AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 26TH FEBRUARY 2019 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 **29th January 2019.**		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 7	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 8	To consider the report of the Mental Health Legislation Committee.	**RS/EM**	**Attached**
Item 9	To receive and note a progress report on the Trust's flu campaign.	**DL**	**Attached**
Item 10	To receive and note the action plan arising from the CQC's inspection of the Trust in June/July 2018.	**EM**	**Attached**

Performance (11.00 am)

Item 11	To consider the Finance Report as at 31st January 2019.	**PM**	**Attached**
Item 12	To consider the Trust Performance Dashboard as at 31st January 2019.	**SP**	**Attached**

Item 13 To consider the Strategic Direction Performance Report for Quarter 3, 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 the next meeting of the Board of Directors will be held on **Tuesday 26th March 2019** 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.

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

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

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

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
20th February 2019

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 29TH JANUARY 2019 IN THE DURHAM CENTRE, BELMONT INDUSTRIAL ESTATE, DURHAM AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Dr. H. Griffiths, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Mr. D. Jennings, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
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
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Dr. J. Whaley, Guardian of Safe Working (minute 19/07 refers)
Mr. L. Buckley, Director of Operations for County Durham and Darlington (minute 19/06 refers)
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications

Mr. A. Davison, Mrs. N. Lonergan, Mrs. L. McCrindle and Mrs. J. Smith, Shadow Board Members

(Note: It was noted that Mr. Martin would be arriving late for the meeting due to another appointment)

19/01 MINUTES

***Agreed** – that the minutes of the last ordinary meeting held on 29th November 2018 and the special meeting held on 18th December 2018 be approved as correct records and signed by the Chairman.*

19/02 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

Further to minute 18/242 (25/9/18) it was noted that the metrics being collated to support the evaluation of the pilot of zonal care had been presented to the Right Staffing Programme Board on 25th January 2019 and were due to be considered by the Executive Management Team on 30th January 2019.

It was agreed that a copy of the metrics should be provided to either Dr. Griffiths, personally, or presented to the next meeting of the Quality Assurance Committee.

Action: Mrs. Moody

19/03 DECLARATIONS OF INTEREST

There were no declarations of interest.

19/04 CHAIRMAN'S REPORT

The Board noted that the Chairman's activities had been curtailed in recent weeks due to health reasons.

19/05 GOVERNOR ISSUES

Mr. Jennings reported on the following matters arising from the Governor Development Day which he and Mrs. Richardson had attended on 24th January 2019.

(1) The Trust's target for patient experience.

The Board noted that:

(a) The issue had been raised during a broader discussion on patient experience.

(b) Governors considered that the target (reported at the event as 95%) was not attainable and continuing failure to achieve it could demotivate staff.

(c) The Governors had been informed that, when reviewing performance, the Board did not just look at whether or not a target had been achieved but also reviewed the direction of travel and how the Trust compared to others.

(d) Staff attending the event had been unable to explain how the target had been set.

On this matter:

(a) Board Members considered that, although targets were widely disseminated, the Trust was not good at articulating those which were business critical; those which were aspirational; and the difference between them.

(b) Mrs. Pickering explained that:

- The Trust's target for the metric "Percentage of patients surveyed reporting their overall experience as excellent or good" was 92% and present performance against it was just under 90%.
- Targets were included in a number of reports.
- Those included in the Performance Dashboard were set to be stretching but also to be achievable.
- Those included in the Strategic Direction Scorecard tended to be more aspirational as they covered a longer time period.
- No targets, however, were purely aspirational.

(c) The Chairman considered that the issue highlighted the need for staff, when presenting to Governor Development Days, to be well briefed and prepared in view of the in-depth nature of discussions at the events.

It was agreed that the matter should be addressed during discussions on the Performance Dashboard Report at the next meeting of the Council of Governors.

Action: Mrs. Pickering

Mrs. Pickering and Mrs. Moody also asked for copies of the slides used in the presentation to the Governor Development Day to be provided to them.

(2) Training for staff on raising concerns.

Mr. Jennings advised that, during his presentation, Mr. Williams, the Trust's Freedom to Speak Up Guardian, had mentioned that training on raising concerns was being rolled out to staff at Band 7 and above only; however, Governors considered that it should be provided to all staff.

Mr. Levy provided clarity that the training referenced by Mr. Williams was specifically for managers to help them to respond to any concerns raised. This was in accordance with the recommendations made by Robert Francis QC. The Trust also had an e-learning package on raising concerns which was available to all staff.

It was agreed that:

(a) The matter should be raised with Mr. Williams.
(b) Clarity on the provision of training on raising concerns should be provided at the next meeting of the Council of Governors.

Action: Mr. Levy

(Note: Mr. Martin joined the meeting)

19/06 LOCALITY BRIEFING – COUNTY DURHAM AND DARLINGTON

Mr. Buckley (Director of Operations) gave a presentation on the key issues facing the County Durham and Darlington Locality.

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

In response to a question, Mr. Buckley advised that he considered the greatest challenges facing the Locality to be:

(1) The creation of a shared vision and how leadership, at all levels, could support it.
(2) Staffing levels, with the Locality having approximately 90 vacancies at present.

The Board noted:

(a) The impact of staffing issues both generally, with the pace of work impacting on the ability of staff to deliver high quality care, and in particular teams e.g. the Darlington Psychosis team.
(b) The work being undertaken within the Locality on new roles.

The Board discussed the following matters:

(1) Cultural issues as, due to the pace at which they were working, staff appeared to be focussing on the completion of tasks and the achievement of performance targets more than quality, safety and patient experience.

Board Members:

(a) Recognised that achieving a balance between quality and safety and performance was always challenging.

(b) Questioned whether the focus on performance was due to the emphasis being placed on it by the Trust.

Mr. Buckley considered that the key issue was ensuring that staff understood the relationship between the key performance indicators (KPIs) and the provision of high quality safe services.

Mrs. Pickering:

- Supported this view and expressed her difficulty in understanding how quality and performance were seen as being different.
- Explained that all the KPIs included in the Performance Dashboard had a quality element.
- Recognised the challenges in communicating the relationship between quality and performance to staff.
- Advised that consideration was being given to refreshing the performance management framework and there might be an opportunity to seek to address the issue through that work.

(c) Considered that the starting point for conversations on quality and safety was also important.

The Chairman observed that those starting with a focus on performance rather than on the matter at hand were beginning in the wrong place.

Mr. Buckley agreed with this assessment drawing attention to the tensions, in relation to clinical outcomes, between those issues important to service users (e.g. settled accommodation and meaningful activity) and the performance metrics used by the Trust relating to capturing outcome measures on the PARIS system.

(d) Sought clarity on whether there were any issues being raised by teams which were not covered by performance measures.

In response, Mr. Buckley considered that a greater focus on the impact of vacancies and temporary staffing on the health and wellbeing of staff would be beneficial.

It was noted that the Locality was seeking to stimulate conversations on this matter through the production of a short video.

(2) Staffing issues within the Locality.

In response to questions, Mr. Buckley advised that:

(a) The greatest challenge was in adult mental health services.

Mrs. Moody agreed with this view highlighting that the Right Staffing Programme had not yet been able to evaluate the impact of the additional resources provided to 20 bedded inpatient wards in the Locality due to vacancies.

(b) Medical vacancies which, although fewer in number, were expensive to cover and had a significant impact on the leadership of teams.

It was noted that:

- As a result of an event undertaken in the Locality, two new CAMHS consultants had been recruited but more difficulty was being experienced in MHSOP.
- Work was also being undertaken with the Director of Therapies and the Senior Programme Manager for Right Staffing on new roles.

(c) The Locality was also seeking to understand those initiatives which were working and those where additional support was required.

(d) The staffing challenges were seen as being the sole responsibility of the senior leadership team and it was considered that a broader plan, including leaders at all levels and for delivery across all the specialties, would be beneficial.

(e) Vacancies appeared to have arisen mostly due to staff moving to other opportunities.

(f) The level of vacancies created disruption and impacted on the sustainability of leadership.

(g) By way of an example, the impact of staffing issues could be seen in the challenges being experienced in implementing and embedding the Triangle of Care in the Locality.

The Chairman recognised the challenges being experienced in the Locality and the really good start being made on addressing them.

Board Members welcomed Mr. Buckley's honesty and thanked him for his presentation.

19/07 REPORT OF THE GUARDIAN OF SAFE WORKING

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

The Non-Executive Directors sought clarity on the likely solution to the position in York where vacant resident night-shifts were being filled with non-resident locum doctors.

Dr. Whaley considered that the issue could be addressed by a night shift manager to field calls and to liaise with services.

He explained that the present approach represented an attempt to deal with the complexity of services in the City; however, the conversion of residential to non-residential shifts was contrary to the Junior Doctors' Contract.

The Board noted that investment in Duty Nurse Night Co-ordinators had been approved approximately 12 months ago but the position in York remained vacant.

The Board thanked Dr. Whaley for his report.

19/08 NURSE STAFFING REPORT

The Board received and noted the six monthly review report, for the period 1st June 2018 to 30th November 2018 , in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire NHS Foundation Trust ("Francis Review") and in line with National Quality Board (NQB) guidance.

The Non-Executive Directors raised the following matters:

(1) The sense, provided by the report, of the pressure in services and the increasing difficulty in solving the staffing problems being experienced in the Trust.

In relation to this matter the position on Cedar Ward in North Yorkshire was highlighted due to it having the highest agency usage; being in the top five wards for missed breaks; and having seen the largest reduction in the number of registered and unregistered nurses during the reporting period.

Mrs. Moody and Mr. Levy summarised the range of actions being taken to respond to the staffing issues, both generally in the Trust and specifically within the North Yorkshire Locality, including:

(a) Seeking greater understanding of, and visibility on, the reasons why staff were leaving the Trust.

The Board noted that:

- A kaizen event was due to be held on this matter including to seek to address turnover rates.
- Following a review of the data, the finding that approximately a quarter of HCAs had left the Trust due to dismissal had been surprising.

(b) Being clear with healthcare assistants (HCAs) on their career paths.

(c) Undertaking more regular recruitment and over recruitment in areas, such as the North Yorkshire Locality, with predictable turnover rates.

(d) Focusing on retention issues amongst HCAs in North Yorkshire during the forthcoming Investors in People review.

(e) Increasing the notice period for staff at bands 4 and 5 to two months.

(f) Amending or introducing new polices e.g. the new retire and return policy and the introduction of the internal transfer scheme.

(g) Holding an RPIW on the introduction of a leaver alert system so that conversations with staff, who had received a conditional offer of alternative employment, could be commenced earlier with the hope of persuading them to remain with the Trust.

(h) Introducing weekly pay for bank workers from March 2019.
(i) Benefiting from the support provided by NHS Improvement (NHSI).

It was noted that feedback from the NHSI team was that the Trust was taking a sensible approach; however, a number of further initiatives and changes had also been suggested.

(2) Whether there was any initial learning from the wards participating in the pilot of zonal care.

In response it was noted that:
(a) The proposal for the piloting of zonal care was due to be considered by the EMT on 30th January 2019.
(b) The Heads of Nursing had visited Mersey Care NHS Foundation Trust and Lancashire Care NHS Foundation Trust and the evaluation data, shared by the trusts, suggested that zonal care could reduce both spend and the number of incidents.
(c) Increasing ward establishments to support the implementation of zonal care, and to reduce agency usage, could be seen as an investment but this was not straightforward as there were also other factors which wards would need to manage.

(3) The increase in pressure felt by staff on wards, due to the levels of sickness absence, which could lead to burnout.

Mrs. Moody considered that sickness absence was a key issue but, due to variations, further detailed work was required to improve understanding of its impact on individual wards and teams.

(4) The contribution of variations in training, leadership and development to the issues being faced by the Trust.

Mr. Levy responded that a new leadership and development programme was due to be introduced in April 2019 but it was recognised that there was more to do on this issue.

(5) Whilst the report reflected known staffing issues and the action being taken on the supply side (e.g. recruitment and retention, training, etc.) to seek to address them, there was less visibility on the demand side (e.g. enhanced observations); the differences, in terms of productivity and outcomes, on how teams were using staff; and how these issues were being addressed within the workstreams of the Right Staffing Programme.

Mrs. Moody responded that it was difficult to discuss quality and safety in the absence of evidenced based ward and community team establishments. From April 2019, under the guidance on "Developing Workforce Safeguards" published by NHSI (minute 18/334 – 18/12/18 refers), the Trust was required to review the establishments of all wards and community teams every 12 months which would take key quality, safety and acuity factors into account. At present, the validated

mental health tool, which had been due to be published last year, had not yet been provided. In the absence of the tool the Trust would need to fall back on the approach it had used previously based on the Hurst Tool and professional judgement. Undertaking reviews of the establishments of community teams was more complex and, as the Trust has more than 200 community teams with no community roster, plans were in place to develop the approach over the next 12 months.

(6) How learning was being taken from wards which were performing well and rolled out across the Trust.

The Non-Executive Directors suggested that this could involve identifying exemplars; setting clear expectations on how the Trust expected staff to work; and minimising the freedom of ward managers to vary from the agreed approach.

Board Members supported the suggested approach.

Mr. Martin observed that, whilst the leadership and management of wards within the Trust was generally good, allowing ward managers freedom to act had, in certain circumstances such as rostering, led to difficulties.

Taking the example of rostering, Mrs. Moody considered that the key issue was visibility and the ward dashboard, being developed by the Right Staffing Programme, could support this, for example by identifying those wards which breached the rostering rules most often.

In response to a question it was noted that compliance with the rostering rules was monitored and upheld by the Modern Matrons.

(7) The reasons why Ward 15 at the Friarage Hospital had not achieved the compliance rate of 75% for mandatory training at November 2018.

It was noted that sickness absence had contributed to the position.

(8) The high use of bank staff in forensic services.

It was noted that sickness absence and vacancies being held due to ward changes might have contributed to the position but further information could be sought from the services.

The Chairman:

(a) Reminded the Board of the significant recruitment activity undertaken by the Locality and the concerns, previously raised, about the proportion of inexperienced nurses on the wards particularly in view of their challenging environments.

(b) Considered that the Forensic Services Locality should provide further details of its staffing position to the Quality Assurance Committee.

This was agreed.

Action: Mrs. Hill

19/09 REPORT OF THE QUALITY ASSURANCE COMMITTEE

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

(1) The confirmed notes of the informal meeting held on 1st November 2018 (Annex 1 to the report).

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

Dr. Griffiths, the Chairman of the Committee highlighted:

(1) The discussions on :

(a) The re-audit of emergency response bags as reported under minute 18/333 (18/12/18).

It was noted that the position had improved and that the Committee had agreed future assurance and monitoring processes and for annual re-audits to be held going forward.

(b) A report which set out options for placing automated defibrillators (AEDs) in those non inpatient areas and/or community teams that did not currently have an emergency response bag.

He advised that the Committee had agreed for further work to be undertaken by the EMT to establish potential locations for the AEDs with a final proposal, including costings, being provided to the Quality Assurance Committee in due course.

(2) That information on the use of mechanical restraint, an issue which had been raised in the last CQC inspection, had not been included in the QuAC's summary report to the Board.

It was also noted that information on this matter had been provided in the patient safety report and in the LMGB report from forensic services to the Committee's meeting.

He asked for the information to be included in the next QuAC report to the Board.

Action: Mrs. Moody

19/10 LEARNING FROM DEATHS

The Board received and noted the Learning from Deaths Report which set out the approach being taken by the Trust towards the identification, categorisation and investigation of deaths.

The mortality dashboard, covering the period July to September 2018, which included 2017/18 data for comparison, was provided as Appendix 1 to the report.

During her introduction to the report, Mrs. Moody highlighted that one of the key learning points arising from the mortality reviews was the number of very frail elderly

patients residing in residential or nursing homes who remained on the CPA but had minimal contact with the Trust's services; an issue which had been passed to the MHSOP SDG for review and to develop proposals on how this could be addressed.

Mrs. Pickering advised that a paper from the SDG, in relation to compliance with NICE guidelines for dementia, had been recently presented to the Mental Health Performance Board. The proposal that patients, if remaining on the CPA for no benefit, should be returned to their GP had been supported and this approach might help address the issue highlighted by the mortality reviews.

In response to a question, Mrs. Moody advised that the increase in the number of reported deaths was part of a trend noted across the region within the Learning from Deaths regional collaborative. Discussions on benchmarking across the nine trusts represented had taken place at its meeting held on 25th January 2019. It had been agreed to focus on three benchmarks: one being the percentage increase in serious incidents over the last two years with the other two still to be agreed.

The Chairman also raised the issue of the tendency to oversimplify the findings of serious incident reviews, for example, a key issue underlying those related to risk assessment and management processes was the consistency of care co-ordination particularly changes of the care co-ordinator. In circumstances where the care co-ordinator was absent or had changed, failure to undertake a proper handover, adjust the risk assessment, etc. increased the risks of a serious incident.

On this matter:

(1) Mrs. Moody emphasised the importance of the level of connectedness between a service user and their care co-ordinator.

(2) The Non-Executive Directors questioned the extent that community services were supporting the resilience of service users rather than just seeing them.

It was noted that the position varied with some staff demonstrating excellent practice whilst this was more of an issue for others.

19/11 MATTERS OF URGENCY - MENTAL HEALTH LEGISLATION COMMITTEE

Mr. Simpson reported that there were no matters of urgency arising from the meeting of the Mental Health Legislation Committee held on 24th January 2019.

19/12 SUMMARY FINANCE REPORT AS AT 31ST DECEMBER 2018

Consideration was given to the summary Finance Report as at 31st December 2018 including the Trust's Quarter 3, 2018/19, submission to NHS Improvement.

In response to questions from the Non-Executive Directors, Mr. McGahon advised that:

(1) The in-month slippage on two schemes and the delayed start of works on the Middlesbrough Crisis Assessment Suite were not considered to be significant in terms of the overall delivery of the capital plan.

(2) With regard to the impact of agency spend on the use of resources rating:

(a) The Trust had been rated as "3" due to a technical adjustment relating to the position on agency spend and, if this had not been applied, would be rated as "2".
(b) Improvements to the other components would not impact on the rating.
(c) It was unlikely that the position on agency spend would improve until next year.

Mr. Martin considered that the agency cap was achievable but not in Quarter 1, 2019/20.

(d) At present no concerns had been raised by NHS Improvement about the rating; however, the regulator had asked the Trust to engage with its national team on agency staffing.

It was also noted that NHSI was aware that the Trust had an historic low cap for agency spending.

(e) The Trust had sought to have the cap reset and would do so again if it could show that it was an exemplar on agency usage.

Board Members cautioned that the Trust needed to be careful in how it communicated the need to reduce agency usage as, if there was a clampdown, services might feel they were being cast adrift.

Mr. Martin considered that the key issue was that the Trust should not be in the position where it was using agency HCAs.

Agreed *– that the Trust's Quarter 3, 2018/19 submission to NHS Improvement, in accordance with the results detailed in the above report, be approved.*

Action: Mr. McGahon

19/13 PERFORMANCE DASHBOARD AS AT 31ST DECEMBER 2018

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

In her introduction to the report Mrs. Pickering:

(1) Drew attention to the three new activity indicators which were being presented to a Board meeting for discussion for the first time.
(2) Advised that, at present, the new activity indicators were based on pure numbers but further discussions were due to be held at the EMT "Time Out" on 30th January 2019 on whether to apply trajectories or trends to them and whether to convert KPIs 9 (External referrals with an assessment completed) and 10 (external referrals which resulted in treatment commencing) to percentages.

The Non-Executive Directors raised concerns about:

(1) The sharp increase in the number of unexpected deaths but recognised that this could just represent a spike.

(2) The position on the indicator "Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)" which had increased over the year and was now approaching 30%.

Mr. Martin recognised the concerns and advised that:

(a) Performance on the metric was frequently discussed during report outs.
(b) The position was symptomatic of the effectiveness of community teams; however, other factors, such as the distortion caused by the nature of the indicator, also had an effect.
(c) The work being undertaken on joining up community and inpatient services through the Purposeful and Productive Services Programme should provide greater understanding of the position.

He considered that there would be benefits in providing further details on the issues impacting on performance against the indicator at an appropriate time as, although the number of cases was low, the percentage and trajectory were concerning.

The Board also noted that a year on year comparison on the indicator might also be helpful so that the impact of the Trust operating with fewer beds could be understood.

In addition, clarity was sought on when the discussions at the recent meeting of the Clinical Leaders Board on outcome measures would be reported to the Board.

Mr. Martin agreed to provide Board Members with an update on this matter.

Action: Mr. Martin

19/14 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 3, 2018/19.

19/15 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.

19/16 DATE OF NEXT MEETING

It was noted that the next ordinary meeting of the Board of Directors was due to be held, in conjunction with a seminar, at 9.30 am on Tuesday 26th February 2019 in the Boardroom, West Park Hospital, Darlington.

19/17 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 terms proposed or to be proposed by or to the Trust in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.

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

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

Following the transaction of the confidential business the meeting concluded at 12.38 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

County Durham and Darlington

Levi Buckley
Director of Operations

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Locality Context

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- New senior leadership team
- Continued development of TAPs and Care Hubs – Durham and Darlington
- AMH/ LD integrated team review – managing TEWV/LA relationship
- IAPT and secondary care interface
- Developing MH&LD Partnership and NCM

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Recent Successes

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- **Core 24**
  - ✓ Accessible urgent and out of hours response increased
  - ✓ For Adults, Older People and Children
  - ✓ Plus Street Triage

- **Children's ASD service**
  - ✓ Extended service across two bases
- **Enhanced LD Community Infrastructure**
  - ✓ To support reduced inpatient bed numbers

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JM1

Our key challenges

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Demand and pace of workload
- Staffing – recruitment, retention and wellbeing
- AMH Community and Access Teams – capacity, burnout, leadership competencies and skills
- Medical recruitment – some positives!
- Managing impact of H&R bed closures
- Achieving Business Plan and CRES
- Compliance with Key Performance Indicators
- Pace of corporate 'enabling' work

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JM2

Our key challenges

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Safety for patients – SI thematic review (interface liaison/crisis/IP/Community), CQC Action Plan, Demand/Capacity issues, impact on level of acuity and risk behaviour in inpatients, Dual diagnosis, physical health
- Focus on patient experience, listening to patients and increasing areas of co-production eg CPA, formulation to treatment plans, peer support
- MDT composite in Inpatients to enable more recovery focussed Trauma informed care

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Opportunities

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Durham, Darlington and Teesside NHS Mental Health and Learning Disability Partnership (formerly ACP) – including case management work
- Crisis, Liaison and Urgent Care Reviews
- North East & North Cumbria STP – be a system leader e.g. what we can offer via PPS/QIS

  to multiagency pathways?
- Care Pathways e.g. Dementia Care
- New Models of Care - AED
- Estate Optimisation

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Our Key Priorities

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Staff Health and Wellbeing
- Innovative approaches to staffing and recruitment
  e.g. AC/RC roles, PWPs, Specialty Doctors, NMPs, ANPs
- Recovery – college and philosophy
- Peer Roles
- Crisis Concordat – Crisis Review
- Stakeholder Engagement -
  patient voice in Locality decision making
- 5YFV and 10 Year Plan, CYP Trailblazer, IPS bids, IC+

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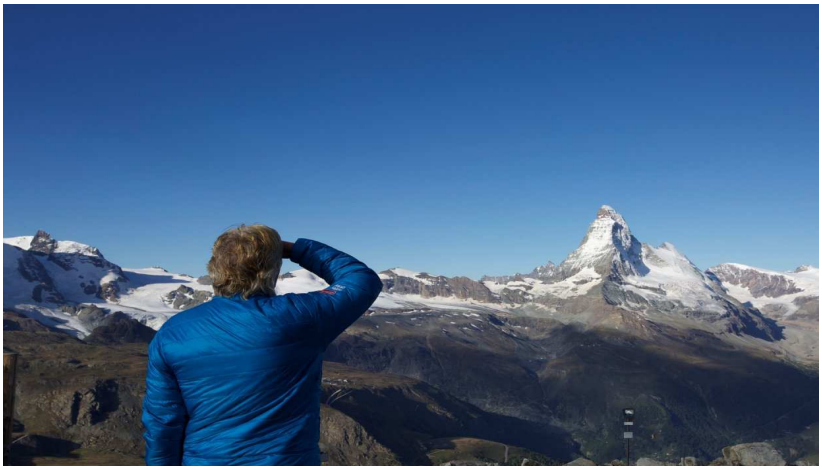
We have a plan……..

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust



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ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th February 2019**
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
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	Jul-19	
03/07/2018	18/185	Discussions to be held with the regional group on the provision of benchmarking information on serious incidents	EM	Feb-19	Completed
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	Mar-19	
19/07/2018	18/218	A further review of the Board's committee arrangements to be undertaken	PB	Mar-19	
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~~ Mar-19	
25/09/2018	18/242	Further consideration to be given to the application and operationalisation of NICE guidance in the forthcoming review of the Engagement and Observation Policy	EM	Apr-19	

	Minute No.	Action	Owner(s)	Timescale	Status
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	Mar-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	18/285	A report 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~~ Mar-19	
30/10/2018	18/289	Case studies on requests to change care records to be provided to the Board	EM	Mar-19	
27/11/2018	18/306	The Board to be updated on the outcome of the discussions between the Director of Therapies and the Chaplains in relation to holding an annual event/ceremony to remember people who have died in the Trust's services	CM	Feb-19	See private agenda item 4
27/11/2018	18/311	A progress report on the implementation of an early warning system for community teams to be presented to the Board	EM	Jun-19	
27/11/2018	18/311	A report to be presented to the Board on the outcome of the merger of the North Yorkshire and York and Selby Localities	RH	30/04/2019	
27/11/2018	18/312	A report to be provided to the Board on when high staffing fill rates of wards, due to levels of acuity, would be considered to be normal and the establishment changed to reflect the position	EM	Feb-19	See agenda item 7
27/11/2018	18/313	The MHL Department, in conjunction with the Patient Safety Team, to look into what has happened to individual patients who were discharged by a panel against the recommendation of the RC and clinical team	EM (on behalf of RS)	Feb-19	Completed (To be reported to the MHLC)

	Minute No.	Action	Owner(s)	Timescale	Status
29/01/2019	19/05	The metrics to support the zonal care pilot to be provided to Dr. Griffiths, personally, or presented to the QuAC	EM	-	Completed
29/01/2019	19/05	Clarity to be provided to the Council of Governors on the Trust's target for patient experience in response to discussions at a recent Governor Development Day	SP	Feb-19	Completed
29/01/2019	19/05	Clarity to be provided on the provision of training for staff on raising concerns at the next meeting of the Council of Governors	DL	Feb-19	Completed
29/01/2019	19/08	Further details on the staffing position in forensic services to be provided to the QuAC	RH	May-19	
29/01/2019	19/09	To ensure that information on the use of mechanical restraint is included in the next QuAC report to the Board	EM	Feb-19	See agenda item 6
29/01/2019	19/12	To note the approval of the Trust's Quarter 3, 2018/19 submission to NHS Improvement	PM	-	To note
29/01/2019	19/13	An update to be provided to Board Members on the discussions on outcome measures at the recent meeting of the Clinical Leaders Board	CM	-	See private agenda item 4

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO 6

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 26 February 2019**
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 07 February 2019

The Quality Assurance Committee has consistently reviewed all relevant Trust quality related processes, in line with the Committee's Terms of Reference.
Key matters considered by the Committee were:

- The top concerns for Durham and Darlington and Tees Services
- Compliance with CQC
- Patient Safety update
- Medicines management
- Safeguarding & Public Protection
- Infection, Prevention and Control
- Patient Experience update
- Quality Account Q3 Update

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 07 February 2019.
- Note the confirmed minutes of the formal meeting held on 06 December 2018 (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 26 February 2019**
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 07 February 2019.

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. 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 Tees Services.

ARE OURSERVICES WELL-LED?

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

4. The Committee received key assurance and exception reports from LMGBs.

4.1 DURHAM AND DARLINGTONSERVICES LMGB

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

The top areas of concern highlighted were:

- Patient acuity and high number of admissions leading to concerns around staff health and wellbeing and patient experience.
  Members discussed whether there was an accurate understanding of the levels of admissions/readmissions across the Wards and it was noted that a Trust wide piece of work was underway to look at this led by the Operational Management Team.
  It was also acknowledged that a contributing factor to patients not feeling safe on wards was linked to patient acuity; however it was clear that there was the need for a deeper understanding and the Committee sought further assurance from the Patient Experience Team around factors that contribute towards patients not feeling safe.
- Pressures in Access Service, where demand has increased to over 1,000 referrals per month. The cumulative impact of vacancies and sickness has left staff exhausted, staff

have left and there have been gaps in medical cover. The service is using the IAPT 'keep in touch' strategy to support patients in the interim. Human Resources are looking at staff redeployment.

- Mechanical Restraint - there has been no incidents of use of mechanical restraint in the Locality for this reporting period.
  Tear Proof Clothing – there were two recorded episodes of use of tear proof clothing for this reporting period. Both were in October 2018 on Cedar. There have been no episodes since.

- LMGB was assured from information provided by QuAGs that the resuscitation bags had been checked daily, in line with policy, on all wards except Birch and Maple where it was found that each had one daily check which had not been completed. LMGB have requested additional monitoring in these areas and an update will be provided within the next report.

4.2 TEES SERVICES LMGB

The Committee discussed the LMGB report for Tees Services.

The top areas of concern highlighted were:

- High bed occupancy within adult mental health and adult learning difficulties with a bed management group now in place who will be clarifying the use of leave beds.
- A paper identifying concerns around the overall planned bed reduction in MHSOP has been discussed at SDG where it is felt that there can be opportunities if there is the ability to address the extreme variation in the admission rates.
- The current inpatient medical staffing provision is a significant concern in MHSOP and two Trust grade doctors have been identified to increase the medical capacity.
- The lack of nursing home care provision, which is an ongoing well known position.
- Consultant Psychiatrist recruitment within children and young people's services.
- Issues in Tier 4 – where physical interventions have been undertaken at Westwood Unit not in line with Trust policy which has resulted in a significant number of staff currently suspended.

  Members sought further assurances around discussions with the children and parents at the Westwood Centre, which have been handled very well and parents have been supportive.

- Mechanical Restraint: 1 incident was reported in October in Adult Mental Health services.
- No reported use of tear proof clothing between October and December 2018.
- The LMGB report assured QuAC that resuscitation bags had been checked daily in line with policy on all inpatient wards

3. Compliance with CQC Requirements

The Board is asked to note that:

- Following the final CQC report the action plan is being worked through and discussion will take place on a monthly basis with the CQC at the routine engagement meetings.

- Phase 1 of a thematic review of the use of restraint, prolonged seclusion and segregation in settings for people with mental health problems was issued on 16 January 2019. The Trust will submit data for children and young people's wards and learning disability/autism services. Phase 2 will then look at Children's residential services that are jointly registered with CQC and Ofsted (Baysdale Unit).
- NHS Improvement issued a safety alert on the "Assessment of ligature points" regarding low level ligatures. Visits have taken place to all inpatient areas to review the current Suicide Prevention Environmental Survey and capture any newly identified low level ligature points (below 1 metre). These will then go to EMT for consideration of any works that may need to be undertaken.
- It was highlighted that the CQC Insight Report, an intelligence tool primarily for CQC operational staff to monitor potential changes to the quality of care, received bi-monthly has been linked mistakenly with Eastbourne CCG and this was being picked up with the CQC directly.
- An unannounced visit to Baysdale Unit has revealed a gap between the health focus of the service and the social care regulatory framework. The Director of Nursing is pursuing that the Unit only be registered with the CQC and not both Ofsted and CQC.
- The Holly Unit will now be de-registered with Ofsted and only regulated by the CQC due to its purpose and function being a health provision.

Assurance is provided 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?

4. Patient Safety

The Committee discussed the Patient Safety Group report.

The Board is asked to note the following:

- A letter was received from an Acute Trust regarding a Liaison Service not assessing patients in A&E when under the influence of drugs and alcohol. Further discussions will take place with the Acute Trust.
- Information regarding a new national Patient Safety Strategy has been circulated for comments and a Trust response will be submitted in February 2019.
- The National Reporting and Learning System (NRLS) have issued a report looking at improvements around reporting culture and reporting patterns. There is no evidence to suggest that the Trust is under reporting at this time.
- For the mortality review process there were 21 deaths for patients on CPA reported in December 2018 and causes of death for 18 are still awaited, the three where the cause of death as known have been reviewed.

There are no significant risks to escalate to the Board.

4.1 Drug and Therapeutics

The Committee discussed the update on medicines management.

The key matters for the Board to note are:

- A Pharmacy Implementation Board will oversee the three locality based dispensaries which will be located at West Park, Roseberry Park and York (initially at The Retreat, then to move to the new hospital at Haxby Road). Regular briefings will be given to LMGBs.
- Coded allergies will be implemented onto Paris and consideration is currently being given as to how to migrate un-coded allergies to coded allergies.
- The drugs Pregabalin and Gabapentin will be reclassified as schedule 3 controlled drugs from 1 April 2019, due to the potential for abusing these drugs, especially in prisons. There will be little impact on the Trust other than the need for them to be ordered and prescribed as controlled drugs.

There are no exceptions or concerns for the Board to be aware of.

4.2 Safeguarding and Public Protection

The Committee received the exception report for Safeguarding and Public Protection.

The key matters for the Board to note are:

- There are serious case reviews underway across the locality areas, all at varying stages and learning lessons from each of these will take place, where necessary for the Trust.
- The Committee discussed the NHS England review of the York homicide and a meeting that was attended by at Quarry House on 23 January 2019 to review the report and recommendations.

Assurance can be provided to the Board that the Trust is meeting its legal requirements for safeguarding adults and children within legislation and there are no exceptions to note.

4.3 Infection, Prevention and Control

The Committee discussed the Quarter 3 report from Infection, Prevention and Control.

The key issues for the Board to note are:

- There have been 2 outbreaks of infection between December 2018 and January 2019.
- One of impetigo within two Forensic LD wards at Roseberry Park, affecting seven patients and two staff which is very unusual within a hospital setting. . Some areas of learning around practice, hand hygiene and poor standards of cleanliness have been found and are being addressed as a result of this and will be monitored through LMGB.

- There was also an outbreak of flu amongst patients and staff on a MHSOP ward in Harrogate leading to sickness absence, with one patient requiring transfer to an acute hospital. The outbreak itself was well managed and all patients recovered. The importance of staff having the flu vaccination will be reinforced with this example of how serious influenza can be.

- A Trust wide mattress audit has revealed that 184 mattresses across inpatient areas breached standards. These are being replaced using non-recurring funding with 16 of the new mattresses to be anti-vandal mattresses.

ARE OUR SERVICES RESPONSIVE?

5. Patient Experience

The Committee discussed the Patient Experience Report covering information from November 2018 to January 2019.

The key updates for the Board to note are:

- The highest number of complaints that were made from January 2018 – December 2018 were around clinical care, 167, compared to 165 in the previous year.
- The total number of PALs raised which are categorised as 'other' was 555 in the period January 2018 to December 2018.
- In Quarter 3 there were 88 comments made by patients about "feeling unsafe" (73%), and only 20% feeling "safe".
- The Committee sought further assurance on the information presented in the report by some further narrative and analysis of the data for future reports and this was something that was currently being looked at by the Information Governance team.
- A service user was now part of the Patient Experience Group which was working very well.

ARE OUR SERVICES EFFECTIVE?

6. Quality Account 2018/19

The Committee received an update on progress in Quarter 3.

The key points for the Board to note are:

- Against the Quality Account, 41 out of 46 of the quality improvement actions are green, which represents 89%.
- The Quality Metrics are currently showing green on 3 out of 9 (33%) with red on 6 out of 9 metrics (66%).
- The key priority to develop a Trust wide approach to Dual Diagnosis (to ensure that people with substance misuse issues can access appropriate services) was on track.
- There were delays on progress with actions around improving the personalisation of care planning due to delays in producing the training package stalled to Quarter 4, however with eight full-day training sessions planned it is anticipated that an additional 200-300 people will be trained.
- Due to sickness absence there has been some slippage on completion of actions for improving the clinical effectiveness and patient experience at times of transition from CYP to AMH services.

7. Exception Reporting

The Director of Nursing and Governance raised an issue following a resuscitation of a patient in Forensic Services.

The Board is to note:

- A patient had been resuscitated in Forensic Services and on checking the clinical response bags and equipment there were a number of issues which suggested non-compliance.
- It was found that a number of the defibrillators were not on the medical devices register and therefore had not been checked.
- Immediate actions were taken to rectify matters and further spot checks of equipment will take place. It had been agreed by QuAC in November 2018 to step down the audits of clinical emergency response bags, with monthly reporting through to the Committee in the executive summary of LMGB reports, stating compliance and any exceptions.
- It was suggested to QuAC that weekly checks could replace daily checks, as well as spot checks and an update would be taken back into the Committee at its meeting to be held on 07 March 2019.

8. IMPLICATIONS

8.1 **Quality**

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

8.2 **Financial/value for money**

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

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

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

8.4 **Equality and Diversity**

There are no issues to note.

9. 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.

10. RECOMMENDATIONS

That the Board of Directors is asked to:

(i) Note the issues raised at the Quality Assurance Committee meeting on 07 February 2019.

(ii) Note the confirmed formal minutes of the meeting held on 06 December 2018.

Mrs E Moody
Director of Nursing and Governance
26 February 2019

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

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mr Colin Martin, Chief Executive
Mrs Shirley Richardson, Non-Executive Director
Mrs Ruth Hill, Chief Operating Officer
Mrs Jennifer Illingworth, Director of Quality Governance
Mr Richard Simpson, Non-Executive Director

In attendance:
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mrs Leanne McCrindle, Head of Quality Governance and Compliance (for minute 18/174)
Mrs Rachel Weddle, Head of Nursing, Forensic Services (for minute 18/164)
Dr Suresh Babu, Deputy Medical Director
Mr Chris Williams, Chief Pharmacist (for minute 18/167)
Mr David Levy, Director of Human Resources and Organisational Development (for minute 18/173)
Mrs Helen Cunningham, Health and Safety Manager (for minute 18/171)
Mr Tim Cate, Director of Operations, North Yorkshire (for minute 18/163)
Mrs Elspeth Devanney, Head of LD Services

18/160 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs Lesley Bessant, Chairman of the Trust Mrs Elizabeth Moody, Director of Nursing & Governance, Mrs Linda Parsons, Associate Director of Operational Services, Dr Ahmad Khouja, Medical Director and Mrs Karen Agar, Associate Director of Nursing and Governance.

18/161 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 01 November 2018 were accepted as a true recording of the discussions and signed by the Chairman.

18/162 ACTION LOG

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

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 considered under agenda item number 9 (minute 18/170).

18/118 Issues around mechanical restraint to be included in LMGB reports by exception. To leave on action log to ensure that all future reports make the assurance statement, including those that do not use mechanical restraint.

18/146 Lack of early warning system when teams are getting into difficulties to be raised to the Board at its meeting held on 27 November 2018, together with staffing related issues coming through serious incidents, relationship between caseloads, sickness levels and lack of escalation system in community teams.

Completed

18/150a Positive and Safe report – to check the accuracy of projection figure for this year for physical intervention.

Completed

18/152 Quality Account Q2: Discuss the narrative around the levels of restraint in CAMHS.

Completed

18/155 Discuss potential gaps in assurance linked to any future publication of national figures around restraint and any potential reputational damage for the Trust.

Completed

18/163 NORTH YORKSHIRE SERVICES LMGB REPORT

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

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

- Meeting the performance targets in MHSOP, which was linked to staffing challenges in key areas.
- Pressures with LD beds due to the lack of investment in local Community services in relation to enhanced models.
- The numbers of suicides in AMH.
  On this matter it was noted that the NY Suicide Prevention Group would provide an overview of the delivery of the NY Suicide Prevention Advisory Group strategic action plan to date. There were four priority areas of focus with 13 key outcomes and number of work streams had been set up which would go to the January 2019 report out to share information and to identify any lessons to be learned across the organisation.

Following discussion it was noted that:

(1) The locality was currently at around the same trajectory as last year with regards to compliance with the flu campaign and it would be difficult to reach the 75% target this year.
(2) It had been raised by the CQC that further assurance was required around mechanical restraint across the Trust. This had been previously discussed by QuAC members as action 18/118 refers.

Agreed: *That a statement would be included the Executive Summary of future LMGB reports around mechanical restraint. This would be cascaded once again to Directors of Operations across the localities.*

Action: Mrs J Illingworth

18/164 FORENSIC SERVICES LMGB REPORT

The Committee received and noted the Forensic Services LMGB Report.

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

- The use of tear proof clothing where further work was required around fully understanding and monitoring its use. Assurance was provided that this was underway.
- Transition from CAMHS secures services into Adult Forensic Service. Areas had been highlighted for development in order to enhance the patient experience and guidance was being developed to support young service users at the point of transition.

- Disclosure and barring service. A process had been developed for Ward Managers to monitor completion and outstanding DBS checks due to variation in the data received from the central team, which had been due to staffing issues and records not being updated.

Following discussion members sought further assurances around the following:

(1) The use of metal cuffs where it had been reported that there was one episode of use on 20 January 2017.
It was noted that this was in relation to a male patient who was on escorted leave to Carlisle and refused to return, despite efforts by staff.
(2) Restrictive practices, particularly around sanitary products and snacks on the Wards.
On these matters it was noted that there were sanitary bins provided in Ward areas however not in some en-suites. With regards to snacks there had been some challenges with snacks being left out in communal areas.
(3) Incidents of stained laundry on Lark Ward at Ridgeway. Eleven bags of laundry had been rejected and this was under discussion with the Facilities Site Manager.

The Head of Nursing for Forensic Services undertook to look into these areas and provide more information to Committee members.

Action: Mrs R Weddle

18/165 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee received and noted an update report on Compliance with CQC Registration Requirements.

The following matters were highlighted:

(1) Following the final CQC report published on 23 October 2018 the Trust was now underway to rectify the 16 'must do' actions identified that related to potential regulatory breaches of the Health and Social Care Act 2008 and which the Trust must act on to ensure compliance.
(2) There were 25 'should do' actions to address and whilst these were not breaches in legislation or regulation the Trust would consider them in equal measure.
(3) Assurance was provided that the Trust continued to maintain full registration with the CQC with no conditions.
(4) The Quality Compliance Group would consider the updated CQC action plan at each meeting to monitor completion of the improvements being made.

18/166 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Group Report and the Patient Safety Group Quality Report for 01 October to 30 September 2018.

The following matters were highlighted from the report:

- Work was underway to ensure that the Trust would meet the eight recommendations within the NQB guidance on working with bereaved families and carers. A family conference had been arranged for March 2019, which would launch this work and a guidance booklet for bereaved families had been drafted and was out for consultation.
- From January 2019 the Trust would no longer record feeds under restraint as a medication incident but as a behavioural incident as it was the act of restraint that would be recorded, as opposed to a true medication incident.
Members acknowledged that the change in reporting should improve the quality of the data.

In addition to the report it was considered whether the Patient Safety Group Report should be considered on a quarterly basis, rather than monthly.

Members of the Committee;
Agreed: *That the Patient Safety Group report would be brought back to the Quality Assurance Committee on a quarterly basis.*

Action: Ms D Oliver

Following discussion members requested:

(i) As part of the current review of the patient safety metrics to re-look at the rag rating for medication errors per occupied bed days at level three or above, which was currently rated as red. It was considered that this metric could also be reported as green since the Trust was encouraging medication errors to be reported.

(ii) Whether some benchmarking with other Trusts around nasogastric feeding could be undertaken.

Action: Mrs J Illingworth

The Patient Safety Group provided assurance that all safety activities had been reviewed in line with the Group's terms of reference and any issues to be addressed had been documented and were being progressed via appropriate leads and monitored by the Group.

18/167 DRUG AND THERAPEUTICS REPORT

The Committee discussed the update on medicines management.

The key matters highlighted from the report were:

(1) The recent press around the reclassifying of certain cannabis containing products to schedule 2 controlled drugs and enabling its use in the NHS.
On this matter it was noted that the way the indications were expected to be managed should not affect TEWV. NICE guidance was due out in October 2019. If a request was made to TEWV, which would be a rare circumstance then the Drug and Therapeutics panel would consider it together with the Medical Director according to National guidance.
(2) The Lloyds Pharmacy contract would expire in October 2019 and following EMT agreement a network of three internal dispensaries would be developed so that each locality will have one dispensary to supply all in-patient and community clinical supplies.

18/168 RE-AUDIT OF CLINICAL EMERGENCY RESPONSE BAGS

The Committee received and considered the re-audit of clinical emergency response bags.

The key matters highlighted were:

- Following the fourth audit of clinical emergency response bags there had been significant improvements made with regards to policy compliance.
- During the two week period that tests were made one daily bag check was missed being compliant in Derwentside Community Mental Health Team and at Ebor Ward, Peppermill Court.
- Ongoing monitoring arrangements on compliance would need to be set with appropriate reporting through to the Quality Assurance Committee.

Agreed: *That for continued assurance from the Directorates there should be a statement included in LMGB reports from each locality, on the current compliance statement to be reported to the Quality Assurance Committee.*

This would provide a positive statement on the cycle of checks made on all resuscitation bags, in line with policy and where there were any wards that had not made full checks additional monitoring would be put in place.

Mrs Illingworth undertook to email Directors of Operations to notify them of this process.

Action: Mrs J Illingworth/Directors of Operations

- There would also be an annual re-audit of the clinical emergency response bags to be reported to the Quality Assurance Committee, with the next one due in December 2019.

Action: Mrs E Moody/Ms D Oliver

18/169 ASSURANCE REPORT OF THE SAFEGUARDING & PUBLIC PROTECTION SUB-GROUP AND EXCEPTION REPORT FOR SAFEGUARDING AND PUBLIC PROTECTION

The Committee received and noted the two reports.

The key matters highlighted from the reports were:

- Additional Safeguarding Adult training would be required following the publication of the Intercollegiate Document for Safeguarding Adults/Prevent. This training for staff would need to be updated every three years instead of as a one off, as it was currently within Safeguarding Level 2 training.
- South Tees Local Authorities were working towards a joint Safeguarding Children's hub with a target date of April 2019 for this to be in place. Within North Yorkshire there was a Multi-Agency Safeguarding Team (MAST) arrangement where developments were taking place around starting to have input into mental health cases.
- There had been two joint Targeted Area Inspections in the last six months in Durham and York that the Trust had been involved in, which had required a significant amount of resource. An action plan had been developed following the inspection in Durham and the York multi-agency action plan was still awaited.

Following discussion it was noted that:

(1) There had been a decrease in the number of review safeguarding children supervision sessions being completed within timescales.
On this matter it was acknowledged that this could be due to a capacity issue within the team.

(2) The Children's referrals for Teesside had been reported as 21 for Quarter 1 and 35 for Quarter 2.
Members queried these figures which were high in comparison with other localities.
Mrs Illingworth undertook to take this back to the team to check the data for factual accuracy.

(3) In Quarter 1 a number of staff had been involved in disciplinary investigation which fell under the remit of safeguarding – there had been three concluded cases and none had been upheld.

Members requested a check on the accuracy around that information since the Head of Nursing for Forensics had been involved in panels where the outcome had been different.

Action: Mrs J Illingworth/Mrs K Agar

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.

18/170 PLACING AUTOMATED DEFIBRILATORS IN NON-PATIENT SETTINGS

The Committee discussed a report setting out initial options for placing automated defibrillators (AEDs) to non-inpatient areas/and or community teams.

Agreed: *That further work should be undertaken at EMT level to establish the final list of locations for the response bags and the associated costings, with a final proposal to be brought back to the Quality Assurance Committee in due course.*

18/171 HEALTH, SAFETY, SECURITY AND FIRE REPORT

The Committee received and noted the Health, Safety, Security and Fire Report.

The main issues highlighted were:

- During Q1 and Q2 there had been 42 out of 700 incidents of violence and aggression reported to the police. Whilst there had been a notable decrease from Q1 to Q2, members were interested to hear of any outcomes from those incidents reported to the Police that were investigated.
  More information would be sought on this matter for the next update to the Quality Assurance Committee at its meeting to be held on 06 June 2019 when the next six monthly report was due.

  Action: Mrs L Parsons

- Smoking related incidents were still an ongoing problem at Primrose Lodge, something that the report did not reflect and it was also something that had been picked up on a recent Directors visit.
  The Chief Executive undertook to discuss this further with the Director of Operations, in order to make some improvement.

18/172 RESEARCH GOVERNANCE REPORT

The Committee received and noted the Research Governance Report.

The key matters highlighted from the report were:

- There were now clear CQC specific standards for inspection on research, which had been welcomed as they focused on both governance and the well led element of how research would be embedded into clinical services across the organisation.
- The collaboration with TEWV and the University of York was progressing very well with recent success for a number of major research grants.
- Funding had been agreed to extend the University of York support for a 0.5WTE Research Development Manager and EMT would consider a business case in 2019 to identify resources from TEWV to support the partnership.

- Assurance was provided that the research and development activity in TEWV remains compliant with the UK policy framework for health and social care research.

Following discussion members welcomed the addition of the conclusion of research projects and acknowledged the

18/173 EQUALITY AND DIVERSITY REPORT

The Committee received and noted the assurance report from the Equality, Diversity and Human Rights Steering group.

The key areas highlighted were:

- The Equality, Diversity and Human Rights (EDHR) Steering Group had met in August 2018 and October 2018 and assurance was provided that all information had been reviewed in line with the Group's Terms of Reference and agreed KPIs. Any issues had been addressed and were being progressed by the appropriate leads.
- Reported incidents around discriminating behaviour had increased in the first six months of 2018/19, compared to the previous year and these were expected to continue to increase.
- A review had taken place of the Trust's first Disability Confident Action Plan, a government sponsored scheme and research undertaken by an MSc student from Durham University Business School had revealed that the Trust performed comparatively well with regard to supporting staff with disabilities, though there was room for improvement.
  Key issues included better communication with disabled staff about the sickness absence management procedure, more support from line management and making some buildings more accessible.
- The Trust Equality and Diversity team had been operating on reduced capacity for a number of months, due to a vacancy and long term sickness and this could potentially impact on the timeliness of completed actions in the future.

Following discussion it was noted that there would be a new Equality and Diversity strategy, together with a new scorecard by June 2019.

18/174 CLINICAL AUDIT AND EFFECTIVENESS REPORT

The Committee received and noted an update report on Clinical Audit and Effectiveness.

The key matters noted were:

(1) There were no issues with the completion of the clinical audit programmes for Quarter 2 and no risks were identified.
(2) AuditOne had recently undertaken a risk based audit on the Trust clinical audit processes, in accordance with the 2018/19 internal audit plan and substantial assurance was achieved.

18/175 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

The Director of Operations briefed the Committee regarding an ongoing investigation into some members of staff at Westwood where it was alleged that patients had been moved and handled inappropriately. Some staff had been suspended while investigations continued. The Board of Directors would be briefed on the situation at its meeting to be held on 18 December 2018.

18/176 ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD

There were no issues that required escalation to the Board.

18/177 ISSUES DISCUSSED THAT MIGHT IMPACT ON THE TRUST'S STRATEGIC OR KEY OPERATIONAL RISKS

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

18/178 QUALITY ASSURANCE COMMITTEE ASSURANCE TRACKER

The Committee received the updated Quality Assurance Committee Assurance Tracker.

18/179 COMMITTEE EVALUATION

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

18/180 ANY OTHER BUSINESS

There was no other business to discuss.

18/181 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 07 February 2019, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

The meeting concluded at 4.25pm

……..

Dr Hugh Griffiths
Chairman

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th February 2019**
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:	**26th February 2019**
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 January 2019 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

3.1 Staffing related to inpatient units have been coordinated during January, 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.

3.2 Wards at West Lane hospital have ensured safe staffing despite staff shortages through daily monitoring of staffing levels and utilising staff across the site, other sites and community. The number of missed breaks in these areas reflects the pressured circumstances under which they have been working to maintain staffing levels.

3.3 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
February 2019

Appendix 1

Safe Staffing Report – January 2019:

Safe Staffing
February Report usin

Safe Staffing – January 2019

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 January 2019:

- The number of rosters equated to 68 inpatient wards in January.
- The highest number of red fill rate indicators relate to Registered Nurses on day shifts. This equated to 19 in January 2019, a reduction of 1 when compared to December 2019.
- The top 3 inpatient areas where a low staffing fill rate has been reported are:
  - Westwood – 65.8% RN on Days; 80.8% RN on Nights; 70.3% HCA on Days; 94.7% HCA on Nights – the shortfall is in relation to staffing pressures. The shortfall is being covered on a daily basis utilising staff from within the unit, other units and the community team.
  - Cedar Ward (D&D) – 68.5% HCA on Nights and 73.1% HCA on Days – The shortfall is in relation to sickness, vacancies and training days.
  - The Evergreen Centre – 71.4% RN on Days; 141.1% HCA on Days – the shortfall is in relation to staffing pressures on the site and have been covered utilising HCA's where appropriate (supported by the data).
  - The Lodge and The Orchards (NY) have been discounted due to issues related to the rosters and transition to a third party organisation.
- There were 63 fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues.
- The top 3 inpatient areas where a high staffing fill rate has been reported are:
  - Holly Unit – 403% HCA on Nights; 373.2% HCA on Days; 261.8% RN on Nights and 254.5% RN on Days – the increase is due to being open 7 days per week due to enhanced observations as a result of the complexities of the children.
  - Westerdale South – 327.9% HCA on Nights and 177.6% 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.
  - Acomb Garth – 230.9% HCA on Nights; 134.7% HCA on Days; 79.5% RN on Days – additional staffing is due to patient acuity and enhanced observations
  - Further to the ongoing high usage of temporary staffing on Westerdale South and Acomb Garth, a paper was taken to EMT outlining a proposal for zonal observation including an increase to staffing establishments. Work is ongoing with the services to agree staffing levels which will be tested alongside a number of agreed practice changes. The remaining ward establishments will be picked up through the establishment reviews planned in over the forthcoming year.

Bank Usage:

- The bank usage across the trust equated to 15.7% in January, an increase of 2% when compared to December.
- There were no wards reporting 50% bank usage in January.
- There were 10 wards that reported greater than 25% bank usage.
- Northdale Centre reported the highest bank usage at 33.9% of the actual hours worked. Enhanced observations were the highest reason given for requesting bank (78 shifts) followed by vacancies (50 shifts).

Agency Usage:

- The agency usage across the trust equated to 7.4% in January, a reduction of 1.5% when compared to December.
- Cedar Ward (NY) reported the highest equating to approximately 57.2% of the total hours worked.

Produced: 13th February 2019

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.

Vacancies were cited as the highest reason for this (133 shifts). The ward is using regular agency where possible and a number of vacancies have now been recruited to.

- Those wards reporting 4% or more agency usage in November equated to 24 wards.

Retinue key highlights:

- Fulfilment levels increased by 8% to 87% in January.
- There were 1685 shifts requested in January compared to 2198 in December.
- Total demand increased by 132% in December and now sits at 77% since the contract started.
- Fulfilment for HCAs increased from 81% to 89% during January with 474 fewer shift requests being observed in January.
- A total of 260 shifts were filled with RN's. Total demand for RN's was lower in January by 39 shifts. RN fulfilment increased from 72% in December to 79% in January.
- Usage across Acomb Garth still remains high at 185 requests in January; however Cedar Ward (NY) was the highest user in January with 188 requests.
- Areas with lowest fulfilment included Cedar Ward, Northdale Centre and The Orchards (NY) – all below 50%.
- The total number of no shows reported for January decreased significantly from 29 to 12.
- Average monthly spend of £282k from October 2017 to January 2019; an increase of £1k on last month
- Overall spend now sits at £4.52m of which HCA attributes to 76% of overall spend
- The Right Staffing programme are undertaking a diagnostic exercise to target agency use and actions are already being taken to reduce usage.

Missed Breaks:

- There were 342 shifts in January where an unpaid break had not been taken. This is a reduction of 104 shifts when compared to December 2018.
- 280 shifts where breaks were not taken were attributable to day shifts and related mainly to Registered Nurses (164 shifts).
- 62 shifts where breaks were not taken were attributable to night shifts and related mainly to HCA's (40 shifts).
- A breakdown by locality is as follows:
  - Teesside = 224 shifts with no breaks (Newberry accounted for 100; Evergreen accounted for 54 and Westwood accounted for 42)
  - Forensics = 36 shifts with no breaks (Linnet and Thistle had the highest with 7 shifts each with no breaks)
  - Durham & Darlington = 35 shifts with no breaks (Tunstall ward had the highest with 9 shifts)
  - North Yorkshire = 29 shifts with no breaks (Cedar Ward NY had the highest with 11 shifts)
  - York & Selby = 18 shifts with no breaks (Oak Risk had the highest with 8 shifts)
- This information is being monitored daily as part of the operational services huddle process.

Incidents Raised Citing Staffing Levels:

- There were 20 incidents reported in January 2019 citing issues with staffing.
- Issues reported were as follows:
  - Staff and patient safety compromised
  - Unable to take required breaks
  - Patient needs not being met and being left vulnerable
  - Insufficient staff available leaving ward environment unsafe
  - Patients not receiving required nutrition as there are insufficient staff to support this.
  - Unable to carry out security checks.

Severity Rating:

- Using a severity rating scale to identify potential outliers, the top 5 is as follows:
  - The Lodge – 10 point awarded
  - Westwood Centre – 10 points awarded
  - Evergreen – 8 points awarded
  - Cedar Ward – 8 points awarded
  - Ward 15 – 8 points awarded
  - Willow Ward – 8 points awarded
- Using the YTD score (Jan 18 to Jan 19) the following appear in the top 5:
  - Evergreen – 102 points awarded
  - Cedar Ward (D&D) – 102 points awarded
  - Westerdale South – 98 points awarded
  - The Lodge – 94 points awarded
  - Ward 15 – 90 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.
- CHPPD overall rating for January is reporting at 12.06 (4.27 registered nurses, 7.51 unregistered nurses, 0.19 registered AHP and 0.09 unregistered AHP).

Key links to documents & guidelines:

Monthly and Daily Staffing Report –January 2019

NQB Guidance July 2016

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

- Using standard deviation (Jan 18 to Jan 19) the following appear as positive outliers:
  - Bankfields Court The Lodge – registered nurses
  - Westerdale South – unregistered nurses

Conclusion: The Trust continues to comply with the requirements of NHS England and the CQC in relation to the Hard Truths commitments

Key links to documents & guidelines:
Monthly and Daily Staffing Report –January 2019
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 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 26 February 2019**
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 3, 2018/19.
Following review of the MHL Committee and levels of assurance there were additional reports for discussion considered at the meeting, as part of the new Annual Schedule of reporting, highlighted below.

Key areas for consideration:

- Reports on Discharges from Detention, use of Section 136, **Section 23 (2) – Notification of Nearest Relative** and **Section 132 – Information to Detained Patients**.
- Seclusion Report
- **Section 15 MHA Medical and Administrative Scrutiny**
- Report on MCA and DoLS
- CQC report
- Honorarium for Associate Hospital Managers
- Report of the Independent Review of the Mental Health Act

Recommendations:

The Board of Directors is asked to:

(i) Receive and note the assurance report, following the MHLC meeting held on 24 January 2019 and to note the approved minutes of the MHLC meeting held on 18 October 2018. (Annex 1)

(ii) Note the recommendation to the Resources Committee to approve the increase in honorarium for Associate Hospital Managers.

Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 26 February 2019**
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 3, 2018-19; through consideration of the work of the Mental Health Legislation Committee at its meeting held on 24 January 2019.

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 18 October 2019 are attached as Annex 1.

The MHLC also met on 24 January 2019. 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 3 there was 144 Hospital Managers' review meetings with one patient discharged from section 3 and one patient discharged from a Community Treatment Order. The section 3 patient was discharged with the agreement of the clinical team and was later readmitted to another area of the Trust under Section 2.
- There were 142 First-tier Tribunals which resulted in 16 patients being discharged.
- There are no concerns to raise to the Board and assurance can be provided that the small proportion, (8%) of patients discharged by the MHT is below the national average.

3.2 Section 136

The Committee considered data and trends around s136.

- There were 181 uses of S136 across the Trust compared to 188 in the previous quarter with various fluctuations in localities - York 49, (29 in previous quarter), Northallerton 9 (19 in previous quarter) and Durham 13 (31 in previous quarter).

- There were 22 episodes that lasted 12 hours or more. None were extended.
  For those that were sectioned for longer than 12 hours there were examples of people that were intoxicated, asleep and some requiring other medical attention.
- The overall use of S136 across the Trust shows TEWV place of safety (PoS) being used as the optimum choice with police stations only being used once across the whole Trust area in the last quarter.
- There were 10 individuals aged between 14 and 17 held under section 136.

  Assurance is provided to the Board that given the pressure on beds and acuity across the Trust there has been the appropriate use of S136, with no exceptions.

3.3 **Section 23 (2) – Notification of discharge by nearest relative**

The Committee discussed this new report, which will provide assurance around the notifications by relatives to discharge.

- Since July 2018 Hospital Managers received five notifications of discharge by nearest relatives, four of which were barred by the Responsible Clinician (RC).
- The barred discharges were reviewed by Hospital Managers Review meetings and for two of them the decision was “not discharged”. The remaining two patients were discharged by their RC before the review date. One nearest relative made an application to the Tribunal and a date was set however it was withdrawn and the hearing was cancelled.

Assurance is provided to the Board that the numbers are low of notification to discharge by a nearest relative and there are no concerns to raise.

3.4 **Section 132**

The Committee discussed a new quarterly report - Section 132 – Information to detained patients.

The key matters for the Board to note are:

- The level of compliance around notifying patients of their rights whilst detained under the MH Act was good.
- In the last quarter the new escalation process was used 22 times, including four times to the MH Legislation team.
- Danby and Esk Wards required the escalation process more than once in the last quarter however the reasons for this were unclear.

  Members requested escalation of this non-compliance to Modern Matrons, the Operational Management Team and also for consideration by the Quality Compliance Group.

COMPLIANCE WITH KEY CODE OF PRACTICE REQUIREMENTS

3.5 **Seclusion**

The Committee discussed the seclusion report.

- In Q 3 there were 71 episodes of seclusion with multiple episodes for patients (82 in previous quarter). Of the 71episodes 58 had been over 12 hours, of which 47 had been over 24 hours.
- The longest completed seclusion for those in excess of 24 hours was 716 hours (29.8 days).
- There were 18 patients that had multiple seclusion episodes, with three patients having five episodes in the Quarter.
- Assurance was provided to the Committee around one exception where a patient was secluded in their bedroom for four hours and 20 minutes. This was following an assault on a staff members and the individual continued to display aggressive behaviour for several hours.

3.6 **Section 15 MHA 1983 (Rectification of applications and recommendations)**

The Committee discussed a new report around the occasions when administrative scrutiny leads to the identification of a fundamental flaw, which invalidates detention or when medical scrutiny leads to a failure of one or more medical recommendations, the processes that follow and the outcomes.

- From January to December 2018 there were 21 occasions where Section 15 could not be used to rectify flaws or insufficiencies. Of those, 10 had been fundamental flaws, for example unsigned applications, wrong statutory forms used and no patient name on forms.
- There were 11 instances where the medical scrutineer felt that there had been insufficient information to warrant detention on joint medical recommendations.
- From July 2018 a new process was agreed with the Medical Director and implemented, whereby medical recommendations can be re-scrutinised and this has resulted in three sections that would have been invalid being passed as sufficient by the second scrutineer.
- Members of the Committee acknowledged that this level of medical and administrative scrutiny was extremely important to prevent any potential distress to patients that could be detained and brought to hospital and then their detention found to be invalid.

  Assurance is provided to the Board that the systems in place to identify invalid detentions are effective and provide the MHL Committee with good level of assurance.

EFFECTIVE IMPLEMENTATION OF THE MCA AND DOLS

3.7 Mental Capacity Act and DoLS

The Committee discussed the quarterly update report on MCA and DoLs.

The key points to note are:

- The DoLS module on Paris continues to be updated and reviewed, however relies on ward areas informing the MHA office of any applications made - some wards at York were not adhering to this process.

The Committee was given assurance that this was being followed up to make improvements.

- A third champions training programme has been arranged for March 2019 following the success of the programmes in 2017/18.
- The Trust is compliant with the Mental Health Act and DoLS legislation, providing assurance to the Board.

KEY GOVERNANCE INFORMATION

4.0 CQC Report

The Committee discussed the CQC update report.

The key matters highlighted were:

- There were eight MHA inspections to Trust wards in Quarter 3 with key themes being around care plans, issues raised by the patients and problems with Section 17 leave forms.
- Engagement by the CQC would include attendance at the MHL Committee in July 2019, along with other Sub Committees to the Board.

4.1 Honorarium for Associate Hospital Managers

The Committee discussed the honorarium for Associate Hospital Managers.

- The key matter for the Board to note is the proposal set out increasing the payment from £25 per panel member to £30 and for the panel chair an increase from £30 to £40. This is in line with other partner Trusts and organisations.

- The Committee recommended that the Resources Committee approve the increase in the honorarium for Associate Hospital Managers at its meeting to be held on 12 March 2019.

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

5.0 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.

HOW THE COMMITTEE DEMONSTRATES AWARENESS OF EXTERNAL PUBLICATIONS

6.0 A report of the Independent review of the Mental Health Act was received. This report set out the key changes proposed to the Mental Health Act 1983 (MHA 1983) following the review chaired by Professor Simon Wessely as set out in the Final Report of the Independent Review of the Mental Health Act 1983 published in December 2018 entitled – *Modernising the Mental Health Act, Increasing choice, reducing compulsion.*

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 however themes from MHA inspections continue to reoccur and it is important that actions and progress against these are closely monitored.

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 18 October 2018.

(ii) Note the recommendation to the Resources Committee to approve the increase in honorarium for Associate Hospital Managers at its meeting to be held on 12 March 2019.

Richard Simpson
Chairman of the Committee
26 February 2019

Background Papers:
Annex 1 – Confirmed minutes of the 18 October 2018 MHL Committee Meeting

Annex 1

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 18 OCTOBER 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
Mr C Allison, Public Governor, Durham
Mrs R Hill, Chief Operating Officer

In Attendance:
Mrs D Oliver, Deputy Trust Secretary, (Corporate)
Miss M Wilkinson, Head of Mental Health Legislation
Mrs J Ramsey, Mental Health Team Manager
Mrs J Harrison, Expert by Experience Representative
Mrs R Down, MHL Advisor
Mrs L McCrindle, Head of Quality Governance and Compliance

Apologies: Apologies for absence were received from Mrs E Moody, Director of Nursing & Governance, Dr A Khouja, Medical Director and Mrs J Illingworth, Director of Quality Governance.

18/46 MINUTES OF LAST MEETING

Agreed – *That the minutes of the last meeting held on 12 July 2018 be approved as a correct record and signed by the Chairman, subject to the correction of Mrs J Ramsey being added to those present.*

18/47 ACTION LOG

The Committee noted the actions and following updates:

17/33 Benchmarking – talk to NTW about seclusions.
A response had been received from NTW following this action which had been outstanding from October 2017, confirming that benchmarking was not really possible due to the difference between the two Trusts in the approach to seclusion. Mrs R Hill agreed to raise this through the Chief Operating Network. The PIR information for NTW would also be considered and an update would be brought to the January 2019 meeting.

Action: Mrs R Hill/Mrs L McCrindle

18/19 Further discussion around why S 136 being used more in York and North Yorkshire, to be raised at next York Operational Group meeting.

It was noted that the meetings had been cancelled, however a series of work plans, together with the consultation around Harrogate would progress including the interface between the S 136 suite and this would be brought back to the January 2019 meeting for an update.

18/20 Separate out CQC feedback report and frame sections around high quality questions.
This would be deferred to January 2019.

18/34 Problems with AMPH finding second doctors.
It was noted that this was still an issue raised at Operational Group meetings and also a national issue. The impact on patient care means that the time for assessment can be lengthened, however assurance was provided that patients were not being detained illegally.

Following discussion on how any improvement could be made Mrs Hill undertook to raise the matter at the Operational Group meeting to check if there was any support that could be given.

Completed

18/38 Seclusion policy to be taken to October 2018 MHLC meeting.
This matter was covered under agenda number 5b, (minute 18/52 refers).

Completed

18/40 Annex A to be sent to Andrea Shotton for future notification around any revision of policies that MHLC might need to consider.

Completed

18/42 Conversation to take place about SOADs
This would be deferred to the January 2019 meeting, when the Medical Director would be present.

18/42a Section 62 information to be reported to MHLC in October 2018 and then annually.
This report would be deferred to January 2019.

18/48 DISCHARGES REPORT

The Committee considered and noted the MHA Discharges Report.

The following was highlighted from the report:

(1) In Quarter 2 there were 138 Hospital Managers' review meetings with one patient discharged from section 3. This had been against the recommendations of the clinical team. The individual was discharged and was not re-admitted.
(2) There were 135 first-tier Tribunals which resulted in 16 patients being discharged.

Following discussion it was noted that:

(i) There was no national average around discharges which the Trust could compare to as there was no national dataset.
(ii) It would be helpful to review and consider the summary of the Hospital Manager's decision in hearings where individuals were discharged against the clinical recommendation.

Mrs J Ramsey undertook to include this level of detail and the summaries in future Discharges Reports.

Action: Mrs J Ramsey

18/49 SECTION 136 REPORT

The Committee received and noted the Section 136 report.

The following was highlighted from the report:

- There had been 188 uses of s136 across the Trust compared to 189 in the previous quarter. Despite the little difference in the overall numbers there had been a sharp increase for Durham 31 (16 in the previous quarter) and a decrease for Harrogate 29 (41 in the previous quarter) and York 29 (40 in previous quarter).
- Of the 187 held in a TEWV place of safety, 40 individuals had been formally detained and 40 accepted informal admission. There were 68 individuals followed up in the community and 39 were returned to the community without follow up.
- There had been 22 episodes which had lasted 12 hours or more.
- From the previous report in July 2018 there had been a recording error which stated that an individual had been held on a section 136 for 24 hours and 46 minutes. This had been checked and had been found to be inaccurate.
- 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 three times across the whole Trust area in the last quarter.
- There were seven individuals under the age of 18 years of age held under section 136, aged between 16 and 17.

Following discussion members highlighted:

(1) Whether it would be possible to obtain information or data from the Planning Directorate on individuals detained under the Mental Health Act including their protected characteristics, which could be considered on an annual basis by the Mental Health Legislation Committee.

Miss Wilkinson undertook to discuss this further with Trust colleagues to check on the feasibility of obtaining the data.

Action: Miss M Wilkinson

(2) That the "key issues" section of the report be separated out to distinguish between information reported around individuals and the conclusions around S136.

Action: Mrs J Ramsey

18/50 ABSENT WITHOUT LEAVE REPORT

The Committee received and noted a new six monthly report on Absence without Leave.

The following key matters were noted:

(1) Examples of AWOLS, the details, number, type and outcome reported via Datix and/or to the MHL team during Quarters 1 and 2 for 2018/19.
(2) There had been 187 AWOL episodes during the two quarters with a spike in numbers up to 50 in July 2018.
(3) Assurance was provided that there had been 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.

18/51 SECLUSION REPORT

The Committee considered and noted the Seclusion Report.

The following was highlighted:

- 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.

Assurance was provided that there were no exceptions to note.

Following discussion members requested some further explanatory narrative around those individuals that were secluded for more than 12 hours and for more than 24 hours, together with a column showing the total number of hours in seclusion.
Mrs Ramsey undertook to provide this for the next report in January 2019.

Action: Mrs J Ramsey

18/52 SECLUSION AND SEGREGATION PROCEDURE

The Committee received the revised Seclusion and Segregation Procedure.

It was highlighted that the procedure had been updated, particularly around the process of moving patients from one area to another and around monitoring seclusion beyond 24 hours.

Assurance was provided that seclusion of individuals was monitored every 15 minutes.

The Committee approved the Seclusion and Segregation Procedure.

18/53 SECTION 5 (4) and 5(2) MHA 1983 (Holding Powers) Report

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.

Arising from the report it was noted that:

(1) This six monthly exception report would detail occasions where Section 5(4) and Section 5(2) had been allowed to lapse, or where the outcome was not usual or lawful.

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

18/54 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:

- In terms of DoLS activity, in Q2 there had been two applications in Middlesbrough in respite services and eight in Stockton, also for respite services.
- There had been 42 active cases across the Trust; however there were still delays with assessments being completed by Middlesbrough Council.

The Chairman of the Committee undertook to discuss this further with the Trust Chief Executive and there would be a further meeting with the DoLs lead for Middlesbrough.

Action: Mr R Simpson/Miss M Wilkinson

- An audit of Mental Capacity Act compliance would commence in November 2018 to examine individual case records to assess the quality of information recorded to determine if any improvements could be made, since the introduction of new documentation and mandatory training. An update would be brought back to the MHL Committee in January 2019.

Following discussion it was noted that the legislation around capacity had been updated and a report would be provided to the January 2019 MHLC meeting.

Action: Miss M Wilkinson

18/55 CQC REPORT

The Committee received and noted the CQC report.

Arising from the report it was noted that:

- There had been 16 MHA inspections in 2018/19 year to date and a review of key themes had been undertaken.
- Care planning, which had been raised seven times on seven wards had been taken over by issues raised by patients - raised 12 times on four different wards.
  On this matter it was noted that where issues had been raised a Provider Action Statement had been completed, approved by EMT and returned to the CQC to provide assurance that actions were being resolved.

18/56 How we might improve the diversity of our Associate Hospital Manager body through recruitment practices?

This matter had been raised as a question by a Trust Governor around the recruitment processes for Associate Hospital Managers and was considered by the members of the Committee.

Following discussion the following was noted:

(1) Committee members discussed the process of recruitment, which tended to be from the existing pool of Hospital Managers and whether any improvements could be made to the diversity of the Associate Hospital Managers.
(2) It was suggested that perhaps the Trust Equality and Diversity Lead could make inroads into the South Asian community in Teesside to seek any future potential interest.

Action: Mrs R Down

(3) There were currently no Associate Hospital Managers under a certain age and it was acknowledged that it was difficult for employed people to have the free time to be involved in this work. Members agreed that this could be pursued further with Mental Health first aiders and MIND.

18/57 CASE STUDY

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

18/58 TRUST'S STRATEGIC RISKS

There were no issues raised that might impact on the Trust's strategic risks.

18/59 ANY OTHER BUSINESS

There was no other business to discuss.

The meeting concluded at 4.10pm

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ITEM NO.9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th February 2019**
TITLE:	**Staff Flu Campaign 2018/19 – Flu vaccination opt-out and vaccination declination update & the Trust Flu campaign update in relation to achieving 100% staff vaccinations**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Information and Assurance**

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

Executive Summary:

The purpose of this report is to inform the Board of Directors about progress made with obtaining flu vaccination opt-out status and reasons for staff refusing the offer of a vaccination and to provide an update about the work being undertaken through the Trust's Flu campaign to strive for 100% of staff receiving a vaccination.
Overall performance has been just a little better than last year's flu campaign and variations between locality flu vaccination rates are apparent.
The forthcoming flu campaign review event will provide a good opportunity to identify potential improvements that can be implemented as part of the next flu campaign.

Recommendations:

To note the contents of the report and to comment accordingly

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**26th February 2019**
TITLE	**Staff Flu Campaign 2018/19**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board of Directors about progress made by the Trust to obtain Flu vaccination opt-out status and reasons for staff refusing the offer of a vaccination and to provide an update about work being undertaken through the Trust's Flu campaign to strive for 100% of staff receiving a vaccination. In December 2018 the Board of Directors previously endorsed the NHS Senior leader's ambition of 100% healthcare workers with direct patient contact receiving a flu vaccination.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Senior NHS leaders wrote to Chief Executives of NHS Trusts on 7th September 2018 (Appendix 1) to highlight the importance of healthcare workers protecting themselves, their patients, colleagues and their families by being vaccinated against seasonal flu, because the disease can have serious and even fatal consequences, especially for vulnerable patients.

2.2 The letter advised how organisations should plan to ensure every staff member is offered the vaccine which will enable NHS organisations to achieve the highest possible level of vaccine coverage this winter. The letter added that senior leader's ambitions were that 100% of healthcare workers with direct patient contact would be vaccinated. The letter also advised that this year Trusts are required to report how many healthcare workers with direct patient contact have been offered the vaccine and opted-out of having a vaccination. This information has been published monthly on the Public Health England website. The slightly adapted version of the explanatory opt-out letter to TEWV staff is attached as Appendix 2.

2.3 The achievement of a target flu vaccination uptake rate for frontline clinical staff also remains a CQUIN indicator (1c) with a value of up to £205,452 in 2018-19. The target rate for CQUIN payment to achieve maximum payment is 75% of frontline clinical staff being vaccinated by 28th February 2019.

3. KEY ISSUES:

Flu vaccination uptake rates

3.1 The Trust's final flu vaccination uptake rate for frontline healthcare workers in 2017/18 was 65.62% (3,519 staff), at that point the Trust's highest ever flu vaccination uptake rate. So far in 2018/18 65.97% (3,554 staff) of frontline healthcare workers in the Trust have had a flu vaccination. This is 0.35% more than last year's final vaccination total with three weeks of the campaign to go (although demand for the vaccination has been reducing as we progress

through February). This means that the 2018/19 Flu campaign has resulted in the highest number of Trust staff receiving a flu vaccination to date.

3.2 To date a total of 4,505 Trust staff have been vaccinated (representing 64.93% of all Trust staff). Vaccination rates vary significantly between localities with Durham and Darlington reporting the highest rate at 71.03% and North Yorkshire the lowest rate at 56.72%.

Numbers of staff formally opting out of a vaccination and the reasons given for doing so

3.3 Since November 2018 opt-out forms have been widely distributed across the Trust throughout all Localities via an initial email to managers and through reminders for staff when sharing ward-team based uptake reports with Heads of Nursing. The form has also been made available to staff on a regular basis within the Trust's weekly e-bulletin sent out to all staff electronically and has been available on the Flu pages of in Touch.

3.4 As at 15th February 2019 the 170 opt-out forms returned from across the Trust indicate the following reasons given by staff for refusing the offer of a vaccination (some staff gave more than one reason for not having a vaccination) the top reasons are highlighted in bold:

I am concerned about side-effects – 65
I don't believe the evidence – 61
I don't like needles – 34
I don't think I'll get Flu – 16
I just don't want it – 12
I am vegan – 10
Advice from my Consultant regarding other medication – 7
Freedom of choice – 6
I always get ill – 4
I have a known anaphylactic reaction to eggs- 4
I've never had any issues with my sickness – 1
Safety of vaccine – 1
Efficacy of vaccine – 1
Inconvenient times of vaccination – 1
I believe in my natural immune system – 1
Due to a severe previous reaction – 1
Family influence – 1
Religious beliefs – 1

127 reasons overall have been given when forms have been returned

3.5 The top reason for staff refusing the offer is concern about the side-effects of having a vaccination. Information to reassure staff about the potential side-effects of having a flu vaccination is contained on the Flu pages of the Trust's intranet and has been a regular feature of the Trust's Flu Communications campaign in 2018/19. The second highest reason for refusing a vaccination is

that staff do not believe the evidence from clinical experts which confirms the reasons why they consider staff should have a vaccination. Information relating to the clinical evidence as to the benefits and reasons for having a vaccination are contained in the Trust's Flu intranet pages. The third highest reason why some staff opted out of a vaccination is because they do not like needles. Where an opportunity has arises it may be possible to liaise with staff to discuss their worries about needles and on some occasions staff have been persuaded to have a vaccination.

3.6 The opt-out data has been reported to NHS England as part of the Trust's regular reporting of Flu uptake data.

Actions taken to deliver NHS senior leaders ambition for 100% frontline staff to have a flu vaccination in 2018/19

3.7 A Staff Flu Vaccination plan for 2018/19 was approved by EMT in June 2018 and is the basis for the continued implementation of the 2018/19 Flu campaign within the Trust

- The 2018/19 staff flu vaccination programme commenced on 1st October 2018.
- vaccinations have been administered since 1st October 2018 across the Trust by an Occupational Health nurse (working full time from 1st October 2018), undertaking a variety of clinics at various times of the day) and by around 80 Trust registered nurses and clinical pharmacists (known as 'Chief Flu Fighters') working across all Localities and Directorates in the Trust, offering vaccinations to their team members/colleagues when convenient to them. The figure of 80 active Chief Flu Fighters compares to the original number of 98 who were recruited and trained in time for the start of the flu campaign.
- The Occupational Health Nurse has attended some 120 established flu clinics and 16 drop in visits to various Trust sites across the Trust since the campaign started on 1st October 2018.
- Efforts to vaccinate staff have continued during the first two months of 2019, with vaccinations being planned to be offered to staff across the Trust until the end of February 2019.
- The Occupational Nurse has vaccinated around 1,600 staff and the Chief Flu Fighters have vaccinated around 2,690 staff between them. Approximately 250 vaccinations recorded have not been attributed to a Chief Flu Fighter nor to the Occupational Health Nurse as these were administered by GPs or other non-Trust vaccinators, such as Community Pharmacists or Acute Trust vaccinators.
- Opportunities to have a flu vaccination have also been offered at planned large scale Trust events throughout the flu campaign period, such as at the 2018 Nursing Conference, a number of Leadership & Management Network meetings (in October, November and February), Trust Induction, Board events and the Infection, Prevention & Control Champions day.
- An extensive and regular communication plan about the Trust's Flu campaign has also continued to be implemented to ensure that the campaign has a high profile since September 2018 until February.

3.8 A multi-disciplinary Flu group meets each month, chaired by David Levy, Director of HR/OD to plan and monitor progress of the Trust's Flu vaccination campaign. Any significant decisions or issues of concern are taken to the Executive Management Team (EMT) meeting for consideration.

3.9 A Staff Flu Compact was introduced at the beginning of this year's Staff Flu Vaccination to remind staff that the Trust expects them to take up the offer of a Flu Vaccination to ensure that they are protected from flu, as well protecting service users, carers, fellow colleagues, family and friends

4. IMPLICATIONS:

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

4.2 Financial/Value for Money: As previously agreed by EMT, the cost of vaccinations is expected to be up to £49,226 and the costs of incentives and additional Flu campaign resources are approximately £22,000

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

4.4 **Equality and Diversity:** None identified

5. RISKS: CQUIN funding of up to £205,452 is at risk should the target vaccination rate not be achieved.

6. CONCLUSIONS:

6.1 Steady progress has been made in the Trust during the 2018/19 Flu campaign though the hoped for and anticipated increase in the vaccination rate compared to 2017/18 has not materialised. For the third Flu campaign in a row there has been an increase in the number of frontline clinical staff receiving a vaccination, with 65.97% staff currently recorded as having a vaccination in 2018/19. The culture of TEWV staff being persuaded or wishing to have a flu vaccination voluntarily has positively shifted by over 25% since 2015 though clearly more remains to be done to increase numbers further.

6.2 **T**he number of frontline staff vaccinated in the Trust has still not reached the NHS England national CQUIN target uptake of 75% and the senior NHS leader's aim for 100% of frontline staff to have a vaccination. The Trust's 2019/20 Flu campaign will strive for as high an uptake of flu vaccinations as possible.

6.3 The NHS England vaccination opt-out process has confirmed that most staff who formally opt out of having a flu vaccination do so because they are worried about the side-effects of having a vaccination and because they do not believe the evidence from clinical experts relating to the benefits of having a vaccination. This is not surprising information Trust staff leading and managing the Trust's Flu campaign. Information to reassure staff about

such concerns has been provided to staff via the Flu teams in Touch pages, through the e-bulletin and directly via the Communication Team's sharing of information via Trust social media platforms. Focus on these areas will again take place during the 2019/20 campaign

6.4 As the 2018/19 Flu campaign comes to an end any learning/improvements identified will be noted and taken forward into the 2019/20 flu campaign planning and implementation. An evaluation event with Occupational Health, Chief Flu Fighters and Flu Group members will also take place on 28th March 2019. The Staff Flu operational plan will be adjusted accordingly in response to feedback about the 2018/19 staff flu campaign and good practice evidence from elsewhere.

7. RECOMMENDATIONS:

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

David Levy
Director of Human Resources and Organisational Development

Background Papers:

- **Appendix 1 – NHS England healthcare worker flu vaccination letter, opt out suggested letter and best practice management checklist, 7th September 2018**
- **Appendix 2 – TEWV letter and Opt-out form October and November 2018**

Appendix 1

NHS
Wellington House
133-155 Waterloo Road
London SE1 8UG
martin.wilson1@nhs.net

Friday 7 September 2018

To: Chief Executives of NHS Trusts and Foundation Trusts

Dear Colleague

Health care worker flu vaccination

We know you appreciate the importance of all healthcare workers protecting themselves, their patients, their colleagues and their families by being vaccinated against seasonal flu, because the disease can have serious and even fatal consequences, especially for vulnerable patients. Your leadership, supported by the Flu Fighter campaign and the CQUIN has increased take-up of the flu vaccine, with some organisations now vaccinating over 90% of staff. Our ambition is for 100% of healthcare workers with direct patient contact to be vaccinated.

In February, the medical directors of NHS England and NHS Improvement wrote to all Trusts to request that the quadrivalent (QIV) vaccine is made available to all healthcare workers for winter 2018-19 because it offers the broadest protection. This is one of a suite of interventions that can and should be taken to reduce the impact of flu on the NHS.

Today we are writing to ask you to tell us how you plan to ensure that every one of your staff is offered the vaccine and how your organisation will achieve the highest possible level of vaccine coverage this winter.

Healthcare workers with direct patient contact need to be vaccinated because:
a) Recent National Institute for Health and Care Excellence (NICE) guidelines[1] highlight a correlation between lower rates of staff vaccination and increased patient deaths;

b) Up to 50% of confirmed influenza infections are subclinical (i.e. asymptomatic). Unvaccinated, asymptomatic (but nevertheless infected) staff may pass on the virus to vulnerable patients and colleagues;

c) Flu-related staff sickness affects service delivery, impacting on patients and on other staff – recently published evidence suggests a 10% increase in vaccination may be associated with as much as a 10% fall in sickness absence;

d) Patients feel safer and are more likely to get vaccinated when they know NHS staff are vaccinated. In order to ensure your organisation is doing everything possible as an

employer to protect patients and staff from seasonal flu we ask that you complete the best practice management checklist for healthcare worker vaccination [appendix 1] and publish a self-assessment against these measures in your trust board papers before the end of 2018.
Where staff are offered the vaccine and decide on the balance of evidence and personal circumstance against having the vaccine, they should be asked to anonymously mark their reason for doing so by completing a form, and you should collate this information to contribute to the development of future vaccination programmes. We have provided an example form [appendix 2] which you may wish to tailor and use locally, though we suggest you use these opt out reasons to support national comparisons.

We specifically want to ensure greatest protection for those patients with specific immune-suppressed conditions, where the outcome of contracting flu may be most harmful. The evidence suggests that in these 'higher-risk' clinical environments more robust steps should be taken to limit the exposure of patients to unvaccinated staff and you should move as quickly as possible to 100% staff vaccination uptake. At a minimum these higher-risk departments include haematology, oncology, bone marrow transplant, neonatal intensive care and special care baby units. Additional areas may be identified locally where there are a high proportion of patients who may be vulnerable, and are receiving close one-to-one to clinical care.

In these higher-risk areas, staff should confirm to their clinical director / head of nursing / head of therapy whether or not they have been vaccinated. This information should be held locally so that trusts can take appropriate steps to maintain the overall safety of the service, including considering changing the deployment of staffing within clinical environments if that is compatible with maintaining the safe operation of the service.

We would strongly recommend working with your recognised professional organisations and trade unions to maximise uptake of the vaccine within your workforce; to identify and minimise any barriers; to discuss and agree which clinical environments and staff should be defined as 'higher-risk'; and to ensure that the anonymous information about reasons for declining the vaccine is managed with full regard for the dignity of the individuals concerned. Medical and nurse director colleagues will need to undertake an appropriate risk assessment and discuss with their staff and trade union representatives how best to respond to situations where clinical staff in designated high risk areas decline vaccination.

It is important that we can track trusts' overall progress towards the 100% ambition. Each trust shall continue to report uptake monthly during the vaccination season via 'ImmForm'. However from this year you are also required to report how many healthcare workers with direct patient contact have been offered the vaccine and opted-out. This information will be published monthly by Public Health England on its website.

By February 2019 we expect each trust to use its public board papers to locally report their performance on overall vaccination uptake rates and numbers of staff declining the vaccinations, to include details of rates within each of the areas you designate as 'higher-risk'. This report should also give details of the actions that you have undertaken to deliver the 100% ambition for coverage this winter. We shall collate this information nationally by asking trusts to give a breakdown of the number of staff opting out against each of the reasons listed in appendix 2.

You can find advice, guidance and campaign materials to support you to run a successful local flu campaign on the NHS Employers Flu Fighter website www.nhsemployers/flufighter

Finally we are pleased to confirm that NHS England is once again offering the vaccine to social care workers free of charge this year. Independent providers such as GPs, dental and optometry practices, and community pharmacists, should also offer vaccination to staff. There are two parallel letters to primary care and social care outlining these proposals in more detail.

Yours sincerely
- signed jointly by the following national clinical and staff side professional leaders -
Prof Stephen Powis ..... National Medical Director, NHS England
..... and on behalf of National Escalation Pressures Panel
Prof Paul Cosford .. Medical Director & Director of Health Protection, Public Health England
Prof Jane Cummings ..... Chief Nursing Officer, NHS England
Sara Gorton (Unison)..... Co-chair, National Social Partnership Forum
Prof Dame Sue Hill ..... Chief Scientific Officer, NHS England
Dame Donna Kinnair. Acting Chief Executive & General Secretary, Royal College of Nursing
Prof Carrie MacEwen ..... Chair of the Academy of Medical Royal Colleges
Ruth May ..... Executive Director of Nursing, NHS Improvement
Dr Kathy Mclean ..... Executive Medical Director NHS Improvement
Danny Mortimer (NHS Employers) ..... Co-chair, National Social Partnership Forum
Pauline Philip ..... National Director of Urgent and Emergency Care
Suzanne Rastrick ..... Chief Allied Health Professions Officer, NHS England
Keith Ridge ..... Chief Pharmaceutical Officer, NHS England
John Stevens ..... Chairman, Academy for Healthcare Science
Gill Walton ..... Chief Executive, Royal College of Midwives

Appendix 2

TEWV Flu opt-out form – to complete

Please tick to confirm that you have chosen not to have the vaccine this year:

☐☐I know that I could get flu and have only mild symptoms or none at all; and that because of this I could give flu to a patient and/or another person, such as a colleague or person I know. I know that vaccination is likely to reduce the chances of me getting flu and of me passing it to a patient or another person. But I still don't want the vaccine.

Please tick each of the boxes below that apply to your decision not to have the jab.

I DON'T WANT TO BE FLU VACCINATED BECAUSE:
☐ I don't believe the evidence that being vaccinated is beneficial
☐ I'm concerned about possible side effects
☐ I don't know how or where to get vaccinated
☐ It was too inconvenient to get to a place where I could get the vaccination
☐ The times when the vaccination is available are not convenient
☐ I don't like needles
☐ I don't think I'll get flu
☐ I have a known anaphylactic reaction to eggs
☐ I am vegan
☐ Other reason – please tell us here:

Please return this form via e-mail to russell.smith2@nhs.net OR in the internal post to
Russell Smith
CQUIN Project Manager
Health & Wellbeing Team
HR/OD
Flatts Lane Centre
Normanby

– PLEASE BE ASSURED THAT ANY FORMS RETURNED VIA EMAIL WILL BE TREATED ANONYMOUSLY AND NO DETAILS OF STAFF ORIGIN WILL BE KEPT AS PART OF THE DATA COLLECTION

Thank you for completing this form.

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM No. 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday 26 February 2019**
TITLE:	**To receive and note the action plan arising from the CQC's inspection of the Trust in June/July 2018**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Information**

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

Executive Summary:

CQC Action Plan

- The CQC have agreed this plan and are monitoring progress of actions on a monthly basis as part of our regular engagement.
- The action plan is a standard agenda item at the Quality Compliance Group to ensure governance and consistent sharing across all localities and services.
- The Compliance Team are tracking and monitoring actions with operational services. All evidence is being requested to be held centrally which includes a review to ensure it meets the requirements of the relevant action.
- A position paper outlining progress against all actions and any emerging issues will be brought to OMT/ EMT early in March 2019.

Recommendations:

The Board of Directors is requested to note the content of this report.

Jennifer Illingworth
Director of Quality Governance
February 2019

TEWV CQC 2018 Action Plan

KEY
Action complete
Action complete - Evidence Required
Action in progress
Action over timescale
Information / Date Required

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

Action Ref	Must Do / Shoul	Service	Locality	Inpatient / Community	CQC Issue Identified	Action	Action Owner	Operational Action owner	Action scheduled for completion	Evidence
1	Must Do	AMH	N York	Inpatient	The Trust must ensure that each ward has a ligature risk assessment that identifies all ligature points on the ward. The strategies identified to reduce these risks must be specific to individual wards and reflect current working practice.	The Trust has in place an existing system for suicide prevention environmental surveys and risk assessments. Completed assessments and action plans are in the process of being reviewed to ensure they are accurate and current for relevant clinical teams.	Modern Matron Nicky Scott	Heads of Service AMH	31/01/2019	Received: Completed ligature risk assessment surveys Health&Safety in receipt of updated surveys Surveys on display in ward office Evidence required: QuAG minutes
1	Must Do	AMH	York & Selby	Inpatient	The Trust must ensure that each ward has a ligature risk assessment that identifies all ligature points on the ward. The strategies identified to reduce these risks must be specific to individual wards and reflect current working practice.	The Trust has in place an existing system for suicide prevention environmental surveys and risk assessments. Completed assessments and action plans are in the process of being reviewed to ensure they are accurate and current for relevant clinical teams.	Modern Matron	Heads of Service AMH	31/01/2019	Received: Completed ligature risk assessment surveys Health&Safety in receipt of updated surveys Surveys on display in ward office Evidence required: QuAG minutes
1	Must Do	AMH	D & D	Inpatient	The Trust must ensure that each ward has a ligature risk assessment that identifies all ligature points on the ward. The strategies identified to reduce these risks must be specific to individual wards and reflect current working practice.	The Trust has in place an existing system for suicide prevention environmental surveys and risk assessments. Completed assessments and action plans are in the process of being reviewed to ensure they are accurate and current for relevant clinical teams.	Modern Matron	Heads of Service AMH	31/01/2019	Received: Completed ligature risk assessment surveys Health&Safety in receipt of updated surveys Surveys on display in ward office Evidence required: QuAG minutes
2	Must Do	AMH	N York	Inpatient	The Trust must ensure that patients have a risk management plan that addresses the risks identified in the assessments and is person centred. Risk assessments should identify all the risks posed to, or by, the patient	Monthly checks of risk assessment plans will continue to be undertaken within the service with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate. This will ensure that risk assessment plans address risks identified in the assessments and are person centred.	Modern Matron	Heads of Service AMH	31/03/2019	Evidence required: QuAG minutes
2	Must Do	AMH	York & Selby	Inpatient	The Trust must ensure that patients have a risk management plan that addresses the risks identified in the assessments and is person centred. Risk assessments should identify all the risks posed to, or by, the patient	Monthly checks of risk assessment plans will continue to be undertaken within the service with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate. This will ensure that risk assessment plans address risks identified in the assessments and are person centred.	Modern Matron	Heads of Service AMH	31/03/2019	Evidence required: QuAG minutes and MM audits
2	Must Do	AMH	D & D	Inpatient	The Trust must ensure that patients have a risk management plan that addresses the risks identified in the assessments and is person centred. Risk assessments should identify all the risks posed to, or by, the patient	Monthly checks of risk assessment plans will continue to be undertaken within the service with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate. This will ensure that risk assessment plans address risks identified in the assessments and are person centred.	Modern Matron	Heads of Service AMH	31/03/2019	Evidence required:QUAG minutes
2	Must Do	AMH	Tees	Inpatient	The Trust must ensure that patients have a risk management plan that addresses the risks identified in the assessments and is person centred. Risk assessments should identify all the risks posed to, or by, the patient	Monthly checks of risk assessment plans will continue to be undertaken within the service with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate. This will ensure that risk assessment plans address risks identified in the assessments and are person centred.	Modern Matron	Heads of Service AMH	Action complete	Evidence received: Care plan audit – covers intervention plans. Also includes review of risks, blue bag etc Additional evidence required: QuAG minutes (completed audits submitted to QuAG)

3	Must Do	AMH	N York	Inpatient	The Trust must ensure that staff monitor and record physical observations following the administration of rapid tranquilisation in line with Trust policy and national guidance.	Bi- monthly checks of the monitoring and recording of physical observations (post rapid tranquilisation) will continue to be undertaken with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Modern Matrons	Heads of Service AMH	31/03/2019	Evidence required: Completed audit submitted to QuAG (minutes)
3	Must Do	AMH	York & Selby	Inpatient	The Trust must ensure that staff monitor and record physical observations following the administration of rapid tranquilisation in line with Trust policy and national guidance.	Bi- monthly checks of the monitoring and recording of physical observations (post rapid tranquilisation) will continue to be undertaken with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Modern Matrons	Heads of Service AMH	31/03/2019	Evidence required: QuAG minutes
3	Must Do	AMH	D & D	Inpatient	The Trust must ensure that staff monitor and record physical observations following the administration of rapid tranquilisation in line with Trust policy and national guidance.	Bi- monthly checks of the monitoring and recording of physical observations (post rapid tranquilisation) will continue to be undertaken with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Modern Matrons	Heads of Service AMH	31/03/2019	Evidence required:QUAG minutes
3	Must Do	AMH	Tees	Inpatient	The Trust must ensure that staff monitor and record physical observations following the administration of rapid tranquilisation in line with Trust policy and national guidance.	Bi- monthly checks of the monitoring and recording of physical observations (post rapid tranquilisation) will continue to be undertaken with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Modern Matrons	Heads of Service AMH	Action complete	Meds optimisation assessment Sept 18 - audit not showing post monitoring compliance (Stockdale) Sample received Jan x2 Bedale Nov Bransdale Dec Bilsdale Dec Overdale Dec Stockdale Required: ?Completed audit submitted to QuAG.
4	Must Do	AMH	D & D	Inpatient	The Trust must ensure that the recording of any episodes of seclusion is in line with Trust policy and complies with the Mental Health Act code of practice.	Monthly checks will be completed for each episode of seclusion in adult mental health inpatient services. This will ensure that the recording of any episodes of seclusion is in line with Trust policy and complies with the Mental Health Act code of practice. The results will be shared at the AMH Locality Quality Assurance Groups. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Modern Matron	Heads of Service AMH	Mar-19	Evidence required:QUAG minutes
4	Must Do	AMH	Tees	Inpatient	The Trust must ensure that the recording of any episodes of seclusion is in line with Trust policy and complies with the Mental Health Act code of practice.	Monthly checks will be completed for each episode of seclusion in adult mental health inpatient services. This will ensure that the recording of any episodes of seclusion is in line with Trust policy and complies with the Mental Health Act code of practice. The results will be shared at the AMH Locality Quality Assurance Groups. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Modern Matron	Heads of Service AMH	Action complete	Evidence received: Restrictive practice report (all wards). This includes an audit of compliance to seclusion reviews (in line with The Code). Also the blanket restrictions register.
5	Must Do	AMH	N York	Inpatient	The Trust must ensure that the wards meet their agreed staffing establishment levels, including registered nurses.	Through proactive recruitment and retention programmes the Trust intends to ensure that all vacant posts are recruited to (whilst acknowledging that recruitment to some disciplines is a national issue). This will include targeted recruitment events and using new approaches to improve the efficiency of recruitment processes. Agreed safe staffing levels will be adhered to.	Ward Managers with support from Modern Matron	Heads of Service AMH	31/03/2019	Health Roster Evidence required: safe staffing monthly submissions
5	Must Do	AMH	York & Selby	Inpatient	The Trust must ensure that the wards meet their agreed staffing establishment levels, including registered nurses.	Through proactive recruitment and retention programmes the Trust intends to ensure that all vacant posts are recruited to (whilst acknowledging that recruitment to some disciplines is a national issue). This will include targeted recruitment events and using new approaches to improve the efficiency of recruitment processes. Agreed safe staffing levels will be adhered to.	Ward Managers with support from Modern Matron	Heads of Service AMH	31/03/2019	Health Roster Evidence required: safe staffing monthly submissions

5	Must Do	AMH	Tees	Inpatient	The Trust must ensure that the wards meet their agreed staffing establishment levels, including registered nurses.	Through proactive recruitment and retention programmes the Trust intends to ensure that all vacant posts are recruited to (whilst acknowledging that recruitment to some disciplines is a national issue). This will include targeted recruitment events and using new approaches to improve the efficiency of recruitment processes. Agreed safe staffing levels will be adhered to.	Ward Managers with support from Modern Matron	Heads of Service AMH	Action complete	Health Roster Evidence required: safe staffing monthly submissions
6	Must Do	AMH	N York	Inpatient	The Trust must ensure care plans are personalised, holistic, recovery-oriented and meet the needs identified during the assessment. Care plans should reflect the thoughts and views of the patient and evidence of patient involvement should be recorded on the electronic record keeping system.	Adult mental health inpatient services undertake baseline clinical review of care plans in Adult Mental Health inpatient services.	Modern Matron	Heads of Service AMH	31/03/2019	Evidence Required: QuAG minutes showing consideration of baseline audit findings.
6	Must Do	AMH	York & Selby	Inpatient	The Trust must ensure care plans are personalised, holistic, recovery-oriented and meet the needs identified during the assessment. Care plans should reflect the thoughts and views of the patient and evidence of patient involvement should be recorded on the electronic record keeping system.	Adult mental health inpatient services undertake baseline clinical review of care plans in Adult Mental Health inpatient services.	Modern Matron	Heads of Service AMH	31/03/2019	Evidence Required: Sample of weekly audits QuAG minutes showing consideration of baseline audit findings.
6	Must Do	AMH	D & D	Inpatient	The Trust must ensure care plans are personalised, holistic, recovery-oriented and meet the needs identified during the assessment. Care plans should reflect the thoughts and views of the patient and evidence of patient involvement should be recorded on the electronic record keeping system.	Adult mental health inpatient services undertake baseline clinical review of care plans in Adult Mental Health inpatient services.	Modern Matron	Heads of Service AMH	31/03/2019	Evidence Required: Completed Audit & action plans QuAG minutes
7.1	Must Do	AMH	N York	Inpatient	The Trust must ensure that quality assurance systems identify inconsistencies in the quality of care across the core service and implement plans to address these inconsistencies.	Inconsistencies in the quality of clinical care will be discussed and actioned operationally in the first instance by relevant locality management groups. Clinical audits will continue to be used both strategically and operationally to identify and action issues. Established clinical audit programmes and processes will be used to support required quality improvements.	Head of Service	Heads of Service AMH	31/03/2019	Evidence required: QuAG and LMGB minutes Audit report showing compliance
7.1	Must Do	AMH	York & Selby	Inpatient	The Trust must ensure that quality assurance systems identify inconsistencies in the quality of care across the core service and implement plans to address these inconsistencies.	Inconsistencies in the quality of clinical care will be discussed and actioned operationally in the first instance by relevant locality management groups. Clinical audits will continue to be used both strategically and operationally to identify and action issues. Established clinical audit programmes and processes will be used to support required quality improvements.	Clinical Director/ Head of Service	Heads of Service AMH	31/03/2019	Evidence required: QuAG and LMGB minutes
7.1	Must Do	AMH	D & D	Inpatient	The Trust must ensure that quality assurance systems identify inconsistencies in the quality of care across the core service and implement plans to address these inconsistencies.	Inconsistencies in the quality of clinical care will be discussed and actioned operationally in the first instance by relevant locality management groups. Clinical audits will continue to be used both strategically and operationally to identify and action issues. Established clinical audit programmes and processes will be used to support required quality improvements.	Head of Service	Heads of Service AMH	31/03/2019	Evidence required: QuAG and LMGB minutes
7.1	Must Do	AMH	Tees	Inpatient	The Trust must ensure that quality assurance systems identify inconsistencies in the quality of care across the core service and implement plans to address these inconsistencies.	Inconsistencies in the quality of clinical care will be discussed and actioned operationally in the first instance by relevant locality management groups. Clinical audits will continue to be used both strategically and operationally to identify and action issues. Established clinical audit programmes and processes will be used to support required quality improvements.	Head of Service	Heads of Service AMH	31/03/2019	Evidence required: QuAG and LMGB minutes

7.2	Must Do	AMH	Tees	Inpatient	The Trust must ensure that local clinical checks identify issues and staff should act on the results when needed.	Escalation of inconsistencies will continue to occur via Trust governance forums including the Patient Safety Group, Clinical Effectiveness Group and Patient Experience Group and onwards, where appropriate, to the trust wide Quality Assurance Committee.	Modern Matron	Heads of Service AMH	31/05/2019	Completed audit for each ward will be submitted to QuAG
7.2	Must Do	AMH	N York	Inpatient	The Trust must ensure that local clinical checks identify issues and staff should act on the results when needed.	Escalation of inconsistencies will continue to occur via Trust governance forums including the Patient Safety Group, Clinical Effectiveness Group and Patient Experience Group and onwards, where appropriate, to the trust wide Quality Assurance Committee.	Modern Matron	Heads of Service AMH	31/05/2019	QuAG minutes
7.2	Must Do	AMH	York & Selby	Inpatient	The Trust must ensure that local clinical checks identify issues and staff should act on the results when needed.	Escalation of inconsistencies will continue to occur via Trust governance forums including the Patient Safety Group, Clinical Effectiveness Group and Patient Experience Group and onwards, where appropriate, to the trust wide Quality Assurance Committee.	Modern Matron	Heads of Service AMH	31/05/2019	Evidence required: QuAG minutes
7.2	Must Do	AMH	D & D	Inpatient	The Trust must ensure that local clinical checks identify issues and staff should act on the results when needed.	Escalation of inconsistencies will continue to occur via Trust governance forums including the Patient Safety Group, Clinical Effectiveness Group and Patient Experience Group and onwards, where appropriate, to the trust wide Quality Assurance Committee.	Modern Matron	Heads of Service AMH	31/05/2019	Evidence required:QUAG minutes
8	Must Do	AMH	N York	Inpatient	The Trust must ensure staff can identify blanket restrictions and that there is a clear process for reviewing blanket restrictions on all wards.	The Trust has an existing policy with existing processes in place to identify and review blanket restrictions. These will be further enhanced through development of standardised blanket restriction registers which will be reviewed by Locality Quality Assurance Groups. Blanket restrictions will be a standard item on the Trust led mock visit programme.	Modern Matron	Heads of Service AMH	31/03/2019	Restrictive practice register and monthly report to QuAG
8	Must Do	AMH	D & D	Inpatient	The Trust must ensure staff can identify blanket restrictions and that there is a clear process for reviewing blanket restrictions on all wards.	The Trust has an existing policy with existing processes in place to identify and review blanket restrictions. These will be further enhanced through development of standardised blanket restriction registers which will be reviewed by Locality Quality Assurance Groups. Blanket restrictions will be a standard item on the Trust led mock visit programme.	Modern Matron	Heads of Service AMH	Jan-19	Evidence Required: Restrictive practice register and monthly report to QuAG
8	Must Do	AMH	Tees	Inpatient	The Trust must ensure staff can identify blanket restrictions and that there is a clear process for reviewing blanket restrictions on all wards.	The Trust has an existing policy with existing processes in place to identify and review blanket restrictions. These will be further enhanced through development of standardised blanket restriction registers which will be reviewed by Locality Quality Assurance Groups. Blanket restrictions will be a standard item on the Trust led mock visit programme.	Modern Matron	Heads of Service AMH	Action complete	Evidence received: Restrictive practice register and monthly report to QuAG
9	Should Do	AMH	N York	Inpatient	The Trust should ensure that all equipment in the emergency bags is in date and ready to use in an emergency. Staff should check the emergency bags daily and record that they have done so.	Daily grab bag checks that are undertaken are to be audited weekly.	Modern Matron	Heads of Service AMH	31/03/2019	Peppermill Court Steering Group and Governance meeting minutes
9	Should Do	AMH	York & Selby	Inpatient	The Trust should ensure that all equipment in the emergency bags is in date and ready to use in an emergency. Staff should check the emergency bags daily and record that they have done so.	Daily grab bag checks that are undertaken are to be audited weekly.	Modern Matron	Heads of Service AMH	31/03/2019	Evidence Required: Peppermill Court Steering Group and Governance meeting minutes Sample of MM checks
9	Should Do	AMH	D & D	Inpatient	The Trust should ensure that all equipment in the emergency bags is in date and ready to use in an emergency. Staff should check the emergency bags daily and record that they have done so.	Daily grab bag checks that are undertaken are to be audited weekly.	Modern Matron	Heads of Service AMH	31/03/2019	Evidence Required: Weekly audits Picture of weekly huddle VCB

9	Should Do	AMH	Tees	Inpatient	The Trust should ensure that all equipment in the emergency bags is in date and ready to use in an emergency. Staff should check the emergency bags daily and record that they have done so.	Daily grab bag checks that are undertaken are to be audited weekly.	Modern Matron	Heads of Service AMH	31/03/2019	Evidence received: monitoring of daily blue bag checks - shows compliance
10	Should Do	AMH	N York	Inpatient	The Trust should ensure that agency staff not having access to electronic care records does not impact on care provision.	Regular agency staff on block bookings are trained in using PARIS	Modern Matron	Heads of Service AMH	31/05/2019	Training records
11	Should Do	AMH	N York	Inpatient	The Trust should ensure than when patients are prescribed more than one medicine to help with extreme episodes of agitation and anxiety, staff have clear guidance as to how these are to be used.	Trust process and guidelines to be developed.	Medical Director and Chief Pharmacist	Heads of Service AMH	31/03/2019	Process and guidelines
11	Should Do	AMH	York & Selby	Inpatient	The Trust should ensure than when patients are prescribed more than one medicine to help with extreme episodes of agitation and anxiety, staff have clear guidance as to how these are to be used.	Trust process and guidelines to be developed.	Medical Director and Chief Pharmacist	Heads of Service AMH	31/03/2019	Evidence Required: Developed process and guidelines
11	Should Do	AMH	D & D	Inpatient	The Trust should ensure than when patients are prescribed more than one medicine to help with extreme episodes of agitation and anxiety, staff have clear guidance as to how these are to be used.	Trust process and guidelines to be developed.	Medical Director and Chief Pharmacist	Heads of Service AMH	31/03/2019	Evidence Required: Process and guidelines
11	Should Do	AMH	Tees	Inpatient	The Trust should ensure than when patients are prescribed more than one medicine to help with extreme episodes of agitation and anxiety, staff have clear guidance as to how these are to be used.	Trust process and guidelines to be developed.	Medical Director and Chief Pharmacist	Heads of Service AMH	31/03/2019	Process and guidelines in place
12	Should Do	AMH	N York	Inpatient	The Trust should ensure that staff are aware of the expectations of assessment and review when patients moved between wards.	Trust process to be developed.	Modern Matrons	Heads of Service AMH	31/03/2019	Trust process in place
12	Should Do	AMH	York & Selby	Inpatient	The Trust should ensure that staff are aware of the expectations of assessment and review when patients moved between wards.	Trust process to be developed.	Modern Matrons	Heads of Service AMH	31/03/2019	Trust process in place
12	Should Do	AMH	D & D	Inpatient	The Trust should ensure that staff are aware of the expectations of assessment and review when patients moved between wards.	Trust process to be developed.	Modern Matrons	Heads of Service AMH	31/03/2019	Evidence Required: Checklist in place for patients who have moved wards
12	Should Do	AMH	Tees	Inpatient	The Trust should ensure that staff are aware of the expectations of assessment and review when patients moved between wards.	Trust process to be developed.	Modern Matrons	Heads of Service AMH	31/03/2019	Evidence received: Transfer checklist template ?Require evidence of this being cascaded/discussed (e.g. minutes, email)
13	Should Do	AMH	N York	Inpatient	The Trust should continue to ensure that staff receive and record supervision and there is senior management oversight of supervision compliance.	Monthly audit of supervision.	Modern Matron	Heads of Service AMH	31/03/2019	Locally held supervision records. Audit data reported to QuAG.
13	Should Do	AMH	York & Selby	Inpatient	The Trust should continue to ensure that staff receive and record supervision and there is senior management oversight of supervision compliance.	Monthly audit of supervision.	Modern Matron	Heads of Service AMH	31/05/2019	Evidence Required: Supervision matrix Audit data reported to QuAG.

13	Should Do	AMH	D & D	Inpatient	The Trust should continue to ensure that staff receive and record supervision and there is senior management oversight of supervision compliance.	Monthly audit of supervision.	Modern Matron	Heads of Service AMH	31/03/2019	Evidence Required: supervision matrix monthly checks
13	Should Do	AMH	Tees	Inpatient	The Trust should continue to ensure that staff receive and record supervision and there is senior management oversight of supervision compliance.	Monthly audit of supervision.	Modern Matron	Heads of Service AMH	31/03/2019	Evidence received: Weekly supervision matrix spreadsheet
14	Should Do	AMH	D & D	Inpatient	The Trust should ensure that Cedar ward at West Park Hospital receives contributions from occupational therapy and psychology staff within multidisciplinary team meetings, such as report out.	OT Hub development to be operational across WPH site from 01 December which will allow opportunity for OT input. Vacancies (including previous Cedar vacancy) now recruited to. Psychology review to be completed to enable options to be assessed at QUAG	Locality Manager/ Professional Leads	Heads of Service AMH	31/03/2019	OT and Psychology input in place
15.1	Should Do	AMH	N York	Inpatient	The Trust should ensure that staff complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	Modern Matron	Heads of Service AMH	31/05/2019	Individual training compliance via IIC
15.1	Should Do	AMH	York & Selby	Inpatient	The Trust should ensure that staff complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	Modern Matron	Heads of Service AMH	31/05/2019	Individual training compliance via IIC
15.1	Should Do	AMH	D & D	Inpatient	The Trust should ensure that staff complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	Modern Matron	Heads of Service AMH	31/05/2019	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act. Compliance via IIC
15.1	Should Do	AMH	Tees	Inpatient	The Trust should ensure that staff complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	Modern Matron	Heads of Service AMH	31/05/2019	Individual training compliance via IIC
15.2	Should Do	AMH	Tees	Inpatient	Staff should record when a patient has, or has been offered an independent mental health advocate. When patients lack capacity, staff should record the discussion and decision-making processes they follow to come to a best interest	Ensure compliance with Mental Capacity Act training and then complete a quarterly random sample audit of IMHA offer. All qualified staff to be reminded of policy.	Modern Matron	Heads of Service AMH	31/05/2019	Evidence required: quarterly random sample audit of IMHA offer
15.2	Should Do	AMH	N York	Inpatient	Staff should record when a patient has, or has been offered an independent mental health advocate. When patients lack capacity, staff should record the discussion and decision-making processes they follow to come to a best interest	Ensure compliance with Mental Capacity Act training and then complete a quarterly random sample audit of IMHA offer. All qualified staff to be reminded of policy.	Modern Matron	Heads of Service AMH	31/05/2019	Peppermill Court Steering Group and Governance meeting minutes
15.2	Should Do	AMH	York & Selby	Inpatient	Staff should record when a patient has, or has been offered an independent mental health advocate. When patients lack capacity, staff should record the discussion and decision-making processes they follow to come to a best interest	Ensure compliance with Mental Capacity Act training and then complete a quarterly random sample audit of IMHA offer. All qualified staff to be reminded of policy.	Modern Matron	Heads of Service AMH	31/05/2019	Evidence required: Sample of Ward Manager checks Peppermill Court Steering Group and Governance meeting minutes
15.2	Should Do	AMH	D & D	Inpatient	Staff should record when a patient has, or has been offered an independent mental health advocate. When patients lack capacity, staff should record the discussion and decision-making processes they follow to come to a best interest decision in line with Trust policy.	Ensure compliance with Mental Capacity Act training and then complete a quarterly random sample audit of IMHA offer. All qualified staff to be reminded of policy.	Modern Matron	Heads of Service AMH	31/05/2019	IIC training compliance IMHA audit checks QUAG minutes

16	Should Do	AMH	Tees	Inpatient	The Trust should ensure that patients have access to activities on the wards throughout the week.	Activity schedules to be in place for all wards.	Locality Manager	Heads of Service AMH	31/05/2019	Evidence received: out of hours activity timetable
16	Should Do	AMH	N York	Inpatient	The Trust should ensure that patients have access to activities on the wards throughout the week.	Activity schedules to be in place for all wards.	Locality Manager	Heads of Service AMH	31/05/2019	Evidence Required: Vacancy control and ESR records ?Activity timetable
16	Should Do	AMH	York & Selby	Inpatient	The Trust should ensure that patients have access to activities on the wards throughout the week.	Activity schedules to be in place for all wards.	Locality Manager	Heads of Service AMH	Complete	Evidence required: copy of weekly activity rota recorded in individual patient notes.
16	Should Do	AMH	D & D	Inpatient	The Trust should ensure that patients have access to activities on the wards throughout the week.	Activity schedules to be in place for all wards.	Locality Manager	Heads of Service AMH	31/05/2019	Staff in post, Hub in place across whole Directorate Evidence Required
17	Should Do	AMH	N York	Inpatient	The Trust should ensure that privacy and dignity is maximised in the bed bays of Cedar ward at the Briary unit. The Trust should ensure that all wards comply with the Trust policy of having privacy curtains in bathrooms off corridors.	**Following discussion at EMT and other key forums decision taken that no action is to be taken. (NY)**	EMT	Heads of Service AMH		
18	Should Do	AMH	Tees	Inpatient	The Trust should ensure staff record what action they take when clinic room temperatures are outside the safe range.	Assurance of impact of actions (i.e. green compliance) to continue to be monitored through QUAG via medicines management reports	Modern Matrons	Heads of Service AMH	Complete	Evidence received: Medicines Management reports show green compliance
18	Should Do	AMH	D & D	Inpatient	The Trust should ensure staff record what action they take when clinic room temperatures are outside the safe range.	Assurance of impact of actions (i.e. green compliance) to continue to be monitored through QUAG via medicines management reports	Modern Matrons	Heads of Service AMH	31/03/2019	Evidence Required: Medicines Management reports show green compliance
19	Should Do	AMH	Tees	Inpatient	The Trust should fully consider all methods and mitigation to maintain patient safety in the absence of call alarms in patient bedrooms and other patients access areas.	To explore possibilities of alarm systems and gain agreement from EMT of any potential action to be taken	EMT	Heads of Service AMH, EFM	30/06/2019	
19	Should Do	AMH	N York	Inpatient	The Trust should fully consider all methods and mitigation to maintain patient safety in the absence of call alarms in patient bedrooms and other patients access areas.	To explore possibilities of alarm systems and gain agreement from EMT of any potential action to be taken	EMT	Heads of Service AMH, EFM	30/06/2019	
20	Must Do	MHSOP	N York	Inpatient	The Trust must ensure staff record physical health observations, including a patient's refusal to be monitored following the administration of rapid tranquilisation in line with the Trust's policy.	Bi- monthly checks of the monitoring and recording of physical observations (post rapid tranquilisation) will continue to be undertaken with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Modern Matrons	Heads of Service MHSOP	31/05/2019	Evidence required: audits/checks QuAG minutes

20	Must Do	MHSOP	D & D	Inpatient	The Trust must ensure staff record physical health observations, including a patient's refusal to be monitored following the administration of rapid tranquilisation in line with the Trust's policy.	Bi- monthly checks of the monitoring and recording of physical observations (post rapid tranquilisation) will continue to be undertaken with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Sarah McGeorge	Heads of Service MHSOP	31/05/2019	Evidence provided: Supervision template of RT, covert medication, post falls proforma Evidence Requested: MM audits QuAG minutes
21	Must Do	MHSOP	N York	Inpatient	The Trust must ensure that patients have easy access to nurse call systems to summon assistance from their bedrooms in an emergency, including shared bedrooms.	MHSOP SDG will give consideration as to the most appropriate nurse call alarm system for inpatient organic units. Based on the outcome of discussions/ decisions, localities will incorporate the chosen system within the estates work plan.	Head of Service	Heads of Service MHSOP	31/03/2019	SDG minutes detailing decision Estates plan for the new model for Meadowfields.
21	Must Do	MHSOP	York & Selby	Inpatient	The Trust must ensure that patients have easy access to nurse call systems to summon assistance from their bedrooms in an emergency, including shared bedrooms.	MHSOP SDG will give consideration as to the most appropriate nurse call alarm system for inpatient organic units. Based on the outcome of discussions/ decisions, localities will incorporate the chosen system within the estates work plan.	Head of Service	Heads of Service MHSOP	31/03/2019	Evidence Required: SDG minutes detailing decision Estates plan for the new model for Meadowfields.
21	Must Do	MHSOP	D & D	Inpatient	The Trust must ensure that patients have easy access to nurse call systems to summon assistance from their bedrooms in an emergency, including shared bedrooms.	MHSOP SDG will give consideration as to the most appropriate nurse call alarm system for inpatient organic units. Based on the outcome of discussions/ decisions, localities will incorporate the chosen system within the estates work plan.	Sarah McGeorge	Heads of Service MHSOP	31/03/2019	SDG minutes detailing decision Evidence Required
22	Must Do	MHSOP	York & Selby	Inpatient	The Trust must ensure prescription charts in relation to the administration of covert medication are completed in line with the Trust's policy.	The service will deliver local staff training and awareness sessions to review trust policy and expectations in relation to completion of prescription charts for the administration of covert medication.	Modern Matron	Heads of Service MHSOP	31/03/2019	Evidence Required: Audit trail of training for staff QuAG minutes
23	Should Do	MHSOP	N York	Inpatient	The Trust should ensure ligature assessments take account all areas of the wards	Review of ligature risk surveys		Heads of Service MHSOP	31/05/2019	Completed ligature surveys QuAG minutes
24	Should Do	MHSOP	N York	Inpatient	The Trust should ensure patients' bedrooms appropriately maintain their privacy, dignity and respect.	As part of the planned work to merge the two inpatient units (Meadowfields and Acomb Garth), it will include an estates review to ensure compliance with privacy, dignity and respect.	Modern Matron /Head of Service	Heads of Service MHSOP	31/03/2019	1.Review provided to QuAG. 2. Identified actions detailed within the estates plan for merging the units.
25	Should Do	MHSOP	N York	Inpatient	The Trust should consider recording patients' capacity and best interest decisions where personal care is being provided.	To discuss and agree what the standard approach across MHSOP should be within SDG	Clinical Director	Heads of Service MHSOP	31/03/2019	SDG minutes Potential standard work developed, agreed and roll out plan in place.
25	Should Do	MHSOP	York & Selby	Inpatient	The Trust should consider recording patients' capacity and best interest decisions where personal care is being provided.	To discuss and agree what the standard approach across MHSOP should be within SDG	Clinical Director	Heads of Service MHSOP	31/03/2019	SDG minutes Potential standard work developed, agreed and roll out plan in place.
25	Should Do	MHSOP	D & D	Inpatient	The Trust should consider recording patients' capacity and best interest decisions where personal care is being provided.	To discuss and agree what the standard approach across MHSOP should be within SDG	Sarah McGeorge	Heads of Service MHSOP	31/03/2019	SDG minutes Potential standard work developed, agreed and roll out plan in place.

25	Should Do	MHSOP	Tees	Inpatient	The Trust should consider recording patients' capacity and best interest decisions where personal care is being provided.	To discuss and agree what the standard approach across MHSOP should be within SDG	Clinical Director	Heads of Service MHSOP	31/03/2019	Copy of SPD Audit of 3 x care plans/capacity assessments per ward monthly Team Briefing Minutes detailing circulation of new SPD
26	Must Do	FMH	Forensic	Inpatient	The Trust must ensure there are enough staff to enable the use of least restrictive practice on Merlin ward and prevent Section 17 leave being cancelled across all wards.	Merlin ward will review, identify and discuss the implementation of restrictive practice within the Forensic Mental Health Quality Assurance Group to provide assurance of monitoring and review in line with the Restrictive Practice Framework. Ongoing work with S17 leave requests will ensure that leave is prescribed in line with ward staffing capacity.	Richard Lambert Matt Gale Matt Gale Lisa Taylor/ Alison Bullock	Head of Service FMH	31/03/2019	Output from ongoing Section 17 work programme Output from Escalation Kaizen Event Leave cancellation recorded in FMH QuAG/FLD minutes Minutes Occupational Therapy Review Final Report
27	Must Do	FMH	Forensic	Inpatient	The Trust must ensure that fridge and clinic room temperatures are monitored and action taken when required in line with the Trust policy.	Monthly reporting of fridge and clinic temperatures will continue through the FMH and FLD Quality Assurance Group. The current monitoring process is currently being reviewed to establish if there are any other solutions to this issue. The above actions will ensure that fridge and clinic room temperatures are monitored and action taken when required in line with the trust policy.	Matt Gale Ruby Bell/Santosh Kumar Ruby Bell/Santosh Kumar Simon Lancashire Simon Lancashire	Head of Service FMH	31/03/2019	Model Ward Project Board minutes QuAG minutes Confirmation email from Estates confirming purchase of new fridges.
28	Must Do	FMH	Forensic	Inpatient	The Trust must ensure activity schedules are in place and therapeutic activities take place on weekends throughout the service.	There will be a review of both occupational therapy and diversional activity provision. This will identify where activity schedules are/are not in place. Following this review, services will ensure that activity schedules are in place and that therapeutic activities (including e.g. leave with family) take place on weekends.	Alison Bullock	Head of Service FMH	Complete	Review document and proposals for consideration Activity schedules (printed and electronic available, audit/monitoring documents linked to post review implementation plan
28	Must Do	FLD	Forensic	Inpatient	The Trust must ensure activity schedules are in place and therapeutic activities take place on weekends throughout the service.	There will be a review of both occupational therapy and diversional activity provision. This will identify where activity schedules are/are not in place. Following this review, services will ensure that activity schedules are in place and that therapeutic activities (including e.g. leave with family) take place on weekends.	Alison Bullock	Head of Service FMH	Complete	Review document and proposals for consideration Activity schedules (printed and electronic available, audit/monitoring documents linked to post review implementation plan
29	Should Do	FLD	Forensic	Inpatient	The Trust should ensure that patients on Hawthorn/Runswick ward have access to their bedrooms without the restriction of snap lock doors and ensure patients on Merlin ward have 24-hour access to snacks in line with the Trust's restrictions policy.	1) The snap locks will be reviewed in collaboration with estates and the clinical team and remedial action taken based on the outcome of the review. Report review into LMGB 2) Merlin ward to review, identify and discuss the implementation of restrictive practise within FMH QuAG, to provide assurance of monitoring and review inline with the Restrictive Practice Framework	Victoria StDenis Richard Lambert	Head of Service FLD	Complete	LMGB Minutes FMH QuAG minutes
30	Should Do	FLD	Forensic	Inpatient	The Trust should ensure that there are processes in place to protect patients' privacy and dignity when being escorted to different wards for the use of seclusion facilities	Briefing Paper to be developed for circulation to all wards outlining the requirement for all patients to be individually assessed prior to being escorted to an alternative seclusion suite. Patient privacy and dignity to be incorporated into the debriefing process	Neil Woodard Heads of Service Rachel Weddle	Head of Service FLD	28/02/2019	Briefing Paper Revised debriefing process
31	Should Do	FMH	Forensic	Inpatient	The Trust should consider why there is a difference between their reported reason for section 17 leave being cancelled and the patients and carers understanding of why leave is being cancelled.	One day event to take place to review current standard process for reporting cancellation of leave (to ensure rationale of leave cancellations is clearly articulated to service users and carers and evidenced within care records).	Steven Barlow	Head of Service FMH	31/03/2019	Revised documentation from the one day event

32	Should Do	FMH	Forensic	Inpatient	The Trust should consider the Department of Health Environmental Design Guide Medium Secure Services guidance with regards to observation panels in patient bedroom doors and in the meantime, manage risks and issues through staff awareness	Observation panel with an antiligature internal thumb turn handle has been identified for the development of block 16.	Simon Lancashire	Heads of Service Forensics	28/02/2019	Confirmation on the instillation of the observation panel by estates.
33	Should Do	FMH	Forensic	Inpatient	The Trust should continue to review the use of mechanical restraint with the aim of eliminating its use.	1) Use of mechanical restraints to be reported to QuAGs on a monthly basis. 2) QuAG to report usage to LMGB and QuAC. 3) Head of Security to continue to report usage of mechanical restraint devices to LMGB. 4) Introduction of the Mechanical Restraint Committee within	Modern Matrons Heads of service	Heads of Service Forensics	31/01/2019	Evidence received: Modern matron report QuAG report to LMGB Mechanical restraint LMGB report FMH QuAG Report to LMGB outlining that QuAGs are being informed on the usage of mechanical restraints
33	Should Do	FLD	Forensic	Inpatient	The Trust should continue to review the use of mechanical restraint with the aim of eliminating its use.	1) Use of mechanical restraints to be reported to QuAGs on a monthly basis. 2) QuAG to report usage to LMGB and QuAC. 3) Head of Security to continue to report usage of mechanical restraint devices to LMGB.	Modern Matrons Heads of service Neil Woodward	Heads of Service Forensics	31/01/2019	Evidence received: Modern matron report QuAG report to LMGB Mechanical restraint LMGB report FMH QuAG Report to LMGB outlining that QuAGs are being informed on the usage of mechanical restraints
34	Should Do	FMH	Forensic	Inpatient	The Trust should fully consider all methods and mitigation to maintain patient safety in the absence of call alarms in patient bedrooms and other patients access areas.	1) Pagers are available for patients to access. 2) Individual patient risk assessment to be completed by MDT prior to allocating pagers. 3) QuAGs to be informed of availability to access pagers following individual risk assessment.	Ruby Bell Santosh Kumar	Heads of Service Forensics	28/02/2019	QuAG Minutes
34	Should Do	FLD	Forensic	Inpatient	The Trust should fully consider all methods and mitigation to maintain patient safety in the absence of call alarms in patient bedrooms and other patients access areas.	1) Pagers are available for patients to access. 2) Individual patient risk assessment to be completed by MDT prior to allocating pagers. 3) QuAGs to be informed of availability to access pagers following individual risk assessment.	Ruby Bell Santosh Kumar	Heads of Service Forensics	28/02/2019	QuAG Minutes
35	Should Do	CAMHS	Tees	Inpatient	The Trust should ensure that capacity assessments are considered where required and recorded in care plans on Baysdale unit.	Capacity assessments to be considered for all patients 16yrs old and above and recorded in PARIS as having been considered/completed	Martin Saunders	Heads of Service CYPS	28/02/2019	Capacity Assessment completed and decision recorded on PARIS
36	Should Do	CAMHS	Tees	Inpatient	The Trust should ensure effective systems and processes are in place to monitor the compliance and quality of clinical supervision.	Clinical supervision spreadsheet to be used to monitor compliance	Martin Saunders	Heads of Service CYPS	27/06/2018	Supervision spreadsheet Evidence Required
37	Should Do	CAMHS	D & D	Inpatient	The Trust should ensure the sensory room on Holly ward is well equipped and maintained.	Costings for new sensory equipment to be obtained and presented to CPSG to request funding. Holly Unit to be redecorated.	Donna Sweet	Heads of Service CYPS	31/03/2019	QuAG minutes Regulation 48 visit reports

38	Should Do	CAMHS	Tees	Inpatient	The Trust should ensure there are sufficient staff available to coordinate activities scheduled for children and young people	Baysdale to evidence how it co-ordinates activities scheduled for children and young people	Martin Saunders	Heads of Service CYPS	01/09/2018	Photographs, Timetable of activities, My Stay At Baysdale, Activities the children and young people like participating in recording in Person Centred Care Plans, Socialisation Receipts, Health Roster Evidence Required
39	Should Do	CAMHS	Tees	Inpatient	The Trust should ensure the quality of food available to patients at West Lane hospital is improved in line with other services.		Heads of Service CYPS/EFM	Heads of Service CYPS	31/05/2019	
40	Should Do	CAMHS	Tees	Inpatient	The Trust should fully consider all methods and mitigation to maintain patient safety in the absence of call alarms in patient bedrooms and other patients access areas.	Baysdale to identify how they maintain patient safety in the absence of call alarms in patient bedrooms and other patient access areas	Martin Saunders	Heads of Service CYPS	27/06/2018	
41	Should Do	AMH	N York	Community	The Trust should ensure it completes its review on the use of emergency equipment to ensure there is a unified approach across all the Trust.	Provide clear guidance on the use of emergency bags in the community.	Elizabeth Moody (N&G)	Heads of Service AMH	31/03/2019	Guidance document
41	Should Do	AMH	York & Selby	Community	The Trust should ensure it completes its review on the use of emergency equipment to ensure there is a unified approach across all the Trust.	Provide clear guidance on the use of emergency bags in the community.	Elizabeth Moody (N&G)	Heads of Service AMH	31/03/2019	Man and stat training compliance records. Emergency response bag check list.
41	Should Do	AMH	D & D	Community	The Trust should ensure it completes its review on the use of emergency equipment to ensure there is a unified approach across all the Trust.	Provide clear guidance on the use of emergency bags in the community.	Elizabeth Moody (N&G)	Heads of Service AMH	31/03/2019	
41	Should Do	AMH	Tees	Community	The Trust should ensure it completes its review on the use of emergency equipment to ensure there is a unified approach across all the Trust.	Provide clear guidance on the use of emergency bags in the community.	Elizabeth Moody (N&G)	Heads of Service AMH	31/03/2019	
42	Should Do	AMH	D & D	Community	Staff should ensure they keep patients medication cards up to date and contemporaneous in line with best practice.	All staff to be reminded of responsibilities.	Clinical Director	Heads of Service AMH	31/03/2019	
43	Should Do	AMH	N York	Community	The community mental health team should ensure they complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	Team Managers	Heads of Service AMH	31/05/2019	IIC training compliance
43	Should Do	AMH	York & Selby	Community	The community mental health team should ensure they complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	Team Managers	Heads of Service AMH	01/05/2019	IIC training compliance January 2019 NE CMHT: MHA1 100% / MHA2 100% / MCA 100% SW CMHT MHA1 100% / MHA2 91% / MCA 93%

43	Should Do	AMH	D & D	Community	The community mental health team should ensure they complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	Team Managers	Heads of Service AMH	31/05/2019	IIC training compliance
43	Should Do	AMH	Tees	Community	The community mental health team should ensure they complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	Team Managers	Heads of Service AMH	31/05/2019	IIC training compliance
44	Should Do	AMH	N York	Community	The Trust should accurately maintain supervision records to reflect what staff are receiving.	Monthly audit of supervision.	Team Manager	Heads of Service AMH	30/04/2019	Locally held supervision records. Audit data reported to QuAG (as recorded in the minutes).
44	Should Do	AMH	York & Selby	Community	The Trust should accurately maintain supervision records to reflect what staff are receiving.	Monthly audit of supervision.	Team Manager	Heads of Service AMH	30/04/2019	Evidence required: Audit data reported to QuAG (as recorded in the minutes). Supervision matrix
44	Should Do	AMH	D & D	Community	The Trust should accurately maintain supervision records to reflect what staff are receiving.	Monthly audit of supervision.	Team Manager	Heads of Service AMH	30/04/2019	Locally held supervision records. Audit data reported to QuAG (as recorded in the minutes).
44	Should Do	AMH	Tees	Community	The Trust should accurately maintain supervision records to reflect what staff are receiving.	Monthly audit of supervision.	Team Manager	Heads of Service AMH	30/04/2019	Locally held supervision records. Audit data reported to QuAG (as recorded in the minutes).
45	Should Do	AMH	N York	Community	The Trust should ensure they use a recognised risk assessment tool in line with best practice.	A monthly random sample audit will be undertaken. The actions from the audit will be fed back to individual clinicians to facilitate any required improvements	Team Managers	Heads of Service AMH	30/04/2019	Audit reported to QuAG and recorded in the minutes.
45	Should Do	AMH	York & Selby	Community	The Trust should ensure they use a recognised risk assessment tool in line with best practice.	A monthly random sample audit will be undertaken. The actions from the audit will be fed back to individual clinicians to facilitate any required improvements	Team Managers	Heads of Service AMH	30/04/2019	Evidence Required: Audit quality of safety summary plan, and respond to any actions from this. Audit reported to QuAG and recorded in the minutes. Training records
45	Should Do	AMH	D & D	Community	The Trust should ensure they use a recognised risk assessment tool in line with best practice.	A monthly random sample audit will be undertaken. The actions from the audit will be fed back to individual clinicians to facilitate any required improvements	Team Managers	Heads of Service AMH	30/04/2019	Audit reported to QuAG and recorded in the minutes.
45	Should Do	AMH	Tees	Community	The Trust should ensure they use a recognised risk assessment tool in line with best practice.	A monthly random sample audit will be undertaken. The actions from the audit will be fed back to individual clinicians to facilitate any required improvements	Team Managers	Heads of Service AMH	30/04/2019	Audit reported to QuAG and recorded in the minutes.

46	Must Do	LD & Autism	Tees	Community	The Trust must ensure that staff are considering patients' capacity to consent where required and are maintaining records that demonstrate that they have done so.	A records review will be undertaken at The Orchards where this was raised to ensure that staff are considering patients' capacity to consent where required and are maintaining records. This action will demonstrate that capacity records are being appropriately maintained.	Modern Matron/ Charge Nurse	Heads of Service LD	30/11/2018	Individual capacity forms
47	Should Do	LD & Autism	D & D	Community	The Trust should ensure that patient risk assessments are continually reviewed and updated for all patients.	Implement a visual control system to monitor review of patient risk assessments	Modern Matron/ Charge Nurse	Heads of Service LD	31/01/2019	Visual Control Board
47	Should Do	LD & Autism	Tees	Community	The Trust should ensure that patient risk assessments are continually reviewed and updated for all patients.	Implement a visual control system to monitor review of patient risk assessments	Modern Matron/ Charge Nurse	Heads of Service LD	31/01/2019	Visual Control Board
48	Should Do	LD & Autism	Tees	Community	The Trust should ensure that staff at Lancaster House continue to work on reducing patient waiting times for a service, to meet National Institute for Health and Care Excellence standards.	Task and Finish Group to be established to consult on a new service model	Jane King/Rebecca O'keeffe	Heads of Service LD	31/03/2019	Minutes of Task & Finish Group
49	Should Do	LD & Autism	Tees	Community	The Trust should ensure that staff at The Orchard are using the National Early Warning Scores tool consistently with all patients and that regular reviews of patient physical health are taking place.	Physical health monitoring to be included on Visual Control Board	Modern Matron/Charge Nurse	Heads of Service LD	30/11/2018	Visual Control Board and monthly audit findings
50	Must Do	Corporate	Corporate	Corporate	The Trust should ensure that staff are aware of the requirement to report a breach of the eliminating mixed sex accommodation requirements in line with Trust policy.	To remind staff of the reporting requirements as part of the roll-out of the refreshed Privacy and Dignity policy	Director of Quality Governance	Compliance Team	30/06/2019	Revised policy and feedback from mock inspection process
51	Must Do	Trust	Corporate	Inpatient	The trust must ensure it reviews further actions that can be taken to mitigate the impact on privacy and dignity where only curtains separate the beds in dormitory style accommodation.	The Trust will continue to review further actions that can be taken to mitigate the impact on privacy and dignity where only curtains separate the beds in dormitory style accommodation.	Director of Quality Governance	Compliance Team	30/06/2019	Revised policy and feedback from mock inspection process

Item 11

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**26 February 2019**
TITLE:	**Finance Report for Period 1 April 2018 to 31 January 2019**
REPORT OF:	**Patrick McGahon, Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 31 January 2019 is a surplus of £8,184k, representing 2.8% of the Trust's turnover and is £922k ahead of the revised NHSI plan.

Performance Against Plan – year to date (3.2)

	Variance £000	Monthly Movement £000	Movement
The Trust is currently £922k **ahead** of its year to date financial plan.	-922	-319	↑

Cash Releasing Efficiency Savings (CRES) (3.3)

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the financial year are £134k **behind** financial plan.	Recurrent	4,445	↑
	Non recurrent	-4,311	→
	Target	0	
	Variance	134	↑

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the rolling 3 year period are £14,717k **behind** the £20,565k CRES target.	Recurrent	14,282	↑

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. The 3 year CRES target has been revised after considering the latest NHS planning and contracting guidance issued in January 2019.

Capital (3.4)

	Variance £000	Monthly Movement £000	Movement
The Trust is currently £883k **behind** its capital plan.	883	96	↑

Expenditure against the capital programme to 31 January 2019 is £12,616k and is £883k behind plan due to slippage on combined heat and power and York and Selby inpatient facility plus a delayed start on Middlesbrough crisis assessment suite. These are partially offset by expenditure incurred on I.T. licenses.

The Trust received a capital rebate relating to prior year schemes (£2,289k) and has incurred £3,102k expenditure relating to Roseberry Park rectification work. With these included, capital expenditure is £70k behind plan.

Workforce (3.5)

	Variance £000	Monthly Movement £000	Movement
The Trust is currently £2,800k (58%) **in excess** of its agency cap.	2,800	379	↓

Agency expenditure remains high in month 10 across all localities, nursing agency expenditure accounts for 77% of the variance and is used 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	3	→

The UoRR for the Trust is assessed as 3 for the period ending 31 January 2019 and is behind plan (Table 4). The agency position exceeds the 50% NHSI cap and is rated as a 4. As a result the Trust's highest achievable rating is overridden as a 3. Excluding this override the Trust would be assessed as a rating of 2 which remains behind plan due to agency expenditure. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

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:	**26 February 2019**
TITLE:	**Finance Report for Period 1 April 2018 to 31 January 2019**

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for 1 April 2018 to 31 January 2019.

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 UoRR for the Trust is assessed as 3 for the period ending 31 January 2019 and is behind plan. Agency expenditure exceeds the 50% NHSI cap and is rated as a 4. As a result the Trust's highest achievable rating is overridden as a 3. Excluding this override the Trust would be assessed as a rating of 2 which remains behind plan due to agency expenditure.

3.2 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 31 January 2019 is a surplus of £8,184k, representing 2.8% of the Trust's turnover and is £922k ahead of the revised NHSI plan. This is summarised in table 1 below:

Table 1	**Annual Plan**	**Year to Date Plan**	**Year to Date Actual**	**YTD Variance**	**Prior Month Variance**
	£000	**£000**	**£000**	**£000**	**£000**
Income From Activities	(337,252)	(274,967)	(274,479)	488	372
Other Operating Income	(16,389)	(14,108)	(14,216)	(108)	(149)
Total Income	**(353,642)**	**(289,075)**	**(288,695)**	**380**	**88**
Pay Expenditure	266,271	221,462	219,970	(1,492)	(1,027)
Non Pay Expenditure	68,408	52,414	52,888	474	439
Depreciation and Financing	9,100	7,937	7,653	(285)	(245)
Variance from plan	**(9,863)**	**(7,262)**	**(8,184)**	**(922)**	**(603)**

The above table does not include the PFI termination impact. This is still in discussion with NHSI.

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 (£134k) and continues to identify schemes to ensure full delivery of recurrent CRES requirements.

Table 2	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the financial year are £134k **behind** financial plan.	Recurrent	4,445	
	Non recurrent	-4,311	
	Target	0	
	Variance	134	

3.4 Capital

Expenditure against the capital programme to 31 January 2019 is £12,616k and is £883k behind plan due to slippage on combined heat and power and York and Selby inpatient facility plus a delayed start on Middlesbrough crisis assessment suite. These are partially offset by expenditure incurred on I.T. licenses.

The Trust received a capital rebate relating to prior year schemes (£2,289k) and has incurred £3,102k expenditure relating to Roseberry Park rectification work. With these included, capital expenditure is £70k behind plan.

3.5 Workforce

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

Table 3	Pay Expenditure as a % of Pay Budgets						
Tolerance	Tolerance Jan-19	Aug	Sep	Oct	Nov	Dec	Jan
Establishment (a) (90%-95%)	93.03%	92.72%	92.31%	93.46%	93.96%	93.37%	93.03%
Agency (b)	1.00%	3.05%	3.19%	3.25%	3.40%	3.40%	3.44%
Overtime (c)	1.00%	1.13%	1.11%	1.09%	1.07%	1.10%	1.02%
Bank & ASH (flexed against establishment) (100%-a-b-c)	4.97%	2.98%	3.09%	3.13%	3.22%	3.20%	3.13%
Total	**100.00%**	**99.88%**	**99.70%**	**100.93%**	**101.65%**	**101.01%**	**100.62%**

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 January 2019 the tolerance for Bank and ASH is 4.97% of pay budgets.

NHS Improvement monitors agency expenditure against a capped target. Agency expenditure at 31 January 2019 is £7,625k which is £2,800k (58%) in excess of the agreed year to date capped target of £4,825k. Nursing agency expenditure accounts for 77% of the variance and is used to support vacancies and enhanced observations with complex clients. 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 January 2019 is £71,246k, and is £5,309k higher than planned, largely due to working capital variations.

3.7 Use of Resources Risk Rating (UoRR) and Indicators

3.7.1 The UoRR for the Trust is assessed as 3 for the period ending 31 January 2019 and is behind plan. Agency expenditure exceeds the 50% NHSI cap and is rated as a 4. As a result the Trust's highest achievable rating is overridden as a 3. Excluding this override the Trust would be assessed as a rating of 2 which remains behind plan due to agency expenditure. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

Table 4: Use of Resource Rating at 31 January 2019

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	1.72x	3	1.49x	3	
Liquidity	43.0 days	1	46.2 days	1	
I&E margin	2.8%	1	2.6%	1	
I&E margin distance from plan	0.2%	1	0.0%	1	
Agency expenditure	£7,625k	4	£4,825k	1	
Overall Use of Resource Rating		**3**		**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 1.72x (can cover debt payments due 1.72 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 43.0 days; this is behind plan, but still 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 2.8%, which is ahead of plan and rated as a 1.

3.7.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding PSF income. The Trust I&E margin distance from plan is 0.2% which is ahead of plan and rated as a 1.

3.7.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is 58% higher than the capped target and is rated as a 4.

The margins on UoRR are as follows:

- Capital service cover - to improve to a 2 a surplus increase of £297k is required.
- Liquidity - to reduce to a 2 a working capital decrease of £38,343k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £922k is required.
- I&E margin distance from plan – to reduce to a 2 an operating surplus decrease of £922k is required.
- Agency Cap rating – to improve to a 3 a reduction in agency expenditure of £388k 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 For the period ending 31 January the Trust is £922k 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 UoRR for the Trust is assessed as 3 for the period ending 31 January 2019 and is behind plan. Agency expenditure exceeds the 50% NHSI cap and is rated as a 4. As a result the Trust's highest achievable rating is overridden as a 3. Excluding this override the Trust would be assessed as a rating of 2 which remains behind plan due to agency expenditure. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

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:	**26th February 2019**
TITLE:	**Board Dashboard as at 30th January 2019**
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 January 2019, 7 (39%) of the indicators reported are not achieving the expected levels and are red across three domains excluding the activity domain. This is a deterioration on the 4 that were reported as at the end of December 2018 and reflects a similar deterioration that occurred in January 2018. In addition there are 5 KPIs (28%) that whilst not achieving the target are within the 'amber' tolerance levels, which is four less than that reported as at the end of December. There is one additional indicator reporting as green in January 2019 compared to December 2018 which is positive.

Of the 12 indicators that are either red or amber 4 are showing an improving trend over the previous 3 months.

The year to date position is that there are 5 KPIs (28%) which are reported as red which is an improvement on the 6 that were reported as at the end of December 2018.

In terms of the Single Oversight Framework targets the Trust achieved all the operational targets in January 2019.

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:	**26th February 2019**
TITLE:	**Board Dashboard as at 30th January 2019**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 30th January 2019 (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 January 2019, 7 (39%) of the indicators reported are not achieving the expected levels and are red across three domains excluding the activity domain. This is a deterioration on the 4 that were reported as at the end of December 2018 and reflects a similar deterioration that occurred in January 2018. In addition there are 5 KPIs (28%) that whilst not achieving the target are within the 'amber' tolerance levels, which is four less than that reported as at the end of December 2018. There is one additional indicator reporting as green in January 2019 compared to December 2018 which is positive.

  Of the 12 indicators that are either red or amber 4 are showing an improving trend over the previous 3 months.

  The year to date position is that there are 5 KPIs (28%) which are reported as red which is an improvement on the 6 that were reported as at the end of December 2018.

- In terms of the Single Oversight Framework targets the Trust achieved all the operational targets in January 2019. Specific issues are as follows:
  - The 7 day follow up following discharge was not achieved in 3 CCGs in January 2019.
  - Access to Early Intervention in Psychosis – we failed to achieve the target in January 2019 in the HRW CCG, Harrogate and Rural District CCG, South Tees CCG and Vale of York CCG.
  - IAPT/Talking Therapies – proportion of people completing treatment who move to recovery" – There were two CCGs areas where the target was not achieved in January 2019 (DDES CCG, and Vale of York CCG).
  - Inappropriate Out of Area Occupied Bed Days – the target was not achieved in 3 CCGs areas in January 2019. These all related to

'Internal' Out of Area admissions i.e. admissions within other areas of the Trust. There were no patients admitted externally from the Trust due to pressure on beds.

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

2.3 Key Risks

- Waiting times (KPI 1 and 2) – Both indicators are currently not achieving the target and have moved to red from amber in January 2019. The decline in performance for both replicates the trend seen in the previous 2 years. Work is ongoing to produce the 'deep dive' report will be presented to the Board in March 2019.
- %age of patients reporting their experience as excellent or good (KPI 4) – Whilst performance is not achieving the target it has improved in January 2019 and is higher than the position in January 2018. The outlier continues to be York and Selby who are undertaking some Quality Improvement Work to improve performance against this indicator. Forensic Services have improved their performance compared to last month and are now achieving the target.
- Number of Unexpected Deaths Classed as a Serious Incident (KPI 5) – Whilst there has been an improvement in performance for the month of January 2019 performance still remains worse than target. There were 8 unexpected deaths classed as a SUI in January 2019 compared to 17 in December 2018.
- Outcome Indicators (KPIs 6 and 7) – Whilst performance against the two outcome indicators (clinically reported (HONOS) and patient reported (SWEMWEBS) continues to be worse than target KPI 6 shows a further improvement and was just below the target in January 2019. KIP 7 however showed a further decrease in January 2019. A paper on the collection of Outcome Data was discussed at the Clinical Leaders Board in January 2019 where the importance of collecting and reporting outcomes was recognised. A number of actions were agreed including the establishment of a Trust Wide All Speciality Outcomes group. A subsequent report is being considered by the Executive Team in February 2019.
- Activity Indicators (KPI 8-11) – Whilst we are only monitoring these indicators for the rest of 2018/19 it can be seen that the actual levels have followed previous years trends in January, although for all indicators the levels in January 2019 are higher than those in January for the previous two years (to varying degrees).
- Bed Occupancy (KPI 12) – Whilst the position continues to be worse than the target there has been continued improvement in January 2019 such that the position is the best in the year to date (although higher than the same point in 2017/18). Whilst the monthly aggregate figure is positive there are particular challenges within Teesside. 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. In addition work across the localities is

continuing as part of improving our approach to bed management across the Trust.

- Sickness Absence Rate (KPI 19) – the Trust continues not to achieve target however the performance reported in January 2019 (sickness in December 2018) is an improvement on the position reported in December 2018. It is also significantly below the figure reported in January 2018. A review of the Trusts approach to managing sickness absence has recently been concluded and a revised procedure for managing absence is currently being considered.
- Financial Targets (KPIs 21) – In the month of January 2019 (and Year to Date) we have not achieved the target for CRES delivery. Work is ongoing via the Programme Board to identify further recurrent CRES schemes.

2.4 Data Quality Assessment.

The data quality assessment of the Dashboard indicators is included in Appendix D. A process is to be established from January 2019 to routinely review this assessment and identify any changes on a more regular basis and the revised data quality scores will be included in the February report.

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

	January 2019				April 2018 To January 2019			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%	83.43%			90.00%	86.73%		90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral	60.00%	47.10%			60.00%	54.82%		60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	2,305.00	1,291.00			2,305.00	1,291.00		2,305.00
4) Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	91.67%			92.45%	91.31%		92.45%
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.44			10.00	18.91		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%	66.67%			67.25%	58.33%		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%	66.30%			78.25%	67.37%		78.25%

Activity

	January 2019				April 2018 To January 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
8) Number of new unique patients referred		7,387.00				69,283.00		
9) The number of new unique patients referred with an assessment completed		4,550.00				43,261.00		
10) Number of new unique patients referred and taken on for treatment		1,772.00				15,527.00		
11) Number unique patients referred who received treatment and were discharged		2,378.00				23,277.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	88.33%			85.00%	93.41%		85.00%

Trust Dashboard Summary for TRUST

	January 2019				April 2018 To January 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
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	65.00			68.00	65.00		68.00
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.93%	18.82%			23.93%	23.28%		23.93%

Workforce

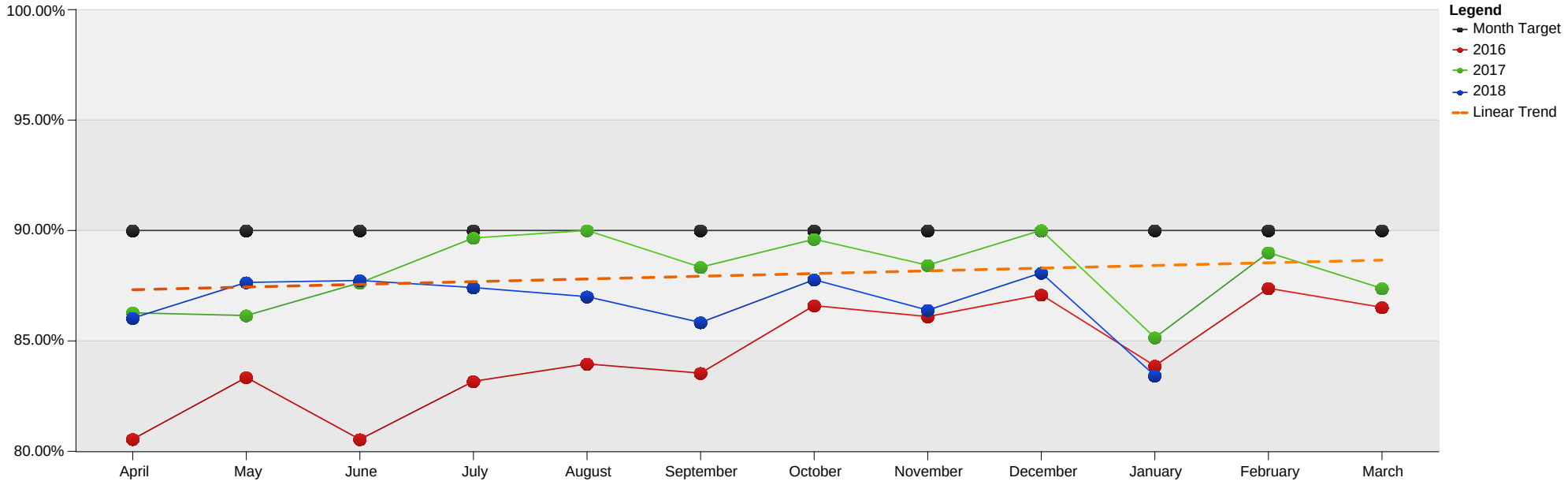
	January 2019				April 2018 To January 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
15) Actual number of workforce in month (Establishment 95%-100%)	95.00%	93.03%			95.00%	93.03%		95.00%
16) Vacancy fill rate	90.00%	84.44%			90.00%	80.10%		90.00%
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	91.81%			95.00%	91.81%		95.00%
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	92.24%			92.00%	92.24%		92.00%
19) Percentage Sickness Absence Rate (month behind)	4.50%	5.05%			4.50%	4.91%		4.50%

Money

	January 2019				April 2018 To January 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
20) Delivery of our financial plan (I and E)	-632,000.00	-945,064.00			-7,262,000.00	-8,184,055.00		-9,864,000.00
21) CRES delivery	686,782.00	568,012.00			6,867,820.00	5,345,444.00		8,241,384.00
22) Cash against plan	65,937,000.00	71,246,000.00			65,937,000.00	71,246,000.00		59,764,000.00

Trust Dashboard Graphs for TRUST

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



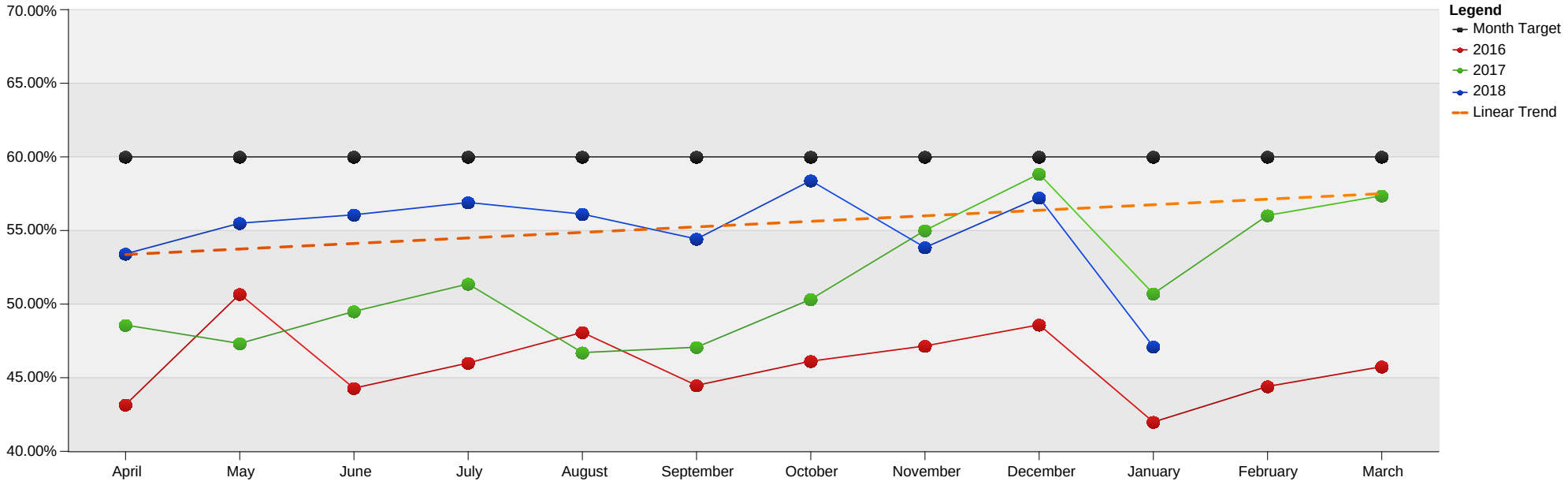
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	83.43%	86.73%	79.87%	85.75%	90.09%	91.67%	72.84%	75.43%	99.62%	99.51%	75.52%	80.75%		

Narrative

The position for January 2019 is 83.43% relating to 5439 patients out of 6518 who were seen within 4 weeks. This is worse than the target of 90% and a deterioration on the position reported in December 2018 and one of the poorest positions since 17/18. This follows seasonal trends when a reduction in performance is seen.Areas of concern:• York AMH at 68.70% (180 of 262 patients) 82 patients were not seen within 4 weeks which is a continued deterioration from December 18. Performance continues to be impacted by the high DNA rate, sickness and vacancies and an agency worker is in place. This is under continuous review through the report out process • North Yorkshire AMH at 68.19% (268 of 393 patients) 125 patients were not seen within 4 weeks. This is a deterioration from December 18. Vacancies have impacted on performance, however posts have been recruited to and improvements in performance are anticipated. • North Yorkshire MHSOP at 67.32% (311 of 462 patients) 151 patients were not seen within 4 weeks. This is a deterioration from December 18. MHSOP have a number of staffing issues and plans are in place which includes a review of processes and skill mix• Durham and Darlington AMH at 50.72% (283 out of 558 patients) 275 patients were not seen and this is a deterioration on the previous month due to a sustained high number of referrals, staff sickness and vacancies. Capacity will increase through the recruitment of fixed term staff and as staff on sick leave return to work.

Trust Dashboard Graphs for TRUST

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

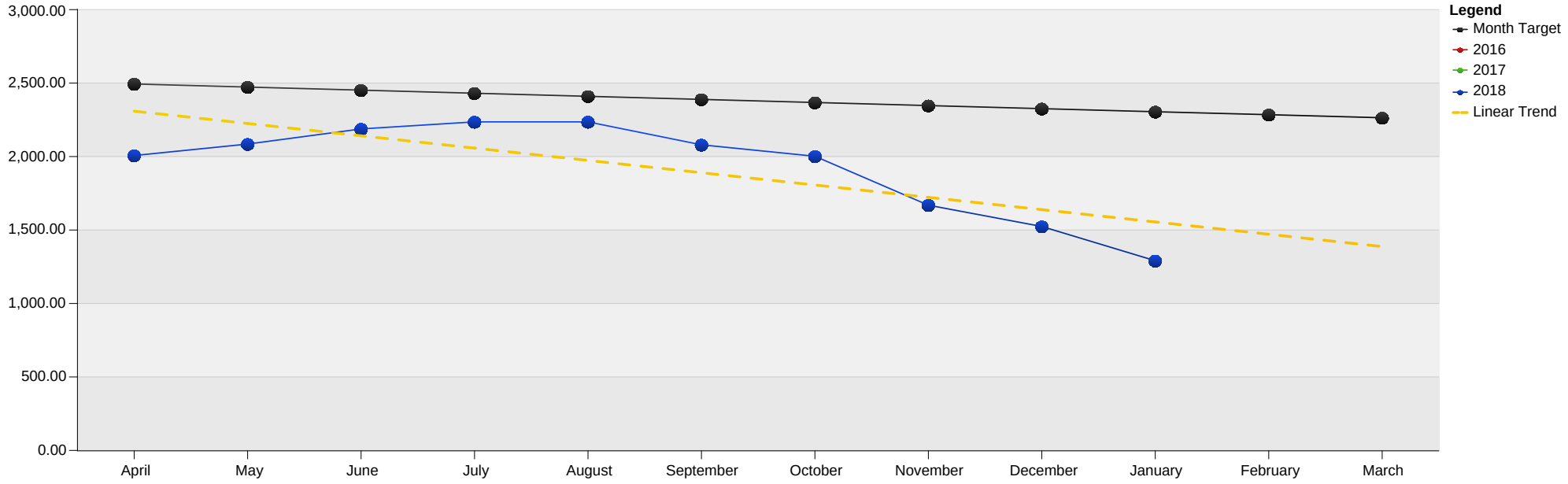


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients starting treatment within 6 weeks of an external referral	47.10%	54.82%	43.17%	52.83%	57.66%	63.03%	34.37%	44.96%	85.71%	90.70%	42.24%	46.16%		

Narrative
The Trust position for January 2019 is 47.10%, which is worse than the target and a deterioration on the position reported in December 2018 and the lowest position in the year to date. The reduction in performance follows a similar trend to that in January of the previous two years. All localities, with the exception of Forensic services, are below target. North Yorkshire report the lowest performance.In North Yorkshire vacancies have impacted on performance, however support has been provided regarding ensuring the correct recording of the interventions included in this metric which has been shared at SDG and improvements in performance are expected.

Trust Dashboard Graphs for TRUST

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

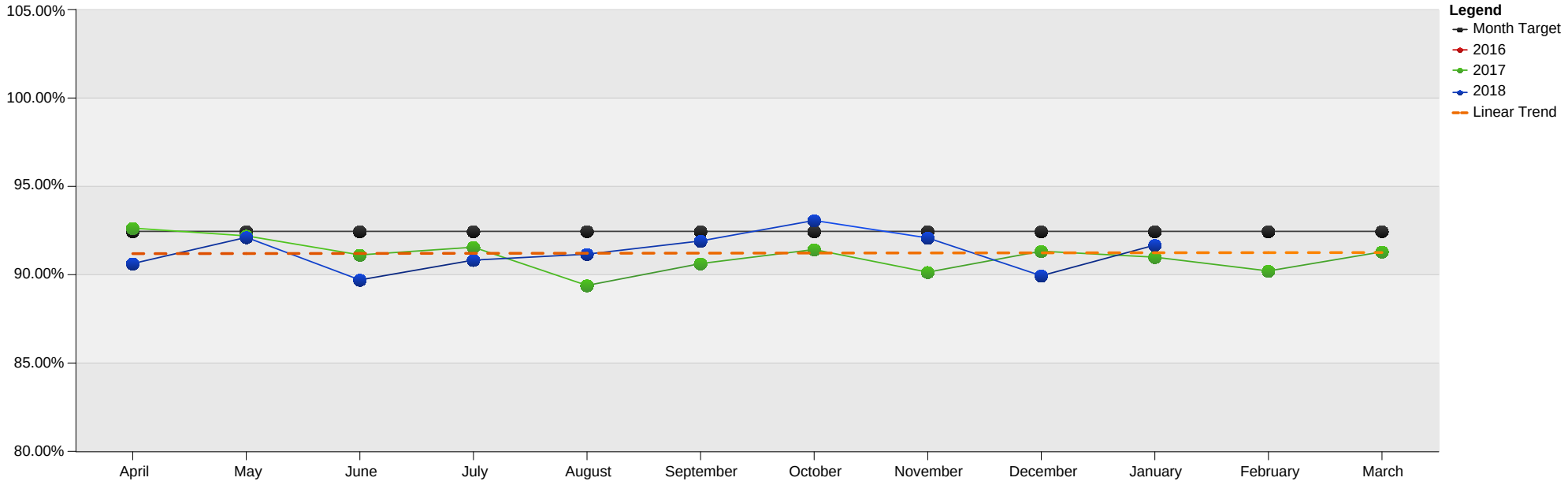


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	1,291.00	1,291.00	156.00	156.00	440.00	440.00	557.00	557.00			134.00	134.00		

Narrative
The Trust position for January 2019 is 1,291 which is meeting the target of 2,305 and is an improvement on the December 2018 position and a continuation of the improving trend seen since September 2018.Durham and Darlington is the only locality not meeting target – 156 occupied bed days (19 AMH and 137 MHSOP. This relates to 4 patients admitted out of area over the 3 month period, 3 MHSOP and 1 AMH)The locality continues to have a number of patients from the other 3 localities admitted to its beds. Work continues to return patients to their home area. The locality is monitoring this on a continual basis with actions agreed in daily huddles and there is an action plan in place with commissioners that is managed jointly with the CCG via the Contract Management Boards.

Trust Dashboard Graphs for TRUST

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

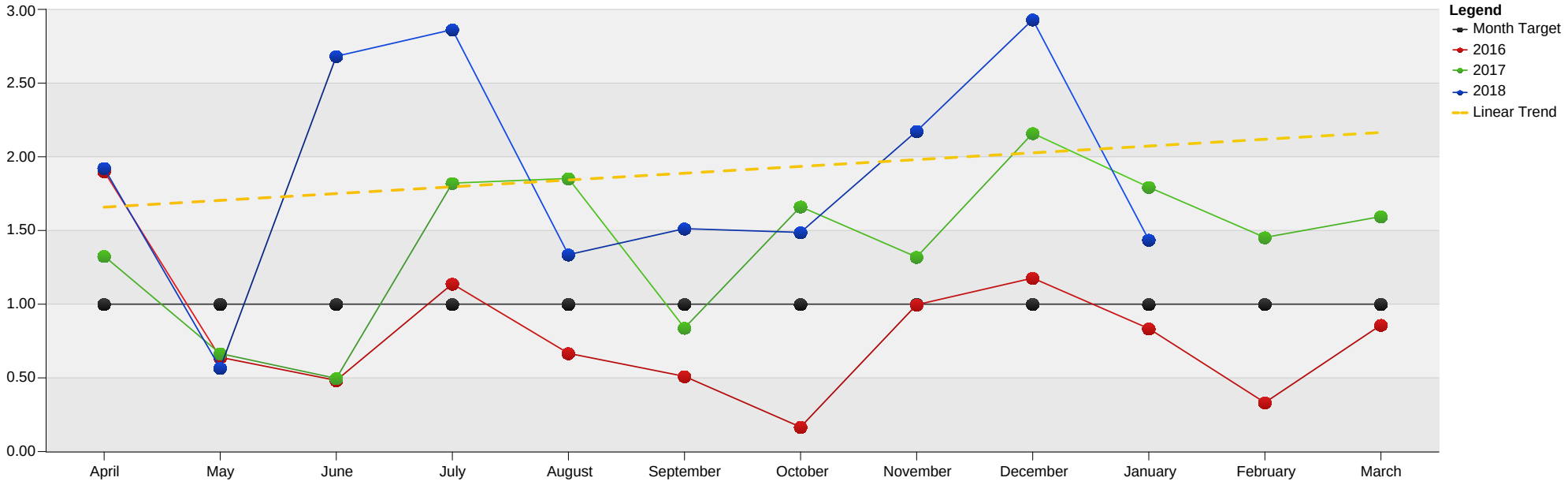


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of patients surveyed reporting their overall experience as excellent or good	91.67%	91.31%	92.01%	92.58%	93.00%	92.36%	93.09%	92.06%	94.26%	82.34%	84.50%	88.92%		

Narrative
The Trust position for January 2019 is 91.67% which is not meeting the target of 92.45% however is an improvement on the position reported in December 2018. Durham and Darlington and York and Selby are not meeting target and York and Selby report the lowest position at 84.50%. QIS work is planned within York and Selby to improve completion rates for patient surveys, timescales are to be confirmed along with confirmation as to which specialities will be involved. A further update will be provided in next month's report.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

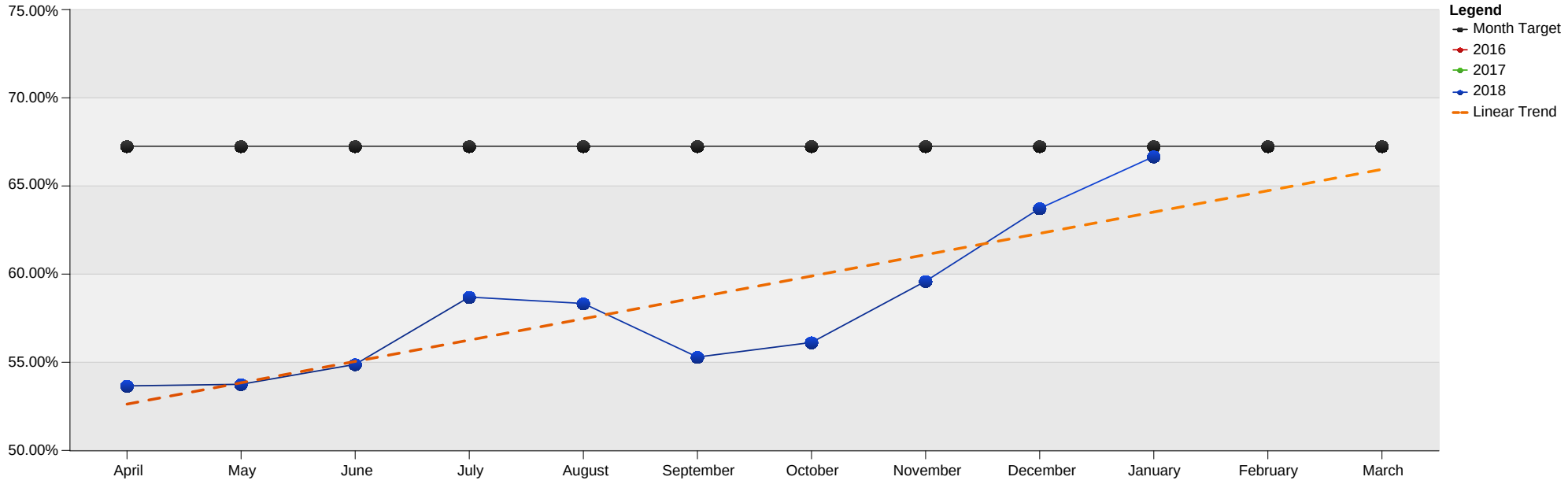


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.44	18.91	0.42	15.83	1.32	14.31	4.26	24.42	0.00	800.00	1.43	20.29		

Narrative
The Trust position for January 2019 is 1.44, which is an improvement on the position reported in December 2018. This rate relates to 8 unexpected deaths in January which is a decrease on the 17 recorded in December. The Patient Safety Team is monitoring the overall trend for any particular patterns, which are monitored and discussed by the Patient Safety Group. Of the 8 unexpected deaths the details below shows a breakdown by locality:• 4 x North Yorkshire• 2 x Teesside• 1 x Durham and Darlington• 1 x YorkOf the unexpected deaths that occurred in January, 6 occurred in AMH, 1 in MHSOP and 1 in CYP.

Trust Dashboard Graphs for TRUST

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

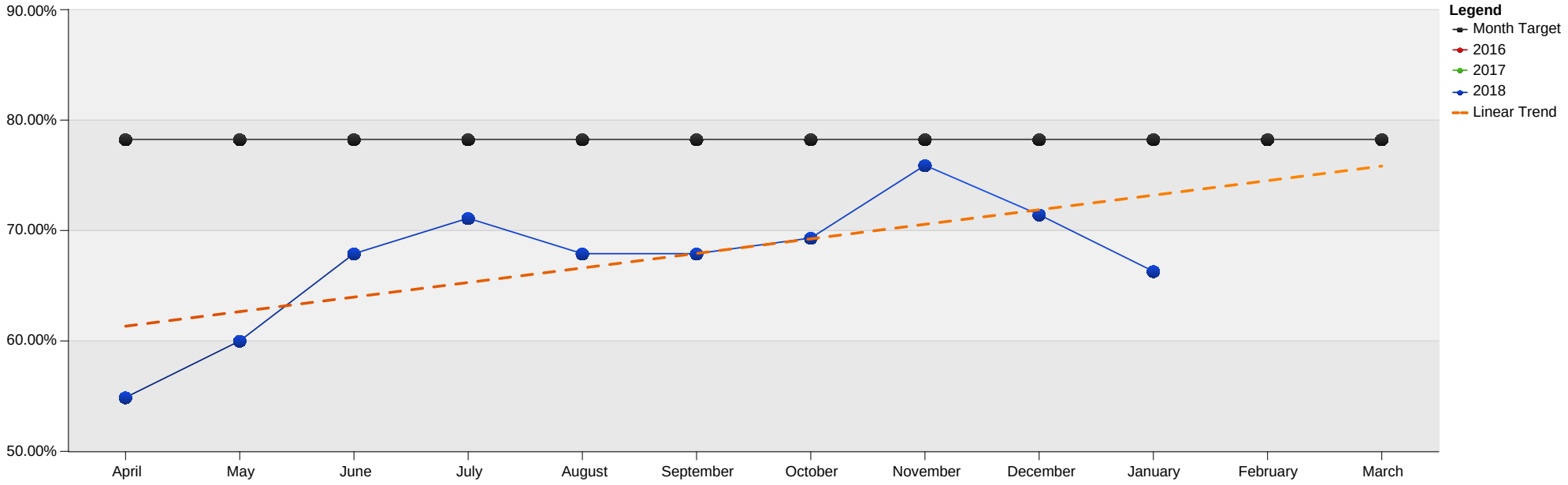


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	66.67%	58.33%	69.70%	53.52%	67.86%	61.96%	56.52%	60.78%			75.00%	56.60%		

Narrative
The Trust position for January 2019 is 66.67%, which is worse than the target of 67.25% however an improvement on the position reported in December 2018.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.The only locality below target is North Yorkshire at 56.52%.Work continues with the services to improve understanding and support increased ownership. Improved information has been supplied for consideration at huddles including both OMT and EMT from January 2018. A paper has been presented to the Trust's Clinical Leaders about the current position on outcomes. Work being taken forward is the establishment of a Trust-wide - all speciality clinical outcomes - steering group and the monitoring of outcome measures monthly via OMT.

Trust Dashboard Graphs for TRUST

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

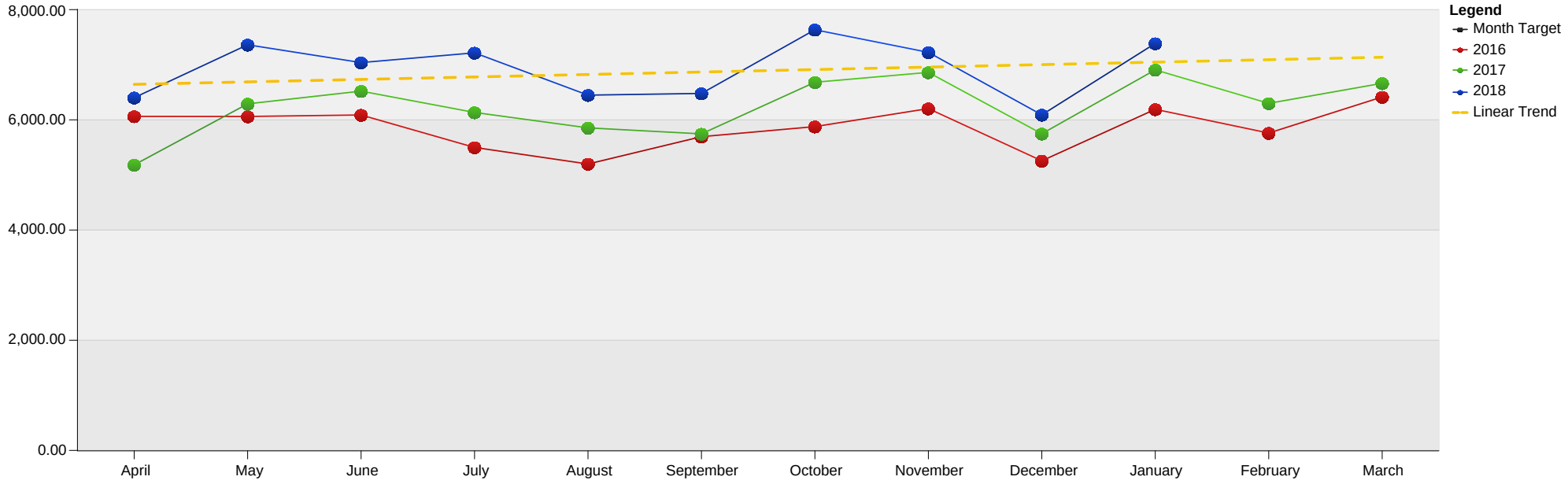


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	66.30%	67.37%	75.00%	65.56%	59.26%	66.80%	77.27%	73.33%			36.36%	58.95%		

Narrative
The Trust position for January 2019 is 66.30%, which is worse than the target of 78.25% and a continued deterioration on the position reported in December 2018.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.Work continues with the services to improve understanding and support increased ownership. Improved information has been supplied for consideration at huddles including both OMT and EMT from January 2018. A paper has been presented to the Trust's Clinical Leaders about the current position on outcomes. Work being taken forward is the establishment of a Trust-wide - all speciality clinical outcomes - steering group and the monitoring of outcome measures monthly via OMT.

Trust Dashboard Graphs for TRUST

8) Number of new unique patients referred

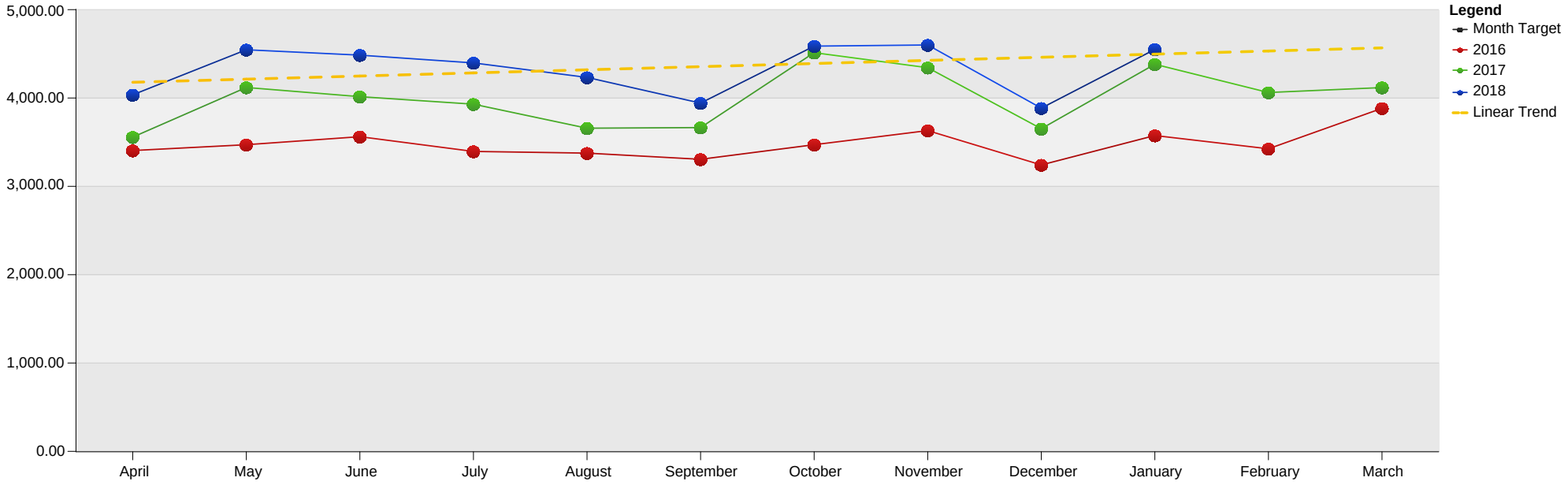


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Number of new unique patients referred	7,387.00	69,283.00	2,280.00	21,352.00	2,678.00	24,254.00	1,160.00	11,618.00	417.00	4,158.00	851.00	7,888.00		

Narrative
The Trust position for January 2019 is 7,387 which is an increase on the position reported for December 2018. This follows the trend in previous years, however the data shows that 2018/19 is higher than the previous two years. This indicator will be monitored for the remainder of this financial year and will be reviewed for the 19/20 Trust Dashboard. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be monitored by EMT as well as the data being reviewed by localities.

Trust Dashboard Graphs for TRUST

9) The number of new unique patients referred with an assessment completed

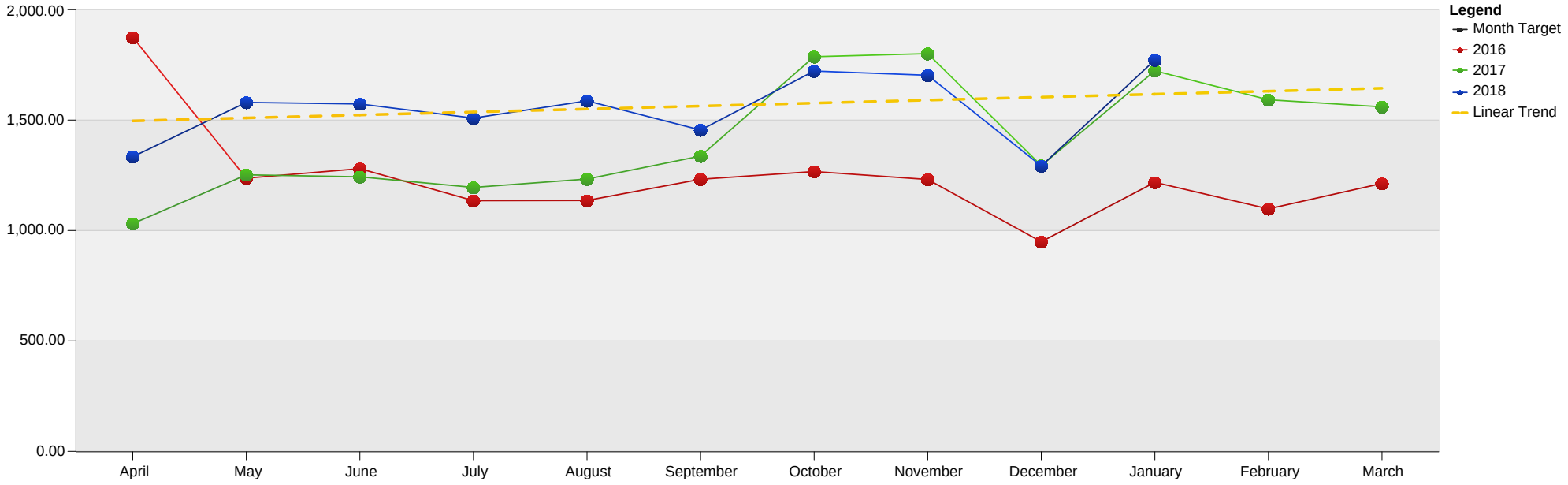


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The number of new unique patients referred with an assessment completed	4,550.00	43,261.00	1,402.00	13,133.00	1,583.00	15,331.00	769.00	7,030.00	304.00	3,052.00	492.00	4,715.00		

Narrative
The Trust position for January 2019 is 4,550 which is an increase on the position reported for December 2018. This follows the trend in the previous years, however the data shows that 2018/19 is higher than the previous two years. This indicator will be monitored for the remainder of this financial year and will be reviewed for the 19/20 Trust Dashboard. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be monitored by EMT as well as the data being reviewed by localities.

Trust Dashboard Graphs for TRUST

10) Number of new unique patients referred and taken on for treatment

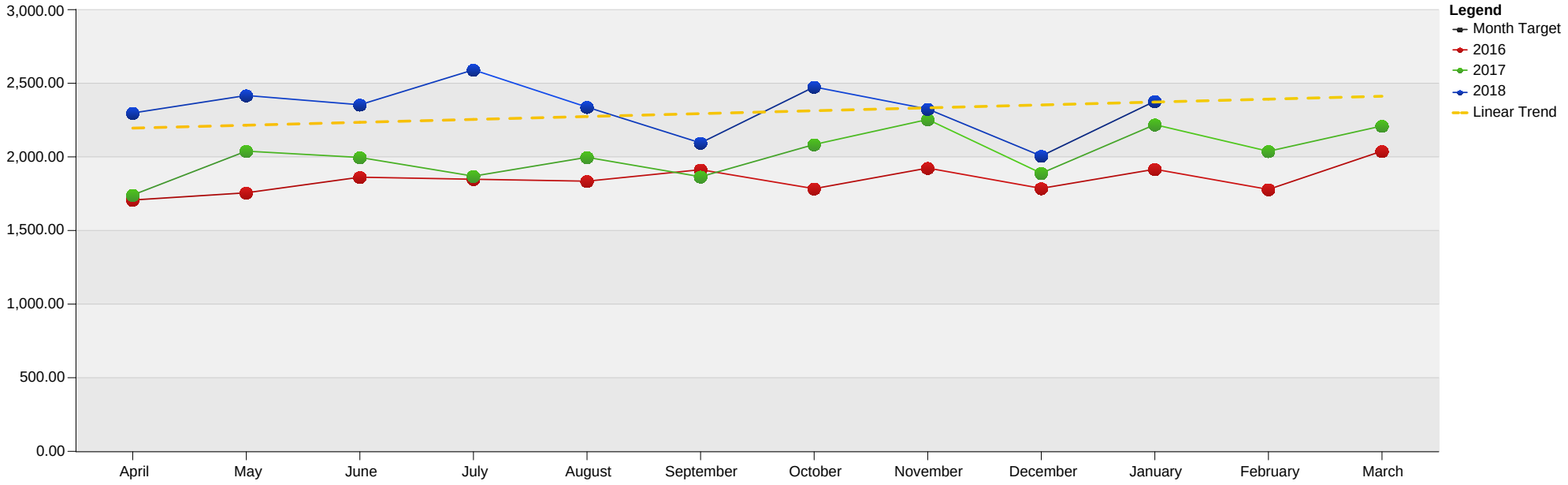


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Number of new unique patients referred and taken on for treatment	1,772.00	15,527.00	584.00	4,787.00	600.00	5,518.00	346.00	3,082.00	30.00	282.00	204.00	1,791.00		

Narrative
The Trust position for January 2019 is 1,772 which is an increase on the position reported for December 2018. This indicator will be monitored for the remainder of this financial year and will be reviewed for the 19/20 Trust Dashboard. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be monitored by EMT as well as the data being reviewed by localities.

Trust Dashboard Graphs for TRUST

11) Number unique patients referred who received treatment and were discharged

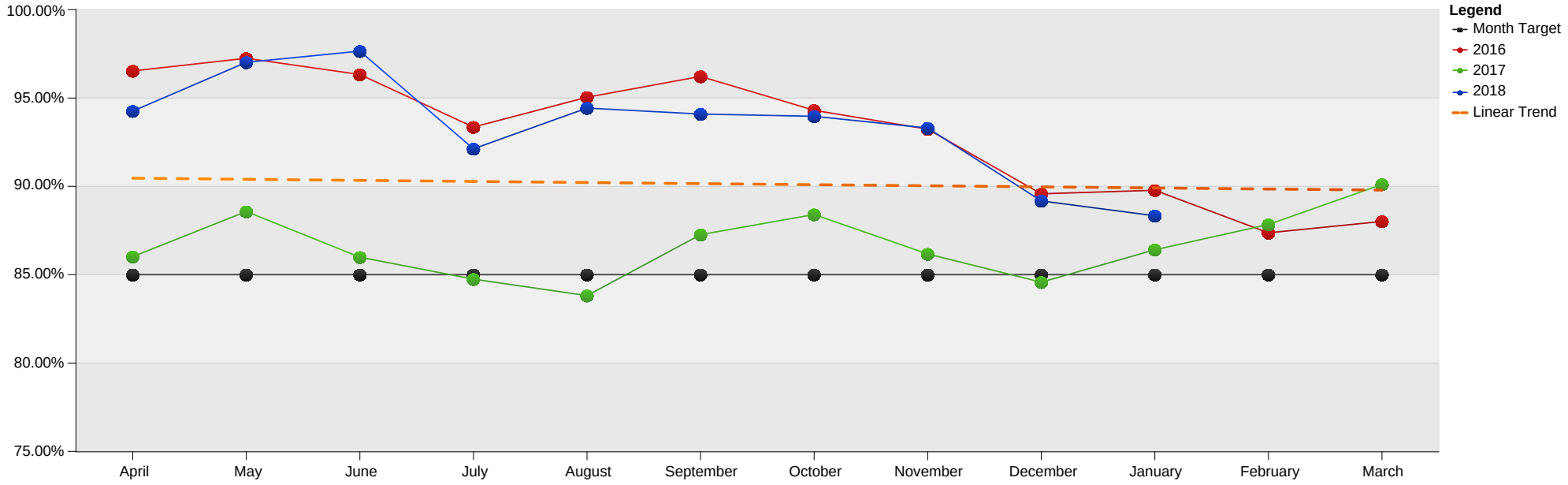


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number unique patients referred who received treatment and were discharged	2,378.00	23,277.00	701.00	6,766.00	843.00	8,225.00	497.00	4,791.00	32.00	422.00	305.00	3,072.00		

Narrative
The Trust position for January 2019 is 2,378 which is an improvement on the position reported for December 2018. This indicator will be monitored for the remainder of this financial year and will be reviewed for the 19/20 Trust dashboard. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be monitored by EMT as well as the data being reviewed by localities.

Trust Dashboard Graphs for TRUST

12) Percentage of bed occupancy

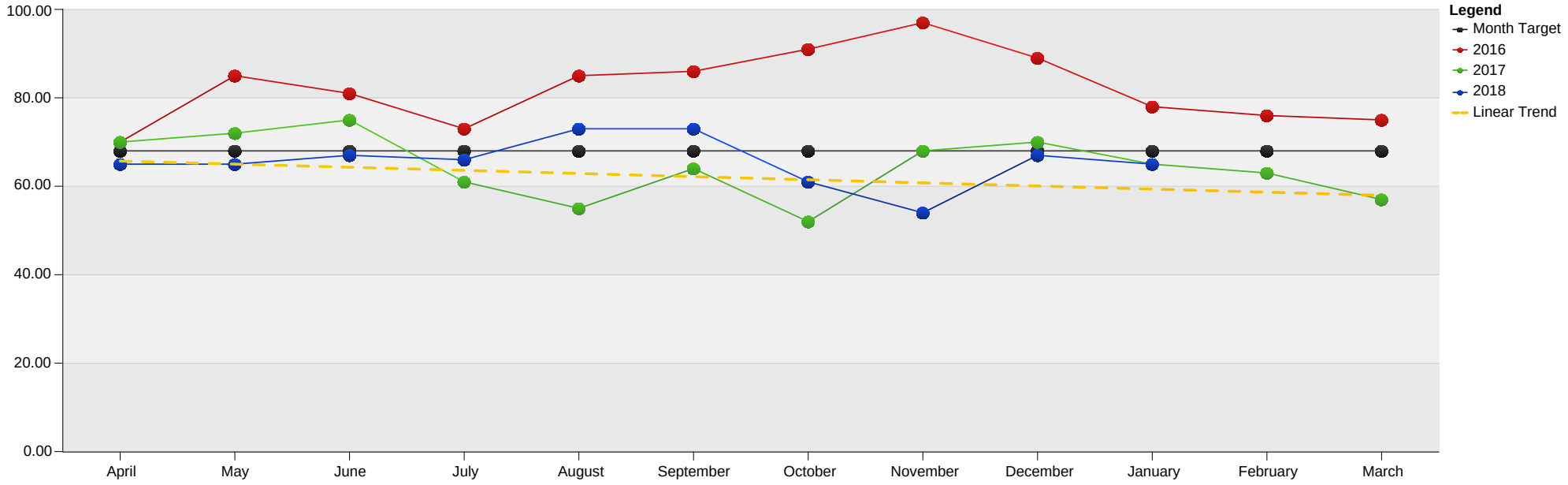


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	88.33%	93.41%	90.61%	92.06%	94.73%	101.03%	81.55%	91.08%	NA	NA	84.29%	88.48%		

Narrative
The Trust position for January 2019 is 88.83% which is worse than target however an improvement to the position reported in December 2018 and the lowest bed occupancy reported in the year to date.Tees are reporting the highest bed occupancy at 94.73%.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) which are also both performing positively in January 2019. Within AMH issues are around short stay admissions and readmissions are under review to ensure appropriate. 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)

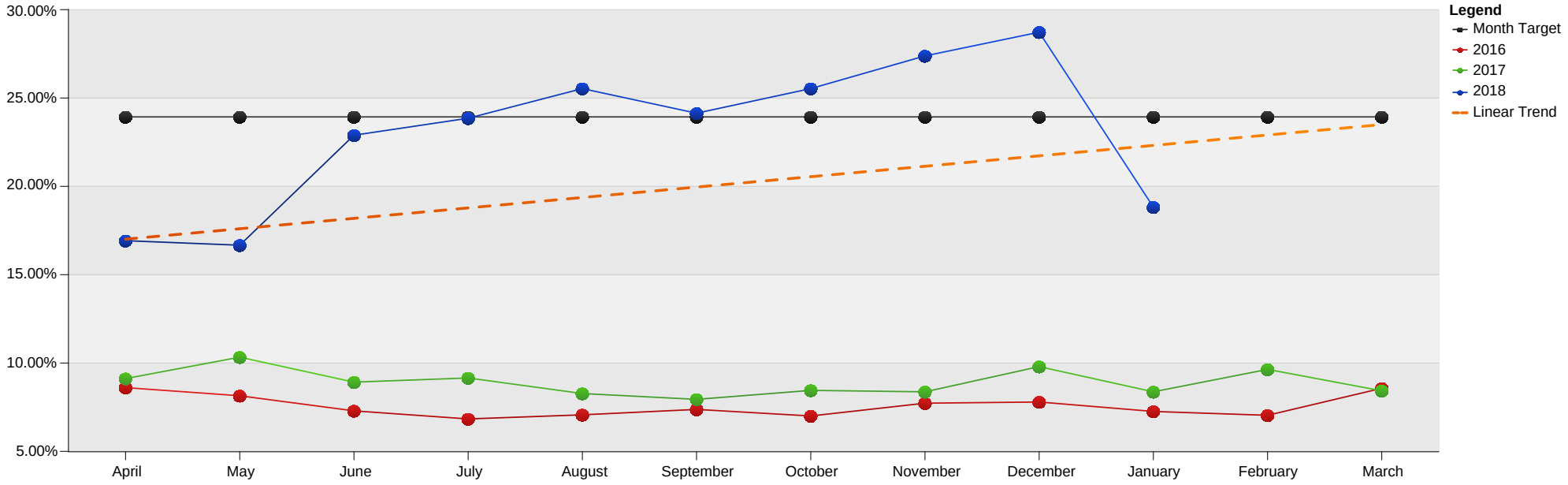


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	65.00	65.00	14.00	14.00	12.00	12.00	20.00	20.00			18.00	18.00		

Narrative
The Trust position for January 2019 is 65 which is meeting the target of 68 and is a similar position to that achieved in December 2018. North Yorkshire report the highest number with 20 patients with a length of stay over 90 days (14 AMH and 6 MHSOP).In North Yorkshire there are issues around patients awaiting placements fort suitable housing and support to meet their needs. The service has weekly calls with NYCC to monitor progress and regular discussions in ward report out and team huddles has led to reduction in length of stay over 90 days. A number of complex patients requiring a longer length of stay that was appropriate to patient need also continue to impact on the metric.

Trust Dashboard Graphs for TRUST

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

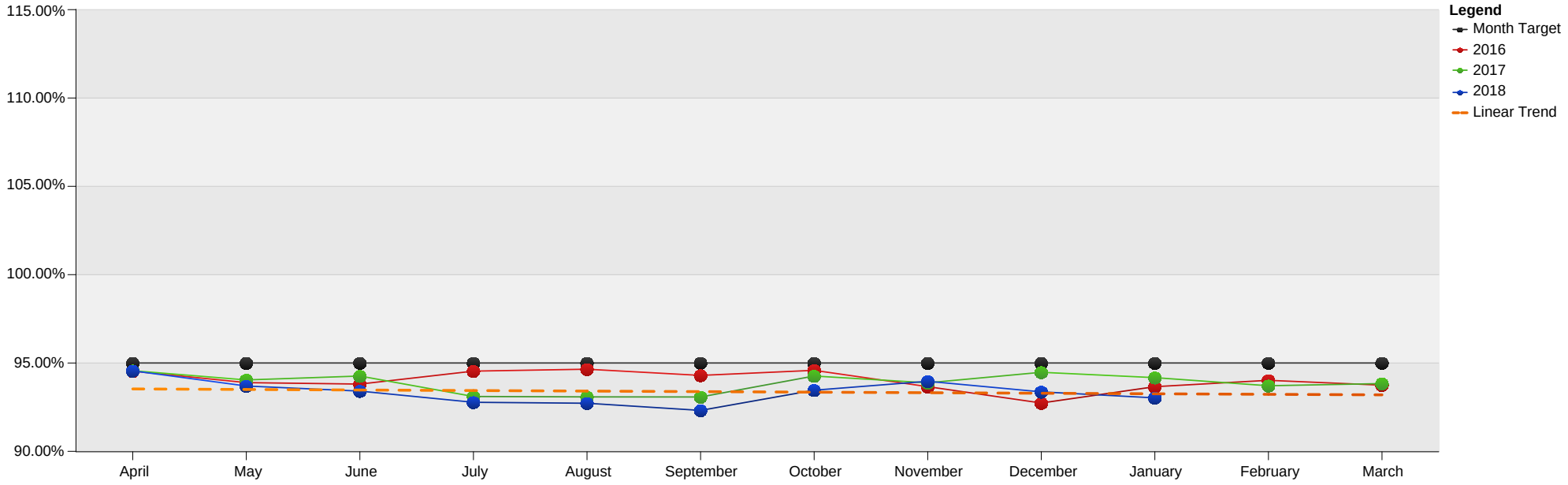


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	18.82%	23.28%	14.81%	21.48%	16.67%	23.55%	31.25%	25.32%			16.67%	22.76%		

Narrative
The Trust position ending January 2019 is 18.82%, which relates to 16 admissions out of 85 that were readmissions within 30 days. This is meeting the target of 23.93% and shows an improvement on the position reported in December 2018.North Yorkshire are worse than target with a position of 31.25%. Those patients that were readmitted within 30 days in January had appropriate discharge plans in place but were complex patients and readmissions were clinically appropriate with some being formal readmissions.

Trust Dashboard Graphs for TRUST

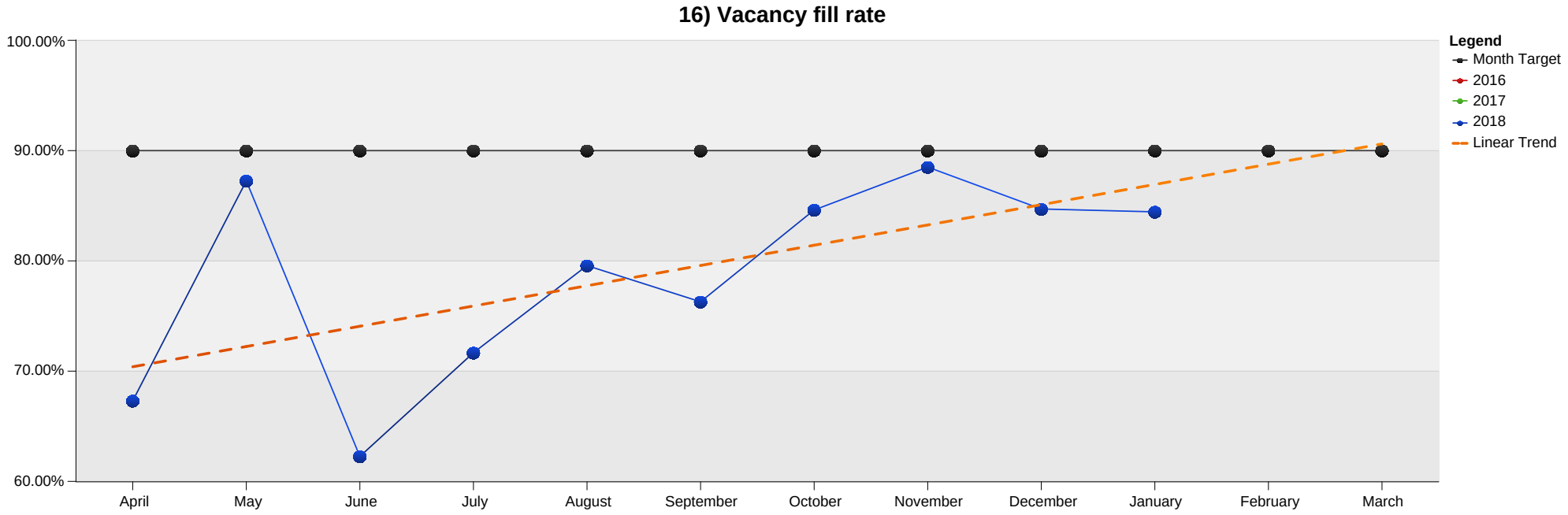
15) Actual number of workforce in month (Establishment 95%-100%)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Actual number of workforce in month (Establishment 95%-100%)	93.03%	93.03%	93.48%	93.48%	99.91%	99.91%	91.29%	91.29%	91.91%	91.91%	86.68%	86.68%		

Narrative
The Trust position for 31 January 2019 is 93.03% which is marginally worse than the targeted establishment level of 95-100%. It is expected that the establishment rate will continue to improve due to staff taking up post after completion of training and further recruitment events that will take place during 2019.

Trust Dashboard Graphs for TRUST

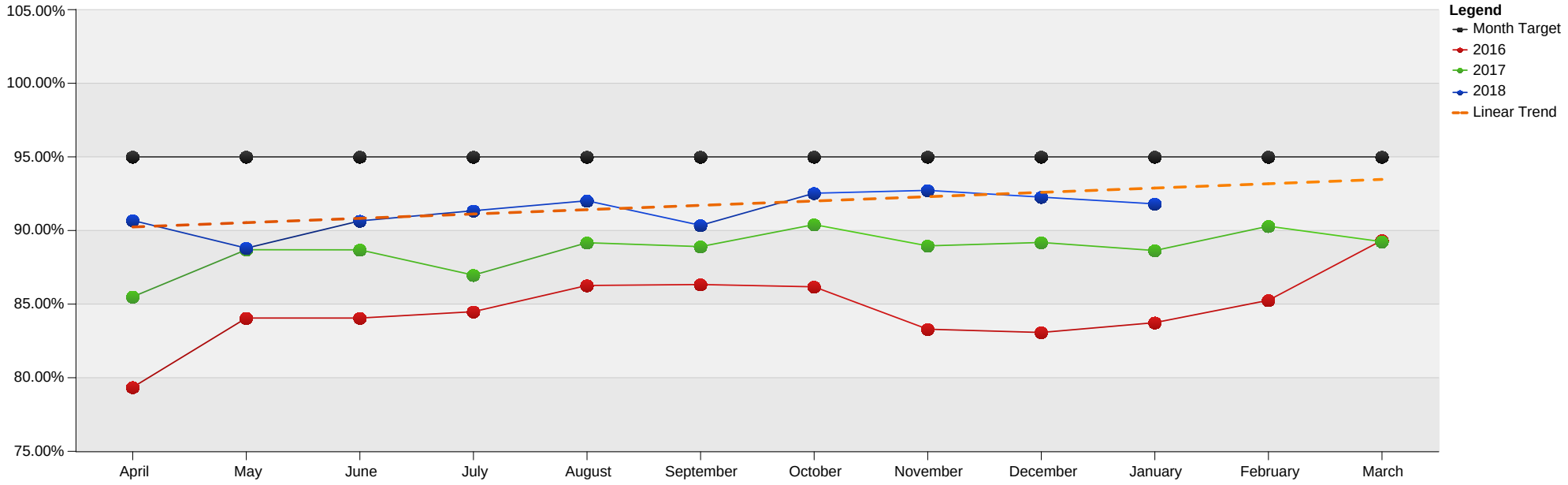


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Vacancy fill rate	84.44%	80.10%	83.33%	82.67%	70.59%	84.18%	82.14%	70.67%	100.00%	88.89%	100.00%	78.79%		

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 January 2019 is comparable to the previous month at 84.44%. This figure is better than the target of 90%. This figure represents 76 vacancies with a conditional offer made out of 90.

Trust Dashboard Graphs for TRUST

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

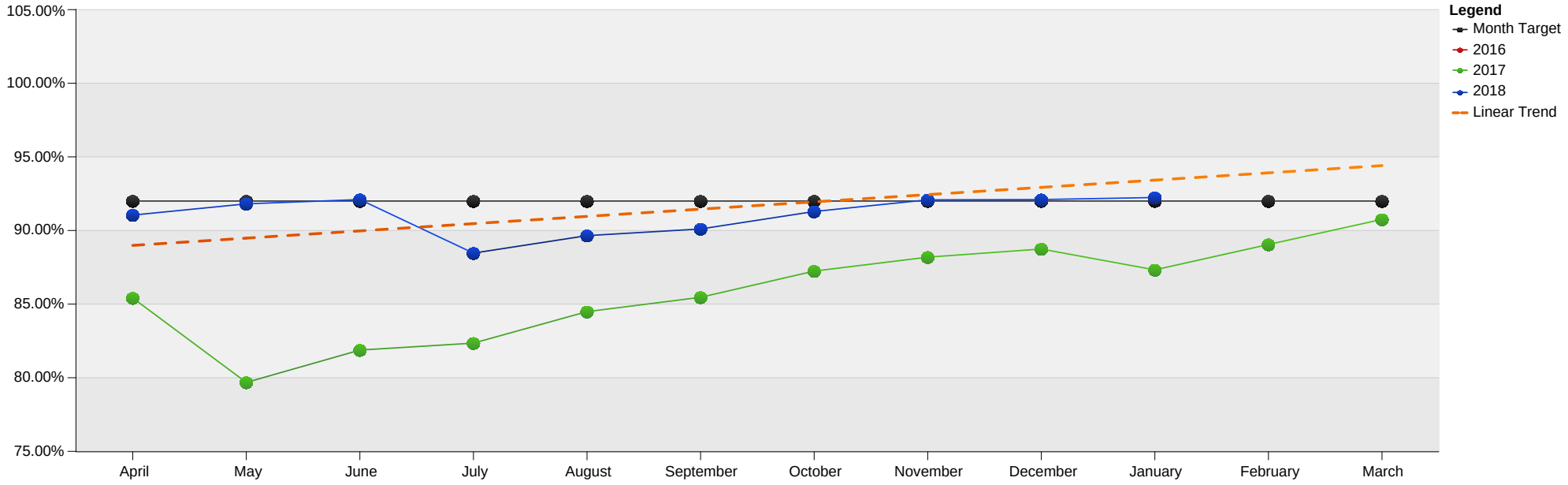


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	91.81%	91.81%	93.83%	93.83%	93.12%	93.12%	86.41%	86.41%	94.54%	94.54%	89.20%	89.20%		

Narrative
The Trust position for January 2019 is worse than target at 91.81% which relates to 476 members of staff out of 5810 that do not have a current appraisal. This represents a continued deterioration since November 2018.All localities are below target with North Yorkshire reporting the lowest position at 86.41%. The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels, However issues such as vacancies and sickness, referred to earlier in the report, impact on the ability to deliver appraisals.

Trust Dashboard Graphs for TRUST

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

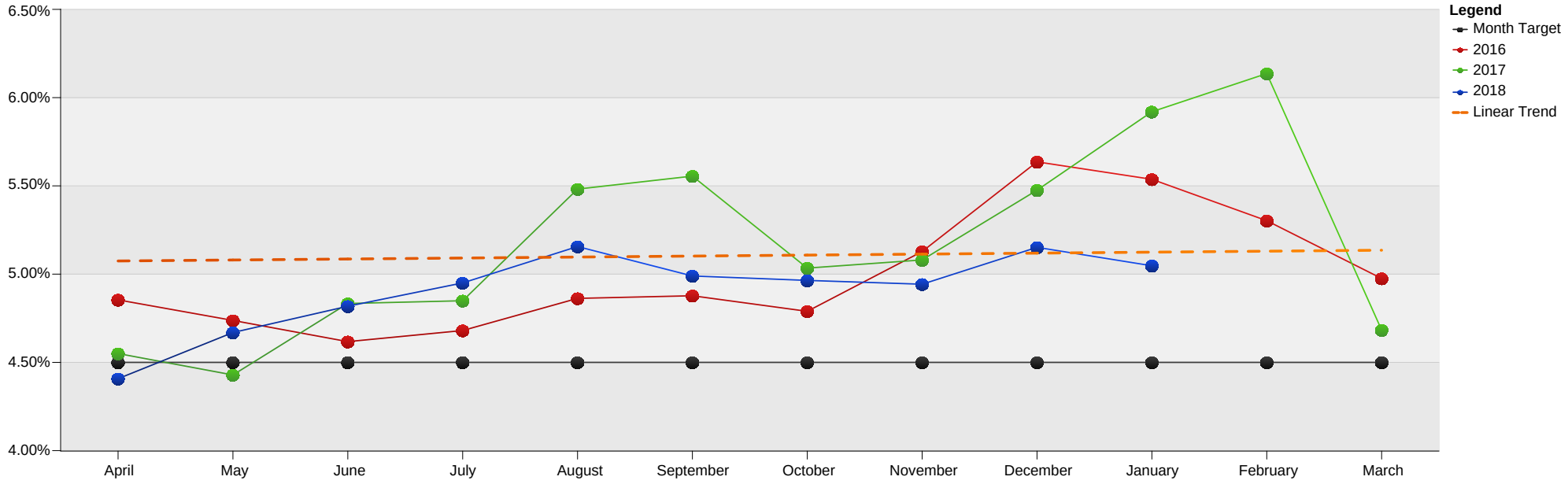


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.24%	92.24%	90.87%	90.87%	93.32%	93.32%	88.53%	88.53%	95.11%	95.11%	92.38%	92.38%		

Narrative
The position for January 2019 is consistent with December 2018, increasing slightly to 92.24% from 92.11% and is better than target for the third time since June 2018The 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)

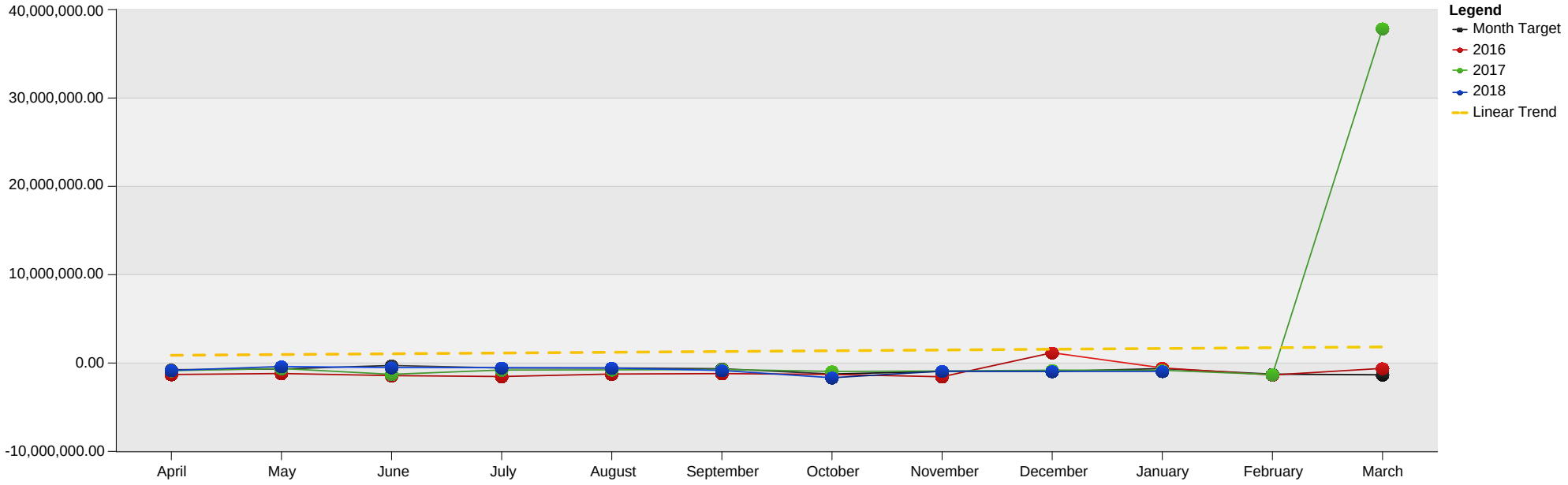


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Percentage Sickness Absence Rate (month behind)	5.05%	4.91%	5.59%	5.48%	5.00%	4.51%	3.70%	4.29%	6.24%	6.24%	5.26%	4.74%		

Narrative
The Trust position reported in January 2019 relates to the December 2018 sickness level. The Trust position reported in January 2019 increased to 5.05% which is worse than the target of 4.50%. A review of the approach to managing sickness absence has recently been concluded with a revised procedure being considered by JCC on 15th February 2019. The agreement was to forward to the Business Disability Forum for their views on the procedure. 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

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

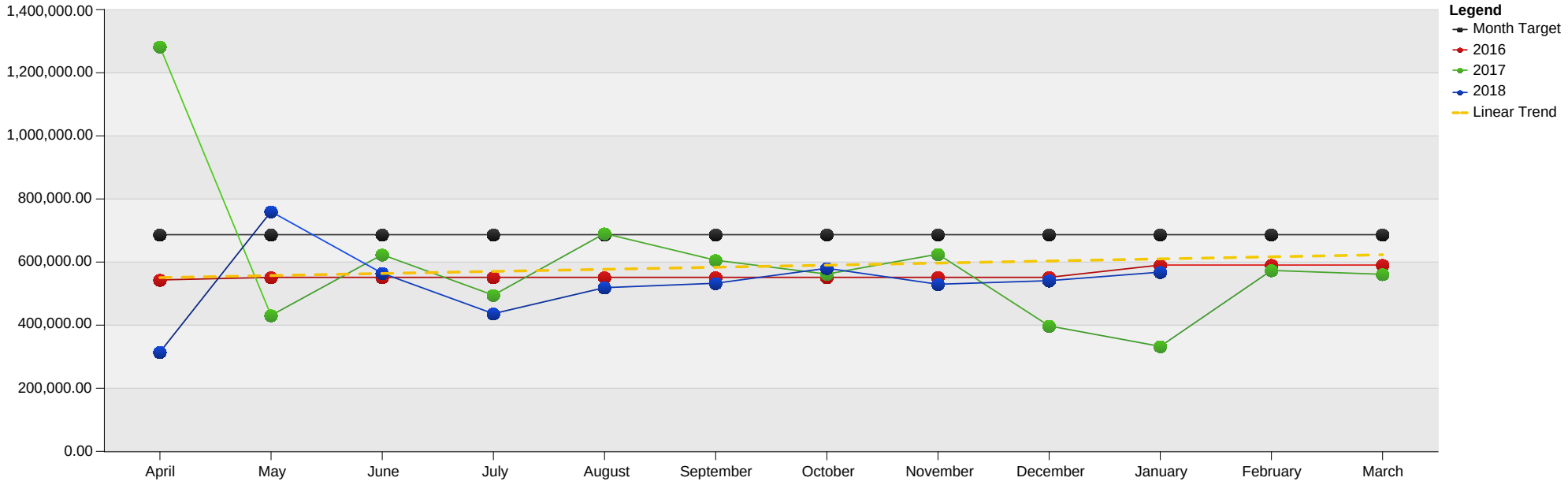


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) Delivery of our financial plan (I and E)	-945,064.00	-8,184,055.00	102,726.00	64,411.00	-66,170.00	1,660,978.00	-299,925.00	566,282.00	255,306.00	1,226,619.00	29,038.00	208,047.00		

Narrative
The comprehensive income outturn for the period ending 31 January 2019 is a surplus of £8,184k, representing 2.8% of the Trust's turnover and is £922k ahead of plan

Trust Dashboard Graphs for TRUST

21) CRES delivery

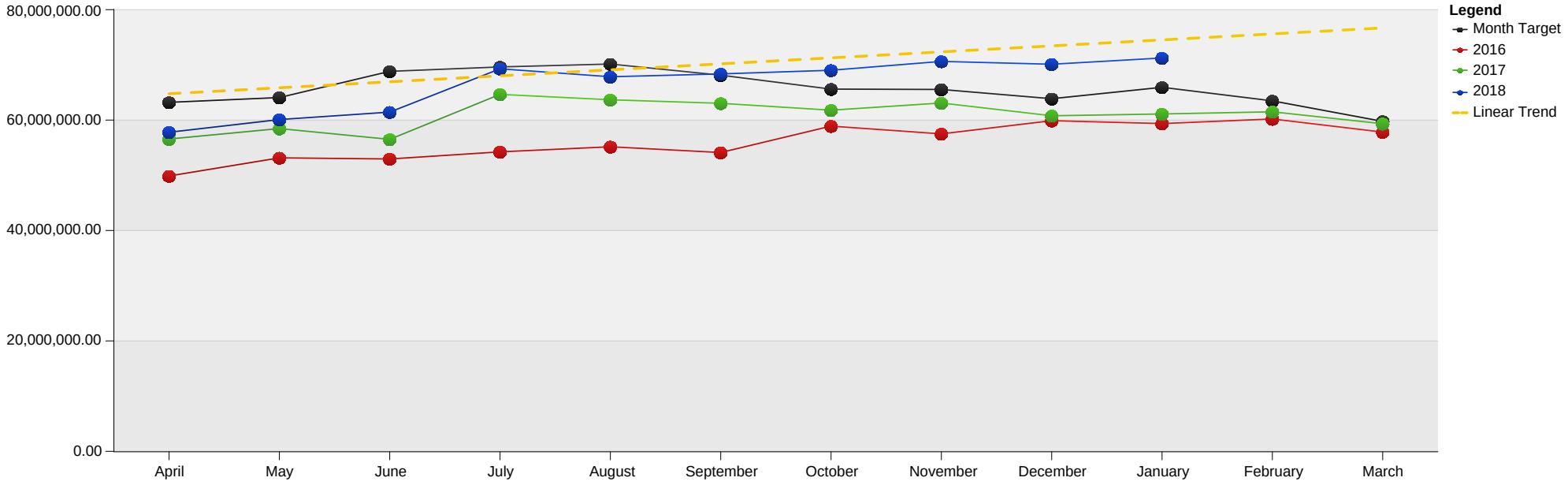


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) CRES delivery	568,012.00	5,345,444.00	49,405.00	816,560.00	69,263.00	457,033.00	34,164.00	165,467.00	45,546.00	210,044.00	78,293.00	782,930.00		

Narrative
Identified Cash Releasing Efficiency Savings at 31 January 2019 is £5,345k and is £1,523k 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 10 (£1,391k). As a result year to date CRES is £132k 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

22) Cash against plan



	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	71,246,000.00	71,246,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
Total cash at 31 January 2019 is £71,246k, and is £5,309k higher than planned, largely due to working capital variations.

Trust Dashboard - Locality Breakdown for TRUST

1 - Quality

	January 2019														April 2018 To January 2019											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral		83.43%		79.87%		90.09%		72.84%		99.62%		75.52%				86.73%		85.75%		91.67%		75.43%		99.51%		80.75%		
2) Percentage of patients starting treatment within 6 weeks of an external referral		47.10%		43.17%		57.66%		34.37%		85.71%		42.24%				54.82%		52.83%		63.03%		44.96%		90.70%		46.16%		
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)		1,291.00		156.00		440.00		557.00				134.00				1,291.00		156.00		440.00		557.00				134.00		
4) Percentage of patients surveyed reporting their overall experience as excellent or good		91.67%		92.01%		93.00%		93.09%		94.26%		84.50%				91.31%		92.58%		92.36%		92.06%		82.34%		88.92%		
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated		1.44		0.42		1.32		4.26		0.00		1.43				18.91		15.83		14.31		24.42		800.00		20.29		
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind		66.67%		69.70%		67.86%		56.52%				75.00%				58.33%		53.52%		61.96%		60.78%				56.60%		
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind		66.30%		75.00%		59.26%		77.27%				36.36%				67.37%		65.56%		66.80%		73.33%				58.95%		

Trust Dashboard - Locality Breakdown for TRUST

2 - Activity

	January 2019														April 2018 To January 2019											
	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
8) Number of new unique patients referred		7,387.00		2,280.00		2,678.00		1,160.00		417.00		851.00				69,283.00		21,352.00		24,254.00		11,618.00		4,158.00		7,888.00		
9) The number of new unique patients referred with an assessment completed		4,550.00		1,402.00		1,583.00		769.00		304.00		492.00				43,261.00		13,133.00		15,331.00		7,030.00		3,052.00		4,715.00		
10) Number of new unique patients referred and taken on for treatment		1,772.00		584.00		600.00		346.00		30.00		204.00				15,527.00		4,787.00		5,518.00		3,082.00		282.00		1,791.00		
11) Number unique patients referred who received treatment and were discharged		2,378.00		701.00		843.00		497.00		32.00		305.00				23,277.00		6,766.00		8,225.00		4,791.00		422.00		3,072.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)		88.33%		90.61%		94.73%		81.55%	NA	NA		84.29%				93.41%		92.06%		101.03%		91.08%	NA	NA		88.48%		
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)		65.00		14.00		12.00		20.00				18.00				65.00		14.00		12.00		20.00				18.00		
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month		18.82%		14.81%		16.67%		31.25%				16.67%				23.28%		21.48%		23.55%		25.32%				22.76%		

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	January 2019														April 2018 To January 2019											
	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%)		93.03%		93.48%		99.91%		91.29%		91.91%		86.68%				93.03%		93.48%		99.91%		91.29%		91.91%		86.68%		
16) Vacancy fill rate		84.44%		83.33%		70.59%		82.14%		100.00%		100.00%				80.10%		82.67%		84.18%		70.67%		88.89%		78.79%		
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)		91.81%		93.83%		93.12%		86.41%		94.54%		89.20%				91.81%		93.83%		93.12%		86.41%		94.54%		89.20%		
18) Percentage compliance with ALL mandatory and statutory training (snapshot)		92.24%		90.87%		93.32%		88.53%		95.11%		92.38%				92.24%		90.87%		93.32%		88.53%		95.11%		92.38%		
19) Percentage Sickness Absence Rate (month behind)		5.05%		5.59%		5.00%		3.70%		6.24%		5.26%				4.91%		5.48%		4.51%		4.29%		6.24%		4.74%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	January 2019														April 2018 To January 2019											
	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)		-945,064.00	NA	102,726.00	NA	-66,170.00	NA	-299,925.00	NA	255,306.00	NA	29,038.00				-8,184,055.00	NA	64,411.00	NA	1,660,978.00	NA	566,282.00	NA	1,226,619.00	NA	208,047.00		
21) CRES delivery		568,012.00		49,405.00		69,263.00		34,164.00		45,546.00		78,293.00				5,345,444.00		816,560.00		457,033.00		165,467.00		210,044.00		782,930.00		
22) Cash against plan		71,246,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA				71,246,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Appendix B

Trust Dashboard 2018/19 KPI Guide

No.	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	60%	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)	2,347	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

Appendix B

Trust Dashboard 2018/19 KPI Guide

No.	KPI	Target	Definition
			transferred to a different In Scope team.
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	N/A	This measure relates to the number of new individual patients referred (so a patient is only counted once and not open to any other team in the Trust). This excludes IAPT patients.
9	The number of new unique patients referred with an assessment completed	N/A	This measure relates to the number of new unique patients with an assessment completed (and is a subset of measure 8).
10	Number of new unique patients referred and taken on for treatment	N/A	This measure relates to the number of new unique patients referred, assessed and then taken on for treatment (and is a subset of measure 9).
11	Number unique patients referred who received treatment and were discharged	N/A	This measure relates to the number of new unique patients referred who were taken on for treatment and then discharged.
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

Appendix B

Trust Dashboard 2018/19 KPI Guide

No.	KPI	Target	Definition
14	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	23.93%	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)	6,864,000	This shows the Trusts surplus or deficit position (£). The target is the planned surplus position.
21	CRES delivery	8,241,384	This shows the CRES Identified against the planned amount
22	Cash against plan	56,640	This shows the actual cash held by the Trust against the amount of cash forecasted to be held

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

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient					Number of unexpected deaths where the patient is an inpatient but the					Number of unexpected deaths where the patient was no longer					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death	1																				**1**
Natural causes					1																**1**
Hanging																					**0**
Suicides	9	2	8		1						1					6	2		1		**30**
Open					1													1	1		**3**
Drug related death		1																			**1**
Drowning																					**0**
Misadventure	1	1																			**2**
Awaiting verdict	12	11	9	6	9	1					2		3			3	6	1	1	3	**67**
Total	**23**	**15**	**17**	**6**	**12**	**1**	**0**	**0**	**0**	**0**	**3**	**0**	**3**	**0**	**0**	**9**	**8**	**2**	**3**	**3**	**105**

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	13	8	8	8	9	17	14		

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
36	23	22	9	15

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

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient and took place in the hospital					Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital					Number of unexpected deaths where the patient was no longer in service					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death			2															2			**4**
Natural causes	2																				**2**
Hanging																	1	1			**2**
Suicides	3	3	6	2	3						1					1		3		1	**23**
Open	1																				**1**
Drug related death	1	2										1				1					**5**
Drowning																					**0**
Misadventure																					**0**
Awaiting verdict	10	9	11	2	4	1	3									7	1	2	2	3	**55**
Total	**17**	**14**	**19**	**4**	**7**	**1**	**3**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**9**	**2**	**8**	**2**	**4**	**92**

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

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%**	

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:	**26th February 2019**
TITLE:	**Strategic Direction Performance Report – Quarter 3 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 3 (31st December 2018).

At the Board Meeting on the 19th July 2018, Board agreed to revise the KPIs for the Strategic Direction Scorecard. 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.

Whilst quarter 3 performance against the KPIs is of some concern with 10 out of 14 metrics being red, 7 metrics in total have reported an improvement on quarter 2. In addition, progress against the Business Plan and qualitative intelligence balances the position on the KPIs.

Recommendations:

Board of Directors is asked to:

- Receive this report and raise any questions/concerns.
- Approve the changes to the Trust Business Plan that require Board approval in Appendix 1.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**26th February 2019**
TITLE:	**Strategic Direction Performance Report – Quarter 3 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 3 (31st December 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 The Strategic Direction Scorecard is shown under each strategic goal with further detail, by exception, in Appendix 1. Proposed changes to the Business Plan, by exception, are detailed in Appendix 2.

3. KEY ISSUES:

3.1 <u>Trust Strategic Direction Scorecard</u>

The Strategic Direction Scorecard is shown under each strategic goal with further detail, by exception, in Appendix 1.

The following table provides a summary of the RAG ratings at quarter 3 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 remained the same as quarter 2, although the percentage has decreased as an additional 2 metrics have been reported, which are green. There remains a number (7) 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		Q3 2018/19	
	No.	%*	No.	%*	No	%*
Indicators rated green	3	25%	2	17%	4	29%
Indicators rated red	9	75%	10	83%	10	71%
Indicators rated	**12**		**12**		**14**	
Indicators with no target agreed						
Indicators currently under development/being finalised	9		9		7	
Indicators where data is not yet available or not applicable in qtr	1		1		1	
Metric will not be possible to report and we are identifying a further indicator	1		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 3; all three report better than in quarter 2.

TRUST STRATEGIC DIRECTION SCORECARD 2018/19									
	Indicator	Q2 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 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%	57.84%	⇧	67.25%	57.84%	44.00%	67.25%
2	Percentage of teams achieving the agreed improvement benchmarks for SWEMWBS	78.25%	67.90%	67.90%	71.43%	⇧	78.25%	71.43%	50.00%	78.25%
3	Number of patients who said we helped them achieve the goals they set	TBC	Metric currently under development			N/A	N/A	Metric currently under development	n/a	TBC
4	Percentage of carers that report feeling listened to and heard	76.20%	76.81%	75.75%	76.07%	⇧	76.20%	76.23%	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 as at December 2018 is 57.84% which relates to 59 out of 102 teams achieving the agreed improvement benchmarks for HoNOS total score. This is 9.41% below the target of 67.25%, but continues an improving trend on the previous quarters.

  York & Selby are the only locality to achieve target. Of note, is a significant drop in performance within Teesside. In quarters 1 and 2 that locality was the highest performing; however during quarter 3 it has been the lowest performing.

  A dedicated Performance Improvement Group was held in early December which focused specifically on Outcomes. A number of actions were agreed including the continuation of work with services to improve

understanding and support increased ownership within services and the provision of a key set of information to be reported at the various huddles including both OMT and EMT started in January. A paper has been drafted about the Trust's current position on outcomes with some recommendations and options of how we might take this forward across the Trust's services. This paper was discussed at the Clinical Leaders Board in January 2019 and a way forward was agreed.

- **KPI 2 Percentage of teams achieving the agreed improvement benchmarks for SWEMWBS** - the Trust position as at December 2018 is 71.43% which relates to 65 out of 91 teams achieving the agreed improvement benchmarks for SWEMWBS. This is 6.82% below the target of 78.25% but is better than the position reported for quarter 2.

  All localities are failing to achieve target.

  A dedicated Performance Improvement Group was held in early December which focused specifically on Outcomes. A number of actions were agreed including the continuation of work with services to improve understanding and support increased ownership within services and the provision of a key set of information to be reported at the various huddles including both OMT and EMT started in January. A paper has been drafted about the Trust's current position on outcomes with some recommendations and options of how we might take this forward across the Trust's services. This paper was discussed at the Clinical Leaders Board in January 2019 and a way forward was agreed.

- **KPI 4 - Percentage of carers that report feeling listened to and heard** – the Trust position for quarter 3 is 76.07% which relates to 445 carers out of 1901 carer survey responses received who stated they did not feel listened to. This is 0.13% below the target of 76.20% but is slightly better than the quarter 2 position reported of 75.75%.

  Localities reporting below target are:
  - North Yorkshire report 71.70% which is a deterioration on quarter 2 (76.79%), continuing a downward trend since quarter 1.
  - York & Selby report 75.91% which is an improvement on quarter 2 (72.25%)

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 3 were rated green 83% (54 out of 65) compared to 67% (34 out if 51) in quarter 2. 83% of the priorities under Strategic Goal 1 are reporting that there is no significant risk to the overall completion on time of the priority; this is an improvement in position compared to 37% in quarter 2. There are 6% of priorities that have a moderate risk of failure to deliver the final milestone or benefits on time.

However, there are 3 (10%) priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget:

- Priority 1.16.24 Tees Rehab Review – an EMT paper has been completed and is planned for submission to EMT for approval in January. The outcome of this will determine the next steps for the priority. As a result of this a request may be submitted for approval at Q4.
- Priority 1.16.36 Durham and Darlington Crisis House Provision – a paper detailing the service model proposal will be presented to the Tees DD MH & LD Partnership on 14th February; the outcome of this will determine the next steps and relevant actions will be included in the 19/20 Business Plan. Therefore Board are requested to remove the action and metrics (approved by EMT).
- Priorities 1.2.10 & 15 PPCS – two of the actions are being requested to be removed

There are 4 metrics for PPCS, CYP to AMH transitions, and Care Planning that require additional time, all were agreed by EMT as all requests are within the current financial year. There are 3 metrics that require Board approval to remove them from the business plan (as above) and a change to wording for 2 actions for the CYP to AMH transitions priority (1.17.2).

3.2.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- The **Integrated Support Unit on I Wing at HMP Durham** were honoured with an award from NEPACS (a north east charity which promotes a positive future for prisoners, offenders and their relatives) for providing a new approach to the management and therapeutic support of prisoners with mental health issues throughout the region's prisons. The service, provided by mental health clinicians from TEWV and prison officers, is one of the first units nationally to provide assessment and treatment to men deemed to have mental health problems, providing a therapeutic and safe environment to support recovery and well-being.
- **All age liaison and diversion service, Middlehaven police station**, Middlesbrough, have won the mental health and emergency services / criminal justice category of the Positive Practice in Mental Health Awards 2018.
- The **older person's functional community mental health team, Lustrum Vale**, Stockton has been recognised for the outstanding initiatives they have consistently put in place to improve patient care at the Positive Practice in Mental Health Awards 2018.
- The CQC has once again rated TEWV as ‘good’. The reports published by the CQC contain some really positive feedback about our services. The inspectors commented staff worked hard to provide quality care, with services meeting the needs of our service users. They thought staff displayed a positive attitude about their role, were motivated and skilled, and we have effective leadership and support in place. Staff and service users felt listened to and service users are treated with dignity and respect.

- In June this year the Trust was successful in its bids to provide **Trustwide perinatal services**. New services launched on 19 November 2018 in Durham and Darlington and launched in January 2019 in North Yorkshire. The services alongside our existing service in Teesside will provide support to women who are experiencing significant mental health difficulties and are considering pregnancy, those who are currently pregnant or are in the first year after having their baby.
- The **Integrated Support Unit on I Wing at HMP Durham** has been nominated for "Team of the Year" in the regional prison awards.
- NHS Harrogate and Rural District Clinical Commissioning Group (CCG) have approved proposals for the future development of mental health services for adults and older people. The agreed model will enable us to reinvest money in community services to focus on supporting people at home whenever possible. It will also ensure that when someone needs inpatient care they will receive it in a safe, high quality environment.
- Work has begun on the construction of the **new purpose-designed mental health hospital** off Haxby Road in York.
- The Executive Management Team has now signed off detailed plans for the transfer of adult and older people's inpatient services from the **Friarage Hospital** in Northallerton by the end of February 2019 (closing to admissions on 1 January 2019). This is in line with the outcome of the public consultation held in 2017.

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. At the Patient Experience Group in December is was agreed that this question would be reframed in the surveys to facilitate patient/carer understanding and will be addressed with the question *Did staff help you to achieve what was important to you?* There will be a phased implementation with the question being available in the Adult Mental Health and Forensic Mental Health surveys from 1 April, with the remaining services planned for 1 October.

3.2.5 In conclusion, whilst all 3 KPIs are under-performing there has been a clear improvement in comparison to quarter 2. There has also been improvement in terms of delivering the Business Plan with just 3 priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget. This together with significant qualitative intelligence creates a more positive 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 2; only 1 reports an improvement to that in quarter 2.

TRUST STRATEGIC DIRECTION SCORECARD 2018/19										
	Indicator	Q2 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 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%	80.04%	⇩	87.00%	81.50%	81.59%	87.00%
6	Percentage of patients who report feeling supported by staff to feel safe	65.20%	64.15%	64.62%	60.70%	⇩	65.20%	63.21%	65.63%	65.20%
7	Percentage of patients who report their overall experience as excellent or good	94.00%	90.82%	91.34%	91.75%	⇧	94.00%	91.30%	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 3 is 80.04% which relates to 371 staff patients out of 1859 reporting that they cannot contribute towards improvement at work. This is 6.96% below the target of 87.00% and is worse than the quarter 2 position reported of 82.88%.

  All localities are reporting below target:
  - Durham & Darlington report 78.94% which is an improvement on quarter 2 (76.50%).
  - Forensics report 80.41% which is a deterioration on quarter 2 (84.00%), continuing a downward trend since quarter 1.
  - North Yorkshire reporting 76.29% which is a deterioration on quarter 2 (81.50%).
  - Teesside report 84.78% which is consistent with quarter 2 (84.75%).
  - York & Selby reporting 76.97% which is a significant deterioration on quarter 2 (90.00%)

- **KPI 6 - Percentage of patients who report feeling supported by staff to feel safe** – the Trust position for quarter 3 is 60.70% which relates to 305 patients out of 776 patient survey responses who stated they did not always feel safe on our wards. This is 4.50% below the target of 65.20% and is worse than the quarter 2 position reported of 64.62%.

  Three localities are reporting below target:
  - Forensics report 56.43% which is a deterioration on quarter 2 (50.00%).
  - Teesside report 52.94% which is a deterioration on quarter 2 (57.53%), continuing a downward trend since quarter 1.

- York & Selby reporting 51.39% which is a significant deterioration on quarter 2 (70.42%), continuing a downward trend since 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. Forensic Services were only surveyed in one month out of three.

Locality	Reason	Number Responding	Total responses for locality
Durham & Darlington	**General non specific**	1	10
	Environment	1	
	Other Patients	5	
	Own illness	2	
	Staff/Staffing	1	
North Yorkshire	**General non specific**	0	4
	Environment	1	
	Other Patients	2	
	Own illness	1	
	Staff/Staffing	1	
Tees	**General non specific**	2	24
	Environment	3	
	Other Patients	12	
	Own illness	7	
	Staff/Staffing	2	
Forensics	**General non specific**	4	19
	Environment	1	
	Other Patients	10	
	Own illness	2	
	Staff/Staffing	4	
York & Selby	**General non specific**	3	10
	Environment	2	
	Other Patients	6	
	Own illness	2	
	Staff/Staffing	1	

- **KPI 7 - Percentage of patients who report their overall experience as excellent or good** – the Trust position for quarter 3 is 91.75% which relates to 421 patients out of 5106 patient survey responses report their overall experience other than excellent or good. This is 2.25% below the target of 94%, but continues an improving trend on the previous quarters.

  All localities are reporting below target, although both Durham & Darlington and Teesside are less than 1% below target:
  - Durham & Darlington report 93.28% which is an improvement on quarter 2 (92.35%).
  - Forensics report 82.20% which is a deterioration on quarter 2 (84.40%).
  - North Yorkshire reporting 91.63% which is a deterioration on quarter 2 (93.38%).
  - Teesside report 93.33% which is an improvement on quarter 2 (91.09%).
  - York & Selby reporting 90.02% which is a deterioration on quarter 2 (90.43%)

3.3.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 3 were rated green 88% which is an improvement compared to 83% in quarter 2. 80% of the priorities under Strategic Goal 2 are reporting that there is no significant risk to the overall completion on time of the priority compared to 60% in quarter 2.

There are no priority / service developments within strategic goal 2 in the Business Plan at high risk of failure to deliver on-time or within budget. There is 1 action "improve consistency & purposefulness of Inpatient care AMH" that requires removal of an action. There are 3 actions for the Right Staffing priority that require additional time, 1 was approved by EMT as it was in year and 2 require Board approval as they extend into the next financial year. A further action for the Preventable Deaths priority required an extension of timescales in year which was approved by EMT.

3.3.3 Other Qualitative Intelligence

In addition to the reported position the following point should be noted:

- The **mental health services for older people in Teesside** were hailed team of the year' in the quality improvement category of the Royal College of Psychiatry awards for their work to release time recording clinical activity resulting in increased face-to-face contact with patients.

3.3.4 In conclusion overall the position is of concern for Strategic Goal 2. Whilst 88% of business plan actions were rated green, all 3 metrics continue to report red with two showing a deterioration in quarter 3 when compared to quarter 2. In addition, qualitative intelligence for this metric has been limited in quarter 3.

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 2 indicators rated red as at quarter 3 out of a possible 2 that could be rated. Of those rated red, one has reported an improvement.

TRUST STRATEGIC DIRECTION SCORECARD 2018/19										
	Indicator	Q2 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 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%	10.34%	⇩	10.00%	10.77%	n/a	10.00%
9	Percentage rolling sickness absence rate	4.50%	4.82%	4.81%	4.82%	⇧	4.50%	0.51%	n/a	4.50%
10	Percentage staff recommending TEWV as a place to work	73.00%	71.00%	70.42%	No FFT During quarter 3	N/A	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	Baseline is due to be available in April 2019			N/A	N/A	Baseline is due to be available in April 2019	n/a	TBC

Indicators of concern are:

- **KPI 8 - Percentage rolling 12 month TEWV labour turnover rate** - Trust position for quarter 3 (as at December) is 10.34% which relates to 702 leavers out of 6789 total staff. This is 0.34% outside the target of 10% and is consistent with quarter 2.

  The Recruitment and Retention Workstream has developed a comprehensive action plan which identifies a range of actions that is expected will help the Trust to reduce labour turnover. A kaizen event was held in October which looked at implementing a proactive process for meeting with staff who are leaving the Trust as early as possible to increase the opportunity to retain them. A review of the Retire and Return scheme has been undertaken and changes to the scheme are due to be finalised at JCC on 15th January 2019. The revised scheme streamlines the process to hopefully make it easier for staff to return to continue working for the Trust. A revised flexible working procedure and an Internal Moves process have recently been developed and are in the process of being implemented both of which have the potential to improve the retention of staff who previously may have left the organisation.

- **KPI 9 - Percentage rolling sickness absence rate -** the Trust position for quarter 3 is 4.82% which relates to 88395 days lost to sickness out of 1835192 available working days for the Trust. This is 0.32% worse than the target of 4.50% and is consistent with quarter 2.

  The long term sickness team continues to support managers and staff experiencing episodes of long term absence. The team support over 200-250 staff at any one time. The team ensure timely referrals are made to Occupational Health and maintain regular contact with managers and staff to hopefully support staff back to work. A review of the approach to managing sickness absence is currently underway and is due to be considered by Joint Consultative Committee on 15th January 2019. Work is also underway to review the Occupational Health provision which is due for retendering in the next 12 months.

3.4.2 Trust Business Plan

The majority (75%) of the business plan actions due to be completed by the end of quarter 3 were rated green, which is an improvement of 67% in quarter 2. 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 1 of action within this priority requiring additional time for completion. As this is within the current financial year, the request has been approved by EMT. Additional actions for this Priority are being developed as part of the Business Plan 19/20 – 21/22.

3.4.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- **Hayley Hawksby**, clinical lead was commended by Nepacs for her work with men in the Separation and Care Unit within the prison who are experiencing mental health problems.
- **Rebecca Stainsby,** street triage clinician, Durham and Darlington, has been nominated for a WOW award by a police inspector for her exemplary efforts supporting police to safeguard a vulnerable male.
- **Jenny Trowsdale**, community nurse, eating disorder service, children's adolescent mental health services, The Glades, West Lane Hospital, Middlesbrough was awarded the Cavell Star Award which is given to nurses, midwifes and health care assistants who shine bright and show exceptional care to either their patients, patients' families or colleagues.
- **Deborah Jeffery**, advanced nurse practitioner, adult learning disability, Eastfield Clinic, Scarborough and **Lynne Taylor**, strategic health facilitator, North Yorkshire learning disabilities, Eastfield Clinic, Scarborough have been shortlisted in the Great British Care Awards
- **Nikki Lonsdale**, trainee social worker in the Trust through the Think Ahead programme, has had a blog about her training experiences shared on the Department for Health and Social Care's Talk Health and Social Care workforce website.
- **Dr Thandar Win**, from Lustrum Vale in Stockton-on-Tees was named specialty doctor of the year in the Royal College of Psychiatry awards; her nominator commending her instrumental role in the Stockton memory service achieving the highest dementia diagnostic rates regionally and among the best nationally.
- **Stacey Daniels**, support worker, recovery and outcomes support team/secure outreach and transitions team, forensic services was awarded the Cavell Star Award which is given to nurses, midwifes and health care assistants who shine bright and show exceptional care to either their patients, patients' families or colleagues.
- **Kali Penfold**, team manager, HMP Holme House, Stockton and **Stacey Daniels**, community support worker, recovery and outcomes team, forensics have been awarded the Cavell Star Award which is given to nurses, midwifes

and health care assistants who shine bright and show exceptional care to either their patients, patients' families or colleagues.

- TEWV nurse consultant and clinical director for older people's mental health services, Durham and Darlington, **Sarah McGeorge** was nominated for the Excellence in Mental Health Care Award of the NHS70 Parliamentary Awards by Kevan Jones, MP for North Durham.
- Junior doctors have once again rated **TEWV** as the best NHS Trust in the North East, and fifth nationally, in the General Medical Council (GMC) National Training Survey. The Trust equally excelled in the GMC trainer survey which placed TEWV as the fourth best NHS Trust in the UK and the highest ranking organisation for trainer development.

3.4.4 Other point to note:

- **KPI 10 - Percentage staff recommending TEWV as a place to work** - the Friends & Family Test is not undertaken during quarter 3; however data released as part of the Staff Survey 2018 reports 63% of staff recommending the Trust as a place to work. This is 10% below the FFT target of 73% and the data indicates that only Forensics Locality is reporting above that target within the Staff Survey, with 74%.

- **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 3; the baseline is due to be available in April 2019. A group of staff from across the Trust are working on the design and delivery of a new multi-professional programme for supercells and the next level up based on the leadership and management development strategy. The aim of the programme is for delegates to understand how compassionate and collective leadership supports a recovery oriented service. The Director of Therapies and the Head of Organisational Development are co-ordinating 8 work streams building the content of the programme. The content will be aligned to the core skills that leaders and managers require. The programme will take place one day per month lasting five days in total. The first programme will be delivered April to October 2019, the second August 2019 to January 2020.

3.4.5 In conclusion, performance against this Strategic Goal is mainly positive. Whilst 2 metrics are reporting red 1 has improved compared to last quarter. Progress against the Business Plan and the amount 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 2 indicators rated red at quarter 3 out of a possible 3 that can be rated, with one of those showing an improvement.

TRUST STRATEGIC DIRECTION SCORECARD 2018/19										
	Indicator	Q2 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 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	58.82%	N/A	80%	65.00%	n/a	80%
13	Percentage of mental health and learning disability budget covered by a ring-fenced budget	85%	77.49%	77.49%	77.23%	⇩	85%	77.23%	n/a	85%
14	Percentage delayed transfers of care due to non Trust issues	3.5%	3.33%	3.38%	2.90%	⇧	3.5%	3.21%	n/a	3.50%
15	Percentage referrals received from GPs using the standard electronic referrals template relevant for the speciality	n/a	Metric Not Available			N/A	N/A	Metric Not Available	n/a	n/a

Indicators of concern are:

- **KPI 12 - Percentage joint bids with CCGs that are successful -** the Trust position for quarter 3 is 58.82% and relates to 8 of a potential 17 joint bids that were not successful during quarter 3. This is 21.18% below the target of 80%.

  The details of the bids submitted during the quarter are as follows:
  - CYP Trailblazer Bids – 3 bids. Unsuccessful; no feedback received.
  - CYP Waiting Lists – 1 bid. Partly successful; reduced amount awarded.
  - Winter Pressures – 13 bids. 9 successful; 4 outstanding.

- **KPI 13 - Percentage of mental health and learning disability budget covered by a ring-fenced budget** - the Trust position for quarter 3 is 77.23% and relates to £254,125,374 of the Mental Health and Learning Disability budget that is ring fenced out of £329,058,667. This is 7.77% below the target of 85% and is slightly worse than the position reported in quarter 2. This is attributable to an increase in the Trust Budget rather than a reduction in the ring fenced budget; that has remained the same.

3.5.2 Trust Business Plan

The majority of the business plan actions due to be completed by the end of quarter 3 were rated green 86% which is an improvement compared to quarter 2 73%. There were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget. 75% of priorities under Strategic Goal 4 are reporting that there is no significant risk to the completion on time of the priority.

There are 2 metrics for Collaborations with Universities requesting additional time (agreed by EMT as all within the current financial year). There is 1 request that requires Board approval for the Secure Services priority as this extends into the next financial year.

3.5.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- The Yorkshire and Humber forensic child and adolescent mental health service (FCAMHS) commissioned by NHS England and provided in partnership between South West Yorkshire Partnership NHS Foundation Trust, Humber Teaching NHS Foundation Trust, Sheffield Children's NHS Foundation Trust and **Tees, Esk and Wear Valleys NHS Foundation Trust,** has been launched. The service will work with young people who are engaged in dangerous, high risk behaviours, who have become, or are likely to become involved in criminal proceedings.
- **Durham liaison and diversion team**, part of an integrated service with the Durham youth offending team and co-commissioned health team have been shortlisted in the Improved Partnerships Between Health and Local Government category of the HSJ awards.
- The **FOCUS network** (Focussed On Collaborative Unmet need Solutions) is a partnership between TEWV urgent care staff, acute care and ambulance services, the police and the local authority, to address the needs of individuals who regularly present to urgent care services for support. Representatives from the crisis resolution and home treatment team, street triage and the Ayckbourn Unit in Scarborough, Whitby and Ryedale, including Lauren Dowson, team manager and Stephen Donaldson, highly specialist clinical psychologist, recently represented the Trust at the Royal College of Psychiatrist's national Home Treatment Accreditation Scheme (HTAS) conference in London showcasing the fantastic partnership work being undertaken by the FOCUS network.
- **TEWV** have won the Liaison & Diversion tenders in Durham, Darlington & Tees and North Yorkshire & York.

3.5.4 Other Points to Note

In addition to the reported position the following points should be noted:

- **KPI 15 – Percentage referrals received from GPs using the standard electronic referrals template relevant for the speciality** - this metric is not available. The Head of Information Services for IT and Systems is currently considering a possible alternative, which will come back to the Board in the appropriate quarterly report.

3.5.5 In conclusion performance against this strategic goal is encouraging. Whilst 2 metrics are reporting red, progress against the Business Plan and the amount of qualitative intelligence available to support this goal is strong.

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 3 indicators rated green out of a possible 3 that can be rated as at quarter 3. This is 1 extra than was reported at quarter 2, as data is now available for KPI 18 – All clinical teams to be able to access pathology results via PARIS and order test by PARIS.

TRUST STRATEGIC DIRECTION SCORECARD 2018/19

	Indicator	Q2 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 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	-£3,144,000.00	-1,760,435	-1,939,011	-3,539,545	⇧	-£6,630,000	-£7,238,991	n/a	-£6,864,000
17	Achieve an NHSI SOF rating of 1 *(reported one quarter behind)*	1	Not available	1	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	23.71%	N/A	0.00%	23.71%	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	Not Available for Quarter 3	N/A	N/A	Not Available to date	n/a	TBC
20	100% clinical pathways developed and in use within PARIS	100%	Not Available for Quarter 1	Not Available for Quarter 2	Not Available for Quarter 3	N/A	100%	Not Available to date	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	Not Available for Quarter 3	N/A	100%	Not Available to date	n/a	100%
22	Placeholder: E&D Strategy		Not Available for Quarter 1	Not Available for Quarter 2	Not Available for Quarter 3	N/A	N/A	Not Available to date	n/a	TBC
23	Placeholder: E&D Strategy		Not Available for Quarter 1	Not Available for Quarter 2	Not Available for Quarter 3	N/A	N/A	Not Available to date	n/a	TBC

There are no concerns for the indicators reported above.

3.6.2 Trust Business Plan

75% of actions have been delivered within quarter 3 which is a decrease from 100% at quarter 2. There is only one business plan priority assigned to Strategic Goal 5. This is to delivery our Digital Transformation Strategy which is currently reporting amber/green. There are 3 actions within this priority that request Board approval to remove them whilst 1 requires an extension of timescales.

3.6.3 Other points to note:

- **KPI 19 - All service users being able to access care plan online or digitally** – data is not available as yet. The plan is that Care Planning will be built in CITO and then patients will receive an electronic copy alongside a

Patient Portal where a patient can access the plan via an online shared portal. The plan is that MHSOP will be aiming to go live in Spring/Summer 2019.

- **KPI 20 - 100% clinical pathways developed and in use within PARIS** - data is not available as yet. Version 2.3 of CITO which will be delivered for testing January 2018 will include level one and two pathways. The plan is that the pilot teams for CITO will include this high level pathways functionality; MHSOP will be aiming to go live in Spring/Summer 2019.

- **KPI 21 - All Trust clinicians to have access to their key service/team/ patient information in near to real time** – Work has progressed at Advanced, but delays for the additional infrastructure have continued which have now been escalated multiple times with Advanced. TEWV have scheduled 3rd party resource (DOT Group) to facilitate the software configuration of this once the infrastructure is in place, which should help to mitigate the delay.

- **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. The target date for agreement of the revised Equality & Diversity Strategy and scorecard is June 2019.

3.6.4 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 remains encouraging, although there has been a deterioration compared to last quarter.

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:

Whilst quarter 3 performance against the KPIs is of some concern with 10 out of 14 metrics being red, 7 metrics in total have reported an improvement on quarter 2. In addition, progress against the Business Plan and qualitative intelligence balances the position on the KPIs.

The main concern with the Business Plan remains Strategic goal 1 and significant work is required to improve.

7. RECOMMENDATIONS:

Board of Directors is asked to:

- Receive this report and raise any questions/concerns.
- 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

Appendix – 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	Q3 Metric Status	Comment and requests for decisions
1.16.36	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - Crisis House Provision	Durham and Darlington	AMH	To commence implementation plan	Implementation plan and crisis house change completed	Q3 18/19	Fran Bergin	R	A paper detailing the service model proposal will be presented to the Tees DD MH LD Partnership on 14th February; the outcome of this will determine the next steps and relevant actions will be included in the 19/20 Business Plan. Therefore Board are requested to remove the action and metrics
4.8.8	Develop and Implement New Care Models - Secure Services	Forensic	Forensic (all)	Develop a Personality Disorder Pathway Framework	Framework developed and agreed	Q3 18/19	Amanda Whiteley	R	Progression of this action has slipped due to a focus on other actions and capacity to deliver these. Therefore Trust Board are requested to extend the timescale to Q2 19/20
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	CITO development has taken priority over this action and by default pathways are being reviewed to fit with CITO developments. This is commencing with MHSOP, followed by AMH for the next roll out. Therefore Board are requested to remove the action and metrics
1.2.15	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	COO	All	Test workforce profiling with 12 teams using C&T data and pathway review information	Workforce profiling tested with the 12 pilot teams and potential team configuration agreed	Q3 18/19	Dominic Gardner / SCDs / SDMs	R	This work will be picked up as part of the new PPS strategic priority. Therefore Board are requested to remove the action and metrics

Appendix 1

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
2.3.8	Improve the consistency and purposefulness of inpatient care across the Trust	COO	AMH	complete environmental review (taking local data and national best practice / policy into account)	environmental review completed	Q2 18/19	Shona Mcilrae	G	Environmental review complete and outcome presented at LMGB/QuAG
2.3.9	Improve the consistency and purposefulness of inpatient care across the Trust	COO	AMH	agree improvements to be made to existing AMH PIPA process	improvement plan agreed	Q2 18/19	Shona Mcilrae	G	Improvement Plan agreed at QUAG September 18.
2.3.15	Improve the consistency and purposefulness of inpatient care across the Trust	COO	AMH	Hold an RPIW focussing on the Home Based Treatment offer from Crisis & IHT Teams	Intensive Home Treatment RPIW held	Q3 18/19	Helen Embleton	R	Due to the initial commissioner review and the review of Urgent Care, this work has not be progressed. Therefore Trust Board are requested to approve the removal of this action.
2.4.2	Right Staffing/Workforce	Nursing and Governance	All	Evaluate establishments on PICU, Forensic and MHSOP wards	Evaluation of establishments complete	Q3 18/19	Joe Bergin	R	The national tools from NHSI are currently being reviewed, therefore are not available to undertake these reviews. Trust Board are requested to extend the timescale to Q2 19/20.
2.4.3	Right Staffing/Workforce	Nursing and Governance	All	Evidence-based staffing establishments: Delivery of proposed plan - Phase Two	Plan delivered	Q3 18/19	Joe Bergin	R	Most of the actions in Phase 2 of the plan have now been achieved; however there are exceptions where timescales have not been achieved due to the availability of the national evidence-based establishment tool which was meant to be released in November 2018. There are also actions related to clinical pathways that have also failed to achieve the timescale due to lack of availability of the tool. A change

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
									request to split this action into separate components will be presented Right Staffing Programme Board on the 18th January Trust Board are requested to extend the timescale to Q2 19/20.
1.17.1	Further Improve the clinical effectiveness and patient experience at times of transition from CYP to AMH services	Nursing and Governance	All	Complete audit and thematic review of patient stories	Audit and thematic review of patients stories completed	Q3 18/19	Jennifer Illingworth	R	There have only been three stories received in 9 months which is not enough to complete a thematic review; different approaches have been undertaken to increase the number of stories received, but potentially young people do not want to share their experiences with the Trust. Board are requested to change the action and metric to "Review patient stories and highlight key learning to C&YPS & Transition steering group by Q4 18/19".
1 17.2	Further Improve the clinical effectiveness and patient experience at times of transition from CYP to AMH services	Nursing and Governance	All	Implement actions from the thematic review of patient stories	Actions from thematic review implemented	Q3 18/19	Jennifer Illingworth	R	There have only been three stories received in 9 months which is not enough to complete a thematic review; different approaches have been undertaken to increase the number of stories received. Board are requested to change the action and metric to "Develop an action plan to implement key learning from patient stories by Q1 19/20".

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
5.5.1	Deliver our Digital Transformation Strategy	Information	All	Build a "core pathway framework"	Core pathway framework will be in use by pilot teams	Q3 18/19	Richard Yaldren	**GY**	This action has been superseded by the CITO development plan. MHSOP are actively working with Information to build CITO around their pathways. Other services will follow. A set of actions and timescales has been proposed in the draft Business Plan 2019/20 - 2021/22. Trust Board are recommended to remove this action from the Business Plan.
5.5.2	Deliver our Digital Transformation Strategy	Information	All	Build a dementia clinical pathway plug in for PARIS	Dementia clinical pathway plug in for PARIS will be in use by pilot teams	Q3 18/19	Richard Yaldren	**GY**	This action has been superseded by the CITO development plan. MHSOP are actively working with Information to build CITO around their pathways. CITO will be tested for these pathways during 19/20 Q1 and should be in full use by 19/20 Q3 for MHSOP. Trust Board are recommended to remove this action from the Business Plan
5.5.3	Deliver our Digital Transformation Strategy	Information	All	Build a psychosis digital pathway plug in for PARIS	Build a psychosis digital pathway plug will be in use by pilot teams	Q3 18/19	Richard Yaldren	**GY**	This action has been superseded by the CITO development plan. MHSOP are actively working with Information to build CITO around their pathways. Other services will follow. A set of actions and timescales has been proposed in the draft Business Plan 2019/20 - 2021/22. Trust Board are recommended to remove this action from the Business Plan.

Appendix 1

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
5.5.4	Deliver our Digital Transformation Strategy	Information	All	Develop a patient on-line portal for patients to access key information about their care	Patient on-line portal in use by service users in a pilot group	Q3 18/19	Richard Yaldren	R	Patient access is dependent upon CITO rollout and so cannot be piloted until 19/20 Q3. This will be included in the new Business Plan. Trust Board are recommended to allow this action to be moved to Q3 19/20.

Please note that if approved, future monitoring will be against the amended timescale.

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO.14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26 February 2019**
TITLE:	**Policies Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

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

Executive Summary:

The policy paper contains the following information:

- 2 policies that underwent full review and required ratification
  - CORP-0002-v6 Nicotine Management Policy
  - HR-0041-v3 Appraisal Policy for Doctors
- 1 policy that underwent minor amendment and required re-ratification
  - IPC-0001-v2.1 Infection Prevention and Control Policy
- 1 scoping document requesting authorisation to develop a new policy
  - Social Media Policy
- 1 policy that had the review date extended
  - CORP-0038 Interpreting and Translation Policy

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meetings held on 13 January 2019.

DATE:	**26 February 2019**
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-0002-v6 Nicotine Management Policy
Review date	13 February 2022
Description of change	The policy has undergone full review with the following amendments made: • Clarity on a possible exception to when staff are permitted to smoke • Maximum number of cigarettes allowed to be stored for patients • Updated information on the availability and use of e-cigarettes • Nicotine Overdose information

Ref and Title	HR-0041-v3 Appraisal Policy for Doctors
Review date	13 February 2019
Description of change	The policy has undergone full revision with minor amendments to wording.

3.2 The following has undergone minor amendment and requires re-ratification:

Ref and Title	IPC-0001-v2.1 Infection Prevention and Control Policy
Review date	13 February 2019
Description of change	Full review with minor amendments – hyperlinks and typos corrected.

3.3 A scoping document has been received requesting authorisation to develop the following new policy:

Title	Social Media Policy
Lead	Information Department and Communications Team
Description of requirement	There are a number of social media platforms/tools available which are not suitable for business/Trust purposes. This policy aims to clarify which platforms are acceptable, those that are not, and how to seek approval for new platforms. The policy also aims to build on current guidance and clarify what social media platforms can or can not be used for.

3.4 The following has had the review date extended:

Ref and Title	CORP-0038 Interpreting and Translation Policy
Review date	30 November 2019
Description	The Trust is in the process of tendering for a new provider which should be completed by the end of September – the policy will need to be reviewed then with the new provider details. The policy review date has been extended pending completion of the tendering process.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Sound policy development improves patient experience and enhances patient safety and clinical effectiveness.

4.2 Financial/Value for Money:

Any financial implications from the proposals arising from operational and/or practice changes will be managed by the Directorates responsible for policy implementation.

4.3 Legal and Constitutional (including the NHS Constitution):

The Trust requires a contemporary policy portfolio to ensure practice is compliant with legislation, regulation and best practice. The policy ratifications, review extensions and withdrawals will ensure the portfolio is managed to provide the necessary evidence based operational and practice frameworks.

4.4 Equality and Diversity:

The current policy portfolio ensures the Trust meets the required legislative and regulatory frameworks and all policies are impact assessed for any equality and diversity implications. Policy revision and /or specific implementation plans would result from any adverse impact assessments.

4.5 Other implications:

None identified

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meetings on 13 January 2019 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
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