AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 25TH JUNE 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 **21st May 2019.**		**Attached**
Item 2	Matters Arising.		**-**
Item 3	Public Board Action Log.		**Attached**
Item 4	Declarations of Interest.		**-**
Item 5	Chairman's Report.	**Chairman**	**Verbal**
Item 6	Chief Executive's Report.	**CM**	**Attached**
Item 7	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.50 am)

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 'must do' actions contained in the CQC Action Plan.	**EM**	**Attached**
Item 11	To consider a report on the actions being taken to ensure the Trust returns to being within its agency cap.	**DL/EM**	**Attached**

Performance (10.40 am)

Item 12	To consider the Finance Report as at 31st May 2019.	**PM**	**Attached**

Item 13	To consider the Trust Performance Dashboard as at 31st May 2019.	**SP**	**Attached**

Governance (10.55 am)

Item 14	To receive and note a report on the outcome of the Board Performance Evaluation scheme and to identify any actions arising therefrom.	**PB**	**Attached**

Items for Information (11.10 am)

Item 15	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 16 To note that the next meeting of the Board of Directors will be held on **Thursday 18th July 2019** in the Middlesbrough Football Club, Riverside Stadium, Middlesbrough TS3 6RS at 9.30 am.

Confidential Motion (11.15 am)

Item 17 **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
19th June 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 21ST MAY 2019 IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON COMMENCING AT 9.30 AM

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

In Attendance:
Ms. H. Griffiths, Public Governor for Harrogate and Wetherby
Prof. J. Reilly, Clinical Director for Research and Development (minute 19/128 refers)
Ms. S. Daniel, Research and Development Manager/Strategic Project Manager (minute 19/128 refers)
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications

19/121 APOLOGIES

Apologies for absence were received from Mr. R. Simpson, Non-Executive Director.

19/122 MINUTES

Agreed *– that the minutes of the last meeting held on 30th April 2019 be approved as a correct record and signed by the Chairman.*

19/123 MATTERS ARISING / PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

In response to a question on the appointment of a Duty Nurse Co-ordinator in York (minute 19/98 – 30/4/19 refers), Mrs. Moody reported that an interim solution was now in place and a flowchart had been developed for staff to seek to reduce demand on the on-call doctor.

19/124 DECLARATIONS OF INTEREST

There were no declarations of interest.

19/125 CHAIRMAN'S REPORT

The Chairman:

(1) Further to minute 19/96 (30/4/19), provided an update on the continuing discussions on the role and governance arrangements of the ICS.

The Board noted that a positive meeting had been held recently between the Chairmen and Chief Executives in the region and Lord David Prior, Chairman of NHS England (NHSE), where the progress being made on the development of the ICS, and further work to be undertaken, had been discussed.

(2) Reported on the excellent Carers' Event which had taken place on 20th May 2019.

The Chairman:

(a) Congratulated those staff involved in the delivery of the event.
(b) Advised that there had been good input from participants and the event had identified many issues to be followed up.

(3) Drew attention to the Annual Accounts (minute 19/134 refers) which demonstrated that the Trust had met its target surplus and control total.

The Chairman paid tribute to staff for achieving the excellent financial results particularly in the present challenging environment.

(4) Advised that the recruitment process for two new Non-Executive Directors, who were due to commence their roles with the Trust in the Autumn, had now commenced.

(5) Drew attention to the paper, presented to the meeting of the Resources Committee held on 14th May 2019, which had articulated the complex issues and varied solutions being taken forward in regard to medical recruitment, retention and development.

19/126 CHIEF EXECUTIVE'S REPORT

The Chief Executive reported on the following matters:

(1) The positive response to the first Trust-wide online workshop (minute 19/C/115 – 30/4/19 refers) which had been launched on 8th May 2019.

It was noted that:

(a) The workshop was due to close on 29th May 2019.
(b) There had been active engagement by staff with a wide range of ideas and suggestions being received.
(c) The initial headlines from the workshop should be available in time for the next Board meeting

(2) The appointment of Dr. Jim Boylan, the Trust's Director of Medical Education, as the Director of Undergraduate Studies for the new Medical School at the University of Sunderland.

(3) The 2019 Excellence in Forensic Psychology Practice Award being awarded to Claire Bainbridge, Consultant Psychologist in Health and Justice Services, by the British Psychological Society Division of Forensic Psychology.

19/127 GOVERNOR ISSUES

No issues were raised.

19/128 ANNUAL REPORT ON RESEARCH AND DEVELOPMENT

Prof. Reilly and Ms. Daniel presented the Annual Report on Research and Development.

Board Members welcomed the report, particularly the strong partnership developed with the University of York.

It was noted that the relationship was appreciated by both parties.

The following issues were raised:

(1) The position on the recruitment of a Commercial Research Nurse.

It was noted that:

(a) The position was fulltime and, following organisational change, had been filled by a clinical research nurse working within the Research and Development Department.

(b) Recruitment processes had commenced to backfill the vacated post.

(2) The benefits of mapping research and development against the Trust's strategic objectives in order to demonstrate their importance to the delivery of the Strategic Direction.

It was noted that the strategic context of research and development was articulated in the research and development strategy but could also be highlighted in future reports.

Mrs. Pickering:

(a) Observed that, previously, it had been difficult to see the progress being made on the delivery of the strategy; however, following the discussions under minute 18/144 (22/5/18), this had now been addressed.

(b) Suggested that, in its next iteration, the objectives of the strategy should be mapped against the strategic goals of the Trust to provide greater understanding of the alignment between them.

(3) The involvement of carers in research and development.

Ms. Daniel drew attention to the development of a Patient and Public Involvement Network in York and the work being undertaken with the University and the acute trust to engage with wider groups including carers.

It was noted that specific work on the involvement of carers was also being undertaken in forensic services.

(4) The purpose of capacity and capability reviews.

Prof. Reilly explained that the purpose of the reviews, which were undertaken at both national and Trust levels as part of research governance processes, was to ensure that the right investigators and other arrangements were in place to support a research project.

(5) The implementation of research which was recognised as not being straightforward.

Whilst recognising that it was taking place, the Non-Executive Directors asked for more information to be provided on this matter in future reports including its links to the Trust's strategic goals e.g. the benefits to medical recruitment of having a strong research programme.

The Chairman considered that it would be helpful for further information, including examples, on the implementation and sharing of research to be provided in future reports.

(6) The risks arising from commercial research which it was considered should be reflected in the report.

Prof. Reilly accepted this point and advised that:
(a) The risks had been covered in his reports to the Quality Assurance Committee and in last year's annual report.
(b) Risks arising from commercial research were well controlled.

(7) From a nursing perspective, the importance of the NIHR '70@70' award to Dr. Valentina Short and the plan to move Prof. David Ekers into the Nursing and Governance Directorate to increase the involvement of nurses in research and to develop a clinical and academic pathway for them.

19/129 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 4th April 2019 (Annex 1 to the report).
(2) The key issues considered by the Committee at its meeting held on 2nd May 2019.
(3) The Positive and Safe Annual Report 2018/19 (Annex 2 to the report).

In his introduction to the report, Dr. Griffiths drew attention to the Committee's discussions on the increase in the use of rapid tranquilisation (a 28% increase on 2017/18) as shown in the Positive and Safe Annual Report.

Mrs. Moody advised that:

(1) The report provided a relatively early position on the impact of the restrictive intervention reduction plan (also known as the positive and safe plan) which had been produced in 2017.

(2) The Trust was seeking to reduce the use of restrictive interventions and progress on this issue, taking into account the position on rapid tranquilisation and the marginal increase in the use of prone restraint, was encouraging.

(3) Although further understanding was required there was now greater clarity:
   (a) On those areas with a high use of restrictive interventions i.e. forensic services, the PICUs and West Lane Hospital.
   (b) That restrictive interventions were being used more to prevent self-harm than, as previously thought, in response to violence and aggression.
   (c) That the use of restrictive interventions tended to be limited to a few patients and was not institutionalised.

Board Members raised the following matters:

(1) The need for data on the use of restrictive interventions by ethnicity to provide assurance that they were not used disproportionately on people from BME backgrounds.

(2) The split in the use of restrictive interventions by gender.

It was noted that this reflected that self-harm, the main reason for the use of restrictive interventions, was more prevalent amongst females and younger people.

Dr. Khouja considered that the data provided in the report, together with other research, highlighted the need for the Trust to alter its approach to engaging with women who self-harmed.

(3) The importance of benchmarking the data to avoid false assurance on the Trust's position.

On this matter:

(a) It was noted that the difficulties in benchmarking the data had been discussed by the QuAC.

(b) Mrs. Moody explained that:
   - There were differences between trusts in how restrictive interventions were defined and recorded e.g. some trusts, unlike TEWV, made distinctions between intentional and unintentional prone restraint.
   - Benchmarking should become easier in the future following the recent agreement of national definitions of restrictive interventions which all trusts were required to build into their recording and reporting arrangements.
   - The Trust had agreed to share data on the use of seclusion with Northumberland, Tyne and Wear NHS Foundation Trust. Although there were differences between the facilities provided in each Trust, the approach would be useful.

(c) Dr. Griffiths also highlighted the potential use of soft intelligence which, although limited, could indicate a host of issues.

Mr. Martin observed that, given the constraints arising from the difficulties in benchmarking, the Trust needed to review its position in any national reporting and take a view based on its own perceptions.

(4) Whether there was a marked difference between the use of restrictive interventions in the ten inpatient areas identified in the report, as the highest users, compared to others.

Mrs. Moody advised that:

(a) The difference between the top three wards and the others included in the list was stark.

(b) The rankings within the list reflected known issues e.g.:

- Those with nasogastric feeding at West Lane Hospital which had been previously discussed.
- The level of acuity of patients in the PICUs.
- The use of restraint to support personal care in older people's organic wards.

The Board noted:

(a) That there were only five wards where the use of restrictive interventions appeared to be an everyday occurrence.

(b) The correlation between the wards included in the list and those featured in the Nurse Staffing Report.

(5) The recording of the use of tear resistant clothing e.g. whether, if it was used for a number of days, it would be classed as one incident or by day.

Mrs. Moody undertook to review this matter.

Action: Mrs. Moody

In view of its importance, the Chairman considered that it would be beneficial for the Board to further discuss the use of restrictive interventions at a future seminar.

Action: Mr. Martin

19/130 NURSE STAFFING REPORT

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

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

The following matters were raised:

(1) The reasons why Elm Ward had been awarded the (joint) highest number of points, using the severity rating scale, as it did not feature on any of the other criteria contained in the report.

Mrs. Moody undertook to review this matter but considered that the ward's position related to the number of serious incidents.

Action: Mrs. Moody

It was noted that further information on the severity ratings of wards would be included in the next six monthly safe staffing report.

(2) The reasons for the decrease in agency usage by 2.5%, compared to March 2019, and how this was reflected in the Finance Report (minute 19/136 refers).

In response it was noted that:

(a) Although the use of agency registered nurses had increased, for the month, the overall position reflected the significant reduction in the use of agency healthcare assistants.
(b) Significant work had been undertaken on recruitment, particularly in North Yorkshire, and on the level loading of annual leave.
(c) Reporting in the Finance Report was based on a different metric, agency expenditure against the (revised) capped target.

Board Members considered that the reduction in agency usage was encouraging.

(3) The benefits of using some form of coding to denote types of wards in the reports in view of some ward names being identical or having changed.

This was taken on board.

Action: Mrs. Moody

19/131 CQC ACTION PLAN

Further to minute 19/39 (26/2/19), the Board received a progress report on the delivery of the CQC action plan.

The following matters were raised:

(1) The reliance, based on the evidence listed in the report, on QuAG minutes for assurance that actions had been completed.

In response it was noted that:

(a) In most cases, evidence for assurance was provided by audits.
(b) Over and above that approach, in terms of the second line of defence, quality compliance visits were also undertaken.
(c) There had been discussions at EMT about sustaining compliance at all levels and it had been agreed that visits, focussing on AMH and the key lines of enquiry of the safe domain, would be undertaken by Directors.

(2) The importance of differentiating between policy and practice, for example, the issues experienced with emergency response bag compliance where the policy was satisfactory but not complied with in all areas.

Mrs. Moody advised that, on emergency response bags, a policy was in place and compliance against it had been audited; however, as this had found that practice was not as robust, as required, further checks had been undertaken.

(3) The omission of an action in the plan in response to the issue identified by the CQC in regard to ensuring improvements to the quality of food available to patients at West Lane Hospital (action ref. 39).

It was noted that relevant actions would be developed in response to the findings of the next PLACE visit to the facility.

(4) The emphasis on inpatient services in the CQC's report when most services were provided in the community.

The Board noted that:
(a) For mental health services, visits were, generally, weighted towards inpatient services and the safe domain reflecting the CQC's concerns.
(b) The fundamental standards for inpatient services were also more developed than for community services.
(c) Most community services in the Trust had not been visited by the regulator during the last five years.

It was noted that, in accordance with minute 19/100 (30/4/19), progress reports on the 'must do' actions (agreed as being by exception) would commence from the Board meeting to be held on 25th June 2019.

19/132 MERGER OF THE NORTH YORKSHIRE AND YORK AND SELBY LOCALITIES

Further to minute 18/311 (27/11/18) the Board received and noted a report on the merger of the North Yorkshire and York and Selby Localities.

The Board congratulated staff on the success of the merger.

19/133 MENTAL HEALTH LEGISLATION COMMITTEE

Further to minute 19/103 (30/4/19) the Board received and noted the report of the Mental Health Legislation Committee (MHLC) including:
(1) The confirmed minutes of its meeting held on 24th January 2019 (Annex 1 to the report).
(2) The key issues considered by the Committee at its meeting held on 24th April 2019.

Mr. Murphy, on behalf of the Committee, drew attention to the following matters:

(1) The success of the work undertaken by Mr. Simpson, the Chairman of the Committee, to encourage interest in becoming an associate hospital manager amongst the South Asian community in Teesside.

(2) The concerns, arising from the results of the re-audit of compliance with the Mental Capacity Act in December/January 2019, that many inpatient and community teams across all directorates could not evidence the consideration of capacity by the completion of appropriate documentation.

The importance of addressing this matter was highlighted particularly in view of the changes arising from the implementation of the Liberty Protection Safeguards in early 2020.

In response to a question, it was noted that patients discharged, either by a tribunal or a hospital managers' review, were tracked and quarterly reports on this matter were provided to the Committee.

19/134 ANNUAL REPORT AND ACCOUNTS 2018/19

On the recommendation of the Audit Committee consideration was given to the approval of:

(1) The draft Annual Report, including the Quality Report/Account, and Accounts 2018/2019.

(2) The Letter of Representation 2019.

Revised versions of the remuneration tables were tabled at the meeting.

In regard to the above matters the Board took into account:

(1) The revised External Auditors' Audit Completion Report (ISA 260) which incorporated update letters, dated 16th and 20th May 2019, on the resolution of outstanding matters.

Mr. McGahon advised that only one issue remained outstanding; a letter of confirmation that a patient monies account with the Royal Bank of Scotland had been closed.

It was noted that the letter, which was required by the External Auditors, had been sought since February 2019.

In response to questions, Mr. McGahon advised that:

(a) Informal discussions had been held with the External Auditors on the position if the letter was not received and on whether any other forms of assurance on the closure of the account might be acceptable to them.

(b) The Audit Completion Report would not be reissued by the External Auditors but needed to be read in conjunction with the update letters.

(2) The External Auditors' draft report on the contents and indicators included in the Quality Account/Report 2018/19 and their limited (scope) Assurance Opinion.

(3) The report of the Director of Finance noting that, in approving the Annual Report and Accounts for the year ended 31st March 2019:

(a) Each Board Member would be confirming that, as far as they were aware, there was no relevant information of which the Trust's External Auditors were unaware.

(b) The Board would be confirming the Trust's Modern Slavery Act 2015 Statements included in the Annual Report.

In response to a question, received prior to the meeting, Mr. McGahon provided an explanation of the difference between the operating surplus included in the Statement of Comprehensive Income and that referenced in the Finance Report to the Board meeting held on 30th April 2019 (minute 19/104 – 30/4/19 refers) which provided the position against the control total.

He also undertook to circulate a note to Board Members to provide further details of this matter.

Action: Mr. McGahon

(4) The report of the Chairman of the Audit Committee on the Committee's review of the Quality Account/Report, the Annual Report and Accounts, and related matters, and the reports of the External Auditors at its meetings held on 9th and 17th May 2019.

Mr. Jennings, the Chairman of the Audit Committee:

(a) Drew attention to the Audit Completion Report which summarised the key audit risks; the work undertaken to provide assurance that they had not been realised; and the audit conclusions relating to them.

(b) Explained that the Audit Committee had reviewed the draft Accounts at each of the meetings, both in detail (at the first meeting), paying particular attention to the treatment of PFI and Modern Equivalent Asset valuations and (at the second meeting) to follow up on issues raised.

He confirmed that, following its reviews, the Audit Committee was content that the documents presented a fair and balanced view of the position of the Trust for the year ended 31st March 2019 and had recommended them to the Board for approval.

In addition, Mrs. Pickering advised, in regard to the Quality Account/Report, that:

(1) A feedback letter had now been received from the Darlington CCG, on behalf of the CCGs in County Durham, Darlington and Teesside, which would be included in the final document. This was important as the CCGs were required to comment on the Quality Account/Report.

(2) The limited (scope) review had been very positive with no significant issues raised by the External Auditors about its contents or data quality.

The Non-Executive Directors highlighted the considered feedback received from stakeholders which was both positive and constructive.

On behalf of the Board, the Chairman thanked all those who had contributed to the preparation of the Annual Report, Quality Account/Report and Accounts.

Agreed – *that subject to no material issues being raised in regard to outstanding matters or during review and closure processes:*

(1) that the Annual Report 2018/19, including the Quality Report, be approved;

(2) that the Annual Accounts 2018/19 be adopted;

(3) that the Letter of Representation 2018/19 be approved;

(4) that the Chairman, the Chief Executive and the Director of Finance and Information be authorised to sign, as appropriate, the Annual Report, the Accounts, the Statement of Financial Position, the Annual Governance Statement, the Remuneration Report, the Statement of the Chief Executive as Accounting Officer, the Chief Executive's Statement on the Quality Report/Account, the Statement on the Responsibilities of Directors for preparing the Quality Report/Account, the Letter of Representation and any other necessary statements and certifications;

Action: Ms. Harte, Mr. Martin and Mr. McGahon

(5) that the Annual Report 2018/19 including the Annual Accounts and the Quality Report be submitted to NHS Improvement and Parliament; and

Action: Mr. McGahon and Mr. Bellas

(6) that the Quality Account 2018/19 be submitted to the Department of Health and Social Care.

Action: Mrs. Pickering

19/135 ANNUAL BOARD CERTIFICATES

On the recommendation of the Audit Committee, consideration was given to the confirmation and sign off of the annual Board certificates required by NHS Improvement (NHSI).

It was noted that, in accordance with NHSI guidance, the Council of Governors would be asked for its views on the confirmation of the certificates at its meeting to be held on 22nd May 2019.

It was suggested that, as previously discussed by the Board, the risks arising from the Trust's workforce, particularly in regard to BME staff, not being representative of local communities should be referenced, together with the mitigations being undertaken, in the sixth component of the Corporate Governance Statement (Annex 1 to the report).

While recognising its importance, Board Members considered that the issue was outside the scope of the relevant component which related to having sufficient staff, both in terms of numbers and qualifications, to ensure compliance with the provider licence.

Agreed – *that, subject to no material issues being raised by the Council of Governors at its meeting to be held on 22nd May 2019:*

(1) the Certificate on Systems for Compliance with Licence Conditions be confirmed 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."

(2) the Corporate Governance Statement (as set out in Annex 1 to the above report) be approved;

(3) the Certificate on the Training of Governors be confirmed 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."*

(4) the Certificate on the Availability of Resources (as set out in Annex 2 to the above report) be approved; and

(5) that the Chairman and Chief Executive be authorised to sign off the above certificates.

Action: Ms. Harte and Mr. Martin

19/136 FINANCE REPORT AS AT 30TH APRIL 2019

The Board received and noted the Finance Report as at 30th April 2019.

It was noted that a decrease of £358k would result in the I&E margin improving, and not reducing, to a rating of "2" under the Use of Resources component as stated in the report.

In response to questions on the implications of the financial outturn in 2018/19, Mr. McGahon advised that:

(1) As a result of PSF received, the Trust would not require a loan in 2019/20 but might need to borrow in the subsequent year.

(2) The receipt of PSF for 2018/19 had no implications for the delivery of the surplus in 2019/20 or in subsequent years.

(3) Potential changes to capital controls in 2019/20 should not impact on the Trust as it was recognised, in principle, by the regulator that neither of its two major schemes could be deferred.

In addition, in response to a suggestion, Mr. McGahon explained that consideration was being given to using short term contracts to employ staff to deliver facilities management services at Roseberry Park, rather than engaging them through agencies, but potential recruitment difficulties had been identified.

Mr. Martin commended Mrs. Hill for the development of the visual control for agency spend monitoring including the progress on the vacancy pathway.

19/137 PERFORMANCE DASHBOARD AS AT 30TH APRIL 2019

The Board received and noted the Performance Dashboard Report as at 30th April 2019.

The Board welcomed the positions on mandatory training (KPI 17) and bed occupancy (KPI 12).

The Non-Executive Directors raised the following matters:

(1) The need to keep the position on KPI 14 under review as the percentage of patients re-admitted to Assessment & Treatment wards within 30 days had increased and the data was showing an upward trajectory.

Mrs. Pickering explained that:

(a) Performance against the indicator was discussed on a monthly basis by the EMT.

(b) In general, breaches tended to be due to appropriate need and not to inappropriate discharges or community services not being as effective as they needed to be.

(c) In the Tees Locality, which made the highest contribution to the increase, the Director of Operations had reviewed each case and provided assurance that all readmissions were appropriate.

(2) Lengths of stay (KPI 13) in North Yorkshire and York which were significantly higher than in other Localities.

It was noted that performance in the Locality was particularly linked to the number of delayed discharges in York.

(3) Potential inconsistencies on the trend lines in the graphs.

Two examples were highlighted:

(a) The graph for KPI 12 (percentage of bed occupancy) where the trend line had an upward trajectory, despite a general reduction in bed occupancy during 2018, and was above actual performance for the year.

(b) The graph for KPI 6 (% of in scope teams achieving the benchmarks for HoNOS score) where the trend line was above both the target and actual performance for 2018.

In regard to KPI 12, Mrs Pickering:

(a) Advised that, although there had been a reduction in bed occupancy in 2018, the position was still higher than in 2017 so, if viewed cumulatively over the full period, there was an upward trend.

(b) Undertook to check whether the y-axis used for the trend line was based on a different scale.

Action: Mrs. Pickering

Dr. Khouja, reflecting on recent discussions during a "deep dive" by the EMT, observed that it was evident that there was increased demand for AMH services in certain areas and, in view of this, the health of people was likely to deteriorate by the time they were seen by services. He considered that it was important for the data to be fed into the Right Care Right Place (RCRP) Programme Board to support discussions on the changes which were required to address the situation.

Mrs. Pickering agreed that it was imperative for the data to be used by the RCRP programme to support the redesign of the pathway and to work with partners to develop a delivery model to respond to demand "upstream."

19/138 STRATEGIC DIRECTION PERFORMANCE REPORT

Consideration was given to the Strategic Direction Performance Report for Quarter 4, 2018/19 including:

(1) Proposed changes to metrics 15 and 21 included in the Strategic Direction Scorecard.
(2) Proposed changes to the Trust Business Plan (as set out in Appendix 1 to the covering report).
(3) The Purposeful and Productive Community Services End of Programme Report (Appendix 2 to the report).

Board Members sought clarity on:

(1) The concerns that metric 21 ("All Trust clinicians to have access to their key service/team/ patient information in near to real time") would not facilitate the accurate reporting of real time information and which had led to work being undertaken to develop a more reflective metric to be included in both the Strategic Direction Scorecard and the Digital Transformation Strategy.

    It was noted that, in view of difficulties in measuring the present metric, alternative approaches were being considered. The outcome of these discussions was awaited but it was hoped that a number of options would be presented.

(2) The number of changes proposed to the Business Plan as there appeared to be more than in previous years.

    Mrs. Pickering explained that there were a number of reasons for the proposed changes.

    Some of the proposals related to priorities where delivery was outwith the control of the Trust (rated "grey") and where the position had changed since the preparation of the Business Plan e.g. there had been an expectation that the procurement of IAPT services would have been completed in-year; however, this had not been the case due to Commissioner decisions.

    Other changes reflected the amount of work the Trust was undertaking; priorities where a more appropriate way of delivery was being taken forward; and those where, perhaps, services had been overly optimistic.

Mr. Martin agreed with this assessment. He considered that the number of proposed changes was not greater than in previous years and reflected the environment in which the Trust was operating.

Board Members considered that it would be beneficial to include an explanation of the RAG ratings and further details of any proposed changes to the priorities in future reports.

Action: Mrs. Pickering

(3) The position in the County Durham and Darlington Locality where staff/staffing, cited by patients as the reason for feeling unsafe on wards, represented an outlier.

Mrs. Pickering advised that, whilst a detailed report on this matter was awaited, the issues were generally linked to the consistency of staffing on wards and the level of familiarity of patients with staff, particularly bank and agency workers.

It was noted that the patients' views on this matter did not reflect actual usage of agency and bank workers.

The Chairman asked for a further discussion on this matter outside the meeting.

(4) In regard to the Purposeful and Productive Community Services End of Programme Report:

(a) Whether the programme was considered to have been successful.

It was considered that, overall, the programme had been successful and many of its elements (cells, huddles and daily lean management) had now become business as usual for operational delivery.

(b) How the learning from the programme was being taken forward into the Right Care Right Place Priority.

Mrs Hill advised that key lessons learnt from the programme had been its application across partners and systems and the challenges of measuring success across all criteria. These issues had been taken on board in the RCRP programme.

(c) The very small percentage change in face-to-face contacts for ALD services compared to indirect and skype contacts.

It was noted that indirect contacts related to those with carers and care agencies and the increase in them, compared to face-to-face contacts, needed to be viewed in the context of the capacity of service users.

(d) How lessons learnt from the programme were to be shared with staff.

It was noted that communications, both general and bespoke to Localities, had been prepared.

In regard to an issue raised about the tone of the communications, Mrs. Hill advised that they had been developed by the Communications Department and quality assured by selected managers.

Agreed –

(1) that the changes to the Trust Business Plan (as set out in Appendix 1 to the report) be approved; and

(2) that the following changes to the metrics included in the Strategic Direction Scorecard be approved:

(a) KPI 15 – the replacement of "percentage referrals received from GPs using the standard electronic referrals template relevant for the speciality" with "Percentage of e-letters developed against the total number of GP letters required";

(b) KPI 21 – to include the outcome of work being undertaken to identify a more reflective metric to facilitate the accurate reporting of real time information.

Action: Mrs. Pickering

19/139 EQUALITY ACT 2010 – PUBLICATION OF INFORMATION

Consideration was given to the report which sought the ratification of the information contained in the Equality Data Documents (appended to the covering report) for publication as required by the Equality Act 2010.

In his introduction to the report Mr. Levy:

(1) Drew attention to the recommendations that:

(a) The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) associated action plans should be presented to the Board for endorsement at its meeting to be held on 18th July 2019.

(b) The Equality Data Documents should be considered in more detail by the Resources Committee as in previous years.

(2) Highlighted the following proposed amendments to the information contained in the Equality Data Documents:

(a) The inclusion, in accordance with guidance received from NHS England, of staff who had not disclosed whether or not they had a disability or their sexual orientation, respectively, in the denominators for the calculation of the "disability breakdown for Trust staff" and the "sexual orientation breakdown for Trust staff".

It was noted, in the former case, that the change would provide consistency with the WDES and reduce the proportion of staff identified as having a disability from 7% to approximately 3% of the workforce.

Board Members suggested that, to support clarity and transparency, the information should be presented in the Document both including and excluding staff who had not declared their status together with a note to explain the reasons for the differences and referencing the NHSE guidance.

Action: Mr. Levy

(b) The change to the calculation of indicator 2 (Relative likelihood of staff being appointed from shortlisting across all posts") under race/ethnicity to exclude those candidates who had applied for a position and being shortlisted but who had withdrawn before interview.

The change was taken on board.

Action: Mr. Levy

In response to a question, Mr. Levy recognised that further information was required on the reasons why candidates withdrew before interview.

Board Members also raised the following matters:

(1) The meaning of the statement "The relative likelihood of white staff accessing non-mandatory and CPD training is 0.95."

It was noted that this showed, based on the ratio of 1:0.95, that BME staff were more likely to access the training than white staff.

(2) The lack of information on the sexual orientation of service users.

On this matter:

(a) In view of potential confusion, Mr. Levy undertook to provide an explanation of the use of the term "null" in the table providing a "Summary of Service Users by Sexual Orientation" under section 2.6 of the document.

Action: Mr. Levy

(b) It was noted that work was planned to be undertaken with the University of Leeds to seek to understand the issues which hampered data collection on this matter.

(3) The reference in the covering paper to emerging evidence that discrimination against staff led to lower levels of patient satisfaction.

Mr. Levy undertook to share the evidence base for the statement, from research by the King's Fund, with the Resources Committee.

Action: Mr. Levy

(4) The findings from an audit of actions taken to improve the experience of staff on extended forms of planned maternity/paternity/adoption leave (the equality objective of forensic services) that, despite action being taken, staff felt less supported than they had previously.

It was noted that this potentially arose from staff being taken off the wards and the impact of this on others.

Agreed -

(1) that the Equality Data Documents, as amended, be ratified and their publication, as required by the Equality Act 2010, be approved;

(2) that the WRES and WDES associated action plans be presented to the Board for endorsement at its meeting to be held on 18th July 2019; and

(3) that the Equality Data documents be considered in more detail by the Resources Committee.

Action Mr. Levy

19/140 USE OF THE TRUST SEAL

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

19/141 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.

19/142 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 25th June 2019 in the Boardroom, West Park Hospital, Darlington.

19/143 CONFIDENTIAL MOTION

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

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

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

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

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

(a) the free and frank provision of advice, or

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

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

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

Following the transaction of the confidential business the meeting concluded at 1.00 pm.

ITEM NO. 3

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th June 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
19/07/2018	18/218	A further review of the Board's committee arrangements to be undertaken	PB	~~Jun-19~~ Sept-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~~ Jul-19	
26/02/2019	19/38	The collection of data on staff sent home due to flu to be looked into	DL	Jul-19	
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	Completed
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	

	Minute No.	Action	Owner(s)	Timescale	Status
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 agenda item 10
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~~ Jul-19	
21/05/2019	19/129	Clarity to be provided on the recording of the use of tear resistant clothing	EM	Jul-19	
21/05/2019	19/129	A Board Seminar discussion to be arranged on restrictive interventions	CM	To be included in the review to be undertaken in August 2019	
21/05/2019	19/130	The reasons for Elm Ward having the joint highest number of points on the safe staffing severity rating scale to be reviewed	EM	-	See agenda item 9
21/05/2019	19/130	Coding to denote types of ward to be introduced in the Nurse Staffing Reports	EM	-	See agenda item 9
21/05/2019	19/134	A note to be circulated to Board Members to provide further details of the difference between the operating surplus in the Statement of Comprehensive Income and that referenced in the Finance Report to the meeting held on 30 April 2019	PM	-	Completed
21/05/2019	19/134	Approval of the Annual Report, including the Quality Report, and Accounts and authorisation to sign off the Letter of Representation and the required reports, statements and certificates	Chairman/CM/PM	May-19	Approved & Sign Off Completed
21/05/2019	19/134	The Annual Report and Accounts to be submitted to NHS Improvement and Parliament	PB/PM	Jun-19	
21/05/2019	19/134	The Quality Account to be submitted to the DoH&SC	SP	-	Completed
21/05/2019	19/134	Approval of and authorisation to sign the Annual Board Certificates subject to no material issues being raised by the CoG	Chairman/CM	May-19	Approved & Sign Off Completed

	Minute No.	Action	Owner(s)	Timescale	Status
21/05/2019	19/137	The scale used for the y-axis in the graph relating to KPI 12 in the Performance Dashboard Report to be checked	SP	Jun-19	Completed
21/05/2019	19/138	To note that an explanation of the RAG ratings and further details of any changes to the Business Plan are to be provided in future Strategic Direction Performance Reports	SP	-	To note
21/05/2019	19/138	To note approval of the changes to the Business Plan and KPIs 15 and 21 as set out in the Strategic Direction Performance Report	SP	-	To note
21/05/2019	19/139	To note ratification of the Equality Data Documents and approval to publish them subject to the following amendments: (1) In the staff document: - The disability and sexual orientation breakdowns to include the data both including and excluding those who had not declared their status together with a explanation of the reasons for the differences and referencing NHSE guidance - The calculation of indicator 2 under race/ethnicity to exclude candidates who had been shortlisted but who had withdrawn prior to interview (2) In the service user document, the inclusion of an explanation for the term "null" in the table providing a summary of service users by sexual orientation	DL	-	To note
21/05/2019	19/139	The WRES and WDES associated action plans to be presented to the Board for endorsement	DL	18/07/2019	
21/05/2019	19/139	The Equality Data documents to be considered in more detail by the Resources Committee *(Evidence from the Kings Fund on the impact of discrimination against staff on patient experience to be provided to the Committee)*	DL	Jul-19	

ITEM NO 6

PUBLIC

BOARD OF DIRECTORS

DATE:	**Tuesday 25 June 2019**
TITLE:	**Chief Executive's Report**
REPORT OF:	**Colin Martin, Chief Executive**
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:

A briefing to the Board of important topical issues that are of concern to the Chief Executive.

Recommendations:

To receive and note the contents of this report.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday 25 June 2019**
TITLE:	**Chief Executive's Report**

1. Thanks to staff involved in managing the impact of Whorlton Hall

The Board is aware that prior to, and since the broadcast of the Panorama programme about Whorlton Hall, staff in our Learning Disability Services have played significant roles in managing and responding to this very difficult situation. I would like to place formally on record my appreciation for what has been a professional, compassionate and person-centred response.

2. New Junior Doctor Contract

The Department of Health and Social Care, NHS Employers and the BMA recently announced a provisional agreement on terms for a new junior doctor contract, with funding to increase pay and other allowances. The new contract would replace the existing terms, imposed by the government following the union's industrial action in 2016, and formally end the current dispute.

The deal is currently a provisional one**,** as the BMA must now seek full agreement via a ballot of its members. While the union eventually reached a settlement with the Government in 2016, members voted against the terms on offer, continuing the dispute over the contract until this point.

The BMA's member ballot will opened on Friday 14 June and its results are expected to be announced soon after voting closes on Wednesday 26 June. If junior doctors confirm their support for the agreement, it will be implemented "as soon as possible" and pay uplifts will be backdated from 1 April 2019.

3. Interim People Plan

NHS England/Improvement recently published the Interim People Plan for the NHS. The 76 page Plan is structured into the themes identified below and each theme includes a number of actions that need to be taken by NHS organisations to enable the people who work in the NHS to deliver the NHS Long Term Plan. The full People Plan is expected to be published when the Spending Review has concluded.

The themes and key actions for employers are as follows:

Make the NHS the best place to work - paying greater attention to why staff leave the NHS, taking action to retain existing staff and attract more people to join.

Develop a new offer for all people working in the NHS, through widespread engagement with our people and staff representatives over the summer of 2019.

All local NHS systems and organisations to set out plans to make the NHS the best place to work as part of their NHS Long Term Plan implementation plans, to be updated to reflect the people offer published as part of the full People Plan.

The Government is bringing forward a consultation on new pension flexibility for senior clinicians. The proposal would give senior clinicians the option to halve the rate at which their NHS pension grows, in exchange for halving their contributions to the Scheme. This proposal is being made in response to concerns expressed by the BMA about the impact of the annual allowance upon some individuals and possible consequences for staff retention.

Improve our leadership culture – addressing how we need to develop and spread a positive inclusive person-centred leadership culture across the NHS, with a clear focus on improvement and advancing equality of opportunity.

Undertake system-wide engagement on a new NHS leadership compact that will establish the cultural values and leadership behaviours we expect from NHS leaders together with the support and development leaders should expect in return.

Prioritise urgent action on nursing shortages – supporting and retaining existing nurses while attracting nurses from abroad and ensuring we make the most of the nurses we already have within our NHS.

Deliver a rapid expansion programme to increase clinical placement capacity to 5,000 for September 2019 intakes. Work directly with Trust Directors of Nursing to assess organisational readiness and provide targeted support and resources to develop the infrastructure required to increase placement capacity.

Develop a workforce to deliver 21st century care –developing a multi-professional and integrated workforce to deliver primary and community healthcare services whilst ensuring we have a flexible and adaptive workforce that has more time to provide care.

Establish a national programme board to address geographical and specialty shortages in doctors, including staffing models for rural and coastal hospitals and general practice.

Support local health systems (STPs/ICSs) to develop five year workforce plans, as an integral part of service and financial plans, enabling us to understand better the number and mix of roles needed to deliver the NHS Long Term Plan and inform national workforce planning.

Develop a new operating model for workforce – putting workforce planning at the centre of our planning processes, continuing to work collaboratively with more people planning activities devolved to local integrated care systems (ICS).

Co-produce an ICS maturity framework that benchmarks workforce activities in STPs/ICSs which also informs decisions on the pace and scale of devolution of workforce activities.

The Interim People Plan also includes specific commitments to:

Increase the number of nurse placements by 5,700;
Increase the number of nurse associates to 7,500;
Increase the numbers of doctors and nurses recruited internationally;
Work with Mumsnet on a return to the NHS campaign;
Better co-ordinate overseas recruitment.

The actions arising from the Interim People Plan are being reviewed within the Trust and certain actions will also form part of discussions with local organisations as appropriate.

Colin Martin
Chief Executive

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 25 June 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 06 June 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 Tees Services
- Compliance with CQC
- Infection, Prevention and Control
- Patient Safety Group
- Safeguarding & Public Protection
- Research Governance
- Equality and Diversity
- Clinical Audit & Effectiveness

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 06 June 2019.
- Note the confirmed minutes of the formal meeting held on 02 May 2019 (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Tuesday 25 June 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 06 June 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 Tees Services.

ARE OURSERVICES WELL LED?

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

4. The Committee received a key assurance and exception report from the Tees LMGB.

4.1 TEES SERVICES LMGB

The Committee discussed the LMGB report for Tees Services covering the period March 2019 – May 2019.

The top areas highlighted were:

- The high levels of bed occupancy in Adult Mental Health and some out of the area placements largely related to MHSOP.
- Activity levels within Adult Mental Health Services and Children and Young People's Services, coupled with sickness absence, which was causing pressure on the services. Some work was underway with the Performance Team to look at demand and capacity, which has seen a surge in the last three years, possibly relating to when the provision of IAPT services ceased.
  Assurance was provided to members that the sickness absence amongst staff was not linked to pressures of work and that the long term sickness numbers were starting to come down with around 40 members off long term currently.

- Work is underway to understand the increase in the rates of seclusion; however it is thought by the Service that there is a degree of double reporting from AMH and PICU as well as some individuals with multiple episodes of seclusion.
  Members discussed how it is important to get the right balance for restrictive approaches and ensuring individuals are placed in seclusion for appropriate periods of time.

- A safeguarding referral made in Westerdale North, MH Services for Older People in relation to the potential inappropriate movement of a patient by staff. The CQC have been informed and an investigation is underway.

- The use of tear resistant clothing had been used on one occasion, during an episode of seclusion
- Resuscitation equipment – all had been checked on a daily basis in line with policy with the exception of five checks across wards. Further assurance was sought from the members of the Committee on actions that had been taken to address the areas which were found to be non-compliant.

The Board is asked to note that there is a national problem with the shortage of LD nurses and this is impacting on Tees. Some Universities have stopped funding the courses to train LD nurses, however the Trust is slightly better off than other parts of the country as locally we have worked with Universities to ensure the courses are still being run.

4.3 Compliance with CQC Requirements

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

The Board is asked to note that:

- The CQC continue to monitor progress on the actions following the well-led inspection as part of the regular engagement meetings. EMT discussed the position on actions on 21 May 2019, which are mainly in relation to the need for evidence to be provided to the Compliance Team.
- Members considered the recent four MHA inspections and the common themes which have been raised.
- The CQC have started a thematic review of restraint, prolonged seclusion and segregation in to services for people with a Learning Disability and also Tier 4 Children and Young Peoples services. Inspections have taken place at West Lane and are due to continue on Lanchester Road site on the 11th June. The Trust will not receive formal feedback from these reviews but will be included within the final report to be published by the CQC in spring 2020.
- The recent screening on Panorama of issues at Whorlton Hall and inadequate care was discussed by the Committee and whether this might lead to a change in the approach to future inspections.

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 Patient Safety

The Committee received an assurance report from the Patient Safety Group.

The Board is to note:

- It has been seen in several SI's that patients who have multiple teams and agencies involved in their care often do not have a single responsible organisation taking overview of what care is provided and by who. This is being picked up by the Right Care Right Place work stream and the Trust learning event planned for early July 2019.
- It has been highlighted there is no single communication system for GPs and this came up in an SI where a GP had changed a patients psychiatric medication unaware the patient was being seen in MH services. Work is underway to look at this and to how improvements can be made.
- Duplication which has been found around the recording of falls is being addressed and all reviews of fractured neck of femur will remain with the Falls Team.

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

5.2 Infection, Prevention and Control Annual Report

The Committee received the Annual Infection, Prevention and Control report for 2018/19.

The Board is to note that an issue of concern discussed by members was around the compliance rates with the flu jab and sought assurance through the Committee that plans are in place for the next flu campaign running this year. It was highlighted that there had been a number of deaths locally due to influenza amongst fit and healthy people and it was important that the serious implications from influenza is communicated to all staff and patients.

5.3 Safeguarding and Public Protection

The Committee received the exception report for Safeguarding and Public Protection, together with the six monthly update and the Annual Report.

The key matters for the Board to note are:

- Durham MAPPA are undertaking a serious case review regarding a sexual assault where the perpetrator of the assault is under 18 years old and the Children's Safeguarding Partnership is undertaking a serious case review. The two processes are separate as the children's serious case review will consider the victim, whereas the MAPPA review will look at processes.
- The Trust remains involved in 9 serious case reviews for children, 5 serious adult reviews and 5 domestic homicide reviews.
- The Safeguarding enquiries at Acomb Garth are still under review with meetings planned.
- The issues regarding Wharlton Hall have been raised by the Safeguarding Adult Board in Durham and there will be a meeting held to review ongoing concerns and to ensure there are no concerns being raised with any other specialist providers in the area.

5.4 Drug and Therapeutics (D&T)

The Committee received the bi-monthly D&T update, the Medicines Optimisation Annual Report for 2018/19 and the Pharmacy & Medicines Optimisation Annual Plan for 2019/20.

The Board is to note:

- The project start date for the electronic prescribing and administration has been agreed for January 2020. This deferred date is to avoid competing priorities when implementing CITO and the pharmacy dispensing system.
- The implementation of coded allergies and reactions will begin on Paris later this year.
- The Annual report had been aligned with the strategic priorities and assurance was provided that the Annual Plan for 2019/20 was aligned to the Trust Business Plan and NICE medicines optimisation guidance.

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 Research Governance

The Committee discussed the Research Governance Report.

The Board is to note the following:

- The partnership with the University of York collaboration was going very well with further support from EMT to develop new posts to sustain the partnership longer term. These posts will be self-funding after three years and will be in place by summer 2019.
- There are a number of new studies that have been opened in the past year and there was an update given on the results of previous research.
- Members discussed how the Research information could fit in with the high quality questions and be tailored around patient safety aspects of research, ethics and research governance as well as a view on tracking how effective the dissemination of knowledge is from research projects as the implementation of results is sometimes difficult.

There are no concerns to raise to the Board.

6.2 Equality, Diversity and Human Rights

The Committee discussed the six monthly update and the Board is to note:

- The EDHR Steering Group have reviewed information relating to equality, diversity and human rights in line with the Group's terms of reference and agreed KPIs.
- There is inconsistency across the Trust around the equality agenda and more work is required to reduce the level of variation across services and localities.
- The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public had marginally reduced from 28% for white staff and 34% for BAME staff in 2017 to 27% and 32% respectively. This links with metric 5 in the WRES.
- A refreshed Equality, Diversity and Human Rights strategy and scorecard will be completed for autumn 2019.

ARE OUR SERVICES EFFECTIVE?

6.3 Clinical Audit and Effectiveness

The Committee received the quarterly update on Clinical Audit and Effectiveness.

The Board is to note:

- The year-end clinical audit programme 2018/19 completion status was 94.37% (67 out of 71 audits complete.
- The current 2019/20 clinical audit programme is on track with 8 out of 77 complete and a further 38 ongoing (50.65%).
- The Clinical Effectiveness Group continues to monitor relevant clinical audit and effectiveness programmes undertaken within the Trust and facilitates actions to address any potential quality or risk issues.

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 meeting.

10. RECOMMENDATIONS

That the Board of Directors is asked to:

(i) Note the issues raised at the Quality Assurance Committee meeting on 06 June 2019.
(ii) Note the confirmed formal minutes of the meeting held on 02 May 2019.

Dr Hugh Griffiths
Chairman of Quality Assurance Committee
25 June 2019

Item 1

NOTES OF THE FORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 02 MAY 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 Shirley Richardson, Non-Executive Director
Dr Ahmad Khouja, Medical Director
Mr Richard Simpson, Non-Executive Director
Mrs Elizabeth Moody, Director of Nursing & Governance

In attendance:
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mr Stephen Davison, Head of Nursing, (for minute 19/61)
Mrs Ann Marshall, Deputy Director of Nursing
Mrs Rachael Weddle, Head of Nursing, Forensic Services (for minute 19/57)
Dr Pratish Thakkar, Medical Director, Forensic Services
Mrs Naomi Lonergan, Director of Operations, North Yorkshire & York Services (for minute 19/58)
Mrs Emma Haimes, Head of Quality Data & Patient Experience (for minute 19/59, 19/62 & 19/64)

19/54 APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Chris Lanigan, Head of Planning and Business Development, Mrs Lisa Taylor, Director of Operations, Forensic Services, Mrs Jennifer Illingworth, Director of Quality Governance, Dr Steve Wright, Medical Director, North Yorkshire and York, Mrs Ruth Hill, Chief Operating Officer and Mrs Karen Agar, Associate Director of Nursing.

19/55 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 04 April 2019 were accepted as a true recording of the discussions, subject to a minor typographical error on page 6 and signed by the Chairman.

19/56 ACTION LOG

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

18/150 Positive and Safe Report: to come to QuAC six monthly.
This item was covered under agenda item number 6 (minute 19/61refers).

18/151 Work to be undertaken to the Patient Experience Report to pull out meaningful data and information, to include narrative and analysis framed around the CQC high quality questions in order to provide QuAC with higher levels of assurance and any exceptions.
The report (covered under agenda item number 6) had started to develop according to the request of QuAC and for the report to be standardised with other reports.

18/151a Patient Experience Report to include details of deep dive into Care Programme Approach.
Mrs Haimes noted that work had begun on this and that it would be included in the July 2019 QuAC meeting.

19/04	Discussion to take place about correlating the longer view of acuity on wards linked to patients feeling safe. Mrs Haimes briefed members that this was being looked into by the data quality team and options around how this could be presented. An update would be brought back to QuaC at the June 2019 meeting.
19/05	All localities to report on mechanical restraint, tear proof clothing and emergency response bags. This action had now been adhered to by all the localities reporting through to QuAC and this would continue in the future. **Completed**
19/16	QuAC Assurance Tracker to report to QuAC every six months. This was covered under agenda item number 15 (minute 19/70 refers). **Completed**
19/24	NY, York and Selby LMGB report: explanation to be provided around percentages in relation to patient experience, where no narrative had been provided for 96.2%. On this matter it was noted that an email had been circulated to members with this information on 10.04.19. **Completed**
19/24	Y&S LMGB report: correction to page 10, patient safety AMH, where it should read “three SI’s for January, two of which were fractured neck of femur”. An email had been sent to the locality lead for this correction to be made. **Completed**
19/42	Reflect in QuAC BoD report that consideration should be given by Board members to whether the CQC action plan “must do’s” should be a stand-alone report on the BoD agenda. It was noted that this had been agreed by the Board of Directors and would be adopted going forward. **Completed**

19/57 FORENSIC SERVICES LMGB REPORT

The Committee received and noted the Forensic Services LMGB Report.

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

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

Mr Simpson welcomed the training and the positive work around trauma informed care and queried how far it reached across the organisation.

Dr Khouja noted that training, which sits under the recovery programme had taken place for around 1500 people and that there were a number of different approaches that were common to all specialties and localities.
Members acknowledged the strategic importance of the trauma informed care and requested that the Board consider this for a future Board Seminar.

Action: Ms M Harte/Mr P Bellas

(2) Physical Health Escalation – following a serious incident that occurred in relation to wound care, it had been found that 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 could potentially lead to risks in delayed treatment.

The daily huddle held by Ward Managers, Matrons and Service Managers were now reviewing all physical health issues and escalated 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' had been established to ensure an MDT approach to meeting complex and chronic needs.

(3) 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 had gone smoothly. Offender Health had been renamed Health and Justice and the two transition wards (Oakwood and Talbot) that previously sat in FLD were now part of this service. Governance arrangements for the new inpatient structure were being considered and a mobilisation plan was in operation to ensure the smooth implementation of the new secure inpatient pathways and structures.

(4) 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 covered the five month period from November 2018 – March 2019.
On this matter it was noted that the reason for the use of soft cuffs had been for the transfer of patients.

Following discussion members:

(a) Requested an annual report to QuAC on the cumulative data around the use of mechanical restraint and tear proof clothing.

Action: Mrs L Taylor/Ms D Oliver – QuAC schedule

(b) Acknowledged the need to be careful around counting leave where patients required escorts 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.
(c) Raised item 10 on the scorecard which showed the forensic mental health score as 54% for staff treated with dignity and respect which seemed really low.
Mrs Weddle undertook to look into the detail of this.

Action: Mrs L Taylor

19/58 NORTH YORKSHIRE& YORK LMGB REPORT

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

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

- Waiting times, which were impacting on services across NY and York and in each directorate, however the most significant waits were in the memory assessment service, the secondary rates in IAPT and for autism assessments. Linked to this were the dementia diagnosis rates across the locality.
- Capacity issues, with vacancies in community and inpatient areas, maternity leave and sickness absence, together with caseloads impacting on productivity. This was then causing pressures with agency spend linked to the ongoing concerns around the quality of agency staff. Assurance was provided that this was being monitored closely by the Head of Nursing and Heads of Service.
- A number of service changes had taken 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 remained a key area of focus,

particularly in York and improving this would be essential to support the merger of Acomb Garth and Meadowfield.

Assurance was provided that there has been no use of mechanical restraints or tear proof clothing over the reporting period.

All areas were fully compliant for emergency response bags, with checks in all areas daily and weekly which was audited by Modern Matrons on a monthly basis. Assurance was provided that all isolated community teams in North Yorkshire and York now had the emergency bags.

Following discussion the following matters were raised:

(a) Whether there would be sufficient staffing resources for the new hospital. It was noted that there had been a successful recent bank recruitment event and the merger of Acomb Garth and Meadowfield would also help. The Harrogate and York Steering Group would be looking at workforce plans going forward.
(b) It was reported that there had been six reported deaths of patients that had come into contact with the Hospital Liaison team. An initial review by the locality manager had not shown any clear trends and some of the contact had been several months ago.
Mrs Moody provided assurance that this had been picked up by the QuAG and that some of these kinds of SIs, which had not typically been reviewed in the past, were now looked into to review if there had been any missed opportunities and this would be reported through the Patient Safety Report.
(c) Mrs Lonergan highlighted that whilst it had been challenging bringing together two QuAGs following the merger of North Yorkshire and York so far there had been some positive developments.

19/59 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:

(1) The CQC action plan continued to be monitored on a bi-monthly basis by the Quality Compliance Group.
(2) Actions outstanding were February (2), March (9), April (8), May (18) and June (5) and a detailed action plan was in place. Assurance was provided that progress was being pursued across localities, wards and departments.
(3) There had been three CQC MHA visits during the reporting period.
With regard to the CQC 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.
Dr Khouja noted that this was a real issue for staff on how to record whether individuals have capacity in respect of their care plan. It was anticipated that the new care plans due to be implemented would help solve this problem.

The Committee welcomed the plans around the new intervention plans.

The Chairman of the Committee noted that the Board of Directors had agreed, following a recommendation from the 04 April QuAC meeting, that there would be a separate report on Board agenda around the “CQC Must Do’s” each month.

19/60 INFECTION, PREVENTION AND CONTROL QUARTERLYREPORT

The Committee received and noted the Infection, Prevention and Control Quarterly Report and the Infection, Prevention and Control Annual Programme for 2019/20.

In introducing the report Mrs Moody highlighted the following:

(1) The Annual IPC Report 2018/19 would be included on the 06 June 2019 QuAC agenda.
(2) The IPC team had reviewed all critical questions in the IPC audit programme and essential steps tool at the request of clinical staff and they had been sent to Matrons for discussion and would be rolled out for the 2019/20 audit cycle. It had been found that when the programme was set up it was 'overly critical' and this had necessitated a re-focus on what the 'critical questions' were. This would ultimately help to target areas that should never fail.
On this matter members discussed why teams scored themselves higher than when the scores were taken in a validated audit and it was noted that this was not uncommon, however did raise the need for further education which would be picked up through validation audits with the IPC team.
(3) Assurance was provided that all key performance indicators were being monitored quarterly by the IPC Committee.

Assurance was given that mattresses had now been purchased and distributed following the red score for the audit on Trust mattresses, raised in the IPC report to the Quality Assurance Committee at its meeting held on 07 February 2019, (minute 19/10 refers), when it had been found that there were 184 mattresses that breached standards. This would be reflected in the Annual IPC Report, which would report to QuAC on 06 June 2019.

Mr Simpson raised a query on page 16 of the quarterly report stating that Elm ward was a green fail and Danby ward was a red pass. Mrs Moody undertook to look into this to see if it was a typographical error.

Action: Mrs E Moody

19/61 POSITIVE AND SAFE DRAFT ANNUAL REPORT 2018-19

The Committee received and noted the draft Positive and Safe Annual Report 2018-19.

Mr Davison highlighted the following:

- It was evident from the data that reported reasons for using physical intervention were changing, with self-harm 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%.
- There had been 583 uses of prone in total for the year with prone use 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 2017/18.
- There had been 297 new episodes of seclusion reported across the financial year involving 131 patients, which was a 6.6% increase on the previous year.
- The most common age range for interventions was the under 18 year olds and the most commonly cited reason why restrictive practice had been required was to support episodes of self-harm (32%).
- The use of tear proof clothing and mechanical restraint had significantly dropped in the last year and this was now reported to QuAC from the localities in the LMGB reports with assurance statements and any exceptions.

Following discussion around benchmarking members acknowledged that it was very difficult to compare the Trust with other MH Trusts and that other organisations collected their data differently with different definitions and methodologies. Seclusion data however would be shared with NTW, however their operational set up was different as they had seclusion facilities on each ward.

Members agreed that it would be useful to break down the data around restrictive interventions even further with a view to using run charts and this would be considered by the Data Quality team and brought back in two months time.

Action: Mrs J Illingworth/Mrs E Haimes

The Medical Director sought further assurance that the ethnicity of patients receiving restrictive interventions was not disproportionate and this would be checked.

Action: Mr S Davison

- A further update would be received in six months' time.

19/62 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Group Report.

The key matters highlighted from the report were:

- An action plan would be produced in response to the report, 'Learning from Gosport', which was about whistleblowing, listening to patients, families and staff and ensuring safe care.
- Due to the need for an upgrade on the Datix system to upload a new form, issues had been 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.

  Action: Mrs J Illingworth

- EMT had discussed the concerns raised via CQC inspections and repetitive themes and considered that there needed to be more robust assurance for each issue with the work clearly identified that was being taken forward to address the problems.
- More work had been undertaken around the draft - 10 step Zero Suicide Plan and assurance was given that wherever possible existing work streams/data sources would be used.

  Following discussion the Medical Director agreed to pick up with Liaison services the issues around uncertainty about who should complete a Datix when they see a patient in A&E that is not known to TEWV.

Dr Thakkar left the meeting.

Following discussion around a recent situation whereby a patient had a DNAR in place, which was likely due to a physical health problem had then attempted suicide. Staff had carried out resuscitation at the time however there had been some confusion as to whether they should have in light of the DNAR.
Mrs Moody confirmed that DNAR would never include suicide attempts and that this should be reflected clearly in the DNAR policy.

Action: Mrs J Illingworth/Mrs A Lowery

19/63 SAFEGUARDING AND PUBLIC PROTECTION REPORT

The Committee received an exception report for Safeguarding and Public protection.

The following was highlighted from the report:

- The Trust was 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, had been followed up and it was believed that police were pursuing an investigation into one member of agency staff. The Trust would ensure going forward that it was a fundamental duty to ensure that agency staff were safely inducted with Trust policies.
- Safeguarding level 3 training for most of the localities was currently in the late 80/90% range and assurance was provided that the target of 98% would be achieved by the summer of 2019.

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.

19/64 PATIENT EXPERIENCE REPORT

The Committee received and noted the Patient Experience Report.

The key matters highlighted from the report were:

- The Patient Experience Group had been going through a period of refinement, both in terms of the meetings, which would be more of a quarterly performance type meeting and presentation of the data in reports.
  The Committee welcomed the evolving report and the improvements to the narrative around the data, whilst noting that there would 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. Mrs Haimes undertook to bring this detail back to QuAC in July 2019.
  Action: Mrs E Haimes/Mrs J Illingworth

- Feeling safe was one of the areas that received the highest proportion of negative comments and something that the Committee had recognised as a concern over the last six months. A deep dive into this area had revealed that the data was within normal variation; however Teesside was showing a downward trend. Further information would be reported through to QuAC in June 2019.

19/65 DRAFT QUALITY ACCOUNT 2018/19 VERSION 2

The Committee received for consideration the draft Quality Account for 2018/19 version 2.

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.

19/66 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no matters of exception raised.

19/67 ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD

There were no other issues that required escalation.

19/68 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.

19/69 COMMITTEE EVALUATION

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

19/70 QUAC ASSURANCE TRACKER

The Committee received for consideration the QuAC Assurance Tracker.

The Chairman of the Committee highlighted:

(1) That the Assurance Tracker covered quarterly information from February – March 2019 which had been agreed by the Committee at its meeting held on 7 February 2019 (minute 19/16 refers).
(2) That the assurance tracker was a useful tool to check whether there were any gaps in assurance over a quarterly period.

It was suggested that the Mental Health Legislation Committee might also want to adopt an assurance tracker and this would be considered in due course.

19/71 ANY OTHER BUSINESS

There was no other business to discuss.

19/72 DATE AND TIME OF NEXT MEETING:

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

The meeting concluded at 4.30pm

……..
Dr Hugh Griffiths
Chairman
06 June 2019

ITEM 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th June 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:	**27th June 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 May 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 May, 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, including the trust agency reduction plan.

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
June 2019

Safe Staffing – May 2019

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

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

Safe Staffing Fill Rates May 2019:

- The number of rosters equated to 66 inpatient wards in May.
- The highest number of red fill rate indicators relate to Registered Nurses on day shifts. This equated to 20 in May 2019, an increase of 3 when compared to April 2019.
- The top 3 inpatient areas where a low staffing fill rate has been reported are:
  - Westerdale South (MHSOP) – 65.3% 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.
  - Acomb Garth (MHSOP) – 74.4% RN on Days - the shortfall is in relation to vacancies.
  - Westwood Centre (CYPS) – 74.4% HCA on Days and 87.5% RN on Days – the shortfall is in relation to a reduction in bed occupancy (currently running at 50%) staffing numbers reduced as a result of this.
  - The Lodge has been discounted due to the transition to a third party organisation. In addition Harland has been discounted due to the ward opening part way through the month.
- There were 66 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 (MHSOP) – 291.8% HCA on Nights and 159.5% HCA on Days – the increase was necessary to support on average 3/4 enhanced observations during the month.
  - Holly Unit (CYPS) – 223.7% HCA on Days; 189.1% HCA on Nights; 195.6% RN on Days - the increase is due to enhanced observations and complexities of the children.
  - Bedale (AMH) – 218.3% HCA on Nights; 157.2% HCA on Days – the increase is in relation to high enhanced observations and seclusion.

Bank Usage:

- The bank usage across the trust equated to 19.3% in May, an increase of 1% when compared to April.
- There were no wards reporting 50% bank usage in May.
- Brambling (FMH) reported the highest bank usage of 47.1% of the actual hours worked. Enhanced Observations (104 shifts) and Business Continuity Plan (31 shifts) were the highest reasons given for requesting bank.
- There were 16 wards that reported greater than 25% bank usage.

Agency Usage:

- The agency usage across the trust equated to 5.8% in May, a decrease of 0.1% when compared to April.
- Cedar Ward (NY) (Adults) reported the highest equating to approximately 39.4% of the total hours worked. Vacancies were cited as the highest reason for this (105 shifts). The ward is using regular agency where possible.
- Those wards reporting 4% or more agency usage in May equated to 23 wards.
- The Retinue report highlights the following information:
  - Fulfilment levels decreased by 1% to 85% in May.
  - Demand reduced by 609 requested when compared to April.
  - May saw 194 shifts go unfilled; our second lowest to date; 14 of which were filled by Off Framework agencies

Produced: 14th June 2019

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

- There remains a linear increase in shifts filled for RMNs. A total of 227 were filled in May with fulfilment being 76%
- Emphasis on booking preferred workers ahead of others is still at the forefront of process. May saw more shifts covered by preferred workers therefore increasing the overall percentage to 50%.
- Usage across Acomb Garth still remains high at 150 requests in May (a decrease of 10) and Cedar Ward (NY) had 135 requests in May compared with 159 in April.
- The total number of no shows reported for April decreased to 12. No shows as a percentage of shifts filled are 1.08% which is as per KPI.
- Average monthly spend of £282k from October 2017– May 2019 – a decrease of £2k on last month. Overall spend now sits at £5.64m. HCA attributes to 73% of overall spend
- New guidance to increase control and support teams with effective use of booking and ensuring appropriate approval for agency usage been recently developed.

Missed Breaks:

- There were 245 shifts in May where an unpaid break had not been taken. This is an increase of 41 shifts when compared to April 2019.
- 198 shifts where breaks were not taken were attributable to day shifts and related mainly to HCA's.
- 47 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 = 93 shifts with no breaks (Westerdale North-MHSOP had the highest with 11 shifts)
  - Forensics = 56 shifts with no breaks (Merlin-FMH had the highest with 12 shifts)
  - Durham & Darlington = 41 shifts with no breaks (Maple-Adults had the highest with 6 shifts)
  - North Yorkshire & York = 55 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 27 incidents reported in May 2019 citing issues with staffing covering both inpatient and community services.
- Issues reported were as follows:
  - Staff and patient safety compromised
  - Long waiting lists
  - Unable to rely on other wards to respond to alarms for assistance in emergency
  - Unable to respond to other wards in emergency
  - Staff working long hours
  - Staff not feeling safe

Severity Rating:

- Using a severity rating scale to identify potential outliers, the top 5 is as follows:
  - Westwood Centre – 12 points awarded
  - Maple Ward – 10 points awarded
  - Elm Ward – 8 points awarded
  - The Lodge – 8 points awarded
  - Birch Ward – 8 points awarded
- Using the YTD score (May 18 to May 19) the following appear in the top 5:
  - The Evergreen Centre – 105 points awarded
  - The Lodge – 97 points awarded
  - Cedar Ward (D&D) – 96 points awarded
  - Westwood Centre – 94 points awarded
  - Newberry Centre – 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 May is reporting at 11.31 (3.93 registered nurses, 7.08 unregistered nurses, 0.20 registered AHP and 0.09 unregistered AHP).
- Using standard deviation (May 18 to May 19) the following appear as positive outliers:
  - Danby Ward – 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 – May 2019

NQB Guidance July 2016

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

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM No. 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25 June 2019**
TITLE:	**To receive and note an update on the 'Must Do' 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 provides a progress update to the Board of Directors on the 15 'Must Do' actions within our action plan from the 2018 compliance inspection. All 'Must Do' actions have now been marked as completed with the exception of 2 which are due to be closed at the end of June 2019 (see below and following page).

Action 50 relates to a refresh of the Privacy and Dignity Policy. This has now been concluded however due to service user engagement in this process it took slightly longer than originally anticipated. It is scheduled for sign off by EMT on July 10th 2019.

Action 51 relates to dormitory style accommodation in North Yorkshire – a form of words on the Trust position on this matter is being prepared for EMT approval on 26th June 2019 which will see this action closed within timescale.

There remain 5 outstanding 'should do' actions (evidence required) at the time of writing this report (see following page for more details).

Recommendations:

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

Jennifer Illingworth
Director of Quality Governance
June 2019

'Must Do' actions due for completion 30/06/19

Action Ref	Must Do / Should Do	Service	Locality	Inpatient / Community	CQC Issue Identified	Action	Action scheduled for completion	Complete	Evidence
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		

'Should Do' actions now overdue

	Action required	Locality	Locality	Locality	Locality
1	Evidence of quarterly checks of IMHA referrals	Durham & Darlington	York & Selby		
2	Evidence of activity schedules	Durham & Darlington	North Yorkshire		
3	Evidence of new food menus	Tier 4 (Tees)			
4	Evidence of recording of supervision in community teams and remedial actions	Durham & Darlington	North Yorkshire	Teesside	York& Selby
5	Evidence of sample checks of risk assessments in community teams	Durham & Darlington	Teesside		

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 11

FOR GENERAL RELEASE

TRUST BOARD

DATE:	**25th June 2019**
TITLE:	**An update on progress against the Trust agency reduction action plan**
REPORT OF:	**Elizabeth Moody**
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:

- There has been a significant and steady increase in demand for nursing temporary staffing in excess of 2000 shifts per month since 2016, an average increase of 42%. However, the Trust has also seen an increase in agency expenditure, this is most apparent from November 2017 where we see a significant rise in nurse agency usage, in particular unregistered nursing.
- For 2018/19 the Trust's (TEWV) ceiling (NHSI agency cap) was £5,789k (1.95% of pay budget); the actual spend was £9,541k, i.e. 65% above target and as such provided a Use of Resource Rating (UoRR) of 4 for agency expenditure. As a result of this rating, this means that the Trust's has an overall UoRR for 2018/19 that is now capped at a rating of 3 despite the good performance in all other indicators in the UoRR in the Single Oversight Framework.
- Additional to the impact on patient care and staff wellbeing from high usage of agency staff, there is the potential for NHSI to take a more 'hands on' approach to the oversight of decision making within the Trust resulting in a lack of autonomy
- The Trust target is a rating of 1 which would indicate that the Trust is below its agency ceiling, which has been increased by £834k to £6,623k for 2019/20.
- A review was undertaken across the Trust using a nationally approved diagnostic tool and framework, which included a desktop data analysis and review, in

conjunction with a series of staff engagements to determine the drivers and a better understanding for the agency spend in the Trust. This has formed the basis of an action plan (see Appendix 1).

- A recent NHSI consultation document published in June 2019 has highlighted the need to expedite certain actions relating to non-clinical staff and non-registered clinical staff; however a supportive relationship with NHSI remains in place, and their recommended actions built into the action plan.

- A trajectory based on completion of the actions set out in the plan details the majority of actions starting to impact in Q2 2019/20, focussing on the reduction of unqualified nursing. It is to be noted that bank worker supply is expected to increase from September/October 2019 when it is planned to transition agency use to be managed internally and following completion of large scale recruitment events that will increase our supply of bank nurses.

- The current trajectory of £6.6 agency expenditure will be very challenging for 19/20 however a forecast through to 20/21 of the actions included in the plan has resulted in agency expenditure of £6.2m. This would result in the Trust being below its capped expenditure rate. Additional actions related to the conversion of admin appointments to substantive contracts (fixed term or otherwise), the development of an admin bank and the reduction of off-framework HCA usage will need to be built into the action plan to meet the new NHSI deadlines and should reduce the forecasted overall agency expenditure.

Recommendations:

To consider the report and agree any additional actions to achieve our 2019/20 target to reduce agency use and to develop a model that will ensure sustainability of this position.

Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF:	**Trust Board**
DATE:	**26th June 2019**
TITLE:	**Agency Use in the Trust – An Evidence Based Action Plan**

1. INTRODUCTION & PURPOSE:

This report outlines the outcomes and actions to reduce the Trust's current agency spend, with a target of not exceeding the agency expenditure ceiling set by NHS Improvement (NHSI) for 2019/20.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The cost of temporary staffing, in particular nursing and medical staff, presents a challenge to the NHS nationally, and is seen as one of the most significant causes of deteriorating NHS trust finances. Medical agency/locums are a particularly expensive solution to staffing shortages; the 2015/16 national bill for medical locums in the NHS in England was £1.3 billion, representing over a third of all agency spend.

2.1 NHSI introduced an annual ceiling of agency spending, which is monitored on a monthly basis through the Trust's monthly data submissions to NHSI. The Trust is assessed on their agency expenditure in line with the 'Use of Resource Rating' (UoRR) theme of the Single Oversight Framework (SOF).

2.2 For 2018/19 the Trust's (TEWV) ceiling was £5,789k (1.95% of pay budget); the actual spend was £9,541k, i.e. 65% above target and as such provided a Use of Resource Rating (UoRR) of 4 for agency expenditure. As a result of this rating, this means that the Trust's has an overall UoRR for 2018/19 that is now capped at a rating of 3 despite the good performance in all other indicators in the UoRR in the Single Oversight Framework.

2.3 By not reducing this UoRR rating, additional to the impacts to patient care and staff wellbeing from high usage of agency staff, there is the potential for NHSI to take a more 'hands on' approach to the oversight of decision making within the Trust therefore a lack of autonomy.

2.4 The Trust target is a rating of 1 which would indicate that the Trust is below its agency ceiling, which has been increased by £834k to £6,623k for 2019/20.

2.5 A review was undertaken across the Trust using a nationally approved diagnostic tool and framework, which included a desktop data analysis and review, in conjunction with a series of staff engagements. In addition to this we performed a self-diagnosis and RAG rating of the Trust against the 43 key questions relating to recommended best practice. This was discussed and

agreed upon by the Right Staffing Programme Board, the results of which are summarised in Table 1 below.

Diagnostic Tool Results	
RAG Rating	No. Questions
Green	**15**
Amber Green	**4**
Amber	**20**
Amber Red	**2**
Red	**2**
Total	**43**

Table 1: Diagnostic Tool Results

2.6 Red and Amber Red areas relate to effective roster practice; highlighting the need for significant improvements in these areas, a paper going to EMT 26th June 2019 sets out recommended actions to support this improvement. The Amber rating shows where progress has been made and there is evidence of some good practice, although recognised that further work is required to develop these areas. These form the basis of the actions in the current plan, some of which have already been recognised as requirements and form part of the ongoing and planned work within Right Staffing, such as formal staffing establishment reviews with evidence based tools.

3 KEY ISSUES

3.1 There has been a significant and steady increase in demand for nursing temporary staffing in excess of 2000 shifts per month since 2016, an average increase of 42%. However, the Trust has also seen an increase in agency expenditure, this is most apparent from November 2017 where we see a significant rise in nurse agency usage, in particular unregistered nursing. We have used the services of a neutral vendor for nursing agency staff since October 2017 which has provided improved and more readily available access to agency staff, in addition to an increased visibility of reporting and expenditure.

3.2 From a national perspective, as of Q4 2018/19, TEWV was below the national average with regards to bank and agency spend as a proportion of total pay costs for Adult Mental Health. However, TEWV has the third lowest spend on bank staff nationally whilst being in the top 5 Nationally for Agency spend for MHSOP.

3.3 Aside from specific issues individual to the ward, analysis supports the view that the main themes for high agency use in the Trust are:

Staff vacancies, management of annual leave and effective roster practice on the Health Roster (also evident across the whole Trust), sickness rates, insufficient numbers of bank temporary staffing in areas where there is high agency use i.e. North Yorkshire and York, patient acuity and demand.

3.4 From June 2019, NHSI will closely scrutinise compliance with the requirement to procure agency staff through an approved framework for non-clinical and clinical unregistered staff. This includes admin and estates staff, healthcare assistant (HCA) roles and some allied health professionals (AHPs). It does not include medical, registered nursing and midwifery, scientific and technical, healthcare science and registered AHP roles. NHSI expect all trusts to have eliminated the use of off-framework agency workers for non-clinical and clinical unregistered roles by September 2019.

3.5 From 16 September 2019 trusts are required to use only bank or substantive workers to fill admin and estates shifts/assignments; there are certain exemptions to this ruling such as Trusts can 'break glass' and procure an agency worker for an admin and estates shift where there is an exceptional patient safety risk.

3.6 The current trajectory of £6.6 agency expenditure will be very challenging for 19/20 however a forecast through to 20/21 of the actions included in the plan has resulted in agency expenditure of £6.2m. This would result in the Trust being below its capped expenditure rate.

3.7 Based on the current end of year projections we may not meet our current target to remain within the agency cap for 2019/20, and therefore not achieve the required UoRR of 1 however additional actions related to the conversion of admin appointments to substantive contracts (fixed term or otherwise), the development of an admin bank and the reduction of off-framework HCA usage will need to be built into the action plan to meet the new NHSI deadlines and should reduce the overall agency expenditure.

Nursing Agency:

In months 1 and 2 there has been an increasing trend in monthly agency spend however it is expected that this will reduce as a result of actions detailed in the agency reduction plan in Q2 and 3 plan including: increased bank usage following recruitment campaigns, appointment to substantive posts following recruitment fairs and service changes such as ward mergers in York, implementation of zonal care and progression of issues in tier 4 children's services.

North Yorkshire and York locality remains the largest user of agency in the Trust, currently accounting for 58% of Trust agency expenditure. 11 out of the 13 highest user wards of agency are in NY and York.

Changes in service provision particularly in North Yorkshire has been seen to have an impact on recruitment and agency use. In the trajectory it is assumed that this will reduce due to service changes and it is anticipated that future temporary staffing arrangements will be via bank staffing and not with agency staff. The Right Staffing Recruitment and Retention Work stream Group is providing focussed support for recruitment and retention issues in the North Yorkshire and York locality.

Currently the management of agency staff in the Trust is managed by a neutral vendor (Retinue) since October 2017; this is planned to transition and be managed internally by October 2019. Adopting the management of agency supply in house, as recommended by NHSI at the previous supportive collaboration meeting, would enable the Trust to: have more control over the ability to negotiate costs; select providers and offer assurance around quality, safety and efficiency; more effectively monitor high cost agency supply; impose restrictions, for example prevent agency workers from moving between agencies to find higher pay rates.

A process has been developed to ensure that all RMN and HCA leavers/retirees are offered the opportunity to remain within or join the Temporary Staffing Service, subject to confirmation from the appropriate Head of Nursing which should increase availability.

Medical Staffing Agency

Medical agency spend has increased over the past two years, but at a rate substantially lower than nursing spend on agency.

Based on the position as of March 2019, there would be a projected overall annual cost of £3,533k for agency medical staff. It is to be noted whilst that this is not a static figure and may change month on month, the picture over the last 2 years remains reasonably stable although with a slight upward trend.

Medical agency usage has remained relatively flat; however costs have risen due to an increase in the hourly rate demanded. The current average of £107.95 for consultants is 40% above the national capped rate of £77.07 per hour, and all are paid above the cap. This is indicative of the competitive market for this role and the difficulties experienced both locally and nationally to recruit to vacancies.

As of February 2019, Medical agency staffing costs account for approximately 29% of the Trust agency expenditure. This remains the same for 2019/20 YTD figures.

Medical staffing actions to reduce agency have previously been reported to the Resources Committee and include:

- To continue to over-recruit Trust Doctors above the theoretical need.
- To support the introduction at risk of Physician Associates into the workforce.
- To agree to a trial of Medical Bank for junior, SAS and consultant doctors using Patchwork (rostering software).
- To advise whether the medical directorate should pursue creating a new grade of doctor; the Internal Locum Consultant.
- To advise how the medical directorate can reduce the hourly rate paid for agency work
- To consider the budget alignment requirements for retired and returning doctors fulfilling Trust wide or non-clinical roles.
- To support the creation of Research Fellows and Educational Fellows and to advise on the required budget alignment.
- To approve the work in redesigning the Trust on-call rota, and in particular to explore the establishment of a middle grade rota.
- To comment on the governance arrangements for medical agency appointments and agency reduction approaches, and in particular whether there should be a formal target.

Further Actions and oversight

It has been agreed that the Right Staffing Establishment Workstream Group (RSEWG) will be responsible for overseeing the development and implementation of the TEWV agency plan, and will determine who from TEWV will meet with the NHSI National Agency Team and the NHSI Regional Team in future to discuss agency issues.

A monthly visual control board (Appendix 2) has been developed to inform services and management of the current position of agency spending across all staff groups within the Trust, and highlights key factors to consider such as staff vacancies and unavailability. This information will support and inform locality report outs, which will then be fed back to the RSEWG on a monthly basis by locality representatives regarding their current position. A monthly deep dive will also form part of this new Agency Tracker process.

New guidance to support teams and strengthen controls with regard to effective use of booking, and ensuring appropriate escalation and approval for agency usage, in particular off framework use has been developed.

Staffing establishment reviews are to be undertaken across all clinical teams in the Trust, in line with 'Developing Workforce Safeguards' (NHSI, 2018). This work is currently on schedule and expected to commence September 2019/20. Outcomes are expected to have a positive impact upon reducing the requirement and use of temporary staffing dependent upon reported outcomes being actioned; however this may not be realised until recommendations have progressed through governance structures, anticipated to be Q4 2019/20.

A vacancy census will take place using the end of June position (to report in July).

A range of developments to aid recruitment and retention of HCA's have already been put in place or are in progress which should impact on agency use going forward including: 8 week notice period, leaver alert process and the recruitment of new starters onto band 3.

4. IMPLICATIONS:

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

Effective use of staffing resources is key to the provision of high quality, safe care. The actions set out in this paper will enable the achievement of this.

4.2 **Financial/Value for Money**:

A number of the schemes that are anticipated to contribute to a reduction of agency expenditure have been identified as a result of 2019/20 business plans and a further number are where one off expenditure will not be incurred in 2019/20.

A further number of schemes have been initially scoped up and have potential for significant reduction in agency expenditure – key will be the scheme which has been worked up in relation to the extension of the Temporary staffing service (TSS) to recruit bank workers and to replace agency arrangements.

In addition, the finding that a significant level of agency expenditure is incurred for planned nursing shifts has identified that measures to increase Trust directly employed staff in post will also provide for a reduction in agency expenditure.

The potential schemes already scoped up have significance in either overall financial value or are areas which NHSI have indicated through consultation

that should be prioritised for reduction are non-clinical, administrative and expenditure on HCAs.

All schemes identified to date in agency expenditure reduction are likely to have additional savings based on agency hourly rates compared to bank or directly employed rates; however whilst these will be reflected in the reduction of agency expenditure and total overall expenditure, these savings are anticipated to mean that services will operate within budget.

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:

Identified risks to achieving the aims of reducing agency expenditure include:-

- There is a risk that the UoRR target is at risk of not being achieved, and therefore increased scrutiny from NHSI/E.
- Staffing challenges in North Yorkshire and York, for example the ability to recruit to vacant substantive posts and bank staff posts, areas known to be difficult to effectively recruit to.
- The potential for acute and sustained fluctuations in the consultant workforce, due to the high hourly cost of this staff group.
- The advent of external issues impacting upon the Trust, for example the closure of a local Learning Disability private hospital.
- Expectations of progress on bank recruitment not meeting the timescales/ trajectories planned.
- Establishment reviews are not completed, or the resulting recommendations are not followed. It is noted that despite this action remaining on track, the impacts of the establishment reviews are not likely to influence 2019/20 agency expenditure, but will have a more significant impact for 2020/21.
- If we do not achieve roster improvements, specifically in relation to unavailability's (annual leave, training days, and sickness), and utilisation of unused hours.

- We are not able to terminate the Retinue contract in October 2019 due to lack of operational readiness to seamlessly undertake the provision this new service for issues unknown at this time.
- The medical directorate will attempt to play its part, however it is unlikely that in 2019/20 there will be a significant reduction in medical agency use (and if the current trend in resignations continues, it may increase)
- Staff and patient well-being from continued use of agency staff and from providing cover beyond contracted working hours.
- The resignation of staff to join an agency for higher rates of pay, particularly for areas/staff groups utilising high usage of agency. There is planned work to consider the potential the preventing such agency staff from working shifts in the immediate and subsequent period of time following this.

6. CONCLUSIONS:

To realise any potential in achieving or approaching the target, it will require the support and prioritised focus of all staff within operational teams and operational management. To this end, increased visibility of reporting has now been put in place across all localities with the support of visual controls and huddles. The Chief Operating Officer is the Board lead for agency use and chairs the establishment work stream of the Right Staffing programme which will oversee implementation of the action plan.

The current trajectory of £6.6 agency expenditure will be very challenging for 19/20 however a forecast through to 20/21 of the actions included in the plan has resulted in agency expenditure of £6.2m. This would result in the Trust being below its capped expenditure rate.

Based on the current end of year projections we may not meet our current target to remain within the agency cap for 2019/20, and therefore not achieve the required UoRR of 1 however the majority of actions detailed will start to impact in Q2 and 3. Additional actions related to the conversion of admin appointments to substantive contracts (fixed term or otherwise), the development of an admin bank and the reduction of off-framework HCA usage will need to be built into the action plan to meet the new NHSI deadlines and should help to reduce the overall agency expenditure.

7. RECOMMENDATIONS:

To consider the report and agree any additional actions to achieve our 2019/20 target to reduce agency use and to develop a model that will ensure sustainability of this position.

Joe Bergin
Right Staffing Senior Programme Manager

PROGRAMME: RIGHT STAFFING	
Programme Manager	

PROGRAMME IMPLEMENTATION PLAN (Tooll T13-2)

RAG
no update
Completed
on-track
mod risk to deadliine
high risk to deadline
can't / didn't deliver on time
paused / deleted

planned dates for work
Milestones to complete
milestone achieved
milestone not achieved
revised milestone date

Interdependency (from end of one piece of work to start of another)

No.	Action or milestone	Lead	Original Target Date	RAG	Currently agreed target date	Comments
1	**To improve the supply of agency staff**		**1 Oct 2019**		**1 Oct 2019**	
	Report to EMT	**TSS Manager**	**29/03/2019**			
	Meeting with neutral vendor/finance/corporate products to discuss transfer. (Contract ends 30 Sept 2019)	**TSS Manager/HR Manager**	**31/03/2019**			
	Meeting with neutral vendor - systems	**TSS Manager**	**30/04/2019**			
	Recruitment team leader agency staffing (fixed term)	**TSS Manager**	**2-Sep-2019**			**post out to re-advert currently due to redeployment trial period end**
	Recruitment agency staffing coordinator (fixed term)	**TSS Manager**	**24-Jun-2019**			**appointed however another Band 3 has secured a secondment**
	Review exit strategy in contract to confirm handover requirements	**TSS Manager**	**31/05/2019**			
	Procurement meeting	**HR Manager**	31/05/2019			
	SLAs to be developed with Trust's terms	**TSS Manager & procurement**	29/07/2019			
	Retinue to provide information as part of termination agreement	**TSS Manager**	21/06/2019			
	Convert process maps from neutral vendor to Trust proceses	**TSS Manager**	31/08/2019			
	Design and implement finance processes/interfaces	**Financial Controller**	31/08/2019			
	Design and implement IT processes/interfaces	**IT systems manager**	31/08/2019			
	Exit meetings	**TSS Manager**	16/09/2019			
	Communication with wards	**TSS Manager**	12/08/2019			
	Suppliler engagement & collation of agreements	**TSS manager**	19/08/2019			
	Issue SLAs with 16 suppliers on framework	**HR Manager**	19/08/2019			**potentially only 10 as there are a number who don't provide currently. Brought forward by 4 weeks**
	Receive and confirm compliance files	**TSS Manager**	15/09/2019			**clarification required if this is necessary as potentially only a requirement for a neutral vendor**
	Transition of data and MI	**TSS Manager**	27/09/2019			
	Commence management of inhouse agency	**TSS Manager**	01/10/2019			
	Final processes	**TSS Manager**	03/10/2019			
2	**Recommendation to increase bank worker supply**	TSS	TBD by TSS		TBD by TSS	
	Recruitment plan report to EMT	**TSS Manager**	29/03/2019			
	Recruit team leader	**TSS Manager**	30/04/2019			
	Team leader in post	**TSS Manager**	17/06/2019			delayed start date due to DBS project unstaffed
	Recruit Recruitment campaign lead (fixed term)	**TSS Manager**	15/05/2019		18/06/2019	previously appointed candidate withdrew
	Recruitment campaign lead in post	**TSS Manager**	30/06/2019		19/08/2019	will try and negotiate earlier release date (sooner than 2 months notice)
	Recruit admin apprentice	**TSS Manager**	31/07/2019			
	Confirm order of campaigns (and review in light of success/demand)	**TSS Manager**	31/05/2019			
	York recruitment event	**TSS Manager/York Locality management**	5th April 2019		5th April 2019	
	York recruitment in place		Jun-19			will need to check status
	Recruitment Event 1 - York (repeat)	**TSS manager/ RC lead**	Jun-19		28/06/2019	York
	Recruitment Event 1 - in place (25 per campaign)	**RC lead**	Sep-19			
	Recruitment Event 2	**RC lead**	Jul-19		11/07/2019	Scarborough MHSOP
	Recruitment Event 2 - in place (25 per campaign)	**RC lead**	Oct-19			
	Recruitment Event 3	**RC lead**	Sep-19			potentially Teesside & D&D - would expect 100 minimum. Teesside was due in August but consideration being given to panel and candidate availability
	Recruitment Event 3 - in place (25 per campaign)	**RC lead**	Nov-19		tbc	
	Recruitment Event 4	**RC lead**	Oct-19		tbc	to be confirmed
	Recruitment Event 4 - in place (25 per campaign)	**RC lead**	Dec-19		tbc	to be confirmed
	Recruitment Event 5	**RC lead**	Nov-19		tbc	to be confirmed
	Recruitment Event 5 - in place (25 per campaign)	**RC lead**	Jan-19		tbc	to be confirmed
	Recruitment Event 6	**RC lead**	Dec-19		tbc	to be confirmed
	Recruitment Event 6 - in place (25 per campaign)	**RC lead**	Feb-20		tbc	to be confirmed
	Recruitment Event 7	**RC lead**	Jan-20		tbc	to be confirmed
	Recruitment Event 7 - in place (25 per campaign)	**RC lead**	Mar-20		tbc	to be confirmed
	Recruitment Event 8	**RC lead**	Feb-20		tbc	to be confirmed
	Recruitment Event 8 - in place (25 per campaign)	**RC lead**	Apr-20		tbc	
	Recruitment Event 9	**RC lead**	Mar-20		tbc	
	Recruitment Event 9 - in place (25 per campaign)	**RC lead**	May-20		tbc	
	Recruitment Event 10	**RC lead**	Apr-20		tbc	
	Recruitment Event 10 - in place (25 per campaign)	**RC lead**	Jun-20		tbc	
	Recruitment Event 11	**RC lead**	May-20		tbc	
	Recruitment Event 11 - in place (25 per campaign)	**RC lead**	Jul-20		tbc	
	Recruitment Event 12	**RC lead**	Jun-20		tbc	
	Recruitment Event 12 - in place (25 per campaign)	**RC lead**	Aug-20		tbc	
	Evaluation of recruitment	**TSS Manager/HR**	Jul-20		tbc	

PROGRAMME: RIGHT STAFFING

Programme Manager

PROGRAMME IMPLEMENTATION PLAN (Tooll T13-2)

RAG
no update
Completed
on-track
mod risk to deadliine
high risk to deadline
can't / didn't deliver on time
paused / deleted

planned dates for work
Milestones to complete
milestone achieved
milestone not achieved
revised milestone date

Interdependency (from end of one piece of work to start of another)

No.	Action or milestone	Lead	Original Target Date	RAG	Currently agreed target date	Comments
3	**Carry out an analysis of admin and consider the creation of a bank to support staffing shortage**		Q2 2019/20			
	Initial scoping meeting	**RS/ HR manager**	30-Jun-19			
	Report on scoping	**RS/ HR manager**	31-Jul-19			
	Consider spot salary / agenda for change position	**HR manager**	TBC			
	Job descriptions - collation and review	**HR manager**	TBC			
	Age profiling	**HR manager**	TBC			
	Retired staff list compiled for potential contact	**HR manager**	TBC			
	Profile of current fxed term contracts due to end	**HR manager**	TBC			
	Review of current agency admin staff and length of contract	**HR manager**	TBC			
	Survey Monkey Questionnaire to be built	**HR manager**	TBC			
	Recruitment campaign	**RS/ HR manager**	TBC			
	Admin bank established	**RS/ HR manager**	16-Sep			
4	**Carry out an analysis of AHPs and consider the creation of a bank to support staffing shortage**					
	Initial scoping meeting	**RS / DoT**	29-Jul			
	Report on scoping	**RS / DoT**	TBC			
5	**Impacts of extending bank to cover Crisis teams/community**					
	Initial scoping meeting	RS / Urgent Care / CRT	29-Jul		Q4 2019/20	
	Report on scoping	RS / Urgent Care / CRT	TBC			
6	**Replace agency staffing resource with DD IAPT**		Mar-19		Apr-19	
	Recruitment	**AR - feedback**	Mar-19		Apr-19	
	Postholders in place	**AR - feedback**	Apr-19		Jul-19	
7	**Recruitment RNs substantively to meet staffing needs**					
	Durham and Darlington		TBD			To be discussed at Rec & Retention W/S
	AMH		TBD			To be discussed at Rec & Retention W/S
	Recruitment campaign	John Savage	TBD			To be discussed at Rec & Retention W/S
	MHSOP		TBD			To be discussed at Rec & Retention W/S
	LD		TBD			To be discussed at Rec & Retention W/S
	CYPS		TBD			To be discussed at Rec & Retention W/S
	Teesside		TBD			To be discussed at Rec & Retention W/S
	AMH		TBD			To be discussed at Rec & Retention W/S
	MHSOP		TBD			To be discussed at Rec & Retention W/S
	LD		TBD			To be discussed at Rec & Retention W/S
	CYPS		TBD			To be discussed at Rec & Retention W/S
8	**Recruitment HCAs substantively to meet staffing needs**					
	Durham and Darlington		TBD			To be discussed at Rec & Retention W/S
	AMH		TBD			To be discussed at Rec & Retention W/S
	MHSOP		TBD			To be discussed at Rec & Retention W/S
	LD		TBD			To be discussed at Rec & Retention W/S
	CYPS		TBD			To be discussed at Rec & Retention W/S
	Teesside		TBD			To be discussed at Rec & Retention W/S
	AMH		TBD			To be discussed at Rec & Retention W/S
	MHSOP		TBD			To be discussed at Rec & Retention W/S
	LD		TBD			To be discussed at Rec & Retention W/S
	CYPS		TBD			To be discussed at Rec & Retention W/S
9	**Recruitment of substantive staff to post in N York & York area – address the shortfall in budgeted establishment**					
	Focussed recruitment strategies to be continued and developed	**Locality Management/HoN/ Right Staffing**			Q2 2019/20	To be discussed at Rec & Retention W/S
	AMH					To be discussed at Rec & Retention W/S
	MHSOP					To be discussed at Rec & Retention W/S
	LD					To be discussed at Rec & Retention W/S
	CYPS					To be discussed at Rec & Retention W/S
10	**Training packageto be reviewed to make it quicker for bank staff to start working on inpatient wards: -**					
	Initial content devised	**TSS MANAGER**	2018			
	Identify requirement in report to EMT and request resources	**TSS MANAGER**	29/03/2019			
	Job description to create with department of nursing	**TSS MANAGER**	Q1 2019/20		Q2 2019/20	to request support from directorate of nursing to create this role
	Recruitment to post initially 0.60 WTE (12 months) 0.40 thereafter	**TSS MANAGER**	Q2 2019/20		Q2 2019/20	
	Develop content of this delivery frequency/method	**TSS MANAGER & PROFESSIONAL LEAD**	Q4 2019/20		Q4 2019/20	
	Review current agency policy in conjunction with medical staffing – ensure they are aligned and in a single paper: -	Right Staffing Establishment Workstream	Q1 2019/20		Q1 2019/20	
	Ensure that locality assurance and governance processes are in place to gain an understanding of our agency use, and this is then raised through QUAC and board: - Develop operational processes through local governance structures, e.g QUAGs, LMGBs are on the agendas to generate discussion and oversight to report to OMT and QUAC	COO / DoOps Right Staffing Establishment Workstream	Q1 2019/20		Q1 2019/20	

Q1 2019/20														Q2 2019/20													Q3 2019/20												Q4 2019/20											
Apr-19				May-19					Jun-19					Jul-19					Aug-19				Sep-19				Oct-19				Nov-19				Dec-19				Jan-20				Feb-20				Mar-20			
1-Apr-19	8-Apr-19	15-Apr-19	22-Apr-19	29-Apr-19	6-May-19	13-May-19	20-May-19	27-May-19	3-Jun-19	10-Jun-19	17-Jun-19	24-Jun-19	1-Jul-19	8-Jul-19	15-Jul-19	22-Jul-19	29-Jul-19	5-Aug-19	12-Aug-19	19-Aug-19	26-Aug-19	2-Sep-19	9-Sep-19	16-Sep-19	23-Sep-19	30-Sep-19	7-Oct-19	14-Oct-19	21-Oct-19	28-Oct-19	4-Nov-19	11-Nov-19	18-Nov-19	25-Nov-19	2-Dec-19	9-Dec-19	16-Dec-19	23-Dec-19	30-Dec-19	6-Jan-20	13-Jan-20	20-Jan-20	27-Jan-20	3-Feb-20	10-Feb-20	17-Feb-20	24-Feb-20	2-Mar-20	9-Mar-20	16-Mar-20	23-Mar-20

PROGRAMME: RIGHT STAFFING

Programme Manager

PROGRAMME IMPLEMENTATION PLAN (Tooll T13-2)

RAG
no update
Completed
on-track
mod risk to deadliine
high risk to deadline
can't / didn't deliver on time
paused / deleted

planned dates for work
Milestones to complete
milestone achieved
milestone not achieved
revised milestone date

Interdependency (from end of one piece of work to start of another)

No.	Action or milestone	Lead	Original Target Date	RAG	Currently agreed target date	Comments
	To develop a process that will mitigate and regulate our off framework use: - Develop assurance and governance process to regulate and control off framework use monitor (Temporary Staffing Procedure)	Locality DoOps, HoS, HoN, MMs TSS Right Staffing Establishment Workstream	Q2 2019/20		15/09/2019	
	Recommended Actions/Future Actions - Medical					
11	**For medical staffing to continue with current work to address reducing consultant agency spend and future reliance upon locums/agency medics, in particular:**		Q4 2019/20		Q4 2019/20	
	• Establishing a collaborative medical bank with neighbouring peer Trusts					
	• Initiatives to make TEWV an attractive place of employment					
	• Support in progressing the recommended actions from agency review project, such as collaboration on a consolidated agency policy and strategy covering medical and non-medical agency usage.					
	• Give consideration to the reduction of the hourly rate paid to consultants as presently this is 40% above the national capped rate. The current projected cost based on March 2019 data for the annual agency consultant requirement cost is £3,208k. If we were limit hourly rates to capped value, this would equate to £2290k, an approximate £917k saving					
	Continue working with NSHI: - Ongoing progress via face to face discussions and monitoring	HR, Right Staffing, TSS, Medical Staffing, Finance	Q4 2019/20		Q4 2019/20	
	To share agency use and costing with staff in a transparent way across the whole of the trust to get buy in from staff and to provide context for impact to Trust: - Develop straight forward easy to read reporting mechanism for cascade	Finance TSS HR STEPHEN PARRY	Q2 2019/20		Q2 2019/20	
	Recommended Actions/Future Actions Right Staffing					
12	**To establish a regular structure for Gemba walks / visits assessing for patient safety, checking staff and patient perspectives with regard to staffing and agency and roster usage: -** Develop a process of regular review by the use of Gemba walks	Locality DoOps, HoS, HoN, MMs	Q1 2019/20		Q1 2019/20	Discussions in progress, although available time to draw up a potential issue.
13	To develop a visible and standardised central plan and protocol to offer guidance and direction for all staff groups, clinical and non-clinical. To ensure that all staff are up to date and feel supported in the use of agency, agency requests and using health roster and appropriate signing/checking of agency use and in particular off framework	Right Staffing Establishment Workstream	Q2 2019/20		Q2 2019/20	
14	**To commence Establishment review process: -** Robust process developed	Right Staffing Establishment Workstream	Q2 2019/20		Q2 2019/20	
	Commence Establishment Reviews		01/09/2019		01/09/2019	
15	**Develop and cascade process for capturing acuity scoring: -** Evidence based process developed and ready for use	Right Staffing Establishment Workstream	Q2/Q3 2019 *depenednt upon national availability		29/07/2019	
16	**Develop Workforce planning model: -** Develop Workforce planning model	Right Staffing Establishment Workstream	Q4 2019/20		Q4 2019/20	
17	**Education for effective and efficient roster practice and a process to embed and sustain consistent and effective roster practice: -** Develop plan for effective delivery of this sustainable practice model • event to be held regarding ownership and responsibility • consider champions • central resource • check and challenge consistency • develop plan to improve consistency across the Trust in roster practice • review potential for restructuring of shifts • resource requirements to support embedding of effective practice • Sustain re roster governance • KPI and monitoring • Roster review process • increase number of clinical staff on roster • improve alignment of ESR, finance and roster • dashboards • Ensure consistent and timely Levels of Access to Health Roster	Right Staffing Establishment Workstream / N&G	Q2 2019/20		Q2 2019/20	To be further developed for granularity
18	**Review overtime usage aspects - reconsider this approach in terms of offering, explore how this process is monitoring: -** Review current process of agency before overtime with respect to consistency and continuity, patient care and staff well being and morale	HR	Q1 2019/20		Q1 2019/20	For further discussion at RS Establishment Workstream
19	**Align medical with nursing - i.e exit interviews, + other professionals to follow nursing initiatives: -** Share current nursing recruitment and retention intiiatives developed in Kaizen events with medical staffing	Medical Director Medical Staffing	Q1 2019/20		Q1 2019/20	For further discussion at RS Establishment Workstream

PROGRAMME: RIGHT STAFFING

Programme Manager

PROGRAMME IMPLEMENTATION PLAN (Tooll T13-2)

RAG
no update
Completed
on-track
mod risk to deadliine
high risk to deadline
can't / didn't deliver on time
paused / deleted

planned dates for work
Milestones to complete
milestone achieved
milestone not achieved
revised milestone date

Interdependency (from end of one piece of work to start of another)

No.	Action or milestone	Lead	Original Target Date	RAG	Currently agreed target date	Comments
20	**Consider flexibility across specialities where staff can support and cover other area out with of their speciality: -** Develop a plan that will consider cross speciality cover and flexibility to allow for dynamic redeployment of staff	Locality DoOps, HoS, HoN, MMs Right Staffing Establishment Workstream	Q4 2019/20		Q4 2019/20	
21	**To review the current bank and substantive recruitment processes to ensure that they are efficient as they can be and that there are no time lags: -** Focussed recruitment startegies to be continued and developed	Right Staffing Recruitment & Retention workstream TSS	Q2 2019/20		Q2 2019/20	
22	**Recommendation to increase bank worker supply: -** Introduce a temporary staffing booking model in the areas that currently experience low uptake of short notice shifts to mirror the booking model successfully operation in Forensics. Option to convert current staffing spend to employ a group of staff (peripatetic workforce) could be considered at a later date if successful.	TSS	TBD by TSS		TBD by TSS	success and feasibility dependent upon recruiting sufficiently in these areas and consistency and spread of work. No dates to roll out at present
23	**Recommendation to increase bank worker supply: -** Introduction of Open days & Reconnection days to encourage staff to work in those areas or to encourage staff to return who may not have worked in a particular area for a while.	TSS	Q4 2019/20			to be designed as part of the induction programme
24	**To have a robust bank worker system / team in place: -** Utilise SNODs / night duty co-ordinators Trustwide to improve communication relating to staffing	TSS	01/10/2019			will be looked at as part of the agency process work
25	**To have a robust bank worker system / team in place: -** Identified the lack of supervision and support available to bank workers. Would need to look at introducing group supervision options for bank workers.	TSS	Q4 2019/20			professional lead to help develop a supervision pathway
26	**To have a robust bank worker system / team in place: -** Introduce a clinical induction programme (including quality orientation to the units) for bank workers to provide a consistent approach to delivering key messages and expectations, clinical skills and workbook competencies to new starters. Additional resources would be required to deliver this and additional training courses would need to be available to meet the increase in bank recruits (included in the proposal of the future team structure)	TSS	Q4 2019/20			as per section 10 (row 118)
27	**Bank pay to change to weekly: -** Increase bank staffing numbers and align to agency process Weekly Pay to be commenced	**TSS**	1st April 2019		1st April 2019	
28	**Introduce Fast track to bank:-** Increase bank staffing numbers by allowing those in existing patient facing roles within the trust to fast track to the bank	**TSS**	complete			this has been in operation for some time - not a new development
29	**Introduce Fast track external recruitment process for current Student Nurses to join the bank: - Fastrack through external process on recommedation from Trust mentor** Increase bank staffing numbers	**TSS**	complete			this has been in operation for some time - not a new development
30	Produce simple guide to payslips		01/04/2019			
31	Evaluate how many people picking up shifts from initiatives to increase bank usage					there will be monthly reporting against KPIs
32	Re-issue guidance on the process for Bank / Agency use	**TSS Manager and Right Staffing**	30/06/2019			is this the same as row 135?
33	Meetings with York and NY regarding the process of Bank first then agency: -	**TSS manager**	12/08/2019			combine with meetings to discuss new agency processes
34	**Offered travel expenses and accommodation in Harrogate - bank staff: -**	**TSS**	complete		TBD by TSS	
35	Recruitent campaign lead stall at Corporate induction	**RC LEAD**	02/09/2019			
36	Poster campaign March 2019	**TSS MANAGER**	complete			
37	E-roster Bank Assignment can replace agency booking	NE	Q2 2019/20		Q2 2019/20	Depenedent upon software patch for Health Roster from Allocate
38	Report to show High Cost Agency supply - non medical	KK/SP	Q2 2019/20		Q2 2019/20	
39	Report to show High Cost Agency supply - medical	B'OL	Q2 2019/20		Q2 2019/20	
40	Explore the potential for a policy whereby former TEWV employees are not permitted to be deployed within TEWV as agency workers and to collaborate with STP partner organisations to make this policy and practice STP wide.	RS Estab W/S	Q2 2019/20		Q2 2019/20	To be dicsussed at next workstream meeting
41	Create a medical agency rate card (average rate) and set the benchmark that TEWV believes is acceptable to stop ad hoc negotiations with agencies	B'OL	TBD if required		TBD	
42	To provide further information about the outsourced managed service provider (Retinue) along with reasons why TEWV feels that the provider offers value for money	KK	**See Item 1**		TBD	

Q1 2019/20: Apr-19, May-19, Jun-19
Q2 2019/20: Jul-19, Aug-19, Sep-19
Q3 2019/20: Oct-19, Nov-19, Dec-19
Q4 2019/20: Jan-20, Feb-20, Mar-20

1-Apr-19, 8-Apr-19, 15-Apr-19, 22-Apr-19, 29-Apr-19, 6-May-19, 13-May-19, 20-May-19, 27-May-19, 3-Jun-19, 10-Jun-19, 17-Jun-19, 24-Jun-19, 1-Jul-19, 8-Jul-19, 15-Jul-19, 22-Jul-19, 29-Jul-19, 5-Aug-19, 12-Aug-19, 19-Aug-19, 26-Aug-19, 2-Sep-19, 9-Sep-19, 16-Sep-19, 23-Sep-19, 30-Sep-19, 7-Oct-19, 14-Oct-19, 21-Oct-19, 28-Oct-19, 4-Nov-19, 11-Nov-19, 18-Nov-19, 25-Nov-19, 2-Dec-19, 9-Dec-19, 16-Dec-19, 23-Dec-19, 30-Dec-19, 6-Jan-20, 13-Jan-20, 20-Jan-20, 27-Jan-20, 3-Feb-20, 10-Feb-20, 17-Feb-20, 24-Feb-20, 2-Mar-20, 9-Mar-20, 16-Mar-20, 23-Mar-20

Appendix 2– Agency VCB

Agency Dashboard — **Developed by Right Staffing Establishment Workstream**

TRUSTWIDE

YTD TOTAL RELATES TO APRIL 2019/20

Please note that the green ticks and red crosses relate to month on month expenditure.
Please also see graphs for Year on Year expenditure.
Eg Year on Year by Month Graph indicates increased expediture when comparing across Years - (May 2018 vs May 2019)

CLICK HERE FOR LOCALITY VIEW | CLICK HERE FOR SPECIALITY VIEW | CLICK HERE FOR GLOSSARY

	Medical and Dental		Qualified Nursing		Unqualified Nursing (HCA)		Administrative and Clerical		Other Agency staff		Total Expenditure (Previous)	Total Expenditure (Current)	Current Projection	YTD Total	
Subjective Category (Summary)	Medical and Dental April	Medical and Dental May	Qualified Nursing April	Qualified Nursing May	Unqualified Nursing (HCA) April	Unqualified Nursing (HCA) May	Administrative and Clerical April	Administrative and Clerical May	Other Agency staff April	Other Agency staff May	Total Expenditure (Previous) April	Total Expenditure (Current) May	Current Projection May	YTD Total	YTD Forecast
CENTRAL	£ -	£ -	£ -	£ -	£ -	£ -	£ 4,078	£ 208	£ -	£ -	£ 4,078	£ 208		£ 4,287	
DURHAM AND DARLINGTON	£ 148,126	£ 86,234	£ -	£ 639	£ 51,888	£ 41,388	£ 8,725	£ 7,239	£ 15,212	-£ 12,441	£ 223,950	£ 123,059		£ 347,010	
ESTATES AND FACILITIES MANAGEMENT	£ -	£ -	£ -	£ -	£ -	£ -	£ 26,597	£ 8,838	£ 29,188	£ 20,147	£ 55,785	£ 28,985		£ 84,770	
FINANCE AND INFORMATION	£ -	£ -	£ -	£ -	£ -	£ -	£ 6,331	£ 2,842	£ -	£ -	£ 6,331	£ 2,842		£ 9,172	
FORENSIC SERVICES	£ -	£ -	£ 867	£ -	£ 580	£ 650	£ -	£ -	£ -	£ -	£ 1,447	£ 650		£ 2,097	
HUMAN RESOURCES AND ORGANISATIONAL	£ -	£ -	£ -	£ -	£ -	£ -	£ 3,920	£ 1,767	£ -	£ -	£ 3,920	£ 1,767		£ 5,687	
MEDICAL	£ -	-£ 800	£ -	£ -	£ -	£ -	£ 1,924	£ 2,670	£ -	£ -	£ 1,924	£ 1,870		£ 3,794	
NORTH YORKSHIRE AND YORK	£ 140,337	£ 64,648	£ 171,839	£ 132,364	£ 139,769	£ 146,762	£ 78,568	£ 27,566	£ 25,765	£ 20,525	£ 556,279	£ 391,864		£ 948,143	
PHARMACY	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ 7,088	£ 5,796	£ 7,088	£ 5,796		£ 12,885	
TEESSIDE	£ 27,052	£ 12,203	£ 5,301	£ 4,112	£ 58,602	£ 70,692	£ 19,956	£ 10,936	£ -	£ -	£ 110,911	£ 97,942		£ 208,852	
TRUST FINANCING															
TOTALS	**£ 315,515**	**£ 162,285**	**£ 178,008**	**£ 137,114**	**£ 250,839**	£ 259,491	**£ 150,099**	£ 62,065	**£ 77,252**	**£ 34,028**	**£ 971,713**	**£ 654,983**	£ -	**£ 1,626,696**	£ -

Item 12

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**25 June 2019**
TITLE:	**Finance Report for Period 1 April 2019 to 31 May 2019**
REPORT OF:	**Patrick McGahon, Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 31 May 2019 is a surplus of £131k, representing 0.22% of the Trust's turnover and is £117k behind the NHS Improvement (NHSI) plan.

Performance Against Plan – year to date (3.2)

	Variance £000	Monthly Movement £000	Movement
The Trust is currently £117k **behind** its year to date financial plan.	117	71	↑

Cash Releasing Efficiency Savings (CRES) (3.3)

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the financial year are forecast to be £1,799k **ahead of** financial plan.	Recurrent	-54	↓
	Non recurrent	-1,744	↑
	Target	0	
	Variance	-1,799	↑

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the rolling 3 year period were £8,544k **behind** the £20,565k CRES target.	Recurrent	8,544	↑

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 £933k **behind of** its capital plan.	-933	-1,127	↑

Expenditure against the capital programme to 31 May 2019 is £5,307k and is £933k behind plan due to a change in the expenditure profile of York and Selby inpatient scheme. In addition the purchase of land for the Worsley Court replacement scheme has been delayed until later in the financial year.

Workforce (3.5)

	Variance £000	Monthly Movement £000	Movement
The Trust is £524k (48%) **in excess** of its agency cap.	524	104	↓

Agency expenditure continues to be high in May across all localities. Nursing (51%), Medical (29%) and Admin (14%) account for the majority of agency expenditure, which is used to support vacancies and enhanced observations with complex clients. However, the level of expenditure has reduced in May largely as a result of four agency locum contracts coming to an end. 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 31 May 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 two month's income and expenditure.

However, in addition the Trust is also behind its income and expenditure target (£117k) and agency expenditure continues to exceed the NHSI cap by 48% and is rated as a 3. Should this position not improve then the Trust will not achieve its planned 1 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:	**25 June 2019**
TITLE:	**Finance Report for Period 1 April 2018 to 31 May 2019**

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for 1 April 2019 to 31 May 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 31 May 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 two month's income and expenditure. However, in addition the Trust is also behind its income and expenditure target by £117k and agency expenditure continues to exceed the NHSI cap by 48% and is therefore also rated as a 3.

3.2 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 31 May 2019 is a surplus of £131k, representing 0.22% of the Trust's turnover and is £117k behind the NHSI plan. This is summarised in table 1 below:

Table 1

	Annual Plan	Year to Date Plan	Year to Date Actual	YTD Variance	Prior Month Variance
	£000	£000	£000	£000	£000
Income From Activities	(345,433)	(56,130)	(56,349)	(79)	(96)
Other Operating Income	(14,092)	(2,677)	(2,652)	24	23
Total Income	**(359,525)**	**(58,946)**	**(59,001)**	**(55)**	**(74)**
Pay Expenditure	274,567	47,036	47,109	74	198
Non Pay Expenditure	70,554	10,174	10,333	159	98
Depreciation and Financing	8,920	1,488	1,427	(61)	(34)
Variance from plan	**(5,485)**	**(248)**	**(131)**	**117**	**188**

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 (£1,799k) 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 £1,799k ahead of financial plan.	Recurrent	-54	↑
	Non recurrent	-1,744	↑
	Target	0	
	Variance	-1,799	↑

3.4 Capital

Expenditure against the capital programme to 31 May 2019 is £5,307k and is £933k behind plan due to a change in the expenditure profile of York and Selby inpatient scheme. In addition the purchase of land for the Worsley Court replacement scheme has been delayed until later in the financial year.

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 May-19	Nov	Dec	Jan	Feb	Mar	April	May
Establishment (a) (90%-95%)	90.89%	93.96%	93.37%	93.03%	92.24%	92.38%	90.66%	90.89%
Agency (b)	1.00%	3.40%	3.40%	3.44%	3.52%	3.51%	4.07%	3.50%
Overtime (c)	1.00%	1.07%	1.10%	1.02%	1.03%	1.02%	1.20%	0.94%
Bank & ASH (flexed against establishment) (100%-a-b-c)	7.11%	3.22%	3.20%	3.13%	3.09%	2.99%	3.10%	3.20%
Total	**100.00%**	**101.65%**	**101.01%**	**100.62%**	**99.88%**	**99.98%**	**99.03%**	**98.51%**

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 May 2019 the tolerance for Bank and ASH is 7.11% of pay budgets.

NHS Improvement monitors agency expenditure against a capped target. Agency expenditure at 31 May 2019 is £1,627k which is £524k (48%) in excess of the agreed year to date capped target of £1,103k. Nursing and Medical agency expenditure accounts for 80% 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 31 May 2019 is £65,512k which is £10,748k ahead of plan due to higher than anticipated creditor accruals where invoices have not been received by the Trust (circa £8m), and underspends on the capital programme.

3.7 Use of Resources Risk Rating (UoRR) and Indicators

3.7.1 The UoRR for the Trust is assessed as 3 for the period ending 31 May 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 two 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 (£117k) and agency expenditure continues to exceed the NHSI cap by 48% (April 76%) and is therefore rated as a 3. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

Should this position not improve then the Trust will not achieve its planned 1 rating and may also not receive its Provider Sustainability Funding allocation.

Table 4: Use of Resource Rating at 31 May 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	0.57x	4	0.42x	4	0
Liquidity	70.30 days	1	74.21 days	1	0
I&E margin	0.2%	2	0.4%	2	0
I&E margin distance from plan	0.2%	2	0.0%	1	-1
Agency expenditure	£1,627k	3	£1,103k	1	-2
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 0.57x (can cover debt payments due 0.57 times), which is in line with plan.

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 70.3 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 on plan and is rated as a 2.

3.7.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding PSF income. The Trust I&E margin distance from plan is 0.2% which is behind plan and rated as a 2.

The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is 48% higher than the capped target and is rated as a 3.

The margins on UoRR are as follows:

- Capital service cover - to improve to a 3 a surplus increase of £1,651k is required.
- Liquidity - to reduce to a 2 a working capital decrease of £66,201k is required.
- I&E Margin – to reduce to a 3 an operating surplus decrease of £473k is required.
- I&E margin distance from plan – to reduce to a 3 an operating deficit increase of £131k is required.
- Agency Cap rating – to improve to a 2 a reduction in agency expenditure of £248k is required.

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUSIONS:

6.1 For the period ending 31 May 2019 the Trust is £117k behind its planned control total surplus (£248k) 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 31 May 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 two month's income and expenditure. The UoRR is planned to improve throughout the financial year to a 1 rating.

7. RECOMMENDATIONS:

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

Patrick McGahon
Director of Finance and Information

ITEM 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th June 2019**
TITLE:	**Board Dashboard as at 31st May 2019**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communication**
REPORT FOR:	**Assurance**

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

Executive Summary:

As at the end of May 2019, 3 (19%) 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 further improvement on the 4 that were reported as at the end of April 2019. In addition there are 5 KPIs (31%) that whilst not achieving the target are within the 'amber' tolerance levels, with 8 achieving the target and being rated as green (50%) which is again an improvement on April 2019.

In terms of the Year to Date position 7 (44%) of the KPIs are rated as green with 3 rated as red.

In terms of the Single Oversight Framework (SOF) targets the Trust achieved all the operational targets with the exception of CPA 7 day follow up in May 2019. The Trust achieved 94.51% against the target of 95% in the month of May however it should be noted that the target was achieved for the year to date as at the end of May.

There has been a slight amendment to the report this month which is described in Section 2.1 of the covering paper. This section also addresses the issue relating to the trend line on the graphs which was discussed at the May Board meeting.

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:	**25th June 2019**
TITLE:	**Board Dashboard as at 31st May 2019**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 31st May 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 Changes to content

Since the last report an agreed change to KPI 1 Percentage of patient who were seen within 4 weeks for a first appointment following an external referral was implemented. Unfortunately this has resulted in an inaccurate reporting of the position and therefore a decision has been taken to remove this indicator from the dashboard for this month only. This is a temporary situation and it is planned that the KPI will be reinstated in the July report.

At the last Board there was a discussion on the appropriateness of the trend lines on the Dashboard graphs. Following further investigation it has been agreed that these lines will be removed from the graphs in future reports, however it was not possible to enact this for the attached dashboard.

2.2 Performance Issues

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

- As at the end of May 2019, 3 (19%) 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 further improvement on the 4 that were reported as at the end of April 2019. In addition there are 5 KPIs (31%) that whilst not achieving the target are within the 'amber' tolerance levels, with 8 achieving the target and being rated as green (50%) which is again an improvement on April 2019.

  Of the 8 indicators that are either red or amber 1 is showing an improving trend over the previous 3 months.

  In terms of the Year to Date position 7 (44%) of the KPIs are rated as green with 3 rated as red.

- In terms of the Single Oversight Framework (SOF) targets the Trust achieved all the operational targets with the exception of CPA 7 day follow up in May 2019. The Trust achieved 94.51% against the target of 95% in

the month of May however it should be noted that the target was achieved for the year to date as at the end of May.

There was variation in terms of delivery of the SOF targets at CCG level. In terms of the position specific issues are as follows:

- CPA 7 day follow up – the target was not achieved in North Durham and Harrogate and Rural District CCGs. A number were due to a breakdown in processes and the importance of following people up following discharge to improve safety has been reiterated to services.
- Access to Early Intervention in Psychosis – we failed to achieve the target in Darlington CCG. There has been an improvement in performance across the 3 North Yorkshire CCGs compared to previously reported positions linked to a reduction in sickness and vacancies.
- IAPT/Talking Therapies – proportion of people completing treatment who move to recovery" – The target was not achieved in North Durham CCG. One of the issues affecting the position is linked to students leaving the area as they return home for vacation. The service have put in place a procedure to ensure that these students can continue to receive therapy via a series of telephone consultations. In addition there have been some staff who have left the service which it is believed has contributed to some patients dropping out of the service as they did not want to be reallocated to a new clinician.
- IAPT Waiting Time to Treatment within 6 weeks – Once again 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 2 CCGs areas (North Durham and Darlington) in May 2019. It should be noted that Durham and Darlington locality accepts more people into its beds from other localities than it sends out of locality. 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 to treatment (KPI 2) – Whilst we are not achieving the target in May 2019 there has been an improvement in the positon compared to April with performance tracking the position reported in 2017/18. There remains particular areas of concern in North Yorkshire and York and Durham and Darlington AMH services. A key issue affecting the position in MHSOP services is the need to refer for scans to inform further treatment which adds a potential delay into the process. The Service Development

Group are going to discuss what additional interventions could be undertaken with service users whilst they are waiting for their scan.

- %age of patients reporting their experience as excellent or good (KPI 4) – Performance continues to be worse than the target but there was a slight improvement in May, with the position tracking that of 2017/18. Forensic services are furthest from target and work is ongoing within the service to try and improve the completion of patient surveys in order to improve the understanding of what needs to be done to improve the position.
- %age of Serious Incidents which are found to have a root or contributory cause (KPI 5) – Whilst the position for May is achieving target there has been a deterioration compared to the April position, with Durham and Darlington accounting for 3 of the 5 incidents where a root/contributory cause was found. This is only the 2nd month that this information has been reported and therefore there is not a three month trend arrow included on the Dashboard summary. Action plans to address the root/contributory causes are developed as part of the Serious Incident Process and themes are identified by the Patient Safety Team and shared via the Patient Safety Group.
- Outcome Indicators (KPIs 6 and 7) – Performance against KPI 6 (HONOS) and 7 (SWEMWEBS) have both improved in May 2019 such that both have achieved target. In both cases performance in May 2019 is greater than that in May 2018. The task and finish group chaired by the Clinical Director for KPO continues to drive this forward and improved reporting via daily lean management is helping to increase awareness of the indicators and the position within localities..
- Activity Indicators (KPI 8-11) – Whilst we are only monitoring these indicators it can be seen that for KPI 8 (unique patients referred) and KPI 10 (of those unique patient referred number taken on for treatment) the positon in May 2019 is similar to that in 2018. However for KPI 9 (of those unique new referrals the number with an assessment complete) the figure has stayed the same as for April 2019 which could mean that more people are waiting for and assessment. In terms of KPI 11 (Number of unique patient referred who received treatment and were discharged) performance in similar to April 2019 but lower than May 2018. It is likely that this will be resulting in an increase in the caseload of teams given the number being taken on for treatment has increased.
- Bed Occupancy (KPI 12) – There has been further improvement in May 2019 with the actual level of bed occupancy achieving the target of 90% and being much lower than that in May 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 however the %age of patients readmitted within 30 days remains worse than target with a further increase in May 2019. This is a particular issue in Durham and Darlington and North Yorkshire and York and both localities are giving this increased focus through their huddle process.
- Vacancy Rate (KPI 15) – the target of 6.5% was not achieved in May 2019. The Right Staffing Programme has a work stream looking at recruitment and retention and has recently developed a dashboard which

demonstrates by localities the number of vacancies and progress being made in terms of the recruitment to those posts.

- Sickness Absence Rate (KPI 19) – Whilst the Trust continues not to achieve target there was a significant decrease in the amount of sickness reported in May 2019 (April sickness) such that it was the best position since May 2018. We have now received the views of Business Disability Forum on our revised procedure and this will be considered by the Policy Working Group when they meet in June.
- Financial Targets (KPI 19, 20 and 21) – Whilst the Trust did deliver a surplus of £131k in May 2019 this was £117k behind the planned position for the month. It should be noted however that this is an improvement on the April 2019 position. Further details are provided within the Finance report. In terms of KPI 20 CRES delivery and KPI 21 Cash against Plan both targets for the month were achieved.

2.4 Data Quality Assessment.

The Data Quality Assessment for the new dashboard indicators is attached in Appendix C. An additional element has been added to this scoring matrix to further improve the robustness of this process. The new element considers the timeliness of when each KPI was last tested. The majority of the KPI's score 95% or above, which is extremely positive and reflects the improvements made in our processes. Seven KPI's score 85% to 90% and one KPI reports a score of 80%. Lower scores are due to data testing requiring update and plans are in place to address this. Also some KPI's are subject to a manual process prior to reporting and where possible this is being addressed to eliminate the manual process and therefore improve the scoring.

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

	May 2019				April 2019 To May 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
2) Percentage of patients starting treatment within 6 weeks of an external referral	60.00%	55.02%			60.00%	53.84%		60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	2,226.00	1,055.00			2,226.00	1,055.00		2,226.00
4) Percentage of patients surveyed reporting their overall experience as excellent or good	94.00%	92.24%			94.00%	91.67%		94.00%
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding	32.00%	27.78%			32.00%	24.14%		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%	60.64%			67.25%	60.11%		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%	66.67%			65.00%	64.61%		65.00%

Activity

	May 2019				April 2019 To May 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
8) Number of new unique patients referred		7,373.00				14,306.00		
9) The number of new unique patients referred with an assessment completed		4,310.00				8,556.00		
10) Number of new unique patients referred and taken on for treatment		1,525.00				2,890.00		
11) Number unique patients referred who received treatment and were discharged		2,253.00				4,545.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	90.00%	86.41%			90.00%	87.90%		90.00%
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	61.00	52.00			61.00	52.00		61.00

Trust Dashboard Summary for TRUST

	May 2019				April 2019 To May 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.00%	31.31%			23.00%	29.83%		23.00%

Workforce

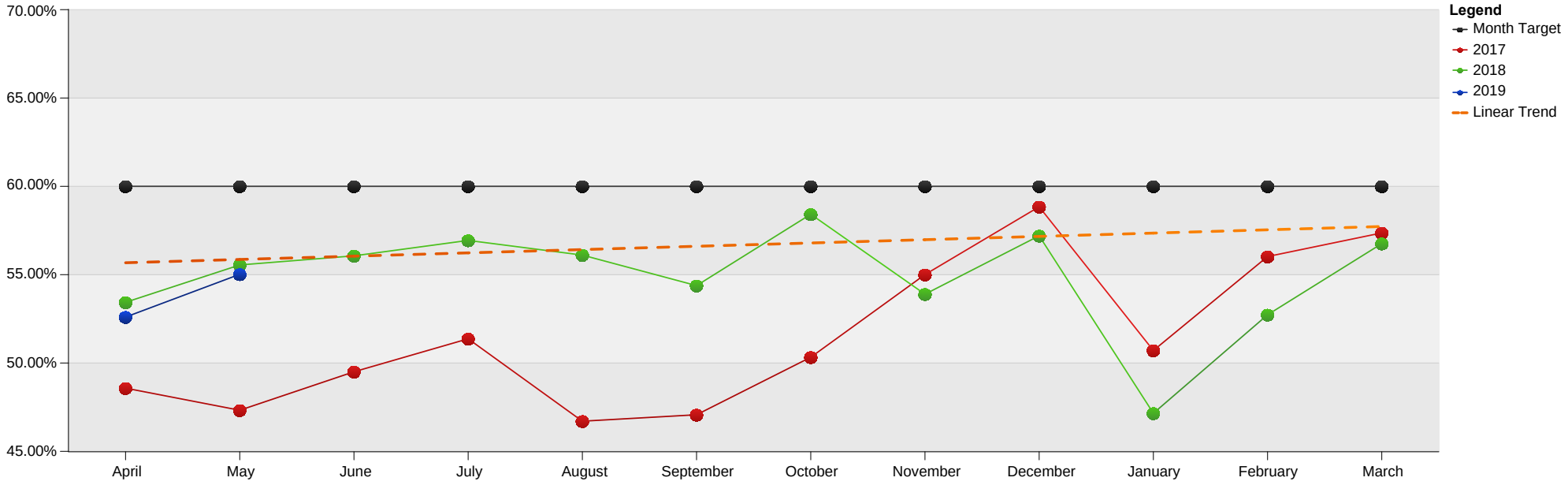
	May 2019				April 2019 To May 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
15) Vacancy Rate (Healthcare Professionals only)	6.50%	7.60%			6.50%	7.61%		6.50%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	91.46%			95.00%	91.46%		95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	93.87%			92.00%	93.87%		92.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.58%			4.50%	4.83%		4.50%

Money

	May 2019				April 2019 To May 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-211,000.00	-186,952.00			-343,000.00	-130,862.00		-5,485,000.00
20) CRES delivery	824,916.00	1,037,200.00			1,649,832.00	1,949,200.00		9,898,992.00
21) Cash against plan	49,508,359.00	65,511,853.00			49,508,359.00	65,511,853.00		12,929,359.00

Trust Dashboard Graphs for TRUST

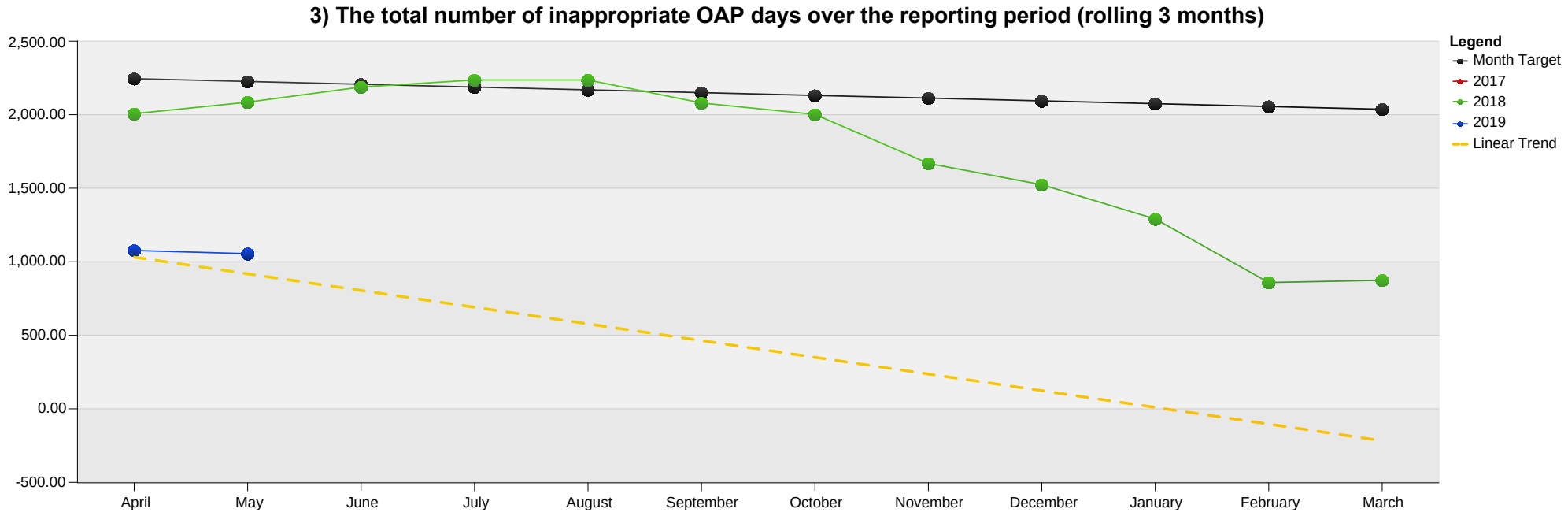
2) Percentage of patients starting treatment within 6 weeks of an external referral



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE 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	55.02%	53.84%	56.92%	52.15%	60.55%	61.56%	48.10%	47.70%	84.62%	88.89%		

Narrative
The position for May 2019 is 55.02%, which is worse than the target of 60.00% however is an improvement on the position reported in April 2019 but lower than that reported in May 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 46.37% and 46.73% respectively.Concerns about the use of appropriate intervention codes remain and guidance has been circulated to improve understanding.Discussions will take place in June at SDG to agree an approach for MHSOP patients who are referred for a memory scan and identify appropriate interventions that can be provided whilst waiting for the memory scan.

Trust Dashboard Graphs for TRUST

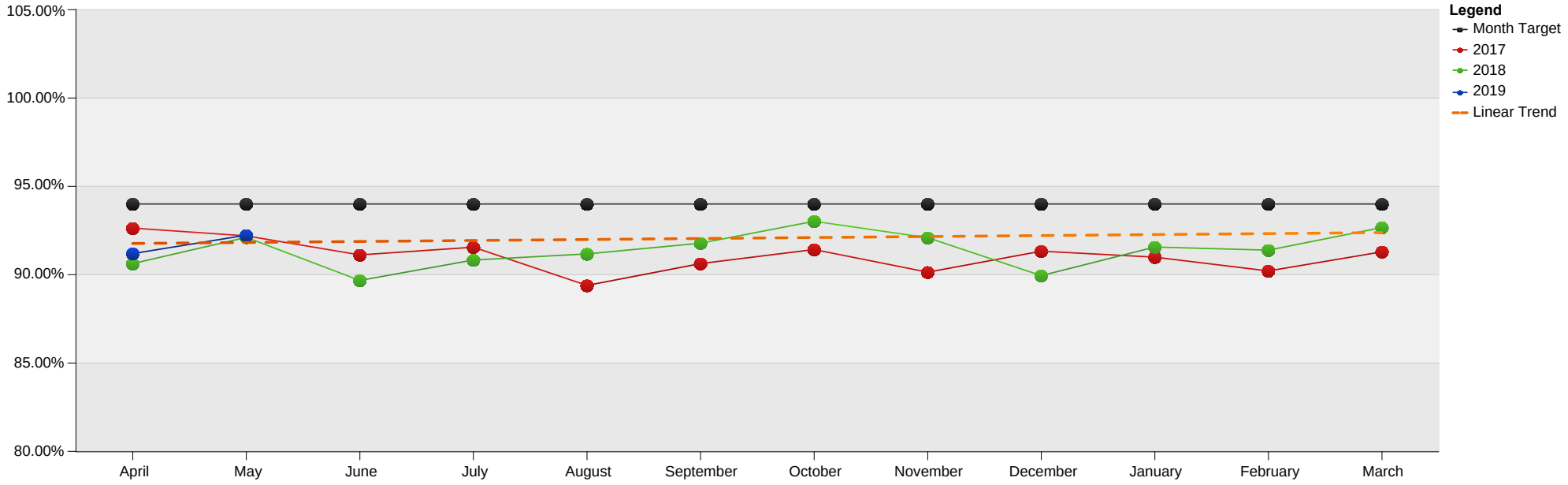


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	1,055.00	1,055.00	198.00	198.00	189.00	189.00	668.00	668.00				

Narrative
The Trust position for May 2019 is 1,055 which is a slight decrease on the 1,077 recorded in April 2019 but meeting the target of 2,226 . This is also an improvement to the figure reported in May 2018.All localities are meeting this indicator with the exception of Durham and Darlington where pressures are seen within MSHOP. All OAP's are internal to the Trust.

Trust Dashboard Graphs for TRUST

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

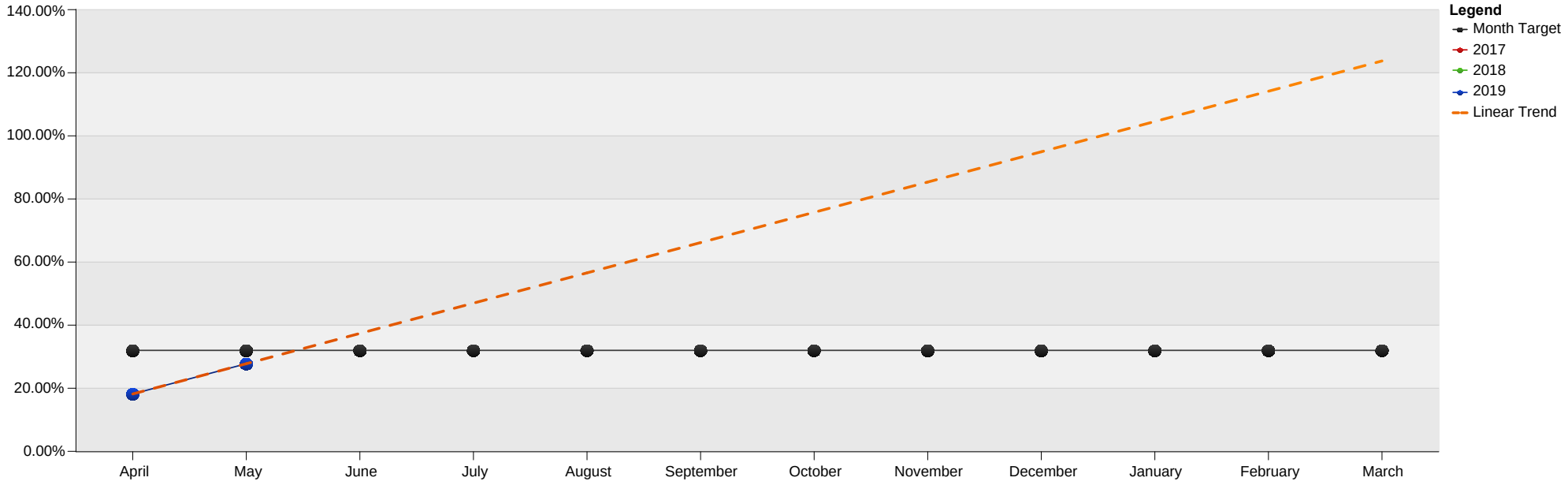


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of patients surveyed reporting their overall experience as excellent or good	92.24%	91.67%	92.55%	91.46%	94.16%	92.03%	91.21%	91.97%	88.28%	89.55%		

Narrative
The Trust position for May 2019 is 92.94% which is not achieving the target of 94.00% however an improvement to that reported in April 2019 is and similar to that reported in May 2018.Teesside are the only locality meeting target for this indicator. Of the localities that are not meeting target Forensics report the poorest position at 88.28%. Work is ongoing to improve completion rates of patient experience surveys to improve performance in this area

Trust Dashboard Graphs for TRUST

5) The percentage of Serious Incidents which are found to have a root cause or contributory finding

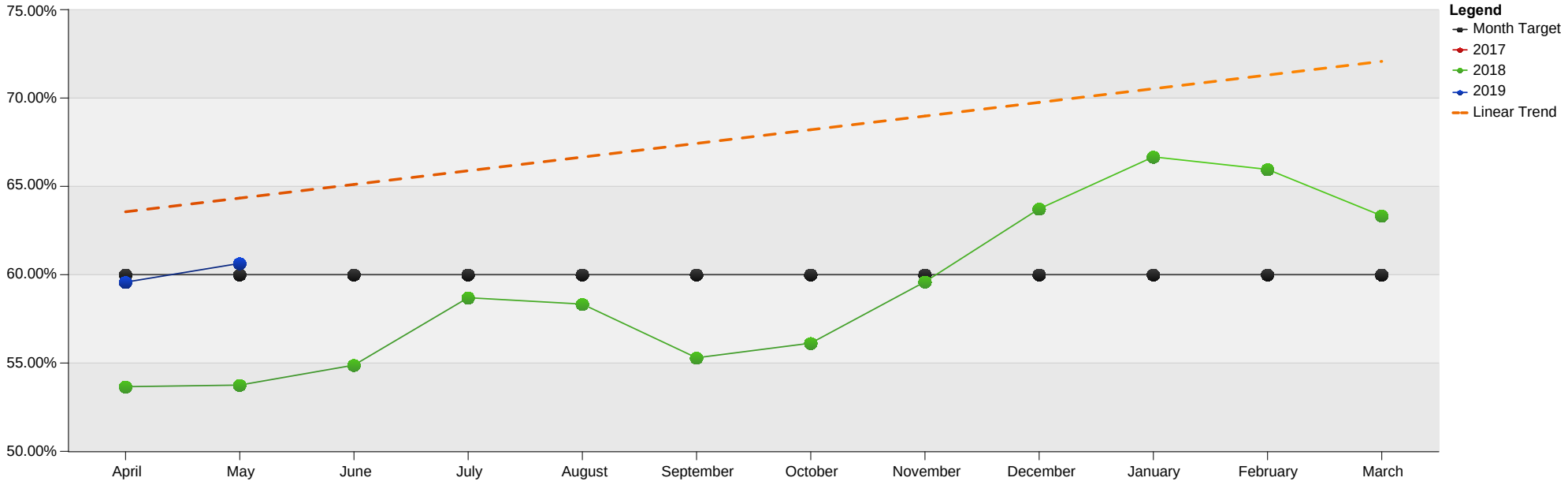


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding	27.78%	24.14%	60.00%	57.14%	11.11%	8.33%	25.00%	20.00%				

Narrative
The Trust position for May 2019 is 27.78% which is meeting the target of 32% ; however is an increase compared to that reported in April 2019This relates to 5 serious incidents out of 18 which were found to have a root cause or contributory finding in May 2019, which is an increase to the 2 serious incidents recorded in April 2019. The 5 incidents were in the following localities:• 3 x Durham and Darlington• 1 x North Yorkshire and York• 1 x TeesideAny themes identified by Patient Safety from these incidents are shared Trust wide through the Patient Safety Group.

Trust Dashboard Graphs for TRUST

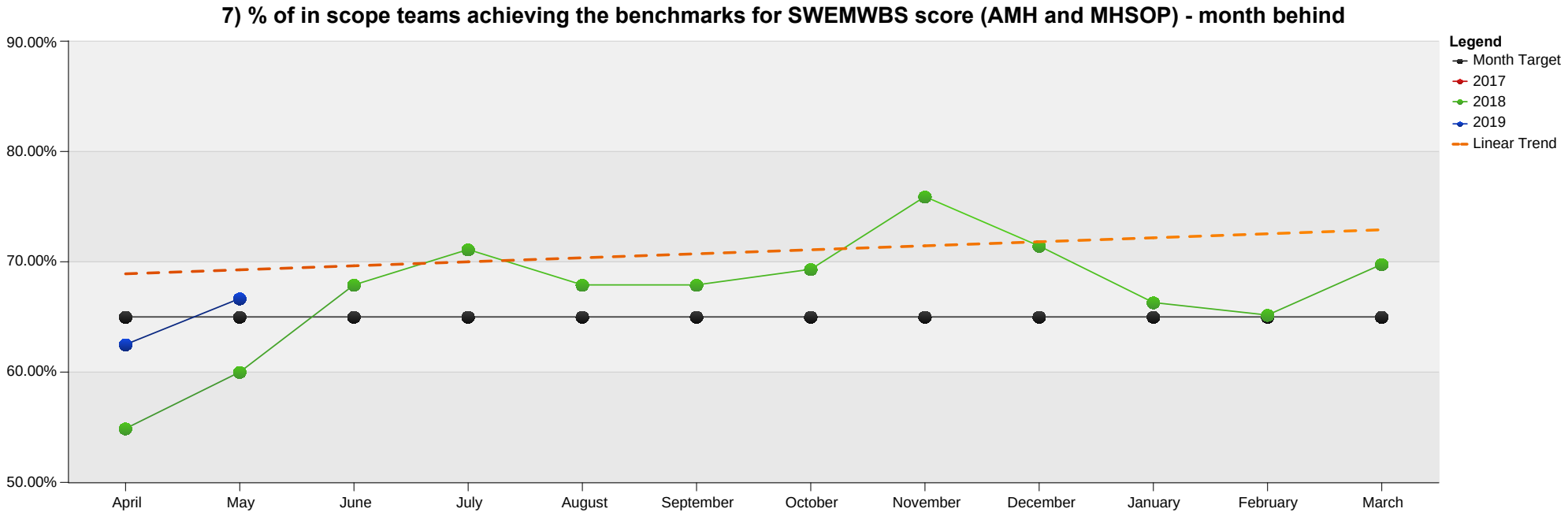
6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE 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	60.64%	60.11%	62.50%	61.29%	53.85%	58.49%	63.89%	60.27%				

Narrative
The Trust position for May 2019 is 60.64%, which is meeting target and a marginal improvement on the position reported in April 2019, and an improvement to that reported in May 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 clinical outcomes group chaired by Dr. Ruth Briel is now established. 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. A paper is due to be presented to EMT in June by Dr Ruth Briel to describe the progress made so far and to agree the next steps.

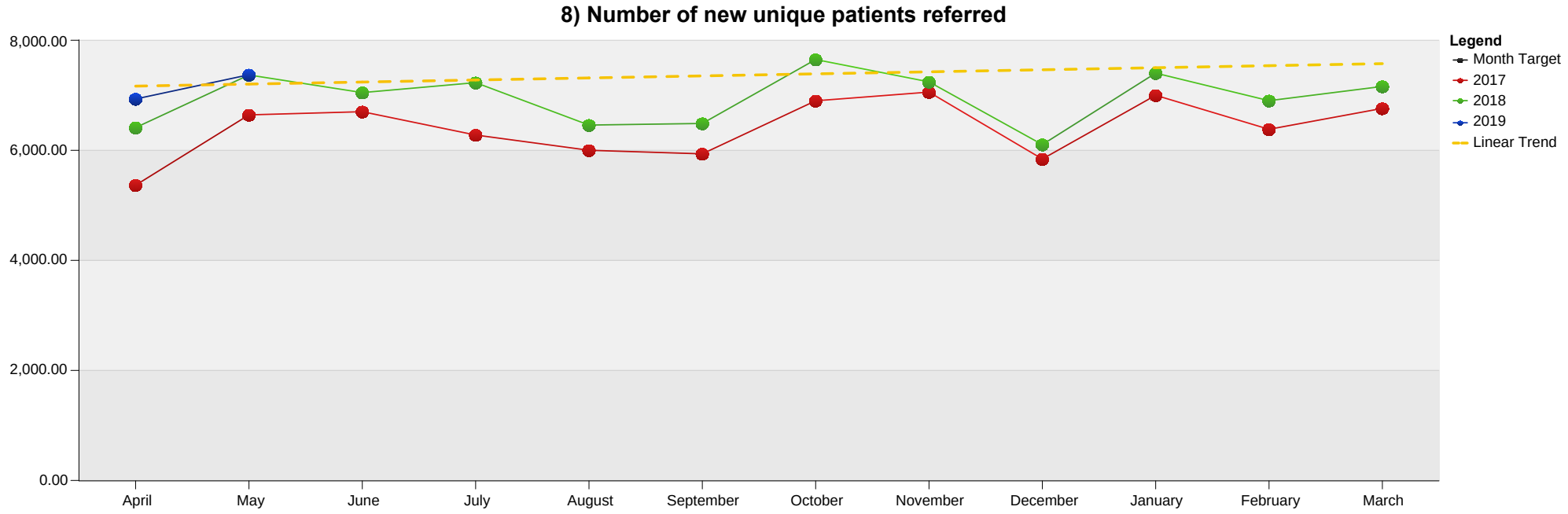
Trust Dashboard Graphs for TRUST



	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	66.67%	64.61%	56.25%	57.14%	74.07%	69.81%	70.97%	67.74%				

Narrative
The Trust position for May 2019 is 66.67%, which is meeting target and an improvement on the position reported in April 2019 and that reported in May 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 clinical outcomes group chaired by Dr. Ruth Briel is now established. 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. A paper is due to be presented to EMT in June by Dr Ruth Briel to describe the progress made so far and to agree the next steps.

Trust Dashboard Graphs for TRUST

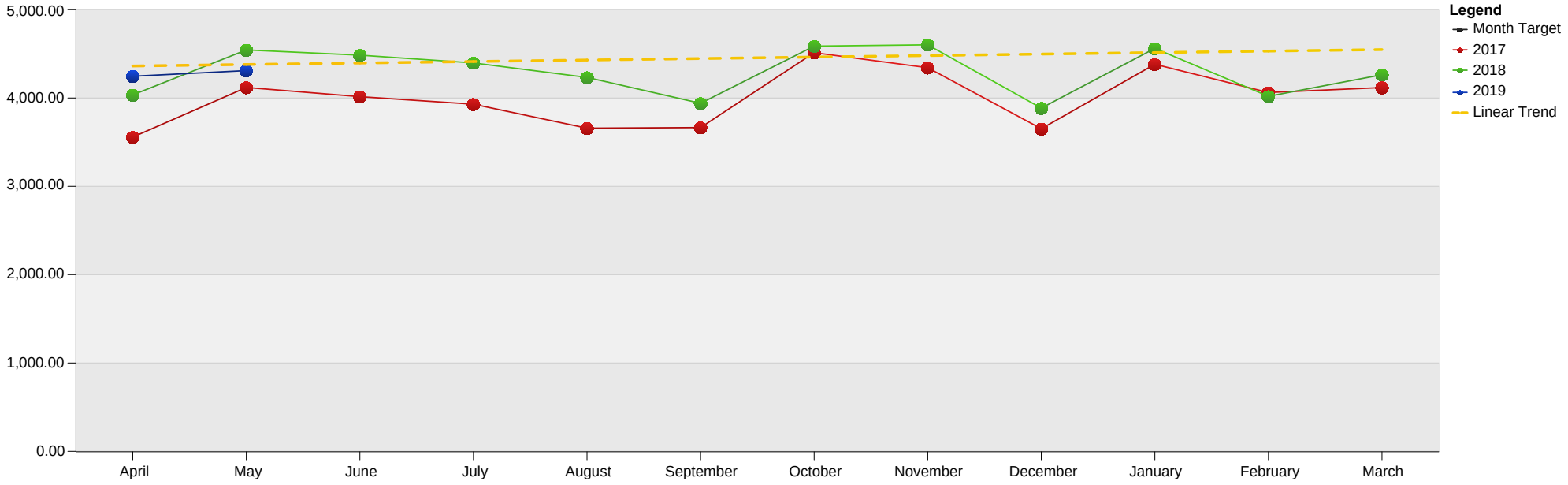


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Number of new unique patients referred	7,373.00	14,306.00	2,199.00	4,375.00	2,667.00	5,101.00	2,104.00	4,022.00	403.00	808.00		

Narrative
The Trust position for May 2019 is 7,373 which is an increase on the position reported for April 2019. This is one of the highest numbers of unique referrals since 2017/18. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be monitored by EMT as well as the data being reviewed by localities.

Trust Dashboard Graphs for TRUST

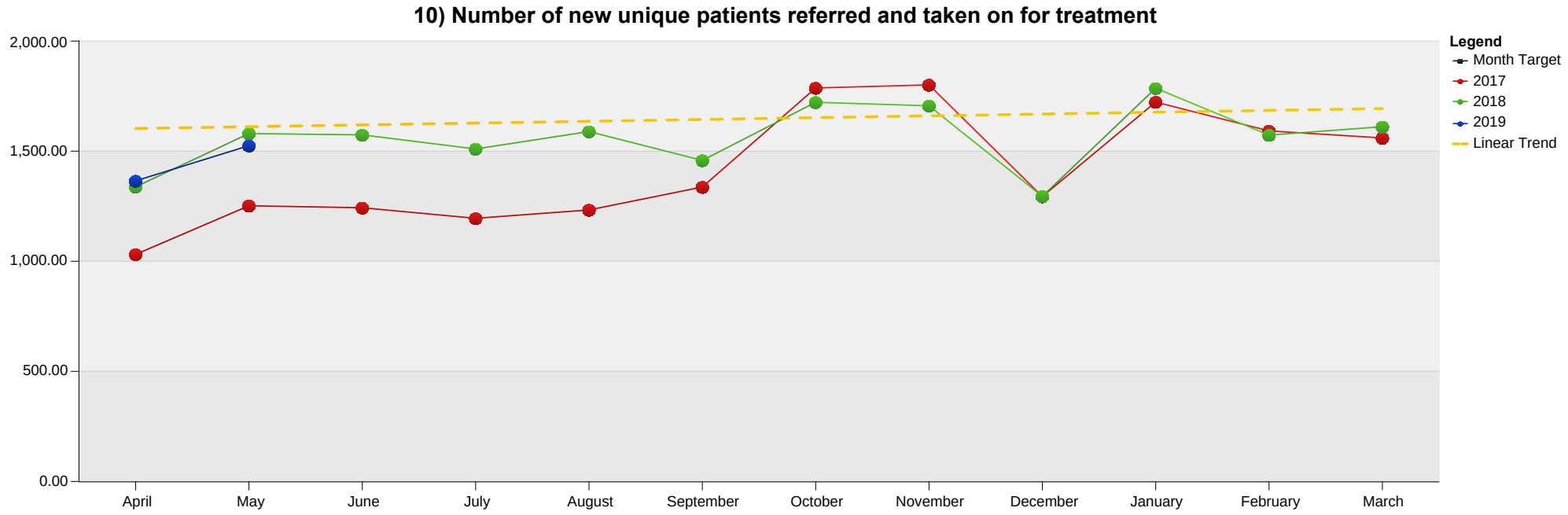
9) The number of new unique patients referred with an assessment completed



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE 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	4,310.00	8,556.00	1,349.00	2,657.00	1,536.00	3,013.00	1,197.00	2,447.00	228.00	438.00		

Narrative
The Trust position for May 2019 is 4,310 which is an increase on the position reported for April 2019. However this is lower than the figure reported in May 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

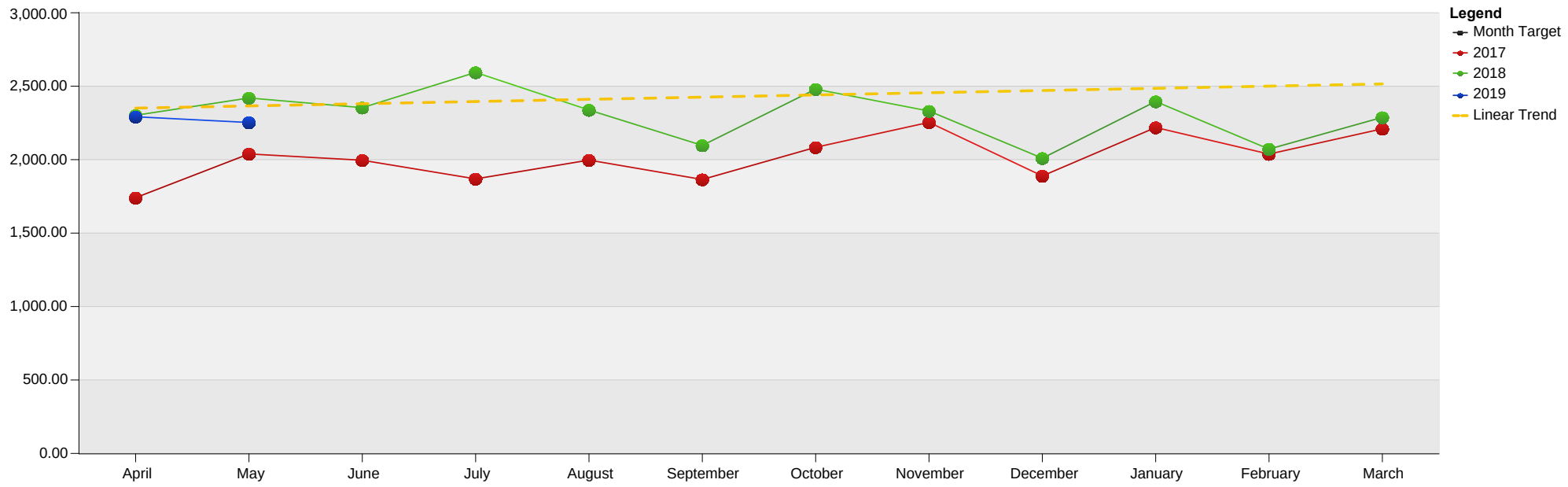


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Number of new unique patients referred and taken on for treatment	1,525.00	2,890.00	495.00	933.00	450.00	856.00	548.00	1,048.00	22.00	35.00		

Narrative
The Trust position for May 2019 is 1,525 which is an increase on the position reported for April 2019 and a slight reduction to that reported in May 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

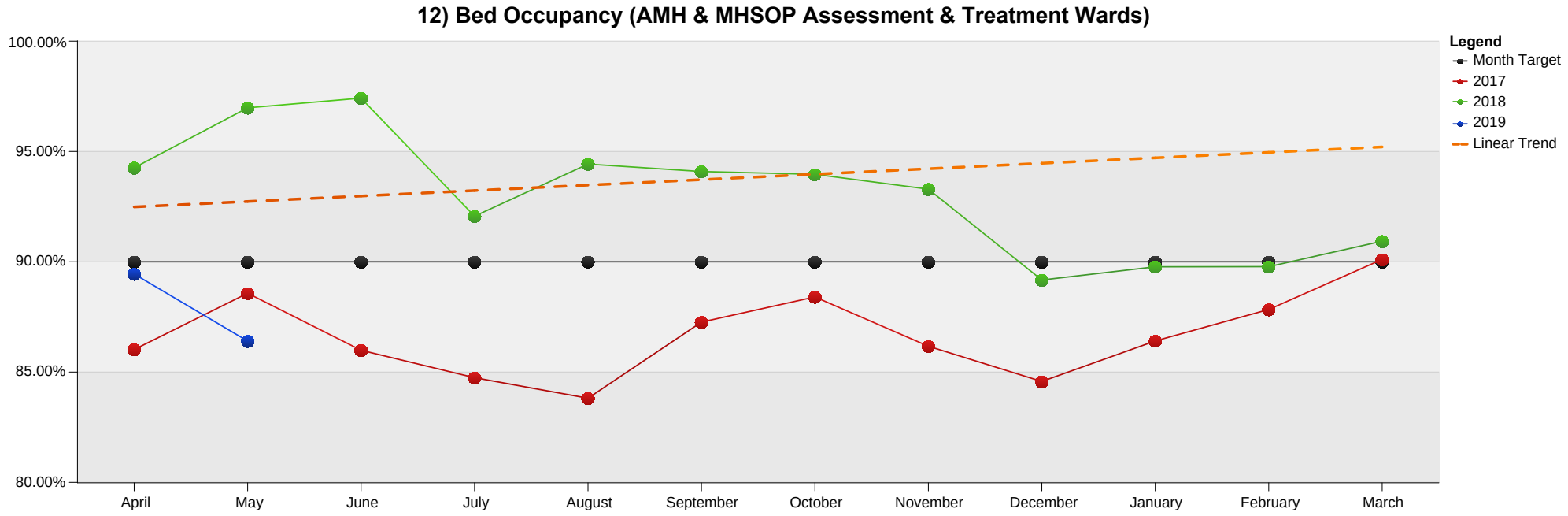
11) Number unique patients referred who received treatment and were discharged



	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	2,253.00	4,545.00	690.00	1,385.00	690.00	1,423.00	851.00	1,691.00	22.00	46.00		

Narrative
The Trust position for May 2019 is 2,253 which is a reduction to that reported for April 2019 and May 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

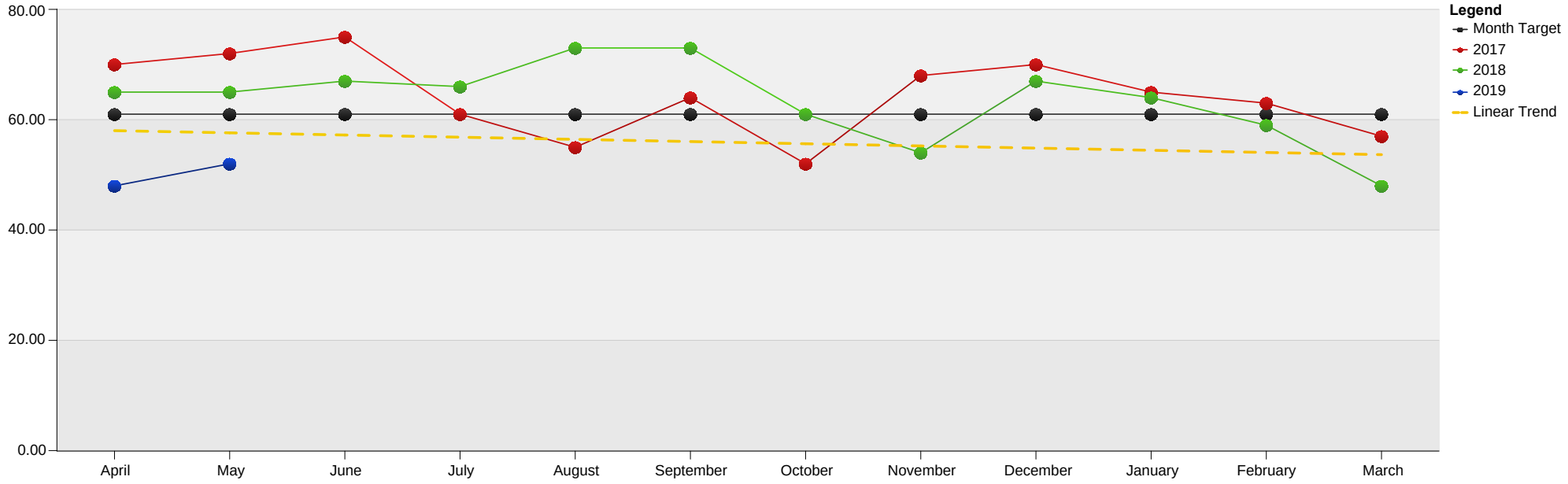


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	86.41%	87.90%	89.17%	91.06%	90.55%	92.25%	80.60%	81.55%	NA	NA		

Narrative
The Trust position for May 2019 is 86.41% which is a reduction to that reported in April 2019 and lower than that reported in April 2018. This is a positive position given the reduction in beds which occurred in Q4 2018/19.

Trust Dashboard Graphs for TRUST

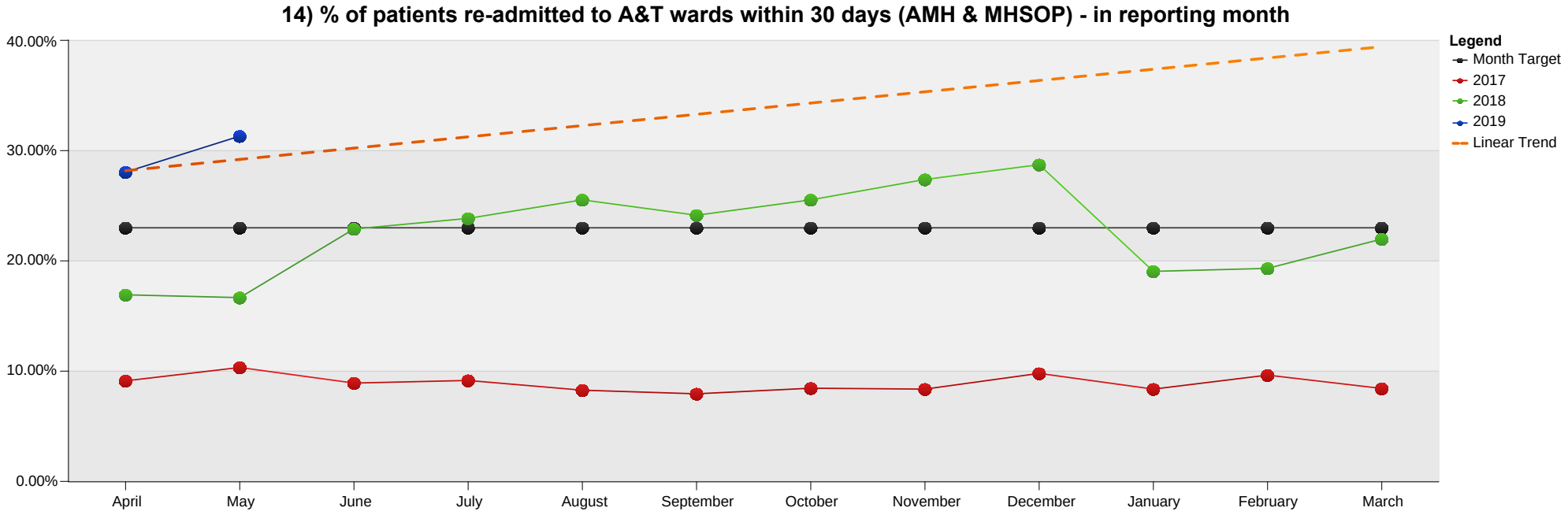
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot



	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) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	52.00	52.00	15.00	15.00	14.00	14.00	23.00	23.00				

Narrative
The Trust position for May 2019 is 52 which is meeting the target however is a deterioration to that reported in April 2019. Nevertheless this is one of the lowest positions recorded since 2017/18.Durham and Darlington and Teesside localities are not meeting target for this indicator. All localities are monitoring this on a continual basis and actions are discussed and agreed in daily huddles.

Trust Dashboard Graphs for TRUST

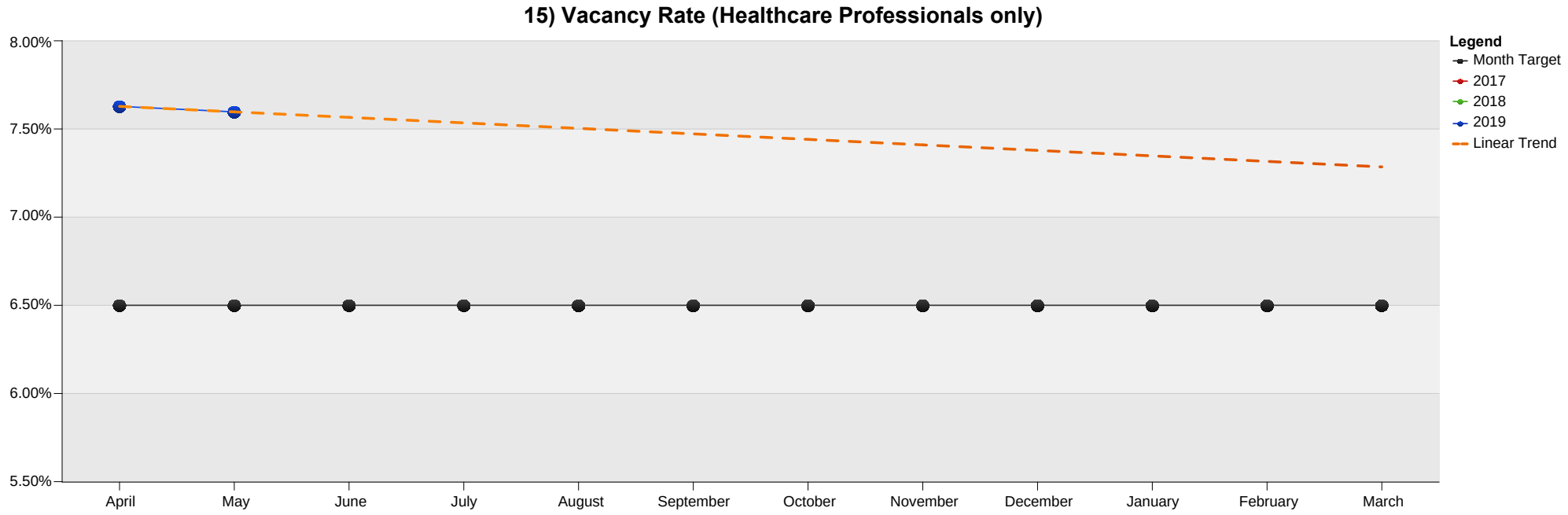


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	31.31%	29.83%	35.14%	30.77%	18.18%	29.79%	30.56%	25.81%				

Narrative

The Trust position for May 2019 is 31.31%, 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 worst position since 2017/18. Teesside is the only locality meeting target and Durham and Darlington and North Yorkshire and York report the poorest positions at 35.14% and 30.56% respectivelyIn North Yorkshire and York the majority of readmissions were in adult services and in Durham and Darlington the majority were in MHSOP. Increased focus is to be given to this indicator through the report out process to improve understanding and agree further action. Some thematic work has been completed in Teeside to improve understanding of issues in this area. Sharing of this work will support other localities as they address performance concerns.

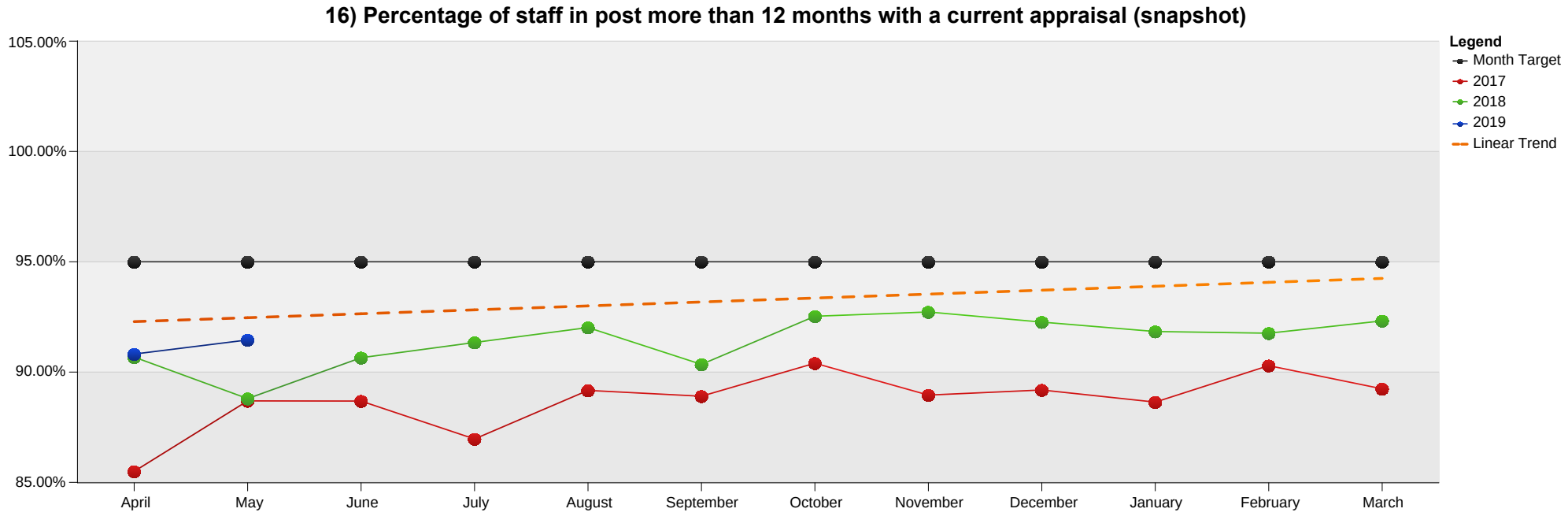
Trust Dashboard Graphs for TRUST



	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)	7.60%	7.61%	7.81%	8.23%	4.99%	4.76%	12.44%	12.12%	3.58%	4.45%		

Narrative
The position for May 2019 is 7.60 % which is above target and equates to 260.77 wte vacancies currently being actively being recruited to. A Right Staffing Agency dashboard has recently been developed to monitor the usage of agency staff. The dashboard includes information on the budgeted and contracted position along with vacancies being recruited to. This will allow operational services to monitor vacancies more effectively.This is a new target for 2019/20 therefore data relating to previous year's performance is not available.

Trust Dashboard Graphs for TRUST

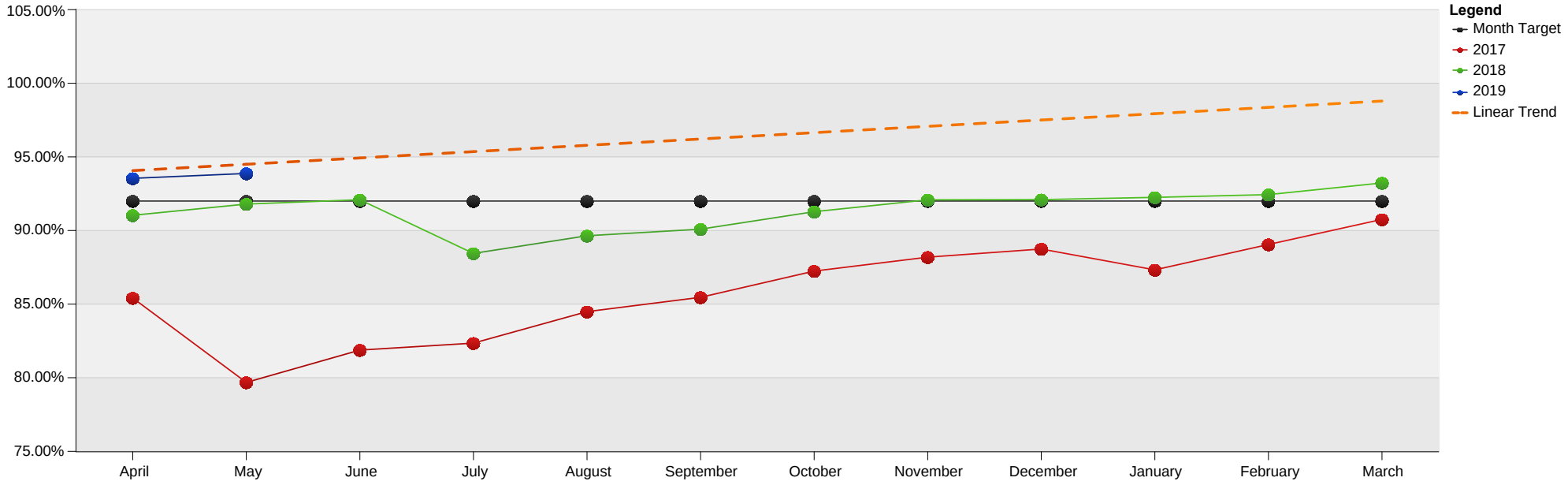


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	91.46%	91.46%	92.87%	92.87%	91.29%	91.29%	89.11%	89.11%	95.80%	95.80%		

Narrative
The Trust position for May 2019 is worse than target at 91.46% which relates to 480 members of staff out of 5815 that do not have a current appraisal. This represents an improvement on the position reported in April 2019 and an improvement to that reported in May 2018. Forensic Services are the best performing locality at 95.80%.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 has been reviewed and video guidance is being progressed. This will support users in the accurate recording of appraisals to prevent data quality issues. Timescales for this work will be provided in next month's report.

Trust Dashboard Graphs for TRUST

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

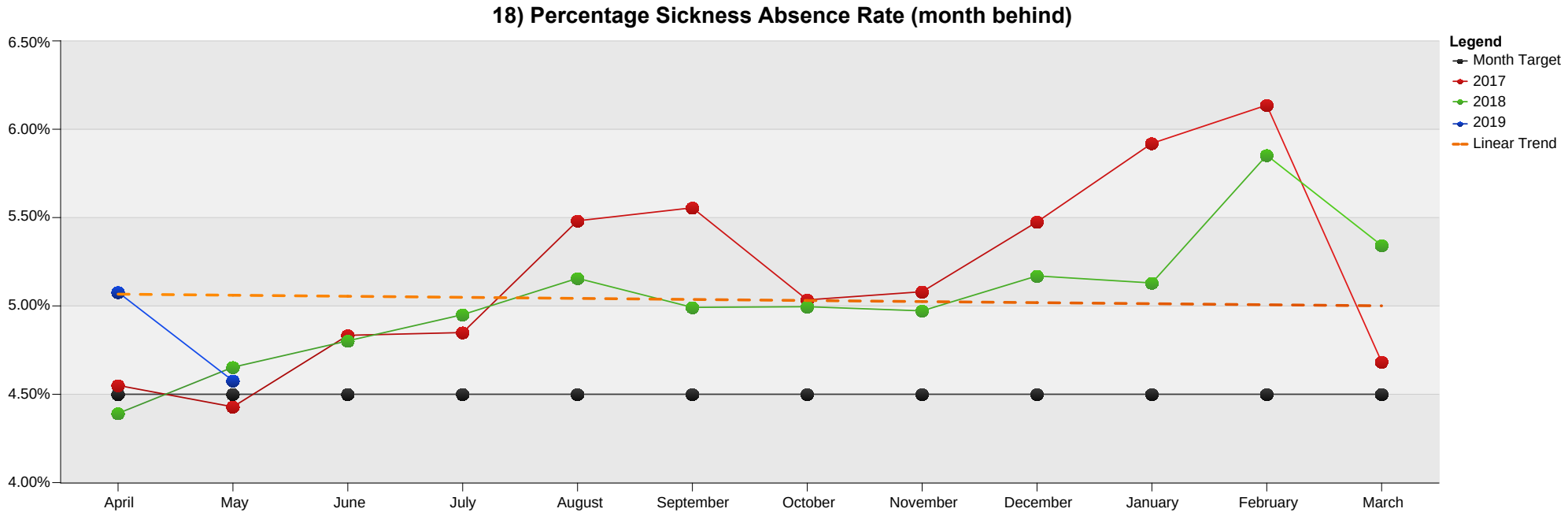


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	93.87%	93.87%	93.07%	93.07%	94.31%	94.31%	91.84%	91.84%	96.56%	96.56%		

Narrative

The position for May 2019 is 93.87% and is similar to that reported for April 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 and North Yorkshire and York report a position of 91.84%. Concerns around the availability of courses are being addressed through the Training Needs Analysis to agree action to increase availability.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.

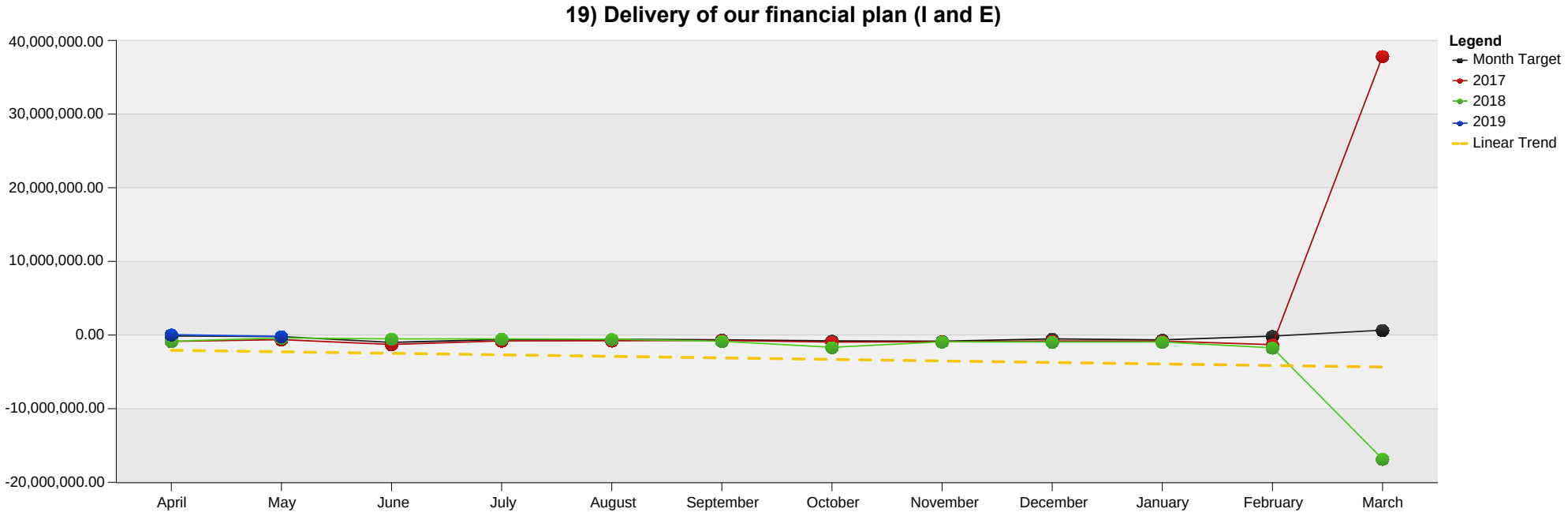
Trust Dashboard Graphs for TRUST



	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)	4.58%	4.83%	4.57%	4.95%	4.91%	5.21%	3.38%	3.96%	6.77%	6.51%		

Narrative
The Trust position reported in May relates to the April sickness level. The Trust position reported in May 2019 decreased to 4.58% which is higher than the target of 4.50%, however a significant improvement on the position reported in April 2019. A review of the approach to managing sickness absence has recently been concluded. This has been considered by the Business Disability Forum for their views and this feedback is being considered by the Policy Working Group, who will meet in June. Work is also underway to review the Occupational Health provision which is due for retendering in the next 12 months

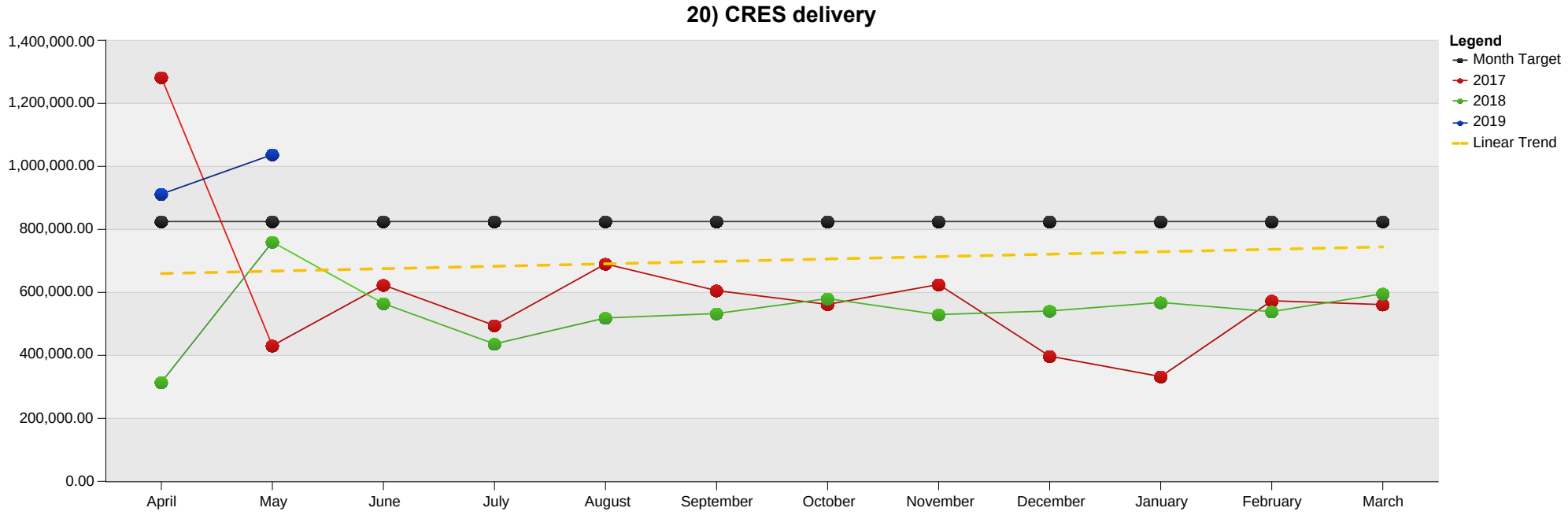
Trust Dashboard Graphs for TRUST



	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)	-186,952.00	-130,862.00	-104,409.00	-84,916.00	253,633.00	578,413.00	261,462.00	456,732.00	124,784.00	170,511.00		

Narrative
The comprehensive income outturn for the period ending 31 May 2019 is a surplus of £131k, representing -0.22% of the Trust's turnover and is £117k behind plan.

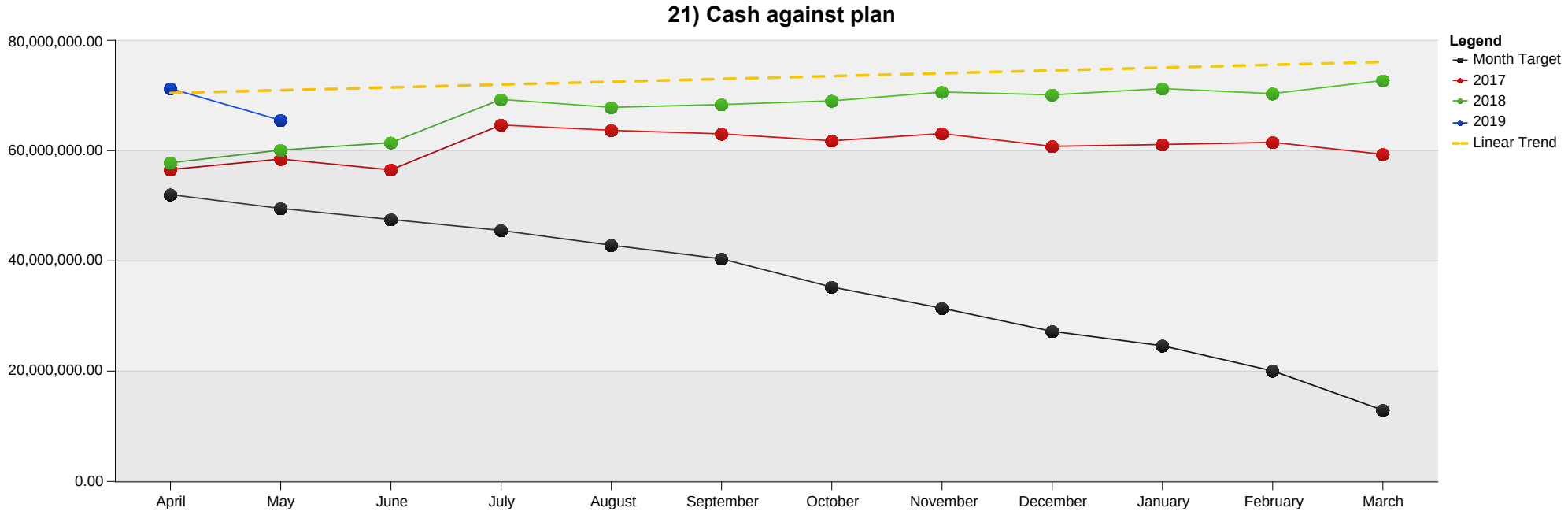
Trust Dashboard Graphs for TRUST



	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	1,037,200.00	1,949,200.00	116,000.00	159,000.00	102,000.00	176,000.00	240,000.00	428,000.00	42,000.00	99,000.00		

Narrative
Identified Cash Releasing Efficiency Savings at 31 May 2019 is £1,950k and is £300k ahead of plan for the year. The Trust is anticipating being ahead of plan (£1,799k) 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	65,511,853.00	65,511,853.00	NA	NA	NA	NA			NA	NA		

Narrative
Total cash at 31 May 2019 is £65,512k which is £10,748k ahead of plan due to higher than anticipated creditor accruals where invoices have not been received by the Trust (circa £8m), and underspends on the capital programme.

Trust Dashboard - Locality Breakdown for TRUST

1 - Quality

	May 2019												April 2019 To May 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
2) Percentage of patients starting treatment within 6 weeks of an external referral		55.02%		56.92%		60.55%		48.10%		84.62%				53.84%		52.15%		61.56%		47.70%		88.89%		
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)		1,055.00		198.00		189.00		668.00						1,055.00		198.00		189.00		668.00				
4) Percentage of patients surveyed reporting their overall experience as excellent or good		92.24%		92.55%		94.16%		91.21%		88.28%				91.67%		91.46%		92.03%		91.97%		89.55%		
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding		27.78%		60.00%		11.11%		25.00%						24.14%		57.14%		8.33%		20.00%				
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind		60.64%		62.50%		53.85%		63.89%						60.11%		61.29%		58.49%		60.27%				
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind		66.67%		56.25%		74.07%		70.97%						64.61%		57.14%		69.81%		67.74%				

Trust Dashboard - Locality Breakdown for TRUST

2 - Activity

	May 2019												April 2019 To May 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		7,373.00		2,199.00		2,667.00		2,104.00		403.00				14,306.00		4,375.00		5,101.00		4,022.00		808.00		
9) The number of new unique patients referred with an assessment completed		4,310.00		1,349.00		1,536.00		1,197.00		228.00				8,556.00		2,657.00		3,013.00		2,447.00		438.00		
10) Number of new unique patients referred and taken on for treatment		1,525.00		495.00		450.00		548.00		22.00				2,890.00		933.00		856.00		1,048.00		35.00		
11) Number unique patients referred who received treatment and were discharged		2,253.00		690.00		690.00		851.00		22.00				4,545.00		1,385.00		1,423.00		1,691.00		46.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)		86.41%		89.17%		90.55%		80.60%	NA	NA				87.90%		91.06%		92.25%		81.55%	NA	NA		
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot		52.00		15.00		14.00		23.00						52.00		15.00		14.00		23.00				
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month		31.31%		35.14%		18.18%		30.56%						29.83%		30.77%		29.79%		25.81%				

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	May 2019												April 2019 To May 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
15) Vacancy Rate (Healthcare Professionals only)		7.60%		7.81%		4.99%		12.44%		3.58%				7.61%		8.23%		4.76%		12.12%		4.45%		
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)		91.46%		92.87%		91.29%		178.22%		95.80%				91.46%		92.87%		91.29%		178.22%		95.80%		
17) Percentage compliance with ALL mandatory and statutory training (snapshot)		93.87%		93.07%		94.31%		91.84%		96.56%				93.87%		93.07%		94.31%		91.84%		96.56%		
18) Percentage Sickness Absence Rate (month behind)		4.58%		4.57%		4.91%		3.38%		6.77%				4.83%		4.95%		5.21%		3.96%		6.51%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	May 2019												April 2019 To May 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
19) Delivery of our financial plan (I and E)		-186,952.00	NA	-104,409.00	NA	253,633.00		261,462.00	NA	124,784.00				-130,862.00	NA	-84,916.00	NA	578,413.00		456,732.00	NA	170,511.00		
20) CRES delivery		1,037,200.00		116,000.00		102,000.00		240,000.00		42,000.00				1,949,200.00		159,000.00		176,000.00		428,000.00		99,000.00		
21) Cash against plan		65,511,853.00	NA	NA	NA	NA			NA	NA				65,511,853.00	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

Data Quality Scorecard 2019/20 - Appendix C

		Data Source					Data Reliability					KPI Construct/Definition					KPI Amended / Tested					Total Score	Total Score as %	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1			
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined	Tested within last 12 months and all associated risks identified on proforma have been accepted or mitigated	Tested within last 12 months and all associated risks identified on proforma	Tested within last 12 months	Tested between 12 and 24 months ago	Tested over 24 months ago			
1	Pergentage of patients who were seen within 4 weeks for a first appointment following an external	5					5					5					5					20	100%	
2	Percentage of patients starting treament within 6 weeks of external referral	5						4				5					5					19	95%	Some data quality issues have been reported in relation to the use of appropriate intervention/treatment codes. Guidance has been circulated to improve understanding and this under review in the report out process. Improvements are expected as awareness about appropriate codes included in this KPI improves
3	Total number of inappropriate OAP days over the reporting period (rolling 3 months)		4				5					5					5					19	95%	Data is extracted electronically, validated manually and reuploaded into the system. Work is underway to amend PARIS to enable this to be recrrded completely on the system, timescale to be confirmed
4	Percentage of patients surveyed reporting their overall experience as excellent or good.	5					5					5							3			18	90%	Data is collected via electronic devices for inpatient areas, on paper surveys for community teams as well as via kiosks in team bases where there are large footfalls. There is also a phone Application now where clinicians can send the survey to patients and carers phones via email or SMS. The Quality Data Team access the system to generate reports.
5	The percentage of Serious Incidents which are found to have a root cause or contributory finding				2		5					5					5					17	85%	Data is collated onto excel for manual process after retrieval from the Datalx system
6	The percentage of teams achieving the agreed improvement benchmarks for HoNOS total score		4				5					5					5					19	95%	
7	The percentage of teams achieving the agreed improvement benchmarks for SWEMWBS total score		4				5					5					5					19	95%	
8	Number of new unique patients referred	5					5					5					5					20	100%	
9	The number of new unique patients referred with an assessment completed	5					5					5					5					20	100%	
10	Number of new unique patients referred and taken on for treatment	5					5					5					5					20	100%	
11	Number unique patients referred who received treatment and were discharged	5					5					5					5					20	100%	
12	Bed Occupancy (AMH & MHSOP A&T wards)	5					5					5					5					20	100%	
13	Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards)	5					5					5							3			18	90%	
14	Percentage of patients readmitted to Assesement and treatment wards within 30 days	5					5					5							3			18	90%	
15	Vacancy rate (score from old KPI)				2			4				5					5					16	80%	Data extracted elecronically but processed manually
16	Percentage of staff in post more than 12 months with a current appraisal	5						4				5							3			17	85%	Issues with appraisal dates being entered to ESR have been reported. Compliance levels are effectively being monitored via monthly Huddle meetings and support is being provided where necessary to address ESR issues. A refresh of ESR guidance is being scheduled to improve accurate recording on the source system.
17	Percentage compliance with ALL mandatory and statutory training	5						4				5					5					19	95%	Issues with training compliance figures being reported have lessened - there appears to be greater confidence in the data being reported and this has been supported by scrutiny of issues in report out processes
18	Percentage Sickness Absence Rate (month behind)	5						4				5							3			17	85%	Sickness absence data for inpatient services is now being taken directly from the rostering system which should help to eliminate inaccuracies the remainder of the Trust continue to input directly into ESR. There are some data quality issues concerned with failing to end sickness in a timely manner– this is picked up and monitored through sickness absence audits that the Operational HR team undertake.
19	Delivery of our financial plan (I and E)		4				5					5					5					19	95%	Data is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
20	CRES Delivery				2		5					5					5					17	85%	Data is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
21	Cash against plan		4				5					5					5					19	95%	An extract is taken from the system then processed manually to obtain actual performance.

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th June 2019**
TITLE:	**Board Performance Evaluation Scheme 2018/19**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Assurance/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:

The annual performance assessment of the Board and its core Committees (known as the "Board Performance Evaluation Scheme") supports compliance with the Code of Governance.

The results of the Board Performance Evaluation Scheme for 2018/19 remain positive.

For the Board, the report highlights two areas for particular discussion:

(a) The level of direct interaction between the Board and service users and carers.

(b) The degree of focus on the quality of services (particularly patient safety) and patient outcomes delivered by the organisation.

The report also provides a summary of the results for the Board's core Committees (the Audit, Mental Health Legislation, Quality Assurance and Resources Committees) together with information on the key developments being taken forward from their results.

Recommendations:

The Board is asked to:

(a) Receive and note this report and the assurances it provides.

(b) Consider the findings of the evaluation of the Board's performance including those matters highlighted in paragraph 3.4.

MEETING OF:	**The Board of Directors**
DATE:	**25th June 2019**
TITLE:	**Board Performance Evaluation Scheme 2018/19**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to enable the Board to review the results of its assessment under the Board Performance Evaluation Scheme and to identify any areas for further development.

1.2 The report also provides a summary of the results for the Board's core Committees to provide assurance on their performance and information on the key developments being taken forward from their results.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Under the Code of Governance (Main Principle B.6.a) the Board should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.

2.2 The Trust's Board Performance Evaluation Scheme (BPES) was originally designed by Deloitte LLP and introduced in 2008. It is based on the completion of feedback questionnaires by Board Members and, as appropriate, other members of the Board's Committees.

2.3 This report is based on the feedback provided on the performance of the Board and its Committees only. Feedback received for individual Directors is used to inform their annual appraisals.

2.4 The performance assessments of the Board and its core Committees have been published on the Diligent systems and in a shared folder on the EMT drive.

3. KEY ISSUES:

The Board of Directors

3.1 A summary of the findings is provided in the following table compared to 2017/18:

	2018/19	2017/18
No. of Maximum Scores	15	14
Average Score	3.86	3.88
Average Scores by theme -		
▪ Board Focus	3.79	3.85
▪ Board Structure and Composition	3.88	3.86
▪ Board Relationships	3.98	3.99

▪ Board Learning and Development	3.73	3.86
Improved Scores	9 (25%)	
Reduced Scores	12 (33%)	
Equal Scores	15 (42%)	

3.3 It is considered that, overall, the results remain positive. There are some fluctuations in the scores (by question) but the majority of them are not material.

3.4 There are two areas, arising from the results, which the Board is invited to discuss:

(a) Q3 – The Board regularly hears about the needs and expectations of service users and their carers.

The score for this question has reduced from 3.29 (2017/18) to 3.14 (2018/19) and now represents the lowest score across all the criteria.

Board Members will recall that this issue was also raised in the Independent Governance Review, undertaken by Grant Thornton, in 2017.

From the comments received it is evident that the inclusion of the experts by experience in the business planning event in October 2018 was regarded as a welcome development; however, there appears to be a general desire for more direct interaction between Board Members and service users and carers.

(b) Q4 – The Board is primarily focussed on the quality of services (particularly patient safety) and patient outcomes delivered by the organisation

The reduction in the score for this question was the greatest at -0.31.

Two areas are highlighted in the comments:

- Disappointment at the rating for safety following the CQC's inspection in 2018.
- The position on the use of patient outcome measures.

(Board Members will recall a recent seminar on this matter which provided an update on the work being undertaken across all specialties)

3.5 The Board is asked to agree any developments to be taken forward from the assessment including in relation to those matters highlighted in paragraph 3.4 above.

The Committees

3.6 The performance of the Audit, Mental Health, Quality Assurance and Resources Committees is also evaluated under the BPES.

3.7 A summary of the findings, together with the developments being taken forward by the Committees, is provided in Annex 1 to this report.

3.8 Once again the results were positive and, as with the Board, many of the changes to the scores are not material. However, there has been a general improvement in those for the Resources Committee and MHLC.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The effectiveness of structures in supporting the delivery of the Trust's strategy and good quality, sustainable services falls within the CQC's well-led domain.

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

4.3 **Legal and Constitutional (including the NHS Constitution):** The Board, as far as reasonably practicable, is required by its Standing Orders to comply with the Code of Governance.

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 The BPES is a control in relation to BAF ref. 366 (Maintaining Effective Governance). The findings of the evaluation provide positive assurance on the operation of the Board and its core Committees.

6. CONCLUSIONS:

6.1 The Board and its core Committees continue to operate effectively; however, there is scope for further development in certain areas.

7. RECOMMENDATIONS:

7.1 The Board is asked to:

(a) Receive and note this report and the assurances it provides.

(b) Consider the findings of the evaluation of the Board's performance including those matters highlighted in paragraph 3.4.

Phil Bellas, Trust Secretary

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Annex 1

Board Performance Evaluation Scheme 2018/19

Board Committees

Summary of the Results and Agreed Developments

	Audit Committee		Resources Committee		Quality Assurance Committee		Mental Health Legislation Committee	
	Number	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
Questions achieving **maximum** scores	**34**	**72%**	**10**	**50%**	**21**	**75%**	**9**	**45%**
Average Score per question (max. 4.0) (2017/18 average score in brackets)	**3.91 (3.95)**		**3.89 (3.58)**		**3.95 (3.91)**		**3.86 (3.73)**	
Questions showing an **increase** in score on the previous year	**3**	**6%**	**10**	**50%**	**10**	**36%**	**11**	**55%**
Questions showing a **decrease** in score on the previous year	**9**	**19%**	**1**	**5%**	**3**	**11%**	**6**	**30%**
Questions showing **no change** on the previous year	**35**	**75%**	**9**	**45%**	**15**	**53%**	**3**	**15%**

Key issues and developments identified	The provision of training; an area where the score had reduced. It was suggested that the briefing sessions should be expanded and moved either to the end of meetings or to separate events.	Whether, given its broad remit, the Committee can give sufficient consideration to both workforce/HR issues and financial matters. The potential establishment of a Workforce Committee is being considered as part of the ongoing review of the Board's Committees	The effectiveness of communication between the QuAC and the LMGBs and the thematic groups In order to deliver a higher level of assurance, the Committee is continuing to work on: ▪ Disseminating the shared definition of "assurance" ▪ What assurance should look like in reports so that there are clear expectations for authors	Improvements to the induction scheme for the Committee recognising that progress on this matter will be linked to the overall induction and training needs of the Board of Directors *(Note: the Committee recognised that other areas with slightly worse scores, e.g. ensuring meetings are quorate, had already been addressed)*

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO.15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25 June 2019**
TITLE:	**Policies Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

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

Executive Summary:

The policy paper contains the following information:

- 2 policies have undergone full review and required ratification:
  - COP-0017-v2 Crisis Operational Policy
  - CORP-0047-v3 Trust Responses to Regulation 28 Reports from Coroners

- 3 policies that have undergone minor amendment:
  - CLIN-0014-v7.3 Rapid Tranquillisation Policy
  - CORP-0011-v6.1 Claims Management Policy
  - MHA-003-v9.1 Section 136 Policy

- 1 policy, 1 strategy and 1 plan that required an extension to the review date:
  - Cleaning Plan
  - Vaccination Strategy
  - CLIN-0035 Clinical Supervision Policy

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meetings held on 12 June 2019.

DATE:	**25 June 2019**
TITLE:	**Policies and Procedures Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

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

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

3. KEY ISSUES:

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

Ref and Title	COP-0017-v2 Crisis Operational Policy
Review date	12 June 2022
Reviewed by	Adele Coulthard
Approved by	Crisis Network – 02 April 2019 Acute Care Group – 11 April 2019 SDG – 16 May 2019
Description of change	The main amendments within the policy are the language used. The policy has been updated to reflect a more recovery focused approach, considering harm

	minimisation and modern approaches to crisis services in line with other Trust policies creating common language and based upon the CHIME principles. Feedback was obtained from a lived experience consultant and reflections made following this on the language, co-production and levels of harm and distress – challenging the culture and attitudes and terminology used. Care and intervention planning section reflects a more trauma informed and recovery agenda and co-production. Changes also made following RPIW work on quality standards in triage, assessment and intensive home treatment undertaken in 2017. Changes to the discharge section from inpatient wards – 72 hour follow up in line with the C-Quin target. Group names have been updated within the policy. Team/locality addendums were updated to reflect any changes in operational functioning. The amendments will now future proof the policy over the forthcoming year given the changes associated and expected from the Right Care, Right Place programme, associated work in trauma and recovery agendas, digital dictation and CITO. It provides an overall operating framework based on quality standards expected by the CRHT's which are recovery and service user focused, in line with core fidelity standards and supporting the national and Trust direction.

Ref and Title	CORP-0047-v3 Trust Responses to Regulation 28 Reports from Coroners
Review date	12 June 2022
Reviewed by	Patient Safety Group 20 May 2019
Approved by	Paul Foxton
Description of change	This procedure has undergone full revision in line with latest regulations.

3.2 The following have undergone minor amendment:

Ref and Title	CLIN-0014-v7.3 Rapid Tranquillisation Policy
Review date	07 September 2019
Reviewed by	Sarah Dexter-Smith
Approved by	Drugs and Therapeutics Committee 24 January 2019
Description of change	Some minor changes relating to the EWS and NEWS2 including prescriptive times around post rapid tranquillisation (RT) monitoring and a post RT form to be used within Paris case note to enable staff to capture all necessary information post-RT

Ref and Title	CORP-0011-v6.1 Claims Management Policy
Review date	08 August 2021
Approved by	N/A
Description of change	Section 12.0 Claims management process flowchart amended to change the notify timescale from 6 weeks to 6-8 weeks in line with audit recommendation.

Ref and Title	MHA-003-v9.1 Section 136 Policy
Review date	06 December 2020
Approved by	N/A
Description of change	Northallerton has been removed as a place of safety.

3.3 The following required an extension to the review date.

Ref and Title	Cleaning Plan
Review date	01 October 2019
Comments	This document is currently under review and an extension is required to enable this work to be completed.

Ref and Title	Vaccination Strategy
Review date	31 December 2019
Comments	This document is currently under review and an extension is required to enable this work to be completed.

Ref and Title	CLIN-0035 Clinical Supervision Policy
Review date	31 December 2019
Comments	A new lead has recently been identified for this policy. An extension is required to enable full review and revision.

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 12 June 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