AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 26th SEPTEMBER 2017 VENUE: THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meetings held on **4th** and **20th July 2017**.		**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 including to sign off the Trust's Triangle of Care submission to the Carers' Trust.	**HG/EM**	**Attached**
Item 7	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 8	To ratify the Learning from Deaths Policy.	**EM**	**Attached**
Item 9	To receive the report of the Mental Health Legislation Committee.	**RS/EM**	**Attached**

Strategic Items (10.30 am)

Item 10	To approve the Nursing Strategy 2017 – 2021.	**EM**	**Attached**
Item 11	To approve the Trust's submission to NHS England with regard to compliance with the Core Standards for Emergency Preparedness, Resilience and Response.	**BK**	**Attached**

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

Performance (10.50 am)

Item 12	To consider the Finance Report as at 31st August 2017.	**DK**	**Attached**
Item 13	To consider the Trust Performance Dashboard as at 31st August 2017.	**SP**	**Attached**
Item 14	To consider the Strategic Direction Performance Report for Quarter 1, 2017/18.	**SP**	**Attached**

Governance (11.10 am)

Item 15	To review Non-Executive Director chairmanship and membership of the Board's Committees.	**Chairman**	**Attached**
Item 16	To approve the indicative Board Business Cycle for October 2017 to December 2018.	**PB**	**Attached**
Item 17	To receive and note the Register of Interests of the Board of Directors.	**PB**	**Attached**

Items for Information (11.20 am)

Item 18	To receive and note a report on the use of the Trust's seal.	**BK**	**Attached**
Item 19	Policies and Procedures ratified by the Executive Management Team.	**BK**	**Attached**

Item 20 To note that the next meeting of the Board of Directors will be held on **Tuesday 31st October 2017** in The Hilton York, 1 Tower Street, York, YO1 9WD at 9.30 am.

Confidential Motion (11.25 am)

Item 21 **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 any particular applicant for, or recipient or former recipient of, any service provided by the Trust.

Any terms proposed or to be proposed by or to the Trust in the course of negotiations for a contract for the acquisition or disposal 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.

Information which is held by the Trust with a view to its publication, by the Trust or any other person, at some future date (whether determined or not), and it is considered reasonable, in all the circumstances, to withhold the information from disclosure until that date.

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
20th September 2017

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 4TH JULY 2017 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON COMMENCING AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Mr. J. Tucker, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Dr. H. Griffiths, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mr. B. Kilmurray, Chief Operating Officer and Deputy Chief Executive
Mr. D. Kendall, Interim Director of Finance and Information
Dr. N. Land, Medical Director
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Mrs. J. Rayment, Public Governor for Hartlepool
Mr. P. Bellas, Trust Secretary
Mr. D. Brown, Director of Operations for Teesside (minute 17/165)
Mr. T. Cate, Acting Director of Operations for North Yorkshire (minute 17/167)
Mrs. J. Illingworth, Director of Quality Governance (representing Mrs. Moody)
Mrs. J. Jones, Head of Communications

17/158 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. D. Jennings, Non-Executive Director, and Mrs. E. Moody, Director of Nursing and Governance.

17/159 MINUTES

Agreed *– that the public minutes of the last ordinary meeting held on 23rd May 2017 and special meeting held on 13th June 2017 be approved as correct records and signed by the Chairman.*

17/160 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

17/161 DECLARATIONS OF INTEREST

There were no declarations of interest.

17/162 CHAIRMAN'S REPORT

The Chairman reported:

(1) That her present round of visits to locality senior management teams was continuing with only those to Teesside and forensic services remaining.

The Board noted that, during her most recent visit to the York and Selby Locality, senior staff had been very positive but had raised concerns about recruitment and CRES.

(2) On her recent visits to inpatient wards and child and adolescent mental health services (CAMHS) in York and Selby.

Mrs. Bessant highlighted:

(a) In relation to Meadowfields:
- The low bed occupancy levels.
- The excellent response of staff to an emergency she had witnessed whilst at the facility.

(b) The need to address the poor condition of Lime Trees as a matter of urgency.

Mr. Martin advised that there had been some improvements to the building including the installation of Wi-Fi; however, he recognised that further upgrading was required.

(c) Concerns raised about the low number of psychiatrists in the Locality.

Dr. Land reported that:
- An experienced locum had recently been engaged but two positions remained vacant.
- There were plans to make two part-time appointments in 2018.
- The Locality was reviewing the roles of other professional groups in order to seek to reduce its over-dependency on psychiatrists.

17/163 GOVERNOR ISSUES

The Chairman reported on her recent round of meetings with the Public Governors.

Mrs. Bessant advised that, whilst a few local issues had been raised, the Governors had been very positive about the quality of services provided in their localities and she had, as ever, been impressed by their commitment, enthusiasm and knowledge.

17/164 REPORT OF THE QUALITY ASSURANCE COMMITTEE

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

(1) The confirmed minutes of its meeting held on 4th May 2017 (Appendix 1 to the report).

(2) The key issues discussed by the Committee at its meeting held on 1st June 2017.

The focus of the discussions was on the pressures being experienced by CAMHS in the York and Selby Locality which the Committee had escalated to the Board.

Dr. Griffiths, the Chairman of the Committee, advised that the Committee had recognised that there were not only significant issues in the Locality but also, generally, across all CAMH services.

Mr. Martin considered that the issues impacting on the service in York and Selby were twofold:

(1) The significant demand placed on the service and the limited capacity to respond to it.
(2) The difficulties in providing more resources, particularly recruiting additional staff, to meet demand.

He advised that the Trust, under its contract with the Vale of York CCG, was responsible for providing any additional resources it required to meet mandated performance levels. Although the Trust had invested £300k in the first six months of the contract, and performance had improved materially, significant pressures remained (e.g. waiting times for autism services) and recruiting staff was difficult.

The Board also noted that demand on CAMHS was a national issue and tackling it was a Government priority; however, within the Trust's area, the spike in referrals over the last couple of years was becoming more sustained.

In relation to this matter:

(1) The Board reflected on the contribution that the New Models of Care initiative could make to addressing the issues.
(2) The review of capacity and demand undertaken by the service, with the business planning team, was noted together with the further work arising from it to challenge assumptions and to consider whether there was scope to remove further waste.
(3) It was recognised that the completion of the implementation of all pathways was an important means of closing the gap between capacity and demand.

In terms of its response to the escalation of the matter by the Committee, the Board considered that reporting arrangements through the QuAC, the Locality Briefing later in the year and the report on CAMHS waiting times scheduled to be presented to its meeting to be held on 20th July 2017, would provide sufficient oversight for the time being.

In relation to other matters contained in the Committee's report, in response to a question, it was noted that further information was being sought on the reasons for the increase in fire incidents from 73 in 2015/16 to 255 in 2016/17.

17/165 LOCALITY BRIEFING – TEES

Mr. Brown (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.

The Board's discussions focussed on staffing issues.

The Chairman observed that:

(1) The staffing difficulties being experienced were unlikely to ease and the significant risks presented by them could only be mitigated through changing working arrangements.

(2) The present situation was not conducive to providing the significant number of newly qualified nurses entering services with positive experiences and a supportive learning environment.

In relation to these matters:

(a) Mr. Brown:
- Recognised the pressure placed on newly qualified nurses.
- Highlighted that there had also been instances, due to staffing pressures, of nurses being promoted more quickly than was beneficial either to themselves or to the services in which they worked.
- In response to a question, assured the Board that proactive arrangements to support "retire and return" had been established in the Locality in order to seek to retain experienced staff.

(b) Dr. Land reported that discussions were due to be held at the Clinical Leaders' Conference, later in the year, to seek greater understanding of the implications of different professions taking on some of the roles of medical staff and on how to equip staff to be effective in undertaking these responsibilities.

(c) Mr. Levy advised that, following discussions with the Heads of Nursing, a more proactive approach was being put in place to ensure earlier conversations with nurses who were leaving the Trust to seek to understand the reasons for them doing so and to discuss whether there were any actions which could be taken to support their return.

(d) Mrs. Illingworth reported that a recent study by the Royal College of Nursing had shown that more nurses were now leaving the profession, than joining it, and a significant number of those were in their thirties or early forties.

The Board considered that this reinforced the need to understand why nurses were leaving the Trust and their destinations.

(e) In response to a question, it was noted that the number of nurses leaving the Trust (approximately 200 over the last two years) and the number of newly qualified nurses joining the Trust was relatively balanced.

The Board also:

(1) Discussed the implications of speciality doctors acting up into consultant positions, where it had not been possible to make substantive appointments, for the sustainability of services.

Dr. Land considered that the Trust needed to change its model of care and provide greater support to consultants in order to make their role sustainable and to prevent burn out.

He also advised that, even though the Trust was taking a range of actions, recruitment difficulties were likely to continue due to the number of vacant places on training schemes.

(2) Commended the Tees Locality for leading the introduction of daily/weekly performance report outs which were now being implemented across the Trust and resulting in performance improvements.

(3) Sought clarity on the future use of Westerdale South Ward.

Mr. Brown advised that the layout of the ward was not fit for purpose and initial plans for the future configuration of MHSOP beds in the Locality were expected to be completed in the next six to eight weeks.

At the conclusion of the discussions the Board thanked Mr. Brown for his presentation and asked him to pass on its appreciation to staff in the Locality for their continuing hard work.

17/166 NURSE STAFFING REPORT

The Board received and noted the exception report on nurse staffing for May 2017 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”).

Board Members raised concerns about the failure of staff to escalate the lack of a registered nurse on a night shift on Willow Ward.

In response assurance was provided that:

(1) The incident had been investigated.

(2) The escalation procedure was being reinforced through supervision.

With regard to the severity scores for individual wards (as set out in Appendix 4 to the report) Board Members:

(1) Highlighted that, whilst Springwood had only 5 points for the month, it had the equal highest number of points on a rolling basis.

A request for the severity scores to be provided on both a monthly basis and as a running total was taken on board.

Action: Mrs. Moody

(2) Recognised that the "red" fill rate for Meadowfields, which contributed to it having the joint highest severity score for the month, arose from staff being rostered on to other wards due to its low bed occupancy.

In response to a question it was noted that the staffing requirements on the ward were reviewed on a daily basis in case circumstances changed.

The Board also discussed future reporting arrangements including the benefits of reflecting "softer" intelligence and constructing the report to draw attention to specific areas for discussion.

The Chairman advised that:
(1) The report, since its inception, had been subject to ongoing development and this would continue.
(2) Further consideration of this matter would be undertaken in the light of the next six monthly nurse staffing report which was due to be presented to the Board at its meeting to be held on 20th July 2017.

17/167 STAFFING PRESSURES AND MITIGATIONS WITHIN NORTH YORKSHIRE INPATIENT SERVICES

Further to minute 17/36 (28/2/17) the Board received and noted a report which:
(1) Detailed the nature and extent of staffing pressures within inpatient wards in the North Yorkshire Locality.
(2) Provided assurance on the mitigations in place to manage the pressures and the steps being taken to reduce their long-term impact.

An update to the table in section 3.2 (recruitment retention and vacancies over the last 12 months) and a revised version of Appendix 1 (Table of issues and actions) to the report were circulated prior to the meeting.

Board Members raised the following issues:
(1) Whether technical solutions were being considered to seek to overcome the isolation of services in the Locality.

Mr. Kilmurray outlined the action being taken in relation to this matter, including the use of technology to support patient contact in the community being piloted by Dr. Mayfield; however, he recognised that further thought needed to be given on how the approach was aligned to the clinical model.

(2) The difficulties in releasing staff from wards to attend training due to short term staffing pressures; an issue which had been included in the original version of Appendix 1 to the report.

Mr. Cate advised that:
(a) He had removed the issue from the Appendix as, due to his short time in post, he had not had the opportunity to consider the evidence with regard to its impact on recruitment and retention.

(b) Whilst the geography made access to face to face training difficult and there were pressures on releasing staff, these issues impacted across the Trust and not only in the North Yorkshire Locality.

(3) The extent joint working with other providers in the area could provide solutions to the issues faced in the Locality.

The Board noted that discussions were taking place with other providers as they were experiencing similar difficulties in recruiting staff. However, whilst some joint initiatives were being explored (e.g. promotional activity) the issues which impacted on recruitment varied across the Locality e.g. the proximity of Leeds on recruitment in Harrogate, the quality of schools in Scarborough, etc.

(4) The importance of seeking to retain staff in the Locality.

Mr. Levy considered that further work was required to understand the reasons for staff leaving, as the Locality had the highest turnover rate in the Trust, and that additional actions to support the retention of staff might need to be developed.

In relation to this matter:

(a) Further to minute 17/165 above, the Chairman considered that it would be interesting to understand the reasons why nurses were leaving the profession during their thirties and forties and whether this suggested that they did not consider nursing to be a long-term career.

(b) The Board noted the risks and opportunities arising from competition for staff from other providers e.g. the private sector.

(c) The impact of potential service changes in the Locality on unsettling staff and the need for the Trust to continue to make them feel valued was highlighted.

(5) Whether the changes made within the NHS to offset the impact of amendments to income tax regulations had been effective.

Dr. Land responded that the decision by NHSI to impose the blanket application of IR35 had exacerbated the changes to the regulations and its subsequent decision to give discretion to providers would now have very little impact.

(6) The benefits of using appreciative inquiry to understand the problems being faced by staff in the Locality and to support them develop their own solutions on which the Trust could build.

(7) The potential benefits from reviewing the roles of other health related professions, and testing different staffing models, to seek to overcome the recruitment and retention issues being experienced and to better reflect the needs of patients.

Whilst supportive of this approach, Mr. Levy advised that, as there were some recruitment and retention difficulties impacting on other staff groups (e.g. dietetics and speech and language therapists), a broader response was required.

Mr. Cate advised that this issue was being considered by the Workforce Task Group and that new ways of working and appreciative inquiry would support overall recruitment and retention.

(8) The need for a whole Trust approach due to potential risks that addressing the recruitment and retention issues in the North Yorkshire Locality might create difficulties elsewhere.

It was noted that over-recruitment, where possible, could make an important contribution to overcoming staffing difficulties across the Trust.

17/168 FINANCE STRATEGY

On the recommendation of the Resources Committee, consideration was given to the approval of the Finance Strategy 2017-2019.

The Non-Executive Directors:

(1) Welcomed the vision of the strategy with finance recognised as a tool for service improvement.

(2) Sought clarity on the assumptions underpinning the expected reduction in bed numbers, as highlighted in the section of the Strategy on the "national position".

It was noted that, nationally, it was expected that bed numbers would reduce in response to efforts to increase efficiency in the NHS; however, as previously discussed, the Trust was, at present, undertaking a review of its future bed requirements.

(3) Questioned, in relation to the "outcomes scorecard", the robustness of the assessment of agency expenditure and the level of confidence that the targets would be achieved.

Mr. Kendall advised that the targets were set by NHSI; however, they were, to an extent, negotiable as the regulator recognised that that there were challenges nationally on this matter.

Agreed *- that the Finance Strategy 2017 – 2019 be approved.*

17/169 FINANCE REPORT AS AT 31ST MAY 2017

The Board received and noted the Finance Report as at 31st May 2017.

The Board's discussions focused on the Trust's CRES position which was £1,114k behind plan.

Mr. Kendall recognised that the delivery of CRES was challenging and the Executive Management Team planned to hold further discussions on this matter.

In response to questions from the Non-Executive Directors it was noted that:

(1) As shown in the budget setting paper (minute 17/C/82 – 28/3/17 refers) there had been a shortfall in CRES of £3m at the start of the year.
(2) The Trust had a robust process for assessing the quality impact of CRES schemes.
(3) The PPCS programme had been successful in delivering productivity improvements but increased demand had limited the Trust's ability to translate these into cash savings.
(4) In the circumstances there were also difficulties in reducing the workforce as it could exacerbate problems already being experienced and the Trust needed to maintain the balance between quality and efficiency.
(5) The step in the delivery of CRES mid-way through the year (as shown in the report) reflected the planning of schemes with some becoming active from October 2017.

The Chairman raised concerns that, as observed with the direction of the Five Year Forward View to address the national financial position, radical solutions were required to enable the Trust to achieve its efficiency targets but the time to develop and implement them was limited.

In response Mr. Kilmurray:

(1) Assured the Board that the focus on delivering the CRES programme would be maintained.
(2) Advised that there were sufficient variations between teams, both in terms of workforce and adherence to pathways, to deliver the planned savings; however, this would remain challenging.

The Chairman considered that it would be beneficial for the Board to have an in-depth discussion on CRES after the EMT had held its planned review.

Action: Mr. Martin

17/170 PERFORMANCE DASHBOARD REPORT AS AT 31ST MAY 2017

The Board received and noted the Performance Dashboard Report as at 31st May 2017.

Whilst recognising the very positive position on the Dashboard indicators, with only four being rated "red" and none of those within the quality and workforce dimensions, Board Members:

(1) Sought clarity on why the staffing issues in the Trust (e.g. recruitment and retention difficulties) were not apparent in the report.

Mrs. Pickering advised that within the staffing theme:

(a) Indicator 14 ("Actual number of workforce in month") was "amber" rated but had an upward trend arrow as a result of the success in recruiting staff.
(b) Concerns had been raised about appraisals and mandatory training; however, the use of daily/weekly report outs and greater visibility through

the Integrated Information Centre had had a marked impact on performance.

It was also noted that:

(a) Concerns about recruitment and retention were being highlighted through the Trust's risk management arrangements to the QuAC.

(b) A significant improvement to the Trust's appraisal rate was not required as it had always been relatively high.

(c) There were concerns about the Trust's ability to sustain improvements in the appraisal rate.

(2) Expressed concern about the continuing increase in referrals.

In relation to this matter:

(a) Further to the discussions under minute 17/169, the Non-Executive Directors recognised that services had already made significant productivity improvements.

(b) In response to a question assurance was provided that the Trust monitored the number of assessments which led to treatments (the "conversion rate").

In addition, further to minute 17/135 (23/5/17), consideration was given to the proposal not to introduce "amber" tolerance levels for the three Financial indicators.

In response to questions it was noted that the Finance Reports, rather than the Performance Dashboard Reports, should provide the focus of the Board's consideration of the Trust's financial performance.

Agreed *– that tolerance levels for the three finance indicators be not introduced.*

Action: Mrs. Pickering

17/171 USE OF THE TRUST SEAL

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

17/172 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.

17/173 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 20th July 2017 in the Board Room, West Park Hospital, Darlington.

17/174 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 any particular applicant for, or recipient or former recipient of, any service provided by the Trust.*

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 1.10 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Tees Locality Board Presentation
4th July 2017

David Brown

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
  - Crisis Assessment Centre, CYP Crisis and Liaison Team, rehabilitation community services, extended ALD teams.
  - CYP waiting times and external feedback, Roseberry Park bed use
- Now
  - Peer support workers, CYP home treatment, delirium and frequent attender work in liaison.
  - Support to independent providers

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To continuously improve the quality and value of our work.

- Previously
  - QIS training, PPCS, PIPA reboot
- Now
  - All the above, one team left for PPCS phase 1
  - Locality Report Out - to help share and spread
  - CD sponsorship
  - QIS with partners

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
  - A lot of internal moves to staff new developments
  - Locality Head of Nursing post appointed full time and better arrangements to recruit registered nurses
  - Ability to recruit medical and nursing staff a concern
- Now
  - 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

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 Concordat, Single Point of Access for Older people (ST), Children's Hubs, Better Care Fund extension to ICLS (NT)
  - LA Health and Wellbeing Boards and sub groups
- National
  - No formal links nationally on Tees
- International
  - Asklepios – Peer Support Workers and Individual Placement Officers
  - EuComms – Recovery and Consensus Document (UK Trusts)

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, medical locums, enhanced observations respite services in LD, delayed CRES and nursing home closures impacting on discharges
  - Now, enhanced observations in MHSOP and nursing home capacity, CYP and CRES
- **LMGB**
  - QAGs managing broad range of issues still
  - LMGB revised after Tier 4 transferred

making a difference together

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 20TH JULY 2017 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON COMMENCING AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Mr. J. Tucker, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Dr. H. Griffiths, Non-Executive 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
Mr. B. Kilmurray, Chief Operating Officer and Deputy Chief Executive
Mr. D. Kendall, Interim Director of Finance and Information
Dr. N. Land, Medical Director
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:
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications

Ms. M. Armstrong, student nurse

17/187 DECLARATIONS OF INTEREST

There were no declarations of interest.

17/188 CHAIRMAN'S REPORT

The Chairman drew attention to her report to the meeting of the Council of Governors held on 13th July 2017.

17/189 GOVERNOR ISSUES

No issues were raised.

17/190 REPORT OF THE QUALITY ASSURANCE COMMITTEE

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

(1) The confirmed minutes of its meeting held on 1st June 2017 (Appendix 1 to the report).
(2) The key issues discussed by the Committee at its meeting held on 6th July 2017.

Dr. Griffiths, the Chairman of the Committee, advised that, in response to the annual assessment under the Board Performance Evaluation Scheme (see also minute 17/201), it had been agreed to revisit communications between the Committee and the Localities.

Arising from the report Board Members:

(1) Raised the long waiting times for autism services.

The Non-Executive Directors considered that the longest possible wait of 151 weeks in North Durham was unacceptable.

On this matter Mr. Kilmurray:

(a) Drew attention to the report on waiting times in child and adolescent mental health services (minute 17/193 refers) which provided the latest position.

(b) Advised that, although there had been some investment, making headway was challenging due to the complexities of the pathway.

(c) Assured the Board that action was being taken to seek to improve performance and that support was made available to families whilst they were waiting.

(2) Sought clarity on the feedback received from the national Intensive Support Team (IST), following its visit to Talking Changes in County Durham, that the 15% prevalence target for IAPT services could be stretched to 16.8% but that this would be challenging.

Mrs. Pickering advised that:

(a) The prevalence target was the proportion of the population expected to enter IAPT services. The original target had been set at 15%; however, IAPT services were now expected to achieve a minimum access rate of 16.8% by the end of 2017/18.

(b) The difficulties in achieving the target varied by Locality:

- In York and Selby there had been vacancies and staffing changes in the team.
- In County Durham referrals were also made to counsellors in GP practices. It had been considered that these counted towards the target; however, the advice received from the IST was that this was inappropriate as the interventions provided by the counsellors did not comply with NICE guidelines.

(3) Sought assurance on the replacement of the Blik alarms at Roseberry Park.

Mr. Kilmurray reported that work was continuing on this matter with the alarms from the latest consignment being configured at present; however, he recognised that the problems experienced at the Hospital would not be fully resolved until all the alarms had been replaced.

In response to a question, Mr. Kilmurray assured the Board that, although the problems affected the whole site, forensic services were being prioritised for the

new alarms and mitigating actions to support staff and patient safety had been put in place.

17/191 SIX MONTH NURSE STAFFING REPORT

The Board received and noted the report on the six monthly review (1st December 2016 to 31st May 2017) 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.

During her introduction to the report, Mrs. Moody advised that:

(1) It was intended to present a report on the findings of the establishment review to the Board meeting to be held on 31st October 2017.

(2) In the table on agency usage within the reporting period (paragraph 3.3.17 of the report) the RAG ratings and the inclusion of both Acomb Garth and Worsley Court were incorrect.

The Board noted the overall conclusions of the report that:

(1) At present, despite extensive analysis, there were no clear correlations between the available staffing data, as set out in the report, and patient safety or significant quality issues.

(2) It was clear that flexible staffing was being used on a regular basis to meet patient need and demand.

(3) Initiatives, as highlighted in the report, attempted to address "having the right staff in the right place at the right time" in order that staffing resources could be better planned and utilised.

Board Members raised the following issues:

(1) The apparent high number of medication errors at Meadowfields and Westerdale North.

Mrs. Moody advised that all medication incidents were investigated by senior nurses and the pharmacy team and undertook to review the reasons for those on the two wards.

Action: Mrs. Moody

(2) Whether, given actual hours worked being consistently higher than hours planned, the establishment review was likely to find that increases in the baseline establishments of wards were required.

The Board noted that:

(a) There might need to be an increase in the baseline establishments for some wards.

(b) In others, the continued use of flexible staffing was appropriate in response to patient need and improvements in the way this was provided were being piloted at West Park Hospital and in forensic services.

It was also suggested that increases in the baseline establishment could impact on the Trust's reference costs.

Mrs. Moody responded that additional costs were already being incurred through the use of temporary staffing and an increase in the baseline establishment could lead to improved quality and, thereby, more effective use of resources.

(3) The number of duties for enhanced observations which, although representing an increase on the previous six months, appeared relatively constant over the reporting period.

The Non-Executive Directors considered that the data might suggest that either patient requirements were relatively consistent or that the categorisation of additional duties as enhanced observations was being used by ward managers to increase staffing if they considered that their establishments were underprovided.

Mrs. Moody advised that the establishment review would provide a view on this matter as the Hurst Tool took into account the complexity and acuity of patients.

(4) The importance of "soft intelligence" as, although Primrose Lodge was cited in the report as having the lowest fill rate for registered nurses on days, feedback received during a visit was that no problems were being experienced.

Mrs. Moody responded that this type of intelligence was being taken into account in the establishment review through the professional judgement discussions.

(5) Whether the reduction in the number of registered nurses in post in certain Localities was due to planned cost improvement measures.

The Board noted that:

(a) The reduction in registered nurses had been due to the Transforming Care agenda or linked to individual placements; none had arisen as a result of CRES schemes.
(b) Where there had been a reduction in posts the registered Nurses had been redeployed to other wards.

(6) The expected locations for the placement of Nursing Associates.

It was noted that this would be guided by the establishment review, particularly the professional judgement discussions.

(7) Whether the Directors of Nursing of other Trusts had found any relationships between staffing data and the quality indicators.

Mrs. Moody advised that:

(a) All Trusts were struggling to find relationships between staffing data and quality indicators.
(b) There was a significant variation in reporting between Trusts in terms of content (Trusts were only required to publish data on planned versus actual staffing levels), frequency and thresholds.

(c) The Chief Operating Officers and Directors of Nursing Network had asked for some work to be undertaken to develop a more standardised approach to monitoring and reporting safe staffing information.

In addition, further to minute 17/166 (4/7/17), discussions were held on the level of detail provided in safe staffing reports in the context of the assurances required by the Board.

Differing views were expressed on this matter.

On the one hand, some Board Members highlighted difficulties in translating the data into assurance that the Trust was providing safe staffing levels and in interpreting the overall positive assurances provided in the reports taking into account known exceptions.

On the other, it was considered that:
(1) Providing only mandated information to the Board would provide poor assurance.
(2) The nature of the subject; the need to ensure safe staffing at all times; and the significant variations that could occur meant that the level of detail provided in the reports was difficult to avoid.
(3) Mrs. Moody's understanding of where problems existed and the action being taken to tackle them, by themselves, provided a degree of assurance.

Whilst recognising that the detail provided in the reports allowed Board Members to gain their own assurances, it was also recognised that an overall collective view of the Board on the safety of services was important.

It was suggested that basing reporting on compliance with the recommendations made by the NQB in its publication "'Safe sustainable and productive staffing, an improvement resource for mental health services" (as set out in paragraph 3.8 of the report) and providing details of any exceptions, their implications/causality and actions being taken to remedy them could provide a more appropriate means of meeting the Board's assurance requirements.

It was also considered that the outcome of the work of the programme board in establishing the future direction on safe staffing would be helpful in shaping the assurance needs of the Board.

17/192 ESSENTIAL STANDARDS STIRLING DEMENTIA DESIGN AUDITS

Further to minute 17/93 (25/4/17) the Board received and noted a report on the progress of work associated with the Essential Standards Stirling Dementia Design Audit within MHSOP Services.

Detailed action plans for wards, arising from the audits of organic wards which took place between 1st April 2017 and 30th June 2017, were provided in Appendix 1 to the report.

Arising from the report:

(1) The Board noted that addressing the issues identified in the audits in relation to meal times could also contribute to work being undertaken on the Business Plan priority in relation to falls.

(2) In response to questions Mr. Kilmurray advised that:
   (a) All MHSOP wards were audited each year.
   (b) Actions to improve compliance levels were taken whenever opportunities arose and, to this end, it was planned, as far as practicable, to address the issues identified at Westerdale South as part of the proposed relocation of the ward.
   (c) Where deteriorations in compliance had been found these were due to greater understanding and awareness of the essential standards. This was the case for Springwood, where planning for the facility had coincided with the publication of the initial essential standards.

(3) Although referenced in the report, it was also noted that any works to the Bowes Lyon Unit would not impact on compliance with the essential standards due to the closure of Picktree Ward as part of the reconfiguration of inpatient assessment and treatment beds for people with dementia in County Durham and Darlington in 2016.

17/193 MANAGEMENT OF WAITING TIMES IN CHILDREN AND YOUNG PEOPLE'S SERVICES

Further to minute 17/09 (31/1/17) the Board received and noted a progress report on the management of waiting times in Children and Young People's Services (C&YPS).

The focus of the Board's discussions was on how the Trust should respond to the potentially significant risks to patient safety if additional investment was not made available to mitigate the impact of continuing increases in demand.

The Board received a briefing on the position on C&YPS both nationally and for each Locality.

In summary it was noted that:

(1) The services operated under block contract arrangements.

(2) The increase in demand was a national phenomenon and tackling it was a key priority for the Government and NHS England.

(3) Improving the mental health and wellbeing of children and young people also featured as a priority in the health and wellbeing strategies of local authorities within the Trust's area.

(4) There was a general understanding of the impact of the increases in demand in the County Durham and Darlington and Tees Localities. Discussions with the CCGs to address the difficulties faced by the services were continuing and South Tees CCG had invested an additional £200k in the service.

(5) The key concerns were in relation to the York and Selby and North Yorkshire Localities.

(6) In York and Selby:
   (a) In accordance with the contract the Trust had invested its own resources in the service; however, demand was continuing to rise.

(b) A large number of information requests were being received from the CCG arising from its discussions with NHS England on the challenges facing the service.
(c) A very detailed demand and capacity study of the service had been undertaken by the Trust and shared with the CCG.
(d) Discussions with the CCG, for example in relation to out of area placements, were continuing.

(7) In North Yorkshire, the impact of the low levels of expenditure in mental health services, generally, was amplified in C&YPS. Notification had been received that the CQC would be undertaking a thematic review of mental health services for children and young people. This was seen as a positive development both in terms of promoting awareness of the concerns about demand but also as a focus for solving the problems faced by the Trust.

(8) In general, it was recognised that:
(a) There were insufficient staff to deal with the number of referrals and those in post were working extremely hard.
(b) Whilst demand was starting to level off in some Localities (e.g. County Durham and Darlington), in others the number of referrals was continuing to increase.
(c) Some Commissioners had made additional investment available in the services but there had not been a consistent response to the increases in demand across all the Trust's Localities.

Board Members recognised that tangible actions were required to mitigate the risks faced by the Trust.

The following approaches were explored:

(1) Increasing investment in the services.

It was suggested that, in view of the high priority of C&YPS, it might be appropriate for the Trust to invest its own resources in the services in the expectation that Commissioners would follow suit.

With regard to this matter, it was noted that:
(a) The Trust had already invested in the services for example in the development of the CAMHS crisis and home treatment service in York and Selby, to build community infrastructure, as a consequence of reducing beds in tier 4 services.
(b) The New Care Models for Tier 4 CAMHS would enable further investment to be made.

Concerns were raised that if the Trust invested its own resources it might perpetuate the lack of investment by some Commissioners.

(2) Raising awareness.

Board Members supported suggestions to raise awareness of the challenges faced by the C&YP services through:

(a) Inviting the Children's Commissioner to visit the Trust and apprising her of concerns.

Action: Mr. Martin

(b) Bringing the matters to the attention of Local Safeguarding Children Boards.

Action: Mrs. Moody

The Board also discussed how to address the variation in understanding about the issues faced by C&YP services amongst local MPs.

(3) Further discussions with Commissioners.

It was considered that discussions with Commissioners to seek to secure additional investment should continue.

Board Members considered that, if demand continued to grow, the Trust needed to understand the point at which, in the interests of patient safety, further referrals would not be able to be taken and the Commissioners should be made aware of this.

(4) Preventing referrals.

The Board Members highlighted that the increase in referrals was partly attributable to preventative work being discontinued in schools as the result of funding redections and academies having greater discretion on expenditure.

It was noted that some investment had been made in preventing referrals e.g. the establishment of the School Mental Health and Wellbeing service by the North Yorkshire CCGs; however, to date, these initiatives had had no discernible impact on demand.

(5) Improving staff resilience.

In view of the pressure placed on staff Mr. Levy acknowledged that efforts to support them and to prevent burnout needed to be redoubled.

(6) Monitoring.

Board Members recognised the importance of continuing to monitor demand on the services.

It was noted that, to date, the emphasis had been on addressing initial waiting times; however, there were risks that, by focussing on this matter, problems could be created later in the pathway.

Mrs. Pickering advised that the introduction of reporting on waiting times for second appointments (i.e. referral to treatment), under the contract, would provide greater transparency on this matter.

Agreed – *that a further report on managing waiting times in children and young people's services be provided to the Board meeting to be held on 19th December 2017.*

Action: Mr. Kilmurray

17/194 THE "TEWV WAY"

Consideration was given to a report on the proposed future direction and next steps of the 'TEWV Way' Business Plan priority.

The Board noted:

(1) That the priority subsumed the work on refreshing the Trust's values and behaviours (minute 16/289 - 29/11/2016 refers).

(2) Feedback received from a workshop attended by a range of staff, both clinical and non-clinical, and experts by experience on 5th May 2017 which had included discussions on the meaning of the priority, its desired future state and the actions needed to achieve it.

The Non-Executive Directors questioned, in the light of previous debates, whether there had been discussions at the workshop about the promotion of leadership behaviours.

Mr. Levy responded that participants had recognised variations in leadership and this was reflected in the feedback received.

The Board discussed the proposals to hold a series of face to face values, behaviours and staff compact consultation events during the period September to November 2017 to gather views and feedback from staff, service users, carers and Governors in all localities and commissioners and local authorities including the use of crowdsourcing.

The following points were made about the purpose and scope of these events:

(1) They should help people bring the values and behaviours to life on a day to day basis.

(2) Discussions should focus on:
   (a) People's understanding of the values at an individual level enabling them to challenge their own behaviours.
   (b) Promoting the view that challenging the behaviours of others should be seen as beneficial and undertaken without retribution.
   (c) Exploring the barriers to people living the values.

The Board also considered feedback from the workshop that there should be an opportunity to review the values and behaviours statements/staff compact during the consultation exercise.

Board Members considered that the events should not proactively seek the views of participants on changing the values but that it would be helpful to understand the extent that they continued to resonate with them.

In addition, Board Members supported a suggestion that they should lead sessions during the events; an approach which had proved beneficial during the consultation on the Francis 2 Action Plan in 2013.

Mr. Levy undertook to contact them to check their availability for the events.

Action: Mr. Levy

Agreed –

(1) that, in response to feedback received from the workshop held on 5th May 2017, the Business Plan priority be called "Making a Difference Together";

(2) that the proposal to hold a series of face to face values, behaviours and staff compact events during the period September to November 2017, taking into account the matters raised during the discussions at the meeting, be endorsed; and

(3) that the initial findings of the consultation exercise be provided to the Board Business Planning event in October 2017 with a full report on its outcomes, together with recommendations, being presented to the Board meeting in January 2018.

Action: Mr. Kilmurray

17/195 ANNUAL REPORT ON DIRECTORS' VISITS

The Board received and noted the annual report on Directors' visits undertaken during 2016/17.

It was suggested that it might be beneficial, in future, for the visits to be arranged thematically (e.g. visits to be held on the same day to a particular type of service) with time set aside at the next Board meeting to consider any findings arising from them.

Mr. Martin agreed to consider this matter when preparing the next programme of visits.

Action: Mr. Martin

17/196 SUMMARY FINANCE REPORT AS AT 30TH JUNE 2017

Consideration was given to the summary Finance Report including the Trust's Quarter 1, 2017/18, submission to NHS Improvement.

The Board noted that the Trust had assessed its Quarter 1 "use of resources" rating as 2 due to agency expenditure being higher than the capped target.

Dr. Land observed that the measure used by NHS Improvement was flawed as underspending on medical staffing (e.g. as a result of vacancies) more than offset the agency costs.

Agreed *– that the Trust's Quarter 1, 2017/18, submission to NHS Improvement, in accordance with the results detailed in the above report, be approved.*

Action: Mr. Kendall

17/197 WORKFORCE REPORT

The Board received and noted the Quarterly Workforce Report for Quarter 1, 2017/18 including:

(1) Information about the non-medical workforce (Appendix 1 to the report).
(2) Information about the medical workforce (Appendix 2 to the report).
(3) The results of the Staff Friends and Family Test (Appendix 3 to the report).

Board Members raised the following matters:

(1) The degree of sophistication in understanding and responding to the results of the Friends and Family Test (FFT).

The Non-Executive Directors, whilst encouraged by the continuing good response rate, highlighted a number of concerning themes arising from the survey.

Mr. Levy responded that the survey provided valuable information and it was important for the Trust to act on the results; however, there were areas for further development including:

(a) Achieving a more consistent, positive and proactive response from managers to the results of the survey across the organisation.
(b) Improving how comments received were matched to teams as this had proved difficult, at times, due to the need to preserve confidentiality.

He also advised that, with regard to bullying and harassment, the feedback from the FFT had been acknowledged and, as discussed under minute 17/130 (23/5/17), action was being taken to address this matter through the development of a Trustwide anti bullying and harassment procedure and actions under the "Making a Difference Together" Business Plan priority.

In addition, the Board discussed an individual response to the FFT, which whilst generally positive, highlighted the additional pressures placed on staff by CRES and the PPCS programme.

In terms of responding to this feedback, Board Members recognised that there was a need to give greater thought to how messages about change were communicated with a greater emphasis on the perspective of patients, in terms of outcomes and experience, rather than on the achievement of targets. It was also considered that the Trust's focus on staff wellbeing needed to be continuously and proactively promoted.

Dr. Land highlighted that a key element of the comment was that the individual did not wish to work elsewhere but that national funding cuts resulting in increased demand were impacting on their enthusiasm for working in the NHS. He considered that these views were concerning and should be escalated.

(2) The status of honorary contracts.

The Board noted that honorary contracts were legal agreements used in instances where, for example, academic post holders undertook clinical work for the Trust. These positions were unpaid but the Trust had some governance responsibilities for them.

(3) Further to the discussions under minute 17/130, the arrangements for identifying, addressing and eliminating inappropriate behaviour amongst leaders and managers in the Trust.

Mr. Levy advised that the Trust was now more prepared to challenge leaders and managers about their behaviours and the new appraisal system supported this approach. However, he also considered that there were challenges, as previously discussed, in relation to awareness of inappropriate behaviour and tackling longstanding cases.

(4) Potential underreporting of anxiety, stress and depression amongst staff in the Trust.

Mr. Levy advised that demand on employee support services, the employee psychology service and occupational therapy was at record levels suggesting that this might be the case.

On the suggestion of the Chairman it was agreed that, in future, the quarterly workforce reports should be presented to the Resources Committee instead of the Board.

Action: Mr. Levy and Mr. Bellas

17/198 SINGLE OVERSIGHT FRAMEWORK

The Board received and noted the report on the Trust's indicative position against NHS Improvement's Single Oversight Framework for Quarter 1, 2017/18, taking into account the difficulties in assessing performance against the quality and operational metrics as discussed under minute 17/14 (31/1/17).

In response to a question, Mr. Martin advised that NHS Improvement had not raised the CQC's rating of "requires improvement" under the "safe" domain during its Quarterly Review Meeting with the Trust on 3rd May 2017.

17/199 WORKFORCE RACE EQUALITY STANDARD ACTION PLAN

Further to minute 17/137 (23/5/17), and on the recommendation of the QuAC, consideration was given to the draft Workforce Race Equality Standard (WRES) Action Plan which was required to be published, together with WRES information provided by NHS England, by 1st August 2017.

Copies of the WRES information and draft action plan, which reflected comments received from the QuAC, were provided in Appendix 1 to the report.

The focus of the Board's discussions was on the levels of, and actions to be taken in response to, bullying and harassment and abuse from patients, relatives or the public in view of 37.23% of BME staff experiencing this in the last 12 months (Indicator 5 of the draft WRES Action Plan).

The Non-Executive Directors were concerned about the proposed length of time proposed (March 2018) to publish posters on the expectations of behaviour for staff and service users across the Trust

Mr. Levy advised that the vast majority of incidents of this type, as recorded on the DATIX system, related to race and the challenge was to understand the reasons for this to help raise awareness in Localities. It was, therefore, proposed to consider the mutual expectations of behaviour for staff and service users as part of the forthcoming engagement events linked to the "Making a Difference Together" priority and to publicise this information on posters throughout the Trust.

The Chairman questioned whether the experience of the Trust on this matter was significantly different to others.

Mr. Levy advised that the issue was widespread in the NHS; however the increase in BME staff reporting bullying and harassment, etc to 37.23%, from 27.27% in the previous survey, was atypical. He undertook to compile comparative information on this matter for circulation to Board Members.

Action: Mr. Levy

17/200 YORK AND SELBY QUALITY GOVERNANCE ACTION PLAN

Further to minute 17/104 (25/4/17), consideration was given to a report on the progress made on implementing the few remaining actions contained in the York and Selby Quality Governance Action Plan.

In response to a question, Mr. Kendall assured the Board that support had been provided to staff in the Locality and there was now greater familiarity with the PARIS system.

Based on the assurances provided in the report it was:

> ***Agreed –*** *that the York and Selby Quality Governance Action Plan be signed off as completed.*

17/201 BOARD PERFORMANCE EVALUATION SCHEME 2016/17

The Board received and noted a report on the results of the Board Performance Evaluation Scheme of 2016/17 including:

(1) A summary of the results of the assessment of Board effectiveness.
(2) Summaries of the results for the Board's Committees and the actions being taken forward by them (as set out in Annex 1 to the report).

(3) An analysis of themes across the Committees which showed none where the scores had decreased and a number where they had increased or maximum scores had been maintained.

The Board noted that:
(1) Overall the results of the evaluation were positive.
(2) The assessment of Board effectiveness had highlighted a couple of potential issues with regard to the standard of reports and engagement with service users and carers.

As recommended in the report, the Board agreed that these matters should be further considered in the context of the findings of the independent governance review being undertaken by Grant Thornton LLP.

Action: Mr. Bellas

Dr. Land observed that, whilst the Mental Health Legislation Committee was fulfilling its role, its results reflected the difficulties experienced by its members in gaining assurance of compliance on the matters included in its terms of reference due to their technical and legalistic nature.

17/202 USE OF THE TRUST SEAL

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

17/203 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.

17/204 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 26th September 2017 in the Board Room, West Park Hospital, Darlington.

17/205 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 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 12.55 pm.

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th September 2017**
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

Date	Minute No.	Action	Owner(s)	Timescale	Status
29/11/2016	16/286	A more refined approach to nurse recruitment focussed on experience as well as numbers to be looked into	DL	20/07/2017	Completed
29/11/2016	16/289	A report on the findings of the values consultation exercise to be provided to the Board	DL	Mar-18	See minute 17/194
29/11/2016	16/289	Team based culture metrics reports to be introduced	DL	~~Nov-17~~ Jan-18	Change of date to align with the consultation under the Making a Difference Together priority
29/11/2016	16/290	Subject to the EMT being assured that sufficient resources are available to support the process, the Trust seek re-accreditation under the Investors in People scheme	DL	Nov-17	The findings of the review to be reported to the Board meeting in January 2018 as part of the report on the outcome of the values, etc. consultation events
20/12/2016	16/313	The operation of the Resources Committee to be reviewed in 12 months or sooner if issues arise	PB	Dec-17	

Date	Minute No.	Action	Owner(s)	Timescale	Status
31/01/2017	17/12	A review of the Trust Performance Dashboard targets to be undertaken	SP	Jul-17	See agenda item 13
31/01/2017	17/13	A stock take of recruitment activity, including in relation to AHPs and medical staff, to be undertaken	DL	20/07/2017	Completed
28/03/2017	17/62	The potential for expanding the proposed managers' tool, for recording concerns raised to the Freedom to Speak Up Guardian to cover all concerns raised by staff, to be explored	DL	~~Jul-17~~ Nov-17	See also minute 17/128
28/03/2017	17/64	Wards with bank usage above planned establishment levels to be highlighted in nurse staffing reports	EM	~~20/07/2017~~ Reporting to commence Sept-17	See agenda item 7
25/04/2017	17/95	Briefing to be provided to a Board Seminar on the Perinatal Service	CM/PB	Sept-17	Completed
25/04/2017	17/98	Report to be provided to the Board on bank staffing arrangements	DL	~~Jul-17~~ Oct-17	
25/04/2017	17/98	To look into the development of an "app" to support staff book onto bank shifts	DL	Jul-17	Completed
25/04/2017	17/102	Changes to the reporting of workforce performance metrics to be implemented in the next quarterly workforce report	DL	20/07/2017	Completed
23/05/2017	17/127	The situation at Lustrum Vale to be checked in view of the increase in the ward's severity score during April 2017	BK	30/09/2017	
23/05/2017	17/128	A report to be presented to the Board on the action being taken to address temporary staffing requirements in community teams	DL	Oct-17	
23/05/2017	17/128	Additional narrative to be provided on the graph on recruitment in future reports on the Recruitment and Retention Action Plan	DL	28/11/2017	
23/05/2017	17/128	A progress report on the Recruitment and Retention Action Plan to be presented to the Board	DL	28/11/2017	

Date	Minute No.	Action	Owner(s)	Timescale	Status
23/05/2017	17/130	A revised version of the Composite Staff Action Plan report, incorporating additional information on staff engagement, to be published on the website	DL	Jul-17	Completed
23/05/2017	17/137	Time to be set aside at a Board meeting or Seminar for a full discussion on the equality data	DL/PB	Dec-17	
04/07/2017	17/166	Ward severity scores to be provided on both a monthly basis and as a running total	EM	Reporting to commence September 2017	See agenda item 7
04/07/2017	17/168	Approval of the Finance Strategy 2017 - 2019	DK	-	To note
04/07/2017	17/169	The Board to hold an in-depth discussion on CRES after the planned review by EMT (Note: under minute 17/C/209 it was agreed that additional detailed information on CRES should be provided in the next quarterly finance report)	DK	Oct-17	
04/07/2017	17/170	Agreement that tolerance levels should not be introduced for the three finance indicators in the Performance Dashboard	SP	-	To note
20/07/2017	17/191	The medication incidents at Meadowfields and Westerdale North to be reviewed	EM	-	Completed
20/07/2017	17/193	The Children's Commissioner to be invited to visit the Trust and to be apprised of the concerns regarding CAMHS	CM	Oct-17	
20/07/2017	17/193	The Trust's concerns re: CAMHS to be brought to the attention of Local Safeguarding Children Boards	EM	-	Completed
20/07/2017	17/193	A further report on managing waiting times in C&YPS to be presented to the Board	BK	Dec-17	
20/07/2017	17/194	The availability of Board Members to lead sessions as part of the values, behaviours and staff compact consultation events to be checked	DL	Sep-17	Completed

Date	Minute No.	Action	Owner(s)	Timescale	Status
20/07/2017	17/194	Approval of: - The name of the "Making a Difference Together" priority - The proposals for the values, behaviours and staff compact consultation events taking into account issues raised during the Board's discussions	BK	-	To note
20/07/2017	17/194	The initial findings of the values, behaviours and staff compact consultation events to be provided to the Board Business Planning Event	BK	Oct-17	
20/07/2017	17/194	A full report (and recommendations) on the values, behaviours and staff compact consultation events to be provided to the Board	BK	Jan-18	
20/07/2017	17/195	Consideration to be given to arranging Directors' visits thematically with time set aside at the next Board meeting to discuss any findings arising from them	CM	-	Completed
20/07/2017	17/196	Approval of the Quarter 1, 2017/18, submission to NHSI	DK	-	Approved
20/07/2017	17/197	In future the quarterly workforce reports to be presented to the Resources Committee	DL/PB	-	To note
20/07/2017	17/199	Comparative information to be provided to Board Members on the levels of bullying, harassment, etc of BAME staff	DL	Oct-17	
20/07/2017	17/200	The York and Selby Quality Governance Action Plan was signed off as completed	PB	-	To note
20/07/2017	17/201	The matters arising from the BPES assessment in relation to the standard of reports and engagement with service users and carers to be considered as part of the report on the findings of the External Governance Review	PB	Sep-17	See confidential agenda item 7

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 26 September 2017**
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 QuAC meeting held on 07 September 2017:

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 Forensics where key concerns were around patient capacity, staffing pressures, estate and security issues and the Transforming Care agenda.
- An update from the Patient Safety Group, following its meetings held on 17 July and 19 August 2017, the Patient Experience Group, following its meetings held on 13 June and 8 August 2017 and the Drug and Therapeutics Report.
- CQC compliance and Safeguarding & Public Protection assurance updates.
- The Quality Account update and the outcomes of the July 2017 Stakeholder workshop which looks at setting the key priorities for next year's Quality Account.
- Update on the triangle of care revalidation.

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 07 September 2017.
- Note the confirmed minutes of the meeting held on 06 July 2017 (appendix 1).
- Approve the submission of self-assessments to the Carers Trust and to continue to support the implementation of the Triangle of Care into other areas of the Trust services.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 26 September 2017**
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 on 07 September 2017.

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 principle risks and concerns, together with assurances and progress from North Yorkshire and Forensic localities.

4. QUALITY ASSURANCE - EXCEPTIONS/ASSURANCE REPORTS FROM THE LOCALITY MANAGEMENT GOVERNANCE BOARDS (LMGBS) AND SUB-GROUPS OF THE COMMITTEE

The Committee received key assurance and exception reports from LMGBs and standing Sub-Groups of the Committee, highlighting any risks and concerns.

4.1 NORTH YORKSHIRE LMGB

The Committee received the LMGB report for North Yorkshire noting the top concerns which were:

- Patient safety and capacity issues in AMH Community Teams in Harrogate and Ripon. There has been a significant turnover of staff and as a consequence a number of patients had been left without a care coordinator therefore caseloads are under review. There are vacant posts in Harrogate and a number of staff on long term sick.

- Critical staffing pressures in Harrogate and Scarborough, Whitby and Ryedale.Flexible staffing options were being implemented and cover has been arranged.

- MHSOP – concerns and sensitivities around Springwood.

- Heads of Nursing were leading recruitment and recommendations regarding safe staffing and at the end of September 2017 there will be five Band 5 vacancies.

In addition there were ongoing problems with:

- Replacing the flooring on Rowan Ward, which would need to happen in phases rather than a full decant of the Ward.

- Transforming care – with a focus on community forensic service developments and the intention of Specialist commissioning/NHS England to stop commissioning locked rehabilitation beds for FLD.There is an aim to develop a proposal for an enhanced community forensic service based on the Secure Outreach Transition Team model (SOTT) for the September Transforming Care meeting.

  The assumptions and trajectories around decommissioning these beds was not felt to be reasonable or deliverable and discussions will continue at EMT to highlight the concerns of TEWV around these plans.

4.2 **FORENSIC SERVICES LMGB**

The Committee received the LMGB report for Forensic Services noting the top concerns which were:

- Estates and security issues- Following a review of a potential key compromise at Ridgeway, Roseberry Park, progress has been made around small works requests and a new key tracker system implemented.

- Nurse staffing – this pressure continues due to a combination of factors including the level of acuity and clinical complexity required, leading to existing establishments not meeting requirements. Various supporting actions have been implemented to support staff and to support perceptees who contribute significantly to the proportion of qualified workforce.

- Roseberry Park – live issues are ongoing around the estate and the impact of delays is being escalated accordingly along with the unresolved agreement for addressing the building defects.

- The transforming care agenda, which it was agreed should now be added to the locality risk register.

4.4 **Patient Safety Group Report**

The Patient Safety Group had met on 17 July 2017 and 19 August 2017 and reviewed all Trust Patient Safety activities in line with the Group's terms of reference.

There were no matters of escalation to the Quality Assurance Committee. Assurance was provided to the Committee on the following matters:

- The thematic review of serious incidents involving patients on planned leave will continue to be monitored against the action plan.

- A new quality strategy scorecard had been introduced to provide a locality and specialty view point for each patient safety metric.

- As part of the mortality review process, two deaths of patients on CPA from May and June 2017 would be looked into using the structured case note review methodology.
- The draft policy 'Responding to Deaths' was circulated during August 2017 and would be taken to the Board of Directors at its September 2017 meeting for formal ratification.

4.5 Patient Experience Group Report

The Committee noted that the Patient Experience Group had met on 13 June 2017 and 8 August 2017 and key matters raised were:

- Waiting times for Autism Spectrum Disorder has increased, due to three members of staff leaving and six clinicians on long term sick. This has led to an increase in complaints. Individual cases have been reallocated however the waiting times were still a concern.

- The Patient Experience Group will be notified of instances where three or more queries relating to discharge or medication are raised. This was agreed following an annual review of PALS queries for discharge and medication issues.

- All inpatient areas now have the meridian system for collecting and recording patient and carer experience feedback, which was going relatively well. There was concern about the number of teams with no carer feedback, it was expected that this will improve as the Triangle of Care work increases as it should impact on both the number of responses and the quality of experience being reported.

- A new question has been added to both patient and carer surveys asking *'Is there anything we can do to make the service better?'* This was generating a significant volume of helpful and practical suggestions from patients and carers that wards and teams can consider.

4.6 Safeguarding and Public Protection Report

The Committee was assured that the Trust continues to meet the legal requirements for safeguarding adults and children within the legislative framework.

All serious case reviews across the locality areas were progressing with action plans being monitored within respective safeguarding boards with oversight by the Safeguarding and Public Protection sub-Group.

Key issues highlighted were:

- A serious incident regarding a 14 year old who had been placed in an adult bed in August 2017. This had been due to a lack of beds locally and nationally and there were growing concerns around the lack of secure accommodation and out of hours beds as well as capacity issues following Section 136 assessments with only a limited amount of time to find a bed.

- Level 3 safeguarding training compliance has improved, however the 98% target has not been reached. The safeguarding children team were working with services to make improvements.

4.7 Infection, Prevention & Control Assurance Report

The Committee received the Infection, Prevention and control Report for Quarter 1 with key matters:

The Estates and Facilities Management team would be leading on the management of the Water Safety Group and the Water Safety plan with quarterly meetings in place to ensure that the Trust was compliant with the updated Health and Social Care Act (2008), updated in 2015. Assurance would be provided through the Infection Prevention and Control Committee (IPCC) on a quarterly basis.
There had been an incident at Roseberry Park where too much chlorine had been found in the water. The Committee was assured that this had been resolved.

There had been significant improvement in the Essential Steps monitoring data following the introduction of an escalation process, agreed by the Director of Infection Prevention and Control.

4.8 Drug & Therapeutics Committee Report

The Committee noted that the Drug & Therapeutics Committee had met on 27 July 2017 and the key matter noted was around the significant improvements made around medicines management standards at month six, which had been previously noted by QuAC at its July 2017 meeting.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 **Compliance with CQC Requirements Report**

The Committee were assured that all actions raised by CQC Mental Health Act inspections were being addressed following six reports received.

A peer review programme commenced across the Trust in July 2017 with members from Nursing and Governance piloting the first visits. The visiting team will use a standard peer review tool and records tool which is based on issues raised during CQC compliance inspections, MHA Review visits and any pertinent issues which are arising nationally. An information pack will be provided by the Compliance Team which will replicate the intelligence CQC may have gathered. A standard report based action plan document will be provided to wards/teams as part of the peer review visit to include; good practice, key issues and actions.
Information will be cascaded through locality governance groups and discussed at the Quality Compliance Group meetings.

Ofsted registration had been approved for Holly and Baysdale to be social care based residences for children. An inspection was expected between 1 October 2017 and 31 March 2018.

5.2 **Quality Account Quarterly Update Report**

The Committee noted updates on the four key quality priorities for 2017/18 set out in the Quality account, as well as performance against the agreed quality metrics. The

five quality priorities for 2017/18 were on track. For the quality metrics, three out of nine (33%) were green with six out of nine (67%) metrics reported at red.
Mrs Pickering had highlighted that the significant amount of metrics not achieving target demonstrated how far the Trust was being stretched in order to try and reach performance levels.

5.3 **Outcomes of the July 2017 Stakeholder Workshop and Key Priorities**

The Committee noted the outcome of the July 2017 event.

A range of suggestions have been put forward for quality improvement priorities, which include:

- Care planning.
- Reduce preventable deaths.
- Improve patient experience.
- Contact with crisis teams.
- Deliver actions in Safe Staffing programme.
- Develop a Trust wide approach for dual diagnosis.
- Reduce falls.
- Improve transition from CAMHS to AMH.

These priorities would feed into the Business Plan Workshop to be held on 3 and 4 October 2017 with final agreement at the Board of Directors on 31 October 2017.

5.4 **Triangle of Care Revalidation**

The Committee welcomed the positive progress with the Triangle of Care project and assurance that the aims and objectives of the Triangle of Care (TOC) project were being met during the first year of implementation.

The project would raise the profile of carers to ensure they would be involved and supported as partners in care as part of the patient's journey.

The Committee heard that:

There was now a well-attended monthly Steering group that monitors and supports implementation of the ToC. The group is chaired by the Director of Nursing and Governance and membership includes Heads of Nursing (HON), a Trust Governor, carer organisation representatives and carers. Key elements of the Trust's carer strategy have now been integrated into the revised Quality Strategy with support from members of the ToC Steering group.

Standard 4 of the ToC requires wards and crisis teams to allocate members of staff as carer champions/carer links with a role description approved by the Steering Group (see Appendix 2). The role involves providing guidance and support to staff in relation to carer issues and ensuring carer support information is available and kept up to date. All teams have identified carer champions.

A total of 385 staff have now received face to face carer awareness training delivered by carers. Additionally this can now be accessed on-line.

72 ward/crisis teams have assessed themselves against each of the standards as red, amber or green. The self- assessments have been validated for each ward or team working with carers and carer organisations and have been approved by

QuAG's and LMGB's and Service Development Group and QuAG in forensic services. The Trust will therefore meet the requirement of membership of ToC. Appendices 3, 4 and 5 show the results by locality/service using the traffic light system. Where teams have scored themselves Red or Amber, action plans are in place and will be monitored for completion.

The Committee agreed to support the submission of the self-assessments to the Carers Trust based on the findings of the report and to continue to support the implementation of TOC into other areas of Trust services.

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

The Committee receives quarterly assurance reports from working groups, one of which is the Equality and Diversity Steering Group.

7. CONCLUSIONS

The Quality Assurance Committee considered and noted the corporate assurance and performance reports that were received. The Committee were assured that all risks highlighted were being either managed or addressed with proposed mitigation plans.

8. RECOMMENDATIONS

That the Board of Directors:

(1) Note the issues raised at the Quality Assurance Committee meeting on 07 September 2017 and to note the confirmed minutes of the meeting held on 06 July 2017 (appendix 1).
(2) Approve the submission of the self-assessments to the Carers Trust based on the findings of the report and to continue to support the implementation of TOC into other areas of Trust services.

Elizabeth Moody
Director of Nursing and Governance

September 2017

APPENDIX 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 6 JULY 2017, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mr Jim Tucker, (Deputy Chairman of the Trust)
Mrs Jennifer Illingworth, Director of Quality Governance
Mr Brent Kilmurray, Chief Operating Officer
Dr Nick Land, Medical Director
Mr Colin Martin, Chief Executive
Mr Richard Simpson, Non-Executive Director
Mrs Shirley Richardson, Non-Executive Director

In attendance:
Mr David Brown, Head of Service for Tees (for minute 17/96)
Ms Donna Oliver, Deputy Trust Secretary
Mrs Lorraine Ferrier, Head of Nursing for Durham & Darlington
Mr Darren Gardner, Head of Service for Tees
Mr Patrick Scott, Head of Service for Durham and Darlington (for minute 19/97)
Dr Ingrid Whitton, Deputy Medical Director, Durham and Darlington
Mr Christopher Williams, Chief Pharmacist (for minute 17/101)

Four student Nurses from York

17/93 APOLOGIES FOR ABSENCE

Apologies for absence were received from, Mrs Lesley Bessant, Chairman of the Trust Mrs Elizabeth Moody, Director of Nursing & Governance, Mrs Karen Agar, Associate Director of Nursing & Governance and Mr David Jennings, Non-Executive Director.

17/94 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 1 June 2017 be signed as a correct record by the Chairman of the Committee.

17/95 ACTION LOG

The Committee updated the QuAC Action Log, taking into account relevant reports provided to the meeting.

17/45 Update on medicines optimisation.
This matter was covered under agenda item number 8 (see minute 17/101)
Completed

17/60 Discussion required at OMT around housekeeping and levels of cleanliness in the York and Selby facilities.
Completed

17/77 Escalate to the Board of Directors the pressures around capacity and demand on CMAHS in the York and Selby locality.
Completed

17/80 PEG – discussion to take place at the next meeting around whether the PEG should move to bi-monthly meetings to ensure full representation from localities.

Dr Whitton noted that this matter had been discussed at the recent PEG meeting and it had been agreed that the Group would be more effective by continuing to meet on a monthly basis. Locality representatives would be encouraged to attend meetings whenever possible.
Completed

17/81 Safeguarding – check whether staff in HM Prisons need to undertake Safeguarding Children level 3 training.
Due to Mrs Agar not being present at the meeting this action would be deferred to the 7 September 2017 QuAC meeting. It was noted however that a meeting had been arranged to discuss this matter.

17/84 Further work required around indicator five of TEWV WRES information before being presented to the Board of Directors.

It was noted that this report would be presented to the 20 July 2017 Board of Directors and would be signed off as an action completed therefore at the 7 September 2017 QuAC meeting.

17/96 TEES SERVICES LMGB REPORT

The Committee received and noted the Tees Services LMGB Report.

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

(1) The unreliability of the alarm system at Roseberry Park and the time taken to replace the alarm, resulting in a risk to staff and the organisation.
(2) The impact of newly qualified nurses in inpatient areas with the proportion of staff with less than two years' experience on inpatient units currently at 50%, with Band six post holders also being relatively inexperienced.
(3) Ongoing concerns included medical recruitment, Transforming Care in LD and the lack of capacity and quality of Nursing Homes in MHSOP.
On this matter it was noted that there was a lack of choice for people and there was a risk around the impact on out of area admissions.
Mr Scott highlighted that in contrast admissions to nursing homes in Durham and Darlington tended to come from home and that the work of the Care Home Liaison Service had been key in restricting admissions.

The Intensive Community Liaison Service had worked with some nursing homes and assessed

Non-Executive Directors sought clarification on the following matters:

(1) The complex patient waiting to be discharged to the Dales in Loftus under the PIPS scheme causing inpatient pressures at Bankfields, due to being unable to admit because of the complexity of the inpatient group.
On this matter it was noted that the Dales was due to become operational later in the year, due to known issues progressing tenants into PIPS residences.

(2) The consequences of Evergreen Unit not receiving accreditation from PNIC due to difficult handover times caused by 12 hour shifts and recording supervision.

Mr Brown noted that this was disappointing however there would be no contractual consequences from Commissioners by not being accredited.

(3) The risk register, number 134, large number of medical staff vacancies with no mitigating actions outlined.

Mr Brown undertook to include the details around the mitigating actions for risk number 134 in the next Tees LMGB report.

Action: Mr D Brown

The Committee noted their thanks and appreciation for the staff on Westwood that had looked after a young male adult in Tier 4 CAMHS that had been secluded for a very long period and who had written to the ward thanking them for saving his life.

Dr Griffiths undertook to write a letter of thanks to Dr Indranil Chakrabarti, Consultant Psychiatrist and Jo Mitchell, Ward Manager to praise them and their teams for all the hard work, support and commitment shown to care for this young man.

Action: Dr H Griffiths

17/97 DURHAM AND DARLINGTON SERVICES LMGB REPORT

The Committee received and noted the Durham & Darlington services LMGB Report.

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

(1) The never event on Willow Ward, relating to the lack of cover on a night shift by a registered nurse. This was being investigated by the central Trust Investigation team, since the level of escalation had not been met.
This matter had also been escalated to the Board of Directors at its meeting held on 4 July 2017.

(2) NHS Intensive Support Team (IST) visit to IAPT services.
Whilst there had been lots of positive messages following the visit, the IST felt that the level of investment in the service should allow TEWV to meet not just the 15% prevalence target but also the new 16.8% target without the PCC contribution and this would be very challenging.

(3) ASD waiting times continued to be a main area of concern, with waits of up to 151 weeks from referral to formulation in North Durham. An ASD strategy group had been set up for children and parents were being informed to manage expectation.

Mr Scott noted that the waiting list initiative would be refreshed and some non-recurrent funding would be invested to mitigate the short term risks.

(4) Staffing and gaps in the workforce, with unsuccessful medical recruitment recently and no further applications. A review of the recruitment strategy was underway and locum staff were covering the current shortfall.

Non-Executive Directors sought clarity on the following matters:

(1) The waiting list for autism services had deteriorated and accelerated to a level where the Chief Executive received regular correspondence weekly on this area of care. On this matter it was noted that the average assessment process took approximately 40 clinical hours spread across the teams and the different pathways and intervention processes made the provision of this service even more of challenging.

The Chief Executive noted that there was a degree of pressure around this position which had reached Commissioners at a fairly high level and had been raised recently at a meeting with MPS being in the top 3 items discussed.

The Trust had been involved in a multi-organisational plan that had been sent to Commissioners in June 2017.

(2) Adult LD non-compliance due to referrals being rejected.
The Acting Service Manager was working with CAMHS and the Local Authority regarding the CQUIN target of joint CAMHS/adult transition period for 17.5 year olds. Mr Scott advised that an improvement event was planned around this to smooth out the transition issues and undertook to provide more context in the next Durham and Darlington LMGB report.

Action: Mr P Scott

Following discussion it was noted that:

(1) There had been a successful care package provided to a young lady in single occupancy at Lanchester Road, where the clinical teams had constructed a care package to suit her individual needs. The young lady had now been transferred to Bankfields.

The Committee noted their thanks appreciation to the staff at Lanchester Road for the heartening outcome for this individual and a letter of thanks would be written to the Julie Leckenby to share with the teams involved.

Dr H Griffiths undertook to write a letter of thanks to the staff at Lanchester Road.

Action: Dr H Griffiths

(2) Some problems had been raised around the technology used to monitor friends and family questionnaires.

Mrs Illingworth undertook to make checks that these issues raised were more around minor glitches, such as charging batteries, since the May returns had been higher and an EMT discussion recently had reported that these had been well received.

Action: Mrs J Illingworth

17/98 PATIENT SAFETY GROUP ASSURANCE REPORT AND PATIENT SAFETY GROUP QUALITY REPORT

The Committee received and noted the Patient Safety Group Report, the Patient Safety Group Quality Report and a report from NEMHDU, a thematic review of 15 serious incidents relating to patients on leave during the period February 2015 – October 2016.

In introducing the report Mrs Illingworth reported that:

(1) The action plan developed as a result of the thematic review of 15 serious incidents would be sent to the Coroner and monitored by the Quality Compliance Panel.
(2) The Falls Executive Group had developed a new report to provide the number of falls that resulted in an SI broken down by locality, time of day and occupied beds. This would be included quarterly to the Patient Safety Group and feed into QuAC.
It was noted that this group looked at data as well as current policies and procedures and the information would be brought together with CLIP information.
(3) An example dashboard had been considered by the Patient Safety Group as a method of publishing data around the numbers of deaths, as a result of the Learning From Deaths Guidance.

17/99 SAFEGUARDING & PUBLIC PROTECTION REPORT

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

Mrs Illingworth highlighted the following matters:

(1) All serious case reviews and serious case review panels were progressing as expected.
(2) Compliance with Safeguarding training continued cause concern and work was underway with localities to address this.

Mr Martin requested that future reports include more detail around compliance levels with Safeguarding training in light of the risk of failing to meet agreed trajectories which could lead to contractual penalties.

Action: Mrs K Agar

17/100 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS REPORT

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

Arising from the report it was noted that:

(1) The Quality Compliance Group had met on 16 June 2017 and updated the action plan to be submitted to the CQC in June 2017. A draft programme of peer review visits to run from July 2017 to June 2018 would be led by ward managers and clinical leads and the tool was currently being tested by a ward manager in York & Selby.
(2) Three MHA inspection reports had been published for Nightingale, Jay and Kirkdale with issues raised and actions being taken to address these.
(3) There had been a meeting with Mr Chris Watson, CQC Lead Inspector to discuss the overarching action plan from the recent CQC Compliance visits. The main issue raised had been the target date of March 2018 for completing some actions and this would be brought forward.

17/101 MEDICINES OPTIMISATION ANNUAL REPORT 2016/17 AND MEDICINES MANAGEMENT ASSESSMENT 6 MONTHLY PROGRESS REPORT

The Committee received and noted the Medicines Optimisation Annual Report for 2016/17 and the Medicines Management Assessment – 6 month progress summary.

Mr Williams in presenting this first Medicines Optimisation Annual Report highlighted the following:

(1) This report was a combination of work undertaken and considered by the Drug & Therapeutics Committee and the Pharmacy Team to look strategically towards implementing a 5 year vision for medicines optimisation.
(2) The work streams included medicines safety, prescribing governance, improved systems and waste minimisation and the development of clinical pharmacy services.

Arising from the Medicines Management Assessment – 6 month progress summary it was noted that:

(1) The assessments had been running for 6 months by a variety of measures with improvements across all standards, with some more significant than others.
(2) The standards included areas of safety monitoring such as fridge and room temperature recording, security of medicines cupboards/fridges, weekly drug checks and omitted administration signatures.

(3) A clinical framework would be introduced in September 2017 to monitor a different range of measures including rapid tranquilisation and high dose antipsychotic standards.

(4) An amber rating would be introduced for wards missing only 1 or 2 days of temperature monitoring within a month for clear visual representation of areas of concern for the QuAG reports.

Non-Executive Directors sought clarification around the following:

(1) Training in medicines management for nurses due for implementation in 2017/18 would be for all registered nurses every three years.
(2) All new Doctors would undertake a medicines management test and prescribing test at induction.

Mrs Illingworth highlighted that the Medicines Management assessments could be fed into the Quality Compliance Group since some of the areas being covered were themes picked up by the CQC and the greater exposure the better to enable improvement.

The Chairman and Non-Executive Directors congratulated Mr Williams on the significant improvements made across the various projects and welcomed the format of the two page summary Annual Report for 2016/17.

17/102 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no exceptions to report.

17/103 ANY MATTERS ARISING TO BE ESCALATED TO THE BOARD OF DIRECTORS OR PROPOSED FOR ADDITION TO THE TRUST RISK REGISTER, AUDIT COMMITTEE, RESOURCES COMMITTEE OR CLINICAL LEADERSHIP BOARD.

There were no matters to be escalated to the Board.

17/104 ANY OTHER BUSINESS

There was no other business to note.

17/105 COMMITTEE MEETING EVALUATION

There was nothing to note.

17/106 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 7 September 2017,
2.00pm – 5.00pm in the Board Room, West Park Hospital.
Email papers/reports by Thursday 31 August 2017 to Donna Oliver donnaoliver1@nhs.net
The meeting concluded at 3.45pm

Appendix 2

The Key elements to achieving a Triangle of Care:

Standard 4 - Defined post (s) responsible for carers are in place are in place

Criteria
4.1 Carer lead posts are in place on each ward
4.2 A member of staff is identified on the ward to act as the carer link on each shift
4.3 A carer champion network or peer support forum is in place locally to provide carer support

Carer Link Role/Carer Champion for each shift:
a. Act as a positive role model for carer engagement for other staff in the team encouraging support for carers, all staff have responsibility for this.

b. Attend training to ensure 'carer awareness' and carer engagement strategies are in place.

c. Ensure areas where carers attend (for example wards and community teams) have an identified Carer Information Board displayed with carer link workers clearly identified and who to contact for support.

d. Update carer boards within their own area and boards in receptions ensuring all information is relevant and up to date, including contact details of local carer support groups.

e. Work with the clinical lead to undertake the self-assessment tool in the Triangle of Care for each ward.

f. Work with clinical leads to ensure staff are aware carers should be involved at the start of care, to advise carers on what they can expect in regard to information and support whilst the service user is in the care of the service.

g. Ensure relevant information is available on the ward and in the community teams, including carer packs, advocacy services and a link to Trust website for information regarding local and national carer support services.

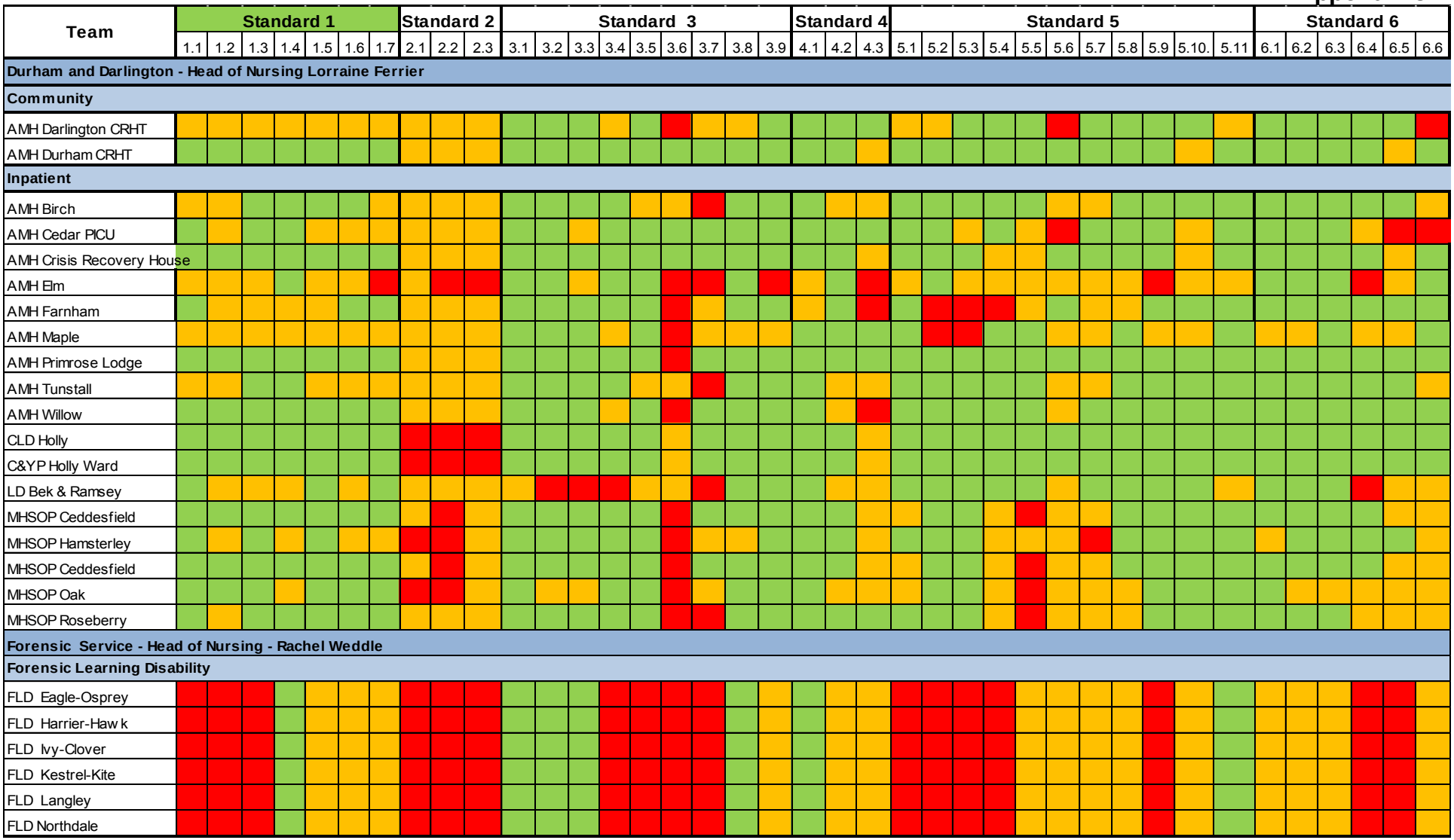
h. Ensure carers are offered the opportunity to complete a Patient & Carer Experience survey at any point throughout the patient's admission to the ward and in the community.

i. Offer guidance and support to staff in relation to confidential information. Although confidential information can only be shared with the agreement of the service user; staff

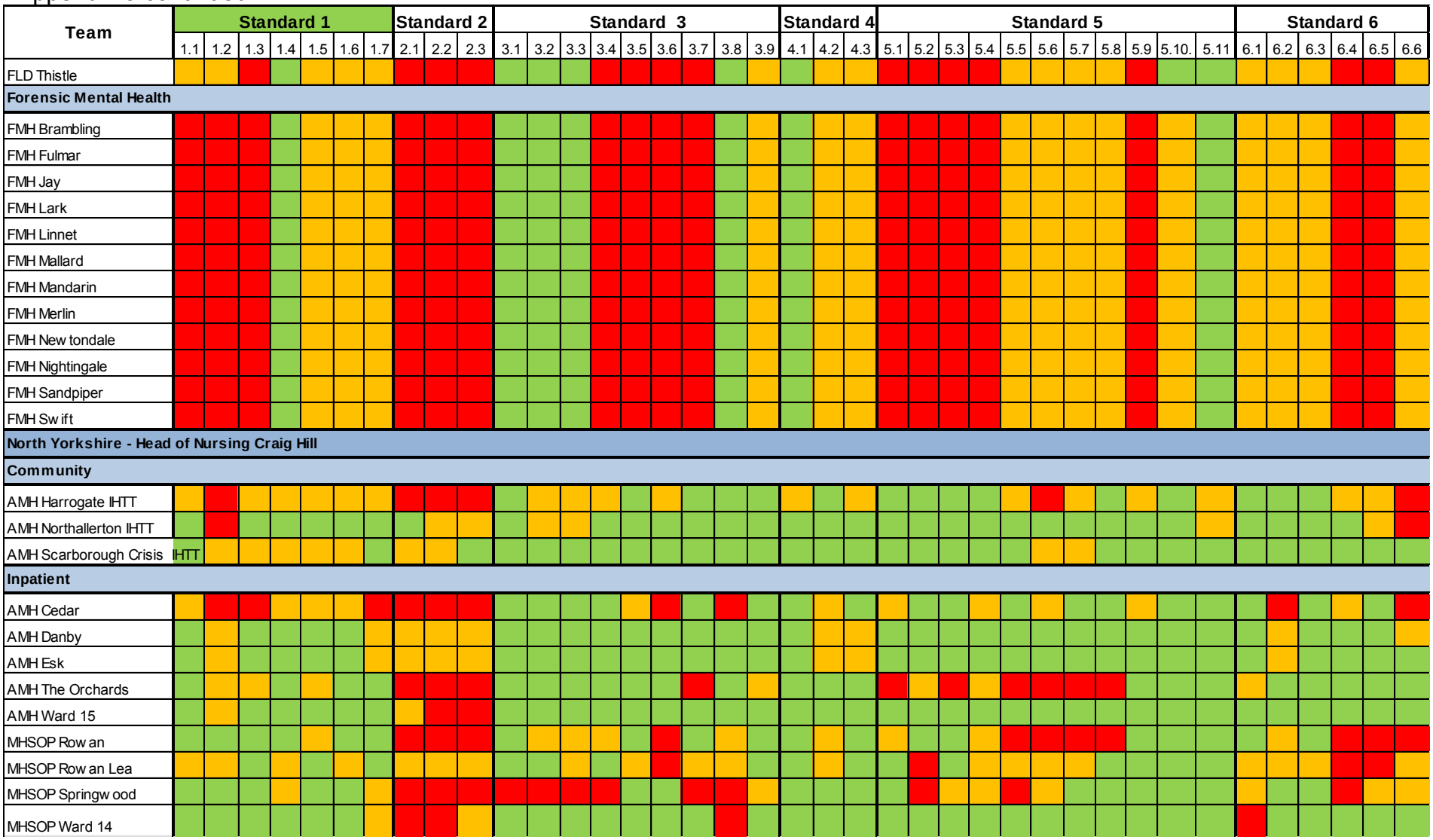
can share general information around medication, diagnosis, relapse etc. (see Common Sense Confidentiality Leaflet)

j. Attend link worker meetings to share good practice and to discuss any issues. Disseminate relevant information to all staff within the team.

Appendix 3


Team
Standard 1
Standard 2
Standard 3
Standard 4
Standard 5
Standard 6
1.1 1.2 1.3 1.4 1.5 1.6 1.7 2.1 2.2 2.3 3.1 3.2 3.3 3.4 3.5 3.6 3.7 3.8 3.9 4.1 4.2 4.3 5.1 5.2 5.3 5.4 5.5 5.6 5.7 5.8 5.9 5.10. 5.11 6.1 6.2 6.3 6.4 6.5 6.6
Durham and Darlington - Head of Nursing Lorraine Ferrier
Community
AMH Darlington CRHT
AMH Durham CRHT
Inpatient
AMH Birch
AMH Cedar PICU
AMH Crisis Recovery House
AMH Elm
AMH Farnham
AMH Maple
AMH Primrose Lodge
AMH Tunstall
AMH Willow
CLD Holly
C&YP Holly Ward
LD Bek & Ramsey
MHSOP Ceddesfield
MHSOP Hamsterley
MHSOP Ceddesfield
MHSOP Oak
MHSOP Roseberry
Forensic Service - Head of Nursing - Rachel Weddle
Forensic Learning Disability
FLD Eagle-Osprey
FLD Harrier-Hawk
FLD Ivy-Clover
FLD Kestrel-Kite
FLD Langley
FLD Northdale

Appendix 3 continued



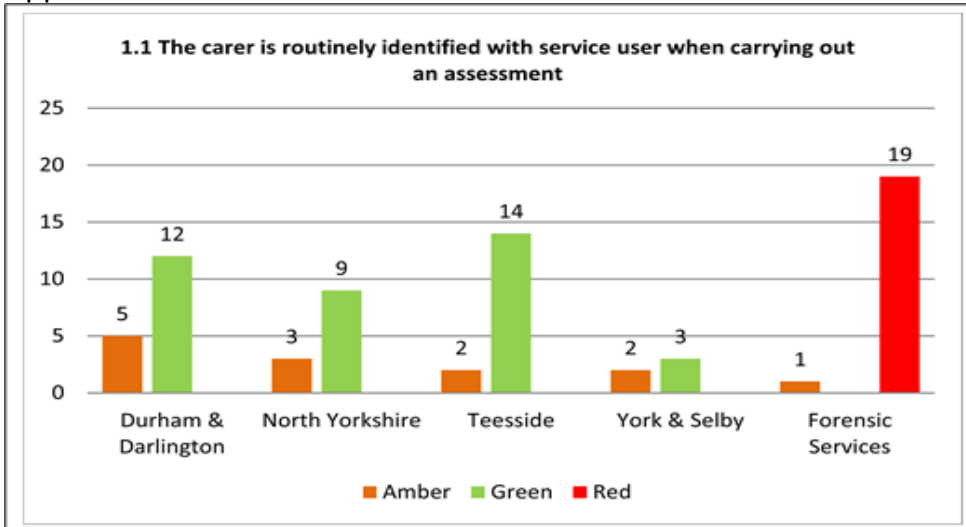
Team	Standard 1							Standard 2			Standard 3									Standard 4			Standard 5											Standard 6					
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	2.1	2.2	2.3	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8	3.9	4.1	4.2	4.3	5.1	5.2	5.3	5.4	5.5	5.6	5.7	5.8	5.9	5.10.	5.11	6.1	6.2	6.3	6.4	6.5	6.6
FLD Thistle																																							
Forensic Mental Health																																							
FMH Brambling																																							
FMH Fulmar																																							
FMH Jay																																							
FMH Lark																																							
FMH Linnet																																							
FMH Mallard																																							
FMH Mandarin																																							
FMH Merlin																																							
FMH New tondale																																							
FMH Nightingale																																							
FMH Sandpiper																																							
FMH Swift																																							
North Yorkshire - Head of Nursing Craig Hill																																							
Community																																							
AMH Harrogate IHTT																																							
AMH Northallerton IHTT																																							
AMH Scarborough Crisis	IHTT																																						
Inpatient																																							
AMH Cedar																																							
AMH Danby																																							
AMH Esk																																							
AMH The Orchards																																							
AMH Ward 15																																							
MHSOP Rowan																																							
MHSOP Rowan Lea																																							
MHSOP Springwood																																							
MHSOP Ward 14																																							

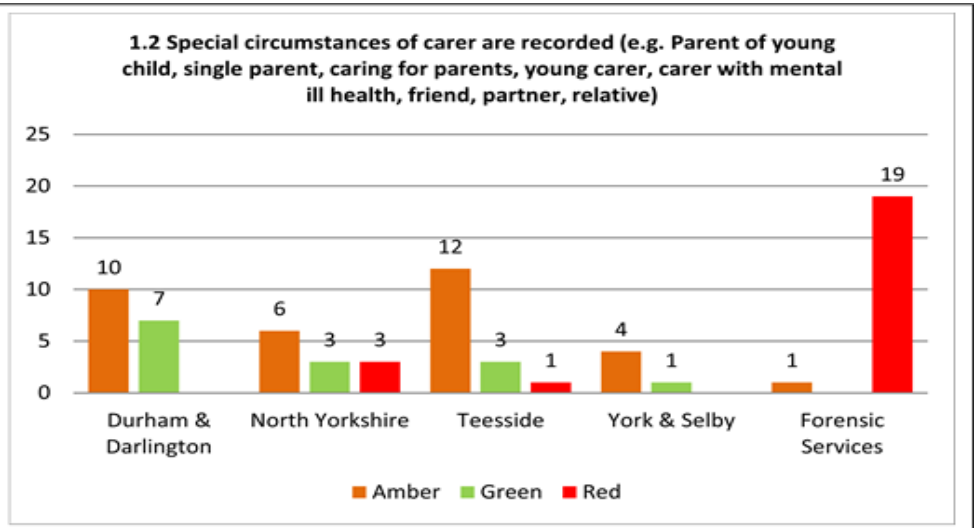
Appendix 3 continued

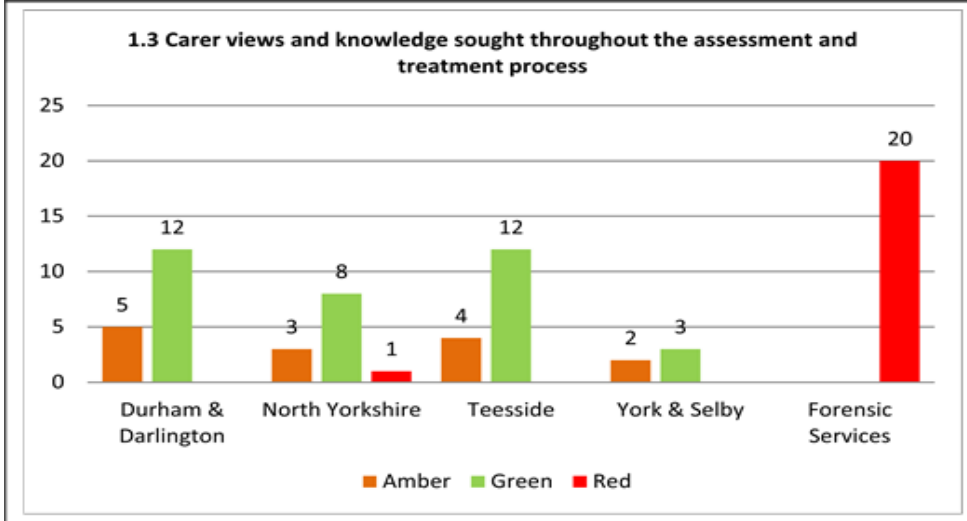
Team	Standard 1							Standard 2			Standard 3									Standard 4			Standard 5											Standard 6					
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	2.1	2.2	2.3	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8	3.9	4.1	4.2	4.3	5.1	5.2	5.3	5.4	5.5	5.6	5.7	5.8	5.9	5.10.	5.11	6.1	6.2	6.3	6.4	6.5	6.6
Community																																							
AMH Tees Crisis Teams																																							
Inpatient																																							
AMH Bedale PICU																																							
AMH Bilsdale																																							
AMH Bransdale																																							
AMH Overdale																																							
AMH Stockdale																																							
AMH Kirkdale																																							
AMH Lincoln																																							
AMH Lustrum Vale																																							
C&YPS Evergreen Centre																																							
C&YPS Newberry Centre																																							
C&YPS Westwood Centre																																							
LD Bankfields Court																																							
MHSOP Westerdale (North)																																							
MHSOP Westerdale (South)																																							
MHSOP Wingfield																																							
York and Selby - Head of Nursing Darren Gargan																																							
Community																																							
AMH York Crisis																																							
Inpatient																																							
AMH Ebor																																							
AMH Minster																																							
LD Oak Rise																																							
MHSOP Acomb Garth	See Dementia sheet as different assessment tool used																																						
MHSOP Cherry Tree House																																							
MHSOP Meadowfields	See Dementia sheet as different assessment tool used																																						

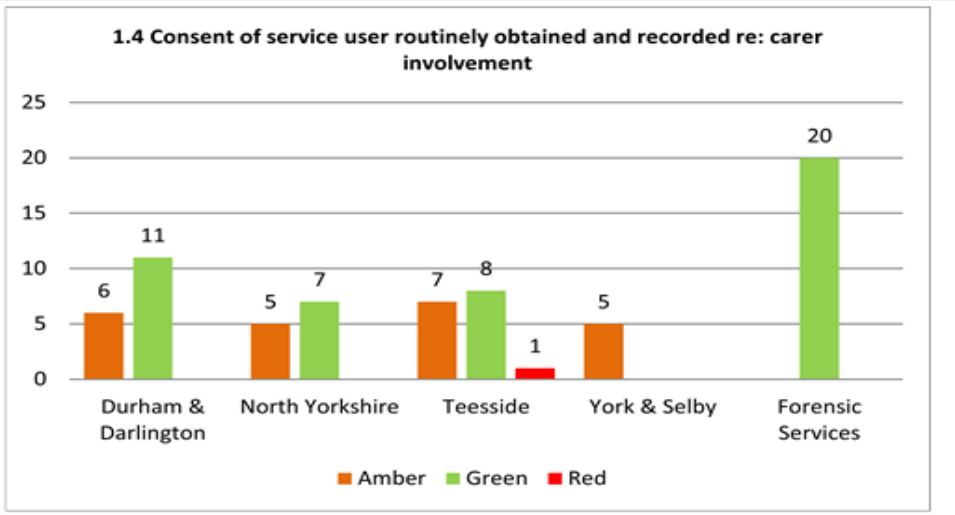
Comparison charts – Locality/Service RAG rating

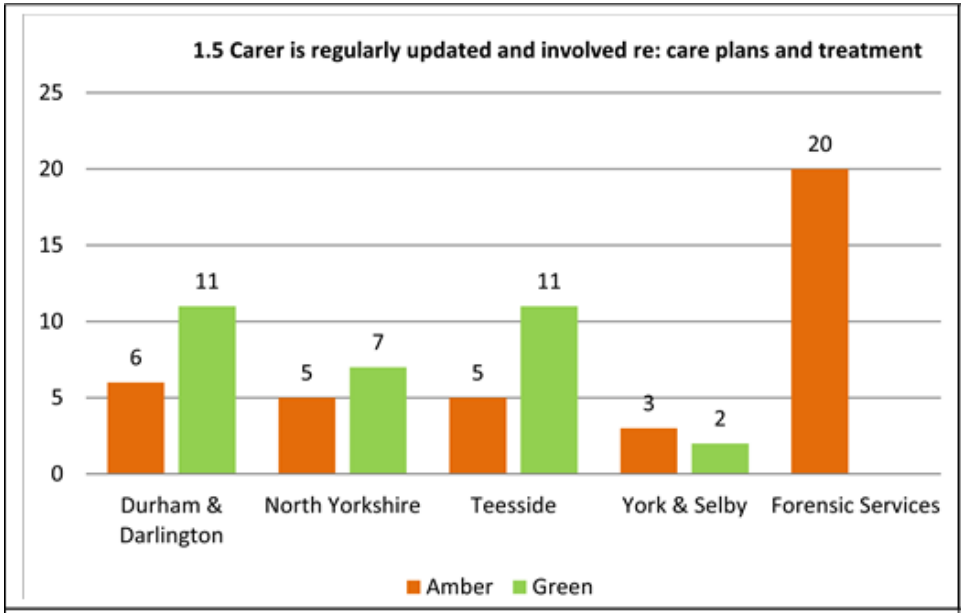
Appendix 4










1.5 Carer is regularly updated and involved re: care plans and treatment
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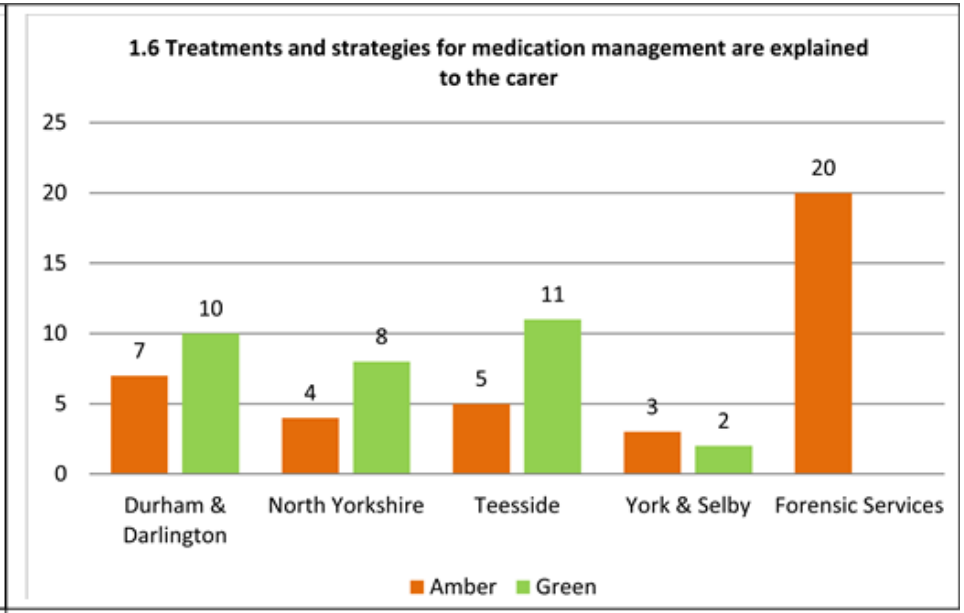
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green


1.6 Treatments and strategies for medication management are explained to the carer
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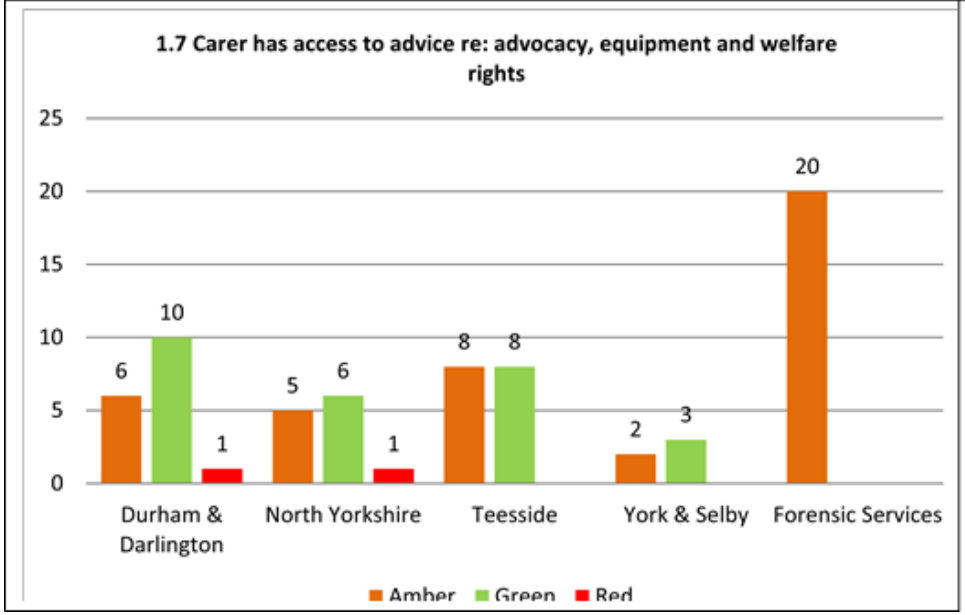
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green


1.7 Carer has access to advice re: advocacy, equipment and welfare rights
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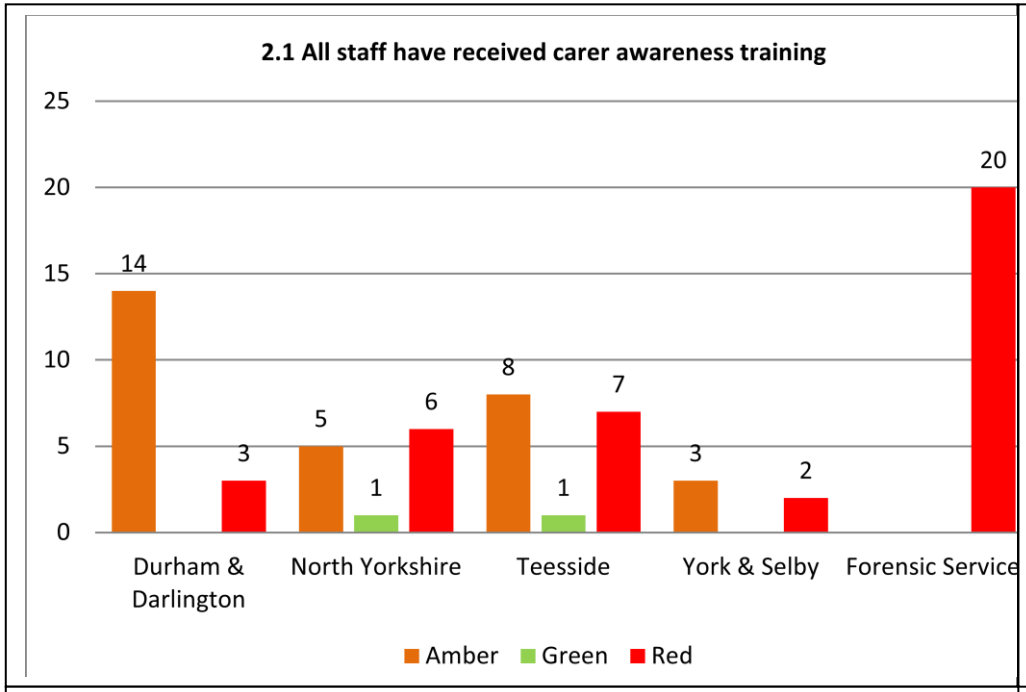
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green
Red


2.1 All staff have received carer awareness training
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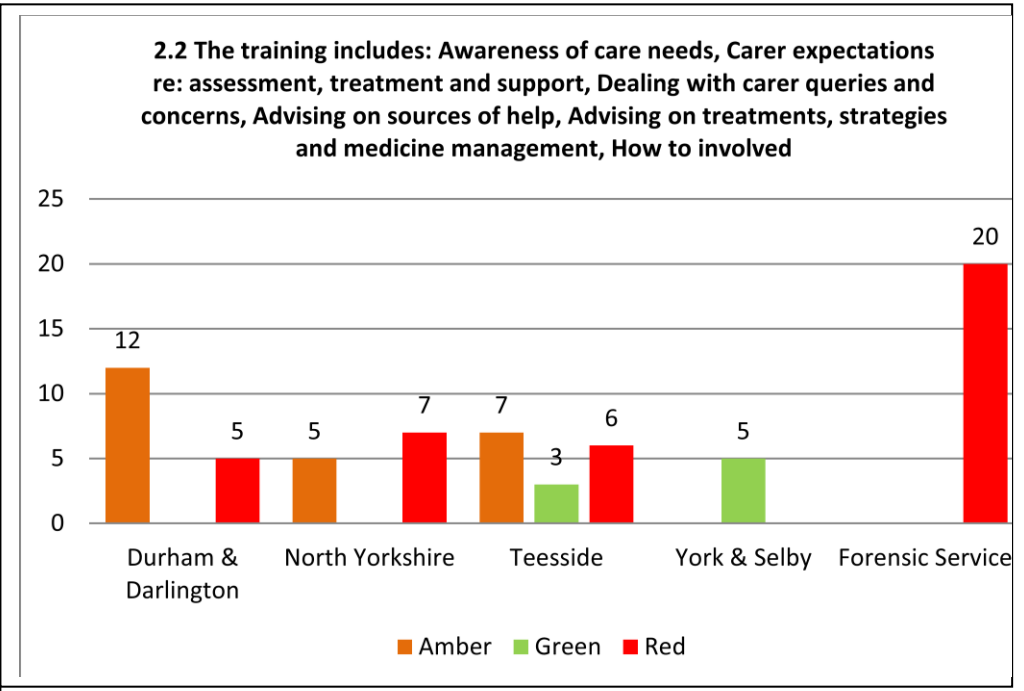
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Service
Amber
Green
Red


2.2 The training includes: Awareness of care needs, Carer expectations re: assessment, treatment and support, Dealing with carer queries and concerns, Advising on sources of help, Advising on treatments, strategies and medicine management, How to involved
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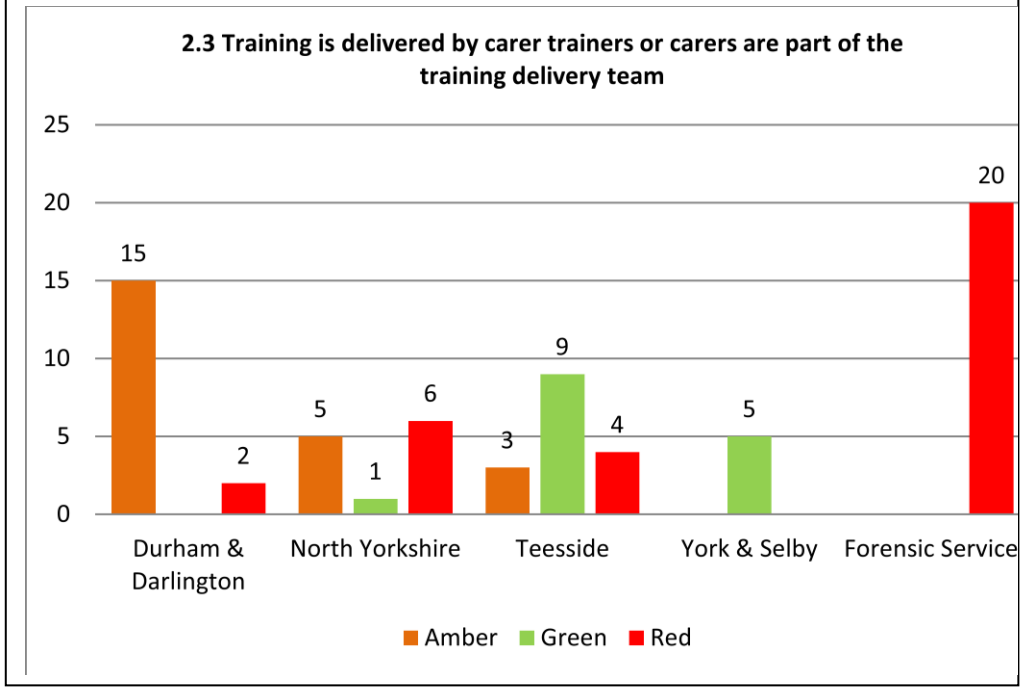
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Service
Amber
Green
Red


2.3 Training is delivered by carer trainers or carers are part of the training delivery team
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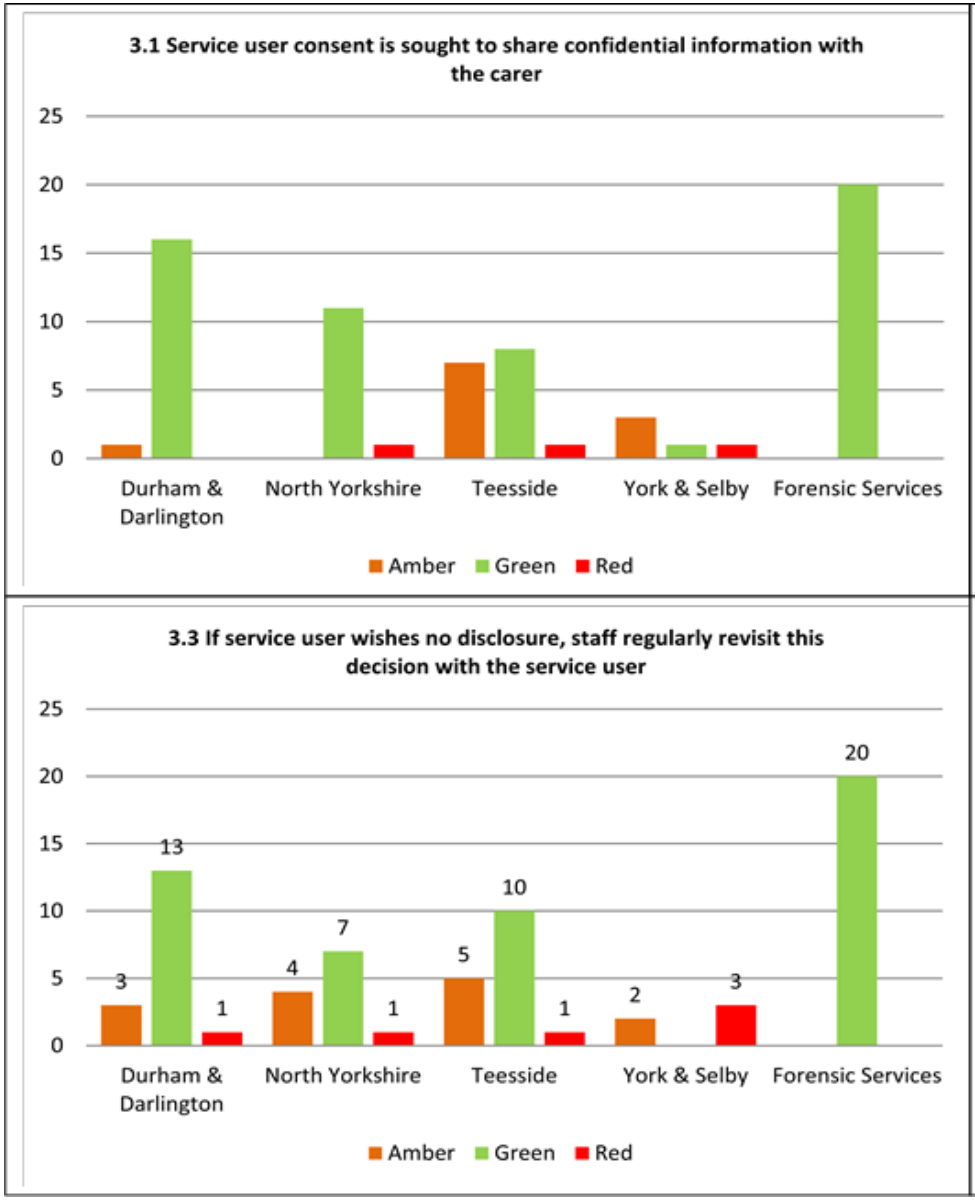
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Service
Amber
Green
Red


3.1 Service user consent is sought to share confidential information with the carer
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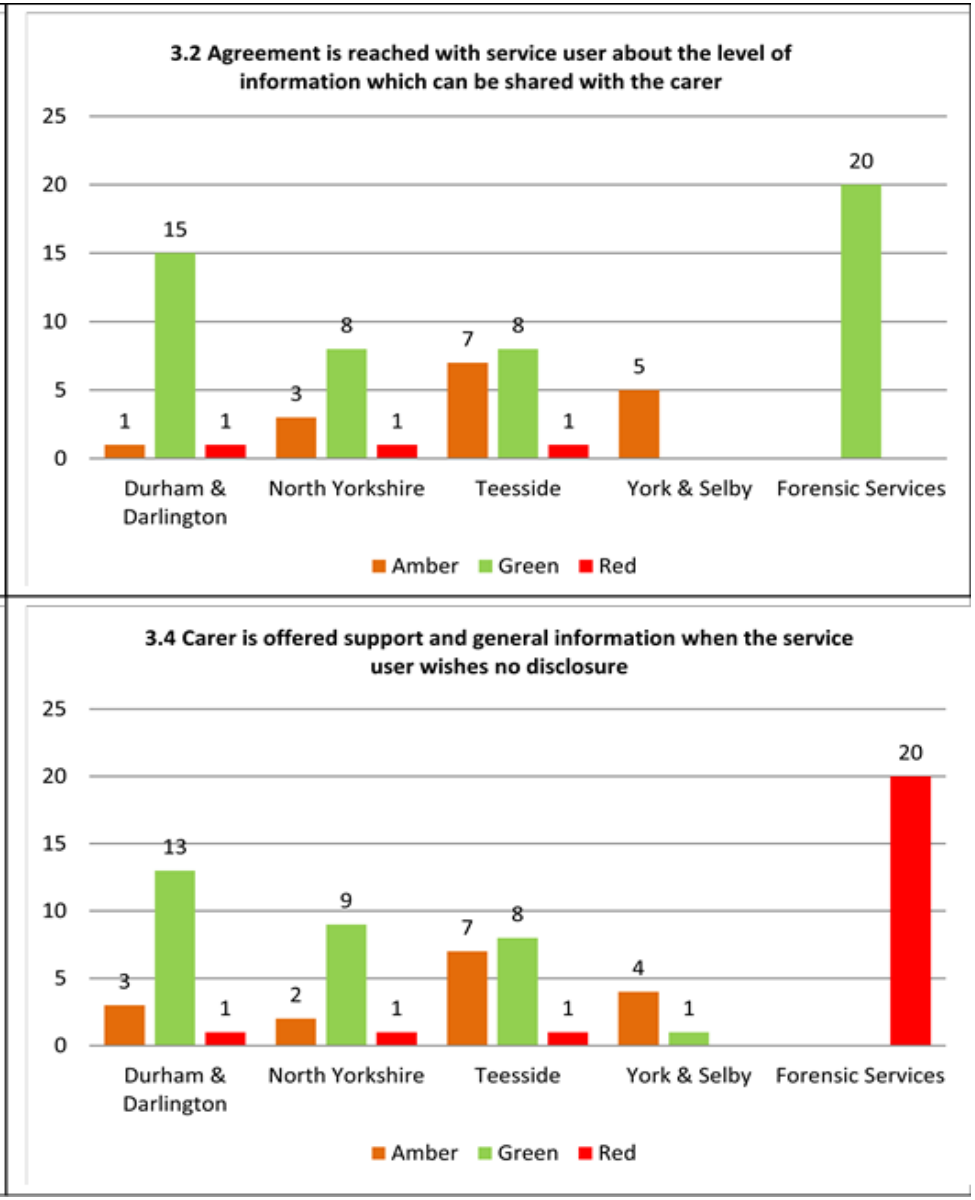
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green
Red


3.2 Agreement is reached with service user about the level of information which can be shared with the carer
25
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Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green
Red

3.3 If service user wishes no disclosure, staff regularly revisit this decision with the service user
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Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green
Red

3.4 Carer is offered support and general information when the service user wishes no disclosure
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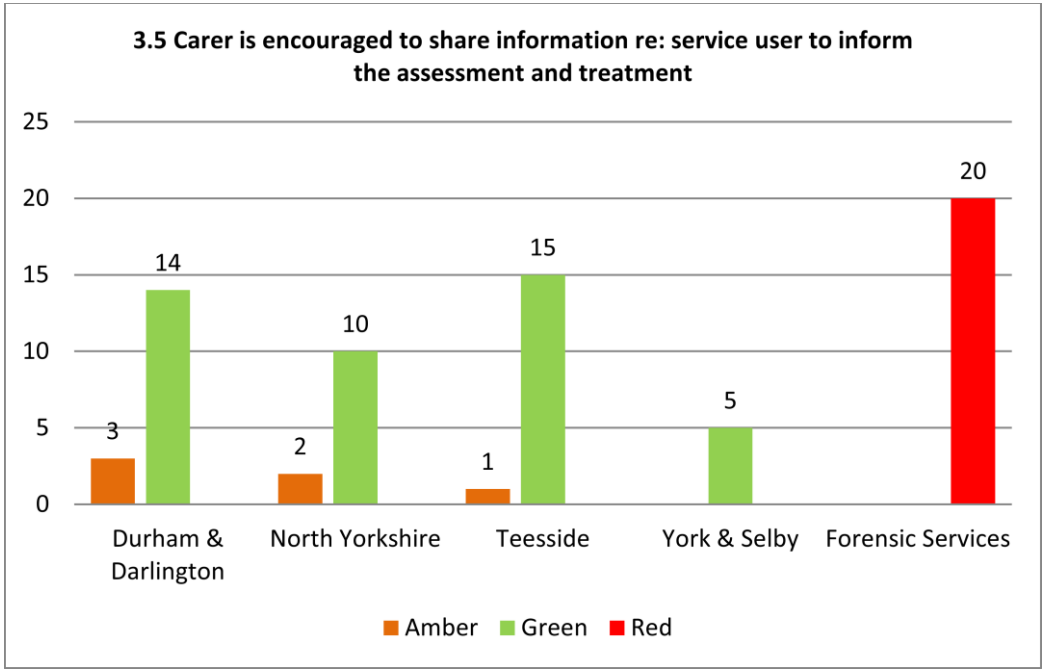
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green
Red


3.5 Carer is encouraged to share information re: service user to inform the assessment and treatment
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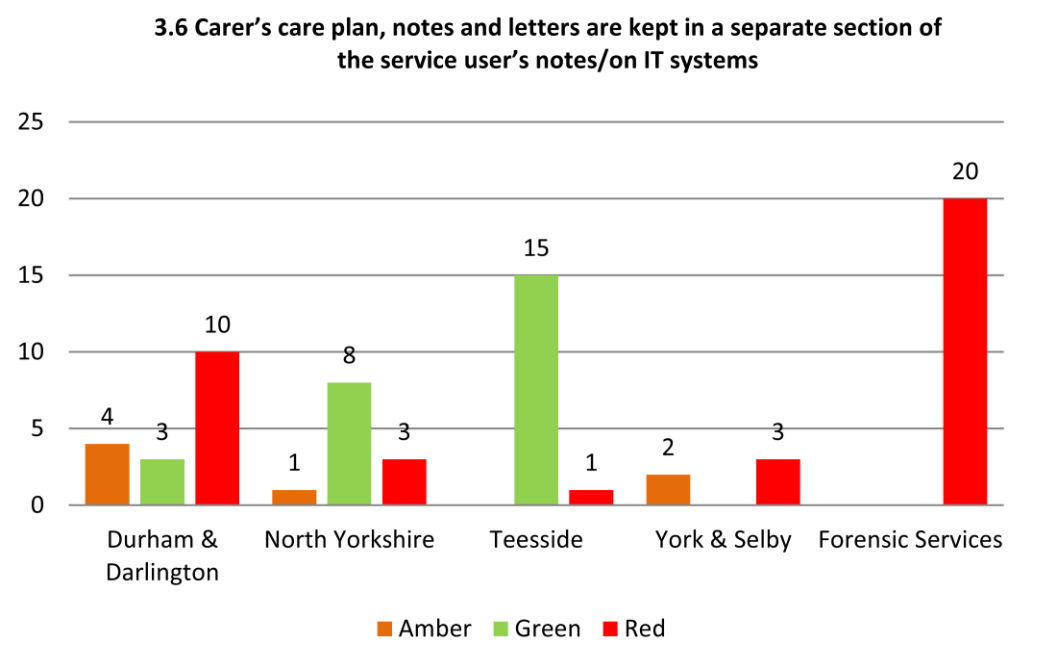
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green
Red


3.6 Carer's care plan, notes and letters are kept in a separate section of the service user's notes/on IT systems
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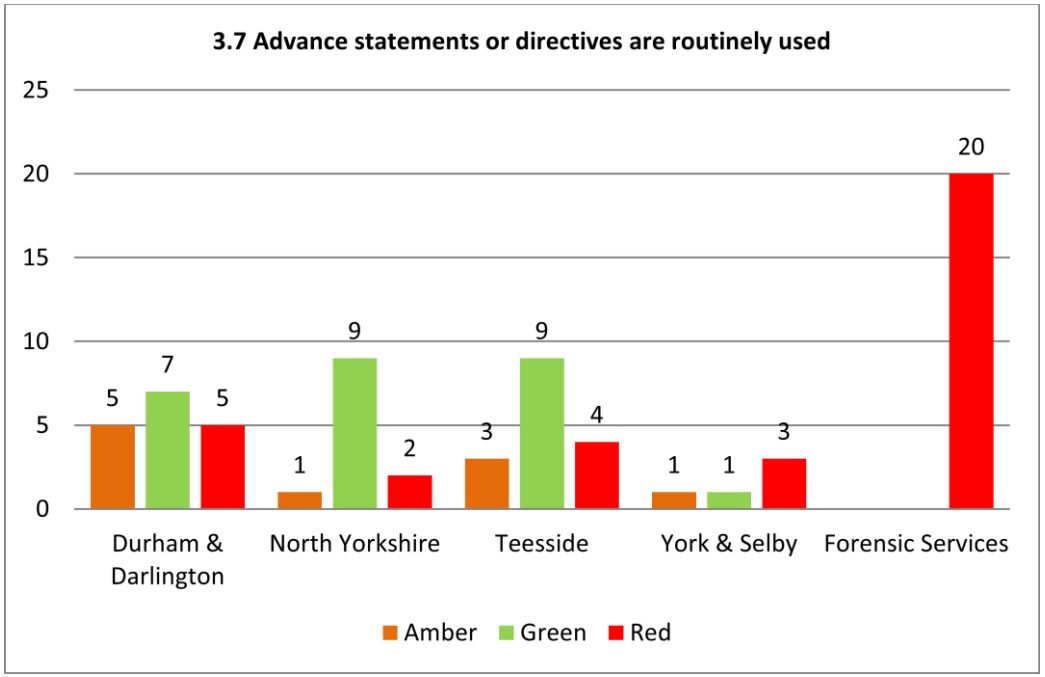
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green
Red


3.7 Advance statements or directives are routinely used
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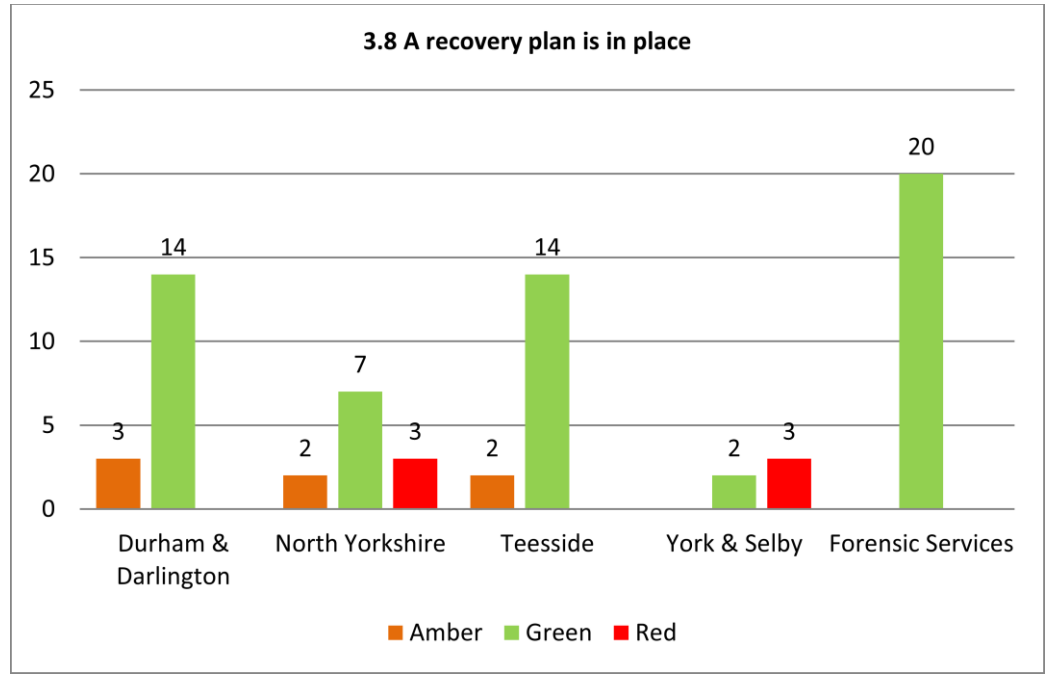
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green
Red


3.8 A recovery plan is in place
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Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
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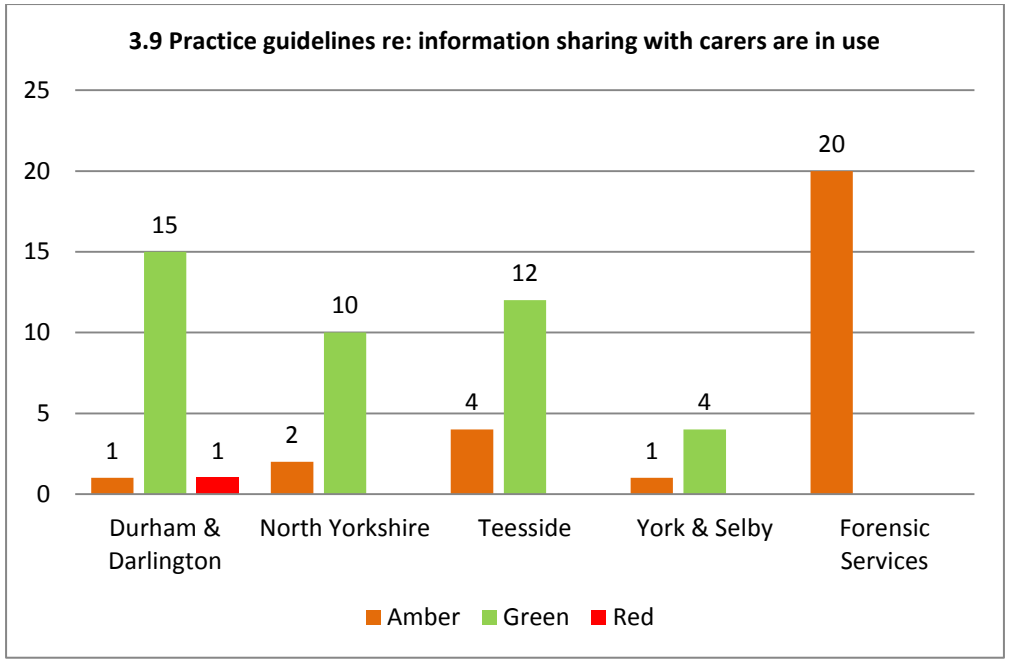
3.9 Practice guidelines re: information sharing with carers are in use
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Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green
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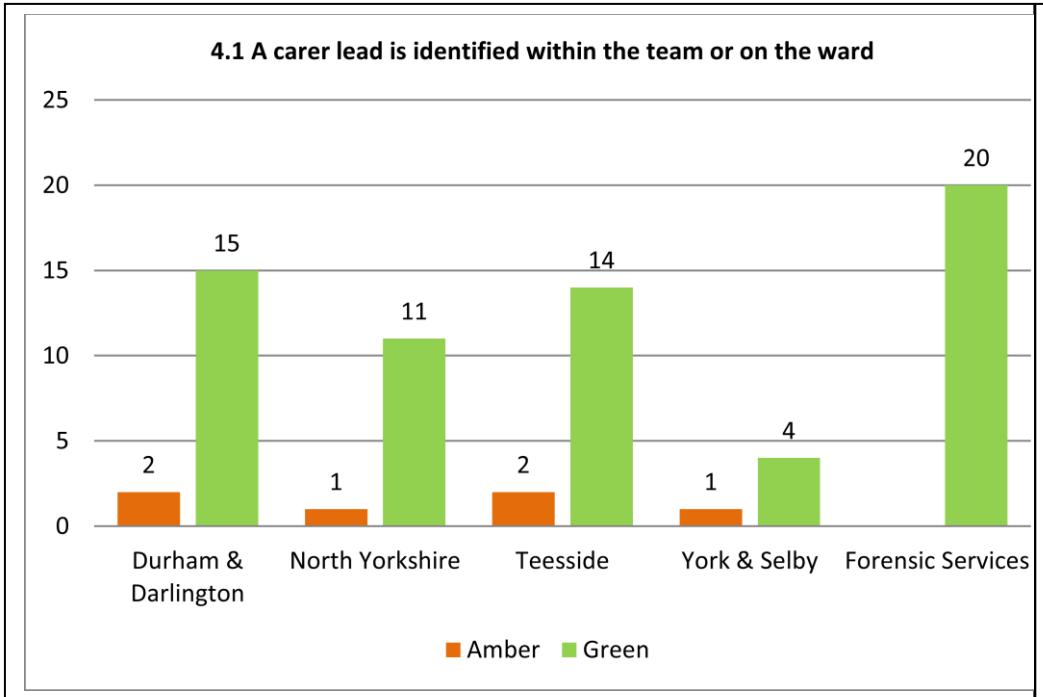
4.1 A carer lead is identified within the team or on the ward
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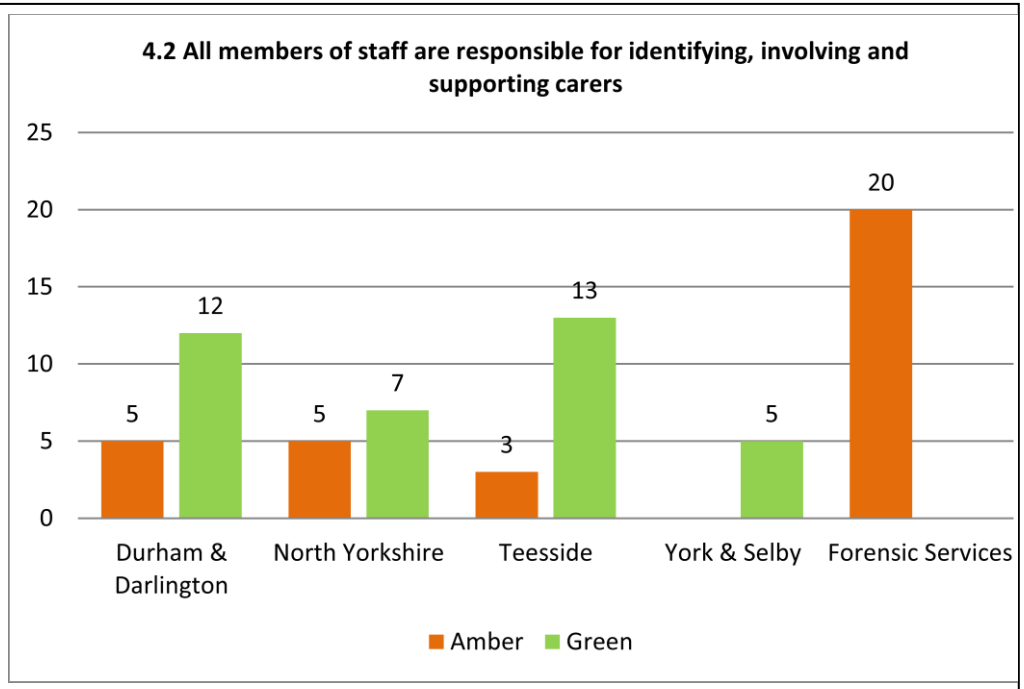
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green


4.2 All members of staff are responsible for identifying, involving and supporting carers
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Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
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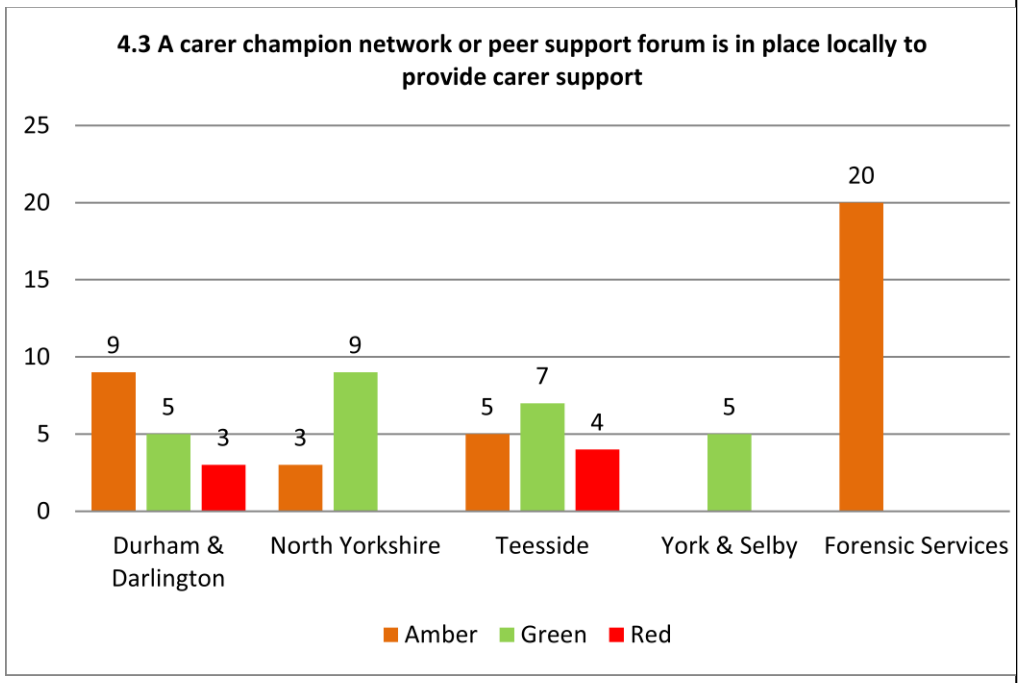
4.3 A carer champion network or peer support forum is in place locally to provide carer support
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Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
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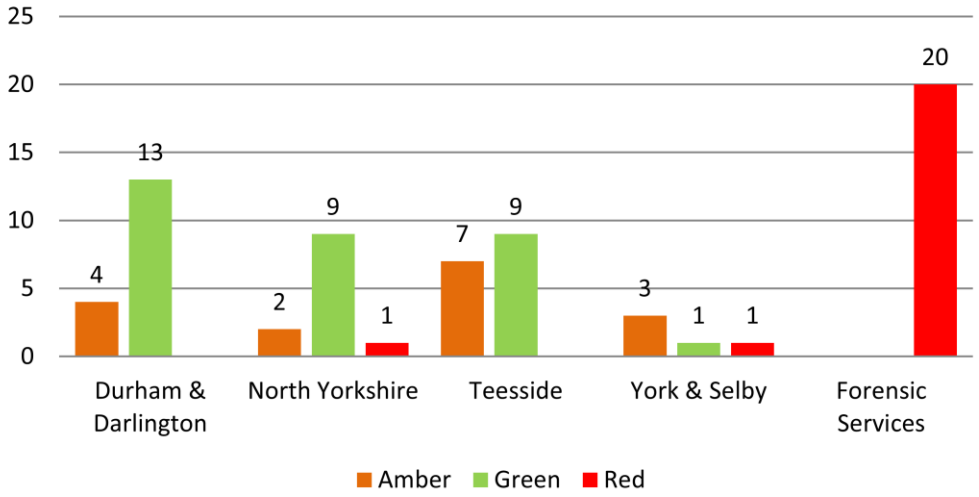
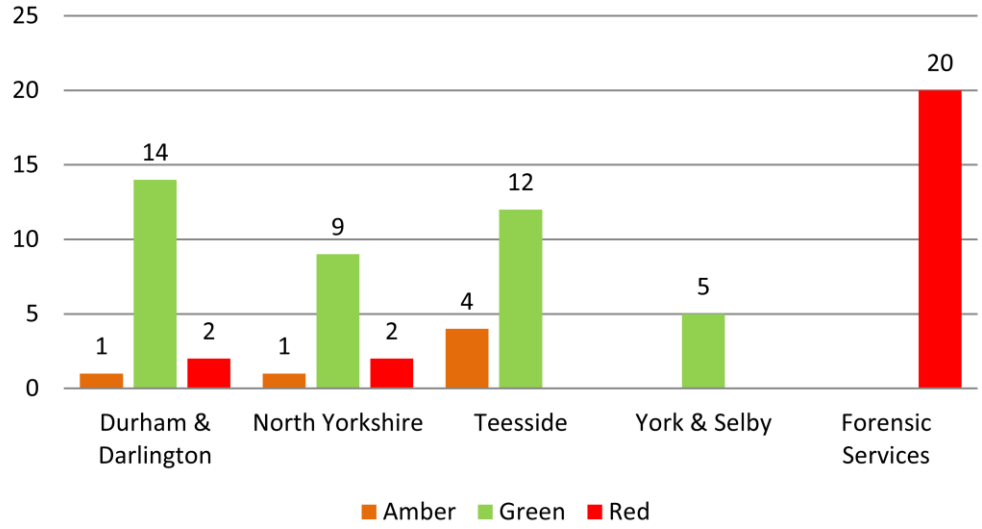
Red

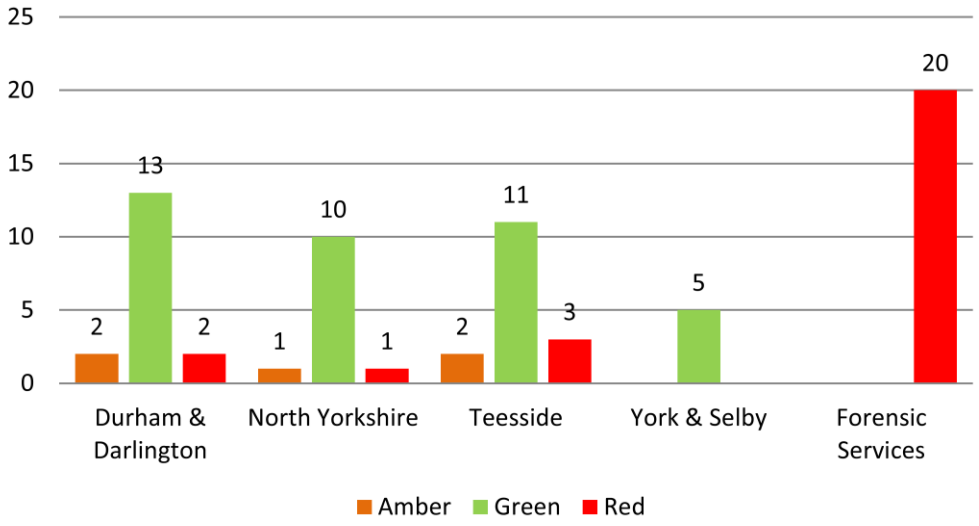
5.1 Upon first contact, the team or ward provides the carer with an introductory letter which explains the service and points of contact (for example, psychiatrist, named nurse and care coordinator's name)



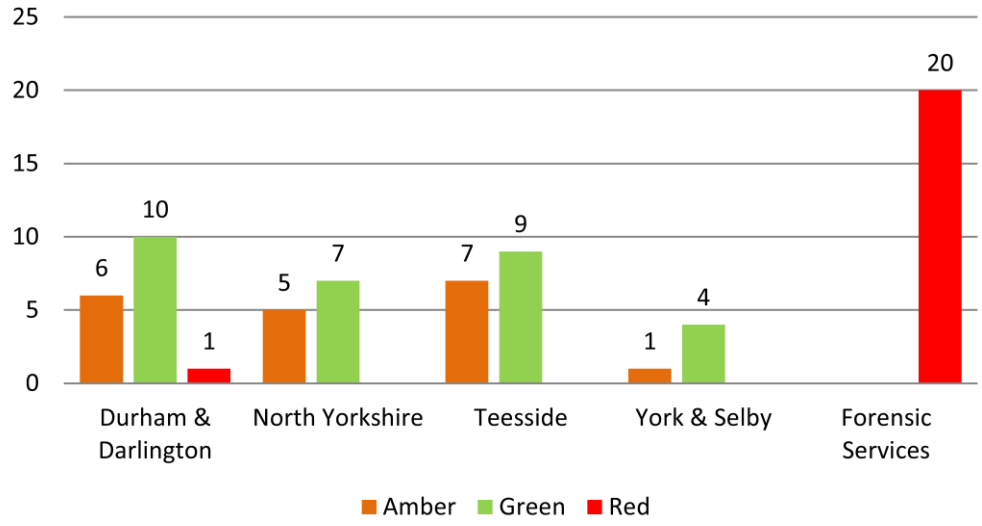
5.2 An early formal appointment is offered to the carer to hear their story, history and address carer concerns

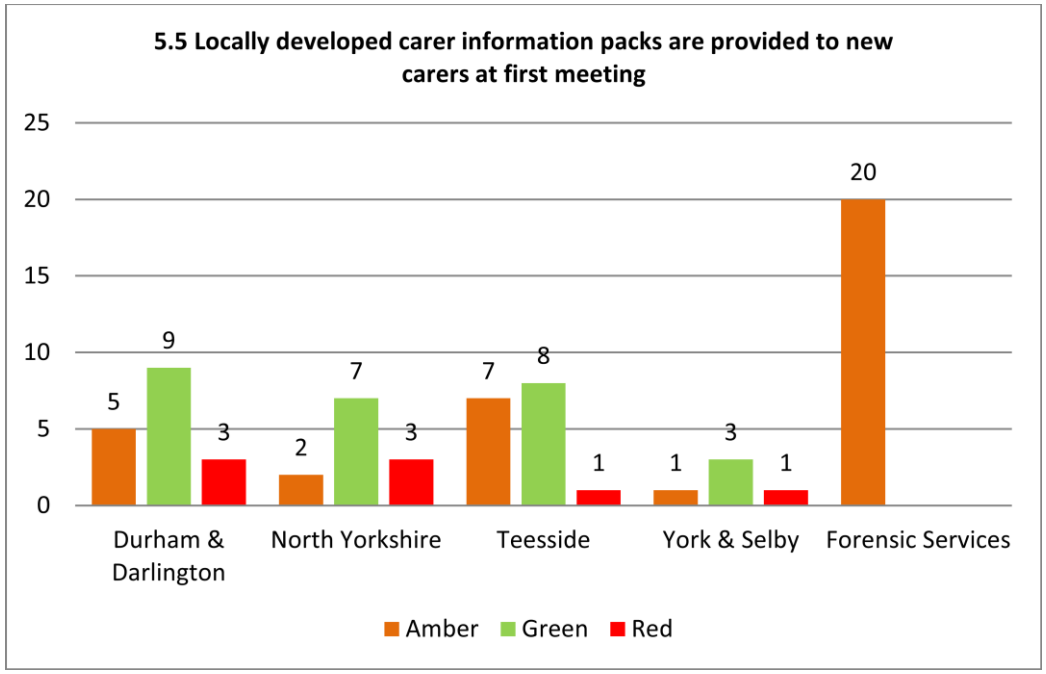


5.3 Upon first contact, the ward or team has meeting and greeting protocols in place to reduce carer distress and address concerns



5.4 Carers are routinely given an information leaflet covering immediate practical matters upon referral to the ward or team




5.5 Locally developed carer information packs are provided to new carers at first meeting
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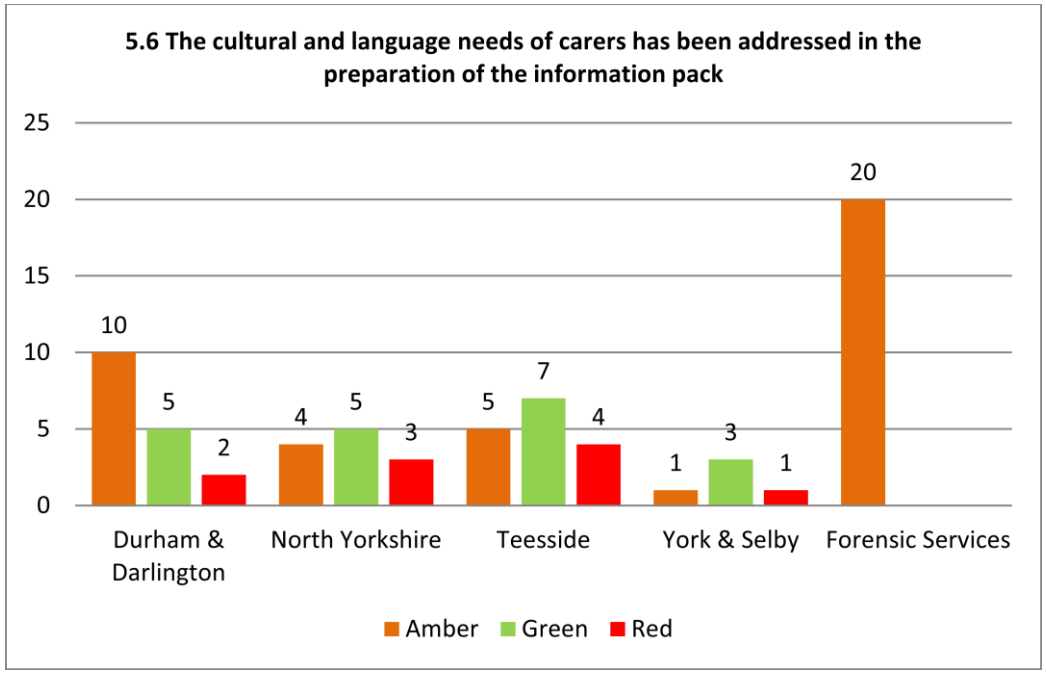
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green
Red


5.6 The cultural and language needs of carers has been addressed in the preparation of the information pack
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Durham & Darlington
North Yorkshire
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York & Selby
Forensic Services
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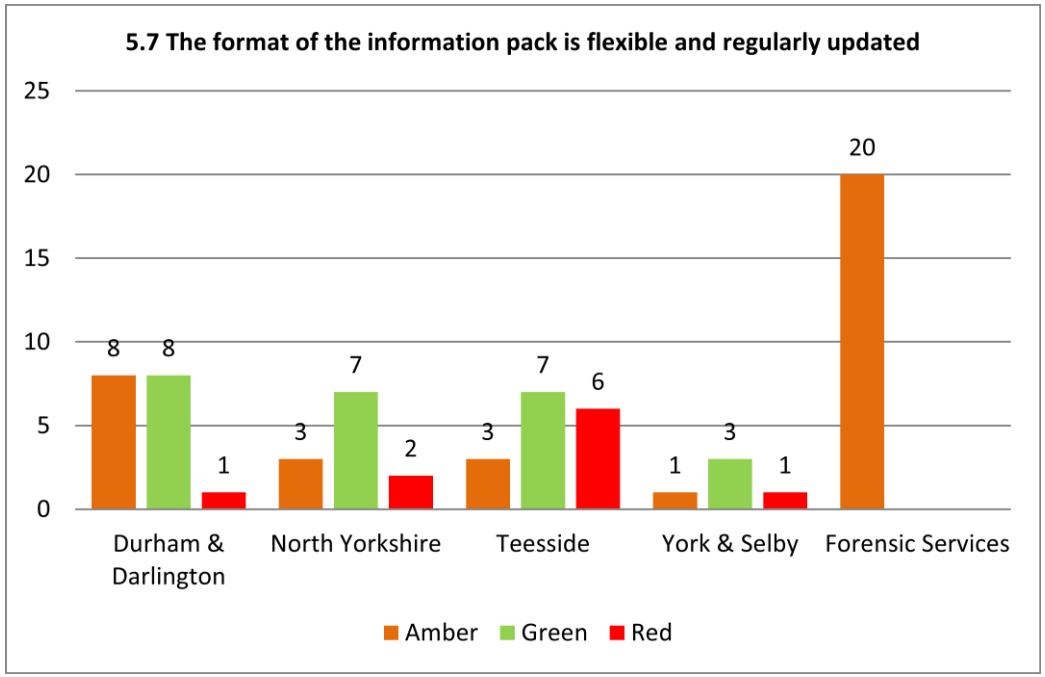
5.7 The format of the information pack is flexible and regularly updated
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Durham & Darlington
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Forensic Services
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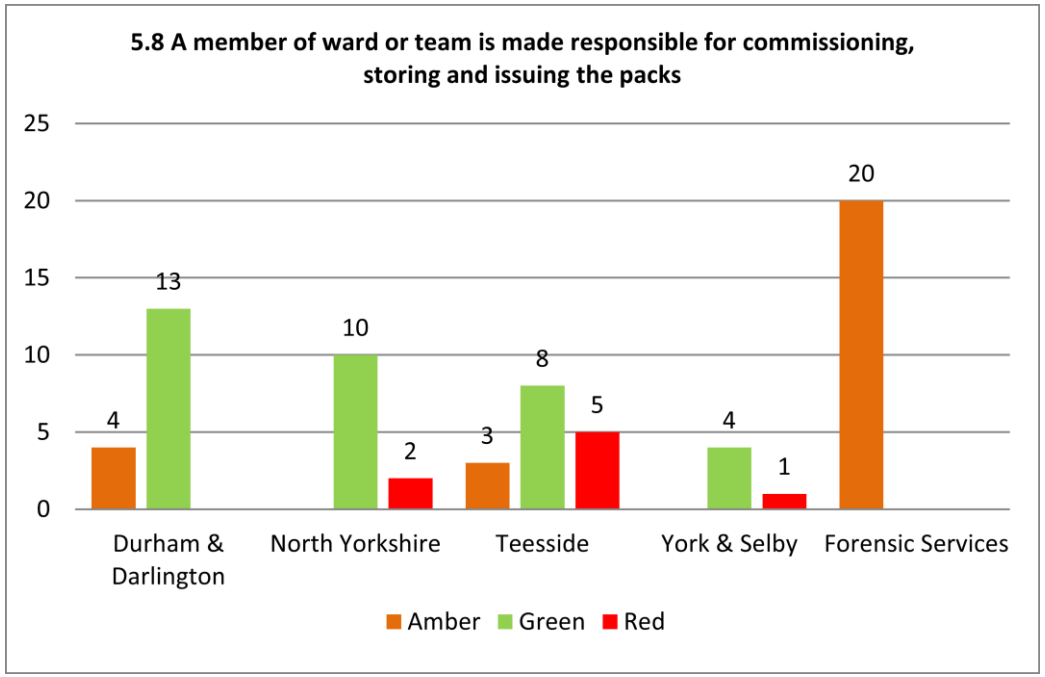
5.8 A member of ward or team is made responsible for commissioning, storing and issuing the packs
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Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
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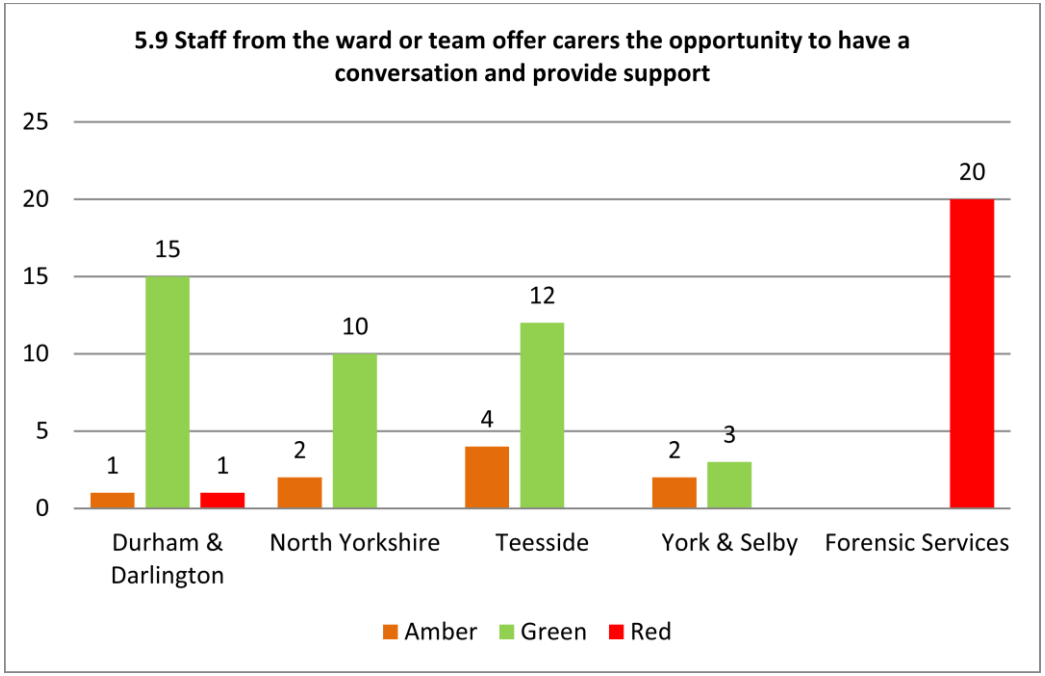
5.9 Staff from the ward or team offer carers the opportunity to have a conversation and provide support
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Durham & Darlington
North Yorkshire
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Forensic Services
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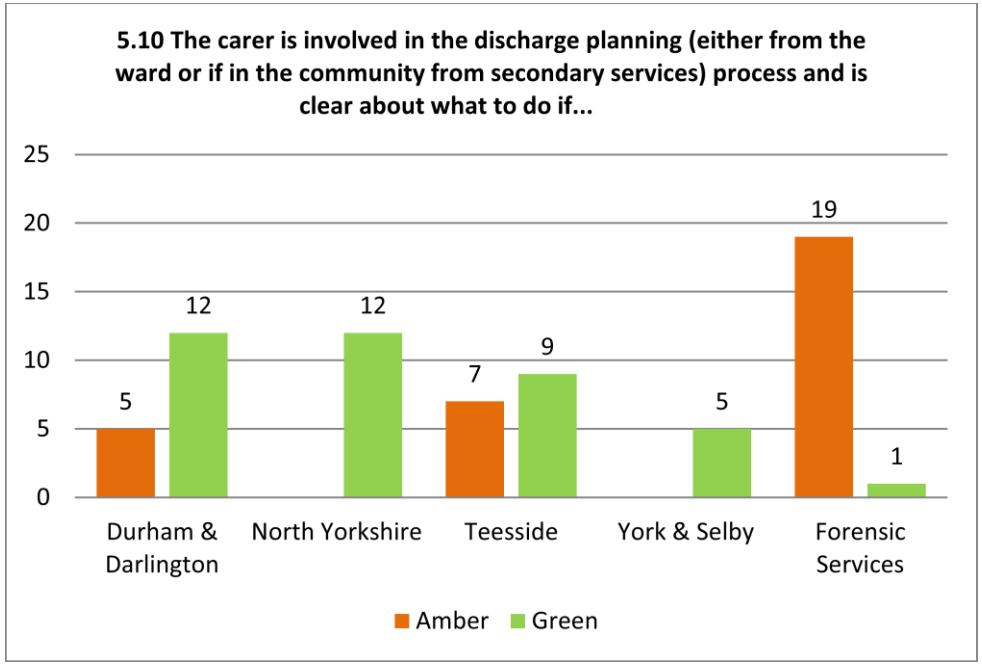
5.10 The carer is involved in the discharge planning (either from the ward or if in the community from secondary services) process and is clear about what to do if...
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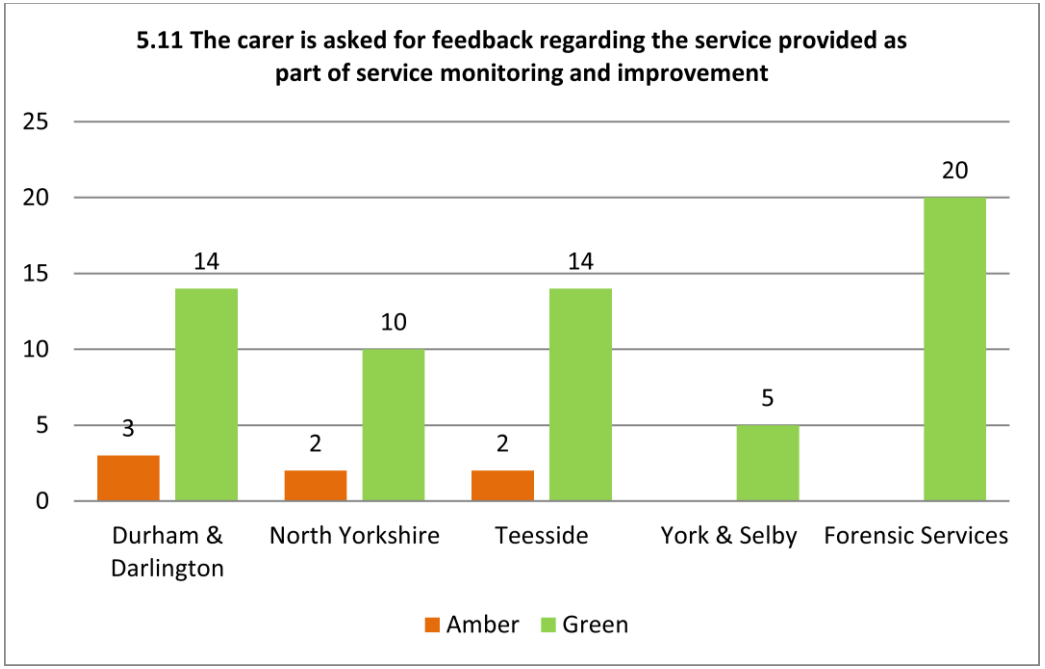
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green


5.11 The carer is asked for feedback regarding the service provided as part of service monitoring and improvement
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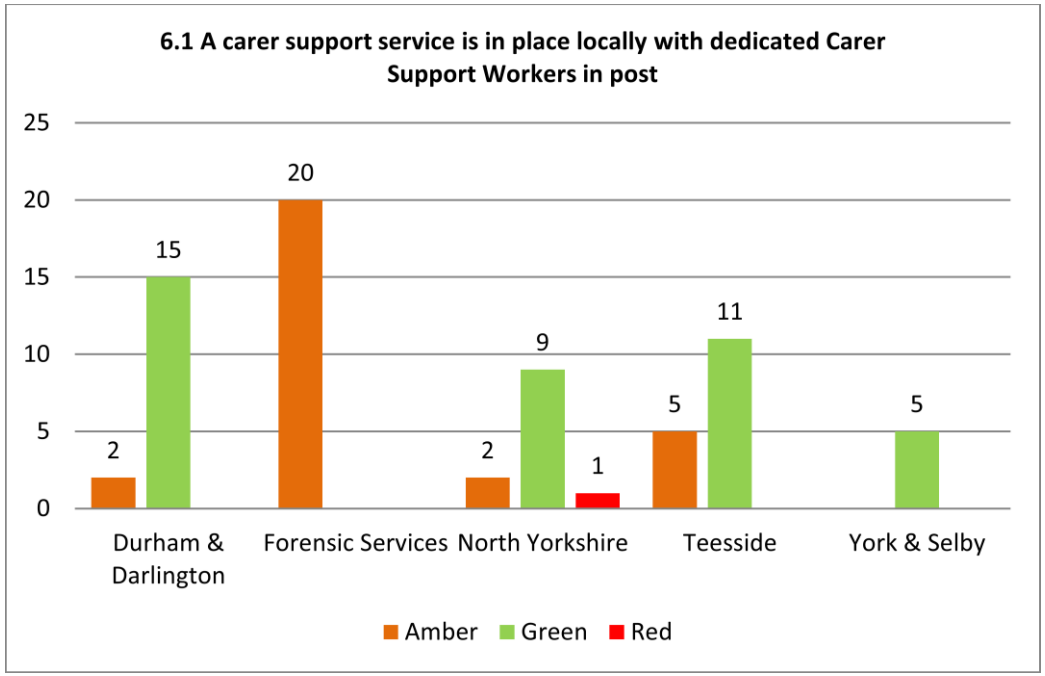
Durham & Darlington
North Yorkshire
Teesside
York & Selby
Forensic Services
Amber
Green


6.1 A carer support service is in place locally with dedicated Carer Support Workers in post
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Forensic Services
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Teesside
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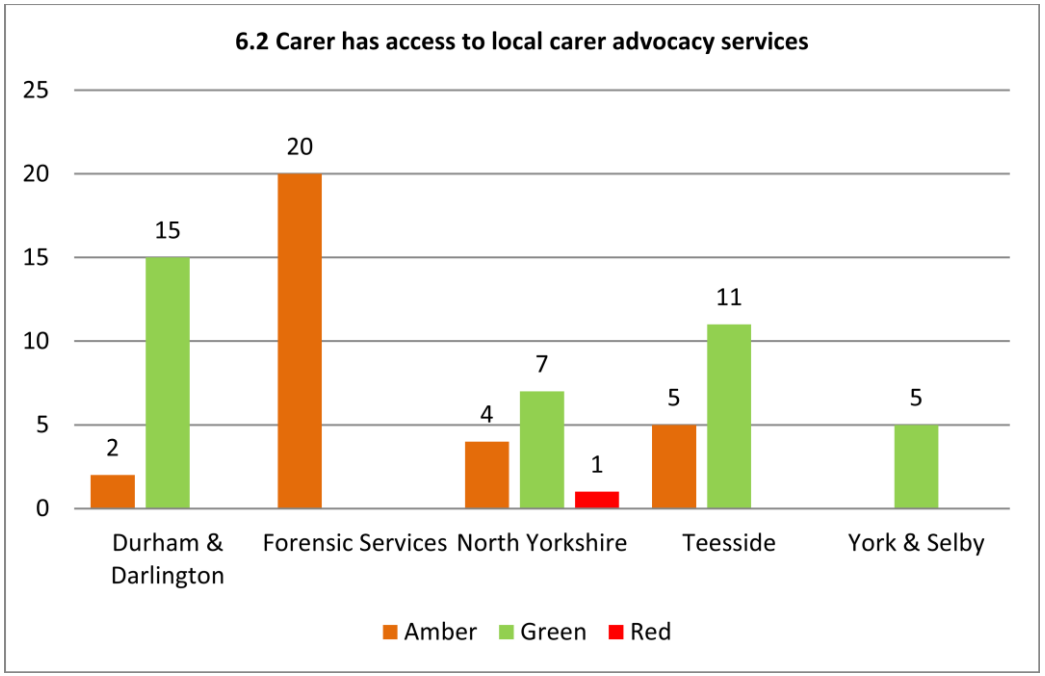
6.2 Carer has access to local carer advocacy services
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Durham & Darlington
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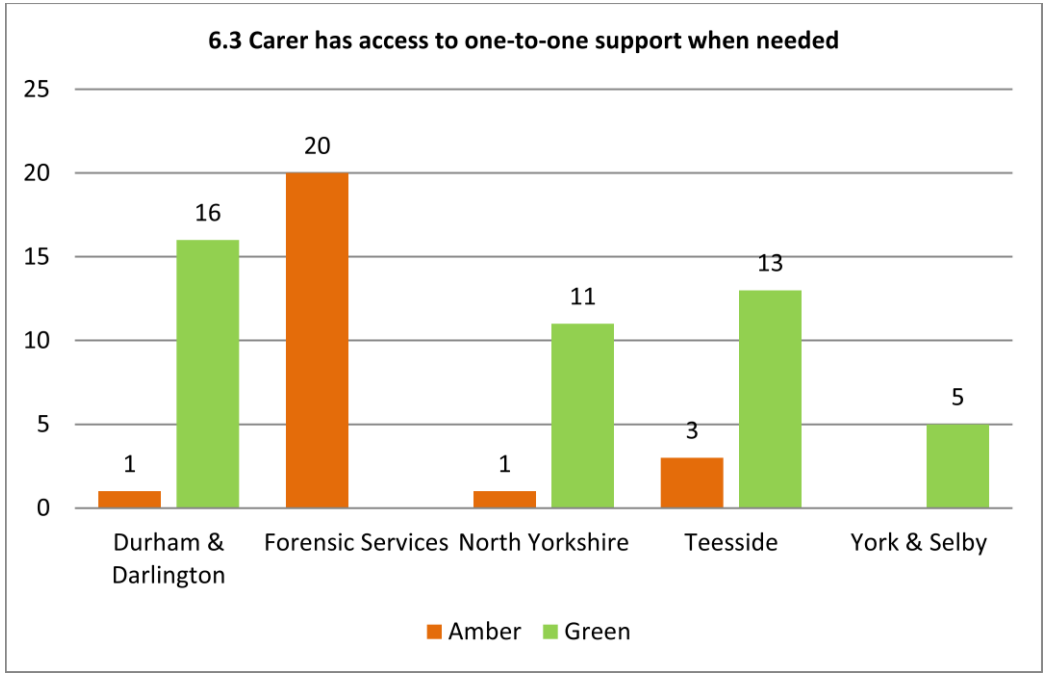
6.3 Carer has access to one-to-one support when needed
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Forensic Services
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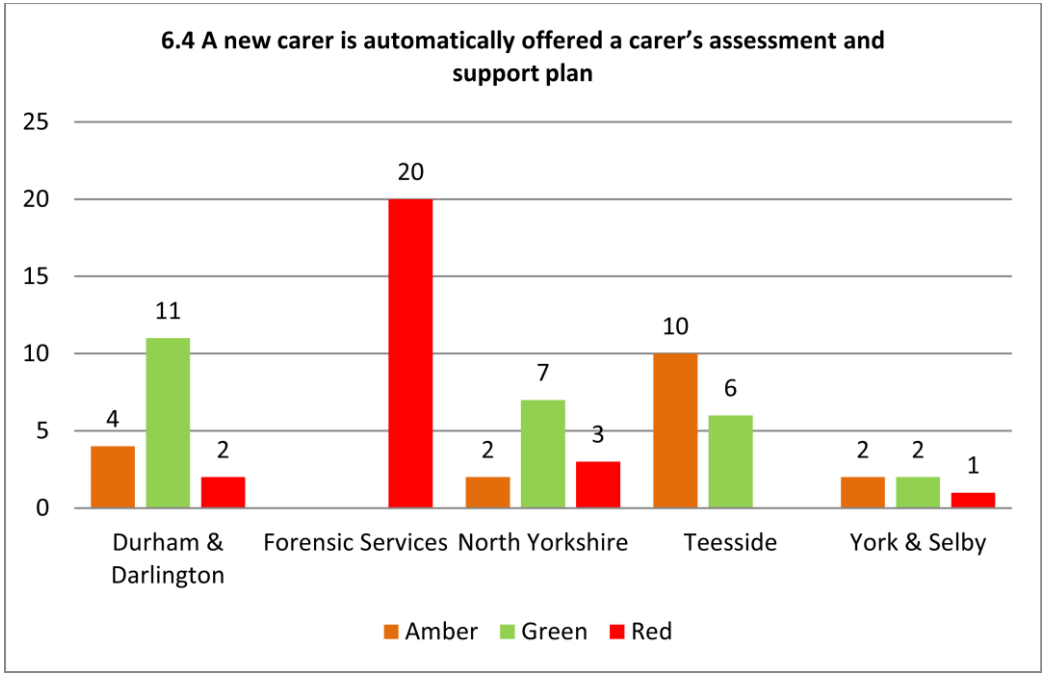
6.4 A new carer is automatically offered a carer's assessment and support plan
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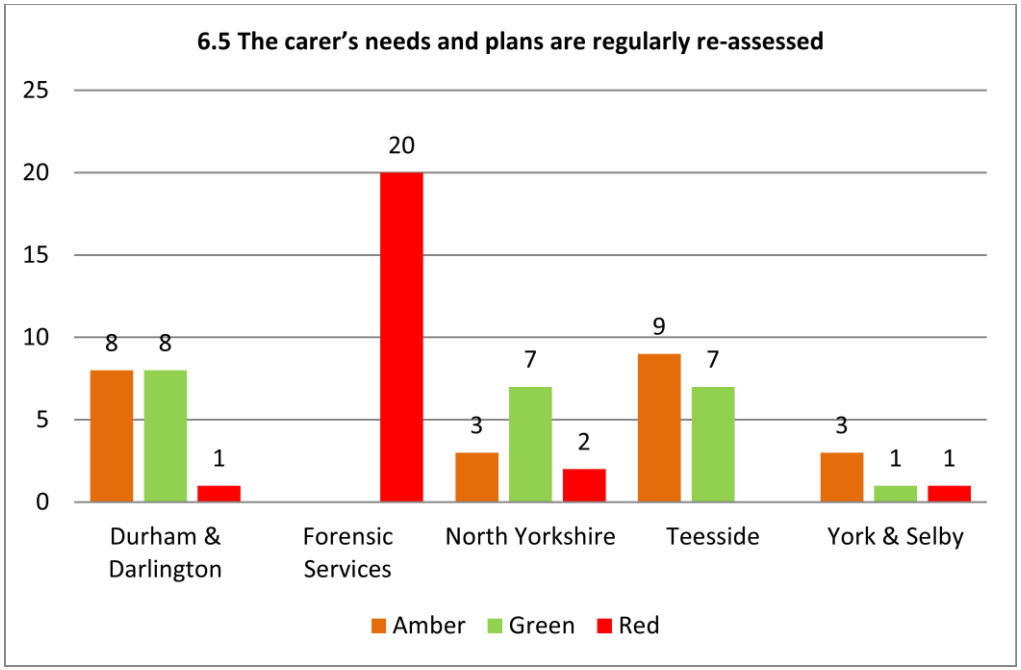
6.5 The carer's needs and plans are regularly re-assessed
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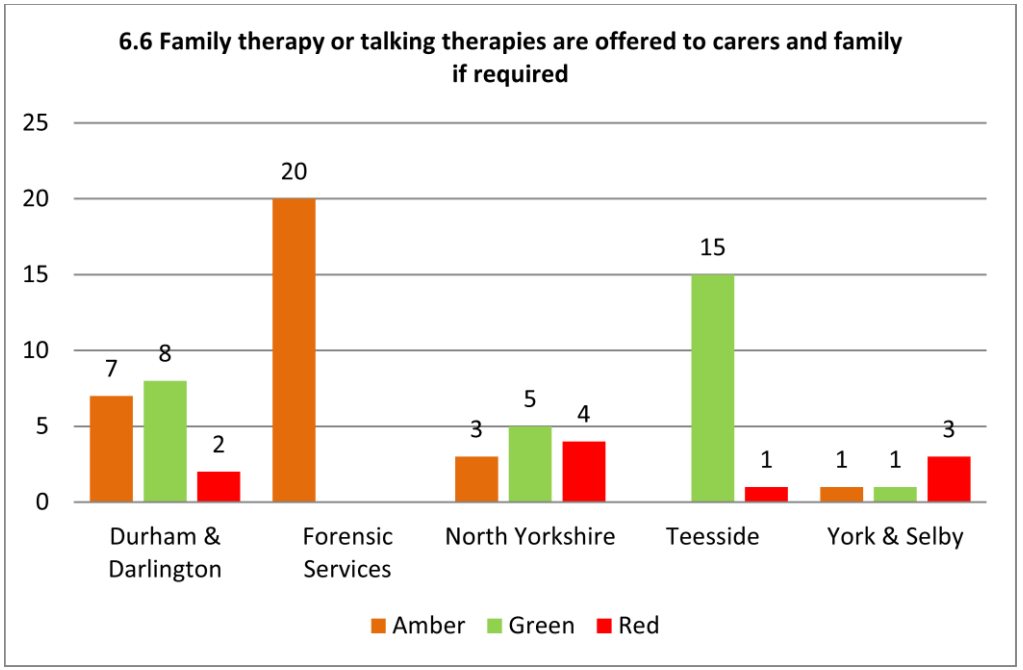
6.6 Family therapy or talking therapies are offered to carers and family if required
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Forensic Services
North Yorkshire
Teesside
York & Selby
Amber
Green
Red

Appendix 5 - Ward RAG table using Dementia Tool

Team	Standard 1								Standard 2			Standard 3						Standard 4			Standard 5											Stanard 6					
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8	2.1	2.2	2.3	3.1	3.2	3.3	3.4	3.5	3.6	4.1	4.2	4.3	5.1	5.2	5.3	5.4	5.5	5.6	5.7	5.8	5.9	5.10	5.11	6.1	6.2	6.3	6.4	6.5	6.6
York and Selby - Head of Nursing Darren Gargan																																					
MHSOP Acomb Garth																																					
MHSOP Meadowfields																																					

Standard 1 - Carers and their essential role are identified at first contact or as soon as possible afterwards

1.1 The carer is routinely identified with the service user when carrying out an assessment
1.2 Special circumstances of carer are recorded
1.3 Carer views and knowledge sought throughout the assessment and treatment process
1.4 Consent of service user routinely obtained and recorded re: carer involvement
1.5 Carer is regularly updated and involved re: care plans and treatment
1.6 Treatments and strategies for medication management are explained to the carer
1.7 Carer has access to advice re: advocacy, equipment and welfare rights

Standard 2 - Staff are carer aware and trained in carer engagement strategies

2.1 All staff have received carer awareness training
2.2 The training includes: Awareness of care needs, Carer expectations re: assessment, treatment and support, Dealing with carer queries and concerns, Advising on sources of help, Advising on treatments, strategies and medicine management, How to involve and engage with carers and service users
2.3 Training is delivered by carer trainers or carers are part of the training delivery team

Standard 3 - Policy and practice protocols re: confidentiality and sharing information, are in place

3.1 Service user consent is sought to share confidential information with the carer
3.2 Agreement is reached with service user about the level of information which can be shared with the carer
3.3 If service user wishes no disclosure, staff regularly revisit this decision with the service user
3.4 Carer is offered support and general information when the service user wishes no disclosure
3.5 Carer is encouraged to share information re: service user to inform the assessment and treatment
3.6 Carer's care plan, notes and letters are kept in a separate section of the service user's notes/on IT systems
3.7 Advance statements or directives are routinely used
3.8 A recovery plan is in place

3.9 Practice guidelines re: information sharing with carers are in use

Standard 4 – Defined post(s) responsible for carers are in place

4.1 A carer lead is identified within the team or on the ward
4.2 All members of staff are responsible for identifying, involving and supporting carers
4.3 A carer champion network or peer support forum is in place locally to provide carer support

Standard 5 - A carer introduction to the service and staff is available, with a relevant range of information across the care pathway

5.1 Upon first contact, the team or ward provides the carer with an introductory letter which explains the service and points of contact (for example, psychiatrist, named nurse and care coordinator's name)
5.2 An early formal appointment is offered to the carer to hear their story, history and address carer concerns
5.3 Upon first contact, the ward or team has meeting and greeting protocols in place to reduce carer distress and address concerns
5.4 Carers are routinely given an information leaflet covering immediate practical matters upon referral to the ward or team
5.5 Locally developed carer information packs are provided to new carers at first meeting
5.6 The cultural and language needs of carers has been addressed in the preparation of the information pack
5.7 The format of the information pack is flexible and regularly updated
5.8 A member of ward or team is made responsible for commissioning, storing and issuing the packs
5.9 Staff from the ward or team offer carers the opportunity to have a conversation and provide support
5.10 The carer is involved in the discharge planning (either from the ward or if in the community from secondary services) process and is clear about what to do if …
5.11 The carer is asked for feedback regarding the service provided as part of service monitoring and improvement

Standard 6 - A range of carer support is available

6.1 A carer support service is in place locally with dedicated Carer Support Workers in post
6.2 Carer has access to local carer advocacy services
6.3 Carer has access to one-to-one support when needed
6.4 A new carer is automatically offered a carer's assessment and support plan
6.5 The carer's needs and plans are regularly re-assessed
6.6 Family therapy or talking therapies are offered to carers and family if required

ITEM 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th September 2017**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

The purpose of this report 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 2017 data.

Key issues during the reporting period can be summarised as follows:

- The number of rosters equates to 71 inpatient wards.
- The number of 'red' fill rate indicators highlights Registered Nurses on Days as having the highest number of 'reds' equating to 42 wards.
- The Forensic directorate have the highest level of 'red' fill rates (15 in August)
- The lowest fill rate indicators in August related to Talbot Direct Care (reduction of bed occupancy), Ward 15 (vacancies) and Newtondale (established for 2 RN with 1 used as a floater across the service)
- The Highest fill rates in August were observed by Cedar (enhanced observations), Bedale (change in establishment) and Holly (supporting 2 patients at Bankfields Court).
- In relation to bank usage there were no wards identified that were utilising in excess of 50% bank during August. The highest bank user was in relation to Cedar with 44.6% bank usage (reasons for bank included: enhanced Observations and vacancies)
- Agency usage equated to 1.77% in August. The highest user of agency within the reporting period related to Acomb Garth. This equated to 25% of the total hours worked within this ward.

- In terms of triangulation with incidents and complaints:

  - There was 1 Serious Incident (SI) that occurred within an inpatient area during the month of August. This ward has not been cited in this report to date.
  - There were 0 level 4 incidents that occurred in August.
  - There were 4 complaints raised in August with the following featuring in this report as follows:
    - Birch (1 incident) – cited in this report for bank usage in excess of 25%
    - Newtondale (1 incident) – cited in this report for having a low staffing fill rate
    - Cherry Tree (1 incident) – cited in this report for using agency during the reporting period.

A number of incidents requiring control and restraint occurred during August. The highest user was the Newberry Centre with a total of 122 incidents.

There were 578 shifts allocated in August where an unpaid break had not been taken. From those shifts where breaks were not taken the majority were in relation to day shifts (382 shifts).

There were 16 incidents raised in August citing concerns in relation to staffing levels. Harland Ward (single occupancy package) was reported as having no RN on duty for the night shift on the 5th August following them being moved to cover another in-patient ward, this is currently being investigated.

A severity calculation has been applied and highlights any areas of concern from a safe staffing point of view. In August Clover/Ivy had the highest score with 10 points awarded. The top 10 for August can be found on page 9 of this report along with an explanation of severity scores and appendix 3 shows all scores for all wards. Appendix 4 shows the severity scores by speciality.

Maintaining planned staffing levels for each ward is always a key focus however August's data demonstrates high levels of patient acuity and complexity in a number of ward areas meaning wards are having to staff to meet the needs of the patient group over and above their planned establishments (250%+ for the highlighted wards). This, at the same time as many wards await the commencement of newly qualified staff who are filling the majority of RN vacancies has led to real staffing pressures. Feedback from Ward Managers and Matrons suggests a number of wards throughout August have addressed staffing needs through Ward Managers working out of hours (weekends and nights) and in the established numbers.

Work continues in localities to address shortfalls where planned establishments are not being met or high levels of registered nurse agency/bank are being used and to provide assurance on how this is being addressed.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**26th September 2017**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of the exceptions arising from the monthly information on nurse staffing 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 2017 data.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Further to the emergent lessons from the Francis review there were a number of issues raised about the impact of the nurse staffing arrangements upon the poor quality of care and increased patient mortality exposed in that organisation.

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013 and subsequent update of the guidance in 2016) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. (http://www.tewv.nhs.uk/site/content/About/How-well-are-we-doing/Nurse-staffing). The full monthly data set of day by day staffing for each of the 71 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

3. EXCEPTIONS:

3.1 Safe Staffing Fill Rates – August 2017

3.1.1 The daily nurse staffing information aggregated for the month of August 2017 are presented at Appendix 1 of this report.

The highest numbers of red fill rate indicators relate to Registered Nurses on day shifts which equates to 42 in August. This is a reduction of 4 when compared to July 2017.

The top 3 inpatient areas within the reporting periods where a low staffing fill rate has been reported along with an explanation for each is as follows:

Ward	Fill Rate Indicator	Comments
August 2017		
Talbot Direct Care	51.9% RN on Days 64.6% HCA on Days 75.3% HCA on Nights	The shortfall was in relation to the reduction in bed occupancy as a result of a patient being moved to Bankfields Court. Any unfilled shifts that were required were

		covered by community staff.
Ward 15	61.1% RN on Days 118.3% HCA on Days	The shortfall is due to vacancies and difficulties in recruiting to these. The ward has flexed staff where it was appropriate to do so.
Newtondale	61.9% RN on Nights	The ward are established for two registered nurses night and day, the night nurse is established as a 'floater' to work as necessary across the FMH clinical area as required. At times due to shortages and high acuity the second registered nurse on duty is moved across service to cover other areas during the day and/or night shift. At times the second registered nurse will be back-filled with a health care assistant to maintain staffing numbers.

It is also important to review the fill rates that exceed the budgeted establishment (shown in blue). In August there were 45 fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues. This is a reduction of 11 when compared to July.

The top 3 inpatient areas whereby a staffing fill rate indicator in excess of the budgeted establishment along with an explanation for each is as follows:

Ward	Fill Rate Indicator	Comments
August 2017		
Cedar Ward (PICU)	256.0% HCA on Days 190.1% HCA on Nights	The additional staffing was in relation to enhanced observations (2 x 2:1 and 1 x 1:1). Staffing increased in line with national standards for PICU that reflects the over established fill rates.
Bedale Ward	236.6% HCA on Days 75.4% RN on Days	Ward manager has worked RN shifts during the working week. Staffing increased in line with national standards for PICU that reflects the over established fill rates. Three new RN's due to start in September.
Holly	223.2% HCA on Nights 129.8% HCA on Days	Additional staffing required to support 2 patients at Holly. Staffing also being used to provide cover at Bankfields Court (for single occupancy package-Talbot).

3.2 **Bank Usage**

There are recognised risks in high use of bank and agency working although these are mitigated by the use of regular bank and agency staff who know the clinical areas.

There were no wards reporting 50% or above for bank usage in August. The highest user of bank in August related to Cedar Ward reporting at 44.6%. It should be noted that Cedar is sometimes used as the 'base ward' for bank staff over-booked to cover Westpark and therefore may not accurately reflect actual usage just on the ward. The reasons Cedar gave for requesting bank are as follows:

- Enhanced Observations (111 shifts)
- Establishment Vacancies (63 shifts)
- Escorts (10 shifts)
- Sickness (7 shifts)
- Annual Leave (2 shifts)

There are 11 wards reporting over 25% and above for bank usage in August are detailed below:

Cedar Ward (D&D)	44.6%
Northdale Centre	37.0%
Westerdale South	35.4%
Merlin	34.0%
Bransdale Ward	33.0%
Bedale Ward	32.4%
Clover/Ivy	29.9%
Birch Ward	29.2%
Aysgarth	28.5%
Fulmar Ward.	27.3%
Ward 15 Friarage	26.3%

Bank usage is shown in full within the appendices of this report alongside the staffing fill rate.

3.3 Agency Usage

When considering staffing levels it is also important to consider the amount of agency worked within the reporting period.

In August the agency usage equated to 1.77% a decrease of 0.23% when compared to July.

The highest user of agency within the reporting period related to Acomb Garth equating to approximately 25% of the total hours worked on this ward. This ward continues to have problems with recruitment of registered nursing staff and was running at reduced bed occupancy to mitigate some of the risks identified with this although is now utilising all beds.

Wards reporting agency usage in August are detailed below:

Acomb Garth	25%
Cedar Ward (NY)	20%
Rowan Ward	20%
Meadowfields	11%
Oak Rise	8%
Minster Ward	7%
Cherry Tree House	7%
Ebor Ward	5%
Springwood Community Unit	5%
Hamsterley Ward	3%
Northdale Centre	2%
Westerdale South	2%

It is positive to note that agency usage is low within the Trust. It is important to continue to monitor this on an ongoing basis due to the potential risks that high agency working has on individual clinical areas.

3.4 Quality Data Triangulation

The triangulation of the staffing data against a range of quality metrics has been undertaken for the month of August with the following reporting as an exception:

- There was 1 Serious Incident (SI) that occurred within inpatient areas during the month of August. This ward has not been cited in the safe staffing report to date.
- There were 0 level 4 incidents that occurred in August.
- There were 7 level 3 incidents (self-harm) that occurred in August with the following featuring in this report as follows:
  - Ebor (1 incident) – cited in this report for agency usage
  - Talbot Direct Care (1 incident) - cited in this report for having a low staffing fill rate
  - Clover/Ivy (2 incidents) - cited in this report for bank usage in excess of 25%
- There were 4 complaints raised in August with the following featuring in this report as follows:
  - Birch (1 incident) – cited in this report for bank usage in excess of 25%
  - Newtondale (1 incident) – cited in this report for having a low staffing fill rate
  - Cherry Tree (1 incident) – cited in this report for using agency during the reporting period
- There were 45 PALS related issues raised with the following featuring within this report as follows:
  - Birch (1 occurrence) – cited in this report for bank usage in excess of 25%
  - Ebor (1 occurrence) – cited in this report for agency usage
  - Minster (1 occurrence) – cited in this report for agency usage

- Clover/Ivy (2 occurrences) – cited in this report for bank usage in excess of 25%
- Northdale (3 occurrences) – cited in this report for bank and agency usage
- Newtondale (1 occurrence) – cited in this report for having a low staffing fill rate
- Oak Rise (2 occurrences) – cited in this report for having agency usage

A number of incidents requiring control and restraint occurred during August. The highest user was the Newberry Centre with a total of 122 incidents.

3.5 Missed Breaks

The working time directive guarantees the right for all workers to have a rest break during working hours if the worker is on duty for longer than 6 hours. Inadequate rest time taken during duty hours is linked to staff burn out, exhaustion and the risk that this may ultimately impact on patient care.

A thorough analysis of the HealthRoster system has identified that there were 578 shifts in August where unpaid breaks had not been taken. This is an increase of 20 when compared to July (558 shifts).

The majority of the shifts where breaks were not taken occurred on day shifts (382 shifts). The number of night shifts where breaks were not taken equated to 196 shifts in August.

The detailed information in relation to missed breaks has been shared with the localities for discussion and monitoring at their Performance Improvement Groups.

3.6 Incidents raised citing Staffing Levels

It is also important to look at the number of incidents that have been raised and categorised in relation to staffing levels. There were 16 incidents reported in August 2017 on Datix citing issues with staffing. All 16 related to Inpatient services.

In terms of triangulating this data with what has been reported within this report the following is of relevance:

- Newberry Centre raised 1 incident in relation to staffing levels. In addition the ward has been cited in this report in relation to having the highest number of incidents resulting in physical interventions.
- Clover and Ivy raised 2 incidents in relation to staffing levels. In addition the ward has been cited in this report in relation to bank usage, level 3 incident and a PALS related issue.
- Northdale raised 1 incident in relation to staffing levels. In addition the ward has been cited in this report in relation to bank and agency usage; and a PALS related issue.

- Cherry Tree raised 1 incident in relation to staffing levels. In addition the ward has been cited in this report in relation to agency usage and a complaint.
- Meadowfields raised 1 incident in relation to staffing levels. In addition the ward has been cited in this report in relation to agency usage.

3.7 Severity

Utilising the data contained within this report it is possible to assign a scoring system to highlight any potential areas of concern. The total score for each inpatient area is contained within Appendix 3 with a speciality view at Appendix 4. The higher the score the higher the number of episodes they have been cited in relation to the number of 'red' fill rate indicators, any over establishment, bank & agency usage and the quality metrics.

The severity rating has been compiled on a very basic model as follows:

A 'red' fill rate = 2 points given for each occurrence
A 'blue' fill rate = 1 point given for each occurrence
Missed breaks = where there was no improvement from the previous month = 1 point awarded
Any episode of agency worked = 1 point
Bank usage = amber score = 1 point and a red rated score equals 2 points
SUI = 1 point
Level 4 = 1 point
Level 3 = 1 point
Complaint = 1 point
Control and Restraint – 11 and 39 incidents requiring C&R = 1 point; 40+ incidents of C&R = 2 points.

The top 10 wards cited utilising the above scoring mechanism is identified below for the reporting period:

WARD	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	Level 4 Incidents	Level 3 Incidents	Complaints	Control & Restraint	TOTAL SCORE (Aug)
Clover/Ivy	2	2	1	0	2	0	0	2	0	1	**10**
Acomb Garth	4	1	0	1	0	0	0	0	0	2	**8**
Westwood Centre	2	2	1	0	1	0	0	0	0	2	**8**
Lustrum Vale	2	3	1	0	1	1	0	0	0	0	**8**
Westerdale South	2	2	1	1	2	0	0	0	0	0	**8**
Cherry Tree House	4	0	1	1	0	0	0	0	1	0	**7**
Elm Ward	2	0	1	0	1	0	0	2	0	1	**7**
Bankfields Court Flats	6	0	1	0	0	0	0	0	0	0	**7**
Talbot Direct Care	6	0	0	0	0	0	0	1	0	0	**7**
Meadowfields	4	0	0	1	1	0	0	0	0	0	**6**
Sandpiper Ward	2	1	0	0	1	0	0	0	0	2	**6**
Northdale Centre	2	1	0	1	2	0	0	0	0	0	**6**

Springwood Community Unit	2	1	0	1	1	0	0	0	0	1	**6**
Bransdale Ward	2	2	0	0	2	0	0	0	0	0	**6**
Cedar Ward	0	2	0	0	2	0	0	0	0	2	**6**
Maple Ward	4	0	1	0	1	0	0	0	0	0	**6**

3.8 **Other**

It has been reported that on the 5th August 2017 Harland Ward (night duty) were left without direct cover by a registered nurse (who had been moved to cover another ward). This incident was not raised via the Datix system but was highlighted following receipt of the monthly safe staffing dashboard presented to OMT as part of the performance VCB.

The Forensic directorate have the highest number (15 wards' in August) of 'red' fill rates for registered nurses on day shifts. In line with Transforming Care, there are plans to reconfigure a further ward which should ease staffing pressures going forward. Additionally, a number of newly qualified nurses are due to commence in September/October.

The safer staffing steering programme has been established to oversee a work plan to ensure the Trust has robust systems and processes in place to assure them that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards / clinical areas day or night, every day of the week as appropriate. This is being led by the Director of Nursing and programme metrics are being worked up.

Establishment reviews have now been undertaken across all in-patient areas using the Hurst tool and professional judgement interviews have concluded. An update and recommendations will be provided to EMT and the Board on conclusion of this work anticipated October 2017.

The proposal to establish a Duty Nurse Coordinator out of hours and at nights was supported at EMT and implementation is being progressed by localities. This will introduce a greater clinical oversight and level of support at these times and strengthen the ability to cover shifts at short notice.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

There are a number of areas that are not able to meet their planned staffing levels on a regular basis particularly with regard to registered nursing staff fill rates on days. This issue has been highlighted as a concern by the CQC in other Mental Health Trusts and may pose a risk as to our ratings in relation to the 'Safe' domain.

4.2 Financial/Value for Money:

It has been identified that there is little spare capacity in nursing establishments as they have been planned for maximum efficiency however it is demonstrated that wards are flexing their establishments with the use of

agency and bank to meet patient need which may not be the most efficient use of resources. Base line establishment reviews have been undertaken and flexible staffing is a key feature of the Safe Staffing work stream referred to above.

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

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

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

4.4 **Equality and Diversity:**

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

4.5 **Other implications:**

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

5. RISKS:

5.1 Safe staffing and the risks regarding the Trusts ability to meet planned staffing levels on a daily basis have been escalated to the Trust Risk Register. Risks will be managed and mitigated through operational services and the work being undertaken as highlighted within the safe staffing work streams.

6. CONCLUSIONS:

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

6.2 The comparative analysis of complaints and incidents, particularly focussing on the areas where staff fell below the planned levels has not shown any significant impact to date.

6.3 Maintaining planned staffing levels for each ward is always a key focus however August's data demonstrates high levels of patient acuity and complexity in a number of ward areas meaning they are having to staff to meet the needs of the patient group over and above their planned

establishments (250%+ for the highlighted wards). This, at the same time as many wards await the commencement of newly qualified staff who are filling the majority of RN vacancies has led to real staffing pressures. Feedback from Ward Managers and Matrons suggests a number of wards throughout August have addressed staffing needs through Ward Managers working out of hours (weekends and nights) and in the established numbers.

Work continues in localities to address shortfalls where planned establishments are not being met or high levels of registered nurse agency/bank are being used and to provide assurance on how this is being addressed.

7. RECOMMENDATIONS:

7.1 That the Board of Directors notes the exception report and the issues raised for further investigation and development.

Emma Haimes
Head of Quality Data and Patient Experience
September 2017

APPENDIX 1

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 31 DAYS IN August							
				DAY		NIGHT	
WARD	Locality	Speciality	Bed Numbers	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	81.2%	112.3%	100.0%	98.4%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	70.3%	106.2%	100.3%	98.7%
Bedale Ward	Teesside	Adults	10	75.4%	236.6%	103.2%	114.7%
Bilsdale Ward	Teesside	Adults	14	83.0%	124.8%	100.0%	96.7%
Birch Ward	Durham & Darlington	Adults	15	94.4%	106.1%	100.0%	145.0%
Bransdale Ward	Teesside	Adults	14	88.3%	152.0%	103.2%	133.9%
Cedar Ward	Durham & Darlington	Adults	10	110.3%	256.0%	100.0%	190.1%
Cedar Ward (NY)	North Yorkshire	Adults	18	96.3%	101.8%	108.0%	102.2%
Ebor Ward	York and Selby	Adults	12	91.9%	86.0%	97.1%	98.4%
Elm Ward	Durham & Darlington	Adults	20	85.3%	108.9%	96.8%	118.0%
Farnham Ward	Durham & Darlington	Adults	20	114.2%	98.2%	96.8%	100.0%
Kirkdale Ward	Teesside	Adults	16	78.7%	132.9%	103.2%	98.4%
Lincoln Ward	Teesside	Adults	20	101.6%	103.3%	103.5%	98.5%
Lustrum Vale	Teesside	Adults	20	80.0%	138.5%	126.7%	121.0%
Maple Ward	Durham & Darlington	Adults	20	69.7%	111.2%	80.0%	104.8%
Minster Ward	York and Selby	Adults	12	92.0%	100.5%	95.5%	104.6%
Overdale Ward	Teesside	Adults	18	89.2%	113.1%	100.0%	100.0%
Primrose Lodge	Durham & Darlington	Adults	15	70.2%	119.4%	100.0%	100.0%

Stockdale Ward	Teesside	Adults	18	82.9%	174.6%	105.9%	142.6%
The Orchards (NY)	North Yorkshire	Adults	10	85.0%	111.3%	95.2%	106.5%
Tunstall Ward	Durham & Darlington	Adults	20	118.4%	100.4%	100.0%	96.8%
Ward 15 Friarage	North Yorkshire	Adults	12	61.1%	118.3%	90.9%	103.2%
Willow Ward	Durham & Darlington	Adults	15	81.4%	127.6%	100.0%	100.1%
Baysdale	Teesside	CYPS	6	126.1%	82.3%	103.2%	98.2%
Holly Unit	Durham & Darlington	CYPS	4	93.4%	129.8%	100.9%	223.2%
Newberry Centre	Teesside	CYPS	14	89.1%	109.1%	109.6%	113.7%
Talbot Direct Care	Durham & Darlington	CYPS	1	51.9%	64.6%	90.1%	75.3%
The Evergreen Centre	Teesside	CYPS	16	92.2%	128.7%	101.1%	116.5%
Westwood Centre	Teesside	CYPS	12	104.2%	149.8%	85.0%	187.6%
Clover/Ivy	Forensics	Forensics LD	12	74.7%	125.6%	100.9%	176.2%
Eagle/Osprey	Forensics	Forensics LD	10	85.5%	86.5%	103.7%	96.8%
Harrier/Hawk	Forensics	Forensics LD	10	80.0%	99.7%	101.2%	123.4%
Kestrel/Kite.	Forensics	Forensics LD	16	89.8%	101.5%	100.3%	145.2%
Langley Ward	Forensics	Forensics LD	10	70.5%	123.2%	100.0%	99.9%
Northdale Centre	Forensics	Forensics LD	12	84.3%	125.4%	101.2%	93.7%
Oakwood	Forensics	Forensics LD	8	85.0%	196.6%	100.0%	100.0%
Thistle	Forensics	Forensics LD	5	61.5%	105.1%	100.0%	96.8%
Brambling Ward	Forensics	Forensics MH	13	89.1%	93.2%	98.1%	93.5%
Fulmar Ward.	Forensics	Forensics MH	12	93.1%	135.0%	100.8%	197.2%
Jay Ward	Forensics	Forensics MH	5	86.8%	84.5%	103.2%	95.2%
Lark	Forensics	Forensics MH	15	84.1%	89.9%	101.4%	92.0%
Linnet Ward	Forensics	Forensics MH	17	81.0%	117.5%	100.0%	115.4%
Mallard Ward	Forensics	Forensics MH	16	90.7%	114.1%	100.3%	177.9%
Mandarin	Forensics	Forensics MH	16	81.6%	152.4%	104.7%	147.9%
Merlin	Forensics	Forensics MH	10	110.1%	142.2%	93.2%	199.5%

Newtondale Ward	Forensics	Forensics MH	20	95.8%	94.4%	61.9%	113.3%
Nightingale Ward	Forensics	Forensics MH	16	85.9%	87.6%	100.6%	97.3%
Sandpiper Ward	Forensics	Forensics MH	8	90.8%	115.7%	72.3%	177.9%
Swift Ward	Forensics	Forensics MH	10	65.4%	95.7%	90.3%	98.4%
Aysgarth	Teesside	LD	6	101.8%	98.2%	100.2%	100.0%
Bankfields Court Flats	Teesside	LD	6	72.1%	89.3%	93.9%	87.9%
Bankfields Court Unit 2	Teesside	LD	5	99.0%	112.7%	100.0%	122.6%
Bankfields Court Unit 3	Teesside	LD	6	63.0%	101.9%	96.7%	100.2%
Bankfields Court Unit 4	Teesside	LD	6	81.1%	88.1%	101.9%	95.9%
Bek-Ramsey Ward	Durham & Darlington	LD	11	145.9%	115.4%	103.2%	94.6%
Oak Rise	York and Selby	LD	8	102.8%	83.9%	93.5%	127.6%
The Lodge	Teesside	LD	1	92.4%	75.3%	88.2%	93.9%
Acomb Garth	York and Selby	MHSOP	14	89.0%	86.9%	97.1%	217.8%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	90.8%	110.7%	100.0%	100.0%
Cherry Tree House	York and Selby	MHSOP	18	76.4%	64.4%	93.8%	96.0%
Hamsterley Ward	Durham & Darlington	MHSOP	15	99.9%	139.6%	110.7%	147.9%
Meadowfields	York and Selby	MHSOP	14	66.4%	82.1%	91.7%	107.5%
Oak Ward	Durham & Darlington	MHSOP	12	96.1%	101.6%	100.0%	101.6%
Roseberry Wards	Durham & Darlington	MHSOP	15	97.8%	104.1%	100.0%	100.0%
Rowan Lea	North Yorkshire	MHSOP	20	100.7%	108.5%	109.7%	94.7%
Rowan Ward	North Yorkshire	MHSOP	16	88.1%	147.4%	105.6%	119.4%
Springwood Community Unit	North Yorkshire	MHSOP	14	62.8%	119.9%	100.0%	129.5%
Ward 14	North Yorkshire	MHSOP	10	94.1%	102.7%	100.6%	105.1%
Westerdale North	Teesside	MHSOP	18	94.5%	116.4%	97.1%	101.9%
Westerdale South	Teesside	MHSOP	14	82.1%	207.4%	101.4%	195.5%
Wingfield Ward	Teesside	MHSOP	10	83.5%	99.3%	103.8%	93.8%

APPENDIX 2

Scored Fill Rate compared to Quality Indicators - August 2017				Agency Usage Vs Actual Hours			Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers	Total Actual Hours	Total Agency Hours	% Against actual Hours	Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI	Level 4	Level 3	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	2578.8		0%	2578.8	341.75	13.3%					1	7		9	9
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2551.5		0%	2551.5	341.5	13.4%				1	1	4		5	5
Bedale Ward	Teesside	Adults	10	3918.7		0%	3918.7	1271.48	32.4%						9		16	16
Bilsdale Ward	Teesside	Adults	14	2607.5		0%	2607.5	138	5.3%					1	2		4	4
Birch Ward	Durham & Darlington	Adults	15	3306.1		0%	3306.1	966.17	29.2%				1	1				
Bransdale Ward	Teesside	Adults	14	3188.3		0%	3188.3	1053.5	33.0%						6		9	9
Cedar Ward	Durham & Darlington	Adults	10	5143.7		0%	5143.7	2292	44.6%						65	6	135	141
Cedar Ward (NY)	North Yorkshire	Adults	18	3253.8	654.25	20%	3253.8	400	12.3%						6	1	8	9
Ebor Ward	York and Selby	Adults	12	2657.6	134.00	5%	2657.6	207	7.8%			1		1	1		2	2
Elm Ward	Durham & Darlington	Adults	20	3112.9		0%	3112.9	659.26	21.2%			2		1	23		30	30
Farnham Ward	Durham & Darlington	Adults	20	2834.5		0%	2834.5	228	8.0%					1				
Kirkdale Ward	Teesside	Adults	16	2996.3		0%	2996.3	393.75	13.1%						1		1	1
Lincoln Ward	Teesside	Adults	20	3149.5		0%	3149.5	466.5	14.8%						3		3	3
Lustrum Vale	Teesside	Adults	20	3149.1		0%	3149.1	754.75	24.0%	1				1	2		6	6
Maple Ward	Durham & Darlington	Adults	20	2526.2		0%	2526.2	446	17.7%						2		2	2
Minster Ward	York and Selby	Adults	12	2599.8	172.50	7%	2599.8	446	17.2%					1	6		7	7
Overdale Ward	Teesside	Adults	18	2603.5		0%	2603.5	368	14.1%					1				
Primrose Lodge	Durham & Darlington	Adults	15	2640.0		0%	2640.0	360	13.6%									
Stockdale Ward	Teesside	Adults	18	3138.3		0%	3138.3	784	25.0%					3	4		7	7

The Orchards (NY)	North Yorkshire	Adults	10	2297.1		0%	2297.1	24	1.0%			1		1				
Tunstall Ward	Durham & Darlington	Adults	20	2756.3		0%	2756.3	48	1.7%					3	1		1	1
Ward 15 Friarage	North Yorkshire	Adults	12	2314.8		0%	2314.8	609.75	26.3%						2		2	2
Willow Ward	Durham & Darlington	Adults	15	2761.2		0%	2761.2	141.66	5.1%									
Baysdale	Teesside	CYPS	6	2631.6		0%	2631.6	160.63	6.1%									
Holly Unit	Durham & Darlington	CYPS	4	918.6		0%	918.6	163.25	17.8%									
Newberry Centre	Teesside	CYPS	14	3741.5		0%	3741.5	393.11	10.5%					1	122		146	146
Talbot Direct Care	Durham & Darlington	CYPS	1	2091.4		0%	2091.4	0	0.0%			1			2		2	2
The Evergreen Centre	Teesside	CYPS	16	5216.1		0%	5216.1	478	9.2%					1	73		114	114
Westwood Centre	Teesside	CYPS	12	5135.8		0%	5135.8	971.75	18.9%						55	1	93	94
Clover/Ivy	Forensics	Forensics LD	12	4621.3		0%	4621.3	1383.5	29.9%			2		2	27		45	45
Eagle/Osprey	Forensics	Forensics LD	10	3092.2		0%	3092.2	324.25	10.5%					1				
Harrier/Hawk	Forensics	Forensics LD	10	3776.5		0%	3776.5	707	18.7%						3	1	4	5
Kestrel/Kite.	Forensics	Forensics LD	16	4292.9		0%	4292.9	689.25	16.1%						1	1	1	2
Langley Ward	Forensics	Forensics LD	10	2174.1		0%	2174.1	252.75	11.6%									
Northdale Centre	Forensics	Forensics LD	12	4994.2	123.75	2%	4994.2	1849.4	37.0%					3	2	1	4	5
Oakwood	Forensics	Forensics LD	8	2053.8		0%	2053.8	135	6.6%									
Thistle	Forensics	Forensics LD	5	2789.6		0%	2789.6	345	12.4%					1	2		2	2
Brambling Ward	Forensics	Forensics MH	13	2700.8		0%	2700.8	417	15.4%					3	20		22	22
Fulmar Ward.	Forensics	Forensics MH	12	4281.1		0%	4281.1	1167	27.3%									
Jay Ward	Forensics	Forensics MH	5	2607.8		0%	2607.8	168.75	6.5%									
Lark	Forensics	Forensics MH	15	2570.0		0%	2570.0	297	11.6%					1				
Linnet Ward	Forensics	Forensics MH	17	3045.8		0%	3045.8	513.5	16.9%					7	3		6	6
Mallard Ward	Forensics	Forensics MH	16	3856.0		0%	3856.0	816	21.2%						2		2	2
Mandarin	Forensics	Forensics MH	16	3647.8		0%	3647.8	906.5	24.9%					4	19		24	24
Merlin	Forensics	Forensics MH	10	4783.0		0%	4783.0	1626.5	34.0%						11		22	22
Newtondale Ward	Forensics	Forensics MH	20	3458.9		0%	3458.9	408	11.8%				1	1	1		1	1
Nightingale Ward	Forensics	Forensics MH	16	2635.8		0%	2635.8	250	9.5%					1	1		1	1

Sandpiper Ward	Forensics	Forensics MH	8	4382.8		0%	4382.8	1005.02	22.9%						80	4	203	207
Swift Ward	Forensics	Forensics MH	10	2792.3		0%	2792.3	323.75	11.6%						2		2	2
Aysgarth	Teesside	LD	6	2278.8		0%	2278.8	648.5	28.5%						1		1	1
Bankfields Court Flats	Teesside	LD	6	1880.7		0%	1880.7	187.49	10.0%									
Bankfields Court Unit 2	Teesside	LD	5	2574.5		0%	2574.5	531.82	20.7%									
Bankfields Court Unit 3	Teesside	LD	6	2319.4		0%	2319.4	144	6.2%						3		4	4
Bankfields Court Unit 4	Teesside	LD	6	2008.7		0%	2008.7	177.17	8.8%						9		15	15
Bek-Ramsey Ward	Durham & Darlington	LD	11	4273.7		0%	4273.7	359.33	8.4%						25	4	28	32
Oak Rise	York and Selby	LD	8	3977.1	330.00	8%	3977.1	250.9	6.3%					2	14		33	33
The Lodge	Teesside	LD	1	1637.4		0%	1637.4	100.66	6.1%						4		6	6
Acomb Garth	York and Selby	MHSOP	14	3950.5	1001.00	25%	3950.5	187	4.7%						84		86	86
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	3234.9		0%	3234.9	126.51	3.9%						7		8	8
Cherry Tree House	York and Selby	MHSOP	18	2751.0	202.00	7%	2751.0	96.5	3.5%				1		2		3	3
Hamsterley Ward	Durham & Darlington	MHSOP	15	3759.5	126.67	3%	3759.5	798.84	21.2%						13		15	15
Meadowfields	York and Selby	MHSOP	14	2949.5	322.00	11%	2949.5	553	18.7%						3		3	3
Oak Ward	Durham & Darlington	MHSOP	12	2878.8		0%	2878.8	36	1.3%									
Roseberry Wards	Durham & Darlington	MHSOP	15	2709.8		0%	2709.8	285.83	10.5%									
Rowan Lea	North Yorkshire	MHSOP	20	3625.9		0%	3625.9	464.44	12.8%						12		21	21
Rowan Ward	North Yorkshire	MHSOP	16	3009.5	593.00	20%	3009.5	310	10.3%						1		1	1
Springwood Community Unit	North Yorkshire	MHSOP	14	3008.0	161.25	5%	3008.0	505.57	16.8%						34		37	37
Ward 14	North Yorkshire	MHSOP	10	2595.5		0%	2595.5	83	3.2%						5		5	5
Westerdale North	Teesside	MHSOP	18	2670.8		0%	2670.8	225.25	8.4%						4		4	4
Westerdale South	Teesside	MHSOP	14	4521.7	89.02	2%	4521.7	1600.91	35.4%						3		4	4
Wingfield Ward	Teesside	MHSOP	10	2364.0		0%	2364.0	491.5	20.8%						1		2	2

Severity Scoring by Total Score

APPENDIX 3

WARD	Locality	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	Control & Restraint	TOTAL SCORE (Aug)
Clover/Ivy	Forensics	2	2	1	0	2	0	0	2	0	1	**10**
Acomb Garth	York and Selby	4	1	0	1	0	0	0	0	0	2	**8**
Westwood Centre	Teesside	2	2	1	0	1	0	0	0	0	2	**8**
Lustrum Vale	Teesside	2	3	1	0	1	1	0	0	0	0	**8**
Westerdale South	Teesside	2	2	1	1	2	0	0	0	0	0	**8**
Cherry Tree House	York and Selby	4	0	1	1	0	0	0	0	1	0	**7**
Elm Ward	Durham & Darlington	2	0	1	0	1	0	0	2	0	1	**7**
Bankfields Court Flats	Teesside	6	0	1	0	0	0	0	0	0	0	**7**
Talbot Direct Care	Durham & Darlington	6	0	0	0	0	0	0	1	0	0	**7**
Meadowfields	York and Selby	4	0	0	1	1	0	0	0	0	0	**6**
Sandpiper Ward	Forensics	2	1	0	0	1	0	0	0	0	2	**6**
Northdale Centre	Forensics	2	1	0	1	2	0	0	0	0	0	**6**
Springwood Community Unit	North Yorkshire	2	1	0	1	1	0	0	0	0	1	**6**
Bransdale Ward	Teesside	2	2	0	0	2	0	0	0	0	0	**6**
Cedar Ward	Durham & Darlington	0	2	0	0	2	0	0	0	0	2	**6**
Maple Ward	Durham & Darlington	4	0	1	0	1	0	0	0	0	0	**6**
Oak Rise	York and Selby	2	1	0	1	0	0	0	0	0	1	**5**
Stockdale Ward	Teesside	2	2	1	0	0	0	0	0	0	0	**5**
Kestrel/Kite.	Forensics	2	1	1	0	1	0	0	0	0	0	**5**
Hamsterley Ward	Durham & Darlington	0	2	0	1	1	0	0	0	0	1	**5**
Rowan Ward	North Yorkshire	2	1	1	1	0	0	0	0	0	0	**5**
Bedale Ward	Teesside	2	1	0	0	2	0	0	0	0	0	**5**
Eagle/Osprey	Forensics	4	0	1	0	0	0	0	0	0	0	**5**
Lark	Forensics	4	0	0	0	1	0	0	0	0	0	**5**
Merlin	Forensics	0	2	0	0	2	0	0	0	0	1	**5**
Mandarin	Forensics	2	2	0	0	0	0	0	0	0	1	**5**
The Lodge	Teesside	4	0	1	0	0	0	0	0	0	0	**5**
Ayckbourn Unit Esk Ward	North Yorkshire	2	0	1	0	1	0	0	0	1	0	**5**

Langley Ward	Forensics	2	1	1	0	1	0	0	0	0	0	**5**
Ebor Ward	York and Selby	2	0	1	1	0	0	0	1	0	0	**5**
Nightingale Ward	Forensics	4	0	1	0	0	0	0	0	0	0	**5**
Bankfields Court Unit 4	Teesside	4	0	1	0	0	0	0	0	0	0	**5**
Newberry Centre	Teesside	2	0	0	0	0	0	0	0	0	2	**4**
Newtondale Ward	Forensics	2	0	0	0	1	0	0	0	1	0	**4**
Birch Ward	Durham & Darlington	0	1	0	0	2	0	0	0	1	0	**4**
The Evergreen Centre	Teesside	0	1	1	0	0	0	0	0	0	2	**4**
Fulmar Ward.	Forensics	0	2	0	0	2	0	0	0	0	0	**4**
Bilsdale Ward	Teesside	2	1	1	0	0	0	0	0	0	0	**4**
Kirkdale Ward	Forensics	2	1	0	0	1	0	0	0	0	0	**4**
Harrier/Hawk	Forensics	2	1	0	0	1	0	0	0	0	0	**4**
Brambling Ward	Forensics	2	0	0	0	1	0	0	0	0	1	**4**
Ward 15 Friarage	North Yorkshire	2	0	0	0	2	0	0	0	0	0	**4**
Holly Unit	Durham & Darlington	0	2	1	0	1	0	0	0	0	0	**4**
Thistle	Forensics	2	0	1	0	1	0	0	0	0	0	**4**
Jay Ward	Forensics	4	0	0	0	0	0	0	0	0	0	**4**
Wingfield Ward	Teesside	2	0	1	0	1	0	0	0	0	0	**4**
Cedar Ward (NY)	North Yorkshire	0	0	1	1	1	0	0	0	0	0	**3**
Overdale Ward	Teesside	2	0	0	0	1	0	0	0	0	0	**3**
Primrose Lodge	Durham & Darlington	2	0	0	0	1	0	0	0	0	0	**3**
Mallard Ward	Forensics	0	1	1	0	1	0	0	0	0	0	**3**
Swift Ward	Forensics	2	0	0	0	1	0	0	0	0	0	**3**
Ayckbourn Unit Danby Ward	North Yorkshire	2	0	0	0	1	0	0	0	0	0	**3**
Minster Ward	York and Selby	0	0	1	1	1	0	0	0	0	0	**3**
Oakwood	Forensics	2	1	0	0	0	0	0	0	0	0	**3**
Aysgarth	Teesside	0	0	1	0	2	0	0	0	0	0	**3**
The Orchards (NY)	North Yorkshire	2	0	0	0	0	0	0	1	0	0	**3**
Linnet Ward	Forensics	2	0	0	0	1	0	0	0	0	0	**3**
Bankfields Court Unit 2	Teesside	0	1	1	0	1	0	0	0	0	0	**3**
Rowan Lea	North Yorkshire	0	0	1	0	1	0	0	0	0	1	**3**
Willow Ward	Durham & Darlington	2	1	0	0	0	0	0	0	0	0	**3**
Baysdale	Teesside	2	1	0	0	0	0	0	0	0	0	**3**
Bankfields Court Unit 3	Teesside	2	0	0	0	0	0	0	0	0	0	**2**
Bek-Ramsey Ward	Durham & Darlington	0	1	0	0	0	0	0	0	0	1	**2**

Lincoln Ward	Teesside	0	0	1	0	1	0	0	0	0	0	**2**
Westerdale North	Teesside	0	0	1	0	0	0	0	0	0	0	**1**
Ward 14	North Yorkshire	0	0	1	0	0	0	0	0	0	0	**1**
Tunstall Ward	Durham & Darlington	0	0	1	0	0	0	0	0	0	0	**1**
Ceddesfeld Ward	Durham & Darlington	0	0	1	0	0	0	0	0	0	0	**1**
Roseberry Wards	Durham & Darlington	0	0	1	0	0	0	0	0	0	0	**1**
Farnham Ward	Durham & Darlington	0	0	0	0	0	0	0	0	0	0	**0**
Oak Ward	Durham & Darlington	0	0	0	0	0	0	0	0	0	0	**0**

Severity Scoring by Speciality

APPENDIX 4

WARD	Locality	Speciality	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	Control & Restraint	TOTAL SCORE (Aug)
Lustrum Vale	Teesside	Adults	2	3	1	0	1	1	0	0	0	0	**8**
Elm Ward	Durham & Darlington	Adults	2	0	1	0	1	0	0	2	0	1	**7**
Bransdale Ward	Teesside	Adults	2	2	0	0	2	0	0	0	0	0	**6**
Cedar Ward	Durham & Darlington	Adults	0	2	0	0	2	0	0	0	0	2	**6**
Maple Ward	Durham & Darlington	Adults	4	0	1	0	1	0	0	0	0	0	**6**
Stockdale Ward	Teesside	Adults	2	2	1	0	0	0	0	0	0	0	**5**
Bedale Ward	Teesside	Adults	2	1	0	0	2	0	0	0	0	0	**5**
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	2	0	1	0	1	0	0	0	1	0	**5**
Ebor Ward	York and Selby	Adults	2	0	1	1	0	0	0	1	0	0	**5**
Birch Ward	Durham & Darlington	Adults	0	1	0	0	2	0	0	0	1	0	**4**
Bilsdale Ward	Teesside	Adults	2	1	1	0	0	0	0	0	0	0	**4**
Kirkdale Ward	Forensics	Adults	2	1	0	0	1	0	0	0	0	0	**4**
Ward 15 Friarage	North Yorkshire	Adults	2	0	0	0	2	0	0	0	0	0	**4**
Cedar Ward (NY)	North Yorkshire	Adults	0	0	1	1	1	0	0	0	0	0	**3**
Overdale Ward	Teesside	Adults	2	0	0	0	1	0	0	0	0	0	**3**
Primrose Lodge	Durham & Darlington	Adults	2	0	0	0	1	0	0	0	0	0	**3**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	2	0	0	0	1	0	0	0	0	0	**3**
Minster Ward	York and Selby	Adults	0	0	1	1	1	0	0	0	0	0	**3**
The Orchards (NY)	North Yorkshire	Adults	2	0	0	0	0	0	0	1	0	0	**3**
Willow Ward	Durham & Darlington	Adults	2	1	0	0	0	0	0	0	0	0	**3**
Lincoln Ward	Teesside	Adults	0	0	1	0	1	0	0	0	0	0	**2**
Tunstall Ward	Durham & Darlington	Adults	0	0	1	0	0	0	0	0	0	0	**1**
Farnham Ward	Durham & Darlington	Adults	0	0	0	0	0	0	0	0	0	0	**0**
Westwood Centre	Teesside	CYPS	2	2	1	0	1	0	0	0	0	2	**8**
Talbot Direct Care	Durham & Darlington	CYPS	6	0	0	0	0	0	0	1	0	0	**7**
Newberry Centre	Teesside	CYPS	2	0	0	0	0	0	0	0	0	2	**4**
The Evergreen Centre	Teesside	CYPS	0	1	1	0	0	0	0	0	0	2	**4**
Holly Unit	Durham & Darlington	CYPS	0	2	1	0	1	0	0	0	0	0	**4**

Baysdale	Teesside	CYPS	2	1	0	0	0	0	0	0	0	0	**3**
Clover/Ivy	Forensics	Forensics LD	2	2	1	0	2	0	0	2	0	1	**10**
Northdale Centre	Forensics	Forensics LD	2	1	0	1	2	0	0	0	0	0	**6**
Kestrel/Kite.	Forensics	Forensics LD	2	1	1	0	1	0	0	0	0	0	**5**
Eagle/Osprey	Forensics	Forensics LD	4	0	1	0	0	0	0	0	0	0	**5**
Langley Ward	Forensics	Forensics LD	2	1	1	0	1	0	0	0	0	0	**5**
Harrier/Hawk	Forensics	Forensics LD	2	1	0	0	1	0	0	0	0	0	**4**
Thistle	Forensics	Forensics LD	2	0	1	0	1	0	0	0	0	0	**4**
Oakwood	Forensics	Forensics LD	2	1	0	0	0	0	0	0	0	0	**3**
Sandpiper Ward	Forensics	Forensics MH	2	1	0	0	1	0	0	0	0	2	**6**
Lark	Forensics	Forensics MH	4	0	0	0	1	0	0	0	0	0	**5**
Merlin	Forensics	Forensics MH	0	2	0	0	2	0	0	0	0	1	**5**
Mandarin	Forensics	Forensics MH	2	2	0	0	0	0	0	0	0	1	**5**
Nightingale Ward	Forensics	Forensics MH	4	0	1	0	0	0	0	0	0	0	**5**
Newtondale Ward	Forensics	Forensics MH	2	0	0	0	1	0	0	0	1	0	**4**
Fulmar Ward.	Forensics	Forensics MH	0	2	0	0	2	0	0	0	0	0	**4**
Brambling Ward	Forensics	Forensics MH	2	0	0	0	1	0	0	0	0	1	**4**
Jay Ward	Forensics	Forensics MH	4	0	0	0	0	0	0	0	0	0	**4**
Mallard Ward	Forensics	Forensics MH	0	1	1	0	1	0	0	0	0	0	**3**
Swift Ward	Forensics	Forensics MH	2	0	0	0	1	0	0	0	0	0	**3**
Linnet Ward	Forensics	Forensics MH	2	0	0	0	1	0	0	0	0	0	**3**
Bankfields Court Flats	Teesside	LD	6	0	1	0	0	0	0	0	0	0	**7**
Oak Rise	York and Selby	LD	2	1	0	1	0	0	0	0	0	1	**5**
The Lodge	Teesside	LD	4	0	1	0	0	0	0	0	0	0	**5**
Bankfields Court Unit 4	Teesside	LD	4	0	1	0	0	0	0	0	0	0	**5**
Aysgarth	Teesside	LD	0	0	1	0	2	0	0	0	0	0	**3**
Bankfields Court Unit 2	Teesside	LD	0	1	1	0	1	0	0	0	0	0	**3**
Bankfields Court Unit 3	Teesside	LD	2	0	0	0	0	0	0	0	0	0	**2**
Bek-Ramsey Ward	Durham & Darlington	LD	0	1	0	0	0	0	0	0	0	1	**2**
Acomb Garth	York and Selby	MHSOP	4	1	0	1	0	0	0	0	0	2	**8**
Westerdale South	Teesside	MHSOP	2	2	1	1	2	0	0	0	0	0	**8**
Cherry Tree House	York and Selby	MHSOP	4	0	1	1	0	0	0	0	1	0	**7**
Meadowfields	York and Selby	MHSOP	4	0	0	1	1	0	0	0	0	0	**6**
Springwood Community Unit	North Yorkshire	MHSOP	2	1	0	1	1	0	0	0	0	1	**6**
Hamsterley Ward	Durham & Darlington	MHSOP	0	2	0	1	1	0	0	0	0	1	**5**

Rowan Ward	North Yorkshire	MHSOP	2	1	1	1	0	0	0	0	0	0	**5**
Wingfield Ward	Teesside	MHSOP	2	0	1	0	1	0	0	0	0	0	**4**
Rowan Lea	North Yorkshire	MHSOP	0	0	1	0	1	0	0	0	0	1	**3**
Westerdale North	Teesside	MHSOP	0	0	1	0	0	0	0	0	0	0	**1**
Ward 14	North Yorkshire	MHSOP	0	0	1	0	0	0	0	0	0	0	**1**
Ceddesfeld Ward	Durham & Darlington	MHSOP	0	0	1	0	0	0	0	0	0	0	**1**
Roseberry Wards	Durham & Darlington	MHSOP	0	0	1	0	0	0	0	0	0	0	**1**
Oak Ward	Durham & Darlington	MHSOP	0	0	0	0	0	0	0	0	0	0	**0**

ITEM NO. 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday 26th September 2017**
TITLE:	**Learning from Deaths Policy: The right thing to do**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Ratification**

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:

Following on from the investigation into deaths at Southern Health trust and in line with the CQC's recommendations into its review of how the NHS investigates patient deaths at the end of last year, in March 2017 the National Quality Board published the first edition of a new national framework for NHS Trusts - *'National Guidance on Learning from Deaths'*.

The framework requirements apply to all acute, mental health and community NHS Trusts and Foundation Trusts. The purpose of the framework was to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning.

Mortality governance is a priority for all Trust Boards and the Learning from Deaths Framework places a greater emphasis on the importance of Board Leadership to ensure that learning from patient deaths becomes embedded in the organisation.The guidance covers how Trusts should respond to deaths in care generally, not just those amounting to 'serious incidents', which will continue to be dealt with under the existing *'Serious Incident Framework'*.

A key focus of the guidance is to improve governance processes around patient deaths, including new board leadership roles, and introducing a new system of 'case record reviews'. It sets out the requirements of trusts to produce quarterly reports including specific information about deaths in care to the public board in the form of a dashboard (commencing in October 2017). It also outlines the requirement for trusts to develop a Learning from Deaths Policy by September 2017, detailing how they will implement the guidance and ensure that families/carers of patients who have died in care are properly involved at every stage as equal partners.

The attached draft Learning from Deaths policy has been widely consulted on and developed in collaboration with 8 other Northern Mental Health trusts, it sets out how the organisation will respond to and learn from patient deaths.

Recommendations:

That the Board of Directors is asked to ratify the Learning from Deaths Policy.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 26th September 2017**
TITLE:	**Learning from Deaths Policy: The right thing to do**

1. INTRODUCTION & PURPOSE:

1.1 Mortality governance is a priority for all Trust Boards and the Learning from Deaths Framework places a greater emphasis on the importance of Board Leadership to ensure that learning from patient deaths becomes embedded in the organisation.

1.2 This paper details the requirement to publish a Learning from Deaths Policy setting out how the organisation will respond to and learn from patient deaths by September 2017 and seeks approval of the attached policy which outlines our approach.

1.3 The draft policy has been developed in line with a cohort of Northern Mental Health Trusts in order to provide greater clarity, consistency and adopt a collaborative approach to learning from deaths across mental health and community settings.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Following on from the investigation into deaths at Southern Health Trust and in line with the CQC's recommendations into its review of how the NHS investigates patient deaths at the end of last year, in March 2017 the National Quality Board published the first edition of a new national framework for NHS Trusts - *'National Guidance on Learning from Deaths'*.

The framework requirements apply to all acute, mental health and community NHS Trusts and Foundation Trusts. The purpose of the framework was to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning.

The NQB guidance covered how Trusts should respond to deaths in care generally, not just those amounting to 'serious incidents', which will continue to be dealt with under the existing *'Serious Incident Framework'*.

While a focus on process is important, everything that is done should place emphasis on the outcomes of learning from deaths and supporting families and carers.

The core objectives of this policy are:

- To prioritise and enable consistently effective, meaningful engagement and compassionate support between families, carers and staff that is open and transparent to allow them to raise questions about the care provided to their loved one.

- To help to identify what can be improved to ultimately reduce the inequality in the life expectancy of people with a serious mental illness/learning disability.

- To standardise approaches to reviewing deaths across the northern cohort of mental health trusts in order to share information and key learning.

- To enhance learning at a personal, team and organisational level.

- To ensure the Trust engages with other stakeholders (Acute Trusts. Primary care, public health, Safeguarding, Health and Wellbeing Boards etc.) to work collaboratively, sharing relevant information and expertise to maximize learning from deaths.

- To support the evaluation of the Trust's approach to learning from deaths in line with the northern cohort of mental health trusts agreed principles.

3. KEY ISSUES:

3.1 It is worth emphasising that the NQB Learning from deaths guidance is described as a 'first edition' and it is envisaged that it will evolve and be revised over time as organisations learn what works best. National guidance for bereaved families is understood to be in the pipe-line. It is important therefore that the trust policy is also reviewed in-line with any policy or practice changes. NHS Improvement is fully aware that many organisations, particularly mental health and community care providers, have less clarity on methodologies and scope for the new requirements of learning from deaths. Therefore it does not expect providers to have developed perfect processes by autumn 2017 and acknowledges that further support will need to be provided over the course of the next 12 months.

The Trust will therefore review the policy to ensure it continues to reflect best practice in April 2018.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
Under its revised inspection regime, the CQC will strengthen its assessment of how providers learn from deaths - e.g. via proposed new 'well-led' assessment questions specifically related to this.

4.2 **Financial/Value for Money:**
The enhanced arrangements set out in the attached policy do have an impact on corporate and clinical staff resources. Whilst this has not required any additional investment at this stage, it will be important to keep activity and outcomes related to the trusts mortality review processes under review.

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

4.4 **Equality and Diversity:**
The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20

years earlier than other people therefore it is important that we widen the scope of deaths which are reviewed in order to maximize learning and narrow the inequality gap.

5. RISKS:

Failure to implement the principles and processes of the policy could lead to a lack of confidence and distress from bereaved relatives and the public. There is also a risk that we fail to learn lessons from the identification of avoidable harm arising from mortality processes and non-compliance with CQC fundamental standards.

6. CONCLUSIONS:

This policy sets out the Trusts expectations / principles on how it responds to deaths in our care based on national guidance and direction and identifies the scope of review for each death and how the Trust will learn from them.

7. RECOMMENDATIONS:

That the Board of Directors ratifies the Learning from Deaths Policy.

Elizabeth Moody
Director of Nursing & Governance

Background Papers:

NQB Learning from deaths

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Learning from Deaths Policy:

The right thing to do

Ref: CORP

Status: Draft

Document type: Policy

Contents

1 Introduction

After the events of Mid Staffordshire the then Prime minister asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review 14 hospital trusts national mortality records. The investigation looked broadly at the quality of care and treatment provided within these organisations and noted that the focus on combined mortality rates was distracting Boards from the practical steps that could be taken to reduce avoidable deaths in NHS hospitals.

These findings were reinforced in the recent Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England 2016. It showed that in some organisations learning from deaths was not being given sufficient priority and that valuable opportunities for improvements were being missed. Importantly the CQC also point out that there is much more we can do to engage families and carers and recognise their insights and experiences are vital to our learning.

The National Quality Board (NQB) guidance on Learning from Deaths (2017) is the starting point to initiate a standardised approach across the NHS to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning. These reviews will provide the Trust with valuable information in deciding how avoidable the death may have been and how Executive Teams and Boards can use these findings.

The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people therefore it is important that organisations widen the scope of deaths which are reviewed in order to maximize learning.

We will make it a priority to work 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).

The Trust fully supports the approach it has developed with other mental health trusts in the north of England as part of our collaborative approach to learning from deaths. The trusts participating are:

- Bradford District Care NHS Foundation Trust
- Cumbria Partnership NHS Foundation Trust
- Humber NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust

- Rotherham Doncaster and South Humber NHS Foundation Trust
- Sheffield Health & Social Care NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Tees, Esk and Wear Valley NHS Foundation Trust

Working collaboratively will enable shared learning and good practice, valid comparisons across organisations and shared capacity.

This policy sets out the principles that guide our work and how we will implement them.

NHS Improvement is fully aware that many organisations, particularly mental health and community care providers, have less clarity on methodologies and scope for the new requirements of learning from deaths. Therefore it does not expect providers to have developed perfect processes by autumn 2017 and acknowledges that further support will need to be provided over the course of the next 12 months.

The Trust will therefore review the policy to ensure it continues to reflect best practice in April 2018.

This policy should be read in conjunction with the *Incident reporting and serious incident review policy (CORP-0043).*

2 Why we need this policy / context

Working with families/carers of patients who have died offers an invaluable source of insight to improve services. Therefore there is a need to ensure appropriate support is provided at all stages of the review process and an understanding that treating bereaved families/carers as equal partners in this process is vital. In line with the NQB guidance on Learning from Deaths, every Trust must have a policy in place that sets out how it identifies, reports, investigates and learns from a patient's death. This should include the care leading up to the patient's death and considering if this could have been improved.

This policy informs the organisation of staffs' roles and responsibilities relating to learning from deaths and promotes a culture of learning lessons.

Learning from a review about the care provided to patients who die in our care is integral to the Trust's governance and quality improvement work.

2.1 Purpose

The purpose of this policy is to set out the Trusts expectation / principles on how it responds to deaths in our care and identifies the scope of review for each death and how the trust will learn from them.

This policy sets out how staff can support the involvement of families and carers when a death has occurred and how to engage with them to ensure there are easy opportunities to discuss or ask questions about the care received by their loved one to their preferred timescale.

2.2 Objectives

While a focus on process is important, everything that is done should place emphasis on the outcomes of learning from deaths and supporting families and carers.

The core objectives of this policy are:

- To prioritise and enable consistently effective, meaningful engagement and compassionate support between families, carers and staff that is open and transparent to allow them to raise questions about the care provided to their loved one.

- To help to identify what can be improved to ultimately reduce the inequality in the life expectancy of people with a serious mental illness/learning disability.

- To standardise approaches to reviewing deaths across the northern cohort of mental health trusts in order to share information and key learning.

- To enhance learning at a personal, team and organisational level.

- To ensure the Trust engages with other stakeholders (Acute Trusts. Primary care, public health, Safeguarding, Health and Wellbeing Boards etc.) to work collaboratively, sharing relevant information and expertise to maximize learning from deaths

- To support the evaluation of the Trust's approach to learning from deaths in line with the northern cohort of mental health trusts agreed principles.

3 Scope

3.1 Who this policy applies to

This policy applies to all Trust staff with a responsibility for patient care as set out below:

The National Quality Board Guidance on Learning from Patients Deaths applies to all acute, mental health/learning disability and community NHS Foundation Trusts.

3.2 Roles and responsibilities

Mortality governance is a priority for all Trust Boards and the Learning from Deaths Framework places a greater emphasis on the importance of Board Leadership to ensure that learning from patient deaths becomes embedded in the organisation.

Role	Responsibility
Chief Executive, Executive Trust Board Directors and Non-Executive Directors	Trust Boards are accountable for ensuring compliance with the 2017 NQB guidance on Learning from Deaths and working towards achieving the highest standards in mortality governance. They must ensure quality improvement remains key by championing and supporting learning that leads to meaningful and effective actions that continually improve patient safety and experience and supports cultural change. They can do this by demonstrating their commitment to the work e.g. spending time developing Board thinking; ensuring a corporate understanding of the key issues around the deaths of service users and by ensuring that sufficient priority and resource is available for the work. The Director of Nursing and Governance has been identified as the Board level 'Patient Safety Director' with responsibility for learning from deaths. Additionally a named Non-Executive Director has taken lead responsibility for oversight of progress to act as a critical friend holding the organisation to account for its approach in learning from deaths. The Board will ensure: • That robust systems are in place for reporting, reviewing and investigating deaths • That bereaved families are engaged and supported • That there is evident learning from deaths both internally and with our external partners and quality improvement is championed

	• That processes focus on learning, can withstand external scrutiny, by providing challenge and support and assurance of published information
Clinical Directors, Medical Staff, Heads of Service, Heads of Nursing Locality Managers, Modern Matrons, Ward and Team Managers and all Registered Nurses Allied Healthcare Professionals	Staff should familiarize themselves with this policy and understand the process for learning from deaths. Identify the key changes required to implement this policy and ensure all appropriate action is taken; In conjunction with the Patient Safety Team, to support staff to review and investigate deaths ensuring they have the time to carry this process out in skilled way to a high standard, and as part of that to: • Ensure staff have the right level of skill through training and experience; • To promote learning from deaths; • That sufficient time is assigned in local governance forums to outline and plan for any lessons learned; • To ensure that learning is acted on
The Patient Safety Team	This corporate Trust department has a responsibility to ensure: • New data is collected and published to monitor trends in deaths (April 2017 onwards) with Board level oversight of this process • Ensuring the Datix incident reporting system is used to its full potential to record deaths (expected and unexpected) in accordance with Trust policy. • Processing information consistently and precisely and in a meaningful way to fulfill governance processes required to ensure high standards in mortality governance are maintained

The Trust requires all staff to be open, honest and transparent about reporting deaths and for engaging with families and carers, actively enabling them to ask questions about care and identify if care can be improved.

4 Policy

4.1 Encouraging a learning from deaths culture

By educating our staff and encouraging a more open culture of listening to the views and opinions of families and carers, staff will become more confident in identifying what can be done differently and improving patient experience in the future.

4.2 Family engagement:

Dealing respectfully, sensitively and compassionately with families and carers when someone has died is crucially important. At times families may have questions, and/or concerns they would like answers to in relation to the care and treatment their loved one received but don't always want to make a complaint.

If you are reading this as a family member of someone who has recently died, and has received care from our Trust and you have anything you would like to discuss, you can contact the Patient Safety Team at Tees, Esk and Wear Valleys NHSFT on 0191 3336522.

Where clinicians have had close contact with a service user and their family/carer, they will often be the first to offer condolences and support and to give appropriate information to those involved regarding the opportunity to be involved in the review of the care.

There are however some circumstances where the Trust may find out about the death of a service user after some delay. In these circumstances a discussion should take place between the Patient Safety team and the clinical team involved to determine the best approach. We have begun a dialogue with families about how they would wish to be involved in reviews of a family member's death or in an investigation. This work will inform the Trusts practice in the future as will anticipated national guidance*.

It is understood that dealing with the death of a loved one is a sensitive matter for families, carers and staff and that all situations are different. Staff may need to offer the opportunity for on-going involvement in-keeping with the family's needs and wishes.

The trusts approach should be to treat the family/carer as an equal in the review process from the beginning taking their views and opinions into account at each stage.

Families can choose how they wish to be involved, this may include:

- agreeing the level of the review / investigation (see 4.5);
- contributing to the terms of reference for serious incident reviews;
- providing evidence / contributions to the review or investigation e.g. providing a pen portrait of the person, time-line of events
- Commenting on a draft report.

Families/carers should also be given the option of seeing final reports to ensure they are comfortable with any findings. Ideally this should be undertaken in a face to face meeting with a staff member talking the family member/carer through the report.

To support families, we will provide a range of information for relatives that explain these processes and what they can expect. This is available at appendix 4.

If the family member/carer decides they do not want to be involved in the review process staff should make it clear they can contact us at any time should their decision change and that any relevant information can still be shared. If the family does not want contact at all about the process or findings, this should be honoured and staff should record their wishes.

Staff should be prepared for the types of questions that families may have such as:

- Why is there an investigation?
- Can I access the records for my relative?
- Can I speak to the staff who were caring for my relative?

One way to ensure that answers are provided to the questions that families/carers have is to ask them, at an early stage, what they want to know and to involve them in writing the terms of reference of any review or investigation. Further information and support can be accessed by the Patient Safety Team.

*Note: The NQB guidance states that a "further development" in 2017 /18 will be: the development of "*guidance for bereaved families and carers. This will support standards already set for local services within the Duty of Candour and the Serious Incident Framework and cover how families should be engaged in investigations*". The Trust will review this policy in this context and as part of the policies evaluation.

4.3 Identifying and Reporting Deaths

The Trust has systems that identify and capture the known deaths of its service users on its electronic patient administration system (PAS) and where appropriate on its risk management systems. This is to help ensure that the Trust Board has a comprehensive picture of the deaths of all its services users and the opportunities to learn from them.

Trust staff must report all deaths that they are made aware of on Datix or by email (MHSOP services only due to volume) to the Patient Safety team within 24 hours of being informed and provide the cause of death where known. Once the Datix is completed staff must immediately attempt to engage with the family and or carers unless otherwise instructed. In the first instance this would take the form of a condolence letter with contact numbers for contacting the service.

This applies to all deaths of patients open to TEWV services.

All deaths that staff are made aware of must be reported through the Datix system to start the process of learning from patient deaths.

All Datix reports for deaths are reviewed by the Patient Safety Team on a daily basis and any unnatural unexpected deaths are taken forward through the Serious Incident process. A

summary of all other reported deaths are taken to the Patient Safety Group (which is a multi-disciplinary forum) where each death is reviewed using the Mortality Review coding methodology (Appendix 1) to establish the category of death and the level of review required.

4.4 The decision to investigate or review

The Trust collects data on all known deaths and has a process in place to determine the scope of deaths which require further review or investigation. The information below sets out these processes in addition to the existing NHS England Serious Incident Framework (2015) which remain and are set out in the Trusts incident reporting and serious incident policy.

For all deaths of people with a Learning Disability the Trust supports the approach of the LeDer program and these incidents will be reported accordingly to LeDer by the Patient Safety Team.

The National Quality Board guidance on Learning from Deaths provides the context to the review or investigation of deaths and establishes a number of “must dos” in terms of deaths to be investigated. These include:

i	all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;
ii	all in-patient, out-patient and community patient deaths of those with learning disabilities
iii	all deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means
iv	all deaths in areas or related to interventions where people are not expected to die, for example ECT, rapid tranquilisation
v	deaths where learning will inform the provider’s existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically;
vi	a further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.

The NQB guidance requires that all inpatient, outpatient and community patient deaths of people with severe mental illness (SMI) should be subject to case record review.

In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder. It is acknowledged that there is substantive criticism of this definition; personality disorders can be just as severe and disabling, as can severe forms of eating disorders, obsessive compulsive disorder, anxiety disorders and substance misuse problems.

Further national guidance is expected to clarify expectations about mortality review in mental health and community services in the future however in the meantime, trusts have been asked to use the above description of SMI.

Where Trusts such as ours provide a wide range of clinical services across inpatient, community and other provider organisations this can lead to both a degree of confusion as to who is responsible for the reporting and investigating of a patient's death and the risk of double reporting and investigation.

It is recognised that people with mental health problems often access a range of health services and may be in receipt of care by multiple agencies at the time of their death. In order to support consistency in determining the scope of deaths for further review by the Trust as the main provider of care or to participate in the review with another provider, the cohort of Northern Mental Health Trusts has agreed the following approach to provide further guidance and clarity to the definition in the NQB guidance:

To support staff in their decision making regarding the investigation of deaths, staff should refer to the following guidelines. However if there is any doubt staff should contact their line manager or the Patient Safety department for advice.

A We are the main provider if at the time of death the patient was subject to:

- An episode of inpatient care within our service.
- An episode of community treatment due to identified mental health needs managed under CPA.
- An episode of community treatment due to identified learning disability or substance misuse needs
- A Community Treatment Order.
- A conditional discharge.
- An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
- Guardianship

B Patients who meet the above criteria but are inpatients within another health care provider or custodial establishment at the time of their death.

In these circumstances the death will be reported by the organisation under whose direct care the patient was at the time of their death. That organisation will also exercise the responsibilities under duty of candour. However there will be a discussion to agree on if it is to be a joint or single agency investigation (this will be determined by the cause of death) and in the case of joint investigations who the lead organisation will be.

C Services provided by the Trust where we are not classed as the main provider.

For the following services the Trust may only be providing a small component of an overarching package of care and the lead provider is the patients GP.

- Tissue viability
- Dietetics
- Drug and alcohol shared care services
- Care home liaison (where not on CPA)
- Acute hospital liaison
- Community physiotherapy

D Exception.

In addition to the above, if any act or omission on the part of a member of Trust staff where we are not classed as the main provider is felt to have in any way contributed to the death of a patient, an investigation will be undertaken by the Trust.

Where problems are identified relating to other NHS Trusts or organisations the Trust should make every effort to inform the relevant organisation so they can undertake any necessary investigation or improvement. A culture of compassionate curiosity should be adopted and the following questions should be asked:

- Which deaths can we review together?
- What could we have done better between us?
- Did we look at the care from a family and carers perspective?
- How can we demonstrate that we have learnt and improved care, systems and processes?

In addition to the above, the Northern Mental Health trusts have identified a number of potential triggers for a Review / Investigation. These include deaths:

Where medication with known risks such as Clozapine was a significant part of the treatment regime;
From causes or in clinical areas where concerns had already been flagged – (possibly at Trust Board level or via complaints or from data);
Where the service user had no active family or friends and so were particularly isolated e.g. with no one independent to raise concerns;
where there had been known delays to treatment e.g. assessment had taken place or a GP referral made but care and treatment not provided, or where there was a gap or wait in services;
Also
Particular causes of death e.g. epilepsy;
Deaths in Distress which might include: drug and alcohol deaths, or deaths of people with an historic sex offence e.g. people who might not be in crisis but need support and from whose experience there may be learning from a thematic review;
Where a proactive initial assessment of a death has potentially identified that there was a deterioration in the physical health of a service user which wasn't responded to in a timely manner;
Random sampling

4.5 The types of review

Practice varies across Trusts with regard to how deaths are reported and categorised. The Northern cohort of Mental Health trusts however have identified the following processes to be in place:

- an initial screen of each death e.g. at a weekly Mortality Review Group or at a Huddle which will always necessitate the collection of core date around the service user and his or her death and sometimes the use of a structured tool;
- a way of making a judgement about which deaths are subject to further review which might be explicit and transparent against a set of criteria or sometimes more reliant on individual and clinical judgement;
- A way of deciding the level of further review however this is described e.g. a local review, clinical review. In this, practice and evidence around the use of structured judgement review (SJR) is still emergent within mental health services.

Local review

The trusts patient Safety Group undertakes the function of a Mortality Review Group. This group receives a summary of all known deaths of patients who:

- Were an in-patient at time of their death
- Had a Learning Disability
- Were on CPA at time of their death

To support the review process, a summary will be provided which will include a brief synopsis of the persons care and treatment including a medication history and any known physical health issues. Each of these deaths will be subject to a multi-disciplinary review and, if it is decided that there is cause for a higher level of scrutiny they will then be put forward for an SJR (see next section). This will be undertaken by a clinical professional in conjunction with the team responsible for the care and treatment of the deceased. The completed SJR will be brought back to the following Patient Safety Group for discussion and any learning points captured and shared as appropriate.

This process is in place for deaths which are ***not*** categorised as Serious Incidents.

Case Note Reviews / Structured judgment Reviews:

A Structured Judgment Review (SJR) blends traditional a clinical judgement based review with a standard format that enables reviewers to make safety and quality judgements over phases of care and which provides explicit written comments and a score for each phase. A SJR provides a relatively short but rich set of information about each case in a format that can be aggregated to provide knowledge about clinical services and systems of care

When the family/carers wish to be involved, their preference regarding how, when and where they want to engage will be paramount and built on the principles of compassionate engagement.

4.6 Governance process / ensuring Learning

The prime objective of a Learning from Death Policy is that we can improve services and the experience of those services of the people that use them.

We are working with eight other mental health trusts to develop a consistent framework around learning. This will focus on whether the activity we do under the guidance of this policy (i.e. talking to the families of those who died, the investigations, thematic reviews, the analysis of data, the review of case notes including SJR) makes a difference.

How we measure the impact of the work will develop over time as the information we access improves, as we evaluate the policy overall including feedback from families and as the national guidance emerges.

We will all assess learning against a common framework that:

1. Identifies potential improvements;
2. Develops a shared understanding of what these improvements might be across the trust;
3. Leads to a series of actions locally, that should be able to be measured;
4. Provides knowledge of the difference made by those actions.

We will take the opportunity to share learning with our partner trusts and other, local stakeholders. For example, there may be common issues we could commission thematic reviews of.

The actual practice in each trust will differ for a variety of reasons: different cultures, priorities and ways of doing things. This co-existence of cohesion and diversity will be a strength as we will have the opportunity (through our continued regional work) to share and learn from each other's approaches and see which ones work best.

The Trust will ensure that lessons learnt result in change in organisational culture and practice by; identifying themes and trends in formal meetings and in the Quality Account; commissioning thematic reviews on a regular basis by the Patient Safety Committee or Quality Assurance Committee and ensuring that associated action plans are implemented.

We will ensure learning is cascaded to frontline clinical staff on a regular basis by use of Patient Safety Bulletins, Learning Lessons information and Incidental Findings thematic summaries.

The structured case review identifying any lessons to be learned will be presented to the Patient Safety Group as a standard agenda item to be reviewed and approved. Any actions required would be agreed and monitored in the first instance through the Patient Safety Group and cascaded through the operational management structure as appropriate. This could take the form of a formal request for a review of a particular theme or topic or more general learning in the Patient Safety bulletin.

4.7 Data reporting

From Quarter 3 trusts are required to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public Board meetings.

The Northern Mental Health Trusts have agreed a common dashboard and will continue to develop this over the next 6 months.

5 Definitions

Term	Definition
Case record review	Reviewing case records/notes to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened. The Royal College of Physicians Structured Judgement Review methodology provides an agreed template for this.
Death due to a problem in care	A death that has been clinically assessed using a recognized methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.
Investigation	The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies and procedures, guidance, good practice and observation – in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred.
Other definitions to be provided locally	

Related documents

This Policy document is to be read in conjunction with:
Incident Reporting and Serious Incident Policy (CORP- 43)
Duty of Candour Policy (CORP- 64)

6 How this policy will be implemented

• This policy will be ratified by the Executive Management Team and published on the Trust's intranet and external website.
• Line managers will disseminate this policy to all Trust employees through a line management briefing.
• As further national guidance emerges over the next 12 months, including family engagement, the Trust will review the policy and its implementation to ensure it continues to reflect best practice.

7 How this policy will be audited/evaluated

The policy and processes and procedures will be audited by the clinical audit team, initially following 6 months of implementation and then annually. The results of which will be considered at the Clinical Effectiveness Group and Quality Assurance Committee.

The audit tool will be designed to capture both qualitative and quantitative data to demonstrate the lessons learned and how they have been shared and used to improve the quality of services.

8 References

National Quality Board: *National Guidance on Learning from Deaths 2017*

NHS Improvement: *Implementing the Learning from Deaths framework – key requirements for trust boards 2017*

NHSE Serious Incident Framework 2015: *Supporting learning to prevent recurrence*

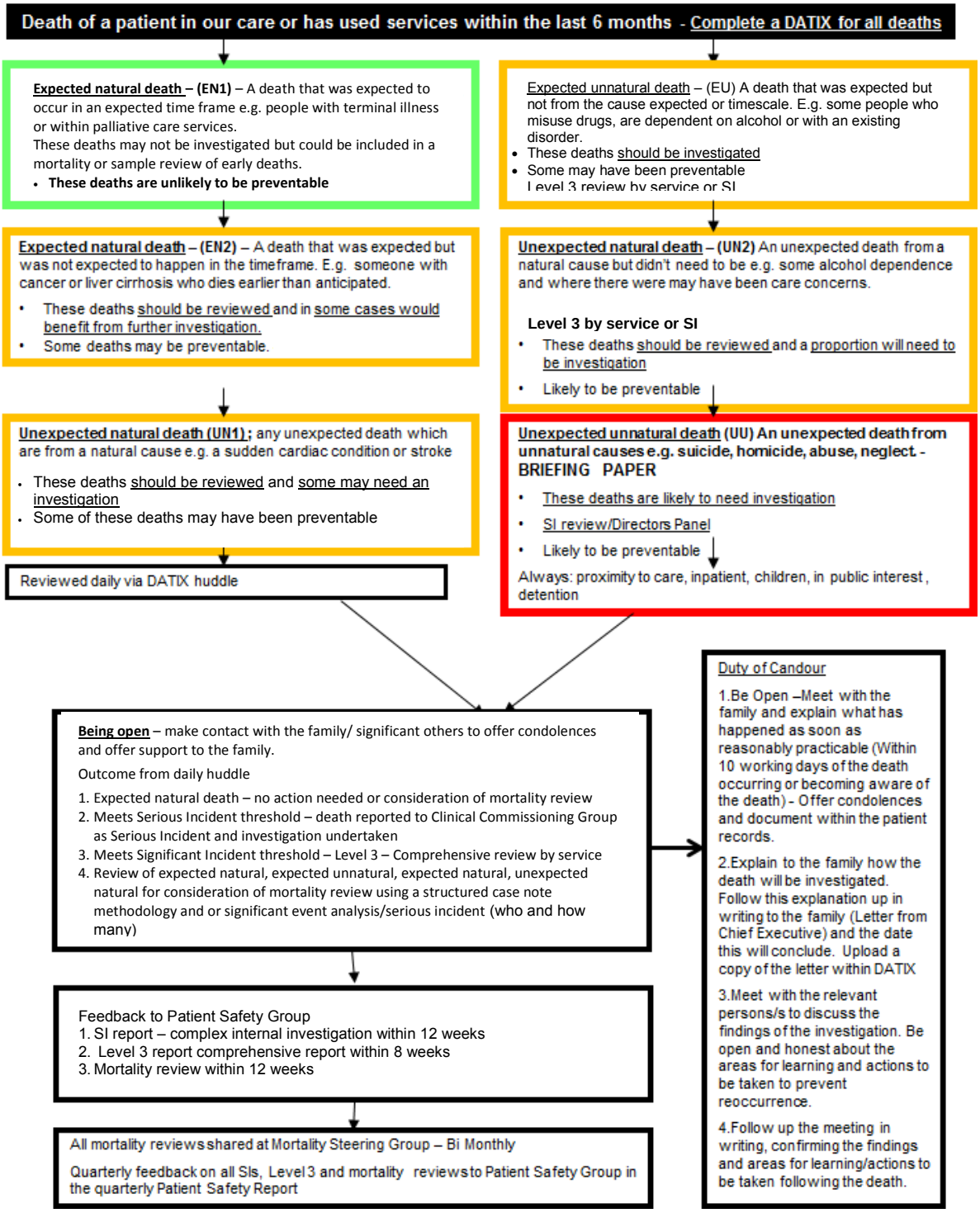
CQC Regulation 20: Duty of Candour 2014

http://www.gmc-uk.org/DoC_guidance_englsih.pdf_61618688.pdf

9. Appendices

Appendix 1

Mortality Review within TEWV NHS Foundation Trust



Appendix 2

Structured Judgement Review Tool

Phase of Care:

We are interested in comments about the quality of care the patient received and whether it was in accordance with current good practice (e.g. Your professional standards or our professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please comment on the care received by the patent during this phase of care, including anything particular you have identified.

Please rate the care received by the patient during this phase Very Poor 1 2 3 4 5 Excellent Please circle only one score

Avoidability of death judgement score:

We are interested in your view on the avoidability of death in this case. Please choose from the following scale:

Score 1. Definitely avoidable

Score 2. Strong evidence of avoidability

Score 3. Probably avoidable, more than 50-50 but close call

Score 4. Probably avoidable, less than 50-50 but close call

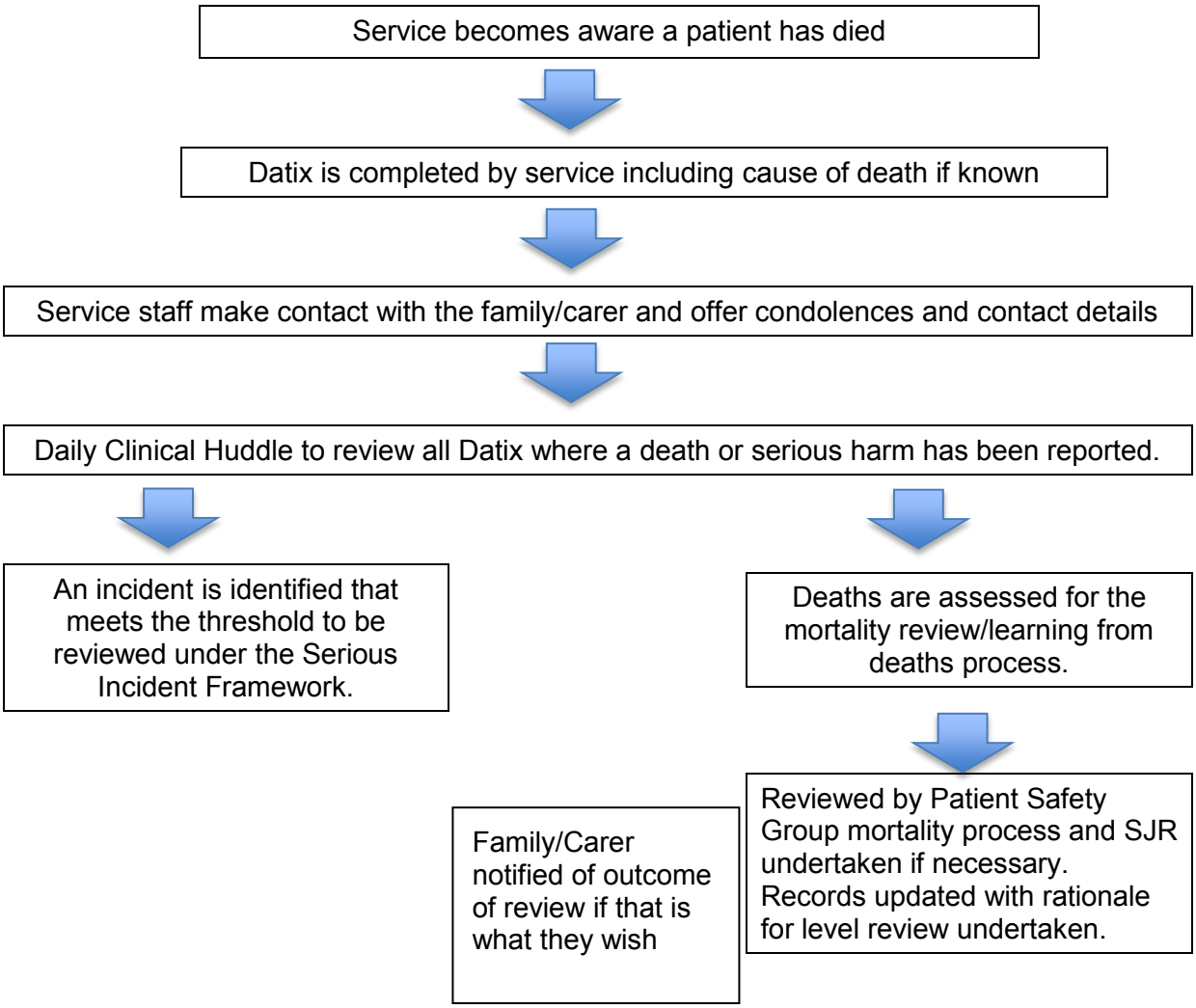
Score 5. Slight evidence of avoidability

Score 6. Definitely not avoidable

Please explain your reasons for your judgement of the level of avoidability of death in this case, including anything in particular you have identified

Appendix 3

When there is to be a structured case review under the Learning from Deaths process



Appendix 4

Information for Families and Carers

Following the death of your relative or friend, you may have questions, and/or concerns that you would like answers to about the care and treatment they were receiving by the Trust. We recognise this is a difficult time for people and we will do our best to respond to you in these circumstances even if you do not wish to make a complaint.

If you are reading this as a family member of someone who has recently died, and has received care from our Trust and you have anything you would like to discuss, you can contact the Patient Safety Team at Tees, Esk and Wear Valleys NHSFT on 0191 3336522. They will be able to put you in contact with the best person to help you.

What does it mean if someone's death is being reviewed?

Sometimes, when a person receiving care from the trust dies, it is important for us to review the care and treatment we provided for them in greater detail. This is to make sure we did everything we could for the person and, if we find things that could have been improved, we can share this with our staff to ensure we learn from that.

Not all deaths will have the same level of review. If a service user has a known disease that they were expected to die from within an expected time frame, we would usually classify this as a *natural* death that was *expected* to happen so no further scrutiny would be required.

If a death is *unexpected* even if it is of *natural causes* e.g. a stroke or cardiac arrest there are 3 types of review we could undertake, depending on the circumstances:

1. Multi-disciplinary case review	**A team of staff including doctors, nurses and other professionals review a short history of a person's care and treatment and discuss whether or not it was appropriate. If more information is required then the case will be put forward for a structured case note review (see point 2).**
2. Structured case note review	**One or two clinical staff undertake a thorough review of a person's clinical records to determine if their care was appropriate. This may include speaking to the clinical team involved with the person. A short report is produced for the team with any learning points. If any major concerns are identified at this stage then the case will be escalated again for a more formal review.**
3. Serious Incident Review	**This is a formal review undertaken by the patient safety team independent of the care team. A more in-depth report is produced and presented to the trust Directors.**

Families/Carers are always asked to be involved in a Serious Incident Review if they wish and they may put forward specific questions to be answered as part of that process. The reviewer will also offer to share a copy of the final report and meet with families to explain any findings and learning points.

The trust recognise the importance of family involvement in reviews and if there are concerns related to care and treatment, a review can also be requested by family members or carers to the Patient Safety Team.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

10 Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Corporate					
Name of responsible person and job title						
Name of working party, to include any other individuals, agencies or groups involved in this analysis						
Policy (document/service) name	Responding to Death Policy: the right thing to do					
Is the area being assessed a;	Policy/Strategy	√	Service/Business plan		Project	
	Procedure/Guidance				Code of practice	
	Other – Please state					
Geographical area						
Aims and objectives						
Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.)						
End date of Equality Analysis Screening (This is when you have completed the analysis and it is ready to go to EMT to be approved)						

You must contact the EDHR team as soon as possible where you identify a negative impact. Please ring Sarah Jay or Tracey Marston on 0191 3336267/3542

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?

All staff in the Trust working in clinical services, especially medics, Registered Nurses and Allied Health Professionals.

2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?

Race (including Gypsy and Traveler)		**Disability** (includes physical, learning, mental health, sensory and medical disabilities)		**Gender** (Men, women and gender neutral etc.)	
Gender reassignment (Transgender and gender identity)		**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)		**Age** (includes, young people, older people – people of all ages)	
Religion or Belief (includes faith groups, atheism and philosophical belief's)		**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)		**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	

Yes – Please describe anticipated negative impact/s
No – Please describe positive impacts/s

No, it will ensure every patient involved in any kind of patient safety incident is treat the same.

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**				

Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports		• NMC and GMC guidance • Allied Health Professionals guidance • Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership

No – Please describe future plans that you may have to engage and involve people from different groups

5. As part of this equality analysis have any training needs/service needs been identified?

Yes/No	Please describe the identified training needs/service needs below

A training need has been identified for;					
Trust staff		Service users		Contractors or other outside agencies	
Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so					
The completed EA has been signed off by: You the Policy owner/manager:				Date:	
Your reporting (line) manager:				Date:	
If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/6542 or email: traceymarston@nhs.net					

11 Document control

Date of approval:		
Next review date:		
This document replaces:	This is a new policy	
Lead:	Name	Title
Members of working party:	Name	Title
This document has been agreed and accepted by: (Director)	Name	Title
This document was ratified by:	Name of committee/group	Date
	Executive Management Team	
An equality analysis was completed on this document on:		

Change record

Version	Date	Amendment details	Status
1	02 Nov 2016	New document	Published

ITEM NO 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 26 September 2017**
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.	x

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, 2017-18.

Key areas for consideration:

- CQC MHA specific inspections summary report
- Report on use of Section 136, Street Triage and CAS activity
- Reports on Discharges from Detention by Associate Hospital Managers and MHT
- Seclusion activity report
- Report on MCA and DoLS update and activity
- Section 49 Assessments
- Annual Committee performance Results

Recommendations:

The Board of Directors is asked to:

i) Receive and note the assurance report, following the MHLC meeting held on 13 July 2017 and to note the approved minutes of the MHLC meeting held on 20 April 2017. (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 26 September 2017**
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, 2017-18; through consideration of the work of the Mental Health Legislation Committee at its meeting held on 13 July 2017.

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 20 April 2017 are attached as Annex 1.

The MHLC also met on 13 July 2017. The key issues considered at this meeting were as follows:

3.2 CQC MHA Visits Feedback Summary Report

The Committee considered the CQC MHA Visits Feedback report**.**

- There had been eight visits to the Trust in the last quarter with 31 issues raised in seven reports. A review of the themes raised following MHA visits over the last 12 months has been undertaken and the top five issues were care plans, MHA Section forms, patients not being referred to IMHA, issues with Section 17 leave forms and patients' rights.

- The Committee was assured that these themes were being addressed with action plans in place that will be monitored by the Quality Compliance Group with a monthly report going to LMGBs to communicate the themes by speciality and locality.

- Governance processes around monitoring the Restrictive Practice policy have been standardised with QuAG's considering information before anything more than routine restrictive practice being taken to LMGBs and escalated to the MH Legislation Committee. Compliance would be monitored through the Quality Compliance Group.

3.3 Section 136, Crisis Assessment Suite (CAS) and Street Triage Report

The Committee considered data and trends around S136, CAS and Street Triage.

- In total there were 199 uses of section 136 across the whole Trust area, an increase of 4% this quarter.

- Those being taken into police custody continues to be low with 3 to Cleveland, 9 to North Yorkshire and 0 to Durham.

- There were 10 under 18 year olds brought to a mental health hospital based place of safety between the ages of 15 to 17.

- There was no Street Triage information for the Committee to consider from Scarborough or York at the time of writing the report.

- Within the Crisis Assessment Suite (CAS) at Roseberry Park activity continues to be significant with 593 assessments undertaken, an average of 200 per month. 125 individuals were brought 'voluntarily' by the police, 408 individuals self-referred and 37 were admitted to MH inpatient services.

- Of the total 593 assessments 159, 27%, were discharged without mental health follow up or sign-posting to other services, this is unchanged from last quarter.

3.4 Discharges Report

The Committee discussed the Discharges report.

- Discharge from detention by either the First Tier Tribunal or the Associate Hospital Managers. In Quarter 1 there were 169 Associate Hospital Managers reviews held which resulted in 3 patients being discharged from the MHA, 2 detained patients and 1 CTO patient.

- The total number of Mental Health Tribunals held in Quarter 1 is not available, however, of the MHTs held, 8 resulted in discharge from the MHA, 2 of which were CTO patients.

The Committee was assured that there were no trends to be found where a tribunal disagrees with the clinical team to proceed to discharge.

3.5 Seclusion Report

The Committee discussed the seclusion report.

- There were 94 episodes of seclusion involving 20 patients with multiple episodes, one of which was from September 2016.

- Of the 94 episodes, 45 (48%) were under 24 hours and of those, 26 were under 12 hours.

- Of those in excess of 24 hours, the longest was just under 17 days, however there is one patient who has been in long term seclusion since September 2016 and a further 3 who remain in seclusion which commenced in June.

  It was agreed that for members to gain a deeper understanding of the high numbers of long term periods of seclusion, some case studies of these complex individuals would be presented to the next MHL Committee meeting.

3.6 Mental Capacity Act and DoLS Report

The Committee was given assurance that the implementation of the Mental Capacity Act and monitoring of DoLS activity across the Trust continues to improve with more robust processes in place.

- Key MHL staff are receiving training to use Lecora, an E-learning system, to enable them to produce the MHA and MCA E-learning packages that will become mandatory training for Trust staff. This should go live in October 2017.

- All DoLS applications are centrally reported by Ward Managers, Staff and Consultants to the MH Advisor.

- A Mental Capacity Act champion's programme has been agreed with 15 staff members identified to develop the skills, knowledge and expertise of staff who have attended MCA DoLS training with the aim to disseminate this across the wards.

3.7 Section 49 Assessments

The Committee discussed the current activity of Section 49 assessments with 69 instructions received to Consultants for these reports from August 2016, the highest area being in MHSOP services in Teesside.

Section 49 assessments were administered by the Legal and Claims team and the Trust had reimbursed Consultants £11,000 since December 2017. Whilst these assessments were recognised as time consuming, with the potential for the cancellation of clinics, there was nothing that could be done as Section 49 assessments were a legal requirement.

3.9 Annual Committee Performance Assessment Results 2016/17

A further discussion took place around the Committee's Performance Results for 2016/17.

The results of the Annual Committee Assessment have shown that half of the scores had improved, however the other half had declined.

A Committee workshop would be held on 19 October 2017 to look at the objectives of the Mental Health Committee and to consider strengthening the assurances provided to the Board of Directors.

4. IMPLICATIONS:

4.1 **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.

4.2 **Financial/Value for Money:**

There are no implications.

4.3 **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.

4.4 **Equality and Diversity:**

There are no implications.

5. 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.

6. 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 20 April 2017.

Richard Simpson
Chairman of the Committee

Background Papers:
Annex 1 – Approved minutes of the 20 April 2017 MHL Committee Meeting

Annex 1

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 20 APRIL 2017 IN SEMINAR ROOM 4, WEST PARK HOSPITAL, DARLINGTON AT 1 PM.

Present:
Mr R Simpson, Non-Executive Director, Chairman of the Committee
Dr N Land, Medical Director
Mrs E Moody, Director of Nursing & Governance
Mr P Murphy, Non-Executive Director
Mrs S Richardson, Non-Executive Director

In Attendance:
Mrs D Oliver, Deputy Trust Secretary, (Corporate)
Mrs J Illingworth, Director of Quality Governance
Miss M Wilkinson, Head of Mental Health Legislation
Mrs R Down, Mental Health Legislation Advisor (MCA Lead)
Ms P Griffin, Mental Health Legislation Advisor
Mrs R Hill, Director of Operations for York & Selby

Apologies: Apologies for absence were received from Mrs L Bessant, Chairman of the Trust, Mr B Kilmurray, Chief Operating Officer, Miss J Clarke, Governor and Ms S Talbot-Landon, Governor.

17/10 MINUTES

Agreed – *That the minutes of the last meeting held on 19 January 2017 be approved as a correct record, subject to a minor typographical error and signed by the Chairman.*

17/11 ACTION LOG

The Committee noted the actions and following updates:

16/29 Summary table of actions following MHA inspections.
This matter was covered under agenda item number 4 (see minute 17/12)
Completed

16/29 Repeated issues raised by the CQC: Solution for scanning forms.
Scanning machines had been delivered to the Trust with the first to be piloted in Middlesbrough. All existing patients' documentation would be scanned onto PARIS and future section papers, with the aim of eradicating repeated issues raised by the CQC around paperwork errors.
Completed

16/29 The lack of uptake around Code of Practice training, which had been mandated by EMT.
This matter was covered under agenda item number 9 (see minute 17/19)
Completed

17/04 Report on the impact of the Police and Crime Bill – This matter was covered under agenda item number 7 (see minute 17/17)
Completed

17/06 Update on assurance around processes in place around seclusion over 24 hours.

Mrs Moody provided a verbal update on the developments around the additional safeguards in place for seclusion periods over 12, 24 and 72 hours. A paper would be presented to the 4 May 2017 Quality Assurance Committee and a copy of this report would be circulated to the MHLC members for information.

Action: Mrs E Moody

17/07 Response to CQC letter regarding SOAD's.
Dr Land reported that currently the Trust had 2 SOAD's, however the aim was to have around 4 to 5. The Senior Medical Staff Committee had been notified and correspondence had been sent to all Consultants, with 1 request for a reference put forward so far. An update would be brought back to the 13 July 2017 MHLC meeting.

Action: Dr N Land

17/08 Report to MHLC showing basic record of section 49 assessments requested.
The Committee agreed that this would be a standing item to be reported to the MHLC on a quarterly basis, to outline the activity and context of issues around Section 49 assessments.

Action : Mrs J Illingworth

17/08 Following results of internal audit on Mental Capacity Act and staff questionnaire action plan to be received by MHLC.
This matter was covered under agenda number 6 (see minute17/16)

Completed

17/12 CARE QUALITY COMMISSION (MHA) VISIT FEEDBACK SUMMARY REPORT

The Committee discussed:

(1) The MHA Visits - 1 January to 31 March 2017.

(a) There had been10 MHA visits across the Trust, eight of which had been reported on, which was a similar number of visits compared to the last quarter.
(b) There had been 37 issues raised, including 1 patient issue (the full details of issues raised were provided in section 3.2 of the report).
(c) The actions arising from the issues raised would be monitored through EMT with Provider Action Statements returned to the CQC.
(d) The Quality Assurance Committee would monitor actions where the original deadline date had not been met.

(2) The Thematic review of MHA visits since April 2016.

(a) The top five themes from April 2016 - April 2017 had been identified from the data following the Mental Health Act Reviewer visits.

In relation to this matter it was noted that:

- There were 59 ongoing actions across 11 separate wards.
- The recurring themes would be communicated across the Trust to create awareness amongst staff and wards to prevent repeated non-compliance issues.
- The compliance group would be distributing a 1 page summary of the top five themes across all localities as well as going to LMGB's for information sharing.

Mrs Richardson advised that a proactive approach was needed, working with the Compliance team, Heads of Nursing and other key leads to help prevent recurring issues being raised by the CQC.

(3) Bankfields - where no issues had been raised by the CQC.

The Committee agreed that the staff on Bankfields should be thanked and congratulated following no issues having been found by the CQC on the MHA inspection.
Mrs Moody undertook to write a letter of congratulations to the staff on Bankfields.

Action: Mrs E Moody

17/13 SECTION 136 REPORT

The Committee received and noted the Section 136 report.

Ms Griffin drew attention to the impact of the use of S.136.

(a) The number of S 136 brought to Trust Places of Safety had increased in all areas in the last quarter and this is reflected in the reduction in the use of Police stations as places of safety.
(b) The Crisis Assessment Suite (CAS) had continued to see high numbers of people, with 43 individuals going on to be admitted to an inpatient ward.
(c) Street Triage in Scarborough, York and Teesside, despite reduced availability continued to provide professional support, with 201 contacts across all areas resulting in the use of S 136 on only 6 occasions.
It was noted that information gathering across teams was variable due to the demands from the various Commissioners and some work would be undertaken to standardise reporting.

The Chairman acknowledged the important work of street triage and asked whether the data could be analysed in further detail to demonstrate the benefits of this service and how it impacted on the CAS and use of TEWV places of safety.

Mrs Hill advised that the increase in the use of TEWV places of safety and the Crisis Assessment Suites, due to the reduction in the numbers of individuals taken to a Police place of safety was an operational matter and it would be useful to discuss this further at OMT to understand the impact on services going forward.

Agreed: that the matter of the increased use of TEWV places of safety, Street Triage and Crisis Assessment Suites be discussed at OMT.

Action: Mr B Kilmurray

17/14 MHA DISCHARGES FROM DETENTION REPORT

The Committee considered and noted the MHA Discharges Report.

Ms Griffin drew attention to the following matters:

(1) The report showed activity for the year 1 April 2016 to 31 March 2017 as opposed to the last quarter, following a request at the last MHLC meeting.
(2) No trends had been identified with regard to Hospital Manager's panels, Mental Health Tribunal or clinicians.
(3) The Trust was below the national average at just under 8% for discharges from detention by MHT.

The Committee was assured that comprehensive reports with good clear evidence for the reasons recommending continued detention were being provided, however there were occasions when the Tribunal disagreed with the clinical team in a minority of cases.

Mrs Moody advised that it would be helpful to understand the reasons why on 6 occasions the Care Coordinator had a different view to that of the RC as to whether the patient should remain subject to the MHA.

Agreed: That there should be an escalation process when this occurs to the Head of Service to review and provide assurance.

Action: Miss M Wilkinson

17/15 SECLUSION REPORT

The Committee considered and noted the Seclusion Report.

Ms Griffin advised that there had been 75 episodes of seclusion reported, involving 40 patients with multiple episodes for 16 patients, with 2 long-term episodes.

The Committee considered that cross checking the information provided to the Mental Health Office and the information pulled from PARIS against the information stored on DATIX would be useful.

Mrs Illingworth undertook to cross check the data on seclusion on DATIX and feedback to the MHL Committee at its meeting on 13 July 2017.

Action: Mrs J Illingworth

The Committee sought assurance that seclusion was not being used for inappropriate reasons, such as the unavailability of staff, when no other accommodation was available.

Mrs Moody responded that all individual cases were regularly reviewed under the Code of Practice to ensure that seclusion was the most appropriate intervention in each case, however there had been a recent incident of a long term seclusion for a service user on Westwood, which had been due to waiting for a suitable adult facility with a seclusion room.

17/16 DEPRIVATION OF LIBERTY LAW COMMISSION PROPOSALS REPORT

The Committee received and noted the Deprivation of Liberty Law Commission Proposals Report.

Arising from the report it was noted that:

(1) Based on the recommendations in the recently published Law Commissions report, there would potentially be a new legislative system replacing on the current DoLS regime.

The following areas would be included in the new scheme:

(a) It would apply to all settings, hospitals and care homes, as well as the supported living arrangements and individual's own homes.
(b) 16-17 year olds would also be included.
(c) Transient care arrangements and transportation.
(d) CCG, NHS and LA responsibility for the arrangements.
(e) Detailed list of criteria for deprivation to be authorised
(f) Scrutiny of proposed care arrangements and rigorous scrutiny should the individual object to arrangements.
(g) Once deprivation authorised entitlement to ongoing rights of advocacy.

(2) The risk of non-compliance in following the legislation could lead to an unlawful deprivation occurring, or penalties through breach of Article 5, involving the automatic right to compensation to anyone unlawfully deprived.
(3) The Department of Health had a 12 month consultation period to respond to the Law Commission, and it was anticipated that there would be no likely impact on DoLS for the next 3 years.

Mrs Down advised that DoLs recording would go live on PARIS in the next couple of weeks, which would enable easier monitoring of the application of DoLS.

17/17 IMPACT OF THE POLICE & CRIME BILL

The Committee received and noted the Impact of the key Mental Health Act Changes made by the Policing and Crime Act 2017.

Miss Wilkinson drew attention to the following matters:

(1) Significant amendments to Sections 135 – 138 of the Mental Health Act 1983, in light of the introduction of the Policing and Crime Act 2017: Mental Health Provisions.

(a) A revised S 136 policy had been drafted taking into account the amendments to the MHA and impact of the Police and Crime Bill and was currently out for consultation to a wide multi-agency circulation list, including, LAs, acute Trusts, all CCG Commissioners and key staff within TEWV.
(b) Operationally the changes would be taken through various forums, including the Crisis Care Concordat.
(c) The original implementation date for the revised S 136 policy of May 2017 had been postponed due to Purdah.

(2) The impact of the implementation of the Police and Crime Bill included:

(a) The reduction of the time limit for S 136 from up to 72 hours to up to 20 hours, which would have potentially significant impact on trying to locate and access appropriate beds for under 18 year olds, who were unmanageably violent within the reduced timeframe.
(b) Extending places of safety, meaning that AMHP's and Trust doctors might need to attend a person's home to carry out a S136 assessment.
(c) Potential breaches of the 24 hour time period due to the reduction in LD beds under the Transforming Care agenda.
(d) Securing a bed for under 18s would be extremely difficult and it was recognised that this was a local and national issue.

The Committee agreed that, whilst not a matter for formal escalation, the potential risk of breaches to the 24 hour time period and of securing LD beds for under 18's should be highlighted to the Board of Directors at its meeting on 23 May 2017.

Action: Mr Simpson

17/18 MENTAL CAPACITY ACT AND DOLS REPORT

The Committee received and noted the Mental Capacity Act and DoLS Report

Arising from the report it was noted that:
(1) Monitoring DoLS performance across the Trust and further work around the implementation of the Mental Capacity Act continued.

(2) Trust wide during July 2016 there had been 65 case file audits undertaken, as well as staff questionnaires to analyse the Trust approach to assessing the consistency of the implementation of patient's capacity to consent. The results of these audits would be used as part of the Trust's wider business priorities in addressing future business plans.

On this matter it was noted that Audit One had also been involved externally to audit and review current progress around MCA and DoLS work.

(3) There were currently delays with Local Authorities not reacting to DoLS applications, with the longest wait being 2 years in Middlesbrough. TEWV staff were carrying out due process with regard to DoLS applications, however there was the need for a debate as to the option of DoLS champions across the Trust to support the work, as well as the importance of training.

Mrs Moody undertook to take the matter of the long waits with LA's for DoLS applications and consideration of Trust champions for DoLs to OMT for discussion.

Action: Mrs E Moody

17/19 CODE OF PRACTICE IMPLEMENTATION AND TRAINING UPDATE REPORT

The Committee received and noted the Update report on the implementation of the MHA Code of Practice.

Arising from the report it was noted that:

(1) A further review of Trust policies, procedures, guidance and arrangements required by the Code of Practice were now in a position of almost total compliance.
(2) Training around the Code of Practice was ongoing (currently at 85% compliance).

Miss Wilkinson highlighted that the version of the Access to and Exit for Wards Procedure on in Touch did not appear to have been updated and the food and drink strategy could not be easily located on the Trust intranet.

Mrs Illingworth undertook to ensure that that this matter was addressed.

Action: Mrs Illingworth

17/20 ANNUAL COMMITTEE PERFORMANCE ASSESSMENT RESULTS

The Committee discussed:

(1) That the Committee had made improvement in 10 areas overall, however there were 10 areas that had gone down in score.
(2) Comments which had scored lower were around providing assurance to the Board of Directors on the Code of Practice, overlap with the Quality Assurance Committee and the need for the Committee to gain more assurance around being compliant with the Mental Health Act and the Mental Capacity Act and members having sufficient knowledge of the MHA and MCA to identify risk areas and to be able to challenge management on critical and sensitive matters.

It was noted that not all members of the Committee had received a copy of the Annual Performance Assessment results before the meeting.

Mrs Oliver undertook to circulate the Annual Committee Performance Assessment results to all Committee members with an invitation for comments and feedback by the 9 May 2017.

Action: Mrs Oliver

17/21 ANY OTHER BUSINESS

The Committee noted that recurrent funding had been secured for the Mental Health Legislation Advisor to become a substantive post.

The Committee welcomed the additional support of Mrs Down, as the MHA Legislation Advisor which would be a pivotal role in the collation and monitoring of information around the MHA Code of Practice and DoLS.

Miss Wilkinson advised the Committee of a piece of case law (MM and PJ) that had been published at the end of March 2017 and an update would be brought to the 13 July 2017 MHLC meeting on the potential impact this might have on the transforming care agenda and conditional discharge of patients.

Action: Miss Wilkinson

The meeting concluded at 2.50pm

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ITEM NO. 10

FOR GENERAL RELEASE/CONFIDENTIAL

BOARD OF DIRECTORS

DATE:	**Tuesday, 26th September 2017**
TITLE:	**Draft Nursing Strategy 2017-2021**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Ratification**

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:

Nurses play a unique and central role in the delivery of excellent care within the trust and are the largest professional group. The attached draft new nursing strategy developed in consultation with nurses across the trust, replaces the trusts previous nursing strategy (which ended in 2016) and describes the aims, vision and objectives for nursing over the next four years.

The strategy outlines 4 themes, 6 key objectives and the actions we will take to support the trust to provide a compassionate, effective, forward thinking nursing response to the challenges ahead.

The Chief Nursing Officers national framework for nursing, “Leading Change, Adding Value” is intended to be an overarching framework to which local Trusts and their nurses can add operational and professional detail, and as such is also strongly reflected in our new trust nursing strategy. The objectives detail how we will deliver each of the 10 commitments set out in the National Nursing Strategy. This framework is directly aligned to the 5 year forward view. It stresses the centrality of nursing to closing the 3 gaps in: health and well-being; care and quality and funding and efficiency.

The strategy will be monitored following the development of locality implementation plans by the Heads of Nursing through the existing professional nursing forums and an overarching Executive Nursing Forum. Building on this there will be an annual review of progress against the strategy led by the Director of Nursing and Governance, with reporting of key issues to EMT and the Trust Board.

A strategy scorecard is in development consisting of a short set of key metrics linked to each objective.

Recommendations:

That the Board of Directors are asked to ratify the draft Nursing Strategy 2017-2021 pending the development of the nursing scorecard.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 26th September 2017**
TITLE:	**Draft Nursing Strategy 2017-2021**

1. INTRODUCTION & PURPOSE:

1.1 Nurses play a unique and central role in the delivery of excellent care within the trust and are the largest professional group. The attached draft new nursing strategy developed in consultation with nurses across the trust, replaces the trusts previous nursing strategy (which ended in 2016) and describes the aims, vision and objectives for nursing over the next four years.

1.2 The strategy has been developed to set out the direction and main areas of development for nurses and nursing over the next few years to better meet the needs of service users, their families and carers in line with the trusts vision and strategic goals.

1.3 In order to inform the nursing strategy themes and objectives it was important all our nurses had input and we held a number of workshops and engagement events as well as inviting comments and suggestions from a range of professionals and experts by experience. The outcomes of this process informed 4 key themes which we feel reflect the priorities for nursing across the trust over the next four years and will support us to provide a compassionate, effective, forward thinking response to the challenges ahead. These in turn shaped the 6 strategy objectives and associated areas of action outlined below. The timeframe for implementing each objective is September 2020.

The 4 key themes are:

- Personalisation, recovery and collaborative nursing practice
- Safe staffing (including recruitment and retention, enhanced knowledge, skills and career opportunities)
- Evidence based practice
- Increased productivity

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The strategy sets out the key national drivers, context and isuses which will impact on professional nursing practice, education and workforce development over the next few years and therefore shape the strategy.

2.2 The Chief Nursing Officers national framework for nursing, “Leading Change, Adding Value” is intended to be an overarching framework to which local Trusts and their nurses can add operational and professional detail, and as such is also strongly reflected in our new trust nursing strategy. The objectives detail how we will deliver each of the 10 commitments set out in the

National Nursing Strategy. This framework is directly aligned to the 5 year forward view. It stresses the centrality of nursing to closing the 3 gaps in: health and well-being; care and quality and funding and efficiency.

2.3 The previous National Nursing Strategy (Compassionate Care – 6 'C's, 2012) remains a key influence on nursing, and our new trust strategy does not seek to replace these timeless values but will ensure they remain embedded in our practice.

3. KEY ISSUES:

3.1 The draft Nursing Strategy outlines the following aims:

- To communicate a vision and future direction for the nursing workforce
- To deliver safe, responsive, high quality, compassionate, recovery focused care for service users in every contact by every nurse
- To develop a highly skilled, accountable and effective nursing workforce with the capacity, capability, leadership and flexibility to take on new roles and retain experience and expertise
- To strengthen and maximise nursing's influence in continuous quality improvement and policy development
- To provide a framework for the development and monitoring of excellent nursing care

3.2 The strategy has been developed to support the delivery of existing key strategies such as Recovery and Workforce with a specific focus on the nursing contribution.

3.3 The strategy will be monitored following the development of locality implementation plans by the Heads of Nursing through the existing professional nursing forums and an overarching Executive Nursing Forum. Building on this there will be an annual review of progress against the strategy led by the Director of Nursing and Governance, with reporting of key issues to EMT and the Trust Board.

3.4 A strategy scorecard is in development consisting of a short set of key metrics linked to each objective.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
The strategy supports the delivery of excellent nursing care by a skilled and accountable workforce therefore assisting the achievement of CQC Fundamental standards.

4.2 **Financial/Value for Money:**
The strategy addresses the nursing responsibility to deliver excellent care whilst working in an effective, productive, sustainable and efficient way.

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

No issues

4.4 **Equality and Diversity:**
No issues

5. RISKS:

It is generally recognised that this is one of the more difficult periods financially for the NHS and as a leading mental health trust, there is a real challenge for us to make the best use of the resources we have and continue to make improvements, keeping the people we serve as our central professional focus. The strategy will support nurses and nursing going forward over the next 4 years.

Due to the size and spread of the nursing workforce, the following risks are related to non-delivery of the strategy:

- Failure to recruit and retain a skilled workforce
- Failure to deliver evidence based, personalised, recovery orientated care impacting negatively on the outcomes and experiences of service users
- Failure to deliver the trusts vision and strategic goals

6. CONCLUSIONS:

The new trust nursing strategy is underpinned by the standards, values and behaviours set out in the NMC Code of Practice. It provides a framework and vision as to how nurses will deliver high quality, compassionate care against the back-drop of on-going reform and change. There is also a major opportunity for nurses to use their influence at the cutting edge of innovation.

7. RECOMMENDATIONS:

That the Board of Directors ratify the draft Nursing Strategy 2017 - 2021 pending the development of the nursing scorecard.

Author, Elizabeth Moody
Director of Nursing and Governance

Background Papers: CNO National Nursing Strategy Leading Change, Adding Value

Tees, Esk and Wear Valleys
NHS Foundation Trust

Nursing Strategy

2017 – 2021

Strategy Sponsor: Elizabeth Moody, Director of Nursing and Governance		
Strategy Lead: Stephen Scorer, Deputy Director of Nursing		
Version:	**Date approved**	**Date of Next Review:**

Contents

Section 1

The Nursing Strategy

Our new TEWV Trust nursing strategy arrives at a key time for the profession, aligning our work to the national framework for nursing and reflecting a number of changes in the developments and regulation of the profession. Nurses play a unique and central role in the delivery of excellent care within the trust. Nurses are the largest professional group (Registered nurses – 2286 Healthcare Assistants – 1267) and are found in almost every clinical service across a range of health and social care settings. Delivery of this strategy will realise our Trust vision to deliver high quality services that exceed people's expectations. Without excellent nursing characterised by genuine collaboration with service users and carers, the trust cannot achieve its strategic goal to provide excellent services working with the individual users of our services and their carers to promote recovery and well-being. This strategy is also a key enabler to the other strategic goals including the delivery of the strategic goal to recruit, develop and retain a skilled, compassionate and motivated workforce.

Building on the progress achieved from the 2012-2016 nursing strategy, this strategy reflects the direction and key priorities for nursing over the next four years,

The aims of the strategy are:

- To communicate a vision and future direction for the nursing workforce
- To deliver safe, responsive, high quality, compassionate, recovery focused care for service users in every contact by every nurse
- To develop a highly skilled, accountable and effective nursing workforce with the capacity, capability, leadership and flexibility to take on new roles and retain experience and expertise
- To strengthen and maximise nursing's influence in continuous quality improvement and policy development
- To provide a framework for the development and monitoring of excellent nursing care

Section 2

The Case for change

Why do we need a Nursing Strategy?

- To be clear about the direction and main areas of development for nurses and nursing over the next few years to better meet the needs of service users, their families and carers
- To describe how we will provide satisfying and meaningful experiences at work for nurses themselves

- To be clear on our ambitions to develop and retain a skilled, motivated and compassionate workforce with the right numbers in the right place to meet clinical and service need.

This strategy seeks to help our Trust nurses to be well positioned to respond to all the issues outlined below. It is generally recognised that this is one of the more difficult periods financially for the NHS and as a leading mental health trust, there is a real challenge for us to make the best use of the resources we have and continue to make improvements, keeping the people we serve as our central professional focus.

Background and National Context:

Whilst the NHS continues to experience challenges, there are a huge range of issues and opportunities which have influenced our new strategy and reflect the exciting and rewarding time this is for the nursing profession. Areas of key focus are set out below which will impact on professional nursing practice, education and workforce development in the coming years and therefore shape the new nursing strategy.

The Chief Nursing Officers national framework for nursing, "Leading Change, Adding Value" is intended to be an overarching framework to which local Trusts and their nurses can add operational and professional detail, and as such is strongly reflected in our trust nursing strategy. This framework is directly aligned to the 5 year forward view, and the health and wellbeing agenda. It stresses the centrality of nursing involvement in helping to close the three major gaps identified in:

Health and wellbeing:

A greater focus on prevention is needed to enable health improvements and counter pressure on services.

Care and quality:

Health needs will go unmet unless we reshape care, harness technology and address variations in quality and safety.

Funding and efficiency:

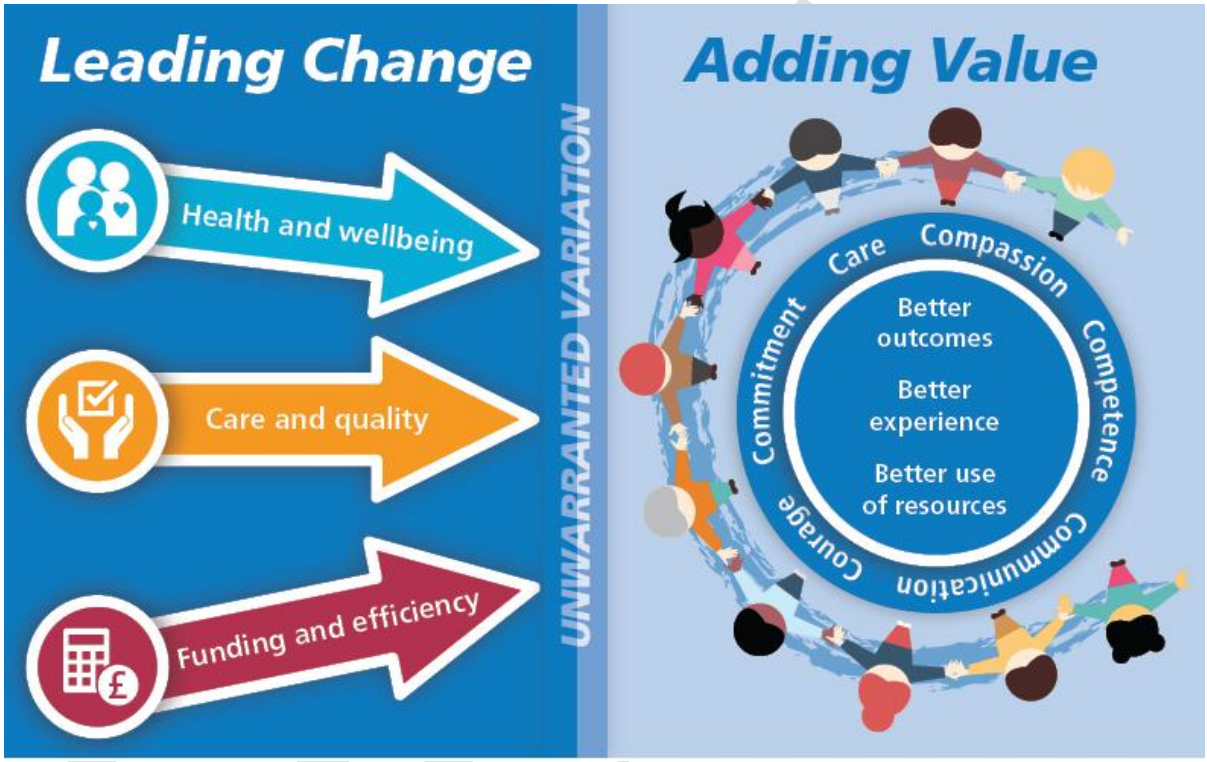
Without efficiencies, a shortage of resources will hinder care services and their progress.

Within this overall model, nurses have a central role in leading change. Key to this approach is the focus on reducing unwarranted variation, in which practice or service models vary for historical or individual reasons rather than because of an evidence base or improved outcomes or experience. Alongside this is the concept of "added value", or focussing on carrying out high value interventions, reducing waste and

missed opportunity (this has particular resonance for our Trust given our approach to continuous lean improvement, QIS).

In order to deliver the 10 commitments outlined in this framework, nurses of the future will work with partners and communities, taking a leading role in promoting prevention, early intervention and building resilience. Meeting the needs of our local population is a key message and will require nurses to take an integrated approach to mental health, disabilities and physical health.

The overarching values and aims of the framework are captured below:



- As shown in the above diagram, the Chief Nursing Officers earlier Nursing Strategy (Culture of Compassionate Care – 6 'C's, 2012) remains a key influence on nursing, and our trust strategy does not seek to replace these timeless values but will ensure they remain embedded in our practice.
- In March 2015 The Nursing and Midwifery Council (NMC) launched the new Code of Practice and professional Revalidation process for nursing. The new code set out the standards and behaviours in 4 key areas central to nursing professional practice whilst ensuring public protection:
    - Prioritise people
    - Practice effectively
    - Preserve safety
    - Promote professionalism and trust

The intention of the strategy is to promote these behaviours and through re-validation processes, to ensure that nurses provide evidence to meet these

standards, remaining professional in their approach as well as fit to practice throughout their careers.

- The 5 year forward view for mental health set out the start of a ten year journey to reflect changing public attitudes to mental health and the growing commitment among communities, workplaces, schools and government to change the way we think about mental health, shifting towards prevention and transformation of NHS care. For nursing staff this will mean:

    - Ensuring physical health needs have equal importance to mental health needs
    - Championing the needs of people with mental health needs to reduce stigma and discrimination
    - Influencing and participating in the reshaping of the way care is delivered
    - increasing access to the right care at the right time
    - Driving down variations in the quality of care ensuring the improvement of outcomes for service users

Meeting this ambition will require nurses to continue to prioritise the physical health and wellbeing of all of those that use our services.

- The increasing demand for mental health services and health care overall (for example we know there are around 1.9 million people with 3 or more long term conditions, will require nurses to work across different settings and with individuals in new ways. Reducing the need for hospital admissions is a key aim of the local Sustainability and Transformation plans.
- Growing recognition of the importance of human factors, openness and transparency around patient safety, and the Duty of Candour
- The Strategy is also informed and influenced by key mental health strategies such as 'No Health Without Mental Health', 2010 and 'Closing the Gap', 2014 with the overall aim of achieving parity and integration between physical and mental health. One of the key strands of work is to address current inequalities experienced by patients with a mental health condition or learning disability in the prevention, assessment, diagnosis and treatment of physical health problems.
- The Safe Staffing agenda, ensuring we have the 'right staff, with the right skills in the right place at the right time'. Local and national challenges around recruitment, retention, and workforce development, including new models of nurse education and recent changes to the funding of registered nurse training means there will need to be continued effort to support this huge agenda.
- The increased recognition of the need to 'grow our own workforce' including further development of the Health Care Assistant role and the pilot of new roles such as the Nursing Associate role, which has scope to work across all fields of nursing and will be regulated by the Nursing and Midwifery Council. This role will supplement, augment and compliment care delivered by registered nurses however there is a need to define the scope of practice across a range of settings as well as building capacity and equipping the workforce with appropriate skills.

- The inspection and regulation regime has a far higher profile that at time of our last nursing strategy. Nursing staff will continue to play an integral role in inspections under the new CQC regime and to ensure the delivery of safe, recovery focussed, collaborative and personalised care as set out in the MHA Code of Practice and CQC Fundamental Standards.
- This strategy reflects the need for nurses to be 'Carer Aware' in our approach and welcome the valuable contribution carers can make, being also mindful of carers' own needs. The Triangle of Care provides a framework to guide three-way partnership between service users, carers and clinical staff with all voices being heard and influencing care and treatment decisions which collectively give the service user the best chance for recovery.

Section 3

The Vision

Our nursing vision for the future

To be a first choice employer with highly skilled, accountable and effective nursing staff delivering high quality, compassionate care, enabling positive experiences and outcomes throughout a service user's recovery journey.

Section 4

Objectives

In order to inform the nursing strategy themes and objectives it was important all our nurses had input and we held a number of workshops and engagement events as well as inviting comments and suggestions from a range of professionals and experts by experience. The outcomes of this process informed 4 key themes which we feel reflect the priorities for nursing across the trust over the next four years and will support us to provide a compassionate, effective, forward thinking response to the challenges ahead. These in turn shaped the 6 strategy objectives and associated areas of action outlined below. The timeframe for implementing each objective is September 2021.

The 4 key themes are:

- Personalisation, recovery and collaborative nursing practice
- Safe staffing (including recruitment and retention, enhanced knowledge, skills and career opportunities)
- Evidence based practice
- Increased productivity

Within this section, we outline the key things we are going to do to deliver these themes in line with the 10 national commitments outlined below which are set out in the national nursing framework.

The ten commitments outlined are;

1. **We will promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff**
2. **We will increase the visibility of nursing and midwifery leadership and input in prevention**
3. **We will work with individuals, families and communities to equip them to make informed choices and manage their own health**
4. **We will be centred on individuals experiencing high value care**
5. **We will work in partnership with individuals, their families, carers and others important to them**
6. **We will actively respond to what matters most to our staff and colleagues**
7. **We will lead and drive research to evidence the impact of what we do**
8. **We will have the right education, training and development to enhance our skills, knowledge and understanding**
9. **We will have the right staff in the right places and at the right time**
10. **We will champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcome**

The link below is designed to produce a short printable booklet of the key objectives of the nursing strategy and example actions.

Nursing Strategy Handbook 2017-2021

(Handbook to be printed double sided)

Objective 1: To further embed the values and approaches of recovery, personalisation and collaboration into the delivery of our nursing care and processes

Key messages – national
(This addresses the National Nursing Strategy Commitments 2,3, 4, 5)

Ensure that service user and carer experience and feedback shape, influence and are at the heart of nursing practice.

Always value and integrate into our work the crucial roles of carers, family members, volunteers and the local community in maximising the health and wellbeing of those in our care.

Always recognise that those in receipt of care are experts by experience.

Truly put people receiving care, their families and carers, at the centre of all we do when developing and delivering all aspects of their care; so that what matters to them always informs our actions and judgement.

Truly get to the core of what matters to individuals by the use of 'I-Statements' for example - "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.

Actions we will take to achieve this:

- We will adopt a person-centred, Recovery based approach in line with phase two of the Trust Recovery strategy, recognising the importance of evidence - based symptom management and nursing interventions blended with a goal centred approach, which enable people to do the things they want to do and live meaningful and purposeful lives.
- We will work jointly with our service users who may display behaviours that are described as challenging, on a personal Positive Behavioural Plan to reduce the need for physical interventions or medication, and will offer training and support to staff in these approaches. We will link the individual plans to the early phase of people's recovery journey.
- We will continue to embed 'Safe-Ward' developments to help create safe and therapeutic environments.
- We will work in partnership with service users, carers and other stakeholders to co-produce clinical records and care documents which place recovery at their heart, as set out in the Trust Recovery Strategy.
- We will ensure that individuals are always supported to influence and direct their own health care decisions, so that they are confident that 'no decision is taken about me without me.'
- We will review the format and guidance for care planning in each speciality with experts by experience to support the delivery of recovery focussed, collaborative care.
- We will deliver care in a way that service users feel that their views and aspirations are taken fully into account in care-planning.
- We will listen to and act upon patient and carer feedback to improve the care

experience, for example from PALS information and FFT feedback

- We will review the Trust-wide Physical Healthcare Policy to incorporate a wellbeing section to reflect the Trust's Recovery Principles (CHIME) in partnership with the Experts by Experience Group
- We will ensure the principles of the Triangle of Care are embedded into all our services.
- We will seek to reach a shared understanding with service users when judging potential risks and how these should be managed, in line with our Harm Minimisation policy. This will involve shared decision making and supporting service users in taking positive risks when it is safe and appropriate for them to do so.
- We will provide a rolling programme of training for our nurses and other colleagues in these principles.
- We will, in line with recovery and person-centred principles, provide the support that people need to access opportunities they value, providing evidence based support and offering choice. For example, in making broader life choices around education, employment and other social roles which will support their overall health and well-being
- We will ensure that all staff are able to address any safeguarding concerns, working within the 'think family' approach to prevent further harm
- We will ensure our nurses understand the health promotion / prevention priorities within their specialist clinical areas and act as health promotion champions for these potentially vulnerable groups
- We will continue to work in partnership with the Recovery Colleges, for example in conjunction with the Physical Healthcare Project Team to deliver a co-produced workshop 'Improving Your Physical Health', and consider other methods for taking this work forward in collaboration with Peer Support Workers.
- We will continue to develop new person-centred models of care and support for people with a learning disability, in-line with latest national guidance and working with people with a learning disability, their families and other agencies.

Objective 2: To ensure we have a co-ordinated and integrated approach to the delivery of safe staffing

Key messages – national
(This addresses the National Nursing Strategy Commitment 4, 8, 9)

Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.

To make sure community and inpatient teams are safely staffed and that staffing is optimised to deliver high quality care.

Safe staffing and deployment of staff will be in line with Carter recommendations and the triple aim of the National Nursing Strategy, achieving better outcomes, better experience and better use of resources.

Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.

Actions we will take to achieve this:

- We will deliver the vision and benefits set out in the Safe Staffing programme as one of the trusts strategic priorities.
- We will undertake an annual review of the baseline staffing establishment across our services, using a combination of evidence based tools and structured professional judgment discussions.
- We will expand this work into community teams.
- We will implement the service specific safe staffing guidance for mental health and learning disability services into our approach.
- We will implement an escalation framework to facilitate staff raising concerns about staffing levels.
- The safe staffing report to trust Board will be simplified in order to highlight our key issues.
- We will improve recruitment from the local Higher Education institutes, and establish a trust-wide approach to recruitment and retention, including workforce planning.
- We will develop a flexible pool of nursing staff to supplement the existing staffing establishments at the various sites.
- We will improve out of hours clinical support to ward nursing staff.
- We will work jointly with Human Resources colleagues to ensure we are well-placed to lead on developing approaches such as the potential Apprenticeship scheme for graduate nurses and the new Associate Nurse roles. We will take part in the regional pilot to test out such schemes, and be proactive in supporting other local developments, such as the potential for these to become apprenticeships.
- We will develop standard work for Modern Matrons, Ward Managers and other nurse leaders which lead to high visibility within services, maximising use of their skills and responsibilities.
- We will ensure that nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties e.g. mentorship and supervision.
- We will further embed the National Quality Board Safe Staffing guidance.

Objective 3: To increase the recruitment and retention of nursing staff

Key messages- national (This addresses the National Nursing Strategy Commitments 4, 6, 8, 9)

The NHS in 2020 will look after more patients that the NHS of today. We are therefore going to need to continue to improve productivity and grow our frontline workforce.

There is a need to support new Advanced Clinical Practice (ACP) nurse roles.

Recognise the importance of consistent compassionate leadership as the cornerstone of a people-centred approach, in a shared ambition to achieve excellence, which includes recognition of the contribution of all nursing staff across all services.

Recognise the need to foster improved staff engagement, commitment and morale

through more positive, strengths based approaches.

To attract new staff to health and care roles, flexible routes into education at pre-degree and post-registration levels, and develop post-registration education standards transferable across teams and sectors.

Actions we will take to achieve this:

- We will build on peoples existing skills, experience and qualifications to promote their entry into the nursing profession. As part of this we will set a target for number of new recruits based on workforce planning information, and monitor their progress on the Nursing Scorecard.
- We will use our workforce planning information pro-actively, to influence the commissioning numbers, and types of professional registration training with education providers.
- We will work with the Higher Education Institutes in light of the changes to post-graduate funding and flexible models of provision, to make relevant professional development opportunities available for our registered nurses.
- We will undertake debrief meetings with colleagues after episodes/incidents, including examples of infection outbreak, or the management of violence and aggression to learn lessons and celebrate good practice.
- We will hold a developmental event for Wards and Community teams each year to ensure all colleagues have access to an opportunity for communication and team building away from the immediate workplace.
- We will deliver programmes specifically designed to provide newly qualified staff the opportunity to engage with colleagues across the localities. The programme will provide nurses with the opportunity to have a greater understanding of the role of a band 5 nursing staff member and the leadership role they have in relation to service delivery, with a personal action plan and support them.
- We will support the roll out of the Organisational Compassion programme across the organisation as nurse leaders, jointly with our colleagues from other disciplines including the Clinical Psychology lead department. Within this, as individual nurses we will set our own Compassionate Leadership personal objectives.
- We will act on the findings for nurses of the national and local staff surveys including the Staff Friends and Family test, and the systems within the trust for raising concerns
- We will continue our programme to support Registered Nurses with their revalidation requirements, both to comply with the NMC processes and Code of Conduct and to use the opportunity revalidation gives us to develop our practice further.
- We will contribute to and support the development of the Trust Talent Management programme to assist nurses in their career development including into advanced nursing roles.
- We will actively promote and contribute to iniatives relating to the retention of nursing staff.

Objective 4: To enhance the skills, knowledge and career opportunities for nurses in line with clinical pathways and service user and carer feedback

Key messages- national
(This addresses the National Nursing Strategy Commitments 2, 5, 9, 10)

Recognise the importance of building up the future workforce and, through talent spotting, building future leadership capability at local, regional and national level.

Make the education, learning and training of staff a priority.

Act as mentors, teachers, coaches and role models; ensuring that this becomes a predominant and consistent style of care, help and support.

Recognise the need to evaluate improvements, so that we can evidence the impact of investment in staff on outcomes and experiences for patients and on reducing unwarranted variation.

Actions we will take to achieve this:

- We will develop flexible career pathways across a range of settings so that nurses working within the trust will be able to develop their clinical, academic, teaching, research and managerial skills and have increased opportunities to be at the forefront of continuous quality improvement in order to provide excellent care for service users.
- We will create clearly identified roles for nurses within pathways related to service user and carer feedback, interventions and extended scope of practice and develop nursing competencies to undertake these roles.
- We will increase, widen and diversify the range of training opportunities available for our HCA colleagues to undertake nurse training, including the increased use of the Open University, and the development of sponsorship programmes to support Learning Disability training as a key pressure area.
- We will ensure there is a strong nursing contribution to the development of the Trust Training Needs Analysis and the subsequent training plan, with a lead role for the Heads of Nursing.
- Further to this we will implement the Talent for Care strategy which is focussed around encouraging entry to the NHS and then subsequent development including to the Associate programme or pre-registration access.
- We will roll out and support the new clinical supervision framework across the trust, with an action plan for each locality led by Heads of Nursing to ensure all colleagues have timely access to personal support and reflection.
- We will continue our programme to support Registered Nurses with their revalidation requirements, both to comply with the NMC processes and Code of Conduct and to use the opportunity revalidation gives us to develop our practice further.
- We will deliver developmental programmes that have been specifically designed to create time for multi-professional team leaders including nurses to work together to reflect upon and plan for the leadership challenges in the future.
- Support, training and supervision will be provided to strengthen the delivery of

recovery focussed, person centred care. The principles of recovery and harm minimisation will be incorporated into Trust-wide training requirements.

- We will engage with the Coaching for Leaders programme and bring this style of communication and development into our teams.
- We will empower staff via the IPC team and Champions, and Modern Matrons, by ensuring relevant education and training, e.g. in ensuring a safe and hygienic environments and managing outbreaks of infection
- We will respond to the needs identified by nurses in the Trust to have guidance and standards regarding physical long term condition management
- We will continue to contribute to the Trust's Talent Management programme to assist with our future workforce development.

Objective 5: To further embed best and evidence based practice into the delivery of our nursing care and processes

Key messages – national strategy
(This addresses the National Nursing Strategy Commitments 1, 2, 4, 5, 7)

Use learning from research to innovate and improve care and define nursing contribution and value.

Recognise the value of collecting data, where possible at the point of care using modern technologies.

Establish partnerships to mutually support learning on best practice, participating in networks that will help drive the uptake of innovation across the sectors such as Academic Health Science Networks.

Mental health and learning disability nurses will use their knowledge, skills and expertise to improve access across the health system and lead improvements in physical health care for people with complex mental health and/or learning disabilities.

Actions we will take to achieve this:

- We will continue to support the Trust QIS for leaders and other lean approach based training programmes.
- We will interpret and implement national guidance and standards to support the recognition of patients' physical deterioration, (for example NICE Clinical Guideline (CG50) regarding physical deterioration of patients within a mental health and learning disability Trust)
- We will support both our staff and service users to reduce the harm from smoking with the aim to improve physical health, by implementing the Trust Nicotine Management policy.
- Learning Disability teams will improve health and well-being within their client population, for example by encouraging service users to access annual health checks and supplying easy read literature on health checks within local welcome packs.

- We will engage with Education partners in research which leads to developing new models of care and interventions, for example within the Mental Health Research Group, and links to the Research Departments at the Universities.
- We will continue to contribute to a number of research studies which will benefit our own service users and beyond to influence national practice.
- We will add value to our nursing care by participating in networks that drive innovation. Two examples we will continue to be involved in include:
    - NHS IQ: Improving the physical health of patients with serious mental illness - a practical toolkit. The Trust added value to the NHS IQ Project by managing the pilot project in TEWV to improve the cardiovascular health outcomes and reduce premature mortality in people with serious mental illness.
    - Department of Health Resource: Improving the physical health of people with mental health problems: Actions for mental health nurses. The resource focuses primarily on adults with common mental illness, severe mental illness (SMI) and personality disorder, with evidence based information in eight key action areas.
- We will use these resources to inform work programmes, working closely with external stakeholders and using information from external organisations to promote best practice and patient safety e.g. MHRA, Back Care Exchange, NICE.
- Learning Disability services will continue to work in Partnership with the North East and Cumbria Learning Disability Network through The GAPS (Good Access to Primary Care Services) Network and Access to Acute Network looking at improving access to primary and hospital care, access to screening, and reviewing deaths.
- We will utilise the best available evidence when developing services and delivering nursing interventions.
- We will support access to higher and PhD level programmes of study in line with service requirements, and will seek to co-ordinate and implement findings from Masters and Doctorate level research.
- We will continue to learn lessons from patient safety incidents, complaints, safeguarding issues, service user and carer feedback and implement recommendations emerging from these. Within this we will contribute to and lead on national patient safety initiatives and thematic reviews
- We will provide people with the information they require, in a suitable format to help them make choices about the treatment and support they receive
- We will promote health and wellbeing to all patients, carers and staff that come into contact with our services. We will continue to embed the Duty of Candour principles within our services and our approaches to learning lessons from incidents.

Objective 6: To increase nursing productivity through the reduction of waste and further embedding of technology and informatics to improve practice, address unwarranted variation and outcomes

Key messages – national
(This addresses the National Nursing Strategy Commitments 9 and 10)

Nurses are custodians of the precious resource within the NHS. Nursing staff have a responsibility to deliver excellent care whilst working in an effective, productive, sustainable and efficient way.

Ensure that the needs and ambitions of nursing staff are reflected in Local Digital Roadmaps, and help build a national picture of IT capability.

Actions we will take to achieve this:

- We will contribute as nurses to the development of QIS and lean approaches, including the PPCS programme within our Community and interlinked services, and the Model Wards developments, and implement the standardised approaches which emerge from this. The programme includes the aim of reducing unwarranted variation and standardising evidence-based lean approaches, in line with the aims of the national nursing framework.
- All Nursing and Governance Directorate teams will have dedicated in touch pages regularly monitored and updated to highlight relevant information, professional issues and good practice for colleagues across the Trust.
- We will continue the Implementation of the Royal Marsden Manual Online (RMMO) of clinical nursing procedures therefore being assured that the procedures we use will reflect the latest in evidence based practice**.**
- We will make use of the information available on our Trust systems, including e-roster performance indicators and IIC, and the forthcoming integrated approach to patient feedback for various sources, to inform our decision making and maintain safety and effectiveness in our services.
- We will make use of evolving technology to enhance our clinical decision making, providing access to the relevant information at the point of care.
- We will make effective and safe use of social media, in line with the NMC Code of Conduct, to help professional development and networking.
- We will continue to be involved in and influence Trust-wide technology–based projects making sure they support nurses to deliver effective and efficient nursing care.
- We will test and implement current technology and medical devices which enable maximum time to be freed up for care, enhance collaboration with service users and safety.

Section Five

Putting it into Practice, Metrics

Within the Trust, we will implement the new strategy by taking the objectives and actions outlined in the previous section and develop locality based implementation plans led by each of the Heads of Nursing. The Locality Professional Nursing Advisory Groups (PNAG's) will be the key forum for agreeing upon and monitoring the implementation of the strategy within their related services. An Executive Nursing Forum will be established to oversee progress of the strategy, this will seek to ensure there is standardisation and cross-learning where appropriate with other programmes (such as Recovery and Workforce), and to monitor trust-wide progress. We will ensure that nurses working in our wards and teams are given opportunities to comment on the implementation plans and provide feedback and evaluation of our progress as an organisation

We will evaluate the success of our strategy using two main methods;

- Monitoring of progress against the locality implementation plans in the PNAGs and at the Head of Nursing meetings. Building on this there will be an annual review of progress against the strategy led by the Director of Nursing and Governance, with reporting of key issues to the Trust Board.
- The development of a strategy scorecard consisting of a short set of key metrics for nursing linked to the strategy main topics, which is envisaged will link to the IIC system and enable areas to view their progress on professional nursing issues within a simple scorecard, aggregating up to a trust-wide position.
- EMT will review the scorecard and escalate to the Board issues as appropriate.

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday 26th September**
TITLE:	**NHS England Core Standards for Emergency Preparedness Resilience and Response**
REPORT OF:	**Brent Kilmurray, Chief Operating Officer**
REPORT FOR:	**Assurance**

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

Executive Summary:

It is 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 are requested to accept 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 26th September**
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 are divided into a number of categories and not all apply to the Trust.

3.2 The date for completion and submission of the self-assessment is September 2017.

3.3 As can be seen by reference to Appendix 1 and Appendix 2 of the standards that apply to the Trust, we have assessed ourselves as Fully Compliant.

3.4 In addition to the core standards, we are required this year to complete a self assessment on a Deep Dive section covering our Governance arrangements. There are two sections we have rated the Trust as Amber and actions have been included in the Emergency and Business Continuity Working Group work plan for 2017/18 to address. This section does not affect the Trust's compliance level.

3.5 This report has been approved by Audit Committee prior to being forwarded to Board of Directors.

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. Following an audit completed in April 2016 to evaluate the design and test the application of controls in place with regards to the Trust's emergency planning and business continuity (EP&BC) arrangements, the Trust received a Significant assurance level.

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 are requested to ratify the self assessment prior to submission to NHS England in September 2017.

Brent Kilmurray
Chief Operating Officer

Attachments:
Appendix 1 : EPRR Core Standards
Appendix 2 : EPRR Statement of Compliance 2017/18

Appendix 1	Core standard	Mental healthcare providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken
Governance				
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)	Y	**COO Director level accountability. EP BCM in post**	
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Y	**Annual work plan agreed and monitored via EP Working Group. Exercises planned within this. Trust plans in place in conjunction with Critical services BCP's.**	
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Y	**COO Director level accountability.Version controlled policies and plans in place. Exercises and tabletops undertaken to test plans Plans amended with lessons learnt**	
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	Y	**COO reports to the Trust Board on significant incidents and an Audit report by an outside agency has been undertaken to ensure Compliance**	

Appendix 1	Core standard	Mental healthcare providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken
Duty to assess risk				
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.	Y	**Risk register reviewed on a quarterly basis. BCP's udated on a regular basis with version controls in place. Summer and Winter plans are in place. A Fuel Policy is also in place Plans readily available and shared with outside agencies**	
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	Y	**LHRP plans available and accessible. Meetings attended by COO (or deputy) and EPBCP Manager. Suppliers information on their plans are documented within their contract LHRP identified risks considered when developing Trust risk register**	
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Y	**Risks are shared in the working groups of the LHRP and the LHRP eg MOU**	
Duty to maintain plans – emergency plans and business continuity plans				
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Y	**Internal Emergency and External Major Incident Plans in place and plans to manage identified risks**	
9		Y	**Corporate and Service Business Continuity Plans in place**	
10		Y	**HAZMAT/CBRN action cards included in plans**	
11		Y	**Summer and Winter Preparedness Plan in place**	
12		Y	**Pandemic Influenza Plan in place**	
13				
14				
15		Y	**Trust Fuel Plan in place**	
16		Y		
17		Y	**Summer and Winter plans in place**	
18		Y	**Pandemic Plan in place and discussed and assessed through the LHRP sub group**	
19		Y	**Evacuation action cards in place**	
20		Y	**Lock down procedures in place**	
21			**Action cards for loss of critical services in place**	
22				
23				

	Appendix 1 Core standard	Mental healthcare providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken
19	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Y	Evacuation action cards in place	
20		Y	Lock down procedures in place	
21			Action cards for loss of critical services in place	
22				
23				
24	Ensure that plans are prepared in line with current guidance and good practice which includes:	Y	Plans are updated on an annual basis and following an exercise, with a locality sitrep auditing system to ensure compliance. Plans are shared with other organisations through LHRP sub groups. Version controls are in place to ensure correct version in place.	
25	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Y	On call arrangements are in place with situation reports and telecommunications systems in place to inform the Trust's Emergency Planning Lead of any major incidents	
26	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Y	All Critical services have BCP's in place which document how to keep these services at an acceptalbe level in the event of disruption	
27	Arrangements explain how VIP and/or high profile patients will be managed.	Y	There are plans in place to ensure that VIP patients are managed appropriately within the services and also for Media interest.	
28	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content	Y	LHRP minutes will evidence the external stakeholder engagement	
29	Arrangements include a debrief process so as to identify learning and inform future arrangements	Y	Incidents / debrief events are discussed at the Emergency planning group to identify any learning outcomes	

Appendix 1	Core standard	Mental healthcare providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken
Command and Control (C2)				
30	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Y	**24/7 on call rota in place and tested . Single point of contact established for Emergency Business and Continuity incidents.**	
31	Those on-call must meet identified competencies and key knowledge and skills for staff.	Y	**All Directors and on call Managers have attended EPRR training as well as being part of all the exercises undertaken throughout the year**	
32	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	Y	**There are three Control rooms within the Trustt strategically placed. There are also Loggists and Admin support trained to support the Chair of the Control room in the event of an incident and appropriate details / plans are available**	
33	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.	Y	**Trained loggists and administrative support are available for Control Room**	
34	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.	Y	**Situations reports are part of every BCP and tested in exercises**	
35	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.		**N/A From the standards, however in the event of a firearms or chemical incident the Trust Security Policy illustrates contact details for the Police in the former and Public Health England in the latter. This is also demonstrated within each locality BCP**	
36	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;		**N/A from the standards perspective and is Acute Hospitals and Ambulance services responsibilities, however, they would laisse with NHS England who would then inform the Trust through the Local Resilience partnership.**	

Appendix 1	Core standard	Mental healthcare providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken
Duty to communicate with the public				
37	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Y	**Communications BCP in place as well as good communication links with NHS England and the LHRP**	
38	Arrangements ensure the ability to communicate internally and externally during communication equipment failures	Y	**All BCP's have plans in place for loss of Communications and technological failures of systems, as well as communication routes via sitreps for incidents**	
Information Sharing – mandatory requirements				
39	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	Y	**There is an agreement through the LHRP to share information which would be in the interest of the Patient and the General public.**	
Co-operation				
40	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)	Y	**The COO or deputy attends the LHRP and the EP Manager attends the appropriate sub groups. The LRFs feed into the LHRP to ensure communications are in place.**	
41	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA	Y	**LHRP attended for each of the two NHS England areas**	
42	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	Y	**Multi agency discussions discussd in LHRP sub groups**	
43	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		**The communications to the LHRP is within the Emergency Policy**	
44	Arrangements outline the procedure for responding to incidents which affect two or more regions.		**Sitreps completed when required by the Trust for NHS England and Unify2**	
45	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Y	**NHS England and members of the sub group are invited to the Trust exercises to ensure that they are aware of Mental Health roles in the event of an incident**	
46	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared		**The communications to the LHRP is within the Emergency Policy**	
47	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months		**NHS England and PHE communicate with the Trust in the event of any incident**	
48	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level	Y	**COO attends LHRP meetings**	

Appendix 1	Core standard	Mental healthcare providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken
Duty to communicate with the public				
Training And Exercising				
49	Arrangements include a curent training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	Y	**Training needs analysis** **Training plans approved EP working group**	
50	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	Y	**Exercise programme approved EP Working Group** **Report from exercises are completed with actions to be undertaken minimum 2 exercises completed each year which include all stakeholders. Exercises attended by NHS England and representatives from Category 1 and Category 2 responders**	
51	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises	Y	**Directors and Senior managers take part in exercises anually**	
52	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.	Y	**All Directors and most On call Managers have been trained**	

Core standard	Mental healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core	Action to be taken
eep Dive				
The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a pubic Board/Governing Body meeting for sign off within the last 12 months.	Y	• Organisation's public Board/Governing Body report • Organisation's public website	Presented to Audit Committee meeting September 2016	
The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	Y	• Organisation's Annual Report • Organisation's public website		EPRR assurance results to be included in EP section of 2017/18 Annual Report
The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	Y	• Organisation's Annual Report • Organisation's public Board/Governing Body report • Organisation's public website • Minutes of meetings		Appoint Non Executive Director
The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	Y	• Minutes of meetings		
The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group	Y	• Minutes of meetings		
The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings	Y	• Minutes of meetings		Regular Deputy is LP who attends meetings in the absence of the Appointed Lead

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)		Mental Health care providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken
Q	**Core standard**			
	Preparedness			
53	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Y	**Exercises are undertaken to include HAZMAT and CBRN so that the Critical BCP's within each locality can be tested.All BCP's have an annual update and a version control mechanism which is audited on a quarterly basis**	
54	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Y	**All Critical areas and reception areas have plans in place and these are accessible electronically**	
55	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	Y	**Approriate Dry decontamination action cards are in place throughout all 24 /7 areas of the Trust**	
56	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		**N/A**	
57	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	Y	**Action Cards identify the Line Managers responsibility to contact the relevent agencies. Exercises assist in the staff awareeness.**	
	Decontamination Equipment			

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)		Mental Health care providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken
Q	**Core standard**			
58	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	Y	**The packs contain Blue towels for wiping down. Plastic bags for placing clothing in. White suits for people to change into and ties to tie the bags up**	
59	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)		**N/A**	
60	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment		**N/A**	
61	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		**N/A**	
62	There are effective disposal arrangements in place for PPE no longer required.		**N/A**	

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)		Mental Health care providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken
Q	**Core standard**			
	Training			
63	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		**N/A**	
64	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	Y	**Exercises are undertaken to include HAZMAT and CBRN so that the Critical BCP's within each locality can be tested.All BCP's have an annual update and a version control mechanism which is audited on a quarterly basis**	
65	The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		**N/A**	
66	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	**Action Cards identify actions to be taken and exercises assist in raising staff awareness**	

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2017-18

STATEMENT OF COMPLIANCE

Tees Esk and Wear Valleys NHS Foundation Trust has undertaken a self-assessment against the NHS England Core Standards for EPRR (v5.0).

Following self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating the following level of compliance against the 2017-18 standards: **Full**

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with **one to five** of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed
Partial	Arrangements are in place however the organisation is not fully compliant with **six to ten** of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address **11 or more** core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

Where areas require further action, this is detailed in the organisations *EPRR Work Plan* and will be reviewed in line with the organisation's governance arrangements.

I confirm that the above level of compliance with the EPRR Core Standards has been or will be confirmed to the organisation's board / governing body.

Signed by the organisation's Accountable Emergency Officer

(Click in cell below and select date)
26/09/2017
Date of board meeting

(Click in cell below and select date)
26/07/2017
Date signed

Item 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26 September 2017**
TITLE:	**Finance Report for Period 1 April 2017 to 31 August 2017**
REPORT OF:	**Drew Kendall, Interim 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 2017 is a surplus of £4,345k, representing 3.1% of the Trust's turnover and is £73k ahead of plan.

Identified Cash Releasing Efficiency Savings at 31 August 2017 are £125k ahead of plan. The Trust continues to identify and develop schemes to ensure full delivery of CRES for current and future years.

The Use of Resources Rating for the Trust is assessed as 2 for the period ending 31 August 2017 and is behind plan, with agency expenditure being £5k higher than planned. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**26 September 2017**
TITLE:	**Finance Report for Period 1 April 2017 to 31 August 2017**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2017 to 31 August 2017.

2. BACKGROUND INFORMATION

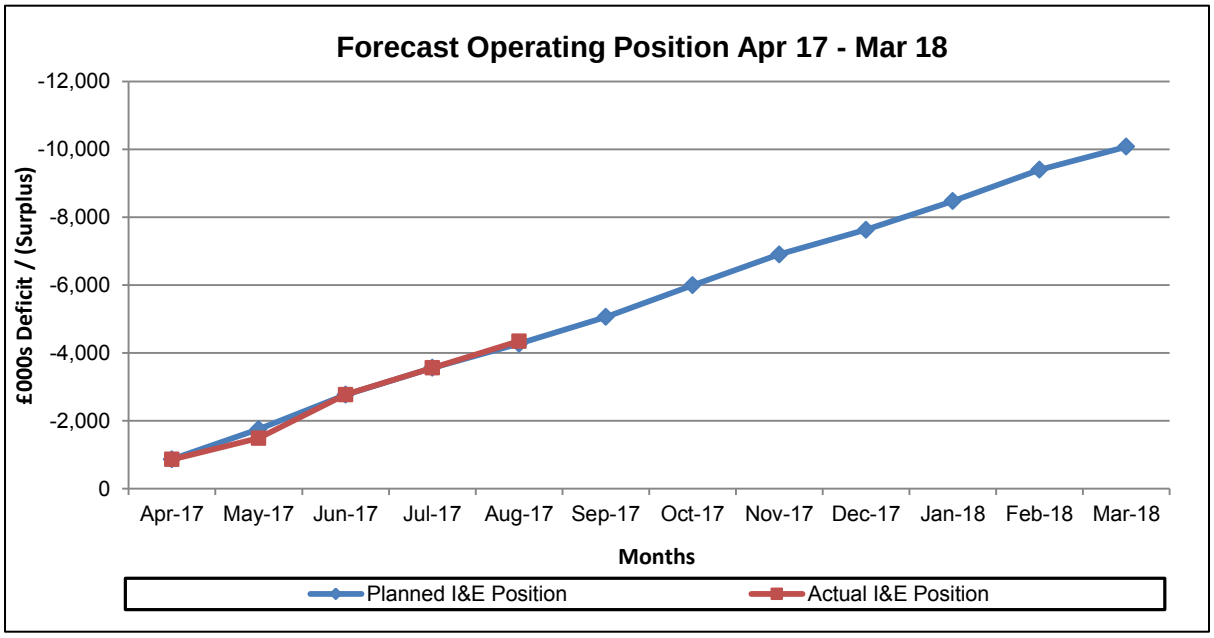
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis on a quarterly basis.

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

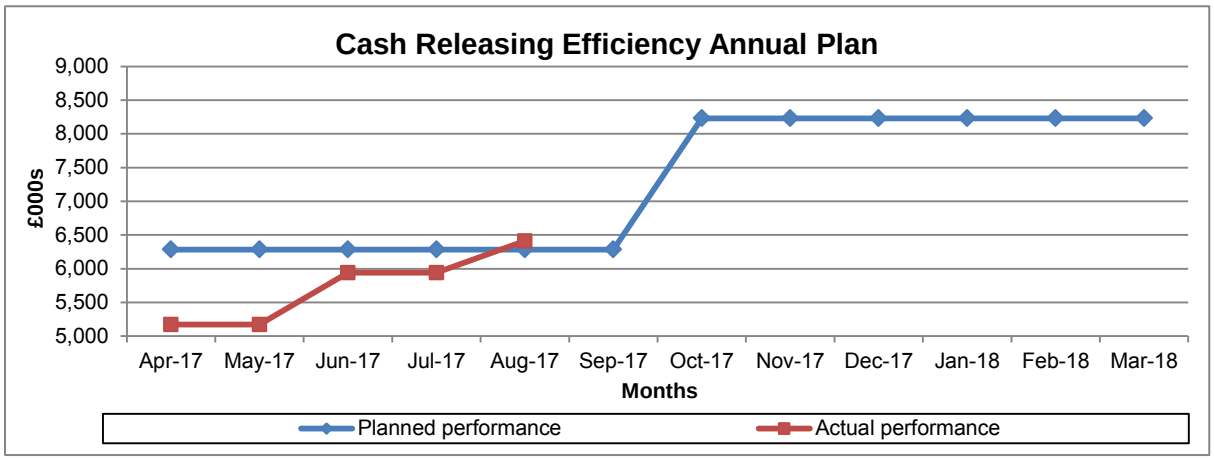
The comprehensive income outturn for the period ending 31 August 2017 is a surplus of £4,345k, representing 3.1% of the Trust's turnover and is £73k ahead of plan.

The graph below shows the Trust's planned operating surplus against actual performance.

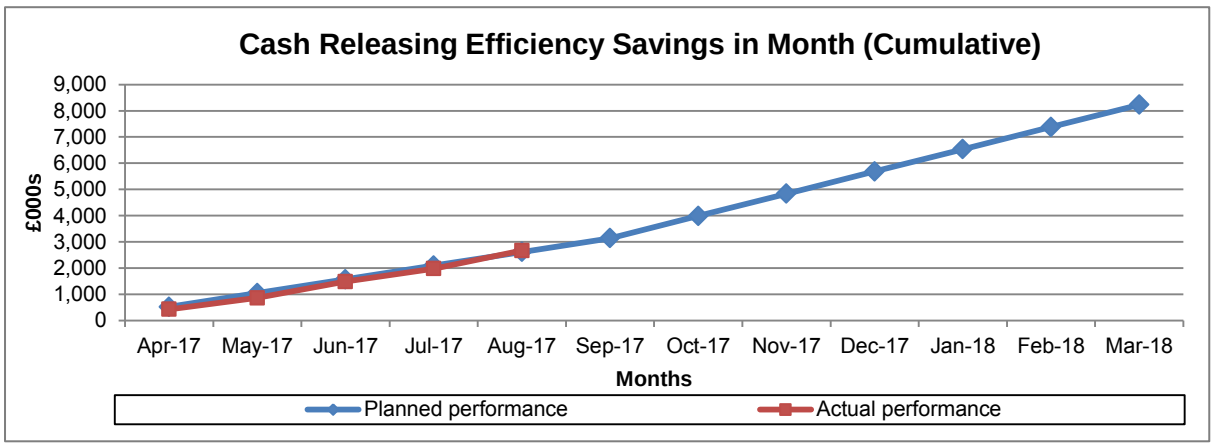


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 August 2017 is £6,409k and is £125k ahead of plan due to new schemes being identified. The Trust has, and continues to identify and progress schemes to deliver CRES in full for current and future years.

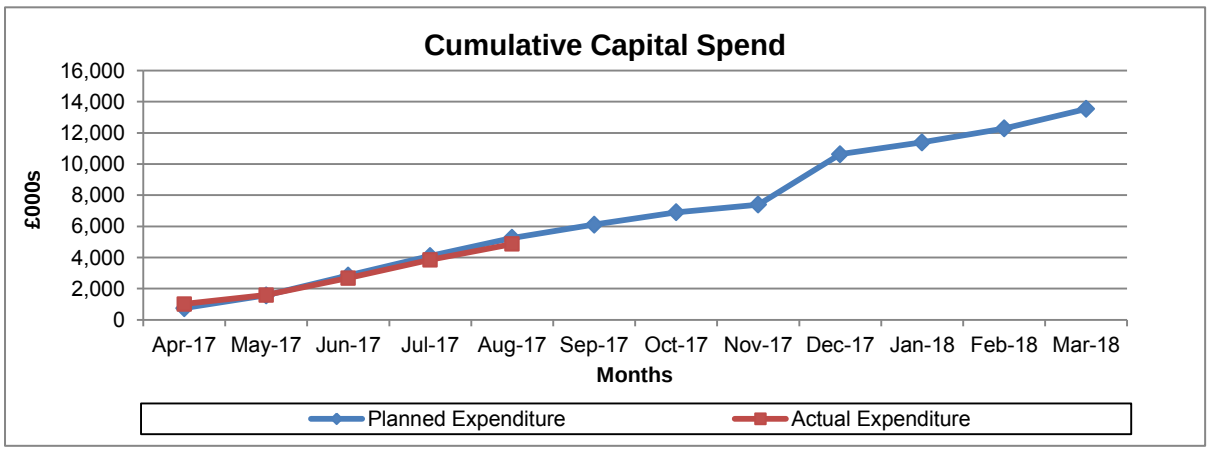


The monthly profile for CRES identified by Localities is shown below.



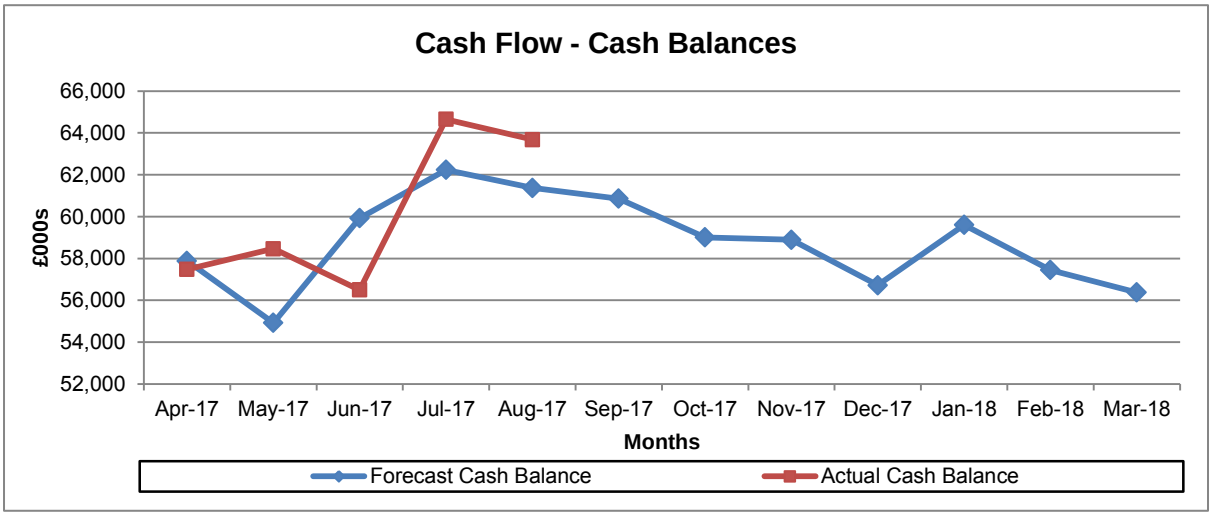
3.3 Capital Programme

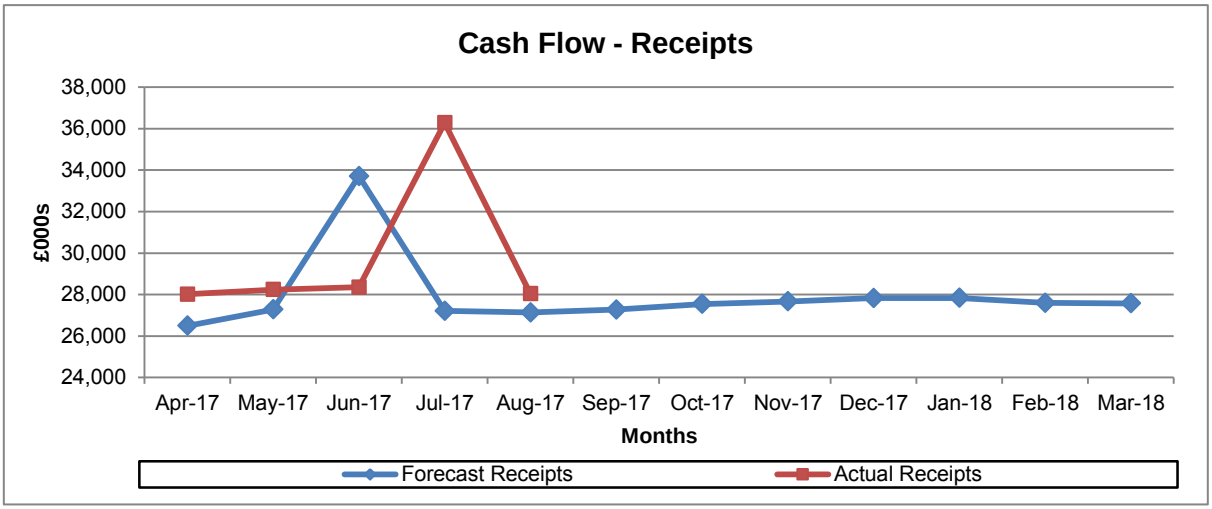
Capital expenditure to 31 August 2017 is £4,867k and is £396k behind plan due to minor delays against identified developments.

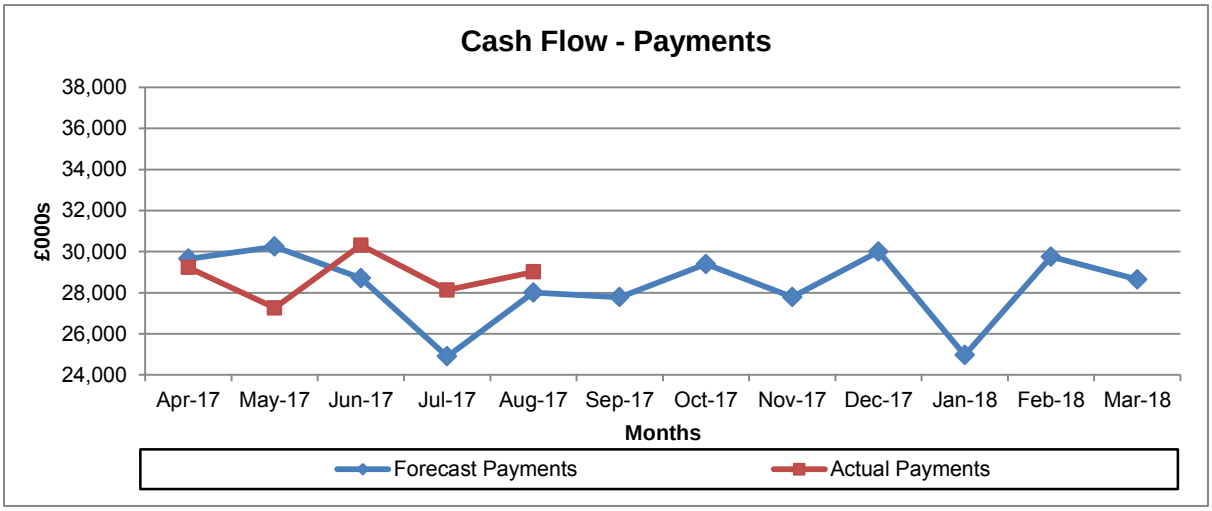


3.4 Cash Flow

Total cash at 31 August 2017 is £63,678k, and is £2,308k ahead of plan largely due to working capital variations.



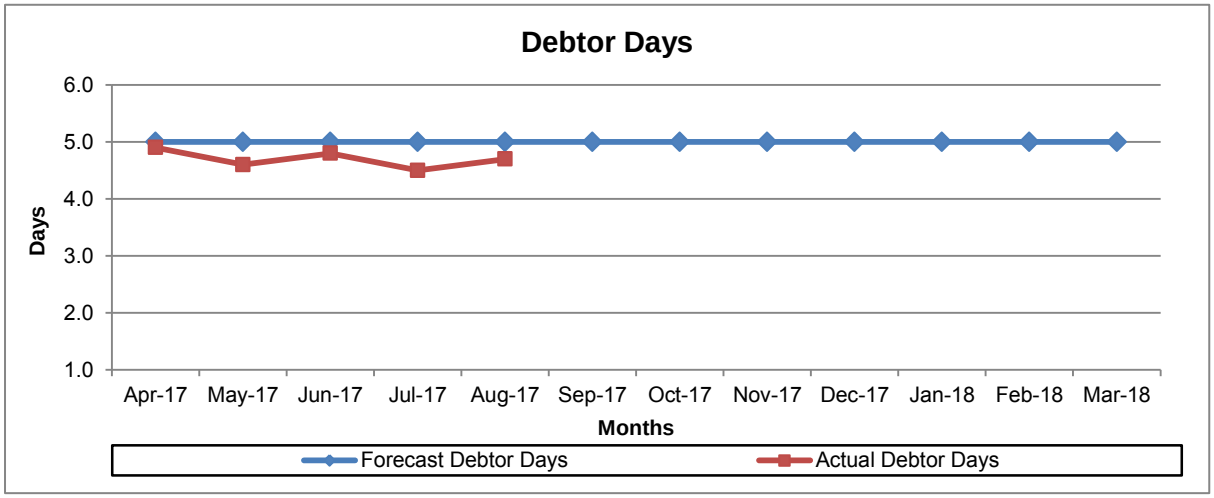




The receipts profile fluctuates over the year for 2016/17 Sustainability and Transformation Fund incentive scheme receipt. The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.

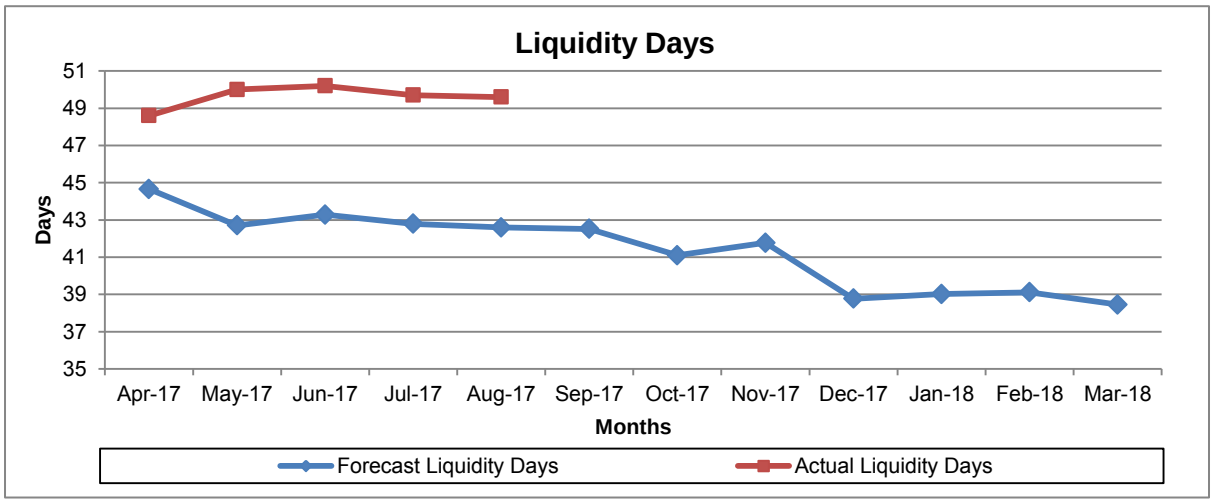
Working Capital ratios for period to 31 August 2017 are:

- Debtor Days of 4.7 days
- Liquidity of 49.6 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 58.9%
  Non NHS 30 Days – 97.2%



The Trust has a debtors' target of 5.0 days, and actual performance of 4.7 days at 31 August 2017, which is ahead of plan.

The liquidity days graph below reflects the metric within NHS Improvement's single oversight framework. The Trust's liquidity day's ratio is ahead of plan due to higher than planned net current assets.



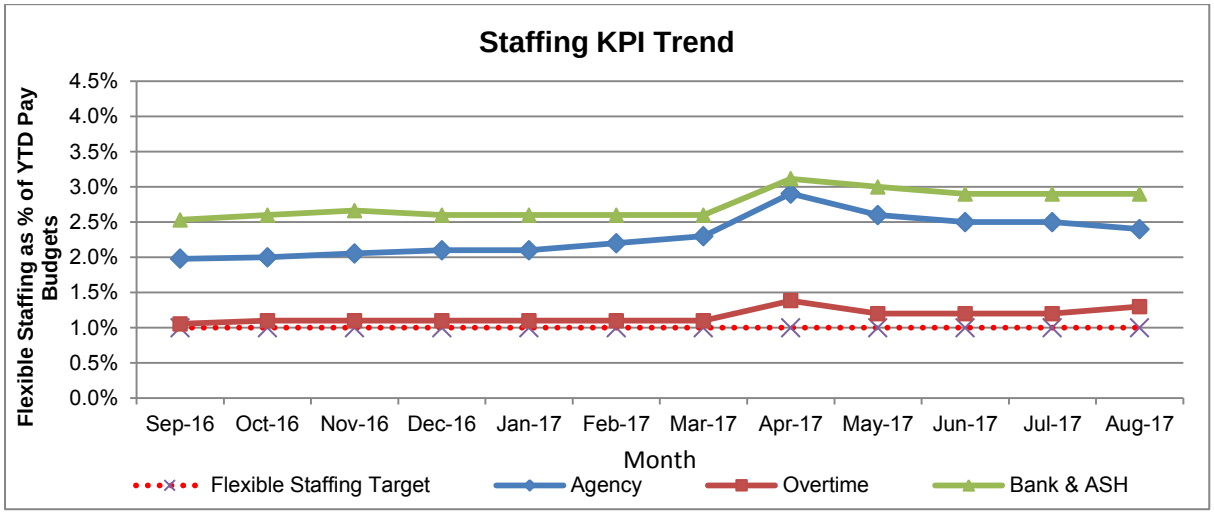
3.5 Financial Drivers

The following table and chart show the Trust's performance on some of the key financial drivers identified by the Board.

Tolerance	Mar	Apr	May	June	July	August
Agency (1%)	2.3%	2.9%	2.6%	2.5%	2.5%	2.4%
Overtime (1%)	1.1%	1.4%	1.2%	1.2%	1.2%	1.3%
Bank & ASH (flexed against establishment)	2.6%	3.1%	3.0%	2.9%	2.9%	2.9%
Establishment (90%-95%)	93.7%	94.6%	94.0%	94.2%	93.1%	93.1%
Total	**99.8%**	**102.0%**	**100.8%**	**100.9%**	**99.7%**	**99.7%**

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 2017 the tolerance for Bank and ASH is 4.9% of pay budgets.

The following chart shows performance for each type of flexible staffing.



Additional staffing expenditure is 6.6% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (47%), enhanced observations (18%), service need (16%) and sickness (11%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating is assessed as 2 at 31 August 2017, and is behind plan. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year.

3.6.2 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 1.59x (can cover debt payments due 1.59 times), which is ahead of plan and rated as a 3.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 49.6 days; this is ahead of plan and is rated as a 1.

3.6.4 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 3.1% and is rated as a 1.

3.6.5 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 -0.1% and is behind plan and is rated as a 2.

3.6.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is £5k higher than the cap and is rated as a 2.

The margins on Use of Resource Rating are as follows:

- Capital service cover - to improve to a 2 a surplus increase of £1,033k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £41,627k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £2,955k is required.
- I&E margin distance from plan – to reduce to a 2 an operating surplus decrease of £112k is required.
- Agency Cap rating – to improve to a 1 a reduction in agency expenditure of £5k is required.

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%
Variance from control total	20	>=0%	-1%	-2%	<=-2%
Agency expenditure	20	<=0%	-25%	-50%	>50%

TEWV Performance	**Actual**		**YTD Plan**		**RAG**
	Achieved	Rating	Planned	Rating	**Rating**
Capital service cover	1.59x	3	1.51x	3	
Liquidity	49.6 days	1	42.6 days	1	
I&E margin	3.1%	1	3.2%	1	
I&E margin distance from plan	-0.1%	2	0.0%	1	
Agency expenditure	£2,575k	2	£2,570k	1	
Overall Use of Resource Rating		**2**		**1**	

3.6.7 17.2% of total receivables (£733k) are over 90 days past their due date, this is above the 5% finance risk tolerance. The Trust has received confirmation of payment for £354k of this debt. Excluding debts with confirmation to pay the ratio reduces to 8.9%, which represents 0.25% of the Trusts turnover at 31 August 2017. £284k of the remaining debt at risk is with other NHS organisations, and discussions are ongoing to arrange payment.

Internal controls have been reviewed and improved to ensure future issues are resolved before the 90 day threshold.

3.6.8 2.5% of total payables invoices (£324k) held for payment are over 90 days past their due date. This is within the 5% finance risk tolerance.

3.6.9 The cash balance at 31 August 2017 is £63,678 and represents 75.4 days of annualised operating expenses.

3.6.10 The Use of Resource Rating is forecast to remain a 2 at the end of the financial year.

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 The comprehensive income outturn for the period ending 31 August 2017 is a surplus of £4,345k, representing 3.1% of the Trust's turnover and is £73k ahead of plan.

6.2 Identified Cash Releasing Efficiency Savings at 31 August 2017 are £125k ahead of plan. The Trust continues to identify and develop schemes to ensure full delivery of CRES for current and future years.

6.3 The Use of Resources Rating for the Trust is a 2 for the period ending 31 August 2017 which is behind plan. The rating is forecast to remain a 2 at the end of the financial year.

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.

Drew Kendall
Interim Director of Finance and Information

ITEM 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th September 2017**
TITLE:	**Board Dashboard as at 31st August 2017**
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:

The purpose of this report is to provide the latest performance for the Board Dashboard as at 31st August 2017 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery.

As at the end of August 2017, 4 (21%) of the indicators reported are not achieving the expected levels and are red. This is the same position as the end July 2017 however all of these indicators are showing a declining position over the previous 3 months.

It should be noted that for the first time this year the three financial targets are achieving target. There has been however a decline in the overall position on workforce where two indicators are red (compared to none in July). Further details are provided in the key issues section of the report.

In respect of performance against the key NHSI operational indicators the Trust did not achieve in August 2017 the IAPT recovery target of 50%, set by NHSI. In August we achieved 48.55% and there is significant risk that we will not achieve the 50% for Quarter 2 (the combined July and August position is 49.7%). In terms of YTD the position is slightly above target at 50.5%.

Recommendations:
It is recommended that the Board consider the content of this paper and raise any areas of concern/query.

MEETING OF:	**Board of Directors**
DATE:	**26th September 2017**
TITLE:	**Board Dashboard as at 31st August 2017**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 31st September 2017 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery.

2. KEY ISSUES:

2.1 Performance Issues

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

- As at the end of August 2017, 4 (21%) of the indicators reported are not achieving the expected levels and are red. This is the same position as the end July 2017. All of these indicators are showing a declining position over the previous 3 months.

  It should be noted that for the first time this year the three financial targets are achieving target. There has been however a decline in the overall position on workforce where two indicators are red (compared to none in July). Further details are given below.

  There are a further 5 indicators which whilst not completely achieving the target levels are within the amber tolerance levels (which is the same number as reported for July.).

- In respect of performance against the key NHSI operational indicators the Trust did not achieve in August 2017 the IAPT recovery target of 50%, set by NHSI. In August we achieved 48.55% and there is significant risk that we will not achieve the 50% for Quarter 2 (the combined July and August position is 49.7%). In terms of YTD the position is slightly above target at 50.5%. There continues to be wide variation at CCG level with performance ranging from 37.3% in Vale of York (a slight improvement on the July position) to 55.8% in North Durham CCG. In total we did not deliver the 50% target in 4 of the 7 CCGs (Vale of York, Scarborough and Ryedale, Darlington and Harrogate). Action plans are in operation in all areas where performance is not achieving target and support from the National Intensive Support Team is still being accessed.

- Appendix B includes the breakdown of the actual number of unexpected deaths.

2.2 Data Quality Assessment.

The Data Quality Scorecard is included in Appendix C. There has been no change from the previous month to highlight to the Board.

2.3 The key risks are as follows:

- Referrals (KPI1) – The number of referrals received in August reduced further from July as has been the trend in previous years. However in previous years we have seen a 'bounce back' of the number of referrals in the month of September following the 'holiday' period so this is likely to be seen in next months report.
- Bed Occupancy (KPI 3) – The Dashboard shows that bed occupancy at a Trust level has reduced further in August and is now slightly below the 85% target. Whilst there is some variation across the localities it is proposed that if this position continues into September that this indicator will not be reported as a risk in future reports.
- Number of instances of patients who have 3 or more admissions in a year (KPI 6) – This indicator is flagged as a risk because there has been an increasing position since the start of the year and the figure is the highest it has been since July 2016. Durham and Darlington account for 42% of the total Trust position and the reasons for this are currently being explored with the services. A verbal update will be provided at the Board meeting.
- Number of unexpected deaths (KPI 11) – There has been a further rise in the number of unexpected deaths with 11 being reported in August. Whilst this is the highest number that has occurred since July 2015 no obvious hotspots/specific themes have been identified at this time.
- Sickness (KPI 20) – There has been an increase in the amount of sickness reported in August to 5.38% which is the highest it has been since January 2016. This is particularly concerning as it is not a position we would expect to see at this time of year. Further work is being undertaken by the HR department to identify particular issues/areas of concern so that targeted action can be taken.

2.4 Review of Targets

As agreed with the Board a review of the targets using the month 4 actual position has been undertaken and discussed with the EMT. Whilst EMT noted that for some indicators performance has been better than the targets set this relates in the main to new/changed indicators. EMT therefore recommend that there is no change to the targets at this time but that a further review is undertaken once the 6 monthly position is known.

3. RECOMMENDATIONS:

3.1 It is recommended that the Board consider the content of this paper and raise any areas of concern/query.

Sharon Pickering
Director to Planning, Performance and Communications

Background Papers:

Appendix A - Trust Dashboard Summary for TRUST

Activity

	August 2017				April 2017 To August 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Total number of External Referrals into Trust Services	7,793.00	8,480.00			38,463.00	42,960.00		91,759.00
2) Caseload Turnover	1.99%	-1.30%			1.99%	-1.30%		1.99%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	84.19%			85.00%	86.01%		85.00%
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	75.00	56.00			75.00	56.00		75.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	8.21%			10.00%	9.12%		10.00%
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	20.00	27.00			99.00	119.67		237.00

Quality

	August 2017				April 2017 To August 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	90.00%	92.49%			90.00%	90.52%		90.00%
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	9.64%			10.00%	8.99%		10.00%
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	13.41%			20.00%	13.16%		20.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	92.50%			92.45%	92.32%		92.45%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	2.21			5.00	5.40		12.00

Trust Dashboard Summary for TRUST

Workforce

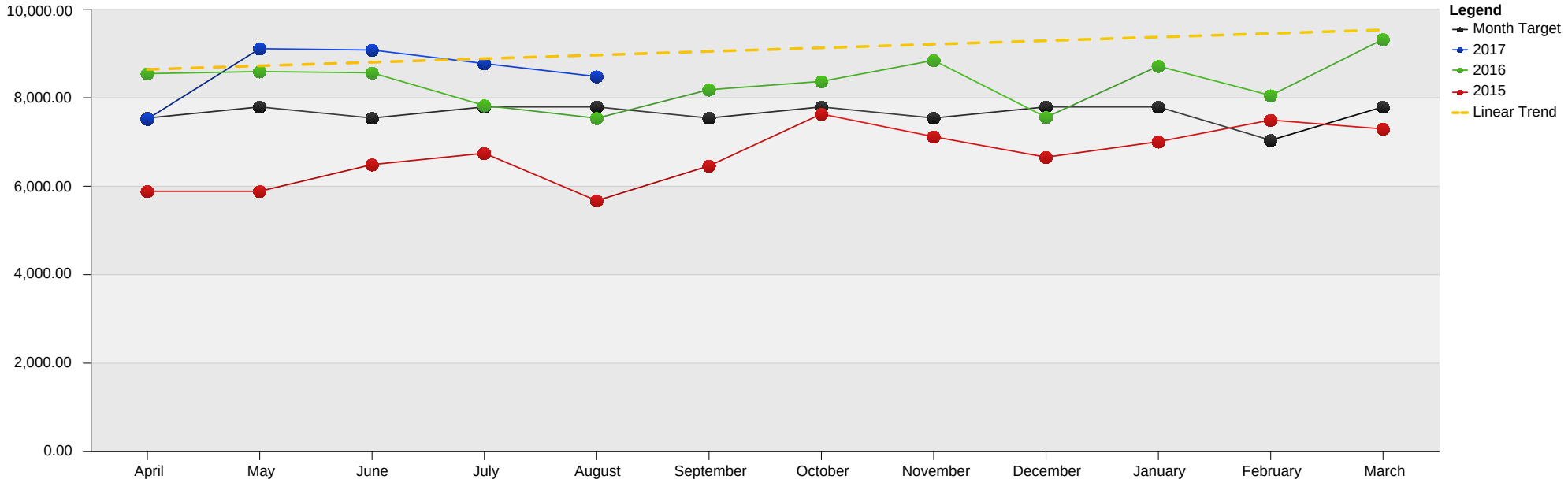
	August 2017				April 2017 To August 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	93.08%			100.00%	93.08%		100.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	31.82%			15.00%	19.30%		15.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	92.49%			95.00%	92.49%		95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	89.04%			90.00%	89.04%		90.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	5.38%			4.50%	4.80%		4.50%

Money

	August 2017				April 2017 To August 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-713,000.00	-777,000.00			-4,272,000.00	-4,345,000.00		-10,076,000.00
20) CRES delivery	523,680.00	690,332.93			2,618,400.00	2,670,323.93		8,230,080.00
21) Cash against plan	61,370,000.00	63,678,000.00			61,370,000.00	63,678,000.00		56,376,000.00

Trust Dashboard Graphs for TRUST

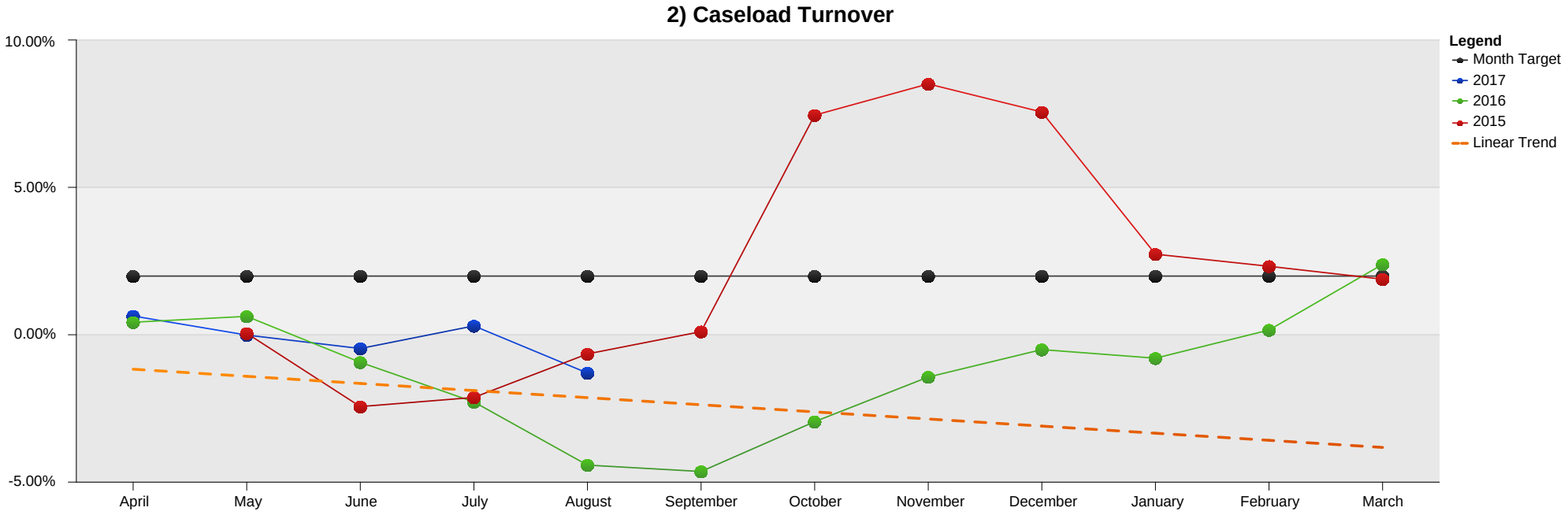
1) Total number of External Referrals into Trust Services



	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) Total number of External Referrals into Trust Services	8,480.00	42,960.00	2,047.00	9,871.00	2,392.00	12,386.00	2,064.00	10,448.00	646.00	3,198.00	1,331.00	7,056.00		

Narrative
The Trust position for August 2017 is 8,480 which is not meeting the Trust target of 7,793. This is a decrease on the number of referrals received in July 2017 and follows a similar trend seen in 2016/17 over the period May to August. Whilst this is bringing the actual closer to the expected level the figure continues to be one of the highest numbers of referrals recorded since 15/16. No localities are meeting target. Based on current trends it is anticipated that we will exceed the annual target of 91,759
The Trust position for August 2017 is 8,480 which is not meeting the Trust target of 7,793. This is a decrease on the number of referrals received in July 2017 and follows a similar trend seen in 2016/17 over the period May to August. Whilst this is bringing the actual closer to the expected level the figure continues to be one of the highest numbers of referrals recorded since 15/16. No localities are meeting target. Based on current trends it is anticipated that we will exceed the annual target of 91,759

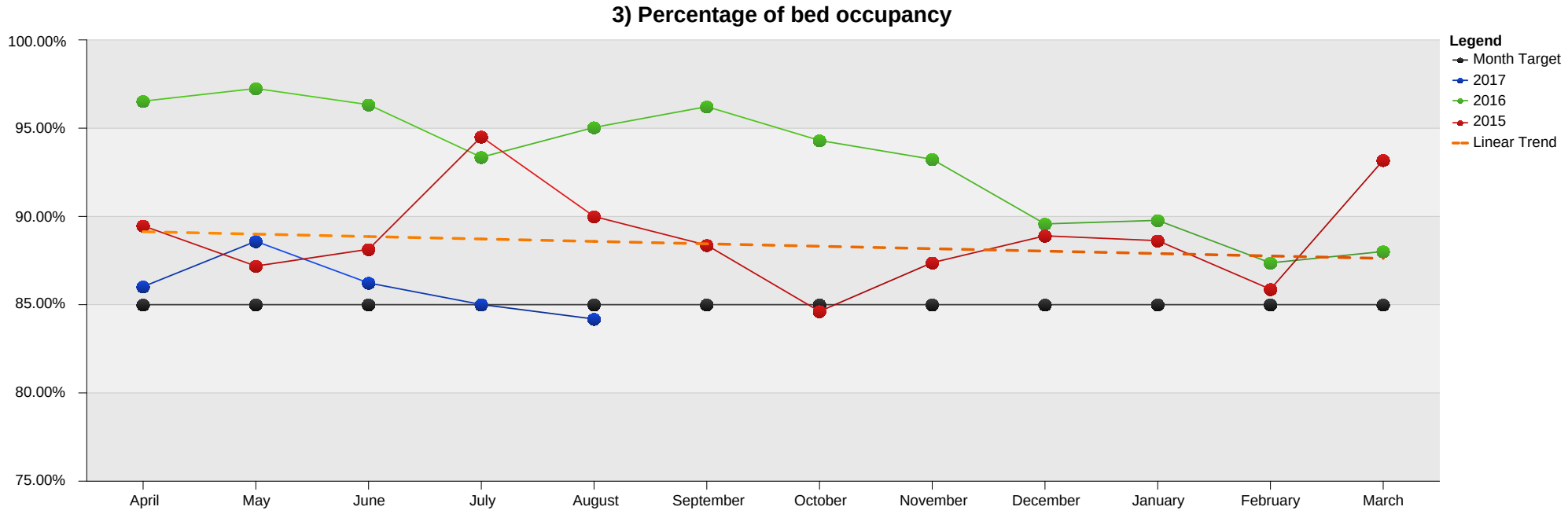
Trust Dashboard Graphs for TRUST



	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
2) Caseload Turnover	-1.30%	-1.30%	-0.14%	-0.14%	-0.23%	-0.23%	-0.16%	-0.16%	NA	NA	-7.11%	-7.11%		

Narrative
The Trust position for August 2017 is -1.30% which is meeting the Trust target of 1.99%. This is an improvement to that reported in July 2017.
All localities are meeting target.
Based on current trends it is anticipated that we will meet the annual target of 1.99%

Trust Dashboard Graphs for TRUST

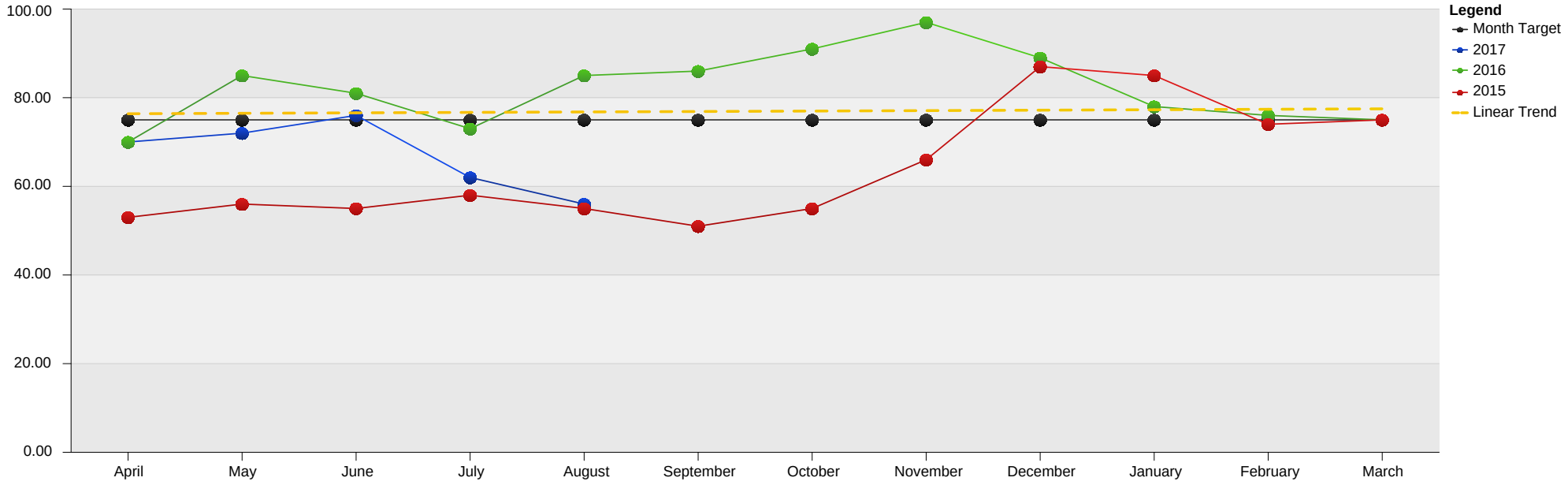


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	84.19%	86.01%	84.23%	88.13%	83.51%	86.74%	90.55%	90.00%	NA	NA	76.73%	75.08%		

Narrative
The Trust position for August 2017 is 84.19% which is slightly worse than the Trust target of 85.00% and a slight deterioration to that reported in July 2017. This position continues to be at similar levels to the improvements seen in the latter part of 2016/17 and one of the best positions since 2015/16. North Yorkshire reports the highest bed occupancy at 90.55% and this is due to the high number of admissions to the service and also a number of out of area admissions into North Yorkshire from other areas in the Trust. Delayed discharges have also impacted on available beds however the numbers are reducing. York and Selby report the lowest bed occupancy at 76.73% which is due to the low occupancy in MHSOP (Meadowfields and Acomb Garth). This is due to the positive impact of the care home liaison team.

Trust Dashboard Graphs for TRUST

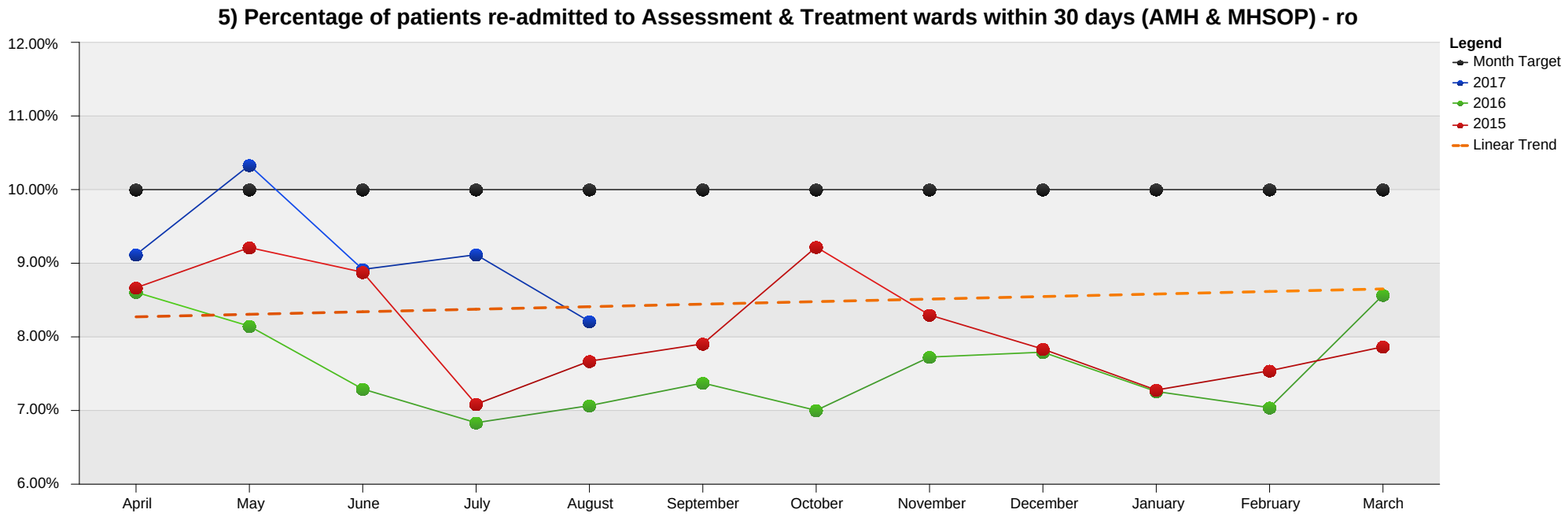
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH



	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) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	56.00	56.00	11.00	11.00	12.00	12.00	23.00	23.00			9.00	9.00		

Narrative
The Trust position for August 2017 is 56 which is meeting the target of 75 and is an improvement compared to that reported in July 2017; this position continues to be one of lowest recorded since 2016/17. Only Teesside and North Yorkshire are not achieving target. Of the 56 patients occupying a bed with a LoS greater than 90 days: • 12 (21%) were within Durham and Darlington (2 MHSOP and 10 ADULTS) • 9 (16%) were within York & Selby (8 MHSOP AND 1 ADULTS) • 12 (21%) were within Teesside (7 MHSOP and 5 ADULTS) • 23 (42%) were within North Yorkshire (12 MHSOP and 11 ADULTS) In North Yorkshire delayed transfers of care in AMH and MHSOP linked to the availability of community placements continues to impact, however improvements have been seen. Close liaison with North Yorkshire County Council continues to review any barriers to discharge. In Tees all patients are subject to review at 60 days and discussed in weekly report outs. Access to nursing home placements continues to be a cause of concern and is being addressed.

Trust Dashboard Graphs for TRUST

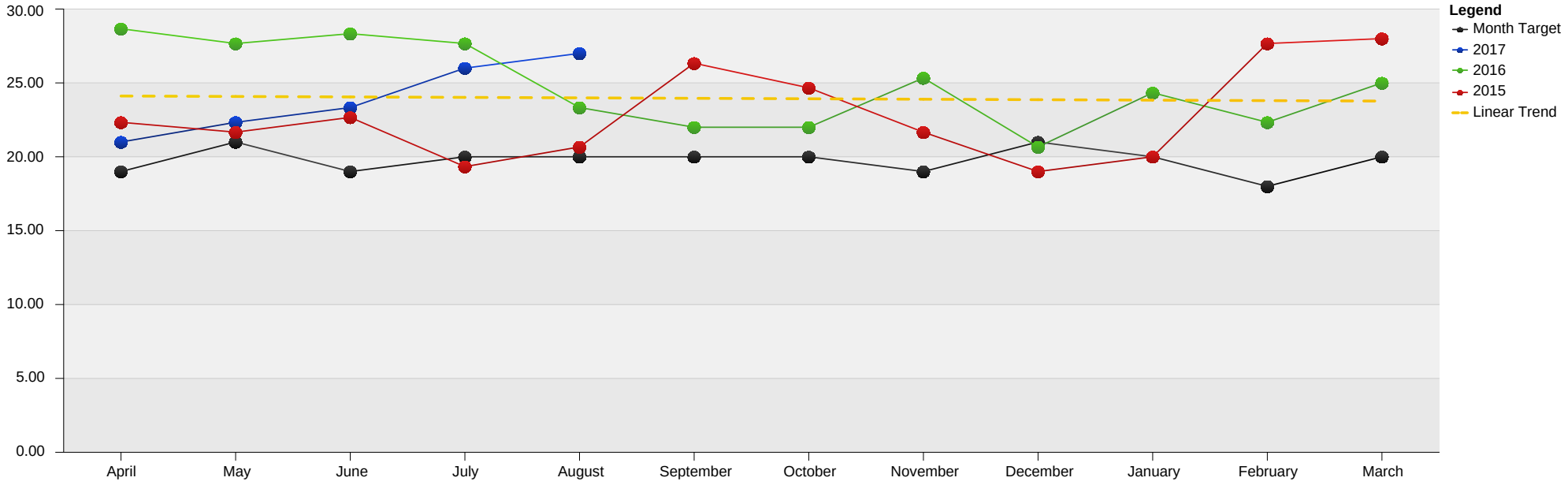


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	8.21%	9.12%	8.42%	8.39%	9.88%	9.15%	5.77%	7.35%			8.33%	12.83%		

Narrative
The Trust rolling 3 month position ending August 2017 is 8.21%, which relates to 21.99 patients out of 268 that were readmitted within 30 days. This is meeting the target of 10% and is an improvement on the position reported in July 17. Of the 21.99 patients re-admitted: • 7.99 (36%) were within Durham & Darlington (6.66 AMH and 1.33 MHSOP) • 2.99 (14%) were within York and Selby (2.66 AMH 0.33 MHSOP) • 2.99 (14%) were within North Yorkshire (2.99 AMH and 0 MHSOP) • 7.99 (36%) were within Teesside (7.66 AMH 0.33 MSOP) (*Please note data is displayed in decimal points due to the rolling position being calculated.) All localities are meeting target for this indicator.

Trust Dashboard Graphs for TRUST

6) Number of instances of patients who have 3 or more admissions in a year (AMH and MHSOP)

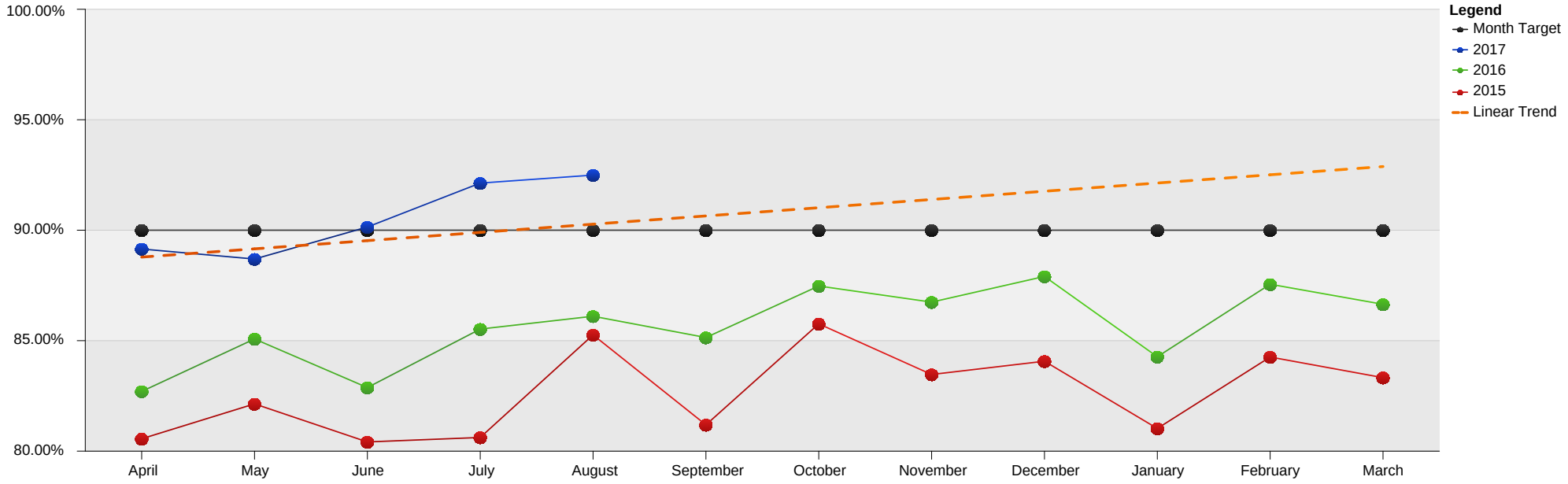


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	27.00	119.67	11.00	44.67	6.33	21.67	4.33	26.33			4.67	23.00		

Narrative
The Trust rolling 3 month position ending August 2017 is 27.00, which is 7.00 worse than the target of 20 and a deterioration compared to the position reported in July 2017 and a deterioration compared to that in August 2016. Overall a deteriorating trend is seen over 2017/18. Only North Yorkshire are achieving target. Of the 27 3 or more readmissions: • 10.99 (42%) were within Durham & Darlington (10.33 AMH and 0.66 MHSOP) • 6.33 (24%) were within Teesside (6.33 AMH) • 4.33 (17%) were within North Yorkshire (3.99 AMH and MHSOP 0.33) • 4.66 (17%) were within York and Selby (4.66 AMH) (*Please note data is displayed in decimal points due to the rolling position being calculated.)

Trust Dashboard Graphs for TRUST

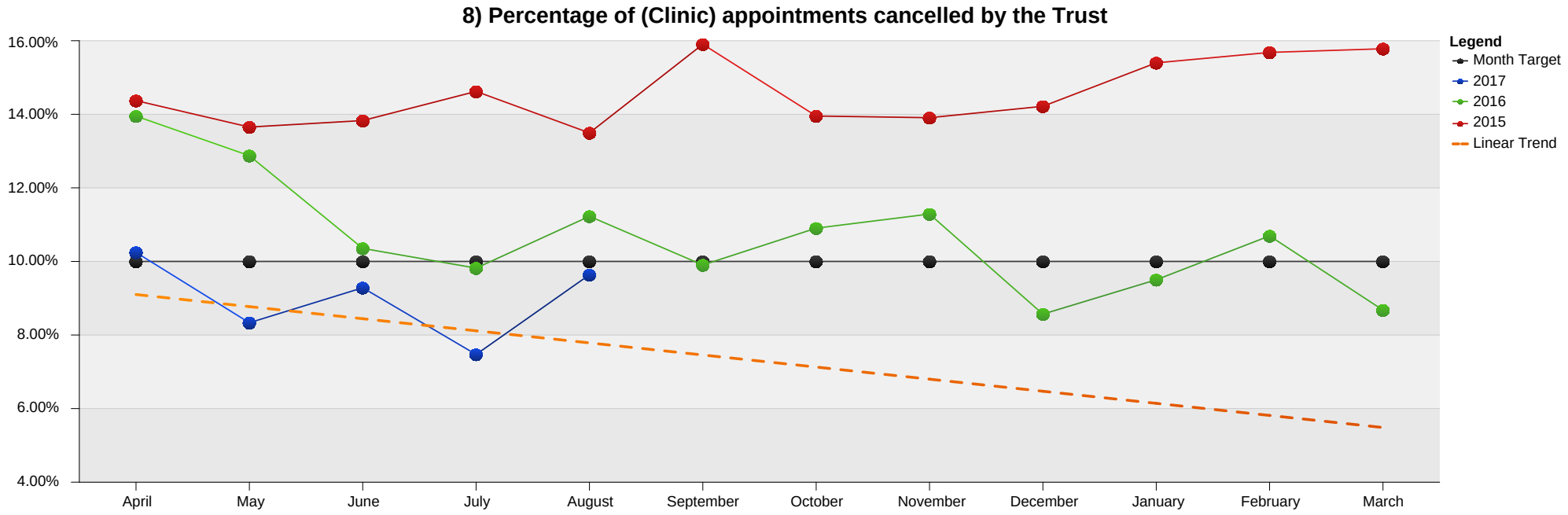
7) Percentage of patients seen within 4 weeks for a first appointment (external referral)



	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
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	92.49%	90.52%	91.08%	88.76%	98.96%	98.54%	87.06%	84.04%	100.00%	99.73%	77.40%	73.40%		

Narrative
The position for August 2017 is 92.49%, relating to 418 patients out of 5569 who waited longer than 4 weeks. This is meeting target and an improvement on the July 2017 position. This is an excellent performance position and the third month that the target has been met since the 4 week indicator was introduced. Areas of concern: • York and Selby Adults at 57.76% (68 out of 161 patients). This is a slight improvement on the July position and an action plan continues to be in place to address areas of concern. • North Yorkshire NHSHOP at 82.56% (75 out of 430 patients) and an action plan continues to be in place. • Durham and Darlington Adults at 79.28%. (98 out of 473 patients) This continues to be due to medic availability and an action plan is in place, a slight improvement in performance has been seen

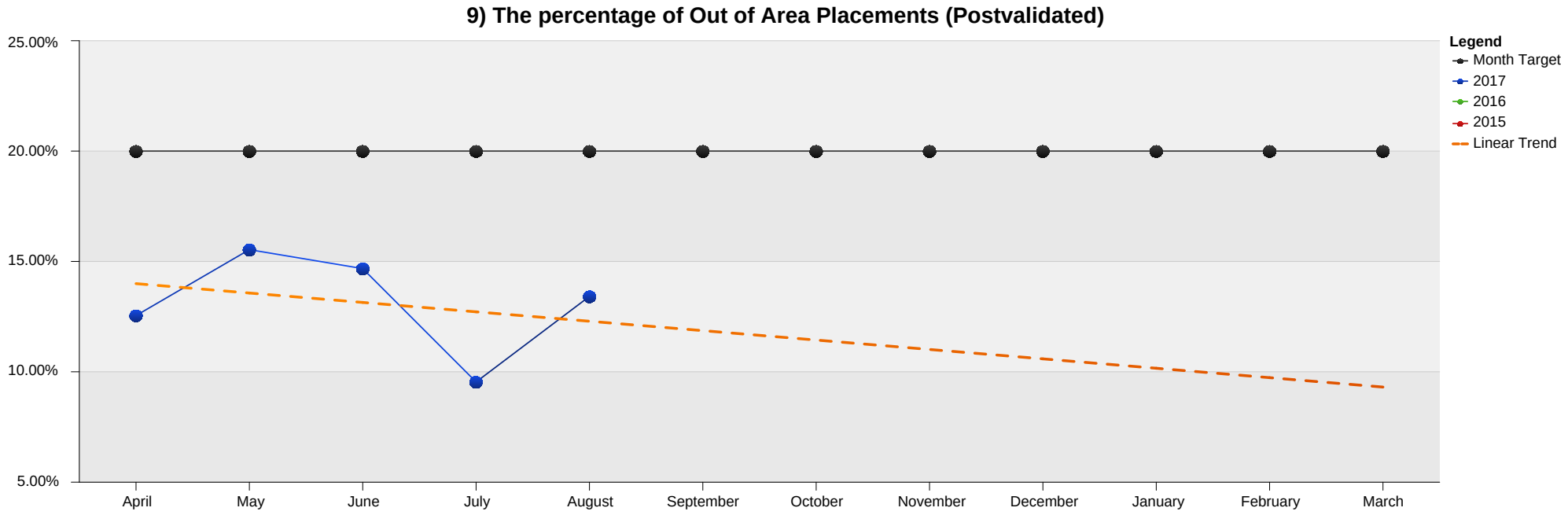
Trust Dashboard Graphs for TRUST



	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
8) Percentage of (Clinic) appointments cancelled by the Trust	9.64%	8.99%	12.01%	12.01%	5.72%	6.03%	13.07%	10.93%			3.93%	3.41%		

Narrative
The Trust position for August 2017 is 9.64% which relates to 311 clinic appointments out of 3227 that have been cancelled. This is meeting the target of 10% however a deterioration on the position in July 2017 but an improvement on the figure reported for August 2016. Durham and Darlington and North Yorkshire are not meeting target. The position in North Yorkshire is due to staff vacancies and the service are progressing recruitment options. The position in Durham has been shared with the Head of Service who is investigating further.

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
9) The percentage of Out of Area Placements (Postvalidated)	13.41%	13.16%	3.74%	6.42%	4.67%	1.70%	39.71%	35.48%			14.63%	26.73%		

Narrative

The Trust position for August 2017 is 13.41%, which relates to 44 admissions out of 328 that were inappropriately admitted out of area. This is better than the target of 20%, but represents a deterioration on the improving trend seen over the previous 3 months.

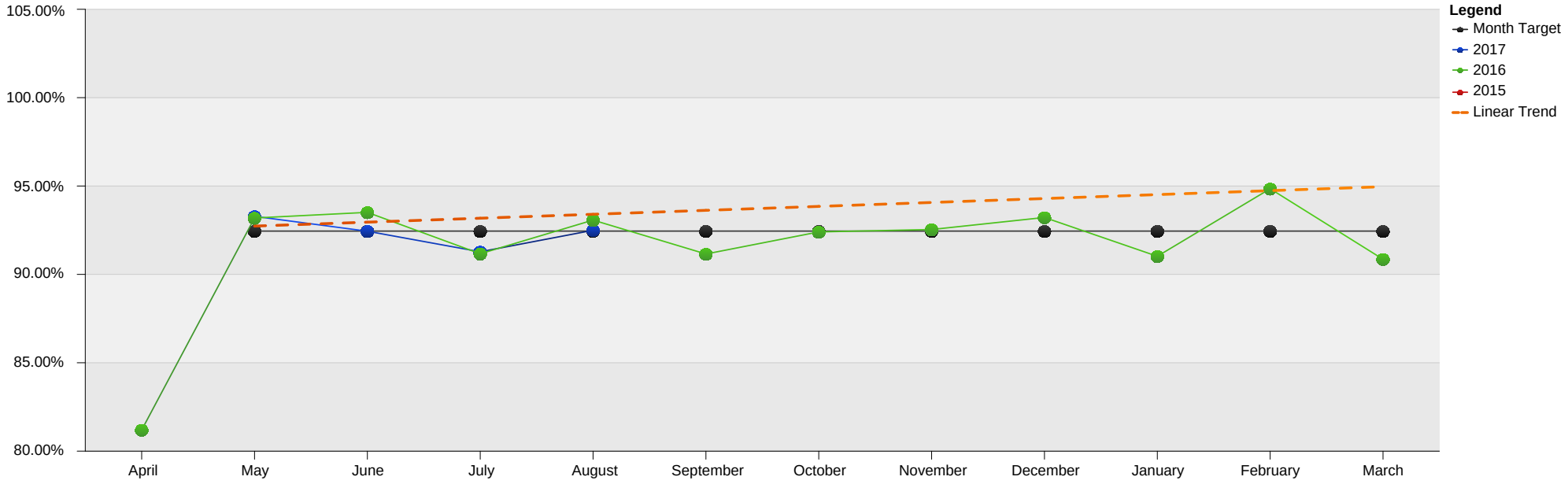
The construction of this indicator has been amended so that it now matches that of the national definition. Therefore there is no historic data available to compare previous performance.

All localities are meeting target with the exception of North Yorkshire. The high level of bed occupancy in North Yorkshire will be impacting on this position.

Of the 44 patients (AMH 29, MHSOP 15) a breakdown of reasons for out of area admission is provided below:
- 14 x patient choice
- 11 x patient / staff safety
- 11 x safeguarding
- 10 x bed availability.

Trust Dashboard Graphs for TRUST

10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		UNKNOWN		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.50%	92.32%	92.44%	92.81%	92.90%	93.13%	92.98%	93.29%	88.89%	80.56%			91.46%	92.27%

Narrative

The Trust position reported in August relates to July's performance. The Trust position for July 2017 is 92.50% which is meeting the target of 92.45% and an improvement on the on the position in June 2017. This represents an improvement on the decreasing trend seen over the previous 3 months.

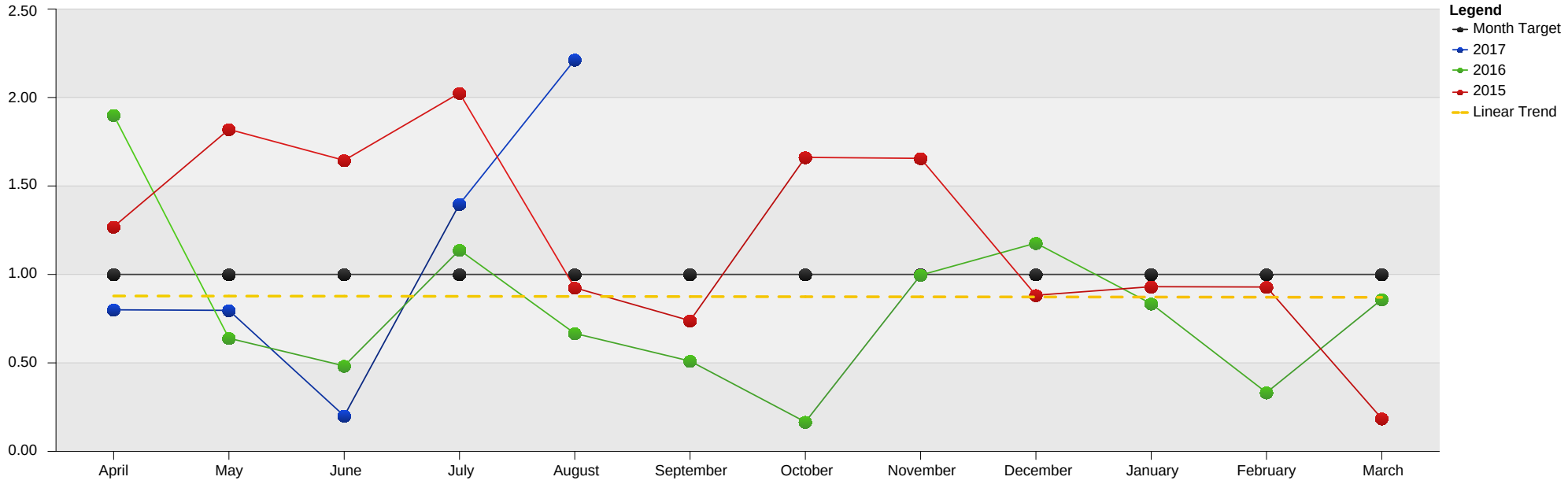
Forensic services continue to report the poorest performance, Teesside and North Yorkshire are the only localities to meet target.

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).

Due to an amendment to the indicator for this year, data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available.

Trust Dashboard Graphs for TRUST

11) 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
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	2.21	5.40	2.01	3.52	1.55	5.38	2.15	7.61	0.00	100.00	4.00	6.39		

Narrative

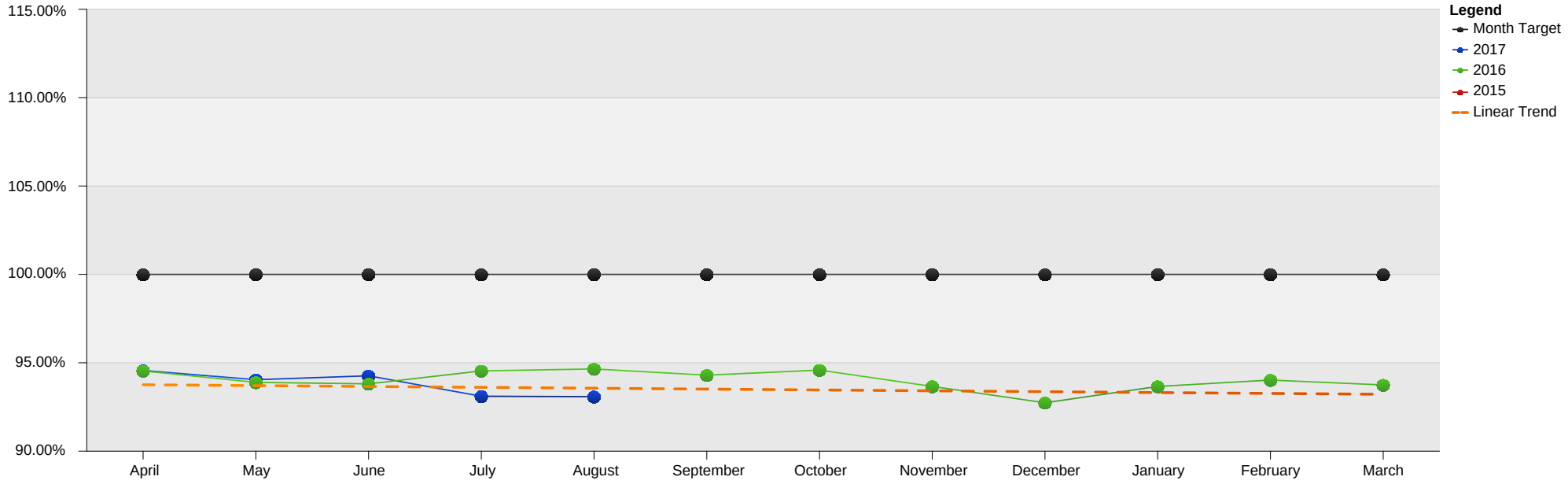
The Trust position for August 2017 is 2.21, which is above the expected number of 1.00. This rate relates to 11 unexpected deaths which occurred in August. This is an increase on the position of no unexpected deaths that was reported in July 2017. This is also an increase on the position reported in August 2016 and is the highest number recorded since 2015/16.

Of the 11 unexpected deaths the table below shows a breakdown by locality:

- 4 x Durham and Darlington
- 3 x York and Selby
- 2 x North Yorkshire
- 2 x Teesside

Trust Dashboard Graphs for TRUST

14) Actual number of workforce in month (Establishment 95%-100%)

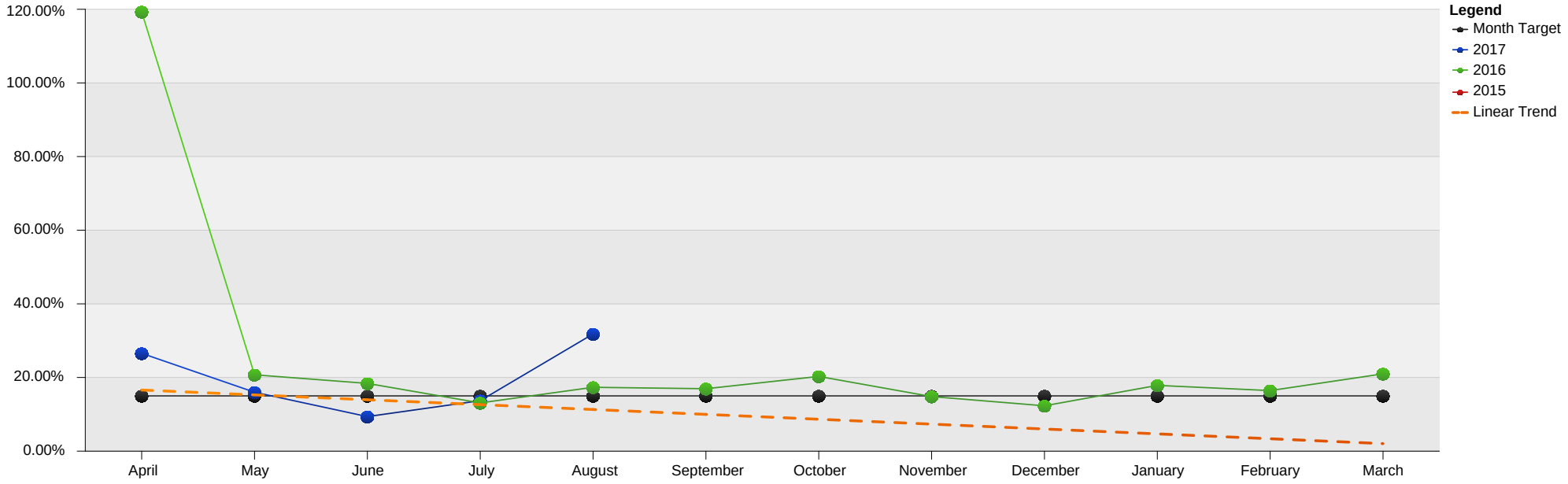


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Actual number of workforce in month (Establishment 95%-100%)	93.08%	93.08%	94.92%	94.92%	95.25%	95.25%	92.20%	92.20%	91.28%	91.28%	89.74%	89.74%		

Narrative
The Trust position for 31 August 2017 is 93.08% which is below the targeted establishment level of 95-100%. It is anticipated that this figure will improve following a number of recruitment events where the Trust have successfully appointed to nursing vacancies with start dates of September 2017 agreed upon completion of training.

Trust Dashboard Graphs for TRUST

15) Percentage of registered healthcare professional jobs that are advertised two or more times

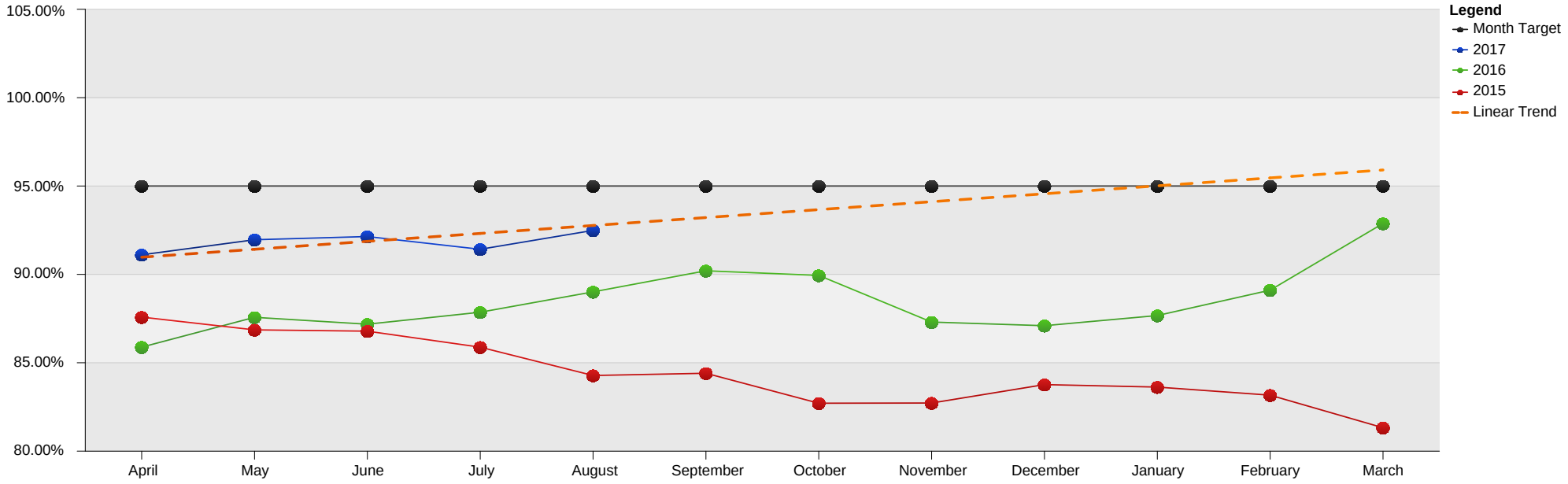


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Percentage of registered healthcare professional jobs that are advertised two or more times	31.82%	19.30%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
The position for August 2017 is 31.82% which is not meeting the target of 15.00%. This represents a significant deterioration on the previous month. There were 17 jobs re-advertised in August out of a total of 59 posts advertised for registered healthcare professional jobs. The majority of the posts were nursing opportunities in the Band range 5 to 7, along with a number of psychological wellbeing practitioner posts. Further work is to be completed by HR to understand the key areas of concern and themes.

Trust Dashboard Graphs for TRUST

16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)

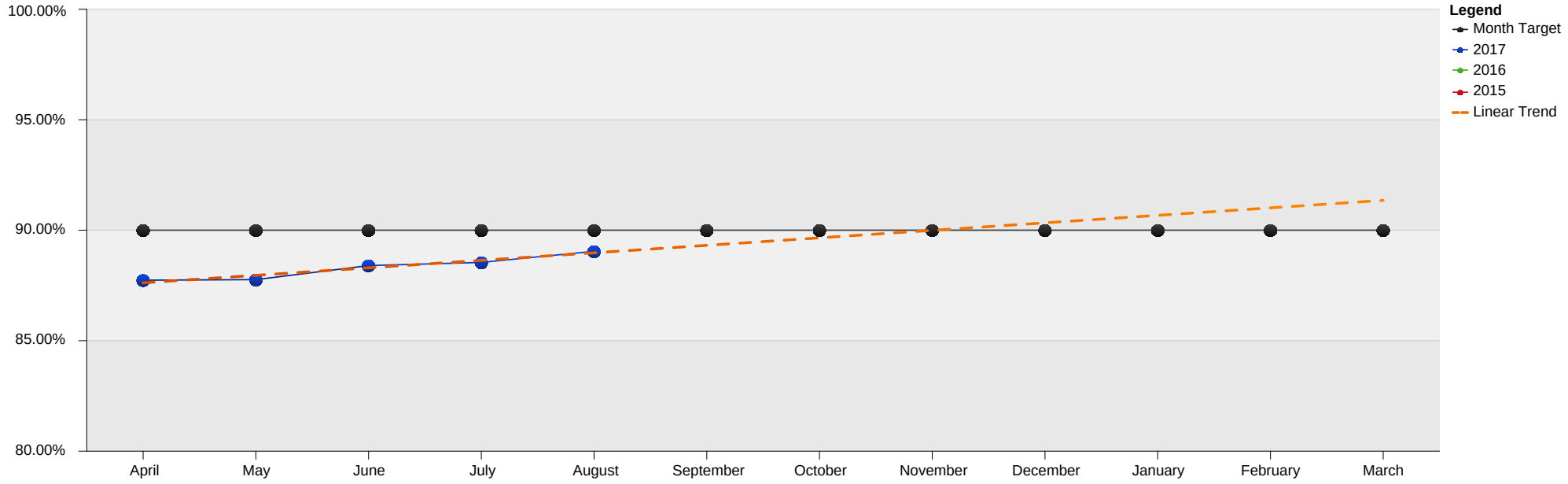


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	92.49%	92.49%	96.17%	96.17%	93.27%	93.27%	89.58%	89.58%	91.91%	91.91%	92.00%	92.00%		

Narrative
The Trust position for August is 2017 is 92.49%which relates to 484 members of staff out of 5644 that do not have a current appraisal. This is not meeting the target of 95% however is an improvement on the previous month and the second best position reported since 2015/16 to date. Durham and Darlington are the only locality that is meeting target and North Yorkshire report the poorest performance at 89.58%; all other localities have performance above 90.00%. The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels; this continues to have a positive impact on performance levels being achieved.

Trust Dashboard Graphs for TRUST

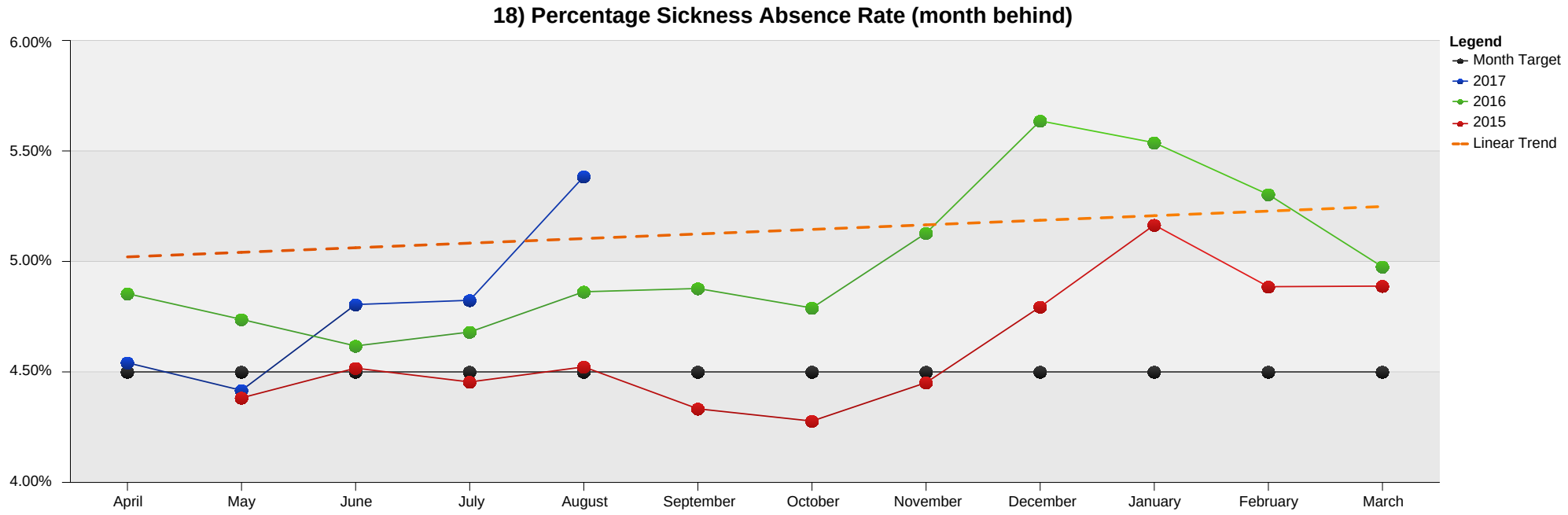
17) Percentage compliance with ALL mandatory and statutory training (snapshot)



	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
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	89.04%	89.04%	87.93%	87.93%	90.96%	90.96%	89.14%	89.14%	88.61%	88.61%	85.54%	85.54%		

Narrative
The position for August 2017 is 89.04%. This is 0.96% lower than the new target of 90%, however a continued improvement on the previous month. Teeside is the only locality that is meeting target. The remaining localities are performing above 80%; York and Selby are achieving the lowest level at 85.54%. This indicator will be discussed at a dedicated Performance Improvement Group meeting in September to review progress around improvement actions including the review of the training needs analysis and the improvement event in respect of the planning of face to face mandatory training sessions. The operational management huddles will reinforce the change to this KPI and drive improvements in performance.

Trust Dashboard Graphs for TRUST

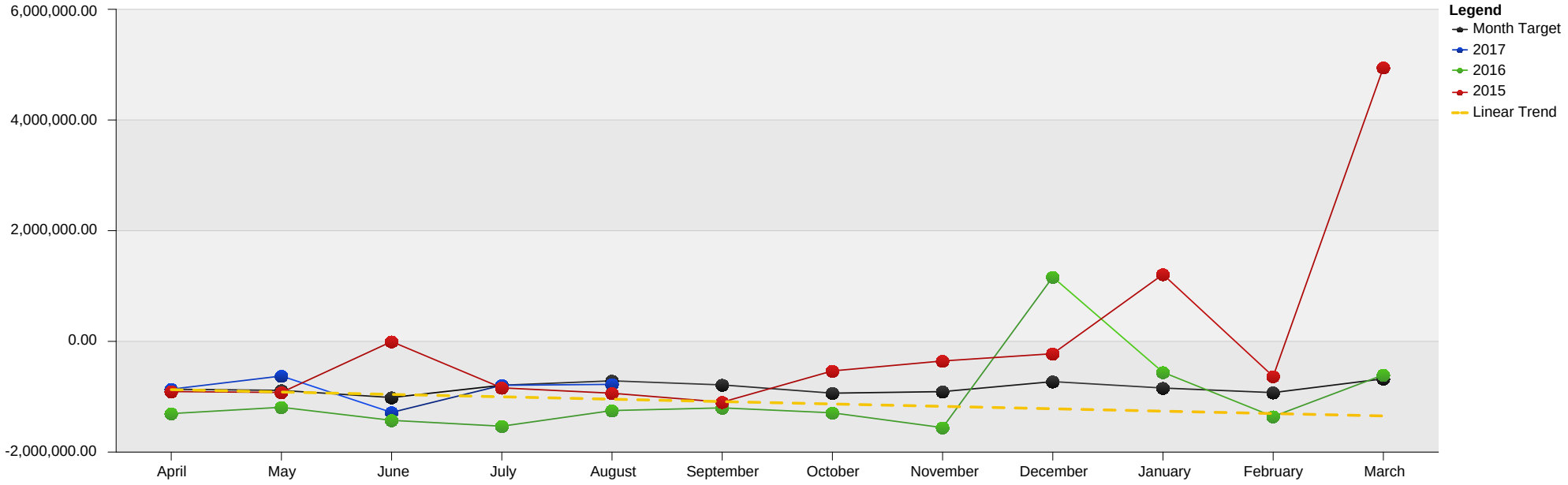


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	5.38%	4.80%	5.77%	4.73%	6.52%	5.68%	5.03%	4.31%	5.37%	4.85%	5.20%	5.75%		

Narrative
The Trust position reported in August relates to the July sickness level. The Trust position reported in August 2017 is 5.38%, which is not meeting the target of 4.50% and is a deterioration compared to both the previous month and August 2016. No localities are meeting target with Tees reporting the poorest performance at 6.52%. Due to the current high level of sickness further work will be completed to understand specific areas of concern to enable appropriate improvement action to be taken. 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

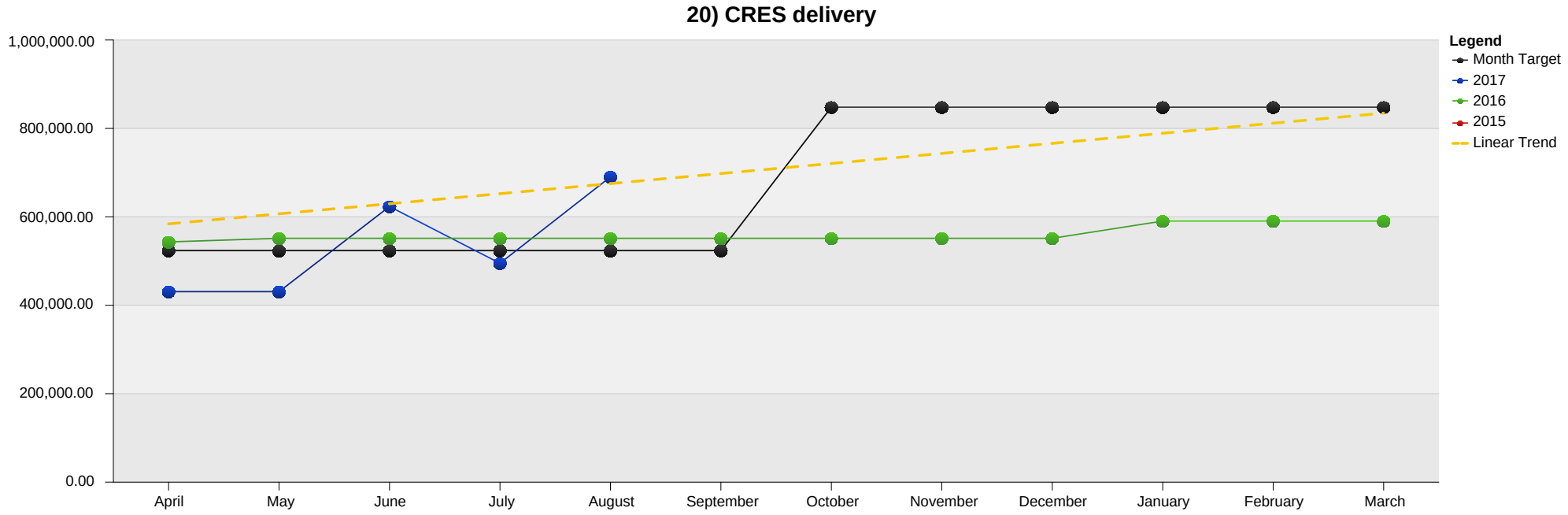
19) Delivery of our financial plan (I and E)



	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
19) Delivery of our financial plan (I and E)	-777,000.00	-4,345,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
The comprehensive income outturn for the period ending 31 August 2017 is a surplus of £4,345k, representing 3.1% of the Trust's turnover and is £73k ahead of plan

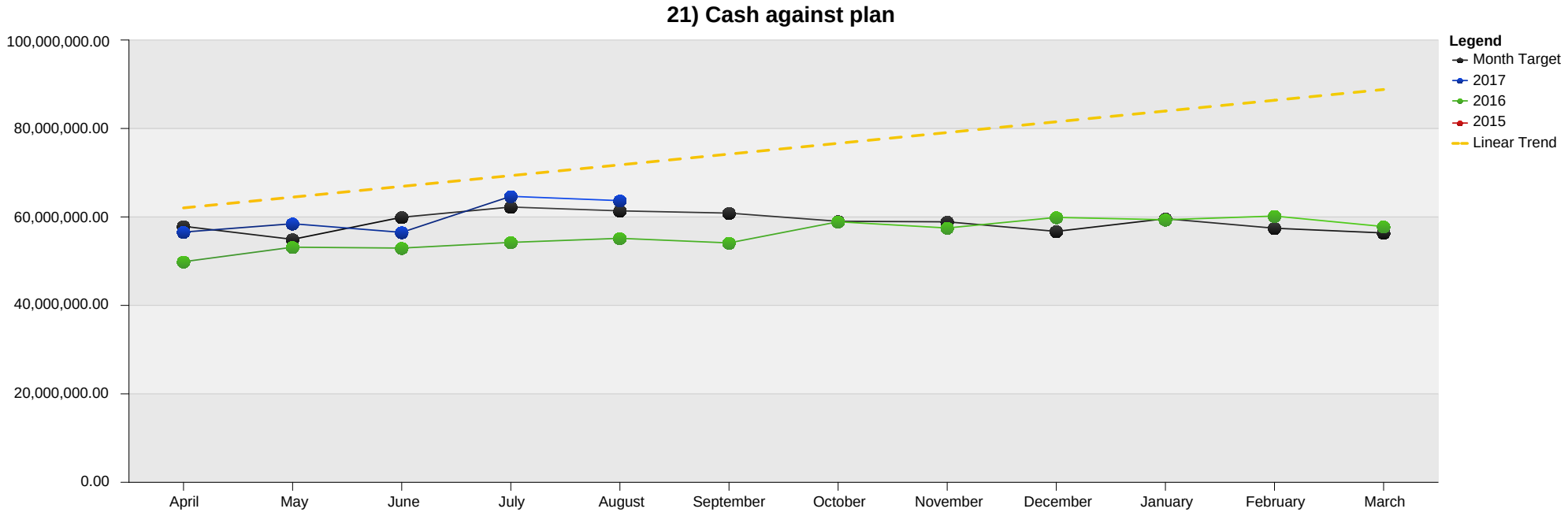
Trust Dashboard Graphs for TRUST



	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
20) CRES delivery	690,332.93	2,670,323.93												

Narrative
Total CRES delivery by the Trust for 31 August 2017 is £2,670,323 and is £51,924 ahead of plan. The Trust continues to identify and develop schemes to ensure full delivery of CRES for current and future years

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
21) Cash against plan	63,678,000.00	63,678,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
Total cash at 31 August 2017 is £63,678k and is £2,308k ahead of plan largely due to working capital variations.

Trust Dashboard - Locality Breakdown for TRUST

1 - Activity

	August 2017														April 2017 To August 2017											
	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) Total number of External Referrals into Trust Services	7,793.00	8,480.00	1,885.00	2,047.00	1,916.00	2,392.00	1,848.00	2,064.00	585.00	646.00	1,559.00	1,331.00			38,463.00	42,960.00	9,303.00	9,871.00	9,456.00	12,386.00	9,122.00	10,448.00	2,889.00	3,198.00	7,693.00	7,056.00		
2) Caseload Turnover	1.99%	-1.30%	1.99%	-0.14%	1.99%	-0.23%	1.99%	-0.16%	NA	NA	1.99%	-7.11%			1.99%	-1.30%	1.99%	-0.14%	1.99%	-0.23%	1.99%	-0.16%	NA	NA	1.99%	-7.11%		
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	84.19%	85.00%	84.23%	85.00%	83.51%	85.00%	90.55%	85.00%	NA	85.00%	76.73%			85.00%	86.01%	85.00%	88.13%	85.00%	86.74%	85.00%	90.00%	85.00%	NA	85.00%	75.08%		
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	75.00	56.00	16.00	11.00	11.00	12.00	22.00	23.00			24.00	9.00			75.00	56.00	16.00	11.00	11.00	12.00	22.00	23.00			24.00	9.00		
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	8.21%	10.00%	8.42%	10.00%	9.88%	10.00%	5.77%			10.00%	8.33%	10.00%		10.00%	9.12%	10.00%	8.39%	10.00%	9.15%	10.00%	7.35%			10.00%	12.83%	10.00%	
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	20.00	27.00	5.00	11.00	5.00	6.33	7.00	4.33			3.00	4.67			99.00	119.67	27.00	44.67	27.00	21.67	33.00	26.33			12.00	23.00		

Trust Dashboard - Locality Breakdown for TRUST

2 - Quality

	August 2017														April 2017 To August 2017											
	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
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	90.00%	92.49%	90.00%	91.08%	90.00%	98.96%	90.00%	87.06%	90.00%	100.00%	90.00%	77.40%			90.00%	90.52%	90.00%	88.76%	90.00%	98.54%	90.00%	84.04%	90.00%	99.73%	90.00%	73.40%		
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	9.64%	10.00%	12.01%	10.00%	5.72%	10.00%	13.07%	10.00%		10.00%	3.93%			10.00%	8.99%	10.00%	12.01%	10.00%	6.03%	10.00%	10.93%	10.00%		10.00%	3.41%		
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	13.41%	20.00%	3.74%	20.00%	4.67%	20.00%	39.71%			20.00%	14.63%			20.00%	13.16%	20.00%	6.42%	20.00%	1.70%	20.00%	35.48%			20.00%	26.73%		
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	92.50%	92.45%	92.44%	92.45%	92.90%	92.45%	92.98%	92.45%	88.89%	92.45%	91.46%			92.45%	92.32%	92.45%	92.81%	92.45%	93.13%	92.45%	93.29%	92.45%	80.56%	92.45%	92.27%		
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	2.21	1.00	2.01	1.00	1.55	1.00	2.15	1.00	0.00	1.00	4.00			5.00	5.40	5.00	3.52	5.00	5.38	5.00	7.61	5.00	100.00	5.00	6.39		

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	August 2017														April 2017 To August 2017											
	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
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	93.08%	100.00%	94.92%	100.00%	95.25%	100.00%	92.20%	100.00%	91.28%	100.00%	89.74%			100.00%	93.08%	100.00%	94.92%	100.00%	95.25%	100.00%	92.20%	100.00%	91.28%	100.00%	89.74%		
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	31.82%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA			15.00%	19.30%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA		
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	92.49%	95.00%	96.17%	95.00%	93.27%	95.00%	89.58%	95.00%	91.91%	95.00%	92.00%			95.00%	92.49%	95.00%	96.17%	95.00%	93.27%	95.00%	89.58%	95.00%	91.91%	95.00%	92.00%		
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	89.04%	90.00%	87.93%	90.00%	90.96%	90.00%	89.14%	90.00%	88.61%	90.00%	85.54%			90.00%	89.04%	90.00%	87.93%	90.00%	90.96%	90.00%	89.14%	90.00%	88.61%	90.00%	85.54%		
18) Percentage Sickness Absence Rate (month behind)	4.50%	5.38%	4.50%	5.77%	4.50%	6.52%	4.50%	5.03%	4.50%	5.37%	4.50%	5.20%			4.50%	4.80%	4.50%	4.73%	4.50%	5.68%	4.50%	4.31%	4.50%	4.85%	4.50%	5.75%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	August 2017														April 2017 To August 2017											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		UNKNOWN		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		UNKNOWN		YORK AND SELBY	
	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
19) Delivery of our financial plan (I and E)	-713,000.00	-777,000.00	NA	NA	NA	NA	NA	NA	NA	NA			NA	NA	-4,272,000.00	-4,345,000.00	NA	NA	NA	NA	NA	NA	NA	NA			NA	NA
20) CRES delivery	523,680.00	690,332.93	107,322.17		198,536.25		148,049.17		124,378.00				59,416.00		2,618,400.00	2,670,323.93	536,610.83		992,681.25		740,245.83		621,890.00				297,080.00	
21) Cash against plan	61,370,000.00	63,678,000.00	NA	NA	NA	NA	NA	NA	NA	NA			NA	NA	288,420,000.00	63,678,000.00	NA	NA	NA	NA	NA	NA	NA	NA			NA	NA

Appendix B Number of unexpected deaths and verdicts from the coroner April 2017 - March 2018

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient and took place in the hospital					Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital					Number of unexpected deaths where the patient was no longer in service					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death																					**0**
Natural causes																					**0**
Hanging																					**0**
Suicides																					**0**
Open																					**0**
Drug related death																					**0**
Drowning																					**0**
Misadventure																					**0**
Awaiting verdict	5	5	5	1	3		1									2	1	2		2	**27**
Total	**5**	**5**	**5**	**1**	**3**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**1**	**2**	**0**	**2**	**27**

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	12							

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
7	7	7	1	5

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 in the community					Number of unexpected deaths of patients who are an inpatient					Number of unexpected deaths where the patient is an inpatient but the					Number of unexpected deaths where the patient was no longer					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death																					**0**
Natural causes	1	1															1				**3**
Hanging					1												1				**2**
Suicides	5	2	2		2							1	2					1			**15**
Open			1																		**1**
Drug related death																					**0**
Drowning													1								**1**
Misadventure			1																		**1**
Awaiting verdict	7	2	7	2	6	1					1						1	1	2	1	**31**
Total	**13**	**5**	**11**	**2**	**9**	**1**	**0**	**0**	**0**	**0**	**1**	**1**	**3**	**0**	**0**	**0**	**3**	**2**	**2**	**1**	**54**

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

Number of unexpected deaths and verdicts from the coroner 2015 / 2016
This table has been included into this appendix for comparitive purposes only

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	% as at October 2016	% as at July 17	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				
1	Total number of external referrals into trust (same)services	5					5					5					15	**100%**	**100%**	
2	Caseload Turnover (same)	5					5					5					15	**100%**	**100%**	
3	Bed occupancy (AMH & MHSOP A&T wards) (same)	5					5					5					15	**100%**	**100%**	
4	Number of patients occupying a bed with a length of stay (from admission) over 90 days (AMH & MHSOP A&T wards)	5					5					5					15	**100%**	**100%**	This KPI has been amended to include patients currently occupying a bed, rather than those subject to discharge. This allows for more pro active monitoring of patients with a longer length of stay to enable a review of the appropriateness of the length of impatient spell and this is monitored in the report out process. The change to this KPI does not impact on the score previously applied, which remains unchanged.
5	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	5						5				5					15	**93%**	**100%**	Historic data for York and Selby prior to 1st April 2016 was not on Trust systems and this impacted on the reliability score applied to this KPI. However due to the new reporting year this concern no longers applies. T and therefore the scoring of this KPI has improved from 93% to 100%
6	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	5						5				5					15	**93%**	**100%**	The previous comments about the lack of historic data on the system with regards to York and Selby data no longer applies and therefore the scoring of this KPI has improved from 93% to 100%
7	Percentage of patients who have not waited longer than 4 weeks following an external referral	5						4				5					14	**93%**	**93%**	Data reliability is remains at 4 due to issues over the recording of DNA's. Although this continues to improve issues are still reported, particularly in the North Yorkshire locality and these are being addressed through the report out process

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	**% as at October 2016**	**% as at July 17**	**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				
8	Percentage of clinic appointments cancelled by the Trust	5					5					5					15	**87%**	**100%**	This KPI has been changed to clinic appointments as the previous use of community contacts was unreliable as you could not future date appointments, and therefore clinicians were likely to record these inaccurately. This KPI now uses the outpatients module on PARIS and there are no concerns of the reliability of this data. The use of a drop down menu to clearly state cancellation reasons provides a high degree of confidence in data quality.
9	The percentage of Out of Area Placements (post validated)		4				5								5		14	**N/A**	**93%**	Data is imported back into the IIC following manual validation. This increases reliability however introduces a manual element into the process. Validation for all breaches must be completed within the timeframe to support a national return, which prevents concerns about some breaches being inappropriately discounted. Therefore the data reliability has been amended from 4 to 5. A change to PARIS with the inclusion of drop downs to eradicate the manual element of the process is planned.

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	% as at October 2016	% as at July 17	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				
10	Percentage of patients surveyed reporting their overall experience as excellent or good.				2		5					5					12	**80%**	**80%**	Questionnaires continue to be are a mix of paper and electronic. All inpatient wards are electronic data collection, however there is also a number of kiosks in a range of services which complement the paper collection. A new provider (Optimum Health Technology) is in place and data collection commenced on 1st April 2017 . Paper surveys are sent to the new provider and entered into their Meridian system. There is a manual upload of the data accessed from Meridian into the IIC (this was the case for the most recent data by the Data Quality Team) but work is ongoing to integrate this data with the IIC.
11	Number of unexpected deaths classed as a serious incident per 10,000 open cases		4				5					5					14	**93%**	**93%**	Data continues to be directly extracted from Datix into the IIC; however, this process is not fully embedded. IAPT caseload is a manual upload.
16	Percentage Sickness Absence Rate (month behind)	5						4				5					14	**93%**	**93%**	Sickness absence data for inpatient services is taken directly from the rostering system which helps to eliminate inaccuracies, the remainder of the Trust continue to input directly into ESR and there continues to be examples where managers are failing to end sickness in a timely manner or inaccurately recording information onto the system. These issues are picked up and monitored through sickness absence audits that the Operational HR team undertake.

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	% as at October 2016	% as at July 17	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				
14	Actual number of workforce in month		4				5					5					14	**93%**	**93%**	Data continues to be extracted electronically but processed manually
15	Percentage of registered health care professional jobs that are advertised two or more times				2			4				5					11	**73%**	**73%**	The form to capture this information is still reliant on recruiting managers completing the section of the form. The recruitment team are more proactive in recording on the tracking spreadsheet where they are aware it is a readvertisement because they know this is being reported through a KPI. The recording of the information is a manual input into a spreadsheet which has the potential for human error.
19	Are we delivering our financial plan (I and E)		4				5					5					14	**93%**	**93%**	Information is extracted from and electronic system but is then subject to a manual process.
16	Percentage of staff in post more than 12 months with a current appraisal – snapshot	5						4				5					14	**93%**	**93%**	Issues with appraisal dates being entered to ESR continue to improve - there appears to be greater confidence in the data being reported and operational clinical services have incorporated the monitoring of compliance into the daily lean management process. Performance has improved and the Trust compliance rate has consistently been above 90%
17	Percentage compliance with mandatory and statutory training – snapshot **	5						4				5					14	**93%**	**93%**	The key issue that impacts on the reliability of the data is that staff do not follow the correct procedures to ensure training is recorded accurately on the source system as being completed and this is being addressed. In terms of training requirements there have been issues with Resus and PAT training and work is underway to resolve these issues
20	Delivery of CRES against plan				2		5					5					12	**80%**	**80%**	Data continues to be collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
21	Cash against plan		4				5					5					14	**93%**	**93%**	An extract continues to be taken from the system then processed manually to obtain actual performance.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th September 2017**
TITLE:	**Strategic Direction Performance Report – Quarter 1 2017/18**
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 2017).

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.

This report reflects that three of the Trusts five goals are in a positive position, whilst still acknowledging that there is work to do to improve some KPI's. There has been a deterioration in KPI performance within Goals 4 and 5; however it is noted that there is significant positive qualitative intelligence reported for these goals.

Recommendations:

Board of Directors is asked to:

- Approve the changes to the Trust Business Plan in Appendix 1.
- Approve the suggested targets noted in each section.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**26th September 2017**
TITLE:	**Strategic Direction Performance Report – Quarter 1 2017/18**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to the Board of Directors the Strategic Direction Performance Report as at Quarter 1 (30th June 2017).

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

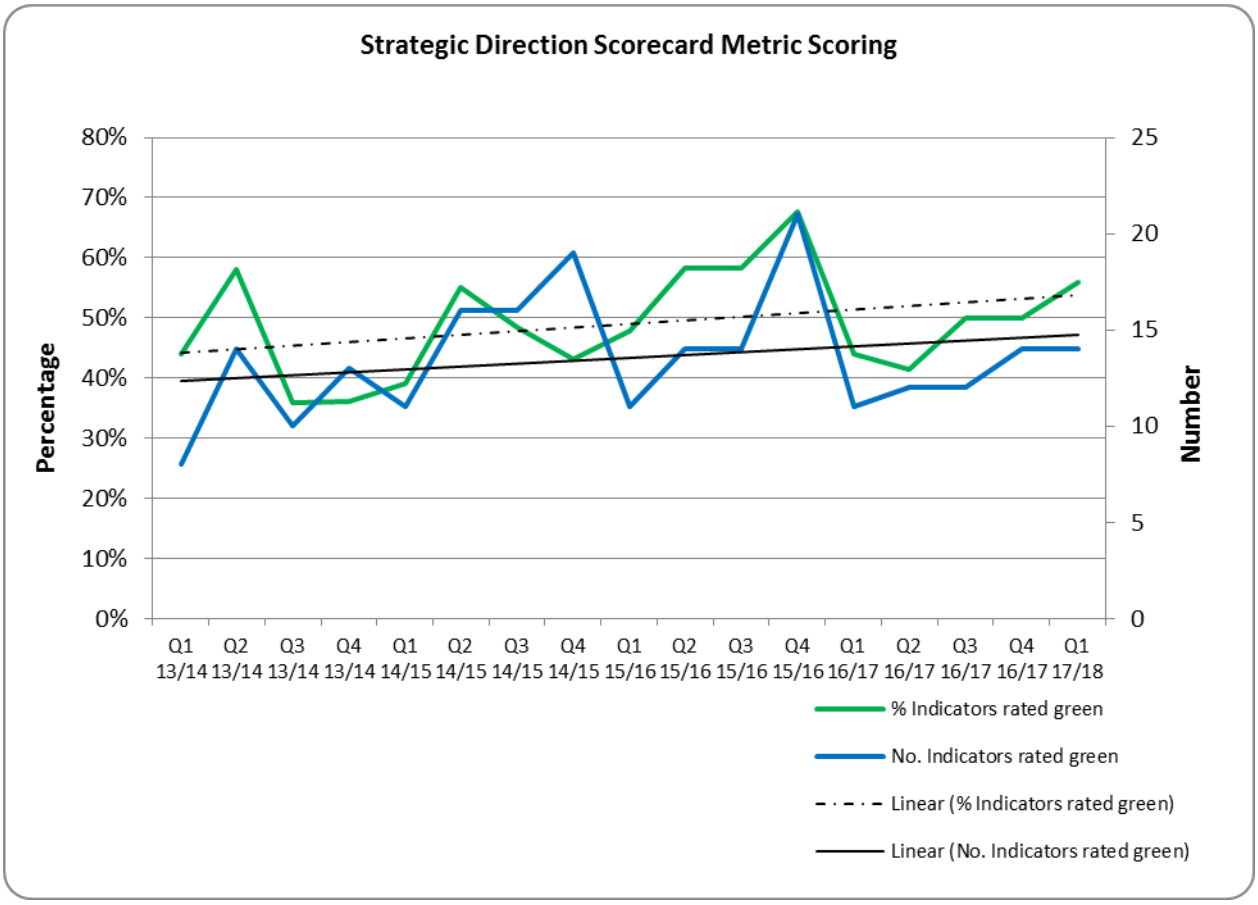
The Strategic Direction Scorecard is shown under each strategic goal with further detail, by exception, in Appendix 1.

The following table and graph provide a summary of the RAG ratings at quarter 1 compared to the position in the previous quarter (Q4 2016/17) and the previous financial years 2015/16 and 2016/17. The Trust is not meeting some of its high ambitions given the number of reds against stretching metrics. The actual number of those rated green have decreased since last quarter; however the number rated red have also decreased, due a number of quarter 1 indictors not being RAG rated, as they are not yet required to be reported. In addition there are some business plan actions that need to be re-profiled in the light of changing circumstances.

	2014/15		2015/16		Q4 2016/17		2016/17		Q1 2017/18		2017/18 YTD	
	No	%*	No	%*	No	%*	No	%*	No	%*	No	%*
Indicators rated green	18	42%	21	66%	14	50%	16	55%	14	56%	14	56%
Indicators rated red	25	58%	11	34%	14	50%	17	59%	11	44%	11	44%
Indicators with no target	2		3		3		2		2		2	
Indicators currently under development/being finaliased	1		1		0		0		0		0	
Indicators where data is not yet available/not applicable in qtr	0		4		6		2		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 improving trend in the percentage of greens since 2013/14. Despite a significant downward trend in quarter 1 2016/17, this trend is continuing.



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 3 indicators rated red out of 6 as at quarter 1; which is the same as was reported in Q4 2016/17 position.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18											
	Indicator	Q1 Target 2017/18	Quarter 1 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	2013/14 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	92.74%	⇩	>92.45	92.74%	92.48%	91.37%	90.14%	90.72%	>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%	88.29%	⇧	90.00%	88.29%	84.76%	83.17%	84.50%	87.01%	98.00%
3	Percentage of patients reporting "yes always" to the question "did you feel safe on the ward?"	85.00%	64.57%	⇩	85.00%	64.57%	82.29%	79.96%	82.11%	77.33%	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	Better or About the Same as other Trusts	Yes	Survey - top 25th %ile	Surveys: top 33%	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 4th	Yes - top MH//LD trust	Survey - top 25th % ile	Surveys: top 25%	Surveys: Top 10% of MH Trusts
6	Percentage of service users with a recovery focussed action plan (Adult Mental Health)	92.00%	88.44%	n/a	92.00%	88.44%	89.73%	93.00%	93.16%	87.50%	95.00%

Indicators of concern are:

- **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 88.29%, which relates to 2,833 patients out of 24,196 who had waited longer than 4 weeks for a first appointment. This is 1.71% below the target of 90% but an improvement on the quarter 4 position.

  (It should be noted that the current position in the Trust Dashboard (July 2017) for Percentage of patients who have not waited longer than 4 weeks from "referral" to "assessment" for external referrals is 92.17%, which indicates an improving positon.)

  Only Forensic Services (99.37%) and Teesside (96.86%) are reporting above target for quarter 1, with York & Selby reporting the lowest performance at 70.33% where there are delays in seeing patients from both external (71.74%) and internal (65.83%) sources.

  Improvements have been seen in Durham and Darlington, North Yorkshire who are reporting below target by 4.27% and 7.72% respectively.

The York & Selby action plan for external CAMHS referrals is progressing and the service has seen an improvement in terms of first appointments within 4 weeks following the introduction of the SPA. An action plan is also in place for AMH as there is an issue with achieving the target for the Access Team, this action plan is reviewed weekly by senior management. The team has also received support from the KPO team and has a Kaizen event planned. Work is ongoing to understand the capacity and demand challenges in Access with a view to potentially re-structuring in order to reduce waiting times. The service has also identified additional staff to undertake appointments. York & Selby MHSOP have issues with the Memory Service and a change in process is being implemented to improve the position. The nursing assessment process will be standardised across the locality from 25th September and nursing assessments are going to be allocated in order (rather than by geographical sector). In addition a process is being pursued whereby patients are given the option of seeing another consultant in another sector if there is a long wait for their own sector consultant.

- **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 64.57% which relates to 326 patients out of 920 patient survey responses who confirmed they felt safe on our wards. This is 20.43% below the target of 85% and a significantly worse position than quarter 4 (82.22%). All localities are reporting below target; Teesside (65.16%), Durham and Darlington (70.21%), North Yorkshire (69.39%), Forensic Services (43.33%) and York and Selby (63.64%).

  The table below shows a brief summary of the main reasons cited by patients for feeling unsafe.

Locality	Reason	Number responding	Total responses for locality
Durham & Darlington	Related to other patients	9	17
	Related to own illness	5	
North Yorkshire	Related to other patients	3	7
	Related to own illness	3	
Tees	Related to other patients	9	22
	Related to own illness	8	
	Staff related	3	
Forensics	Related to other patients	11	26
	Related to own illness	3	
	Staff related	3	
York & Selby	Related to other patients	3	7
	Related to own illness	2	
	Staff related	1	

- **KPI 6 - Percentage of service users with a recovery focused action plan (Adult Mental Health)** – The Trust position for quarter 1 is 88.44% which is 3.56% below the target of 92%. The position is not directly comparable with previous quarter's data as the construction of the KPI has been updated, as agreed by Board. This update was to reflect that, in the model line, there is a window of 12 weeks from first appointment to when a recovery star needs to be completed. The construction has been amended to reflect this.

  All localities are under performing, Teesside (91.41%), North Yorkshire (88.89%), with Durham and Darlington reporting the lowest position at 85.54

  - Within Durham and Darlington a number of patients have not engaged with the service, which may have been affected by the number of new staff within the teams. A proportion of patients were clinically inappropriate to complete a recovery star plan. Clinical meetings and team discussions are taking place within the teams with a view to preventing breaches, providing increased focus on recovery focussed outcome plans for patients.

  - Within Teesside a number of patients have not engaged with the service, which may have been affected by high workloads and capacity issues within teams.

Other points to note:

- **KPI 1 - Percentage of patients surveyed reporting their overall experience as excellent or good** – It is proposed that the target change from >91.44% to >92.45% to align this KPI with the Trust Dashboard. **Board are asked to approve this change.**

- **KPI 6 – Percentage of service users with a recovery focussed action plan** – the target has been updated to 92.00% in line with the agreed trajectories for this KPI. **Board are asked to confirm this change remains appropriate.**

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 (73%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

There is 1 priority / service development reporting an overall status of amber/green and 1 priority / service development reporting an overall status of grey, both require additional time going beyond the current year to complete actions (to be agreed by Board).

Where a Board decision is required to change or remove an action, this is contained in Appendix 2 for approval.

3.2.3 Other Qualitative Intelligence

In addition to the reported position the following point should be noted:

- The **smoking cessation project team** were selected to present their work at the National Institute for Clinical Excellence (NICE) annual conference. The project was also highly commended by a panel of judges at the NICE Shared Learning Awards.

3.2.4 In conclusion it can be seen for this strategic goal that whilst the number of red KPIs on the scorecard remains unchanged when compared to the previous quarter, only 4 of the 6 KPIs can be RAG rated. Of these, only 1 has reported an improvement. The deterioration in performance has continued from quarter 4 2016/17 and further work is needed to ensure progress against the strategic goal is delivered. This will be supported by further work around waiting times and patient experience.

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 3 indicators rated red out of 8, which is the same as in quarter 4, with two of these indicators reporting an improvement.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18											
	Indicator	Q1 Target 2017/18	Quarter 1 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	2013/14 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	8	⇧	0	8	23	0	n/a (indicator changed)	n/a (indicator changed)	0
8	Number of action points on action plans for complaints and clinical audit that are outstanding for **more than 31 days**	0	2	⇧	0	2	24	13	8	n/a	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	87.68%	⇧	>86.56	87.68%	86.56%	86.01%	89.75%	45 (PREM) net score	> previous year out-turn
10	Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication	50%	14.29%	⇩	50.00%	14.29%	17.14%	53.57%	34.48%	0.00%	>=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	76.00%	79% and in top 20%	77% but in top 20%	79% & best MH Trust	> 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%	83.98%	⇧	>82.58%	83.98%	81.22%	82.58%	n/a	n/a	> 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%	#DIV/0!	50.00%	80.00%	75.00%	75.00%	80%
14	Hospitality Assured Accreditation score*	82.00%	No scoring for 2017/18	n/a	82.00%	No scoring for 2017/18	81.10%	Assessment now due Q1 16/17 & results in Q2	80.5% (Mar 2015)	79.1%	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 8 against a target of zero, but this is a significant improvement on quarter 4 when we reported 23. All relate to Level 5 SIs.

  At the time of writing this report 3 actions remained outstanding in relation to one action plan in North Yorkshire.

- **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 2, which is above the target of zero, but a significant improvement on quarter 4 when we reported 24.

  One relates to a complaint. It became apparent that more resources were required to get the improvement work back on track and to support the action owner. This is now in place and a new target date for the actions will be agreed. There was also a Serious Incident report for this complaint and a need for a joined up approach to actions. This has now been completed.

  One relates to Clinical Audit of Safeguarding Casefiles in CYPS. Sign-off required minutes from a number of meetings to evidence discussion of the issues identified; some were delayed and were followed up with the project leads, including escalation to the Head of Safeguarding. The Clinical Audit and Effectiveness Team is working with Safeguarding to establish a clinical audit subgroup to support Safeguarding clinical audit activity, review outstanding actions and provide support to facilitate completion and sign off of actions. Outstanding actions are also monitored each month by the Clinical Effectiveness Group and where appropriate any actions >90 days are escalated to the Quality Assurance Committee. This has now been completed.

- **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 14.29%, against a target of 50% and a deterioration on the quarter 4 position of 20.00%.

  There were 7 baseline assessment tools signed off by the Clinical Effectiveness Group (CEG); however only one was within 6 months of publication.

  Concerns have been raised about the continued validity of this indictor. A new NICE guidance implementation process has been introduced within the Trust which requires the collation and analysis of broader governance assurance evidence available to services in order to make a more detailed, informed judgement regarding baseline compliance. As such it involves review of incident data, complaints, audit data, gathering patient stories etc. This will therefore potentially take longer than the process that has been operating previously. The new process is currently in pilot phase and is being evaluated by the Clinical

Effectiveness Group. The sign off process also involves NICE BATs going to Acute Care Forums or other specialist groups in addition to SDGs prior to CEG sign off, which in itself can take 2-3 months trying to fit in with existing meeting scheduling. This impacts on the 6 month target, however, this needs to happen to maintain robust governance arrangements but also makes the target somewhat unachievable. CEG have requested the opportunity to consider and propose an alternative KPI. **Board approval is sought for this proposal**.

Other points to note:

- **KPI 9 – Friends & Family Test – Patient Survey Question** – the target has been updated to >86.56% in line with the agreed trajectories for this KPI. **Board are asked to confirm this change remains appropriate.**

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 (92%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

There is 1 priority / service development reporting an overall status of grey, but requires removal from the business plan as the actions have been superseded by another project (to be agreed by Board).

Where a Board decision is required to change or remove an action, this is contained in Appendix 2 for approval.

3.3.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- **Mental Health Team at HMPYOI Low Newton, Durham** have had their hard work and dedication to improve the quality of care to female offenders recognised nationally on Friday the 5 May at the RCNi Nursing Awards. Nominated in the Celebrating Excellence in Nursing Care, Mental Health Practice Award, the team's hard work to improve perinatal care within a challenging environment was judged to be within the top five nationally.

- The Royal College of Psychiatrists International Congress 2017 has accepted a poster presentation on audit of acute wards of Roseberry Park, Middlesbrough by **Muhammad Malik**, CT2, Sandwell Park Hospital, Hartlepool. The Congress is being held in Edinburgh this June.

3.3.4 In conclusion it can be seen for this strategic goal that of the five KPIs that can be compared to quarter 4, four have improved. In addition, achievement of the Business Plan actions and qualitative intelligence provides an encouraging position that can be improved with further work around the number of outstanding action points for level 5 SIs.

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 out of 12 as at quarter 1 which is an improvement compared to quarter 4 2016/17; both of these indicators are reporting an improvement.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18											
	Indicator	Q1 Target 2017/18	Quarter 1 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	2013/14 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%	72.00%	⇔	>70.95%	72.00%	70.45%	70.95%	n/a	n/a	> previous year out-turn
16	Percentage of medical students and junior doctors reporting satisfaction with their placement	89.00%	90.77%	⇧	89.00%	90.77%	89.97%	89.09%	87.25%	83.02%	90.00%
17	Percentage of positive nursing placement evaluations received	95.00%	95.20%	⇧	95.00%	95.20%	95.69%	95.17%	94.93%	95.13%	95.00%
18	Excess cost of employing medical agency versus substantive	£75,000	£129,656	⇧	£50,000	£129,656	£697,684	£200k	n/a	n/a	zero
19	NHS Employers Assessment of Wellbeing	100%	100.00%	⇔	100%	100.00%	100.00%	100.00%	100.00%	92.86%	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	To be reported at July 16 Trust Board	16.67%	66.67%	100%
21	Percentage of positive staff responses for training/development evaluations received (data is a month behind	75.00%	77.66%	⇧	75.00%	77.66%	74.18%	75.30%	deferred	Not available	TBC
22	Quality of Appraisals	>4.0	Results due in Q4	n/a	>4.0	Results due in Q4	4.00	3.36	49% but in top 20%	52% & in Top 20%	>= 2018/19 & in top 20%
23	Percentage of medical staff successfully revalidated	100%	n/a	n/a	100%	n/a	90.00%	98.15%	100.00%	100%	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	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%	17.65%	⇧	50.00%	17.65%	8.08%	32.00%	34.02%	Not available	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	33.00%	28% and top 20% (best for MH/LD Trusts)	38% but in top 20% (DEC 14)	38% & in Top 20% (DEC 13)	< 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 £129,656 against a target of £50,00.

  As at the end of quarter 1, 11 agency staff were required to support vacancies in Durham and Darlington (2 AMH and 1 MHSOP), Forensic (1 FMH), North Yorkshire (2 MHSOP and 1 CYPS) and York and Selby (2 MHSOP and 2 CYPS).

  A further 3 agency staff were used to cover sickness in North Yorkshire (1 AMH and 1 CYPS) and York and Selby (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 17.65% which is an improvement on quarter 4 when we reported 3.85%. The quarter 1 position reflects 3 advertised post out of 17 that had at least 2 internal candidates above the line for Band 7 posts and above.

  In order to increase the number of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above, the Trust is re-energising the Talent Management process. A Kaizen event held in March 2017 has redesigned the talent management approach with 20 items on the newspaper now having been completed and a further 23 planned to be tested and communicated over the next two quarters. A key target is publication of a new Value Stream Map in January 2018.

  This increased focus has resulted in more people being trained in talent management and appraisal. There has also been a small increase in the number of talent management returns; 7 returns were received in the last 30 days (compared to a baseline of 2 in the whole of 2017). Piloting of the new combined appraisal documentation will take place in August and September with the new approach being published for all appraisers to use from 1st October 2017.

- **KPI 26 - Percentage of staff reporting that they 'suffered work related stress in last 12 months' -** The Trust position for 2016/17 is 33%, which is worse than the 2015/16 position of 28%.

  A process has been developed by the Organisational Development department that aims to provide advice, guidance and tailor made intervention to improve staff engagement for teams identified via the Staff Friends & Family Test. Interventions include working with Team Managers to identify activities such as social safeness and team building days to support team resilience.

Other points to note:

- **KPI 16 – Percentage of medical students and junior doctors reporting satisfaction with their placement** – the target has been updated to 89.00% in line with the agreed trajectories for this KPI. **Board are asked to confirm this change remains appropriate.**

- **KPI 18 – Excess cost of employing medical agency versus substantive** – when the Medical target of £400k was initially implemented in 2015/16 it was on the basis that it would reduce by £100k each year. As this is the third year it should be £200k per annum, £50k per quarter; however it is proposed that the target remain £75,000 in light of the significant challenges on medical recruitment. **Board are asked to approve this change.**

- **KPI 22 – Quality of Appraisals** – the target has been updated to >4.0 in line with the agreed trajectories for this KPI. **Board are asked to confirm this change remains appropriate.**

- **KPI 23 Percentage of medical staff successfully revalidated** – There have been no revalidations due in quarter 1.

3.4.2 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.

3.4.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- The workforce development team were highly commended in the HSJ Value Awards (Improving the value of NHS support services category) for their work in developing the Health Care Assistant Framework

- Community learning disabilities team secretaries from Systems House, York, were runners up in the Best Team Award at the Yorkshire PA Awards

- Ruby Bell, head of psychology for the forensic service, has been awarded the highly prestigious 2017 Senior Award for Distinguished Contributions to Professional Practice in Forensic Psychology by the Division of Forensic Psychology. The award is a reflection of Ruby's notable work in the field of forensic psychology and recognition of this achievement by other members of the discipline.

- Matty Caine, team manager, offender health / community services, Durham, was shortlisted in the RCNi Nurse Awards in the 'mental health practice award' category.

- Each year junior doctors on placement in the Trust are asked to complete a GMC trainee survey to provide feedback on the quality of their training experience. The Trust received confirmation from Health Education England that we had been ranked 6th nationally out of all NHS providers from survey feedback, which is an improvement from 10th place the previous year. This is now also the fifth year in a row that the Trust has maintained its position as number one in the North East.

3.4.4 In conclusion it can be seen for this strategic goal that the number of red KPIs has reduced since last quarter, with those that are red reporting an improvement. Of the seven KPIs that can be compared to quarter 4, five have improved and two have remained the same. In addition, achievement of the Business Plan actions and significant qualitative intelligence provides an encouraging position for this strategic goal. The Trust will continue to benefit from an increased focus on talent management.

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 one indicator rated red at quarter 1. This is an improvement on quarter 4 when we reported 3 indicators as red.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18											
	Indicator	Q1 Target 2017/18	Quarter 1 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	2013/14 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%	76.92%	⇩	90%	76.92%	85.71%	87.50%	97.06%	79.41%	90%
28	Attendance rate at Statutory Safeguarding Boards & MAPPA Strategic Management Boards	98%	100.00%	⇔	98%	100.00%	100.00%	100.00%	98.59%	100%	98%
29	Proportion of student nursing placements provided as a % of placements requested	90%	99.58%	⇩	90.00%	99.58%	100.26%	99.12%	99.77%	41.47%	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	300	⇩	n/a	300	1105	412			10% increase year on year
31	R&D Outcomes - Annual external R&D income (including external grants and commercial income)	n/a	£168,674	⇩	£678,014	£168,674	£585,215	£616,376	n/a	n/a	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	Signed & Green	Signed & Green	Signed & GREEN	Signed & Green

Indicator of concern is:

- **KPI 27 Attendance at Health and Well Being Boards** – There were 10 H&WB Boards attended out of 13, with 1 each being unattended in Middlesbrough, County Durham and Darlington and York and Selby.

3.5.2 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.

3.5.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- The Trust commenced the North West Prison contract on 1st April; sub contracted by Spectrum to provide MH services to 3 prisons.
- Adult Mental Health in Tees received funding for a mental health advisor to be based in police control room, as part of the Force Control Room project.

- A Trust bid, in partnership with Northumberland, Tyne and Wear NHS Foundation Trust, was successful to become a Wave 2 site for New Care Models for Tertiary Mental Health Services for adult secure mental health services for Cumbria and the North East, including adult secure learning disability services.

3.5.4 In conclusion, whilst four of the six KPIs have reported a deterioration compared to the previous quarter, taking into account progress against the Business Plan and the qualitative intelligence the overall position remains positive for this strategic goal. It should be noted that whilst attendance at Health & Wellbeing Boards has been particularly low this quarter, this only accounts for 3 meetings across 3 different local authority areas.

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 7 as at quarter 1, which is a slight deterioration quarter 4 position when we reported 1 indicator as red.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18											
	Indicator	Q1 Target 2017/18	Quarter 1 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	2013/14 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%	71.43%	⇩	37.50%	71.43%	64.29%	57.14%	75.00%	Not available	<=6.25%
34	Percentage of Information Strategy metrics on target that are reported on Information Strategy Metrics Scorecard	81.25%	85.71%	⇩	81.25%	85.71%	81.25%	5 yr Strategy & metrics approved EMT March 2016	n/a	n/a	TBC
35	Percentage change in income for Trust contracted services compared to previous year	0.10%	-0.27%	⇩	0.10%	-0.27%	7.42%	8.09%	0.90%	3.27%	Better than deflator
36	Reference Cost Index score for in-scope PbR Services	<=95	104	n/a	<=95	104	100	92	n/a	n/a	TBC
37	Reference Cost Index score for out of scope PbR Services	<=95	82	n/a	<=95	82	88	95			TBC
38	EBITDA **	7.40%	7.70%	⇩	7.70%	7.70%	7.79%	8.22%	8.73%	8.80%	8.00%
39	Good Corporate Citizenship audit scores*	70.00%	Due in Q4	n/a	70.00%	Due in Q4	66%	66.00%	51% (March 15)	Not available	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 14 is 71.43%, which is a deterioration on quarter 4 (64.29%) and 33.93% more than expected and therefore an underperformance.

Of the 10 metrics reporting red, 5 have shown an improvement on quarter 4. Those showing a deterioration are the patients recorded on PARIS for which ethnicity and gender are missing, CPA level not recorded and the number of 'system' breaches for crisis gatekeeping. There is a data quality action plan which is underway led by the Information Department with the clinical services to address the data quality issues.

- **KPI 36 Reference Cost Index Score for in-scope PbR services** – The 2016/17 reference costs draft submission shows an in scope index of 104, which is a deterioration on the last reported position in quarter 3 (100). This is based on the 2015/16 published national averages hence once the 2016/17 process is completed we would expect these numbers to improve.

  The deterioration is primarily attributable to the inclusion of York and Selby locality for the first time. Specific issues include:

  - Under Occupancy on MHSOP wards – average for the year is 80.01%. The average across the other 3 localities is 93.14% occupancy.
  - Stranded fixed costs associated with partial opening and closure of units in year such as Peppermill, Acomb Garth and Worsley Court.
  - Activity assumptions regarding cluster days due to PARIS 16/17 rollout across locality. Cluster days are based on the quarter 4 position extrapolated. The basis for this, is the clustering trajectory to achieve the 95% target (Q1 2017/18).
  - Out of Area Bed activity and expenditure is included albeit not at individual cluster level. This is currently reported all against cluster 99. Currently we are seeking clarification from the DoH team.

  Further analysis will be undertaken with the service ahead of the submission in August.

Other points to note:

- **KPI 35 – Percentage change in income for Trust contracted services compared to previous year** – the target has been updated to 0.10% in line with the agreed financial uplift to contracts for 2017/18. **Board are asked to confirm this change remains appropriate.**

- **KPI 39 - Good citizenship scores** - the target has been updated to 70% in line with the agreed trajectories for this KPI. **Board are asked to confirm this change remains appropriate.**

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.

However, Executive Management team have identified that an additional strategic priority should be added to the Business Plan. The proposed priority text is:

Support the development and implementation of New Care Models

The completion timescale for this would be the end of the current Business Plan period – i.e. March 2020.

At this stage, it is recommended that the actions and metrics should be relatively high level – i.e.

Action	Metric	Timescale
Deliver the agreed business case actions for the Children and Young People NMC budget pilot	Agreed business plan actions completed as planned	Q4 2019/20
Agree a final business case for NMC Adult Secure services with NHSE	Agree the final business case with NHS England	Q2 2017/18
Deliver the agreed business case actions for the Adult Secure NMC budget pilot	Agreed business plan actions completed as planned	Q2 2019/20
Deliver an Accountable Care Partnership for Learning Disability services in Durham, Darlington and Tees	Further develop and implement the ACP's plan for learning disability services	Q4 2019/20
Deliver and Accountable Care Partnership for Mental Health services in Durham, Darlington and Teesside	ACP for mental health goes live at date agreed with ACP Board	To be confirmed

There will be an opportunity to review and refresh these actions, metrics and timescales as part of the business planning process leading up to agreement on the 2018/19-2020/21 Business Plan. **Board are asked to approve this proposal**

3.6.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- Durham and Darlington were successful in Core 24 bids with £396k to be made available in 2018/19. The money will be used for enhancements to the Acute Liaison Service.

- **Louise Robertson** and **Jayne Headland** senior information analysts, Flatts Lane Centre, Middlesbrough were invited by the Mental Health Transformation Programme to deliver a presentation to the London Payment and Outcomes Technical and Clinical Group to illustrate how we have successfully approached Systematized Nomenclature of Medicine -- Clinical Terms (SNOMED-CT) in relation to the Mental Health Services DataSet (MHSDS). The group were very impressed with our approach and we have subsequently been asked to deliver the presentation to London Payment and Outcomes Technical Group with a view to encourage the London Trusts to adopt a similar approach.

3.6.4 In conclusion it can be seen for this strategic goal that all of the KPIs that could be compared to the previous quarter have deteriorated; however taking into account progress against the Business Plan and qualitative intelligence, the overall position remains positive and the majority of indicators remain green.

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 2017/18 and reports progress against the Strategic Direction Scorecard and the Trust Business Plan whilst also considering other forms of qualitative intelligence.

This report reflects that three of the Trust's five goals are in a positive position, whilst still acknowledging that there is work to do to improve some KPI's. There has been a deterioration in KPI performance within Goals 4 and 5; however it is noted that there is significant positive qualitative intelligence reported for these goals.

Overall the scorecard position has improved when compared to quarter 4; however this is attributable to the fact that the data is not yet available for a large number of KPIs. There remains the same number of greens reported. Of the 11 KPIs reporting red at quarter 1, 4 have reported a deterioration. In comparison to the end of year position for 2016/17, of those indicators that can be compared the RAG status of 13 has improved, 12 deteriorated and 2 remained the same.

7. RECOMMENDATIONS:

Board of Directors is asked to:

- Approve the changes to the Trust Business Plan in Appendix 1.
- Approve the suggested targets noted in each section.

Sharon Pickering
Director of Planning and Performance

Background Papers:

Appendix 1

Board requests for changes:

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
2.7i	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **New models of care / Enhanced community services in NY**	North Yorkshire	MHSOP	Define the scope of enhanced community service and submit scoping document (PM1) to EMT.	Scoping document (PM1) submitted to EMT	Q1 17/18	Naomi Lonergan		This action is subsumed in Harrogate and Hambleton & Richmondshire Transformation projects. Learning from these will be rolled into Scarborough, Whitby and Ryedale if deemed appropriate. **Therefore request Board approve the removal from the Trust Business Plan.**
				Design the delivery model including the functions of intensive Home treatment, care home Liaison, Care Coordination	Service model established and agreed functions with reduced estates and management costs	Q2 17/18			
				Develop skill mix arrangements to deliver the service	Fully costed model based on PPCS data developed	Q3 17/18			
				Develop implementation plan	Implementation plan developed and pilot site identified	Q4 17/18			
				PM3 (business case) finalised and approved	EMT approve PM3 (business case)				
				Implementation Commences	Commencement of implementation	Q1 18/19			

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
				Implementation of new enhanced community services completed	Completion of implementation	TBC in PM3			
1.11	Develop a Trust-wide approach to delivering services to service users with Autism	COO	N/A	Deliver "phase 1" autism training programme	Autism training for staff in AMH access teams, adult community mental health teams, crisis and liaison teams **completed**	Q4 17/18	Jackie Dyson	**N/A - Not due in Q1**	The project plan in the PM3 which was approved on 15th March had slightly revised timescales due to comments made by the COO requesting the inclusion of a 'development phase'. This pushed commencement of Phase 1 training back to September. EMT approved the extension to the timescale of this metric to Q2 17/18 at their meeting on the 19th July. **Request Board approve the extension of this action to Q1 18/19.**
				Deliver "phase 2" autism training programme	Autism training for staff in Community LD, Offender Health Forensics, Community CYP and Community MHSOP teams **commenced**	Q1 17/18			**EMT approved the extension to the timescale of this metric to Q3 17/18 at their meeting on the 19th July.**
					Autism training for staff in Community LD, Offender Health Forensics, Community CYP and Community	Q1 18/19		**N/A - Not due in Q1**	**Due to the above approval, request Board approve the extension of this action to Q3 18/19.**

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
					MHSOP teams **completed**				
1.11	Develop a Trust-wide approach to delivering services to service users with Autism	COO	N/A	Deliver "phase 3" autism training programme to ward-based staff	Autism training for inpatient AMH, Forensic, ALD, CYP, MHSOP ward staff **commenced**	Q4 17/18	Jackie Dyson	**N/A - Not due in Q1**	**Due to the above approval, request Board approve the extension of this action to Q1 18/19.**
					Autism training for inpatient AMH, Forensic, ALD, CYP, MHSOP ward staff **completed**	Q4 18/19			**Due to the above approval, request Board approve the extension of this action to Q1 19/20.**
				Deliver "phase 3" autism training programme to non-clinical staff	Autism training for governors, EMT, PPI and Corporate Services commenced	Q4 17/18			**Due to the above approval, request Board approve the extension of this action to Q1 18/19.**
1.7h	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **Deliver a CORE 24 acute liaison service**	Tees	MHSOP	Confirmation of funding to CORE 24 standards agreed	Funding secured	Q1 17/18	Elaine Wells		Meetings with South Tees CCG and acute trust ongoing potential application to be submitted when wave 2 opens (expected 2018). **Request Board approve the extension of this action to Q1 18/19.**

ITEM NO. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th September 2017**
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.

(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 2017.

MEETING OF:	**The Board of Directors**
DATE:	**26th September 2017**
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 matter reserved to the Board 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 The Board is asked to approve 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 2017.

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 2017.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution

Annex 1

Non-Executive Director Committee and SUI Panel Membership from 1st October 2017

	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	4	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. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th September 2017**
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.

Whilst the draft business cycle follows the same pattern as in previous years, it has been updated to include new requirements e.g. reporting on learning from deaths.

In response to previous discussions, the findings of the external governance review (private agenda item 7) and the Board Performance Evaluation Scheme for 2016/17, the report also seeks the Board's support for proposals to review the operational arrangements of certain Board committees.

Recommendations:

The Board is asked to:

(1) Approve its business cycle for the period 1st October 2017 to 31st December 2018.

(2) Support the proposed reviews of the operational arrangements of the Resources and Quality Assurance Committees.

MEETING OF:	**The Board of Directors**
DATE:	**26th September 2017**
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 2017 to December 2018.

1.2 The report also seeks the Board's support to review the operational arrangements of the Resources and Quality Assurance Committees in response to the findings of the external governance review and the Board Performance Evaluation Scheme.

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 might be required to be 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 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. These are usually held on the second Tuesday except that the December seminar is held in conjunction with the Board meeting.
- 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 2017 to 31st December 2018 are set out in Annex 1 to this report.

3.2 The Board is asked to note that:

- The "June" Board meeting will be deferred to early July 2018 at the request of the Chairman.
- The date for the submission of the Annual Report and Accounts has not yet been confirmed by NHS Improvement. Board Members are asked to hold two potential dates in their dairies. The actual date of the meeting in May 2018 will be confirmed in due course.
- The reporting cycles, generally, remain the same as previously; however, the following changes have been made:
  - The Quarterly Workforce Report has been deleted from the schedule following the decision under minute 17/196 (20/7/17) for these reports to be presented to the Resources Committee.
  - In accordance with NQB guidance, quarterly reporting on learning from deaths will commence from October 2017.
  - Reporting on equality issues (i.e. EDS2 and the WRES action plan) has been increased in response to feedback from the CQC.

3.3 As discussed during the informal feedback session with Grant Thornton on the findings and recommendations of the external governance review on 20th July 2017, a review has been undertaken of how the strategic and key operational risks of the Trust map against the reporting schedule. The findings of the review are that:

(a) There is generally good coverage of key risks within the Board's reporting arrangements.

(b) As expected the Board places significant reliance on the assurances provided by its committees and this lends weight to the proposed review of their operational arrangements (see below).

Board Seminars

3.4 Annex 2 to this report sets out the proposed arrangements for Board seminars during the period. It includes the usual items considered by the Board on an annual basis and, where appropriate, matters suggested by the Board's committees and Executive Directors. In the latter cases these have either been scheduled in the programme or will be arranged following further discussions.

3.5 Board Members are asked to note that there are some gaps in the programme. This is not unusual and additional topics tend to be identified in year. However, at this time, the Board is asked to consider whether there are any other matters which it would like to propose for inclusion in the programme.

Board Committees

3.6 A number of reports and discussions have highlighted the need to undertake a review of the operational arrangements of certain Board committees i.e.:

(a) The requirement to review the operation of the Resources Committee within 12 months of its establishment (minute 16/313 – 20/12/16 refers).

(b) The Grant Thornton review (see private agenda item 7) which highlighted:

- Concerns raised about the potential increase in the workload of Non-Executive Directors following the reduction in their number in September 2017.
- The need to monitor the ability of the Resources Committee "to do justice to the financial and workforce agendas."

(c) The actions arising from the Board performance evaluation scheme for 2016/17 (minute 17/200 - 20/7/17) which included:

- A review of the relationship between the QuAC and the Localities.
- A workshop on the operation of the MHLC (this is already planned).

3.7 Taking into account the above matters and following discussions with the Chairman, it is proposed that the operational arrangements of the Resources and Quality Assurance Committees should be reviewed focussing on:

- Their cycle of meetings to be held each year.
- The balance and spread of the business transacted by them.

3.8 The Board is asked to support the reviews noting that it is anticipated that any changes will be implemented in April 2018.

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.

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

4.4 **Equality and Diversity:** The Board business cycle has been amended to strengthen the assurances provided on equality and diversity in response to findings of the CQC's inspection of the Trust in January 2017.

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 2017 to December 2018.
(b) Propose any additional topics for inclusion in the Board Seminar programme for 2018.
(c) Support the proposed reviews of the operational arrangements of the Resources and Quality Assurance Committee.

Phil Bellas, Trust Secretary

Background Papers: Highlighted in the report

Tees, Esk and Wear Valleys NHS Foundation Trust

Schedule of Board Business (Oct 2017 - December 2018)

					2017			2017										
	Meeting Date	**Lead**	**Strategic Goal**	**Risk Ref:**	**25-Oct**	**29-Nov**	**20-Dec Special**	**30-Jan**	**27-Feb**	**27-Mar**	**24-Apr**	**22-May (poss. 29 May dep. on the ARM)**	**03-Jul**	**19-Jul**	**25-Sep**	**30-Oct**	**27-Nov**	**18-Dec Special**
	Venue				**York**	**WP**	**WP**	**Durham**	**WP**	**WP**	**Harrogate**	**WP**	**Middlesbrough/WP**	**WP**	**WP**	**York**	**WP**	**WP**
1	**Standard Items**																	
	Apologies for Absence		-		√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Minutes		-		√	√		√	√	√	√	√	√	√	√	√	√	
	Board Action Logs (Public and Confidential)	PB	All	-	√	√		√	√	√	√	√	√	√	√	√	√	
	Declarations of Interest	-	-		√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Chairman's Report	Chair	All		√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Chief Executive's Report	CM	All	295, 364, 366	√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Governor Issues	Board	All		√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Reportable Issues Log	CM	5	366, 369	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2	**Quality**																	
	Locality Briefings	DoOps	All	296, 365, 366, 367, 368, 371,	**Y&S**			**CD&D**		**Forensic**	**NY**		**Tees**			**Y&S**		
	Quality Assurance Committee Report	Cttee Chair/ EM	1, 2 & 5	175, 179, 296, 366, 367, 368, 369, 371, 372, 377	√	√	√	-	√	√	√	√	√	√	√	√	√	√
	"Hard Truths" Nurse Staffing Report	EM	1, 2, 3 & 5	175, 179, 182, 296, 367, 369	√	√	*	6 monthly	√	√	√	√	√	6 monthly	√	√	√	*
	MHLC Report	Cttee Chair/ EM	1 & 2	179, 364, 366, 367, 369		√			√			√			√		√	
	Progress report on Intensive Team Support	SP	1, 2, 3 & 5	296					√						√			
	Progress report on the Composite Staff Action Plan	DL	2, 3 & 5	182		√						√					√	
	Report on implementation of phase 3 of the County Durham Rehabilitation Strategy	BK	All	179, 364, 365		√												
	Guardian of Safe Working Report	NL	2, 3 & 5	179, 296, 367, 369, 377	√			√			√			√		√		
	Summary report on NHS England Independent Investigations (Investigation Reports will also be reported as and when received from NHS England)	EM	1, 2 & 5	366			√						(Included in the Annual Patient Safety Report)					√
	Staff Survey	DL	2, 3 & 5	175, 182, 377						Results								
	Freedom to Speak Up Guardian Report	DL	2 & 3	179, 296, 367	√					√					√			
	Reports on Learning From Deaths	EM	2 & 5	179, 366, 367, 369	√			√			√			√		√		
	Annual Patient Safety Report (via QuAC)	EM	1, 2 & 5	175, 179, 366, 367, 369									√					
	Progress Report on the Recruitment and Retention Action Plan	DL	1, 3 & 5	182, 296, 367		√												
	Annual Report on Temporary Staffing Service	DL	1 & 3	296, 367	√											√		
	Update report on C&YPS	BK	All	179, 364, 367, 369			√											
	Feedback on the "Making a Difference Together" Priority consultation	BK	1, 2 & 3	182				√										
	Workforce Race Equality Scheme update (via QuAC report)	DL	All	182, 366, 367, 369	√			√			√			√		√		
	Equality Delivery System (EDS) 2	DL	All	179, 182, 366, 367, 369				√										
	Directors' Visits Annual Report	BK	All	179, 189, 296, 365										√				

Tees, Esk and Wear Valleys NHS Foundation Trust

Schedule of Board Business (Oct 2017 - December 2018)

					2017			2017										
	Meeting Date	**Lead**	**Strategic Goal**	**Risk Ref:**	**25-Oct**	**29-Nov**	**20-Dec Special**	**30-Jan**	**27-Feb**	**27-Mar**	**24-Apr**	**22-May (poss. 29 May dep. on the ARM)**	**03-Jul**	**19-Jul**	**25-Sep**	**30-Oct**	**27-Nov**	**18-Dec Special**
3	**Strategic**																	
	Budget/Capital Programme	DK	5	295, 365, 366, 367, 369, 371						√								
	Business/NHSI Plan	SP	All	179, 182, 364, 365, 366, 367, 369, 371,	√	√			√	√						√		
	IiP Re-accreditation	DL	2, 3 ,4 & 5	182				√										
	IT Strategy (TBC) (via RC)	DK	2 & 5	366, 367														
	Workforce Strategy (via RC)	DL	3 & 5	182, 367				√										
	CRES update	DK	All	296, 367, 369	√													
	Programme Business Cases/Visioning Documents (TBC)	TBC	All	179, 189, 364, 367														
4	**Services Developments/Investments**																	
	Tender submission approvals (as and when required)	SP/DK	All	364														
	Business Cases (via RC) (indicative dates):																	
	- Y&S Inpatient Development	BK/DK	All	179, 364, 365, 368, 371					FBC									
	- Y&S CMHT (Worsley)	BK/DK	All	179, 364, 365, 368, 371	OBC								FBC					
	- H&R CMHT (TBC)	BK/DK	All	179, 364, 365, 371														
	- CAMHS PICU (TBC)	BK/DK	All	179, 364, 365														
	- Y&S CAMHS (Limetrees) (TBC)	BK/DK	All	179, 368, 365														
	- Research Partnership with York University (TBC)	CM	2, 4 & 5	364														
	Update report on Forensic Services NMC	BK/SP	1, 4 & 5	179, 364, 367, 371,												√		
	Update report on CAMHS NMC	BK/SP	1, 4 & 5	179, 364, 367, 371									√					
	Feedback on the Harrogate Engagement	BK/SP	2, 4 & 5	179, 364, 371		√												
5	**Performance**																	
	Performance Dashboard (Reports poss. to be tabled in August and December)	SP	All	179, 366, 368, 369, 370, 371	√	√	*	√	√	√	√	√	√	√	√	√	√	*
	Finance Report	DK	5	366, 369	√ (x2)	√	*	√ (x2)	√	√	√ (x2)	√	√	√ (x2)	√	√ (x2)	√	*
	Strategic Direction Performance Report	SP	All	179, 189, 364, 365, 366, 369, 370, 367		√			√			√			√		√	
6	**Governance**																	
	Register of Directors' Interests	PB	5	366, 369											√			
	Board Business Cycle	PB	5	366											√			
	Annual Review of Board Committee's terms of reference	PB	5	366			√								√			
	NED Committee Membership Review	Chair	5	366											√			
	NHSI Governance Certificates (via AC)	PB	5	366, 369								√						
	Annual Report (including the Annual Governance Statement and Quality Report/Account) and Accounts together with the External Auditors' Reports (via AC)	DK	5	366, 369								√						

Tees, Esk and Wear Valleys NHS Foundation Trust

Schedule of Board Business (Oct 2017 - December 2018)

					2017			2017										
	Meeting Date	**Lead**	**Strategic Goal**	**Risk Ref:**	**25-Oct**	**29-Nov**	**20-Dec Special**	**30-Jan**	**27-Feb**	**27-Mar**	**24-Apr**	**22-May (poss. 29 May dep. on the ARM)**	**03-Jul**	**19-Jul**	**25-Sep**	**30-Oct**	**27-Nov**	**18-Dec Special**
	Charitable Funds Annual Report and Accounts (via AC)	DK	5									√						
	Integrated Assurance Framework and Risk Register	PB	All	366	Summary	Summary	Full	Summary	Summary	Summary	Summary	Summary	Review	Full	Summary	Summary	Summary	Full
	Single Oversight Framework Report	PB	All	366, 369	√			√			√			√		√		
	Approval of IG Toolkit Submission	DK	1, 2, 3 & 5	189, 366, 369						√								
	Annual Report on Research and Development	NL	All	364		√											√	
	Annual Report of the Responsible Officer for Medical Revalidation	NL	2, 3 & 5	296, 366											√			
	Medical Education Annual Report	NL	All	364, 377	√											√		
	Annual Claims Report	EM	5	366									√					
	Equality Act Data Publication	DL	1,2 4 & 5	369							√							
	Core standards on emergency preparedness, resilience and response (via AC)	BK	5	364, 365, 366, 369											√			
	Integrated Governance Framework (via AC)	PB	5	366			√											√
	Annual Board Performance Report	PB	5	366										√				
7	**Other Standing Committee Reports**																	
	Audit Committee Report	Cttee Chair	All	179, 182, 189, 366, 369, 370, 419	√			√			√	Verbal		√		√		
	Resources Report (additional reports dependent on provisional meetings)	Cttee Chair/ DK	All	189, 296, 364, 367, 370, 377				√			√		√		√			
	Commercial Oversight Committee	Chair	5	366				√		√			√		√			
	Board Nomination and Remuneration Committee Report (as and when required)	Chair	5	366														
8	**For Information**																	
	Register of Seals (as and when required)	CM	5	366	√	√		√	√	√	√	√	√	√	√	√	√	
	Policies and Procedures	CM	All	366	√	√		√	√	√	√	√	√	√	√	√	√	

(Note:* indicates report to be circulated under separate cover outside the meeting)

Draft Board Seminar Programme

Annex 2

October 2017 - December 2018

Month	Topic	Lead
3 & 4/10/2017	*Business Planning Event*	*CM/SP*
14/11/2017	SDG Briefing - Forensic	Dr. Khouja
	Risk Management	Audit One
19/12/2017	Equality and Diversity	DL
	Criminal Investigations in Health and Social Care	EM (Briefing to be provided by DAC Beachcroft solicitors)
09/01/2018	*Business Planning Event*	CM/SP
13/03/2018	Strategic Briefing on Safeguarding	EM
	Briefing from the C&YPS SDG	Dr. Davies
10/04/2018	Briefing from the Forensic Services SDG	Dr. Khouja
	TBC	-
08/05/2018	Briefing from the MHSOP SDG	Dr. Olusoga
	TBC	-
10/07/2018	Reflections from the new Medical Director	TBC
	TBC	-
11/09/2018	Briefing from the AMH SDG	Dr. Wise
	TBC	-
02/10/2018 - 03/10/2018	*Board Business Planning Event*	*CM/SP*
13/11/2018	Update on KPO	Dr. Briel
	TBC	-
18/12/2018	Briefing from the LD SDG	Dr. Passmore
	TBC	-

Additional Topics to be scheduled:

- Update on the PPCS Programme
- Briefing on the purposefulness and productive inpatient wards programme
- Briefing on the digital transformation agenda

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th September 2017**
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:	**26th September 2017**
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 has been reformatted in response to revised guidance on the management of conflicts of interest published by NHS England earlier in the year.

3.3 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 of Review: September 2017

Note: 1 - This Register has been established in accordance with the National Health Service Act 2006 (as amended)
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)
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
Note: 6 - The Register should be a record of interests over time and additional lines should be inserted as required

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	Non-Executive Director **(B)**	**Yes** Director of Hugh Griffiths Associate 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)**	**Yes** Area Manager, Northern for the Royal British Legion	**None**	**Yes** Volunteer with the Great North Air Ambulance Service	**None**
David Jennings	Non-Executive Director **(B)**	**Yes** Financial Services Manager and Deputy Section 151 Officer (Chief Finance Officer) at Redcar and Cleveland Borough Council Pensioner Audit Commission Membership of Local Government Pension Scheme Co-opted Member to the Board of the Bernicia Housing Group	**Yes** Independent Appointed Member: Northumbria University Audit Committee	**Yes** Member of the Pathways Special School Interim Executive Board	**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**	**Yes** Northumbria University - Associate	**None**	**None**

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**
Brent Kilmurray	Chief Operating Officer **(B)**	**Yes** Director of Putney North Limited	**None**	**None**	**Yes** Wife employed as a Clinical Psychologist by Northumberland, Tyne and Wear NHS Foundation Trust.
Drew Kendall	Interim Director of Finance and Information **(B)**	**None**	**Yes** Member of HFMA mental health finance group	**None**	**None**
Nick Land	Medical Director **(B)**	**None**	**Yes** Chairman of the Psychiatric Workforce Planning Group (a sub-committee of the School of Psychiatry of the Northern Deanery) Member of the British Medical Association Member of the Royal College of Psychiatrists	**Yes** Member of the General Synod of the Church of England Director of Board of Finance for Diocese of York Non-Executive for Areté multi-school academy	**None**
Elizabeth Moody	Director of Nursing and Governance **(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**	**None**	**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. 18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th September 2017**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

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

Executive Summary:

This report provides information on the use of the Trust Seal as required under Standing Order 15.6.

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**26th September 2017**
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
310	7.8.17	Deed of standstill in relation to Roseberry Park	Colin Martin, Chief Executive Phil Bellas, Trust Secretary

4. IMPLICATIONS:

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

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

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

7.1 The Board is asked to receive and note this report.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution
Seals Register

ITEM NO. 19

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26 September 2017**
TITLE:	**Policies Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

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

Executive Summary:

The policy paper contains the following information:

1 policy that has had minor amendments:

- CORP-0001-v5 Governance of Policies

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meeting held on 06 September 2017

DATE:	**26 September 2017**
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 and procedures.

2.3 Each policy and procedure 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 have had minor amendments:

CORP-0001-v5 Governance of Policies
Review date: 18 January 2020

This has had minor amendment to reflect the responsibility for ensuring policies and procedures reflect changes in the evidence base.

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 meeting on 07 June 2017 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