff teaching and mentoring whilst delivering direct patient care. • Facilities eg Room Hire, materials • Administration support • Nursing: 2.6 WTE Senior Nurse Practice Placement Facilitator posts The organisation has increased the number of placements offered with no increase in tariff from 17/18, and has itself funded learning disability and apprentice nursing backfill costs to help maintain a sustainable workforce
Additional Funding *Please confirm how any additional money has been spent.*	

Section 5: Simulation, Patient Safety and Human Factors

5.1. Patient safety

Please consider the following questions below.

Questions	Trust's response
1. Who is the Lead for Patient Safety in your organisation? What support do they receive in delivering this role? E.g. job-planned time, resources etc.	Jennifer Illingworth, Director Quality Governance is the lead for Patient Safety and Elizabeth Moody, Director of Nursing and Governance has Board responsibility for this role. There is job planned time and a patient safety team whose role focusses on serious incidents (SI) along with a well embedded governance process to assure all SI's are investigated, that learning takes place any action plans monitored. Additionally, patient safety related factors are fed into the Patient Safety Group (a high level governance forum) which is a themed sub-group reporting monthly to the Trusts Quality Assurance Committee which in turn reports directly to the Trust Board.
2. Please advise up to three areas relating to patient safety agenda that you have worked on in the last two years and you are most proud of? Could these be applied regionally and be shared with HEE?	• Implementation of the Learning from Deaths framework and the mortality process now in place linking with high level governance process and groups in the Trust. Yes this could be shared. • Family involvement in the SI process in which families are contacted as a first point of contact and share their experiences with front line clinicians. Yes, this could be shared. • Thematic reviews both locally and Trustwide e.g. Leave from Inpatient wards, comparison of university student deaths between 2 localities
3. In which areas would you like support from HEE? E.g. educational events, funding, specific areas of training for example quality improvement?	Funding for further training for patient safety team to aid a 'train the trainer' model in analysis and human factors, to improve head of service reviews.

5.2. Simulation

Prompt: We advise you to consult with your Simulation Manager or Lead when compiling your response.

Questions	Trust's response
1. Who is the Simulation lead in your organisation? Please advise on name, job title and email address. What support do they receive in delivering this role? E.g. job-planned time, resources etc. Are they linked in with the HEE Simulation Network in their locality?	Physical health in mental health and learning disability is a high priority within this Trust. Aware that many patients in psychiatric settings suffer premature deaths although the causes of death in the majority remains the same as those in the general population. Specifically to support this the Trust has a steering group that has been set up 'Recognising and assessing medical problems in psychiatric settings' (RAMPPS). This approach consists of scenario based learning with a clear MDT focus which can be used flexibly in a range of situations and areas. The simulation lead is Karen Naylor, a Nurse Practitioner for Physical Health Care who chairs the RAMPPS steering group and is taking this forward in the Trust. Patient safety has a representative on this steering group to share learning from SI's where simulation could be used for training.
2. Who is responsible for keeping an inventory of the simulation equipment within the Trust including all task trainers and low fidelity mannequins?	The Trust does not keep an inventory as mannequins and equipment are not used in the simulations. All simulations involve a live person who is an actor (from a registered list) and all the equipment used is replica, as there is no test of staff being able to use equipment in the simulations.
3. How many simulation specific trained faculty does the Trust have?	The Trust has five trained faculty members who have completed the national course. There is a plan to grow this number to broaden across the multi-disciplinary professions with the aim to sustain the simulation work. Following on from 2 successful pilots EMT have approved 6 further pilot days in order to gain further evidence and evaluation from a larger cross section of the workforce with further involvement from AHP' s.
4. Which directorates or inter-professional groups are actively engaged with simulation based education within your organisation? How do you encourage equitable access to simulation for all staff?	Simulation based training is generally accepted as the gold standard method of training and there is significant signposting and discussion within the debrief in regards to physical health re EWS, Rapid Tranquilisation, Blue Bags, emergency drugs, Diabetes and First Response etc. The Trust has a multi-disciplinary approach to simulation and all pilots involve all clinical roles appropriate to the simulation. All simulations are in line with the national handbook scenarios. As a further example in practice, a simulation event

	involving multidisciplinary staff took place as an experiential learning event in Tier 4 inpatient Children and Young People's Services, following a series of Serious Untoward Incidents occurring on the same shift. This was collaborative, involving Health Care Assistants and Staff Nurses who were on shift leading the simulation, support from nursing governance, managers and staff psychology service. Learning included addressing clinical needs, human factors and practical environmental changes. Additionally, in April 18 the Pharmacists and Pharmacy Technicians participated in interactive case-based learning about type 2 diabetes facilitated by the Centre for Pharmacy Postgraduate Education as part of their 'focal point' series.
5. Is there strategic engagement and representation in simulation activity in the organisation i.e. board level, clinical governance, patient safety, incident reviews?	The support for taking forward this work is supported by the Executive Management Team (EMT) who are in full support of the work and the pilots.

5.3. Human Factors

Questions	Trust's response
1. Who is the Lead for Human Factors in your organisation? What support do they receive in delivering this role? Eg job-planned time, resources etc.	The Director of Quality Governance and the Senior Nurse Quality Governance have the lead for Human Factors. The Senior Nurse is based in the patient safety team and Human Factors is an integral part of the teams role.
2. Please describe the extent to which your HF training covers the following domains: • People – the individual & teamwork • Environment – the physical aspects of a workspace • Equipment and technology • Tasks and processes • Organisation • Ergonomics and research methods	All of the areas on this list align with the Root Cause Analyses (RCA) 'Fishbone' tool which is used in SI investigations and the Trust has a robust model in place for assuring all factors are taken into account in the SI process. All staff are fully trained in RCA methodology before they can lead on an RCA with a team/service where an incident has occurred.
3. For the training delivered in the reporting period please also consider and describe the following: • The audience to which HF training is being delivered, including details of multi-professional staff. • Frequency of training, or whether ad hoc events. • Who are the faculty that deliver the training? Please describe their "HF expertise", professional background, specialty, whether they have job-planned	The PST reviewers are all trained in RCA**,** which includes human factors aspects, and training for these factors. By the nature of the RCA process human factors knowledge gained from the SI investigation is used as a basis for learning lessons and improving patient safety and performance of Trust staff across all disciplines. This is also covered in the Trust induction presentation for all new staff starting in the Trust regardless of profession. Additionally, this features on the agenda for the patient safety group to support the

time to deliver HF training. • What is the wider Trust context within which HF training is delivered. Is there a link between patient safety incidents, SI investigations, root cause analysis? • To what extent is HF training seen as part of a wider patient quality and safety agenda or integrated into clinical governance structure/process?	Trust taking this forward

Section 6: Equality and Diversity

The HEE Quality Framework states clearly that education and training opportunities should be based on principles of diversity and inclusion.

The HEE equality, diversity and inclusion strategy reflects HEE's commitment to this important area of work and features strategy for HEE employees, as well as the opportunity to influence wider. An example of this is the HEE workforce strategy, used to inform our work in developing a comprehensive system-wide understanding of workforce needs for the future. Diversity and inclusion will be integral in how we look to influence the healthcare system to achieve greater representation and social mobility.

As well as applying these principles across all professional groups, there is also a specific work stream and duty to consider and capture information for doctors in training. The GMC continue their work in equality and diversity, reflecting their standards; promoting excellence.

For medical education, the GMC and local offices continue to consider differential attainment; different rates of attainment between different groups of doctors. This work includes ethnicity and country of primary medical qualification.

Prompt: In the responses below, please consider:

- *Organisation wide themes*
- *Examples of good practice from across professional groups*
- *As well as specific consideration and comment on differential attainment for doctors in training*

Question	Trust Response
Name of Trust Equality, Diversity and Inclusion Lead:	David Levy – Director Human Resources and Organisational Development and Sarah Jay – Head of Equality and Diversity
1. How do you ensure that learners with different protected characteristics are welcomed and supported into the Trust, demonstrating that you value diversity as an organisation?	Tees, Esk and Wear Valleys NHS Foundation Trust is committed to actively recognising and promoting Equality and Diversity. The Trust believes in making every effort to be a fair and unbiased organisation. Further to this, the Trust aspires to be an organisation that embraces and values people, recognising the benefits that diversity brings to the Trust both as an employer and in the delivery of services. As a public body within the NHS the Trust expects a continuous and exemplary commitment from all of its staff regardless of pay grade or position, taking a proactive approach to Equality, Diversity, Human Rights and the Care Quality Commission's Essential Standards of Quality and Safety. As an employer the Trust is continually working towards the development of an organisational culture in which diversity is valued and staff are able to promote equality and challenge unlawful harassment, discrimination and bullying.

	As part of the medical education departments normal practice, all of the protected characteristics are covered, some examples include :: • Language Testing for Overseas Doctors • Allowances for special needs doctors, including visually impaired, and equipment for storage of insulin • Ongoing recruitment campaign for overseas doctors, to attract all ethnicities and genders • Mixed culture of faculty members within the medical development directorate • Use of demographics in various surveys across the Trust.
2. How do you liaise with your Trust Equality, Diversity and Inclusion Lead to: • Ensure Trust reporting mechanisms and data collection take learners into account? • Implement reasonable adjustments for disabled learners? • Ensure your policies and procedures do not negatively impact learners who may share protected characteristics? • Analyse outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic?	Some data is collected, but this is limited to only 2 of the protected characteristics. Further work to further embed the collation of this data across all groups will be a key action going forward The Trust has signed up to the Disability Confident Scheme level 2, and has subsequently developed an action plan. This, alongside some work undertaken by a Masters student, looking at the work experiences of those people who have a disability in TEWV, have led to the identification of further work on the issue of reasonable adjustments in the learning environment. The Trust has recently become a member pf the Business Disability Forum as part of efforts to improve local policy and practice with regard to the employment of disabled staff and learners The Trust has an Equality Analysis Toolkit which helps support the review of Trust policies, procedures, strategies, functions and services in order to establish the impact on Equality by the Trust. The Equality Analysis Toolkit supports the Trust and its staff to work towards fulfilling the legislative requirements of the Equality Act 2010. Part of normal day to day decision-making for all public sector bodies should involve assessing in so far as is relevant and proportionate, the impact they have on equality in our society. An equality analysis must be completed: • For all new polices, procedures, functions, strategies, services and business plans, codes of practice, projects and guidance • Dynamic assessment for all Trust Board decisions

	and proposals. The Trust Board of Directors will not ratify any document or proposal that has not had an equality analysis • Reviewed as a minimum every three years for all existing policies, procedures, functions, strategies and services • Reviewed when significant (more than minor/trivial) amendments and changes are made The Trust's Equality Analysis Toolkit can be found on the Trust website at: www.tewv.nhs.uk/policies or by copying and pasting this link below into a web browser. http://www.tewv.nhs.uk/About-the-Trust/Policies/Corporate/ • Following an external monitoring visit, this is an area where we will wish to make further improvements and take actions, reporting outcomes through the relevant governance structures.
3. How do you support learners with protected characteristics to ensure that known barriers to progression can be managed effectively?	An example, the Trust has acknowledged in its Workplace Race Equality Standard action plan that those employees with a BAME background are not well represented in senior non-medical roles. As a result, the Trust developed a BAME leadership programme for bands 5 – 7. The first 3 day programme has been completed, involving 10 members of staff. The programme evaluated very well and a second programme is to take place. As part of the Trusts service user involvement, ongoing development work continues with the programme. Any individual requirements are dealt with as and when they arise, and action plans agreed, implemented and monitored. There is consideration being given towards attracting a wider range of ethnic groups to be involved as our service users. This is part on the ongoing development work of the team of the specialist nurses.
4. How do you educate learners on equality and diversity issues that may relate to themselves, their colleagues, or the local population of the Trust?	Equality and Diversity Training is essential, it supports the development of empathy, compassion, understanding and knowledge. It enables staff to put equality and diversity into practice within their role, regardless of their position in the organisation and helps to ensure the Trust remains compliant with the Equality Act.

	The Trust uses a variety of different training methods which include sharing patient stories, face to face training and e-learning. These different approaches promote good practice and encourage empathy. Members of staff with good levels of E&D awareness are more likely to demonstrate higher levels of emotional intelligence, tact and professionalism. Equality and Diversity Training is mandatory for all Trust staff. Some other examples of where equality and diversity is embedded within the training are: • Corporate Induction • Leadership and Organisational Development Training • Trust Values Training • Recruitment and Selection Training • Hospital Managers Training • Equality Analysis Training • Bullying and Harassment Training • Equality Act and Human Rights Act Seminars • Complaints Investigation and PALS Team Training The Trust is working in partnership with other organisations to deliver the following specific awareness raising training sessions. • Asylum Seeker Awareness Training • Deaf and Visual Awareness Training • Deaf and Mental Health Awareness Training • Gender Sensitivity Training • LGB Awareness Training Investing in Equality and Diversity training leads to competent staff that are able to deliver services that meet people's needs.
5. How do you support your educators to develop their understanding of, and support for, learners with protected characteristics?	Equality and Diversity training is mandatory for all Trust employees, bank workers and volunteers.

Section 7: Libraries and Knowledge Services (LQAF)

We recommend that you consult with your Library and Knowledge Services Manager or Lead to complete this section. Please provide narrative and evidence (for 1, 3 and 4) on the following 4 areas for your Library and Knowledge Service. Please also highlight any issues or concerns, including any areas which are not being met. If your Library and Knowledge Service is provided via a service level agreement, please consult with the providing Library and Knowledge Services Manager. Additional prompts have been added under each heading.

1. Describe how your Trust is implementing the ***HEE Library and Knowledge Services Policy*** (https://hee.nhs.uk/sites/default/files/documents/NHS%20Library%20and%20Knowledge%20Services%20in%20England%20Policy.pdf) namely:

   "To ensure the use in the health service of evidence obtained from research, Health Education England is committed to:

   - Enabling all NHS workforce members to freely access library and knowledge services so that they can use the right knowledge and evidence to achieve excellent healthcare and health improvement.
   - Developing NHS librarians and knowledge specialists to use their expertise to mobilise evidence obtained from research and organisational knowledge to underpin decision-making in the National Health Service in England."

   Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence from your Library and Knowledge Services' strategy or annual action/implementation/business/service improvement plan.

All staff (including students) have access to comprehensive Trust Library and Information services across four library sites, plus pop up libraries across the Trust geography and also through on-line resources and support. The service plays a key role in supporting the education and continuous learning of the whole workforce. The Trust Library and Knowledge Services strategy is interlinked with a range of other strategies within TEWV:
Research and Development Strategy
Nursing Strategy

Multidisciplinary working is part of the culture within the organisation and students from all disciplines are encouraged to learn more about one another's roles through the use of case studies and Schwartz rounds providing inter-professional learning opportunities.

Students are informed of library services available within the Trust and students are encouraged to join as part of their placement. Through a shared library catalogue https://of-nenhs.olib.oclc.org/folio/ all staff and students have access to other Trust resources and can return library books to other Trust library services

TEWV has a Library and Information Services (LIS) strategy which is based on Knowledge for Healthcare, . This ensures that all TEWV staff, students and volunteers have access to library and knowledge services, increasingly in a remote way, although we still maintain four physical library spaces.

Library & Knowledge Services plays a key role in supporting the education and continuous learning of the whole workforce, through building up links with the TEWV Workforce Development Team, the Research and Development Department as well as further strengthening well-established links with Medical Education but in addition this framework is interlinked with a range of other strategies within TEWV:

Nursing Strategy 2017-2021

Which aims to promote safe and effective practice by building a culture of shared knowledge, information and good practice" and takes into account the NMC Code of Practice (2015) which requires nursing staff to practice effectively using the evidence base and the need to revalidate every three years.

- Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.
- Use learning from research to innovate and improve care and define nursing contribution and value.

Forensic Services – Positive behaviour support (PBS) pathway

- Person Centred Pathways of Care detail the locally agreed evidenced based clinical standards for addressing a particular clinical problem.

Leadership and Management Development Strategy 2018-2022

- Providing appropriate education, training, development and leadership opportunities for all staff
- Providing high quality placements for student health care professionals and trainees as the future workforce

Research and Development Strategy 2015-2020

- *to provide excellent services'*, access to clinical trials for service users contributes to the effectiveness of their care and improves knowledge and use of clinical evidence by professionals.
- Use research evidence to ensure the care we provide is effective and cost-effective

LIS is managed as a part of the Trust Medical Education Department and as such play a key role in disseminating evidence on care and treatment relevant to the Trust's services and providing evidence in response to clinical questions and queries.

We have a clinical librarian who works closely with clinical teams to provide evidence-based clinical solutions. In addition, the LIS has close working links with other regional services, and is working towards more streamlined processes around promotion of regional current awareness in a range of topics related to mental health, while further initiatives around links with academic partners will develop this regional approach further.

2. HEE's ***Library and Knowledge Services Policy is*** delivered primarily through local NHS Library and Knowledge Services.
   - Please identify the budget allocated to your Library and Knowledge Service in the current financial year.
   - If possible please identify the sources of this funding, differentiating for example between educational tariff funding and any contribution from your organisation.

Prompt: Your Finance department and/or your Library and Knowledge Service Manager should be able to supply this information.

TEWV receives its funding through many different sources and types of contracts. Library and information services do not have their own distinct income stream but are funded from various different income streams to the desired level within our organisation.
TEWV Library and Knowledge Services (LIS) are located across four main sites:

- Darlington – West Park
- Durham – Lanchester Road
- Middlesbrough – Roseberry Park
- Scarborough – Cross Lane

The library staff support Pop Up libraries across the Trust

The TEWV staff have access to 10 other libraries across the North East

- County Durham and Darlington (Darlington Memorial and Prospect House)
- Gateshead (Queen Elizabeth)
- Newcastle (Freeman and the RVI)
- Northumberland (Cramlington, Hexham , North Tyneside and Wansbeck)
- University of North Tees (Stockton)

The library service makes use of Core Collection e Resources purchased centrally for all NHS libraries

The library service has been successful in bidding for extra grants to improve the electronic book stock and e journal resources

3. Please tell us about any areas of Library and Knowledge Services good practice that you would like to highlight.

Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence of impact on clinical practice, impact on management decision-making (including cost savings) and any innovation submissions originating from your Library and Knowledge Service.

The Catalysing Knowledge Exchange between the University of York, Tees Esk and Wear Valleys NHS Foundation Trust and Northumberland Tyne and Wear NHS Foundation Trust' This project is collaborating with library services in both mental health Trusts to build on and develop enhanced methods of knowledge exchange, led by Rachel Churchill, Professor of Evidence Synthesis in the University's Centre for Reviews and Dissemination

Pop Up Libraries the library service has developed an outreach programme to support staff and students in buildings across the Trust geography – to date 45 sessions have been held.
Supporting Trust Conferences – the library service has attended several Trust conferences to highlight the library service.

Teaching sessions across the trust focused on various curriculum elements including Evidence Based Psychiatry and Critical Appraisal programme

4. The **Learning and Development Agreement** that Health Education England has with your organisation states that the LKS should achieve a minimum of 90% compliance with the national standards laid out in the current Library Quality Assurance Framework (LQAF).

   If your LKS has a score below 90% please describe the improvements you are planning to attain this minimum requirement in 2018-19.

   Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. The details should be available from the LQAF Action Plan developed following the 2017-18 LQAF.

The library and information service scored 77% in the 2017 Library Quality Assurance Framework. The improvements agreed with HEE NHS library and Knowledge Services Development Manager North East have been implemented through the year – with increased teaching sessions and raising the profile of the library outside the traditional library venue. Library Quality Assurance Framework (LQAF) Action Plan for 2018 is available for reference if required.

Section 8: Additional Information

8.1 Supporting Learners at Coroners' Court and following Serious Incidents

To help HEE better understand how your organisation supports learners please complete the questions below.

Serious Incidents and Never Events

Questions	Trust's Response
Please provide an account of how your organisation identifies learner involvement in Serious Incidents. How is that degree of involvement defined?	Any member of staff can find themselves involved in a SI situation whether in a learner capacity or not. When a SI occurs this is taken forward by the patient safety team, anyone involved in a SI would be invited and supported to attend the RCA meeting including identified learners. This would involve a discussion of human factors as well as exploring how the incident happened. During this process there will be a discussion of recognised good practice that can be shared across the Trust as well identifying lessons to be learned and associated remedial actions. This learning will be shared through local governance forums (QuAGS), patient safety bulletin and to look at / identity issues that are Trust wide as opposed to service specific and are taken to the patient safety group. The Trust has a system of training in place that assures clinical staff have regular training in critical physical health processes for example EWS, Diabetes, first response as well as psychiatric emergencies i.e. ligatures. The Trust Datix reporting system has an identifier for incidents involving student nurses (all levels of reported incident not necessarily SI's) which is notified to the PPFs team for support and follow-up as required We have 3 formal opportunities for learners in this domain. 1 - Critical incident review forums- Quarterly, attendance encouraged from Higher Trainees. We have arranged for Higher Trainees to attend the critical (serious) incident review forum. This is a quarterly forum that reviews the SUI investigation outcomes and learning points. This attended by the consultants, but we have extended this learning opportunity for Higher Trainees. 2 - Formal Level 3,4, or 5 SUI investigations- We have agreed with patient safety team , who will share the details of al SUI investigations within the organisation every month. This allows for trainees (senior registrar level) to access an SUI investigation. This involves following the process from the first day until completion and feedback of report. *3* - Monthly assessment of all datix incidents involving junior doctors. This allows for medical development to

	share all new datix incidents involving trainees of all grades with the Associate director of medical education in each locality. The ADME will review the incidents, and identify any learning opportunity, will contact the learner to feed back, and the supervisor to support the development of an action plan. We have a monthly email communication to all ADMEs to act on any findings.
What support systems exist to support learners? How are these systems monitored?	The Trust has a robust model of staff support for all staff which includes learners. In a clinical environment all staff (learners included) receive regular supervision and appraisal through line managers which are monitored through the ESR. Where staff need additional support due to being involved in an incident the Trust has a Staff Support Team who will offer support, and if further input is needed refer them on to the in-house Psychology service. There is also a Counselling service that staff can self-refer themselves to. Locality Associate Directors of Medical Education (ADMEs) get informed of all Datixs involving trainees, and they provide feedback and support to the trainees. The clinical supervisor is also involved in supporting the learning of a trainee if there is particular learning need identified. A monthly report is produced and shared with all ADMEs.
What feedback do you receive from learners about their experience of being involved in Serious Incidents?	All staff involved in an SI are asked for feedback at the end of the RCA meeting. General comments received are: they appreciate the fact that it is a learning culture as opposed to a blame culture, that is to say, a 'Just Culture', and often feel relieved after the RCA as they were not sure what to expect. Most say it is good that they feel they have been listened to about what went wrong as well as what good practice has been observed It is very rare that medical trainees are directly involved in SIs, however, in these few cases we I can testify that trainees report that they felt supported by their supervisors and found this a learning experiences. They felt satisfied of their contribution to patient safety. We have also recently agreed that positive feedback or actions completed following incidents involving trainees- this will be shared at junior doctor's forum.
What formal organisational links exist between the Governance team coordinating investigations and the Postgraduate team supervising the trainees?	There are regular contacts from the medical post grad unit about using SI's as learning tools in their training and present them to their peers; this is also used in their appraisals. Also localities have critical incident review

the HEIs supporting learners?	days where several SI's are considered with the MDT and they review the lessons learned as a learning tool. PST also carries out bi-annual presentations to degree nursing students. We have formal communication and agreement with patient safety teams to allow for medical trainees to access and attend the SI investigations. Higher trainees can also attend SI panels.
How many patient safety incidents have you reported to NHSI.	None
How many serious incidents impacting on trainees revalidation have you made to your HEE local office within the reporting period? What proportion of these have been resolved/closed after completion of investigations?	None
How does your organisation disseminate learning from Root Cause Analysis reports? How does your organisation promote a patient safety culture?	Reports are circulated to relevant clinical services and learning is shared via the appropriate quality assurance groups. Lessons are also shared externally with the relevant clinical commissioning group and uploaded to the STEIS system. Where contributory or root cause findings are identified appropriate action plans are developed and monitored centrally. Regular Patient Safety, Pharmacy and Clinical Effectiveness bulletins are circulated Trustwide. Quarterly analysis of lessons learnt supports the development of a lessons learnt bulletin which is then shared with services through LMGB (the locality management and governance boards). As a case example of how reporting a medication never event near miss (methotrexate prescribed daily instead of weekly by an on-call Dr, reported by pharmacist, patient didn't receive any medication) facilitated learning for junior doctor. All reported prescribing errors made by trainee Dr's are coded on Datix to go to medical education to flag to supervisor so that learning from individual errors or trends for a Doctor can be picked up and addressed. The reports once finalised are shared with the relevant teams and contain root causes, learning points, and action time lines. Following this, the Critical incident review forum (consultant/trainee peer group developed to learn from SIs) reviews the reports and brings the summaries to the forum for further reflection and learning among the wider body of medical colleagues, including trainees. There are other formal ways- e.g. SBARDS which are sent to all relevant services and clinicians

Coroners Hearings

Questions	Trust's Response
What support is available for learners who are required to provide statements and/or attend Coroners hearings?	A request from the Coroner for reports in respect of an inquest would come into the Trust by e-mail from his Officer via the Inquests and Legal Services Manager. The relevant Head of Service would then be contacted and asked to review and nominate relevant, involved staff to draft reports for the Coroner. At that time guidance notes are provided in relation to writing reports for the Coroner, storing reports and attending inquests. Those staff nominated (including any identified learners) would then be contacted by their manager and the request passed on to them. Staff are requested/encouraged to keep their own line managers updated to the fact that they are involved in the inquest at various stages during the process so that they are fully appraised with where we are currently. Draft reports would be written, supported by line managers and drafts would be expected to be with the Inquests and Legal Services Manager within two weeks of the date of request, as far as practically possible. Upon receipt of a draft report the Inquests and Legal Services Manager would review the report for accuracy, third party references and any sensitivities, and then guidance/comments are offered back to the author of the report for their consideration. The report would then be finalised by the author, in conjunction with their line manager and filed with the Coroner by the Inquests and Legal Services Manager within one month of the date of request, as far as practically possible. Once all relevant information has been filed with the Coroner, the Inquests and Legal Services Manager keeps in close contact with his Officer for any news of the inquest being listed and regularly updates TEWV staff in this regard. When an inquest has been listed by the Coroner, should staff be required to attend the inquest on the day as a witness to give evidence, then the Inquests and Legal

	Services Manager will offer to either meet, Skype or at the least have a telephone conversation with the TEWV witnesses, by way of preparation, to go through the purpose of an inquest, the process in general ie. what to expect on the day etc., to do some question spotting with them and to assist them with any queries they may have at that time, providing relevant documentation/guidance to assist their preparations. The Inquests and Legal Services Manager would then attend the inquest with the TEWV witnesses, if they feel this would assist them, to provide practical support in relation to process. Witnesses are also encouraged to ask their line manager or a colleague (as they so wish) to attend with them for emotional support. For inquests where family intend to be legally represented or for particularly complex inquests, for example Deaths In Custody, the Inquests and Legal Services Manager is able to instruct Trust solicitors hence providing additional support for staff before, during and after the inquest so that staff feel that they have an equal level of support as others present at the inquest. Where appropriate, de-briefing sessions can be arranged following an inquest to review how staff felt the process went, and to provide feedback on the service provided by the Legal Services Department in relation to support at inquests.
How is your organisation involving learners in responding to Duty of Candour responsibilities?	The Trust has a clear policy that guides actions to fulfil DOC responsibilities and the clinicians involved have a training role to support learners by observation of such situations and then recording the electronic record. This is also discussed at the Trust induction event for all new staff.

Guardians of Safe Working

Questions	Trust's Response
10. Please describe the interrelationship between the GOSW and the Director of Education?	There is well established close working relationship between our appointed GOSW and our Medical Development faculty and DME. While the Guardian remains independent they also contribute to our central senior Medical Education strategy group, chaired by the DME. Our GOSW chairs our trust-wide bi-monthly Junior Doctors Forums and the DME also attends this.
11. Please provide a summary of the exception reports you have received within the reporting period, number, type and time to resolve.	Over the reporting period 601 exception reports were received from all localities. 581 were in relation to Hours, (e.g. difference in work pattern) and 20 were education exception reports. The average time to resolve the exception reports during the reporting period was 4 days

8.2. Educational Opportunities during winter pressures

Please describe how your organisation Maintains curriculum delivery opportunities during winter pressures

Questions	Trust's response
1a) Please describe how winter pressures in 2017/18 affected your ability to deliver training to all learners within your organisation? 1b) Please detail the specific areas, placements and programmes which were adversely affected by last winter's pressures.	There were no specific issues identified during this period and no impact on training programmes linked to winter period
2. Please describe what strategies you used to protect training for all learners across their whole placement with your organisation in 2017/18 e.g. moving educational sessions to times of less pressure, ringfencing specific clinics, lists etc for training	As above
3. Please describe what plans you are putting in place to mitigate the effects of winter service pressures on training in 2018/19.	The Trust has produced a yearly capacity and demand process for all mandatory training, this includes approach to try to mitigate any winter concerns The Trust takes a bespoke approach where necessary, for example with the resuscitation training focus, with weekly reports and review by Executive team members at a huddle report, with training amended weekly to go to areas of concern to maintain patient safety

Item 11

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**27 November 2018**
TITLE:	**Finance Report for Period 1 April 2018 to 31 October 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:

During October 2018 NHS Improvement offered Trusts the opportunity to receive additional incentive Provider Sustainability Funding (PSF). This incentive PSF requires an improvement to the planned 2018/19 bottom line position, with incentive PSF paid at a ratio of £2 incentive PSF for each £1 of bottom line improvement.

The Trust agreed to deliver an additional £1m surplus, which results in £2m additional incentive income. This report reflects the resulting £3m plan increase in all metrics.

The comprehensive income outturn for the period ending 31 October 2018 is a surplus of £5,367k, representing 2.6% of the Trust's turnover and is £634k ahead of plan.

Performance Against Plan – year to date (3.2)

	Variance £000	Monthly Movement £000	Movement
The Trust is currently £634k **ahead** of its year to date financial plan.	-634	-422	↑

Cash Releasing Efficiency Savings (CRES) (3.3)

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the financial year are £255k **behind** financial plan.	Recurrent	4,566	↑
	Non recurrent	-4,311	→
	Target	0	
	Variance	255	↑

Identified CRES schemes for the rolling 3 year period are £14,773k **behind** the £21,000k CRES target.	**CRES Type**	**Annual Variance £000**	**Movement**
	Recurrent	14,773	

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

Capital (3.4)

The Trust is currently £1,748k **in excess** of its capital plan.	**Variance £000**	**Monthly Movement £000**	**Movement**
	1,748	505	

The Trust received a capital rebate relating to prior year schemes (£2,289k), with this included, capital expenditure is £541k behind plan.

Workforce (3.5)

The Trust is currently £1,629k (48%) **in excess of** its agency cap.	**Variance £000**	**Monthly Movement £000**	**Movement**
	1,629	331	

Agency expenditure remains high in month 7 across all localities and is largely required for nursing agency to support vacancies and 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 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:	**27 November 2018**
TITLE:	**Finance Report for Period 1 April 2018 to 31 October 2018**

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for 1 April 2018 to 31 October 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

During October the Trust submitted a revised financial plan to NHS Improvement increasing the planned surplus by (£3,000k) to (£9,863k). This report reflects this update and performance year to date is measured accordingly.

The comprehensive income outturn for the period ending 31 October 2018 is a surplus of £5,367k, representing 2.6% of the Trust's turnover and is £634k ahead of plan.

Table 1	**Annual Plan**	**Year to Date Plan**	**Year to Date Actual**	**YTD Variance**	**September Variance**
	£000	**£000**	**£000**	**£000**	**£000**
Income From Activities	(335,394)	(191,280)	(191,241)	39	310
Other Operating Income	(15,970)	(10,331)	(10,521)	(190)	(114)
Total Income	**(351,365)**	**(201,611)**	**(201,762)**	**(151)**	**195**
Pay Expenditure	264,056	153,865	153,284	(581)	(537)
Non Pay Expenditure	68,397	36,815	37,096	280	274
Depreciation and Financing	9,048	6,197	6,015	(182)	(145)
Variance from plan	**(9,863)**	**(4,733)**	**(5,367)**	**(634)**	**(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 (£255k) and continues to identify schemes to ensure full delivery of recurrent CRES requirements.

Table 2 Identified CRES schemes for the financial year are £255k **behind** financial plan.	**CRES Type**	**Annual Variance £000**	**Movement**
	Recurrent	4,566	
	Non recurrent	-4,311	
	Target	0	
	Variance	255	

3.4 Capital

Expenditure against the capital programme to 31 October 2018 is £8,073k and is £1,748k in excess of plan largely due to expenditure incurred on the Roseberry Park MIST system and IT licenses.

The Trust received a capital rebate relating to prior year schemes (£2,289k), with this included, capital expenditure is £541k less than planned.

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 Oct-18	May	Jun	Jul	Aug	Sep	Oct
Establishment (a) (90%-95%)	93.5%	93.70%	93.41%	92.77%	92.72%	92.31%	93.46%
Agency (b)	1.0%	2.80%	2.80%	2.98%	3.05%	3.19%	3.25%
Overtime (c)	1.0%	1.20%	1.12%	1.12%	1.13%	1.11%	1.09%
Bank & ASH (flexed against establishment) (100%-a-b-c)	4.5%	2.90%	3.08%	2.93%	2.98%	3.09%	3.13%
Total	**100.0%**	**100.60%**	**100.41%**	**99.80%**	**99.88%**	**99.70%**	**100.93%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For October 2018 the tolerance for Bank and ASH is 4.5% of pay budgets.

NHS Improvement monitors agency expenditure against a capped target. Agency expenditure at 31 October 2018 is £5,006k which is £1,629k (48%) in excess of the agreed year to date capped target of £3,377k. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

3.6 Cash

Total cash at 31 October 2018 is £69,021k, and is £3,847k higher than planned, largely due to working capital variations. The Trust implemented a

new finance system during October which resulted in delayed payments to creditors, it is expected that cash will be in line with plan next month.

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 31 October 2018 and is behind plan (Table 4). Agency expenditure remains 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.

Use of Resource Rating at 31 October 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	1.38x	3	1.30x	3	
Liquidity	47.6 days	1	51.1 days	1	
I&E margin	2.9%	1	2.4%	1	
I&E margin distance from plan	0.5%	1	0.0%	1	
Agency expenditure	£5,006k	3	£3,377k	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 1.38x (can cover debt payments due 1.38 times), which is ahead of plan and rated as a 3.

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 47.6 days; this is 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 2.9% and is rated as a 1, which is ahead of 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 0.5% 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 £3,143k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £42,346k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £525k is required.
- I&E margin distance from plan – to reduce to a 2 an operating surplus decrease of £634k is required.
- Agency Cap rating – to improve to a 2 a reduction in agency expenditure of £785k 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 October the Trust is £634k ahead of the revised control total submitted to 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 31 October 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 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th November 2018**
TITLE:	**Board Dashboard as at 31st October 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 October 2018, 5 (28%) of the indicators reported are not achieving the expected levels and are red. This is a considerable improvement on the 8 that were reported as at the end of September. These are spread over all four domains. In addition there are 8 KPIs (44%) that whilst not achieving the target are within the 'amber' tolerance levels, which is one more than that reported as at the end of September.

Of the 13 indicators that are either red or amber 12 (92%) are showing an improving trend over the previous 3 months.

The year to date position is that there are 7 KPIs (47%) which are reported as red which is one less than the position reported as at the end September.

In terms of the Single Oversight Framework targets the Trust achieved all the operational targets in October as a whole

The outstanding KPIs around activity have now been built and tested and will be included within the Dashboard in Decembers report.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**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 31st October 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 October 2018, 5 (28%) of the indicators reported are not achieving the expected levels and are red across all four domains. This is a considerable improvement on the 8 that were reported as at the end of September. In addition there are 8 KPIs (44%) that whilst not achieving the target are within the 'amber' tolerance levels, which is one more than that reported as at the end of September.

  Of the 13 indicators that are either red or amber 11 (85%) are showing an improving trend over the previous 3 months.

  The year to date position is that there are 7 KPIs (47%) which are reported as red which is one less than the position reported as at the end September.

- In terms of the Single Oversight Framework targets the Trust achieved all the operational targets in October as a whole. Specific issues are as follows:
  - The 7 day follow up following discharge was not achieved in 2 CCGs in October but there are no specific concerns in terms of trends.
  - IAPT/Talking Therapies – proportion of people completing treatment who move to recovery" – There were two CCG where the target was not achieved in October (DDES CCG and Vale of York although DDES was at 49.6%.) Work continues in York to implement the IAPT action plan however the current focus is on increasing access rates whilst maintaining waiting times.
  - Access to Early Intervention in Psychosis - the Trust as a whole significantly overachieved against the target in October. However the North Yorkshire Services failed to achieve the target. There has been particularly challenges regarding staffing across all these services, particularly in Scarborough and the service is exploring what it can do to try and address this.

- Inappropriate Out of Area Occupied Bed Days – the target was not achieved in 3 CCGs in October. 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.

- The outstanding KPIs around activity have now been built and tested and will be included within the Dashboard in Decembers report.

2.3 Key Risks

- Waiting times (KPI 1 and 2) – Whilst both indicators have improved within October both are under target (although within the amber tolerance range). There are some areas where achieving the targets is more of a challenge. A 'deep dive' report will be presented to the Board in early 2019 as requested at the October Board meeting.
- Number of Unexpected Deaths Classed as a Serious Incident (KPI 5) – Whilst the rate per 10,000 open cases improved further in October it still remains above target and the absolute number had only reduced by 1 in comparison to the figure in September.
- 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 although both showed some improvement in October. 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. A follow up 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. These actions are ongoing.
- Bed Occupancy (KPI 12) – The pressures on beds has continued in October with occupancy levels remaining similar to those in the previous two months. There has been an improvement in the number of people with a LOS over 90 days and the number of inappropriate Out of Area days. 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 work across the localities is taking place as part of improving our approach to bed management in order to support the reprovision of inpatient services from the Friarage which will commence in January 2019.

- Sickness Absence Rate (KPI 19) – whilst performance is similar to the position reported in October (September 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 November 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 continue to be Forensic and Durham and Darlington.
- Financial Targets (KPIs 21) – In the month of October (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

Appendix A

Quality

	October 2018				April 2018 To October 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%	87.85%			90.00%	87.12%		90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral	60.00%	50.50%			60.00%	30.39%		60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	2,368.00	1,978.00			2,368.00	1,978.00		2,368.00
4) Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	93.11%			92.45%	91.37%		92.45%
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.30			7.00	12.32		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%	56.57%			67.25%	56.03%		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%	69.32%			78.25%	65.75%		78.25%

Activity

	October 2018				April 2018 To October 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	94.18%			85.00%	94.85%		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	61.00			68.00	61.00		68.00
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.93%	25.26%			23.93%	22.47%		23.93%

Workforce

Trust Dashboard Summary for TRUST

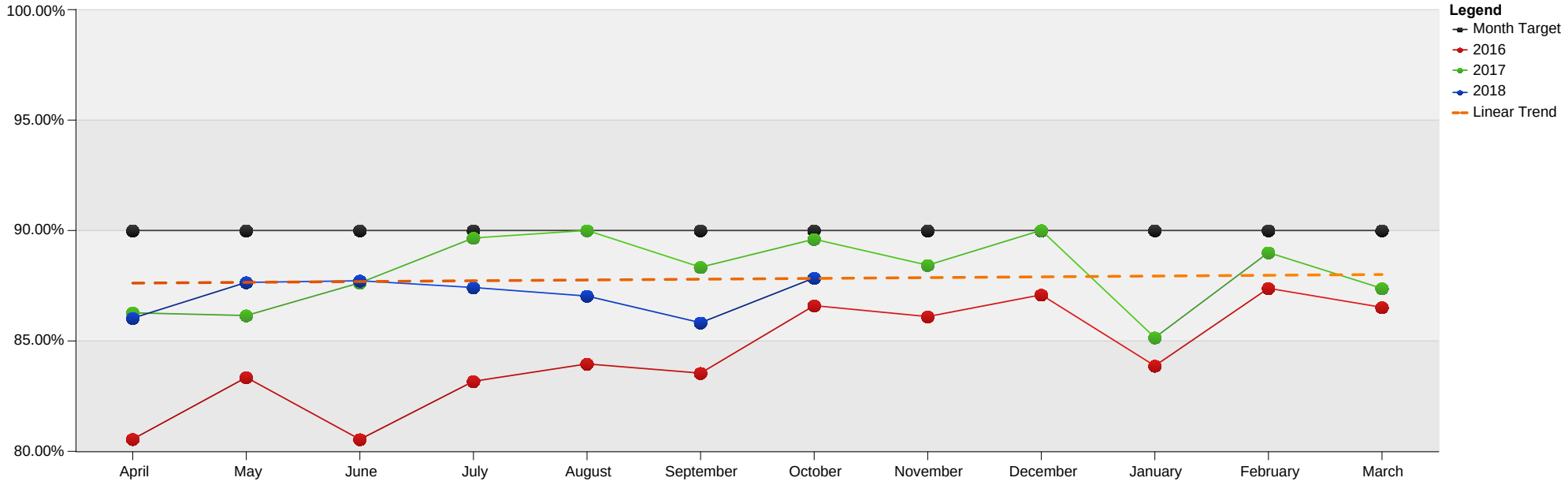
	October 2018				April 2018 To October 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
15) Actual number of workforce in month (Establishment 95%-100%)	95.00%	93.46%			95.00%	93.46%		95.00%
16) Vacancy fill rate	90.00%	84.62%			90.00%	77.56%		90.00%
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	92.52%			95.00%	92.52%		95.00%
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	91.27%			92.00%	91.27%		92.00%
19) Percentage Sickness Absence Rate (month behind)	4.50%	4.87%			4.50%	4.82%		4.50%

Money

	October 2018				April 2018 To October 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
20) Delivery of our financial plan (I and E)	-815,000.00	-1,667,699.00			-4,301,000.00	-5,367,145.00		-6,864,000.00
21) CRES delivery	686,782.00	544,853.00			4,807,474.00	3,671,507.00		8,241,384.00
22) Cash against plan	63,962,000.00	69,021,000.00			63,962,000.00	69,021,000.00		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

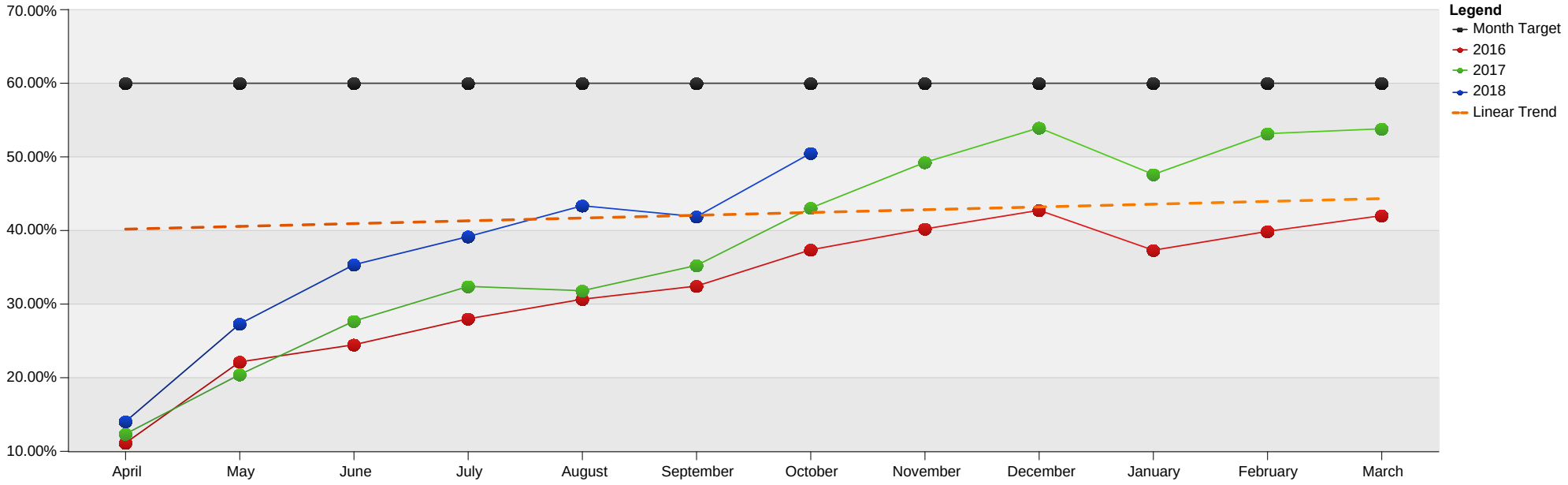


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	87.85%	87.12%	85.48%	86.86%	90.74%	92.17%	78.23%	75.27%	99.28%	99.39%	89.35%	79.98%		

Narrative
The position for October 18 is 87.85% relating to 5697 patients out of 6485 who were seen within 4 weeks. This is below target of 90% but a slight improvement on the position reported in September 18. Areas of concern: • York AMH at 84.94% (220 of 259 patients) 39 patients were not seen within 4 weeks which is a continued improvement on the 81.90% reported in September 18. Performance continues to be impacted by the high DNA rate within the Access Team, the team continues to fit patients in to cancelled slots to utilise capacity.. • North Yorkshire AMH at 77.38% (284 of 367 patients) 83 patients were not seen within 4 weeks. This is an improvement compared to the position reported in September 18 of 65.53%. There continues to be issues within Harrogate and Riponaround sickness and vacancies, however agency staff are having a positive impact. The integration of teams in Hambleton and Richmondshire is also improving performance. • North Yorkshire MHSOP at 72.67% (359 of 494 patients) 135 patients were not seen within 4 weeks. This is slight improvement on the 67.74% reported in September 18. MHSOP have a number of staffing issues (Sickness and Vacancies) particularly within the memory service and actions are in place. • Durham and Darlington AMH at 66.30% (366 out 552 patients) 186 patients were not seen. Sickness and vacancies have impacted in the access service, however teams are now operating at full establishment so improvements are expected.

Trust Dashboard Graphs for TRUST

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

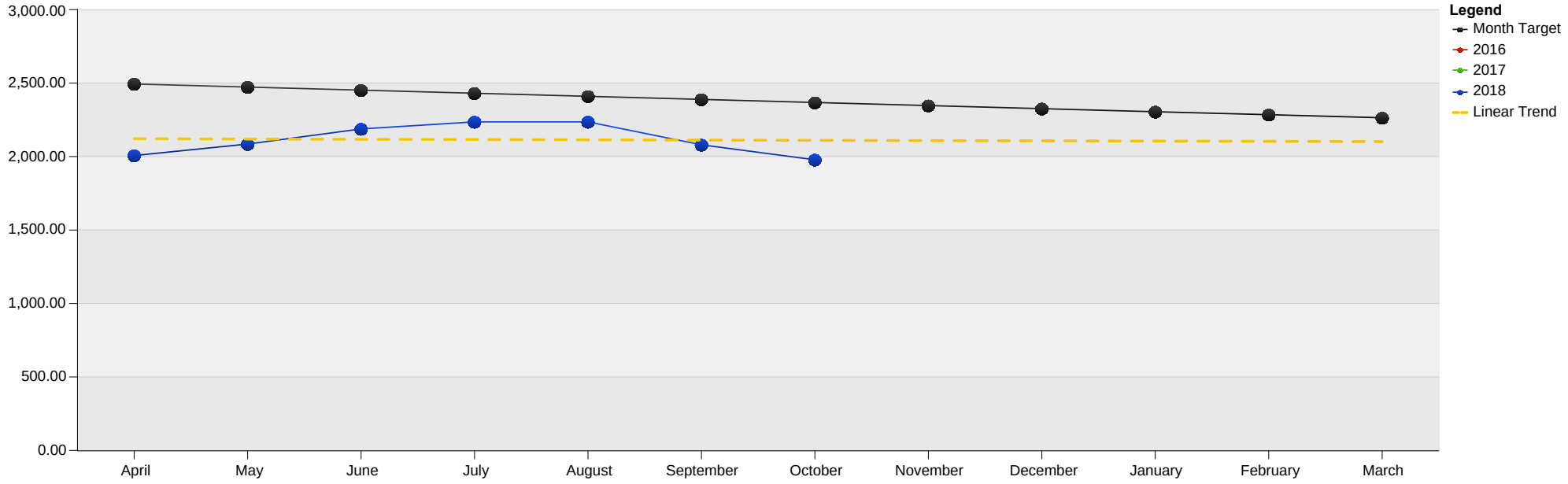


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients starting treatment within 6 weeks of an external referral	50.50%	30.39%	41.33%	25.35%	58.22%	35.93%	45.44%	25.52%	94.12%	83.48%	47.45%	27.22%		

Narrative
The Trust position for October 2018 is 50.50%, which is below target however an improvement on the 41.62% reported in September 18. 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 and action that can be taken to address. A further update will be provided in next month's report as to any issues identified along with action taken to resolve this .

Trust Dashboard Graphs for TRUST

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

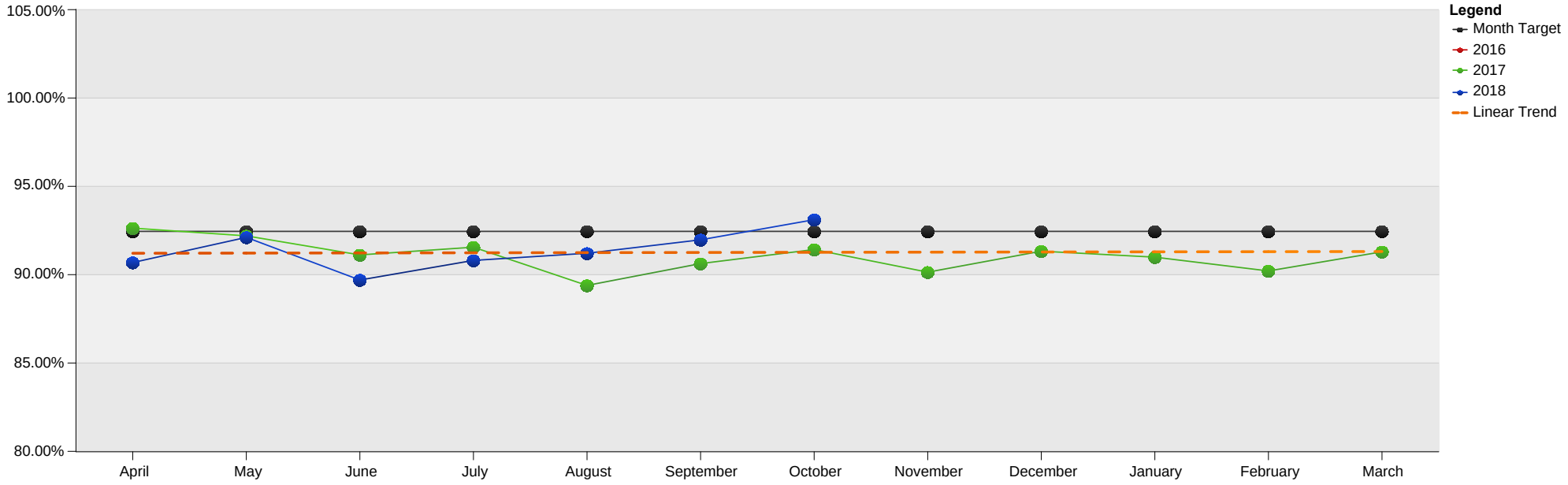


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	1,978.00	1,978.00	200.00	200.00	786.00	786.00	650.00	650.00			342.00	342.00		

Narrative
The Trust position for October 18 is 1978 2,198 which is meeting the target of 2,368 and is an improvement on the September position.The following localities are not meeting target: - • Durham and Darlington–200 occupied bed days (148 AMH and 52 MHSOP). This relates to 80 patients admitted out of area (beds within D&D) over the 3 month period (63 AMH, 17 MHSOP)• Tees–786 occupied bed days (154 AMH and 632 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. 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

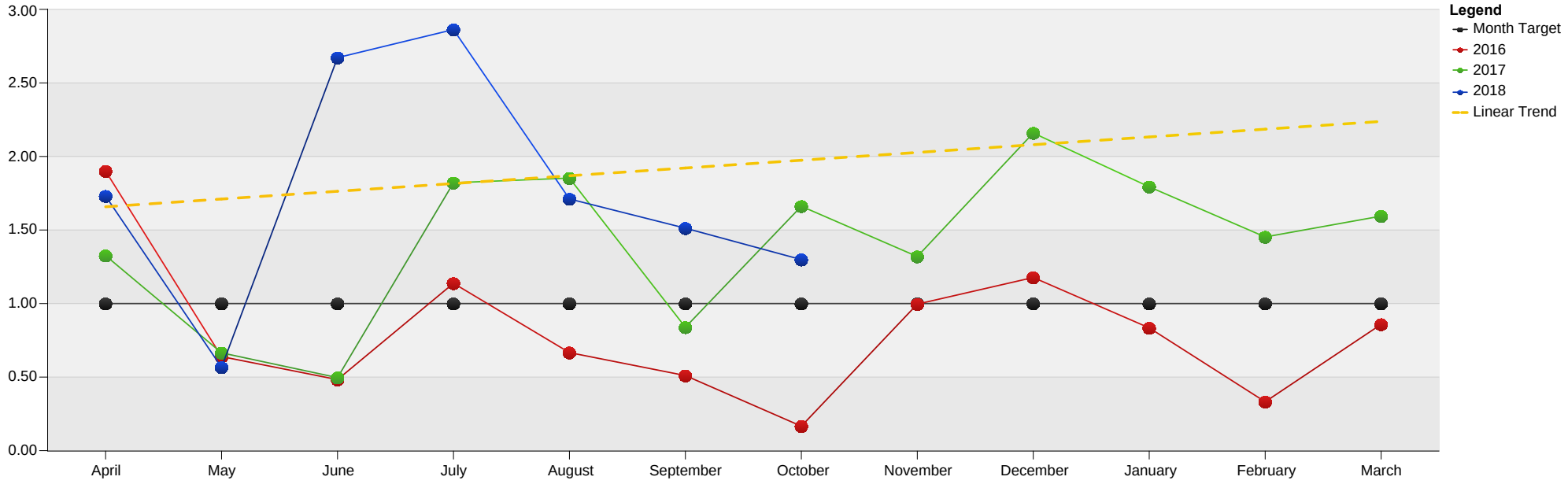


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of patients surveyed reporting their overall experience as excellent or good	93.11%	91.37%	94.12%	92.66%	93.03%	92.03%	93.67%	92.45%	89.36%	81.35%	91.50%	89.57%		

Narrative
The Trust position for October 2018 is 93.11% which is now meeting the target of 92.45% and improvement on the position reported in September 18 (August data). This is the best position that has been reported for this indicator since it was reported in the Dashboard. Forensic Services and York and Selby are the only localities not meeting target at 89.36% and 91.50% respectively. Within York and Selby work is underway to ensure all devices for data capture are operational to maximise patient responses. Discussions have also taken place in report outs about tracking discharges to ensure all patients are offered the opportunity to complete the survey to increase uptake and all comments provided in surveys are reviewed and actioned. Engagement with service users to incorporate this element as part of business priorities for the merged locality is ongoing. Within Forensics, inpatient services have facilitated a number of quality improvement events, with further planned focussed specifically on patient experience and recovery. The aim is to ensure service users feel more actively engaged and connected in planning and reviewing their care and treatment which will improve experience ratings. Opportunities to capture learning from similar services are also being explored. Please note due to changes with this indicator in 2016, this year is not displayed on the graph above.

Trust Dashboard Graphs for TRUST

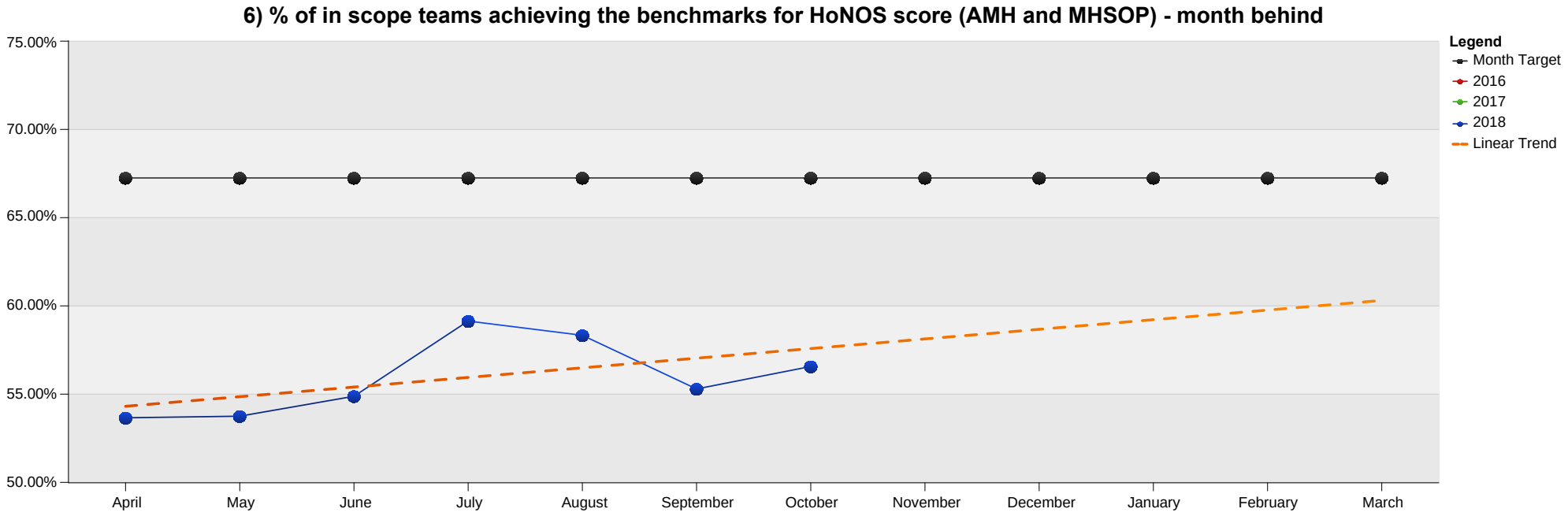
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated



	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	1.30	12.32	0.00	9.39	0.00	8.23	4.44	21.42	100.00	500.00	2.86	11.72		

Narrative
The Trust position for October 2018 is 1.30, which is not achieving the expected number of 1.00. This rate relates to 7 unexpected deaths in October which is a reduction on the 8 recorded in September. Of the 7 unexpected deaths the details below shows a breakdown by locality:• 4 x North Yorkshire• 2 x York• 1x ForensicsOf the unexpected deaths that occurred in October, 4 occurred in AMH, 2 in MHSOP and 1 in Offender Health.

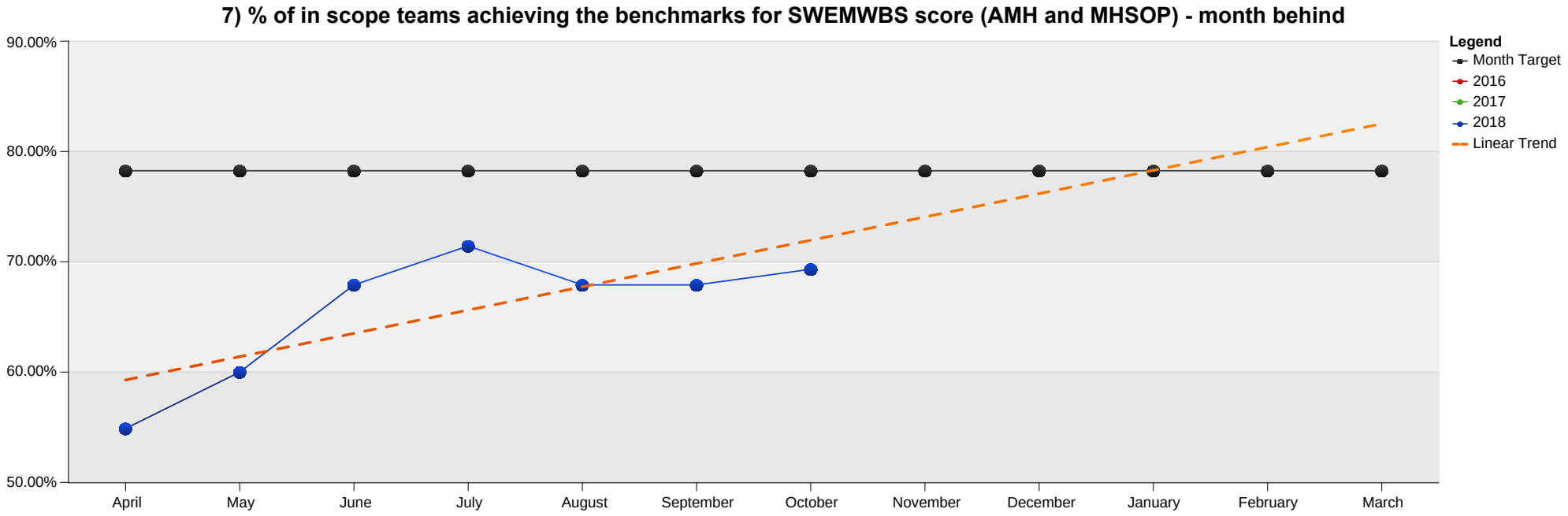
Trust Dashboard Graphs for TRUST



	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
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	56.57%	56.03%	56.67%	47.85%	48.15%	62.57%	62.50%	60.34%			60.00%	50.72%		

Narrative
The Trust position for October 2018 is 56.57%, which is not meeting the target of 67.25% however it is a slight improvement on the position reported in September. 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 however all are within 10% of achieving the target, with the exception of Tees who report the lowest performance at 48.15% 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. Furthermore the Head of Corporate Performance is to meet with the Chief Operating Officer and Head of Currency, Tariff and Clinical Outcomes to review reporting for this KPI.

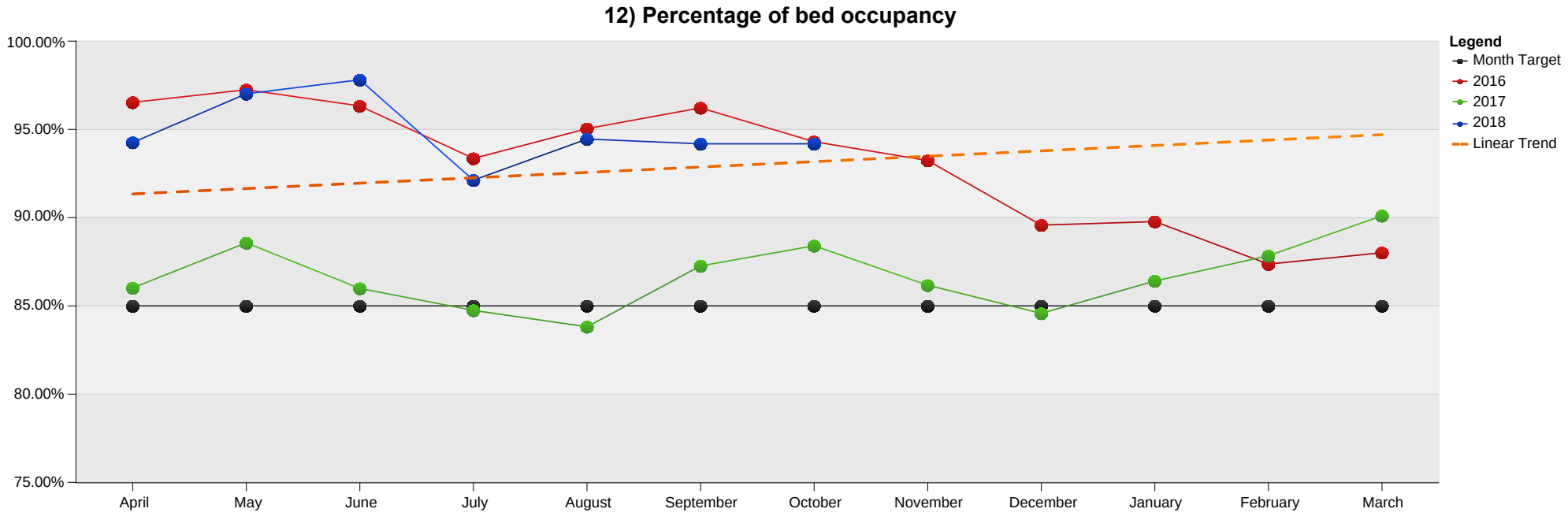
Trust Dashboard Graphs for TRUST



	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	69.32%	65.75%	62.96%	62.84%	73.08%	65.27%	74.07%	71.76%			62.50%	59.38%		

Narrative
The Trust position for October 2018 is 69.32%, which is not meeting the target of 78.25% and is a similar position to that reported in September.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. 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. Furthermore the Head of Corporate Performance is to meet with the Chief Operating Officer and Head of Currency, Tariff and Clinical Outcomes to review reporting for this KPI.

Trust Dashboard Graphs for TRUST

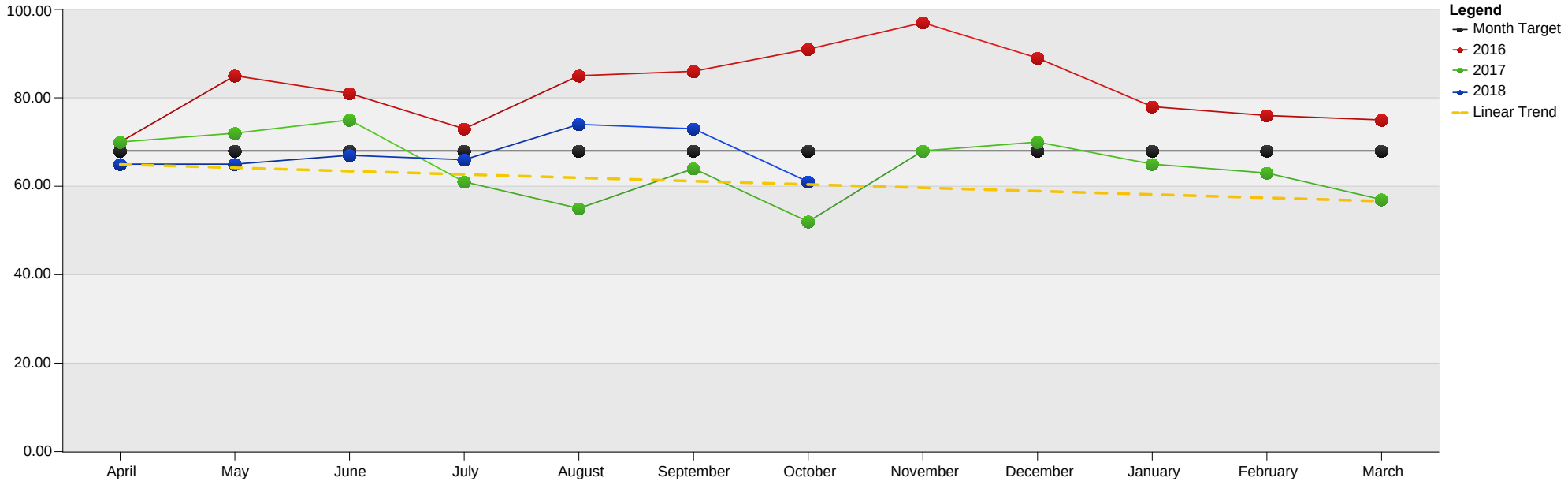


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	94.18%	94.85%	93.26%	92.54%	100.40%	102.07%	90.97%	94.06%	NA	NA	91.57%	90.23%		

Narrative
The Trust position for October 2018 is 94.18% which is worse than target and the same as the position recorded in September 2018. Tees are reporting the highest bed occupancy at 100.40%.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 a significant spike in admission rates for organic patients which have impacted on bed occupancy. Occupancy levels are monitored weekly with barriers to discharge being escalated to the Head of Service. Within both AMH and MHSOP in Tees there is also a number of complex patients who require long lengths of stay, however discharge planning is ongoing for these patients and 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

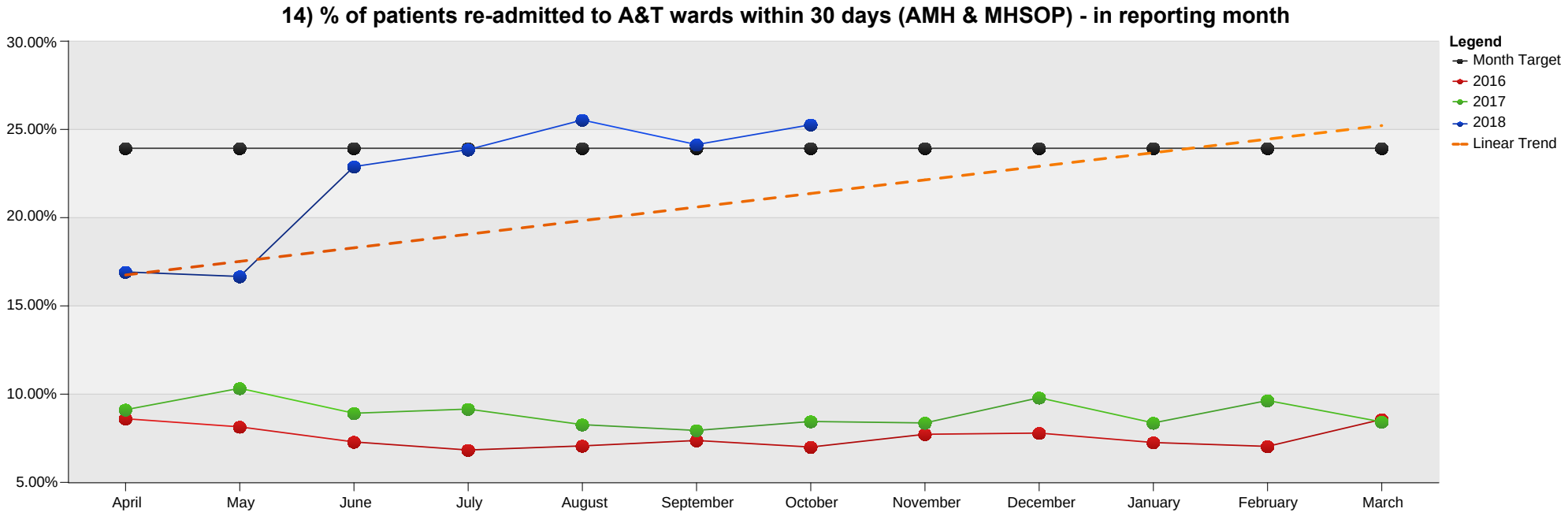
13) No. of patients occupying a bed with a LoS (from admission) > 90 days (AMH and MHSOP A&T Wards)



	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)	61.00	61.00	14.00	14.00	11.00	11.00	19.00	19.00			15.00	15.00		

Narrative
The Trust position for October 2018 is 61 which is meeting the target of 68 and an improvement on the 73 achieved in September 2018. All localities are meeting target, however North Yorkshire and York Selby record the highest number of patients:• North Yorkshire – 19 patients (14 AMH and 5 MHSOP)• York and Selby – 15 patients (15 MHOSP)In North Yorkshire there are issues around finding suitable packages of care and care home placements for patients upon discharge. Also a number of complex patients have required a longer length of stay that was appropriate to patient need.In York there are concerns 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 continuing to deteriorate . 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.

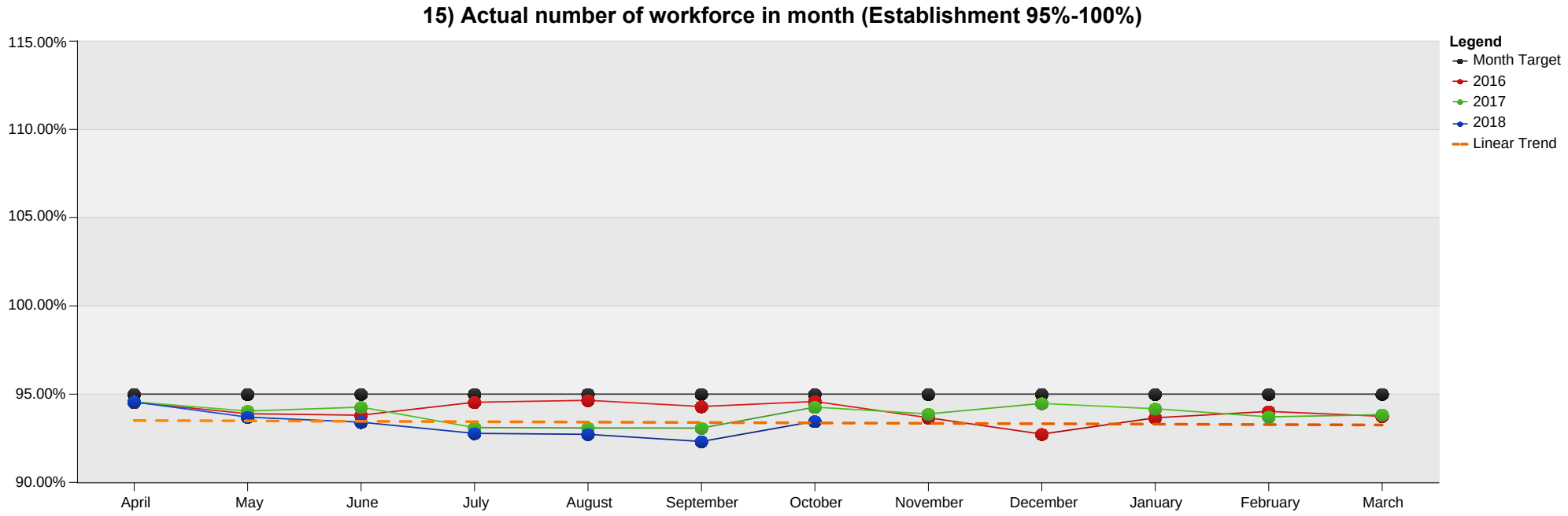
Trust Dashboard Graphs for TRUST



	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	25.26%	22.47%	26.92%	21.80%	32.35%	23.32%	6.25%	20.37%			20.00%	22.00%		

Narrative
The Trust position ending October 2018 is 25.26%, which relates to 24 patients out of 95 that were readmitted within 30 days. This is within 10% of the target of 23.93% however a slight deterioration on the position achieved in September 2018. Tees are worse than target with a position of 32.35%, this is 10 patients out of 31 in AMH. Durham and Darlington are also worse than target with a position of 26.92%, this is 7 patients out of 25 in AMH. All readmissions are monitored closely within the localities to ensure where it is appropriate a readmission is avoided.

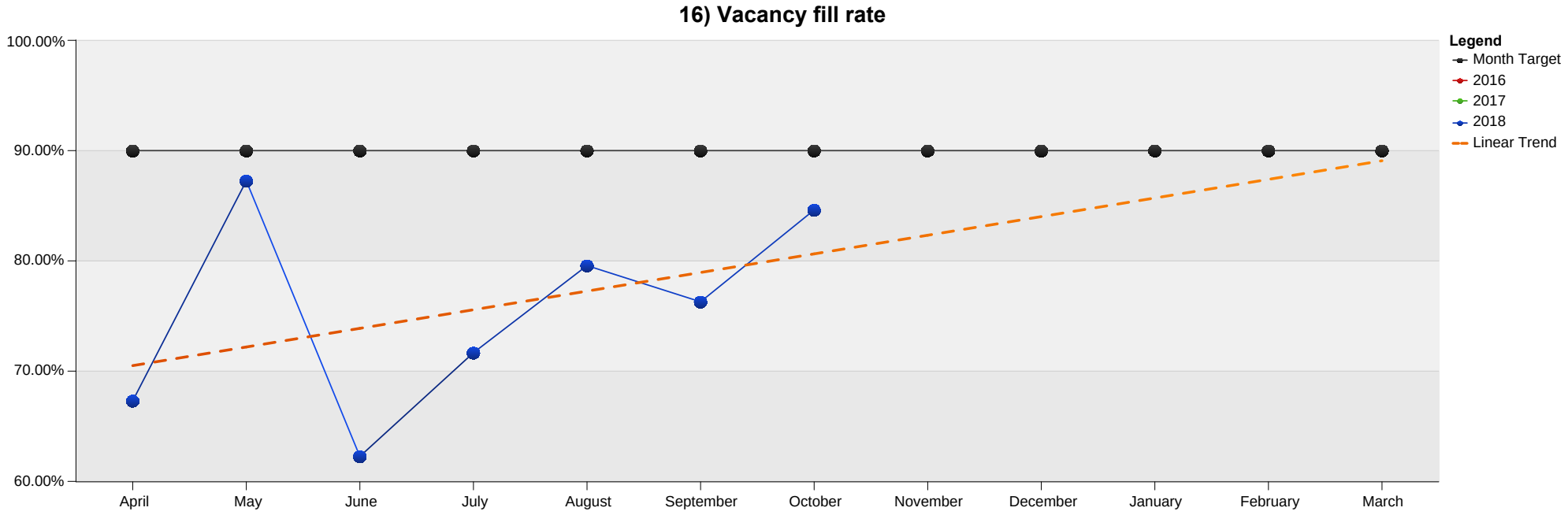
Trust Dashboard Graphs for TRUST



	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%)	93.46%	93.46%	92.91%	92.91%	99.69%	99.69%	92.48%	92.48%	93.02%	93.02%	87.26%	87.26%		

Narrative
The Trust position for 31 October 2018 is 93.46% which is marginally below the targeted establishment level of 95-100%. It is expected that the establishment rate will continue to improve due to on-going recruitment events.

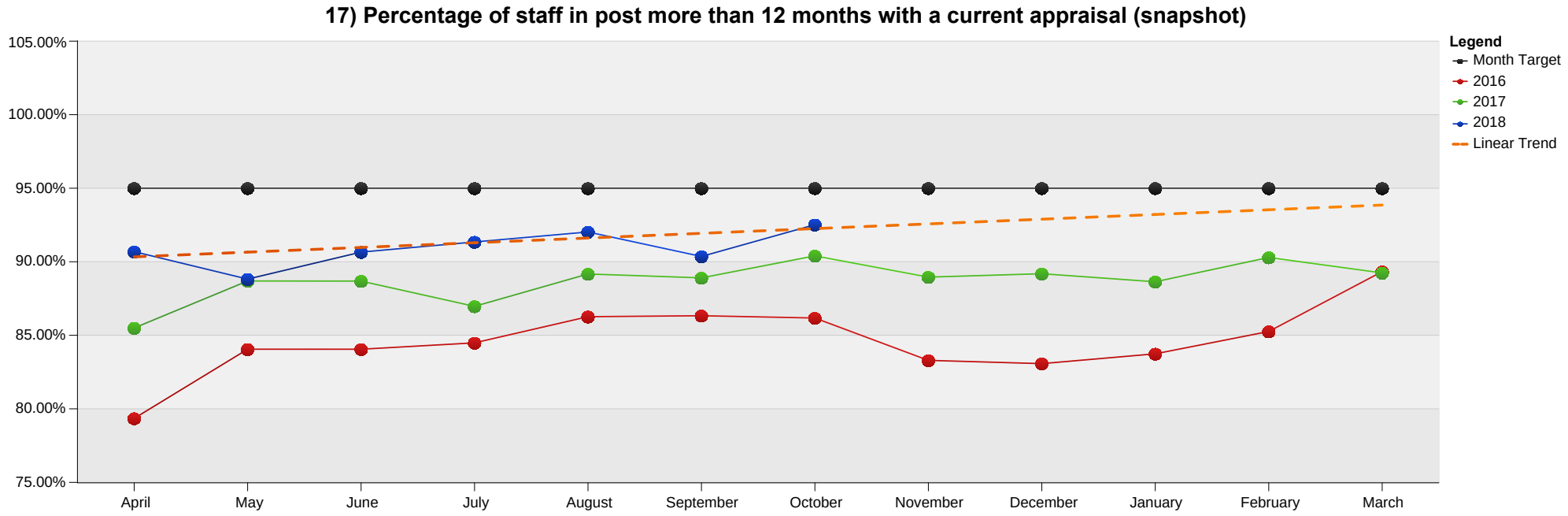
Trust Dashboard Graphs for TRUST



	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	84.62%	77.56%	70.59%	80.77%	92.50%	84.00%	70.59%	63.57%	89.47%	86.67%	90.00%	75.00%		

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 October improved to 84.62% from 76.29% in September, however is worse than the target of 90% but it is the best position in May 2018. This figure represents 88 vacancies with a conditional offer made out of 104. During the 8 week reporting period 2 vacancies were reported as not filled and this was due to no applicants, no applicants meeting shortlisting requirements or no applicants being appointed at interview. These vacancies do not form part of the above calculation as they are considered closed, although they were not successfully appointed to. The vacancies were a Care Co-ordinator band 6 role in York and Selby and IAPT PWP band 5 in North Yorkshire.

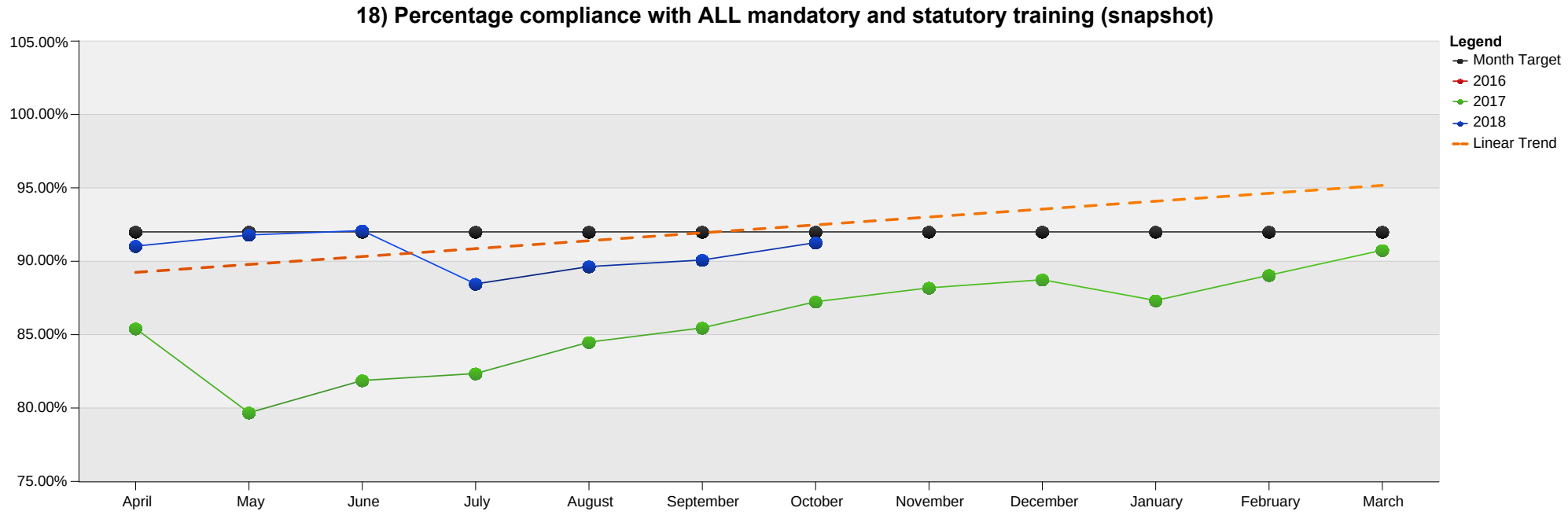
Trust Dashboard Graphs for TRUST



	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)	92.52%	92.52%	94.11%	94.11%	95.40%	95.40%	83.19%	83.19%	96.20%	96.20%	91.06%	91.06%		

Narrative
The Trust position for October 2018 has increased from 90.40% in September to 92.52% which relates to 464 members of staff out of 5804 that do not have a current appraisal. This is the best position in 2018/19 to dateTeesside and Forensic Services are meeting target. 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 have been put in place to ensure these are completed as soon as possible and an improvement in performance has been seen. Durham and Darlington and York and Selby 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

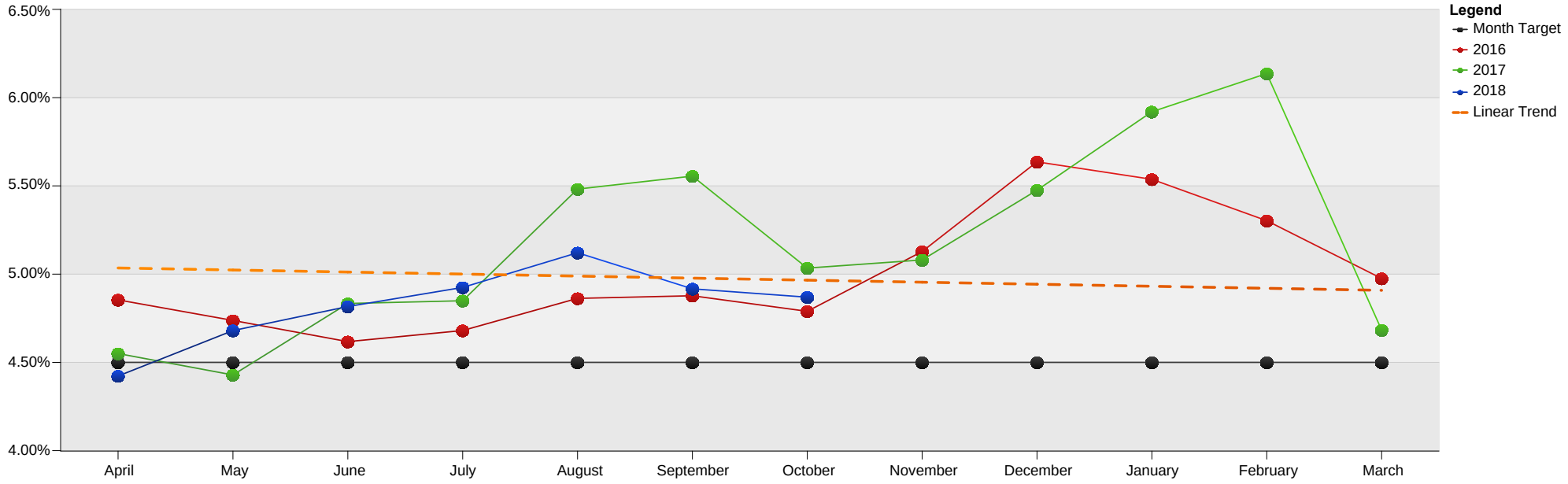


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	91.27%	91.27%	89.49%	89.49%	92.66%	92.66%	87.16%	87.16%	94.03%	94.03%	92.34%	92.34%		

Narrative
The position for October 2018 continues to improve and has increased to 91.27% from 90.09% in September 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

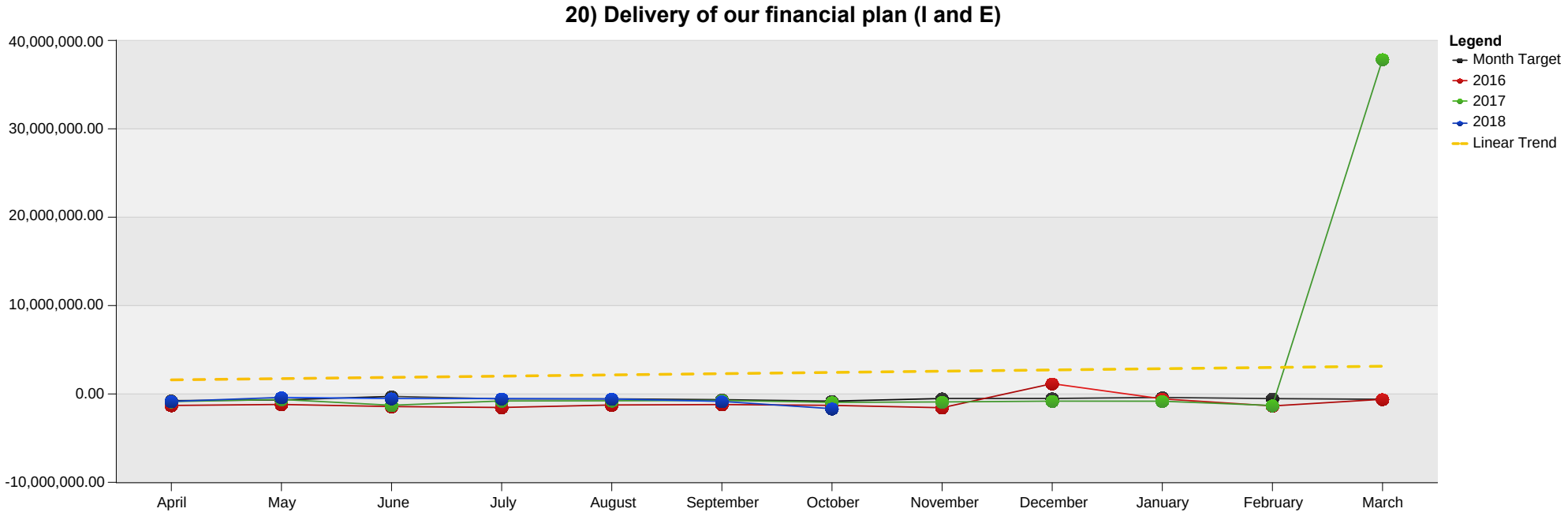
19) Percentage Sickness Absence Rate (month behind)



	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)	4.87%	4.82%	6.00%	5.44%	4.54%	4.29%	4.55%	4.24%	5.46%	6.36%	3.84%	4.43%		

Narrative
The Trust position reported in October relates to the September sickness level. The Trust position reported in October 2018 is similar to that reported in September at4.87% 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.

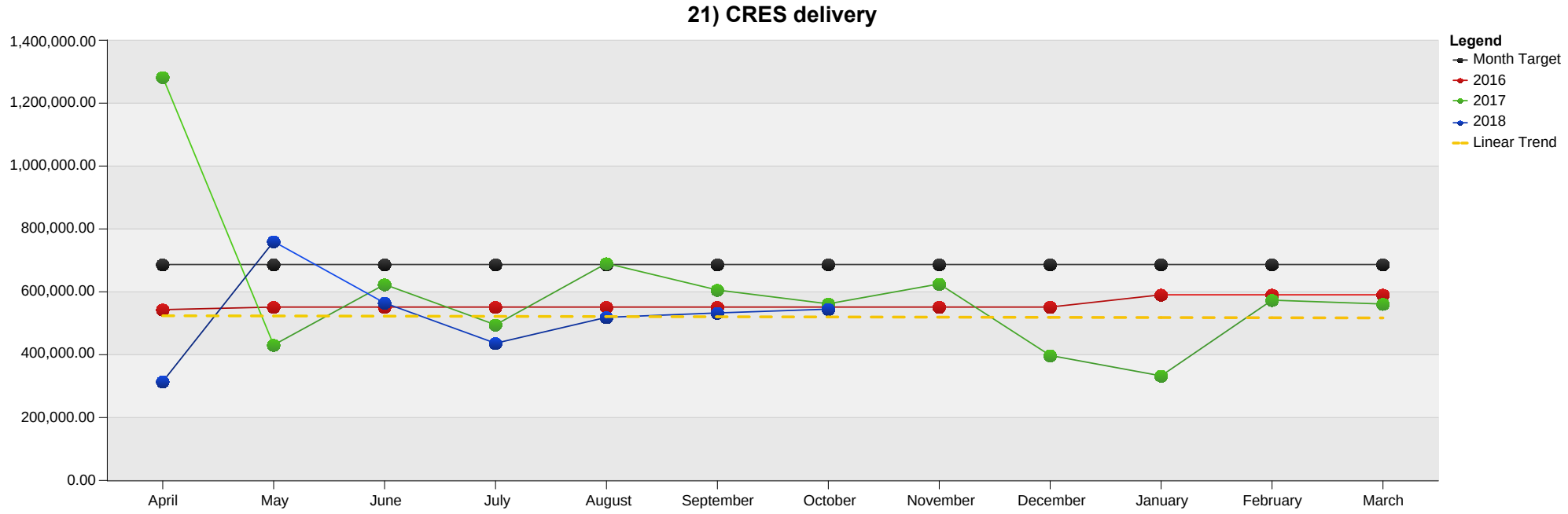
Trust Dashboard Graphs for TRUST



	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)	-1,667,699.00	-5,367,145.00	-47,346.00	-142,188.00	-116,158.00	1,020,594.00	234,488.00	860,319.00	16,758.00	633,884.00	-94,316.00	230,268.00		

Narrative
The comprehensive income outturn for the period ending 31 October 2018 is a surplus of £5,367k, representing 2.6% of the Trust's turnover and is £634k ahead of plan

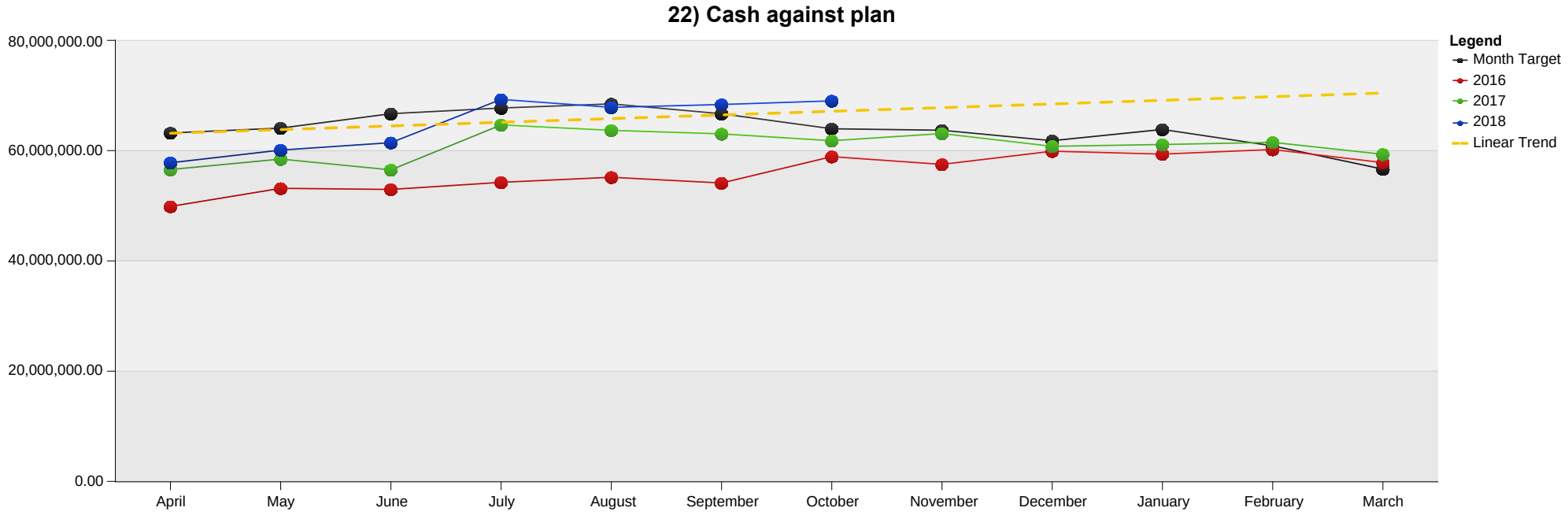
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) CRES delivery	544,853.00	3,671,507.00	84,780.00	593,462.00	38,153.00	267,070.00	34,008.00	95,592.00	18,278.00	127,945.00	78,293.00	548,051.00		

Narrative
Identified Cash Releasing Efficiency Savings at 31 October 2018 is £3,672k and is £1,136k 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 7 (£947k). As a result year to date CRES is £189k 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	69,021,000.00	69,021,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
Total cash at 31 October 2018 is £69,021k, and is £3,847k higher than planned, largely due to working capital variations. The Trust implemented a new finance system during October which resulted in delayed payments to creditors, it is expected that cash will be in line with plan next month

Trust Dashboard - Locality Breakdown for TRUST

1 - Quality

	October 2018														April 2018 To October 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIIRE		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		87.85%		85.48%		90.74%		78.23%		99.28%		89.35%				87.12%		86.86%		92.17%		75.27%		99.39%		79.98%		
2) Percentage of patients starting treatment within 6 weeks of an external referral		50.50%		41.33%		58.22%		45.44%		94.12%		47.45%				30.39%		25.35%		35.93%		25.52%		83.48%		27.22%		
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)		1,978.00		200.00		786.00		650.00				342.00				1,978.00		200.00		786.00		650.00				342.00		
4) Percentage of patients surveyed reporting their overall experience as excellent or good		93.11%		94.12%		93.03%		93.67%		89.36%		91.50%				91.37%		92.66%		92.03%		92.45%		81.35%		89.57%		
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated		1.30		0.00		0.00		4.44		100.00		2.86				12.32		9.39		8.23		21.42		500.00		11.72		
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind		56.57%		56.67%		48.15%		62.50%				60.00%				56.03%		47.85%		62.57%		60.34%				50.72%		
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind		69.32%		62.96%		73.08%		74.07%				62.50%				65.75%		62.84%		65.27%		71.76%				59.38%		

Trust Dashboard - Locality Breakdown for TRUST

2 - Activity

	October 2018														April 2018 To October 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)		94.18%		93.26%		100.40%		90.97%	NA	NA		91.57%				94.85%		92.54%		102.07%		94.06%	NA	NA		90.23%		
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)		61.00		14.00		11.00		19.00				15.00				61.00		14.00		11.00		19.00				15.00		
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month		25.26%		26.92%		32.35%		6.25%				20.00%				22.47%		21.80%		23.32%		20.37%				22.00%		

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	October 2018														April 2018 To October 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%)		93.46%		92.91%		99.69%		92.48%		93.02%		87.26%				93.46%		92.91%		99.69%		92.48%		93.02%		87.26%		
16) Vacancy fill rate		84.62%		70.59%		92.50%		70.59%		89.47%		90.00%				77.56%		80.77%		84.00%		63.57%		86.67%		75.00%		
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)		92.52%		94.11%		95.40%		83.19%		96.20%		91.06%				92.52%		94.11%		95.40%		83.19%		96.20%		91.06%		
18) Percentage compliance with ALL mandatory and statutory training (snapshot)		91.27%		89.49%		92.66%		87.16%		94.03%		92.34%				91.27%		89.49%		92.66%		87.16%		94.03%		92.34%		
19) Percentage Sickness Absence Rate (month behind)		4.87%		6.00%		4.54%		4.55%		5.46%		3.84%				4.82%		5.44%		4.29%		4.24%		6.36%		4.43%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	October 2018														April 2018 To October 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)		-1,667,699.00	NA	-47,346.00	NA	-116,158.00	NA	234,488.00	NA	16,758.00	NA	-94,316.00				-5,367,145.00	NA	-142,188.00	NA	1,020,594.00	NA	860,319.00	NA	633,884.00	NA	230,268.00		
21) CRES delivery		544,853.00		84,780.00		38,153.00		34,008.00		18,278.00		78,293.00				3,671,507.00		593,462.00		267,070.00		95,592.00		127,945.00		548,051.00		
22) Cash against plan		69,021,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA				69,021,000.00	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

Appendix C 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	7					

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
22	13	19	5	9

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

Data Quality Scorecard 2018/19

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 Quality Scorecard 2018/19

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				
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.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th November 2018**
TITLE:	**Strategic Direction Performance Report – Quarter 2 2018/19**
REPORT OF:	**Sharon Pickering, Director of Planning and Performance**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to present to Board of Directors the Strategic Direction Performance Report as at Quarter 2 (30th September 2018).

At the Board Meeting on the 19th July 2018, Board agreed to revise the KPIs for the Strategic Direction Scorecard. These were subsequently agreed with appropriate targets at the Board Meeting on the 30th October 2018. This report reflects the new key performance indicators that were agreed against which we will monitor and report progress against the Trust's 5 year strategic direction in conjunction with the Trust Business Plan and other forms of intelligence.

Overall performance is balanced. There is some concern in terms of delivery against the KPIs with 10 out of 12 showing red, although 5 of these have reported an improvement. This position is offset by good progress in terms of delivery of the Business Plan and significant amounts of qualitative intelligence particularly for Strategic Goal 1

Recommendations:

Board of Directors is asked to:

- Receive this report and raise any questions/concerns.
- Approve the proposed amendment to KPI 14 – "Percentage delayed transfers of care due to non-Trust issues" noted in section 3.5.4.
- Approve the changes to the Trust Business Plan that require Board approval in Appendix 1.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**27th November 2018**
TITLE:	**Strategic Direction Performance Report – Quarter 2 2018/19**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to Board of Directors the Strategic Direction Performance Report as at Quarter 2 (30th September 2018).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report demonstrates progress against the Strategic Direction via progress against the agreed KPI Scorecard, the Trust Business Plan and other forms of qualitative intelligence.

2.2 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 strategies which underpin the 5 Strategic Goals 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 The revised KPIs for the Trust Strategic Direction Scorecard were agreed by the Board on the 19th July 2018, with the majority of targets being agreed at the October 2018 Board meeting.

2.4 Requested changes to the Business Plan are detailed in Appendix 1. A complete list of the new KPIs with the targets agreed is shown in Appendix 2.

3. KEY ISSUES:

3.1 <u>Trust Strategic Direction Scorecard</u>

The Strategic Direction Scorecard is shown under each strategic goal.

The following table provides a summary of the RAG ratings at quarter 2 compared to the position in the previous quarters. The Trust is not meeting some of its high ambitions given the number of reds (10) against stretching metrics.

The actual numbers of those rated red has increased by 1 since last quarter; however there is a significant number (9) that are not being rated as they are not required to be reported in this quarter or are still under development.

SDS 2018/19	Q1 2018/19		Q2 2018/19	
	No.	%*	No.	%*
Indicators rated green	3	25%	2	17%
Indicators rated red	9	75%	10	83%
Indicators rated	**12**		**12**	
Indicators with no target agreed				
Indicators currently under development/being finalised	9		9	
Indicators where data is not yet available or not applicable in qtr	1		1	
Metric will not be possible to report	1		1	

3.2 Strategic Goal *1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)*

3.2.1 Trust Strategic Direction Scorecard

This strategic goal is showing 3 indicators rated red out of a possible 3 that can be rated as at quarter 2, with 1 showing an improving position.

	Indicator	Q2 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Change on previous quarter	YTD Target 2018/19	FYTD 18/19 Actual	2017/18 Actual	Annual Target 2018/19
Strategic Goal 1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)									
1	Percentage of teams achieving the agreed improvement benchmarks for HoNOS total score	67.25%	54.88%	55.29%	⇧	67.25%	55.29%	44.00%	67.25%
2	Percentage of teams achieving the agreed improvement benchmarks for SWEMWBS	78.25%	67.90%	67.90%	⇔	78.25%	67.90%	50.00%	78.25%
3	Number of patients who said we helped them achieve the goals they set	TBC	Not Available for Quarter 1	Not Available for Quarter 2	N/A	N/A	Not Available for the FYTD	n/a	TBC
4	Percentage of carers that report feeling listened to and heard	76.20%	76.81%	75.75%	⇩	76.20%	76.32%	76.08%	76.20%

Indicators of concern are:

- **KPI 1 Percentage of teams achieving the agreed improvement benchmarks for HoNOS total score –** the Trust position for quarter 2 (September 2018) is 55.29% which relates to 47 out of 85 teams achieving the agreed improvement benchmarks for HoNOS total score. This is 11.96% below the target of 67.25% and is an improvement on the position reported for quarter 1 and the 2017/18 figure.

  All localities are below target however Tees locality 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 where 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.

- **KPI 2 Percentage of teams achieving the agreed improvement benchmarks for SWEMWBS** - the Trust position for quarter 2 (September 2018) is 67.90% which relates to 55 out of 81 teams achieving the agreed improvement benchmarks for SWEMWBS. This is 10.35% below the target of 78.25% and is the same as the position reported for quarter 1 but an improvement on 2017/18.

  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 where 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.

- **KPI 4 - Percentage of carers that report feeling listened to and heard** – the Trust position for quarter 2 is 75.75% which relates to 1362 carers out of 1798 carer survey responses received who stated they did feel listened to. This is 0.45% below the target of 76.20% and is consistent with the quarter 1 position reported at 76.81%.

  Localities reporting below target are:
  - Durham & Darlington reporting 74.81% which is a deterioration on quarter 1 (77.55%)
  - York & Selby reporting 72.25% which is a deterioration on quarter 1 (74.17%)
  - Forensic services reporting 62.50% which is a deterioration on quarter 1 (65.22%)

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 2 were rated green 67% (34 out of 51) compared to 76% (26 out of 34) in quarter 1. Only 37% of the priorities under Strategic Goal 1 are reporting that there is no significant risk to the completion on time of the priority, this is deterioration in position compared to 69% in quarter 1. There are 26% of the priorities that have a moderate risk of failure to deliver the final milestone or benefits on time. A number of these require changes to be approved by the Board and these are listed in Appendix 1.

There are three priorities reporting Grey on the basis that they have not been completed on time and/or benefits realised due to external factors:

- Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners – **Respite Review & implications for Day Services (Tees)** Anticipated commissioner procurement exercise has not taken place. Discussions are underway with commissioners regarding the provision of service. Timescales have not been confirmed.
- Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners – **STP wide Individual Placement Support (Tees)** The service were ineligible for Wave 1 transformation funding therefore awaiting timescales for Wave 2 application.
- **Implement the Transforming Care agenda in Learning Disability Services** – the model has been agreed in Tees and Durham, but still waiting further discussion by Transforming Care Partnership for North Yorkshire and York.

3.2.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- **Perinatal multi-disciplinary team, HMP YOI Low Newton**, Durham has won the maternity and midwifery services category of the HSJ Patient Safety Awards for the development of perinatal and maternity care pathways for women in the judicial system.
- **Learning disabilities service, North Yorkshire** have been shortlisted for a Nursing Times Award in the learning disabilities nursing category for their work around annual health checks and cancer screening uptake
- **Mental Health Services for Older People Team, Acomb Garth, York** have won a Healthwatch York Making a Difference 2018 award for their excellence in health and social care services, as nominated by the people of York
- **Mental health services for older people community team, Harrogate** have been shortlisted in the team of the year category and the **learning disabilities team, North Yorkshire** has been shortlisted in the learning disabilities nursing category of the Nursing Times Awards 2018
- **HMP Durham Integrated Support Unit** has been chosen to receive an award from the NEPACS Service, to recognise the positive work the unit and staff do, engaging with patients and offering a positive approach to the care and management of prisoners.
- **Stockton community mental health team, Lustrum Vale,** Stockton has been shortlisted in the Positive Practice in Mental Health Awards 2018.
- **Stockton community mental health team** are finalists in the RCPsych Awards 2018 for older adults team of the year.
- **Cleveland all age liaison and diversion (mental health and the emergency services/criminal justice system)** are finalists in the Positive Practice in Mental Health Awards.
- Trust Board have approved plans to bring **York and Selby and North Yorkshire** together into one locality. This will result in a more streamlined management structure which will support consistent, effective and cohesive

working. It will also help focus on shared learning across the locality and support the continued development of 'super' specialist services across North Yorkshire and York.

- **The mental health team at HMP YOI Low Newton in Durham** have been awarded a performance recognition certificate from the Governor in recognition of the care provided in delivering supportive interventions in a challenging custodial environment and contribution to the recent positive 'Her Majesties Inspectors of Prison' report
- **The mental health services for older people, Rowan Lea ward**, Cross Lane Hospital, Scarborough has been re-accredited with Accreditation for Inpatient Mental Health Services (AIMS) from the Royal College of Psychiatrists for a further three year period
- **The older people's community mental health team**, **Harrogate** have been shortlisted for a Nursing Times Award in the team of the year category
- **The 2018 GP Survey** obtained the views of 18% of the GPs in the area served by TEWV. The Trust-wide results show that satisfaction with MHSOP services has remained broadly the same as two years ago, satisfaction with AMH and CAMHS services have declined. The 3 key themes – accessibility, waiting times and communication identified from the qualitative comments provided in previous GP surveys remain the Top 3 themes identified in this survey. To some extent, these results emphasise the wider challenge facing the NHS, but there are clearly messages for the Trust in the results will be considered in the forthcoming business planning round.

3.2.4 Other points to note:

- **KPI 3 - 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 or 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. Therefore data will not be available until April 2019.

3.2.5 In conclusion, whilst all 3 KPIs are under-performing the financial year to date position for them all show an improvement on the 17/18 positions. There is some concern with the delivery of priorities identified for Strategic Goal 1 within the Business Plan and the Board is asked to agree a number of changes to the Business Plan (See Appendix 1). Whilst quantitative data highlights some concern in terms of delivery there is significant qualitative intelligence that creates a more balanced position in terms of delivery of this strategic goal.

3.3 Strategic Goal 2 - *To continuously improve the quality and value of what we do*

3.3.1 Trust Strategic Direction Scorecard

This strategic goal is showing all 3 indicators rated red that can be rated, which is a same as that reported in quarter 1. However, all 3 red indicators are showing an improving position.

	Indicator	Q2 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Change on previous quarter	YTD Target 2018/19	FYTD 18/19 Actual	2017/18 Actual	Annual Target 2018/19
Strategic Goal 2 (To continuously improve the quality and value of what we do)									
5	Percentage of staff reporting that they can contribute towards improvement at work (reported a quarter behind)	87.00%	81.59%	82.88%	⇧	87.00%	81.98%	81.59%	87.00%
6	Percentage of patients who report feeling supported by staff to feel safe	65.20%	64.15%	64.62%	⇧	65.20%	64.37%	65.63%	65.20%
7	Percentage of patients who report their overall experience as excellent or good	94.00%	90.82%	91.34%	⇧	94.00%	91.07%	90.68%	94.00%

Indicators of concern are:

- **KPI 5 - Percentage of staff reporting that they can contribute towards improvement at work (reported a quarter behind)** – The Trust position for quarter 2 is 82.88% which relates to 1409 staff patients out of 1700 reporting that they can contribute towards improvement at work. This is 4.12% below the target of 87.00% but it is a slight improvement on the quarter 1 position reported as 81.59% and the 2017/18 outturn position.

  Only York & Selby locality is above target at 90% - all other localities are reporting below target:
  - Teesside at 84.75%
  - Forensics services at 84%
  - North Yorkshire at 81.5%
  - Durham & Darlington at 76.5%

  The Trust continues to encourage staff to engage in the Quality Improvement System programme. The Trust is also implementing a Coaching programme called “Think On” which will be a key enabler to improving this position.

- **KPI 6 - Percentage of patients who report feeling supported by staff to feel safe** – the Trust position for quarter 2 is 64.62% which relates to 504 patients out of 780 patient survey responses who stated they always feel safe on our wards. This is 0.58% below the target of 65.20% but it is a slight improvement on the quarter 1 position reported as 64.15%.

  Localities reporting below target are:
  - Teesside reporting 57.53% and a deterioration on quarter 1
  - Forensics reporting 50.00% and a deterioration on quarter 1

The table below shows a brief summary of the reasons cited by patients for feeling unsafe, not all patients provide a reason and some can give more than one.

Reasons/Locality	D&D	Tees	NY	Y&S	TOTAL
General	1	8	1		**10**
Environment	4	2			**6**
Other Patients	6	13	11	4	**34**
Personal Illness	1	7	1	2	**11**
Staff/Staffing	4	4			**8**
Total	**16**	**34**	**13**	**6**	**69**

- **KPI 7 - Percentage of patients who report their overall experience as excellent or good** – the Trust position for quarter 2 is 91.34% which relates to 4337 patients out of 4748 patient survey responses report their overall experience as excellent or good. This is 2.66% below the target of 94% but an improvement on quarter 1 reported as 90.82% and the 2017/18 figure.

  All localities are reporting below target:

  - **North Yorkshire at 93.38%** although this is an improvement on the position reported at quarter 1. Each Quality Assurance Group has a focus on service user feedback and compares to previous month figures, comparing teams, look at specific feedback and take actions/ recommendations forward.
  - **York and Selby at 90.43%** although this is an improvement on the position reported at quarter 1. The locality is ensuring all static devices are working due to previous issues in both CAMHS & AMH services. Discussions have taken place in report out about tracking the discharges to ensure that all patients have been offered the opportunity to complete the survey to increase update and all comments provided in surveys are reviewed and actioned. There are initiatives ongoing across parts of the locality. We will be having engagement with service users to incorporate this element as part of business priorities for the merged locality. However the locality is gradually improving in this area.
  - **Forensic Services at 84.40%** although this is an improvement on the position reported at quarter 1.
    - For inpatient services there have been a number of quality improvement events to date, with further events planned focussed specifically on patient experience and recovery. The aim is to ensure service users feel much more actively engaged and connected in planning and reviewing their care and treatment and it is envisaged as these processes are rolled out and embedded there will be a correlating improvement in experience ratings.
    - Offender Health services have reviewed their current process of when to request patient experience returns such as Friends &

Family test (FFT). Offender Health are seeking greater returns across the OH pathway so that issues can be better understood and explored which will lead to a greater ability to plan for actions required. All 11 prisons within the North East and West have now applied and been accepted for the fourth cycle of the Quality Network for Prison Mental Health Network (Royal College of Psychiatrists). This includes completing peer reviews within other national prisons and being peer reviewed. This offers an opportunity to learn from the network about how other teams have enhanced service user experience in prison settings.

- **Durham & Darlington** are reporting 92.35% which is a deterioration on the position reported for quarter 1.
  - CYP: the service is experiencing a low number of returns which was higher when the service recruited volunteers to complete but most have now left. Each team manager has been tasked with looking at recruiting and using volunteers to support this requirement. The Team Managers review any comments added to Meridian where there are specific concerns and action where appropriate.
  - MHSOP: the service consistently does well on this. Recently the patient experience team visited Roseberry Ward to learn lessons as this ward was really good. All QIS work across inpatient and community is about improving patient experience in one way or another.

- **Teesside** are reporting 91.09% which is a deterioration on the position reported for quarter 1.
  - CYPS was an improving position at the end of the quarter, although slight deterioration in October. We are undertaking some analysis to further understand any particular areas of difficulty / themes. CYPS also use a counter system which children seem to prefer, and tends to evaluates the services far more positively – we are discussing with Patient experience as to how to include this within our scoring systems.
  - LD had a particularly poor evaluation in September (though they do have far smaller numbers of returns hence % are more easily influenced). The scores during the months July and August and particularly September have been influenced by the inclusion of a broader group of people in the denominator (particularly at Bankfields in September survey). Previously they have been excluded on capacity grounds and we are trying to agree an appropriate way of measuring their experience moving forward

3.3.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 2 were rated green 83% which is an improvement compared to 75% in quarter 1. 78% of the priorities under Strategic Goal 2 are reporting that there is no significant risk to the completion on time of the priority compared to 60% in quarter 1.

There are 2 priorities / service developments (22%) in the Business Plan at high risk of failure to deliver on-time or within budget and EMT have agreed to extend the timescales to quarter 4 2018/19 on these.

3.3.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- Teesside locality mental health services for older people are finalists in the RCPsych Awards 2018 for quality improvement team of the year
- On the 13 September CQC published the report Quality Improvement in Hospital Trusts: Sharing Learning from Trusts on a Journey of QI. A system's leadership case study and learning from the TEWV Quality Improvement Systems are featured as good practice within the publication.

3.3.4 In conclusion overall the position is positive for Strategic Goal 2. Whilst 3 metrics report red all have shown an improvement in quarter 2 when compared to quarter 1 with 2 metrics showing an improvement on 2017/18. There has also been an improvement on the percentage of Business Plan actions achieved and some positive qualitative feedback.

3.4 Strategic Goal 3 - *To recruit, develop and retain a skilled, compassionate and motivated workforce*

3.4.1 Trust Strategic Direction Scorecard

This strategic goal is showing 3 indicators rated red as at quarter 2 out of a possible 3 that could be rated which is the same as that reported for quarter 1. Of those rated red, one has reported an improvement.

	Indicator	Q2 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Change on previous quarter	YTD Target 2018/19	FYTD 18/19 Actual	2017/18 Actual	Annual Target 2018/19
Strategic Goal 3 - To recruit, develop and retain a skilled, compassionate and motivated workforce									
8	Percentage rolling 12 month TEWV labour turnover rate	10.00%	**10.77%**	**10.35%**	⇧	10.00%	**10.56%**	n/a	10.00%
9	Percentage rolling sickness absence rate	4.50%	**4.82%**	**4.81%**	⇔	4.50%	**4.81%**	n/a	4.50%
10	Percentage staff recommending TEWV as a place to work	73.00%	**71.00%**	**70.42%**	⇩	71.00%	**70.74%**	70.95%	73.00%
11	Report and increase the % frontline multi-professional leadership and management teams that have trained in the core skills identified.	TBC	**Not Available for Quarter 1**	**Not Available for Quarter 2**	N/A	N/A	**Not Available for the FYTD**	n/a	TBC

Indicators of concern are:

- **KPI 8 - Percentage rolling 12 month TEWV labour turnover rate** - the Trust position for quarter 2 (September) is 10.35% which relates to 688 leavers out of 6645 total staff. This is 0.35% outside the target of 10% however this is showing an improvement on the reported position for quarter 1.

  Of the 688 leavers 24.4% (167) were recorded as retirements not returning to work. In addition 22 staff opted to retire and return. Retirement continues to be the largest reason for staff leaving. There are a number of initiatives being implemented which may have an impact on staff retirement options. These initiatives are detailed below:
  - A review of the Retire and Return scheme has recently concluded and changes to the way the scheme operates are being implemented which leave the decision making process at a local operational level which may encourage more staff to return following retirement.
  - A revised Flexible Working procedure has been developed which hopefully will encourage and support staff to continue to work in the Trust.
  - Work is currently underway to develop a process for mid-career review conversations to take place to help staff to start to plan their career and support open dialogue about future retirement intentions.

- **KPI 9 - Percentage rolling sickness absence rate -** the Trust position for quarter 2 is 4.81% which relates to 52880 days lost to sickness out of

1099326 available working days for the Trust. This is 0.31% above the target of 4.50% but remains similar to that of quarter 1.

The cumulative figure of **4.81% is lower than t**he figure of 5.0% reported for the same period last year. The long term sickness team continue to support managers and staff experiencing an episode of long term absence.

Actions being taken are detailed below:

- A greater focus has been placed on ensuring managers are applying the sickness absence procedure associated with the management of short term absence. The primary focus to begin with has been to effectively manage those staff experiencing 5 or more episodes within a 12 month period. Over 50 members of staff are now recorded as having a warning on file relating to their attendance. It is acknowledged this is an area that we need to focus more energy on, to ensure the procedure is robustly applied.
- A review of the Sickness Absence procedure is underway and is currently being looked at by the Policy Working Group.

- **KPI 10 - Percentage staff recommending TEWV as a place to work** - the Trust position for quarter 2 is 70.42% and relates to 1564 staff recommending the Trust as a place to work out of 2221 survey responses received. This is 2.58% below the target of 73% and a slight deterioration from that reported in quarter 1.

  Three of the localities are below target; Durham and Darlington are reporting 65.15%; North Yorkshire at 64.16% and York & Selby at 56.07%. All localities are encouraged to review the results of the staff surveys with their teams to ascertain any issues that can be addressed to improve this position.

3.4.2 Trust Business Plan

The majority of the business plan actions due to be completed by the end of quarter 2 were rated green (67%), which is a vast improvement on the 33% in quarter 1. There is only one business plan priority assigned to Strategic Goal 3. This is “Making a Difference Together” which is currently reporting a moderate risk of failure to deliver the final milestone or benefits on time. This is due to two of the actions within this priority require additional time for completion. As these are within the current financial year, these requests have been approved by EMT.

3.4.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- **Judith Hurst,** Head of Workforce Development for the Trust attended an event at The House of Commons to celebrate apprenticeships. The Trust is in the top 200 businesses in the country for apprenticeship growth.
- For the 6th year running TEWV are the highest performing Trust in the GMC trainee feedback survey.
- **Annette McKeown**, highly specialist forensic psychologist and **Ellen Harvey**, higher assistant psychologist, Primrose service, HMP YOI Low Newton, Durham has had their violent women: treatment approaches and psychodynamic considerations article published within Emerald Insight (a research journal).
- **Mani Krishnan**, consultant psychiatrist, Lustrum Vale, Stockton-on-Tees, on being awarded clinical supervisor of the year by the Durham and Tees Valley GP training programme.
- In June the General Medical Council undertook an inspection visit regarding quality of **medical education** that we provide. The comparator figures for annual appraisal of medics show that **TEWV** is an outstanding performer. The details for the 2017/18 Annual Organisational Audit are as follows:

	TEWV	All MH Trusts	All Trusts
Consultants	99 %	95 %	93 %
SAS doctors	95 %	92 %	89 %

- **Thandar Win**, speciality doctor, is a finalist in the RCPsych Awards 2018 for SAS doctor of the year
- **Sarah Ryan**, advanced nurse practitioner, Merrick House, Easington has contributed to a published article on offender health and ADHD.

3.4.4 Other point to note:

- **KPI 11 - Report and increase the % frontline multi-professional leadership and management teams that have trained in the core skills identified** - there is no data available for quarter 1 and 2; however work is ongoing to collect the baseline for this indicator and once this available the data will be included and a target will also be proposed.

3.4.5 In conclusion, performance against this Strategic Goal is mainly positive. Whilst all 3 metrics are reporting red with 2 of the 3 deteriorating compared to last quarter progress against the Business Plan and the amount and breadth of qualitative intelligence is encouraging.

3.5 Strategic Goal 4 - *To have effective partnerships with local, national and international organisations for the benefit of the communities we serve*

3.5.1 Trust Strategic Direction Scorecard

This strategic goal is showing 1 indicator rated red at quarter 2 out of a possible 1 that can be rated. For KPI 12 there were no joint bids during quarter 2.

	Indicator	Q2 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Change on previous quarter	YTD Target 2018/19	FYTD 18/19 Actual	2017/18 Actual	Annual Target 2018/19
Strategic Goal 4 - To have effective partnerships with local, national and international organisations for the benefit of the communities we serve									
12	Percentage joint bids with CCGs that are successful	80%	100.00%	n/a	N/A	80%	100.00%	n/a	80%
13	Percentage of mental health and learning disability budget covered by a ring-fenced budget	85%	77.49%	77.49%	⇔	85%	77.49%	n/a	85%
14	Percentage delayed transfers of care due to non Trust issues	TBC	Not Available for Quarter 1	Not Available for Quarter 2	N/A	N/A	Not Available for the FYTD	n/a	TBC
15	Percentage referrals received from GPs using the standard electronic referrals template relevant for the speciality	n/a	Metric Not Available	Metric Not Available	N/A	N/A	Metric Not Available	n/a	n/a

Indicators of concern are:

- **KPI 13 - Percentage of mental health and learning disability budget covered by a ring-fenced budget** - the Trust position for quarter 2 is 77.49% and relates to £254,125,374 of the Mental Health and Learning Disability budget that is ring fenced out of £327,939,974. This is 7.51% below the target of 85% and remains the same as that reported for quarter 1. This includes the commissioning budgets in Durham, Darlington and Teesside, Vale of York and the New Care Models in Specialised services. Work is continuing to agree a ring fenced budget approach with CCGs in North Yorkshire and a business case to implement a NCM in Adult Eating Disorders in the North East & Cumbria is being developed.

3.5.2 Trust Business Plan

The majority of the business plan actions due to be completed by the end of quarter 2 were rated green (73%) which is an improvement compared to 36% in quarter 1. There were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget. 67% of priorities under Strategic Goal 4 are reporting that there is no significant risk to the completion on time of the priority.

There are 3 metrics for Collaborations with Universities priority requesting additional time (agreed by EMT as all within the current financial year).

3.5.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- **A new pre-registration mental health and learning disability nursing pre-registration apprenticeship programme** has been approved by the Nursing and Midwifery Council and University of Sunderland. The programme has been actively developed by the Trust in conjunction with partners.
- **A tender for Liaison & Diversion** for the whole North region - the Trust has submitted a response to the tender for the provision of Liaison & Diversion services for the 3 separate Police Force area Lots of Durham, Cleveland and North Yorkshire. The response which detailed a model which will be delivered with 2 sub-contractors, Humankind and Spectrum, was submitted 11th October and notification is expected 5th December.
- **IAPT tender in Durham, Darlington & Teesside –** the Trust with our partners Mental Health Matters and Sunderland Counselling Services submitted a response to the tender for provision of Improving Access to Psychological Therapies (IAPT) Service, MUPS and long term conditions (LTC) across Durham, Darlington and Teesside as required on 17th October. The notification of award is expected 29th November.
- The **all age liaison and diversion team, Middlehaven Police Station,** Middlesbrough and partnership working between TEWV and Rethink (IAPT) has been shortlisted in Positive Practice in Mental Health Awards 2018

3.5.4 Other Points to Note

In addition to the reported position the following points should be noted:

- **KPI 14 - 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. **Therefore the Executive Management Team recommend monitoring all delayed transfers of care as most DTOCs require us to work collaboratively with our partners in social services and/or the CCGs or both.**

- **KPI 15 – 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 for 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.

3.5.5 In conclusion performance against this strategic goal is encouraging, with only one metric rated red and progress against the Business Plan showing an improvement.

3.6 Strategic Goal 5 - *To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve*

3.6.1 Trust Strategic Direction Scorecard

This strategic goal is showing 2 indicators rated green out of a possible 2 that can be rated as at quarter 2, which is the same position as reported at quarter 1.

	Indicator	Q2 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Change on previous quarter	YTD Target 2018/19	FYTD 18/19 Actual	2017/18 Actual	Annual Target 2018/19
Strategic Goal 5 - To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve									
16	Delivery of control total in full as per NHSI financial plan	-£1,771,000.00	-1,760,435	-1,939,011	⇧	-£3,486,000.00	-£3,699,446	n/a	-£6,864,000
17	Achieve an NHSI SOF rating of 1 *(reported one quarter behind)*	1	Not available	1	N/A	1	1	n/a	1
18	All clinical teams to be able to access pathology results via PARIS and order test by PARIS	10.00%	Not Available for Quarter 1	Not Available for Quarter 2	N/A	0.00%	Not Available for the FYTD	n/a	10.00%
19	All service users being able to access care plan online or digitally	TBC	Not Available for Quarter 1	Not Available for Quarter 2	N/A	N/A	Not Available for the FYTD	n/a	TBC
20	100% clinical pathways developed and in use within PARIS	100%	Not Available for Quarter 1	Not Available for Quarter 2	N/A	100%	Not Available for the FYTD	n/a	100%
21	All Trust clinicians to have access to their key service/team/patient information in near to real time	100%	Not Available for Quarter 1	Not Available for Quarter 2	N/A	100%	Not Available for the FYTD	n/a	100%
22	Placeholder: E&D Strategy		Not Available for Quarter 1	Not Available for Quarter 2	N/A	N/A	Not Available for the FYTD	n/a	TBC
23	Placeholder: E&D Strategy		Not Available for Quarter 1	Not Available for Quarter 2	N/A	N/A	Not Available for the FYTD	n/a	TBC

There are no concerns for the indicators reported above.

3.6.2 Trust Business Plan

100% of actions have been delivered within quarter 2. There is only one business plan priority assigned to Strategic Goal 5. This is to establish and develop TEWV EFM Ltd which is currently reporting Grey. The Board of Directors agreed not to pursue the development of TEWV EFM Ltd in September 2018 following a review of the Business Case. Therefore Board are asked to approve the request to remove this priority from the Trust Business Plan (Appendix 1).

3.6.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- **The Information Department** moved the Trust over onto the new website on 26 September 2018. The new content management system is much more user friendly, easier to manage and is more reliable. The next phase will involve a 'discovery phase' covering user experience and journey along with design and content. Plans and timescales for this are currently being finalised with the development company.

3.6.4 Other points to note:

- **KPI 18 – All clinical teams to be able to access pathology results via PARIS and order test by PARIS** – data is not currently available as yet; however a solution is being implemented and a pilot of approximately 10% of teams in the Trust will be in place by the end of December 2018. If this is successful this will be rolled out to all teams and it is expected that all will be live by 1st April 2019.

- **KPI 19 - All service users being able to access care plan online or digitally** – data is not currently available as yet; however the new Care Planning capability on Paris became available in September and a small subset of CAMHS is piloting the new functionality. The Trust are planning to expand this pilot further with a requirement added to record if a care plan has been delivered to the patient in an electronic format. In the longer term, Care Planning will be built into CITO and patients will receive access to the plan via an online shared portal. Timescales on this are currently unknown but once they are data will be provided and a target and trajectory will be established.

- **KPI 20 - 100% clinical pathways developed and in use within PARIS** - data is not currently available as yet; 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 pilot teams for CITO will include this high level pathways functionality but a start date has not been confirmed. Once this is known data will be provided and a target and trajectory will be established.

- **KPI 21 - All Trust clinicians to have access to their key service/team/ patient information in near to real time** – data is not currently available as yet; the Board approved plans to report this indicator later in the year however the Trust is awaiting a start date form a 3rd party (Advanced) for the Datix Dashboard rollout to go ahead.

- **KPI 22/23 - E&D Strategy metrics** – these metrics are not yet finalised. There is no scorecard and further work is required to refresh the strategy and develop the associated scorecard.

3.6.5 In conclusion performance against this Strategic Goal remains positive. However there are a significant number of metrics to be developed. Progress against the business plan is encouraging.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
There are no issues of compliance with the CQC fundamental standards.

4.2 **Financial/Value for Money:**
The report highlights that none of the Sustainability metrics are below target.

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

4.4 **Equality and Diversity:**
There are no direct equality and diversity implications from this paper, however, one metric does measure the variance in the responses of staff in the NHS Staff Survey who report as 'disabled' compared to those reporting 'non-disabled'.

4.5 **Other implications:**
There are no other implications associated with this paper.

5. RISKS:

There are no identified risks associated with this paper.

6. CONCLUSIONS:

Overall performance is balanced. There is some concern in terms of delivery against the KPIs with 10 out of 12 showing red, although 5 of these have reported an improvement. This position is offset by good progress in terms of delivery of the Business Plan and significant amounts of qualitative intelligence particularly for Strategic Goal 1.

7. RECOMMENDATIONS:

Board of Directors is asked to:

- Receive this report and raise any questions/concerns.
- Approve the proposed amendment to KPI 14 – "Percentage delayed transfers of care due to non-Trust issues" noted in section 3.5.4.
- Approve the changes to the Trust Business Plan that require Board approval in Appendix 1.

Sharon Pickering
Director of Planning, Performance & Communications

Background Papers:

Appendix 1

Requests to the Board of Directors for a Change to the Business Plan

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
1.15.39	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - Reconfiguration of Access	Durham and Darlington	AMH	Following review in Q4 17/18 submit proposal to LMGB/LCC	Proposal and organisational change details submitted	Q2 18/19	Stuart Tweddle	R	This work has now been superseded by the work undertaken by the PPCS and PPCJ programme Therefore Board are requested to remove the actions
1.15.40	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - Reconfiguration of Access	Durham and Darlington	AMH	Carry out communication and briefings to internal and external stakeholders re new model and referral process etc	Communications complete	Q2 18/19	Stuart Tweddle	R	This work has now been superseded by the work undertaken by the PPCS and PPCJ programme Therefore Board are requested to remove the actions
1.15.41	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - Reconfiguration of Access	Durham and Darlington	AMH	Complete organisational change process and implement new access model	New access model in place	Q2 18/19	Stuart Tweddle	R	This work has now been superseded by the work undertaken by the PPCS and PPCJ programme Therefore Board are requested to remove the actions
1.15.11	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - CYP PICU	Tees	CAMHS	PICU: built and accepting patients by 2019	PICU open	Q4 18/19	Chris Davis		Evergreen may be an option for PICU facility, therefore no new build required. PICU option will be assessed in line with West Lane reconfiguration plans which are currently been worked on Therefore Board are requested to extend timescales to Q1 2020/21

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Specialty	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
1.16.25	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **Rehab Review**	Tees	AMH	Improve community rehab provision through the review of inpatient provision	Review complete and submitted for discussion	Q3 18/19	Alison McIntyre / Joanne Hodgen / Ben Smith		The service are in the process of managing patient flow to ensure patients are moved across from RPH to Lustrum in an appropriate timely manner. The proposed transfer date was original set to coincide with the approval of community rehab EMT paper. However the paper has been delayed going to EMT due to changes in management structure, delaying process to transfer patients The Paper is now due to be presented to EMT Oct/Nov 18 Board are requested to extend timescales to Q1 2019/20
1.16.26	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **Rehab Review**	Tees	AMH	Return services from Lustrum Vale back to Roseberry Park upon completion of building works	Services returned to Roseberry Park	Q4 18/19	Alison McIntyre / Joanne Hodgen / Ben Smith		The service are in the process of managing patient flow to ensure patients are moved across from RPH to Lustrum in an appropriate timely manner. The proposed transfer date was originally set to coincide with the approval of community rehab EMT paper. However any move back to RPH is dependent on the rectification works and timescales for this is not yet clear. Therefore Board are requested to remove this action

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Specialty	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
1.16.27	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **Rehab Review**	Tees	AMH	Remodel service based on review to improve community provision	Service provision revised	Q4 18/19	Alison McIntyre / Joanne Hodgen / Ben Smith		The service are in the process of managing patient flow to ensure patients are moved across from RPH to Lustrum in an appropriate timely manner. The proposed transfer date was original set to coincide with the approval of community rehab EMT paper. However the paper has been delayed going to EMT due to changes in management structure, delaying process to transfer patients The Paper is now due to be presented to EMT Oct/Nov 18 Board are requested to extend timescales to Q2 2019/20
1.14.1	Deliver a new model of care for Adult Mental Health and Mental Health Services for Older People in Harrogate	North Yorkshire	AMH / MHSOP	Develop revised Service Model	Revised Service Model approved by TEWV Board and HaRD CCG	Q4 18/19	Adele Coulthard		Due to clinical senate timescales and additional requirements of NHSE sense check 2 there is a further delay to the timescales by 3 months. The Business case has been finalised and presented to EMT 17.10.18 and Trust Board 30.10.18 for submission to NHS England 6.11.18. Following the approval of the preferred solution and engagement process this will be considered at TEWV & CCG governance forums. For engagement/consultation to commence January 2019 Board are requested to extend timescales to Q1 2019/20

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
1.13.2	Deliver a new model of care for Adult Mental Health and Mental Health Services for Older People in Harrogate	North Yorkshire	AMH / MHSOP	Mobilise agreed Service Model	New Service Model is live	Q1 20/21	Adele Coulthard		Due to the clinical senate timescales and additional requirements of NHSE for sense check 2 there is a further delay to the timescales by 3 months. The Business case has been finalised and presented to EMT 17th Oct 18 and Trust Board 30th Oct 18 for submission to NHS England 6th November 18 Following the approval of the preferred solution and engagement process this will be considered at TEWV and CCG governance forums. For engagement/consultation to commence January 2019 Board are requested to extend timescales to Q2 2020/21
1.1.9	Implement Phase 2 of the Recovery Strategy and develop Phase 3	COO	All	To work with other leadership programmes in TEWV to ensure an integrated approach	Integrated approach in place	Q2 18/19	Alison Brabban/ Kate Hughes	GY	Meeting held on 30 August to scope an integrated leadership approach across a number of programmes and this will require the timescales to be revisited. This has been reported as grey as it is now managed as a co-ordinated approach and single module for leadership which will include recovery and other relevant strategic priorities. Further meeting held 10 October as part of a single Trust leadership & training approach. This was attended by M Brown, R Briel, L Webb, K

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
									Hughes and A Kennedy, it was agreed which Recovery elements will be included in the training materials and where they will sit within a single leadership syllabus and module. Board are requested to extend timescales to Q4 2018/19 and to change the key metric wording from "Integrated approach in place" to "Agreed Recovery elements to be included in training materials and syllabus in place".
1.2.6	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	COO	All	Develop a share and spread 'package' for other CMHTs for PARIS entry for reviews and initial assessment	Implementation plan developed	Q2 18/19	Ruth Hill / Locality Directors / KPO	R	There has been a change in Sponsor and subsequent revision in programme workstreams. Each new workstream has been tasked with developing a scope and an implementation plan by to submit to the Programme Board for approval. A revised scope and implementation plan will be submitted to EMT and Board in Q3 2018/19. Revised business plan objectives will be submitted as part of the Q3 18/19 update report.
1.2.10	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	COO	All	SCDs and SDMs support localities to embed existing clinical pathways in all 12 teams	Evidence of pathways being used for every service user via daily discussion in huddle	Q2 18/19	Dominic Gardner / SCDs / SDMs	R	There has been a change in Sponsor and subsequent revision in programme workstreams. Each new workstream has been tasked with developing a scope and an

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Specialty	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
									implementation plan by to submit to the Programme Board for approval. A revised scope and implementation plan will be submitted to EMT and Board in Q3 2018/19. Revised business plan objectives will be submitted as part of the Q3 18/19 update report.
5.7. 2	Establish and Develop TEWV EFM Ltd	EFM	NA	Agree a Business Case	Business Case Agreed	Q2 18/19	David Brown	**GY**	TEWV's board of directors have decided against transferring all the Trust's estates and facilities management services into a wholly owned subsidiary. As a result Board are requested to approve the removal of this priority.
5.7.3	Establish and Develop TEWV EFM Ltd	EFM	NA	Implement actions as planned	Actions implemented by agreed deadlines	Q4 18/19	David Brown	**GY**	TEWV's board of directors have decided against transferring all the Trust's estates and facilities management services into a wholly owned subsidiary. As a result Board are requested to approve the removal of this priority.
5.7.4	Establish and Develop TEWV EFM Ltd	EFM	NA	Implement actions as planned	Actions implemented by agreed deadlines	Q4 19/20	David Brown	**GY**	TEWV's board of directors have decided against transferring all the Trust's estates and facilities management services into a wholly owned subsidiary. As a result Board are requested to approve the removal of this priority.

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
5.7.5	Establish and Develop TEWV EFM Ltd	EFM	NA	Implement actions as planned	Actions implemented by agreed deadlines	Q4 20/21	David Brown	**GY**	TEWV's board of directors have decided against transferring all the Trust's estates and facilities management services into a wholly owned subsidiary. As a result Board are requested to approve the removal of this priority.

Please note that if approved, future monitoring will be against the amended timescale.

Strategic Direction Scorecard 3 year KPIs and Targets agreed to date: **Appendix 2**

	Indicator	Source	Proposed Target 2018/19	Proposed Target 2019/20	Proposed Target 2020/21
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
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
3	Number of patients who said we helped them achieve the goals they set	TBC	TBC	TBC	TBC
4	Percentage of carer that report feeling listened to and heard	Quality Strategy	76.20%	76.20%	TBC – new strategy
5	Percentage of staff reporting that they can contribute towards improvement at work	Quality Strategy	87.00%	87.00%	87.00%
6	Percentage of patient who report feeling supported by staff to feel safe	Quality Strategy	65.20%	65.20%	TBC – new strategy
7	Percentage of patient who report their overall experience as excellent or good	Quality Strategy	94.00%	94.00%	94.00%
8	Percentage rolling 12 month TEWV labour turnover rate	Workforce Strategy	10%	9%	8%
9	Percentage rolling sickness absence rate	Workforce Strategy	4.50%	4.40%	4.30%
10	Percentage staff recommending TEWV as a place to work	Workforce Strategy	73%	76%	80%

11	Report and increase the % of frontline multi-professional leadership and management teams that have trained in the core skills identified.	Leadership Strategy	TBC	TBC	TBC
12	Percentage joint bids with CCGs that are successful	Planning & Business Development	80%	80%	80%
13	Percentage of mental health and learning disability budget covered by a ring-fenced budget	Finance	85%	85%	85%
14	Percentage delayed transfers of care due to non Trust issues	Recommendation included in report	TBC	TBC	TBC
15	Percentage referrals received from GPs using the standard electronic referrals template relevant for the speciality	Digital Transformation Strategy	TBC	TBC	TBC
16	Delivery of control total in full as per NHSI financial plan	Finance Strategy	£6,864,000	£6,864,000	£6,864,000
17	Achieve an NHSI SOF rating of 1	Phil Bellas	1	1	1
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%
19	All service users being able to access care plan online or digitally	Digital Transformation Strategy	tbc	100.00%	100.00%

20	100% clinical pathways developed and in use within PARIS	Digital Transformation Strategy	tbc	tbc	tbc
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%
22	Placeholder: E&D Strategy				
23	Placeholder: E&D Strategy				

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27 November 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 polices that have undergone full review and require ratification:
  - CORP-0050-v4 Research Governance Policy
  - CLIN-0051-v6 Management of coexisting mental illness and substance misuse (Dual Diagnosis)

- 1 plan that has undergone full review and requires ratifying for 12 months:
  - Water Safety Plan

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meetings held on 14 November 2018

DATE:	**27 November 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-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.

Ref and Title	CLIN-0051-v6 Management of coexisting mental illness and substance misuse (Dual Diagnosis)
Review date	14 November 2021
Reviewed by	Tim Cate
Approved by	Adult SDG 10 March 2018
Description of change	Revised in line with current national guidelines including NICE guideline [NG58].

3.2 The following have had their review date extended:

Ref and Title	Water Safety Plan
Review date	01 September 2019
Approved by	Water Safety Group 09 October 2018
Description of change	The plan was reviewed and no changes or amendments made. The plan will be reviewed in 12 months.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Sound policy development improves patient experience and enhances patient safety and clinical effectiveness.

4.2 Financial/Value for Money:

Any financial implications from the proposals arising from operational and/or practice changes will be managed by the Directorates responsible for policy implementation.

4.3 Legal and Constitutional (including the NHS Constitution):

The Trust requires a contemporary policy portfolio to ensure practice is compliant with legislation, regulation and best practice. The policy ratifications, review extensions and withdrawals will ensure the portfolio is managed to provide the necessary evidence based operational and practice frameworks.

4.4 Equality and Diversity:

The current policy portfolio ensures the Trust meets the required legislative and regulatory frameworks and all policies are impact assessed for any

equality and diversity implications. Policy revision and /or specific implementation plans would result from any adverse impact assessments.

4.5 Other implications:

None identified

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meeting on 14 November 2018 have been presented for ratification.

7. RECOMMENDATIONS:

The Board is required to ratify the decisions of the Executive Management Team and is requested to accept this report.

Author: Colin Martin
Title: Chief Executive