AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 26TH NOVEMBER 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 ordinary meeting held on **29th October 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 receive a briefing on the key issues in Forensic Services.	**Lisa Taylor to attend**	**Presentation**
Item 9	To receive and note the report of the Guardian of Safe Working.	**Dr. Julian Whaley to attend**	**Attached**
Item 10	To receive and note the report of the Freedom to Speak Up Guardian.	**Dewi Williams to attend**	**Attached**
Item 11	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 12	To receive and note the monthly safe staffing report.	**EM**	**Attached**

Item 13	To receive and note a progress report on the recruitment and retention action plan. *(Note: A report was considered by the Resources Committee at its meeting held on 19th November 2019 and a verbal update on its discussions will be provided to the meeting).*	**DL**	**Attached**
Item 14	To consider feedback received from the CQC following its well-led inspection of the Trust.	**EM**	**Attached**
Item 15	To consider the report of the Mental Health Legislation Committee.	**PM/EM**	**Attached**
Item 16	To receive and note the Self-Assessment Report in relation to Multi-professional Education and Training.	**EM**	**Attached**

Performance (12.00 noon)

Item 17	To consider the Finance Report as at 31st October 2019.	**PMc**	**Attached**
Item 18	To consider the Trust Performance Dashboard as at 31st October 2019.	**SP**	**Attached**
Item 19	To consider the Strategic Direction Performance Report for Quarter 2, 2019/20.	**SP**	**Attached**

Items for Information (12.20 pm)

Item 20	To receive a report on the use of the Trust seal.	**CM**	**Attached**
Item 21	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 22 To note that a special meeting of the Board of Directors will be held, in conjunction with a seminar, at 9.30 am on **Tuesday 17th December 2019** in the Boardroom, West Park Hospital, Darlington.

Confidential Motion (12.25 pm)

Item 23 **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
20th November 2019

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 29TH OCTOBER 2019 IN THE HILTON YORK, 1 TOWER STREET, YORK 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
Prof. P. Hungin, Non-Executive Director
Mr. D. Jennings, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. B. Reilly, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mrs. R. Hill, Chief Operating Officer
Dr. A Khouja, Medical Director
Mrs. E. Moody, Director of Nursing and Governance and Deputy Chief Executive
Mr. D. Levy, Director of HR and Organisational Development
Mrs. S. Pickering, Director of Planning, Performance and Communications

In Attendance:
Mrs. C. Hodgson, Public Governor for York
Ms. H. Griffiths, Public Governor for Harrogate and Wetherby
Mr. P. Bellas, Trust Secretary
Mrs. S. Paxton, Head of Communications
Dr. E. Herring, Head of Adult Mental Health Services for North Yorkshire and York (minute 19/260 refers)
Mrs. W. Griffiths, Head of Financial Control (representing Mr. McGahon)
Mr. S. Sinclair, Liaison Workforce

19/253 APOLOGIES

Apologies for absence were received from Mr. P. McGahon (Director of Finance and Information).

19/254 MINUTES

Agreed *– that, subject to the replacement of "static" with "longitudinal" in minute 19/228, the minutes of the special meeting held on 17th September 2019 and the last ordinary meeting held on 24th September 2019 be approved as correct records and signed by the Chairman.*

19/255 MATTERS ARISING AND PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

Arising from the report:
(1) The suggestion, to include further analysis or benchmarking on the number of deaths over the last three years (minute 19/228 – 24/9/19 refers) as part of a

broader briefing to a seminar from the new Director of Public Health, was supported.

Board Members asked for the briefing to be given a high priority in the review of the seminar programme for 2020.

(2) The timescale for work on medical reviews for seclusion (minute 19/231 – 24/9/19 refers) was extended to January 2020 to allow for the completion of planned audits.

(3) It was agreed that the action arising from minute 19/233 (24/9/19) should be closed as the information on serious incidents, broken down by finding, had been included in the Learning from Deaths Report (see minute 19/265).

(4) Consideration was given to whether the action under minute 19/66 (23/3/19), in regard to a letter sent to the Department of Work and Pensions highlighting concerns about the impact of benefit cuts on some vulnerable service users, should be closed as it appeared unlikely that the Trust would receive a response.

The Chairman asked for the entry in the action log to be retained as a reminder to the Board.

19/256 DECLARATIONS OF INTEREST

There were no declarations of interest.

19/257 CHAIRMAN'S REPORT

The Chairman reported that:

(1) Her present round of meetings with BAME staff had been completed and a verbatim record of the discussions had been prepared.

Ms. Harte asked Board Members:

(a) To be aware of, and more attuned to, the issues raised in the discussions.

(b) To ensure that they engaged with BAME colleagues, who could feel isolated, during Directors' visits and reassure them that the Trust was aware of the issues they faced and was seeking to make improvements.

The Chairman, on behalf of the Board, emphasised that casual racism, bullying and harassment had no place in the organisation.

(2) Meetings were being arranged by the ICS for Non-Executive Directors.

It was noted that concerns had been raised about the lack of independent non-executive views in the governance structure of the ICS.

The Chairman asked the Non-Executive Directors to attend the events, if practicable, and advised that the issue would also be kept under review by the Trust Chairmen's group.

19/258 CHIEF EXECUTIVE'S REPORT

The Board received and noted the Chief Executive's Report.

In regard to the matters contained in the report Mr. Martin:

(1) Advised that, whilst it had been announced that NHS Tees Valley CCG and NHS County Durham CCG would be established on 1st April 2020, the discussions on the merger of the CCGs in North Yorkshire were continuing and no formal announcement had yet been made.

(2) Acknowledged the significant contribution made to the Trust by Prof. Joe Reilly who was stepping down from his role as the Clinical Director for Research and Development.

Prof. Hungin, who had been involved in undergraduate training, advised that the Trust had a fine reputation for research and development and recognised that this was of crucial importance to recruitment and retention.

(3) Highlighted that the Trust had been ranked fourth, and in the top five organisations for the third consecutive year, for medical education in the annual General Medical Council (GMC) trainee survey.

Mr. Martin considered that the findings of the survey were a testament to Dr. Khouja's leadership and the work undertaken across the Trust in this area.

(4) Reported the presentation of a prestigious Silver Chief Nursing Officer Award to Mr. John Savage, Head of Nursing in Durham and Darlington, at the Trust's Annual Nursing Conference held on the 3rd October 2019.

Mr. Martin considered the award to have been thoroughly deserved.

19/259 GOVERNOR ISSUES

The Chairman reported that:

(1) The discussions on information requirements and provision, at the Governor Development Day held on 8th October 2019, had been very useful.

(2) There were no issues raised by Governors, at this time, which needed to be brought to the Board's attention.

19/260 LOCALITY BRIEFING – NORTH YORKSHIRE AND YORK

Dr. Herring (Head of Adult Mental Health Services) gave a presentation on the key issues facing the North Yorkshire and York Locality.

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

Board Members:

(1) Recognised the challenges facing the Locality and congratulated the staff for the positive feedback received, to date, from the CQC following the recent inspection.

(2) Highlighted the number of key priorities for the Locality and sought clarity on how they would all be managed.

Dr. Herring, recognising the breadth of work to be undertaken, explained that some of the key priorities were specific to individual specialties whilst others were reliant on other providers; however, the overarching priority for the Locality was focussed on staff wellbeing. She considered that the position should become easier to manage over the next 12 months.

(3) Welcomed the work being undertaken on suicide prevention, as highlighted during the recent Trustwide report out, and asked for the learning arising from it not to be confined to the Locality as it would benefit the whole organisation.

Assurance was provided that the project would be sustained and that learning would be shared.

(4) Recognised the significant amount of work undertaken by the Trust's staff at the Friarage Hospital to deliver the Hambleton and Richmondshire transformation and the assistance this had provided in taking forward the Harrogate transformation.

(5) Observed that the investment attracted by the Locality tended to be fixed term and recognised the challenge of continuing to free up resources to ensure its benefits were sustained.

(6) Sought assurance that issues raised during the engagement on the transformation, in regard to the role of the local authority in the provision of housing, social care, etc., were being picked up and addressed.

Dr. Herring advised that:

(a) Initial discussions had been held but the implications of the issues raised during the engagement and their operational impact across partners had not yet been worked through.
(b) It was recognised that the Trust and the local authority needed to hold each other to account and addressing the matters could not wait until the position had stabilised.
(c) Some actions had been put in place, for example in regard to supported living, but it was difficult for the Trust to respond when the responsibilities lay with social care.

(7) Sought clarity on views of patients and carers on the services provided in the Locality.

Dr. Herring advised that:

(a) The quantum of feedback received, to date, was limited and did not provide a representative view.
(b) In the main, patients were generally positive about their experience of services.
(c) One key issue, arising from the staffing position in the Locality, was the challenge of providing continuity of care and it was recognised that work was required to stabilise the workforce.
(d) Overall, the Locality was seeking to listen to patients, address issues raised and provide feedback to them.

(8) Questioned whether there was any early learning to share from the CYPS Trailblazer.

It was noted that this approach had not yet commenced.

(9) Sought clarity on whether any additional support could be provided or other approaches taken to addressing the staffing challenges within the Locality.

Dr. Herring advised that:

(a) Additional dedicated support had been made available for recruitment and HR processes; however, the challenges of recruiting new staff remained.
(b) The experience in the Locality was that new roles added value and the highlighted the benefits of being creative in response to the issues faced.
(c) By December 2019, the organisational change within the Locality should have been completed and enable greater focus on attracting new staff.

19/261 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 5th September 2019 (Annex 1 to the report).
(2) The key issues considered by the Committee at its meeting held on 3rd October 2019.

Dr. Griffiths, the Chairman of the Committee, advised that:

(1) There were no matters arising from its meeting held on 3rd October 2019 to be brought to the Board's attention.
(2) The minutes of the special meeting held on 29th August 2019 had been agreed, in draft, and would be presented, for approval, to a confidential session of the Committee's next meeting and thence reported to the Board.

The Non-Executive Directors sought clarity on the reference in the report to a qualitative piece of work (now completed) being undertaken in regard to staff treating patients with respect and dignity in Forensic Services.

In response it was noted that:

(1) In general terms, the Locality did not achieve the scores on patient experience that were hoped for and work had been undertaken to encourage feedback so that issues could be tackled.

(2) The piece of work highlighted in the report referred to action taken to address concerns raised by two patients about how they were treated by staff.

19/262 NURSE STAFFING REPORT

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

Clarity was sought on the following matters:

(1) The additional management oversight and support which had been put in place at Cedar Ward, North Yorkshire.

Mrs. Hill advised that:

(a) Oversight and support, including role modelling, had been increased through the regular attendance of the Head of Nursing and the rostering of modern matrons and senior staff onto the ward.

(b) Whilst recognising that additional support was required, at present, the arrangements would need to be kept under review as they impacted on the capacity available from the modern matrons elsewhere.

(2) The use of the term "positive outliers" in reference to three wards in the section of the report on Care Hours per Patient Day (CHPPD).

Mrs. Moody explained that:

(a) The reference related to the wards having a higher ratio of registered nurses compared to other areas.

(b) As previously reported, establishment reviews were taking place. To date, data collection had been completed; a kaizen event had been held; and a scoring mechanism had been used to assess patient acuity and dependency to inform the next steps of the process.

(c) The CHPPD metric was based on activity against the planned roster, which was volatile, and the assessment of patient acuity and dependency had provided a deeper understanding of patient need.

(d) Plans were in place to mainstream the approach and, if the information could be captured on CITO, it would be included in future reports.

(3) In regard to agency usage, the statement, in Appendix 1 to the report, that "All shifts booked during this period have been booked below cap with zero breaches recorded."

The Board noted that the agency cap could be breached either by the use of off framework workers or in terms of price. The Trust had previously had issues with compliance but arrangements had been put in place requiring authorisation by the Director of Nursing and Governance or her deputy if there were risks that the cap would be breached. Whilst there had been no breaches of the cap for the period this did not mean that the overall financial limit for agency usage had not been exceeded.

(4) Whether there was evidence that the use of agency staff, compared to substantive staff, was detrimental to quality, performance, etc.

Mrs. Moody advised that:

(a) It was, generally, accepted that continuity of care provided higher levels of quality and safety but this was difficult to quantify.
(b) The Trust was seeking consistency in the use of individual agency staff so they were familiar with the wards on which they worked.
(c) There had also been issues with agency staff, for example, due to some of them not turning up for work.

It was also noted that:

(a) The use of agency staff impacted on substantive staff as they were required to provide them with training, support, etc.
(b) Agency usage had decreased by over 20% in September 2019 compared to the previous month.

(5) The bank usage rate of 72.1% on Eagle Ward, for September 2019, to provide an enhanced care package for a single patient.

It was noted that:

(a) The provision of the enhance care package had been agreed by the New Care Models Board.
(b) Discussions had been held on the use of temporary contracts, rather than bank usage, but the latter approach had been able to provide the consistency of care required.

Mrs. Pickering advised that the Partnership Board had received a report on the enhanced care package which had provided assurance on the positive progress of the patient under the arrangements.

(6) As the provision of safe staffing was a widespread concern within the NHS, whether action was being taken at a national/system level which might support the Trust.

Mrs. Moody considered that:

(a) Until recently there had appeared to be no cohesive national approach and changes (e.g. the apprenticeship levy and the removal of bursaries for nurse training) had not been in the Trust's interests; however, this was now starting to change.

(b) The Right Staffing Programme brought together all elements of, and provided control on, safe staffing and was focussed on the Trust growing its own workforce.
(c) The majority of agency usage was in North Yorkshire and arose from the isolated position of some services. The Trust was working with Coventry University and York University to increase the number of training places for healthcare professionals but this was likely to take two to three years before having an impact.

Mr. Martin added that:
(a) At a system level, the final version of the Interim People Plan was yet to be published and the Treasury Settlement was still in negotiation.
(b) Whilst action taken by the Trust (e.g. the work on transformation, the implementation of the recruitment and retention plan, and the expansion of training), had relieved pressure, it did not detract from the need to increase staff numbers.
(c) There needed to be a step change in training and, even with this, it would take time before there was a significant increase in the number of staff available.
(d) The development of different roles was also important but these would not replace the need for the traditional professions.

He considered that the Trust needed to focus on staff wellbeing; responding to particular pressures; and growing its own workforce. This would take sustained effort and would not provide a quick and easy solution.

(7) The overseas recruitment of nurses and HCAs and the level of retraining required for those staff.

In response it was noted that:
(a) Healthcare Assistants were not included on the Shortage Occupation List and would not, therefore, be eligible for recruitment from outside the European Economic Area.
(b) The Trust had previously examined the overseas recruitment of nurses but had concluded that the focus should be on growing its own staff and on recruitment and retention.
(c) Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) had sought to recruit nurses from overseas and, whilst this had achieved some success, it had required significant effort and there had been a low conversion rate.

It was considered that, given the difficulties experienced in securing new staff, the Trust should be reconfiguring its services to consolidate requirements within inpatient settings.

It was noted that this approach was being taken forward through the transformation work undertaken in North Yorkshire but these approaches needed to take into account the increase in staffing required within community teams.

The Non-Executive Directors considered that:

(a) Although overseas recruitment had been discussed previously it should continue to be kept in mind.

(b) With the emphasis on safe staffing, and there being limits on attracting replacements, it was crucial for the Trust to retain existing staff.

In addition, the Non-Executive Directors considered that when risks were highlighted, (for example the incidents involving the Easington Affective Disorders Team which cited staffing levels) there was a need for assurance that they arose from a blip, rather than underlying issues, and that mitigation plans had been put in place.

It was noted that the Heads of Nursing received all incident reports and were expected to discuss the findings within the management structure and with the LMGB.

Although Mrs. Moody offered to include further information in reports where specific issues arose, the Non-Executive Directors were assured that a process was in place.

19/263 CQC INSPECTION – INITIAL FEEDBACK

The Board received and noted a report on initial feedback received from the CQC from its responsive inspection of a range of core services across the Trust during the weeks commencing 23rd and 30th September 2019.

Letters from the CQC, which confirmed verbal feedback received during the inspection, were provided as Appendix 1 to the report.

It was noted that the regulator had raised no immediate safety concerns.

Board Members considered that the feedback provided by the CQC was, generally, positive and the issues identified in its letters were known about and being addressed.

The following areas were highlighted in the discussions:

(1) The improvement to the personalisation of care plans in many areas.

(2) The absence of references to restrictive practices particularly in the context of the inspection being a responsive review and brought forward due to the events at West Lane Hospital.

(3) The references to positive feedback from carers and the support and clear information provided to them which indicated that the work undertaken was starting to be effective.

However, it was recognised that the letters did not replace the formal reports produced by the CQC and there were risks about how the issues identified by the regulator would be reflected in the final ratings.

Clarity was sought on the following matters:

(1) The lack of a formal local protocol to manage vistamatic blinds at The Orchards, Ripon.

It was noted that, from a privacy and dignity perspective, the Trust had a protocol that vistamatic blinds should be closed when a patient was in their bedroom and the comment in the report probably referred to the blinds being open during the visit.

(2) The reference to there being no evidence of quarterly legionella monitoring, from January 2019, although monthly and annual checks had been carried out.

Mrs. Moody advised that the issue had been discussed with the Infection Prevention and Control Committee (which included the water safety group) and assurance had been provided that there were no benefits from undertaking quarterly checks when monthly and annual checks were carried out.

It was noted that this issue would be raised with the CQC, as a matter of factual accuracy, if it was referenced in the draft report.

(3) The reference to the discharge plan for one patient at Oakwood referring to "waiting for the law to change".

It was noted that:

(a) The statement was probably correct as the judgment in the case, Secretary of State for Justice v MM, had created barriers, in certain circumstances, to the discharge of patients from secure services.

(b) It was likely that the issue had been part of a verbal response from a member of staff in the unit and not included, as indicated, in the patient's discharge plan.

19/264 OUTCOME MEASURES

Further to discussions at the seminar held on 14th May 2019, the Board received and noted a progress report on the work of the Clinical Outcomes Group.

Board Members welcomed the one-page summary provided on the final page of the report, which enabled the impact of outcome measures to be understood by teams and individuals in a visual way, and asked Dr. Khouja to feedback their views to the staff who had created the document.

Action: Dr. Khouja

The Chairman highlighted that, in a briefing provided to her by Dr. Briel, the document had been accompanied by quotes from patients which were very powerful.

Dr. Khouja responded that there was a significant amount of detail behind the report and he had tried to condense the salient points.

The Non-Executive Directors also commended the language used in the report which had made very technical issues interesting and understandable.

In addition, in response to questions, Dr. Khouja advised that:

(1) The timescale for full implementation had been revised to be more realistic but the Board would be informed if issues arose.

(2) The membership of the Clinical Outcomes Group included a representative from the IT Department.

(3) It was intended that the work on outcome measures would enable comparisons between teams. Whilst it would also be possible to use them to make comparisons between individual clinicians, this was not being progressed due to the complexities which arose from multi-disciplinary working and as it would be detrimental to gaining buy-in from staff.

(4) As recognised in step 3 (Communications strategy) of the "Step to step guide on embedding clinical outcomes" (Appendix 3 to the report) outcome measures needed to be integrated into clinical practice as, if perceived as an add-on, they would be regarded as a bureaucratic burden.

19/265 LEARNING FROM DEATHS REPORT

The Board received and noted the Learning from Deaths report which set out the approach taken by the Trust toward the identification, categorisation and investigation of deaths in line with national guidance.

The mortality dashboard for Quarters 1 and 2, 2019/20, was attached as Appendix 1 to the report and included 2018/19 data for comparison.

Arising from the report:

(1) The changes to the process for mortality reviews, including the "red flag" categories of deaths, were welcomed.

(2) The Chairman highlighted that the 62 serious incident reviews completed during the period demonstrated that the Trust had a higher rate of reporting than many other Trusts.

(3) In response to questions from the Non-Executive Directors:

  (a) Mrs. Moody advised that the learning points from structured judgement reviews (as appended to the report) reflected incidental findings arising from mortality reviews of patients who had died from natural causes.

  (b) Dr. Khouja provided assurance that the introduction of CITO would prevent the Safety Summary being overwritten and, thereby, address the issues about the document not being updated or accessible as identified as learning points from Structured Judgement Reviews.

  (c) It was noted that information, on the root causes and contributory findings arising from serious incident investigations, was provided in the six monthly learning from deaths reports. All root causes and contributory findings were addressed through action plans which were collated and monitored by the patient safety team. Although the findings would vary by incident, the focus was on preventing the recurrence of those of greater impact.

  (d) Dr. Khouja advised that the Trust undertook a tiered approach to reviewing deaths from natural causes with, if concerns arose from a local review, a structured judgement review of the case notes being undertaken.

(e) It was noted that Margaret Kitching, the Chief Nurse for the North East and Yorkshire, was undertaking work on benchmarking and the CQC, as part of the well-led review, had undertaken an audit of deaths.

19/266 GENDER PAY GAP REPORT

The Board received and noted a report on the latest position on the gender pay gap as part of arrangements to support compliance with the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

Information on the Trust's gender pay gap, which it was intended to publish by no later than 30th March 2020, was attached as Appendix A to the report. This showed that the 2019 TEWV mean and median gender pay gaps had fallen by 10% and 0.1%, respectively, compared to 2018.

Board Members raised the following matters:

(1) Whether the reduction in the appointment of internal candidates, at band 8b and above and for medical vacancies, from 89% in 2018, to 60%, reflected that staff in the Trust were no longer seeking or ready for promotion.

Mr. Levy responded that the number of internal staff considered to be "above the line" during recruitment exercises had not decreased; however he undertook to look into this matter further.

Action: Mr. Levy

(2) How the gender pay gap in the Trust compared to those of other organisations.

It was noted that the majority of organisations had not yet published their gender pay gap reports (the requirement being to do so before 31st March 2020) but based on information available from the Office of National Statistics, the Trust's gender pay gap was less than other organisations and average for NHS organisations in the North East region.

Mr. Hawthorn, the Chairman of the Resources Committee, requested that the report to be presented to the Committee in January 2020 (as recommended) should include a further analysis of the statistics and details of the actions planned by the Trust to close the pay gap.

Agreed -

(1) that the gender pay gap information (as set out in Appendix A to the report) be approved for publication by 31st October 2019; and

(2) that the Resources Committee be asked to consider additional information about the reason(s) for the scale of the gender pay gap, and potential actions to close the pay gap, at its meeting held in January 2020.

Action: Mr. Levy

19/267 ANNUAL REPORT ON MEDICAL EDUCATION

The Board received and noted the Annual Report on Medical Education 2018/19.

Dr. Khouja recorded his personal appreciation to Dr. Jim Boylan, the previous Director of Medical Education, for his work and advised that Dr. Hany El Sayeh had been recently appointed as his successor.

Board Members welcomed the position described in the report.

Clarity was sought on the table included in the report entitled "HEE North East & North Cumbria Current View of Tees Esk & Wear Valleys NHS FT" as a significant number of the factors were rated as zero.

Dr. Khouja explained that Health Education England used a scale of 0 to 5 with 0 being excellent.

Board Members also sought assurance on the work being undertaken to futureproof the Trust's positon as the report highlighted: that the number of medical students on placement was expected to increase significantly by 2022; that the trainer feedback indicated increased operational pressure on doctors; and that neighbouring Trusts had established education centres with better resources than those provided in TEWV.

Dr. Khouja reassured the Board that considerable thought was being given to these matters and advised that:

(1) The Trust could not provide the number of placements sought by the medical schools and, whilst work was being undertaken with them to seek to increase availablity, it did not wish to see the quality of medical education diminished.
(2) Work was being undertaken with the Estates Department to ensure good facilities were available to junior doctors and medical students.
(3) It was recognised that time spent on operational service delivery by consultants was restricting their capacity to support medical education but the introduction of electronic job plans should provide greater visibility on this matter.

19/268 MENTAL HEALTH LEGISLATION COMMITTEE

Mr. Murphy, the Chairman of the Mental Health Legislation Committee, advised that:

(1) There were no matters of urgency arising from its meeting held on 23rd October 2019 to bring to the Board's attention.
(2) Overall, the direction of travel on the metrics reviewed by the Committee was positive.
(3) During Quarter 2, 2019/20, no discharges had been agreed by panels against the recommendations of the clinical team.

    It was highlighted that this could suggest that the panels were being too amenable to the views of clinicians.

    Mr. Murphy responded that a second metric showed that only 3, of 117 patients, had been discharged by First Tier Tribunals during the Quarter and this provided

assurance that the Associate Hospital Managers were undertaking their role appropriately.

19/269 SUMMARY FINANCE REPORT AS AT 30TH SEPTEMBER 2019

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

The Non-Executive Directors sought clarity on:

(1) Whether an estimate of the impact of the position at West Lane Hospital had been included in the forecast outturn.

Mrs. Griffiths advised that:

(a) The financial position to the end of September 2019 included £200k (nett) for the costs of services provided to patients from West Lane in other care settings and reflected savings on staffing costs.

(b) Further clarity on the impact on the Trust's "bottom line" would be available by the end of November 2019 but, at present, the position appeared to be manageable.

(2) The position on the delivery of CRES as the table in the Executive Summary showed that all types of schemes were rated "red" with downward movements.

In response it was noted that:

(a) Although there had been delays on some schemes which had impacted, marginally, on the overall position, there was confidence that the annual target would be delivered.

(b) Plans were in place to deliver 75% of the 2020/21 CRES target which was an improvement on the position, at this stage, on previous years.

19/270 PERFORMANCE DASHBOARD AS AT 30TH SEPTEMBER 2019

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

The focus of discussions was on the position against the metric "IAPT- proportion of people completing treatment who move to recovery", as included in the NHS Oversight Framework, where the 50% target had not been achieved in September 2019 or for Quarter 2, 2019/20, as a whole.

It was noted that the main area of concern was in relation to the County Durham and Darlington Locality.

The Non-Executive Directors, noting that the national intensive support team (during its visit to the Trust approximately 18 months ago) had highlighted issues about staffing levels and morale, questioned whether the Board should be concerned about the position or whether it required further investigation.

Mrs. Pickering responded that:

(1) The position had changed over the last 18 months and a new service manager and clinical lead had been appointed to the team.

(2) To an extent the problems being experienced arose from: uncertainty about the future provision of the service; the extension of the service model, to include counsellors, to create a more primary care/IAPT service; and delays in introducing the model which had impacted on staffing and training.

(3) Performance against the indicator was kept under review through the monthly EMT performance huddles and, in view of the present position, the metric had also now been included in the weekly performance report outs.

In addition, in response to a question, it was noted that KPI 3 (The total number of inappropriate OAP days over the reporting period) related only AMH and MHSOP placements outside of the patient's own locality. Assurance was provided that there were no admissions for those services outside the Trust's area.

19/271 NHS OVERSIGHT FRAMEWORK

The Board received and noted the report on the Trust's position against the NHS Oversight Framework for Quarter 2, 2019/20.

19/272 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.

19/273 DATE OF NEXT MEETING

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

19/274 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).

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

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

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

The transaction of the confidential business the meeting concluded at 2.00 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

North Yorkshire & York

Naomi Lonergan
Director of Operations

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Locality Context

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- New senior leadership team and new locality – merger of NY and Y
- Positive outcomes from H&R Transformation
- Harrogate and York Transformation engagement programme concluded – next steps
- Developing partnership with NY CCG and case management approach
- Positive progress with Rehab and Recovery, York
- Planned changes to CCG and STP structures

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Recent Successes

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Core 24 Harrogate – moving to 24/7 provision
- Trailblazer CYPS -successful Mental Health in Schools Teams for 2 pilot sites in Scarborough and Selby
- IAPT, EIP, Crisis and IPS support investment
- Trailblazer for enhanced LD community infrastructure to pilot enhanced community team working across York and Harrogate localities
- Additional investment from York CCG into Memory Services and work with South Ryedale PCN
- NY and Y Suicide Prevention Work
- LD Shadow Quality Group has been successfully extended to include York service users. They are completing an audit of all services this year.

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Recent Successes

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Merger of Meadowfields, MHSOP
- Development of Estates Plan including Foss Park Hospital, York; Kings Park, Northallerton and Bacchus House, York
- Positive CQC feedback re compassionate and caring staff
- AIMS Accreditation for Rowan Lea, Scarborough
- "Think Ahead" (3rd Cohort complete) and Nurse Development programme
- Collaborative working between Adult Mental Health an Learning disabilities has seen an increase in successful greenlight admissions

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Key Challenges

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Demand and pace across all specialties
- ADHD Service in Scarborough – exciting opportunity but challenging, given the size of the legacy caseload and medical recruitment issues
- Staffing – high use of agency, recruitment, retention and wellbeing 'hotspots'
- Medical recruitment and use of locums

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Key Challenges

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Embedding new processes, teams and structures across NY and Y
- Safety for patients – CQC areas for improvement, ongoing focus on personalisation, embedding assurance as custom and practice, MHA and MCA compliance
- Impact of Social Care Pathway with NYCC
- Managing impact of Transformation in Harrogate
- Compliance with quality and performance indicators

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Key Priorities

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Focus on staff health and wellbeing
- Focus on recruitment and retention
- Leadership team development
- Improved patient experience and clinical outcomes
- Programme of quality improvement to support staff wellbeing, patient experience and outcomes
- Build on suicide prevention work across NY and Y

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Key Priorities

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Partnership with NY and Y CCG's including case management work
- Partnership with NYCC and CYC including delayed discharges improvement, supported accommodation and older peoples care
- Expansion of CYPS including Enhanced Eating Disorders Team, potentially using funding from V of Y CCG and New Models of Care and Crisis service to 24/7
- 'Right Care Right Place' – a co-produced vision for AMH and MHSOP

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Questions

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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ITEM NO. 3

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th November 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
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
25/06/2019	19/165	The opportunities for Board Members to engage with service users and carers to be mapped	CM	Nov-19	
18/07/2019	19/185	Discussions on AHPs and their future role in delivering care to be included in a future nurse staffing report or as part of an update on the Right Staffing Programme to a Board Seminar	EM	Jan-20 (six monthly Nurse Staffing Report)	
17/09/2019	19/208	Update reports on the Recruitment and Retention Action Plan (following review by the Resources Committee) and Agency Usage to be provided to the Board	DL	Nov-19 & Dec 19	See agenda item 13
24/09/2019	19/224	A detailed report on how local policy compares to the national guidance on learning lessons to improve people practices and next steps to be presented to the Resources Committee.	DL	Jan-20	
24/09/2019	19/236	The proposed list of topics for Board seminars to be held in 2020 to be reviewed and prioritised	Chairman/PB	Nov-19	Completed
29/10/2019	19/264	The positive comments from Board Members on the one-page summary on outcome measures to be fed back to the staff who prepared it	AK	-	Completed

	Minute No.	Action	Owner(s)	Timescale	Status
29/10/2019	19/266	The issue of whether the number of internal staff, considered to be "above the line" during recruitment exercises, has decreased is to be looked into	DL	Jan-20	
29/10/2019	19/266	To note that the gender pay gap information (as set out in Appendix A to the report) was approved for publication by 31st October 2019	DL	-	To note
29/10/2019	19/266	The report on the gender pay gap, to be presented to the Resources Committee, to include a futher analysis of the statistics and details of actions planned by the Trust to close it	DL	Jan-20	

ITEM NO 6

PUBLIC

BOARD OF DIRECTORS

DATE:	**Tuesday 26 November 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 26 November 2019**
TITLE:	**Chief Executive's Report**

1. Staff Survey

The 2019 NHS Staff Survey has been launched. At the time of writing, 37% of the workforce (2,484 eligible staff) have completed their staff survey and we continue to encourage everyone to take an opportunity to feedback on their experiences of working at the Trust. The survey will close at the 28 November 2019. The final response for the 2018 staff survey was 30%.

2. Clinical Commissioning Groups Merger

It has been recently announced that with effect from 1 April 2020 a single North Yorkshire CCG will be created. It will replace Hambleton, Richmondshire and Whitby CCG; Harrogate and Rural District CCG and Scarborough and Ryedale CCG. Amanda Bloor who is currently the Accountable Officer for the existing CCGs will assume this role in the new CCG.

3. National Review into the Quality of Children's Inpatient Services

NHS England has set up an independent Panel to review the quality of inpatient mental health, learning disabilities and autism services for children and young people, amid growing safety concerns nationally. John Lawlor, Chief Executive of CNTW has been invited to Chair the Panel which will be given the task of proposing rapid improvements in existing services, examining approaches to complex issues such as inappropriate care, out of area placements, length of stays and oversee the development of genuine alternatives to care, closer to home.

4. CQC State of Health and Adult Social Care in England 2018/19 Report

The Care Quality Commission has published its Annual Report on the NHS and Social Care, looking at trends in quality, sharing examples of good practice and highlighting key areas for improvement. The Report highlights that overall quality of care has improved slightly from last year. When people receive care it is mostly good quality but people often struggle to get access to the care they need when they need it, impacting on their experience of care provided.

It was noted that emergency attendance and admissions continues to rise year on year impacting on access to non-urgent services and access and staffing are presenting challenges across all settings with particular problems experienced in some areas of the country.

There is a particular focus on mental health and learning disability services. The CQC note that while the overall picture remains relatively stable there has been a deterioration across specialist inpatient services. The report also notes that too many people with mental health or learning disability needs are supported by staff

without the necessary skills, training, experience or support. In particular the CQC notes that this reflects the national shortage of nurses in these areas. Concerns are raised about the sustainability of adult social care services with providers continuing to exit the market.

The report calls for actions in the following areas: more and better services in the community; innovation in technology; workforce and models of care; system-wide action on workforce planning; and long term sustainable funding for adult social care. The report can be found on the CQC website.

5. Digital Transformation Strategy

The Trust's current Strategy has already improved our digital services and 2020 will see the rollout of our new electronic patient record (Cito) that has been designed by our clinicians, but this is only the beginning.

The Trust's current Digital Transformation Strategy needs to be refreshed to provide a clear the direction of travel for the period until March 2024. The use of technology and associated services is a key component in the effective and safe delivery of high quality care, the use of which will increase substantially over the years ahead. The NHS has ambitions to be "the most advanced health and care system in the world, and to become the global leader in healthtech", with the Trust aiming to be recognised as a centre of excellence in this field.

Timing of this refreshed Strategy aligns with the business planning process, and will help inform and influence the 2020 workshops. Collaborative working with the planning team will ensure that key agendas align such as; Right Care/Right Place and interoperability challenges. During the live span of this Strategy new technology will emerge and new opportunities will be presented to improve patient safety and experience and it is important that the Strategy outlines how we will make best use of emerging technology.

6. New Clinical Director for Health and Justice

Claire Bainbridge, Health & Justice Locality Lead for Psychology has recently been appointed as the new Clinical Director for Health and Justice, succeeding Dr Steve Barlow.

7. External Recognition Awards

Royal College of Psychiatrists Awards 2019

I am delighted to inform you that the Trust won three Awards this year:

- John Venable as Service User/Patient Contributor of the Year;
- North Tees Adult Learning Disability Team from Wessex House in Stockton as Team of the Year in the Intellectual Disability team category;

- Jim Boylan as Psychiatric Educator of the Year.

Nursing Times Award

Well done to the Cleveland Liaison and Diversion team who won the Mental Health Nursing Award category at the Nursing Times Awards 2019. The team, based at Cleveland Police's Middlehaven station, offers assessment and advice to people who come into contact with the criminal justice system as suspects, defendants or offenders and who have mental ill health, learning disabilities or other vulnerabilities.

Colin Martin
Chief Executive

ITEM NO. 9

Trust Board of Directors

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

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

Executive Summary:

It is the responsibility of the Guardian of Safe Working to provide a quarterly report to the Trust Board for assurance that Junior Doctors are safely rostered and working hours that are safe and in compliance with Terms and Conditions of Service.
The 2016 Junior Doctor Contract was implemented for psychiatry trainees starting new contracts in February 2017. 2018 Revisions were agreed in August 2019 for staggered implementation up to August 2020. Mandated monitoring processes for this quarter have not identified any breaches to terms and conditions of service requiring the levy of a fine.
The Trust Exception Reports reflect variation in work on non-resident rotas, some late finishes & missed educational opportunities. Processes are in place for ongoing scrutiny and review of work schedules to provide assurance of safe working environments and consideration of training and service needs. Further work is underway to provide assurance around 2018 revisions; fines are expected from December in relation to non-resident on-call work. Junior Doctor engagement in processes has remained high.

Recommendations:

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

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

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours and during negotiation, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS doctors in training to oversee the process of ensuring doctors are properly paid for all their work and ensure they are not working unsafe hours. It is a requirement that all doctors on the contract have an individualised schedule of work for each placement, variation from which requires them to place an exception report, based on hours of work and/or educational experience.
The Guardian role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The guardian is required to levy a fine against a department(s) if a doctor works on average over 48 hours/week, works over 72 hours in 7 days or misses more than 25% of required rest breaks. Further contract negotiations have led to 2018 revisions, many of which we are already fulfilling as an organisation but a few require further consideration. The work of the guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by Health Education England.

3. KEY ISSUES:

- A detailed breakdown of Junior Doctor numbers, status, exception reporting and locum usage is contained in Appendices 1&2 with a short narrative explaining the data from the relevant medical staffing officer for each area. The relevant appendix is shared with the corresponding Health Education England body.
- I am satisfied that all exception reports submitted by doctors on the new contract have been actioned within specified timeframes. The medical staffing department have supported doctors' supervisors to action these appropriately and maintain a log that enables trends to be spotted and reports submitted to locality forums. The newly introduced on-call log forms allow for further scrutiny of out of hours working to ensure appropriate schedules of employment.
- The majority of exception reports have been placed for additional hours of work but a significant number (especially in Harrogate) have been for long days and we welcome some for missed educational opportunity. I am satisfied that doctors are paid or given time off for work undertaken. There has been no justification to levy a fine on any department within the organisation.

- A meeting has been held with our Estates department to ensure relevant national documents pertaining to junior doctors are incorporated in future plans of work.
- Further to concerns relating to lone working procedures not being followed, a pilot is planned to supplement the Scarborough policy with 'SkyGuard' from February with a view to full roll-out if successful.
- 'Rostering, Facilities & Fatigue' meetings continue to be held and consideration is being given to becoming a sub-group of the Health & Wellbeing trustwide group. Furthermore, the wellbeing of the transcient medical workforce is being considered within an extended remit of the Guardian of Safe Working.
- The Harrogate & Northallerton Hybrid Resident system has been subject to further review to ensure the right balance between safety, service delivery and educational experience.
- Switchboard concerns led to a meeting identifying that whilst a tracking system is in place, there is no switchboard or recording system and I would therefore ask the Board to consider whether this is sufficient for an organisation of this size?
- An Acting Champion of Flexible Working is in place pending a more formal recruitment process in line with contract revisions.
- Most of the 2018 contract revisions are already incorporated in our current working practices. Consideration will need to be given to ensuring where possible, the maximum number of consecutive shifts is reduced from 8 to 7 and that junior doctors work no more than 1 in 3 weekends. In the exceptional circumstances where these changes cannot be met, a process for agreement and review requires cementing. This will be pertinent to the Scarborough rota.
- It is likely that from December the Guardian will be fining departments for non-adherence to the 5 hours continuous rest rule during antisocial hours on the non-resident rotas. This will be especially pertinent to the North Durham rota.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

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

4.2 Financial/Value for Money:

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

4.3 Legal and Constitutional (including the NHS Constitution):

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

4.4 Equality and Diversity:

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

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

5. RISKS:

Failure to anticipate scenarios following service change may lead to a Junior Doctor being placed in an unsafe situation.
The high levels of exception reporting have been reported in the medical press and without adequate understanding of our processes may lead to reputational risk.
2018 revisions will for the first time make it likely that fines will be imposed.
Junior Doctor Locality Forums are running in each area, including operational and educational leaders as well as the guardian, in order to find systemic solutions. These inform the quarterly Junior Doctor forum, chaired by the Guardian who also attends LNC, MEQAS & Medical Directorate meetings. These systems should provide assurance of interventions to mitigate some of the potential risks highlighted.

6. CONCLUSIONS:

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

7. RECOMMENDATIONS:

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

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

Background Papers:

Appendices 1 & 2: detailed information on numbers, exception reports and locum usage.

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

High level data

Number of doctors / dentists in training (total):	83
Number of doctors / dentists in training on 2016 TCS (total):	82
Number of clinical supervisors	71
Amount of time available in job plan for guardian to do the role:	1.5 PA
Admin support provided to the guardian (if any):	4 days per quarter
Amount of job-planned time for educational supervisors:	0.125 PA per trainee

Exception reports (with regard to working hours) from 1st July 2019 up to 30th September 2019

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	0	0	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	0	0	0
F2 - Teesside & Forensic Services Juniors	0	11	11	0
F2 –North Durham	0	2	2	0
F2 – South Durham	0	0	0	0
CT1-2 Teesside & Forensic Services Juniors	0	13	13	0
CT1-2 –North Durham	0	10	10	0
CT1-2 – South Durham	0	0	0	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	16	16	0
CT3 – North Durham	0	3	3	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	3	3	0
Trust Doctors - North Durham	0	2	2	0
Trust Doctors - South Durham	0	0	0	0
Trust Doctors - Teesside	0	1	1	0
Total	**0**	**61**	**61**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	28	28	0
Teesside & Forensic Senior Registrars	0	13	13	0
North Durham Juniors	0	17	17	0
South Durham Juniors	0	0	0	0
South Durham Senior Registrars	0	1	1	0
North Durham Senior Registrars	0	2	2	0
Total	**0**	**61**	**61**	**0**

Hours monitoring exercises (for doctors on 2002 TCS only)					
Locality	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**
Teesside & Forensic Juniors	Not applicable as all junior doctors are on the new contract				
Teesside & Forensic Senior Registrars	ST6	34	34	FC(F8)	Yes
Teesside CAMHS	Not applicable as all Senior Registrars are on the new contract				
Durham & Darlington CAMHS	Not applicable as all Senior Registrars are on the new contract				
South Durham Juniors	Not applicable as all junior doctors are on the new contract				
South Durham Senior Registrars	Not applicable as all Senior Registrars are on the new contract				
North Durham Juniors	Not applicable as all junior doctors are on the new contract				
North Durham Senior Registrars	Not applicable as all Senior Registrars are on the new contract				

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
Teesside & Forensic Services	F2	New	Unknown	34	4	0	34	2
	CT3	New	Unknown		2			
	TD	New	Unknown		5			
	F2	New	Unknown		1			
	TD	New	Unknown		1			
	GP	New	Unknown		2			
	CT2	New	Unknown		2			
	CT1	New	Unknown		9			
	SAS		Unknown		4			
	Ct1	New	Unknown		4			
North Durham	CT1	New	Unknown	4	3	0	4	0
	CT3	New	Unknown		1			
South Durham	SAS	N/A	Unknown	17	6	0	17	0
	SAS	N/A	Unknown		1			
	SAS	N/A	Unknown		2			
	CT1	New	Unknown		1			
	Trust Doctor	N/A	Unknown		1			
	SAS	N/A	Unknown		2			
	MTI	N/A	Unknown		2			
	F2	New	Unknown		1			
	Trust Doctor	N/A	Unknown		1			
Total				**55**	**55**	Unknown	**55**	**0**

Narrative around Exception Reporting

Durham & Darlington

There were 20 exception reports received from the Durham and Darlington locality during the reporting period and that includes data from 5 rotas (South Durham junior doctors, North Durham junior doctors, South Durham Senior Registrars, North Durham Senior Registrars and D&D CAMHS Senior Registrars).

The exception reports were from the North Durham junior doctor rota and North and South Durham Senior Registrar rota's.

18 were in relation to claiming additional plain and enhanced time worked over the 8 week NROC period whereas 2 reports were for claiming TOIL. Locum cover was needed due to 2 Trust Doctors leaving earlier than expected, a Doctor who was advised to come off the on call rota and a Doctor who had restricted working hours.

Teesside & Forensics

There were 28 exception reports by junior doctors. Seven of these were educational reported by the same F2 for not being able to attend teaching programmes. DME was made aware and supervisor was informed. Six reports were also made to claim shadowing (ADME arranged for new doctors to shadow a 4 hour resident shift if they wanted). The rest were for work done above the work schedule.

There was a high number of locum shifts due to 2 vacancies and 1 long term sick. Since the August changeover, there is a new member of staff on long term sick. The NROC monitoring period ended mid-September, therefore there may be more exceptions to come in for mid to end September.

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

High level data

Number of doctors / dentists in training (total):	65
Number of doctors / dentists in training on 2016 TCS (total):	63
Number of clinical supervisors	47
Amount of time available in job plan for guardian to do the role:	1.5 PA
Admin support provided to the guardian (if any):	4 days per quarter
Amount of job-planned time for educational supervisors:	0.125 PA per trainee

Exception reports (with regard to working hours) from 1st July 2019 up to 30th September 2019

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F1 - Scarborough	0	0	0	0
F1 - York	0	0	0	0
F2 - Northallerton	No F2 Doctors in North Yorkshire			
F2 - Harrogate				
F2 - Scarborough				
F2 - York	0	1	1	0
CT1-2 - Northallerton	0	0	0	0
CT1-2 - Harrogate	0	0	0	0
CT1-2 - Scarborough	0	7	7	0
CT1-2 - York	0	1	1	0
CT3/ST4-6 – Northallerton	0	0	0	0
CT3/ST4-6 – Harrogate	0	0	0	0
CT3/ST4-6 – Scarborough	0	0	0	0
CT3/ST4-6 – York	0	5	5	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	13	13	0
Trust Doctors - Scarborough	0	9	8	1
Trust Doctors - York	0	1	1	0
Total	**0**	**37**	**36**	**1**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton	0	0	0	0
Harrogate	0	13	13	0
Scarborough	0	16	15	1
York	0	8	8	0
Total	**0**	**37**	**36**	**1**

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
Harrogate & Northallerton	CT1	New	No	30	30	0	30	1
	CT2	New	Unknown					
	CT2	New	Yes					
	CT2	New	No					
	CT3	New	Unknown					
	TD	New	Unknown					
	TD	New	No					
	TD	New	Yes					
	TD	New	No					
	SD	N/A	Unknown					
	SD	N/A	No					
	SD	N/A	Unknown					
Scarborough	CT1	New	Unknown	10	10	0	10	0
	CT2	New	Yes					
	CT3	New	Unknown					
	TD	New	No					
	TD	New	Yes					
	SD	NA	Unknown					
York & Selby	CT3	New	No	13	13	0	13	0
	CT3	New	Unknown					
	ST4	New	Unknown					
	ST6	New	No					
	SD	N/A	Unknown					
	SD	N/A	Unknown					
Total				**53**	**53**	**0**	**53**	**1**

Narrative around Exception Reporting

York & Selby

The main reasons for locum usage in York have been to cover short term sickness and gaps created as a result of LTFT trainees.

The majority of exception reports submitted for the York locality are senior registrars claiming payment for hours worked above the work schedule.

Scarborough

Since August the main reason for locum usage in Scarborough has been due to 2 WTE WAST Doctors not starting on calls from the outset.

The majority of exception reports raised from doctors in Scarborough are submitted to claim payment for additional hours following the completion of the NROC monitoring form, or to claim compensatory rest following busy on call shifts. Three exceptions were to report missing the weekly teaching in York due to on call work and one was submitted to report a late finish to the normal working day.

Harrogate & Northallerton

There is currently 1 WTE vacancy in Northallerton as the FY2 originally due to start in August 2019 moved to the Teesside rota. There are also 2x WTE not currently working night shifts due to occupational health reasons. In addition to this there are usual gaps due to short term sicknesses. Locums have also been required to cover Trust Doctors attending exams/interviews for Core Training.

The majority of exception reports submitted during this period have been in relation to early starts/late finishes to the normal working day. One missed educational event and one missed break has also been reported.

ITEM NO.10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th November 2019**
TITLE:	**FREEDOM TO SPEAK UP GUARDIAN UPDATE REPORT**
REPORT OF:	**THE FREEDOM TO SPEAK UP GUARDIAN**
REPORT FOR:	**INFORMATION**

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

Executive Summary:

The number of contacts that I received during the last six months was similar to the number received in the preceding six months period. Concerns on the part of some staff about their potentially suffering detriment as a consequence of speaking up have increased during the last six months and the range of issues highlighted has become more diverse.

More needs to be done to ensure that TEWV staff can speak up and feel safe to do so and a review of some of our local speaking up processes is planned to take place in the near future.

There have been some positive developments including the delivery of more training, a growth in the number of Dignity at Work Champions who are now in place and receipt of national recognition the freedom to speak up culture within TEWV.

Recommendations:

To note the contents of the report and to comment accordingly

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**26th November 2019**
TITLE:	**FREEDOM TO SPEAK UP GUARDIAN UPDATE REPORT**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board about the last 6 months of the Freedom to Speak Up activities. The report will outline developments and activities to date and shares information about how we intend to further develop freedom to speak up activities in the coming year.

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 In the six months from April to September 2019 I was contacted about 28 new cases. 10 referrals related to allegations of bullying, 8 related to patient safety/quality issues, 5 were about staff safety and 4 were about organisational culture, and 1 related to systems and processes. Overall some 23 cases were resolved during this time though a total 37 cases remain ongoing. During the previous 6 months (October 2018 to March 2019) I was contacted about 29 new cases, 22 relating to allegations of bullying and 7 about patient safety. However, a significant change between the two reporting periods has been the number of people coming forward who wish to remain anonymous with there being only 4 between October 2018 and March 2019 compared to 24 between April 2019 and September 2019. Most staff stated that they were fearful of experiencing a negative consequence even when I explain that any future investigation may be hampered without identified people to express their viewpoint.

2.3 In the year October 2017 to September 2018 there were 18 cases in total, 11 related to allegations of bullying, 4 to patient safety, and 3 to systems/processes.

3. KEY ISSUES:

3.1 **Training**. The mandatory ½ day training for band 7 and above staff continues to be offered. Demand remains high in Teesside and Durham but sessions have been cancelled in York and Scarborough due to lack of numbers.

We have been considering how best to ensure that all staff can have access to training but to date have been challenged by my lack of time. Our current offering appears to meet the needs of middle and senior management. However the National Guardians Office has recently published guidance for trusts regarding training, and has recommended that training be offered to all staff. The Executive Management Team has agreed in principle that freedom to speak up training be mandatory for all staff from April 2020 and efforts are

underway to develop specific proposals for consideration by the Executive Management Team prior to a final decision being made. We have been awaiting the National Guardians Office developing an e-learning/video but do not currently have a definitive time line, so we are looking into developing our own tool to aid coverage. We envisage that the Dignity at Work Champions role could include assistance with the delivery of locality based face to face training that would complement the provision of e-learning.

3.2 **Support networks.** Locally, Barry Speak continues to act as Deputy FTSUG. He also provides a dual role for people who see him when accessing the Employee Psychology Service.

Our local network forum continues to meet regularly for sharing of intelligence, and peer support. This has proved invaluable. Through our sharing we have been better able to coordinate action plans with teams and offer more focussed feedback to services.

Our regional network for guardian meets quarterly. We have a rotating chair which has recently been supported by the NGO who have appointed regional representatives to support us, keep up to date with developments, and continue the work of developing the service to ensure equity of provision.

Our National Guardians office continues to support and become increasingly clear about what 'best practice' might look like, through a weekly newsletter, and the publication of their Services reviews.

3.3 **Development of Dignity at Work Champions.** After a slow start, we are now managing to recruit. We currently have 23 staff who have attended a training session and a further 10 have volunteered to undertake this role. We aspire to have 40 Dignity at Work Champions in place by early 2020. We will continue to hold a number of training events to help ensure that these staff possess the right skills and attitudes to carry out this challenging role. Dignity at Work Champions will provide vital local visibility and means of access for those staff who wish to raise concerns about bullying and harassment. They will support staff to feel comfortable to come forward, support staff during any review process and deliver training.

3.4 **Data Management.** The collection and analysis of data is central to ensuring that we can learn from experience. Our managers reporting tool has again proved somewhat unreliable. When the reporting tool has been available some managers have chosen not to use it despite my stating in training that the collection of data, the development of a library of experience, and learning from others experience is valued. Currently we have no other way of learning about cases of speaking up that are successfully addressed by our managers, and therefore at present we cannot learn from this experience, celebrate good practice, or provide more comprehensive information to interested parties. It is proposed that we survey managers to seek a better understanding about the

number and type of issues that they deal with, and what information gathering approach might be used in the future.

3.5 **Feedback.** As mentioned in the previous reports to the Board of Directors the experience of perceived detriment remains a concern. Some staff tell us that their feelings are about a loss of trust in the organisations ability to keep them safe, and they question whether staff welfare remains a priority. Investigations can be harrowing, and despite adherence to TEWV policies and procedures, some staff do report feeling alienated. However some senior staff have recently started trying to 'heal' this loss of trust by direct informal and confidential meetings to 'debunk' rumour. And ensure that clear messages are shared rather that the all too frequent misinformation. This has proved more effective than many other approaches.

3.5.1 The recent crowdsourcing conversations feedback has highlighted the importance of doing more to ensure that everyone's voice can be heard. In response to this feedback a number of actions have been agreed and publicised, including efforts to bolster the Dignity at Work Champions network, revisions to freedom to speak up training and identifying new ways that staff can safely put forward ideas and suggestions to help improve services. A commitment has also been made to holding a crowdsourcing conversation in February 2020 about how to ensure that TEWV has a just and fair culture. We will also be looking to publish more information about number of freedom to speak up cases that are reported within TEWV, including themes and outcomes, albeit without any breach of confidentiality.

3.6 **Learning from experience.** We have been operating for 3 years and have made iterative changes to our method of working, learning from mistakes, and adapting to the increases in demand. This half we had 2 cases where teams were investigated following complaint, but were found to be exemplary. I am very grateful to the two team leaders who gave feedback about just how upsetting the process had been. They felt considered unfit and feared that others might believe 'no smoke without fire!' They were also very offended by the word investigation.

3.6.1 As we are learning more about the experiences of all those involved in raising concerns we believe that now is a good time to review our methods of working, evaluate what is working well, and what can be improved. We have therefore planned an 'away day' on the 6th of December with some team leaders who have been investigated, some investigators, and those who support our current processes.

3.7 **Celebrating success.** The National Guardians Office recently published its Index report. They have used results from the annual survey using 4 questions which ask staff about how confident they are to speak up in their organisation. Nicola Rutherford, Senior HR Manager, and I represented the trust to receive one of 10 awards given to the highest ranking trusts in the county. An achievement we can be rightly proud of.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** Having effective speaking up arrangements in place is an important way to help ensure that TEWV can meet CQC standards.

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

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

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

4.4 **Other implications:** None identified.

5. RISKS: None identified.

6. CONCLUSIONS:

6.1 The number of cases referred to me during the last 12 months has been more than double the number that was referred during the preceding 12 months though the rate of referral has stabilised more recently.

6.2 Concerns on the part of some staff about the potential for detrimental treatment continue and a planned review of our freedom to speak up processes and ways of working is intended to help address, at least in part, these concerns.

7. RECOMMENDATIONS:

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

Dewi Williams
Freedom to Speak Up Guardian

Background Papers:

ITEM NO 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday 26 November 2019**
TITLE:	**Assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to update the Board of Directors on any current areas of concern in relation to quality and to provide assurance on the systems and processes in place.

Assurance statement pertaining to the QuAC formal meeting held on 07 November 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 North Yorkshire Services and Durham and Darlington
- Compliance with CQC
- Patient Safety and Patient Experience
- Positive and Safe
- Safeguarding & Public Protection
- Quality Account Q2 Update

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 07 November 2019.
- Note the confirmed minutes of the formal meetings held on 05 September and 03 October 2019 (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Thursday 26 November 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 any concerns and exceptions, together with levels of assurance in meeting the CQC fundamental high quality questions.

2. BACKGROUND INFORMATION AND CONTEXT

This report makes reference to the regular assurance and exception reports from the working groups of the Quality Assurance Committee, the localities and compliance with the Care Quality Commission regulatory standards.

3. KEY ISSUES

4 ARE OUR SERVICES 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?*

4.1 North Yorkshire Locality

The key concerns highlighted from the locality include:

- Staffing – with issues across nursing and medical staff and prevalent across specialties.
- Access to services and the ongoing pressures in the Memory Service in relation to waiting times, linked with consultant retirements, sickness absences and an increase in referrals from York.
- Inpatient provision and bed management in adult mental health with challenges around recruitment and staff absences impacting on all four crisis home treatment teams. A locality wide approach is in place to maintain Cedar Ward, Harrogate operating with safe staffing levels and this has been discussed at EMT for further support for the ward and to maintain patient safety and quality until the transformation in April/May 2020.

Assurance can be provided to the Board that resuscitation bags were checked daily in line with policy, there had been no instances of tear proof clothing required and no instances of the use of mechanical restraint.

4.2 Durham and Darlington Locality

The key concerns highlighted by the locality include:

- The admissions of under 18s to adult mental health beds, (five since mid-September 2019). Work is being undertaken to develop alternatives to Tier 4 admissions including developing the community infrastructure.

- Medical recruitment – with consultant vacancies, some of which are being covered by locums for MHSOP. CYPS are really struggling with temporary cover being provided however not at full complement and difficulties filling the post of Dietician in Adult LD. These pressures are impacting on services.

- The impact of West Lane Hospital temporary closure on the children's services in the locality. This relates to the ability to provide safe and effective home treatment for young people within current resources – this has been escalated to EMT and the locality is committed to supporting the development of the new service model.

Assurance can be provided to the Board that there were no incidents of the use of tear proof clothing in the period August to October 2019, all resuscitation bags had been checked daily, in line with policy. There had been a single incident of the use of mechanical restraint in LD services due to a patient wanting to use a harness in a vehicle. This was written into the care plan and the risk assessment for this individual.

4.3 Compliance with CQC Requirements

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

The Board is to note:

- Early feedback from the CQC following the core and recent well led inspection was felt to be largely positive, with the first report due late December or early January 2019 for the Trust to check for accuracy.
- There has been a number of Mental Health Act inspections since August 2019 with a total of 11 wards and areas included, some of which had included some immediate feedback and actions to pick up around restrictive practices. Themes for these inspections were detailed for the quarter.
- The Trust continues to maintain full registration with the CQC however with a current condition of registration following the closure of West Lane Hospital.

4.4 Positive and Safe Update

The Committee discussed the six monthly update on Positive and Safe.

The Board is to note:

- Overall the trust-wide progress has been positive with an improving trend in the use of restraint and rapid tranquilisation, evidenced in the review of the dashboard highlights.
- Forensic services have seen significant improving trends in the use of both prone and supine restraints.
- Learning disabilities have reported significant increases throughout the reporting period in both restraints and supine restraints.
- York and North Yorkshire are reporting significant reduction in episodes of self-harm.
- An area for further work following a publication by the CQC on their thematic review of restrictive interventions will be to look at the use of segregation in services.
- Overall the use of tear-proof clothing has reduced since escalation processes were introduced in September 2018.

Assurance can be provided to the Board that:

- Following an action in June 2019, (minute 19/06/19 refers), further consideration has been given to ensuring that patients have equal access to services and that approaches are carried out fairly and consistency across IP settings, it was reported that 67% of patients involved in restrictive interventions were female, 22% male and 10% gender neutral. Of the patients involved 93% were categorised as white with 7% from BAME communities.

- Members of the Committee requested that these characteristics be expanded further to include LGBT, however it was acknowledged that this was a complicated area for data collection, but one that would be pursued in the future.

5 ARE OUR SERVICES SAFE? *Are lessons learned and improvements made when things go wrong?*

5.1 Patient Safety Group

The Committee received the assurance report of the Patient Safety Group following its meeting held in October 2019.

The key matters for Board members to note are:

- Appointments have been made to recruit a Family Liaison Officer and a Mortality Review Coordinator as part of the actions and gap analysis following the NQB Learning From Deaths guidance.
- Members requested close monitoring of the concerns raised at Bankfields Court around the increased use of restraint, despite noting the high level of complexity of this group and a new patient that staff have been working positively with. The PBS team will also do some additional work with the team at Bankfields Court.
- Members agreed that following the positive feedback from the CQC about the good assurances provided in the MHSOP report on the Governance and Assurance Structure that his should be replicated in other areas and this would be taken to Clinical Leaders for sharing.
- The patient safety key performance indicator for 72hour report compliance was 94% relating to one report and the 60 day report compliance was 38%, where this relates to 10 reports where extension requests are not being supported by the CCGs.
- It is disappointing that serious incident panels, which Non-Executive Directors are part of were not including representation by all CCGs on all occasions, who are able to join the panels by teleconference. Verbal feedback has been received that this provides a good level of assurance where attended.
- A draft plan 10 step zero suicide plan was presented; this focusses on the steps outlined in the National Confidential Inquiry (NCI). There are elements that are business as usual and a number of outstanding actions due to internal capacity that need to be taken forward. It was agreed to propose to EMT a suicide prevention lead to take this work

5.2 Safeguarding and Public Protection

The Committee received an exception report for safeguarding.

The Board is to note:

- There are no exceptions to raise from the 11 serious case reviews for children, 5 serious adult reviews and six domestic homicide reviews.
- Further scrutiny will take place to consider if there are multi agency concerns that may require a multi-agency review following the community patient in Redcar that subsequently died.

6 ARE OUR SERVICES RESPONSIVE? Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care

6.1 Patient Experience

The Committee received the Patient Experience Group report covering the Patient Experience Group meetings in September and October 2019.

The Board is to note:

- The report has undergone some improvements in terms of demonstrating the key information around complaints and PALs using SPC charts.
- Members requested that the increasing number of PALs, which it is recognised that some are for calls requesting signposting and advice be looked into further and how this compares to other Trusts? Also to think about other ways of making the advice and signposting available, ie through the Trust Website. Assurance was given that there is a key performance indicator monitoring this data.
- Assurance can be provided that there is a task and finish group exploring the learning from both complaints and PALS.
- The Committee also queried the negative comments around the number of staff available for Q2 which was 85% as this was the second month it had been higher than feeling safe (78%) for Q2) and it would be useful to understand this further.

7 ARE OUR SERVICES EFFECTIVE? – Outcomes for people who use services are consistently better than expected when compared with other similar services

7.1 Quality Account Q1

The Committee received a progress report for Q2 on the Quality Account.

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

- Progress in Quarter 2 has been good with 49/56 actions either completed or on track. The most significant delays are for personalised care planning and the transition priorities.
- For the quality metrics four out of 10 are green (40%) with six reported as red (60%). Three of these saw significant improvement from Q1 (the percentage treated with respect, rates of physical restraint/intervention in MHSOP average length of stay). The other three metrics remain pretty static.
- Overall there were no concerns to escalate to the Board.

7.2 Trust Risks

The Committee discussed the risks set out on the Board Assurance Framework (BAF).

The key area considered was the need to ensure that any risks following the closure of West lane Hospital be adequately captured in the BAF, in particular the potential bed shortage for those under 18 years old as well as reputational damage.

(The BAF will be discussed at the Audit Committee on the 12 December 2019 and then any recommended changes to the Board of Directors, at its meeting to be held on 17 December 2019).

8 IMPLICATIONS

9 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.

10 CONCLUSIONS

The Quality Assurance Committee considered the corporate assurance and performance reports during the meeting.

11 RECOMMENDATIONS

That the Board of Directors is asked to:

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

(ii) Note the confirmed formal minutes of the meetings held on 05 September and 03 October 2019.

Dr Hugh Griffiths
Chairman of Quality Assurance Committee
26 November 2019

Annex 1

NOTES OF THE FORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 05 SEPTEMBER 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
Mrs Shirley Richardson, Non-Executive Director
Dr Ahmad Khouja, Medical Director
Mrs Jennifer Illingworth, Director of Quality Governance
Mrs Ruth Hill, Chief Operating Officer
Mrs Elizabeth Moody, Director of Nursing & Governance

In attendance:
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Dr Steve Wright, Deputy Medical Director
Mrs Bev Reilly, Non-Executive Director
Mrs Naomi Lonergan, Director of Operations
Miss Laura Kirkbride, Planning & Business Development Manager
Mr Anthony Davison, Head of Nursing, NY& York
Mrs Delia Hopkins, Community Nurse for LD in Scarborough
Mrs Emma Haimes, Head of Data Quality & Patient Experience, Nursing and Governance
Mrs Ann Marshall, Deputy Director of Nursing
Sharon Pickering, Director of Planning, Performance & Communications

19/112 APOLOGIES FOR ABSENCE

Apologies for absence were received from, Mrs Karen Agar, Associate Director of Nursing and Mr Colin Martin, Chief Executive

19/113 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 04 July 2019 were accepted as a true recording of the discussion and signed by the Chairman.

The Chairman noted that in light of events at West Lane Hospital the Quality Assurance Committee held an Extraordinary meeting on 29 August 2019 to discuss the position and future actions.

19/114 ACTION LOG

The Committee received and noted the QuAC action log.

Arising from the report:

18/166 Patient Safety Group Report: benchmarking with other Trusts who provide nasogastric feeding and other interventions.
This item was deferred to the 07 November 2019 QuAC meeting.

18/170 Report on automated defibrillators had been previously deferred to the July 2019 QuAC meeting.

The Director of Nursing and Governance noted that the requirements for patients in terms of emergency resuscitation were in place, this next step was around an enhanced community response. This item was deferred to November 2019 QuAC.

19/04 Discuss the possibility of correlating the longer view of acuity on wards linked to patients feeling safe.
Mrs Illingworth confirmed that discussions had taken place with IT around whether there could be a link between acuity and feeling safe on the wards, however this would be more difficult than thought. Some targeted work on AMH wards had taken place in order to try to get some quality narrative about how patients were feeling and this work would continue and be reported in the future PEG reports

Completed

19/30 A review of audits rated red and amber at the March 2019 position to identify any trends/seek assurance why audits had not been compliant.
This item was deferred to the 05 December 2019 QuAC meeting.

19/115 NORTH YORKSHIRE AND YORK SERVICES LMGB REPORT

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

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

- Waiting times, impacting on services across NY and York, with the most significant waits in the memory assessment service, secondary waits in IAPT and for autism services.
- This was linked to issues such as the capacity in nursing and medical posts across community and inpatient teams where vacancies, maternity leave, sickness, referrals rates and caseloads was impacting on productivity.
- Service changes with the final agreement to close the rehab and recovery inpatient unit, the planned merger of the two organic wards and the engagement plan for Harrogate in partnership with the CCG. It was noted that there had been some support from Organisational Development to manage the team dynamics following the merger of teams on Oakrise, together with daily lean management processes in place and a service manager supporting the ward manager.

  It was noted that there would be a report going to the Board of Directors at its meeting to be held on 24 September 2019, on the matter of teams requiring support.
- Recruitment

Following discussion it was noted that:

(1) The risk register for North Yorkshire and York services was currently being coordinated, however this would also be dependent on a Datix fix. The risk register would be considered in more detail at the September 2019 LMGB meeting.
(2) A lead psychiatry role was being established in CAMHS, similar to Teesside that would support the Clinical Director to ensure medical management requirements were being met.
Dr Khouja noted his full support of this role and that a paper was currently being written with a view to arranging the finances.
(3) Ongoing recruitment plans for inpatient wards included over-establishment and at interview stage any other suitable applicants would also be considered. Other ideas for making recruitment more attractive included social media avenues.
(4) It had been disappointing that NHS England had cancelled the visit to York to discuss autism waiting times. This would be pursued. The current waiting times around autism services for a new referral was currently 52 weeks for the full ASD assessment.

19/116 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 report:

- Following the CQC enforcement action on the Trust around issues at West Lane Hospital and the notice to close the IP services the Trust had been focussing on minimising the impact on the patients and families involved and had been working closely with NHS England and other partners to ensure the effective and safe transition for patients to alternative services.
  On this matter it was noted that there were five young remaining individuals currently moving towards discharge and transfers with the latest date planned for 16 September 2019.
  Mrs Moody advised that some of the concerns around observation and policy compliance raised by the CQC had led to the development of proformas for enhanced compliance on these matters and these would be rolled out across the Trust. Care rounds had been built into the Trust observational policy to ensure it complied with NICE guidance, which stated the minimum level of observation should be every sixty minutes.

  In addition it was highlighted that all inpatient services across the Trust would be visited to check for any similar issues that needed to be rectified.
- The Quality Assurance Committee had held a confidential extraordinary meeting on 29 August 2019 to discuss the issues at West Lane Hospital in detail where all Non-Executive Directors had been invited to attend.
- There would be a CQC inspection of core services commencing on 23 September 2019 for two weeks. There would be a Well-Led inspection taking place on the 5th and 6th of November 2019 and preparations were being made for this with Trust staff.

Non-Executive Directors raised issues picked up by the CQC following the MHA Inspection on 6 June 2019 and sought assurance as to how actions would be undertaken to ensure issues would not escalate.

The Medical Director advised that assurance was now being provided through the live audits that were being undertaken on the ward.

19/117 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Group Report and the Quarterly Quality Report for the period 1 April to 30 June 2019.

The key matters highlighted from the report were:

- Two items had been discussed from Director Panels involving CAMHS and EIP services not adhering to agreed standard operating processes when delivering care. There had been failings around communication and transition between the crisis team and EIP.

  Assurance was provided to the Committee that all those involved had been sent communication to reinforce processes.

- The Patient Safety Group had developed a risk register on any patient safety issues considered to be a risk to the organisation where assurance wasn't strong or clear. This would be known as the "issues log". The role of the Patient Safety Group as a sub Committee to QuAC would be to provide assurance around any potential risks to patient safety.

Non-Executive Directors queried incidents on the issues log that correlated with staffing levels and it was noted that this data was presented in the monthly safe staffing report and that twice a year a piece of work was undertaken to look at any correlation between safe staffing and complaints.

- From the data quality report the Group had discussed concerns around the number of level 3 self-harm incidents. Elm Ward was currently the biggest outlier in terms of self-harm and it had been agreed that some work would be undertaken to look at teams on both Elm and Maple Ward, together with any support that might be needed in terms of cultural and leadership issues.
- Teesside are outliers in relation to restraint which is not reducing however includes the Tier 4 CAMHS data which explains the majority of the incidents for the locality.
- A draft strategy on sexual safety was tabled for discussion. It was agreed that some further work was required and that it would be brought back to QuAC at the October 2019 meeting.

The following matters were raised in discussion:

(1) Members welcomed the SPC charts for the presentation of the information, which made for easier reading and understanding of the data.
(2) Work was being undertaken to look at factors around patient deaths in LD inpatients including any deaths of patients with a diagnosed learning disability in the last 12 months, or if there have not been any in 12 months, the last time such a death occurred? Also the numbers of those deaths where duty of candour had been applied and any that had resulted in family/carer complaints, highlighting any that had subsequently gone to the PHSO (complaints where a death had occurred, not just complaints in general).
(3) Assurance was sought that there would be an investigation into the upward spike in the physical interventions up to June 2019 for Teesside.
It was confirmed that the Tees locality had set out a number of actions to address this.

(4) The level of self-harm incidents on Elm had been reported as significantly higher than other areas.
The Director of Nursing and Governance stated that this had been discussed recently at EMT and was something that would be looked into in more detail with consideration of leadership and the culture of the ward and a report would be brought back to QuAC in November 2019.
Action: Mrs E Moody

(5) Physical intervention incidents for CYPS for inpatients were reported between April and June 2019 as being an outlier which was typical for these services.
Mrs Moody suggested that it might be useful to do a deep dive of the repeated instances of physical interventions for one individual, in order to look at safety and whether there were any lessons to be learned.
Mrs Moody undertook to bring something back to QuAC on this to the 03 October 2019 meeting.

(6) Confirmation that the information contained in the Patient Safety Group quality report was shared with Commissioners along with some specific details for individual Commissioners.
(7) It was highlighted that there was an error on page 3 of the report under key issues: i. Decision making and involving young patients where it was written “young person aged 17 years old who was discharged from the service after a call from his mother, ***who was also his GP*** ”and this should be amended.

19/118 INFECTION, PREVENTION AND CONTROL REPORT

The Committee received and noted the Infection, Prevention and Control Report.

Mrs Moody drew attention to the following:

(1) A new Head of Infection, Prevention and Control had been appointed, who had previously worked at NTW Foundation Trust. One of the first things planned for implementation would be for the IP&C team to wear uniforms when visiting the wards.

(2) There were no significant exceptions to note from the reporting period of quarter one, apart from fails by Elm and Esk wards around validation audits. There were 20 outstanding actions due to be completed for Elm Ward and three for Esk and the IPC Committee would be monitoring progress.

Following discussion it was noted that the data for West Lane Hospital needed to be moved into the Teesside section of the report rather than North Yorkshire where it currently sat in the report.
Mrs Moody undertook to take that back to the Group.

Action: Mrs E Moody

19/119 SAFEGUARDING AND PUBLIC PROTECTION EXCEPTION REPORT

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

The following matters were raised:

- The serious adult review had been agreed by Durham Safeguarding Adult Board, expected to start in 2020.
- Both of the recent deaths of young people on West Lane site were subject to a rapid response meeting, part of the Child Death Overview process.
- One of the deaths had been referred by Middlesbrough LSCB to the independent chair for a serious case review as the individual was a Looked After Child, detained under the Mental Health Act.
- Concerns had been raised by Darlington Local Authority and the CQC regarding an adult acute patient at West Park Hospital. Safeguarding had been in place for this person however there were some wider concerns about responding to safeguarding which were being explored by doing some 'dip-sampling' of safeguarding concerns that were not escalated to the local authority to look for any themes.
  On this matter it was advised that the CQC would be kept appraised of the situation.

Assurance was provided in the report that the Trust was compliant with the safeguarding regulations as set out in Working Together (2018) and the Care Act (2014).

19/120 PATIENT EXPERIENCE GROUP REPORT

The Committee received and noted the assurance report of the Patient Safety Group.

The key matters highlighted from the report were:

- The Patient Experience Report had been through a period of redevelopment in the layout and presentation of the data and now contained SPC charts with narrative and analysis of the information. There was still some way to go towards working on how matters could be triangulated from patient experience to things like safe staffing.
  The report was now presented to QuAC on a quarterly basis and Dr Wright acknowledged that this allowed for more time for working on the actions.

  Members of the Committee welcomed the new style of reporting as a significant improvement in terms of understanding the information, in a clear format and agreed they felt better informed.

- The 2018 Community Mental Health Survey results and action plan were detailed in the update report, however it was noted that the 2019 results were now available, although at the time of the meeting, embargoed for internal use only. Members suggested that the 2019 Community Mental Health Survey results should be considered in a timelier manner and reported on sooner.

  Following discussion:
  (a) Non-Executive Directors requested that feeling safe needed to include "sexual safety" and asked the Patient Experience Group to think about how this could be captured and reported in future.
  Action: Mrs J Illingworth

  (b) Non-Executives sought assurance on patient advocacy and it was confirmed that this could be evidenced though patient groups which were very active and engaged.

19/121 CLINICAL AUDIT AND EFFECTIVENESS REPORT

The Committee received and noted the progress report on Clinical Audit and Effectiveness.

The main points highlighted from the report were:

- The Clinical Audit Programmes at the end of Q1 were 15.58% complete (12 out of 77 audits complete) and by the end of August 26.25% complete.
- The re-audit of blanket restrictions, subject to approval of the policy around this would be undertaken in December 2019 and reported to a future QuAC meeting.

19/122 TRIANGLE OF CARE STAGE 2 SUBMISSION

The Committee received and noted the report around Triangle of Care stage 2 Submission.

Arising from the report:

(1) Mrs Moody was pleased to advise that following further assessments the Trust had achieved stage 2 of the Triangle of Care (and the 2 star kite mark). Triangle of Care involved Trust staff working with carers and carers organisations to complete and submit self-assessment tools based on six national key standards.
(2) Community teams had taken time out to consider how they supported and involved carers on a day to day basis. Staff attending training heard first-hand how they could help carers and carers were asked their opinions and involved in the whole process.

Non-Executive Directors acknowledged the significant progress that had been made, with nearly two thousand staff receiving face to face training.

Mrs Richardson commented that during a recent Director's visit it had been apparent that there was a real improvement in the level of understanding around the Triangle of Care work.

19/123 COMMUNITY MENTAL HEALTH SURVEY 2019

The Committee received and noted the Community Mental Health Survey results for 2019.
The key matters highlighted were:

- The report was embargoed for internal use only until the CQC published the Trust results in November 2019.

- The overall results showed a positive picture with all scores either in the top 20% or intermediate 60% ranges, with no scores in the lower 20% range. The results were comparable with 52 other MH Trusts.
- A further report would be written with an action plan for the Board later in the year.

19/124 QUALITY ACCOUNT – Q1 PROGRESS REPORT

The Committee received the progress report on quarter one for the Quality Account.

The key areas highlighted from the report were:

- Progress on Q1 had been good with 53/56 (95%) either completed or on track for planned completion.
- Three out of nine of the quality metrics (33%) were reported as green. There were six out of nine metrics reported as red (66%) however three of the four patient reported figures (feeling safe on the ward, overall experience excellent or good and respect from staff) was improving.
- Of the red metrics, the most concerning was the number of physical interventions and restraint which was double the target rate and steadily going up.
  Mrs Moody advised the Committee that action plans and regular reports on this would be received through the Positive and Safe report.

19/125 REPORT OF QUALITY ACCOUNT STAKEHOLDER WORKSHOP AND PRIORITIES FOR NEXT YEAR'S QUALITY ACCOUNT

The Committee received and considered the Quality Account Stakeholder Event Outcomes and possible priorities for 2020/21.

The priorities recommended by the Committee for discussion at the Business Planning Workshop on 1st and 2nd October were:

1. To reduce the number of preventable deaths;
2. Feeling safe on the wards;
3. Improving the CYP to AMH transition;
4. Introducing personalised care planning.

19/126 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no matters of exception raised.

19/127 ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD

There were no other issues that required escalation.

19/128 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.

19/129 COMMITTEE EVALUATION

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

19/130 QUAC ASSURANCE TRACKER

The Committee received and noted the Committee's Assurance Tracker for the period May to July 2019. Members considered that the Tracker was up to date and represented the levels of assurance for that period.

19/131 ANY OTHER BUSINESS

There was no other business to discuss.

19/132 DATE AND TIME OF NEXT MEETING

The next meeting of the Quality Assurance Committee will be held on Thursday 03 October 2019, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

NOTES OF THE FORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 03 OCTOBER 2019, IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Ms Miriam Harte, Chairman of the Trust
Mr Colin Martin, Chief Executive
Dr Hugh Griffiths, Chairman of the Committee
Dr Ahmad Khouja, Medical Director
Mrs Jennifer Illingworth, Director of Quality Governance

In attendance:
Mrs Rachael Weddle, Head of Nursing, Forensic Services, (for minute 19/136)
Dr Sarah Hopper, Professional Lead for Psychology, Tees Locality
Mr Dominic Gardner, Director of Operations, Tees Services (for minute 19/137)
Dr Pratish Thakkar, Deputy Medical Director, Forensic Services
Mr Chris Williams, Chief Pharmacist (for minute 19/140)
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mrs Jayne Lightfoot, CQC Inspector, Observer

19/133 APOLOGIES FOR ABSENCE

Apologies for absence were received from, Mrs Ruth Hill, Chief Operating Officer, Mrs Elizabeth Moody, Director of Nursing & Governance, Mrs Karen Agar, Associate Director of Nursing, Mrs Bev Reilly, Non-Executive Director, Dr Pali Hungin, Non-Executive Director, Mrs Sharon Pickering, Director of Planning, Performance & Communications and Mrs Lisa Taylor, Director of Operations, Forensic Services.

19/134 MINUTES OF THE PREVIOUS MEETING

The Chairman noted that the minutes of the Extraordinary QuAC meeting would be presented to the 07 November 2019 QuAC meeting, as part of a confidential item.

The minutes of the meeting held on 05 September 2019 were withdrawn due to some amendments that were required and they would be brought back to the 07 November 2019 QuAC meeting for formal ratification.

19/135 ACTION LOG

The Committee received and noted the QuAC action log.

Arising from the report:

18/170 Report on automated defibrillators in non-patient settings.
This report had been deferred by Nursing & Governance due to other urgent matters of Trust business.

19/164 Breakdown required around the high number of PALS termed as “other”.
It was noted that due to the reporting category of “other” under PALS, this included lots of various questions and queries, signposting etc, it was not however helpful when considering the numbers for any trends or themes.

Mrs Illingworth advised that work was underway with the Datix team to breakdown certain categories like "other", in order to be able to look behind the data, with almost a secondary category and the same was being done for complaints. The narrative update around this would be included in the December 2019 Patient Experience Report to QuAC.

19/100 There was an error on the date for completion of this action which should state **Feb 20**.

19/100b All localities to include in LMGB reports dashboard with narrative and analysis.
This action was discussed further in the meeting for clarification and it was noted that it was the weekly huddle dashboards used within localities that should be included in LMGB reports. This had been included in the Forensic LMGB report (covered under agenda item number 3, minute 19/137 refers) and members welcomed the presentation of the data in this format.

19/112 All localities to review section 4 of LMGB reports in the covering paper: "Implications: Compliance with the CQC fundamental standards".
It was noted that these sections had been checked and updated in the Tees and Forensic LMGB reports covered on the agenda.
The Chairman suggested that all papers reporting to QuAC should ensure this section was updated for future meetings.

19/114b Initiate a deep dive into multiple physical intervention incidents for an individual IP on CYPS. Look at triggers and process and consider whether patients feel safe.
It was noted that this item would be deferred to the November 2019 QuAC meeting when the Director of Nursing and Governance would be present.

19/136 TEES SERVICES LMGB REPORT

The Committee received and noted the Tees Services LMGB Report.

Mr Gardner apologised that the report sent to members of the Committee had not been the final version and this would be circulated following the meeting.

Action: Mr D Gardner/Ms D Oliver

Arising from the report the following main concerns were highlighted:

(1) The CQC serving notice to the Trust under Section 31 of the Health and Social Care Act 2009 that it should not provide CAMHS inpatient services at West Lane Hospital.
The closure of West Lane Hospital would have an impact on CYPs community and crisis teams and the ability to sustain referrals into the Trust and action plans were being worked through to support this.

(2) The continued high levels of bed occupancy within adult mental health services. This was currently being discussed with Commissioners.
The Chairman of the Trust noted that this was influenced by discharges and 30- day readmissions which was currently being reviewed by the Clinical Director.

(3) The viability and sustainability of other independent Hospitals in the region for people with a learning disability since this would impact on accommodating patients from TEWV.

(4) There had been an increase in physical interventions relating to one service user transferred from Whorlton Hall to Bankfields Court. Plans were being made to move the individual to The Lodge with a team of support staff that would need to be recruited.

(5) There had been 24 serious incidents reported in adult mental health, 15 of which were patient deaths.
Members queried how the locality would be responding to these serious incidents and the Director of Operations advised that a thematic review would be undertaken with the analysis and any lessons to be learned were presented to the Executive Management Team on 30 October 2019.

In addition to the focus around the main concerns it was noted that:

(1) The trans e slide within Tier 4 CYPS had been used on one occasion and AMH had used soft cuffs and belts on one occasion. Tear proof clothing had been used on four occasions across AMH and CYPS over the reporting period.
(2) Resuscitation bags had been checked daily in line with policy, with the exception of 13 checks across four wards. Daily huddles had now been organised to prevent any further checks being missed.

Following discussion:

(a) Members sought assurance on the medication errors per 100 OBD which were above target.

It was explained that a review of incidents by ward had identified that Westwood Tier 4 had the highest number of reported incidents. The highest rate of error was in relation to nursing administration of medication. Actions taken by Matrons had included supervision of individual staff and checking medicine charts at each nursing handover.

(b) Staffing pressures raised, particularly at Bankfields and actions taken to improve this included staff moving there to take off the pressure along with some discharges planned for individuals on the unit.

The Chairman of the Trust highlighted that the process of recruiting additional LD nurses jointly with the neighbouring Trust NTW had commenced and this was also being discussed by the Chief Executive at regional level.

(c) The Medical Director sought assurance on the wellbeing of staff that had moved from West Lane Hospital into other localities across the Trust and advised that this matter should remain on the risk register.
It was noted that these staff had been given support through a number of ways including individual interviews, reconnection events and staff had been invited to keep in touch in order to keep them informed.

(d) Members requested that a copy of the assurance report provided to the CQC following a number of patient safety and safeguarding incidents raised across MHSOP - Trust wide, (referenced on page 9 of the LMGB report) be included in the locality report next time.
Assurance was provided that the CQC had informed the Trust that they were assured by the response.
Mrs Illingworth undertook to include this as appendices to the next Patient Safety Group report as it was a Trust wide piece of work.

Action: Mrs J Illingworth

19/137 FORENSIC SERVICES LMGB REPORT

The Committee received and noted the Forensic Services LMGB report.

The following main concerns were highlighted within the locality:

(1) Ongoing challenges over the three month reporting period around nurse staffing impacting on consistency of care, continuity and potentially patient experience. There had been within the SIS (16 wards based at Roseberry Park Hospital) some particular staffing pressures on Kestrel Kite ward and an action plan had been put into place, which would be monitored closely by the Head of Service, Clinical Director and the supercell report out process.
(2) There had been a reduced level of cover on the wards during August, peak holiday time when the number of additional bank shifts picked up and worked had reduced. This was a recurring theme in the summer months, despite planning for the reduced levels of staff.
(3) Roseberry Park environmental work – which had recently started in September. Plans were in place to minimise disruption and respond to any issues that might arise. It was expected that there would be inevitable problems arising from a reduction in the car park spaces.
(4) Patient experience – a qualitative piece of work had been completed following issues highlighted around patients being treated with respect and dignity by staff. An action plan had been put in place to address the findings including a series of 'culture' workshops being delivered across the whole service and two further band seven staff had been recruited to support clinical leadership.

The quality scorecard demonstrated the issue with patients feeling safe on the wards and this was challenging in whether it was the environment or peers that led to patients feeling unsafe. Mrs Weddle advised that a piece of work would be undertaken

In addition to the main concerns the following was highlighted:

(1) The locality reported seven uses of soft restraint devices and 31 uses of tear proof clothing over the reporting period.
(2) There had been an increase in cancelled patient leave over the period June to August 2019 going up to 9% of which 3.5% related to staffing. The respective Heads of Service were exploring the cancellations, however it was noted that there were significant challenges around staffing levels, highly complex individuals requiring intense levels of observation, which leads to staff being pulled to the wards which are highest risk.

Dr Khouja suggested that it might be useful to compare cancelled leave in Forensic services with other large sites and Mrs Weddle undertook to look into this and bring any information back to the Committee.

Action: Mrs R Weddle

Following discussion a query was raised around the high levels of suicide in Durham prison and whether the Trust investigated deaths in custody.

Dr Thakkar stated that the highest levels of individuals with mental health issues were situated in remand prisons such as Durham and assurance was given that not only were the suicides tracked but also rates of self-harm.

19/138 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

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

Mrs Illingworth highlighted the following:

(1) The CQC were currently undertaking an inspection of the Trust covering the following areas:

- Forensic Inpatient/Secure Wards

- Long stay/rehabilitation mental health wards for working age adults
- Acute wards for adults of working age and psychiatric intensive care units
- Wards for people with learning disabilities or autism
- Mental Health crisis services and health-based places of safety
- Community based Mental Health Services for Older People
- Specialist Community Mental Health services for children and young people
- Wards for older people with mental health problems
- Specialist Eating Disorder Services

(2) Some of the focus group sessions for clinical and non-clinical staff to meet with the CQC inspectors had been better attended than others and some thought would be given to how this could be improved in future.
(3) The Mental Health Act inspections had been placed into a period of suspension and information on these would be fed back to the November 2019 QuAC meeting.

19/139 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Group Report and the Quarterly Quality Report for the period 1 April to 30 June 2019.

The key matters highlighted from the report were:

(1) Learning from Directors panels, which included maintaining contact with patients and how community teams manage patients' appointments on a care coordinator case load when they are on unplanned leave. A briefing would be shared on the problem with the Safe Staffing and Right Care Right Place Boards.
(2) A GP had prescribed the wrong dose of the drug Mirtazapine and the necessary follow up action with a reminder of the pathway for this medicine had been included in the PSB Bulletin and passed to the GP.
(3) To prepare staff who might be required to attend an inquest a pack had been developed and this would be available on the intranet, through the patient safety bulletin and taken to the Professional Nursing Advisory Group.
(4) To protect staff and to ensure there is a just culture a paper had been developed to improve the communication of the outcome of SI reviews from Directors panels to staff to ensure no one feels blamed. This paper would go to the MADT Programme Board.

Dr Khouja provided assurance that a just culture was being adopted at Directors panels; however the issue was around the level of information that doctors were given as they currently only saw the lessons table and not the steps beforehand. He suggested that it might be beneficial to open up the meetings and include more front line staff.

Mrs Illingworth undertook to consider this further noting that observers did attend the panels, however this could potentially be expanded.

Action: Mrs J Illingworth

(5) There had been a drop in the performance of the 60 day KPI to 42% which related to the increased volume of SIs and staff sickness and would continue for the medium term future. Seeking any displaced staff that could help would be pursued in order to try and make an improvement.
On this matter Mrs Illingworth advised that a member of staff had gone off with a serious illness and a 12 month secondment would now be put in place.

(6) A report relating to Tier 4 CAMHS incidents had been received by the Patient Safety Group. There had been an increase in self-harm incidents from 54 to 232, with two patients in particular contributing to these high levels.

The Director of Quality Governance advised that:

(a) The positive and safe dashboard would be developed further to include all level of self-harm incidents rather than the current position of level 3 only.

(b) The report around the deep dive into Tier 4 CAMHS would be refreshed with more supporting narrative and included in the Patient Safety Report to QuAC in November 2019.

Action: Mrs J Illingworth

The report also included:

(1) A poster on raising staff awareness on sexual safety on the wards

(2) A draft strategy on sexual safety on inpatient wards.

The Medical Director noted that the strategy would need wider consultation, however had been well received by the Patient Safety Group and had been based on a thematic review by the CQC. The Trust had also joined a national collaborative on the matter and one of the mixed sex wards, Bedale would be contributing to this piece of work.

A query was raised around regional developments with mortality reviews.

It was noted that:

(a) A meeting had recently been held to look at whether there could be any learning from deaths.

(b) There were currently nine other Trusts using the same mortality review framework as TEWV and it was anticipated that some further learning could be picked up from benchmarking however the long term aim would be for a single framework nationally.

19/140 DRUG AND THERAPEUTICS REPORT

The Committee received and noted the Drug and Therapeutics (D&T) Report.

The following was highlighted from the report:

(1) The report covered the business and updates from the July and September 2019 D&T Committees, which included information around improved systems and reducing waste, prescribing governance, medicines safety and information.

(2) The report contained an error in the third bullet point around the new inpatient prescription chart which should have stated the deadline for full Trust wide implementation was **31 October 2019.**

(3) A new Medication Safety Series document would be drafted, following agreement at the Safe Medication Practice Group to support best practice on the safe transfer of Depot prescribing from inpatient to community teams.

Following discussions:

(1) The Medical Director queried the tolerances around the drug Depot and whether this just applied to weekly Depots. It was clarified that only the weekly Depot lacked any tolerances over administration time and that this had now been harmonised between the community and in-patient procedure.

(2) Dr Thakkar commented about the three hour monitoring period for a patient once they had received the long acting Olanzapine injection and ensuring that the infrastructure was in place prior to discharge.

(3) Reassurance was provided that there would be no issues with the supply and delivery of the Trust influenza vaccines, and it was anticipated that they would arrive two weeks early.

(4) Mr Gardner raised a query around the shared care template which related to responsibilities for prescribing between primary and secondary care and whether there were any reps from the PCNs at the APC.
The Chief Pharmacist noted that there were not any specific PCN reps, but all CCGs were represented and the APC has been given delegated authority around decision making for prescribing guidelines.

19/141 SAFEGUARDING AND PUBLIC PROTECTION EXCEPTION REPORT

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

The following matters were raised:

(1) There was an error on page three of the report, under section 4.1, which should have been read: "The issues raised do **not** raise any concerns regarding the CQC fundamental standards".
(2) There were three cases currently under the LADO, two awaiting outcome for internal investigations and the third waiting for the outcome from a police investigation.
(3) There were 11 serious case reviews for children with varying input from the Trust from full reports and management reviews being submitted, two were waiting publication. There were five serious adult reviews, five domestic homicide reviews and one MAPPA serious case review.

The Chairman of the Trust raised a query around the geographical spread of the serious case reviews and Mrs Illingworth undertook to provide this.

Action: Mrs J Illingworth

Assurance was provided in the report that the Trust was compliant with the safeguarding regulations as set out in Working Together (2018) and the Care Act (2014).

19/142 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no matters of exception raised.

19/143 ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD

There were no other issues that required escalation.

19/144 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.

19/145 COMMITTEE EVALUATION

Members expressed no concerns around the meeting, agenda and reports, other than that there be consideration around balancing the timings of agendas for each meeting. (This related to two items being removed from the agenda following publication of the papers and the meeting had therefore ended at 3.55pm rather than the diarised time of 5pm).
The Chairman noted that discussions around the coordination of agendas for the Committee 2020 would take place in the planning meeting which would be scheduled during November 2019. It had been welcomed by members that meetings over 2019 had concluded more often around 4.30pm rather than the planned time of 5pm.

19/146 ANY OTHER BUSINESS

There was no other business to discuss.

19/147 DATE AND TIME OF NEXT MEETING

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

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th November 2019**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

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

Assurance Statement:

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

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**26th November 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 October 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 October, through the participation of inpatient services in daily huddles to review and understand staffing levels across sites and specialties. This has allowed for the staffing resource to be used in the most effective way to ensure high quality, patient centred care continues to be delivered safely across all inpatient units.

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 need and complexity.

Including

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 including Locality Heads of Nursing 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 Trust has complied with the directive *'Safe, sustainable and productive staffing: An improvement resource for mental health (NHSI , 2018)* with regard to its approach to safe staffing.

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.

5.2 There are risks that we will not reduce agency staffing in line with plan due to continued issues with sickness and recruitment particularly in N.Yorkshire.

5.3 Due to continued vacancies, sickness and level of agency usage, additional management oversight and support for safe staffing has been put in place at Cedar Ward, North Yorkshire.

5.4 The highest risks to safe staffing as indicated through Octobers data including roster activity, agency usage and incident reporting are Springwood (MHSOP, NY), Forensic Services and Cedar Ward.

6. CONCLUSIONS:

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

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

7. RECOMMENDATIONS:

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

Emma Haimes
Head of Quality Data and Patient Experience
November 2019

Appendix 1

Safe Staffing Report – October 2019:

Safe Staffing
November Report usi

Safe Staffing – October 2019

Tees, Esk and Wear Valleys NHS Foundation Trust

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

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

Safe Staffing Fill Rates October 2019:

- The number of rosters equated to 63 inpatient wards in October.
- The highest number of red fill rate indicators relate to Registered Nurses on day shifts. This equated to 20 in October 2019 which remains consistent with previous months.
- The top 3 inpatient areas where a low staffing fill rate has been reported are:
  - Jay (FMH) – 61.6% RN on Days – the low fill rate is due to a reduction of bed occupancy which reduced the demand for having 2 registered nurses on each shift.
  - Westerdale South (MHSOP) – 62.2% RN on Nights – low fill rate is due to the 2nd RN on nights being based on the ward but used across Westerdale North due to clinical need.
  - Nightingale (FMH) – 63.6% RN on Days and 88.3% HCA on Nights – low fill rates as a result of sickness which bank were unable to cover.
  - Sandpiper (FMH) – 63.6% RN on Nights and 80.1% RN on Days – low fill rates due to sickness. The ward has confirmed that there has been at least 1 registered nurse on duty.
- There were 64 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) – 380.8% HCA on Nights and 209.2% HCA on Days - the increase was necessary to support on average 3/4 enhanced observations during the month. The zonal observation pilot has now commenced with positive early indications.
  - Brambling (FMH) – 239% HCA on Nights and 184.3% HCA on Days – the increase was necessary due to clinical need requiring enhanced observations. A twilight shift was created each day for high acuity and environmental risk.
  - Springwood (MHSOP) – 223.9% HCA on Nights and 142.5% HCA on Days – the increased staffing was necessary to cover 4 patients on 1:1 observations and high levels of personal care.

Bank Usage:

- The bank usage across the trust equated to 19.8% in October, which is a decrease of 2% when compared to September.
- There was one ward (Eagle Enhanced Care Package) that had a bank usage rate of 71.9% of the actual hours worked in October and were the highest users of bank. The enhanced care package of 3:1 observations results in the number of request to bank, alongside a number of existing vacancies. A number of the bank shifts are picked up by substantive staff and bank staff workers are redeployed across the service to maintain continuity and consistency for the individual service user. The service continues to actively recruit staff for all its vacancies including the care package.
- There were 16 wards that reported greater than 25% bank usage.

Agency Usage:

- The agency usage across the trust equated to 6.7% in October with no significant change from previous month.
- Cedar Ward NY (AMH) again reported the highest agency usage in October equating to 55.5% of the total hours worked. Vacancies (122 shifts) were cited as the highest reason for using agency. The ward are using regular agency where possible. The ward has recently recruited to some posts.
- Those wards reporting 4% or more agency usage in October equated to 19 wards.

Produced: 20th November 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 October 2019 data.

- The Trust's Agency report (now transferred from the previous provider) highlights the following:
  - Number of shifts requested increased from September by 315. Shift numbers filled increased by 232 in comparison to September.
  - The average number of shifts requested sits at 1576 which is similar to previous months.
  - October saw 428 shifts go unfilled.
  - Fulfilment for HCAs was 1074 shifts in October compared to 877 in September. 290 shifts were unfilled.
  - Fulfilment for RNs increased in October, 226 shifts were filled in October compared to 191 in September. This is the highest number filled in the past 5 months. 138 shifts remained unfilled.
  - The agency supply was focused on increasing RN supply to Cedar Ward (NY), Rowan Lea and Springwood and HCA supply to Rowan Lea and Springwood. Elm Ward in Darlington is also experiencing high RN demand.
  - HCA spend accounts for 76% of total monthly spend. N.Yorkshire accounts for the majority of this.
  - The total number of no shows reported in October fell to 10. No show as a percentage of shifts filled in October was 0.77%.
  - All shifts booked have been booked below the cap with zero breaches recorded.

Missed Breaks:

- There were 239 shifts in October where an unpaid break had not been taken. This is a decrease of 25 shifts when compared to September 2019. The majority are day shifts.
- A breakdown by locality is as follows:
  - Teesside = 44 shifts with no breaks (Thornaby Road, had the highest with 18 shifts)
  - Forensics = 117 shifts with no breaks (Brambling had the highest with 23 shifts)
  - Durham & Darlington = 30 shifts with no breaks (Birch and Elm had the highest with 9 shifts each)
  - North Yorkshire & York = 48 shifts with no breaks (Springwood and Esk, had the highest with 9 shifts each)
- This information is being monitored daily as part of the operational services huddle process. Clinical activity is cited as the main reason for breaks not taken.

Incidents Raised Citing Staffing Levels:

- There were 26 incidents reported in September 2019 citing issues with staffing covering both inpatient and community services. The majority were from forensic services and Springwood Malton.
- Issues reported were as follows:
  - Staff feeling unsafe due to staffing shortages
  - Staff and patient safety compromised due to ward acuity and lack of staff.
  - Unable to rely on other wards to respond to alarms for assistance in emergency, particularly across Forensic wards at Roseberry Park.
  - Breaks not taken.
  - Essential care needs and processes unable to be undertaken for short period.
  - The Heads of Nursing and Directors of Operations are able to review all of the staffing incidents raised to pick up themes and take relevant action.

Severity Rating:

- Using a severity rating scale to identify potential outliers, the following are noted:
  - Birch Ward – 10 points awarded
  - Elm Ward – 9 points awarded
  - Sandpiper – 9 points
  - Rowan Ward – 8 points
  - Kestrel/Kite – 8 points
  - Bek/Ramsey – 8 points
  - Merlin – 8 points
  - Rowan Lea– 8 points
  - Mandarin– 8 points
- Using the YTD score (October 18 to October 19) the following appear in the top 5:
  - Elm Ward – 96 points awarded
  - Westerdale South – 93 points awarded
  - Birch Ward – 89 points awarded
  - Rowan Ward – 87 points awarded
  - Cedar Ward (D&D) – 87 points awarded

Care Hours per Patient Day:

- This metric tracks the total number of direct nursing care hours compared to the number of patients as a count at midnight.
- CHPPD overall rating for October is reporting at 1083 and is broken down as follows:
  - 3.70 registered nurses
  - 6.66 unregistered nurses
  - 0.03 registered nurse associates
  - 0.11 non-registered nurse associates
  - 0.22 registered AHP
  - 0.12 unregistered AHP
- Using standard deviation (October 18 to October 19) the following appear as positive outliers:
  - Harland – registered and unregistered nurses

Key links to documents & guidelines:

Monthly and Daily Staffing Report – October 2019

NQB Guidance July 2016

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

- The Lodge – registered nurses
- Jay Ward – registered 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 – October 2019

NQB Guidance July 2016

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

ITEM NO 13

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**26th November 2019**
TITLE:	**Recruitment and Retention Action Plan Update**
REPORT OF:	**Director of Human Resources and Organisational Development**
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:

Implementation of the actions described within the Recruitment and Retention Action Plan is on track overall. A number of actions have been completed and new polices and processes are currently being embedded. Though some time ought to be allowed for new approaches to realise benefits it is also important to refresh the action plan over the coming months. Performance is not currently meeting Workforce Strategy targets for 2019/20 though TEWV compares well to its peers with regard to a number of indicators.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**26th November 2019**
TITLE:	**Recruitment and Retention Action Plan Update**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide Directors with an update about the progress that is being made with implementation of the TEWV Recruitment and Retention Action Plan (Appendix 1) as at Q2 2019/20. The report will also make reference to the agency staffing position though more information about this issue will be reported at the December Board of Directors meeting.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Recruitment and Retention Action Plan is based upon actions identified within the TEWV Workforce Strategy and through the work of the Right Staffing Programme. A Recruitment and Retention Group provides regular reports about implementation of the action plan to the Right Staffing Programme Board which in turn reports to the Executive Management Team.

3. KEY ISSUES:

3.1 A good deal of progress has been made with implementation of the Recruitment and Retention Action Plan. A number of new policy/processes have been developed and these are being implemented. The current focus is upon embedding these new processes and some communication challenges have been encountered but are being addressed.

3.2 There will be a need to refresh the Recruitment and Retention Action Plan for 2020/21 and this work will be undertaken through the Right Staffing programme.

3.3 The percentage of TEWV healthcare professional vacancies that were filled following one advertisement was 80% during the period July to September 2019. This figure represented an improvement compared to the previous quarter (77%) but is below the 2019/20 target rate of 90%. The position in North Yorkshire and York has improved (83%) but has deteriorated in the Durham and Darlington locality (76%). We employ more nurses and healthcare assistants in 2019 than we did in 2018 though workforce pressures are as evident as ever before.

3.4 TEWV is now using social media to increase the number of job applications received. An Assistant Project Manager has been appointed to lead on this work and the feedback received to date has been encouraging. By way of example social media was used to seek applications for healthcare assistants to work at Springwood in Malton. The last time that such a position was advertised, in 2018, no applications were received but a recent social media

recruitment campaign contributed to generating 29 healthcare assistant applications.

3.5 At 10.3% labour turnover is currently above the 2019/20 target rate of 9%. There is some variation in labour turnover rates between localities with Teesside reporting a rate of 7.5% compared to 13.3% for North Yorkshire and York. Leaving for promotion/a better reward package accounted for 17% of North Yorkshire and York leavers, a higher figure for this reason than that reported by other localities. NHS England and NHS Improvement data tells us that TEWV has one of the lowest labour turnover rates of mental health and learning disabilities trust within the North East and Yorkshire region.

3.6 Some 31% of people leave TEWV due to age retirement and this is the largest single reason for leaving. Retirement accounts for a greater proportion of leavers within TEWV compared to the national average for mental health and learning disability trusts. There has been a welcome increase in the number and proportion of people retiring and returning to work for TEWV, up from 15% in 2018 to 24%. Use of the revised Retire and Return Scheme will continue to be encouraged.

3.7 The number of staff employed by TEWV for more than one year continues to be 90%, slightly below the target rate for 2019/20 of 93%. Maintaining the right balance of experience within the workforce continues to be important and an increase in the amount of retire and return activity along with ensuring that we can offer flexible working are seen as being key ways of helping to maintain this balance. Compared to other mental health and learning disability trusts more people leave TEWV within 12 months of starting work. This difference issue requires investigation.

3.8 There continues to be a significant level of demand for agency nurses, healthcare assistants and doctors. Demand for agency nurses and healthcare assistants is understood to be largely driven by specific service pressures, sickness absence levels and the number of vacancies. The labour turnover rates of inpatient nurses and healthcare assistants have fallen appreciably during 2019 compared to 2018 and sickness absence rates have been stable. Despite this demand for agency workers has continued to be strong. Agency medical staff use is mainly due to vacancy related factors. More detailed information will be reported to Directors at the December Board meeting.

4. IMPLICATIONS:

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

4.2 **Financial/Value for Money:** The costs of temporary staffing use are significant and can affect the TEWV Use of Resources Rating

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: Failing to recruit and retain sufficient suitably skilled and experienced staff would pose a major risk to service delivery and quality of care within TEWV.

6. CONCLUSIONS:

6.1 Progress with implementing the actions within the Recruitment and Retention Action Plan is being made. Though there are signs of improved performance in respect of some indicators the Workforce Strategy recruitment and retention targets are not being met at present. A refresh of recruitment and retention actions is to be undertaken whilst also allowing time for previous actions to take full effect.

7. RECOMMENDATIONS:

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

David Levy
Director of Human Resources and Organisational Development

Background Papers:

APPENDIX 1

RECRUITMENT

AIM	KEY DRIVERS	ACTIVITY IDENTIFED IN WORKFORCE STRATEGY ✓	CHANGE IDEAS	Timescale	Progress Update
Workforce Strategy Objective 1 To implement new approaches to recruitment to increase by 10% each year the proportion of posts filled with high quality candidates in a timely way	Value based approaches	✓ **Activity 1a**	Undertake a PDSA review of the current approach to using values based questions in recruitment with a view to assessing validity. This will include:- • undertaking research to identify evidence based approaches to designing values based questions and processes. • Giving due consideration in to whether internal candidates are at an unfair advantage due to their knowledge of the Trust values. • Consider the impact unconscious bias may be having on the recruitment and selection procedure. • Revised questions used By Forensic Services and EFM with effect from 1st November 2019 and all other services from 1st December 2019	Q4 2018/19 Q3 2018/19 Q3 2018/19 Q3 2018/19 Q3 2019/20	Project scope agreed – **To review the current values based recruitment questions. Key success factors include:** • **Everyone is aware of the values – internal and External candidates** • **Review balance of values, leadership and competency based questions** • **Less restrictive/more flexible** • **Improved process to prepare candidates for behavioural questions** • **Equitable and addresses unconscious bias** 30 interviews have been reviewed as a sample size. This identified that some questions are never used; some questions are used more than others. Focus groups with managers and service users, experts by experience and peer workers were held at the end of March 2019, a further workshop us due to be held with service users/carers in early May to design questions. A questionnaire has been sent to 282 recruiting managers to gather their views. We have received 127 (45%) responses. Main themes • Like the prescriptive nature of values based questions – 57 Yes, 43 o • Questions need refreshing – 88 Yes, 12 No • Like the freedom to develop own questions – 83 Yes, 17 No • Would prefer more wild cards – 70 Yes, 30 No • Would like different suite of questions for specific job families – 90 Yes, 10 No Key areas being considered: • Similar to NTW, support TEWV values with a list of positives and negatives • Increase the numbers of wild cards • Widen the suite of questions • Values/questions can be viewed by both internal and external candidates • Update the training module • Review the language used in the criteria • Review if questions vary depending on level of role • Time period when the questions will be reviewed on a regular basis Representatives from the BME and those employees who have a disability have been involved in the design and review of the questions to ensure there are no unconscious biases **COMPLETED**
	To review all recruitment and promotional materials ensure all aligned to the values of the Trust		Improve the quality and consistency of adverts used to promote employment with the Trust. This will include working with operational services, service users and carers to develop a range of standardised adverts eg Inpatient Services. Also consider how we can best promote employment opportunities within less	Q4 2019/20	Work to commence on this action once the new band 5 post is filled. The post has been advertised.

<table>
<tr><th>AIM</th><th>KEY DRIVERS</th><th>ACTIVITY IDENTIFED IN WORKFORCE STRATEGY ✓</th><th>CHANGE IDEAS</th><th>Timescale</th><th>Progress Update</th></tr>
<tr><td></td><td></td><td></td><td>well represented communities, to improve the diversity of our workforce.</td><td></td><td></td></tr>
<tr><td></td><td>Work in partnership with universities to ensure students are fit for purpose</td><td></td><td>Continue to collaboratively work with Universities to influence their recruitment processes to ensure alignment with the NHS and Trust values.</td><td>Q4 2019/20</td><td></td></tr>
<tr><td></td><td></td><td></td><td>Develop a standardised student information pack to share with students when they are on placement and moving into employment which describes the Trust values and behaviours.
• At start of placement
• At start of preceptorship</td><td>Q1 2019/20</td><td>The Trust holds a Home trust induction day for new nursing students (for Teesside, and York Universities) led by the PPF team. This includes the trust values and compact and a welcome to students from Deputy Director of Nursing or equivalent. Copies of written material are placed on the University “Blackboard” system for access by students. Consideration will be given as to whether there are or could be similar process for other professions students

The Occupational Therapy team have a well-regarded placement booklet, this is being reviewed by other professions to produce a tailored version for each group as a supplement to above. KA and JS are leading on this and will liaise with AHP lead, by end of quarter 4

The PPF team will be reviewing the student information due to the imminent changes in the NMC standards and curricula being adopted by the local Universities from September this year.

COMPLETED</td></tr>
<tr><td></td><td>Regularly review turnover analysis, looking at leavers by locality and speciality to better understand why staff are leaving.</td><td>Activity 1b</td><td>Undertake analysis on leavers and staff moving internally to better understand reasons for moving. The information will be presented in report format at team speciality and locality level. Nhsi suggested to analyse those staff under the age of 35 years

Undertake an improvement event to review the current processes for capturing leavers views via an exit questionnaire.
Change of Scope
As agreed with the Sponsor (DL) of the Kaizen event the focus was to ensure that we received notification of an employee’s intention to leave at the earliest point and, if a healthcare professional, have an exit interview</td><td>Q4 2018/19

Q3 2018/19</td><td>
<table>
<tr><td>All included</td><td></td><td></td><td></td></tr>
<tr><td>June 16 - May 17</td><td>leavers</td><td>staff in post</td><td>turnover rate</td></tr>
<tr><td>Trust</td><td>206</td><td>2271</td><td>9.1%</td></tr>
<tr><td>Durham & Darlington</td><td>61</td><td>654</td><td>9.3%</td></tr>
<tr><td>Forensic</td><td>13</td><td>291</td><td>4.5%</td></tr>
<tr><td>North Yorks</td><td>35</td><td>350</td><td>10.0%</td></tr>
<tr><td>Tees</td><td>62</td><td>689</td><td>9.0%</td></tr>
<tr><td>York & Selby</td><td>30</td><td>223</td><td>13.5%</td></tr>
<tr><td>Corporate</td><td>6</td><td>66</td><td>9.1%</td></tr>
</table>
<table>
<tr><td>All included</td><td></td><td></td><td></td></tr>
<tr><td>June 17 - May 18</td><td>leavers</td><td>staff in post</td><td>turnover rate</td></tr>
<tr><td>Trust</td><td>239</td><td>2301</td><td>10.4%</td></tr>
<tr><td>Durham & Darlington</td><td>87</td><td>645</td><td>13.5%</td></tr>
<tr><td>Forensic</td><td>20</td><td>309</td><td>6.5%</td></tr>
<tr><td>North Yorks</td><td>38</td><td>350</td><td>10.9%</td></tr>
<tr><td>Tees</td><td>56</td><td>717</td><td>7.8%</td></tr>
<tr><td>York & Selby</td><td>26</td><td>218</td><td>11.9%</td></tr>
<tr><td>Corporate</td><td>11</td><td>62</td><td>17.7%</td></tr>
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<table>
<tr><th>AIM</th><th>KEY DRIVERS</th><th>ACTIVITY IDENTIFED IN WORKFORCE STRATEGY ✓</th><th>CHANGE IDEAS</th><th>Timescale</th><th>Progress Update</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>Based on the data presented above, feedback from NHSI and the triangulation with other key data e.g. agency spend, it was agreed with NHSI that our initial focus will be on the North Yorkshire and York locality. Albeit over the period there has also been a significant increase in Durham and Darlington turnover from 9.3% to 13.5%.

The table below relates to analysis undertaken to better understand internal movement within each Directorate. The analysis looked at health care professional band 5,6 and 7. The majority of staff, 68% are moving following a promotion, which is a positive indication from a retention perspective and demonstrates there are opportunities for career progression. The analysis was over a 6 month period considering adverts placed between January 2018 – June 2018
<table>
<tr><th>total</th><th>Promotion</th><th>Same band</th><th>Lower band</th><th>Permanent</th><th>Fixed term/ secondment</th></tr>
<tr><td>Durham and Darlington</td><td>33</td><td>18</td><td>4</td><td>39</td><td>16</td></tr>
<tr><td>Forensic</td><td>7</td><td>3</td><td>1</td><td>6</td><td>5</td></tr>
<tr><td>North Yorkshire</td><td>21</td><td>5</td><td>0</td><td>24</td><td>2</td></tr>
<tr><td>Teesside</td><td>32</td><td>9</td><td>2</td><td>25</td><td>18</td></tr>
<tr><td>York & Selby</td><td>12</td><td>5</td><td>3</td><td>18</td><td>2</td></tr>
<tr><td>Trust</td><td>105</td><td>40</td><td>10</td><td>112</td><td>43</td></tr>
</table>
COMPLETED</td></tr>
<tr><td></td><td>Increase the % of times that we appoint to a healthcare professional post without needing to re-advertise the post.
To include:
• Nurses
• AHPs
• Medics
• Pharmacists
• Psychology</td><td></td><td>Undertake analysis to establish a baseline measurement from the recruitment tracking database to enable vacancy fill rate reporting at first advertisement.

Work to pro-actively identify those roles proving difficult to recruit to and work with operational services, service users and carers to identify a range of initiatives which may help to improve the compliance rate</td><td>Q4 2018/19

Q3 2018/19</td><td>Data shared with members of the Recruitment and Retention group.

August 2018 – November 2018 (source: TRAC system), all healthcare professional activity including AHPs
<table>
<tr><th></th><th>No of Vacancies</th><th>% Fill rate at 1st advert</th><th>% Fill rate at 2nd advert</th><th>Recruitment Difficulties</th></tr>
<tr><td>Durham and Darlington</td><td>69</td><td>59.4%</td><td>72.5%</td><td>Difficulties being experienced recruiting band 5 and 6 inpatient and community nurses - AMH and CAMHS. Dietitians band 5 and 6. Psychologist band 7, Speech & Language Therapist band 6, Occupational Therapist band 5.</td></tr>
<tr><td>Forensic Services</td><td>24</td><td>70.8%</td><td>75%</td><td>Difficulties in Pscyhology band 7, Dietitian band 6, PWP roles x band 5</td></tr>
<tr><td>North Yorkshire</td><td>79</td><td>64.6%</td><td>73.4%</td><td>Difficulties recruiting to PWP roles band 5 AMH, Registered Nurses - band 5 and 6 - inpatient and Community. Psychologist posts band 7 and 8a, Physiotherapist, Occupational Therapist</td></tr>
<tr><td>Teesside</td><td>58</td><td>69%</td><td>75.9%</td><td>Difficulties in recruiting to Dietitians, Psychologist in CAMHS, Speech and Language Therapists - band 5 & 6, Occupational Therapist</td></tr>
<tr><td>York and Selby</td><td>35</td><td>37.1%</td><td>48.6%</td><td>Difficulties recruiting to nursing roles bands 5 & 6, PWP - bands 5</td></tr>
<tr><td>Total</td><td>265</td><td>61.1%</td><td>70.6%</td><td></td></tr>
</table></td></tr>
</table>

AIM	KEY DRIVERS	ACTIVITY IDENTIFED IN WORKFORCE STRATEGY ✓	CHANGE IDEAS	Timescale	Progress Update
					Work to improve recruitment and retention rates of nurses has been in place since 2016, still areas where difficulties are still experienced. In terms of AHPs – there was a particular issue with recruiting dieticians, the Head of Dietetics has worked hard to try and ease this pressure. Actions taken have included, designing a bespoke programme in partnership with Teesside university, explored options to recruit internationally Other areas where there are known difficulties include: • Healthcare Assistants – regularly reviewing the HCA framework has led to the reduction in the length of time to complete the HCA trainee framework to 12 months. The latest change, yet to be agreed, is to move all trainees to the bottom of band 3 pay band making it more attractive to new HCAs to join us. • Consultants – this has always been a challenge and continues to be a challenge. A reliance on international recruitment and offering incentives to attract consultants in these roles from abroad has been the key focus. • Speech and Language Therapists – Director of Therapies has confirmed that this will be a priority in year 2 The Trust has introduced with effect from 1st April 2019 a new Key Performance Indicator which will monitor the vacancy rate. **COMPLETED**
	Recruitment initiatives	✓ **Activity 1b**	Proactively promote initiatives identified through a broad range of mediums. Consider where and how we market posts using social media and review materials describing wider marketing information i.e. housing, schools etc	Q4 2019/20	
	Increase the number of placement opportunities to student attending universities	✓ **Activity 1c**	Undertake analysis to establish the current baseline and work with services to identify if this is possible. Consider the new NMC standards and the impact on the Trust.	Q2 2018/19	A baseline exercise was carried out by the Professional Nursing and Education team in February 2019, this was also to meet external HEE requirements. The Trust-wide clinical placement capacity is 378 approved placements; an undertaking has been given to increase this by 10 % to 416 by end of 2019/20. This is to reflect the additional activity from Sunderland University in particular, and a smaller increase from Teesside University and the new Nursing Associate role. The placement model will change from September 2019, and most registered nurses (and other professions) will be classed as educators which will increase educator capacity from the previous mentor model – we have given an undertaking to increase this by 20% from current 791 to 896 wte educators. The above figure reflects clinical placement activity in general, of which the majority is nursing student activity but placements are accessed by a wide range of professions including AHP colleagues and also Paramedic trainees. Advice will be sought from AHP colleagues over any predicted trends for their areas of practice. In 17/18, 139 nursing students were supported at Teesside University. In 19/20 this will increase to 168. A further 25 apprentice pre-registration nurses have commenced at Sunderland university and there will be an additional 30 students per year on the new Sunderland BSc programme. The increase is primarily driven by the nursing profession; other professions appear to be relatively stable.

<table>
<tr><th>AIM</th><th>KEY DRIVERS</th><th>ACTIVITY IDENTIFED IN WORKFORCE STRATEGY ✓</th><th>CHANGE IDEAS</th><th>Timescale</th><th>Progress Update</th></tr>
<tr><td rowspan="4"></td><td></td><td></td><td></td><td></td><td>COMPLETED</td></tr>
<tr><td></td><td></td><td>Explore the feasibility of implementing talent management spotting opportunities for students.</td><td>Q4 2019/20</td><td>Task and Finish Group to be established involving Gordon Lees and Michelle Brown</td></tr>
<tr><td>Review current use of social media and collate some base line data</td><td>✓
Activity 1d</td><td>Explore how the Trust might better utilise the full range of social media tools available to promote recruitment opportunities within the Trust. Measurement will be linked to an increase in TEWV followers.

Work with IT colleagues to ensure IT infrastructure is able to fully support any initiatives identified.

Liaise with NHS network group and NHSI Retention representatives to understand what other Trusts are currently doing in relation to social media.</td><td>Q4 2018/19

Q3 2018/19

Q3 2018/19</td><td>Approval has been given to establish a band 5 fixed term contract. This role will support promoting the use of social media as part of our recruitment processes. Communications team have agreed to participate in the interview panel to ensure we recruit for the right skills. As a result, this objective will be updated with a revised timescale.

The Trust’s Facebook page has been used on an ad-hoc basis particularly to advertise internal recruitment fairs held across localities. 4 recruitment fairs were held during 2018, more are planned in 2019

With effect from August 2019 Facebook, Twitter and Linked In are all being used as a recruitment marketing tool.

COMPLETED</td></tr>
<tr><td>Involving service users</td><td>✓
Activity 1e</td><td>Work will be undertaken to establish the current baseline.</td><td>Q4 2018/19</td><td>In order to establish a baseline, the recruitment team send an e-mail to all recruiting managers for the month to see if they have involved service users and carers in the process

Data below shows the percentage of posts advertised, where the manager has confirmed that there has been service user/carer involvement in the recruitment process

<table>
<tr><th>Month</th><th>No of recruitment episodes</th><th>Service user carer involved</th><th>Did not have involvement</th><th>Did not respond</th></tr>
<tr><td>Dec 2018</td><td>50</td><td>18%</td><td>42%</td><td>40%</td></tr>
<tr><td>Jan 2019</td><td>108</td><td>16%</td><td>41%</td><td>47%</td></tr>
<tr><td>Feb 2019</td><td>100</td><td>18%</td><td>50%</td><td>32%</td></tr>
<tr><td>Mar 2019</td><td>114</td><td>18%</td><td>42%</td><td>40%</td></tr>
</table>

In addition, we do run recruitment fairs across the localities, each recruitment fair involves service user/carer is invited to work alongside the recruitment team and sitting on interviewing panels.

COMPLETED</td></tr>
<tr><td>Working with the Involvement team and service user representatives and carers a review of the current systems operating to capture the data will be undertaken using QIS methodology. This may include developing case study scenarios to share good practice.

Work will be undertaken to ensure recruitment</td><td>Q4 2019/20

Q4 2019/20</td><td>The focus on this action during 2019/20 will be to improve performance on the numbers of interviews taking place where a service user/ carer have been involved in the recruitment of posts at band 7 and above. This will enable the trust to develop the capacity level of trained service users and carers who are equipped with the knowledge and skills required to participate.</td></tr>
</table>

<table>
<tr><th>AIM</th><th>KEY DRIVERS</th><th>ACTIVITY IDENTIFED IN WORKFORCE STRATEGY ✓</th><th>CHANGE IDEAS</th><th>Timescale</th><th>Progress Update</th></tr>
<tr><td></td><td></td><td></td><td>training for service users is accessible to all.

Review recruitment training to ensure it promotes service user involvement</td><td>Q4 2019/20</td><td></td></tr>
<tr><td></td><td>Pilot, test and evaluate staff internal transfer scheme.

If positive evaluation – roll out to all staff</td><td>✓ Activity 1f</td><td>Work will be undertaken to establish the baseline

Communicate Internal Transfer scheme to all staff using a variety of methods to promote the scheme.</td><td>Q3 2018/19

Q3 2018/19</td><td><table><tr><th>Numbers of internal moves</th><th>2016/17</th><th>2018/19</th><th>Numbers of staff that have accessed the register as at September 2019</th></tr><tr><td>Band 5 and 6</td><td>281</td><td>Unknown</td><td>39</td></tr></table>Procedure approved on 8th October 2018.

The Challenge with this change is making managers aware of the new system. Presentations/information sessions have been set up but attendance has been low. Examples include:
14 HR sessions arranged across the Trust – 61 people attended
Modern Matron meeting – approx. 10 people
Modern Matron meeting – cancelled due to low attendance
Ward Managers meeting – cancelled due to low attendance
COMPLETED</td></tr>
<tr><td></td><td></td><td></td><td>Monitor the impact the scheme has had on the reduction in time to fill a vacancy.</td><td>Q2 2019/20</td><td>Between January and July 2019 14 staff found a post within TEWV using the Internal Transfer Scheme. Due to the small number the impact of the scheme upon the amount of time taken to fill a vacancy has been very limited to date.</td></tr>
<tr><td></td><td></td><td></td><td>Consider the value of developing a process to support opportunities for a temporary job swap to allow staff to build up experience in an alternative speciality.</td><td>Q3 2019/20</td><td></td></tr>
</table>

RETENTION

<table>
<tr><th>AIM</th><th>KEY DRIVERS</th><th>ACTIVITY IDENTIFED IN WORKFORCE STRATEGY ✓</th><th>CHANGE IDEAS</th><th>Timescale</th><th>Progress update</th></tr>
<tr><td rowspan="3">Workforce Strategy Objective 3b

Over 12 month period to reduce the amount of clinical staff leaving the Trust by 10% of the overall current leave rate

t</td><td>Improve a percentage of the “unknown reasons” for staff leaving
As at 31 March 2018 – 17.8% unknown reasons</td><td></td><td>• Identify staff groups i.e. bands 5/6/7 etc, extract the unknown data and focus on top 5 areas. Following top 5, target all staff with specific interviews every quarter. Improve as part of the exit interview process
• Raising awareness with managers the importance of recording the reason for leaving on ESR.
• Amend the ‘Advert’ proforma to make a direct link to exit interview</td><td>Q3 2018/19

Q3 2018/19

Q3 2018/19</td><td><table><tr><th></th><th>As at 31 March 2018</th><th>As at 31 March 2019</th></tr><tr><td>Unknown Reasons recorded on ESR</td><td>17.8%</td><td>16.53%</td></tr></table>
Between December 2018 and March 2019, a total of 31 leavers left with an unknown reason. Workforce Information have so far, received 10 reasons for unknown, equating to a 32% response. A further follow up is planned to obtain the outstanding information.

Kaizen event held on 29th and 30th October 2018, reviewed the current process and strengthened the guidance notes for managers to complete the reason for leaving on ESR. An additional manual system has been established involving workforce information following up on all leavers recorded on ESR as unknown. This is a monthly task where an e-mail is sent to the manager requesting the reason.

Following on from the kaizen event we have seen a gradual, but slow improvement as follows:
• 30 day report out = Process not in place at this point
• 60 day report out = 14%
• 90 day report out = 14%
• March 2019 – 11.76% unknown reasons = 6.24% improvement

COMPLETED</td></tr>
<tr><td>Offer all healthcare professionals an exit interview i.e. nurses, AHPs, medics, Pharmacists and Psychology</td><td>✓ Activity 2j</td><td>Establish a robust system to identify those healthcare professionals who are leaving the trust:</td><td>Q4 2018/19</td><td>Kaizen event w/c 29th October 2018 – to review the ‘Leaver Alert System’. No system currently in place to offer all healthcare professionals an exit interview. A system will be in place as at November 2018.

IMPACT - as at 15 April 2019 - First ‘Intention to Leave form’ received on 19 December 2018. As at 2nd April 2019 – the OD team had received 5 ‘Intention to Leave Forms’ in total .

As outlined above there are challenges with making managers aware of the new system. Presentations/information sessions have been set up but attendance has been low. Examples include:
• 14 HR sessions arranged across the Trust – 61 people attended
• Modern Matron meeting – approx. 10 people
• Modern Matron meeting – cancelled due to low attendance
• Ward Managers meeting – cancelled due to low attendance

HQQ – What else could we possibly do to engage Managers in HR update sessions

COMPLETED</td></tr>
<tr><td>Improved process of obtaining exit interview information</td><td></td><td>To run an Kaizen event on Leaver Alert System process
Consider the following:
• Who should carry out the exit interview - choice based
• To have someone complete the interview who has a sphere of influence</td><td>Q4 2018/19</td><td>As above

As at 15 April 2019 – Next report out meeting is arranged for May 2019. See previous comments for update

COMPLETED</td></tr>
</table>

<table>
<tr><th>AIM</th><th>KEY DRIVERS</th><th>ACTIVITY IDENTIFED IN WORKFORCE STRATEGY ✓</th><th>CHANGE IDEAS</th><th>Timescale</th><th>Progress update</th></tr>
<tr><td rowspan="5"></td><td></td><td></td><td>• Do we want questionnaire plus interview?</td><td></td><td></td></tr>
<tr><td>To develop an Improved process to feedback the outcome of the exit interviews to Managers so that this may influence key decisions about retention.</td><td></td><td></td><td>Q4 2018/19</td><td>As above – COMPLETED

See comments above</td></tr>
<tr><td rowspan="3">Gain a greater understanding of the views of staff to attain what elements are key to retention e.g. retire and return, opportunities for career development</td><td></td><td>To run a number of focus groups involving, nurses bands 5, to establish, what else could we do to retain staff</td><td>Q4 2018/19</td><td>Key themes from the focus groups included:
• Community – little difference in practice between band 5 and 6
• Experience of band 5 – significant leap from leaving university to working on the wards
• Acknowledgement that T&Cs are better than private sector
COMPLETED – INFO SHARED WITH RSPB</td></tr>
<tr><td></td><td>Consider the concept of ‘stay interviews’</td><td>Q2 2019/20</td><td>Review date on the back of the work linked to mid career reviews for 40s and 50s</td></tr>
<tr><td>✓ Activity 2i</td><td>To review the retire and return scheme, implementing agreed changes as part of PDSA process</td><td>Q3 2018/19</td><td>Scheme has been reviewed, amended and approved in January 2019. It is available on the Trust intranet site –Same issues relating to communicating with line managers as outlined above

April to March data
<table><tr><th></th><th>2017/18</th><th>2018/19</th></tr><tr><td>Numbers of staff that retire and return</td><td>20.7%</td><td>16.9%</td></tr></table>
The scheme has been reviewed twice recently, the first review we believe had a negative impact on the numbers of staff choosing to retire and return, a further review has been undertaken as outlined above. It is hoped that this will facilitate an improvement.

COMPLETED</td></tr>
<tr><td>✓ Activity 3g</td><td>• Develop a TEWV career path template to capture career pathways across TEWV.</td><td>Q4 2019/20</td><td>Real challenges with identifying a lead that is able to give this work the priority it requires to be delivered. This came to light in the last quarter of the year. In addition, the non-recurrent post ceased to be funded in 2018/19 reducing capacity within the team.

The establishment of a non-recurrently funded recruitment post was agreed by EMT and the post-holder is leading a piece of work to develop a template

We have identified a template used by another Trust, the TEWV Information Technology department is making contact to see if we can use their template which looks like it is easy to use and is simple.

On Track – Expect to have the template with all the job descriptions currently available via AfC job evaluation by the end of December 2020. Assuming we can use the prototype used by the external trust.</td></tr>
</table>

<table>
<tr><th>AIM</th><th>KEY DRIVERS</th><th>ACTIVITY IDENTIFED IN WORKFORCE STRATEGY ✓</th><th>CHANGE IDEAS</th><th>Timescale</th><th>Progress update</th></tr>
<tr><td></td><td></td><td></td><td>• supported by access to relevant development programmes</td><td>Q1 - 2019/20</td><td></td></tr>
<tr><td></td><td>Listen to the views of those people who have completed their probationary periods to gather feedback on their work experiences</td><td></td><td>Establish baseline

Interview all new staff to gather feedback about their work experiences during their first six months of their start date
• Establish baseline data to see how long staff stay with us e.g. < 6months, < 1 year, < 2yrs etc</td><td>Q1 2019/20

Q3 2019/20</td><td>Baseline data

<table><tr><th>Numbers of leavers</th><th>2017/18</th><th>2018/19</th></tr><tr><td>Average number of new starters each month</td><td>68</td><td>63</td></tr><tr><td>Leavers with <6months over 12 month period</td><td>86</td><td>80</td></tr><tr><td>Leaver with >6 months but < 12 months over 12 month period</td><td>71</td><td>65</td></tr><tr><td>Leavers with > 12 months but < 24 months over 12 month period</td><td>129</td><td>96</td></tr></table>
<table><tr><th>Reasons for leaving excluding end of fixed term contracts</th><th>2017/18</th><th>2018/19</th></tr><tr><td>Retirement</td><td>9.9% (22)</td><td>4.1% (8)</td></tr><tr><td>Unknown reason</td><td>27.8% (62)</td><td>33.2% (65)</td></tr><tr><td>Promotion/Better Reward Package</td><td>15.2% (34)</td><td>15.8% (31)</td></tr><tr><td>Work life balance/caring responsibilities</td><td>17.0%(38)</td><td>15.3% (30)</td></tr></table>
COMPLETED</td></tr>
<tr><td></td><td></td><td>✓ Activity 2g</td><td>• Establish a system to ensure that all new staff employed during first 6 months are interviewed</td><td>Q4 2018/19</td><td>Probationary period policy sets out the process as to when new staff should be reviewed to provide a consistent means by which new employees can be supported to become effective as quickly as possible and to enable a manager to objectively assess the capability, attitude and potential of the new employee. These reviews should take place at 4, 10, 16, 20 and 26 weeks.

The recruitment and retention working group agreed to use the review at the 26 week period to ask additional questions relating to the employee's career plans to further reinforce and cement the long term contractual relationship between both parties.

In addition to the above change, the plan is to:
• Check if it is possible for managers to record completion date of probationary period on ESR
• Undertake an audit of the system via Audit North
• Contact a number of staff who have been with the Trust for 6 months and 12 months to gain information about their experiences, level of support etc.

COMPLTED THOUGH FURTHER WORK IDENTIFIED</td></tr>
<tr><td></td><td></td><td></td><td>• Communicate and roll out</td><td>Q3 2019/20</td><td></td></tr>
</table>

AIM	KEY DRIVERS	ACTIVITY IDENTIFED IN WORKFORCE STRATEGY ✓	CHANGE IDEAS	Timescale	Progress update
			• Monitor and evaluate results – have improvements been made	Q3 2020/21	
		✓ **Activity 2f**	Provide values based corporate and local induction programmes and preceptorship arrangements where relevant • Ensure that both the corporate and local induction programmes support the values based approach • Ensure that both the preceptorship arrangements support the values based approach to induction	Q4 2020/21 Q4 2020/21	To be completed by the Training and Development Work-stream within the Right Staffing Programme
	To reduce work related stress Reduce the amount of physical and verbal abuse that staff receive	✓✓ **Activity 4g**	Managers undertake daily wellbeing checks • Design, develop and consult on the introduction of daily wellbeing checks. • Evaluate via staff survey/ Staff FFT	Q4 2019/20 Q4 2020/21	The recruitment and retention Group has sought the assistance of the Health and Wellbeing Group to address this issue. Initial discussions were focussed on what services are currently doing in this area. There were strong views expressed that local implementation of this intervention ought not to be directed corporately by TEWV as some services had already implemented a variety of approaches linked to engagement, involvement and wellbeing. Views about daily wellbeing checks were sought as part of the crowdsourcing conversation and mixed responses were received. E-mail sent to Modern Matrons across all inpatient services via the Heads of Nursing. The e-mail is to establish who is offering wellbeing checks and what tools are they using that could be shared across the Trust. 20 responses were received and information is being reviewed including an analysis of which services have adopted this approach and which services have not. We will be able to offer those services that have not, ways in which they can introduce these checks, using a buddy system etc. **ON TRACK**
		✓ **Activity 4j**	• Evaluate the impact of TEWV health and wellbeing interventions and support services through use of either qualitative and/or quantitative data. • Present evaluation reports to the Health and Wellbeing Strategy Group	Q4 2018/19	**Mental Health and Physical Interventions** - Annual reports have been produced and presented to EMT and the Health and Wellbeing Strategy Group at various points throughout the year. In particular, Employee Psychology Services, Employee Support Services, Mindfulness, Counselling and Physio. All reports presented include an element on the evaluation/impact. In terms of national research on the subject matter, the Trust has attended an event at York University, involving participants from all sectors i.e. universities, employers, third sector and there is no or very little evidence based research relating to mental health interventions. Consequently, the Trust EPS, ESS, Mindfulness services managers have met to try and establish what evidence our services can produce to show impact on absence figures etc. **Physical Health interventions.** Plans are in place to replicate the work undertaken with mental health in the Physical Health programme of activities. Health and Wellbeing Group will identify a lead. **IMPACT -** **2017/18** / **2018/19** **Physical Health Total** / **65.5%** / **63.2%**

AIM	KEY DRIVERS	ACTIVITY IDENTIFED IN WORKFORCE STRATEGY ✓	CHANGE IDEAS	Timescale	Progress update
					Mental Health Total | **34.5%** | **36.8%** **COMPLETED**
		✓ **Activity 4i**	Develop and agree a procedure for staff to report abuse • Bullying and Harrassment procedure • Identify and introduce Dignity At Work Champions • Taking action to support staff to report abuse and to minimise the likelihood of abuse being repeated from service users, carers and their families	Q2 2018/19 Q4 2018/19	Bullying and Harassment procedure has been separated out from the grievance procedure. Procedure has been published. Approximately 16 Dignity At Work Champions have expressed an interest in taking on this role. A new process for tackling verbal abuse of staff by service users and carers has been developed and agreed by the Executive Management Team. 3 awareness raising sessions for managers about the new process have taken place. In addition, awareness sessions have taken place at the leadership and management network meetings and further training sessions are planned. **COMPLETED**
		✓ **Activity 2c**	Understand the possible opportunities to offer improved Flexible working opportunities in clinical services. What are the barriers and how could we work differently to provide these opportunities.	Q4 2019/20	Work to commence asap in North Yorkshire and York locality as per NHSI recommendations. **Inpatient services** In 2018, York University, in partnership with the Trust, has carried out some research on the impact of 12 hour shifts. The report on the key findings has recently been produced and shared with the Trust. A TEWV-wide working group has now been established to produce recommendations for the Executive Management Team about addressing a range of 12 hour shift working related issues. The Executive Management Team will then consider the recommendations and decide whether they are supported. **Community Services** On the 12th April 2019, meeting arranged with Head of Nursing, North Yorkshire and York locality to scope our approach with the aim of gaining an understanding of the possible barriers to staff accessing flexible working in front line services. We have identified the key stakeholders, next step is to arrange an event to explore the barriers and find solutions using the Think On methodology. **ON TRACK**
			Implement the new flexible working procedure and monitor effectiveness	Q4 2019/20	New procedure is live. Same issues as stated earlier with raising awareness with line managers. HR Manager is developing a system to monitor the take up of flexible working as outlined in the procedure. In response to crowdsourcing conversation feedback in July 2019 a further review of the approach of TEWV to staff taking planned time off for non-urgent appointments and carer leave commitments is being undertaken. **ON TRACK**
			To consider the possibility of increasing the notice period for band 5 and above in order to reduce the length of time a post is vacant Streamline recruitment process to match notice periods	Q3 2018/19 Q4 2018/19	Proposal approved by Joint Consultative Committee to increase the maximum notice period for Bands 1- 5 from 1 month to 2 months. The change became effective on1st April 2019 for new starters and 1st June 2019 for some 3,500 existing staff No specific changes to the recruitment process. Need to consider how we evidence that this has made a difference. **COMPLETED**

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 26 November 2019**
TITLE:	**To consider feedback received from the CQC following its well-led inspection of the Trust.**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Information**

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

Executive Summary:

The CQC undertook a well-led inspection of the Trust on 5th and 6th November 2019.

Verbal feedback was provided by the CQC at the end of the second day which has subsequently been provided to the Trust in a letter (attached at appendix 1).

This letter does not replace the draft report and evidence appendix that will be sent to us, but simply confirms what was verbally fed back on during the inspection and provides the Trust with a basis to start considering what action is needed.

The early feedback has been summarised in the main body of the report under key issues.

Recommendations:

That the Trust Board note the content of the report and consider any action needed.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday 29, October 2019**
TITLE:	**To consider feedback received from the CQC following its well-led inspection of the Trust.**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of the report is to provide early feedback from the Trust's recent Well-led inspection, which took place on the 5th and 6th November 2019**.**

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The well-led inspection draws to a close our recent compliance inspection activity including core services inspection. The attached letter has been provided to the Trust as a basis to start considering what action is needed. The letter does not replace the draft reports which are expected to come to the Trust at the end of December 2019.

3. KEY ISSUES:

3.1 The CQC letters detailing feedback from the well-led inspection is attached at appendix 1.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
Whilst the feedback is largely positive with no immediate actions to address, the Trust will not know if its core services or an overall rating has been re-rated until after the well-led report has been received.
Once the final report has been received, the Trust will develop an action plan to address any should do's or must do's in order to comply with fundamental standards.

4.2 **Financial/Value for Money:**
The CQC have made an additional comment within the letter, noting that measures should be put in place promptly to address the privacy issues that have arisen as a consequence of the removal of the en-suite doors within AMH in-patient wards. A business case has been approved through EMT to address this.

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

4.4 **Equality and Diversity:**
Following the well-led inspection, the CQC feedback will be reviewed and considered to ensure all actions promote equality and diversity across the Trust.

5. RISKS:

No immediate safety issues or breaches have been highlighted at this point, however the risk to the trusts overall rating must still be considered in the context of an inadequate core service rating for CAMH's.

6. CONCLUSIONS:

The Trust has received some positive feedback in relation to its leadership, vision and strategy, culture, governance, management of risk, issues and performance, information management, engagement and learning, continuous improvement and innovation. The inspection team have indicated that they will request some further information in relation to the Mental Health Act.
The CQC recognised the work the Trust has already initiated to review its governance structures, our participation in the external review as well as how we are strengthening our management of risks. They have identified the need to promote and integrate equality and diversity for all staff (particularly people who are LGBT).

7. RECOMMENDATIONS:

That the Trust Board note the content of the report and consider any action needed.

Elizabeth Moody
Director of Nursing & Governance

Background Papers:

CQC feedback letters

By email

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

Colin Martin
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust
Trust Headquarters
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

11 November 2019

CQC Reference Number: INS2-5165095284

Dear Colin

Re: CQC inspection of well-led

Following your feedback meeting with you and colleagues on the 6 November 2019, I thought it would be helpful to give you written feedback as highlighted at the feedback meeting.

This letter does not replace the draft report and evidence appendix we will send to you, but simply confirms what we fed-back and provides you with a basis to start considering what action is needed.

You are welcome to use this letter to discuss the findings of our inspection at your next board meeting if you have not yet received our draft reports.

An overview of our feedback

The feedback to you was:

W1 Leadership

- The trust had a talented and experienced leadership team.
- The board was working together well to respond appropriately to the ongoing challenges following the closure of the wards for young people at West Lane.
- The importance of the leadership team being visible and approachable was recognised. There were well structured arrangements to visit services across the wide geographical area served by the trust.

- Arrangements were in place to promote leadership development for staff across the organisation. Staff spoke positively about the opportunities for their personal development including access to coaching.

W2 Vision and Strategy

- The board and senior leadership team had developed a clear strategy and staff were aware of what it was. It was evident that staff and patients had been engaged during the formation of the strategy. The trust continued to embed the strategy as it developed its ongoing operational priorities.
- The trust worked effectively in partnership with other stakeholders across a large and complex health and social care economy. The trust actively contributed to plans to meet the needs of the local population.
- The trust was pro-active in seeking guidance and support where needed and was working collaboratively to consider future plans for young peoples mental health inpatient services.

W3 Culture

- The trust had a values-based culture which was positive and open. There was a high degree of openness and transparency in the senior leadership team.
- Staff spoke about the positive culture during the inspections of services.
- The trust recognised the importance of supporting staff to speak up. This was reflected in their plans for dignity at work champions.
- The trust recognised the low completion rate of the previous NHS staff survey and had plans in place to increase the participation this year.
- There was more to do to promote equality and diversity for staff and patients and ensure this was fully integrated into all areas of the work of the organisation. This was particularly needed for people who are LGBT+.

W4 Governance

- The trust had recognised that a review was needed of the governance structures and processes following the closure of the wards at West Lane. They had highlighted this as a strategic risk on their board assurance framework.
- The trust knew it was not appropriate to make quick changes to the governance processes and that they needed to learn from an external review that was going to take place. In the meantime they were applying more rigour to identified concerns and were making better use of soft information.

W5 Management of risk, issues and performance

- The trust was strengthening how it managed risk. The audit committee was now also looking at the systems and processes for the escalation and gaining assurance on risk.
- Staff and service leaders understood their risks and were able to report them and escalate them when required.
- Each of the trust directorates had a risk register and the trust was bringing these together in a corporate risk register which was under development.
- The board assurance framework was used actively by the board. It identified areas of strategic risk and these were examined systematically.

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W6 Information management

- The organisation had data available and accessible to all levels of staff. This same information informed the board on the performance of the trust.
- The trust was making significant changes to support staff to access and use the patient record system with greater ease.
- Leaders told us that data was clear and usable and allowed them to manage their services effectively.
- The trust was making increasing use of digital technology to support the delivery of services to patients.

W7 Engagement

- The trust engaged positively with patients, carers and staff. This included a wide range of co-production work. The trust was also extending the number of peer support workers. However, it would be helpful to have a trust strategy for user involvement to ensure this was embedded throughout the organisation.
- Staff engagement was positive. The making a difference programme included a number of workstreams to promote a positive working experience for staff. This included initiatives to improve staff health and well-being.

W8 Learning, continuous improvement and innovation

- The quality improvement programme was well embedded across the trust. There were a number of trust wide quality improvement priorities including work to increase the proportion of inpatients who feel safe on the wards.
- Staff had been engaged in various ways to learn, improve and innovate and were given time to do this in their day to day roles.
- There was positive progress in research with research leads across the trust. The trust had a senior nurse research leadership programme.

Additional comments of note:

- The inspection team are still looking at the governance processes in relation to the use of the Mental Health Act – thank you for sending any additional information requested.
- The reasons for the removal of ensuite bathroom doors on acute wards was understood, but measures to ensure privacy must be put into place promptly whilst a permanent means of addressing the risk is implemented.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

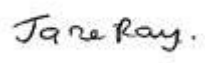
If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely



Jane Ray

Head of Hospitals Inspection

London Mental Health and CHS team

CC

Dr Kevin Cleary (Deputy Chief Inspector of Hospitals Mental Health, CQC)

NHSI

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday 26 November 2019**
TITLE:	**Report of the Mental Health Legislation Committee**
REPORT OF:	**Paul Murphy, Non-Executive Director**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 2, 2019/20.

Key areas for consideration:

- Reports on Discharges from Detention, use of Section 136, Section 132 (information to detained patients), Section 5 (Holding Powers and Section 18 (absent without leave)
- Seclusion Report
- Report on MCA and DoLS
- CQC Quarterly Update
- Case study

Recommendations:

The Board of Directors is asked to:

Receive and note the assurance report, following the MHLC meeting held on 23 October 2019 and to note the approved minutes of the MHLC meeting held on 24 July 2019. (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Tuesday 29 November 2019**
TITLE:	**Report of the Mental Health Legislation Committee**

1. INTRODUCTION & PURPOSE:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for Quarter 2, 2019-20; through consideration of the work of the Mental Health Legislation Committee at its meeting held on 23 October 2019.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

The confirmed minutes of the Mental Health Legislation Committee held on 24 July 2019 are attached as Annex 1.
The MHLC also met on 23 October 2019. The key issues considered at this meeting were as follows:

COMPLIANCE WITH MHA PROCESSES

3.1 Discharges from Detention

The Committee considered the Discharges report and the key matters are in Quarter 2 there were 155 Hospital Managers' review meetings with no patients discharged. There were 117 First-tier Tribunals in Q2, which resulted in 3 patients being discharged. There are no concerns.

3.2 Section 136

The Committee considered data and trends around S136.

- There were 174 uses of S136 across the Trust, compared to 165 in the previous quarter.
- There were 19 episodes that lasted 12 hours or more, with some lasting more than 18 hours and these will be looked into to check how well escalation processes are being adhered to.
- There were five individuals aged between 14 and 17 held under section 136 in Q2 a reduction from nine in Q1.
- There were higher numbers in Scarborough over the summer period of individuals placed in a TEWV place of safety and this was happening annually, thought to be due to the higher population at that time.

3.3 **Section 132**

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

The key matters for the Board to note are:

- In Q2 the escalation process was used 19 times, up from 13 in Q1.
- Following implementation of escalation processes all the relevant paperwork was completed.
- Members picked up that a small number of patients had not been receiving their rights in over seven days and this was going to be referred to the Operational Management (OMT). It is recognised that capturing this information is limited to admission only, however this will improve with the introduction of CITO.

3.4 **Section 5 – Holding Powers**

The Committee received this report and the exceptions in the use of section 5(4) nursing holding power and Section 5(2) doctors or AC holding power and where it had lapsed or the outcome was not usual or lawful. The key assurance for the Board is that there were only two out of 200 examples of this happening and the information around these was fed back to the appropriate staff members.

3.5 **Section 18 – Absent without Leave (AWOL)**

The Committee discussed this report and the key issues for the Board to note are:

- There were 179 episodes across Q1 and Q2 and sadly one patient died whilst absent without leave. Of these there are a number of multiple absences, with one patient absent on 13 occasions.
- Members agreed that there was a bigger piece of work required around which wards have the highest numbers of AWOL and the reasons behind it, perhaps a Task and Finish Group and this would be thought through.

COMPLIANCE WITH KEY CODE OF PRACTICE REQUIREMENTS

3.4 Seclusion

The Board is to note:

- In Q2 there were 89 episodes of seclusion, (99 in previous quarter). Of the 89 episodes 77 were over 12 hours, of which 64 were over 24 hours.
- The longest completed seclusion for those in excess of 24 hours was 350 hours higher than last quarter at 328.
- There were 23 patients that had multiple seclusion episodes.
- A further piece of work will be undertaken to look at 20 episodes of seclusion both prospectively and retrospectively to ensure that medical reviews are done in a timely manner. (Board of Directors minute: 24.09.19, 19/231 refers where Non-Executive Directors sought a timescale for this work, whch will be brought back to Committee in January 2020.
- Segregation was also considered and further work required around reviewing clinical procedures in light of the CQC publication, and recommendations.

EFFECTIVE IMPLEMENTATION OF THE MCA AND DOLS

4.0 Mental Capacity Act and DoLS

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

The key points to note are:

- The Liberty Protection Safeguards (LPS) will replace the Deprivation of Liberty Safeguards (DoLS) with implications around the Liberty Protection Safeguards for those aged between 16-18 years as this age range will now be included. This is important given the recent (September 2019) piece of case law which has made it clear that parental consent cannot be relied upon to authorise a deprivation of liberty for 16 and 17 year olds. This would particularly affect wards such as Holly and Baysdale.

- Guidance was provided to Holly and Baysdale prior to the case law being handed down and this guidance will be revised in light of the Supreme Court decision.

KEY GOVERNANCE INFORMATION

5.0 CQC Report

The key issues for the Board to note are:

- The Trust continues to maintain full registration with the CQC however some conditions of registration had been imposed following the unannounced inspection to the children and young people's inpatient services.
- The top themes and trends for recent MHA reviews which included the recurring themes around care plans and section 17 leave forms.
- The well led inspection by the CQC would commence in November 2019, with the draft reports expected over Christmas to check for accuracy

HOW THE EXPERIENCES AND VIEWS OF DETAINED PATIENTS FORM PART OF THE COMMITTEE'S CONSIDERATIONS

5.1 Case Study

The Committee received a case study of a patient requiring seclusion on Cedar Ward, Psychiatric Intensive Care Unit at West Park Hospital, which as usual gives a close look into the complexity and acuity of patients that we care for.

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

There are no concerns to raise that might impact on the Trust's strategic or key risks.

7.0 IMPLICATIONS:

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

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

7.2 **Financial/Value for Money:**

There are no implications.

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

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

7.4 **Equality and Diversity:**
There are no implications.

8. CONCLUSIONS:

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

9. RECOMMENDATIONS:

The Board of Directors is asked to:

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

Mr Paul Murphy
Chairman of the Committee/Non-Executive Director
29 November 2019

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

Annex 1

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 24 JULY 2019 IN STAFF MEETING ROOM 2, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

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

In Attendance:
Ms D Oliver, Deputy Trust Secretary, (Corporate)
Miss M Wilkinson, Head of Mental Health Legislation
Mrs J Ramsey, Mental Health Team Manager
Mrs J Harrison, Expert by Experience Representative
Mrs S Jay, Equality and Diversity Lead
Mr A Williams, Public Governor, Redcar & Cleveland
Mrs H Griffiths, Public Governor, Harrogate & Wetherby
Mr J Creer, Public Governor, Durham
Mr C Watson, CQC Inspector

Apologies: Apologies for absence were received from Mrs J Illingworth, Director of Quality and Governance and Mrs R Down, MHL Advisor.

19/42 MINUTES OF LAST MEETING

Agreed – *That the minutes of the last meeting held on 24 April 2019 be approved as a correct record and signed by the Chairman, subject to a correction of a typographical error on page 3, item 19/19, penultimate paragraph, which should have read: "The Chairman of the Committee suggested thinking about the introduction of SPC charts to outline trends and* ***tolerances…"***

Matters Arising - Hospital Managers

Members raised a query around any progress that had been made over the last quarter with recruiting Hospital Managers from the South Asian Community.

Miss Wilkinson updated the Committee that following the initial meeting six people had remained interested and had attended a follow up meeting, however, the majority had also wanted to work on the Trust's bank which precluded them from becoming Hospital Managers, it was encouraging however that there had been one firm application for a Hospital Manager role.

A further positive outcome from the meeting with the Asian community had been sharing information around patients' rights and individuals having the right to appeal should they be detained.

19/43 ACTION LOG

The Committee noted the actions and following updates:

17/33 Benchmarking – talk to NTW about seclusions.
Members discussed the difficulties around benchmarking with other Trusts due to the variances in facilities and wards and the kinds of seclusion. Whilst NTW had agreed to share their information this could not provide a direct comparison as they provided seclusion facilities on all inpatient units.
It was acknowledged that with the pending changes to the new national definitions around restraint and record that information around benchmarking would improve in the future.
This action would be brought back to the October 2019 meeting for any update.

18/42 Conversation to take place about SOADs
It was noted that this was a national as well as a regional problem. A conversation had taken place with NTW, Leeds and York about how people could be encouraged to take up the role of SOAD, including those who had retired.

18/42a Section 62 information to be reported to MHLC in October 2018 and then annually.
This report had been deferred to the July 2019 meeting, however information was required from the CQC in order to understand the true nature of the issue and this remained outstanding.
This report would come to the 23 October 2019 MHLC meeting if sufficient information was available to produce a meaningful report.

18/54 MCA/DoLS report: Issue of long waiting list for DoLS at Middlesbrough County Council, with some clients waiting more than two years.
Completed

19/06 Section 132 Report to be shared with OMT, Quality Compliance Group and Modern Matrons.
Completed

19/22 MHA inspection feedback report: colour code in next report compliance with code of practice.
Completed

19/34 Seclusion report: demonstrate data with comparisons over last three years.
Completed

19/40 Discuss risks around SOADs with Trust Secretary.
It was noted that a discussion had taken place and this was felt to be a corporate risk rather than strategic.
Completed

HOW DOES THE TRUST DEMONSTRATE COMPLIANCE WITH MHA PROCESSES?

19/44 DISCHARGES REPORT

The Committee considered and noted the MHA Discharges Report.

The following was highlighted from the report:

- In Quarter 1 there had been 116 Hospital Managers' review meetings with no patients discharged.

On this matter it was noted that whilst it was unusual to see over Q1 that no patients had been discharged compared to the last quarter, it was not uncommon over the last few years for this to happen on occasion.
Members were assured that there were no concerns.

- There had been 135 First-tier Tribunals in Q1, which had resulted in 13 patients being discharged.

19/45 SECTION 136 REPORT

The Committee received and noted the Section 136 report.

The following was highlighted from the report:

- There had been 165 uses of S136 across the Trust, compared to 174 in the previous quarter.
- There had been 11 episodes that lasted 12 hours or more. One was recorded as extended but further exploration revealed that extension had not been used. An explanation was provided to members around - "extension not used" which referred to the form being ticked to say the extension would be used and then it wasn't, perhaps if the patient went on to an acute hospital.
- For those that had been held for longer than 12 hours details were provided in the report with the rationale behind this, including assessment delay due to the unavailability of an AMHP and an aggressive and hostile individual that had to be taken into custody for a time due to risk before being returned to Roseberry Park Hospital for assessment.
- There had been nine individuals aged between 14 and 17 held under section 136 in the last quarter.
- The overall use of S136 across the Trust showed TEWV place of safety (PoS) being used as the optimum choice with police stations not being used across the whole Trust area in the last quarter.

Following discussion:

(i) A query was raised regarding the numbers included in the table on page 6 of the report "outcome of Section 136 for Q1" showing there had been 19 not open to services and returned to the community with no follow up for Tees.

Members were advised that these numbers were not exceptional for that locality.

(ii) The Medical Director noted the assurance provided in the report which demonstrated improvements in the reduced amount of time that individuals had spent under 12 hours in a place of safety. It also demonstrated that the Trust had good working relationships with the Police.

(iii) Members agreed that it would be helpful if the table on page 6 of the report setting out the individuals under the age of 18 brought to a TEWV place of safety in the last quarter could be shown with comparisons with the previous quarter.

Action: Mrs J Ramsey

19/46 SECTION 132 REPORT

The Committee received and noted the Section 132 report.

The key issues highlighted from the report were:

- In Q1 it had been recorded that the escalation process had been used 13 times, including twice to the MHL Team Manager. All 132b forms had been eventually received.
- Assurance was provided that the number of times escalation had been required was negligible compared to the number of sections applied, however it could be that not all instances had been captured due to the newness of reporting this information.
  Mrs Moody highlighted that this report only provided assurance of patients being given their rights on admission, however it was anticipated that with the introduction of CITO, the newTrust information system there would be further developments and improvements on this matter.

  Governor Cliff Allison sought assurance on the way patients' rights could be communicated due to the huge variances between individuals with different needs.

  It was noted that their rights were required to be given in both written and oral formats. The Trust accesses interpreters if the first language was not English and had leaflets for all sections in a range of languages; there were also DVDs available for use which show BSL. The Trust had also produced easy read leaflets for all sections.

19/47 MENTAL HEALTH ACT INSPECTION FEEDBACK Q4 2018/19

This matter was covered within the paper under agenda item number 7: CQC Quarterly Report. (minute 19/51 refers).

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

19/48 HUMAN RIGHTS, EQUALITY AND DIVERSITY INFORMATION REVIEW

The Committee received a report on Human Rights, Equality and Diversity.

In introducing the report Mrs Jay drew attention to the following:

(1) The report had been written to seek the views of the Mental Health Legislation Committee on information recorded by the Trust concerning the number of detentions under the Mental Health Act by gender and ethnicity and to agree what actions needed to be taken going forward.
(2) The reporting of this information would provide assurance to the Committee through robust monitoring of equalities to understand how people with protected characteristics could be affected by the Mental Health Act.
(3) There were some errors to the table on page 3, titled "sex" and the numbers should have read:
    - Standardised rates of detention per 100,000 - Female 80.9, Male 88.9.
    - Anticipated numbers of detentions – Female 945, Male 995.

(4) The Trust's IT department were currently replicating the database used by NHS Digital and it was anticipated that this would be completed by the end of 2019.
(5) In order to analyse, consider and seek assurances from the numbers of detentions by gender and race consideration would be given with the E&D team and the MHL Team on processes and reporting mechanisms.
(6) An update would be brought back to the January 2020 MHL Committee.

Non-Executive Directors welcomed this data which would provide a degree of understanding around the rates of detention linked to gender and ethnicity.

19/49 SECLUSION QUARTERLY REPORT

The Committee received and noted the Seclusion report.

The key points highlighted from the report were:

- In Q1 there had been 99 episodes of seclusion, (81 in previous quarter). Of the 99 episodes 75 had been over 12 hours, of which 64 had been over 24 hours.
- The longest completed seclusion for those in excess of 24 hours was 328 hours (13.6 days), which compared well with 739 (30.8 days) hours in Q4.
- There had been 23 patients that had been in multiple seclusion episodes, of these two patients had five episodes in the quarter.
- The Committee had agreed at its meeting held on 24 April 2019 (minute 19/34 refers) that a piece of work would be undertaken by the MHL team which would entail clinically auditing every completed seclusion for a period of at least two weeks to determine whether the requirements of the policy had been adhered to. This was following concerns with regard to whether the requirements of the Code of Practice and Trust Policy were being adhered to on every occasion that seclusion occurred.

- A sample of ten individuals had been audited and the longest period for seclusion had been 12 days. Assurance was provided to the Committee that the full data around seclusion was reported to the Quality Assurance Committee through the Positive and Safe report.

- Members considered whether it would be useful to look in greater detail at the medical reviews for seclusion and Miss Wilkinson undertook to look at those episodes of seclusion where the MHL team were notified within 24 hours at Roseberry Park to provide qualitative information.

Action: Miss Wilkinson

Following discussion it was noted that there was a typographical error on the table shown on page 11, Appendix 3, comparison of the use of seclusion across Q1 for 2017-19, where FLD shown should be LD.

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

19/50 MENTAL CAPACITY ACT AND DOLS REPORT

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

Arising from the report it was noted that:

(1) Following the publication by the Government of a Mental Capacity amendment bill in May 2019, the Liberty Protection Safeguards (LPS) would replace the Deprivation of Liberty Safeguards (DoLS). It was expected that the target date for implementation would be October 2020.
On this matter it was noted that the implications for the Trust would become clearer with the publication of the revised MCA Code of Practice and regulations.

(2) E learning training modules for the MC Act and MH Act continued for staff with compliance at 96%.
On this matter it was noted that once the MC Act was finalised then the Trust training programmes would be adapted to target different groups in different ways.
(3) There were currently 44 active cases under DoLS, all within respite settings.
(4) Appendix 2 to the report - Clinical Audit of the Mental Capacity Act set out a proposed set of actions for completion by the end of 2019, which would improve the working knowledge of the Mental Capacity Act for frontline staff.
Mrs Hill suggested that it might be worthwhile asking one of the Trust master coaches to be involved in this work.

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

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

19/51 CQC REPORT

The Committee received and noted the CQC report.

The following key matters were highlighted from the report:

(1) The Trust continued to maintain full registration with the CQC however some conditions of registration had been imposed following the unannounced inspection to the children and young people's inpatient services. The Trust would be working with the CQC to manage the situation and immediate steps and actions had been taken to ensure the safety and quality of care at West Lane be improved.
(2) There had been five CQC Mental Health Act inspections: Springwood, MHSOP York, Acomb Garth MHSOP North Yorkshire, Jay Ward, AMH secure IP services Teesside, Ebor Ward, AMH North Yorkshire & York and Westerdale North MHSOP, Teesside. The top themes raised were restrictive practices, care plans and MHA leave.
(3) There had been a thematic review by the CQC to MHSOP core services (excluding liaison) following different concerns such as safeguarding issues, complaints and serious incidents and this combined with an unimproved rating of 'requires improvement' in the latest inspection had led to them requesting assurance. A report had been submitted to the CQC on 14 June 2019.
(4) There were various wards that had not received an inspection in over a year and would potentially be inspected by the CQC in the near future. The localities had been informed.

19/52 LIBERTY PROTECTION SAFEGUARDS UPDATE

The Committee received and noted an update around Liberty Protection Safeguards.

The key points to note were:

(1) There would be significant changes following the implementation of LPS when it replaced DoLS, namely that the Trust would not be reliant upon Local Authority Supervisory Bodies to authorise deprivations of liberty within TEWV settings - if the requirements within LPS were satisfied then the Trust would become responsible and accountable as the 'Responsible Body'.
(2) It would be difficult to plan what processes would look like in great detail for TEWV until the Code of Practice and Regulations became available. In the meantime further

work would continue to embed the Mental Capacity Act to ensure a sound understanding amongst clinicians.

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

19/53 CASE STUDY

A case study of a patient requiring seclusion on Merlin Ward, Forensic Secure IP service, Roseberry Park was received.

Members thanked the staff involved for preparing the case study, which all agreed was extremely useful at humanising the statistics and data presented to the Committee.

19/54 TRUST'S STRATEGIC RISKS

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

19/55 ANY OTHER BUSINESS

There was no other business to discuss.

The meeting concluded at 4.07pm

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 16

FOR GENERAL RELEASE / CONFIDENTIAL

BOARD OF DIRECTORS

DATE:	**26th November 2019**
TITLE:	**Self-Assessment Report in relation to Multi-professional Education and Training – Health Education England**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Sign off**

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

Executive Summary:

- The attached report is the comprehensive Self-Assessment Report required as part of the Health Education England educational governance process for Medical and non-medical multi-professional education and training.
- It is an annual requirement to submit this multi-professional return. Information is requested from professional leads, and the Workforce Development and other HR teams, and consolidated into a single joint report by the Medical Development and Professional Nursing Education teams, supported by the Director of Therapies.
- As last year, the return is a multi-professional return, colleagues have worked across the professions to identify the key Trust developments and issues for this latest report and confirmed these with relevant Directors.
- The information is assessed by HEE and then ordinarily taken to a scrutiny meeting with HEE colleagues for further questions and assurance, known as the Annual Dean's Quality Meeting (ADQM).
- As part of the governance process for this report, HEE ask that an Executive Director signs off the assessment report and it is presented to the Trust Board.
- We are awaiting the date for the 2020 meeting with HEE to scrutinise the report.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**26th November 2019**
TITLE:	**Self-Assessment Report in relation to Multi-professional Education and Training – Health Education England**

1. INTRODUCTION & PURPOSE:

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

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 As last year a single report was requested, which maintains detail on medical and non-medical requirements in some of the sections but asks for an overall Trust position on the key issues. There were contributions sought from all professional groupings to capture all perspectives.

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

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

3. KEY POINTS TO NOTE:

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

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

3.3 Key successes highlighted within the report include;

- The NMC approval and subsequent commencement of a new pre-registration nursing course at Coventry University at Scarborough, with twenty places initially, including some staff supported onto the course by the Trust. Scarborough is an area which is traditionally difficult to recruit into.

- The Trust has also supported successful NMC re-approval events for the new standards for education at all other local HEI's across the year and has continued to grow its Nursing Associate workforce and approach to apprenticeship based learning, including a focus upon increasing educational opportunities within the Learning Disability service.

- A new contract has been established with the York St John University establishing a counselling doctorate, 12 trainees started this September in York and Knaresborough localities.

- In 2019, the feedback from the GMC annual trainee survey ranked the Trust as 4th overall in the whole of the UK. It has been the highest ranked Trust in the North East region over the last 7 years and in 2019 became the highest ranked Trust in the Yorkshire and Humber region too.

3.4 The key challenges highlighted within the report refer to;

- The West Lane Hospital concerns were shared with the local HEI's from a training perspective so that they could maintain their communication with their regulator. Support was offered to affected students/trainees on placement by the appropriate professional leaders.

- The provision of increasing numbers of placements for multi-professional trainees is an ongoing challenge however the trust continues to explore and map out new options to increase capacity. Specifically, nursing are currently working on introducing the new NMC standards and roles for assessment across the organisation which may assist with capacity for placements.

- Recruitment of senior medical staff and significant consultant level vacancies pose the biggest challenge to maintaining our established excellence in supervision and training to medical undergraduates and trainees

4. IMPLICATIONS:

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

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

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

4.4 **Equality and Diversity:**
The SAR assessment incudes factors relating to equality and diversity at section 7,there is a detailed overview of actions taken.

5. RISKS:

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

6. CONCLUSIONS:

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

6.2 It is an annual requirement to submit this multi-professional return.

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

6.4 We are awaiting the date for the 2020 meeting with HEE to scrutinise the report.

Background Papers:

2019 SAR Report for Health Education England

7. RECOMMENDATIONS:

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

Name – Ann Marshall
Title - Deputy Director of Nursing

NHS
Health Education England

2019 Education & Training

Self-Assessment Report (SAR)

Reporting Period: 1 August 2018 to 31 July 2019

Deadline for submission to HEE: 31 October 2019

Trust's name:	Tees, Esk and Wear Valleys NHS Foundation Trust
Value of contract / funding with HEE:	1. Total funding received for education and training from HEE 18/19: £6,695,027 2. Total initial 19/20 LDA value: £4,571,034
Trust Chief Executive's name:	Colin Martin
Director(s) of Education's name: **(or equivalent, please state job title):**	Director of Medical Education: Dr Jim Boylan (Until 31st March 2020) Dr Hany El-Sayeh (From 1st October 2019)
Name of Board Level Exec/Non-exec Director responsible for Education and Training strategy within your organisation:	Dr Ahmad Khouja, Medical Director, Elizabeth Moody, Director of Nursing and Governance and David Levy, Director of Human Resources
Report compiled by (responsible for completion of):	Nursing components by Elizabeth Moody, Stephen Scorer & Ann Marshall Professional Nursing & Education Team Medical components by Bryan O'Leary, Hayley Lonsdale & Val Holmes, Medical Development Team
Report signed off by:	Elizabeth Moody, Director of Nursing and Governance and Bryan O'Leary, Associate Director of Medical Development
Date signed off:	31st October 2019
Board Approval: **1. Approved by / on behalf of the Trust Board: (date / details)** **2. Date seen at or scheduled for Board meeting**	26th November 2019

Section 1: Organisation overview linked to the HEE Quality Framework

1.1 Organisation's Governance for Education and Training

Please describe how your organisation ensures the governance of education.

Please attach an organisational diagram or visual that describes the governance and team structures relating to education and training.

**This SAR is aligned to the HEE Quality Framework. For medical education the SAR is also aligned to the GMC Promoting Excellence*

Trust's response

Tutor roles are a significant part of the Trust governance framework. They are appointed to posts through competitive interview and are accountable through the two Associate Directors of Medical Education (ADME). All posts sit within the Faculty of Medical Education and are accountable to the Director of Medical Education. The medical development function that supports and advises the faculty is overseen by the Associate Director of Medical Development. Both senior roles work in close partnership to oversee the agenda and report through to the Medical Director who is a Board Member. Medical Education Committees oversee the operational delivery of the different programmes and these are cited in the Medical Education Operating Framework.

There are various ways in which the activity of the department is overseen. Each year two annual reports are written for the Trust Board. One is based on recruitment and retention and the other medical education. The reports reflect activity over the previous twelve months and sets out the strategic direction for the forthcoming cycle. The Medical Director provides an update to Board and this includes oversight of the Quality Improvement Plan (QiP) and Self-Assessment Report (SAR).

A further report is compiled by the Guardian of Safe Working, supported by the medical staffing team, on compliance with the junior doctor contract. The Guardian of Safe Working attends Board meetings for regular updates and this highlights areas that are of concern in relation to safe working or rest break provision and also some educational matters. It was decided that it provides more value and independence to invite the Guardian to strategic educational committees and events.

The Director of Medical Education (DME), attends the monthly management meeting with the Medical Director and has a standard agenda item to update colleagues on matters of strategic importance, discuss issues and raise concerns. The DME also briefs consultants at the quarterly Trust-wide consultant meeting.

The Trust uses the Quality Improvement Plan (QiP) to set direction and ensure progress against all of the actions that are set. Each of the committees set their own QiP for the relevant area of their work and this is tabled and updated at each committee.

The forthcoming year will see amendments to the faculty structure following the appointment of a new DME. This will allow consolidation of some of the existing tutor roles and the introduction of some new Trust-wide roles, including physician associate and inter-professional education (IPE) tutors.

In 2020, the intention is to develop a new IPE group to oversee the governance behind compliance with the LDA and to also take forward the operational delivery of inter-professional training.

1.2. Top three education and training successes

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

Description of success	Domain(s)	Standard(s)
The NMC approval and subsequent commencement of a new pre-registration nursing course at Coventry University at Scarborough, with twenty places initially, including some staff supported onto the course by the Trust. Scarborough is an area which is traditionally difficult to recruit into. The Trust has also supported successful NMC re-approval events for the new standards for education at all other local HEI's across the year and has continued to grow its Nursing Associate workforce and approach to Apprenticeship based – learning including a focus upon Learning Disability service	4,5 and 6	All within these domains
A new contract with the York St John University counselling doctorate has been introduced – 12 trainees started this September in York and Knaresborough localities	5	
In 2019, the feedback from the GMC annual trainee survey ranked the Trust as 4th overall in the whole of the UK. It has been the highest ranked Trust in the North East region over the last 7 years and in 2019 became the highest ranked Trust in the Yorkshire and Humber region too.	All	

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

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

Description of challenges	Domain(s)	Standard(s)
The West Lane Hospital concerns have been shared with the local HEI's from a training perspective so that they can maintain their communication with their regulator. Support was offered to affected students/trainees on placement by the appropriate professional leaders.	1,2 and 3	
The provision of increasing numbers of placements for multi-professional trainees is an ongoing challenge however the trust continues to explore and map options. Specifically nursing are currently working on introducing the new NMC standards and roles for assessment across the organisation which may assist with capacity for placements.		
Recruitment of senior medical staff and significant consultant level vacancies pose the biggest challenge to maintaining our established excellence in supervision and training to medical undergraduates and trainees at all levels combined with an increased demand for placements.	1,2	

Section 2: Assurance and Exception Reporting

2.1. Multi-professional

2.1.1. Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

Please consider all domains and standards in the table below and declare any areas where standards are partially or not met. Please ensure that any areas highlighted as partially or not met are listed in your organisation's Quality Improvement Plan (QIP).

Domain 1 Learning Environment and Culture *Please see **HEE Quality Framework** page 9&10.*			
Domain 1 Quality Standards	**Met** *If all professions in scope meet the standard, please state 'All'* *If not all professions meet the standard please state:* *'All professions meet the standard with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list profession(s) partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list profession(s) not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	Yes, with proviso opposite regarding West Lane site opposite	The West Lane hospital issues referred to above may impact on this domain although generally these are met across the organisation	
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	The educational audits would suggest that this is complied with for pre-reg nursing and therapies.		
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	Yes, there is a 2 week service improvement placement for student nurses additionally all staff can access THINK – On coaching.		
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	All areas have the family and friends and other service user feedback available		
1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	Yes, assessed within the educational audit		

1.6 The learning environment promotes inter-professional learning opportunities.	As above and opportunities continue to be explored with the Psychiatry team and across professions to strengthen these options further		
Domain 2 Educational governance and leadership *Please see **HEE Quality Framework** page 11&12.*			
Domain 2 Quality Standards	**Met** *If all professions in scope meet the standard, please state 'All'* *If not all professions meet the standard please state:* *'All professions meet the standard with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list profession(s) partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list profession(s) not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	Audit is completed 2 or 3 year cycle and more frequently if issues identified – this is based on the quality standards. We also respond to concerns as they are raised.		
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	As above		
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	The Education and training group is multi-disciplinary. Simulation training alongside medical colleagues takes place and has been well-received		
2.4 Education and training opportunities are based on principles of equality and diversity.	Processes in place for recruitment to opportunities such as Apprenticeships, Nursing Associate programme which focus on widening access to those who may not have accessed training through the traditional routes. Additionally therapies staff are trying different ways to access secondary and undergraduate students		
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	Datix incidents are notified to nursing education team with a process in place including escalation, and there is an		

	established “Cause for Concern” process. Workshops are offered in supporting the under-achieving student. This happens across the heath and HEI systems so that we can support each other with any problems		
Domain 3 Supporting and empowering learners *Please see HEE Quality Framework page 13&14.*			
Domain 3 Quality Standards	**Met** *If all professions in scope meet the standard, please state ‘All’* *If not all professions meet the standard please state:* *‘All professions meet the standard with exception of those listed in partially met and/or not met box’*	**Partially met** *Please list profession(s) partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list profession(s) not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	This is embedded in the PPF role and also the preparatory workshops which support service-based nurses to carry out the roles in this section Additional resource is available.		
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	The new NMC standards in the area are being supported by the PPF team and the Universities Study is built into placements for therapies trainees.		
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	Student evaluations would support this in general		
3.4 Learners receive an appropriate and timely induction into the learning environment.	Home Turs induction takes place at the start of the programme and this is followed up by local inductions in each placement		
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys .			

Domain 4 Supporting and empowering educators *Please see HEE Quality Framework page 15.*			
Domain 4 Quality Standards	**Met** *If all professions in scope meet the standard, please state 'All'*	**Partially met** *Please list profession(s) partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list profession(s) not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	All nurses with a mentorship qualification are being prepared for transition to the new assessor roles within the NMC standards. In addition practice supervisors are being prepared through a workshop model of delivery. Psychologists have to be an approved supervisor to take on a trainee.		
4.2 Educators are familiar with the curricula of the learners they are educating.	Introducing the new curricula is a challenge but is being addressed through the above workshops and involvement in the development and delivery of the curricula.		
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	Triennial review is completed every year at appraisal for mentors.		
4.4 Formally recognised educators are appropriately supported to undertake their roles.	As above		

Domain 5 Delivering curricula and assessments *Please see HEE Quality Framework page 16.*			
Domain 5 Quality Standards	**Met** *If all professions in scope meet the standard, please state 'All'* *If not all professions meet the standard please state:* *'All professions meet the standard with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list profession(s) partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list profession(s) not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	All the pre-registration courses are approved by the regulatory body the NMC though a rigorous process which includes the trust as partners. There are programme boards and partnership groups which continuously review these. . Professional heads or delegates contribute to the process to ensure that the learning meets the needs of both the university and the profession/ NHS.		
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	The nursing team have been involved in the NMC approval events and developing the new curricula. The apprenticeship – based schemes are employer led so there has been significant involvement		
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	The 360 degree tool includes service user and practice based assessment. Service users are involved in the home trust induction		

Domain 6 Developing a sustainable workforce *Please see HEE Quality Framework page 17.*			
Domain 6 Quality Standards	**Met** *If all professions in scope meet the standard, please state 'All'* *If not all professions meet the standard please state:* *'All professions meet the standard with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list profession(s) partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list profession(s) not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	The Trust is involved in the initial shortlisting and recruitment onto pre-registration programmes across nursing and therapy professions. All efforts are made to support learners to complete their courses. Apprentices are continuously monitored as requirements of the scheme and issues detected at an early stage		
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	Job fairs are held, and the trust has a recruitment and retention group which looks at career development. Careers sessions are held for post-registration preceptorship students . Over the last two years professional therapies have been looking at career pathways and made changes such as to JD/ roles available, and also now offering assistant (pre reg) programmes and mid-career programmes		
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	There is a Right Staffing Programme ("Safe Staffing") which includes workforce reviews and has a sub-group which considers new roles such as advanced practice		
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	There is an established preceptorship programme, with work-based programme and development days to support increased		

	competence and confidence. This is formalised differently in each professional group but well supported e.g. new AYSE year in social work for think ahead students		

2.1.2. Good Practice Items

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

Description of good practice and profession(s) it relates to (and a named contact for further information)	Description of why this is considered to be good practice	HEE Domain(s)	HEE Standard(s)
The continued growth of apprenticeship based approaches within the organisation, including both pre-registration training and Nursing Associates, the Trust has supported significant numbers of trainees with backfill and associated costs and has grown the number of HEI's it works with in order to increase training opportunities and placements	The Trust, along with local partners has been very pro-active in a topic which we understand there has been relatively slow progress nationally and has supported a number of staff to develop in line with widening access and retaining local staff	5, 6	
There has been Ongoing success within the Think Ahead social work training programme, and staff have been recruited into post following qualification	It is a good example of developing inter-agency methods of working	1, 5 and 6	

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

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

Description of challenges (please include the profession / professions)	HEE Domain(s)	HEE Standard(s)
The provision of increasing numbers of placements for nursing trainees is an ongoing challenge however the nursing and education team continue to explore and map options, and are currently working on introducing the new NMC standards and roles for assessment across the organisation which may assist with this	1 and 3	

There is a challenge in introducing the new curricula and supporting roles for the NMC standards, in particular because these may be introduced at different times by the various HEIs. However the risk is mitigated by the ongoing working relationships and planning around this issue.		

2.2. Postgraduate Medical

2.2.1. Organisation assurance statement and exception reporting against the GMC Quality Themes, Standards and Requirements and the HEE Domain 6 Standards

Please consider all themes, standards and requirements in the table below and declare any areas where standards and requirements are partially or not met. Please ensure that any areas highlighted as partially or not met are listed in your organisation's Quality Improvement Plan (QIP).

Theme 1 Learning Environment and Culture *Please see the GMC Promoting Excellence pages 8-15.*			
Theme 1 Quality Standards	**Met** *If all posts/programmes in scope meet the standard, please state 'All'* *If not all posts/programmes meet the standard, please state:* *'All posts/programmes meet the standard with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list post(s)/ programme(s) partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list post(s)/ programme(s) not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.	All		
S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.		100% of trainees based at Foxrush House rated their overall satisfaction for quality of experience in this post as fair. Actions plans have been produced to improve workplace orientation for all trainees at every intake for this site.	

Theme 1 Quality Requirements	Met *If all posts/programmes in scope meet the requirement, please state 'All'*	Partially met *Please list post(s)/ programme(s) partially meeting the requirement* *Please ensure all items declared as partially met are added to the QIP*	Not met *Please list post(s)/ programme(s) not meeting the requirement*
R1.1 Organisations* must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences	All		
R1.2 Organisations must investigate and take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.	All		
R1.3 Organisations must demonstrate a culture that investigates and learns from mistakes and reflects on incidents and near misses. Learning will be facilitated through effective reporting mechanisms, feedback and local clinical governance activities.	All		
R1.4 Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional duty of candour – and help them to develop the skills to communicate with tact, sensitivity and empathy.	All		
R1.5 Organisations must demonstrate a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care, and on education and training.	All		
R1.6 Organisations must make sure that learners know about the local processes for educational and clinical governance and local protocols for clinical activities. They must make sure learners know what to do if they have concerns about the quality of care, and they should encourage learners to engage with these processes.	All		
R1.7 Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities.	All		

R1.8 Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor. Foundation doctors must at all times have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session. Medical students on placement must be supervised, with closer supervision when they are at lower levels of competence.	All		
R1.9 Learners' responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an appropriately graded level of clinical supervision.	All		
R1.10 Organisations must have a reliable way of identifying learners at different stages of education and training, and make sure all staff members take account of this, so that learners are not expected to work beyond their competence.		The GMC trainee survey reported a red outlier for F1 trainees in Clinical Supervision OOH. F1 trainees felt they were forced to cope with clinical problems beyond their competence or experience. Action plan in situ. Probing questions to be asked during Foundation Programme mid-point and end of placement meetings to cover the areas highlighted and query whether the survey results are linked to acute trust experience as F1 trainees do not undertake on-calls within Psychiatry.	
R1.11 Doctors in training must take consent only for procedures appropriate for their level of competence. Learners must act in accordance with General Medical Council (GMC) guidance on consent.5 Supervisors must assure themselves that a learner understands any proposed intervention for which they will take consent, its risks and alternative treatment options.		The GMC trainee survey reported a red outlier for F1 trainees in Clinical Supervision OOH. 33% of trainees felt they were expected to obtain consent for procedures they did not understand the proposed interventions and its risk. Action plan in situ. Probing questions to be asked during Foundation Programme mid-point and end of placement meetings to cover the areas highlighted and query whether the survey results are linked to acute trust experience as F1 trainees do not undertake on-calls within Psychiatry.	
R1.12 Organisations must design rotas to: **a** make sure doctors in training have appropriate clinical supervision **b** support doctors in training to develop the professional values, knowledge, skills and behaviours required of all doctors		The GMC trainee survey reported 33% of trainees based within General Adult Psychiatry at Foxrush House agreed that rota gaps are rarely lost to educational training. However 33% of trainees strongly disagreed that rota	

working in the UK **c** provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme **d** give doctors in training access to educational supervisors **e.g.** minimise the adverse effects of fatigue and workload.		gaps were dealt with appropriately. Trainees at Harrogate highlighted that 50% were not treated at the appropriate level of clinical experience. 50% of trainees disagreed that rota gaps were appropriately dealt with. 50% disagreed that educational and development was optimised.	
R1.13 Organisations must make sure learners have an induction in preparation for each placement that clearly sets out: **a** their duties and supervision arrangements **b** their role in the team **c** how to gain support from senior colleagues **d** the clinical or medical guidelines and workplace policies they must follow **e** how to access clinical and learning resources. As part of the process, learners must meet their team and other health and social care professionals they will be working with. Medical students on observational visits at early stages of their medical degree should have clear guidance about the placement and their role.	All		
R1.14 Handover* of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.		A red outlier in the GMC trainee survey was indicated for GP Trainees in regards to handover at Cross Lane Hospital. An action plan is in situ. The College Tutor for the Scarborough locality will support trainees in undertaking a handover audit to set standards for future audit including consideration of involvement of MDT and learning opportunities within handover.	
R1.15 Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance, and gives an appropriate breadth of clinical experience.		33% of core trainees based at the Briary Wing in Harrogate reported that encouragement to take study leave was poor. This feedback resulted in a pink outlier in the GMC trainee survey. An action plan has been agreed between the ADME and the DME to address the issue.	
R1.16 Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses and other learning opportunities to meet the requirements of their curriculum. In timetabled educational sessions, doctors in training must not be	All		

interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety.			
R1.17 Organisations must support every learner to be an effective member of the multiprofessional team by promoting a culture of learning and collaboration between specialties and professions.	All		
R1.18 Organisations must make sure that assessment is valued and that learners and educators are given adequate time and resources to complete the assessments required by the curriculum.	All		
R1.19 Organisations must have the capacity, resources and facilities* to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by their curriculum or training programme and to provide the required educational supervision and support.		33% of core trainees based at the Briary Wing in Harrogate experienced difficulty in obtaining study leave resulting in a pink outlier in the GMC trainee survey. 33% failed to find prospectus and 33% had difficulties due to fixed leave pattern.	
R1.20 Learners must have access to technology enhanced and simulation-based learning opportunities within their training programme as required by their curriculum.	All		
R1.21 Organisations must make sure learners are able to meet with their educational supervisor or, in the case of medical students, their personal adviser as frequently as required by their curriculum or training programme.	All		
R1.22 Organisations must support learners and educators to undertake activity that drives improvement in education and training to the benefit of the wider health service.	All		

Theme 2 Educational governance and leadership *Please see the GMC Promoting Excellence pages 16-22.*			
Theme 2 Quality Standards	**Met** *If all posts/programmes in scope meet the standard, please state 'All'*	**Partially met** *Please list post(s)/ programme(s) partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list post(s)/ programme(s) not meeting the standard*
S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.	All		
S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.	All		
S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.	All		
Theme 2 Quality Requirements	**Met** *If all posts/programmes in scope meet the requirement, please state 'All'*	**Partially met** *Please list post(s)/ programme(s) partially meeting the requirement* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list post(s)/ programme(s) not meeting the requirement*
R2.1 Organisations must have effective, transparent and clearly understood educational governance systems and processes to manage or control the quality of medical education and training.	All		
R2.2 Organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show they are meeting the standards for the quality of medical education and training within their organisation and responding appropriately to concerns.	All		
R2.3 Organisations must consider the impact on learners of policies, systems or processes. They must take account of the views of learners, educators and, where appropriate, patients, the public, and employers. This is particularly important when services are being redesigned.	All		

R2.4 Organisations must regularly evaluate and review the curricula and assessment frameworks, education and training programmes and placements they are responsible for to make sure standards are being met and to improve the quality of education and training.	All		
R2.5 Organisations must evaluate information about learners' performance, progression and outcomes – such as the results of exams and assessments – by collecting, analysing and using data on quality and on equality and diversity.	All		
R2.6 Medical schools, postgraduate deaneries and LETBs must have agreements with LEPs to provide education and training to meet the standards. They must have systems and processes to monitor the quality of teaching, support, facilities and learning opportunities on placements, and must respond when standards are not being met.	All		
R2.7 Organisations must have a system for raising concerns about education and training within the organisation. They must investigate and respond when such concerns are raised, and this must involve feedback to the individuals who raised the concerns.	All		
R2.8 Organisations must share and report information about quality management and quality control of education and training with other bodies that have educational governance responsibilities. This is to identify risk, improve quality locally and more widely, and to identify good practice.	All		
R2.9 Organisations must collect, manage and share all necessary data and reports to meet GMC approval requirements.			
R2.10 Organisations responsible for managing and providing education and training must monitor how educational resources are allocated and used, including ensuring time in trainers' job plans.	All		
R2.11 Organisations must have systems and processes to make sure learners have appropriate supervision. Educational and clinical governance must be integrated so that learners do not pose a safety risk, and education and training takes place in a safe environment and culture.	All		
R2.12 Organisations must have systems to manage learners' progression, with	All		

input from a range of people, to inform decisions about their progression.			
R2.13	*(Not Applicable to Postgraduate Medical)*		
R2.14 Organisations must make sure that each doctor in training has access to a named clinical supervisor who oversees the doctor's clinical work throughout a placement. The clinical supervisor leads on reviewing the doctor's clinical or medical practice throughout a placement, and contributes to the educational supervisor's report on whether the doctor should progress to the next stage of their training.		33% of trainees based at Foxrush House across all programmes did not know who was providing clinical supervision but advised there was usually someone they could contact. There have been recent changes to the substantive clinical supervisor role at this site. The Clinical Director will identify a named interim clinical supervisor to provided interim clinical supervision. The ADME will closely monitor the situation until a substantive consultant is identified. Formal communication with TPD following core trainee clinics will allow for assessing progress in this area.	
R2.15 Organisations must make sure that each doctor in training has access to a named educational supervisor who is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements.		Educational Supervision at Cross Lane Hospital across all programmes is a pink outlier as 25% of trainees stated they did not know if they have a learning agreement with an educational supervisor. Huntington House rated pink across all training programmes for Educational Supervision. An action plan has been created by the ADME. The ADME will contact all trainees and trainers to remind there must be clear lines of supervision at all times. The ADME will recirculate the who's who in medical development document and ensure this is included in all future junior doctor induction communications. The ADME to further explore the results during the Foundation programme mid-point reviews.	
R2.16 Organisations must have systems and processes to identify, support and manage learners when there are concerns about a learner's professionalism, progress, performance, health or conduct that may affect a learner's wellbeing or patient safety.	All		
R2.17 Organisations must have a process for sharing information between all relevant organisations whenever they identify safety, wellbeing or fitness to practise concerns about a learner, particularly when a learner is progressing to the next stage of training.	All		
R2.18 Medical schools (and the universities of which they are a part)	All		

must have a process to make sure that only those medical students who are fit to practise as doctors are permitted to graduate with a primary medical qualification. Medical students who do not meet the outcomes for graduates or who are not fit to practise must not be allowed to graduate with a medical degree or continue on a medical programme. Universities must make sure that their regulations allow compliance by medical schools with GMC requirements with respect to primary medical qualifications. Medical schools must investigate and take action when there are concerns about the fitness to practise of medical students, in line with GMC guidance. Doctors in training who do not satisfactorily complete a programme for provisionally registered doctors must not be signed off to apply for full registration with the GMC.			
R2.19 Organisations must have systems to make sure that education and training comply with all relevant legislation.	All		
R2.20 Organisations must make sure that recruitment, selection and appointment of learners and educators are open, fair and transparent.	All		

Theme 3 Supporting learners

Please see the GMC Promoting Excellence pages 23-27.

Theme 3 Quality Standards	**Met** *If all posts/programmes in scope meet the standard, please state 'All*	**Partially met** *Please list post(s)/ programme(s) partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list post(s)/ programme(s) not meeting the standard*
S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.	All		
Theme 3 Quality Requirements	**Met** *If all posts/programmes in scope meet the requirement, please state 'Al*	**Partially met** *Please list post(s)/ programme(s) partially meeting the requirement* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list post(s)/ programme(s) not meeting the requirement*
R3.1 Learners must be supported to meet professional standards, as set out in *Good medical practice* and other standards and guidance that uphold the medical profession. Learners must have a clear way to raise ethical concerns.	All		

R3.2 Learners must have access to resources to support their health and wellbeing, and to educational and pastoral support, including: **a** confidential counselling services **b** careers advice and support **c** occupational health services. Learners must be encouraged to take responsibility for looking after their own health and wellbeing.	All		
R3.3 Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.	All		
R3.4 Organisations must make reasonable adjustments for disabled learners, in line with the *Equality Act 2010*.* Organisations must make sure learners have access to information about reasonable adjustments, with named contacts.	All		
R3.5 Learners must receive information and support to help them move between different stages of education and training. The needs of disabled learners must be considered, especially when they are moving from medical school to postgraduate training, and on clinical placements.	All		
R3.6 When learners progress from medical school to foundation training they must be supported by a period of shadowing† that is separate from, and follows, the student assistantship. This should take place as close to the point of employment as possible, ideally in the same placement that the medical student will start work as a doctor. Shadowing should allow the learner to become familiar with their new working environment and involve tasks in which the learner can use their knowledge, skills and capabilities in the working environment they will join, including out of hours.	All		
R3.7 Learners must receive timely and accurate information about their curriculum, assessment and clinical placements.	All		
R3.8 Doctors in training must have information about academic opportunities in their programme or specialty and be supported to pursue an academic career if they have the appropriate skills and aptitudes and are inclined to do so.	All		
R3.9	*(Not Applicable to Postgraduate Medical)*		

R3.10 Doctors in training must have access to systems and information to support less than full-time training.	All		
R3.11 Doctors in training must have appropriate support on returning to a programme following a career break.	All		
R3.12 Doctors in training must be able to take study leave appropriate to their curriculum or training programme, to the maximum time permitted in their terms and conditions of service.	All		
R3.13 Learners must receive regular, constructive and meaningful feedback on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it. Feedback should come from educators, other doctors, health and social care professionals and, where possible, patients, families and carers.		A pink outlier was identified at both Foxrush House and Roseberry Park in regards to feedback across all programmes. The ADME has created an action plan to address the GMC trainee survey results. The ADME will encourage clinical supervisors to attend the feedback skills training sessions provided within the in-house teaching programme. The ADME will also liaise with junior doctor locality representatives to request that they liaise with their trainee colleagues and encourage them to seek formal and informal feedback on their progress from their supervisor and wider clinical team.	
R3.14 Learners whose progress, performance, health or conduct gives rise to concerns must be supported where reasonable to overcome these concerns and, if needed, given advice on alternative career options.	All		
R3.15 Learners must not progress if they fail to meet the required learning outcomes for graduates or approved postgraduate curricula.	All		
R3.16 Medical students who are not able to complete a medical qualification or to achieve the learning outcomes required for graduates must be given advice on alternative career options, including pathways to gain a qualification if this is appropriate. Doctors in training who are not able to complete their training pathway should be given career advice.	All		

Theme 4 Supporting educators *Please see the GMC Promoting Excellence pages 28-30.*			
Theme 4 Quality Standards	**Met** *If all posts/programmes in scope meet the standard, please state 'All'*	**Partially met** *Please list post(s)/ programme(s) partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list post(s)/ programme(s) not meeting the standard*
S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.		Trainer overall satisfaction at Lanchester Road Hospital across general psychiatry shows 33% strongly disagree that they enjoy their trainer role 33% stated that support from the department is very poor	
S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.	All		
Theme 4 Quality Requirements	**Met** *If all posts/programmes in scope meet the requirement, please state 'All'*	**Partially met** *Please list post(s)/ programme(s) partially meeting the requirement* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list post(s)/ programme(s) not meeting the requirement*
R4.1 Educators must be selected against suitable criteria and receive an appropriate induction to their role, access to appropriately funded professional development and training for their role, and an appraisal against their educational responsibilities.	All		
R4.2 Trainers must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.	All		
R4.3 Educators must have access to appropriately funded resources they need to meet the requirements of the training programme or curriculum.	All		
R4.4 Organisations must support educators by dealing effectively with concerns or difficulties they face as part of their educational responsibilities.	All		

R4.5 Organisations must support educators to liaise with each other to make sure they have a consistent approach to education and training, both locally and across specialties and professions.		The GMC trainer survey indicated a pink outlier for supportive environment at North End House. The ADME will explore the survey results in further detail with medical managers for this locality and offer appropriate support as necessary.	
R4.6 Trainers in the four specific roles must be developed and supported, as set out in GMC requirements for recognising and approving trainers.	All		

Theme 5 Delivering and implementing curricula and assessments *Please see the GMC Promoting Excellence pages 31-37.*			
Theme 5 Quality Standards	**Met** *If all posts/programmes in scope meet the standard, please state 'All'*	**Partially met** *Please list post(s)/ programme(s) partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list post(s)/ programme(s) not meeting the standard*
S5.1	*(Not Applicable to Postgraduate Medical)*		
S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.	All		
Theme 5 Quality Requirements	**Met** *If all posts/programmes in scope meet the requirement, please state 'All'*	**Partially met** *Please list post(s)/ programme(s) partially meeting the requirement* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list post(s)/ programme(s) not meeting the requirement*
R5.1 to R5.6	*(Not Applicable to Postgraduate Medical)*		
R5.7 Assessments must be mapped to the curriculum and appropriately sequenced to match progression through the education and training pathway.	All		
R5.8 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the medical student's performance and being able to justify their decision.	All		
R5.9 Postgraduate training programmes must give doctors in training: **a** training posts that deliver the curriculum and assessment requirements set out in the approved curriculum **b** sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum **c** an educational induction to make sure they understand their curriculum and how their post or clinical placement fits within		Adequate experience at Foxrush House indicates a red outlier for trainees based within general adult. The ADME has created an action plan which includes an enhanced work place orientation with inclusions of: 1. Scope for Audit, QI project 2. Scope for covering curriculum competencies The ADME will also hold an initial meeting with the Clinical Supervisor for	

the programme **d** the opportunity to develop their clinical, medical and practical skills and generic professional capabilities through technology enhanced learning opportunities, with the support of trainers, before using skills in a clinical situation **e** the opportunity to work and learn with other members on the team to support inter-professional multidisciplinary working **f** regular, useful meetings with their clinical and educational supervisors **g** placements that are long enough to allow them to become members of the multidisciplinary team, and to allow team members to make reliable judgements about their abilities, performance and progress **h** a balance between providing services and accessing educational and training opportunities. Services will focus on patient needs, but the work undertaken by doctors in training should support learning opportunities wherever possible. Education and training should not be compromised by the demands of regularly carrying out routine tasks or out-of-hours cover that do not support learning and have little educational or training value.		the Foundation Programme doctor to agree a PDP which is aimed at helping the trainee achieve competencies within their 4 month placement. ADME to share with Clinical Supervisors at Foxrush House a template and outline of orientation programme used during a pilot in AMH inpatient units at Roseberry Park. The GMC trainee survey results highlighted a pink outlier for adequate experience for core trainees at the Briary Wing in Harrogate and general psychiatry trainees at both Cross Lane Hospital and Huntington House. The ADME for North Yorkshire and York will arrange focus groups to explore these issues further. Curriculum coverage for core trainees based at Roseberry Park and trainees across all programmes at West Park Hospital indicates a pink outlier. The ADME will promote peer groups for core trainers and foundation programme trainers throughout Durham, Darlington and Teesside. The ADME will also meet with Core TPD, locality tutors, and FP Tutors to agree on dates to deliver the peer group sessions. The ADME will write to individual supervisors outlining areas for improvement. ADME plans to use one of the FP and GP peer group sessions to promote the use of the London Deanery Competency Checklist. Curriculum Coverage across all programmes at Huntington House indicates a pink outlier. The ADME for North Yorkshire and York will arrange focus groups to explore these issues further. Whilst conducting the foundation programme mid-point reviews the ADME will also ask further probing questions to explore the feedback received from the GMC trainee survey results.	
R5.10 Assessments must be mapped to the requirements of the approved curriculum and appropriately sequenced	All		

to match doctors' progression through their education and training.			
R5.11 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the doctor in training's performance and being able to justify their decision. Educators must be trained and calibrated in the assessments they are required to conduct.	All		
R5.12 Organisations must make reasonable adjustments to help disabled learners meet the standards of competence in line with the *Equality Act 2010*, although the standards of competence themselves cannot be changed. Reasonable adjustments may be made to the way that the standards are assessed or performed (except where the method of performance is part of the competence to be attained), and to how curricula and clinical placements are delivered.	All		

HEE Domain 6 Developing a sustainable workforce

Please see HEE Quality Framework page 17.

Domain 6 Quality Standards	**Met** *If all posts/programmes in scope meet the standard, please state 'All'*	**Partially met** *Please list post(s)/ programme(s) partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list post(s)/ programme(s) not meeting the standard*
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	All		
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	All		
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	All		
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support	All		

developed and delivered in partnership with the learner.			
7. Providers must proactively develop and implement activities that will support individual learners to successfully transition from their education programme to employment. Feedback from learners needs to be utilised to develop activities and outcomes evaluated to assess the impact on retention levels and spread good practice.	All		

2.2.2. Good Practice Items

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

Description of good practice (and a named contact for further information)	Description of why this is considered to be good practice	HEE/GMC Domain(s)	HEE/GMC Standard(s)
Management & Leadership programme for trainee doctors continues to be delivered	The programme is now attracting trainees external to the Trust resulting is a regular waiting list of trainees to join the programme	2	Educational Governance & Leadership
CESR programme continues to be developed for SAS doctors	Dedicated tutor in place to ensure the programme is embraced an all clinicians engaged.	6	Developing a sustainable workforce
Overseas recruitment programme continues	Overseas doctors skills embraced within the services of the Trust	6	Developing a sustainable workforce
In House Training Programme	Annual programme of training sessions available to all grades of trainees with new subjects being added as requirements arise	6	Developing a sustainable workforce

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

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

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
Ongoing recruitment challenges for substantive consultant staff, resulting in fewer colleagues wishing to take up supportive faculty tutor roles within the medical education arena.	6	Developing a sustainable workforce

2.3. Undergraduate Medical

2.3.1. Organisation assurance statement and exception reporting against the GMC Quality Themes, Standards and Requirements and the HEE Domain 6 Standards

Please consider all themes, standards and requirements in the table below and declare any areas where standards and requirements are partially or not met. Please ensure that any areas highlighted as partially or not met are listed in your organisation's Quality Improvement Plan (QIP).

Theme 1 Learning Environment and Culture *Please see the GMC Promoting Excellence pages 8-15.*			
Theme 1 Quality Standards	**Met** *If all placements in scope meet the standard, please state 'All'* *If not all placements meet the standard please state: 'All placements meet the standard with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list placements partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list placements not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.	All		
S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.	All		
Theme 1 Quality Requirements	**Met** *If all placements in scope meet the requirement, please state 'All'* *If not all placements meet the requirement please state: 'All placements meet the requirement with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list placements partially meeting the requirement* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list placements not meeting the requirement* *Please ensure all items declared as not met are added to the QIP*
R1.1 Organisations* must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences	All		
R1.2 Organisations must investigate and	All		

take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.			
R1.3 Organisations must demonstrate a culture that investigates and learns from mistakes and reflects on incidents and near misses. Learning will be facilitated through effective reporting mechanisms, feedback and local clinical governance activities.	All		
R1.4 Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional duty of candour – and help them to develop the skills to communicate with tact, sensitivity and empathy.	All		
R1.5 Organisations must demonstrate a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care, and on education and training.	All		
R1.6 Organisations must make sure that learners know about the local processes for educational and clinical governance and local protocols for clinical activities. They must make sure learners know what to do if they have concerns about the quality of care, and they should encourage learners to engage with these processes.	All		
R1.7 Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities.	All		
R1.8 Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor. Foundation doctors must at all times have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session. Medical	All		

students on placement must be supervised, with closer supervision when they are at lower levels of competence.			
R1.9 Learners' responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an appropriately graded level of clinical supervision.	All		
R1.10 Organisations must have a reliable way of identifying learners at different stages of education and training, and make sure all staff members take account of this, so that learners are not expected to work beyond their competence.	All medical students provided with pink lanyards in accordance with the NHS *"found my place"* guidance		
R1.11 Doctors in training must take consent only for procedures appropriate for their level of competence. Learners must act in accordance with General Medical Council (GMC) guidance on consent.5 Supervisors must assure themselves that a learner understands any proposed intervention for which they will take consent, its risks and alternative treatment options.	All		
R1.12 Organisations must design rotas to: **a** make sure doctors in training have appropriate clinical supervision **b** support doctors in training to develop the professional values, knowledge, skills and behaviours required of all doctors working in the UK **c** provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme **d** give doctors in training access to educational supervisors **e** minimise the adverse effects of fatigue and workload.	All		
R1.13 Organisations must make sure learners have an induction in preparation for each placement that clearly sets out: **a** their duties and supervision arrangements **b** their role in the team **c** how to gain support from senior colleagues **d** the clinical or medical guidelines and workplace policies they must follow **e** how to access clinical and learning resources. As part of the process, learners must meet their team and other health and social care professionals they will be working with. Medical students on	All medical students receive a comprehensive induction on the first day of their rotation		

observational visits at early stages of their medical degree should have clear guidance about the placement and their role.			
R1.14 Handover* of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.	All		
R1.15 Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance, and gives an appropriate breadth of clinical experience.	All		
R1.16 Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses and other learning opportunities to meet the requirements of their curriculum. In timetabled educational sessions, doctors in training must not be interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety.	All		
R1.17 Organisations must support every learner to be an effective member of the multiprofessional team by promoting a culture of learning and collaboration between specialties and professions.		While there have been no specific placement areas identified by medical students, evaluation indicates that medical students feel that nursing students are often given priority in terms of clinical experience as they have longer placements with an identified placement mentor	
R1.18 Organisations must make sure that assessment is valued and that learners and educators are given adequate time and resources to complete the assessments required by the curriculum.	All		
R1.19 Organisations must have the capacity, resources and facilities* to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by their curriculum or training programme and to provide the required educational supervision and support.		Medical students have identified that they feel that they are not always provided with patient responsibilities appropriate to their learning.	

		There is no identifiable area specifically; however, this appears to relate to Community Mental Health teams and available opportunities in these areas, which is an area currently under development for student attendance	
R1.20 Learners must have access to technology enhanced and simulation-based learning opportunities within their training programme as required by their curriculum.	All		
R1.21 Organisations must make sure learners are able to meet with their educational supervisor or, in the case of medical students, their personal adviser as frequently as required by their curriculum or training programme.	All		
R1.22 Organisations must support learners and educators to undertake activity that drives improvement in education and training to the benefit of the wider health service.	All		

Theme 2 Educational governance and leadership *Please see the GMC Promoting Excellence pages 16-22.*			
Theme 2 Quality Standards	**Met** *If all placements in scope meet the standard, please state 'All'* *If not all placements meet the standard please state:* *'All placements meet the standard with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list placements partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list placements not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.	All		
S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.	All		
S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.	All		
Theme 2 Quality Requirements	**Met** *If all placements in scope meet the requirement, please state 'All'* *If not all placements meet the requirement please state:* *'All placements meet the requirement with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list placements partially meeting the requirement* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list placements not meeting the requirement* *Please ensure all items declared as not met are added to the QIP*
R2.1 Organisations must have effective, transparent and clearly understood educational governance systems and processes to manage or control the quality of medical education and training.	All		
R2.2 Organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show they are meeting the standards for the quality of medical education and training within their organisation and responding appropriately to concerns.	All		
R2.3 Organisations must consider the impact on learners of policies, systems or processes. They must take account of the views of learners, educators and, where appropriate, patients, the public, and employers. This is particularly important	All		

when services are being redesigned.			
R2.4 Organisations must regularly evaluate and review the curricula and assessment frameworks, education and training programmes and placements they are responsible for to make sure standards are being met and to improve the quality of education and training.	All		
R2.5 Organisations must evaluate information about learners' performance, progression and outcomes – such as the results of exams and assessments – by collecting, analysing and using data on quality and on equality and diversity.	All		
R2.6 Medical schools, postgraduate deaneries and LETBs must have agreements with LEPs to provide education and training to meet the standards. They must have systems and processes to monitor the quality of teaching, support, facilities and learning opportunities on placements, and must respond when standards are not being met.	All		
R2.7 Organisations must have a system for raising concerns about education and training within the organisation. They must investigate and respond when such concerns are raised, and this must involve feedback to the individuals who raised the concerns.	All		
R2.8 Organisations must share and report information about quality management and quality control of education and training with other bodies that have educational governance responsibilities. This is to identify risk, improve quality locally and more widely, and to identify good practice.	All		
R2.9 Organisations must collect, manage and share all necessary data and reports to meet GMC approval requirements.	All		
R2.10 Organisations responsible for managing and providing education and training must monitor how educational resources are allocated and used, including ensuring time in trainers' job plans.	All		
R2.11 Organisations must have systems and processes to make sure learners have appropriate supervision. Educational and clinical governance must be integrated so that learners do not pose a safety risk, and education and training takes place in a safe environment and culture.	All	All medical students are provided with an individualised timetable detailing all medical staff, ward managers and clinical leads working within	

		each area that the medical students are assigned to for supervision purposes. However, students have highlighted that they would prefer to spend more time with Consultant Psychiatrists. All relevant staff are emailed copies of the student timetables in advance of the rotation. Inpatient wards are also telephoned to agree and confirm which member of nursing staff the medical student should report to on their first day upon the inpatient ward.	
R2.12 Organisations must have systems to manage learners' progression, with input from a range of people, to inform decisions about their progression.	All		
R2.13 Medical schools must have one or more doctors at the school who oversee medical students' educational progression. They must have one or more doctors at each LEP who coordinate training of medical students, supervise their activities, and make sure these activities are of educational value.	All		
R2.14 and R2.15	*(Not Applicable to Undergraduate Medical)*		
R2.16 Organisations must have systems and processes to identify, support and manage learners when there are concerns about a learner's professionalism, progress, performance, health or conduct that may affect a learner's wellbeing or patient safety.	All		
R2.17 Organisations must have a process for sharing information between all relevant organisations whenever they identify safety, wellbeing or fitness to practise concerns about a learner, particularly when a learner is progressing to the next stage of training.	All		
R2.18 Medical schools (and the	All		

universities of which they are a part) must have a process to make sure that only those medical students who are fit to practise as doctors are permitted to graduate with a primary medical qualification. Medical students who do not meet the outcomes for graduates or who are not fit to practise must not be allowed to graduate with a medical degree or continue on a medical programme. Universities must make sure that their regulations allow compliance by medical schools with GMC requirements with respect to primary medical qualifications. Medical schools must investigate and take action when there are concerns about the fitness to practise of medical students, in line with GMC guidance. Doctors in training who do not satisfactorily complete a programme for provisionally registered doctors must not be signed off to apply for full registration with the GMC.			
R2.19 Organisations must have systems to make sure that education and training comply with all relevant legislation.	All		
R2.20 Organisations must make sure that recruitment, selection and appointment of learners and educators are open, fair and transparent.	All		

Theme 3 Supporting learners

Please see the GMC Promoting Excellence pages 23-27.

	Met	**Partially met**	**Not met**
Theme 3 Quality Standards	*If all placements in scope meet the standard, please state 'All'* *If not all placements meet the standard please state:* *'All placements meet the standard with exception of those listed in partially met and/or not met box'*	*Please list placements partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	*Please list placements not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.	All		
Theme 3 Quality Requirements	**Met** *If all placements in scope meet the requirement, please state 'All'* *If not all placements meet the requirement please state:* *'All placements meet the requirement with exception of those listed in partially met*	**Partially met** *Please list placements partially meeting the requirement* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list placements not meeting the requirement* *Please ensure all items declared as not met are added to the QIP*

	and/or not met box'		
R3.1 Learners must be supported to meet professional standards, as set out in *Good medical practice* and other standards and guidance that uphold the medical profession. Learners must have a clear way to raise ethical concerns.	All		
R3.2 Learners must have access to resources to support their health and wellbeing, and to educational and pastoral support, including: **a** confidential counselling services **b** careers advice and support **c** occupational health services. Learners must be encouraged to take responsibility for looking after their own health and wellbeing.	All		
R3.3 Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.	All		
R3.4 Organisations must make reasonable adjustments for disabled learners, in line with the *Equality Act 2010*.* Organisations must make sure learners have access to information about reasonable adjustments, with named contacts.	All		
R3.5 Learners must receive information and support to help them move between different stages of education and training. The needs of disabled learners must be considered, especially when they are moving from medical school to postgraduate training, and on clinical placements.	All		
R3.6 When learners progress from medical school to foundation training they must be supported by a period of shadowing† that is separate from, and follows, the student assistantship. This should take place as close to the point of employment as possible, ideally in the same placement that the medical student will start work as a doctor. Shadowing should allow the learner to become familiar with their new working environment and involve tasks in which the learner can use their knowledge, skills and capabilities in the working environment they will join, including out of hours.	All		
R3.7 Learners must receive timely and accurate information about their curriculum, assessment and clinical placements.	All		

R3.8	*(Not Applicable to Undergraduate Medical)*		
R3.9 Medical students must have appropriate support while studying outside medical school, including on electives, and on return to the medical programme.	All		
R3.10 to R3.12	*(Not Applicable to Undergraduate Medical)*		
R3.13 Learners must receive regular, constructive and meaningful feedback on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it. Feedback should come from educators, other doctors, health and social care professionals and, where possible, patients, families and carers.	All		
R3.14 Learners whose progress, performance, health or conduct gives rise to concerns must be supported where reasonable to overcome these concerns and, if needed, given advice on alternative career options.	All		
R3.15 Learners must not progress if they fail to meet the required learning outcomes for graduates or approved postgraduate curricula.			
R3.16 Medical students who are not able to complete a medical qualification or to achieve the learning outcomes required for graduates must be given advice on alternative career options, including pathways to gain a qualification if this is appropriate. Doctors in training who are not able to complete their training pathway should be given career advice.	All		
Theme 4 Supporting educators *Please see the GMC Promoting Excellence pages 28-30.*			
Theme 4 Quality Standards	**Met** *If all placements in scope meet the standard, please state 'All'* *If not all placements meet the standard please state:* *'All placements meet the standard with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list placements partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list placements not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.	All		
S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.	All		
Theme 4 Quality Requirements	**Met** *If all placements in scope meet the requirement, please state 'All'*	**Partially met** *Please list placements partially meeting the requirement*	**Not met** *Please list placements not meeting the requirement*

	If not all placements meet the requirement please state: 'All placements meet the requirement with exception of those listed in partially met and/or not met box'	*Please ensure all items declared as partially met are added to the QIP*	*Please ensure all items declared as not met are added to the QIP*
R4.1 Educators must be selected against suitable criteria and receive an appropriate induction to their role, access to appropriately funded professional development and training for their role, and an appraisal against their educational responsibilities.	All		
R4.2 Trainers must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.	All		
R4.3 Educators must have access to appropriately funded resources they need to meet the requirements of the training programme or curriculum.	All		
R4.4 Organisations must support educators by dealing effectively with concerns or difficulties they face as part of their educational responsibilities.	All		
R4.5 Organisations must support educators to liaise with each other to make sure they have a consistent approach to education and training, both locally and across specialties and professions.	All		
R4.6 Trainers in the four specific roles must be developed and supported, as set out in GMC requirements for recognising and approving trainers.	All		
Theme 5 Delivering and implementing curricula and assessments *Please see the GMC Promoting Excellence pages 31-37.*			
Theme 5 Quality Standards	**Met** *If all placements in scope meet the standard, please state 'All'* *If not all placements meet the standard please state: 'All placements meet the standard with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list placements partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list placements not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.	All		
S5.2	*(Not Applicable to Undergraduate Medical)*		

Theme 5 Quality Requirements	Met *If all placements in scope meet the requirement, please state 'All'* *If not all placements meet the requirement please state: 'All placements meet the requirement with exception of those listed in partially met and/or not met box'*	Partially met *Please list placements partially meeting the requirement* *Please ensure all items declared as partially met are added to the QIP*	Not met *Please list placements not meeting the requirement* *Please ensure all items declared as not met are added to the QIP*
R5.1 Medical school curricula must be planned and show how students can meet the outcomes for graduates across the whole programme.	All		
R5.2 The development of medical school curricula must be informed by medical students, doctors in training, educators, employers, other health and social care professionals and patients, families and carers.	All		
R5.3 Medical school curricula must give medical students: **a** early contact with patients that increases in duration and responsibility as students progress through the programme **b** experience in a range of specialties, in different settings, with the diversity of patient groups that they would see when working as a doctor **c** the opportunity to support and follow patients through their care pathway **d** the opportunity to gain knowledge and understanding of the needs of patients from diverse social, cultural and ethnic backgrounds, with a range of illnesses or conditions and with protected characteristics **e** learning opportunities that integrate basic and clinical science, enabling them to link theory and practice **f** the opportunity to choose areas they are interested in studying while demonstrating the learning outcomes required for graduates **g** learning opportunities enabling them to develop generic professional capabilities **h** at least one student assistantship during which they assist a doctor in training with defined duties under appropriate supervision, and lasting long enough to enable the medical student to become part of the team. The student assistantship must help prepare the student to start working as a foundation doctor and must include exposure to out-of-hours on-call work.	All		
R5.4 Medical school programmes must	All		

give medical students: **a** sufficient practical experience to achieve the learning outcomes required for graduates **b** an educational induction to make sure they understand the curriculum and how their placement fits within the programme **c** the opportunity to develop their clinical, medical and practical skills and generic professional capabilities through technology enhanced learning opportunities, with the support of teachers, before using skills in a clinical situation **d** experiential learning in clinical settings, both real and simulated, that increases in complexity in line with the curriculum **e** the opportunity to work and learn with other health and social care professionals and students to support inter-professional multidisciplinary working **f** placements that enable them to become members of the multidisciplinary team, and to allow team members to make reliable judgements about their abilities, performance and progress.			
R5.5 Medical schools must assess medical students against the learning outcomes required for graduates at appropriate points. Medical schools must be sure that medical students can meet all the outcomes before graduation. Medical schools must not grant dispensation to students from meeting the standards of competence required for graduates.	All		
R5.6 Medical schools must set fair, reliable and valid assessments that allow them to decide whether medical students have achieved the learning outcomes required for graduates.	All		
R5.7 Assessments must be mapped to the curriculum and appropriately sequenced to match progression through the education and training pathway.	All		
R5.8 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the medical student's performance and being able to justify their decision.	All		
R5.9	*(Not Applicable to Undergraduate Medical)*		
R5.10 Assessments must be mapped to the requirements of the approved curriculum and appropriately sequenced to match doctors' progression through	All		

their education and training.			
R5.11 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the doctor in training's performance and being able to justify their decision. Educators must be trained and calibrated in the assessments they are required to conduct.	All		
R5.12 Organisations must make reasonable adjustments to help disabled learners meet the standards of competence in line with the *Equality Act 2010*, although the standards of competence themselves cannot be changed. Reasonable adjustments may be made to the way that the standards are assessed or performed (except where the method of performance is part of the competence to be attained), and to how curricula and clinical placements are delivered.	All		

HEE Domain 6 Developing a sustainable workforce *Please see HEE Quality Framework page 17.*			
Domain 6 Quality Standards	**Met** *If all placements in scope meet the standard, please state 'All'* *If not all placements meet the standard please state:* *'All placements meet the standard with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list placements partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list placements not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	All		
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	All		
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	All		
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	All		

2.3.2. Good Practice Items

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

Description of good practice (and a named contact for further information)	Description of why this is considered to be good practice	HEE/GMC Domain(s)	HEE/GMC Standard(s)
Students consistently comment on receiving timely information regarding assessment	Students feel prepared for their final Summative In course MOSLER assessment.	3	Supporting learners
Induction prepares the medical students for the placement	Clear guidance is provided on all aspects of the placement, including expectations during the placement, how to raise concerns, how to achieve learning outcomes	1	Learning Environment and Culture
Final Summative In Course MOSLER assessment	Organisation of the assessment, consistency ensured between assessors as all briefed beforehand, training and briefing also provided to expert patients involved.	5	Delivering and implementing curricula and assessments

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

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

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
The forthcoming closure of in-patient services in Harrogate in April. TEWV are currently working on implementing an in-patient model using the Orchards in Ripon which is a 9 bed recovery unit for adults experiencing mental ill health. We are working closely with TEWV staff & staff from Leeds Medical school to ensure that the placement will provide students with the appropriate learning opportunities required for them to meet their learning outcomes.	1	Learning Environment and Culture
The expansion of HYMS medical students in York & Scarborough will require changes to the current placement model in place in order to accommodate the additional students. TEWV have proposed a community model to HYMS which is currently being considered & if accepted, the model will be piloted prior to the increase in students coming into TEWV in September 2021.	5	Delivering and implementing curricula and assessments

2.4. Academic Training

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

Good Practice

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

Challenges

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

Section 3: Reporting against HEE 2019/20 Priorities

Please consider HEE's priorities for 2019/2020 for both medical and multi-professional.

Summary of training provision by exception
Areas of sustained high-level training provision
Sustained high level performance in training provision is noted in the following areas:
• Overall Trainee NTS Feedback
• Support to Trainers/NTS Feedback

Escalated/Continuing training concerns requiring action in 2019-20 Training Cycle
Concern regarding the performance of training provision has been noted in the following areas:

• CQC Concerns re West Lane - extract below already submitted to HEENE

On Friday 23 August the Care Quality Commission (CQC) made the decision to close the three children and young people inpatient wards at West Lane Hospital – Evergreen Centre, Newberry Centre and Westwood Centre. This followed an inspection which took place earlier that week.

When the decision was made there were 11 young people on the wards and our immediate focus was to minimise the impact this had on the young people and their families.

Over the last few weeks we have been working closely with the young people, their families and carers, our staff and our partners to identify arrangements for the safe and timely discharge or transfer of the young people.

We had already agreed discharge plans for a small number of these patients and, working alongside NHS England, we have been able to identify suitable, specialist providers for the patients who continue to need inpatient care. All 11 young people have now safely moved and the inpatient wards at West Lane Hospital have closed.

We have put in additional resource to ensure we provide enhanced support for our child and adolescent mental health (CAMHS) community and crisis teams. This will help towards reducing the need for inpatient admissions and to support young people in the community. Where a young person does require hospital admission we will continue to work with NHS England and other partners

We are also working with staff affected by the closure to temporarily move them into other Trust services. Thank you to staff across the Trust for all the work that you have done to provide support in what has been a very challenging situation. We realise that it has affected a number of teams and departments, as well as those at West Lane Hospital, including the wider CAMHS service, and other clinical and corporate services.

A number of internal and external reviews and investigations will now take place to look at the issues and events at West Lane Hospital over the last few months. This includes an independent investigation, commissioned by NHS England, which will involve a number of different people including families. The findings will be published and shared once they are complete.

We are working closely with NHS England to look at future services at West Lane Hospital and we will continue to provide you with regular updates.

The actions from Medical Development have been outlined in details as per the emails sent to yourselves on 28th & 30th August from the departments Associate Director of Medical Development and Medical Education Business Lead.

To summarise the F2 post has been amended to remove the in-patient element of clinical work and the F2 post is now split between community CAMHS and community AMH. An amended job description has been forwarded to NDFS.

The core training post based within the inpatient services at West Lane Hospital has now been removed and the core trainee in post is now working in community CAMHS in Teesside. The Core Training Programme Director (Core) and the Head of School for Psychiatry are aware of the change and have supported the same.

There were x2 Senior Registrar posts based within the inpatient services at West Lane Hospital who have now also moved. x1 Senior Registrar has moved to an approved training post in Darlington alongside her clinical supervisor. x1 Senior Registrar has commenced early in the approved training post in a community CAMHS post that she was due to rotate to in January 2020. The CAMHS Training Programme Director and the Head of School for Psychiatry are aware of the changes and have supported the same.

The junior doctors who have been affected by the closure of the inpatient services at West Lane Hospital will continue to be closely monitored and supported.

Emerging or recurrent training concerns requiring further triangulation/action in 2019-20
During the 2018-19 training cycle, areas of potential concern have been identified which require further triangulation following which formal escalation may result if these concerns are confirmed:

• General Psychiatry West Park - 2018 data highlighted numerous red indicators in workload, teamwork, curriculum coverage and rota design. Pink indicators in overall satisfaction, supportive environment, induction, adequate experience and feedback.

Actions plan had been put in place to address all areas by the ADME and tutors and was regularly monitored to ensure compliance. In 2019 no data was available to download for this site.

• Core Psychiatry Roseberry Park – 2018 data highlighted a red outlier in reporting systems, with overall satisfaction, workload, teamwork, supportive environment, induction, adequate experience, curriculum coverage, and educational governance showing pink.
2019 data has improved with only two pink indicators this year, curriculum coverage and feedback.
Actions plans have been implemented to address all areas by the ADME and tutors and continues to be monitored.

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

• Widespread workforce shortages across Mental Health Services

3. To address and update HEE NE on the GMC requirements and recommendations from their 2018/2019 regional review

• **Requirement 1 (QA11228)** - The trust must ensure doctors in training are not asked to take clinical responsibility for management decisions made by clinicians who are not appropriately qualified.

To be monitored at PSTC meetings and Junior Doctor forums.
Statement prepared and circulated to medical managers, non-medical prescribers and trainees.
Statement also to be taken to QUAG (Quality Assurance Group).

• **Requirement 2 (QA11229, Undergraduate)** - The trust must ensure all learners feel supported to raise concerns about patient safety without fear of adverse consequences.

Applies to both Postgraduate and Undergraduate programmes.
To be taken to PSTC meetings and Junior Doctor forums for discussion.
To be taken forward for discussion at the Right Staffing Board Meeting and Medical Directorate meeting via the Guardian of Safe working.
Universities have processes in place to support the Medical Students within the Trust.

• **Requirement 3 (QA11230) -** The trust must ensure the transfer of information and care between acute trusts and mental health providers is safe and provides continuity of care for patients.

DME to liaise with South Tees DME.
Explore Patient Safety Group and seek advice at the Medical Directorate meeting.
To be discussed under Patient Safety agenda item.
Feedback to be provided through committee structure to PSTC's and Junior Doctor forums.

• **Recommendation 1 (QA1231, Undergraduate)** - The trust should ensure all learners know how to report patient safety concerns, and a robust process is in place to respond to feedback from learners.

Covered in Induction by DME & Guardian of Safe Working in conjunction with the Freedom to Speak Guardian.
Discussed at PSTC's which locality reps attend and Junior Doctor Forums.
DME to explore process with Patient Safety Team to establish what their process is for providing feedback.
The DME to develop a process to feedback to members through the committee structure meetings.
Newcastle University already has a process in situ.
DME & ADME to discuss current understanding and feedback to MEQAS members.

September Update - Induction presentations all include information in regards to how to report patient safety concerns.
We have identified mechanisms to flag when junior doctors are involved in an SUI and offer meeting / support on an individual basis for these doctors with our relevant locality tutors in the first instance which would follow through to resolution and management of feedback.
There is also the offer of coaching sessions for those that wish to access our in-house coaching service.

• **Recommendation 2 (QA11233, Undergraduate)** - The trust should ensure the administration of medical student placements consistently ensures there is an appropriate level of clinical supervision at all times, and that the students are provided with learning opportunities to meet the requirements of their curriculum.

All medical students receive an individualised timetable specifically created for their placement to ensure this meets the requirements of their curriculum.
To continue to monitor at the end of each rotation, evaluation and feedback to be taken to the PIIG meeting and Undergraduate Committee meetings.

September Update - Students still receive individual placement timetables ensuring opportunities to achieve all of their learning outcomes. Students are encouraged to contact the Nurse Lead in UG Medical Education if they have any concerns regarding learning opportunities and level of clinical supervision. A Tutor Lead and named Consultant are identified for each student for the duration of the entire rotation. Feedback is formally monitored mid-point and at the end of each rotation. Feedback continues to be discussed at PIIG and UG Committee meetings.

• **Recommendation 3 (QA1123, Undergraduate)** - The trust should ensure learners at different stages of education and training can be reliably identified by all staff members, so they are not asked to work beyond their competence.

This applies across both the undergraduate and postgraduate programmes.

Junior doctors and medical students have coloured lanyards depicting their current grade and competence level.
Medical students are advised that they must also wear their university name badge as their ID at all times.
Discussion to be had with Right Staffing Board around working relationships regarding junior doctor and student feedback received.
Teesside ADME working with IT Department to ensure all professional roles are mapped correctly across smartcards and PARIS.

September Update - The DME has checked availability of guidance leaflets and notices across units. Lanyards in use. The issue raised at Right Staffing Board will be discussed with the various heads of nursing as to potential initiatives to improve this. Clear advice and emphasis to new starters during induction to work within their level of competence and to assert this and seek help where necessary. Situation is subject to regular checks and monitoring through the PSTC and Junior Doctor forums. The Teesside ADME has worked with the IT Department to ensure all professional roles are mapped correctly across smartcards and PARIS.

• **Recommendation 4 (QA11234, Undergraduate)** - The trust should review the resources available to support and supervise the doctors in training timetabled research sessions.

This is being actively addressed between DME and Director of R&D to provide more research supervisors, to be monitored.

September Update - We continue to work with our R&D department to improve access to research supervision and have made some progress for Senior Registrars. The DME has also had had conversations with Dr Ann Aboaja, Forensic Consultant Psychiatrist about encouraging research in core trainees. Dr Aboaja presented a research session to core trainees at the August 2019 induction. This is an ongoing process.

HEE Domain 1 Learning Environment and Culture
HEE priority for 2019/20 reporting in this domain is:

In your organisation, in which clinical service areas does clinical workload regularly impact adversely on your ability to deliver clinical training? What strategies do you employ to maintain both clinical service and training on a daily basis?

Clinical services are very busy but this reflects the reality of service provision which the learners will be entering once registered. Within this every effort is made to preserve protected time for learning and the meeting of training objectives to ensure a quality learning environment.

HEE Domain 2 Educational Governance and Leadership
HEE priority for 2019/20 reporting in this domain is:

Many clinical services are undergoing review and change as part of the NHS Long Term Plan & People Plan, what governance steps have you put in place to ensure the required notification of any change in service is given to both HEE and the HEIs to ensure continued clinical placements within your organisation?

The Professional Nursing and education team are represented on the Partnership and Programme Boards at the HEI s and any concerns and issues regarding service changes or placement capacity are raised there (an example being the recent West Lane issues). The ARC-PEP system is used in the North–East locality and PPQA, shortly to become PARE, in the North Yorkshire area to support placement management. The team maintain a register of educational supervisors and assessors and Montero for any issues. There are bespoke meetings with the business teams from the Universities to agree the placement capacity each financial year in addition to the above, and a placement agreement or Schedule 3 to capture this, which is signed at Executive level by the Director of Nursing.

HEE Domain 3 Supporting and Empowering Learners
HEE priority for 2019/20 reporting in this domain is:

Please describe how your organisation provides support to medical trainees who submit Exception Reports or Code of Practice concerns? How do you encourage trainees to identify Educational Exception Reports (e.g. loss of specific training session to cover clinical service gap) from ERs relating to working beyond regular hours?
How have you used the 'Rest Monies' allocated to you from central funding to support doctors in training?
Please describe how your organisation provides support to learners to ensure they can access rest facilities, IT resources and pastoral support during their placement.

All trainees are encouraged to submit exception reports via the Safe Guardian of Working route. However, we would like highlight that as a Trust we have never been fined in this area.

The 'Rest Monies' of £30,000 are being discussed in the Junior Doctors Forums to agree the best use of the allocated funds. We have recently developed a Rostering, Facilities & Fatigue working group and the group have been exploring ways of improving facilities for junior doctors whilst on-call. It is anticipated that some of the allocated funds will be used to improve current on-call facilities for junior doctors.

The Medical Development department has also invested heavily in technology by providing all trainees with individual laptops and smartphones, which will remain with the trainees throughout their time spent within the Trust.

Junior Doctors are provided with an electronic version of the Trust junior doctor handbook upon

commencement in post. The handbook is an invaluable resource and provides learners with information including, pastoral support, counselling services, occupational health services and careers advice. All junior doctors have an allocated educational supervisor who is available to provide advice and career support upon request. Mechanisms are in place to provide trainees with the provision of accommodation to support the rotas and rest periods.

HEE Domain 4 Supporting and Empowering Educators
HEE priority for 2019/20 reporting in this domain is:

MEDICAL TRAINING: Please provide details of the specific SPA time you allocate to individual trainers undertaking the roles of named Educational and Clinical Supervisor. Job planned 'one hour per week per trainee under named supervision' is the accepted standard and this is covered by the placement tariff sent with the LDA. Does your organisation meet this standard; if not, what tariff do you apply?

MULTIPROFESSIONAL TRAINING: Please provide details of the protected annual time for continued development you allocate to those providing educational roles over and above the time required annually for their continuing clinical development. What in house courses/support do you provide; what external courses do you regularly use?

Every consultant has protected time for clinical supervision and educational supervision in their job plans. Electronic job planning planned for 2020 will provide a mechanism for further scrutiny and understanding. All SPA time is met by the Educational and Clinical Supervisors, one hour per week, per trainee.

The Trust meets the required protected learning time and off-the job training time for apprentices including Nursing Associates.

HEE Domain 5 Delivering Curricula and Assessments
HEE priority for 2019/20 reporting in this domain is:

With the introduction of new workforce roles (e.g. Physicians Associates) and increased numbers of Advanced Practitioners in training, together with an increased reliance on Locally Employed Doctors on service rotas, how do you ensure that doctors in training receive their required curricular opportunities and where necessary how are these needs prioritised?

The NHS People Plan identifies the need for increased placement numbers to accommodate the planned growth in student numbers to meet future workforce demand. What plans do you have in place to accommodate increased student placements? What impact do you envisage this will have on your ability to maintain the learning experience provided to current students and to clinical service provision?

The Trust has significantly increased its nurse training capacity as part of its approach to recruitment and retention. This includes new courses, both student –funded BSc and Apprenticeship, at Sunderland University, (around 50 extra students combined) a new programme at Coventry at Scarborough campus (twenty further places) and has agreed uplifts with Teesside University from previous years. We have a small but growing number of students placed with the Open University. We also have Nursing Associates in training in various cohorts, some of whom aspire to be registered nurses in due course. The new NMC standards will assist with placement management but we have highlighted in other sections of the report that it will be a challenge to increase to these levels; we will be monitoring impact on quality as a result including student evaluations.

HEE Domain 6 Developing a Sustainable Workforce

HEE priority for 2019/20 reporting in this domain is: **The People Plan identifies as a priority the need to tackle both 'The Nursing Challenge' (Chapter 3) and to create the workforce needed to deliver '21st Century Care' (Chapter 4).** **What plans for 2019-21 does your organisation have to meet these challenges from an educational and training perspective?**
The Trust has taken a pro-active approach to supporting increased numbers of pre-registration nurses in training, and the new Nursing Associate role. This has included new co-produced courses at local HEI's such as Sunderland University who are a new entrant to our training portfolio, with a nationally recognised new programme, and the developments at the Coventry University at Scarborough campus for which the Trust supported NMC approval of a new pre-registration course in an area which is traditionally difficult to recruit to. The Trust has made considerable use of its Apprenticeship levy to send internal staff onto these programmes and has also met the backfill costs for release for training time. For example, 20 apprentices were sent on to the Sunderland pre-registration programme in January 2019. The trust is sponsoring up to ten students to go on to the new Coventry pre-registration programme this year, as part of an additional cohort of 20 students in that locality. In addition we have an active Nursing Associate programme with typically two cohorts per year. This year we have ten trainees at Teesside and will be supporting up to five staff each on the programmes at York University and Coventry University. We worked pro-actively with York University and partner trusts to re-establish the latter programme after its future was in doubt, and the Coventry programme is a new addition to our training options this year. The Trust has an approach to advanced clinical practice derived from its Right staffing programme, and we are supporting up to ten staff to access the ACP training at local HEI's for next year's intake to increase clinical support at this level of practice and provide career progression support to assist retention.

Section 4: Reference List of Supporting Information

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

Please copy this section from your last year's SAR and highlight any changes and updates.
Please list any new policies and processes and provide a brief narrative how the policy helps the organisation to meet the domains and standards. Add as many rows as required.
Please advise which domains and standards are being supported the policy.
Please note, we do not require copies of documents. Please do not embed documents or insert links. If required, the quality team will request a copy by exception.
Please advise if you have made a reference to a policy/process in other section(s) of the SAR.

Description of supporting information	HEE/GMC Domain(s)	HEE/GMC Standard(s)	Please advise if document referenced in the SAR e.g. *SAR, section 1.4 and 2.1.1*
CLIN-0020-v6.1 Professional Registration Policy. This policy has been updated to reflect the new registered profession of Nursing Associate		NMC registration and revalidation requirements	
There are no other significant changes to last year's submission from the professional nursing and education team, as follows however there are workshops and training materials on the new NMC standards			
Health and Safety Workbooks and Policy CQC outcome report and action plan Friends and Family Test Staff Survey Evaluation of placement by student Educational Audit competed every two years Trust values and behaviours Trust Compact Equality and Diversity Policy Staff Development Policy	Domain 1		
QIS Tools and methodology – from within the Trust's overall Kaizen approach to quality improvement managed through a KPO (Kaizen Promotion Office) Student placements in service improvement area (evidenced within students journey)	Domain 1		

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

Triennial review Process – which is an NMC standard and is also an agenda item in their appraisal			
Membership of Curriculum planning groups to meet new NMC standards and shape programmes to MH/LD requirements, TofR, minutes available	Domain 5		
Robust selection process jointly with University – with values based approach Flexible programmes to maximise retention. Trainee Nursing Associate and sponsorship onto Learning disability programmes support existing staff to develop their careers with high probability of retention Open University part-time distance learning to support those in work place learning, is supported by the organisation (55pprox.. 20 students currently on either pre-registration or access modules) Programme framework and reporting requirements for overall Right Staffing Programme (reported at Executive level; Preceptorship policy Preceptor development programme Work based preceptee programme Preceptee development locality programme (band 5 development) which meets HEE standards	Domain 6		
In House Training Programme	1, 4, 5	Learning Environment & Culture:/Supporting Educators: / Developing & Implementing curricula & assessments	2.2.1 2.3.1
QiP	1	Learning Environment & Culture	2.2.1
Medical Education Operating Framework	2	Educational Governance & Leadership	2.2.1 2.3.1
In house CESR Programme Overseas CESR programme			

Section 5: 19/20 Financial Accountability Report

5.1. Details of LDA funding

In this section please describe how the trust has utilised the HEE funding received via LDA payments. Please consider each contract heading.

Levy	Contract heading	Funding	Trust response
Non Med	Pharmacy	19,917	Pharmacy salary support.
Non Med	IAPT	924,000	Re-provision of IAPT training income to HEE
Non Med	Trainer Grant	20,554	Funding has been deployed to support YH Adult Nurse training
Non Med	Advanced Clinical Practitioners	52,500	Funding has been deployed to support Advanced Clinical Practitioner training
Non Med	Libraries	9,867	Library services development funding for 1 day per week salary
Non Med	Nursing Associates	26,200	This is used to support two cohorts of ten per year of trainees including release from clinical area for protected learning time. The Trust is adding considerable funding of its own to support these trainees and their host services
Non Med	Non-medical Tariff	943,725	The cost collection for each professional group costings and expenditure covers: • Pre Placement planning and support • Direct Teaching • Teaching staff time spent on training courses • Staff teaching and mentoring whilst delivering direct patient care. • Facilities eg Room Hire, materials • Administration support • Nursing: 3.0 WTE Senior Nurse Practice Placement Facilitator posts The organisation has increased the number of placements offered, and has itself funded learning disability and apprentice nursing backfill

			costs to help maintain a sustainable workforce
Non Med	IAPT EIP	19,838	Supports recruitment and supervision of IAPT students
Non Med	IAPT CYP	301,428	Supports recruitment and supervision of IAPT students
Non Med	Return to Practice	1,500	
Non Med Total		**471,529**	
Postgraduate	Education Contract Posts	4,067,294	The Trust utilises this fund in line with the guidance set out in the Department of Health and Social Care Education and Tariff document. The NHSi cost collection exercise outlines the cost associated with the training of medical students and junior doctors. Activity and expenditure in relation to training remain largely consistent with last year. Work is currently underway to understand a placement model for the anticipated expansion of students with Sunderland Medical School
Postgraduate	Foundation Activity Related	8,000	
Postgraduate	NIHR Academic Hull	10,903	
Postgraduate	Primary Care Funding Support	6,240	
Postgraduate	Tariff Transition	- 9,450	
Postgraduate Total		**4,082,987**	
Other	Other	30,000	A junior doctor focus has been established to consider the facilities provided Trust-wide and it has also included the agendas of wellbeing and fatigue.
Other	Adjustment for Apr,May & June payment on account	271,315	
Other Total		**241,315**	
Workforce Development	SAS Funding	18,500	
Workforce Development	CWD	84,485	Funding will be deployed based on the training needs analysis initially submitted to support the CWD bid.
Workforce Development Total		**102,985**	
Undergraduate Medical	Placement activity funding	1,161,242	The Trust uses this fund to employ tutors, nurse specialists and clinical

			fellows and it is also used for office and managerial support. Faculty training is provided to trainers.
Undergraduate Medical Total		**1,161,242**	
Education Support	TPD	76,777	Contribution to TPD salaries.
Education Support Total		**76,777**	
Postgraduate	Education Contract Posts	35,302	
Postgraduate Total		**35,302**	
Postgraduate	Education Contract Posts	86,292	
Postgraduate Total		**86,292**	
Grand Total		**4,571,034**	

5.2. Additional in year funding already provided

In this section please list any additional funding received from HEE, for example any regional or national funding received outside of the LDA payments. Please state the amount received, provide a high-level description of what this additional funding is for and please describe how the trust has utilised this funding.

Funding Amount	High level description	Please describe how the trust has used this funding

5.3. Use of funding to support Staff and Specialty Grade Doctors (SASG) and Locally Employed Doctors (LEDs) Faculty development

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

Questions	Trust's answer
Number of SASG doctors within the trust	**48**
Total SASG funding received	**£39k**
Is the SASG funding ring-fenced to support SASG doctors only? (Y/N)	Yes
Please describe the process by which the development needs of SASG doctors within your organisation were individually and collectively identified. Using funding allocated for SASG development; How were priorities decided?	The training needs of SAS doctors are identified through their individual clinical supervision meetings and also through appraisal. In addition, the SAS tutor is responsible for the in-house teaching programme for SAS doctors and regularly asks for feedback about the programme and discusses future topics at the business meetings. There is a comprehensive programme for trust doctors and those appointed to the CESR programme.
SASG nominated lead within the trust	Dr Huma Aazer

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

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

Section 6: Patient Safety, Simulation and Human Factors

6.1. Patient safety

Please consider the following questions below.

Questions	Trust's response
1. Who is the Lead for Patient Safety in your organisation? What support do they receive in delivering this role? E.g. job-planned time, resources etc.	Jennifer Illingworth Director Quality Governance is the lead for Patient Safety and is supported by Elizabeth Moody, Director of Nursing in delivering this role. There is job planned time and a dedicated patient safety team who carry out RCA's into all serious incidents (SI) in the Trust. There is an established governance process in place to assure all SI's are investigated and considered by a Directors Panel to assure the right level of finding is agreed and that associated learning takes place. All action plans are monitored by the patient safety team. Specific SI learning has a route to the Patient Safety Group (a high level governance forum) which feeds into the Director Level Quality Assurance Committee and then the Trust Board.
2. Please advise up to three areas relating to patient safety agenda that you have worked on in the last two years and you are most proud of? Could these be applied regionally and be shared with HEE?	Implementation of the Learning from Deaths framework and the mortality process now in place linking with high level governance process and groups in the Trust. Yes this could be shared. Family involvement in the SI process in which families are contacted as a first point of contact and share their experiences with front line clinicians. Yes, this could be shared. Holding an annual family conference where we invite families bereaved by suicide who have experienced our SI process to give us feedback and learn from them how to improve our approach to families at this very sensitive and difficult time for them
3. In which areas would you like support from HEE? E.g. educational events, funding, specific areas of training for example quality improvement?	Funding for further training for patient safety team to aid a 'train the trainer' model implementing human factors and Just Culture around the Trust.

6.2. Simulation

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

Questions	Trust's response
1. What is the governance structure in place within your organisation with regard to simulation- based education training? Who is the responsible Simulation Lead within the organisation?	Physical health in mental health and learning disability is a high priority within this Trust. Aware that many patients in psychiatric settings suffer premature deaths although the causes of death in the majority remains the same as those in the general population. Specifically to support this the Trust has a steering group that has been set up 'Recognising and assessing medical problems in psychiatric settings' (RAMPPS). This approach consists of scenario based learning with

	a clear MDT focus which can be used flexibly in a range of situations and areas. The simulation lead is Karen Naylor, a Nurse Practitioner for Physical Health Care who chairs the RAMPPS steering group and is taking this forward in the Trust. Patient safety has a representative on this steering group to share learning from SI's where simulation could be used for training.
2. Please describe your process for accessing education funding received for simulation and/or TEL bids and who is responsible for this?	The Trust does not keep an inventory as mannequins and equipment are not used in the simulations. All simulations involve a live person who is an actor (from a registered list) and all the equipment used is replica, as there is no test of staff being able to use equipment in the simulations.
3. Does your Trust offer multidisciplinary faculty training including specific simulation-based education debriefing in line with ASPiH standards?	The Trust has five trained faculty members who have completed the national course. There is a plan to grow this number to broaden across the multi-disciplinary professions with the aim to sustain the simulation work. Following on from 2 successful pilots EMT have approved 6 further pilot days in order to gain further evidence and evaluation from a larger cross section of the workforce with further involvement from AHP' s.
4. Which directorates or inter-professional groups are actively engaged with simulation-based education within your organisation? How do you encourage equitable access to simulation for all staff? Add how is this monitored?	Simulation based training is generally accepted as the gold standard method of training and there is significant signposting and discussion within the debrief in regards to physical health re EWS, Rapid Tranquilisation, Blue Bags, emergency drugs, Diabetes and First Response etc. The Trust has a multi-disciplinary approach to simulation and all pilots involve all clinical roles appropriate to the simulation. All simulations are in line with the national handbook scenarios. As a further example in practice, a simulation event involving multidisciplinary staff took place as an experiential learning event in Tier 4 inpatient Children and Young People's Services, following a series of Serious Untoward Incidents occurring on the same shift. This was collaborative, involving Health Care Assistants and Staff Nurses who were on shift leading the simulation, support from nursing governance, managers and staff psychology service. Learning included addressing clinical needs, human factors and practical environmental changes. Additionally, in April 18 the Pharmacists and Pharmacy Technicians participated in interactive case-based learning about type 2 diabetes facilitated by the Centre for Pharmacy Postgraduate Education as part of their 'focal point' series.

5. Please describe strategic engagement and representation in simulation activity in the organisation i.e. board level, clinical governance, patient safety, incident reviews, quality improvement?	The support for taking forward this work is supported by the Executive Management Team (EMT) who are in full support of the work and the pilots.

6.3. Human Factors

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

Section 7: Equality and Diversity

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

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

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

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

Prompt: In the responses below, please consider:

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

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

	As part of the medical education departments normal practice, all of the protected characteristics are covered, some examples include :: • Language Testing for Overseas Doctors • Allowances for special needs doctors, including visually impaired, and equipment for storage of insulin • Ongoing recruitment campaign for overseas doctors, to attract all ethnicities and genders • Mixed culture of faculty members within the medical development directorate • Use of demographics in various surveys across the Trust. The Equality Analysis Toolkit supports the Trust and its staff to work towards fulfilling the legislative requirements of the Equality Act 2010. Part of normal day to day decision-making for all public sector bodies should involve assessing in so far as is relevant and proportionate, the impact they have on equality in our society. An equality analysis must be completed: • For all new policies, procedures, functions, strategies, services and business plans, codes of practice, projects and guidance • Dynamic assessment for all Trust Board decisions and proposals. The Trust Board of Directors will not ratify any document or proposal that has not had an equality analysis • Reviewed as a minimum every three years for all existing policies, procedures, functions, strategies and services • Reviewed when significant (more than minor/trivial) amendments and changes are made The Trust's Equality Analysis Toolkit can be found on the Trust website at: www.tewv.nhs.uk/policies or by copying and pasting this link below into a web browser. http://www.tewv.nhs.uk/About-the-Trust/Policies/Corporate/ • Following an external monitoring visit, this is an area where we will wish to make further improvements and take actions, reporting outcomes through the relevant governance
2. How do you liaise with your trust Equality, Diversity and Inclusion Lead to: • Ensure trust reporting mechanisms and	Most of our nursing learners are BSc students from the local Universities, which we provide the placements for

data collection take learners into account? • Implement reasonable adjustments for disabled learners? • Ensure your policies and procedures do not negatively impact learners who may share protected characteristics? • Analyse and promote awareness of outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic?	in practice, so they manage the recruitment process and "own" the information although we are involved in the recruitment process. The difference is for our (currently small) number of apprentices who are our employees. For these learners we gather information on race, gender, age, sexual orientation, religion, disability and marital/ civil partnership status through our electronic staff record. In relation to data collection for medical students the School of Psychiatry oversee this data and it is collated on a regional basis. This makes it difficult for us to interpret Trust based information The Trust has signed up to the Disability Confident Scheme level 2, and has subsequently developed an action plan. This alongside a consultation on the development of a new Equality, Diversity and Human Rights strategy has identified more work that needs to be undertaken in relation to reasonable adjustments and this will form one of the objectives in the new strategy. The Trust is a member of the Business Disability Forum as part of efforts to improve local policy and practice with regard to the employment of disabled staff and learners The Trust has an Equality Analysis Toolkit which helps support the review of Trust policies, procedures, strategies, functions and services in order to establish the impact on Equality by the Trust. The Equality Analysis Toolkit supports the Trust and its staff to work towards fulfilling the legislative requirements of the Equality Act 2010. Part of normal day to day decision-making for all public sector bodies should involve assessing in so far as is relevant and proportionate, the impact they have on equality in our society. An equality analysis must be completed: • For all new policies, procedures, functions, strategies, services and business plans, codes of practice, projects and guidance • Dynamic assessment for all Trust Board decisions and proposals. The Trust Board of Directors will not ratify any document or proposal that has not had an equality analysis • Reviewed as a minimum every three years for all existing policies, procedures, functions, strategies

	and services • Reviewed when significant (more than minor/trivial) amendments and changes are made The Trust's Equality Analysis Toolkit can be found on the Trust website at: www.tewv.nhs.uk/policies or by copying and pasting this link below into a web browser. http://www.tewv.nhs.uk/About-the-Trust/Policies/Corporate/ • In relation to the exam data for medical students, it has been difficult to understand the analysis because the trust is grouped in HE regions and we are therefore aggregated with a couple of other organisations North and South. The trust has asked the GMC about this and they are looking into. • The trust's medical staffing business lead is to consider the GMC papers 'Fair to Refer' and 'Welcomed and Valued' and an update and proposed action plan in Q3
3. How do you support learners with protected characteristics to ensure that known barriers to progression can be managed effectively?	An example, the Trust has acknowledged in its Workplace Race Equality Standard action plan that those employees with a BAME background are not well represented in senior non-medical roles. As a result, the Trust developed a BAME leadership programme for bands 5 – 7. The first 3 day programme has been completed, involving 10 members of staff. The programme evaluated very well and a second programme is to take place. As part of the Trusts service user involvement, ongoing development work continues with the programme. Any individual requirements are dealt with as and when they arise, and action plans agreed, implemented and monitored. There is consideration being given towards attracting a wider range of ethnic groups to be involved as our service users. This is part on the ongoing development work of the team of the specialist nurses.
4. How do you educate learners on equality and diversity issues that may relate to themselves, their colleagues, or the local population of the trust?	Equality and Diversity Training is essential, it supports the development of empathy, compassion, understanding and knowledge. It enables staff to put equality and diversity into practice within their role, regardless of their position in the organisation and helps to ensure the Trust remains compliant with the Equality Act.

	The Trust uses a variety of different training methods which include sharing patient stories, face to face training and e-learning. These different approaches promote good practice and encourage empathy. Members of staff with good levels of E&D awareness are more likely to demonstrate higher levels of emotional intelligence, tact and professionalism. Equality and Diversity Training is mandatory for all Trust staff. Some other examples of where equality and diversity is embedded within the training are: • Corporate Induction • Leadership and Organisational Development Training • Trust Values Training • Recruitment and Selection Training • Hospital Managers Training • Equality Analysis Training • Bullying and Harassment Training • Equality Act and Human Rights Act Seminars • Complaints Investigation and PALS Team Training The Trust is working in partnership with other organisations to deliver the following specific awareness raising training sessions. • Asylum Seeker Awareness Training • Deaf and Visual Awareness Training • Deaf and Mental Health Awareness Training • Gender Sensitivity Training • LGB Awareness Training Investing in Equality and Diversity training leads to competent staff that are able to deliver services that meet people's needs.
5. How do you support your educators to develop their understanding of, and support for, learners with protected characteristics?	Equality and Diversity training is mandatory for all Trust employees, bank workers and volunteers.
6. Is there monitoring or strategies in place to look at those accessing progression opportunities, and those progressing into more senior roles? What is the Trust view on data on progression in the trust? Are there any responses or resulting	This has proved difficult to monitor. However as part of the trust's WRES action plan in response to Metric 7 Percentage believing that Trust provides equal opportunities for career progression or promotion. The trust is going to review how temporary appointments and secondments are identified and appointed to. This will include exploring whether it is possible to monitor progression in the trust.

objectives to data held by the Trust?	
7. Does the Trust invest in additional Equality and Diversity training for some or all staff I.e. more than statutory training? Any training or initiatives (in place or being considered) to learn from cases that have an E&D theme?	Following the consultation on the Equality, Diversity and Human Rights strategy training is to be developed to support clinical staff to work more confidently with service users who identify as trans. The trust's Equality, Diversity and Human Rights steering group currently receives reports on any PALs issues, complaints and SUIs that have an E & D theme feeding back any issues that need to be taken forward.

Section 8: Libraries and Knowledge Services (LQAF)

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

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

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

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

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

Trust's response

The Trust Libraries enable all Trust staff and placement students to utilise the services that they provide both within the library environments at Cross Lane, Lanchester Road, Roseberry Park, and West Park

Hospital Libraries and Pop Up Libraries across other TEWV sites and also in the wider Trust geography via the Trust's Intranet and from home/anywhere via Open Athens authenticated e-resources that the libraries subscribe to.

This is evidenced in the targeted service provision leaflets that are produced by the libraries.
The Trust Library Services Plan on Page (strategy) *references* the up-skilling of library staff including details of recent attendance at: critical appraisal skills training, systematic reviews, health literacy training, strategy development training and mobilising knowledge training.

The Trust Library Service Evaluation of Impact Report includes impact case studies and impact interviews, including one that was carried out with a group of occupational therapists after a literature search training event with library staff. This details positive impact upon service provision and service development for these therapists, but also costs out potential financial savings in terms of time saved now that the therapists are more competent at conducting their own searches.

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

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

Trust's response

£193,334 total library budget

Broken down to:

£147,842 staffing budget
£45,492 resource budget

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

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

Trust's response

- Outreach Programme - with the Pop-Up libraries around the Trust and postal loans – so that people don't have to visit a library space have started to increase usage.
- Attendance at departmental conferences with a pop up library to highlight new books /journals in that professional area of interest.
- Regular staffed sessions at West Park and Cross Lane Hospital.
- Roseberry Park Hospital Library now has a 24/7 swipe access for all staff to access the library outside of core staffed hours.
- E Books are been used well so that gives a 24/7 service for in demand items.
- E journals are increasing use
- Stock is now purchased in direct response to staff's information needs and/or suggestions.
- Links with organisational development to see all staff who are studying Trust sponsored courses.
- Regular emails to users – new stock lists etc.
- Current Awareness Bulletin distribution list is increasing
- Knowledge Share implemented - a personalised current awareness alerting system.
- Number of Literature Searches is increasing
- Evidence Summaries for service improvement.
- New library management system (funded by HEE) means we can market book stock at current library members.
- New library management system has a catalogue that allows access to book stock from(County Durham and Darlington NHS FT, Gateshead Health NHS FT, Newcastle Hospitals NHS FT, North Tees and Hartlepool NHS FT, Northumberland Tyne and Wear NHS FT Northumbria Health Care NHS FT) https://of-nenhs.olib.oclc.org/folio/
- Mindfulness and a health and wellbeing collections introduced in all libraries.
- Critical Appraisal Sessions now offered across the TEWV geography.

4. The Learning and Development Agreement that Health Education England has with your organisation states that for 2018-19 the LKS should have achieved a minimum of 90% compliance with the national standards laid out in the NHS Library Quality Assurance Framework (LQAF). **LKS that scored below 90% submitted an action plan to Health Education England in March 2019 describing their planned improvements.**
   If you submitted an action plan, please describe the improvements you have made against the plan.

   Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. The details should be available from the LQAF Action Plan developed following the 2018-19 LQAF.

Trust's response

The Tewv library scored 89% in the 2018 LQAF (77% in 2017) compliant with the national standards and therefore has increased to amber rating which is only just below the LDA requirement of 90%.

In place new reporting to managers across the Trust. Undertaking more external networking to inform developments in the library service. Working with the Research and Development Department to develop Writing for Publication and Embedding Research into Trust activities.

Section 9: Healthcare Science

9.1 Governance of Healthcare Science

Please consider the following questions below.

Questions	Trust's response
1. Who is the Lead for Healthcare Science in your organisation? What support do they receive in delivering this role? e.g. job-planned time, resources etc.	Not applicable to TEWV
2. Please advise up to three areas relating to the healthcare science agenda and their workforce that you have worked on in the last two years and you are most proud of? Could these be applied regionally and be shared with HEE?	

9.2 Training Provision of Healthcare Science Workforce

Prompt: We advise you to consult with all your Healthcare Science Specialist Managers or Lead Healthcare Scientist when compiling your response.

Questions	Trust's response
1. How are the Healthcare Science workforce trained within your organisation? Who oversees this training and ensures quality training is delivered? Please advise on names, job title and email address. What support do they receive in delivering this role? e.g. job-planned time, resources etc. Are they linked in with the HEE Healthcare Science Network in their locality?	
2. Who is responsible for keeping a record of all healthcare science learners within the Trust including their trainers? Please advise on name/s, job title and email address/es. How often are these records audited for accuracy?	
3. Do directorates participate in inter-professional learning with their healthcare science learners as they compete work-based learning outcomes and portfolios? How do you encourage equitable access to inter-professional learning for all staff?	
4. Is there strategic representation and / or recognition of healthcare science at board level? Who is the representative?	

9.3 Recruitment of Healthcare Scientists (commissioned programme)

Prompt: We advise you to consult with all your Healthcare Science Specialist Managers or Lead Healthcare Scientist when compiling your response.

Questions	Trust's response
1. Has your organisation been involved in the NSHCS national recruitment of STP / HSST Clinical Scientist trainees? If Yes: a. As an organisation what internal process have you set up to manage this recruitment process. b. Who has been involved in the process and does this fall within their job remit? c. Overall what are your views of the NSHCS recruitment process? If No: a. Why as an organisation do you not need Clinical Scientist STP / HSST trainees? b. Where in the future are you going to recruit your Clinical Scientist workforce from if you are not training them?	
2. For those organisations that have hosted STP / HSST trainees. During the training period to date: a. Has the department felt supported by the NSHCS? b. Has the department felt content with the academic programme employer arrangements? c. Has the department known where to get support from the local HEE office if required? d. Has the department known where to get support if the trainee required mental health support? e. As an organisation are you happy with the funding arrangements put in place by HEE for these programmes i. Salary ii. Support costs iii. Payment schedule arrangements Please comment on any of the above. f. With reference to the above training programmes are there any specific concerns that the organisation would like to raise with HEE through this SAR?	
3. For those organisations that host the BSc Healthcare Science students (PTP) on placements, which although not a commissioned programme attracts non-medical tariff. Please answer the following: a. How does your departments determine	

how many placement students / year they can accommodate? b. Could the training supervision model be changed from mentor to coach to accommodate more students? c. Could the students work 24/7 if departments operated those hours? If not, why not? d. Are departments allocated the non-medical tariff to their budget line when they host PTP placement students to support training these students? If not, why not?	
4. For those staff that support these trainees and placement students; mentors, training supervisors, training officers. a. Does this activity fall within their job role? b. Is it within their job plans? c. Are they allocated protected time to complete their tasks? d. Are they allocated time to complete short listing, attend interviews and complete training updates?	

9.4 Future Training Provision of Healthcare Science Workforce

Prompt: We advise you to consult with all your Healthcare Science Specialist Managers or Lead Healthcare Scientist when compiling your response. Please consider where does HSC fit in People Plan.

Questions	Trust's response
1. The training provision of the healthcare science workforce is changing. There is a significant drive for employers to utilise levy and several healthcare science apprenticeship programmes are now available at level 2, 4 and 6. Further work is ongoing for a level 7 apprenticeship. a. As an organisation have you engaged in the healthcare science apprenticeship programme and if so at what level and for what specialisms? b. How do you recruit your apprentices? c. What provider/s have you used? d. Are you providing your own assessors? e. Do you expect the demand for healthcare science apprenticeships to increase and at which level? f. If you have not engaged in the healthcare science apprenticeship programmes do you anticipate doing so in the future? If not, why not?	
2. As an organisation do you see the role of the healthcare science workforce changing / diversifying in line with the Long-Term Plan? a. How would you support this change?	

b. How do you think HEE should support this change?	
3. There will be a new T level award starting in 2021 for Healthcare Science which requires students from FEs to have placements for a minimum of 45 days. a. Have you heard of T levels? b. Would your organisation support this award and these placements?	
4. The existing healthcare science workforce is a significant contributor to patient care. As an organisation how to you support them to ensure they meet their statutory registration requirements such as CPD? a. Do you try to ensure CPD equity and align to the other non -medical multi-professional groups, e.g. nursing and AHP? b. Do you believe HEE to be the sole offer of CPD programmes suitable for all and why? c. Can you offer any other ideas how the CPD demand / expectation can be met for our workforce?	
5. Based on recent NHS publications; NHS Long Term Plan, Interim People Plan, as an organisation where do you see your healthcare science workforce in the next: a. 5 years? b. 10 years? c. 15 years?	

ITEM NO. 17

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**26 November 2019**
TITLE:	**Finance Report for Period 1 April 2019 to 31 October 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 October 2019 is a surplus of £3,801k, representing 1.8% of the Trust's turnover and is £43k ahead of the NHSI plan.

Performance Against Plan – year to date (3.1 / 3.2)

	Variance £000	Monthly Movement £000	Movement
The Trust is currently £43k **ahead** of its year to date financial plan.	-43	-32	⇧

Cash Releasing Efficiency Savings (CRES) (3.3)

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the financial year are forecast to be £1,762k **ahead of** financial plan.	Recurrent	499	→
	Non recurrent	-2,261	→
	Target	0	
	Variance	-1,762	→

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the rolling 3 year period were £8,084k **behind** the £21,810k CRES target.	Recurrent	8,084	⇧

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 £1,075k **behind of** its capital plan.	-1,075	-507	↑

Expenditure against the capital programme to 31 October 2019 is £22,727k and is behind plan by £1,075k. The variance reflects the short delay to the start of the rectification programme at Roseberry Park Hospital, plus there have been adjustments to the cash flow profiling of expenditure to the York and Selby inpatient facility (Foss Park Hospital).

Workforce (3.5)

	Variance £000	Monthly Movement £000	Movement
The Trust is £1,230k in **excess** of its agency cap (32%)	1,230	173	→

Agency expenditure is 32% (September 32%) in excess of cap for October, with expenditure across all localities. Agency expenditure has reduced during the year, reflecting the impact of the Trust's agency reduction plan.

Use of Resources Risk Rating (UoRR) (3.7)

	Plan	Actual	Movement
The Trusts UoRR is behind plan which is rated 1 to 4 with 1 being good.	1	2	↓

The UoRR for the Trust is assessed as 2 for the period ending 31 October 2019 and is behind plan (Table 4). The actual rating of 2 arises due to agency expenditure continuing to exceed the NHSI cap by 32% and is rated as a 3. Recruitment options are being explored and monthly agency expenditure has reduced since April 2019. Progress continues to be monitored and inform conversations with NHSI.

Should agency expenditure reduce to be within cap the UoRR would improve at the year end to a rating of 1.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**26 November 2019**
TITLE:	**Finance Report for Period 1 April 2018 to 31 October 2019**

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for 1 April 2019 to 31 October 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 ahead of plan against the control total set by NHSI.

The UoRR for the Trust is assessed as 2 for the period ending 31 October 2019 and is behind plan. The actual rating of 2 arises due to agency expenditure continuing to exceed the NHSI cap by 32% and is rated as a 3.

Should agency expenditure reduce to be within cap the UoRR would improve at the year end to a rating of 1.

3.2 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 31 October 2019 is a surplus of £3,801k, representing 1.8% of the Trust's turnover and is £43k ahead of 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	(349,308)	(199,659)	(199,663)	(5)	(435)
Other Operating Income	(15,852)	(8,483)	(8,369)	114	255
Total Income	**(365,160)**	**(208,142)**	**(208,032)**	**109**	**(180)**
Pay Expenditure	279,625	163,759	161,893	(1,866)	(1,014)
Non Pay Expenditure	71,005	35,418	37,389	1,971	1,391
Depreciation and Financing	8,920	5,205	4,948	(258)	(208)
Variance from plan	**(5,610)**	**(3,758)**	**(3,801)**	**(43)**	**(11)**

Non-pay expenditure is higher than the original plan and is largely due to additional investment in IT infrastructure in preparation for the improvements to the patient information system, and purchase of replacement furniture and fittings in clinical services.

The improvement in pay expenditure is largely due to the establishment of new posts following an increase in contracted income in North Yorkshire and York within Liaison, Crisis and Intensive Support Services. Recruitment is ongoing.

The surplus position within income from activities has decreased mainly due to a reduction of income to fund external care packages in Teesside, and a decrease in income for a specific care package in North Yorkshire and York.

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 (£1,762k) at the financial year end and continues to identify schemes for future years.

Table 4: Cash Releasing Efficiency Scheme Performance 2019/20	**2019/20 Target**	**2019/20 Identified Schemes**	**Variance from Target**
Locality	**£000**	**£000**	**£000**
Chief Operating Officer	4,319	5,530	-1,211
Corporate and EFM	1,014	1,411	-397
Trustwide recurrent schemes	4,566	4,720	-154
Total identified and approved recurrent CRES	**9,899**	**11,661**	**-1,762**

3.4 Capital

Expenditure against the capital programme to 31 October 2019 is £22,727k and is lower than plan by £1,075k. The variance reflects the marginal delay to the start of the refurbishment programme at Roseberry Park Hospital, there has also been adjustments made to the profiling of expenditure to the York and Selby inpatient facility (Foss Park Hospital).

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 October-19	May	June	July	August	September	October
Establishment (a) (90%-95%)	92.45%	90.89%	91.59%	92.32%	92.60%	92.01%	92.45%
Agency (b)	1.00%	3.50%	3.20%	3.10%	3.20%	3.13%	3.11%
Overtime (c)	1.00%	0.94%	0.90%	0.87%	0.87%	0.88%	0.90%
Bank & ASH (flexed against establishment) (100%-a-b-c)	5.55%	3.20%	3.50%	3.52%	3.59%	3.55%	3.50%
Total	**100.00%**	**98.51%**	**99.11%**	**99.11%**	**99.11%**	**99.11%**	**99.11%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For October 2019 the tolerance for Bank and ASH is 5.55% of pay budgets.

NHS Improvement monitors agency expenditure against a capped target. Agency expenditure at 31 October 2019 is £5,090k which is £1,230k (32%) in excess of the agreed year to date capped target of £3,861k. Nursing and

Medical agency expenditure accounts for 84% of total agency expenditure, and is used to support vacancies and enhanced observations with complex clients.

Agency expenditure has reduced during the year, reflecting the impact of the Trust's agency reduction plan.

Recruitment options are being explored to reduce dependency on agency further, and progress continues to inform conversations with NHSI.

3.6 Cash

Total cash at 31 October 2019 is £85,058k; this is £9,996k ahead of plan and is largely due to higher than anticipated creditor accruals where invoices have not been received by the Trust and a re-profiling of the capital expenditure plan.

3.7 Use of Resources Risk Rating (UoRR) and Indicators

3.7.1 The UoRR for the Trust is assessed as 2 for the period ending 31 October 2019 and is behind plan (Table 4). The actual rating of 2 arises due to agency expenditure continuing to exceed the NHSI cap by 32% and is rated as a 3.

Should agency expenditure reduce to be within cap the UoRR would improve at the year end to a rating of 1.

The Trust is ahead of its income and expenditure target (£43k) despite the agency expenditure position.

Table 4: Use of Resource Rating at 31 October 2019

NHS Improvement's Rating Guide	Weighting	Rating Categories			
	%	1	2	3	4
Capital service Cover	20	>2.50	1.75	1.25	<1.25
Liquidity	20	>0	-7.0	-14.0	<-14.0
I&E margin	20	>1%	0%	-1%	<=-1%
I&E margin distance from plan	20	>=0%	-1%	-2%	<=-2%
Agency expenditure	20	<=0%	-25%	-50%	>50%

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	1.4x	3	1.4x	3	
Liquidity	58.2 days	1	59.2 days	1	
I&E margin	1.8%	1	1.8%	1	
I&E margin distance from plan	0.0%	1	0.0%	1	
Agency expenditure	£5,090k	3	£3,861k	1	
Overall Use of Resource Rating		**2**		**1**	

3.7.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.4x (can cover debt payments due 1.4 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 58.2 days; this is slightly behind 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 1.8%, which is on plan and is rated as 1.

3.7.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding PSF income. The Trust I&E margin distance from plan is 0% which is on plan and rated as a 1.

The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is 32% 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 2 a surplus increase of £2,520k is required.
- Liquidity - to reduce to a 2 a working capital decrease of £54,292k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £1,650k is required.
- Agency Cap rating – to improve to a 2 a reduction in agency expenditure of £264k 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 October 2019 the Trust is £43k ahead of its planned control total surplus (£3,758k) 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 2 for the period ending 31 October 2019 and is behind plan (Table 4).

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

ITEM 18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th November 2019**
TITLE:	**Board Dashboard as at 31st October 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 October 2019, 3 (18%) of the indicators reported are not achieving the expected levels and are red across two of the four domains (one in the Quality domain and two in the Workforce domain). This is the same position as at the end of September 2019. In addition there are 4 KPIs (23%) that whilst not achieving the expected standard are within the 'amber' tolerance levels, with 10 achieving the standards and being rated as green (59%) which is one more than in September 2019. The Year to Date position shows 9 (53%) of the KPIs are rated as green with 3 rated as red as was the case last month.

In terms of the Oversight Framework (OF) the Trust did not achieve the IAPT-proportion of people completing treatment who move to recovery standard in September. The main area of concern is within Durham and Darlington where the standard was not achieved in the three CCG areas. Further work has been initiated with the commissioners in terms of revisiting the action plan for the IAPT services with a view to improving the performance. Commissioners have expressed significant concern about this position.

In addition to the above there were also variances in achievement of the OF standards at CCG levels and further detail is provided within the report.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**26th November 2019**
TITLE:	**Board Dashboard as at 31st October 2019**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 31st October 2019 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. Definitions of the KPIs within the dashboard are provided in Appendix B.

2. KEY ISSUES:

2.1 Performance Issues

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

- As at the end of October 2019, 3 (18%) of the indicators reported are not achieving the expected levels and are red across two of the four domains (one in the Quality domain and two in the Workforce domain). This is the same position as at the end of September 2019. In addition there are 4 KPIs (23%) that whilst not achieving the expected standard are within the 'amber' tolerance levels, with 10 achieving the standards and being rated as green (59%) which is one more than in September 2019. Of the 7 indicators that are either red or amber 2 are showing an improving trend over the previous 3 months.

  The Year to Date position shows 9 (53%) of the KPIs are rated as green with 3 rated as red as was the case last month.

- In terms of the Oversight Framework (OF) there was one area in October that remained a concern from September as follows:
  - IAPT- proportion of people completing treatment who move to recovery. The Trust continues to not achieve the standard in October achieving 46.65% which is lower than the performance in September. The main area of concern is within Durham and Darlington where the standard was not achieved in the three CCG areas. Further work has been initiated with the commissioners in terms of revisiting the action plan for the IAPT services with a view to improving the performance. Commissioners have expressed significant concern about this position. The standard was not achieved in the Scarborough and Ryedale CCG however this was closer to the standard at 47%.

  In addition to the above there were also variances in achievement of the Oversight Framework (OF) standards at CCG level as described below:
  - Proportion of people discharged from a ward that were followed up within 7 days – The standard was not achieved in the 3 North Yorkshire CCG areas and in Hartlepool and Stockton CCG area.

This is unusual and the requirement and importance of the standard has been reiterated to teams.

- Access to Early Intervention in Psychosis Services – Whilst the Trust overachieved against the standard in October we did not deliver the required standard in Harrogate and Rural District CCG.
- Inappropriate Out of Area Occupied Bed Days – the standard was not achieved in October for 4 CCGs (Darlington, North Durham, Durham Dales, Easington and Sedgefield, and Hartlepool and Stockton). These all related to 'Internal' Out of Area admissions i.e. admissions within other areas of the Trust. There were no patients were admitted externally from the Trust due to pressure on beds.

3.2 Key Risks

- Waiting times for first appointment (KPI 1) – As a Trust delivery of the 4 week waiting time standard continues to be a challenge and whilst there has been some improvement in October the overall trend since April is a deteriorating position. From a quality perspective this can impact on patient safety and experience. There continues to be concern in terms of delivering against the standard in North Yorkshire and York. Vacancies and sickness are key factors contributing to this position although 2 additional staff have been appointed, who will commence in November. Extended working hours have been agreed within Adult Mental Health Services (AMH). Within Older Peoples Services early work has started on reviewing the pathway for the memory service in order to identify any changes that would help address the gap between demand and the capacity available to meet that demand. In addition concerns remain in Durham and Darlington AMH services; however capacity has been improved following recruitment in August and September. In addition there was an Improvement Event in October which is expected to free up additional capacity to support improvement in the position.
- Percentage of patients reporting their experience as excellent or good (KPI 4) – The feedback from patients in October was better than previous months in 2019/20 and is just below the agreed standard. It will be important to continue to monitor whether this improvement is sustained in future months.
- Percentage of Serious Incidents which are found to have a root or contributory cause (KPI 5) – Whilst the position remains better than the standard set the position has fluctuated considerably over the year. This position will continue to be monitored and reported back to EMT at the Patient Safety Deep Dive in December 2019.
- %age of teams achieving the benchmarks for HoNOS score (KPI 6) – Following a strong performance in the year to September there has been a considerable decline in performance against the standard in October, such that the position for October was worse than target. Further work is being done to understand the factors that have contributed to this reduction and what can be done to improve the position.
- Bed Occupancy (KPI 12) – Bed occupancy increased to almost 92% in October which is one of the highest positions year to date. Work is continuing in terms of how we manage access to beds across the Trust as

part of the Right Care Right Place Programme. However pressure on beds continued in October.

- Vacancy Rate (KPI 15) – The level of vacancies being actively recruited to continues to be higher than we planned, with a worsening position in October. **It should be noted that a number of these vacancies will still have staff in post working their notice.** The ability to recruit to posts in a timely way impacts on the quality of care we can deliver and the financial position of the Trust as we use other ways to cover the vacancies, should they not be replaced within the notice period, such as overtime and agency staff. EMT has agreed that quarterly 'vacancy census' should be presented and discussed at EMT in order to identify specific areas of concern.
- Sickness Absence Rate (KPI 19) – The Trust continues to have a greater amount of sickness than it would wish, which clearly impacts on service users, the member of staff and also the other staff in the team. However there was a further reduction in the level of sickness reported in October. The position in September did improve although it is still higher than the same period last year. Teesside and Forensic Services report the highest levels of sickness.

2.4 Data Quality Assessment.

The refreshed Data Quality Assessment for the dashboard indicators is attached in Appendix C. This shows a reduction in the overall score from 93.09% to 85%. This is due to a number of factors relating to the reliability of data, linked to concerns about the consistent use of assessment and intervention coding which underpin a number of the KPIs and also due to the timeliness of when specific metrics was most recently tested. Work is underway to resolve issues and improve this position, and progress will be monitored on a monthly basis via the Data Quality Working Group.

3. RECOMMENDATIONS:

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

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Appendix A

Quality

	October 2019				April 2019 To October 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral	90.00%	83.64%			90.00%	83.84%		90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral	60.00%	65.93%			60.00%	59.00%		60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	2,131.00	1,753.00			2,131.00	1,753.00		2,131.00
4) Percentage of patients surveyed reporting their overall experience as excellent or good	94.00%	93.86%			94.00%	91.87%		94.00%
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding	32.00%	30.77%			32.00%	33.33%		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%	52.63%			60.00%	62.84%		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%	72.53%			65.00%	69.25%		65.00%

Activity

	October 2019				April 2019 To October 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
8) Number of new unique patients referred		8,359.00				50,557.00		
9) The number of new unique patients referred with an assessment completed		4,367.00				29,024.00		
10) Number of new unique patients referred and taken on for treatment		1,943.00				11,495.00		
11) Number unique patients referred who received treatment and were discharged		3,269.00				18,713.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	90.00%	91.96%			90.00%	90.58%		90.00%

Trust Dashboard Summary for TRUST

	October 2019				April 2019 To October 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	61.00	56.00			61.00	56.00		61.00
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.00%	25.00%			23.00%	25.26%		23.00%

Workforce

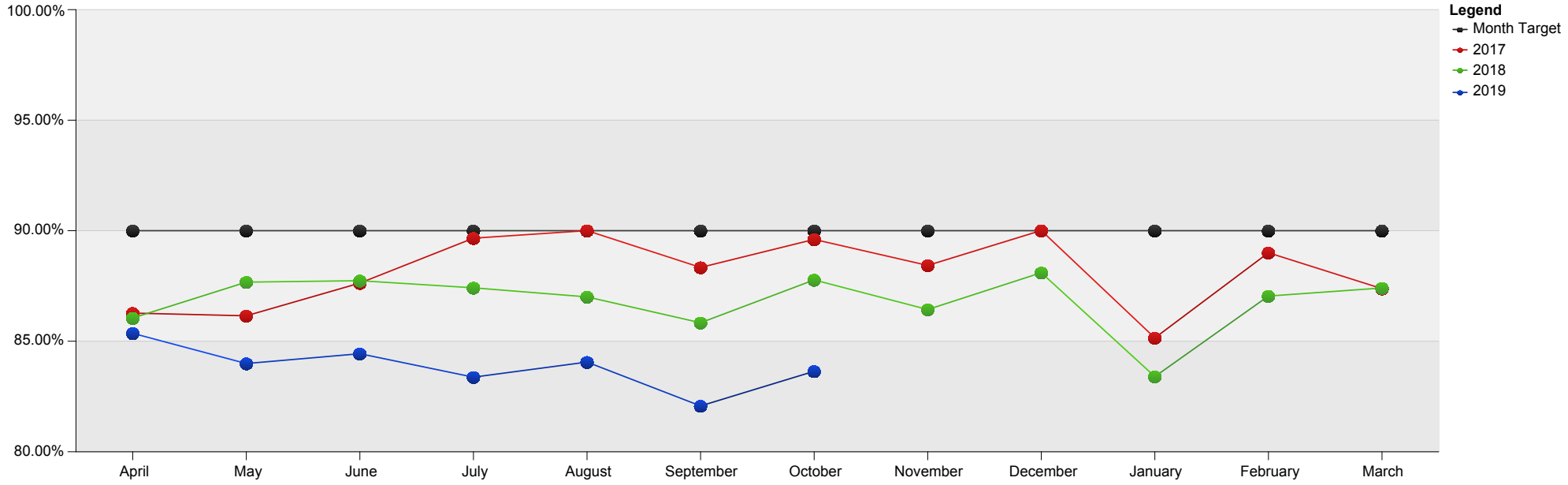
	October 2019				April 2019 To October 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
15) Vacancy Rate (Healthcare Professionals only)	6.50%	12.56%			6.50%	10.39%		6.50%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	91.65%			95.00%	91.65%		95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	93.88%			92.00%	93.88%		92.00%
18) Percentage Sickness Absence Rate (month behind)	4.40%	5.35%			4.40%	5.20%		4.40%

Money

	October 2019				April 2019 To October 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-751,000.00	-782,785.00			-3,758,000.00	-3,800,750.00		-5,610,000.00
20) CRES delivery	824,916.00	971,754.00			5,774,412.00	6,802,280.17		9,898,992.00
21) Cash against plan	75,062,000.00	85,057,618.00			75,062,000.00	85,057,618.00		54,409,000.00

Trust Dashboard Graphs for TRUST

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



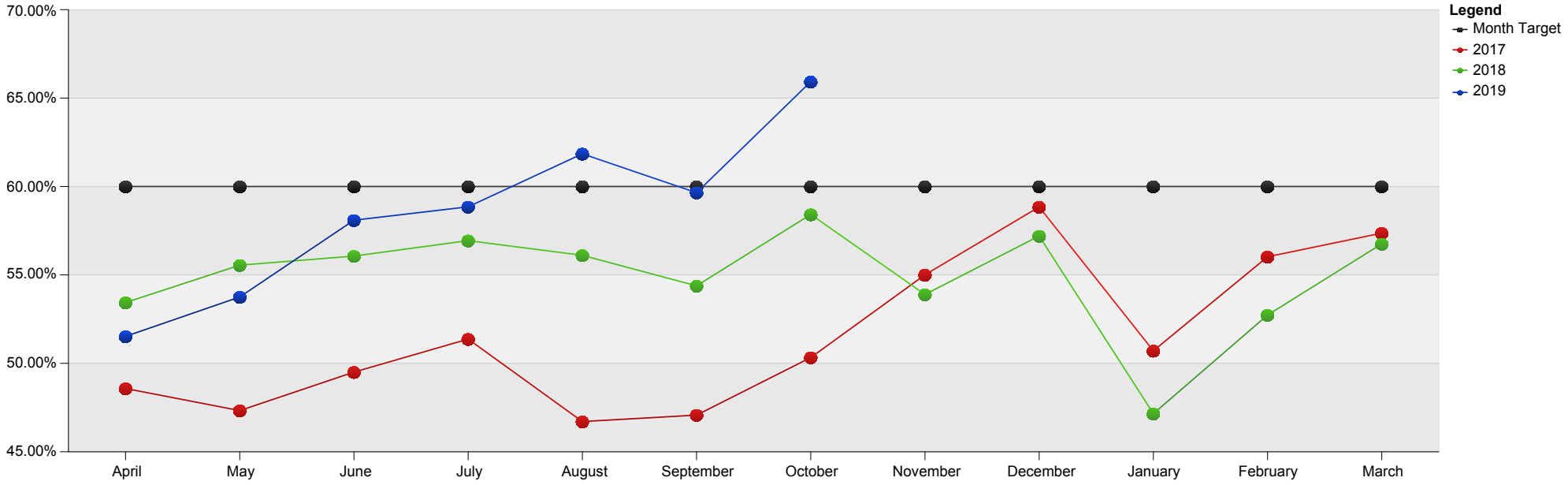
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral	83.64%	83.84%	82.40%	82.19%	91.26%	89.98%	73.93%	76.11%	99.61%	99.04%		

Narrative

The position for October 2019 is 83.64%, which is not meeting the standard of 90.00% but is better than that reported in September 2019. However this continues to the one of the lowest position reported since 2017/18. Durham and Darlington and North Yorkshire and York localities are reporting furthest from the standard at 82.40% and 73.93% respectively. Key areas of concern are as below:• Durham and Darlington AMH at 57.96% (353 out of 609 patients). This is better to the position reported in September 2019. Capacity has been improved by the recruitment of staff in August and September 2019, staffing levels are over budgeted establishment. The RPIW event held in October 2019 has agreed changes to the assessment process to free up capacity and increase patient flow. Improvements in performance are expected.• North Yorkshire and York AMH at 70.90% (609 of 859 patients). This is better than the position reported in September. Performance continues to be impacted by high sickness levels, two new members of staff will start in November and extended working hours to increase appointment slots continues.• North Yorkshire and York MHSOP at 68.73% (545 of 793 patients). Issues in the memory service across all areas are due to capacity not meeting demand. An action plan has been agreed to review the pathway and it is anticipated this will be completed by December 2019.

Trust Dashboard Graphs for TRUST

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

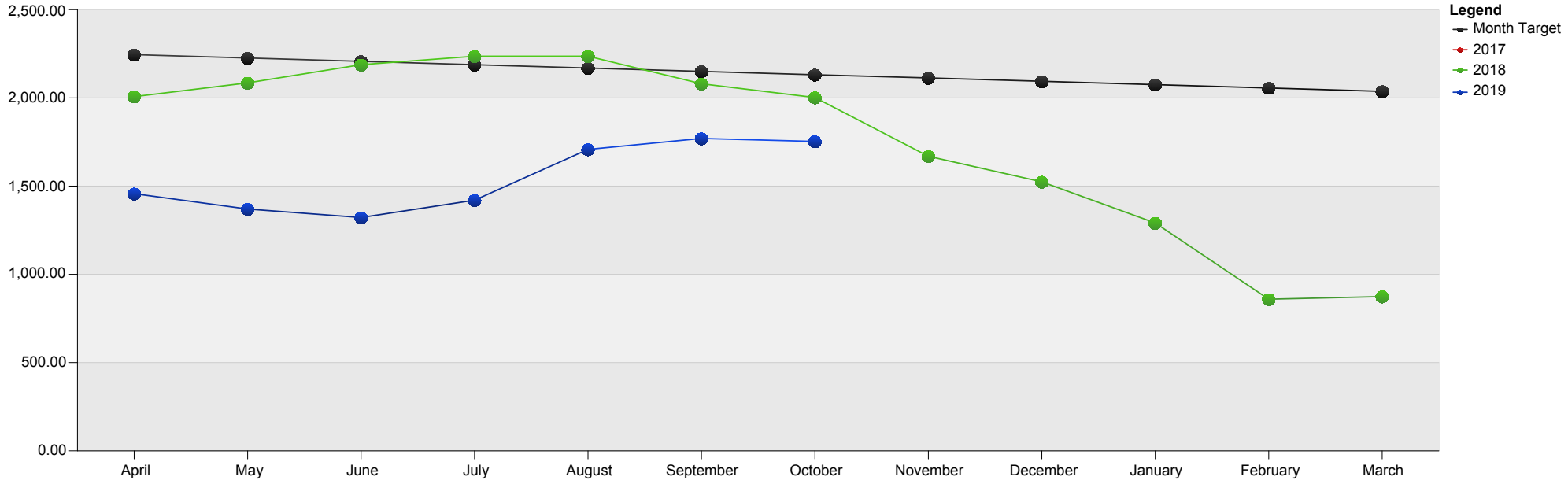


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients starting treatment within 6 weeks of an external referral	65.93%	59.00%	71.97%	63.26%	64.80%	58.15%	59.36%	54.43%	99.12%	96.49%		

Narrative
The position for October 2019 is 65.93% which is meeting the standard of 60.00% and is better than that reported in September 2019. This is the best position reported since 2017/18. All localities are meeting the standard with the exception of North Yorkshire and York who are reporting a position of 59.36%. Performance in North Yorkshire is being impacted by the capacity issues in the memory service as mentioned above. The action plan to address this will be completed by December 2019.This indicator was discussed at the Performance Improvement Group (PIG) that took place in October 2019. The purpose of the discussion was to ensure that there is consistent recording of intervention codes across specialities and localities as it is the use of these codes that 'stop the clock' for this indicator. An action plan was developed from the PIG which included a range of actions to progress. This will be monitored by the Corporate Performance Team and progress reported to the Chief Operating Officer.

Trust Dashboard Graphs for TRUST

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

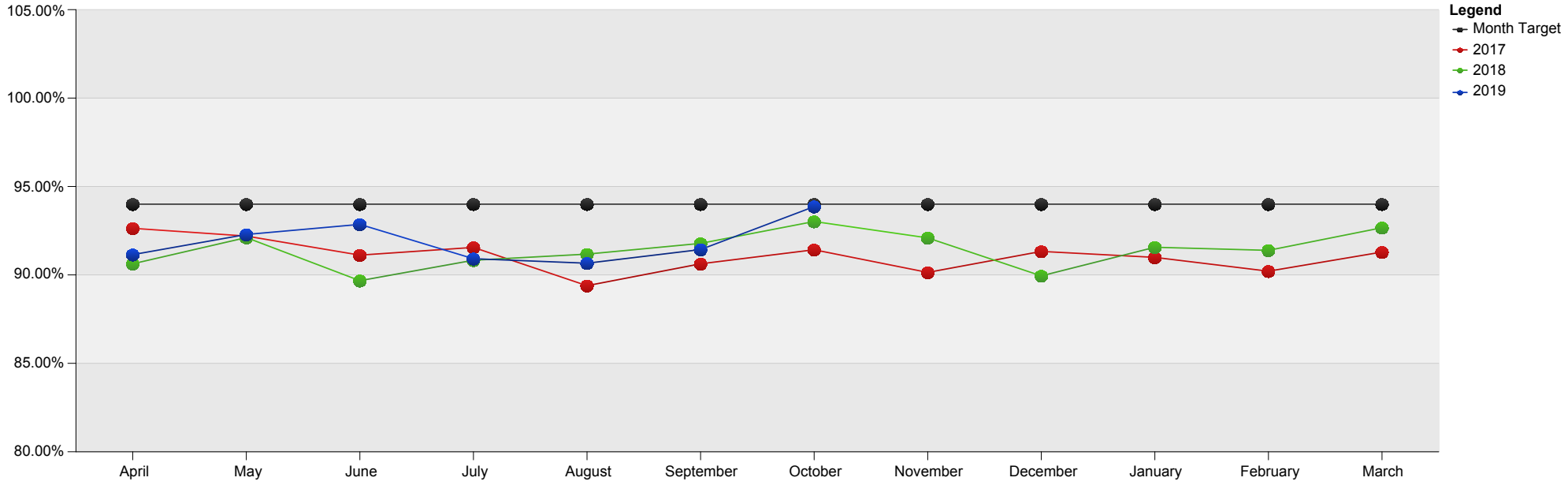


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	1,753.00	1,753.00	363.00	363.00	571.00	571.00	819.00	819.00				

Narrative
The Trust position for October 2019 is 1,753 which is similar to the position recorded in September 2019 and better than the standard of 2,131. This is better than the figure reported in October 2018.Durham and Darlington is the only locality not meeting the standard for this indicator. Bed pressures here are due to the admission of patients from localities elsewhere in the Trust.Specific work is being taken forward with regards to bed management as part of the Right Care Right Place Programme.

Trust Dashboard Graphs for TRUST

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

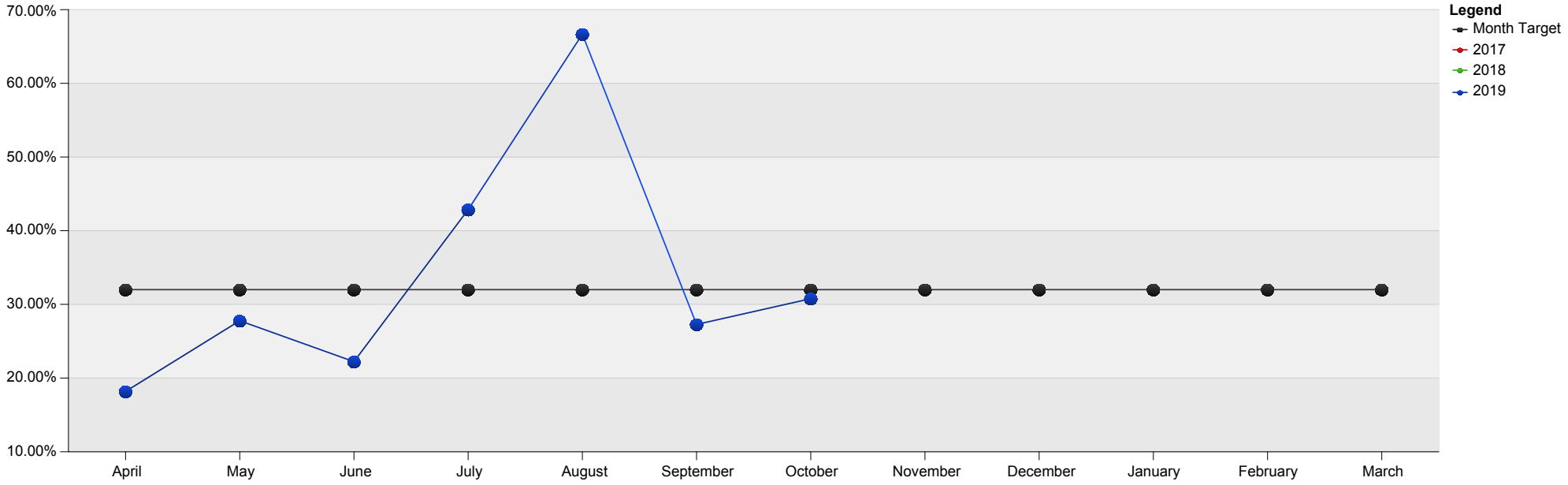


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of patients surveyed reporting their overall experience as excellent or good	93.86%	91.87%	96.37%	92.36%	94.81%	92.18%	91.07%	91.81%	90.51%	89.26%		

Narrative
The Trust position for October 2019 is 93.86% which is almost acheiving the standard of 94.00% and better than that reported in September 2019. This is also the best position reported since 2017/18.North Yorkshire and York and Forensic Services are the localities not meeting the standard for this indicator, however both report positions greater than 90%. Forensics report the lowest position at 90.51%.

Trust Dashboard Graphs for TRUST

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

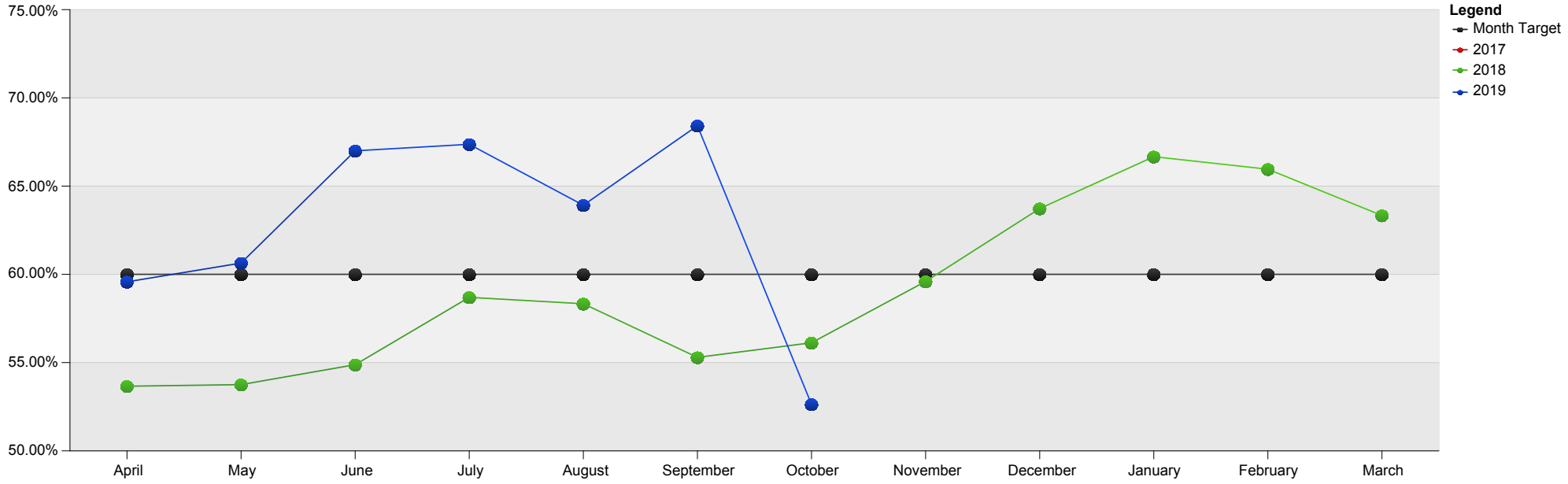


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding	30.77%	33.33%	50.00%	47.37%	28.57%	17.65%	25.00%	42.86%				

Narrative
The Trust position for October 2019 is 30.77% which is better than the standard of 32%.This relates to 4 serious incidents out of 13 which were found to have a root cause or contributory finding in October 2019. The 4 incidents occurred in the following localities:• 2 x Teesside• 1 x North Yorkshire and York• 1 x Durham and DarlingtonAny themes identified 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

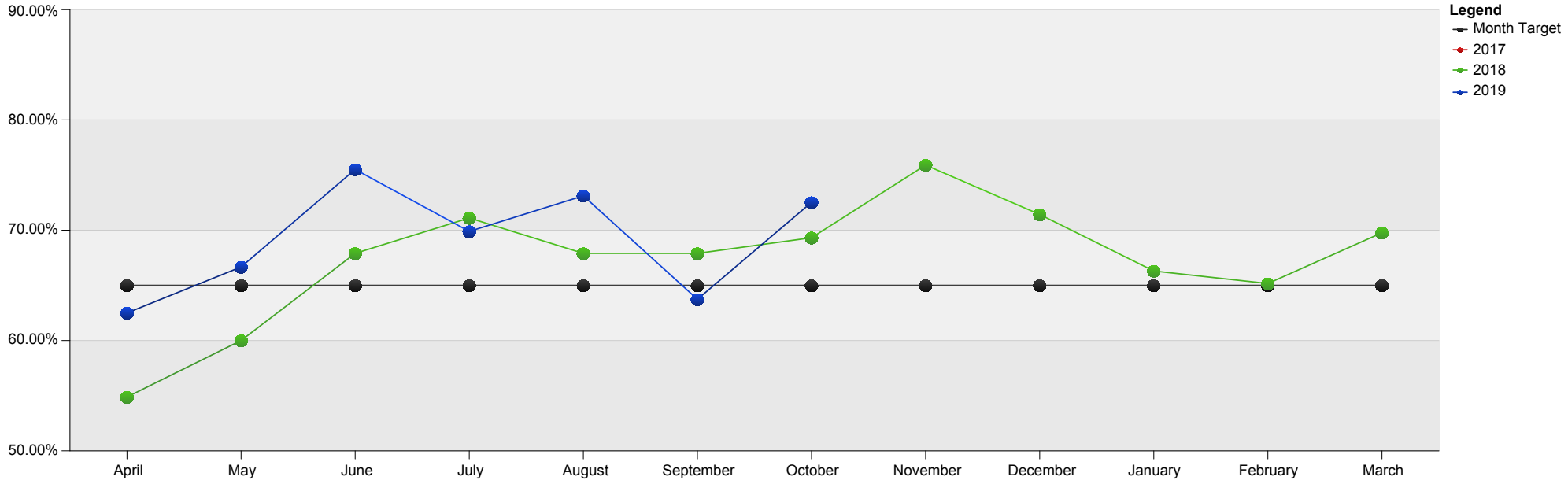


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	52.63%	62.84%	50.00%	62.90%	50.00%	61.27%	58.06%	63.93%				

Narrative
The Trust position for October 2019 is 52.63%, which is not meeting the standard and a much worse position to that reported in September 2019 and one of the lowest positions reported since 2018. No localities are meeting target for this indicator. An update regarding the reasons behind this underperformance will be provided at the Board meeting. Within this KPI an improvement in HONOS is shown by a decrease in the patient's actual HONOS score on PARIS. The change is identified by comparing the first HONOS score calculated on admission to TEWV, and the score on discharge.

Trust Dashboard Graphs for TRUST

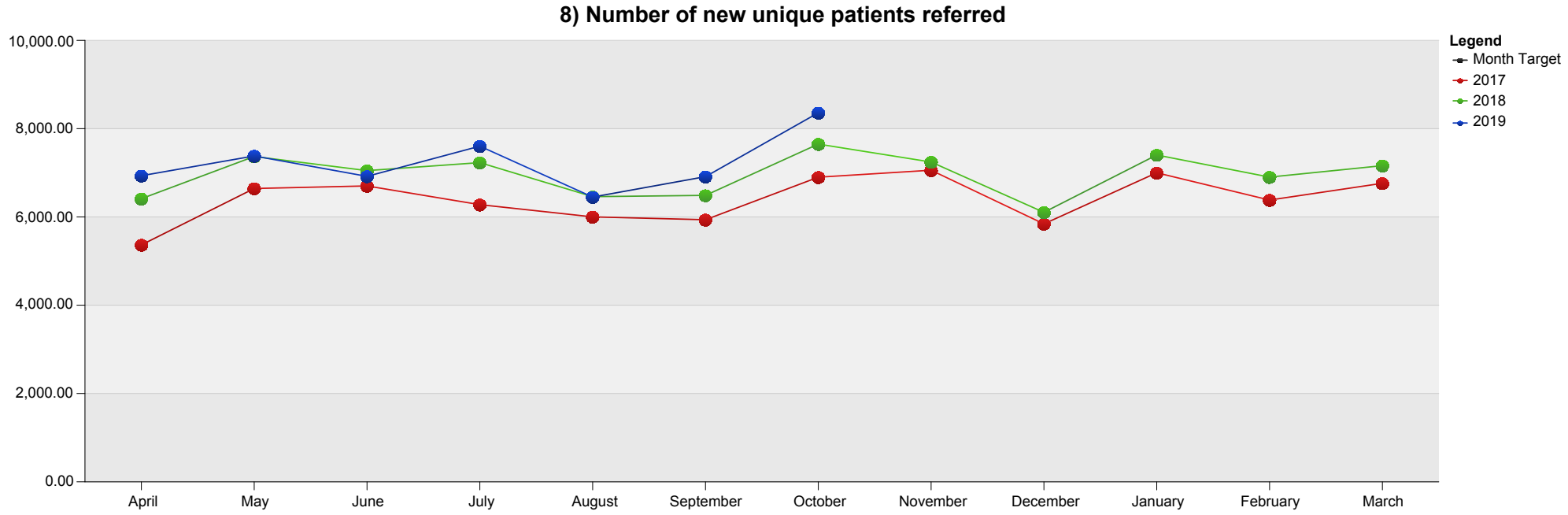
7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE 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	72.53%	69.25%	78.79%	70.91%	65.52%	68.50%	72.41%	68.30%				

Narrative
The Trust position for October 2019 is 72.53%, which is better than the standard and the position reported in both September 2019 and October 2018. All localities are meeting target.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.

Trust Dashboard Graphs for TRUST

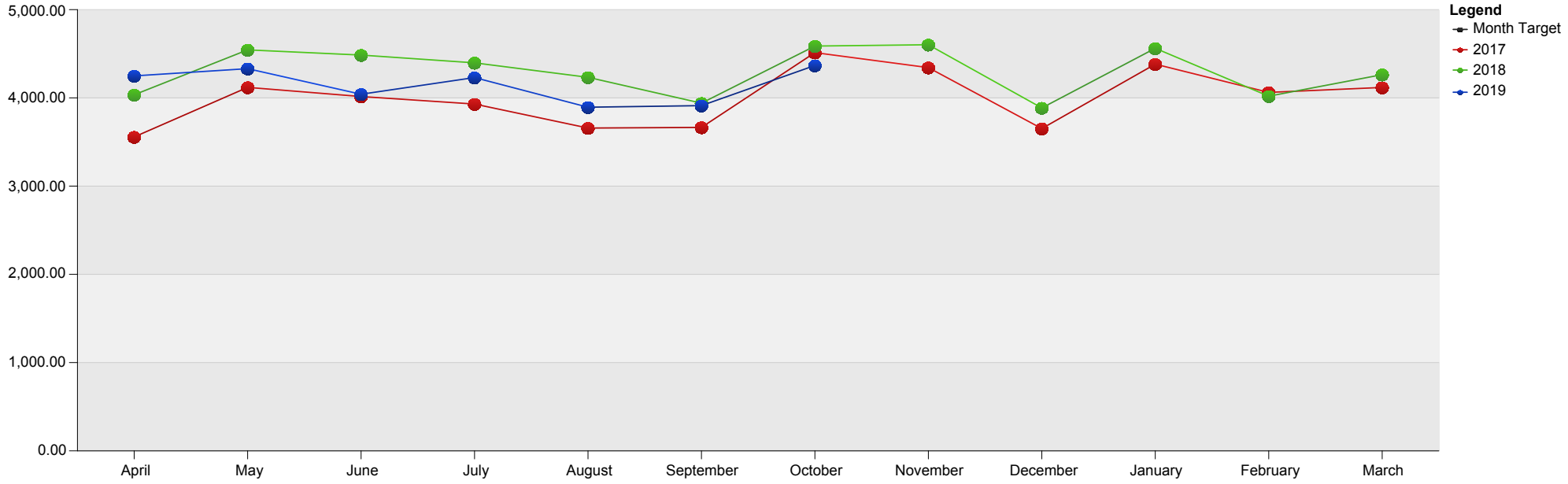


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Number of new unique patients referred	8,359.00	50,557.00	2,592.00	15,496.00	2,575.00	17,088.00	2,360.00	14,247.00	825.00	3,453.00		

Narrative
The Trust position for October 2019 is 8,359 which is an increase on the position reported for September 2019 and the highest number recorded since 2017/18. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be discussed by EMT on a quarterly basis at 'speciality' level in addition to the data and charts being reviewed by localities.

Trust Dashboard Graphs for TRUST

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

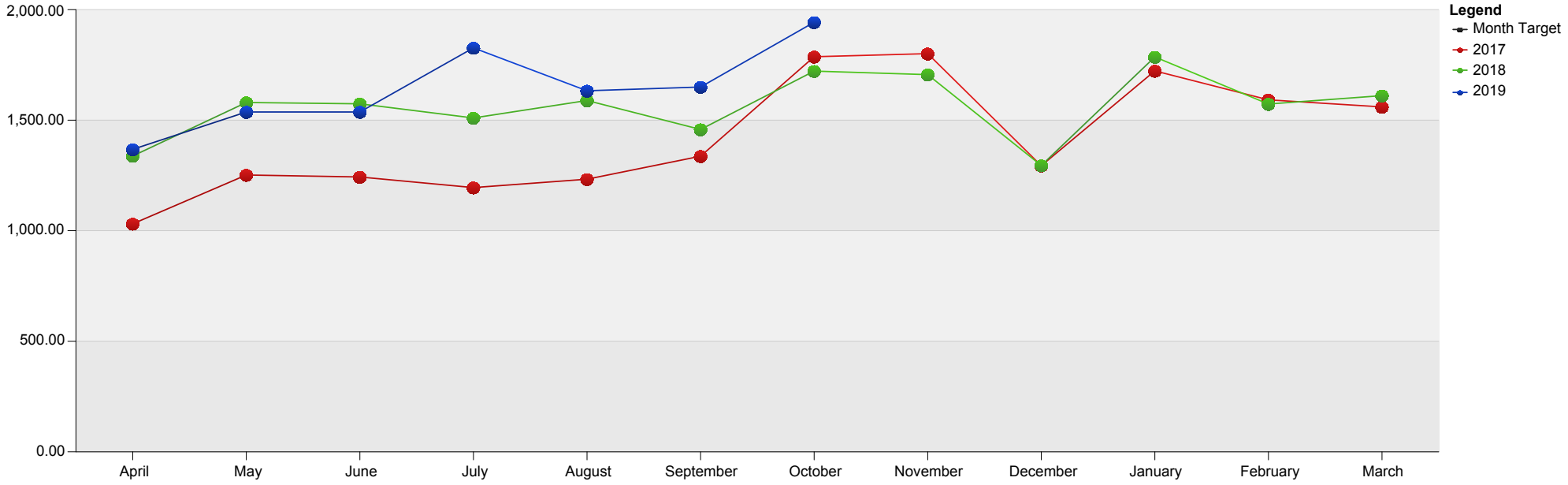


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The number of new unique patients referred with an assessment completed	4,367.00	29,024.00	1,234.00	8,494.00	1,497.00	10,285.00	1,294.00	8,488.00	309.00	1,669.00		

Narrative
The Trust position for October 2019 is 4,367 which is an increase to the position reported for September 2019 however a reduction to that reported in October 2018. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be discussed by EMT on a quarterly basis at 'speciality' level in addition to the data and charts being reviewed by localities.

Trust Dashboard Graphs for TRUST

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

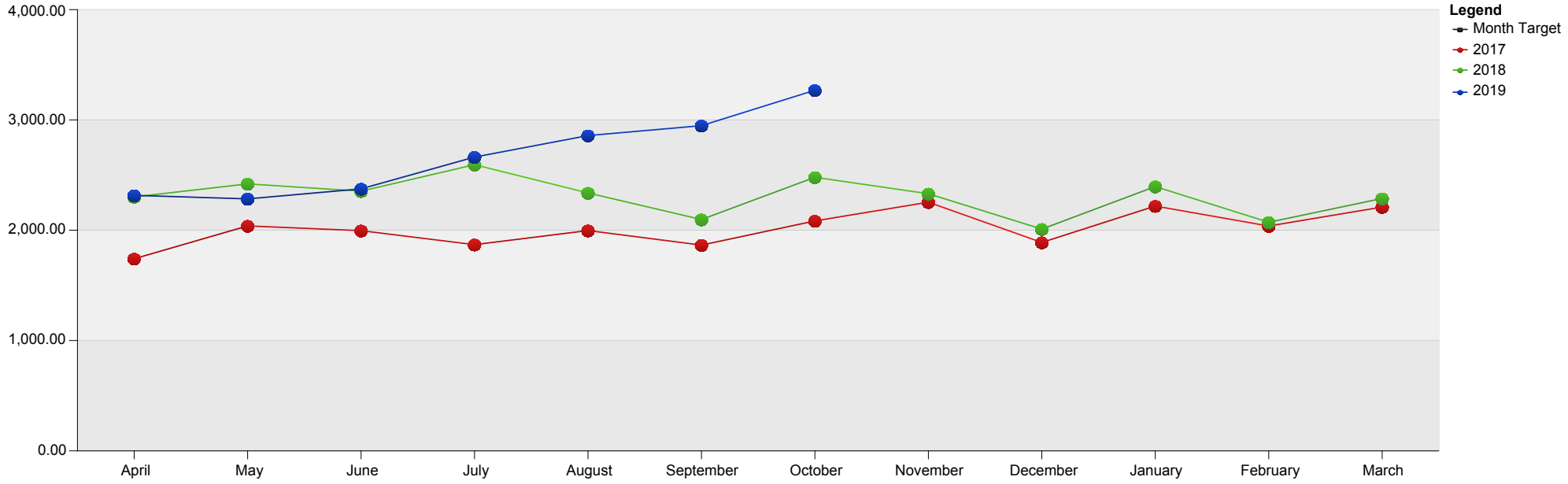


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Number of new unique patients referred and taken on for treatment	1,943.00	11,495.00	584.00	3,568.00	606.00	3,508.00	699.00	4,179.00	34.00	157.00		

Narrative
The Trust position for October 2019 is 1,943 which is an increase to the position reported for September 2019 and the highest number recorded since 2017/18. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be discussed by EMT on a quarterly basis at 'speciality' level in addition to the data and charts being reviewed by localities.

Trust Dashboard Graphs for TRUST

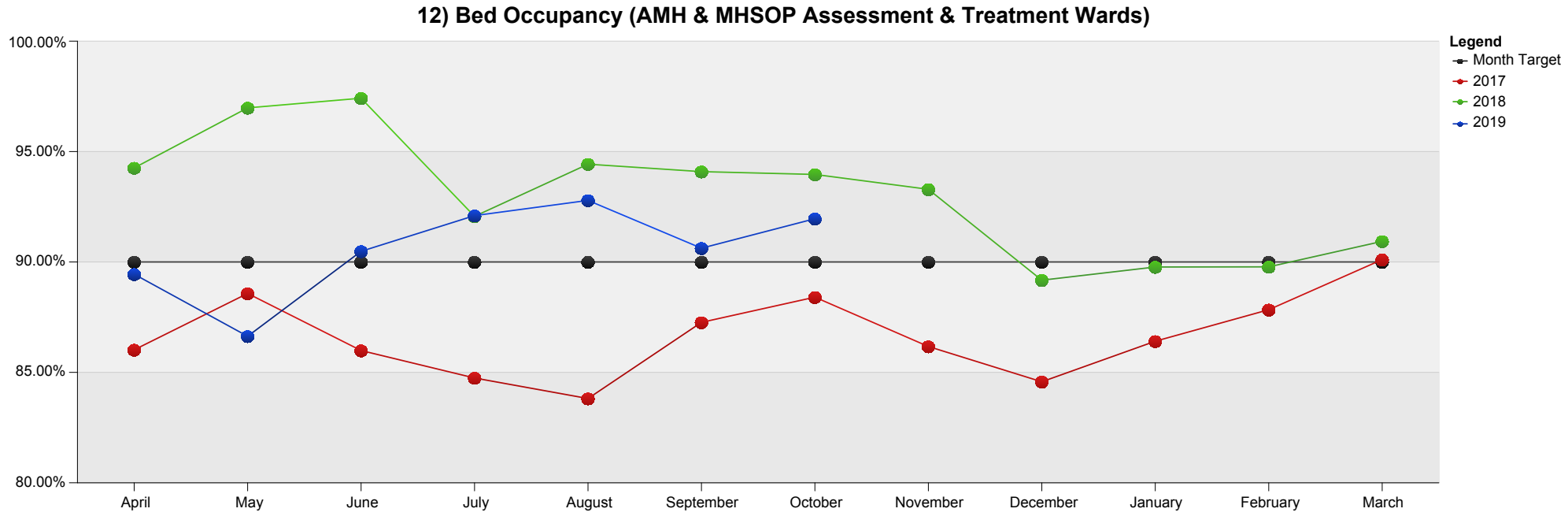
11) Number unique patients referred who received treatment and were discharged



	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	3,269.00	18,713.00	1,010.00	5,940.00	1,170.00	6,207.00	966.00	6,216.00	121.00	339.00		

Narrative
The Trust position for October 2019 is 3,269 which is an increase to that reported for September 2019 and the highest number recorded since 2017/18. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be discussed by EMT on a quarterly basis at 'speciality' level in addition to the data and charts being reviewed by localities.

Trust Dashboard Graphs for TRUST

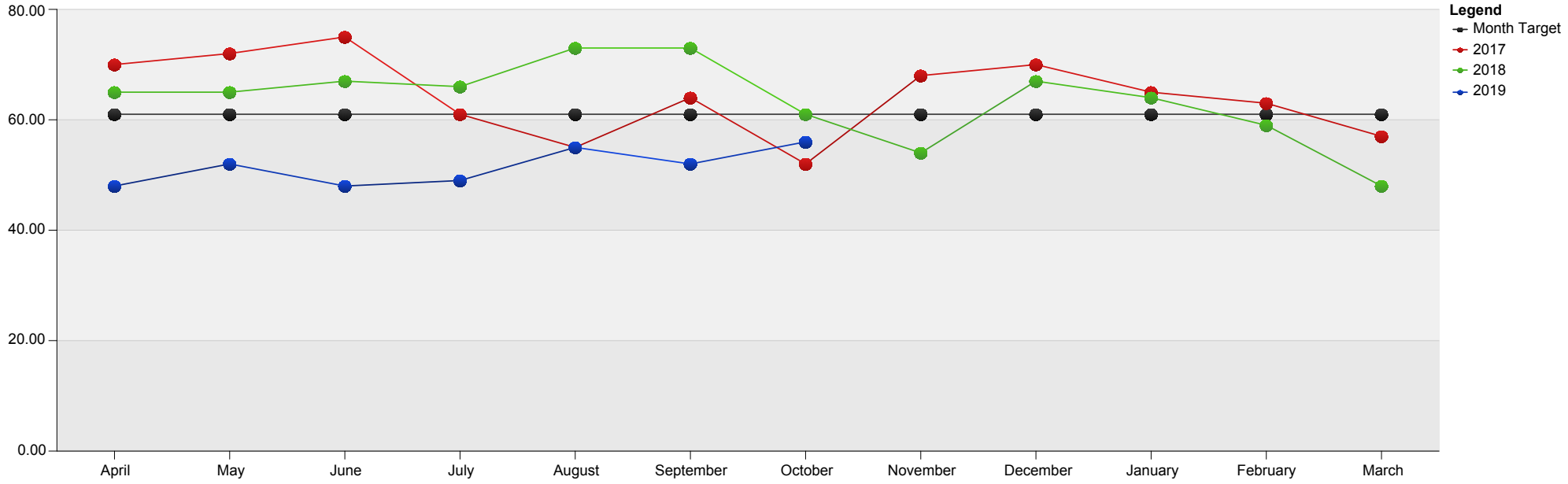


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	91.96%	90.58%	94.59%	93.49%	96.38%	96.62%	86.20%	83.30%	NA	NA		

Narrative
The Trust position for October 2019 is 91.96% which is worse than the standard and the position reported in September 2019.. Teesside report the poorest position at 96.38%, which is due to increased demand on beds within both AMH and MHSOP. This demand has been further impacted by the reduction of beds in Elm ward within Durham and Darlington locality and the temporary redirection of new admission from Cedar Ward in North Yorkshire, linked to patient acuity and staffing availability. This is monitored on a continual basis and appropriate actions are discussed and agreed in daily huddles.

Trust Dashboard Graphs for TRUST

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

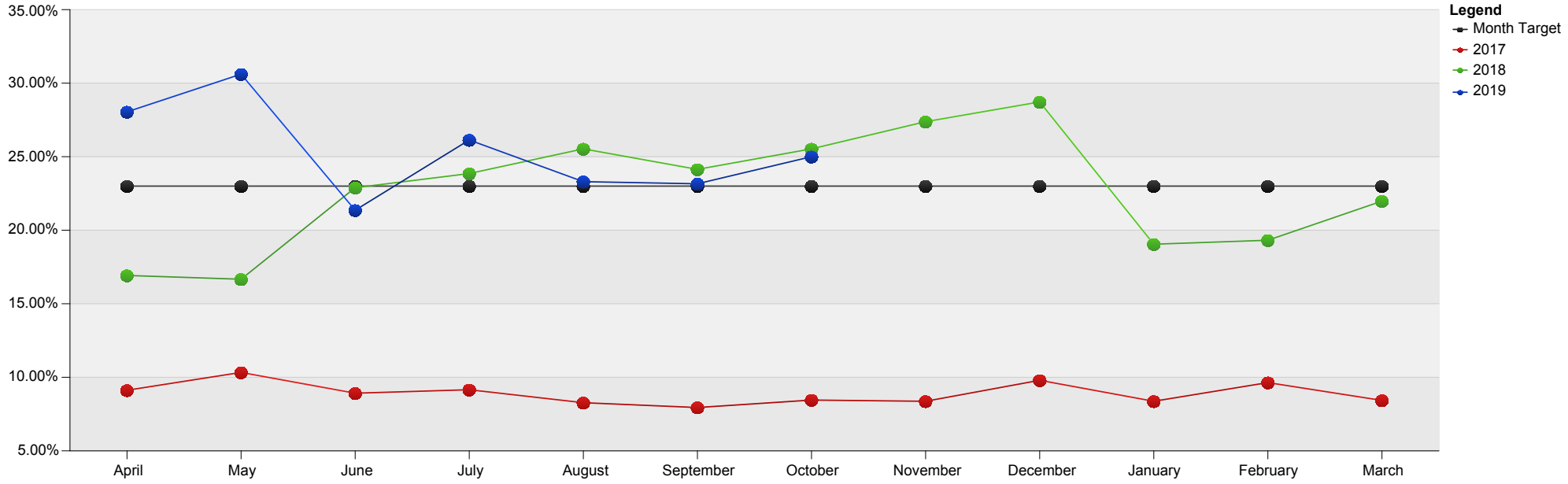


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	56.00	56.00	15.00	15.00	10.00	10.00	29.00	29.00				

Narrative
The Trust position for October 2019 is 56 which is better than the standard and at a similar level to that reported in September 2019.Durham and Darlington and Teesside localities are not meeting target for this indicator. Both localities report issues relating to complex patients as impacting on performance in this area. All localities are monitoring this on a continual basis and actions are discussed and agreed in daily huddles.

Trust Dashboard Graphs for TRUST

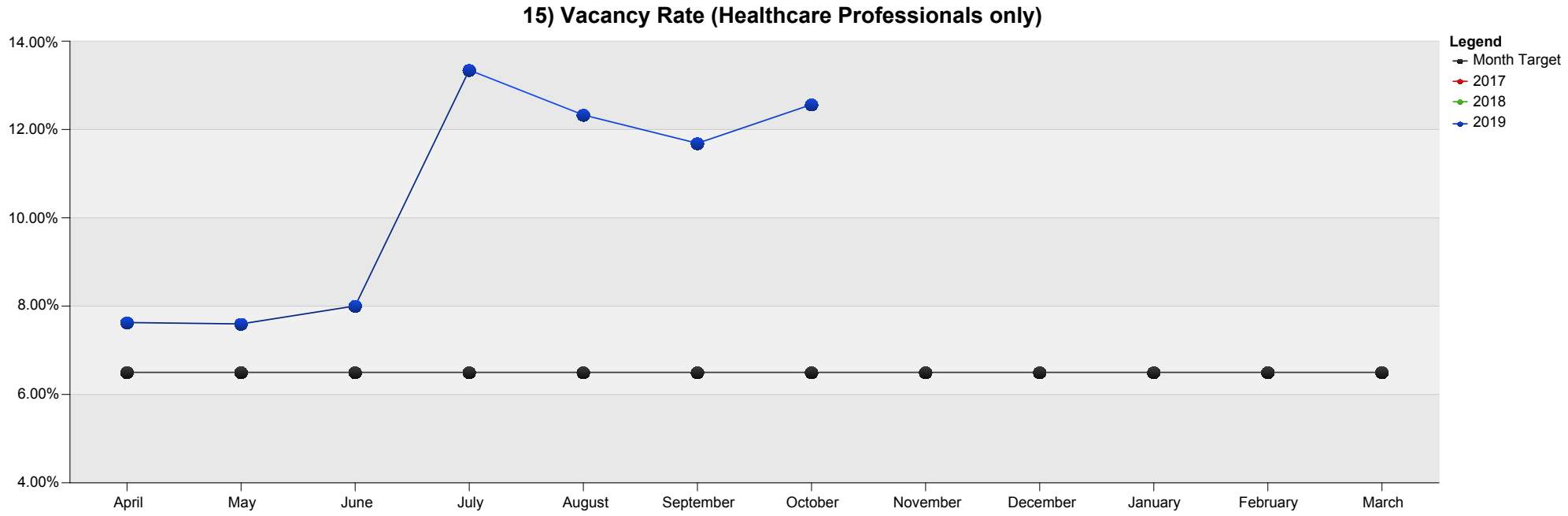
14) % of patients re-admitted to A&T wards within 30 days (AMH & MHSOP) - in reporting month



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE 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	25.00%	25.26%	23.68%	23.83%	29.63%	27.07%	24.00%	25.24%				

Narrative
The Trust position for October 2019 is 25.00% which is not quite meeting the standard. This relates to 23 readmissions out of 92 readmissions that were within 30 days. Teesside report the lowest position at 29.63%, however all of the readmissions were clinically appropriate due to patients needs at the time.

Trust Dashboard Graphs for TRUST

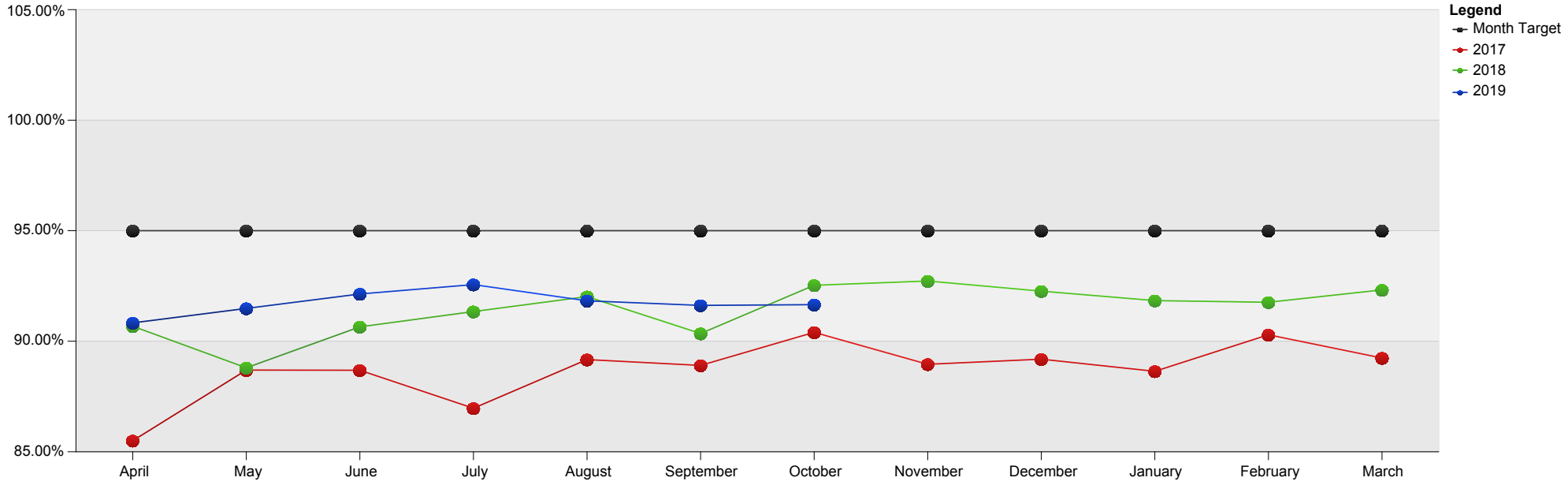


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Vacancy Rate (Healthcare Professionals only)	12.56%	10.39%	18.76%	13.44%	6.15%	6.69%	13.27%	13.11%	11.05%	6.50%		

Narrative
The position for October 2019 is 12.56% which continues to not meet the standard. This equates to 400.26 wte vacancies currently being actively being recruited to (It should be noted that some of these will still have staff in post working their notice)Vacancy census reports are due to be produced and presented to EMT in December 2019 and it is planned for these reports to be produced on a quarterly basis going forward.This is a new indicator for 2019/20 therefore data relating to previous year's performance is not available.

Trust Dashboard Graphs for TRUST

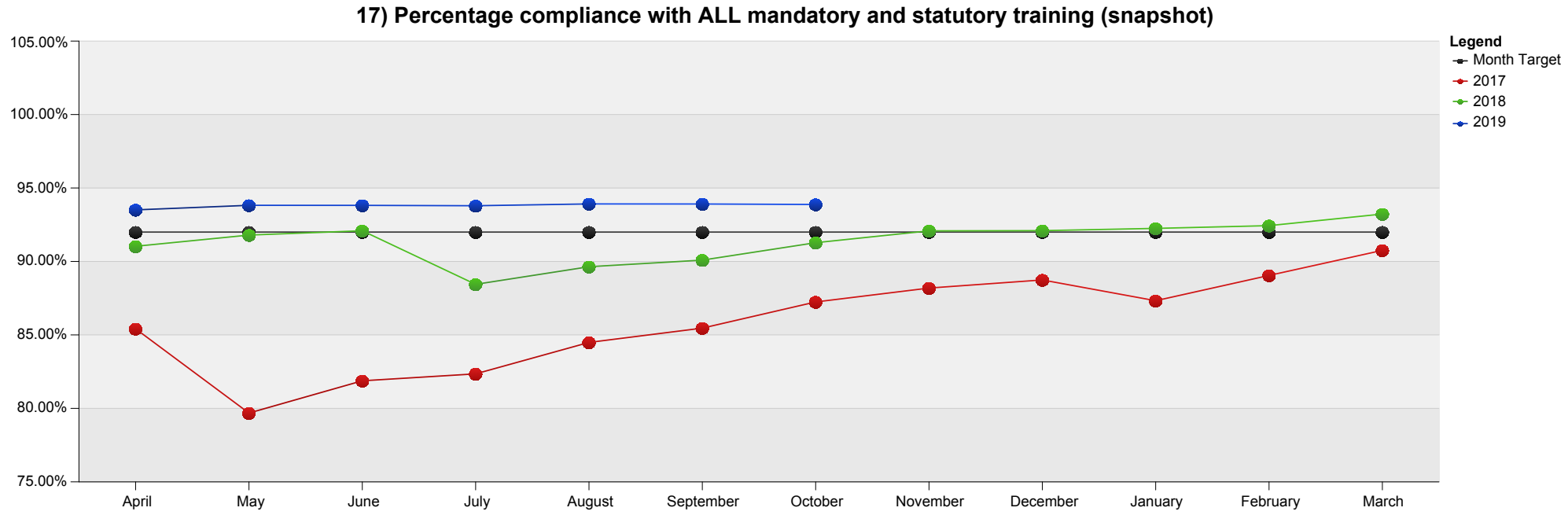
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)



	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
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	91.65%	91.65%	92.38%	92.38%	93.32%	93.32%	89.14%	89.14%	94.11%	94.11%		

Narrative
The Trust position for October 2019 is 91.65% which is worse than the standard and relates to 508 members of staff out of 6104 that do not have a current appraisal. The position has remained at a similar level since the start of the year. 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 within this report, impact on the ability to deliver appraisals.

Trust Dashboard Graphs for TRUST

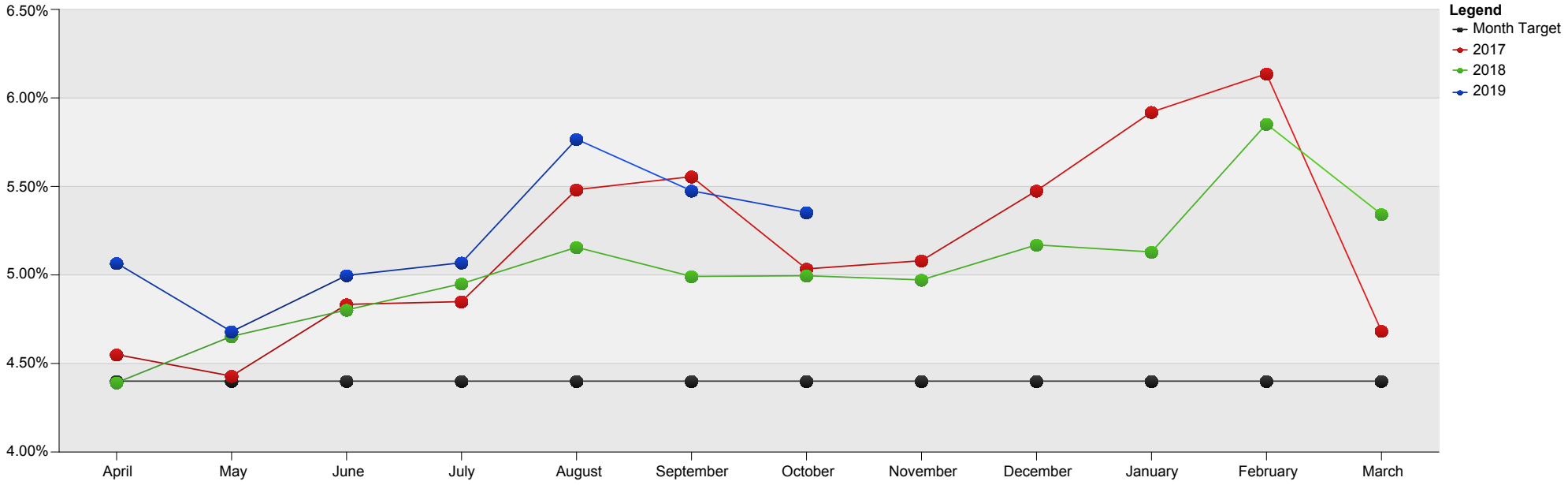


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	93.88%	93.88%	93.89%	93.89%	94.40%	94.40%	91.07%	91.07%	96.55%	96.55%		

Narrative
The position for October 2019 is 93.88% which is meeting the standard and has been static across the year to date. This continues to be one of the best positions reported since 2017/18. All localities are achieving the standard with the exception of North Yorkshire and York who report the lowest position of 91.07%. This is due to the fact that within North Yorkshire junior doctors are included in the denominator of this metric as they are employed by the Trust, however their completion of mandatory and statutory training is not recorded on the Trust's staff system. Therefore this will impact on compliance levels within this locality.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

18) Percentage Sickness Absence Rate (month behind)



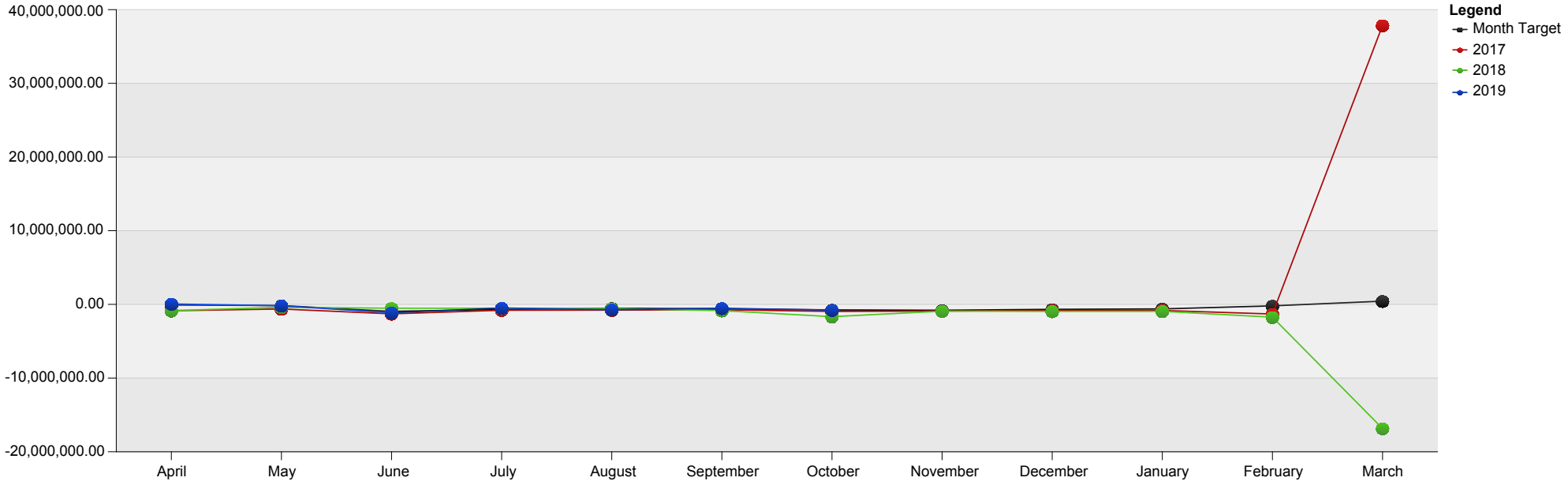
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	5.35%	5.20%	5.17%	5.09%	6.46%	6.19%	4.44%	4.09%	6.47%	6.54%		

Narrative

The Trust position reported in October relates to the September sickness level. The Trust position reported in October 2019 is 5.35% which is not meeting the standard of 4.50%. North Yorkshire and York are the only locality to meet the standard.Forensic Services are reporting the highest figure at 6.47%. There is a number of staff within secure inpatient services who are on long term sick leave and who are due for review to identify appropriate next steps. The level of sickness absence within Offender Health is also being reviewed by the Head of Service.The tendering exercise for a new Occupational Health provider is progressing well and is set to transfer to the new provider in December 2019. The Sickness Absence Management Procedure is currently being reviewed and a revised procedure is due to be agreed by January 2020.

Trust Dashboard Graphs for TRUST

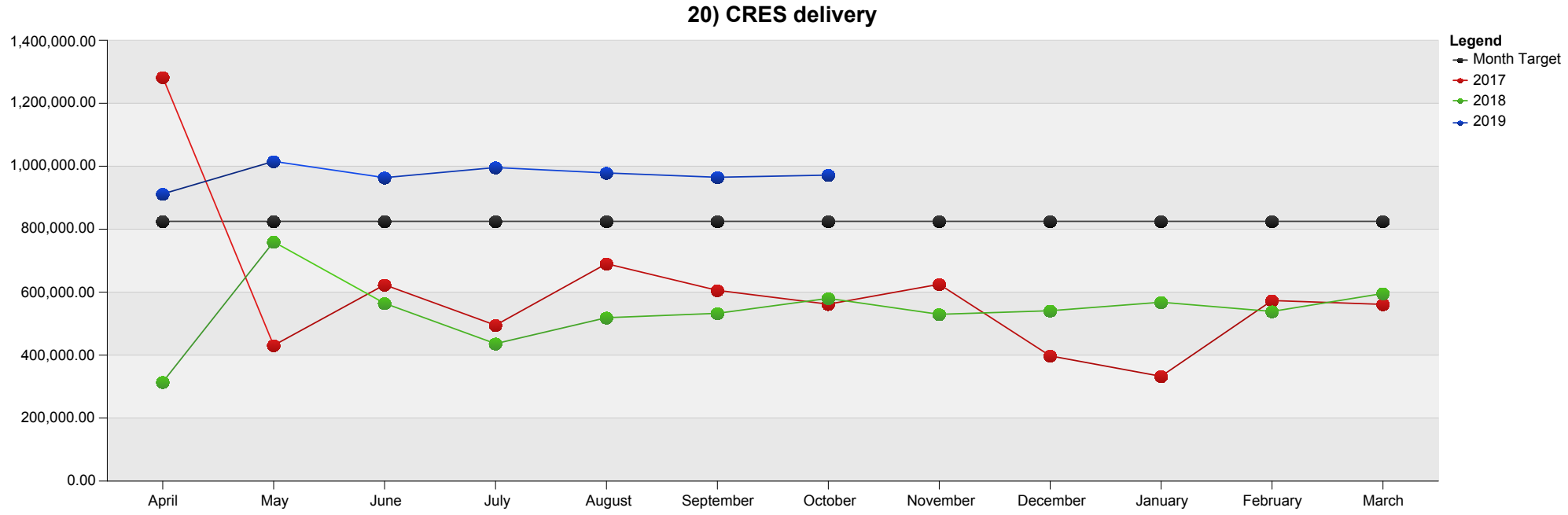
19) Delivery of our financial plan (I and E)



	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)	-782,785.00	-3,800,750.00	-75,354.00	-414,621.00	409,681.00	2,679,699.00	-532,567.00	81,575.00	-155,385.00	-198,457.00		

Narrative
The comprehensive income outturn for the period ending 31 October 2019 is a surplus of £3,801k, representing 1.8% of the Trust's turnover and is £43k ahead of the NHSI plan.

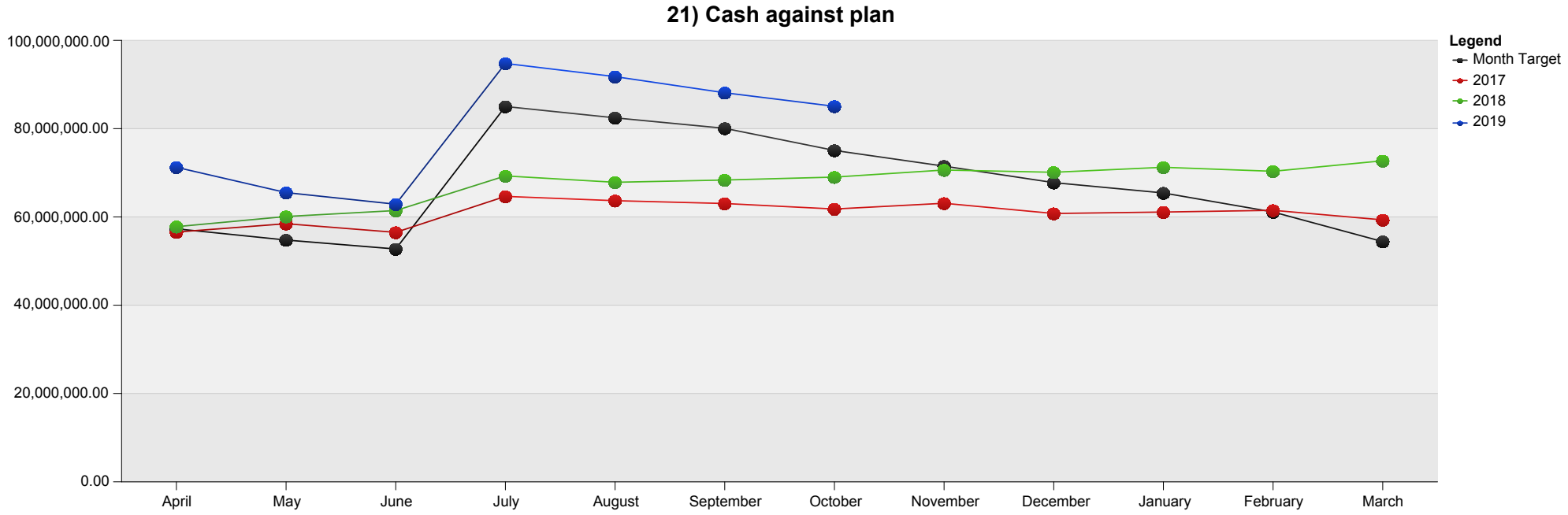
Trust Dashboard Graphs for TRUST



	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	971,754.00	6,802,280.17	97,692.00	683,844.17	84,647.00	592,528.00	214,034.00	1,498,238.00	49,483.00	346,380.00		

Narrative
Identified Cash Releasing Efficiency Savings at 31 October 2019 is £6,802k and is £1,028k ahead of plan for the year to date. The Trust is anticipating being ahead of plan (£1,762k) 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	85,057,618.00	85,057,618.00	NA	NA	NA	NA			NA	NA		

Narrative
Total cash at 31 October 2019 is £85,058k; this is £9,996k ahead of plan and is largely due to higher than anticipated creditor accruals where invoices have not been received by the Trust and a re-profiling of the capital expenditure plan.

Trust Dashboard - Locality Breakdown for TRUST

1 - Quality

	October 2019												April 2019 To October 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
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral		83.64%		82.40%		91.26%		73.93%		99.61%				83.84%		82.19%		89.98%		76.11%		99.04%		
2) Percentage of patients starting treatment within 6 weeks of an external referral		65.93%		71.97%		64.80%		59.36%		99.12%				59.00%		63.26%		58.15%		54.43%		96.49%		
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)		1,753.00		363.00		571.00		819.00						1,753.00		363.00		571.00		819.00				
4) Percentage of patients surveyed reporting their overall experience as excellent or good		93.86%		96.37%		94.81%		91.07%		90.51%				91.87%		92.36%		92.18%		91.81%		89.26%		
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding		30.77%		50.00%		28.57%		25.00%						33.33%		47.37%		17.65%		42.86%				
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind		52.63%		50.00%		50.00%		58.06%						62.84%		62.90%		61.27%		63.93%				
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind		72.53%		78.79%		65.52%		72.41%						69.25%		70.91%		68.50%		68.30%				

Trust Dashboard - Locality Breakdown for TRUST

2 - Activity

	October 2019												April 2019 To October 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		8,359.00		2,592.00		2,575.00		2,360.00		825.00				50,557.00		15,496.00		17,088.00		14,247.00		3,453.00		
9) The number of new unique patients referred with an assessment completed		4,367.00		1,234.00		1,497.00		1,294.00		309.00				29,024.00		8,494.00		10,285.00		8,488.00		1,669.00		
10) Number of new unique patients referred and taken on for treatment		1,943.00		584.00		606.00		699.00		34.00				11,495.00		3,568.00		3,508.00		4,179.00		157.00		
11) Number unique patients referred who received treatment and were discharged		3,269.00		1,010.00		1,170.00		966.00		121.00				18,713.00		5,940.00		6,207.00		6,216.00		339.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)		91.96%		94.59%		96.38%		86.20%	NA	NA				90.58%		93.49%		96.62%		83.30%	NA	NA		
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot		56.00		15.00		10.00		29.00						56.00		15.00		10.00		29.00				
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month		25.00%		23.68%		29.63%		24.00%						25.26%		23.83%		27.07%		25.24%				

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	October 2019												April 2019 To October 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)		12.56%		18.76%		6.15%		13.27%		11.05%				10.39%		13.44%		6.69%		13.11%		6.50%		
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)		91.65%		92.38%		93.32%		89.14%		94.11%				91.65%		92.38%		93.32%		89.14%		94.11%		
17) Percentage compliance with ALL mandatory and statutory training (snapshot)		93.88%		93.89%		94.40%		91.07%		96.55%				93.88%		93.89%		94.40%		91.07%		96.55%		
18) Percentage Sickness Absence Rate (month behind)		5.35%		5.17%		6.46%		4.44%		6.47%				5.20%		5.09%		6.19%		4.09%		6.54%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	October 2019												April 2019 To October 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)		-782,785.00	NA	-75,354.00	NA	409,681.00		-532,567.00	NA	-155,385.00				-3,800,750.00	NA	-414,621.00	NA	2,679,699.00		81,575.00	NA	-198,457.00		
20) CRES delivery		971,754.00		97,692.00		84,647.00		214,034.00		49,483.00				6,802,280.17		683,844.17		592,528.00		1,498,238.00		346,380.00		
21) Cash against plan		85,057,618.00	NA	NA	NA	NA			NA	NA				85,057,618.00	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 (reviewed November 2019)

		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	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	5						4					4						3			16	**80%**	There are issues concerning telephone assessments and when this type of assessment should stop the clock. The logic for this metric currently only acknowledges a clock stop for CAMHS. The KPI pro forma specifies this should be applied to AMH, however this is not reflected with in the data and this inconsistency was not picked up in previous testing. Also 'was not brought' is counting as a successful contact, this should be treat the same as DNA and should no stop the clock. Also there is a concern about records with a zero duration which are acknowledged by this metric but not clinically correct. A deep dive will take place at Performance Improvement Group in October 2019
2	Percentage of patients starting treatment within 6 weeks of external referral	5						4					4						3			16	**80%**	Some data quality issues have been reported in relation to the use of appropriate intervention/treatment codes. Guidance has been circulated to improve understanding however there is still a lack of understanding and clarity. A deep dive will take place at Performance Improvement Group in October 2019
3	Total number of inappropriate OAP days over the reporting period (rolling 3 months)		4				5					5							3			17	**85%**	Data is extracted electronically, validated manually and reloaded into the system. Work is underway to amend PARIS to enable this to be recorded completely on the system, timescale to be confirmed. National standards suggest that when a patient is offered an in area bed however refuses this, then this change to 'patient choice' should be reflected in a change from inappropriate to appropriate OAP during the stay. This means we are currently potentially overstating our OAP inappropriate days. Potential developements wthin the PARIS system are bing considered to address this issue
4	Percentage of patients surveyed reporting their overall experience as excellent or good.				2		5					5							3			15	**75%**	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 Dataix 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							3			18	**90%**	
9	The number of new unique patients referred with an assessment completed	5								2				3					3			13	**65%**	The data is currently including telephone assessments for MHSOP, LD and Forensics which is not in line with the pro forma. Assessments are only being counted at first successful contact so this means that some patients may have an assessment but this would not be capture red within the KPI if it didn't take place at the first contact
10	Number of new unique patients referred and taken on for treatment	5								2				3					3			13	**65%**	The metric is currently a sub set of TD 9 but the pro forma states that is a subset of TD 8. This means that we are under reporting the number of patients treated.
11	Number unique patients referred who received treatment and were discharged	5					5					5							3			18	**90%**	
12	Bed Occupancy (AMH & MHSOP A&T wards)	5					5					5							3			18	**90%**	

Data Quality Scorecard 2019/20 - Appendix C (reviewed November 2019)

		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			
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 Assessment 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 electronically 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. Issues around the inclusion of medical staff within this data is being investigated
17	Percentage compliance with ALL mandatory and statutory training	5						4				5							3			17	**85%**	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. Inclusion of PREVENT training within this data is being resolved
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. Work is being progressed to improve this process to enable direct system transfer to the IIC. However, due to other priorities identified by the Managing the Business group no date has been agreed for the finance development
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 (Oracle Cloud) then processed manually to obtain actual performance. Work is being progressed to improve this process to enable direct system transfer to the IIC. However, due to other priorities identified by the Managing the Business group no date has been agreed for the finance development

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 19

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th November 2019**
TITLE:	**Strategic Direction Performance Report – Quarter 2 2019/20**
REPORT OF:	**Sharon Pickering, Director of Planning and Performance**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to present to Board of Directors the Strategic Direction Performance Report as at Quarter 2 (30th September 2019).

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

Quarter 2 has reported a number of metrics deteriorating with 56% (9) of the metrics reporting green compared to 67% (10) in quarter 1. Of the 44% (7) metrics reporting red, none have reported an improvement compared to quarter 1. Progress against the Business Plan is mixed, in particular in relation to Strategic Goal 5, which has only delivered one action in quarter 2. A significant issue that occurred in Quarter 2 is the CQC Notice of Decision at West Lane Hospital and its subsequent closure.

Recommendations:

Board of Directors is asked to:

- Note the changes to the Trust Business Plan that require Board approval in Appendix 1.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**26th November 2019**
TITLE:	**Strategic Direction Performance Report – Quarter 2 2019/20**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to Board of Directors the Strategic Direction Performance Report as at Quarter 2 (30th September 2019).

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 The current KPIs for the Trust Strategic Direction Scorecard were agreed by the Board on the 19th July 2018, with the majority of targets being agreed at the October 2018 Board meeting.

2.3 The Strategic Direction Scorecard is shown under each strategic goal with proposed changes to the Business Plan requiring approval, by exception, detailed in Appendix 1.

3. KEY ISSUES:

3.1 Trust Strategic Direction Scorecard

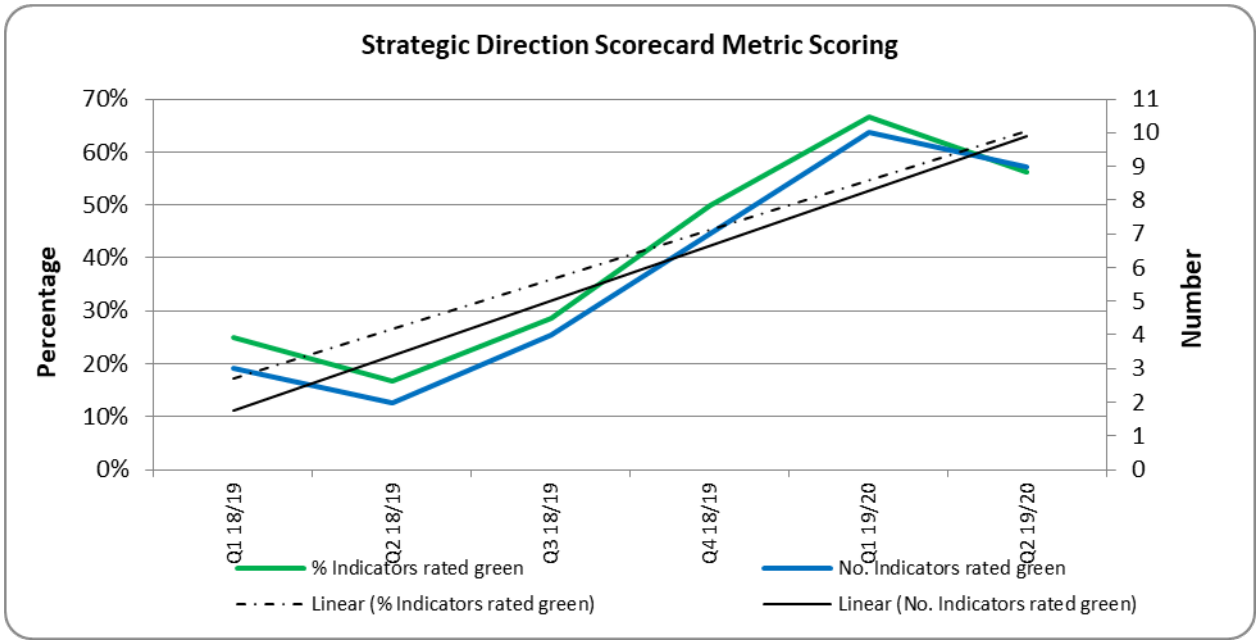
The following table provides a summary of the RAG ratings at quarter 2 compared to the position in the previous quarters. The Trust is not meeting some of its high ambitions given the number of reds (7) against stretching metrics.

Quarter 2 has reported an overall deterioration with 56% (9) of the metrics reporting green compared to 67% (10) in quarter 1. Of the 44% (7) metrics reporting red, none have reported an improvement compared to quarter 1.

There remains a number (7) that are not being rated as they are either not required to be reported in this quarter or are still under development.

SDS	Q4 2018/19		Q1 2019/20		Q2 2019/20	
	No	%*	No.	%*	No.	%*
Indicators rated green	7	50%	10	67%	9	56%
Indicators rated red	7	50%	5	33%	7	44%
Indicators rated	**14**		**15**		**16**	
Indicators with no target agreed						
Indicators currently under development/being finalised	7		7		6	
Indicators where data is not yet available or not applicable in qtr	1		1		1	
Metric will not be possible to report and we are identifying a further indicator	1					

The graph below shows the improving trend in the percentage of greens since the metrics were introduced in 2018/19. However, quarter 2 has reported the first dip in performance against the strategic direction since quarter 2 last year.



3.2 **Strategic Goal *1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)***

3.2.1 Trust Strategic Direction Scorecard

This strategic goal is showing 1 metric rated red. That is a deterioration on the quarter 1 position when all 3 reportable metrics were green. Of the metrics that can be reported, two are reporting an improvement on the quarter 1 position.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20									
	Indicator	Q2 Target 2019/20	Quarter 2 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20	2018/19 Actual	2017/18 Actual	Annual Target 2019/20
Strategic Goal 1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)									
1	Percentage of teams achieving the agreed improvement benchmarks for HoNOS total score	60.00%	66.55%	⇧	60.00%	64.52%	59.41%	44.00%	60.00%
2	Percentage of teams achieving the agreed improvement benchmarks for SWEMWBS	65.00%	68.95%	⇧	65.00%	68.72%	67.38%	50.00%	65.00%
3	Number of patients who said we helped them achieve the goals they set	TBC	Metric currently under development	N/A	N/A	Metric currently under development	N/A	N/A	TBC
4	Percentage of carers that report feeling listened to and heard	76.20%	74.84%	⇩	76.20%	75.98%	76.45%	76.08%	76.20%

Indicators of concern are:

- **KPI 4 - Percentage of carers that report feeling listened to and heard –** The Trust position reported in quarter 2 is 74.84% which relates to 563 carers out of 2238 who stated they did not feel listened to and heard. This is 1.36% worse than the standard and less than the 77.13% reported for quarter 1.

  Three localities are reporting below target:

  - Durham & Darlington report 75.46% which is consistent with quarter 1 (75.95%)
  - Forensics report 63.64% which is worse than quarter 1 (73.91%).
  - North Yorkshire & York report 71.71% which is slightly better than quarter 1 (70.77%).

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 2 were rated green 88% (53 out of 60) compared to 69% (25 out of 34) in quarter 1 2019/20. 83% of the priorities under Strategic Goal 1 are reporting that there is no significant risk to the completion on time of the priority. There are 2% of priorities that have a moderate risk of failure to deliver the final milestone or benefits on time.

However, there are 6 (15%) priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget:

- 1 priority (1.13.53) **D&D New community team model** -The new Head of Service and Locality Manager have requested a period to review and further engage with the teams to ensure commitment and support; further update to be submitted to October QUAG, before next steps agreed. EMT have approved an extension to quarter 4 19/20.
- 1 Priority (1.13.16) **Tees GP Communication** - The current pilot has been extended for another 6 months therefore the evaluation will not be undertaken until the pilot has completed (March 20). **Trust Board are requested to approve an extension to quarter 1 2020/21**.

- 1 priority (1.13.20) **Tees Urgent Care** - The Transformation funding will enable implementation of a model which addresses the recommendations of the crisis review. This will form part of the Right Care Right Place (RCRP) work. EMT approved the extension to quarter 4 19/20
- 1 priority (1.13.33) **Tees Review of Access Service** - This work is a key element of the RCRP work which is underway therefore EMT approved the extension to quarter 4 19/20.
- 1 priority (1.13.1) **New Care Model Secure Services** - The bid for central funding for enhancements to community services was submitted as required. Outcomes of the bid were anticipated beginning September however this has not as yet been received. EMT approved the extension to quarter 4 19/20 to enable recruitment should the bid be successful.
- 1 Priority (1.7.7 – 1.7.9) **Implement the transforming care agenda** – Due to the change of North Yorkshire & York scope for this priority Trust Board are requested to approve the removal of 3 actions and replace with 2 new actions detailed in the table in appendix 1.

There are six priorities reporting Grey on the basis that they have not been completed on time and/or benefits realised due to external factors:

- **New Care Models Eating Disorders (D&D)** - The work has been superseded by provider collaborative, led by NTW therefore Trust Board are requested to remove the priority and actions.
- **Remodelling ALD Inpatient Beds Environment (D&D) -** This work has been superseded by the Trust work on single occupancy / pop ups. The D&D LD service is working on a whole system business case in response to recent challenges within the LD system. This action is identified in the 2020/21-2022/23 business plan and actions are been developed to progress agreed next steps. Trust Board is requested to remove this action (1.13.63).
- **Configuration of West Lane Site** – Whilst work is ongoing following the CQC announcement to close the site, timescales for this area of work are still unknown. Trust Board is requested to remove this priority, with additional actions to be added in line with the work of Programme Board when known.
- **CYP Eating Disorders** - Whilst work is ongoing following CQC announcement to close the site, timescales for this area of work are still unknown. Therefore Trust Board is requested to remove this priority, with additional actions to be added in line with the work of Programme Board when known.
- **HMP Haverigg Procurement** - The Procurement process has not been launched by the commissioners.
- **CORE 24 Tees** - NHSE advised that whilst they supported the bid, funding would be allocated to sites first and foremost who do not have CORE 24 in place. The service received a further update that there is £191k available for 2019/20 but this would require CCGs to deliver funding in 2020/21. A Paper was prepared advising what is feasible with £191k and ongoing commitment for funding from the CCGs to be discussed with the Partnership. This has subsequently been resolved and a bid for non-

recurring monies was submitted and approved for recurrent funding for staff.

There are 6 metrics for (Tees GP Communication, Tees MH Support teams, Tees Access service, LD Transforming care) that require Board approval to remove them from the business plan, change to wording and timescales noted in the table attached in appendix 1.

3.2.3 Other Qualitative Intelligence

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

- **Dr Lynne Howey, Dr Corrine Reid** and **Mark Porter** contributed to a recent national scoping workshop on the productivity and effectiveness of Children and Young People's Mental Health Services (CYPMHS). TEWV was one of the most productive providers according to NHS Benchmarking data on contacts per clinical FTE per day within CYPMHS, and our staff were able to attend the workshop and steer national thinking regarding the elements of a productive service; providing their own story of delivering productivity improvements in the ASD service.

- Kevan Jones, MP mentioned **TEWV** in the House of Commons on the 16th July, praising the Trust as a good example for the work that has been undertaken piloting mental health triage in GP surgeries.

- The **South West Community Mental Health Team**, Mental Health Services for Older People, Acomb Health Centre, York and Worsley Court, Selby, has won a medical education award for demonstrating outstanding creativity and innovation skills.

- The **Adult Mental Health Acute Care Services** at Roseberry Park, has been shortlisted for the Psychiatric Team of the Year: Working-age adults at the Royal College of Psychiatry Awards 2019.

- The **Stockton Community Mental Health Team** has been shortlisted for the Psychiatric Team of the Year: Older-age adults at the Royal College of Psychiatry Awards 2019.

- **Adult Learning Disability North Tees Community Team** has been shortlisted for the Psychiatric Team of the Year: Intellectual Disability at the Royal College of Psychiatry Awards 2019.

- **TEWV** has been awarded Stage 2 Triangle of Care. Since 2016, 97 community teams and 73 wards and crisis teams have completed and submitted self-assessments in relation to 6 key standards aimed at recognising and supporting carers. TEWV staff were commended for their commitment to completing these, attending carer awareness training and the hosting of a carers' conference, which was attended by carers and carer champions this summer.

- The **Mental Health Team, HMP Holme House**, Stockton were winners of the NEPACS Ruth Cranfield Good Practice Awards for Rehabilitation 2019 for being inspirational and passionate about establishing and implementing new ideas and practices.

- The **Adult learning disability team,** Flatts Lane Centre, Middlesbrough has been awarded a Cavell Star Award for shining bright and showing exceptional care.

- **TEWV** has received funding to provide local people with additional crisis services and alternative places of safety across North Yorkshire. Over half a million pounds worth of funding from local clinical commissioning groups will be used to help reduce the impact of mental health crisis on both individuals in crisis and wider services, such as the police, ambulance and accident and emergency.

- The **Harrogate Core 24** Transformation Funding liaison bid has been successful. NHSE have agreed with the Trust proposal for a consultant-led service and once the funding allocation is understood across the region for those bids, they will discuss how any underspend can be utilised to support our bid.

- Staff from **Ceddesfeld Ward**, Auckland Park Hospital, Bishop Auckland, have created a sports themed activity room for older people staying on the ward. Facilities including table football, table tennis and basketball make it easier for individuals to engage in activities that promote physical and mental wellbeing.

3.2.4 Other points to note:

- **KPI 3 - Number of patients who said we helped them achieve the goals they set** – The additional question did not go live until 1st September and has only been implemented for adult mental health teams. Changes for the other teams are anticipated go live from the 1st April 2020. The implementation and rollout of this question has taken longer than previously expected due to ensuring that adequate consultation had taken place, all changes were captured and the required changes were made to the electronic solution. Processes have now been agreed for the initial reporting of the metric in quarter 3.

3.2.5 In conclusion, a positive position is presented in terms of this strategic goal and the services we provide to patients and carers, with two of the three reportable metrics green (both reporting an improvement on quarter 1) and the significant amount of qualitative intelligence. However there remains work required on the business plan as six priorities/service developments are at high risk of failure to deliver on time or within budget.

3.3 Strategic Goal 2 - *To continuously improve the quality and value of what we do*

3.3.1 Trust Strategic Direction Scorecard

This strategic goal is showing two indicators rated red, which is consistent with the quarter 1 position. Of the two metrics reporting red, neither has reported an improvement.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20									
	Indicator	Q2 Target 2019/20	Quarter 2 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20	2018/19 Actual	2017/18 Actual	Annual Target 2019/20
Strategic Goal 2 (To continuously improve the quality and value of what we do)									
5	Percentage of staff reporting that they can contribute towards improvement at work (reported a quarter behind)	87.00%	81.87%	⇩	87.00%	82.13%	81.50%	81.59%	87.00%
6	Percentage of patients who report feeling supported by staff to feel safe	65.20%	70.83%	⇧	65.20%	66.90%	61.53%	65.63%	65.20%
7	Percentage of patients who report their overall experience as excellent or good	94.00%	90.85%	⇩	94.00%	91.48%	91.41%	90.68%	94.00%

Indicators of concern are:

- **KPI 5 - Percentage of staff reporting that they can contribute towards improvement at work –** this metric is reported a quarter behind; the quarter 2 data therefore relates to the quarter 1 survey. The Trust position for quarter 1 is 81.87% which relates to 300 members of staff out of 1655 who stated they did not feel they can contribute towards improvements at work. This is 5.13% worse than the standard of 87%.

  All areas are reporting below target:
  - Durham & Darlington report 79.90% which is consistent with quarter 4 (79.22%)
  - Forensics report 83.04% which is consistent with quarter 4 (83.74%).
  - North Yorkshire report 82.52% which is consistent with quarter 4 (82.38%).
  - Teesside report 82.07% which is slightly worse than quarter 4 (83.12%).

  Feedback indicates that staff are committed to making suggestions but do not always feel they are in a position to follow them through; either due to time, resources or staffing issues. In addition, the time it can take to implement changes can mean that it is not immediately apparent to staff that their suggestions are being implemented, which may result in some staff believing that they have limited influence.

- **KPI 7 - Percentage of patients who report their overall experience as excellent or good** – The Trust position for quarter 2 is 90.85% which relates to 393 patients out of 4296 patient survey responses that report their overall experience other than excellent or good. This is 3.15% worse than the standard of 94%.

All localities are reporting below target:

- Durham & Darlington report 90.35% which is worse than quarter 1 (92.60%)
- Forensics report 88.43% which is consistent with quarter 1 (88.75%).
- North Yorkshire & York report 91.32% which is worse than quarter 1 (92.59%).
- Teesside report 91.67% which is consistent with quarter 1 (93.87%).

Patient experience is monitored at weekly directorate report outs, but there is some concern that the data on its own does not always indicate themes or specific improvements that are required in the services. Tees Locality is to review the visual control board to see if information can be presented differently to enable meaningful conversations and the Forensics Directorate is to undertake a deep dive on this topic.

3.3.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 2 were rated green 63% (12 out of 19) compared to 92% in quarter 1 2019/20. 33% of the priorities under Strategic Goal 2 are reporting that there is no significant risk to the completion on time of the priority. There are 67% of priorities that have a moderate risk of failure to deliver the final milestone or benefits on time.

There is 1 metric for Right Care Right Place that requires Board approval to remove the action from the business plan.

A change form has been completed to extend the RCRP programme trajectory to continue the work to develop locality models and outline implementation plan from November 2019 to March 2020. It is anticipated that there would be a positive impact upon the achievement of the programme's expected benefits by allowing more time for localities to fully engage with stakeholders and analyse feedback in order to co-produce a future state that will meet the needs of each locality.

The change form was approved by the RCRP programme Board and is attached in appendix 1 for Trust Board to consider the approval of the extended timescales.

There are 7 metrics (Trust wide Dual Diagnosis, Urgent care, Transition from CYP to AMH, Care plans) that requested an extension to time within this year which has been approved by EMT.

3.3.3 Other Qualitative Intelligence

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

- On Friday 23 August the Care Quality Commission (CQC) made the decision to close the three children and young people inpatient wards at **West Lane Hospital** following an inspection that week; Evergreen,

Newberry and Westwood Wards. The Trust worked closely with the young people, their families and carers, our staff and our partners to identify arrangements for the safe and timely discharge or transfer of the young people.

- The Care Quality Commission (CQC) has visited inpatient and community teams across the **Trust** to carry out the annual inspection of our core services during September.

- **Dual Diagnosis** has been shortlisted for the Psychiatric Team of the Year: Quality Improvement at the Royal College of Psychiatry Awards 2019.

3.3.5 In conclusion, performance against this strategic goal is of some concern. Qualitative intelligence for this metric is mixed this quarter and the CQC Notice of Decision at West Lane Hospital has had a significant impact on the Trust. Two KPIs continue to perform below target, both reporting a deterioration compared to quarter 1 and only 63% of the Business Plan priorities are reporting green, compared to 92% last quarter.

3.4 **Strategic Goal 3** - ***To recruit, develop and retain a skilled, compassionate and motivated workforce***

3.4.1 Trust Strategic Direction Scorecard

This strategic goal is showing all indicators rated red as at quarter 2 out of a possible 3 that could be rated, which is consistent with quarter 1. None have reported an improvement on quarter 1.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20

	Indicator	Q2 Target 2019/20	Quarter 1 Actual	Quarter 2 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20 Actual - Q1	FYTD 19/20	FYTD 19/20 Actual - Q3	FYTD 19/20 Actual - Q4	2018/19 Actual	2017/18 Actual	Annual Target 2019/20
Strategic Goal 3 - To recruit, develop and retain a skilled, compassionate and motivated workforce													
8	Percentage rolling 12 month TEWV labour turnover rate	9.00%	10.35%	10.46%	⇩	9.00%	10.35%	10.41%	10.35%	#DIV/0!	10.44%	N/A	10.00%
9	Percentage rolling sickness absence rate	<4.40%	5.03%	5.06%	⇩	<4.40%	5.03%	5.06%	#DIV/0!	#DIV/0!	5.17%	N/A	<4.40%
10	Percentage staff recommending TEWV as a place to work	76.00%	70.72%	67.78%	⇩	76.00%	70.72%	69.26%	69.26%	69.26%	74.04%	70.95%	76.00%
11	Report and increase the % frontline multi-professional leadership and management teams that have trained in the core skills identified.	TBC			N/A	N/A					N/A	N/A	TBC

Indicators of concern are:

- **KPI 8 - Percentage rolling 12 month TEWV labour turnover rate** - The Trust position for quarter 2 is 10.46% which relates to 721 leavers out of 6890 total staff. This is 1.46% worse than the standard of 9%.

  Only Forensics and Teesside are reporting above target.

  Trust-wide 31% of leavers highlight retirement as their reason for leaving; with 24% of retirees returning under the Trust flexible retirement scheme, indicating the revised approach to Flexible Retirement implemented last year is having a

positive impact. The labour turnover rate for Durham and Darlington has decreased in the last quarter and analysis highlights 34% of leavers are for reason of retirement, with 12.5% opting to return. Analysis of reasons for leaving in North Yorkshire and York highlights 31% of leavers are for retirement with only 6.3% opting to return. 17% of leavers are indicating they are leaving for a better reward package or promotion, which is high compared to the other localities, which report between 10% and 13% for this reason, and 15% of leavers have left for health or work/life balance reasons in North Yorkshire and York, as opposed to 9% to 13% in the other localities.

In order to improve our ability to retain staff, the Trust is encouraging staff to request a leaver's debrief before they leave. The new Leavers Process is currently being piloted to clinical staff and managers that support front line services plus Healthcare Assistants, as a way of offering alternative solutions to retain both knowledge and skills within the Trust. HR has started reviewing the leaver forms that have been returned but to date there has been a limited number returned; therefore no underlying reasons for turnover have as yet been identified.

- **KPI 9 - Percentage rolling sickness absence rate -** The Trust position for quarter 2 is 5.06% which relates to 109889 days lost to sickness out of 2171922 available working days for the Trust. This is 0.66% worse than the standard of 4.40%.

  The target has been reduced from 4.5% to less than 4.40%, in line with the Workforce Strategy.

  Only North Yorkshire & York and Corporate Services are reporting better than target.

  Forensics report 6.28%, Teesside 5.67% and Durham & Darlington 5.11%; however both Durham & Darlington and Forensics are showing a reducing trajectory from April to September. Teesside is reporting an increase, some of which is attributable to the closure of West Lane Hospital. The percentage of staff with no episodes of absence in the rolling 12 month period is 33%, which is comparable to the same time frame 12 months ago. Teesside and Forensic Services are report the lowest rates at 26% and 20% respectively.

  Mental health/stress and anxiety related issues continue to account for the largest number of absences, with 39.8% of absence (over a rolling 12 months) attributable to mental health related conditions; compared to 37.7% in quarter 1. Durham & Darlington report 44.5%, Forensic Services 43.4% and Teesside 41.5%. North Yorkshire and York report the lowest figure at 31.54%.

- **KPI 10 - Percentage staff recommending TEWV as a place to work -** The Trust position for quarter 2 is 67.78% which relates to 620 members of staff out of 1924 that responded they would not recommend TEWV as a place to work. This is 8.22% worse than the standard of 76%.

As with the previous few surveys, the response rate for this quarter was particularly low and it coincided with the second conversation of crowdsourcing. There is some concern that staff may be feeling overwhelmed with surveys at the current time, which may be negatively impacting the number of surveys that are being completed. It is envisaged that the Making a Difference Together Programme will have a positive impact as work becomes embedded.

3.4.2 Trust Business Plan

The majority of the business plan actions due to be completed by the end of quarter 2 were rated green 73% compared to 80% in quarter 1. There are 2 business plan priorities assigned to Strategic Goal 3 which are currently reporting amber green (Right Staffing) and amber red (Making a difference together) due to there been a moderate risk of failure to deliver the final milestone or benefits on time.

There are 2 metrics for MADT that requires Board approval to remove them from the business plan, change to wording and timescales noted in the table attached in appendix 1.

There is 1 metric for Right Staffing that requested an extension to time within 19/20 which has been approved by EMT.

3.4.3 Other Qualitative Intelligence

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

- At the 2018 National Freedom to Speak Up Conference, Simon Stevens presented preliminary findings from the NHS staff survey that he suggested could be used as a proxy measure of the Freedom to Speak Up culture in trusts. Following analysis of the most recent results, **TEWV** have received communication from the National Freedom to Speak Up Guardian that we have recorded the equal highest score for Combined Mental Health/ Learning Disability Trusts. Reporting 81% against an overall highest score across all Trusts of 87%.

- **Claire Bainbridge**, locality lead psychologist for TEWV Health and Justice and Forensic Mental Health Services, Roseberry Park, Middlesbrough has been awarded the 2019 Excellence in Forensic Psychology Practice Award by the British Psychological Society Division of Forensic Psychology.

- **Jo-Anne Smith**, professional head, Dietetic Services has won the AHP Public Health Champion category of the NHS England - Chief Allied Health Professions Officer's Awards 2019.

- **Dr Venkatraghavan Ramaswamy,** consultant psychiatrist and associate clinical director, Durham Affective Disorders team has won the Clinical Supervisor (hospital specialist) Award of the Year in the Durham and Tees

Valley GP Training Programme.

- **Corinne Walsh**, project lead, North Tees Dementia Collaborative, Lancaster House, Stockton has won the Older People's Mental Health (OPMH) Dementia Individual Staff of the Year Award in the Positive Practice National OPMH and Dementia Awards 2019.

- This year's annual audit of medical appraisal results continue to show **TEWV** has an excellent record in medic staff engaging in appraisal, ahead of other MH Trust and the wider NHS:

	Completed Appraisals 2018/19		
	TEWV	**Other MH Trusts**	**All Sectors**
Consultants	98.7%	93.7%	93.7%
Staff grade, Associate specialists and specialty doctors	95.6%	93.0%	88.2%

100% of TEWV's missed appraisals were authorised, comparing to 1.2 % unapproved for consultants and 0.6 % unapproved for other grades within other MH Trusts and 2.2% and 3.2% respectively within all Sectors.

- **Ros Savege** carer, has been shortlisted for the Carer Contributor of the Year at the Royal College of Psychiatry Awards 2019.

- **Dr Jim Boylan**, consultant psychiatrist, Roseberry Park, Middlesbrough, has been shortlisted for the Psychiatric Educator of the Year at the Royal College of Psychiatry Awards 2019.

- **John Venable**, service user, has been shortlisted in this year's Royal College of Psychiatrists Awards.

- **TEWV** is piloting an Internal Transfer Scheme with Bands 5 and 6 Registered Nurses and Trainee HCA/HCAs, which allows staff to register interest in applying for an internal transfer to a vacant post of the same substantive pay band, without the need to apply through the normal recruitment process. Subject to successful evaluation the scope of the scheme will be increased to include other staff groups. The aim is to reduce the number of leavers by making it easier for staff to move to a new position within TEWV that is of interest to them in a way that reduces the length of time taken to fill a vacant post.

- **TEWV** has completed the second Trustwide conversation via crowdsourcing. Actions were drafted following the first online workshop and the second conversation asked staff to tell the Trust what was strong, wrong, or missing. The Trust now has a much better understanding of how we can improve staff wellbeing together, how we can make sure that everyone gets their voice heard, and how we can ensure our work has the best possible impact. Actions have been finalised and will be established over the next few months.

- The **Trust** now has a number of staff who have volunteered to become a Staff Dignity at Work Champions. They can provide confidential support and a safe discussion space for staff who believe they may be experiencing bullying and/or harassment by another member of staff or a manager. They can also help those staff wishing to raise concerns about risk, malpractice or wrong doing that they believe could have a detrimental impact on the service delivered.

3.4.4 Other points to note:

- **KPI 11 - Report and increase the % frontline multi-professional leadership and management teams that have trained in the core skills identified** – The first programme is due to be completed in December 2019, after which baseline data will be available. The first cohort of supercell training in Teesside commenced on 30th September 2019; a pre–evaluation was completed and used to inform the content of the programme. A successful bid was made to support independent evaluation of the programme from NELA's "Inclusive Leadership Practice Bursary Scheme", which will provide important information for each of the teams about how their collective leadership impacts on service user experience and outcomes.

3.4.5 In conclusion, performance against this Strategic Goal is mixed as all three metrics are reporting red; all deteriorating compared to last quarter. Progress against the Business Plan and the significant amount of qualitative intelligence is more positive for the recruitment, development and retention of our workforce.

3.5 Strategic Goal 4 - *To have effective partnerships with local, national and international organisations for the benefit of the communities we serve*

3.5.1 Trust Strategic Direction Scorecard

This strategic goal is showing all metrics are rated green out of a possible 3 metrics that can be rated, which is consistent with the quarter 1 position. Only one metric has reported an improvement on that quarter.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20									
	Indicator	Q2 Target 2019/20	Quarter 2 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20	2018/19 Actual	2017/18 Actual	Annual Target 2019/20
Strategic Goal 4 - To have effective partnerships with local, national and international organisations for the benefit of the communities we serve									
12	Percentage joint bids with CCGs that are successful	80%	N/A	N/A	80%	80.56%	70.83%	N/A	80%
13	Percentage of mental health and learning disability budget covered by a ring-fenced budget	85%	90.14%	⇩	85%	90.14%	77.17%	N/A	85%
14	Percentage delayed transfers of care due to non Trust issues	3.5%	2.28%	⇧	3.5%	2.40%	3.01%	N/A	3.50%
15	Percentage of e-letters developed against the total number of GP letters required	100%	100.00%	⇔	N/A	100.00%	N/A	N/A	100%

There are no concerns for the indicators reported above.

3.5.2 Trust Business Plan

There are no business plan priorities assigned to Strategic Goal 4.

3.5.3 Other Qualitative Intelligence

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

- **TEWV** is working in partnership with the British Institute for Human Rights to pilot a new project to embed human rights within decision making processes, following the receipt of funding from the Health Foundation. Exploring ways to empower people to know and claim their rights, the fifteen month project will seek to understand the core issues faced by staff and service users in relation to managing risks and protecting people's rights.

- **TEWV** has been awarded a contract to work with Spectrum Community Health CIC and Humankind to deliver integrated healthcare services at seven prisons in the North East - HMPs Durham, Frankland, Holme House, Low Newton, Northumberland, Kirklevington Grange and Deerbolt. Spectrum will be the lead provider.

- **TEWV** has joined The Northern Health Science Alliance (NHSA), which brings together 24 research active NHS Trusts and universities across the North and the four Northern Academic Health Science Networks. It works closely with members to promote the North's life science sector to increase awareness of and drive investment into the Northern Powerhouse. As an Associate Member, TEWV will benefit from a range of opportunities through the NHSA's joint research partnerships, advocacy, business development and international and national programmes.

- Organisations from across Scarborough, Whitby and Ryedale have come together to raise awareness of the support available to those experiencing mental health difficulties in the area. Forty delegates from 28 local organisations attended an event hosted by **TEWV** and North Yorkshire County Council's stronger communities team, to share information about the services they provide and offer advice on guidance on how these can be accessed. Delegates also benefitted from presentations on hoarding and compassion focused therapy.

- Over 100 people attended a three day event exploring the importance of spirituality in mental health care. The conference, jointly hosted by **TEWV** and the University of Durham, welcomed clinicians, service users and carers to consider spirituality as part of a recovery focused approach to care. Representatives from education, academia, the third sector and faith and community groups were also in attendance.

- **TEWV** has been working with colleagues from Northumberland, Tyne and Wear NHS Foundation Trust, the Northern Clinical Network, Public Health England, local authorities and Teesside University, as well as service users and carers to develop a regional weight management plan which aims to address the needs of those in our care.

- **TEWV**'s partnership with law firm Ward Hadaway has been shortlisted in the 'Partnership Award of the Year' category of the Health Service Journal (HSJ) Awards 2019.

- Darlington Borough Council is undertaking a consultation exercise, via Positive Partnerships Consultancy, to inform the model requirements for a drug and alcohol service and have contacted **TEWV** to engage in this work, which will provide an opportunity to influence the service specification. A market engagement event is to be held 10th September.

- Following review of the business model assessment, EMT agreed to pursue the HMPs Wymott & Garth tender opportunity with Spectrum who would lead as the prime provider.

- The Children's Trailblazer Funding bids within **Tees** and **Durham and Darlington** and **Scarborough** have been successful. Final notification in respect of the other areas is awaited. Mental Health Support Teams (MHST), supervised by NHS children and young people's mental health staff, will provide specific extra capacity for early intervention and ongoing support within an education setting.

- Submitted 3 Provider Collaborative proposals in partnership with CNTW, Schoen Clinic and Leeds & York Partnership.

3.5.4 Other Points to Note

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

- **KPI 12 - Percentage joint bids with CCGs that are successful** – No joint bids with CCGs were submitted during quarter 2.

- **KPI 15 - Percentage of e-letters developed against the total number of GP letters required** – All letters are developed in PARIS; however PARIS is unable to email them/send them electronically at this current time. A way forward has been identified but this relies on CITO being implemented.

3.5.5 In conclusion performance against this strategic goal indicates work with our partners is strong. All three of the reportable metrics are green and these are supported by a significant amount of qualitative intelligence.

3.6 Strategic Goal 5 - *To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve*

3.6.1 Trust Strategic Direction Scorecard

This strategic goal shows that all three metrics of those that can be reported are rated green.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20

	Indicator	Q2 Target 2019/20	Quarter 1 Actual	Quarter 2 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20	2018/19 Actual	2017/18 Actual	Annual Target 2019/20
Strategic Goal 5 - To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve										
16	Delivery of control total in full as per NHSI financial plan	-£1,806,000.00	**-1,267,392**	**-1,970,573**	⇧	-£1,201,000	**-£3,237,965**	-£26,766,868	n/a	
17	Achieve an NHSI SOF rating of 1 *(reported one quarter behind)*	1	**1**	**1**	⇔	1	**1**	1	N/A	1
18	All clinical teams to be able to access pathology results via PARIS and order test by PARIS	50.00%	**68.82%**	**98.39%**	⇧	25.00%	**98.39%**	24.30%	N/A	100.00%
19	All service users being able to access care plan online or digitally	TBC		**Not Available for Quarter 2**	N/A	N/A	**Not Available for the FYTD**	N/A	N/A	TBC
20	100% clinical pathways developed and in use within PARIS	100%		**Not Available for Quarter 2**	N/A	100%	**Not Available for the FYTD**	N/A	N/A	100%
21	All clinicians to have access to Datix Incidents, Datix Risks, Datix Complaints, Clinical Caseload, Clinical Huddle Dashboard, Bed Management View in near to real-time	100%		**0.00%**	N/A	N/A	**0.00%**	N/A	N/A	TBC
22	Placeholder: E&D Strategy			**Not Available for Quarter 2**	N/A	N/A	**Not Available for the FYTD**	N/A	N/A	TBC
23	Placeholder: E&D Strategy			**Not Available for Quarter 2**	N/A	N/A	**Not Available for the FYTD**	N/A	N/A	TBC

Indicators of concern are:

- **KPI 21 - All clinicians to have access to Datix Incidents, Datix Risks, Datix Complaints, Clinical Caseload, Clinical Huddle Dashboard, Bed Management View in near to real-time** - The Trust position for quarter 2 is 0.00%.

  This metric has been included following last quarter's approval by Board.

  Initial work with the Trust's third party suppliers has been delayed. This has been resolved and it is anticipated that work will commence on Datix provision (the first three elements of the metric) within the coming weeks.

3.6.2 Trust Business Plan

Only 1 of the 4 (25%) business plan actions due to be completed by the end of quarter 2 has been delivered on time.

There are two business plan priority assigned to Strategic Goal 5; one to Identify and Reduce Waste and the other to deliver our Digital Transformation Strategy which are both currently reporting Red.

In respect of Waste Reduction, a paper on next steps on reducing travel and venue hire costs was presented to the waste reduction programme board on the 16th October, which identified that there has been a number of system set up issues that has delayed the pilot commencing as planned; a new timescale was proposed to fully commence the pilot during quarter 3 19/20. There is also a consensus that it may be too early to tell whether sufficient information will be gathered by the end of 2019/20 to allow a decision on full implementation to be made or whether the pilot will need to be extended into quarter 1 20/21 before a final decision on roll-out is made. Therefore the programme Board have requested a further update in November to identify all the outstanding issues and develop actions to resolve each issue, provide further detail to give assurance that the pilot can fully commence in December and the plans for 'go live' in full by April 2020. Following the outcome a change request will be submitted for approval to extend the timescales of the programme.

For Digital Transformation much progress is being made; however there are some delays to some projects caused by a combination of supplier issues, staffing capacity and technical issues. EMT have approved an extension to quarter 3 19/20 for 2 metrics.

3.6.3 Other Qualitative Intelligence

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

- **The Currency and Tariff Development Team**, Flatts Lane Centre, Middlesbrough, has been shortlisted in the 'Best use of Data' category of the Health Tech Awards, which celebrate and showcase exceptional projects, teams, technology and organisations across health and care. The team was shortlisted for the development and implementation of a Trust wide dashboard that describes clinical outcomes for patients.

3.6.4 Other points to note:

- **KPI 19 - All service users being able to access care plan online or digitally** – data is not available as yet. The plan is that care planning will be built in CITO and then patients will receive an electronic copy alongside being able to access a Patient Portal where a patient can access their plan. CITO rollout is being managed but the plan is now that MHSOP will be aiming to go live during Spring 2020; a delay from the original plan of Autumn 2019.

- **KPI 20 - 100% clinical pathways developed and in use within PARIS** - data is not available as yet. Version 2.3 of CITO includes workflow functionality to allow development of pathways. The plan is that the pilot teams for CITO will include this high level pathways/workflow functionality. CITO rollout is being managed but the plan is now that MHSOP will be aiming to go live during Spring 2020; a delay from the original plan of Autumn 2019.

- **KPI 22/23 - E&D Strategy metrics** – these metrics are not yet finalised. At the July meeting, the Resources Committee agreed that the Equality & Diversity Strategy will go to the November meeting.

3.6.5 In conclusion performance against this Strategic Goal is mixed. Whilst all three reportable KPIs are green, only one Business Plan actions has been delivered this quarter.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
There are no issues of compliance with the CQC fundamental standards. The report includes the CQC visit in June and subsequent action regarding West Lane Hospital.

4.2 **Financial/Value for Money:**
The report highlights that none of the Sustainability metrics are below target.

4.3 **Legal and Constitutional (including the NHS Constitution):**
There are no direct legal or constitutional implications from this paper.

4.4 **Equality and Diversity:**
There are no direct equality and diversity implications from this paper, however, one metric does measure the variance in the responses of staff in the NHS Staff Survey who report as 'disabled' compared to those reporting 'non-disabled'.

4.5 **Other implications:**
There are no other implications associated with this paper.

5. RISKS:

There are no identified risks associated with this paper.

6. CONCLUSIONS:

Quarter 2 has reported a number of metrics deteriorating with 56% (9) of the metrics reporting green compared to 67% (10) in quarter 1. Of the 44% (7) metrics reporting red, none have reported an improvement compared to quarter 1. Progress against the Business Plan is mixed, in particular in relation to Strategic Goal 5, which has only delivered one action in quarter 2. The significant risk is the CQC Notice of Decision at West Lane Hospital and its subsequent closure.

7. RECOMMENDATIONS:

Board of Directors is asked to:

- Note the changes to the Trust Business Plan that require Board approval in Appendix 1.

Sharon Pickering
Director of Planning, Performance & Communications

Background Papers:

Appendix 1

Requests to the Board of Directors for a Change to the Business Plan

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
1.13.49	New Care Models Eating Disorders	D&D	AMH	Develop a business case to NCM Board for approval	Business case completed	Q2 19/20	Donna Sweet	**GY**	Action has been superceded by provider collaborative, led by NTW **Trust Board are requested to remove this priority and actions**
1.13.50	New Care Models Eating Disorders	D&D	AMH	Obtain approval from TEWV, NTW and NHSE	approval attained from TEWV, NTW and NHSE	Q3 19/20	Donna Sweet	**GY**	Action has been superceded by provider collaborative, led by NTW **Trust Board are requested to remove this priority and actions**
1.13.51	New Care Models Eating Disorders	D&D	AMH	Implement in line with agreed plan within the Business Case	actions delivered within timescales set out in business case	Q4 19/20	Donna Sweet	**GY**	Action has been superceded by provider collaborative, led by NTW **Trust Board are requested to remove this priority and actions**
1.13.63	Remodelling Inpatient Beds Environment	D&D	ALD	To produce a Business Case exploring the need for Single occupancy care packages, including case study examples (linking with Trust-wide estates work where appropriate)	Business Care produced an submitted to QUAG/LMGB	Q2 19/20	Sheila Halpin	**GY**	This action has been superceded by the Trust work on single occupancy / pop ups. The LD service is also working on a whole system business case in response to recent challenges within the LD system. This action is identified in the 2020/21-2022/23 business plan and actions are been developed to progress agreed next steps **Trust Board are requested to**

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
									remove this actions
1.13.11	Configuration of West Lane Site	Tees	CYP (all)	Review options for bed reconfiguration on West Lane Site	Review completed and plan signed off by Trust Board and New Care Models Governance route	Q3 19/20	Chris Davis		Whilst work is ongoing following CQC announcement to close the site, timescales for this area of work are still unknown. **Therefore Trust Board are requested to remove this priority, with additional actions to be added in line with work of Programme Board.**
1.13.12	Configuration of West Lane Site	Tees	CYP (all)	Implementation of agreed bed reconfiguration plan for West Lane	Bed numbers reduced across West Lane site as per agreed milestones	Q2 22/23	Chris Davis		Whilst work is ongoing following CQC announcement to close the site, timescales for this area of work are still unknown. **Therefore Trust Board are requested to remove this priority, with additional actions to be added in line with work of Programme Board.**
1.13.13	CYP Eating Disorders	Tees	CYP (all)	Development of enhanced community eating disorders service	Business case milestones delivered	Q3 19/20	Chris Davis		Whilst work is ongoing following CQC announcement to close the site, timescales for this area of work are still unknown. **Therefore Trust Board are requested to remove this priority, with additional actions to be added in line with work of Programme Board.**

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
1.13.15	Mental Health Support to Schools	Tees	CYP (all)	Improve mental health support in schools	FFT - analyse feedback from patients	Q3 19/20	John Barnard		Based upon consideration from the new HoS for CAMHS. This action is no longer relevant to the work being undertaken by the Trailblazer bids in HAST. **Trust Board are requested to remove this action**
1.13.16	GP Communications	Tees	CYP (all)	Develop proposed model for phase 2 of the GP Psychologist pilot	Proposed model developed and implementation plan agreed	Q2 19/20	Cathy Byard	**R**	The current pilot has been extended for another 6 months therefore the evaluation will not be undertaken until the pilot has completed (March 20). **Trust Board are requested that to approved an extension to Q1 2020/21.**
1.13.25	Core 24	Tees	MHSOP	Should application for Wave 2 National funding be successful, implement model	Model implemented	Q4 19/20	Shaun Mayo		NHSE advised that whilst they supported the bid, funding would be allocated to sites first and foremost who do not have CORE 24 in place. The service has now received a further update that there is £191k available for 2019/20 but this would require CCGs to deliver funding in 2020/21. A Paper has been prepared advising what is feasible with £191k and ongoing commitment for funding from the CCGs to be discussed with the Partnership. If no bid for £191k is forthcoming, further discussions will be required to explore other potential options – including decommissioning of unfunded

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
									elements of current provision.
1.13.7	HMP Haverigg Procurement	Forensic	OH	Respond to Commissioner procurement in line with contract timescales (current contract ends July 2020)	Tender documents completed and submitted as required	Q1 19/20	Simon Harrison	**GY**	Procurement process not as yet commenced by commissioners.
1.13.8	HMP Haverigg Procurement	Forensic	OH	Respond to Commissioner procurement in line with contract timescales (current contract ends July 2020)	Notification of award	Q2 19/20	Simon Harrison	**GY**	Procurement process not as yet commenced by commissioners.
2.2.3	Improve the purposefulness and productivity of our services	COO	All	Prepare and undertake a “Perfect week” to help support better patient flow and bed capacity	Perfect Week event held	Q2 19/20	Nicola D'North-wood	**R**	It was agreed by OMT that it was not appropriate to progress this action due to the level of resource required. **Trust Board are requested to approve the removal of this action**
3.4.9	Make a Difference Together by embedding TEWV’s values and behaviours throughout the organisation	COO	All	understand the factors that have been in place where staff have raised important concerns	Factors that encourage raising concerns are understood	Q2 19/20	Sarah Dexter-Smith	**R**	This has now been superceded by the workstream addressing Just & Fair Culture. **Trust Board are requested to remove this action.**

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
3.4.10	Make a Difference Together by embedding TEWV's values and behaviours throughout the organisation	COO	All	Implementation of Crowdsourcing as a way to communicate and engage in real time with staff about how we can consistently apply the values	Crowdsourcing conversation on application of values commences	Q3 19/20	David Levy		It has now been agreed that the next crowdsourcing conversation will focus on Just and Fair Culture however given the Staff Survey has only just been advertised it was felt that the timing of this should be delayed in order to maximise participation. **Therefore Trust Board are requested to change the action to Crowdsourcing conversation on Just & Fair cultures commences and extend the timescale to Q4 19/20**
5.6.3	Identify and Reduce Waste	COO	All	Pilot a new process for booking venues and travel	pilot commences	Q2 19/20	Martin Dale	R	A paper on next steps was presented to the waste reduction programme board 16th October with a new timescale to fully commence the pilot during Q3 19/20. There is a consensus that it may be too early to tell whether sufficient information will be gathered by the end of 19/20 to allow a decision on full implementation to be made Therefore the programme Board have requested a further update to come back in in November to

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q2 Metric Status	Comment and requests for decisions
									identify all the outstanding issues and develop actions to resolve each issue, provide further detail to give assurance that the pilot can fully commence in December and the plans for 'go live' in full by April 2020.
1.7.7	Implement the Transforming Care agenda	COO	ALD	To commence public Consultation	Public Consultation complete	Q2 19/20	Sarah Walker	R	Due to the change of scope in NYY for this priority we are **requesting Trust Board to approve the removal of this action and replace with a new action Harrogate & York LD enhanced support team goes live by Q3 19/20**
1.7.8	Implement the Transforming Care agenda	COO	ALD	To develop revised service model	Revised model approved by TEWV Board and TCP/ACP	Q3 19/20	Sarah Walker	R	Due to the change of NYY scope for this priority we are **requesting Trust Board to approve the removal of this action and replace with a new action Review and evaluation of pilot presented to NYY TCP by Q2 20/21**
1.7.9	Implement the Transforming Care agenda			Implement agreed service model	New service model live	Q1 20/21	Sarah Walker	R	**Due to the change of NYY scope for this priority we are requesting Trust Board to approve the removal of this action**

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

Appendix X Programme Change Request Form

Programme Name:	Right Care, Right Place
Date this form discussed by Programme Board	14th October 2019
Date this form is being considered) by EMT	23rd October 2019

Is this request for a change in…?	Dead-lines	√	Resources		Benefits	
	Programme Board membership or Terms of Reference / tolerances					

Will the change alter a Trust Business Plan milestone if approved? (please note relevant milestones below)	YES

Having reviewed the business plan actions it is proposed that a number of changes are made to realign the existing actions and ensure these are applicable and appropriate to the RCRP programme. The following changes / additions for RCRP are therefore proposed:

Remove Priority Ref action no. 2:3 Prepare and undertake a "Perfect week" to help support better patient flow and bed capacity – following further consideration by EMT it was agreed not to continue with this work at this time.

Remove Priority Ref action no. 18:8 Develop key principles and future vision for future urgent care model - Urgent care models will be incorporated into the RCRP work undertaken by the localities.

Action	Milestone	Date
(addition) Development of new locality delivery models that reflect a system wide change that will meet the needs of the local community**.**	Co-produced locality model developed.	Qtr 4 19/20
	Implementation plan developed.	Qtr 4 19/20

What is the request?

The Programme board are asked to consider and agree to:

- Changes to some of the current business plan actions (all additions and amendments have been highlighted above
- To extend the programme trajectory in relation to the development of locality models and outline implementation plan from November 2019 to March 2020

What is the impact on the programme's achievement of the expected benefits if this change is approved

It is anticipated that there would be a positive impact upon the achievement of the programmes expected benefit's by allowing more time for localities to fully engage with stakeholders and analyse feedback in order to co-produce a future state that will meet the needs of each locality.

In addition the changes proposed to the business plan actions will ensure that the key milestones are aligned to the RCRP programme and will therefore contribute to the achievement of the programmes overall benefits.

What changes will there be to key outputs / product / deliverables which are associated with this programme?

There will be a delay in localities producing their locality model / vision and implementation plans.
What is the impact on this programme's achievement of the expected benefits if this change is rejected?
The Programme will be unable to achieve its current trajectory to have a defined model for each locality and outline plan of implementation.
What are the alternative options? (if applicable)
The only option available is to support the request to extend the current timelines from November 2019 to March 2020 allowing sufficient time to work with stakeholders to co-produce a meaningful and transformational model that will deliver improved outcomes, experience and wellbeing for our service users and carers.

ITEM NO. 20

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th November 2019**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**26th November 2019**
TITLE:	**Report on the Register of Sealing**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

3. KEY ISSUES:

3.1 The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
355	06/11/2019	Deed of Appointment of Services Design Partnership Ltd	Colin Martin, Chief Executive Patrick McGahon, Director of Finance and Information
356	06/11/2019	Deed of Appointment of P+HS Architects Ltd	Colin Martin, Chief Executive Patrick McGahon, Director of Finance and Information
357	06/11/2019	Deed of Appointment of BGP Consulting Ltd	Colin Martin, Chief Executive Patrick McGahon, Director of Finance and Information

4. IMPLICATIONS:

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

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

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

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

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution
Seals Register

ITEM NO.21

FOR GENERAL RELEASE

BOARD OF DIRECTORS

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

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

Executive Summary:

The policy paper contains the following information:

- 1 policy that had minor amendment:
  - PHARM-0002-v7.2 Medicines Overarching Framework Policy
- 2 procedures that underwent review with minor amendment and required approval:
  - Interpreting and translation guidance
  - Equality Analysis Guidance
- 2 policies that required an extension to the review date:
  - HR/0013 Human Rights, Equality and Diversity Policy
  - PHARM-0001 NMP Policy & Procedure to Practice

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meetings held on 23 October 2019.

DATE:	**26 November 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 has undergone minor amendment.

Ref and Title	PHARM-0002-V7.2 Medicines Overarching Framework
Review date	01 May 2021
Reviewed by	Phil Bellas
Approved by	Drugs and Therapeutic Committee
Description of change	This policy has had minor amendments. • Nursing Associates has been added to roles and responsibilities (page 6). • Reference to contracted pharmacies has been removed (pages 8, 11 and 24). The change regarding contracted pharmacies is effective

	04 November 2019 due to end of contract.

3.2 The following procedures have undergone review with minor amendment and require approval.

Please note that these procedures are presented to EMT at the request of the Responsible Director due to there being no other suitable group for their approval.

Ref and Title	Interpreting and translation guidance (Appendix 2)
Review date	23 October 2019
Update	Reference to the interpreting and translation services provider has been updated.

Ref and Title	Equality Analysis Guidance (Appendix 3)
Review date	23 October 2019
Update	Minor changes to include generic phone numbers instead of particular individuals.

3.3 The following require extension to the review date.

Ref and Title	HR/0013 Human Rights, Equality and Diversity Policy
Review date	28 February 2020
Comments	This policy has had the review date extended to allow review.

Ref and Title	PHARM-0001 NMP Policy & Procedure to Practice
Review date	31 December 2020
Comments	This policy has had the review date extended to allow independent Director review of the revised document.

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 23 October 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