AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 21ST MAY 2019 VENUE: THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the last meeting held on **30th April 2019.**		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	Chief Executive's Report	**CM**	**Verbal**
Item 6	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.50 am)

Item 7	To receive and note the annual report on research and development.	**Prof. Reilly 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 a progress report on the CQC Action Plan.	**EM**	**Attached**
Item 11	To receive and note a report on the merger of the North Yorkshire and York and Selby Localities.	**RH**	**Attached**
Item 12	To receive and note the report of the Mental Health Legislation Committee.	**RS/EM**	**Attached**

Regulatory Items (11.00 am)

Item 13 NHS Foundation Trust Annual Report and Accounts 2018/19:

(1) To approve the Annual Report, including the Quality Report, and Annual Accounts 2018/19.	**CM/PM**	**Attached**

(2) To approve the Letter of Representation.

(3) To authorise the sign-off of:

- The Performance Report
- The Accountability Report
- The Statement on Quality
- The Statement on Directors' Responsibilities for Preparing the Quality Report
- The Annual Governance Statement
- The Remuneration Report
- The Statement on the Accounting Officer's Responsibilities
- The Statement of the Financial Position
- The Letter of Representation
- Any certificates relating to the above as required by NHS Improvement.

(4) To approve the submission of the Annual Report, including the Quality Report, and Annual Accounts, to NHS Improvement and Parliament.

(5) To authorise the submission of the Quality Account to the Department of Health and Social Care.

(Notes:

(1) The final draft version of the Annual Report and Accounts will be circulated following the Special meeting of the Audit Committee to be held on 17th May 2019 together with supporting information including the External Auditor's Audit Completion Report and the External Assurance Report on the Quality Report prepared by Mazars LLP.

(2) The recommendations of the Audit	**DJ**	**Verbal**

	Committee on the above matters will be reported verbally to the meeting.		
	(3) The report of the Director of Finance and Information on the Annual Accounts will be circulated prior to the meeting.	**PM**	**Attached**
	(4) Any additional information or updated documents will be tabled at the meeting).		
Item 14	On the recommendation of the Audit Committee to sign-off the annual Board certificates required by NHS Improvement. *(Subject to review by the Council of Governors).*	**DJ/PB**	**Attached**

Performance (11.25 am)

Item 15	To consider the Finance Report as at 30th April 2019.	**PM**	**Attached**
Item 16	To consider the Trust Performance Dashboard as at 30th April 2019.	**SP**	**Attached**
Item 17	To consider the Strategic Direction Performance Report for Quarter 4, 2018/19.	**SP**	**Attached**

Governance (11.50 am)

Item 18	To approve the publication of information on compliance with the public sector duty under the Equality Act 2010.	**DL**	**Attached**

Items for Information (12.00 noon)

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

Item 21 To note that the next meeting of the Board of Directors will be held on **Tuesday**

25th June 2019 in the Boardroom, West Park Hospital, Darlington at 9.30 am.

Confidential Motion (12.05 pm)

Item 22 The Chairman to move:

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

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

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

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

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
15th May 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 30TH APRIL 2019 IN LAKE HOUSE, 20 MANOR COURT, SCARBOROUGH AT 9.30 AM

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

In Attendance:
Mr. A. Williams, Public Governor for Redcar and Cleveland
Mrs. J. Webster, Public Governor for Scarborough and Ryedale
Dr. J. Whaley, Guardian of Safe Working (minute 19/98 refers)
Mr. D. Williams, Freedom to Speak Up Guardian (minute 19/99 refers)
Mr. P. Bellas, Trust Secretary
Ms. A. Binns, Communications Manager
Ms. D. Hopkins, Community LD Nurse (shadowing Mrs. Moody as part of the Florence Nightingale Leadership Course)
Mr. N. Ayre, York Healthwatch

19/92 APOLOGIES

Apologies for absence were received from Mr. M. Hawthorn, Senior Independent Director.

19/93 MINUTES

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

19/94 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

Arising from the report:
(1) Dr. Griffiths, the Chairman of the Quality Assurance Committee, confirmed that a detailed breakdown of performance against the indicator on the percentage of readmissions to A&T wards within 30 days had been provided to the Committee in accordance with minute 19/41 (26/2/19) but it was recognised that there was some further work to be undertaken on this matter.

(2) Further to minute 19/66 (26/3/19) and in response to a question, Dr. Khouja offered to prompt the Department of Work and Pensions for a response to his letter on the impact of benefit cuts on some vulnerable service users.

(3) Further to minute 19/64 (26/3/19) Dr. Khouja also advised, following a conversation with the Director of Operations for Forensic Services, that the staffing establishments of wards would need to be increased, as in the case of Brambling Ward, to ensure lines of sight were maintained as a result of the moves during the Roseberry Park rectification works.

19/95 DECLARATIONS OF INTEREST

There were no declarations of interest.

19/96 CHAIRMAN'S REPORT

The Chairman reported on:

(1) Her first four weeks in office which had included opportunities:

 (a) To meet and hold discussions with Directors and staff; to receive briefings on new developments, particularly the new hospital and changes to the Locality in York; and to visit services.

 (b) To meet with the Governors for the first time, at a recent Development Day, and to discuss future working arrangements with them.

 Ms. Harte advised that the Trust had been very welcoming and supportive.

(2) The continuing discussions on the development of the ICS, focussing at present on its future governance structure, which would be kept under review.

19/97 GOVERNOR ISSUES

No issues were raised.

19/98 ANNUAL REPORT OF THE GUARDIAN OF SAFE WORKING

The Board received and noted the Annual Report of the Guardian of Safe Working.

Dr. Whaley assured the Board that Junior Doctors continued to be safely rostered with working hours that were safe and in compliance with the terms and conditions of service.

Board Members raised the following matters:

(1) The continuing concerns about the local agreement in York to fill vacant resident night-shifts with non-resident locum doctors.

 It was noted that:

 (a) Due to the complexity of the service, ward staff did not appreciate the limited cover being provided and continued to contact the doctor at will.

 (b) The situation also caused issues in other areas when gaps in the rota were filled from elsewhere and those doctors covering them worked additional hours.

(c) It was hoped that the issue would be resolved by the appointment of a senior nurse, on call, who could act as a filtering mechanism but there had been delays in appointing to the position.

It was noted that the position of the Duty Nurse Co-ordinator in York had been advertised twice but, to date, no appointment had been made.

(2) The review of compensatory rest arrangements for Junior Doctors that exceeded the requirements set out in the contract (in the context of exploring “local bank” arrangements across the region) as it was considered that the Trust should provide them with as much rest as practicable.

Dr. Whaley explained that the benefits provided by the Trust, compared to those in the contract, were not material but did have a cushioning effect. He considered that any change, in itself, would not be significant but, of more importance, would be how it would be viewed by the Junior Doctors and impact on them taking additional shifts.

(3) The progress being made on the establishment of a regional locum bank.

Dr. Khouja advised that the provision of a locum bank was being taken forward on two fronts:

(a) The Trust was in final discussions with a company to provide a locum bank for medical staff, at all levels, and this was expected to be in place by the autumn.

(b) The regional locum bank was in development but issues had arisen due to the proposed rates being in excess of those offered by trusts.

Dr. Whaley highlighted the difficult balance between enabling Junior Doctors to undertake locum work, which could be very lucrative for them, and the provision of services, by them, for their own Trust in accordance with the contract.

(4) The work to be undertaken in addressing the ‘Fatigue and Facilities Charter’.

Dr. Whaley advised that the work would focus on providing facilities to allow Junior Doctors to rest in accordance with the contract as at present, whilst most buildings had designated spaces, some had no or limited facilities to support rest.

It was also noted that the BMA was also very clear in its expectations of the facilities to be provided.

Mrs. Hill, noting that the first meeting on this matter was due to be held in a couple of weeks’ time, asked to be informed of any particular issues identified.

Action: Dr. Whaley

19/99 REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN

The Board received and noted the report of the Freedom to Speak Up Guardian (F2SUG).

Board Members raised the following matters:

(1) The difficulties experienced by the F2SUG in gaining feedback from management on the actions taken in response to concerns raised by staff.

Mr. Williams explained that the outcomes of investigations tended to be reported back to local management teams who then developed an action plan. As the process was undertaken often without reference to him, it reduced his ability to share learning which was an important aspect of his role.

It was noted that, in response to this matter:

(a) Mr. Williams and Mrs. Hill had discussed how to increase his involvement in investigations and for learning to be shared with him.
(b) It was recognised that the Trust needed to review whether learning was effective and, where appropriate, Mrs. Hill had followed up issues raised and sought further assurance.
(c) There were a number of staff who had used the Trust's services and finding ways to better use the feedback they could provide would be beneficial.

(2) The benefits of including comparative data in future reports on previous periods (e.g. no. of cases, percentage resolved, cases split by criteria such as patient safety, bullying, etc.) and against the information published in the annual reports from the national Guardians Office.

This was taken on board; however, it was noted that there was a significant difference in the number and types of cases between acute and mental health and learning disability trusts.

Action: Mr. Williams

(3) The recognition, from the case example provided in the report, of the challenges for the Trust in building confidence to increase the willingness of staff, who had raised concerns, to provide feedback.

(4) Concerns, from a patient experience perspective, about the poor quality reported to Mr. Williams by some staff who had used the Trust's services.

Mr. Martin advised that he had received both positive and negative feedback from staff who had used the Trust's services. In the latter case, the key theme was that they had struggled to access the right services and were unaware of the reciprocal arrangements with other trusts to provide services to staff. He considered that these arrangements were not generally understood within the Trust and needed to be more visible within the organisation.

It was noted that Mrs. Moody was working with a couple of clinicians, who had used the Trust's services, to develop guidelines on the offer provided to staff, working within TEWV, when mental health care was needed.

19/100 REPORT OF THE QUALITY ASSURANCE COMMITTEE

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

(1) The confirmed minutes of its meeting held on 7th March 2019 (Annex 1 to the report).

(2) The key issues considered by the Committee at its meeting held on 4th April 2019 including a recommendation that the Board should consider receiving monthly progress reports on the "must do" actions contained in the CQC Action Plan.

It was noted that the recommendation was in addition to, and did not replace, the Trust's usual reporting arrangements.

In response to questions:

(1) Mrs. Moody, having not yet received any feedback, undertook to circulate an update on the outcome of the meeting held to follow up safeguarding enquires raised at Acomb Garth, which were in connection with agency staff.

Action: Mrs. Moody

(2) It was noted that the spike in the use of rapid tranquilisation during January and February 2019 related to West Lane Hospital. There had been a reduction in March 2019 following changes to the presentation of patients and to the techniques employed by the clinical team.

Dr Griffiths, the Chairman of the QuAC, advised that this matter would continue to be kept under review by the Committee.

(3) It was noted that the concerns raised in the Tees LMGB report, about the performance and quality of care being delivered within inpatient services, were longstanding and related to the continuing high demand for services in the Locality.

Mrs. Hill reported that, whilst bed occupancy remained high, there was good oversight on the use of beds; better control of lengths of stay; and improved escalation arrangements; however, the level of demand was affecting the services' ability to engage and undertake activities with individual patients.

It was also noted that this issue impacted on all the Localities to varying degrees.

***Agreed** – that the Board receive monthly reports on the "must do" actions contained in the CQC Action Plan.*

Action: Mrs. Moody

19/101 NURSE STAFFING REPORT

The Board received and noted the exception report on nurse staffing for March 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.

Noting the continuing increase, clarity was sought on the expected timescale for agency usage to be reduced.

Mrs. Moody advised that:

(1) An action plan was now in place which was being taken forward by the staffing establishment group, under the Right Staffing Programme, chaired by the Chief Operating Officer.

(2) A change in the position was not expected during Quarter 1, 2019/20 as, although significant recruitment activity had been undertaken, for example an additional 20 bank staff had been recruited in the North Yorkshire and York Locality, it would take a few months for it to have an impact.

(3) It was hoped that a change in the position on agency usage would be seen during Quarters 2 and 3, 2019/20.

In response to a question, assurance was provided that the trajectory for reducing agency usage was reflected in the Trust's plans and budgets. It was also noted that work was being undertaken to ensure emerging deviations from the plans were addressed promptly.

In addition:

(1) Assurance was sought that action was being taken, as part of the merger of Acomb Garth and Meadowfields, to bring the staff together and build a cohesive culture.

    Mrs. Moody recognised the importance of this matter and advised that:

    (a) Work was being undertaken on the model of care and culture of the service as part of its preparations to move into the new hospital.

    (b) It had been agreed to use the same metrics as developed for the pilots of zonal care (e.g. temporary staffing, patient experience, falls, etc.) to enable quality and safety to be monitored.

(2) Clarity was sought on the proportion of the 45 incidents reported in March 2019 citing staffing issues which related to the cancellation of Section 17 leave.

    Mrs. Moody undertook to review the position.

Action: Mrs. Moody

19/102 LEARNING FROM DEATHS

The Board received the report on the approach being taken towards the identification, categorisation and investigation of deaths in line with national guidance.

The mortality dashboard for 2018/19, including 2017/18 data for comparison, was attached as Appendix 1 to the above report.

Arising from the report:

(1) The Non-Executive Directors asked for information on the age profile of those service users who had died to be included in future reports.

This was taken on board.

Action: Mrs. Moody

(2) Clarity was sought on how learning from deaths was itemised as it was understood that the classifications of root causes and contributory findings had been changed, approximately 18 months ago, and this might have impacted on the data included in the report.

Mrs. Moody assured the Board that the only change to the classifications had been to provide standard and shared definitions and this had had no impact on the data.

(3) The Non-Executive Directors asked for Regulation 28 matters to be included in future reports as this would provide external assurance that the Trust was learning and acting on the learning from deaths.

Mrs. Moody took this on board but advised that no Regulation 28 matters had been received by the Trust over the last year.

Action: Mrs. Moody

(4) The Non-Executive Directors suggested comparing local reviews into the deaths of people with learning disabilities with the national LeDer report.

This was recognised as the correct approach; however, it was noted that the Trust had not received any feedback from the LeDer programme on the deaths reported to it.

Mr. Martin assured the Board that informal benchmarking had been undertaken as there was, at present, no other source of comparative information available to the Trust.

(5) Recognising that the report was focussed on the mortality review process, clarity was sought on how learning from deaths was reported and assurance provided that it had been embedded.

Mrs. Moody advised that the learning had been captured, to an extent, in the report provided to the meeting held on 26th March 2019 (minute 19/66 refers) and

would also be included in the annual patient safety report which was due to be presented to the Board at its meeting to be held on 18th July 2019.

19/103 MENTAL HEALTH LEGISLATION COMMITTEE - MATTERS OF URGENCY

Mr. Simpson, the Chairman of the Mental Health Legislation Committee, reported that, whilst there were no matters of urgency arising from its meeting held on 24th April 2019, the Committee had identified a risk relating to the availability of Second Opinion Approved Doctors (SOADs) which it considered should be included in the corporate risk register.

Dr. Khouja explained that:
(1) There was a national shortage of SOADs.
(2) Contingency processes were in place when a SOAD was unavailable but these had an operational impact on services.
(3) Discussions were being held on the approach to recruiting additional SOADs but there needed to be more effective regional co-ordination and for the matter to be included in recruitment and retention initiatives.

The proposal to include the risk in the corporate risk register was taken on board.

Action: Mrs. Hill

19/104 SUMMARY FINANCE REPORT AS AT 31ST MARCH 2019

Consideration was given to the summary Finance Report as at 31st March 2019 including the Trust's Quarter 4, 2018/19, submission to NHS Improvement.

The Non-Executive Directors, noting the impact of a number of technical adjustments on the Trust's year-end financial position, welcomed Mr. McGahon's intention to present a briefing note on these matters to the Audit Committee but also asked, for assurance, for the document to include the views of Government and regulators on the Trust's approach and the acceptance of the accounting treatment by the External Auditors.

Action: Mr. McGahon

Mr. Martin advised that he, Mr. McGahon and the Head of Communications had discussed the approach to explaining the Trust's financial position in view of the complex nature of the technical adjustments and the underlying robustness of the Trust's financial performance.

***Agreed** – that the Trust's Quarter 4, 2018/19, submission to NHS Improvement, in accordance with the results detailed in the above report, be approved.*

Action: Mr. McGahon

19/105 PERFORMANCE DASHBOARD AS AT 31ST MARCH 2019

The Board received and noted the Performance Dashboard Report as at 31st March 2019.

The attainment of the targets for mandatory training, particularly as the indicator had been broadened for 2018/19 to cover all mandatory training and not just the seven core elements, and patient experience, together with the improvement on patient reported outcome measures, was recognised by the Board.

19/106 SINGLE OVERSIGHT FRAMEWORK

The Board received and noted a report on the indicative position against the requirements of NHS Improvement's Single Oversight Framework which provided assurance, to the extent available, that the Trust would maintain its segment 1 rating for Quarter 4, 2018/19.

19/107 USE OF THE TRUST SEAL

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

19/108 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.

19/109 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 21st May 2019 in the Boardroom, West Park Hospital, Darlington.

19/110 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).*
>
> *Information which, if published would, or be likely to, inhibit -*
> *(a) the free and frank provision of advice, or*
> *(b) the free and frank exchange of views for the purposes of deliberation, or*
> *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.*

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

Following the transaction of the confidential business the meeting concluded at 12.22 pm.

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**21st May 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	See Agenda Item 7
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	May-19 ~~Jul-19~~	Completed
19/07/2018	18/218	A further review of the Board's committee arrangements to be undertaken	PB	Jun-19	
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	May-19	See Agenda Item 11
29/01/2019	19/08	Further details on the staffing position in forensic services to be provided to the QuAC	RH	May-19	Completed
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	See Agenda Item 10

	Minute No.	Action	Owner(s)	Timescale	Status
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	19/65	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	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	
30/04/2019	19/98	To note that Mrs Hill is to be informed of any particular issues identified from the work being undertaken on the 'Fatigue and Facilities Charter'	Dr. Whaley	-	To note
30/04/2019	19/99	To note that comparative data is to be included in future Freedom to Speak Up Guardian Reports including: - On previous periods (e.g. no. of cases, percentage resolved, cases split by criteria such as patient safety, bullying, etc.) - Against information published in the annual reports of the National Guardians Office	Dewi Williams	-	To note
30/04/2019	19/100	An update on the outcome of the meeting held to follow up safeguarding enquires raised at Acomb Garth to be circulated to Board Members	EM	May-19	Completed
30/04/2019	19/100	To note that monthly progress reports on the "must do" actions included in the CQC Action Plan are to be presented to the Board	EM	Jun-19	(see also minute 19/39)
30/04/2019	19/101	The level of cancelled section 17 leave to be checked	EM	-	Completed

	Minute No.	Action	Owner(s)	Timescale	Status
30/04/2019	19/102	To note that the following matters are to be included in future Learning from Deaths reports: - The age profile of people who have died - Information on Regulation 28 matters - Comparisons of local mortality reviews with national LeDer reports (where available)	EM	-	To note
30/04/2019	19/103	The shortage of SOADs and its impact on operational services to be included in the corporate risk register	RH	Jun-19	
30/04/2019	19/104	A briefing note on the technical adjustments to the accounts, to also include the views of Government and regulators on the Trust's approach and the acceptance of the accounting treatment by the External Auditors, to be provided to the Audit Committee	PM	May-19	Completed
30/04/2019	19/104	To note approval of the Quarter 4, 2018/19, finance submission to NHSI	PM	-	To note

ITEM 7

CONFIDENTIAL

BOARD OF DIRECTORS

DATE:	**21st May 2019**
TITLE:	**Research and Development Annual Report 2018/2019**
REPORT OF:	**Dr Ahmad Khouja, Medical Director**
REPORT FOR:	**Information**

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

Executive Summary:

The Trust is committed to supporting and promoting research opportunities across all of our services and localities. The more research active we are as a Trust the better care we will provide. Our involvement in large-scale clinical trials continues to give service users and carers access to treatments at the forefront of knowledge. In our work with the National Institute for Health Research (NIHR) and our collaboration with national and international academic partners, we contribute to the worldwide evidence base for mental health care. We seek to create a culture of enquiry within our services which welcomes innovation and challenge. Research conducted in the Trust is compliant with the UK Framework for Health and Social Care Research and meets required quality and governance standards. The Trust's 2015-2020 R&D strategic priorities are being implemented, including the critical area of academic partnership development with the University of York. This report outlines activity for the period April 2018 to March 2019.

Recommendations:

The Board is asked to receive the 2018/2019 Annual Research and Development Report.

MEETING OF:	Board of Directors
DATE:	21st May 2019
TITLE:	Research and Development Annual Report

1. INTRODUCTION & PURPOSE:

- To report on Research and Development activity for the period April 2018 to March 2019.

2. BACKGROUND INFORMATION AND CONTEXT:

In November 2015 the Board approved a new 5 year Trust R&D Strategy with the following five goals, which provide the structure for this year's Report:

1. Maintain excellent performance in the governance, management and delivery of research.
2. Move from collaboration to leadership in research.
3. Ensure that our research drives improvement in care.
4. Embed research access and participation in all geographies and specialties of the Trust's services
5. Substantial growth in research-related income for the Trust

We have achieved major successes during the 4 years so far of the current R&D strategy, in particular the developments with the academic partnership with the University of York. Engagement to shape a new R&D strategy has already commenced and will be further developed during the next 6 months.

3. KEY ISSUES:

3.1 Maintain excellent performance in the governance, management and delivery of research

3.1.1 New CQC Research Indicator

As of 21 September 2018 the CQC's Well-Led Inspection framework details expectations of NHS organisations in relation to research. This is already actively forming part of current CQC inspections. Key line of enquiry W8.1 is as follows: *In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?* The five Trust-level guidance points are:

- Are divisional staff aware of research undertaken in and through the Trust, how it contributes to improvement and the service level needed across departments to support it?
- How do senior leaders support internal investigators initiating and managing clinical studies?

- Does the Vision and Strategy incorporate plans for supporting clinical research activity as a key contributor to best patient care?
- Does the Trust have clear internal reporting systems for its research range, volume, activity, safety and performance?
- How are patients and carers given the opportunity to participate in or become actively involved in clinical research studies in the trust?

Nationally the grouping of R&D leaders in Trusts, UKRD, is providing excellent support and information for us to prepare for Well-Led inspections in this regard, including the sharing of experiences from inspections so far. In considering our own self-assessment as an organisation, one area of importance is the extent to which a research culture is embedded throughout. To support the Trust with this indicator, we are working closely with our Specialty Development Group research leads as detailed in the Embedding Research Access and Participation section of this report below.

3.1.2 Research Governance activity

All research is now reviewed and approved by the National Health Research Authority which includes an ethical review for studies involving service users as participants in addition to a governance review for all studies. Following Health Research Approval, local R&D assessment of Capacity and Capability must be confirmed prior to a research study opening in our Trust. Quarterly Research Governance Group meetings oversee the activity and governance of the Research and Development activities in the Trust including performance and finance activity.

In 2018/19 a total of 48 research studies were confirmed for conduct in the Trust. Of these 23 were on the NIHR portfolio, the national list of externally funded studies of high quality. 25 non-portfolio studies (most frequently undertaken as part of a postgraduate masters or doctoral qualification) were confirmed. The time from when the Trust is selected as a site to run the study to local confirmation of capacity and capability for conduct in the Trust is externally monitored by the NIHR CRN. In 2018/19, the national target was 40 days; the Trust achieved an average approval time of 29 days.

Due to research grant success in the Trust during this year we have sponsorship responsibilities for two NIHR grant awards (CHEMIST and MODS). The governance for sponsoring research studies including the financial management of these has required us to put new systems in place to enable us to have robust oversight. We are putting in place new sponsorship Standard Operating Procedures and have arranged to host an external training programme inviting other Trusts in the North East region so we can work together to learn and share best practice.

3.1.3 Research study activity

Recruitment to NIHR (National Institute of Health Research) studies in 18/19 totalled 909 participants. As predicted in our 17/18 annual report, this is a decrease in actual recruitment numbers from the 1338 recruited in 17/18. This is due to a particularly high recruiting study in 17/18 which recruited a total of 771 participants alone. We

have noted an increase in the number of participants recruited to interventional studies which has increased from 102 in 17/18 to 187 in 18/19 demonstrating the increase in complexity of studies we are opening.

TEWV R&D department continued to receive funding for staff to recruit to studies in other NHS Trusts in the region, including 69 participants to Parkinson's disease studies from South Tees NHS Foundation Trust.

3.1.4 Commercial Research

Commercial activity has continued with a particular focus on recruitment to the following two studies:

- **A phase III, multicentre, randomised, double-blind, placebo controlled, parallel group, efficacy and safety study of Gantenrumab in patients with prodromal to mild Alzheimer's Disease (Graduate study). PI Dr Tolu Olusoga** This study has now seen 17 participants for a screening visit however due to the stringent inclusion/exclusion criteria no participants to date have been randomised to the treatment stage of the study. Screening visits are still underway for 4 of these participants and we are hopeful that at least one of these will reach the randomisation phase

- **Janssen GYAO2603 Treatment Resistant Depression cohort study in Europe – PI Dr Sumeet Gupta** 4 participants have been recruited to the study in TEWV from a target of 7. The study is due to close in July 2019. We understand this study will lead on to a future treatment study for this cohort of participants.

To continue to support the growth of further commercial research work, a B6 Commercial Research Nurse post was approved at EMT. This post holder will be able to undertake further scoping work with commercial companies to attract innovative treatment studies to open at our new Foss Park research facility.

Dr Tolu Olusoga, has conducted some engagement work with other Consultants in the Trust to upskill individuals to work on commercial research studies with a view to becoming future Principal Investigators.

We have completed an additional 3 expressions of interest for new commercial studies.

3.1.5 Excess Treatment Costs

Excess Treatment Costs (ETC's) are the costs of providing treatment interventions in clinical trials which exceed the costs of standard care. Their funding has often been contentious in the past, forming a barrier to the timely launch of clinical trials. This was because they were met on a case by case basis either from existing provider commissioned care income, or where they are substantial, by application to commissioners or the Department of Health and Social Care. NHS England have implemented a new system for the funding of ETC's for all newly funded NIHR portfolio studies, This will provide most ETC's via a new route through the regional

NIHR Clinical Research Networks where the total sum is funded above a threshold per financial year based on Trust income. The Trust incomes will be banded to offer stability around the threshold year on year. Therefore for all non-commercial studies that have ETC, Trusts will be required to absorb ETCs up to their threshold. Once the provider has absorbed their threshold for that year, they will have additional applicable ETCs funded via the Clinical Research Networks through new arrangements.

Phased implementation began in October 2018 with full operation by 1st April 2019. The consequences for the Trust will be clearer as we progress through its first full year of implication. The Trust's threshold is approximately £30k per annum, so the level of exposure to ETC's which will have to be accommodated by the Trust is small in absolute terms, with the larger ETC's going beyond this figure commonly associated for example with large psychotherapy trials now fully funded automatically by the Clinical Research Network. Discussions are ongoing regarding an internal system for meeting ETC's up to the annual threshold.

3.1.6 Contribution to the National Institute for Health Research (NIHR) and Clinical Research Network (CRN)

In addition to the NIHR participant recruitment activity demonstrated above, the Trust has had representation in a number of Clinical Research Network groups as follows

Group	TEWV Representative
Non-Exec group	Dr Hugh Griffiths
Partnership group	Prof Joe Reilly
R&D Managers group	Aileen Henderson
HR managers group	Helen Cooke
Pharmacy group	Angie Hardy
NMAHP strategy implementation group	Hannah Crawford

The Trust has continued to participate in a consortium arrangement for CRN-funded research support with Northumberland, Tyne and Wear NHSFT and Cumbria Partnership NHSFT. This Mental Health and DeNDRoN (Dementia and Neurodegenerative Diseases) Delivery Partnership is recognised regionally and nationally as an example of excellence in research collaboration across trust boundaries and has benefited the consortium sharing financial resource across the region.

Dr Dave Ekers continues in post as the LCRN Mental Health Specialty group lead and Dr Anne Aboaja has been appointed as the regional Research Careers Associate Lead for Mental Health. Both of these leadership roles have regional influence to increase and support new researchers across the region and bring additional research opportunities to our Trust.

Dr Valentina Short has been chosen as one of 70 nurses across the country to receive an NIHR '70@70' award which will support 2 days per week of her time over a period of 3 years. The 70@70 programme is for senior nurse and midwife clinical leaders with experience of building a research-led care environment for patients, and

a record of developing existing practice and contributing to a research rich environment.

A number of clinicians continue to received funding from the CRN to backfill their time to undertake research delivery as part of their roles.

3.2 Move from collaboration to leadership in research

3.2.1 University of York Research Partnership

Much progress has sprung from a wide range of creative conversations brokered by the Partnership's developing Leadership Team, comprised of R&D Manager Sarah Daniel, the University's Research Development Manager Louisa Shilton, Professor Simon Gilbody and Professor Joe Reilly. A particular highlight was the discussion at the November 2018 Board Seminar on the evaluation of 12 hour nursing shift implementation in York and Selby locality, conducted by the University's Management School and Centre for Health Economics. Key achievements from 18/19 are below.

- EMT supported a paper to further develop the Partnership to move from the scoping phase to develop new posts to sustain the partnership in the longer term. The financial projections suggest that these posts will be self-funding after 3 years.
- A new joint Clinical Research Facility between the University of York and TEWV is planned as part of the new Foss Park Hospital with contracts in the final stages of completion.
- Christina Van Der Feltz-Cornelis has been appointed to the Department of Health Sciences and Hull York Medical School as Professor of Psychiatry and Epidemiology from July 2018, with an honorary clinical consultant appointment at the Trust as liaison psychiatrist. Her work focuses on common mental disorders such as somatic symptom disorders, depression and anxiety, and the promotion of mental and physical health amongst those with combined chronic medical conditions and mental disorders.
- Dr David Ekers was awarded an Honorary Visiting Professorship with the University in May 2018. He is the Trust's first Nurse Professor, having studied at York to gain his PhD and established a successful programme of research in primary care mental health in his Trust role as a Consultant Nurse.
- Dr Lina Gega from Health Sciences UoY has been appointed as an Honorary Nurse Consultant in Mental Health in TEWV.
- Consultant Forensic Psychiatrist Dr Anne Aboaja has been appointed as Honorary Visiting Fellow to the University, and also as NIHR North East and Cumbria Clinical Research Network Lead for research career development in mental health.
- The University has won a prestigious Mental Health Network Plus programme grant from the UK's Research Councils, to investigate new approaches to improving physical health in severe mental illness, entitled "Closing the Gap", in which the Trust is a primary NHS partner.

- The mental health research charity MQ recently identified the University of York as one of the top ten UK institutions receiving the highest levels of funding for mental health research in the UK.
- In October 2018 Professor Dave Ekers was awarded a 5 year National Institute for Health Research Programme Grant with a total grant value of £2.4million which is hosted by the Trust. The programme will examine the use of Behavioural Activation and focussed collaborative care with older adults with physical health issues and low mood/depression.
- A number of smaller grant successes including the development of a Patient and Public Involvement Network at York and an animation to share research findings on the completed workforce project have also been achieved and others are in development.
- An Economic and Social Research Council-supported Knowledge Mobilisation project led by Professor Rachel Churchill is working closely with library services across both TEWV and Northumberland Tyne and Wear Mental Health NHS Foundation Trusts to better implement research findings into practice. The project has developed 7 new online critical appraisal skills resources which will develop the research skills of staff across the Trusts.
- The Partnership has identified a number of research priorities for the future including workforce mental health, common mental disorders, and improving physical health in severe mental illness.
- Bi-monthly meetings of the joint working group have continued throughout the year and the membership has extended to include both TEWV Directors of Nursing and Therapies.
- A Strategic Partnership Board meeting was held in March 2019 with Colin Martin, Chief Executive, TEWV and Saul Tendler, Acting Vice-Chancellor and President, University of York where an annual review of partnership activity and discussions of the potential future activity and opportunities were discussed.

3.3 Ensure that our research drives improvement in care

3.3.1 Applied Research Collaborations

The Trust has been substantially involved in two regional applications in the North East, and in Yorkshire and Humber, for NIHR Applied Research Collaborations (ARC’s). These are the largest scale external research grants available to NHS organisations, awarded on a five year cycle, and succeed the previous NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRCs). The purpose of an ARC is to build regional collaborations across health, social care and academic institutions in a region to support work on the better implementation of research into practice. The Trust’s geographical position and its partnership with the University of York afforded it the opportunity to join applications from both the North East and North Cumbria hosted by NTW, and from Yorkshire and Humber hosted by Bradford Acute Trust. Prof Joe Reilly and a number of Trust and University colleagues are involved in the North East ARC’s Integrating Physical Health, Mental Health and Social Care, and Knowledge Mobilisation themes. The Yorkshire and Humber region’s application has a theme led by Professor Simon Gilbody on physical health in severe mental illness, building on the existing strengths of our partnership work in this field. The process began with applications in August 2018,

interviews in October 2018, with a funding decision now anticipated during August 2019. Our involvement in the ARC's will build on the existing knowledge mobilisation work led by Professor Rachel Churchill of the University of York, in which we already partner with Northumberland Tyne and Wear NHS FT.

3.3.2 Research Results

The Trust contributes to a wide range of clinical trials and other high-quality studies during the course of each year. We have set a standard that wherever possible, the results of research conducted in the Trust should be shared with service users and local services within one year of the study completion date. A number of NIHR-funded studies reported during the past year; two are highlighted in this report.

SCIMITAR+ study

Research published in *the Lancet Psychiatry* :
http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30047-1/fulltext
found a dedicated intervention to help people with severe mental illness stop smoking can double quit rates at six months compared to standard care.

Led by the University of York's Mental Health Addictions Research Group, SCIMITAR+ is the largest ever trial to support smoking cessation among people who use mental health services. Smoking rates among people with mental health conditions are among the highest of any group having changed little over the last 20 years, while other smokers have quit. This new study demonstrates that with the right support this inequality could be a thing of the past.

Mental health nurses were trained to deliver evidence based behavioural support to smokers with severe mental illness in smokers' homes, alongside providing access to Nicotine Replacement Therapy (NRT) and medications. The researchers found that smokers who received this support were more than twice as likely to have quit six months following the intervention than smokers who had received standard care, usually a referral to the local stop smoking service.

The results of the SCIMITAR+ study will be presented at our R&D conference on 24th May 2019, with a session to consider barriers and enablers to implementing the results of this research.

Blue Room study – Virtual Reality Therapy for autism phobias

Funded by the NIHR, the research findings published in two journals Journal of Autism and Developmental Disorders
https://link.springer.com/article/10.1007%2Fs10803-018-3861-x
and in Autism in Adulthood https://www.liebertpub.com/doi/10.1089/aut.2018.0019

Immersive virtual reality has been shown to help children with autism with nearly 45% remaining free from their fears and phobias six months after treatment.
The Blue Room, developed by specialists at Newcastle University working alongside innovative technology firm Third Eye NeuroTech, allowed the team to create a

personalised 360 degree environment involving the fear which may debilitate the person with autism in real life.

Within this virtual environment, which requires no goggles, the person can comfortably investigate and navigate through various scenarios working with a therapist using iPad controls but remain in full control of the situation.

The study randomised 32 children with autism aged 8-14, half received the treatment in the Blue Room straight away and half acted as a control group, receiving delayed treatment six months later. Participants underwent four sessions a week involving a personalised scenario in the Blue Room with parents able to watch the treatment via a video link.

Two weeks after treatment, the research shows that four of the first 16 (25%) had responded to treatment and were able to cope with a specific phobia. This effect remained with a total of six showing improvement after six months (38%), however, one reported a worsening of their phobia. Meanwhile, in the control group, five untreated participants had become worse in the six months.
The control group went on to be treated in the Blue Room after this time. Results showed that overall 40% of children treated showed improvement at 2 weeks, and 45% at 6 months.
Other published research from work conducted in the Trust during the past year includes:

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- Kellett S, Ghag J, Ackroyd K, Freshwater K, Finch J, Freear A, Hartley J,Simmonds-Buckley M. Delivering cognitive analytic consultancy to community mental health teams: Initial practice-based evidence from a multi-site evaluation. Psychol Psychother. 2019 Mar 28. doi: 10.1111/papt.12221. [Epub ahead of print] PubMed PMID: 30924294.

- Blenkiron P, Goldsmith L. Patient-reported outcome measures in communitymental health teams: pragmatic evaluation of PHQ-9, GAD-7 and WEMWBS. BJPsych Bull. 2019 Mar 22:1-7. doi: 10.1192/bjb.2019.20. [Epub ahead of print] PubMed PMID: 30898178.

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- Wheatley A, Bamford C, Shaw C, Flynn E, Smith A, Beyer F, Fox C, Barber R, Parry SW, Howel D, Homer T, Robinson L, Allan LM. Developing an Intervention for Fall-Related Injuries in Dementia (DIFRID): an integrated, mixed-methods approach. BMC Geriatr. 2019 Feb 28;19(1):57. doi:

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- Thakur A, O'Leary B, Cowie W, Soklaridis S. The Development and Validation of a Workplace-Based Leadership Program for Senior Residents in Psychiatry. Acad Psychiatry. 2019 Feb;43(1):123-127. doi: 10.1007/s40596-018-0982-7. Epub 2018 Oct 2. PubMed PMID: 30280319.

- Holt RIG, Gossage-Worrall R, Hind D, Bradburn MJ, McCrone P, Morris T, Edwardson C, Barnard K, Carey ME, Davies MJ, Dickens CM, Doherty Y, Etherington A, French P, Gaughran F, Greenwood KE, Kalidindi S, Khunti K, Laugharne R, Pendlebury J, Rathod S, Saxon D, Shiers D, Siddiqi N, Swaby EA, Waller G, Wright S. Structured lifestyle education for people with schizophrenia, schizoaffective disorder and first-episode psychosis (STEPWISE): randomised controlled trial. Br J Psychiatry. 2019 Feb;214(2):63-73. doi: 10.1192/bjp.2018.167. Epub 2018 Sep 25.PubMed PMID: 30251622; PubMed Central PMCID: PMC6330076.

- Paton LW, Tiffin PA. Modelling out-of-area admissions. Br J Psychiatry. 2018 Oct;213(4):615-616. doi: 10.1192/bjp.2018.119. PubMed PMID: 30247110.

- Painter J, Ingham B, Trevithick L, Hastings RP, Roy A. IdentifyingNeeds-Based Groupings Among People Accessing Intellectual Disability Services. Am J Intellect Dev Disabil. 2018 Sep;123(5):426-442. doi:10.1352/1944-7558-123.5.426. PubMed PMID: 30198769.

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3.4 Embed research access and participation in all geographies and specialties of the Trust's services

3.4.1 Specialty Development Group Leads

In order to better embed research in the specialties the Trust has designated Specialty Development Group Leads, senior clinicians tasked with developing research capacity and delivery in their specialty area. They are now linked with Clinical Studies Officers in the R&D team to feed into directorate QuAG meetings and supporting the integration of research in clinical teams. MHSOP already have a 'Research Champion' model where champions are embedded in clinical teams and link with the SDG lead and R&D and we are discussing ways to roll this out in other clinical areas. The SDG research lead roles have become more formalised with a clearer role outline and the leads meet regularly with the R&D leadership team to share best practice among specialties. During the coming year this group will be helping us to shape the next 5 year R&D strategy. They are Dr Hannah Crawford (Learning Disability), Dr Ollie O'Mara (Children and Young People), Dr Chris Clarke (Mental Health Services for Older People), Dr Anne Aboaja (Forensic Mental Health), and Dr Hany El-Sayeh (Adult Mental Health).

We are also supporting the development of Research Interest Groups across the specialities. The Forensic Mental Health Research Interest Group has grown substantially over the year with strong university participation, culminating in a one day conference on sleep problems in forensic mental health, work which is progressing towards an external grant application. A new locality-focused Research and Evaluation Interest Group has also been launched in March 2019, led by Dr Jo Nadkarni.

3.4.2 Patient and Public Involvement

In 2018/2019, we had feedback from **75** research participants in TEWV about their experience of taking part in research. **94%** of participants strongly agreed or agreed that taking part in research should be a normal part of NHS Healthcare. **91%** strongly agreed or agreed that they would be happy to take part in another research study. We are continuing to receive feedback in a number of areas from research participants about their experience in research and will use this feedback to develop and improve the participant experience.

We have two PPI representatives on our Research Governance Group and the same two members support our University of York/TEWV Partnership working group. We also ensure that we have PPI representation on study oversight working groups for our local research teams and this has proved valuable in considering recruitment methods and reviewing study materials. One of our PPI members is a co-applicant on a successful awarded grant application along with the University of York and York Acute Trusts to develop a PPI research partnership to ensure that involvement is a key part of any developed grant applications. The newly formed 'Involvement@York' group meet regularly and are linked with our Trust PPI team to share best practice.

3.5 Substantial growth in research-related income for the Trust

3.5.1 Research Income

The Trust's external research income for 18/19 was £1,097,814, exceeding £1million for the first time, and an increase from the 17/18 income of £841,941. The following table shows the type and funding source for external income for 18/19. We anticipate that the income for 19/20 will continue to grow with continued income for MODS and other newly funded NIHR studies.

Description	**Funder**	**Amount**
Research support funding	NIHR Clinical Research Network North East and North Cumbria	£451,051
Research Capability Funding	Department of Health	£50,484
Journeying through Dementia Study income	University of Hull and Sheffield Health and Social Care Trust	£54,155
SCIMITAR + grant funding	NIHR Health Technology Assessment	£13,221
REMEDY grant funding	Imperial College London	£37,812
CHEMIST grant funding	NIHR Public Health Research	£360,504
MODS grant funding	NIHR Programme Grant	£113,260
Insomnia AD study	Merck, Sharpe and Dohme	£2,909
Additional grant funding	Various	£14,418
Total		**£1,097,814**

4. IMPLICATIONS/RISKS:

4.1 Compliance with the CQC Fundamental Standards:

Research activity in the Trust is compliant with CQC Fundamental Standards.

4.2 Financial/Value for Money:

As above in section 3.5.1.

4.3 Legal and Constitutional (including the NHS Constitution):

The Trust's responsibility for the monitoring and standards of research activity involving its service users, carers and staff are laid down in the Framework for UK Health and Social Care Research. The R&D office processes are designed to ensure compliance by all involved via the Trust's Standard Operating Procedures for research. The Trust R&D strategy and its implementation seek to fulfil the NHS Constitution commitment to make research participation accessible to as many service users, carers and staff as possible.

4.4 Equality and Diversity:

The Trust's R&D strategy explicitly seeks to ensure that wherever possible there is equity of access to research for service users and carers across the Trust's specialties and geographies.

4.4 Other implications:

None

5. RISKS:

None

6. CONCLUSIONS:

The Trust's Research and Development activity continues to enable service users and carers across all Trust localities to access new research opportunities for research involvement. We have made substantial progress with the University of York Partnership to develop an academic collaboration based firmly on shared interests and priorities.

7. RECOMMENDATIONS:

The Board is asked to receive and approve the 18/19 R&D annual report.

Professor Joe Reilly
Clinical Director for Research and Development

ITEM NO 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 21 May 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 02 May 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 Forensics and North Yorkshire & York Services
- Compliance with CQC
- Infection, Prevention and Control
- Positive and Safe Update
- Patient Safety Group
- Safeguarding & Public Protection
- Patient Experience
- Draft Quality Account 2018/19 Version 2
- Quality Assurance Committee Assurance Tracker

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 02 May 2019.
- Note the confirmed minutes of the formal meeting held on 04 April 2019 (Annex 1)

MEETING OF:	Board of Directors
DATE:	Tuesday, 21 May 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 02 May 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 Forensic Services and North Yorkshire & York 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 FORENSIC SERVICES LMGB

The Committee discussed the LMGB report for Forensic Services.

The top areas highlighted were:

- Resuscitation equipment – with issues around the emergency bags where some items had expired or were not present.
  This has raised the matter of staff providing reassurance versus assurance and some training has been undertaken to this end on the wards.

- Physical Health Escalation – following a serious incident that occurred in relation to wound care, it was found there were deficits in escalating physical health care issues appropriately to the right practitioners in a timely way. There was a lack of understanding around physical health pathways which potentially led to risks in delayed treatment.

  The daily huddle held by Ward Managers, Matrons and Service Managers now reviews all physical health issues and escalates appropriately as required.

In areas with a higher level of ongoing physical health issues across the majority of the ward population, a physical health 'ward round' has been established to ensure an MDT approach to meeting complex and chronic needs.

- Service Restructure – the two inpatient based elements of the service FMH and FLD have merged into one Secure Inpatient Service (SIS) with one Head of Service and so far things have gone smoothly. Offender Health has been renamed Health and Justice and the two transition wards (Oakwood and Talbot) that previously sat in FLD are now part of this service. Governance arrangements for the new inpatient structure are being considered and a mobilisation plan is in operation to ensure the smooth implementation of the new secure inpatient pathways and structures.

The Board is asked to note that:

- There had been 15 uses of soft restraint devices, 63 uses of tear proof clothing in FMH and 12 uses of tear proof clothing in FLD. This covers the five month period from November 2018 – March 2019. The QuAC report detailed the reason for use of soft cuffs which were all for transfer of patients.
  Members requested that an annual report to QuAC providing a view of the cumulative data on the use of mechanical restraint and tear proof clothing would be useful.
- Members discussed the reporting of cancelled patient leave and the need to be careful around counting leave where patients require escorts for leave and some where an escort may still be required for unescorted leave. Assurance was provided that overall the numbers of cancelled leave due to staff were reducing.

4.2 NORTH YORKSHIRE AND YORK SERVICES LMGB

The Committee discussed the LMGB report for North Yorkshire & York Services.

The top areas highlighted were:

- Waiting times – impacting on services across NY and York and in each directorate, however the most significant waits are to be seen in the memory assessment service, the secondary rates in IAPT and for autism assessments. Linked to this are the dementia diagnosis rates across the locality.
- Capacity issues with vacancies in community and inpatient areas, maternity leave and sickness absence, together with caseloads is impacting on productivity. This is then impacting on pressures with agency spend and the concerns around the quality of agency staff. This is being monitored closely by the Head of Nursing and Heads of Service.
- A number of service changes are taking place; with the closure of the rehab and recovery inpatient unit, the merger of the two organic wards into one in July 2019 and the engagement plan for Harrogate in partnership with the CCG. Delayed discharges remain a key area of focus, particularly in York and improving this will be essential to support the merger of Acomb Garth and Meadowfield.

The Board is asked to note that:

- There has been no use of mechanical restraints or tear proof clothing.
- All areas are fully compliant for emergency response bags, with daily checks in all areas daily, weekly and audited by Modern Matrons on a monthly basis. Assurance was provided that all isolated community teams in North Yorkshire and York now have the emergency bags.

4.3 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 action plan continued to be monitored on a bi-monthly basis by the Quality Compliance Group.
- Actions requiring confirmation of completion were February (2), March (9), April (8), May (18) and June (5).
- There had been three CQC MHA visits during the reporting period to Oakwood, Forensic Services, Cedar Ward, Durham and Darlington and Nightingale, Forensic Services.
- On the MHA visit to Oakwood, it had been found that individual intervention plans were clearly not reflecting the views of patients, even though they had been written in the first person. Assurance was provided that a kaizen event was taking place that week and the new care plans which will be implemented will help to address this problem.

Assurance is provided to the Board that the Trust continues to maintain full registration with the CQC with no conditions.

ARE OUR SERVICES SAFE?

5 Are lessons learned and improvements made when things go wrong?

5.1 Infection, Prevention and Control

The Committee received the quarterly Infection, Prevention and Control report for Quarter 4 and noted the Infection, Prevention and Control Annual Programme 2019/20.

The Board is asked to note the following:

- The IPC team have reviewed all critical questions in the IPC audit programme and essential steps tool at the request of clinical staff and they have been sent to Matrons for discussion and will be rolled out for the 2019/20 audit cycle. It was found that when the programme was set up it was 'overly critical' and this had necessitated a re-focus on what were actually 'critical questions'. This will ultimately help to target areas that should never fail.
  There was a discussion amongst members around why teams score themselves higher than when the scores are taken in a validated audit and it was noted that this is not uncommon, however does raise the need for further education which is picked up through validation audits with the IPC team.
- Assurance is provided that all key performance indicators are being monitored quarterly by the IPC Committee.
- The red score for the audit on Trust mattresses, raised in the IPC report to the Quality Assurance Committee in February 2019, where it was found that there were 184 mattresses breaching standards, assurance was given that mattresses have now been purchased and distributed making this action 'green', this would be reflected in the Annual IPC Report, which will go to QuAC at its meeting to be held on 06 June 2019.

5.2 Positive and Safe

The Committee discussed the draft Positive and Safe Annual report 2018/19

The Board is asked to note the following:

- It is evident from the data that reported reasons for using physical intervention are changing, self-harm was reported as the most frequent reason with 32% of the Organisations total incidents, aggressive/inappropriate behaviours directed towards staff from patients was 21% of the total and administration to patients was 19% .

- Total prone use for the year was 583. Prone use was at its highest in Q1 and Q3 of 2018/19 with 191 incidents, the lowest was Q4 with 113. Prone usage for 2017-18 was 581, highlighting a 0.3% increase for the current year.
- Use of rapid tranquilisation for the year was 2136 administrations, a 28% rise on the 1674 administrations of 17/18.
- There were 297 new episodes of seclusion reported across the financial year involving 131 patients, a 6.6% increase on the previous year.
- The most common age range for interventions is for under 18 year olds and the most commonly cited reason why restrictive practices are required is to support episodes of self-harm (32%).
- The use of tear proof clothing and mechanical restraint has significantly dropped and this is now reported to QuAC from the localities in the LMGB reports.
- Benchmarking was discussed amongst members, however it was acknowledged that it is very difficult to compare the Trust with other MH Trusts and other organisations collect data differently with different definitions and methodologies. Seclusion data will be shared with NTW, however their operational set up is different as they have seclusion facilities on each ward.
- Members did agree that it would be useful to break down the data around restrictive interventions even further with a view to using run charts and this will be considered by the Data Quality team.
- Assurance was sought that the ethnicity of patients receiving restrictive interventions is not disproportionate and this will be checked.

There are no significant risks to escalate to the Board and a further update will be received in six months' time.

5.3 Patient Safety

The Committee received an assurance report from the Patient Safety Group and a copy of a report, 'Learning from Gosport', from the Department of Health and Social Care.

The Board is to note:

- An action plan will be produced in response to the report, 'Learning from Gosport', which is about whistleblowing, listening to patients, families and staff and ensuring care is safe.
- Due to the need for an upgrade on the Datix system to upload a new form, issues were raised with regard to the reporting of incidents on Datix. Members of the Committee agreed that this should be discussed further at EMT to consider the balance of priorities for the IT department to work through, bearing in mind the importance of the introduction of CITO.
- EMT has considered the concerns raised via CQC inspections and repetitive themes and considered there needs to be more robust assurance for each issue and what work is being taken forward to address the problems.
- More work has been undertaken around the draft - 10 step Zero Suicide Plan and assurance was given that wherever possible existing work streams/data sources will be used.
- The Medical Director agreed to pick up with Liaison services the issues around uncertainty around who should complete a Datix when they see a patient in A&E who is not known to TEWV.

Assurance was provided that there are no concerns to raise to the Board.

5.4 Safeguarding and Public Protection

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

The key matters for the Board to note are:

- The Trust is currently involved in 11 serious case reviews for children, five serious adult reviews and four domestic homicide reviews.
- The issue raised at the 07 March 2019 QuAC meeting around safeguarding in relation to agency staff at Acomb Garth, has been followed up and it is believed that police are pursuing an investigation into one member of agency staff. The Trust will ensure going forward that there is a fundamental duty to ensure that agency staff are safely inducted with Trust policies.
- Safeguarding level 3 training for most of the localities is in the late 80/90% range and assurance has been provided that the target of 98% will be achieved by the summer of 2019.

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.

ARE OUR SERVICES RESPONSIVE?

6. How are people's concerns and complaints listened and responded to and used to improve the quality of care?

6.1 Patient Experience

The Committee discussed the Patient Experience Group assurance Report.

The Board is to note the following:

- The Patient Experience Group have been going through a period of refinement, both in terms of the meetings, which will be more of a quarterly performance type meeting and presentation of the data in reports. QuAC welcomed the evolving report and the improvements to the narrative around the data, whilst noting that there will be further transitions to a better reporting system with more analysis.
- Committee members sought further assurance around the breakdown of the detail around the high number of PALS termed as "other", however it was noted that this category included corporate services, where individuals have asked to remain anonymous and other general calls asking for signposting. This detail will go back to QuAC in July 2019.
- Feeling safe is one of the areas that received the highest proportion of negative comments and something that the Quality Assurance Committee has recognised as a concern over the last six months. A deep dive into this area has revealed that the data is within normal variation; however Teesside is showing a downward trend. Further information will be reported through to QuAC in June 2019.

Assurance was provided that the Patient Experience Group have reviewed all relevant Trust patient experience activities in line with the group's Terms of Reference and issues to be addressed are documented and are being progressed by the Group.

ARE OUR SERVICES EFFECTIVE?

6. Draft Quality Account 2018/19 Version 2

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

Members approved the Quality Account, subject to a couple of suggestions for amendments around the proportion of patient deaths (pages 20 and 47) and whether further explanation could be added to give context to the data. Dr Lanigan agreed to look at the comments made and see whether there was any flexibility in changing the text, since some of the narrative was statutory, before the Account was presented to the Audit Committee on 09 May 2019.

6.1 QuAC Assurance Tracker 2018/19

The Committee reviewed the newly implemented Assurance Tracker from September 2018.

The Board is to note that members of QuAC reviewed three months of assurance information from February 2019 and agreed that the tracker was a useful tool to check whether there are any gaps in assurance. It was suggested that the Mental Health Legislation Committee might also want to adopt an assurance tracker and this will be considered in due course.

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 issues raised at the Quality Assurance Committee meeting on 02 May 2019.
(ii) Note the confirmed formal minutes of the meeting held on 04 April 2019.

Mrs E Moody
Director of Nursing and Quality Governance
21 May 2019

Item 1

NOTES OF THE FORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 04 APRIL 2019, IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

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

In attendance:
Mrs Karen Atkinson, Head of Nursing, Tees
Dr Suresh Babu, Deputy Medical Director, Durham and Darlington
Dr Lenny Cornwall, Deputy Medical Director, Tees
Mrs Sarah Hopper, Locality Lead for Psychology, Tees
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mr Dominic Gardner, Director of Operations, Tees (for minute 19/41)
Mr Levi Buckley, Director of Operations, Durham and Darlington (for minute 19/40)
Mr Chris Williams, Chief Pharmacist (for minute 19/44)
Mrs Ann Marshall, Deputy Director of Nursing
Dr Chris Lanigan, Head of Planning and Business Development (for minute 19/47)

19/37 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs Elizabeth Moody, Director of Nursing & Governance and Mrs Karen Agar, Associate Director of Nursing.

19/38 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 07 March 2019 were accepted as a true recording of the discussions, subject to a couple of minor typographical errors and signed by the Chairman.

19/39 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. This matter was covered under agenda item number 5, (minute 19/46 refers).

Completed

19/05 All localities to report on mechanical restraint, use of tear proof clothing and compliance around clinical emergency response bags.
Members of the Committee agreed that whilst LMGB reports had now started to come through with these matters reported in the Executive Summary, it would be left on the action log until the meeting held on 2 May 2019 to ensure that all locality reports were standardised and provided sufficient assurance.

19/05 Letter of congratulations to go to staff in Tees.

Completed

18/170 Report on placing automated defibrillators in non-patient settings with cost proposals.
It was noted that this matter was being discussed by the Executive Management Team, week commencing 8 April 2019 and an update would be brought back to the 02 May 2019 QuAC meeting.

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.
It was noted that Mrs Agar had communicated with the relevant lead regarding this matter and it would appear that this was anecdotal, however if this was reported in the future it should be escalated at the time to ensure it could be reviewed.

Completed

19/08 A one page summary to be prepared on how the reconciliation between un-coded allergies could be migrated to coded allergies.
Mr Williams advised that an update would be included in the next report to QuAC on 6 June 2019.

19/24 York and Selby LMGB report: explanation to be given to percentage for patient experience (96.2%) and correction to page 10, patient safety in AMH, three SI's, which should have read *"one of which was in relation to fractured neck of femur".*
This would be followed up with an email to the locality for the information.

Completed

19/28 Check Datix whether it is feasible to look at any safeguarding incidents relating to agency staff.
Mrs Illingworth advised that this was not currently possible on Datix, individual incidents could be looked into, however staff were the second field in the levels of recording so any searches can only be made on individual patient names. There was also the issue of the information only being as good as the details that were inputted at the time and there were instances where staff would enter their name but not their role or job title. This was something that would be considered when reviewing and changing the overall functionality of Datix.
The Safeguarding and Public Protection report would include, in future any incidents relating to agency staff, where this was known.

19/40 DURHAM AND DARLINGTON SERVICES LMGB REPORT

The Committee received and noted the Durham and Darlington Services LMGB Report.

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

(1) Pressures in adult mental health services.
This had been impacting on staff health and wellbeing over the last few months; however there had been some improvement recently with extra capacity coming in for IAPT services. In addition, it was anticipated that the new crisis model would be approved on 11 April 2019 which would allow more change and hopefully more improved capacity.

(2) Pressure in learning disability inpatient services.
The complexity and acuity of patients had been causing these pressures with one individual recently requiring the use of a full ward. Mitigating actions included Tees 'loaning' the ward to Durham and Darlington together with a registered nurse for one month and the current Charge Nurse had been working differently to have greater visibility on the ward.

(3) Nine week waits in Children & Young People's Service.

The KPI for a second appointment within nine weeks had been breached. An action plan to improve performance and minimise breaches had been implemented. The service had also introduced psycho-education groups from the Single Point Access for low/moderate anxiety and low mood which should hopefully create some capacity and reduce waiting times.

In addition to the report Mr Buckley advised that:

(1) There would be some work undertaken on the locality risk register on 7 May 2019 and this would fit into the Trust wide piece of work on risk registers where the focus would be on North Yorkshire, York and Selby locality first.

(2) There were concerns over significant gaps in medical recruitment for Children and Young People's services with some locum cover to address some of the shortfall, in addition neighbouring Trusts had been contacted to enquire about any possible solutions.

The Chairman of the Committee expressed a wider concern around the impact of medical gaps on the delivery of safe, quality care and the pressure on staff and teams trying to manage in the circumstances.

Members of the Committee raised the following matters:

(a) The score for the mattress audit, which had scored red in the report.
Mr Buckley advised that mattresses had been checked, except when a patient still remained in a bed. Assurance was provided that a full complement of mattresses had now been ordered.

(b) The accuracy of the reference to the increased levels of referrals stated as 40% in the report compared to previous years.
On discussion it was acknowledged that this was in fact a false positive as it included the welcomed increased referrals through IAPT, however it was crisis services that were feeling the most pressure. The Medical Director highlighted that it would be interesting to know the number of people in IAPT services that were referred to the access teams and how many were actually taken on for treatment.

Mr Buckley undertook to look into this further and report back in the next locality report.

Action: Mr L Buckley

Compliance around emergency response bags provided assurance that daily checks had been undertaken on all wards except Elm and Roseberry. Additional monitoring had been put in place for those two areas and extra communication with agency staff would take place to ensure that they were fully briefed on the processes.

An assurance statement was provided in the report that there had been no instances of the use of mechanical restraint or of tear proof clothing in the locality during the reporting period.

(Mr L Buckley left the meeting)

19/41 TEES LMGB REPORT

The Committee received and noted the Tees LMGB Report.

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

(1) High levels of bed occupancy in AMH, MHSOP.
A piece of work had started to look at the levels of referrals and to break down any discrepancies between total referrals and unique referrals. The decommissioning of some primary care services in the last 18 months was thought to be a contributory factor.

(2) 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.

There had been an increase in the numbers of people on remand for low level crime with MH needs that had been transferred to Adult MH Services rather than Forensics. This will be discussed at SDG.
The high levels of activity were inevitably causing pressure on teams and staff wellbeing in order to try and manage the demand.

(3) Ongoing concerns in relation to the performance and quality of care being delivered within inpatient services.
There had been high levels of physical intervention and a lack of consistent understanding and application of the Trust Policy on restrictive practices with limited compliance in relation to appraisal and training.
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.

In addition to the report, Mr Gardner drew attention to the positive wok that had been undertaken by Hartlepool CAMHS where they had made a short film for secondary school PSHE lessons on the effects of being bullied.

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

Tear proof clothing had been used on one occasion in Tier 4 CYPS.

Non-Executive Directors raised concern that the tear proof clothing had not been approved at Director level, which was a requirement even when out of hours.

Mrs Atkinson confirmed that the use of tear proof clothing on this occasion had been for a very short period of time and it had been appropriate to use it. The use of clothing was agreed and documented within the young person's intervention plan which actually negated the necessity to inform the Director on call.

Following discussion the following matters were raised:

- 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 since that period and during March 2019 had dropped significantly from 48 episodes per month to four.
- The excellent scores shown on the quality scorecard given by carers on the service, which was a positive achievement.
- Whether some thought should be given to 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.

- The instances of level 3 self-harm which had been reported as not achieving target.
  Mrs Illingworth undertook to look at the algorithm behind the data.

Action: Mrs J Illingworth

- That consideration should be given to replacing any plastic crockery across the ward areas of the locality.

Action: Mr D Gardner

19/42 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

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

The following key matters were highlighted from the update:

- The CQC continued to monitor progress on the action plan monthly and through regular engagement meetings and attendance at Trust Committee meetings.
- There were a number of actions that required further evidence of assurance before they could be signed off for the January (5), February (3) and March 2019 (45) deadline.
  On this matter it was noted that a deadline had been set of Monday 8 April for localities to provide evidence of assurance.

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

  The Committee agreed that this should be recommended to the Board of Directors in the QuAC Report for discussion on 30 April 2019.

- The engagement meetings by members of the CQC had happened in Teesside adult MH and the feedback had been positive.
  Mrs Illingworth had been advised that following all the visits a pack would be collated by the CQC which would be given to the inspection team in advance of the next CQC Trust wide inspection.
- There were actions due for completion by May (22) and June 2019 (4), which were underway.
- Mental Health Act Inspections had been carried out at five services across the Trust and common themes were care planning, leave forms and reading patients' rights being the top issues picked up.
- 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.

Following discussion the following point was raised: whether or not being able to grant leave was another form of restriction.

(1) Mrs Illingworth explained that in relation to the table on page 10 of the report, this was in connection with patients not being given a copy of their leave programme.

(2) It was acknowledged that the CQC did view leave not being granted as ineffective, however in Forensic services the level of leave was quite high based on the flow of patients through services, however the Trust was judged on the percentage of leave that was not achieved i.e. 3%.
The Medical Director emphasised that the Trust tried very hard to match the capacity on the Wards to what has been prescribed for individuals and it had to be realistic.

19/43 ZERO INPATIENT SUICIDE PLAN

The Committee received and noted a draft report – Zero Inpatient Suicide Plan.

In introducing the report Mrs Illingworth highlighted the following:

(1) The Trust had been tasked with submitting a Zero Inpatient Suicide plan by the end of March 2019.
(2) The report had been circulated to leads in the three STPs in which the Trust sits for approval and would be monitored by the Patient Safety Group. The Group would also set baselines and improvement trajectories for the relevant parts of the plan, which would be reported back to QuAC in May 2019 as part of the Patient Safety Report.
(3) The plan had been based upon the '10 ways to improve safety' in the National Confidential Inquiry into Suicide and Homicide in mental health.

Dr Cornwall advised that the tension between personalised and non-personalised risk plans would need to be captured in the thinking within the Plan and how the Trust's protocol for the management of borderline personality disorder was used in light of the aim for personalised risk management.
Dr Khouja commented that the protocol should be used as a means for personalised care.

Members raised a query around whether the reduction for inpatient suicides would be aimed at 10% and how the action plan would be managed and communicated.

(1) It was noted that the aim was to work towards a reduction of 10%; a lot of the work set out in the plan was already underway across the Trust, there would be a change introduced to follow up, which would be reduced from seven days to three and there would be other work streams Trust wide that this work would fit into.
(2) The Director of Operations stated the need for this plan to also sit within the public health role, as currently the STPs had their own zero inpatient suicide plans and it was unclear why the plans needed to be written separately.

(3) The Chief Executive informed the Committee that the Director of Public Health for Tees was cited on this matter. A recent bid had been successful for the joint appointment of a Director of Public health for TEWV and Durham and Darlington.

19/44 DRUG AND THERAPEUTICS REPORT

The Committee received and noted the bi-monthly Drug and Therapeutics update report.

The following two areas of focus were highlighted from the report:
(1) Future Pharmacy Supply Arrangements.
The implementation of the three internal pharmacy dispensaries was on track for 1 November 2019 and progress reports were now being provided to LMGBs on a monthly basis. The main focus currently was the procurement of an IT dispensing system. This was currently now out to tender.

(2) Compliance with national medicines guidance.
There had been two new national medicines guidelines and the Pharmacy team had undertaken a gap analysis of current TEWV policies and procedures. The TEWV documents were found to be in line with the new national documents with only minor tweaks required during the next review process. One of the national documents had taken a softer view on utilising transcribing in organisations. This would require some internal discussion before considering whether the Trust stance to not allow transcribing, should be reviewed.

Mr Williams pointed out that the action from the 7 February 2019 QuAC meeting (minute 19/08 refers), regarding the one page summary detailing how the reconciliation would be undertaken to migrate uncoded allergies to coded would be included in the June 2019 report. This work had not yet been finalised and it was anticipated that sign off would be in May 2019.

Members raised the following queries:

(1) The Chairman of the Committee wanted to confirm that the new maximum dose of Haloperidol was a maximum of 20mg daily.
Mr Williams confirmed that this change had previously been noted, but now the Rapid Tranquilisation policy would be adjusted in line with this licensing change.

(2) Could a practical example be given of where transcribing might work?
It was noted that an example of transcribing would be when a drug chart needed re-writing.

(3) Further clarification on administering depots in own homes and the requirement to have adrenaline.
It was noted that requests had been received for community nurses to carry their own adrenaline. Initial doses of depots should be administered in a clinical setting where adrenaline was available. If there were rare circumstances where the first dose must be administered in a patient's own home, then the nurse would be required to ensure adrenaline was available for this occasion.

(3) Future Pharmacy Supply Arrangements.

The implementation of the three internal pharmacy dispensaries was on track for 1 November 2019 and progress reports would be provided to LMGBs on a monthly basis. The main focus currently was procurement of an IT dispensing system. This was currently now out to tender.

(4) Compliance with national medicines guidance.
There had been two new national medicines guidelines and the Pharmacy team had undertaken a gap analysis of current TEWV policies and procedures

Assurance was provided in the report 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.

19/45 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:

- There would be a Domestic Homicide Review in April 2019 following an incident in Middlesbrough whereby a service user had killed their mother.
  It was known that the individual had stopped taking their medication nine days before the incident and had used illicit substances.
- An individual management review would be completed for an individual who had died due to taking an Insulin overdose - they had been seen by services, however had not engaged.
- Safeguarding Partnership Arrangements had been published for York, Durham and North Tees (this was Stockton and Hartlepool combined). Redcar and Middlesbrough had joined with South Tees and all would be working towards the September 2019 deadline to have these arrangements in place.
- There would be a meeting held during April 2019 to follow up the safeguarding enquires at Acomb Garth.

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

19/46 AMH AND MHSOP INPATIENT UPDATE REPORT

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

In introducing the report, Mrs Hill drew attention to:

- The report had been requested following the rising bed pressures across localities and there has been focus on:
  - Better oversight of bed use.
  - The implementation of a structured approach to escalation.
  - Using information to understand service variation.
  - The development of an action plan to address issues identified.

- AMH and PICU admissions and readmissions.
  - 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 had 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), which represents five beds in the year.

- The range of data sets provided to inform localities and specialties about their operational issues was relatively new and would need more time to become fully embedded and to influence clinical practice.

Following discussion members queried:

(1) Whether it would be possible to look at the diagnostic profiles of those individuals re-admitted in 30 days.
Mrs Hill noted that individual data sets (including PARIS IDs) were being examined on a weekly basis via the report out, however the specifics around readmissions would be a longer piece of work.

(2) The interface between this work and the community.
This particular piece of work would focus on the pragmatic here and now, along with how services would need to be developed for the future, including community services, crisis and primary care.

(3) Whether readmissions for planned respite and booked elective was zero.
Mrs Hill advised that the deep dive work had found some practical issues around these areas which would need to be addressed.

The report provided an assurance statement that the Trust recognised the importance of addressing bed capacity and a number of systems and processes have been put in place to develop a deeper understanding of bed pressures and flow. Ongoing work would continue with localities to address the variation in length of stay, admission and readmission rates.

19/47 DRAFT QUALITY ACCOUNT 2018/19

The Committee received for consideration the drat Quality Account for 2018/19.

Dr Lanigan in introducing the Quality Account for 2018/19 highlighted that the draft Account had been presented to the Quality Assurance Committee this year a little earlier, as it would normally have been presented following consultation with key stakeholders and amendments.

Following a discussion on the content suggestions for amendment were raised around:

(1) The level of detail included around the CQC and MHA inspections.
(2) Whether a definition could be included on page 22, to explain “20 relevant health services”.
(3) Reference to the Audit Commission on page 29 to be removed.
(4) The section on learning from deaths on page 33 to be contextualised.

Dr Lanigan undertook to make these amendments before the meeting with the Task and Finish Group on 11 April 2019 and bring the amended version back to QuAC at its meeting to be held on 2 May 2019.

Action: Dr Lanigan

19/48 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no matters of exception raised.

19/49 ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD

There were no other issues that required escalation, other than the recommendation to Board members to consider whether there should be a stand-alone report to the Board on the CQC action plan “Must Do’s”.

19/50 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.

19/51 COMMITTEE EVALUATION

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

19/52 ANY OTHER BUSINESS

There was no other business to discuss.

19/53 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 02 May 2019, 2.00pm – 5.00pm in the Board Room, West Park Hospital.
The meeting concluded at 3.55pm

Item No 6

Positive and Safe
Annual Report
(Draft)

2018-2019

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1.0 Executive Summary

1.1 Introduction

Following TEWV's implementation of its restrictive intervention reduction plan in January 2015, the Positive & Safe Update Report aims to provide a review of current usage of restrictive intervention across Inpatient Services and consider the implementation and effectiveness of the strategies set out within its Restrictive Intervention Reduction Plan.

1.2 Summary of Performance

For the financial year 2018/2019, 9737 incidents occurred that involved the use of restrictive interventions.

From the overall data usage we can identify that 1131 patients were involved in restrictive intervention during 2018/19. The most common age range for interventions was Under 18 year olds with 46% of the total population; the lowest was those aged 30-44 with 6%

It is evident from the data that reported reasons for using physical intervention are changing, self-harm was reported as the most frequent reason with 32% of the Organisations total incidents, aggressive/inappropriate behaviours directed towards staff from patients was 21% of the total and administration to patients was 19%

Total prone use for the year was 583. Prone use was at its highest in Q1 and Q3 of 2018/19 with 191 incidents, the lowest was Q4 with 113. Prone usage for 2017-18 was 581, highlighting a 0.3% increase for the current year.

Use of rapid tranquilisation for the year was 2136 administrations, a 28% rise on the 1674 administrations of 17/18.

There were 297 new episodes of seclusion reported across the financial year involving 131 patients, a 6.6% increase on the previous year.

1.3 Significant Risk

Despite significant reductions in the uses of restrictive interventions across the organisation a number of services continue to report the use of restrictive interventions as part of the care and treatment that they deliver to patients.

1.4 Recommendations

Group members are asked to receive this report and provide comments/feedback as appropriate

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2.0 Introduction

The Positive & Safe Update Report aims to provide a review of current usage of restrictive intervention across Clinical Services and considers the implementation and effectiveness of the strategies set out within the Organisations plan to reduce the use of restrictive Interventions.

National Context

The National Agenda to reduce the use of restrictive intervention has continued to gather momentum over the last 12 months, key considerations for the organisation to consider:

- On November 1st 2018 the Mental Health Units Use of Forces Act was introduced which identified a number of requirements all health and social care organisations will be required to provide. Key requirements of the Act include the gathering and publication of data, senior organisational leadership in the use of restrictive intervention, the provision of appropriate training and the provision of patient centred information in the use of restrictive intervention. NHS England is currently in the process of developing statutory guidance and clarification of when the act will come into force.

- In December 2018 CQC announced that they will undertake a thematic review on the use of restraint, seclusion and segregation. The focus of the review will look at how inpatient and residential care settings use restrictive interventions and make recommendations to providers that can minimise the use of these types of interventions. Interim feedback is expected in May 2019 with a full report expected in March 2020.

- NHS Improvement are currently working alongside the Institute of Psychiatry to facilitate a national collaborative aimed at reducing the use of restrictive interventions by a third. The collaborative focuses on the use of service improvement methodology as a tool that aids services to develop alternative approaches. 42 services from 27 different organisations commenced work on the collaborations in November 2018, the project is expected to run until March 2020.

- On February 1st 2019 the restraint reduction network in partnership with Health Education England introduced national standards for training which focuses on the prevention and management of violence and aggression (PMVA). In conjunction with the new standards an accreditation scheme has been developed to evidence organisations compliance to the new approach. NHS England has set preliminary targets that all services providing specialist NHS provision will deliver accredited training by April 2020.

- CQC have recently undertaken a piece of work to develop unified definitions of the different types of restrictive intervention i.e. physical, chemical and mechanical restraint, and the use of segregation and seclusion. It is expected that these new definitions will now be included in data gathering completed as part of the national mental health data set with an aim to provide more robust benchmarking on the use of restrictive intervention.

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Local Context

TEWV's efforts to reduce the use of restrictive intervention commenced in January 2015 with the introduction of a 2 year project aimed at understanding the organisations use of restrictive intervention and developing alternatives to these approaches. Following completion of the project in 2017 the interventions developed with the 'force reduction project were revised and consolidated to form TEWV's restrictive intervention reduction plan, also referred to as the organisations Positive and Safe plan.

Centred on best practice in reducing the use of restrictive intervention TEWV's Positive and Safe plan centres around 5 core work streams as follows:

- Considering how data can be gathered and presented to influence staff decisions for using restrictive intervention.
- Support all inpatient areas to adopt the principles and 10 core interventions of the Safewards Model.
- Embed the principles of person centred behaviour support, with specific focus on the collaborative development and use of behaviour support plans for those individuals presenting behaviours that can challenge.
- Support the development of tools to facilitate debriefing and post incident review following incidents involving the use of restrictive interventions for both the patient involved and the staff that were supporting them
- Support the workforce in developing skills that will reduce the reliance on using restrictive interventions when managing behaviours that challenge, with specific focus on the mandatory Prevention and Management of Violence and Aggression (PMVA)

The development of these work streams, alongside the usage of restrictive interventions is reviewed quarterly by the Trust wide Patient Safety Group and the Recovery Programme Board.

2.1 Work Stream Update

Data Informed Practice

Ongoing support is provided to inpatient areas to use available data on the use of restrictive intervention with a clear message that this can be an effective tool to inform their clinical decision making when supporting patients with behavioural needs.

A significant number of wards now use safety crosses as a visual aid to prompt discussion about when restrictive intervention is used or when it is not being used. A number of wards report this is now a key part of huddles and handovers and an integral part of day to day record keeping. The positive and safe team continue to encourage services to utilise the approach and this will remain ongoing.

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In addition to the safety cross 5 inpatient areas have recently commenced a pilot in using the Broset Violence Checklist (BVC). The checklist asks 6 simple questions completed at each handover and provides a clinically valid indication that an incident may likely occur within the next 24 hours , providing staff with a clear indication that preventative strategies supported by the clinical approaches of person centred behaviour support and Safewards can be utilsed. The tool is internationally recognised as best practice in the field of behaviour management and is endorsed within the NICE guidance for the short term management of violence and aggression. 2 PICU areas, acute admission, low secure CAMHS, and adult Learning Disabilities services commenced pilot on March 1st with an expectation that the pilot will run for a 3 month period, when a formal review can take place and consideration can be given to a wider Trust roll out.

In order to encourage services to use data as part of their positive and safe practice it was always acknowledged that tools would need to be developed that provided both meaningful and timely information. As a result a key priority as part of the Trust positive and safe plan was to develop a data dashboard aimed at providing 'at a glance' information on the use of restrictive intervention. The expectation was this would be a tool which could be utilised within huddles, handovers, supervision, staff meetings etc. In partnership with the data quality team we have now developed a positive and safe dashboard for services to use. The dashboard became active from 1st April 2019 and will be updated on a weekly basis. A key aim for the positive and safe team over the next 12 months will be to embed use of the tool across inpatient areas.

An ongoing aim of the positive and safe agenda is to produce good quality data that provides a clear and transparent account of any restrictive intervention that has taken place and information that will allow lessons to be learnt and potential alternative approaches to be developed. In order to achieve this we continue to review the datix process for recording incidents identifying any recommendations for changes or improvements as part of the national positive and safe agenda.

Safewards

Implementation of the Safewards model continues across services. All wards are asked to identify 2/3 ward based champions to lead with the approach and contribute to the Trust wide network of staff supporting the implementation.

The Positive Safe team continue to provide support offering service specific training and consultancy to develop their intervention. We have also provided a number of sharing practice events offering staff opportunities to present their good practice and learn from each other to overcome barriers to implementation

Sustainability of the approach continues to prove challenging, competing demands within ward environments has often delayed the development of specific interventions or resulted in established interventions losing focus. The Positive and Safe team has developed a checklist for services to monitor progress and will review regularly through the Positive and Safe Advisory Group.

As part of our ongoing positive and safe aims we have recently commenced a pilot to introduce the Safewards model as part of crisis and home treatment teams. Services in Durham and Darlington and North Yorkshire have been identified to take part, staff working in these teams have received

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training and will commence pilot from June 1st. It is expected that the pilot will last for a minimum 6 month period with ongoing monitoring via the positive and safe advisory group.

Whilst the organisation have made significant steps to embed Safewards model it is acknowledged that greater emphasis on the approach may assist in delivering greater reductions, scoping work needs to be undertaken to consider how the model could be further developed with a specific emphasis on the cultural elements of Safewards and how these may be able to become more visible within clinical settings.

Person Centred Behaviour Support

Work to embed the development of patient focused behaviour support plans continues across services. We have provided services across the Trust with additional training in the approach and, additional supervision and consultancy for patients with complex needs continues to increase from both community and inpatient services.

Work is currently ongoing to support Adult mental health service in revising and effectively implementing their Person Centred Behaviour Support pathway. 2 scoping events have now taken place to agree content, with a further consolation event planned for May 2019, it is expected once approved the pathway will commence use form July 2019.

We have recently commenced work with CAMHS services to review their existing Positive behaviour support pathway exploring potential options that would see increased use of the approach within T4 services.

Services continue to increase their use of behaviour support planning, with increased numbers of patients having person centred plans available. However quality and visibility of plans continues to prove challenging. Current developments within Pairs may provide opportunity to look at more effective options for storing plans in a more consistent way.

Post Incident Review following the use of restrictive intervention

As part of the overarching Positive and Safe plan, all services are encouraged to utilise the rapid reflection tools that are available, following all episodes of behaviours that challenge, if services require the use of restrictive intervention as part of their support approach then it is expected that both reflection tools for staff and patient will be completed and documented within Datix. The graph below identifies numbers of completed post incident reviews alongside incident numbers for the same time periods

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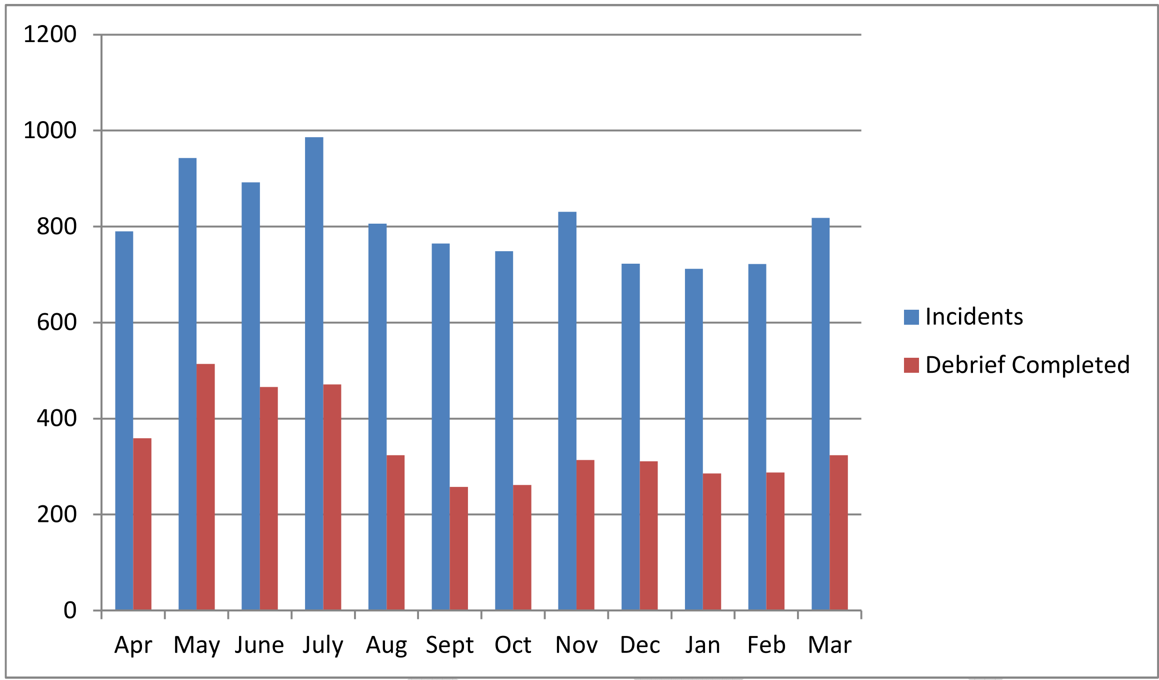
Post Incident Review completion 18/19



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Data suggest that post incident reviews are taking place in 43% of incidents, highest reporting services for reviews taking place is the PICU at West Park Hospital, completing reviews following 66% of its incidents. Expectation as an organisation would be that we aim to complete reviews for 80% of the incidents involving restrictive intervention.

Debriefing of patients continues to prove challenging for staff, who often that they feel the approach will lead to further incidents and lacks any benefits. Consideration needs to be given of how staff confidence can be increased, through training and wider communication.

In addition to the rapid reflection tool available to staff, we have recent developed and piloted a detail review that is completed following the use of prone restraint. The review gathers great detail regarding the decision making for using prone and includes escalation that the approach was used to the head of nursing for that locality and the Trust Positive and Safe Lead. The approach was recently piloted within the Tees locality with positive result. Work is ongoing with Heads of Nursing for each locality to look at wider trust roll out.

Scoping of a project that will look at using body worn as part of the management of behaviours that challenge is currently ongoing. Services in T4 CAMHS, AMH and Forensics are keen to be involved in what would be a 3 month pilot of using cameras. Nationally Trusts have reported significant reductions in both restrictive interventions and staff sickness as a result of similar projects. Work is currently ongoing to establish security and privacy protocols for the use of the cameras. If approved it is expected that a pilot would commence form June 2019

As the national Positive and Safe agenda evolves a clearer distinction between a post incident review and a psychological debrief is emerging, great understanding needs to be developed regarding the role of debriefing, standards for how the process is completed and its interactions with the post incident review process.

Positive & Safe Training

Revised Positive Approaches Training (PAT) continues to be delivered across the Trust, receiving positive feedback. In addition to the face to face training received by staff a reflective workbook was introduced in June 2019 offering staff the opportunity to update practice on an annual basis.

The current Positive Approach Training curriculum was recently reviewed by the Trauma informed care leads for the Trust; there aim to look at ways to further embed the principles within the course. Feedback was positive with only small changes required to the curriculum.

In partnership with the Positive Approaches Training Team the new National Training Standards are been reviewed in order to identify any potential changes that will be required to the course and to consider the process for achieving accredited status for the current training. It is expected a paper will be prepared for the consideration by the Executive Management Team outline potential changes in May 2019.

In addition to the training offered via the Positive Approaches Team, training in the Positive and Safe agenda is now incorporated within the Trusts corporate induction programme and all locality preceptorship programmes across the Trust.

Workshops to develop skills in administering rapid tranquilisation have continued to be well attended with dates now available till December 2019. The workshops focus on the use of giving injections in sites that don't require the use of prone restraint i.e. Arm or Hip

A series of masterclasses aimed at increasing skills in the development and writing of behaviour support plans was well received from staff working across the Trust, with a number of requests for additional dates. Further workshops are now scheduled until December 2019

It's recommended that scoping work is carried out to establish if additional training in supporting patients displaying Self Harm can be developed across the trust, with specific emphasis upon development with T4 CAMHS services.

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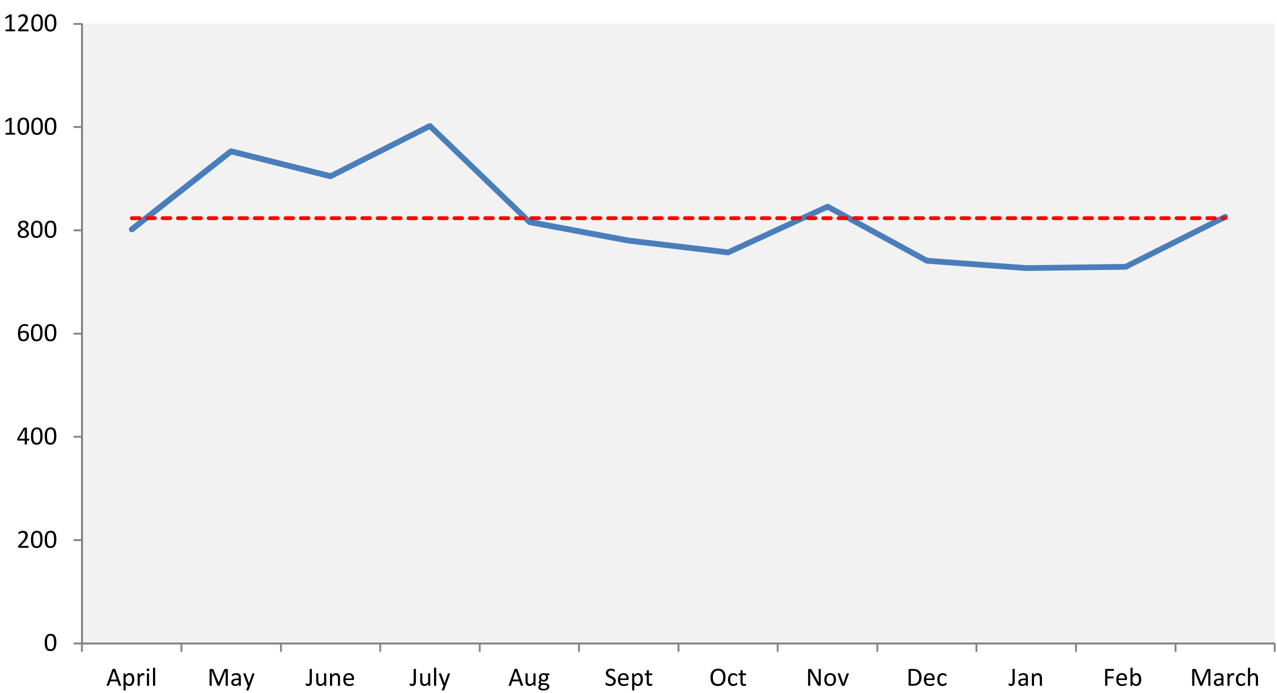
Use of Physical Restraint

For the financial year 2018 – 2019, 9,737 incidents occurred that involved the use of restrictive interventions, these incidents involved 1131 patients. The graph below outlines the frequency of incident occurrence across the year.



Q1 was reported as the highest quarter for the year with 2,659 incidents. Quarter 4 was the lowest with 2,285. The financial year 2017-2018 reported total incidents of 8,628, highlighting a 14.5% increase for this year in the total use of physical intervention.

From our analysis we can identify that there is little to no variation in the frequency of restraint and days of the week. However we can identify a small trend in increased incidents during the late afternoon early evening.

From the overall data usage we can identify that 1131 patients were involved in interventions during 2018/19. The most common age range for interventions was Under 18 year olds with 46% of the total population; the lowest was those aged 30-44 with 6%.

The ethnicity of patients involved in the use of restrictive interventions was highest in those categorised as White British with 8505 incidents 87% of the total population. When looking at the gender split between those involved in the use of restrictive intervention it can be identified that 23% of the population were male, 75% female.

The table below outlines the most commonly reported categories of incidents suggesting why restrictive interventions may have been used across 2018/19.

Count of Incident ID		
Common Classification System 1st TIER Description	**Common Classification System 2nd TIER Description**	**Total**
Administrative Processes (Excluding Documentation)	Safeguarding/Protection	17
	Transfers/Transitions	57
Behaviour	Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self-harm)	630
	Inappropriate/Aggressive Behaviour towards a Patient by a Patient	395
	Missing Patient (absconded/abducted patient)	139
	Patient refusal of diagnostic/therapeutic recommendations/interventions	1190
	Self-harming Behaviour	3255
	Use/Possession of Prohibited/Stolen Goods	28
Behaviour (Including Violence and Aggression)	Inappropriate/Aggressive Behaviour towards Staff by a Patient	2014
Nutrition Pharmacy Products	Administration to Patient	1910

Most commonly cited reasoning why restrictive intervention is required is to supported episodes of self-harm, representing 32 % of total incidents. Episodes of behaviours that challenge towards staff represents 21% and restraint use to support administration of nasogastric tube feeds represented 20% of the Trust usage.

Reporting systems were recently updated to allow distinction between incidents of restrictive intervention that were unplanned and part of an emergency response to those that were planned as part of a person's care or treatment. Since implementation in October 18 we now identify for Quarters 3 and 4 of the current year that that there were 3263 (70%) were part of an unplanned response with 1422 (30%) reported as part of planned treatment or care.

The table below outlines frequency of usage across each of the localities across the current financial year, figures for 17/18 are included as a comparison.

	Patients		Q1		Q2		Q3		Q4		**Total**	**Total**
	17/18	**18/19**	17/18	18/19	17/18	18/19	17/18	18/19	17/18	18/19	**17/18**	**18/19**
AMH	**408**	**509**	368	474	433	432	362	472	251	382	**1,414**	**1,760**
C&YP	**137**	**196**	748	1143	981	1468	892	1182	1008	1130	**3,629**	**4,923**
FLD	**77**	**38**	93	168	87	74	56	44	92	74	**328**	**360**
FMH	**127**	**53**	479	301	387	148	308	171	316	159	**1,490**	**779**
ALD	**94**	**72**	125	185	180	169	213	160	70	296	**588**	**810**
MHSOP	**232**	**263**	210	347	418	257	284	268	267	233	**1,179**	**1,105**
										Totals	**8,628**	**9,737**

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Comparisons with reported figures for the previous financial year see significant increases with Tier 4 CAMHS services (36%).

Both FLD and ADL services reported lower numbers of patients involved in incidents , however both services reported increases in frequency if restrictive intervention uses, suggesting the same patients requiring higher numbers of physical restraint.

Forensics mental health services have demonstrated significant reductions 48%, which has maintained lower rates since Q2 18/19.

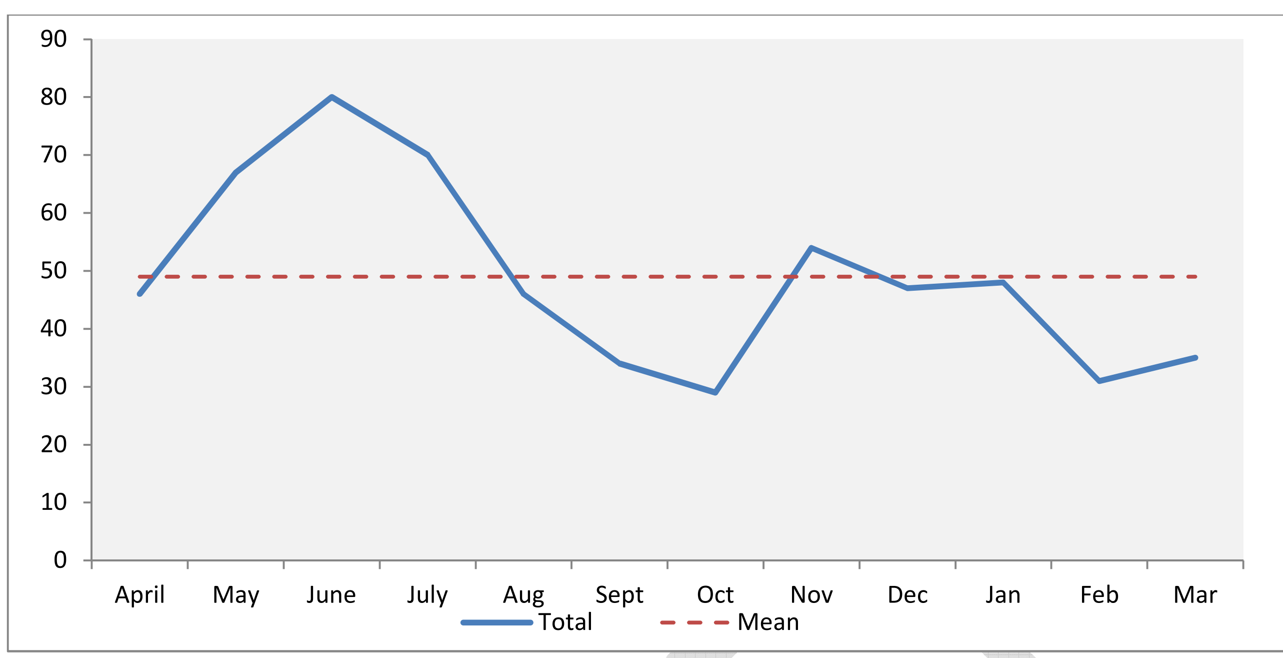
Ward breakdown for total use of physical intervention is detailed in the chart below identifying the 10 inpatient areas reporting as the highest users (69% of the Trusts total usage), 17/18 figures have been included as a comparison alongside a RAG rating identifying increase/decrease.

WARD	17/18	18/19	Change in Use
CAMHS IP WLH EVERGREEN CENTRE	1550	**2271**	
CAMHS IP WLH WESTWOOD CENTRE	500	**1703**	
CAMHS IP WLH NEWBERRY CENTRE	1492	**729**	
FMH RP SANDPIPER WARD	881	**490**	
AMP WP CEDAR WARD	346	**368**	
ALD IP 4 + 6 OAK RISE, ACOMB	154	**302**	
MHSOP IP MALTON SPRINGWOOD	221	**256**	
AMH RP BEDALE PICU	126	**206**	
MHSOP RP WESTERDALE SOUTH	120	**205**	
MHSOP IP SELBY ACOMB GARTH	387	**202**	
Grand Total	5777	**6732**	

Both Evergreen and Newberry centres report as significant outliers for the organisation representing 41% of the Trusts total usage in physical restraint, and incidents rising by over 90% on the previous year. However the Newberry centre has seen positive reduction of 51% in incidents over the last 12 months. Sandpiper ward have also reported similar decreases.

Prone Physical Restraint Use

Total reported uses of prone physical restraint were 586 incidents. The graph below identifies frequency across the year 18/19



Total prone use for the year was at its highest in Q1 of 2018-19 with 192, the lowest usage was reported in Q4 with 113. Use of Prone physical restraint for the last financial year 17/18 reported 581 episodes suggesting a small 0.3% increase for 18/19

Of the 586 prone physical restraints that took place it's identified that 331 were reported as intentional use of the procedure (PNT), representing 56% of the total usage. 255 or 43% incidents were reported as unintentional usage of prone restraint (PRO)

The breakdown below identifies use by each speciality across the financial year

	Q1		Q1		Q2		Q2		Q3		Q3		Q4		Q4		Totals	
	17/18		18/19		17/18		18/19		17/18		18/19		17/18		18/19		17/18	18/19
	PNT	PRO	PNT	PRO	PNT	PRO	PNT	PRO	PNT	PRO	PNT	PRO	PNT	PRO	PNT	PRO	PRONE	
AMH	35	11	30	17	23	19	20	21	20	19	11	22	28	19	14	12	174	147
C&YP	25	3	23	37	24	4	19	30	15	5	29	13	20	10	30	14	106	195
FLD	5	1	6	3	3	5	9	7	4	3	7	6	7	5	3	5	33	46
FMH	76	28	38	6	43	10	34	6	28	10	30	9	19	8	18	5	222	146
ALD	5	2	3	27	9	8	0	4	8	3	1	2	2	1	4	9	38	50
MHSOP	2	0	1	0	1	0	0	0	3	1	1	0	1	0	0	0	8	2
Totals	193		191		149		150		119		191		120		114		581	586

Whilst the table suggests only slight increase in usage as an organisation it evident that a number of specialities have seen significant changes in the usage of prone restraint. Forensic mental health services have reporting significant decreases of 34% and Adult Mental Health Services have also reduced by 15%

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compared to last year. However significant increase was reported in T4 CAMHS services rising over 80% on the previous year. Both Forensic and Adult Learning Disability services have also increased by 34%

Ward breakdown for total use of prone is detailed in the chart below identifying the 10 inpatient areas reporting as the highest users (73% of the Trusts total usage), 17/18 figures have been included as a comparison alongside a RAG rating identifying increase/decrease.

Ward	17/18	18/19	Change in Use	Percentage of Trust Usage
CAMHS IP WLH EVERGREEN CENTRE	33	110		16%
FMH RP SANDPIPER WARD	165	88		15%
CAMHS IP WLH WESTWOOD CENTRE	24	65		11%
MERLIN WARD	26	39		7%
AMH RP BEDALE PICU	22	33		6%
AMH IP HARROGATE BRIARY WING CEDAR	15	19		3.2%
ALD LRH BEK WARD	9	19		3.2%
AMP WP CEDAR WARD	37	17		2.9%
NORTHDALE CENTRE–HAWTHORNE AND RUNSWICK WARD	6	17		2.9%
ALD LRH RAMSEY WARD	14	15		2%
Grand Total		422		

The Evergreen Centre has reported significant increase compared to the previous year, all 110 incidents can be identified as unintentional usage of the approach and were taking place as part of a planned intervention to provide nutrition to patients, whilst this provides clinical context, the use of this approach requires intensive monitoring across the next 12 months and further consideration must be given to potential alternatives that could be used.

Whilst Sandpiper remains high users of the approach, it's evident that significant reductions have been made across the current financial year with episodes of prone restraint reducing by 44%.

Use of Chemical Restraint: Rapid Tranquilisation

There were 2136 administrations of Rapid Tranquilisation during the financial year 18/19, a 28% rise on the 1674 administrations of 17/18. The table below highlights the usage of RT across each of the specialities.

	No. of Patients		Q1		Q2		Q3		Q4		Totals	
Rapid Tranquilisation	17/18	18/19	17/18	18/19	17/18	18/19	17/18	18/19	17/18	18/19	17/18	18/19
Adults	161	195	76	165	98	151	98	199	71	129	343	633
T4 CAMHS	52	45	150	189	265	190	139	322	71	330	780	1031
Forensic LD	14	14	21	63	16	11	10	4	29	12	76	90
Forensic MH	25	13	110	59	60	31	74	28	99	65	343	183
ALD Services	30	6	4	27	13	6	9	1	4	23	30	57

MHSOP	48	54	22	35	26	21	32	31	22	44	102	131
Totals	330	327	383	538	478	410	362	585	296	603	1674	2136

Use of rapid tranquilisation was reported highest within Children & Young People's Services, 48% of the Trust total usage and an increase of 32% on their 17/18 usage.

Interestingly both forensic and adult learning disability services reported either the same or decrease numbers for patients involved in the administration of rapid tranquilisation, however reported increased usage across the reporting period. Similarly AMH services reported only a small increase in the number of patients involved, however frequency of administrations increased by 85%.

Ward breakdown for total use of rapid tranquilisation is detailed in the chart below identifying the 10 inpatient areas reporting as the highest users (77% of the Trusts total usage), 17/18 figures have been included as a comparison alongside a RAG rating identifying increase/decrease.

Rapid tranquilisation use ward by ward is highlighted below:

Ward	17/18	18/19	Change of use
CAMHS IP WLH WESTWOOD CENTRE	250	672	
CAMHS IP WLH EVERGREEN CENTRE	178	219	
FMH RP SANDPIPER WARD	280	155	
AMP WP CEDAR WARD	73	151	
CAMHS IP WLH NEWBERRY CENTRE	335	128	
WPH IP EATING DISORDERS	0	79	
AMH IP HARROGATE BRIARY WING CEDAR	18	74	
AMH RP BEDALE PICU	31	70	
FLD RP CLOVER IVY WARD	70	65	
ALD BEK/RAMSEY WARD	8	46	

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The Westwood centre reported as the highest user during 17/18, reporting a 168% increase on the previous year, it is evident from the data that the ward reported significant increase from Q2 to Q3, 80% of the incidents were related to the needs of one specific patient. Whilst the data does not reflect this, significant reductions have been reported during Q4 with incidents reducing by over 80%.

Following the trend reported in other types of restrictive intervention Sandpiper have reduced compared to the previous year with reductions of 44%. The Newberry Centre have reported similar reductions

Comparison on the previous year's show high increases for both PICU wards, with administrations doubling in frequency in both sites.

Further work also needs to be undertaken to understand the increases within both Adult eating disorders and learning disability services, as both services have reported high increase despite the local and national trends for limited uses in these areas.

New episodes of Seclusion

There were 297 new episodes of seclusion reported throughout 18/19. The total number of new episode of seclusion was a 6.6% increase on the previous year. The new episodes of seclusion throughout the year involved 131 patients.

New Episode of Seclusion	Tier 4 CAMHS	Forensic Services	Durham and Darlington	York and Selby	North Yorkshire	Teesside	Grand Total
Q1 2017-18	8	56	0	1	12	10	87
Q2 2017-18	3	51	1	2	10	18	85
Q3 2017-18	6	40	0	0	5	17	68
Q4 2017-18	0	51	10	1	12	4	78
Total	17	198	11	4	39	49	318
Q1 2018-19	7	35	10	1	7	20	80
Q2 2018-19	5	18	20	1	5	24	73
Q3 2018-19	0	21	17	1	2	15	56
Q4 2018-19	5	34	16	0	2	20	77
Total							

The table below highlights the highest users in the approach which is compared to 17/18 – 258 episodes of seclusion involving 111 patients.

WARDS – NEW EPISODES OF SECLUSION	17/18 – 111 patients	18/19 – 131 patients	Change of Use
AMH RP BEDALE PICU	39	74	
AMP WP CEDAR WARD	10	59	
FMH RP SANDPIPER WARD	84	30	
MERLIN WARD	41	22	
FMH RP THISTLE WARD MED SEC FEMALE	6	18	
FLD RP CLOVER IVY WARD	25	11	
FLD ASD NORTHDALE CENTRE	3	11	
CAMHS IP WLH NEWBERRY CENTRE	11	9	
AMH ESK WARD	14	8	
AMH DANBY WARD	17	5	

Significantly both PICU Wards have reported high increase in comparison to the previous year. Positively a number of wards have reported reductions with Sandpiper and Merlin wards, both reducing by half.

Use of Tear Proof Clothing

There were was 138 incidents that involved the use of tear proof clothing across the financial year. These incidents involved 59 patients. Below is a breakdown of each Specialities use of Tear Proof Clothing.

Tear Proof Clothing	DURHAM AND DARLINGTON	FORENSIC SERVICES	NORTH YORKSHIRE	TEESSIDE	TIER 4 CAMHS	YORK AND SELBY	Q total
Q1 2017/18	0	78	1	11	0	0	90
Q2 2017/18	2	59	3	25	20	1	110
Q3 2017/18	0	46	2	26	9	1	84
Q4 2017/18	6	58	5	7	4	0	80
Total 17-18	**8**	**241**	**11**	**69**	**33**	**2**	**364**
Q1 2018/19	5	43	2	18	6	0	74
Q2 2018//19	10	31	1	16	6	0	64
Q3 2018/19	2	19	1	0	0	0	22
Q4 2018/19	1	15	0	0	1	0	17
Total 18/19	**18**	**108**	**4**	**34**	**12**	**0**	**177**

Ward breakdown of services using Tear Proof Clothing

Service	Total 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total
FMH RP SANDPIPER	146	15	8	14	13	50
AMH RP BEDALE PICU	60	16	17	0	0	33
AMH WP CEDAR PICU	5	3	9	2	1	15
FLD RP THISTLE MED SEC	0	1	1	2	2	6
FLD RP IVY CLOVER WARD	4	4	0	1	0	5
Grand Total						

Use of Mechanical Restraint Devices

There were was 60 incidents that involved the use of mechanical restraint devices across the financial year. These incidents involved 27 patients. Below is a breakdown of each Specialities use of Mechanical Restraint.

Use of Mechanical Restraint Devices							
	DURHAM AND DARLINGTON	FORENSIC SERVICES	NORTH YORKSHIRE	TEESSIDE	TIER 4 CAMHS	YORK AND SELBY	Q Total
Q1 17-18	0	12	0	1	0	0	13
Q2 17-18	0	12	1	5	0	0	18
Q3 17-18	0	9	0	2	2	0	13
Q4 17-18	0	10	0	0	0	1	11
Total 17-18	**0**	**43**	**1**	**8**	**2**	**1**	**55**
Q1 2018-19	0	19	0	3	0	0	22
Q2 2018-19	0	13	0	4	0	0	17
Q3 2018-19	0	7	0	2	0	0	9
Q4 2018-19	0	12	0	0	0	0	12
Total 18-19	**0**	**51**	**0**	**9**	**0**	**0**	**60**

Services have reported increased use of mechanical restraint during the reporting period, however highest usage was reported during Q1 remaining at however levels throughout the year have remained lower. Soft cuffs were reportedly used on 50 0ccasions. Emergency response belts were reportedly on 13 occasions.

Wards reported as using mechanical restraint are identified in the table below

DRAFT

Service	Total 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total
NORTHDALE CENTRE	2	3	5	2	3	13
FMH RP SANDPIPER WARD	5	2	0	3	7	12
AMP RP BEDALE PICU	7	2	4	1	0	7
MERLIN WARD	13	0	6	1	0	7
FMH RP LINNET	1	2	0	1	1	4
Grand Total						

Restrictive Intervention Use: Patient Breakdown

The table below outlines restrictive intervention use for the ten patients reported with the highest occurrence of incidents.

ID	Wards	PI 18/19	RT Use 18/19	Seclusion Use 18/19
530602	WLH EVERGREEN CENTRE	92	68	0
568951	WLH WESTWOOD CENTRE	637	422	3
495075	WLH EVERGREEN CENTRE	438	21	0
455532	WLH EVERGREEN CENTRE	426	0	0
610785	WLH EVERGREEN CENTRE	364	35	0
578264	WLH EVERGREEN CENTRE	348	91	0
374032	WLH NEWBERRY CENTRE	267	115	0
568709	FMH RP SANDPIPER WARD	186	33	14
520053	WLH WESTWOOD CENTRE	115	50	0
97117	FMH RP SANDPIPER WARD	109	45	15
	Grand Total	**3852**	**880**	**32**

Total figures for restrictive intervention used for these ten patients contribute 38% of total PI use, 41% of total rapid tranquilisation use and 10% of seclusion usage across TEWV.

3.0 Positive & Safe Plan 2019/20

Whilst the report demonstrates a number of services have worked hard to reduce their use of restrictive interventions and embed the Positive and Safe agenda within their teams, it highlights that a number of barriers and challenges continue to impact on services and their abilities to implement the changes needed in reducing the use of restrictive interventions.

Usage of restrictive intervention across the financial years has highlighted the challenges faced by services currently. In line with the national agenda rises within Tier 4 CAMHS and Learning Disabilities Services are clearly evident. Despite the organisation increase in total usage it must be acknowledged the success a number of wards have had across the year in reducing their numbers of restrictive interventions i.e. Sandpiper, Beadle and the Westwood Centre. In addition the continued reductions in the use of prone restraint demonstrates a willingness to adopt these approaches, whilst recognising that the culture change required to assist its implementation will take time.

In using the data to inform our plans for the following year we have set the key actions for 2019-20 that will continue to develop alternative approaches with TEWV and continue to assist wards in reducing their reliance and usage of restrictive interventions.

Positive and Safe Plan 2019-2020

(Reducing the Use of Restrictive Interventions)

PLAN DEVELOPED BY: **Positive and Safe Advisory Group (PASAG)** **DATE PLAN AGREED:**

NO.	RECOMMENDATION/FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	COMMENTS PROGRESS	PROGRESS RATING
1	New staff awareness of the Positive and Safe agenda is at times limited	Staff at all levels have an awareness of TEWV's RIR plan	Positive and Safe and person centred behaviour support plans are introduced to new staff at Corporate induction	Lead Nurse P&S	Monthly/Ongoing		
2	Practice leadership is an essential element of embedding PBS	Newly registered nurse have opportunities to improve awareness and confidence in the approach	Time allocated for Positive and Safe/PBS Training on all locality Preceptorship programmes	Heads of Nursing Lead Nurse P&S	Dates agreed for the year		
3	Despite high usage of RI in specific areas TEWV's approach remains contemporary within the national agenda	Create an opportunity on a large scale to develop partnerships and celebrate achievements of best practice in this area.	To facilitate a Joint Conference with the Positive and Safe team from NTW offering staff working in both Trust and wider delegates the opportunities to share their good work in the field	Conference Steering group	Scheduled for 13th Nov 2019		
4	External opportunities for training in Positive & Safe approaches remain limited nationally	University based training in Positive and Safe approaches becomes available for staff working across	Working in Partnership with the P&S team from NTW to scope the development of level 5 and level 7 university based training	Task and finish group	Sep 2019		

		the north of England					
5	A significant proportion of RI use occurs within 10 wards areas	Areas with higher reported uses have greater access to support and ability to make greater changes	With the support of the P&S team teams will develop their own service based RIR plan. 8 services identified	Ward Mangers/ Modern Matrons QuAG	Ongoing/ reviewed monthly		
Data informed practice							
6	Staff knowledge of when and what type of RI is difficult to access	Staff has readily available information on the use of RI that can inform future practice.	Embedding the Positive and Safe electronic Dash board for use within report outs/staff meetings/ supervision/handover	P&S Team Wards Quality Data Team			
7	Locality management structure may not be aware of changes to RI use in their areas	LMGB and SDG have clear information of Positive and Safe progress with their areas	Publication of a quarterly report detail RI usage and a review of the P&S plan	P&S Team LMGB QuAG	Each Quarter		
8	Significant changes to RI use can escalate quickly and staff may be unware	Staff to receive notification when changes occur that they were unware off	Positive and Safe team to regularly monitor RI activity and notify services when necessary	P&S Team	Monthly		
9	Information on RI usage and the systems in place to reduce it should be publically available	Accessible information is available to the general public on the use of RI	Publication of a annual Positive and Safe Report via the TEWV website	P&S Team	Q2 current financial year		
Person Centred Behaviour Support							
10	Behaviours that	A review of	Support implementation of AMH	P&S Team			

	challenge Clip pathways are underutilised in developing BS plans across each of the specialities	Behaviours that challenge clips and the TEWV behaviours that challenge algorithm	pathway and revised implementation of CAMHS pathway for T4 services	Pathway Leads	Ongoing		
11	The development of Behaviour Support plans and their application to practice requires ongoing quality checks	Plans in place for the regular audit of behaviour support plans/incident reports	Positive and Safe Audit to be reviewed via PSAG To be completed annually	P&S Team Central Audit Team	Data sample based on Q3 19-20 incident No.		
13	Staff have identified that the development of BS plans is complex and is a task they lack confidence in completing	Registered nurses/AHP to have access to training in developing/writing BS plans	Regular half day masterclasses to be available across multiple Trust locations, focusing upon the development and writing of behaviour support plans	P&S team to facilitate	1 classes to be offered each month Venues to alternate Trust wide		
14	Patients with complex needs can escalate quickly and staff may not be aware	Staff to have access to tools that will allow them to access behaviour for potential changes and early warning signs of behaviour	The Brøset Violence Checklist (BVC) to be piloted across each of the specialities, effects to be analysed, Trust wide roll out to then be considered.	P&S team Pilot Wards PASAG	Review and possible Trust Wide implementatio n from Q1 19-20		
15	Behaviour support plans are difficult to access /locate on Paris	Staff will have a specified care document within Paris to document a Behaviour Support Plan	Work with the Positive and Safe Advisory group to explore options for standard documentation for BS plans	PASAG/ Task & Finish Group	Ongoing		

16	Developing behaviour support plans for patients with complex needs can be challenging	Staff to have access to additional PBS support when challenged or unable to identify effective interventions	Lead Nurse Positive and Safe to be involved in Complex case supervision/formulation when appropriate	Lead Nurse	On request from clinical areas	Requests logged by P&S team	
17	Use of PBS approaches remains new to services	Staff to have a network of support focused upon delivery of PBS interventions	Positive and Safe team to facilitate regular network events across the year for all practitioners using PBS.	Positive & Safe Team	Half day events 3 time per year		
Safewards							
18	Sustainability of the Safewards interventions is challenging and can be difficult to monitor	Staff to regularly complete the Safewards checklist and to review progress	Positive and Safe team to review progress each quarter, using completed checklist	Ward Managers Positive & Safe Team	Each Quarter/ review to take place within PASAG meeting		
19	Development of Safewards interventions can be used to inform other staff and services	Staff to have access to a wider network of champions that are implementing Safewards	The Positive and Safe team to facilitate locality based network events for staff to share practice	Positive & Safe Team Safewards Champions	1 event each month		
20	Data analysis reports increased use in the frequency and severity of RI use across crisis teams	Staff working in crisis teams to have access to the Safewards model and its 10 interventions	Designated teams to pilot the model from June 1st	Positive & Safe Team CHT Teams	Ongoing		
21	Sustainability of Safewards interventions is	Staff to have access to service specific training helping them	Service Specific workshops available , provided by the Positive and Safe Team	Positive & Safe Team	On request from clinical areas	Requests logged by P&S team	

	challenging, key staff may move to other posts	to re-establish the approach.					
22	Sustainability of Safewards interventions is challenging, key staff may move to other posts	Staff to have access to a wider network of champions that are implementing Safewards	Positive & Safe team to assist specialities in developing their own Safewards groups	Positive & Safe Team Speciality groups	To be agreed		
Positive Approaches Training							
23	PATT training recently developed and re-introduced to services	Available training remains contemporary and in accordance with national guidance	Training to be reviewed in line with new national standards	PAT Team Positive & Safe Team	Paper to EMT by May 19		
24	National guidance supports the completion of annual Positive and Safe CPD training for all staff	Staff have access to annual training/CPD in positive approaches and the Positive and Safe agenda	E learning based Positive Approaches Training to be made available to all staff, supporting the bi annual face to face PAT programme.	PAT Team Positive & Safe Team	Complete		
25	Expert involvement and recovery approaches need to be a central them within all PMVA courses	Staff have access to training that supports and embeds recovery approaches	Clinical Trainers with lived experience to be established within the PAT training team, supporting the delivery of primary/secondary preventative interventions	PAT Team Positive & Safe Team	Complete		
26	Emerging research suggests that successful PMVA training is focused upon Trauma informed care	Have access to PMVA training that is focused upon the effects of trauma and the delivery of trauma informed care.	All Positive Approaches training courses to be review and amended to reflect the impact of trauma on patients and consider how staff can deliver trauma informed care.	PAT Team Positive & Safe Team Trauma	Ongoing		

				informed care project			
27	Staff continue to administer RT that requires the use of prone PI	Staff to build confidence in using alternative RT sites that do not require the use of prone restraint	Workshops to be available for all registered nurses that will increase their skills in administering the use of RT.	Positive & Safe Team monthly	Ongoing		
28	Staff at times continue to use prone restraint to support complex patients	Staff to be taught further physical intervention skills that do not require prone restraint	Paper requesting to teach Tbar supine as part of overall PAT programme	PATT	Ongoing		
Post incident Review and Support							
29	Evidence suggests technological equipment can assist in reducing the use of RI	Staff have access to equipment that may assist in reducing the use of RI	Develop a proposal for the trial of body cameras within services and monitor for its effects.	Positive & Safe Team	Ongoing		
30	Despite the significant reductions across services in the use of prone, use of the approach remains high	When prone is used staff have the opportunity to access a external review of the process	Development of an external monitoring service for the use of prone restraint i.e. checklist Pilot with specific services	Positive & Safe Team Wards using Prone	Pilot complete , considering Trust wide roll out.		
31	Tools to support post incident review are limited	Staff have debriefing tools available that assist in reducing the use of RI	Review of the Rapid reflection tools developed specifically for TEWV services for effectiveness.	Positive & Safe Team PASAG	Review date to be agreed		

ITEM 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**21st May 2019**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

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

Assurance Statement:

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

Recommendations:

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

MEETING OF:	Board of Directors
DATE:	21st May 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 April 2019 data.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. EXCEPTIONS

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

3.2 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.

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

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

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

4.2 Financial/Value for Money:

It has been identified that there is little spare capacity in nursing establishments as they have been planned for maximum efficiency – it is therefore implied that the workforce deployment needs closer scrutiny to ensure those efficiencies do not constitute risks. This work is being progressed and will be a feature of this financial year's Right Staffing work stream referred to above.

4.3 Legal and Constitutional (including the NHS Constitution):

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

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

4.4 Equality and Diversity:

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

4.5 Other implications:

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

5. RISKS:

5.1 Safe staffing and the risks regarding the Trusts ability to meet planned staffing levels on a daily basis have been escalated to the Trust Risk Register. Risks

are managed and mitigated through operational services and the work being undertaken as highlighted within the Right Staffing work streams.

6. CONCLUSIONS:

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

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

7. RECOMMENDATIONS:

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

Emma Haimes
Head of Quality Data and Patient Experience
May 2019

Safe Staffing – April 2019

"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 April 2019:

- The number of rosters equated to 65 inpatient wards in April.
- The highest number of red fill rate indicators relate to Registered Nurses on day shifts. This equated to 17 in April 2019, the same reported in March 2019.
- The top 3 inpatient areas where a low staffing fill rate has been reported are:
  - Westwood – 62.7% RN on Nights; and 79.7% RN on Days – the shortfall is in relation to staffing pressures which have been covered from the neighbouring wards and low bed occupancy.
  - Langley – 66.8% RN on Days – the shortfall is in relation to sickness and planned annual leave.
  - Westerdale South – 69.4% RN on Nights – the shortfall is in relation to not being able to cover all of the second qualified shifts due to sickness and staff on alternative duties.
  - The Lodge has been discounted due to the transition to a third party organisation.
- There were 68 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:
  - Westerdale South – 299% HCA on Nights and 175.2% HCA on Days – the increase was necessary to support on average 3/4 enhanced observations during the month.
  - Holly Unit – 261% HCA on Days; 251.6% HCA on Nights; 196.2% RN on Days - the increase is due to enhanced observations and complexities of the children.
  - Merlin – 241.2% HCA on Nights and 161% HCA on Days – the increase is due to constant observations.

Bank Usage:

- The bank usage across the trust equated to 18.3% in April, a decrease of 0.5% when compared to March.
- There were no wards reporting 50% bank usage in April.
- Merlin reported the highest bank usage of 38.6% of the actual hours worked. Enhanced Observations (130 shifts) and Establishment Vacancies (20 shifts) were the highest reasons given for requesting bank.
- There were 15 wards that reported greater than 25% bank usage.

Agency Usage:

- The agency usage across the trust equated to 5.9% in April, a decrease of 2.5% when compared to March.
- Cedar Ward (NY) reported the highest equating to approximately 47.2% of the total hours worked. Vacancies were cited as the highest reason for this (128 shifts). The ward is using regular agency where possible.
- Those wards reporting 4% or more agency usage in April equated to 22 wards.
- The Retinue report highlights the following information:
  - Fulfilment levels increased by 1% to 86% in April.
  - Demand reduced by 621 requested when compared to March.
  - Overall demand has reduced to just 35% above the levels seen at the start of the contract despite reaching 132% in December.
  - HCA fulfilment increased from 86% to 89% during April with 544 fewer requests. 893 HCA shifts were filled in April.
  - A total of 212 RN shifts were filled in April with fulfilment reporting at 76%. Total demand for RN's was much lower in April.

Produced: 11th May 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 April 2019 data.

- April saw fewer shifts covered by preferred workers however, this was expected due to the overall drop in demand.
- Interestingly demand remained the same within York & Selby for March however, the number of shifts filled by preferred workers dropped to 195 from 219.
- Usage across Acomb Garth still remains high at 160 requests in April. Cedar Ward (NY) had 159 requests in April.
- Areas with lowest fulfilment – Langley ward (33% - 3 shifts), The Orchards (0% - 2 shifts) and York Crisis Team (29% - 7 shifts) – all above 50%.
- The total number of no shows reported for April increased to 15. No show as a percentage of shifts filled is 1.36%.
- Average monthly spend of £284K (Oct '17 to Apr '19) – a decrease of £5K on last month. Overall spend now sits at £5.40m. HCA attributes to 74% of overall spend.

Missed Breaks:

- There were 203 shifts in April where an unpaid break had not been taken. This is a reduction of 43 shifts when compared to March 2019.
- 165 shifts where breaks were not taken were attributable to day shifts and related mainly to HCA's.
- 38 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 = 68 shifts with no breaks (Westerdale North had the highest with 11 shifts)
    - Forensics = 41 shifts with no breaks (Merlin had the highest with 12 shifts)
    - Durham & Darlington = 17 shifts with no breaks (Maple had the highest with 6 shifts)
    - North Yorkshire & York = 77 shifts with no breaks (Esk Ward had the highest with 21 shifts)
- This information is being monitored daily as part of the operational services huddle process.

Incidents Raised Citing Staffing Levels:

- There were 13 incidents reported in April 2019 citing issues with staffing covering both inpatient and community services.
- Issues reported were as follows:
    - Staff and patient safety compromised
    - Unable to take required breaks
    - Unable to respond to other wards in emergency

Severity Rating:

- Using a severity rating scale to identify potential outliers, the top 5 is as follows:
    - Elm Ward – 12 points awarded
    - Newberry Centre – 12 points awarded
    - Brambling – 10 points awarded
    - Westwood Centre – 9 points awarded
    - The Lodge – 8 points awarded
    - Cedar (NY) – 8 points awarded
- Using the YTD score (Apr 18 to Apr 19) the following appear in the top 5:
    - The Evergreen Centre – 107 points awarded
    - Cedar Ward (D&D) – 100 points awarded
    - The Lodge – 98 points awarded
    - Newberry Centre – 92 points awarded
    - Westerdale South – 92 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 April is reporting at 13.01 (4.42 registered nurses, 8.31 unregistered nurses, 0.19 registered AHP and 0.10 unregistered AHP).
- Using standard deviation (Apr 18 to Apr 19) the following appear as positive outliers:
    - Danby Ward – registered nurses
    - The Lodge – registered nurses
    - Jay Ward – registered nurses
    - Westerdale South – unregistered nurses

Conclusion:

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

Key links to documents & guidelines:
Monthly and Daily Staffing Report – March 2019
NQB Guidance July 2016

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

ITEM No. 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**21 May 2019**
TITLE:	**To receive and note an update on the actions within the 2018 CQC report**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Information**

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

Executive Summary:

CQC Action Plan progress update

- This report and attached action plan provides a progress update to the Board of Directors on the actions within our action plan from the 2018 compliance inspection.

- The Compliance Team are tracking and monitoring actions with operational services. All evidence is being held centrally which includes a quality review to ensure that it meets the requirements of the relevant action prior to final sign off.

- Outstanding 'Must Do' actions are detailed within appendix 1 of this report. These relate primarily to all evidence not yet being provided to the compliance team – these are highlighted in amber in the attached action plan:

  1 x Forensic
  1 x MHSOP York
  2 x Tees AMH
  1 x D&D AMH
  There is also one red action for N Yorks AMH with regards to safe staffing for which we require further information.

- In addition to the above there remain 2 'must do' actions requiring completion at the end of May 2019 and 2 for the end of June 2019.

- There are also 11 outstanding ‘should do’ actions (evidence required) at the time of writing this report with a further 6 due to be completed during May and June 2019 (please note that this does not include the same action for a different locality).
- For monitoring purposes this information is also shared via EMT and the Quality Compliance Group.

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

Jennifer Illingworth
Director of Quality Governance
May 2019

TEWV CQC 2018 Action Plan

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

Action Ref	Must Do / Should Do	Service	Locality	Inpatient / Community	CQC Issue Identified	Action	Action scheduled for completion	Evidence	Progress Update
1	Must Do	AMH	N York	Inpatient	The Trust must ensure that each ward has a ligature risk assessment that identifies all ligature points on the ward. The strategies identified to reduce these risks must be specific to individual wards and reflect current working practice.	The Trust has in place an existing system for suicide prevention environmental surveys and risk assessments. Completed assessments and action plans are in the process of being reviewed to ensure they are accurate and current for relevant clinical teams.	Complete	Received: Completed ligature risk assessment surveys QuAG minutes	
1	Must Do	AMH	York & Selby	Inpatient	The Trust must ensure that each ward has a ligature risk assessment that identifies all ligature points on the ward. The strategies identified to reduce these risks must be specific to individual wards and reflect current working practice.	The Trust has in place an existing system for suicide prevention environmental surveys and risk assessments. Completed assessments and action plans are in the process of being reviewed to ensure they are accurate and current for relevant clinical teams.	Complete	Received: Completed ligature risk assessment surveys QuAG minutes	
1	Must Do	AMH	D & D	Inpatient	The Trust must ensure that each ward has a ligature risk assessment that identifies all ligature points on the ward. The strategies identified to reduce these risks must be specific to individual wards and reflect current working practice.	The Trust has in place an existing system for suicide prevention environmental surveys and risk assessments. Completed assessments and action plans are in the process of being reviewed to ensure they are accurate and current for relevant clinical teams.	Complete	Received: Completed ligature risk assessment surveys	
2	Must Do	AMH	N York	Inpatient	The Trust must ensure that patients have a risk management plan that addresses the risks identified in the assessments and is person centred. Risk assessments should identify all the risks posed to, or by, the patient	Monthly checks of risk assessment plans will continue to be undertaken within the service with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate. This will ensure that risk assessment plans address risks identified in the assessments and are person centred.	Complete	Evidence Received: QuAG minutes Sample MM audits	
2	Must Do	AMH	D & D	Inpatient	The Trust must ensure that patients have a risk management plan that addresses the risks identified in the assessments and is person centred. Risk assessments should identify all the risks posed to, or by, the patient	Monthly checks of risk assessment plans will continue to be undertaken within the service with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate. This will ensure that risk assessment plans address risks identified in the assessments and are person centred.	31/03/2019	Evidence received: MM audits Evidence Required: QUAG minutes	Update from service 17/01/19 Monthly audits to continue with exception reports provided to QuAG. Ongoing - presented to QuAG each month All part of MM checks
2	Must Do	AMH	Tees	Inpatient	The Trust must ensure that patients have a risk management plan that addresses the risks identified in the assessments and is person centred. Risk assessments should identify all the risks posed to, or by, the patient	Monthly checks of risk assessment plans will continue to be undertaken within the service with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate. This will ensure that risk assessment plans address risks identified in the assessments and are person centred.	31/03/2019	Evidence received: Risk assessment audits. Locality MM Group agenda with audit templates Additional evidence required: QuAG minutes (completed audits submitted to QuAG) - Informed May 2019 agenda/minutes will be sent	UPDATE 05/04/2019: Audit due for QuAG submission. Discussed at Locality Modern Matrons Group, see attached email, agenda item 5.
2	Must Do	AMH	York & Selby	Inpatient	The Trust must ensure that patients have a risk management plan that addresses the risks identified in the assessments and is person centred. Risk assessments should identify all the risks posed to, or by, the patient	Monthly checks of risk assessment plans will continue to be undertaken within the service with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate. This will ensure that risk assessment plans address risks identified in the assessments and are person centred.	Complete	Evidence received: QuAG minutes and MM audits February - Ebor - compliant February - Minster - compliant	

3	Must Do	AMH	N York	Inpatient	The Trust must ensure that staff monitor and record physical observations following the administration of rapid tranquilisation in line with Trust policy and national guidance.	Bi- monthly checks of the monitoring and recording of physical observations (post rapid tranquilisation) will continue to be undertaken with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Complete	Evidence received: MM audits Completed audit submitted to QuAG [showing 100% compliance]	
3	Must Do	AMH	York & Selby	Inpatient	The Trust must ensure that staff monitor and record physical observations following the administration of rapid tranquilisation in line with Trust policy and national guidance.	Bi- monthly checks of the monitoring and recording of physical observations (post rapid tranquilisation) will continue to be undertaken with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Complete	Evidence Received: MM audit for Feb/Ebor (compliant) as part of MM audit. No RT for Minster QuAG minutes discussing MM report -item 8.6	
3	Must Do	AMH	D & D	Inpatient	The Trust must ensure that staff monitor and record physical observations following the administration of rapid tranquilisation in line with Trust policy and national guidance.	Bi- monthly checks of the monitoring and recording of physical observations (post rapid tranquilisation) will continue to be undertaken with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Complete	Evidence received: QUAG minutes showing checks taking place and being monitored. QuAG - showing compliance	
3	Must Do	AMH	Tees	Inpatient	The Trust must ensure that staff monitor and record physical observations following the administration of rapid tranquilisation in line with Trust policy and national guidance.	Bi- monthly checks of the monitoring and recording of physical observations (post rapid tranquilisation) will continue to be undertaken with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate.	31/03/2019	Meds optimisation assessment Sept 18 [audit not showing post monitoring compliance (Stockdale)] Weekly trust dashboard monitored via performance: compliant Required: QuAG agenda & minutes when available. Informed May 2019 agenda/minutes will be sent	09/02/19 - Action completed. Evidence - green compliance for post RT monitoring UPDATE 05/04/2019: Page 4, section highlighted in yellow. This is monitored weekly via performance. From April 2019 this will be included in our locality summary to QUAG.
4	Must Do	AMH	D & D	Inpatient	The Trust must ensure that the recording of any episodes of seclusion is in line with Trust policy and complies with the Mental Health Act code of practice.	Monthly checks will be completed for each episode of seclusion in adult mental health inpatient services. This will ensure that the recording of any episodes of seclusion is in line with Trust policy and complies with the Mental Health Act code of practice. The results will be shared at the AMH Locality Quality Assurance Groups. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Complete	Evidence received: QUAG agenda Restrictive proactive report (showing seclusion use)/ Exception reporting only. Dec18 minutes shared.	
4	Must Do	AMH	Tees	Inpatient	The Trust must ensure that the recording of any episodes of seclusion is in line with Trust policy and complies with the Mental Health Act code of practice.	Monthly checks will be completed for each episode of seclusion in adult mental health inpatient services. This will ensure that the recording of any episodes of seclusion is in line with Trust policy and complies with the Mental Health Act code of practice. The results will be shared at the AMH Locality Quality Assurance Groups. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Complete	Evidence received: Restrictive practice report (all wards). This includes an audit of compliance to seclusion reviews (in line with The Code). Also the blanket restrictions register.	
5	Must Do	AMH	N York	Inpatient	The Trust must ensure that the wards meet their agreed staffing establishment levels, including registered nurses.	Through proactive recruitment and retention programmes the Trust intends to ensure that all vacant posts are recruited to (whilst acknowledging that recruitment to some disciplines is a national issue). This will include targeted recruitment events and using new approaches to improve the efficiency of recruitment processes. Agreed safe staffing levels will be adhered to.	31/03/2019	Evidence required: safe staffing monthly submissions	03/04/19 Requested further information regarding corporate guidance on this matter
5	Must Do	AMH	York & Selby	Inpatient	The Trust must ensure that the wards meet their agreed staffing establishment levels, including registered nurses.	Through proactive recruitment and retention programmes the Trust intends to ensure that all vacant posts are recruited to (whilst acknowledging that recruitment to some disciplines is a national issue). This will include targeted recruitment events and using new approaches to improve the efficiency of recruitment processes. Agreed safe staffing levels will be adhered to.	Complete	Evidence received safe staffing monthly submissions	

5	Must Do	AMH	Tees	Inpatient	The Trust must ensure that the wards meet their agreed staffing establishment levels, including registered nurses.	Through proactive recruitment and retention programmes the Trust intends to ensure that all vacant posts are recruited to (whilst acknowledging that recruitment to some disciplines is a national issue). This will include targeted recruitment events and using new approaches to improve the efficiency of recruitment processes. Agreed safe staffing levels will be adhered to.	Complete	Evidence received: Safe staffing monthly submissions	
6	Must Do	AMH	N York	Inpatient	The Trust must ensure care plans are personalised, holistic, recovery-oriented and meet the needs identified during the assessment. Care plans should reflect the thoughts and views of the patient and evidence of patient involvement should be recorded on the electronic record keeping system.	Adult mental health inpatient services undertake baseline clinical review of care plans in Adult Mental Health inpatient services.	Complete	Evidence Received: MM audits QuAG minutes showing consideration of baseline audit findings.	
6	Must Do	AMH	D & D	Inpatient	The Trust must ensure care plans are personalised, holistic, recovery-oriented and meet the needs identified during the assessment. Care plans should reflect the thoughts and views of the patient and evidence of patient involvement should be recorded on the electronic record keeping system.	Adult mental health inpatient services undertake baseline clinical review of care plans in Adult Mental Health inpatient services.	Complete	Evidence Received: audits completed, embedded within QuAG minutes	
6	Must Do	AMH	York & Selby	Inpatient	The Trust must ensure care plans are personalised, holistic, recovery-oriented and meet the needs identified during the assessment. Care plans should reflect the thoughts and views of the patient and evidence of patient involvement should be recorded on the electronic record keeping system.	Adult mental health inpatient services undertake baseline clinical review of care plans in Adult Mental Health inpatient services.	Complete	Evidence received: QuAG minutes and MM audits	
7.1	Must Do	AMH	N York	Inpatient	The Trust must ensure that quality assurance systems identify inconsistencies in the quality of care across the core service and implement plans to address these inconsistencies.	Inconsistencies in the quality of clinical care will be discussed and actioned operationally in the first instance by relevant locality management groups. Clinical audits will continue to be used both strategically and operationally to identify and action issues. Established clinical audit programmes and processes will be used to support required quality improvements.	Complete	Evidence received: QuAG	
7.1	Must Do	AMH	Tees	Inpatient	The Trust must ensure that quality assurance systems identify inconsistencies in the quality of care across the core service and implement plans to address these inconsistencies.	Inconsistencies in the quality of clinical care will be discussed and actioned operationally in the first instance by relevant locality management groups. Clinical audits will continue to be used both strategically and operationally to identify and action issues. Established clinical audit programmes and processes will be used to support required quality improvements.	Complete	Evidence received QuAG agenda & minutes LMGB agenda & minutes Clinical Audit Report discussed at QuAG March 2019 (item 19/41) Clinical Audit of seclusion & segregation discussed at LMGB LMGB minutes	
7.1	Must Do	AMH	D & D	Inpatient	The Trust must ensure that quality assurance systems identify inconsistencies in the quality of care across the core service and implement plans to address these inconsistencies.	Inconsistencies in the quality of clinical care will be discussed and actioned operationally in the first instance by relevant locality management groups. Clinical audits will continue to be used both strategically and operationally to identify and action issues. Established clinical audit programmes and processes will be used to support required quality improvements.	Complete	Evidence received: QuAG minutes	
7.1	Must Do	AMH	York & Selby	Inpatient	The Trust must ensure that quality assurance systems identify inconsistencies in the quality of care across the core service and implement plans to address these inconsistencies.	Inconsistencies in the quality of clinical care will be discussed and actioned operationally in the first instance by relevant locality management groups. Clinical audits will continue to be used both strategically and operationally to identify and action issues. Established clinical audit programmes and processes will be used to support required quality improvements.	Complete	Evidence Received: QuAG minutes item 8.2 - inpatient locality managers report	

7.2	Must Do	AMH	N York	Inpatient	The Trust must ensure that local clinical checks identify issues and staff should act on the results when needed.	Escalation of inconsistencies will continue to occur via Trust governance forums including the Patient Safety Group, Clinical Effectiveness Group and Patient Experience Group and onwards, where appropriate, to the trust wide Quality Assurance Committee.	Complete	Evidence Received: QuAG minutes MM reports	
7.2	Must Do	AMH	York & Selby	Inpatient	The Trust must ensure that local clinical checks identify issues and staff should act on the results when needed.	Escalation of inconsistencies will continue to occur via Trust governance forums including the Patient Safety Group, Clinical Effectiveness Group and Patient Experience Group and onwards, where appropriate, to the trust wide Quality Assurance Committee.	Complete	Evidence Received: QuAG minutes item 8.2 - inpatient locality managers report	
7.2	Must Do	AMH	D & D	Inpatient	The Trust must ensure that local clinical checks identify issues and staff should act on the results when needed.	Escalation of inconsistencies will continue to occur via Trust governance forums including the Patient Safety Group, Clinical Effectiveness Group and Patient Experience Group and onwards, where appropriate, to the trust wide Quality Assurance Committee.	31/05/2019	Evidence required: QUAG minutes	Update 17/01/19 All Ward Managers with AMH RPH will check their clinics daily to monitor compliance. Pharmacy will continue with monthly audits to ensue that each ward complies with these standards. This will be monitored within the local QuAG. Audit reports submitted to QUAG monthly and actions identified for Matrons and Associate Clinical Director (ref junior doctors).
7.2	Must Do	AMH	Tees	Inpatient	The Trust must ensure that local clinical checks identify issues and staff should act on the results when needed.	Escalation of inconsistencies will continue to occur via Trust governance forums including the Patient Safety Group, Clinical Effectiveness Group and Patient Experience Group and onwards, where appropriate, to the trust wide Quality Assurance Committee.	31/05/2019	Audits presented to locality MM meeting Requested further evidence in line with action e.g. escalation to PSG, QuAG	Audit reports submitted to QUAG monthly and actions identified for Matrons and Associate Clinical Director (ref junior doctors). UPDATE 05/04/2019: Locality Modern Matron Meeting Agenda Item 5.
8	Must Do	AMH	Tees	Inpatient	The Trust must ensure staff can identify blanket restrictions and that there is a clear process for reviewing blanket restrictions on all wards.	The Trust has an existing policy with existing processes in place to identify and review blanket restrictions. These will be further enhanced through development of standardised blanket restriction registers which will be reviewed by Locality Quality Assurance Groups. Blanket restrictions will be a standard item on the Trust led mock visit programme.	Complete	Evidence received: Restrictive practice register and monthly report to QuAG	
8	Must Do	AMH	D & D	Inpatient	The Trust must ensure staff can identify blanket restrictions and that there is a clear process for reviewing blanket restrictions on all wards.	The Trust has an existing policy with existing processes in place to identify and review blanket restrictions. These will be further enhanced through development of standardised blanket restriction registers which will be reviewed by Locality Quality Assurance Groups. Blanket restrictions will be a standard item on the Trust led mock visit programme.	Complete	Evidence Received: Restrictive practice register QuAG reports - exception reporting	
8	Must Do	AMH	N York	Inpatient	The Trust must ensure staff can identify blanket restrictions and that there is a clear process for reviewing blanket restrictions on all wards.	The Trust has an existing policy with existing processes in place to identify and review blanket restrictions. These will be further enhanced through development of standardised blanket restriction registers which will be reviewed by Locality Quality Assurance Groups. Blanket restrictions will be a standard item on the Trust led mock visit programme.	Complete	Restrictive practice register and monthly report to QuAG	
9	Should Do	AMH	N York	Inpatient	The Trust should ensure that all equipment in the emergency bags is in date and ready to use in an emergency. Staff should check the emergency bags daily and record that they have done so.	Daily grab bag checks that are undertaken are to be audited weekly.	Complete	Evidence Received: MM audits. [2 showing 100% compliance, 1 showing missed checks]. April - compliant QuAG minutes	

9	Should Do	AMH	York & Selby	Inpatient	The Trust should ensure that all equipment in the emergency bags is in date and ready to use in an emergency. Staff should check the emergency bags daily and record that they have done so.	Daily grab bag checks that are undertaken are to be audited weekly.	Complete	Evidence Received: Sample of MM checks (compliant) QuAG minutes showing MM audits discussed	
9	Should Do	AMH	Tees	Inpatient	The Trust should ensure that all equipment in the emergency bags is in date and ready to use in an emergency. Staff should check the emergency bags daily and record that they have done so.	Daily grab bag checks that are undertaken are to be audited weekly.	Complete	Evidence received: monitoring of daily blue bag checks - shows compliance	
9	Should Do	AMH	D & D	Inpatient	The Trust should ensure that all equipment in the emergency bags is in date and ready to use in an emergency. Staff should check the emergency bags daily and record that they have done so.	Daily grab bag checks that are undertaken are to be audited weekly.	Complete	Evidence Received: QuAG minutes Audits - showing compliance weekly huddle board VCB	
10	Should Do	AMH	N York	Inpatient	The Trust should ensure that agency staff not having access to electronic care records does not impact on care provision.	Regular agency staff on block bookings are trained in using PARIS	31/05/2019	Training records	Update 07/01/19 Ongoing
11	Should Do	AMH	N York	Inpatient	The Trust should ensure than when patients are prescribed more than one medicine to help with extreme episodes of agitation and anxiety, staff have clear guidance as to how these are to be used.	Trust process and guidelines to be developed.	Complete	Evidence Received Developed process and guidelines	
11	Should Do	AMH	York & Selby	Inpatient	The Trust should ensure than when patients are prescribed more than one medicine to help with extreme episodes of agitation and anxiety, staff have clear guidance as to how these are to be used.	Trust process and guidelines to be developed.	Complete	Evidence Received Developed process and guidelines	
11	Should Do	AMH	Tees	Inpatient	The Trust should ensure than when patients are prescribed more than one medicine to help with extreme episodes of agitation and anxiety, staff have clear guidance as to how these are to be used.	Trust process and guidelines to be developed.	Complete	Evidence Received Developed process and guidelines	
11	Should Do	AMH	D & D	Inpatient	The Trust should ensure than when patients are prescribed more than one medicine to help with extreme episodes of agitation and anxiety, staff have clear guidance as to how these are to be used.	Trust process and guidelines to be developed.	Complete	Evidence Received Developed process and guidelines	
12	Should Do	AMH	D & D	Inpatient	The Trust should ensure that staff are aware of the expectations of assessment and review when patients moved between wards.	Trust process to be developed.	31/03/2019	Trust process in place Evidence Required; circulation of new template / SDG minutes	10/05/19 trust standard template developed at SDG on 10/05/19. Circulated and final consultation/comments due 13/05/19.
12	Should Do	AMH	N York	Inpatient	The Trust should ensure that staff are aware of the expectations of assessment and review when patients moved between wards.	Trust process to be developed.	31/03/2019	Trust process in place Evidence Required; circulation of new template / SDG minutes	10/05/19 trust standard template developed at SDG on 10/05/19. Circulated and final consultation/comments due 13/05/19.
12	Should Do	AMH	York & Selby	Inpatient	The Trust should ensure that staff are aware of the expectations of assessment and review when patients moved between wards.	Trust process to be developed.	31/03/2019	Trust process in place Evidence Required; circulation of new template / SDG minutes	10/05/19 trust standard template developed at SDG on 10/05/19. Circulated and final consultation/comments due 13/05/19.
12	Should Do	AMH	Tees	Inpatient	The Trust should ensure that staff are aware of the expectations of assessment and review when patients moved between wards.	Trust process to be developed.	31/03/2019	Evidence received: Transfer checklist template Evidence of this being cascaded/discussed-Overdale team meeting minutes. Requested more evidence across locality	10/05/19 trust standard template developed at SDG on 10/05/19. Circulated and final consultation/comments due 13/05/19.

13	Should Do	AMH	N York	Inpatient	The Trust should continue to ensure that staff receive and record supervision and there is senior management oversight of supervision compliance.	Monthly audit of supervision.	31/03/2019	Evidence Received: QuAG minutes showing spreadsheets reviewed MM audit presented to QuAC Evidence Required: Compliance rates with supervision	Update 07/01/19: programme of monthly audit of supervision to be established by the locality & team managers for inclusion into Locality reports to QuAG Update 26/02/19: it was agreed at QuAG that weekly monitoring & team based visual control will be introduce from 1 March - supported by a leadership campaign to improve access & quality of supervision. To be signed off as complete by 31/03/19 if practice standards are consistently achieved 04/04/19 : not completed - considered at QuAG - revisit in June 2019 **Compliance notes: QuAG minutes evidence discussion re supervision spreadsheet so is this complete? Have requested further information and supporting evidence to close off.**
13	Should Do	AMH	Tees	Inpatient	The Trust should continue to ensure that staff receive and record supervision and there is senior management oversight of supervision compliance.	Monthly audit of supervision.	Complete	Evidence received: Weekly supervision matrix spreadsheet	
13	Should Do	AMH	D & D	Inpatient	The Trust should continue to ensure that staff receive and record supervision and there is senior management oversight of supervision compliance.	Monthly audit of supervision.	Complete	Evidence Received supervision matrix MM monthly checks. [Feb/march - not fully compliant] QuAG minutes	
13	Should Do	AMH	York & Selby	Inpatient	The Trust should continue to ensure that staff receive and record supervision and there is senior management oversight of supervision compliance.	Monthly audit of supervision.	31/03/2019	Evidence Received: MM audits Audit data reported to QuAG. Evidence requested: Supervision matrix	22/01/19 Action complete Compliance reviewed in weekly leadership meetings and quarterly audits completed and fed back into steering group and head of nursing. Update 05/03/19 Electronic supervision recording to be developed trust wide. Reviewed in Modern Matron audits and discussed in QuAG

14	Should Do	AMH	D & D	Inpatient	The Trust should ensure that Cedar ward at West Park Hospital receives contributions from occupational therapy and psychology staff within multidisciplinary team meetings, such as report out.	OT Hub development to be operational across WPH site from 01 December which will allow opportunity for OT input. Vacancies (including previous Cedar vacancy) now recruited to. Psychology review to be completed to enable options to be assessed at QUAG	31/03/2019	Evidence Received: email trail re EMT paper and interim arrangements Evidence Required: EMT options paper	Update 17/01/19 OT Hub development to be operational across WPH site from 1 December which will allow opportunity for OT input. Vacancies (including previous Cedar vacancy) now recruited to. Psychology review to be completed to enable options to be assessed at QUAG. OT and Psychology already attend report outs when possible. Previous EMT paper (April 2017) identified this as a shortfall in the establishment. OT Hub in place in part, to be fully in place from April 2019. Psychology capacity addressed in short term via input from Locality Psychology lead - Paper for EMT tabled for 12/04/19 seeking Strategic Change Funding. Either option 1 or 2 was supported at QuAG AMH and last LMGB. interim arrangement with Professional Psychology Lead until alternatives agreed.
15.1	Should Do	AMH	York & Selby	Inpatient	The Trust should ensure that staff complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	31/05/2019	Evidence Required: Screen shot of IIC training compliance	Update 22/01/19 Current position of 4 outstanding courses to be completed by two staff- both new starters. Ward managers aware and will discuss with staff to complete. Update 05/03/19. 95% met across Y&S AMH.
15.1	Should Do	AMH	D & D	Inpatient	The Trust should ensure that staff complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	31/05/2019	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act. Compliance via IIC	Update 17/01/19: Level 1 – 94% = 10 non compliant of which 4 LTS Level 2 – 93% = 32 non compliant of which 2 LTS/retiring/leaving. 5 junior doctors still showing on report (1 of which has left) Total acute staff outstanding - 15, of which 2 LTS
15.1	Should Do	AMH	N York	Inpatient	The Trust should ensure that staff complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	31/05/2019	Individual training compliance via IIC	Update 07/01/19: weekly report out across the system tracks compliance of this. Update 26/02/19: currently at 88% weekly report out across the system tracks compliance of this. 03/04/19: 91% compliance
15.1	Should Do	AMH	Tees	Inpatient	The Trust should ensure that staff complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	31/05/2019	Individual training compliance via IIC	Current training compliance MHA 1= 96% MHA 2 = 100% MCA currently 93% (long term sick for the staff outstanding)
15.2	Should Do	AMH	York & Selby	Inpatient	Staff should record when a patient has, or has been offered an independent mental health advocate. When patients lack capacity, staff should record the discussion and decision-making processes they follow to come to a best interest decision in line with Trust policy.	Ensure compliance with Mental Capacity Act training and then complete a quarterly random sample audit of IMHA offer. All qualified staff to be reminded of policy.	31/05/2019	Evidence required: Sample of Ward Manager checks IIC training compliance	22/01/19 - Action complete Update 05/03/19. MCA training compliance above 95% Weekly checks completed by ward manager **- example of these as evidence**
15.2	Should Do	AMH	D & D	Inpatient	Staff should record when a patient has, or has been offered an independent mental health advocate. When patients lack capacity, staff should record the discussion and decision-making processes they follow to come to a best interest decision in line with Trust policy.	Ensure compliance with Mental Capacity Act training and then complete a quarterly random sample audit of IMHA offer. All qualified staff to be reminded of policy.	31/05/2019	IIC training compliance IMHA audit checks QUAG minutes	Update 17/01/19: Ensure compliance with Mental Capacity Act training and then complete a Quarterly random sample audit of IMHA offer. Audits in place and reported to QUAG - no exceptions reported at January 19

15.2	Should Do	AMH	Tees	Inpatient	Staff should record when a patient has, or has been offered an independent mental health advocate. When patients lack capacity, staff should record the discussion and decision-making processes they follow to come to a best interest decision in line with Trust policy.	Ensure compliance with Mental Capacity Act training and then complete a quarterly random sample audit of IMHA offer. All qualified staff to be reminded of policy.	31/05/2019	Evidence Received: Audit of IMHA's being offered Evidence required: Compliance with MCA training (IIC snapshot) Staff being reminded of policy (team notes, emails?)	09/02/19 Action completed. MHA training above 95% for Tees AMH-Inpatients at RPH. IMHA referral checks carried out.
15.2	Should Do	AMH	N York	Inpatient	Staff should record when a patient has, or has been offered an independent mental health advocate. When patients lack capacity, staff should record the discussion and decision-making processes they follow to come to a best interest decision in line with Trust policy.	Ensure compliance with Mental Capacity Act training and then complete a quarterly random sample audit of IMHA offer. All qualified staff to be reminded of policy.	31/05/2019	Peppermill Court Steering Group and Governance meeting minutes	Update 26/02/19; Training Compliance. Audit to commence November 2018 - audit to be initiated through Locality managers
16	Should Do	AMH	York & Selby	Inpatient	The Trust should ensure that patients have access to activities on the wards throughout the week.	Activity schedules to be in place for all wards.	31/05/2019	Evidence required: copy of weekly activity rota recorded in individual patient notes.	22/01/19 - Action complete Both wards have a weekly activity rota-this is documented in individual patient notes.
16	Should Do	AMH	D & D	Inpatient	The Trust should ensure that patients have access to activities on the wards throughout the week.	Activity schedules to be in place for all wards.	31/05/2019	Staff in post, Hub in place across whole Directorate Evidence Required	Update 17/01/19: Implement activity co-ordinators and OT Hub. OT hub on track for implementation in April 2019. Activity co-ordinators in post at LRH, some posts held for redeployment which has delayed recruitment - this has been escalated to HR
16	Should Do	AMH	Tees	Inpatient	The Trust should ensure that patients have access to activities on the wards throughout the week.	Activity schedules to be in place for all wards.	Complete	Evidence received: out of hours activity timetable	
16	Should Do	AMH	N York	Inpatient	The Trust should ensure that patients have access to activities on the wards throughout the week.	Activity schedules to be in place for all wards.	31/05/2019	Evidence Required: Vacancy control and ESR records ?Activity timetable	07/01/19 Action complete Full occupational therapy team in Peppermill Court
17	Should Do	AMH	N York	Inpatient	The Trust should ensure that privacy and dignity is maximised in the bed bays of Cedar ward at the Briary unit. The Trust should ensure that all wards comply with the Trust policy of having privacy curtains in bathrooms off corridors.	Following discussion at EMT and other key forums decision taken that no action is to be taken. (NY)			
18	Should Do	AMH	D & D	Inpatient	The Trust should ensure staff record what action they take when clinic room temperatures are outside the safe range.	Assurance of impact of actions (i.e. green compliance) to continue to be monitored through QUAG via medicines management reports	Complete	Evidence Received QuAG Minutes showing escalation to QuAG	
18	Should Do	AMH	Tees	Inpatient	The Trust should ensure staff record what action they take when clinic room temperatures are outside the safe range.	Assurance of impact of actions (i.e. green compliance) to continue to be monitored through QUAG via medicines management reports	Complete	Evidence received: Medicines Management reports show green compliance	
19	Should Do	AMH	Tees	Inpatient	The Trust should fully consider all methods and mitigation to maintain patient safety in the absence of call alarms in patient bedrooms and other patients access areas.	To explore possibilities of alarm systems and gain agreement from EMT of any potential action to be taken	30/06/2019	Emails requesting works/purchasing: Reprogramming of the blick pagers to sound with nurse call alarm	Update 09/02/19: Temporary Nurse call requested. Alarms to be given to patients if requested. UPDATE 05/04/2019: works requested to reprogram blick pagers to sound with nurse call alarm

19	Should Do	AMH	N York	Inpatient	The Trust should fully consider all methods and mitigation to maintain patient safety in the absence of call alarms in patient bedrooms and other patients access areas.	To explore possibilities of alarm systems and gain agreement from EMT of any potential action to be taken	30/06/2019	QuAG minutes & completion of order	Update 07/01/19 care needs to be documented and individual alarms issued to patients when required Update 26/02/19: February QuAG consider & supported the action form replacement handsets for Cedar ward - so all patient areas can issue alarms according to patient need for self care & vulnerability concerns 11/04/19 - QuAG supports that we should do that & we have the means to do it.
20	Must Do	MHSOP	D & D	Inpatient	The Trust must ensure staff record physical health observations, including a patient's refusal to be monitored following the administration of rapid tranquilisation in line with the Trust's policy.	Bi- monthly checks of the monitoring and recording of physical observations (post rapid tranquilisation) will continue to be undertaken with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Complete	Evidence received Supervision template of RT, covert medication, post falls proforma MM audits QuAG minutes	
20	Must Do	MHSOP	N York	Inpatient	The Trust must ensure staff record physical health observations, including a patient's refusal to be monitored following the administration of rapid tranquilisation in line with the Trust's policy.	Bi- monthly checks of the monitoring and recording of physical observations (post rapid tranquilisation) will continue to be undertaken with exception reports provided to the Locality Quality Assurance Group. An additional assurance check will be made by staff from the Nursing & Governance directorate.	Complete	Evidence Received: MM audit QuAG minutes	
21	Must Do	MHSOP	N York	Inpatient	The Trust must ensure that patients have easy access to nurse call systems to summon assistance from their bedrooms in an emergency, including shared bedrooms.	MHSOP SDG will give consideration as to the most appropriate nurse call alarm system for inpatient organic units. Based on the outcome of discussions/ decisions, localities will incorporate the chosen system within the estates work plan.	Complete	N/A	
21	Must Do	MHSOP	York & Selby	Inpatient	The Trust must ensure that patients have easy access to nurse call systems to summon assistance from their bedrooms in an emergency, including shared bedrooms.	MHSOP SDG will give consideration as to the most appropriate nurse call alarm system for inpatient organic units. Based on the outcome of discussions/ decisions, localities will incorporate the chosen system within the estates work plan.	Complete	Evidence Received: SDG minutes	
21	Must Do	MHSOP	D & D	Inpatient	The Trust must ensure that patients have easy access to nurse call systems to summon assistance from their bedrooms in an emergency, including shared bedrooms.	MHSOP SDG will give consideration as to the most appropriate nurse call alarm system for inpatient organic units. Based on the outcome of discussions/ decisions, localities will incorporate the chosen system within the estates work plan.	Complete	Evidence Required: SDG minutes detailing decision 21/03/19	
22	Must Do	MHSOP	York & Selby	Inpatient	The Trust must ensure prescription charts in relation to the administration of covert medication are completed in line with the Trust's policy.	The service will deliver local staff training and awareness sessions to review trust policy and expectations in relation to completion of prescription charts for the administration of covert medication.	31/03/2019	Evidence Received: Meadowfields training & policy log Evidence Required: Audit trail of training for staff QuAG minutes	18/01/19 update Ward managers in York have started to roll out training to the staff on the wards and keep a record of this. April - Requested update. 24/04/19 Received evidence of staff being trained and policy sent for Meadowfileds. Requested same for Acomb Garth; Unit merging shortly? No admissions to Acomb?

23	Should Do	MHSOP	N York	Inpatient	The Trust should ensure ligature assessments take account all areas of the wards	Review of ligature risk surveys	Complete	Evidence Received: Completed ligature surveys QuAG minutes	
24	Should Do	MHSOP	York & Selby	Inpatient	The Trust should ensure patients' bedrooms appropriately maintain their privacy, dignity and respect.	As part of the planned work to merge the two inpatient units (Meadowfields and Acomb Garth), it will include an estates review to ensure compliance with privacy, dignity and respect.	Complete	1.Review provided to QuAG. 2. Identified actions detailed within the estates plan for merging the units.	
25	Should Do	MHSOP	N York	Inpatient	The Trust should consider recording patients' capacity and best interest decisions where personal care is being provided.	To discuss and agree what the standard approach across MHSOP should be within SDG	Complete	Evidence Received Copy of SPD Staff Briefing MM audits	
25	Should Do	MHSOP	York & Selby	Inpatient	The Trust should consider recording patients' capacity and best interest decisions where personal care is being provided.	To discuss and agree what the standard approach across MHSOP should be within SDG	Complete	Evidence Received Copy of SPD Staff Briefing MM audits	
25	Should Do	MHSOP	Tees	Inpatient	The Trust should consider recording patients' capacity and best interest decisions where personal care is being provided.	To discuss and agree what the standard approach across MHSOP should be within SDG	Complete	Evidence Received Copy of SPD Staff Briefing MM audits	
25	Should Do	MHSOP	D & D	Inpatient	The Trust should consider recording patients' capacity and best interest decisions where personal care is being provided.	To discuss and agree what the standard approach across MHSOP should be within SDG	Complete	Evidence Received Copy of SPD Staff Briefing MM audits	
26	Must Do	FMH	Forensic	Inpatient	The Trust must ensure there are enough staff to enable the use of least restrictive practice on Merlin ward and prevent Section 17 leave being cancelled across all wards.	Merlin ward will review, identify and discuss the implementation of restrictive practice within the Forensic Mental Health Quality Assurance Group to provide assurance of monitoring and review in line with the Restrictive Practice Framework. Ongoing work with S17 leave requests will ensure that leave is prescribed in line with ward staffing capacity.	31/03/2019	Evidence Received -QuAG minutes discussing 2 day s17 event planned -email re standard coding for cancelled leave -standard process for recording leave -email re recording leave in Paris -KPO project form for governance escalation process Evidence Required Output from ongoing Section 17 work	Need assurance revised processes are happening/working

27	Must Do	FMH	Forensic	Inpatient	The Trust must ensure that fridge and clinic room temperatures are monitored and action taken when required in line with the Trust policy.	Monthly reporting of fridge and clinic temperatures will continue through the FMH and FLD Quality Assurance Group. The current monitoring process is currently being reviewed to establish if there are any other solutions to this issue. The above actions will ensure that fridge and clinic room temperatures are monitored and action taken when required in line with the trust policy.	Complete	Evidence Received QuAG minutes: fridge temperatures being monitored at QuAG LMGB minutes	
28	Must Do	FMH	Forensic	Inpatient	The Trust must ensure activity schedules are in place and therapeutic activities take place on weekends throughout the service.	There will be a review of both occupational therapy and diversional activity provision. This will identify where activity schedules are/are not in place. Following this review, services will ensure that activity schedules are in place and that therapeutic activities (including e.g. leave with family) take place on weekends.	Complete	Review document and proposals for consideration Activity schedules (printed and electronic available, audit/monitoring documents linked to post review implementation plan	
28	Must Do	FLD	Forensic	Inpatient	The Trust must ensure activity schedules are in place and therapeutic activities take place on weekends throughout the service.	There will be a review of both occupational therapy and diversional activity provision. This will identify where activity schedules are/are not in place. Following this review, services will ensure that activity schedules are in place and that therapeutic activities (including e.g. leave with family) take place on weekends.	Complete	Review document and proposals for consideration Activity schedules (printed and electronic available, audit/monitoring documents linked to post review implementation plan	
29	Should Do	FLD	Forensic	Inpatient	The Trust should ensure that patients on Hawthorn/Runswick ward have access to their bedrooms without the restriction of snap lock doors and ensure patients on Merlin ward have 24-hour access to snacks in line with the Trust's restrictions policy.	1) The snap locks will be reviewed in collaboration with estates and the clinical team and remedial action taken based on the outcome of the review. Report review into LMGB 2) Merlin ward to review, identify and discuss the implementation of restrictive practise within FMH QuAG, to provide assurance of monitoring and review inline with the Restrictive Practice Framework	Complete	LMGB Minutes 15/01/19 FMH QuAG minutes	
30	Should Do	FLD	Forensic	Inpatient	The Trust should ensure that there are processes in place to protect patients' privacy and dignity when being escorted to different wards for the use of seclusion facilities	Briefing Paper to be developed for circulation to all wards outlining the requirement for all patients to be individually assessed prior to being escorted to an alternative seclusion suite. Patient privacy and dignity to be incorporated into the debriefing process	Complete	Evidence Received: Briefing Paper circulated on 24/01/19 by Neil Woodward	
31	Should Do	FMH	Forensic	Inpatient	The Trust should consider why there is a difference between their reported reason for section 17 leave being cancelled and the patients and carers understanding of why leave is being cancelled.	One day event to take place to review current standard process for reporting cancellation of leave (to ensure rationale of leave cancellations is clearly articulated to service users and carers and evidenced within care records).	Complete	Evidence received: Development of leave codes - emails Kaizen event report out presentation	
32	Should Do	FMH	Forensic	Inpatient	The Trust should consider the Department of Health Environmental Design Guide Medium Secure Services guidance with regards to observation panels in patient bedroom doors and in the meantime, manage risks and issues through staff awareness	Observation panel with an antiligature internal thumb turn handle has been identified for the development of block 16.	Complete	Evidence received: Email from Capital Planning confirming identification of observation panels.	
33	Should Do	FMH	Forensic	Inpatient	The Trust should continue to review the use of mechanical restraint with the aim of eliminating its use.	1) Use of mechanical restraints to be reported to QuAGs on a monthly basis. 2) QuAG to report usage to LMGB and QuAC. 3) Head of Security to continue to report usage of mechanical restraint devices to LMGB. 4) Introduction of the Mechanical Restraint Committee within	Complete	Evidence received: Modern matron report QuAG report to LMGB Mechanical restraint LMGB report FMH QuAG Report to LMGB outlining that QuAGs are being informed on the usage of mechanical restraints	

33	Should Do	FLD	Forensic	Inpatient	The Trust should continue to review the use of mechanical restraint with the aim of eliminating its use.	1) Use of mechanical restraints to be reported to QuAGs on a monthly basis. 2) QuAG to report usage to LMGB and QuAC. 3) Head of Security to continue to report usage of mechanical restraint devices to LMGB. 4) Introduction of the Mechanical Restraint Committee within Secure Services. The committee will review all individual episodes on the application of the devices by identifying areas of good practice and areas for development and report to LMGB.	Complete	Evidence received: Modern matron report QuAG report to LMGB Mechanical restraint LMGB report FMH QuAG Report to LMGB outlining that QuAGs are being informed on the usage of mechanical restraints	
34	Should Do	FLD	Forensic	Inpatient	The Trust should fully consider all methods and mitigation to maintain patient safety in the absence of call alarms in patient bedrooms and other patients access areas.	1) Pagers are available for patients to access. 2) Individual patient risk assessment to be completed by MDT prior to allocating pagers. 3) QuAGs to be informed of availability to access pagers following individual risk assessment.	Complete	Evidence Required: QuAG Minutes	
34	Should Do	FMH	Forensic	Inpatient	The Trust should fully consider all methods and mitigation to maintain patient safety in the absence of call alarms in patient bedrooms and other patients access areas.	1) Pagers are available for patients to access. 2) Individual patient risk assessment to be completed by MDT prior to allocating pagers. 3) QuAGs to be informed of availability to access pagers following individual risk assessment.	28/02/2019	Evidence Received: QuAG Minutes Email re individual disabled patient being issued alarm for 24hr call	
35	Should Do	CAMHS	Tees	Inpatient	The Trust should ensure that capacity assessments are considered where required and recorded in care plans on Baysdale unit.	Capacity assessments to be considered for all patients 16yrs old and above and recorded in PARIS as having been considered/completed	28/02/2019	Evidence Required: Capacity Assessment completed and decision recorded on PARIS Ward Manager records audits	Update 13/03/19: MHA team visited ward to support development. Outcome: looked at authorising the stay of patients and how this is recorded, the other was around considering/recording capacity with care plans. Statement added to each Paris record. Bespoke session being arranged with MHA office to team on capacity which will further improve the recording of this. Ward Manager will audit records.
36	Should Do	CAMHS	Tees	Inpatient	The Trust should ensure effective systems and processes are in place to monitor the compliance and quality of clinical supervision.	Clinical supervision spreadsheet to be used to monitor compliance	27/06/2018	Supervision spreadsheet Evidence Required	14/02/19 Action Complete Clinical supervision spreadsheet now being used (separate to management supervision) and reported to Tees CYPS weekly report out
37	Should Do	CAMHS	D & D	Inpatient	The Trust should ensure the sensory room on Holly ward is well equipped and maintained.	Costings for new sensory equipment to be obtained and presented to CPSG to request funding. Holly Unit to be redecorated.	Complete	Evidence Received: LMGB minutes confirming furniture & equipment ordered QuAG December minutes evidencing redecoration and equipment	

38	Should Do	CAMHS	Tees	Inpatient	The Trust should ensure there are sufficient staff available to coordinate activities scheduled for children and young people	Baysdale to evidence how it co-ordinates activities scheduled for children and young people	01/09/2018	Photographs, Timetable of activities, My Stay At Baysdale, Activities the children and young people like participating in recording in Person Centred Care Plans, Socialisation Receipts, Health Roster Evidence Required	14/02/19 Action complete Since June 2018 Baysdale has a planned monthly timetable of activities . A Ward camera has been purchased to enable staff to photograph activities in progress to evidence when the activities have taken place . Each Child young person has "My Stay at Baysdale" filled in during each stay which records the activities they have participated in during the morning , afternoon and evening . This is sent home after each admission allowing parents to discuss with their child what their child has done during their admission to Baysdale . The activity plan is running effectively and the evidence file was one of the things that the Ofsted inspector was complimentary about during the recent inspection
39	Should Do	CAMHS	Tees	Inpatient	The Trust should ensure the quality of food available to patients at West Lane hospital is improved in line with other services.		31/05/2019	Response required	Response Required
40	Should Do	CAMHS	Tees	Inpatient	The Trust should fully consider all methods and mitigation to maintain patient safety in the absence of call alarms in patient bedrooms and other patients access areas.	Baysdale to identify how they maintain patient safety in the absence of call alarms in patient bedrooms and other patient access areas	27/06/2018		Baysdale – do not have an electronic call system. However the layout of the unit and the staff: patient ratio ensures close observations and close proximity for responsive actions. Also there are monitors (sound and video)
41	Should Do	AMH	D & D	Community	The Trust should ensure it completes its review on the use of emergency equipment to ensure there is a unified approach across all the Trust.	Provide clear guidance on the use of emergency bags in the community.	31/03/2019	Evidence Received: Emails confirming process N.Durham Psychosis, weardale affective and south durham psychosis -blue bag checks Evidence Required: derwentside/CLS affective team-no checks in place QuAG evidencing blue bag checks monitoring	Team processes in place. Derwentside/CLS affective team - no checks in place. Commencing 12/04/19 Easington Affective & Psychosis/ Merrick House - not fully equipped yet. Checks will start once in place. Update 03/04/19: process has been agreed and each Team is aware. The Assistant Locality Manager is monitoring and feeding back to QuAG re this.**Requested further information/evidence around this. Checks not fully in place in all areas so requested further evidence when available.**

41	Should Do	AMH	Tees	Community	The Trust should ensure it completes its review on the use of emergency equipment to ensure there is a unified approach across all the Trust.	Provide clear guidance on the use of emergency bags in the community.	31/03/2019	Evidence Required: Procedure in place BLS compliance figures blue bag checks Review of checks at QuAG - minutes	Update 16/04/19. Blue bags ordered. Staff training being progressed (booked on or advised to book on). Review of checks will be completed at the next QUAG. Head of Nursing supporting community teams with blue bag check process. Update 23/04/19: April update, Middlesbrough, Redcar, Hartlepool compliant for clinics, Stockton 5 booked May 2019. Existing Policy for blue bag checks will be implemented. BLS training information provided (not attached-re-requested). May QUAG blue bag checks. BLS compliance 89%, 5 people booked May 2019.
41	Should Do	AMH	York & Selby	Community	The Trust should ensure it completes its review on the use of emergency equipment to ensure there is a unified approach across all the Trust.	Provide clear guidance on the use of emergency bags in the community.	31/03/2019	Man and stat training compliance records. Emergency response bag check list.	Update 16/04/19: all community teams are in the process of being training in the new requirements with staff booked onto session in April & May (access to course is an issue) . Kit is available for them to access.
41	Should Do	AMH	N York	Community	The Trust should ensure it completes its review on the use of emergency equipment to ensure there is a unified approach across all the Trust.	Provide clear guidance on the use of emergency bags in the community.	31/03/2019	Evidence Required: Guidance document & training compliance	Update 07/01/19: Work has commenced. Update 26/02/18: delivery of blue bag is in progress - all staff needed to be able use them are being booked onto training 04/04/19:Update 03.04.19: all sites now have blue bags being commissioned in line with trusts requirements & staff are progressing with their training. Not all teams are registered in IIC as yet so unable to reflect compliance for NY
42	Should Do	AMH	D & D	Community	Staff should ensure they keep patients medication cards up to date and contemporaneous in line with best practice.	All staff to be reminded of responsibilities.	Complete	Evidence Received: Audit/service evaluation QuAG Jan19 showing meds management exception discussion Meds management training compliance 96% Safer Medication Prescribing Group's Feb meeting December QuAG minutes - audit results	
43	Should Do	AMH	York & Selby	Community	The community mental health team should ensure they complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	Complete	IIC training compliance 05/03/19 Y&S AMH compliance over 95%	
43	Should Do	AMH	D & D	Community	The community mental health team should ensure they complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	31/05/2019	IIC training compliance	Update 07/01/19 Currently 93% compliance for Y&S
43	Should Do	AMH	N York	Community	The community mental health team should ensure they complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	31/05/2019	IIC training compliance	Update 07/01/19 Currently 93% compliance for Y&S Update 26/02/19: Ham/rich locality is currently non-compliant & action being taken with key staff to address this

43	Should Do	AMH	Tees	Community	The community mental health team should ensure they complete their mandatory training modules in Mental Capacity Act and Mental Health Act by May 2019, in line with the Trusts trajectory.	Achieve 95% compliance in training modules in Mental Capacity Act and Mental Health Act	31/05/2019	IIC training compliance	Update 14/03/19: IIC training compliance MCA Community 99% (@28/02/2019) MHA Community - 99% (@28/02/2019)
44	Should Do	AMH	D & D	Community	The Trust should accurately maintain supervision records to reflect what staff are receiving.	Monthly audit of supervision.	30/04/2019	Locally held supervision records. Audit data reported to QuAG (as recorded in the minutes).	Information required
44	Should Do	AMH	N York	Community	The Trust should accurately maintain supervision records to reflect what staff are receiving.	Monthly audit of supervision.	30/04/2019	Locally held supervision records. Audit data reported to QuAG (as recorded in the minutes).	Update 11/04/19 Head of Service: introduce monthly audit of supervision via the locality managers this month – this will feed into the locality manager reports into QuAG
44	Should Do	AMH	York & Selby	Community	The Trust should accurately maintain supervision records to reflect what staff are receiving.	Monthly audit of supervision.	30/04/2019	Evidence required: Audit data reported to QuAG (as recorded in the minutes). Supervision matrix	Update 14/01/19: Implement the revised TEWV supervision record keeping Update 05/03/19: ANP's to undertake audit findings to QUAG
44	Should Do	AMH	Tees	Community	The Trust should accurately maintain supervision records to reflect what staff are receiving.	Monthly audit of supervision.	30/04/2019	Locally held supervision records. Audit data reported to QuAG (as recorded in the minutes).	Update 14/03/19 Community - C - 70.45% (@28/02/2019) M - 75% (@28/02/2019) Weekly report out to Performance meeting
45	Should Do	AMH	D & D	Community	The Trust should ensure they use a recognised risk assessment tool in line with best practice.	A monthly random sample audit will be undertaken. The actions from the audit will be fed back to individual clinicians to facilitate any required improvements	30/04/2019	Audit reported to QuAG and recorded in the minutes.	Information required
45	Should Do	AMH	N York	Community	The Trust should ensure they use a recognised risk assessment tool in line with best practice.	A monthly random sample audit will be undertaken. The actions from the audit will be fed back to individual clinicians to facilitate any required improvements	30/04/2019	Audit reported to QuAG and recorded in the minutes.	Update 11/04/19:matron report already includes an audit of records & quality or risk assessment – with feedback to those staff & into QuAG
45	Should Do	AMH	York & Selby	Community	The Trust should ensure they use a recognised risk assessment tool in line with best practice.	A monthly random sample audit will be undertaken. The actions from the audit will be fed back to individual clinicians to facilitate any required improvements	30/04/2019	Evidence Received: MM Audit reported to QuAG and recorded in minutes (compliant) Evidence Requested: additional MM audits and QuAG minutes	Update 14/01/19: Ensure the clinical staff use the Safety Summary Plan collaboratively with the service user and families. Audit quality of safety summary plan, and respond to any actions from this. Training records 16/04/19 MM audits showing checks. Discussed at QuAG. Requested additional MM audits and QuAG minutes.
45	Should Do	AMH	Tees	Community	The Trust should ensure they use a recognised risk assessment tool in line with best practice.	A monthly random sample audit will be undertaken. The actions from the audit will be fed back to individual clinicians to facilitate any required improvements	30/04/2019	Evidence Required: Annual audit including summary report Monthly audits Audit reported to QuAG and recorded in the minutes.	Update 14/03/19: Annual audit via Audit programme for all teams, plus programme for monthly audits to be agreed subject to discussion at QuAG. March 2019 audit for all teams to be considered as Month 1. Results awaited from Audit team

No.	Type	Service	Locality	Setting	Requirement	Action	Status/Date	Evidence	Update
46	Must Do	LD & Autism	Tees	Community	The Trust must ensure that staff are considering patients' capacity to consent where required and are maintaining records that demonstrate that they have done so.	A records review will be undertaken at The Orchards where this was raised to ensure that staff are considering patients' capacity to consent where required and are maintaining records. This action will demonstrate that capacity records are being appropriately maintained.	Complete	Evidence Received: Visual Tool Board	
47	Should Do	LD & Autism	Tees	Community	The Trust should ensure that patient risk assessments are continually reviewed and updated for all patients.	Implement a visual control system to monitor review of patient risk assessments	Complete	Evidence Received: Visual Tool Board	
47	Should Do	LD & Autism	D & D	Community	The Trust should ensure that patient risk assessments are continually reviewed and updated for all patients.	Implement a visual control system to monitor review of patient risk assessments	Complete	Evidence Received: QuAG minutes Feb	
48	Should Do	LD & Autism	Tees	Community	The Trust should ensure that staff at Lancaster House continue to work on reducing patient waiting times for a service, to meet National Institute for Health and Care Excellence standards.	Task and Finish Group to be established to consult on a new service model	31/03/2019	Minutes of Task & Finish Group	Work continues to reduce and improve efficiencies to reduce waiting times for Adult ASD assessment. Task and Finish group is consulting on a new service model. Due to significant increase in demand v capacity, business case is in development. This service is commissioned for Tees, Durham & Darlington Update 16/4/19: The Durham, Darlington & Tees Partnership are currently reviewing the ASD provision and mapping the gaps, this will be taken back to the Commissioning group for consideration and action.. Business case completed and will be submitted to the next Commissioning meeting.(commissioning issue)
49	Should Do	LD & Autism	Tees	Community	The Trust should ensure that staff at The Orchard are using the National Early Warning Scores tool consistently with all patients and that regular reviews of patient physical health are taking place.	Physical health monitoring to be included on Visual Control Board	Complete	Evidence Received EWS audit peer supervision record Visual Control Board	
50	Must Do	Corporate	Corporate	Corporate	The Trust should ensure that staff are aware of the requirement to report a breach of the eliminating mixed sex accommodation requirements in line with Trust policy.	To remind staff of the reporting requirements as part of the roll-out of the refreshed Privacy and Dignity policy	30/06/2019	Revised policy and feedback from mock inspection process	
51	Must Do	Trust	Corporate	Corporate	The trust must ensure it reviews further actions that can be taken to mitigate the impact on privacy and dignity where only curtains separate the beds in dormitory style accommodation.	The Trust will continue to review further actions that can be taken to mitigate the impact on privacy and dignity where only curtains separate the beds in dormitory style accommodation.	30/06/2019	Revised policy and feedback from mock inspection process	

ITEM NO. 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**21st May 2019**
TITLE:	**Update on the merger of North Yorkshire and York Locality**
REPORT OF:	**Ruth Hill, Chief Operating Officer**
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 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 provide assurance and information to the Trust Board following the merger of North Yorkshire and York and Selby localities.

Key areas for consideration include the outcome of the reconfiguration of the leadership and management structures, communication with staff, and development of internal processes to manage the business across the new locality that are now business as usual.

The merger to date is in line with the original proposals with two exceptions:

- Reduction of 2.69wte admin staff
- Appointment of Clinical Director for CAMHS NY and Y

Recommendations:

The Board is requested to note that the North Yorkshire and York locality is now operating business as usual processes and to support the proposed new timelines to deliver the CRES from admin structures.

MEETING OF:	Board of Directors
DATE:	21st May 2019
TITLE:	Update on the merger of North Yorkshire and York Locality

1. INTRODUCTION & PURPOSE:

The purpose of the report is to provide the Board of Directors with an update on progress against the reconfiguration of the leadership and management structures for North Yorkshire and York including the staffing structure, work undertaken to communicate with staff, developing the new locality infrastructure and CRES delivery.

2. BACKGROUND INFORMATION AND CONTEXT:

The merger of the former localities 'North Yorkshire' and 'York and Selby' became formalised on 1 April 2019, creating the new locality to be known as North Yorkshire and York. Preparation work for this had been ongoing since autumn 2018, initially under the former Director of Operations for YS but finalised by the interim Director of Operations who handed over to the substantive new Director of Operations for North Yorkshire and York (NL).

The decision to merge the two localities was signed off by the Trust Board in September, 2018. The Board announced the decision Trust wide and followed up with targeted communication to staff in the affected localities. It was anticipated that the merger would streamline service delivery in the area and release potential CRES of £531k.

3. KEY ISSUES:

A project team was established, led by the Director of Operations and supported by KPO and planning teams. A 'guiding team' was also formed (a group of senior colleagues from other parts of the Trust) to act as 'critical friend' to the project team, offering oversight and a perspective view on developments. At their meeting in February 2019 their main considerations were to consider how to support the new locality including matters such as the six to 12 month business plan and any training needs of newly appointed staff and those who report to them. The guiding team role will be reviewed at their next meeting in June 2019.

Leadership and Management Structures

The organisational change process for Head of Service roles concluded in February 2019 and the anticipated reduction in staffing complement has been achieved and the Director of Operations for North Yorkshire and York is in post. Clinical Director roles have been clarified and shadow arrangements are in place in both AMH and MHSOP to support this process until end Sep 2019.

Further work is required however to deliver the anticipated reductions as below:

- Administrative posts 2.69 WTE
- Clinical Director Sessions and Associate Clinical Director Sessions 0.70 WTE – Clinical Director for CAMHS is to be appointed

The process to reconfigure admin provision in the locality has been considered by LCC in April 2019 and further consultation with staff will be carried out in May and June 2019 with a view to concluding the process in September 2019.

Staff Communication

The project team had two priorities for the merger: communication and staff support. The team used a wide mix of approaches and strategies to reach and communicate with staff about the process:

In March 2019 a handover of this communication was made from the Director of Ops Y&S to the new Director of Operations NY and Y with no outstanding issues or staffing concerns that required any further action. There are plans to issue a further Survey Monkey in June 2019 to check in with staff about how the merger has played out in practice and with a key area of focus being whether the number of staff with concerns has reduced. Findings will inform future communications with all staff.

Locality Infrastructure

Performance report out processes, senior leadership weekly huddles and joint QUAG and LMGB meetings are in place and are now business as usual for the locality. Shared learning across the locality has also commenced with a Celebration Event on 30 April 2019 that was attended by approx. 80 staff and all specialties.

4. IMPLICATIONS:

The merger of the locality is in line with the original proposals agreed by EMT with the two exceptions outlined above. Full delivery of CRES released from the admin and clinical leadership structure is planned for September 2019.

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

There should be no change in compliance with CQC fundamental standards as result of the management changes.

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

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

4.4 **Equality and Diversity:**
None

4.4 **Other implications:**
None

5. RISKS:
None

6. CONCLUSIONS:

The leadership and management restructure to support the merger of North Yorkshire and York and Selby is complete with the exception of the appointment of a Clinical Director in CAMHS. There are clear plans in place to support the admin restructure and deliver the CRES proposals as outlined in the body of the report and new structures and processes to manage the business and governance of the locality are in place and are now considered business as usual.

7. RECOMMENDATIONS:

The Board is requested to note that the North Yorkshire and York locality is now operating business as usual processes and to support the proposed new timelines to deliver the CRES from admin structures.

Naomi Lonergan
Director of Operations North Yorkshire and York

ITEM NO 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday 21 May 2019**
TITLE:	**Report of the Mental Health Legislation Committee**
REPORT OF:	**Richard Simpson, Non-Executive Director**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 4, 2018/19.
Following review of the MHL Committee and levels of assurance there were additional reports for discussion considered at the meeting, as part of the new Annual Schedule of reporting, highlighted below.

Key areas for consideration:

- Reports on Discharges from Detention, use of Section 136, **Section 132, Section 18 Absent Without Leave, MHA Inspection Feedback Q4 2018/19.**
- Associate Hospital Managers
- Seclusion Report
- **Section 5 MHA 1983 (Holding Powers)**
- CQC Thematic Review
- Report on MCA and DoLS
- CQC Quarterly report
- Annual Committee Performance Results

Recommendations:

The Board of Directors is asked to:

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

MEETING OF:	Board of Directors
DATE:	Tuesday 21 May 2019
TITLE:	Report of the Mental Health Legislation Committee

1. INTRODUCTION & PURPOSE:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for Quarter 4, 2018-19; through consideration of the work of the Mental Health Legislation Committee at its meeting held on 24 April 2019.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

The confirmed minutes of the Mental Health Legislation Committee held on 24 January 2019 are attached as Annex 1.
The MHLC also met on 24 April 2019. The key issues considered at this meeting were as follows:

COMPLIANCE WITH MHA PROCESSES

3.1 **Discharges from Detention**

The Committee considered the Discharges report.

The key points for the Board to note are:

- In Quarter 4 there were 106 Hospital Managers' review meetings with three patients discharged.
  The patient detained under section 3 was discharged from detention with agreement of the clinical team and remained as an informal patient at the time of writing the report to MHLC; one individual was discharged against the agreement of the RC or care coordinator but remained under community care and the third patient detained under section 37 was discharged without the agreement of the RC and named nurse but with the agreement of the care coordinator and they were not readmitted.
- There were 123 First-tier Tribunals in Q4, which resulted in 5 patients being discharged.
- There are no concerns to raise to the Board and assurance can be provided regarding processes for discharge from detentions. Over the last three months the Frist Tier tribunal disagreed with clinicians that some patients needed to remain subject to the Mental Health Act. The Mental Health Legislation department monitors all of these discharges; however it is inevitable that professionals will disagree over certain issues despite the comprehensive written and oral reports.
- Members were provided with further assurance (appendix 1) to the report, with a detailed narrative around a patient discharged from CTO.

3.2 **Section 136**

The Committee considered data and trends around S136.

- There were 174 uses of S136 across the Trust compared to 193 in the previous quarter.
- There were 16 episodes that lasted 12 hours or more.
- For those that were sectioned for longer than 12 hours assurance was provided in the report with the background details for the rationale behind this.
- There were 10 individuals aged between 14 and 17 held under section 136 in the last quarter.
- The overall use of S136 across the Trust shows TEWV place of safety (PoS) being used as the optimum choice with police stations only being used once across the whole Trust area in the last quarter.

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

3.3 **Section 132**

The Committee discussed the Section 132 report – Information to detained patients.

The key matters for the Board to note are:

- The level of compliance around notifying patients of their rights following admission to hospital under the MH Act was good.
- In the last quarter the escalation process was used 9 times, none which required escalation to the MH Legislation team, which included wards Bilsdale, Esk, Newberry, Overdale, Rowan and Tunstall.
- Three of the wards had been escalated to Modern Matrons.
- Compared to the number of sections applied, the number of times escalation was used was low however this process only captures the period following admission and S132 continues to feature on MHA inspection reports therefore additional processes are being implemented and monitored at ward level.
- Members were reassured that the numbers had slightly decreased and requested that repeat offenders be highlighted in future reports.

3.4 Section 18 AWOL

The committee discussed the six monthly Absence without Leave Report.

The key issues for the Board to note are:

- In Q3 and Q4 there were 170 AWOL episodes across the Trust and the background details to these were provided. There were numerous people who are AWOL on repeat occasions.
  Members considered whether it would be helpful to record the reasons behind why individuals abscond and it was recognised anecdotally that there are various reasons, including to have alcohol and drugs or to go home and most individuals return of their own accord.
- Members were assured that the Trust can demonstrate that it captures information regarding AWOL and that the notifications are sent to the CQC as

required by the Regulations. All patients who were AWOL were returned using section 18, or their whereabouts/circumstances are known.

3.5 Mental Health Act Inspection Feedback Q4 2018/19

The Committee received a report in a new format, MHA Inspection Feedback Q4 2018/19.

The key areas for the Board to note are:

- The report detailed the CQC activity for January to March 2019, when there had been 10 MHA inspections compared to 8 in the previous quarter.
- A review of the key themes picked up from the inspections showed frequent issues with care plans (20 times), issues with leave (20 times) and issues with patients' rights (13 times).
- Localities had been asked for a response to the matters picked up in the inspections and EMT had discussed additional actions to be taken.
- Members recognised that this was an ongoing problem for the Trust and noted the frustration of not being able to rectify, what sometimes feel like basic processes.
- The Committee sought further assurance in this report next time with demonstration of compliance against the Code of Practice.

3.6 Associate Hospital Managers (AHM)

The Committee received the annual Associate Hospital Managers Report with an overview and assurance of the key issues.

The Board is to note:

- There are currently 49 AHM's across the Trust and 3 NEDs involved in MHA reviews of detention.
- There has been a recent event to expand the diversity of AHM's through engagement with the South East Asian community and this was very positive - it is anticipated that there will be an opportunity to include members of this group as AMH's in the future.
- The expenditure in 2018/19 was approximately £10,000 less than the previous year and this was due to better planning in using AHM's who live closest to the hearing venue.
- All AHM's go through an appraisal and review undertaken by the Mental Health Legislation team.
- All AHM's have now been registered with the electronic Disclosure and Barring Service.
- Assurance is provided that the Trust has established a committed and skilled group who undertake the role of AHM.

COMPLIANCE WITH KEY CODE OF PRACTICE REQUIREMENTS

3.7 **Seclusion**

The Committee discussed the seclusion report.

The Board is to note:

- In Q4 there were 81 episodes of seclusion, (71 in previous quarter). Of the 81episodes 66 had been over 12 hours, of which 52 had been over 24 hours.

- The longest completed seclusion for those in excess of 24 hours was 739 hours (30.8 days).
- There were 15 patients that had multiple seclusion episodes, with 1 patient having 5 episodes in the Quarter.
- Following concerns with regard to whether the requirements of the Code of Practice and Trust Policy are adhered to on every occasion that seclusion occurs. From week commencing 22 April, a piece of work will be undertaken by the MHL team which will entail clinically auditing every completed seclusion for a period of at least 2 weeks to determine whether the requirements of the policy have been adhered to.

3.8 Section 5 (4) and Section 5 (2) MHA 1983 (Holding Powers Report)

The Committee discussed the new Holding Powers report for Q3 and Q4 2018/19.

The Board is to note the following:

- The report is to provide assurance that Section 5(4) and Section 5(2) 'holding powers' are used appropriately and lawfully.
- There were 36 uses of Section 5(4) and 190 uses of Section 5(2) in Q3 and 4 with no exceptions.
- Assurance is therefore provided that the Trust can demonstrate it captures information regarding the use of Section 5 holding powers and that any lapses or issues are investigated to ensure that there are no adverse effects.

3.9 CQC Thematic Review

The Committee received a short briefing on the CQC Thematic Review.

The key matters to highlight to the Board are:

- The Trust has submitted data as part of phase 1 of the Thematic Review for the use of restraint, seclusion and segregation for December 2018 in Children and Young People inpatient wards and Learning Disability and Autism inpatient wards.
- Phase 2 of the Thematic Review has been received from the CQC requesting information on low secure and rehab inpatient wards.
- Once national data has been analysed the CQC will undertake visits to every location from phase 1 with interviews with people who have been subject to segregation/prolonged seclusion with families and carers.
- The CQC will publish findings in May 2019 with a full report expected by March 2020.

EFFECTIVE IMPLEMENTATION OF THE MCA AND DOLS

4.0 Mental Capacity Act and DoLS

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

The key points to note are:

- The results from a re-audit around compliance with the Mental Capacity Act in December/January 2019 highlighted that many of the Inpatient and Community Teams across all directorates audited, could not evidence the consideration of capacity by the completion of appropriate documentation. Specific work with operational teams, staff and the MCA Champions will focus

on areas that require improvement. Additional work will be required in order to ensure we are adequately prepared for the implementation of the Liberty Protection Safeguards in early 2020.
- DoLS activity for the period January to March 2019 revealed that there are 45 current active cases
- E Learning modules continue to provide training for staff, as well as face to face around the Mental Capacity Act and MH Act and compliance has reached 93%.
- A third cohort of Champions with 20 successful participants has taken place in March 2019.
- Assurance was provided that work continues collaboratively with clinical and governance teams to ensure compliance with the legislative requirements around MCA/DoLS.

KEY GOVERNANCE INFORMATION

4.1 CQC Report

The Committee discussed the CQC update report for Q4.

The key matters highlighted were:
- Updates around CQC engagement meetings, CQC Insight, Learning from Deaths and the CQC's annual report on the use of the Mental Health Act where it has been found that there have been some improvements in aspects of care in 2016-2018.
- This report was currently being considered against the fundamental CQC questions to provide more tailored assurance going forward.

4.2 Annual Committee Performance Assessment Results 2018/19

Committee members discussed the annual performance results for 2018/19.

The Board is to be aware that there has been considerable improvement in the performance of the Committee in the last year, with more focused reporting demonstrating a greater level of assurance. Eleven out of twenty areas saw improvement with only six slightly worse than the year previous.

Going forward members look forward to some improvement around induction for new members onto the Committee, however this will be linked to the induction and training needs of the Board of Directors as a whole.

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

A case study of a patient requiring seclusion was received which was felt to be very useful in describing the personal circumstances and context in which this occurs and a good example of bringing the subject matter of the Committee 'to life'.

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

There were no concerns at present.

6.0 IMPLICATIONS:

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

CQC MHA visit reports do not indicate any significant issues with regard to compliance with the Fundamental Standards in terms of the MHA and MCA however themes from MHA inspections continue to reoccur and it is important that actions and progress against these are closely monitored.

6.2 **Financial/Value for Money:**

There are no implications.

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

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

6.4 **Equality and Diversity:**

There are no implications.

7. CONCLUSIONS:

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

9. RECOMMENDATIONS:

The Board of Directors is asked to:

(i) Receive and note this report including the confirmed minutes of the meeting of the MHLC held on 24 January 2019.

Mrs Elizabeth Moody
Director of Nursing & Governance
21 May 2019

Background Papers: Annex 1 – Confirmed minutes of the 24 January 2019 MHL Committee Meeting

Annex 1

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 24 JANUARY 2019 IN SEMINAR ROOM 4, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM.

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

In Attendance:
Ms D Oliver, Deputy Trust Secretary, (Corporate)
Miss M Wilkinson, Head of Mental Health Legislation, (for minute 19/08 and 19/12)
Mrs J Ramsey, Mental Health Team Manager, (for minute 19/03/04/05/06/07)
Mrs J Harrison, Expert by Experience Representative
Mrs R Down, MHL Advisor (for minute 19/09)
Mrs L McCrindle, Head of Quality Governance and Compliance, (for minute 19/10)

Apologies: Apologies for absence were received from Mrs R Hill, Chief Operating Officer, Mrs S Richardson, Non-Executive Director, Dr A Khouja, Medical Director and Mrs J Illingworth, Director of Quality Governance.

19/01 MINUTES OF LAST MEETING

Agreed – *That the minutes of the last meeting held on 18 October 2018 be approved as a correct record and signed by the Chairman, subject to the correction of Mrs L McCrindle being added to those present and section 18/52: Seclusion and Segregation Procedure to amend the minute to: "Assurance was provided that seclusion of individuals was monitored every 15 minutes".*

19/02 ACTION LOG

The Committee noted the actions and following updates:

17/33 Benchmarking – talk to NTW about seclusions.
Mrs R Hill agreed to raise this through the Chief Operating Network. The PIR information for NTW would also be considered and an update would be brought to the January 2019 meeting.
This was deferred to the April 2019 MHLC meeting when the Director of Operations would be present.

18/19 Further discussion around why S136 was being used more in York and North Yorkshire, to be raised at the next York Operational Group meeting. There was still no explanation around why S136 use was higher other than due to the geographical size.
A series of work plans, together with the consultation around Harrogate was underway which would include the interface between the S136 suite. This would be discussed further at the April 2019 MHLC meeting.

18/20 Separate out CQC feedback report and frame sections around high quality questions.

This was deferred to the April 2019 meeting. Mrs Moody explained that the purpose of the change to the formatting of the report was to frame the relevant legislative information around the high quality questions used on the agenda which would provide further assurance for the Committee and the CQC.

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

18/42a Section 62 information to be reported to MHLC in October 2018 and then annually.
This report was deferred to the April 2019 MHLC meeting. Miss Wilkinson sought clarification on the content of the report and undertook to bring it next time.

18/48 Include summaries from Hospital Managers' decisions in hearings not tribunals where individuals discharged against clinical recommendation.
This matter was covered under agenda item number 4a (minute 19/03 refers).
Completed

18/49 Break up the "key issues" section of the Section 136 Report to distinguish between talking about individuals and the conclusions around S 136.
This matter was covered under agenda item number 4b (minute 19/04 refers).
Completed

18/49a Look at possibility of obtaining data from Planning for an annual report on individuals detained under the MHA and their protected characteristics.
This was an ongoing project and the Committee would receive an update as discussions progressed.

18/51 Seclusion report: explain narrative around those individuals secluded for more than 12 hours and for more than 24 hours. Also re-add the column showing the number of hours in seclusion.
This matter was covered under agenda item number 5a (minute 19/07 refers).

18/54 MCA/DoLS report: Issue of long waiting list for DoLS at Middlesbrough County Council, with some clients waiting more than two years.
It was noted that a meeting was due to take place in the next week regarding this matter and an update would be brought back to the April 2019 MHLC meeting.

18/54a An update on Mental Health Act legislation to be brought to the Committee.
This matter was covered under agenda item number 9a (minute 19/12 refers).

18/56 Talk to Equality and Diversity lead regarding the potential for volunteers from the South Asian community in Teesside to carry out the Hospital Managers role.
The Chairman of the Committee would meet with the E&D Lead in order for this matter to be progressed and would update members at the next meeting.

HOW DOES THE TRUST DEMONSTRATE COMPLIANCE WITH MHA PROCESSES?

19/03 DISCHARGES REPORT

The Committee considered and noted the MHA Discharges Report.

The following was highlighted from the report:

(1) In Quarter 3 there had been 144 Hospital Managers' review meetings with one patient discharged from section 3 and one patient discharged from a Community Treatment Order. The section 3 patient had been discharged with the agreement of the clinical team and was later readmitted to another area of the Trust under Section 2 and one of them stayed.

(2) There were 142 First-tier Tribunals which resulted in 16 patients being discharged. Of those Section 2 patients discharged one stayed until the next day and was re-sectioned seven days later due to a suicide attempt.
On this matter members acknowledged that it would be sensible to have some discussion with the team to reflect on the events that happened following discharge.

Miss Wilkinson advised that in some cases where it was obvious for the need that an individual be detained, the evidence and reviews were not as thorough in the reporting compared to others which were more borderline. There were no checks made by clinical leaders and the reports followed a template layout.

Assurance was provided to the Committee however that it was a small proportion (8%) where patients were discharged by the MHT, which was below the national average.

(3) A copy of the Hospital Managers' decision in hearings where individuals were discharged against clinical recommendation had been included in the report, as agreed at the October 2018 MHLC meeting.

Mrs L McCrindle, Head of Quality Governance and Compliance, on behalf of Mrs J Illingworth joined the meeting for item 7.

19/04 SECTION 136 REPORT

The Committee received and noted the Section 136 report.

The following was highlighted from the report:

- There had been 181 uses of S136 across the Trust compared to 188 in the previous quarter. Increases had been seen in York 49, (29 in previous quarter), decreases in Northallerton 9 (19 in previous quarter) and Durham 13 (31 in previous quarter).
- There had been 22 episodes which had lasted 12 hours or more.
- Examples of individuals being sectioned for longer than 12 hours on S 136 included examples of people that had been intoxicated, asleep and requiring other medical attention.
- The overall use of S136 across the Trust had shown a TEWV place of safety (PoS) being used as the optimum choice with police stations only being used once across the whole Trust area in the last quarter.
- There had been 10 individuals aged between 14 and 17 held under section 136.

Following discussion members acknowledged that given the pressure on beds and acuity across the Trust they had no concerns around the four cases where S 136 had lasted more than 12 hours.

19/05 SECTION 23 (2) ASSURANCE REPORT – NOTIFICATION OF DISCHARGE BY NEAREST RELATIVE

The Committee received and noted the first report on the key issues with regard to notification of discharge by the nearest relative.

The following key issues were highlighted:

(1) This new annual report to the Committee would provide assurance around the notifications by relatives to discharge.
(2) Since July 2018 Hospital Managers had received five notifications of discharge by nearest relatives, four of which had been barred by the Responsible Clinician (RC).
(3) The barred discharges were reviewed by Hospital Managers Review meetings and for two of them the decision was "not discharged". The remaining two patients were discharged by their RC before the review date. One nearest relative made an application to the Tribunal and a date was set however it was withdrawn and the hearing was cancelled.
(4) The number of notifications to discharge remained low, however they did tend to appear in cycles where there might be four or five in succession.

Following discussion members were assured by the low numbers of notification to discharge by a nearest relative.

19/06 SECTION 132 REPORT – INFORMATION TO DETAINED PATIENTS

The Committee received and noted a new quarterly report - Section 132 – Information to detained patients.

The key issues highlighted from the report were:

- The level of compliance around notifying patients of their rights whilst detained under the MH Act was good.
- In the last quarter the escalation process had been used 22 times, including four times to the MH Legislation team.
- Wards requiring the escalation process more than once in the last quarter had been Danby and Esk and the reasons for this were unclear, however it was sometimes due to non-compliance of the patient and there were instances when it was not being recorded.

Following discussion members felt that this matter should be escalated to Modern Matrons, the Operational Management Team and also to be considered by the Quality Compliance Group.

Action: Mrs E Moody/Mrs L McCrindle

HOW DOES THE TRUST DEMONSTRATE COMPLIANCE WITH KEY CODE OF PRACTICE REQUIRMENTS?

19/07 SECLUSION REPORT

The Committee received and noted the Seclusion report.

- In Q 3 there were 71 episodes of seclusion with multiple episodes for patients (82 in previous quarter). Of the 71episodes 58 had been over 12 hours, of which 47 had been over 24 hours.
- The longest completed seclusion for those in excess of 24 hours had been 716 hours (29.8 days)

- There had been 18 patients who had had multiple seclusion episodes, with three patients having five episodes in the Quarter.

Assurance was provided around one exception, where a patient had been secluded in their bedroom for four hours and 20 minutes. This had been following an assault on a staff members and the individual continued to display aggressive behaviour for several hours.

19/08 SECTION 15 MHA MEDICAL AND ADMINISTRATIVE SCRUTINY REPORT

The Committee received a new annual report around Section 15 – medical and administrative scrutiny.

The key matters highlighted were:

- The report set out the occasions when administrative scrutiny leads to the identification of a fundamental flaw, which invalidates detention or when medical scrutiny leads to a failure of one or more medical recommendations, the processes that follow and the outcomes.
- From January to December 2018 there had been 21 occasions where Section 15 could not be used to rectify flaws or insufficiencies. Of those, 10 had been fundamental flaws, for example unsigned applications, wrong statutory forms used and no patient name on forms.
- There had been 11 instances where the medical scrutineer felt that there had been insufficient information to warrant detention on joint medical recommendations or on both single medical recommendations which ended the detention.
- From July 2018 a new process had been agreed with the Medical Director whereby medical recommendations could be re-scrutinised by the ACD or above and this had resulted in three sections that would have been invalid being passed as sufficient by the second scrutineer.

Following discussion members noted:

(1) That this level of medical and administrative scrutiny was extremely important to prevent any potential distress to patients that could be detained and brought to hospital and then their detention found to be invalid, requiring a fresh assessment. Also, to continue to provide feedback to AMHPs and doctors where things had gone wrong in order to improve practice and recording.
(2) That the systems in place to identify invalid detentions were effective, providing the Committee was a good level of assurance.

HOW DOES THE TRUST DEMONSTRATE EFFECTIVE IMPLEMENTATION OF THE MCA AND DOLS?

19/09 MENTAL CAPACITY ACT AND DOLS REPORT

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

Arising from the report it was noted that:

(1) The Trust wide audit of MCA compliance would be completed by end of January 2019 and an action plan would be developed to address areas for improvement.

(2) The DoLS module on Paris continued to be updated and reviewed, however relied on ward areas informing the MHA office of any applications made and some wards at York were not adhering to this process.
(3) There would be implications for the Trust from 2020 when the Deprivation of Liberty Safeguards changed to the Liberty Protection Safeguards; however this was still subject to parliamentary scrutiny.
(4) A third champions training programme had been arranged for March 2019 following the success of the programmes in 2017/18.

The Committee was assured that the Trust was compliant with the Mental Health Act and DoLS legislation.

WHAT KEY GOVERNANCE INFOMRATION DOES THE MHLC NEED TO BE AWARE OF/AGREE?

19/10 CQC REPORT

The Committee received and noted the CQC report.

Arising from the report it was noted that:

(1) Following the CQC inspection in summer 2018, the 16 ‘must do’ actions were now being addressed.
(2) There had been eight MHA inspections to Trust wards in Quarter 3 with key themes being around care plans, issues raised by the patients and problems with Section 17 leave forms.
(3) Monthly CQC meetings had been re-established. From January 2019 engagement by the CQC would include attendance at Board meetings and Sub Committees to the Board.

19/11 REPORT ON THE HONORARIUM FOR ASSOCIATE HOSPITAL MANAGERS

The Committee received a report on the honorarium for Associate Hospital Managers.

The key matter highlighted from the report was the proposal to increase the payment from £25 per panel to £30 and for the panel chair an increase to be made from £30 to £40. This was in line with other partner Trusts and organisations.

Agreed: *(i) That the honorarium for Associate Hospital Managers be increased for panel members from £25 to £30 and for the panel chair from £30 to £40.*
(ii) To recommend that the Resources Committee approve the increase in the honorarium at its meeting to be held on 12 March 2019.

HOW DOES THE COMMITTEE DEMONSTRATE IT IS AWARE OF EXTERNAL PUBLICATIONS?

19/12 REPORT OF THE INDEPENDENT REVIEW OF THE MENTAL HEALTH ACT

The Committee received for information a report setting out the key changes proposed to the Mental Health Act 1983, following a review chaired by Professor Wessely as set out in the Final Report of the Independent Review of the MH Act published in December 2018 entitled – Modernising the Mental Health Act, increasing choice, reducing compulsion.

The key matters highlighted were:

(1) A number of recommendations would have significant resource implications in terms of financial requirements, personnel availability and environmental requirements.
(2) Some of the recommendations would require amendments to the Code of Practice rather than legislation.
(3) One of the key drivers for the review was the disproportionate use of the MHA for those people from black and minority ethnic backgrounds and proposals within the report were around monitoring the use of the Act in relation to protected characteristics and specifically around children and young people with learning disabilities and/or autism.
(4) It was currently unclear when a response was expected from Government and whether the proposals would be accepted. It was doubtful that any changes in legislation would happen within the next three years.
(5) The Committee would be kept up to date on any progress.

HOW IS THE COMMITTEE ASSURED THAT IT IS REFLECTING THE VIEWS AND LIVED EXPERIENCES OF SERVICE USERS?

19/13 CASE STUDY

The Committee had not received a case study for this meeting; however this would be rectified for the next meeting to be held on 24 April 2019.

19/14 TRUST'S STRATEGIC RISKS

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

19/15 ANY OTHER BUSINESS

There was no other business to discuss.

The meeting concluded at 4.13pm

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Richard Simpson
Chairman – Mental Health Legislation Committee
March 2019

ITEM NO. 13 (Note: 2)

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**21 May 2019**
TITLE:	**Approval of accounts for the financial year ended 31 March 2019**
REPORT OF:	**Patrick McGahon Director of Finance and Information**
REPORT FOR:	**Approval**

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

Executive Summary:

The Board is required to approve and formally adopt the accounts for the period ended 31 March 2019 for submission to NHS Improvement.

The Trust achieved an operating surplus of £58,365k, which was higher than planned mainly due to additional Provider Sustainability Funding (PSF) received centrally from NHS Improvement, and a non cash benefit linked to the unwinding of borrowings following the termination of Roseberry Park PFI.

Recommendations:

The Board of Directors is requested to adopt the accounts and authorise the auditors to submit them as the audited accounts of the Trust for the period ended 31 March 2019 to NHS Improvement.

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

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

The Board of Directors are asked to confirm that in approving the annual report they agree to the Modern Slavery Act 2015 statements included in the annual report.

MEETING OF:	Board of Directors
DATE:	21 May 2019
TITLE:	Approval of accounts for the financial year ended 31 March 2019

1. PURPOSE OF REPORT

1.1 The purpose of this report is to ask the Board of Directors to approve the accounts for the period ended 31 March 2019 to the Trust Board.

2. BACKGROUND

2.1 In line with statutory requirements the Board is required to approve and formally adopt the accounts for the period ended 31 March 2019 for submission to NHS Improvement, the Independent Regulator for NHS Foundation Trusts.

2.2 Mazars LLP has carried out an audit of the accounts and they presented the outcome of the audit to the Audit Committee on the 17 May 2019.

3. KEY ISSUES

3.1 Key areas of Performance

The Audit Committee received a copy of the audited accounts on 17 May 2019. A copy of the latest audited accounts for 2018-19 are enclosed within Appendix 1 (please note at time of delivery these are not signed off by Audit – any changes will be tabled). The highlights are summarised below;

Income
Total operating income for the twelve months ended 31 March 2019 was £384,205k which was 10.8% higher than the previous year mainly due to additional PSF, contract variations with commissioners and funding for the pay award.

Operating Expenses
Total operating expenses increased during 2018-19, mainly due to fixed asset impairments (£43,680k) largely linked to a modern equivalent asset review of all Trust sites using the optimal estate model, and higher staffing costs. Staffing cost increases were linked to the pay award, a provision for annual leave pay, flexible staffing usage and contract variations. Excluding these items operating expenses remained broadly consistent with 2017-18.

Operating Surplus
The Trust achieved an operating surplus of £58,365k. Excluding non-recurring items (impairments, the benefit on unwinding borrowings following termination of PFI arrangements, and bonus PSF amounts received); the Trust achieved an operating surplus of £10,213k; which was higher than planned mainly due to additional contract income with commissioners.

Statement of Financial Position
Property, Plant and Equipment have decreased over the year by £36,658k, as follows:

	£000
Property, Plant and Equipment NBV 31 March 2018	**170,694**
Additions	18,650
Depreciation	-4,346
Impairments - Operating expenses	-43,680
Impairments - Revaluation reserve	-7,267
Reclassifications	-15
Property, Plant and Equipment NBV 31 March 2019	**134,036**

Cash at bank and in hand has increased by £14,313k to £72,728k. The increase in cash is mainly due the underlying operating surplus supporting the in year capital investment, and working capital variations.

3.2 Items of note in the accounts

There are items of special note in the accounts for 2018-19 which have been discussed with the Trust's auditors.

- The valuation movements of £50,947k, particularly the MEA valuation based on an optimal estate.
- The Trust has received £34,288k of incentivised sustainability and transformation fund income from NHS Improvement due to an agreed increase to its control total during the financial year, and its surplus in excess of its revised control total.
- Accounting policies have been updated in line with the NHSI template for accounts following the release of IFRS 9 and 15.

3.3 Explanations to some notes in the accounts

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

- After the main statements in the accounts there are notes on accounting policy (commencing page 5) which describe the basis on which the accounts have been completed. It summarises the methodology used and highlights any change in policy from last year.
- The supporting note to property, plant and equipment (note 12.1) shows a column headed 'assets under construction' this relates to schemes in the capital programme that were not completed at 31 March 2019 and in line with capital accounting policy these cannot be capitalised. The £23,075k at the end of 2018-19 related largely to developments at York and Roseberry Park.
- The 'financed by' section of the statement of financial position is predominately supported by the Statement of Changes in Taxpayers' Equity (page 3) and details the changes in the year.
- Details of the Trusts PFI schemes in operation are shown under note 36, page 27.

3.4 Annual Governance Statement

The Annual Governance Statement included within item 13 of the agenda has been reviewed by Mazars LLP and the Audit Committee.

3.5 Annual Report

The disclosure to auditors' statement is included within the annual report (item 13(1)). This disclosure states the Board of Directors confirm as far as they are aware, there is no relevant information of which the Trust's auditors are unaware.

3.6 Going Concern

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

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

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

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

4. IMPLICATIONS

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

4.2 The Trust is required within the terms of its authorisation as a Foundation Trust to submit accounts to Parliament by 25 June 2019.

5. RISKS

5.1 There are no risks associated with this paper.

6. CONCLUSION

6.1 The Trust has prepared accounts in line with the requirements of NHSI and the Group Accounting Manual, with the audit process only making minor changes from the accounts submitted on the 23 April 2019.

7. RECOMMENDATIONS

7.1 The Board of Directors is requested to adopt the accounts and authorise the auditors to submit them as the audited accounts of the Trust for the period ended 31 March 2019 to NHS Improvement.

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

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

Patrick McGahon
Director of Finance and Information

Associated Papers: Audit Committee item 14 (9th May 2019)

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**21st May 2019**
TITLE:	**Annual Self-Certifications**
REPORT OF:	**Phil Bellas, Trust Secretary/Patrick McGahon, Director of Finance and Information**
REPORT FOR:	**Decision**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their 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 seeks the Board's approval to sign off of the annual certificates required by NHS Improvement as follows:

(1) The Certificate on "Systems for Compliance with Licence Conditions" – Licence Condition G6 (3).
(2) The Corporate Governance Statement.
(3) The Certificate on the "Training of Governors".
(4) The Certificate on "The Availability of Resources" - Licence Condition CoS7 (3).

The Audit Committee, following an assurance review, has recommended that the Board should confirm and authorise the signing off the above certificates.

The Board is asked to approve the recommendations of the Audit Committee subject to no material issues being raised by the Council of Governors at its meeting to be held on 22nd May 2019.

Recommendations:

To confirm and authorise the signing off of the annual certificates, as set out in this report, subject to no material issues being raised by the Council of Governors.

MEETING OF:	Board of Directors
DATE:	21st May 2019
TITLE:	Annual Self-Certifications

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek sign off of the annual certificates required by NHS Improvement (NHSI).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Board Members will be aware that NHSI requires the Boards of Foundation Trusts to self-certify, annually, the following certificates:

(a) The Certificate on “Systems for Compliance with Licence Conditions” – Licence Condition G6 (3).

(b) The Corporate Governance Statement.

(c) The Certificate on the “Training of Governors”.

(d) The Certificate on “The Availability of Resources - Licence Condition CoS7 (3).

2.2 At its meeting held on 9th May 2019 the Audit Committee undertook an assurance review and its recommendations are set out in section 3 below.

(Note: The assurances supporting the sign off of the certificates, as amended in response to the Audit Committee’s discussions, are available on the Diligent system or on request).

2.3 The Board’s position on the confirmation of the certificates will be subject to review by the Council of Governors, in accordance with NHSI guidance, at its meeting to be held on 22nd May 2019.

2.4 The signed certificates are not required to be submitted to NHS Improvement; however, the regulator may undertake spot audits to test that Foundation Trusts have carried out the self-certification process.

3. KEY ISSUES:

3.1 The Audit Committee has recommended the confirmation and signing off of:

(a) The Certificate on Systems for Compliance with Licence Conditions in the following form:
“Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.”

The Board is asked to note that a signed copy of the certificate is required to be published on the Trust's website by 30th June 2019.

(b) The Corporate Governance Statement as attached as Annex 1 to this report.

(c) The Certificate on the Training of Governors in the following form: "*The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in S.151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.*"

(d) The Certificate on the Availability of Resources as set out in Annex 2 to this report.

4. IMPLICATIONS:

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

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

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are risks that, if following testing, NHS Improvement does not consider that the Trust's approach to self-certification is sufficiently robust it would consider this to be a breach of the Licence and take appropriate enforcement action.

6. CONCLUSIONS:

6.1 The annual self-certifications are required by NHS Improvement. The responses agreed by the Board may be used by the regulator to determine its approach to oversight of the Trust.

7. RECOMMENDATIONS

The Board is recommended to:

(1) Confirm the following certificates:
- (a) The Certificate on Systems for Compliance with Licence Conditions.
- (b) The Corporate Governance Statement as set out in Annex 1 to this report.
- (c) The Certificate on the "Training of Governors".
- (d) The Certificate on the Availability of Resources as set out in Annex 2 to this report.

(2) Authorise the signing off of the certificates subject to no material issues being raised by the Council of Governors at its meeting to be held on 22nd May 2019.

Phil Bellas, Trust Secretary

Background Papers: The Trust's Provider Licence

Annex 1

Corporate Governance Statement (May 2019)

	Corporate Governance Statement Component	Risks & Mitigating Actions	Response (Confirmed/Not Confirmed)
1	The Board is satisfied that Tees, Esk & Wear Valleys NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	The Trust has identified variations in the understanding, and inconsistent provision, of "assurance" in certain areas The following actions are being taken in response: ▪ The Board is due to further discuss the operation of the "Three Lines of Defence" model in the Trust at a Seminar in July 2019. ▪ Assurance mapping will be undertaken during 2019/20 with a significant number of days allocated in the Internal Audit Operational Plan to support the approach ▪ Discussions are being held on the meaning and application of assurance through the leadership and management networks and the CQC compliance group ▪ A review of the standard agenda of LMGBs, QuAGs and SDGs has been undertaken to improve compliance	Confirmed
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	None	Confirmed
3	The Board is satisfied that Tees, Esk and Wear Valleys NHS Foundation Trust has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for	None	Confirmed

	committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.		
4	The Board is satisfied that Tees, Esk and Wear Valleys NHS Foundation Trust has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going	None	Confirmed

	concern; (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements		
5	The Board is satisfied that the systems and/or processes referred to in (4) above should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) The Board's planning and decision-making processes take timely and	None	Confirmed

	appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That it receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That Tees, Esk & Wear Valleys NHS Foundation Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Tees, Esk & Wear Valleys NHS Foundation Trust including, but not restricted to, systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		
6	The Board is satisfied that there are systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to	The Trust has recognised that difficulties in recruiting and retaining sufficient staff in all its Localities and at all times could impact on its ability to provide high quality care. This is being addressed through the Right Staffing	Confirmed

	ensure compliance with the conditions of its NHS provider licence.	Business Plan Priority The Trust has also undertaken the NHSI agency review process and has a detailed action plan in place to reduce reliance on temporary staffing	

Annex 2

Continuity of services condition 7 – Availability of Resources (FTs designated CRS only)

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	**Confirmed**
After making enquires the Directors of the licensee have a reasonable expectation, subject to what is explained below, that the licensee with have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the licensee to provide Commissioner Requested Services.	
In the opinion of the Directors of the Licensee, the licensee with not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration
In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

(e.g. key risks to deliver of CRS, assets or subcontractors required to deliver CRS, etc)

- The Trust's approved Business Plan.
- The contracts agreed and signed off with all Commissioners as part of the planning round.
- The budget for 2019/20, signed off by the Board, including the capital programme and CRES programme (based on quality assurance processes) which is planned to achieve a surplus, which will ensure compliance with the Control Total agreed with NHSI, and a Use of Resources rating of 2.
- The assurances provided in determining that the Trust will remain a "going concern" during 2019/20 (March 2019).
- The Trust's segment 1 position reflecting its "good" CQC rating and strong financial and operational performance.
- Board oversight supported by a reporting framework covering, finance, quality and staffing.
- The progress being made on the Trust's strategic priorities.

Item 15

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**21 May 2019**
TITLE:	**Finance Report for Period 1 April 2019 to 30 April 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 30 April 2019 is a deficit of £56k, representing 0.19% of the Trust's turnover and is £188k behind the NHSI plan.

Performance Against Plan – year to date (3.2)

	Variance £000	**Monthly Movement £000**	**Movement**
The Trust is currently £188k **behind** its year to date financial plan.	188	188	↓

Cash Releasing Efficiency Savings (CRES) (3.3)

	CRES Type	**Annual Variance £000**	**Movement**
Identified CRES schemes for the financial year are forecast to be £744k **ahead of** financial plan.	Recurrent	-845	↑
	Non recurrent	101	↓
	Target	0	
	Variance	-744	↑

	CRES Type	**Annual Variance £000**	**Movement**
Identified CRES schemes for the rolling 3 year period were £8,969k **behind** the £20,565k CRES target.	Recurrent	8,969	↑

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

Capital (3.4)

	Variance £000	Monthly Movement £000	Movement
The Trust is £194k **ahead of** its capital plan.	194	194	↓

Expenditure against the capital programme to 30 April 2019 is £3,053k and is £194k ahead of plan due to the York and Selby inpatient facility being slightly ahead of its expenditure profile. This scheme is expected to be in line with plan upon completion.

Workforce (3.5)

	Variance £000	Monthly Movement £000	Movement
The Trust is £420k (76%) **in excess** of its agency cap.	420	420	↓

Agency expenditure continues to be high in April across all localities. Nursing (44%), Medical (32%) and Admin (17%) account for the majority of agency expenditure, which is used to support vacancies and enhanced observations with complex clients. A plan is being implemented to reduce the level of agency spend following a 10 week review based upon the NHSI diagnostic.

Use of Resources Risk Rating (UoRR) (3.7)

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

The UoRR for the Trust is assessed as 3 for the period ending 30 April 2019 and is in line with plan (Table 4). The planned rating of 3 arises due to a loan repayment of £1.5m made in April 2019 being measured against one month's income and expenditure.

However, in addition the Trust is also behind its income and expenditure target (£188k) and agency expenditure continues to exceed the NHSI cap by 76% (2018/19 – 65%) and is therefore also rated as a 4. Should this position not improve then the Trust will not achieve its planned 2 rating. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

Recommendations:

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

MEETING OF:	Board of Directors
DATE:	21 May 2019
TITLE:	Finance Report for Period 1 April 2018 to 30 April 2019

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for 1 April 2018 to 30 April 2019.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

3.1 Key Performance Indicators

The Trust is behind plan against the control total set by NHSI.

The UoRR for the Trust is assessed as 3 for the period ending 30 April 2019 and is in line with plan. The planned rating of 3 arises due to a loan repayment of £1.5m made in April 2019 being measured against one month's income and expenditure. However, in addition the Trust is also behind its income and expenditure target by £188k and agency expenditure continues to exceed the NHSI cap by 76% and is therefore also rated as a 4.

3.2 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 30 April 2019 is a deficit of £56k, representing 0.19% of the Trust's turnover and is £188k behind the NHSI plan. This is summarised in table 1 below:

Table 1	Annual Plan £000	Year to Date Plan £000	Year to Date Actual £000	YTD Variance £000	Prior Month Variance £000
Income From Activities	(345,433)	(28,522)	(28,618)	(96)	0
Other Operating Income	(14,092)	(1,250)	(1,227)	23	0
Total Income	**(359,525)**	**(29,772)**	**(29,846)**	**(74)**	**0**
Pay Expenditure	274,567	23,902	24,280	379	0
Non Pay Expenditure	70,554	4,995	4,911	(83)	0
Depreciation and Financing	8,920	744	710	(34)	0
Variance from plan	**(5,485)**	**(132)**	**56**	**188**	**0**

3.3 Cash Releasing Efficiency Savings (CRES)

The Trust's performance against the 2019/20 CRES target is shown in Table 2 below. The Trust is anticipating being ahead of plan (£744k) at the financial year end and continues to identify schemes for future years.

Table 2	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the financial year are forecast to be £744k ahead of financial plan.	Recurrent	-845	↑
	Non recurrent	101	↓
	Target	0	
	Variance	-744	↑

3.4 Capital

Expenditure against the capital programme to 30 April 2019 is £3,053k and is £194k ahead of plan due to the York and Selby inpatient facility being slightly ahead of its expenditure profile. This scheme is expected to be in line with plan upon completion.

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	Nov	Dec	Jan	Feb	Mar	April
Establishment (a) (90%-95%)	92.38%	93.96%	93.37%	93.03%	92.24%	92.38%	90.66%
Agency (b)	1.00%	3.40%	3.40%	3.44%	3.52%	3.51%	4.07%
Overtime (c)	1.00%	1.07%	1.10%	1.02%	1.03%	1.02%	1.20%
Bank & ASH (flexed against establishment) (100%-a-b-c)	5.62%	3.22%	3.20%	3.13%	3.09%	2.99%	3.10%
Total	**100.00%**	**101.65%**	**101.01%**	**100.62%**	**99.88%**	**99.98%**	**99.03%**

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 April 2019 the tolerance for Bank and ASH is 7.34% of pay budgets.

NHS Improvement monitors agency expenditure against a capped target. Agency expenditure at 30 April 2019 is £972k which is £420k (76%) in excess of the agreed year to date capped target of £552k. Nursing and Medical agency expenditure accounts for 76% of total agency expenditure, and is used to support vacancies and enhanced observations with complex clients. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

3.6 Cash

Total cash at 30 April 2019 is £71,244k, and is £363k behind the planned working capital run rate.

3.7 Use of Resources Risk Rating (UoRR) and Indicators

3.7.1 The UoRR for the Trust is assessed as 3 for the period ending 30 April 2019 and is in line with plan (Table 4). The planned rating of 3 arises due to a loan repayment of £1.5m made in April 2019 being measured against one month's income and expenditure. The UoRR is planned to improve throughout the financial year to a 2 rating.

However, in addition the Trust is also behind its income and expenditure target (£188k) and agency expenditure continues to exceed the NHSI cap by 76% (2018/19 – 65%) and is therefore rated as a 4. Should this position not improve then the Trust will not achieve its planned 2 rating. 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 30 April 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	0.32x	4	0.43x	4	0
Liquidity	68.70 days	1	34.84 days	1	0
I&E margin	-0.2%	3	0.4%	2	-1
I&E margin distance from plan	-0.6%	2	0.0%	1	-1
Agency expenditure	£972k	4	£552k	1	-3
Overall Use of Resource Rating		**3**		**3**	

3.7.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 0.32x (can cover debt payments due 0.32 times), which is in line with plan. The deterioration in this rating from March 2019 arises due to a loan repayment made during in April 2019.

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 68.7 days; this is ahead of plan, but still rated as a 1.

3.7.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of -0.2%, which is behind plan and rated as a 3.

3.7.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding PSF income. The Trust I&E margin distance from plan is -0.6% which is behind plan and rated as a 2.

The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is 76% higher than the capped target and is rated as a 4.

The margins on UoRR are as follows:

- Capital service cover - to improve to a 3 a surplus increase of £2,346k is required.
- Liquidity - to reduce to a 2 a working capital decrease of £32,996k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £358k is required.
- I&E margin distance from plan – to reduce to a 2 an operating surplus decrease of £56k is required.
- Agency Cap rating – to improve to a 3 a reduction in agency expenditure of £144k is required.

4. IMPLICATIONS:

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

5. RISKS:

5.1 There are no risks arising from the implications identified in section 4.

6. CONCLUSIONS:

6.1 For the period ending 30 April 2019 the Trust is £188k behind its planned control total surplus (£132k) submitted to NHSI.

6.2 The amount of CRES identified for the financial year is ahead of plan and the Trust continues to identify schemes to ensure full delivery of recurrent CRES requirements for the 3 year rolling programme.

6.3 The UoRR for the Trust is assessed as 3 for the period ending 30 April 2019 and is in line with plan (Table 4). The planned rating of 3 arises due to a loan repayment of £1.5m made in April 2019 being measured against one month's income and expenditure. The UoRR is planned to improve throughout the financial year to a 2 rating.

7. RECOMMENDATIONS:

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

Patrick McGahon
Director of Finance and Information

ITEM 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**21st May, 2019**
TITLE:	**Board Dashboard as at 30th April 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:

This is the first dashboard report of 2019/20 and includes the two new indicators agreed by the Board. The targets have also been amended, as appropriate, in line with the agreement reached at the Board meeting held in March 2019.

As at the end of April 2019, 4 (24%) of the indicators reported are not achieving the expected levels and are red across three of the four domains excluding the Quality domain. This is a slight improvement on the 5 that were reported as at the end of March 2019. In addition there are 6 KPIs (35%) 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 10 indicators that are either red or amber 1 is showing an improving trend over the previous 3 months.

The position in April 2019 is much improved compared to that in April 2018 where 7 KPI were rated as red.

In terms of the Single Oversight Framework targets the Trust achieved all the operational targets in April 2019 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:	21st May, 2019
TITLE:	Board Dashboard as at 30th April 2019

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 30 April 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:

- This is the first dashboard report of 2019/20 and includes the two new indicators agreed by the Board:
  - %age of Serious Incidents which are found to have a root or contributory cause (replacing the previous indicator of Number of unexpected deaths classified as a Serious Incident per 10,000 open cases)
  - Vacancy Rate (Healthcare Professionals only) (replacing the previous indicator of Vacancy Fill Rate).

  The targets have also been amended, as appropriate, in line with the agreement reached at the Board meeting held in March 2019.

- As at the end of April 2019, 4 (24%) of the indicators reported are not achieving the expected levels and are red across three of the four domains excluding the Quality domain. This is a slight improvement on the 5 that were reported as at the end of March 2019. In addition there are 6 KPIs (35%) 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 10 indicators that are either red or amber 1 is showing an improving trend over the previous 3 months.

  The position in April 2019 is much improved compared to that in April 2018 where 7 KPI were rated as red.

- In terms of the Single Oversight Framework targets the Trust achieved all the operational targets in April 2019 however there was variation in terms of delivery at CCG level. In terms of the position specific issues are as follows:
  - Access to Early Intervention in Psychosis – we failed to achieve the target in 3 CCGs: Darlington CCG, Scarborough and Ryedale CCG and Vale of York CCG. 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 addition staff sickness and vacancies have contributed to the position. 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.
- IAPT Waiting Time to Treatment within 6 weeks – This target was not achieved in the Scarborough and Ryedale CCG service. This is due to the high number of severe and increasingly complex cases they receive and a number of vacancies within the team. Individual performance management with staff is undertaken monthly and there are clinical skills groups held as well as daily team huddles and weekly leadership huddles.
- Inappropriate Out of Area Occupied Bed Days – the target was not achieved in 4 CCGs area (North Durham, DDES, Darlington and Scarborough and Ryedale) in April 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.

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 April 2019 but with a declining trend. There are particular areas of concern in North Yorkshire and York and Durham and Darlington AMH services. Staff issues including vacancies and sickness, together with high DNA rates are factors contributing to the position. A further area of concern is MHSOP in North Yorkshire and York linked mainly to the North Yorkshire Memory Service and plans are in place to address this.
- %age of patients reporting their experience as excellent or good (KPI 4) – Performance is worse that the target and declined in April 2019. None of the localities are achieving the target and various actions are being undertaken/discussed in order to understand the issues contributing to the position.
- Outcome Indicators (KPIs 6 and 7) – Performance against KPI 6 (HONOS) and 7 (SWEMWEBS) has deteriorated in April 2019 and is not achieving target although KPI 6 is just under the target of 60%. For KPI 6 the outlier is North Yorkshire and York which is the only locality not achieving the target. For KPI 7 Teesside is the only locality achieving the expected %age of teams achieving the benchmark improvement. The Board recently

received a briefing on the implementation of using outcomes within clinical services and the challenges associated with this.

- Activity Indicators (KPI 8-11) – Whilst we are only monitoring these indicators it can be seen that the actual levels in April 2019 are above or at similar levels to those in April 2018. Three of the four indicators have shown a reduction compared to March which may be accounted for by the two bank holidays associated with Easter.
- Bed Occupancy (KPI 12) – There has been an improvement in April 2019 with the actual level of bed occupancy achieving the target of 90% and being much lower than that in April 2018. This is very positive given that there are now less beds open than there were in April 2018 following the reprovision of services at the Friarage. KPI 13 (Number of patients occupying a bed with a LOS >90 days) is also achieving target and work continues to ensure that people are discharged in a timely, but clinically safe, manner.
- Compliance with Mandatory Training (KPI 18) – the target of 92% was achieved in April 2019 which is the sixth month in a row that over 92% of our workforce has completed all the necessary mandatory training for their role, thus contributing to the delivery of safe and effective care.
- Sickness Absence Rate (KPI 19) – the Trust continues not to achieve target although did show an improvement in the figure reported in April 2019 (March sickness). We have now received the views of Business Disability Forum on our revised procedure and whilst generally positive the Trust is currently considering their feedback prior to finalising the procedure.
- Financial Targets (KPI 19 and 20) – Whilst the Trust did deliver a surplus of £56k in April 2019 this was £188k behind the planned position for the month. Further details are provided within the Finance report. In terms of KPI 20 CRES delivery the target for the month was achieved which is a much improved position compared to April 2018.

2.4 Data Quality Assessment.

The Data Quality Assessment for the new dashboard indicators is currently being completed and will be include in the report that comes to the June Board meeting.

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

	April 2019				April 2019 To April 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%	85.42%			90.00%	85.42%		90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral	60.00%	51.62%			60.00%	51.62%		60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	2,245.00	1,077.00			2,245.00	1,077.00		2,245.00
4) Percentage of patients surveyed reporting their overall experience as excellent or good	94.00%	91.19%			94.00%	91.19%		94.00%
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding	32.00%	18.18%			32.00%	18.18%		32.00%
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	60.00%	59.57%			67.25%	59.57%		60.00%
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	65.00%	62.50%			65.00%	62.50%		65.00%

Activity

	April 2019				April 2019 To April 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
8) Number of new unique patients referred		6,920.00				6,920.00		
9) The number of new unique patients referred with an assessment completed		4,226.00				4,226.00		
10) Number of new unique patients referred and taken on for treatment		1,359.00				1,359.00		
11) Number unique patients referred who received treatment and were discharged		2,281.00				2,281.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	90.00%	89.49%			90.00%	89.49%		90.00%

Trust Dashboard Summary for TRUST

	April 2019				April 2019 To April 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)	61.00	48.00			61.00	48.00		61.00
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.00%	28.40%			23.00%	28.40%		23.00%

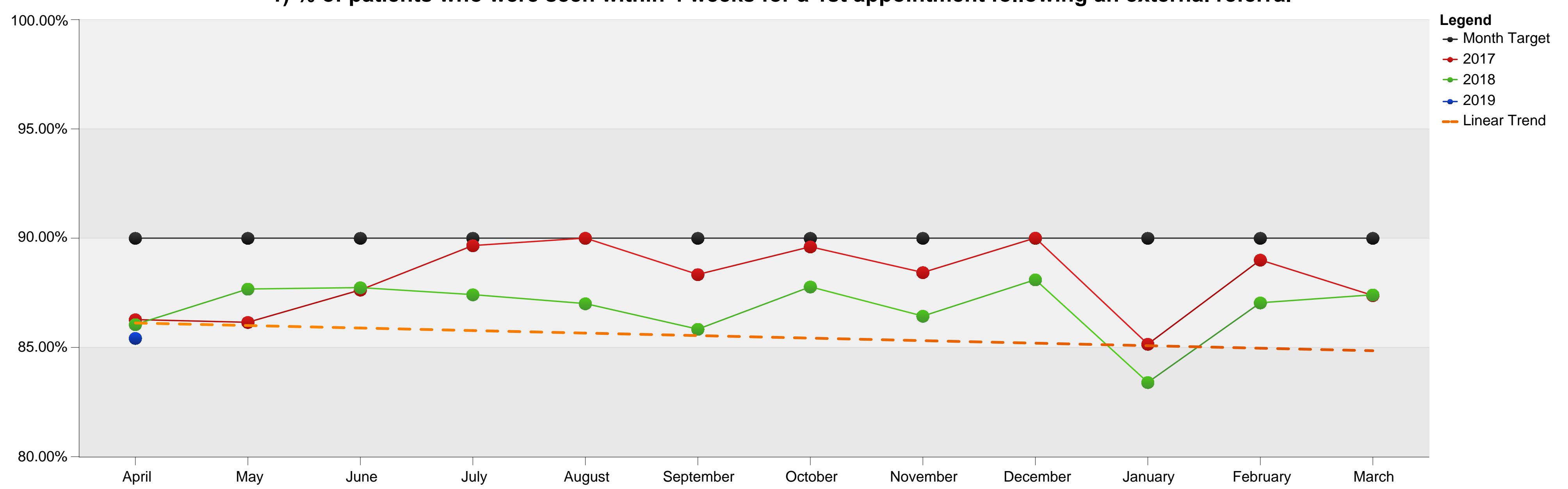
Workforce

	April 2019				April 2019 To April 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
15) Vacancy Rate (Healthcare Professionals only)	6.50%	7.63%			6.50%	7.63%		6.50%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	90.81%			95.00%	90.81%		95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	93.54%			92.00%	93.54%		92.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	5.05%			4.50%	5.05%		4.50%

Money

	April 2019				April 2019 To April 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-132,000.00	56,090.00			-132,000.00	56,090.00		-5,485,000.00
20) CRES delivery	824,916.00	912,000.00			824,916.00	912,000.00		9,898,992.00
21) Cash against plan	52,027,650.00	71,244,207.00			52,027,650.00	71,244,207.00		12,929,359.00

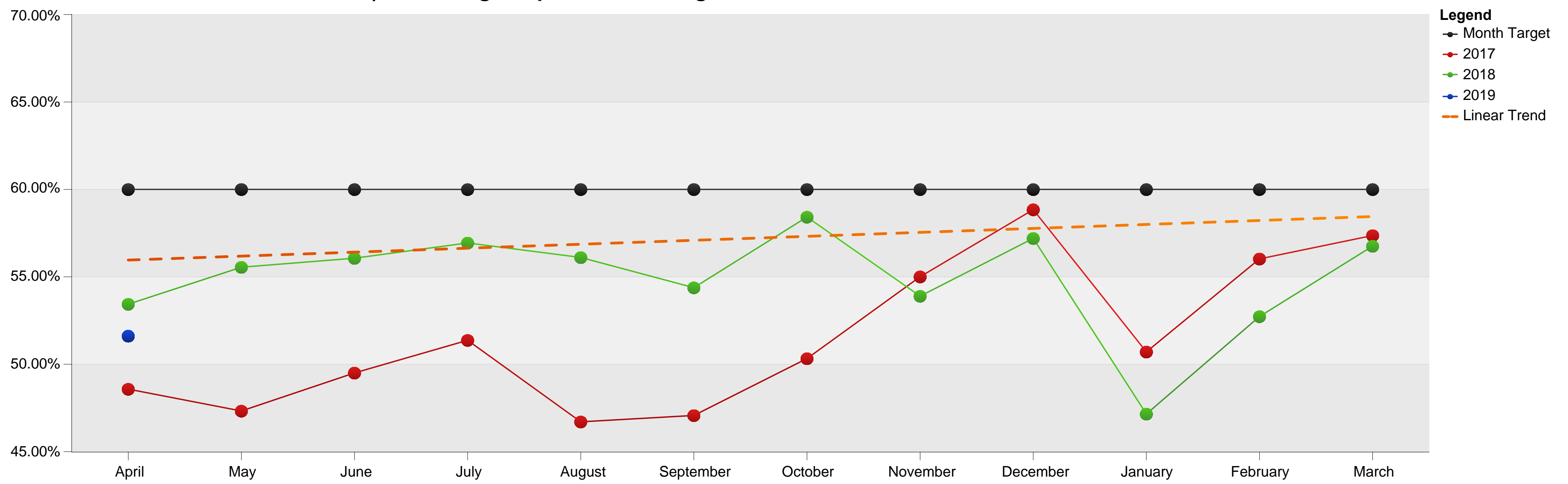
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	85.42%	85.42%	84.05%	84.05%	90.33%	90.33%	79.02%	79.02%	99.13%	99.13%		

Narrative
The position for April 2019 is 85.42% relating to 4950 patients out of 5795 who were seen within 4 weeks. This is worse than the target of 90% and a deterioration to the position reported in in March 2019. This is also the third lowest position recorded since 2017/18Areas of concern:• North Yorkshire and York AMH at 79.27% (524 of 661 patients). Performance continues to be impacted by the high DNA rate, sickness and vacancies. Agency staff are now in post as an interim measure until permanent staff are in post.• North Yorkshire and York MHSOP at 74.16%. (508 out of 685 patients) This is impacted by issues related to capacity in the memory service and plans are in place to address this.• Durham and Darlington AMH at 58.54% (288 out of 492 patients) which is a deterioration on the previous month. Concerns continue due to a sustained high number of referrals, staff sickness and vacancies and this is under investigation.

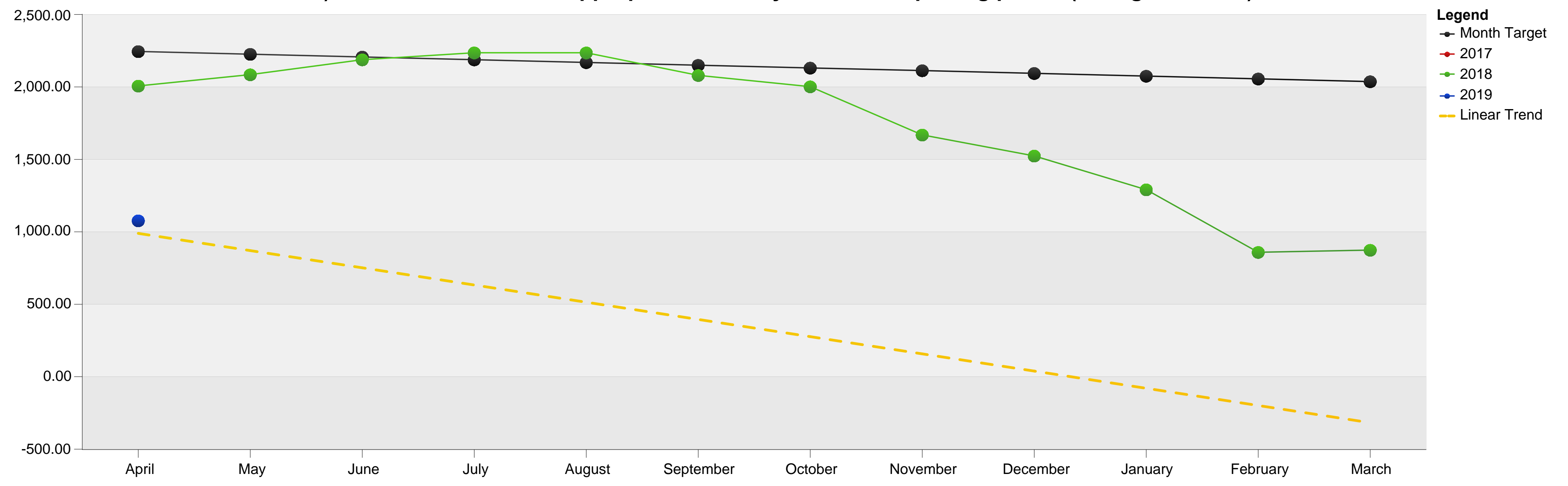
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	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	51.62%	51.62%	46.73%	46.73%	60.85%	60.85%	46.37%	46.37%	94.44%	94.44%		

Narrative
The position for April 2019 is 51.62%, which is worse than the target of 60.00% and a deterioration on the position reported in March 2019 and also on that reported in April 2018. All localities, with the exception of Forensic services and Teesside, continue to perform below target. North Yorkshire and York and Durham and Darlington both report similar positions at 46.58% and 46.73% respectively.Low performance is linked to capacity issues highlighted within the 4 weeks for first appointment KPI. However concerns about the use of appropriate intervention codes remain and further guidance is to be circulated to educate staff in the recording of this data . Improvements in performance will be reviewed at weekly locality report outs and any concerns escalated.

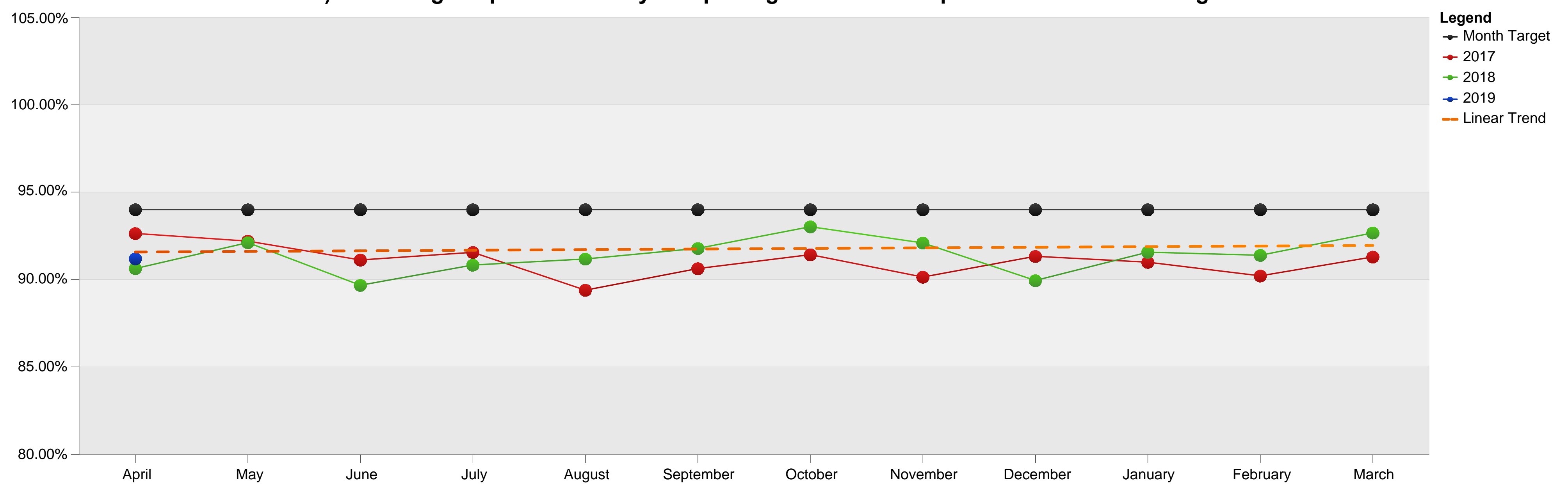
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	1,077.00	1,077.00	204.00	204.00	151.00	151.00	722.00	722.00				

Narrative
The Trust position for April 2019 is 1,077 which is an increase on the 874 recorded in March 2019 but meeting the target of 2,245 . This is also an improvement to the figure reported in April 2018 and the positive performance of the bed occupancy KPI.All localities are meeting this indicator .

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of patients surveyed reporting their overall experience as excellent or good	91.19%	91.19%	90.69%	90.69%	90.48%	90.48%	92.81%	92.81%	91.30%	91.30%		

Narrative
The Trust position for April 2019 is 91.19% which is not achieving the target of 94.00% and is a deterioration to that reported in March 2019. However this is an improvement compared to that reported in April 2018.No localities are meeting the revised target for this indicator and Teeside report the poorest position at 90.48%. This is to be addressed through the locality QUAG, which will include actions to improve the process to feedback to patient's actions taken to address their concerns.

Trust Dashboard Graphs for TRUST

40.00%
35.00%
30.00%
25.00%
20.00%
15.00%

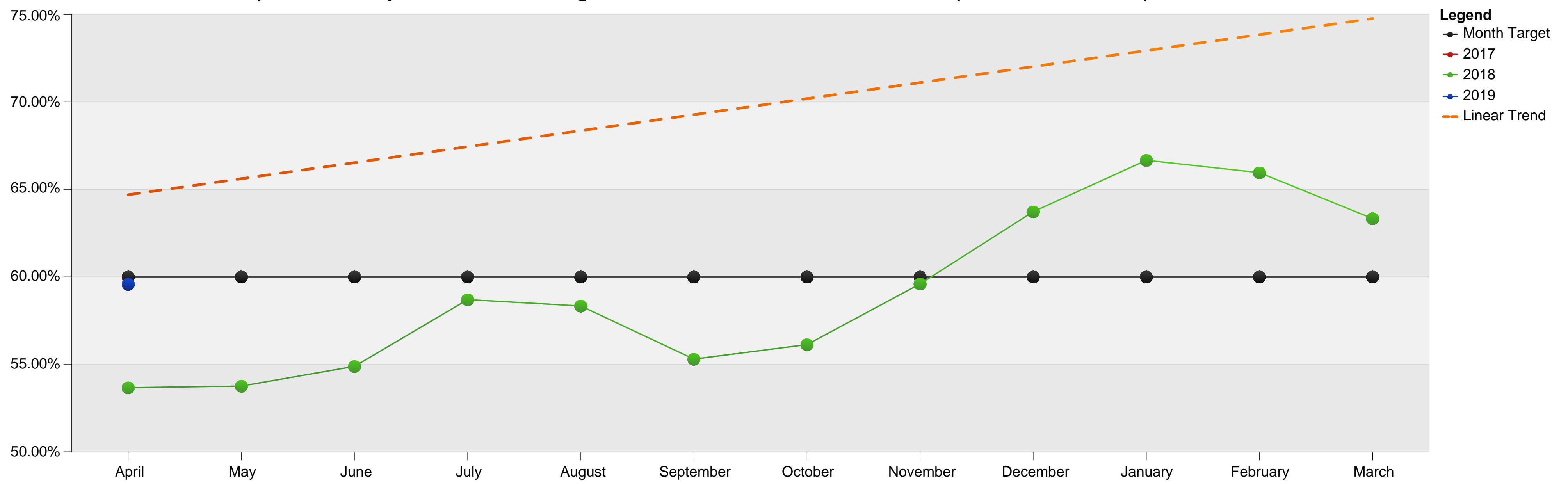
April May June July August September October November December January February March

Legend
Month Target
2017
2018
2019
Linear Trend

	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding	18.18%	18.18%	50.00%	50.00%	0.00%	0.00%	16.67%	16.67%				

Narrative
The Trust position for April 2019 is 18.18% which is meeting the target of 32% This relates to 2 serious incidents which were found to have a root cause or contributory finding in April 2019. Of the two incidents please find a breakdown by locality below:• 1 x Durham and Darlington• 1 x North Yorkshire and YorkAny themes identified by Patient Safety from these incidents are shared Trust wide through the Patient Safety Group.

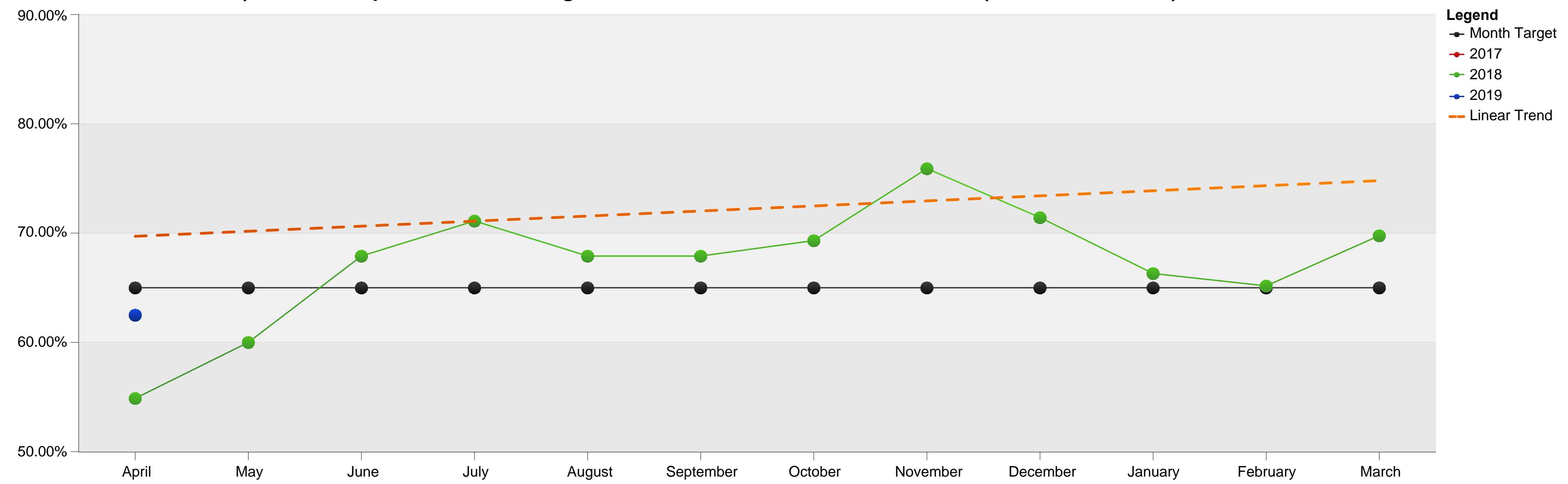
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	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	59.57%	59.57%	60.00%	60.00%	62.96%	62.96%	56.76%	56.76%				

Narrative
The Trust position for April 2019 is 59.57%, which is worse than the target of 60.00% and a deterioration on the position reported in March 2019, however an improvement to that reported in April 2018Within 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.Work continues with the services to improve understanding and support increased ownership across all specialities. Improved information has been supplied for consideration at huddles including both OMT and EMT. A trust wide speciality clinical outcomes chaired by Dr. Ruth Briel has now met twice. This group has is agreeing what clinical leaders feel is the most important thing to measure and a process for doing this, and also creating a guide to using clinical outcomes at both clinical and team level in TEWV.

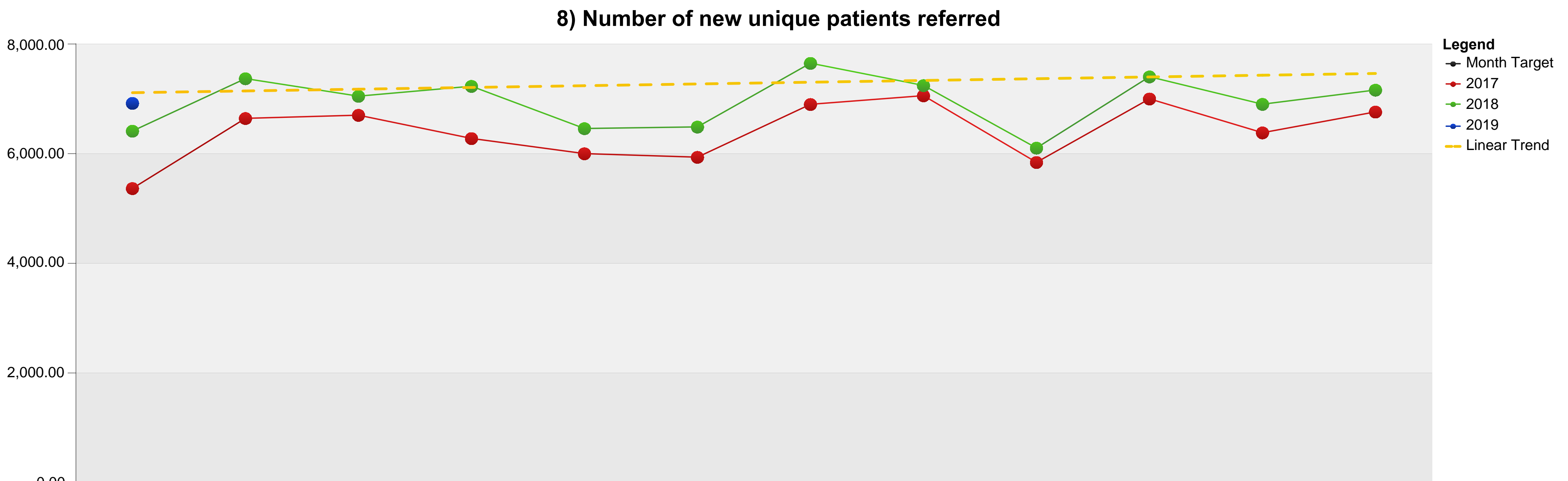
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	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	62.50%	62.50%	58.06%	58.06%	65.38%	65.38%	63.33%	63.33%				

Narrative
The Trust position for April 2019 is 62.50%, which is worse than the target of 65.00% and a deterioration on the position reported in March 2019, however an improvement on that reported in April 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 across all specialities. Improved information has been supplied for consideration at huddles including both OMT and EMT. A trust wide speciality clinical outcomes chaired by Dr. Ruth Briel has now met twice. This group is agreeing what clinical leaders feel is the most important thing to measure and a process for doing this and also creating a guide to using clinical outcomes at both clinical and team level in TEWV.

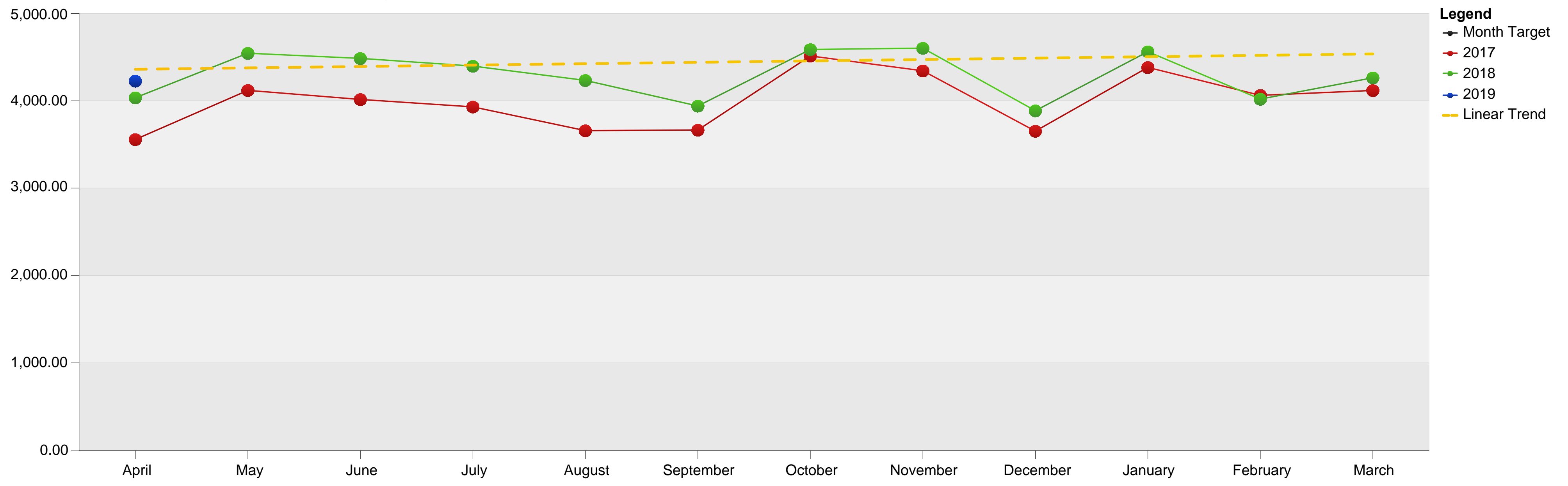
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	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	6,920.00	6,920.00	2,165.00	2,165.00	2,435.00	2,435.00	1,914.00	1,914.00	406.00	406.00		

Narrative
The Trust position for April 2019 is 6,920 which is a decrease on the position reported for March 2019. However this is the highest number of unique referrals recorded in April when compared to the same periods in 2017/18 and 2018/19. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be monitored by EMT as well as the data being reviewed by localities.

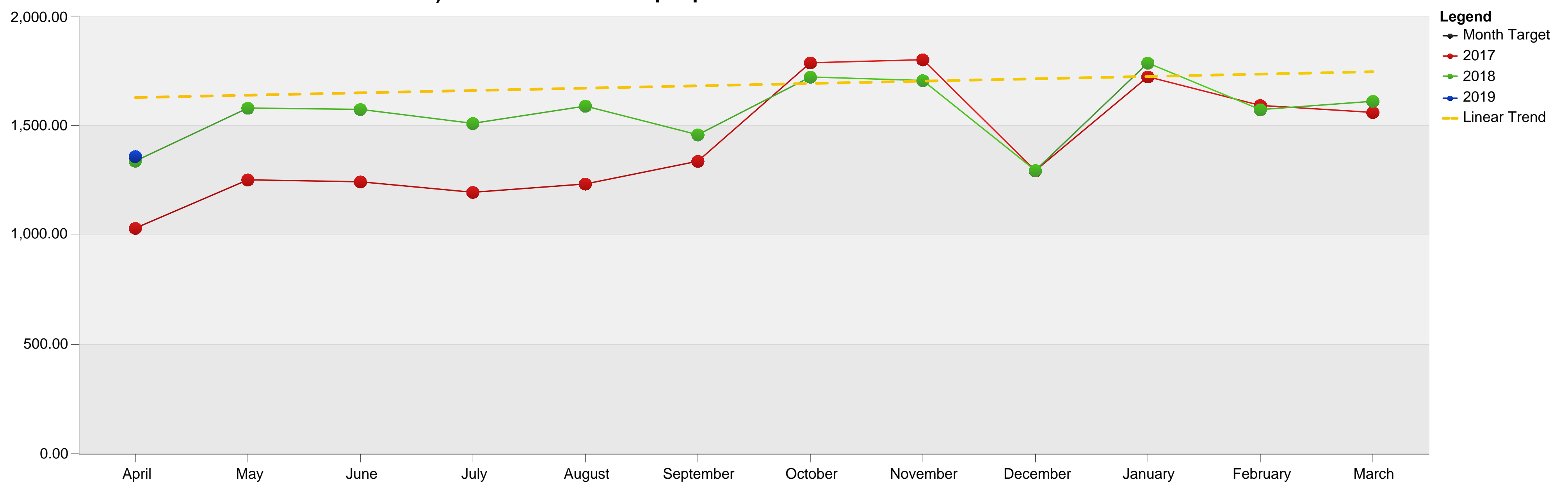
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	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	4,226.00	4,226.00	1,304.00	1,304.00	1,468.00	1,468.00	1,243.00	1,243.00	210.00	210.00		

Narrative
The Trust position for April 2019 is 4,226 which is a slight decrease on the position reported for March 2019. However this is the highest number of unique patients referred with an assessment completed recoded in April when compared to the same periods in 2017/18 and 2018/19. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be monitored by EMT as well as the data being reviewed by localities.

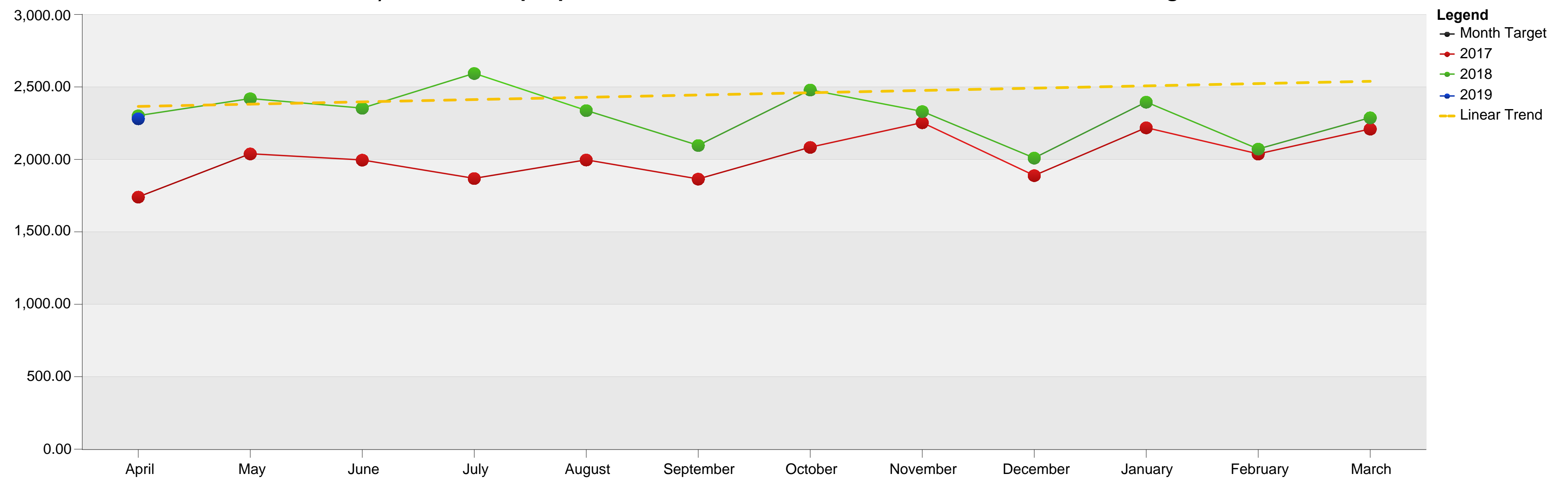
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	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	1,359.00	1,359.00	434.00	434.00	406.00	406.00	498.00	498.00	13.00	13.00		

Narrative
The Trust position for April 2019 is 1,359 which is a decrease on the position reported for March 2019 and similar to that reported in April 2018. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be monitored by EMT as well as the data being reviewed by localities.

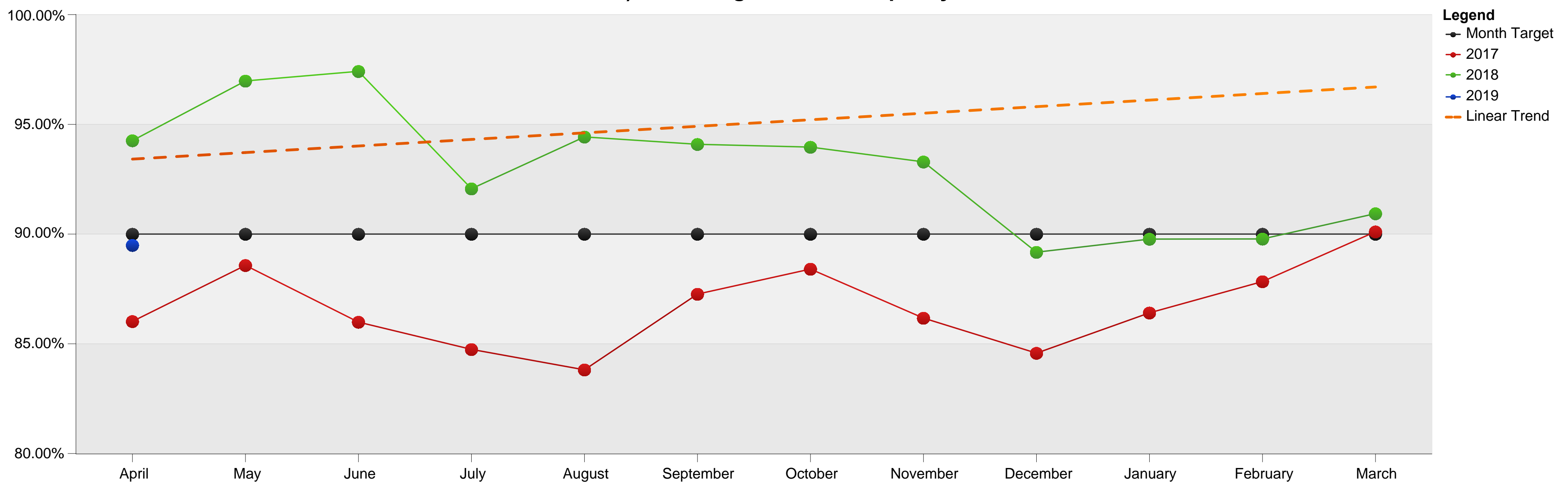
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	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	2,281.00	2,281.00	691.00	691.00	728.00	728.00	839.00	839.00	23.00	23.00		

Narrative
The Trust position for April 2019 is 2,281 which is similar to the position reported for March 2019 and April 2018. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be monitored by EMT as well as the data being reviewed by localities.

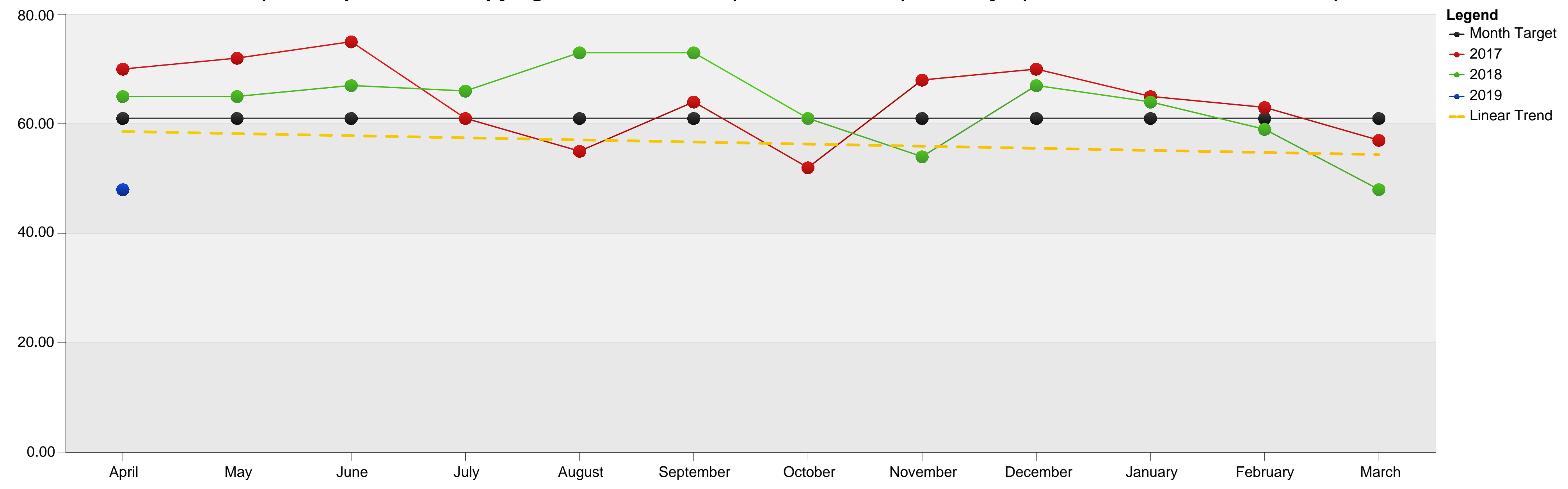
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	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)	89.49%	89.49%	93.06%	93.06%	94.01%	94.01%	82.61%	82.61%	NA	NA		

Narrative
The Trust position for April 2019 is 89.49% which is meeting target and is a slight improvement on the position reported in March 2019 and lower than that reported in April 2018. This is positive given the reduction in beds that has taken place across the Trust during 2018/19 linked to the reconfiguration of services in North Yorkshire. 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 April. All localities are not achieving target . Tees are reporting the highest bed occupancy at 94.01%. Within AMH issues relating to delayed transfers of care 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.

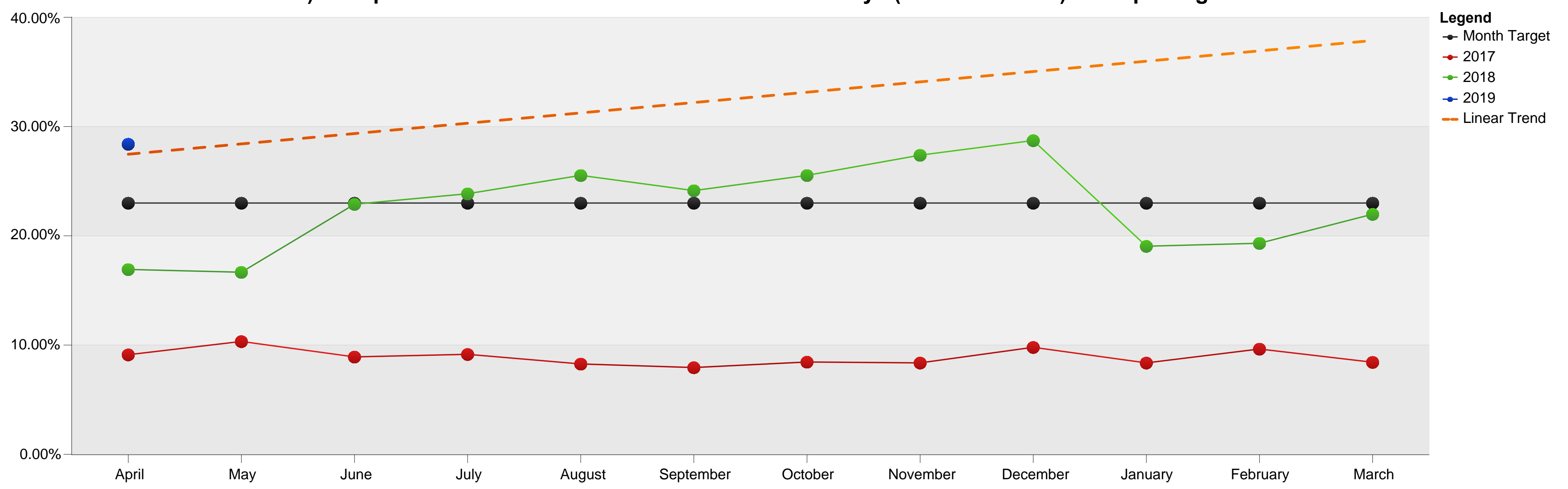
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	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	11.00	11.00	9.00	9.00	28.00	28.00				

Narrative
The Trust position for April 2019 is 48 which is meeting the target and is the same as that achieved in March 2019. This is the lowest position recorded since 2017/18.All localities are meeting target for this indicator.

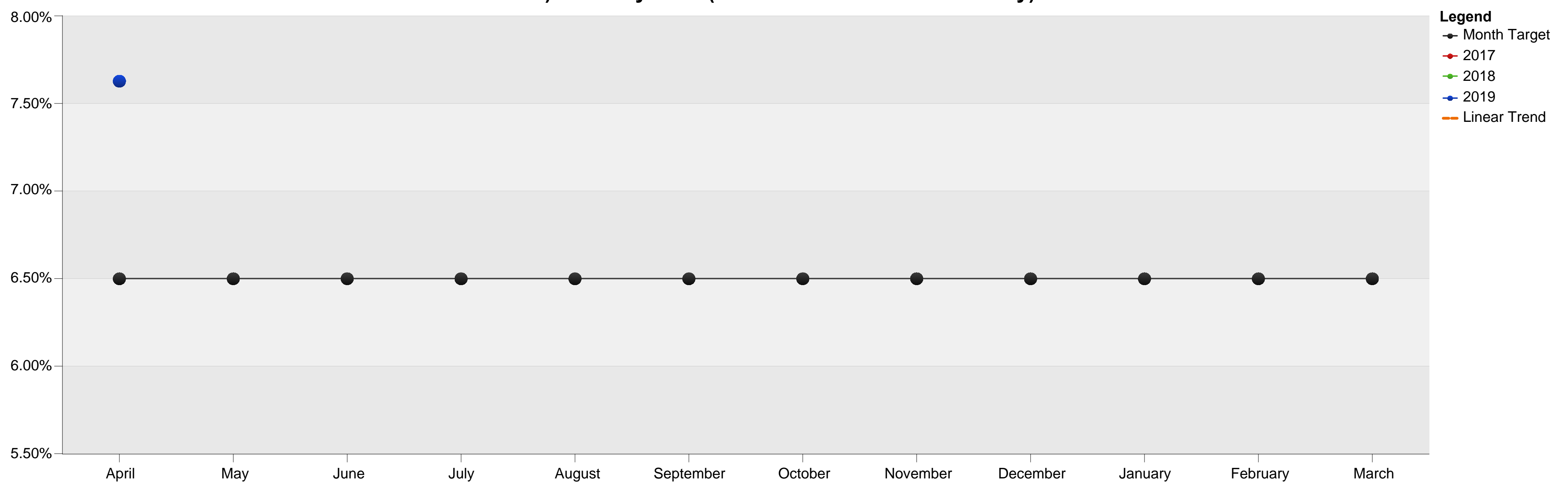
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	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	28.40%	28.40%	28.57%	28.57%	40.00%	40.00%	19.23%	19.23%				

Narrative
The Trust position ending April 2019 is 28.40%, which relates to 23 readmissions out of 81 readmissions that were within 30 days. This is not meeting the target of 23.00% and is the second worst position since 2017/18. .North Yorkshire and York are the only locality meeting target and Tees report the poorest position at 40.00%. All readmissions in Tees were clinically appropriate, however some thematic work is ongoing to understand this more to identify what, if anything, can be done to prevent these readmissions.

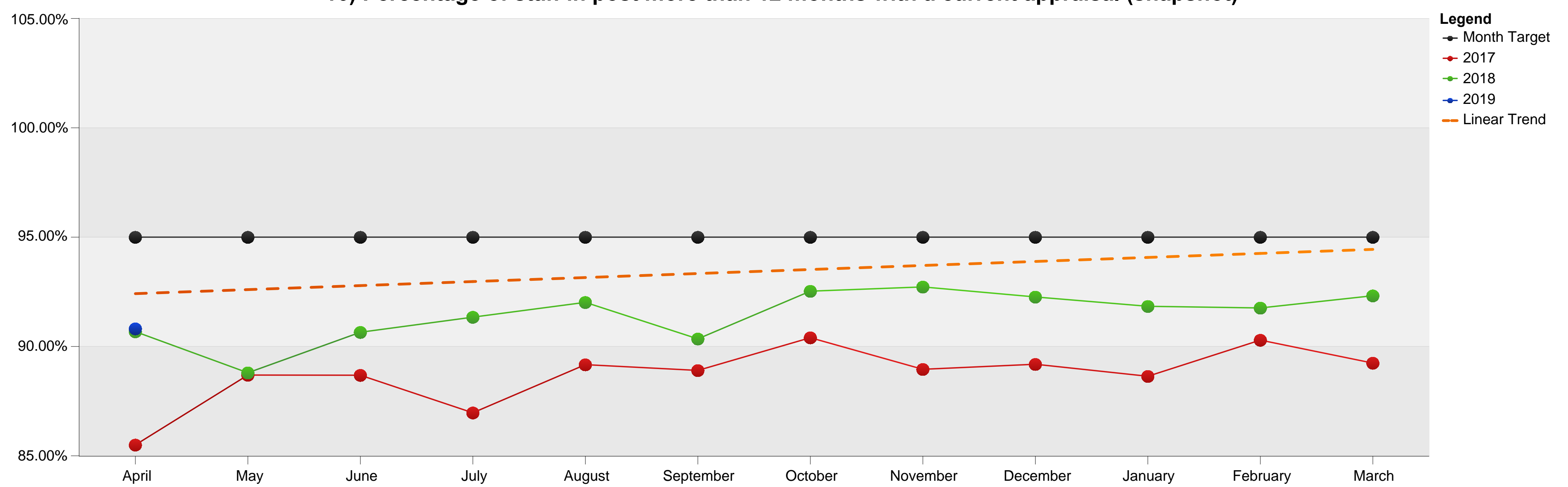
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Vacancy Rate (Healthcare Professionals only)	7.63%	7.63%	8.65%	8.65%	4.52%	4.52%	11.79%	11.79%	5.29%	5.29%		

Narrative
The position for April 2019 is 7.6 %, which equates to 266.37 wte vacancies currently being actively being recruited to. North Yorkshire and York vacancy rate is the highest at 11.8% and 28 of the vacancies have been advertised more than once. A recruitment fair was held recently which was successful in recruiting 17 registered nurses for North Yorkshire and York. Fixed term funding has been receive to support a project post to focus on marketing the Trust as an employer of choice and utilising social media more effectively to attract applicants to vacancies. This is a new target for 2019/20 therefore data relating to previous years performance is not available.

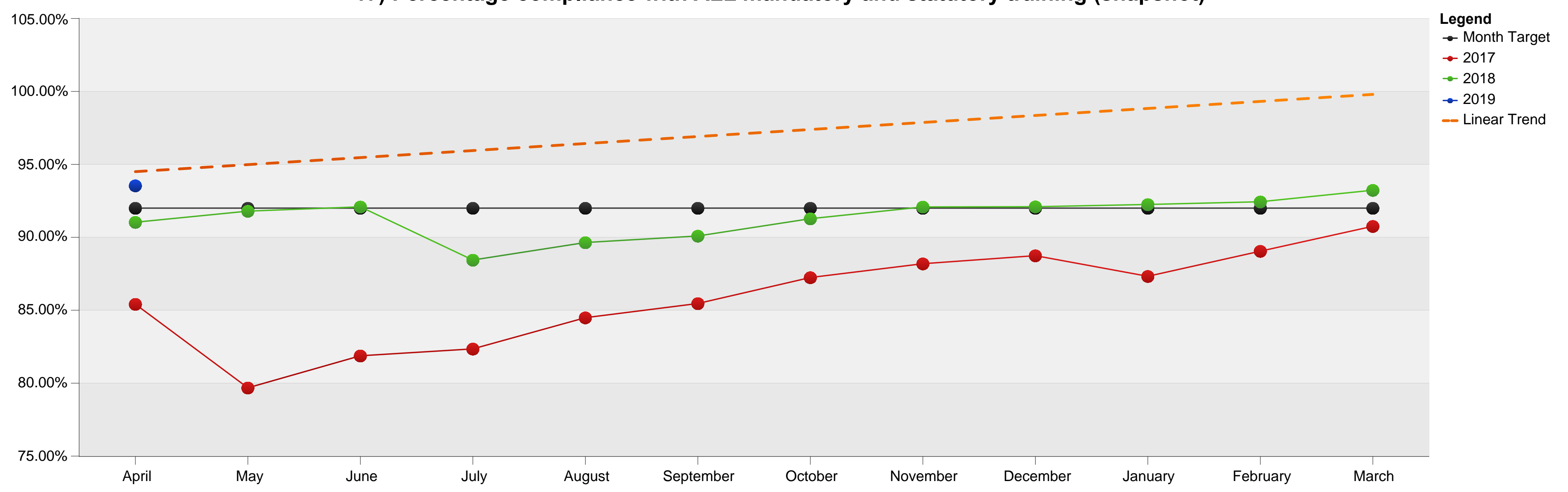
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	90.81%	90.81%	91.95%	91.95%	91.01%	91.01%	87.68%	87.68%	93.66%	93.66%		

Narrative
The Trust position for April 2019 is worse than target at 90.81%% which relates to 480 members of staff out of 5815 that do not have a current appraisal. This represents a deterioration on the position reported in March 2019 but is similar to that reported in April 2018. Forensic Services are the best performing locality at 93.66%.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. Guidance about the recording of an appraisal on the source system is being reviewed to support users in the accurate recording of appraisals to prevent data quality issues.

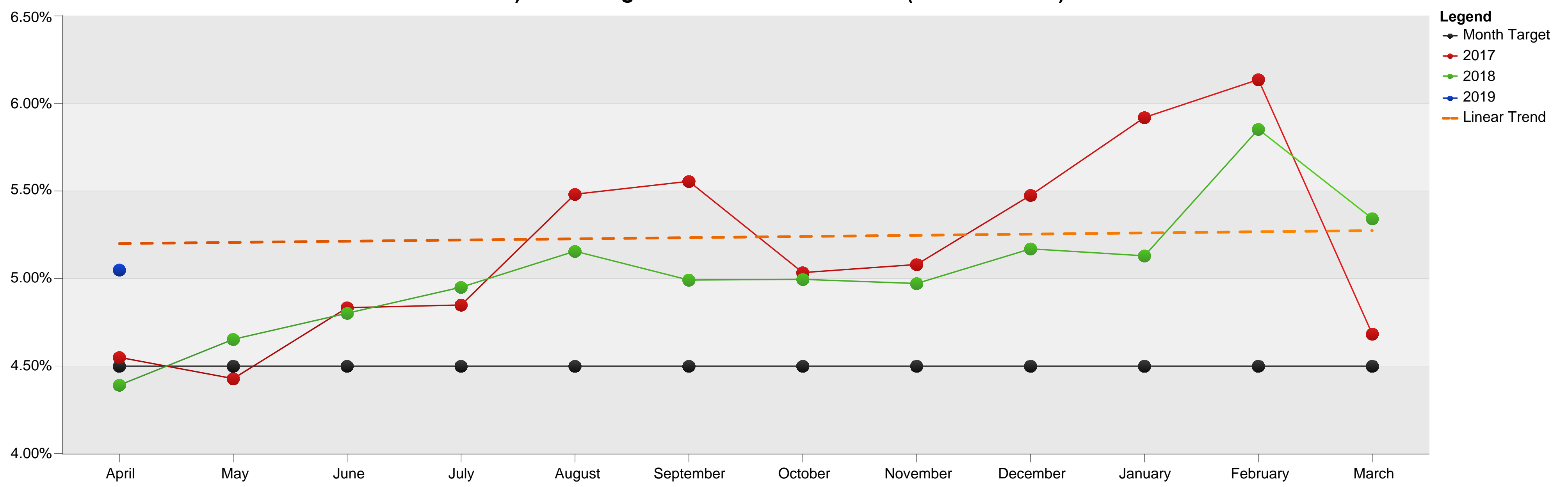
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	93.54%	93.54%	92.74%	92.74%	93.95%	93.95%	91.38%	91.38%	96.44%	96.44%		

Narrative
The position for April 2019 has slightly increased to 93.54% compared to that reported in March 2019 and is achieving target. This is the best position reported since 2017/18. All localities with the exception of North Yorkshire and York are achieving the 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.

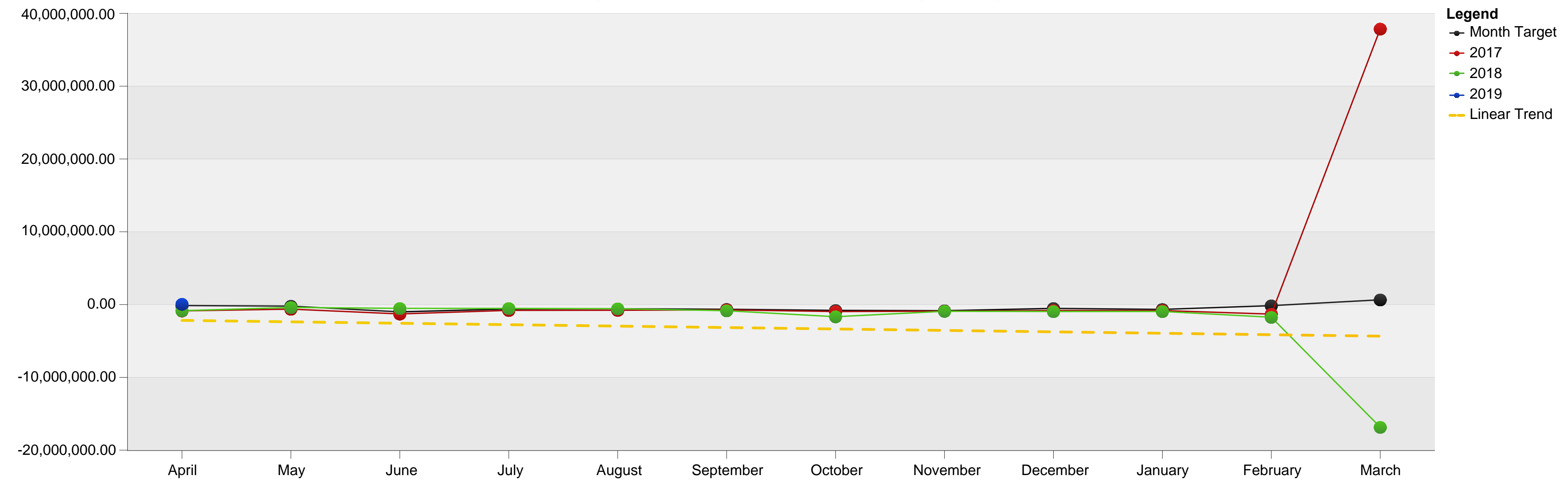
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	5.05%	5.05%	5.38%	5.38%	5.52%	5.52%	4.36%	4.36%	6.18%	6.18%		

Narrative
The Trust position reported in April relates to the March sickness level. The Trust position reported in April 2019 decreased to 5.05% which is higher than the target of 4.50%. A review of the approach to managing sickness absence has recently been concluded with a revised procedure was considered by JCC on 15th February. This has been considered by the Business Disability Forum for their views and this feedback is being considered. . Work is also underway to review the Occupational Health provision which is due for retendering in the next 12 months

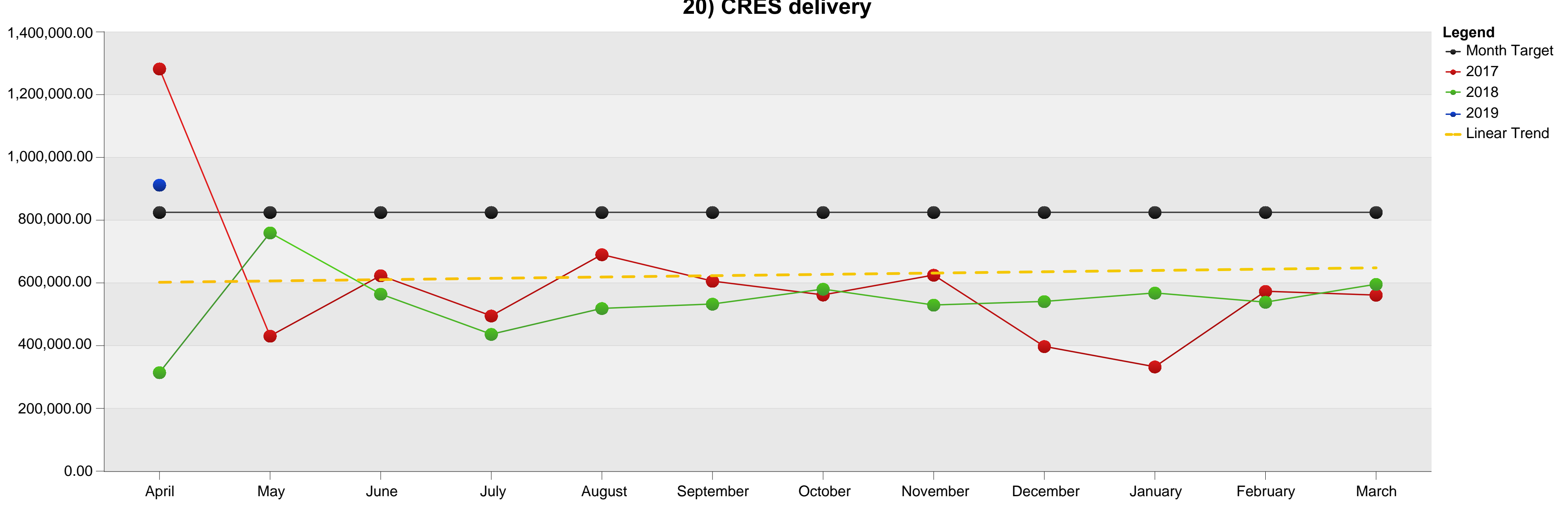
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Delivery of our financial plan (I and E)	56,090.00	56,090.00	19,493.00	19,493.00	324,780.00	324,780.00	195,270.00	195,270.00	45,727.00	45,727.00		

Narrative
The comprehensive income outturn for the period ending 30 April 2019 is a surplus of £56k, representing -42 .3% of the Trust's turnover and is £188k behind plan.

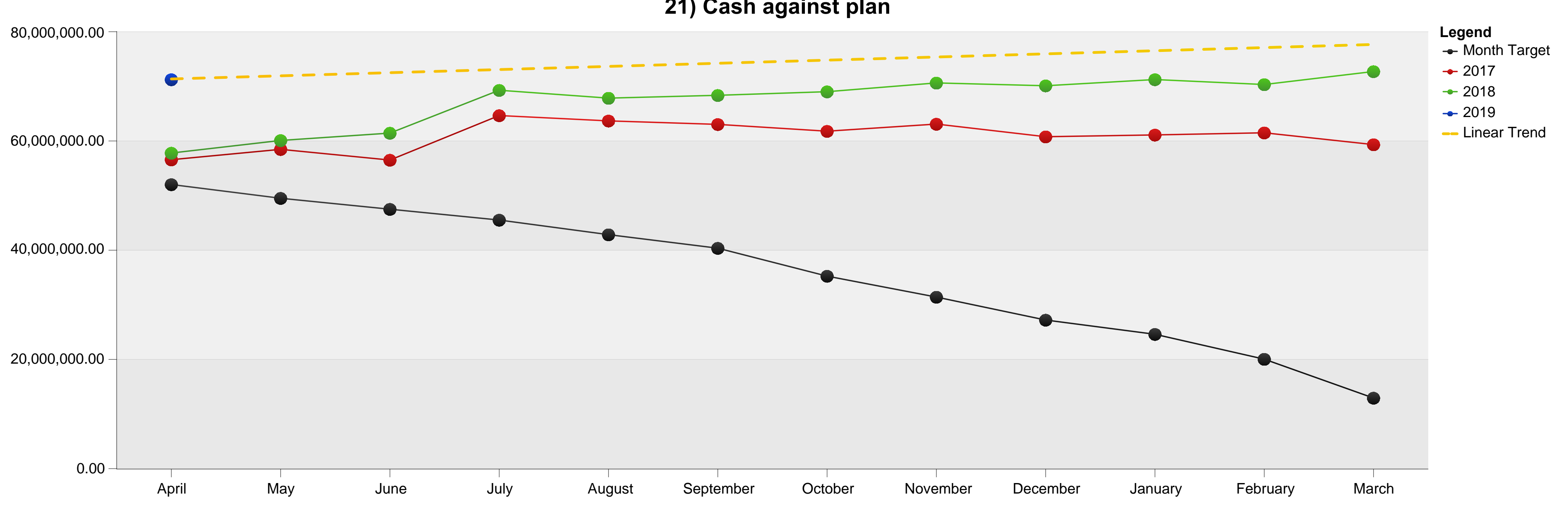
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) CRES delivery	912,000.00	912,000.00	43,000.00	43,000.00	74,000.00	74,000.00	188,000.00	188,000.00	57,000.00	57,000.00		

Narrative
Identified Cash Releasing Efficiency Savings at 30 April 2019 is £924k and is £199k ahead of plan for the year. The Trust is anticipating being ahead of plan (£744k) at the financial year end and continues to identify schemes for future years.

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Cash against plan	71,244,207.00	71,244,207.00	NA	NA	NA	NA			NA	NA		

Narrative
Total cash at 30 April 2019 is £71,244k and is £363k lower than planned, largely due to working capital variations.

Trust Dashboard - Locality Breakdown for TRUST

1 - Quality

	April 2019											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral		85.42%		84.05%		90.33%		79.02%		99.13%		
2) Percentage of patients starting treatment within 6 weeks of an external referral		51.62%		46.73%		60.85%		46.37%		94.44%		
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)		1,077.00		204.00		151.00		722.00				
4) Percentage of patients surveyed reporting their overall experience as excellent or good		91.19%		90.69%		90.48%		92.81%		91.30%		
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding		18.18%		50.00%		0.00%		16.67%				
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind		59.57%		60.00%		62.96%		56.76%				
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind		62.50%		58.06%		65.38%		63.33%				

	April 2019 To April 2019											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral		85.42%		84.05%		90.33%		79.02%		99.13%		
2) Percentage of patients starting treatment within 6 weeks of an external referral		51.62%		46.73%		60.85%		46.37%		94.44%		
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)		1,077.00		204.00		151.00		722.00				
4) Percentage of patients surveyed reporting their overall experience as excellent or good		91.19%		90.69%		90.48%		92.81%		91.30%		
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding		18.18%		50.00%		0.00%		16.67%				
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind		59.57%		60.00%		62.96%		56.76%				
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind		62.50%		58.06%		65.38%		63.33%				

Trust Dashboard - Locality Breakdown for TRUST

2 - Activity

	April 2019												April 2019 To April 2019											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		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
8) Number of new unique patients referred		6,920.00		2,165.00		2,435.00		1,914.00		406.00				6,920.00		2,165.00		2,435.00		1,914.00		406.00		
9) The number of new unique patients referred with an assessment completed		4,226.00		1,304.00		1,468.00		1,243.00		210.00				4,226.00		1,304.00		1,468.00		1,243.00		210.00		
10) Number of new unique patients referred and taken on for treatment		1,359.00		434.00		406.00		498.00		13.00				1,359.00		434.00		406.00		498.00		13.00		
11) Number unique patients referred who received treatment and were discharged		2,281.00		691.00		728.00		839.00		23.00				2,281.00		691.00		728.00		839.00		23.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)		89.49%		93.06%		94.01%		82.61%	NA	NA				89.49%		93.06%		94.01%		82.61%	NA	NA		
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		11.00		9.00		28.00						48.00		11.00		9.00		28.00				
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month		28.40%		28.57%		40.00%		19.23%						28.40%		28.57%		40.00%		19.23%				

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	April 2019											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
15) Vacancy Rate (Healthcare Professionals only)		7.63%		8.65%		4.52%		11.79%		5.29%		
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)		90.81%		91.95%		91.01%		175.36%		93.66%		
17) Percentage compliance with ALL mandatory and statutory training (snapshot)		93.54%		92.74%		93.95%		91.38%		96.44%		
18) Percentage Sickness Absence Rate (month behind)		5.05%		5.38%		5.52%		4.36%		6.18%		

	April 2019 To April 2019											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
15) Vacancy Rate (Healthcare Professionals only)		7.63%		8.65%		4.52%		11.79%		5.29%		
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)		90.81%		91.95%		91.01%		175.36%		93.66%		
17) Percentage compliance with ALL mandatory and statutory training (snapshot)		93.54%		92.74%		93.95%		91.38%		96.44%		
18) Percentage Sickness Absence Rate (month behind)		5.05%		5.38%		5.52%		4.36%		6.18%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	April 2019											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
19) Delivery of our financial plan (I and E)		56,090.00	NA	19,493.00	NA	324,780.00		195,270.00	NA	45,727.00		
20) CRES delivery		912,000.00		43,000.00		74,000.00		188,000.00		57,000.00		
21) Cash against plan		71,244,207.00	NA	NA	NA	NA			NA	NA		

	April 2019 To April 2019											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
19) Delivery of our financial plan (I and E)		56,090.00	NA	19,493.00	NA	324,780.00		195,270.00	NA	45,727.00		
20) CRES delivery		912,000.00		43,000.00		74,000.00		188,000.00		57,000.00		
21) Cash against plan		71,244,207.00	NA	NA	NA	NA			NA	NA		

Appendix B

Trust Dashboard 2019/20 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)	2,245	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	94%	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	The percentage of Serious Incidents which are found to have a root cause or contributory finding	32%	This measure looks at the percentage of serious incidents that are investigated and found to have a root cause or contributory finding
6	The % teams achieving the agreed improvement benchmarks for HoNOS total score	60%	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 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 2019/20 KPI Guide

No.	KPI	Target	Definition
			transferred to a different In Scope team.
7	The % teams achieving the agreed improvement benchmarks for SWEMWBS	65%	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)	90%	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)	61	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

No.	KPI	Target	Definition
14	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	23%	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	Vacancy Rate (Healthcare Professionals only)	6.50%	This measures the total number of advertised vacancies against the total number of budgeted staff
16	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.
17	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
18	Percentage Sickness Absence Rate	4.50%	This measures the number of days lost to sickness out of the number of days within the month
19	Delivery of our financial plan (I&E)	132,000	This shows the Trusts surplus or deficit position (£). The target is the planned surplus position.
20	CRES delivery	824,916	This shows the CRES Identified against the planned amount
21	Cash against plan	52,027	This shows the actual cash held by the Trust against the amount of cash forecasted to be held

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**21st May 2019**
TITLE:	**Strategic Direction Performance Report – Quarter 4 2018/19**
REPORT OF:	**Sharon Pickering, Director of Planning and Performance**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to present to Board of Directors the Strategic Direction Performance Report as at Quarter 4 (31st March 2019).

At the Board Meeting on the 19th July 2018, Board agreed to revise the KPIs for the Strategic Direction Scorecard. This report reflects the new key performance indicators that were agreed against which we will monitor and report progress against the Trust's 5 year strategic direction in conjunction with the Trust Business Plan and other forms of intelligence.

Whilst quarter 4 performance reports that 7 out of 14 metrics being red, 5 (71%) have reported an improvement; 10 metrics in total have reported an improvement on quarter 3. In addition, progress against the Business Plan and qualitative intelligence balances the position on the KPIs.

Recommendations:

Board of Directors is asked to:

- Approve the suggested change to KPI 15 detailed in section 3.5.4 and the proposal to change the KPI 21 detailed in 3.6.4.
- Approve the changes to the Trust Business Plan in Appendix 1.

MEETING OF:	BOARD OF DIRECTORS
DATE:	21st May 2019
TITLE:	Strategic Direction Performance Report – Quarter 4 2018/19

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to Board of Directors the Strategic Direction Performance Report as at Quarter 4 (31st March 2019).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report demonstrates progress against the Strategic Direction via progress against the agreed KPI Scorecard, the Trust Business Plan and other forms of qualitative intelligence.

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

2.3 The revised KPIs for the Trust Strategic Direction Scorecard were agreed by the Board on the 19th July 2018, with the majority of targets being agreed at the October 2018 Board meeting.

2.4 The Strategic Direction Scorecard is shown under each strategic goal. Proposed changes to the Business Plan requiring approval, by exception, are detailed in Appendix 1.

3. KEY ISSUES:

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

The Strategic Direction Scorecard is shown under each strategic goal with further detail.

The following table provides a summary of the RAG ratings at quarter 4 compared to the position in the previous quarters. The Trust is not meeting some of its high ambitions given the number of reds (7) against stretching metrics.

Quarter 4 had reported an overall improvement with 50% (7) of metrics reporting green compared to 29% (4) in quarter 3. Of the 50% (7) metrics reporting red, 5 have reported an improvement compared to quarter 3.

There remains a number (8) that are not being rated as they are not required to be reported in this quarter or are still under development.

SDS 2018/19	Q1 2018/19		Q2 2018/19		Q3 2018/19		Q4 2018/19	
	No.	%*	No.	%*	No	%*	No	%*
Indicators rated green	3	25%	2	17%	4	29%	7	50%
Indicators rated red	9	75%	10	83%	10	71%	7	50%
Indicators rated	**12**		**12**		**14**		**14**	
Indicators with no target agreed								
Indicators currently under development/being finalised	9		9		7		7	
Indicators where data is not yet available or not applicable in qtr	1		1		1		1	
Metric will not be possible to report and we are identifying a further indicator	1		1		1		1	

3.2 **Strategic Goal *1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)***

3.2.1 Trust Strategic Direction Scorecard

This strategic goal is showing 2 indicators rated red out of a possible 3 that can be rated as at quarter 4; one reports better than in quarter 3.

	Indicator	Q4 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Quarter 4 Actual	Change on previous quarter	YTD Target 2018/19	2018/19 Actual	2017/18 Actual	Annual Target 2018/19
Strategic Goal 1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)											
1	Percentage of teams achieving the agreed improvement benchmarks for HoNOS total score	67.25%	54.10%	57.47%	59.87%	65.36%	⇧	67.25%	59.41%	44.00%	67.25%
2	Percentage of teams achieving the agreed improvement benchmarks for SWEMWBS	78.25%	60.91%	69.05%	72.14%	67.04%	⇩	78.25%	67.38%	50.00%	78.25%
3	Number of patients who said we helped them achieve the goals they set	TBC	Metric currently under development				N/A	N/A	Not Available for 2018/19	n/a	TBC
4	Percentage of carers that report feeling listened to and heard	76.20%	76.70%	75.73%	76.02%	77.22%	⇧	76.20%	76.45%	76.08%	76.20%

Indicators of concern are:

- **KPI 1 Percentage of teams achieving the agreed improvement benchmarks for HoNOS total score –** The Trust position as at quarter 4 is 65.36% which relates to 183 out of 280 teams achieving the agreed improvement benchmarks for HoNOS total score. This is 1.89% below the target of 67.25%, representing a significant improvement since quarter 1. The position for 2018/19 is 59.41%, which is 7.84% below target but better than the 2017/18 position.

  Durham & Darlington and York & Selby are both achieving target.

  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.

- **KPI 2 Percentage of teams achieving the agreed improvement benchmarks for SWEMWBS** - The Trust position as at quarter 4 is 67.04% which relates to 179 out of 267 teams achieving the agreed improvement benchmarks for SWEMWBS. This is 11.21% below the target of 78.25% and is worse than the position reported for quarter 3 but better than quarter 1. The position for 2018/19 is 67.38%, which is 11.21% below target but better than the 2017/18 position.

  Only North Yorkshire is achieving target.

  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.

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 4 were rated green 87% (89 out of 102) compared to 83% (54 out if 65) in quarter 3. 88% of the priorities under Strategic Goal 1 are reporting that there is no significant risk to the completion on time of the overall priority; this is a slight improvement in position compared to 83% in quarter 3. There are 4% of priorities that have a moderate risk of failure to deliver the final milestone or benefits on time.

However, there are 2 (8%) priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget:

- 1 priority (1.16.24) **Tees Rehab Review** – The Rehab paper is due to be submitted to EMT in April 2019. A delay was agreed to support demand for beds at RPH due to the closure of the independent provider which was not anticipated, this necessitated 5 beds to be occupied. The outcome of this paper will determine the next steps for the priority. Therefore a request to extend the time has been submitted.
- 1 priority (1.10.1) **Implement the Transforming Care agenda in Learning Disability Service** - Revised trajectories have been agreed with Specialist Commissioners and included within 2019/22 business plan

There are 6 priorities reporting Grey on the basis that they have not been completed on time and/or benefits realised due to external factors:

- Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **To carry out agreed environmental improvements on Roseberry Ward Bowes Lyon Unit (BLU) (EMSA), and Oak ward if required** A Paper presented to EMT in Summer 2018, agreed that no further action should be taken at that time. Work can be actioned if required as part of the Trust wide bed work. Therefore Trust Board are asked to approve the removal of this priority
- Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **Respite Review & implications for Day Services (Tees)** - The anticipated commissioner procurement exercise has not taken place. It has been agreed that provision will continue for those patients currently accessing the service. Therefore Trust Board are asked to approve the removal of this priority
- Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **CORE 24** - National Wave 2 funding not advertised by NHSE. Discussions are ongoing with DDT Partnership about funding and the future model.
- Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners – **IAPT (Tees and D&D)** Commissioners have made a decision not to complete the procurement of IAPT services across Tees, Durham and Darlington, and are considering next steps. The Service has developed a mobilisation plan to implement new service model from 1 April in line with commissioner requirements.
- Develop and deliver the **Purposeful and Productive Community Services Programme (PPCS)** - Board agreed to close down the PPCS programme and scope a new Right Care Right Place programme in 2019/20 as part of Business Plan development. Milestones for RCRP are included in the 19/20 business plan and will be added to as the programme plan develops. A close down form is attached in Appendix 2 for Trust Board approval.

All proposed changes requiring Board approval are included in Appendix 1.

3.2.3 Other Qualitative Intelligence

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

- The **Trustwide Autism Project team** has won the Outstanding Health Services category at this year's Autism Professionals Awards.

- **The Northdale Centre, Roseberry Park**, Middlesbrough has been shortlisted in the Outstanding Health Services category at this year's Autism Professionals Awards.

- **Recovery College Online** has launched an area for young people providing information and resources for children and young people, as well as for their parents and carers.

- The Trust has been awarded the tender for the provision of **Liaison & Diversion** services for the 3 separate Police Force area lots of Durham, Cleveland and North Yorkshire. Mobilisation has commenced with our 2 sub-contractors, Humankind and Spectrum.

- **Talking Changes service**, Durham has gained the Accreditation Programme for Psychological Therapies Services (APPTS).

- The **Integrated Support Unit at HMP Durham** has been awarded the 'Team of the Year' in the regional Her Majesty's Prison and Probation Service Awards.

- The **Trust** has won the Outstanding Health Services Award at the National Autistic Society's Autism Professionals Awards, in recognition of the work it is doing to ensure that there is a clear pathway to diagnosis across the Trust, that all staff are trained in autism awareness, and that reasonable adjustments to treatment pathways are available.

- The **Trust** is committed to addressing health inequalities and has pledged its support to a national campaign (STOMP) to stop the over medication of people with a learning disability, autism or both.

3.2.4 Other points to note:

- **KPI 3 - Number of patients who said we helped them achieve the goals they set** – The implementation of the new surveys in Adult Mental Health Service inpatients has been delayed due to technical issues and will go ahead from 1 May 2019. Due to the changes in the Forensic inpatient wards it has been agreed that Secure Inpatient Services will use an Easy Read version that will be available when the service is next due to survey in June 2019. Planned changes to community AMH surveys have been put on hold as publication of new FFT guidance is imminent and implications for further changes to the surveys are confirmed.

3.2.5 In conclusion, 2 of the 3 measurable metrics have reported an improvement during quarter 4 and all 3 have improved compared to 2017/18. There has been a slight improvement in terms of delivering the Business Plan, with just 2 priorities/service developments at high risk of failure to deliver on time or within budget. Together with significant qualitative intelligence, a positive position is presented in terms of this strategic goal and the service we provide to patients and carers.

3.3 Strategic Goal 2 - *To continuously improve the quality and value of what we do*

3.3.1 Trust Strategic Direction Scorecard

This strategic goal is showing both indicators rated red that can be rated, which is one less than that reported in quarter 3; however one metric is not available for quarter 4. Both metrics rated have reported an improvement.

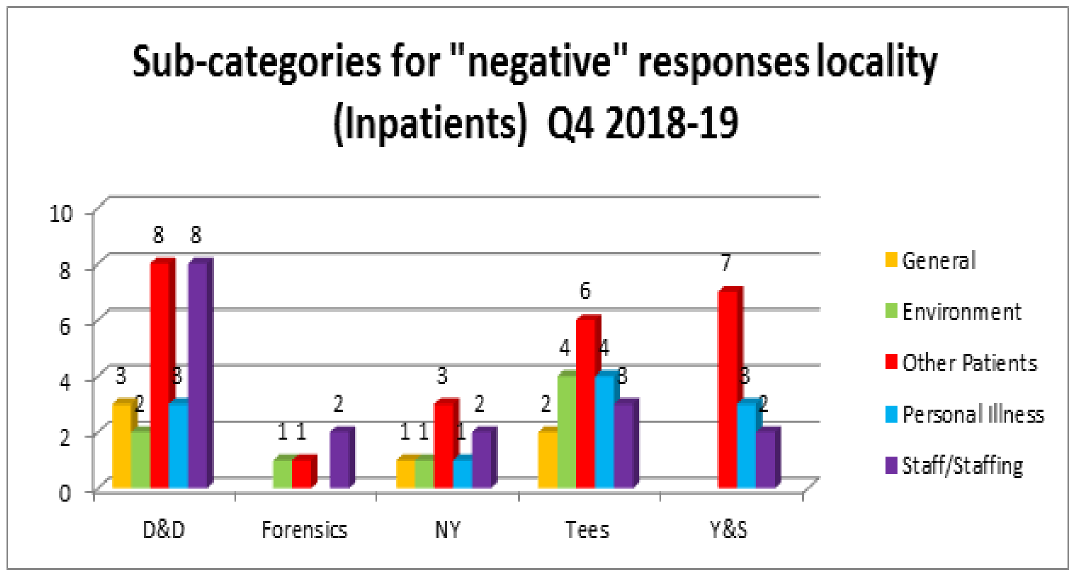
	TRUST STRATEGIC DIRECTION SCORECARD 2018/19										
	Indicator	Q4 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Quarter 4 Actual	Change on previous quarter	YTD Target 2018/19	2018/19 Actual	2017/18 Actual	Annual Target 2018/19
Strategic Goal 2 (To continuously improve the quality and value of what we do)											
5	Percentage of staff reporting that they can contribute towards improvement at work (reported a quarter behind)	87.00%	81.59%	82.88%	80.04%	Not Available for Quarter 4	N/A	87.00%	81.50%	81.59%	87.00%
6	Percentage of patients who report feeling supported by staff to feel safe	65.20%	62.45%	59.72%	60.74%	63.19%	⇧	65.20%	61.53%	65.63%	65.20%
7	Percentage of patients who report their overall experience as excellent or good	94.00%	90.78%	91.25%	91.75%	91.92%	⇧	94.00%	91.41%	90.68%	94.00%

Indicators of concern are:

- **KPI 6 - Percentage of patients who report feeling supported by staff to feel safe** – The Trust position for quarter 4 is 63.19% which relates to 268 patients out of 728 patients surveyed who stated they did not always feel safe on our wards. This is 2.01% below the target of 65.20% but is better that the quarter 3 position reported of 60.74%. The position for 2018/19 is 61.53%, which is 3.67% below target and worse than the 2017/18 position.

  Three localities are reporting below target:
  - North Yorkshire report 54.69% which is significantly worse than quarter 3 (74.19%).
  - Teesside report 54.48% which is slightly better than quarter 3 (52.48%).
  - York & Selby reporting 60.92% which is significantly better than quarter 3 (51.39%).

The graph below shows a brief summary of the reasons cited by patients for feeling unsafe, not all patients provide a reason and some can give more than one. Durham & Darlington is an outlier for the number indicating staff as the reason for not feeling safe on the ward. There are no particular patterns and general comments returned by patients relate to staff not being available or the use of bank staff with a reduced knowledge of the ward.



Work is ongoing within a number of Trust areas to help promote patients feeling safe on the wards. This includes the Head of Durham & Darlington Adult Learning Disabilities reviewing the ward to create quiet spaces to support patients who are struggling with the environment, Children & Young People's Services creating participation groups on Evergreen and Westwood wards, North Yorkshire offering alarms to patients who need assistance with care or feel vulnerable because of other patients, and Forensics working with the recovery team and patient focus group.

- **KPI 7 - Percentage of patients who report their overall experience as excellent or good** – The Trust position for quarter 4 is 91.92% which relates to 391 patients out of 4838 patient survey responses that report their overall experience other than excellent or good. This is 2.08% below the target of 94% and is consistent with the quarter 3 position. The position for 2018/19 is 91.41%, which is 2.59% below target but better than the 2017/18 position.

  All localities are reporting below target, although both Durham & Darlington and Teesside are less than 1% below target:
  - Durham & Darlington report 92.72% which is slightly worse than quarter 3 (93.22%).
  - Forensics report 88.56% which is better than quarter 3 (82.20%).
  - North Yorkshire reporting 91.04% which is slightly worse than quarter 3 (91.58%).
  - Teesside report 93.59% which is consistent with quarter 3 (93.35%).
  - York & Selby reporting 88.98% which is worse than quarter 3 (90.07%)

3.3.2 <u>Trust Business Plan</u>

The majority of business plan actions due to be completed by the end of quarter 4 were rated green 97% which is an improvement compared to 88% in quarter 3. 100% of the priorities under Strategic Goal 2 are reporting that there is no

significant risk to the completion on time of the priority compared to 80% in quarter 3.

There are 2 actions for the Right Staffing priority, which requires Board approval to extend the timescale of one action and remove another action from the business plan and these are included in Appendix 1.

3.3.3 Other points to note:

- **KPI 5 - Percentage of staff reporting that they can contribute towards improvement at work (reported a quarter behind)** – this metric is reported a quarter behind; the quarter 4 data would therefore relate to the quarter 3 survey. However, this question is not asked on the questionnaire during quarter 3 of each year.

3.3.4 In conclusion, whilst all three KPIs continue to perform below target, 2 have reported an improvement continuing increasing trends in performance and one has been unavailable for reporting. Qualitative intelligence for this metric has been limited during the quarter; however 97% of Business Plan priorities are reported green maintaining an encouraging position for this strategic goal.

3.4 Strategic Goal 3 - *To recruit, develop and retain a skilled, compassionate and motivated workforce*

3.4.1 Trust Strategic Direction Scorecard

This strategic goal is showing 2 indicators rated red as at quarter 4 out of a possible 3 that could be rated; both have reported an improvement.

TRUST STRATEGIC DIRECTION SCORECARD 2018/19

	Indicator	Q4 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Quarter 4 Actual	Change on previous quarter	YTD Target 2018/19	2018/19 Actual	2017/18 Actual	Annual Target 2018/19
Strategic Goal 3 - To recruit, develop and retain a skilled, compassionate and motivated workforce											
8	Percentage rolling 12 month TEWV labour turnover rate	10.00%	10.77%	10.35%	10.34%	10.44%	⇧	10.00%	10.44%	n/a	10.00%
9	Percentage rolling sickness absence rate	4.50%	5.27%	5.20%	5.17%	5.17%	⇔	4.50%	5.17%	n/a	4.50%
10	Percentage staff recommending TEWV as a place to work	73.00%	71.00%	70.42%	No FFT During quarter 3	80.60%	N/A	71.00%	74.04%	70.95%	73.00%
11	Report and increase the % frontline multi-professional leadership and management teams that have trained in the core skills identified.	TBC	Baseline is due to be available in April 2019				N/A	N/A	Not Available for 2018/19	n/a	TBC

Indicators of concern are:

- **KPI 8 - Percentage rolling 12 month TEWV labour turnover rate** - The Trust position for quarter 4 (and 2018/19) is 10.44% which relates to 716 leavers out of 6855 total staff. This is 0.44% outside the target of 10% and is slightly higher than the 10.34% reported for quarter 3.

A number of initiatives have been developed by the Recruitment and Retention Working Group which may have a positive impact on labour turnover. The procedures below were identified within the Recruitment and Retention Acton Plan.

- A review of the Retire and Return scheme resulted in changes to the way the scheme operates leaving the decision making process at a local operational level which may encourage more staff to return following retirement.
- A revised Flexible Working procedure is available which hopefully will encourage and support staff to effectively manage any competing work life responsibilities and ultimately retain them in the Trust.
- Work is currently underway to develop a process for mid-career review conversations to take place to help staff to start to plan their career and support open dialogue about future retirement intentions.

A number of presentations have taken place with members of staff in leadership roles to inform them of the changes to a range of HR related policies and procedures including the leaver alert process. We are currently looking at how we may make better use of Webinar technology which will enable staff to access awareness raising sessions from their workplace via skype. Access to Webinar events would also be made available via Intouch for those staff unable to participate in the live events.

- **KPI 9 - Percentage rolling sickness absence rate -** The Trust position for quarter 4 (and 2018/19) is 5.17% which relates to 125840 days lost to sickness out of 2432127 available working days for the Trust. This is 0.67% above the target of 4.50% and is consistent with the previous three quarters.

  The long term sickness team continue to support managers and staff experiencing an episode of long term absence. The majority of staff successfully return to work following a period of absence. A monthly case management review is held with Occupational Health to discuss cases experiencing over 100 days absence. The team average a caseload of between 250 – 300 cases at any one time.

  A review of the Sickness Absence procedure has recently concluded; the procedure has been developed in collaboration with the staff side representatives through the Policy Working Group.

  The Trust invests a significant amount of resources to ensure support is available to staff who are experiencing difficulties at work and in their personal life. A number of key activities are identified within the Health and Well-being Action Plan which it is hoped will have a positive impact on staff health. The Trust has recently developed a Bullying and Harassment Resolution procedure which includes the role of Dignity at Work Champion. It is envisaged that staff experiencing difficulties with work relationships will seek support and guidance from the Dignity at Work Champion staff volunteers. A

presentation regarding conflict at work was included on the agenda of the latest Leadership Development Network events.

3.4.2 Trust Business Plan

The majority of the business plan actions due to be completed by the end of quarter 4 were rated green 83%, which is an improvement of 75% in quarter 3. There is only one business plan priority assigned to Strategic Goal 3. This is Making a Difference Together which is currently reporting Grey due to 1 of the actions being put on hold and with EMT agreement for this action to be reviewed as part of the new MADT plan. The other action is requiring additional time for completion of the crowdsourcing evaluation as described in Appendix 1.

3.4.3 Other Qualitative Intelligence

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

- **Deborah Jeffery**, Advanced Nurse Practitioner, Scarborough, Whitby and Ryedale Community team, **Sarah Waite**, nurse, Memory Clinic, Friarage Hospital, Northallerton and **Linda Schumacher**, nurse, mental health services for older people South West, Acomb Health Centre and Worsley Court, York and Selby have won the Cavell Nursing Award for shining bright and showing exceptional care to their patients.

- 100% of staff from **Improving Access to Psychological Therapies (IAPT) in North Yorkshire** reported job satisfaction in the staff friends and family test.

- **Valentina Short**, associate clinical director, has been chosen as one of seven senior nurses across the North East and Cumbria to take part in the 70@70 Senior Nurse and Midwife Research Leadership Programme.

- **Delia Hopkins**, registered nurse, Eastfield Clinic, Scarborough; **Laura Simmonds**, learning disability (LD) nurse, Harrogate and District community learning disability team, Alexander House, Knaresborough; **Sam Hicks**, LD nurse, North Durham integrated team, Chester le Street Health Centre and **Beth Thomas**, community nurse, secure outreach transition team, Roseberry Park, Middlesbrough, have been chosen to attend the NHS70 Learning Disability Nurse Leadership programme.

- **Megan McKerr**, administrator / receptionist, psychosis team, West Park Hospital, Darlington has won the Level 2 Apprentice of the Year category of the Northern Skills Group Apprenticeship Awards 2019.

- **North Tees liaison psychiatry team, Farndale**, University Hospital North Tees and Hartlepool has been awarded a certificate of excellence from Teesside University after being nominated as an excellent practice placement by student nurses.

- **TEWV** has launched an innovative new scheme to help people from BAME communities across Teesside learn more about mental health issues and at the same time, embark on a career with the NHS. Local people are given the chance to embark on a five week course developed jointly by TEWV, Nur Fitness and Middlesbrough Council's Community Learning Service. Following on from this, the ladies are invited to volunteer in Teesside mental health hospital, after which there is an opportunity to become a paid member so staff through our temporary staffing team. A positive segment was broadcast on ITV Tyne Tees evening news, on Wednesday 13 March 2019.

3.4.4 Other points to note:

- **KPI 11 - Report and increase the % frontline multi-professional leadership and management teams that have trained in the core skills identified** – The first programme is completed is due to be completed in December 2019, after which baseline data will be available.

3.4.5 In conclusion, performance against this Strategic Goal is mainly positive. Whilst 2 metrics are reporting red, both have improved compared to last quarter and are only just above their target positions. Progress against the Business Plan and the significant amount of qualitative intelligence is encouraging.

3.5 Strategic Goal 4 - *To have effective partnerships with local, national and international organisations for the benefit of the communities we serve*

3.5.1 Trust Strategic Direction Scorecard

This strategic goal is showing 1 indicator rated red at quarter 4 out of a possible 3 that can be rated; this has shown a deterioration.

TRUST STRATEGIC DIRECTION SCORECARD 2018/19

	Indicator	Q4 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Quarter 4 Actual	Change on previous quarter	YTD Target 2018/19	2018/19 Actual	2017/18 Actual	Annual Target 2018/19
Strategic Goal 4 - To have effective partnerships with local, national and international organisations for the benefit of the communities we serve											
12	Percentage joint bids with CCGs that are successful	80%	100.00%	n/a	58.82%	100.00%	⇧	80%	70.83%	n/a	80%
13	Percentage of mental health and learning disability budget covered by a ring-fenced budget	85%	77.49%	77.49%	77.23%	77.17%	⇩	85%	77.17%	n/a	85%
14	Percentage delayed transfers of care due to non Trust issues	3.5%	3.33%	3.38%	2.90%	2.36%	⇧	3.5%	3.01%	n/a	3.50%
15	Percentage referrals received from GPs using the standard electronic referrals template relevant for the speciality	n/a	Metric Not Available				N/A	N/A	Not Available for 2018/19	n/a	n/a

Indicators of concern are:

- **KPI 13 - Percentage of mental health and learning disability budget covered by a ring-fenced budget** - The Trust position for quarter 4 (and 2018/19) is 77.17% and relates to £257,415,694 of the Mental Health and Learning Disability budget that is ring fenced out of £333,554,000. This is

7.83% below the target of 85% and is consistent with the position reported in quarter 4. The Partnership and new care model agreements are in place for the majority of the clinical income to the value 77%, remaining income predominately relates to North Yorkshire CCGs and Offender for health block contracts. During 19/20 it is anticipated that the North Yorkshire CCGs will form a partnership therefore increasing performance of this metric.

3.5.2 Trust Business Plan

The majority of the business plan actions due to be completed by the end of quarter 4 were rated green 94% which is an improvement compared to quarter 3 86%. There were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget. 75% of priorities under Strategic Goal 4 are reporting that there is no significant risk to the completion on time of the priority.

There are 2 actions for Collaborations with Universities requesting additional time to identified university liaison leads and develop an engagement plan. (See Appendix 1.)

3.5.3 Other Qualitative Intelligence

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

- The **Trust** along with Ward Hadaway has been shortlisted in the Legal Services Provider of the Year category of the HSJ Partnership Awards for the Roseberry Park scheme.

- The **Trust** has been working in partnership with Hull York Medical School to introduce an innovative programme designed to improve attitudes towards psychiatry and increase the numbers of students choosing it as a career.

- The **Trust** has been successful in retaining provision of inpatient services for the Ministry of Defence, including the provision of an 'outpatient' service which for TEWV referrals will be received from RAF Leeming. The contract variation with the service to start from 1st April 2019.

- The **Trust** has been successful in securing non-recurrent funding to support CYP mental health waiting list initiatives in conjunction with HAST CCG; this will be utilised to procure a digital mental health intervention.

3.5.4 Other Points to Note

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

- **KPI 15 – Percentage referrals received from GPs using the standard electronic referrals template relevant for the speciality** - this metric is not available. Board approval is sought to replace this metric with the

Percentage of e-letters developed against the total number of GP letters required.

3.5.5 In conclusion performance against this strategic goal remains encouraging. Whilst 1 metric is reporting red, progress against the Business Plan and the amount of qualitative intelligence available to support this strategic goal is strong.

3.6 Strategic Goal 5 - *To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve*

3.6.1 Trust Strategic Direction Scorecard

This strategic goal is showing 3 indicators rated green out of a possible 3 that can be rated as at quarter 4; two of which have reported an improvement.

	TRUST STRATEGIC DIRECTION SCORECARD 2018/19										
	Indicator	Q4 Target 2018/19	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Quarter 4 Actual	Change on previous quarter	YTD Target 2018/19	2018/19 Actual	2017/18 Actual	Annual Target 2018/19
	Strategic Goal 5 - To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve										
16	Delivery of control total in full as per NHSI financial plan	-£3,234,000.00	-1,760,435	-1,939,011	-3,539,545	-19,527,877	⇧	-£6,630,000	-£26,766,868.00	n/a	-£6,864,000
17	Achieve an NHSI SOF rating of 1 *(reported one quarter behind)*	1	Not available	1	1	1	⇔	1	1	n/a	1
18	All clinical teams to be able to access pathology results via PARIS and order test by PARIS	10.00%	Not Available for Quarter 1	Not Available for Quarter 2	23.71%	24.88%	⇧	0.00%	24.30%	n/a	10.00%
19	All service users being able to access care plan online or digitally	TBC	Not Available for Quarter 1	Not Available for Quarter 2	Not Available for Quarter 3	Not Available for Quarter 4	N/A	N/A	Not Available for 2018/19	n/a	TBC
20	100% clinical pathways developed and in use within PARIS	100%	Not Available for Quarter 1	Not Available for Quarter 2	Not Available for Quarter 3	Not Available for Quarter 4	N/A	100%	Not Available for 2018/19	n/a	100%
21	All Trust clinicians to have access to their key service/team/patient information in near to real time	100%	Not Available for Quarter 1	Not Available for Quarter 2	Not Available for Quarter 3	Not Available for Quarter 4	N/A	100%	Not Available for 2018/19	n/a	100%
22	Placeholder: E&D Strategy		Not Available for Quarter 1	Not Available for Quarter 2	Not Available for Quarter 3	Not Available for Quarter 4	N/A	N/A	Not Available for 2018/19	n/a	TBC
23	Placeholder: E&D Strategy		Not Available for Quarter 1	Not Available for Quarter 2	Not Available for Quarter 3	Not Available for Quarter 4	N/A	N/A	Not Available for 2018/19	n/a	TBC

There are no concerns for the indicators reported above.

3.6.2 Trust Business Plan

100% of actions have been delivered within quarter 4 which is an improvement compared to 75% at quarter 3. There is only one business plan priority assigned to Strategic Goal 5. This is to deliver our Digital Transformation Strategy which is currently reporting amber/green. The majority of projects are on track, but there is a low-medium level of risk that CITO may not achieve the benefits that were anticipated (or be implemented in line with the timescales set out in the Business Plan). The necessary mitigation is for the complexity and volume of MHSOP requirements to be reduced. Work is ongoing to align AMH and MHSOP requirements and workflows.

The end of the 18/19 outcome metrics for this programme show a mixture of targets that have been achieved (e.g. staff registration and use of IIC; smartphone availability and skype-enabled laptops). The outcomes that are behind trajectory such as digital mailroom and windows 10 roll-out should see accelerated progress in 2019/20 and the end of 2019/20 targets for these are likely to be achieved. However, as there is some residual risk due to the complexities of some of the Information projects the Digital Transformation Board continues to assess that Amber-Green is the appropriate status for this programme at the present time

3.6.3 Other Qualitative Intelligence

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

- **TEWV** staff have been shortlisted in the financial or procurement initiative of the year category of the HSJ Value awards for their work to release cash savings using coaching methodologies.

3.6.4 Other points to note:

- **KPI 19 - All service users being able to access care plan online or digitally** – data is not available as yet. The plan is that Care Planning will be built in CITO and then patients will receive an electronic copy alongside a Patient Portal where a patient can access the plan via an online shared portal. CITO rollout will commence with MHSOP aiming to go live in Autumn 2019.

- **KPI 20 - 100% clinical pathways developed and in use within PARIS** - data is not available as yet. Version 2.3 of CITO includes workflow functionality to allow development of pathways. The plan is that the pilot teams for CITO will include this high level pathways/workflow functionality. CITO rollout will commence with MHSOP aiming to go live in Autumn 2019.

- **KPI 21 - All Trust clinicians to have access to their key service/team/ patient information in near to real time** – Work is progressing to facilitate access to key information systems in near to real time; however upon further consideration the Head of Information Services – IT and Systems and Head of Information Systems are concerned that this metric will not facilitate the accurate reporting of real time reporting. They will, therefore, be leading a piece of work in the coming weeks to facilitate reporting of a more reflective metric to be included in both the Strategic Direction Scorecard and the Digital Transformation Strategy; this proposal will be included within the quarter 1 Strategic Direction Scorecard.

- **KPI 22/23 - E&D Strategy metrics** – these metrics are not yet finalised. It is planned to have a new E&D Strategy approved by the Board at the end of September.

3.6.5 In conclusion performance against this Strategic Goal remains positive. However there are a significant number of metrics to be developed. Progress against the business plan is positive will all actions being delivered during the quarter.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
There are no issues of compliance with the CQC fundamental standards.

4.2 **Financial/Value for Money:**
The report highlights that none of the Sustainability metrics are below target.

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

4.4 **Equality and Diversity:**
There are no direct equality and diversity implications from this paper, however, one metric does measure the variance in the responses of staff in the NHS Staff Survey who report as 'disabled' compared to those reporting 'non-disabled'.

4.5 **Other implications:**
There are no other implications associated with this paper.

5. RISKS:

There are no identified risks associated with this paper.

6. CONCLUSIONS:

Whilst quarter 4 performance reports that 7 out of 14 metrics being red, 5 (71%) have reported an improvement; 10 metrics in total have reported an improvement on quarter 3. In addition, progress against the Business Plan and qualitative intelligence balances the position on the KPIs.

7. RECOMMENDATIONS:

Board of Directors is asked to:

- Approve the suggested change to KPI 15 detailed in section 3.5.4 and the proposal to change the KPI 21 detailed in 3.6.4.
- Approve the changes to the Trust Business Plan that require Board approval in Appendix 1.

Sharon Pickering
Director of Planning, Performance & Communications

Background Papers:

Appendix 1

Appendix – Requests to the Board of Directors for a Change to the Business Plan

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
1.16. 43	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - IAPT Tender	D&D	AMH	Plan and implement all specification / process changes required for commencement of new contract	New processes and managerial arrangements in place for contract commencement	Q4 18/19	Jo Dawson	**GY**	Procurement process has been abandoned by commissioners. Service have developed a mobilisation plan to implement new service model from 1 April in line with commissioner requirements. A revised priority will be included in the 2019/20 Business Plan.
1.16. 44	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **To carry out agreed environmental improvements on Roseberry Ward Bowes Lyon Unit (BLU) (EMSA), and Oak ward if required**	D&D	MHSOP	To complete works to the ward to meet required standards	Work completed	Q4 18/19	Christine Murphy	**GY**	Proposal completed for inpatient areas and submitted to EMT summer 2018 and can be actioned if required as part of the Trust wide bed work. Trust Board are requested to remove this action.
1.15. 8	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **Respite Review & implications for Day Services**	Tees	ALD	Should the Trust agree that the service specification is appropriate and deliverable respond to commissioner procurement exercise	Procurement requirements completed as required	Q1 18/19	Pam Ridings	**GY**	Anticipated commissioner procurement exercise has not taken place. Agreed that provision will continue for those patients currently accessing the service. Trust Board are requested to remove this action.

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
1.15.9	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **Respite Review & implications for Day Services**	Tees	ALD	Dependant on above, should TEWV be successful, implementation of service model as specified	Service operational	Q3 18/19	Pam Ridings	**GY**	Anticipated commissioner procurement exercise has not taken place. Agreed that provision will continue for those patients currently accessing the service. Trust Board are requested to remove this action.
1.15.10	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **Respite Review & implications for Day Services**	Tees	ALD	Should TEWV agree not to respond to the procurement or be unsuccessful, decommission respite as appropriate	Service decommissioned	Q3 18/19	Pam Ridings	**GY**	Anticipated commissioner procurement exercise has not taken place. Agreed that provision will continue for those patients currently accessing the service. Trust Board are requested to remove this action.
1.16.14	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **CORE 24**	Tees	MHSOP	Work with commissioners to agree a sustainable service in line with CORE 24 national guidelines	Bid to NHSE submitted	Q4 18/19	Elaine Wells	**GY**	National Wave 2 funding not advertised by NHSE. Discussion ongoing with DDT Partnership about submission of a bid when Wave 2 is released.
1.16.20	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - IAPT Tender	Tees	AMH	If successful, implement service specification as defined within tender	Implementation complete	Q4 18/19	Jane King	**GY**	Procurement process has been abandoned by commissioners.

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
1.16. 24	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **Rehab Review**	Tees	AMH	Complete decant of services at Roseberry Park to Lustrum Vale	Decant complete	Q4 18/19	Alison McIntyre / Clare Cuthbertson	R	The Rehab paper is due to be submitted to EMT in April 2019. A delay was agreed to support demand for beds at RPH due to closure of independent provider which was not anticipated, this necessitated 5 beds to be occupied. Following discussion of paper at EMT it is likely there will be a request to extend the timescales of these actions to align to the outcomes of the paper. Trust Board are requested amend the action to enable EMT to consider the paper and extend the time to Q1 19/20
1.12. 4	Complete the transformation of our York & Selby services	Y&S	AMH/ MHSOP	Development of new fit for purpose Mental Health Hospital in York	Design of workforce planning reviewing each element of workforce to ensure that the planned workforce maximises efficiency and effectiveness across all areas of the site.	Q4 18/19	Naomi Lonergan		The Y&S Workforce Strategy Group has reviewed each discipline required for the new hospital. The workforce planning tasks are now being undertaken by the AMH and MHSOP Harrogate and York Working Groups, and overseen by the HoS for each specialty. Following the Trust's agreement that Harrogate patients will be admitted to Inpatient Units within York, further work is now being undertaken to ascertain an interim solution for beds in order to accommodate York &

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
									Harrogate patients. The proposed plan is to open the interim unit for 12 months. Trust Board are requested to extend this metric to Q2 19/20
1.3. 23	Improve the consistency and purposefulness of inpatient care across the Trust	Forensic	All	Review of Trust wide diagnostic pathways already in place and alignment to the clinical needs of the Forensic patient population	Alignment complete	Q4 18/19	Matt Gale	R	The service continues to access Trustwide diagnostic pathways where appropriate. However due to the ongoing work with CITO and SDG's with regards to pathways a full review would not be possible. Trust Board are requested to remove this action.
1.3. 24	Improve the consistency and purposefulness of inpatient care across the Trust	Forensic	All	Development of Forensic Pathways for the management of Risk and/ or offending behaviours	Pathways for management of risk and/or offending behaviour	Q4 18/19	Matt Gale	R	This has been partially completed as part of the high level pathway development. However work is being undertaken as part of the Forensic service review with regards to access to interventions and therapies. The output of this work will support the completion of this action. Future monitoring of this will be aligned through SDG. Trust board are requested to extend the timescale for this action to Q1 19/20
1.10. 4	Implement the Transforming Care agenda in Learning Disability Services	Forensic	ALD /FLD	Achievement of bed reductions in line with trajectories - Locked Rehab	Bed numbers = 11	Q4 18/19	Heads of Service	R	Revised trajectories agreed with Specialist Commissioners and included within 2019/22 plan. Trust Board are requested to agree to those trajectories superseding these.

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
1.10.5	Implement the Transforming Care agenda in Learning Disability Services	Forensic	ALD/ FLD	Achievement of bed reductions in line with trajectories - Forensic LD	Bed numbers = 39	Q4 18/19	Heads of Service	R	Revised trajectories agreed with Specialist Commissioners and included within 2019/22 plan. Trust Board are therefore to those trajectories superseding these.
1.10.5	Implement the Transforming Care agenda in Learning Disability Services	Forensic	ALD/ FLD	Achievement of bed reductions in line with trajectories - Forensic LD	Bed numbers = 36	Q4 19/20	Heads of Service	GY	Revised trajectories agreed with Specialist Commissioners and included within 2019/22 plan. Trust Board are requested to agree to those trajectories superseding these.
1.1.15	Implement Phase 2 of the Recovery Strategy and develop Phase 3	COO	All	Develop team/ service accreditation pack and gain initial approval	Approval in place	Q4 18/19	Alison Brabban/ Kate Hughes	R	Following consultation agreed that a recovery framework rather than accreditation will be developed. This is in progress with a structure for sections agreed and first section in draft. Further meeting in April and May planned. Trust Board are requested to change the wording of the action to Develop team/service Recovery Framework and extend the timescale to end Q1 19/20.
1.1.16	Implement Phase 2 of the Recovery Strategy and develop Phase 3	COO	All	To develop a draft recovery/TIC team / service accreditation tool	Tool agreed	Q4 18/19	Alison Brabban /Kate Hughes	R	Following consultation agreed that a recovery framework rather than accreditation will be developed. This is in progress with a structure for sections agreed and first section in draft. Further meeting in April and May planned. Trust Board are requested to change the wording of the action to Develop

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Specialty	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
									Recovery/TIC Framework and extend the timescale to end Q1 19/20.
1.2.1	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	COO	All	Implement CRES plans across all localities	Plan implemented	Q3 18/19	Ruth Hill	GY	Board has agreed to close down the PPCS programme and establish RCRP. Milestones are included in the 19/20 business plan and will be added to as the programme plan develops" Trust Board are asked to approve the close down
1.2.3	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	COO	All	Phase one lessons learned for sustainability to be shared across all CMHTs	Quality Assurance RAG tool in all CMHTs	Q4 18/19	Locality Directors	GY	Board has agreed to close down the PPCS programme and establish RCRP. Milestones are included in the 19/20 business plan and will be added to as the programme plan develops" Trust Board are asked to approve the close down
1.2.6	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	COO	All	Develop a share and spread 'package' for other CMHTs for PARIS entry for reviews and initial assessment	Implementation plan developed	Q2 18/19	Ruth Hill / Locality Directors / KPO	GY	Board has agreed to close down the PPCS programme and establish RCRP. Milestones are included in the 19/20 business plan and will be added to as the programme plan develops" Trust Board are asked to approve the close down
1.2.7	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	COO	All	Implement PARIS standard work across all CMHTs	Share and spread implemented	Q3 18/19	Locality Directors	GY	Board has agreed to close down the PPCS programme and establish RCRP. Milestones are included in the 19/20 business plan and will be added to as the programme plan develops" Trust Board are asked to approve the close down

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
1.2.8	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	COO	All	Implement Standard Work for Leaders within 12 pilot teams	Development of new standard work	~~Q1 18/19~~ Q3 18/19	KPO / Locality Managers	GY	Board has agreed to close down the PPCS programme and establish RCRP. Milestones are included in the 19/20 business plan and will be added to as the programme plan develops" Trust Board are asked to approve the close down
1.2.9	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	COO	All	Develop a share and spread 'Package' for other CMHTs for Standard work for Leaders	Share and spread implemented	~~Q2 18/19~~ Q4 18/19	KPO / Locality Managers	GY	Board has agreed to close down the PPCS programme and establish RCRP. Milestones are included in the 19/20 business plan and will be added to as the programme plan develops" Trust Board are asked to approve the close down
1.2. 11	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	COO	All	Identify opportunities for sharing good practice in embedding clinical pathways to apply to all CMHTs	Share and spread implemented	Q4 18/19	Dominic Gardner / SCDs / SDMs	GY	Board has agreed to close down the PPCS programme and establish RCRP. Milestones are included in the 19/20 business plan and will be added to as the programme plan develops" Trust Board are asked to approve the close down
1.2. 16	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	COO	All	Implement the plan for robust and sustainable process for co-production with in the 12 teams	Plan implemented	Q4 18/19	Ruth Briel / Alison Brabban / Sally Smith	GY	Board has agreed to close down the PPCS programme and establish RCRP. Milestones are included in the 19/20 business plan and will be added to as the programme plan develops" Trust Board are asked to approve the close down
1.2. 17	Develop and deliver the Purposeful and Productive	COO	All	Develop a 'product' to share across all CMHTs in relation to	Share and spread implemented	Q4 18/19	Ruth Briel / Alison Brabban /	GY	Board has agreed to close down the PPCS programme and establish RCRP. Milestones are

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
	Community Services Programme (PPCS)			co-production			Sally Smith		included in the 19/20 business plan and will be added to as the programme plan develops" Trust Board are asked to approve the close down
1.11.1	Develop a Trust-wide approach to enabling service users with autism to access Trust mental health services	COO	All	Complete implementation of ASD clip	ASD clip in use across all Trust Localities	Q4 18/19	Jacqui Dyson	R	Clip was not finalised until February 2019, roll out will commence in May 2019. There are actions in the 19/20 plan which replace this action. Trust Board are asked to approve the removal of these action and metric
1.15.3	Improve the physical environment at Roseberry Park	COO	All	Implementation of rectification plan	Implementation of plan commenced	Q4 18/19	Patrick McGahon	R	Trust Board are requested to change the wording of the metric to "*Trust framework in place"* and to extend the timescale to end Q2 19/20.
1.15.4	Improve the physical environment at Roseberry Park	COO	All	Key actions delivered in line with Programme Plan	Implementation of plan commenced	Q4 18/19	Patrick McGahon	R	Trust Board are requested to change the wording of the metric to "*Programme Plan revised to reflect cessation of P22 Framework process"* and extend the timescale to end Q2 19/20.
2.4.9	Right Staffing/Workforce	Nursing and Governance	All	Complete Phase 1 of community-based roster roll-out	Phase 1 completed	Q4 18/19	Joe Bergin	R	Work continues to finalise the finance and roll-out phase 1 of the pilot involving a cohort of 4 teams Trust Board are asked to approve the extension to time to Q1 19/20
2.4.10	Right Staffing/Workforce	Nursing and Governan	All	Provide data for External Audit in relation to Roster	Data provided for External Audit	Q4 18/19	Joe Bergin	GY	Audit One were due to come and perform a re-audit and check actions from previous audit -

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
		ce		Practices and Escalation					however they have now abandoned plans to do this as they feel it is not appropriate Trust Board are asked to approve the removal of these action and metric
1.18. 6	Improve the personalisation of care planning	Nursing and Governance	All	Re-audit and report as per Q4 17/18	Re-audit as per 2017/2018 audit and compare Review patient and carers experience January 19 and compare Report on findings and recommendations and re-start cycle of continuous improvement	Q4 18/19	Michael Cowan	R	As the original audit did not take place on time it has been necessary to delay the re-audit to Q3 2019/20 Therefore Trust Board are asked to approve the extension to time to Q3 19/20
1.19. 10	Develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services	Nursing and Governance	All	To engage partner and stakeholders to agree a future approach and produce the framework/document which outlines the forward view for dual diagnosis	Framework and future plan agreed by appropriate TEWV governance meetings	Q4 18/19	Wolfgang Kuster	R	Due to the Trust-wide Dual Diagnosis lead acting into another role and no permanent replacement being appointed as yet this action has not been completed. Trust Board are asked to approve an extension to Q1 19/20

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
3.6.3	Making a Difference Together	Human Resources	All	Evaluate and report the impact of crowdsourcing activities to the Board of Directors	Crowdsourcing evaluation presented to members of Board of Directors	18/19 Q4	David Levy	R	There is an event scheduled 8th May to launch the results of the staff survey. Trust Board are asked to approve an extension to Q1 19/20
3.3.6	Making a Difference Together	Human Resources	All	Agree future culture metrics	Trust cultural metrics and collection systems / frequency agreed by Executive Management Team	Q4 18/19	David Levy	GY	EMT agreed to put this action on hold and review it as part of the new MADT plan
4.9.2	Evaluate and agree future collaboration with universities on research, education and training	Medical	All	To identify a lead liaison link for each university to enhance engagement and communication	University Liaison leads identified	Q4 18/19	Joe Reilly	R	There is still work outstanding n - The Academic Liaison Group have met and drafted a list of potential Trust contacts for each institution, but work continues to finalise this. Work will be completed by June 19. Trust Board are requested to approve an extension to Q1 19/20
4.9.3	Evaluate and agree future collaboration with universities on research, education and training	Medical	All	To develop an engagement plan to support services to engage with universities more widely for research, training, education and service evaluations	Engagement plan presented at the University Liaison Group	Q4 18/19	Joe Reilly	R	Work continues to finalise this and due to be completed by June 19. Trust Board are requested to approve an extension to Q1 19/20

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

Tees, Esk and Wear Valleys NHS

NHS Foundation Trust

END OF PROGRAMME REPORT

Please do not use this form for stand-alone projects that do not report to a programme board.

Programme name	Purposeful & Productive Community Services (PPCS)
Programme Manager:	Nicola D'Northwood

"parent" programme	Purposeful & Productive Community Services (PPCS)
Programme Board discussion date	11/02/2019

In February 2016 the Trust launched the Purposeful and Productive Community Services (PPCS) Programme, encompassing all community services across the Trust. The Programme set out to deliver 7 key targets by March 2019, this comprised:

- 30% increase in contacts
- 30% increase in "purposeful time" (activity recording)
- 15% reduction in direct cost budget
- 100% patients on an agreed purposeful pathway
- 90% satisfaction of patients through FFT
- 90% of referrals seen within 28 days
- 100% completeness of CROMs/PROMs/PREMs

To support the delivery of these key targets the programme was to be delivered in two phases:

- Phase I improving and making more efficient team processes
- Phase II improving and making clinical pathways more purposeful

Phase I saw the development and implementation of a number of "products" to achieve operational stability and increase service efficiency, this comprised of:

- The development and introduction of cells comprising of a CPN, nurse/ care co-ordinator, lead professional and an AHP
- The introduction of huddles to primarily discuss service users seen the previous working day, articulate aims of involvement and ongoing interventions, support improvement and reinforce focusing on the right things.
- The development and introduction of standard systems such as the huddle timesheet and visual control boards (whiteboards)
- The introduction of diary / activity management, ensuring standard approach to organising and managing the working day and week to ensure optimum efficiency.
- The introduction of direct inputting into PARIS

Later as the programme developed there were further considerations and new work streams developed to compliment Phase I; this included the scoping and identification of the most efficient and effective use of the current technology in use to reduce waste which led to a more recent development in 2018 seeing the introduction of business conferencing facilities. In addition, the programme also included a programme of leadership for leaders using the ThinkOn approach and methodology, helping to support teams and staff to feel empowered to make decisions and in doing so bring about improved and sustainable change. These two elements will require analysis when more data is collected.

A review of how well Phase I products were being implemented across community services was undertaken, this involved the teams self-assessment as well as the undertaking of a quality assurance process by the KPO team. Due to the level of variation amongst teams with regards to the implementation of Phase I products, each locality have provided their own summary of how well the products have been embedded. D&D have progressed further with their self-assessment of the phase I products which can be seen in the report attached in Annex 1, however the other localities are to take a similar approach, therefore in the interim NY, Y&S and Teesside localities have provided a summary statement in Annex 2.

Following the implementation of the phase I products, the programme undertook a refresh in November 2017 with the aim of reviewing the programme's progress as well as formally launching phase II. It was at this stage of the programme, that a proposal was made to identify twelve community teams that could support a more focused approach in relation to any new developments or testing of new processes. The identification of the teams, the workplan and associated improvement work within the 12 teams gave valuable learning around ways of working but the full potential benefits of this approach was not realised.

It was realised that the scope of the programme was too limited having a sole focus upon community teams when work is also needed to be undertaken around urgent care and inpatients services as well. On this basis the PPCS programme board and Executive Management team considered it appropriate to identify a new priority widening the scope to all services.

An evaluation has been made against the 7 key targets that were identified at the launch of the PPCS programme in 2016, with comparisons being made where possible, against baseline data obtained for the financial year 2015 / 16. The findings are detailed below:

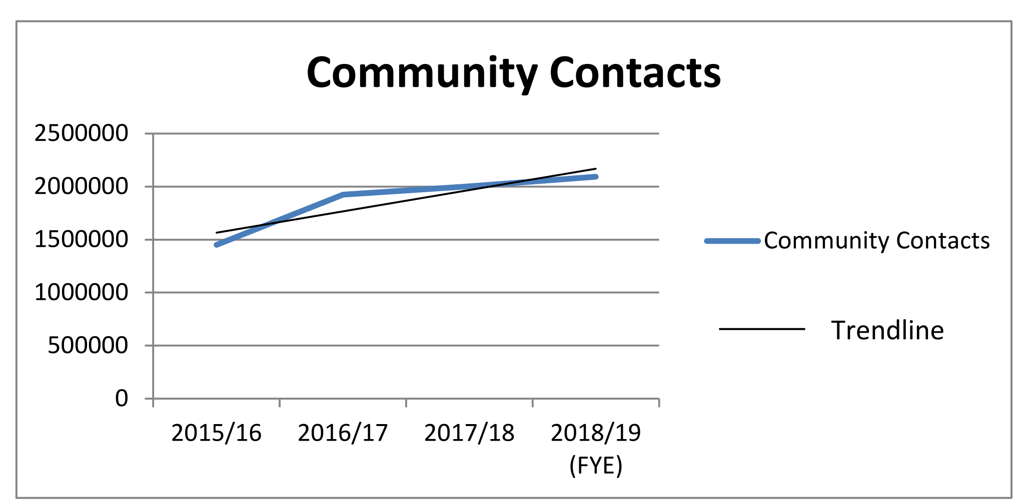
Target 1. 30% increase in contacts

Data was collected for all community teams within each speciality (Table 1, page 3.) If the predicted trajectory is correct, and there is a consistent incremental rise in the number of contacts as has been shown year on year, then the 30% target will be exceeded. It is anticipated that by March 2019 community services as a whole will have increased their contacts by approximately 44%. Graph 1, page 3 demonstrates the incremental rise in contacts year on year.

Table 1.

Timeline	MHSOP	AMH	LD	CYPS
15/16 Baseline	360,396	767,999	113,410	208,039
16/17	508,527	1001,449	148,056	264,685
17/18	512,046	885,374	154,737	308,466
18/19	455,550	885,374	129,226	272,350
18/19 FYE	546,660	1062,449	155,071	326,820

Graph 1.



Further analysis was undertaken to identify the % increase in contacts per WTE through efficient and more productive ways of working. Due to the timelines for the integration of the York & Selby services into the Trust it was not possible to use April 2015 as a baseline, therefore for comparison purposes the WTE data has been used for the months of April 2016, April 2017 and April 2018 and January 2019.

The tables 2a and 2b below show the WTE for the months stated above (2b) and the total number of contacts recorded for the corresponding year (2a). The % increase has therefore been derived by calculating the difference between the number of contacts and WTE for the period 2016/17 and the difference in 2018/19 using the FYE figure. If the contact trajectory continues as expected then this would demonstrate a 4.5% increase in contacts per WTE.

Table 2a

Reporting period	Total Contacts
2016/17	3697508
2017/18	3846180
2018/19 (31st Jan)	3354112
2018/19 (FYE)	**4096740**

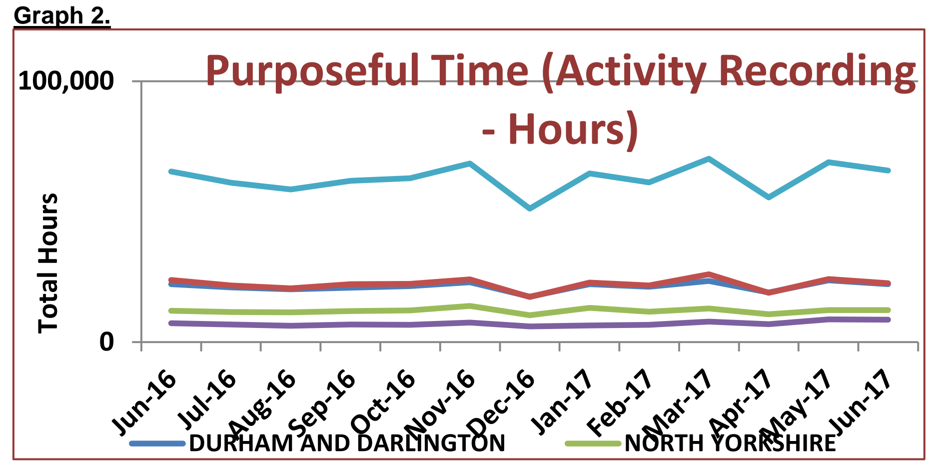
Table 2b

Reporting period	Clinical WTE
April 2015	1876.95
April 2016	2100.22 * integration of Y&S services
April 2017	2138.2
April 2018	2183.46
January 2019	2225.31

Target 2. 30% increase in "purposeful time" (activity recording)

For approximately 12 months (June 2016 to June2017) the programme tracked "purposeful time" / activity recording. During this period which denotes the early stages of the programme there appeared to be no significant changes to activity recording as can be seen in Graph 2.

Graph 2.

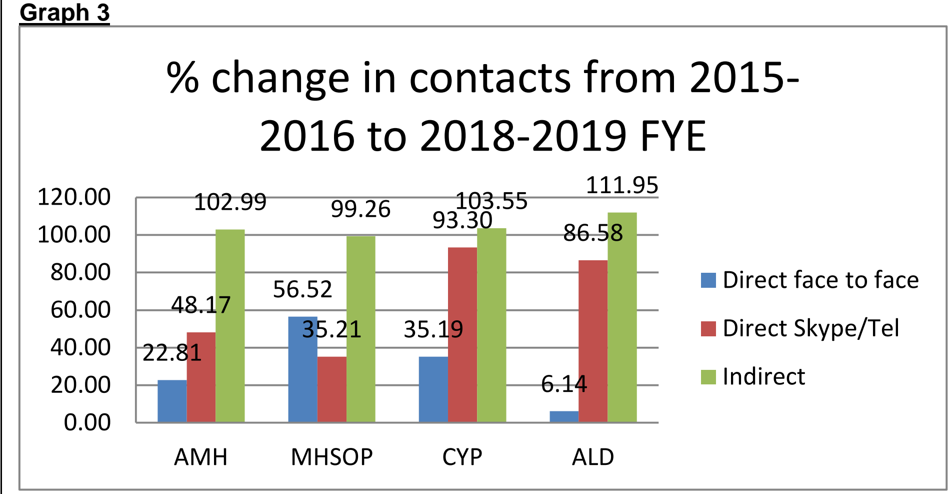


Unfortunately due to a review of the metrics part way through the programme; reporting upon this target ceased after this period and therefore specific data relating to Direct face to face, Direct Skype/ telephone and Indirect contacts were obtained from the IIC.

Graph 3 (page 5) shows the percentage change by contact type within each speciality comparing the data from 2015 /16 (baseline) to 2018/19 (FYE). Children's and LD services are showing the greatest % increase in skype/telephone contacts, whilst all four specialities are showing an increase in indirect contacts.

There is an overall increase in contacts by each type; however there are some noticeable differences between the AMH and MHSOP services compared with Children and LD services which may be due to a combination of the client group, variations in practice and service set up i.e. the Single Point of Access within Children's services. Unfortunately due to no baseline data being available we have been unable to determine whether the target of 30% has been achieved, however the graph shows some significant increases in "purposeful time" activity recorded.

Graph 3



In addition to the activity recording data provided above, work was undertaken within the 12 teams to implement and assess the impact to PARIS inputting time and completion of the clinical record as a result of direct inputting (phase I product).

The results of this development have shown some significant benefits in efficiency / productivity gains across most of the teams however the level of variation in efficiency / productivity gains is variable with some teams showing deterioration from baseline which may require further exploration following the programme closure.

Completion of the clinical record in single instance (at 120 day report out):

Team	Baseline (time in minutes)	Method of Input	120 day re-measure (time in minutes)	% change from baseline
Ham and Rich LD	413	Andon and protected diary time	135	67% IMP
		Direct inputting/ co-production	35	92% IMP
York and Selby LD	1070	Andon and protected diary time	765	29% IMP
		Direct inputting/ co-production	40	96% IMP
Durham, CLS and Easington	182	Andon and protected diary time	172	5% IMP
		Direct inputting/ co-production	206	13% DET
	328	Andon and protected diary time	193	41% IMP
		Direct inputting/ co-production	163	50% IMP
MHSOP Redcar and Cleveland	811	Andon and protected diary time	146	82% IMP
	78	Direct inputting/ co-production	61	22% IMP
MHSOP Stockton	87	Andon and protected diary time	388	346% DET
		Direct inputting/ co-production	48	44% IMP
Darlington Psychosis	1531	Andon and protected diary time	1271	17% IMP
		Direct inputting/ co-production**	45	97% IMP
		Begin entry with service user, complete at base	130	92% IMP
	148	Andon and protected diary time	20	87% IMP

Target 3. 15% reduction in direct cost budget

In July 2016 the PPCS data model was rolled out to teams and suggested as a Trust we had a potential of £20m+ savings in community teams. As a result the target was refined to achieving £6.1m per year for 3 years to 2018/19. This was later extended to 2019/20 in acknowledgement of the work required to validate the PPCS data as well as rolling out the phase one products into teams.

To date £7.1m of CRES has been delivered from community teams, with a further £1.8m identified to deliver in 2019/20. It is acknowledged that not all CRES Schemes where linked directly to the PPCS programme but have been delivered through a combination of PPCS products and other non PPCS initiatives all of which has been included here.

The direct cost budget at the time of the programme launch was £122.4m and therefore this represents 7.24% of direct cost savings (£8,861k / £122,365k).

Table 3 (page 6) shows details of the £6.1m expected savings by locality and delivery against target.

Table 3 **PPCS Programme CRES Delivery**

Financial Year	D&D £000	Tees £000	NY £000	Y&S £000	**Total £000**
Target					
2016/17	2,189	1,949	1,227	753	**6,118**
2017/18	2,189	1,949	1,227	753	**6,118**
2018/19	2,189	1,949	1,227	753	**6,118**
Target	**6,567**	**5,847**	**3,681**	**2,259**	**18,354**
Identified schemes					
2016/17 *	1,111	848	36		1,995
2017/18 *	746	1,341	378	529	2,994
2018/19 *	200	957	149	800	2,106
2019/20	1,062	622	-52	134	1,766
Delivered & Identified	**3,119**	**3,768**	**511**	**1,463**	**8,861**
Further savings anticipated	**3,448**	**2,079**	**3,170**	**796**	**9,493**

* delivered

Target 4. 100% patients on an agreed purposeful pathway

It was acknowledged that this element of the programme presented some challenges in trying to identify the purpose and scope of this work stream. Unfortunately no metrics were identified that would allow evaluation of this target.

Target 5. 90% satisfaction of patients through FFT

Unfortunately 2015/16 data was unable to be obtained and therefore no comparison could be made against baseline however the data collected between June 2016 and June 17 showed an average patient satisfaction rate of 88.24%. Current data (January 2018 to 31st January 2019) shows community services achieving an average patient satisfaction rate of 88.39%.

Across the 2 reporting years (2017/18 and 2018/19) every month with the exception of January 2019, has demonstrated patient satisfaction being between 87% and 89%, with January 2019 showing a satisfaction rate of 90.05%. Although January 2019 shows a 90% satisfaction rate analysis of the data for the past two years shows a consistent pattern of being below target, January being the exception.

Target 6. 90% of referrals seen within 28 days

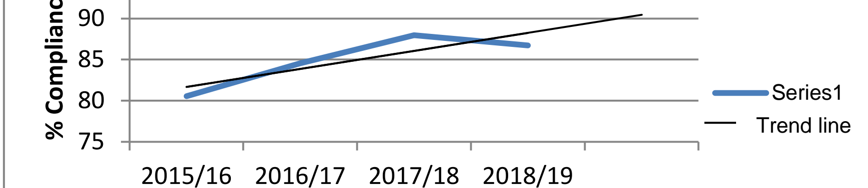
Since the launch of the PPCS programme in February 2016, analysis of the data for the period 1st April 2015 to 31st Jan 2019, taken from the Trust dashboard, shows a difference of -3.27% against the target. However the data demonstrates that there has been an incremental rise year on year from 2015/16 to 2017/18 in the number of referrals seen within 28 days.

The current % rate for 18/19 is not a full year effect therefore it is possible that if trajectory continues as expected the 90% target may be reached by the end of March 2019. Table 4 and graph 4 below, shows the trend year on year. Of interest there has been a similar trend associated with the number of new patient referrals over the same time period, which has been increasing year on year.

Table 4.

Baseline data 2015/16	2016/17	2017/18	April 18 to Jan 19
80.55%	84.57%	87.96%	86.73%

Graph 4.



Target 7. 100% completeness of CROMs/PROMs/PREMs

For a period of 12 months from when the programme commenced the completeness of the PROM and CROM tools were tracked. The data recorded between June 2016 and June 2017

showed that the level of completeness for both was below 100%, however CROM showed a 96.8% completion rate and PROM had a much lower rate of 68%. Due to a review and change in the PPCS metrics the tracking of this stopped. It has been difficult to obtain meaningful data from IIC, therefore no further analysis could be undertaken in relation to this target.

Conclusion

Unfortunately due to issues in retrieval of baseline data and inability to measure some of the targets due to no meaningful metric and measurement in place or conversely a change in metric and measurements part way through the programme it proved difficult to make comparisons for some of the targets to establish if it had been achieved. However, despite this, what data could be obtained did demonstrate a very positive position with an increased level of productivity and efficiency within community services across the Trust.

If trajectory continues as expected then two of the targets should be achieved, (target 1 and 6) which would show an even greater level of productivity than that expected from the start of the programme. Furthermore, we can see incremental improvements year on year across all of the targets with the exception of targets 4 and 7 where meaningful data could not be obtained.

Unfortunately the £18 million CRES allocated to this programme which equated to the15% reduction in base line budgets was not fully realised with 7.24% (£8,861million) being achieved. Further work will need to continue out with this programme to identify and deliver this, however the localities have identified that not all products are embedded, therefore there may be further contributions that can be identified as this work is taken forward by localities and teams.

It is evident that there has been an improving picture for the lifetime of the programme against most of the targets, however it is difficult to say with confidence that this is solely due to the PPCS programme. It is reasonable to assume that where improvements have been demonstrated these may have been a result of the combined effect of products delivered through PPCS and the outputs of various service developments / changes and / or other strategic programmes, this can be evidenced through the CRES schemes which were not all aligned to product delivery, never the less this should not detract from the positive impact that has been demonstrated.

Despite the closure of the programme, it will be the responsibility of the localities and teams to ensure that the products are fully embedded and consistently used. This should then be followed up with a quality assurance assessment, along with the canvassing of staff, like that undertaken within D&D to assess the impact upon staff.

Is there anything that was supposed to be delivered but has not been? (and why)

The programme was successful in delivery and implementation of the phase I products, however there was less success in delivery of phase II which focused upon pathway development. Primarily this was due to a change in programme focus part way in, and uncertainty around scope and vision for the phase II element which caused the programme to lose momentum.

Has anything that has been delivered been below the quality standard or specification originally agreed (and why)?

There have been no products identified that have been below the required standard, However the sustainability and scale of spread of using the products has been variable.

Are there any ongoing issues that cannot be "closed" by the programme team and which must either be taken on by someone else or left "open" and unresolved

Issue No.	"Open" Issue	Action Required	Responsibility
1	Delivery of CRES	The delivery of this needs to explored further and realistic target set against other programmes or work.	COO and Director of Finance
2	Development of purposeful and productive pathways	This will be transferred across to the PPS Programme, however further work is required around this to define scope.	COO and Programme Manager PPS
3	Undertaking of a follow up quality assurance assessment within each locality with an assessment / evaluation of the impact upon staff.	Discussions between each locality and the KPO team.	Directors of Operations and the KPO office.

Lessons Learned	
What Worked Well?	• Working relationship between OD/coaching and KPO • Adoption and scale of implementation of the products in Phase I • Improving the efficiency and productivity of community teams through the development and implementation of the phase I products. • Contribution to the overall positive impact on efficiency and productivity of services and at such scale across a geographically large Trust • Using QIS methodology to provide a framework to

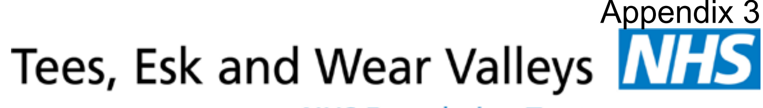
	undertake the work • Good leadership within teams that supported staff and brought about effective change • Involvement of the Information team in discussing clinical usage of hardware / software. • The PARIS/IT work created some 'penny dropping' situations, particularly in relation to diary management – this confirmed that staff need to feel the benefits themselves rather than just being told
What didn't work well	• There was a lack of robust planning prior to the commencement of the programme to build a detailed business case around the vision, goals and benefits (including baseline data) to fully enable true programme benefits to be measured. • The message and direction for teams lacked clarity and consistency, therefore failing to engage and empower teams. • Challenge to deliver change due to the size and scale of the organisation • Phase one products were not sustained as was initially thought – there was a strong sense that this explicitly linked to the variation in leadership across the teams, this took rework / time to ensure sustainability. • Quality Assurance has limited impact if not followed up with methods of Quality Control (QC) which need to be locally owned within the team/service • Not all teams are engaged in understanding the benefits • Multiple changes in Programme sponsorship which altered the direction of the programme within short time periods, causing an element of uncertainty and confusion • Change of metrics part way through the programme and no baseline data to refer to. • Keeping staff / localities up to date with progress and impact • Visibility and identification of change managers to support the scale and scope of work • Scope of the programme was too big • Variations in understanding of what needed to be achieved and in what a pathway was • Lack of programme change control

What would you do differently?	• Be clear about the vision, model and goals of the programme • Consider carefully the scope, scale and pace of the programme to ensure that deliverables / outputs are achievable. • Agree communication plan at the start • Assess willingness and motivation of staff to engage • Ensure regular scheduled checkpoints within programmes to take stock and assess whether the programme can deliver on those metrics agreed at the start. • Ensure there is baseline data identified and reporting mechanisms built in at the start of the programme to facilitate easier review and evaluation during and the end of the programmes life cycle. • Consider testing out of ideas and involving a range of staff at different stages to hear their thoughts and actively engage them • Clarity of clinical pathways is critical in supporting the development of IT systems as well as the broader PPCS agenda of reducing variation • Consider carefully the need to change any part of the programme scope or metrics after the start of the programme and the impact this may have in evaluation • Agree delivery model before identifying systems and processes • Preparation, engagement and communication with staff • Identification and visibility of change managers to support fully the work. • If metrics are to be reviewed part way through a programme the impact / risk of being able to measure from baseline and at the end of the programme needs to be considered

Programme Delivery Summary	
Was the Programme Delivered within the allocated resources?	The project was delivered within the allocated resources

Programme Delivery Summary	
Was the programme delivered to the agreed timescale?	Due to multiple factors the programme has not been fully delivered within the agreed timeframes. As a result of this, the programme is to be evaluated and closed.
The number of Change requests submitted	Throughout the programme there has been one change request form completed and approved by EMT and SCOB.

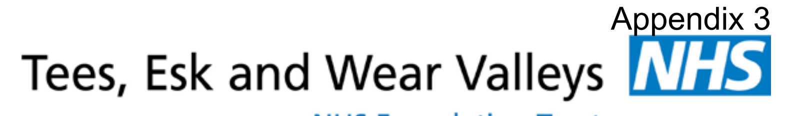
Sign off -				
We confirm that the programme is to be closed having fully considered the information presented within the programme evaluation.				
	Signature	**Print name**	**Position**	**Date**
Project Manager				*DD/MM/YY*
Programme Board (signed by Chair)				*DD/MM/YY*



Annex 1

Durham and Darlington Summary Feb 2019
Durham and Darlington continue to utilise the PPCS Phase 1 products across all specialities. In December 2018, we agreed a locality wide focus to reduce clinical time spent on PARIS, underpinned by phase 1 products. This has reaffirmed, for many teams, how important the phase 1 products are in: understanding demand and capacity; levelling work; sharing decision making as a team; achieving one piece flow to maintain accurate clinical records and in promoting staff health and well-being. This work is a key enabler for co-production, with the expectation that our service users and carers are encouraged to be involved in agreeing the content of their PARIS recording at every stage of their journey.

A summary of the feedback from all specialities is included below:



Durham and Darlington Locality QIS Report Out 7 December 2018 – Speciality Feedback

Speciality:	**Adult Mental Health**
Helpful Thoughts • Improved staff well-being – not worrying about work • Improved flow and decreased batching • Done on the day and with the patient/carer • Accuracy of info improved – real time • Provide date/time, share vision – do it then! → • Free up staff time • CITO developments will help to streamline and support	**Hindering Thoughts** • Does this lead to more work, more appointments? • Staff 'hindering' thoughts • Cover of work (current) to cascade work • Difficulties with more 'complex' clients • Potential to minimise complaints as patients more aware of info • Impersonal – must be mindful of relationship building/eye contact/room/non verbal's • Issues with technology and approach • Staff well-being – health and safety • Slowness of doing – on PARIS? CITO will improve
Staff Questionnaire • Doesn't include desk top computers • Confidence in smart phone/keyboard skills/IT • Other methods of input as opposed to just typing in? • Suggestions listed on questionnaire	**How will you cascade information from today?** • Huddles • Podcasts • Team meetings/leadership plans • Access clinicians to cascade • Community managers meetings - agenda
Which team/teams are ready now or in the near future? • Some doing already (Access) but not all • Identify those teams with equipment needs • Crisis teams ready • EIP 80% ready • Darlington Community Teams – once staff in situ • NB to achieve this we need: - Equipment - Time to learn	**What is your defined goal in a single sentence?** By June 2019 all of the AMH teams in scope will be undertaking direct inputting in the electronic system and benefits will be realised **How strong is your reason for wanting to achieve this?** Extremely Weak ... Extremely Strong **1 2 3 4 5 6 7 8 9 10**

- Training/skills	**How achievable do you believe this goal to be (on scale of 1-10)?** Extremely Weak ... Extremely Strong **1 2 3 4 5 6 7 8 9 10**
	What could increase these scores e.g. resources/support/further clarification/information? Kit, technology, then with further training, learning and skills SMART phones Confidence increase and culture

Speciality:	**Mental Health Services for Older People**

Helpful Thoughts	**Hindering Thoughts**
• Can use word documents then transfer to PARIS – help to resolve/ mitigate IG • Honest, objective view of direct inputting • Investment in new equipment – different types • Not having to complete target progress report for all teams re PARIS event • Carrot, not stick approach • CITO from clinicians perspective • Laptops for clinicians • Acknowledge staff have different skills	• Basic IT skills • Lack of clarity as to what is direct inputting • Individuals don't want to try it • Need realistic benchmark • Risk clinical support • Include liaison patients • What has gone before may have disengaged some staff • How to involve medics
Staff Questionnaire	**How will you cascade information from today?**
• What is the purpose of the questionnaire – what are we trying to achieve? • Q7a, 7b, 7c – combine and ask 1 question "If yes, how many hours?" • Questions 16 and 17 – minimise space by reducing rows; having 'yes' 'no' 'sometimes' next to the question and just circle answer • Add a question with regard to phone signal (i.e. black spots) • Question 8, change to read "Do you have **access** to a laptop?" • Add sub-question to 8, if Yes – is it your own laptop? • Question 9 - don't understand how relevant data can be gathered from the rating scale – suggest yes/no answers • Question 12 – staff may feel confident using a laptop but may not have adequate IT skills, suggest re-framing the question • Use more open questions, i.e. "what is it which causes you not to direct input?" • Need to consider a different questionnaire for liaison staff	• Consensus that there should be a communication message from Levi Buckley re how the future will look • Incorporate into Team Briefing

<table>
<tr>
<td rowspan="4">Which team/teams are ready now or in the near future?

• All teams – with access to IT
- Clinic based
- Andons
- Diary Time</td>
<td>What is your defined goal in a single sentence?

Process that staff feel able to accomplish that incorporates record keeping that is required</td>
</tr>
<tr>
<td>How strong is your reason for wanting to achieve this?
Extremely Weak … Extremely Strong
1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>How achievable do you believe this goal to be (on scale of 1-10)?
Extremely Weak … Extremely Strong
1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>What could increase these scores e.g. resources/support/further clarification/information?

Information Technology
CITO
Clear structure/guidance</td>
</tr>
</table>

Speciality: **Children and Young Peoples' Service**

Helpful Thoughts

- Positive to see that this has released time for clinicians
- Feels very appropriate for the majority of our 'population' who are so comfortable with technology – suspect most prefer IT options!
- Being able to touch type is a big advantage
- Hearts and minds is so important
- Most of out appointments are in a team base so tethering shouldn't be needed
- Must not forget that our experience in South Durham has demonstrated that prep time for clinician before appointment is really important to review referral/ATS and avoid duplication of assessment/questioning
- Peer to peer sharing of learning is so important
- Using telephone slots to deal with non-urgent queries has really helped us to reduce interruptions

Hindering Thoughts

- Issues with kit – some take so long to load
- Basic key board skills – not all staff have these and no in house training available

Staff Questionnaire

- No concerns
- Agreed Team Managers will distribute via huddles w/b 10 Dec and bring completed copies back to Team Manager Meeting on 17 Dec and share with KPO for analysis

How will you cascade information from today?

- Share and spread event planned in Jan 2019
- Via leadership teams
- Huddles
- Team Managers' Meeting

Which team/teams are ready now or in the near future?

- Will discuss further in share and spread event planned for Jan 2019

What is your defined goal in a single sentence?

We will decrease the time clinicians spend after appointments on administrative tasks by ensuring clinicians have the right skills, kit and processes which will increase our time available for clinical work

How strong is your reason for wanting to achieve this?

Extremely Weak								Extremely Strong
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**

<table>
<tr><td colspan="2"></td><td>10</td></tr>
<tr><td colspan="2"></td><td>How achievable do you believe this goal to be (on scale of 1-10)?
Extremely Weak ... Extremely Strong
1 2 3 4 5 6 7 8 9 10</td></tr>
<tr><td colspan="2"></td><td>What could increase these scores e.g. resources/support/further clarification/information?
• Touch typing/basic keyboard skills training is essential
• Will CITO have spell check function (like word) to show in real time?
• Diary management– diaries are set up with planned slots but day to day management/juggling proves very difficult</td></tr>
<tr><td>Speciality:</td><td colspan="2">Learning Disability</td></tr>
<tr><td colspan="2">Helpful Thoughts
• Protected time already being used in some teams – so teams are engaged
• Excited about what we have heard today
• CITO will revolutionise the way we work
• Cut down on wasted time
• This will give us more time to co-produce
• Direct inputting in other environments is the norm – so why wouldn’t we do it
• Should be able to use outcome tools in real time too (CITO & direct inputting)</td><td>Hindering Thoughts
• Need to win over the leadership teams in the LA
• Protected time or andons can and have been introduced but still need people in the team to adhere to it (office etiquette)
• Must have the new kit to support this (direct inputting) that will meet the needs of the service from both a connectivity and hardware perspective
• Still have confusion over what information can and cannot be entered into a diary entry (name, address etc) – IG are too rigid and need to learn from acute sector</td></tr>
<tr><td colspan="2">Staff Questionnaire
The only comment was can it be adapted to meet the needs of the LA so replace PARIS with ‘electronic patient record or SID)</td><td>How will you cascade information from today?

For integrated teams, this will have to go through the TEWV/LA board – need to agree who and how this will happen?</td></tr>
</table>

	Also, to note this needs to potentially link to the service review that is about to commence. Would be good to hear from peers within LD who are direct inputting – can this be arranged?
Which team/teams are ready now or in the near future? Darlington LD Health Facilitation Team Specialist Health Team *Questionnaires have gone out to these teams* Score for integrated teams Score for other teams	**What is your defined goal in a single sentence?**
	How strong is your reason for wanting to achieve this? Extremely Weak ... Extremely Strong **1 2 3 4 5 6 7 8 9 10**
	How achievable do you believe this goal to be (on scale of 1-10)? Extremely Weak ... Extremely Strong **1 2 3 4 5 6 7 8 9 10**
	What could increase these scores e.g. resources/support/further clarification/information?

Inevitably we continue to see variation in the embeddedness of Phase 1 products, however leadership teams are engaged in understanding the reasons for this. Since January 2019, all specialities have sought community staff feedback to understand current issues regarding PARIS in terms of 'people, process and technology'. Leadership teams are currently reviewing this feedback and engaging with their teams to understand this further. Some common themes have emerged and examples of team level data are shown below. Phase 1 underpins this work and issues being explored include – why are diary slots not being protected? If they are, why aren't they being used? Why are staff being interrupted when making PARIS entries? Are the interruptions necessary (e.g. urgent clinical issues) or could this wait until the next cell huddle? How does this impact on the working week – are staff working additional hours to 'catch up'? What impact does this have on staff health and well-being?

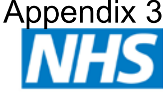
We will continue to test this approach over the coming months.

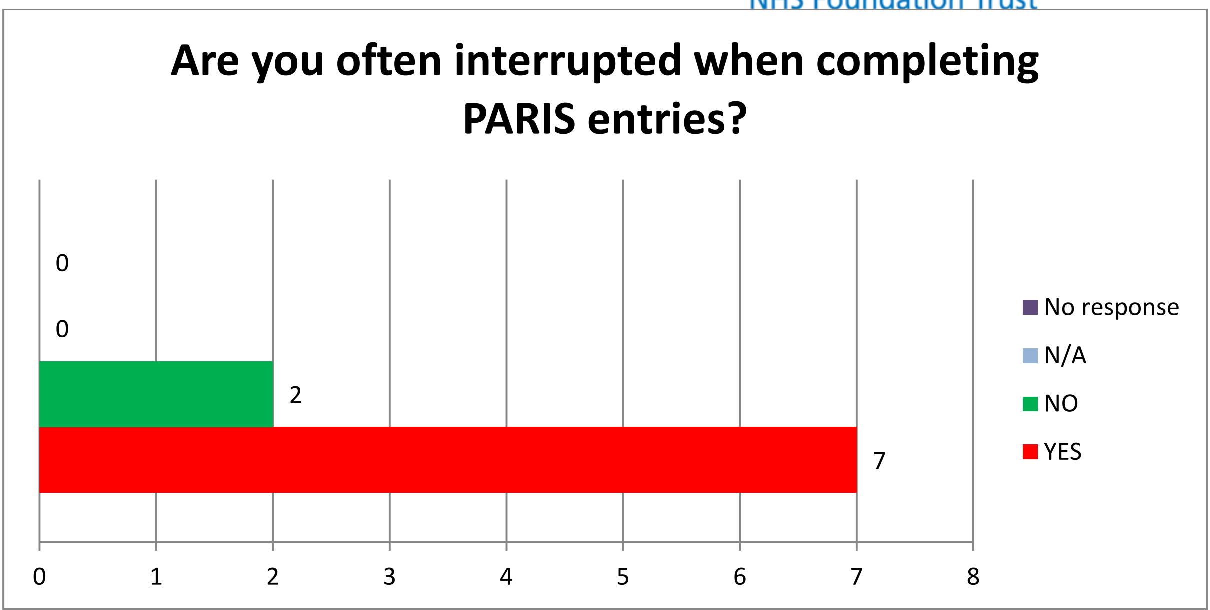
Do you have diary slots for PARIS inputting time protected in your diary on a daily basis?

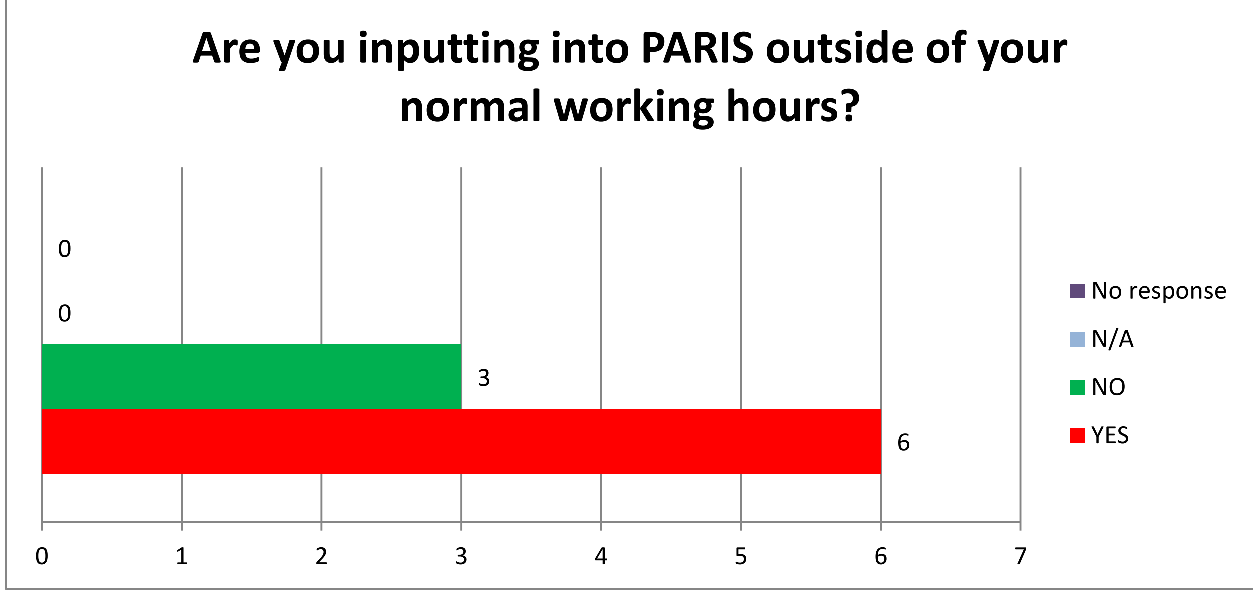
Response	Count
No response	0
N/A	0
NO	2
YES	7

If yes, are you usually able to use these protected slots to make PARIS entries?

Response	Count
No response	0
N/A	0
NO	3
YES	4


NHS


Are you often interrupted when completing PARIS entries?
0
0
2
7
0
1
2
3
4
5
6
7
8
No response
N/A
NO
YES


Are you inputting into PARIS outside of your normal working hours?
0
0
3
6
0
1
2
3
4
5
6
7
No response
N/A
NO
YES

Annex 2

Teesside Summary February 2019

Phase 1 PPCS products were at October 2017 embedded within 23 in scope teams within Teesside. This was largely a locality self-assessed position with only 5 of the 23 teams having a quality assurance assessment (both ALD teams, 2 MHSOP teams and 1 AMH team). Clinical pathways were the area where full implementation was still required, ALD pathways were viewed as fully implemented , the AMH Affective Disorders pathway was partially implemented, the MHSOP Functional Pathway was fully implemented in half of the teams and the MHSOP and the Behaviours that challenge CLIP was agreed with an implementation plan in place. There was no pathway available relevant to CYPs services. Further Quality Assurance undertaken in December 2017 in preparation for phase 2 products with Tees Teams who were to be pilot sites demonstrated full implementation of Phase 1 products within MHSOP with partial implementation of the Behaviours that Challenge Clip, partial Implementation of Phase 1 products and clinical pathway within CYPs and ALD. Since this time further teams who were not originally 'in scope' across Tees have adopted all or some of the products as benefits have been realised.

The findings of the 2017 self and quality assurance assessments suggest that there is scope to embed the Phase 1 products further. This is consistent with the views gathered across Tees Teams as more recently as part of the ongoing PPCs work stream. Locality management and clinical leads viewed that there may have been an adaptation of the original application of some products from Phase 1 and that full benefits from the products may not be being realised due to the basic principles being applied rather than the product as a whole. Across the locality it was agreed that there would be benefits to a further piece of quality assurance work revisiting the implementation of Phase 1 products and a process of Governance of products similar to that within the Purposeful Inpatient Admission processes that allows for the ongoing development of products and standard work but ensures appropriate evaluation of any change prior to larger implementation to ensure consistency and shared learning across services.

The implementation of Phase two products across Tees involved three of the four specialities Children and Young Peoples Services, Mental Health Services for Older People and Adult Learning Disabilities. Direct inputting was progressed in seven teams largely within the initial assessment element of the pathway with varying degrees of uptake by staff and greatest progress within Older Peoples Services. All of the pilot teams felt further observation and implementation work was required. Andons were adopted, though more recent discussions have highlighted a need to continuously reinvigorate the etiquette surrounding these as the impact was reducing. Supercells and teams felt they benefited from the support of master coaches across Tees in developing the team vision and umbrella goals. Latterly master coaches were at the request of Heads of Service providing support into additional teams due to the previously noted benefits, however capacity of master coaches at that point in time was highlighted as a potential block and there was a need to prioritise.

York & Selby Summary February 2019

York and Selby used to have regular updates on the PPCS phase 1 products until about 6 months ago. After this observations were carried out by two staff from KPO who went to each team looking at the implementation of the PPCS tools. At this time there was a good take up of the products and a good understanding of the use of huddles and visual control but patchy implementation of some of the phase 2 tools and methods particular direct entry. Overall there has been a very positive impact from the use of PPCS tools by teams across York and Selby and this can be easily seen and working is clearly carried out differently than before the project started. There are some individuals who have adopted the changes more readily than others and there has perhaps been more of a focus on those who want to take up the alternative ways of working, rather than ensuring everybody does. This will be the challenge of the next 6 to 12 months and is part of the merger plans when there will be a focus on the differences between teams and a determination to ensure greater consistency.

North Yorkshire Summary February 2019

There has been a good uptake of the products with a real emphasis and focus on leadership to help support the embedding and sustainability of the products within teams. There has been a good uptake and understanding of the daily huddles which has worked very well and there is now medic involvement within the Hambleton cell, which has proven to be really beneficial and therefore has supported the clinical leadership in more meaningful conversations and supported decision making. The clinical leadership cell is very much in its early days but work continues to be progressed to ensure a lean process and full engagement with the team.
The addition of Skype huddles has been a real positive progression however there have been issues with the IT infrastructure which has impacted upon the ability to use this to its optimum effect, however there have been Skype trials of consultant to patient on two occasions and this has worked well with very positive feedback received from the patients.
The diary management is undergoing some change due to changes in working and the model for seven day working.
Overall some changes have embedded really quickly with other changes requiring a little more time, with some staff requiring additional support and encouragement to utilise this change in practice (CLS).
Areas that still require attention are identification of a safe clinical caseload and the ideal community workforce. This will therefore be the challenge of the next 6 to 12 months and is part of the merger plans when there will be a focus on the differences between teams and a determination to ensure greater consistency.

FOR GENERAL RELEASE **Item No 18**

BOARD OF DIRECTORS

DATE:	**21st May 2019**
TITLE:	**To consider the publication of information on compliance with the public sector duty under the Equality Act**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Decision**

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

Executive Summary:

The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users and staff who share a relevant protected characteristic who are affected by its policies and practices. The attached papers contain the necessary information in relation to service users and staff.
The information highlights that considerable disparities exist for both service users and staff within protected groups compared to those in non-protected groups and efforts to address these differences must continue.

Recommendations:

- The Board is asked to ratify the publication of equality data documents and approve their publication on the trust website as required by the Equality Act.
- The Board are asked to note the differences in outcomes and experiences for staff from protected groups outlined in the paper on staff equality and to receive the action plans that are referenced in paragraphs 7.2 and 7.3 at the July 2019 Board meeting.
- The Board is asked to agree that the papers are considered in more detail by the Resources Committee.

MEETING OF:	Board of Directors
DATE:	21st May 2019
TITLE:	To consider the publication of information on compliance with the public sector duty under the Equality Act

1.0 INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek ratification of the information to be published under the Trust's Equality Act duties

2.0 BACKGROUND INFORMATION AND CONTEXT:

2.1 The general equality duty of the Equality Act 2010 requires the Trust in the exercise of its functions to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

2.2 The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users and staff who share a relevant protected characteristic who are affected by its policies and practices

3.0 KEY ISSUES:

3.1 The Trust needs to ensure compliance with the Equality Act 2010, by publishing information to demonstrate its compliance with the general equality duty.

3.2 There is increasingly a national focus upon improving outcomes and experiences for people from protected groups.

- The NHS The Long Term Plan states that the NHS will set out specific, measurable goals for narrowing inequalities, including those relating to protected groups. All local health systems will be expected to set out during 2019 how they will reduce health inequalities by 2023/24 and by 2028/29. The NHS Equality and Diversity Council is currently considering a number of interventions to help support achievement of this aim.
- NHS England have introduced two measurement tools, the Workforce Race Equality Standard and the Workforce Disability Equality Standard to improve the outcomes and experience for BAME staff and disabled staff

3.3 This report describes where the outcomes and experience of TEWV staff and service users from particular protected groups are less than staff and service users who do not share those protected characteristics. There is evidence that the greater the proportion of staff from protected groups who report experiencing discrimination at work in the last 12 months the lower the levels of patient satisfaction. It is hoped that some of the interventions intended to improve outcomes and experience for staff will also impact positively on the experience and outcomes of service users.

4.0 IMPLICATIONS:

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

It is a requirement of the CQC fundamental standards that the Trust meets its obligations under the Equality Act 2010.

4.2 **Financial/Value for Money:**

Financial penalties can be incurred for non- compliance with the legislative requirements of the Equality Act. This may result in reputation loss for the Trust.

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

The Trust is required to publish information demonstrating its compliance with the general public sector duties of the Equality Act 2010. This document will meet that legal requirement and as Equality Act compliance is a pre-requisite of Care Quality Commission registration will maintain Trust registration.

4.4 **Equality and Diversity:**

The Trust must demonstrate compliance with statutory equality requirements. Failure to do so may result in legal action and subsequent financial penalties and damage to the Trust’s reputation.

4.5 **Other implications:**

None have been identified.

5.0 RISKS:

5.1 The quality of information submitted for publication continues to be subject to improvement and there may be risks related to the data quality

6.0 CONCLUSIONS:

6.1 The Trust needs to publish information demonstrating it is compliant with the general public sector duties of the Equality Act 2010 and the information in the attached document will meet that requirement.

6.2 The Trust needs to understand whether and why particular groups in the community are under or over represented in its service user population and to take action as appropriate. The Trust also needs to ensure that any differences in experience between protected groups and the service user population in general are understood and appropriate action taken to ensure high quality care is delivered for all.

6.3 The trust needs to understand the differences in experience and outcome for its staff and to take action where necessary to lessen the disparities.

6.4 Whilst actions have been undertaken for some time to address the issues described above it must be noted that considerable disparities still exist for both staff and service users from protected groups and that serious consideration is needed of both the actions required and the resources available to lessen the differentials in experience and outcomes for these groups.

7.0 RECOMMENDATIONS:

7.1 The Board is asked to ratify the publication of equality data documents.

7.2 The Board is asked to note the differences in outcomes and experiences for staff from protected groups outlined in the paper on staff equality and to receive the action plans that are referenced in paragraphs 7.2 and 7.3 at the July 2019 Board meeting.

7.3 The Board is asked to agree that the equality data documents are considered in more detail by the Resources Committee

David Levy, Director of Human Resources and Organisational Development
Sarah Jay, Equality, Diversity and Human Rights Lead

Background Papers:

PUBLICATION OF SERVICE USER EQUALITY DATA

1 APRIL 2018– 31 MARCH 2019

Published 21st May 2019

making a difference together

If you need this information summarised in another language or format such as Braille, talking tape or DVD please call the number below.

Polish:
Jeżeli potrzebujesz streszczenia tych informacji w innym języku lub formacie, np. w Braille'u lub w formie nagrania dźwiękowego, zadzwoń na poniższy numer.

Arabic:
إذا أردت منا تلخيص هذه المعلومات بلغة أخرى أو بصيغة مختلفة مثل لغة بريل أو شريط صوتي أو قرص DVD
يرجى الاتصال برقم الهاتف التالي.

Bengali:
যদি আপনি অন্য একটি ভাষায় এই তথ্যের সংক্ষিপ্তসার চান অথবা ব্রেইল, কথা বলা টেপ অথবা ডি.ভি.ডি. ফরম্যাট-এ এই তথ্য চান, তাহলে অনুগ্রহ করে নিচের নম্বরে টেলিফোন করুন।

Farsi:
در صورتی که مایلید خلاصه این اطلاعات را به زبان یا فرمت دیگری مانند بریل، نوار یا دی وی دی دریافت کنید، لطفا با شماره زیر تماس بگیرید.

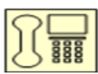
Hindi:
यदि आप इस सूचना का सारांश किसी अन्य भाषा या स्वरूप में, जैसे ब्रेल, टाकिंग टेप या DVD में चाहते हों, तो कृपया नीचे दिए गए नंबर पर फोन करें।

Kurdish (Kurmanji):
Heke hun vê agahîyê bi kurtî bi zimanekî din an formateke din a wek Braille (ji bo kêmasîya dîtinê), teypa axaftinê yan jî DVD dixwazin, ji kerema xwe telefonî hejmara jêrîn bikin.

Punjabi:
ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਦਾ ਸਾਰ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈਂਟ ਜਿਵੇਂ ਬ੍ਰੇਲ, ਟਾਕਿੰਗ ਟੇਪ ਜਾਂ DVD ਵਿੱਚ ਚਾਹੀਦਾ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।

Simplified Chinese:
如果您需要该条信息用其他语言或格式概述，例如盲文，录音磁带或 DVD。请联系以下号码：

Urdu:
اگر آپ کو ان معلومات کے خلاصہ کی کسی دیگر زبان یا شکل مثلاً بریل، ٹاکنگ ٹیپ یا ڈی وی ڈی میں ضرورت ہو تو برائے مہربانی درج ذیل نمبر پر کال کریں۔



Telephone 0191 3336267

PUBLICATION OF EQUALITY DATA

1. INTRODUCTION

1.1 The general equality duty of the Equality Act 2010 requires the Trust in the exercise of its functions to have due regard to the need to :

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

1.2 The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users who share a relevant protected characteristic who are affected by its policies and practices. The protected characteristics are sex, race, sexual orientation, gender reassignment, disability, religion and belief, marriage and civil partnership, age and pregnancy and maternity.

1.3 The Trust has published information to meet its public sector duties for the last seven years. During this time the quality of the data has steadily improved however the Trust recognises that there are still qualifications around the quality and validity of the data; particularly as in some areas the numbers are relatively low. The Trust wants to be transparent in demonstrating its compliance with its Equality Act duties and has decided to publish raw data. The information published must therefore be viewed as descriptive and any interpretations of it must be conservative.

1.4 The information in this report includes:

- An analysis of service users who were referred to Trust services between 1st April 2018 and 31st March 2019 by race and ethnicity, sex, disability, religion, sexual orientation, age, marriage and civil partnership. The data is taken from information given by service users who at times refuse to provide information requested, giving incomplete data. In the data a blank is recorded as null, refuse to disclose means that the service user preferred not to give the trust that information and not known means that the clinician has recorded that they do not know that information.
- An analysis of the length of waiting time from referral to first contact by ethnicity and an analysis of length of hospital stay by ethnicity.
- Where possible the Trust's data has been compared to that of the 2011 Census produced by the Office of National Statistics. Copyright is acknowledged as adapted from data from the Office for National Statistics licensed under the Open Government License v.1.0.

2. ACCESS TO SERVICES

2.1 The following data is for the year 1st April 2018 to 31st March 2019 and is the information contained on the Trust's electronic clinical record system. Some of the fields are incomplete for some service users and some service users have preferred not to give the Trust certain information. The level of missing values and non-disclosure is indicated in each section.

2.3 Where it is available the makeup of the Trust's service user population has been compared to the information on the general population that was gathered in the 2011 census.

2.4 Summary of Service Users by Ethnic Group Compared to the ONS 2011 Census

Ethnic Group	Ethnic breakdown of service users in the Trust (number)	Ethnic Breakdown of service users in the Trust (%)	Ethnic Breakdown 2011 Census (number)	Ethnic Breakdown 2011 Census (%)
White; British	181,925	88.06%	1857153	93.7
White; Irish	491	0.24	7592	0.38
White; Other White includes Eastern European	2,444	1.17	38067	1.92
Mixed; White and Black Caribbean	89	0.04	5229	0.27
Mixed; White and Black African	239	0.12	2544	0.14
Mixed; white and Asian	338	0.16	6934	0.35
Mixed; Other Mixed	615	0.30	4443	0.23
Asian or Asian British; Indian	326	0.16	9517	0.48
Asian or Asian British; Pakistani	661	0.32	12739	0.64
Asian or Asian British; Bangladeshi	126	0.06	2338	0.12
Asian or Asian British; Other Asian	455	0.22	10009	0.5
Black or Black British; Caribbean	309	0.15	1200	0.06
Black or Black British; African	324	0.16	5792	0.29
Black or Black British; Other Black	226	0.11	1178	0.07
Asian or Asian British Chinese	164	0.08	8735	0.45
Other Ethnic Group includes Iranians and Arabs	1066	0.52	5688	0.29
Travellers including Gypsy, Roma Traveller/Irish Traveller	185	0.09	2183	0.11
Not stated and declined to disclose	7957	3.85		
NULL	8648	4.19		
Total	206,588	100%	1,981,391	100%

2.4.1 8648, 4.19% of service users' race/ ethnicity is not available as the data field on PARIS has not been completed. This compares to 4.08 % last year. There are variations from the census norms which the Trust will use to explore access issues.

2.4.2 Length of waiting time from referral to first contact by ethnicity

The Trust has produced its own figures on the length of waiting time from first referral to first contact analysed by ethnicity. There are some differentials in these which will be explored and appropriate action taken. A degree of caution must be applied in interpreting these figures because of the number of service users whose ethnicity is not known or not stated.

Ethnic Group	No. of patients	Average length of time (days)
White; British	55702	11.26
White; Irish	152	15.79
White; Other White includes Eastern European	648	9.17
Mixed; White and Black Caribbean	80	7.43
Mixed; White and Black African	74	12.67
Mixed; white and Asian	90	14.28
Mixed - Other Mixed	176	10.84
Asian or Asian British; Indian	106	11.53
Asian or Asian British; Pakistani	193	9.17
Asian or Asian British; Bangladeshi	38	13.68
Asian or Asian British; Other	143	10.51
Black or Black British; Caribbean	23	7.33
Black or Black British; African	85	8.07
Black or Black British; Other Black	62	11.16
Asian/Asian British - Chinese	54	11.7
Travellers including Gypsy, Roma, Irish	57	6.88
Other Ethnic Group including Iranian/Arabs	393	9.77
Null	3044	8.11
Decline to disclose	2841	16.55
TOTAL	63961	

2.4.3 Length of hospital stay by ethnicity

Following feedback figures have been produced for long stay wards, acute wards and short stay respite to provide a more accurate understanding of differences between ethnic groups These figures are for the period 1st April 2018 to 31st March 2019 Some patients were admitted to hospital prior to 1st March 2018 and this is not reflected in these figures.

Length of hospital stay by Ethnicity 01/04/2018 - 31/03/2019

ACUTE WARDS:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	2892	41.80	0	365
White; Irish	6	68.50	4	153
White; Other White	54	100.11	2	293
Mixed; White and Black African	3	34.67	29	171
Mixed White/Black Caribbean	9	66.56	2	365
Mixed; white and Asian	5	24.8	9	173
Mixed; Other Mixed	11	23.09	2	239
Asian/Asian British Bangladesh	1	29.00	29	29
Asian or Asian British; Indian	9	21.33	1	88
Asian or Asian British; Pakistani	24	47.88	6	269
Asian or Asian British; Other Asian	13	32	5	97
Black or Black British; Caribbean	3	29	10	50
Black or Black British; African	13	34.92	13	68
Black or Black British; Other Black	5	21.6	5	50
Asian / Asian British - Chinese	6	39.17	3	85
Other Ethnic group includes Iranians/Arabs	18	29.07	2	365
Travellers including gypsy, Roma, Irish	5	50.75	2	155
Null	92	20.33	0	349
Not stated, declined to disclose	20	31.47	5	312
Total	3189		0	365

Long Stay wards:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	560	159.32	0	365
White; Irish	1	365	365	365
White; Other White	6	19.67	5	156
Mixed; White and Black Caribbean	1	198	198	198
Mixed white, Asian	1	112	112	112
Traveller including Gypsy, Roma and Irish	1	109	109	109
Mixed White/Black African	3	197.67	107	365
Mixed; Other Mixed	2	204.5	113	365
Other Ethnic group – any other				
Asian/Asian British Indian	2	78.5	50	143
Asian or Asian British; Pakistani	5	56.2	6	122
Asian or Asian British; Other Asian	6	170.67	22	365
Black or Black British; African	12	242.67	2	365
Black British, other black	1	6	6	6
Black, Black British Caribbean	1	11	11	11
Asian / Asian British - Chinese	1	365	365	365
Other ethnic group , Iranians and Arab	5	86.37	18	365
Not stated, declined to disclose	3	3.5	3	43
Null	13	13.23	2	61
Total	624		0	365

Short stay/respite stay:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	160	28.81	0	130
White Irish	1	0	0	0
White; Other White includes Eastern European	0	0	0	0
Mixed; Other Mixed	0	0	0	0
Asian, Asian British Indian	1	22	22	22
Asian or Asian British; Pakistani	5	37	30	41
Asian or Asian British; Other Asian	0	0	0	0
Asian/Asian British Chinese	0	0	0	0
Black or Black British; African	1	32	32	32
Black or Black British; Other	0	0	0	0
Gypsy	0	0	0	0
Other ethnic group, includes Irian and Arab	1	3	3	3
Null	4	6.25	5	8
Not stated, declined to disclose	2	32.5	4	61
Total	175		0	130

Other:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	545	65.5	0	365
White Irish	3	58	5	145
White; Other White includes Eastern European	18	22.87	4	258
Mixed; Other Mixed	6	57	4	239
Asian, Asian British Indian	2	16	13	24
Asian or Asian British; Pakistani	1	3	3	3
Asian or Asian British; Other Asian	1	45	45	45
Asian/Asian British Chinese	2	10	7	13
Black or Black British; African				
Black or Black British; Caribbean	1	24	24	24
Mixed white Black Caribbean	1	4	4	4
Mixed white Black African	1	25	25	25
Other ethnic group, includes Irian and Arab	3	13	9	25
Null	27	36.11	0	349
Not stated, declined to disclose	23	47.15	0	312
Traveller including Gypsy, Roma, Irish	2	57.5	21	119
Total	636		0	365

2.5 Summary of Service Users by age compared to the ONS 2011 Census

Age	Breakdown of Service Users in the Trust by age (Number)	Breakdown of Service Users in the Trust by age (%)	ONS Census 2011 Breakdown by age (number)	ONS Census 2011 Breakdown by age (%)
0-18	41487	20.08	414839	18.6
18-29	43341	20.98	342007	15.3
30-44	40677	19.69	422893	18.9
45-64	37945	18.37	629030	28.3
Over 65	43120	20.87	423194	18.9
Null	18	0.01		
Total	**206588**	**100 %**	**2231963**	

2.5.1 Comparing the age categories of the Trust to those of the ONS 2011 Census the number of service users in the 45 - 64 categories are less than the Census figures, which needs to be explored. The number of service users in the over 65 age group is expected due to the increased prevalence of age related mental health problems in this group. 0.01% of the trust's data on the age of service users was incomplete.

2.6 Summary of Service Users by Sexual Orientation

Sexual Orientation	Breakdown of service users by sexual orientation (number)	Breakdown of service users by sexual orientation (%)
Person does not know	3384	1.64
Null	186970	90.5
Persons of the opposite sex	15287	7.4
Persons of the Same or opposite sex	229	0.11
Persons of the Same Sex	333	0.16
Prefer not to say	301	0.15
Other	84	0.04
Total	**206588**	**100%**

2.6.1 In 2005 HM Treasury and the Department of Trade and Industry completed a survey to help the Government analyse the financial implications of the Civil Partnerships Act (such as pensions, inheritance and tax benefits). They concluded that there were 3.6 million gay people in the United Kingdom – around 6% of the total population or 1 in 16.66 people.

Most of the time, the figure of between 5-7% of the population is used. Stonewall, a National Lesbian, Gay and Bisexual campaigning organisation feel this is a reasonable estimate. However, as this question was not asked in the 2011 UK census there is no way of knowing for sure how many Lesbian, Gay or Bisexual people there are in the UK.

Comparing these estimated figures with the Trust's service users the Trust has an under-representation of those who have declared that they are lesbian, gay or bisexual. This is a particularly sensitive area for many service users and this is possibly reflected in the fact that for 186970 or 90.5% of service user's information about their sexual orientation is not recorded on PARIS. However this is a 3.68% deterioration on last year's figures.

2.7 Summary of Marital and Civil Partnership Status of Service Users within the Trust compared to the ONS 2011 Census.

Status	Breakdown of service users in the Trust by Marriage Civil Partnership (number)	Breakdown of service users in the Trust by Marriage Civil Partnership (%)	ONS Census 2011 Breakdown by Marriage/ Civil Partnership (number)	ONS Census 2011 Breakdown by Marriage/ Civil Partnership (%)
Divorced/ Civil Partnership Dissolved	8737	4.02	177476	9.38
Married / Civil Partnership	37320	17.16	923446	48.78
In a relationship	6823	3.14		
Living with a partner	5598	2.56		
Not Disclosed	15226	7.00		
Separated	5124	2.36	45932	2.44
Single	111512	51.26	598958	31.64
Surviving Partner/ Widowed	14674	6.75	147062	7.76
Null	12244	5.63		
Not known	270	0.12		
Total	**217528**	**100%**	**1892874**	

2.7.1 For 12244 or 5.63 % of service users' marital and civil partnership status information is not recorded on PARIS. This is a 1.8% improvement in the data completeness compared to last year. 'In a relationship' and 'living with a partner' were added as additional fields in PARIS in 2016 to better reflect the range of relationships amongst our service users. There are no categories in the 2011 census with which to compare these options.
There is a variation between the Trust's data for marriage and civil partnership and that of the ONS 2011 in the categories of those who are divorced or whose civil partnership has been dissolved, those married or in civil partnerships and those who are single.

2.8 Summary of sex of service users within the Trust compared to the ONS 2011 Census

Status	Breakdown of service users in the Trust by sex (number)	Breakdown of service users in the Trust by sex (%)	ONS Census 2011 breakdown by sex (number)	ONS Census 2011 breakdown by sex (%)
Male	100516	48.66	1,119,471	49
Female	104496	50.57	1,169,017	51
Null	1213	0.59		
Birth sex female gender neutral	261	0.13		
Birth sex male gender neutral	49	0.02		
Indeterminate	32	0.02		
Not known/not specified	21	0.01		
Total	**206588**	**100%**	**2,288,488**	

2.8.1 The sex breakdown of the Trust's service users is very similar to that of the ONS data. For 1213 or 0.59 % of service users the data on sex is incomplete. This is an improvement of 0.06% compared to last year. Additional fields have been added to PARIS in 2018 to allow service users' sex to be recorded in ways that better reflect their gender identity.

2.9 Summary of Service Users by religion compared to the ONS 2011 Census service user Population by religion

Religion	Breakdown of Service Users in the Trust by religion (number)	Breakdown of Service Users in the Trust by religion (%)	ONS 2011 Census Breakdown by religion (number)	ONS 2011 Census Breakdown by religion (%)
Any other	3982	1.92	6619	0.29
Buddhist	298	0.14	8008	0.35
Christian	81950	39.67	1568297	68.46
Hindu	109	0.05	4921	0.21
Jewish	94	0.05	1368	0.06
Muslim	1384	0.67	23328	1.01
Sikh	105	0.05	3118	0.15
None	57155	27.67	525253	22.93
Null	12521	6.06		
Baha-i	31	0.02		
Pagan	211	0.10		
Declined to disclose/not stated	19230	9.31	149976	6.54
NULL	29518	14.29		
TOTAL	206588	100%	2,290,888	

2.9.1 Data on religion is not available for 29518 or 14.29% % of the Trust's service users the data is incomplete. This is an improvement of 1.09 % compared to the level of data completeness last year.

There are differences between the data on the religion of the Trust's service users and the data in the 2011 Census in the categories of any other religion, Christian, Muslim, Hindu, Sikh and none.

2.10 Summary of Servicer Users by Disability

Disability	Breakdown of Service Users in Trust (number)	Breakdown of Service Users in Trust (%)
Hearing Impairment	3205	1.55
Mobility impairment	3281	1.59
Multi-sensory impairment	457	0.22
Other Disability	935	0.45
Physical disability	1876	0.91
Visual Impairment	5590	2.70
Speech Impairment	473	0.23
Mental Health	6045	2.93
Learning Disability	2924	1.42
Null	181802	88.0
Total number of unique referrals	206588	100%

2.10.1 The Trust has been able to report on the numbers of service users with hearing impairment, mobility impairment, multi- sensory impairment, other disability, physical disability, visual impairment and speech impairment. Some service users have more than one disability so may appear in more than one category. Figures from the Royal National Institute of Blind people suggest that 1 in 30 people have sight loss, and figures from Action on Hearing loss state that 1 in 6 people or 16.66 % have some kind of hearing loss. The figures for service users with mental health difficulties or learning disabilities have not been included. Information from the 2011 census states that 38% of the population of the North East and 33% of the population of Yorkshire and Humber report a long standing illness or disability with 20% of the population of the North East and 19% of the population of Yorkshire and Humber reporting a limiting long standing illness or disability

3. Equality Objectives

3.1 Service user and carer involvement is essential to help the Trust deliver and develop services which are service user centred and feedback on services is essential in order to continually improve our services in response to what we are told. The Trust has well- established mechanisms for engaging with its service users and carers in a variety of ways.

3.2 In March 2016 each locality was asked to develop an equality objective for 2016 – 2020. There has been evidence of good consultation and activities in localities which led to the development of the equality objectives. An update about progress made is provided on pages 14 and 15.

3.2.1 **Durham and Darlington Equality Objective 2017 - 2020**
To continue to ensure that the principles of Green Light are embedded in services

Progress:
Due to multiple changes in the locality in the summer the Green Light Kaizen which was due to take place in Q3 was delayed. The locality is now working towards an innovation event at the end of April aimed at achieving a cultural change in the locality and seeing green light as a move to providing needs led reasonably adjusted services rather than diagnostic services.

3.2.2 **York and Selby overall objective 2016 - 2020**: Working with partners to improve access and experience of mental health services for students and young people (16 – 25) in York and Selby.**Progress:**

An audit was carried out to identify if service users' transition goals were addressed within the care plan developed by the AMH community team and if these transition goals had been evaluated since their acceptance into the AMH community team. Following this audit AMH and CAMHS services met to review the whole system for mapping and improving transitions and a training programme was rolled out to all AMH and CAMHS teams. Progress has also been made on improving the number of service user satisfaction surveys that are completed and returned.

3.2.3 **Forensic Services Equality Objectives 2017/2020**
Objective 1 To improve the support for staff that is on extended forms of planned maternity / paternity / adoption leave.

Progress:
Actions were undertaken to improve the experience of staff on extended forms of planned maternity/ paternity / adoption leave. Training was given to all ward/ team managers on the support to be given to people on this kind of extended leave. A further audit was carried out which showed that staff felt less supported than they had previously. A further action plan has been developed to improve the experiences of those on extended forms of planned maternity/ paternity / adoption leave.

3.2.4 **Teesside objective 1 2016-2020.** To continue implementation of the Greenlight audit in adult services, building on the work carried out last year and completing the self-assessment.

Progress:

A Rapid Improvement Workshop (RPIW) was held in Teesside in June 2018 involving Adult Learning Disabilities (ALD) staff and Adult Mental Health staff (AMH). The aim of the event was to develop standard processes to ensure that staff from ALD had training in mental health and that AMH staff had training re ALD.
During the week the teams developed a range of standard work to ensure that both ALD and AMH staff understood referral criteria, referral pathway, developed joint working protocol and ensured that training was available re ALD and AMH. Appendix 2 describes the output for the week.
At 90 days, the majority of staff had undertaken the respective training but importantly staff reported that they had a greater degree of confidence in working with ALD/AMH patients. Shadowing was also an output and recently we have had ALD nurses recruited into AMH posts which is a positive outcome.
Another positive outcome is the development of the role of the Greenlight champion.

Teesside Objective 2. Under/ Over - Represented Communities 2017 – 2020. Based upon the information identified from analysis of our data, the locality has begun to explore the reasons for the under/over representation of particular BAME communities within services.

This has involved utilising a Community development approach to review experience of our services for those communities, and identify remedial actions that need to be taken to support access for

people to achieve successful outcomes. Work this year in MHSOP has included continuing to improve access to dementia services for the South Asian community by running locally based clinics, developing an awareness raising video in Urdu and partnership work with Middlesbrough College to encourage the South Asian community to seek employment in the trust. The five week health and social care course, is run by the Trust, a third sector partner and Middlesbrough community learning services. The aim is for women who have taken the course to become volunteers and eventually work for the Trust through the temporary staffing team. This opportunity allowed the trust to begin changing the staffing demographic within older people's services, to ensure it was more reflective of the communities that it serves as well as breaking barriers around mental health. The impact of the course on the women attending has included that they now feel confident about their understanding of mental health and the treatment options open to them. The Trust now has four paid BAME staff who secured posts by completing the course and another 25 participants have now completed the course.

It is planned to roll these initiatives out to adult mental health in 19/20. During 2018/19 AMH services have had meetings with public health to help kick start some of the work that fell out of the focus groups held in 17/18 specifically around raising awareness and understanding of mental health within the BAME communities. The meetings have also provided insight into work already ongoing from a public health perspective and have provided direction in terms of areas that would be beneficial to focus on over the next financial year.

3.2.5 **North Yorkshire objective 2016 - 2020:** To better understand the mental health needs of the farming communities in North Yorkshire and where appropriate take action to improve and increase access to services.
Progress: The locality has made good progress with this equality objective, evidence of which was provided to the EDHR steering group, and is to continue work on the objective for the period 2017 – 2020. This includes the development of a training package which is being rolled out to staff, The locality have engaged with an increasing number of stakeholder this year and have attended farming related events including the Yorkshire Show and the NFU meeting. The group are to attend the Great Yorkshire show to raise awareness of mental health issues and are to do some outreach work into 'farmer friendly GP surgeries.' They have been working with the communications team to use social media as a tool to raise awareness of mental health issues within the farming community and have recently filmed a series of talking heads which will be used for this.

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4. Analysis of the effects of the Trust's policies and practices

4.1 Equality analyses are carried out on all Trust policies and procedures and these are available on the Trust website.

4.2 Equality analysis is also carried out on service developments and improvements and is an integral part of the Trust's project management processes through which all major service changes are progressed.

5. Equality in Practice

The Trust is committed to ensuring that all people have equal access to its services. Some of the initiatives the Trust has taken to realising this vision are described in the information relating to the Trust's equality objectives in section 3. Others are described below.

5.1 Disability Access Audits
The Trust recognises the importance of ensuring that people with disabilities can access its premises. The Health and Safety team have carried out audits on all inpatient sites. These audits are to continue as part of the health and safety workbook audit programme and in 18/19 audits were carried out on outpatient areas. It must be acknowledged that the audit only covers limited areas and do not include clinic rooms, ward and other areas in which patients are seen or areas which are solely used by staff. Progress on these is monitored by the EDHR steering group and reported bi-annually to QAC.

5.2 Interpreting Services
In order to deliver an equitable service to those whose first language is not English the Trust has a contract with an interpreting agency, ensuring quick access to appropriately qualified interpreters. The quality and usage of the service is regularly monitored. The service is currently out for tender. A provider will be in place by 30th September 2019.

5.3 Data Completeness
Measurement is key to understanding whether there are differences in experience or outcomes for those in protected groups and then acting on these. Crucial to this is achieving a high level of data completeness and accuracy in the demographic data on PARIS.

5.4 Equality, Diversity and Human Rights Strategy
The trust is currently developing a new Equality, Diversity and Human Rights Strategy and associated objectives. Consultation with staff, service users, carers and other stakeholders is going to take place in June and July 2019 and the intention is that the strategy will be approved by the Board in autumn 2019.

5.5 Patient Friends and Family Test (FFT)
The trust analyses its patient FFT by sexual orientation, gender, disability, ethnicity and age. This information is included at appendix 1.
Response rates are lower than expected but work has identified that the demographic questions were preceded by a question 'is there anything else you would like to tell us?' which unless answered positively did not take respondents to the demographic questions. This question has now been removed so it is hoped demographic information will be more complete in the future.

Responses during 2018/19 showed:

- Those who identify as lesbian or bisexual did not rate the care they received as highly as those identifying as gay or heterosexual
- Service users identifying as white other, mixed race or other did not rate the care they received as highly as those identifying as other ethnicities.
  Work will be undertaken to better understand these differences.

6 Conclusions

6.1 The levels of data completeness available to the Trust to measure its performance in its public sector duties have either remained static or deteriorated. Further work is needed to improve rates of completeness in certain categories. Higher levels of data completeness would allow the Trust to have greater confidence in its understanding of the makeup of its service users and their needs.

6.2 **P**rogress has been made on the Trust's equality objectives and localities have taken ownership of these and are committed to achieving them

7. Recommendations

7.1 It is proposed that the information contained in this report is published on the Trust's website as evidence that the Trust is meeting its public sector equality duties.

7.3 It is recommended that further work be undertaken to support staff to improve the level of data completeness so that we can better understand any differences in outcomes and experiences for our patients.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

SEXUAL ORIENTATION

APPENDIX 1

Sexual Orientation and Year	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Total Surveys	Overall % 2013-14 to 2018-19
Heterosexual - Total % of Excellent and Good Responses	92.3% 3319	91.2% 4327	88.3% 2420	90.9% 2185	90.8% 658	90.7% 594	13503 (out of 14865)	90.8%
Gay - Total % of Excellent and Good Responses	84.5% 60	80.2% 69	73.4% 47	85.0% 51	71.4% 10	93.3% 14	251 (out of 310)	81.0%
Lesbian - Total % of Excellent and Good Responses	74.4% 29	84.3% 59	75.0% 36	81.3% 39	77.3% 17	81.8% 9	189 (out of 238)	79.4%
Bisexual - Total % of Excellent and Good Responses	88.3% 91	79.5% 105	80.9% 127	81.4% 83	78.7% 37	76.6% 36	479 (out of 588)	81.5%
Prefer not to say - Total % of Excellent and Good Responses	86.8% 511	81.2% 474	86.1% 346	82.3% 311	84.5% 1772	83.7% 477	3891 (out of 4620)	84.2%
Unknown - Total % of Excellent and Good Responses	87.1% 101	91.8% 2142	92.6% 11088	93.2% 12408	0 0	0 0	25739 (out of 27742)	92.8%
Total for all Responses where Excellent or Good	4111	7176	14064	15077	2494	1130	44052 (out of 48363)	

Key:
90% and over
85%-89.9%
Below 85%

GENDER

Gender and Year	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Total Surveys	Overall % 2013-14 to 2018-19
Male - Total % of Excellent and Good Responses	91.9%	84.6%	92.4%	92.2%	92.3%	92.3%	15017 (out of 16305)	92.1%
	237	307	1163	1636	5456	6218		
Female - Total % of Excellent and Good Responses	94.1%	95.2%	96.4%	94.4%	93.5%	93.1%	17788 (out of 18990)	93.7%
	269	295	1373	1687	6812	7352		
Other - Total % of Excellent and Good Responses	100.0%	66.7%	66.7%	0.0%	40.0%	77.8%	22 (out of 35)	62.9%
	3	4	4	0	4	7		
Prefer not to say - Total % of Excellent and Good Responses	83.3%	71.4%	80.0%	50.0%	85.8%	86.5%	4590 (out of 5344)	85.9%
	5	5	4	2	3455	1119		
Unknown - Total % of Excellent and Good Responses	90.8%	90.4%	90.7%	92.3%	0	0	33434 (out of 36661)	91.2%
	3597	6565	11520	11752	0	0		
Total for all Responses where Excellent or Good	4111	7176	14064	15077	15727	14696	70851 (out of 77335)	

Key:
90% and over
85%-89.9%
Below 85%

DISABILITY

Disability Answer and Year	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Total Surveys	Overall % 2013-14 to 2018-19
Yes - Total % of Excellent and Good Responses	-	93.7%	94.9%	93.6%	92.8%	92.2%	13856 (out of 14923)	92.8%
	0	193	1263	1795	5075	5530		
No - Total % of Excellent and Good Responses	-	92.6%	93.6%	92.5%	94.1%	94.3%	14394 (out of 15312)	94.0%
	0	87	991	1282	5686	6348		
Prefer not to say - Total % of Excellent and Good Responses	-	0.0%	59.1%	72.7%	86.5%	87.9%	5778 (out of 6659)	86.8%
	0	0	13	8	4105	1652		
Unknown - Total % of Excellent and Good Responses	91.1%	90.2%	90.9%	92.3%	0	0	34796 (out of 38130)	91.3%
	4111	6896	11797	11992	0	0		
Total for all Responses where Excellent or Good	4111	7176	14064	15077	14866	13530	68824 (out of 75024)	

Key:
90% and over
85%-89.9%
Below 85%

AGE BAND

Age Band and Year		2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Total Surveys	Overall % 2013-14 to 2018-19
Under 18 - Total % of Excellent and Good Responses (0-18 in 2017-18)	%	100.0%	100.0%	79.7%	70.9%	88.9%	90.4%	5612 (out of 6292)	89.2%
	Count	1	9	59	122	2233	3188		
18-29 - Total % of Excellent and Good Responses (19-29 in 2017-18)	%	74.4%	76.0%	87.4%	89.5%	91.5%	90.7%	5041 (out of 5583)	90.3%
	Count	58	76	167	468	2075	2197		
30-44 - Total % of Excellent and Good Responses	%	96.4%	79.1%	84.6%	91.4%	92.6%	91.9%	5583 (out of 6093)	91.6%
	Count	53	87	226	466	2340	2411		
41-50 - Total % of Excellent and Good Responses	%	93.6%	85.4%	-	-			143 (out of 160)	89.4%
	Count	73	70	0	0	0	0		
45-64 - Total % of Excellent and Good Responses	%	97.0%	91.2%	95.6%	93.8%	93.5%	93.6%	7007 (out of 7477)	93.7%
	Count	98	104	390	576	2929	2910		
65 and over - Total % of Excellent and Good Responses	%	96.1%	98.5%	97.3%	97.2%	95.9%	96.3%	9316 (out of 9646)	96.6%
	Count	219	258	1741	1712	2578	2808		
Prefer not to say - Total % of Excellent and Good Responses	%	100.0%	75.0%	63.6%	25.0%	86.6%	87.3%	4723 (out of 5450)	86.7%
	Count	12	6	7	1	3544	1153		
Unknown - Total % of Excellent and Good Responses	%	90.8%	90.4%	90.7%	92.2%	0.0%	0.0%	33369 (out of 36597)	91.2%
	Count	3597	6566	11474	11732	0	0		
Total for all Responses where Excellent or Good		4111	7176	14064	15077	15699	14667	70794 (out of 77298)	

Key:
90% and over
85%-89.9%
Below 85%

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ETHNICITY

Ethnicity and Year		2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Total Surveys	Overall % 2013-14 to 2018-19
White British - Total % of Excellent and Good Responses	%	91.7%	91.0%	92.2%	93.1%	93.7%	93.6%	56358 (out of 60739)	92.8%
	n	3740	5981	12130	12960	10208	11339		
White Other - Total % of Excellent and Good Responses	%	83.7%	97.3%	100.0%	-	89.8%	89.4%	1596 (out of 1780)	89.7%
	n	36	36	2	0	794	728		
Black or Black British - Total % of Excellent and Good Responses	%	83.3%	68.1%	74.4%	77.4%	87.1%	93.7%	399 (out of 502)	79.5%
	n	20	32	90	137	61	59		
Asian or Asian British - Total % of Excellent and Good Responses	%	87.9%	76.0%	84.7%	86.8%	89.7%	91.6%	877 (out of 1012)	86.7%
	n	58	76	211	211	157	164		
Mixed Race - Total % of Excellent and Good Responses	%	89.4%	87.3%	84.6%	89.9%	90.7%	89.4%	861 (out of 968)	88.9%
	n	42	69	121	143	225	261		
Other - Total % of Excellent and Good Responses	%	87.5%	80.4%	80.5%	88.5%	90.7%	85.4%	432 (out of 503)	85.9%
	n	21	37	91	116	97	70		
Prefer not to say - Total % of Excellent and Good Responses	%	0.0%	0.0%	0.0%	0.0%	85.9%	85.6%	4371 (out of 5095)	85.8%
	n	0	0	0	0	3370	1001		
Unknown - Total % of Excellent and Good Responses	%	83.6%	88.2%	88.3%	90.6%	0	0	4068 (out of 4578)	88.9%
	n	194	945	1419	1510	0	0		
Total for all Responses where Excellent or Good		4111	7176	14064	15077	14912	13622	68962 (out of 75177)	

Key:
90% and over
85%-89.9%
Below 85%

PUBLICATION OF STAFF EQUALITY DATA

1 APRIL 2018 – 31 MARCH 2019

Published 21st May 2019

making a difference together

Tees, Esk and Wear Valleys **NHS**
NHS Foundation Trust

If you need this information summarised in another language or format such as Braille, talking tape or DVD please call the number below.

Polish:
Jeżeli potrzebujesz streszczenia tych informacji w innym języku lub formacie, np. w Braille'u lub w formie nagrania dźwiękowego, zadzwoń na poniższy numer.

Arabic:
إذا أردت منا تلخيص هذه المعلومات بلغة أخرى أو بصيغة مختلفة مثل لغة بريل أو شريط صوتي أو قرص DVD
يرجى الاتصال برقم الهاتف التالي.

Bengali:
যদি আপনি অন্য একটি ভাষায় এই তথ্যের সংক্ষিপ্তসার চান অথবা ব্রেইল, কথা বলা টেপ অথবা ডি.ভি.ডি. ফরম্যাট-এ এই তথ্য চান, তাহলে অনুগ্রহ করে নিচের নম্বরে টেলিফোন করুন।

Farsi:
در صورتی که مایلید خلاصه این اطلاعات را به زبان یا فرمت دیگری مانند بریل، نوار یا دی وی دی دریافت کنید، لطفا با شماره زیر تماس بگیرید.

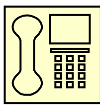
Hindi:
यदि आप इस सूचना का सारांश किसी अन्य भाषा या स्वरूप में, जैसे ब्रेल, टाकिंग टेप या DVD में चाहते हों, तो कृपया नीचे दिए गए नंबर पर फोन करें।

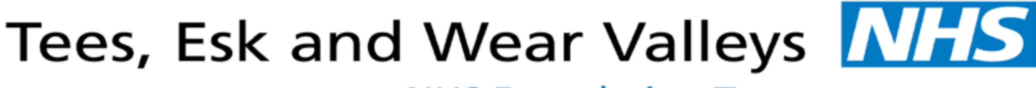
Kurdish (Kurmanji):
Heke hun vê agahîyê bi kurtî bi zimanekî din an formateke din a wek Braille (ji bo kêmasîya dîtinê), teypa axaftinê yan jî DVD dixwazin, ji kerema xwe telefonî hejmara jêrîn bikin.

Punjabi:
ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਦਾ ਸਾਰ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈੱਟ ਜਿਵੇਂ ਬ੍ਰੇਲ, ਟਾਕਿੰਗ ਟੇਪ ਜਾਂ DVD ਵਿੱਚ ਚਾਹੀਦਾ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।

Simplified Chinese:
如果您需要该条信息用其他语言或格式概述，例如盲文，录音磁带或 DVD。请联系以下号码：

Urdu:
اگر آپ کو ان معلومات کے خلاصہ کی کسی دیگر زبان یا شکل مثلاً بریل، ٹاکنگ ٹیپ یا ڈی وی ڈی میں ضرورت ہو تو برائے مہربانی درج ذیل نمبر پر کال کریں۔


Telephone 0191 3336267



PUBLICATION OF EQUALITY DATA

1. INTRODUCTION

1.1 The general equality duty of the Equality Act 2010 requires the Trust in the exercise of its functions to have due regard to the need to :

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

1.2 The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users who share a relevant protected characteristic who are affected by its policies and practices. The protected characteristics are sex, race, sexual orientation, gender reassignment, disability, religion and belief, marriage and civil partnership, age and pregnancy and maternity.

1.3 The Trust has published information to meet its public sector duties for the last six years.

1.4. The information in this report as far as possible replicates the indicators of the Workforce Race Equality standard (WRES). The information in the disability section mirrors the indicators for the Workforce Disability Equality Standard (WDES) which has to be published for the first time this year.
The information relates to staff employed by the trust and contains information from about age, sex, disability, race and sexual orientation for the period 1st April 2018 – 31st March 2019.The information sources are as follows:

- Indicator 1 is data obtained from ESR, the trust's electronic staff rota. VSM in this indicator stands for very senior manager.
- Indicator 2 is data pulled from NHS jobs which is the database the trust uses to advertise jobs and to recruit staff.
- Indicator 3 has been sourced from detailed records kept throughout the year on disciplinary cases.
- Indicator 4, the relative likelihood of staff accessing non mandatory training and CPD has been obtained from responses to a question in the staff friends and family test.
- Indicators 5 – 11 and 5 – 16 in relation to disability come from the national staff survey which again was sent to all staff. It is to be noted that there have been changes in the ways in which the staff survey is published nationally and this has resulted in some changes in the data fields – in particular in relation to sexual orientation, but also in other fields.
- Information for the indicator on the make-up of the trust board has been pulled from ESR and shows the percentage difference between the board makeup and that of the trust as a whole by each protected characteristic. A minus sign preceding the figure indicates that the representation on the board of a particular protected characteristic is less than the representation of that characteristic in the trust as a whole. A plus sign preceding the figure would indicate that the board representation of a particular characteristic is greater than that in the trust as a whole.

2. **AGE:**

	Indicator.	Data for reporting year						
	For each of these four workforce indicators, compare the data for Age Groups.							
1.	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members)	**Clinical Staff %**						
		Age	**Band 1-4**	**Band 5-7**	**Band 8 a,b,c,d**	**Band 9**	**VSM**	**Medics**
		16-20	0	0	0	0	0	0
		21-30	14	20	2	0	0	7
		31-40	20	29	32	0	0	25
		41-50	26	25	36	50	0	41
		51-65	39	25	29	50	0	26
		66+	1	1	1	0	0	1
		Non- clinical staff %						
		Age	**Band 1-4**	**Band 5-7**	**Band 8 a,b,c,d**	**Band 9**	**VSM**	**Medics**
		16-20	1	0	0	0	0	n/a
		21-30	9	8	0	0	0	n/a
		31-40	16	30	16	0	0	n/a
		41-50	24	28	42	0	35	n/a
		51-65	47	33	42	0	65	n/a
		66+	3	1	0	0	0	n/a
2.	Likelihood of staff being appointed from shortlisting across all posts.	**20 & under**	0.36 (0.24)	**45-49**	0.25 (0.16)			
		20-24	0.26 (0.15)	**50-54**	0.27 (0.17)			
		25-29	0.28 (0.17)	**55-59**	0.27 (0.17)			
		30-34	0.33 (0.19)	**60-64**	0.2 (0.14)			
		35-39	0.31 (0.17)	**65+**	0.07 (0.06)			
		40-44	0.29 (0.17)					
3.	Likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	**16-20**	0.08	**41-50**	0.01			
		21-30	0.01	**51-65**	0.01			
		31-40	0.01	**66+**	0.01			
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	It is not possible to provide this information for age.						
	National NHS Staff Survey indicators For each of the four staff survey indicators, compare the outcomes of the responses for each of the age							

	groups.		
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	**21-30**	30%
		31-40	27%
		41-50	28%
		51-65	26%
		66+	23%
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	**21-30**	18%
		31-40	14%
		41-50	17%
		51-65	15%
		66+	4%
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	**21-30**	92%
		31-40	90%
		41-50	90%
		51-65	91%
		66+	95%
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	**21-30**	7%
		31-40	5%
		41-50	5%
		51-65	6%
		66+	0%
9.	KF17. % feeling unwell due to work related stress in the last 12 months.	**21-30**	40%
		31-40	39%
		41-50	44%
		51-65	35%
		66+	15%
10.	KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure	**21-30**	55%
		31-40	51%
		41-50	54%
		51-65	50%
		66+	42%
11.	Overall staff engagement	**21-30**	7.0
		31-40	7.4
		41-50	7.2
		51-65	7.2
		66+	7.9

	Board representation indicator: For this indicator, compare the difference for age groups.				
12.	Percentage difference between the organisation's Board voting membership, non-voting membership and NEDs and its overall workforce.	**Age**	**Voting**	**Non-voting**	**NEDs**
		16-20	-1%	-1%	-1%
		21-30	-15%	-15%	-15%
		31-40	-25%	-25%	-25%
		41-50	-9%	-27%	-27%
		51-65	+50%	+67%	+67
		66+	-1%	-1%	-1%

AGE BREAKDOWN FOR TRUST STAFF

Age Range	16-20	21-30	31-40	41-50	51-65	66+	Grand Total
Number	6	970	1637	1772	2216	78	6679
%	0.08	15	25	26	33	1	100

3. **DISABILITY**:

	Indicator.	Data for reporting year		
	For each of these four workforce indicators, compare the data for Disability.			
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members)	**Clinical Staff %**		
		Band	**Disabled %**	**Not Disabled %**
		1-4	9	91
		5-7	7	93
		8 ab	5	95
		8 cd	7	93
		9	0	100
		VSM	0	0
		Medics	1	99
		Non-Clinical Staff %		
		Band	**Disabled %**	**Not Disabled %**
		1-4	7	93
		5-7	7	93
		8 ab	6	94
		8cd	13	87
		9	0	0
		VSM	0	100
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	Non-disabled staff are 1.27 (1.5) times more likely to be appointed than disabled staff.		
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	The likelihood of disabled staff entering a formal disciplinary process is 0.4 compared to non-disabled. Disabled staff are therefore less likely to enter the formal disciplinary process than staff without a disability.		
4.	Relative likelihood of staff entering the formal capability process, as measured by entry into a formal process. This indicator will be based on data from a two year rolling average of the current year and the previous year.	Disabled staff are 1.7 times more likely to enter formal capability than non-disabled staff.		
5.	Relative likelihood of staff accessing non-mandatory training and CPD. (Based on responses to Q4 staff FFT).	Non-disabled staff are 1.06 times more likely to access non-mandatory training and CPD than disabled staff.		
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for disability/non disability.			
6.	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	**Disabled**	32%	
		Not disabled	25%	
7.	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	**Disabled**	20%	
		Not disabled	14%	
8.	Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months	**Disabled**	15%	
		Not disabled	8%	

9.	Percentage reporting or had a colleague report their last experience of harassment, bullying or abuse	**Disabled**	61%
		Not disabled	57%
10.	Percentage believing that Trust provides equal opportunities for career progression of promotion	**Disabled**	87%
		Not disabled	92%
11.	% attending work in the last 3 months despite feeling unwell because they felt pressure e) Have you felt pressure from your manager to come to work?	**Disabled**	68%
		Not disabled	45%
		Disabled	22.5%
		Not disabled	17%
12	How satisfied are you with each of the following aspects of your job: f) the extent to which my organisation values my work	**Disabled**	46%
		Not disabled	57%
13	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	**Disabled**	10.6%
		Not disabled	3.4%
14	KF17. % feeling unwell due to work related stress in the last 12 months	**Disabled**	54%
		Not disabled	33%
15	(Reasonable adjustment): Has your employer made adequate adjustments to enable you to carry out your work?	**Disabled:** 89%	
16.	Overall staff engagement	**Disabled**	6.9
		Not disabled	7.4
	Board representation indicator: For this indicator, compare the difference for disability/non disability.		
17.	Percentage difference between the organisation's Board voting, non- voting and NED membership and its overall workforce.	The difference between the trust board, voting, non-voting and NED membership is -7% in all categories.	

DISABILITY BREAKDOWN FOR TRUST STAFF

Not disabled	Disabled	Grand Total
4488	350	4838
93%	7%	100%

1841 staff, 28% have not declared on ESR whether they are disabled or not, this is a 2% decrease from 2018.However the number of staff identifying as disabled has decreased by 1% from 8% in 2018 to 7% in 2019.

When compared to staff without a disability those who identify as disabled:

- Experience a higher level of harassment, bullying and abuse from patients, relatives or the public, from staff and from managers than those without a disability.
- They have experienced more discrimination from managers/team leader or other colleagues Whilst the percentage reporting this has decreased from last year for both disabled and non- disabled staff the difference between the percentages reporting discrimination from manager/ team leader or other colleagues has remained the same at 7%
- Non-disabled staff are 1.27 times more likely to be appointed from shortlisting compared to those with a disability. This is an improvement from last year's result which was 1.8
- Are less likely to enter the disciplinary process than those without a disability
- Are more likely to enter formal capability than those without a disability
- Are less likely to access non- mandatory training and CPD than those without a disability.
- Are significantly more likely to have felt unwell due to work related stress in the last 12 months
- Are significantly more likely to have attended work in the last three months despite feeling unwell
- Are less satisfied with the the extent to which the organisation values their work
- Are less convinced that the Trust provides equal opportunities for career progression or promotion.
- 10% more staff reported that reasonable adjustments had been made in 2019 when compared to 2018.

Tees, Esk and Wear Valleys NHS

NHS Foundation Trust

4. SEX

	Indicator.	Data for reporting year		
	For each of these four workforce indicators, compare the data for sex.			
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	**Clinical Staff %**		
		Band	**Male**	**Female**
		1-4	26	74
		5-7	19	81
		8ab	24	76
		8cd	30	70
		9	0	100
		VSM	0	0
		Medics	47	53
		Non-clinical staff %		
		Band	**Male**	**Female**
		1-4	13	87
		5-7	36	64
		8ab	24	76
		8cd	44	56
		9	0	0
		VSM	60	40
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	Males are 1.01(previously 0.96) times more likely to be appointed than females once shortlisted.		
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	Men are 2.5 times more likely to enter the formal disciplinary process.		
4.	Relative likelihood of staff accessing non-mandatory training and CPD. (Based on responses to Q4 staff FFT).	There is no difference in the relative of male and female staff accessing CPD.		
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for male/female.			
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	**Male**	30%	
		Female	26%	
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	**Male**	12%	
		Female	16%	
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	**Male**	86%	
		Female	92%	
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	**Male**	5%	
		Female	5%	

9.	KF17. % feeling unwell due to work related stress in the last 12 months.	**Male**	36%		
		Female	40%		
10.	KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure	**Male**	48%		
		Female	52%		
11.	Overall staff engagement	**Male**	7.3		
		Female	7.1		
	Board representation indicator: For this indicator, compare the difference for male/female.				
12.	Percentage difference between the organisation's Board voting, non- voting and NED membership and its overall workforce.	**Sex**	**Voting**	**Non-Voting**	**NEDs**
		Female	-45%	-28%	-61%
		Male	+45%	+28%	+61%

SEX BREAKDOWN FOR TRUST STAFF

Female	Male	Grand Total
5236	1443	6679
78%	22%	100%

The data on age is complete.

- Men are overrepresented in VSM posts when compared to the overall staff makeup.
- Men are 2.5 times more likely to enter the disciplinary process than women. This is an increase of 0.2 from last year's figure of 2.3
- Men are less convinced that the trust offers equal opportunities for career progression or promotion.

5. RACE/ETHNICITY:

	Indicator.	Data for reporting year		
	For each of these four workforce indicators, compare the data for White and BME staff.			
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members)	**Clinical Staff %**		
		Band	**White**	**BAME**
		1-4	97%	3%
		5-7	96%	4%
		8ab	97%	3%
		8cd	99%	1%
		9	100%	0%
		VSM	0%	0%
		Medics	59%	41%
		Non-clinical staff %		
		Band	**White**	**BAME**
		1-4	99%	1%
		5-7	96%	4%
		8ab	97%	3%
		8cd	100%	0%
		9	0%	0%
		VSM	100%	0%
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	White staff are 1.47 (1.9) times more likely to be appointed from shortlisting compared to BAME staff.		
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	BAME staff are 2.0 times more likely to enter the formal disciplinary process.		
4.	Relative likelihood of staff accessing non-mandatory training and CPD. (Based on responses in Q4 FFT)	The relative likelihood of White staff accessing non-mandatory and CPD training is 0.95.		
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.			
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	**White**	27%	
		BAME	32%	
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	**White**	20%	
		BAME	24%	
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	**White**	91%	
		BAME	81%	
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	**White**	5%	
		BAME	7%	
9.	KF17. % feeling unwell due to work related	**White**	39%	

	stress in the last 12 months.	**BAME**	30%		
10.	KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure	**White**	52%		
		BAME	43%		
11.	Overall staff engagement	**White**	7.2		
		BAME	7.7		
	Board representation indicator: For this indicator, compare the difference for White and BME staff.				
12.	Percentage difference between the organisation's Board voting, non- voting and NED membership and its overall workforce.	**Ethnicity**	**Voting**	**Non-Voting**	**NEDs**
		BAME	+4%	-4%	-4%
		White	-4%	+4%	+4%

RACE/ETHNICITY BREAKDOWN FOR TRUST STAFF

White (including Medics)	6358	96%
BAME (including Medics)	281	4%
Total	6639	100%
White (excluding Medics)	6207	97%
BAME (excluding Medics)	174	3%
Total	6381	100%

The data for 40 people, 0.60%, is not available on ESR.

- BAME staff are 1.47 times less likely to be appointed from shortlisting, which has decreased from 1.6 in 2018.
- BAME staff are underrepresented in bands 8a and above in non-clinical and clinical posts.
- BAME staff are overrepresented in the medical workforce.
- BAME staff are 2.0 times more likely to enter the disciplinary process than white staff, this has reduced since 2018 when BAME staff were 2.59 times more likely to enter the disciplinary process than white staff
- More BAME staff than white staff have experienced harassment, bullying or abuse from patients, relatives or the public and staff in the last 12 months. However the figures for BAME staff experiencing harassment, bullying or abuse from staff have decreased by 5 % from 29% to 24% and the difference between the results for white staff and BAME staff for this indicator has decreased from 10% to 4%.
- More BAME staff experience discrimination from manager/ team leader/ or other colleagues, however this figures has dropped from 18% last year to 7% this year and the difference between BAME staff and white staff for this indicator has decreased from 12% to 2%.
- More White staff have felt unwell due to work related stress in the last 12 months than BAME staff.
- More White staff have attended work in the last 3 months despite feeling unwell than BAME staff.
- Apart from Medical staff there are low numbers of BAME staff employed by the trust.
- BAME staff have higher levels of staff engagement than white staff

6. SEXUAL ORIENTATION:

<table>
<tr><th></th><th>Indicator.</th><th colspan="3">Data for reporting year</th></tr>
<tr><td></td><td colspan="4">For each of these four workforce indicators, compare the data for Heterosexual/Lesbian/gay/bisexual.</td></tr>
<tr><td rowspan="17">1</td><td rowspan="17">Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members).</td><td colspan="3">Clinical staff %</td></tr>
<tr><td>Band</td><td>Heterosexual</td><td>LGB</td></tr>
<tr><td>1-4</td><td>97%</td><td>3%</td></tr>
<tr><td>5-7</td><td>96%</td><td>4%</td></tr>
<tr><td>8 ab</td><td>97%</td><td>3%</td></tr>
<tr><td>8cd</td><td>99%</td><td>1%</td></tr>
<tr><td>9</td><td>100%</td><td>0%</td></tr>
<tr><td>VSM</td><td>0%</td><td>0%</td></tr>
<tr><td>Medics</td><td>98%</td><td>2%</td></tr>
<tr><td colspan="3">Non-clinical staff %</td></tr>
<tr><td>Band</td><td>Heterosexual</td><td>LGB</td></tr>
<tr><td>1-4</td><td>99%</td><td>1%</td></tr>
<tr><td>5-7</td><td>97%</td><td>3%</td></tr>
<tr><td>8ab</td><td>98%</td><td>2%</td></tr>
<tr><td>8cd</td><td>100%</td><td>0%</td></tr>
<tr><td>9</td><td>0%</td><td>0%</td></tr>
<tr><td>VSM</td><td>92%</td><td>8%</td></tr>
<tr><td>2.</td><td>Relative likelihood of staff being appointed from shortlisting across all posts.</td><td colspan="3">Heterosexual staff are 1.05 (1.2) times more likely to be appointed from shortlisted posts than LGB staff.</td></tr>
<tr><td>3.</td><td>Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.</td><td colspan="3">LGB staff are 2.5 times more likely to enter the formal disciplinary process than heterosexual staff.</td></tr>
<tr><td>4.</td><td>Relative likelihood of staff accessing non-mandatory training and CPD. (Based on responses to Q4 staff FFT).</td><td colspan="3">Heterosexual staff and LGB staff are equally likely to access non-mandatory training and CPD.</td></tr>
<tr><td></td><td>National NHS Staff Survey indicators (or equivalent).
For each of the four staff survey indicators, <u>compare the outcomes of the responses for each of heterosexual/lesbian/gay/bisexual.</u></td><td colspan="3"></td></tr>
<tr><td rowspan="5">5.</td><td rowspan="5">KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.</td><td>Heterosexual</td><td colspan="2">26%</td></tr>
<tr><td>Bisexual</td><td colspan="2">40%</td></tr>
<tr><td>Gay Man</td><td colspan="2">36%</td></tr>
<tr><td>Gay Woman (Lesbian)</td><td colspan="2">26%</td></tr>
<tr><td>Other</td><td colspan="2">17%</td></tr>
<tr><td rowspan="3">6.</td><td rowspan="3">KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.</td><td>Heterosexual</td><td colspan="2">15%</td></tr>
<tr><td>Bisexual</td><td colspan="2">17%</td></tr>
<tr><td>Gay Man</td><td colspan="2">18%</td></tr>
</table>

		Gay Woman (Lesbian)	16%
		Other	27%
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	**Heterosexual**	92%
		Bisexual	80
		Gay Man	91%
		Gay Woman (Lesbian)	100%
		Other	No result available
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	**Heterosexual**	5%
		Bisexual	17%
		Gay Man	4%
		Gay Woman (Lesbian)	0%
		Other	7%
9.	KF17. % feeling unwell due to work related stress in the last 12 months**.**	**Heterosexual**	38%
		Bisexual	67%
		Gay Man	43%
		Gay Woman (Lesbian)	28%
		Other	33%
10.	KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure	**Heterosexual**	51%
		Bisexual	67%
		Gay Man	57%
		Gay Woman (Lesbian)	53%
		Other	42%
11.	Staff Engagement	**Heterosexual**	7.3
		Bisexual	7
		Gay Man	7.3
		Gay Woman	7.7
		(Lesbian) Other	6.3
	Board representation indicator: For this indicator, compare the difference for heterosexual/lesbian/gay/bisexual.		
12.	Percentage difference between the organisations' Board voting, non- voting and NED membership and its overall workforce.	Percentage difference between the organisations' Board voting, non-voting and NED membership and its overall workforce is -3%	

SEXUAL ORIENTATION BREAKDOWN FOR TRUST STAFF

Heterosexual	LGB	Grand Total
5508	168	5676
97%	3%	100%

1003 staff, 15% have not declared their sexual orientation on ESR. Whilst there has been on increase in the percentage of staff identifying as LGB there has been an increase in the number of people identifying as LGB

When compared to heterosexual staff, LGB staff are

- 2.5 times more likely to enter the disciplinary process, this is the same figure as last year. However it should be noted that 7 of the total number of people in the disciplinary process identified as LGB and for 15% of staff data on sexual orientation is not available so caution must be applied to this data.
- More likely to feel unwell due to work related stress in the last 12 months.
- Staff who identify as bisexual report less satisfactory experiences of working in the trust than those identifying as lesbian, gay or heterosexual.

7. CONCLUSIONS

7.1 There are clear differences in some of the metrics for staff from protected groups.

7.2 Actions to address issues for BAME staff will be identified in the WRES associated action plan which will go to Board for endorsement at the July 2019 meeting.

7.3 Actions to address issues for disabled staff will be identified in the WDES associated action plan which will go to Board for endorsement at the July 2019 Board meeting.

7.4 Amongst the benefits of addressing these are:

- Organisations that treat their staff fairly, that listen to them and develop their talent to the full, are more likely to provide better care for all patients.
- Developing a more inclusive workplace can help improve staff engagement, service quality and productivity,

8. RECOMMENDATIONS

8.1 It is proposed that the information contained in this report is published on the Trust's website as evidence that the Trust is meeting its public sector equality duties.

8.2 The Board is asked to note the differences in experience and outcome for staff from protected groups and to receive the action plans referenced in paragraphs 7.2 and 7.3 at the July 2019 Board meeting.

ITEM NO. 19

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**21st May 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:	21st May 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
347	09/05/2019	Contract for the design and installation of a high pressure watermist system at Roseberry Park Hospital, Middlesbrough	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

ITEM NO.20

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28 May 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 policy that underwent full revision and required ratification:
  - FIN-0003-v6 Anti-Fraud and Corruption Policy

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meetings held on 08 May 2019.

DATE:	28 May 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 policy underwent full review and required ratification:

Ref and Title	FIN-0003-v6 Anti-Fraud and Corruption Policy
Review date	08 May 2022
Reviewed by	Lisa Taylor
Approved by	Finance Committee
Description of change	The policy has undergone full review following release of new guidance with changes throughout.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

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

4.2 Financial/Value for Money:

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

4.3 Legal and Constitutional (including the NHS Constitution):

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

4.4 Equality and Diversity:

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

4.5 Other implications:

None identified

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meetings on 08 May 2019 have been presented for ratification.

7. RECOMMENDATIONS:

The Board is required to ratify the decisions of the Executive Management Team and is requested to accept this report.

Author: Colin Martin
Title: Chief Executive