Board of Directors Meeting (PUBLIC)

25 July 2018, 14:00 to 16:00
Kiff Kaff, St George's Park, Morpeth, NE61 2NU

Agenda

1. Service User/Carer Experience

Information

2. Apologies

Information

Chair

3. Declarations of Interest

Information

Chair

4. Minutes of the previous meeting: Wednesday 27 June 2018

Decision

Chair

2 - Draft Minutes 27 June 2018.pdf (6 pages)

5. Action list and matters arising not included on the agenda

Discussion

Chair

5 - Action List.pdf (2 pages)

6. Chair's Remarks

Information

Chair

7. Chief Executive's Report

Information

Chief Executive

7 - CE Report July 2018.pdf (6 pages)

Quality, Clinical and Patient Issues

8. Flu Plan 2018-19

Decision

Executive Director of Nursing/Chief Operating Officer

8 - Flu Plan 2018-19 VERSION 2.pdf (24 pages)

9. Guardian Report on Safe Working Hours (Q1)

Discussion

Executive Medical Director

9 - Quarterly Report on Safe Working Hours (Apr to Jun 2018).pdf (6 pages)

10. Medical Revalidation submission

Decision

Executive Medical Director

10 - 1. Medical Revalidation Submission.pdf (2 pages)

10 - 2. Medical Revalidation Annual Board Report NTW.pdf (8 pages)

10 - 3. Revalidation Report - ST OSWALD'S HOSPICE.pdf (2 pages)

10 - 4. NHSE Board Report Template.pdf (17 pages)

10 - 5. Statement of Compliance St Oswalds.pdf (4 pages)

10 - 6. Statement of Compliance NTW 2018.pdf (4 pages)

11. Smoke Free update

Discussion

Executive Director of Nursing/Chief Operating Officer

11 - Smoke Free Update VERSION 2.pdf (6 pages)

12. Safer Care Report (Q1)

Discussion

Executive Director of Nursing/Chief Operating Officer

12 - Q1 Safer Care Report (including Learning From Deaths) Board of Director...pdf (33 pages)

13. Safer Staffing Levels (Q1) Including 6 monthly skill mix review.

Discussion

Executive Director of Nursing/Chief Operating Officer

13 - Safer Staffing Q1 - Six Month Skill Mix Review.pdf (6 pages)

14. Visit Feedback Themes

Discussion

Executive Director of Nursing/Chief Operating Officer

14. Feedback from Service Visits (6 month report - Jan to Jun 2018).pdf (8 pages)

15. Service User and Carer Experience (Q1)

Discussion

Deputy Director of Commissioning and Quality Assurance

15 - Service User and Carer Report Q1.pdf (12 pages)

16. Integrated Commissioning and Quality Assurance Report (Q1, Month 3)

Discussion

Deputy Director of Commissioning and Quality Assurance

16 - Commissioning Quality Assurance Report 18-19 month 3.pdf (36 pages)

17. Board Assurance Framework and Corporate Risk Register

Discussion

Deputy Director of Commissioning and Quality Assurance

17 - 1.Board Of Directors Trust Risk Management Report July 2018.pdf (21 pages)

17 - 2. Q2 BAF CRR 2018 - 2019.pdf (16 pages)

Strategy and Partnerships

18. Delivering Transforming Care in CYPS: Closure of the Riding ward

Decision

Executive Director of Nursing/ Chief Operating Officer

18 - Transforming Care and New Models of Care Summary Business Case - Public .._ VERSION 2.pdf (7 pages)

19. Provision of Outpatient Dispensing Services by NTW Solutions Limited.

Decision

Executive Medical Director

19 - Business Case - Provision of Outpatient Dispensing Services by NTW Solutions Limited.pdf (17 pages)

Workforce

20. Staff Friends and Family Report

Discussion

Acting Executive Director of Workforce and Organisational

20 - Staff Friends and Family Test Qtr1 (2018-19) V1 2018.pdf (32 pages)

21. Equality and Diversity WRES update

Discussion

Acting Executive Director of Workforce and Organisational

21 - EDS2 WRES Trust Board Report July 2018.pdf (15 pages)

Regulatory

22. NHS Improvement Single Oversight Framework (Q1)

Discussion

Deputy Director of Commissioning and Quality Assurance

22 - NHS Improvement Single Oversight Framework (Q1).pdf (6 pages)

Minutes/Papers for Information

23. Committee updates

Information

Non-Executive Directors

24. **Council of Governors' Issues**

Information

Chair

25. **Any other Business**

Chair

26. **Questions from the Public**

Discussion

Chair

Date, time and place of next meeting:

27. **Wednesday, 26 September 2018, 1:30 to 3:30pm, St Nicholas Hospital, Gosforth, NE3 3XT.**

Information

Chair

Board of Directors Meeting (PUBLIC)

27 June 2018, 13:30 to 15:30
The Large Training Room, Hopewood Park, Ryhope, Sunderland, SR2 0NB.

Attendees

Board members

Ken Jarrold (Chair) , John Lawlor (Chief Executive) , Alexis Cleveland (Non-Executive Director) , Peter Studd (Non-Executive Director) , Miriam Harte (Non-Executive Director) , Ruth Thompson (Non-Executive Director) , Martin Cocker (Non-Executive Director) , James Duncan (Executive Director of Finance and Deputy Chief Executive) , Lynne Shaw (Acting Executive Director of Workforce and Organisational Development) , Les Boobis (Non-Executive Director) , Gary O'Hare (Executive Director of Nursing and Chief Operating Officer) , Rajesh Nadkarni (Executive Medical Director) , Lisa Quinn (Executive Director of Commissioning and Quality Assurance)

In Attendance

Jennifer Cribbes (Corporate Affairs Manager) , Chris Cressey (Associate Director Of Finance & Business Development)

Meeting minutes

1. Service User/Carer Experience

Information

Lyndsay Tunney delivered a verbal presentation to share her personal experiences of using NTW services.

The Board thanked Lyndsay for sharing her story which was very powerful and thought provoking.

In response to questions raised by non-executive directors relating to Lyndsay's bariatric surgery, Lyndsay explained she did not receive support from services in relation to her relationship with food. Furthermore, at that time, the connection with her mental health was not explored. John Lawlor advised that he was aware of this issue and work was ongoing to bridge the gap between these services.

John Lawlor asked Lyndsay if there was anything that the Trust could do to improve services. Lyndsay advised that she would like to see more peer support worker posts in community services as it is valuable to have staff with lived experience. Discussion took place relating to the value of such posts and the Trust's desire to recruit more peer support workers into community services.

Peter Studd raised a question regarding Smart Recovery. Lyndsay explained that Smart Recovery focuses on the here and now, is CBT based, scientifically proven and gives people helpful practical tools that can be used to self-manage their recovery.

Lyndsay advised that she would be appearing on a documentary on the 3 July 2018, BBC2, hosted by Adrian Childs, which is called Alcohol and Me.

2. Welcome and Apologies

Information
Chair

Ken Jarrold opened the meeting and welcomed attendees.

Apologies were recieved from James Duncan. The Board were advised that Chris Cressey, Associate Director Of Finance & Business Development, was in attendance to deputise for James.

3. Declarations of Interest

Information
Chair

There were no interests declared.

4. Minutes of the previous meeting: Wednesday 23 May 2018

Decision
Chair

The minutes of the meeting held on 23 May 2018, were agreed as a true and correct record.

Item 4 - Meeting Minutes Board of Directors 23 May 2018.pdf

5. Action list and matters arising not included on the agenda

Discussion
Chair

Action List
John Lawlor referred to completed action, (8) 23.05.18, and advised that he had received an e-mail from the Safety Team in relation to the violence statistics which clarified the differences were a result of the opening of Mitford ward.

The Board agreed that all four completed actions could be removed from the action list.

Alexis Cleveland requested that the timescales for all current actions have at least the date of the next update against them instead of just stating ongoing.

Matters arising
There were no matters arising.

Item 5 - Action List.pdf

6. Chair's Remarks

Information
Chair

Ken Jarrold provided a verbal update and referred to the Prime Minister's speech on NHS funding in which a new five-year funding settlement for the NHS was announced.

Ken further highlighted the proposal for a NHS 10 year plan and work on integration. Ken stated the importance of understanding the new environment and to influence direction where possible to support those we serve.

In response to a question raised by Ken Jarrold. Gary O'Hare advised that a Learning and Improvement Group had been established to facilitate continuous improvement and share learning; a Safer Care bulletin is issued to staff monthly; and Prevent information will be presented within the bi-monthly safeguarding report.

7. Chief Executive's Report

Information
Chief Executive

John Lawlor spoke to the enclosed Chief Executive's report to update the Board on key areas.

John advised that the Trust had received the draft CQC report in the last hour which will be checked for factual accuracy. The results will, therefore, be published in the near future.

Detail was provided in relation to the Gateshead System Partnership; Applied Research Collaboration (ARC); 10-year plan for the NHS; NHS funding; Carter Report; and NHS England and NHS Improvement joint working.

Peter Studd referred to the Carter Report in relation to potential savings from back office services and advised that NTW Solutions Ltd could provide opportunities in relation to shared services.

In response to a question raised by Les Boobis, John Lawlor advised that the Carter review found the Trust to be an outlier in relation to the size of the safeguarding team. However, the Trust was not intending to reduce the team as Mental Health Trusts generally have a larger safeguarding team than Acute Care Trusts.

Ken Jarrold referred to the item on Gateshead System Partnership and made the Board aware he had received positive feedback in relation to James Duncan's contribution.

John Lawlor referred to the item on NHS England and NHS Improvement joint working and advised that a Director of People will be appointed at a National level.

Item 7 - CE Report June 2018.pdf
Item 7a - Appendix 1. NHS Providers OTDB 201718 Q4 Finances and Performance.pdf
Item 7b -Appendix 2. NHS Providers OTDB.pdf
Item 7c -Appendix 3. NHS Providers OTDB.pdf
Item 7d -Appendix 4. HSC OTDB 11 June 2018.pdf

Quality, Clinical and Patient Issues

8. Integrated Commissioning and Quality Assurance Report (May Month 2)

Discussion
Executive Director Of Commissioning And Quality Assurance

Lisa Quinn spoke to the enclosed Integrated Commissioning and Quality Assurance Report (month 2) to update the Board on issues arising in the month and progress against quality standards. Lisa advised that the Trust is broadly on track with all quality standards. However, improvement is still required in relation to training and sickness absence. Lisa explained that there had been an increase in sickness absence which is currently being explored. Lisa brought the Board's attention to page 11 of the report that detailed a number of brief guides that had been published by the CQC as their areas of focus.

Chris Cressy spoke to the finance section of the report and highlighted the position in relation to agency and bank staff.

Ken Jarrold expressed concerns regarding the waiting times for Children and Young People's Services. John Lawlor advised that work was ongoing to look at the differences between the North and South localities and that he would aspire to achieve a position where no children or young people are waiting over 18 weeks for our services and, ideally, no one waiting over 6 weeks.

A significant discussion took place relating to staff sickness. Lynne Shaw advised that the HR team had delivered a presentation to the Council of Governors at their meeting on 14 June 2018, which detailed the extensive amount of proactive work that is being conducted in the Trust to reduce staff sickness. However, despite this, staff sickness levels have slowly increased over the last 6 months. Discussion took place in relation to the possibility of staff sickness being a culture issue.

Further discussion took place relating to the Trust's sickness policy. Peter Studd advised that the findings of a recent internal audit report had found that the policy may not be consistently applied by managers.

Ruth Thompson questioned if staff sickness levels were a risk to the FDP productivity plan. Gary O'Hare advised that a significant amount of work is being done to release time to care and reduce sickness absence.

Ken Jarrold summed up the item and highlighted that sickness absence was a concern.

Item 8 - Intergrated Commissioning and Quality Assurance Report (Month 2).pdf

Strategy and Partnerships

9. Announcement from NHS Improvement and NHS England

Information
Chief Executive

John Lawlor spoke to the enclosed paper, NHS Improvement and NHS England; Meeting in Common of the Boards of NHS England and NHS Improvement. John highlighted pages 13 and 14 of the report that detailed the core functions of the regional teams and explained potential changes in control at the level as a consequence of this.

The Board received the report for information.

Item 9 - Announcement from NHS Improvement and NHS England.pdf

10. Integrated Care System (ICS) Capital Bid to deliver on Integrated Secure Site

Discussion
Deputy Chief Executive/ Executive Director Of Finance

John Lawlor spoke to the enclosed Integrated Care System (ICS) Bid for the Integrated Secure Site.

Gary O'Hare explained that capital schemes require approval through the ICS. Therefore, the Trust must submit a bid to obtain capital money through the ICS to progress the plan to consolidate services at the Northgate site.

Chris Cressey provided detail regarding the investment required, land sale, and payback period.

Lisa Quinn advised that the proposal supports a number of priorities identified in the Mental Health 5 Year Forward View, it is aligned with the Trust Strategy and supports the new models of care. Lisa highlighted that the Trust needs to communicate with local commissioners to gain their support.

Ken summed up the item and highlighted that obtaining the funding supports a key part of the Trust strategy.

The Board approved the Integrated Care System capital bid.

Item 10 - Integrated Care System (ICS) Bid (formerly STP) Integrated Secure Site.docx.pdf
Item 10b - STP Capital VFM template (NTW) (130618 Submission File).pdf

11. Interim Accommodation for Newcastle and Gateshead Adult In-Patient Services

Decision
Executive Director Of Nursing And Chief Operating Officer

Gary O'Hare spoke to the enclosed paper that outlined the proposals for the interim accommodation arrangements for Newcastle and Gateshead Adult in-patient services. Gary advised that the changes were required to facilitate the refurbishment of the Hadrian Clinic and subsequent relocation of services. Gary further provided detail in relation to the temporary changes.

Discussion took place in relation to the importance of improving the environment in which services are delivered, consolidation of wards/beds and current bed occupancy levels.

The Board approved the Business Case to commence refurbishment work on Hadrian Clinic and then the relocation of services and staff to the new base as articulated in the paper.

Item 11 - Interim Accommodation for Newcastle and Gateshead Adult In-Patient Services.docx.pdf

Regulatory

12. Board Self Certification to NHS Improvement – Governors' Training

Decision
Executive Director Of Commissioning And Quality Assurance

Lisa Quinn spoke to the enclosed Board Self-Certification to NHS Improvement report and explained that NHS Foundation Trusts are required by NHS Improvement to annually self-certify the declarations to maintain their Provider Licence. Lisa referred to the evidence provided, that had been prepared by Caroline Wild, which demonstrates the Trust's compliance.

Lisa advised that the Council of Governors, at their meeting on the 17 May 2018 confirmed that they are happy to recommend to the Board of Directors completion of the Board Statement confirming that the Trust has provided the necessary training to its Governors during 2017/18.

The Board approved the Trust's compliance with Governors' Training.

Item 12 - Board self Certification - Governors Training.doc.pdf

Minutes/Papers for Information

13. Committee updates

Information
Non-Executive Directors

There was nothing to update from Committees.

14. Council of Governors' Issues

Information
Chair

Ken Jarrold provided an update in relation to the ongoing Chair and Governor one to one meetings. Ken advised that he had met with 16 Governors so far and a further 4 appointments had been scheduled. Ken stated that the meetings had been very enjoyable and had been invaluable in terms of understanding the skills and life experience of NTW Governors.

Ken updated the Board on the vacant Governor position for the Community and Voluntary Sector constituency. Ken advised there had been two candidates that had been considered by the Nominations Committee. The successful candidate was confirmed to be Annie Murphy from Moneywise Credit Union.

15. Any other Business

John Lawlor raised that Gary O'Hare had recently visited India as part of the Trust's international recruitment programme.

Gary explained that the Trust had 20 positions to offer; 7 consultant posts; 7 fellowship posts; and 6 SAS posts. Gary stated that the candidates were of a very high calibre and very focused on multi-disciplinary working.

Gary further advised that he had attended a two-day seminar hosted by the Indian National Insitute of Mental Health and Neuro Sciences. The event had a number of academics presenting their research and there could be an opportunity for the Trust to collaborate with them. Gary advised that a Memorandum of Understanding would be developed that would be presented at a future Board meeting.

Gary further explained that he had met with the British High Commission, New Delhi. Gary advised that there were opportunities to develop a relationship with them going forward and invite them to visit the Trust and meet the Board.

John Lawlor finally raised the current investigation into Gosport War Memorial Hospital. John advised that further National policies may be introduced as a result of the investigation.

16. Questions from the Public

Discussion
Chair

There were no questions from the public.

Date, time and place of next meeting:

17. Wednesday 25 July 2018, 13:30 to 15:30, Kiff Kaff, St Georges Park, Morpeth, NE61 2NU.

Information
Chair

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Action Sheet

Item No.	Subject	Action	By Whom	By When	Update/Comments
Month June 2018					
21/18	Safer staffing	Possible development session re care hours per patient day	Gary O'Hare	To be added to Board cycle	
50/18	Safer Care Summary of changes to practice	Changes to practice to be added to all serious incident templates	Damian Robinson/ Gary O'Hare	July 2018	
50/18	Safer Care Violence and Aggression	Board to be kept updated on progress within the Positive and Safe Strategy	Damian Robinson/ Gary O'Hare	26/09/18	
(8) 23.05.18	Annual Security Management Report	The Board to receive progress reports in relation to lone working devices	Tony Gray/ Gary O'Hare	24/10/18	Update to be included in the Q2 Safer Care Report
(9) 23.05.18	Integrated Commissioning and Quality Assurance Report	The Board to receive an update on the outcome of discussions relating to Payroll costs and Legal costs	James Duncan	July 2018	
Complete					
(8) 23.05.18	Annual Security Management Report	Update to be provided on our Smoke Free Strategy.	Tony Gray/ Gary O'Hare	25/07/18 24/10/18	Board to receive the Annual Smoke free update and a development session on smoking in July 2018. An update on progress will also be added to the Q2 Safer Care report.

50/18	Safer Care Embedding learning from Actions	Learning and Improvement Group will consider this further to make sure that learning is embedded in practice.	Damian Robinson/ Gary O'Hare	27/07/18	Safe Care, embedding learning from actions has been incorporated into the Learning and Improvement Group cycle of business commencing 27/7/18

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date:	25 July 2018

Title and Author of Paper:	Chief Executive's Report John Lawlor, Chief Executive

Paper for Debate, Decision or Information: Information

Key Points to Note:

Trust update

1. Annual Members Meeting
2. Human Factors Training
3. Project Choice Graduation
4. Mental Health Network Launch for South Community Business Unit (CBU)

Regional update

5. Northumberland Transformation Board
6. Colloquium
7. Integrated Care System (ICS) Mental Health Steering Group
8. Care Environment Development and Reform (CEDAR) Programme Board

National update

9. How Good is the NHS
10. National Pay Award

Outcome required: For information

Chief Executive's Report

25 July 2018

Trust updates

1. **Annual Members Meeting**
   This year's Annual Members Meeting was held on Thursday 19th July in the Jubilee Theatre at St Nicholas' Hospital with the theme of *'Past, Present and Future'.* Invited guest speaker, 87 year old Ethel Armstrong gave a personal account of her NHS career commencing in 1948, in recognition of 70 years of the NHS and Denise Porter, Trust Governor gave an account of her NTW journey.

   The event included over 30 information stalls, showcasing different services and initiatives from across the Trust. A significant number of people attended the event, where there was an opportunity to chat with staff and governors over a cuppa and a celebratory cupcake. Also included was the formal Annual Meeting and presentation of the Annual Report and Accounts.

2. **Human Factors Training**
   NHS Improvement promotes the use of a Human Factors (HF) framework in undertaking effective investigations and reviews. It has become clear that such a framework is best able to identify underlying systemic causes behind incidents to identify learning leading to targeted remedial actions designed to reduce future occurrence. Over the last year NTW has engaged NICHE consulting to enhance our ability to deliver HF informed investigations that promote learning following serious incidents, including death.

   The first phase of training took place in summer 2017 when NICHE delivered a two day comprehensive training package on using an HF framework in investigations to all serious incidents for and members of the serious incident review panel. The second phase took place on 28th June when NICHE provided a one day session on HF for executive and non-executive directors and senior operational directors from the locality groups. This session focussed on how Boards and senior managers might interpret and challenge investigation methods, findings and action plans. NICHE have also undertaken an evaluation of a sample of recent investigations and a report is due soon. Apart from training, ongoing support and supervision is important in ensuring embedding of the correct methodology. It is also clear that a HF framework could be extended to other types of investigations including complaints and disciplinaries.

3. **Project Choice Graduation**
   This year has seen the Trust support an initiative called Project Choice. This is a Health Education England programme which supports young people with learning difficulties and/or Autism to get into training or employment. Project Choice is hosted within the NTW Training Academy and we have supported a number of staff to take up secondments to help deliver the project and support the interns. We have also been overwhelmed by the enthusiasm shown by Trust staff to act as mentors across a variety of areas taking placements.

   Project Choice offers young people the opportunity to learn new skills in a real work environment. As part of its support the Trust has supported fifteen placements. The project runs throughout the academic year from September until July and involves interns working at their placements for four days plus a day at college. It gives young people the chance to get experience of being an employee, and develop appropriate

attitudes and behaviours for the working environment. Importantly, it offers an understanding of their skills and strengths in how to do a job successfully.

We have been working in partnership with City Hospitals Sunderland NHS Foundation Trust, The Newcastle upon Tyne Hospitals, NHS Foundation Trust, Tees Esk and Wear Valley NHS Foundation Trust, Newcastle City Council and Sunderland City Council on this work.

Quotes:
Mentors:

- 'My intern has said on more than one occasion how much they're enjoying working in the team'.
- 'My intern always works hard in whatever task he is doing and is polite and courteous to both staff and patients alike'.
- 'During my time as a mentor, I have learned a lot about myself – for the better!'

Interns:

- 'The Project has built my confidence up, helped me achieve and interview and get a part time job'.
- 'Project Choice provides excellent support and guidance to help interns choose the field of work that is best for them, by receiving placements within different timescales. As well as this, you receive support with their Maths and English and be able to hone those skills while learning new ones. Overall, I believe it is a worthy experience worth taking on'.

4. **Mental Health Network Launch for South Community Business Unit (CBU)**
   The Launch of the South CBU Adult Mental Health Clinical Network took place on 18 July. This event brings together service users, carers and families, some NTW practitioners, and the third sector across South Tyneside and Sunderland. The event is a creative interactive space aimed at co-producing a shared vision of how a network can celebrate and share good practice across the two localities and understand what people want from the network locally and across the Trust. Various work-streams discussed; Seamless Transitions, Reaching Out to Others, Trauma-Informed Care, Psychosocial Care and Environments, Encourage and Inspire, NTW Service User and Carer Involvement Strategy. There were also workshops which were aimed at sharing positive innovative practice within NTW.

Regional updates

5. **Northumberland Transformation Board**
   The Northumberland Transformation Board was relaunched during the latter part of 2017 following the pause in the further development of the ACO. The Board has senior representation from key statutory agencies including all of the providers as well as the Local Authority and the respective GP Locality Groups. The Board meets on a monthly basis and has set itself a robust transformational plan which incorporates a clinical strategy and a QUIPP development programme. In recognition of the financial and system challenges faced, it was agreed that external expert advisors would be commissioned to undertake a whole system review to gauge the appetite and ability to undertake fundamental and sustainable change within the "system".

   NTW has participated fully in this review via direct interviews, the completion of questionnaires and the provision of Trust data. The first stage feedback session took

place on the 11th July 2018 which provided organisations the opportunity to consider and analysis the data received to date. This was a positive workshop with mutually agreed outcomes, these being:

1) Development of a robust governance and oversight framework that would work effectively across systems within Northumberland.
2) The development of a clinical model and effective delivery approach.

It was agreed that these two priority areas would be given significant consideration over the next few months with a follow up workshop in September 2018 prior to a formal approach to the regulators in October 2018.

6. Colloquium

This was the tenth event in this series of meetings between paediatrics, child and adolescent mental health and lawyers, chaired by a senior judge. These encounters offer the opportunity for medical and legal professions to present cases that raise complex medico-legal questions. Termed colloquiums (or colloquia), these are unique to Newcastle.

Issues presented included suitability of a psychotic young person for police interview; a young asylum seeker claiming to be a child but resembling a young adult admitted to a child mental health facility; an infant with multiple congenital anomalies incompatible with life whose family were insisting on life prolonging treatment; and a transgender child requesting hormonal treatment.

All these cases prompted interdisciplinary debate and authoritative comment from the chair, on this occasion, Sir James Munby, President of the Family Division of the High Court. Interestingly, this was his second such event and this was arranged at his request. We enjoyed an excellent modern theatre in Northumbria University Business School and we have drafted a summary of the event and hope to publish it.

7. Integrated Care System (ICS) Mental Health Steering Group

The 7 priority area working group sponsors provided updates on the work that has progressed to date. Discussions took place with regard to engaging GPs and other partners. A summary briefing is being prepared for circulation and Steering Group members have been identified to lead on taking forward plans. The Group discussed plans for the second mental health programme workshop on 30th October. The agenda for the event will be progressed by the operational management group.

I provided an update on governance arrangements and plans to progress the ICS footprints for NENC. The communications pack to support a collaborative and consistent dialogue regarding our emerging picture across North Cumbria and the North East was shared with group members. James Duncan led a discussion on resources. The funding document will be updated and circulated to group members for comment. A regional profile presentation was also discussed.

8. Care Environment Development and Reform (CEDAR) Programme Board

Work continues on taking forward the CEDAR Programme. Following Board approval of the Business case for the intermediate solution for inpatient services for Working Age adults in Newcastle and Gateshead, implementation planning has been finalised including detailed planning and procuring of works. This has resulted in about two months of delay, with the work now commencing in September. This will see the expected closure of the Tranwell Unit being put back to August 2019. In addition

further discussions are required on the solutions for In-patient services for Older People in Newcastle.

Discussions continue about the potential development of an integrated centre of excellence for older people's service as part of the re-development of the Centre for Ageing and Vitality site in Newcastle, which continues to offer an exciting opportunity for the long term development of services. However the time horizon for this is likely to be 4-5 years.

Work continues on developing a viable intermediate model, and considering other options for the long term given the emerging models for Integrated Care Partnerships, and the need to ensure the delivery of a high quality and sustainable model for inpatients services for older people in Newcastle. The capital bid for Integrated Secure Services and Delivering Together has been finalised, approved by the ICP ad is progressing to the next stage for national consideration.

National updates

9. **How Good is the NHS?**

Overall, analysis shows that the NHS performs neither as well as its supporters sometimes claim nor as badly as its critics often allege. Compared with health systems in similar countries, it has some significant strengths but also some notable weaknesses. Its main weakness is health care outcomes. The UK appears to perform less well than similar countries on the overall rate at which people die when successful medical care could have saved their lives.

Although the gap has closed over the last decade for stroke and several forms of cancer, the mortality rate in the UK among people treated for some of the biggest causes of death, including cancer, heart attacks and stroke, is higher than average among comparable countries. The UK also has high rates of child mortality around birth.

Among its strengths, the NHS does better than health systems in comparable countries at protecting people from heavy financial costs when they are ill. People in the UK are also less likely than in other countries to be put off from seeking medical help due to costs. Waiting times for treatment in the UK appear to be roughly in line with those of similar countries and patient experience generally compares well.

While data is limited, the NHS seems to be relatively efficient, with low administrative costs and high use of cheaper generic medicines. The NHS appears to perform well in managing certain long-term illnesses, including diabetes.

Health care spending in the UK is slightly lower than the average in comparable countries, both in terms of the proportion of national income spent on health care and in terms of spending per person. The UK has markedly fewer doctors and nurses than similar countries, relative to the size of its population, and fewer CT scanners and MRI machines. You can find the full information in the link below.

Link: https://www.nuffieldtrust.org.uk/files/2018-06/the-nhs-at-70-how-good-is-the-nhs.pdf

10. National Pay Award

The National Pay Award negotiated between the Unions and NHS Employers for staff on Agenda for Change conditions of service was confirmed following consultation and is to be implemented this month (July). Staff will receive a cost of living uplift in July, and will receive backdated pay to April 2018 in their August pay. They will then move onto the new Agenda for Change scale relevant for their pay point at their next incremental date. It was agreed that this would be funded nationally at a cost of £4bn over 3 years. The first year allocation to cover the additional cost of the pay award amounts to £800m. Future years funding is now included within the uplift of 3.6% which has been recently announced by the Government so there will be no further separately allocated funding stream for the pay award in future years.

We have been awaiting details of how this will be implemented and how the additional funding will be allocated. Final guidance was issued on 16th July. NTW has been allocated additional funding of £3.075m for 2018/19. Having reviewed the guidance, compared with budget and completed final calculations of the impact, we believe this is broadly in-line with the additional cost of the pay award for the Trust. We continue to liaise with NHS Improvement regarding the guidance and implementation and will give a final update to the Board in September. Funding will be allocated in July and August broadly to match the additional costs incurred.

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 25th July 2018

Title and Author of Paper: Seasonal Flu Vaccination Plan 2018/19, Carole Rutter, Modern Matron, Infection Prevention and Control

Executive Lead: Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

Paper for Debate, Decision or Information: Information

Key Points to Note:

- We continue to improve year on year vaccination uptake rates , 73.5% of front line staff were vaccinated
- 194 registered staff attended vaccination training in 2017.
- CQUIN target set at 70% uptake in front line staff for 2017/18 achieved.
- CQUIN target for 2018/19 is 75% of all front line staff to be vaccinated
- Quadrivalent vaccine ordered for 2018/19 for both patients and staff
- Changes to vaccination type in age 65 years and above (adjuvanted Trivalent Inactivated Vaccine (aTIV))

Risks Highlighted to Board :

- Failure to achieve 75% uptake in front line staff, herd immunity and CQUIN will not be achieved.
-

Does this affect any Board Assurance Framework/Corporate Risks?
Please state **Yes** or **No**
If Yes please outline

Equal Opportunities, Legal and Other Implications: NONE

Outcome Required: Approval and support from the Trust Board to the 2018/19 flu campaign

Link to Policies and Strategies:

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Seasonal Flu Vaccination Plan 2018/19

Caring | Discovering | Growing | **Together**

CONTENTS

Seasonal Flu Vaccination Plan

1. Purpose

This plan sets out Northumberland Tyne and Wear (NTW) strategic approach to the delivery of seasonal influenza vaccination to both patients and staff.

The plan should be read in conjunction with the Pandemic Influenza Plan as a framework for vaccination in the event of a pandemic.

The plan is not intended to provide clinical guidance on seasonal flu vaccine. Guidance for the management of patients with an influenza like illness or confirmed influenza is set out in IPC- PGN- 26, (part of NTW (C) 23 Infection Prevention and Control Policy).

2. Seasonal Influenza (Flu)

Influenza is a highly infectious respiratory illness which can affect all population groups with severe morbidity and mortality common amongst elderly and specific high risk groups. Symptoms include sudden onset of headache, fever, sore throat, lethargy aching muscles and joints.

There are three influenza types; Influenza A and influenza B responsible for most acute respiratory illness with the third Influenza C less typical. Influenza A is the cause of large outbreaks and epidemics.

Influenza viruses are transmitted from person to person by inhalation of large and small droplets from the secretions of an infected person. Environmental contamination with secretions also plays a role in transmission.
The incubation period for influenza ranges from 1-5 days, typically 2-3 days. The infectious period lasts from the onset of symptoms until 3-5 days afterwards, although virus can be detected prior to the onset of symptoms.
Infants and children may continue to shed the virus up to 2 weeks after the onset of illness.

Common complications from influenza include bronchitis, ear infections, sinusitis and more seriously pneumonia and meningitis .Most people will recover from the virus within a few days however people from high risk groups frequently develop secondary bacterial infections.

Influenza viruses undergo frequent changes in their surface antigen therefore new influenza vaccines must be developed annually to match those influenza viruses expected to circulate in the next season.
Antigenic drift, occurring more in Influenza A than B signals minor changes in the virus envelope.
Antigenic shift signifies major changes in the virus envelope, different from those of previously circulating viruses and are responsible for major epidemics and pandemics where populations have no immunity to the new strain.

Moderate to high levels of influenza activity were seen in the UK during the winter of 2017/18, with influenza B and influenza A(H3) co circulating.

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The impact of influenza was predominantly seen in older adults, with a consistent pattern of outbreaks in care homes noted. In addition, admissions to hospital and ICU/HDU were the highest seen for the last six seasons.

3. Seasonal Influenza Vaccination Programme

The epidemiology of circulating flu viruses are monitored continually by the World Health Organisation (WHO). Virus strains selected for seasonal flu vaccines are announced by WHO in the first quarter of the New Year. These strains are those expected to be in wide circulation in the Northern hemisphere in the following winter months.

Influenza vaccines for the 2018/19 season for staff and patients under 65 years is a quadrivalent inactivated vaccine containing two subtypes of both influenza A and B.The adjuvanted trivalent inactivated vaccine for age group 65 years and over contains two subtypes of Influenza A and one type B. Vaccines previously and currently used are inactivated and therefore unable to cause influenza.

In the event of an emerging pandemic influenza strain, the seasonal flu vaccination will probably be ineffective. The development of a monovalent vaccine will be undertaken and implemented although there may be a considerable delay before the vaccine is freely available for mass vaccination.

3.1 Seasonal Flu Vaccination 2017/18 Lessons Learnt

The 2017/18 seasonal flu vaccination campaign was the most successful to date with 73.5% of frontline clinical staff choosing to be vaccinated, this represented a 9% increase from the previous year.

2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
48.9%	55.3%	62.4%	63.6%	64.4%	73.5%

Employing initiatives that have proven to be successful in previous years, the flu team working closely with a range of colleagues in clinical areas , continued to offer a flexible approach to vaccination across the Trust

In 2017/8 we:

1. Achieved above the CQUIN target of 70% frontline staff vaccination uptake
2. Consistent year on year increase, despite the frontline denominator being significantly higher
3. Only one ward in the Trust experienced an influenza outbreak despite high levels of co-circulation of both influenza and viral diarrhoea and vomiting
4. Highest number of trained vaccinators across the Trust. Senior leaders trained to vaccinate supporting the campaign and delivering key messages
5. Use of quadrivalent vaccine as clinical evidence suggests it offers the best protection
6. A continual move towards a more positive cultural attitude towards vaccination and the protection of the wider health economy

7. Introduced an electronic vaccinator training book accessible through SharePoint with up to date information for all vaccinators. Incorporated into the training was the introduction of a competency framework for all vaccinators.

The flu team held a lessons learnt event in April 2018 which was very well attended promoting discussion and proposals to increase uptake rates in front line health care workers.

Proposals:

- To continue to identify those patients in clinical risk groups and offer vaccination.
- To provide vaccination training to established vaccinators and to recruit vaccinators into areas across all services with particular focus upon community teams
- Focus upon engagement with medical staff to be vaccinated and encourage vaccination across clinical teams.
- Ensure that positive messages and true facts about the vaccine are available to all staff.
- Continue to provide education around the impact of flu and the consequences of flu on health.
- Continue with a flexible easy to access vaccination plan.

3.2 Seasonal Flu group

The overarching aim of the Seasonal flu group is to

- Produce an effective flu vaccination delivery programme to protect patients , staff and visitors
- Ensure that all patients in clinical risk groups are identified and offered flu vaccine
- Produce weekly reports of front line healthcare worker vaccination uptake rates to Group Directors.
- Provide monthly reports to the Department of Health through the ImmForm web site.

Established in 2011, the group has Nurse Director leadership, with the Infection Prevention and Control Matron with operational lead responsibilities. The group has multi departmental representation from both clinical and non-clinical areas. The terms of reference of the group are included in Appendix 1.

Meeting dates for the group reflect the activity required as the flu season approaches, although additional meetings may be required to suit the needs of the programme.

The group will report into the Infection Prevention and Control Committee, the Physical Health and Wellbeing Group and the Emergency Preparedness Resilience and Response group to give assurance to the Clinical Commissioning Groups (CCGS) in respect of winter planning.

Seasonal Flu Group Meeting Dates 2018/19

Date	Time	Venue
31/05/2018	12.00pm - 1.30pm	Top floor meeting room SNH
28/06/2018	2.00pm – 4.00pm	Committee Dining Room
26/07/2018	2.00pm – 4.00pm	Collingwood Court SNH
30/08/2018	2.00pm – 4.00pm	Committee Dining Room

27/09/2018	2.00pm – 4.00pm	Collingwood Court SNH
25/10/2018	2.00pm – 4.00pm	Committee Dining Room
22/11/2018	2.00pm – 4.00pm	Committee Dining Room

3.3 Influenza Vaccine 2018/19

As with the 2017/18 campaign, the trust has placed orders with Sanofi for the quadrivalent vaccine to be offered to both inpatients and staff. This is in accordance with the recommendations from NHS England.

Patients who are 65years and over will receive the adjuvanted trivalent vaccine as recommended by the NHS England. The vaccine has a higher immunogenicity and effectiveness than the non adjuvanted vaccine and is regarded as the best option for this age group.

Flu strains included in the 2018/19 **quadrivalent inactivated vaccine (QIV)** are:

- A/Michigan /45/2015 (H1N1)pdm09-like virus
- A/ Singapore /INFIMH-16-0019/2016(H3N2) -like virus
- B/ Colorado/06/2017-like virus (B/Victoria/2/87 lineage)
- B/Phuket/3073/2013-like virus (B/Yamagata/16/88 lineage)

Flu strains in the 2018/19 **adjuvanted trivalent inactivated vaccine (aTIV)** are

- A/California/7/2009(H1N1)pdm09-like virus
- A/Hong Kong/4801/2014(H3N3)-like virus
- B/Brisbane/60/2008-like virus

Vaccine Type	Age	Dose
Inactivated intramuscular vaccine (number of different brands)	Children aged 6 months and less than 2 years old and adults, although some of the vaccines are not authorised for young children.	Single injection of 0.5ml
Adjuvanted inactivated vaccine	65years and over	Single injection of 0.5 ml
Live attenuated influenza vaccine LAIV .Fluenz Tetra®	Childhood vaccination programmes	Both nostrils total dose 0.2ml.

The national flu immunisation programme 2018/19 available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/694779/Annual_national_flu_programme_2018-2019.pdf

Contraindications
There are very few individuals who cannot receive influenza vaccine. None of the influenza vaccines should be given to those who have had:

- a confirmed anaphylactic reaction to a previous dose of the vaccine

- a confirmed anaphylactic reaction to any component of the vaccine (other than ovalbumin).
- Are presenting with a febrile illness or who are systemically unwell.

More common allergic reactions include rashes but are not contraindications to further vaccination.

The clinical risk groups are included in Appendix 2.

3.4 Vaccine Delivery

Vaccine delivery schedule into the Trust is as follows, although the dates are subject to change according to the supplier.

QIV

Site	Date expected	Doses to be delivered
St. Nicholas Hospital Pharmacy	w/b 17/09/2018	4200
St. Georges Park Hospital pharmacy	As above	1500
Hopewood Park	As above	750

aTIV

Site	Date expected	Doses to be delivered
St. Nicholas Hospital Pharmacy	28/09/2018	80
St. Nicholas Hospital Pharmacy	26/10/2018	70

Distribution of the vaccine reflects the activity across the Trust and can be transported to community areas adhering to the maintenance of the cold chain in discussion with the pharmacy department.

It is anticipated that the seasonal flu vaccination campaign for patients and staff will commence on Monday 24th September 2018. This is subject to delivery dates as stated above.
As delivery of the aTIV is expected later, this vaccine will be offered to patients from the 1st October 2018 to those age 65 years and above.

3.5 Patient Vaccination

To ensure the health and well-being of our service users, influenza vaccine is offered throughout the flu season to ensure protection against the common circulating flu strains.

Wards are reminded to review all patients who are in the clinical risk groups and offer flu vaccination to both current inpatients and new admissions throughout the flu season. It is also an opportunity to ensure that patients are also protected against pneumococcal infection where indicated. A sample letter is included in Appendix 5.

Consent must always be obtained prior to vaccination. For further information staff are advised to refer to NTW (C) (05) - Consent to Examination or Treatment Policy.

Community teams and day units across the Trust are encouraged to promote influenza vaccination to patients who they have contact with and are in the clinical risk groups, vaccination is provided by GP services.

In some instances, where patients have no access to GP services, eg drug and alcohol services, flu vaccine is offered and prescribed by the clinician responsible for the care of the individual.

Patients are prescribed seasonal influenza vaccine as a once only medication on their drug kardex by the ward Doctor

NHS England following recommendations by the Joint Committee on Vaccination and Immunisation (JCVI) have advised the use of an adjuvanted trivalent influenza vaccine (aTIV) for all those aged 65 years and over, whilst adults aged under 65 years in clinical at risk groups should be offered the quadrivalent vaccine (QIV). Currently there is only one supplier of aTIV, Seqirus who have confirmed to the Department of Health and Social Care their capacity to supply adequate numbers of vaccine.

NTW have ordered 150 vaccines and delivery is expected in two phases, the first is expected week commencing 28/9/2018 with the remainder of the vaccines to follow week beginning 26/10/2018.

Changes to the vaccine type in this age group will be included in the communication campaign to all clinical staff.

3.6 Children and Young Peoples Services (CYPS)

GP services are contracted to provide physical health care to children and young people within NTW in patient services. Children and young people who are admitted into the service as inpatients are assessed on admission. Those who are identified to be in the clinical risk groups are referred to the GP who will offer vaccination in discussion with parents and child/young person.
Community teams working within CYPS have a duty and responsibility to ensure that the patients under their care have information and access to relevant immunisations. In this instance the patient and family are directed to the GP clinic

3.7 Flu Vaccination of Health Care Workers

The Health and Social Care Act 2008 states that all health organisations should;
Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care. (Department of Health [DH] 2008).
Transmission of the flu virus from health care workers to patients has been well documented. (Public Health England [PHE] 2016)
The purpose of vaccination of health care workers is

- To protect clinical risk groups in whom flu vaccination may not offer complete protection and thereby reducing the rates of flu like illness, hospitalisation and mortality.
- To protect the health care worker and their family
- To ensure business continuity by reducing sickness leave.

The table below shows the uptake rates of the front line clinical workers in NTW in 2017/18

Category	% flu vaccination uptake
Doctors	75%
Qualified nurses	77%
All other professionally qualified clinical staff	73%
Support to clinical staff	71%

Vaccine uptake in both Doctors and qualified nursing staff was the highest to date demonstrating the understanding of the importance of vaccination in ensuring the protection of both our patients and work colleagues.

For the purpose of identifying front line health care workers in NTW, appendix 4 outlines the front line staff groups. This list is not exhaustive and each post should be assessed in accordance with ESR and clinical activity.

3.8 Peer Vaccinators

In 2017/18, 198 registered staff from community teams, pharmacy, nurse directors and medical staff undertook training to be able to vaccinate all NTW staff. As in previous years this provided an accessible flexible approach to vaccination and was very well received by staff who often found it difficult to access vaccination clinics. To continue to build upon this success, vaccination training will be provided to existing vaccinators and new vaccinators who have been recruited to cover all clinical areas in the 2018/19 flu season. Community teams have been encouraged to ensure that they have access to vaccinators within their teams.

Vaccinator training is competency based and includes basic/intermediate life support and anaphylaxis training through the Training Department at St Nicholas Hospital.

Training dates for vaccinators 2018.

Course name	Venue	Date
Flu Vaccinators Training update	Tranwell Unit	28/08/2018
Flu Vaccinators Training Foundation	Hopewood Park	31/08/2018
Flu Vaccinators Training update	Ferndene	3/09/2018
Flu Vaccinators Training update	Northgate	4/09/2018
Flu Vaccinators Training Foundation	Walkergate Park	5/09/2018
Flu Vaccinators Training update	St. Nicholas Hospital	6/09/2018
Flu Vaccinators Training update	St. Nicholas Hospital	07/09/2018
Flu Vaccinators Training update	St. Nicholas Hospital	10/09/2018
Flu Vaccinators Training update	Hopewood Park Hospital	11/09/2018
Flu Vaccinators Training update	St. Georges Park	12/09/2018
Flu Vaccinators Training Foundation	St. Nicholas Hospital	13/09/2018
Flu vaccinators Training update	Monkwearmouth Hospital	14/09/2018
Flu vaccinators Training update	St. Nicholas Hospital	17/09/2018
Flu Vaccinators Training Foundation	Northgate	18/09/2018

Flu Vaccinators Training Foundation	St. Georges Park	19/09/2018

All NTW staff will have the opportunity to receive flu vaccine by attending a planned clinic across all hospital sites, by a trained vaccinator, at the flu trailer or at one of the many pop up clinics throughout the campaign.

3.9 Patient Group Direction

All trained vaccinators will administer seasonal influenza vaccine to all NTW staff under a Patient Group Direction (PGD) reviewed and ratified by the Medicines Management Committee.
The PGD sets out the required characteristics of staff who will undertake seasonal flu vaccination:

- Qualified Nurses or Pharmacist with current professional registration
- Abide by the NTW standards for record keeping and guidelines for the administration of medicines
- Must attend an annual CPR update
    1. Inpatient areas Immediate Life support (ILS)
    2. Community areas Basic Life support (BLS)
- Attend annual infection prevention and control training
- Undergo annual anaphylaxis training
- Attend annual influenza vaccination training

3.10 Flu Vaccination Clinics

In addition to trained vaccinators, the Infection Prevention and Control Matrons will hold clinics across the Trust in main hospital sites as set out in Appendix 3. In addition, ad hoc clinics will be held in both community areas and hospital sites to facilitate a flexible approach, these will also be in response to requests from teams, and where the vaccination surveillance system indicates areas of low uptake.

Flu vaccine will be offered to all staff by Occupational health who attend health screening clinics throughout the flu season. Meetings and Trust events provide an opportunity to vaccinate large numbers of staff.

In recognising the importance of accessibility to vaccination to all frontline health care workers in both the NHS and other organisations, NTW will be offering flu vaccination to all staff working within, or into NTW. This includes North East Ambulance staff, social workers, teachers and others who provide front line care /services to our patients.

Following the success of the flu trailer in previous campaigns, staff can be vaccinated or receive general information about the flu vaccine in the trailer which will be sited throughout the flu season on all of the hospital sites (Appendix 6). This allows community teams the flexibility of planning their vaccination around their daily work routine.

Community teams that find it difficult to access the above mentioned clinics will be offered bespoke flu vaccination clinic sessions at a time and place suitable to the teams that operate in these areas.

4. Data Collection

4.1 External reporting

As in previous years, vaccination of front line health care workers will be reported through the ImmForm website. Uptake data information for healthcare workers will be collected on immunisations given from September 2018 to the end of February 2019 (final data collected in March 2019).

It is anticipated that further reporting through the Clinical Commissioning Groups and NHS England Area Team will be required

4.2 Internal reporting

NTW Informatics Department have created a system that accommodates information governance and data protection issues, and allows the collection of data to be used in the reporting to ImmForm and any other relevant organisation.

The production of a weekly statistical report to trust senior managers will assist with identifying areas of poor vaccination uptake in front line health care workers. Monthly reporting to Group Quality and Performance (Q&P) and locality care group quality standards meetings will enable the flu vaccination team to focus upon these wards/areas to ensure staff have access to vaccination.

5. Communication

Communication of key messages to front line health care workers is crucial in informing staff about the benefits to both patients and colleagues of the flu vaccine

Following our lessons learnt event we continue to recognise the importance of effective communication throughout the campaign in dispelling myths and in delivering key messages.

The communication campaign will continue to use the animated characters (Matron Carole and Bugsy) to deliver key messages to all NTW staff. NHS employer's campaign material also serves as a valuable communication tool and will be used in conjunction with NTW promotional material

Peer vaccinators continue to play a pivotal role in providing clinical information to frontline health care workers and acting as role models. This is a key priority in all seasonal flu campaigns. All vaccinators will have access to power point presentations and the latest vaccine information through an e-book available through the internal intranet share point site, this will facilitate the delivery of key messages at team brief and other meetings.

There is good local evidence to suggest that where the team/ward manager supports the flu vaccination campaign the clinical team in that area has a high level of vaccine uptake. In the capacity of role model and clinical leader, all managers will be asked to sign a flu pledge to demonstrate their commitment to ensuring that flu vaccination is high priority in protecting patient's health. This will be used in a wider context for the purposes of the communication campaign.

Communication of key messages will start with a phased approach in the Trust Bulletin. This will be followed by more frequent key messages as the flu season approaches.

Pay slip flyers with flu clinic dates and flu facts will be attached to Septembers pay slip.

A dedicated flu page on the Trust intranet is instrumental in relaying key messages, clinic dates and myth busters. All NTW staff now have access to Twitter and internal messaging through Chatterbox.

A dedicated flu fighter e-mail address for all trust staff to access will be monitored by the IPC Team to offer timely support and advice to all staff.

Following the positive reviews from staff of the “real life” personal stories posters, these will continue into the 2018/19 campaign to raise awareness of the importance of vaccination to protect people in clinical risk groups.

Engagement with patients and carers in the flu campaign will both encourage and support patients and all front line clinical staff to be vaccinated where appropriate. The art therapy department for both adult and children’s services have in previous years worked with patients to produce posters to be displayed across the Trust. The departments will again be approached to take part in the campaign.

Following an outbreak of influenza on an NTW inpatient ward at St. Georges Park in 2017, the communication team working with the clinical staff from the ward have produced a video describing their experience during the outbreak and the importance of vaccination. This will be used Trust wide to promote vaccination and will be made available on the Trust intranet to be shown at team briefings and meetings.

6. Reviewing and monitoring

6.1 CQUIN indicator 2018/19

Incorporated into CQUIN 1 Improving Staff Health and Wellbeing, the Trust had a key milestone in 2017/18 to achieve uptake of flu vaccinations for frontline clinical staff of 70% by February 2018. This was achieved with an overall uptake of 73.5% staff. The second year of the CQUIN is to achieve 75% uptake in front line clinical staff.

Our commitment is to achieve 75% uptake in front line staff in all flu vaccination campaigns to ensure herd immunity. Whilst this remains challenging we will continue to

- Work closely with clinical teams to ensure patients are offered and supported to be vaccinated.
- Support carers to ensure they make the right decisions in encouraging their relatives to be vaccinated.
- Provide clinical staff with current information regarding vaccination, including myth busting and common questions through both electronic and paper communications.
- Ensure that all patients and staff across NTW have access to vaccination to assist with the promotion of health and wellbeing.
- Continue to provide information trust wide around the benefits of flu vaccination

- Undertake weekly internal reporting of vaccination uptake rates in front line health care workers to address areas within the Trust where there is poor vaccination uptake.
- Work with NHS colleagues to give assurances in our winter preparedness.
- Respond to and share lessons learnt both internally and externally

Carole Rutter
Modern Matron
Infection Prevention & Control

References

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APPENDICES

APPENDIX 1.Terms of Reference (A standing agenda is included in the terms of reference)

Purpose of meeting

- To act as a subgroup of the Infection Prevention and Control Committee(IPCC) to promote and protect the health and wellbeing of service users, carers, staff and visitors from seasonal flu , contributing to the business continuity of all services
- To provide the IPCC with assurance that appropriate systems are in place to achieve herd immunity in staff groups and provide external assurances on flu vaccine uptake levels.
- Provide the Emeregency preparedness Group that measures to prevent and protect against flu support the Trusts overall winter preparedness.

Membership

Group Nurse Director, Safer Care/Director of Infection Prevention & Control (Chair)

Infection Prevention & Control Modern Matron (Deputy Chair)

Associate Nurse Directors x3

Community Matrons x 2

Workforce Representative

Team Prevent Representative

Systems Development Support Manager, Informatics

Pharmacy Technician – Procurement

Senior Communications Adviser

Resilience Lead

Staff side Representative

Staffing Solutions Manager

Medical Representative

Medical Staffing Manager

NTW Solutions Representation

Allied Health Professional Representative

Public Health Support Officer

Quorum

Six, including the chair or deputy chair

Deputies

A nominated deputy should attend if the member is unavailable

Key Outputs

- Delivery of annual flu vaccination campaign to patients /service users and staff
- Embedding the peer vaccinators model, to ensure the delivery of the physical health programme, which could be replicated for other mass vaccination campaigns
- Embedding the Trust communications campaign for seasonal flu
- To ensure that a robust reporting system is in place to identify the number of frontline healthcare workers vaccinated, both internally and externally, via ImmForm
- Production of Seasonal flu plan

Linkages to other meetings & groups

Updates will be provided to the IPC Committee.

Vaccine uptake figures will be reported to :Corporate Decisions Team, Business Delivery Group and Group Management meetings.

Key updates will also be given to the Physical Health Group and Strategic EPRR Group.

Time, Frequency & Duration

Monthly between June and November for a maximum of 90 minutes. Additional meetings may be held if necessary.

Support Arrangements

Venue:	Depends on availability
Secretary:	Public Health Support Officer
Minutes:	Draft by one week of meeting
Papers:	Circulated one week prior to meeting.

Governance, rules and behaviours

- All members are expected to attend – if members are unable to attend a nominated deputy should attend on their behalf
- Meetings will start and end on time
- Papers should not be used where a verbal update / slides will suffice
- Papers are to have a maximum length of 4 sides of A4
- Authority to cancel meeting lies with the chair or deputy chair
- To review its Terms of Reference annually
- To review its performance against its Terms of Reference annually.

APPENDIX 2

Clinical Risk Groups

Those eligible for vaccination are:

All patients aged 65 years and over	Defined as people aged 65years or over (including those becoming age 65 years by 31st March 2018.
Chronic respiratory disease (6 months or older)	Asthma that requires continuous or repeated use or inhaled or systemic steroids or exacerbations requiring hospital admission. COPD including chronic bronchitis Emphysema Bronchiectasis Cystic fibrosis Interstitial lung fibrosis Pneumoconiosis Bronchopulmonary dysplasia Children who have previously been admitted to hospital for lower respiratory tract infection.
Chronic heart disease aged 6 months or older	Congenital heart disease Hypertension with cardiac complications Chronic heart failure Individuals requiring regular medication and/or follow up for ischaemic heart disease
Chronic kidney disease aged 6 months or older	Chronic kidney disease at stage 3,4 or 5 , Chronic kidney failure Nephritic syndrome, kidney transplantation.
Chronic Liver disease aged 6 months or older	Cirrhosis, biliary atresia, chronic hepatitis
Chronic neurological disease aged 6 months or older	Stroke transient ischaemic attack (TIA). Conditions in which respiratory function might be compromised due to neurological disease (eg polio) Clinicians should consider on an individual basis the clinical needs of the patient s including individual with cerebral palsy, multiple sclerosis and related similar conditions; or hereditary and degenerative disease of the nervous system or muscles; or severe neurological disability.
Diabetes aged 6 months or older	Type 1 diabetes, type2 diabetes requiring insulin or oral hypoglycaemic medicines, diet controlled diabetes
Immunosuppression aged 6 months or older	Due to disease or treatment. Patients undergoing chemotherapy. Asplenic or splenic dysfunction HIV infection at all stages. Individuals treated with or likely to be treated with

	systemic steroids for more than a month as a dose equivalent to prednisolone at 20mg or more per day (any age) or for children under 20kg a dose of 1mg or more per kg per day. It is difficult to define at what level of immuno- suppression a patient could be considered to be at greater risk of the serious consequences of flu and should be offered flu vaccination. This decision is best made on an individual basis and left to the patients clinician. Some immunocompromised patients have suboptimal immunological response to vaccine. Consideration should also be given to the vaccine of household contacts of immunocompromised individuals i.e. individuals who expect to share living accommodation on most days over the winter and therefore for whom continuing close contact is unavoidable. This may include carers (see below.)
Pregnant women	Pregnant women at any stage of pregnancy (first, second and third trimester)
People in long stay residential or homes	Vaccination is recommended for people living in long stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality. This does not include, for instance prisons, young offender institutions or university halls of residence.
Carers	Those who are in receipt of carer's allowance, or those who are the main carer, or the carer of the elderly or disabled person whose welfare may be at risk if the carer falls ill.
Health and Social Care Staff	Professional health and social care workers who are in direct contact with patients/clients should be vaccinated by their employer as part of an occupational health programme.
Morbid obesity(class III obesity)	Adults with a Body Mass Index ≥ 40kg/m²

https://www.gov.uk/government/publications/influenza-the-green-book-chapter-19

The above list is not exhaustive and the healthcare practitioner should apply clinical judgement to take into account the risk of influenza exacerbating any underlying disease that a patient may have, as well as the risk of serious illness from influenza itself.

APPENDIX 3

Seasonal Flu Campaign – Trust wide clinic dates 2018

Date	Time	Location	Venue
Monday 2 October	9.30am – 12.30pm	St Nicholas Hospital	Conference room , St Nicholas house
Monday 2 October	1.30pm – 4.30pm	Walkergate Park	Conference Room 2
Tuesday 3 October	9.30am – 12.30pm	Northgate	Conference Room ?
Tuesday 3 October	1.30pm – 4.30pm	St Georges Park	North meeting room ?
Wednesday 4 October	9.30am – 12.30pm	Monkwearmouth	Board Room
Wednesday 4 October	1.30pm – 4.30pm	Hopewood Park	Meeting Room 2
Thursday 5 October	9.30am – 12.30pm	Tranwell Unit	ECT Room
Thursday 5 October	1.30pm – 4.30pm	Palmers	Room 4
Friday 6 October	9.30am – 12.30pm	St Nicholas Hospital	Committee Dining Room
Friday 6 October	1.30pm – 4.30pm	Walkergate Park	Conference Room 3
Monday 9 October	9.30am – 12.30pm	St George's Park	Physical Treatment Centre
Monday 9 October	1.30pm – 4.30pm	Northgate	Conference Room
Tuesday 10 October	9.30am – 12.30pm	Hopewood Park	Meeting Room 2
Tuesday 10 October	1.30pm – 4.30pm	Monkwearmouth	Conference Room
Wednesday 11 October	9.30am – 12.30pm	St Nicholas Hospital	Conference Room St Nicholas House
Wednesday 11 October	1.30pm – 4.30pm	Ravenswood Clinic	Portakabin
Friday 13 October	9.30am – 12.30pm	Ferndene	Oak Room
Friday 13th October	1.30-4.30pm	Oxford Centre	Assertive Outreach, North Tyneside West CMHT

APPENDIX 4

Seasonal Flu Campaign – Frontline Staff Definitions for NTW

Staff Group	Description
Doctor	All grades of hospital, community and public health doctor.
Qualified Nurse	Qualified nursing staff, working on hospital sites and community services. Includes nurse consultants, nurse managers and bank nurses but not student nurses.
Other Professionally Qualified This comprises : • Qualified scientific and therapeutic &technical staff • Qualified allied health professionals • Other qualified ST&T	Qualified allied health professionals (AHPs): • Chiropodists/podiatrists • Dieticians • Occupational therapists • Physiotherapists • Art/music/drama therapists • Speech & language therapists. Other qualified health professionals: • Pharmacists • Psychologists Qualified ambulance staff • Ambulance paramedics , technicians, emergency care practitioners.
Support to Clinical Staff This comprises : • Support to doctors and nurses • Support to ST &T • Support to ambulance staff	Nursing assistants/auxiliaries, nursery nurses, health care assistants and support staff in nursing areas. Also includes clerical & administrative staff and maintenance & works staff working specifically in clinical areas, for example medical secretaries and medical records officers. Also includes porters and similar roles provides support to inpatient areas.

APPENDIX 5

Northumberland, Tyne and Wear NHS Foundation Trust

Public Health
St. Nicholas Hospital
C/o Above Mental Health Act Office
Gosforth
Newcastle upon Tyne
Tel: 0191 2456650
E-mail: carole.rutter@ntw.nhs.uk

PH/IPC/18/01
To:
Medical Staff, NTW
Chief Pharmacist, NTW
Clinical Directors
Nurse Directors/Associate Nurse Directors/ Associate Directors
Associate Allied Health Professional Directors
Clinical Nurse Managers

Dear Colleagues

THE SEASONAL INFLUENZA IMMUNISATION AND PNEUMOCOCCAL VACCINATION PROGRAMME 2018/19

We are fast approaching the **Annual Influenza** vaccination programme and I am writing to request inpatient wards and units to commence identifying to the pharmacy department those patients who are eligible to receive the seasonal flu vaccine and or pneumococcal vaccination.

It is crucial to the health and wellbeing of our patients that they have access to vaccination to protect them against this year's circulating flu strains. This applies to all new and recurrent admissions who are assessed for eligibility to receive the vaccines.
Please note that pneumococcal vaccine should be offered to those patients who are in the clinical risk groups and where there is no evidence to support previous vaccination.

Following recommendations from the Joint Committee on Vaccination and Immunisation, NHS England have recommended the use of an adjuvanted Trivalent Inactivated Vaccine (aTIV) for all people who are 65years and over.
Those patients who are in clinical risk groups and under 65 years will continue to receive the Quadrivalent Inactivated Vaccine (QIV) as in 2017/18.

I enclose a copy of Chapter 19, Influenza and Chapter 25 Pneumococcal from the Green Book for your reference; these chapters identify the clinical risk groups. Also enclosed is a copy of the annual national flu immunisation programme 2018/19 to assist you with informing patients of the importance of vaccination

As in previous years we will continue to audit the uptake of both seasonal flu vaccine and pneumococcal across all groups.

There is continuing evidence that people with enduring mental illness and learning disability in the community, often fail to get access to preventative health services. Once

again can I ask you to publicise the criteria for eligibility for vaccination amongst community staff so they facilitate their clients seeking vaccination from the registered GP. Can I thank you in advance for your help this year as in previous years.

Yours sincerely

Carole Rutter, Modern Matron, Infection Prevention and Control

Appendix 6

Seasonal Flu Campaign 2018/19

Flu Trailer Dates

Date	Venue
Mon 15 October	St Nicholas Hospital
Tue 16 October	Move
Wed 17 October	Walkergate Park
Thu 18 October	Move
Fri 19 October	Northgate
Mon 22 October	St. Georges Park
Tue 23 October	Move
Wed 24 October	St. Nicholas Hospital
Thu 25 October	Move
Fri 26 October	MWM

Opening Times: 9.30am – 3.30pm

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 25th July 2018

Title and Author of Paper:
Quarterly Report on Safe Working Hours (Apr to Jun 2018) : Dr Clare McLeod (Trust Guardian)

Executive Lead: Dr Rajesh Nadkarni

Paper for Debate, Decision or Information: Information

Key Points to Note:

- The New TCS for trainees in Psychiatry came into force in February 2017
- Quarter reported on is Apr to Jun 2018
- Guardian is nationally and locally linked with other Trust Guardians
- Establishment of Junior Doctors Guardian of Safeworking Forum (which includes representative from BMA & LNC Chair)
- Increase in Trainees moving to 2016 Terms & Conditions of Service

Risks Highlighted to Board :

- 5 Exception Reports raised during the period Apr to Jun 2018 with TOIL being granted for 4 due to hours and rest, and no action for 1 case which was due to education.
- 12 Agency Locums booked during the period covering vacant posts
- 110 shifts lasting between 4hrs and 12hrs were covered in the 3mth period by internal doctors
- On 13 occasions during the period the Emergency Rotas were implemented
- There has been 1 fine during the last quarter due to insufficient rest between shifts
- Safety issues continue at CAV Site

Does this affect any Board Assurance Framework/Corporate Risks?
Please state No

Equal Opportunities, Legal and Other Implications: None

Outcome Required: None

Link to Policies and Strategies: None

Northumberland, Tyne and Wear NHS Foundation Trust

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING – April to June 2018

Executive summary

All new Psychiatry Trainees and GP Trainees rotating into a Psychiatry placement on 2nd August 2017 are now on the New 2016 Terms and Conditions of Service. There are currently 111 trainees working into NTW with 73 on the new Terms and Conditions of Service via the accredited training scheme via Health Education England. There are an additional 17 trainees employed directly by NTW working as Trust Grade Doctors or Teaching Fellows. (Total 128).

Introduction

This is the 7th quarterly board report on Safe Working Hours which focuses on Junior Doctors. The process of reporting has been built into the new junior doctor contract and aims to allow trusts to have an overview of working practices of junior doctors as well as training delivered.

The new contract is gradually implemented by being offered to new trainees' as they take up training posts, in effect this will mean for a number of years we will have trainees employed on two different contracts. It is also of note that although we host over 160 trainee posts, we do not directly employ the majority of these trainees, also with current recruitment challenges a number of the senior posts are vacant.

High level data

Number of doctors in training (total): 128 Trainees (Apr to Jun)

Number of doctors in training on 2016 TCS (total): 73 Trainees (Apr to Jun)

Amount of time available in job plan for guardian to do the role: This is being remunerated through payment of 1 Additional Programmed Activity

Admin support provided to the guardian (if any): Ad Hoc by MedW Team

Amount of job-planned time for educational supervisors: 0.5 PAs per trainee

New Trust Guardian of Safeworking : Dr Clare McLeod

Exception reports (with regard to working hours)

		Exception Reports Received Apr to Jun				
Grade	Rota	Apr	May	Jun	Total Hours & Rest	Total Education
F2						
CT1-3	St Nicholas		1			1
CT1-3	NGH/CAV					
CT1-3	St George's Park	1	1	2	4	
CT1-3	RVI/CAMHS					
CT1-3	Hopewood Park					
CT1-3	Gateshead					
ST4+	North of Tyne					
ST4+	South of Tyne					
Total		1	2	2	4	1

Work schedule reviews

During the last quarter there have been 5 Exception Reports submitted from Trainees; 4 on the new 2016 TCS in respect to exceeding Hours & Rest (all for late finishes) & 1 for Education. The outcome of which was that TOIL was granted for 4 cases, 1 no action required. The exceeded hours ranged from a minimum of 1.5 hours to a maximum of 5 hours. Emergency Rota cover is arranged when no cover can be found from either Agency or current Trainees. The Rota's are covered by 2 trainees rather than 3 and payment is made to the 2 trainees providing cover at half rate.

a) Locum bookings

i) Agency

Locum bookings (agency) by department				
Specialty	Apr	May	Jun	Total
Neuro Rehab				
Hopewood Park	1	1	1	3
Gateshead				
NGH	1	1	1	3
RVI				
SNH				
CAMHS				
LD				
SGP	2	2	2	6
South of Tyne				
North of Tyne				
Total	4	4	4	12

Locum bookings (agency) by grade				
	Apr	May	Jun	Total
F2				
CT1-3	3	3	3	9
ST4+	1	1	1	3
Total	4	4	4	12

Locum bookings (agency) by reason				
	Apr	May	Jun	Total
Vacancy	4	4	4	12
Sickness				
Total	4	4	4	12

b) Locum work carried out by trainees

Area	Number of shifts worked	Number of hours worked	Number of hours to cover sickness +	Number of hours to cover a vacant post
SNH	22	208	160	48
SGP	26	232	76	156
Gateshead	10	80	4	76
Crisis	4	16	4	12
Hopewood Park	20	160	16	164
RVI	4	16	16	
NGH	6	72	48	24
North of Tyne	11	92	92	
CAMHS	4	80		80
Total	110	981	444	540

c) **Vacancies**

Vacancies by month						
Area	Grade	Apr	May	Jun		
NGH/CAV	CT GP	1 1	1 1	1 1		
SNH	CT					
SGP	CT GP	3 1	3 1	3 1		
RVI	CT					
HWP	CT GP	3	3	3		
Gateshead	CT GP		1	1		
Total		9	10	10		

d) **Emergency Rota Cover**

Emergency Rota Cover by Trainees				
	Rota	Apr	May	Jun
Vacancy	SGP, RVI		1	1
Sickness/Other	SNH, Crisis, HWP, NOT, SGP, GHD, RVI	3	6	2
Total		3	7	3

e) **Fines**

There has been 1 fine during the last quarter. This was due to inadequate rest between shifts due to working late following emergency admissions at St George's Park. The doctor has received payment accordingly and the Guardian has issued a fine to the service as recommended in the Terms and Conditions of Service. A decision will be taken at the Junior Doctor Forum in July on how the money will be allocated.

Qualitative information:

Very low numbers of Exception Reports in this Quarter.

Issues arising

The forthcoming inpatient service configuration changes are likely to add further to the workload of the trainees at St George's Park.

Daytime cover for the Hadrian Clinic at the CAV site will need to be reviewed as there will be fewer trainees on the site once the ward moves take place.

Actions taken to resolve issues:

Meeting with SGP Trainees (Medical Staffing Manager and Guardian) to address concerns of both daytime and out of hours cover arrangements due to gaps in both Consultants and Junior Doctors. The trainees were encouraged to exception report when appropriate, particularly with the forthcoming ward moves, to gain a more accurate picture of workloads and times of most pressure.

Discussions are taking place with the Old Age Psychiatry service at CAV to look at cross-cover options for the Hadrian clinic.

There have been two meetings with trainees to discuss the inpatient service changes, attended by the Director of Medical Education, the Guardian and Head of Workforce Planning and Medical Education.

The Guardian and Medical Staffing Manager have jointly met with new trainees at induction to promote the importance of accurate exception reporting. Comments have been received regarding the document "What is Work"; it is planned to ratify the document which will be useful to guide trainees of when to exception report.

Following discussion with the Medical Director, Director of Medical Education and the Junior Doctors a process has been agreed and implemented within Patient Safety for Junior Doctors to record when insufficient Medical Handover is given. Since the introduction of this system there have been 4 incidents recorded.

Summary

Work is continuing to promote the importance of Exception Reporting and emphasise that it is a positive process.

There is now a process to record episodes of insufficient Medical Handover which will be reviewed at the Guardian forum in July.

The impact of the proposed changes to inpatient services, both to day time cover and out of hours working is being considered and will be reviewed at the Guardian forum.

Dr Clare McLeod

Trust Guardian

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 25th July 2018

Title and Author of Paper: Medical Revalidation Annual Board Report 2018

Executive Lead:

Dr Rajesh Nadkarni, Executive Medical Director & Responsible Officer
Professor Eilish Gilvarry, Deputy Medical Director (Appraisal & Revalidation)

Paper for Debate, Decision or Information: Information & Sign-Off

Key Points to Note:

The purpose of this paper is to:

- Update the Board on the situation with regards to Medical Revalidation within the Trust
- Highlight emerging issues and risks
- Request the authority to sign-off the Statement of Compliance for the higher level Responsible Officer for NTW & St Oswald's Hospice

Risks Highlighted to Board :

The report highlights the processes in place to provide assurance of compliance with Medical Regulations (the regulations are described in the paper)

Figures for 2017/18 show:

- 236 out of 243 doctors with a prescribed connection with NTW completed appraisal
- 7 had a reasonable excuse for non-completion (agreed by the RO)
- 31 doctors had revalidation dates in the 2017/18 year and all received positive recommendations to the GMC by the RO.

Does this affect any Board Assurance Framework/Corporate Risks?
Please state NO

Equal Opportunities, Legal and Other Implications: None

Outcome Required: Agreement for Board to Sign-Off Report and Statement of Compliance for both NTW & St Oswald's Hospice

Link to Policies and Strategies:

- Appraisal Policy and Medical Appraisal Practice Guidance NTW(C)33,V03
- Medical Job Plan Policy NTW(C)56,V02
- Private Practice Policy NTW(O)46,V01.5
- Medical re-skilling, rehabilitation, remediation and targeted support policy NTW(C)57,V03
- Handling Concerns about Doctors Policy NTW(HR)02, V02.5

Northumberland, Tyne and Wear NHS Foundation Trust

Medical Revalidation Annual Board Report 2018

Executive summary

In 2017/18 there were 243 doctors with a prescribed connection to the Trust.

236 doctors had a completed appraisal in support of their revalidation and 7 had adequate reasons for incomplete appraisals such as sickness or maternity leave. There was one doctor who did not complete their appraisal within the appraisal window, however this has now been satisfactorily completed.

As part of the revalidation process 31 doctors (13%) had positive recommendations made to the GMC within the year. One doctor was deferred due to having insufficient clinical evidence following a return to clinical practice. There were no instances of non-engagement with the revalidation process.

At the end of March 2018 the appraisal compliance for the Trust was at 99.5%.

The Responsible Officer (RO) within NTW is the Executive Medical Director.

The RO is also responsible for Appraisal and Revalidation for the doctors working at St Oswalds' Hospice. The Annual Report has been submitted for approval by their Board (Copy attached).

Purpose of the paper

The purposes of this report are to:-

- Update the Board on the situation with regard to medical revalidation in the Trust.
- Highlight emerging issues and risks.
- Request the authority to sign off the Statement of Compliance for the higher level Responsible Officer.

Background

Medical Revalidation is the process by which licensed doctors demonstrate to the General Medical Council (GMC) that they are up to date and fit to practice and that they are complying with all the relevant professional standards.

The purpose of revalidation is to ensure that licensed doctors remain up to date and are fit to practise. It is also to provide assurance of this fitness to practise to patients, the public, employers and other healthcare professionals. Revalidation also aims to improve the quality and safety of patient care, strengthen professional development and identify doctors who need support early.

Revalidation is achieved through satisfactory annual appraisal that is based upon the doctor collecting and reflecting upon specified data about their performance. (The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (License to Practice and Revalidation) Regulations Order of Council 2012')

Provider organisations are known as Designated Bodies and appoint a Responsible Officer who has duties which are set out in statute. The Responsible Officer (RO) has to have been a licensed medical practitioner for 5 years and is accountable to the Board. Every doctor has a prescribed connection to a specific designated body and RO.

The process of Revalidation is that the RO makes a recommendation to the GMC on the fitness to practice of every doctor for whom they are responsible once every five years. The RO makes the recommendation but it is the GMC that revalidates the doctor. If the RO does not feel that there is enough evidence to make a positive recommendation he or she can defer the recommendation until such information is available or give notice of non-engagement in the process. The RO also has responsibilities covering the clinical governance of the doctors.

Provider organisations have a statutory duty to support their RO in discharging duties under the Responsible Officer Regulations[1] and it is expected that trust boards will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations;
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors, responding to concerns and communicating with the GMC
- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

This report will show how the above is achieved.

Governance arrangements

Responsible Officer (RO)

The Trust RO is the Executive Medical Director who is managed by the Chief Executive Officer and professionally accountable to the GMC and to the Level 2 Responsible Officer in NHS England. The RO meets quarterly with the GMC Employment Liaison Advisor (ELA) and minutes of this meeting are taken. The RO makes direct contact with the ELA about any issues of concern. The RO is supported by the Deputy Medical Director for Revalidation and Appraisal, supported by an Associate Medical Director for Revalidation and an Associate Medical Director for Appraisal. The RO/Deputy Medical Director and Medical Staffing Manager for the HR Revalidation Team regularly attend the Regional Revalidation Network meetings.

Ensuring the list of doctors with a connection to NTW is accurate and up to date.

The GMC web-site (called GMC Connect) provides lists of doctors and their connections to designated bodies. The web site is regularly checked against staff lists held on the Electronic Staff Record by a member of the HR Revalidation Team.

Compliance with regulations

- *Monitoring the frequency and quality of medical appraisals*

  An electronic database SARD (Strengthened Appraisal and Revalidation Database) records appraisal information for all doctors with a prescribed connection to NTW and provides information regarding compliance with timing of appraisal.

  The RO/Deputy Medical Director and HR Revalidation Team review all completed appraisals for each individual doctor to ensure they have the requisite information prior to making a recommendation for revalidation to the GMC.

  All appraisers in the Trust receive training on how to perform appraisals and how to judge the information provided against the standards set. There are regular support and development meetings for appraisers and all must attend at minimum one meeting per year.

- *Checking there are effective systems in place for monitoring the conduct and performance of their doctors*

  All concerns about doctors are dealt with using the Handling Concerns about Doctor's Policy.

- *Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors.*

Multi source feedback is produced by every doctor at least once in each 5 year revalidation cycle to inform their appraisal. Without this minimum standard a recommendation cannot be made. More feedback using different sources is encouraged.

- *Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.*

  Prior to employment a checklist is completed to ensure that the doctor has appropriate qualification, registration and a current appraisal or equivalent, and that any concerns raised about the doctor in a previous employment are given to the RO.

Policy and guidance

The relevant policies are: -

- Medical Appraisal Policy and Medical Appraisal Practice Guidance NTW(C)33,V03
- Medical Job Plan Policy NTW(C)56,V02
- Private Practice Policy NTW(O)46,V01.5
- Medical re-skilling, rehabilitation, remediation and targeted support policy NTW(C)57,V03
- Handling Concerns about Doctors Policy NTW(HR)02, V02.5

1. Medical Appraisal

Appraisal and Revalidation Performance Data

- Number of doctors 243
- Number of completed appraisals 236
- Number of approved incomplete/missed appraisals 7
- Number of doctors in remediation or disciplinary processes 11

See appendices A and C

Appraisers

During the period 2017/18 the Trust had 32 trained appraisers who are appointed through interview and receive specific training prior to commencement as an appraiser. Each appraiser must have regular training updates, once in five years as a minimum. Each appraiser is expected to have further training by attending at least one of the four Appraiser Development Group meetings per year. The Appraiser Development Group meetings provide an opportunity for appraisers to discuss current appraisal issues, calibrate their judgements, problem-solve and to share good practice. Attendance at the meetings has increased with positive feedback received from Appraisers regarding topics for discussion/debate.

In 2017/18 26 appraisers attended one or more Development Group meetings. A revised process of support and monitoring of the appraisers is now in place following the appointment of the Deputy Medical Director for Revalidation & Appraisal and AMD's for Revalidation and Appraisal. This is to ensure greater support and assurance of quality of the appraisals. The 6 appraisers who did not attend during 2017/18 have been individually addressed by the HR Revalidation Team.

Quality assurance

Outline of quality assurance processes:

For the appraisal portfolio:-

Prior to each doctor's revalidation date the RO, Deputy Medical Director, AMD for Revalidation and HR Revalidation Team comprehensively review all aspects of the doctor's appraisals over the previous years to provide assurance that all required inputs and outputs are of the required standard. A standard assurance template from the Appraisal Policy is used for this purpose. In addition, serious untoward incident and complaint data is cross-checked with Trust databases to ensure that the doctor has declared all relevant information at their appraisal.

For appraisers:-

Every appraiser is expected to attend at least one Appraisal Development Group meeting per year. An attendance register is kept.

Every doctor is asked to complete a feedback form after their appraisal. These are collated for each appraiser and the appraisers are expected to reflect on this feedback in their own appraisal.

For the organisation:-

During the year 31 appraisals were reviewed to measure compliance with appraisal input and output standards. The ASPAT Tool was used for this purpose. All met the appropriate standards. Areas for improvement were noted and fed back to Appraiser Development Group on Themes for future development. Any particular issues were discussed individually.

The electronic database SARD produces information regarding timelines and timeliness of appraisals inputs and outputs.

The Work plan for 2017/18 was agreed in September 2017 and shared with NHS England who were very supportive and complementary of the plan. We now have a fully updated Work plan for 2018/19 which also includes an External Audit ongoing at present.

See Appendix B

Access, security and confidentiality

Appraisal information is stored securely on the database SARD on the Trust servers. The only people that have access to all this information are the RO, Deputy Medical Director, Associate Medical Directors, the HR Revalidation Team and their nominated administrative support staff. Appraisers have access to the doctor's appraisals whom they appraise.

Doctors and appraisers are warned not to include patient identifiable information in appraisal folders. One appraisal included some identifiable information this was reviewed and all appropriate actions taken.

Preparation is underway with Information Governance Team for the introduction of GDPR. The HR Revalidation Team have also reviewed the SARD on-line Medical Appraisal system Level Security Policy NTW(O)76 and have received an updated Business Continuity Plan from SARD.

Clinical Governance

All serious untoward incidents (SUI) and complaint data held by the Trust Safety Team, that names an individual doctor, and all clinical activity data that is held on RiO, is made available to the doctor. The doctor is expected to bring this information to the appraisal, appropriately removing all identifiable information.

2. Revalidation recommendations

Revalidation dates are set by the GMC. The RO has a period of 120 days prior to the doctor's revalidation date in which to make their recommendation to the GMC. There are only three possible recommendations: that the doctor is up to date and fit to practice (a positive recommendation), a request to defer the date of the recommendation (deferral request) a notification of the doctor's non-engagement with revalidation (non-engagement notification).

In order to make a positive recommendation, the RO must be satisfied that the doctor has met the GMC's requirements for revalidation, they have participated in systems and processes to support revalidation and they have collected the required supporting information for revalidation. The RO must also be able to confirm that there are no unaddressed concerns about the doctor's fitness to practice.

A deferral request is a request made by the RO to ask the GMC to provide more time in which to submit a recommendation. Deferral requests can be made for doctors who are engaged in the systems and processes that support revalidation, but their required supporting information is incomplete, for example, because of prolonged sickness or other absence from work. A deferral request can also be made in connection with a doctor who is involved in an ongoing human resource or disciplinary process, the outcome of which will need to be considered in making the revalidation recommendation.

A doctor is not engaging in revalidation where, in the absence of reasonable circumstances, they are not participating in local processes and systems that support revalidation or do not participate in the formal revalidation process. It is a matter for the RO's judgement to determine what a "reasonable circumstance" may be and whether therefore to issue a notification of non-engagement.

In the last year, all revalidation recommendations were made on time and within the 120-day window prior to the doctor's revalidation date. There was no non-engagement from medical staff with the revalidation process.

3. Recruitment and engagement background checks

The Medical Recruitment Team collect information prior to employment of all doctors. For the unusual case where a doctor does not have previous appraisal information (for example doctors from Egypt do not have an appraisal system) other information is taken into account to make a decision about employment and appraisal organised soon after the doctor starts working.

See Appendix E

4. Monitoring performance

The performance of doctors is monitored by Medical Managers through the Medical Performance Dashboard, which displays the performance data held on each doctor. This data consists of attendance information, compliance with essential training requirements, SUI and complaint data and clinical activity data.

5. Responding to concerns and remediation

The Trust's response to concerns about the performance of doctors is governed by the Handling Concerns about Doctors Policy. The Trust Medical Management meet frequently with the Revalidation Team to ensure appraisals are up to date and any concerns about a doctor's practice are dealt with effectively. All Medical Managers have had training from Capsticks on MHPS investigations.

See Appendix D

6. Risk and issues

Although there has been much improvement over the last year with regards to appraisal, there is still a potential risk in the timeliness of completion within the year and signed completion within the 28 day deadline. During the period 2017/18, 188 (77%) of appraisals were completed within the 28 day sign off period. However 48 (20%) of appraisals were signed off after the 28 period. We have procedures in place to address these concerns including review of the Policies, more training and greater monitoring.

7. Recommendation

The Board is asked:-

To accept this Report and approve the sign-off of the Statement of Compliance confirming to the Higher Level RO that the Trust, as a Designated Body, is in compliance with the regulations as outlined below:

Provider organisations have a statutory duty to support their RO in discharging duties under the Responsible Officer Regulations and it is expected that trust boards will oversee compliance by:-

- ***Monitoring the frequency and quality of medical appraisals in their organisations***
- ***Checking there are effective systems in place for monitoring the conduct and performance of their doctors, responding to concerns and communicating with the GMC***
- ***Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors***
- ***Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.***

Additional documents attached:-

Appendix F NHS England Comparator document with similar sector and national organisations appertaining to revalidation.

Appendix G Statement of compliance for the 2017/18 revalidation period

Dr Rajesh Nadkarni
Executive Medical Director (RO)
July 2018

Northumberland, Tyne and Wear NHS Foundation Trust

REVALIDATION REPORT FOR CLINICAL GOVERNANCE AND QUALITY COMMITTEE MEETING, ST. OSWALD'S HOSPICE
JULY 2018

The purpose of this report is to assure and inform St. Oswald's Hospice Directors and Management that Northumberland, Tyne & Wear NHS Foundation Trust is providing an efficient and reliable revalidation function in terms of the Responsible Officer role.

1. Dr Rajesh Nadkarni is the Executive Medical Director and Responsible Officer for NTW since 16th January 2016.

2. St. Oswald's Hospice currently employs 8 doctors, who are subject to the GMC Revalidation process.

3. St Oswald's Hospice currently has 2 fully trained appraisers, both of which have been actively involved in appraising staff. Northumberland, Tyne & Wear also continue to provide appraisals for St Oswald's staff.

4. All doctors employed by St Oswald's have engaged with and are up to date with appraisal.

5. SARD (Strengthened appraisal and revalidation database), an online appraisal system, was implemented on 22nd September, 2014 and has been well received. This system provides electronic storage function and the relevant appraisal documentation with appropriate expiry dates so that doctors can plan and prepare for their appraisal in preparation for revalidation. The evidence portfolio automatically informs pertinent sections of the appraisal document. Both documents function using the 'traffic light' system so progress is visual making it a relatively simple process. NTW IT governance requirements were extremely exacting and an audit and monitoring of the process is in place.

6. There have been no concerns reported around Fitness to Practice since the last Board Report in July 2017.

7. Monthly meetings are scheduled into diaries of key staff at St Oswald's Hospice and Northumberland, Tyne & Wear NHS Foundation Trust to raise any Fitness to Practice concerns that may arise. So far no concerns have been reported, therefore, the meetings have not taken place.

Dr Rajesh Nadkarni
Executive Medical Director & RO
June 2018

REVALIDATION BOARD REPORT

These reports are intended to improve and maintain communication and to inform St. Oswald's Board of Directors in regard to Revalidation.

1. Revalidation was introduced by the General Medical Council on 3rd December, 2012 with the purpose of assuring patients, the public, employers and other healthcare professionals that licensed doctors in the UK are up-to-date and practising to the appropriate professional standards. It was intended that revalidation would be a formal, structured process which would provide a platform to ensure ongoing improvement in the quality of medical care delivered to patients. Revalidation should be supported by appraisal and clinical governance processes that were already in place and embedded in the practice of individual organisations.

2. Within the terms of the regulations governing revalidation, St. Oswald's Hospice is a Designated Body. In common with many Hospices, St Oswald's is supported in its work as a Designated Body by using the services of a Responsible Officer (RO) employed by a nearby NHS Foundation Trust. In this case the relationship between St Oswald's and the RO is governed by a Service Level Agreement between the hospice and Northumberland Tyne and Wear Foundation NHS Trust (NTW). As part of this agreement, NTW supplies the service of its RO to the hospice to make revalidation recommendations about its doctors and to oversee the quality assurance of the processes that support revalidation.

3. St. Oswald's Hospice currently employs 8 doctors, all of whom have participated in annual appraisal for the 2017/18 period. 1st April 2017 to 31st March 2018. There have been no doctors required to revalidate during this period the next one for revalidation with the GMC is 2019.

4. The main responsibility of the Designated Body within the revalidation regulations is to ensure that the processes to support revalidation are adequately resourced. Therefore it is important that time is allocated to doctors for CPD activities, participation in quality improvement activity and appraisal. The Designated Body must also ensure that doctors have timely access to accurate supporting information that is required for appraisal. This is particularly important in regard to Clinical Governance information, such as the outcomes of complaint and untoward incident investigation. The Designated Body also has important responsibilities for supporting the remediation of doctors whose performance causes concern. There must be explicit policies in place to govern these areas.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D - Annual Board Report Template

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**03551**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report Template
Author	Gary Cooper, Project Manager Quality and Assurance, Professional Standards Team
Publication Date	16 June 2015
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS Trust Board Chairs, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, Directors of HR, NHS Trust CEs
Description	A template board report for use by designated bodies to monitor their organisation's progress in implementing the Responsible Officer Regulations.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report Template, version 4 April 2014.
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers.
Timing / Deadlines (if applicable)	**From June 2015**
Contact Details for further information	england.revalidation-pmo@nhs.net http://www.england.nhs.uk/revalidation/

Document Status

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Annual Board Report Template

Version number: 2.0

First published: 4 April 2014

Updated: 16 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Contents

1. Executive summary

Insert here an executive summary of the report including highlights such as the number of doctors with a prescribed connection and the number of completed appraisals within the appraisal year, as well as any issues and the action plan to respond to those issues.

2. Purpose of the Paper

Include here the purpose of the report.

3. Background

Include here some background to reporting within the organisation and perhaps reference to any previous reports that may have been submitted.

The following may be of use:

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards / executive teams [*delete as applicable*] will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

4. Governance Arrangements

Insert here an outline of the organisational structures and responsibilities, including how progress is monitored monthly/quarterly.

Include details of the process within the organisation for maintaining an accurate list of prescribed connections

Include details of your process of internal assurance, perhaps including what assurance the board / executive can have regarding compliance to regulations. Include details of any new guidance that has been published or amendments to existing documentation.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

Include here detailed activity levels of appraisal outputs in individual departments such as:

- *Number of doctors,*
- *Number of completed appraisals,*
- *Number of doctors in remediation and disciplinary processes*

Also include details of any exceptions (missed appraisals and reasons, incomplete appraisals etc). See "**Annual Report Template Appendix A;** Audit of all missed or incomplete appraisals audit" *as an example of what could be carried out.*

b. Appraisers

Include here numbers of appraisers, details of new appraiser training and quality assurance of this, further appraiser training support provided, such as attendance at appraiser networks etc

c. Quality Assurance

Include an outline of quality assurance processes such as:

Appraisal portfolios:

- Review of appraisal folders to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is appropriate and available - by whom and sign offs.
- Review of appraisal folders to provide assurance that the appraisal outputs: personal development plan, summary and sign offs are complete and to an appropriate standard - by whom and sign offs.

- Review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs - by whom and sign offs.

For the individual appraiser:

- An annual record of the appraiser's reflection on his or her appropriate continuing professional development.
- An annual record of the appraiser's participation in appraisal calibration events such as reflection on appraisal network meetings.
- 360° feedback from doctors for each appraiser – how collected, reviewed, collated and fed back to the appraiser, how calibrated with the feedback for other appraisers?

For the organisation:

- Audit of timelines of process of appraisal by department,
- System user feedback,
- Review of lessons learned from any complaints,
- Review of lessons learned from any significant events.

Also see **"Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs" *as an example of what could be carried out*

d. Access, Security and Confidentiality

Include an outline of any information access, quality, security or retention issues relating to appraisal folders.

Include reference to the steps taken to ensure that patient Identifiable data is not found in appraisal portfolios.

Note any information governance breaches with actions taken.

e. Clinical governance

Include reference to the type of data for appraisal, such as corporate data used for individual doctors as a contribution to their supporting information. Perhaps detail what is provided to individuals by the organisation for appraisal e.g. clinical incident and complaint database, record keeping audit, activity data etc

Also see **"Annual Report Template Appendix C;** Audit of concerns about a doctor's practice" *as an example of what could be carried out*.

6. Revalidation Recommendations

Include statistics such as the number of:

- *Recommendations between April – March*
- *Recommendations completed on time / not on time,*
- *Positive recommendations,*
- *Deferral requests,*
- *Non-engagement notifications,*

Also include reference to reasons recorded for missed or late recommendations. See **"Annual Report Template Appendix D;** Audit of revalidation recommendations" *for an example of an audit that can be carried out in this area.*

7. Recruitment and engagement background checks

Include details of pre and post-employment checks including checks carried out on locums.

Also see "**Annual Report Template Appendix E.** Audit of recruitment and engagement background" *as an example of an audit that can be carried out in this area.*

8. Monitoring Performance

Include an outline of the process by which the performance of all doctors is monitored.

9. Responding to Concerns and Remediation

Include reference to any relevant resources and/or policies. Perhaps include numbers and types of remediation programmes used.

10. Risks and Issues

List any risks and issues that should be escalated to the board's / executive team's attention.

11. Board / Executive Team [Delete as applicable] Reflections

Include here anything about future developments proposed for the revalidation process.

12. Corrective Actions, Improvement Plan and Next Steps

Include here anything about future developments proposed for the revalidation process.

13. Recommendations

Normal practice would be to ask the board to accept the report (noting it will be shared, along with the annual audit, with the higher level responsible officer) and to consider any needs/resources.

The board should also be requested to approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations. This is also submitted annually to the higher level responsible officer.

14. Reporting with small numbers

When completing appendices A-E, please note:

It is recommended that the submission of this report to your organisation's Board takes into account whether the contents should be treated as confidential annexe with an appropriately controlled distribution. Any further publication or dissemination of the report should take into account whether this will identify individuals or make them potentially more identifiable. In such cases, it would be appropriate to provide a summary of the findings that removes or reduces these issues. Organisations with small numbers of relevant staff should take particular note of this issue.

15. Annual Report Template Appendix A – Audit of all missed or incomplete appraisals

Doctor factors (total)	**6**
Maternity leave during the majority of the 'appraisal due window'	*2*
Sickness absence during the majority of the 'appraisal due window'	*2*
Prolonged leave during the majority of the 'appraisal due window'	*1*
Suspension during the majority of the 'appraisal due window'	
New starter within 3 month of appraisal due date	
New starter more than 3 months from appraisal due date	
Postponed due to incomplete portfolio/insufficient supporting information	
Appraisal outputs not signed off by doctor within 28 days	
Lack of time of doctor	
Lack of engagement of doctor	*1*
Other doctor factors	
(describe)	
Appraiser factors	
Unplanned absence of appraiser – family bereavement	*1*
Appraisal outputs not signed off by appraiser within 28 days	
Lack of time of appraiser	
Other appraiser factors (describe)	
(describe)	
Organisational factors	**0**
Administration or management factors	
Failure of electronic information systems	
Insufficient numbers of trained appraisers	
Other organisational factors (describe)	

16. Annual Report Template Appendix B – Quality assurance of appraisal inputs and outputs

Total number of appraisals completed		Number
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs	31	31
Scope of work: Has a full scope of practice been described?	31	31
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	31	31
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	31	31
Patient feedback exercise: Has a patient feedback exercise been completed?	Yes	
Colleague feedback exercise: Has a colleague feedback exercise been completed?	31	29
Review of complaints: Have all complaints been included?	31	31
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	31	31
Is there sufficient supporting information from all the doctor's roles and places of work?	31	31
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	31	31
Appraisal Outputs	31	31
Appraisal Summary	31	31
Appraiser Statements	31	31
Personal Development Plan (PDP)	31	31

17. Annual Report Template Appendix C – Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[2]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern				
Capability concerns (as the primary category) in the last 12 months	1	1	3	5
Conduct concerns (as the primary category) in the last 12 months	0	0	3	3
Health concerns (as the primary category) in the last 12 months	0	1	2	3
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2018 who have undergone formal remediation between 1 April 2017 and 31 March 2018. Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice A doctor should be included here if they were undergoing remediation at any point during the year				5
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				2
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				3
General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical				0

[2] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	11
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	0
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	2
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	1
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	2
Number of NCAS assessments performed	0

18. Annual Report Template Appendix D – Audit of revalidation recommendations

Revalidation recommendations between 1 April 2017 to 31 March 2018	
Recommendations completed on time (within the GMC recommendation window)	31
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	31
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	
New starter/new prescribed connection established within 2 weeks of revalidation due date	
New starter/new prescribed connection established more than 2 weeks from revalidation due date	
Unaware the doctor had a prescribed connection	
Unaware of the doctor's revalidation due date	
Administrative error	
Responsible officer error	
Inadequate resources or support for the responsible officer role	
Other	
Describe other	
TOTAL [sum of (late) + (missed)]	0

19. Annual Report Template Appendix E – Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	14
Temporary employed doctors	8
Locums brought in to the designated body through a locum agency	54
Locums brought in to the designated body through 'Staff Bank' arrangements	0
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	
TOTAL	76

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS	Disclosure and Barring Service	2 recent references	Name of last responsible officer	Reference from last responsible	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance
Permanent employed doctors	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14
Temporary employed doctors	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8

Locums brought in to the designated body through a locum agency	54	54	54	54	54	54	54	54	54	54	54	54	54	54	48	54
Locums brought in to the designated body through 'Staff Bank' arrangements																
Doctors on Performers Lists																
Other (independent contractors, practising privileges, members, registrants, etc)																
Total	76	76	76	76	76	76	76	76	76	76	76	76	76	76	70	76

For Providers of healthcare i.e. hospital trusts – use of locum doctors:

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery					
Medicine					
Psychiatry	54	2965	1353	139	5348
Obstetrics/Gynaecology					

Accident and Emergency					
Anaesthetics					
Radiology					
Pathology					
Other					
Total in designated body (This includes all doctors not just those with a prescribed connection)	54	2965	1353	139	5348
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less	1	1	1	Unknown	0
3 days to one week	2	2	2	Unknown	0
1 week to 1 month	9	9	9	Unknown	0
1-3 months	18	18	18	Unknown	1
3-6 months	22	22	22	Unknown	0
6-12 months	14	14	14	Unknown	0
More than 12 months	2	2	2	n/a	0
Total	68	68	68	Unknown*	1

*Exit Reports are sent to the appropriate Line Manager following the end of a placement. We are experiencing difficulty in gathering the information from the Locum Agencies on the number of Exit Reports submitted following the end of a placement. We endeavour to set up a system internally to gather this information going forward to enable future reporting.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Designated Body Statement of Compliance

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   Comments: Yes

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   Comments: Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments: Yes

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

   Comments: Yes

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

   Comments: Yes

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

    Comments: Yes

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body:

Northumberland, Tyne & Wear NHS Foundation Trust (St Oswald's Hospice)

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

A Framework of Quality Assurance for Responsible Officers and Revalidation

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10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

    Comments: Yes

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[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body:

Northumberland, Tyne & Wear NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 25th July 2018

Title and Author of Paper: Smoke Free update, Dr Damian Robinson, Group Medical Director, Safer Care

Executive Lead: Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

Paper for Debate, Decision or Information: Information

Key Points to Note:

This report updates the Board on actions undertaken during the last year to further strengthen the support offered to service users to reduce harm from smoking.

- Audit of the implementation of trust-wide smoke free policy
- Launch of reducing harm from smoking group
- Review of smoking related incidents
- External evaluation of implementation of smoke free
- Review on the management of smoking-related items and electronic nicotine delivery systems
- Developing specialist stop smoking pathways
- Plummer court addiction services in Newcastle
- Community services in the central locality
- NHS smoke free pledge

Risks Highlighted to Board: None

Does this affect any Board Assurance Framework/Corporate Risks? Please state Yes or No NO If Yes please outline

Equal Opportunities, Legal and Other Implications:

Outcome Required: Discussion and support for moving forwards

Link to Policies and Strategies: Trust-wide Smoke Free Policy NTW(O)13

SMOKE FREE UPDATE - REDUCING HARM FROM SMOKING

This report updates the Board on actions undertaken during the last year to further strengthen the support offered to service users to reduce harm from smoking.

AUDIT OF THE IMPLEMENTATION OF TRUST-WIDE SMOKE FREE POLICY

A risk based audit of the implementation of the Trust-wide Smoke Free Policy NTW(O)13 was undertaken as part of the 2017/18 internal audit plan and the report issued in January 2018.

The audit concluded that "governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. A high level of compliance with the control framework was found to be taking place. Minor remedial action is required".

The following issues were identified for action:

- Job adverts do not include information relating to the Smoke Free Policy – this was previously included but appeared to have stopped at some point.
- Smokefree Working Group attendance and audit monitoring tool.
- Smoking-related complaints and incidents – monitoring by group
- Sharing positive stories.

All actions have subsequently been completed

LAUNCH OF REDUCING HARM FROM SMOKING GROUP (RHfS)

One of the issues raised by the above audit was the attendance and regularity of meetings. Several meetings had been cancelled due to lack of attendance or absence of key personnel.

The previous meeting had been established primarily to deliver smoke free sites to comply initially with the Smoke Free Regulations (2006) and NICE Public Health Guidance 48 Smoking: acute, maternity and mental health services. The membership was also lacking engagement from senior leaders who were in a position to take actions forward within clinical services

To reflect a change of emphasis towards harm reduction across all services the group has been relaunched as the Reducing Harm from Smoking (RHfS) group which has been meeting since March 2018. The relaunched group has an expanded membership including senior management and clinical representation from each of the new locality groups, NTW Solutions and external membership from local authority smoking cessation services. Attendance and engagement has been significantly better. The RHfSG has a comprehensive strategy which will maintain action and focus on smoke free agenda.

REVIEW OF SMOKING RELATED INCIDENTS

The table indicates the number of incidents recorded on SafeGuard where smoking is mentioned in either the code heading or incident narrative. The number of reports does not reflect the total number of breaches of the smoke free policy as simple breaches are not routinely reported. However, where a breach leads to, for example, aggression or violence, then the breach should be reported.

	2017/8 Q1	2017/8 Q2	2017/8 Q3	2017/8 Q4	2018/9 Q1
Actual Fire F01	2	0	0	2	1
Smoking IPB02/IB06	58	174	231	82	58
Violence All V codes	20	28	13	21	19
Other Codes	36	43	34	42	60

Reports of simple incidents of smoking peaked in Q3 but subsequently fell back in Q1 2017/18 to the same number as in the same quarter in 2017/18.

The number of actual fires where smoking is mentioned is small, and more often related to deliberate fire setting using smoking materials than accidental fire as a result of concealed smoking.

The number of incidents of violence where smoking is mentioned as a contributory factor is small, generally less than 20 per quarter. Including smoking as a trigger to violence and aggression within the Positive and Safe initiative is being explored.

Data on incidents is now considered in each RHfS group meeting.

EXTERNAL EVALUATION OF IMPLEMENTATION OF SMOKE FREE

As part of the plan for the introduction of smoke free policies in NTW and TEWV, both Trusts and Public Health England commissioned an independent external evaluation to be undertaken by Teesside University and FUSE – The Centre for Translational Research in Public Health. The final report was published in May 2018. The evaluation used both qualitative and quantitative methods to provide both trusts with some insight into the effectiveness of the move to being smoke free and to explore and share opportunities and challenges from the implementation with other trusts.

The evaluation found that the prevalence of smoking amongst admissions to NTW fell from 51% to 42% in the two-year period surrounding the introduction of the

smoke free policy. Among discharges the proportion fell from 50% to 44%. Data was complete for 85-90% of admissions but was less common amongst longer stay inpatients. The monthly cost of NRT products was £3,000 to £4,000.

A number of challenges and issues were identified in the qualitative interviews including differing views on the practicalities of enforcement, risk, implications for service users and best interest concerns.

The report provided 17 recommendations. Five covered improving surveillance (i.e. data capture with ongoing analysis regular reporting). Many other recommendations related to promoting culture change, such as fostering reflective learning and open dialogue, ensuring interventions are co-produced with patients, providing meaningful diversionary activities, adopting clear and consistent language and having continued and visible senior support until changes are normalised.

These recommendations will be considered and taken forward through the review of policy and guidance undertaken by the RHfS group.

REVIEW ON THE MANAGEMENT OF SMOKING-RELATED ITEMS AND ELECTRONIC NICOTINE DELIVERY SYSTEMS (ENDS)

The Board previously agreed to the supply of up to three e-cigarettes of a specified type to service users on admission to an in-patient unit and facilitation of purchase thereafter. Also, the identification and removal of smoking related items from service users on in-patient settings.

Over the last year there has been a significant number of reports from official bodies such as the national Tobacco Control delivery Plan and the Public Health England (2018) review of e-cigarettes which concluded that:-

- vaping is around 95% safer for users than smoking
- there is no evidence of harm to bystanders from exposure to e-cigarette vapour
- the evidence does not support the concern that e-cigarettes are a route into smoking among young people
- there is much public misunderstanding about nicotine (less than 10% of adults understand that most of the harms to health from smoking are not caused by nicotine)
- e-cigarettes could be contributing to at least 20,000 successful new quits per year and possibly many more
- switching completely from smoking to vaping conveys substantial health benefits
- there is compelling evidence that e-cigarettes be made available to NHS patients

A public health registrar has undertaken an extensive review of the evidence supporting the use of vaping as a support to reducing harm; also, the regulation covering the removal of smoking related items from inpatients. This review suggests that a more flexible approach to the use of e-cigarettes than previously envisaged

should be adopted to acknowledge their wide availability, acceptance and use amongst the public. This report is under consideration by the RHfS group and will form the basis of recommendations to be brought through CDTQ.

DEVELOPING SPECIALIST STOP SMOKING PATHWAYS

Assisting service users to reduce harm from smoking and cease smoking is more likely to be successful in community settings, where the vast majority of service users are in contact with NTW. Over the last year NTW has successfully engaged with multiagency partners in a number of projects which aim to provide increased opportunities to receive harm reduction advice and support and access physical health services. This work has been led by a further Public Health Registrar attached to NTW.

1) **Plummer Court Addiction Services In Newcastle**

   Working with NHS NUTH FT, Newcastle City Council, Newcastle CCG and CGL Specialist Stop Smoking Service NTW has developed a respiratory health service for service users accessing addiction services at Plummer Court in Newcastle city centre. There is a high prevalence of undiagnosed respiratory disease in the addictions service user population, attributed to a number of risk factors and in particular smoking rates. Similarly, there are barriers to access specialist respiratory care for Plumber Court services users due the current pathway requiring a GP referral and attendance at the RVI.

   Working with clinicians from the specialist respiratory service at Newcastle Hospitals and Newcastle CCG, NTW has developed a pathway to screen all patients' risk of respiratory disease and address existing signs and symptoms. All patients will receive health improvement interventions (facilitated by Newcastle City Council and Plumber Court clinicians) such as stop smoking support, exercise referral and flu Immunisation. Symptomatic patients will receive an appointment with the NUTH specialist respiratory team in our new outreach clinic to be held within Plumber Court. The single respiratory appointment will include full assessment of respiratory health, diagnosis and appropriate treatment in a one-stop shop model.

   The CCG have approved a one-year Quality Improvement pilot, with expected outcomes to be: improved equity of access to appropriate treatment; improved management of respiratory disease with reduced exacerbations; reduced prevalence of acute respiratory illness; and improved expertise to address physical health within Plummer Court staff.

2) **Community Services In The Central Locality**

   Working with Newcastle City Council, CGL Specialist Stop Smoking Service and Gateshead Council a pathway to enhance stop smoking support has been developed for the central locality community settings. This work has been championed by Alison Thain, Associate Director (Central Locality) who sits on the working group.

The pathway aligns with the NICE guidelines PH48 to address smoking within healthcare providers and CQUIN 9, for health professionals to ASK, ADVISE and ACT in relation to risk behaviours (i.e. smoking). As such, the role of NTW staff is focused on i) screening for patients smoking status and motivation to stop, ii) brief advice about harms of smoking and effectiveness of specialist cessation support, iii) referral to the SSS in order for appropriate cessation support to be agreed with patient. A bespoke training will be delivered for NTW using scenarios specific to our patients and to reduce training time requirements.

A range of evidence-based support options will be provided to service users. This includes group-based SSS within NTW community venues, 1:1 support (GPs or pharmacy) and 1:1 support with the specialist service. Data on quit attempts and successful quits will be collated and fed-back to referral sources in order to identify quits associated with NTW community settings and provide motivation for referring clinicians.

The ambition is to implement in early autumn, with staff training dates currently waiting to be confirmed.

NHS SMOKE FREE PLEDGE

NTW became a signatory of the NHS Smoke Free Pledge on World No Tobacco Day on 31st March.

The commitments in the Pledge include:

- Treat tobacco dependency among patients and staff who smoke as set out in the Tobacco Control Plan for England
- Ensure that smokers within the NHS have access to the medication they need to quit in line with NICE guidance on smoking in secondary care
- Create environments that support quitting through implementing smokefree policies as recommended by NICE

Dr Damian Robinson
Group Medical Director Safer Care
July 2018

NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST

Board of Directors Meeting

Meeting Date: Wednesday 25th July 2018

Title and Author of Paper: Quarter 1 – Safer Care Report (Including Learning from Deaths) – April - June 2018 Author of Paper in response to this report – Jan Grey – Associate Director of Safer Care Tony Gray - Head of Safety , Security and Resilience Claire Taylor – Head of Clinical Risk and Investigations Vicky Clark – Incidents, Complaints and Claims Manager Craig Newby – Deputy Head of Safety , Security and Resilience Dr Damian Robinson – Deputy Medical Director – Safer Care

Executive Lead: Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

Paper for Debate, Decision or Information: Information

Key Points to Note: • This report contains all the safety related activity for the period April - June 2018, including the formal reporting mechanism for reporting how the Trust is "Learning from Deaths". • This report contains the lessons learnt of 28 Serious Incident Investigations and 20 Mortality Reviews from the activity reviewed in the months April - June, that occurred in the previous quarter. • This report further integrates Safer Care reporting and provides detailed quarterly information and analysis of Safeguarding and Public Protection activity that was previously a separate Q and P report.

Risks Highlighted to Board: None
Does this affect any Board Assurance Framework/Corporate Risks? No Please state **Yes** or **No** If Yes please outline
Equal Opportunities and Legal and Other Implications: None
Outcome required: Noted for Information
Date for completion: N/A
Links to Policies and Strategies: • Incidents Policy • Complaints Policy • Claims Policy • Health & Safety Policy • Security Management Policy • Central Alert System Policy • Safeguarding and Public Protection Policies

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Safer Care Report – Quarter 1
July 2018
Reporting Period: April - June 2018

Caring | Discovering | Growing | **Together**

Contents

Introduction

This Safer Care Report includes activity relating to quarter 1 – April 2018 – June 2018, this report builds on the monthly report that is produced for the organisation and Clinical Commissioning Groups every month and is presented to the Corporate Decisions Team – Quality.

Incident Reporting and Management

Incident Reporting

The following information gives a detailed breakdown of the incidents that have occurred in the Trust in the last quarter, in comparison to the previous year, there is detailed analysis of this information every month through the Trust's governance systems as well as the monthly reports which gives a greater level of analysis down to service line.

	Q1	Q2	Q3	Q4	Q1
Incident Type	Apr – Jun 17	Jul – Sep 17	Oct – Dec 17	Jan – Mar 18	Apr – Jun 18
Aggression And Violence	3637	3155	3442	3206	3126
Inappropriate Behaviour (Including smoking)	526	523	638	498	612
Safeguarding	1458	1651	1693	1849	2102
Self Harm	601	558	547	563	504
Security	1395	1205	1198	1108	1132
Totals	**7617**	**7092**	**7518**	**7224**	**7476**

All Other Incidents	2149	2175	2465	2348	2288
Totals	**9766**	**9267**	**9983**	**9572**	**9764**

It can be seen from the above table incident reporting is broadly comparable to the same period in 2017. There were a total of 38,588 incidents reported throughout the full year, and quarter 1 is comparable with the same quarter last year, with only a difference of 2 incidents.

Aggression and Violence has dropped for the 2nd quarter, which is encouraging, and this is being closely monitored in line with the trust Positive and Safe Strategy.

Safeguarding and Public Protection concerns continue to rise, and are up to over 2,000 concerns for the 1st Quarter. More detail on this is included in the newly created Safeguarding and Public Protection section later in this report.

All the activity is suitably considered at the Corporate Decision Team's – Quality Meeting and through the Trust's Quality and Performance Committee, where the themes and trends are analysed and understood. The clinical groups also provide an update through the Quality and Performance Committee on a 6 monthly rotational basis, exploring their own activity and the reasons for it.

Serious Incidents Reported – Quarter 1

The following information gives a detailed breakdown of the serious incidents that have occurred in the Trust in the last quarter, in comparison to the quarters before, within quarter 4 report, it also provides an annual review of serious incident activity.

Table 1 – Serious Incidents Reported – Quarter 1

	Q1			Q2			Q3			Q4			Q1		
Incident Type	Apr-17	May-17	June-17	Jul-17	Aug-17	Sept-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May 18	Jun-18
Death	11	13	6	10	13	16	11	23	17	14	7	14	16	21	12
All Other Serious Incidents	6	2	4	7	3	3	8	2	4	7	3	1	4	2	9
Totals	17	15	10	17	16	19	19	25	21	21	10	15	20	23	20
Quarterly Totals	42			52			65			46			64		
	Serious Incidents 206-2017									187					
	Serious Incidents 2017-2018									205					
	Serious incidents 2018-19									64 YTD					

The average rate for incidents that are subject of a review in line with the serious incident framework for each quarter is 53. Q1 was higher than the average, but comparable to Q3 in the previous year. When reporting on deaths as serious incidents it is acknowledged that due to the changes we have made to the serious incident policy, and the weekly discussion with Directors we have around deaths, more deaths that are reported are likely to be reviewed as serious to allow for a concise investigation to be carried out in line with the National Serious Incident Framework.

28 Serious Incident investigations were heard at panels this quarter. A summary of all investigations heard at the weekly panel including associated learning are discussed at Business Delivery Group – Safety. (See appendix 1 for monthly summary of learning themes)

When looking over an annual basis on deaths investigated there were 156 deaths subject to a serious incident investigation in 2017 -18, so far in Q1 there have 49 deaths that are subject to a serious incident investigation. This will be closely monitored by the Safer Care Team in collaboration with the Clinical Care Groups to review any trends. No areas of concern are identified and the activity is evenly spread across the organisation.

All deaths reported and level of investigation

The Trust has robust policies and procedures for identifying and investigating deaths which follow guidance issued by the National Quality Board. Where applicable, investigations are conducted using a root cause and human factors framework and in partnership with families and carers. Learning points are identified, disseminated, embedded and their impact evaluated with the entire process monitored by the Trust-wide Learning and Improvement Group

Investigations are undertaken as part of a wider learning system which includes the following partners and agencies:

- Strategic Executive Information System (STEIS) – as a serious incident and in line with the Serious Incident Framework, overseen by Commissioners.
- National Reporting and Learning System (NHS Improvement) – as a reportable patient safety incident for any immediate learning.
- Care Quality Commission – Due to the death of a detained patient and to notify of the safety concerns from a registered location.
- Learning Disabilities Mortality Review Programme (LEDER) as a learning disability death
- Through Safeguarding Adult's and Children's processes as identified.
- HM Coroner – via the Police when the incident is discovered.
- Health & Safety Executive – Workplace fatality.

The Trust conducts investigations at several levels in line with NHS Improvements Serious Incident Framework:

- External investigations (Level 3) – for Homicides by those patients in receipt of mental health services at the time of the offence, and for incidents of significant concern.
- Serious Incident Reviews (Level 2) – for deaths which fulfil requirements for reporting under STEIS.
- After Action Reviews (Level 1 – Concise Investigations) – for deaths occurring in alcohol and drug services, and other deaths which appear to be unnatural but not fulfilling requirement for reporting under STEIS.
- Structured case note review (Mortality Review) – for natural cause deaths of service users receiving care under the Care Programme Approach; or death where concern has been raised by families, carers or staff.

Table 2 – Deaths Recorded, Reported, Reviewed and Investigated

Category	Apr – Jun 17	Jul 17 – Sep 17	Oct 17 – Dec 17	Jan – Mar - 18	Apr – June - 18
	Q1	Q2	Q3	Q4	Q1
Death as Serious Incident (Level 3) Homicide by a Patient	0	0	0	1	0
Deaths investigated as SIRI	16	18	23	11	13
Deaths reviewed as after action reviews.	14	21	28	24	36
Deaths reported to NRLS	25	8	9	4	8
Deaths reported to LEDER	5	9	7	7	19
Deaths subject to mortality reviews	11	15	18	17	6
Deaths being investigated due to family concerns that are not part of any investigation process above	0	0	0	0	0
Deaths subject to a Safeguarding Process*	1	2	4	1	0
All other deaths not subjected to review or investigation**	182	202	233	274	230

****It is acknowledged that natural deaths of those patients not on Care Programme Approach at the time of death, would not be subject to a review unless, there was concerns identified around care and treatment by the family.**

The above table indicates the numbers of deaths the Trust records in each of the previous quarters, but it is the individual cases where true learning and improvement are identified.

Safeguarding and Public Protection

Trust-wide Safeguarding and Public Protection concerns

Since January 2017 when the reporting of all Safeguarding and Public Protection concerns through the Web Based System was implemented, there continues to be a steady increase of monthly activity, in the last reporting period, the average monthly concerns reported were 592. In quarter 1 the Safeguarding and Public Protection concerns totalled 2102 an average of 700 per month.

Cause	Central Locality Care Group	North Locality Care Group	Nursing & Chief Operating Officer	South Locality Care Group	Total	%
Safeguarding Adults - Staff Allegation	17	21	1	17	56	2.66
Safeguarding Children - Staff Allegation	0	6	0	0	6	0.29
Safeguarding Adults Patient On Patient	26	57	0	11	94	4.47
Safeguarding Children Patient On Patient	0	18	0	0	18	0.86
MAPPA	19	14	2	13	48	2.28
MARAC	65	77	1	91	234	11.13
PREVENT	4	2	0	4	10	0.48
Safeguarding Adults - Concerns	357	203	1	317	878	41.77
Safeguarding Children - Concerns	199	244	0	315	758	36.06
Total	687	642	5	768	2102	100.00

Safeguarding concerns

As with previous reports the highest types of concerns raised are Safeguarding adults 878 and Safeguarding children 758.

Public Protection concerns

Multi-Agency Risk Assessment Conference (MARAC)

Over the three month period there have been 234 MARAC concerns where a significant incident of Domestic Abuse has occurred and a MARAC meeting has been held to safeguard the victim. There are 12 MARAC meetings held per month in 6 Local Authority Areas that a SAPP Practitioner attends on behalf of the trust. On average 7 victims or perpetrators are active to trust services that are discussed at each multi agency meeting to safeguard the victim wherever possible. As expected these incidents occur within the home and the majority reported by community services or by inpatient services when a patient makes a disclosure.

Multi-Agency Public Protection (MAPPA)

There were 48 MAPPA cases discussed for those service users where an assessment indicated that a service user person maybe posing a high or very high risk of serious harm to the public and the case requires active involvement and co-ordination of interventions from multi agency partners to manage the presenting risks of serious harm.

Prevent

Of the 10 Prevent referrals this quarter, 6 did not require a Prevent multi-agency meeting. The police were initially contacted to discuss the patient's presentation and no further actions were required at that time. 2 referrals were made into the Prevent process and 2 are pending a decision.

Patient on Patient abuse

There were 94 adults and 18 young people where there were safeguarding concerns reported of patient on patient abuse.

Staff Allegations

61 staff allegations were reported 56 were in relation to Adults and 6 children.

Locality Care groups activity and analysis

Central Locality

Cause	Community Central CBU	Inpatients Central CBU	Secure Care Services CBU	Access Central CBU	Total	%
Safeguarding Adults - Staff Allegation	2	1	14	0	17	2.47
Safeguarding Adults Patient On Patient	2	12	12	0	26	3.78
MAPPA	9	1	4	5	19	2.77
MARAC	31	1	11	22	65	9.46
PREVENT	1	1	1	1	4	0.58
Safeguarding Adults - Concerns	206	44	37	70	357	51.97
Safeguarding Children - Concerns	106	12	9	72	199	28.97
Total	357	72	88	170	687	100.00

North Locality

Cause	Inpatients North CBU	Specialist Children & Young Peoples Services CBU	Community North CBU	Access North CBU	Total	%
Safeguarding Adults - Staff Allegation	20	1	0	0	21	3.27
Safeguarding Children - Staff Allegation	0	5	1	0	6	0.93
Safeguarding Adults Patient On Patient	56	0	1	0	57	8.88
Safeguarding Children Patient On Patient	0	18	0	0	18	2.80
MAPPA	6	1	2	5	14	2.18
MARAC	3	2	16	56	77	11.99
PREVENT	2	0	0	0	2	0.31
Safeguarding Adults - Concerns	47	10	69	77	203	31.62
Safeguarding Children - Concerns	5	112	52	75	244	38.01
Total	139	149	141	213	642	100.00

South Locality

Cause	Community South CBU	Inpatients South CBU	Neurological & Specialist Services CBU	Access South CBU	Total	%
Safeguarding Adults - Staff Allegation	1	12	4	0	17	2.21
Safeguarding Adults Patient On Patient	1	8	1	1	11	1.43
MAPPA	8	3	0	2	13	1.69
MARAC	41	2	4	44	91	11.85
PREVENT	0	2	0	2	4	0.52
Safeguarding Adults - Concerns	124	35	35	123	317	41.28
Safeguarding Children - Concerns	117	8	13	177	315	41.02
Total	292	70	57	349	768	100.00

Access CBUs- Public Protection concerns raised across the three Access CBU's provide similarity in referrals into the MAPPA process where concerns are identified within assessments of a significant risk of harm to others. Domestic abuse and active service users being discussed at MARAC meetings as a victim or perpetrator of abuse within Access CBU teams are as expected high totalling 122 this quarter. Many of those service users are being seen in crisis where domestic abuse is either disclosed or suspected by NTW clinicians or made by another agency involved at the time e.g. police/A and E staff at the point of NTW referrals/assessments.
Positive reporting by Crisis teams, Addictions, Liaison and Street Triage of 324 safeguarding children concerns across the 3 Access CBUs trust-wide acknowledging "think family" and associated risk/concerns to child/ren from the parent/carer in relation to the presenting crisis or addiction impacting on the ability to parent at that time. 273 safeguarding adult concerns were reported this quarter, again positive reporting by Access CBU's when assessing service users in crisis identifying associated vulnerabilities with safeguards being put in place. One Prevent referral was also made.
Again in this quarter, South Access CBU has the greatest number of safeguarding children and safeguarding adult concerns raised, this is in keeping with the client population and associated services within Sunderland and South Tyneside.

Community CBU's- As expected Community services CBU's have high prevalence of reported activity in respect of safeguarding adult and children of 399 and 273 reported concerns respectively. These concerns raised by service users/staff are in respect of alleged or actual abuse by family members, carers or people within the community. As with Access CBUs positive reporting of safeguarding children concerns when working with adult service users. 88 victims of Domestic Abuse were discussed in MARAC who were active to clinicians in community teams. In all cases the risk intelligence and multi-agency plan to safeguard the victim was shared with the clinicians involved. The Community CBU's this quarter have the highest number of referrals made into MAPPA. Community clinicians together with SAPP Practitioner attend the MAPPA meeting to provide information, define the risk to the public and develop a multi-agency risk management plan to safeguard. One Prevent referral was made.

Inpatient CBU's- Inpatient CBU's have the highest reported category for patient on patient abuse, 76 concerns were raised, with minor harm occurring to patients on wards. 56 of those 76 concerns raised were reported within the North Care Group, 2 wards accounted for 38 of those concerns. It is worth noting that 5 patients accounted for a high number of

incidents within this quarter, none of which resulted in significant harm with care plans put in place. All actual or alleged abuse is routinely reported, resulting in safety planning being put in place by MDT's to prevent wherever possible further abuse between patients supported by the trust SAPP team. Referrals are made to the Local Authority Safeguarding Teams and or Police where necessary.
The Inpatients CBU's as expected had the highest reported staff allegation concerns, 33 out of 61, of those 1 from Central locality, 12 from South Locality and 20 from North Locality. One ward in the North Locality had 13 of those concerns raised. The SAPP Practitioner has provided extensive support to the ward as one patient accounts for 12 of those reported allegations. All allegations have been investigated appropriately and all were found to be unsubstantiated,
South Locality had 12 staff allegations from adult Inpatient CBU, all have been investigated by SAPP team and care plans updated, 6 are currently still being investigated at the time of this report. Central Locality there were 17 staff allegations, one ward being the highest reporter with 14 allegations made. Ten of those staff allegations made on this ward were from 1 patient, all were investigated fully and unsubstantiated.

There was positive reporting made by inpatient wards in respect of 126 safeguarding adult concerns and 27 safeguarding children concerns, where the patient had disclosed or assessed as having being assessed as being a victim of abuse within the community prior to being admitted to the ward e.g. financial abuse, sexual exploitation or neglect.
10 MAPPA referrals and 6 MARAC referrals were made by Inpatient MDT's acknowledging risk and the requirement for multi-agency risk management plans to be put in place prior to a patients discharge.
The Inpatient CBU's have the highest reported incidents of Prevent this Quarter of 5.

Nursing & Chief Operating Officer

These 5 concerns raised are those where the SAPP practitioner (categorised in Safeguard system as Nursing and Operations directorate) been provided via another agency e.g. Probation contacted advising of a concern in relation to a service users current risk. All 5 concerns raised required a multi-agency meeting to manage the risk.

Trust Wide Themes and Analysis

Outcome Type	Central Locality Care Group	South Locality Care Group	North Locality Care Group	Nursing & Chief Operating Officer	Total	%
Tier 1 (Low Level): SG Concern Action By Ward/Dept	348	404	292	0	1044	49.67
Tier 1 (Low Level): LA Referral	98	75	124	0	297	14.13
Tier 2 - 4(Significant Harm):LA Referral	96	149	93	1	339	16.13
Tier 2-4 (Significant Harm): Police Involvement	88	63	75	1	227	10.80
Local After Action Review	0	1	0	0	1	0.05
SUI Review	0	1	0	0	1	0.05
T2-4: MAPPA/PDP Risk Management Plan (NTW)	1	1	0	0	2	0.10
T2-4: MARAC Referral Made (NTW)	8	6	6	0	20	0.95
T2-4: MARAC Safety Plan (NTW Referral)	6	4	3	0	13	0.62
T2-4: MARAC Safety Plan (Other Agency Referral)	39	63	47	0	149	7.09
T2-4:MAPPA/PDP Referral Made NTW	2	1	1	1	5	0.24
T2-4:MAPPA/PDP Risk Management Plan (Other Agenc	1	0	1	2	4	0.19
Total	687	768	642	5	2102	100.00

As with previous reports the highest outcome in relation to safeguarding children and adult concerns outcome were action by the ward/department, this was 50% of all concerns raised in this quarter. This is in respect of early identification of concerns that require single

agency action planning only, having not met the threshold for significant harm. The trustwide reporting culture of a preventative model is clearly embedded in practice.
The low level referrals to the Local Authorities are those concerns were the abuse reported is not meeting the threshold of significant harm, however a referral is made to the LA in order for that intelligence/information to be known e.g. Concerns that a person may have early indicators of being sexually exploited/groomed/financially abused, however no known perpetrators identified.

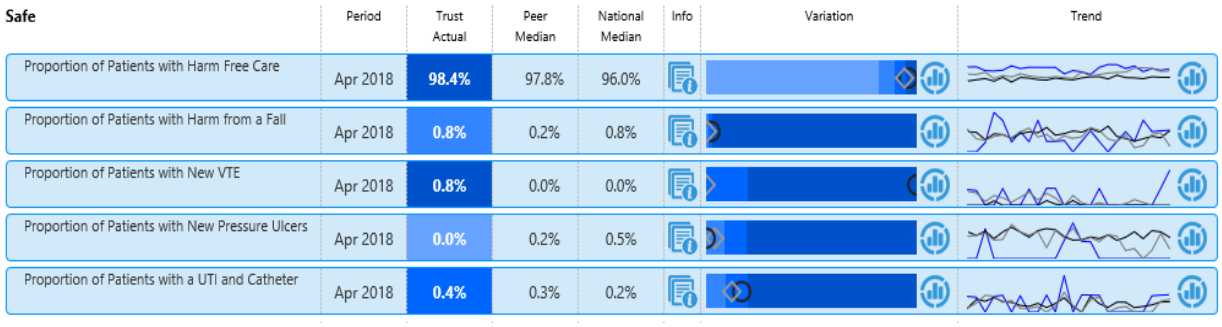
227 (11%) of all incidents were reported directly to the police. These are incidents were staff have identified a crime may have been committed and/or the patient/service user wants to report the incident as a crime e.g. alleged sexual abuse, financial abuse.

Case Reviews

There have been no Serious Case reviews, Serious Adult Reviews or Domestic Homicide Reviews commissioned this quarter by local Safeguarding and Safer Community partnership boards.

Safety Thermometer / Mental Health Safety Thermometer

The following is the current presentation of the Safety Thermometer information which is now available through NHS Improvement – Model Hospital.



Safe	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Proportion of Patients with Harm Free Care	Apr 2018	98.4%	97.8%	96.0%			
Proportion of Patients with Harm from a Fall	Apr 2018	0.8%	0.2%	0.8%			
Proportion of Patients with New VTE	Apr 2018	0.8%	0.0%	0.0%			
Proportion of Patients with New Pressure Ulcers	Apr 2018	0.0%	0.2%	0.5%			
Proportion of Patients with a UTI and Catheter	Apr 2018	0.4%	0.3%	0.2%			

It can be seen above that the Trust overall is above the national median for harm free care.

In relation to specifics around the Mental Health Safety Thermometer, whilst the Trust is not currently completing the data submission, the following information gives a breakdown of the activity in detail as recorded in the Trust Risk Management System as opposed to the the snapshot data available in the national system. It is important to note that only half of Mental Health organisations are currently submitting data.

The four criteria are as follows:-

- Proportion of patients that have self harm in the last 72 hours.
- Proportion of patients that feel safe at the point of survey.
- Proportion of patients that have been a victim of violence and aggression in the last 72 hours
- Proportion of patients that have had an ommission of medication in the last 24 hours

In order to try to give a reflection of this activity the following table gives a breakdown on the number of incidents for points 1, 3, and 4, further information for point 2 will be included in the next report.

Proportion of patients that self harmed – reporting period April – June 2018 – Quarter 1

There were 1,134 epsisodes of self harm between 1st April 2018 – 30th June 2018, this involved 404 patients. Of the 404 patients 19 self harmed 10 or more times accounting for 507 incidents or 45% of the total. Of the 404 patients 286 self harmed once in this quarter. 1 patient self harmed over 100 times in the quarter.

Proportion of patients that were a victim of violence and aggression – reporting period April – June 2018 – Quarter 1

There were 373 epsisodes of aggression and violence where a patient was a victim between 1st April 2018 – 30th June 2018, this involved 218 patients. Of the 218 patients 3 were victims 10 or more times. Of the 218 patients 145 were a victim once in this quarter, 66% of the total number of patients. The remaining 33% were a victim between 2 and 9

times. This activity directly correlates to the increase in Safeguarding concerns being reported, so that appropriate systems are put in place to support victims of violence and aggression.

Proportion of patients with omitted medication – reporting period April 2018 – June 2018 – Quarter 1

There were 62 medication incidents of omitted medication / ingredient reported between 1st April 2018 – 30th June 2018, this involved 59 patients. Of the 59 patients 3 had their medication omitted more than once. The other 56 patients experienced an omission once. Each medication incident is reviewed by Pharmacists with the patient supported and advised of corrective action to take. The Pharmacists support the individual clinical teams to review the incidents to prevent the re-occurrence.

Central Alert System – Exception Report

This report contains information of any non-compliance with the CAS system for the Trust. This is a nil report for this quarter, as an assurance process the link below is the current published data from NHS Improvement which indicates which Trust's have outstanding CAS alert activity.

https://improvement.nhs.uk/resources/data-patient-safety-alert-compliance/

Learning from Deaths

On 25th May 2018 Northumberland, Tyne & Wear NHS Foundation Trust (NTW) hosted a meeting in Durham with the nine Northern Mental Health and Learning Disability Trusts that had previously met as a group facilitated by Mazars. The group had been formed to develop a joint Learning from Deaths policy and explore cross organisational learning, but had not met since 2017 due to the support from Mazars coming to an end. The group was joined, on this occasion, by some Trusts from the North West and also by Professor Wendy Burn, president of the Royal College of Psychiatrists who spoke of the College work in developing a methodology for undertaking structured case note review. It was agreed that the group would continue to meet and noted that funding has been made available from Trusts to support a co-ordinator for this work for two days each week.

Following representation from NTW and Tees Esk and Wear Valleys NHS Foundation Trust, it has been agreed that both Trusts will become members of the LeDeR steering group. This should ensure that the views of provider organisations are taken in to account in developing review processes which avoid duplication and ensure that learning is relayed back to Trusts in a timely manner.

As part of the process to embed human factors into the investigation process a training session on strategic human factors awareness was given by NICHE on 27th June. This session was attended by executive and non-executive directors, and directors of Locality Care Groups. It follows the training in human factors given to the trust Investigating Officers and Serious Incident panel members in 2017. New Investigating officers are scheduled to attend further training in the next two months.

Learning process developments

The Learning process within the Trust can be two-fold, how we learn from adopting the new process, the tools that are used to learn and disseminate the information we have learned, and the improvements it makes to practice as well as the individual learning from each death, where we would respond to families concerns and reflect on whether anything clinically or operationally could or should have been different, acknowledging that similar to serious incident outcomes it may not have prevented the death, but is nonetheless an opportunity to improve practices and processes within the Trust.

It is acknowledged that there is a patient at the centre of each review the Trust undertakes with the full involvement of family and carers through our Duty of Candour responsibilities to identify and appropriately answer any questions they may have around care and treatment prior to death, even if the death is deemed as a natural occurrence.
The following case vignette, outlines the details of the incident, the care provision and the reflection and learning from the case. This acknowledges that this level of activity is replicated for each death that is investigated, but gives the assurance into what the Incident Policy, serious incident process and newly developed mortality process achieves in bringing about changes to care and treatment within the Trust.

Learning from Deaths – Case Vignette

This is the review of a 67 year old gentleman with a history of paranoid schizophrenia diagnosed as a teenager who died on an inpatient ward.

After a period of many previous admissions to hospital with various antipsychotics trialled, the gentleman had been stable for 25 years on a small dose of clozapine medication. He was known to be a socially isolated man, who did, however, maintain contact with his neighbours who were supportive of him. He had no contact with family members. He discontinued clozapine medication in December 2017. This led to a relapse of his illness that required him to be admitted under the Mental Health Act. He was nursed on eyesight observations whilst he was an in-patient due to the risks of aggressive behaviour.
Whilst on the ward he continually refused to consider the use of clozapine and other treatments provided made minimal impact into the severity of his symptoms. Given his presentation it was agreed to receive Electro Convulsive Therapy (ECT). The treatment plan alongside ECT was to continue haloperidol, a long acting intramuscular injection, supported with additional haloperidol and lorazepam, orally or intramuscularly, when needed for his agitation.

On the day of the incident he had been agitated. He was noted to have put himself on the floor; query collapsed, but had not fallen. The alarms were activated and it was thought he may have been choking therefore abdominal thrusts were started and any food removed from his mouth. It was noted he had stopped breathing and CPR was immediately commenced. Emergency services were called and Paramedics took over CPR on arrival. Intravenous access was gained and fluids and adrenaline (3 doses) were given via this route. The ECG (electrocardiogram) showed various rhythms but none that were recognised by the Automatic External Defibrillator as being amenable to electric shock, and largely asystole (flat line indicating no cardiac activity). Suction removed some food, along with some by forceps but this made no difference, it was also confirmed that air had been getting to both lungs. The patient was pronounced dead at around 5.45pm.The cause of death has yet to be established.

Core Learning

The investigation found the emergency response to be timely and well supported. An incidental finding identified there had been a momentary delay in attaching oxygen tubing correctly to the mask.

The investigation found that the gentleman although not being given rapid tranquilisation as such, but an intra muscular dose of haloperidol due to refusal of oral medication did not have physical health observations recorded/taken. This should have been completed due to the physiological effects of the medication. On reviewing the Rapid Tranquilisation Policy as part of the investigation, physical health observations is not clear within the current policy and associated guidance.

The phrase Zonal Observations was used within documentation for observations which is not within policy. It was felt that care planning in relation to observations, could have been improved to ensure a consistent approach to observation, however it was noted that at the time of the incident the observations were being completed as per policy.

Good practice was also identified within this investigation in relation to the ongoing care and treatment and all of the physical health assessments requested and undertaken, including a SALT assessment that identified no swallowing concerns.

Key Actions

The finding re tubing and connection will be taken to the Trust Resuscitation Group as a trust wide learning point to agree an outcome.

The Rapid Tranquillisation policy is due for review and the learning from this review will be included to ensure clear guidance for staff.

To ensure the accurate recording, care planning of observations and the correct terminology of those observations are to be used as per policy.

Coroner - Regulation 28 of the new Coroners Act

Following the receipt of a Regulation 28 made by HM Senior Coroner for South Tyneside and Gateshead Mr. Carney into the death of a patient visited the Trust to learn about how the trust investigated deaths and the purpose of our investigations. This meeting occurred on the 5th June, chaired by the Executive Director of Nursing/Chief Operating Officer. Mr Carney received a presentation including;

- Explanation of the National Serious Incident Framework 2015
- 7 Key principles of Serious Incident Management
- NTW Serious Incident /Investigation Process
- After Action Review's- benefits of this approach
- Quality assurance, internally and externally
- Organisational Learning

Complaints Reporting and Management

Complaints Received

The following table gives a breakdown of the Trust activity for all complaints received.

Complaints have increased in Quarter 1 by approximately 10% in comparison to Quarter 4, although remain a similar number from Quarter 1 of 2017; this is currently under close scrutiny by the Executive Director of Nursing and Chief Operating Officer and the Operational Directors.

Complaint Type	Q1 Apr – Jun 17	Q2 Jul – Sept 17	Q3 Oct – Dec 17	Q4 Jan – Mar 18	Q1 Apr – Jun 18	Total
Complex	59	45	53	44	37	238
Joint Not Lead	1	1	2	2	5	11
Joint NTW Lead	0	2	1	3	3	9
Standard	85	89	71	84	102	431
Total	**145**	**137**	**127**	**133**	**147**	**689**

Complaints by Category

The following table gives a breakdown of complaints received by category, these categories are nationally approved, and information is sent to NHS Digital on a quarterly basis. In line with national reporting to NHS Digital which occurs every quarter, the following is the category of complaints.

The three highest categories, communication, patient care and values and behaviours accounted for 63% of all complaints received and reflects the National picture.

Appointed investigating officers are now requested to determine the correct categories after they have made contact with the complainant to ensure wherever possible the correct category is identified.

Although all complaints are individual, there has been a general increase in patient dissatisfaction with new ways of working (episodic care). This way of working has a focus on recovery and in some cases has impacted on benefit levels where it is felt the person no longer requires long term care co-ordination. Waiting lists in CYPS, multiple assessments and a general lack of communication around progress or diagnosis has also resulted in several complaints from dissatisfied parents. A thematic review of CYPS complaints is currently being undertaken.

Category Type	Q1 Apr – Jun 17	Q2 Jul – Set 17	Q3 Oct – Dec 17	Q4 Jan – Mar 18	Q1 Apr – Jun 18	Total
Access To Treatment Or Drugs	3	1	3	3	0	10
Admissions And Discharges	14	9	5	9	9	46
Appointments	9	5	7	11	9	41
Clinical Treatment	1	5	8	7	8	29
Communications	23	24	17	19	27	110
Consent	0	0	1	0	0	1
Facilities	2	2	1	2	4	11
Other	4	6	1	2	1	14
Patient Care	45	32	43	36	33	189
Prescribing	9	12	4	6	10	41
Privacy , Dignity And Wellbeing	1	1	1	1	1	5
Restraint	0	2	2	0	0	4
Staff Numbers	0	1	1	0	1	3
Trust Admin/ Policies/Procedures Including Rec Man	4	3	4	6	14	31
Values And Behaviours	26	29	25	27	29	136
Waiting Times	4	5	4	4	1	18
Total	**145**	**137**	**127**	**133**	**147**	**689**

Complaints Relating to Death

The table below shows those complaints that have been received with the theme of the complaint is relating to the death of a patient. It also needs to be acknowledged that not all complaints relating to death are received straight after death, some are received following the outcome of a serious incident investigation, or the outcome of a coronial investigation, this can be six months after the death. This information has been included as it directly correlates to the Learning from Death activity and guages family and carers responses of the care provided prior to the death of a patient irrespective of cause.

In collecting this data, the base line over the last 3 years the Trust has averaged 11 complaints per year, this is in comparison to over 1,000 deaths reported each year. This also acknowledges that many families and carers seek answers around concerns relating to care which are responded to as part of the serious incident investigations under the Trust's Duty of Candour processes. It is also hoped that with the full implementation of Learning From Deaths Policy, that if family and carer's want to answers to care and treatment issues, we can do so through the mortality review process, acknowledging that we would always investigate complaints received.

	Q1	Q2	Q3	Q4	Q1	Total
Services	Apr – Jun 17	Jul – Sep 17	Oct – Dec 17	Jan – Mar 18	Apr – Jun 18	
Addictions Services SLD 4 To 6 Mary Street	0	0	0	1	0	1
Crisis Response & Home Treatment S Tyne Palmers	0	0	0	1	0	1
Crisis Response & Home Treatment SLD HWP	0	0	1	0	0	1
EIP NLD Greenacres	1	0	0	0	0	1
GHD Community Non Psychosis Team Dryden Rd	0	0	0	1	0	1
GHD Community Psychosis Team Tranwell	1	0	0	0	0	1
Liaison Psychiatry Service NCL & N Tyne RVI	0	0	0	1	0	1
North Tyneside Recovery Partnership Wallsend	0	1	0	0	1	2
S Tyneside Psychosis/Non Psychosis Palmers	0	1	0	0	0	1
Springrise	0	0	0	0	1	1
Street Triage North Of Tyne Ravenswood	0	0	1	0	0	1
Totals	2	2	2	4	2	12

Parliamentary Health Service Ombudsman

The following information is the current activity that has been reported / requested via the PHSO.
The Trust as part of every complaint response letter includes the PHSO contact details. Complainants have the right to take their complaint to the PHSO even if the findings of the complaint are partially or fully upheld if they are still dissatisfied. The following is the current and ongoing complaint activity with the PHSO.

North Locality Care Group

Opened	Complaint Number	PHSO Reference	Current Status	Current Position	Trust Investigation Outcome
03.01.2018	3619	C2036693	PHSO – intention to investigate	Files and records sent back 24.01.18	Partially upheld
03.04.2018	3884	To be confirmed	PHSO – Preliminary Enquiry	Request for complaint information and copy of an incident report form 04.04.18 Information sent	Partially upheld

Central Locality Care Group

Opened	Complaint Number	PHSO Reference	Current Status	Current Update	Trust Investigation Outcome
02.08.2016	3033	262023	PHSO – intention to investigate	19.02.18 Scope of investigation revised 03.07.18 Update from the PHSO. Complainant requested a further extension until August. PHSO could not see that it was reasonable to NTW to keep matters open for another month. They did	Partially upheld

				not agree the extension request and asked complainant to confirm whether he accepts the amended scope by Friday 13 July 2018. If they do not hear from him by then they will discontinue	
26.10.2017	3776	C2027320	PHSO – intention to investigate	26.10.17 informed by PHSO of their intention to investigate	Partially upheld
07.06.2018	3539	C2045699	PHSO – request for health records	Records prepared and sent 25.06.18	Partially upheld / partially upheld

South Locality Care Group

Opened	Complaint Number	PHSO Reference	Current Status	Current Update	Trust Investigation Outcome
28.03.18	3698	C2036582	PHSO request for records	Request for patient records and complaint file 20.04.18 Information sent	Partially upheld
18.04.18	2869	C2047857	PHSO request for records	Request for patient records and complaint file by 08.05.18 04.06.18 Further info required from service and provided. PHSO to take advice and inform us whether they will be investigating	Upheld / not upheld
01.05.18	3362	C2040052	PHSO request for records	Copy of records requested and sent	Upheld / partially upheld
03.05.18	3540	C2034689	PHSO request for records	Copy of records requested and sent	Partially upheld / not upheld
11.05.18	4258	Enquiry 0673000292	PHSO preliminary enquiry	Request for confirmation that Trust formal complaint procedure completed	Partially upheld / not upheld
02.07.18	3421	To be advised	PHSO request for records	Request for copy of complaint file	Partially upheld x 3 Decision not to investigate

Claims

Claims received by Case Type

Case Type	Q1 Apr – Jun 17	Q2 Jul – Sep 17	Q3 Oct – Dec 17	Q4 Jan – Mar 18	Q1 Apr – Jul 18	Total
Claims Not Covered By NHSLA	0	0	0	0	0	0
CNST	3	3	2	2	0	10
Employers Liability	4	3	3	1	3	14
Ex-Gratia	15	20	11	11	13	70
Ex-Gratia PHSO	1	0	0	0	1	2
Public Liability	1	0	0	2	0	3
Third Party Claim	2	1	1	1	0	5
Total	**26**	**27**	**17**	**17**	**17**	**104**

Ex gratia claims predominantly make up the largest proportion of claims and the numbers have decreased over the last three quarters. Employer liability claims are the second largest group however there has been a gradual reduction in the number of employer liability claims overall but the reason for this is not clear. This will be kept under review, and we will await annual information from NHS Resolutions around the national picture of claims activity.

Claims received by Category

Category	Q1 Apr - Jun 17	Q2 Jul to Sep 17	Q3 Oct - Dec 17	Q4 Jan - Mar 18	Q1 Apr - Jun 18	Total
Accidental Injury	6	1	2	1	2	12
All. Of Failure To Provide Approp. Care	3	3	1	0	0	7
Assault On Other	0	0	1	0	0	1
Assault on Staff	1	4	2	3	1	11
Carpal Tunnel Syndrome	1	0	0	0	0	1
Damage To Patient Property (Accident)	1	2	0	0	3	6
Damage To Patient Property (Violence)	1	0	1	3	0	5
Damage To Staff Property (Accident)	0	3	1	1	1	6
Damage To Staff Property (Violence)	7	9	2	3	6	27
Expenses Incurred Due To A Trust Process	1	1	1	0	1	4
Industrial Deafness	0	0	0	1	0	1
Information Governance	0	0	0	1	0	1
Loss Of Patients Property	5	4	7	2	1	19
Missing Patient Monies	0	0	0	0	2	2
Unexpected Death	0	0	0	2	0	2
Total	**26**	**27**	**18**	**17**	**17**	**105**

The highest ex gratia claim categories are damage to staff property and loss of patient property. The damage to staff property claims relate to clothing or spectacles damaged by patients either due to assault on the staff member or damage sustained in the course of restraining a patient.

The highest employer liability categories are accidental injury and assault on staff. Accidental injury claims include slips, trips and falls and also manual handling claims.

Appendix 1

Serious Incidents Reviewed at Panel in April to June 2018

Eight serious incidents were reviewed at panel during April, six were STEIS reported deaths, two have since been categorised as natural cause deaths. There was one Under 18 admissions investigated to AAR level and STEIS reported and one natural cause death which was not STEIS reported but escalated to AAR investigation due to concerns about the titration of Lithium.
Of the seven (STEIS reportable) incidents reviewed 3 reports have gone within the 60 day timescale. Extensions were requested for 4 and they were all sent within the agreed timescale.

Learning identified from Serious Incidents and Deaths reviewed in April 2018

Documentation and Record Keeping

Four investigations highlighted issues in relation to:

Missed appointments not being documented.

Appointment letters not being recorded as sent and missed appointments not recorded and therefore not followed up.

Consent to share had not been updated since 2009.

Records not updated in a timely manner as per policy expectation.

The Administration team were part of the learning process to reflect on the above and individuals and teams were reminded of the requirements to document the above.

Family Involvement/ Getting To Know You

Two investigations highlighted issues in relation to:

This has been a finding of several previous serious incidents and a trust wide RPIW was completed January 2018.The outcome of this to have less focus on completing forms, but documenting family/carer involvement.

On this occasion in one incident the family could have been offered a greater degree of support considering the involvement they had with the patient.

In another incident the Getting To Know You was not documented to reflect support provided.

Risk Assessment

Three incidents reviewed identified learning in relation to risk assessment

One incident reviewed had learning identified about the use of 2 risk assessments, when there are two NTW services providing care and two risk assessments are being completed in isolation without collaboration and therefore identifying risk at different levels.

Identified it is best practice for one to be completed in collaboration, this has been a finding of previous investigations.

One incident identified there was no conformity in relation to completion of narrative risk assessment.

Review of an Under 18 admission found review of the adults risk assessment had not taken place to identify any potential risks posed to the under 18.

Training and policy awareness to be carried out and learning to be taken to respective learning groups.

Safeguarding

Two cases identified two different learning points in relation to Safeguarding and the support that can provide to teams in everyday practice.

The first was the lack of awareness of the general support that can be provided by the internal Safeguarding Team and when to request this and why.

The second was the consideration or lack of it raise a Safeguarding alert to concerns specific to the patient swapping prescribed medication for illicit substances.

Specific awareness raising to be carried out by the Safeguarding rep for the CBU.

To remind staff how the role of the Safeguarding Team can support and facilitate this.

Good Practice

Extremely good practice was identified during two investigations.

Medication reviews carried out in a timely manner and the patient supported to be involved in the decisions made about prescribing.

Good examples of a team/individual attempting engagement with a challenging individual who had a long history of non-engagement.

Physical Health

Three investigations identified learning points specific to recording/non recording of physical health management/monitoring of mental health patients.

This included the Nutritional Screening tool, the VTE documentation and the Alcohol Audit tool not being fully completed.

The above to be addressed individually and within team reviews to emphasise the necessity, will also be raised in the programme time to care as staff identify duplication in some areas.

Care Co-ordination

One incident reviewed identified an issue relating to care co-ordination, this was in relation to the Under 18 Admission the community team didn't follow policy to allocate a Care Co-ordinator following admission.

This is to be addressed as part of the policy review and links to the previous months learning re policy review and the lack of clarity re the Responsible Clinician.

Lithium Prescribing and Monitoring

This was a “natural cause” death referred to the Coroner due to initial concerns re lithium toxicity. Several learning points were identified including the PGN Safer Lithium Therapy, this is to be reviewed for further clarity. For example the policy indicates that lithium monitoring can be reduced to 3 monthly once stable, however doesn’t define stable.

Clarity and agreement on shared care prescribing and the inpatients teams understanding of Shared Care.

The recording of monitoring using the appropriate from.

Understanding and use of the two sections of a discharge summary which potentially can lead to confusion i.e. the investigation section v advice, recommendation and future plan section.

All the above actions have been identified within an action plan to be addressed.

Mortality Reviews of Natural Cause Deaths-April

Six natural cause deaths of patients on CPA were reviewed in April the average age of the patient being 83.

The learning points to come out focused on if a dementia diagnosis is present we would expect to see the rationale for prescribing anti-psychotics should be documented, no documented evidence of arrangements for physical health monitoring specifically in relation to prescribing of anti – psychotic medication.

An article to be placed in the Safer Care Bulletin and individuals/teams reminded of this.
The other learning points / incidental findings of the reviews related to documentation and risk assessment, the Braden risk assessment was not completed for someone with identified red areas of skin and a falls risk assessment underscoring risk.

Serious Incidents Reviewed at Panel in May 2018

Ten incidents were reviewed at panel during April, all ten were STEIS reported. There were five unexpected deaths, one homicide and one serious self-harm. There was one Under 18 admissions and two fractured femurs investigated to AAR level.Of the ten (STEIS reportable) incidents reviewed 7 reports have gone or will go within the 60 day timescale. Extensions were requested for 3 and they were all sent /will be sent within the agreed timescale.

Learning identified from Serious Incidents and Deaths reviewed in May 2018

Documentation and Record Keeping

Five investigations highlighted issues in relation to:

One investigation highlighted the lateness of discharge summaries being sent out by two months, the alcohol audit being out of date and the care plan being out of date.

One investigation identified records not being validated for 23 days.

Three investigations identified record keeping standards not meeting required standards.

Individual supervision and team meetings to address and discuss the above and the expected trust standards.

Family Involvement/ Getting To Know You

One investigation highlighted this had not been completed.

The trust has invested a lot of time in this process carrying out an RPIW, to ensure that the new ways of addressing/involving families and evidencing practice is embedded within teams.

Risk Assessment/ Risk Management

Seven incidents highlighted issues and learning relating to Risk Assessment.

One incident reviewed had learning identified about the use of 2 risk assessments, when there are two NTW services providing care and two risk assessments are being completed in isolation without collaboration and therefore identifying risk at different levels. This has been identified in several SI's and is to be looked at from a thematic perspective.

One incident identified risk assessment had not been reviewed at the point of discharge.

One incident identified that there was a considerable amount of historical risk missing from the risk assessment.

Two incidents had risk assessment not fully completed, both these incidents related to the falls risk assessment when reviewing the fractured femur incidents.

Two incidents found that increasing clinical risk had not been considered a trigger to update the Face Risk Assessment.

Three incidents found that a change of risk had not been reflected within the risk assessment/documentation.

The use of two risk assessments to be reviewed thematically via the Learning and Improvement group.

Individual supervision, reflection and team briefs carried out. Learning to be discussed in respect

Training and policy awareness to be carried out and learning to be taken to respective learning groups within CBU's.

Safeguarding

Two cases identified two different learning points in relation to Safeguarding and the support it can provide to teams in everyday practice.

The practice of raising Safeguarding alerts when there has been a specific incident to inform and the support that can follow this. This was identified in two cases.

The process of obtaining forensic history from the police /probation via the Safeguarding route not fully understood in one case.

Specific awareness raising to be carried out by the Safeguarding rep for the team as part of their local induction/training programme.

To remind staff how the role of the Safeguarding Team can support and facilitate this.

Good Practice

Extremely good practice was identified during three investigations.

Good examples of a team/individual attempting engagement with a challenging individual who had a long history of non-engagement with a persistent but collaborative approach.

Good prescribing practices in relation to Methadone and providing bereavement support to a partner.

Maintaining the same Care Co-ordinator to provide continuity.

Care Co-ordination

Two incidents identified areas for reflection.

One the wrong level of CC was documented although the team were providing the appropriate level of care.

CC reviews were not being carried out in line with policy requirements.

Communication

Three incidents reviewed found issues relating to communication which was not of the expected standard

One related to external communication with the GP, not updating re plans.

Two relating to internal communication between teams and information relating to appointments and failure to action an internal referral.

All of the above have been discussed and reflected on in individual supervision and team level for learning.

Incident Reporting

One review highlighted the lack of reporting incidents on an in-patient unit relating to self- harm.

Discussed the importance of what this information can provide in relation to care and treatment and reporting expectations as per trust policies.

Daily Reviews

The review of one case highlighted the Daily Review Process and that the discussions had not being reflected in the patients care record.

Reflections with the team of the importance of this to avoid plans not being carried out as discussed.

Clustering

One incident highlighted clustering had not been carried out on admission or discharge.

This appeared to have been an oversight; however there have been previously identified the lack of training in relation to clustering.

Observations

One incident occurred following a change to the agreed observation care plan.

This incident highlighted that a care plan was not followed and an individual made this decision uni-laterally. This is being picked up by the CBU.

Mortality Reviews of Natural Cause Deaths - May

Nine natural cause deaths of patients on CPA were reviewed in May the average age of the patient being 62 compared to last month's review the average age being 83.

The learning points to come out focused on if a dementia diagnosis is present we would expect to see the rationale for prescribing anti-psychotics to be documented, no documented evidence of arrangements for physical health monitoring specifically in relation to prescribing of anti –psychotic medication. This learning point was also found in the previous mortality cases reviewed.

An article has been prepared for the June Safer Care Bulletin, and individuals/teams reminded of this.

The other learning points / incidental findings of the reviews related to documentation re risk assessment and Care Co-ordination.

One incident flagged up the patient hadn't been seen at 7 day follow up or for four weeks post this.

Physical health issues weren't identified within the risk assessment.

Consideration should have been given to a VTE assessment when admitted to the acute ward (psychiatry).

Not considering obesity as a risk factor for physical health

Alcohol AUDIT not completed in one case when indicated.

General documentation issues and a lack of health care planning.

These were incidental findings and very individual, however will be fed back to the teams for learning and reflection.

Serious Incidents Reviewed at Panel in June 2018

Ten incidents were reviewed at panel during June, eight were STEIS reported. All ten incidents were unexpected deaths. Of the eight (STEIS reportable) incidents reviewed all reports have gone or will go within the 60 day timescale

Learning identified from Serious Incidents and Deaths reviewed in June 2018

Documentation and Record Keeping

Nine investigations highlighted issues in relation to:

Most of the incidental findings related to core documentation not being completed in a timely manner or at all as per policy and falling below expected record keeping standards.

Noted in several investigations that there wasn't a recording of a clear rationale for clinical decision making and in one specific case the Mental Health Act assessment documentation not reflecting the full assessment.

Also the lack of update in relation to consent and patients change of address.

Individual supervision and team meetings to address and discuss the above and the expected trust standards.

Risk Assessment and Risk Management

Four incidents highlighted issues and learning relating to Risk Assessment.

One incident reviewed had learning identified about the use of 2 risk assessments, when there are two NTW services providing care and two risk assessments are being completed in isolation without collaboration and therefore identifying risk at different levels. This has been identified in several SI's and is to be looked at from a thematic perspective.

One incident identified the lack of accuracy in relation to risk assessment and the level of risk presented.

One incident identified a lack of a contingency risk assessment when aware of the potential for not engaging.

One incident found that a change of risk had not been reflected/updated within the risk assessment/documentation, therefore affecting the risk management and contingency plan.

The use of two risk assessments to be reviewed thematically via the Learning and Improvement group.

Individual supervision, reflection and team briefs carried out.

Training and policy awareness to be carried out and learning to be taken to respective learning groups within CBU's.

Communication

Four incidents reviewed found issues relating to communication which was not of the expected standard
Two related to external communication with the GP, not updating re plans for discharge and updates.

Two relating to internal communication between teams and information relating to appointments.

All of the above have been discussed and reflected on in individual supervision and team level for learning.

Good Practice

Good practice was identified during one investigation. This was in relation to policy adherence, and providing appropriate treatment for optimal relief and communication with the GP.

Care Co-ordination

One incident identified areas for reflection.

This was in relation to the use of generic care plans and was being addressed in supervision and across the team.

Access to Rio

One incident identified that due to lack of access on one specific day the patient had to return again for another unscheduled appointment.

The team were to recirculate their business continuity document which provides guidance should such an event occur.

Duty of Candour

One incident identified this hadn't been carried out as per trust guidance.

To discuss in team meetings the trust expectation and support available if required.

Clustering

One incident highlighted clustering had not been carried out appropriately.

This has been raised in previous investigations due to unavailability of training. Training to be implemented in the CBU's via cascade.

Mortality Reviews of Natural Cause Deaths- June

Five natural cause deaths of patients on CPA were reviewed in June the average age of the patient being 84 compared to last month's review the average age being 62.

The learning points to come out focused on two cases as three of the cases reviewed had no core learning identified.

The learning points / incidental findings of the reviews related to documentation re risk assessment and Care Co-ordination.

One incident flagged up no VTE assessment had been undertaken when an in-patient.

Consideration should have been given to a VTE assessment when admitted to the acute ward (psychiatry).

No evidence of the Braden Scale being completed.

No review of CPA status undertaken.

No evidence of the arrangements in place for physical health monitoring following discharge.

The second incident identified physical health monitoring forms were not completed and the falls risk assessment was not re-visited.

These were incidental findings and very individual, however will be fed back to the teams for learning and reflection

Appendix 2

Learning From All Deaths Dashboard - Within Mental Health and Learning Disability Services

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths. Working with eight other mental health trusts in the north of England we have developed a reporting dashboard that brings together important information that will help us to do that. We will continue to develop this over time, for example by looking into some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur. We have decided not
to initially report on what are described in general hospital services as “avoidable deaths” in inpatient services. This is because there is currently no research base on this for mental health services and no consistent accepted basis for calculating this data. We also consider that an approach that is restricted to inpatient services would give a misleading picture of a service that is predominately community focused. We will review this decision not later than April 2018 and will continue to support work to develop our data and general understanding of the issues.

Learning From Deaths Dashboard – Quarter 1 – April - June 2018

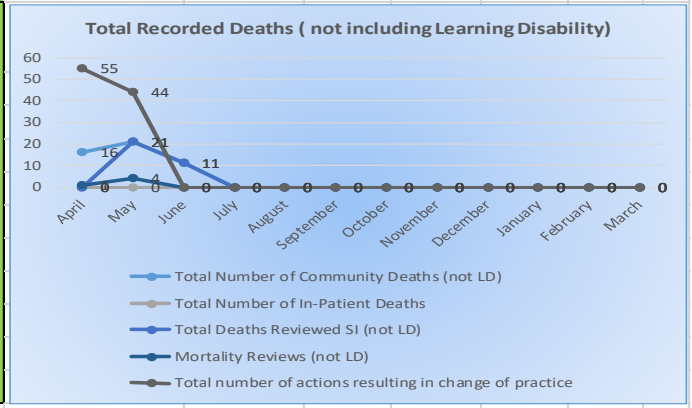
Learning from Deaths Dashboard - Data Taken from Trust's Risk Management System Reporting Period - Quarter 1- April 2018 - June 2018

NHS Northumberland, Tyne and Wear NHS Foundation Trust

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

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

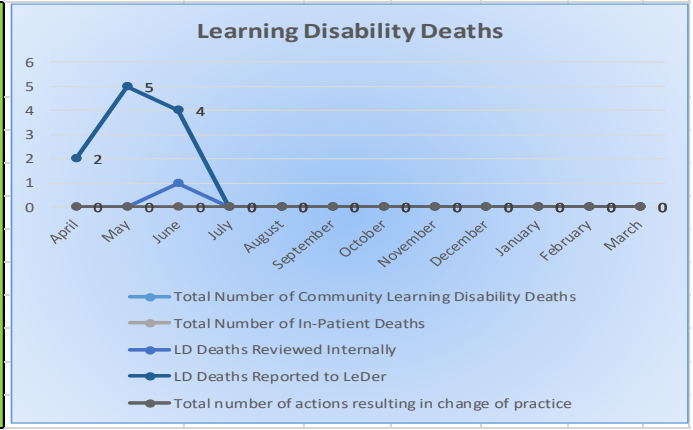
Total Number of Deaths Reported	Total Number of Community Deaths	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework	Total number of deaths subject to Mortality Review	Total number of actions resulting in change of practice
Q1	Q1	Q1	Q1	Q1	Q1
269	**48**	**0**	**32**	**5**	**99**
Q2	Q2	Q2	Q2	Q2	Q2
0	**0**	**0**	**0**	**0**	**0**
Q3	Q3	Q3	Q3	Q3	Q3
0	**0**	**0**	**0**	**0**	**0**
Q4	Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD	YTD
269	**48**	**0**	**32**	**5**	**99**



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

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

Total Number of Learning Disability Deaths Reported	Total Number of Community Learning Disability Deaths	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework or Subject to Mortality Review	Total number of deaths reported through LeDer (All Deaths Reported)	Total number of actions resulting in change of practice
Q1	Q1	Q1	Q1	Q1	Q1
10	**11**	**0**	**1**	**11**	**0**
Q2	Q2	Q2	Q2	Q2	Q2
0	**0**	**0**	**0**	**0**	**0**
Q3	Q3	Q3	Q3	Q3	Q3
0	**0**	**0**	**0**	**0**	**0**
Q4	Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD	YTD
10	**11**	**0**	**1**	**11**	**0**



NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST

Board Report

Meeting Date: 25th July 2018

Title and Author of Paper: Safer Staffing Quarter 1 Report, including Six Month Skill Mix Review Update
Jackie King, Clinical Nurse Manager, and Anne Moore, Group Nurse Director, Safer Care

Executive Lead: Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

Paper for Debate, Decision or Information: Information

Key Points to Note:
The report includes exception data and analysis of all ward staffing against Safer Staffing levels for Quarter 1.

The report highlights exceptions to Safer Staffing from each Locality Care Group. Exceptions will include wards that have exceeded their planned staffing levels and wards who have fallen below planned staffing levels.

The report also includes current levels of bank and agency usage for inpatient wards.

Wards which experienced staffing pressures were able to maintain safe patient care through use of roster management and the staffing escalation procedure.

There were no instances of harm attributed to safer staffing levels.

As part of the ongoing Skill Mix Review the care groups are currently developing their three year locality workforce plans.

Risks Highlighted to Committee: None

Does this affect any Board Assurance Framework/Corporate Risks?: No
Please state Yes or No
If Yes please outline

Equal Opportunities, Legal and Other Implications: N/A

Outcome Required: The Board of Directors are to note the content of the report.

Link to Policies and Strategies:
Safer Staffing
Carter 90 day Rapid Improvement Review

Background

In line with the National Quality Board Guidance issued in November 2013, and in order to assist provider organisations to fulfil their commitments as outlined in Hard Truths (now known as Safer Staffing) the Government made a number of commitments to make this information more publically available. The Trust continues to comply with the requirements of safer staffing.

The commitments were:

- To publish staffing data from April 2014
- A Board report describing the staffing capacity and capability, following an establishment review, using evidence based tools where possible. To be presented to the Board every six months
- Information about the nurses, midwives and care staff deployed for each shift compared to what has been planned and this is to be displayed at ward level
- A Trust Board report is made available containing details of planned and actual staffing on a shift by shift basis at ward level for the previous months. To be presented to the Trust Board every three months
- The quarterly report must also be published on the Trust's website, and Trusts will be expected to link or upload the report to the relevant hospital(s) web page on NHS Choices.

NTW has adopted a robust application of the guidance including;

- An agreed methodology is in place incorporating both the electronic and paper rostering systems to gather the staffing information in a systematic manner
- RAG system is in place to alert Group Nurse Directors of any wards that have deviated from the agreed staffing levels
- Ward Managers report on a weekly basis highlighting any variance and reasons why on the planned staffing for their ward
- An escalation process is in place for both in hours and out of hours including on-call mechanisms
- The information is collated to support analysis of ward staffing
- A Clinical Nurse Manager who oversees the process and escalates as required to service and director leads
- Safer staffing is discussed and monitored at ward/service group and key Trust wide meetings.

The Care Quality Commission (CQC) will seek compliance with all the actions as part of their inspection regime and NHS Improvement will act where the CQC identifies any deficiencies in staffing levels in Foundation Trusts.

Quarter 1 update

South CBU

- **Rose Lodge**
  The ward is operating above the planned staffing numbers for all unqualified staff. This is due to the high acuity of the current patient group. The senior team are working with Local Commissioners to review the staffing levels on the unit considering the changes in case mix.

- **Ward 1, Walkergate Park Hospital**
  Ward 1 is operating below the planned staffing numbers due to both qualified and unqualified vacancies and sickness. The management team are currently reviewing staffing levels across sub ward 1a and 1b to deliver a more effective use of staff. Newly qualified staff have been recruited following Campaign 23, and will be in post by October 2018

- **Bridgewell**
  The ward is operating over the planned staffing numbers for all staffing, with the exception of qualified staff on night duty this is due to increased observation for a sustained period.

- **Clearbrook**
  The ward is over planned staffing numbers for unqualified staff on both days and nights which is due to increased acuity of the current patient group requiring escort for general hospital stays and increased observation.

- **Walkergate Park**
  Wards 3 and 4 at Walkergate continue to have qualified staffing recruitment issues and has a rolling advert out with recruitment however there is a small increase in the qualified staff coverage in April May and June.

- **Beadnell** *(mother and baby unit)*
  The ward in under its planned staffing level due to the number of patients on the ward and on leave. This is not unusual for this ward and the manager plans with her staff to utilise annual leave during the periods of reduced occupancy

North CBU

- **Lennox**
  There has been an increase in individual care packages for 2 patients with additional care needs requiring additional staff. This is in full agreement with commissioner's occupancy which has released staff to work across the service on other wards who have vacancies or absences.

- **Newton**
  The ward is operating below the planned staffing numbers due to qualified vacancies and the change in activity levels of the patients. This has resulted in increases to the number of unqualified on day duty and reduced on night duty.

- **Woodhorn**
  There are a number of qualified vacancies which are being filled with experienced unqualified staff and increased acuity of the current patient group. In line with The Carter actions, this ward has been supported with qualified staff from the other wards in St Georges Park.

- **Warkworth**
  The ward is utilising increased staffing levels due to increased acuity of the patient group and levels of observations.

Central CBU

- **Fellside**
  The ward is operating above the planned staffing numbers for all unqualified staff. There has been an increase in the acuity levels of the patient due to increased eyesight observations.

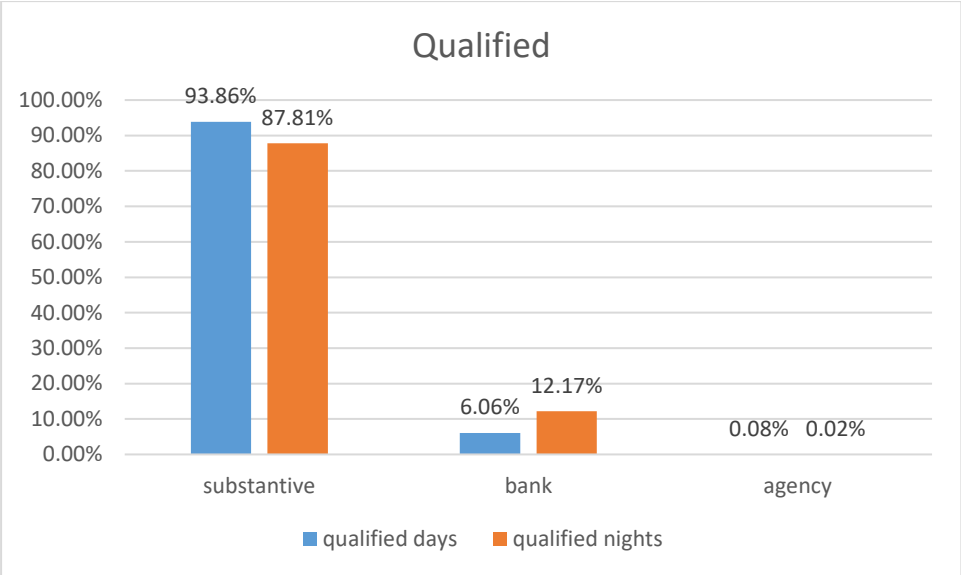
- **Willow View**
  The ward is operating below the planned staffing numbers. The ward has reduced the number of unqualified staff on night duty and increased on day duty to maximise the therapeutic interactions, whilst maintaining ward safety.

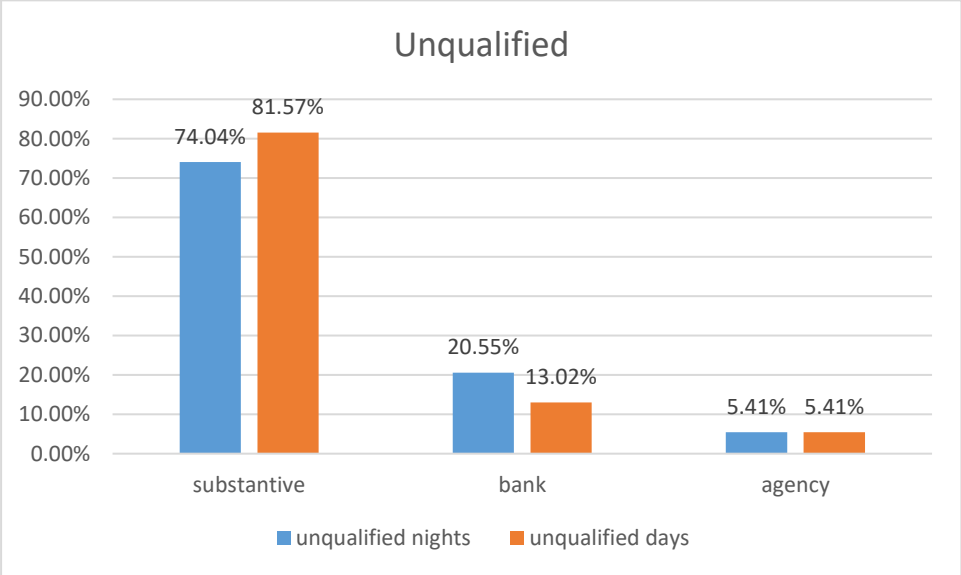
- **Collingwood**
  There has been a temporary increase in the unqualified staff which has not as yet been reflected in the planned figures and has resulted in the ward being over the planned staffing. As part of the financial review it was decided by the group to increase the unqualified staffing numbers as a trial to reduce bank and agency usage.

- **Wansbeck**
  The ward has a number of qualified staff vacancies and long term sickness which is being supported with experienced unqualified staff filling the shortfall and support from the other wards in the KDU.

Bank and Agency and Fill Rates

There has been minimal change in the bank and agency usage for inpatient wards during this quarter.





Strategic staffing group

The strategic staffing meet monthly to discuss the key issue for the delivery of safe, sustainable and productive staffing. All locality care groups are represented and regular review of bank and agency use across the Trust as a whole are a key part of the plans and discussions.

Values Based Central recruitment

This group meets on a weekly basis and have moved to a monthly recruitment schedule to enable fluid movement of vacancies identified to appointment. Values Based Central Recruitment campaigns 22/23 have recently concluded and processing and clearances are underway for successful qualified nursing candidates.

There are approximately in excess of 70 students who have been successful and offered posts and will join the organisation as Newly Qualifies Staff Nurses. We will not see a change in the qualified staffing levels until these staff are in post in September 2018. The wards who are awaiting these staff are utilising experienced support staff to supplement this shortfall although no ward has been without a qualified nurse on duty.

Six Monthly Skill Mix Review

There are no significant developments of note since the last update to the Board in February 2018.

The Care Groups are in the process of developing their respective three year workforce plans which will be incorporated in the Safer Staffing / Skill Mix Review update scheduled to come to Board in January 2019.

Conclusion

The Board of Directors are asked to recognise the work which is underway and the impact that this has made. Much cross Trust collaboration is now being undertaken to use the learning from this work to inform developments and action planning in relation to the challenges associated with ongoing staffing and recruitment.

NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING

Meeting Date:	25th July 2018

Title and Author of Paper:	Six Monthly Visit Feedback Themes January 2018 to June 2018 Johanne Wiseman, PA to Executive Director of Nursing and Chief Operating Officer, and Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

Executive Lead:	Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

Paper for Debate, Decision or Information:	Information

Key Points to Note:

To provide an update to the Board of Directors on visit reports that have been received from Senior Managers for the period January to June 2018. A list of all areas visited is available at appendix 1 and copies of individual reports are available by contacting Johanne Wiseman, PA to Gary O'Hare.

Key themes and issues arising from the visits include:

- The team is based in an outdated, cramped building, on the Sunderland Royal Hospital site, which stands in marked contract with the many new and refurbished departments nearby. It is not fit for purpose and relocation to better on-site accommodation would not only boost morale but would, more appropriately, represent recognition by the Acute Trust for their important and highly valued work.

- The environment can be very cold in winter, however whilst this issue has been raised with the site landlords (NuTH Trust) no solutions have been found as yet.

- Unit is clean, tidy and highly organised.

- Ward is divided into two units and is currently undergoing a process of integrating the two wards into a single unit, which involves the removal of two locked doors between the units.

- The environment is a little dated, but with a great deal of activity / therapy and engagement options such as a sports hall and gym.

- There were problems with medical consultant cover over the Christmas, and other holidays, which has led to delays for patients and wasted time for team members.

- Challenges are being faced in relation to medical workforce shortages and the team have identified the need for a clinical pharmacist to join the MDT to support medication reviews and increase independent prescribing capacity.

- Effective succession planning is important ahead of the retirement of the team's most experienced staff within the next five years.

- Staff members were positive and enthusiastic about their roles and how they are supported by management.

- Although clearly busy, the staff were helpful and engaging, and clearly highly committed to their work.

- The main issue for the team is the difficulty in recruiting suitable admin cover via the central recruitment process (having previously received two unsuitable staff members via this route). It is felt that the complexities of the role, including activities such as understanding clinical trials and blinding procedures, would be better suited to a more targeted recruitment campaign.

- Whilst there is a quiet area for the young people to see their visitors, on rare occasions if there are a number of visitors at the same time then some visits may need to take place in the young person's room.

- Calm atmosphere with plenty of facilities, including: activities and recreation centre; art room; café; educational and IT suite; flower meadow; group rooms; interview rooms; listening posts, providing young people's poetry; and meeting rooms.

- A fantastic team, incredibly enthusiastic about the service they provide working across the NTW and TEWV footprint, however they expressed the challenges they face in relation to meeting the needs of a significant geographical area down to Yorkshire and concerns around national funding split based on population rather than demand.

- Working across the two organisations the team were able to express areas of good practice and improvements we could learn from, however one of the things the team are keen to resolve is the issue to PARIS (which is TEWV's clinical information system), but this is being taken forward jointly across the two trusts.

- Service is currently open two days per week but there is potential to return to opening more days per week.

- The loss of digital dictation is seen as a serious error which has led to increased waste and staff dissatisfaction and there is a need to reconsider digital dictation availability.

- There are multiple compliments and thank you cards in evidence on the unit with frequent reports in the bulletin.

- An impressive team, highly skilled and a credit to our organisation.

- Dealing with a complex range of issues, the new data protection regulations to be implemented during 2018 are going to add further to their workload and complexity of the tasks.

- The team provide an ageless service and received over 4000 referrals in 2016/2017 and the average response time for patients being seen in the emergency department is 40 minutes (97% within target).

- The team score highly in service user and carer satisfaction surveys, and their work is highly regarded and valued by ED colleagues.

- High functioning, progressive service which clearly has service development, improvement and innovation as its core strategy.

- A high quality, tertiary care service which is highly regarded and generates an operating surplus for the organisation. Even though the cost of care provided is relatively high, it is recognised by commissioners as representing good value as it has been shown to reduce costs in the longer term.

- Makes significant use of technology (Skype, surface hub, etc.) to maintain contact with families living at distance, commissioners and other providers.

- No major day to day problems but there is concern with regard to future funding as block contracts for inpatient services may be withdrawn.

- There is concern that the service could be used with significant benefit earlier in patient journeys and that better outcomes are being missed.

- The service has many ideas on how to expand and develop which could be explored with benefit, as well as offering their highly specialised expertise more widely as this is only one of three centres in the UK.

- Service has existed with no change for many years, providing a high level of support for a very small number of people with a high level of need. There have been very few Director visits to the service and there is a sense that there is little understanding of their work at very senior levels of NTW.

- A busy range of diverse clinics on different days led by a range of professionals and supported by specialised highly trained nurses.

- The main issues for the team are external – they feel bed closures across the system due to Transforming Care have created extra pressures for the highly specialised beds in the KDU.

- Aware of some discussion around a new infrastructure planning / moves which may affect them in the future, whilst creating some uncertainty staff feel that they are kept informed by their management structure.

- Withdrawal of digital dictation has been seen as a major limitation and there is a high level of frustration and significant dissatisfaction with M Modal.

- Problems with finding parking places, by both staff and patients, has resulted in a number of missed appointments over the last six months as people could not get parked.

- There have been problems with late cancellation of assessment appointments, together with a number of DNA events.
- The number of people on the waiting list for treatment has reduced over previous months, currently there are 110 people on the waiting list, however the waiting time from assessment to treatment has reduced from 18 months to 7 months.
- Service users and clients were positive about staff – especially Support Worker Carl.
- Very committed and caring staff supporting some service users with complex and enduring needs. Good feel to the ward
- True multidisciplinary working with significant focus on activities of daily living through the occupational therapist and psychological sessions, Police liaison identified as highly effective with good working relationships with the officer.
- Smoking ban has presented some challenges, which have been managed to the best of the staffs' abilities.
- Delayed discharges occasionally cause problems in patient pathway flows.
- Highly specialised service dealing with very complex cases in an innovative way, including magnetic resonance.
- Wonderful service, atmosphere and culture, deeply caring and focused on recovery.
- Superb department with excellent staff, leadership and innovation.
- Great service, great staff, great leadership, enthusiastic and hardworking team.
- Remarkable service with highly complex cases. An excellent MDT retaining enthusiasm and commitment effective of change. An example to us all of how to maintain excellent service user focus throughout difficult change.
- Services are accessed by a locality single point of access and all referrals are triaged by a local duty team made up of senior clinicians. Team plan to continue working with commissioners and partners on the improvement and development of the wider emotional health and wellbeing patient for young people via the relevant strategic groups (to target longest waiters for service whilst meeting demand for urgent appointments, improving patient throughput and reducing stays whilst improving service productivity and efficiency by increasing direct patient contact).
- Issues raised regarding RiO and the impact this has on teams.
- Overall a very positive place to work and the team are meeting with the Locality Senior Management Team to discuss the history of the development of CYPS; issues; and potential solutions in more detail.
- Friendly and welcoming environment, all staff enthusiastic about jobs, both clinical and admin.

- Enjoyed an hour on my own listening and talking with three service users.

- Positive comments from service users, apart from one comment around smoking where I was passed a petition from a service user challenging our policy. Helpful to have an update on where we are at with the rollout of vapes.

- Very positive visit and really encouraged to see the improvements made specifically in relation to access to computers for service users.

- Ward manager highlighted where further improvements could be made and I committed to following this up with Estates.

- Staff were kind, caring and enthusiastic about the service.

- A pleasant visit, ward clean, tidy and fully occupied. Discussed nursing strategy and ongoing plans for Secure Services related to TCA and NCM.

- Step up provision / alternative to admission is an ongoing challenge for the team. Step up can be provided internally either within individual pathways or wider provided by the whole staff LDCTT team, and whilst it is in the team's remit / objectives to provide such provision there is currently no accommodation available. This has been an ongoing unmet need for the last five years plus, however it is on the agenda for discussion at the Local Implementation Group which includes membership from the CCG, NTW and Local Authority.

- Sunderland CCG have recently confirmed that they are looking to develop a pathway for individuals with Autism without a learning disability in Sunderland. Current provision is provided by the ASD Diagnostic Service however there are no identified pathways for this group of individuals and this may result in them falling through services.

- The team is not currently commissioned to provide a service / pathway to individuals with forensic needs / offending behaviour without an additional health need, however with the transforming care bed reduction pressures the numbers of beds in the community are reducing and the number of individuals living in the community increasing. Work needs to be completed to identify an appropriate pathway and identify appropriate provision.

- It was apparent from discussions that service users and carers are very much included in the process of both assessment and intervention. Points of View questionnaires were available on a table with other magazines and leaflets, however it was suggested that it would be useful to have these at the reception area where people could be offered the opportunity to complete these. A subsequent call has confirmed that this is now in place.

- The team are currently going through a local review to look at how they provide the service and new ways of working / staffing. The staff present were very positive about this and advised that they felt very much included and part of the process.

- The team raised concerns about how they are perceived as having lighter workloads than other teams (currently have approximately 15 per WTE). Whilst acknowledging that caseloads have been higher whilst working in other teams, they explained that the assessment process for patients within this team are often timely and complex. Discussion took place with regard to how to address this perception and one of the suggestions was in relation to opportunities for people to spend time in other teams.

- It would be useful to have informal local programmes / opportunities where staff are offered the chance to shadow a team for a session to observe other environments and practice to give an insight into other services, what they offer and how they work. Another possibility would be to do awareness work around 'a day in the life of …..' which could go into the bulletin, onto the web site and possibly be sent to partner agencies and the 3rd sector. This would provide a snap shot of what teams provide, and promote a better understanding about different services.

- Spoke to a number of service users and staff about what matters most to them and it was clear that having local services in the community was really important to them. It was evident that attending the day hospital is an important part of their therapy and recovery.

- Service users were very complimentary about the staff and there was a real connection between them.

- Although in need of some refurbishment the unit was very pleasant and the cups of tea and refreshments were very welcomed by the service users.

Risks Highlighted to Board : None

Does this affect any Board Assurance Framework/Corporate Risks? No
Please state Yes or No
If Yes please outline

Equal Opportunities, Legal and Other Implications: None

Outcome required: Board of Directors are asked to receive this report for information.

Link to Policies and Strategies: Staff and patient engagement

APPENDIX 1

Name of Service	Date	Senior Manager
Redburn & PICU, Ferndene	3rd January 2018	Jackie Jollands
Veterans Service	5th January 2018	Lisa Quinn
Bamburgh Clinic	11th January 2018	Tim Docking
Ingram Ward, Northgate	17th January 2018	Tim Donaldson
Jane Palmer Day Unit	29th January 2018	Carole Kaplan
Newcastle North Older Peoples Community Mental Health Team	30th January 2018	Tim Donaldson
Medico Legal & Information Governance	1st February 2018	Rajesh Nadkarni
Sunderland Psychiatric Liaison Team	5th February 2018	Tim Donaldson
Pharmacy, St Nicholas Hospital	7th February 2018	Rajesh Nadkarni
Neuro Outpatients, Walkergate Park	8th February 2018	Simon Douglas
Ward 1a / b, Walkergate Park	8th February 2018	Simon Douglas
Regional Affective Disorders Service	15th February 2018	Carole Kaplan
Cheviot Day Unit	8th March 2018	Simon Douglas
Longview, Hopewood Park	15th March 2018	Rajesh Nadkarni
Gibside, St Nicholas Hospital	16th March 2018	Ken Jarrold
Willow View, St Nicholas Hospital	16th March 2018	Ken Jarrold
Pharmacy Department, St Nicholas Hospital	16th March 2018	Ken Jarrold

Name of Service	Date	Senior Manager
Older Peoples Wards, Monkwearmouth	22nd March 2018	Ken Jarrold
Specialist Children's Service, Ferndene	23rd March 2018	Ken Jarrold
Intensive Support Team, Monkwearmouth	26th March 2018	Carole Kaplan
Sunderland North Team, Monkwearmouth	26th March 2018	Carole Kaplan
Complex Neurodevelopmental Disorders Service, Walkergate Park	29th March 2018	Simon Douglas
CYPS Community, South of Tyne, Monkwearmouth Hospital	10th April 2018	Jonathan Richardson
Drug and Alcohol Service, Plummer Court	26th April 2018	John Lawlor
Aldervale Inpatient Unit, Hopewood Park	30th April 2018	John Lawlor
Jane Palmer Day Hospital	30th April 2018	Sarah Rushbrooke
Aidan Ward, Bamburgh Clinic	23rd May 2018	David Muir
Alnwood, Ashby Ward	12th June 2018	Lisa Quinn
Learning Disability Service, Monkwearmouth	12th June 2018	Jackie Jollands
Challenging Behaviour Team, Monkwearmouth	12th June 2018	Jackie Jollands

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 16th July 2018

Title and Author of Paper: Service User and Carer Experience Summary Report - Quarter 1 2018/19 Anna Foster, Deputy Director of Commissioning & Quality Assurance

Executive Lead: Lisa Quinn, Executive Director of Commissioning & Quality Assurance

Paper for Debate, Decision or Information: Information

Key Points to Note:

- The overall Friends and Family Test average recommend score for Quarter 1 was 88%, a slight decrease on the previous quarter's score of 89%.
- 1,992 service users and carers have provided feedback during Quarter 1 2018-19, which is a 13% increase compared with the previous quarter. Service users provided 70% of feedback and 30% was from carers.
- Compared to the previous quarter, there is little change in scores with higher scores on questions regarding staff being kind and caring (question 2) and being helped to feel safe (question 8) – with most core services scoring 9 or above out of 10. The question which showed the lowest score (8.4) is the time we spend with the service user or carer. Compared to the previous quarter, there is little change in scores.
- Comments received remain mostly positive in line with previous quarters.
- During the period there were 15 comments posted on NHS Choices, Care Opinion & Healthwatch.

Risks Highlighted: n/a

Does this affect any Board Assurance Framework/Corporate Risks: No

Equal Opportunities, Legal and Other Implications: n/a

Outcome required: for information

Link to Policies and Strategies: n/a

Service User and Carer Experience
Quarter 1 2018/19 Update

1. Purpose and Background

To present a summary of the Quarter 1 2018/19 service user and carer experience feedback received across the Trust.

The Trust is committed to improve the quality of services by using experience feedback to understand what matters the most to our service users and carers. The information included in this paper outlines the Quarter 1 position on the following:

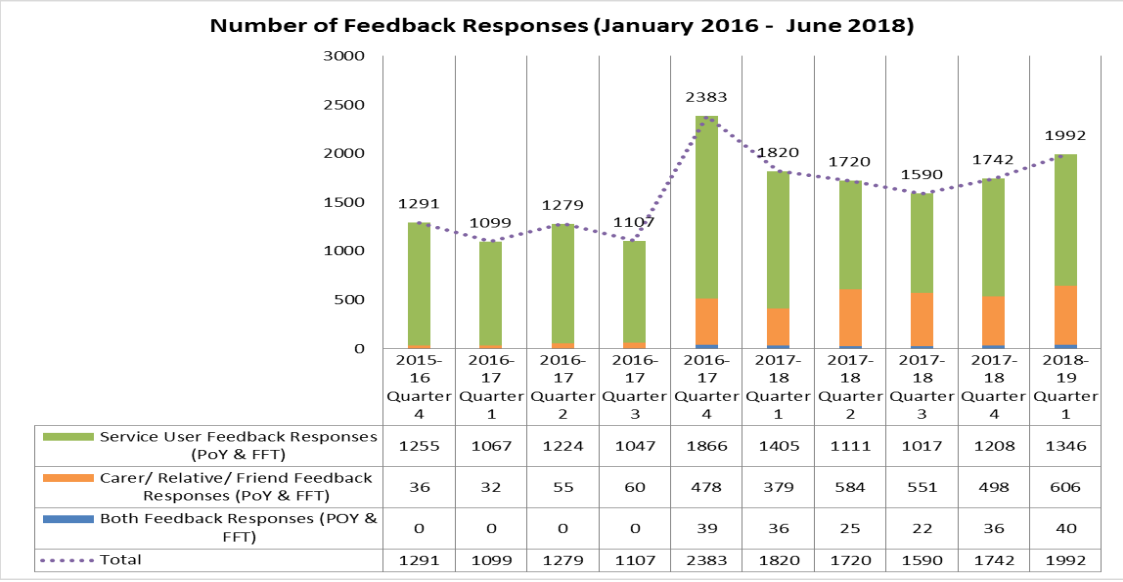
- Friends and Family Test
- Points of You (Service User & Carer) (& Gender Dysphoria Survey)
- NHS Choices/ Care Opinion / Healthwatch
- Compliments

3. What did our Service Users and Carers tell us in the period April – June 2018?

Nearly **2,000** service users and carers provided feedback on their experience with the Trust during the period.

Experience feedback is shared with clinical and operational teams via locality Group Quality Standards meetings and via a near real time dashboard.

Figure 1: Total number of service users and carer experience responses since January 2016 – 2017/18



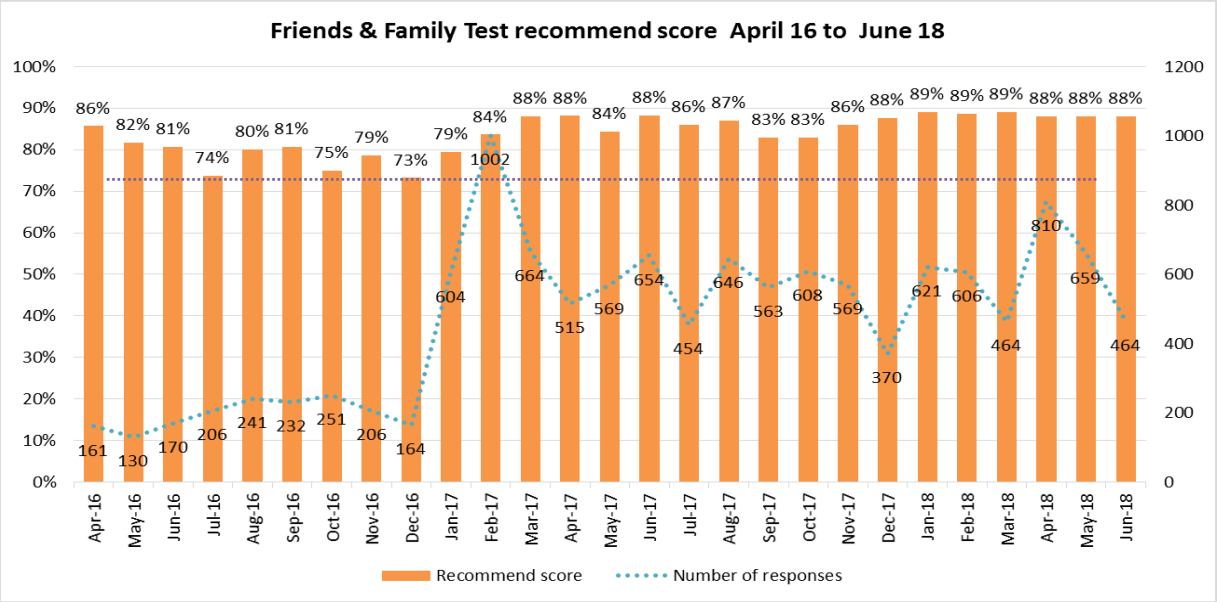
	2015-16 Quarter 4	2016-17 Quarter 1	2016-17 Quarter 2	2016-17 Quarter 3	2016-17 Quarter 4	2017-18 Quarter 1	2017-18 Quarter 2	2017-18 Quarter 3	2017-18 Quarter 4	2018-19 Quarter 1
Service User Feedback Responses (PoY & FFT)	1255	1067	1224	1047	1866	1405	1111	1017	1208	1346
Carer/ Relative/ Friend Feedback Responses (PoY & FFT)	36	32	55	60	478	379	584	551	498	606
Both Feedback Responses (POY & FFT)	0	0	0	0	39	36	25	22	36	40
Total	1291	1099	1279	1107	2383	1820	1720	1590	1742	1992

4. NHS Friend & Family Test Q1 2018/19

The Points of You survey includes the Friends and Family Test (FFT) question which asks respondents to rate the likelihood they would recommend the service they have received to family or friends. Scoring ranges from extremely likely to extremely unlikely.

The Trust's overall average recommend score for Quarter 1 has slightly decreased to 88%, (89% in quarter 4). The recommend score is broadly in line with the most recent published average for providers of mental health services, which was 89% in April 18 (published 7th June 18).

Figure 2: Friends & Family Test responses and recommend score Q1 16/17 to Q1 18/19. (NB the national average recommend score resides around 88%/89% – indicated by the purple dotted line)



Friends and Family Test (Points of You question 1) by Locality

	Number of Responses Qtr1 18/19 (Qtr4 17/18)	% would recommend
Trust	1933	88%
	(1680)	(89%)
North Locality Care Group	462	85%
	(468)	(87%)
Central Locality Care Group	557	88%
	(459)	(88%)
South Locality Care Group	913	90%
	(717)	(90%)

(excluding not answered)

Nb - 1 response unable to be mapped to a core service Q1

Nb - 36 responses unable to be mapped to a core service Q4

Friends and Family Test scores by CBU, Q1 2018/19

	responses to friends and family question								
CBU and Locality	Extremely Likely	Likely	Neither likely not unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	**% would recommend**	change on prevous quarter (% points)
Access North CBU	45	16	4	4	4		73	**84%**	↓10
Community North CBU	183	79	20	11	13	3	309	**85%**	↓2
Inpatients North CBU	13	5	2	1	2		23	**78%**	↑11
Specialist Children & Young Peoples Services CB	37	13	4	1		2	57	**88%**	↑4
North Locality Care Group Total	**278**	**113**	**30**	**17**	**19**	**5**	**462**	**85%**	**↓2**
Access Central CBU	30	9	3	1	2		45	**87%**	↓6
Community Central CBU	262	121	27	5	11	10	436	**88%**	↑1
Inpatients Central CBU	32	12			1	2	47	**94%**	↑3
Secure Care Services CBU	17	7	1	2		2	29	**83%**	↓6
Central Locality Care Group Total	**341**	**149**	**31**	**8**	**14**	**14**	**557**	**88%**	**↔**
Access South CBU	41	12		1	1	3	58	**91%**	↑6
Community South CBU	275	124	26	13	9	4	451	**88%**	↓1
Inpatients South CBU	70	29	6	4	5	2	116	**85%**	↓2
Neurological & Specialist Services CBU	216	58	8	2	3	1	288	**95%**	↔
South Locality Care Group Total	**602**	**223**	**40**	**20**	**18**	**10**	**913**	**90%**	**↔**
Trust total	1222	485	101	45	51	29	1933	**88%**	↓1

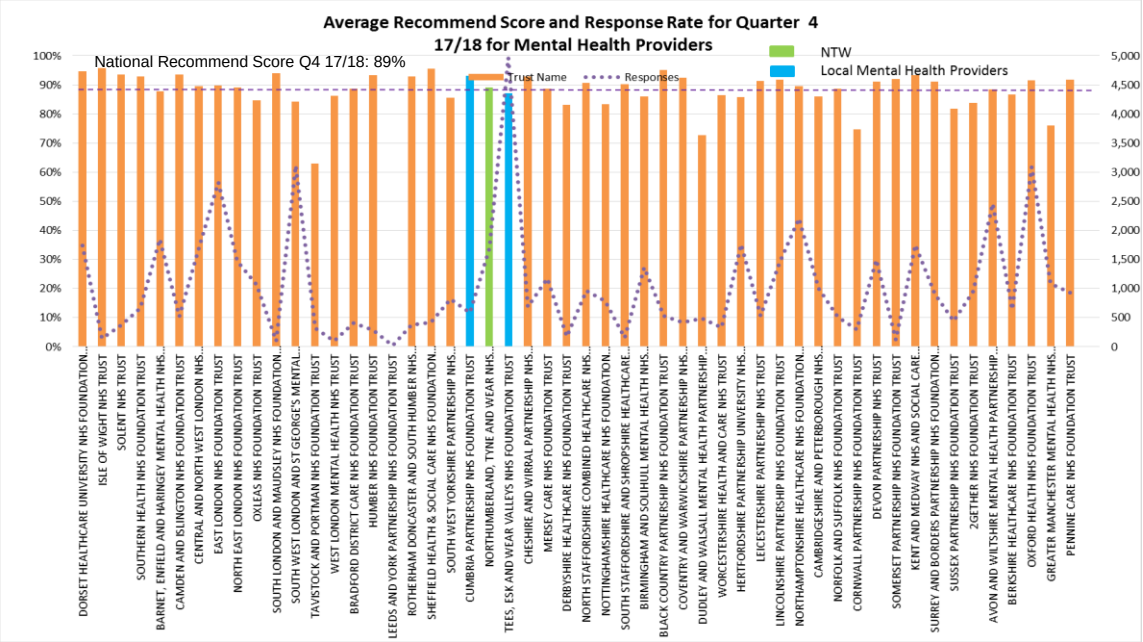
1 response unable to be mapped to service in Q1 2018/19

The FFT recommend score ranges from 85% in the north locality to 90% in the south locality. The south locality has a higher volume of responses, which is partly attributable to the neuro rehab services.

Analysis of published national data shows significant variation in the volume of FFT responses from providers of mental health services ranging from 63% to 96%.

Please note that several of the Trusts in the upper quartile for their recommend score have a low proportion of responses. NTW are the 12th highest submitter of FFT responses in Quarter 4.

Figure 3: Average recommend score and response rate for Quarter 4 17/18 for Mental Health Providers



5. Points of You Experience Feedback – Q1 2018/19

The Points of You survey is the Trust's predominant service user and carer experience measure. The survey is comprised of the FFT (question 1) and a further 8 questions plus the opportunity to make further comments. The questions are as follows:

1. How likely are you to recommend our team or ward to friends and family if they needed similar care or treatment?
2. How kind and caring were staff to you?
3. Were you encouraged to have your say in the treatment or service received and what was going to happen?
4. Did we listen to you?
5. If you had any questions about the service being provided did you know who to talk to?
6. Were you given the information you needed?
7. Were you happy with how much time we spent with you?
8. Did staff help you to feel safe when we were working with you?
9. Overall did we help?
10. Is there anything else you would like to tell us about the team or ward? (You can also use this space to tell us more about the questions on this survey)

Experience Responses

During Quarter 1, 68% of POY returns were from service users, 30% from carers/ relatives/ friends and 1% from respondents who identified themselves as both, service user and carer/ relative / friend. Of those who responded to the demographic questions:

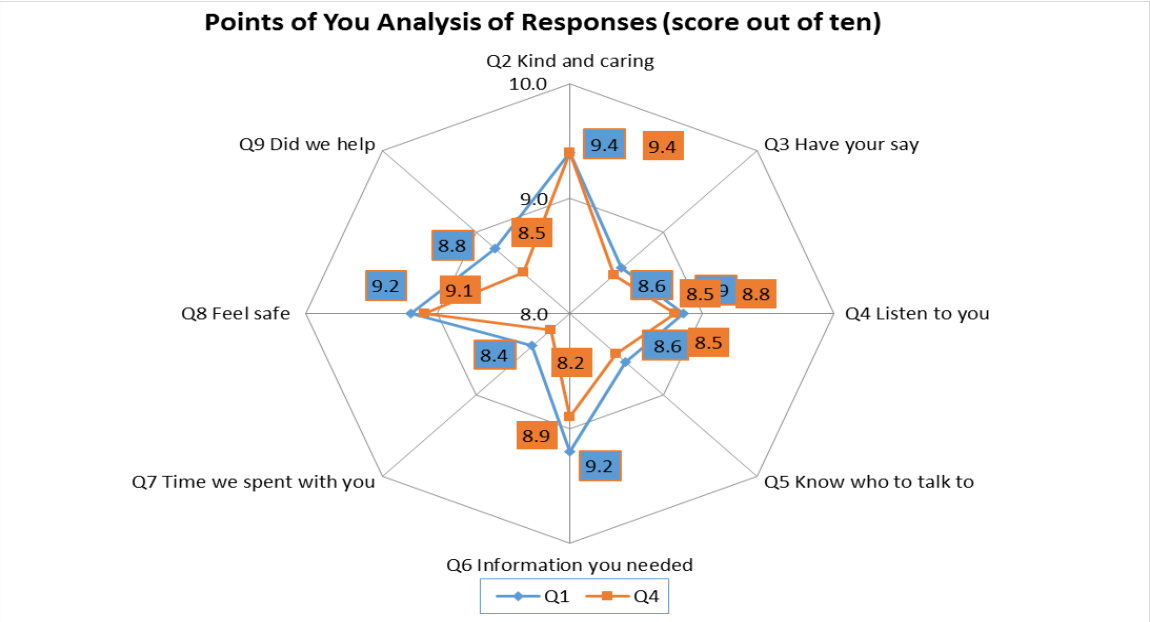
- 42% were male, 52% were female (6% did not answer).
- 90% were White, 2% were Asian/ Asian British, 0.7% were Black/ African/ Caribbean/ Black British, 0.6% were other ethnic groups, 0.2% were mixed/ multiple ethnic groups (6.8% did not answer)
- The highest proportion of respondents were aged between 55-64 years (19%), followed by 65-74 years and 65-74 both at (15%). The smallest proportion of respondents were aged between 0-18 years (1%).

Points of You Experience Analysis

A score out of ten is calculated for each of the points of you questions, and Figure 4 illustrates the average score for each question during Quarter 1.

It is evident the Trust performed better (scoring higher) on questions regarding staff being kind and caring (question 1) and being helped to feel safe (question 8) – scoring 9 or above out of 10. The question which showed the lowest score (8.2), thus less satisfaction, is the time we spend with the service user or carer. Compared to the previous quarter, scores have improved overall for all questions.

Figure 4: Average score for questions 2-9 for all Trust services for Q1 (10 being the best, 0 being the worst)



The following analysis in Figure 5 shows a breakdown of the average score per question by core service. The colour highlights which of the answer options the score would fall into (green being the best, red being the worst), and can be compared against the Trust to identify areas for service improvements.

Figure 5: Average score per question by core service (and percentage of detained OBDs during Q1)

	Number of Responses Q1 (Q4)	Q2 - Kind and caring	Q3 - Have your say	Q4 - Listen to you	Q5 - Know who to talk to	Q6 - Information you needed	Q7 - Time we spent with you	Q8 - Feel safe	Q9 - Did we help	% of detained OBDs during Q1
Trust	**1992** (1729)	**9.4** -	**8.6** ↑	**8.9** -	**8.6** ↓	**9.2** -	**8.4** -	**9.2** -	**8.8** -	
Neuro Rehab Inpatients (Acute Medicine)	35 (28)	9.9 ↑	8.7 ↓	9.1 ↓	8.8 ↓	8.6 ↓	7.9 ↓	9.5 ↓	9.4 ↓	22%
Neuro Rehab Outpatients (Acute Outpatients)	184 (158)	9.7 ↓	9.1 ↓	9.3 ↓	9.3 -	9.3 ↓	9.0 ↓	9.6 ↓	9.5 -	
Community mental health services for people with learning disabilities or autism	64 (57)	9.4 ↓	8.9 ↑	9.0 -	8.6 ↑	8.6 ↓	8.5 ↑	9.3 -	9.2 ↑	
Community-based mental health services for adults of working age	427 (321)	8.9 ↓	8.3 ↓	8.5 ↓	8.1 ↓	8.9 ↓	7.9 ↓	8.9 ↓	8.2 ↓	
Community-based mental health services for older people	563 (430)	9.7 -	8.8 ↓	9.2 -	8.5 ↓	9.4 -	8.6 ↓	9.4 ↓	9.1 ↓	
Mental health crisis services and health-based places of safety	81 (86)	9.1 ↑	8.4 ↑	8.8 ↑	8.1 ↑	8.9 ↑	8.1 ↑	8.9 ↑	8.2 ↑	
Acute wards for adults of working age and psychiatric intensive care units	50 (48)	8.3 ↓	6.7 ↓	7.2 ↓	7.1 ↓	8.3 ↑	7.4 ↑	7.9 ↓	7.2 ↓	74%
Child and adolescent mental health wards	25 (21)	9.6 ↑	8.2 ↑	9.1 ↑	9.2 ↓	9.6 ↑	8.4 ↑	8.9 ↑	9.6 ↑	93%
Forensic inpatient/secure ward	5 (1)	8.0 ↓	6.0 ↓	5.5 ↓	10.0 -	10.0 -	6.5 ↓	8.0 ↓	7.5 ↓	100%
Long stay/rehabilitation mental health wards for working age adults	29 (36)	9.8 ↑	8.2 ↓	8.8 ↓	9.3 ↓	10.0 ↑	8.4 ↓	9.0 ↓	9.3 ↑	83%
Wards for older people with mental health problems	29 (29)	9.7 ↑	8.8 ↑	9.0 ↑	9.3 ↑	9.3 ↑	8.7 ↑	9.5 ↑	9.3 ↑	87%
Wards for people with learning disabilities or autism	11 (10)	9.1 ↑	7.8 ↓	8.2 ↑	8.2 ↓	7.3 ↓	8.2 ↑	9.5 ↑	8.6 ↑	97%
Children and Young Peoples Community Mental Health Services	197 (156)	9.4 ↑	8.6 ↑	8.9 ↑	8.2 ↓	8.6 ↓	8.1 ↑	9.4 ↑	8.3 ↑	
Substance Misuse	98 (153)	9.3 ↓	8.3 ↓	8.6 ↓	9.1 ↓	9.1 ↓	8.1 ↓	9.2 ↓	8.6 ↑	
Other	193 (195)	9.7 ↑	8.7 ↑	9.2 ↑	9.3 ↑	9.6 ↑	8.7 ↑	9.4 ↓	9.3 ↑	37%

Nb. 1 response was unable to be assigned to a core service

Key:				
Score 8-10 (highest score)	Score 6-7.9	Score 4-5.9	Score 2-3.9	Score 1.9-0 (lowest score)
↑ Score has improved (compared to last quarter)		↓ Score has deteriorated (compared to last quarter)		

Analysis of Quarter 1 2017/18 POY scores by locality across all questions

Points of You (questions 2 to 9)

	Number of Responses Qtr1 18/19 (Qtr4 17/18)	Q2 - Kind and caring	Q3 - Have your say	Q4 - Listen to you	Q5 - Know who to talk to	Q6 - Information you needed	Q7 - Time we spent with you	Q8 - Feel safe	Q9 - Did we help
Trust	**1992**	**9.4**	**8.6**	**8.9**	**8.6**	**9.2**	**8.4**	**9.2**	**8.8**
	(1724)	(9.4)	(8.5)	(8.9)	(8.7)	(9.2)	(8.4)	(9.2)	(8.8)
North Locality	474	9.3	8.5	8.7	8.4	9.1	8.1	9.1	8.5
Care Group	(484)	(9.3)	(8.3)	(8.7)	(8.7)	(9.2)	(8.1)	(9.1)	(8.6)
Central	576	9.4	8.4	8.8	8.4	9.0	8.2	9.2	8.8
Locality Care	(470)	(9.3)	(8.6)	(8.9)	(8.5)	(9.4)	(8.4)	(9.2)	(8.7)
South Locality	941	9.5	8.7	9.0	8.8	9.4	8.6	9.3	9.0
Care Group	(734)	(9.5)	(8.6)	(9.0)	(8.7)	(9.1)	(8.5)	(9.3)	(8.9)

Nb - 1 reponse unable to be mapped to a core service Q1

Nb - 36 responses unable to be mapped to a core service Q4

Points of You question (2 to 9) responses Quarter 1 2018/19

CBU and Locality	Number of Responses Q1 2018/19 (Q4 2017/18)	Q2 - Kind and caring	Q3 - Have your say	Q4 - Listen to you	Q5 - Know who to talk to	Q6 - Information you needed	Q7 - Time we spent with you	Q8 - Feel safe	Q9 - Did we help
Access North CBU	76 (118)	9.2 ↓0.4	8.3 ↓0.4	8.6 ↓0.4	8.5 ↓0.8	8.9 ↓0.6	8.1 ↓0.3	9.2 ↔	8.3 ↓0.9
Community North CBU	317 (306)	9.3 ↑0.1	8.5 ↑0.2	8.7 ↔	8.2 ↓0.3	9.2 ↑0.2	8.0 ↓0.1	9.1 ↑0.1	8.5 ↑0.1
Inpatients North CBU	23 (26)	8.9 ↑0.1	7.5 ↓0.1	7.5 ↓0.2	7.8 ↓0.2	7.8 ↓0.8	7.3 ↓0.1	8.9 ↔	8.3 ↑0.5
Specialist Children & Young Peoples Services CBU	58 (34)	9.6 ↑0.5	8.5 ↑0.7	9.2 ↑0.5	9.1 ↓0.6	9.4 ↓0.3	8.6 ↑0.4	9.3 ↑0.2	8.9 ↑0.3
North Locality Care Group Total	**474 (484)**	**9.3 ↔**	**8.5 ↑0.2**	**8.7 ↔**	**8.4 ↓0.3**	**9.1 ↓0.1**	**8.1 ↔**	**9.1 ↔**	**8.5 ↓0.1**
Access Central CBU	46 (57)	9.0 ↓0.4	8.1 ↓0.3	8.4 ↓0.4	8.7 ↑0.4	8.9 ↓0.3	7.9 ↓0.4	8.6 ↓0.3	8.3 ↓0.5
Community Central CBU	452 (339)	9.4 ↑0.1	8.5 ↓0.1	8.8 ↓0.1	8.2 ↓0.2	9.0 ↓0.3	8.2 ↓0.1	9.3 ↑0.1	8.8 ↑0.2
Inpatients Central CBU	48 (46)	9.5 ↓0.1	8.7 ↔	8.9 ↓0.1	8.9 ↓0.4	9.3 ↓0.5	8.7 ↔	9.0 ↓0.3	9.3 ↑0.1
Secure Care Services CBU	30 (28)	9.5 ↑0.2	8.3 ↓0.8	8.6 ↓0.3	9.6 ↑0.7	9.6 ↓0.4	8.4 ↑0.1	9.1 ↓0.5	8.9 ↔
Central Locality Care Group Total	**576 (470)**	**9.4 ↑0.1**	**8.4 ↓0.2**	**8.8 ↓0.1**	**8.4 ↓0.1**	**9.0 ↓0.4**	**8.2 ↓0.2**	**9.2 ↔**	**8.8 ↑0.1**
Access South CBU	59 (73)	9.5 ↑0.5	8.6 ↑0.1	9.2 ↑0.5	8.8 ↑0.5	9.3 ↑0.6	8.3 ↔	9.2 ↑0.3	8.8 ↑0.1
Community South CBU	459 (306)	9.4 ↓0.1	8.8 ↑0.3	9.0 ↑0.1	8.4 ↑0.1	9.2 ↑0.2	8.5 ↑0.2	9.3 ↑0.1	8.7 ↑0.1
Inpatients South CBU	128 (132)	9.5 ↑0.1	8.1 ↓0.1	8.8 ↑0.4	9.1 ↑0.1	9.5 ↑0.7	8.4 ↑0.2	9.0 ↑0.1	9.1 ↑0.4
Neurological & Specialist Services CBU	295 (223)	9.7 ↓0.1	8.9 ↓0.2	9.2 ↓0.2	9.2 ↓0.1	9.5 ↔	8.8 ↓0.2	9.5 ↓0.3	9.3 ↓0.3
South Locality Care Group Total	**941 (734)**	**9.5 ↔**	**8.7 ↑0.1**	**9.0 ↔**	**8.8 ↑0.1**	**9.4 ↑0.3**	**8.6 ↑0.1**	**9.3 ↔**	**9.0 ↑0.1**
Trust total	1,992 (1,724)	9.4 ↔	8.6 ↑0.1	8.9 ↔	8.6 ↓0.1	9.2 ↔	8.4 ↔	9.2 ↔	8.8 ↔

arrows showing change on Q4 2017/18 scores. 1 response not mapped to service for Q1 (36 in Q4 2017/18)

The above analysis demonstrates there is a general consistency across localities within the questions with South locality receiving the highest number of responses returned in the quarter and the highest overall scores per question.

When comparing Quarter 1 question scores to the previous quarter, many core services have seen an improvement in the majority of the question scores:

- Mental health crisis services and health-based places of safety, other and wards for older people with mental health problems (scores for all 8 questions have improved).
- Child and adolescent mental health wards (scores for 7 out 8 questions have improved
- Children and young people's community mental health services (scores for 6 out of 8 have improved)

There has been 2 core services where the majority of the question scores deteriorated:

- Neuro rehab inpatients (acute medicine) and substance misuse (scores for 8 out of 8 questions have deteriorated though they are still reported within upper scores).

For all other core services there has been a mix of improvements and deterioration across all 8 questions.

A Trust-wide thematic analysis has been undertaken and the most prevalent positive and negative themes to emerge are highlighted in Figure 6.

Figure 6: Prevalent themes from comments (question 10) – Quarter 1 :

Positive Themes (A total of 2,290 comments were received during Quarter 1, nearly 72% of these were positive/ complimentary)
1) Staff / Staff Attitude (61%) 2) Service Quality / Outcomes (18%) 3) Care / Treatment (13%) Examples of comments: *"Nice lovely atmosphere"* *"Excellent care from the whole team"* *"They're always nice and listen to me"*

Negative Themes:
In terms of the negative comments provided (n = 405) there was a much broader spectrum of feedback across a selection of themes. Several repeating themes emerged during quarter 1 and are identified below.
1) Care and treatment (31%) 2) Staff/Staff Attitude (21%) 3) Communication (18%)
Examples of comments: *"Had to wait quite a long time to be seen"* *"Inadequate follow up"* *"I found it difficult to contact some staff"*

Gender Dysphoria Survey - Responses and Analysis

The Northern Region Gender Dysphoria Service is the only exemption to the Trust-wide Points of You service users and carer experience programme. The service uses a survey developed nationally with all other Gender Dysphoria service in England.

During Quarter 1 18/19 the Northern Region Gender Dysphoria Service received 46 surveys. All responses were positive (rating extremely likely or likely) for 9 out of the 9 questions. There were no negative responses to any question, which are listed below:

1. Likely to recommend this clinic to friends and family
2. Admin Staff were pleasant and Respectful
3. Clinician was pleasant and respectful
4. I feel listened to
5. I feel involved in my treatment
6. I have confidence in the abilities of my clinician
7. Information was understandable
8. Questions were answered
9. Given opportunity to discuss treatment

6. NHS Choices, Care Opinion & Healthwatch Comments Q1 2018/19

The three main websites for service users and carers to leave feedback are NHS Choices, Care Opinion and Healthwatch (Newcastle/ Gateshead/ North Tyneside). Figure 7 illustrates the star rating allocated by service users/ carers who commented on the care they received.

Figure 7: Star rating for the Trust/ Site/ Service according to NHS Choices

Hospital Site	Star Rating	Number of Reviews
NTW		12
Hopewood Park		17
Ferndene		3
Monkwearmouth		5
Northgate	Not Rated	0
St Nicholas Hospital	Not Rated	0
St Georges Park		3
Walkergate Park		3

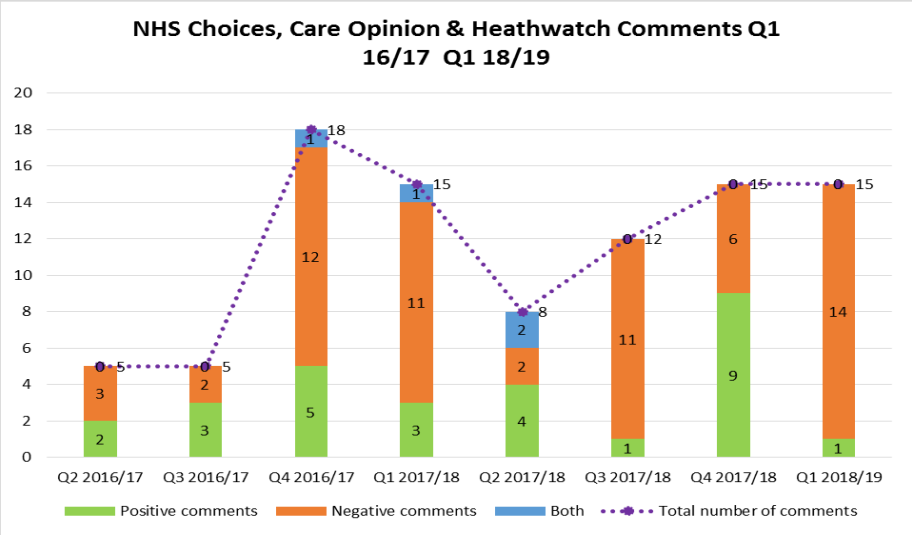
During Quarter 1 2018/19 the Trust received 15 comments through these sites – 1 was positive and 14 were negative. Some examples are shown below

Having suffered from mental health issues such as severe depression after an incredibly difficult experience dealing with university and financial problems, I decided upon seeking help and finding solutions to my problem. From the 1st time of attending my appointments here at Jarrow, I have felt a great connection and a feeling of worthlessness and respect to what I've had to say. The staff have been great advocates, and have provided absolutely amazing support to my recovery, through the situations I have been through and have given me great feedback and solutions. I would definitely recommend people to this service, who have suffered through similar experiences as me and take advantage of the great services, to talk and speak out rather than staying silent.

Locum psychiatrist.C.P.N.gives false promises.No continuity of care.Frequently cancelled or missed appointments.Crisis team pick and choose if they can help.The worst service in the NHS.

Figure 8 shows the number of comments posted on the sites from Quarter 1 2016/17 to Quarter 1 18/19.

Figure 8 – Number of comments published on NHS Choices, Care Opinion & Healthwatch sites each quarter (Q1 2016/17 to Q1 2018/19)



7. Compliments and Thank You's – Q1 2018/19

During Quarter 1, 94 thank you's and compliments were received via Points of You and from other routes (including Chatterbox). This is a decrease from 111 received during quarter four.

8. Recommendations

The Board are asked to note the information included within this report.

Anna Foster
Deputy Director of Commissioning and Quality Assurance
July 2018

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 16th July 2018

Title and Author of Paper: Integrated Commissioning & Quality Assurance Report (Month 3 June 2018) – Anna Foster, Deputy Director of Commissioning & Quality Assurance

Executive Lead: Lisa Quinn, Executive Director of Commissioning & Quality Assurance

Paper for Debate, Decision or Information: Information & Discussion

Key Points to Note:

- This report provides an update of Commissioning & Quality Assurance issues arising in the month, including progress against quality standards.
- Challenges remain waiting times across many adult and children's services, in particular South of Tyne Services for Children and Young People
- There has been little change in the month in relation to other workforce, training and quality standards.
- The provisional in month sickness absence rate for June 2018 of 5.83% is an increase in comparison to May 2018, which is now confirmed as 5.6%. The 12 month rolling average sickness rate has decreased to 5.65%.
- The contract has underperformed for Quarter 1 in North Tyneside (Crisis and Contingency) Newcastle (7 day follow up) and Sunderland (IAPT access).
- Doctors in training figures now include records of prior learning and are above the trust standard for all courses except fire and information governance.
- The executive summary on page 1 provides further points to note.

Risks Highlighted: waiting times and sickness.

Does this affect any Board Assurance Framework/Corporate Risks: Yes

Equal Opportunities, Legal and Other Implications: none

Outcome Required / Recommendations: for information and discussion

Link to Policies and Strategies: NHS Improvement – Single Oversight Framework, 2017/18 NHS Standard Contract, 2017-19 Planning Guidance and standard contract, 2017-18 Accountability Framework

Northumberland, Tyne and Wear NHS Foundation Trust

NTW Integrated Commissioning & Quality Assurance Report 2017-18 Month 3 (June 2018)

Contents:

1. Executive Summary:

- The Trust remains assigned to segment 1 by NHS Improvement as assessed against the Single Oversight Framework (SOF). (page 4).
- At Month 3, the Trust has a year to date deficit of £0.3m which is £0.2m ahead of plan. The Trust is forecasting to meet its control total of £3.5m by delivering a surplus before Provider Sustainability Funding of £1.5m and receiving its Sustainability funding of £2.0m. The Trust's finance and use of resources score is currently a 3 (this is a sub theme of the Single Oversight Framework) and the forecast year-end risk rating is also a 3. The main financial pressures during month 3 relate to pay overspends in some areas although non-pay costs were also higher than planned. To achieve this spending on temporary staffing needs to reduce. Work is ongoing to deliver the required staffing reductions and to improve efficiency and productivity across the Trust. See page 21-22
- South Tyneside, Northumberland and NHS England fully achieved the contract requirements during month 3 and Quarter 1 however, there are a number of contract requirements largely relating to CPA metrics which were not achieved across other local CCGs during the month. (page 12)
- There are continuing pressures on waiting times across the organisation, particularly within community services for children and young people. Each locality group has developed action plans which continue to be monitored via the Business Delivery Group and the Executive Management Team. (page 17)
- All of the ten CQUIN scheme requirements have been assessed internally as achieved for quarter 1. (page 13)
- The waiting times and improving the inpatient quality experience quality priority have been assessed as amber for quarter 1. (page 24)
- The Accountability Framework for each group is currently forecast as 4 due to the continuing underperformance in each group against a small number of quality metrics. (p 25)
- Reported appraisal rates have remained the same in the month at 84.4% Trustwide. Areas of underperformance are primarily corporate services. (p23)
- The recent increase in sickness has continued with the provisional in month sickness absence rate for June 2018 at 5.83%, which is an increase in comparison to May 2018, (now confirmed as 5.6%). The 12 month rolling average sickness rate has slightly decreased to 5.65%.(p 23)
- Training rates have continued to see most courses above the required standard. There remains one course more than 5% below the required standard which is MHA Combined Training (77.0% was 78.1% last month) (p 23)
- The service user and carer FFT recommended score has remained at 88% in May which is broadly in line with the national average. (page 26)

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

SOF:	1	The Trust's assigned shadow segment under the Single Oversight Framework remains assigned as segment "1" (maximum autonomy).

Waiting Times

- The number of people waiting across adult services has decreased in the month (excluding gender dysphoria, adult autism diagnosis etc), the number waiting over 18 weeks has also decreased in the month.
- The number of people waiting for specialised adult services has remained static in the month along with the proportion of those waiting more than 18 weeks which has continued to increase.
- Waiting times to treatment for children and young people have increased in the month across all areas with the exception of Newcastle and Gateshead, those waiting more than 18 weeks have increased in the month across some areas, whilst those waiting over 30 weeks has increased in the month.

Quality Priorities:

Quarter 1:	Quarter 1 part achieved:	Quarter 1 not achieved:	
2	2	0	In total there are four quality priorities identified for 2018-19 and at quarter 1 the waiting times and improving the inpatient experience quality priority have been assessed as amber

CQUIN:

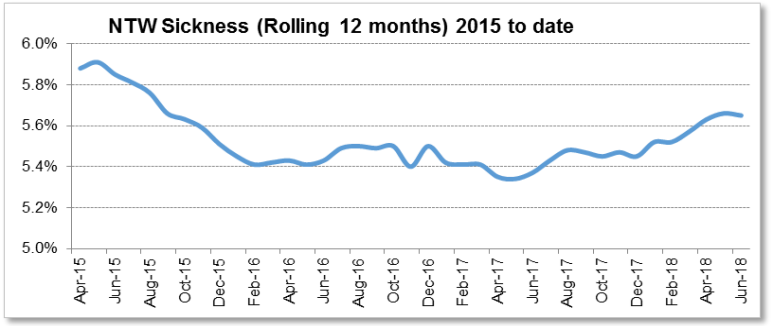
Quarter 1:	Quarter 1 part achieved:	Quarter 1 not achieved:	
10	0	0	There are a total of ten CQUIN schemes in 2017-18 across local CCGs and NHS England commissioned services. All have been internally assessed as achieved at quarter 1.

Workforce:

Statutory & Essential Training:

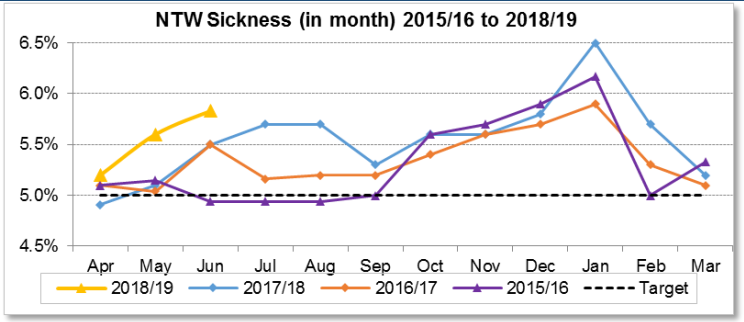
Standard Achieved Trustwide:	Performance <5% below standard Trustwide:	Standard not achieved (>5% below standard):		**Appraisals**:
14	4	1	Rapid Tranquilisation training (84.4%), PMVA Basic training (80.5%), PMVA Breakaway (84.6%) and Information Governance (92.9%) are within 5% of the required standard, MHA combined training (77.0%) is more than 5% below the standard.	Appraisal rates have remained at 84.4% in June 18 (was 84.4% last month).

Sickness Absence:



The provisional "in month" sickness absence rate is above the 5% target at 5.83% for June 2018

The rolling 12 month sickness average has slightly decreased to 5.65% in the month



Finance:		At Month 3, the Trust has a year to date deficit of £0.3m which is £0.2m ahead of plan. Pay spend at Month 3 was £63.0m which is in line with plan and includes £1.9m agency spend which is £0.2m below the planned trajectory to hit our agency ceiling of £8.0m but £0.4m above planned spend. The Trust is forecasting to meet its control total of £3.5m by delivering a surplus before Provider Sustainability Funding of £1.5m and receiving its Sustainability funding of £2.0m. The Trust's finance and use of resources score is currently a 3 (this is a sub theme of the Single Oversight Framework) and the forecast year-end risk rating is also a 3. The main financial pressures at Month 3 relate to pay overspends in some areas although non-pay costs are also higher than planned. Pay costs were lower this month and this trend needs to continue as the Trust needs to reduce pay spend to bring the financial position back in line with plan and to achieve this year's control total. To achieve this, spending on temporary staffing (agency, bank and overtime) needs to reduce. Work is ongoing to deliver the required staffing reductions and to improve efficiency and productivity across the Trust.

Contract Summaries:	NHS England	Northumberland CCG	North Tyneside CCG	Newcastle / Gateshead CCG	South Tyneside CCG	Sunderland CCG	Durham, Darlington & Tees CCGs	Cumbria CCG
	100% of metrics achieved in month 3	100% of metrics achieved in month 3	90% of metrics achieved in month 3	90% of metrics achieved in month 3	100% of metrics achieved in month 3	93% of metrics achieved in month 3	75% of metrics achieved in month 2	87% of metrics achieved in month 3
	100% of metrics achieved in quarter 1	100% of metrics achieved in quarter 1	90% of metrics achieved in quarter 1	90% of metrics achieved in quarter 1	100% of metrics achieved in quarter 1	93% of metrics achieved in quarter 1	75% of metrics achieved in quarter 1	87% of metrics achieved in quarter 1
	The areas of under performance continue to relate mainly to CPA metrics and 7 day follow up in line with previous quarters							

2. Compliance

a) NHS Improvement Single Oversight Framework

Self assessment as at Quarter 1 2018 to date against the "operational performance" metrics included within the Single Oversight Framework:

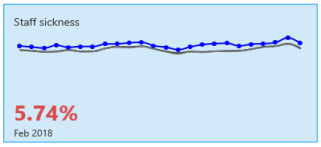
Metrics: (nb concerns will be triggered by failure to achieve standard in more than 2 consecutive months)	Frequency	Source	Standard	Quarter 1	NTW % as per most recently published MHSDS/RTT/EIP/IAPT data	National % from most recently published MHSDS data	Comments. NB those classed as "NEW" were not included in the previous framework	Data Quality Kite Mark Assessment
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	Monthly	UNIFY2 and MHSDS	92%	100%	100%	87.10%	National data includes all NHS providers and is at April 2018	
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	Quarterly	UNIFY2 and MHSDS	*53%*	83.9%	77%	74.40%	Published data is as at April 2018	
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:								
a) inpatient wards	Quarterly	Provider return / CQUIN audit	90%	99%	no data	no data	Q1 Metric 1426	
b) early intervention in psychosis services	Quarterly	Provider return / CQUIN audit	90%	92%	no data	no data	Q1 Metric 1427	
c) community mental health services (people on Care Programme Approach)	Quarterly	Provider return / CQUIN audit	65%	97%	no data	no data	Q1 Metric 1425	
Data Quality Maturity Index Score (DQMI)			95%	92%			Published data is at Quarter 3 2017	
Number of Out of Area Placements (Active at period end)				0	5	645	Published data relates to March 2018. NTW self assessment data relates to May 2018	
Improving Access to Psychological Therapies (IAPT)/talking therapies							NTW data relates to March	
· proportion of people completing treatment who move to recovery	Quarterly	IAPT minimum dataset	50%	51.1%	53.0%	52.5%	NEW metric 1079 published data February 2018	
· waiting time to begin treatment :								
- within 6 weeks	Quarterly	IAPT minimum dataset	75%	99.7%	99.0%	89.2%	published data March 2018	
- within 18 weeks	Quarterly	IAPT minimum dataset	95%	100.0%	100.0%	98.7%	published data March 2018	

NHS Improvement Single Oversight Framework & Model Hospital Portal

As at the end of June 2018, the Trust remains at segment 1 within the Single Oversight Framework as assessed by NHS Improvement. There are currently 16 mental health providers nationally achieving this rating. There is currently one MH provider in the lowest segment (segment 4), 27 providers within segment 2 and four providers remain in segment 3.

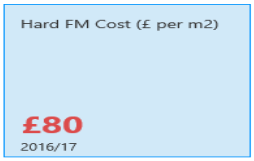
Sickness

The model hospital shows two notifications for the Trust in relation to sickness. The overall staff sickness rate is showing as 5.74%, this is in comparison to the benchmark for sickness which is 4.89% and sickness for nursing and health visitors at 6.7% which puts the Trust into the upper quartile for both of these metrics. It should be noted that the data in the model hospital is as at January 2018 and February 2018.



Estates and Facilities

There continues to be wide variation between reported data included in the model hospital. Currently there are three notifications against metrics in this compartment:

1	Hard Facilities Management Cost – the recommended benchmark for this metric is £67 which puts the Trust within the 3rd quartile. The Trust with the highest cost is South West London and St George's Mental Health NHS Trust with £363 per m2. Tees, Esk and Wear Valleys NHS Foundation Trust at £29 per m2.	
2	Food Costs (£ per meal) – the Trust with £4.13 per meal is within the 3rd quartile the benchmark is £4.03. East London NHS Foundation Trust has the lowest cost with £0.96 per meal, Surrey and Borders Partnership NHS Foundation Trust has the highest cost at £15.50 per meal. Tees, Esk and Wear Valleys NHS Foundation Trust has a cost of £3.21 per meal.	
3	Estates and Property Maintenance (£ per m2) – The Trusts costs for 16/17 were £80 per m2 the benchmark for this metric is £36 per m2 the highest cost is South West London and St George's Mental Health NHS Trust with £341 per m2 and the lowest is Kent and Medway NHS and Social Care Partnership Trust with £2 per m2. Tees, Esk and Wear Valleys NHS Foundation Trust is currently at £6 per m2.	

Procurement Function, Finance Function, Payroll Function, Legal Function

There remains as reported in last month's update three notifications in relation to the above functions:-

Procurement	Standards of Procurement – level achieved
Finance	Cost of Accounts Receivable per Invoice Raised
Payroll	Payroll Function Cost per £100m Turnover
Legal	Legal Function Cost per £100m Turnover

All of the notifications above which are currently showing in Model Hospital (with the exception of the Procurement notification) are taken from available data for the period 2016/2017. This will be updated when 2017/2018 data is available.

It should be noted that the information shown within this report is exception based, there is further data on a wide range of other metrics available within the model hospital portal.

2. Compliance
b) CQC Update June 2018

CQC Well Led with Core Service Inspection

Inspections to the following core services have taken place - CAMHS inpatient wards, specialist community CYPS, acute wards for adults of working age and psychiatric intensive care units and wards for older people with mental health problems. These inspections took place between 16 April 2018 and 27 April 2018 and the review of the well-led domain took place between 15-17 May 2018. The trust has received the draft inspection reports which are currently being reviewed for factual accuracy. Publication of the reports has not been confirmed but is anticipated in July 2018.

National Never Event Thematic Review

The trust awaits the findings from this review and the CQC plan to publish their national report in autumn 2018.

Focussed Inspections

Publication of the reports following a focussed inspection visit to two core services (acute wards for adults of working age/psychiatric intensive care units and long stay rehabilitation mental health wards for working age adults) in May 2017 are awaited. The delay in publication relates to an ongoing investigation.

Registration notifications made in the month:

No registration notifications have been made to the CQC this month.

Mental Health Act Reviewer visits in the month:

There were no Mental Health Act Reviewer visits to the trust this month.

Recently published CQC inspection reports to note:

Trust	Date of Inspection	Date of Report	Overall rating	Comments	Link to Report
2gether NHS Foundation Trust	March 2018	June 2018	Good	This trust's overall rating remains the same following re-inspection.	here
Cambridgeshire and Peterborough NHS Foundation Trust	March 2018	June 2018	Good	This trust's overall rating remains the same following re-inspection.	here

Trust	Date of Inspection	Date of Report	Overall rating	Comments	Link to Report
East London NHS Foundation Trusts	March 2018	June 2018	Outstanding	This trust's overall rating remains the same following re-inspection.	here
Rotherham Doncaster and South Humber NHS Foundation Trust	January 2018	June 2018	Good	The trust's overall rating remains the same following re-inspection. The rating for the safe key question has changed from good to requires improvement.	here
South West London and St George's Mental Health NHS Trust	Feb 2018	June 2018	Good	This trust's overall rating remains the same following re-inspection. The rating for the safe key question has improved to good.	here
Worcestershire Health and Care NHS Trust	March 2018	June 2018	Good	This trust's overall rating remains the same following re-inspection. The rating for the safe key question has improved to good.	here

CQC Recent News Stories:

Beyond barriers: how older people move between health and social care in England

In June 2018 the CQC published a report called beyond barriers, bringing together key findings and recommendations for change, following completion of 20 local authority area reviews exploring how older people move between health and adult social care services in England.

Beyond barriers highlights some examples of health and care organisations working well together, and of individuals working across organisations to provide high quality care. But the reviews also found too much ineffective coordination of health and care services, leading to fragmented care.

The report sets out a number of recommendations designed to encourage improvement in the way organisations and professionals work to support older people to stay well, including:

- The development of an agreed joint plan created by local leaders for how older people are to be supported in their own homes, helped in an emergency and then enabled to return home.

- Long term funding reform, underpinned by a move from short-term to long-term investment in services, and from an activity-based funding model towards population-based budgets.
- A single joint framework for measuring the performance of how organisations collectively deliver improved outcomes for older people. This would operate alongside oversight of individual provider organisations and reflect the contributions of all health and care organisations.
- The development of joint workforce plans, with more flexible and collaborative approaches to staff skills and career paths. National health and social care leaders should make it easier for individuals to move between health and care settings, enabling people to work and gain skills in a variety of different settings so that services can remain responsive to local population needs.
- New legislation to allow CQC to regulate systems and hold them to account for how people and organisations work together to support people to stay well and to improve the quality of care people experience across all the services they use.

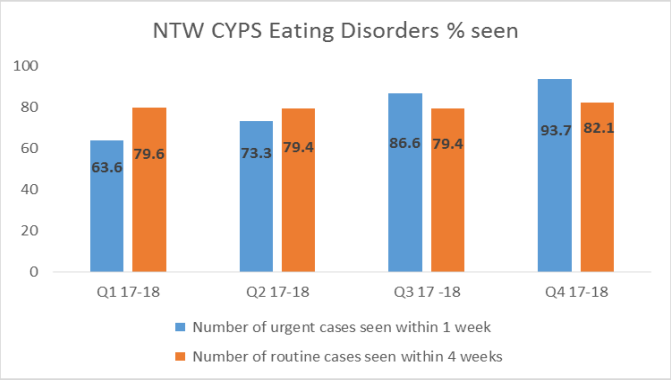
Adding a new regulated activity to your registration

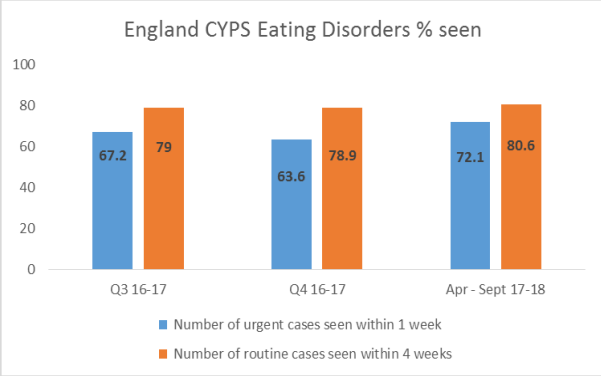
The CQC is working to improve the process for making a registration application and are seeking views from providers who have experience of applying to add a new regulated activity to a registration. The deadline for responses is 12 July 2018 and NTW will participate in this consultation.

2. Compliance

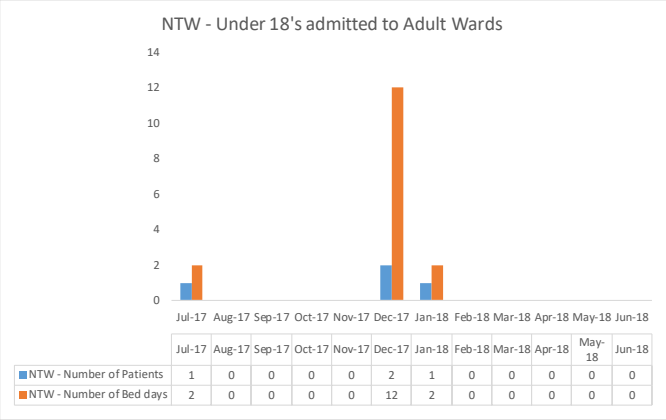
c) Five Year Forward View for Mental Health

Children and Young People Eating Disorders

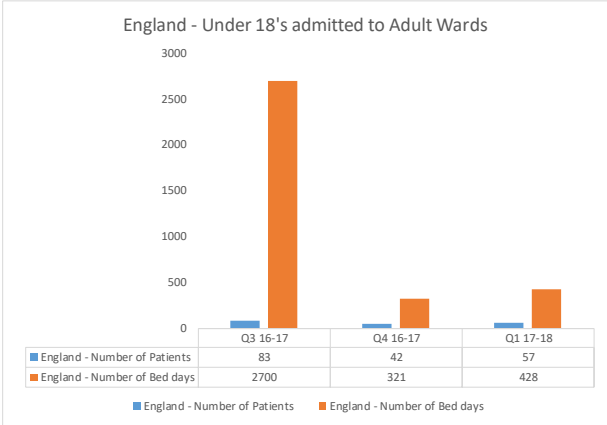




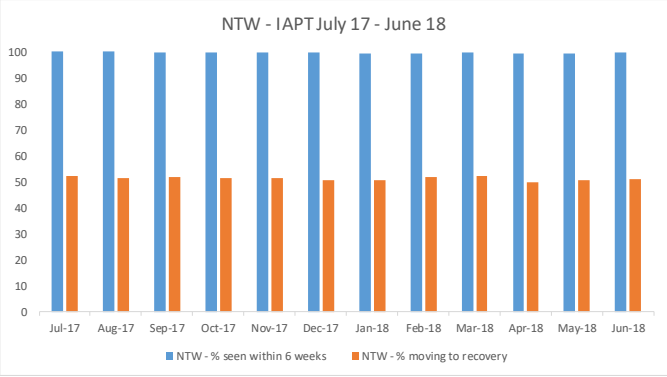
Under 18's admitted to an Adult Ward

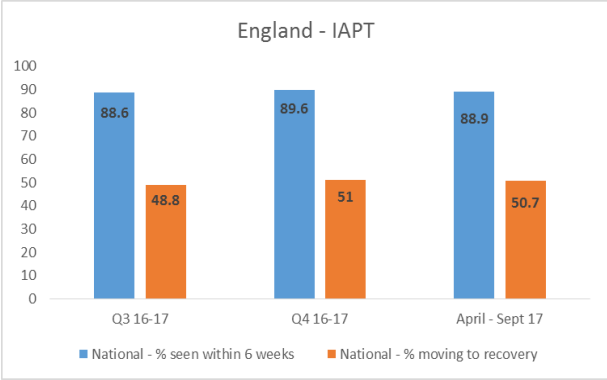


	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
NTW - Number of Patients	1	0	0	0	0	2	1	0	0	0	0	0
NTW - Number of Bed days	2	0	0	0	0	12	2	0	0	0	0	0

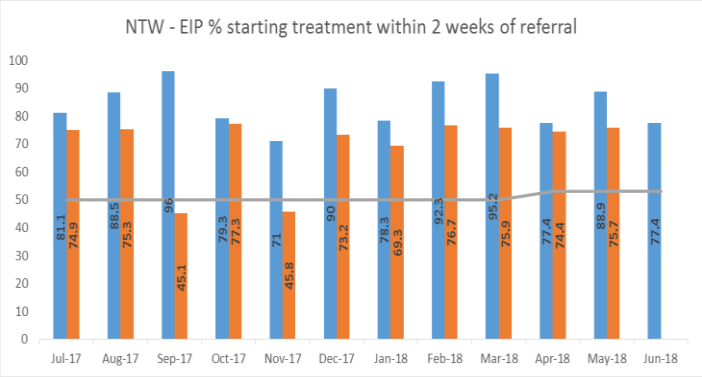


Improving Access to Pyschological Therapies (IAPT)

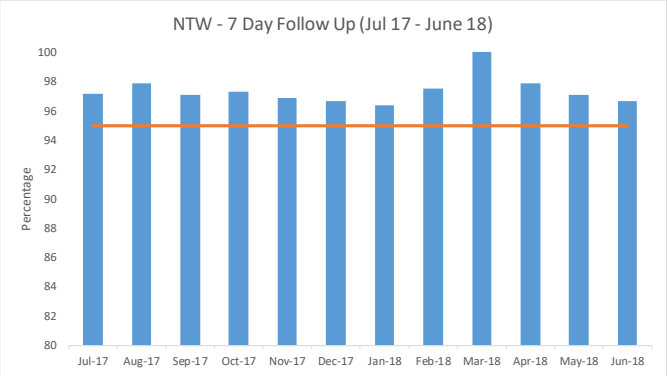


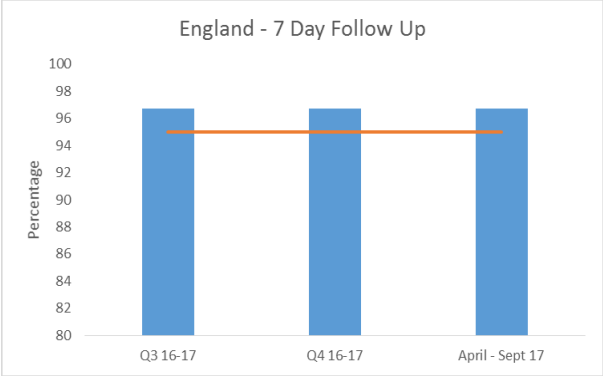


Early Intervention in Psychosis (EIP)

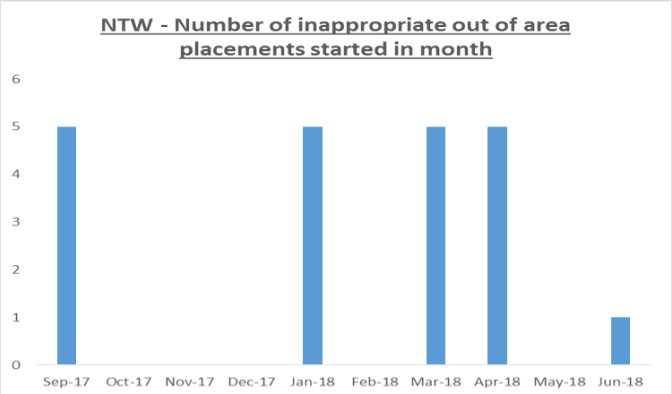


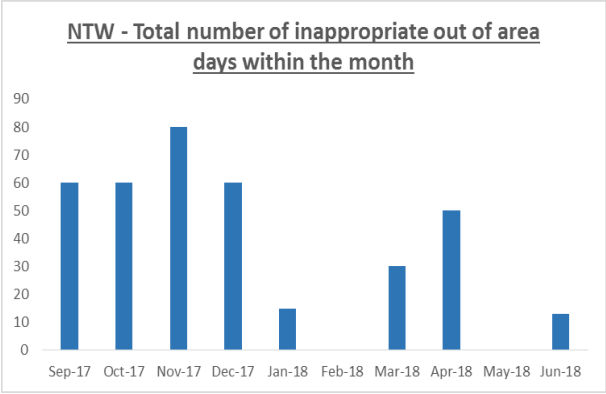
Seven Day Follow Up





Out of Area Placements

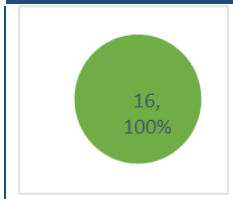
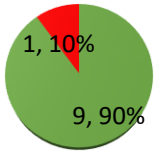
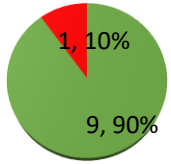
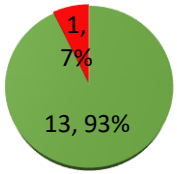
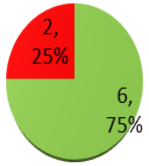
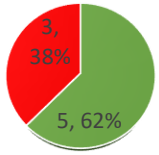




Latest NHS England Five Year Forward View CCG dashboards are available here

3. Contract Update June 2018

a) Quality Assurance – achievement of quality standards June 2018

NHS England	Northumberland CCG	North Tyneside CCGs	Newcastle / Gateshead CCG	South Tyneside CCG	Sunderland CCG	Durham, Darlington & Tees CCGs	Cumbria CCG
							
All achieved in month 3 and quarter 1	All achieved in month 3 and quarter 1	The contract underperformed in month 3 and quarter 1 on Crisis & Contingency (15 patients, 94.4%)	The contract underperformed in month 3 and quarter 1 on 7 day follow up (3 patients, 92.7%)	All achieved in month 3 and quarter 1	The contract underperformed on IAPT numbers accessing service in month 3 and quarter 1	The contract under performed in month 3 and quarter 1 on Crisis & Contingency (4 patients, 89.7%) and completion of Risk assessment (3 patients, 94.2%)	The contract under performed in month 3 and quarter 1 on Completion of Risk assessment (1 patients, 87.5%), valid ethnicity completed MHSDS only (3 patient, 81.3%)
							

3. Contract update June 2018

b) CQUIN update June 2018

CQUIN Scheme:	Annual Financial Value	Requirements	Quarterly Forecast:				
			Q1	Q2	Q3	Q4	Comments
1. Improving Staff Health and Wellbeing	£208k	To improve the support available to NHS Staff to help promote their health and wellbeing in order for them to remain healthy and well.	£0	£0	£0	£208k	
	£208k	Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff	£0	£0	£0	£208k	
	£208k	Healthy food for NHS staff, visitors and patients	£0	£0	£0	£208k	
2. Improving physical healthcare to reduce premature mortality in people with serious mental illness(PSMI)	£500k	Improving physical healthcare to reduce premature mortality in people with serious mental illness - 3a) Cardio metabolic assessment and treatment for patients with psychoses	£50k	£0	£0	£450k	
	£125k	Improving physical healthcare to reduce premature mortality in people with serious mental illness 3b)- Collaboration with primary care clinicians	£25k	£63k	£13k	£25k	
3. Improving services for people with mental health needs who present to A&E	£625k	Ensuring that people presenting at A&E with mental health needs have these met more effectively through an improved, integrated service, reducing their future attendances at A&E.	£0	£125k	£0	£500k	
4. Transitions out of Children and Young People's Mental Health Services	£625k	To improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services.	£31k	£281k	£0	£313k	
5. Preventing ill health by risky behaviours – alcohol and tobacco	£625k	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.	£0	£0	£0	£625k	
6. Health and Justice patient Experience	£5k	NHS England has a national priority and focus on patient experience in order to improve the quality of services.	£1.25k	£1.25k	£1.25k	£1.25k	
7. Recovery Colleges for Medium and Low Secure Patients	£312k	The establishment of co-developed and co-delivered programmes of education and training to complement other treatment approaches in adult secure services.	£16k	£16k	£16k	£264k	
8. Discharge and Resettlement	£496k	To find initiatives to remove hold-ups in discharge when patients are clinically ready to be resettled into the community. To include implementation of CUR for MH at pilot sites	£124k	£124k	£124k	£124k	
9. CAMHS Inpatient Transitions	£248k	To improve transition or discharge for young people reaching adulthood to achieve continuity of care through systematic client-centred robust and timely multi-agency planning and co-ordination.	£62k	£62k	£62k	£62k	
10. Reducing Restrictive Practices within Adult Low & Medium Secure Services	£188k	The development, implementation and evaluation of a framework for the reduction of restrictive practices within adult secure services, to improve patient experience whilst maintaining safe services.	£47k	£47k	£47k	£47k	
Grand Total	**£4.37m**		**£356k**	**£718k**	**£262k**	**£3,035k**	

3. Contract update June 2018

c) Service Development and Improvement Plan – No update this month

3. Contract update June 2018

d) Mental Health Currency Development Update

Mental Health Currency Development Update																	
			Q4 2017-18			Q1 2018-19			Q2 2018-19			Q3 2018-19			Q4 2018-19		
Key Metrics	Contract Standard	Internal Standard	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Current Service Users, in scope for CPP, who are in settled accommodation			60.1%	60.3%	60.2%	60.6%	60.7%	61.4%									
Current Service Users on CPA			9.4%	9.4%	9.4%	9.4%	9.4%	9.4%									
Current in scope patients assigned to a cluster			88.1%	88.2%	88.2%	88.7%	88.9%	88.5%									
Number of initial MHCT assessments that met the mandatory rules			85.6%	86.1%	84.3%	81.9%	83.8%	83.9%									
Number of Current Service Users within their cluster review threshold		85%	79.5%	79.3%	79.7%	81.1%	82.1%	82.9%									
Current Service Users with valid Ethnicity completed MHMDS only	90%	90%	93.6%	93.8%	93.8%	94.0%	94.1%	94.3%									
Current Service Users on CPA, in scope for CPP who have a crisis plan in place	95%	95%	91.3%	91.8%	91.6%	91.9%	92.1%	92.8%									
Number of CPA Reviews where review cluster performed +3/-3 days either side of CPA review within CPP spell		85%	75.0%	77.5%	74.0%	74.8%	74.6%	70.3%									
Number of Lead HCP Reviews where review cluster performed +3/-3 days either side of review within CPP spell		85%	57.3%	58.0%	58.6%	57.4%	54.4%	60.2%									
Current Service Users on CPA reviewed in the last 12 months	95%	95%	97.0%	96.5%	96.4%	97.1%	97.1%	96.5%									

1. **Contracts**
   e. **Commissioner Quality Assurance Visits June 2018**

None to report this month

4. Waiting Times

Adult and Older Peoples Mental Health Services

As at 30th June 2018, are 5,512 people waiting for treatment (adult and older people's mental health service users) which is a decrease of 1% from the previous month. 74.7% of these were waiting less than 18 weeks at that date (an improvement from 72.9% last month).

As at 30th June 2018, there were 143 service users who had been waiting more than 18 weeks with no attended appointments to date, a reduction compared with 169 the previous month.

Specialised Mental Health Services

The numbers waiting for Gender Dysphoria have not changed in the month, but waiting times have continued to lengthen.

The number waiting to access the adult ADHD service has fallen in the month by 3.5%.

Numbers waiting to access the adult ASD diagnosis service continue to increase (+3% this month)

Children and Young Peoples Service

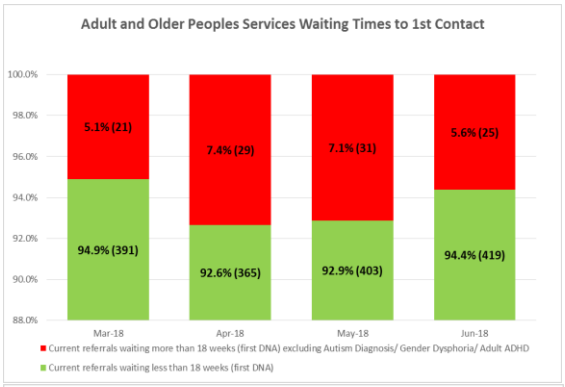
Newcastle has seen the largest change in numbers waiting for treatment compared to last month, with a 8% reduction. Gateshead has also seen a reduction, while all other CCGs have seen an increase

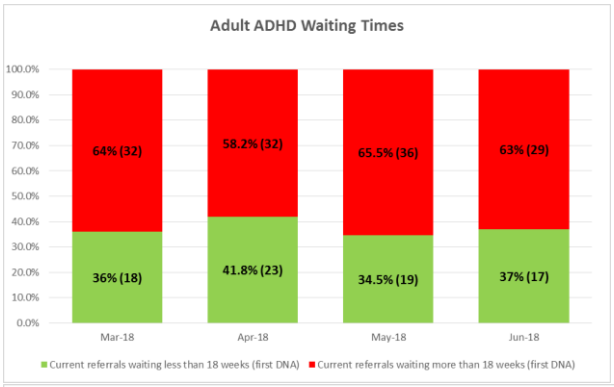
The proportion of young people waiting more than 18 weeks at 30th June compared with 31st may has remained relatively stable in South Tyneside (48%) and Sunderland (43%) and increased across Newcastle and Gateshead (now 13% and 27% respectively).

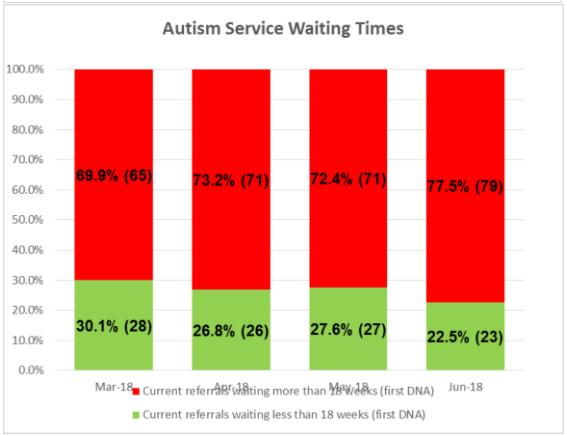
There remain no young people waiting more than 18 weeks for treatment at 30th June in Northumberland

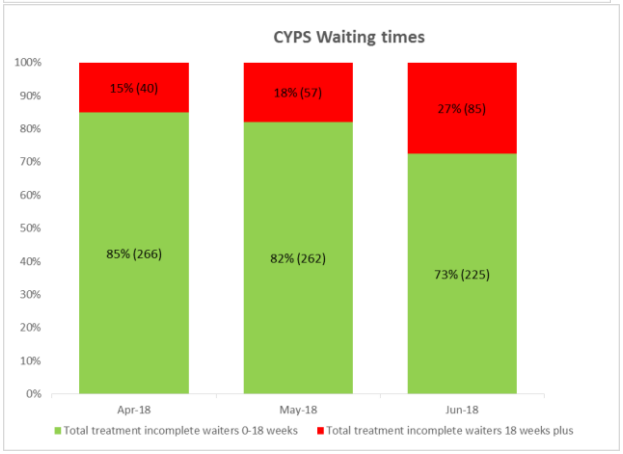
Please see overleaf for a more detailed analysis by CCG.

GATESHEAD CCG Waiting times summary as at 30th June 2018

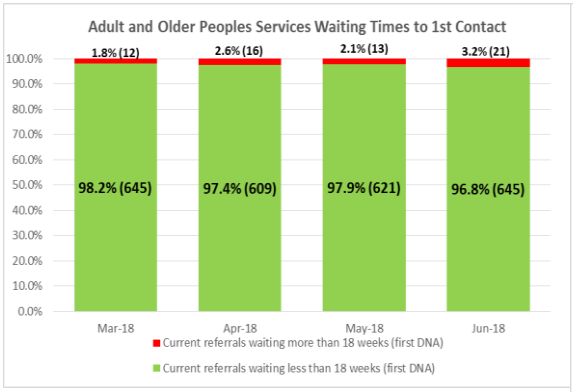


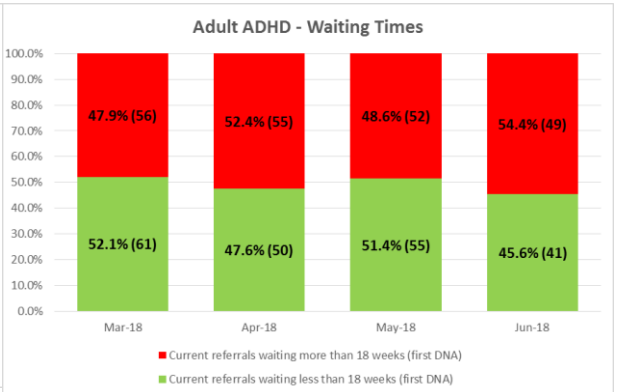


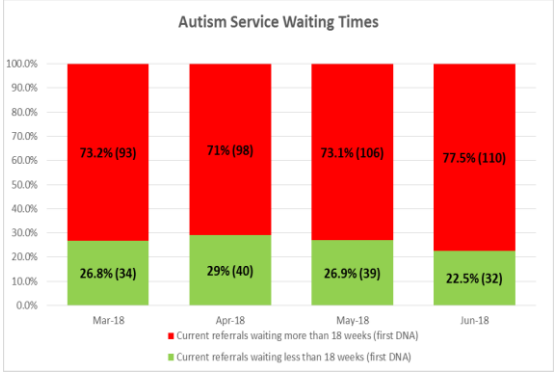


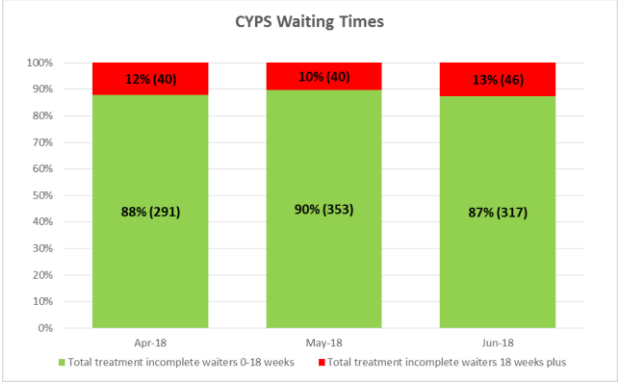


NEWCASTLE CCG Waiting times summary as at 30th June 2018

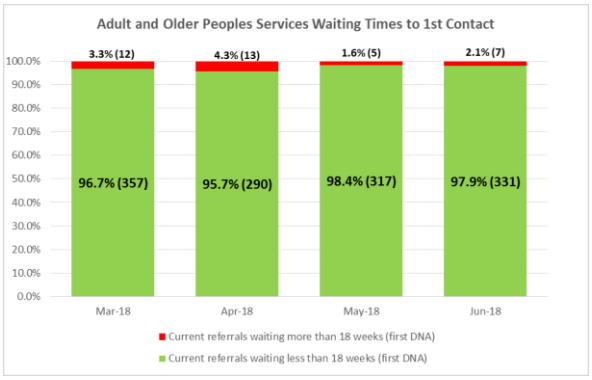


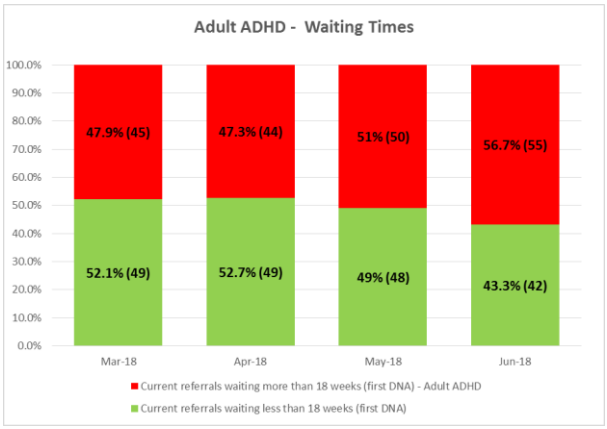


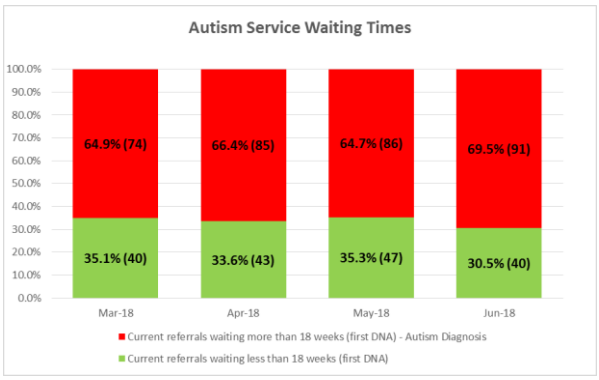




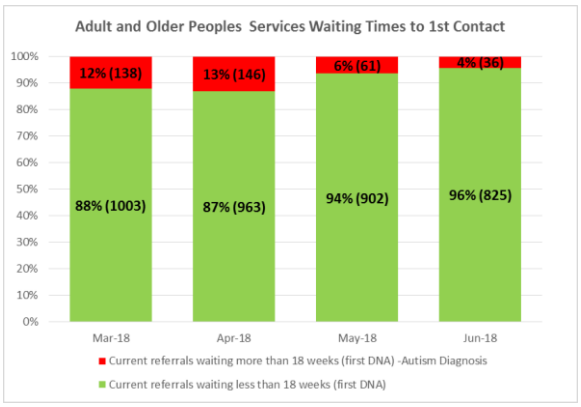
NORTH TYNESIDE CCG Waiting times summary as at 30th June 2018

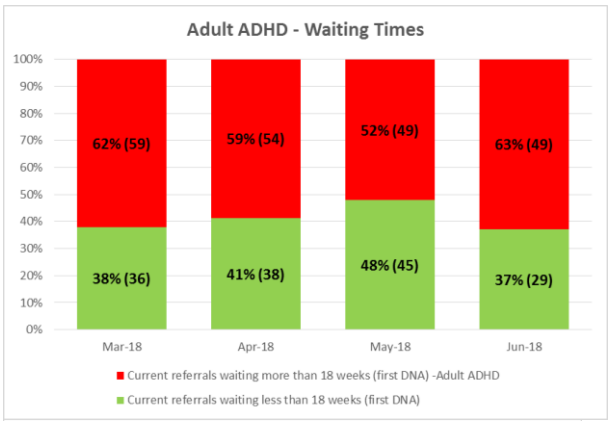


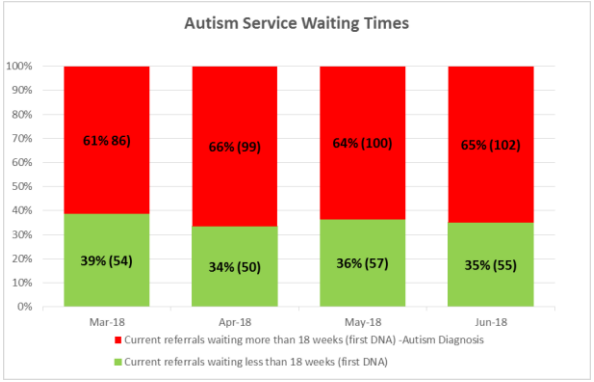


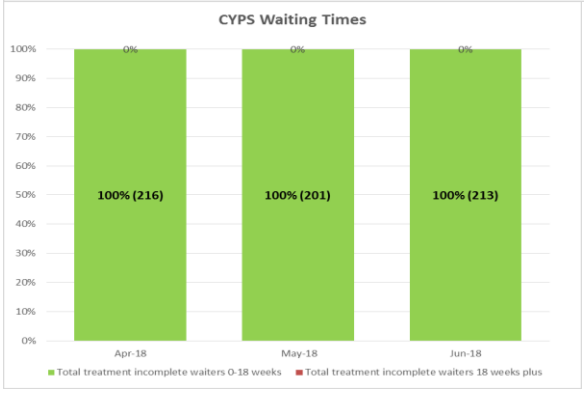


NORTHUMBERLAND CCG Waiting times summary as at 30th June 2018

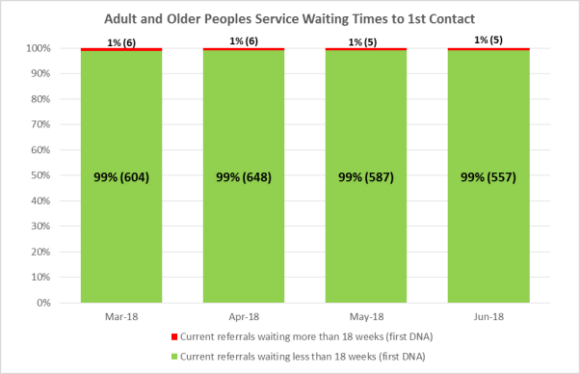


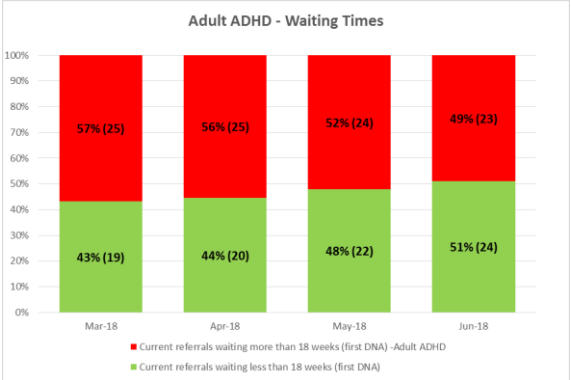


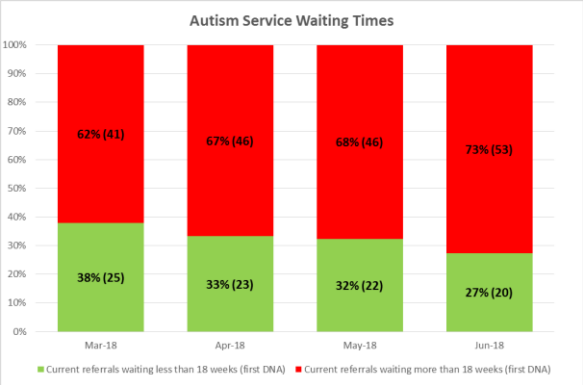


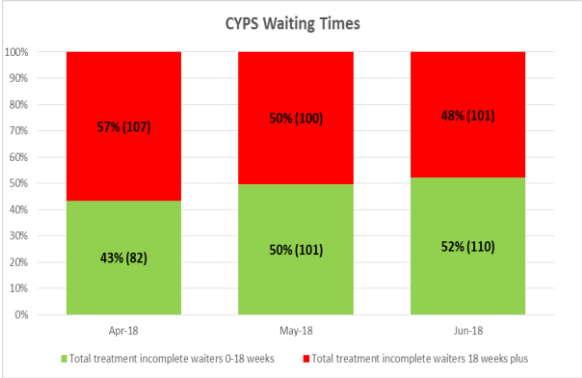


SOUTH TYNESIDE CCG Waiting times summary as at 30th June 2018

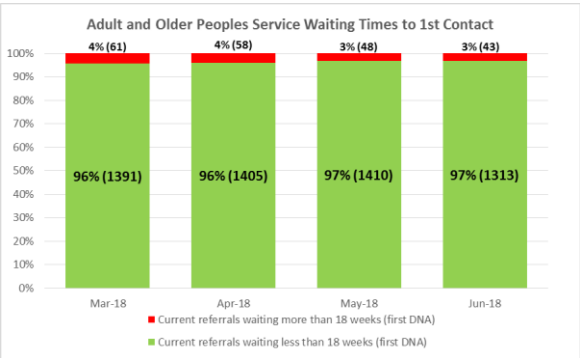


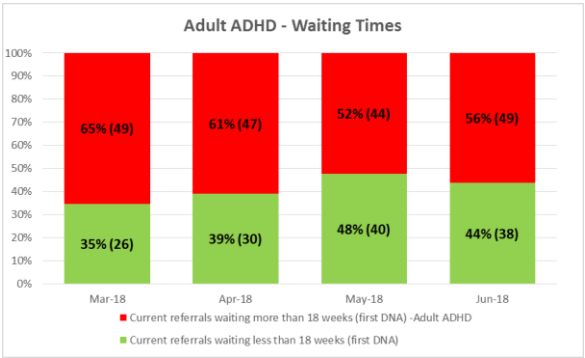


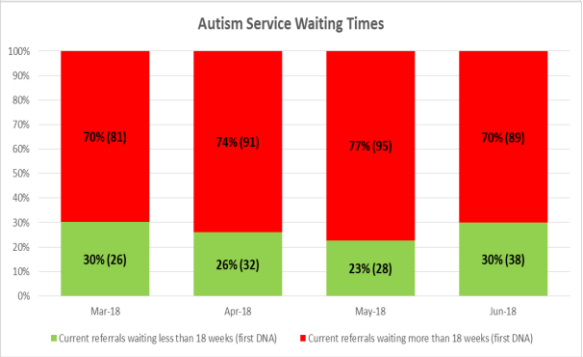


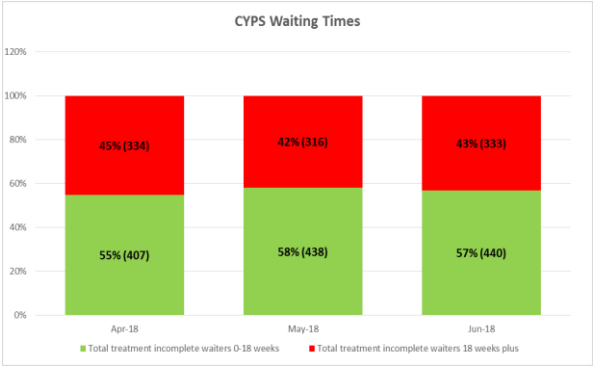


SUNDERLAND CCG Waiting times summary as at 30th June 2018









5. Finance Update June 2018

Financial Performance Dashboard

NTW Income & Expenditure

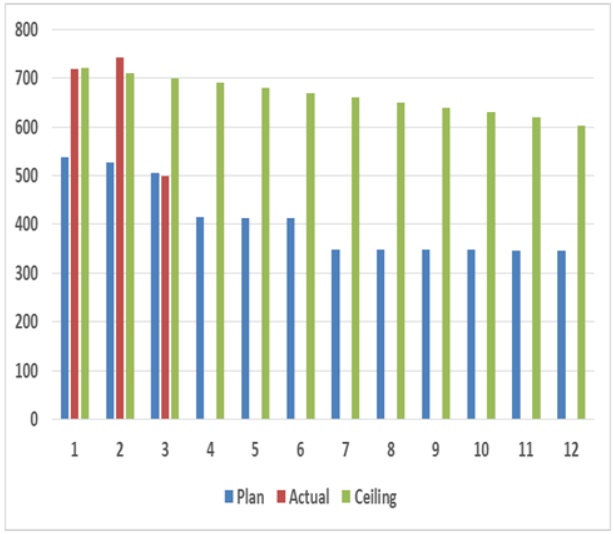
	YTD Plan £m	YTD Actual £m	YTD Variance £m
Income	77.7	78.3	(0.6)
Pay	(63.0)	(63.0)	(0.0)
Non Pay	(15.2)	(15.6)	0.4
Surplus/(Deficit)	**(0.5)**	**(0.3)**	**(0.2)**

Control Totals

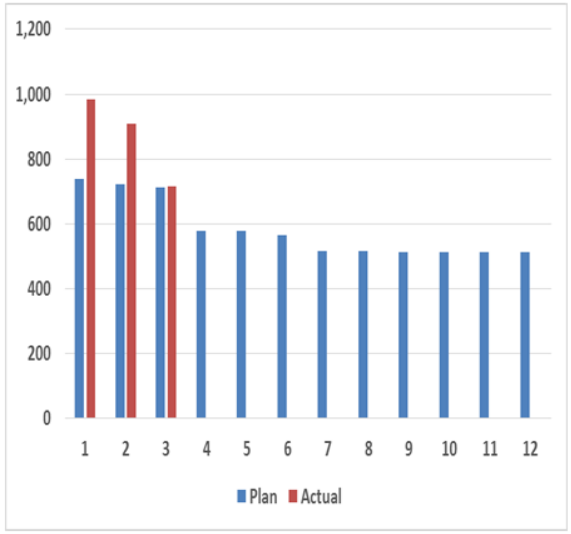
	YTD Plan £m	YTD Actual £m	YTD Variance £m
North	5.5	5.6	(0.1)
Central	6.0	5.6	0.4
South	7.1	7.6	(0.5)
Central Depts	(19.1)	(19.1)	0.0
Surplus/(Deficit)	**(0.5)**	**(0.3)**	**(0.2)**

Key Indicators	YTD	Plan / Forecast
Risk Rating	3	3
Agency Spend	£1.9m	£6.5m
FDP Delivery	£1.6m	£12.6m
Cash	£18.1m	£19.6m
Capital Spend	£1.4m	£13.2m

Agency Spend



Bank Spend

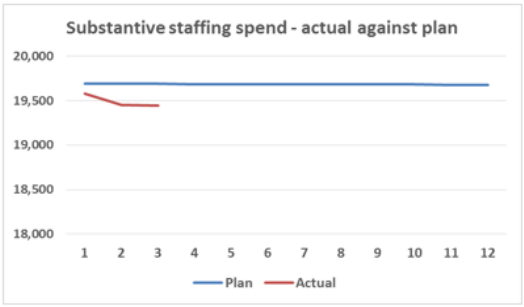


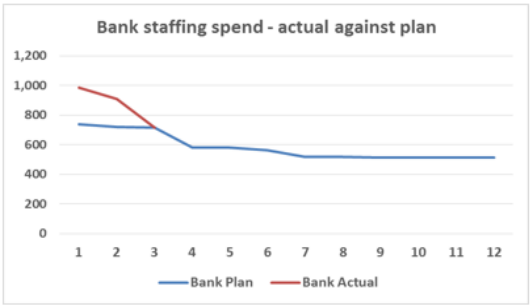
Key Issues/Risks

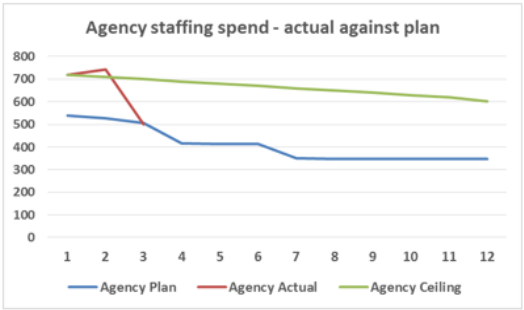
- Surplus/Deficit - £0.3m deficit at Mth3 which is £0.2m ahead of plan.
- Control Total – The Trust is forecasting delivery of its £3.5m Control Total.
- Risk Rating – The Use of Resources rating is a 3 at Mth3 & the forecast year-end rating is also a 3.
- Pay costs are in line with plan following a reduction in pay costs this month. Pay spend needs to continue to reduce if the Trust is to meet its control total.
- Main pressures - There are pay overspends in a number of areas and non-pay costs are also above plan.
- Agency Spend – Agency ceiling is £8.0m and Trust planned spend is £4.9m in 18/19. Spend at Mth3 is £1.9m which is £0.2m below the ceiling trajectory but £0.4m above plan.
- Financial Delivery Plan - Savings of £1.6m have been achieved at Mth3 which is in line with plan.
- In addition to its planned £12.6m efficiency savings the Trust needs to deliver £2.3m of service retractions to support Northumberland CCG's Recovery Plan.
- Cash – £18.1m at Mth3 which is £2.5m above plan.
- Capital Spend - £1.4m at Mth3 which is £0.5m less than plan.

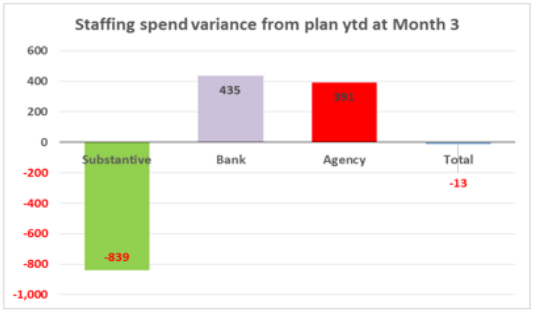
Finance - Staffing Dashboard

Staffing Dashboard – Month 3 2018/19









Staffing spend at month 3 is in line with plan. Both Bank and Agency spending levels were at planned levels in month 3 and the Trust spend on substantive posts is less than plan. The Trust's agency ceiling for 18/19 is £8m. Year to date agency spend at Mth 3 is £1.9m which is £0.4m above plan, but £0.2m below the ceiling.

Reporting to NHSI – Number of Agency shifts and number of shifts that breach the agency cap

	04/06/2018		11/06/2018		18/06/2018		25/06/2018	
Medical	90	21	90	21	87	21	87	21
Qual Nursing	121	5	126	5	126	5	111	5
Unq Nursing	311		310		299		347	
A&C	185		163		184		192	
	707	**26**	**689**	**26**	**696**	**26**	**737**	**26**

In June the Trust reported an average of 26 price cap breaches (21 medical and 5 qualified nursing). In June 4 medics were paid over the price cap.

6. Monthly Workforce Update June 2018

Workforce Dashboard

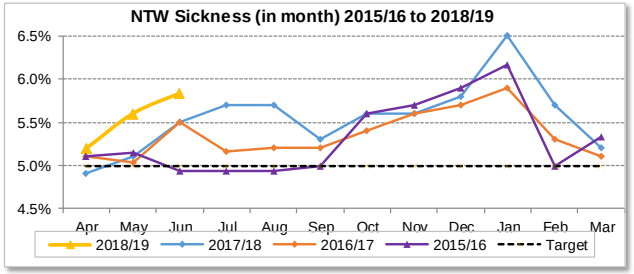
Training and Appraisals	Standard	M3 position	Overall Trend	North Locality Care Group	Central Locality Care Group	South Locality Care Group	Support & Corporate	Doctors in Training *	Staffing Solutions - Nursing	Staffing Solutions - Psychology	NTW Solutions
Fire Training	85%	90.1%	▼	91.4%	90.1%	91.2%	88.1%	80.3%	83.3%	60.0%	94.9%
Health and Safety Training	85%	95.6%	▲	96.8%	95.0%	96.0%	94.1%	91.3%	93.0%	92.0%	97.7%
Moving and Handling Training	85%	95.9%	▼	96.5%	94.6%	96.4%	94.1%	89.8%	97.5%	92.0%	97.7%
Clinical Risk Training	85%	92.1%	▲	91.0%	93.1%	93.1%			82.1%		
Clinical Supervision Training	85%	85.8%	▲	83.5%	88.3%	86.2%			77.4%		
Safeguarding Children Training	85%	92.7%	▼	92.4%	91.9%	93.7%	91.4%	86.6%	93.9%	96.0%	94.2%
Safeguarding Adults Training	85%	94.6%	▼	96.1%	94.1%	95.0%	93.0%	90.6%	94.1%	92.0%	94.6%
Equality and Diversity Introduction	85%	94.9%	▼	96.5%	94.1%	95.2%	93.5%	91.3%	91.4%	96.0%	96.9%
Hand Hygiene Training	85%	93.6%	▼	95.2%	93.3%	94.5%	92.5%	92.1%	92.1%	96.0%	90.1%
Medicines Management Training	85%	88.1%	▲	89.7%	87.9%	87.7%	95.1%		78.3%		
Rapid Tranquilisation Training	85%	84.4%	▼	92.8%	93.1%	88.4%			44.3%		
MHCT Clustering Training	85%	91.9%	▲	89.4%	91.2%	94.3%					
Mental Capacity Act/ Mental Health Act/ DOLS Combined Training	85%	77.0%	▼	79.8%	80.0%	79.2%			53.5%		
Seclusion Training (Priority Areas)	85%	94.5%	▼	93.7%	95.8%	92.3%					
Dual Diagnosis Training (80% target)	80%	88.3%	▼	94.5%	92.2%	87.3%			60.3%		
PMVA Basic Training	85%	80.5%	▼	84.5%	85.5%	85.7%			65.0%		
PMVA Breakaway Training	85%	84.6%	▲	87.1%	81.8%	84.6%					
Information Governance Training	95%	92.9%	▼	94.2%	93.3%	94.0%	90.4%	75.6%	84.9%	64.0%	99.0%
Records and Record Keeping Training	85%	98.6%	▼	99.5%	98.8%	99.1%	93.3%	86.6%	99.1%	100.0%	99.1%

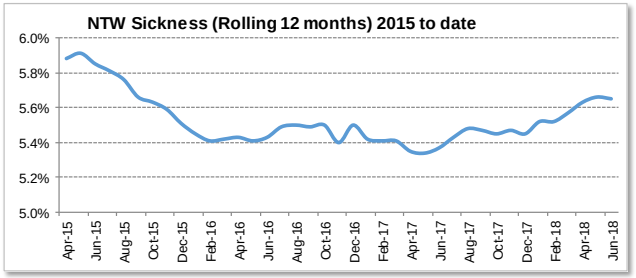
* NB Prior learning may not be reflected in these figures and is being investigated

Appraisals	85%	84.4%	–	87.0%	84.2%	85.2%	74.5%				93.2%

Managing Attendance - includes NTW Solutions	Target	M3 position	Trend
In Month sickness (provisional)	<5%	5.83%	▼
Short Term sickness (rolling)		1.54%	
Long Term sickness (rolling)		4.11%	
Average sickness (rolling)	<5%	5.65%	▼

NB - NTW Solutions Sickness absence in the month was 4.19%





Best Use of Resources	Target	M3 position	Trend
Agency Spend		£499,635	▲
Admin & Clerical Agency (included in above)		£72,737	▲
Overtime Spend		£142,394	▲
Bank Spend		£711,933	▲

Recruitment, Retention & Reward	Target	M3 position	Trend
Corporate Induction	100%	100.0%	–
Local Induction	100%	99.6%	–
Staff Turnover (includes NTW Solutions)	<10%	8.5%	▲
Current Headcount		6273	

*this is a rolling 12 month figure

Behaviours and Attitudes	M3 position
Disciplinaries (new cases since 1/4/18)	87
Grievances (new cases since 1/4/18)	5

* Trainee Doctors rotate every 4-6 months and it takes approx. one month for them to complete all of the training they are required to complete. There have been issues identified relating to the different systems used to record training completion. These issues are being addressed as part of the streamlining process, which should be in place for the rotation in August 2018 whereby the training record will move with the Doctor.

Please note that to improve data quality, the INS month sickness figure reported in this report is provisional and will be updated each month with the final figure.

The May 2018 in month sickness figure provisionally reported as 5.53% last month, is now confirmed as 5.60% and the graph above has been updated to reflect this

7. Quality Goals/Quality Priorities/Quality Account Update June 2018

Progress for the quarter one requirements for each of the 2018-19 quality priorities is summarised below.

Quality Goal:	2017-18 Quality Priority:		Quarterly Forecast Achievement:				
			Q1	Q2	Q3	Q4	Comments
Keeping you safe	1	Improving the inpatient experience					
Working with you, your carers and your family to support your journey	2	Improve waiting times for referrals to multidisciplinary teams.					
	3	Implement principles of the Triangle of Care					
Ensure the right services are in the right place at the right time to meet all your health and wellbeing needs	4	Embedding Trust values					

8. Accountability Framework

N.B reflects the revised Accountability Framework for 2017-18 which took effect from 1st April 2017 (please see Appendix 2)

		North Locality Care Group				Central Locality Care Group				South Locality Care Group				Comments:
	Overall Rating	Q1 forecast	Q2	Q3	Q4	Q1 forecast	Q2	Q3	Q4	Q1 forecast	Q2	Q3	Q4	
		4				4				4				
Quality Governance	Performance against National Standards:	1				1				1				
	CQC Information:	2				1				1				
	Performance against Contract Quality Standards:	3				3				3				
	Clinical Quality Metrics:	3				4				4				
Use of Resources	YTD Contribution	1				4				1				
	Forecast Contribution	4				4				1				
	Agency Spend	4				1				1				

9. Service User & Carer Experience Monthly Update June 2018

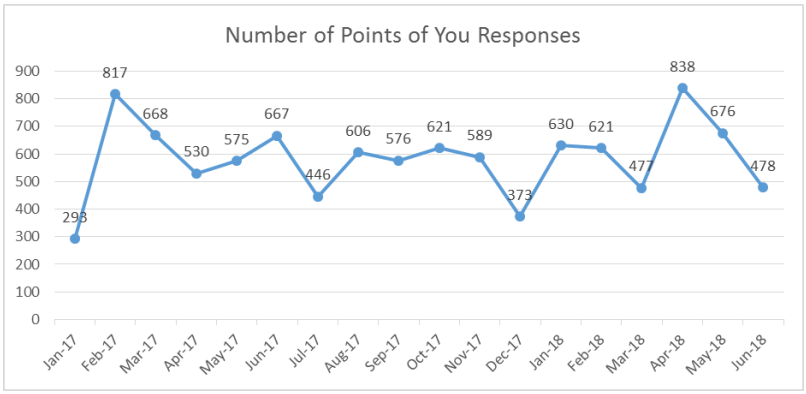
Experience Feedback:

Feedback received in the month – June 2018:

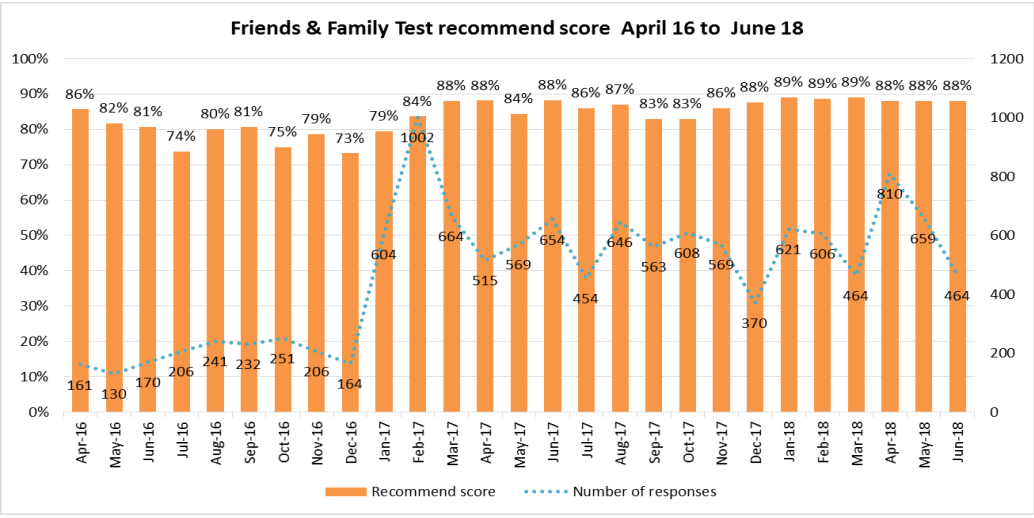
	Responses received June 2018	Results June 2018
Points of You Feedback from Service Users ('Both' option included here)	357	Overall, did we help? Scored: 8.8 out of 10* (8.9 in May)
Points of You Feedback from Carers	121	
Total Points of You responses received	478	FFT Recommend Score**: 88% (88% in May)

* score of 10 being the best, 0 being the worst
** national average recommend score resides around 89%

Graph showing Points of You responses received by month:



In June the number of Points of You responses decreased compared to the previous month of May. The results have remained static with 88% of respondents identifying they would recommend our services to family or friends, which is slightly below the national average of 89%.



Nb 14 of the 478 PoY responses in the month did not answer the FFT question within the survey

10. Mental Health Act Dashboard

Mental Health Act Dashboard			
Key Metrics	**April**	**May**	**June**
Record of Rights (Detained) Assessed within 7 days of detention start date	93.3%	93.7%	93.5%
Record of Rights (Detained) Revisited in past 3 months (inpatients)	97.4%	96.1%	93.6%
Record of Rights (Detained)Assessed at Section Change within the Period	92.0%	97.4%	92.7%
Record of Capacity/CTT for Detained clients Part A completion within 7 days of 3 month rule Starting	30.6%	22.1%	17.1%
Community CTO Compliance Rights Reviewed in Past 3 months			49.1%
Community CTO Compliance Rights Assessed at start of CTO	70.0%	100.0%	77.8%

Compliance with the provision of rights to detained patients is above 90% across all of the key metrics. Variations in the percentage compliance with the provision of rights to patients at the start of a CTO are noted, this is due to the low number of patients involved. The relevant dashboard has (over a number of months) shown compliance with the repeat of rights for CTO patients (within a 3 month period) as consistently above 90%. A problem with this particular metric was identified at the beginning of July. This has now been rectified and the correct compliance is reflected for June. This issue has been reported to the Mental Health Legislation Steering Group and all of the Locality Groups notified. Work will be undertaken to ensure those patients who are affected will be provided with their rights as soon as possible.

Monthly reports are provided to each of the Locality Care Groups with any exceptions highlighted.

A quarterly activity and monitoring which includes compliance with the provision of rights is reviewed by the Mental Health Legislation Steering Group.

The inclusion of the provision of a repeat explanation of rights within the review date set is to be included in the ‘At a Glance’ boards which are currently being redeveloped.

Compliance with the completion and recording of capacity assessments in relation to Section 58 type treatment (medication for mental disorder) is low across all metrics measured via the dashboards. In relation to completing and recording a capacity assessment close to the point of detention (Part A of the local form) the dashboards show compliance as 22.1% in May and 17.1% for June.

However some detailed investigation/analysis of the dashboard data for that metric has been undertaken and has shown that (as at 19/05/18) capacity assessments had been undertaken in around a further 55% cases. However the dashboard was not counting these as they had either been completed/recorded outside of the required timescales, the recording form was not completed fully or a combination of both. Had the above issues not prevailed then actual compliance at that date would have been around 78%

Some promotional work to address these issues is underway.

11. Outcomes/Benchmarking/National datasets Update and Other Useful Information

Benchmarking

The NHS Benchmarking collection for Mental Health Community and Inpatient data has been submitted to the NHS Benchmarking team in line with national timescales.

The submission of the CAMHS data collection is currently being collated within the organisation and will be submitted in July 2018.

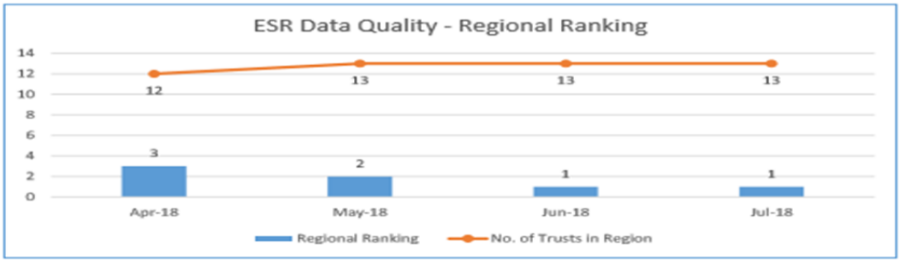
The community report has been received back from the NHS Benchmarking team and this is currently being reviewed internally.

ESR Data Quality

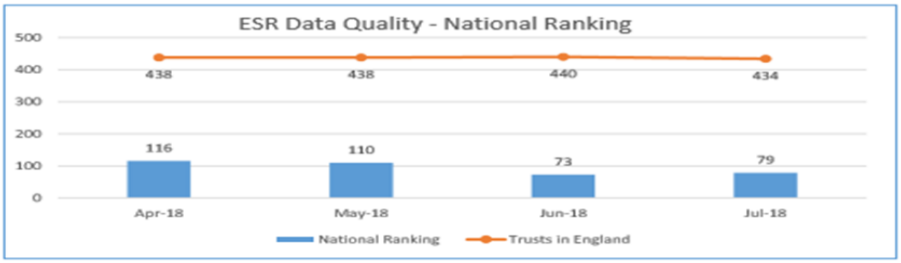
The latest results from the ESR data quality report has been released. NTW are first in the region at 79th out of 434 nationally.

ESR Data Quality – WOVEN Report **Jul-18**

Source Data:
https://digital.nhs.uk/data-and-information/areas-of-interest/workforce/electronic-staff-record-data-quality-reports-woven



National Ranking	Regional Organisation Names
79	Northumberland, Tyne and Wear NHS Foundation Trust
102	Newcastle Upon Tyne Hospitals NHS Foundation Trust
135	South Tyneside NHS Foundation Trust
136	Tees, Esk and Wear Valleys NHS Foundation Trust
159	Gateshead Health NHS Foundation Trust
182	North Tees and Hartlepool NHS Foundation Trust
192	South Tees Hospitals NHS Foundation Trust
224	County Durham and Darlington NHS Foundation Trust
277	Northumbria Healthcare NHS Foundation Trust
359	City Hospitals Sunderland NHS Foundation Trust
377	North East Ambulance Service NHS Foundation Trust
428	NHS South Tees CCG
434	Mental Health Concern



12. Improving Access to Psychological Therapies (IAPT)

Listed below are the Sunderland IAPT Outcome Measures for June 2018.

SUNDERLAND CCG PATIENTS - IAPT Only Patients - Quality Metrics in 2018-2019

Outcome Measure	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Access - BAME (% of total service users entering treatment)	TBA	1.55%	3.55%	1.86%									
Access - Over 65 (% of total service users entering treatment)	TBA	6.06%	5.74%	6.99%									
Access - Specific Anxieties (% of total service users entering treatment)*	TBA	11.38	10.81%	12.11%									
Choice - % answering no	TBA	0%	0%	0%									
Choice - % answering partial	TBA	3.25%	2.20%	2.01%									
Choice - % answering yes	TBA	96.75%	97.80%	97.99%									
Employment Outcomes - Moved from Unemployment into Employment or Education	TBA	4	3	2									
Patient Satisfaction (Average Score)	TBA	19.70	19.47	19.66									
Recovery	50% of patients completing treatment	49.80%	50.50%	51.10%									
Reduced Disabilty Improved Wellbeing	TBA	35.02%	30.79%	34.29%									
Reliable Improvement	TBA	70.03%	69.84%	71.34%									
Self Referrals (% of discharges who had self referred)	TBA	74.73%	73.97%	77.46%									
Waiting Times	95% entering treatment within 18 weeks	99.85%	100.00%	100.00%									
Waiting Times	75% entering treatment within 6 weeks	99.23%	99.66%	99.69%									

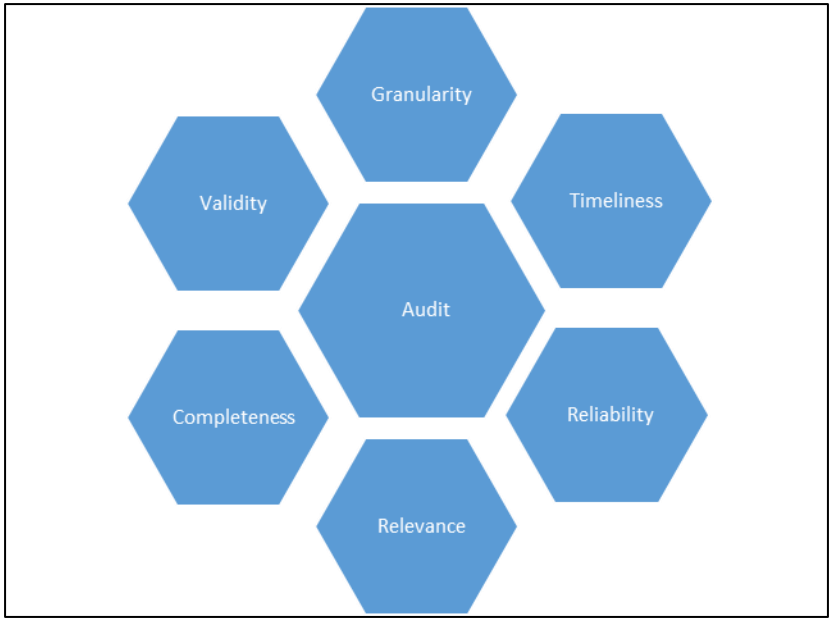
13. Data Quality Plan

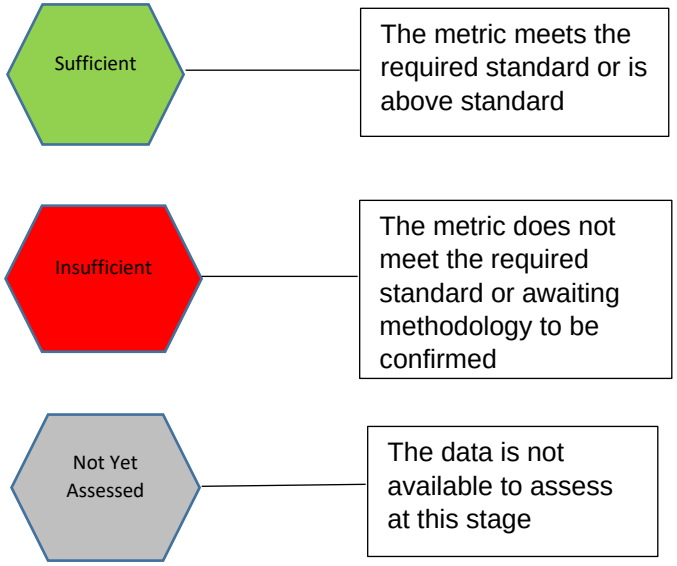
Good quality information underpins the effective delivery of care and is essential if improvements in quality of care are to be made. The Trust has already made extensive improvements in data quality. During 2017/18 the Trust will build upon the actions taken to ensure that we continually improve the quality of information we provide.

Clinical Record Keeping	We will continue to monitor the use of the RiO clinical record system, learning from feedback and incidents, measuring adherence to the Clinical Records Keeping Guidance and highlighting the impact of good practice on data quality and on quality assurance recording. We will continue to improve and develop the RiO clinical record system in line with service requirements.
NTW Dashboard development	We will continue to review the content and format of the existing NTW dashboards, to reflect current priorities including the development and monitoring of new and shadow metrics that are introduced in line with national requirements. We will continue to develop the Talk 1st and Points of You dashboards.
Data Quality Kitemarks	We will continue to roll out the use of data quality kitemarks in quality assurance reports further.
Data Quality Group	We will implement a Trust wide data quality group.
Mental Health Services Dataset (MHSDS)	We will continue to understand and improve data quality issues and maintain the use of national benchmarking data. We will seek to gain greater understanding of the key quality metric data shared between MHSDS, NHS Improvement and the Care Quality Commission. We will improve our data maturity index score and understand areas where improvement is required.
Consent recording	We will continue to redesign the consent recording process in line with national guidance and support the improvement of the recorded consent status rates.
ICD10 Diagnosis Recording	We will continue to increase the level of ICD10 diagnosis recording across community services.
Mental Health Clustering	We will increase the numbers of clinicians trained in the use of the Mental Health Clustering Tool and improve data quality and data completeness, focusing on issues such as cluster waiting times analysis, casemix analysis, national benchmarking and HoNOS 4-factor analysis to support the consistent implementation of outcomes approaches in mental health.
Contract and national information requirements	We will continue to develop quality assurance reporting to commissioners and national bodies in line with their requirements.
Quality Priorities	We will develop a robust reporting structure to support the quality priorities relating to waiting times and improving inpatient care.
Outcome Measures	We will enhance the current analysis of outcome measures focusing on implementing a system for reporting information back to clinical teams. We will also focus on Improving Access to Psychological Therapies (IAPT) outcomes to ensure preparedness for the introduction of IAPT outcomes based payment in 2018-19.
Sexual orientation monitoring information standard	We will work towards meeting the requirements of the sexual orientation monitoring standard.
Electronic Staff Record (ESR)	We will develop data quality monitoring of ESR data and develop action plans to address issues identified.

Appendix 1 Data Quality Kite Marks

Data Quality Kite Mark Assessment





Each metric has been assessed using the seven elements listed in blue to provide assurance that the data quality meets the standard of sufficient, insufficient or Not Yet Assessed

Data Quality Kite Mark – This page provides guidance relating to how the metrics have been assessed within NHS Improvements, Single Oversight Framework and Contract Standards

Data Quality Indicator	Definition	Sufficient	Insufficient	What does it mean if the indicator is insufficient	Action if metric is insufficient
Timeliness	Is the data the most up to date and validated available within the system?	The data is the most up to date available	Data is not available for the current period due to problems with the system or process	The data is not the most up to date and decisions may be made on inaccurate data	Understand why the data was not completed within given timeframes. Report this to relevant parties as required
Granularity	Can the data be broken down to different levels e.g. Available at Trust level down to client level?	Where relevant the Trust has the ability to drill down into the data to the correct level	The Trust is unable to drill down into the data to the correct level	It is not possible to drill down to the relevant level of data to understand any issues	Work with relevant teams to ensure the data can be broken down to varying levels
Completeness	Does the data demonstrate the expected number of records for that period?	There is assurance that effective controls are in place to ensure 100% of records are included within the metrics as required and no individual records are excluded without justification	There is inadequate assurance or no assurance that effective controls are in place to ensure 100% of records are included within the metrics	Performance cannot be assured due to the level of missing data	Understand why the data was not complete and request when the data will be updated. Report this to relevant parties as required

Data Quality Indicator	Definition	Sufficient	Insufficient	What does it mean if the indicator is insufficient	Action if metric is insufficient
Validity	Is the data validated by the Trust to ensure the data is accurate and compliant with relevant rules and definitions?	The Trust have agreed procedures in place for the validation and creation of new metrics and amendments to existing metrics	A metric is added or amended to the dashboard without the correct procedures being followed	The data has not been validated therefore performance cannot be assured	The metrics are regularly reviewed and updated as appropriate
Audit	Has the data quality of the metric been audited within the last three years?	The data quality of the metric has been audited within the last three years	The metric has not been audited within the last 3 years	The system and processed have not been audited within the last three years therefore assurance cannot be guaranteed	Ensure metrics that are outside the three year audit cycle are highlighted and completed within the next year. Review the rolling programme of audit
Reliability	The process is fully documented with controls and data flows mapped	Mostly a computerised system with automated controls	Mostly a manual system with no automated controls	Process is not documented and/or for manual data production controls and validation procedures are not adequately detailed	Ensure processes are reviewed and updated accordingly and changes are communicated to appropriate parties
Relevance	The indicator is relevant to the measurement of performance against the Performance question, strategic objective, internal, contractual and regularity standards	This indictor is relevant to the measurement of performance	This indicator is no longer relevant to the measurement of performance	The metric may no longer be relevant to the measurement of standards	Ensure dashboards are reviewed regularly and metrics displayed are relevant and updated or retired if no longer relevant

Accountability Framework – Appendix 2

		1	2	3	4
Quality Governance	**Performance against national standards**	All Achieved or failure to meet any standard in no more than one month	Failure to meet any standard in 2 consecutive months triggered during the quarter	Failure to meet any standard in 3 or more consecutive months triggered during the quarter	Trust is assigned a segment of 3 (mandated support) or 4 (special measures)
	CQC Information	No Concerns -all core services are rated as Good or Outstanding and there are no "Must Do's" with outstanding actions.	No Concerns - all core services are rated as Good or Outstanding however there are "Must Do's" with outstanding actions.	Concerns raised – one or more core services are rated as "Requires Improvement"	Concerns raised – one or more core services are rated as "Inadequate"
	Performance against contract quality standards *(measured at individual contract level)*	All Achieved	All but a small number of contract metrics are achieved for the quarter and there is a realistic plan in place to recover the underperformance within the following quarter.	Quarterly standard breached in 2nd consecutive quarter, or there is a contract metric not achieved which is not recoverable within the following quarter.	Quarterly standard breached and contract penalties applied or are at risk of being applied.
	Clinical Quality Metrics	All Achieved	All but a small number of contract metrics are achieved for the quarter and there is a realistic plan in place to recover the underperformance within the following quarter.	Quarterly standard breached in 2nd consecutive quarter, or there is a contract metric not achieved which is not recoverable within the following quarter.	Quarterly standard breached in 3rd consecutive quarter.
Use of resources	**YTD contribution**	Exceeding or meeting plan.	Just below plan (within 1%).	Between 1% and 2% below plan	More than 2% below plan
	Forecast contribution				
	Agency Spend	Below or meeting ceiling.	Up to 25% above ceiling.	Between 25% and 50% above ceiling.	More than 50% above ceiling.
	Use of resources metrics	TBC	TBC	TBC	TBC

Northumberland, Tyne and Wear NHS Foundation Trust
Board of Directors Meeting

Meeting Date: Board Of Directors, 25th July 2018

Title and Author of Paper: Board Assurance Framework and Corporate Risk Register – Natalie Yeowart, Risk Management Lead.

Executive Lead: Lisa Quinn, Executive Director of Commissioning and Quality Assurance

Paper for Debate, Decision or Information: Information

Key Points to Note:

Pg.1 As at July 2018 there has been a decrease in the overall number of risks held on the BAF/CRR from 12 to 10.
Pg.2 Following the recent Board of Directors review it was agreed to seek opinions on the risk appetite descriptions. The CDTR group has discussed and considered several options and agreed to continue with current risk appetite until the development of a risk appetite impact table using risk appetite categories is complete. The CDTR group will review and consider all three options again when impact table is complete, and will report back to the Board of Directors in September 2018.
Pg.3 The highest risk appetite category on the BAF/CRR remains Quality Effectiveness (4) in Q2.
Pg.3 There are currently 8 BAF/CRR risks exceeding a risk appetite. A detailed description is provided on Pg.4.
Pg.6 There has been 1 risk de-escalated from the BAF/CRR.
Pg.6 A decision was made to merge risk number SA1.9 with SA4.2. The Exec Risk Lead will be joint between James Duncan and Gary O'Hare.

Risks Highlighted:
As highlighted in the paper.

Does this affect any Board Assurance Framework/Corporate Risks?
Yes – Report detailing the review of the Board Assurance Framework and Corporate Risk Register.

Equal Opportunities, Legal and Other Implications:
Addressed in Board Assurance Framework and Corporate Risk Register

Outcome Required: To note Board Assurance Framework and Corporate Risk Register and Groups/Corporate Risks.

Link to Policies and Strategies:
Risk Management Strategy and Risk Management Policy

Northumberland, Tyne and Wear NHS Foundation Trust

Board Assurance Framework and Corporate Risk Register

Purpose

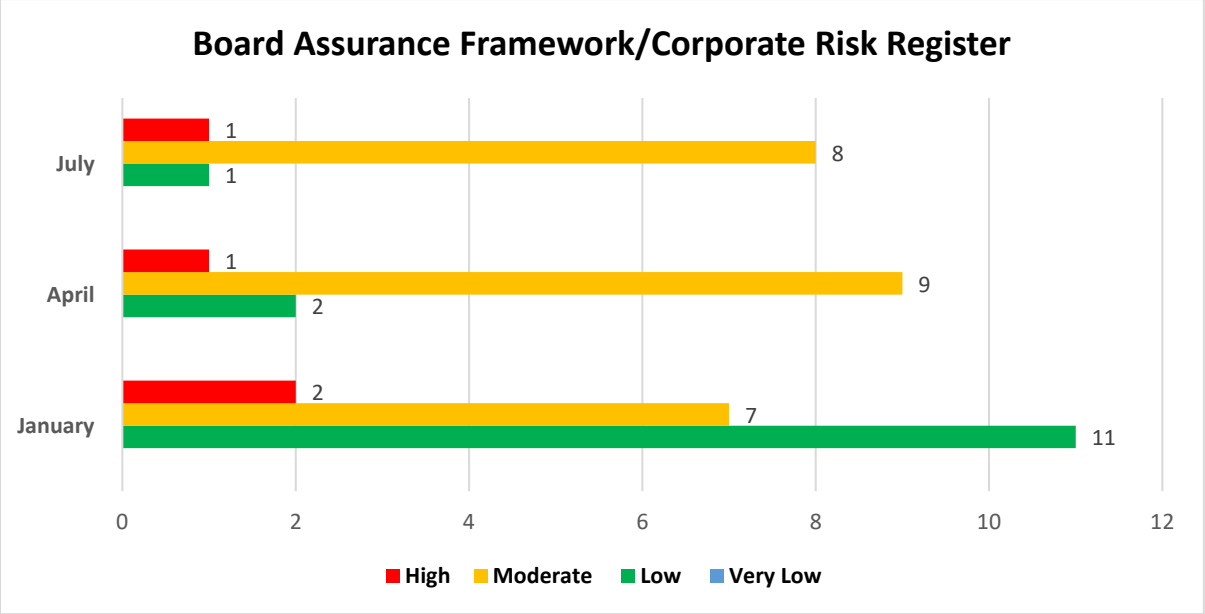
The Northumberland, Tyne & Wear NHS Foundation Trust Board Assurance Framework/Corporate Risk Register identifies the strategic ambitions and key risks facing the organisation in achieving the strategic ambitions.

This paper provides:

- A summary of both the overall number and grade of risks contained in the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).
- A detailed description of the risks which have exceeded a Risk Appetite included on the BAF/CRR, Locality Group and Corporate Directorate Risk Registers.
- A detailed description of any changes made to the BAF and CRR.
- A detailed description of any BAF/CRR reviewed and agreed risks to close.
- A summary of both the overall number and grade of risks held by each Clinical Group and Executive Corporate Risk Registers on the Safeguard system as at December 2017.

1.0 Board Assurance Framework and Corporate Risk Register

The below graph shows a summary of both the overall number and grade of risks held on the Board Assurance Framework/Corporate Risk Registers as at July 2018. In the quarter there has been a decrease in the overall number of risks from 12 to 10.



1.1. Risk Appetite

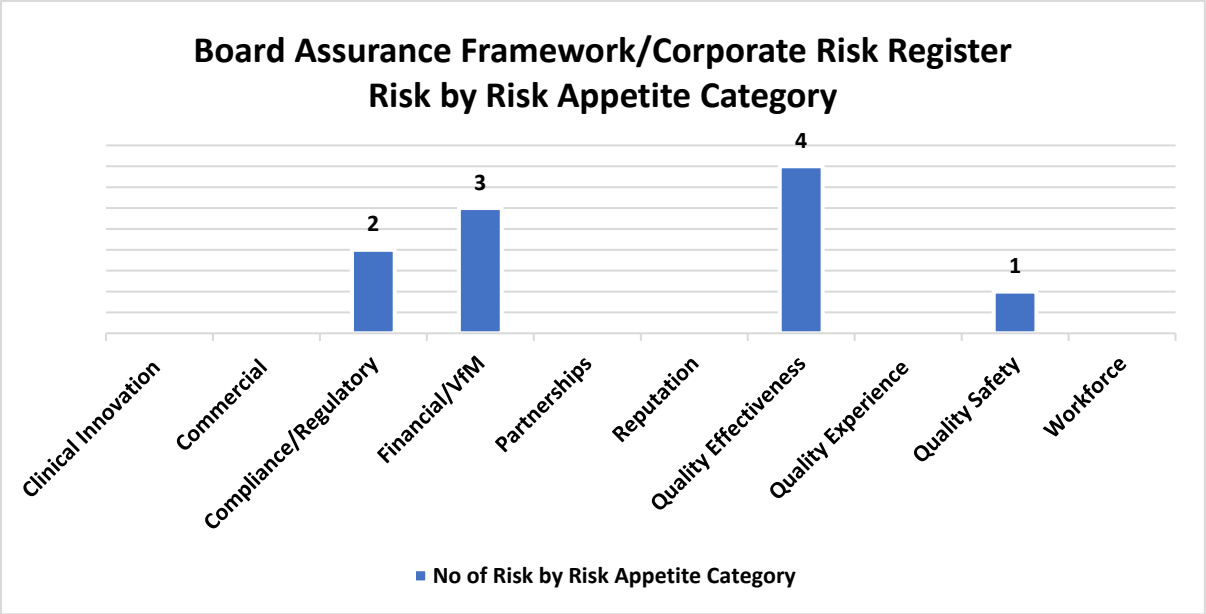
Risk Appetite was reviewed at the Board of Directors in April 2018. Following the Board of Directors review it was agreed to seek opinions on the risk appetite descriptors used on the risk appetite statement. The CDT Risk Management Group has considered 3 options:

1. To remove the additional quality element of the descriptor,
2. To remain the same and
3. To develop a new risk impact table to include the risk appetite categories and new descriptors.

The group agreed to continue with current risk appetite and develop option 3, risk appetite impact table and review and consider all three options again when option 3 is complete, reporting back to the Board of Directors in September 2018.

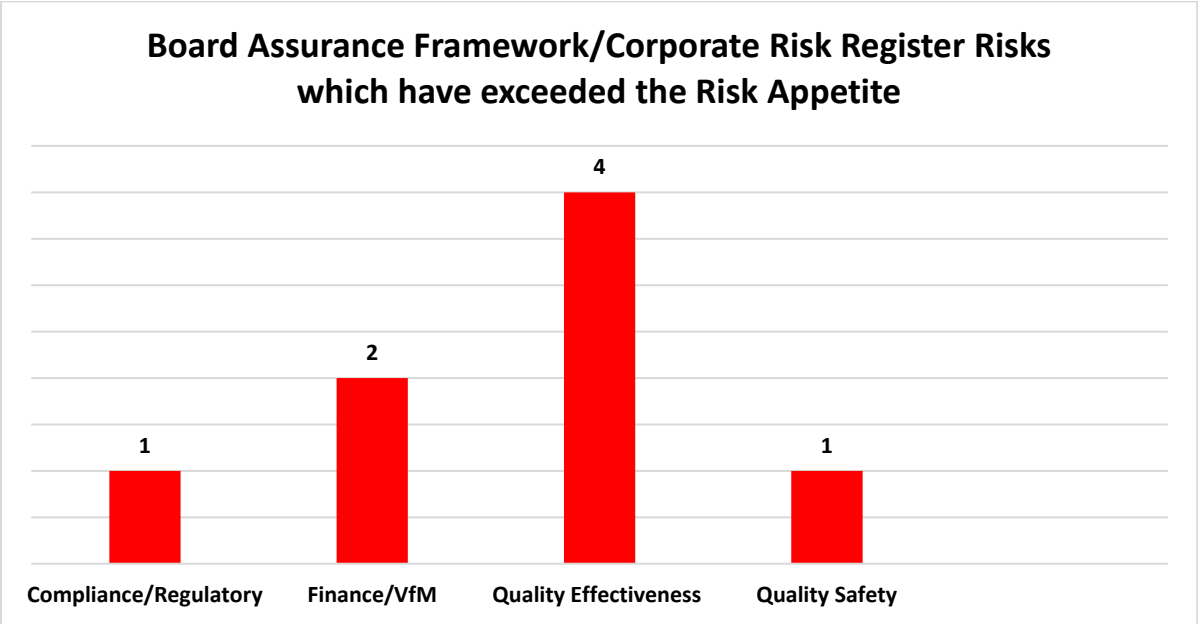
Category	**Risk Appetite**	**Risk Appetite Score**
Clinical Innovation	NTW has a **MODERATE** risk appetite for Clinical Innovation that does not compromise quality of care.	**12-16**
Commercial	NTW has a **HIGH** risk appetite for Commercial gain whilst ensuring quality and sustainability for our service users.	**20-25**
Compliance/Regulatory	NTW has a **LOW** risk appetite for Compliance/Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	**6-10**
Financial/Value for money	NTW has a **MODERATE** risk appetite for financial/VfM which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.	**12-16**
Partnerships	NTW has a **HIGH** risk appetite for partnerships which may support and benefit the people we serve.	**20-25**
Reputation	NTW has a **MODERATE** risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.	**12-16**
Quality Effectiveness	NTW has a **LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users.	**6-10**
Quality Experience	NTW has a **LOW** risk appetite for risks that may affect the experience of our service users.	**6-10**
Quality Safety	NTW has a **VERY LOW** risk appetite for risks that may compromise safety.	**1-5**
Workforce	NTW has a **MODERATE** risk appetite for actions and decisions taken in relation to workforce.	**12-16**

Risk appetite was implemented throughout the Board Assurance Framework/Corporate Risk Register in April 2017. The below table shows risks by risk appetite category. The highest risk appetite category is Quality Effectiveness (4) which is defined as risk that may compromise the delivery of outcomes.



Each risk category has an assigned risk tolerance score. The risk tolerance score highlights when a risk is below, within or has exceeded a risk appetite tolerance. There are currently 8 risks which have exceeded a risk appetite tolerance in the quarter.

The table below shows all BAF/CRR risks which have exceeded a risk appetite tolerance.



A detailed description of each BAF/CRR risk which has exceeded a risk appetite can also be found below. Action plans are in place to ensure these risks are managed effectively.

Risk Reference	Risk description	Risk Appetite	Risk score	Executive Lead
SA1.3	That there are adverse impacts on clinical care due to potential future changes in the clinical pathways through changes in commissioning of Services.	Quality Effectiveness (6-10)	12	Lisa Quinn
SA1.4	The risk that high quality, evidence based and safe services will not be provided if there are difficulties in accessing services in a timely manner due to waiting times and bed pressures resulting in the inability to sufficient sufficiently responsive to demands.	Quality Effectiveness (6-10)	12	Gary O'Hare
SA3.2	Inability to control regional issues including the development of integrated new care models and alliance working could affect the sustainability of MH and disability services.	Quality Effectiveness (6-10)	12	John Lawlor
SA4.1	That we have significant loss of income through competition and national policy including the possibility of losing large services and localities.	Finance/VfM (12-16)	20	Lisa Quinn
SA4.2	That we do not manage our resources effectively though failing to deliver required service change and productivity gains included within the Trust FDP	Finance/VfM (12-16)	15	James Duncan/Gary O'Hare
SA5.2	That we do not meet statutory and legal requirements in relation to Mental Health Legislation	Compliance/ Regulatory (6-10)	12	Rajesh Nadkarni
SA5.5	That there are risks to the safety of service users and others if we do not have safe and supportive clinical environments.	Quality Safety (1-5)	10	Gary O'Hare

Risk Reference	Risk description	Risk Appetite	Risk score	Executive Lead
SA5.9	Inability to recruit the required number of medical staff or provide alternative way of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services.	Quality Effectiveness (6-10)	12	Gary O'Hare

1.2. Amendments

Following review of the BAF/CRR with each lead Executive Director/Directors, the following amendments have been made:

Risk Reference	Risk description	Amendment	Executive Lead
SA1.2	That restrictions on capital funding nationally lead to a failure to meet our aim to achieve first class environments to support care, increasing the risk of harm to patients through continuing use of sub-optimal environments.	Actions complete and moved to controls. Action added.	James Duncan
SA1.3	That there are adverse impacts on clinical care due to potential future changes in clinical pathways through changes in commissioning of services.	Actions complete and moved to controls. Target risk score amended from 4x1 to 4x2 in line with risk appetite	Lisa Quinn
SA1.4	The risk that high quality, evidence based and safe services will not be provided if there are difficulties in accessing services in a timely manner due to waiting times and bed pressures resulting in the inability to sufficient sufficiently responsive to demands.	Risk description amended to include access and waiting times. Actions completed and moved to controls. Residual risk increased from 4x2 to 4x3.	Gary O'Hare
SA3.2	Inability to control regional issues including the development of integrated new care models and alliance working could affect the sustainability of MH and disability services.	Minor wording changes to description (removal of ICS, MCP, STP). Residual risk score reduced from 4x4 to 4x3.	John Lawlor

Risk Reference	Risk description	Amendment	Executive Lead
SA4.2	That we do not manage our resources effectively though failing to deliver required service change and productivity gains included within the Trust FDP	Minor wording changes to description. Decision to merge risk to include creating capacity to care risk SA1.9. Residual risk score reduced from 5x4 to 5x3.	James Duncan/Gary O'Hare
SA5.1	That we do not meet compliance & Quality Standards	Actions completed and moved to controls.	Lisa Quinn
SA5.2	That we do not meet statutory and legal requirements in relation to Mental Health Legislation.	Minor working changes, removal of 'significant'. Actions complete and moved to controls.	Rajesh Nadkarni
SA5.3	That we misreport compliance and quality standards through data quality errors.	Action amended	Lisa Quinn

1.3. Risks to be de-escalated.

Following review of the BAF/CRR with each of the lead Executive Directors/Directors there has been 1 risk de-escalated.

Risk Reference	Risk description	Risk Appetite	Risk score	Executive Lead	Comment
SA1.7	If staff do not follow information governance and informatic policies and procedures there is a risk to the staff, patients and the quality of service we deliver.	Compliance/ Regulatory	8	Lisa Quinn	To be de-escalated to Executive Director of Commissioning and Quality Assurance Risk Register

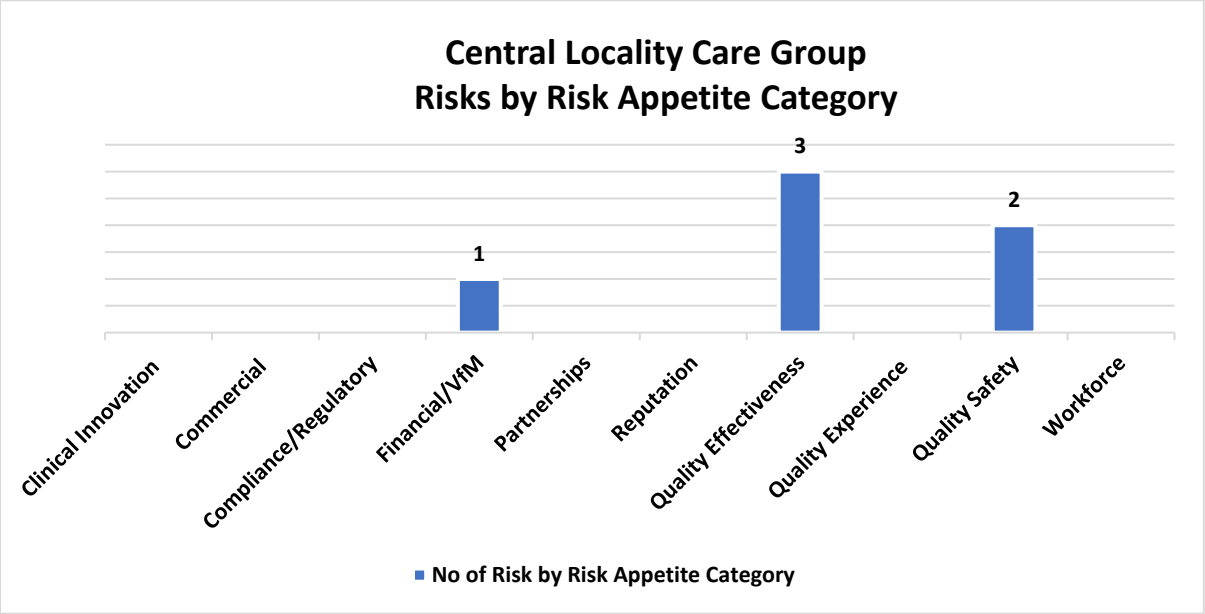
The following risk has been reviewed and a decision to merge with a current risk on the Board Assurance Framework/Corporate Risk Register has been made by the Executive Lead.

Current Risk ref:	Current Risk Description	New Risk ref:	New Risk Description
SA1.9	Inability to deliver the creating capacity to care initiatives could affect the quality, safety and sustainability of the services we deliver.	SA4.2	That we do not manage our resources effectively though failing to deliver required service change and productivity gains included within the Trust FDP

2.0. Clinical Locality Care Groups and Executive Corporate Trust Risk Registers.

The below charts show a summary of the number of risks by risk appetite category held by each Locality Care Group (Group Locality Risk Register) and Executive Corporate risk registers. Central Locality Care Group now hold 6 Group risks, North Locality Care Group hold 8 Group Risks and South Locality Care Group hold 11 Group Risks. Safeguard Web Risk Management and Risk appetite has been fully implemented throughout the group risk registers/executive corporate risk registers and risk continue to be monitored at the CDT Risk Management Sub Group monthly.

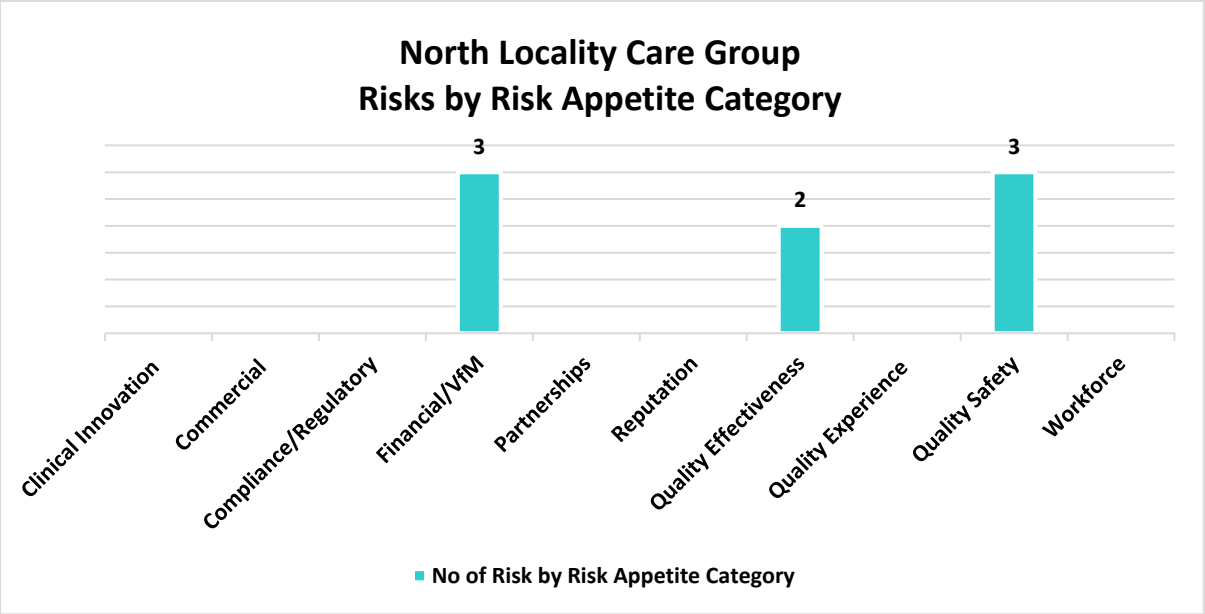
2.1 Clinical Groups



Central Locality Care Group as at July 2018 hold 6 risks, 2 risks within the risk appetite and 4 risks which have exceeded the risk appetite. All risks are being managed within the Community Care Group and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1038.v10	Medication pages on RiO are not being kept up to date as per NTW Policy.	Quality Safety (1-5)	16	4	4	Tim Docking
1175.v5	Access and waiting times within community services, increasing level of referrals are being made. Assessments are being completed but through flow of patients is not keeping pace with the number of referrals and so there is an increasing waiting list for treatment.	Quality Effectiveness (6-10)	12	4	3	Tim Docking

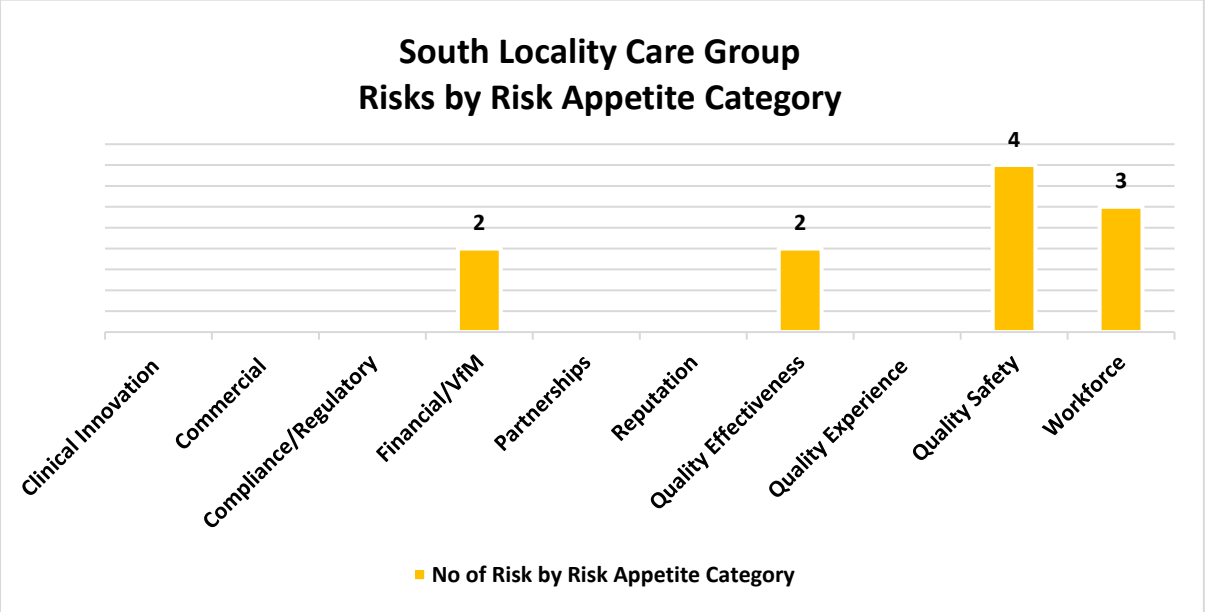
Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1513.v2	Access and waiting times within ADHD/ASD service. Weekly reports indicate that there has been no significant improvement in flow and the waiting lists are not reducing. Discussion regarding capacity and demand with commissioners however no further investment has been made to date.	Quality Effectiveness (6-10)	15	3	5	Tim Docking
1545.v1	Potential ligature risk identified within central locality care group wards during CERA process 2017-2018.	Quality Safety (1-5)	20	5	4	Tim Docking



North Locality Care Group as at July 2018 hold 8 risks, 1 risk lower than the risk appetite, 2 risks within the risk appetite and 5 risks which have exceeded the risk appetite. All risks are being managed within the North Locality Care Group and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1176.v4	There are increasing difficulties recruiting and retaining clinical staff within North Locality.	Quality Effectiveness (6-10)	16	4	4	Kedar Kale
Risk Reference	**Risk Description**	**Risk Appetite**	**Risk Score**	**S**	**L**	**Owner**
1293.v8	Access and waiting times- a review of the waiting lists within the North Locality has highlighted that there remains a significant issue from operational, clinical risk and reputational perspective with regard to the two primary issues; 1. Number of people waiting (head count) 2. Duration of wait.	Quality Effectiveness	12	4	3	Russell Patton

1184.v18	If Alnwood was to fail to address CQC outcome shortfalls (Musts and Shoulds) in an effective timely manner this could be potentially damaging to our CQC outstanding status.	Quality Safety (1-5)	9	3	3	Russell Patton
1287.v9	Medication pages on RiO are not being kept up to date as per NTW Policy.	Quality Safety (1-5)	16	4	4	Kedar Kale
1291.v8	Internal doors have been identified as a potential ligature risk following incidents within the Trust.	Quality Safety (1-5)	15	5	3	Russell Patton

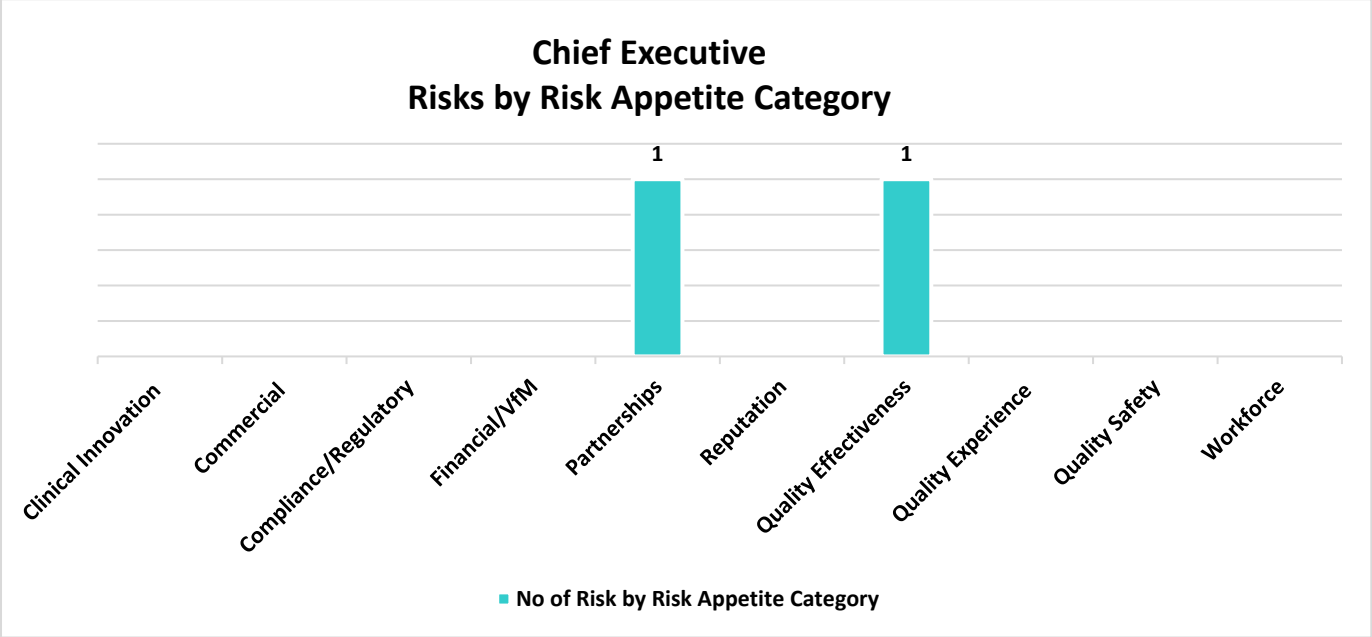


South Locality Care Group as at July 2018 hold 11 risks, 2 risk lower than the risk appetite, 3 risks within the risk appetite and 6 risks which have exceeded the risk appetite. All risks are being managed within the South Locality Care Group and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

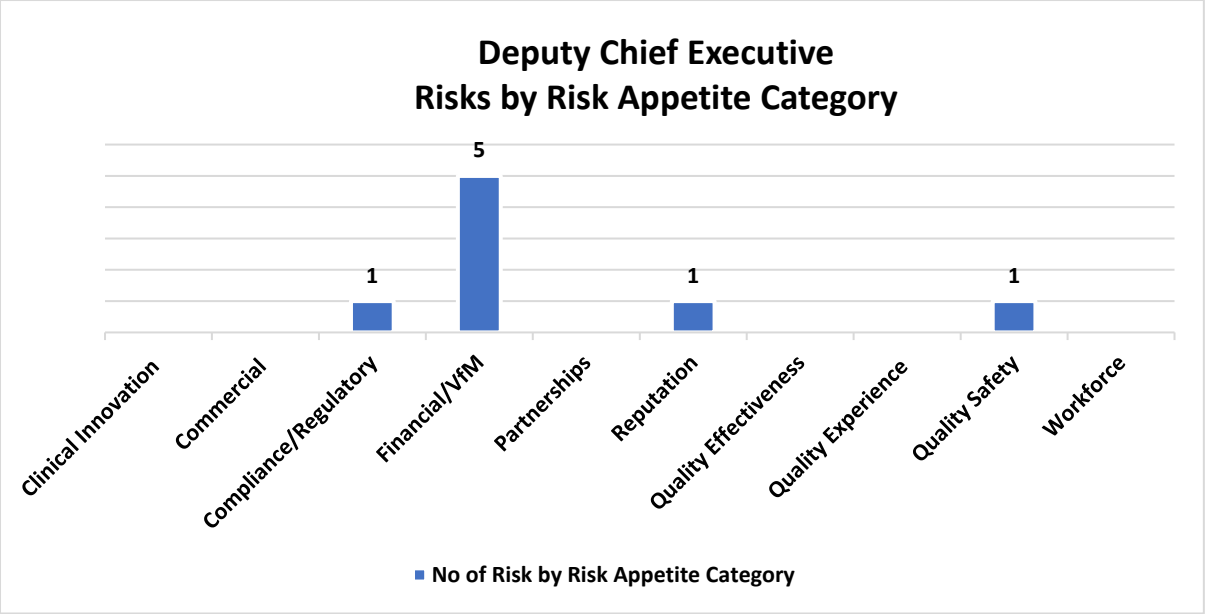
Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1288.v2	Medication pages on RiO are not being kept up to date as per NTW Policy.	Quality Safety (1-5)	16	4	4	Sarah Rushbrooke
1294.v9	Through flow of patients is not keeping pace with the number of referrals due to multi-faceted factors including increased level of referrals and assessments. This is resulting in waiting lists for treatment.	Quality Effectiveness (6-10)	12	4	3	Sarah Rushbrooke
1497/v1	Staffing pressures due to vacancies and difficulty recruiting and retaining medical staff within the south locality group.	Workforce (12-16)	20	5	4	Sarah Rushbrooke
1084.v13	The Personality Disorder Hub team are based at Benfield house at Walkergate Park and have been allocated desk space for up to 8 people At present the room is being used by up to 23 members of the team resulting in lack of space and privacy.	Quality Safety (1-5)	6	3	2	Sarah Rushbrooke

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
857.v11	Internal doors have been identified as a potential ligature risk following incidents across the Trust	Quality Safety (1-5)	10	5	2	Sarah Rushbrooke
1632.v4	Due to weakness in the current self-declaration process there are high numbers of outstanding DBS and self-declarations which could result in failure to comply with internal standards.	Quality Safety (1-5)	12	4	3	Sarah Rushbrooke

2.2. Executive Corporate.

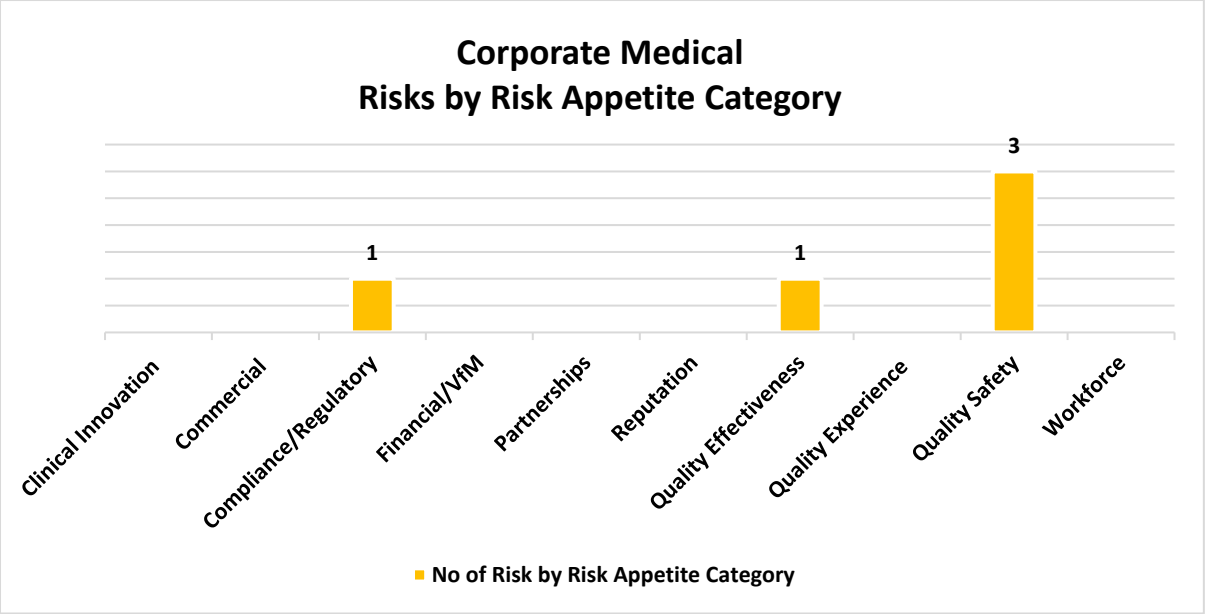


The Chief Executive as at July 2018 hold 2 risks, both risks are within the risk appetite. No risks have exceeded a risk appetite. All risks are being managed within the Chief Executive's Office and no requests to escalate to BAF/CRR have been received.



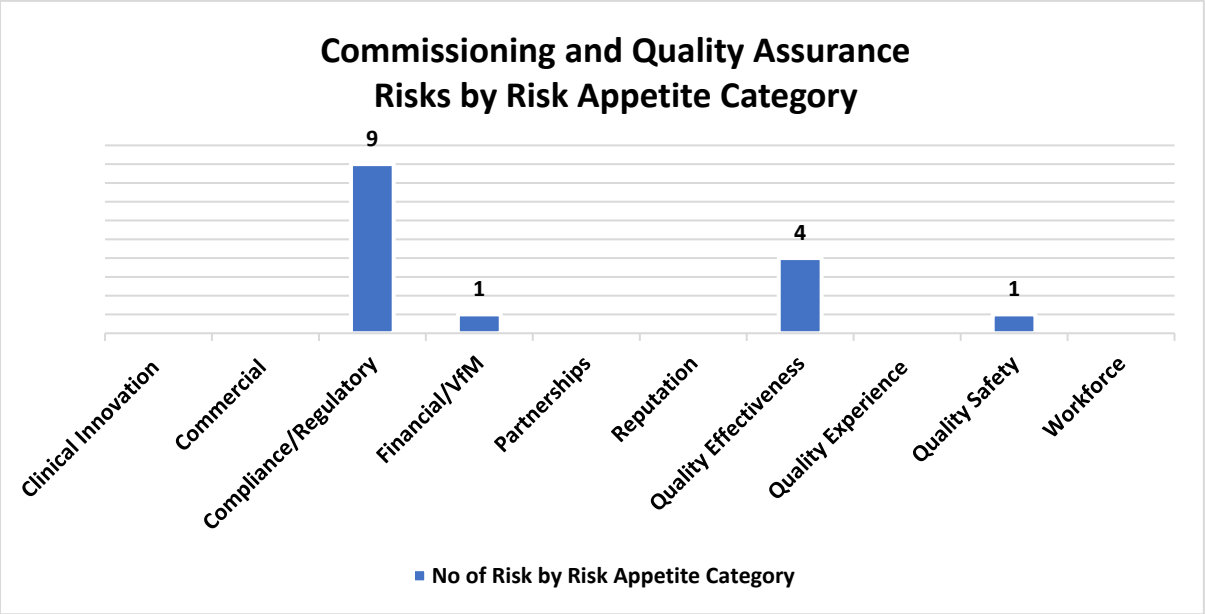
The Deputy Chief Executive as at July 2018 holds 8 risks, 2 risk lower than the risk appetite, and 4 risks within the risk appetite and 2 risks which have exceeded a risk appetite. All risks are being managed within the Deputy Chief Executive Directorate and no requests to escalate to BAF/CRR have been received.

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1506.v3	That there is lack of investment in backlog maintenance of buildings, leading to health and safety risks and risks of non-compliance with regulatory requirements and not meeting essential accommodation standards.	Quality Safety (1-5)	20	3	3	James Duncan
1440.v1	That the Trust fails to deliver the Financial Delivery Plan saving scheme.	Finance/VfM (12-16)	20	5	4	Chris Cressey



The Executive Medical Director as at July 2018 holds 5 risks, 1 risk within the risk appetite and 4 risks which have exceeded a risk appetite. All risks are being managed within the Medical Directorate and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

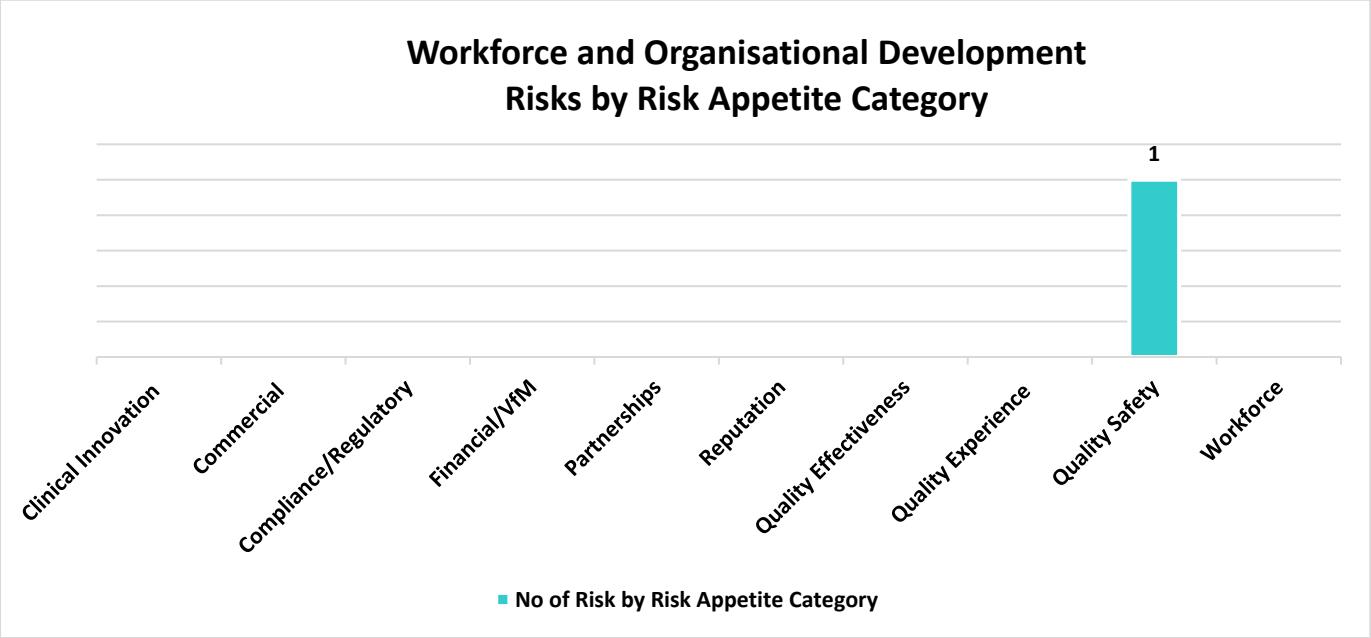
Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1205.v2	Occasional delays seen by CQC in the allocation of SOADs impacting on patient treatment pathways.	Quality Safety (1-5)	9	3	3	Rajesh Nadkarni
1651.v1	The Falsified Medicines Directive is due to come into effect in Feb 19. There is a risk the Trust will not be able to meet these requirements. Meeting the directive will require additional funding for hardware and software as well as support from IT implementation.	Compliance/ Regulatory (6-10)	15	5	3	Tim Donaldson
500.v13	Reliant on paper systems increasing risk of prescribing and admin errors.	Quality Safety (1-5)	9	3	3	Claire Thomas
1648.v1	Due to weakness in the current self-declaration process there are high numbers of outstanding DBS and self-declarations which could result in failure to comply with internal standards.	Quality Safety (1-5)	8	4	2	Ewan Maule



The Executive Director of Commissioning and Quality Assurance as at July 2018 holds 16 risks, 7 risks within the risk appetite and 9 risks which have exceeded a risk appetite. All risks are being managed within Commissioning and Quality Assurance Directorate and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

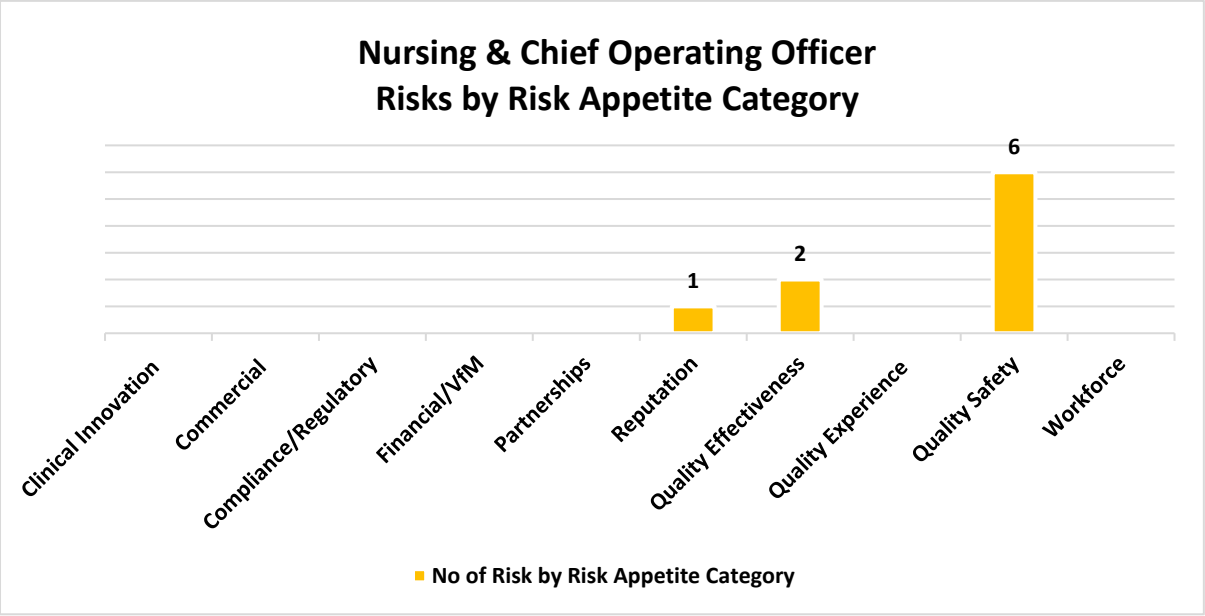
Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1636.v3	That we do not further develop integrated information systems across partner organisations.	Quality Safety (1-5)	8	4	2	Lisa Quinn
1171.v5	If servelec do not have the ability to meet delivery schedules for upgrades and new functionality this could have a potential impact on the informatics strategy and GDE delivery.	Quality Effectiveness (6-10)	12	4	3	Darren McKenna
1653.v2	GDPR – Data Mapping Non-compliance with GDPR in not having a record or business areas when processing personal data. A number of business areas have not yet completed data mapping.	Compliance/ regulatory (6-10)	12	4	3	Angela Faill
1576.v2	Data leakage risk of Trust Users transferring sensitive information via insecure methods or to untrusted destinations	Compliance/ Regulatory (6-10)	15	5	3	Jon Gair

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1172.v4	Increased risk of security threats coupled with increasing type and range of device access to the network linked to technology developments increasing attack vectors and increased sophistication of exploits.	Quality safety (1-5)	12	4	3	Jon Gair
1654.v3	GDPR – Policies: a number of polices are no currently in place yet as the Data protection act 2018 received royal assent on the 23rd May 2018	Compliance/ Regulatory (6-10)	12	4	3	Angela Faill
1655.v2	GDPR - Subject Access Requests: There is a risk of non-compliance with the reduced time frame The volume of requests for access to information (staff and service users) is likely to rise by 25-40% % and there are current pressures on this process	Compliance/ Regulatory (6-10)	12	4	3	Angela Faill
1656.v1	GDPR - Contracts: In the absence of a centralised system it has not been possible to identify / locate all contractual arrangements in place throughout the Trust. Therefore the Trust cannot ensure that appropriate amendments can be made to the relevant contract in light of GDPR.	Compliance/ Regulatory (6-10)	12	4	3	Angela Faill
1657.v2	GDPR - Contracts: In the absence of a centralised system it has not been possible to identify / locate all contractual arrangements in place throughout the Trust. Therefore the Trust cannot ensure that appropriate amendments can be made to the relevant contract in light of GDPR.	Compliance/ Regulatory (6-10)	12	4	3	Angela Faill



The Executive Director of Workforce and Organisational Development as at July 2018 holds 1 risk which is exceeding a risk appetite. No risks to escalate to the BAF/CRR have been received.

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1626.v1	Due to weakness in the current self-declaration process there are high numbers of outstanding DBS and self-declarations which could result in failure to comply with internal standards.	Quality Safety (1-5)	12	3	4	Lynne Shaw



The Nursing & Chief Operating Officer as at July 2018 holds 9 risks, 1 risk lower than the risk appetite, 4 risks within the risk appetite and 4 risks which have exceeded a risk appetite. All risks are being managed within Nursing & Chief Operating Officer Directorate and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1087.v12	Clients that do not meet the service spec for the PD Hub are being referred to CMHTs who do not have the relevant training to manage the Anti-social personality disorder, psychopathy and risk behaviour client group.	Quality Effectiveness (6-10)	20	4	3	Gary O'Hare
1220.v10	Women of childbearing age are prescribed valproate without appropriate awareness of the risks involved. Risk identified in POMH-UK 15a Bipolar Disorder audit results, baseline assessment of NICE CG192 and MHRA Patient Safety Alert NHS/PSA/RE/2017/002	Quality Safety (6-10)	15	5	3	Gary O'Hare
576.v5	The provision of safe and effective care within inpatient wards on non NTW sites is compromised due to the location of the facilities resulting in little direct control over environmental issues	Quality Safety (1-5)	16	4	4	Gary O'Hare

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
628.v5	Risk of fire resulting from service users smoking in contravention of the Trust wide Smoke Free Policy resulting in damage to building and/or loss or life.	Quality Safety (1-5)	10	5	2	Gary O'Hare

3. Emerging Risks.

Emerging Risks are reviewed at the CDT Risk Sub Committee monthly. Any emerging risks identified by the committee will be detailed below.

4. Recommendation

The Board of Directors are asked to:

- Note the changes and approve the BAF/CRR.
- Note the risks which have exceeded a risk appetite.
- Note any risk escalations.
- Note the summary of risks in the Locality Care Groups/corporate Directorate risk registers.
- Provide any comments of feedback.

Natalie Yeowart
Risk Management Lead
July 2018

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Board Assurance Framework and Corporate Risk Register

2018-19

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Strategic Ambition: 1
Working together with service users and carers we will provide excellent care, supporting people on their personal journey to wellbeing.

Corporate Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
Restrictions on capital funding nationally and lack of flexibility on PFI leading to a failure to meet our aim to achieve first class environments to support care and increasing the risk of harm to patients through continuing use of sub-optimal sub-optimal environments.	Risk on Identification	5	**3**	15	**Moderate**
	Residual Risk (with current controls in place):	5	**3**	15	**Moderate**
	Target Risk (after improved controls):	5	**1**	5	**Very Low**
	Risk Appetite:	**Finance/VfM**			**Within**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(actions to achieve target risk)**
1. CEDAR Programme Board Established with key Partners. 2. CEDAR Programme Delivery 3. CERA Programmes 4. Business Case approved for interim solution for WAA and Newcastle/Gateshead. 5. ICS Bid submitted. 6. CEDAR Business Case process in place	1. Minutes of CEDAR Programme Board 1. Feedback/update via Sub Committees/board 2. CEDAR Documents 3. CERA Documents. 4. Business Case Document. 5. ICS Bid Document. 6. Business case cycle for board meetings.	1. Identify next wave of Asset Sales 2. Await ICS Bid outcome - Oct 18

Ref: SA1.2

Review Comments: Actions complete and moved to Controls. Action added.

Executive Lead: Deputy Chief Executive	**Board Sub Committee: RBAC**	**Updated/Review Date: July 2018**

Strategic Ambition: 1
Working together with service users and carers we will provide excellent care, supporting people on their personal journey to wellbeing.

Corporate Risk:	Risk Rating:	Impact	Likelihood	Score	Rating
That there are adverse impacts on clinical care due to potential future changes in clinical pathways through changes in the commissioning of Services.	Risk on Identification	4	**3**	12	**Moderate**
	Residual Risk (with current controls in place):	4	**3**	12	**Moderate**
	Target Risk (after improved controls):	4	**2**	8	**Low**
	Risk Appetite:	**Quality Effectiveness:**			**Exceeded**

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Actions to achieve target risk)
1.Integrated Governance Framework. 2.Agreed contracts signed and framework in place. for managing change. 3.Locality Partnerships. 4. Well led action plan complete. 5. All CCG contracts agreed.	1. Independent review of governance-Process Amber/Green rating assessment. 2.Contract monitoring and contract change reporting process to CDT and RBAC. 3. Updates from Locality Partnership meetings 4. Well led action plan document. 5. Contract documentation.	1. Move towards lead/prime provider models and alliance contracts by April 2019

Ref: SA1.3		
Review Comments: Risk action complete and moved to controls. Target risk amended from 4x1 to 4x2 in line with Risk appetite		
Executive Lead: Executive Director of Commissioning & Quality Assurance	**Board Sub Committee: RBAC**	**Updated/Review Date:** July 2018

Strategic Ambition: 1
Working together with service users and carers we will provide excellent care, supporting people on their journey to wellbeing.

Principal Risk:	Risk Rating:	Impact	Likelihood	Score	Rating
There is a risk that high quality, evidence based safe services will not be provide if there are difficulties accessing services in a timely manner due to waiting times and bed pressures resulting in the inability to sufficiently respond to demands.	Risk on identification (Feb 2012):	4	**4**	16	**Moderate**
	Residual Risk (with current controls in place):	4	**3**	12	**Moderate**
	Target Risk (after improved controls):	4	**1**	4	**Very Low**
	Risk Appetite:	**Quality Effectiveness**			**Exceeded**

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (actions to take to achieve target)
1.Integrated Grovernance Framework. 2.Performance review monitoring and reporting incl compliance with standards, indicators,CQINN. 3.Operational and Clinical Policies and Procedures. 4. Annual Quality Account. 5. CQC Compliance Group. 6. Trustwide access and waiting times standard group established. 7. Waiting times dashboard.	1.Independent review of governance against Well-Led Framework January 2016 1/2/4.External Audit of Quality Account 1.Operational Plan 2016/17 reviewed by NHSI. 2.Reports to CDTQ,Q&P and QRG's. 3. Compliance with policies reviewed annually 5. CQC review rated outstanding. 6. Minutes of access and waiting times standard group. 7. Monitoring of the waiting times dashboard.	1. Monitoring and Delivery of Operational Plan 18/19 2. Delivery of 5 Year Trust Strategy 2017-2022 and supporting strategies. 3. Access and Waiting times Standard Group Action Plan. 4. Internal Audit 18/19 - please see audit plan.

Ref: SA1.4

Review Comments: Risk description amended to include access and waiting times. Actions added. Controls added. Residual risk increased from 4x2 to 4x3.

Executive Lead: Executive Director of Nursing and Chief Operating Officer	Board Sub-Committee: Q&P	Reviewed: July 2018

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Strategic Ambition: 1
Working together with service users and carers we will provide excellent care, supporting people on their personal journey to wellbeing.

Corporate Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
If staff do not follow Information Governance and Informatics policies and procedures there is a risk to staff, patients and the quality of service we deliver.	Risk on Identification	5	**2**	10	**Low**
	Residual Risk (with current controls in place):	4	**2**	8	**Low**
	Target Risk (after improved controls):	4	**1**	4	**Very Low**
	Risk Appetite:	**Compliance & Regulatory:**			**Within**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(Actions to achieve target risk)**
1.Integrated Governance Framework. 2.Trust Policies and Procedures. 3.Caldicott and Health Information Group. 4.Information Governance Toolkit. 5. Monitoring of Information Governance training levels and action plans.	1.External Audit of Annual Governance Statement. 1/3/4.Reports to Sub Committees of the Board and Action Plans. 1/2/4.Information Risk Review by ICO (May 2016) and Action Plan. 4 NTW1617 46 IGT - substantial assurance 2. NTW1617 Information sharing with commissioners - substantial assurance	1. Improve Mandatory Training for Staff by achieving target of 95% (currently 93.1%) by Feb 2018 2. Internal Audits 18/19 - Please see audit Plan.

Ref: SA1.7

Review Comments: Risk reviewed, Mandatory training now at 93.1%. Decision to de-escalate to Executive Director of Commissioning and Quality Assurance Risk Register.

Executive Lead: Executive Director of Commissioning & Quality Assurance	**Board Sub Committee: Q&P**	**Updated/Review Date: July 2018**

Strategic Ambition: 1
Working together with service users and carers we will provide excellent care, supporting people on their personal journey to wellbeing.

Corporate Risk:	Risk Rating:	Impact	Likelihood	Score	Rating
Inability to deliver the creating capacity to care initiatives could affect the quality, safety and sustainability of the services we deliver.	Risk on Identification (April 2018)	5	**3**	15	**Moderate**
	Residual Risk (with current controls in place):	5	**3**	15	**Moderate**
	Target Risk (after improved controls):	5	**2**	10	**Low**
	Risk Appetite:	**Quality Effectiveness**			**Exceeded**

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Actions to achieve target risk)
1. Programme of delivery in place	1. Programme with NTW Innovations	1. Delivery of Individual project workstreams
2. Key Project enablers identified	2. Individual project descriptors	
3. Project Governance in place	3. Project review via BDG Away Days	

Ref: SA1.9

Review Comments: Following executive lead review, duplication felt with SA4.2, decision to merge risk with SA4.2. SA4.2 Risk to be co-owned by Gary O'Hare and James Duncan		
Executive Lead: Executive Director of Nursing and Chief Operating Officer	**Board Sub Committee: Q&P**	**Updated/Review Date: July 2018**

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Strategic Ambition: 3
Working with partners there will be "no health without mental health" and services will be "joined up"

Principal Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
Inability to control regional issues including the development of integrated new care models and alliance working could affect the sustainability of MH and Disability Services.	Risk on identification (May 2017):	5	**4**	20	**High**
	Residual Risk (with current controls in place):	4	**3**	12	**Moderate**
	Target Risk (after improved controls):	4	**2**	8	**Low**
	Risk Appetite:	**Quality Effectiveness**			**Exceeded**

Controls & Mitigation (what are we currently doing about the risk)	**Assurances/ Evidence** (how do we know we are making an impact)	**Gaps in Controls** (Actions to achieve target risk)
1. Executive and Group leadership embedded in each CCG/LA area to ensure that MH and disabilities services are sustainable. 2. Leadership of the ICS MH workstream. 3. Involvement in DTDT programme for OP and and acute MH Services. 4. Member of Gateshead care partnership 5. Member of Exec Group for MCP in Sunderland.	1. Successfully influenced service models and across a number of localities. 2. Established close relationships with senior clinicians, managerial leaders across acute trusts and some GP practices. 2/3/4/5. Regular update/monitoring of ICS via Exec/CDT/Board. 2. Papers from MH ICS Workstream.	1. To be the Lead/Prime/Lead Provider for MH and Disabilities across NTW footprint 2. Finalise the plan for STP MH Workstream 3. To deliver the NCM Business Case. 4. System leadership arrangements to be agreed.

Ref: SA3.2

Review Comments: Minor wording changes to description (removal of ICS,MCP,STP) Residual Risk score reduced from 4x4 to 4x3.

Executive Lead: Chief Executive	**Board Sub Committee: Board**	**Last Updated/Reviewed: July 2018**

Strategic Ambition 4
The Trusts Mental Health and Disability Services will be sustainable and deliver real value to the people who use them.

Principal Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That we have significant loss of income through competition, choice and national policy,including the possibility of losing large services & localities.	Risk on identification May 2009):	4	**4**	16	**Moderate**
	Residual Risk (with current controls in place):	5	**4**	20	**High**
	Target Risk (after improved controls):	5	**2**	10	**Low**
	Risk Appetite:	**Finance/VfM**			**Exceeded**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(actions to take to achieve target)**
1. Agreed contracts in place and process for variations for managing change. 2. Locality Partnerships 3. New Models of Care for CAMHS Tier 4. 4. Business Case and Tender Process 5. Achievement of contractual standards.	1. NTW1617 27 Agreements - Substantial Assurances with no issues of note. 1. NTW 1718 22 Commissioning income Monitoring - Substantial Assurance 2/3 Quarterly partnership meetings minutes. 4. NTW1617 36 Responding to Tenders - Substantial Assurance 5. Monitored via Commissioning Report Monthly.	1. Internal project structure for future Forensic services and specialist childrens services 2. Central locality to develop proposals for future or forensic services. 3. Seek agreement of Recovery programme with Northumberland CCG. 4. Small areas of non compliance with Quality standards being monitored with action in place.

Ref: SA4.1

Review Comments: No Change.

Executive Lead: Executive Director of Commissioning and Quality Assurance	**Board Sub-Committee: RBAC**	**Updated/Review Date: July 2018**

Strategic Ambition: 4 The Trusts Mental Health and Disability Services will be sustainable and deliver real value to the people who use them.

Corporate Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That we do not manage our resources effectively through failing to deliver required service change and productivity gains included within the Trust FDP	Risk on Identification	5	**3**	15	**Moderate**
	Residual Risk (with current controls in place):	5	**3**	15	**Moderate**
	Target Risk (after improved controls):	5	**2**	10	**Low**
	Risk Appetite:	**Financial/VfM**			**Exceeded**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(Actions to achieve target risk)**
1. Integrated Governance Framework 2. Financial Strategy/FDP 3. Financial and Operational Policy and proceedure. 4. Quality Goals and Quality Account 5. Accountability Framework 6. Quarterly review of financial delivery.	1/2/6 Annual Governance statement/ quality account/annual accounts. 2. Operational Plan 18/19 agreed by NHSI. 3. Policy and PGN. 4. External Audit of Quality Account. 5. Accountability Framework Reports 2. NTW1617 20 Quality Impact of FDP - Substantial assurance with minor issues. 6. Quartely review of Financial deliver at RBAC	1. Programme Approach to delivery and reporting. 2. Capacity to support internal change. 3. Delivery of workforce plan. 4. Delivery of creating capacity to care workstreams. 5. Workforce plan to deliver. 6. Internal Audit - please see internal audit plan

Ref: SA4.2
Review Comments: Minor wording changes to description, decision to merge and include capacity to care risk SA1.9. Residual risk score reduced from 5x4 to 5x3.

Executive Lead: Deputy Chief Executive/Executive Director of Nursing and Chief Operating Officer	**Board Sub Committee: RBAC**	**Updated/Review Date: July 2018**

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Strategic Ambition: 5
The Trust will be a centre of excellence for Mental Health and Disability.

Corporate Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That we do not meet compliance & Quality Standards	Risk on Identification	5	**3**	15	**Moderate**
	Residual Risk (with current controls in place):	5	**3**	15	**Moderate**
	Target Risk (after improved controls):	5	**1**	5	**Very Low**
	Risk Appetite:	**Compliance/Regulatory:**			**Within**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(Actions to achieve target risk)**
1. Integrated Governance Framework. 2.Trust Policies and Procedures. 3.Compliance with NICE Guidance. 4.CQC Compliance Group-review of compliance and Action Plans. 5.Performance Review/Integrated Commissioning and Assurance reports. 6. Accountability Framework meetings 7. Regulatory framework of CQC and NHSI. 8. Agreement of Quality Priorities	1.Independent review of governance 1/3/4/5.Reports/Updates to Board sub Committees. 2. Compliance with policies reviewed annually 2/3/4.CQC MHA compliance visits and completed action plans. 6. Accountability Framework document 7. NTW1718 09 CQC Process Substantial Assurance 8. Monitoried via reports/updates	1. Well led action plans complete however Alnwood actions are ongoing. Review quartely 2. Internal Audit 18/19 - please see audit plan 3. Clinical Audit 18/19 - Please see audit Plan

Ref: SA5.1

Review Comments: actions complete and moved to assurances.

Executive Lead: Executive Director Commissioning & Quality Assurance	**Board Sub Committee: Q&P**	**Updated/Review Date: July 2018**

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Strategic Ambition 5
The Trust will be a centre of excellence for Mental Health and Disability.

Corporate Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That we do not meet statutory and legal requirements in relation to Mental Health Legislation	Risk on Identification	4	**3**	12	**Moderate**
	Residual Risk (with current controls in place):	4	**3**	12	**Moderate**
	Target Risk (after improved controls):	4	**2**	8	**Low**
	Risk Appetite:	**Compliance/Regulatory:**			**Exceeded**

Controls & Mitigation (what are we currently doing about the risk)	**Assurances/ Evidence** (how do we know we are making an impact)	**Gaps in Controls** (Actions to achieve target risk)
1.Integrated Governance Framework. 2.Trust Policies and Procedures relating to relevant Acts and practice. 3.Decision Making Framework. 4.Review of CQC MHA Reports and monitoring of Action plans. 5.Performance Review/Integrated Performance Report and Action Plans. 6. Mental Health Legislation Committee. 7. Process for 135/136 legislation with external stakeholders.	1.Independent review of governance 2. Compliance with policy/training requirement 2. NTW1617 33 MHA Section 17 Good level of assurance 2. NTW1617 34 MHA Section 136 good level of assurance. 3. Decision making framework document 1/4/5.Reports to Board and sub Committees NTW1718 09 CQC Process Substantial Assurance. 6. Minutes of Mental Health Legislation Committee. 7. 135/136 action plan complete.	1. IA 1415/NTW/30: MHA Patients Rights Complete management actions identified in limited assurance audit & re-audit April 18 2. CQC MHL Reviewer visit themes/issues to be reviewed - Jan 18 3. 117 Aftercare arrangements. 4. Improvement review of MHA Training (75.5%) 5. Internal Audit 18/19 - Please see audit plan 6. Clinical Audit 18/19 - Please see audit plan 7. CQC/MHL reviewer session to be delivered at learning and development meeting - Sept 18

Ref: SA5.2

Review Comments: Risk description amended to remove 'significant'. Action completed and added to controls (no7)

Executive Lead: Executive Medical Director	**Board Sub Committee: MHL Group**	**Updated/Review Date: July 2018**

Strategic Ambition: 5 The Trust will be a centre of excellence for Mental Health and Disability.

Corporate Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That there are risks to the safety of service users and others if we do not have safe and supportive clinical environments.	Risk on Identification	5	**3**	15	**Moderate**
	Residual Risk (with current controls in place):	5	**2**	10	**Low**
	Target Risk (after improved controls):	4	**2**	8	**Low**
	Risk Appetite:	**Quality Safety:**			**Exceeded**

Controls & Mitigation (what are we currently doing about the risk)	**Assurances/ Evidence (how do we know we are making an impact)**	**Gaps in Controls (Further actions to achieve target risk 2016/17)**
1.Integrated Governance Framework. 2.Trust Policies and Procedures. 3.Reporting and monitoring of complaints, litigation,incidents etc. 4.National Reports on Quality and Safety. 5.Health and Safety Inspections. 6.Trust Programme of Service and PLACE visits. 7.CQC Compliance Group. 8.Quality Goals and Accounts.	1. Annual review of Governance Framework. 2. Policy Monitoring Framework including Auditable standards, KPI and Annual review. 3.Safety Report to Board Sub Committee and Board. 3/4/7/9.Performance reports to Q and P 5/6/7.Health and Safety,PLACE,service visit and CQC Action Plans. 2. NTW1617 32 Risk Management - Substantial Assurance with remedial actions to take 8.External Audit of Quality Account. 7. CQC Outstanding Review Rating.	1. IA NTW/1516/20: Medical Devices Complete management actions identified in limited assurance audit & re-audit. Due 18/19 2. Outcome and completion of Deciding Together. April 2018 3. Internal Audits 2018/2019 - Please see audit plan. 4. Clinical Audit 18/19 - please see audit plan 5. Delivery of Older Persons Interim Plan.

Ref: SA5.5		
Review Comments: No change.		
Executive Lead: Executive Director of Nursing and Chief Operating Officer	**Board Sub Committee: Q&P**	**Updated/Review Date: July 2018**

Strategic Ambition: 5 The Trust will be a centre of excellence for Mental Health and Disability.

Principal Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services.	Risk on identification (April 2018):	**4**	**4**	**16**	**Moderate**
	Residual Risk (with current controls in place):	**4**	**3**	**12**	**Moderate**
	Target Risk (after improved controls):	**4**	**2**	**8**	**Low**
	Risk Appetite:	**Quality Effectiveness**			**Exceeded**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(Actions to achieve target risk)**
1. Workforce Strategy 2. RPIW Medical Recruitment 3. NTW International recruitment competency process. 4. OPEL Framework 5. MDT Collegiate Leadership Team in place	1. Delivery of worforce strategy 2. RPIW Medical Recruitment outcomes papers 3. NTW Recruitment competency documents. 4. OPEL Framework Documents. 5. MDT leadership advice and support available	1. Complete international recruitment campaign. Quartely updates. 2. Implementation of Medical Induction Programme 2018 - quarterly updates. 3. Streamlining of recruitment process.

Ref: SA5.9		
Comments:		
Executive Lead: Executive Director of Nursing and Chief Operating Officer	**Board Sub Committee: Q&P**	**Last Updated/Reviewed: July 2018**

Internal Audit Plan						
Review Area	2018/19					
	Q1	Q2	Q3	Q4	BAF/CRR Ref	Final Issue Date
Head of Audit Opinion				•		
Assurance Framework				•		
Leadership, Management and Governance (WELL-LED)		•				
Complaints and claims		•				
Research and Development			•			
Third Party Assurance				•		
Risk Management				•		
IM&T Governance, Controls & Strategy (incl.GDE)			•		SA1.7	
GDPR	•				SA1.7	
Network Continous Testing - Server Operational Management		•		•	SA1.7	
Penetration Test			•		SA1.7	
Desktop management: Windows 10 deployment		•			SA1.7	
TAeR System - IT General Controls			•		SA1.7	
IAPTUS System - IT General Controls			•		SA1.7	
UK CRIS Research System	•				SA1.7	
TRAC System - NTW Solutions system		•			SA1.7	
IT Security Incident Management			•		SA1.7	
Information Governance Toolkit				•	SA1.7	
Premises Assurance Model		•			SA5.5	
NHS Improvement Single Oversight Framework - Finance/UoR				•	SA5.5	
Security Management	•				SA5.5	
Patient Experience		•			SA5.1	
Performance Management and Reporting		•				
Quality Account				•	SA1.4	
Waste Management	•					
Fire Safety	•					
Organisational Culture			•			

Review Area	2018/19					
	Q1	Q2	Q3	Q4	BAF/CRR Ref	Final Issue Date
Joint Working Arrangements				●		
Capital Procurement			●			
Salary Overpayments		●			SA4.2	
Procurement (Rolling Programme)		●			SA4.2	
Key Financial Systems			●		SA4.2	
Cashiering Services	●				SA4.2	
Patient Monies and belongings	●				SA4.2	
Non-Pay PAYE		●			SA4.2	
Losses and Special Payments		●			SA4.2	
Charitable Funds	●				SA4.2	
Recruitment and Selection (inc DBS)				●	SA1.4	
Time and Attendance			●			
Medical Revalidation	●					
Medical Job Planning	●					
Professional Registration				●		
Occupational Health Service		●				
Staff Appraisal				●		
Skills and Training			●			
Monitoring of Absence				●		
Local Level Clinical Audit Process				●		
Mortality Reporting			●		SA5.1	
Incident Mangement (excl. Serious Incidents)		●				
Mental Health Act Rolling Programme (patient rights/CTO)	●			●	SA5.2	
Medical Devices			●		SA5.5	
Medicine Management	●					
Medicine Management EPMA				●		
Health and Safety			●			
Domestic Homecide	●					

Clinical Audit Plan						
Review Area	2018/19					
	Q1	Q2	Q3	Q4	BAF/CRR Ref	Final Issue Date
Clinical Supervision			•		SA5.5	
Nutrition			•			
Seclusion		•			SA5.1	
Care Coordination (North)		•			SA5.1	
Care Coordination (Central)			•		SA5.1	
Care Coordination (South)				•	SA5.1	
Clustering			•		SA5.1	
POMH - UK National Audit: Assessement of the side effects of Depot Antipsychotics and Physical Health Monitoring				•	SA5.1	
Medication Summaries and Discharge Letters	•				SA5.1	
Domestic Homicide Investigation action plan		•				
Mental Health Act Patient Rights	•				SA5.2	
Mental Health Act CTO			•		SA5.2	

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 25th July 2018

Title and Author of Paper: Delivering Transforming Care in CYPS: Closure of the Riding ward, John Padget, Associate Director, Specialist Children & Young Peoples CBU, and Garry Schulz, Project and Programme Manager – CAMHS New Care Models

Executive Lead: Gary O'Hare, Executive Director of Nursing & Chief Operating Officer

Paper for Debate, Decision or Information: Decision

Key Points to Note:

Further to the Business Case presented to and approved by the Board in September 2017 for a New Care Models 2 year pilot in relation to Children & Young Peoples Tier 4/Specialised Services, this business case seeks approval for the closure of the Riding as outlined in that original business case. The closure of the Riding is part of the Transforming Care National Strategy. Its Closure is in line with the national and regional bed reduction trajectory

Risks Highlighted to Board :
Risks are identified within the Business Case

Does this affect any Board Assurance Framework/Corporate Risks?
Please state **No**
If Yes please outline

Equal Opportunities, Legal and Other Implications: None

Outcome Required: Approval to proceed

Link to Policies and Strategies: Service Strategy and Trust Strategic Plan

Summary Business Case

Delivering Transforming Care in CYPS: Closure of the Riding ward	
Targeted area for improvement	Closure of learning disability beds (including the closure of Riding Ward) at Ferndene
Service / Group	Specialist Children and Young Peoples Services (CYPS) CBU North Locality
Project Lead	John Padget (Associate Director – Specialist CYPS)
Author(s)	Garry Schulz (Project Manager, NTW CYPS New Care Models), John Padget (Associate Director – Specialist CYPS)
Date of completion	16th July 2018
Project Details	
Background to Case of Need	In June 2017, Northumberland, Tyne and Wear NHS Foundation Trust (NTW) submitted a successful proposal to NHS England to become a New Model of Care Wave 2 pilot site for Tier 4 Children and Young People's Services across Mental Health and Learning Disability services as part of NHS England's 'Five Year Forward View for Mental Health'. The New Model of Care project will develop a revised pathway across Northumberland, Tyne, Wear and North Cumbria for Tier 4 Mental Health services and across the whole of the North East and North Cumbria for Tier 4 Learning Disability services; the aim being to reduce, wherever possible, the reliance on Tier 4 beds with more services being delivered in the community and closer to home. Any savings that may arise from the new pathway will subsequently be invested into local services for children and young people. The aim of the Wave 2 New Model of Care pilot is to introduce new integrated models that ensure the individual is at the centre of care with specialist service provision wrapped around them, no matter where they are located. The pilot's key objectives are as follows: • *Greater focus on prevention and early intervention* • *Provision of integrated care closer to home* • *Reduced reliance on inpatient beds* • *Better use of resources across the whole pathway* • *Delivery of the specialised service element of Transforming Care*
Strategic Fit	This business case aligns to a number of national strategies and programmes. Bed reduction is required through the ongoing Learning Disability Transformation Programme whilst the emphasis on the development and implementation of New Care Models was born of the Five Year Forward View. The Five Year Forward View has encouraged efforts to deliver more healthcare out of acute hospitals and closer to home, with the aim of providing better care for patients. NTW's commitment to developing New Care Models sets the organisation on a course to ensure: • *Greater focus on prevention and early intervention* • *Provision of integrated care closer to home* • *Reduced reliance on inpatient beds* • *Better use of resources across the whole pathway*

<table>
<tr><td></td><td>NTW has committed to achieving the Transforming Care bed reductions through the development of sustainable new models of care (the business case for which was supported by Trust Board in September 2017), key to which is realignment of existing budget to provide enhanced community provision in which services are wrapped around the child. A key component of the model and of transforming care is to re-provide the function of the Riding inpatient service and deliver it as an outreach model of care</td></tr>
<tr><td>The Case for Change</td><td>Ferndene is situated on the former Prudhoe Hospital site and provides an inpatient regional and national service for children and young people up to 18 years of age. Ferndene comprises of 3 learning disability inpatient wards (Riding, Fraser and, Stephenson) providing a total of 26 beds.

Transforming Care will see the closure of 11 learning disability beds (a reduction of 42%, to 15). The bed closures proposed and agreed within the national Transforming Care programme are to be delivered through of the New Care Models project. This will see the realignment of existing budget to provide enhanced community provision in which services are wrapped around the child, with the objective of reducing the reliance on inpatient beds. The new model is designed specifically to address the Transforming Care agenda.

• The Riding is a six bed unit providing comprehensive assessment and treatment for patients aged from 4-18 years with mild to moderate learning disability (4 to 12 year olds) or moderate to severe learning disability (13 to 18 year olds). In addition young people admitted to Riding will present requiring assessment and treatment for complex mental health/behavioural and emotional needs. Referrals to the Riding have been in decline and there is currently no waiting list. The service has maintained a low occupancy rate. Successful delivery of the Transforming Care bed reduction will see the full closure of the Riding ward.

• Fraser ward is a 12 bed unit providing comprehensive assessment and treatment for patients aged from 12 to 18 years with mental health and developmental needs and mild to moderate learning disability.

• Stephenson is an eight bed low secure unit providing comprehensive assessment and treatment for patients aged from 14 to 18 years with mild to moderate learning disability and a requirement for high levels of supervision in a safe environment.</td></tr>
<tr><td>Description of Options reviewed</td><td>Option 1 – Do nothing
<table>
<tr><th>Advantages</th><th>Disadvantages</th><th>Viable Option</th></tr>
<tr><td>• No disruption to the status quo</td><td>• Service users will continue to require inpatient admission
• Failure to meet NTW’s commitment to Transforming Care trajectories
• Failure to meet NTW’s commitment to develop New Models of Care; a key component of the Five Year Forward View</td><td>No</td></tr>
</table>
Option 2 – Seek to defer the ward closure until a future point.</td></tr>
</table>

	<table><tr><th>Advantages</th><th>Disadvantages</th><th>Viable Option</th></tr><tr><td></td><td>• Fails to achieve the bed closures previously agreed as part of Transforming Care • Risks loss of staff owing to extended transition and uncertainty, which will see the loss of key skills from specialist children's services</td><td>No</td></tr></table> **Option 3 - Approve bed closures in line with Transforming Care trajectories and commitment to re-provide services in the community** <table><tr><th>Advantages</th><th>Disadvantages</th><th>Viable Option</th></tr><tr><td>• Achieves the bed closures previously agreed as part of Transforming Care • Provides staff with certainty and, in so doing, retains highly skilled staff for redeployment into new model. • Invests sufficiently to provide the specialist skills required to meet the needs of young people</td><td>• Significant period of change (but for which clinical staff are engaged and enthused)</td><td>Yes</td></tr></table>
Outline of Preferred Option / Proposal	**The preferred option is option 3.** Our proposal would see the full reinvestment of learning disabilities funding in a model that provides enhanced levels of intensive community support alongside a robust inpatient service. A key component of the new model and of transforming care is to re-provide the function of the Riding inpatient service and deliver it as an outreach model of care. A small, highly specialist team will work intensively with young people and will skill up the specific team around the child to support the family in the longer term. As part of providing a 7 day service with enhanced hours, this service will also link into existing community services to provide scaffolding, advice and support. Geographically, the Riding ward provides service not only to the young people of Northumberland, Tyne and Wear but also for young people from Tees, Esk and Wear Valleys and for North Cumbria. The developing community model will also ensure equitable service standards across those localities, either through a direct provision or through ensuring a standard quality of provision as part of robust commissioning arrangements. Work with providers in those areas is ongoing in that regard through the New Care Models process. It is anticipated that there will be a small proportion of patients that would currently be admitted to the Riding, and for whom enhanced community support may not be sufficient to avoid admission. These patients who do go on to require an inpatient admission are likely to be admitted to Fraser ward in the future model. The new model will support this through the offer of an LD in-reach function, to affect timely discharge and maintain appropriate "flow" on the ward. Furthermore, the model will ensure sufficient investment remains within Fraser ward to robustly sustain the inpatient element of the model.

	Intensive Community Treatments Services (ICTS) team are commissioned by CCGs to provide crisis support and home-based treatment to individuals presenting in a mental health crisis. ICTS teams are not skilled or resourced to respond to individuals with a learning disability presenting in a mental health crisis. This proposal will see a modest staffing increase in order to both increase capacity to provide support for this population and extend hours of operation to 8am – 8pm throughout the week. Crucially ICTS staff will additionally receive training to support work with individuals who also have a learning disability and/or autism, as part of a sustainable learning disability model. The final reinvestment proposed within the model will see the development of a small, dedicated team tasked with bed management and care navigation functions. This team will provide a 7 day service and play a key role in all potential admissions and discharges, as well as repatriation of any patients currently placed "out of area". This team will provide a primary contact point and will build relationships with referrers, providers, NHS England, local commissioners and local authorities to secure appropriate input to support young people through the pathway.
Outline of Benefits, Outcomes and Impact **(Include baseline position, any metrics expected to improve as a result of the proposal etc.)**	Some of the main benefits include: • Earlier access to specialised clinical intervention for young people that would otherwise have had to wait for an inpatient admission • Reduction in Beds which supports current demand levels and future bed model, in line with Transforming Care. • Reduced admissions • No increase in (there are currently zero) LD out of area placements • The planned phased transition ensures continuity of service and an opportunity to test the future model prior to full implementation • Contributes to delivery of the Five year forward view aim to provide care closer to home. • Increased patient satisfaction as a result of earlier intervention and the provision of care closer to home.
Contribution towards requisite quality standards / targets	NTW is committed to the NCM being the delivery vehicle for the specialised service elements of Transforming Care and to delivering the commitments set out within Building the Right Support (NHS England, Local Government Association, Associate of Directors of Adult Social Service, October 2015). In particular, the Transforming Care Programme makes it incumbent upon NTW CYPS to close 11 inpatient Learning Disability beds over the coming two years, reducing from 26 to 15 learning disability beds. Quality measures will be monitored through the NCM Quality Governance group who will provide regular reports to the NCM Partnership Board.

Quality Impacts			
Safety	**Clinical Effectiveness**	**Patient Experience**	**General**
This work will create a greater knowledge base within local teams, supported by scaffolding options. There is potential that Patient Safety could be	The Five Year Forward View has encouraged efforts to deliver more healthcare outside of acute hospitals and closer to home, with the aim of providing better care for patients.	There should be no adverse impact on the overall patient experience arising from this reduction in beds. Our engagement with young people indicates	Systems will be developed across the pathways to ensure they are effective in fulfilling their purpose. The new service provision will ensure a

compromised if demand for beds increases and wards operate at full capacity for long durations.		that they would prefer to receive care in their own communities rather than in hospital.	greater level of sustainability across the local and regional health economy.

Resource Requirements and Risks

Outline Resources Required	**Staffing** Staff impacted by this change (29WTE Riding) will go through a full formal consultation process. Opportunities for staff will arise from the development of new teams; primarily through the creation of the enhanced community learning disability service. It is anticipated that the new service will provide adequate opportunity for qualified staff. For unqualified staff, the new model requires fewer staff than are currently employed on the Riding. In mitigation, the CBU proposes to create a flexible team, using funds currently spent on Bank and Agency, to provide a resource on the Ferndene site. This is a significant opportunity to not only reduce the use of bank and agency across the site but also improve quality through access top experienced staff with a working knowledge of the site, services and service users.	
	Estates The proposed team will, at least initially, be based at Ferndene hospital.	
	IMT Liaison with other provider organisations	
	Non Staff Costs Travel costs will be incurred as part of an outreach model	
	Pharmacy There could be a reduction in pharmacy costs associated with ward closure	
Interdependencies	• The timing of the closure will depend on the ability to effect timely discharge for the patients residing on the Riding in the lead up to the planned closure date. • Enhanced Community Services being implemented locally and regionally	
Risks and Mitigations	**Risks**	**Mitigations**
	Displacement of staff team	Staff will be formally consulted with and supported to find employment in the new teams (specifically the enhanced community learning disability service. Furthermore, Ferndene currently has a regular usage of bank and agency staff; the closure of the Riding and release of associated staffing presents an opportunity to reduce the use of bank and agency across the site.)
	Failure to identify suitable alternative care provision for existing service users	Inpatients on the Riding are admitted (planned admissions only) for a standard 12 week programme and then leave the unit. There is no existing waiting list for admissions and plans are in place to monitor referrals and admissions to facilitate the timely closure. In the event that a timely discharge becomes unlikely, intensive work will be undertaken (to include discharge facilitators) to ensure this is managed effectively. There remains one young person on the Riding without a clear exit strategy. This has been raised with NHS England and a complex case review has taken place. Work remains on-going in that regard.

	Overhead costs associated with the premises of the current Riding Ward become a cost pressure until such a time that the building is occupied by another service.	Work is being undertaken to identify how best to make use of the Ferndene site in its entirety as bed numbers change and ward functions change. A site strategy group has been set up to work through this as services across Ferndene continue to transform. The development of new care models presents a range of opportunities. Mitigation is, in part, reliant on the availability of capital to ensure the building currently occupied by the Riding is suitable for the intended future use.

Finance

Financial impact on clinical service contracts

This business case proposes to fully reinvest all funding associated with the reduction in inpatient beds as prescribed by the national Transforming Care programme. The specific investments into each of the above proposals will be agreed through the New Care Models Commissioning Group and approved by the New Care Models Partnership Board.

Reinvestment will include the payment of nationally agreed dowries. Dowries will be paid by the NHS to local authorities for people leaving hospital after continuous spells in inpatient care so are a national agreement as part of Transforming Care (and quite distinct from New Care Model investments).

The overall income impact on NTW is a deficit of £151K.

Proposed Timetable / Implementation Plan

- Jan 2018 – community work starts to develop pathways and processes to support enhanced LD community provision
- Mar 2018 – 2 beds close on Riding Ward (reduce 6 to 4)
- Mar 2018 – 2 beds close on Fraser Ward (reduce 12 to 10)
- Feb 2018 – Aug 2018 – small scale testing and refinement of the model. As patients are discharged from the Riding, the staffing resource is released in order to scale up the Community model and support LD admissions and discharges to and from Fraser Ward.
- August 2018 – formal staff consultation (to include staff affected by Riding Closure)
- September 2018 – remaining 4 Riding beds close to allow the formal ward closure and formal staff redeployment. Intensive community LD team formally begins.
- March 2019 – close one bed Stephenson (reduce 8 to 7)
- June 2019 – close two beds Fraser (reduce 10 to 8)

Approvals (date)

Project Sponsor	
North Locality Group	
Trust Board	

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 25 July 2018

Title and Authors of Paper: Business Case - Provision of Outpatient Dispensing Services by NTW Solutions Limited.
Tracey Sopp and Grahame Ellis (NTW Solutions Limited)
Tim Donaldson & Ewan Maule (Chief and Deputy Chief Pharmacists, NTW NHS FT)

Executive Lead: Rajesh Nadkarni, Medical Director; James Duncan, Finance Director

Paper for Debate, Decision or Information: Decision

Key Points to Note:

- Proposal fits with Trust and NTW Solutions' strategies
- Provision of this service by NHS wholly owned subsidiary companies is common
- There is no expected impact on NTW service users or NTW clinical staff – the service would be provided by the same staff, working to existing Trust policies and procedures and General Pharmaceutical Council regulations and guidance
- The service would be managed through a legal agreement, including the supply of staff by the Trust and a service level specification.
- Expected delivery of recurring financial savings of approximately £150k per annum to the NTW Group, contributing to the Trust's Financial Delivery Plan
- The potential to develop this service for other organisations, generating additional income for the NTW Group

Risks Highlighted to Board :

- Risks identified in paragraph 8 of the Business Case.
- Risk to achievement of Financial Delivery Plan if not implemented

Does this affect any Board Assurance Framework/Corporate Risks?
Please state **Yes** or **No:** No

Equal Opportunities, Legal and Other Implications:

- Service would be managed through a legal agreement between the Trust and NTW Solutions Limited

Outcome Required: The Board is asked to consider approval of the proposal

Link to Policies and Strategies:

- NTW Trust Financial Delivery Plan
- NTW Pharmacy and Medicines Optimisation Strategy 2017– 22
- NTW Solutions Strategy 2018-2021

Northumberland, Tyne and Wear NHS Foundation Trust

Business Case

Provision of Trust Outpatient Dispensing Service by NTW Solutions Limited

July 2018

CONTENTS

1. INTRODUCTION / PURPOSE OF DOCUMENT

This document makes the case for the proposal that the outpatient dispensing pharmaceutical service currently provided by Northumberland, Tyne and Wear NHS Foundation Trust (the Trust) is transferred from the Trust to NTW Solutions Limited.

This business case is for approval by the NTW NHS Foundation Trust Board of Directors. The business case proposal was previously agreed by the NTW Solutions Board of Directors on 17 July 2018.

It is planned that the transfer of this service to NTW Solutions will take place on 1st August 2018.

2 STRATEGIC CONTEXT

2.1 Nationally

NTW Solutions Limited was established by the Trust in April 2017 as a wholly owned subsidiary company, to provide it with estates, facilities, procurement and some financial and workforce transactional services. It is common in other NHS Foundation Trusts which have subsidiary companies for their outpatient dispensing service to be provided through their subsidiary company. This is particularly so for acute service Foundation Trusts where there is a larger volume of outpatient dispensing. But this model of service is also found in other mental health trusts, including another NHS FT which has been helpful in providing us with information and advice.

2.2 NTW NHS FT – Setting up NTW Solutions

The Business Case to establish the company, approved by the Trust, identified a number of benefits including those below.

- cost effective and quality support services being provided by the company, which focus on this and this alone, enabling the Trust to focus on its core services

  The outpatient dispensing service would continue to be provided by the Trust's pharmacy staff, who provide the highest General Pharmaceutical Council rating (see the Current Service Provision section)

- helping to improve quality through detailed service specifications and KPIs as part of the Operated Healthcare Facility Agreement and Service Level Agreements

  The outpatient dispensing service currently has KPIs and these would continue through the robust contractual arrangements described in the Operational Arrangements section

- providing greater flexibility and freedoms for the Trust's subsidiary company to build upon the expertise of its staff and systems and develop a more commercial focus, with the aim of being better able to seize opportunities to generate additional income, for the benefit of the NTW Group

Since the establishment of the company, this benefit is being realised with the transfer of the Trust's Patients' Finance, Car Leasing and Digital Dictation services to the company. The transfer of the outpatient dispensing service to NTW Solutions would also be a strategic fit and provide business opportunities to generate additional income through providing this service to other organisations (see Business Development section)

- delivering a significant and tangible contribution to the Trust's financial delivery plan, supporting NTW to contribute to delivering sustainable, high quality services

  The proposal has been identified as a source of savings in the Trust's financial delivery plan as described in the Finance section

2.3 NTW NHS FT - Pharmacy and Medicines Optimisation Strategy

The proposal is consistent with the objectives outlined in the Trust's Pharmacy and Medicines Optimisation Strategy, which supports the Trust's Strategic Ambition Four ('The Trust's mental health and disability services will be sustainable and deliver real value to the people who use them). In particular, the proposal would help to meet the strategy's objectives of:

- continuing to develop and innovate in managing service delivery costs and delivering efficiency gains;

- re-investing pharmacy resources, released through new productivity initiatives and funding bids, towards patient-facing roles to reduce reliance on agency staff; and

- growing the pharmacy service by releasing resources and generating income through collaborative working with neighbouring providers (Carter Report);

2.4 NTW Solutions Strategy – 2018-2021

NTW Solutions' newly developed strategy sets out five strategic aims, one of which is "providing and growing strong, sustainable services". This includes identifying and implementing new business opportunities that are sustainable going forward, for example by providing other services to the Trust and providing services to other organisations. This proposal would provide a new service for the Trust, which also has the potential to be provided to other organisations.

In summary, it is considered that the proposal has a good strategic fit with:

- the national context
- the perceived benefits that would be delivered from establishing NTW Solutions;
- the Trust's Pharmacy and Medicines Optimisation Strategy; and
- NTW Solutions' Strategy

3 CURRENT SERVICE PROVISION

Out-patient medicines prescribed by NTW clinicians for service users in the community are usually supplied by community retail pharmacies. However, in some cases this is not possible. Clozapine is almost entirely supplied by the Trust pharmacy department due to the essential blood monitoring required to ensure its safe use. Likewise, long-acting antipsychotic 'depot' injections are usually supplied by the Trust as they are administered by Trust clinical staff at various clinics across the NTW area.

The dispensing service is provided from the St Nicholas Hospital centralised pharmacy department. 40% of clozapine dispensing activity is now undertaken using the Trust's new pharmacy robot, which can dispense Monitored Dosage Systems (MDS, 7 day calendar packs of medicines) more efficiently and safely than by traditional manual dispensing methods. The robot currently has significant spare capacity.

The service comprises of:

- clinical screening of prescriptions
- dispensing of drugs, medicines and appliances to patients who present with a prescription issued by or on behalf of the Trust
- answering medicines information questions from patients or staff relating to the outpatient pharmacy services
- answering patient enquiries about their drug treatment as appropriate and in accordance with Trust Policies;
- providing a final check on dispensing
- answering queries from medical and nursing staff in relation to outpatient prescribing;
- resolving any clinical, pharmaceutical, legal or formulary issues with prescriptions; and
- supplying clinical trial materials as required

The outpatient dispensing service is currently staffed as part of the overall Trust dispensary service, which also covers dispensing for inpatients – staffing resources are not separated. There are about 10 whole time equivalent staff employed directly in providing the day to day dispensing service, some of which is undertaken within the dispensary at St. Nicholas Hospital and some providing support in clinics and wards e.g. providing inpatient leave and discharge dispensing.

The service is governed through a range of Trust Pharmaceutical Standard Operating Procedures and medicines are dispensed in accordance with Trust policies and procedures and the General Pharmaceutical Council's professional standards and guidance. The Trust's General Pharmaceutical Council rating, for its pharmaceutical service, is "Good" - the highest rating for hospital pharmacy services.

4. CASE FOR CHANGE

In summary, there is a strong case for change founded upon:

- the provision of this model of service being common in other NHS FTs / subsidiary companies
- the proposal being compatible with the benefits outlined in the Trust's Business Case which set up NTW Solutions; the Trust's Pharmacy and Medicines Optimisation Strategy; and NTW Solutions' Strategy
- the opportunity to continue to deliver a good quality service, whilst also delivering financial savings, contributing to the Trust's Financial Delivery Plan;
- and the opportunity for another model of service to help generate additional income for the NTW Group

5. OPTIONS FOR SERVICE PROVISION

There are considered to be three options for providing this service in the future.

5.1. **Do Nothing**

The outpatient dispensing service would continue to be provided by the Trust, delivering a high quality service, including a low dispensing error rate. However, as described above a key part of the Trust's Pharmacy and Medicines Optimisation Strategy is to continue to develop and innovate in managing service delivery costs and delivering efficiency gains. This is necessary, not just to help the Trust's financial performance, but also to help the service meet the challenge of the increasing prescription of higher cost medicines and to invest in the development of value added pharmaceutical services. Continuing with the existing service model would not release any resources to help deliver the Trust's pharmacy strategy.

5.2 **Outsourcing the Service**

Some Trusts have outsourced this service to community retail pharmacy companies. A high quality service, with a low rate of dispensing errors can continue to be provided in this way, although the Trust would lose some control over the way in which this service would be delivered operationally. Financial savings would be expected from this option through the commercial advantages which retail pharmacies have compared to the NHS. This would release resources which would help the Trust's financial performance and /or release resources which could help to deliver the Trust's pharmacy strategy. However, these savings would take longer to deliver due to the timescale that would be involved in the procurement process and the agreement of contracts. This option would also have a much greater impact on staff in the pharmacy service, involving staff being TUPE transferred to the outsource company.

5.3 **Provision of the service by NTW Solutions**

The service would continue to be provided by the same staff, working to the same Trust pharmacy policies and procedures, delivering a high quality service, including a low dispensing error rate. Financial savings would be delivered as NTW Solutions would access similar commercial advantages to the retail pharmacies. As with the

outsourcing option the resources that would be released would help the Trust's financial performance and / or release resources to help deliver the Trust's pharmacy strategy. The delivery of the financial savings would be quicker than in the outsourcing option. This option will have a minimal impact on Trust pharmacy staff.

It was considered that the preferred option was for the service to be provided by NTW Solutions, the Trust's wholly owned subsidiary company. The following section sets out in more detail how this would be managed.

6. OPERATIONAL ARRANGEMENTS

6.1 **Service Provision**. The key points in the delivery of the service are:

- All the services currently provided, as set out in section 3 above, will continue to be provided
- The service will continue, as present, to be governed through a range of Trust Pharmaceutical Standard Operating Procedures and medicines will continue to be dispensed in accordance with Trust policies and procedures and the General Pharmaceutical Council's (GPC) professional standards and guidance
- The provision of the service by NTW Solutions requires approval by the GPC. This has required some capital investment work within the pharmacy department to create a discrete outpatient dispensing room – this has been completed, funded by NTW Solutions. It also requires the GPC to be satisfied with the policies and procedures that will be used; the separation of outpatient and inpatient medication; and with the appointment of the Superintendent Pharmacist (see staffing below). GPC approval was received on 25 June.
- The contractual Outpatient Dispensing Agreement under which the service will be provided will include a Service Level specification, including the key performance indicators which the outpatient dispensing service currently use. Performance against these indicators will be monitored through regular Trust / Company Informed Client meetings, similar to the existing Informed Client arrangements for the other services provided by NTW Solutions. This would therefore provide an additional performance monitoring mechanism, in addition to current reporting in the Trust through the Pharmacy and Medicines Optimisation Group and the Trust Board's Quality and Performance Committee. Although not expected, any significant change in the key performance indicators would be quickly identified and acted upon through these reporting processes. KPIs include:
    - accuracy of automated MDS dispensing (VBM), as identified through both internal "near miss" monitoring and medicines incidents
    - accuracy of manual MDS dispensing, as identified through both internal near miss monitoring and medicines incidents
    - timeliness of incident investigation as reported to monthly incident investigation meeting
- The pharmacy robot will continue to be used, as at present, to physically dispense medication. As part of the new arrangement it will be purchased by NTW Solutions from the Trust (see Finance section)

- The Trust's Chief Pharmacist / Controlled Drugs Accountable Officer considers that there would be no expected impact on either NTW service users or NTW clinical staff, who administer the medication to service users, if the proposal is approved

6.2 **Staffing.** The key points are:

- The service will continue to be provided by the same staff who currently provide the service.
- There will be no TUPE arrangements – an Outpatient Dispensing Agreement between the Trust and NTW Solutions will include the number of staff, and the percentage of their time per week, who will be allocated to NTW Solutions to provide this service. This covers a range of staff from pharmacy assistants to the Trust's Chief Pharmacist and equates overall to just under 8.7 whole time equivalent staff. This staffing model is similar to that in the other mental health NHS FT that has provided advice.
- The staffing resource will be set out in the Outpatient Dispensing Agreement. The staffing level will be monitored and reviewed by the Trust and NTW Solutions and any agreed adjustments will result in changes to the Agreement, including changes to the price of the service.
- General Pharmaceutical Council regulations require that NTW Solutions has a suitably qualified Superintendent Pharmacist in place. The Superintendent Pharmacist, an existing Trust pharmacist, has been identified as part of the staffing complement referred to above, and the nomination has been approved by the GPC.
- In many, but not all, other subsidiary companies that provide this service the Superintendent Pharmacist is employed by the subsidiary company, particularly where there is a large volume of dispensing. It is the intention that NTW Solutions will directly employ a Superintendent Pharmacist, following the initial set up of the service and a period of embedding. The Superintendent Pharmacist would continue in this future arrangement to be able to access professional mentoring and development from the Trust's Chief Pharmacist. In the meantime, the current temporary arrangement regarding this post will help to provide continuity of service provision.

6.3 **Financial**

The key points are:

6.3.1 Asset Transfers – the following assets will be transferred to NTW Solutions. The values of these assets are shown below.

Assets	**Value (£)**
Robot (asset register value)	205,970
Furniture (not already owned by NTW Solutions under existing Operated Healthcare Facility Agreement)	325
Stock	0
Total	**206,295**

The assets will be purchased in cash, therefore no loan or share issue is required. Stock is shown as a zero value as it is planned that stock will be purchased by NTW Solutions prior to 1st August 2018 in time for the go-live date. Should a purchase of stock be required, this will be done through an invoice from the Trust. However, this is not planned and should not be material based on procurement plans.

For the IT equipment in the pharmacy area, these assets will be purchased and provided by the Trust as part of the reverse SLA charges.

6.3.2 Set up Costs

The following items will be purchased by NTW Solutions:

Items	Value (£)
Capital works to discrete pharmacy area	21,896
New furniture	324
QEF Consultancy	5,000
Womble Bond Dickinson legal fees	11,250

As referred to in paragraph 6.1 above, capital works were required to provide a discrete outpatient dispensing area within the Trust's pharmacy department, to meet GPC requirements. This has been completed, funded by NTW Solutions at a cost of £21,896. NTW Solutions will be able to apply to deduct a capital allowance from its taxable profit for this work.

The following items will be purchased by the Trust:

Items	Value (£)
IT equipment for discrete pharmacy area	1,007

6.3.3 SLA for services supplied by the Trust to NTW Solutions. This will include the following costs.

Items	Value (£)
Supply of Staff	310,314
Supply of systems and licenses	9,664
Total per annum	319,978

The cost of the staff providing this service will be a cost neutral transaction to the Group, managed through the Outpatient Dispensing Agreement.

6.3.4 There is a small of amount of additional recurring revenue costs to the Group as follows, which is factored into the projected savings:

Items	Value (£)
Registration and insurance costs (NTW Solutions)	2,200
Additional pharmacy procurement resource band 3 (NTW Trust)	7,100

6.3.5 Financial Model

The contract with NTW Solutions Limited is for approx. £1.480m per annum as a cost to the Trust.

The £1.480m contract is made up of dispensed drugs costs of £1.025m. The contract is made up of charges for drugs costs, plus dispensing costs and profit.

The main dispensing costs include the supply of staff and systems and system licenses through an SLA with the Trust of £0.320m as detailed above. This is the apportionment of staff and systems which are currently part of the pharmacy service and which will be utilised to provide the outpatient pharmacy dispensary service.

Other non-pay costs include items such as depreciation charges, maintenance costs of the robot and other miscellaneous costs of running the service.

Financial savings are estimated to be in the region of £150k per annum to the NTW Group and it is planned to generate external income and additional profits for the Company as detailed in the business development section of this paper (section 7).

6.4 **Procurement** A number of procurement related actions have been necessary as part of this proposal:

- Establishing formal agreement with all existing suppliers to ensure access to the NHS Commercial Medicines Unit's framework agreement prices.
- Novating existing contract and SLA with Omnicell, for the robot
- Setting up the procurement authorisation process for ordering of medication
- Resolving licensing issues relating to company access to Trust owned systems and identifying an appropriate payment e.g. Ascribe pharmaceutical software system

At the time of writing some of these arrangements are still being progressed but this should not affect the transfer of the service taking place on 1st August. If agreement is not obtained from any suppliers by 1 August, initial orders with those suppliers would attract the slightly higher NHS List price until agreement is reached.

6.5. **Governance and Quality Assurance**. The key points, not covered elsewhere, are:

- Pharmacy staff have been road testing practical processes, prior to going live, with no major issues emerging

- As part of developing the proposal, the Trust's Information Governance team has reviewed the information systems to ensure that they are secure and comply with relevant NHS guidelines and statutory law. Minor outstanding items are being completed.

- There will be an increased monitoring of service performance. The current quarterly reports on key performance indicators will continue to go to the Trust's Pharmacy and Medicines Optimisation Group and then on to the Trust Board's Quality and Performance Committee. The new arrangements will see additional reporting on service performance and financial issues through the Company and Trust "Informed Client" meetings, which then feed into the Trust Board's Resource and Business Assurance Committee.

- The KPIs for this service will be added to the monthly Performance Report to the NTW Solutions' Board of Directors. The performance parameters within the Service Level Agreement will also be monitored.

- There will be additional bureaucracy involved but it is considered that this will be outweighed by the other benefits described.

- The service will continue to receive Internal Audits, as identified, on an NTW Group basis

7 BUSINESS DEVELOPMENT

The strategic context section above described that one of the aims of the Trust, in setting up NTW Solutions, was that it would be better able to seize opportunities to generate additional income, for the benefit of the NTW Group. As NTW Solutions can access some commercial advantages there is added potential for the outpatient dispensing service to be provided to other organisations.

This part of the business case only scopes the potential for providing this service to others - any proposal to do so would require to be agreed and developed as a business case for approval by the NTW Solutions Board of Directors and by the Trust.

There are four market sectors where there could be opportunities. The existence of our robot, its efficiency, low error rate and spare capacity is a unique selling point which would provide a benefit to other potential customers.

7.1 Local Acute NHS Trusts All local acute Trusts do their own Monitored Dosage System (MDS) dispensing either in-house or through their own subsidiary companies, with the exception of the Newcastle Hospitals NHS FT which currently outsources its outpatient dispensing service.

As acute Trusts don't do repeat MDS dispensing in the same volume as mental health trusts or community retail pharmacies, some local acute Trusts have already expressed an interest in NTW providing this service. This would also fit with the regional STP/ICS collaboration plans and Lord Carter recommendations on

minimising pharmacy infrastructure costs. Acute Trusts can't provide the same advance notice of their requirements as mental health trusts, so there is some advantage in us being closely located to them.

7.2 Other Mental Health Trusts nationally Additional transportation costs and logistical considerations would have to be taken into consideration. However, other mental health trusts have a similar requirement and workload to NTW, so scaling up our outpatient dispensing service would be easier compared with the other sectors described here. Although many of these Trusts will have outsourced their service, our robot combined with access to NHS Commercial Medicines Unit pricing would provide us with some advantages over private providers.

7.3 Community Retail Pharmacy Providers in this sector dispense large volumes of planned and repeat MDS prescriptions which fits very well with the NTW robot design and function. This is a large market but also a more competitive one. There could be a potential to collaborate with a community retail pharmacy company. However, a significant risk to developing in this sector would be whether NTW Solutions would be able to continue to access the NHS Commercial Medicines Unit's pricing for medications. Being unable to access these prices would have an adverse financial impact.

7.4 Other Organisations Other opportunities could be identified through the Trust's and the Pharmacy Department's horizon scanning of invitations to tender for this type of service e.g. for prisons.

There are different benefits and risks relating to all these market sectors. Any proposal would be carefully considered by the Trust and NTW Solutions before any significant resources were invested in working up a business case.

8. RISKS

Some of the risks and controls to manage the risks have been referred to in the preceding sections. The perceived risks and controls and mitigations are summarised on the following page.

RISK	CONTROLS AND MITIGATIONS
That the change in service delivery arrangements results in a lower quality service	• Service specifications set out in the SLA, which will be monitored by the Trust & NTW Solutions • Service will be provided by the same staff in line with the same Trust policies and procedures and GPC regulations and guidance
That the change in service delivery arrangements results in poorer performance against key indicators	• Service will be provided by the same staff, working to the same KPIs as at present • There will be increased monitoring of performance through the current Trust process and a new NTW Solutions reporting process (Informed Client meetings)
That the change in service delivery arrangements leads	• There will be no change to the current arrangements for clinical staff prescribing and administering medication

to an increase in patient safety risks	• Dispensing will be provided by the same staff, using same policies and procedures as at present • In the event of an incident occurring, financial risk is mitigated by existing Trust insurance cover for prescribing and administrating medication; and NTW Solutions insurance cover relating to dispensing
That there is short term disruption in service delivery due to the changes in processes for staff in the pharmacy department	• The changes in day to day service delivery processes are limited and have been road tested by the pharmacy department • There has been regular engagement with staff in pharmacy department by the Chief and Deputy Chief Pharmacist about the changes
That we cannot access the Commercial Medicine Unit's framework prices for medicines from those suppliers who have not agreed this by 1 August	• Medicines would still be procured, but initial orders would be at the slightly higher NHS List price, until formal agreement is received from those suppliers • The biggest suppliers who have not yet provided approval are being prioritised for follow up
Appointment of a superintendent pharmacist to NTW Solutions	• After the initial set up of the service and a period of embedding, NTW Solutions must directly employ a senior pharmacist to this post. There is a risk if we do not directly employ a resource and continue to rely on a supply of staff arrangement. The temporary supply of staff will allow time to evaluate the full requirements for this post. Current levels of service only require a part-time resource, so there is a risk to the ability to recruit to a part time post on non-NHS terms and conditions and there would be a requirement for investment to this post to enable the Company to expand the business into the areas detailed above. • A superintendent pharmacist employed directly into the company will require a formal arrangement with the Trust from a professional support perspective, including mentoring and continuing professional development.
Financial risks due to changes in HMRC position on NHS subsidiary companies and NHS subsidiary pharmacy arrangements	• This risk applies to NTW Solutions as a whole and also to all other NHS organisations operating under these models. It is already registered on the Company's risk register

9. PROGRESSING THE PROPOSAL

9.1 **Project Team**. The proposal has been developed by a Project Team comprising of:

- Chief Pharmacist, NTW Trust
- Deputy Chief Pharmacist – Operational Services, NTW Trust

- Lead Pharmacist – Safer Care, NTW Trust
- Director of Finance, NTW Solutions
- Associate Director of Finance and Business Development, NTW Trust
- Company Secretary, NTW Solutions

It has been advised by QE Facilities Ltd and another similar size mental health NHS Foundation Trust which operates this service model.

The Project Team would continue for a brief time, following approval, to deal with any immediate issues and to oversee a post project evaluation report.

9.2 Communications and Engagement

A Communications and Engagement Plan was developed and followed, including:

- Briefing of pharmacy staff and meetings with staff directly affected
- Information provided to Staff Side
- Paper to Trust Pharmacy and Medicines Optimisation Group meeting
- Paper to Trust Business Delivery Group meeting
- Approval of business case for capital works to Trust Integrated Business Development Group
- Updates to NTW Solutions Board of Directors; NTW Trust Executive Directors and NTW Trust Board

Communication to Trust and NTW Solutions staff about the transfer of the service would take place through the Trust Bulletin, Trust intranet and NTW Solutions' Newsletter.

9.3 Timescales

Key tasks looking forward are:

<u>Phase 1 - To "Go Live"</u> • Business Case to NTW Solutions Board – 17 July • Business Case to Trust Board – 25 July • Signing of legal documentation – between 26 July to 31 July • Go Live – 1 August (first dispensing run Monday, 6 August)
<u>Phase 2 (August – October)</u> • Ongoing management of service by NTW Solutions • Begin Informed Client meetings and reporting arrangements • Project team to continue, as required, to ensure some post go live tasks are completed and manage any emerging issues • Project team to agree post project evaluation format
<u>Phase 3 (January 2019 onwards)</u> • Complete post project evaluation. • Consider following up horizon scanning for opportunities to provide the service to other organisations (depending on other business opportunities that may be available and company resources)

- Progress the appointment of the superintendent pharmacist and consider investment into this post if the horizon scanning and market analysis determines the opportunities warrant investment

10 CONCLUSION

In summary, it is considered that there is a strong case for agreeing this proposal on the following basis:

Strategically – this service is commonly provided by other wholly owned Trust subsidiaries; it accords with the benefits and remit of the Trust in setting up NTW Solutions; and it fits with Trust and NTW Solutions' financial and service development plans.

Service Provision – there is little change required as the same service will be provided by the same staff, working to existing Trust policies and procedures and General Pharmaceutical Council regulations and guidance. Therefore it is considered that there will be no expected adverse impact on service users. There will be robust processes in place to monitor performance and to report to Trust Committees for assurance purposes and to NTW Solutions Board of Directors.

Commercially – market opportunities exist to provide the service to other organisations, maximising the capacity of the robot and generating additional income for the NTW Group.

Financially – the proposal will provide a significant contribution to the Trust's and NTW Solutions' Financial Delivery Plan, irrespective of future growth opportunities in providing this service

In conclusion, it is recommended that the proposal is agreed.

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 25 July 2018

Title and Author of Paper:
Staff Friends and Family Test Update Quarter One 2018/19
Lisa Quinn, Executive Director of Commissioning & Quality Assurance

Executive Lead:
Lynne Shaw, Acting Executive Director of Workforce & OD
Lisa Quinn, Executive Director of Commissioning and Quality Assurance

Paper for Debate, Decision or Information: Information

Key Points to Note:

- This paper includes the results of the Qtr1 18/19 Staff Friends and Family Test Survey administered to all staff accessing the Trust network via an NTW Login.
- Response rates this quarter increased to 47% from 43% in Qtr4 17/18.
- There was a 2% increase in positive responses to the question "How likely are you to recommend the organisation to friends and family as a place to work?" from 70% to 72%
- However extremely unlikely has increased by 3% in Qtr 1 18/19 to 6%.
- There was 3% increase in positive responses to the question, "How likely are you to recommend our services to friends and family if they needed care or treatment?" from 76% to 79%.
- The trend for staff being more likely to recommend the Trust to family and friends for care and treatment than as a place to work continues. Staff continue to be less likely to recommend the Trust for care and treatment than those service users and carers responding to the FFT question.
- There appears to be no seasonal pattern to results.
- The Trust remains above the national average for the percentage of staff who would recommend the Trust as a place to work and below the national average for those who would recommend for care and treatment.
- The actions undertaken by the Groups to address themes which emerged from Quarter 4 17/18 are reported in Appendix 6 and trend analysis has been included in Appendices 1-3.

Risks Highlighted: N/A

Does this affect any Board Assurance Framework/Corporate Risks: No

Equal Opportunities, Legal and Other Implications: N/A

Outcome Required / Recommendations: For information and action

Link to Policies and Strategies: Workforce & OD Strategy

Staff Friends and Family Test (FFT) Update Quarter One 2018/19

1. Executive Summary

1. The proportion of staff recommending the organisation to friends and family as a place to work:
    a. Has increased in the quarter from 70% to 72%.
    b. Remains higher than the most recently published national average of 63%.
    c. Medical and Dental staff and Allied Health Professionals are the staff groups most likely to recommend the organisation as a place to work, while the staff group least likely to recommend are Additional Clinical Services as well as Estates and Ancillary.
    d. The Directorates most likely to recommend NTW as a place to work are the CEO Office, Workforce & Organisational Development and Commissioning & Quality Assurance. The directorates least likely to recommend are the Central Locality Group and NTW Solutions
    e. The Directorates with the biggest change in the quarter are NTW Solutions with a reduction from 73% to 66% and Workforce Directorate with an increase from 64% to 76%.

2. The proportion of staff recommending the organisation to friends and family if they needed care and treatment:
    a. Has increased in the quarter from 76% to 79%.
    b. Is below the most recently published national average of 80%.
    c. Nursing and Midwifery, Allied Health Professionals, Admin & Clerical staff groups are those most likely to recommend NTW for care and treatment, while the staff groups least likely to recommend are Medical & Dental and Estates and Ancillary staff group.
    d. The Directorates with the biggest change in the quarter are Deputy Chief Executive Office from 76% to 68% and Workforce Directorate with an increase from 86% to 95%.

3. The response rate in the period has increased to 47% from 43% of staff (those presented with FFT questions when logging onto the Trust network). 3,319 staff responded during the period.

4. Analysis of the respondents suggests that the proportion of respondees by staff group is broadly in line with the Trust staff demographic, with the exception of Estates and Ancillary staff – this may be reflective of lower access to the Trust network by employees within this staff group.

5. A total of 1,172 comments and suggestions from staff have also been collected and analysed.

2. Introduction

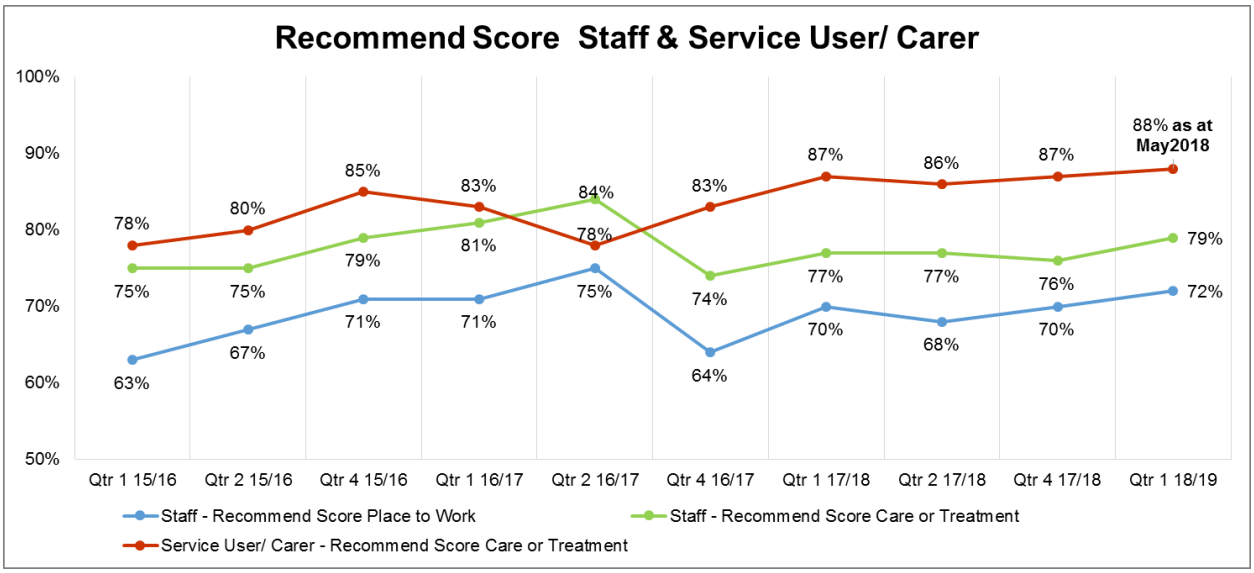
All NHS Trusts are required to ask staff their responses to the two Staff Friends and Family Test (FFT) questions, which are also included with the national staff survey conducted in Qtr3 of each year. The two Staff FFT questions are as below, with answer options ranging from 'extremely likely' to 'extremely unlikely' (6-point Likert scale, including 'don't know' option):

1. **How likely are you to recommend the organisation to friends and family as a place to work? ('work' question)**
2. **How likely are you to recommend our services to friends and family if they needed care and treatment? ('care' question)**

NTW provides staff with the opportunity to feedback their views on the organisation throughout the year via a range of mechanisms, such as the annual Staff Survey, the Staff FFT (which is administered quarterly except Qtr3), SpeakEasy events and the Chatterbox facility. Since 16/17, all staff have been asked their views in every quarter, therefore significantly increasing the volume of Staff FFT responses in the year.

The Staff FFT responses are published nationally, allowing for national benchmarking to take place. Internally, anonymised responses to the staff FFT are made available to managers via the Trust dashboard.

The graph below shows the recommend score from both the staff and service users/ carers' FFT over a quarterly time period:



N.B. Quarter 3 results are not included above as the Staff FFT is asked via the Staff Survey during this quarter.

Service User/ Carer – Recommend Score Care or Treatment is as at 31st May due to this report being required for beginning of July, this score will be updated in the Qtr2 18/19 report.

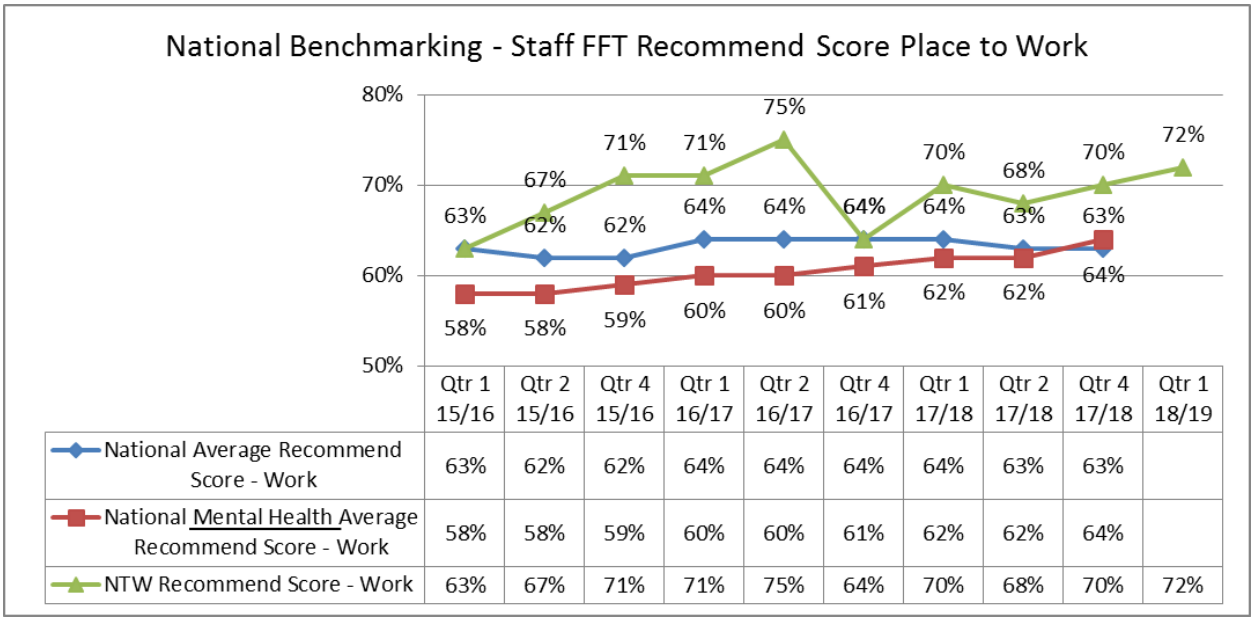
3. National Benchmarking Data - Update Quarter 1 - 2018/19

The table below shows the responses to the Staff FFT questions from Northumberland, Tyne and Wear NHS Foundation Trust in comparison to the National and Local Area responses. The data below is the most recently published NHS England Staff FFT for Qtr4 17/18

	Total Response	HSCIC Workforce Headcount	Work		Care	
			% Recommend	% Not Recommend	% Recommend	% Not Recommend
National	**138,325**	**1,164,133**	**63%**	**18%**	**80%**	**6%**
NHS England Cumbria & North East	9,984	84,991	66%	15%	80%	5%
Northumberland, Tyne and Wear NHS Foundation Trust	3,108	5,632	70%	9%	76%	5%
Tees, Esk and Wear Valleys NHS Foundation Trust	2,686	6,664	69%	14%	81%	5%

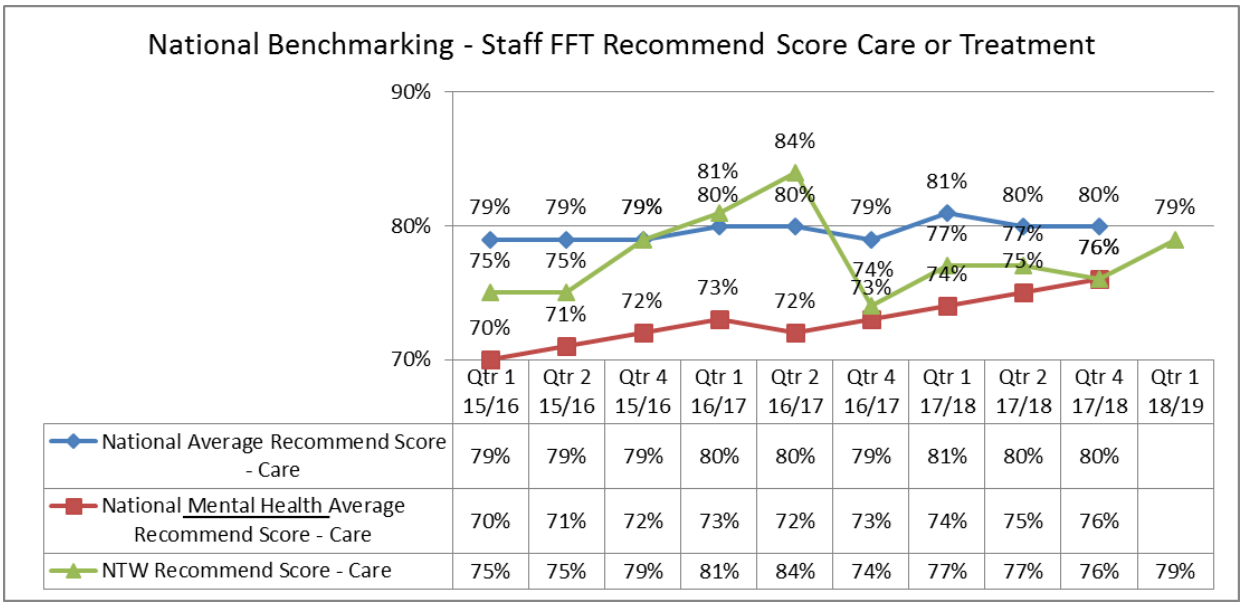
N.B. Qtr 1 18/19 data is due to be published 23rd August 2018
Qtr 2 18/19 data is due to be published 22nd November 2018
Qtr 4 18/19 data is due be published 30th May 2019

It can be seen that in Qtr4 17/18 the Trust was above the national averages for the percentage of staff who would recommend the Trust as a place to work and below the national average for those who would recommend the Trust for care and treatment. If the national position remains unchanged from Qtr4 17/18 to Qtr1 18/19, at 63% the most recent (Qtr118/19) results NTW would be above the national average for recommending the Trust as a place to work, and at 79% be below the national average of 80% for recommending the organisation for care and treatment.



	Qtr 1 15/16	Qtr 2 15/16	Qtr 4 15/16	Qtr 1 16/17	Qtr 2 16/17	Qtr 4 16/17	Qtr 1 17/18	Qtr 2 17/18	Qtr 4 17/18	Qtr 1 18/19
National Average Recommend Score - Work	63%	62%	62%	64%	64%	64%	64%	63%	63%	
National Mental Health Average Recommend Score - Work	58%	58%	59%	60%	60%	61%	62%	62%	64%	
NTW Recommend Score - Work	63%	67%	71%	71%	75%	64%	70%	68%	70%	72%

The above graph illustrates that the Trust has been above or equal to the national average, and above the sector average since Qtr115/16 for the percentage of staff who would recommend the Trust as a place to work.



	Qtr 1 15/16	Qtr 2 15/16	Qtr 4 15/16	Qtr 1 16/17	Qtr 2 16/17	Qtr 4 16/17	Qtr 1 17/18	Qtr 2 17/18	Qtr 4 17/18	Qtr 1 18/19
National Average Recommend Score - Care	79%	79%	79%	80%	80%	79%	81%	80%	80%	
National Mental Health Average Recommend Score - Care	70%	71%	72%	73%	72%	73%	74%	75%	76%	
NTW Recommend Score - Care	75%	75%	79%	81%	84%	74%	77%	77%	76%	79%

As illustrated above the Trust has been above or equal to the sector average since Qtr115/16 for the percentage of staff who would recommend the Trust as a place for care and treatment. During Qtr4 16/17 the Trust recommend score was marginally above the sector average by 1% and equal to the sector average in Qtr4 17/18. If the national average remains unchanged the trust recommend score will be below the average by 1%.

4. Results for Quarter 1 - 2018/19

4.1 Response rates

Appendix 1 shows the response rates by Group/Directorate over time. In Qtr1 18/19 the Trust response rate was 47%, receiving a total of 3,319 responses this is an increase of 4%. The lowest response rate of those staff was from Medical Directorate (42%) and the highest response rate was from Chief Executive Office (95%).

Table 1 – Response rates by group/directorate

Response rate – proportion of responses of those offered the Staff FFT through their NTW login	**Qtr 1 17/18**	**Qtr 2 17/18**	**Qtr 4 17/18**	**Qtr 1 18/19**
Trust	**49%**	**49%**	**43%**	**47%** ↑
Specialist Care Group	52%	52%	-	-
Community Care Group	55%	54%	-	-
In-Patient Care Group	52%	51%	-	-
Deputy Chief Executive	33%	45%	41%	44% ↑
Nursing & Chief Operating Officer	57%	57%	60%	64% ↑
Medical Directorate	44%	45%	44%	42% ↓
Commissioning & Quality Assurance	66%	65%	65%	63% ↓
Workforce & Organisational Development	56%	58%	59%	58% ↓
Chief Executive	57%	60%	81%	95% ↑
NTW Solutions	47%	45%	41%	46% ↑
North Locality Group	-	-	43%	49% ↑
Central Locality Group	-	-	44%	48% ↑
South Locality Group	-	-	46%	51% ↑

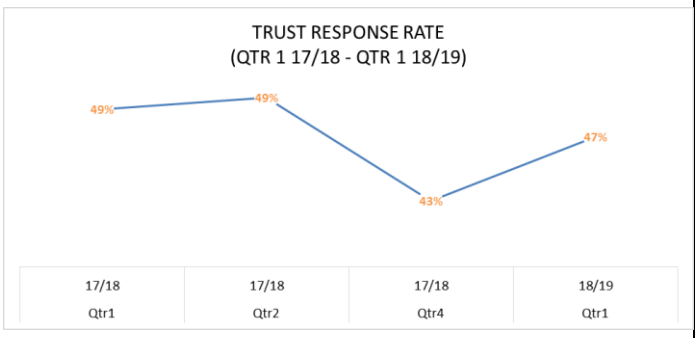


Table 2 – Breakdown by staff group of those who responded in Qtr1

Breakdown by staff group - proportion of responses of those offered the Staff FFT through their NTW login	**Response Breakdown**				**Proportion of Staff Group (source:ESR)**
	Qtr 1 17/18	**Qtr 2 17/18**	**Qtr 4 17/18**	**Qtr 1 18/19**	
Add Prof Scientific and Technical	6%	7%	5.95%	6.03%	6.04%
Additional Clinical Services	26%	24%	23.78%	24.13%	27.24%
Administrative and Clerical	20%	20%	20.50%	20.49%	19.73%
Allied Health Professionals	5%	4%	4.89%	5.24%	4.78%
Estates and Ancillary	2%	2%	2.12%	2.11%	7.92%
Medical and Dental	4%	4%	4.34%	4.09%	3.97%
Nursing and Midwifery	29%	28%	27.90%	29.01%	30.33%
Other	-	11%	10.52%	8.90%	N/A
Total	-	100%	100%	100%	100%

N.B. included in the Trust total includes staff "other" within the breakdown of staff group these staff have an NTW login but are not held on ESR e.g agency staff.

4.2 Responses by answer options and recommend score

Question 1:- How likely are you to recommend the organisation to friends and family as a place to work? (Work Question)

Table 3 shows the findings from Question 1 work question by answer.

N.B. positive responses refer to 'extremely likely' and 'likely' responses, this is also known as the 'recommend score'.

Table 3 – **Responses by Answer for Question 1**

Question 1 **- How likely are you to recommend the organisation to friends and family as a place to work?**	**Qtr 1 17/18**	**Qtr 2 17/18**	**Qtr 4 17/18**	**Qtr 1 18/19**	While comparing the Qtr1 percentages with the same period last year 17/18, there has been an overall increase in positive responses (or recommend score) from 70% to 72%. This is an increase from the last Qtr (Qtr4 17/18) the recommend score has increased by 2%. There has been a decrease in unlikely responses compared to both the same period last year and compared to the previous quarter. However extremely unlikely has increased by 3% in Qtr 1 18/19 to 6%.
Extremely Likely	25%	24%	23%	26% ↑	
Likely	45%	44%	47%	46% ↓	
Total Recommend	***70%***	***68%***	**70%**	***72%*** ↑	
Neither	18%	17%	17%	16% ↑	
Unlikely	7%	7%	6%	3% ↑	
Extremely Unlikely	4%	3%	3%	6% ↓	
Don't Know	2%	3%	3%	3% ↔	

Table 4 shows the comparison of staff who would 'recommend' the Trust as a place to work by Group/Directorate.

Table 4 - Results table: **Recommend Score for Question 1 by Group/Directorate**

Question 1 **- How likely are you to recommend the organisation to friends and family as a place to work?**	**Qtr 1 17/18**	**Qtr 2 17/18**	**Qtr 4 17/18**	**Qtr 1 18/19**	There has been an increase in recommend score across the 3 locality Groups (North Central & South) whereas the majority of the Corporate Directorates have all seen a decrease in their recommend score, most notably NTW Solutions however the
Trust	70%	68%	70%	72% ↑	
Specialist Care Group	68%	67%	-	-	
Community Care Group	67%	66%	-	-	
In-Patient Care Group	69%	66%	-	-	
Deputy Chief Executive	72%	71%	76%	73% ↓	
Corporate Nursing Directorate	76%	71%	74%	75% ↑	

Corporate Medical Directorate	70%	73%	75%	73% ↓	Workforce Directorate has seen an increase in their recommend score.
Commissioning and Quality Assurance	84%	81%	79%	76% ↓	
Workforce Directorate	65%	73%	64%	76% ↑	
CEO Office	77%	83%	82%	78% ↓	
NTW Solutions	68%	69%	73%	66% ↓	
North Locality Group	-	-	68%	71% ↑	
Central Locality Group	-	-	64%	68% ↑	
South Locality Group	-	-	70%	71% ↑	

Table 5 is a comparison of the staff who would 'recommend' the Trust as a place to work by staff group.

Table 5 - Results table: **Recommend Score for Question 1 by Staff Group**

Question 1 **- How likely are you to recommend the organisation to friends and family as a place to work?**	**Qtr 1 17/18**	**Qtr 2 17/18**	**Qtr 4 17/18**	**Qtr 1 18/19**	Comparing the recommend scores in Qtr4 17/18 with Qtr1 18/19 there has been an increase in 5 of the 7 Staff Groups, most notably in Add Prof Scientific and Technical & Nursing Midwifery with a large reduction in recommend score across Estates and Ancillary.
Trust	70%	68%	70%	72% ↑	
Add Prof Scientific and Technical	69%	68%	69%	73% ↑	
Additional Clinical Services	68%	63%	66%	67% ↑	
Administrative and Clerical	73%	72%	74%	73% ↓	
Allied Health Professionals	74%	72%	75%	77% ↑	
Estates and Ancillary	61%	66%	68%	59% ↓	
Medical and Dental	63%	68%	71%	74% ↑	
Nursing and Midwifery	68%	68%	66%	71% ↑	

Appendix 2 illustrates the percentage of staff who would recommend, not recommend (rating extremely unlikely or unlikely) and those who are unsure (rating either neither or don't know) to question 1 by Group/Directorate over time (Qtr1 17/18 to Qtr1 18/19).

Question 2:- How likely are you to recommend our services to friends and family if they needed care or treatment? (Care Question)

Table 6 shows the findings from Question 2 Care Question by answer.

Table 6 – Results table: **Responses by Answer for Question 2**

Question 2 **- How likely are you to recommend our services to friends and family if they needed care or treatment?**	**Qtr 1 17/18**	**Qtr 2 17/18**	**Qtr 4 17/18**	**Qtr 1 18/19**	While comparing the Qtr1 percentages with last year (Qtr1 17/18), there has been an overall increase in the recommend score (positive responses) for this question (from 29% to 31%). This has increased from Qtr4 17/18. There has been a small increase in negative responses compared the same period last year however.
Extremely Likely	29%	29%	28%	31% ↑	
Likely	48%	48%	49%	48% ↓	
Total Recommend	***77%***	***77%***	***76%***	***79%*** ↑	
Neither	14%	13%	14%	13% ↑	
Unlikely	3%	4%	4%	4% ↔	
Extremely Unlikely	2%	2%	2%	3% ↓	
Don't Know	4%	4%	4%	2% ↑	

Table 7 is a comparison of staff who would 'recommend' the Trust for care or treatment by Group/Directorate.

Table 7 - Results table: **Recommend Score for Question 2 by Group/Directorate**

Question 2 **- How likely are you to recommend our services to friends and family if they needed care or treatment?**	**Qtr 1 17/18**	**Qtr 2 17/18**	**Qtr 4 17/18**	**Qtr 1 18/19**	Overall there has been an increase in the recommend score (positive responses) when comparing Qtr4 17/18 to Qtr1 18/19, this is due to an increase across 7 of the 9 Directorates. Significant increases in the recommend score for Commissioning and Quality Assurance and Workforce Directorate. There is a notable decrease in recommend across Chief Executive Office and Deputy Chief Executive.
Trust	77%	77%	76%	79% ↑	
Specialist Care Group	75%	76%	-	-	
Community Care Group	78%	78%	-	-	
In-Patient Care Group	75%	73%	-	-	
Deputy Chief Executive	72%	64%	76%	68% ↓	
Corporate Nursing Directorate	84%	81%	83%	85% ↑	
Corporate Medical Directorate	75%	73%	71%	76% ↑	
Commissioning and Quality Assurance	84%	81%	79%	85% ↑	
Workforce Directorate	74%	68%	86%	95% ↑	
CEO Office	77%	83%	71%	67% ↓	

NTW Solutions	77%	80%	80%	76% ↓
North Locality Group	-	-	75%	79% ↑
Central Locality Group	-	-	72%	75% ↑
South Locality Group	-	-	79%	80% ↑

Table 8 is a comparison of staff who would 'recommend' the Trust for care or treatment by Staff Group.

Table 8 - Results table: **Recommend Score for Question 2 by Staff Group**

Question 2 **- How likely are you to recommend our services to friends and family if they needed care or treatment?**	**Qtr 1 17/18**	**Qtr 2 17/18**	**Qtr 4 17/18**	**Qtr 1 18/19**	Comparing the recommend scores in Qtr1 18/19 with Qtr1 17/18 there have been increases in 4 of the 7 Staff Groups, most notably in the Allied Health Professionals (from 80% to 84%) as well as Medical and Dental (from 69% to 73%). When comparing Qtr1 18/19 against the previous quarter (Qtr4 17/18) there has been an increase in recommend score in 5 of the 7 Staff Groups most significant in Nursing and Midwifery. There was decrease in the recommend score for 1 of the 7 staff groups Estates and Ancillary (7%).
Trust	77%	77%	76%	79% ↑	
Add Prof Scientific and Technical	79%	81%	75%	79% ↑	
Additional Clinical Services	75%	72%	73%	75% ↑	
Administrative and Clerical	81%	80%	81%	82% ↑	
Allied Health Professionals	80%	81%	82%	84% ↑	
Estates and Ancillary	75%	78%	80%	73% ↓	
Medical and Dental	69%	71%	73%	73% ↔	
Nursing and Midwifery	82%	77%	74%	79% ↑	

Appendix 3 illustrates the percentage of staff who would recommend, not recommend and those who are unsure to Question 2 by Group/Directorate over time (Qtr1 17/18 to Qtr1 18/19).

4.3 Results by Thematic Analysis

Staff also have the opportunity to provide comments into free text boxes designed to elicit improvement suggestions for each of the mandatory questions. Staff are asked:

1. **Please suggest any improvements to make NTW a better place to work.**

2. **Please suggest any changes NTW can make to improve the care or treatment offered.**

Table 9 is the number of free text comments made.

Table 9 – **Number of Free Text Comments and Response Rate**

	Question 1 – 'work' question		Question 2 – 'care' question	
	No of free text comments	% of respondents	No of free text comments	% of respondents
Qtr 1 18/19	615	18.53%	557	16.78%

35% of the staff who responded also made further suggestions as how NTW can make improvements, which is a decrease of 3% from Qtr4 17/18 although overall there were more free text comments this Qtr the percentage reduction is due to more completed questionnaires from staff.

In terms of the comments provided by staff regarding improvements, a full spectrum of feedback was received across a selection of themes. Several repeating themes emerged during Qtr1 and this thematic analysis is shown in tables 10 ('Work' question) and 11 ('Care' question) by Group

Table 10 – Top 3 themes per category for Question 1 (find full list in Appendix 4) by Group

North Locality Care Group - Work Question						
				Response to Staff FFT Question 1 - Work Question		
Category	Theme	Total	% of Responses	Recommend	Unsure	Not Recommended
Staff Feedback - Organisation change	General	2	50%	100%	0%	0%
Staff Feedback - Organisation change	Organisational Change	2	50%	100%	0%	0%
Staff Feedback - Patient Care	Staffing Levels	49	72%	31%	37%	33%
Staff Feedback - Patient Care	Parking / Transport	10	15%	100%	0%	0%
Staff Feedback - Patient Care	Treatments/ Pathways	3	4%	100%	0%	0%
Staff Feedback - Policy and Practice	Case Loads / Work Load	9	17%	0%	0%	100%

Staff Feedback - Policy and Practice	Available resources	7	13%	29%	0%	71%
Staff Feedback - Policy and Practice	Pay and Conditions (includes flexible working)	6	11%	100%	0%	0%
Staff Feedback - Wellbeing	Engagement	11	22%	36%	27%	36%
Staff Feedback - Wellbeing	General	9	18%	67%	33%	0%
Staff Feedback - Wellbeing	Management Support / Supervision	8	16%	50%	0%	50%

Central Locality Care Group - Work Question						
				Response to Staff FFT Question 1 - Work Question		
Category	Theme	Total	% of Responses	Recommend	Unsure	Not Recommend
Staff Feedback - Organisation change	Organisational Change	5	100%	40%	60%	0%
Staff Feedback - Patient Care	Staffing Levels	44	88%	34%	34%	32%
Staff Feedback - Patient Care	Access	2	4%	100%	0%	0%
Staff Feedback - Patient Care	Smoking ban	2	4%	100%	0%	0%
Staff Feedback - Policy and Practice	Pay and Conditions (includes flexible working)	15	24%	33%	40%	27%
Staff Feedback - Policy and Practice	Case Loads / Work Load	14	22%	14%	21%	64%
Staff Feedback - Policy and Practice	Shift Patterns	6	10%	100%	0%	0%
Staff Feedback - Wellbeing	General	13	19%	46%	23%	31%
Staff Feedback - Wellbeing	Respect	11	16%	18%	0%	82%
Staff Feedback - Wellbeing	Rewarding environment/ value/ praise	9	13%	67%	33%	0%

South Locality Care Group - Work Question						
				Response to Staff FFT Question 1 - Work Question		
Category	Theme	Total	% of Responses	Recommend	Unsure	Not Recommend
Staff Feedback - Organisation change	Organisational Change	3	100%	0%	100%	0%
Staff Feedback - Patient Care	Staffing Levels	38	69%	50%	24%	26%

Staff Feedback - Patient Care	Parking / Transport	11	20%	55%	0%	45%
Staff Feedback - Patient Care	Waiting Times	5	9%	40%	60%	0%
Staff Feedback - Policy and Practice	Pay and Conditions (includes flexible working)	25	22%	40%	12%	48%
Staff Feedback - Policy and Practice	Case Loads / Work Load	18	16%	39%	33%	28%
Staff Feedback - Policy and Practice	Available resources	13	12%	31%	0%	69%
Staff Feedback - Wellbeing	General	13	21%	31%	0%	69%
Staff Feedback - Wellbeing	Respect	9	14%	11%	33%	56%
Staff Feedback - Wellbeing	Communication	7	11%	100%	0%	0%

Table 11 – Top 3 themes per category for Question 2 (find full list in Appendix 5) per Group

North Locality Care Group - Treatment Question						
				Response to Staff FFT Question 2 - Treatment Question		
Category	Theme	Total	% of Responses	Recommend	Unsure	Not Recommend
Staff Feedback - Organisation change	Organisational Change	2	100%	100%	0%	0%
Staff Feedback - Patient Care	Staffing Levels	28	42%	75%	25%	0%
Staff Feedback - Patient Care	Waiting Times	16	24%	81%	13%	6%
Staff Feedback - Patient Care	Environment / Facilities	5	8%	60%	20%	20%
Staff Feedback - Policy and Practice	Available resources	3	21%	33%	67%	0%
Staff Feedback - Policy and Practice	Training and Development	3	21%	100%	0%	0%
Staff Feedback - Policy and Practice	Information Technology	2	14%	50%	50%	0%
Staff Feedback - Wellbeing	Administrative Process	3	38%	67%	33%	0%

Staff Feedback - Wellbeing	Morale	3	38%	100%	0%	0%
Staff Feedback - Wellbeing	Rewarding environment/ value/ praise	1	13%	0%	100%	0%

Central Locality Care Group - Treatment Question						
				Response to Staff FFT Question 2 - Treatment Question		
Category	Theme	Total	% of Responses	Recommend	Unsure	Not Recommend
Staff Feedback - Organisation change	Organisational Change	2	67%	50%	0%	50%
Staff Feedback - Organisation change	Cost Improvement	1	33%	0%	100%	0%
Staff Feedback - Patient Care	Staffing Levels	33	37%	82%	12%	6%
Staff Feedback - Patient Care	Waiting Times	28	31%	64%	25%	11%
Staff Feedback - Patient Care	Patient Care	9	10%	89%	11%	0%
Staff Feedback - Policy and Practice	Available resources	5	26%	100%	0%	0%
Staff Feedback - Policy and Practice	Case Loads / Work Load	3	16%	100%	0%	0%
Staff Feedback - Policy and Practice	General	2	11%	50%	0%	50%
Staff Feedback - Wellbeing	Morale	4	57%	100%	0%	0%
Staff Feedback - Wellbeing	Being listened too	2	29%	100%	0%	0%
Staff Feedback - Wellbeing	Administrative Process	1	14%	100%	0%	0%

South Locality Care Group - Treatment Question						
				Response to Staff FFT Question 2 - Treatment Question		
Category	Theme	Total	% of Responses	Recommend	Unsure	Not Recommend
Staff Feedback - Patient Care	Staffing Levels	33	34%	70%	24%	6%
Staff Feedback - Patient Care	Waiting Times	23	24%	87%	9%	4%
Staff Feedback - Patient Care	Patient Care	7	7%	71%	29%	0%
Staff Feedback - Policy and Practice	Available resources	9	26%	78%	0%	22%
Staff Feedback - Policy and Practice	Training and Development	7	21%	71%	14%	14%
Staff Feedback - Policy and Practice	General	5	15%	80%	20%	0%
Staff Feedback - Wellbeing	Morale	5	33%	40%	40%	20%
Staff Feedback - Wellbeing	Being listened too	3	20%	67%	33%	0%
Staff Feedback - Wellbeing	Administrative Process	3	20%	100%	0%	0%

From the thematic analysis, it is evident that 'Patient Care - Staffing Levels' is the most prevalent theme for each Group, for both questions (table 10 and 11). In relation to Question 1, 'Policy and Practice - Pay and Conditions (includes flexible working)' emerged as a repeating theme for each Group. For both North and Central Locality Care Group, out of the top prevalent themes, 'Case Loads / Work Load' had the highest proportion of 'Not Recommend' answers. For South Locality Care Group the lack of 'Policy and Practice - Available resources' and 'Wellbeing - General' staff feel less likely to recommend NTW as a place to work.

In relation to Question 2 'Patient Care - Staffing Levels' and 'Waiting times' were common themes across all three Groups. Although these themes highlight areas for improvement, these themes do not make staff less likely to recommend the Trust to family or friends for treatment i.e. all three Groups 'Waiting time' emerged as a negative, the average recommend score across the Groups was 77% would still recommend the Trust as a place for treatment.

The FFT results are available anonymously via the dashboards. Clinical Groups and Operational Departments are again asked to consider their results, not only for the quarter

but over the time the FFT has been running to determine themes and local issues and consider actions to address these.

Included below are examples of improvements comments received by staff in Qtr1 (who identified they were happy for their comments to be published):

Improvements to make NTW a better place to work:

"Work is becoming increasingly stressful due to high demand and not enough staff"

"Nursing secondments or apprenticeships to enable progression for support workers."

"The employees feel disempowered by proposed changes in staffing levels which are seemingly being imposed due to financial pressures and there does not seem any scope for discussion - it seems to be that you either "get on with or it or leave". This does have an impact on staff morale and they are finding it hard to express their views or else they may be targeted."

"Increasingly more frustrating and pressured. However, the communication and transparency from top management now is much more helpful for context and also more confidence that changes such as refining Care Coordination documentation will be done."

"I suspect a lot of what makes my place of work good is the individual approach of my manager not because its NTW policy. More access to health promotion facilities - staff gyms, exercise/yoga classes at lunchtime. Standing desks, rather than been expected to work sat down at a desk all day."

Changes NTW can make to improve the care or treatment offered:

"Address staffing issues - low staff numbers are leading to increased waiting times and reduced quality of service"

"To upgrade some of the 'older' wards as the environment is not appropriate for the client group."

"Improve staff retention which will maintain a consistent workforce to help reduce the excessive patient waiting list"

"Upgrade outdated menu for young people, consider having fresh food cooked daily on the wards .Young people always comment on how much they enjoy the food ,when they are aware it has been cooked fresh. This is often the only time that they consume all the food, and often request extra. Young people with capacity have a preconception that the food is of poor quality, because it is hospital food which is mostly regenerated .Theme nights birthdays and Sunday lunches, that are cooked on the ward by staff receive very positive feedback from are young people here on Stephenson house at Ferndene Prudhoe. Secondly young people needs are sometimes not met, due to been admitted on a ward that does not meet their specific requirements. This will obviously impact on the individual, and possibly prolong their stay in hospital."

"Address the daily parking issues for families. Look at staffing levels so that we can meet the demands on the service."

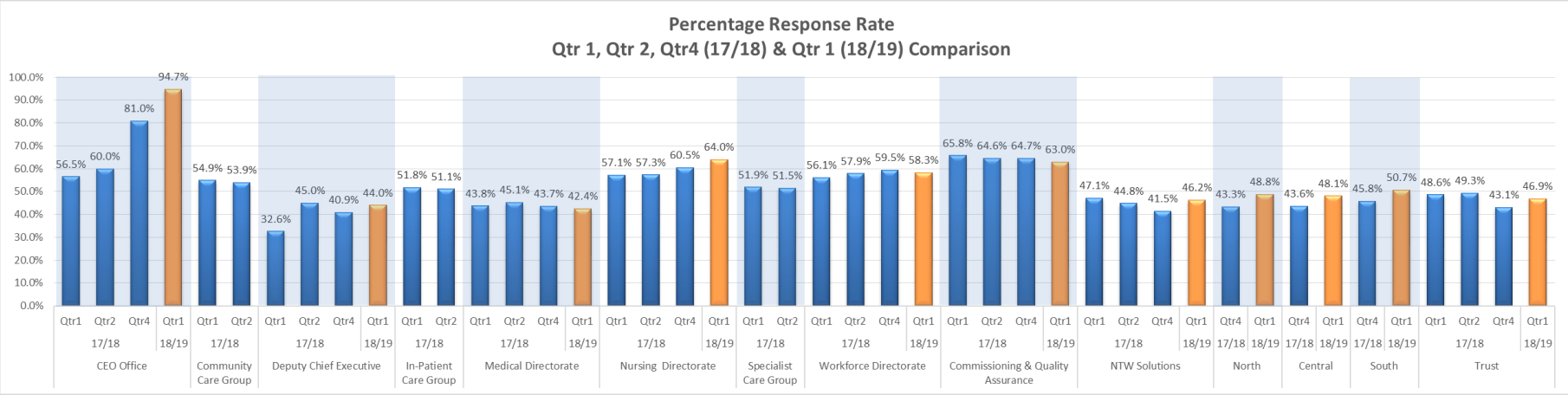
"Please please please change the phone system so that there is a call waiting facility at Newcastle CYPS (I am both a member of staff and a carer for a service user). It is infuriating for the automated voice to say there are no call handlers and to cut you off. This week I have phoned repeatedly over 3 days and still never got through - I have no idea how families cope with this when they are in crisis. I think the system possess a serious risk."

5. Conclusion

All departments are asked to note their results from quarter four in conjunction with other staff feedback mechanisms, and consider appropriate actions in response to staff views.

Lisa Quinn, Executive Director of Commissioning and Quality Assurance
June 2018

Response Rates



Response rate	**Qtr 1 17/17**	**Qtr 2 17/18**	**Qtr 4 17/18**	**Qtr 1 18/19**	**Qtr 1 18/19** number of responses
Trust	49%	49%	43%	47%	3,319
Specialist Care Group	52%	52%	-	-	-
Community Care Group	55%	54%	-	-	-
In-Patient Care Group	52%	51%	-	-	-
Deputy Chief Executive	33%	45%	41%	44%	44
Nursing Directorate	57%	57%	61%	64%	142
Medical Directorate	44%	45%	44%	42%	115
Commissioning and Quality Assurance	66%	65%	65%	63%	75
Workforce Directorate	56%	58%	60%	58%	21
CEO Office	57%	60%	81%	95%	18
NTW Solutions	47%	45%	42%	46%	135
North Locality Group	-	-	43%	49%	750
Central Locality Group	-	-	44%	48%	721
South Locality Group	-	-	46%	51%	894

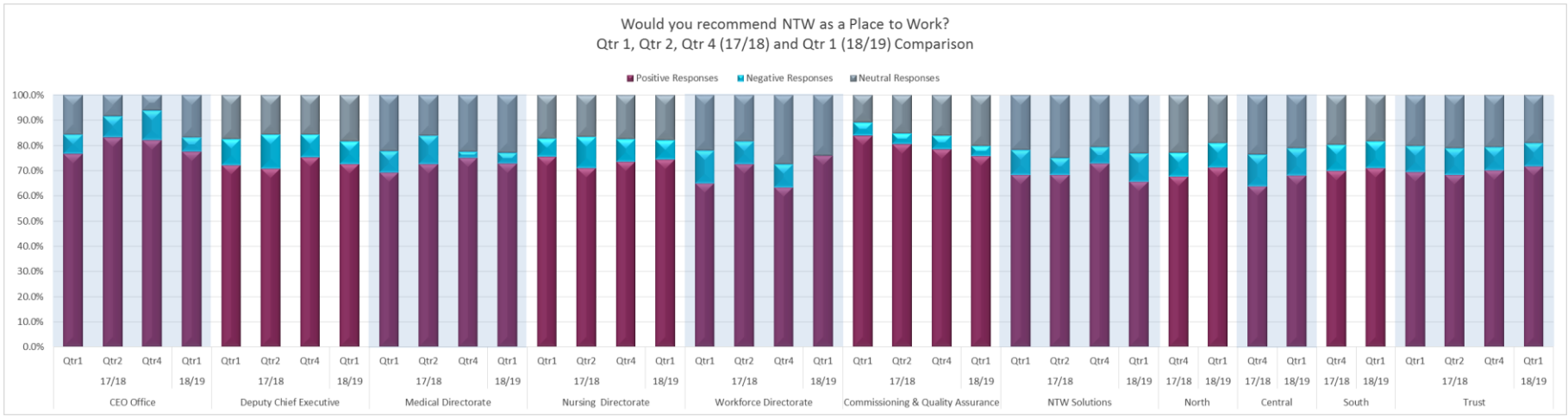
~ In Qtr1 response rates have increased to 47% there have been more respondents than Qtr4 17/18 (212 more respondents).

~ 6 out of 9 Directorates have seen an increase in response rates, the most significant increase in response rate was seen from the Workforce Directorate (from 60% to 81%).

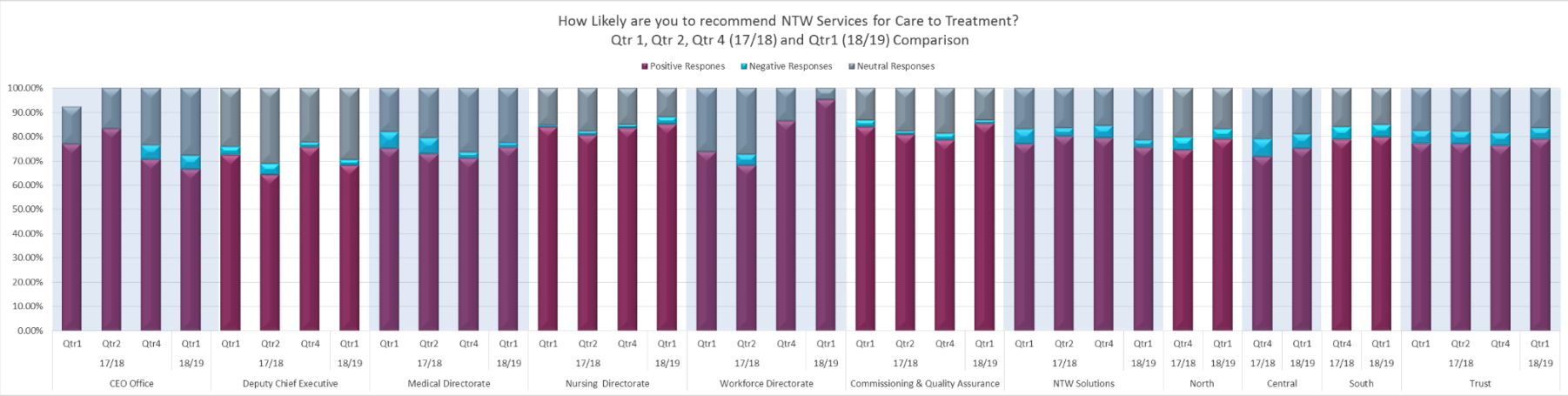
~ 3 Directorates have seen a decrease in response rates.

NB the Staff FFT questionaire is not asked in Qtr3 due to the staff survey being undertaken.

Appendix 2


Would you recommend NTW as a Place to Work?
Qtr 1, Qtr 2, Qtr 4 (17/18) and Qtr 1 (18/19) Comparison
Positive Responses
Negative Responses
Neutral Responses
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Qtr1 Qtr2 Qtr4 Qtr1
17/18 18/19
CEO Office
Deputy Chief Executive
Medical Directorate
Nursing Directorate
Workforce Directorate
Commissioning & Quality Assurance
NTW Solutions
North
Central
South
Trust

Appendix 3


How Likely are you to recommend NTW Services for Care to Treatment?
Qtr 1, Qtr 2, Qtr 4 (17/18) and Qtr1 (18/19) Comparison
Positive Respones
Negative Responses
Neutral Responses
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Qtr1 Qtr2 Qtr4 Qtr1
17/18 18/19
CEO Office
Deputy Chief Executive
Medical Directorate
Nursing Directorate
Workforce Directorate
Commissioning & Quality Assurance
NTW Solutions
North
Central
South
Trust

North Locality Care Group - Work Question						
				Response to Staff FFT Question 1 - Work Question		
Category Work	Theme	Total	% of Responses	Recommend	Unsure	Not Recommended
Staff Feedback - Organisation change	General	2	50%	100%	0%	0%
Staff Feedback - Organisation change	Organisational Change	2	50%	100%	0%	0%
	Staff Feedback - Organisation change Total	**4**	**2%**	**100%**	**0%**	**0%**
Staff Feedback - Patient Care	Staffing Levels	49	72%	31%	37%	33%
Staff Feedback - Patient Care	Parking / Transport	10	15%	100%	0%	0%
Staff Feedback - Patient Care	Treatments/ Pathways	3	4%	100%	0%	0%
Staff Feedback - Patient Care	Waiting Times	3	4%	0%	100%	0%
Staff Feedback - Patient Care	Activities	2	3%	100%	0%	0%
Staff Feedback - Patient Care	Environment / Facilities	1	1%	100%	0%	0%
	Staff Feedback - Patient Care Total	**68**	**39%**	46%	31%	**24%**
Staff Feedback - Policy and Practice	Case Loads / Work Load	9	17%	0%	0%	100%
Staff Feedback - Policy and Practice	Available resources	7	13%	29%	0%	71%
Staff Feedback - Policy and Practice	Pay and Conditions (includes flexible working)	6	11%	100%	0%	0%
Staff Feedback - Policy and Practice	Recruitment & Induction	5	9%	20%	0%	80%
Staff Feedback - Policy and Practice	General	4	8%	100%	0%	0%
Staff Feedback - Policy and Practice	Training and Development	4	8%	25%	75%	0%
Staff Feedback - Policy and Practice	Transparency	4	8%	0%	0%	100%
Staff Feedback - Policy and Practice	Use of Time	4	8%	0%	0%	100%
Staff Feedback - Policy and Practice	Career Progression	3	6%	0%	100%	0%
Staff Feedback - Policy and Practice	Culture / Leadership of Management	3	6%	0%	100%	0%
Staff Feedback - Policy and Practice	Information Technology	2	4%	100%	0%	0%
Staff Feedback - Policy and Practice	Staff Retention	2	4%	100%	0%	0%
	Staff Feedback - Policy and Practice Total	**53**	**30%**	34%	17%	**49%**
Staff Feedback - Wellbeing	Engagement	11	22%	36%	27%	36%
Staff Feedback - Wellbeing	General	9	18%	67%	33%	0%

Staff Feedback - Wellbeing	Management Support / Supervision	8	16%	50%	0%	50%
Staff Feedback - Wellbeing	Morale	6	12%	0%	100%	0%
Staff Feedback - Wellbeing	Being listened to	5	10%	0%	0%	100%
Staff Feedback - Wellbeing	Stress at Work	4	8%	100%	0%	0%
Staff Feedback - Wellbeing	Working Conditions	4	8%	100%	0%	0%
Staff Feedback - Wellbeing	Administrative Process	3	6%	0%	100%	0%
Staff Feedback - Wellbeing Total		**50**	**29%**	**44%**	**30%**	**26%**
Grand Total		**175**	**100%**	**43%**	**26%**	**31%**

Central Locality Care Group - Work Question						
				Response to Staff FFT Question 1 - Work Question		
Category	Theme	Total	% of Responses	Recommend	Unsure	Not Recommend
Staff Feedback - Organisation change	Organisational Change	5	100%	40%	60%	0%
Staff Feedback - Organisation change Total		**5**	**3%**	40%	60%	0%
Staff Feedback - Patient Care	Staffing Levels	44	88%	34%	34%	32%
Staff Feedback - Patient Care	Access	2	4%	100%	0%	0%
Staff Feedback - Patient Care	Smoking ban	2	4%	100%	0%	0%
Staff Feedback - Patient Care	Environment / Facilities	2	4%	100%	0%	0%
Staff Feedback - Patient Care Total		**50**	**27%**	42%	30%	28%
Staff Feedback - Policy and Practice	Pay and Conditions (includes flexible working)	15	24%	33%	40%	27%
Staff Feedback - Policy and Practice	Case Loads / Work Load	14	22%	14%	21%	64%
Staff Feedback - Policy and Practice	Shift Patterns	6	10%	100%	0%	0%
Staff Feedback - Policy and Practice	Transparency	6	10%	0%	100%	0%
Staff Feedback - Policy and Practice	Available resources	5	8%	100%	0%	0%
Staff Feedback - Policy and Practice	Recruitment & Induction	5	8%	40%	60%	0%
Staff Feedback - Policy and Practice	General	4	6%	100%	0%	0%
Staff Feedback - Policy and Practice	Staff Retention	3	5%	0%	100%	0%
Staff Feedback - Policy and Practice	Training and Development	3	5%	100%	0%	0%
Staff Feedback - Policy and Practice	Career Progression	2	3%	100%	0%	0%

	Staff Feedback - Policy and Practice Total	**63**	**34%**	46%	33%	21%
Staff Feedback - Wellbeing	General	13	19%	46%	23%	31%
Staff Feedback - Wellbeing	Respect	11	16%	18%	0%	82%
Staff Feedback - Wellbeing	Rewarding environment/ value/ praise	9	13%	67%	33%	0%
Staff Feedback - Wellbeing	Senior Management Structure	7	10%	0%	43%	57%
Staff Feedback - Wellbeing	Working Conditions	7	10%	57%	43%	0%
Staff Feedback - Wellbeing	Stress at Work	6	9%	0%	100%	0%
Staff Feedback - Wellbeing	Communication	6	9%	17%	0%	83%
Staff Feedback - Wellbeing	Engagement	4	6%	25%	75%	0%
Staff Feedback - Wellbeing	Management Support / Supervision	4	6%	25%	75%	0%
Staff Feedback - Wellbeing	Manager's Knowledge	2	3%	100%	0%	0%
	Staff Feedback - Wellbeing Total	**69**	**37%**	33%	35%	32%
	Grand Total	**187**	**100%**	40%	34%	26%

South Locality Care Group - Work Question						
				Response to Staff FFT Question 1 - Work Question		
Category	Theme	Total	% of Responses	Recommend	Unsure	No Recommend
Staff Feedback - Organisation change	Organisational Change	3	100%	0%	100%	0%
	Staff Feedback - Organisation change Total	**3**	**1%**	**0%**	**100%**	**0%**
Staff Feedback - Patient Care	Staffing Levels	38	69%	50%	24%	26%
Staff Feedback - Patient Care	Parking / Transport	11	20%	55%	0%	45%
Staff Feedback - Patient Care	Waiting Times	5	9%	40%	60%	0%
Staff Feedback - Patient Care	Environment / Facilities	1	2%	100%	0%	0%
	Staff Feedback - Patient Care Total	**55**	**24%**	**51%**	**22%**	**27%**
Staff Feedback - Policy and Practice	Pay and Conditions (includes flexible working)	25	22%	40%	12%	48%
Staff Feedback - Policy and Practice	Case Loads / Work Load	18	16%	39%	33%	28%
Staff Feedback - Policy and Practice	Available resources	13	12%	31%	0%	69%
Staff Feedback - Policy and Practice	Recruitment & Induction	12	11%	58%	0%	42%
Staff Feedback - Policy and Practice	Shift Patterns	9	8%	22%	33%	44%

Staff Feedback - Policy and Practice	Training and Development	7	6%	100%	0%	0%
Staff Feedback - Policy and Practice	Career Progression	7	6%	100%	0%	0%
Staff Feedback - Policy and Practice	General	6	5%	100%	0%	0%
Staff Feedback - Policy and Practice	Staff Retention	5	4%	40%	60%	0%
Staff Feedback - Policy and Practice	Use of Time	4	4%	0%	0%	100%
Staff Feedback - Policy and Practice	Information Technology	3	3%	100%	0%	0%
Staff Feedback - Policy and Practice	Consistency	2	2%	100%	0%	0%
Staff Feedback - Policy and Practice	Senior Management Structure	1	1%	100%	0%	0%
Staff Feedback - Policy and Practice Total		**112**	**48%**	**52%**	**13%**	**35%**
Staff Feedback - Wellbeing	General	13	21%	31%	0%	69%
Staff Feedback - Wellbeing	Respect	9	14%	11%	33%	56%
Staff Feedback - Wellbeing	Communication	7	11%	100%	0%	0%
Staff Feedback - Wellbeing	Bullying and Harassment	7	11%	29%	0%	71%
Staff Feedback - Wellbeing	Engagement	7	11%	29%	0%	71%
Staff Feedback - Wellbeing	Administrative Process	6	10%	17%	0%	83%
Staff Feedback - Wellbeing	Rewarding environment/ value/ praise	4	6%	100%	0%	0%
Staff Feedback - Wellbeing	Access to / Visibility of Management	3	5%	0%	100%	0%
Staff Feedback - Wellbeing	Working Conditions	3	5%	100%	0%	0%
Staff Feedback - Wellbeing	Stress at Work	2	3%	100%	0%	0%
Staff Feedback - Wellbeing	Morale	1	2%	100%	0%	0%
Staff Feedback - Wellbeing	Being listened too	1	2%	100%	0%	0%
Staff Feedback - Wellbeing Total		**63**	**27%**	**44%**	**10%**	**46%**
Grand Total		**233**	**100%**	**49%**	**15%**	**36%**

Appendix 5

North Locality Care Group - Treatment Question						
				Response to Staff FFT Question 2 - Treatment Question		
Category	Theme	Total	% of Responses	Recommend	Unsure	Not Recommend
Staff Feedback - Organisation change	Organisational Change	2	100%	100%	0%	0%
Staff Feedback - Organisation change Total		**2**	**2%**	**100%**	**0%**	**0%**
Staff Feedback - Patient Care	Staffing Levels	28	42%	75%	25%	0%
Staff Feedback - Patient Care	Waiting Times	16	24%	81%	13%	6%
Staff Feedback - Patient Care	Environment / Facilities	5	8%	60%	20%	20%
Staff Feedback - Patient Care	Treatments/ Pathways	2	3%	50%	0%	50%
Staff Feedback - Patient Care	Access	3	5%	100%	0%	0%
Staff Feedback - Patient Care	Communication / Interaction (SU / Carer / Families)	2	3%	50%	50%	0%
Staff Feedback - Patient Care	Parking / Transport	2	3%	50%	0%	50%
Staff Feedback - Patient Care	Patient Care	2	3%	50%	50%	0%
Staff Feedback - Patient Care	Smoking ban	1	2%	100%	0%	0%
Staff Feedback - Patient Care	Use of Bank / Agency Staff	1	2%	100%	0%	0%
Staff Feedback - Patient Care	Activities	1	2%	100%	0%	0%
Staff Feedback - Patient Care	Involvement & Collaboration (Carer / Families)	1	2%	100%	0%	0%
Staff Feedback - Patient Care	Localised services	1	2%	100%	0%	0%
Staff Feedback - Patient Care	More Beds	1	2%	100%	0%	0%
Staff Feedback - Patient Care Total		**66**	**73%**	**76%**	**18%**	**6%**
Staff Feedback - Policy and Practice	Available resources	3	21%	33%	67%	0%
Staff Feedback - Policy and Practice	Training and Development	3	21%	100%	0%	0%
Staff Feedback - Policy and Practice	Information Technology	2	14%	50%	50%	0%
Staff Feedback - Policy and Practice	Bureaucracy	1	7%	0%	100%	0%
Staff Feedback - Policy and Practice	Consistency	1	7%	0%	100%	0%

Staff Feedback - Policy and Practice	General	1	7%	100%	0%	0%
Staff Feedback - Policy and Practice	Recruitment & Induction	1	7%	100%	0%	0%
Staff Feedback - Policy and Practice	Staff Retention	1	7%	100%	0%	0%
Staff Feedback - Policy and Practice	Use of Time	1	7%	100%	0%	0%
Staff Feedback - Policy and Practice Total		**14**	**16%**	**64%**	**36%**	**0%**
Staff Feedback - Wellbeing	Administrative Process	3	38%	67%	33%	0%
Staff Feedback - Wellbeing	Morale	3	38%	100%	0%	0%
Staff Feedback - Wellbeing	Rewarding environment/ value/ praise	1	13%	0%	100%	0%
Staff Feedback - Wellbeing	Respect	1	13%	100%	0%	0%
Staff Feedback - Wellbeing Total		**8**	**9%**	**75%**	**25%**	**0%**
Grand Total		**90**	**100%**	**74%**	**21%**	**4%**

Central Locality Care Group - Treatment Question						
				Response to Staff FFT Question 2 - Treatment Question		
Category	Theme	Total	% of Responses	Recommend	Unsure	Not Recommend
Staff Feedback - Organisation change	Organisational Change	2	67%	50%	0%	50%
Staff Feedback - Organisation change	Cost Improvement	1	33%	0%	100%	0%
Staff Feedback - Organisation change Total		**3**	**3%**	**33%**	**33%**	**33%**
Staff Feedback - Patient Care	Staffing Levels	33	37%	82%	12%	6%
Staff Feedback - Patient Care	Waiting Times	28	31%	64%	25%	11%
Staff Feedback - Patient Care	Patient Care	9	10%	89%	11%	0%
Staff Feedback - Patient Care	Treatments/ Pathways	5	6%	100%	0%	0%
Staff Feedback - Patient Care	Access	5	6%	60%	20%	20%
Staff Feedback - Patient Care	Environment / Facilities	2	2%	100%	0%	0%
Staff Feedback - Patient Care	Appointments	1	1%	100%	0%	0%
Staff Feedback - Patient Care	Communication / Interaction (SU / Carer / Families)	1	1%	100%	0%	0%
Staff Feedback - Patient Care	Service Gaps	1	1%	100%	0%	0%

Staff Feedback - Patient Care	Smoking ban	1	1%	0%	0%	100%
Staff Feedback - Patient Care	Activities	1	1%	100%	0%	0%
Staff Feedback - Patient Care	Involvement & Collaboration (Carer / Families)	1	1%	100%	0%	0%
Staff Feedback - Patient Care	More Beds	1	1%	100%	0%	0%
Staff Feedback - Patient Care Total		**89**	**75%**	**78%**	**15%**	**8%**
Staff Feedback - Policy and Practice	Available resources	5	26%	100%	0%	0%
Staff Feedback - Policy and Practice	Case Loads / Work Load	3	16%	100%	0%	0%
Staff Feedback - Policy and Practice	General	2	11%	50%	0%	50%
Staff Feedback - Policy and Practice	Pay and Conditions (includes flexible working)	2	11%	50%	50%	0%
Staff Feedback - Policy and Practice	Training and Development	2	11%	0%	100%	0%
Staff Feedback - Policy and Practice	Use of Time	2	11%	100%	0%	0%
Staff Feedback - Policy and Practice	Information Technology	1	5%	0%	0%	100%
Staff Feedback - Policy and Practice	Service collaboration	1	5%	100%	0%	0%
Staff Feedback - Policy and Practice	Transparency	1	5%	100%	0%	0%
Staff Feedback - Policy and Practice Total		**19**	**16%**	**74%**	**16%**	**11%**
Staff Feedback - Wellbeing	Morale	4	57%	100%	0%	0%
Staff Feedback - Wellbeing	Being listened too	2	29%	100%	0%	0%
Staff Feedback - Wellbeing	Administrative Process	1	14%	100%	0%	0%
Staff Feedback - Wellbeing Total		**7**	**6%**	**100%**	**0%**	**0%**
Grand Total		**118**	**100%**	**77%**	**14%**	**8%**

South Locality Care Group - Treatment Question						
				Response to Staff FFT Question 2 - Treatment Question		
Category	Theme	Total	% of Responses	Recommend	Unsure	Not Recommend
Staff Feedback - Patient Care	Staffing Levels	33	34%	70%	24%	6%
Staff Feedback - Patient Care	Waiting Times	23	24%	87%	9%	4%
Staff Feedback - Patient Care	Patient Care	7	7%	71%	29%	0%
Staff Feedback - Patient Care	Access	6	6%	83%	17%	0%
Staff Feedback - Patient Care	Treatments/ Pathways	4	4%	100%	0%	0%
Staff Feedback - Patient Care	Communication / Interaction (SU / Carer / Families)	4	4%	75%	25%	0%
Staff Feedback - Patient Care	Service Gaps	4	4%	75%	0%	25%
Staff Feedback - Patient Care	More Beds	4	4%	100%	0%	0%
Staff Feedback - Patient Care	Environment / Facilities	3	3%	67%	33%	0%
Staff Feedback - Patient Care	Localised services	2	2%	50%	50%	0%
Staff Feedback - Patient Care	Involvement & Collaboration (SU)	2	2%	100%	0%	0%
Staff Feedback - Patient Care	Appointments	1	1%	100%	0%	0%
Staff Feedback - Patient Care	Food	1	1%	100%	0%	0%
Staff Feedback - Patient Care	Privacy & Dignity	1	1%	100%	0%	0%
Staff Feedback - Patient Care	Activities	1	1%	0%	100%	0%
Staff Feedback - Patient Care Total		**96**	**66%**	**78%**	**18%**	**4%**
Staff Feedback - Policy and Practice	Available resources	9	26%	78%	0%	22%
Staff Feedback - Policy and Practice	Training and Development	7	21%	71%	14%	14%
Staff Feedback - Policy and Practice	General	5	15%	80%	20%	0%
Staff Feedback - Policy and Practice	Recruitment & Induction	4	12%	75%	25%	0%
Staff Feedback - Policy and Practice	Case Loads / Work Load	3	9%	100%	0%	0%
Staff Feedback - Policy and Practice	Pay and Conditions (includes flexible working)	2	6%	50%	50%	0%
Staff Feedback - Policy and Practice	Use of Time	2	6%	50%	50%	0%
Staff Feedback - Policy and Practice	Bureaucracy	1	3%	0%	0%	100%
Staff Feedback - Policy and Practice	Career Progression	1	3%	100%	0%	0%

Staff Feedback - Policy and Practice Total		**34**	**23%**	**74%**	**15%**	**12%**
Staff Feedback - Wellbeing	Morale	5	33%	40%	40%	20%
Staff Feedback - Wellbeing	Being listened too	3	20%	67%	33%	0%
Staff Feedback - Wellbeing	Administrative Process	3	20%	100%	0%	0%
Staff Feedback - Wellbeing	General	3	20%	100%	0%	0%
Staff Feedback - Wellbeing	Engagement	1	7%	0%	100%	0%
Staff Feedback - Wellbeing Total		**15**	**10%**	**67%**	**27%**	**7%**
Grand Total		**145**	**100%**	**76%**	**18%**	**6%**

Appendix 6

Actions being taken by Group/Directorate in response to improvement suggestions raised in Qtr4 17/18

North Locality Care Group:

Staffing -

- We've implemented the Lord Carter work at St. Georges Park and it is being rolled out in CYPS and at Mitford.
- Mitford are in the process of implementing a new shift pattern at the request of staff.
- Work continues to try to reduce sickness absence.
- There are a number of registered nursing vacancies at St. Georges Park and these are looking to be backfilled by a combination of newly qualified nurses and Nursing Assistants to provide some stability and consistency of staffing.

Additional Clinical Services Staff Group-

- We would like to understand why, in general, the results are lower in this staff group. At our Speak Easys we found out that our Nursing Assistants would like to be more involved in MDT working and care planning, so we will be further exploring this and other reasons at our next round of Speak Easys in June/July and via some semi-structured interviews at St. Georges Park, again, in June and July.

Central Locality Care Group:

Staffing -

Analysis of the narrative provided around staffing highlights the theme around requests for additional staffing. Within Central Locality work is ongoing with Workforce Planning taking into account service demands and then looking at the workforce needed to meet this demand both in the immediate and the future workforce. Work is also ongoing within services to look at Time to Care which is about ensuing that front line clinicians are enabled with the right support to enhance time with patients.

Waiting Times -

Waiting times is another area highlighted and work is ongoing to address this with the Trustwide access and waiting times group which meets on a monthly basis, with the themes from the overarching group being fed back into to locality working. The information is explored looking at high waits and also how waiting times are reported. Themes such as how to use Rio differently as a support tool are being explored. In community pathway there are waiting list initiatives the Gateshead Team steering group is chaired by the Associate Director and have a ring-fenced set of staff to look at the waiting list. Children's service where there is a national focus on wait times is reported into the steering group and has a very high focus.

South Locality Care Group:

Staffing -

- There continues to be a high number of qualified nursing vacancies across the inpatient wards, including those at Walkergate Park. Walkergate Park are due to receive their third internationally recruited nurse shortly and continue to have a monthly rolling advert for the RGN vacancies. Posts across Hopewood Park have been identified for the recruitment and allocation of newly qualified nurses.
- Work is ongoing to address the workforce challenges within the locality with the development of Workforce Plans per CBU.
- HR forums have been arranged for managers to come and talk to a Workforce and OD Manager about absence in their areas, what strategies can be used to support staff and manage absence robustly.
- A programme of OD work is being developed for areas who have a particularly high absence rate and a high proportion of cases with Capsticks, also linked with clinical information such as high waiting times.
- A scoping exercise is being carried out to better understand the flexible working arrangements across the locality, to understand what is in place to review and support managers with requests.

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 25th July 2018
Title and Author of Paper: EDS2 and WRES Report, E&D Lead
Executive Lead: Lynne Shaw, Acting Executive Director Workforce and Organisational Development
Paper for Debate, Decision or Information: Debate/Decision
Key Points to Note: When the locality ratings are available it is proposed we will update the Trust-wide EDS2 rating too as part of our Public Sector Equality Duty reporting requirements – next report due April 2019. It is proposed that EDS2 grades be agreed in consultation with our partners to include service user. carer and governor representation, plus interested groups from each of the localities. WRES submission suggests actions for the following areas: recruitment, discipline and grievance, disclosure of information, training and the WRES metrics associated with the Staff Survey findings. Approval is being sought for the broad actions, which if agreed will be worked up to a detailed action plan.
Risks Highlighted to Board :
Does this affect any Board Assurance Framework/Corporate Risks? Please state No If Yes please outline
Equal Opportunities, Legal and Other Implications: Meets EDS2 and WRES requirements
Outcome Required Decision
Link to Policies and Strategies: Trust Strategy/Equality, Diversity and Inclusion Strategy/ Workforce Strategy.

Background

The NHS Equality and Diversity Council (EDC) implemented two measures to improve equality across the NHS into the Standard Contract, from April 2015 under SC13 Equity of Access, Equality and Non-Discrimination, namely Equality Delivery System 2 (EDS2) and the Workforce Race Equality Standard (WRES).

The contract requires that providers 'must implement EDS2' and that 'the provider must implement the National Workforce Race Equality Standard and submit an annual report to the Co-ordinating Commissioner on its progress in implementing the standard'.

The Trust has complied with both of these requirements since 2015. Acknowledgement of our use of EDS2 is made by our inclusion on NHS England's EDS dashboard which can be found here. Our WRES submission has been made to NHS England annually since 2015 and the annual summary can be found here.

EDS2

In last year's report we stated that It has become increasingly apparent that the decision to replace an Equality and Diversity strategy with a yearly update of EDS2 has led to a detailed focus on actions, which is important, but lacks the steer that a 'bigger picture' strategy could give. It is recommended that consideration is given to the development of a strategy taking a Diversity and Inclusion approach that will have to complement and support the Trust Strategy and the emerging associated support strategies. This was the agreed action at Trust Board in July 2017.

A Draft 2018-2022 Strategy has been prepared and is ready for consultation to be approved at September Board. It contains high level actions for the four year period of the strategy.

Since March 2018 our locality groups have been collecting evidence to arrive at local EDS2 ratings and local equality actions. When the locality ratings are available it is proposed we will update the Trust-wide EDS2 rating too as part of our Public Sector Equality Duty reporting requirements – next report due April 2019. It is proposed that EDS2 grades be agreed in consultation with our partners to include service user. carer and governor representation, plus interested groups from each of the localities.

WRES

The National findings from the 2017 submissions can be summarised as follows:

- White shortlisted job applicants are 1.60 times more likely to be appointed from shortlisting than BME shortlisted applicants, who continue to remain absent from senior grades within Agenda for Change (AfC) pay bands (NTW 1.54)
- BME staff are 1.37 times more likely to enter the formal disciplinary process in comparison to white staff. This is an improvement on the 2016 figure of 1.56. (NTW went from parity in 15/16 to twice as likely for BME staff to enter the

disciplinary process. Though it should be stated that this likelihood is based on only 8 cases).

- BME staff remain significantly more likely to experience discrimination at work from colleagues and their managers compared to white staff, at 14% and 6% respectively. (NTW BME staff 12% White 5%)
- Similar proportions of white (28%) and BME (29%) staff are likely to experience harassment, bullying or abuse from patients, relatives and members of the public in the last 12 months. (NTW BME Staff 50% White 31%)
- The overall percentage of BME staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months dropped from 27% to 26%. BME staff remain more likely than white staff to experience harassment, bullying or abuse from other colleagues in the last 12 months.(For NTW this increased from 19%-24% - a danger of just looking at the average).
- There is a steady increase in the number of NHS trusts that have more than one BME board member. There are now a total of 25 NHS trusts with three or more BME members of the board; an increase of 9 trusts since 2016. (For NTW Board representation at 7.1% greater than Trust representation of 3.4%).

Four of the WRES indicators are drawn from the national NHS staff survey. Their reliability is dependent on the size of samples surveyed, the response rates, and whether the numbers of BME staff are so small that they may undermine the confidence in the data. For our 2016 Staff Survey on which the national report is based 104 BME of Staff out of a possible 232 staff completed the survey

Regionally, (with caveats about the accuracy of %BME Board representation), we compare as follows:

2017 WRES indicators 2 – 9 data

		Unify 2017 submission			Staff Survey 2017				% BME
Organisations name	% BME	Ind 2	Ind 3	Ind 4	Ind 5	Ind 6	Ind 7	Ind 8	Board
CITY HOSPITALS SUNDERLAND	11.4%	1.15	1.59	0.98	34.8%	31.7%	74.1%	19.1%	0.0%
COUNTY DURHAM AND DARLINGTON	6.0%	0.96	0.34	1.07	27.2%	31.8%	85.1%	14.3%	0.0%
NORTH CUMBRIA	4.6%	1.08	0.58	1.08	13.6%	49.4%	60.4%	21.0%	0.0%
NORTH TEES AND HARTLEPOOL	9.3%	0.74	0.33	0.60	36.0%	38.0%	80.0%	14.0%	7.1%
NORTHUMBERLAND, TYNE AND WEAR	3.1%	1.54	2.07	1.11	44.1%	24.8%	80.8%	8.4%	7.1%
NORTHUMBRIA HEALTHCARE	5.4%	1.89	0.50	0.79	31.8%	32.6%	80.6%	20.9%	5.3%
SOUTH TEES HOSPITALS	6.1%	1.27	0.30	1.01	22.6%	35.5%	70.0%	14.3%	6.3%
SOUTH TYNESIDE	3.8%	1.58	1.29	0.80	23.4%	27.7%	73.3%	12.5%	7.7%
TEES, ESK AND WEAR VALLEYS	4.2%	1.32	2.08	1.15	33.6%	28.6%	80.2%	18.0%	-
THE NEWCASTLE UPON TYNE HOSPITALS	7.9%	0.90	0.72	0.82	18.5%	22.8%	83.4%	10.7%	0.0%
Trusts Median	5.7%	1.21	0.65	1.00	29.5%	31.7%	80.1%	14.3%	5.3%
National Average	20%	1.57	1.37	1.22	28.0%	23.7%	85.5%	12.6%	7.0%

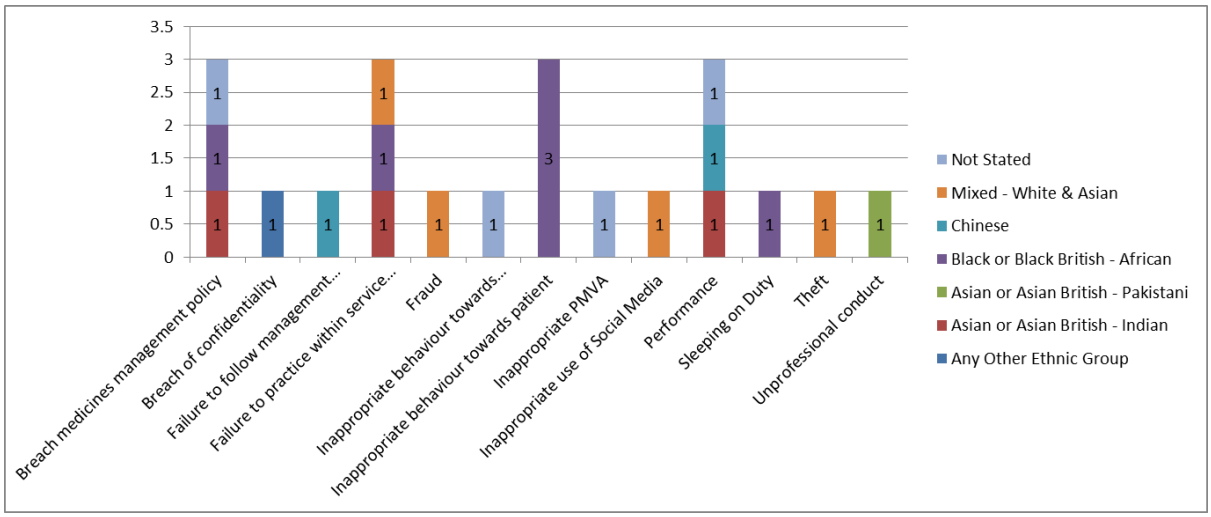
IND 2: Relative likelihood of white staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting
IND 3: Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff
IND 4: Relative likelihood of white staff accessing non mandatory training and CPD as compared to BME staff
IND 5: Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
IND 6: Percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months
IND 7: Percentage of BME staff believing that trust provides equal opportunities for career progression or promotion
IND 8: Percentage of BME staff experiencing discrimination at work from manager/team leader or other colleague

Region-wide indicates that there is considerable work to do on this agenda. NTW performance on the Staff Survey metrics is broadly good, but we know when compared to the national WRES data is no better than average.

We are entering phase two of WRES implementation. NHS England state that, this is about enabling people to work comfortably with race equality. Through communications and engagement we will work to change the deep rooted cultures of race inequality in the system, learn more about the importance of equity, to build capacity and capability to work with race. Part of the capacity and capability to work with race is to work more at a regional level to pull up performance on the metrics by sharing and developing best practice together. A first regional wide WRES focused meeting is taking place in July and will be attended by the Trust E&D Lead and the Chair of the BME Staff Network.

Actions arising from 2017 Submission

An analysis of BME disciplinary and grievance cases has taken place which has looked at the trend since 2014 – the year on which the first WRES submission data was based on.



Taking this data to the BME Staff Network, it was felt by the network members that differences in culture may explain issues such behaviour deemed to be inappropriate towards patients and provides further impetus for us to adopt the RCN's Cultural Ambassador Programme approach.

The cultural ambassador is a voluntary role established by the Royal College of Nursing. Volunteers will be a member of investigation teams and panels considering disciplinary allegations against Black Asian and minority ethnic (BME) staff and students. The aim of the cultural ambassador is to help ensure fairness in how BME staff and students are treated amid concerns that they are disproportionately subject to disciplinary action. The programme involves a three-day training course for volunteers to increase their knowledge and understanding of relevant legislation and topics, including the Equalities Act, cultural intelligence, unconscious bias and influencing skills. Volunteers are supported by mentorship throughout their involvement with the project. Six volunteers have been recruited to the project – all

from nursing/medical backgrounds and their three day training will take place in August with a launch of the Ambassador Programme in Autumn 2018.

With regard to recruitment the new information system on applications TRAC is providing us with clear information on each stage of recruitment looking at all protected characteristics under the Equality Act – not just Ethnicity. A review of the ethnicity report from TRAC was completed earlier this year with the following recommendations.

- The E&D Lead in conjunction with the BME Staff Network review recruitment materials - particularly those used in central recruitment group exercises to ensure that they are free from cultural references. This has taken place, no evidence of exercises that might bias an outcome were found.
- The figures - albeit small suggest that either conscious or unconscious bias is having an impact at the interview stage. We need to set an expectation with senior managers that appointments at interview should, on average, over time be the same for white and BME Staff. It is recommended that unconscious bias training be part of the expected training for membership of a recruitment panel. Unconscious bias training will form part of the forthcoming E&D Masterclasses and we are also looking to bring in Joy Warmington from BRAP to deliver an equality and diversity session this Autumn, part of which will focus on unconscious bias.
- It is suggested that we audit and review decision making from sample of recent recruitment processes. Potential for audit publicised to recruiting managers to improve the rigour of decision making and the quality of appointments made.
- More needs to be done to attract applications from BME backgrounds. It is suggested that a meeting between the Trust and tenants within the Beacon (at Newcastle) is set up to explore how we become more visible in the community. This could be through campaigns on Radio such as Spice FM or through work with organisations such as the Millin Charity and that this approach is then spread across the region that we serve.
- We might want to consider positive action with a BME targeted recruitment campaign, particularly for non-clinical roles.

WRES Submission 2018

Indicator 1 Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce (NB Whilst the indicator is in % terms the prepopulated template from NHS England has staff numbers

			31st MARCH 2017			31st MARCH 2018		
INDICATOR			**White**	**BME**	**Unknown**	**White**	**BME**	**Unknown**
1	**Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce**	**1a) Non Clinical workforce**						
		Under Band 1	30	0	1	22	0	2
		Band 1	1	0	0	1	0	0
		Band 2	562	7	62	476	6	59
		Band 3	358	5	29	308	4	28
		Band 4	282	5	44	221	3	35
		Band 5	92	2	18	91	1	16
		Band 6	80	1	22	98	1	22
		Band 7	51	1	9	57	1	8
		Band 8A	30	0	10	31	0	11
		Band 8B	41	1	3	22	0	4
		Band 8C	2	0	1	3	0	1
		Band 8D	7	0	2	1	0	1
		Band 9	4	0	0	1	0	0
		VSM	5	0	0	5	0	0
		1b) Clinical workforce of which Non						

		Medical						
		Under Band 1	0	0	0	2	0	0
		Band 1	1	0	0	1	0	0
		Band 2	54	2	1	78	0	2
		Band 3	1575	86	150	1589	106	137
		Band 4	161	3	12	225	4	17
		Band 5	703	30	94	710	40	78
		Band 6	968	23	115	1005	27	107
		Band 7	419	10	55	438	10	48
		Band 8A	143	8	29	153	11	27
		Band 8B	62	0	10	64	0	8
		Band 8C	43	1	3	44	1	2
		Band 8D	25	0	5	24	0	4
		Band 9	2	0	1	5	0	0
		VSM	1	0	0	1	1	0
		Of which Medical & Dental						
		Consultants	83	42	63	83	41	60
		of which Senior medical manager	8	1	2	8	1	1
		Non-consultant career grade	14	5	17	20	5	16

		Trainee grades	3	0	8	6	5	11
		Other	0	0	0	0	0	0

- 1540 non-clinical staff. Of the 1353 where ethnicity is known 98.8% White, 1.2% BME.(2017 98.5% 1.5%)
- For non-clinical staff no known BME representation for under Band 1, Band 1 and above Band 7 – similar picture to 2017 though have lost a BME member of staff at 8B in the last year
- Best non-clinical % representation Band 7 1.7%
- Ethnicity is not known for 12% of non-clinical workforce (11.4% 2017)
- Work generally needs to be undertaken to try to improve the profile of BME staff in non-clinical roles across all bands.
- 4969 Clinical Staff. Of the 4539 where ethnicity is known 95.5% is White, 4.5% BME (2017 96.2% 3.8%)
- Ethnicity not known for 8.65% of clinical workforce (10% 2017)
- No BME representation in Clinical Roles at Bands <1, 1, 2,8B,D & 9.
- Best clinical % representation at VSM (50%)

INDICATOR 2: Likelihood of appointment from shortlisting

	2013-14		2014-15		2015-16		2016-17		2017-18	
	White	**BME**	**White**	**BME**	**White**	**BME**	**White**	**BME**	**White**	**BME**
Shortlisted applicants*	n/a	n/a	3798	347	4980	413	3942	358	5056	624
Appointed*	n/a	n/a	686	47	754	43	765	45	636	56
Likelihood of appointment from shortlisting	n/a	n/a	0.18	0.14	0.15	0.10	0.19	0.13	0.13	0.09
Relative likelihood (white/BME)		n/a		1.33		1.45		1.54		1.44

- A relative likelihood of 1.44 is better than the 2017 national average (1.57), but worse than the 2017 regional median, (1.21)
- Rolling average since 2014/15 = 1.44.
- Figures suggest a standstill picture rather than an improvement.

INDICATOR 3: Likelihood of entering a formal disciplinary process

	2014-15		2015-16		2016-17		2017-18	
	White	**BME**	**White**	**BME**	**White**	**BME**	**White**	**BME**
Staff entering formal process	107	6	72	2	97	8	158	12
Staff in workforce	5439	195	5630	205	5830	232	5843	267
Likelihood	0.020	0.031	0.01	0.01	0.017	0.034	0.027	0.045
Relative likelihood (BME/White)		1.55		1.00		2		1.66
Two year rolling relative likelihood*)*				**1.28**		**1.50**		**1.83**

- A slight improvement over 2016/17, though still above both the national average and the regional median for 2016/17.
- The E&D Lead has asked Capsticks for a quarterly report on this so that the trend may be better monitored but also the impact of initiatives such as the Cultural Ambassadors' programme be assessed.

INDICATOR 4: Relative likelihood of accessing non-mandatory training and CPD

	2013-14		2014-15		2015-16		2016-17		2017-18	
	White	**BME**	**White**	**BME**	**White**	**BME**	**White**	**BME**	**White**	**BME**
Staff who have accessed non-mand training/CPD*	72	15	28	4	87	8	139	5	46	1
Staff in workforce	5423	175	5439	195	5630	205	5830	232	5843	267
Likelihood	0.013	0.086	0.005	0.021	0.015	0.039	0.024	0.022	0.008	0.004
Relative likelihood (white/BME)		0.15		0.25		0.40		1.11		2.10

- During the course of WRES reporting we have gone from BME members of staff being more likely to access non-mandatory training, to a position roughly of parity in 2016-17, to one now where white staff are more than twice as likely to access non-mandatory training compared to BME members of staff.
- Work needs to take place in the next year to understand this shift. It is suggested as a starting point that we make sure that the recording of non-mandatory training and CPD is as accurate as possible, followed an analysis of appraisal outcomes to assess whether there is disparity between the outcomes of requests to access non-mandatory training.

INDICATORS 5,6,7,8, Staff Survey Metrics

			Your Trust in 2017	Average (median) for mental health	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	34%	32%	31%
		BME	44%	36%	50%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	16%	21%	17%
		BME	25%	26%	24%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	92%	87%	93%
		BME	81%	77%	84%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	5%	6%	5%
		BME	8%	14%	12%

- Marginal improvement for KF25 and below average performance
- Marginal deterioration for KF26 figures around the average for mental health trusts
- Marginal deterioration for KF21, but above national average
- Improvement closing the gap for Q17b and results better than national average.
- A deep dive of these indicators has taken place, whilst this cannot be analysed by ethnicity we will be able to match ‘hotspots’ from the analysis to the staff demographic to develop a picture where the disparity between BME and White members of staff is likely to problematic.

INDICATOR 9: Voting board members

	2013-14 (N=14)		2014-15 (N=14)		2015-16			2016-17			2017-18		
	Board	Trust	Board	Trust	Count	Board	Trust	Count	Board	Trust	Count	Board	Trust
BME	0.0%	2.7%	0.0%	3.0%	1	7.1%	3.1%	1	6.3%	3.3%	1	6.3%	3.89%
WHITE	54.5%	84.4%	50.0%	83.6%	8	35.7 %	84.5 %	14	87.5 %	84.6 %	14	87.5 %	85.10 %
Chose not to state	36.4%	11.8%	42.9%	12.1%	5	35.7 %	11.3 %	1	6.3%	11.0 %	1	6.3%	10.87 %
No info recorded	9.1%	1.1%	7.1%	1.3%	0	0.0%	1.2%	0	0.0%	1.1%	0	0.0%	0.15%
Board BME % compared to Trust BME% (+/- %)		-2.7%		-3.0%			4.10 %			3. 0%			2.41%

- No change at Board level for 2017/18 compared to 2016/17
- Slight narrowing of gap between representativeness of the workforce compared to the Board.

Suggested actions arising out of 2017/18 WRES reporting

Recruitment:

- We need to set an expectation with senior managers that appointments at interview should, on average, over time be the same for white and BME Staff. It is recommended that unconscious bias training be part of the expected training for membership of a recruitment panel. Unconscious bias training will form part of the forthcoming E&D Masterclasses and we are also looking to bring in Joy Warmington from BRAP to deliver an equality and diversity session this Autumn, part of which will focus on unconscious bias.
- It is suggested that we audit and review decision making from sample of recent recruitment processes. Potential for audit publicised to recruiting managers to improve the rigour of decision making and the quality of appointments made.
- More needs to be done to attract applications from BME backgrounds. It is suggested that a meeting between the Trust and tenants within the Beacon (at Newcastle) is set up to explore how we become more visible in the community. This could be through campaigns on Radio such as Spice FM or through work with organisations such as the Millin Charity and that this approach is then spread across the region that we serve.
- We might want to consider positive action with a BME targeted recruitment campaign.
- Work generally needs to be undertaken to try to improve the profile of BME staff in non-clinical roles across all bands.

Discipline and Grievance

- Cultural Ambassadors are being trained in August 2018
- Launch of Cultural Ambassadors in Autumn 2018
- Capsticks to provide a quarterly report on this so that the trend may be better monitored but also the impact of initiatives such as the Cultural Ambassadors' programme be assessed.

Disclosure of Information

- Aligned to the Trust-wide Equality Strategy detailed action plan a campaign around improving the reporting of protected characteristic information needs to focus on trying to change hearts and minds of those staff who have chosen not to state their ethnicity. The campaign will need to focus on the benefits of disclosure

Training

- We make sure that the recording of non-mandatory training and CPD is as accurate as possible, followed an analysis of appraisal outcomes to assess whether there is disparity between the outcomes of requests to access non-mandatory training.

Staff Survey

- Analysis undertaken to match ‘hotspots’ from the analysis of the Key Findings to the staff demographic to develop a picture where the disparity between BME and White members of staff is likely to problematic.

Next Steps

If the broad themes for action are agreed that a detailed action plan for WRES be drawn up for approval.

Christopher Rowlands
Equality and Diversity Lead
July 2018

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 25th July 2018

Title and Author of Paper:

Quarter 1 update - NHS Improvement Single Oversight Framework

Anna Foster, Deputy Director of Commissioning & Quality Assurance
Dave Rycroft, Deputy Director of Finance & Business Development

Executive Lead: Lisa Quinn, Executive Director of Commissioning & Quality Assurance

Paper for Debate, Decision or Information: Information

Key Points to Note:

1. The Trust position against the Single Oversight Framework remains assessed by NHS Improvement as segment 1 (maximum autonomy).

2. Finance templates are submitted to NHS Improvement on a monthly basis. The Trust's Use of Resources rating is a 3 at Q1.

3. From October 2016, NHSI introduced a Board Assurance statement, which must be completed if a trust is reporting an adverse change in its forecast out-turn position. At Q1 the Trust is reporting it will achieve its year-end control total so this statement is not required.

4. Information on the Trust's Workforce is submitted to NHSI on a monthly basis. This report includes a summary of the information which has been submitted in the first quarter of 2018/19.

5. Information on agency use including any price cap breaches and longest serving agency staff is submitted to NHSI on a weekly basis this report includes a summary of this information for the first quarter of 2018/19.

6. Governance Information/Updates, any changes to Trust Board and Council of Governors; any adverse national press attention which have taken place during quarter 1 of 2018/2019 have been included within the report.

Risks Highlighted to Board: None

Does this affect any Board Assurance Framework/Corporate Risks?
Please state Yes or No No
If Yes please outline

Equal Opportunities, Legal and Other Implications: None

Outcome Required:

To note the Finance submissions which are approved by the Director of Finance/Deputy Chief

Executive on behalf of the Board are submitted to NHS Improvement on a weekly and monthly basis during the year.

To note the Quarter 1 self-assessed position against the requirements of the Single Oversight Framework.

Link to Policies and Strategies: N/A

Northumberland, Tyne and Wear NHS Foundation Trust

BOARD OF DIRECTORS

25th July 2018

Quarterly Report – Oversight of Information Submitted to External Regulators

PURPOSE

To provide the Board with an oversight of the information that has been shared with NHS Improvement and other useful information in relation to Board and Governor changes and any adverse press attention for the Trust during Quarter 1 2018-19

BACKGROUND

NHS Improvement oversees foundation trusts using the Single Oversight Framework. NHS Improvement have assessed NTW as segment 1 – maximum autonomy.

Until October 2016, Monitor provided all Trusts with ratings in relation to continuity of services and governance risk ratings. These are now overseen by NHS Improvement using the Single Oversight Framework who have assessed the Trust for Quarter 1 of 2018-19 as segment 1 – maximum autonomy, this is the same as the segmentation during 2017-18.

A summary of the Trust ratings since the start of financial year 2016-17 are set out below:

	Q1 & 2 16-17	Q3 & Q4 16-17	Q1 – Q4 17-18	Q1 18-19
Single Oversight Framework Segment	n/a	2	1	1
Use of Resources Rating	n/a	2	1	3
Continuity of Services Rating	2 (Q1) & 3 (Q2)	n/a	n/a	n/a
Governance Risk Rating	Green	n/a	n/a	n/a

Key Financial Targets & Issues

A summary of delivery at Month 3 against our high level financial targets and risk ratings, as identified within our financial plan for the current year, and which is reported in our monthly returns is shown in the tables below (Finance returns are submitted to NHSI on a monthly basis):-

	Year to Date			Year End		
Key Financial Targets	**Plan**	**Actual**	**Variance/ Rating**	**Plan**	**Forecast**	**Variance/ Rating**
Monitor Risk Rating	3	3	Amber	3	3	Amber
I&E – Surplus /(Deficit)	(£0.5m)	(£0.3m)	£0.2m	£3.5m	£3.5m	£0.0m
FDP - Efficiency Target	£1.6m	£1.6m	£0.0m	£12.6m	£12.6m	£0.0m
Agency Ceiling	£2.1m	£1.9m	(£0.2m)	£8.0m	£6.5m	(£1.5m)
Cash	£15.6m	£18.1m	(£2.5m)	£19.6m	£19.6m	£0.0m
Capital Spend	£1.9m	£1.4m	(£0.5m)	£13.2m	£13.2m	£0.0m
Asset Sales	£0.0m	£0.2m	£0.2m	£0.3m	£0.3m	£0.0m

Risk Rating

Risk Ratings	Weight	Year to Date		Year-End	
		Plan	Risk Rating	Plan	Risk Rating
Capital Service Capacity	20%	4	4	4	4
Liquidity	20%	1	1	1	1
I&E Margin	20%	3	3	1	1
Variance from Control Total	20%	1	1	1	1
Agency Ceiling	20%	1	1	1	1
Overall Rating		**3**	**3**	**3**	**3**

From October 2016, NHSI introduced a new Board Assurance statement, which must be completed if a trust is reporting an adverse change in its forecast out-turn position. This month the Trust is reporting achievement of its control total so this statement is not required.

Workforce Numbers

The workforce template provides actual staff numbers by staff group. The table below shows a summary of the information provided for the first quarter of the year. Workforce returns are submitted to NHSI on a monthly basis.

SUMMARY STAFF WTE DETAIL	Month 1	Month 2	Month 3
	Actual WTE	Actual WTE	Actual WTE
Total non medical - clinical substantive staff	3,980	3,953	3,932
Total non medical - non-clinical substantive staff	1,590	1,583	1,581
Total medical and dental substantive staff	330	334	334
Total WTE substantive staff	**5,901**	**5,870**	**5,846**
Bank staff	338	261	255
Agency staff (including, agency and contract)	173	156	148
Total WTE all staff	**6,412**	**6,287**	**6,249**

Agency Information

The Trust has to report to NHS Improvement on a weekly basis, the number of above price cap shifts and also on a monthly basis the top 10 highest paid and longest serving agency staff.

The table below shows the number of price cap shifts reported during the year.

Staff Group	April 2/4 - 23/4	May 30/4 - 28/5	June 4/6 - 25/6
Medical	88	108	84
Nursing	20	25	20
Total	**108**	**133**	**104**

At the end of June the Trust was paying 4 medical staff above price caps (1 consultant, 2 associate specialist and 1 Speciality Doctor).

At the end of March, the top10 highest paid agency staff were all consultants. The one above cap is costing the Trust £99.98/hour and the Trust were also paying for 9 consultants at the cap rate of £76.10/hour.

The length of time the top 10 longest serving agency staff have been with the Trust is shown in the table below:-

Post	**7 to 8 years**	**5 to 6 years**	**4 to 5 years**	
Consultant	1			
Associate Specialist			1	
Audio Typists		3	5	Transferred into NTW Solutions on July 1

GOVERNANCE

There is no longer a requirement to submit a governance return to NHS Improvement; however there are specific exceptions that the Trust are required to notify NHS Improvement and specific items for information, it is these issues that are included within this report.

Board & Governor Changes 2018

Board of Directors:

Les Boobis and Alexis Cleveland were reappointed as Non- Executive Directors for a further term of 3 years on 17 May 2018

Council of Governors:

- Cllr Alan Smith, Appointed Governor, South Tyneside Council – appointed 4.4.18 and resigned 9.4.18
- Cllr Audrey Hunter, Appointed Governor, South Tyneside Council - appointed 26.4.2018
- Cllr Graham Miller, Appointed Governor, Sunderland - resigned 17.5.18
- Cllr Geoff Walker, Appointed Governor, Sunderland City Council – appointed 18.5.18
- Cllr Alison Thompson, Appointed Governor, Gateshead Council – resigned 5.5.18
- Annie Murphy, Appointed Governor, Community and Voluntary Sector – appointed 22.6.18

Present vacancies

- Carer Governors x 3 (Adult Services, Children and Young People's Services and Learning Disability Services)
- Public Governor for Newcastle/Rest of England and Wales
- Appointed Governor, Gateshead Council

Never Events

There were no never events reported in Quarter 1 2018 - 2019 as per the DH guidance document.

Adverse national press attention Q1 2018-19

April

Nothing of note

May

Nothing to note

June

Nothing to note

Other items for consideration

As well as the items noted in the report above the Trust also completes submissions to NHSI for the following data:-

Weekly

- Total number of bank shifts requested/total filled (from October 17)

Monthly

- Care Hours Per Patient Day.
- Estates and Facilities Costs

Annually

- NHSI request information for corporate services national data collection on an annual basis. This data includes information in relation to Finance, HR, IM&T, Payroll, Governance and Risk, Legal and Procurement. This information will be used to update information within Model Hospital on an annual basis.

Carter Review

- Community and Mental Health (Productivity) – Community services
- Corporate Benchmarking – First submission in 16/17.

RECOMMENDATIONS

To note the information included within the report.

Anna Foster, Deputy Director of Commissioning & Quality Assurance
Dave Rycroft, Deputy Director of Finance & Business Development
July 2018