AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 30TH APRIL 2019
VENUE: LAKE HOUSE, 20 MANOR COURT, SCARBOROUGH, YO11 3TU
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 **26th March 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 receive and note the annual report of the Guardian of Safe Working.	**Dr. Julian Whaley to attend**	**Attached**
Item 7	To receive and note the report of the Freedom to Speak Up Guardian.	**Dewi Williams to attend**	**Attached**
Item 8	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 9	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 10	To receive and note the report on Learning from Deaths.	**EM**	**Attached**
Item 11	To consider any matters of urgency arising from the meeting of the Mental Health Legislation Committee held on 24th April 2019.	**RS/EM**	**Verbal**

Performance (11.20 am)

Item 12	To consider the summary Finance Report as at 31st March 2019 and to approve the Quarter 4, 2018/19, submission to NHS Improvement.	**PM**	**Attached**
Item 13	To consider the Trust Performance Dashboard as at 31st March 2019.	**SP**	**Attached**

Governance (11.45 am)

Item 14	To consider a report on the Single Oversight Framework.	**PB/SP**	**Attached**

Items for Information (11.50 am)

Item 15	To receive and note a report on the use of the Trust Seal.	**CM**	**Attached**
Item 16	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 17 To note that the next meeting of the Board of Directors will be held on **Tuesday 21st May 2019** in the Boardroom, West Park Hospital, Darlington at 9.30 am.

Confidential Motion (11.55 am)

Item 18 **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 the financial or business affairs of any particular person (other than the Trust).

Information which, if published would, or be likely to, inhibit -
(a) the free and frank provision of advice, or

(b) the free and frank exchange of views for the purposes of deliberation, or

(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.

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

The meeting will adjourn for a refreshment break

Miriam Harte
Chairman
24th April 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 26TH MARCH 2019 IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Dr. H. Griffiths, Deputy Chairman
Mr. 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:
Ms. M. Harte, Chairman of the Trust (Designate)
Mr. M. Williams, Public Governor for Durham
Mr. A. Williams, Public Governor for Redcar and Cleveland
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Mr. A. Grundy, Member of the Public
Mr. A. Metcalfe, Middlesbrough Gazette

19/58 MINUTES

Agreed *– that the minutes of the last meeting held on 26th February 2019 be approved as a correct record and signed by the Chairman.*

19/59 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

Arising from the report:

(1) Further to minute 18/274 (30/10/18), Mrs. Moody advised that, although Dr. Paul Tiffin of York University remained keen to support the Trust understand variations in outcomes, and the reasons for them, he was still awaiting final approval of the related national research project.

Dr. Khouja undertook to discuss the matter with Prof. Reilly (Clinical Director for Research and Development) and to ask him to keep it under review.

Action: Dr. Khouja

(2) Further to minute 18/278 (30/10/18), the Board noted that the Director of Quality Governance was reviewing the agenda for LMGBs and QuAGs and developing new standard templates based on those used in the York and Selby Locality. These would be introduced once the outcome of the reviews had been agreed.

19/60 DECLARATIONS OF INTEREST

There were no declarations of interest.

19/61 CHAIRMAN'S REPORT

Mrs. Bessant reported on the final meeting of the present cohort of the Shadow Board held on 25th March 2019.

The Chairman advised that, at the meeting, the participants had further demonstrated strategic thinking across a range of issues and their growth during the programme had been evident.

It was noted that the participants had been awarded certificates by Mr. Martin at the conclusion of the meeting.

In response to a question on future arrangements, Mr. Martin advised that:
(1) Consideration was being given to how to continue to keep connected to the group in order to underline and build on their experiences during the programme.
(2) The Shadow Board programme had been very successful and plans were being made to develop a second cohort during the coming months.

19/62 GOVERNOR ISSUES

No issues were raised.

19/63 REPORT OF THE QUALITY ASSURANCE COMMITTEE

The Board received and noted the report of the Quality Assurance Committee including:
(1) The confirmed minutes of its meeting held on 7th February 2019 (Annex 1 to the report).
(2) The key issues considered by the Committee at its meeting held on 4th March 2019.

Dr. Griffiths, the Chairman of the Committee, drew attention to the following matters contained in the report:
(1) The approval of the Clinical Audit Programme 2019/20.

It was noted that the programme had subsequently been reviewed and endorsed by the Audit Committee.

(2) The discussions at the meeting on the reporting of medication incidents.

Dr. Griffiths explained that, although the Trust sought to encourage the reporting of medication incidents, the current metric included in the Quality Strategy Scorecard might unintentionally undermine this. Whilst the existing metric would remain, the Committee had also agreed to seek to increase reporting and reduce medication errors which caused harm.

Mrs Pickering, whilst understanding that the Committee was not seeking to amend the metric at this time, considered that it would be worthwhile to obtain historical data to inform discussions, if required, on this matter during the forthcoming refresh of the Quality Strategy.

To place the discussions in context, the Chairman highlighted that the majority of medication errors were minor and did not cause harm.

The Non-Executive Directors:

(1) Questioned, with reference to the minutes and taking into account previous discussions, whether committees were prompted to come to conclusions on the level of assurance provided to them.

In response it was noted that:

(a) The Committee had taken steps towards this matter by restructuring its agenda but there also needed to be a further review of reporting which would be considered in due course.
(b) Further to minute 19/59, the development of revised standard agenda for the LMGBs should support the provision of assurance to the QuAC and the Board.
(c) A session on assurance was due to be provided at the next meeting of the Quality Compliance Group.
(d) There were difficulties in framing the assurances provided to the Committee and the Board in view of the complexity and breadth of the issues.

(2) Sought clarity on the reference in the report that the Trust had not been included in the Darlington serious case reviews.

Mrs. Moody explained that, in usual circumstances, the Trust would be asked to contribute to serious case reviews, for example in the preparation of a multi-agency chronology of events; however, its involvement had not been indicated in the reported serious case review in Darlington.

19/64 NURSE STAFFING REPORT

The Board received and noted the exception report on nurse staffing for February 2019 as required to meet the commitments of “Hard Truths”, the Government’s response to the Public Inquiry into Mid Staffordshire NHS Foundation Trust (the “Francis Review”).

The report included an assurance statement that the Trust was meeting its requirements for safe staffing within the current legislative framework.

The focus of the discussions was on agency usage. On this matter:

(1) The Non-Executive Directors sought clarity on the level of confidence that the Trust would soon meet its cap on agency expenditure.

Mrs. Moody explained that a number of actions were in place to address agency usage including:

(a) The increase in recruitment campaigns for healthcare assistants in North Yorkshire.

It was noted that, although the campaigns had been successful, it would be a while before the new staff were in post.

(b) The merger of Acomb Garth and Meadowfields which would result in the service having a full complement of staff for the first time.

(c) The discussions on progressing zonal care including increases to the staffing establishment.

(d) The assessment of agency usage and the development of an action plan, under the Right Staffing Programme, which was due to be considered by the Executive Management Team on 27th March 2019.

It was noted that there were different reasons for agency demand but the key issue, to be taken forward through the proposed action plan, was to make more effective use of the temporary staffing service and recruitment to the bank.

(2) Mr. Jennings, the Chairman of the Audit Committee, highlighting discussions at recent meetings of the Committee, sought assurance on the controls in place to ensure that appropriate pre-employment checks were undertaken for shifts filled by 'off framework' agency providers.

Mr. Levy responded that only a few shifts were filled by 'off framework' agency providers and the Trust took a direct approach to gaining assurance from them that employment checks had been undertaken.

(3) In response to questions relating to Retinue it was noted that:

(a) The company was a neutral vendor; arranging staff from a number of agency providers.

(b) The Trust attempted to fill shifts through the bank, then agency and finally overtime.

(c) Typically, 88% of shifts were filled.

(d) In general, where shifts were unfilled, staff worked additional hours.

(e) Actions to reduce the number of unfilled shifts included increasing the bank; improving the management of the rosters; and advertising shifts earlier.

(f) Whilst not all shifts were being filled by the company, its performance was close to target; reasonable in the context of increasing demand; and compared well to others.

In addition, clarity was sought on whether the additional staffing requirements for Brambling Ward (the first ward within the secure perimeter to be moved as part of the

rectification works at Roseberry Park), to ensure lines of sight were maintained in its new facilities, would need to be replicated for other wards.

Dr. Khouja advised that the issue depended on the level of acuity and the establishments of other wards would need to be reviewed if the same issues arose. He undertook to discuss this matter with the Director of Operations for Forensic Services.

Action: Dr. Khouja

Mrs. Pickering reported that, at the Ridgeway Recovery Awards held on 20th March 2019, the staff had reported that the move had gone well and this had been supported by the work undertaken to involve patients and to develop collective ownership.

19/65 ANALYSIS OF WAITING TIMES

Further to minute 18/285 (30/10/18) the Board received and noted a report which provided an analysis of the Trust-wide position on the waiting times indicators contained in the Trust Dashboard.

Board Members welcomed the report.

The focus of the discussions was on the Trust's approach to understanding and implementing sustainable solutions to address waiting times.

The Chairman considered that, based on previous discussions on this issue, the Trust seemed to be constantly reacting to waiting times by putting in place measures, which proved only to be short-term in addressing the problems, and this was likely to continue until there was a holistic understanding of the reasons for them.

In response the Executive Directors recognised that the issues contributing to waiting times were multifaceted and highlighted:

(1) The importance of the Positive and Productive Services (PPS) programme in supporting changes to ways of working, including referral management and waiting times, to address those aspects which were within the Trust's control.

(2) The need to undertake further analysis of waiting times both between Localities and between teams within them to provide understanding of the variations and what could be achieved in terms of addressing waiting times and both internally and externally in relation to primary care. This was seen as critical to the work of the PPS programme.

(3) The importance of ensuring the right people were seen at the right time given the present conversion rate between people referred, assessed and treated.

In this regard the success of the pilot at the Harewood Medical Practice at Catterick Garrison in significantly reducing referrals was noted.

Mr. Martin observed that, as when discussed by the EMT, the consideration of the report had generated a broad range of issues. He considered that there would be benefits from the topic being further discussed by the Board at regular intervals. This was supported.

On the suggestion of the Non-Executive Directors, Board Members were asked to provide Mrs. Hill, outside the meeting, with any additional questions or issues to be included in the further work.

The Chairman, noting that work was being undertaken to analyse the data using SPC charts, considered that this would be useful to support understanding of the effectiveness of actions taken to address waiting times.

In addition, in response to a question on the implications of the withdrawal of social workers from teams in North Yorkshire, it was noted that:

(1) Different models were in place in each Locality and, in many cases, these had gone through a number of iterations reflecting their respective impact on local authority budgets and priorities.
(2) When the changes in North Yorkshire were implemented, only County Durham would have integrated teams.
(3) In other areas, there had been differential consequences arising from the changes and it was important for the Trust to see the impact of those in North Yorkshire and to understand their consequences.
(4) Work was continuing within the Locality on the response to the changes.

Agreed *- that a further report on waiting times be presented to the Board at its meeting to be held on 24th September 2019.*

Action: Mrs. Hill

19/66 LEARNING LESSONS FROM SERIOUS INCIDENTS

Further to minute 18/241 (25/9/18), the Board received and noted a report on the lessons learnt from serious incident reviews together with a summary of the ongoing and planned worksteams and system implementation relating to patient safety issues.

In discussions on the Trust's approach to learning, the Non-Executive Directors:

(1) Observed that the report provided differential levels of assurance that the Trust was learning from deaths depending on the theme.

(2) Sought clarity on what was considered to be the most effective method of learning.

Mrs. Moody advised that the Trust was undertaking a multifaceted approach to learning and was seeking to ensure the key themes were woven into the business and strategic priorities. In regard to the means of disseminating learning mentioned in the report:

(a) The Patient Safety Bulletin reached a wide audience but had limitations in terms of impact.
(b) The proposed patient safety workshops, including experts by experience and families, were considered to be a more effective means of providing feedback on recurring findings from serious incidents but were constrained in terms of the number of staff who could attend them.

(3) Highlighted that a number of the serious incident findings identified in the report (e.g. inadequate risk assessments, communications, etc) had been known about, nationally, for some time and questioned whether the evidence base and knowledge management to support changes to practice in response to them were known and understood.

It was noted that, in terms of knowledge management, the Trust's quality improvement system (QIS) was very successful; however, it was recognised that share and spread at scale was difficult and this issue might need to be looked into.

(4) Considered that, whilst the report focussed on learning from serious incidents, it was also important to understand and capture excellent performance. An approach to this, based on the best performing teams potentially being used as ambassadors, could complement the QIS and enable learning to be shared in a different way.

Mrs. Moody advised that this approach had been looked at previously but considered there was merit in doing so again.

(5) Highlighted the importance of ensuring a sustainable approach to learning.

As an operationally focused organisation, it was considered that there might be risks that issues, once fixed, might recur if not understood by future cohorts.

The Board also discussed the findings from serious incidents provided in the report.

It was recognised that, as these included both process and human issues, tackling them would require different approaches. In the latter case, some of them related to confidence, for example in communicating with patients and their families, and this could be affected when staff were under pressure. It was, therefore, considered to be important for the Trust to ensure that it had the right tools in place to support them.

The Chairman considered that, at a rudimentary level, some of the themes identified from serious incidents were not, intrinsically, difficult and should not be beyond the collective ability of the Trust to address. However, from experience, it was apparent that changing processes would not solve the problems and the recovery approach, culture, values and leadership were of more importance. To do this, the Trust could not rely solely on the experts by experience and families, given the personal impact on them, but needed to find alternative approaches.

Mrs. Bessant also observed that there were risks of learning from serious incidents being compartmentalised rather than examined in a broader context of values and behaviours and focussed on the contribution it could make to recovery.

In response, the Board noted that:

(1) Learning might appear to be compartmentalised but this arose from the context of the report and its specific focus on serious incidents.

(2) In general, learning within the Trust, for example clinical supervision, was considered to be recovery focussed and values driven. The harm minimisation work undertaken to improve risk assessment was also a key workstream of the Recovery Programme.
(3) Pressure on staff, and the environment in which they worked, could create conditions where the human factors, which led to serious incidents, were more likely to be prevalent.
(4) The work being undertaken on the "Just Culture Guide", published by NHS Improvement, provided a challenge to the Trust on its response to serious incidents; encouraged managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way; and gave an insight into behaviours.

On a separate matter, the Non-Executive Directors asked whether the letter to the Department of Work and Pensions (DWP), highlighting concerns about the impact of benefit cuts on some vulnerable service users, had been copied to MPs.

Dr. Khouja advised that he was awaiting a reply to the letter and, depending on the response, would consider whether to disseminate it to the MPs.

As the issue had been raised by the Governors, the Chairman highlighted the need for them to be informed of the response from the DWP through the Governor Briefing.

Action: Dr. Khouja

19/67 GENDER PAY GAP REPORT

Consideration was given to the gender pay gap report 2018/19 prepared in accordance with the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

In his introduction to the report, Mr. Levy drew attention to the recommendations:
(1) That the Resources Committee should be provided with the outcome of further gender pay gap analyses.

Mr. Hawthorn, the Chairman of the Resources Committee, asked for the paper presented to the Committee to provide details of the levers available for the Trust to support it close the pay gap and their likely impact.

Mr. Levy took this on board but explained that closing the pay gap might take some time due to the structural nature of some of the factors impacting on it.

Whilst appreciating this view, the Non-Executive Directors considered that the contribution made by the clinical excellence awards to the pay gap should be able to be addressed in the short-term.

In response it was noted that changes had already been made to the CEAs and their impact should be visible in the next report.

(2) That the gender pay gap information should be published earlier, in the autumn, rather than waiting until almost 12 months after the annual reporting snapshot

date in order to make the published information more contemporary and avoid potential confusion about reporting periods.

Board Members, noting the contribution salary sacrifice made to the pay gap, considered that, as this was voluntary, two sets of data should be provided showing the positions both including and excluding this issue.

Mr. Levy recognised that salary sacrifice provided benefits for staff but advised that, under the national guidance, the data reported had to be based on earnings following the deductions.

It was considered that this issue should be raised at a national level.

Action: Mr. Levy

Dr. Khouja also highlighted that the information on medical staff did not reconcile with other information available to him and needed to be looked into.

Agreed -

(1) that the publication of the gender pay gap report be endorsed;

(2) that the Resources Committee be provided with the outcome of further gender pay gap analyses.

(3) that the gender pay gap report as at March 2019 be produced and published in October 2019.

Action: Mr. Levy

19/68 FINANCE REPORT AS AT 28TH FEBRUARY 2019

The Board received and noted the Finance Report as at 28th February 2019.

19/69 PERFORMANCE DASHBOARD AS AT 28TH FEBRUARY 2019

The Board received and noted the Performance Dashboard Report as at 28th February 2019.

The Non-Executive Directors highlighted:

(1) Bed occupancy (KPI 12) where the position in January 2019 had been maintained even though the beds at the Friarage had been removed from the denominator.

It was noted that a significant amount of work was being undertaken on this matter.

(2) The position on KPI 14 (Percentage of patients re-admitted to Assessment & Treatment wards within 30 days) where the reduction in January 2019 (minute 19/41 – 26/2/19 refers) was being maintained.

Mr. Martin recognised the improvement and advised that performance against the indicator had been, and would continue to be, kept under review by the EMT.

19/70 TRUST PERFORMANCE DASHBOARD 2019/20 – PROPOSED TARGETS

On the recommendation of the Executive Management Team, consideration was given to the proposed targets for the agreed Key Performance Indicators (KPIs) for the 2019/20 Trust Performance Dashboard (as set out in Appendix A to the report).

The Non-Executive Directors:

(1) Whilst accepting the explanation provided in the report, questioned the intent of recommendations to reduce the targets for the metrics relating to outcome measures (KPIs 6 and 7) in the context of the Trust being a recovery focussed organisation.

Mrs. Pickering explained that the issue had been subject to a lengthy debate by the EMT. As stated in the report, it had been considered that the first step was to ensure an increase in the number of patients with a timely paired outcome so that the results could be relied upon. Once this had been achieved, efforts would then be made to understand the actions required to increase achievement of improvement benchmarks.

(2) Challenged the proposal to increase the target for KPI 12 (bed occupancy) to 90% as the national target (85%) enabled trusts to cope with natural fluctuations and the position was now tighter due to the reduction in bed numbers.

The Board noted that, in proposing the revised target, the EMT had taken into account:

(a) The increase in community services which had led to the reduction in bed numbers.
(b) The more effective use of beds enabling occupancy levels to be higher than previously.
(c) The significant reduction in delayed transfers of care.

Overall, the EMT had considered that the national target, which had been set some time ago, was now outdated.

Agreed – *that the proposed targets for the 2019/20 Trust Dashboard (as set out in Appendix 1 to the report) be approved.*

Action: Mrs. Pickering

19/71 DATA SECURITY AND PROTECTION TOOLKIT

The Board received and noted a report on the Trust's position against the requirement of the Data Security and Protection Toolkit (formerly the Information Governance Toolkit) prior to submission by 31st March 2019.

The Chairman reminded Board Members of the need to complete their Information Governance training if they had not already done so.

19/72 USE OF THE TRUST SEAL

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

19/73 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.

19/74 DATE OF NEXT MEETING

It was noted that the next ordinary meeting of the Board of Directors was due to be held at 9.30 am on Tuesday 30th April 2019 in Lake House, 20 Manor Court, Scarborough, YO11 3TU.

19/75 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 the financial or business affairs of any particular person (other than 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.

19/76 MRS. LESLEY BESSANT

This being her last meeting prior to retirement, Mr. Martin led the Board in paying tribute to Mrs. Bessant for her leadership and contribution to the development of the Trust; for the sensitive manner in which she had conducted her role and in making sure all voices were heard; and for her passion in promoting the values and recovery approach of the Trust.

Following the transaction of the confidential business the meeting concluded at 12.25 pm.

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th April 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	
19/07/2018	18/218	A further review of the Board's committee arrangements to be undertaken	PB	Jun-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	Completed
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~~ May-19	
29/01/2019	19/08	Further details on the staffing position in forensic services to be provided to the QuAC	RH	May-19	

	Minute No.	Action	Owner(s)	Timescale	Status
26/02/2019	19/38	The collection of data on staff sent home due to flu to be looked into	DL	Jul-19	
26/02/2019	19/39	A progress report on the delivery of the CQC Action Plan to be provided to the Board	EM	21/05/2019	
26/02/2019	19/41	A detailed breakdown of performance against the indicator on the percentage of readmissions to A&T wards within 30 days to be provided to the QuAC	RH	Apr-19	Completed
26/03/2019	19/59	Prof. Reilly to be asked to keep the proposed research project with York University (on variations in outcomes and the reasons for them) under review	AK	May-19	
26/03/2019	19/64	The potential need to review staffing establishments in response to environmental changes arising from moves required for the Roseberry Park rectification works to be discussed with the Director of Operations for Forensic Services	AK	April-19	
26/03/2019	19/65	A further report on waiting times to be presented to the Board	RH	Sep-19	
26/03/2019	19/66	The response from the DWP to the letter highlighting concerns about the impact of benefit cuts on some vulnerable service users to be provided to Governors via the Governor Briefing	AK	-	Timing dependent on the receipt of the response from the DWP
26/03/2019	19/67	To note: - the endorsement of the gender pay gap report for publication - the Resources Committee is to be provided with the outcome of further gender pay gap analyses - the gender pay gap report as at March 2019 is to be produced and published in October 2019	DL	-	To note
26/03/2019	19/67	The issue of reporting two sets of data on the gender pay gap, due to the impact of salary sacrifice, to be raised at a national level	DL	Sep-19	
26/03/2019	19/70	Approval of the proposed targets for the 2019/20 Trust Dashboard (as set out in Appendix 1 to the report)	SP	-	Approved

ITEM NO. 6

Trust Board of Directors

DATE:	**April 2019**
TITLE:	**Guardian of Safe Working Annual Report**
REPORT OF:	**Julian Whaley, Guardian of Safe Working**
REPORT FOR:	**Assurance**

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

Executive Summary:

It is the responsibility of the Guardian of Safe Working to provide Annual & quarterly reports to the Trust Board for assurance that Junior Doctors are safely rostered and working hours that are safe and in compliance with Terms and Conditions of Service.
The 2016 Junior Doctor Contract was implemented for psychiatry trainees starting new contracts in February 2017. Mandated monitoring processes for the year have not identified any breaches to terms and conditions of service requiring the levy of a fine.
The Trust Exception Reports mainly reflect variation in work on non-resident rotas and a new process for this has been implemented and is under review. Processes are in place for ongoing scrutiny and review of work schedules to provide assurance of safe working environments and consideration of training and service needs. There has been extensive Junior Doctor engagement in planning & implementation of rota changes and recording activity.

Recommendations:

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

MEETING OF:	**Trust Board**
DATE:	**April 2019**
TITLE:	**Annual Report by Guardian of Safe Working for Junior Doctors**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

3. KEY ISSUES:

- A detailed breakdown of Junior Doctor numbers, status, exception reporting and locum usage is contained in Appendices 1&2 with a short narrative explaining the data from the relevant medical staffing officer for each area. The relevant appendix is shared with the corresponding Health Education England body.
- I am satisfied that all exception reports submitted by doctors on the new contract have been actioned within specified timeframes. The medical staffing department have supported doctors' supervisors to action these appropriately and maintain a log that enables trends to be spotted and reports submitted to locality forums.
- The majority of exception reports over the year have been placed for additional hours of work. High levels of exception reports relate to the high degree of variation in out of hours non-resident on call rota work. A reduction in such reports in this quarter is due to the implementation of an 'on-call log form' (see appendices 3, 4a & 4b). I am satisfied that doctors are paid for work undertaken. There has been no justification to levy a fine on any department within the organisation. The Trust provides compensatory rest arrangements that exceed requirements set out in the contract, although this is now under review in the context of exploring a 'locum bank' arrangement across the region.

- The on-call log form is now on a second 8 week cycle and we are able to review its success. Doctors will continue to submit exception reports in the usual way for all other work or if their night-time work breaches safety limits. Unfortunately returns in some areas have been incomplete.
- Changes to mental health services across Hambleton & Richmond triggered extensive consultation on the delivery out of hours Junior Doctor cover. A number of options were considered with agreement for a hybrid resident rota for Harrogate and Hambleton & Richmond. This will mean that Monday to Thursday Junior Doctors working in Harrogate will be on a 1 in 8 resident rota and Junior Doctors working in Northallerton will rotate a long day shift until 9pm after which it is felt there will be no requirement for an 'on-site' Junior. Friday to Sunday, the two sets of Junior Doctors combine to provide a 1 in 13 resident rota. This rota will commence in May 2019.
- The South Durham rota changed to a resident shift system, prompting consideration of IT solutions to improve ability to attend training events. This has also prompted a drive to increase engagement with the CITO project.
- There remain concerns for the running of a local agreement to fill vacant resident night-shifts in York with non-resident locum doctors. The complexity of the service makes it difficult for key members of staff to understand the implications of calling the doctor and I have not been assured that a filtering process exists. The doctor concerned may then have to take time from their substantive job to maintain their safety. It is likely that a similar practice will be used in Harrogate.
- The 7-day working pilots across Durham locality have raised concerns both in terms of current expectations and future viability of roll-out.
- Looking forward to the next year, there additionally remains work to be done in addressing the Fatigue & Facilities charter, considering the appropriateness of different grades of doctor in different posts and the impact of further planned service change.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The work of the guardian will help to inform CQC in the areas of Safety, Good Governance, Staffing and Duty of Candour. This report evidences maintenance of these standards.

4.2 Financial/Value for Money:

The new contract is underpinned by the principle that junior doctors are paid for the work they do. Implementation of the contract has cost the organisation a significant amount of money. It is necessary that the Board understands that extra costs will be incurred for additional anti-social hours work and breaches of hours and rest agreements. It is vital that broader resources are effectively utilised to ensure work passed to junior doctors is necessary and appropriate.

4.3 Legal and Constitutional (including the NHS Constitution):

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

4.4 **Equality and Diversity:**
The revised 2016 terms and conditions included the responsibility of the guardian to oversee issues relating to Equality & Diversity. The Head of Equality and Diversity has therefore been co-opted to the quarterly trustwide Junior Doctor Forum. An Equality Impact Assesment has been completed and is updated within the forum. The Champion of Flexible Working is a core member of the Junior Doctor forum and holds an additional forum / network for less that full time doctors.

4.5 **Other implications:**
It is important that our junior doctor colleagues continue to believe that we are supporting them in providing an appropriate and safe learning environment.

5. RISKS:
Failure to anticipate scenarios following service change may lead to a Junior Doctor being placed in an unsafe situation. Gaps in the new hybrid rota may prove difficult to fill.
The high levels of exception reporting have been reported in the medical press and without adequate understanding of our processes may lead to reputational risk. Junior Doctor Locality Forums are running in each area, including operational and educational leaders as well as the guardian, in order to find systemic soutions. These inform the quarterly Junior Doctor forum, chaired by the guardian who also attends LNC & MEQAS meetings. The Guardian also now attends the Medical Directorate meetings ona quarterly basis. These systems should provide assurance of interventions to mitigate some of the potential risks highlighted.

6. CONCLUSIONS:
The organisation continues to fulfil requirements of the new 2016 Junior Doctor Contract and junior doctors are appropriately submitting exception reports which are being handled appropriately. I am satisfied that processes are in place to identify and rectify issues of safety.
The ongoing need for whole system engagement with these issues cannot be underestimated.

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

Author: Dr Julian Whaley
Title: Guardian of Safe Working for Junior Doctors

Background Papers:
Appendices 1 & 2: detailed information on numbers, exception reports and locum usage.
Appendices 3, 4a & 4b detailing ‘On-Call log form’.

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

High level data

Number of doctors / dentists in training (total):	84
Number of doctors / dentists in training on 2016 TCS (total):	79
Number of clinical supervisors	62
Amount of time available in job plan for guardian to do the role:	1.5 PA
Admin support provided to the guardian (if any):	4 days per quarter
Amount of job-planned time for educational supervisors: trainee	0.125 PA per

Exception reports (with regard to working hours) from 1st January 2019 to 31st March 2019

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	0	0	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	7	7	0
F2 - Teesside & Forensic Services Juniors	0	1	1	0
F2 –North Durham	0	6	6	0
F2 – South Durham	0	8	8	0
CT1-2 Teesside & Forensic Services Juniors	0	8	8	0
CT1-2 –North Durham	0	3	3	0
CT1-2 – South Durham	0	1	1	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	23	23	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	4	4	0
ST4-6 –North & South Durham Seniors	0	0	0	0
Trust Doctors - North Durham	0	0	0	0
Trust Doctors - South Durham	0	0	0	0
Trust Doctors - Teesside	0	0	0	0
Total	**0**	**61**	**61**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	10	10	0
Teesside & Forensic Senior Registrars	0	22	22	0
North Durham Juniors	0	13	13	0
South Durham Juniors	0	9	9	0
South Durham Senior Registrars	0	0	0	0
Total	**0**	**54**	**54**	**0**

Hours monitoring exercises (for doctors on 2002 TCS only)					
Locality	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**
Teesside & Forensic Juniors	N/A				
Teesside & Forensic Senior Registrars	ST6	36	NA	FC(F9)	Yes
Teesside CAMHS	ST6	43	43	1C	Yes
Durham & Darlington CAMHS	Not undertaken within the timeframe – please note that there was only 1 doctor on the 2002 contract until March.				
South Durham Juniors	Not undertaken within the timeframe – please note that there was only 1 doctor on the 2002 contract until March 2019.				
South Durham Senior Registrars	Not applicable as all Senior Registrars are on the new contract				
North Durham Juniors	Not undertaken within the timeframe – please note that there was only 1 doctor on the 2002 contract until March 2019.				
North Durham Senior Registrars	Not applicable as all Senior Registrars are on the new contract				

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
Teesside & Forensic Services	F2	New	Unknown	73	71	0	71	x2 F2 Vacancies
	CT3/SAS	Old	Unknown					
	SAS	N/A	Unknown					
	F2	New	Unknown					
	CT1	New	Unknown					
	GP	New	Unknown					
	Trust/SAS	New	Unknown					
	CT3/SAS	Old	Unknown					
	GP	New	Unknown					
	CT3	New	Unknown					
	CT1	New	Unknown					
	Trust/SAS	New	Unknown					
	MTI	New	Unknown					
	GP	New	Unknown					
	Trust	New	Unknown					
	CT3	New	Unknown					
	MTI	New	Unknown					
	CT3	New	Unknown					
	CT2	New	Unknown					
North Durham	MTI	New	No	10	10	0	10	0
	CT1	New	Unknown					
	SAS	New	No					
	CT2	New	Yes					
	SAS	N/A	No					
	SAS	N/A	No					
	SAS	N/A	No					
	SAS	N/A	Unknown					
	CT1	New	Unknown					
	SAS	N/A	No					
South Durham	GP	New	Unknown	24	24	0	24	0
	Trust Doctor	New	No					
	GP	New	Unknown					
	GP	New	Unknown					
	GP	New	Unknown					
	GP	New	Unknown					
	MTI	New	Unknown					
	CT3	Old	No					
	CT3	Old	No					
	CT3	Old	No					
	SAS	N/A	No					
	SAS	N/A	No					
	SAS	N/A	No					
	CT3	New	Unknown					
	Trust Doctor	New	Unknown					
	CT3	New	Unknown					
	SAS	N/A	Unknown					
	Trust	New	Unknown					

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
	Doctor							
	SAS	N/A	No					
	MTI	New	Unknown					
	MTI	New	Unknown					
	SAS	N/A	No					
	SAS	N/A	Unknown					
Total				**107**	**105**	**0**	**105**	**2**

NROC Exception Forms

Following a number of ongoing concerns regarding the implementation of the Junior Doctor Contract in relation to monitoring of NROC work, the trust has developed guidance (Appendix 3), in collaboration with junior doctor colleagues, for the purpose of ensuring that work undertaken during NROC is safe and the doctors are being paid at the correct rate. We have devised a NROC monitoring form (Appendix 4a & 4B) to be used for recording any work undertaken in a rota cycle of 8 weeks duration. At the end of each 8 week cycle, we have asked the doctors to complete and submit an On Call form to medical staffing via the designated medical staffing contact for each locality. Once received the On Call form will be reviewed by medical staffing and the doctor will be advised of the outcome within 7 days. In instances where the form confirms that an exception report is required the doctor will be asked to complete the exception report (including the details of the claim being made) also within 7 days. In instances where additional payment is required this will be processed by medical staffing and the doctor can expect to receive payment within the same months' salary.

The first 8 week rota cycle ended on the 2nd April so further details will be reported in the next period.

Narrative around Exception Reporting

Durham & Darlington

There were 29 exception reports raised during that period for the Durham & Darlington locality. This includes data from 5 rotas – South Durham junior doctors, North Durham junior doctors, South Durham Senior registrars, North Durham senior registrars and Durham and Darlington CAMHS Senior Registrars. 14 of the exception reports were in relation to claiming time of in lieu due to finishing later than their normal time, 4 were in relation to missed breaks and 11 were for claiming additional plain and enhanced time worked whilst on-call. 7 of these exception reports were submitted by an F1 doctor hence not included in the total number of exception reports submitted by rota in the table.

Teesside & Forensics

January to March saw x2 F2 vacancies, plus 1 F2 and a trust doctor dropped out of hours work due to occupational health reasons. A GP went on sick leave from the end of February until the end of March. In February, there were x3 new trust doctors who commenced from overseas and it took x2 of them 6-8 weeks to be able to do out of hours work, the other one

remains unable to do out of hours work. Therefore there were a lot of shifts that required cover. On two occasions, the Medical Staffing Advisor was unable to cover resident weekends, therefore the non-resident switched to resident and locum cover was found for the non-resident shift.

Narrative around Amendments to Work Schedules

Durham & Darlington

The South Durham junior doctor work schedules were revised in time for the August 2018 rotation to reflect the change from a non-resident to a resident rota.

Other schedules in other localities have also been amended, in line with the contract deadlines, to reflect any variations in the numbers of doctors participating in each rota at the start of each rotation.

Teesside & Forensics

There were no changes to the Work Schedules except at the start of the rotation (only because of having different numbers on the Rota), but no changes throughout the rotation.

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

High level data

Number of doctors / dentists in training (total):	58
Number of doctors / dentists in training on 2016 TCS (total):	58
Number of clinical supervisors	48
Amount of time available in job plan for guardian to do the role:	1.5 PA
Admin support provided to the guardian (if any):	4 days per quarter
Amount of job-planned time for educational supervisors:	0.125 PA per trainee

Exception reports (with regard to working hours) from 1st January 2019 to 31st March 2019

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F1 - Scarborough	0	0	0	0
F1 - York	0	0	0	0
F2 - Northallerton	No F2 Doctors in North Yorkshire			
F2 - Harrogate				
F2 - Scarborough				
F2 - York	0	3	3	0
CT1-2 - Northallerton	0	8	8	0
CT1-2 - Harrogate	0	5	5	0
CT1-2 - Scarborough	0	1	0	1
CT1-2 - York	0	2	2	0
CT3/ST4-6 – Northallerton	0	0	0	0
CT3/ST4-6 – Harrogate	0	0	0	0
CT3/ST4-6 – Scarborough	0	6	6	0
CT3/ST4-6 – York	0	0	0	0
Trust Doctors - Northallerton	0	7	7	0
Trust Doctors - Harrogate	0	9	6	3
Trust Doctors - Scarborough	0	6	6	0
Trust Doctors - York	0	3	3	0
Total	**0**	**50**	**46**	**4**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton	0	5	5	0
Harrogate	0	15	15	0
Scarborough	0	14	11	3
York	0	13	12	1
Total	**0**	**40**	**36**	**4**

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
Northallerton	Trust Doctor	New	No	4	4	0	4	0
	SAS Doctor	N/A	Yes					
	SAS Doctor	N/A	Yes					
Harrogate	Trust Doctor	New	No	24	24	0	24	1
	Trust Doctor	New	No					
	Trust Doctor	New	No					
	CT1	New	Yes					
	ST1	New	No					
	CT2	New	No					
	CT2	New	No					
	SAS Doctor	N/A	Yes					
	SAS Doctor	N/A	Yes					
Scarborough	CT2	New	No	29	29	0	29	1
	CT2	New	No					
	CT3	New	No					
	ST4	New	No					
	SAS Doctor	N/A	Yes					
York & Selby	Trust Doctor	New	No	20	18	2	16	1 until February 2019.
	CT2	New	No					
	CT2	New	No					
	CT2	New	No					
	CT3	New	No					
	Agency	N/A	No					
Total				**77**	**75**	**2**	**73**	**3**

NROC Exception Forms

Following a number of ongoing concerns regarding the implementation of the Junior Doctor Contract in relation to monitoring of NROC work, the trust has developed guidance (Appendix 3), in collaboration with junior doctor colleagues, for the purpose of ensuring that work undertaken during NROC is safe and the doctors are being paid at the correct rate. We have devised a NROC monitoring form (Appendix 4a & 4B) to be used for recording any work undertaken in a rota cycle of 8 weeks duration. At the end of each 8 week cycle, we have asked the doctors to complete and submit an On Call form to medical staffing via the designated medical staffing contact for each locality. Once received the On Call form will be reviewed by medical staffing and the doctor will be advised of the outcome within 7 days. In instances where the form confirms that an exception report is required the doctor will be asked to complete the exception report (including the details of the claim being made) also within 7 days. In instances where additional payment is required this will be processed by medical staffing and the doctor can expect to receive payment within the same months' salary.

The first 8 week rota cycle ended on the 2nd April so further details will be reported in the next period.

Narrative around Exception Reporting

York & Selby

There were 13 exceptions during the reporting period in the York & Selby locality. 6 exceptions were reported by a higher trainee in relation to on call work. 6 exceptions were reported by two Trust Doctors who joined the locality in February. These were due to late finishes to the normal working day. One exception remains outstanding. This was raised by a CT2 who submitted one exception report to cover the entirety of their August 18 to February 19 placement. Management within the medical staffing department is working on the most suitable response to this report. The majority of locum shifts in this period have been due to sickness.

Scarborough

During the reporting period there were 14 exceptions from the Scarborough locality. 9 of these were due to additional hours worked during the out of hours on call period. 1 exception was submitted as a result of late finish to the normal working day; and 1 submitted as a result of missing an educational event. There 3 outstanding exceptions are from a Trust Doctor reporting an extended working day as a result of travelling to training. Management within the medical staffing department is working on the most suitable response to this report. At the time of writing there have not been any NROC forms submitted for the period 6th February to 2nd April so this report contains no data for that period. Locum shifts have arisen as one of the doctors is not doing on call work following an occupational health review. In addition to this there have been two Trust Doctors that started in January who were unable to join the rota until they had completed a shadowing period.

Northallerton

There were 5 exception reports raised during the reporting period in the Northallerton locality. All exceptions were due to additional hours worked during the out of hours on call period. 19 exceptions were due to additional hours worked during the out of hours on call period. Doctors in this locality are paid 2 additional hours at plain rate in their work schedule. The inpatient wards at The Friarage Hospital closed during this period. At the time of writing there have not been any

NROC forms submitted for the period 6th February to 2nd April so this report contains no data for that period. Locum shifts a result of sickness.

Harrogate

There were 15 exception reports in the reporting period due largely working additional hours when on call out of hours. There were 5 exceptions raised as a result of late finishes to the normal working day. At the time of writing there have only been 3 NROC forms submitted for the period 6th February to 19th March so this report contains only limited data for that period. The second NROC monitoring period started on 20th March and as a result there this report contains no data relating to on calls for the period 20th-31st March. Locums have been needed mainly due to one doctor unable to work out of hours due to pregnancy risk assessment, and due to a Trust Doctor not starting until mid-March.

Narrative around Amendments to Work Schedules

All junior doctors in Harrogate and Northallerton were issued revised work schedules as the rota's are merging from 1st May 2019. The only other revised work schedule that has been issued was to a Trust Doctor in Scarborough. This was because their initial work schedule included no on call work while they completed their shadowing period. Once the shadowing period was complete they were able to join the on call rota and a new work schedule was issued accordingly.

Guidance for monitoring Non Resident On Call Work (NROC)

Non Resident on Call rotas can be particularly challenging to design given the nature of NROC work. The average number of hours worked is likely to fluctuate day to day and may therefore differ from the overall number of hours that have been estimated in your work schedule.

Following a number of ongoing concerns regarding the implementation of the Junior Doctor Contract, in relation to monitoring of NROC work; this guidance has been developed in collaboration with junior doctor colleagues for the purpose of ensuring that work undertaken during NROC is in the first instance safe, (with mandatory rest taken where necessary) alongside being paid at the correct and fair rate. This process aims to minimise the administrative burden placed on junior doctors and therefore forms can be completed electronically or by hand.

How to complete the On Call form

NROC monitoring will be undertaken using a rota cycle of 8 weeks duration.

Each 8 week cycle will begin on the first Wednesday of a given month and end on the last date prior to this point (i.e. the Tuesday before)

As an example the anticipated schedule for 2019 will be as follows;

- **6th February to the 2nd April**

(Forms to be submitted to Medical Staffing no later than 9th April)

Doctors should aim to complete and submit an On Call form within 7 days of the end of an 8 week period. Forms should be submitted to medical staffing via the designated medical staffing contact for each locality.

Once received the On Call form will be reviewed by medical staffing and the doctor will be advised of the outcome within 7 days. In instances where the form confirms that an exception report is required the doctor will be asked to complete the exception report (including the details of the claim being made) also within 7 days.

In instances where additional payment is required this will be processed by medical staffing and the doctor can expect to receive payment within the same months' salary.

In instances where a review indicates that NROC work is under the levels expected in the work schedule, an exception report is not required however a work schedule review may be undertaken. In the event that changes to the work schedule are required and result in a decrease in pay, the doctors total pay will be protected and remain unchanged until the end of the placement covered by the work schedule.

In instances where a doctor may disagree with the outcome of the review undertaken by medical staffing then the process for reviewing Exception Reports under Schedule 5 of the Junior Doctor Terms and Conditions, will apply.

This process applies to all doctors in training undertaking NROC work for TEWV (it excludes FY1 doctors employed by an Acute Trust that do not undertake NROC work in Psychiatry).

Effectiveness of the process will be reviewed by the Junior Doctor Forum, involving locality representatives, on a quarterly basis. Medical Staffing will undertake periodic reviews of instances

where an exception report resulted in additional payment in order to identify trends/ meaningful differences which may result in a work schedule review.

This form is to be used only for monitoring of NROC work. The usual process for exception reporting applies to all other instances where there are concerns that working hours have exceeded those anticipated in the work schedule.

Where NROC work has triggered time off in lieu (TOIL) an exception report should be completed as per the normal process, however payment will be made under this agreement.

If there are any queries in relation to the completion of this form, the review process applied or concerns relating to safety of hours worked then please contact either Medical Staffing (via locality advisor) or the Guardian of Safe Working tewv.jrdrguardian@nhs.net as appropriate to discuss.

EXCEPTION REPORTING

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Full Name:		
On-Call Rota – Please Indicate	Teesside Junior Doctor	☐
	Teesside Senior Registrar	☐
	Teesside Senior Registrar CYPS	☐
	South Durham Junior Doctor	☐
	South Durham Senior Registrar	☐
	North Durham Junior Doctor	☐
	North Durham Senior Registrar	☐
	Durham & Darlington Senior Registrar CYPS	☐
	Harrogate Junior Doctor	☐
	Harrogate Senior Registrar	☐
	Northallerton Junior Doctor	☐
	Northallerton Senior Registrar	☐
	Scarborough Junior Doctor	☐
	Scarborough Senior Registrar	☐
	York Junior Doctor	☒
	York Senior Registrar	☐
	North Yorkshire Senior Registrar CYPS	☐
	Trustwide Learning Disabilities CYPS	☐

Start and end times include travel.

Date	Start Time	End Time	Nature of Contact
Click here to enter a date.			Please choose
Click here to enter a date.			Please choose
Click here to enter a date.			Please choose
Click here to enter a date.			Please choose
Click here to enter a date.			Please choose
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Click here to enter a date.			Please choose
Click here to enter a date.			Please choose
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Click here to enter a date.			Please choose
Click here to enter a date.			Please choose
Click here to enter a date.			Please choose

Please complete the form after each on-call and forward directly to your Medical Staffing Advisor on a 8 weekly basis. They will contact you to remind you.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

On-Call Log Form

Name	
On Call Rota	

Codes
1: Admission Process
2: Physical Health Review
3: Mental Health Review
4: Seclusion Review
5: Administrative Duties
6: Crisis Team/ Acute Hospital Work
7: Telephone Advice

Date	Start hh:mm	End hh:mm	Reason for call If multiple reasons for call specify all reasons. Use codes if possible.
	:	:	
	:	:	
	:	:	
	:	:	
	:	:	
	:	:	
	:	:	
	:	:	
	:	:	
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	:	:	
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	:	:	

ITEM NO 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th April 2019**
TITLE:	**FREEDOM to SPEAK UP GUARDIAN REPORT**
REPORT OF:	**DEWI WILLIAMS, FREEDOM TO SPEAK UP GUARDIAN**
REPORT FOR:	**Information**

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

Executive Summary:

This report is for information and outlines developments within the Freedom to Speak Up role over the last 6 months.
It discusses local, regional, and national issues, and concludes with an anonymised case study, and some points for consideration.

Recommendations:

To note the contents of the report and comment accordingly

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**30th April 2019**
TITLE:	**FREEDOM TO SPEAK UP GUARDIAN REPORT**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board about the last 6 months of the Freedom to Speak Up role. The report will outline developments and activity to date and discuss how we intend to further develop the role in the coming year

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 I have been in post since October 2016 and continue to work 18 ½ hours a week.

2.2 Over the last 6 months I have received 29 concerns. 3 staff wished to remain anonymous, 7 related to patient safety/care quality, and 22 related to allegations of a culture of bullying. A number of people started to engage with me and then withdrawn their complaint. Mostly these people were concerned about possible detriment though others withdrew because they said things had improved, or that the local management had now taken their concerns on board and were addressing them.

3. KEY ISSUES:

3.1 **Training**. The mandatory ½ day training session for band 7 and above staff continues to be offered. Attendance numbers remain encouraging and there is a full programme for this year.

A frequent issue raised in training this year has been why we do not provide this training to the remainder of our staff. Currently staff are only introduced to the role of the Guardian during induction. We are dependent on attending managers to share their learning with their staff. Whilst I agree that it would be beneficial, logistically it would be a significant challenge. We are reviewing the usefulness of some e-learning materials produced by Health Education England that all staff can access, and waiting to see whether the National Guardian's Office develop some training packages for non-managerial staff in the near future.

3.2 **Support networks.** Locally, Barry Speak continues to act as Deputy Freedom to Speak Up Guardian. Barry continues to support those staff who are seeing him via the Employee Psychology Service and who also wish to speak up.

Our local speaking up forum continues to meet monthly. The networking and support is proving valuable.

Our regional Freedom To Speak Up Guardian's group also continues to meet every other month. We continue to use this group primarily as a case discussion forum, receiving national team updates, and look for opportunities to standardise our practice. The national team has recently appointed a network of national officers to represent and coordinate regional activity. How this network will interact with our current regional group is as yet unclear as they cover slightly different geographical boundaries. However, initially their focus will be on supporting primary care providers who are in the process of developing their own Freedom to Speak Up Guardians.

The National Guardians Office continues to gradually develop a range of support and guidance/instruction materials. Their website has many useful items including the reports of its service reviews which also include lessons learned. They also hold twice yearly conferences to share updates. As stated above they are currently focussing on the primary care development. The chair of the National Guardian's Office, Henrietta Hughes, is currently considering the implications for guardians of proposed organisational changes involving the greater integration of care services.

3.3 **Development of Champions.** As noted in the previous report, we remain committed to developing a network of TEWV 'dignity at work champions.' There is an open ended recruitment initiative but uptake has been slower than we would like. HR staff are currently pursuing a range of opportunities to encourage more people to come forward. We need them primarily to raise the profile of speaking up and hopefully meet some of the training requirement of the staff mentioned above.

3.4 **Data Management.** The collection and analysis of data is central to ensuring that we can learn from experience. Our managers reporting tool has again been unreliable and therefore remains only used to record opening and closing of cases. The service was recently audited and they felt my data management and case notes should be held together. So we are working with the Information Technology Department to develop an acceptable solution.

3.5 **Feedback.** At the end of engagement I am committed to asking people two questions that the national office would like to know about. "Would you feel confident to speak up again in the future?" and "did you feel you experienced any detriment because you spoke up?" Despite asking 'closed cases' directly I have nearly always failed to, get a response, even when the people concerned have written to thank me for the service provided. We are not unusual as nationally this is seen as a problem.

3.6 **Case Example.** A non-registered staff member was concerned about the mental health of their supervising qualified staff, and its impact upon their ability to safely carry out their caring role. They raised their concern with their senior managers but felt they were not being heard and made to feel that they were not being compassionate enough. They felt that their concerns were not

being addressed. However upon investigation it transpired that considerable intervention and support had been put in place, but because of the need to respect the confidentiality of those involved, the complainant was unaware of these developments. This lack of any feedback had left the complainant feeling the trust did not listen, and therefore had concluded that it would not be worthwhile speaking up in the future.

Recently I have met a few staff with ongoing mental health issues that have impacted upon their ability to perform their role. It would seem that our approach to supporting staff can be inconsistent. Some would appear to have been well supported and encouraged to continue in service, even on occasion when it would seem to have been unwise, and others appear to have encountered an unsympathetic and uncaring attitude which may have contributed to their ill health. Developing greater equity of approach perhaps through the provision of more guidance for managers, in addition to challenging instances of unsupportive behaviour, is suggested.

I have met a few staff who have been using our mental health services and who report poor experiences. It is acknowledged that TEWV also receives positive feedback from staff using our mental health services. These sources of feedback could provide an opportunity to find ways to continue to improve our services.

3.7 **Communications strategy.** I am indebted to Sarah Everett from the communications department for developing a wide range of initiatives to support the awareness of the guardian role. There is a monthly message on In-touch and recently the communications team has developed messages on YouTube talking about our commitment to speaking up and how to contact us.

3.7 **Learning lessons.** The Medical Director, Ahmad Khouja, is committed to ensuring we learn the lessons following the Independent panel review into the used of opioids in the Gosport War Memorial published in June 2018. From a speaking up perspective it provides an unsettling picture of how staff and carers concerns can be minimised or ignored for many years with catastrophic results. The National Guardian's Office is also keen to use the case to encourage organisations to review their practices. In our organisation it is heartening to see the current focus upon the use of medication in learning disabilities as an example of positive action.

National Guardian Freedom to Speak Up

Background

Gosport War Memorial Hospital
The report of the Gosport Independent Panel

Early in **1991**, Anita Tubbritt, a Staff Nurse at Gosport War Memorial Hospital ... rang Keith Murray, the local branch convenor of the Royal College of Nursing (RCN) ... Staff Nurse Tubbritt expressed concerns shared by other members of the night staff working at Redclyffe Annexe over the use of diamorphine and syringe drivers.

... there was a disregard for human life and a culture of shortening the lives of a large number of patients by prescribing and administering "dangerous doses" of a hazardous combination of medication not clinically indicated or justified ... whereas a large number of patients and their relatives understood that their admission to the hospital was for either rehabilitation or respite care, they were, in effect, put on a terminal care pathway. **[published 2018]**

National Guardian Freedom to Speak Up

Background

Wilfred Harrington

Peggy Coates

Arthur Cunningham

Ethel Thurston

Gladys Richards

Elsie Devine

"... the lives of over 450 patients were shortened ..."

National Guardian Freedom to Speak Up

Background

Inappropriate instruction issued

Response	Impact	Issue
I don't know any better	Instruction carried out	Capability and knowledge
I think there's something wrong – I'm not going to say anything	Instruction may or may not be carried out	Speaking up
I think there's something wrong – I will speak up	Instruction may or may not be carried out	Speaking up
I know it's wrong but I do it anyway	Instruction carried out	Criminality?

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** Having effective speaking up arrangements in place supports achievement of CQC standards.

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

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

4.4 **Equality and Diversity:** All staff should be able to access the Freedom to Speak Up Guardian within TEWV regardless of job role, location or any protected characteristic.

4.4 **Other implications:** None identified

5. RISKS: None identified

6. CONCLUSIONS:

6.1 Awareness of my role within TEWV is increasing, contacts received are increasing and the level of participation in manager training is encouraging. We do need to encourage more staff to become dignity at work champions and continue follow up reports of poor behaviours.

7. RECOMMENDATIONS:

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

Dewi Williams
Freedom to Speak Up Guardian

Background Papers:

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 30 April 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 04 April 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 & Darlington and Tees Services
- Compliance with CQC
- Zero Inpatient Suicide Plan
- Drug & Therapeutics
- Safeguarding & Public Protection
- AMH and MHSOP Inpatient Update
- Draft Quality Account 2018/19

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 04 April 2019.
- Note the confirmed minutes of the formal meeting held on 07 March 2019 (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 30 April 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 04 April 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 & DARLINGTON SERVICES LMGB

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

The top areas highlighted were:

- Pressures in adult mental health, learning disability inpatient services and breaching the nine week wait in Children and Young People's services.
- Ongoing concerns around medical staffing gaps, where some locum cover has been arranged, however the Committee acknowledged the impact this is having on staff wellbeing.

The Board is asked to note that:

- The required number of replacement bed mattresses was ordered, following the recent audit which scored red.

- Compliance around emergency response bags - daily checks had been undertaken on all wards except Elm and Roseberry. Additional monitoring has been put in place and extra communication with agency staff will take place to ensure that they fully briefed on the processes.

- There have been no instances of the use of mechanical restraint or tear proof clothing in the locality during the reporting period.

4.2 TEES SERVICES LMGB

The Committee discussed the LMGB report for Tees Services.

The top areas highlighted were:

- High levels of bed occupancy in AMH, MHSOP.
  A piece of work has started to look at the levels of referrals and to break down any discrepancies between total referrals and unique referrals.

- High levels of activity in AMH and CYPs.
  The service is reviewing bed usage including the number of admissions and length of stay in order to develop targeted work with teams/wards and Local Authorities.
  The high levels of activity were inevitably causing pressure on teams and staff well-being in order to try and manage the demand.

- Ongoing concerns in relation to the performance and quality of care being delivered within inpatient services.

Assurance was provided that a number of initiatives had been undertaken and there had been some positive changes and improvements with the positive and safe dashboard showing a drop in the number of physical interventions and episodes of rapid tranquilisation in the inpatient setting.

The Board is asked to note that:

- Compliance around emergency response bags - daily checks had been undertaken on a daily basis, with the exception of seven checks across four wards during the reporting period. Additional monitoring has been put in place and an update will be provided in the next LMGB report.

- Tear proof clothing has been used on one occasion in Tier 4 CYPS and had not been approved at Director level, however assurance was given to the Committee that it had been for a short period of time and had been appropriate as it was documented in the young person's intervention plan.

- The Chairman of the Committee raised concerns over the high use of rapid tranquilisation during January and February 2019.
  Assurance was provided that the use of rapid tranquilisation had reduced during March 2019 and had dropped significantly from 48 episodes per month to 4.

- The Committee requested further consideration around the restrictive practice on Kirkdale and Lustrum where razors were being kept in storage and to look at the possibility of having individual sharp boxes in rooms.
  Assurance was given that all restrictive practices were currently being reviewed.

3. Compliance with CQC Requirements

The Committee received the monthly update on compliance with CQC and Ofsted registration requirements.

The Board is asked to note that:

- The CQC continue to monitor progress on the action plan monthly and through regular engagement meetings and attendance at Trust Committee meetings.
- There are a number of actions that require further evidence of assurance before they can be signed off for the January (5), February (3) and March 2019 (45) deadline.
- The engagement meetings by members of the CQC with Teesside Adult MH inpatients, which included patient/carer and staff focus groups received positive feedback.

Members discussed the visibility of the CQC action plan and whether there should be a stand-alone report on the CCQ "must do's" to the Board.

Recommend: *that the Board of Directors consider whether there should be a stand-alone report on the CQC Action Plan – "Must Do's".*

- Mental Health Act Inspections have been carried out at five services across the Trust and common themes were the usual topics such as care planning, leave forms and reading patients' rights being the top of the list.
- There were due/overdue Mental Health Act Inspections across services and the localities had been informed of the date of the last inspection in anticipation of another visit this year.

Assurance is provided to the Board 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. 1 Zero Inpatient Suicide Plan

All NHS mental health organisations are required to have a 'zero suicide plan' in place in line with recommendations from the implementation plan of the *Five Year Forward View for Mental Health*. The Committee received the draft plan for information. It was noted that further work was required to establish progress measures and that this would be undertaken by the Patient Safety Group.

The key matter for the Board to note is the Zero Inpatient Suicide Plan has been shared with our three STPs. The plan is intended to work alongside other work streams currently ongoing in the Trust and will be monitored quarterly by the Patient Safety Group.

4.2 Drug & Therapeutics

The Committee discussed the Drug & Therapeutics Group report.

The Board is asked to note the following:

- The implementation of the three internal pharmacy dispensaries is on track for 1 November 2019 and progress reports will be provided to LMGBs on a monthly basis. The procurement of an IT dispensing system is currently now out to tender.
- Two new national medicines guidelines have been released and the Pharmacy team has undertaken a gap analysis of current TEWV policies and procedures with relevant updates to be made.
- The reconciliation work around migrating un-coded allergies to coded is looking to be complete in May 2019 and assurance on this work will be provided to the Quality Assurance Committee in June 2019.

There are no significant risks to escalate to the Board.

The Board can be assured that all safety activities have been reviewed in line with the Group's terms of reference and any issues to be addressed have been documented and will be progressed via appropriate leads and monitored by the Group.

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 will be a Domestic Homicide Review in April 2019 following an incident in Middlesbrough whereby a service user had killed their mother.
- An individual management review would be completed for someone who had died due to taking an Insulin overdose - they had been seen by services but not engaged.
- Safeguarding Partnership Arrangements have been published for York, Durham and North Tees (this is Stockton and Hartlepool combined). Redcar and Middlesbrough has joined with South Tees and all will be working towards a September 2019 deadline to have these arrangements in place.
- There will be a meeting held during April 2019 to follow up the safeguarding enquires raised at Acomb Garth, which were in connection with agency staff.

The Board can be assured that both the safeguarding adult and children teams continue to deliver a comprehensive safeguarding service within the Trust and are compliant with legislation.

4.3 AMH AND MHSOP INPATIENT UPDATE

The Committee received an update report on inpatients in Adult Mental Health and Mental Health Services for Older People.

- The report was requested by the Quality Assurance Committee (minute 18/145 refers), following the rising bed pressures across localities, with the aim to implement a structured approach to escalation with better awareness around bed use and an understanding of the variation across services.

- The fluctuation in admissions will be considered in a future work stream by SDG and work will continue to monitor the use of PICU, MOD and leave beds to increase awareness of how bed pressures reflect in the operational delivery.
- Comparison of readmissions and occupied bed days has revealed that whilst the percentage of patients readmitted is relatively low against the number of admissions the number of occupied bed days is significant (10,819).

The Board can be assured that there is recognition around the importance of addressing bed capacity across the Trust and a number of systems and processes have been put in place to develop a deeper understanding of bed pressures and flow. Ongoing work will continue with localities to address the variation in length of stay, admission and readmission rates and updates will continue to the Quality Assurance Committee.

ARE OUR SERVICES EFFECTIVE?

6. Draft Quality Account 2018/19

The Committee considered the Draft Quality Account for 2018/19.

Members approved the Account, subject to some minor amendments before it was presented to the Task and Finish Group on 11 April 2019 with a view to it going back to the Quality Assurance Committee at its meeting to be held on 2 May 2019.

7. **Exception Reporting**

There were no exceptions raised.

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 recommendation to consider whether the Board of Directors should receive a stand-alone report on the CQC action plan "Must Do's".*
(ii) *Note the issues raised at the Quality Assurance Committee meeting on 04 April 2019.*
(iii) *Note the confirmed formal minutes of the meeting held on 07 March 2019.*

Mrs J Illingworth
Director of Quality Governance
30 April 2019

NOTES OF THE FORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 07 MARCH 2019, IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Mrs Lesley Bessant, Chairman of the Trust
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 Miriam Harte, Trust Chairman Designate
Mr Tim Cate, Director of Operations, North Yorkshire
Mr David Brown, Director of Operations, York and Selby (for minute 19/24)
Mrs Karen Agar, Associate Director of Nursing (for minute 19/28)
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mrs Michelle Brown, Head of Organisational Development
Mrs Ann Marshall, Deputy Director of Nursing & Governance
Dr Tolulope Olusoga, Deputy Medical Director, North Yorkshire
Dr Steven Wright, Deputy Medical Director, York and Selby
Mr Anthony Davison, Head of Nursing, York and Selby

19/20 APOLOGIES FOR ABSENCE

Apologies for absence were received from, Mrs Elizabeth Moody, Director of Nursing & Governance, Dr Ahmad Khouja, Medical Director and Dr Suresh Babu, Deputy Medical Director.

19/21 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 07 February 2019 were accepted as a true recording of the discussions and signed by the Chairman.

19/22 ACTION LOG

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

18/145 Escalation protocol/bed pressures to be worked through and reported back to QuAC. It was noted that this work was being led by Mrs Ruth Hill and that a report would come back to the Committee at its meeting to be held on 4 April 2019.

18/151 Work to be done on the Patient Experience Report to pull out the meaningful data from the tables and include narrative and analysis framed around the CQC high quality questions.
This action was deferred to the 2 May 2019 QuAC meeting.

19/04 Look to the possibility of correlating the longer view of acuity on the wards linked to patients feeling safe.

Mrs Illingworth noted that conversations had begun around this however more time would be needed and this action was deferred to the 2 May QuAC meeting.

19/05 letter of congratulations to go to Tees staff: waiting for names from Director of Operations.
Following no response from emails to find out who the staff members were, this would be chased once again.

19/07 Report of Accident and Emergency at The James Cook University Hospital flagging anyone who has had contact with West Lane Hospital as a potential risk to staff.
This action was deferred to the 4 April QuAC meeting.

19/13 Update on Clinical Emergency Response bags.
This matter was covered under agenda item number 5 (minute 19/ refers).

19/23 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 matters to note were:

- The implications to the Liaison and Crisis services at The Friarage Hospital following the unexpected announcement of recent changes to the A&E Department there by South Tees Hospitals NHS Trust.
  For now the service would remain unchanged and staff had been reassured that there would be roles for everyone in the new transformed community services.
- The closure of Wards 14 and 15 at Northallerton, with the transfer of patients to Roseberry Park Hospital and West Park Hospital, which has gone smoothly.
- Both Acute Trusts in York and Harrogate had given notice on the provision of their paediatric services for conducting assessments for children with autism from the contract end date in Spring 2019 and the Trust would take part in discussions about how this service could be provided in the future.
- Staffing establishment across the locality was stable across all areas including inpatients; however it is difficult to recruit to the IAPT service in North Yorkshire.
- The outbreak of flu on Rowan Ward which affected two patients and two members of staff will be used as a lesson learned in this year's campaign for flu vaccination.

Following agreement by the Committee in February 2019, (action19/05 refers) assurance was provided that the resuscitation bags had been checked daily, in line with policy, on all wards over the reporting period and there has been no incidents of use of mechanical restraint in the Locality.

19/24 YORK AND SELBY LMGB REPORT

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

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

- There were a number of service changes planned with the rehabilitation and recovery inpatient unit to close and the planned merger of the two organic wards in July 2019, as well as working towards moving inpatient services from Harrogate. This would all be taking place at the same time as bringing North Yorkshire and York and Selby together, from a management perspective, as one locality.
  It was anticipated that the merger of the two wards would reduce the use of agency staff.

- Waiting times, with the most significant for assessment in the memory assessment service, the secondary rates in IAPT and assessments for children who may have autism.
- Capacity in community mental health teams is being impacted by vacancies, maternity leave and sickness, creating large caseloads. Work is underway to try and resolve this, including using QIS tools, reconfiguration and short term investment internally as well as proposals for future investment from the CCG.

- There had been a safeguarding issue at Acomb Garth in relation to agency staffing.

  Members expressed concern over this matter and questioned whether it would be worth taking a Trust wide view to look at any correlation between agency staffing and safeguarding.

  Mrs Agar advised that the matter in relation to Acomb Garth had been raised with the Local Authority and York Safeguarding, however noted, that there is no overarching organisation that monitors the quality of agency staffing. In addition, the use of agency staff was particularly high in York, however there was some reassurance in the fact that the problem had been reported by a member of TEWV staff.

  The Committee members requested some work to be undertaken to see if there were any Datix incidents relating to safeguarding issues and that any safeguarding incidents relating to agency staffing to be included in future Safeguarding Reports.

Action: Mrs J Illingworth/Mrs K Agar

Non-Executive Directors raised the following matters:

(1) How things had gone with the children and parents at the Westwood Centre and assurance was provided that discussions had been handled very well and parents had been supportive.

(2) There was an error in the Y&S LMGB report on page 10, patient safety AMH, relating to the two serious incidents for January 2019, which should have read three serious incidents, one of which was in relation to fractured neck of femur.

Action: Mr D Brown

(3) There needed to be further explanation in future reports around the percentages relating to patient experience, as this had been stated as 96.2%, with no narrative.

Action: Mr D Brown

(4) Whether the closure of the therapeutic community had impacted on the people involved and if there had been any local publicity.

Dr Wright advised that it had been a planned ending to the service as it had not been providing sufficient interventions to enough people and was therefore not cost effective, however the therapeutic model was indeed still valid.

Assurance was provided to the Committee that resuscitation bags had been checked daily, in line with policy, on all wards and there had also been a weekly check by the clinical leads and ward managers. Additionally, modern matrons were checking and auditing the process monthly.
There have been no incidents of use of mechanical restraint/soft cuffs or tear proof clothing.

19/25 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

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

(1) A paper outlining the current position statement against the 2018 action plan following the CQC inspection would got to EMT in March 2019 and return to the QuAC in April 2019. Assurance was provided that many of the actions had a completion date of the end of March 2019.
(2) New style engagement sessions were now taking place rotating across services for a full day each month throughout the year to include patient/carer staff focus groups and an opportunity for services to showcase improvements and good practice.
(3) The Quality Compliance Group would now meet bi-monthly to review the CQC action plan and the meeting on 28 March 2019 would focus on "What is assurance and care planning"?

Mrs Richardson queried how the engagement meetings with the CQC would be captured.

Mrs Illingworth undertook to ask the CQC for further information on this matter.

19/26 COMPLIANCE OF CLINICAL EMERGENCY RESPONSE BAGS

The Committee received a verbal update on the compliance around clinical emergency response bags.

In her introduction to the verbal update, Mrs Illingworth drew attention to:

- An incident that had occurred in Forensic services which had resulted in non-compliance. Assurance was provided that immediate actions had been taken.
  It was frustrating that despite repeated audits over the previous year, reported to the Quality Assurance Committee, that there was still margin for errors to be made.

- The Chairman of the Trust expressed concerns over the significant amount of time and resources that had gone into this important matter, which ultimately was about a checklist that could potentially save a life and how assurance could be sought around sustaining the position of compliance for the future.

  On this matter, the Director of Operations outlined how the escalation process and daily lean management for staff would be considered in some detail to look at the reasons why the checks might not be completed and how staff can be supported in their busy working days to ensure that the relevant checks be made.

19/27 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Group Report.

The following matters were highlighted from the report:

(1) A recent serious incident review report had highlighted inconsistencies regarding the implementation of the PIPA process and formulation, particularly in MHSOP services; this had been picked up by the relevant heads of service.
(2) The Patient Safety Group had discussed, at its meeting held on 18 February 2019, how to develop in line with internal and external developments, together with the Quality Assurance Committee agenda.
  Members discussed and agreed that it would be more effective to see the Patient Safety Quality Report containing all the information and data on a quarterly basis.

(3) There would be further exploration by the Patient Safety Group regarding the increase in serious incidents in December 2018; level 3 self-harm incidents and the use of physical intervention.
(4) The Group had also looked at the current medication error metric in the Quality Strategy Scorecard, which was expecting a reduction in the number of incidents reported.

Mrs Illingworth explained that in reality, the Trust encouraged reporting of incidents and what it was actually looking for was a reduction in the level of harm, rather than in the number of incidents reported. It was noted that from April 2019 the existing metric would remain, but as an inverted target and another additional metric would be included aimed at seeing a reduction in level 3 or above medication incidents.

Assurance was provided 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.

19/28 SAFEGUARDING & PUBLIC PROTECTION REPORT

The Committee received and noted the exception report for Safeguarding and Public protection.

The key matters highlighted from the reports were:

(1) A number of safeguarding referrals had been made in respect of Acomb Garth, as referred to under agenda item number 3 (minute 19/24 refers), three of which had been initiated by Trust staff on the unit and all involved agency staff providing care. Two others had been made by the same family member regarding the care of their relative. The Trust Safeguarding team were leading on the Section 42 enquiry with the local authority, mainly to look at the use of agency staff. An update on this matter would be included in the April 2019 safeguarding report.

(2) The Trust was involved in serious case reviews across localities, which were progressing at different stages.

Following a concern raised by Mrs Richardson regarding not including a number of agencies from meetings, Mrs Agar advised that there was inclusion of Durham, however not for Darlington in serious case reviews

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.

19/29 CLINICAL AUDIT ANNUAL FORWARD PROGRAMME OF WORK

The Committee received for consideration the Clinical Audit Programme of work for 2019/20.

In introducing the report, Mrs Illingworth, drew attention to:

(1) The Clinical Audit Programme would be monitored via the Clinical Effectiveness Working Group and would be facilitated by the corporate operational team in partnership with the clinical and other corporate services as appropriate.
(2) A total of 84 clinical audits had been included.

The Committee: *Approved the Clinical Audit Programmes for 2019/20.*

19/30 CLINICAL AUDIT AND EFFECTIVENESS QUARTERLY REPORT

The Committee received and noted the quarterly update on the current clinical audit programme.

Mrs Illingworth highlighted from the report:

(1) Quarter 3 was demonstrating progress at 54%, which was a 15% improvement from the same point in the previous year.
(2) It was predicted that the programme would be at around 91% completion by the year end.

Following discussion the Committee members requested:

(i) To include in the next report a breakdown of the audits rated as red - not compliant, (currently only 3 out of 14 rated as green, the rest red and amber) as a comparison with last year;
(ii) Some understanding about why these audits were not compliant.
(iii) To look to see if there were any trends to seek assurance around why the audits are not compliant and link with the Audit Committee to check for any similarities/issues.

19/31 ANNUAL COMMITTEE PERFORMANCE RESULTS

The Committee received and noted the results from the annual performance questionnaire.

The key areas from the results were:

- The Committee has been through a period of review over the last year and work continued to standardise and improve reporting from the sub-groups, in order to provide more assurance with associated narrative and a deeper analysis of the information and data presented.
- The results had revealed that 10 areas had improved in performance with only three areas that had gone down. 21 out of 28 of the questions (75%) received the full score (4).
- The areas that scored lower were around addressing risks, communication with LMGBs and assurance groups and information distributed in enough time prior to the meeting.

Following discussion Dr Griffiths noted that the Committee would continue to work on disseminating the shared understanding of the definition of “assurance” and what that should look like in reports for authors of reports, with clear expectations set out in order to deliver a higher level of assurance.

Furthermore, consultation would take place with Mrs Harte, Chairman Designate, in due course around any further improvements that could be made.

19/32 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no matters of exception raised.

19/33 ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD

There were no other issues that required escalation.

19/34 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.

19/35 COMMITTEE EVALUATION

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

19/36 ANY OTHER BUSINESS

There was no other business to discuss.

19/36 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 04 April 2019, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

The meeting concluded at 3.55pm

……..

Dr Hugh Griffiths
Chairman
04 April 2019

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th April 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.

Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF:	**Board of Directors**
DATE:	**30th April 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 March 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 March 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 Themes remain consistent with previous issues that the Board have been appraised of with planned staffing not always met due to sickness, vacancies and high levels of patient acuity. In addition, wards at west Lane hospital have had periods of low bed occupancy.

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. In addition, Heads of Nursing have been asked to review the previous 6 months of staffing escalation datix forms to check for any themes or hot-spots and to take relevant 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
April 2019

Safe Staffing – March 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 March 2019:

- The number of rosters equated to 65 inpatient wards in March.
- The highest number of red fill rate indicators relate to Registered Nurses on day shifts. This equated to 26 in February 2019, an increase of 8 when compared to January 2019.
- The top 3 inpatient areas where a low staffing fill rate has been reported are:
  - Westwood – 63.5% RN on Days; 63.1% RN on Nights; 77.7% HCA on Days; 93.5% HCA on Nights – the shortfall is in relation to reduced bed occupancy and dependency. There were no breaches of RN on shift.
  - Thistle – 67% RN on Days – The shortfall is in relation to vacancies. All shifts are sent to bank and the ward are utilising HCA's to cover where appropriate. There were no breaches of RN on shift.
  - The Evergreen Centre – 73.3% RN on Days – the shortfall is in relation to discharges and low bed occupancy in the month as well as staffing pressures.
  - The Lodge and Danby Ward have been discounted due to the transition to a third party organisation and identified issues with HealthRoster.
- There were 74 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 – 367.4% RN on Days; 286.7% HCA on Days; 157.6% RN on Nights and 360% HCA on Nights - the increase is due to being open 7 days per week due to an emergency admission.
  - Westerdale South – 148.6% RN on Days; 167% HCA on Days; 88.1% RN on Nights and 323.4% HCA on Nights - Additional HCA's used to accommodate enhanced observations (averaging 4 per day). Additional RN days are due to 2 staff on alternative duties and roster amendments required for a B6 nurse currently on secondment. On nights-unable to always cover the second RN, providing cover with additional HCA.
  - Acomb Garth – 213% HCA on Nights; 77.8% RN on Days – the increase is due to the ward holding the floating post for the service.

Bank Usage:

- The bank usage across the trust equated to 18.8% in March, an increase of 1.7% when compared to February reflecting some end of year pressures related to annual leave.
- There were no wards reporting 50% bank usage in March.
- Lustrum Vale reported the highest bank usage of 38.8% of the actual hours worked. Enhanced Observations (59 shifts) and Establishment Vacancies (51 shifts) were the highest reasons given for requesting bank.
- There were 16 wards that reported greater than 25% bank usage.

Agency Usage:

- The agency usage across the trust equated to 8.4% in March, an increase of 0.3% when compared to February.

- Cedar Ward (NY) reported the highest equating to approximately 61.2% of the total hours worked. Vacancies were cited as the highest reason for this (165 shifts). The ward is using regular agency where possible.

Produced: 16th April 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.

- Those wards reporting 4% or more agency usage in March equated to 31 wards.

Missed Breaks:

- There were 246 shifts in March where an unpaid break had not been taken. This is a reduction of 13 shifts when compared to February 2019.
- 188 shifts where breaks were not taken were attributable to day shifts and related mainly to Registered Nurses.
- 58 shifts where breaks were not taken were attributable to night shifts and related mainly to HCA's.
- A breakdown by locality is as follows:
  - Teesside = 75 shifts with no breaks (The Evergreen Centre had the highest with 12 shifts)
  - Forensics = 72 shifts with no breaks (Lark had the highest with 13 shifts)
  - Durham & Darlington = 32 shifts with no breaks (Bek and Ramsey were the highest with 9 shifts)
  - North Yorkshire = 45 shifts with no breaks (Cedar NY had the highest with 20 shifts)
  - York & Selby = 22 shifts with no breaks (Oak Risk had the highest with 11 shifts)
- This information is being monitored daily as part of the operational services huddle process and monthly via EMT performance visibility wall.

Incidents Raised Citing Staffing Levels:

- There were 45 incidents reported in March 2019 citing issues with staffing covering both inpatient and community services.
- Issues reported were as follows:
  - Staff and patient safety compromised
  - Cancelled patient outpatient appointments
  - Section 17 leave cancelled
  - Unable to take required breaks
  - Unable to carry out security checks.
  - Unable to respond to other wards in emergency.

  Heads of Nursing have been asked to undertake a 6 monthly review of staffing escalation for their areas to identify themes/hot-spots.

Severity Rating:

- Using a severity rating scale to identify potential outliers, the top 5 is as follows:
  - Westwood Centre – 10 points awarded
  - The Lodge – 9 points awarded
  - Maple – 9 points awarded
  - Ebor – 9 points awarded
  - Danby Ward – 9 points awarded
- Using the YTD score (Mar 18 to Mar 19) the following appear in the top 5:
  - The Evergreen Centre – 108 points awarded
  - Cedar Ward (D&D) – 101 points awarded
  - The Lodge – 98 points awarded
  - Westerdale south – 95 points awarded
  - Bedale Ward – 94 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 March is reporting at 14.89 (4.82 registered nurses, 9.81 unregistered nurses, 0.17 registered AHP and 0.09 unregistered AHP).
- Using standard deviation (Mar 18 to Mar 19) the following appear as positive outliers:
  - Ward 15 – unregistered nurses (due to ward closure)
  - Jay Ward – registered nurses
  - Ward 14 – registered nurses (due to ward closure)
  - 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 – March 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.10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th April 2019**
TITLE:	**Learning from deaths – Dashboard Report 2018/19**
REPORT OF:	**Jennifer Illingworth, Director of Quality Governance**
REPORT FOR:	**Information**

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

Executive Summary:

The Learning from Deaths dashboard report sets out the approach the Trust is taking towards the identification, categorisation and investigation of deaths in line with national guidance. The mortality dashboard for the 2018/19 financial year is included at Appendix 1 and includes 2017/18 data for comparison.

Work continues to ensure the numbers of deaths reported (both in and out of scope) are as accurate as possible to allow us to gain maximum learning from this process. There has been an 89% increase in the number of mortality reviews undertaken when compared to the previous year and, although there were more serious incidents reported relating to deaths, the number of those where there was significant learning for the Trust has reduced from 44% in 2017/18 to 30% in 2018/19.

Recommendations:

The Board of Directors is requested:

- To note the content of this report, the dashboard and the areas for ongoing improvement

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**30th April 2019**
TITLE:	**Learning from deaths - Dashboard Report 2018/19**

1. INTRODUCTION & PURPOSE:

1.1 To formally report to the Board of Directors key information on 'Learning from deaths' in line with national guidance and the Trust 'Learning from deaths: the right thing to do' policy (CORP 00-65).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Following the publication of the Southern Health report in 2015 there has been enhanced national scrutiny on how all NHS organisations respond to the deaths of service users in their care. This culminated in the release of a 'Learning from deaths framework' which was published by the National Quality Board (NQB) in 2017. The ongoing implementation of the requirements of this framework will be monitored on a quarterly basis via the Patient Safety Group.

All NHS Trusts are now required to publish a dashboard (Appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis, which are in-scope of the learning from deaths policy, and also the proportion of those deaths which were subject to any investigation or mortality review. It is important to note that when reviewing the data presented in the dashboard all of the deaths categorised as 'in scope for the learning from deaths policy' are subject to an initial clinical review before determining if they require further investigation.

3. KEY ISSUES:

3.1 Identification of deaths to be reviewed

We have continued to observe an increase of the numbers of deaths that are now reported through our incident management system (over and above the unexpected deaths that have always been reported via this route). This is a positive development as it allows a greater number of incidents to be channelled through our mortality review process which, in turn, will lead to greater opportunities for learning.

3.2 CQC Learning from deaths – A review of the first year of NHS trusts implementing national guidance

This CQC report was published in March 2019 and states that from their perspective Trusts are at different stages of implementing the guidance with some finding it more difficult than others to make the changes needed. They also write that there is evidence to suggest that the guidance is better suited to acute trusts rather than mental health or community services. This included the high number of deaths in the more community based services and the fact that the majority of these will not be serious incidents. It was noted that this may be taken into account when updating guidance in future.

3.2 Mortality Review

Our current approach to mortality review is to identify those service users on the Care Programme Approach who have died but do not fall into the category of a Serious Incident. During 2018/19 there were 204 mortality reviews undertaken which greatly exceeds the total of 108 reviews undertaken in 2017/18. This reflects both the

improved formal reporting of deaths considered to be of 'natural causes' and improvements to the Trusts own mortality review processes.

3.3 Appendix 1: Dashboard

The learning from deaths dashboard is attached at Appendix 1 which also includes 2017/18 data for comparison. For 2018/19 the dashboard highlights the following:

- 2308 deaths were recorded in total (2306 in 2017/18)
- 128 serious incident reviews relating to deaths were completed (99 in 2017/18)
- 39 learning points* were identified from the 128 serious incidents reviewed (this equates to 30% - in 2017/18 it was 44%)
- 204 cases were reviewed as part of the mortality review process (89% increase on previous year)
- 13 learning disability deaths (community) were reviewed and also reported to LeDeR which shows improved reporting processes from 2017/18
- 25 deaths of in-patients were reported in 2018/19 (5 were investigated as serious incidents, 10 were patients who were transferred to an acute trust due to deterioration in physical health and died there and 10 were patients who died on TEWV wards from known physical health issues such as cancer). The 20 patients (not SI's) were all subject to a mortality review.

*For the purpose of this report the learning identified from Serious Incidents has been categorised as those cases which concluded with either a root cause or contributory finding meaning the outcome *may* have been different if different decisions had been made or different circumstances in place.

5.0 IMPLICATIONS:

5.1 Compliance with the CQC Fundamental Standards:
CQC look at a range of data to help them monitor trusts that provide mental health services. This report provides evidence in respect of Regulation 17 – Good Governance.

5.2 Financial/Value for Money:
There are financial and reputational implications associated with poor standards of quality service.

5.3 Legal and Constitutional (including the NHS Constitution):
CQC's Fundamental Standards in respect of Regulation 17 - Good Governance.

5.4 Equality and Diversity:
Feedback received associated with discrimination is, where this is apparent, forwarded for review by the Equality and Diversity lead.

5.5 Other implications: No other implications identified.

6. RISKS: There is a risk that the data published is compared by others with the data of other organisations that may not provide similar services.

7. CONCLUSION:
This dashboard report contains the trust information relating to the national learning

from deaths agenda. Work continues to ensure the numbers of deaths reported (both in and out of scope) are as accurate as possible to allow us to gain maximum learning from this process. There has been an 89% increase in the number of mortality reviews undertaken when compared to the previous year and, although there were more serious incidents reported relating to deaths, the number of those where there was significant learning for the Trust has reduced from 44% in 2017/18 to 30%.

8. RECOMMENDATIONS:

The Board of Directors is requested:

- To note the content of this report, the dashboard and the areas for ongoing improvement

Jennifer Illingworth
Director of Quality Governance
April 2019

Background Papers:

Learning From Deaths Framework
https://www.england.nhs.uk/?s=Learning+from+Deaths

Southern Health Report
https://www.england.nhs.uk/2015/12/mazars/

Serious Incident Framework
https://www.england.nhs.uk/?s=serious+incident+framwework

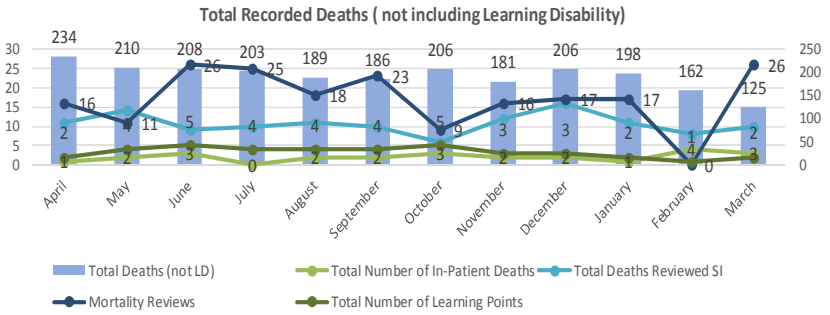
Appendix 1 Dashboard

Learning from Deaths Dashboard - Data Taken from Paris and Datix **Reporting Period - 2018/19**

Summary of total number of deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)

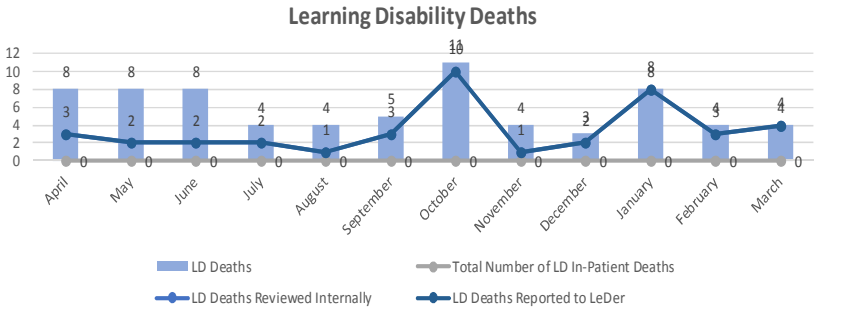
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed SI		Mortality Reviews		Total Number of Learning Points	
	2018/19	2017/18	**2018/19**	2017/18	**2018/19**	2017/18	**2018/19**	2017/18	**2018/19**	2017/18
Q1	**652**	↗ 539	**6**	↗ 2	**34**	↗ 17	**53**	↗ 26	**11**	↗ 9
Q2	**578**	↗ 521	**4**	↗ 3	**31**	↗ 16	**66**	↗ 26	**12**	↗ 7
Q3	**593**	↗ 568	**7**	↗ 6	**34**	↗ 30	**42**	↗ 28	**11**	↘ 12
Q4	**485**	↘ 678	**8**	↗ 5	**29**	↘ 36	**43**	↗ 28	**5**	↘ 16
YTD	**2308**	↗ 2306	**25**	↗ 16	**128**	↗ 99	**204**	↗ 108	**39**	↘ 44



Summary of total number of Learning Disability deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Learning Disability Deaths, and total number reported through LeDer

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2018/19	2017/18	**2018/19**	2017/18	**2018/19**	2017/18	**2018/19**	2017/18
Q1	**24**	↗ 10	**0**	↔ 0	**7**	↗ 0	**7**	↗ 5
Q2	**13**	↗ 12	**0**	↔ 0	**6**	↗ 3	**6**	↗ 4
Q3	**18**	↗ 14	**0**	↘ 1	**13**	↗ 3	**13**	↗ 7
Q4	**16**	↗ 11	**0**	↔ 0	**15**	↗ 6	**15**	↗ 4
YTD	**71**	↗ 47	**0**	↘ 1	**41**	↗ 12	**41**	↗ 20



Item 12

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**30 April 2019**
TITLE:	**Finance Report for Period 1 April 2018 to 31 March 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 March 2019 was a surplus of £55,088k, representing 15.5% of the Trust's turnover and was £45,255k ahead of the revised NHSI plan.

This above plan performance reflects a number of technical accounting adjustments relating to property and a benefit from additional provider sustainability fund (PSF) allocation from NHS Improvements. Excluding these technical adjustments the Trust was £456k ahead of its operational plan.

Performance Against Plan – year to date (3.2)

	Variance £000	**Monthly Movement £000**	**Movement**
The Trust was £45,225k **ahead** of its annual financial plan.	-45,225	-43,827	↑

Cash Releasing Efficiency Savings (CRES) (3.3)

	CRES Type	**Annual Variance £000**	**Movement**
Identified CRES schemes for the financial year were £69k **behind** financial plan.	Recurrent	4,380	↑
	Non recurrent	-4,311	→
	Target	0	
	Variance	69	↑

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

A Waste Reduction Programme was established during 2018/19 to assist the Trust in delivering the 3 year recurrent CRES plan.

Capital (3.4)

	Variance £000	Monthly Movement £000	Movement
The Trust was £1,365k **behind** its capital plan.	1,365	557	↑

Expenditure against the capital programme to 31 March 2019 was £18,561k and was £1,365k behind plan due to payment slippage on Foss Park Hospital development and the delayed start on an emergency facility and crisis assessment suite. These were partially offset by expenditure incurred on I.T. licenses.

The Trust received a capital rebate relating to prior year schemes (£2,289k) and incurred £3,216k expenditure relating to Roseberry Park rectification work. With these included, capital expenditure was £438k behind plan.

Workforce (3.5)

	Variance £000	Monthly Movement £000	Movement
The Trust was £3,751k (65%) **in excess** of its agency cap.	3,751	461	↓

Agency expenditure remains high in March across all localities. Nursing (55%) and Medical (29%) accounted for the majority of agency expenditure, which was used to support vacancies and enhanced observations with complex clients. EMT approved the enhancement of the temporary staffing team to support the reduction of agency expenditure during 2019/20.

Use of Resources Risk Rating (UoRR) (3.7)

	Plan	Actual	Movement
The Trust was **behind** its planned UoRR which is rated 1 to 4 with 1 being good.	1	3	→

The UoRR for the Trust was assessed as 3 for the period ending 31 March 2019 and was behind plan (Table 4). Agency expenditure exceeded the 50% NHSI cap and was rated as a 4. As a result the Trust's highest achievable rating was 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 initiatives are being introduced to reduce dependency on agency, and progress continues to inform conversations with NHSI.

Recommendations:

The Board of Directors are requested to note the delivery of the Trust's control total for 2018/19 which is subject to review by external audit.

MEETING OF:	**Board of Directors**
DATE:	**30 April 2019**
TITLE:	**Finance Report for Period 1 April 2018 to 31 March 2019**

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for 1 April 2018 to 31 March 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 achieved the control total set by NHSI.

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

3.2 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 31 March 2019 was a surplus of £55,088k, representing 15.5% of the Trust's turnover and was £45,255k ahead of the revised NHSI plan.

This above plan performance reflects a number of technical accounting adjustments relating to property and a benefit from additional provider sustainability fund (PSF) allocation from NHS Improvements. Excluding these technical adjustments the Trust was £456k ahead of its operational 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	(338,415)	(338,415)	(339,259)	(844)	468
Other Operating Income	(17,530)	(17,530)	(16,584)	946	(494)
Total Income	**(355,945)**	**(355,945)**	**(355,843)**	**102**	**380**
Pay Expenditure	271,949	271,949	268,274	(3,675)	(1,756)
Non Pay Expenditure	65,033	65,033	67,786	2,753	701
Depreciation and Financing	9,100	9,100	9,464	364	(318)
Variance from plan	**(9,863)**	**(9,863)**	**(10,319)**	**(456)**	**(1,398)**
Property Technical Adjustment	0	0	(12,481)	(12,481)	0
Additional PSF	0	0	(32,288)	(32,288)	0
Variance from plan	**(9,863)**	**(9,863)**	**(55,088)**	**(45,225)**	**(1,398)**

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 was behind plan (£69k) and continues to identify schemes to ensure full delivery of recurrent CRES requirements.

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the financial year are £69k **behind** financial plan.	Recurrent	4,380	
	Non recurrent	-4,311	
	Target	0	
	Variance	69	

3.4 Capital

Expenditure against the capital programme to 31 March 2019 was £18,561k and was £1,365k behind plan due to payment slippage on Foss Park Hospital development and the decision to delay the start on an emergency facility and crisis assessment suite. These were partially offset by expenditure incurred on I.T. licenses.

The Trust received a capital rebate relating to prior year schemes (£2,289k) and incurred £3,216k expenditure relating to Roseberry Park rectification work. With these included, capital expenditure was £437k 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 Mar-19	Oct	Nov	Dec	Jan	Feb	Mar
Establishment (a) (90%-95%)	92.38%	93.46%	93.96%	93.37%	93.03%	92.24%	92.38%
Agency (b)	1.00%	3.25%	3.40%	3.40%	3.44%	3.52%	3.51%
Overtime (c)	1.00%	1.09%	1.07%	1.10%	1.02%	1.03%	1.02%
Bank & ASH (flexed against establishment) (100%-a-b-c)	5.62%	3.13%	3.22%	3.20%	3.13%	3.09%	2.99%
Total	**100.00%**	**100.93%**	**101.65%**	**101.01%**	**100.62%**	**99.88%**	**99.98%**

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 March 2019 the tolerance for Bank and ASH was 5.62% of pay budgets.

NHS Improvement monitors agency expenditure against a capped target. Agency expenditure at 31 March 2019 was £9,541k which was £3,752k (65%) in excess of the agreed annual capped target of £5,789k. Nursing and Medical agency expenditure accounts for 83% of total agency expenditure, and was 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 March 2019 was £72,720k, and was £12,956k 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 was assessed as 3 for the period ending 31 March 2019 and was behind plan. Agency expenditure exceeds the 50% NHSI cap and was rated as a 4. As a result the Trust's highest achievable rating was overridden as a 3. Excluding this override the Trust would be assessed as a rating of 2 which remained 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 March 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	5.24x	1	1.65x	3	
Liquidity	81.46 days	1	41.84 days	1	
I&E margin	26.3%	1	2.9%	1	
I&E margin distance from plan	23.4%	1	0.0%	1	
Agency expenditure	£9,541k	4	£5,789k	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 had a capital service capacity of 5.24x (can cover debt payments due 5.24 times), which was ahead of plan and rated as a 1.

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 81.46 days; this was ahead of plan and 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 had a I&E margin of 26.3%, which was 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 was 23.4% which was 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 was 65% higher than the capped target and was rated as a 4. EMT approved the enhancement of the temporary staffing team to support the reduction of agency expenditure during 2019/20.

4. IMPLICATIONS:

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

5. RISKS:

5.1 Any findings from the external audit may alter the financial outturn position and associated financial risk rating indicators.

6. CONCLUSIONS:

6.1 For the period ending 31 March 2019 the Trust was £45,225k ahead of the revised control total surplus submitted to NHSI mainly due to technical adjustments and additional provider sustainability fund (PSF) allocation from NHS Improvements. Excluding these technical adjustments the Trust was £456k ahead of its operational plan.

6.2 The amount of CRES identified for the financial year and rolling 3 year period was 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 was assessed as 3 for the period ending 31 March 2019 and was behind plan. Agency expenditure exceeded the 50% NHSI cap and was rated as a 4. As a result the Trust's highest achievable rating was overridden as a 3. Excluding this override the Trust would be assessed as a rating of 2 which remained 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 are requested to note the delivery of the Trust's control total for 2018/19 which is subject to review by external audit.

Patrick McGahon
Director of Finance and Information

ITEM 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th April 2019**
TITLE:	**Board Dashboard as at 31st March 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 March 2019, 5 (28%) of the indicators reported are not achieving the expected levels and are red across three of the four domains excluding the activity domain. This is a slight decrease on the 4 that were reported as at the end of February 2019. In addition there are 6 KPIs (33%) that whilst not achieving the target are within the 'amber' tolerance levels, with 7 achieving the target and being rated as green (39%).

Of the 11 indicators that are either red or amber 4 are showing an improving trend over the previous 3 months.

The position for the year is that there are 6 KPIs (33%) which are reported as red which is better than performance in 2017/18 where 42% of the indicators were rated red for the year as a whole.

In terms of the Single Oversight Framework targets the Trust achieved all the operational targets in March 2019 and for Quarter 4 however there was variation in terms of delivery at CCG level.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**30th April 2019**
TITLE:	**Board Dashboard as at 31st March 2019**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 31st March 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 March 2019, 5 (28%) of the indicators reported are not achieving the expected levels and are red across three of the four domains excluding the activity domain. This is a slight decrease on the 4 that were reported as at the end of February 2019. In addition there are 6 KPIs (33%) that whilst not achieving the target are within the 'amber' tolerance levels, with 7 achieving the target and being rated as green (39%).

  Of the 11 indicators that are either red or amber 4 are showing an improving trend over the previous 3 months.

  The position for the year is that there are 6 KPIs (33%) which are reported as red which is better than performance in 2017/18 where 42% of the indicators were rated red for the year as a whole.

- In terms of the Single Oversight Framework targets the Trust achieved all the operational targets in March 2019 and for Quarter 4. In terms of the **quarterly** position specific issues are as follows:
  - The 7 day follow up following discharge was achieved in all CCGs which is the first time since Quarter 1.
  - Access to Early Intervention in Psychosis – we failed to achieve the target in 4 CCGs: the three CCGS in North Yorkshire and Vale of York. Capacity within the North Yorkshire service has remained problematic and the service are making attempts to use agency staff to address this. Investment in Vale of York services is lower than would be expected however the CCG has agreed to increase investment into EIP services in 2019/20.
  - IAPT/Talking Therapies – proportion of people completing treatment who move to recovery" – There were two CCGs areas where the target was not achieved (DDES CCG, and Vale of York). In DDES there was a significant number of patients who did not attend or dropped out of treatment and therefore are not classed as 'recovered' as the outcome measure cannot be completed. In Vale

of York a significant amount of patients made some recovery but this was not at sufficient levels to be classed as the patient moving towards recovery. In addition the target was not achieved in North Durham for the month of March 2019.

- Inappropriate Out of Area Occupied Bed Days – the target was not achieved in 3 CCGs area (North Durham, Darlington and Scarborough and Ryedale) in March 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.

3.2 Key Risks

- Waiting times (KPI 1 and 2) – Both indicators are currently not achieving the target although they are both rated amber in March 2019 (and for the year as a whole). The 6 week treatment indicator showed a further improvement in March building on that seen in February. Sickness and vacancies continue to impact on Performance in a number of teams in North Yorkshire and York and Selby services.
- %age of patients reporting their experience as excellent or good (KPI 4) – Performance achieved target in March 2019 for the first time since October 2018. For the year as a whole it was 1 percentage point below target. The outlier is Forensic services and this relates to poorer performance in the Offender Health Services. Action has now been identified which it is expected will improve performance in the future. Durham and Darlington and Teesside exceeded the target in March 2019.
- Number of Unexpected Deaths Classed as a Serious Incident (KPI 5) – There has been a deterioration in performance for the month of March 2019 with the rate being higher than the previous two years. There were 10 unexpected deaths classed as a SUI in March 2019 which is two more than in February. The majority were within Teesside but no particular themes have been identified at this stage.
- Outcome Indicators (KPIs 6 and 7) – Performance against KPI 6 (HONOS) has deteriorated for the second month in March 2019. Whilst no locality is achieving the target, Teesside is performing the best at 66.7% in March. In terms of KPI 7 (SWEMWEBS) there has been an improvement in performance in March 2019, which is positive given that the position has deteriorated in the previous 3 months. The Clinical Outcomes Steering Group, chaired by Dr Ruth Briel, has held its first meeting and will oversee some focused work over the next 6-months.
- Activity Indicators (KPI 8-11) – Whilst we are only monitoring these indicators for 2018/19 it can be seen that the actual levels in March 2019 have mainly followed previous years trends in previous years.
- Bed Occupancy (KPI 12) – There has been a slight deterioration in bed occupancy in March 2019 compared to February. The main areas of concern continues to be Teesside. The work on bed management continues with a particular focus on addressing reasons for inappropriate

long lengths of stay. The improved performance of KPI 13 (Number of patients with a LOS >90 days) demonstrates the impact that this is having.

- Actual Workforce Number in month (KPI 15) – The position remains worse that target and shows a similar position to that in February 2019. Work is ongoing, for both medical and non-medical staffing, to improve recruitment and retention of staff in order to improve performance against this indicator.
- Compliance with Mandatory Training (KPI 18) – the target of 92% was achieved in March 2019 which is positive given that the target now includes all mandatory training. Performance has been better than 2017/18 for every month.
- Sickness Absence Rate (KPI 19) – the Trust continues not to achieve target although did show an improvement in the figure reported in March 2019 (February sickness) which mirrors the trend in previous years. However the position reported was greater than that reported in March 2018 and 2017. The revised approach to managing sickness absence has been sent to the Business Disability Forum in order to gather their views on it.
- Financial Targets (KPI 21) – In the month of March 2019 (and Year to Date) we have not achieved the target for CRES delivery, although we did achieve the I &E target and the cash against plan target. Further details are provided in the Finance Report on the Board agenda.

2.4 Data Quality Assessment.

The data quality assessment of the Dashboard indicators is included in Appendix D. There are no changes to the scores to highlight.

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

	March 2019				April 2018 To March 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%	87.41%			90.00%	86.82%		90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral	60.00%	56.76%			60.00%	54.82%		60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	2,264.00	874.00			2,264.00	874.00		2,264.00
4) Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	92.67%			92.45%	91.41%		92.45%
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.74			12.00	21.31		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%	63.33%			67.25%	59.41%		67.25%
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	78.25%	69.77%			78.25%	67.38%		78.25%

Activity

	March 2019				April 2018 To March 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
8) Number of new unique patients referred		7,161.00				83,472.00		
9) The number of new unique patients referred with an assessment completed		4,263.00				51,553.00		
10) Number of new unique patients referred and taken on for treatment		1,611.00				18,742.00		
11) Number unique patients referred who received treatment and were discharged		2,288.00				27,682.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	90.93%			85.00%	93.06%		85.00%

Trust Dashboard Summary for TRUST

	March 2019				April 2018 To March 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	48.00			68.00	48.00		68.00
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.93%	21.98%			23.93%	22.86%		23.93%

Workforce

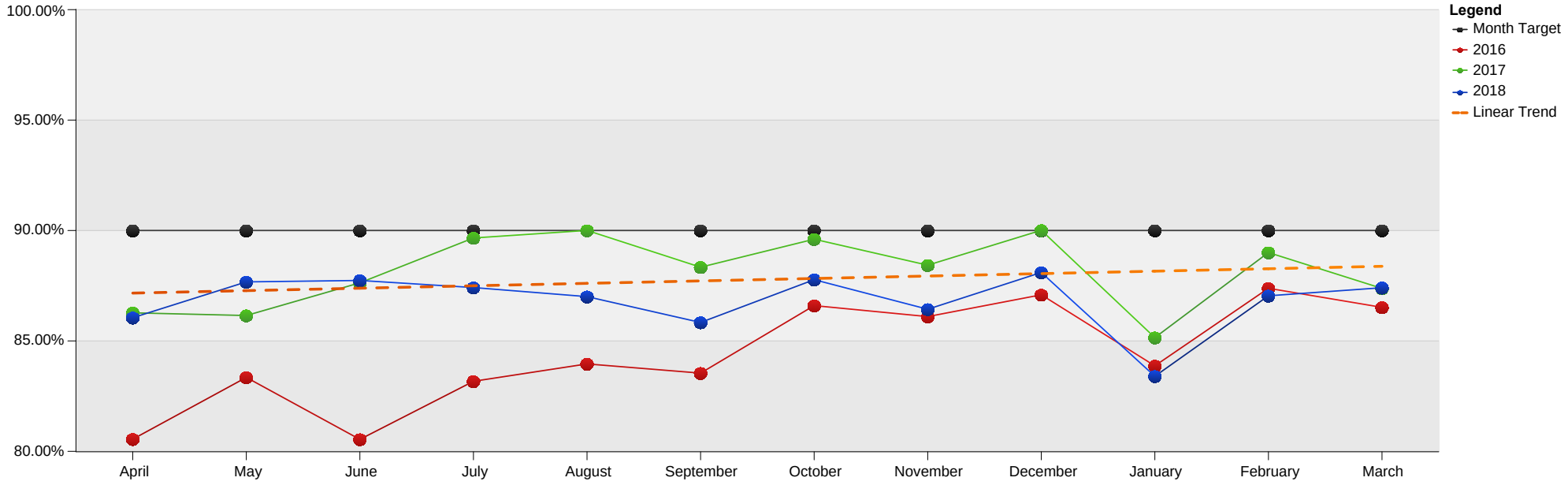
	March 2019				April 2018 To March 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
15) Actual number of workforce in month (Establishment 95%-100%)	95.00%	92.38%			95.00%	92.38%		95.00%
16) Vacancy fill rate	90.00%	61.24%			90.00%	78.88%		90.00%
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	92.32%			95.00%	92.32%		95.00%
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	93.23%			92.00%	93.23%		92.00%
19) Percentage Sickness Absence Rate (month behind)	4.50%	5.34%			4.50%	5.03%		4.50%

Money

	March 2019				April 2018 To March 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
20) Delivery of our financial plan (I and E)	-1,340,000.00	-16,844,825.00			-9,864,000.00	-26,766,868.00		-9,864,000.00
21) CRES delivery	686,782.00	595,763.00			8,241,384.00	6,479,880.00		8,241,384.00
22) Cash against plan	59,764,000.00	72,719,743.00			59,764,000.00	72,719,743.00		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

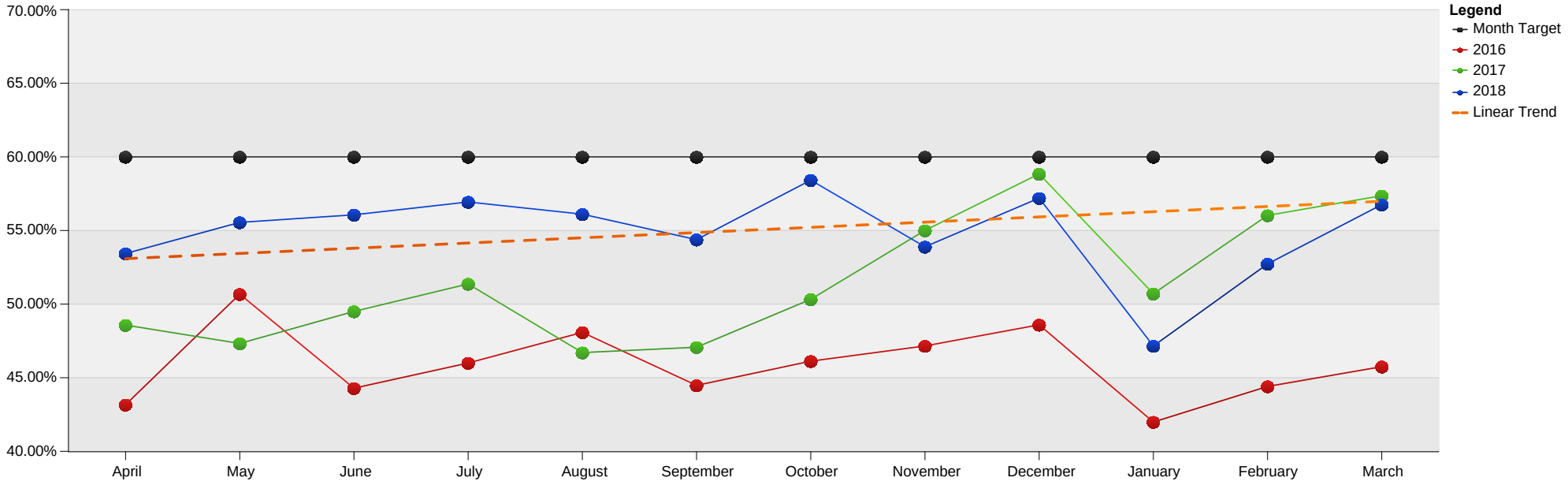


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	87.41%	86.82%	85.59%	85.68%	92.15%	91.79%	77.30%	75.75%	99.76%	99.52%	84.42%	81.22%		

Narrative
The position for March 2019 is 87.41% relating to 5421 patients out of 6202 who were seen within 4 weeks. This is worse than the target of 90% and similar to the position reported in in February 2019.Areas of concern:• York AMH at 85.02%% (227 of 267 patients) which is an improvement from February 19. Performance continues to be impacted by the high DNA rate, sickness and vacancies. • York MHSOP at 83.09%. (280 out of 337 patients) This is impacted by issues related to capacity in the memory service and plans are in place to address this.• North Yorkshire AMH at 74.45% (274 of 368 patients).This is an improvement from February 19. The withdrawal of local authority integrated team members in Harrogate has impacted and this is under review.• North Yorkshire MHSOP at 73.95%. (335 of 453 patients) This is an improvement from February 19. Plans are under way to review processes and skill mix.• Durham and Darlington AMH at 63.94% (321 out of 502 patients) and this is a slight deterioration on the previous month. Concerns continue due to a sustained high number of referrals, staff sickness and vacancies. Capacity will increase through the recruitment of staff and as staff on sick leave return to work.The Trust position for the financial year 2018/19 is 86.82% which has not achieved the target and a deterioration on the 90.73% outturn of 2017/18.

Trust Dashboard Graphs for TRUST

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

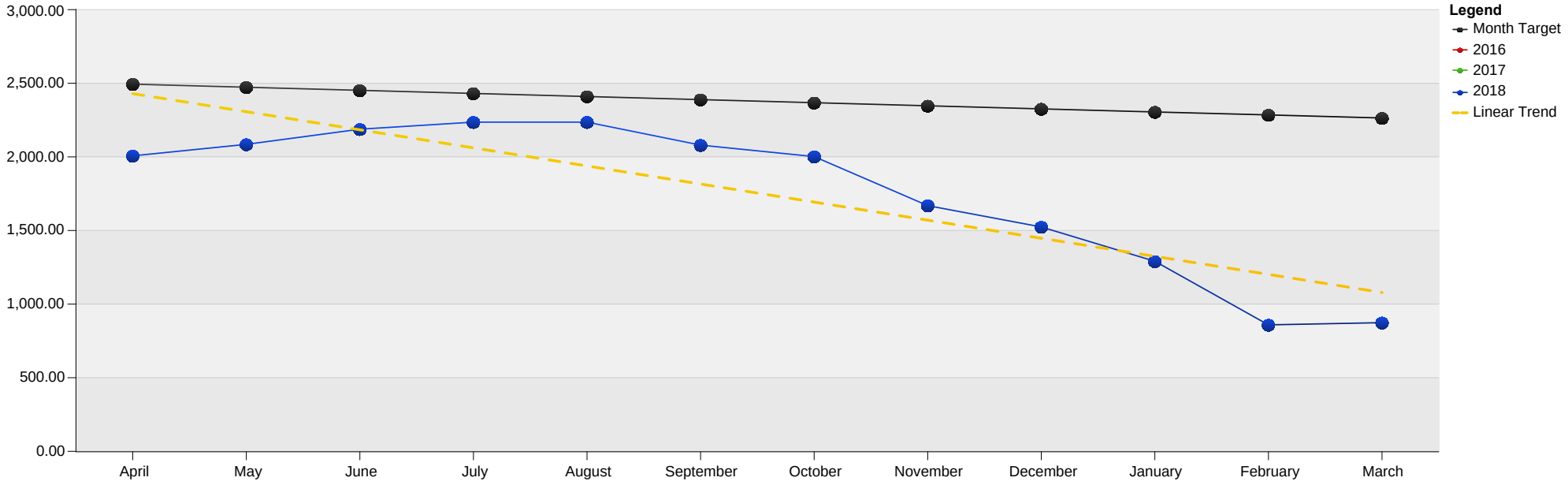


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients starting treatment within 6 weeks of an external referral	56.76%	54.82%	52.34%	53.02%	64.87%	63.01%	45.43%	44.63%	95.45%	91.35%	57.70%	47.15%		

Narrative
The position for March 2019 is 56.76%, which is worse than the target however an improvement on the position reported in February 2019. The improvement in performance follows a similar trend to that seen in March of the previous two years. All localities, with the exception of Forensic services and Teeside continue to perform below target. North Yorkshire and Durham and Darlington report the lowest performance.Within North Yorkshire guidance around appropriate activity code has been provided to ensure treatment is recorded correctly. Within York and Selby data quality had been of concern in terms of the use of appropriate intervention codes. This has been resolved and the anticipated improvements in performance have been seen.The Trust position for the financial year 2018/19 is 54.82% which has not achieved the target, as this was a new indicator for 2018/19 no comparison with 2017/18 can be made.

Trust Dashboard Graphs for TRUST

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

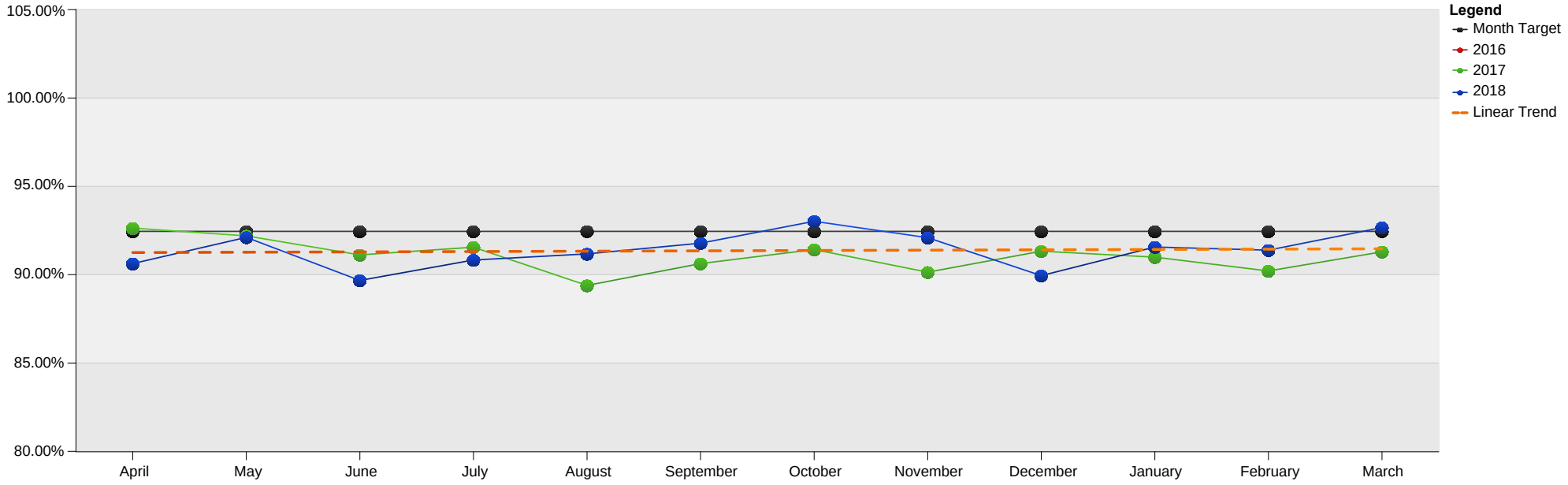


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	874.00	874.00	93.00	93.00	207.00	207.00	419.00	419.00			155.00	155.00		

Narrative
The Trust position for March 2019 is 874 which is a slight increase on the 859 recorded in February and meeting the target of 2,264. All localities are meeting this indicator.

Trust Dashboard Graphs for TRUST

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

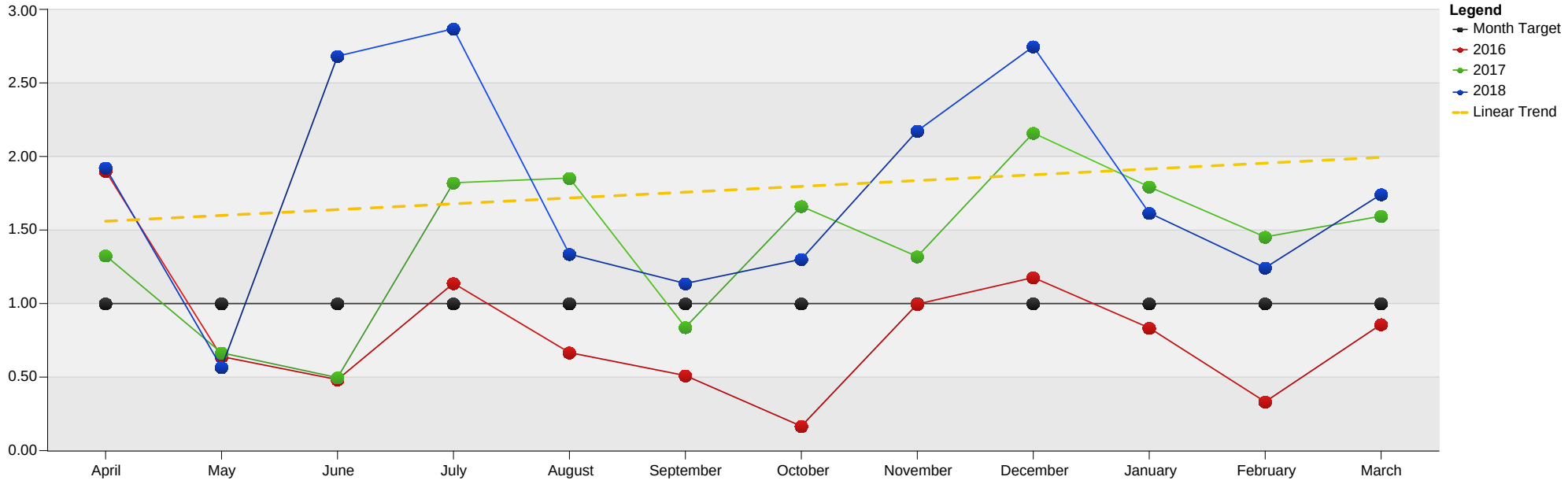


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of patients surveyed reporting their overall experience as excellent or good	92.67%	91.41%	95.32%	92.64%	94.57%	92.60%	89.44%	91.55%	83.46%	82.95%	92.35%	89.35%		

Narrative
The Trust position for March 2019 is 92.67% which is achieving the target of 92.45% and an improvement to that reported in February 2019. This is the second best position in the year to date.Teeside and Durham and Darlington are meeting target. Forensic services report the lowest position at 83.46%. This is attributable to Offender Health and plans are in place which includes focus groups to improve the understanding of service user's feedback and concerns and action to identify and address them..The Trust position for the financial year 2018/19 is 91.41% which is not achieving the target and is similar to the 91.56% out turn recorded for 2017/18. 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



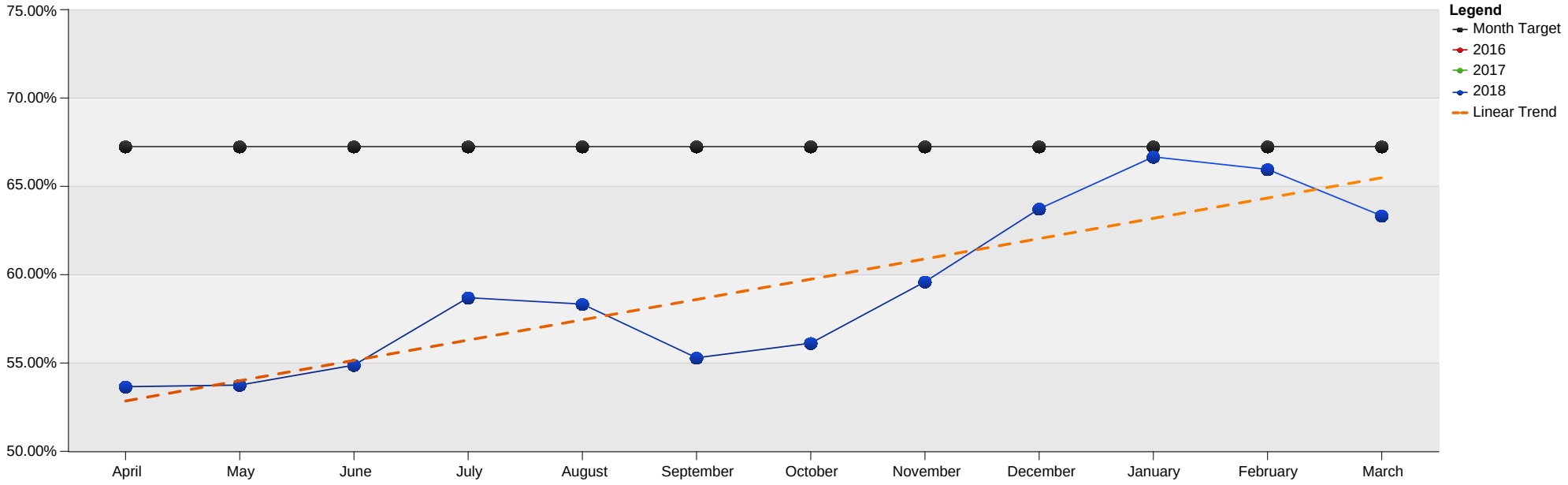
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.74	21.31	0.41	16.09	3.85	21.65	2.06	27.47	0.00	700.00	1.32	20.02		

Narrative

The Trust position for March 2019 is 1.74, which is a deterioration on the position reported in February 2019. This rate relates to 10 unexpected deaths in March 2019 which is an increase on the 7 recorded in February. The Patient Safety Team is monitoring the overall trend for any particular patterns, which are discussed by the Patient Safety Group. Of the 10 unexpected deaths the details below shows a breakdown by locality:• 6 x Teeside• 2 x North Yorkshire• 1 x York and Selby• 1 x Durham and DarlingtonOf the unexpected deaths that occurred in March 2019, 8 occurred in AMH and 2 in MHSOP The Trust position for financial year 18/19 is 21.31 which is not achieving the target and an increase on the 16.34 out turn reported for 2017/18.

Trust Dashboard Graphs for TRUST

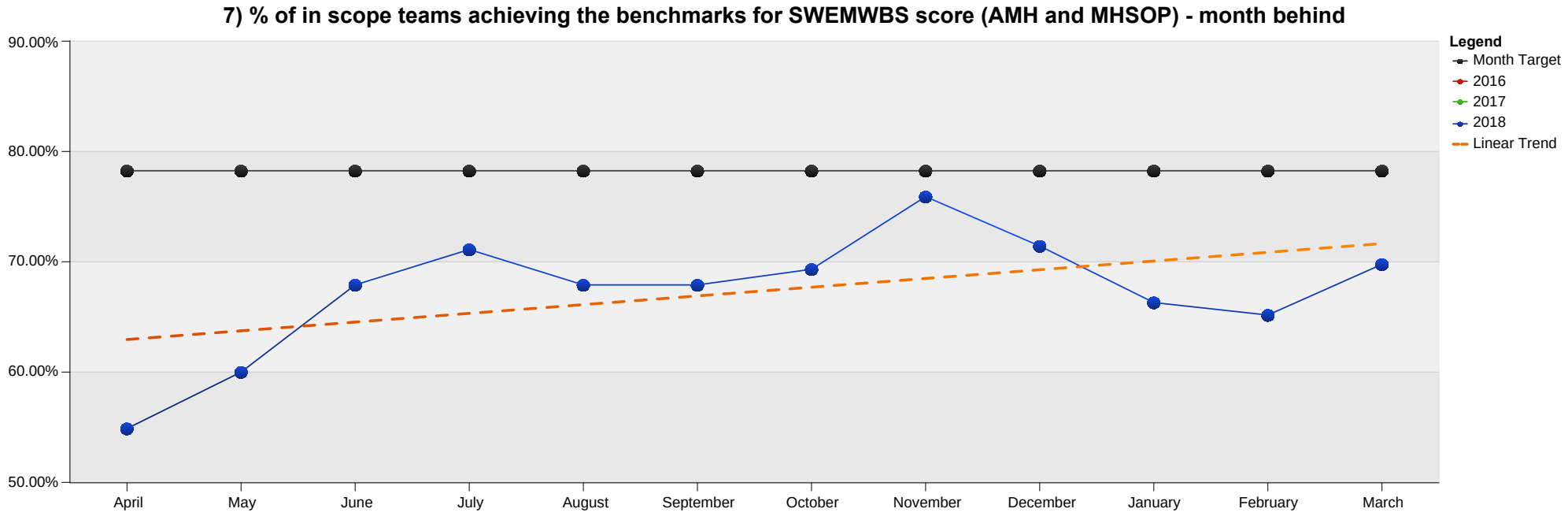
6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind



	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	63.33%	59.41%	67.86%	56.10%	66.67%	62.14%	54.17%	60.93%			63.64%	58.14%		

Narrative
The Trust position for March 2019 is 63.33%, which is worse than the target of 67.25% and a continued slight deterioration on the position reported in February 2019.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.Durham and Darlington is the only locality meeting target with North Yorkshire reporting the poorest position at 54.17%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 2019. A paper has been presented to the Trust's Clinical Leaders about the current position on outcomes. Work being taken forward includes the establishment of a Trust-wide all speciality clinical outcomes chaired by Dr. Ruth Briel.The Trust position for the financial year 2018/19 is 59.41% which is not achieving the target, as this was a new indicator for 2018/19 no comparison with 2017/18 can be made.

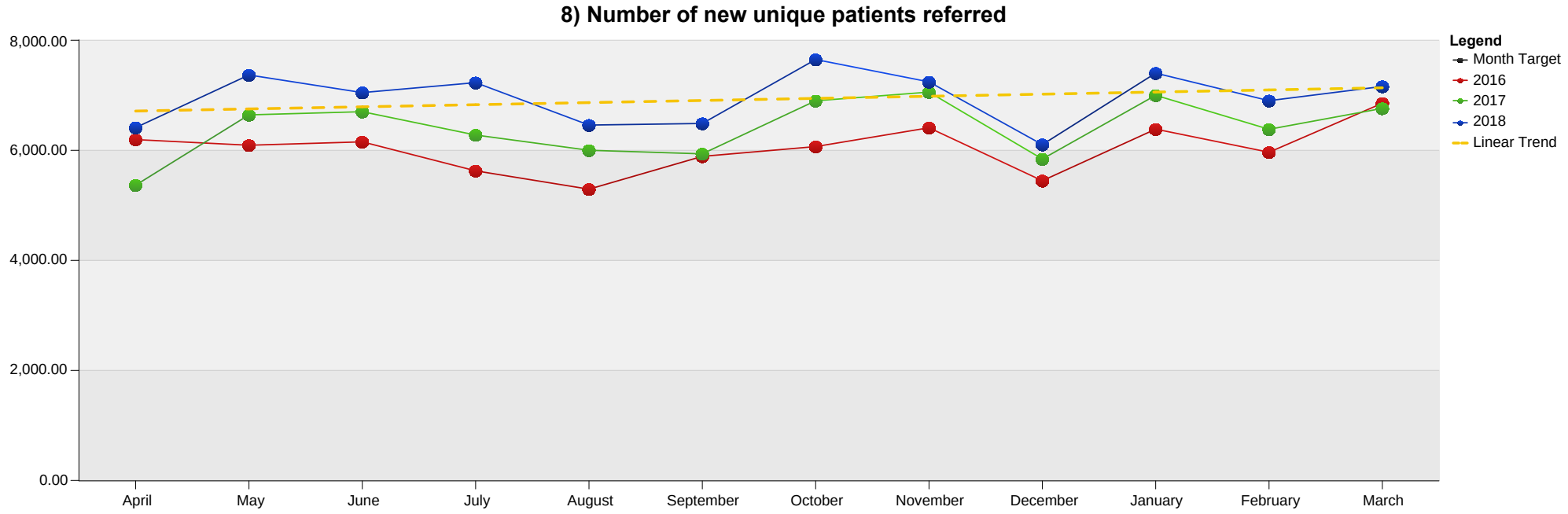
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	69.77%	67.38%	66.67%	65.95%	70.37%	66.33%	81.82%	74.39%			50.00%	56.90%		

Narrative
The Trust position for March 2019 is 69.77%, which is worse than the target of 78.25% however an improvement on the position reported in February and to the deteriorating trend seen since 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 includes the establishment of a Trust-wide all speciality clinical outcomes chaired by Dr. Ruth Briel.The Trust position for the financial year 2018/19 is 67.38% which is not achieving the target, as this was a new indicator for 2018/19 no comparison with 2017/18 can be made.

Trust Dashboard Graphs for TRUST

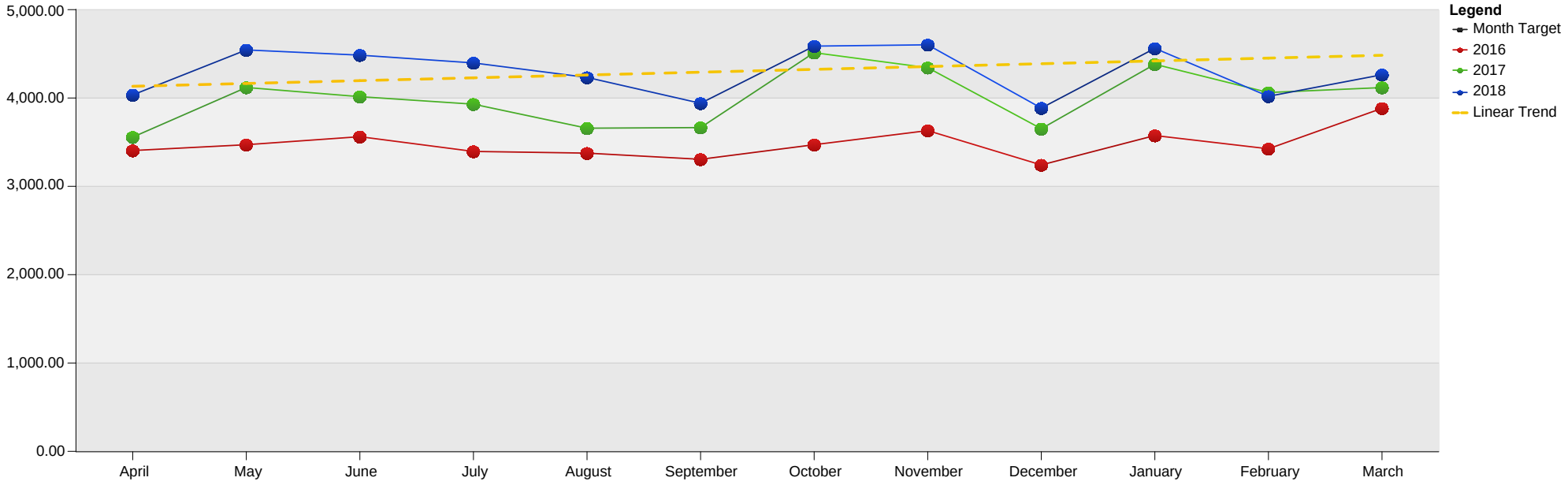


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Number of new unique patients referred	7,161.00	83,472.00	2,258.00	25,774.00	2,571.00	29,365.00	1,064.00	13,742.00	372.00	4,882.00	891.00	9,704.00		

Narrative
The Trust position for March 2019 is 7,161 whilst this is an increase on the position reported for February 2019. This follows the trend in previous years, however the data shows that 2018/19 is higher than the previous two years. . 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.The Trust position for the financial year 2018/19 is 83,472, which is an increase on the 76,871 out turn recorded for 2017/18 .

Trust Dashboard Graphs for TRUST

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

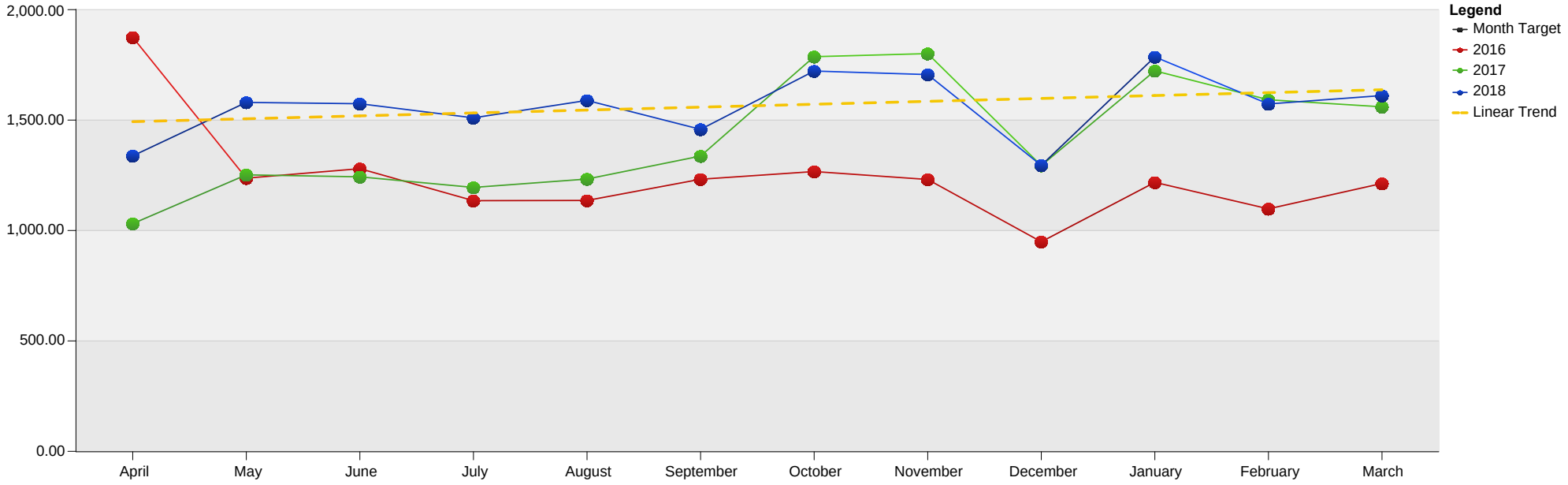


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The number of new unique patients referred with an assessment completed	4,263.00	51,553.00	1,352.00	15,683.00	1,477.00	18,241.00	697.00	8,451.00	223.00	3,500.00	512.00	5,676.00		

Narrative
The Trust position for March 2019 is 4,263 which is an increase on the position reported for February 2019. This follows the trend in the previous years. . 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.The Trust position for the financial year 2018/19 is 51,553 which is an increase on the 48,014 out turn recorded for 2017/18 .

Trust Dashboard Graphs for TRUST

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

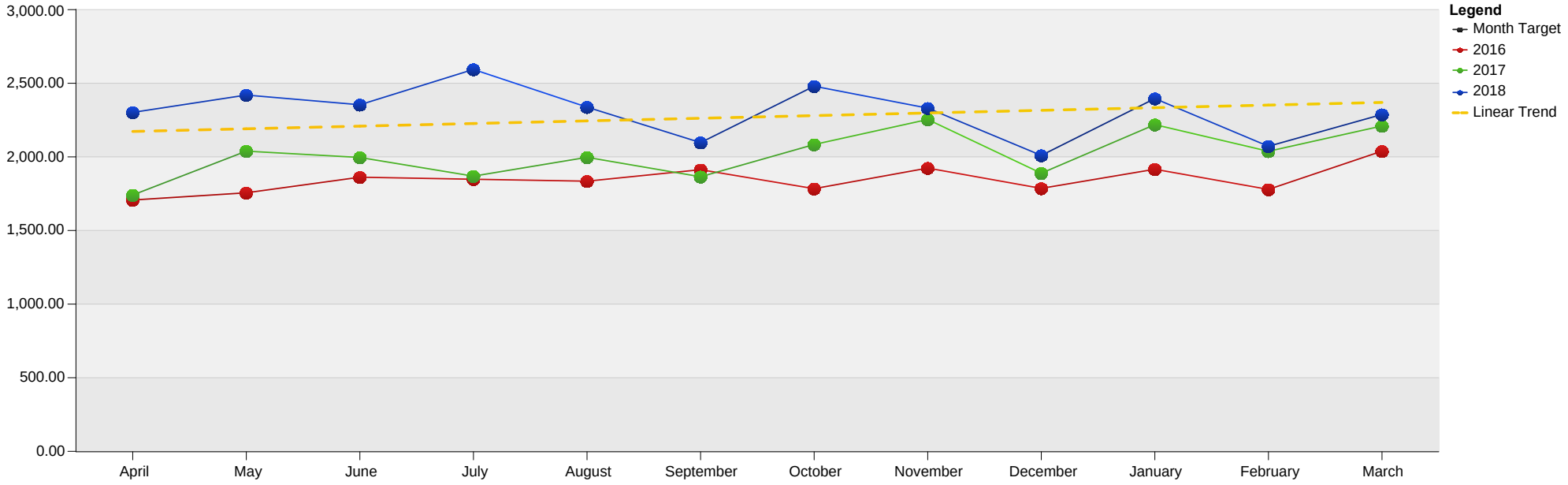


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Number of new unique patients referred and taken on for treatment	1,611.00	18,742.00	562.00	5,878.00	489.00	6,515.00	319.00	3,740.00	18.00	321.00	215.00	2,208.00		

Narrative
The Trust position for March 2019 is 1,611 which is an increase on the position reported for February 2019 but this is within the expected normal range. . 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.The Trust position for the financial year 2018/19 is 18,742 which is an increase on the 17,048 out turn recorded for 2017/18..

Trust Dashboard Graphs for TRUST

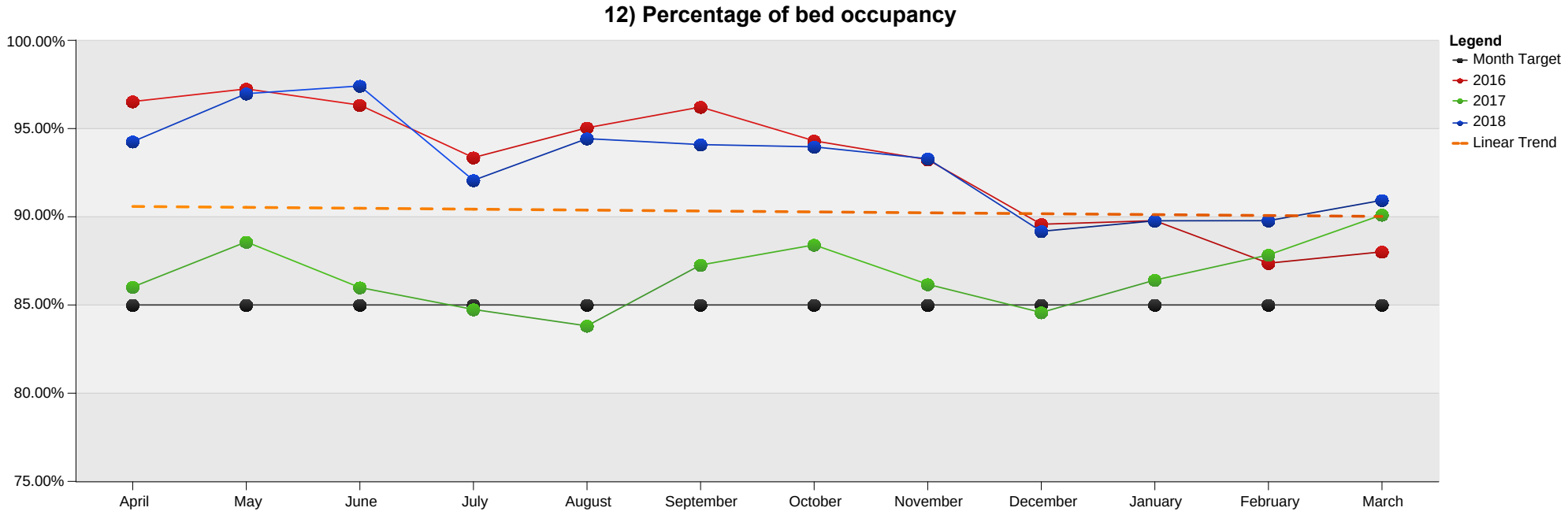
11) Number unique patients referred who received treatment and were discharged



	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	2,288.00	27,682.00	621.00	7,880.00	789.00	9,697.00	462.00	5,663.00	36.00	567.00	374.00	3,765.00		

Narrative
The Trust position for March 2019 is 2,288 which is an increase on the position reported for February 2019. 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.The Trust position for the financial year 2018/19 is 27,682 which is an increase on the 24,210 out turn recorded for 2017/18.

Trust Dashboard Graphs for TRUST

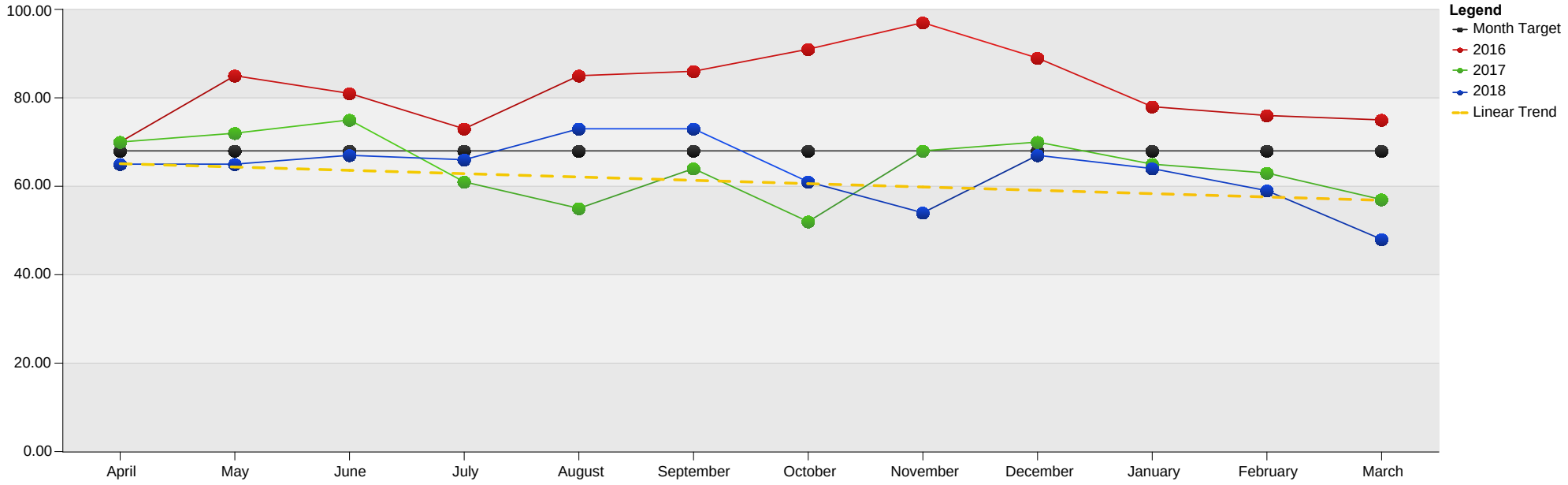


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	90.93%	93.06%	96.44%	92.34%	99.11%	100.44%	79.64%	90.51%	NA	NA	79.94%	87.29%		

Narrative
The Trust position for March 2019 is 90.93% which is not meeting target and is a deterioration to the position reported in February 2019. This KPI is impacted by the number of patients occupying a bed with a length of stay greater than 90 days (KPI 13), which is performing positively in March. It is also impacted by the percentage of patients readmitted within 30 days (KPI 14) which however has seen a slight reduction in performance in March 2019All localities are not achieving target. Tees are reporting the highest bed occupancy at 99.11%. Within AMH issues relating to patients with a length of stay over 90 days are impacting on performance due to challenges in securing placements. This is under daily review within the report out process.All localities are monitoring this on a continual basis and actions are discussed and agreed in daily huddles. The Trust position for financial year 2018/19 is 93.06% which has not achieved the target and is a deterioration on the 86.63% out turn reported for 2017/18.

Trust Dashboard Graphs for TRUST

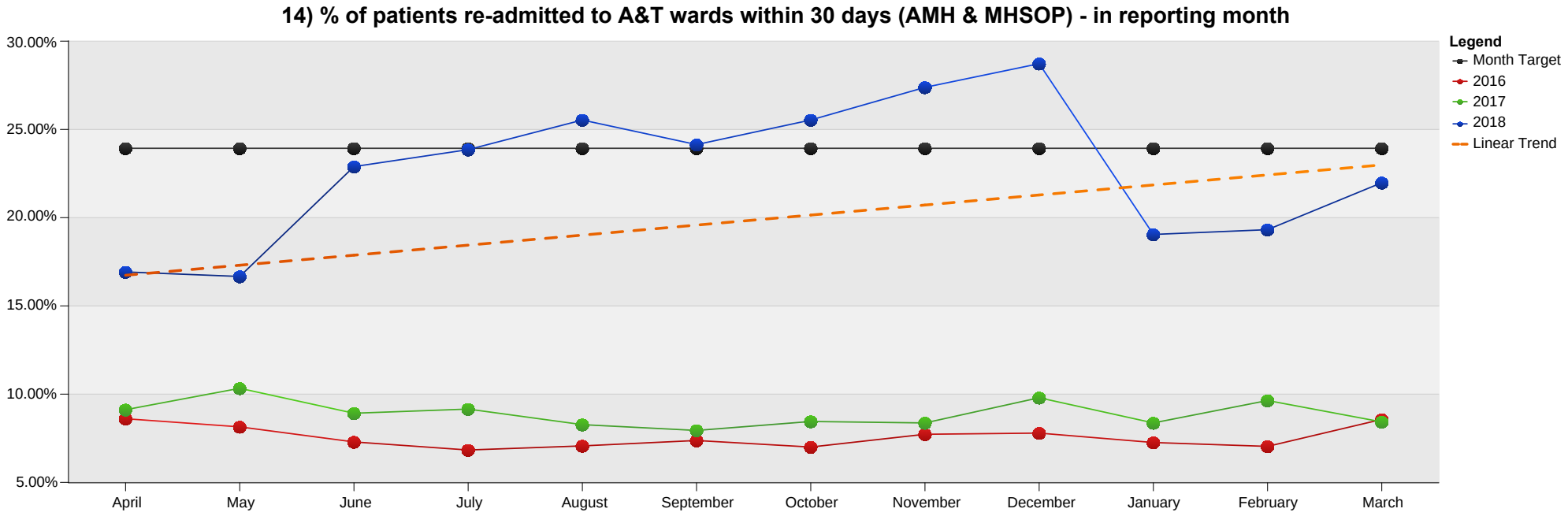
13) No. of patients occupying a bed with a LoS (from admission) > 90 days (AMH and MHSOP A&T Wards)



	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)	48.00	48.00	13.00	13.00	7.00	7.00	11.00	11.00			17.00	17.00		

Narrative
The Trust position for March 2019 is 48 which is meeting the target and is a reduction to that achieved in February 2019. This is the lowest position recorded since 2016/17.York and Selby are the only locality not meeting target with 17 patients with a length of stay over 90 days (13 MHSOP and 4 MHSOP). The service continues to monitor this on a weekly basis and there is regular discussion in ward report outs and team huddles. Blockages exist around confirming appropriate care packages are in place to support discharges for more complex patients and this is under daily review.

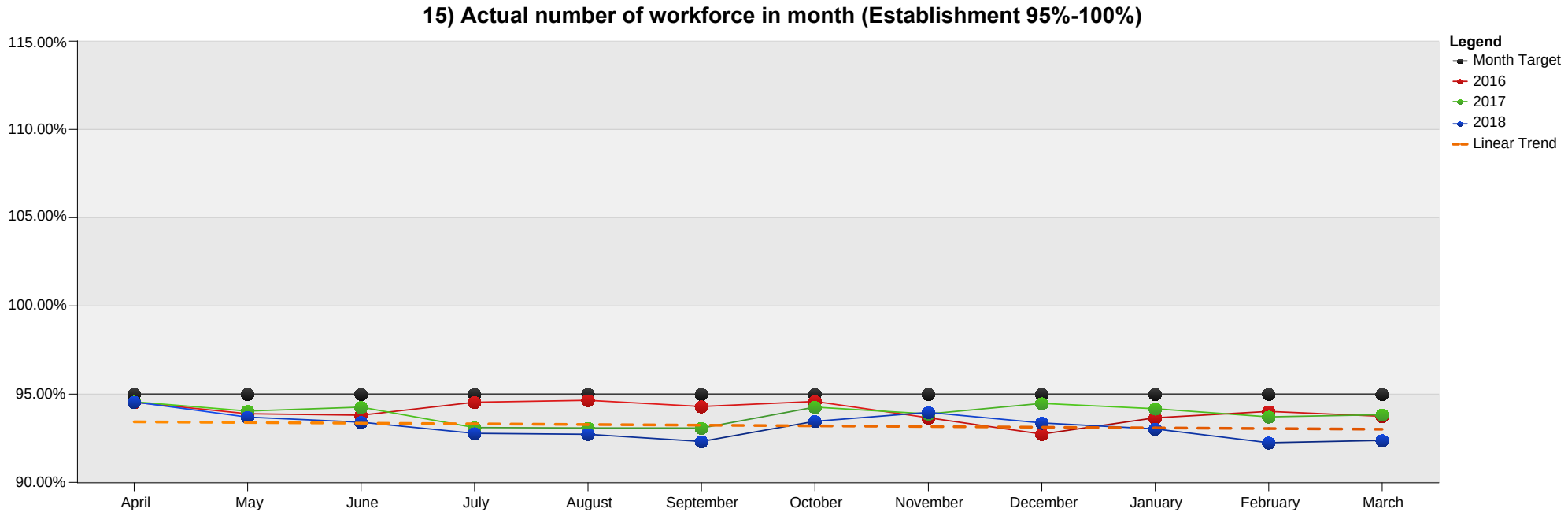
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	21.98%	22.86%	20.51%	20.82%	18.52%	23.40%	30.00%	24.02%			26.67%	23.73%		

Narrative
The Trust position ending March 2019 is 21.98%, which relates to 20 readmissions out of 91 readmissions that were within 30 days. This is meeting the target of 23.93% however is a slight increase to that reported in February 2019.York and Selby and North Yorkshire are not meeting target, with York and Selby at 26.67% along with North Yorkshire at 30%. The position for North Yorkshire is a deterioration from the 11.67% reported in February. Within York and Selby these readmissions were appropriate due to complex needs. The position in North Yorkshire is under investigation.The Trust position for financial year 2018/19 is 22.86% which is not achieving the target as this a new indicator a comparison with 2017/18 cannot be made.

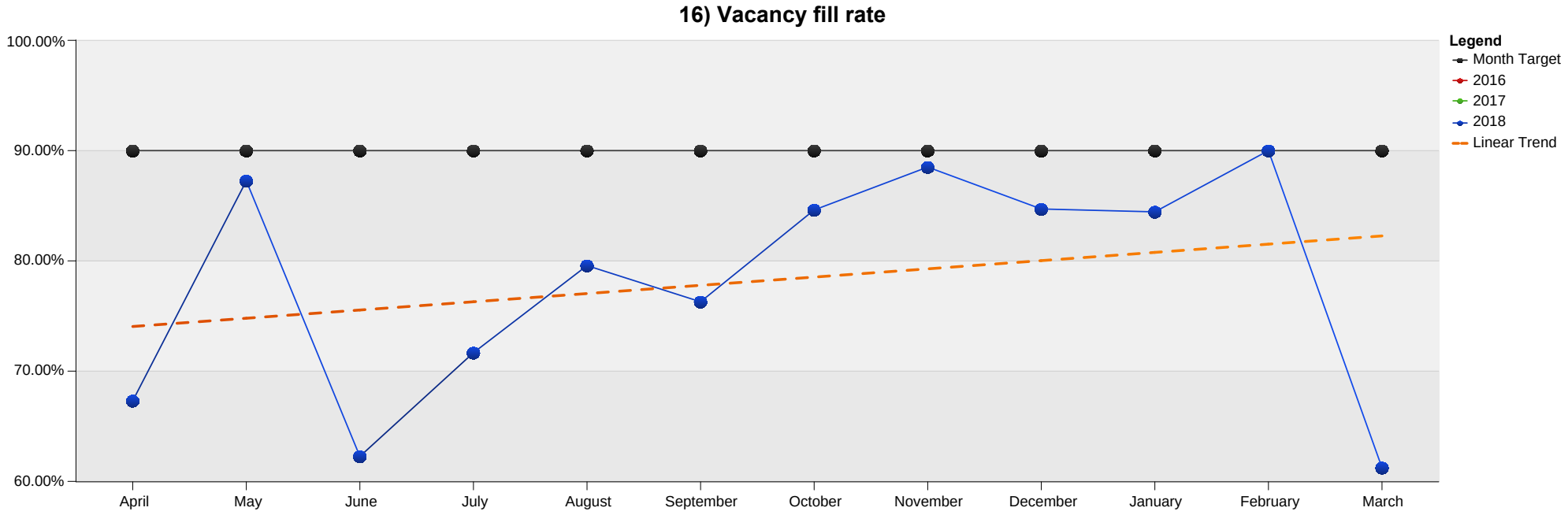
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Actual number of workforce in month (Establishment 95%-100%)	92.38%	92.38%	94.31%	94.31%	97.10%	97.10%	91.32%	91.32%	91.83%	91.83%	87.31%	87.31%		

Narrative
The Trust position for 31 March 2019 is 92.38% which is a slight improvement on the position reported in February and below targeted establishment level of 95-100%. Within medical staffing work is ongoing to maximise all recruitment and workforce planning opportunities. Within non-medical posts the establishment number is lower for Healthcare Assistants and this is under investigation. It is expected that the establishment rate will improve due to staff taking up post after completion of training and further recruitment events that will take place during 2019.

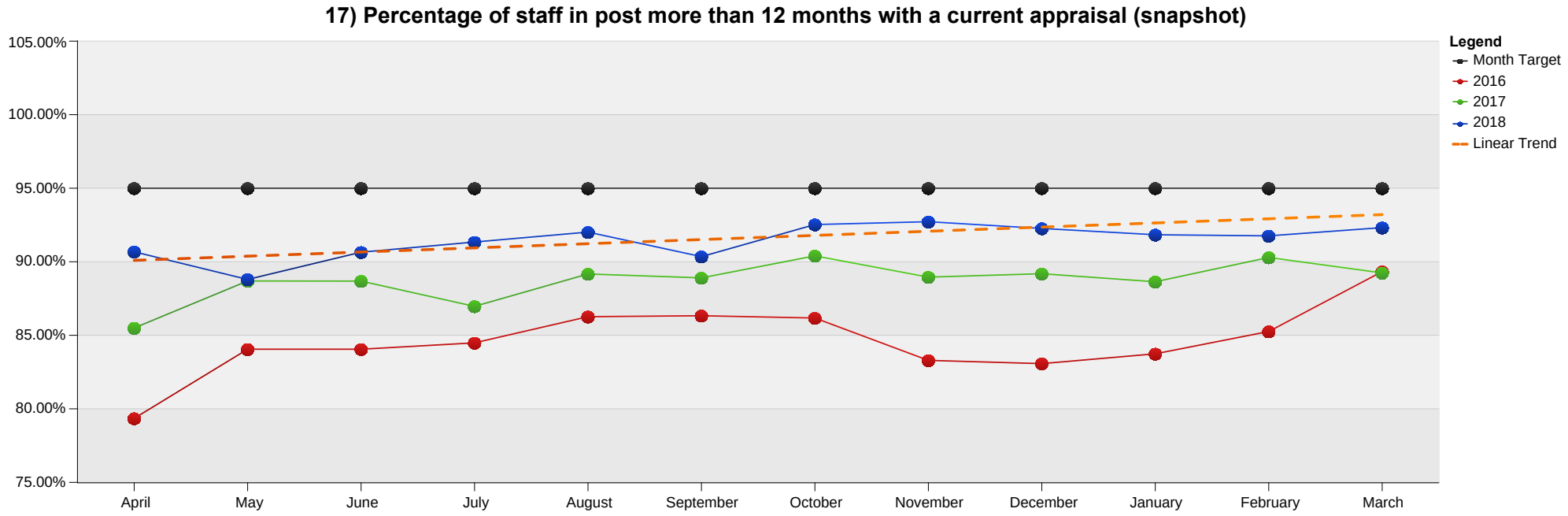
Trust Dashboard Graphs for TRUST



	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	61.24%	78.88%	66.67%	81.31%	71.43%	83.26%	51.92%	70.07%	40.00%	87.37%	73.33%	78.29%		

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 March shows a significant reduction from the previous month at 61.24%. and below the target of 90%. This figure represents 79 vacancies with a conditional offer made out of 129. This figure is under investigation to understand the reduction. The Trust position for financial year 2018/19 is 78.88% which is not achieving the target as this a new indicator a comparison with 2017/18 cannot be made.

Trust Dashboard Graphs for TRUST

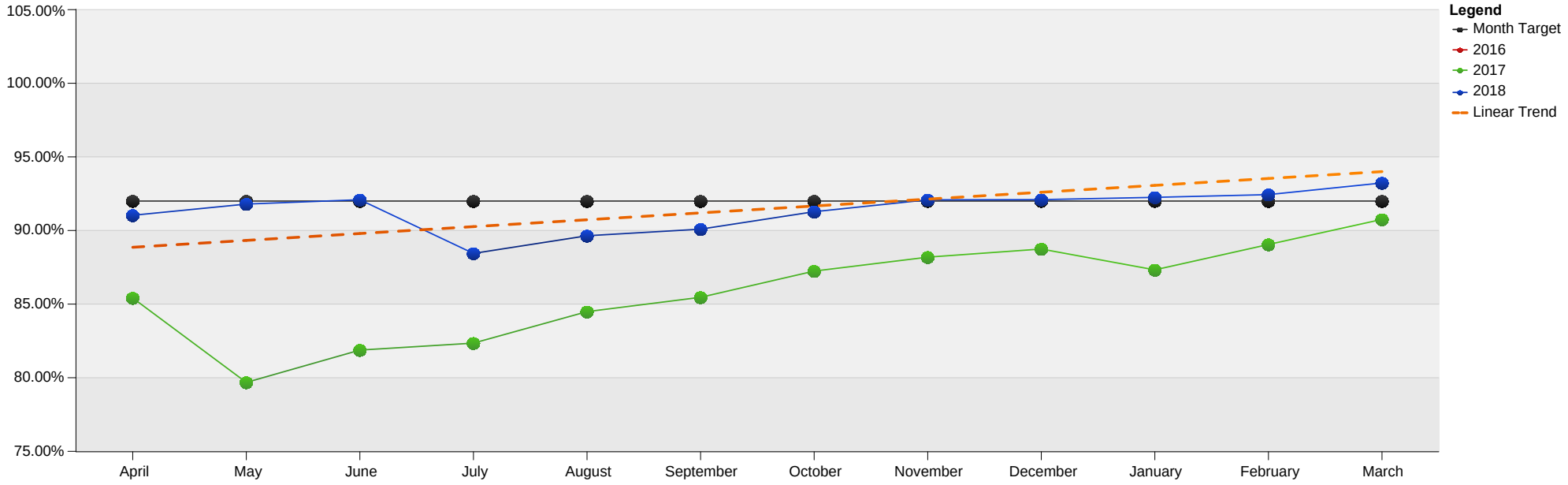


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	92.32%	92.32%	94.32%	94.32%	91.90%	91.90%	87.71%	87.71%	95.71%	95.71%	91.19%	91.19%		

Narrative
The Trust position for March 2019 is worse than target at 92.32% which relates to 480 members of staff out of 5815 that do not have a current appraisal. This represents an increase on the position reported in February 2019.All localities are below target with the exception of Forensic Services. North Yorkshire is reporting the lowest position at 87.71%. 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. .The Trust position for financial year 18/19 is 92.32% which is not achieving the target however an increase on the 89.24% out turn reported for 2017/18.

Trust Dashboard Graphs for TRUST

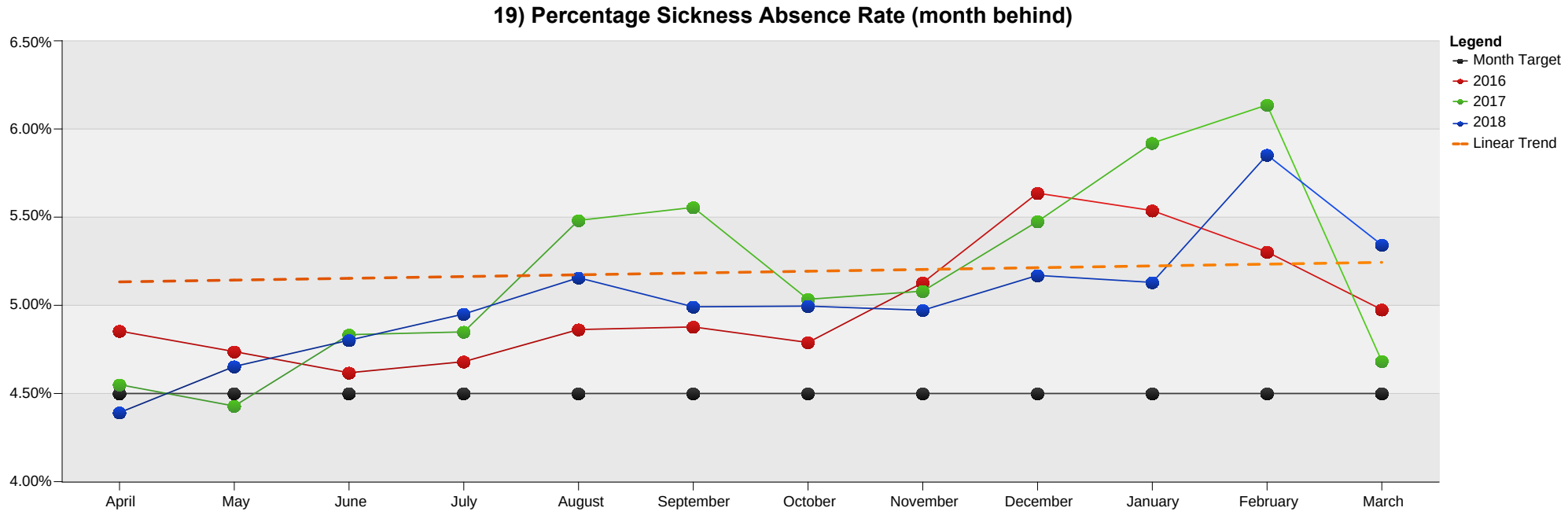
18) Percentage compliance with ALL mandatory and statutory training (snapshot)



	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)	93.23%	93.23%	92.16%	92.16%	93.83%	93.83%	90.13%	90.13%	95.94%	95.94%	92.97%	92.97%		

Narrative
The position for March 2019 has increased to 93.23% which is similar to the position reported in February and is achieving target.The operational management huddles continue to drive improvements in performance. The improved frequency of the IIC refresh also allows a timelier update of accurate performance information to managers, enabling proactive action to take place.The Trust position for financial year 18/19 is 93.23% which is achieving the target and is an increase on the 90.75% out turn reported for 2017/18.

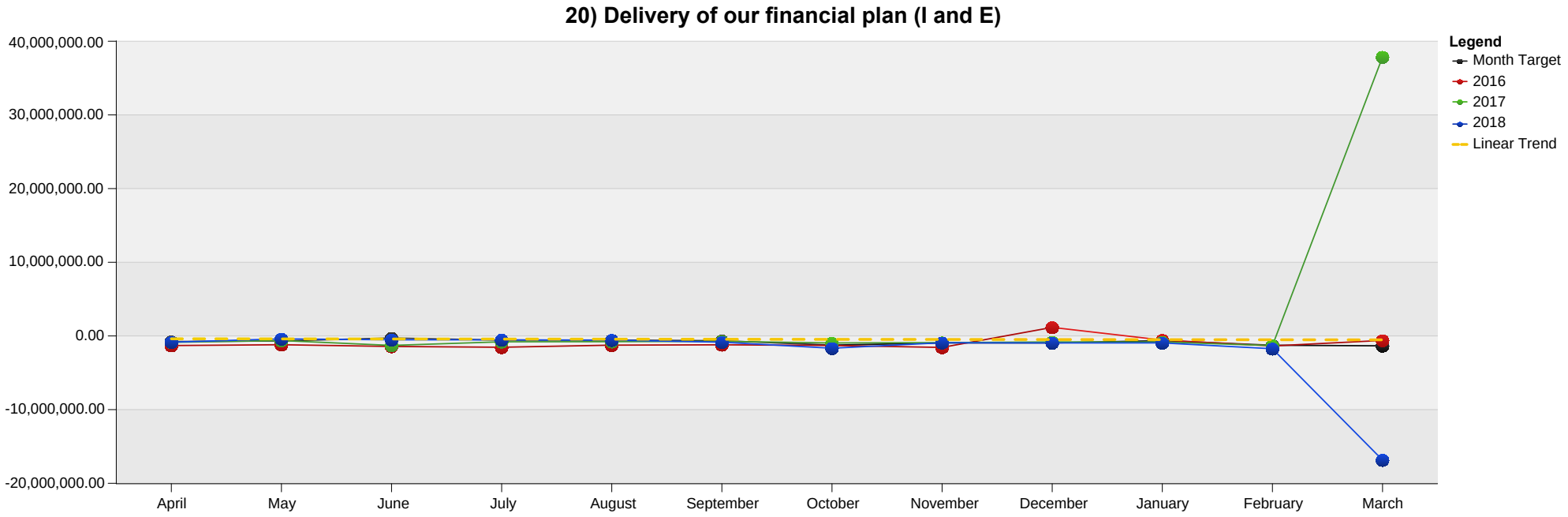
Trust Dashboard Graphs for TRUST



	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
19) Percentage Sickness Absence Rate (month behind)	5.34%	5.03%	5.30%	5.55%	5.75%	4.73%	4.08%	4.30%	6.99%	6.43%	5.58%	4.87%		

Narrative
The Trust position reported in March relates to the February sickness level. The Trust position reported in March 2019 decreased to 5.34% which is not meeting target however is an improvement on the position reported in February.A review of the approach to managing sickness absence has recently been concluded with a revised procedure considered by JCC on 15th February. An agreement was made to forward this to the Business Disability Forum for their views on the procedure and this feedback will be considered. Work is also underway to review the Occupational Health provision which is due for retendering in the next 12 monthsThe Trust position for the financial year 18/19 is 5.03% which is an improvement on the 5.18% out turn reported for 2017/18.

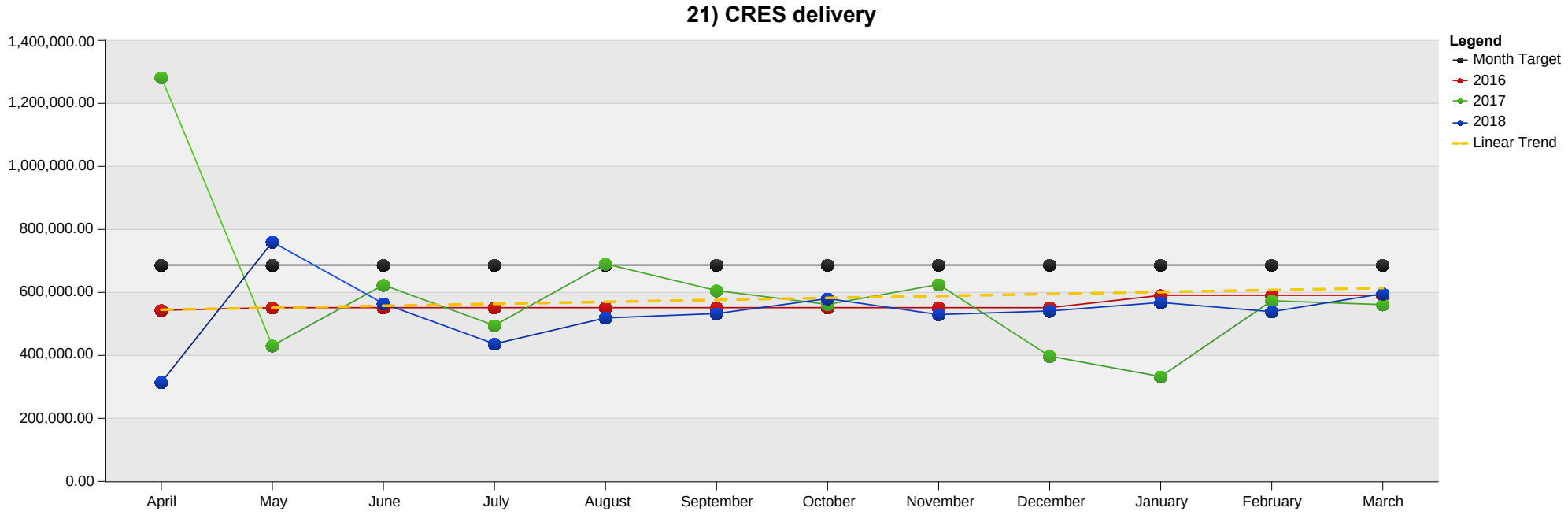
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) Delivery of our financial plan (I and E)	-16,844,825.00	-26,766,868.00	-158,616.00	-41,172.00	188,001.00	1,585,742.00	282,638.00	1,387,133.00	-156,234.00	883,025.00	108,731.00	126,260.00		

Narrative
The comprehensive income outturn for the period ending 31 March 2019 was a surplus of £26,767k, representing 7.5% of the Trust's turnover and was £16,904k ahead of plan. The surplus included the benefit of the default termination of the PFI contract for Roseberry Park Hospital (£59,544k) largely offset by unplanned impairments and depreciation following a review of Trust properties. Excluding these technical adjustments the Trust was £4,341k ahead of plan

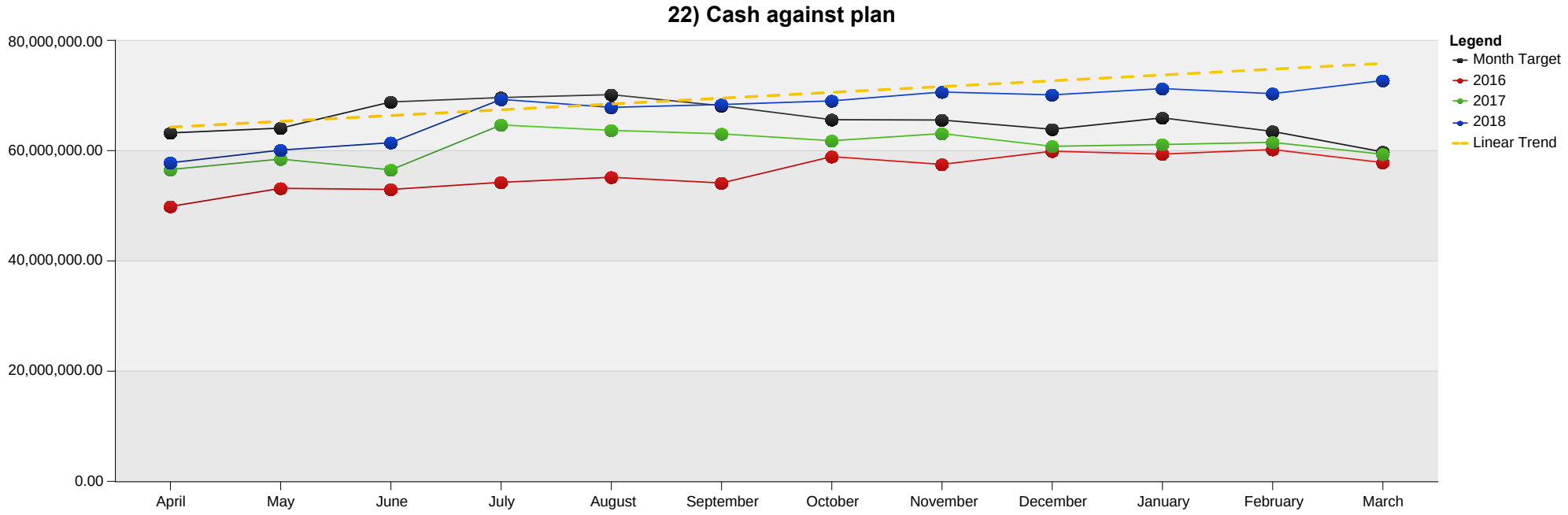
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) CRES delivery	595,763.00	6,479,880.00	82,031.00	984,376.00	87,456.00	590,192.00	16,547.00	198,561.00	21,004.00	252,052.00	97,384.00	958,607.00		

Narrative
Identified Cash Releasing Efficiency Savings at 31 March 2019 was £6,480k and was £1,761k behind plan for the year. The NHS Improvement reduction in the Trust's annual control total of £1,692k has non-recurrently mitigated the shortfall on CRES delivery. As a result CRES was £69k behind plan at the financial year end. The Trust continues to identify and develop schemes to ensure the full delivery of the next 3 years CRES requirements

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
22) Cash against plan	72,719,743.00	72,719,743.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
Total cash at 31 March 2019 was £72,720k and was £12,956k higher than planned, largely due to working capital variations and the surplus position being higher than plan.

Trust Dashboard - Locality Breakdown for TRUST

1 - Quality

	March 2019														April 2018 To March 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		87.41%		85.59%		92.15%		77.30%		99.76%		84.42%				86.82%		85.68%		91.79%		75.75%		99.52%		81.22%		
2) Percentage of patients starting treatment within 6 weeks of an external referral		56.76%		52.34%		64.87%		45.43%		95.45%		57.70%				54.82%		53.02%		63.01%		44.63%		91.35%		47.15%		
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)		874.00		93.00		207.00		419.00				155.00				874.00		93.00		207.00		419.00				155.00		
4) Percentage of patients surveyed reporting their overall experience as excellent or good		92.67%		95.32%		94.57%		89.44%		83.46%		92.35%				91.41%		92.64%		92.60%		91.55%		82.95%		89.35%		
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated		1.74		0.41		3.85		2.06		0.00		1.32				21.31		16.09		21.65		27.47		700.00		20.02		
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind		63.33%		67.86%		66.67%		54.17%				63.64%				59.41%		56.10%		62.14%		60.93%				58.14%		
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind		69.77%		66.67%		70.37%		81.82%				50.00%				67.38%		65.95%		66.33%		74.39%				56.90%		

Trust Dashboard - Locality Breakdown for TRUST

2 - Activity

	March 2019														April 2018 To March 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		7,161.00		2,258.00		2,571.00		1,064.00		372.00		891.00				83,472.00		25,774.00		29,365.00		13,742.00		4,882.00		9,704.00		
9) The number of new unique patients referred with an assessment completed		4,263.00		1,352.00		1,477.00		697.00		223.00		512.00				51,553.00		15,683.00		18,241.00		8,451.00		3,500.00		5,676.00		
10) Number of new unique patients referred and taken on for treatment		1,611.00		562.00		489.00		319.00		18.00		215.00				18,742.00		5,878.00		6,515.00		3,740.00		321.00		2,208.00		
11) Number unique patients referred who received treatment and were discharged		2,288.00		621.00		789.00		462.00		36.00		374.00				27,682.00		7,880.00		9,697.00		5,663.00		567.00		3,765.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)		90.93%		96.44%		99.11%		79.64%	NA	NA		79.94%				93.06%		92.34%		100.44%		90.51%	NA	NA		87.29%		
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)		48.00		13.00		7.00		11.00				17.00				48.00		13.00		7.00		11.00				17.00		
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month		21.98%		20.51%		18.52%		30.00%				26.67%				22.86%		20.82%		23.40%		24.02%				23.73%		

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	March 2019														April 2018 To March 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%)		92.38%		94.31%		97.10%		91.32%		91.83%		87.31%				92.38%		94.31%		97.10%		91.32%		91.83%		87.31%		
16) Vacancy fill rate		61.24%		66.67%		71.43%		51.92%		40.00%		73.33%				78.88%		81.31%		83.26%		70.07%		87.37%		78.29%		
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)		92.32%		94.32%		91.90%		87.71%		95.71%		91.19%				92.32%		94.32%		91.90%		87.71%		95.71%		91.19%		
18) Percentage compliance with ALL mandatory and statutory training (snapshot)		93.23%		92.16%		93.83%		90.13%		95.94%		92.97%				93.23%		92.16%		93.83%		90.13%		95.94%		92.97%		
19) Percentage Sickness Absence Rate (month behind)		5.34%		5.30%		5.75%		4.08%		6.99%		5.58%				5.03%		5.55%		4.73%		4.30%		6.43%		4.87%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	March 2019														April 2018 To March 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)		-16,844,825.00	NA	-158,616.00	NA	188,001.00	NA	282,638.00	NA	-156,234.00	NA	108,731.00				-26,766,868.00	NA	-41,172.00	NA	1,585,742.00	NA	1,387,133.00	NA	883,025.00	NA	126,260.00		
21) CRES delivery		595,763.00		82,031.00		87,456.00		16,547.00		21,004.00		97,384.00				6,479,880.00		984,376.00		590,192.00		198,561.00		252,052.00		958,607.00		
22) Cash against plan		72,719,743.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA				72,719,743.00	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

Appendix 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																		**2**
Natural causes					1											1					**2**
Hanging		1																			**1**
Suicides	10	2	8		2						1					6	2		1	1	**33**
Open					1													1	1		**3**
Drug related death		1																			**1**
Drowning																					**0**
Misadventure	1	1																			**2**
Awaiting verdict	12	13	10	6	9	1	1				2		2			2	10	3		1	**72**
Total	**24**	**18**	**19**	**6**	**13**	**1**	**1**	**0**	**0**	**0**	**3**	**0**	**2**	**0**	**0**	**9**	**12**	**4**	**2**	**2**	**116**

Number of unexpected deaths classed as a serious untoward incident											
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
10	4	14	15	6	6	7	10	14	13	7	8

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
37	31	25	8	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

Data Quality Scorecard 2018/19

Appendix D

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

Data Quality Scorecard 2018/19

		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.

Data Quality Scorecard 2018/19

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

Data Quality Scorecard 2018/19

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

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th April 2019**
TITLE:	**Single Oversight Framework**
REPORT OF:	**Phil Bellas, Trust Secretary & Sharon Pickering, Director of Planning, Performance and Communications**
REPORT FOR:	**Information & Assurance**

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

Executive Summary:

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

The purpose of this report is to examine the Trust's position against the requirements of the SOF at the end of Quarter 4, 2018/19.

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

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**30th April 2019**
TITLE:	**Single Oversight Framework**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to examine the Trust's position against NHS Improvement's (NHSI) Single Oversight Framework (SOF) at the end of Quarter 4, 2018/19.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

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

2.4 The Trust has been placed in segment 1 since the introduction of the SOF. This segmentation reflects the Trust's "Good" CQC rating and strong financial and operational performance.

2.5 In previous reports the Board has noted that:

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

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

2.6 The Board is asked to note that the next Quarterly Review Meeting with NHSI is due to be held on 16th May 2019 and, therefore, feedback from the regulator will not be available for the meeting.

3. KEY ISSUES:

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

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

Quality of Care

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

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

3.4 The Board is asked to note that:

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

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

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

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

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

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

Finance and Use of Resources

3.5 The Finance Report (agenda item 12) provides a summary of the Trust's position against the Use of Resources theme.

(See also paragraph 3.11 below)

Operational Performance

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

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

3.7 The Board is asked to note that, from the data available, there were no breaches of the targets at a Trustwide level during the reporting period.

3.8 Further information on the operational performance metrics is provided in the Performance Dashboard Report (agenda item 13).

Strategic Change

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

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

Leadership and Improvement Capability (Well-led)

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

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

3.11 In relation to this theme:

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

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

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

Board Members will be aware that the Trust has undertaken the NHSI agency review process and has a detailed action plan in place to address this matter.

(d) The position on the delivery of the CQC Action Plan is due to be discussed at the meeting of the Executive Management Team on 24th April 2019 and a verbal update will be provided at the Board meeting.

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

4. IMPLICATIONS:

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

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

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 In-quarter risks to the Trust's segmentation under the SOF continue to be reported in the monthly Performance Dashboard reports.

6. CONCLUSIONS:

6.1 Overall, the Trust should expect to maintain its segment 1 position for Quarter 4, 2018/19; however, close monitoring by NHSI is expected to continue.

7. RECOMMENDATIONS:

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

Phil Bellas, Trust Secretary
Ashleigh Lyons, Corporate Performance Manager

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

SINGLE OVERSIGHT SCORECARD - QUALITY INDICATORS - 2018/19

All Providers																	
Quality Indicators	**SOF Source**	**Other known source**	Freq.	Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
Written compliants - rate	NHS Digital	N/A	Q	N/A			9.49			12.10			11.22				Last published data December 2018
Staff and Friends and Family test % recommended - care	NHSE	Trust assessment	Q	N/A			86.59%			88.34%			87.19%				
		N/A	Q	N/A			70.17%			70.30%							Last published data December 2018
Occurrence of Never Event	NHS Improvement	Governance - verified	M	N/A	0	0	0	0	0	0	0	0	0	0	0		Data published up to 28th February 2019
NHS England/NHS Improvement Patient Safety Alerts outstanding	NHS Improvement	Governance - verified	M	N/A	0	0	0	0	0	0	0	0	0	0	0		Data published up to 1st March 2019
Mental Health Providers																	
Quality Indicators	**SOF Source**	**Other known source**	Freq.	Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
CQC inpatient/mental health and community survey	CQC	N/A	A	N/A													
Mental Health scores from Friends and Family Test - % positive	NHSE	N/A	M	N/A	87.58%	87.75%	84.83%	88.48%	88.19%	88.40%	88.01%	86.77%	86.68%	88.70%			Latest published data January 2019
Admissions to adult facilities of patients who are under 16 years old	NHS Digital	Trust assessment	M	N/A	0	0	0	0	0	0	0	0	0	0	0	0	
		N/A	M	N/A													No public data available
Quality Indicators	**SOF Source**	**Other known source**	Freq.	Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
Proportion of discharges from hospital followed up within 7 days (all discharges treated as being on CPA)		Trust assessment - pre validated IIC	M	95%	**98.54%**	**96.67%**	**97.86%**	**96.53%**	**97.13%**	**96.31%**	**96.13%**	**97.18%**	**95.71%**	**97.31%**	**96.51%**	**97.13%**	Pre-validated position is reported direct from the IIC
		Trust assessment - post validated IIC			**98.54%**	**97.07%**	**98.57%**	**96.53%**	**97.13%**	**96.31%**	**96.11%**	**97.18%**	**96.19%**	**97.31%**	**97.82%**	**99.18%**	Post validated position stated is from our intenal files which are used to provide the UNIFY submission.
		UNIFY	Q		**98.16%**			**97.43%**			**96.69%**						Latest published data as at 31st December 2018
% clients in settled accommodation	NHS Digital	Trust assessment	M	N/A			82.95%	83.42%	83.37%	82.93%	82.58%	82.58%	82.95%	82.17%	82.19%		Latest data based on the refresh MHSDS submission for February 2019
		NHS Digital	M	N/A	82.54%	82.63%	83.13%	83.79%	83.46%	82.95%	83.16%	82.67%	82.56%				Latest published data December 2018
% clients in employment	NHS Digital	Trust assessment	M	N/A			14.34%	14.53%	14.81%	15.02%	15.04%	15.03%	14.64%	15.56%	15.66%		Latest data based on the refresh MHSDS submission for February 2019
		NHS Digital	M	N/A	13.86%	14.20%	14.30%	14.47%	14.71%	14.85%	15.17%	14.97%	15.31%				Latest published data December 2018
Potential under-reporting of patient safety incidents	NHS England Dashboard	N/A	M	N/A													No data is published to reflect 'under-reporting'. Published data reports 9204 incidents occurring between 01 April 2018 and 30 September 2018 and reported to NRLS.

SINGLE OVERSIGHT SCORECARD - OPERATIONAL PERFORMANCE METRICS - 2018/19

Mental Health Providers																					
Operational Performance Metrics	**SOF Identified source**	**Other Identified Source**	Freq.	**Standard**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**
People with a first episode of psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral	UNIFY2 and MHSDS	Trust assessment	Q	53%	**57.14%**	**48.84%**	**72.41%**	**63.41%**	**60.00%**	**70.83%**	**75.61%**	**67.24%**	**62.50%**	**56.36%**	**72.73%**	**66.67%**	**61.03%**	**64.75%**	**68.35%**	**65.27%**	
		NHS Digital	Q		**57.14%**	**48.84%**	**71.93%**	**63.41%**	**59.18%**	**70.21%**	**75.00%**	**67.24%**	**62.50%**	**56.36%**			**60.74%**	**64.23%**	**68.12%**	**56.36%**	Last published data January 2019
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **inpatient wards**	Board declaration but can be triangulated with results of CQUIN audit	Trust assessment	Q	90%	Data for 2018/19 has been collated and sent to the NCAP Team. A sample will be generated and then returned to us for internal analysis and national submission in Quarter 3									**92.00%**						**92.00%**	
		National assessment			National data not available until June 2019																2018/19 Audit results as assessed by the Royal College of Psychiatry's have been delayed until June 2019
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **early intervention in psychosis services**		Trust assessment	Q	90%	Data for 2018/19 has been collated and sent to the NCAP Team. A sample will be generated and then returned to us for internal analysis and national submission in Quarter 3								**91.55%**						**91.55%**		
		National assessment			National data not available until June 2019																2018/19 Audit results as assessed by the Royal College of Psychiatry's have been delayed until June 2019
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **community mental health services (people on CPA)**		Trust assessment	Q	65%	Data for 2018/19 has been collated and sent to the NCAP Team. A sample will be generated and then returned to us for internal analysis and national submission in Quarter 3									**78.00%**						**78.00%**	
		National assessment			National data not available until June 2019																2018/19 Audit results as assessed by the Royal College of Psychiatry's have been delayed until June 2019
IAPT/Talking Therapies - proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	IAPT minimum dataset	Trust assessment	M	50%	**51.48%**	**52.52%**	**51.77%**	**47.29%**	**51.86%**	**51.08%**	**51.06%**	**52.44%**	**50.50%**	**51.17%**	**54.19%**	**50.05%**	**51.93%**	**50.08%**	**51.43%**	**51.79%**	
		PAVE Reports	Q		**51.29%**	**52.76%**	**51.43%**	**49.12%**	**51.76%**	**50.67%**	**50.93%**	**53.48%**	**49.28%**	**50.42%**			**51.28%**	**50.80%**	**51.36%**	**50.42%**	Latest PAVE data January 2019
IAPT/Talking Therapies - waiting time to begin treatment (from IAPT minimum dataset) - **within 6 weeks**	IAPT minimum dataset	Trust assessment	M	75%	**96.79%**	**97.24%**	**97.60%**	**98.68%**	**98.29%**	**98.39%**	**98.60%**	**99.24%**	**98.78%**	**97.34%**	**97.27%**	**96.50%**	**97.22%**	**98.45%**	**98.88%**	**97.05%**	
		PAVE Reports	Q		**97.06%**	**97.32%**	**97.36%**	**97.46%**	**97.86%**	**95.76%**	**90.90%**	**92.95%**	**95.15%**	**94.97%**			**97.25%**	**96.97%**	**92.72%**	**94.97%**	Latest PAVE data January 2019
IAPT/Talking Therapies - waiting time to begin treatment (from IAPT minimum dataset) - **within 18 weeks**	IAPT minimum dataset	Trust assessment	M	95%	**98.62%**	**99.83%**	**99.59%**	**99.82%**	**100.00%**	**99.81%**	**99.84%**	**100.00%**	**100.00%**	**99.31%**	**100.00%**	**100.00%**	**99.36%**	**99.88%**	**99.94%**	**99.76%**	
		PAVE Reports	Q		**99.91%**	**99.83%**	**99.34%**	**99.82%**	**100.00%**	**99.90%**	**99.83%**	**100.00%**	**99.62%**	**99.70%**			**99.68%**	**99.92%**	**99.83%**	**99.70%**	Latest PAVE data January 2019
Data Quality Maturity Index (DQMI) – Mental Health Services Data Set Data Score	MHSDS	N/A	M	95			**95.5**			**95.4**							**95.5**	**95.4**			Latest published data Quarter 2 2018/19
Inappropriate out of area placements for adult mental health services	MHSDS	Trust assessment	M	2264	**2007**	**2085**	**2188**	**2236**	**2236**	**2080**	**2002**	**1669**	**1524**	**1291**	**859**	**874**	**2188**	**2080**	**1524**	**1291**	
		NHS Digital	M	N/A	1945	2040	2195	2180	2215	2055	1970	1670	1440				2195	2180	2215	2055	Latest published data December 2018

SINGLE OVERSIGHT SCORECARD - Organisational Health- 2018/19

All Providers																	
Quality Indicators	**SOF Source**	**Other known source**	**Freq.**	**Standard**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Comments**
Staff Sickness	NHS Digital	Trust assessment (month behind)	M	N/A	4.39%	4.65%	4.80%	4.95%	5.16%	4.99%	5.00%	4.97%	5.17%	5.13%	5.85%	5.34%	IIC reporting a month behind
		Finance Return	M & Q	N/A													Finance Return to NHS Improvement - not required to report in April. All other figures are a month behind
		N/A	M & Q	N/A	4.68%	4.77%	4.90%	5.12%	4.91%	4.95%	4.96%	5.14%					Last published data November 2018
Staff turnover (Finance Return)	NHS Digital	Finance Return	M & Q	N/A	0.85%	0.58%	1.00%	0.97%	0.97%	0.75%	0.74%	0.71%	0.65%	1.01%	0.81%	0.74%	All figures are a month behind
NHS Staff survey	CQC	N/A	A	N/A													Trusts are rated as Better, About the Same or Worse on a range of questions in ten themes. Our Trust scored "Better than average" in 8 of the themes, performing best for Quality, Diversity & Inclusion and Safety Culture. The remaining 2 themes performed at average.
Proportion of temporary staff	Provider Return	N/A	Q	N/A	2.65%	2.79%	2.81%	3.02%	3.06%	3.20%	3.27%	3.36%	3.42%	3.47%	3.55%	3.60%	Finance Return to NHS Improvement

ITEM NO. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th April 2019**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

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

Executive Summary:

This report provides information on the use of the Trust Seal as required under Standing Order 15.6.

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**30th April 2019**
TITLE:	**Report on the Register of Sealing**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board of Directors of the use of the Trust's Seal in accordance with Standing Orders.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 An entry of every sealing is made and numbered consecutively in a Register specifically provided for the purpose. It is signed by the persons who have approved and authorised the document and those who attested the seal.

3. KEY ISSUES:

3.1 The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
346	10.4.19	Lease of substation accommodation at land on the east side of Haxby Road, York	Patrick McGahon, Director of Finance and Information Phil Bellas, Trust Secretary

4. IMPLICATIONS:

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

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

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

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

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution
Seals Register

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO.16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23 April 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:

- 1 new policy that has been developed and required ratification:
  - CLIN-0094-v1 Tissue Viability Policy
- 3 policies that have undergone review and required ratification:
  - CLIN-0013-001-v1.3 Use of Visual and Audio Recordings in Clinical Procedures
  - CLIN-0090-v1.1 Mobile Phone Policy Service Users and Visitors
  - CLIN-0053-v3 Clinical Audit Policy
- 1 policy that has undergone minor revision and required re-ratification:
  - CORP-0019-v10.1 Complaints Policy
- 2 policies that have had the review date extended:
  - FIN-0005 Lease car policy
  - IA-0002 Care Programme Approach (CPA) Policy

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meetings held on 10 April 2019.

DATE:	**23 April 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 new policy has been developed and required ratification:

Ref and Title	CLIN-0094-v1 Tissue Viability Policy
Review date	10 April 2019
Description of change	This is a new policy which has been developed to draw together and overarch the various procedures and guidance documents in place regarding the subject of tissue viability.

3.2 The following policies have undergone full review and required ratification:

Ref and Title	CLIN-0013-001-v1.3 Use of Visual and Audio Recordings

	in Clinical Procedures CLIN-0090-v1.1 Mobile Phone Policy Service Users and Visitors
Review date	10 April 2022
Description of change	Healthcare professionals have mixed feelings regarding service users making recordings of clinical contact/appointments. Many clinical staff feel that it is their privacy that is being breached, especially when the recording is covert but that is not the case. The **Mobile Phones Policy For Service Users and Visitors** and the **Use of Audio Visual Recordings in Clinical Procedures** have been reviewed to ensure that they reflect the correct legal perspective and to ensure the documents are clear and do not contradict each other. TEWV's Director of Nursing & Governance understands that service users recording clinical contact/appointments is an emotive subject but supports the advice to not stop any recording unless it could be detrimental to the service user. The Trust's advice is based on guidance received from one of TEWV's legal advisers. This advice is also echoed by the Medical Protection Society and Medical Defence Union. The Royal College of Nursing has a slightly different view. The RCN advise their members to stop recording unless there is good reason for doing so (e.g. the patient is unable to recall oral advice or there is a problem with interpreting written material). This view is too restrictive under current data protection law. TEWV's Direct of Nursing & Governance will be taking this up directly with the RCN.

Ref and Title	CLIN-0053-v3 Clinical Audit Policy
Review date	10 April 2022
Description of change	Full revision with minor amendments throughout. Changes are highlighted in blue.

3.3 The following has undergone minor amendment and required re-ratification.

Ref and Title	CORP-0019-v10.1 Complaints Policy
Review date	05 April 2020
Description of change	The section relating to consent has been revised in line with the requirements of the Data Protection Act 2018 (GDPR).

3.4 The following had the review date extended:

Ref and Title	FIN-0005 Lease car policy
Review date	04 November 2019
Description	Work is underway to review and revise this policy. The review date has been extended to allow this work to be completed.

Ref and Title	IA-0002 Care Programme Approach (CPA) Policy
Review date	06 April 2020
Description	This policy is being revised within the scope of the CPA project. A 12 month extension has been requested due to the amount of work required.

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 10 April 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.

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