AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 25TH SEPTEMBER 2018 VENUE: THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meetings held on **3rd** and **19th July 2018.**		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To consider the report of the Quality Assurance Committee.	**HG/JI**	**Attached**
Item 7	To consider the monthly Nurse Staffing Report.	**JI**	**Attached**
Item 8	To consider the report of the Mental Health Legislation Committee.	**RS/JI**	**Attached**
Item 9	To consider the learning from deaths report.	**JI**	**Attached**
Item 10	To consider a report on the use of enhanced observations.	**JI**	**Attached**
Item 11	To review Freedom to Speak Up arrangements using the tool developed by NHS Improvement.	**DL**	**Attached**

Regulatory Items (10.50 am)

Item 12	To approve the Trust's submission to NHS England with regard to compliance with the Core Standards for Emergency Preparedness, Resilience and Response.	**RH**	**Attached**

(Note: The views of the Audit Committee on the above matter will be reported verbally to the meeting).

Performance (11.00 am)

Item 13	To consider the Finance Report as at 31st August 2018.	**PM**	**Attached**
Item 14	To consider the Trust Performance Dashboard as at 31st August 2018.	**SP**	**Attached**
Item 15	To consider the Strategic Direction Performance Report for Quarter 1, 2018/19.	**SP**	**Attached**

Governance (11.15 am)

Item 16	To review Non-Executive Director chairmanship and membership of the Board's Committees.	**Chairman**	**Attached**
Item 17	To approve the indicative Board Business Cycle for October 2018 to December 2019.	**PB**	**Attached**
Item 18	To receive and note the Register of Interests of the Board of Directors.	**PB**	**Attached**

Items for Information (11.25 am)

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

Item 21 To note that the next meeting of the Board of Directors will be held on Tuesday 30th October 2018 at the York Hilton, 1 Tower Street, York, YO1 9WD at 9.30 am.

Confidential Motion (11.30 am)

Item 22 **The Chairman to move:**

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

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

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

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

The amount of any expenditure proposed to be incurred by the Trust under any particular contract for the acquisition of property or the supply of goods or services.

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

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

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
19th September 2018

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 3RD JULY 2018 IN THE DIRECTORS' LOUNGE, MIDDLESBROUGH FOOTBALL CLUB, RIVERSIDE STADIUM, MIDDLESBROUGH AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. B. Kilmurray, Deputy Chief Executive
Dr. H. Griffiths, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Mr. D. Jennings, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Dr. A. Khouja, Medical Director
Mr. P. McGahon, Director of Finance and Information
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Ms. H. Griffiths, Public Governor for Harrogate and Wetherby
Mrs. R. Hill, Chief Operating Officer (Designate)
Mrs. J. Illingworth, Director of Quality Governance (representing Mrs. Moody)
Mr. P. Bellas, Trust Secretary
Mr. D. Gardner, Acting Director of Operations for the Tees Locality
Mrs. J. Jones, Head of Communications
Mr. C. Watson, Inspection Manager, Care Quality Commission

18/173 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. C. Martin, Chief Executive, Mrs. E. Moody, Director of Nursing and Governance and Mr. D. Brown, Acting Chief Operating Officer.

18/174 MINUTES

***Agreed** – that the minutes of the last meeting held on 22nd May 2018 be approved as a correct record and signed by the Chairman.*

18/175 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

18/176 DECLARATIONS OF INTEREST

There were no declarations of interest.

18/177 CHAIRMAN'S REPORT

The Chairman reported that her activities since the last meeting had been curtailed due to leave and there were no new material issues to bring to the Board's attention.

18/178 GOVERNOR ISSUES

No issues were raised.

18/179 LOCALITY BRIEFING – TEES

Mr. Gardner (Acting Director of Operations) gave a presentation on the key issues facing the Tees Locality.

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

Arising from the report, Board Members:

(1) Sought clarity, further to the Board Seminar held on 15th December 2015, on the progress of the Trust's engagement with Asian communities in Middlesbrough, particularly in relation to dementia, and whether it had led to increased awareness and understanding.

Mr. Gardner responded that the impact of the engagement activities could be seen in increased access rates but recognised that there was still further work to be undertaken.

He also advised that, as part of this work, a video had been produced in partnership with a local community group.

Board Members:

(a) Asked for the video to be shown at a future Board Seminar.

Action: Mr. Bellas

(b) Considered that the project should be considered for nomination for national awards.

(2) Congratulated the Locality on the work taking place on dual diagnosis and observed that, through making advances to the independent sector, the Trust was mitigating the risks arising from the loss of substance misuse services over the last few years.

With regard to this matter the Non-Executive Directors questioned whether the Trust would provide feedback on its experiences in order to prompt more intelligent commissioning, for example, to address the position at West Park Hospital where NECA, the provider of substance misuse services, was only allowed to support people with a Darlington postcode.

In response:

(a) It was noted that the Accountable Care Partnership (ACP) should provide greater influence on commissioning decisions.

(b) Assurance was provided that learning from the Trust's experiences was being fed back to the CCGs.

(3) Sought clarity on the present situation on nursing home provision, in view of the closure of a number of independent providers, and whether there was confidence in the Locality that sufficient resources were available to enable patients to move on from the Trust's services.

Mr. Gardner responded that:
(a) The position continued to be challenging.
(b) Standard and specialist nursing home provision was available but nothing in between them. It was considered that the ACP could help develop a response to this gap.
(c) The Trust was also seeking to support nursing home providers through the development of the skills and knowledge of their staff.
(d) At present the Trust was also contributing to the strategic commissioning framework.

At the conclusion of the discussions, the Chairman asked Mr. Gardner to pass on the Board's appreciation to staff in the Locality for their hard work and, in particular, to thank those staff at Roseberry Park for their co-operation and resilience during recent service moves.

18/180 REPORT OF THE QUALITY ASSURANCE COMMITTEE

The Board received and noted the report of the Quality Assurance Committee including:
(1) The confirmed minutes of the meeting held on 3rd May 2018 (Annex 1 to the report).
(2) The key issues considered by the Committee at its meeting held on 7th June 2018.

Dr. Griffiths, the Chairman of the Committee, highlighted the following matters:
(1) The inaccurate description of the meeting held on 7th June 2018 as being "informal" in the "Executive Summary" to the report.

Mr. Bellas undertook to correct the version of the report published on the Trust's website.

Action: Mr. Bellas

(2) The Committee's concerns, arising from its review of the North Yorkshire LMGB report, about the recent increase in the number of serious incidents (SIs) in the Locality.

The Board noted that:
(a) A thematic review of the SIs was being undertaken and a clinically led task force had been established to focus on learning lessons from them.
(b) There had been a very positive response from services in Scarborough following the increase in unexpected deaths.
(c) The increase in SIs had been discussed by North Yorkshire County Council and the local authority was keen to be involved in the review.

(d) The Committee had asked for an update report to be presented to its meeting to be held on 4th December 2018.

(3) The Committee's request for a report to be provided to its meeting on 5th July 2018 on the actions to be taken by the Trust in response to the Patient Safety Alert from NHS Improvement on the insertion of nasogastric tubes.

Arising from the report:

(1) In response to a question on the "red" compliance rating arising from the clinical audit of the use of restraint in Tier 4 CAMHS it was noted that:
   (a) As stated in the report, the key issue was the disparity between the level of detail provided in incident reports and in clinical records.
   (b) The Committee had received assurance that the findings of the clinical audit were being addressed and some improvements had already been made to recording processes.
   (c) Although the clinical audit had highlighted recording issues, the Committee was also concerned about the incidence of the use of restraint in the services.

   Assurance was provided that the actual position on the use of restraint in the services would be provided to the Committee.

(2) The Non-Executive Directors highlighted concerns about the position on level 3 safeguarding training which, although meeting the statutory requirement, was below contractual targets.

   In response it was noted that:
   (a) The present compliance rate was the highest ever achieved by the Trust.
   (b) There was good visibility on the issue and the compliance rate was being monitored, on a weekly basis, by the Operational Management Team.
   (c) Action was being taken to improve the position with more courses being made available.
   (d) At its next meeting the Performance Improvement Group was due to discuss the introduction of arrangements to support staff book on to courses before their compliance expired.

18/181 "HARD TRUTHS" MONTHLY NURSE STAFFING EXCEPTION REPORT

The Board received and noted the exception report on nurse staffing for May 2018 as required to meet the commitments of "Hard Truths", the Government's response to the Public Inquiry into Mid Staffordshire NHS Foundation Trust (the "Francis Review").

The following issues were raised in relation to the matters covered in the report:

(1) The position at Acomb Garth, which represented an outlier due to its high fill rates and agency usage, and, in particular, the extent the issues faced on the ward could be tackled by the Trust or resulted from specific intractable factors.

   Mrs. Hill responded that:
   (a) The ward had been identified by the Locality as a significant concern.

(b) A review by the Head of Nursing and the Nursing and Governance Directorate was ongoing.
(c) Factors identified included the sickness absence rates amongst the HCAs and the high demand for enhanced observations.
(d) With regard to the latter issue, the Locality was exploring the use of zonal observation and an update on this matter was due to be provided to the Right Staffing Programme Board.
(e) Work was also being undertaken to seek to ensure that recruitment to the ward was at the optimum level.
(f) Where possible only those agency workers known to the service were used.
(g) The iterative action plan developed in the Locality was due to be finalised by the Locality Management and Governance Board (LMGB) and would be provided to the QuAC.

(2) The meaning of "zonal observation".

Dr. Khouja explained that, traditionally, observation was based on one staff member per patient and it was recognised, from feedback, that this was not welcomed by service users. For zonal observation, a member of staff was allocated an area so that patients could move around but could be supported if required. There were a number of advantages from the approach, including cost savings, as one member of staff could look after a number of patients.

The Non-Executive Directors sought clarity on why, given its benefits, zonal observation was not being used in all wards.

In response it was noted that:
(a) Policy had been amended to enable its introduction.
(b) The introduction of the approach had been hampered by logistical factors (e.g. the difficulties in recording the frequent hand overs of care on the PARIS system) and cultural reasons.
(c) Zonal observation was also not appropriate in all areas and worked best in high intensity environments.
(d) It was also recognised that learning from other organisations, training and support were important to ensure its successful introduction.

(3) Mr. Levy highlighted the need for a fresh approach to temporary staffing as there were now more staff in post but also lower fill rates.

He advised that this matter was due to be discussed at the next meeting of the Resources Committee and it was also planned to hold an engagement event with services, in the next month, with a report on the future model due to be provided to the EMT.

The Board also discussed future reporting arrangements.

Mrs. Illingworth sought the Board's views on the charts provided in Appendix 6 to the report on Care Hours per Patient Day (CHPPD) which included the use of standard deviations to enable similar types of wards to be benchmarked.

Overall Board Members welcomed the use of the charts; however, it was considered that further work was required to ensure the appropriate grouping of wards. Dr. Khouja offered to liaise with Mrs. Moody on this matter.

Board Members also highlighted:

(1) The need for the severity scores to be more sensitive as, for example, the use of any agency staff by a ward attracted a score of "1" but this was not increased where a greater proportion of those staff were deployed e.g. Acomb Garth.

(2) The presentation of the quality data triangulation in section 3.4 of the report.

The Chairman considered that it had been intended that the monthly safe staffing reports would highlight exceptions and provide only basic assurances with further information and analysis provided in the six monthly reports.

This approach was supported as it was recognised that, in many cases, it was difficult to know, for example, whether SIs citing staffing issues were valid until the outcomes of investigations into them had been completed.

Board Members supported the inclusion of the data quality triangulation in the six month reports only.

(3) The need to consider how to triangulate the information on CHPPD into the safe staffing data.

(4) The need for assurance, in the six monthly reports, on how the Trust was responding to those wards with high severity scores.

Mrs. Illingworth agreed to discuss the above matters with Mrs. Moody.

Action: Mrs. Illingworth

18/182 RECRUITMENT AND RETENTION ACTION PLAN

Further to minute 17/301 (28/11/17) the Board received and noted:

(1) A progress report on the implementation of the Recruitment and Retention Action Plan (Appendix A to the covering report) which reflected revisions recently agreed by the Executive Management Team.

(2) The refreshed Action Plan (Appendix B to the report) which was aligned to the Workforce Strategy and had been developed in the format required by NHS Improvement as part of its Retention Support Programme.

The Board welcomed:

(1) The new format of the Action Plan; however, it was considered that the outcomes needed to be linked to specific measureable targets.

Action: Mr. Levy

(2) The removal of barriers to staff moving between services.

Clarity was sought on the following matters:

(1) The position of the EMT on the use of recruitment and retention premia.

The Board noted that a process had been put in place by the EMT and the onus was now on services to submit a business case for authorisation to employ the approach.

(2) The Derbyshire responsive workforce model.

Mr. Levy explained that the model was based on the establishment of a mobile and flexible group of staff who could undertake a broad range of clinical work and, thereby, reduce reliance on temporary staff. Feedback from the trust, which had developed and implemented the model, albeit on a small scale, was that it had proved beneficial except for the attempted poaching of the staff by neighbouring trusts.

(3) The actions taken to address staff being discouraged from participating in the retire and return scheme due to them not being able to continue to work in their present service.

It was noted that the key lesson learned was for the Trust to provide greater flexibility to returners and not to be overly concerned about equality of opportunity.

(4) The "Nurse conversations" included in the present Action Plan.

Mr. Levy explained that former nurses, and those approaching retirement, had been invited to participate in conversations about opportunities to continue, or return, to work for the Trust. There had been a high level of interest, initially, in participating in the conversations; however, this had dwindled. Overall, he considered that the Trust had tried the approach but would not be taking it forward.

In response to a question, he advised that, in many cases, the reasons for the high attrition rate were not known; however, it was considered that the Trust being unable to provide assurances on future working arrangements had contributed to the position.

(5) The increase in the number of leavers, and decrease in returners, of staff at Band 7.

Mr. Levy considered that the position reflected the higher age profile of Band 7 staff and the proportion of them with mental health officer status.

(6) Whether BREXIT had impacted on recruitment and retention.

It was noted that:

(a) The Trust employed approximately 100 nationals of other EU states.

(b) There was no evidence, at present, that these staff were considering leaving the Trust due to concerns about BREXIT.
(c) The matter would continue to be monitored.

(7) The Trust's approach to overseas recruitment.

Mr. Levy advised that, to date, the Trust had taken a cautious approach to overseas recruitment. The reasons for this were the recruitment cap and that, to date, the Trust's position on recruitment had not reached the point at which the development of the infrastructure required for overseas recruitment would be warranted.

He assured the Board that the matter was being kept under review and, with the recruitment cap now having been lifted, it might be worth reconsidering overseas recruitment to complement other approaches.

(8) The governance arrangements for oversight of the implementation of the Action Plan.

It was noted that oversight was provided by the Right Staffing Programme Board, reporting to the EMT, with assurance being provided to the Resources Committee.

18/183 LEARNING FROM DEATHS

Further to minute 18/39 (27/2/18) the Board received and noted the Learning from Deaths Report which set out the approach being taken by the Trust towards the identification, categorisation and investigation of deaths.

The mortality dashboard for Quarter 1, 2018/19 was provided as Appendix 1 to the report. The information was also presented in a new format in Appendix 3 to the report.

Whilst recognising that the compilation and publication of the statistics on unexpected deaths was a requirement, Board Members questioned how the process could be made useful for the Trust e.g. in terms of learning lessons (both within the Trust and to other providers); benchmarking findings; and in making improvements.

Mrs. Illingworth responded that:
(1) Deaths were reviewed by the Patient Safety Group with some being subject to structured judgement reviews.
(2) The Royal College of Psychiatrists was due to release a tool which would be piloted by some trusts in the regional group. This would support the right questions relating to deaths to be asked.
(3) The Trust supported the mortality review process but recognised that it had to be meaningful.
(4) A report was due to be presented to the Patient Safety Group to provide an overview of the year and a summary of the learning identified.
(5) Overall, it was considered that the Trust generally reported more deaths than others but there was still further work to do.

It was also noted that being part of the regional group provided greater opportunities to influence the "centre" on how the national process could be made more meaningful.

Related to this matter, questions were raised about how, where an expected death of a Trust patient occurred in the acute sector, the system would pick up potential poor quality care in the week or so beforehand and which might have contributed towards it.

In response it was noted that:
(1) The Trust was not the principal provider of care in these circumstances.
(2) To date only a couple of instances of this type had been seen and it was difficult to identify whether there had been a significant difference to the patients' lives.

In addition, Board Members:
(1) Noting the age profile of reported deaths in Appendix 2 to the report, suggested that it might be worthwhile for the regional group to focus on those within the younger age group.

Mrs. Illingworth took this on board.

(2) Sought assurance, following previous concerns, that the LeDer approach had improved.

Mrs. Illingworth advised that:
(a) Processes had improved with the Trust now invited to attend meetings of the regional steering group where learning was identified.
(b) Further information on the work of the regional group would be provided in the next report.

Action: Mrs. Illingworth

However, the Board also noted that learning could only take place once the cause of death was known and so depended on the timeliness of the work of the Coroners.

Overall, the Chairman considered that, over the last year, the processes for reviewing serious incidents had improved significantly and were now more robust; however, further work was required to capture reporting and learning from near misses and to support prevention.

18/184 ANNUAL REPORT ON PATIENT SAFETY

Further to minute 17/C/181 (4/7/17), the Board received and noted the Annual Report on Patient Safety.

Arising from the report:
(1) The Chairman commented that the Trust had improved its approach to the identification of the root causes of serious incidents and that, although the number reported appeared high, those identified were appropriate.

(2) The Board discussed the Trust's approach to identifying and responding to the themes identified from serious incidents.

In relation to this matter:

(a) It was considered that the analysis of themes, in the table provided on page 16 of the report, omitted some key areas of practice (e.g. dual diagnosis, lack of recognition of symptoms) which it was important to understand.

(b) Clarity was sought on how the Trust responded to the key themes identified from serious incidents (e.g. inadequate risk assessment, formulation, intervention planning, management and failure to follow procedure/policy/pathways, etc).

Mrs. Illingworth advised that the reporting of serious incidents to the EMT had changed. Under the new process a report on patient safety was provided each quarter which, in terms of the key themes identified, examined what the issues were and what actions were required in response to them. This information was then fed into the report to the Quality Assurance Committee. However, it was also recognised each theme needed to be reviewed individually and in-depth.

(c) The Chairman observed that there were clear links between the themes identified and other systems, for example, the quality of supervision. Assurance was, therefore, required on whether this was happening, whether it was challenging, etc.

On this matter:

- The development of leadership through the PPCS programme was highlighted.
- It was recognised that there could be multiple reasons for staff not following policy which the Trust needed to better understand.

(3) Clarity was sought on the approach to developing suicide prevention strategies.

It was noted that the development of suicide prevention strategies was at different levels. In general, they fell within the remit of local authorities as part of their public health functions; however:

(a) Some national monies had been allocated to the CCGs in County Durham and Tees in relation to suicide prevention.

(b) The North East and Cumbria STP had zero suicides as one of its strategic aims.

(c) The Trust produced the strategy for York and there were a number of forthcoming events to support its preparation.

(4) The issue of how the Trust compared to others in terms of the reporting and severity of incidents was raised.

In response it was noted that:

(a) Although benchmarking information was not available, and would be difficult to compile due to the differences between trusts, it was considered that TEWV was not an outlier.

(b) Information was available from the NRLS on the number of deaths but this did not cover all serious incidents.

Mrs. Illingworth undertook to discuss the provision of benchmarking data with the nine other trusts in the regional group.

Action: Mrs. Illingworth

18/185 FINANCE REPORT AS AT 31ST MAY 2018

The Board received and noted the Finance Report as at 31st May 2018.

The Non-Executive Directors questioned the arrangements for the oversight of CRES schemes as the position on the programme had been raised by the Board and at meetings of the Resources and Audit Committees.

Mr. McGahon advised that:

(1) The CRES Board would be examining a number of potential schemes each month and those which were contentious would be brought before the Resources Committee for discussion.

(2) Communications would be provided on the CRES programme over the next few months.

(3) The arrangements introduced provided a more rigorous way of evaluating schemes and encompassed the Trust's quality impact assurance processes.

In addition it was noted that:

(1) The Audit Committee's role included reviewing the effectiveness of systems used to identify and monitor the implementation of CRES schemes.

(2) It was important for identified CRES schemes to be fed into the business planning arrangements in order for the Board to be updated at its event in October 2018.

18/186 PERFORMANCE DASHBOARD AS AT 31ST MAY 2018

The Board received and noted the Performance Dashboard Report as at 31st May 2018.

Board Members recognised the work undertaken by services which had led to the Trust achieving its target for statutory and mandatory training.

The discussions focussed on whether the Trust should continue to use outcome indicators as, based on the underperformance highlighted in the report, they did not seem to be effective.

Mrs. Pickering advised that:

(1) The indicators required the collection of two paired outcomes and the level of these reported was low; however, the data provided in the report, even if less than target, did provide some assurance.
(2) Work was being undertaken with services to improve reporting and, once there was assurance on the representativeness of the data, attention would turn to achieving the targets.
(3) In addition, the Performance Improvement Group had undertaken a "deep dive" review on outcomes reporting and there had been discussions at the Clinical Leaders and Operational Managers Group.

Dr. Khouja added that the production of information to support the outcome measures was often subject to data quality issues; however, he considered that they remained vitally important.

In response to a question on this matter, it was noted that:

(1) The data provided by the Information Department, together with the work of the Experts by Experience, was being promoted as integral to the delivery of services.
(2) Overall, it was considered that steady progress was being made.

18/187 DATA QUALITY STRATEGY

On the recommendation of the Resources Committee, it was:

Agreed – *that the Data Quality Strategy 2018 – 2021 be approved.*

Action: Mr. McGahon

18/188 USE OF THE TRUST SEAL

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

18/189 POLICIES AND PROCEDURES RATIFIED BY THE EXECUTIVE MANAGEMENT TEAM

The Board received and noted the report on the Executive Management Team's ratification of policies and procedures.

18/190 DATE OF NEXT MEETING

It was noted that the next meeting of the Board of Directors was due to be held at 9.30 am on Thursday 19th July 2018 in the Boardroom, West Park Hospital, Darlington.

18/191 CONFIDENTIAL MOTION

Agreed *– that representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the*

business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:

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

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 12.20 pm.

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 19TH JULY 2018 IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 AM

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

In Attendance:
Ms. H. Griffiths, Public Governor for Harrogate and Wetherby
Mrs. R. Hill, Chief Operating Officer (Designate)
Mr. P. Bellas, Trust Secretary
Dr. J. Whaley, Guardian of Safe Working (minute 18/207 refers)
Dr. F. Naclad, Specialty Registrar, North Yorkshire Locality
Mr. S. Lancashire, Head of Forensic Mental Health
Mrs. J. Jones, Head of Communications

18/203 APOLOGIES FOR ABSENCE

The Board noted that Mr. Brown, Acting Chief Operating Officer, and Mrs. Hill had apologised for their late arrival at the meeting due to their required attendance at another event.

18/204 DECLARATIONS OF INTEREST

Mr. Bellas, as a Director of TEWV Estates and Facilities Management Ltd, declared a non-pecuniary interest in the matters recorded under minute 18/C/226.

18/205 CHAIRMAN'S REPORT

The Chairman reported that the Annual General Meeting had gone very well and Mr. Andy Bell (Deputy Chief Executive at the Centre for Mental Health) had delivered an interesting keynote speech.

Mr. Murphy reported that, on behalf of the Chairman, he had attended a service at York Minster on 5th July 2018 as part of the NHS 70 celebrations with two members of staff from Roseberry Park. He had found the event to be very powerful and moving.

Mr. Kilmurray added that he had attended the service at Westminster Abbey, on the same day, accompanied by two staff, both of whom had welcomed the opportunity to participate in the celebrations.

18/206 GOVERNOR ISSUES

No issues were raised.

18/207 REPORT OF THE GUARDIAN OF SAFE WORKING

The Board received and noted the report of the Guardian of Safe Working.

Dr. Whaley confirmed that the Trust continued to comply with the 2016 Junior Doctor Contract and junior doctors were appropriately submitting exception reports which were being handled appropriately.

Arising from the report Board Members:

(1) Recognised the impact of increased activity in the South Durham, Scarborough and Harrogate localities on the junior doctors.

Dr. Whaley assured the Board of management's receptiveness to discuss the issues and welcomed the invitation he had received to attend meetings of the Medical Directorate.

(2) Sought clarity on the "on-call tablet".

It was noted that the "on-call tablet" provided a means of replicating the benefits of the "hospital at night" system (minute 18/114 – 24/4/18 refers) without the need to import new software. Under the arrangements, tasks would be posted on the system which could then be prioritised or removed if appropriate.

(3) Sought assurance on the progress of work to reduce the volume of inappropriate calls in South Durham.

The Board noted that the position on this matter would become clearer over the next six months as the Duty Night Co-ordinators, who had been appointed, commenced work and the impact of the significant work undertaken on the duties of foundation doctors could be assessed.

Dr. Khouja advised that:

(a) There was significant variation between the Localities on the tasks it was considered appropriate for on-call doctors to perform.
(b) Working arrangements between the junior doctors and the Duty Night Co-ordinators had been discussed as part of an RPIW but it was recognised that these needed to be further considered.

On this point, Dr. Whaley asked for the KPO department to be mindful of the impact of changes to processes on the junior doctors and, where appropriate, to invite them to participate in improvement events.

(4) Sought assurance that concerns raised about the use of taxis (minute 17/264 – 31/10/17 refers) had been addressed.

Dr. Whaley responded that:
(a) The issue was included on the agendas of all locality meetings.
(b) Assurance had been received that all taxi drivers were DBS checked.
(c) The procedure for using taxis was being simplified.
(d) No further instances of inappropriate behaviour by taxi drivers had been reported.

The Board thanked Dr. Whaley for his report.

18/208 REPORT OF THE QUALITY ASSURANCE COMMITTEE

The Board received and noted the report of the Quality Assurance Committee including:
(1) The confirmed minutes of the meeting held on 7th June 2018 (Annex 1 to the report).
(2) The key issues considered by the Committee at its meeting held on 5th July 2018.

Dr. Griffiths, the Chairman of the Committee, drew attention to the presentation it had received on restraint and physical interventions in Tier 4 CAMHS.

He reported that the Committee was concerned that there were no comparable national benchmarks on this issue and considered this should be worked towards.

On the recommendation of the Committee, it was agreed that the issues relating to the use of restraint and physical interventions in Tier 4 CAMHS should be considered at a future Board Seminar.

Mr. Bellas advised that this topic would be included in the draft programme for the seminars to be held in 2019 which was due to be presented to the Board at its next meeting.

Action: Mr. Bellas

The Board also noted the concerns raised in the report of the County Durham and Darlington LMGB about importing patients from other areas and the impact of this, including high occupancy rates, on services in the Locality.

18/209 SIX MONTHLY NURSE STAFFING REPORT

The Board received and noted the six monthly review report, for the period 1st December 2017 to 31st May 2018, in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire NHS Foundation Trust ("Francis Review") and in line with National Quality Board (NQB) guidance.

In response to questions:

(1) Mrs. Moody undertook to provide clarity on the statement in section 3.7.2 of the report that "The CHPPD across all inpatient areas was 10.3 (3.8 registered nurses and 6.5 healthcare assistants) with an inpatient average of 14.3 CHPPD."

Action: Mrs. Moody

(2) Assurance was provided that the low level of compliance with mandatory training on Rowan Lea (73.79%) was being monitored on a weekly basis by the Operational Management Team.

It was noted that:

(a) The key issues relating to the ward's position were the significant number of vacancies and high levels of acuity resulting in difficulties in releasing staff.
(b) There had been a change in the leadership of the ward and the position was improving.
(c) Additional training opportunities were also being made available.

(3) The Board noted that no national work was being undertaken to link dependency into the Care Hours Per Patient Day data but the impact of this issue should be covered through the use of the Mental Health Optimal Staffing Tool (MHOST formerly known as the "Hurst tool").

(4) In relation to the actions taken where correlations were found between staffing levels and the findings of serious incident investigations, Mrs. Moody advised that:

(a) The report sought to draw out the themes from the findings of investigations relating to staffing levels.
(b) Serious incidents were as likely to occur on wards with "blue" or "green" rated fill rates as for those with "red" rated fill rates.
(c) The patient safety team had been asked to specifically consider staffing levels and skill mix in relation to the investigations of inpatient serious incidents to support more robust triangulation of staffing data and to aid root cause analysis.
(d) Where Directors' Panels highlighted contributory findings regarding staffing levels (as in the two cases mentioned in the report), an action plan would be put in place and monitored by the relevant Quality Assurance Group.
(e) Whilst this process provided assurance on the completion of individual actions, assurance that the Trust was addressing themes relating to safe staffing was provided by the patient safety reporting processes.
(f) It was considered that, as evidenced by the number of relevant DATIX forms completed during the reporting period (111), the formal escalation of issues was improving.
(g) The DATIX form had also been amended and escalation processes put in place to capture actions to be taken in response to the incidents. These were reviewed by the Heads of Nursing to support the identification of trends.

The Board also discussed the Trust's future approach to 12 hour shifts; an issue where staff unhappiness had been raised during a recent Directors' visit.

It was noted that the research project, in partnership with the University of York, was due to be completed by the end of the year.

The Chairman considered that it would be beneficial if the researchers were invited to present their findings to the Board possibly at a seminar.

Action: Mr. Bellas

Mrs. Richardson advised that, from discussions with the researchers at the Annual General Meeting (AGM), it appeared that younger workers were better able to cope with the demands of 12 hour shifts and this should inform the Trust's approach to recruitment and extending working lives.

It was noted that this issue had also been highlighted by Mr. Andy Bell (Deputy Chief Executive at the Centre for Mental Health) during his keynote speech at the event.

The Chairman asked for copies of the poster on the initial findings of the research project, which had been made available at the AGM, to be circulated to Board Members.

Action: Mr. Levy

18/210 WORKFORCE RACE EQUALITY STANDARD

On the recommendation of the Resources Committee, consideration was given to the latest iteration of the Trust's Workforce Race Equality Standard (WRES) information set and associated action plan.

Arising from the report:

(1) Mr. Levy suggested that the action plan should be amended to promote the ability of the Trust, as enshrined in the Equality Act 2010, to take "positive action" to appoint BAME candidates where they were of equal merit to others.

This was taken on board.

(2) At the request of Board Members, Mr. Levy also undertook to ensure clarity was provided on the relevant reporting year for the data contained in the action plan.

(3) The Non-Executive Directors reported that they had received positive feedback from participants in the BAME leadership course particularly in understanding cultural differences about self-promotion.

Agreed - *that the Trust's Workforce Race Equality Standard information set 2017/18 and associated action plan (as amended) be ratified and be published by 28th September 2018.*

Action: Mr. Levy

18/211 GENDER PAY GAP

Further to minute 18/C/55 (27/2/18), the Board received and noted a report on the analysis, undertaken to date, of the Trust's gender pay gap statistics and which highlighted some areas where further work might be beneficial.

The following matters were discussed:

(1) The impact of breaks on length of service, highlighted in the report as the key determinant of the pay gap, and whether there was anything the Trust could do in mitigation.

The Board noted that:

(a) There was scope under the agenda for change pay system for accelerated pay progression but this would need to be introduced for objective reasons.

(b) The new pay scales and performance related pay arrangements (at certain grades) would have, over time, a condensing effect and reduce the impact of breaks on pay.

(2) Whether the analysis of issues producing the gender pay gap was correct.

The Non-Executive Directors highlighted that the data did not seem to suggest that length of service was the greatest determinant of the pay gap but that other issues, e.g. staff turnover or the spread of men and women at each band across the pay structure, were of more importance. If this was the case, actions to address cultural, rather than structural, reasons for the pay gap would be of more relevance.

In relation to this matter:

(a) It was noted that the data suggested that staff turnover was relatively high in the first year, but small in number, and could be taken into account in the further analysis of the pay gap statistics.

(b) Mr. Levy considered that the issues of length of service and spread of genders between pay bands were both issues contributing to the pay gap but, from the analysis undertaken, the Trust could account for the impact of the operational pay system.

(3) The impact of clinical excellence awards (CEAs) and the potential cultural reasons why applications for them were more likely to be from men than from women.

Dr. Khouja advised that:

(a) He had set up a working group to seek to understand the impact of CEAs on the gender pay gap.

(b) Although there was a significant difference in terms of the number of applications by gender, this narrowed, but was still at 10%, in terms of the approval of the awards.

(c) As constituted, CEAs discriminated against part-time staff, for example, opportunities for them to undertake research was limited.

(d) New guidelines on CEAs were far more based on local determination and fairer, to both genders, by focussing on the delivery of high quality services rather than on broader issues such as training and development.

(e) A survey of consultants on the new proposals was planned.

The Non-Executive Directors recognised that applications for CEAs were not supposed to be modest documents and it was, therefore, important for the Trust to be mindful of this when interpreting them. This had been addressed, ad hoc, during the last round of awards but it was felt that more could be done.

(4) The importance of talent management in overcoming the cultural issues underpinning the pay gap.

It was noted that the Trust had taken a very positive approach in this area including in relation to recruitment and retention processes, appraisals, coaching, etc.

(5) The Trust's pay gap compared to those of other trusts.

Mr. Levy advised that TEWV was in the midspread for trusts in the North East region.

Overall the Board recognised that the report had met its intended purpose of generating questions. However, it was considered that a further analysis was required, taking into account the issues raised during the discussion, for consideration by the Board.

Noting that the Council of Governors had asked for a report to be provided to its meeting in September 2018, it was considered that this should reflect the points made during the discussions on the impact of the gender spread across pay bands and include some of the actions being taken to address the pay gap.

(Note: Mrs. Hill joined the meeting during the consideration of the above item).

18/212 LEADERSHIP AND MANAGEMENT DEVELOPMENT STRATEGY

Consideration was given to the draft Leadership and Management Development Strategy.

The focus of the discussions was on the notion of leadership within the Strategy.

The Chairman considered that the Strategy appeared to focus on managers as leaders rather than recognising that all staff should undertake this role and promote associated behaviours by them.

This view was supported by the Non-Executive Directors who highlighted the importance of all staff demonstrating and exhibiting leadership qualities for example by challenging bullying and harassment and through participation in quality improvement events. In the latter case the quality improvement system, by transcending pay bands and providing confidence, was seen as a key leadership development tool.

In relation to this matter, Board Members:

(1) Whilst recognising that collective leadership and coaching were referenced and signposts were provided to other documents on the meaning of leadership,

considered that greater prominence should be given to those issues in the Strategy.

(2) Highlighted that the issues raised during the discussions, were redolent of those at the Board business planning event in 2017 which had led to the identification of the "Making a Difference Together" Priority.

It was considered that the Strategy provided an opportunity to re-emphasise the original concept of the Priority by recognising that, through living the values and delivering expected behaviours, staff would be acting as leaders.

In addition Board Members considered that:

(1) Greater emphasis should be placed on permissive management i.e. managers being open to challenge.

It was suggested that this issue could be made more explicit in the third objective of the Strategy.

(2) Whilst diversity was mentioned in the objectives of the Strategy, gender diversity should be given greater emphasis.

Mr. Martin, noting the above discussions, considered that, to avoid risks of overcomplicating the key messages of the Strategy, it would be preferable for only minimal changes to be made including:

(1) Giving greater prominence to the links to other documents on leadership within the executive summary.

(2) Providing greater focus on the important elements of management and leadership, without losing the sense of the developmental aspects of leadership, and the relationship between them.

Agreed-

(1) that, subject to minimal changes, the revised Leadership and Management Development Strategy 2018-2022 be approved; and

Action: Mr. Levy

(2) that the final sign off of the document be delegated to the Chairman and Chief Executive.

Action: Mrs. Bessant and Mr. Martin

18/213 ANNUAL REPORT ON DIRECTORS' VISITS

The Board received and noted the Annual Report on Directors' Visits which covered the period June 2017 to May 2018.

The log of visits, which provided assurance that the majority of the actions arising from them had been completed, was attached as Appendix 1 to the report. Copies of the individual visit reports were also provided on the Boardpad system.

Board Members considered that:

(1) The decision to undertake the visits by theme had been beneficial as it highlighted variations between services and prompted debate.

(2) The report, which focussed on issues arising from the visits, did not provide visibility on the outstanding practice identified during them.
(3) The number of visits, over 80 during the period, together with those undertaken personally by the Chairman and Chief Executive, provided a high degree of understanding of the issues facing frontline services.
(4) Whilst recognising the difficulties in condensing the issues raised during the visits, one theme which resonated, but was not drawn out in the report, was the transformative effect of changes in team leadership.

18/214 MATTERS OF URGENCY – MENTAL HEALTH LEGISLATION COMMITTEE

Mr. Simpson, the Chairman of the Committee, confirmed that there were no matters of urgency for consideration by the Board arising from the meeting of the Mental Health Legislation Committee held on 12th July 2018.

18/215 SUMMARY FINANCE REPORT AS AT 30TH JUNE 2018

The Board received and noted the summary Finance Report as at 30th June 2018 including the Quarter 1, 2018/19, submission to NHS Improvement.

The Board noted that the information contained in the report represented the Trust's position against the revised financial plan provided to NHS Improvement following the receipt of a reduced control total.

Arising from the report, the Non-Executive Directors questioned whether the variance in non-pay expenditure (£213k) raised any concerns about the ability of the organisation to deliver its (revised) financial plans.

In response, Mr. McGahon provided assurance on the arrangements put in place through the financial accountability framework to support the Localities return to financial balance.

***Agreed** – that the Trust's Quarter 1, 2018/19 submission to NHS Improvement, in accordance with the results detailed in the above report, be approved.*

Action: Mr. McGahon

18/216 STRATEGIC DIRECTION PERFORMANCE REPORT – REVISED KEY PERFORMANCE INDICATORS

Consideration was given to a revised set of key performance indicators (KPIs), proposed by the Executive Management Team, to be used to measure the progress of the Trust in delivering its Strategic Direction (as set out in Appendix 2 to the report).

It was noted that:
(1) The revised indicators had been identified to provide greater alignment with the Trust's core strategies.
(2) As shown in Appendix 2, place holders had been included in relation to Strategic Goals 3 and 5 for KPIs to be drawn from the Leadership and Management

Development Strategy and the Equality and Diversity Strategy once their respective scorecards had been agreed.

The Non-Executive Directors made the following points:

(1) The potential benefits, in terms of a "golden thread" linking the strategic goals to operational delivery, of including KPIs relating to the delivery of CRES; changes in reference costs; and the Quality Improvement System under Strategic Goal 2.

Mrs. Pickering advised that the matters raised had not been considered by the EMT but were more relevant to the governance and sustainability of the organisation (Strategic Goal 5).

(2) The meaning, in relation to Strategic Goal 4, of having effective partnerships "… for the benefit of the communities we serve".

It was noted that the Strategic Goal was intended to demonstrate that the Trust would seek to work in partnership with other organisations where important to support the delivery of the Strategic Direction (e.g. the pooling of budgets as part of the ACP and NCMs as this enhanced the Trust's ability to develop robust pathways) and would not enter into those which were of no benefit.

(3) The appropriateness of the KPIs proposed under Strategic Goal 2 to understanding whether or not to continue to do something in terms of the added value to customers.

(4) Whether the number of proposed KPIs was excessive.

Mrs. Pickering responded that previously the number of KPIs in the Strategic Direction Performance Reports was approximately double the number recommended in Appendix 2. The EMT had been challenged to identify between 15 and 20 metrics; the number which would be expected in a good Dashboard. In the event, the maximum of 23 KPIs, as set out in Appendix 2, had been accepted.

Mrs. Pickering also advised that targets for most of the proposed KPIs would be drawn from the relevant strategic scorecards; however, for others, it would be necessary to establish baselines. This matter would be covered in the next Strategic Direction Report.

Agreed -

(1) that the KPIs set out in Appendix 2 to the report be approved as the basis for monitoring progress against the Strategic Direction;

(2) that baseline data and proposed targets for the KPIs, where not already available in the relevant Strategy Scorecards, be established; and

Action: Mrs. Pickering

(3) that the Strategy Sponsor for the Leadership and Management Development Strategy and the Equality and Diversity Strategy identify the most appropriate KPIs from the respective scorecards to be added to the

KPIs in Appendix 2 under Strategic Goal 3 and Strategic Goal 5 where indicated.

Action: Mr. Levy

18/217 SINGLE OVERSIGHT FRAMEWORK

The Board received and noted a report on the Trust's indicative position against the requirements of NHS Improvement's Single Oversight Framework for Quarter 1, 2018/19.

18/218 REVIEW OF THE OPERATIONAL ARRANGEMENTS OF THE BOARD'S COMMITTEES

Further to minutes 17/230 (19/7/17) and 17/299 (28/11/17) consideration was given to a report on the work being undertaken to further develop the operational arrangements of the Mental Health Legislation, Quality Assurance and Resources Committees.

Agreed *-*

(1) that the changes to the operational arrangements of the Committees, as summarised in the report, be supported;

(2) that the proposed changes to the terms of reference of the Resources and Mental Health Legislation Committees, as set out in Annex 1 to the report, be approved with effect from 1st October 2018; and

(3) that a further review of the Board's committee arrangements be undertaken in December 2018.

Action: Mr. Bellas

18/219 POLICIES AND PROCEDURES RATIFIED BY THE EXECUTIVE MANAGEMENT TEAM

The Board received and noted the report on the Executive Management Team's ratification of policies and procedures.

18/220 DATE OF NEXT MEETING

It was noted that the next meeting of the Board of Directors was due to be held at 9.30 am on Tuesday 25th September 2018 in the Boardroom, West Park Hospital, Darlington.

18/221 CONFIDENTIAL MOTION

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

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

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

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

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

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

18/222 MR. BRENT KILMURRAY

This being Mr. Kilmurray's last Board meeting prior to him leaving the Trust to take up the position of Chief Executive of Bradford District Care NHS Foundation Trust, the Chairman, on behalf of the Board, thanked him for his significant contributions to the development and success of the Trust.

Following the transaction of the confidential business the meeting concluded at 12.40 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Tees Locality Board Presentation
3rd July 2018

Dominic Gardner

Acting Director of Operations

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To provide excellent services, working with the individual users of our services and their carers to promote recovery and well being

- Previously
  - Peer Support Workers, CYP Home Treatment, Delirium and Frequent Attender Work in Liaison
  - Support to independent providers
- Now
  - Urgent Care Centre, Street Triage and Police Force Control Room Pilot, Perinatal, CYPS CRHTT
  - Support to independent providers (Transforming Care / ACP)
  - MHSOP & AMH RPH Implications

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To continuously improve the quality and value of our work.

- Previously
  - One team left for PPCS Phase 1
  - Locality Report Out - to help share and spread
  - CD sponsorship / QIS with partners
- Now
  - PPCS Phase 2 Pilot Teams
  - Coaching
  - QIS with Partners – Dual Diagnosis / Transforming Care

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To recruit, develop and retain a skilled, compassionate and motivated workforce

- Previously
  - Ability to recruit consultant medical staff a serious concern
  - Proportion of newly qualified and < 24 months post qualification nurses very high
  - Potential for unintended consequences from PPCS
- Now
  - Ability to recruit consultant medical staff a serious concern (CYPS/AMH)
  - Embedding roles of AC
  - Proportion of newly qualified and < 24 months post qualification nurses high

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To have effective partnerships with local, national and international organisations for the benefit of our communities.

- Local
  - Crisis Care Concordat, Suicide Prevention Task Force
  - LA Health and Wellbeing Boards and Sub-groups
  - MBC Trauma Informed Care
- National
  - No formal links nationally on Tees
- International
  - Asklepios – Peer Support Workers / Transcultural Psychiatry

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of our communities.

- **Financial Issues**
  - Previously, enhanced observations in MHSOP and nursing home capacity, CYP and CRES
  - Now, LD Respite Services, Crisis Review, Enhanced Observations in MHSOP and DToC's, Enhanced Observations in CYPS Tier 4 (Acuity / Pathways)
- **LMGB**
  - Daily lean management
  - QuAGs managing broad range of issues still
  - LMGB revised after Tier 4 transferred

making a difference together

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th September 2018**
TITLE:	**Board Action Log**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information/Assurance**

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

Executive Summary:

This report allows the Board to track progress on agreed actions.

Recommendations:

The Board is asked to receive and note this report.

Board of Directors Action Log

RAG Ratings:

	Action completed/Approval of documentation
	Action due/Matter due for consideration at the meeting.
	Action outstanding but no timescale set by the Board.
	Action outstanding and the timescale set by the Board having passed.
	Action superseded
	Date for completion of action not yet reached

	Minute No.	Action	Owner(s)	Timescale	Status
28/11/2017	17/305	A briefing to be provided to the Board on the event in 2018 in relation to sickness absence and whether further action can be taken to support the health and wellbeing of staff	DL	Jul-18	Completed
19/12/2017	17/327	A report to be presented to the Board on the outcome of the review of the 12 hour shift system	DL	Jan-19	See minute 18/209
30/01/2018	18/08	A report to be presented to the Board on the use of enhanced observations (including trends) together with information on contemporary best practice in this area.	EM	~~19/07/2018~~ Sept 18	See Agenda Item 10
27/02/2018	18/40	The need for guidance on how the starting point on the Ladder of Participation will be chosen to be raised with the Recovery Programme	DL	~~31/07/2018~~ Nov-18	
27/03/2018	18/73	A university to be invited to undertake a project for the Trust in relation to variations in outcomes, and the reasons for them, between different types and sizes of wards	EM	Sept-18	Completed
22/05/2018	18/144	The objectives of the Research and Development Strategy to be used as the framework for future annual reports	Prof. JR	May-19	
22/05/2018	18/146	Whether patients on leave were included in the CHPPD data provided to NHS Improvement to be checked	EM	Sept-18	Completed
22/05/2018	18/146	Consideration to be given to the best way of tracking performance against the CHPPD metric over time	EM	Sept-18	Completed

	Minute No.	Action	Owner(s)	Timescale	Status
22/05/2018	18/150	The Annual Report and Accounts for the Charitable Trust Funds to be submitted to the Charities Commission	PM	~~01/07/2018~~ Sept-18	Completed
22/05/2018	18/153	A Board Seminar to be held on outcome measures including a personal view on patient reported outcome measures and their impact on recovery	CM	Dec-18	See agenda item 17
03/07/2018	18/180	A corrected version of the QuAC report to be published on the Trust's website	PB	Aug-18	Completed
03/07/2018	18/181	Discussions to be held with Mrs Moody on the future content of the nurse staffing reports taking into account the issues raised by Board Members at the meeting	JI	-	Completed
03/07/2018	18/183	Information on the work of the regional LeDer steering group to be provided in the next learning from deaths report	EM	Oct-18	See agenda item 9
03/07/2018	18/185	Discussions to be held with the regional group on the provision of benchmarking information on serious incidents	JI	Dec-18	
03/07/2018	18/187	To note approval of the Data Quality Strategy 2018 - 2021	PM	-	To note
19/07/2018	18/208	A briefing to be provided to a Board Seminar on the use of restraint and physical interventions in Tier 4 CAMHS	PB	Feb-19	See agenda item 17
19/07/2018	18/209	A briefing on the findings of the research conducted by York University on 12 hour shifts to be provided to a Board Seminar	PB	Nov-18	See agenda item 17
19/07/2018	18/209	Copies of the poster on the initial findings of the research project on 12 hour shifts (made available at the AGM) to be circulated to Board Members	DL	-	Completed
19/07/2018	18/210	To note approval of the WRES and associated action plan (as amended)	DL	-	To note
19/07/2018	18/213	To note the approval of the Leadership and Management Development Strategy subject to minor amendments	DL	-	To note
19/07/2018	18/213	To sign off the final version of the Leadership and Management Development Strategy	Chairman/CM	-	Completed

	Minute No.	Action	Owner(s)	Timescale	Status
19/07/2018	18/215	To note the approval of the Quarter 1, 2018/19 finance submission to NHSI	PM	-	To note
19/07/2018	18/216	To note: - the approval of the KPIs for monitoring progress against the Strategic Direction as proposed - baseline data and proposed targets for the KPIs to be established where not already available in the relevant Strategy Scorecards	SP	-	To note
19/07/2018	18/216	Appropriate KPIs to be identified from the scorecards of the Leadership and Management Development Strategy and the Equality and Diversity Strategy to be added to those to be used to monitor progress (under Strategic Goals 3 and 5) against the Strategic Direction	DL	Nov-18	
19/07/2018	18/218	To note the approval of amendments to the terms of reference of the Mental Health Legislation and Resources Committees to come into effect on 1st October 2018	PB	-	To note
19/07/2018	18/218	A further review of the Board's committee arrangements to be undertaken	PB	Dec-18	

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO 6

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 25 September 2018**
TITLE:	**Assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
REPORT FOR:	**Assurance**

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

Executive Summary:

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

Assurance statement pertaining to the QuAC meeting held on 06 September 2018:

The Quality Assurance Committee has consistently reviewed all relevant Trust quality related processes, in line with the Committee's Terms of Reference. Issues to be addressed have been documented, are being progressed via appropriate leads and monitored via the appropriate sub-groups of QuAC.

Key matters considered by the Committee are summarised as follows:

- The Locality areas of North Yorkshire and York and Selby services and top concerns.
- Patient Safety and Patient Experience updates.
- Trust criteria for the location of emergency response bags in community units and potential of placing automated defibrillators (AEDs) into non-patient areas.
- CQC compliance.
- Safeguarding & Public Protection.
- Infection, Prevention and Control.
- Drug and Therapeutics.
- Clinical Audit and Effectiveness.
- Quality Account Quarter 1 and consideration of the quality priorities for the Trust Business Plan 2019/20.

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 06 September 2018.
- Note the confirmed minutes of the meeting held on 05 July 2018 (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 25 September 2018**
TITLE:	**Assurance report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting held on 06 September 2018.

2. BACKGROUND INFORMATION AND CONTEXT

This report makes reference to the regular assurance reports from the clinical governance infrastructure, which includes the Locality Management and Governance Boards, together with the corporate assurance working groups of the Quality Assurance Committee, including progress reports. Monthly compliance with the Care Quality Commission regulatory standards, with copies of assurance reports to support the regulatory standards were also considered.

3. KEY ISSUES

The Committee received updates from the Locality Directors of Operations around the principal risks and concerns, together with assurances and progress from North Yorkshire and York and Selby Services.

ARE OUR SERVICES WELL-LED?

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

The Committee received key assurance and exception reports from LMGBs.

4.1 NORTH YORKSHIRE SERVICES LMGB

The Committee discussed the LMGB report for North Yorkshire Services.

The top areas of concern highlighted were:

- Management capacity in MHSOP services affecting the stability of both AHLS teams in Northallerton and Harrogate as well as the Hambleton and Richmondshire CMHT and Ward 14.
  The Committee was given assurance that mitigating plans are in place, however capacity will be significantly reduced and there are concerns regarding the resilience of band 7 staff.
- For learning disability Services the risks to the future provision of the Community Crisis Intervention Services.

- Ongoing challenges to meet the eating disorder waiting times and access standards with the expectation from NHS England that this service will be a specialist 'stand-alone' service in the coming months. This is not felt to be achievable.
  The Committee was given assurance that a business case was currently being prepared to look at an option appraisal.

The Committee agreed that for future reporting, NY Services are to include further assurances around statements relating to Adult Mental Health and MHSOP where it could be seen that indicators were deteriorating.

4.2 **YORK AND SELBY SERVICES LMGB**

The Committee received the LMGB report for York and Selby.

The top areas of concern highlighted were:

- Continued challenges for IAPT services linked to recruitment and retention and meeting the locally agreed prevalence target and recovery rate. A deep dive report into recovery rates will address some of the issues found together with a new clinical leadership structure.
- Significant financial pressures in MHSOP due to the use of bank and agency staff in three inpatient units, out of locality admissions where a new admission process was being introduced and the need for a locum consultant due to unsuccessful recruitment.
- Capacity and demand in CAMHS with the roll out of group programmes as a first line of treatment choice for children and young people who require emotional intervention. These are different CBT groups, which aim to release the capacity for clinicians to offer more intensive interventions for the most serious presentations.

Members commented on the excellent sickness absence rate of 1%, despite the challenges across the services.

Assurance was provided that the mandatory training deterioration, predominantly on Oak Rise was being addressed and a new band 7 post has commenced employment which would further support this.

4.3 Compliance with CQC Requirements

The Committee received the CQC update report.

The key matters discussed were:

- The Trust has received the draft report from the CQC for rehabilitation services to be checked for factual accuracy.
- There have been two requirement notices from the CQC regarding nurse call points and environmental blind spots. An action plan will be drawn up very quickly for these and returned to the regulator.
- The introduction of an intelligence tool 'CQC Insight' has been developed to support the regulatory function of the CQC to help monitor any potential changes to the quality of care provided and to support regulatory decision making. The Trust will receive bi-monthly intelligence reports, the first of which was provided for in 2018.
  Members requested that as this data set develops that the Committee is provided with an explanatory narrative.

- There have been four MHA inspections and one social care inspection since June 2018 and all recommendations are being addressed.
- Since April 2018 there is a notable increase in the amount of specific patient issues raised. These issues relate to four different wards and due to the anonymity of the information it cannot be identified whether the issues raised are by the same individual on each ward.

The Board is assured that the Trust continues to maintain full registration with the CQC with no conditions.

ARE OUR SERVICES SAFE?

Are lessons learned and improvements made when things go wrong?

5.1 Patient Safety

The Committee discussed the Patient Safety Group reports from July 2018 and August 2018.

The key matters highlighted were:

- The Group has agreed a template for serious incident fractured neck of femur reports which will be trialled over a six month period.
- There have been issues regarding the Aligned Professional Service (APS) raised as a result of Serious Incident Reviews and this is being picked up by the Locality Manager.
- Work will be taken forward on guidance for NHS Trusts working with bereaved families from the National Quality Board.
- Assurance was provided that following a report by the Healthcare Safety Investigation Board – an investigation into the transition from child and adolescent mental health services to adult MH services, the findings which apply to the Trust will be followed up, including an RPIW.

The Committee received assurance on the Patient Safety Quality Reports for May 2018 and June 2018 and key matters highlighted were:

- There were five SI's reported in May and 15 in June 2018.
- There is work underway to look at the statistical data of SI's in more detail to check for repeated root causes and contributory factors.
  The Committee requested for further assurance that future reporting around SI's in the Patient Safety Report include for audit trail purposes any SI's previously raised that are still being progressed.
- There remains and ongoing risk around establishing processes in the absence of clear national guidance for MH providers on mortality reviews.
  The Committee sought assurance that all 18 deaths in June 2018 were reviewed even though only the cause of death was established for three and it was clarified that the Trust reviews all deaths regardless of the cause. It was noted that some deaths are difficult to categorise and assign a level of review to due to delays on cause of death from the coroners.

There are no significant risks to escalate to the Board.

5.2 The Trust Criteria for the location of emergency response bags in community units and the placing of automated defibrillators (AEDs) into non-patient areas.

The Committee discussed the above matters.

- The location of emergency response bags in community units has been discussed at Operational Management Forum and EMT and it was proposed that those community units with a Clozapine clinic or those who administer antipsychotic drugs to patients should have an emergency response bag in the clinic. All other bags could be removed. Staff working in the community setting will be expected to undertake CPR training and in those settings with access to an emergency equipment bag BLS training.

The Committee agreed to this proposal.

The Board can be assured that the standardisation of emergency response bags in the community and related training will not introduce any new risks and will ensure that the Trust has a consistent and defensible approach to ensure we maintain a level of competence appropriate to an individual's employed role.

- The proposal that stand alone AEDs will be made available in non-clinical areas for community teams when there are no emergency response bags. In numbers this will be around 80 to 90 defibrillators; however the Trust currently already has approximately 40 machines.

The Committee agreed that this option and costing should be developed further and taken to EMT for ratification.

5.3 How do we ensure the safe and appropriate use of medicines?

5.3.1 Drug and Therapeutics Report

The Committee considered the Drug and Therapeutics Report for July 2018

The key matters raised were:

- The launch of a bi-monthly assessment by pharmacists on in-patient units to focus on rapid tranquilisation, covert administration, unlicensed medicines and Lithium.
- The agreement by the Drug and Therapeutics Committee to remove Flumazenil on the Wards, where it has not been used for many years with the safest approach to be adopted to ring (9)999.
- A business case will be produced to look at the options around the pharmacy supply contract which expires at the end of October 2019.
- The development of a section on the pharmacy intranet page for Patient Decision Aids, which will signpost to nationally available mental health related aids.

Committee members welcomed the one sided concise update with the key matters highlighted.

5.4 How are standards of cleanliness and hygiene maintained? Are there reliable systems in place to prevent and protect people from health care associated infection?

5.4.1 Infection, Prevention and Control Report

The Committee noted the Infection, Prevention and Control Report for Quarter 1.

The Board is asked to note that the main risks are concerning the cleaning scores from the National Standards of Cleanliness audits undertaken by Hotel Services. There is an escalation process in place which will be monitored in localities by Matrons and Heads of Service and through QuAGs. A number of actions have been put in place and Hotel services are reviewing the scores in Q2 2018 and an action plan will be discussed at the next meeting of the IPCC.

5.5 How do systems, processes and practices keep people safe and safeguarded from abuse?

5.5.1 Safeguarding and Public Protection

The Committee noted the exception report and the annual report for Safeguarding and Public Protection.

The Committee discussed the higher numbers of external CQC inspections including the recent Joint Targeted Area Inspections and serious case reviews in the Durham locality. There were no themes for the SCR's and no known reason for this. There has also been increasing demand for inter-agency working and competing priorities for the safeguarding team with an increase in the number of cases coming through for consideration.

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

ARE OUR SERVICES RESPONSIVE?

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

6.1 Patient Experience

The Committee received the Patient Experience Report:

The key matters highlighted were:

- Issues with the meridian feedback system for the completion of surveys in teams and roll out into the community with problems for staff trying to use the mobile phone app.
- That service user and Governor representation at the Patient Experience Group over the last few months has been limited following the resignation of the appointed Governors and difficulty in securing a new appointee. There was however a wish to have a stronger presence and representation at the Group by service users and carers and this will be taken forward at the next meeting.

The Board is asked to note that robust systems are in place for monitoring patient and carer feedback and when problems are identified, actions are being taken to make improvements.

ARE OUR SERVICES EFFECTIVE?

7. Does people's care, treatment and support achieve good outcomes, promote a good quality of life and is it based on the best available evidence?

7.1 Clinical Audit and Effectiveness

The Committee considered the Clinical Audit and Effectiveness progress report for Quarter 1.

Committee members discussed the issue highlighted for escalation to QuAC where clinical outcome measures continue to indicate significant variation between teams and across Specialties and Directorates. This is due to variation in completion rates with little confidence when looking at the results of one team against another. Work will be undertaken to further support the improvement around clinical practice and ensure consistent engagement with SDG's.

The Board is asked to note that the Clinical Effectiveness Group continues to monitor clinical audit and effectiveness programmes undertaken across the Trust and that assurance is provided on the completion status of clinical audits for Quarter 1.

8. How much progress has the Trust made in implementing the improvement priorities contained in its Quality Account?

8.1 Quality Account Quarter 1 Progress Report

The Committee received the Quarter 1 Progress Report.

In addition to the report it was noted that there will be a national NHSI programme to look at reducing restrictive practice and three Wards at West Lane have been put forward hopefully for inclusion in this work.

The Board is asked to note that the four key quality priorities for 2018/19 are largely on track for delivery and two out of nine of the Quality Metrics are reporting as green. There has been no significant deterioration from the previous year.

9. Are we achieving our Quality Metric Targets?

9.1 Consideration of quality priorities from Quality Account Stakeholder event for Trust Business Plan 2019/20.

The Committee considered the quality priorities from the Quality Stakeholder Event held on 10 July 2018 and the suggestions put forward for future quality improvement priorities.

The key areas that members drew attention to were:

- That the existing four Trust quality account improvement priorities should be considered by the Board Planning Workshop on 2nd and 3rd October 2018 for inclusion in the next Quality Account, unless there is assurance that work on the current priorities will be complete by March 2019.
- Crisis and "pre-crisis" services should be recommended to the Board workshop as a possible priority.
- That improved consistency of care co-ordination is suggested as a further potential priority for 2019/20; however this could possibly be subsumed into the care planning improvement priority or a different priority within the Trust Business Plan.
- That further consideration be given to improved reporting around the impact that the quality improvement priorities are having.

5.6 **Exceptions to report to the Board**

There are no exceptions to report to the Board.

6. IMPLICATIONS

6.1 Quality

One of the key objectives within the QuAC terms of reference is to provide assurance to the Board of Directors that the organisation is discharging its duty of quality in compliance with section 18 of the Health Act 1999. This is evidenced by the quality assurance and exception reports provided, with key priorities for development and actions around any risks clearly defined.

6.2 Financial/value for money

There were no direct financial implications arising from the agenda items discussed.

6.3 Legal and Constitutional (including the NHS Constitution)

The terms of reference, reviewed annually, outline compliance requirements that are addressed by the Quality Assurance Committee.

6.4 Equality and Diversity

There are no issues to note.

7. CONCLUSIONS

The Quality Assurance Committee considered the corporate assurance and performance reports during the informal meeting. The Committee were assured that as far as practicable, all risks highlighted were being either managed or addressed with proposed mitigation plans.

8. RECOMMENDATIONS

That the Board of Directors is asked to:

(i) Note the issues raised at the Quality Assurance Committee meeting on 06 September 2018.
(ii) Note the confirmed minutes of the meeting held on 05 July 2018.

Elizabeth Moody
Director of Nursing and Governance
September 2018

Annex 1

NOTES OF THE FORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 5 JULY 2018, IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mrs Elizabeth Moody, Director of Nursing & Governance
Mr Richard Simpson, Non-Executive Director
Mrs Shirley Richardson, Non-Executive Director
Dr Ahmad Khouja, Medical Director
Mrs Jennifer Illingworth, Director of Quality Governance

In attendance:
Dr Suresh Babu, Clinical Director, Durham and Darlington
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mr Levi Buckley, Director of Operations, Forensic Services
Mrs Karen Atkinson, Head of Nursing, Durham and Darlington
Mr Mac Williams JP, Public Governor, Durham
Mrs Ruth Hill, Director of Operations York and Selby
Mr Carl Bashford on behalf of Mr Patrick Scott, Director of Operations, Durham and Darlington
Mr John Savage, Head of Nursing, Durham and Darlington
Dr Jose Mediavilla, Consultant Psychiatrist
Mrs Rachel Weddle, Head of Nursing, Forensic Services

18/88 APOLOGIES FOR ABSENCE

Apologies for absence were received from: Mrs Lesley Bessant, Chairman of the Trust, Mr Patrick Scott, Director of Operations, Durham and Darlington, Mr Colin Martin, Chief Executive, Mrs Karen Agar, Associate Director of Nursing and Mr David Brown, Acting Chief Operating Officer.

18/89 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 07 June 2018 were agreed as true and correct.

18/90 ACTION LOG

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

18/64 Some work to be facilitated around the high numbers of the use of rapid tranquilisation in CAMHS.
This matter was covered under agenda item number 10 (minute 18/98)

18/75 Tees LMGB report: occasional reports of Blik alarms not working.
This matter would be brought back to the October 2018 QuAC meeting.

18/76 Appendices from the Patient Safety Group (NHSI Patient Safety Alert and How to understand and improve your patient safety incident reporting and learning system) to be reported back to the July QuAC meeting for further consideration.
This matter was covered under agenda item numbers 8 and 9 (minute 1897)

Completed

18/91 FORENSIC SERVICES LMGB REPORT

The Committee received and noted the Forensic Services LMGB Report.

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

(1) Cancelled leave, which had varied over March and April 2018 due to the inclement weather and staffing pressures. This had been monitored in daily huddles and improvements had been seen in recent months.
(2) The rising levels of obesity of patients in Forensic services with 86% of the forensic population found to be overweight or obese. A second Kaizen event had been held and various initiatives had been introduced on the wards.
On this matter it was noted that there were also some patients with type II diabetes and these long term conditions would be managed with regular monitoring along with Pharmacy for the appropriate medication.
(3) Triangle of Care – where the National Secure Carers toolkit has been recently launched which included good practice from TEWV Forensic Services. This would continue to be developed to support carers.

In addition to the report Mr Buckley drew attention to an SDG Thematic Report of Engagement and Observation, 17 May 2018. This piece of work would feed into the RPIW planned for October 2018 also the Trust wide work.

18/92 DURHAM AND DARLINGTON SERVICES LMGB REPORT

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

Arising from the report it was noted that the top concerns at present were:

(1) Out of locality bed pressures with growing concerns around staff morale and job satisfaction.
(2) Bed management over the weekends – with an increase of 34% admissions across Lanchester Road and West Park in May 2018. A Kaizen event had been planned.
(3) Utilising the segregation policy in Adult Learning Disabilities – a patient was currently being managed in inpatients from York who had transferred from PICU and they had caused extensive damage to the physical environment and upset patients. As a result Ramsey Ward had been opened to accommodate this individual.

Following discussion it was noted that:

(1) There was uncertainty over the status of the Crisis House and whether it was open to patients. Mr Bashford undertook to ascertain whether it was open or closed and an email would be sent to the Committee.

Action: Mr C Bashford/Mr P Scott

(2) The risk register for the locality regarding medical staffing had been scored at 20 however it was felt that this risk should be aligned to the Board of Directors risk register which was 35.

Action: Mr P Scott

18/93 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Report for the period 1 to 30 April 2018, including appendices on:

(i) Information on reflections from recent serious incidents Directors panels – June 2018;

(ii) Risks associated with the use of illicit substances in inpatient settings;
(iii) An example of intoxication test in MH assessment.

Assurance was provided to the Committee that the Patient Safety Group had reviewed all relevant Trust Patient Safety activities in line with the Group's terms of reference. Any issues had been documented and were being progressed by the appropriate leads.

Following discussion it was noted that there was an error on page 3 of the report, 1.2, summary performance where the arrows were incorrect. Mrs Illingworth undertook to amend the information.

Action: Mrs J Illingworth

18/94 SAFEGUARDING & PUBLIC PROTECTION REPORT

The Committee received and noted the Exception Report for Safeguarding and Public Protection.

Arising from the report it was noted that:

(1) A joint targeted inspection (JTAI) would commence in Durham on 10 July 2018 on domestic abuse. This would involve preparation for multi-agency case file audits with practitioners and managers and practitioner focus groups to follow the journey of a child through services.

Mrs Moody agreed to circulate a briefing paper on this matter outside the meeting.

Action: Mrs E Moody

(2) Risks continued around not meeting the agreed trajectories for Safeguarding Children Level 3 training, which although improving, could lead to contractual penalties if the 98% target was not met.

Assurance was provided that the Trust was meeting its legal requirements for safeguarding adults and children within the current legislative framework.

18/95 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee received and noted the Compliance with CQC Registration Requirements Report.

Arising from the report it was noted that:

(1) The letters of feedback received from the CQC regarding each core service had been mostly positive.
(2) The well led inspection would commence on the 23 July 2018, a briefing pack had been sent round to the relevant people and mock interviews would take place before this to assist people with their preparations.

Committee members expressed their concerns about the need to keep up the momentum of improvement following the well led inspection and assurance was provided that there were now more robust processes in place to ensure this happens.

18/96 NHSI: PATIENT SAFETY ALERT: RESOURCES TO SUPPORT THE SAFE ADOPTION OF THE REVISED EARLY WARNING SCORE (NEWS2)

The Committee received and noted the NHSI patient safety alert.
Mrs Illingworth highlighted that:

(1) The Patient Safety Alert had been presented to the QuAC at its meeting held on 7 June 2018 as an appendix to the Patient Safety Report and it had been agreed to discuss it further at the July 2018 QuAC meeting.
(2) The Alert had been released for the attention of all acute and ambulance Trusts, however TEWV had recognised the benefits of mirroring the work.
(3) Consideration had been given to actions for the Trust to take forward in response to the Alert and these would be followed up by Physical Health and Wellbeing Group.

The Committee welcomed the approach by the Trust and were impressed by the proactive work and actions including the update to the Trust Early Warning Score recording chart.

18/97 NHSI: HOW TO UNDERSTAND AND IMPROVE PATIENT SAFETY INCIDENT REPORTING TO THE NATIONAL REPORTING AND LEARNING SYSTEM

The Committee received and noted the NHSI publication.

Mrs Illingworth highlighted that:

(1) The NHS Improvement publication was intended to be used by the Trust to better understand incidents that are reported to NRLS.
(2) The publication had been presented to the QuAC at its meeting held on 7 June 2018 (minute 18/76 refers) as an appendix to the Patient Safety Report and it had been agreed to discuss it further at the July 2018 QuAC meeting.
(3) The Trust had been positively highlighted as having a good reporting culture for reporting incidents as evidenced by the significant increase.

18/98 RESTRAINT AND PHYSICAL INTERVENTIONS IN CAMHS TIER 4 SERVICES

The Committee received a presentation on Restraint and Physical Interventions in CAMHS Tier 4 services.

Dr Mediavilla concluded the presentation by noting the support needed for the development of a standard discharge agreement with EDOP teams, further improvements around inpatient transitions from CYPS to AMH and support and the development of a protocol for the management of nasogastric feeding in younger people.

Following discussion members noted their ongoing concerns around the complexity of restraint and physical interventions and the increase in the use of rapid tranquilisation and agreed that this matter be discussed further at a future Board Seminar.

Action: Mrs L Bessant/Mr P Bellas

18/99 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no matters of exception to note.

18/100 ANY MATTERS DISCUSSED TO BE ESCALATED TO THE BOARD OF DIRECTORS THAT MIGHT IMPACT ON THE TRUST'S STRATEGIC OR KEY OPERATIONAL RISKS.

The Committee noted that there were no issues that could impact on the Trust's risks.

18/101 ANY OTHER BUSINESS

There was no other business to discuss.

18/102 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 06 September 2018, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

The meeting concluded at 4.30pm

……..

Safe Staffing – August 2018

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

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

Safe Staffing Fill Rates August 2018

- The number of rosters equated to 69 inpatient wards in August.
- The highest number of red fill rate indicators relate to Registered Nurses on day shifts. This equated to 23 in August 2018, an increase of 5 when compared to July 2018.
- The top 3 inpatient areas where a low staffing fill rate has been reported are:
  - The Lodge – 38.7% HCA on Nights; 60.1% HCA on Days; and 80.9% RN on Days – the shortfall is in relation to a private provider who is working into the Lodge as part of the transition.
  - The Orchards (NY) – 52.5% RN on Nights; 79.5% RN on Days – the shortfall is in relation to a reduction in the number of RN's required to work which has still not been reflected on HealthRoster.
  - Springwood – 62.2% RN's on Days – the shortfall is in relation to 3 RN's on long term sickness as well as a vacancy.
- There were 69 fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues.
- The top 3 inpatient areas where a high staffing fill rate has been reported are:
  - Holly Unit – 250.8% RN on Days; 197.8% HCA on Days; 123.1% RN on Nights; and 215.4% HCA on Nights – the increase is due to the school holidays and more staff needing to be on duty to support this.
  - Westerdale South – 235.6% HCA on Days; 225.8% HCA on Nights; and 125.8% RN on Nights – the increase in staffing was necessary to cover 6 enhanced observations. RN on nights, the roster template does not reflect budget template.
  - Oakwood – 221.4% HCA on Days – additional staffing was to support leave and attendance at activities. Roster review has been scheduled to take place in October 2018.

Bank Usage:

- The bank usage across the trust equated to 17.5% in August, an increase of 1.1% when compared to July.
- There were no wards reporting 50% bank usage in August.
- Northdale Centre reported the highest bank usage at 38.5% of the actual hours worked. Enhanced observations were the highest reason given (111 shifts).
- There were 11 wards that reported greater than 25% bank usage.

Agency Usage:

- The agency usage across the trust equated to 7.2% in August, an increase of 0.7% when compared to July.
- Cedar Ward (NY) reported the highest equating to approximately 56.5% of the total hours worked. Vacancies were cited as the highest reason for this (129 shifts). The ward is using regular agency where possible as there is limited availability of bank nurses within the North Yorkshire and York and Selby locality.
- Those wards reporting 4% or more agency usage in August equated to 23 wards.
- In July the WTE for Nursing has increased significantly for Band 2 HCAs month on month and now sits at an average of 66 since inception, an increase of 2.44 on last month. Band 5 WTE remains consistent at an average of 15.40.
- There is an average monthly spend of 260k on agency usage from July, an increase of £12K from June. Overall spend now sits at £2.60m. HCA contributes to 75% of the overall spend.

Produced: 17th August 2018

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

- All agency shifts in the period have been at cap with no breaches recorded.
- In July, Acomb Garth has now been surpassed by Meadowfields as the largest user of Agency, following a spike in usage in June and July.
- Other areas with high demand include Cedar Ward (NY), Cherry Tree House, Ebor, Oak Rise, Rowan Lea, Rowan Ward, Springwood, The Evergreen Centre, Ward 15 and Westerdale North and South.
- Areas with lowest fulfilment are Cedar Ward (D&D), Esk Ward, Elm Ward, Kilton View, Langley, Newberry Centre, Oak ward and Willow Ward. These are areas with fewer requests than other areas with larger fulfilment.

Quality Data:

- There were 3 Serious Incident's that were reviewed at Directors Panel in August citing concerns with regards to staffing:
  - There are a number of staff vacancies. The use of flexible staffing was shown on occasions to impact on the completion and quality of documentation. Attempts continue to be made to recruit to vacant positions. Block booking of temporary staff wherever possible for the purpose of consistency is being progressed.
  - It had been highlighted that there had been some challenges in relation to staffing on the day of the incident. Staffing was reduced at short notice due to unplanned leave and an agency staff did not turn up for shift. The ward was described as being exceptionally busy with fifteen patients on the ward, some of whom were unsettled and required the staff to be especially vigilant due to their potential for behaviours that challenge.
  - Wait time for Step 3 treatment was longer than normal at that time due to staffing issues; the service were waiting for a CBT therapist to join the team; starting date was 04/01/2018.
  - None of the SI's identified above had a root cause or contributory finding in relation to staffing.
- There were no complaints raised in August 2018 citing concerns with regards to staffing levels however there was 1 complaint raised citing staff attitude.

Missed Breaks:

- There were 334 shifts in August where an unpaid break had not been taken. This is a reduction of 58 when compared to July 2018.
- The majority of the shifts where breaks were not taken occurred on day shifts (249 shifts). The number of night shifts where breaks were not taken equated to 85 shifts in August 2018.
- This information is being monitored daily as part of the operational services huddle process.

Incidents Raised Citing Staffing Levels:

- There were 36 incidents reported in August 2018 citing issues with staffing.
- Issues reported were as follows:
  - Staff and patient safety compromised
  - Observations not carried out
  - Only 1 member of staff left on duty
  - Unable to respond to alarms from other wards in difficulty
  - Unable to contact on call doctor

Severity Rating:

- Using a severity rating scale to identify potential outliers, the top 5 is as follows:
  - Bedale Ward – 10 points awarded
  - Acomb Garth – 8 points awarded
  - Hamsterley Ward – 8 points awarded
  - The Lodge – 7 points awarded
  - The Evergreen Centre – 7 points awarded
  - Harland – 7 points awarded
  - Ward 15 – 7 points awarded
  - Kestrel/Kite – 7 points awarded
- Using the YTD score (Aug 17 to Aug 18) the following appear in the top 5:
  - Cedar (D&D) – 102 points awarded
  - Westerdale South – 98 points awarded
  - Bedale Ward – 96 points awarded
  - Evergreen Centre – 91 points awarded
  - Clover/Ivy – 81 points awarded

Care Hours per Patient Day:

- This metric tracks the total number of direct nursing care hours compared to the number of patients as a count at midnight.
- Reporting of AHP's CHPPD data will commence in October 2018 and will be reported alongside our current fill rate and nursing CHPPD.
- CHPPD overall rating for August is reporting at 12.51 (4.42 registered nurses and 8.1 unregistered nurses) this is an increase of 2.31 when compared to July.

Key links to documents & guidelines:

Monthly and Daily Staffing Report –August 2018

NQB Guidance July 2016

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

- Using standard deviation (Aug 17 to Aug 18) the following appear as positive outliers:
  - Bankfields Court – registered nurses
  - Jay Ward – registered nurses
  - Westerdale South – unregistered nurses
- Oakwood appear negatively under the lower bracket for unregistered nurses.
- A local quality dashboard will be developed as part of the Right Staffing Programme which will enhance this data.

Conclusion:

- The Trust continues to comply with the requirements of NHS England and the CQC in relation to the Hard Truths commitments.
- The operational risks identified have been managed and mitigated at service level. Strategic risks are being addressed through the implementation of the Right Staffing programme and related workstreams.

Key links to documents & guidelines:

Monthly and Daily Staffing Report –August 2018

NQB Guidance July 2016

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

ITEM NO 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 25 September 2018**
TITLE:	**Report of the Mental Health Legislation Committee**
REPORT OF:	**Richard Simpson, Non-Executive Director**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 1, 2018-19.

- **Key areas for consideration:**
- Report on Discharges from Detention, use of Section 136, Section 15 – medical scrutiny element.
- Review of the scheme of delegation in relation to assurance to the Committee
- Seclusion activity report
- CQC MHA specific inspections summary report
- Example of Section 18 report.
- Code of Practice Policy Schedule
- Report on MCA and DoLS update and activity
- Draft Annual Schedule of Reports to MHLC
- Patient case study

Recommendations:

The Board of Directors is asked to receive and note the assurance report, following the MHLC meeting held on 12 July 2018 and to note the approved minutes of the MHLC meeting held on 19 April 2018. (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 25 September 2018**
TITLE:	**Report of the Mental Health Legislation Committee**

1. INTRODUCTION & PURPOSE:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for Quarter 1, 2018-19; through consideration of the work of the Mental Health Legislation Committee at its meeting held on 12 July 2018.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

The confirmed minutes of the Mental Health Legislation Committee held on 19 April 2018 are attached as Annex 1.

The MHLC also met on 12 July 2018. The key issues considered at this meeting were as follows:

COMPLIANCE WITH MHA PROCESSES

3.1 Discharges from Detention

The Committee considered the Discharges report.

- In Quarter 1 there were 142 Associate Hospital Managers reviews held which resulted in one patient being discharged from a CTO. This was against the recommendation of the Community RC and Care Coordinator.

- The total number of Mental Health Tribunals held in Quarter 1 was 128, of the MHTs held, seven resulted in discharge from section 2, two patients from section 3 and one patient discharged from a CTO.

The Committee was assured that there continues to be comprehensive reports and clear evidence for the reasons in recommending continued detention/community treatment, despite there being occasions when the Tribunal disagrees with the clinical team and proceeds to discharge the patient. This however continues to be in a minority of cases.

3.2 Section 136 Report

The Committee considered data and trends around s136.

- There were 189 uses of s136 across the Trust compared to 180 in the previous quarter. There have been increases for North Yorkshire (99 to 110) and Cleveland (34 to 42).

- Of those, 47 people were formally detained and 21 accepted informal admission. 87 were followed up in the community and 34 returned to the community without follow up.

- The overall use of section 136 across the Trust has shown a TEWV place of safety (PoS) being used as the optimum choice with police stations only being used five times across the whole Trust area in the last two quarters.

  The Committee requested further explanatory narrative in future reports where police stations are used as a place of safety.

- There were 13 individuals under the age of 18 years of age held under section 136, all aged between 14 and 17, one was held on a 136 twice in the quarter and another four times, both are open to services.

3.3 **Example of Section 18 Report – Return of Patients Absent without Leave.**

The Committee were provided with a previous example of a report regarding Section 18: Absent without leave for consideration.

The Committee agreed that this matter, which has previously been raised by the Council of Governors, will be reported and discussed at future MHLC meetings from January 2019. The report will include figures in relation to detained patients and trends across the various localities.

COMPLIANCE WITH KEY CODE OF PRACTICE REQUIREMENTS

3.5 **Seclusion Report**

The Committee discussed the seclusion report.

- In Q1 there were 82 episodes of seclusion with multiple episodes for 13 patients. Of the 82 episodes, 29 were less than 24 hours, of which 15 were under 12 hours.
- It was noted that the revised Seclusion Policy, currently out for consultation will be taken to the 18 October 2018 Mental Health Legislation Committee meeting.

The Board can be assured that there are no exceptions to note.

3.6 **CQC MHA Visits Feedback Summary Report**

The Committee were provided with a verbal update on the CQC MHA Visits Feedback with no exceptions to be raised to the Board.

The key matter to note is some work that will take place on the reporting of CQC MHA visits and how this will feature on the MHLC agenda in future. This will evolve over the next few meetings.

3.7 **Code of Practice Policy Schedule**

The Committee received a verbal update and assurance that all policies have been reviewed to ensure compliance against the Code of Practice and are within date.

The Board is to note that future policies will be presented to the MHL Committee when required and this will be done in liaison with the Trust Policy Manager.

EFFECTIVE IMPLEMENTATION OF THE MCA AND DOLS

3.9 Mental Capacity Act and DoLS Report

The Committee noted the quarterly update report on the key issues with regards to the effective implementation of the Mental Capacity Act within the Trust and the use of DoLS.

The key matters discussed were:

- The TEWV Deprivation of Liberty Safeguards data is now being captured electronically.
- Mental Capacity Act training will now be mandatory for staff of all disciplines and will be provided via e-learning and some face to face training and the MCA policy has been updated.
- Paper recording has been replaced by forms MCA 1 and MCA2 being uploaded onto Paris and have been well received by staff.
- In terms of DoLS activity, in Q1 there were 49 active cases.

KEY GOVERNANCE INFORMATION

4.0 Draft Annual Schedule of Reports to MHLC

The Committee approved the Annual Schedule of Reports.

The Board is asked to note that following a discussion around emergency treatment for detained patients and the responsible clinician that the Medical Director would initiate further discussion around the process for SOADs and that a report will be provided to the October MHLC meeting.

4.1 Revised Procedures

The Committee approved the following procedures:

(i) Independent Mental Health Advocacy (IMHA)
(ii) Section 132/132A MHA – providing information to patients and patients' nearest relatives
(iii) Patients' correspondence – section 134 Mental Health Act 1983

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

5.0 Case Study

The Committee noted a case study in relation to an individual taken to a Police station on Section 136 in March 2018 due to Scarborough and York places of safety being full.

The Committee was given assurance that the patient had been detained appropriately.

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

There were no concerns at present, however the progress with MHA information being made available on IIC would be pursued.

6.0 IMPLICATIONS:

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

CQC MHA visit reports do not indicate any significant issues with regard to compliance with the Fundamental Standards in terms of the MHA and MCA.

6.2 **Financial/Value for Money:**

There are no implications.

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

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

6.4 **Equality and Diversity:**

There are no implications.

7. CONCLUSIONS:

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

8. RECOMMENDATIONS:

The Board of Directors is asked to:

(i) Receive and note this report including the confirmed minutes of the meeting of the MHLC held on 19 April 2018.

Richard Simpson
Chairman of the Committee
25 September 2018

Background Papers:
Annex 1 – Confirmed minutes of the 19 April 2018 MHL Committee Meeting

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 19 APRIL 2018 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM.

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

In Attendance:
Mrs D Oliver, Deputy Trust Secretary, (Corporate)
Miss M Wilkinson, Head of Mental Health Legislation
Ms Hazel Griffiths, Public Governor, Harrogate and Wetherby
Mrs J Ramsey, Mental Health Team Manager

Apologies: Apologies for absence were received from Mrs L Bessant, Chairman of the Trust,
Ms S Talbot-Landon, Governor and Mrs R Down, Mental Health Legislation Advisor (MCA Lead).

18/15 REVISED AGENDA

The Chairman noted that the agenda for the meeting had been revised, framed around high quality questions and included some new reports for consideration.

Following discussion members welcomed the new style of the agenda and newly added reports that provided a higher level of assurance around compliance with the Mental Health Act and Code of Practice.

18/16 MINUTES OF LAST MEETING

Agreed – *That the minutes of the last meeting held on 26 February 2018 be approved as a correct record and signed by the Chairman.*

18/16 ACTION LOG

The Committee noted the actions and following updates:

17/33 Benchmarking – talk to NTW about seclusions.
It was noted that following correspondence to NTW via email no response had been received. This would be deferred to the July 2018 MHLC meeting when an update would be provided.

17/34 Formal feedback as part of CQC report in six months to show progress on repeated themes raised in MHA inspections.
This matter was covered under agenda item number 5b (minute 18/23)
Completed

18/03 Provide data in seclusion report showing comparison with same time in previous year.
This matter was covered under agenda item number 5a (minute 18/22)
Completed

18/05 Investigate the case of the patient that spent 18 hours in a S136 suite to understand reasons for the delay of the Doctor from the crisis team.
This matter was covered under agenda item number 4b (minute 18/19)

Completed

18/06 Discussion at SDMs and SDGs around the importance of completion of formal capacity assessments to be on an MCA1 form.
This action had been picked up through e-learning and through policy and the message had started to be cascaded through to Clinical Leaders and would also go to Medical staff.

Completed

18/11 Revised scheme of delegation to be reviewed before going to the Board of Directors.
This matter was covered under agenda item number 4d (minute 18/21)

Completed

18/13 Set out a one page summary of issues with AMPs sourcing doctors for assessments leading to delays. These issues to be raised at Director of Ops meeting and LMGBs.
An update on this matter would be provided to the July 2018 MHLC meeting.

18/14 Bring back report on Trust response to Government request for feedback on Mental Health Act review following Governor feedback session.
This item was covered under agenda item number 9a, (minute 18/29)

Completed

18/18 MHA DISCHARGES REPORT

The Committee considered and noted the MHA Discharges Report.

The following was highlighted from the report:

(1) In Quarter 4 there were 156 Associate Hospital Manager reviews held which resulted in two patients being discharged from the MHA. One patient was discharged from section three where the panel did not feel the patient was likely to be dangerous and one from a Community Treatment Order (CTO).

(2) The total number of Mental Health Tribunals held in Quarter 4 was 117, of the MHTs held, seven resulted in discharge, four from section two, one on section three, one conditional discharge and one discharged from a CTO.

Following discussion the Committee considered whether the Trust could adequately demonstrate compliance with the MHA processes for the MH tribunals held.

Ms Wilkinson noted that the number of tribunals for the Trust was higher than other Mental Health Trusts nationally which provided assurance on safeguarding patients and that patients were exercising their rights. It was agreed that this would be factored into future Discharge Reports as an assurance statement.

Action: Mrs J Ramsey

The Committee was assured that there were no trends identified in relation to RC or team where a MHT had discharged contrary to the clinical view.

18/19 SECTION 136 REPORT

The Committee received and noted the Section 136 report.

The following was highlighted from the report:

- There had been 180 uses of s136 across the Trust compared to 153 in the previous quarter. There had been increases for York (34 to 48) and Durham (16 to 34). Of those, 46 people were formally detained and 24 accepted informal admissions (compared to 16 in the last quarter).

The Committee requested some further consideration of the reasons for the increase of Section 136 use at the Operational Group meeting for York and North Yorkshire. The next meeting was due to be held in May 2018 and Mr Brown undertook to ensure that there would be appropriate Trust operational representation at the meeting.

Action: Mr D Brown

- There were three people taken to a police place of safety (POS), one of which was due to the fact that both Scarborough and York PoS was full. This individual would be the focus for the case study to be provided to the 12 July 2018 MHLC meeting.

Action: Mrs E Moody

The Committee requested that further clarification on the escalation processes relating to Section136 arrangements would be included in future reports on individuals waiting more than 12 hours to gain more understanding around the issues, such as patient not fit to be assessed, bed availability and/or waiting for a Doctor.

Action: Mrs J Ramsey

- There had been eight individuals under the age of 18 years of age held under section 136, all aged 16, one lasting for just over 20 hours due to being too unwell to be assessed as they had taken an overdose.

The Committee was assured that this time period included treatment at an Acute Hospital.

18/20 SECTION 15 MHA 1983 – MEDICAL SCRUTINY ELEMENT

The Committee received and noted a new report on Section 15 MHA 1983 – Medical Scrutiny.

The purpose of the report was to consider whether the Committee would receive information going forward to demonstrate compliance with the requirements of Section 15 of the Mental Health Act.

In introducing the report Ms Wilkinson highlighted:

(1) Section 15 of the MHA was applicable to rectification of recommendations and applications of detention documents and it was standard practice for both administrative and medical to ensure that all statutory documents that supported admission under the MHA were scrutinised.
(2) There were anonymous rotas in place for medically approved clinicians to undertake robust scrutiny in order to prevent challenges being made directly to the scrutineer if a medical recommendation failed.
(3) The MHL team through experience were able to identify “good” or “poor” medical recommendations and when medical scrutiny had not occurred they would contact the scrutineer to prompt action or identify a further available scrutineer.

Following discussion members considered that a future annual report on Medical Scrutiny would provide assurance to the Committee around compliance with Section 15, with an exception report of any failings to be presented to the MHL Committee if required. Also that this would be shared with the medical workforce by a presentation on the process to escalate by exception by a Senior Clinican to the Senior Medical Staff Committee.

Action: Ms M Wilkinson

Agreed:

(i) *That a report on Section 15 MHA Medical Scrutiny be provided to the MHL Committee on an annual basis;*
(ii) That any failings be reported to the MHL Committee on an exception basis;
(iii) That a presentation be given to the Senior Medical Staff Committee around the process to escalate by exception for a senior clinician to overrule medical scrutiny.

18/20 SCHEME OF DELEGATION IN RELATION TO THE RECEIPT OF ASSURANCE REPORTS BY THE MHLC

The Committee considered and reviewed the Scheme of Delegation in respect of the MHA 1983, in accordance with its terms of reference.

In introducing the report it was highlighted that:

(1) The Scheme of Delegation set out various functions, set against the statutory reference of the MHA and the authorised person/s responsible.
(2) The Scheme of Delegation, following review by the MHL Committee would be approved by the Board of Directors at its meeting to be held on 22 May 2018.

Members considered the Scheme of Delegation against the current reporting arrangements and levels of assurance to the MHL Committee and acknowledged that there were further areas of information that should be brought to the Committee. This would improve scrutiny by answering the high quality question, "How does the Trust demonstrate compliance with MHA processes?"

In addition Members discussed:

(1) The CQC (MHA) visit feedback report that was presented both at MHL Committee and the Quality Assurance Committee and that for future MHLC agendas in order to provide levels of assurance in relation to the high quality questions, that it would be useful to separate out the various elements of the CQC report and factor the relevant parts of information under the new headings of the agenda.

    Mrs Illingworth undertook to separate the information from the CQC (MHA) Visit Feedback report to be placed on the agenda under the relevant high quality headings/questions.

    Action: Mrs J Illingworth

(2) A query regarding patients' rights an explanation was provided and assurance that this would be moving to recording on Paris shortly rather than paper.

Agreed:

That reports on the following functions aligned to the MHA and Code of Practice would be presented to the MHL Committee to provide further levels of assurance and that the annual schedule of reporting to the MHL Committee would be updated accordingly:

Action: Ms D Oliver

(i) Annual report on:
- *Section 23 (2) Receipt of nearest relative order for discharge showing annual activity.*

(ii) Six monthly reports on:
- *Section 5 (2) Receipt of documents in respect of holding powers – staff authorising inpatient detention for up to 72 hours.*

- *Section 5 (4) Record of hospital inpatient - power to detain an inpatient for a maximum of six hours.*

(iii) Quarterly report on:

- *Section 132 Information to patients – duty of hospital managers to give information to detained patients.*

(iv) Future report on:

- *Section 18: return of patients absent without leave.*

Recommended: *to the Board of Directors that the Scheme of Delegation in relation to the MHA and Code of Practice be ratified.*

18/22 SECLUSION REPORT

The Committee considered and noted the Seclusion Report.

The following was highlighted:

(1) In Q4 there had been 83 episodes of seclusion with multiple episodes for 15 patients. Of the 83, 39 were less than 24 hours, of which 24 were under 12 hours.

(2) An exception had been reported regarding a patient in their bedroom due to the lack of a seclusion room; efforts were made to move the patient to PICU however this was refused by staff as the patient was not detained under section 2 or section 3 (the patient was sectioned under Section 5(2)). The seclusion lasted just over 3 hours.

(3) An exception had been reported where staff used "flexible seclusion" for a time for a patient who had been in seclusion for some weeks. The plan had been that if the patient demonstrated settled behaviour for a 24 hour period they would be allowed out of seclusion but with the option to return them if needed. The patient came out of seclusion and commenced "flexible seclusion" on 6 April 2018. No returns to seclusion recorded which ended on 09 April 2018.

Assurance was provided that robust reporting mechanisms were in place for the escalation of prolonged periods of seclusion and there would be further work undertaken around reporting on the IIC.

18/23 CARE QUALITY COMMISSION (MHA) VISIT FEEDBACK SUMMARY REPORT

The Committee received and noted the Care Quality Commission MHA visit feedback report.

The following was highlighted:

(1) There had been eleven visits to the Trust in Quarter 4 with 28 issues raised in the inspection feedback summaries. The review of the themes raised following visits continued to raise similar issues as in previous inspections and these were included in monthly reports to QuAGs and quarterly reports presented to LMGBs.

(2) The top five key issues identified during inspection were:

- Issues with Capacity assessments/consent (raised 6 times)
- Issues with Care plans (raised 6 times)
- Issues with Section 17 leave forms (raised 3 times)
- Issues with MHA section forms (raised 3 times)
- Issues with Patient's rights (raised 3 times)

The Committee requested that these messages should be reinforced to the medical

workforce and the Medical Director undertook to send out an exceptional bulletin.

Action: Dr A Khouja

(3) Information had been submitted to the CQC and a couple of queries had come back to the Trust which had been answered. A CQC inspector had also visited the Trust and looked at the "war wall".

Following discussion it was noted that the report had included monthly information that was sent to QuAGs and quarterly reports to LMGBs, covering key themes raised within each locality.
These documents had been embedded into the CQC report and would be placed into the MHLC reading room for access and information.

Action: Ms D Oliver

18/24 SCHEDULE OF AUDIT REPORTS

The Committee considered a risk based internal audit on compliance with the Mental Health Act and Code of Practice.

In introducing the report it was highlighted that:

- The audit looked at the overall arrangements and assurance mechanisms that the Trust had in place to ensure compliance with the MH Act.
- The audit linked to risk ref. 369 of the Board Assurance Framework and Risk Register: "we could be subject to regulatory action and suffer reputational damage if it fails to comply with national targets and standards".
- The audit concluded that: Governance, risk management and control arrangements provide a good level of assurance that the risks identified were managed effectively. A high level of compliance with the control framework was found to be taking place.

The Committee discussed the relevance of audit reports that demonstrated effectiveness of controls around compliance with legislation and considered that it would be useful for further audits to be reported to the Committee. It was noted that there would be an audit forthcoming around seclusion and this would be provided to the Committee in due course.

Action: Ms M Wilkinson

Agreed: *That internal audit reports be reported to the MHL Committee.*

18/25 APPROVAL AND MONITORING OF CODE OF PRACTICE REQUIRED POLICIES

The Committee received a verbal update on the approval and monitoring of Code of Practice required policies.

Members welcomed the opportunity to receive a verbal update on the current position of policies and to review any future amended relevant policies, which would be presented to the MHL Committee.

Agreed: *That following any future review of MH Act and Code of Practice policies that a report be provided to the MHL Committee.*

18/26 MENTAL CAPACITY ACT AND DOLS REPORT

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

Arising from the report it was noted that:

- There had been 20 MCA champions successfully trained who would be assessed against national capabilities with set competencies to achieve prior to receiving their 'champion status'.
- Following the introduction of MCA mandatory training in April 2018, the updated MCA1/2 forms were being uploaded onto Paris and would be linked with e-learning and available on In touch. DoLS was now also being recorded in Paris.
- In terms of DoLS activity, in Q4 there were 70 currently active, the majority of which had been in LD respite services with 16 new requests.

Following discussion it was noted that the high number of new requests for DoLS in Stockton (13 in Quarter 4) was attributable to the DoLS respite unit being in the Stockton area.

18/27 ANNUAL COMMITTEE PERFORMANCE RESULTS 2017/18

The Committee received and considered the annual performance results for 2017/18.

Key matters to note were:

(1) Overall there had been a decline in score for 8 of the 20 questions and an improvement for 8, which members felt was a balanced view.

(2) The Committee had undergone an overall review in the last year, including a revised agenda framed around high quality questions in line with CQC key lines of enquiry, further reports considered to provide more robust assurance and exceptions with any gaps addressed.

Members welcomed the more robust levels of assurance going forward.

(3) Following the review of the Scheme of Delegation (minute 18/21), with agreement to include further information through reporting on future agendas, members acknowledged that the MHL Committee had made significant improvements over the last six months.

18/28 PARTNERSHIP WORKING REPORT

The Committee received and noted the Partnership Working Report with regard to the MH Act 1983 and the Mental Capacity Act 2005.

In introducing the report Ms Wilkinson noted that:

- There were arrangements in place across the TEWV footprint to enable partnership working with regards to the Mental Health Act 1983 and the Mental Capacity Act 2005.
- The Locality Mental Health Legislation Operational Group met quarterly and would continue to feed into the MHLC and the terms of reference and communication chart were attached to demonstrate how the Operational Groups linked to the MHL Committee.

Following discussion members did not feel there needed to be any amendments to the Locality Mental Health Legislation Group terms of reference and welcomed exception reports when required.

Agreed: *that exception reports be provided to the MHL Committee when required.*

18/29 RESPONSE TO THE DEPARTMENT OF HEALTH RE: MHA REVIEW REPORT

The Committee received and noted the evidence submitted by the Trust following a commissioned review in October 2017 by the Prime Minister of the Mental Health Act.

In introducing the report Ms Wilkinson highlighted:

(1) The Trust had been invited to contribute to the review of the MHA in terms of providing views from a provider perspective, as well as from a service user and carer perspective.
(2) The Trust facilitated two focus groups involving service users and carers to help formulate the response.
(3) Engagement with the review would continue until its conclusion to ensure that the views of service users and carers had been represented.

18/30 CASE STUDY

The Committee received and noted a case study in relation to an individual that had been subject to long term seclusion within a PICU.

Members welcomed the quarterly case study for information and requested that the Heads of Nursing preparing the case studies be thanked.

Action: Mrs E Moody

Following discussion it was recognised the importance of the Committee considering the views of the patient's experience

Going forward it was felt important to include any key or thematic feedback from MHA inspections framed around the question, "How does the Committee assure itself it is considering the views and lived experience of service users?"

Action: Mrs J Illingworth/Ms D Oliver

18/31 TRUST'S STRATEGIC RISKS

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

18/32 ANY OTHER BUSINESS

There was no other business to discuss.

The meeting concluded at 4.20pm

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Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM No. 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th September 2018**
TITLE:	**Learning from deaths**
REPORT OF:	**Jennifer Illingworth, Director of Quality Governance**
REPORT FOR:	**Information**

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

Executive Summary:

The Learning from Deaths report and sets out the approach the Trust is taking towards the identification, categorisation and investigation of deaths. The new style mortality dashboard is included at Appendix 1.

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

National Quality Board (NQB) guidance for NHS trusts on working with bereaved families and carers was published in July 2018 and details how trusts should support and engage families after a loved one's death in their organisation's care. More information about the key points of the guidance can be found at Appendix 3 and a link to the full document is included in the 'Background Papers' section of this report. A full briefing on the guidance was received by the Patient Safety Group on 20th August 2018 with agreed actions for adapting the recommendations of the guidance within the Trust.

Recommendations:

The Board of Directors is requested:

- To note the content of this report and the areas for ongoing improvement
- To provide feedback on the new style dashboard
- To note the recent publication of the NQB guidance for NHS trusts on working with bereaved families and carers and the action the Trust is taking in response

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**25th September 2018**
TITLE:	**Learning from deaths**

1. INTRODUCTION & PURPOSE:

1.1 To formally report to the Board of Directors key information on 'Learning from deaths' in line with national guidance and the Trust 'Learning from deaths: the right thing to do' policy (CORP 00-65). The Trust has prioritised working more closely with families and carers of patients who have died and to ensure meaningful support and engagement with them at all stages, from the notification of the death of their loved one right through to actions taken following from an investigation (if deemed appropriate). Understanding the data around the deaths of our service users is a vital part of our commitment to learning from deaths. We will also learn from developments nationally as these occur.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

3.1 Identification of deaths to be reviewed

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

3.2 Mortality Review

Our current approach to mortality review is to identify those service users on the Care Programme Approach who have died but do not fall into the category of a Serious Incident. The process for learning from these reviews is still being established however emerging areas for improvement would appear to be similar to those incidental findings from our Serious Incident reviews.

3.3 Appendix 1: Dashboard

The revised learning from deaths dashboard is attached at Appendix 1, total number of deaths for Q1 is 4, all of whom died from natural causes. The definitions of the information included as Appendix 2. Feedback is requested from the Board of Directors on the new style and whether any further improvements are required. There remain some data quality issues that need to be addressed with regards to the timeliness and accuracy of reporting deaths that are not classed as Serious Incidents – a report detailing what remedial action needs to be taken/have been taken to resolve this will be discussed by the EMT on 26th September 2018.

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

3.4 National Quality Board Guidance for NHS trusts on working with bereaved Families and Carers

The NQB guidance published in July 2018 details how trusts should support and engage families after a loved one's death in their organisation's care. The information within the guidance is also intended to be used by families following bereavement and therefore it includes explanations of some terms and processes that are already familiar to NHS staff. The guidance notes it uses the term 'families' in its broadest sense and includes friends, partners and carers.

Although the guidance highlights general good practice for engaging families following a death, it particularly focuses on when a death is subject to an investigation, or where concern arises that problems occurred in care related to the death. Families can use it to find out what to expect in these circumstances. The guidance is supported by an editable information leaflet '*Information for families following a bereavement'* which trusts can adapt and personalise. The information included has been developed in collaboration with families who have had experience of the loss of a loved one whilst in NHS care.

More information about the key points of the guidance can be found at Appendix 3 and a link to the full document is included in the 'Background Papers' section of this report. A full briefing on the guidance was received by the Patient Safety Group on 20th August 2018 with agreed actions for adapting the recommendations of the guidance within the Trust. An action plan for implementation is being prepared and will be signed off at the Patient Safety Group meetings in September and October 2018.

4.0 Next Steps

As previously mentioned within this report this is an enhanced process of reporting which continues to be refined and therefore the information should be considered with this in mind. The new guidance relating to family engagement is in the process of being implemented as outlined above.

5.0 IMPLICATIONS:

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

CQC look at a range of data to help them monitor trusts that provide mental health

services. This report provides evidence in respect of Regulation 17 – Good Governance.

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

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

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

5.5 **Other implications:**
No other implications identified.

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

7. CONCLUSION:
This report contains the trust information relating to the national learning from deaths agenda. Ongoing work continues to ensure the numbers of deaths reported (both in and out of scope) are as accurate as possible to allow us to gain maximum learning from this process.

A full briefing on the National Quality Board guidance on family engagement following bereavement was received by the Patient Safety Group on 20th August 2018 with actions agreed for adapting the recommendations of the guidance within the Trust.

8. RECOMMENDATIONS:

The Board of Directors is requested:

- To note the content of this report and the areas for ongoing improvement
- To provide feedback on the new style dashboard
- To note the recent publication of the NQB guidance for NHS trusts on working with bereaved families and carers and the action the Trust is taking in response

Jennifer Illingworth
Director of Quality Governance
September 2018

Background Papers:

NQB Learning from Deaths – Guidance for NHS trusts on working with bereaved families and carers
https://www.england.nhs.uk/ourwork/part-rel/nqb/national-guidance-for-nhs-trusts-engaging-with-bereaved-families/

Learning From Deaths Framework

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

Trust Learning from deaths policy
http://www.tewv.nhs.uk/site/search-results?query=learning+from+deaths+policy

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

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

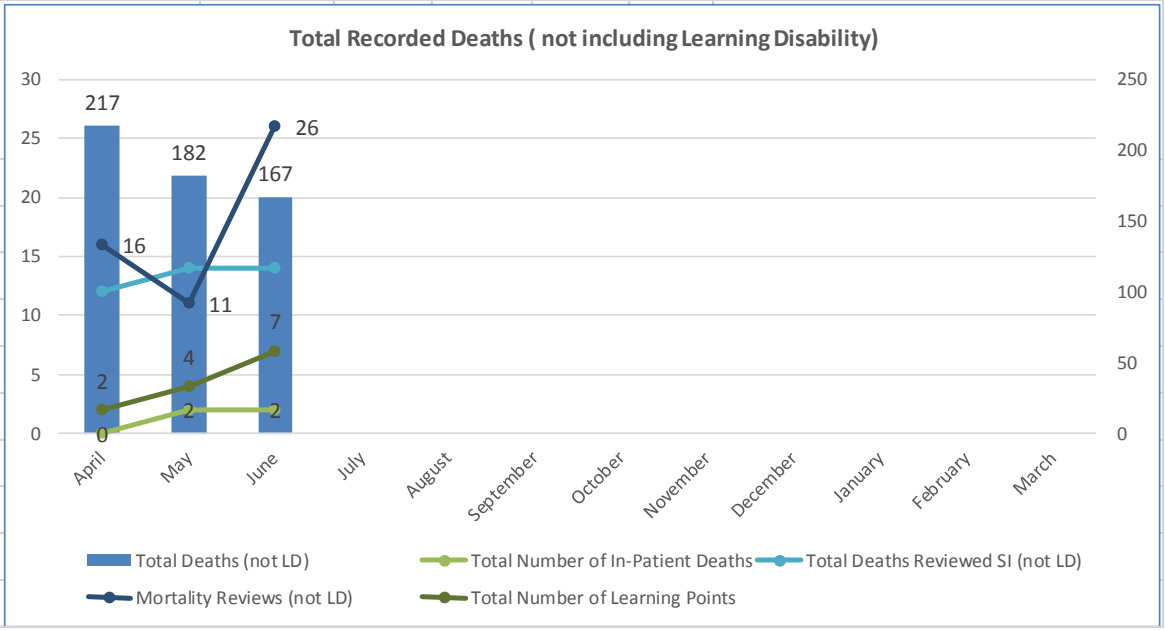
Appendix 1 Dashboard

Learning from Deaths Dashboard - Data Taken from Paris and Datix
Reporting Period - Quarter 1 - April - June 2018

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

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

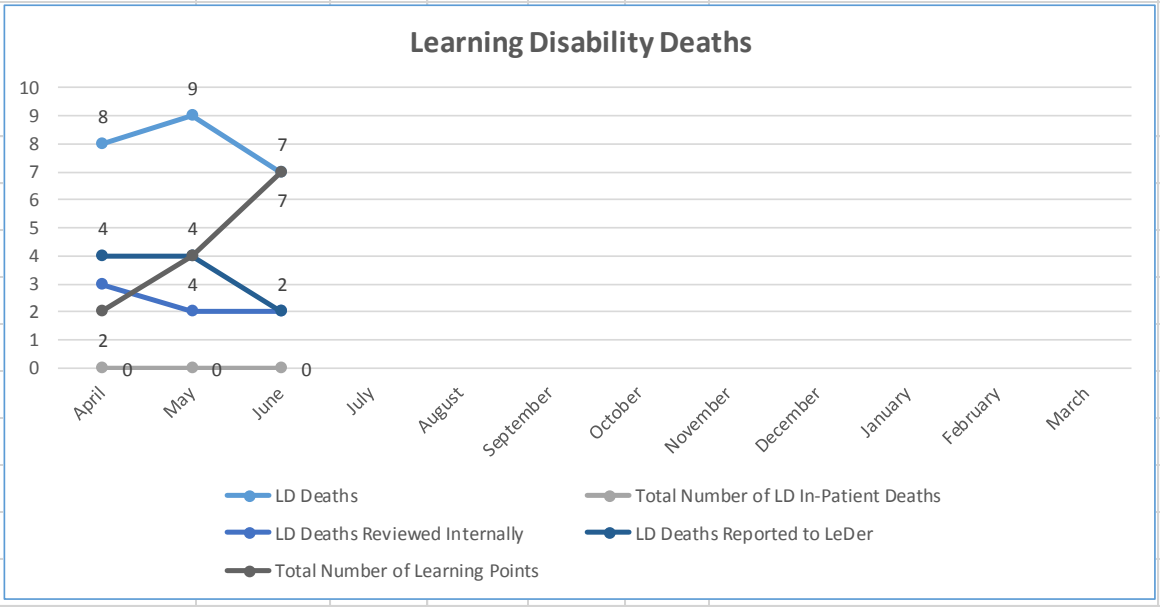
Total Deaths (not LD)	Total Number of In-Patient Deaths	Total Deaths Reviewed SI (not LD)	Mortality Reviews (not LD)	Total Number of Learning Points
Q1	Q1	Q1	Q1	Q1
566	**4**	**40**	**53**	**13**
Q2	Q2	Q2	Q2	Q2
0	**0**	**0**	**0**	**0**
Q3	Q3	Q3	Q3	Q3
0	**0**	**0**	**0**	**0**
Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD
566	**4**	**40**	**53**	**13**



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

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

LD Deaths	Total Number of LD In-Patient Deaths	LD Deaths Reviewed Internally	LD Deaths Reported to LeDer	Total Number of Learning Points
Q1	Q1	Q1	Q1	Q1
24	**0**	**7**	**10**	**13**
Q2	Q2	Q2	Q2	Q2
0	**0**	**0**	**0**	**0**
Q3	Q3	Q3	Q3	Q3
0	**0**	**0**	**0**	**0**
Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD
24	**0**	**7**	**10**	**13**



Appendix 2

The headings in the mortality dashboard are currently defined as follows:

Metric	Description
Total Deaths (not LD)	Total number of service users who have died in the period – this information will be subject to robust quality checking to ensure its accuracy
Total Number of In-Patient Deaths	Number of in-patient service users who have died in the period (included in numbers above)
Total Deaths Reviewed SI (not LD)	Total number of deaths of service users who meet the criteria for being 'in scope' as per the learning from deaths policy
Mortality Reviews (not LD)	Number of cases reviewed via the mortality review process (excluding SI numbers above)
Total Number of Learning Points	Number of individual cases where learning was identified from Serious Incidents completed in the period
LD Deaths	Total number of LD service users who have died in the period – this information will be subject to robust quality checking to ensure its accuracy
Total Number of LD In-Patient Deaths	Number of LD in-patient service users who have died in the period (included in numbers above)
LD Deaths Reviewed Internally	Total number of service users with a Learning Disability who have died and have had their care reviewed in the period
LD Deaths Reported to LeDer	Total number of service users with a Learning Disability who have died and have had their case referred for review by the LeDeR programme
Total Number of Learning Points	Number of individual cases where learning was identified from Serious Incidents completed in the period

Appendix 3 – NQB Learning from Deaths – Guidance for NHS trusts on working with bereaved families and carers

The guidance has set out eight principles that families can expect Trusts to follow after the death of someone in NHS care which are outlined below:

1. Bereaved families and carers should be treated as equal partners following a bereavement.
2. Bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment.
3. Bereaved families and carers should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support.
4. Bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one.
5. Bereaved families and carers views should help to inform decisions about whether a review or investigation is needed.
6. Bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison.
7. Bereaved families and carers should be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better form investigations.
8. Bereaved families and carers who have experienced the investigation process should be supported to work in partnership with trusts in delivering training for staff in supporting family and carer involvement where they want to.

There is further detail within the guidance of how trusts are expected to meet the above principles. There is also additional information on immediate actions following a death, bereavement services and support, raising concerns and duty of candour.

Case Note Reviews

The guidance also sets out the principles for family engagement in case note reviews which are carried out as part of our mortality review process. It states that trusts should explain to the families of all deceased patients that they routinely carry out case note reviews on a proportion of all deaths to learn about the quality of care they provide. Families should be informed of any findings from these reviews and a review should be automatically triggered where a family raises a significant concern.

Information and participation in an investigation

This section of the guidance sets out what should be done when a serious incident investigation is required. This mirrors our current practices with the exception of providing written minutes to families when meetings are held with them and providing a named deputy if their lead reviewer is unavailable. We will also need to try harder to

work with families in setting the terms of reference for our investigations which does happen currently but not routinely.

The concluding sections of the guidance focus upon access to independent advice, information and advocacy, family and carer participation in training, involving families in action planning and assurance processes and action if a family is dissatisfied with an investigation or their involvement.

Proposed initial actions for TEWV as discussed and agreed at Patient Safety Group on 20th August 2018:

A gap analysis of all of the points raised within the report will be undertaken with any actions identified to be brought back to the Patient Safety Group in October 2018 for agreement and onward monitoring.

Work has commenced as a matter of priority on the customisation of the information leaflet '*Information for families following a bereavement.'* A first draft of this will be received by the September 2018 meeting of the Patient Safety Group.

ITEM NO. 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 25th September 2018**
TITLE:	**Enhanced Observations**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Consideration**

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

Executive Summary:

The Trust is committed to providing a safe and supportive environment to all service users wherever their care is provided. Those admitted into our in-patient services are often deemed at their most vulnerable and at risk. The effective and appropriate implementation of supportive engagement and observations is fundamental to discharging our duty of care in these circumstances.

Observation and particularly engagement is a core nursing skill and can be extremely resource intensive. Changes in levels of engagement and observation across in-patient services are responsible for reallocation of resources on a shift by shift basis and can impact on other elements of care provision, service user and carer as well as staff experience.

This paper provides an overview of the key evidence relating to the practice of observation and engagement, Trust policy and context of current use across the Trust. The paper seeks to inform the Board of current developments in terms of new approaches to observation being adopted and tested and highlights recommendations for discussion regarding future work in this area.

Recommendations:

That the focus on observation and engagement practice continues as a priority within the Right Staffing and Model Ward programmes with a focus on the areas detailed in the paper.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**Tuesday, 25th September 2018**
TITLE:	**Enhanced Observations**

1. INTRODUCTION & PURPOSE:

1.1 Purpose of observations

The Trust is committed to providing a safe and supportive environment to all service users wherever their care is provided. Those admitted into our in-patient services are often deemed at their most vulnerable and at risk. The effective and appropriate implementation of supportive engagement and observations is fundamental to discharging our duty of care in these circumstances.

Observation and particularly engagement is a core nursing skill and can be extremely resource intensive. Changes in levels of engagement and observation across in-patient services are responsible for reallocation of resources on a shift by shift basis and can impact on other elements of care provision, service user and carer as well as staff experience.

This paper provides an overview of the key evidence relating to the practice of observation and engagement, Trust policy and context of current use across the Trust. The paper seeks to inform the Board of current developments in terms of new approaches to observation being adopted and tested and highlights recommendations for discussion regarding future work in this area.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Background and context

The Department of Health (DOH) (2014), reducing the need for restrictive interventions provides a framework whereby Adult Health and Social Care providers are obliged to develop a culture where restrictive interventions are only ever used as a last resort and for the shortest possible time. Supportive observation and associated practices are potentially highly restrictive.

A review of the literature in relation to observations describes a poorly researched intervention, with little empirical evidence to guide nurses or medical staff, Cutcliffe & Stevenson (2008), Stewart, Bilyin, & Bowers (2010). This has resulted in practice, which is poorly understood.

Enhanced or intensive observations are generally used to reduce the risk of self-harm and suicide, or to prevent aggressive behaviour or absconding. It has been suggested that the use of intensive observation might be an effective treatment strategy to prevent suicide in cases of severe depression, but that it could also be counterproductive with violent and paranoid service users (Bowers & Park, 2001:780). Stewart, Bilyin & Bowers (2010) have described intensive observations as a ritualistic rather than needs based practice.

Across the Trust, engagement and observation is used largely to manage and minimise risks to service users and others but Heyman et al (2013) argue that the links between risk management and risk assessment can also create an unhelpful paradox suggesting that an unwanted but inescapable consequence of adopting preventative

measures is that risk reduction obscures direct observation of what might have happened if prophylaxis had not been attempted.

Feedback from service users experience of intensive observation is not always described as a positive experience.

Bowles et al (2002) argued "There has got to be ways of helping a person feel safe and supported without reducing them to victims of voyeurism and seriously eroding away their basic human rights".

Whilst the research base is acknowledged, enhanced observation can be seen as a therapeutic intervention aimed at reducing factors which contribute to increased risk and promoting recovery if the focus is on engaging the person therapeutically and enabling them to address their difficulties constructively (therapeutic engagement is one of the few areas relating to Supportive Observation/Engagement where there is national consensus regarding value).

This paper focuses on the use of observations and engagement because it is an intrinsic but very resource intensive aspect of nursing care. The rapidly changing frequency of engagement and observation levels and impact on the level of subsequent resources required affects many aspects of staff and service user experience and so a greater understanding of the issues and impact by the Board is valuable.

There are different engagement and observation levels stipulated in Trust policy. The policy states all in-patient's will be allocated a level of engagement and observation:

I. *General Engagement and Observation: Staff to be aware of the general location of the service user, dedicated engagement time at least once per shift. This is linked to the 'care rounds SBARD'.

II. **Enhanced Engagement: Where a service user requires a higher level of engagement than general. The number and frequency of contacts will be identified and recorded in an intervention plan.

III. Continuous supportive engagement and observation within eyesight or at arm's length: This may be with one or more staff, consideration for any times when this can be reduced (e.g. access to bathroom) would be agreed and recorded. This would always apply to a service user in seclusion.

IV. Zonal Engagement and Observations: A staff member is assigned to observe and engage with individuals within specified zones within the ward area. It can be used for an individual or a particular group of service users within a specific ward or environment.

* The SBARD in relation to general observations stated:

That all in-patients should have an individual care-plan setting out how they will be observed at night. Unless the individual plan sets out different arrangements based on an MDT risk-assessment, all patients must be observed a minimum of hourly. This is described as an hourly 'care round'.

** The Trust observation levels are consistent with NICE Clinical Guidance 10 (2015) Violence and Aggression: short term management in mental health settings. In relation to the NICE Clinical Guidance on enhanced observations it suggests that low level

intermittent observations should be at a frequency between 30-60 minutes and high level intermittent observations between 15 – 30 minutes in frequency. If engagement is required more frequently than 15 minutes to maintain safety it recommends the next appropriate level of observations is continuous 1:1.

In addition the Trust has developed an approach of Care Rounds within its Adult Mental Health settings; these are based on the concept of Intentional Rounding. They are separate from the policy of Engagement and Observation, but there is some overlap in terms of low-intensity, regular structured discussions with services users as to their general well-being, and whether the nurse can support or intervene in any way or signpost to others if helpful.

3. KEY ISSUES:

3.1 Purpose of observations

The Trust strategic goals highlight that the prime purpose of mental health and learning Disability services is to promote recovery. Observation of service users is by its very Nature intrusive, particularly where it is prolonged for many hours or even days, and if managed inappropriately can damage that recovery process. Moreover, service users have said that they can find observations provocative and that it can lead to feelings of isolation and dehumanization. Therefore interventions should be undertaken sympathetically and only when necessary.

It is important that staff balance the distressing effects and potential long term harm of being on high level observations (e.g. loss of skills, loss of privacy and autonomy) against the risk of immediate harm (e.g. serious self-harm or violence). As this will change over time, this balance needs to be continually assessed.

Trust policy states that each patient should have a documented plan, agreed by the MDT so that staff and the service user understand what the observation level is, and what the reason for it is. If it is above general observations then it should be clear what the presentation / situation needs to be for observations to be reduced and the intervention plan should give clear guidance to staff and service users about what needs to happen during the engagements to achieve this.

The engagement and observation policy states: ‘The rationale supporting the decision to increase or reduce the levels of engagement and observation should be documented in the case notes. The current risks and how the level of observation is being used to manage that risk should also be documented in the case notes section supported by an appropriate intervention plan. Ward teams should look to plan ahead and work with individual service users to ensure that the plan of care for each service user outlines the conditions and observed behaviours that would facilitate a prompt reduction in observation levels.

In discussions by Heads of Nursing with staff and based on reviews of Paris documentation we know currently that this is not always clearly or consistently recorded across services.

3.2 Levels of observation

The use of increased observation levels should never be regarded as routine practice, but must be based on assessed and current need. Enhanced observations should be recognised as a restrictive practice and may be perceived by service users as a coercive intervention. It should therefore only be implemented after positive

engagement with the service user has failed to reduce the risk to self or others and only used for the least amount of time clinically required. It should be recognised that for some individuals extended use of enhanced observations can create dependence for service users who may feel abandoned or unsafe when observation levels are reduced. Equally multi-disciplinary Teams can become dependent on enhanced observation as a risk management tool.

NICE Clinical Guidance suggests that the highest level of intermittent engagement should be no more frequent than 15 minutes and that if risks are greater than this then continuous 1:1 should be considered. Within Forensic and CAMH's services it is noted that they frequently allocate up to 12 engagements an hour with higher risk service users. This would exceed the guidance and the therapeutic benefits of this practice need to be better understood. The Trust policy advises avoiding predictability when undertaking intermittent observation and how this will be avoided as ritualistic practices i.e. '5 min checks' are not likely to reduce risk of harm to self.

In MHSOP services, 1:1 observation is used to manage vulnerability and risk of falls which is not covered by NICE Guidance NG 10. It should be noted that there is lack of consensus within available feedback that NG 10 guidance should be so central to managing service users requiring enhanced observation/engagement and who may not be presenting with violent or aggressive behaviour, however if departing from the only National Guidance available, trusts are expected to include clear reasons for departure from the NICE guidance.

3.3 Allocation and levels of resource for observation and engagement

Anecdotally, over the past couple of years, there appears to have been a rise in the use of enhanced observation levels particularly across a number of specialties including CAMH's, Forensics and Older persons organic services. In terms of observation below 1:1 level, there is no minimum level for how many service users can be engaged safely and therapeutically by one member of staff before it requires additional staff to be allocated so this relies on professional judgement.

There is a lack of evidence available in an easily extractable form to demonstrate the true extent of observations in place each day across services or how many staff have been allocated to engagement and observations across each service. Therefore it is not possible to accurately ascertain the total resource allocated to this.

In order to provide some indication of some of the resource used, the tables below detail the use of temporary staffing booked for the reason of additional observations. This demonstrates an increasing year on year cost which has previously been highlighted through the safe staffing report. Further analysis of observation practice at ward and across specialties is required in order to better understand this.

Table 1 – Top 10 wards

Top 10 Wards by Total Enhanced Observation Spend

Sum of Enhanced Observations 17/18		Apr-17	May-17	Jun-17	Jul-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Grand Tota	Average
436326	MHSOP IP SELBY ACOMB GARTH	7,130	8,170	33,730	181	40,748	11,767	27,871	56,794	66,772	98,984	79,472	431,619	35,968
430733	MHSOP RP WESTERDALE SOUTH	7,222	16,707	19,739	20,070	63,117	36,532	40,752	71,630	37,492	57,268	57,125	427,653	35,638
432742	MHSOP IP MALTON SPRINGWOOD	35,063	9,295	31,769	4,182	9,356	14,773	34,214	17,380	10,085	17,533	12,112	195,761	16,313
430111	CHILD AND YP IP WLH WESTWOOD CENTRE	38,978	18,537	14,016	12,649	5,346	32,297	30,003	10,421	11,111	9,052	10,982	193,391	16,116
430611	MERLIN WARD	24,276	19,163	26,486	24,191	22,353	17,043	17,492	-	7,652	19,672	13,446	191,774	15,981
431622	AMP WP CEDAR WARD	20,704	9,646	8,199	11,018	20,404	13,783	28,460	-	8,919	9,646	5,658	136,437	11,370
430100	CHILD AND YP IP WLH NEWBERRY CENTRE	14,346	11,127	10,407	9,685	6,485	6,588	13,614	-	19,192	16,312	9,261	117,016	9,751
431078	FLD RP CLOVER/IVY WARD	21,611	23,136	22,448	10,728	5,839	4,544	3,881	3,318	4,241	4,409	7,573	111,728	9,311
431065	NORTHDALE CENTRE - HAWTHORNE AND RUNSWICK WARD	11,448	7,393	20,361	7,667	12,224	4,260	1,429	-	5,920	13,097	17,317	101,116	8,426
432156	MHSOP AP HAMSTERLEY CB	1,692	6,031	5,363	1,789	15,371	23,328	18,631	-	3,351	9,964	12,898	98,418	8,201
Grand Total		**182,470**	**129,203**	**192,517**	**102,161**	**201,243**	**164,915**	**216,346**	**159,544**	**174,735**	**255,936**	**225,844**	**2,004,913**	

Sum of Enhanced Observations 18/19		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Grand Total	Average
436326	MHSOP IP SELBY ACOMB GARTH	63,338	94,142	61,039	47,037	32,735	298,290	59,658
430733	MHSOP RP WESTERDALE SOUTH	64,855	51,678	49,867	49,223	41,483	257,105	51,421
432742	MHSOP IP MALTON SPRINGWOOD	16,110	15,666	24,410	19,854	27,373	103,413	20,683
430611	MERLIN WARD	14,582	8,464	21,391	19,827	30,647	94,910	18,982
430678	FMH RP MANDARIN WARD MED SEC MALE	21,231	21,925	22,498	12,488	13,446	91,589	18,318
430100	CHILD AND YP IP WLH NEWBERRY CENTRE	32,695	15,438	15,105	10,728	13,141	87,106	17,421
436230	MHSOP IP YORK MEADOWFIELD	-	-	29,826	10,731	33,888	74,445	14,889
431078	FLD RP CLOVER/IVY WARD	10,373	11,260	24,007	15,752	10,436	71,828	14,366
430687	FLD RP KESTREL KITE ASD	9,175	7,060	12,759	15,087	19,959	64,039	12,808
431069	FLD RP HARRIER/HAWK WARD	9,473	9,361	17,043	12,556	15,463	63,896	12,779
Grand Total		**241,831**	**234,993**	**277,943**	**213,284**	**238,570**	**1,206,622**	

Table 2 – Data by Directorate

Enhanced Observations 17/18 & 18/19

Enhanced Observations	01/04/2017	01/05/2017	01/06/2017	01/07/2017	01/08/2017	01/09/2017	01/10/2017	01/11/2017	01/12/2017	01/01/2018	01/02/2018	01/03/2018	Grand Total	Average
DURHAM AND DARLINGTON	43,511	28,350	30,434	22,342	24,635	72,171	56,512	94,167	3,481	44,367	29,450	28,766	478,185	39,849
FORENSIC SERVICES	78,834	59,913	79,522	99,364	113,603	104,473	78,844	69,039	27,838	46,474	100,806	106,100	964,809	80,401
NORTH YORKSHIRE	70,727	16,819	49,007	22,769	23,433	14,122	16,527	63,947	28,081	16,343	20,751	19,014	361,541	30,128
TEESSIDE	94,038	90,298	92,262	88,885	90,774	138,126	134,444	164,627	96,663	91,254	119,066	102,905	1,303,341	108,612
YORK AND SELBY	7,130	8,170	33,730	5,855	2,509	42,943	16,528	42,598	73,197	82,878	104,895	80,482	500,913	41,743
Grand Total	**294,240**	**203,550**	**284,954**	**239,215**	**254,953**	**371,835**	**302,856**	**434,377**	**229,259**	**281,315**	**374,968**	**337,267**	**3,608,790**	

Enhanced Observations	01/04/2018	01/05/2018	01/06/2018	01/07/2018	01/08/2018	Grand Total	Average
DURHAM AND DARLINGTON	56,887	34,501	48,795	46,888	36,954	224,024	44,805
FORENSIC SERVICES	108,876	100,334	145,632	119,464	140,268	614,574	122,915
NORTH YORKSHIRE	19,037	25,844	60,748	39,309	74,964	219,903	43,981
TEESSIDE	138,410	97,159	119,341	116,033	130,261	601,204	120,241
YORK AND SELBY	69,809	103,584	103,020	59,767	79,950	416,130	83,226
Grand Total	**393,018**	**361,422**	**477,536**	**381,461**	**462,397**	**2,075,835**	

3.4 Initiation and Reviews of engagement and observation levels – policy and guidance

The Trust policy sets out that in order for us to comply with the law observations must be justifiable and proportionate. Clinicians therefore need to make sure that the use of supportive engagement is no more intrusive – nor continues longer – than is required by the circumstances. Therefore they need to ensure that the right to life (Article 2) is sufficiently threatened to make the use of observations justifiable.

In relation to initiation of observations above general the Trust policy states:
'A minimum of two practitioners in the clinical area can initiate engagement and observation levels above general. At least one must be a registered nurse who has personally undertaken a clinical risk assessment review of the service user. The second practitioner may be any member of the multi-disciplinary team that has been involved in the clinical risk assessment of that service user'.

'Decisions about supportive engagement and observations should be made as far as possible via multi-disciplinary discussion, based on the on-going assessment of the service user's needs. This process should include the service user wherever possible'

In relation to reduction of observations above general the Trust policy states:
'Registered nursing staff with delegated responsibility for a ward area have the authority to implement an increase or decrease in the level of observation once the person is above general engagement levels.

In relation to review of observations above general the Trust policy states:
'Engagement and observation practice will be reviewed at a minimum once every shift handover. There will be ongoing review with the service user which recognises the dynamic nature of risk.

If enhanced or continuous engagement and observation continues for 1 week or more then at least once a week a full review of observation levels must take place by the MDT and the discussion outcome recorded in PARIS'.

Detailed thematic analysis across Forensic services led by the Head of Nursing detailed that initiations and discontinuation reviews of continuous observations are significantly skewed on different days of the week.

For example, the initiations of continuous observations that are 2:1 based on days of the week suggest the majority commence on a Wednesday (43%). The lowest days for initiation of 2:1 are Thursday, Saturday and Sunday (all 0%). There is only evidence that observations were reduced on a Thursday or Saturday in 3% of cases.

In terms of duration of continuous observations, a number of patients were on enhanced levels of observation for over 2 months.

A review of Paris case notes suggested reviews were not always recorded in line with policy each shift. Further data is being gathered to understand and contextualise the above. This information would also suggest there is scope to review and potentially reduce engagement and observation levels.

The National Mental Health Directors Forum have developed a national policy template for observation and engagement reaching consensus across Mental health trusts and in collaboration with NHSI. This suggests trusts should identify how extended episodes

of constant observation will be reviewed, proposing that anything extending beyond 14 days should consider peer review and if 3 months should include a formulation of the behaviour/presentation leading to the requirement for an extended period.

It also recommends trusts should consider targeted interventions for those service users requiring continuous observation for longer than 14 days, developed with the service user and MDT.

3.5 Qualitative experience of engagement and observations

Whilst well intended and used to reduce risk, enhanced or continuous engagement and observations can be challenging for both staff and service users. Consideration also needs to be given to the impact on the rest of the patient population when constant observation is being used on the ward in terms of leave and getting their needs met.

As previously highlighted to the Board, service user feedback suggests that perceptions of 'feeling safe' has reduced and is linked to the behaviour of other patients and the environment. Our staff also report feeling unsafe at times, particularly from risk of allegations and from violence and aggression.

A survey of service users carried out by the Mental Health Nurse Directors Forum as part of the national observation and engagement policy development suggests that patients being able to access a variety of activities was felt to be useful in managing their distress/intrusive thinking and that there should be more available. This resonates with our own Trust feedback. Patients who had been on enhanced observations also raised the importance of communicating with someone who knows them. The high numbers of temporary staffing utilised for observations would suggest we are not always able to achieve this on a consistent basis across our services.

As a Trust we do not currently have any data, quantitative or qualitative on the staff or service user's experience of enhanced or continuous observations.

3.6 Zonal Care

Zonal observations and engagement is an approach to be used in a ward or clinical area to enhance the observation of a particular group of service users within a specified ward or clinical area. Zonal observations can be plotted against certain times or functions dependent on the ward layout and key tasks relevant to the service user group. Individual needs assessment informs individual care plans and individual observation levels.

This approach supports observation of individual service users without the need to assign a particular nurse to be in close proximity to the service user for long periods based on clinical need. Identified staff are responsible for observing and engaging with all service users within a particular zone (area) of the Ward which entails assisting a person to find their way about within the zone and intervening when necessary to maintain safety of those in the zone. Not all wards are suitable for zonal engagement and observation so any introduction will need to be carefully introduced.

Through the Right Staffing workstream, a number of clinical staff have now visited two trusts who have implemented Zonal Care and Care Zoning. Staff have been impressed with levels of patient and staff reported satisfaction and engagement as a result of this being introduced. A pilot will commence later this year across York and Tees locality to implement Zonal Care and training is taking place in September in advance of this.

Relevant approaches are also being considered in Forensic Services and CAMH's inpatient services. A range of base-line metrics are currently being collated to support evaluation of the pilot.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The proposed approaches set out in this paper seek to strengthen policy compliance, safety and patient experience in line with CQC Fundamental standards.

4.2 **Financial/Value for Money:** Observation and engagement practice can be extremely resource intensive but should always be clinically rather than financially driven. However issues highlighted in the paper suggests there is scope to improve elements of care provision in this area as well as service user and staff experience whilst using our staff resources more effectively.

4.3 **Legal and Constitutional (including the NHS Constitution):** The Trust policy sets out that in order for us to comply with the law observations must be justifiable and proportionate. Clinicians therefore need to make sure that the use of supportive engagement is no more intrusive – nor continues longer – than is required by the circumstances. A focus on current practice and introduction of innovative ways of working will support this.

4.4 **Equality and Diversity:** The paper recommends that further focused work with service users is required to understand their experience and the impact of being on enhanced / continuous engagement and observations.

5. RISKS:

Without a greater understanding of the issues relating to observation and engagement there are risks to service user's experience of receiving care and there is potential for iatrogenic harm.

Without a greater understanding of the issues there is a risk that staff resilience and subsequent retention may be adversely affected.

Engagement and observation is also extremely costly from a financial perspective and this creates challenges for the service and organisation.

6. CONCLUSIONS:

It is apparent that the practice of engagement and observations if implemented therapeutically are necessary to maintain the safety of service users and others and are a necessary clinical intervention. Levels above general can however be highly intrusive and resource intensive.

Issues associated with engagement and observation are multi-faceted and a much greater understanding of all elements is required. The work undertaken in Forensic services through Model Wards and a thematic review conducted in conjunction with the Head of Nursing has highlighted a range of elements that require further exploration to aid understanding and enable more specific actions to be identified where necessary.

The pilot of zonal care and care zoning bring opportunities to address many of the issues outlined in this paper.

7. RECOMMENDATIONS:

That the focus on observation and engagement practice continues through the Right Staffing and Model Ward programmes with a focus on the areas detailed below:

- Commence pilot of Zonal care and engagement, explore how this is supported via policy and if there are opportunities to extend its use.
- Review of current recording of levels of engagement and observations across services to ensure they are in line with policy.
- Consider prospective recording processes to accurately understand the number of engagements and observations above general on a daily basis by ward in order to target variation and practice.
- Carry out an accurate financial assessment of the costs of engagements and observations above general.
- Through Model Ward, gather further data to understand and contextualise the apparent disproportionate number of initiations, reviews and reductions in levels of engagement and observations within Forensic Services.
- Gather further information on the processes in place in the service for initiating, reviewing and reducing engagement and observation levels.
- Review current recording to ascertain if there is evidence of reviews each shift and address any deficits in reviews in line with policy.
- Consider whether, in line with recommendations from the work carried out by the National Mental Health Nurse Leaders and Directors Forum and NHS Improvements there should be an escalation outside the immediate team and a peer review process commenced where continuous observations exceed 14 days duration.
- Undertake focused work with service users to understand their experience of being on enhanced / continuous engagement and observations.
- Undertake focused work with nursing staff to understand their experience of carrying out enhanced / continuous engagement and observations.

Elizabeth Moody
Director of Nursing and Governance
September 2018

ITEM NO. 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25TH SEPTEMBER 2018**
TITLE:	**FREEDOM TO SPEAK UP SELF-REVIEW**
REPORT OF:	**DIRECTOR OF HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT**
REPORT FOR:	**CONSULTATION AND DECISION**

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

Executive Summary:

The report provides Directors with draft responses to the Freedom to Speak Up self-review tool and seeks views about actions to take in response to the self-review.

Progress is being made with embedding Freedom to Speak Up policy and practice within TEWV however, the self-review helps to highlight that certain issues require further attention.

Recommendations:

(1) To provide feedback about whether or not the attached self-review tool draft responses are reasonable.

(2) To endorse the proposed actions described within paragraph 3.6.

(3) To agree responses to the two questions posed within paragraph 3.7

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**25th SEPTEMBER 2018**
TITLE:	**FREEDOM TO SPEAK UP SELF-REVIEW**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek the views of Directors about the draft responses within the attached Freedom to Speak Up self-review tool and about proposed actions to help embed speaking up within TEWV.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The National Guardian's Office and NHS Improvement published Freedom to Speak Up Guidance for boards and a Freedom to Speak Up self-review tool for use by trust boards in May of this year. These documents are attached to this report.

2.2 The Guidance for boards sets out expectations of boards in relation to Freedom to Speak Up and is intended to help boards create a culture that is responsive to feedback and focused on learning and development.

2.3 The self-review tool is intended to help boards review trust leadership and governance arrangements in relation to Freedom to Speak Up and to identify areas to develop and improve.

2.4 The TEWV Freedom to Speak Up Guardian has been in post since October 2016. A TEWV report in May 2018 concluded that the revised whistleblowing arrangements introduced in late 2016 are leading to more TEWV staff coming forward and raising concerns than was previously the case, which is welcome, but that there was scope for further improvement.

3. KEY ISSUES:

3.1 The extent to which the expectations that are described within the attached self-review tool are currently being met have been described using the following ratings:

- Fully met
- Mainly met
- Partly met
- Not met at all

3.1.1 The above ratings have not been used in respect of two of the expectations as it is felt that it is too soon to be able to provide a rating. Information about how the Board is assured about meeting expectations can be included when the remainder of the contents of the self-review tool have been confirmed.

3.2 The attached self-review tool includes draft responses regarding the extent to which the Freedom to Speak Up expectations of the National Guardian's Office and NHS Improvement are currently being met within TEWV. The views of Directors about these draft responses will be welcomed.

3.3 The TEWV Freedom to Speak Up Guardian was asked to complete the self-review tool, excluding the Individual responsibilities sections, and their ratings were similar to those within the attached document.

3.4 It is understood that the National Guardian's Office is currently developing guidance for trusts with regard to the Freedom to Speak Up vision that is referenced within the self-review toolkit.

3.5 Should the draft responses be agreed this would indicate that, as part of efforts to embed Freedom to Speak Up, particular attention ought to be paid to addressing the expectations within the following sections of the self-review tool:

(i) Leaders are knowledgeable about Freedom to Speak Up
(ii) Leaders have a structured approach to Freedom to Speak Up
(iii) Leaders are confident that wider concerns are identified and managed
(iv) Leaders receive assurance in a variety of forms
(v) Leaders are focused on learning and continual improvement

3.6 The proposed actions in response to the self-review include:

(i) That future planned contact arrangements between the Freedom to Speak Up Guardian and senior leaders are confirmed. These planned contacts would be in addition to the existing six monthly board reports and current contacts with the Chief Executive and the Director of Human Resources and Organisational Development.

(ii) To ensure that future Board reports about raising concerns, whether from the Freedom to Speak Up Guardian or others, routinely include lessons learned and outcomes information.

(iii) To ensure that the contents of future TEWV leadership and management development programmes include a strong emphasis the importance of learning from concerns that are raised.

(iv) To undertake an audit of compliance with the TEWV Whistleblowing Policy.

(v) To further increase awareness of the issue of raising concerns amongst TEWV staff during visits by Director and through further corporate communications.

(vi) To actively support the newly established TEWV Dignity at Work Champions network.

(vii) The Executive Management Team to consider whether TEWV is to adopt the use of the NHS Improvement Just Culture Guide

(viii) To include summary information about raising concerns within the 2018/19 TEWV annual report

3.7 In addition to the proposed actions views are also sought about the following:

Whether to defer a decision about the development of a TEWV Freedom to Speak Up vision and strategy until national guidance is available

Whether to review the TEWV Whistleblowing Policy every year, as suggested within the self-review tool, or to retain the current three year review period.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The Care Quality Commission assesses a trust's speaking up culture during inspections as part of the well led question.

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

4.3 **Legal and Constitutional (including the NHS Constitution):** Being able to raise a concern with their employer is one of the Staff Rights within the NHS Constitution

4.4 **Equality and Diversity:** The importance of seeking to overcome barriers to speaking up for more vulnerable groups is acknowledged.

4.4 **Other implications:** None identified

5. RISKS: None identified

6. CONCLUSIONS:

6.1 Completion of the self-review tool highlights that though progress is being made to embed Freedom to Speak Up policy and practice within TEWV certain issues do require further attention. Implementation of the proposed actions ought to assist efforts that are already underway to create a culture within TEWV that is responsive to feedback and focused on learning and continual improvement.

7. RECOMMENDATIONS:

7.1 To provide feedback about whether or not the attached self- review tool

draft responses are reasonable.

7.2 To endorse the proposed actions described within paragraph 3.6.

7.3 To agree responses to the two questions posed within paragraph 3.7.

David Levy
Director of Human Resources and Organisational Development

Background Papers:

National Guardian
Freedom to Speak Up

NHS
Improvement

Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts

May 2018

Contents

Introduction

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led trust.

This guide sets out our expectations of boards in relation to Freedom to Speak Up (FTSU). Meeting the expectations set out in this guide will help a board to create a culture responsive to feedback and focused on learning and continual improvement.

This guide is accompanied by a self-review tool. Regular and in-depth reviews of leadership and governance arrangements in relation to FTSU will help boards to identify areas of development and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and oversight bodies to evaluate how healthy the trust's speaking up culture is.

About this guide

This guide has been produced jointly by NHS Improvement and the National Guardian's Office and represents current good practice.

We want boards to treat this guide as a benchmark; review where they are against it and reflect on what they need to do to improve. We expect that the board, and in particular the executive and non-executive leads for FTSU, will complete the review with proportionate support from the trust's FTSU Guardian.

The good practice highlighted here is not a checklist: a mechanical 'tick box' approach to each item is not likely to lead to better performance.

The attitude of senior leaders to the review process, the connections they make between speaking up and improved patient safety and staff experience, and their judgements about what needs to be done to continually improve, are much more important.

Key terms used in this guide

- **The board**: we use this term when we mean the board as a formal body.
- **Senior leaders**: we use this term when we mean executive and non-executive directors.
- **Workers**: we use this term to mean everyone in the organisation including agency workers, temporary workers, students, volunteers and governors.

We will review this guide in a year. In the meantime, please provide any feedback to enquiries@improvement.nhs.uk

Our expectations

Leaders are knowledgeable about FTSU

Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office. Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up. They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up. Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.

Leaders have a structured approach to FTSU

There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement. There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement. The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian). It aligns with existing guidance from the National Guardian. Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.

Leaders actively shape the speaking up culture

All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up. They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty. Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers. Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian. Senior leaders model speaking up by acknowledging mistakes and making improvements. The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.

Leaders are clear about their role and responsibilities

The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility. They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support. Other senior leaders support the FTSU Guardian as required. For more information see page 8 below.

Leaders are confident that wider concerns are identified and managed

Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.

Leaders receive assurance in a variety of forms

The executive lead for FTSU provides the board with a variety of reliable, independent and integrated information that gives the board assurance that:

- workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process
- steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers
- speak up issues that raise immediate patient safety concerns are quickly escalated
- action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority
- lessons learnt are shared widely both within relevant service areas and across the trust
- the handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented
- FTSU policies and procedures are reviewed and improved using feedback from workers.

In addition the board receives a report, at least every six months, from the FTSU Guardian. For more information see page 11 below. Boards should consider inviting workers who speak up to present their experience in person.

Leaders engage with all relevant stakeholders

A diverse range of workers' views are sought, heard and acted on to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.

The organisation is open and transparent about speaking up internally and externally. Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement. Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals). The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture. Reviews and audits are shared externally to support improvement elsewhere.

Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture. Likewise, senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians. Senior leaders request external improvement support when required.

Leaders are focused on learning and continual improvement

Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience. Senior leaders and the FTSU Guardian engage with other trusts to identify best practice. Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities. Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.

The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.

The FTSU policy and process are reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them. A sample of cases is audited to ensure that:

- the investigation process is of high quality; outcomes and recommendations are reasonable and the impact of change is being measured
- workers are thanked for speaking up, are kept up to date throughout the investigation and are told of the outcome
- investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored.

Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up. This is demonstrated in organisational data and audit.

Individual responsibilities

Chief executive and chair

The chief executive is responsible for appointing the FTSU Guardian and is ultimately accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust. The chief executive and chair are responsible for ensuring the annual report contains information about FTSU and that the trust is engaged with both the regional Guardian network and the National Guardian's Office.

Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.

Executive lead for FTSU

The executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian's Office
- overseeing the creation of the FTSU vision and strategy
- ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian
- ensuring that the FTSU Guardian has a suitable amount of ringfenced time and other resources and there is cover for planned and unplanned absence.
- ensuring that a sample of speaking up cases have been quality assured
- conducting an annual review of the strategy, policy and process
- operationalising the learning derived from speaking up issues
- ensuring allegations of detriment are promptly and fairly investigated and acted on
- providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.

Non-executive lead for FTSU

The non-executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian's Office
- holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy. Where necessary, they should robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement
- role-modelling high standards of conduct around FTSU
- acting as an alternative source of advice and support for the FTSU Guardian
- overseeing speaking up concerns regarding board members – see below.

We appreciate the challenges associated with investigating issues raised about board members, particularly around confidentiality and objectivity. This is why the role of the designated non-executive director is so important. In these circumstances, we would expect the non-executive director to take the lead in determining whether:

- sufficient attempts have been made to resolve a speaking up concern involving a board member(s) and
- if so, whether an investigation is proportionate and what the terms of reference should be.

Depending on the circumstances, it may be appropriate for the non-executive director to oversee the investigation and take on the responsibility of updating the worker. Wherever the non-executive director does take the lead, they should inform the FTSU Guardian, confidentially, of the case; keep them informed of progress; and seek their advice around process and record-keeping.

The non-executive director should inform NHS Improvement and CQC that they are overseeing an investigation into a board member. NHS Improvement and CQC can then provide them with support and advice. The trust would need to think about how to enable a non-executive director to commission an external investigation (which might need an executive director to sign-off the costs) without compromising the

confidentiality of the individual worker or revealing allegations before it is appropriate to do so.

Human resource and organisational development directors

The human resource (HR) and/or organisational development (OD) directors are responsible for:

- ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up
- ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust
- ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.

Medical director and director of nursing

The medical director and director of nursing are responsible for:

- ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues
- ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up
- ensuring learning is operationalised within the teams and departments they oversee.

FTSU Guardian reports

Reports are submitted frequently enough to enable the board to maintain a good oversight of FTSU matters and issues, and no less than every six months. Reports are presented by the FTSU Guardian or a member of the trust's local Guardian network in person.

Reports include both quantitative and qualitative information and case studies or other information that will enable the board to fully engage with FTSU in their organisation and to understand the issues being identified, areas for improvement, and take informed decisions about action.

Data and other intelligence are presented in a way that maintains the confidentiality of individuals who speak up.

Board reports on FTSU could include:

Assessment of issues

- information on what the trust has learnt and what improvements have been made as a result of trust workers speaking up
- information on the number and types of cases being dealt with by the FTSU Guardian and their local network
- an analysis of trends, including whether the number of cases is increasing or decreasing; any themes in the issues being raised (such as types of concern, particular groups of workers who speak up, areas in the organisation where issues are being raised more or less frequently than might be expected); and information on the characteristics of people speaking up (professional background, protected characteristics)

Potential patient safety or workers experience issues

- information on how FTSU matters relate to patient safety and the experience of workers, triangulating data as appropriate, so that a broader picture of FTSU culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve can be built

Action taken to improve FTSU culture

- details of actions taken to increase the visibility of the FTSU Guardian and promote the speaking up processes
- details of action taken to identify and support any workers who are unaware of the speaking up process or who find it difficult to speak up
- details of any assessment of the effectiveness of the speaking up process and the handling of individual cases
- information on any instances where people who have spoken up may have suffered detriment and recommendations for improvement
- information on actions taken to improve the skills, knowledge and capability of workers to speak up and to support others to speak up and respond to the issues they raise effectively

Learning and improvement

- feedback received by FTSU Guardians from people speaking up and action that will be taken in response
- updates on any broader developments in FTSU, learning from case reviews, guidance and best practice

Recommendations

- suggestions of any priority action needed.

Resources

Care Quality Commission (2017): Driving Improvement Accessed at: www.cqc.org.uk/sites/default/files/20170614_drivingimprovement.pdf

National Guardian Office (2017): Example job description Accessed at: http://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

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NHS Improvement (2014) Strategy development toolkit Accessed at https://improvement.nhs.uk/resources/strategy-development-toolkit/

NHS Improvement (2016) Freedom to speak up: whistleblowing policy for the NHS Accessed at https://improvement.nhs.uk/resources/freedom-to-speak-up-whistleblowing-policy-for-the-nhs/

NHS Improvement (2017): Creating a vision https://improvement.nhs.uk/resources/creating-vision/

NHS Improvement (2016/17): Creating a culture of compassionate and inclusive leadership Accessed at https://improvement.nhs.uk/resources/culture-leadership/

NHS Improvement (2017): Well Led Framework Accessed at: https://improvement.nhs.uk/resources/well-led-framework/

National Framework (2017): Developing People - Improving Care Accessed at: https://improvement.nhs.uk/resources/developing-people-improving-care/

National Guardian Office (2018): Guardian education and training guide

Accessed at: http://www.cqc.org.uk/sites/default/files/20180419_ngo_education_training_guide.pdf

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This publication can be made available in a number of other formats on request.

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National Guardian
Freedom to Speak Up

NHS
Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	Mainly met	More FTSU training opportunities provided, more regular provision of updates	
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	Partly met	Develop a formal vision statement, share more feedback about concerns raised/actions taken. Future reports to the BOD to provide more information about investigation outcomes.	
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	Mainly met	Ensure that revised TEWV leadership programmes include a strong emphasis upon learning from concerns	

		raised	
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	Partly met	Develop and launch a formal vision statement	
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	Not met at all	Either develop a FTSU Strategy or identify relevant links between existing strategies. Consider national guidance when available.	
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Fully met	N/A	
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian)and it aligns with existing guidance from the National Guardian.	Partly met	Decide whether a bespoke strategy is needed. Undertake a consultation exercise as appropriate	
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative		Formalise progress reviews and report to the BOD. Undertake an	

and quantitative measures.	Partly met	audit of the current policy.	
Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Mainly met	Provide more opportunities for suggesting ideas and initiatives.	
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	Fully met	N/A	
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	Fully met	N/A	
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	Mainly met	Increase the frequency of planned contact between BOD FTSU leads and the FTSU Guardian	
Senior leaders model speaking up by acknowledging mistakes and making improvements.	Fully met	N/A	

The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	Mainly met	Include greater reference to speaking up issues within Directors visits. Increase corporate communications about FTSU.	
Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	Fully met	N/A	
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	Partly met	More regular planned meetings to take place between the BOD leads and the FTSU Guardian	
Other senior leaders support the FTSU Guardian as required.	Fully met	N/A	
Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to	Mainly met	Refine information sharing	

enable them to triangulate speaking up issues to proactively identify potential concerns.		arrangements between the FTSU Guardian, other TEWV support services and operational services.	
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	Fully met	N/A	
Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Partly met	Develop and communicate a formal TEWV FTSU vision statement. Visible BOD support for the roll out of the Dignity at Work Champions/FTSU network. Increase BOD communications about the importance of speaking up.	

Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	Partly met	Scrutiny of implementation of the WRES action plan. Implementation of the Dignity at Work Champions Network. Review and respond to protected characteristics staff research findings (BAME and Disabled groups)	
Speak up issues that raise immediate patient safety concerns are quickly escalated	Fully met	N/A	
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	Mainly met	Include information about victimisation in BOD reports about FTSU	
Lessons learnt are shared widely both within relevant service areas and across the trust	Partly met	Introduce regular reports about lessons learnt to the EMT and BOD for wider sharing. Consider adoption of the NHSI Just Culture	

		Guide	
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	Not met at all	Agree an audit process and timescale	
FTSU policies and procedures are reviewed and improved using feedback from workers	Mainly met	Review the impact of implementation of the Bullying and Harassment Resolution Procedure	
The board receives a report, at least every six months, from the FTSU Guardian.	Fully met	N/A	
Leaders engage with all relevant stakeholders			
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	Mainly met	Develop a formal FTSU vision statement	
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	Fully met	N/A	
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting			

the confidentiality of individuals).	Fully met	N/A	
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	Not met at all	Decide the type and level of information to be included in the 2018/19 annual report.	
Reviews and audits are shared externally to support improvement elsewhere.	Fully met	N/A	
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	Mainly met	Strengthen regional contacts to increase learning	
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	Fully met	N/A	
Senior leaders request external improvement support when required.	Fully met	N/A	
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers'	N/A to date	N/A	

experience.			
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	Partly met	Provide more engagement opportunities between senior leaders and other trusts counterparts	
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Partly met	Review future arrangements for Executive and non-executive leads	
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	Fully met	N/A	
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	Not met at all	Agree whether to develop a FTSU Strategy	

The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Partly met	Decide whether to increase the frequency of policy review from every three years to every year.	
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored	Not met at all	Decide about the introduction of a case review process	
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	N/A to date	N/A	
Individual responsibilities			

Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.	Fully met	N/A	
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	Fully met	N/A	
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Fully met	N/A	
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	Fully met	N/A	
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	Fully met	N/A	
Executive lead for FTSU			

Ensuring they are aware of latest guidance from National Guardian's Office.	Fully met	N/A	
Overseeing the creation of the FTSU vision and strategy.	Partly met	Develop a FTSU Vision statement and decide about whether to have a FTSU strategy	
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	Fully met	N/A	
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	Mainly met	Review cover arrangements given the development of a Dignity at Work Champions network	

Ensuring that a sample of speaking up cases have been quality assured.	Not met at all	Introduce a quality assurance process	
Conducting an annual review of the strategy, policy and process.	Partly met	Confirm whether a strategy is to be developed and whether the frequency of policy review is to be amended	
Operationalising the learning derived from speaking up issues.	Partly met	Agree a formal process for sharing more information with services	
Ensuring allegations of detriment are promptly and fairly investigated and acted on.	Fully met	N/A	
Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.	Mainly met	Provide more assurance about non FTSU Guardian concerns	
Non-executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	Fully met	N/A	
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up	N/A	A decision is needed about whether to have a	

strategy.		FTSU strategy	
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	Fully met	N/A	
Role-modelling high standards of conduct around FTSU.	Fully met	N/A	
Acting as an alternative source of advice and support for the FTSU Guardian.	Fully met	N/A	
Overseeing speaking up concerns regarding board members.	Mainly met	Confirm respective responsibilities with the SID.	
Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	Fully met	N/A	

Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	Mainly met	Consider adoption of the NHSI Just Culture guide	
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	Mainly met	Provide formal training for all managers	
Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	Mainly met	Consider arranging more regular planned contact with the FTSU Guardian	
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Fully met	N/A	
Ensuring learning is operationalised within the teams and departments that they oversee.	Fully met	N/A	

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday 25th September 2018**
TITLE:	**NHS England Core Standards for Emergency Preparedness Resilience and Response**
REPORT OF:	**Ruth Hill, Chief Operating Officer**
REPORT FOR:	**Assurance/Approval**

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

Executive Summary:

It is a requirement for all health organisations to undertake an annual Emergency Preparedness Resilience and Response (EPRR) self assessment which is lead by NHS England via Local Health Resilience Partnerships.

The purpose of this process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards. Compliance with the standard gives assurance that the NHS in England can respond to emergencies and business continuity incidents and are resilient in relation to continuing to provide safe patient care.

Recommendations:

Board of Directors is requested to approve the self assessment which gives assurance the Trust can demonstrate it can effectively respond to emergency planning and business continuity incidents whilst maintaining services to patients.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday 25th September 2018**
TITLE:	**NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this paper is to provide Board of Directors with assurance that the Trust is complying with NHS England's Core Standards for Emergency Preparedness, Resilience and Response.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health and patient safety.

2.2 The core standards for EPRR aim to clearly set out the minimum standards which NHS organisations must meet to ensure that they can effectively respond to emergency and business continuity incidents whilst maintaining services to patients.

2.3 In addition, they enable agencies to co-ordinate Emergency Preparedness, Resilience and Response activities and provide a framework for self-assessments and assurance processes.

3. KEY ISSUES:

3.1 The core standards have domains specific to Mental Health which we need to adhere to.

3.2 The date for completion and submission of the self-assessment is September 2018.

3.3 The standards and details have been amended by NHS England for the 2018 assessment and as can be seen by reference to Appendix ,1 of the 54 standards that apply to the Trust, we have assessed ourselves as Fully Compliant with 48 standards and partially compliant with 6 standards.

3.4 In addition to the core standards, we are required to complete a self assessment on a Deep Dive section. This year, the Deep Dive section covered Incident Co-ordination Centres and command structures. The Trust has assessed itself as fully compliant with all 8 standards. This section does not affect the Trust's compliance level.

3.5 The overall assessment rating for the Trust is 'substantially compliant'. The Emergency and Business Continuity Planning Steering Group have added to their work plan actions to address the partially compliant standards (see Action Plan included in the core standards).

3.6 Assurance that the Trust can respond to a range of emergency and business continuity issues can also be demonstrated by the programme of exercises that have taken place during the year. Three internal and two external exercises have been held, covering a range of issues including fire, flooding, decanting of services and testing of Incident Co-ordination Centres and communication routes.

3.7 The core standards assessment and supporting evidence has been accepted by the Trust's Audit Committee.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The EPRR Core Standards are not part of the CQC inspection framework, but they help us to plan and manage Trust arrangements to effectively deal with any internal or external incident and ensure continuity of our services.

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

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

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

4.4 **Other implications:** None identified.

5. RISKS:

There are no risks associated with this report, as the overall assessment shows that the Trust is substantially compliant with the core standards.

6. CONCLUSIONS:

The self-assessment gives assurance to Board of Directors that the Trust can demonstrate it can effectively respond to emergency planning and business continuity incidents whilst maintain services to patients.

7. RECOMMENDATIONS:

Board of Directors is requested to approve the self assessment which will then be submitted to NHS England.

Ruth Hill
Chief Operating Officer

Attachments:
Appendix 1 : EPRR Core Standards

Appendix 1

Tees, Esk and Wear Valleys
NHS Foundation Trust

SUPPORTING EVIDENCE TO CORE STANDARDS 2018

Ref	Domain	Standard	Detail	Comments	Evidence
1	**Governance**	**Appointed AEO**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	The COO is the Board Level Director nominated as AEO. They are supported by Associate Director of operational Services and a dedicated Emergency Planning Manager and cover from the Health and Safety Manager. It was a Trust decision not to have a non-executive board member in support. Support is given by other Trust Directors.	Command and Control Plan Section 3.2/4.4.
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Policy statements are included in the Trust's Business Continuity policy and command and control Plan. The policy is reviewed annually and is version controlled and includes a responsibility matrix.	Trust Business Continuity Policy and Command and Control Plan.

3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	The Core standards assessment is reported through the Emergency Planning Group then through Audit Committee to the Board of Directors. Core standard report will include training exercises. Any major incident will be reported direct to Board of Directors by the COO.	Audit Committee/Board of Directors Report.
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	An annual work plan is agreed by the Emergency Planning Group. The work plan is informed by assurance process, risks and exercises. The group monitors implementation of the work plan Exercise reports and work plan available. Sitrep of BCP's also available for scrutiny	Emergency Planning and Business Continuity Group Workplan 2018/19.
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Policy and Command and Control plan identify resources available. EP Lead in post with cover provided by Health and Safety Manager and Associate Director of Operational Services. Emergency Planning leads in place in each locality to assist the Trust in ensuring EPRR standards are reached. These are tested through regular exercises.	Command and Control Plan 4.4/4.5 details. Command and Control Team.
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Action plans are developed to implement lessons identified during the exercises. Incidents and exercise debriefs are taken and discussed at the Emergency Planning Group	Exercise White Rose
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Copy of LHRP Risk Registers considered when developing Trusts Risk Register. Risk Register reviewed at Emergency Planning Group. Trust Risk Register in place and a specific one for Emergency Planning. Also working with two	LHRP Risk Register Emergency Planning and Business Continuity Group Risk Assessment.

				LHRP to ensure that risks are discussed and exercises undertaken to ensure that processes are in place.	
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	The Trust has a recorded method of reporting and recording incidents documented in its Command and Control Plan and Service BCP's. Trust Risk Register and Emergency Planning Risk register in place.	Command and Control Plan 4.2 and Appendix 2/3 Tees Locality Business Plan Action Cards A1/2/3.
9	**Duty to maintain plans**	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Attendance at LHRP's and LHRP sub groups in the North East and in Yorks and Humber. Joint exercises carried out to test plans across organisations	Exercise White Rose attendance.
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Plans are reviewed and tested regularly through exercises as to Trust guidance and best practice guidance and legal requirements.	Command and Control Plan and Service BCP's example Tees. Other service plans see 4.9 of Command and Control Plan. Exercise White Rose Report.
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Internal and External Plans in place and tested regularly. Command and Control and Service BCP's also in place.	External major Incident Plan Internal Emergency Plan. Command and Control Plans. Service Plans.

13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Summer and Winter plan in place.	TEWV Summer and Winter Preparedness Plan.
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Summer and Winter plan in place.	Summer and Winter Preparedness Plan.
15	**Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Pandemic Influenza Plan in place and reviewed on a regular basis but also as per Trust Policies every three years. Next review 2019.	Pandemic Influenza Plan.
16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Policies and Procedures in place and liaison with PHE, NHS England and Local Acute Hospitals.	Infection, Prevention and Control Policy. Infectious Diseases procedure.

17	**Duty to maintain plans**	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution e.g. mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependent on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Presently undertaking this in conjunction with the two LHRP's, CCG's, NHS England and Public Health England. No further action required by Trust will be advised if required to assist with distribution dependent on incidents.	
18	**Duty to maintain plans**	**Mass Casualty - surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Mass casualty plan to be incorporated within the External Major Incident Plan. This draft plan has been tested in two exercises. Presently working with the LHRP sub groups to ensure that it complies with Mass Casualty framework.	Partial compliance - See 2018/19 Emergency Planning and Business Continuity Group Workplan.
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Decant facilities available and MOU for Forensic services. Information re decant facilities within the Director on call folder.	List of Trust Decant facilities Tees Locality Business Continuity Plan Appendix 4 and Action Card A4.
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Each locality have BCP's which include lockdown arrangements and are updated annually to ensure continuity of service.	Tees Locality Business Continuity Plan Page 83 Action Card A5.

22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	This is presently identified within the Forensic BCP for high profile patients and VIP visitors. To be discussed in the Emergency Planning Group as to what protocols or processes are required for the other. localities	Partial compliance - See Business Continuity Group Workplan 2018/19.
23	**Duty to maintain plans**	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	Trust Emergency Planning Lead included in the planning process with the two LHRP and local authorities.	
24	**Command and control**	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	24/7 arrangements are now in place with on call. Escalation to Trust COO or On call Direct and Chief Executive if required.	Command and Control Plan 4.2and 4.5.
25	**Command and control**	**Trained on call staff**	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	22 Trust Directors/Senior Managers have undertaken training according to NHS England EPRR competencies.	Incident Management Training Report.

26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Exercises in place and undertaken with appropriate staff in attendance. All Loggists have undertaken PHE training. All Directors and some Senior Managers have attended Incident Management training.	Business Continuity Policy 3.3 details training requirements.
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Exercises undertaken with multi agencies for joint collaboration to test the plans. Outcome and actions discussed at the Emergency Planning Group and implementation of actions monitored. Communication Tests are undertaken by the Trust and NHS England on a regular basis minimum every six months. Live exercises held within the Trust: Armadillo October 2017 White Rose June 2017 Table top simulation Children and Adolescent Mental Health Services October 2017. Command and Control tested as part of live exercise.	Exercise White Rose Report.
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Directors attended strategic and tactical responder training. Exercises undertaken with key staff attending.	Exercise White Rose attendees. Incident Management Training Report.
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a pre-identified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Trust ICC in place and three locality ICC's. ICC'S tested and documentation exists for activation and operation.	Command and control Plan 4.6. Action Cards 7/8/9.
31	**Response**	**Access to planning arrangements**	Version controlled hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Plans in place on Intouch and hard copies in each Incident Co-ordination Centre. Services print off relevant section of service plans.	

32	**Response**	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.	Business continuity response plans in place and tested with Information taken to Emergency Planning Group meeting.	Command and Control Plan. Service Business Continuity Plan.
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	List of Loggists are available in Directors folder. Loggist information in Command and Control Plan Training programme for Loggists exists.	Command and Control Plan See appendix 4 Trained list of Loggists.
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (Sitreps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Sitreps and action cards available in all plans.	Command and Control Plan 4.2 and Appendix 3.
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	The communications team will liaise with health partners and blue light services, Twitter, Facebook and website notices can also be utilised. Social media (Facebook and Twitter) and the website can be used to inform the general public and service users.	Command and Control Plan Action Card 2 and 4.5. Communication Lead Member of Command and Control Team.
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	The communications team can place urgent messages and supporting information for staff on the Trust Intranet. It should be noted that a number of our staff also follow our social media activity. Contingency plans for loss of IT are outlined in the communications service continuity plan. Staff can also be contacted by text messaging via the information team, however this involves some manual processing.	Command and Control Plan Action Card 2 and 4.5. Communication Lead Member of Command and Control Team.
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	The communications team will assist the directors in making statements to the media and preparing for media interviews where appropriate. It will also place information on the website and social media (Twitter and Facebook) for the media, general public and service users.	Command and Control Plan. Action Card 2 and 4.5. Communication Lead Member of Command and Control Team.

40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	COO or appropriate Deputy to attend northern LHRP and EP lead to attend the North Yorkshire LHRP. Minutes received for all meetings.	Partial compliance as did not achieve 75% attendance. In 2018/19 Workplan.
41	**Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	NHS England attend the LRF for all the Trusts and feedback is given via the LHRP and LHRP sub groups. LHRP attend Trust exercises and Trust attends relevant exercise for other LHRP members.	
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Mutual aid through MOU in Forensic Services. There is a working partnership with Local authorities and LHRP. The trust does not have written agreements for mutual aid with other Trusts.	Partial compliance - See Workplan 2018/19.
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Agreed processes for sharing information with LHRP partners in the event of a major incident in place.	Command and Control Plan. 4.3/4.5 Action Card 2. .
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Policy and Command and Control Plans in place.	Business Continuity Policy. Command and Control Plan
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	Policy and Command and Control Plans in place and identify scope and objectives of BCMS and risk management process.	Business Continuity Policy. Command and Control Plan.

49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	BIA's checked as part of BCP updates. All BCP's reviewed regularly or annually to ensure that they are up to date. Sitrep of these given to the Emergency Planning group.	Command and Control Plan. Outcome BIA's 4.9 and 4.10.
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	The Trust achieved a rating of Satisfactory against Information Governance Toolkit v14.1. The Trust is signed up to the new Data Security and Protection Toolkit and is working towards its completion by the required date of 31 March 2019.	
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Corporate and Locality plans in place and regularly updated in line with exercises and change. Covers response recovery and management of critical elements including • people • information and data • premises • suppliers • IT	Tees Locality Business Continuity Plan. Command and Control Plan. List of Service Plans 4.9.
52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	BCMs monitored via core standards assessments and exercises. Annual report taken to the Trusts Board by COO with any reports of any major incidents taken as they occur.	.
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Audited in 2016 - to request inclusion in 2019 audit plan.	Audit Report 2016
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	Plans tested and action plans implemented to ensure continual improvement.	White Rose Exercise Report.

55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Critical suppliers identified and Business Continuity plans available some suppliers included in exercises. Most providers have BCP's in place but need to check this covers all critical suppliers.	Partial compliance - see Emergency Planning and Business Continuity Group 2018/19 Workplan.
56	**CBRN**	**Telephony advice for CBRN exposure**	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.	Telephone advice from Public Health England. Contacts available to Public Health England through Command and Control Plan and Service Plans.	Command and Control Plan. Appendix 5 Emergency Contact List.
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).	Planning in place. The advice for staff is within the BCPs Action Cards.	Tees Locality Business Continuity Plan. Action Card B8.
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Risk assessments take place and action cards and response equipment circulated to risk areas identified.	Tees Locality Business Continuity Plan. Action Card B8.

60	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Response equipment available at key receptions in line with action cards. - Disposable paper suits - Paper towels - Plastic bags	Tees Locality Business Continuity Plan. Action Card B8.
66	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	Full decontamination would not be carried out by Trust as emergency services would transfer to acute Trust. . Action Cards used to advise staff on immediate actions to be taken.	Tees Locality Business Continuity Plan. Action Card B8.
68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Action Cards in Service Business Continuity Plans cover requirements to isolate	Tees Locality Business Continuity Plan. Action Card B8.
69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.	The equipment will be accessed by IPCT through liaison with Public Health England, NHS England, LHRP and Local Acute Hospitals .Our Trust do not routinely do Aerosol generating procedures and so would not need to have FFP3 masks but in the rare cases that we might we would rely on our Acute colleagues for training and supply.	Partial compliance - See Emergency Planning and Business Continuity Group Workplan 2018/19.

Item 13

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**25 September 2018**
TITLE:	**Finance Report for Period 1 April 2018 to 31 August 2018**
REPORT OF:	**Patrick McGahon, Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 31 August 2018 is a surplus of £2,854k, representing 2.0% of the Trust's turnover and is £16k ahead of plan.

Performance Against Plan – year to date (3.2)

	Variance £000	Monthly Movement £000	Movement
The Trust is currently £16k **ahead** of its year to date financial plan.	-16	-5	↑

Cash Releasing Efficiency Savings (CRES) (3.3)

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the financial year are £324k **behind** financial plan.	Recurrent	4,635	↓
	Non recurrent	-4,311	→
	Target	0	
	Variance	324	↓
Identified CRES schemes for the rolling 3 year period are £15,214k **behind** the £21,000k CRES target.	**CRES Type**	**Annual Variance £000**	**Movement**
	Recurrent	15,214	↓

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

Capital (3.4)

The Trust is currently £297k **in excess** of its capital plan.	**Variance £000**	**Monthly Movement £000**	**Movement**
	297	130	↑

The Trust received a capital rebate relating to prior year schemes (£2,289k), with this included, capital expenditure is £1,992k behind plan.

Workforce (3.5)

The Trust is currently £920k (38%) **in excess of** its agency cap.	**Variance £000**	**Movement £000**	**Movement**
	920	249	↓

Agency expenditure has increased in month 5 across all localities and is required to support enhanced observations with complex clients.

Use of Resources Risk Rating (UoRR) (3.7)

	Plan	**Actual**	**Movement**
The Trust is currently **in line** with its planned UoRR which is rated 1 to 4 with 1 being good.	2	2	↑
The Trust is forecasting to be **behind** its planned UoRR at the financial year end.	1	2	→

The Trust is forecasting to be behind plan due to agency expenditure being in excess of the cap.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**25 September 2018**
TITLE:	**Finance Report for Period 1 April 2018 to 31 August 2018**

1. INTRODUCTION & PURPOSE:

1.1 This report sets out the financial position for 1 April 2018 to 31 August 2018.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

3.1 Key Performance Indicators

The Trust is achieving the control total set by NHSI and the use of resource rating targets, although there are variances within categories. The amount of CRES identified is below required levels, and actions taken to rectify are detailed in section 3.3.

3.2 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 31 August 2018 is a surplus of £2,854k, representing 2.0% of the Trust's turnover and is £16k ahead of plan.

Table 1	Annual Plan	Year to Date Plan	Year to Date Actual	YTD Variance
	£000	£000	£000	£000
Income From Activities	(332,226)	(135,922)	(135,729)	193
Other Operating Income	(16,154)	(8,327)	(8,268)	59
Total Income	**(348,379)**	**(144,249)**	**(143,997)**	**252**
Pay Expenditure	261,847	109,223	108,820	(403)
Non Pay Expenditure	68,351	27,476	27,731	255
Depreciation and Financing	11,317	4,712	4,592	(120)
Variance from plan	**(6,864)**	**(2,838)**	**(2,854)**	**(16)**

3.3 Cash Releasing Efficiency Savings (CRES)

The Trust's performance against the 2018/19 CRES target is shown in table 2 below. The Trust is behind plan (£324k); which is a deterioration since July and is due to delays in the implementation of a scheme in Durham and Darlington.

The Trust continues to identify schemes to ensure full delivery of recurrent CRES requirements.

Table 2

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the financial year are £324k **behind** financial plan.	Recurrent	4,635	↓
	Non recurrent	-4,311	→
	Target	0	
	Variance	324	↓

3.4 Capital

Expenditure against the capital programme to 31 August 2018 is £4,299k and is £297k in excess of plan largely due to expenditure incurred on the Roseberry Park MIST system being offset by delays on the York and Selby Inpatient facility.

The Trust received a capital rebate relating to prior year schemes (£2,289k), with this included, capital expenditure is £1,992k behind plan.

3.5 Workforce

Table 3 below show the Trust's performance on some of the key financial drivers identified by the Board.

Table 3	**Pay Expenditure as a % of Pay Budgets**						
Tolerance	Tolerance Aug-18	Mar	Apr	May	Jun	Jul	Aug
Establishment (a) (90%-95%)	92.7%	93.80%	94.60%	93.70%	93.41%	92.77%	92.72%
Agency (b)	1.0%	2.60%	2.70%	2.80%	2.80%	2.98%	3.05%
Overtime (c)	1.0%	1.30%	1.60%	1.20%	1.12%	1.12%	1.13%
Bank & ASH (flexed against establishment) (100%-a-b-c)	5.3%	2.90%	3.30%	2.90%	3.08%	2.93%	2.98%
Total	**100.0%**	**100.60%**	**102.20%**	**100.60%**	**100.41%**	**99.80%**	**99.88%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For August 2018 the tolerance for Bank and ASH is 5.3% of pay budgets.

NHS Improvement monitors agency expenditure against a capped target. Agency expenditure at 31 August 2018 is £3,332k which is £920k (38%) in excess of the agreed year to date capped target of £2,412k. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

3.6 Cash

Total cash at 31 August 2018 is £67,845k, and is £2,305k behind plan largely due to working capital variations.

3.7 Use of Resources Risk Rating (UoRR) and Indicators

3.7.1 The Use of Resources Rating for the Trust is assessed as 2 for the period ending 31 August 2018 and is behind plan (table 4). Agency expenditure

increased again in August which is higher than anticipated and in excess of the NHSI cap. Work is on-going; and continues to be monitored, in order to improve this position.

Table 4 - Use of Resource Rating at 31 August 2018

NHS Improvement's Rating Guide	Weighting %	Rating Categories 1	2	3	4
Capital service Cover	20	>2.50	1.75	1.25	<1.25
Liquidity	20	>0	-7.0	-14.0	<-14.0
I&E margin	20	>1%	0%	-1%	<=-1%
I&E margin distance from plan	20	>=0%	-1%	-2%	<=-2%
Agency expenditure	20	<=0%	-25%	-50%	>50%

TEWV Performance	Actual Achieved	Actual Rating	YTD Plan Planned	YTD Plan Rating	RAG Rating
Capital service cover	1.31x	3	1.35x	3	
Liquidity	49.9 days	1	52.8 days	1	
I&E margin	2.0%	1	2.0%	1	
I&E margin distance from plan	0.0%	1	0.0%	2	
Agency expenditure	£3,332k	3	£2,412k	1	
Overall Use of Resource Rating		**2**		**2**	

3.7.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.31x (can cover debt payments due 1.31 times), which is marginally behind plan and rated as a 3. This rating is in line with the plan for quarter 2.

3.7.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 49.9 days; this is marginally behind plan and is rated as a 1.

3.7.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 2.0% and is rated as a 1, which is in line with plan.

3.7.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding STF income. The Trust I&E margin distance from plan is 0.0% and is in line with plan and is rated as a 1 which is ahead of plan.

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

The margins on Use of Resource Rating are as follows:

- Capital service cover - to improve to a 2 a surplus increase of £2,545k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £44,625k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £1,379k is required.
- I&E margin distance from plan – to reduce to a 2 an operating surplus decrease of £26k is required.

- Agency Cap rating – to improve to a 2 a reduction in agency expenditure of £317k is required.

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUSIONS:

6.1 At the end of August the Trust is £16k ahead of the control total set by NHSI.

6.2 The amount of CRES identified for the financial year and rolling 3 year period is below required levels; however, the Trust continues to identify schemes to ensure full delivery of recurrent CRES requirements.

6.3 The Use of Resources Rating for the Trust is assessed as 2 for the period ending 31 August 2018 and is in line with plan. The Trust is forecasting a rating of 2 at the end of the financial year which is behind plan due to the agency expenditure rating.

7. RECOMMENDATIONS:

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

Patrick McGahon
Director of Finance and Information

ITEM 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25h September 2018**
TITLE:	**Board Dashboard as at 31st August 2018**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communication**
REPORT FOR:	**Assurance**

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

Executive Summary:

Performance data for KPI 2 "Percentage of patients starting treatment within 6 weeks of external referral" is now included in the dashboard. The potential target for this indicator was considered by the Executive Management Team in August and the proposal from EMT to set the target at 60% for 2018/19.

As at the end of August 2018, 8 (47%) of the indicators reported are not achieving the expected levels and are red. This is a deterioration on the 5 indicators that were reported red as at the end of July. The indicators which are rated red are spread across all 4 domains. In addition there are 7 KPIs (41%) that whilst not achieving the target are within the 'amber' tolerance levels. Of the 15 indicators that are either red or amber 7 (41%) are showing an improving trend over the previous 3 months.

The year to date position is that there are 8 KPIs (47%) which are reported as red which is a deterioration on the position as at the end July 2018.

In terms of the Single Oversight Framework targets the Trust achieved all the targets in August. However we did not achieve the targets in all CCGs

A revised Data Quality Scorecard has been included in Appendix D which includes a new criteria/dimension against which all the indicators have been assessed.

Recommendations:
It is recommended that the Board: • Approve a target of 60% for the new KPI “Percentage of patients starting treatment within 6 weeks of external referral” which has been proposed by EMT (see 2.1) • Consider the content of this paper and raise any areas of concern/query.

MEETING OF:	**Board of Directors**
DATE:	**25th September 2018**
TITLE:	**Board Dashboard as at 31st August 2018**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 31st August 2018 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. Definitions of the KPIs within the dashboard are provided in Appendix B.

2. KEY ISSUES:

2.1 General Issues

Work has now been completed on the development of the new KPI 2 "Percentage of patients starting treatment within 6 weeks of external referral" and actual performance is now included in the dashboard. The potential target for this indicator was considered by the Executive Management Team in August and the proposal from EMT to set the target at 60% for 2018/19. **Board of Directors are asked to approve this target**.

There are still 4 outstanding KPIs which are in the development phase and therefore not yet included within the Dashboard. These are highlighted in italics in Appendix B. Work is continuing on the development of these indicators on the IIC in order that they can been reported as soon as possible.

2.2 Performance Issues

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

- As at the end of August 2018, 8 (47%) of the indicators reported are not achieving the expected levels and are red. This is a deterioration on the 5 indicators that were reported red as at the end of July. The indicators which are rated red are spread across all 4 domains. In addition there are 7 KPIs (41%) that whilst not achieving the target are within the 'amber' tolerance levels.

  Of the 15 indicators that are either red or amber 7 (41%) are showing an improving trend over the previous 3 months.

  The year to date position is that there are 8 KPIs (47%) which are reported as red which is a deterioration on the position as at the end July 2018.

- In terms of the Single Oversight Framework targets the Trust achieved all the targets in August. However we did not achieve the targets in all CCGs as follows:
  - IAPT/Talking Therapies – proportion of people completing treatment who move to recovery" as at the end of August 2018. The target

was not achieved in Hambleton, Richmondshire and Whitby CCG and in the Vale of York CCG.

- Inappropriate Out of Area Occupied Bed Days – the target was not achieved in a number of the CCGs but these all related to 'Internal' Out of Area admissions i.e. admissions within other areas of the Trust. There were no patients admitted externally from the Trust due to pressure on beds.
- Early Intervention in Psychosis Access – this was only achieved in 3 of the CCGs however it should be noted that the numbers of people accessing the services are small which has a greater impact on the percentage figures reported

- Appendix C includes the breakdown of the actual number of unexpected deaths by month.

2.3 Key Risks

- Use of Beds (KPIs 3 12, 13 and 14) – During August there has been further pressure on beds with bed occupancy increasing. The increase in number of patients with lengths of stay over 90 days and number of people re-admitted within 30 days will be contributory factors to this. The increase in bed occupancy has however not resulted in an increase in Inappropriate Out of Area Bed days which has remained better than target although there is variance across the different localities. Action plans continue to be implemented to improve performance in terms of Out of Area admissions and these include actions that will also impact on Length of Stay and readmissions. The use of beds continues to be monitored on a daily basis and the localities are undertaking deep dives of patients who have a LOS over 30 days to ensure that they can address issues that may be preventing discharge. However there are a number of very complex patients on the wards who require longer lengths of stay in addition to a number of delayed discharges particularly in York and Selby and Teesside.

- Number of Unexpected Deaths Classed as a Serious Incident (KPI 5) – The rate per 10,000 open cases improved in August although the year to date remains above target. The position in August related to 8 deaths of which the majority (4) were in Durham and Darlington.

- Outcome Indicators (KPIs 6 and 7) – Performance against the two outcome indicators (clinically reported (HONOS) and patient reported (SWEMWEBS)) is considerably below target with both showing a declining position in August. The PBR team continue to share reports with services to allow them to focus on the reasons for the 'breaches' and work is being undertaken in all localities on reemphasising the need to record outcome scores in order to be able to demonstrate improvement made. Following the Performance Improvement Group in May, chaired by the COO, it has been agreed that there will be a further PIG meeting dedicated to these indicators in October to follow up on whether the actions agreed in May are having an impact.

- Sickness Absence Rate (KPI 19) – performance for this indicator has continued to worsen from the position reported in April (although it is not as high as the same month last year). A review of the Trusts approach to managing sickness absence is underway and it is expected that a new procedure will be available from September. Teesside and North Yorkshire are achieving the target with Forensic services being the outlier at slightly over 7%.

- Financial Targets (KPIs 21 and 22) – In the month of August (and Year to Date) we have not achieved the target for CRES delivery and Cash against plan. Work is ongoing via the Programme Board to identify further CRES schemes and it is expected that the target will be achieved by the year end. In terms of cash the variance is largely due to working capital variations with no risk relating to outstanding receivables having been identified.

2.4 Data Quality Assessment.

The data quality assessment of the Dashboard indicators is included in Appendix D. Following the issue highlighted in July regarding the accuracy of the appraisal information it has been agreed to add a further dimension/criteria to the assessment which is that the indicator has gone through a robust testing phase at its development or when any amendment is made. This has now been added and the revised scores are included within Appendix D. It can be seen that overall data quality of the information provided in the Dashboard is considered to be high with the lowest score being 80% however a more robust testing of the sickness indicator is required given this was developed at the same time as the appraisal indicator when the level of testing was not as robust as it is currently. A timescale for this testing is currently being agreed.

3. RECOMMENDATIONS:

3.1 It is recommended that the Board:

- Approve a target of 60% for the new KPI "Percentage of patients starting treatment within 6 weeks of external referral" which has been proposed by EMT (see 2.1).
- Consider the content of this paper and raise any areas of concern/query.

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Quality

	August 2018				April 2018 To August 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	90.00%	87.21%			90.00%	87.22%		90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral		42.90%				26.77%		
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	2,410.00	2,198.00			2,410.00	2,198.00		2,410.00
4) Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	91.24%			92.45%	90.94%		92.45%
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.27			5.00	7.79		12.00
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	67.25%	58.33%			67.25%	56.06%		67.25%
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	78.25%	67.90%			78.25%	64.58%		78.25%

Activity

	August 2018				April 2018 To August 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	94.55%			85.00%	95.14%		85.00%
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	68.00	74.00			68.00	74.00		68.00
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.93%	25.53%			23.93%	21.54%		23.93%

Workforce

Trust Dashboard Summary for TRUST

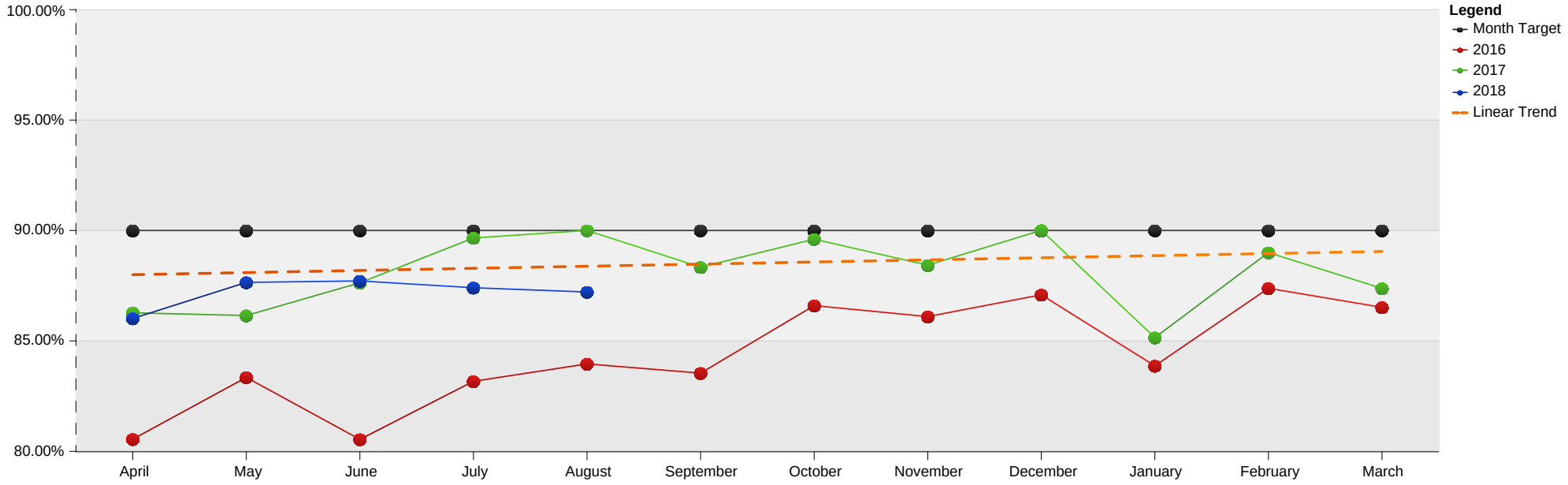
	August 2018				April 2018 To August 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
15) Actual number of workforce in month (Establishment 95%-100%)	95.00%	92.72%			95.00%	92.72%		95.00%
16) Vacancy fill rate	90.00%	79.57%			90.00%	76.02%		90.00%
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	92.09%			95.00%	92.09%		95.00%
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	89.66%			92.00%	89.66%		92.00%
19) Percentage Sickness Absence Rate (month behind)	4.50%	5.09%			4.50%	4.77%		4.50%

Money

	August 2018				April 2018 To August 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
20) Delivery of our financial plan (I and E)	-560,000.00	-565,945.00			-2,838,000.00	-2,853,970.00		-6,864,000.00
21) CRES delivery	686,782.00	518,787.00			3,433,910.00	2,593,930.00		8,241,384.00
22) Cash against plan	68,474,500.00	67,845,000.00			68,474,500.00	67,845,000.00		56,640,000.00

Trust Dashboard Graphs for TRUST

1) % of patients who were seen within 4 weeks for a 1st appointment following an external referral

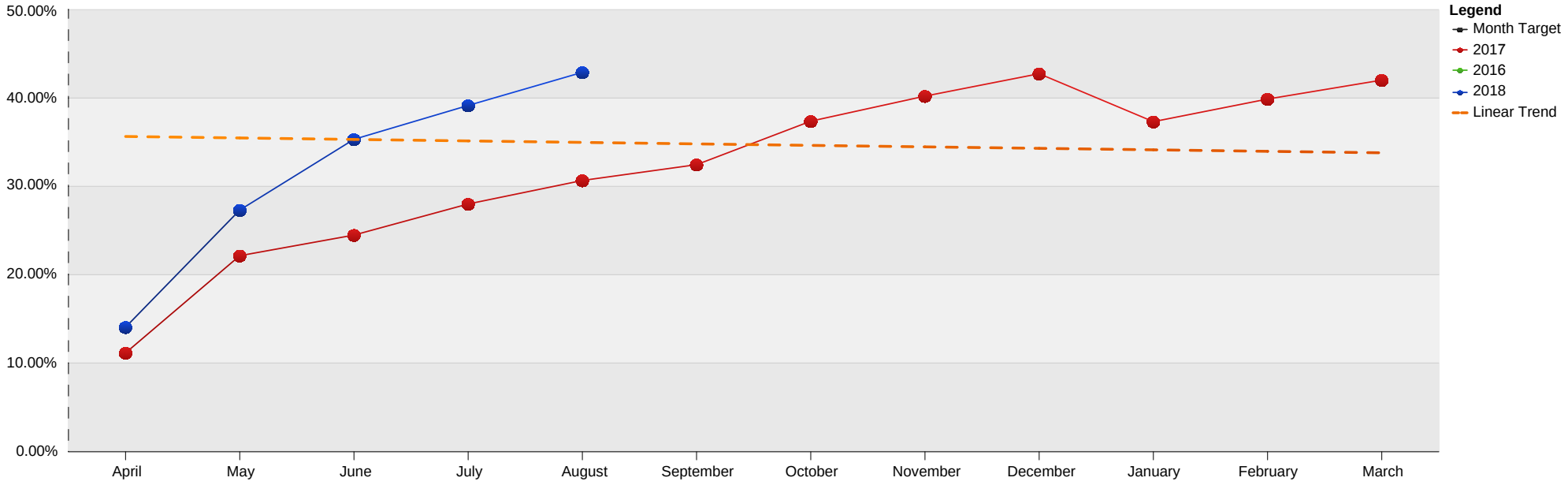


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	87.21%	87.22%	87.78%	87.35%	91.88%	92.82%	72.87%	75.44%	99.26%	99.38%	84.63%	77.08%		

Narrative
The position for August 18 is 87.21% relating to 5198 patients of 5960 who were seen within 4 weeks. This is below target of 90% and a slight deterioration on the position reported in July 18. Areas of concern:• York AMH at 81.25% (182 of 224 patients) 42 patients were not seen within 4 weeks which is a significant improvement on the 60% reported in July 18. Performance is impacted by the high DNA rate within the Access Team. The team are reviewing this regularly and are trying to fit patients in to the cancelled slots in order to help capacity and throughput. All referrals are coded correctly to eliminate data quality issues is complete and this has impacted positively on the position achieved. • North Yorkshire AMH at 66.67% (298 of 447 patients) 149 patients were not seen within 4 weeks. This is a deterioration compared to the position reported in July. There continues to be issues particularly within Harrogate and Ripon teams around sickness and vacancies with agency staff being brought in to help manage demand. Plans are being developed to ensure assessments are booked and completed as soon as possible.

Trust Dashboard Graphs for TRUST

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

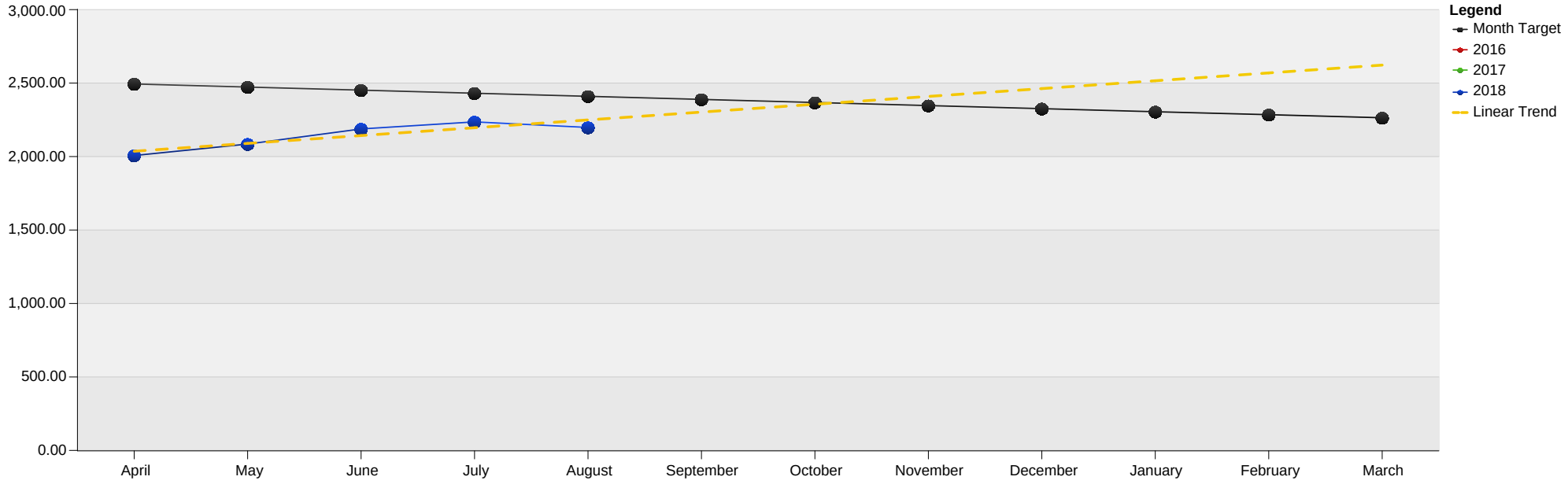


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients starting treatment within 6 weeks of an external referral	42.90%	26.77%	37.13%	22.21%	48.23%	32.33%	41.92%	22.03%	72.73%	79.76%	36.67%	22.63%		

Narrative
The Trust position for August 2018 is 42.90%, which continues the improvement since April 2018. The target proposed for this indicator is 60%. If this target was in place, only forensic services would achieve this. York and Selby are the lowest performance locality achieving 36.67%. All localities are starting to look at this data and identify reasons for under performance.

Trust Dashboard Graphs for TRUST

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



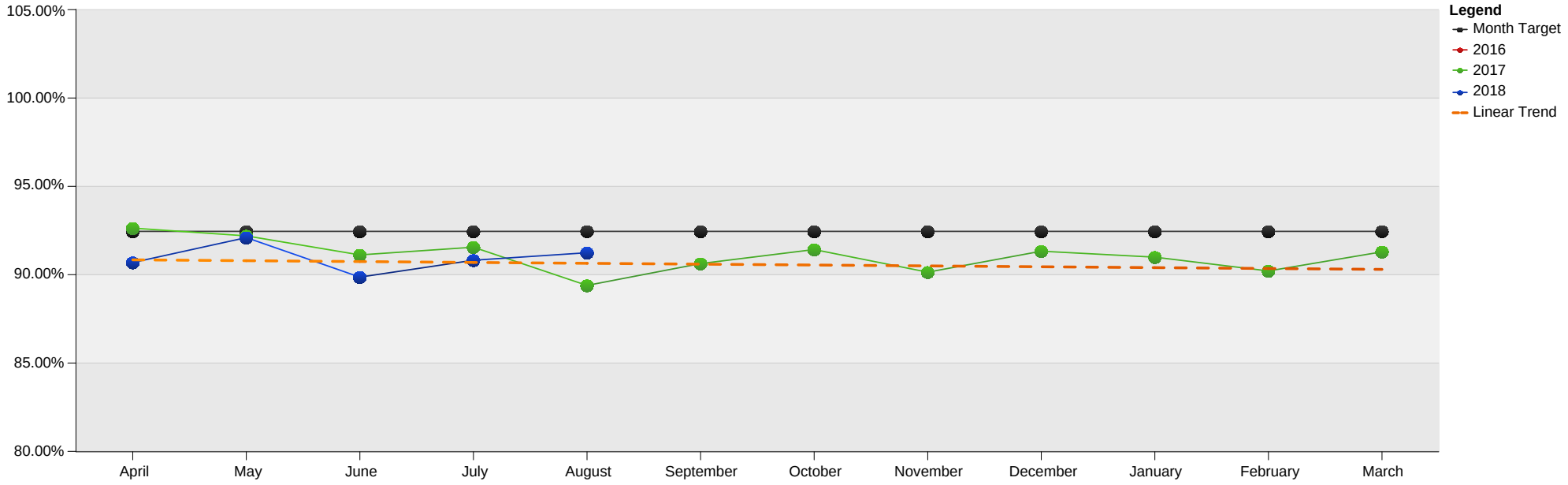
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	2,198.00	2,198.00	212.00	212.00	741.00	741.00	728.00	728.00			517.00	517.00		

Narrative

The Trust position for August 2018 is 2,198 which is meeting the target of 2,410 and is an improvement on the July position and reverses the increasing trend which has been seen over the first 4 months. The following localities are not meeting target: - • Durham and Darlington – 212 occupied bed days (197 AMH and 15 MHSOP). This relates to 21 patients admitted out of area over the 3 month period (17 AMH and 4 MHSOP)• York and Selby – 517 occupied bed days (324 AMH and 193 MHSOP). This relates to 46 patients admitted out of area over the 3 month period (36 AMH and 10 MHSOP) Both localities continue to have a number of patients from other areas admitted to their beds. As a result they have had to find alternative beds for patients from the home areas. Within York, there have been a number of 'out of area' patients who have remained in beds due to delayed transfers of care and issues around finding suitable accommodation, mainly around care home placements. Work is underway to return patients to their home area and it is expected improvements will be seen in the next couple of months. All localities are monitoring this on a continual basis with actions agreed in daily huddles. There are two action plans agreed with commissioners (one for Durham and Darlington and Tees and one for North Yorkshire and York). These are managed jointly with the CCGs via the Contract Management Boards.

Trust Dashboard Graphs for TRUST

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

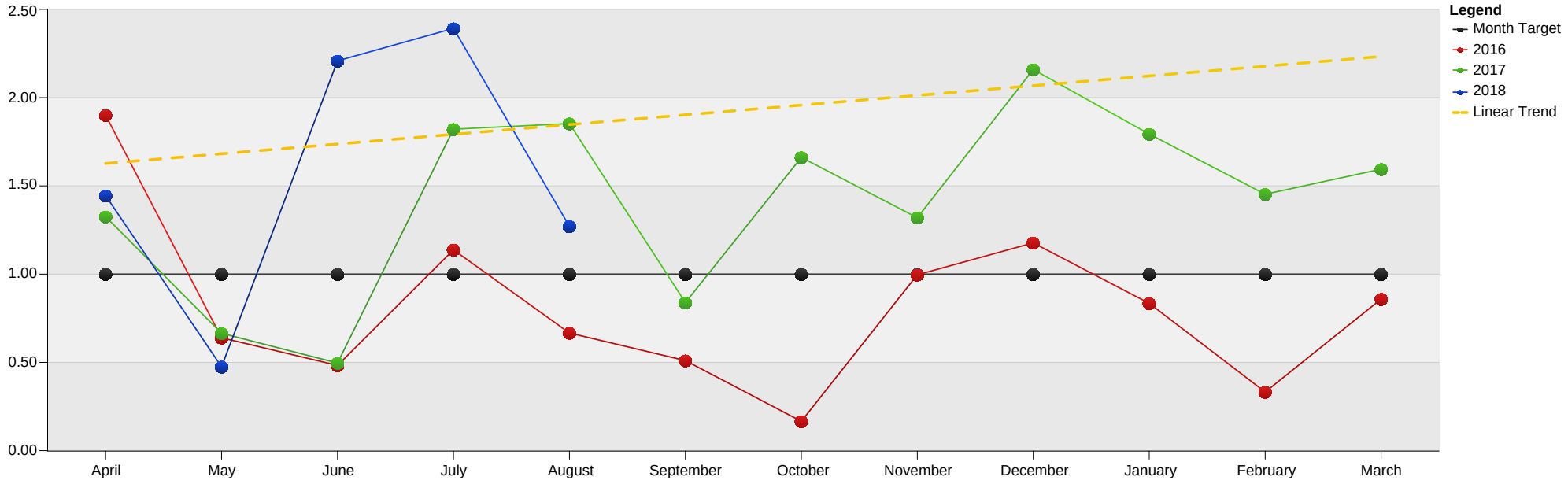


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of patients surveyed reporting their overall experience as excellent or good	91.24%	90.94%	91.98%	92.32%	91.84%	91.80%	94.14%	92.44%	83.22%	80.03%	89.27%	88.85%		

Narrative
The Trust position for August 2018 is 91.24% which is not meeting the target of 92.45% but is an improvement on the position reported in July (June data).Forensic Service are below target for this indicator whilst North Yorkshire are meeting the target and the remaining localities achieved within 10% of the target. Work continues within each locality to review performance against this indicator and identify any areas of concern. Please note due to changes with this indicator in 2016, this year is not displayed on the graph above.

Trust Dashboard Graphs for TRUST

5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated

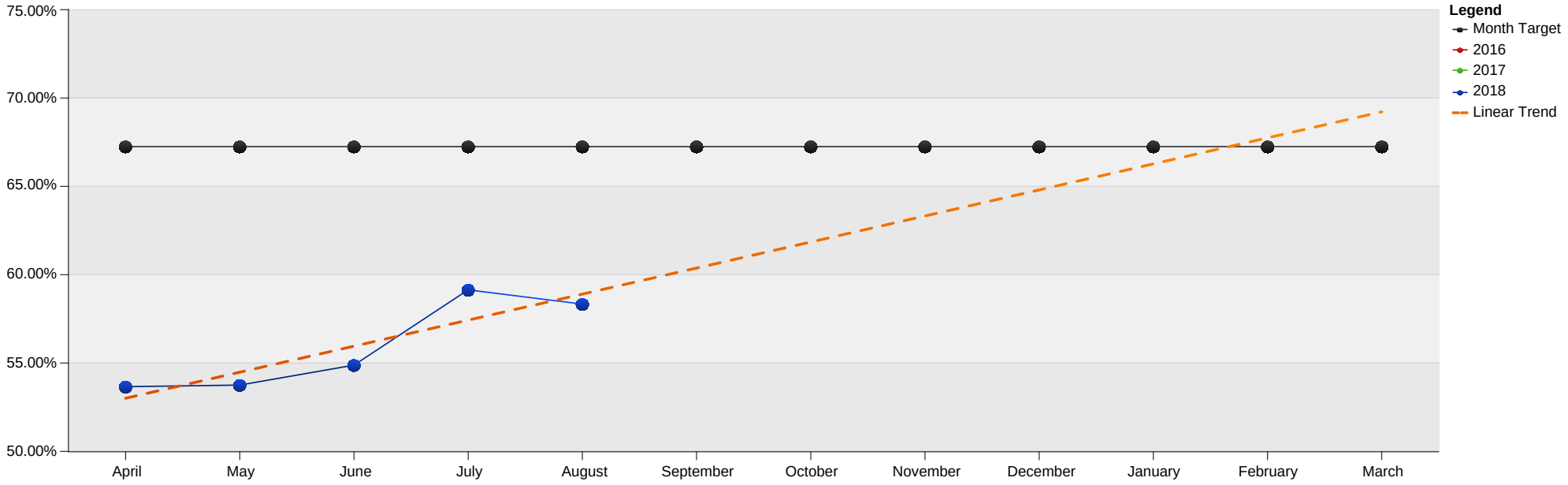


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.27	7.79	1.58	8.32	1.11	5.03	1.82	10.86	0.00	32.94	0.00	6.17		

Narrative
The Trust position for August 2018 is 1.27, which is not achieving the expected number of 1.00. This rate relates to 8 unexpected deaths in August which is a reduction in the position in June and July 2018 where 14 was reported in both months. Of the 8 unexpected deaths the details below shows a breakdown by locality:4 x Durham and Darlington2 x North Yorkshire2 x TeesOf the unexpected deaths that occurred in August, 5 occurred in AMH, 2 in MHSOP and 1 in CYPS.

Trust Dashboard Graphs for TRUST

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

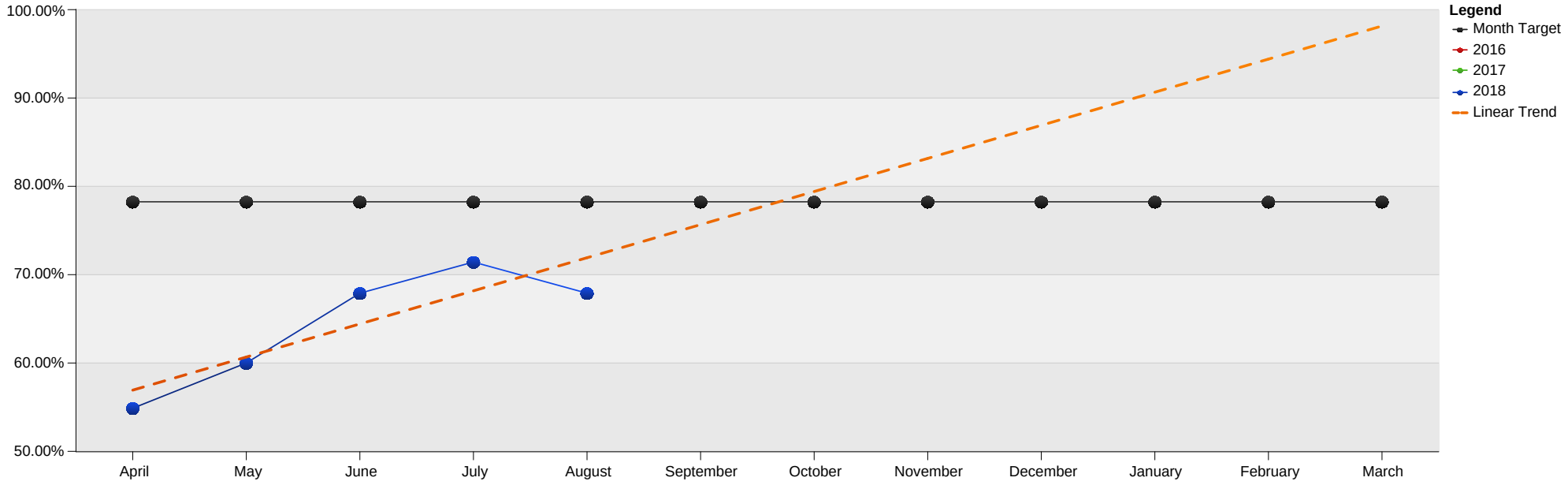


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	58.33%	56.06%	46.15%	45.38%	66.67%	65.55%	58.33%	60.98%			70.00%	48.98%		

Narrative
The Trust position for August 2018 is 58.33%, which is not meeting the target of 67.25% and is a deterioration on the position reported in July. Within this KPI an improvement in HONOS is shown by a decrease in the patient's actual HONOS score on PARIS. The change is identified by comparing the first HONOS score calculated on admission to TEWV, and the score on discharge.All localities are below target with the exception of York. Tees and North Yorkshire are within 10% of the target. The PBR team provide services with weekly breach reports to allow issues to be addressed. Services are working to increase the number of patients they report outcomes for and to report them in a timely way. Focusing on this will enable teams to improve performance against this KPI. A follow up session focused on the outcome indicators is planned for the Performance Improvement Group meeting in October.

Trust Dashboard Graphs for TRUST

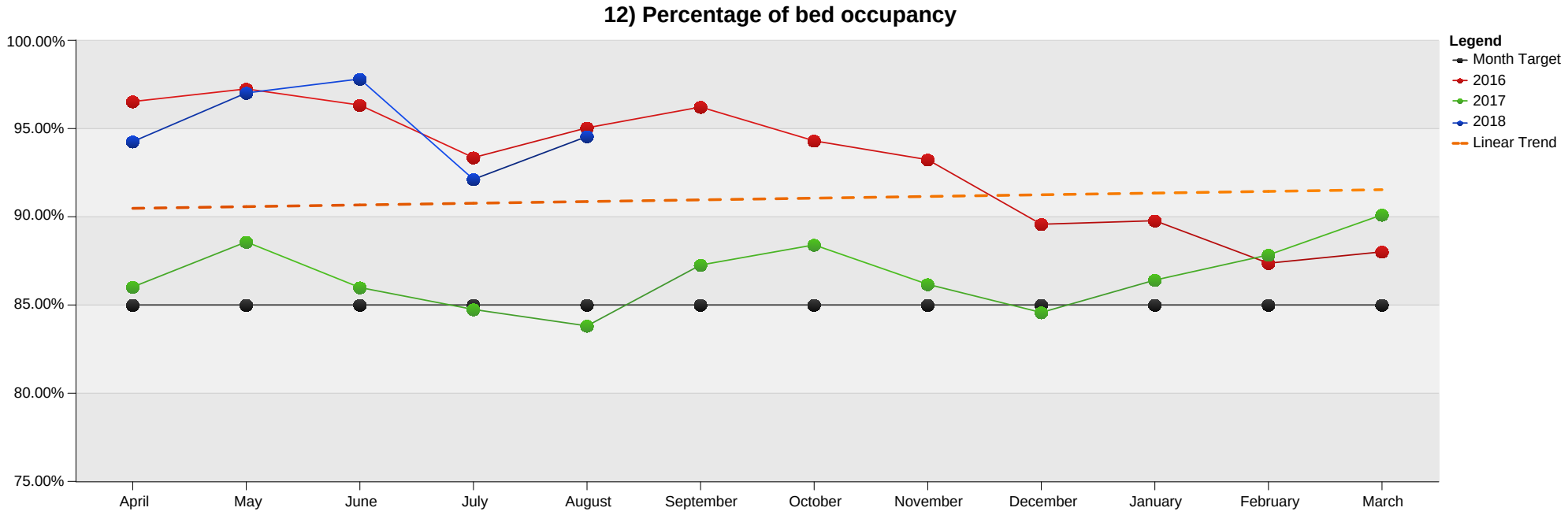
7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	67.90%	64.58%	64.00%	63.08%	70.83%	63.87%	73.91%	69.17%			55.56%	58.70%		

Narrative
The Trust position for August 2018 is 67.90%, which is not meeting the target of 78.25% and is a deterioration on the position reported in July.Within this KPI, an improvement in SWEMWBS (which is a patient experience measure) is shown by an increase in the patients actual SWEMWBS score. The change is identified by comparing the first SWEMWBS score calculated on admission, and the score on discharge.All localities are below target with North Yorkshire and Tees being the highest performers within 10% of the target. The PBR team provide services with weekly breach reports to allow issues to be addressed. Services are working to increase the number of patients they report outcomes for and to report them in a timely way. Focusing on this will enable teams to improve performance against this KPI. A follow up session focused on the outcome indicators is planned for the Performance Improvement Group meeting in October.

Trust Dashboard Graphs for TRUST

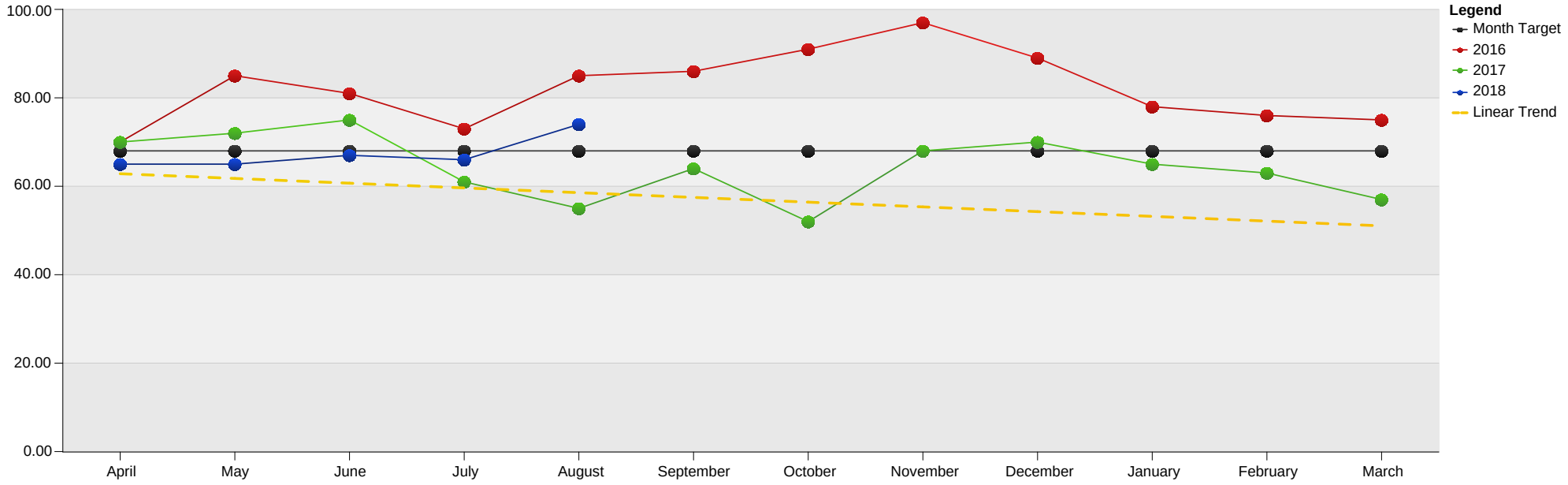


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	94.55%	95.14%	92.54%	92.44%	102.40%	102.41%	93.99%	94.72%	NA	NA	88.16%	90.68%		

Narrative
The Trust position for August 2018 is 94.55% which is worse than target and a deterioration on the position of 92.22% recorded in July 2018.All localities are over target with York and Selby being within 10% of target. Tees are reporting the highest bed occupancy at 102.40%.This KPI is impacted by the number of patients occupying a bed with a length of stay greater than 90 days (KPI 13) and percentage of patients readmitted within 30 days (KPI 14) Within MHSOP in Tees there has been an increase in organic and functional admissions during the month which is impacting on this area. Within both AMH and MHSOP in Tees this is as a result of complex patients who require long lengths of stay as well as a small number of patients who's transfer of care has been delayed. Steps are in place to ensure these patients are transferred as soon as possible All localities are monitoring this on a continual basis and actions are discussed and agreed in daily huddles.

Trust Dashboard Graphs for TRUST

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

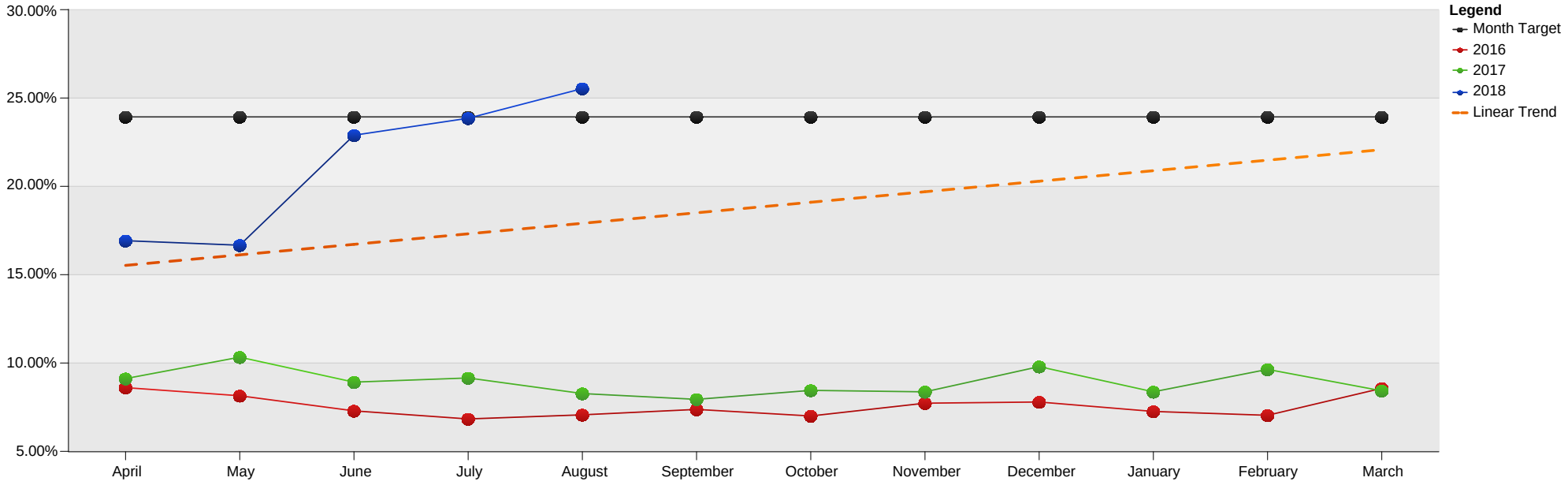


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	74.00	74.00	14.00	14.00	16.00	16.00	17.00	17.00			24.00	24.00		

Narrative
The Trust position for August 2018 is 74 which is worse than target of 68 and is a deterioration on that achieved in July 2018. The following locality is not meeting target: • York and Selby – 24 patients (2 AMH and 22 MHOSP)York are worse than target due to delayed transfers of care because of problems in finding suitable placements. Work was starting to have a positive impact however their remains an issue around care home placements which will continue to impact on this area as a result of a small number of care homes closing. Patients from other localities admitted out of area are also impacting but work continues to ensure patients are returned to beds in their home area as soon as possible and the speed at which this is happening is improving.

Trust Dashboard Graphs for TRUST

14) % of patients re-admitted to A&T wards within 30 days (AMH & MHSOP) - in reporting month



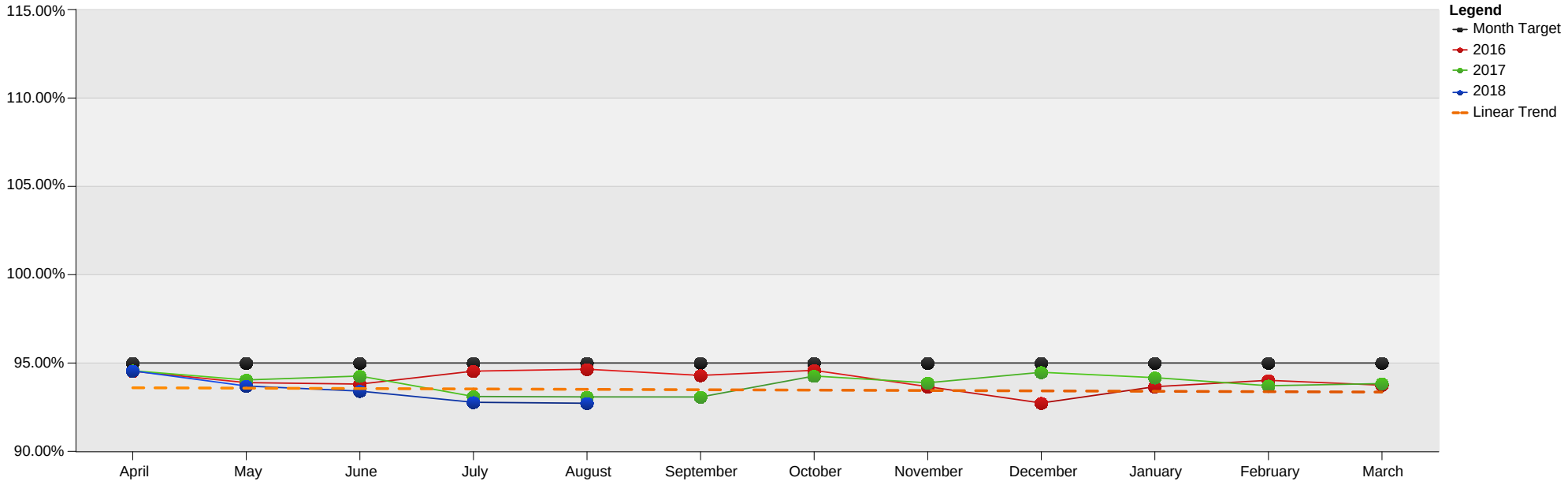
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	25.53%	21.54%	31.03%	22.67%	29.03%	23.36%	14.29%	17.95%			22.22%	19.72%		

Narrative

The Trust position ending August 2018 is 25.53%, which relates to 24 patients out of 94 that were readmitted within 30 days. This is within 10% of the target of 23.93% but is a deterioration on the position achieved in July 2018. Durham and Darlington are worse than target with a position of 31.03%, this is 9 patients out of 29, 8 AMH and 1 MHSOP. Tees are also worse than target with a position of 29.03%, this is 9 patients out of 31, 8 AMH and 1 MHSOP. All readmissions were clinically appropriate and care plans followed. This is being monitored closely within the locality to ensure where it is appropriate a readmission is avoided. This indicator has been revised from the previous year and is no longer a rolling 3 month position, as a result of this the data in the graphs looks higher for 2018 than previous years.

Trust Dashboard Graphs for TRUST

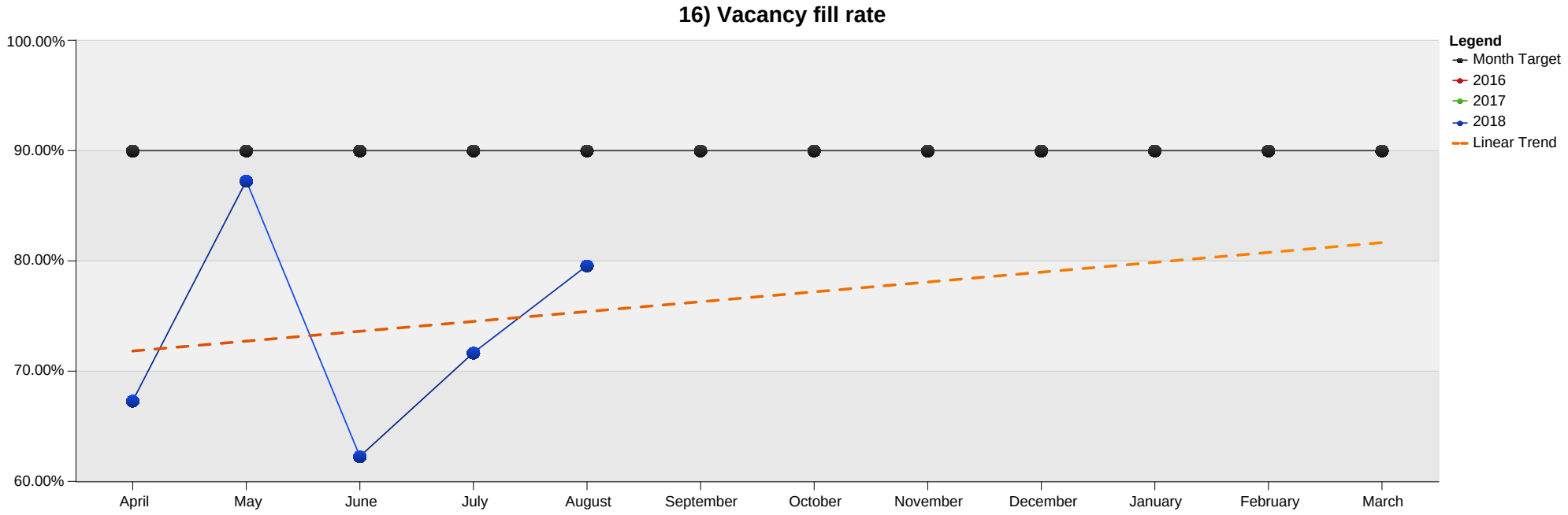
15) Actual number of workforce in month (Establishment 95%-100%)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Actual number of workforce in month (Establishment 95%-100%)	92.72%	92.72%	93.16%	93.16%	97.87%	97.87%	91.33%	91.33%	93.45%	93.45%	86.03%	86.03%		

Narrative
The Trust position for 31 August 2018 is 92.8% which is marginally below the targeted establishment level of 95-100%. It is expected that the establishment rate will continue to improve due to on-going recruitment events. At the last events held earlier in the summer a number of applicants were Student nurses who are due to qualify in September and will then take up their roles in the Trust.

Trust Dashboard Graphs for TRUST

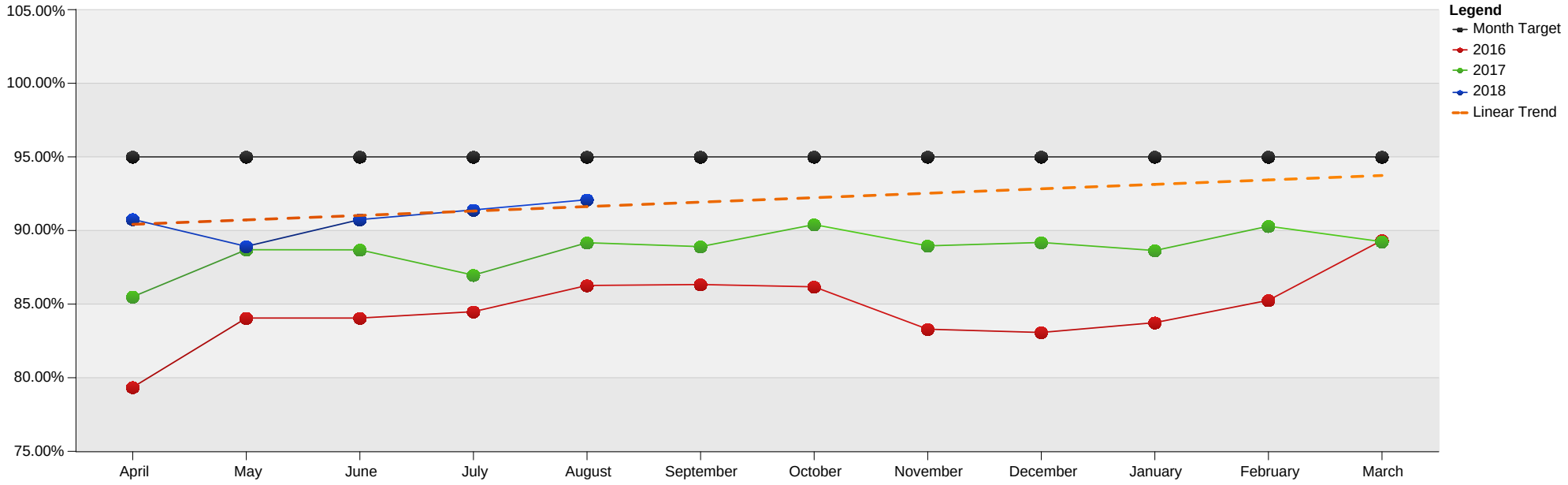


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Vacancy fill rate	79.57%	76.02%	93.94%	87.40%	76.47%	76.81%	59.26%	61.16%	100.00%	88.46%	77.78%	72.09%		

Narrative
The vacancy fill rate reports the percentage rate of health care professional vacancies band 5 and above with a conditional offer of employment made within 8 weeks of the post being advertised. The rate for August is 79.57% which is below target but represents a continued improvement on the June position. This figure represents 74 vacancies with a conditional offer made out of 93. During the 8 week reporting period 4 vacancies were not filled – this was due to no applicants, no applicants meeting shortlisting requirements or no applicants being appointed at interview. These vacancies do not form part of the above calculation as they are considered closed, although they were not successfully appointed to. The vacancies included Community Mental Health Nurse – Darlington, Positive Behavioural Support Nurse, and 2 x Staff Nurses band 5 – Acomb Garth – York and Selby.

Trust Dashboard Graphs for TRUST

17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)

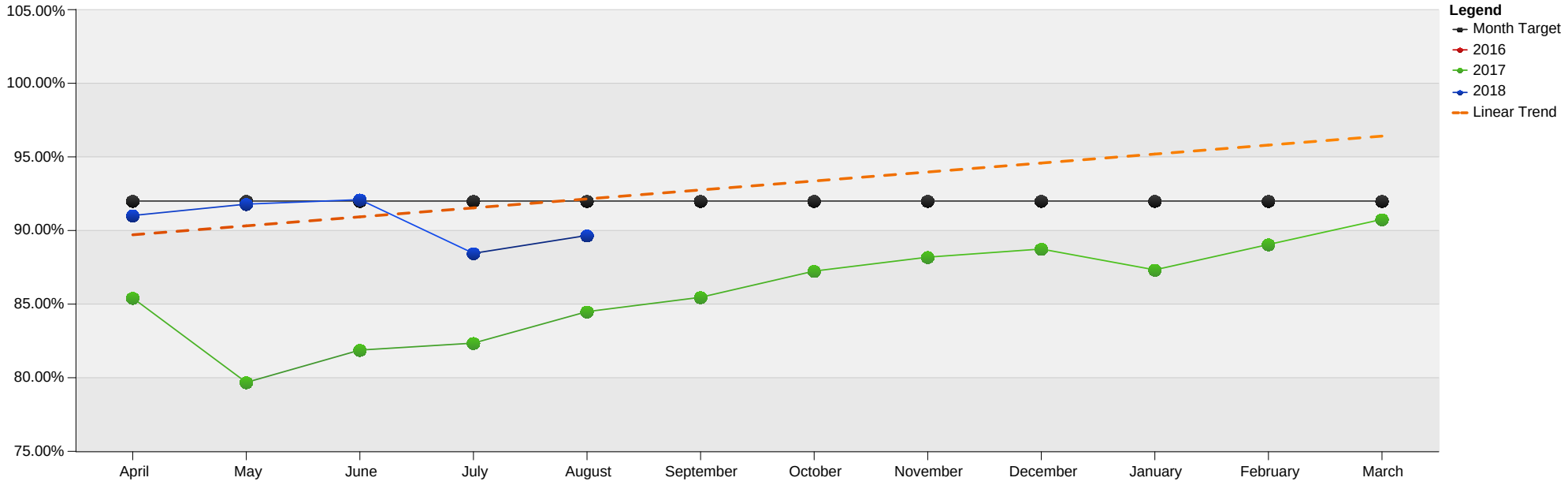


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	92.09%	92.09%	95.00%	95.00%	93.53%	93.53%	85.08%	85.08%	96.52%	96.52%	90.61%	90.61%		

Narrative
The Trust position for August 2018 has improved from 91.37% in July to 92.09% which relates to 450 members of staff out of 5688 that do not have a current appraisal.Durham and Darlington and Forensic Services are the only operational service reporting above target. The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels.

Trust Dashboard Graphs for TRUST

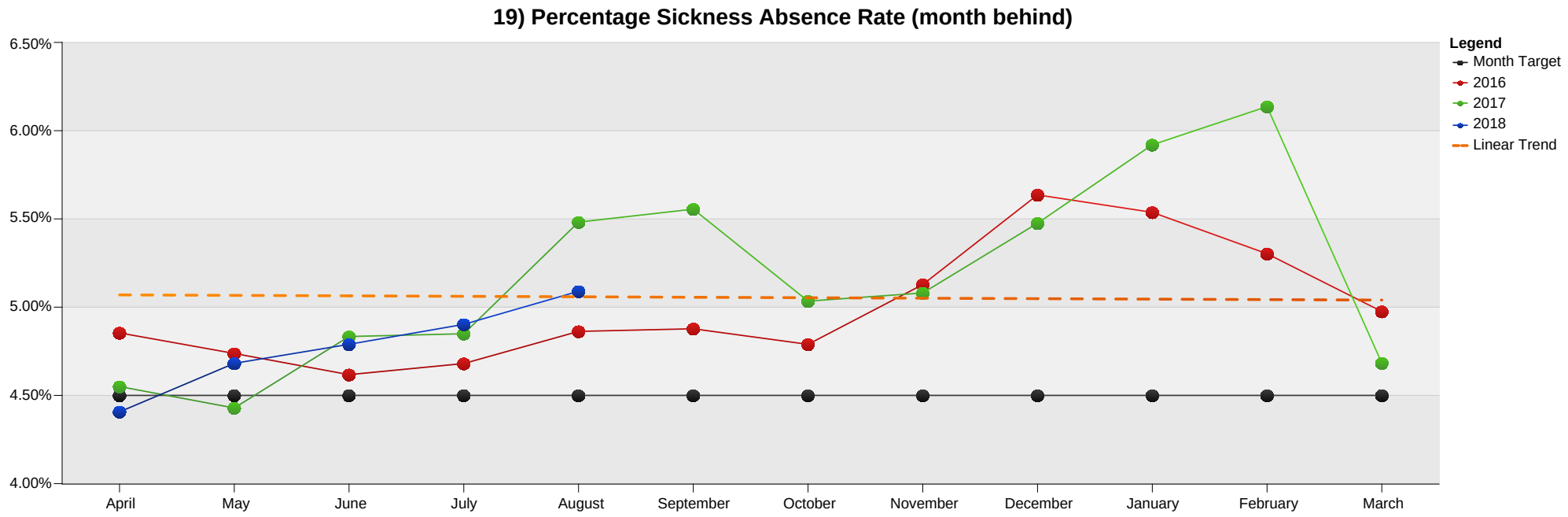
18) Percentage compliance with ALL mandatory and statutory training (snapshot)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	89.66%	89.66%	87.88%	87.88%	90.67%	90.67%	87.26%	87.26%	91.76%	91.76%	91.51%	91.51%		

Narrative
The position for August 2018 has increased to 89.66%, from 88.45% in July 2018. The operational management huddles continue to drive improvements in performance. The improved frequency of the IIC refresh also allows a timelier update of accurate performance information to managers, enabling proactive action to take place.

Trust Dashboard Graphs for TRUST

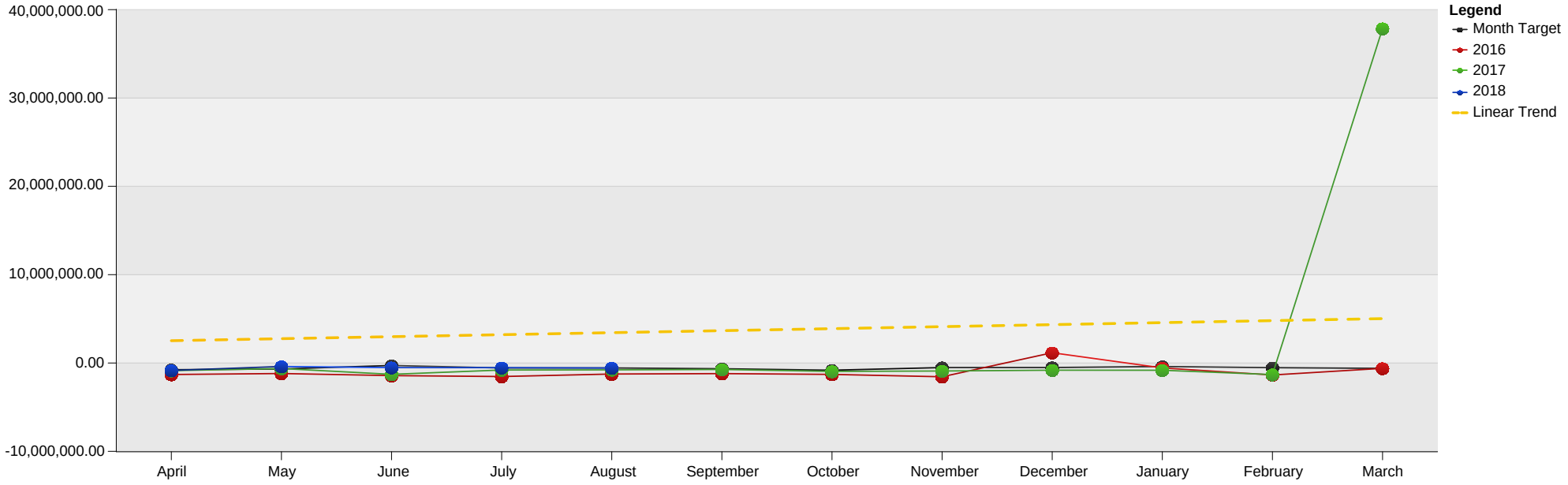


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Percentage Sickness Absence Rate (month behind)	5.09%	4.77%	5.57%	5.24%	4.12%	4.19%	4.34%	4.13%	7.09%	6.38%	4.71%	4.65%		

Narrative
The Trust position reported in August relates to the July sickness level. The Trust position reported in August 2018 has increased to 5.09% which is higher than the target of 4.50% although not as high as the same month in 2017. A review of the approach to managing sickness absence is currently underway and it is envisaged a new procedure will be available from September 2018. Work is also underway to review the Occupational Health provision which is due for retendering in the next 12 months.As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive).

Trust Dashboard Graphs for TRUST

20) Delivery of our financial plan (I and E)

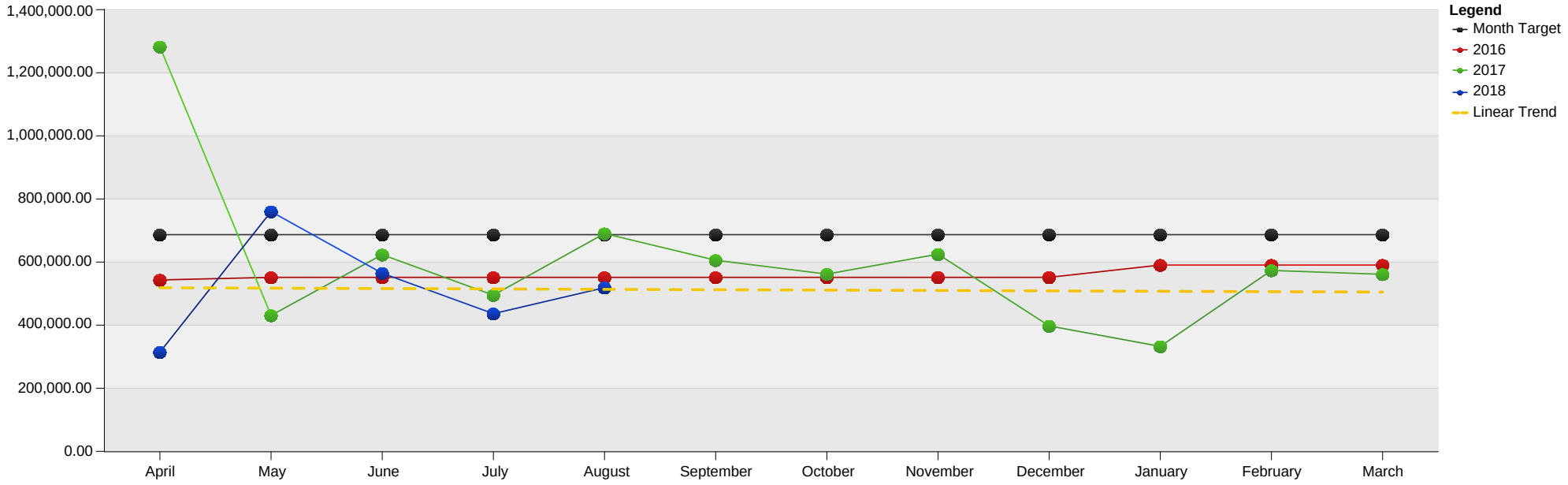


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) Delivery of our financial plan (I and E)	-565,945.00	-2,853,970.00	-299,682.00	47,191.00	195,779.00	528,316.00	189,383.00	438,859.00	280,696.00	892,000.00	-75,083.00	460,906.00		

Narrative
The comprehensive income outturn for the period ending 31 August 2018 is a surplus of £2,854k, representing 2.0% of the Trust's turnover and is £16k ahead of plan.

Trust Dashboard Graphs for TRUST

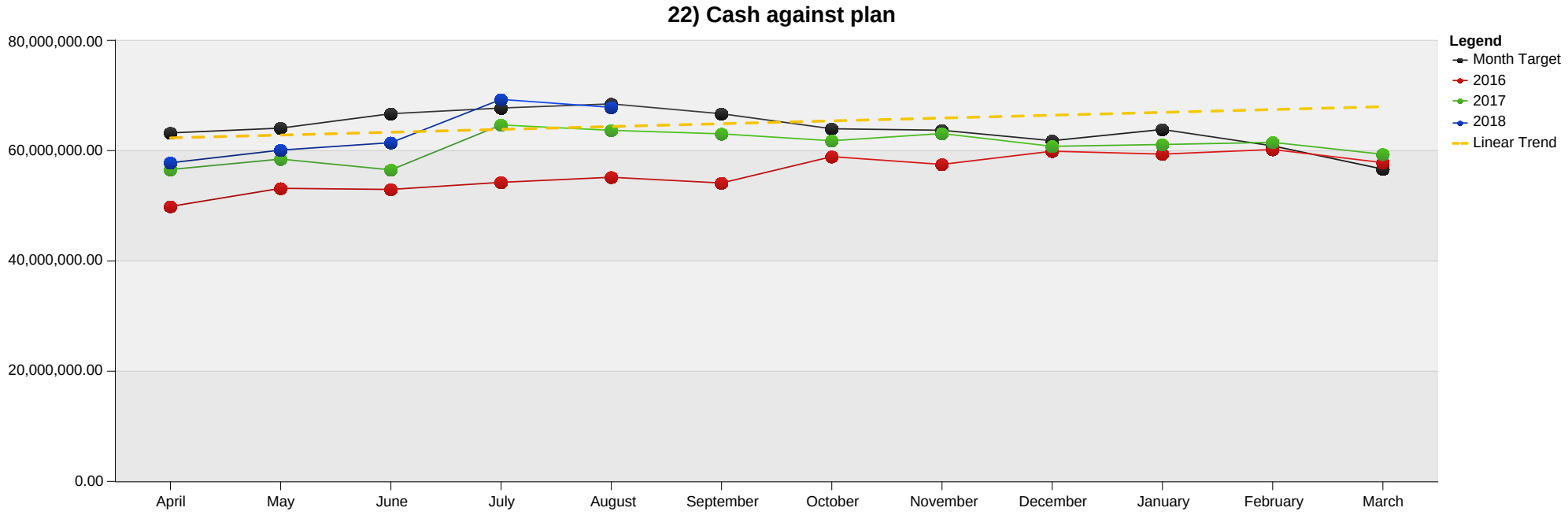
21) CRES delivery



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) CRES delivery	518,787.00	2,593,930.00	83,064.00	415,318.00	38,153.00	190,764.00	10,264.00	51,320.00	18,278.00	91,389.00	78,293.00	391,465.00		

Narrative
Identified Cash Releasing Efficiency Savings at 31 August 2018 is £2,594k and is £840k behind plan for the year to date. NHS Improvement has confirmed a reduction in the Trust's annual control total (£1,692k) which is non-recurrently mitigating CRES delivery at month 5 (£619k). As a result year to date CRES is £221k behind plan. The Trust continues to identify and develop schemes to ensure the full delivery of the next 3 years CRES requirements.

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
22) Cash against plan	67,845,000.00	67,845,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
Total cash at 31 August 2018 is £67,845k, and is £2,305k behind plan largely due to working capital variations. The Trust does not anticipate any risk relating to outstanding receivables.

Trust Dashboard - Locality Breakdown for TRUST

1 - Quality

	August 2018														April 2018 To August 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral		87.21%		87.78%		91.88%		72.87%		99.26%		84.63%				87.22%		87.35%		92.82%		75.44%		99.38%		77.08%		
2) Percentage of patients starting treatment within 6 weeks of an external referral		42.90%		37.13%		48.23%		41.92%		72.73%		36.67%				26.77%		22.21%		32.33%		22.03%		79.76%		22.63%		
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)		2,198.00		212.00		741.00		728.00				517.00				2,198.00		212.00		741.00		728.00				517.00		
4) Percentage of patients surveyed reporting their overall experience as excellent or good		91.24%		91.98%		91.84%		94.14%		83.22%		89.27%				90.94%		92.32%		91.80%		92.44%		80.03%		88.85%		
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated		1.27		1.58		1.11		1.82		0.00		0.00				7.79		8.32		5.03		10.86		32.94		6.17		
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind		58.33%		46.15%		66.67%		58.33%				70.00%				56.06%		45.38%		65.55%		60.98%				48.98%		
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind		67.90%		64.00%		70.83%		73.91%				55.56%				64.58%		63.08%		63.87%		69.17%				58.70%		

Trust Dashboard - Locality Breakdown for TRUST

2 - Activity

	August 2018														April 2018 To August 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)		94.55%		92.54%		102.40%		93.99%	NA	NA		88.16%				95.14%		92.44%		102.41%		94.72%	NA	NA		90.68%		
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)		74.00		14.00		64.00		17.00				24.00				74.00		14.00		64.00		17.00				24.00		
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month		25.53%		31.03%		29.03%		14.29%				22.22%				21.54%		22.67%		23.36%		17.95%				19.72%		

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	August 2018														April 2018 To August 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
15) Actual number of workforce in month (Establishment 95%-100%)		92.72%		93.16%		97.87%		91.33%		93.45%		86.03%				92.72%		93.16%		97.87%		91.33%		93.45%		86.03%		
16) Vacancy fill rate		79.57%		93.94%		76.47%		59.26%		100.00%		77.78%				76.02%		87.40%		76.81%		61.16%		88.46%		72.09%		
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)		92.09%		95.00%		93.53%		85.08%		96.52%		90.61%				92.09%		95.00%		93.53%		85.08%		96.52%		90.61%		
18) Percentage compliance with ALL mandatory and statutory training (snapshot)		89.66%		87.88%		90.67%		87.26%		91.76%		91.51%				89.66%		87.88%		90.67%		87.26%		91.76%		91.51%		
19) Percentage Sickness Absence Rate (month behind)		5.09%		5.57%		4.12%		4.34%		7.09%		4.71%				4.77%		5.24%		4.19%		4.13%		6.38%		4.65%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	August 2018														April 2018 To August 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
20) Delivery of our financial plan (I and E)		-565,945.00	NA	-299,682.00	NA	195,779.00	NA	189,383.00	NA	280,696.00	NA	-75,083.00				-2,853,970.00	NA	47,191.00	NA	528,316.00	NA	438,859.00	NA	892,000.00	NA	460,906.00		
21) CRES delivery		518,787.00		83,064.00		38,153.00		10,264.00		18,278.00		78,293.00				2,593,930.00		415,318.00		190,764.00		51,320.00		91,389.00		391,465.00		
22) Cash against plan		67,845,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA				67,845,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Trust Dashboard 2018/19

KPI Guide

	KPI	***Target***	***Definition***
1	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	90%	This measures, the number of patients who attend their first appointment in 4 weeks of their referral date out of the total number of people who attend their first appointment following their referral. This KPI has been amended for 2018/19 and the clock will now NOT restart if the patient DNAs or the patient cancels an appointment. This looks at patients with an external referral only. This Excludes IAPT patients.
2	Percentage of patients starting “treatment” within 6 weeks of external referral	TBC	This measures, the number of people starting treatment within 6 weeks of an external referral against number of people starting treatment. This looks at patients with an external referral only.
3	The total number of inappropriate OAP days over the reporting period (Rolling 3 months)	2,494	This measures, the total number of days patients have spent in an out of area bed inappropriately. In line with national reporting this measures a rolling 3 months time frame
4	Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	Within all inpatient and community services, this measures: Of the number of people in the Patient Survey who answered the question: - "Overall how would you rate the care you have received?," the number of patients who have scored "excellent" or "good".
5	Number of unexpected deaths classed as a serious incident per 10,000 open cases	12	This measure looks at the number of unexpected deaths classed as a serious incident per 10,000 open cases. This mirrors the data that is reported to the National Reporting and Learning System (NRLS)
6	The % teams achieving the agreed improvement benchmarks for HoNOS total score	67.25%	This measure relates to patients discharged from TEWV In Scope services (Spells ended with a Adult or MHSOP subject to Currency & Tariff National requirements). Patients total HoNOS scores are compared from the first rating against the last. A reduction in total HoNOS score is classified as improvement. 80% of patients in the Non Psychotic and Psychotic superclass and 40% in the organic superclass are expected to achieve this reduction. Teams are subject to the measure if they discharge more than 5 patients in any of the superclasses. The measure will report against the team the patient was with at the point they are discharged entirely from TEWV not if they are transferred to a different In Scope team.

Trust Dashboard 2018/19

KPI Guide

7	The % teams achieving the agreed improvement benchmarks for SWEMWBS	78.25%	This measure relates to patients discharged from TEWV In Scope services (Spells ended with a Adult or MHSOP subject to Currency & Tariff National requirements). Patients total SWEMWBS scores are compared from the first rating against the last. An increase in SWEMWBS score is classified as improvement. 80% of patients in the Non Psychotic and Psychotic superclass and 50% in the organic superclass are expected to achieve this reduction. Teams are subject to the measure if they discharge more than 5 patients in any of the superclasses. The measure will report against the team the patient was with at the point they are discharged entirely from TEWV not if they are transferred to a different In Scope team.
8	*Number of new unique patients referred*	*TBC*	*This measures the number of new individual patients referred ie a patient is only counted once. This is when the patient is not open to any other team in the Trust.* *This Excludes IAPT patients.*
9	*The number of external referrals with an Assessment completed*	*TBC*	*This measures the number of all external referrals into Trust with an assessment completed* *This Excludes IAPT patients.*
10	*The number of external referrals which were subsequently accepted onto caseload*	*TBC*	*This measures all external referrals to all services that have been accepted onto teams caseload.* *This Excludes IAPT patients.*
11	*The number of discharges from total caseload*	*TBC*	*This measures **all discharges** excluding* • *Patients who were not appropriate to accept onto caseload* • *Patients who had a referral closed without being seen* • *Patients who were assessed but not offered treatment.* • *IAPT patients.*
12	Bed Occupancy (AMH & MHSOP A & T Wards)	85%	This measures the number of days beds that are occupied out of the number of possible bed days available. (The calculation is on the number of beds available and the days in the month). This looks at AMH and MHSOP Assessment and Treatment wards only
13	Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards (Snapshot)	68	This measures the number of patients occupying a bed with a length of stay longer than 90 days from the day they were admitted. This looks at AMH and MHSOP Assessment and Treatment wards only

Trust Dashboard 2018/19

KPI Guide

14	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	TBC	This measures the number of patients who are readmitted onto a ward within 30 days of their last discharge. This looks at AMH and MHSOP Assessment and Treatment wards only
15	Actual number of workforce in month	95%	This measures the total number of contracted staff against the number of budgeted staff.
16	Vacancy fill rate	90%	This measures the number of vacancies where an offer of employment has been made out of the number of vacancies that are being recruited to. There are vacancies that have been advertised and not filled due to no applicants or no one shortlisted, however from a recruitment vacancy perspective are closed off as an episode – These are not included in the figures as they do not go over the 8 week time frame. This looks at posts that have been vacant longer than 8 weeks. This KPI will exclude bank staff and only include professional health care posts of Band 5 and above
17	Percentage of staff in post more than 12 months with a current appraisal	95%	This measures the number of staff in post more than 12 months and of those how many have a current appraisal. For medical staff this is monitored against 13 months.
18	Percentage compliance with ALL mandatory and statutory training	92%	This measures the total number of courses completed by each member of staff for ALL mandatory and statutory training out of the number of courses due to be completed for each member of staff
19	Percentage Sickness Absence Rate	4.50%	This measures the number of days lost to sickness out of the number of days within the month
20	Delivery of our financial plan (I&E)	-8556,000	This shows the Trusts surplus or deficit position (£). The target is the planned surplus position.
21	CRES delivery	8,241,384	This shows the CRES Identified against the planned amount
22	Cash against plan	56,640	This shows the actual cash held by the Trust against the amount of cash forecasted to be held

Number of unexpected deaths and verdicts from the Coroner April 2018 - March 2019

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
10	4	14	14	9							

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
21	10	12	3	6

Number of unexpected deaths and verdicts from the Coroner April 2017 - March 2018

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
4	3	1	7	11	5	11	10	10	10	10	10

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
28	20	27	6	11

Number of unexpected deaths and verdicts from the Coroner 2016 / 2017
This table has been included into this appendix for comparitive purposes only

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
5	4	3	7	5	3	1	6	7	5	3	5

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
15	9	16	4	10

Y&S recorded in old Datix not included

Data Quality Scorecard 2018/19

Appendix D

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

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th September 2018**
TITLE:	**Strategic Direction Performance Report – Quarter 1 2018/19**
REPORT OF:	**Sharon Pickering, Director of Planning and Performance**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to present to Board of Directors the Strategic Direction Performance Report as at Quarter 1 (30th June 2018).

The Trust has identified key performance indicators to monitor and report progress against its 5 year strategic direction in conjunction with the Trust Business Plan and other forms of intelligence.

Overall the scorecard position has remained static when compared to quarter 4 2017/18; whilst 11 KPIs have reported an improvement, 11 have reported a deterioration. This report reflects that three of the Trust's five goals are in an encouraging position, whilst still acknowledging that there is work to do to improve some KPI's. The percentage of reds and greens reports has remained the same as in quarter 4 2017/18; however few KPIs are available for quarter 1. Goals 1 and 2 remain a concern and would benefit from further work to improve their position.

At the Board Meeting on the 19th July 2018, Board agreed to revise the KPIs for each Strategic Goal. Work has now commenced to include these in this progress report from quarter 2 2018/19.

Recommendations:

Board of Directors are asked to:

- Approve the changes to the Trust Business Plan that requires Board approval in Appendix 1.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**25th September 2018**
TITLE:	**Strategic Direction Performance Report – Quarter 1 2018/19**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to Board of Directors the Strategic Direction Performance Report as at Quarter 1 (30th June 2018).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report demonstrates progress against the Strategic Direction Scorecard and the Trust Business Plan as well as other forms of qualitative intelligence.

2.2 The 5 year targets for the Trust Strategic Direction Scorecard were agreed by the Board on the 18th August 2015, with any amendments being approved in subsequent relevant quarterly reports.

3. KEY ISSUES:

3.1 Trust Strategic Direction Scorecard

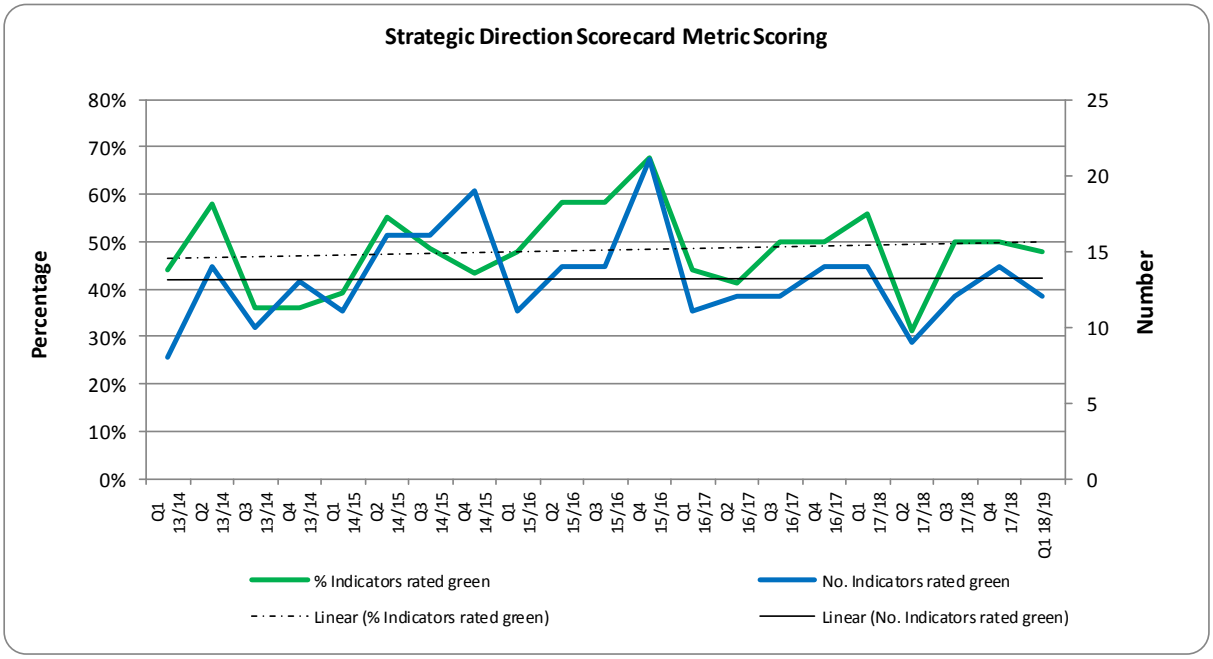
The Strategic Direction Scorecard is shown under each strategic goal with further detail, by exception, in Appendix 1.

The following table and graph provide a summary of the RAG ratings at quarter 1 compared to the position in the previous quarters and the previous financial years. The Trust is not meeting some of its high ambitions given the number of reds against stretching metrics. The actual numbers of those rated red has decreased since last quarter; however there is a significant number (12) that are not being RAG as they are not required to be reported in this quarter or are no longer applicable. When comparing this quarter's performance against the 2017/18 position as a whole, there is a significant decrease in the percentage of metrics reported red; 13 out of 25 KPIs compared to 21 out of 34 (2017/18).

	2015/16		2016/17		Q4 2017/18		2017/18		Q1 2018/19		2018/19 YTD	
	No	%*	No	%*	No	%*	No	%*	No	%*	No	%*
Indicators rated green	21	66%	16	55%	14	48%	13	38%	12	48%	12	48%
Indicators rated red	11	34%	17	59%	15	52%	21	62%	13	52%	13	52%
Indicators with no target	3		2		2		0		2		2	
Indicators currently under development/being finaliased	1		0		0		0		0		0	
Indicators where data is not yet available/not applicable in qtr	4		2		6		5		12		12	

*The percentage is based on the number of indicators that can be RAG rated (25 for quarter 1).

The graph below shows that there has been a general slowly improving trend in the percentage of greens since 2013/14.



3.2 **Strategic Goal *1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)***

3.2.1 Trust Strategic Direction Scorecard

This strategic goal is showing 4 indicators rated red out of a possible 4 that can be rated as at quarter 1; which is one more than reported in quarter 4 2017/18. However, 3 of the 4 red indicators are showing an improving position.

TRUST STRATEGIC DIRECTION SCORECARD 2018/19											
	Indicator	Q1 Target 2018/19	Quarter 1 Actual	Change on previous quarter	YTD Target 2018/19	FYTD 18/19 Actual	2017/18 Quarter 4	2017/18 Actual	2016/17 Actual	2015/16 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)											
1	Percentage of patients surveyed reporting their overall experience as excellent or good	>92.45	90.82%	⇩	>92.45	90.82%	91.35%	90.12%	92.48%	91.37%	>18/19 out-turn
2	Percentage of patients who have not waited longer than 4 weeks from "referral " to "assessment" for external and internal referrals	90.00%	87.91%	⇧	90.00%	87.91%	87.74%	89.15%	84.76%	83.17%	98.00%
3	Percentage of patients reporting "yes always" to the question "did you feel safe on the ward?"	85.00%	62.40%	⇧	85.00%	62.40%	61.17%	62.88%	82.29%	79.96%	85.00%
4	The Trust ranks in the top 20th percentile of all mental health Trusts for the CQC Service User Survey (annual)	Surveys: Top 20% of MH Trusts	Results due in Q2	n/a	Surveys: Top 20% of MH Trusts	Results due in Q2	Results published in Q3	National scoring has changed	Better or About the Same as other Trusts	Yes	Surveys: Top 20% of MH Trusts
5	The Trust ranks in the top 10th percentile of all mental health Trusts for the NHS Staff Survey (annual)	Surveys: Top 10% of MH Trusts	Results due in Q4	n/a	Surveys: Top 10% of MH Trusts	Results due in Q4	Ranked 3rd	Ranked 3rd	Ranked 4th	Yes - top MH//LD trust	Surveys: Top 10% of MH Trusts
6	Percentage of service users with a recovery focused action plan (Adult Mental Health)	92.00%	90.72%	⇧	92.00%	90.72%	87.62%	87.62%	89.73%	93.00%	95.00%

Indicators of concern are:

- **KPI 1 Percentage of patients surveyed reporting their overall experience as excellent or good. –** The Trust position for quarter 1 is 90.82% which is 1.63% worse than the target of 92.45% and a deterioration on quarter 4 2017/18 when we reported 91.35% but slightly better than the 2017/18 full year performance.

  Three localities are reporting below target; York and Selby (87.19%), North Yorkshire (91.62%) and Forensic Services (77.53%).

  The overall position is largely affected by the lower position of Forensics; this directorate has historically reported a lower positon, due to the nature of the service. There is also a concern within York & Selby that there may be an issue with the data transfer and service leads will be liaising with both patient experience & their Clinical Engagement Manager from Information to investigate this. All staff with smartphones are to be asked to download the app so that the survey can be completed following home visits, or sessions away from the buildings with the static devices, and the locality leads will liaise with Tees services to see what they are doing to get such high levels of returns and if there is anything they could do the same/similar.

- **KPI 2 Percentage of patients who have not waited longer than 4 weeks from "referral " to "assessment" for external and internal referrals** - The Trust position for quarter 1 is 87.91%, which is 2.09% worse than the target of 90% but better than the quarter 4 2017/18 position of 87.74%.

Only Forensic Services (99.30%) and Teesside (95.10%) are reporting above target for quarter 1, with York & Selby reporting the lowest performance at 72.92%.

Areas to note are:

- York Adult Mental Health has been impacted by high DNA rates within the Access Team; actions are in place to improve this position and progress is monitored on a weekly basis.

- North Yorkshire Adult Mental Health continues to experience issues across the service but particularly within the Harrogate and Ripon teams around sickness and vacancies. The teams are seeking support from Clinical Psychologists to help manage the demand.

- **KPI 3 – Percentage of patients reporting 'yes always' to the question 'did you feel safe on the ward?'** – The Trust position for quarter 1 is 62.40% which is 22.60% worse than the target of 85% but a slight improvement on the quarter 4 2017/18 position when we reported 61.17% and just below 2017/18 full year performance.

  All localities are reporting below target; Durham and Darlington (64.53%), York and Selby (76.92%), Teesside (58.43%), North Yorkshire (69.92%) and Forensic Services (55.56%). However, only Durham and Darlington are not showing an improvement on the previous quarter.

  Following the Board of Directors Deep Dive on this metric, The Director of Nursing will be raising this at the Patient Experience Group.

  The table below shows a brief summary of the reasons cited by patients for feeling unsafe, not all patients provide a reason and some can give more than one.

Locality	Reason	Number Responding	Total responses for locality
Durham & Darlington	General	3	15
	Environment	1	
	Other Patients	10	
	Own illness	2	
	Staff/Staffing	2	
North Yorkshire	General	0	11
	Environment	6	
	Other Patients	2	
	Own illness	3	
	Staff/Staffing	2	
Tees	General	1	10
	Environment	0	
	Other Patients	5	
	Own illness	3	
	Staff/Staffing	1	
Forensics	General	0	1
	Environment	0	
	Other Patients	0	
	Own illness	1	
	Staff/Staffing	0	
	General	0	
York & Selby	Environment	1	4
	Other Patients	1	
	Own illness	2	
	Staff/Staffing	0	
Data Extracted from Meridian System 19/6/18 Data Range April 18 to June 18 inclusive			

- **KPI 6 - Percentage of service users with a recovery focused action plan (Adult Mental Health)** – The Trust position for quarter 1 is 90.72% which is 1.28% worse than the target of 92% but better than the quarter 4 2017/18 position of 87.62% and 2017/18 full year performance.

  Only Durham (95.49%) is achieving the commissioner target. The following should be noted:

  - Within North Yorkshire, work is ongoing to ensure staff have appropriate training in using the recovery star. It is expected once this is achieved, performance will increased.

  - Staffing issues have continued to impact on performance within all Tees psychosis teams. Recruitment for 2 Band 6s is progressing, which will improve this position.

  Whilst the Strategic Direction Scorecard target (92%) was not achieved during the quarter, it must be noted that the commissioner target (90%) was achieved for the first time since quarter 1 2017/18.

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 1 were rated green (76%). 69% of the priorities under Strategic Goal 1 are reporting that there is no significant risk to the completion on time of the priority as a whole.

However, there are 6 (21%) priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

- 1 Priority (1.16.39) **Reconfiguration of Access** within Durham & Darlington action requires additional time from Q1 18/19 to Q2 18/19 (agreed by EMT).
- 1 Priority (1.16.11) **CYP Psychiatric Intensive Care Unit -** the service is currently developing a clinical model which will be discussed at Service Development Group to inform the development. Following this proposal new business plan actions will be presented to Board for approval.
- 1 priority (1.13.) **NY Hambleton and Richmondshire** to deliver a new model of care for AMH and MHSOP requires a change in wording and additional time (approved by EMT).
- 1 priority (1.14.) **NY Harrogate** - requires additional time for both actions (revised service model agreed and Service Model is Live). As one of these actions requires extension into the next financial year 2020/2021 this is to be presented to the Board of Directors for approval.
- 1 priority (1.2) **PPCS** - due to lack of assurance on the achievement of planned financial savings. The new Programme sponsor is working with each Director of Operations to look at financial plans. An outcome scorecard will be drafted during August 18 for approval at the PPCS Programme Board and will identify the key benefit trajectories. Within the business plan there are six actions requesting additional time (approved by EMT).
- 1 priority (1.14) **Roseberry Park Hospital** - for one of the actions the timescales are unknown due to legal consideration, any changes will be presented to EMT and Board.

There is 1 metric (Y&S hospital operational) requesting approval for additional time which moves into the next financial year 2020/21 (this is connected to the business cases recently considered by Resources Committee and Trust Board, but it has to be formally agreed by the Board of Directors). This request is contained in the appendix for approval.

There are four priorities reporting Grey on the basis that they have not been completed on time and/or benefits realised due to external factors:

- Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners – **IAPT Tender (Tees and D&D) –** The tender has not been issued by the CCG as scheduled. Although the Prior Information Notice has been published, the tender documentation was not released as expected on 6th August.
- Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners – **Respite Review & implications for Day Services (Tees)** Anticipated commissioner procurement exercise has not taken place.

Discussions are underway with commissioners regarding the provision of service. Timescales have not been confirmed.

- Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners – **STP wide Individual Placement Support (Tees)** The service were ineligible for Wave 1 transformation funding therefore are currently awaiting timescales for Wave 2 application.

Where a Board decision is required to change or remove an action, this is contained in Appendix 2 for approval (2 changes).

3.2.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- The **Trauma informed care project** has produced example scenarios for staff regarding safeguarding around abuse disclosures. It is hoped that these will be used to support good practice and reduce staff worries around having conversations about trauma.

- **Dr Muthukrishnan** was nominated for and got through the first shortlisting for the BBC One Show Lifetime Achievement Award in their NHS 70 Awards.

- The Carers Trust has given the Trust a Stage 1 Award recognising the Trust's commitment to becoming an organisation that involves and supports carers through implementation of the **Triangle of Care** (ToC). The Carers Trust said the progress made by services over the past year has been impressive and encouraging. Work continues to embed ToC across all services, including roll out to community teams over this next year.

- **Harrogate memory service,** Alexander House, Knaresborough has gained the Memory Services National Accreditation Programme for the third time.

- **Improving access to psychological therapies (IAPT) team** (York, Selby, Tadcaster and Easingwold), Huntington House, York, were winners of the Honorary Contribution to Student Life Award at the Love York Awards, as voted for by students at the University of York. This year's awards focus on 'community' and the team was nominated by the Students' Union as they feel 'the team's work has had a significant impact on the lives of students at York' and that 'the team is a great asset to the community'.

- The Board of Directors has approved the full business case for the new hospital in **York**. The new purpose-designed 72 bed hospital will be located off Haxby Road in York. It will provide two adult, single sex wards and two older people's wards - one for people with dementia and one for people with mental health conditions such as psychosis, severe depression or anxiety. This follows the purchase of the land and planning permission which was granted by City of York Council.

- EMT approved the Outline Business Case (OBC) for a new hub in **Selby** which would replace a number of sites in the Selby area.

- We have started discussions with service users, carers, staff and the local community about the future of the **crisis and recovery house in County Durham and Darlington**. The nine bedroomed house is available for men and women living in County Durham. Admissions are planned and the house provides an alternative environment for intensive home based treatment. We are holding a number of public events in June to gather suggestions about the future role of the house.

3.2.4 In conclusion it can be seen that performance against this strategic goal is of some concern and whilst there is a significant amount of positive qualitative intelligence, further work is required to drive improvements forward. The number of KPIs rated red is concerning, although it must be noted that three of the four have reported an improvement on quarter 4 2017/18. Whilst the majority of business plan actions are green (76%), there are a number of actions that are showing some level of risk to delivery. Continued work to improve the position for recovery star has reflected a more positive performance within that metric; however, further work is required around patient experience to drive up performance and with the business plan to ensure achievement.

3.3 **Strategic Goal 2** - ***To continuously improve the quality and value of what we do***

3.3.1 Trust Strategic Direction Scorecard

This strategic goal is showing 4 indicators rated red out of a possible 5 that can be rated, which is a deterioration on quarter 4 2017/18 when we reported 3 rated red. However, 2 of the 4 red indicators are showing an improving position.

TRUST STRATEGIC DIRECTION SCORECARD 2018/19											
	Indicator	Q1 Target 2018/19	Quarter 1 Actual	Change on previous quarter	YTD Target 2018/19	FYTD 18/19 Actual	2017/18 Quarter 4	2017/18 Actual	2016/17 Actual	2015/16 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 2 (To continuously improve the quality and value of what we do)											
7	Number of outstanding action points for **more than 31 days** for Level 5 SIs and action points for safeguarding serious case reviews and domestic homicide reviews	0	4	⇧	0	4	13	13	23	0	0
8	Number of action points on action plans for complaints and clinical audit that are outstanding for **more than 31 days**	0	12	⇧	0	12	18	18	24	13	0
9	Friends & Family Test - **Patient** Survey Question: "How likely are you to recommend our ward/services to friends and family if they needed similar care or treatment?"	>86.56	86.59%	⇩	>86.56	86.59%	86.91%	87.30%	86.56%	86.01%	> previous year out-turn
10	Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication	50%	0.00%	⇩	50.00%	0.00%	50.00%	21.05%	17.14%	53.57%	>=75%
11	Percentage of staff reporting that they can 'contribute towards improvements at work'*	>2015/16 (79%) and in top 20%ile of MH/LD trusts	Results due in Q4	n/a	>2015/16 (79%) and in top 20%ile of MH/LD trusts	Results due in Q4	75.00%	75.00%	76.00%	79% and in top 20%	> 2018/19 and in top 20%ile for MH/LD Trusts
12	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family if they need care or treatment?"	>82.58%	82.00%	⇔	>82.58%	82.00%	82.00%	82.13%	81.22%	82.58%	> previous year out-turn
13	For Trust hospital sites with over 10 beds, the trust score for each category (Cleanliness, Food, Privacy & Dignity, Condition, Appearance & Maintenance, Dementia Friendly, Learning Disability) > national average PLACE (new PEAT) assessments.	80%	Assessment due in Q2	n/a	80%	Assessment due in Q2	Assessment completed in Q2	33.33%	50.00%	80.00%	80%
14	Hospitality Assured Accreditation score*	82.00%	Assessment due in Q3	n/a	82.00%	Assessment due in Q3	No scoring for 2017/18	No scoring for 2017/18	81.10%	Assessment now due Q1 16/17 & results in Q2	86.00%

Indicators of concern are:

- **KPI 7 - Number of outstanding action points on action plans for more than 31 days for Level 5 SI's and action points for safeguarding serious case reviews and domestic homicide reviews**– The Trust position for quarter 1 is 4 against a target of zero, which is a significant improvement on quarter 4 2017/18 when we reported 13. All relate to Level 5 SIs.

  The 4 outstanding actions are from a total of 12 action plans. At the time of writing this report only 1 of these action points remains outstanding.

- **KPI 8 - Number of action points on action plans for complaints and clinical audit that are outstanding for more than 31 days** – The Trust position for quarter 1 is 12 outstanding action points against a target of zero, which is better than the quarter 4 2017/18 position of 18.

  Two action points were in relation to complaints. These were both regarding North Yorkshire locality and they have not been completed as a result of the responsible owner leaving the trust. The complaints team are currently establishing a new owner.

  At the time of writing both action points remain outstanding.

  Ten action points were from 6 clinical audit action plans:

- Rapid Tranquilisation 17/18 - 1 outstanding action point)
- IPC Validation Audit Hamsterley - 2 outstanding action points
- Clinical Audit of Early Warning Score (EWS) - 1 outstanding action point
- IPC Audit Imperial Avenue - 3 outstanding action points
- Clinical Audit of Duty of Candour - 2 outstanding action points
- Clinical Audit of Hand Hygiene Facilities and Staff Knowledge (2017/18) 1 1 outstanding action point

At the time of writing 1 action point remains as outstanding.

- **KPI 10 - Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication** –The Trust position for quarter 1 is 0%, against a target of 50%, which reflects no baseline assessment tools out of 1 being signed off by CEG within 6 months of publication. This is a worse position than the quarter 4 2017/18 position of 14.29% and the 2017/18 full year position.

  The delayed NICE BAT was NG69 Eating Disorders: recognition and treatment (Update). The delay with this was due to the change in the AMH Service Development Manager post, which caused difficulties that were subsequently resolved once the position was filled.

3.3.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 1 were rated green (75%). 60% of the priorities under Strategic Goal 2 are reporting that there is no significant risk to the completion on time of the priority as a whole.

There are 2 priorities / service developments (40%) in the Business Plan at high risk of failure to deliver on-time or within budget.

- 1 Priority (2.3.1) **improve consistency & purposefulness of Inpatient care MHSOP** action requires additional time from Q1 18/19 to Q2 18/19 (agreed by EMT).
- 1 Priority (2.19.1) **Preventable deaths -** action requires additional time from Q1 18/19 to Q2 18/19 (agreed by EMT).

There is 1 action which requires additional time from Q1 18/19 to Q3 18/19 (agreed by EMT) but this is not expected to delay delivery of the overall priority.

There are no changes that require Board approval.

3.3.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- **Hambleton and Richmondshire memory service**, Friarage Hospital, Northallerton has achieved the Memory Services National Accreditation Programme award, which recognises and celebrates the quality of memory services for people with memory problems / dementia and their carers.

3.3.4 In conclusion it can be seen that performance against this strategic goal remains of some concern. Four out of five KPIs are rated red and only two have reported an improvement compared to the previous quarter. Whilst the majority of business plan actions have been completed (75%), there remain two priorities that are at high risk of delivery. Further work is required around several KPIs including the number of outstanding action points for clinical audit and sign-off of the NICE baseline assessment tool within 6 months to achieve a more positive position.

3.4 **Strategic Goal 3** - ***To recruit, develop and retain a skilled, compassionate and motivated workforce***

3.4.1 Trust Strategic Direction Scorecard

This strategic goal is showing 2 indicators rated red as at quarter 1 out of a possible 8 that could be rated. This is significantly better than the quarter 4 2017/18 position when we reported 7 reds out of 11 rateable metrics. Of those rated red, only one has reported an improvement.

TRUST STRATEGIC DIRECTION SCORECARD 2018/19											
	Indicator	Q1 Target 2018/19	Quarter 1 Actual	Change on previous quarter	YTD Target 2018/19	FYTD 18/19 Actual	2017/18 Quarter 4	2017/18 Actual	2016/17 Actual	2015/16 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 3 (To recruit, develop and retain a skillled, compassionate and motivated workforce)											
15	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family as a place to work?"	>70.95%	71.00%	⇧	>70.95%	71.00%	69.00%	70.44%	70.45%	70.95%	> previous year out-turn
16	Percentage of medical students and junior doctors reporting satisfaction with their placement	89.00%	97.01%	⇩	89.00%	97.01%	90.14%	86.84%	89.97%	89.09%	90.00%
17	Percentage of positive nursing placement evaluations received	95.00%	95.30%	⇧	95.00%	95.30%	90.78%	94.46%	95.69%	95.17%	95.00%
18	Excess cost of employing medical agency versus substantive	£75,000	£239,067	⇩	£75,000	£239,067	£235,477	£601,550	£697,684	£200k	zero
19	NHS Employers Assessment of Wellbeing	100%	100.00%	⇔	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100%
20	Percentage of Culture Metrics showing improvement at year end*	n/a	no longer reported	n/a	n/a	no longer reported	no longer reported	no longer reported	no longer reported	To be reported at July 16 Trust Board	100%
21	Percentage of positive staff responses for training/development evaluations received (data is a month behind	75.00%	76.28%	⇩	75.00%	76.28%	89.51%	80.78%	74.18%	75.30%	TBC
22	Quality of Appraisals	>4.0	Results due in Q4	n/a	>4.0	Results due in Q4	3.24	3.24	4.00	3.36	>= 2018/19 & in top 20%
23	Percentage of medical staff successfully revalidated	100%	100.00%	⇔	100%	100.00%	100.00%	100.00%	90.00%	98.15%	100%
24	Percentage of indicators in the NHS Staff Survey for which there was no noticeable or sufficient different in responses of those who identified themselves as disabled, compared to those who did not identify themselves as disabled	>93.75%	Results due in Q4	n/a	>93.75%	Results due in Q4	87.50%	87.50%	93.75%	n/a	TBC
25	Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above	50%	17.39%	⇧	50.00%	17.39%	11.11%	21.21%	8.08%	32.00%	80.00%
26	Percentage of staff reporting that they 'suffered work related stress in last 12 months'*	<2015/16 outturn (28%)	Results due in Q4	n/a	<2015/16 outturn (28%)	Results due in Q4	39.00%	39.00%	33.00%	28% and top 20% (best for MH/LD Trusts)	< previous year out-turn

Indicators of concern are:

- **KPI 18 - Excess cost of employing medical agency versus substantive** - the Trust position for quarter 1 is £239,067 against a target of £75,000.

  As at the end of quarter 1, 13 agency staff were required to support vacancies in Durham and Darlington (2 MHSOP and 2 AMH), Teesside (1 CYPS), North Yorkshire (3 MHSOP and 1 AMH) and York and Selby (2 MHSOP, 1 AMH and 1 CYPS).

  An additional 2 agency staff were required to cover sickness in York and Selby (1 AMH and 1 CYPS)

- **KPI 25 - Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above** – The Trust position for quarter 1 is 17.39%, which reflects 19 advertised posts out of 23 that did not have at least 2 internal candidates above the line for Band 7 posts and above. This is 32.61% worse than the target of 50% but is better than the quarter 4 2017/18 position of 11.11%.

  Talent management continues to be a priority as a significant proportion of the posts advertised are Band 7 Ward Manager/Team Manager roles. A more

focused approach on Band 6 to 7 progression needs to be explored further in the services, especially with regard to hard to fill posts, and this is to be discussed with the Heads of Service going forward. The Locality Manager Talent Management Facilitator role currently being piloted in MHSOP is due to be reviewed at the end of August. If successful, this approach can then be rolled out in other services/Localities.

3.4.2 Trust Business Plan

A minority of the business plan actions due to be completed by the end of quarter 1 were rated green (33%) There is only one business plan priority assigned to Strategic Goal 3. This is Making a Difference Together which is currently reporting a low to moderate risk of failure to complete the priority on time, within budget to the agreed specification. Two of the actions within this priority require additional time for completion. As these are within the current financial year, these requests have been approved by EMT.

3.4.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- **Janice Featherstone**, Bridges to Learning project worker, Lanchester Road Hospital, Durham has been one of 25 union learning reps honoured for her contributions to workplace learning at the 25th anniversary of the UNISON conference.

- **Joe Atkinson**, mental health student nurse, Harrogate assertive outreach team, Windsor House, Harrogate, has won the Student Nurse of the Year: Mental Health category of the Student Nursing Times Awards 2018.

- **Rachel Orr**, clinical psychologist and **Katy Philips**, clinical psychologist who are based within the Local Authority Opportunity Team for Care Leavers in North Yorkshire, were winners of the Team Achievement of the Year Award at the North Yorkshire County Council CYPS Celebrating Good Practice Awards 2018. Rachel and Katy are part of the psychologically informed partnership approach (PIPA) group of Trust clinicians that work together with the local authority to enhance access to a psychological service for the most vulnerable and marginalised children and young people.

- University of York Senate has accorded the status of Honorary Visiting Professor in the department of Health Sciences to one of our **nurse consultants, David Ekers** to for three years. As the Trust's first professor of nursing, this is an outstanding milestone.

- **Paula Maddison**, lead statistician/researcher, Flatts Lane Centre, Middlesbrough has been chosen to present her 'research on productivity in mental health and

how it is measured' at the 5th EuHEA PhD Student-Supervisor and Early Career Researcher Conference, in Catania, Italy.

- **Mani Krishnan**, consultant in old age and liaison psychiatry, Lustrum Vale, Stockton-on-Tees and **Eleni Fixter**, specialty registrar, Woodside Resource Centre, Middlesbrough, hosted a workshop at the American Delirium Society Annual conference in San Francisco, and presented their work on attitudes towards delirium management in acute settings and educational interventions.

- **Judith Hurst**, Head of Workforce Development for the Trust attended an event at The House of Commons to celebrate apprenticeships. The Trust is in the top 200 businesses in the country for apprenticeship growth.

- **Mani Krishnan,** consultant psychiatrist, Lustrum Vale, Stockton-on-Tees, has been awarded clinical supervisor of the year by the Durham and Tees Valley GP training programme.

- During June the General Medical Council undertook an inspection visit regarding the quality of **medical education** that we provide. The visit was positive and the Trust has been identified as the best educator in the region and ranked sixth nationally.

3.4.4 In conclusion it can be seen that performance against this strategic goal is very positive. Only two KPIs are rated red; one of which is improving and there is a significant amount of qualitative intelligence for this goal which provides a very positive position. However, the Business Plan shows a less encouraging position with only 25% of action plans completed although it is anticipated that the outstanding actions will be delivered within 2018/19.

3.5 Strategic Goal 4 - *To have effective partnerships with local, national and international organisations for the benefit of the communities we serve*

3.5.1 Trust Strategic Direction Scorecard

This strategic goal is showing 1 indicator rated red at quarter 1 out of a possible 3 that can be rated, which is worse than the quarter 4 2017/18 position of 0.

TRUST STRATEGIC DIRECTION SCORECARD 2018/19											
	Indicator	Q1 Target 2018/19	Quarter 1 Actual	Change on previous quarter	YTD Target 2018/19	FYTD 18/19 Actual	2017/18 Quarter 4	2017/18 Actual	2016/17 Actual	2015/16 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 4 (To have effective partnerships with local, national and international organisations for the benefit of the communities we serve)											
27	Attendance rate at H&WB Boards	90%	87.50%	⇩	90%	87.50%	100.00%	87.50%	85.71%	87.50%	90%
28	Attendance rate at Statutory Safeguarding Boards & MAPPA Strategic Management Boards	98%	100.00%	⇧	98%	100.00%	88.89%	97.40%	100.00%	100.00%	98%
29	Proportion of student nursing placements provided as a % of placements requested	90%	99.54%	⇩	90.00%	99.54%	99.66%	99.50%	100.26%	99.12%	90.00%
30	R&D Outcomes - Annual number of recruits to National Institute of Health Research studies supported by TEWV R&D staff	n/a	147	⇩	n/a	147	186	1271	1105	412	10% increase year on year
31	R&D Outcomes - Annual external R&D income (including external grants and commercial income)	n/a	£182,854	⇧	n/a	£182,854	£319,178	£841,941	£585,215	£616,376	10% increase year on year
32	Corporate Governance Statement signed off annually by Board with no conditions* and Monitor Governance Risk Rating maintained at 'GREEN' each quarter	n/a	no longer reported	n/a	n/a	No longer reported	No longer reported	No longer reported	No longer reported	Signed & Green	Signed & Green

Indicators of concern are:

- **KPI 27 - Attendance rate at H&WB Boards** - The Trust position for quarter 1 is 87.50%, which is 2.5% below target and worse than the 100% reported in quarter 4 2017/18.

  There were 7 H&WB Boards attended out of 8, with 1 unattended in County Durham. It should be noted that only the Member or Named Deputy can attend the meetings, no other representative can be sent.

3.5.2 Trust Business Plan

A minority of the Strategic Goal 4 business plan actions due to be completed by the end of quarter 1 were rated green (36%). None of the priorities under this strategic goal in the Business Plan are at high risk of failure to deliver on-time or within budget.

There are 6 metrics (New Care Models secure services) and 1 metric from Collaborations with Universities requesting additional time (agreed by EMT as all within the current financial year)

3.5.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- The Trust is working in partnership with Northumberland, Tyne and Wear NHS Foundation Trust (NTW) to deliver the **North East and North Cumbria forensic child and adolescent mental health service**, which was launched in April 2018.

- For **IAPT services across Teesside and Durham and Darlington**, a new partnership between TEWV, Mental Health Matters and Sunderland Counselling Services has been agreed to tender for this work. The existing partnership, which includes County Durham & Darlington Foundation Trust, will continue until the current contract ends and there is agreement that collaborative work will be maintained. There will be concurrent governance arrangements put in place.

- The **Trust** has secured funding from NHS England to introduce new, much needed community perinatal mental health services across County Durham and Darlington, North Yorkshire and the Vale of York. We were part of a successful bid with local CCGs and services will support local women who are experiencing mental health difficulties during pregnancy or in the first year after they have had their baby. In addition, the bid includes funding to expand on services that the Trust already provides in Teesside.

- Building on the good work we have done already in Teesside and County Durham we have now started work with the CCGs in **North Yorkshire** to develop an accountable care partnership. The ultimate aim of these partnerships is to improve the quality of care for people with learning disability and mental ill health by breaking down the barriers between commissioning and provision.

3.5.4 In conclusion performance against this strategic goal is encouraging, with only one KPI rated red and a significant amount of qualitative intelligence. However, the Business Plan shows a less encouraging position at quarter 1, with only 40% of actions completed. However, this does not pose significant risk to overall delivery.

3.6 **Strategic Goal 5 - *To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve***

3.6.1 Trust Strategic Direction Scorecard

This strategic goal is showing 2 indicators rated red out of a possible 5 that can be rated as at quarter 3, which is worse than the 1 reported in quarter 4 2017/18.

TRUST STRATEGIC DIRECTION SCORECARD 2018/19											
	Indicator	Q1 Target 2018/19	Quarter 1 Actual	Change on previous quarter	YTD Target 2018/19	FYTD 18/19 Actual	2017/18 Quarter 4	2017/18 Actual	2016/17 Actual	2015/16 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 5 (To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve)											
33	Percentage of data quality issues reported on Data Quality Scorecard (reds on scorecard)	37.50%	61.54%	⇩	37.50%	61.54%	84.62%	84.62%	64.29%	57.14%	<=6.25%
34	Percentage of Information Strategy metrics on target that are reported on Information Strategy Metrics Scorecard	Superseded by the Digital Transformation Scorecard			N/A	N/A	85.71%	85.71%	81.25%	5 yr Strategy & metrics approved EMT March 2016	TBC
35	Percentage change in income for Trust contracted services compared to previous year	0.10%	-0.16%	⇧	0.10%	#DIV/0!	0.73%	0.73%	7.42%	8.09%	Better than deflator
36	Reference Cost Index score for in-scope PbR Services	<=95	104	n/a	<=95	104	Reported in Q3	100	100	92	TBC
37	Reference Cost Index score for out of scope PbR Services	<=95	90	n/a	<=95	90	Reported in Q3	88	88	95	TBC
38	EBITDA **	5.60%	5.40%	⇩	5.50%	5.40%	8.20%	8.20%	7.79%	8.22%	8.00%
39	Good Corporate Citizenship audit scores*	Replaced by the Sustainable Development Assessment Tool			N/A	N/A	Replaced by Sustainable Development Assessment Tool	N/A	66%	66%	75.00%

Indicators of concern are:

- **KPI 33 - Percentage of data quality issues reported on Data Quality Scorecard (reds on scorecard)** – The Trust position for quarter 1 is 61.54%, which is worse than that reported in quarter 4 2017/18 and 24.04% more than expected and therefore an underperformance but much better than the 2017/18 full year position and the lowest since 2015/16.

  Of the 8 metrics reporting red, 2 have shown some improvement on quarter 4 2017/18. The data quality scorecard will continue to be monitored at the Data Quality Working group and escalated as required.

- **KPI 36 – Reference cost index score for in-scope PbR services** - The Trust position for quarter 1 is 104 which is 9 above target and worse than the last submitted position in quarter 3 2017/18 of 100.

  The reference cost index is based on all submissions across the country and hence is influenced by other providers' submissions. The figure reported is pre-submission for the Trust so it is anticipated to move following submissions by all other Trusts.

Other points to note:

- **KPI 34 – Percentage of Information Strategy metrics on target that are reported on Information Strategy Metrics Scorecard** – This metric relates to the old Information Strategy which has been superseded by the Digital Transformation Strategy and Scorecard. Work is ongoing to complete the

definitions of the new KPIs and targets for this but some of these will not start until later in the year or beyond.

- **KPI 39 – Good Corporate Citizenship audit scores** –the Sustainable Development Unit (SDU) have replaced the Good Corporate Citizenship Assessment Tool (GCCAT). The replacement Sustainable Development Assessment Tool (SDAT) became active in February 2018 and we are currently building a score on the new assessment tool.

3.6.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 1 were rated green (100%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

3.6.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- Planning approval has been granted for a new block at **Roseberry Park**. This block would be used to accommodate patients from secure services who will need to move from their current wards to enable rectification works to be undertaken. The planning consent included permission to create car parking spaces which will be the first of the new developments on site.

- **TEWV Estates and Facilities Management Ltd** (TEWV EFM) have successfully stepped in to provide estates and facilities management services at Roseberry Park in Middlesbrough.

3.6.4 In conclusion it can be seen for this strategic goal that the overall position remains positive. Progress against the business plan and significant qualitative intelligence is encouraging. Further work is required around data quality to drive up performance and ensure achievement.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
There are no issues of compliance with the CQC fundamental standards.

4.2 **Financial/Value for Money:**
The report highlights that none of the Sustainability metrics are below target.

4.3 **Legal and Constitutional (including the NHS Constitution):**
There are no direct legal or constitutional implications from this paper.

4.4 **Equality and Diversity:**
There are no direct equality and diversity implications from this paper, however, one metric does measure the variance in the responses of staff in the NHS Staff Survey who report as 'disabled' compared to those reporting 'non-disabled'.

4.4 **Other implications:**
There are no other implications associated with this paper.

5. RISKS:
There are no identified risks associated with this paper.

6. CONCLUSIONS:

This is the first Strategic Direction Performance Report for 2018/19 and reports progress against the Strategic Direction Scorecard and the Trust Business Plan whilst also considering other forms of qualitative intelligence.

Overall the scorecard position has remained static when compared to quarter 4 2017/18; whilst 11 KPIs have reported an improvement, 11 have reported a deterioration. This report reflects that three of the Trust's five goals are in an encouraging position, whilst still acknowledging that there is work to do to improve some KPI's. The percentage of reds and greens reports has remained the same as in quarter 4 2017/18; however few KPIs are available for quarter 1. Goals 1 and 2 remain a concern and would benefit from further work to improve their position.

7. RECOMMENDATIONS:

Board of Directors is asked to:

- Approve the changes to the Trust Business Plan in Appendix 1.

Sharon Pickering
Director of Planning, Performance & Communications

Background Papers:

Appendix 1

Appendix – Requests to the Board of Directors for a Change to the Business Plan

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q1 Metric Status	Comment and requests for decisions
1.13.2	Deliver a new model of care for Adult Mental Health and Mental Health Services for Older People in Harrogate	North Yorkshire	AMH / MHSOP	Mobilise agreed Service Model	New Service Model is live	Q3 19/20	Adele Coulthard		Due to the Harrogate Transformation Review requiring a 4 month extension to complete the Business Case which meets the criteria set out for the NHS England sense check 2 this has impacted on the timescales for the commencement of the Public consultation, which will now start 8th Oct 18 to January 18. Therefore Board are requested to extend the action timescales to Q1 2020/21
1.11.1	Complete the transformation of our York & Selby services	York and Selby	All	Development of new fit for purpose Mental Health Hospital in York	Hospital commissioned and open for inpatient care	Q3 19/20	Ruth Hill		Due to delay re: construction and revised design. Board are requested to approve the extension of the timescale of this metric to Q1 2020/21

Please note that if approved, future monitoring will be against the amended timescale.

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th September 2018**
TITLE:	**Appointment of the Non-Executive Chairmen and Members of Committees of the Board of Directors**
REPORT OF:	**Lesley Bessant, Chairman of the Trust**
REPORT FOR:	**Decision**

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

Executive Summary:

The Board is asked to appoint:

(1) The Non-Executive Director chairmen and members of its committees in accordance with their terms of reference.

(2) The panel of Non-Executive Directors to participate in reviews of serious incidents.

Recommendations:

The Board is asked to approve the appointments set out in Annex 1 to this report with effect from 1st October 2018.

MEETING OF:	**The Board of Directors**
DATE:	**25th September 2018**
TITLE:	**Appointment of the Non-Executive Chairmen and Members of Committees of the Board of Directors**

1. INTRODUCTION & PURPOSE:

1.1 To seek the appointment of Non-Executive Directors as the chairmen and members of the Board's committees and to participate in reviews of serious incidents.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The appointment of members of the Board's committees is a reserved matter under Annex 8 of the Constitution.

2.2 The number of Non-Executive seats on the committees is set out in their terms of reference.

3. KEY ISSUES:

3.1 Approval is sought for the appointment of Non-Executive Directors to seats on the Board's committees and to participate in serious incident review panels, as set out in the schedule attached as Annex 1 to this report, with effect from 1st October 2018.

3.2 The only change, to the present arrangements, arises from the reduction of one seat on the Resources Committee as agreed under minute 18/218 (19/7/18).

4. IMPLICATIONS:

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

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

4.3 **Legal and Constitutional (including the NHS Constitution):** The appointment of members to its committees is a matter reserved to the Board under Annex 8 of the Constitution.

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with the Constitution.

7. RECOMMENDATIONS:

7.1 The Board is asked to appoint the Non-Executive Directors as the chairmen and members of its committees and to participate in serious incident review panels (in accordance with the schedule attached as Annex 1 to this report) with effect from 1st October 2018.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution

Annex 1

Non-Executive Director Committee and SUI Panel Membership from 1st October 2018

	Audit Committee	Resources Committee	Mental Health Legislation Committee	Quality Assurance Committee	Commercial Oversight Committee	SUI Panel
Maximum Number of Non-Executive Director seats (inc. the Chair of the Committee) excluding Ex Officio Members	4	3	3	4	**All Ex Officio Members**	-
Lesley Bessant		**Ex Officio Member**	**Ex Officio Member**	**Ex Officio Member**	**Ex Officio Member**	**Ex Officio Member**
Dr. Hugh Griffiths	✓			**Chair**		✓
Marcus Hawthorn	✓	**Chair**			**Ex Officio Member**	
David Jennings	**Chair**	✓			**Ex Officio Member**	
Richard Simpson			**Chair**	✓		
Paul Murphy	✓	✓	✓			✓
Shirley Richardson			✓	✓		✓

(Note: All Non-Executive Directors are members of the Board Nomination and Remuneration Committee)

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th September 2018**
TITLE:	**Board Business Cycle**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Decision**

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

Executive Summary:

The business cycle sets out the matters to be considered by the Board at its formal meetings and seminars taking into account key corporate processes.

The Board is asked to:

(1) Note that no significant changes are proposed to the Board's meeting arrangements at this time but the position might need to be reviewed.

(2) Consider the following proposals in relation to the seminar programme:

- The introduction of two dedicated Board training and development sessions in April and September 2019 in place of the usual seminars.
- The provision of an extra seminar in February 2019 to provide additional time to review the draft Business Plan.

Recommendations:

The Board is asked to:

(1) Approve its indicative business cycle for the period 1st October 2018 to 31st December 2019 (as set out in Annexes 1 and 2 to this report) noting that changes might be required to meeting arrangements during the period.

(2) Propose any additional topics for inclusion in the Board Seminar/Training and Development Programme.

MEETING OF:	**The Board of Directors**
DATE:	**25th September 2018**
TITLE:	**Board Business Cycle**

1. INTRODUCTION & PURPOSE:

1.1 To enable the Board to consider its meeting arrangements and business cycle for the period October 2018 to December 2019.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The business cycle sets out the matters to be considered by the Board at its formal meetings and seminars.

2.2 It takes into account:

- The need for the provision of timely assurance to the Board to support achievement of the Trust's strategic goals and regulatory compliance.
- The delivery of key corporate processes.
- The reporting requirements of the Board's committees as set out in their terms of reference.

2.3 The Board's present meeting arrangements are based on the following approach:

- All formal meetings being held in public as required by the Health and Social Care Act 2012.
- Formal ordinary meetings being held, generally, on the last Tuesday of each month except that:
  - The Board meeting in May being held earlier in the month due to the submission date for the Annual Report and Accounts.
  - No meetings being held during August.
  - The Board meeting in December being held early in the month combined with a Seminar.
  - The Board meeting in July being held on the Thursday of the penultimate week of the month to enable Board Members greater flexibility in taking holidays during the summer period.
  - Other changes as may be required and agreed by the Board.
- Board meetings being held at West Park Hospital, Darlington except that end of quarter meetings are usually held in one of the Trust's geographic Localities. For North Yorkshire, the meeting venues alternate, annually, between Scarborough and Harrogate.
- Seven private Board seminars being held each year usually on the second Tuesday of the month.
- Board Business Planning Events in October (two days) and January (one day).

2.4 The business cycle is only indicative and the matters to be included on the agenda for each Board meeting are agreed by the Chairman following consultation with the Executive Management Team.

3. KEY ISSUES:

Formal Board Meetings

3.1 The proposed dates, venues and reporting arrangements for formal Board meetings for the period 1st October 2018 to 31st December 2019 are set out in Annex 1 to this report.

3.2 The Board is asked to note that, generally, the meeting arrangements remain the same as in previous years; however:

- A meeting has been scheduled for June 2019 (instead of holding two meetings in July).
- Venues and reporting arrangements might need to be reviewed in the light of the decision to be made under private agenda item 7.

Board Seminars and Training and Development Sessions

3.3 The Board is asked to consider the following proposed changes to its seminar arrangements:

(a) The introduction of an extra seminar in February 2019.

This matter was raised at a recent meeting of the Resources Committee as a means of providing Board Members with additional time to review the draft Business Plan.

(b) The introduction of dedicated training and development sessions in response to feedback received from the Resources Committee as part of the Board Performance Evaluation Scheme in 2018.

The Board is asked to note that:

- Sessions have been scheduled for April (full day) and September (half day due to a meeting of the Resources Committee) 2019.
- Suggested topics for the sessions are as follows:
  - Understanding Foundation Trust accounts (proposed by the Audit Committee)
  - Information Security and GDPR (proposed by the Audit Committee)
  - Introduction to the "TEWV Think-On" approach to coaching
  - TEWV QIS
  - Safeguarding
  - Recovery/trauma informed care
  - The Trust's approach to learning lessons
  - The new Mental Health Act
  - Whistleblowing and Freedom to Speak Up

(Note: It is recognised that some of the above topics have already been covered by the EMT and the Audit Committee and it is, therefore, intended that attendance would be a matter of personal choice).

3.4 The Seminar/Training and Development Programme (attached as Annex 2 to this report) has been prepared taking the above proposals into account.

3.5 Board Members are also invited to suggest any additional topics for the seminars or the training and development sessions at the meeting.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The Board business cycle seeks to ensure that assurances are available to the Board on the Trust's compliance with the CQC's Fundamental Standards.

4.2 **Financial/Value for Money:** The Board business cycle seeks to ensure that assurances are available to the Board on the Trust's compliance with its financial and value for money obligations.

The Board is asked to note that changes to meeting arrangements might be required to meet CRES requirements.

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are risks that the Board might be unsighted on significant issues if its reporting and assurance processes are not robust.

6. CONCLUSIONS:

6.1 The report supports good governance in the Trust.

7. RECOMMENDATIONS:

7.1 The Board is asked to

(a) Approve its business cycle for the period October 2018 to December 2019 (as set out in Annexes 1 and 2 to this report) noting that changes might be required to meeting arrangements during the period.

(b) Propose any additional topics for inclusion in the Board Seminar/Training and Development Programme.

Phil Bellas, Trust Secretary

Background Papers: None

Tees, Esk and Wear Valleys NHS Foundation Trust

Schedule of Board Business (Oct 2018 - December 2018)

			2018			2019										
	Meeting Date	**Lead**	**30-Oct**	**27-Nov**	**18-Dec Special**	**29-Jan**	**26-Feb**	**26-Mar**	**30-Apr**	**21-May**	**25-Jun**	**18-Jul**	**24-Sep**	**29-Oct**	**26-Nov**	**17-Dec Special**
	Venue		**York**	**WP**	**WP**	**Durham**	**WP**	**WP**	**Scarborough**	**WP**	**WP**	**Middlesbrough**	**WP**	**York**	**WP**	**WP**
1	**Standard Items**															
	Apologies for Absence		√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Minutes		√	√		√	√	√	√	√	√	√	√	√	√	
	Board Action Logs (Public and Confidential)	TS	√	√		√	√	√	√	√	√	√	√	√	√	
	Declarations of Interest	-	√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Chairman's Report	Chair	√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Chief Executive's Report	CEO	√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Governor Issues	Board	√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Reportable Issues Log	CEO	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2	**Quality**															
	Locality Briefings	DoOps	**Y&S**			**CD&D**		**Forensic**	**NY**			**Tees**		**Y&S**		
	Quality Assurance Committee Report	Cttee Chair/ DoN&G	√	√	√	-	√	√	√	√	√	√	√	√	√	√
	"Hard Truths" Nurse Staffing Report	DoN&G	√	√	*	6 monthly	√	√	√	√	√	6 monthly	√	√	√	*
	MHLC Report	Cttee Chair/ DoN&G		√			√			√			√		√	
	Progress report on Intensive Team Support	DoPP&C						√					√			
	Progress report on the Composite Staff Action Plan	DoHR&OD		√						√					√	
	Guardian of Safe Working Report	MD	√			√			√ (Q4 & Annual Report)			√		√		
	Summary report on NHS England Independent Investigations (Investigation Reports will also be reported as and when received from NHS England)	DoN&G			√							√ (Included in the Annual Patient Safety Report)				√
	Freedom to Speak Up Guardian Report	DoHR&OD	√					√					√			
	Raising concerns report	DoHR&OD									√					√
	Reports on Learning From Deaths	DoN&G				√			√			√ (Included in the Annual Patient Safety Report)		√		
	Annual Patient Safety Report (via QuAC)	DoN&G										√				
	Progress Report on the Recruitment and Retention Action Plan (via RC)	DoHR&OD						√					√			
	Workforce Race Equality Scheme update (via RC)	DoHR&OD						√				√				
	Workforce Disability Equality Scheme (via RC)	DoHR&OD										√				
	Equality Delivery System (EDS) 2 (via RC)	DoHR&OD								√						
	Equality Act Information (via RC)	DoHR&OD								√						
	Directors' Visits Annual Report	COO										√				
3	**Strategic**															
	Budget/Capital Programme	DoF&I						√								
	Business/NHSI Plan	DoPP&C	√				√	√						√		
4	**Services Developments/Investments**															
	Tender submission approvals (as and when required)	DoPP&C/DoF &I/COO														
	Mental health services in the Harrogate Locality	COO	√													
	Business Cases (via RC). Those likely to be considered in the period are set out below. Dates to be determined.	DoF&I/COO														
	- Hambleton and Richmondshire Community Hub FBC															
	- Selby Community Hub FBC															
	- Limetrees OBC															

Tees, Esk and Wear Valleys NHS Foundation Trust

Schedule of Board Business (Oct 2018 - December 2018)

			2018			2019										
	Meeting Date	**Lead**	**30-Oct**	**27-Nov**	**18-Dec Special**	**29-Jan**	**26-Feb**	**26-Mar**	**30-Apr**	**21-May**	**25-Jun**	**18-Jul**	**24-Sep**	**29-Oct**	**26-Nov**	**17-Dec Special**
	- West Lane PICU OBC															
	Roseberry Park Updates (reporting schedule forf 2019 to be determined)	DoF&I	√	√	√											
5	**Performance**															
	Performance Dashboard	DoPP&C	√	√	*	√	√	√	√	√	√	√	√	√	√	*
	Finance Report	DoF&I	√ (x2)	√	*	√ (x2)	√	√	√ (x2)	√	√	√ (x2)	√	√ (x2)	√	*
	Strategic Direction Performance Report	DoPP&C		√			√			√			√		√	
6	**Governance/Regulatory**															
	Register of Directors' Interests	TS											√			
	Board Business Cycle	TS											√			
	Annual Review of Board Committee's terms of reference	TS											√			
	NED Committee Membership Review	Chair											√			
	NHSI Governance Certificates (via AC)	TS								√						
	Annual Report (including the Annual Governance Statement and Quality Report/Account) and Accounts together with the External Auditors' Reports (via AC)	CEO/DoF&I								√						
	Charitable Funds Annual Report and Accounts (via AC)	DoF&I								√						
	Board Assurance Framework	TS	Summary	Summary	Full	Summary	Summary	Summary	Summary	Summary	Summary	Full	Summary	Summary	Summary	Full
	Single Oversight Framework Report	TS/ DoPP&C	√			√			√			√		√		
	Information Governance Toolkit	DoN&G	√ (Half year progress report)					√ (Annual Submission)					√ (Half year progress report)			
	Annual Report on Research and Development	MD								√						
	Annual Report of the Responsible Officer for Medical Revalidation	MD											√			
	Medical Education Annual Report	MD	√											√		
	Annual Claims Report	DoN&G										√				
	Core standards on emergency preparedness, resilience and response (via AC)	COO											√			
	Integrated Governance Framework (via AC)	TS						√								
	Annual Board Performance Evaluation Scheme Report	TS						√								
	Gender Pay Gap Report	DoHR&OD						√								
7	**Other Standing Committee Reports**															
	Audit Committee Report	Cttee Chair				√		√		√			√			
	Resources Report	Cttee Chair/ DoF&I		√	√	√		√		√		Verbal (urgent business only)	√		√	
	Commercial Oversight Committee	Chair			√			√			√		√			√
	Board Nomination and Remuneration Committee Report (as and when required)	Chair														
8	**For Information**															
	Register of Seals (as and when required)	CEO	√	√		√	√	√	√	√	√	√	√	√	√	
	Policies and Procedures	CEO	√	√		√	√	√	√	√	√	√	√	√	√	

(Note:* indicates report to be circulated under separate cover outside the meeting)

Draft Board Seminar/Training and Development Programme

Annex 2

October 2018 - December 2019

Month	Topic	Lead
02/10/2018 - 03/10/2018	*Board Business Planning Event*	*CM/SP*
13/11/2018	Update on KPO	Dr. Briel
	Briefing on the research conducted by the University of York on 12 hour shifts	DL
	Review of CQC final report on 'well led'	CM/EM
18/12/2018	Briefing from the LD SDG	Dr. Passmore
	Briefing on outcome measures	PM
08/01/2019	*Board Business Planning Event*	
12/02/2019	Revierw of the draft Business Plan	CM/PM/SP
	Briefing on restraint and restrictive practices	EM
12/03/2019	C&YPS SDG Briefing	Dr. Davies
	Briefing on veterans' services	RH
09/04/2019 (Full Day)	*Board Training and Development Session*	-
14/05/2019	MHSOP SDG Briefing	Dr. Krishnan
	Briefing on staff health and wellbeing	DL
09/07/2019	Forensic Services SDG Briefing	Dr. Barlow
	To be determined	-
10/09/2019 (1/2 Day)	*Board Training and Development Session*	-
1 & 2/10/2019	*Business Planning Event*	*CM/SP*
12/11/2019	AMH SDG Briefing	Dr. Bell
	To be determined	-
17/12/2019	LD SDG Briefing	Dr. Passmore
	To be determined	-

ITEM NO. 18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th September 2018**
TITLE:	**Register of Interests of the Board of Directors**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

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

Executive Summary:

The Trust is required to have a Register of Interests of the Board of Directors under the NHS Act 2006 and the Constitution.

This report presents the updated version of the Register of Interests following the annual review.

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**25th September 2018**
TITLE:	**Register of Interests of the Board of Directors**

1. INTRODUCTION & PURPOSE:

1.1 To present the revised Register of Interests of the Board of Directors.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The National Health Service Act 2006 and the Constitution require the Trust to maintain a Register of Interests of Members of the Board of Directors.

2.2 The Register is formally reviewed, at least, on an annual basis.

3. KEY ISSUES:

3.1 The updated Register of Interests of Members of the Board of Directors of Tees, Esk and Wear Valleys NHS Foundation Trust is attached as Annex 1 to this report.

3.2 The Register is a public document which is published on the Trust's website and publicised in the Annual Report.

4. IMPLICATIONS:

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

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

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with the NHS Act 2006 and the Constitution.

7. RECOMMENDATIONS:

7.1 The Board is asked to receive and note the revised Register of Interests of the Board of Directors.

Phil Bellas, Trust Secretary

Background Papers:
The National Health Service Act 2006 (as amended)
The Trust's Constitution
"Managing Conflicts of Interest in the NHS" NHS England
Conflicts of Interest Policy

Tees, Esk and Wear Valleys NHS Foundation Trust

Register of Interests of Members of the Board of Directors

Date: September 2018

Note: 1 - This Register has been established in accordance with the National Health Service Act 2006 (as amended) and the Consitution
Note: 2 - Descriptions of the types of interests are provided in NHS England Guidance "Managing Conflicts of Interests in the NHS" (Publications Gateway Number 06419) and the Trust's Conflicts of Interest Policy
Note: 3 - (B) denotes that the Director is a voting member of the Board of Directors
Note: 4 - Changes of interest should be recorded as notified
Note: 5 - The Register should be refreshed annually

Name	Position	Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
Lesley Bessant	Chairman **(B)**	**None**	**None**	**None**	**Yes** Husband undertakes consultancy work for Teesside University
Dr Hugh Griffiths	Deputy Chairman **(B)**	**Yes** Director of Hugh Griffiths Associates Ltd Associate contract with GE Finnamore Healthcare	**Yes** Fellow of the Royal College of Psychiatrists	**None**	**Yes** Wife is an Improvement Director with NHS Improvement
Marcus Hawthorn	Senior Independent Director **(B)**	**None**	**None**	**None**	**Yes** Director of NRCPD
David Jennings	Non-Executive Director **(B)**	**Yes** Programme and Project Assurance Manager at Redcar and Cleveland Borough Council to 31/8/18 Pensioner Audit Commission Membership of Local Government Pension Scheme to 31/8/18 Pensioner Local Government Pension Scheme from 1/9/18 Member to the Board of the Bernicia Housing Group and Audit Committee Chairman	**Yes** Independent Appointed Member: Northumbria University Audit Committee	**Yes** Member of the Pathways Special School Interim Executive Board to 31/5/18 **None** From 1/6/18	**None**
Paul Murphy	Non-Executive Director **(B)**	**Yes** Ad hoc consultancy work for City of York Council, North Yorkshire County Council and East Riding Council	**None**	**Yes** Chair of Trustees at the York and North Yorkshire Benefits Unit Member of the Board of Trustees at the National Centre for Early Music	**Yes** Daughter is Head of Office for the Office of the National Director, Operations and Information, NHS England
Shirley Richardson	Non-Executive Director **(B)**	**None**	**None**	**Yes** Chairman of Carers Together Foundation, a charity which carries out carers' assessments and gives advice and support to carers in Middlesbrough, Redcar and East Cleveland	**None**
Richard Simpson	Non-Executive Director **(B)**	**None**	**None**	**None**	**Yes** Northumbria University - Employee

Name	Position	Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
Colin Martin	Chief Executive **(B)**	**None**	**Yes** Director of North East Transformation System (NETS) Ltd	**None**	**None**
Ruth Hill	Chief Operating Officer **(B)**	**None**	**None**	**None**	**None**
Dr Ahmad Khouja	Medical Director **(B)**	**None**	**None**	**None**	**None**
Patrick McGahon	Director of Finance and Information **(B)**	**None**	**Yes** Chairman Carlisle College (part of NCG Group)	**None**	**None**
Elizabeth Moody	Director of Nursing and Governance & Deputy Chief Executive **(B)**	**None**	**None**	**None**	**Yes** Husband is employed as a clincial manager in forensic services by Northumberland, Tyne and Wear NHS Foundation Trust
David Levy	Director of Human Resources and Organisational Development	**None**	**Yes** Director of Achieving Real Change for Communities (CIC) Ltd	**None**	**None**
Sharon Pickering	Director of Planning, Performance and Communications	**None**	**None**	**None**	**Yes** Husband employed by Durham Dales Easington and Sedgefield CCG as Chief Finance Officer

ITEM NO. 19

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th September 2018**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**25th September 2018**
TITLE:	**Report on the Register of Sealing**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

3. KEY ISSUES:

3.1 The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
344	3.8.18	Lease relating to the first floor of premises at Craglea, Lanchester Road Hospital *(Note: the lease was executed by the Trust as both the landlord and as a joint tenant as part of the Talking Changes Joint Venture Partnership)*	Patrick McGahon, Director of Finance and Information Phil Bellas, Trust Secretary

4. IMPLICATIONS:

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

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

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

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

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution
Seals Register

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 20

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25 September 2018**
TITLE:	**Policies Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

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

Executive Summary:

The policy paper contains the following information:

- 6 policies and 1 procedures for ratification:-
  - Data Management Policy
  - Claims Management Policy
  - Medical Devices Policy
  - Conflicts of Interest Policy
  - Bullying and Harassment Resolution Procedure

- 1 scoping document for consideration:-
  - Scoping document Peer Support Procedure

- 2 policies that have had their review dates extended:-
  - Privacy and Dignity Policy
  - Consent to examination and treatment

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meetings held on 08 August 2018 and 12 September 2018.

DATE:	**25 September 2018**
TITLE:	**Policies and Procedures Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

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

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

3. KEY ISSUES:

3.1 The following policies have undergone full review and were ratified at the meeting of EMT held on 08 August 2018:

Ref and Title	IT-0030-v2 Data Management Policy
Review date	08 August 2021
Description of change	The policy has undergone full revision in line with Data Protection Act 2018 (GDPR) and current information department structure.

Ref and Title	CORP-0011-v6 Claims Management Policy
Review date	08 August 2021
Description of	This policy has undergone full review with amendments to

change	terminology and addition of portal claims.

Ref and Title	CORP-0008-v5 Medical Devices Policy
Review date	08 August 2021
Description of change	This policy has had full review with minor amendments in line with current legislation.

Ref and Title	HR-0020-v4.1 Conflicts of Interest Policy
Review date	31 May 2020
Description of change	Minor additions now incorporated in sections 11.2 and 11.8. Also section 11.12 added regarding sponsorship of printing and publications.

Ref and Title	HR-0052-v1 Bullying and Harassment Resolution Procedure
Review date	08 August 2021
Description of change	This is a new procedure which aims to provide a supportive framework where concerns can be explored in a non-confrontational facilitated manner with the aim of resolving any differences ideally in an amicable way

3.2 The following policies have undergone full review and were ratified at the meeting of EMT held on 12 September 2018:

Ref and Title	MHA-0003-001-v1.3 Leave of absence under S17 MHA 1983 and time away from hospital
Review date	12 September 2021
Description of change	An audit of compliance of the S17 / Time away from the ward policy had highlighted that a previous SBARD contradicted the policy in places. The policy has been reviewed and updated to include the most important elements of the SBARD and supporting documentation into the body of the policy and added an example of a leave monitoring form and flow chart.

Ref and Title	CLIN-0021-v9 Resuscitation Policy
Review date	12 September 2021
Description of change	The policy has been updated with minor changes: • Adult and Adult & Child daily check lists includes the new supraglottic airways, stethoscope, catheter mount, transpore white tape.

	• Updated with pictures of the new and original equipment that should be in the emergency equipment bag • Added hyperlink for both MSS9 Administration of Adrenaline and MSS10 Oxygen administration in an emergency • Updated App.1 - Flowchart Adult Basic Life Support • Updated App.2 - Flowchart Paediatric Basic Life Support • Updated App.3 - Anaphylactic Reactions – Initial Treatment • Updated App.7 - The ABCDE approach to the deteriorating patient • Update App.15 - Request form for a new, additional or removal of the emergency response bag

3.3 One scoping document has been received requesting approval to develop a new procedure:

Title	Peer Support Procedure
Lead	Victoria Price - Peer Support and Recovery Expert by Experience Lead
Rationale	The purpose of the recommended procedure is to define the standard processes and conditions for recruiting peer support workers including:- • Standards for employment (i.e. number of peers in a team, minimum funding requirements etc.) • Guidance for bidding for money for peer support (internal and external funding sources) • Training and recruitment processes including linking in with central peer structures. • Team preparation • Supervision arrangements • Terms and conditions of employment (i.e. will not be involved in control and restraint, invasive practices or physical health care etc.)

3.4 The following had their review date extended:

Ref and Title	CLIN-0067-v3 Privacy and Dignity Policy
Review date	31 December 2018
Rationale	This policy has recently been assigned a new lead (Head of Quality Governance and Compliance). Due to the recent CQC inspection, this policy is requested to be extended to enable a full review to take place.

Ref and Title	CLIN-0001 Consent to examination and treatment
Review date	02 December 2018
Rationale	This policy has been reviewed and is out for full consultation. The lead has requested that the policy is extended for 3 months to enable consultation and subsequent feedback to be incorporated.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Sound policy development improves patient experience and enhances patient safety and clinical effectiveness.

4.2 Financial/Value for Money:

Any financial implications from the proposals arising from operational and/or practice changes will be managed by the Directorates responsible for policy implementation.

4.3 Legal and Constitutional (including the NHS Constitution):

The Trust requires a contemporary policy portfolio to ensure practice is compliant with legislation, regulation and best practice. The policy ratifications, review extensions and withdrawals will ensure the portfolio is managed to provide the necessary evidence based operational and practice frameworks.

4.4 Equality and Diversity:

The current policy portfolio ensures the Trust meets the required legislative and regulatory frameworks and all policies are impact assessed for any equality and diversity implications. Policy revision and /or specific implementation plans would result from any adverse impact assessments.

4.5 Other implications:

None identified

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meetings on 08 August 2018 and 12 September have been presented for ratification.

7. RECOMMENDATIONS:

The Board is required to ratify the decisions of the Executive Management Team and is requested to accept this report.

Author: Colin Martin
Title: Chief Executive